SUBJECT: Chronic Pain Management

Effective Date: 11/17/2017

Policy: BHH recognizes the need for appropriate treatment of chronic pain. Providers will be knowledgeable about best clinical practices in regard to prescribing opioids for chronic pain, be aware of the associated risks, and aim to provide appropriate treatment of pain, recognizing non-treatment, inadequate treatment, overtreatment, and continued use of ineffective treatments as inappropriate. Providers will comply with federal and state laws and regulations when prescribing opioid analgesics. The goal is the management of the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors, and mitigating risk of misuse, abuse, diversion and overdose.

Procedure:

1. Understanding Pain
    a. In order to cautiously prescribe opioids, providers must understand the relevant pharmacologic and clinical issues in the use of such analgesics, and carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient.

2. Patient Evaluation and Risk Stratification
    a. The medical record should document the presence of one or more recognized medical indications for prescribing an opioid analgesic and reflect an appropriately detailed patient evaluation. Such an evaluation should be completed before a decision is made as to whether to prescribe an opioid analgesic. The nature and extent of the evaluation depends on the type of pain and the context in which it occurs.
    b. Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse also should be part of the initial evaluation and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics.
    c. All patients should be screened for depression and other mental health disorders, as part of risk evaluation. Patients with untreated depression and other mental health problems are at increased risk for misuse or abuse of controlled medications, including addiction, as well as overdose.
    d. Treatment of a patient who has a history of substance use disorder should, if possible, involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up as needed). Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program or alternatives are established such as co-management with an addiction professional.
    e. Information provided by the patient is a necessary but insufficient part of the evaluation process. Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers, if possible.
    f. The Montana Prescription Drug Registry (MPDR) https://app.mt.gov/pdr should be consulted to determine whether the patient is receiving prescriptions from any other physicians, and the results obtained from the MPDR should be documented in the patient record.

3. Development of a Treatment Plan and Goals
    a. The goals of pain treatment include reasonably attainable improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of

medications.

b. The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies. The treatment plan should contain information supporting the selection of therapies, both pharmacologic (including medications other than opioids) and nonpharmacologic. It also should specify the objectives that will be used to evaluate treatment progress, such as relief of pain and improved physical and psychosocial function.
c. The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered.

4. Informed Consent and Treatment Agreement
    a. The decision to initiate opioid therapy should be a shared decision between the provider and the patient. The provider should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient, with persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity.
    b. If opioids are prescribed, the patient (and possibly family members) should be counseled on safe ways to store and dispose of medications.
    c. Informed consent will be documented and signed by the provider and the patient and maintained in the medical record, with a copy given to the patient.
    d. A Contract for Controlled Medications (linked document) will be completed and signed by the provider and the patient and maintained in the medical record, with a copy given to the patient.

5. Initiating an Opioid Trial
    a. Generally, safer alternative treatments should be considered before initiating opioid therapy for chronic, non-malignant pain. Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with specified evaluation points.
    b. The provider should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety.
    c. When initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient and titrate to effect. It is generally suggested to begin opioid therapy with a short acting opioid and rotate to a long acting/extended release if indicated.
    d. A decision to continue opioid therapy beyond the trial period should reflect a careful evaluation of benefits versus adverse events and/or potential risks.

6. Ongoing Monitoring and Adapting the Treatment Plan
    a. The provider should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of function. When possible, collateral information about the patient's response to opioid therapy should be obtained from family members or other close contacts, and the MPDR.
    b. The patient should be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled less frequently. (However, if the patient is seen less

than monthly and an opioid is prescribed, arrangements must be made for the patient to obtain a refill or new prescription when needed.)

c. At each visit, the results of chronic opioid therapy should be monitored by assessing what have been called the "5As" of chronic pain management; these involve a determination of whether the patient is experiencing a reduction in pain (Analgesia), has demonstrated an improvement in level of function (Activity), whether there are significant Adverse effects, whether there is evidence of Aberrant substance-related behaviors, and mood of the individual (Affect).
d. Continuation, modification or termination of opioid therapy for pain should be contingent on the provider's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as overdose or diversion.

7. Periodic Drug Testing
    a. Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs.
    b. Initial testing may be done using class-specific immunoassay drug panels (point-of-care or laboratory-based), which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug. If necessary, this can be followed up with a more specific technique, such as gas chromotography/ mass spectrometry (GC/MS) or other chromatographic tests to confirm the presence or absence of a specific drug or its metabolites. In drug testing in a pain practice, it is important to identify the specific drug not just the class of the drug.
    c. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist.
    d. Test results that suggest opioid misuse should be discussed with the patient. It is helpful to approach such a discussion in a positive, supportive fashion, so as to strengthen the provider-patient relationship and encourage healthy behaviors (as well as behavioral change where that is needed). Both the test results and subsequent discussion with the patient should be documented in the medical record.
    e. Periodic pill counting is also a useful strategy to confirm medication adherence and to minimize diversion (e.g., selling, sharing or giving away medications).
    f. Consulting the MPDR during ongoing use is highly recommended. This can be useful in monitoring compliance with the treatment agreement as well as identifying individuals obtaining controlled substances from multiple prescribers.
    g. Evidence of misuse of prescribed opioids demands prompt intervention by the provider. Documented drug diversion or prescription forgery, obvious impairment, and abusive or assaultive behaviors require a firm, immediate response.

8. Consultation and Referral
    a. The treating provider should seek a consultation with, or refer the patient to, a pain, psychiatry, addiction or mental health specialist as needed.

9. Discontinuing Opioid Therapy
    a. Throughout the course of opioid therapy, the provider and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate.

b. If opioid therapy is continued, the treatment plan may need to be adjusted to reflect the patient's changing physical status and needs, as well as to support safe and appropriate medication use.
c. Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, failure to improve the patient's quality of life despite reasonable titration, deteriorating function, or significant aberrant medication use.
d. If opioid therapy is discontinued, the patient who has become physically dependent should be provided with a safely structured tapering regimen. Withdrawal can be managed either by the prescribing provider or by referring the patient to an addiction specialist. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate.
e. Additionally, providers should not continue opioid treatment unless the patient has received a benefit, including demonstrated functional improvement.

10. Medical Records
    a. Every provider who treats patients for chronic pain must maintain accurate and complete medical records. Information that should appear in the medical record includes the following:
        i. Copies of the Contract for Controlled Medications (scanned into the Media Tab in Epic) with notation in the Problem List for continuity of care.
        ii. The patient's medical history.
        iii. Results of the physical examination and all laboratory tests.
        iv. Results of the risk assessment, including results of any screening instruments used.
        v. A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity).
        vi. Instructions to the patient, including discussions of risks and benefits with the patient and any significant others.
        vii. Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement.
        viii. Notes on evaluations by and consultations with specialists.
        ix. Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors.
    b. The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record.
    c. The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed.

11. Compliance with Controlled Substance Laws and Regulations
    a. To prescribe, dispense or administer controlled substances, the provider must be registered with the DEA, licensed by the state in which he or she practices, and comply with applicable federal and state regulations.

References:

Federation of State Medical Boards Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain, July 2013
http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/FSMB_pain_policy_july2013.pdf

Opioid Risk Tool, 2005
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf

Screener and Opioid Assessment for Patients with Pain, 2008
http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf

Common Elements in Guidelines for Prescribing Opioids for Chronic Pain, 2013
https://www.cdc.gov/drugoverdose/pdf/common_elements_in_guidelines_for_prescribing_opioids-a.pdf

Consent for Chronic Opioid Therapy, American Academy of Pain Medicine, 2013
http://www.painmed.org/files/consent-for-chronic-opioid-therapy.pdf

CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm