Assessment and Treatment of Chronic Pain

Tools and Procedures at Peace Health
• I have nothing to disclose
Goals of this presentation

• Brief overview of chronic pain as a clinical problem

• Review standard of care for evaluation and treatment of chronic pain

• Review PHMG tools and process recommendations
Chronic Pain: Definition

• Pain: “An unpleasant sensory and emotional experience associated with actual or potential tissue damage.”

• Chronic pain: is pain that lasts beyond normal tissue healing time—about 3 months

• Chronic cancer pain is differentiated from other chronic pain, for treatment purposes
• 37% of the U.S. population has some type of chronic pain.

• Comparison: Diabetes 8% *(diagnosed and undiagnosed)*

• 20% of American adults report pain that disrupts sleep

• Annual U.S. cost est. **$560 billion to $635 billion** *(costs of care + disability days +lost wages and productivity)*

• **Of those with chronic pain:**
  
  • 59% affected report reduced enjoyment of life.
  
  • 77% report feeling depressed
• **Low back pain**: 27% of chronic pain - the leading cause of disability in Americans under 45 years old.

• **Severe headache or migraine**: 15% of chronic pain - the most common pain cause of lost productive time

• **Neck pain**: 15% of chronic pain

• **Facial pain**: 4% of chronic pain

• **Fibromyalgia**: 2% of population - 5% of chronic pain
• Biggest dis-satisfier of clinicians, staff 😞
• Providers are reluctant to accept patients with chronic pain, reducing patient access for those most suffering and the underserved 😞
• 71% of Americans feel that pain research and management should be a top, or high, medical priority 😞
• Prescription drugs are the second-most abused category of drugs in the US, after marijuana. 😞
• Nearly half of all drug related deaths are from prescription pain relievers 😞

• It’s a Problem!!
PHMG Chronic Pain Resources:

1. Peace Health Chronic Pain Website

2. Language of Caring Training
   http://teams/site/LOC-Sys/PHOR/SitePages/Home.aspx
Language of Caring Training

• 9 module training course, available on-line and live
• Continuous training for all providers and caregivers

Communicating caring is central when addressing chronic pain;
Particularly if the treatment desired is not medically appropriate, to avoid unhelpful interactions
Click on Quality and Safety

Peace Health Chronic Pain Website:

The Caregiver

We heard you. You asked for an easier way to get news and information. It's here!

Your new website, The Caregiver, makes it easy to get PeaceHealth news from anywhere, including your smartphone and tablet. And there's a section on the site dedicated to PHMG news.

- Welcome to The Caregiver
- How-to guide
- Frequently asked questions

Last current community NOW Live on Epic

Clinic caregivers in Vancouver went live on Epic ambulatory over the weekend, March 1. The next rollout of Epic ambulatory is slated for August 1, 2014 in Sedro-Woolley and specialty practices elsewhere in the system.

Work on the Epic Enterprise project (Epic in the hospitals) is also well under way. Expect to see and hear more in the coming months. In the meantime, visit the Care Transformation blog for more information.

PatientConnection enrollment contest!

In February, PHMG launched a contest to build enrollment in PatientConnection. According to Dr. Karen Sharpe, we’re seeing steady increase in the number of patient activations among our primary care clinics. In particular, we are excited to see the rapid growth in the Oregon West Network.

Stephanie Drews, Santa Clara clinic manager, recently reported 166 activations over a 10-day span. Excellent progress!

Our contest closes June 30 and our goal is to have 50,000 patients activated in the system. There are currently 21,629 total activations as of Feb. 27.

For more information on the contest and latest enrollment figures, visit the PatientConnection resources page.
PHMG Quality and Safety

Welcome to the PHMG Quality and Safety SharePoint site!

The purpose of this site is to keep providers and staff informed and up-to-date about the FY14 Priorities and Work of PHMG and the Quality and Safety Committee. Here you will also find information about chronic pain management, the Measure Up, Pressure Down hypertension campaign, how to use your DRP recognition, ABIM Maintenance of Certification credit and much, much more.

We welcome your suggestions on how to improve this new site and what information you would find “Contact Us” link at the top of the page and send us a message.

FY14 Priorities and Current Work

- **Readmissions**: Reducing the all-cause readmission rate.
- **Performance Metrics**: Working with specialty collaboratives to develop and report reliable, core measures for specialty providers.
- **Pay for Value**: Quality performance expectation measures for compensation.
- **Transitions of Care**: Development of Care Coordination Agreements for high-volume and/or high-referral to improve quality of care and enhance the patient experience.
- **Compliance/Risk**: Selection of Epic measures and reporting mechanism to ensure successful participation in the Physician Quality Reporting System (PQRS).
- **Clinical Guidelines/Algorithms**: Adoption of clinical guidelines and development of clinical algorithms to support provider decision support.

Read About It!
Chronic Pain and Narcotic Management

Optimal treatment of patients with chronic pain presents a number of challenges for physicians and other health care providers in primary care. Issues range from the scientific basis for efficacy (safe and appropriate use), to health care providers’ fears of legislative reprimand for indiscriminate prescribing and varying state regulations across our communities. Among the most significant issues is the abuse and misuse of narcotics (opioids), their use has increased substantially since 1990, along with a rising mortality rate from aberrant behaviors. Primary care clinicians and specialists alike require evidence-based recommendations for the safe and appropriate use of narcotics in treating this large and increasingly growing patient population.

As a result, PHMG has developed an algorithm - Narcotic Management for Patients with Chronic Non-Malignant Pain - supported by a provider toolbox. The foundation for this material is based on best practices from our communities and was developed by the Clinical Guidelines and Protocols Workgroup chaired by PHMG Medical Director of Primary Care, Karen Sharpe MD.

PHMG gratefully extends that recognition to: Jill Chaplin, Jon Dykstra, Ralph Fillingame, Peter Rice, Ron Shearer, and Matt Williams.

View the Provider Toolkit

Fig 1. Spectrum of "suitedness" of chronic opioid therapy for specific medical conditions.
<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Modified</th>
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<td>6/30/2014 1:07 PM</td>
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<td>Chronic Pain Questionnaire</td>
<td>7/17/2013 9:14 AM</td>
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<td>Complete Pain Treatment Program</td>
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<td></td>
<td>Tapering Narcotics Guidelines</td>
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<td>Termination of Patient Relationship Policy</td>
<td>7/17/2013 9:14 AM</td>
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<tr>
<td></td>
<td>Urine Drug Screen</td>
<td>7/17/2013 9:14 AM</td>
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Narcotic Management for Patients with Chronic Non-Malignant Pain*

*Pain not related to cancer which persists beyond the usual course of an acute disease or the healing of an injury. It may or may not be associated with a pathologic process (acute or chronic) that causes intermittent pain over months or years. Acute pain is described as something which is "time-limited, often <3-months in duration and usually <6-months (WAC 246.919-852).

The history should include:
2. Any comorbidities (risk screening).
4. A review of pain-related issues including:
   - Nature and intensity of the pain
   - Effect of pain on physical and psychological function
5. List of the patient's medications, including their indications, date, type, dosage, and quantity prescribed.

The assessment should include:
1. A physical examination.
3. The presence of one or more indications for the use of pain medications.

Documentation should include:
1. Diagnosis.
2. Treatment plan.
3. Medications prescribed.
4. Instructions to the patient.

OPIOID DOSE CALCULATOR
Opioid dose conversion to the morphine equivalent dose (MED) (Note: reduce dose by 25% when converting from one opioid to another).
CLICK IN THIS BOX TO ACCESS THE CALCULATOR

Patient has pain

Initial History and Assessment

Is pain chronic and non-malignant?

NO

Out of scope

YES

Is there a correctable cause of pain?

YES

Specialty Care Providers (pain, sleep, addiction, psychiatry) or other providers (Click box for Community Information)

NO

Trial of narcotic medication indicated

NO

Out of scope

YES

MS equivalent <10 mg/day or hospice patient or less than 3 months duration?

YES

May opt patient out of process if clinically appropriate

NO

Determine risk level for abuse, misuse, or addiction

ORT (to assess baseline risk), PHQ-9, STOP BANG, UDS PetProtect Pain Management Panel 36286, Medical Records Review (Past behavior is best predictor of future behavior)

State Prescribing Policies (select state)

State Prescription Drug Monitoring Program Instructions (Oregon) (click for Tool Box)

OR Drug Monitoring Program (click box)

WA Drug Monitoring Program (click box)

AK Drug Monitoring Program (click box)
High Risk
- ORT Score 8+
- Active Psychiatric Illness
- STOP BANG 3+
- UDS inconsistent with Rx/illicit drug use
- Active Alcoholism
- Benzodiazepine Rx
- Recurrent Aberrant Behaviors
- Misrepresentation of History
- Narcotics >120 mg/day MS equivalent

Initiate Specialist Referral (pain, sleep, addiction, psychiatry)
Consider Case Management Referral (if available)

Moderate Risk
- ORT Score 4-7
- 1-2 Episodes of Aberrancy

Consider Specialist Referral (pain, sleep, addiction, psychiatry - Click box for Community Information) and/or Case Management Referral (if available)

Low Risk
- ORT Score 0-3
- No Aberrancy

Narcotic Pain Medicine Agreement (click for Tool Box)

Initial Appointment
- Maximize non-narcotic management strategies
- Patient education
- Care plan developed (update annually)
- UDS PiProtect Pain Management Panel 36286
- State Prescription Drug Monitoring Program (Review and track patients receiving RX outside of Network)

Follow-Up UDS and Risk Reassessment Visit Schedule
- High Risk Visit: Q1-3 months (Randomized UDS PiProtect Pain Management Panel 36286 2-4/yr)
- Moderate Risk Visit: Q3-6 months (Randomized UDS PiProtect Pain Management Panel 36286 1-2/yr)
- Low Risk Visit: Q6-12 months (Randomized UDS PiProtect Pain Management Panel 36286 1/yr)

Patient Reassessment
1. Administer SOAPP-R (to assess ongoing risk)
2. Structured Assessment
   - Analgesia (pain level)
   - Activities (functional goals and level)
   - Adverse effects
   - Aberrancy
3. Re-Evaluation of Narcotic Management Plan
   - Continue without change.
   - Adjust the dose regimen.
   - Add/Replace with a long-acting agent.
   - Rotate to another narcotic.
   - Discontinue narcotic therapy.
4. Consider Alternative Treatments

Tapering Narcotics Guidelines
Patient Reassessment
1. Administer SOAPP-R (to assess ongoing risk)
2. Structured Assessment
   - Analgesia (pain level)
   - Activities (functional goals and level)
   - Adverse effects
   - Aberrancy
3. Re-Evaluation of Narcotic Management Plan
   - Continue without change.
   - Adjust the dose regimen.
   - Add/Replace with a long-acting agent.
   - Rotate to another narcotic.
   - Discontinue narcotic therapy.
4. Consider Alternative Treatments
   - Physical therapy/acupuncture
   - Pain psychology
   - Nutrition/Exercise
   - Elimination diet
   - Neuroleptics/Tricyclics
5. Pill count/State Rx Drug Monitoring Program (if needed)

Click box for PHMG System Policy

YES

Dismissal Indicated?

NO

Click box for definition of aberrant behavior and aberrancy interventions

YES

Aberrant patient behavior?

NO

Specialists
(pain, sleep, addiction, psychiatry)
or other providers
(Click box for Community Information)

NO (CONSIDER REFERRAL)

Patient Responding to Tx per Structured Assessment?

YES

Continue Tx; patient monitoring and risk assessment

Algorithm last updated: 6.12.13
PHMG Quality and Safety Committee approved: 7.24.13
PHMG Pain Treatment Algorithm:

Addresses:

• Evaluation
• Treatment
• Monitoring
• Referral
• Detecting and addressing aberrancy
• Dismissing patients
These sources were used in developing these guidelines:

- **Current practice:** PHMG regions, several other large private and government groups
- **Pain specialists in Eugene area**
- **State and Federal Laws**
- **Published standards, guidelines, and resources**
- **Federated State Medical Board Guidelines**
- **Oregon Medical Board published statements**
- **Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain- Washington State Agency Medical Directors Group**
History for evaluation of chronic pain includes:

- **Current Symptoms**: location, quality, severity, timing of the pain; modifying factors, related symptoms
- **History of the Pain**: onset, duration, diagnosis, treatments and their efficacy, past providers
- **General Medical History**
PHMG Chronic Pain Tool

• A 3 page questionnaire, incorporating several standardized screening tools
• Used at every pain visit, to assess current status
• The tool is kept in exam rooms and given to the patient by staff to complete prior to provider evaluation.
• **Includes the Brief Pain Questionnaire, which reviews current symptoms:** location, quality, severity, effects and side effects of medication
• The key to the tool is in the website and in exam rooms.
Patient to complete this page - Provider review with patient

Pain: Brief Pain Questionnaire

1.) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.
Circle: burning  aching  stabbing  pounding  other: ____________

2.) Please RATE YOUR PAIN by circling the number that best describes your pain:

<table>
<thead>
<tr>
<th>0 = No Pain</th>
<th>Mild Pain</th>
<th>Severe Pain</th>
<th>10 = Can’t talk/screaming</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At its WORST in the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10
At its LEAST in the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10
On the AVERAGE: 0 1 2 3 4 5 6 7 8 9 10

3.) What treatments, and what medications, are you receiving for your pain? ____________

4.) Any side effects? (circle) None  Tiredness  Constipation  Nausea  Other: ____________

How likely are you to doze or fall asleep in these situations? Your chance of Dozing or Sleeping:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Never</th>
<th>Slight</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being a passenger in a motor vehicle for an hour or more</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Lying down in the afternoon</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sitting quietly after lunch (no alcohol)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Stopped for a few minutes in traffic while driving</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total (doctor add up columns):

Grand total (doctor add columns together) = Grand total x 5 = Global function score (5-100%)
**Patient to complete this page - Provider review with patient**

<table>
<thead>
<tr>
<th></th>
<th>How much?</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
<tr>
<td><strong>Street drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
</tbody>
</table>

**PHQ-9:** Circle the number that best describes your situation:

<table>
<thead>
<tr>
<th>In the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not At all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little or no interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling sad about yourself, or that you are a failure or have let your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*Doctor add up columns, then add numbers together for Total PHQ9 score = *

If your score is greater than 0, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle)

- Not difficult
- Somewhat difficult
- Very difficult
- Extremely difficult

**Med team to use this page**

**Key to Patient Questionnaire:**

- Brief Pain Inventory: Average daily pain - compare to past scores.
  - If pain not improving by 30% with narcotics, they are not helpful; consider discontinuing.
  - Pain may not go down if function increases; increased activity can increase pain back to baseline.
- FAQS: Compare to past scores; no improvement with treatment = may be ineffective; consider changing.
  - Global score 40-60% = typical, if below, consider inaccuracy vs. very low function.
  - If above, pain may be non-serious.
  - Discordance between reported function and observable function = psych factors or secondary gain.
- Epworth Scale: 0-8 = normal / average; 9-24 = abnormal. High risk over-sedation and/or sleep apnea.
- PHQ-9 Depression score: 0-4 = mild; 5-14 = moderate; 15-19 = moderately severe; 20-27 = severe depression.
  - Consider counseling for any depression, consider medication for moderate; medication indicated for moderately severe or severe.
  - Risk: SOAPP-R score: 22 or greater = high risk for drug misuse and abuse. Consider avoiding narcotics, or monitoring monthly rather than every 3 months. Note: Score is sensitive, but not specific. The SOAPP-R is better at identification of high-risk rather than low-risk patients.
*General Medical History is because:

- “Be cautious when using opioids with conditions that may potentiate opioid adverse effects (COPD, CHF, sleep apnea, EtOH or substance abuse, elderly, renal or hepatic dysfunction.)”
- “Do not combine opioids with sedative-hypnotics, benzodiazepines, or barbiturates unless there is a specific medical or psychiatric indication for the combination.”
Review the Records

• Treatment prior to reviewing records may be unsafe in many cases.
• Decision to treat prior to record review is per provider judgment, not system policy.
• New patient coordinators inform patients they may not be able to be prescribed opioids without medical record transfer first, (when the patient lets them know this is the reason for the visit).
Other history sources: State prescription drug monitoring program

- Can be checked at first visit, or any time thereafter
- Links for each state are included in the pain algorithm
- Requires provider to establish an account and password
- Review can now be delegated to staff
Evaluation of Function includes assessment of:

- Current function
- Effect of pain on function
- Confirmed improvement in function with treatment
Treatment must be aimed towards improving function, not just reducing pain.

- Function may improve without improvement in pain, if pain control increases activity. The improved function alone may demonstrate adequate treatment.

- Improved pain but reduction in function may represent treatment failure, and may be an indication to reduce or stop opioids.
• Most groups use a standardized screening tool for evaluation of function
• PHMG uses the FAQ5, in the PHMG Pain tool
• Discussion of activities, and observation are also evaluation of function.
Psychiatric illness is a risk factor for chronic pain, and some are risks for misuse of opioid medication.

Evaluation should include:

- Psychiatric diagnoses
- Current psychiatric symptoms: depression, anxiety, other
• Some groups use a standardized screening tool for evaluation of current psychiatric symptoms
• PHMG uses the PHQ9.
• GAD 7 may also be helpful.
• Treatment of psychiatric symptoms often reduces pain
Evaluation of narcotic use risk includes:

- **Standardized screening tools** - PHMG uses ORT for baseline risk, and SOAPP-R or COMM for current risk.

- **Review of history of aberrant behaviors** - from old or current records. “The best predictor of future behavior is past behavior.”

- **Urine drug screens** - done at least yearly, more often if higher risk.

- **Random pill counts** - may also be useful.
Screening tools:

ORT: assesses history of alcohol and substance abuse and sexual abuse to predict risk of misuse of medications.

COMM: asks about current misuse, current mood and cognitive symptoms

SOAPP-R asks a combination of past and current status questions
• Pain related physical exam

(Yes, that’s all!)
### CHRONIC PAIN TREATMENT PLAN OPTIONS

<table>
<thead>
<tr>
<th>ALL TREATMENT OPTIONS (check/circle)</th>
<th>HIGHER COST TREATMENT OPTIONS (check/circle)</th>
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<tbody>
<tr>
<td><strong>EXERCISE:</strong></td>
<td><strong>EXERCISE:</strong></td>
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<tr>
<td>Aerobic</td>
<td>Tai Chi</td>
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<tr>
<td>Core Strengthening</td>
<td>Water Exercise</td>
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<td>Stretching</td>
<td>Physical Therapy</td>
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<tr>
<td>Yoga</td>
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<tr>
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<td><strong>SPIRITUAL:</strong></td>
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<tr>
<td>Meditation</td>
<td>Support Group</td>
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<tr>
<td>Prayer/Religious groups</td>
<td>Counseling</td>
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<td>Relaxation Exercises</td>
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<td><strong>ALTERNATIVE:</strong></td>
<td><strong>ALTERNATIVE:</strong></td>
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<tr>
<td>Breathing techniques</td>
<td>Massage</td>
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<td>Visualization</td>
<td>Acupuncture</td>
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<td></td>
<td>Biofeedback</td>
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<td><strong>SLEEP DISORDER TREATMENT:</strong></td>
<td><strong>SLEEP DISORDER TREATMENT:</strong></td>
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<td>Medication</td>
<td>Sleep Disorder Therapy</td>
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<td><strong>MENTAL ILLNESS TREATMENT:</strong></td>
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<td>Antidepressants</td>
<td>Psychiatry Referral</td>
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<td>Antianxiety</td>
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<td>Mood Stabilizers</td>
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<td><strong>SOCIAL ACTIVITY for ISOLATION:</strong></td>
<td><strong>COUNSELING for DYSFUNCTIONAL RELATIONSHIPS</strong></td>
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<td><strong>DIET</strong></td>
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<td>Weight Loss for Obesity</td>
<td>Weight Watchers</td>
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<tr>
<td>Nutritious</td>
<td>Other Weight Programs</td>
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<td><strong>CHECK FOR DEFICIENCIES:</strong></td>
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<tr>
<td>Supplements</td>
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<tr>
<td>Vitamin D</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
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<tr>
<td>Vitamin B12</td>
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<tr>
<td><strong>SUBSTANCE ABUSE CESSATION:</strong></td>
<td><strong>SUBSTANCE ABUSE CESSATION:</strong></td>
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<tr>
<td>Tobacco</td>
<td>Drug Rehab</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Caffeine</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Street Drugs</td>
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<tr>
<td><strong>REFERRAL to SPECIALIST if TREATMENT OPTIONS POSSIBLE or UNCERTAIN</strong></td>
<td><strong>REFERRAL to SPECIALIST if TREATMENT OPTIONS POSSIBLE or UNCERTAIN</strong></td>
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<tr>
<td></td>
<td>Injections</td>
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<td></td>
<td>Radiofrequency ablation</td>
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<td></td>
<td>Surgery</td>
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<tr>
<td><strong>REFER to SPECIALIST if NARCOTIC DOSE &gt;120 mg MS/DAY</strong></td>
<td><strong>PAIN MEDICATIONS:</strong></td>
</tr>
<tr>
<td><strong>PAIN MEDICATIONS:</strong></td>
<td>Adjunctive Medications: Gabapentin, Lyrica</td>
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<tr>
<td>NSAIDs</td>
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<tr>
<td>Adjunctive Medications: Tricyclics</td>
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<tr>
<td>Tramadol</td>
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<tr>
<td><strong>NARCOTICS: IF USED:</strong></td>
<td></td>
</tr>
<tr>
<td>• Sleep apnea screen yearly</td>
<td></td>
</tr>
<tr>
<td>• No sedating medications or alcohol use</td>
<td></td>
</tr>
<tr>
<td>• No medical contraindications</td>
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<tr>
<td>• Laxatives given</td>
<td></td>
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<tr>
<td>• Compazine or metoclopramide for nausea</td>
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<tr>
<td><strong>HYDROCODONE:</strong></td>
<td><strong>FENTANYL</strong></td>
</tr>
<tr>
<td>• If over 60 mg or oxycodone over 40 mg change to long acting</td>
<td></td>
</tr>
<tr>
<td><strong>MORPHINE SR</strong></td>
<td><strong>OXYCONTIN</strong> (higher abuse potential)</td>
</tr>
<tr>
<td><strong>METHADONE – USE ONLY IF:</strong></td>
<td></td>
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<tr>
<td>• No cognitive impairment, developmental delay</td>
<td></td>
</tr>
<tr>
<td>• No severe mental illness with poor judgment or impulse control</td>
<td></td>
</tr>
<tr>
<td>• Not frail elderly</td>
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<tr>
<td>• EKG rule out ST prolongation before and once using</td>
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</tbody>
</table>
• Narcotics are rarely needed for chronic pain.
• Pain treatment must use a holistic treatment approach.
• Narcotics are appropriate only if benefit exceeds risk, only in patients with moderate or severe pain that can’t be controlled otherwise
• Narcotics may not be effective with long term use
Example: ICSI guidelines: Level 1
Pain Management:  (find this on Crossroads, Physician Web Portal)

Mechanical/ Compressive Pain:

(back pain, visceral pain, musculoskeletal pain) Or:

Inflammatory Pain:

(inflammatory arthritis, post-surgical pain, infection)

RX: Physical rehab, behavioral management, NSAIDs, antidepressants

Neuropathic Pain:

(Neuropathy, HIV, CVA, MS, fibromyalgia, migraine)

RX: Local or systemic neural modulators
On the other hand:

- **Not** treating pain is not the standard of care.
- **Not** considering the patient’s individual circumstance is not the standard of care.

- General rules about use of opioids are not appropriate, but must be considered in the context of the individual case.
Example: VA policy:

“1. A trial of opioid therapy is indicated for a patient with chronic pain who meets all of the following criteria:
   a. Moderate to severe pain that has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions
   b. The potential benefits of opioid therapy are likely to outweigh the risks (i.e., no absolute contraindications)
   c. The patient is fully informed and consents to the therapy
   d. Clear and measurable treatment goals are established

2. The ethical imperative is to provide the pain treatment with the best benefit-to-harm profile for the individual patient.”
• Use opioids for *acute or chronic* pain only after determining that alternative therapies do not deliver adequate pain relief.

• Use the lowest effective dose.
Medical indications for opioids:

Dosing opioids

- Doses >120 mg morphine equivalent show increased frequency of morbidity and mortality
- Dose equivalency calculator is linked to the algorithm

http://agencymeddirectors.wa.gov/mobile.html
• Use the lowest effective dose
• Convert to long acting agent when safe and available
• When converting from one opioid to another, reduce morphine equivalency initially and taper back up, in case differences in metabolism increase the effect
• Dose methadone very carefully, increase very very slowly!
Prescribing Opioids

- Write all prescriptions in 4 week increments, rather than monthly, so the patients don’t run out on weekends.
- Write the name of the pharmacy the patient uses on the prescription.
- If writing scripts to fill ahead of time, write the date of fill on the script, and update the start date in the Epic sig
- Make appointment for patient to get refills when due, rather than allowing them to call for refills.
Assessing for Side Effects

• The PHMG Pain Tool includes a list of common side effects in the Brief Pain Questionnaire, and the Epworth Sleepiness Scale, for use at each visit.

• On methadone, check EKG yearly and consider checking also with dose changes, for QT prolongation.

• Get sleep study in patients with significant STOPBANG scores (3- 4+)
Assessing for Side Effects, cont.

- Withdrawal symptoms can occur between doses with short acting opiates. Be alert for new symptoms.
- Accidents, mood symptoms, and bowel dysfunction may be opioid related.
- Give laxatives when prescribing opioids to prevent constipation.
Treatment plan must include:

- Establishment and documentation of goals of therapy.
- Goals must be functional, not just pain related.

The PHMG Pain tool includes question “what is your goal in treatment”. Patients often list “no pain” as their goal. This unrealistic expectation must be corrected.

30% reduction in pain is the actual average pain reduction possible from opioids.
Treatment plan must include:

- Discussion of risks and benefits- informed consent

- Consideration of use of medication agreement in high risk patients

- High risk is defined by patient status, and by dose.
PHMG chronic opioid policy:

**Narcotic Medications for Patients with Chronic Non-Malignant Pain**

**Medication Management Policy**

<table>
<thead>
<tr>
<th>System Wide</th>
<th>Narcotic Medications for Patients with Chronic Non-Malignant Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date: 2/28/2014</td>
<td>Document #: PHMG SYS 457.4</td>
</tr>
<tr>
<td>Version #: 1</td>
<td>Next Review: 11/1/2016</td>
</tr>
<tr>
<td>Page: 1 of 5</td>
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</table>

**SCOPE:** PeaceHealth Medical Group (PHMG) employed providers and staff.

**PURPOSE:** To define the parameters relating to narcotic medications that optimizes the health, safety, and well-being of the patients we serve.

**POLICY:** PHMG will provide tools and information to providers and staff about the purposes, rules, and expectations involved in the use of narcotic medications for patients with chronic non-malignant pain.

**DEFINITION:**
- Chronic Non-Malignant Pain

**REQUIREMENTS:**

1. Patients with a diagnosis of chronic non-malignant pain requiring ongoing management with narcotic medications shall be monitored by the patients’ Primary Care Provider, unless all narcotic medications are prescribed by a specialty provider (e.g., pain, sleep, addiction, psychiatry, or other providers).

   1.1. Narcotic medications managed entirely by specialty providers shall be clearly documented in the patient’s Electronic Medical Record (EMR), Epic PMR Chronic Pain SmartSet (E28) and communicated to the PCP.

2. Providers shall utilize the PHMG Narcotic Management for Patients with Chronic Non-Malignant Pain clinical algorithm and the forms and tools in the Chronic Pain and Narcotic Management provider toolkit to manage patients on narcotic medications for chronic non-malignant pain.

3. Providers shall use the form(s) titled Narcotic Pain Medication Agreement—for all patients on narcotic medications. The agreement is required when narcotic medications are initially prescribed until narcotic medications are no longer prescribed.

   3.1. Providers or their designees shall allow sufficient office time either during the initial visit or a follow up visit to review and explain the Narcotic Pain Medicine Agreement with the patient and validate patient understanding using “teach-back” or other methodology.

   3.2. The patient and the provider or designee shall sign and date the Narcotic Pain Medicine Agreement.

   3.3. A copy shall be given to the patient.

   3.4. The Narcotic Pain Medicine Agreement shall be reviewed annually.

3.5. A new Narcotic Pain Medicine Agreement shall be reviewed and modified as clinically indicated whenever the patient changes providers.

3.6. Exceptions. The Narcotic Pain Medicine Agreement is not required if:
- The MS equivalent dosage is <10 mg/day.
- Duration of <3 months for acute, non-chronic non-malignant pain.
- The patient is in hospice or other living situation where narcotic medications are administered by a health care worker. The provider will document the exception in the patient’s medical record.

3.7. The provider shall review the EMR prior to prescribing narcotic medications:

   3.7.1. Verify that a Narcotic Pain Medicine Agreement is on file.

   3.7.2. When a current Narcotic Pain Medicine Agreement is on file the prescribing provider shall be contacted prior to prescribing new narcotic medications.

4. Covering provider / partner may provide prescription refills in the same quantity and for the same duration as the PCP and make adjustments to the medication regimen.

4.1. The covering provider / partner shall communicate to the PCP information regarding any prescription refill or any adjustment to the medication regimen.

5. Managing / Wasting Unused Medications:

   5.1. If, for any reason, the patient requests a prescription change, he/she may be required to return any unused narcotic medications to his/her provider’s office before a prescription for a replacement medication will be issued. The medication received will be witnessed by two licensed staff members, double-counted in the patient’s presence, documented in the patient’s medical record, and sent to the pharmacy to be wasted, according to pharmacy policy and procedure.

6. Termination of the Narcotic Pain Medicine Agreement

   6.1. Termination of the Narcotic Pain Medicine Agreement may occur if patients violate any section of the Narcotic Pain Medicine Agreement.

   6.2. The provider shall notify the patient of their decision to terminate the Narcotic Pain Medicine Agreement. Notification will include reason for termination of the agreement and subsequent actions / plan for the management of the patient’s pain.

   6.3. Notification of termination should preferably be in person through an office visit. If however deemed appropriate a Narcotic Termination Letter signed by the provider may be mailed to the patient via certified mail.
Medication agreement

What is a narcotic pain medicine agreement?

Your provider has prescribed a controlled narcotic medicine for you to reduce your pain and help you to function better. The misuse of drugs law has a list of medicines that are "controlled" in order to keep people from being harmed by them. These medicines can have serious or fatal side effects. A narcotic pain medicine agreement is used when you are put on a controlled narcotic medicine to help keep you safe.

What are the risks of using narcotic medicines?

The risks of narcotic medicines can be divided into five categories:

1. Life-threatening:
   - Sleeplessness and confusion
   - Poor decision-making
   - Accidents
   - Breathing problems (which can lead to death)
   - Alcohol and some other drugs can increase your risk when taken with narcotic medicines

2. Serious:
   - Constipation
   - Nausea and vomiting
   - Trouble urinating
   - Loss of sexual function
   - Irregular periods
   - Itching and rash
   - Allergic reactions

3. Physical Dependence: If you stop your medicine suddenly, you may go through "withdrawal". Babies born to moms who have a physical dependence on a narcotic medicine may also have these symptoms. Here are the possible withdrawal symptoms:
   - Nausea and vomiting
   - Cramps and diarrhea
   - Sweating
   - Runny nose
   - Body pain
   - Pounding heart
   - Goose flesh

4. Addiction: A psychological need for the medicine for how it makes you feel. Your risk of addiction increases if you have a history of alcoholism, smoking or drug abuse. A family history of the above also increases your risk. Some mental illnesses also increase your risk.

5. Tolerance: Over time you may need more medicine to give you the same pain relief.

Is there anything else I can do to help with my pain?

Yes! We want you to be able to do the things that are important to you in your daily life. There are many things you can do to help with your pain. Your treatment may include diet, exercise, and lifestyle changes. It may also include physical therapy, other treatments, specialists, counseling or other types of medicines. These things are just as important to help your pain as your medicine.

What will I have to do while on this agreement?

There are some things that you will need to agree to before your provider can give you your medicine. This is to keep you safe while taking your medicine. See the next page for the agreement.

I WILL:

1. Get my medicine from only one provider or his/her partners.
2. Get my medicine only from the pharmacy I say I will.
3. Take my medicine exactly as prescribed.
4. Keep my medicine in a safe place. This is to be sure it will not get lost, stolen, or into the hands of children.
5. Tell every provider or dentist that cares for me about all medicines I am taking, including all pain medicines. This includes prescription, over-the-counter, herbs, and vitamins.
6. Tell my provider if any other provider or dentist prescribes a pain medicine for me.
7. Allow my provider to talk to other providers about my health problems.
8. Follow my treatment program for diet, exercise, and other therapies.
9. Make and keep all my appointments, including with other providers and therapists. If I miss my appointment, I know I may not be able to get my medication refilled.
10. Agree to random urine testing to be sure I am taking my medicine right. I know I will have to pay for the tests if my insurance does not cover it. I also know if I don't have the test when I am asked (usually within 24 hours), I may not get any more medicine.
11. Agree to bring in my medicine in the pharmacy bottle for random pill counts to be sure I am taking it right. I also know if I don't do this if asked (usually within 24 hours), I may not get any more medicine.

I WILL NOT:

12. Tell my provider about any side effects I may be having. I may also let my provider know if I feel I am becoming addicted. I know if I have serious side effects or start to become addicted, the provider will have to reduce or stop my medicine.
13. Have some way for my provider to get hold of me (phone, email, or mail).

For staff use only: Interpreter service and/or special accommodations provided?  YES  ☐ Not Needed

Patient Name: ______________________  Signature: ______________________  Date: __________
Witness Name: ______________________  Signature: ______________________  Date: __________

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Narcotic Pain Medicine Agreement

Page 1 of 1

Med Agreement-Signed
Periodic Review when using opioids

- **FSMB Guidelines**: evaluation is “periodic”.
- **Most groups**, Q3 months is baseline, and frequency varies per risk
- **PHMG process**: 
  - **Recheck Q12 weeks**, to correspond with need for refills
  - **increased frequency (monthly)** for patients with high baseline risk or high risk behaviors
  - **decreased frequency (every 6 months)** for patients with very low risk (very low doses, infrequent use of drug, end stage cancer, etc.)
Documentation:

- There are several Epic Smartphrases for documenting pain visits.
- Lorne Bigley and Jill Chaplin and others have written Smartphrases to document pain visits including the information gathered from the chronic pain tool.
- “.pain” is the name of the smartphrase
- The Medical Assistant can transfer information from the tool to the visit note for you.
• Opioids should be discontinued if:
• There is no improvement in function or pain with treatment
• There are significant adverse effects
• There are serious contraindications
• There is evidence of misuse, addiction, or diversion.
FYI: Washington State Policy:

- If a patient’s dosage has increased to 120 mg/day MS equivalent without substantial improvement in function and pain, seek a consult from a pain specialist.
• If substantial risk is identified through screening, extreme caution should be used and a specialty consultation is strongly encouraged.
Refer to Specialist when:

- Diagnosis or treatment options are unclear
- Treatments must be performed by specialist
- Need confirmation on the right treatment
- Poor response to treatment
- High doses of opioids
- High risk patients
- Complicating medical issues: sleep apnea, addiction, unresponsive psychiatric issues, etc.
Specialists for referrals:

- PHMG Chronic Pain tool kit includes lists of specialists in the Oregon region for referral
- Other areas have not yet submitted lists to include
- Specialists listed include Pain, Sleep, Neurosurgery, Orthopedics, Neurology, and Addiction treatment programs.
Insurance Issues:

- *Trillium* (Medicaid carrier for Lane County) will pay for specialist consultation for 2 visits, and ongoing care if needed and agreed to by specialist. In practice, specialists often don’t accept Trillium patients.
- *Oregon Medicaid* otherwise does not pay for diagnoses “below the line”, including PT or other treatments.
- Other insurances have variable coverage.
- *Medicare* generally covers treatment of chronic pain very well.
Addressing Aberrancy:

Suggested Interventions for Aberrancy with Opioid use in Chronic Pain

<table>
<thead>
<tr>
<th>Aberrancy - Drug related</th>
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<tbody>
<tr>
<td>Deliberate Overdose</td>
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<tr>
<td>Alcohol Abuse or DUI</td>
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<tr>
<td>Resisting Drug Change in Spots of Serious Side Effects</td>
</tr>
<tr>
<td>Accidental Overdose, or Over sedation, or sequelae therefore, other serious Side Effects</td>
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<tr>
<td>On Medical marijuana</td>
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<tr>
<td>On prescribed Benzos</td>
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<table>
<thead>
<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Consider not prescribing Opioids at all</td>
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<table>
<thead>
<tr>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Refer to Psychiatry</td>
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<tr>
<td>Refer to Rehab</td>
</tr>
<tr>
<td>Opioid Safe at Lower Dose?</td>
</tr>
<tr>
<td>D/C marijuana vs D/C opioids</td>
</tr>
<tr>
<td>Prefers to continue marijuana</td>
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<tr>
<td>Reduce or stop Benzos</td>
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<tr>
<td>Reduce Dose Opioid</td>
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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Loss of control, missed appointments, sharing drug, using drug for non-pain symptom, heavy use of name brand or specific drug only. Can't give urine for UDS.</td>
</tr>
<tr>
<td>Run out early, used more than 1 week, FED, ER, or UCG visits for pain getting drug also from another source</td>
</tr>
<tr>
<td>Patient or family member aggressively arguing for drug</td>
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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Evaluate Pain Control - increase if appropriate</td>
</tr>
<tr>
<td>Re-educate on safe use of drug and medication agreement. Get UDS if not done; consider D/C opioid, consider random pill counts; F/U MONTHLY</td>
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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Stop Opioid. Refer to Rehab</td>
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<tr>
<td>Consider discharge from PHMG</td>
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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Threatening or abusive behavior, forging or stealing RX's and drugs, selling RX's drugs</td>
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<tr>
<td>STOP OPIOID</td>
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</table>

Aberrancy Response Flow Sheet Explanation

All notations are suggestions; the best response for any situation should be assessed individually.

1. High baseline risk: Patients with a history of substance abuse are approximately 50% likely to abuse opioid, even when in a recovery program. Strongly consider avoiding opioids. If used, a concurrent recovery program is recommended by the Oregon Medical Board.

2. Fibromyalgia: Opioids shown not to be effective. Use for concomitant pain source only if warranted.

3. Deliberate or accidental overdose: changing form of drug may also be an option.

4. Alcohol Rehab may include rehab programs, AA, counseling.

5. Stopping opioids: Consider tapering, if patient is using opioid, avoid withdrawal.

6. Resisting change of dosing in spite of serious complications may indicate addiction.

7. Serious side effects of opioids may include sedation, QT prolongation and arrhythmias, aspiration pneumonia, bowel obstruction, allergic reactions, accidents. See opioid medication agreement.

8. Marijuana use: license status does not alter medical or legal risk. Prescribing opiates to patients on medical marijuana increases risk of additive sedating side effects, accidents, and judgment errors. Combination should not be used in patients who drive, operate machinery, care for children. There is evidence of benefit of marijuana only for neuropathic pain, nausea, wasting disease, pain relief equal to about 4 mg morphine. Mainly used by patients for mood and sedating effect, and intoxication.

9. Benzo use: very high risk for additive side effects - avoid combination, use lowest possible dose of both drugs. Consider psychiatric consultation if at all possible regardless of need for benzodiazepines.

10. 3 events in 1 year. Keep track of events. Discontinuation of drug is appropriate when patient is not willing or able to understand or comply with standards for safe opioid use.

11. Sharing drugs, or getting these from friends or family, is very common due to public lack of understanding of risk. Our new opioid medication contract explains it to them.

12. Increase frequency of visits to monitor and increased monitoring of drug use with pill counts and urine drug screens is recommended if there is question of patient's ability or willingness to use drugs safely. Monthly (or even more often) is appropriate.

13. Pill counts patient's pharmacy may also be willing to do this. Be sure to correctly identify pills.

14. Urine drug screening: find out what the patient is taking, last time of dose of drug before announcing UDS will take place. Order pain management panel. Avoid invalid samples – see UDS guidelines.

15. Aggressive arguing for drug can be a sign of inadequate pain control. Can also be a sign of drug abuse. Provider has options of discharging patients who are intimidating or uncooperative - discuss with pain team or risk management.

16. Lying to provider about use is evidenced by non-confirmatory urine drug screens, changing or unreliable history, reports from police or other health professionals. Provider has the option of discharging patient if therapeutic relationship is compromised.

17. Absence of prescribed drug in urine can represent diversion, running out early, lack of use, or rapid metabolism. The lab toxicologist can let you know whether drug should be in urine or not depending on dose and time. No need to taper drug if not present in urine - just stop.

18. Behavior with threat of violence should trigger 911 call, as well as report to manager and call to PH Security. Abusive behavior, evidence of illegal behavior, should trigger report to manager, review by risk management; may need referral to police if illegal behavior is taking place on PH property. All of these usually warrant discharge from PH.
SCOPE. All Primary and Specialty Care Practices

PURPOSE: To guide decisions regarding appropriately dismissing patients taken as a last resort after reasonable efforts to work with the patient have failed.

POLICY. It is the policy of PeaceHealth to relieve pain and suffering, to treat every patient in a caring and compassionate manner. However, under certain circumstances, it may be appropriate for a provider to recommend terminating his/her relationship with a patient. Providers may recommend termination from a service line and/or the entire group practice if other treatment options are available. Terminating a care relationship of one family member does not necessarily require terminating care for other/all family members. Terminating a provider-patient relationship is a serious action and should only be taken as a last resort after reasonable efforts to work with the patient have failed.

TABLE OF CONTENTS:
- Late Arrival to Appointments (Definition / Procedure)
- Late Cancellation/Reschedule of Appointments (Definition / Procedure)
- Not Arriving to Appointments - No Show
  - Established Patient (Definition / Procedure)
  - New Patient (Definition / Procedure)
- Illegal or Threatening Behavior (Definition / Procedure)
- Patient’s Lack of Follow Through on Agreed Treatment/Care Plan (Definition / Procedure)
- Lack of Trust in Patient/Provider Relationship (Definition / Procedure)
- Care Team Procedures
- Dismissal Committee Operations
- Administrative Operations
- Patient Appeals

DEFINITIONS:
Providers may consider dismissing a patient based on the following circumstances and have the discretion to permit exceptions to these criteria for extenuating circumstances. Some circumstances may benefit from the consultation and advisement of the Dismissal Committee.

Persistent late arrivals and/or late cancelled/rescheduled appointments by Patient/Family/Caregiver (Back to TOC)
- Pattern is defined as three or more events within the last six months based on a rolling calendar starting with first occurrence.
- Late cancellation/reschedule is defined as calling less than four business hours in advance of appointment start time. (Appointments for procedures may require a different time period)

Patient’s Lack of Follow through on Agreed Treatment/Care Plan(s) (Back to TOC) share in the partnership of care, demonstrate non-compliance with medication agreements, failure to come to agreements on goals of care in spite of efforts to educate, negotiate and activate patient with the assistance of Social Services, Nursing Care Management, PCP and Behavioral Health, etc.

Lack of Trust in Patient/Provider relationship is such that it interferes with maintaining a relationship of care – e.g. threat of legal action and repeated misrepresentation. (Back to TOC)

PROCEDURES:
Care Team Procedures (Back to TOC)
Questions?

• Ask:
  • Your mentor,
  • Your AMD,
  • Me: jchaplin@peacehealth.org
Review article: “2009 Clinical Guidelines from the American Pain Society and the American Academy of Pain Medicine on the use of chronic opioid therapy in chronic noncancer pain”, Roger Chou, Department of Medicine and Department of Medical Informatics and Clinical Epidemiology, Oregon Health & Science University, Portland, OR, United States


Model Policy for the Use of Controlled Substances for the Treatment of Pain:
Federation of State Medical Boards of the United States, Inc.

Responsible Opioid Prescribing: A Physician’s Guide; Scott M. Fishman, MD
• Institute for Clinical Systems Improvement: Health Care Guideline: Assessment and Management of Chronic Pain

• Veteran’s Administration guidelines on opioid therapy for chronic pain
  http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp

• Coalition of Community Health Clinics/ Multnoma County Health Clinics Opioid Prescription policies
  http://www.coalitionclinics.org/clinical-guidelines.html

• Agency Medical Director’s Group- Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy, 2010 Update