Assessment and Treatment of Chronic, Non-malignant Pain

Jill Chaplin, MD
• I have nothing to disclose

• I work for Peace Health Medical Group, and will share some of our processes, but have no commercial interest
• Brief overview of chronic pain as a clinical problem
• Review standard of care for evaluation and treatment of chronic pain
• Review examples of tools and processes that make this care easier and safer
• To increase the safety of our patients and communities, the standardization to best practice and the professional satisfaction of our provider colleagues
Chronic Pain: Definition

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

• **Acute** = 6 weeks; **Subacute** = 6-12 weeks

• **Chronic** = beyond normal tissue healing—about 3 months
Chronic Pain:

How bad is it?
Chronic Pain: incidence and impact

U.S. population: 37% with chronic pain
- Comparison: Diabetes = 8%
- American adults: 20% report pain disrupting sleep
- Cost: $560 billion to $635 billion/ year, US
  (care + disability + lost wages & productivity)

Those with chronic pain:
- 59% - reduced enjoyment of life.
- 77% - depressed
Chronic Pain Treatment Challenges

- Biggest dis-satisfier of clinicians and staff
- Providers reluctant to accept pain patients, reducing access for the underserved
- Majority of Americans feel, “pain should be a high, or top, medical priority”
- Prescription drugs= second-most abused in the US, after marijuana.
- Nearly half of all drug deaths are from prescription pain relievers
Chronic pain:
What causes it?
What we know:
Chronic Pain: Top Diagnoses

National Health and Nutrition Examination Survey (NHANES) 1999 to 2002:

- **Low back pain**: 10%
  - Leading cause of disability, Americans < age 45
- **Chronic Regional Pain**: 11.1%
- **Leg/foot pain**: 7.1%
- **Arm/hand pain**: 4.1%
- **Severe headache or migraine**: 3.5%
  - Most common pain causing lost productive time
• **Fibromyalgia**: 2% of US population

Majority of patients with chronic pain have more than one type of pain
Types of pain:

- **Neuropathic pain**
  
  *peripheral*, e.g., post-herpetic neuralgia, diabetic neuropathy;

  vs **central**, e.g., post-stroke pain or multiple sclerosis

- **Musculoskeletal pain**

  e.g., back pain, myofascial pain syndrome, ankle pain
Types of pain:

- **Inflammatory pain**
  eg, inflammatory arthropathies, infection

- **Mechanical/compressive pain**
  eg, renal calculi, visceral pain from expanding tumor masses

*Note: these are not mutually exclusive*

eg back pain might be both musculoskeletal and mechanical/compressive, (nerve root compression)
Chronic Pain-

What we suspect:

“Neuroplasticity”
Neuroplasticity and chronic pain

- increased sensibility of the spinal cord upon severe, long lasting pain perception, a mechanism called wind-up. Hyperalgesia is accompanied by persisting genetic changes of spinal cord cells, which may contribute to the chronification of pain. The severity and duration of acute pain apparently contributes to the possibility of chronic pain development.
Contribution of central neuroplasticity to pathological pain: review of clinical and experimental evidence:

changes in central neural function may play a significant role.

noxious stimuli may sensitize central neural structures involved in pain perception..

in addition to a contribution of neuronal hyperactivity to pathological pain, there are specific cellular and molecular changes that affect membrane excitability and induce new gene expression.

Terence J. Coderre a,b,c, Joel Katz d,e, Anthony L. Vaccarino c,* and Ronald Melzack
Mental vs Physical Pain - “A broken Heart and a Broken Leg- Much the Same to our Brains

“the neural circuits important for emotional distress — feelings of social isolation, grief, jealousy, and shame — have much in common with those responsible for pain following physical injury.

“The overlap is strongest in those parts of the brain thought to be important in the suffering or “avoidance” aspect of physical pain”

- Mary Heinricher, Ph.D.
  Professor, departments of Neurological Surgery and Behavioral Neuroscience
  OHSU Brain Institute
“Mental and Physical Pain may be Different After All”

“Physical pain and social rejection do activate similar regions of the brain. But by using a new analysis tool, we were able to look more closely and see that they are actually quite different.”

Opioids may cause chronic pain

“After adjustment for pain, function, injury severity, and other baseline covariates, receipt of opioids for more than 7 days (odds ratio = 2.2; 95% confidence interval, 1.5–3.1) and receipt of more than 1 opioid prescription were associated significantly with work disability at 1 year”

Spine, 2008
“After controlling for the covariates, mean disability duration, mean medical costs, and risk of surgery and late opioid use increased monotonically with increasing MEA. Those who received more than 450 mg MEA were, on average, disabled 69 days longer than those who received no early opioids.”
Opioid Tolerance and Hyperalgesia in Chronic Pain Patients After One Month of Oral Morphine Therapy: A Preliminary Prospective Study

“There is accumulating evidence that opioid therapy might not only be associated with the development of tolerance but also with an increased sensitivity to pain.”
Chronic pain: How Do We Treat It?
Sources for Standard of Care

- Private and government group guidelines
- Pain specialist guidelines and practices
- State and Federal Laws
- Published standards, guidelines, and resources eg ICSI
- 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
Treatment of Chronic Non-cancer Pain

1. Evaluation
History for evaluation of chronic pain includes:

1. **History of the Pain**: onset, duration, **diagnosis**, past treatments and their efficacy, past providers

2. **General Medical History**

3. **Current Symptoms**: location, quality, severity, timing of the pain; modifying factors, related symptoms

4. **Function**

5. **Psychiatric Comorbidities**

6. **Narcotic Use Risk**
Record Review

- Treatment prior to record review may be unsafe.

- At PHMG, decision to treat prior to record review is per provider judgment, not system policy. This may change.
Drug use history: State prescription drug monitoring programs

- **Should** check at first visit; **may** any time thereafter
- Requires provider to establish an account and password
- Review may be delegated to staff

http://www.orpdmp.com/ Oregon
http://www.wapmp.org/ Washington
http://www.alaskapdmp.com/ Alaska
General Medical History:

“Be cautious when using opioids with conditions that may potentiate opioid adverse effects (COPD, CHF, sleep apnea, Alcohol 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.”
Current Symptoms: “location, quality, severity, timing, modifying factors, related symptoms”

- Check every visit

- Most groups use patient handouts to assess current symptoms

- PHMG uses Brief Pain Inventory. Others are available.
Evaluation of Function:

- 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. Improved function alone may demonstrate adequate treatment.

- Improved pain with reduction in function may represent drug side effect, and may be an indication to reduce or stop opioids.
Most groups use a standardized screening tool for evaluation of function.

Evaluate at each visit.

PHMG uses the FAQ5, and questions about activity.

Discussion of patient activities, and observation of function are also valid assessment.
Assessment of Psychiatric Comorbidity includes:

- Psychiatric Diagnoses
- Current psychiatric symptoms

Many psychiatric diagnoses are risks for chronic pain, and also risks for misuse of narcotic medication.

Treatment of psychiatric symptoms often reduces pain.
- Many groups use a standardized screening tool for evaluation of current psychiatric symptoms

- PHMG screens for depression; used by PHQ9

- GAD 7 measures anxiety, another risk
Evaluation of risk of use of narcotics includes:

- **Medical conditions** potentially impacted, and
- **Risk for drug misuse:**
  Standardized screening tools: ORT, SOAPP-R, COMM
- **Past aberrant behaviors** - "The best predictor of future behavior is past behavior"
- **Urine Drug Screens** - at least yearly; more if higher risk
- **Random pill counts** - sometimes helpful
Screening Tools for Drug Misuse Risk:

ORT: includes history of alcohol and substance abuse and sexual abuse, predicts baseline risk of misuse of medications.

-use only once

COMM: asks about current misuse, current mood and cognitive symptoms *(must be licensed)*

SOAPP-R asks a combination of past and current status questions

-use sometimes, or every time
PHMG Chronic Pain Questionnaire

Combines 4 standardized, validated screening tools:

• Brief Pain Questionnaire
• FAQ5
• Epworth Sleepiness Scale
• PHQ9
• (may also include COMM or SOAPP-R)

One, 3 page handout for patients to complete

For use at each visit
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 one number that best describes your pain:

<table>
<thead>
<tr>
<th></th>
<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>At its WORST in the past 24 hours:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>At its LEAST in the past 24 hours:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>On the AVERAGE:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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

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

5.) In the past 24 hours, how much relief did pain treatments or medications provide? Please circle the one percentage that shows how much RELIEF you have received.

<table>
<thead>
<tr>
<th>No relief</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete relief</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FAQS: Circle the phrase that best describes what you can do:

<table>
<thead>
<tr>
<th>(points)</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing, toileting, dressing:</td>
<td>I need total care</td>
<td>I need frequent help</td>
<td>I need help sometimes</td>
<td>I can do these myself</td>
</tr>
<tr>
<td>Chores, hobbies, driving, sex:</td>
<td>I can't do any</td>
<td>I can do some</td>
<td>I can do many</td>
<td>I can do all</td>
</tr>
<tr>
<td>Walking and stairs:</td>
<td>Need help to walk</td>
<td>Can't do stairs</td>
<td>Can walk, and climb one flight of stairs</td>
<td>Can walk short distance and more than one flight of stairs</td>
</tr>
<tr>
<td>Lifting, occasionally:</td>
<td>10 lbs</td>
<td>20 lbs</td>
<td>50 lbs</td>
<td>more than 50 lbs</td>
</tr>
<tr>
<td>Work:</td>
<td>Unable to work</td>
<td>Part time, with limitations</td>
<td>Part time without limits, or full time with limitations</td>
<td>Normal work</td>
</tr>
</tbody>
</table>

Total (Doctor add up columns): ____________

Grand total (Doctor add columns together) = ____________

Total x 5 - 100% = Global function score (5-100%)

Epworth Scale: Circle the number that best fits the situation:

<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): ____________
Patient to complete this page - Provider review with patient

Do you, or did you ever use: (circle) How much? How often?

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Never</th>
<th>Previous</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
<tr>
<td>Caffeine</td>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
<tr>
<td>Street drugs</td>
<td>Never</td>
<td>Previous</td>
<td>Now</td>
</tr>
</tbody>
</table>

Which street drugs?

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 bad 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 around 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 PHQ 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

Any trouble with anxiety / panic attacks? (circle) Yes No Previous

Any other mental health problems?
Assess “4 A’s” at every visit:

- Analgesia
- Activity
- Adverse effects
- Aberrancy

PHMG handout eg screens for all of these. May use with every pain visit for patients on chronic opioids
Pain Questionnaires: process for use

• Identify chronic pain patients during **scrub and huddle**
• MOA give labeled questionnaire to front desk to give to patient to complete; check that it is done before provider visit.
• Provider reviews questionnaire during visit.

• Key is included with the form (don’t give to patient)
• May be scanned to patient chart.
• Managers can get forms printed for clinic supply.
• “Pain related physical exam”

• Don’t forget to do it
Treatment:

1. Establish diagnosis
2. Establish treatment goals
3. Comprehensive treatment plan
Medical indications for opioids:

- Central SSCNP
- Pelvic Pain
- CRPS/PAP
- OA, RA and other rheumatic conditions
- Visceral/Abdominal Pain (pancreatitis)
- Sickle Cell Pain
- Burn pain
- Perioperative/Acute Pain
- Cancer Pain

Less well-suited for COT

• **Goals of treatment** should be specific, related to function, and established and documented at outset.

*The Peace Health Pain Questionnaire asks, “what is your goal in treatment?” Patients often say “no pain”. This expectation is not realistic, and should be corrected. Realistic, functional goals should be negotiated instead.*
Example of Functional Goals:

What do you want to be able to do?

- Clean my house and take care of my kids
- Sleep without pain waking me
- Work
- Exercise
• Effective pain treatment is comprehensive and holistic
  • Narcotics are rarely needed for chronic pain.
  • Narcotics are appropriate only if benefit exceeds risk, only in patients with moderate or severe pain that can’t be controlled otherwise
  • Narcotics give on average 30% pain reduction
  • 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
Treatment plan should/may include:

- Lifestyle modifications, exercise
- Non-opioid medications
- Treatment for nutritional or endocrine deficiencies
- Physical and behavioral therapies
- Spirituality and social support.

- Not just opioids!
# CHRONIC PAIN TREATMENT PLAN OPTIONS

<table>
<thead>
<tr>
<th>ALL TREATMENT OPTIONS (check/circle)</th>
<th>HIGHER COST TREATMENT OPTIONS (check/circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>() EXERCISE:</strong></td>
<td><strong>() EXERCISE:</strong></td>
</tr>
<tr>
<td>Aerobic</td>
<td>Tai Chi</td>
</tr>
<tr>
<td>Core Strengthening</td>
<td>Water Exercise</td>
</tr>
<tr>
<td>Stretching</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Yoga</td>
<td></td>
</tr>
<tr>
<td><strong>() SPIRITUAL:</strong></td>
<td><strong>() SPIRITUAL:</strong></td>
</tr>
<tr>
<td>Meditation</td>
<td>Support Group</td>
</tr>
<tr>
<td>Prayer/Religious groups</td>
<td>Counseling</td>
</tr>
<tr>
<td>Relaxation Exercises</td>
<td></td>
</tr>
<tr>
<td><strong>() ALTERNATIVE:</strong></td>
<td><strong>() ALTERNATIVE:</strong></td>
</tr>
<tr>
<td>Breathing techniques</td>
<td>Massage</td>
</tr>
<tr>
<td>Visualization</td>
<td>Acupuncture</td>
</tr>
<tr>
<td></td>
<td>Biofeedback</td>
</tr>
<tr>
<td><strong>() SLEEP DISORDER TREATMENT:</strong></td>
<td><strong>() SLEEP DISORDER TREATMENT:</strong></td>
</tr>
<tr>
<td>Medication</td>
<td>Sleep Disorder Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>() MENTAL ILLNESS TREATMENT:</strong></td>
<td><strong>() MENTAL ILLNESS TREATMENT:</strong></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Psychiatry Referral</td>
</tr>
<tr>
<td>Antianxiety</td>
<td></td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td></td>
</tr>
<tr>
<td><strong>() SOCIAL ACTIVITY for ISOLATION</strong></td>
<td><strong>() COUNSELING for DYSFUNCTIONAL RELATIONSHIPS</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>() DIET:</strong></td>
<td><strong>() DIET:</strong></td>
</tr>
<tr>
<td>Weight Loss for Obesity</td>
<td>Weight Watchers</td>
</tr>
<tr>
<td>Nutritious</td>
<td>Other Weight Programs</td>
</tr>
<tr>
<td><strong>() CHECK FOR DEFICIENCIES:</strong></td>
<td></td>
</tr>
<tr>
<td>Supplements</td>
<td></td>
</tr>
<tr>
<td>Vitamin D</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td></td>
</tr>
<tr>
<td>Vitamin B12</td>
<td></td>
</tr>
<tr>
<td><strong>() SUBSTANCE ABUSE CESSATION:</strong></td>
<td><strong>() SUBSTANCE ABUSE CESSATION:</strong></td>
</tr>
<tr>
<td>Tobacco</td>
<td>Drug Rehab</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
</tr>
<tr>
<td>Street Drugs</td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td>Injectons</td>
</tr>
<tr>
<td></td>
<td>Radiofrequency ablation</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
</tr>
<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></td>
<td>Adjunctive Medications: Gabapentin</td>
</tr>
<tr>
<td><strong>() PAIN MEDICATIONS:</strong></td>
<td>Lyrica</td>
</tr>
<tr>
<td>NSAIDs</td>
<td></td>
</tr>
<tr>
<td>Adjunctive Medications: Tricyclics</td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td></td>
</tr>
<tr>
<td><strong>() NARCOTICS: IF USED:</strong></td>
<td><strong>() NARCOTICS: IF USED:</strong></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>
<td></td>
</tr>
<tr>
<td>Laxatives given</td>
<td></td>
</tr>
<tr>
<td>Compazine or metoclopramide for nausea</td>
<td></td>
</tr>
<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 (higher abuse potential)</strong></td>
</tr>
<tr>
<td><strong>() METHADONE – USE ONLY IF:</strong></td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>EKG rule out ST prolongation before and once using</td>
<td></td>
</tr>
</tbody>
</table>
When to use Opioids:

- **Not** treating pain at all is not the standard of care.
- Nor is refusal to treat patients with chronic pain.
- In considering use of opioids, consider the patient’s individual circumstance.
- General rules about non-use of opioids are not appropriate, but must be considered in the context of the individual patient.
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.
Dosing opioids

• Doses >120 mg morphine equivalent show increased frequency of morbidity and mortality

• Washington State guidelines require specialist consultation if using >120 mg MED without pain relief

• American College of Occupational and Environmental Medicine, March 26, 2014, “MED doses should be limited to 50 mg in most cases, particularly in the acute setting; although, sub-acute and chronic pain patients may require higher doses”.
American College of Occupational and Environmental Medicine:

- “Short-acting, breakthrough pain opioid analgesics are generally not recommended in chronic pain. Long-acting, baseline pain agents should be utilized in this patient population, if necessary.”
For safe opioid use:

- Use the lowest effective dose
- Convert to long acting opioid if possible to reduce dependency potential.
- When converting from one opioid to another, reduce morphine equivalency initially and taper back up, to avoid increasing effect from differences in metabolism
- Give laxatives to prevent constipation.
For safe opioid use:

- Dose methadone very carefully, increase very slowly! It shows non-linear pharmacokinetics
- Consider pain specialist referral for any patient needing more than 120 mg morphine equivalent per day.
Prescribing Opioids - mechanics

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

- Brief Pain questionnaire includes list of side effects
- Epworth Sleepiness Scale assesses sedation
- Methadone: check EKG yearly for QT prolongation and consider checking also prior to start, and for dose changes.
- Get sleep study in patients with significant STOPBANG scores (3-4+)
- Beware: accidents, mood symptoms, and bowel dysfunction may all be opioid related- don’t ignore if occurring.
Treatment plan must include:

- **Informed consent**: review risks and benefits - all patients

- **Medication agreement**: Consider 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**

<table>
<thead>
<tr>
<th>System Wide</th>
<th>Medication Management Policy</th>
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**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 [428] 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 Medicine 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, the PCP 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.
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 Act 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 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:
   - Stupor and confusion
   - Poor decision-making
   - Accidents
   - Breathing problems (which can lead to death)
   - Alcohol and some other drugs can increase your risk taken with narcotics

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

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
   - Goosy flesh

4. Addictions: 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 illness also increases 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 understand that if I do not follow this agreement, my provider may not be able to give me any more medicine.

I have read this agreement or had it explained to me. All my questions have been answered. I understand the risks of taking narcotic medicines. I would like to use these as part of my treatment plan. I agree to follow all the safety rules listed above.

For staff use only: Interpreter service and/or special accommodations provided?  YES  NO
Periodic Review when using opioids

- **FSMB Guidelines**: evaluation should be “periodic”.
- **Most groups, Q3 months is baseline, with frequency varied per risk**
- Suggested process:
  - Recheck Q12 weeks, to correspond with need for refills
  - *Increase frequency (to monthly)* for patients with high baseline risk or high risk behaviors
  - *Decrease frequency (every 6 months)* only for patients with very low risk (very low doses, infrequent use, end stage cancer, etc.)
Document:

• “If you didn’t write it down, it didn’t happen”
• **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.
• 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:

Consider:

- Pain
- Sleep
- Neurosurgery
- Orthopedics
- Neurology
- Addiction treatment

Keep a list of your local and regional resources
Addressing Aberrancy:

Suggested Interventions for Aberrancy with Opioid use in Chronic Pain

Aberrancy – Drug related

- Deliberate Overdose
- Alcohol Abuse or DUI
- Resisting Drug Change in Spite of Serious Side Effects
- Accidental Overdose, or Over sedation, or sequelae therefore, other serious Side Effects

Action

- Refer to Psychiatry
- Refer to Rehab
- Opioid Safe at Lower Dose?
- D/C medications vs D/C opioids
- Refers to continue medication
- Reduce dose
- Reduce Dose

Aberrancy – Red Flags

- Loss/stolen scripts, missed appointments, sharing drugs, using drug for non-pain symptoms, insist on name Brand or specific drug
- Only can’t give Urina for UDS

Action

- Re-educate on safe use of drug and Med Agreement, get UDS if not done
- Consider D/C opioid
- Consider random pill counts
- F/U MONTHLY

Aberrancy – Crime Related

- On street drugs or RX drugs not fixed in patient
- Taping out or topical drugs
- Tying to provider about use

Action

- Stop Opioid, Refer to Rehab
- Consider discharge from PHMG
- STOP OPIOID

Aberrancy Response Flow Sheet Explanations

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

1. High baseline risk: Patients with history of substance abuse are 50% likely to abuse opioid, even when in a recovery program. Strongly consider avoiding opioids. If used, a concomitant 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 opioids, to prevent withdrawal.
6. Resisting change of drug in spite of serious complications may indicate addiction.
7. Serious side effects of opioids 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 patient on medical marijuana increases risk of additive sedating side effects, accidents, and judgment error combination should not be used in patients who drive, operate machinery, for children. There is evidence of benefit of marijuana only for neuropathic pain, nausea, wasting disease, pain relief is 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 regarding use for benzodiazepines.
10. 3 events in one 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 use, and increased monitoring of drug use with pill counts and urine drug screens is recommended if there is question of the 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 option of discharging patients who are intimidating or non-cooperative—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 of testing. 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.
Aberrancy:

- Don’t ignore it!
- Some aberrancies are red flags:
- Some are absolute contraindications!

Examples: street drugs in urine, selling or diverting drugs, absence on UDS, lying about use, overdosing (usually), life threatening side effects, DUI, alcohol abuse, reports by family or friends of drug abuse.
Addressing Aberrancy

• Use “Language of Caring”
• Don’t make it about your comfort; this is about the patient’s safety
• Best practice for addiction is treatment, not dismissal
### Dismissing patients

**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.

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- Not Arriving to Appointments - No Show
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- 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:**

- 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)

- Late arrival is defined as having arrived late more than half (1/2) of the scheduled appointment time and is unable to be worked in without making other patient wait.

Not Arriving for Appointments - Established patient displays the pattern of not arriving to scheduled appointments. I.e. No Show (Back to TOC)

- Pattern is defined as having not arrived to three or more appointments within last 12 months based on a rolling calendar starting with first occurrence.

Not Arriving for Appointment - New patient displays a pattern of not having not arrived to scheduled appointments. I.e. No Show (Back to TOC)

- Pattern is defined as having not arrived to two or more appointments within last six months based on a rolling calendar starting with first occurrence.

Patient displays Illegal/Threatening/Disruptive Behavior. (Back to TOC)

The definitions are as follows:

- **Illegal behaviors** - May include fraudulent or illegal acts, including altering prescriptions, permitting the use of insurance or identification cards by others, theft, assault or other criminal acts committed on PeaceHealth property.

- **Threatening behaviors** - May include credible verbal threats or the commission of an act of physical violence directed at a practitioner, caregiver, other patient or visitor. Threats may also include badgering, intimidation or threats to sue resulting in a disruption of the trusting provider-patient relationship. Assessment of threats may include reviewing the history of threats and violence, and patterns of behavior.

- **Disruptive behaviors** - May include disruptive, unruly or abusive behaviors that impair the ability of PeaceHealth practitioners and caregivers from providing services either to the patient or others. (Offensive language or behavior is not necessarily disruptive behavior).

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, fail 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?

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• 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

• The American Academy Of Pain Medicine, http://www.painmed.org/patient/facts.html#chronic

• 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/ Multnomah 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