

Chronic Pain Management Protocol

(Pain lasting >90 days, excluding pain due to malignancy or at the end of life)

Prior to initiating opioid medications for a chronic problem, at transition from acute pain to chronic pain management, or at initial evaluation of a patient on pain medication transferring from another provider, the following should be assessed:

- Does this person have **contraindications** to opioid use, including previous adverse reactions, current untreated addiction, substantial risk for adverse events, or others? If so, other avenues for pain control should be explored, and opioids should be avoided. The patient may benefit from a referral to a pain specialist.

If not, should **assess the following**:

- Has this person **failed non-opioid pain medications** such as acetaminophen, 1 or more NSAIDs, or, if appropriate, tramadol? If not, treatment with these medications should be attempted as clinically appropriate prior to initiation of chronic opioid therapy.
- Has this person tried and failed or had **insufficient relief from non-drug therapies** (physical therapy, diet modifications, activity modifications and other physical treatments)? If not, treatment with these measures should be attempted as clinically appropriate prior to initiation of chronic opioid therapy.
- Has this person **failed appropriate adjunct pain medications**, including antiepileptics and antidepressants? If not, treatment with these medications should be attempted as clinically appropriate prior to initiation of chronic opioid therapy.
- Has this person been **shown to have functional improvement** with a previous opioid trial for this problem? If never attempted, should have a limited trial of opioids to determine effectiveness prior to initiating long term use. If an adequate trial of opioids failed to improve pain and function previously, alternative treatments should be used instead.
- Has this person had **appropriate imaging/testing/specialist evaluation** to objectively evaluate and document the problem (ie MRI, xrays, EMG, neurology evaluation, orthopedic evaluation, psychiatric/psychological evaluation, etc.)? If not, these should be done prior to or concurrent with the initiation of opioid prescribing.

If so, and opioids appear warranted, the provider should initiate the chronic pain management protocol.

INITIATION:

For all patients (those initiating pain medications at WFH and those transferring from other practices), prior to or at the visit in which opioids are initiated:

- Patient should complete the Opioid Risk Tool, CAGE-AID screening, and PHQ-9 screening. A Urine Drug Screen (UDS) should be done. A graded Chronic Pain Scale (2-item) should be completed.

UDS Results

- If the UDS is positive for drugs of abuse other than marijuana, no opioids will be prescribed from WFH, and the patient should be referred to pain management if needed. A patient can be reassessed for appropriateness for opioids 3 years after being deemed high risk/not eligible; prior to this, no opioids should be prescribed from WFH.
- If the UDS is positive for marijuana, OK to initiate opioids pain therapy if indicated. Provider should counsel appropriately on the health risks of marijuana and that in the future a UDS that is positive for marijuana will result in no future opioids being prescribed.
- If the UDS is positive for non-prescribed prescription medication, OK to prescribe opioids in the absence of other red flags. Patient should be counseled never to use others' medications of any type, and that in the future a UDS that is positive for a pain medication other than that which was prescribed will result in no future opioids being prescribed.
- If the UDS is positive for prescribed pain medications, OK to prescribe opioids.

ORT and CAGE-AID results

- If the ORT or the CAGE-AID screenings show high risk for abuse, no opioids will be prescribed from WFH, and the patient should be referred to a pain specialist if needed. (ORT- high risk ≥ 8 ; CAGE-AID- high risk ≥ 2). A patient can be reassessed for appropriateness for opioids 3 years after being deemed high risk/not eligible; prior to this, no opioids should be prescribed from WFH.

PHQ-9 results

- If the PHQ-9 indicates severe, untreated depression, no opioids will be prescribed from WFH. A score of >15 indicates depression; severity should be assessed clinically by the provider. The patient should be referred to a mental health provider and/or treatment for depression should be initiated. The patient should also be referred to a pain specialist if needed. A patient can be reassessed for appropriateness for opioids at any time that she/he obtains consistent, effective treatment for depression or if mood improves.

Risks and benefits

- The risks and benefits of opioids for chronic pain therapy should be reviewed.

Opioid Pain Management Agreement

- If opioids are planned, an Opioid Pain Management Agreement should be reviewed and signed; this includes selecting a single provider and a single pharmacy to use consistently.

Follow up

- Treatment goals should be established, and a follow up plan should be discussed. Initially, this should include at least monthly follow up visits.

Transferring patients

For patients transferring to WFH on pain medications initially prescribed by an outside physician:

Prior discharge

- **Was this patient discharged from pain management** or from another provider's office due to breaking a pain management agreement? If so, how many times?
 - **If discharged from one practice, provider should review the records and/or speak to the discharging physician.** Opioids can be prescribed if, in the provider's opinion, risk is acceptably low. For example, this may occur if the provider does not agree with the rationale for discharging the patient.
 - **If discharged from multiple practices** for reasons associated with pain medication/abuse, **no opioids will be prescribed** from WFH. The patient can be referred to a pain specialist or encouraged to identify a pain specialist with whom to follow up if needed.

Maximum acceptable dose

- Is this patient on a dose of pain medication that is **equivalent to or greater than a dose of 120mg of morphine daily**? (See attached opioid conversion guide.) If so, no opioids will be prescribed from WFH, and the patient should be referred to a pain specialist for management. (See Appendix A.)

UDS Results

- A UDS should be performed on the first visit for these patients as discussed above. In addition to the guidelines listed above under "Initiation", the following guidelines will apply:
 - If the UDS matches what the patient or the record (if received) reports the patient is taking, OK to proceed with initiation of chronic pain protocol.
 - If the UDS does not match what the patient or the record (if received) reports the patient is taking, no opioids will be prescribed, and the patient can be referred to a pain specialist if needed.

Medical records

- On or before the first visit, the patient must request records to be sent to WFH directly from their previous provider(s); records hand-carried by the patient are not acceptable.
 - WFH medical record staff must document request of records in EMR.
 - The patient should be encouraged to follow up with his/her previous provider to ensure timely receipt of records.
 - If the records are not received within a reasonable amount of time, or if the records from the previous provider are documented to be unavailable (such as in the case of some office

closures), the provider and/or WFH nursing staff will contact the patient's pharmacy to obtain records of filled opioid prescriptions.

- If the records received from the previous provider or the pharmacy match the patient's report of prescribed medication, OK to proceed with the chronic pain management protocol.
- If the records from the previous provider are received promptly and do not match the patient's report of prescribed medication, or if they do not corroborate the patient's report of why he/she left the previous practice, no opioids will be prescribed from WFH, and the patient should be referred to a pain specialist.
- If the records from the previous provider are received, but the WFH provider does not feel that the objective or clinical evidence of disease justifies the treatment provided previously, or if the WFH provider does not feel that the treatment plan initiated by the previous provider is clinically appropriate for the patient, the WFH provider is under no obligation to continue the treatment plan as outlined in the notes received. In these cases, the WFH provider will recommend an alternative treatment strategy to address the patient's pain.
- If records are received after substantial delay which do not match the patient's initial report of prescribed meds or reason for leaving the previous practice, and chronic pain management with opioids has already been initiated, it is up to the discretion of the provider to assess the situation and determine whether to continue to treat the patient, or to stop prescribing opioids and refer the patient elsewhere for treatment. As with other transfers of care, in most cases the patient will need to be treated for an appropriate amount of time to allow him/her the opportunity to identify a new pain management provider prior to discontinuing provision of medication.

No opioid meds on first visit

- No opioid pain medication will be provided on the first visit to a patient transferring from another office. The patient should be encouraged to return to the office in one month to discuss, or sooner if records have been received.

MAINTENANCE THERAPY:

All patients receiving opioid medications chronically should be regularly assessed for adherence to pain medication regimen and adjunct treatments, side effects, pain control, functional improvements, and red flag behaviors. The medication and adjunct pain control regimen should be reevaluated frequently and adjusted using the findings from these assessments.

Routine visits

- All patients should **complete the graded chronic pain scale at each visit**. All patients should be evaluated for improvements in functional capacity and decreased pain at each follow up visit. If no improvement in pain or functional capacity is noted after an adequate trial of medication, opioid medication should be tapered off and the patient should be referred to a pain specialist for evaluation.
- Providers should **document the treatment plan clearly** in the assessment and plan of each office visit, including dose and schedule of opioid medications, number of pills prescribed, additional medications to be used, adjunct treatment to be used, and plans for follow up and refill.

- Providers should **titrate doses cautiously** as needed to improve function and limit pain, to a maximum morphine equivalent dose (MED) of 120mg daily. If a patient reaches this threshold without achieving adequate pain relief, the patient should be maintained on the 120mg MED and referred to a pain specialist. (See Appendix A.)
- All patients should be evaluated for **transition to longer acting pain medications**, such as fentanyl, methadone, Kadian or Oxy-Contin, after 3 or more months on chronic pain medications. Transition should be attempted for most patients; exceptions include patients using medication intermittently or patients on low or infrequent doses of short acting medications. If the patient does not tolerate transition to long acting medications, or if the patient resists transition, the WFH provider may choose to continue with short acting medications or continue to attempt transition. In these cases, the WFH provider is under no obligation to continue to prescribe short-acting opioid medications if the WFH provider feels this is not a clinically appropriate treatment strategy.

Interval monitoring

- **ORT, CAGE-AID, and PHQ-9 screenings should be repeated yearly and as clinically indicated.** The Opioid Pain Management Agreement should be reviewed and signed yearly as well.
- **Initially, patients should be seen monthly** to assess medication benefits, side effects, and adherence to recommendations. After a patient has been stable for several months, at the provider's discretion, a patient may follow up in the office less frequently (but no less often than every 3 months) and call to pick up refill prescriptions in between visits. Any change in symptomatology, dosage change or other provider concern should prompt resumption of monthly office visits.

Medication refills

- If pick up of a refill prescription between office visits is deemed clinically appropriate, the patient will call the office 3-7 days prior to needing a refill.
 - The nurse will alert the primary pain management provider to the refill request; this provider then will print the prescription and give it to the nursing staff at the office site.
 - Once the prescription is ready, the patient will come to pick up the prescription.
 - The patient or his or her designee will provide identification to the nurse at the time of pick up, and the nurse will document the date, time and identity of the person picking up the prescription in the patient's chart. For a designee to pick up the prescription, the patient, in advance, must inform the nurse of the name of the person who will be picking up the prescription.
 - Prescriptions should not be post-dated.

Designated provider unavailable

- **A patient should plan to follow up at each visit with his or her designated provider.** However, if the patient's designated provider is not available when a refill prescription is due, another provider should provide appropriate continuation of therapy in the absence of the patient's designated provider.
- Patients should plan ahead to take into consideration the possibility of her or his designated provider being away from the office for a short period of time.
- If the patient's designated provider has a planned absence, the provider can make arrangements ahead of time for the patient to follow up with a different provider.

- If arrangements have not been made in advance, any available provider should refill the opioid medication on the appropriate date in accordance with the treatment plan that has been established. **A patient should not be denied an appropriate refill of chronic opioid medication because his or her provider is unavailable**; however, generally this prescription should be limited to continuing the previous dose/strength prescribed.
- If documentation in the EHR reflects that prescription would have been filled outside of an office visit, the medication should be refilled by the covering provider without a visit. If the EHR reflects that the medication refill would have required an office visit, or if any interval concerns were documented by the patient's designated provider or another provider, the patient should make an appointment for the refill of the opioid medication.

Urine Drug Screens

- **All patients should receive random UDS testing**, generally 3-4x a year, although frequency will vary based on level of risk of abuse/diversion. UDS testing can also be done at any time at the discretion of the provider. UDS testing at every visit is likely to be less useful than random testing, and should be avoided in most circumstances.
 - **If there is concern that the urine sample has been altered** (e.g. the patient added water or is using another's urine), the provider will have the patient repeat the urine testing immediately. If there is persistent concern with repeat testing, medications can be provided or discontinued based on the provider's judgment. If the medications are continued, the patient will be asked to repeat the UDS at a visit in the near future, and the provider will determine follow up plans based on the results. If concern that the urine has been altered persists, then no further opioid medications will be provided from WFH, and the patient should be referred to a pain specialist.
 - **If the result of the UDS is unexpected** (i.e. positive for something the patient denies or negative for something the patient reports), after discussion with the patient to uncover potential reasons (OTC meds, etc.), the UDS should be repeated immediately.
 - If the result of the repeat UDS is still unexpected, the result can be confirmed with serum testing using GCMS. At that visit, the patient will be provided with a prescription for a 1 week supply of medication, and given a prescription to have GCMS testing for the substance in question to be drawn that day on site when possible, or to be done within 24 hours if on-site lab testing is not available. If the testing is not done as requested, or if the GCMS confirms the unexpected result, then no further opioids will be prescribed and the patient should be referred to a pain specialist. If the GCMS does not confirm the unexpected result and instead confirms the patient's account, the provider will continue with the treatment plan as previously developed. The cost of the testing will be paid by the patient.
 - **If the UDS is positive for street drugs** including marijuana, no further opioids will be provided by WFH, and the patient should be referred to a pain specialist.
 - **If the UDS is positive for medication prescribed** by another provider for a new, concrete, acute problem (i.e. surgery, kidney stone), the provider can continue to prescribe opioid medication at that visit but the patient should be informed that this is a breach of the Opioid Pain Management Agreement. The patient should be reminded that for this issue all future pain meds should be obtained from WFH only, and that future emergency situations in which opioids are used in an acute care setting, such as after surgery or an MVA, should be reported immediately to the WFH provider; records will then be obtained immediately to document this.

- Subsequent occurrences will result in the termination of the Opioid Pain Management Agreement and referral to an outside pain specialist.
- If the UDS is positive for a opioid medication that was prescribed by another provider for the chronic problem, or if the WFH provider receives information that the patient is obtaining opioid medication for his/her chronic pain from multiple providers, no further opioids will be provided by WFH and the patient should be referred to a pain specialist.
 - **If the UDS is positive for a prescription medication that was not prescribed**, no further opioids will be provided by WFH and the patient should be referred to a pain specialist.
 - **If the UDS is negative for the prescribed pain medication** and this is expected (patient reports running out previously due to delayed follow up appointment, or for other reasons), OK to continue with pain management regimen; the patient should be counseled on the importance of timely follow up for future visits.
 - If the UDS is negative for the prescribed pain medication and this is not expected, the UDS will be repeated in the office immediately. If the repeat UDS is also negative, the provider will provide a 1 month supply of medication, and repeat the UDS at a different visit in the near future. If follow up UDS testing is again unexpectedly negative, no further opioids will be provided by WFH and the patient should be referred to a pain specialist if needed.

Aberrant behavior

- **Any evidence of diversion of medication** (such as selling the medication or giving it to others) **will result in termination of the Opioid Pain Management Agreement**, and no further opioids will be provided by WFH.
 - **Any evidence of ongoing high risk behavior** (hospitalization for drug overdose, positive drug screens for street drugs other than marijuana in an acute care setting, unsanctioned dose changes, obtaining opioid medication from outside providers, pharmacy reports of prescription tampering or other aberrant behavior, etc.) **will result in termination of the Opioid Pain Management Agreement**, and no further opioids will be provided by WFH.
 - **Other breaches of the Opioid Pain Management Agreement** will be addressed as stipulated in the Agreement or at provider discretion.
 - **Lost medications will not be replaced.** Stolen medications will be replaced only when a police report is provided.
-

Appendix A: Opioid dosing conversion

The maximum dose of chronic pain medications that Westside providers will prescribe is 120 mg of morphine, or an equivalent dose. In order to standardize this maximum dose across all providers, a set of standard conversion factors have been adopted (based on the Morphine Equivalent Dose, or MED, of these medications). These conversion factors are to be used only to determine the maximum dose allowable under this protocol, not for transition from one opioid to another. (For transition from one opioid to another, the MED should be used to calculate an approximate equivalent dose, with subsequent appropriate reduction of dose to account for incomplete cross-tolerance of the opioids.)

Table 1:

Opioid	Equianalgesic Dose (mg) Oral or transdermal	Westside standard conversion factor
Morphine	30 mg	1
Hydromorphone	7.5 mg	4
Codeine	200 mg	0.15
Fentanyl transdermal	12.5mcg/hr	2.4
Hydrocodone	30 mg	1
Methadone- chronic	4 mg	7.5
Oxycodone	20 mg	1.5
Oxymorphone	10 mg	3

For a given medication, that medication's current dose is multiplied by the conversion factor to calculate the morphine equivalent dose.

Based on these conversion factors, the following are the maximum doses of these medications to be prescribed under this protocol (Per the protocol, these doses triggers referral to specialist. Do not start chronic pain medication management at Westside if patient presents on greater than or equal to the maximum dose.)

Table 2:

Opioid	Maximum daily dose for protocol	Comments
Morphine	120 mg	Example: MS Contin 60 mg twice daily
Hydromorphone	30 mg	Example: Dilaudid 30 mg total daily
Codeine	360 mg	Note: Codeine dose based on safety, not on morphine equivalent. Note: Acetaminophen max daily dose = 4 grams
Fentanyl transdermal	50 mg	Example: Duragesic 50 mcg/hr patch
Hydrocodone	120 mg	Example: Vicodin Note: Acetaminophen max daily dose = 4 grams
Methadone-chronic	16 mg	Example: Methadone 10 mg + 5 mg daily
Oxycodone	80 mg	Example: Oxycontin 40 mg twice daily

Appendix B: Permitted Use

Westside Family Healthcare is providing this information to other organizations as a resource. It is the responsibility of the end-user to verify this information, and to follow appropriate clinical standards-of-care.