Maintenance Management of Chronic Pain in Adults

Maintenance Therapy with Opioids for Non-Malignant Pain

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Management of Chronic Pain in Adults

Initiation or Continuation of Opioid Therapy for Non-Malignant Pain

Assessment of Chronic Pain (pain greater than 3 months) should include the steps in the Initial Assessment of Pain Protocol including the HPI, PE, and any diagnostic testing determined to be indicated based on findings or 'red flags'

The goal of chronic pain management should be to prioritize function first and foremost. It is highly recommended that the management plan for chronic pain of any etiology include Non-Opioid Pharmacologic Therapies and Non-Pharmacologic Therapies. Opioids should cautiously be employed lastly as a means to improve function and manage pain. The following requirements should be met prior to prescribing narcotic analgesics:

- Document the condition that requires treatment with an opioid medication;
- Document a history and physical examination that includes relevant information regarding the condition requiring treatment with an opioid medication, other treatments tried or considered, and an assessment for any contraindications to opioid use (Opioid Risk Tool [ORT] and Behavioral Screening Tools);
- Document discussion of risks, anticipated benefits, and alternatives to treatment with opioid medication;
- Obtained a signed Informed Consent and Patient Agreement;
- Query the Tennessee and/or Virginia Prescription monitoring program(s) called the Controlled Substance Monitoring Database (CSMD) program to review for prior prescription history;
- Obtain a urine drug screen; and,
- Plan periodic follow-up visits for monitoring progress toward the medical goals of treatment and the patient's self-identified goals and document new or continued pharmaceutical and non-pharmaceutical treatments; alternatively, document whether the patient would better be served with a referral to a pain management specialist or substance abuse specialist.

Prescription of Opioid Pain Medications for Chronic Pain

Prior to initiating opioid pain medications for a chronic condition, transitioning from acute to chronic pain management, or at an initial evaluation of a patient transferring from another clinic on opioid medications the following should be assessed or addressed:

- Potential contraindications to opioid therapy, including past adverse drug events and current untreated substance use disorder;
- Non-opioid pain medications failed to effectively improve function and manage pain, such as acetaminophen, one or more NSAIDs, or other adjunct medications; if not,

treatment with these medications should be attempted as clinically appropriate prior to initiation of chronic opioid therapy;

- Non-pharmaceutical therapies tried and failed or with insufficient response; if not, treatment with these modalities should be attempted as clinically appropriate prior to initiation of chronic opioid therapy
- Prior opioid therapy demonstrating functional improvement; if not, a limited trial of an opioid medication should be considered to determine effectiveness prior to initiating long-term use; if a trial of opioids deemed appropriate was tried and failed to improve pain and function previously, alternative treatment options other than opioids should be used instead
- Prior imaging, diagnostic testing, specialist evaluation has been done to objectively evaluate and document the problem for which the opioids are to address; if no prior diagnostic evaluation, strong consideration should be given to performing this evaluation prior to or concurrent with the initiation of opioid medication
- Opioid medications deemed appropriate and
- Review the informed consent and the patient agreement, answer questions, and include a signed copy in the EMR once opioid medications are deemed appropriate

Initiation of Opioid therapy

When opioids are determined appropriate to address chronic pain (pain greater than 3 months or 90 days) the following steps should be taken before choosing and prescribing or continuing an opioid:

1. Document the specific condition that requires treatment with an opioid medication.
2. Document a thorough pain complaint assessment (*See the Initial Pain Assessment Algorithm*) that includes the relevant history and physical examination regarding the condition requiring treatment with the opioid medication and any contraindications of opioid therapy based on the patient's history, including the presence of co-morbid conditions which could impact the decision to start opioids.
3. Document a graded pain scale result and assess function using the *PEG scale* (**P**ain on average, **E**njoyment of life, **G**eneral activities).
4. Assess risk factors for misuse, abuse, or diversion using the ORT and other Behavioral Health or Substance Misuse Screening tools deemed appropriate. It recommended that at a minimum the PHQ-9 depression screening tool be performed.
5. Document details of other pharmacologic and non-pharmacologic treatments tried, including use of any opioids as described previously.
6. Maximize non-opioid therapies, including the use of non-pharmacologic therapies.
7. Query the CSMD and document in the electronic medical record (EMR). Check the CSMD to obtain a prescription history of controlled substances.
8. Obtain a urine drug screen (UDS). The patient should be advised of testing. An inquiry of any predicted or expected results should occur in consultation with the patient.

9. Choose a short-acting opioid medication to be prescribed, using the lowest dosage determined to be appropriate for the patient and match duration to the scheduled reassessment.
10. Treatment goals should be established, discussed, and documented in the care plan along with a follow-up assessment schedule. These should include pain and function goals. Criteria should be set for stopping or continuing the opioids at follow-up visits.
11. Prior to supplying the prescription, an informed consent and patient agreement should be reviewed, questions answered, and signed prior to prescribing any controlled substance. The risk of harm and misuse should be part of the informed consent conversation.
12. Women of child-bearing age with reproductive capability should be advised of the risks associated with use of opioids on the pregnancy and the risk of neonatal abstinence syndrome in the neonate
13. Contraception should be offered to women who wish to avoid an unintended pregnancy, particularly the use of reversible long-acting contraceptives
14. If opioid pain medications are planned, a prescription for naloxone may be appropriate to mitigate risk for the patient with the initiation of the opioids. The risks, benefits, and use of naloxone should be reviewed with the patient and a family member or support person prior to providing a naloxone prescription.

INITIATION:

All patients for whom opioid medications are initiated or continued shall at a minimum:

- Complete the ORT and PHQ-9
- Perform a UDS
- Document a graded Chronic Pain Scale
- Query the CSMD to obtain a controlled substance prescription history

UDS/UDT:

- A urine drug screen (UDS) or urine drug test (UDT) should be done prior to prescribing any controlled medication. The results should be used as one piece of information along with a comprehensive history and physical examination in considering initiation of opioids. If the UDS/UDT is positive for drugs of abuse other than marijuana, no opioids should be prescribed and the clinician should discuss the decision with the patient and offer a referral to medication assisted treatment.
- If the UDS/UDT is positive for marijuana, there are no red flags, and opioids are deemed appropriate, opioids can still be considered but the patient should be counseled regarding the health risks of marijuana use and its illegal status in Tennessee. Additionally, the patient should be advised that should future drug tests be positive for marijuana, no further opioids will be prescribed.
- If the UDS is positive for a non-prescribed prescription medication and there are no red flags and opioids are deemed appropriate, opioids could still be considered but the patient

should be counseled that they should never use someone else's medications and should future drug tests be positive for any medication other than that prescribed as part of a comprehensive treatment plan, no further opioid medications will be prescribed.

- If the UDS is positive for prescribed pain medications, opioids can be considered.
- Interpreting UDS/UDT results: Interpretation is not as simple as a positive or negative result. To interpret the results appropriately the concept of interference must be understood. This is especially important when the results are used to influence clinical decisions with inappropriate actions being taken on presumptive results that could have detrimental consequences to the doctor-patient relationship and the treatment plan. Both false positive and false negative results can occur. Cross-reactivity with common prescription and over-the-counter medications (NSAIDS, decongestants, and antacids) can cause false positive results, necessitating the need to obtain a comprehensive medication list from the patient prior to ordering a UDS.

  The following table is only an example of false positive results that could occur and not a comprehensive list:

  Common False Positives

Drug Screen	Source of False Positives
Amphetamine	Bupropion, labetalol, pseudoephedrine, trazodone
Benzodiazepine	Sertraline, HIV antivirals
Cannabinoids	NSAIDs, PPIs, HIV antivirals
Cocaine	Coca tea leaf, topical anesthetics with cocaine
Opioid	Quinolones, diphenhydramine, naloxone, quetiapine, verapamil, ranitidine, quinine
PCP	Dextromethorphan, diphenhydramine, ibuprofen, venlafaxine, tramadol

- Drug testing should be a therapeutic tool used to monitor therapy, provide reinforcement and explore substance use behavior. Results of testing should be employed to achieve these objectives. Results should be presented in a non-confrontational and compassionate manner. Unexpected results will inevitably be encountered and requires a systematic approach to address. It can conflict with the patient's self-report, the medication the patient is taking, medications prescribed, or a substance misuse pattern. If the results conflicts with the patient's self-report, the results should be confirmed if at all possible before a clinical decision is to be made to alter the treatment plan. A patient-centered approach is recommended. Caution is advised when considering abrupt discontinuation of a patient's medication. The patient should be informed of the concern for substance misuse and offer referral to medication assisted treatment. Abrupt discontinuation of opioids or benzodiazepines can lead to significant harm.

ORT:

- If the ORT screenings indicate high risk (≥ 8), no opioid medication will be prescribed but other pain management options will be offered/recommended, such as non-opioid analgesic medication and/or non-pharmaceutical, integrative medical therapies, such as physical therapy, Osteopathic Manipulative Medicine, and Acupuncture

PHQ-9:

- If the PHQ-9 scoring indicates severe, untreated depression then caution should be used in considering opioid initiation and is not routinely recommended. A score of ≥ 15 indicates moderately severe depression and should be used along with the clinician assessment to determine severity. The patient should be given a treatment plan for depression which may include referral to behavioral health services. If opioid medications are not indicated due to the severe depression, a treatment plan for pain should be offered/recommended that excludes opioids until the depression is effectively treated and the patient's mood is improved.

Risks and Benefits, Notice of Informed Consent:

Review risks and benefits of opioid pain medication for chronic pain and include goals of anticipated pain reduction and improvement in function using shared decision-making and document in a treatment plan in the EHR. Include alternative treatment options and other adjunct therapies recommended/prescribed. Review the informed consent and patient agreement with the patient. Documentation of informed consent must be completed and signed by the patient and the clinician.

Risk Mitigation with Naloxone:

If opioids are being prescribed, the clinician should provide education to the patient and family member or support person on the risks, benefits, and use of naloxone and receive a prescription for naloxone, along with the prescription for opioids.

Documentation and Follow-up:

- In review, documentation must include the identification of the condition requiring treatment with an opioid analgesic, documentation of other treatments tried or considered, and efficacy of previous treatments for management of pain.

- Treatment goals should be established and documented along with a follow-up plan. With the initiation of opioids for chronic pain management, it is recommended that follow-up visits be no longer than 4 weeks to assess for efficacy, adverse side effects, and progress toward meeting treatment goals.
- Behavioral health diagnoses and medical comorbidities that can influence the use of opioids for pain should be addressed concurrently with the treatment for pain.

Transferring Patients on Opioids:

Patients transferring on opioid medications prescribed by an outside physician. All patients for whom opioid medications are initiated or continued shall at a minimum have the following:

- Complete the ORT and PHQ-9
- Perform a UDS
- Document a graded pain scale result and assess function using the *PEG scale* (**P**ain on average, **E**njoyment of life, **G**eneral activities).
- Query the CSMD to obtain a controlled substance prescription history

Medical Records:

- Prior to opioid therapy initiation, the medical record should be obtained and reviewed for documentation of the diagnoses for which the opioids are prescribed along with the treatment plan created to improve function and manage pain. Additionally, the clinician should obtain a comprehensive history including prior therapies and medications used as part of the treatment plan and a physical examination to determine if continuing opioids seems appropriate. The clinician may continue the current opioid treatment, alter the opioid dosing, or discontinue the opioids and recommend an alternative treatment strategy to address the patient's pain and functioning. Should the patient have a history of being discharged from multiple practices for reasons associated with pain medication or misuse/abuse, no opioid medications should be prescribed. The patient should be offered referral to substance abuse treatment if appropriate.
- If the patient is prescribed opioids that are equivalent to or greater than a total daily dose of morphine 120mg, it is strongly recommended the patient see a pain management specialist if possible or consider tapering the dosage to a total daily dose of 90 mg or less following the tapering protocol.
- No opioid pain medications will be prescribed to a patient transferring from another practice on the first office visit *except* at the discretion of the physician deeming it necessary for patient health and safety.

UDS/UDT:

- A UDS should be performed on the first office visit. The following shall guide the decision of continuing opioids:
    - If the UDS matches what the patients and/or record reports the patient is taking, continuation of opioids can be considered if deemed appropriate.
    - If the UDS does NOT match what the patient and/or record reports is taking, no opioid medications should be prescribed unless patient health and safety are at risk.

ORT:

- If the ORT screenings indicated high risk (≥ 8), strong consideration should be given to whether continuation of opioid medication is appropriate and consider other pain management options such as non-opioid analgesic medication and/or non-pharmaceutical, integrative medical therapies, such as physical therapy, Osteopathic Manipulative Medicine, and Acupuncture. If the patient is currently taking opioid medications, a tapering and discontinuation plan should be discussed. The patient may be offered substance abuse treatment referral if appropriate.

PHQ-9:

- If the PHQ-9 scoring indicates severe, untreated depression then caution should be used in considering continuation of opioid medication. A score of ≥ 15 indicates moderately severe depression and should be used along with the clinician assessment to determine severity. The patient should be given a treatment plan for depression which may include referral to behavioral health services. If opioid medications are not indicated due to the severe depression, a treatment plan for pain should be offered/recommended that excludes opioids until the depression is effectively treated and the patient's mood is improved.

Risks and Benefits, Notice of Informed Consent:

Review risks and benefits of opioid pain medication for chronic pain and include goals of anticipated pain reduction and improvement in function using shared decision-making and document in a treatment plan. Include alternative treatment options and other adjunct therapies recommended/prescribed. Review the informed consent and patient agreement with the patient. Documentation of informed consent must be completed and signed by the patient and the clinician.

Risk Mitigation with Naloxone:

If opioids are being prescribed, the clinician should provide education to the patient and family member or support person on the risks, benefits, and use of naloxone and receive a prescription for naloxone, along with the prescription for opioids.

Documentation and Follow-up:

- Documentation must include the identification of the condition requiring treatment with an opioid analgesic, documentation of other treatments tried or considered, and efficacy of previous treatments for management of pain.
- Treatment goals should be established and documented along with a follow-up plan. It is recommended that a follow-up visit be made for no longer than 4 weeks to assess for efficacy, adverse side effects, and progress toward meeting treatment goals