

Use of Opioids for Chronic Non Malignant Pain (CNMP)

I. PURPOSE

We the Safe Opioid Prescribing and Review Committee (SOPARC) are inspired to support a shift in opioid prescribing that improves clinical treatment while minimizing doctor shopping and chaos. This clinic-wide policy is based on similar policy from San Francisco General Hospital (SFGH) and Contra Costa Regional Medical Center /Health Centers (CCRMC/HC) Guidelines for Prescribing Controlled Substances for Chronic Non-malignant Pain (CNMP).

II. POLICY

All health care team members of CCRMC/HC will serve our patients with CNMP with compassion while recognizing the unique risks associated with the use of opioids.

III. AUTHORITY/RESPONSIBILITY

Safe Opioid Prescribing and Review Committee

Medical Staff President.

IV. PROCEDURE

All physicians and nurse practitioners will sign a statement that they have read this policy on the use of Opioids for CNMP at the time of credentialing and re-credentialing

V. GUIDELINES

With the development of a clinic wide policy, we each sacrifice some of our clinical autonomy for a more unified approach to patients with CNMP at CCRMC/HC. We believe this will be good for the patients, the community and the clinic. As before, you can still use your clinical judgement to make an exception to this policy. If you do make an exception, you are agreeing to document your reasons for making the exception. In addition if you do make an exception, it is strongly suggested that you seek internal or external pain management consultation. If opioid treatment is expected to last longer than three months, the CCRMC/HC's guidelines for CNMP should be followed. Standardized charting is useful for clinical care because it improves efficiency of short notice clinics, specialty treatment, and cross coverage. Treating clinicians must use clinical judgment in the prescription of all medications. Nothing in this protocol should be construed as requiring a clinician to continue to prescribe a medication that is no longer indicated. Avoiding opioids whenever possible can mitigate significant risks to patient long-term health such as hormone disruption, weaker bones, increased risk of CVD, infection, permanent gut motility changes, constipation, acid reflux, reduced response time, short-term memory

problems, depression, weight gain, urine retention, triggering unknown predisposition to SUD, erectile dysfunction, and increased pain sensitization. Educating patients about risk of opiate addiction, pain sensitization and signs of addiction when considering opioids is recommended and can mitigate risk as well as improve outcomes if addiction behaviors emerge. Use of opioids of greater than 5 days has been associated with increased risk for developing substance use disorder (SUD). SUD risk further increases when opioids are continued for 1 month with further increase at 12 weeks (4). Early discussions about risks with patients can mitigate risk (4). Caution is suggested in prescribing Tramadol, which has the second highest risk of transition to long-term opiate use (4).

If opioid treatment is expected to last longer than three months, the CCRMC/HC's guidelines for CNMP should be followed. Standardized charting is useful for clinical care because it improves efficiency of short notice clinics, specialty treatment, and cross coverage:

- It is recommended that all patients receiving opioids for CNMP will have the diagnosis code G89.29 or G89.4 (chronic pain) entered in the problem list (3)
- The Chronic Pain overview .CHRONICPAINOVERVIEW will be included in the problem list under Chronic Pain to facilitate cross coverage for new and established patients. The chronic pain overview documents patient Provider, Condition requiring opioids, drug regimen, last Utox, last cures, pain agreement, and red flags. (3)
- CURES Report review will be documented with smart phrase .CURESPDMP (3)
- A signed Patient agreement will be obtained (1,2) and scanned into the EMR and documented with smart phrase .PAINAGREEMENT. (3)

A. Management of Chronic Non-malignant Pain (CNMP) with Opioids for New Patients

There will be an initial assessment of pain, function, and risk of opioid misuse to assess whether opioid treatment is appropriate. This will include at minimum:

- Pain history (1,2)
- Pain treatment history (1,2)

- Assess if opioids have been stopped by prior provider for any reason. (3)
- Substance use history (1,2)
- Mental Health history (1,2)
- Requesting outside records not present in chart/care everywhere (1,2)
- Physical exam of effected body area (1,2)
- CURES Report (1,2)
- U-Tox: -Informed consent regarding opioid risk and benefits (1,2)
- Consider prescribing naloxone rescue kit for MS meq > 50 mg (1,2)
- Conduct PEG (1,2) or Opiate Risk Tool (ORT) (1,2) which can be found under (.ORT)
- Risk Stratify patient using ORT score and aberrant behavior history.

Low risk: ORT <4 and no aberrant behaviors*.

Moderate risk: ORT 4-7 and no concerning behaviors* or ORT <3 and 1 concerning behavior*

High risk: ORT >8 or any ORT and >2 concerning behaviors* (3)

- Establish realistic treatment goals for pain and function (1,2)

B. Management of Integrated Care for CNMP

Patients treated should have a trial of both non-opioid medication management and non-medication management of chronic pain. Patients should have identified functional improvement and pain management goals. As risk and opioid dose increase there is an increased need for coordination of care and development of integrated care team. (1,2)

- Assess for and treat anxiety, PTSD, depression, insomnia because each impact pain in a bidirectional manner. Consider referral to health psychology (Health Coaching) or behavioral health for management of symptoms. (3)
- Same day consultation with health psychologist (Health Coaching) or behavioral health consultant (BHC) are available for 1. Motivational interviewing 2. Assessing for mental health treatment needs 3. Substance use risk. (3)

*** Addendum 1 - list of aberrant/concerning behaviors**

C. Management of CNMP on Chronic Daily Opioids

There will be regular re-assessment of patient's goals, pain, function, and signs of misuse to assess whether the current treatment strategy is appropriate. (1,2) This will include at minimum:

- Regular assessment of functional status, pain, and quality of life are captured in the Pain Enjoyment and General Activity (PEG) tool (.peg) (1,2). Consider updating PEG at each chronic pain visit (3).
- For individuals with morphine equivalent dosing (MED) > 50 mg consider increasing frequency of visits to every three months.
- Chronic pain medicine agreement should be reviewed, signed, and documented (1,2) and consider updating agreement annually and with assignment of new primary care provider (PCP) (3)
- Evaluate for appropriateness of non-opioid pain management modalities and order. Re-evaluate every six months or three months for MED > 50 mg (3). Multiple modalities of pain relief should be utilized with all patients. (1,2)
- CURES report checked, documented with smart phrase and scanned to chart at least every 3 months. (1)
- Urine drug test at least annually and as clinically indicated (1,2).
- Aberrant behavior charted on problem list using diagnosis code G89.29 or G89.4. Universal documentation patterns allow easy access for all providers to review aberrant behaviors.

D. Management of Refills of Controlled Medications

Early refills will be provided rarely and will be treated as behaviors concerning for possible misuse of opioids: (3)

- Documentation on problem list of: All patients receiving opioids for CNMP will have the diagnosis code G89.29 or G89.4 (chronic pain) entered in the problem list with Chronic Pain overview .CHRONICPAINOVERVIEW. This is essential for team care (cross coverage and short notice).
- Early refills must also be noted in problem list under Chronic Pain G89.29 G89.4 in the chronic pain overview (note: refills for travel that do not increase total number of pills or reset refill cycle are not considered early refills).
- Patients with more than one early refill in a 12 month should be assessed for risk. For patients identified as being at high risk, consider a formal or informal consultation if controlled medication are to be continued.

E. Managing Concerning Behaviors for Patients on Controlled Substances: Concerning behaviors will be documented in the problem list under chronic pain in the chronic pain overview. (3)

Subsection 1: Behaviors requiring immediate termination of controlled medications with or without taper. Patient will not be dismissed from practice and pain management should continue using non-opioid and non-medication interventions. Clarity should be maintained that medications were not discontinued punitively but rather due to concerns for the patient's health and the well-being of the community.

- Falsification of secure prescriptions
- Selling of controlled substances
- Obtaining prescriptions from multiple undisclosed provider
- Refusing to sign a patient agreement without justifiable cause.
- Refusal to sign release of patient records from other providers

Subsection 2: Behaviors requiring immediate increase in monitoring (i.e. more frequent visits, random urine drug screens and CURES), re-evaluation of risks and benefits of chronic daily opioids, and reevaluation of doses of opioid (dropping dose after aberrant behaviors often clarifies for all parties the need for behavior change to maintain safe prescribing) (Termination of controlled medications may be appropriate in some cases.)

- Request for early refill due to:
 - o a) lost or stolen medication
 - o b) having used prescribed quantity faster than agreed upon.
- Refusal to provide urine for drug screen
- Urine drug screen negative for prescribed medications and positive for non prescribed drugs (confirmed by GCMS or patient admission)
- Urine drug screen negative for prescribed medications and NOT positive for anything not prescribed confirmed by GCMS. (consider assessment for under treatment of pain as motivation for running out early and optimize non opioid treatment while supporting coping strategies)
- Urine drug screen positive for prescribed medications and for non prescribed drugs or illicit substances. (If non prescribed drugs are opioids, consider assessment for under treatment of pain as motivation for using outside opioids, set clear limits and optimize non opioids treatment while supporting non-opioid coping strategies)
- CURES showing controlled medications from outside providers that were not reported by the patient, as required by Chronic Pain Medicine Agreement. (ie dental work, ER visit)
- Providers will respond to concerning behaviors by increasing patient monitoring (monthly visits, urine drug testing, CURES), changing the treatment plan, or discontinuing controlled medication. Consider formal or informal consultation and document clearly.

Subsection 3: Cumulative behaviors warranting re-evaluation of continuing controlled medications (3)

- Any of behaviors listed in Subsection 2 that re-occur
 - Consider a formal or informal consultation related to pain and the resulting behavior.
- Monitor with more frequent visits, urine drug testing, and CURES.

F. Management of patients on controlled substance who transfer to new providers. (3)

- Assess patient pain treatment history with particular attention to: patient's goals, aberrant behaviors, urine toxicology screens, CURES report, functioning and pain scores (e.g. PEG scores). Also assess for pain consultation notes from CCRMC/HCs pain management primary care providers as well as external providers.
- Treat transferring patients as a new patient evaluation (See Section 1) and monitor all chronic pain & chronic daily opioid prescriptions using above protocol (See Section 2).
- Consider continuing the current plan or adjusting existing plan with minimal changes provided that:
 - o the patient is meeting stated goals
 - o serial function and pain scores (PEG scores) indicate that the patient is well maintained
 - o u-tox screens, and CURES report are appropriate

If the patient is not currently taking controlled medication and does not show signs of opioid withdrawal (.COWS), it is strongly encouraged that non-opioid medication and treatment is suggested to patient and controlled medications are not started on the first visit, and perhaps never (4). Opioids will rarely be restarted after they have been discontinued secondary to concerns of risks outweighing benefits. Restarting opioids should be based on re-evaluation of substance use disorder and consultation should be considered as appropriate. If restarting opioids, the following should be clearly documented (3)

- A review of the previous discontinuation and documentation of a clear change in the patient's state or situation that will protect the patient from recurrent harm.
- A behavioral health evaluation has been completed.
- A medical pain evaluation has been completed
- A specific appraisal of functional goals has been delineated.
- Documentation of repeatedly negative urine drug tests over the course of intervening months.
- If Substance Use Disorder (SUD) is current or was the reason for discontinuation of chronic daily opioid prescription, active prolonged and regular involvement in SUD treatment is required and must be clearly documented.

If the patient is currently taking controlled medications, it is strongly encouraged that non-opioid medication and treatment be recommended with latter attempts to minimize opioid dose. (1,2,3,4)

- Providers who are not the patient’s PCP should not change most recent PCP controlled medication plan for CNMP without discussion with the PCP

G. Management of daily opioid medication in Sub-specialty care. (3)

Opioids are not currently recommended for chronic daily, long-term use (4). Opioid medication duration and dose are both predictive of hyperalgesia, loss of function and long-term opioid misuse.

- When initiating opioids for an opioid naive patient or starting a new course of opioid treatment in a patient, it is important to follow guidelines in Section 1 – Management of Chronic Non-malignant Pain (CNMP) with Opioids for New Patients and Section 2 – Management of Integrated Care for CNMP.
 - Assess ORT (Opiate Risk Tool), CURES report, and U-Tox screening.
 - If opioids previously discontinued by PCP or pain specialist seek consultation prior to resuming opioids.
 - If the patient has CNMP and is opioid naïve consider consulting PCP prior to starting opioids as part of evaluating risk of opioids (e.g. opiate use disorder, sleep apnea, osteoporosis etc.).
 - Consider prescribing naloxone rescue kit
- Acute surgery related pain is most appropriately managed by the Sub- specialist.
- Consider consultation with Pain Management Primary Care Specialist/ Pain Specialist for acute and/or perioperative pain management

References

- 1) **CDC Guidelines March 18, 2016**
- 2) **California State Guidelines Nov 2014**
- 3) **SOPARC recommendations**
- 4) **MMWR/CDC Initial prescription & long-term opiate risk, March 2017**

DATE APPROVED BY APC:	9/21/2017
DATE APPROVED BY PHARMACY:	10/17/2017
DATE APPROVED BY PCP+E :	11/1/2017
FINAL REVIEW AND APPROVAL BY APC:	11/16/2017
DATE APPROVED BY MEC :	11/20/17

Addendum 1: List of Aberrant/Concerning Behaviors

Yellow Flags

- 1) Requests early or late refills 1-2 times
- 2) Requests for dose escalations after first 3 months
- 3) Requesting brand name
- 4) Reporting lost/stolen Rx
- 5) Missing appointments
- 6) Sedation/appearing intoxicated
- 7) History of abuse/misuse/overdose
- 8) Not adhering to adjunctive treatments
- 9) Multiple refills by other providers
- 10) Pill count discrepancy
- 11) Declining functional status despite appropriate therapy

Red Flags

- 1) Non-prescribed medications in Utox
- 2) Borrows others controlled medications
- 3) Negative Utox for prescribed substance
- 4) Alters, forges or rewrites prescription
- 5) Suffers an accidental overdose
- 6) Patient threatens you or your staff
- 7) Continually raises yellow flags despite your warning and attempts to reorient