Pain Management Protocol for ERMC Family Practice

Goal: To provide safe and effective care for patients experiencing pain by aligning our practice with the standards set forth by National and State authorities who oversee prescriptive practice in Michigan.

Process: Evaluate patient's history of pain and type of pain, potential for addiction, functional status, psychosocial risks, medical co-morbidities and ongoing response to treatment.

1) Identify type of pain and source of pain. Review/obtain imaging or other studies such as EMG to provide clear diagnosis of type of pain.
    a. Acute vs Chronic Pain
        i. Acute: tissue injury which resolves with healing
        ii. Chronic: Initially pain generated by injury but lasting longer than 3 months or longer than expected healing time for the injury. In chronic pain a shift occurs from acute injury and healing to abnormal maladaptive pain. This occurs in the peripheral and central pain pathways.
    b. Four types of pain
        i. Centralized pain: peripheral and central sensitization without detectable peripheral origin. EG: fibromyalgia, irritable bowel syndrome, tension headaches.
        ii. Inflammatory pain: Nociceptive pain with localized immune response that generates pro-inflammatory mediators to facilitate tissue repair.
        iii. Neuropathic pain: originates from injury to specific peripheral nervous system or central nervous system structures. EG: diabetic neuropathy, post herpetic neuralgia.
        iv. Nociceptive pain: Normal acute response to peripheral tissue damage.
2) Psychosocial Risk Assessment
    a. Abuse and trauma
    b. Coping and social support
    c. Smoking, alcohol abuse, substance abuse
3) Co-morbidity assessment
    a. Depression and anxiety
    b. Sleep impairment
    c. Chronic respiratory disease
    d. Neurologic disorders
    e. Cardiovascular disease
    f. Metabolic disorders

    g. Endocrine disorders
    h. Gastrointestinal disorders
4) Assessment of medication side effects including:
    a. Psychological: Euphoria, depression, anxiety, thought disorders, addiction, serotonin syndrome, etc
    b. Functional: sedation, respiratory depression, constipation, nausea, vomiting, etc.
    c. Physical ability to care for oneself and to work
    d. Immunologic changes: puritis, skin reactions
    e. Endocrine changes

Program Components:

1) Assessment: addiction, functional status, imaging, neuromuscular testing, etc.
2) Cognitive Behavioral Therapy and coping skills (Behavioral Health)
3) Progressive strengthening and functional restoration (in conjunction with Physical Therapy and Health Works)
4) Medication in compliance with CDC recommendations
    a. Establish treatment goals for pain and function
    b. Consider how therapy will be discontinued if benefits do not outweigh risks
    c. Continue opioid therapy only if clinically meaningful improvement in pain and function outweighs safety risks
    d. Non-pharmacologic therapy and non-opioid therapy are preferred for chronic pain
    e. When using opioid therapy, combine with non pharmacologic therapy and non-opioid therapy as appropriate.
    f. Review with patient risk/benefit and side effects of medications.
5) Pain Management Contracts – including random drug screening, functional assessment, participation in functional restoration through physical therapy and exercise, MAP monitoring, pill counts at every appointment, attendance and participation in all aspects of pain management, etc.
6) Violations to adhering to pain management contract
    a. Patient will be safely tapered off medication and referred to appropriate resources for care such as pain management specialist, addiction counseling and recovery, etc.
    b. Patient will be encouraged to continue with our practice for non-pain management care.
7) Criteria for referral to Pain Specialist:
    a. Scope of care is beyond CDC guidelines for primary care
    b. Patient is not improving with prescribed therapies
    c. Patient is a candidate for spinal injections/blocks
    d. Patient requires >90MEQ of morphine daily

e. Patient requires >90 pills per month to manage pain
f. Patient use of long acting opioid medications

Criteria for long term Primary Care Pain Management:

1) All diagnostic studies are filed in EMR which support diagnosis of pain and type of pain
2) Addiction Assessment
3) Functional Capacity Assessment
4) Co-Morbidity Assessment
5) UDS compliance
6) Full participation in Physical Therapy/Exercise program with documentable improvements in functional status
7) No missed appointments for therapy or medical management, initial evaluation will be followed up at frequent intervals of not longer than 3 months.
8) MAP consistency
9) Pill count consistency
10) Signed Pain Contract
11) Quarterly review of adherence, addiction and functional status as well as medication side effects
12) Participation in smoking cessation, alcohol abuse treatment, substance abuse treatment as determined in treatment plan

Consequences of Non Adherence to full treatment plan, including appointment attendance.

1) Pt will be safely weaned off of all controlled substances
2) No further scripts for controlled substances will be written by our practice.

Practice Prescribing Policy

Our prescribing policies are aligned with the CDC guidelines for prescribing opiod medications.

1) Utilize non-pharmacologic therapies first
2) Manage co-morbidities with non opioid, non benzodiazepine medications.
3) When treating acute pain will only use opioid medications if the acute benefit out weighs the risk of utilizing opioid medication for a period of 3 days and not longer than 7 days.
4) For chronic pain, maximize non-opioid medications such as:
    a. Tylenol/NSAIDS
    b. Tricyclic anti-depressants
    c. Gabapentin
    d. Pregabalin
    e. Etc
5) Document clinically meaningful functional status at each appointment.

    a. Annually complete comprehensive functional status assessment
    b. At all f/u appointments complete PEG assessment
    c. Scores should improve by 30 % to be considered clinically significant improvement in functional status.
6) Screen for addiction at every encounter for pain management
7) Review known risks of and realistic benefits of opioids at every appointment for pain management.
    a. No evidence of long term benefit from opioids
    b. The primary goal of our care is to restore function, not eliminate all pain
    c. Fatal respiratory depression does occur
    d. Potentially serious life long opioid use disorder leads to increase distress and inability to fulfill major role obligations.
    e. Common effects of opioids include
        i. Constipation (prevention with increasing fluids, fiber and exercise)
        ii. Dry mouth
        iii. Nausea, vomiting
        iv. Drowsiness
        v. Confusion
        vi. Tolerance
        vii. Physical dependence
        viii. Withdrawal symptoms
    f. Driving or operating equipment while impaired is illegal in the State of Michigan
8) Prescribe immediate release opioids and not extended release
9) Prescribe lowest effective dose
    a. If dosing >50MME (morphine miliequivalents) – reassess and consider pain management referral
    b. Refer to Pain Management if dosing is >90MME
10) After starting or increasing opioids re-evaluate in 1 to 4 weeks.
    a. If benefit does not outweigh harm:
        i. Optimize other therapies and work with patient to taper opioids to lowest possible dose and then discontinue.
11) Plan strategies to mitigate risks of opioids.
12) Review MAPPs at initiation of opioid medication and at least every 3 months
13) Obtain a urine drug screen for which patient is responsible for cost at least annually
14) Avoid prescribing opioids with benzodiazapines
15) Provide resources for opioid dependence disorder.

From DrFernander - Forum Medical Clinic Wording:

1. On a first new patient visit, no narcotics or other controlled substances will be prescribed in the absence of a clear, acute injury.
2. Patients requiring chronic pain medications or long term controlled substance therapy must enter a written controlled substance contract and agree to use only one doctor, and only one pharmacy.
3. Urine drug screens may be requested at any time and are the financial responsibility of the patient.
4. Chronic narcotic management requires individual visits to address the diagnosis and its treatment independent of other medical problems. Usually this requires a dedicated visit every 3 months or more often.
5. Patients found in violation of controlled substance contract will no longer be prescribed narcotic medications and may be discharged from the practice.