Keywords: controlled substance, opioids, pain

|  |  |
| --- | --- |
| **Table of Contents** | **Page Number** |
| 1. **PURPOSE/SCOPE**
 | **1** |
| 1. **POLICY**
 | **1-3** |
| 1. **SUPPORTIVE INFORMATION**
 | **4** |

1. **POLICY**

Clinic Health Centers Ongoing Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain Policy.

1. **PROCEDURE**

These are the guidelines for how providers at Clinic Health Centers will manage and document patients on opioids for chronic non-cancer/non-terminal pain. The following guidelines apply to any **new** chronic non-cancer/non-terminal pain patients who will have ongoing opioid prescriptions. For established patients, demonstrated reasonable efforts are expected from the provider to bring the patient into compliance in subsequent visits. It is the expectation that a treatment plan overview of any chronic non-cancer/non-terminal pain patient will be easily found in the EPIC problem list.

* 1. Every chronic non-cancer/non-terminal pain patient must review and sign the Controlled Substance Agreement and the Materials Risk Notice.
		1. Scan signed copies into the patient’s chart in EPIC.
	2. Chronic non-cancer/non-terminal painpatient charts will contain a patient evaluation/history including:
		1. Detailed Pain History;
		2. Review prior primary care provider and specialist notes (i.e. Care Everywhere);
		3. Perform an appropriate physical exam including periodic evaluation of neurologic and musculoskeletal systems;
		4. Review and periodically update mental health and substance abuse history;
		5. A behavioral health assessment with particular attention paid to trauma history.
	3. Assess for functionality in relation to pain and opiate use periodically.
		1. Consider utilizing standardized evidence-based forms, like the PEG Pain Screening Tool.
	4. Regularly monitor and document subjective pain measures
	5. Regularly monitor for opioid risk.
		1. Utilize Opioid Risk Tool at least once (The Opioid Risk Tool is available as a dot phrase in EPIC).
		2. Check the prescription drug monitoring program at least annually and document in the patient record.
		3. Perform a random urine drug screen at least annually
		4. If aberrant behavior occurs, such as early refill requests, inappropriate urine drug screen results, or outside prescriptions, increased frequency of urine drug screening and pill counts may be necessary, as well as, shorter opioid refills.
		5. If methadone is prescribed, obtain an electrocardiogram at least annually for high doses or in patients with increased cardiovascular risk or symptoms such as syncope, seizure, or palpitations. Also, please ensure methadone is being used for pain management and not opioid addiction treatment.
			1. Please note that it is illegal to utilize methadone for opioid addiction treatment in the clinic setting.
	6. Maintain a comprehensive treatment plan with agreed upon treatment goals.
		1. Regularly evaluate effectiveness and safety of opioid treatment.
		2. Regularly recommend physical modalities and self-care strategies to manage chronic pain.
		3. Chronic non-cancer/non-terminal pain patients should not expect to have opiates reduce their pain by more than 30%.
	7. Frequency of Assessment
		1. Chronic non-cancer/non-terminal pain patients taking chronic opioid medications should be seen by their primary prescriber a minimum of every 3 months.
			1. Patients with high risk behaviors may be required to be seen more frequently at the primary provider’s discretion.
			2. Assessment of treatment adherence, side effects, and progress toward treatment goals should be assessed at each visit.
		2. Multi-modal management of chronic pain should be discussed at each visit.
	8. Opioid prescribing daily dosing limit.
		1. This applies to every patient with chronic non-cancer/non-terminal pain regardless of how long they have been with Clackamas Health Centers and their provider.
		2. Avoid a total opioid dose greater than 50-90 MED (milliequivalents of morphine) for patients who have been managed with chronic opiates (patients on “legacy” prescriptions). For patients new to Clinic Health Centers, who are not patients on legacy prescriptions, the **MED maximum is 50 MED.** The MED calculator of reference is found at: <https://www.oregonpainguidance.org/opioidmedcalculator/>.
		3. If patient is above the limit, two paths may be followed
			1. Include, in every progress note the plan for taper with time frame.
			2. If taper is not in the plan, documentation of a qualified review is required. This includes, but is not limited to, a pain specialist or the Opioid Oversight Committee. Consultation with the Medical Director or Clinical Lead Provider is an acceptable step if the other two are not available.
	9. Co-prescriptions
		1. This applies to every chronic non-cancer/non-terminal pain patient regardless of how long they have been with Clinic Health Centers and their provider.
		2. As stated in the Ongoing Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain Policy*,* chronic non-cancer/non-terminal pain patients who is on chronic opioids should not be prescribed chronic benzodiazepines.
		3. If co-prescribing is occurring, two paths may be followed:
			1. Include, in every progress note the plan for taper with time frame.
			2. If taper is not in the plan, documentation of a qualified review is required. This includes, but is not limited to, a psychiatric consultation or the Opioid Oversight Committee. Consultation with the Medical Director or Clinical Lead Provider is an acceptable step if the other two are not available.
		4. If concurrent tetrahydrocannabinol use is documented on urine drug screen or patient report, a discussion of risk and/or cessation efforts needs to be documented in the chart.
		5. Avoid concomitant use of alcohol and opioids.
		6. Clinic Health Centers does not prohibit a patient from being prescribed opiates and stimulants. However, this is **strongly** discouraged. If this is occurring, a mental health assessment, justification based on functionality, and a risk-benefit analysis **must** be documented. Non-stimulant medications used to manage ADHD should be utilized for any existing COT patient.
	10. Prescribing Restrictions
		1. Carisoprodol (Soma) is not to be prescribed to patients in any cases unless they meet hospice criteria.
		2. Patients are not to be started on methadone for pain control. Any new patient who establishes care with Clinic Health Centers and is currently taking methadone, it is provider discretion for assuming the management of it. Any patient who is accepted under these circumstances must have a plan to be weaned off of methadone, though the taper can be quite long based on best evidence (2016 CDC guidelines). Furthermore, the patient must commit to this prior to assuming care.
	11. When problems appear
		1. Patients who develop an opioid use disorder according to DSM-5 criteria should be referred to a behavioral health clinician for assessment and possible internal/external consult for medication-assisted treatment.
	12. Naloxone rescue kit should be prescribed to high-risk individuals (MED>50, co-Rx with benzodiazepines, any patient with co-morbid conditions).
	13. When a provider is covering controlled substance refills for a provider who is out of the office, it is expected that a basic review of a patient’s chart is performed. It is preferred that providers include any policy compliance issues via interim note in EPIC to aid the primary care provider in management. If a provider feels a patient safety issue exists, consultation with a behavioral health clinician and/or the Medical Director or Clinical Lead Provider is appropriate.
	14. Requests to change providers will not be honored if the reason is for opiate or benzodiazepine prescribing practices
1. **SUPPORTIVE INFORMATION**
	1. Accompanying Policy:
		1. Clinic Health Centers Ongoing Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain Policy
	2. Related Links/Information/Forms/Policies:
		1. Clinic Health Centers Controlled Substance Agreement for Controlled Substance and Other Medications Policy
		2. OAR 847-015-0030
	3. Policy Written by:
		1. Policy Analyst
		2. Medical Director
	4. Reviewed by:
		1. Medical Director
		2. Psychiatry Director
	5. Review Cycle: Annual
	6. To be read by:
		1. Prescribers
	7. Inquiries: Medical Director

Approved: TBD Title: Health Centers Director