SAN FRANCISCO HEALTH PLAN
Here for you

Proposed language for Chronic Pain Management Protocols

Goal:

- **Every clinic has a protocol,** reviewed and signed by all providers, that allows consistent practice for the most common challenges in pain management
- **Exceptions** to the protocol should require review by medical director or pain management peer review committee

1. New Patients

- Providers review prior records and do a physical exam prior to prescribing opiates for any patient new to the practice.
- If a patient arrives at the first visit without records, and the provider does not have easy access to records (e.g. LCR, eCW, jail), then it is the patient's responsibility to obtain them.*

Rationale: *this helps identify patients seeking medications from multiple providers.*

*******Clinics should work on systems to manage exceptions, such as hospital discharge, jail or prison release that make it impossible for patients to obtain refills from previous provider. In those cases, it is the responsibility of the provider to check the DOJ CURES report and obtain records.*

Optional:

- Develop a workflow that alerts new pain management patient to clinic policies at time of scheduling, to decrease negotiations during the first visit.
- **Examples:** phone screen new patients

  "Do you take pain medicines every day?"

  If YES, explain policy of requiring records prior to prescriptions

Clinics will make sure the following is in place for any new opiate regimens for existing patients:

1. Signed patient agreement and informed consent
2. Urine drug screen (UDS) within 1-3 months
3. Health education on chronic pain: class, pain management orientation, behaviorist referral, and/or document describing clinic's policies.
4. Annual assessment of treatment plan.

Rationale: *ensuring consistency in new starts will help avoid problems later on.*

2. Management Of Urine Drug Screens (UDS)

- All patients receive a UDS within 1-3 months of starting opiates, and at least once a year (more frequently with concerning behaviors)
- All providers agree to a consistent system of managing UDS:
  - **Which test(s) to order** (type of test(s) should be standardized for the clinic for specific indications)
  - **How to** interpret positive or negative results
  - **System in place** to act on unexpected results.

Rationale: *inconsistent approaches leave providers struggling to balance the role of patient advocate with the need to ensure safe prescribing.*

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3. Refill Policy

- Every clinic has a standard practice about early refill management that all providers agree to follow. Patients are informed of this policy in the pain management agreement, which is then reinforced by the provider.
- **Examples of potential clinic policies:**
    - **No refills** for lost or stolen medications, for any reason.
    - **Only one early refill** per 12 months, no exceptions
    - **No refills** for lost or stolen medication, but each patient is given an "extra" two week supply of medications for emergencies, only filled once a year.
    - **All early refills** require review by medical director or pain management peer review committee
    - **Annual assessment with treatment plan efficacy**

Rationale: *if early refills are allowed for "acute or chronic pain," or for lost meds, then the provider is in the position of having to police whether the patient's story is "good enough" to justify an exception, which rewards drug-seeking behavior. A consistent policy frees the provider from this role. Exceptions should be rare and for specific indications (e.g. new fracture) not for common predictable problems (e.g. back pain flare).*

4. Concerning Behavior Policy

- All providers should agree on what defines high-priority concerning behaviors, how to track on them, when to act, and what to do. Examples: when and how to refer to substance use? When and how to taper as opposed to stop opiates? When is consult required?

- Every clinic must have a monitoring system in place to ensure this policy is followed, tailored to that clinic. Examples may include:
    - **Template** in the electronic record to track date, type of behavior, and response
    - **Form** on the back of the pain management agreement documenting date, behavior, and response/plan
    - **Use of i2i** to track abnormal UDS
    - **Random chart audits,** reviewed by peer group or medical director
    - **Calls to pharmacy** to confirm refill history
    - **Systematic** review of all high-dose opiate patients over the course of the year by peers or medical director, using checklist from protocols.
    - **Review of all abnormal UDS** by pain management team or medical director
    - **Medical director** coaching of providers not following the policy
    - **Provider education**

Sample policies are available.

Rationale: *inconsistent, provider-dependent approaches leave providers to play role of "bad cop" instead of patient advocate. Consistent clinic policies take the work away from the provider.*