THE PAIUTE INDIAN TRIBE OF UTAH
440 North Paiute Drive • Cedar City, Utah 84721 • (435) 586-1112

Policy for Pain Management

Policy: This policy establishes a standardized plan for treating patients in pain

Procedure:

Opioid Treatment for Acute Pain

1) Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies will not provide adequate pain relief.

   Implement Non-Opioid Management Tool prior to starting opioids for pain management.

   Define 'acute pain' as < six weeks. At the end of the six weeks refer to either a pain management center or other appropriate specialty (further work up should have been taking place during this time period).

   Decide if a pain contract will be signed for acute pain medication recipients. If the decision is made to have a patient sign an opioid contract, it will be signed at the follow up 10-14 days after initial visit for presenting problem.

   Do a DOPL on ALL patients receiving scheduled medications, including 'acute' pain patients. A Nevada and Utah DOPL will be accessed prior to the initial prescription of opioid medication.

   Drug screen prior to prescribing opioid pain medications (provider discretion). And always to be done at the time of opioid contract signing.

2) When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed based on the usual duration of pain severe enough to require opioids for that condition.

   Only prescribe 10 – 14 days of prescription pain medication initially and only after non-opioid interventions have been attempted and failed.

   Require patient to return to the clinic for a follow up after 10-14 days of initial visit of presentation of acute pain problem.

   Never provide an 'acute' pain patient with a month worth of opioid pain medication.

   NEVER fill early for an 'acute' pain patient.

3) When opioid medications are prescribed for treatment of acute pain, the patient should be counseled to store the medications securely, to not share with others, and to dispose of medications properly when the pain has resolved in order to prevent non-medical use of the medications.

   Educational material regarding proper use of opioid pain medication is to be given with the first prescription written.

   If a patient fails to follow this advice, it is not the clinics problem. NEVER give another prescription or early refill.

4) Long duration-of-action opioids should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted. Methadone is rarely if ever indicated for treatment of acute pain.

   Methadone is not to be prescribed under any circumstance for acute pain. No long acting pain medications should be used for the treatment of acute pain.

   If treating post-operative pain, call the surgeon to get an estimated course of pain duration, document that and then follow it. Another option is to have the surgeon manage post-operative pain. It is imperative to communicate with other providers treating for potentially painful health problems.

   If continued pain postoperatively, refer back to the surgeon and make pain management their responsibility.

   If determined, by the surgeon, that there has been a failed surgery, re-evaluate for chronic pain management.

5) The use of opioids should be reevaluated carefully, including assessing the potential for abuse, if persistence of pain suggests the need to continue opioids beyond the anticipated time period of acute pain treatment for that condition.

   If the need arises that an 'acute' pain patient is transitioning to a 'chronic' pain patient, refer for a pain clinic consultation (to be returned to the Paiute clinic for treatment).

Continue all non-opioid treatment options available.

Educate patient, sign contract, obtain urine drug screen, do DOPL, create treatment plan, formulate an exit strategy, do appropriate evaluations on patients (Opioid Risk Tool, pain & Function Ability Assessment, etc.).

A copy of the signed Opioid Contract is to be given to all patients with documentation that they received education regarding the contract in office and that they were instructed to read it thoroughly and that they understood the contract and had all questions answered.

Opioid Treatment for Chronic Pain

1) The patient should be informed of the risks and benefits and any conditions for continuation of opioid treatment, ideally using a written and signed treatment agreement.

2) Opioid treatment for chronic pain should be initiated as a treatment trial, usually using short-acting opioid medications.
Never use Methadone, Fentanyl or any other long acting medication without prior pain clinic consultation. If these medications are indicated, the patient may need to be treated at a pain clinic until adequate base line regimen has been established.

3) Regular visits with evaluation of progress against goals should be scheduled during the period when the dose of opioids is being adjusted (titration period).

'Chronic' pain medication patients are to be seen face to face on a monthly basis. There may be some extenuating circumstances but this is very rare.

4) Once a stable dose has been established (maintenance period), regular monitoring should be conducted at face- to-face visits during which treatment goals, analgesia, activity, adverse effects, and aberrant behaviors are monitored.

Random urine drug screens are to be done on a quarterly basis for ALL 'chronic' pain patients. No exceptions. Dismissal of patients should not be done on a screening only. Screenings are just that. Confirmation of results of a screen should be obtained prior to dismissal of patients on opioid contracts.

The Utah and Nevada DOPL is to be pulled up at EVERY visit (this does not become a part of the chart).

5) Continuing opioid treatment after the treatment trial should be a deliberate decision that considers the risks and benefits of chronic opioid treatment for that patient. A second opinion or consult may be useful in making that decision

An annual consult from a pain clinic is to be done on ALL 'chronic' pain patients. More often if Paiute provider deems necessary.

6) An opioid treatment trial should be discontinued if the goals are not met and opioid treatment should be discontinued at any point if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated.

A refused drug screen is considered a failed drug screen.

Early refills are NEVER to be given unless previously discussed with provider (not when medications are gone). NO EXCUSE IS VALID, even if it is.

Absent drug in the drug screen is considered either a drug that is not needed or a sold on the street drug. Always send the specimen off for confirmation if you question is validity.

If patient consistently reports a high pain level and no improved function, taper off pain medication. This is simple to do if you have created an exit strategy in the initial treatment plan.

7) Clinicians treating patients with opioids for chronic pain should maintain records documenting the evaluation of the patient, treatment plan, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant behavior observed.
If aberrant behavior documented, document action taken.

8) Clinicians should consider consultation for patients with complex pain conditions, patients with serious co-morbidities including mental illness, patients who have a history or evidence of current drug addiction or abuse, or when the provider is not confident of his or her abilities to manage the treatment.

DO NOT ATTEMPT TO MANAGE THESE PATIENTS. Refer to a pain clinic for treatment.

9) Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use, and who are prepared to conduct the necessary careful monitoring. Never prescribe Methadone.

10) Exit strategy is to be employed when aberrant behavior is evident, medications consistently do not relieve pain, risk out weight benefit and/or function does not improve.

Any variance from this policy must first be approved by the consulting pain specialist or the collaborative physician.

*Reference material for this policy is primarily from the State Guidelines listed in the "Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain".

Compliance: Not adhering to this policy will result in disciplinary action.

CERTIFICATION

I heareby certify that the foregoing Pain Management Policy was full considered and adopted by the Health Commitee at a duly called meeting in Cedar City, Utah, at which a quorum was present, and that the same was passed by a vote of 4 in favor, 0 opposed, 1 absent, and 0 abstained, this 7 day of May, 2013

Robert Pete Sr., Health Committee Vice-Chair

ATTEST:

Laurel Yellowhorse, Administrative Assistant

CERTIFICATION

I heareby certify that the foregoing Pain Management Policy was full considered and adopted by the Tribal Council at a duly called meeting in Cedar City, Utah, at which a quorum was present, and that the same was passed by a vote of 5 in favor, 0 opposed, 0 absent, and 0 abstained, this 3rd day of June, 2013

Gari Lafferty, Tribal Chairwomen

ATTEST:

Naomi Colorow, Tribal Council Secretary