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| **UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**  **OU PHYSICIANS FAMILY MEDICINE CENTER**  **POLICY AND PROCEDURES** | |
| **Policy Name:** | **Chronic Pain Patients - Residency** |
| **Subsection:** | **R1- Residency Clinic Expectations** |
| **Page:** | **1 of 3** |
| **Effective Date:** | **08/01/2014** |
| **Revision Date:** | **07/18/2016** |

**STATEMENT OF PURPOSE:**

In order to provide a standardized clinical practice which is aligned with the approved Chronic Pain Curriculum of the residency division, it is necessary to set expectations regarding the evaluation and treatment of patients with chronic pain within the resident practice. This document is intended to address the curricular expectations for residents’ assessment and management of patients while under supervision by an attending physician in the Family Medicine Center Clinics.

**POLICY & PROCEDURES:**

**NOTE: The Objectives-based Curriculum in Chronic Pain Management was reviewed and adopted by the Residency Division of the Department of Family and Preventive Medicine in 2013. This document establishes the expectations for residents’ care of patients for the duration of a resident’s practice with the clinic. Possessing a DEA or OBNDD number does not release a resident physician from compliance with this policy.**

**CHECK-IN/CHECK-OUT PROCESS**

***At Check-In:***

1. Clerical Staff will identify adult patients (over 18 years old) as “COAT” (chronic opiate analgesic therapy) and schedule them as such, excepting that **first-year residents are not to have such patients scheduled for the first six months of their practice.**
   1. Initial evaluations will be identified through scripted questions at the time of scheduling
   2. Patients requiring follow up for chronic pain will be identified by the presence of “pop-ups” on their charts (see Check-Out, below)
2. Clerical Staff will provide patient with PatientLink history forms at check-in:
   1. New patients/initial evaluation: pain history, risk assessment, functional status assessment
   2. Returning patients: pain follow up, functional status assessment
3. Nursing staff will check patients’ problems, medications, and allergies and confirm whether pain is a reason for visit or whether a refill of a controlled substance for pain is needed. If so, nursing staff will:
   1. Ensure that PatientLink forms have been completed and scanned prior to physician visit
   2. Ensure that patient’s OBNDD PMP report is printed for provider
   3. Document patient’s reported use of prescribed controlled substances within the prior 24 hours, or last dose if patient reports no use for >24 hours
   4. Ensure that a valid and active controlled substance agreement is in the chart and will print a new one for resident to discuss with patient if agreement is not present or is invalid. A new controlled substance agreement must be signed each time a patient changes resident PCP.
4. Nursing staff will add “chronic pain or COAT” to reason for visit
5. Nursing staff may order a qualitative urine drug screen as indicated, under supervision of attending physician

***At Check-Out:***

1. Nursing staff will identify patients who have signed a controlled substance (“narcotic”) agreement
2. Nursing staff will enter “Narcotics agreement” into the directives field of the patient’s chart and name patient’s assigned resident PCP
3. Nursing staff will route the completed agreement to the clerical team leader via the check-out clerk
4. Clerical team leader will create a “pop-up” in the patient’s chart to alert team to patient’s status as a “chronic pain/COAT patient,” and will notify Clinic Manager to update the COAT registry
5. Agreement will be sent to medical records to be scanned into the chart

**RESIDENTS: CONDUCT OF THE VISIT AND EXPECTATIONS FOR THE PRESENTATION TO ATTENDING PHYSICIAN**

1. Resident will establish and document, by patient interview and review of PatientLink and EMR records, the following information:
   1. Nature and intensity of pain, including “red” and “yellow” flags
   2. Current and past treatments for pain, **focusing on all non-pharmacologic and non-opiate therapies tried, and results**
   3. Underlying/coexisting diseases
   4. Effect of pain on physical and psychological function
   5. History of substance abuse
2. Resident will determine and document, through history and physical examination and under supervision of faculty, the diagnosis and appropriate medical indications for treatment, including a **goal-directed treatment plan that focuses on functional status of the patient**
   1. Determine etiology of pain: nociceptive (somatic or visceral), neuropathic, functional or mixed
   2. Document the objectives that will determine success for the individual patient, including:
      1. Pain relief, using subjective and objective measures
      2. Improved physical/psychological function, **emphasizing this as the primary goal of treatment**
      3. Current modalities being used
      4. Further plans for evaluation or treatment
3. Resident will document risk stratification of patients who present with chronic pain, including:
   1. Score of opiate risk tool
   2. Score of CAGE-AID questionnaire
   3. Review of OBNDD PMP report
   4. Current morphine equivalent dose prescribed
   5. Assessment regarding appropriateness for care to be delivered in a primary care setting, with referral to specialists for management as necessary
      1. Low risk and moderate risk patients are appropriate for resident practice
      2. High risk patients are not appropriate for resident practice and should be referred
4. Resident will obtain and document informed patient consent for treatment, including a narcotic agreement for patients on a trial of controlled substances.
5. Resident will complete a periodic review of patient’s pain and functional status at continuity appointments and will determine and document based on patient history, review of PatientLink, OBNDD PMP and EMR records:
   1. Compliance with scheduled appointments and refills
   2. Confirmation of last 24 hours’ use of controlled substances for pain, or last dose if patient reports no use for >24 hours
   3. Response to current therapy, including change in pain level and functional status
   4. Review of third party information (family, caregiver, other) as available
   5. Whether or not a change in therapy is warranted
   6. Whether additional modalities are indicated
   7. Whether specialist referral is needed
6. Resident will order a Comprehensive Urine Drug Screen (UDS) on every patient initially, with additional testing as determined by:
   1. Patient’s risk assessment
   2. Resident’s clinical judgment (under supervision by an attending physician) at the time of visit
   3. Results of previous testing, reviewed in light of patient self-reported use prior to testing

**LIMITS ON RESIDENT PRACTICE**

In order to provide a standardized patient experience given the transient nature of residency, these limitations shall continue to be imposed **even when a resident has an OBNDD or DEA number**.

Violation of these limits will result in corrective action, in accordance with the policies of the residency division.

1. Resident physicians **must present all patients with chronic pain who take controlled substances** to the attending physician. Patients must be presented by the end of the clinic session. The minimum standard for presentation is:
   1. Brief pain history, including likely etiology
   2. For follow-up patients, whether functional status is improved, declining or stable on current therapy
   3. Patient risk category
   4. Current morphine equivalent dose
   5. Patient’s compliance with goal-directed care plan
   6. Results of OBNDD
   7. Results of last UDS, if applicable
2. Resident physicians are encouraged to adhere to a morphine equivalent dose limit of 50mg daily. Residents are **strictly limited to prescribing a morphine equivalent dose (MME) of no more than 90mg daily**, as defined by the residency-approved calculation tool.
   1. When MME exceeds 50mg daily, resident shall co-prescribe naloxone, educate patients and caregivers in its use and ensure compliance with prescription fill
   2. Residents should make every effort to limit co-prescribing of opiates and anxiolytics, and should co-prescribing be deemed medically necessary, shall co-prescribe naloxone, educate patients and caregivers in its use and ensure compliance with prescription fill
3. Resident physicians **may not prescribe** the following agents:
   1. Methadone
   2. Suboxone
   3. Carisoprodol (Soma)
4. Resident physicians shall assign patients taking **anxiolytics** (alprazolam, midazolam, clonazepam and others) while on chronic opiate therapy to **one risk category higher** than was determined by the results of their ORT and CAGE-AID assessments. These patients’ care will be determined by their amended level of risk.
   1. Low and moderate risk patients may be managed in the resident practice under these guidelines
   2. High risk patients may not be managed by resident physicians; these patients should be referred to pain management unless a faculty member wishes to assume the patient’s care
5. Residents **may not prescribe** controlled dangerous substances to patients whose UDS is positive for illegal drugs.
6. Residents may refer patients who are determined to be at high risk to pain management specialists. Due to the scarcity of pain management consultants, patients are limited to **two (2) pain management referrals.**
7. Residents **may not prescribe** controlled dangerous substances for pain to patients who have been dismissed by their pain management specialist.

**RESIDENT CERTIFICATION**

1. A 3rd year (PGY-3) resident may receive certification from the residency division, removing the requirement that s/he present all patients under the following conditions:
   1. Resident is in good standing in the residency program
   2. Resident has completed REMS training and the SAM in chronic pain, as confirmed by residency program
   3. Resident has DEA and OBNDD numbers on file with residency division
2. Certification does not exempt the resident from:
   1. The 90mg limit on morphine equivalent dosing
   2. The prohibition against managing high risk patients
   3. The prohibition against prescribing to patients using illicit drugs

**REFILLS**

1. Resident physicians may not independently authorize refills of controlled dangerous substances. Refills are to be done in accordance with the clinic’s policy on refills of controlled dangerous substances.
2. Completed refills, both approved and denied, will be forwarded to the resident for co-signature.

**Objectives-Based Curriculum in Chronic Pain Assessment and Management**

**UNIVERSITY OF OKLAHOMA FAMILY MEDICINE RESIDENCY PROGRAM**

**Chronic Pain Curriculum Committee**

Rachel Franklin, M.D., Chair

**Committee Members: Ex-officio members:**

Kalyanakrishnan Ramakrishnan, M.D. Steven Crawford, M.D.

Audra Fox, M.D. James Barrett, M.D.

Bryan Billings, M.D.

Chris Shadid, M.D.

Reuben Walia, M.D.

Dan McNeill, Ph.D., PA-C

Cynthia Thomas, LCSW

Annette Prince, J.D., LCSW

Sherrie Moser, Patient Advocate

**Charge to the Committee:**

Dr. Crawford has charged this committee, hereafter called the Chronic Pain Curriculum Committee (CPCC), to review the available evidence and to develop a structured residency curriculum, in compliance with ACGME requirements, for the evaluation and treatment of patients who present in a primary care setting with a complaint of chronic pain. He has further instructed the committee to create the framework for a clinical environment within which to provide care according to the curriculum’s guidelines.

Once the curriculum and its clinic are established, it is the committee’s charge to provide oversight and periodic review of the curriculum. The Clinical Quality Improvement Committee (CQI) will provide oversight of the curriculum’s clinic and will work in cooperation with the CPCC to maintain a clinical environment appropriate for curricular delivery to resident learners, staff and patients.

From the charge:

“Abuse, misuse and diversion of prescription painkillers have reached epidemic proportions in the United States and here in Oklahoma. Accidental overdose of prescription drugs has become one of the leading causes of death in our state, and yet many of our fellow citizens lack access to evidence-based, effective care for chronic nonmalignant pain. Both the National Institutes of Health and the Institute of Medicine have stated that effective pain management is a “moral imperative, a professional responsibility, and the duty of people in the healing professions.”[[1]](#footnote-1)

Family Medicine physicians are uniquely positioned to be the primary care providers to patients suffering from chronic pain… Medical school curricula, including our own, are presently being evaluated for how we teach the treatment of chronic pain to learners at all levels. I am asking you to help our department evaluate the evidence and develop a curriculum that provides a framework within which we can provide care for our patients who suffer with chronic pain in our clinical setting, and from which we can disseminate knowledge to our fellow Family Physicians.

I am asking this committee to review the evidence and develop the curriculum, as well as a clinical environment within which to deliver the curriculum, no later than the end of 2013. In order to provide the environment for success, I have asked Dr. Franklin to remodel the Narcotic and CQI committees as they restart in 2013.”

**Baseline Data, 2013:**

1. 1 in 12 Oklahomans reports engaging in nonmedical use of painkillers (2008).[[2]](#footnote-2)
2. Nearly 16 per 100,000 Oklahomans dies due to an overdose of painkillers – more than die from car accidents (2008).[[3]](#footnote-3)
3. Oklahoma ranks 9th nationally for the rate of overdose deaths due to prescription painkillers.[[4]](#footnote-4)
4. Oklahoma ranks in the top 10 among states for kilograms of prescription painkillers per 10,000 people[[5]](#footnote-5)

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| **Patient Care:** Resident provides patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health |
| * Demonstrate compassionate, appropriate, and effective patient care under faculty supervision in an ambulatory primary care office setting; * Demonstrate efficient focused history-taking and physical examination skills; * Develop a differential diagnosis and describe the rationale for the diagnosis; * Identify appropriate diagnostic tests and procedures needed for conditions encountered in the diagnosis of chronic pain, including lab studies, screening tests and procedures, and radiological studies and procedures performed by specialists; * Demonstrate understanding of the importance of longitudinal, comprehensive patient care and how it benefits the individual and the community; * Demonstrate an understanding of the importance of and components of an adequate informed consent discussion and its documentation, including the use of narcotic contracts; * Perform/interpret results of therapies commonly performed or recommended to patients in the primary care pain management setting, including but not limited to:   1. injections (subcutaneous, intramuscular, intra-articular)   2. urine drug screens   3. multimodal, non-narcotic pain therapy   4. complementary and alternative therapies for pain   5. appropriate dosing, monitoring and alteration of therapy using controlled substances * Demonstrate understanding of the bio-psychosocial determinants of health and illness and their application to the individual patient’s care, including but not limited to:   1. barriers to access   2. cultural/language barriers   3. physician-related barriers * Demonstrate early recognition of serious complications of patient illness and of therapeutic interventions, including:   1. Deterioration in patient’s physiological cause of pain   2. Addiction and pseudoaddiction   3. Diversion of controlled substances   4. Adverse effects of medication |
| **Medical Knowledge:** Resident must demonstrate knowledge of established and evolving biomedical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. |
| 1. Perform an appropriate medical history on a patient who presents with chronic pain; including:    1. Nature and intensity of pain    2. Current and past treatments for pain    3. Underlying/coexisting diseases    4. Effect of pain on physical and psychological function    5. History of substance abuse 2. Document appropriate medical indications for treatment, including a goal-directed treatment plan    1. Determine etiology of pain: nociceptive (somatic or visceral), neuropathic or mixed    2. Document the objectives that will determine success for the individual patient, including:       1. Pain relief, using subjective and objective measures       2. Improved physical/psychological function       3. Current modalities being used       4. Further plans for evaluation or treatment    3. Identify the biopsychosocial determinants of health that may affect treatment success, including:       1. Depression       2. Anxiety       3. Somatization       4. Psychosocial stressors       5. Coping resources       6. Patient expectations of treatment       7. Quality of life       8. Disability due to pain       9. Legal disability status       10. Potential for opiate abuse       11. Illness behavior and beliefs       12. Readiness to adopt a self-management approach to pain control 3. Document evidence-based, unbiased risk stratification of patients who present with chronic pain, including:    1. Past or current history of substance abuse    2. Past or current history of psychiatric disease    3. Family History of substance abuse 4. Document a risk stratification-based assessment of appropriateness for care to be delivered in a primary care setting, with referral to specialist(s) for management as appropriate.  * Obtain and document informed patient consent for treatment, including a narcotic contract when appropriate.  1. Complete a periodic review of patient’s pain at longitudinal, continuity care appointments. Use a validated assessment (such as the 4/5 A’s)\* to document:    1. Patient response to current therapy    2. New information about patient’s state of health or etiology of pain    3. Objective evidence about patient’s level of function    4. Third party information (family, caregiver, state narcotics report)    5. Whether or not a change in therapy is warranted    6. Whether additional modalities (physical therapy, massage and so on) are warranted    7. Whether specialist referral is indicated   \*The four/five A’s are:   1. Analgesia 2. ADLs 3. Adverse effects of treatment 4. Aberrant behavior 5. Patient affect |
| **Practice-Based Learning and Improvement:** Resident must demonstrate the ability to investigate and evaluate his/her care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and life-long learning. Resident is expected to develop skills and habits to be able to meet the following goals:   1. Identify strengths, deficiencies, and limits in one’s knowledge and expertise 2. Set learning and improvement goals 3. Identify and perform appropriate learning activities 4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement 5. Incorporate formative evaluation feedback into daily practice 6. Locate, appraise, and assimilate evidence from scientific studies related to patients’ health problems 7. Use information technology to optimize learning 8. Participate in the education of patients, families, students, residents and other health professionals |
| * Develop, under supervision, probabilistic thinking skills related to the care of patients who present with chronic pain * Identify appropriate sources of medical information related to the treatment of chronic pain * Apply findings of diagnostic procedures to the evidence-based healthcare management of the patient; * Identify evidence-based resources that guide screening, diagnosis and treatment recommendations and their application to lifelong learning. |
| **Interpersonal and Communication Skills:** Resident must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Resident is expected to:   * 1. Communicate effectively with patients, families and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds   2. Communicate effectively with physicians, other health professionals and health-related agencies   3. Work effectively as a member or leader of a health care team or other professional group   4. Act in a consultative role to other physicians and health professionals   5. Maintain comprehensive, timely, and legible medical records, if applicable |
| * Demonstrate ability to use motivational interviewing techniques to facilitate change behaviors in patients with chronic pain * Demonstrate effective interviewing and listening skills, and to convey information to the patient in an accurate and understandable manner; * Demonstrate ability to educate patients about health promotion and self-management interventions for pain; * Perform accurate, complete, succinct and organized oral and written presentations of patient encounters; * Demonstrate the ability to work in a multidisciplinary team environment * Demonstrate the ability to develop rapport with patients, staff members and others through empathy, sensitivity, respect for others, compassion, integrity and personal accountability |

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| **Professionalism:** Resident demonstrates a commitment to carrying out professional responsibilities and an adherence to ethical principles. Resident is expected to demonstrate:   1. compassion, integrity, and respect for others; 2. responsiveness to patient needs that supersedes self-interest; 3. respect for patient privacy and autonomy; 4. accountability to patients, society and the profession; and, 5. sensitivity and responsiveness to a diverse patient 6. population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. |
| * Demonstrate the ability to develop rapport with patients, staff members and others through empathy, sensitivity, respect for others, compassion, integrity and personal accountability. * Maintain appropriate record of care, including appropriate documentation of:   1. Medical history and examination   2. Diagnostic, therapeutic and lab results   3. Results of all evaluations and external consultations   4. Patient-specific treatment objectives   5. Informed consent discussion and patient consent   6. Current and past treatments   7. Current and past medication use   8. Patient instructions, with expression of patient understanding of and agreement with the care plan   9. Periodic reviews * Demonstrate an understanding of the fundamentals of management of patients who present with chronic pain:   1. The patient as the center of care   2. The need to assess/quantify pain   3. Treatment of chronic pain as a negotiation between provider and patient   4. Maximizing patient function as a primary goal of care   5. Awareness of culture and gender differences in chronic pain   6. The need to promptly identify and manage potentially serious causes of symptoms (“red flags”)   7. The need to promptly identify and manage adverse prognostic indicators (“yellow flags”)   8. The requirement to differentiate between tolerance, dependence and addiction (including pseudoaddiction)   9. The responsibility to identify and minimize adverse effects of treatment   10. Awareness of complementary and alternative therapies and their role in chronic pain treatment   11. The responsibility to recognize and treat psychological aspects of pain |
| **Systems-Based Practice:** Resident must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the  system to provide optimal health care. Resident is expected to:   1. work effectively in various health care delivery settings and systems relevant to their clinical specialty; 2. coordinate patient care within the health care system relevant to their clinical specialty; 3. incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; 4. advocate for quality patient care and optimal patient care systems; 5. work in interprofessional teams to enhance patient safety and improve patient care quality; and, 6. participate in identifying system errors and implementing potential systems solutions. |
| * Explain the role of the Family Physician as leader of the multidisciplinary patient care team and coordinator of the patient’s health care; * Identify helpful community resources for patients; * Explain when to refer patients presenting with chronic pain to specialists; * Demonstrate coordination of care with consultants and others in the healthcare team; * Demonstrate the application of patient case management skills to the individual patient case * Participate in departmental Continuous Quality Improvement activities related to the care of patients with chronic pain |

1. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research. The National Academies Press, 2011. [↑](#footnote-ref-1)
2. “Prescription Painkiller Overdoses in the US.” CDC Vital Signs, November 2011 <http://www.cdc.gov/vitalsigns/PainkillerOverdoses/> [↑](#footnote-ref-2)
3. CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers – United States, 1999-2008. MMWR 2011; 60:1-6 [↑](#footnote-ref-3)
4. Fact Sheet on Prescription Drug Abuse, Misuse and Consequences Among Oklahoma (sic). Oklahoma Department of Mental Health and Substance Abuse Services. <http://ok.gov/odmhsas/documents/PR%20RxAbuse-FactSheet.pdf> [↑](#footnote-ref-4)
5. Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2010 [↑](#footnote-ref-5)