

Partnership HealthPlan of California

Managing Pain Safely Initiative

Recommendations for Structure and Standards of Pain Management Oversight Committees

Introduction

The overuse of opioid medication in patients with chronic, non-terminal, non-malignant pain has led to a large increase in morbidity and mortality in the last 2 decades in the United States. Partnership HealthPlan of California launched its Managing Pain Safely initiative in March 2014 to address this issue both with changes to Health Plan policies and procedures, in cooperation with prescribers in our health care delivery system and our public health colleagues.

Managing patients who have chronic pain can be quite challenging and many clinicians in our network are seeking help and advice in addressing the complex issues involved. Options for addressing this include individual clinicians increasing their expertise with prescribing controlled substances through continuing medical education or by participating in Project ECHO (Extension for Community Health Outcomes). Developing a community-wide standard can be helpful; several counties in the Partnership HealthPlan area are building such a consensus. Few board-certified pain specialists in our region are willing to accept referrals for patients to manage their pain medications, often leaving it up to the primary care clinician to struggle with finding the best treatment plan. Many patients with chronic pain have comorbid behavioral health conditions which may not be adequately addressed, compounding the complexity of the medical decision making and communication with patients.

In some parts of the country, multidisciplinary treatment programs have had good success in safely managing chronic pain and optimizing safety when opioid medications are used, in the most complex and challenging cases. PHC is partnering with the California HealthCare Foundation to develop standards for such programs and hopes to bring some into existence in our area in late 2015 or early 2016. In the meantime, though, many complex patients can be managed safely by their primary care provider, if the PCP has adequate support. A best practice to provide this support is the use of local Pain Management Oversight Committees.

Purpose of Pain Management Oversight Committee

Pain Management Oversight Committees support clinicians caring for patients with chronic pain by providing evidence-based advice on managing pain safely, including the use and management of controlled substances (including opioids), use of adjunctive therapy (including behavioral health and physical modalities), and appropriate referrals to interventional pain specialists. In some cases, the Pain Management Oversight Committee is granted the authority of go beyond offering advice, to balancing risk and benefit of use and dosage of opioid medication and approving or denying requested changes in dose or continuing high doses.

Composition of Pain Management Oversight Committee

The minimum composition should include:

- a physician with experience and expertise in managing medications in patients with chronic pain and knowledgeable in interventional pain options, and
- a behavioral health specialist with knowledge and experience in therapeutic approaches to helping patients with chronic pain, as well as addiction counselling and treatment of co-morbid depression and anxiety.
- an administrative support person to coordinate meetings, materials, notes and follow-up.

Optional participants include:

- a physical therapist or physical medicine specialist knowledgeable in physical therapeutic options and the medical evidence behind these options
- a local physician leader responsible for consistency in medical practice (such as a Medical Director of a medical group, health center or hospital)
- a health professional with in-depth knowledge of the state, federal, and health plan policies and legal issues involved in managing pain medications and chronic pain
- a pharmacist
- a nurse
- a care manager
- a complementary medicine provider.

The committee members should be free of conflicts of interest. For example, patients reviewed by the committee should not generally be referred to a committee member on the advice of the committee. An exception may be made in small communities where no other physician is accepting referrals, but the parameters of such referrals should be discussed ahead of time, for example an agreement on standards for when referrals are generally indicated or specific references that would be used to drive medical decision-making.

Finally, administrative support for the committee is needed for scheduling meetings, processing cases for review, and coordinating communication.

Frequency of Meeting of Pain Management Oversight Committee

Referrals are not generally emergencies, so the committee can meet up to monthly, depending on the volume of referrals.

Reasons for Referral to Pain Management Oversight Committee

Recommended reasons for referral to PMOC:

1. Patients on stable chronic opioids:
 - a. With total opioid dose greater than 120mg MED
 - b. If a dosage escalation is being contemplated
 - c. If pain is not under adequate control
 - d. If a clinician is suspicious (but not sure) of diversion or drug abuse
 - e. If a patient is having side effects of chronic opioid use (sleep apnea, decreased testosterone, accidents, etc.)
2. If a patient *not* taking opioid pain medication is experiencing inadequate pain relief.
3. Patients taking acute opioid pain medication for more than 1 month.

Materials Submitted

The following materials should be submitted to the Pain Management Oversight Committee for a full evaluation to occur: (See Appendix III for example of form to be filled out).

1. Reason for referral to committee.
2. Summary of patient history (including complete medication list) and physical exam (would minimally include mental status exam, neurological exam, musculoskeletal exam).
3. Description of co-morbidities (both physical and mental) with assessment of severity
4. Relevant imaging studies.
5. Patient's one year prognosis, and the conditions on which this is based.
6. If the patient is on chronic, high doses of opioids, completion of tool evaluating the side effects of chronic opioid use. (See Appendix I)
7. Opioid risk score. (See Appendix II)
8. PHQ 9 score.
9. Mini-mental status exam.
10. Recent CURES report.
11. Recent urine toxicology report with confirmatory testing if indicated.
12. Copy of signed medication use agreement.
13. Listing of history of medications used for chronic pain in the past and present, with side effects.
14. Description on non-medication modalities tried in the past and present, with assessment of effectiveness, and planned modalities in the future.
15. Referring clinician's recommended outcome, if there is one, and any other factors related to the patient's situation or the patient-clinician relationship which the committee should consider.

If the PCP is willing to be available to present the case, this is ideal, but it does not preclude the need for the committee to have access to the above information.

Committee Activity

Confidentiality

The committee is considered a peer review committee, from a legal perspective. A policy detailing its administrative status in relation to other peer review functions is recommended. All participants must sign a confidentiality agreement and a conflict of interest statement. While all materials are protected in the context of peer review, the specific names of the clinician and the patient involved will be known to members of the committee. For decorum, the name of the patient will not be used in the discussion of the case.

Note taking

For each case reviewed, the committee will record a brief summary of the key elements of the case, a list of recommendations and decisions, including a response to the reason for referral to the committee. This "summary and recommendations" document should be written from the perspective that it will be shared with the patient whose case is presented. If recommendations or sensitive comments are to be addressed to the referring clinician that would be inappropriate to communicate to the patient, these will be recorded separately from the summary and recommendations. All records will be stored in a secure location, following procedures used for other peer review materials.

The referring clinician is encouraged to share the results of the summary and recommendation with the patient. Any summary intended for potential sharing with the patient (it is ultimately the referring

clinician's decision whether to do so) will need to use different wording than the version for peer review. It should be clearly labeled as the version for the patient. Inclusion of any PMOC materials into the medical record is at the discretion of the prescriber who referred the patient to the PMOC.

Basis of recommendations

The recommendations should reflect sound, scientific medical decision-making, including use of evidence from the medical literature and professional judgment balancing the risks and benefits of different treatment options. If committee members are not all in agreement with a recommendation, the options will be listed in the "summary and recommendations" section, including the pros and cons of each option, with a statement that the committee did not have a definitive recommendation. In such situations, it is generally anticipated the summary and recommendations document will not be given to the patient, though this decision will remain with the referring clinician.

Standards of Decision Making

Escalation of Opioid Dose above 120mg MED

1. Patients in hospice or palliative care, where the goal of care is patient comfort, even if life may be shortened and there is no intention or medical need to eventually taper a high dose of medication.
2. Patients with severe, objectively identified and diagnosed pain associated with malignancy or significant ongoing tissue/bone destruction, where other modalities are insufficient to control symptoms.
3. A limited, temporary escalation may be indicated for treatment of added pain due to an acute injury or surgery. Generally such escalations should last no more than 4 weeks, and the patient should be clearly advised at the time of the escalation that it will be temporary.

Tapering Opioid Dose with chronic non-malignant pain

1. Tapering is indicated when there is a high suspicion (but not definitive proof) of diversion or drug abuse.
2. For patients taking both a benzodiazepine or chronic muscle relaxant and chronic opioids, without objective need for these medications (e.g. quadriplegia with spasms), should first have their benzodiazepine or muscle relaxant tapered, before consideration of opioid taper.
3. Tapering is indicated for medical safety reasons if a patient is taking greater than 120 mg MED per day has no significant mental or behavioral co-morbidities, is not pregnant, has no objective evidence of ongoing tissue damage, and *is* receiving physical therapy or other physical medicine modalities *and* psycho-social support.

When Tapering should be deferred:

1. Tapering may not be advisable or possible when done by a PCP if the patient has severe depression (PHQ9 >15) or psychological instability. These cases should be stabilized by a behavioral health therapist before initiating tapering.
2. Patients with limited cognitive ability or a history of traumatic brain injury may be quite challenging to taper. A strong multi-disciplinary team approach may be needed.
3. Patients who are pregnant are also challenging to taper. Rapid tapering of opioids in pregnancy is associated with adverse pregnancy outcomes, and maternal use of opioids (especially methadone) is associated with neonatal abstinence syndrome. Conversion to buprenorphine may be advisable if the patient is on high doses of medication; expert consultation should be obtained.
4. Patients already under comprehensive care of a pain specialist may not be appropriate for a Pain Management Oversight Committee; this may be evaluated on a case by case basis.

Alternative Names for Pain Management Oversight Committee

Options for alternative names include:

1. Opioid Oversight Committee
2. Pain Medication Safety Committee

Appendices

I. Evaluation of side effects of chronic opioid use

- a. History:
 - i. Risks of abuse or diversion:
 1. Early refills
 2. Lost or stolen medications
 3. Escalating dose requests
 4. Emergency room visits for pain medication (CURES report will help)
 5. History of substance abuse (current substance abuse warrants immediate referral for substance abuse treatment)
 - ii. Medical risks
 1. Decreased libido or energy
 2. [Screen for sleep apnea](#)
 3. Use of multiple psycho-active or sedating medications
 4. Fractures while taking opioids
 - iii. Psychological risks
 1. Screen for depression ([PHQ9](#))
 2. Screen for cognitive decline (mini-mental status exam)
 3. Evaluate for relationship issues related to use of opioids
 - iv. Functional risks
 1. Document disabilities
 2. Inability to self-manage co-morbid chronic disease
 3. Falls
 4. Injuries while operating motor vehicle or bicycle
- b. Physical Examination
 - i. EKG if taking methadone
 - ii. Bone density scan
 - iii. Endocrine evaluation (TSH, testosterone)
 - iv. If positive screen for OSA:
 1. Sleep study
 - v. If cognitive deficit:
 1. workup for dementia

II. Referral to Pain Management Oversight Committee

Referral to: (Name of Pain Management Oversight Committee)

Name of Patient: _____ Sex: _____

Date of Birth: _____ Age: _____

Name of Referring Clinician: _____ Name of PCP (if different): _____

Email of Referring Clinician: _____ Phone of Referring Clinician: _____

Name of Practice or Health Center: _____ Date of Referral: _____

Patient Insurance type: PHC Medi-Medi PHC Medi-Cal Other: _____

Select one.

- Referring Clinician would like to participate in meeting
- Send referring Clinician a report after the meeting is completed

1. Reason for referral to committee:

2. History and Physical: Check here if attachment from electronic health record system

a. Summary of patient history

b. Complete medication list

c. Physical exam

i. Vitals:

Blood Pressure: _____ Pulse: _____ Respirations: _____
Height _____ inches/cm Weight _____ lb/kg BMI _____
Neck circumference _____ cm

ii. General:

iii. Mini Mental Status Exam score: _____ Cognitive impairment: _____ none (25-30)
Details of missed items: _____ mild (19-24)
_____ moderate (10-18)
_____ severe (<=9)

iv. Neurological exam:

v. Musculoskeletal/Back exam:

3. Description of co-morbidities (both physical and mental) with assessment of severity

4. Relevant imaging studies

5. Patient's one year prognosis:

a. Conditions on which this is based

6. PHQ9 Score: _____ Degree of Depression: _____

7. If the patient is on chronic, high doses of opioids, complete this section:

a. History:

i. Risks of abuse or diversion:

1. Early refills

2. Lost or stolen medications

3. Escalating dose requests

4. Emergency room visits for pain medication (consult CURES report)

5. History of substance abuse (current substance abuse warrants immediate referral for substance abuse treatment)

ii. Medical risks

1. Decreased libido or energy

2. [Screen for sleep apnea](#)

STOP BANG screening tool

1. Snoring

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes No

2. Tired

Do you often feel tired, fatigued, or sleepy during daytime?
 Yes No

3. Observed

Has anyone observed you stop breathing during your sleep?
 Yes No

4. Blood pressure

Do you have or are you being treated for high blood pressure?
 Yes No

5. BMI

BMI more than 35 kg/m²? Yes No

6. Age

Age over 50 yr old? Yes No

7. Neck circumference (neck circumference is measured by staff)

Neck circumference greater than 40 cm? Yes No

8. Gender

Gender male? Yes No

Number of items with yes answer: _____

- High risk of OSA*: answering yes to three or more items
- Low risk of OSA*: answering yes to less than three items

3. Use of multiple psycho-active or sedating medications

4. Fractures while taking opioids

iii. Psychological risks

1. MMSE (above) shows cognitive impairment

2. Relationship issues related to use of opioids

iv. Functional Risks

1. Document disabilities:

2. Depression noted on PHQ9 Score (above)

3. Poorly controlled chronic disease

- 4. Recent falls: Indicate number of falls and the time frame: _____
- 5. Recent injuries while operating motor vehicle or bicycle

- b. Supplementary Materials: Please attach the following if indicated:
 - i. EKG if taking methadone
 - ii. Bone density scan
 - iii. Endocrine evaluation (TSH, testosterone)
 - iv. If positive sleep apnea screen
 - 1. sleep study
 - v. If cognitive deficit on MMSE
 - 1. workup for dementia

- 8. Recent CURES report attached. Date of CURES report: _____
Summary of results: _____

- 9. Recent urine toxicology report with confirmatory testing if indicated is attached
Summary of results: _____

- 10. Copy of signed medication use agreement attached

- 11. Relevant imaging studies

- 12. List of prior medications used for chronic pain in the past: with side effects:

- 13. Description of non-medication modalities tried in the past and present, with assessment of effectiveness.

- 14. Planned modalities in the future:

- 15. Referring clinician's recommended outcome, if there is one, and any other factors related to the patient's situation or the patient-clinician relationship which the committee should consider:

16. Opioid risk score

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[]	1	3
	Illegal Drugs	[]	2	3
	Prescription Drugs	[]	4	4
2. Personal History of Substance Abuse	Alcohol	[]	3	3
	Illegal Drugs	[]	4	4
	Prescription Drugs	[]	5	5
3. Age (Mark box if 16-45)		[]	1	1
4. History of Preadolescent Sexual Abuse		[]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[]	2	2
	Depression	[]	1	1

TOTAL

Total Score Risk Category

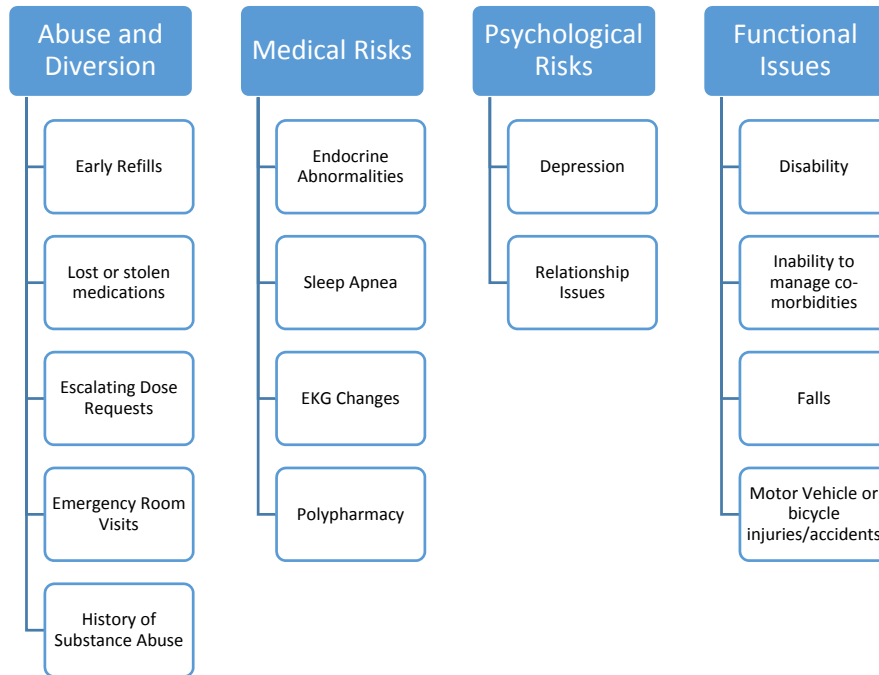
Low Risk 0-3

Moderate Risk 4-7

High Risk ≥ 8

Reference: Webster LR, Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442 Used with permission.

Summary of clinical risks of opioid use (use data above to shade in the applicable bubbles):



Adapted from Dr. Andrea Rubinstein, Kaiser Santa Rosa, who often shares this with individual patients.

Example of report from Pain Management Oversight Committee (PMOC) to Clinician

Clinician Name:

Clinician wants to attend meeting? Yes No

Clinician contact email:

Patient Name: **Test, Patient**

Patient DOB:

Patient CIN (if available):

Date referred to committee:

Date reviewed by PMOC:

Name/associated organization of PMOC:

Reviewer Names and titles:

Reason(s) for referral: **Total opioid dose >120 MED; Side effects of chronic opioid use.**

Introduction: Thank you for referring this case to the PMOC. The purpose of the committee is to review complex clinical situations for patients with chronic pain, especially those on high doses of opioids, and recommend further diagnostic workup and/or treatment options customized to the needs of the patient referred.

Summary of Referral (**full referral attached**)

Brief summary of the case: **34 year old man with chronic lumbar back pain since 2008, initially precipitated by an automobile accident with a vertebral compression fracture. He says the pain currently ranges from 6/10 at best to 10/10 at worst.**

Summary of current medications: **100 mg TID of extended release morphine sulfate (300 MED) and 8 mg QID of PO Dilaudid (128 MED). The dose has been stable for the past 6 months. Total MED 428.**

Pertinent positive findings on physical exam:

Vitals: **BMI=38**

General: **Obesity**

MMSE: **score 20, mild cognitive impairment**

Neurologic exam: **somewhat sleepy, but arousable.**

Musculoskeletal/back exam: **Scar from prior surgery on back**

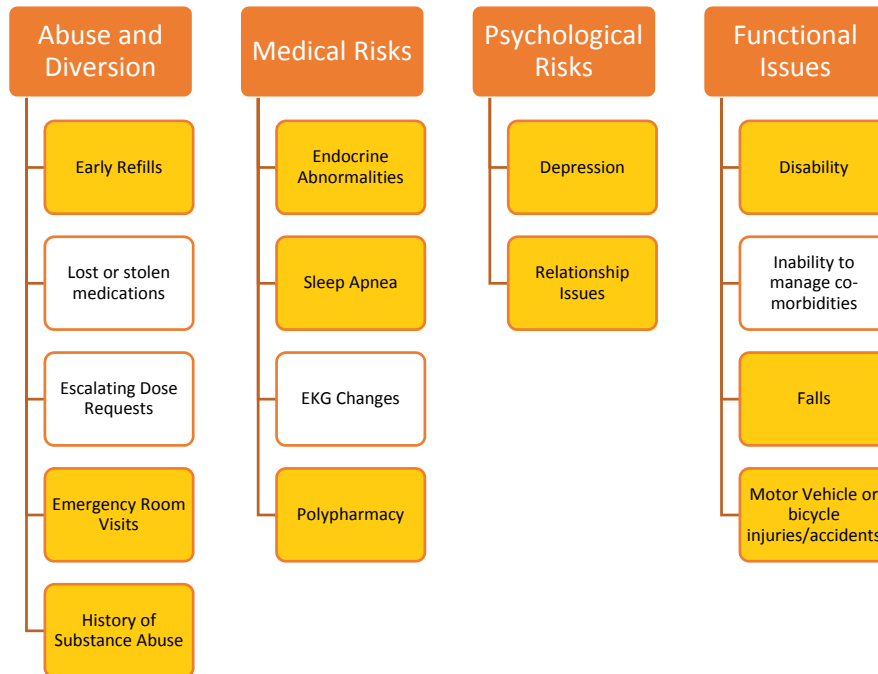
Co-morbidities: **Depression, anxiety, obesity, intermittent migraine headaches, irritable bowel syndrome.**

One year prognosis: **good**

PHQ9 score: **18, severe depression**

Summary of clinical risks of opioid use: **See chart for summary**

Detail: **High risk for OSA on screen, confirmed on sleep study; 3 falls in past year; workup for other cause of reversible dimension negative; Osteoporosis confirmed; low testosterone level.**



CURES Report Summary: The CURES report shows all medications are prescribed only by you.

Urine tox summary: His urine toxicology screen is as expected for the regimen his taking (no other drugs noted)

Medication use agreement: Reviewed by the committee and found to be adequate.

Summary of Prior Medications: Vicodin and Norco were used until they stopped working, years ago

Summary of Modalities: Trial of physical therapy 2 years ago which he stated made the pain worse. Six months ago he had an epidural spinal injection and sacroiliac joint injection with steroids which provided partial relief of pain for about 2 hours. He has not tried acupuncture, meditation, yoga. He has been given a mental health referral.

The opioid risk score: 7

Committee discussion: This patient's pain is poorly controlled, although he is on a stable dose of opioid pain medication. He is at risk of opioid addiction and is already having significant side effects from use of high doses of opioids. His severe depression and impaired cognitive ability will make tapering difficult, unless the prescriber works closely with the PCP.

Committee recommendation: Referral to mental health therapist for evaluation of therapy +/- antidepressant therapy, plus mindfulness meditation. Consider a reduction in generic Dilaudid to 6 mg QID for now; then wait on further tapering until depression stabilized (PHQ9<11). Evaluate patient belief system around yoga and acupuncture, and consider referral if he seems amenable.

Specific Opioid Medication management recommendation: Continue long acting morphine dose without change (100 mg TID). Reduce the PRN dose of Dilaudid to 6 mg QID. Write for 28 days of medication

at a time, scheduled to fill the prescription on a Tuesday, Wednesday, or Thursday every 4 weeks. After starting yoga/acupuncture and therapy with a behavioral health therapist, begin **slow** tapering of opioids according to the principles outlined by Dr. Andrea Rubinstein in her video on the [PHC website](#) or consult the following reference: [Suttner et al. *Best Practices in Tapering Methods in Patients Undergoing Opioid Therapy*, Advances in Pharmacology and Pharmacy 1\(2\): 42-57, 2013.](#)