SUQUAMISH TRIBE HEALING HOUSE

Policy & Procedure

Policy Title:	OPIOID PRESCRIBING		
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Signature Authority:	DocuSigned by: Steve Kutz 6AF380C345104DA...	12/13/2022	

PROCEDURE

Non-cancer pain management and opioid prescribing.

DEFINITIONS

Prescribing clinician: Any credentialed health care clinician with controlled prescribing privileges and DEA registration at the Suquamish Health Division including employed, locums or contracted clinicians working within the scope of their practice.

Controlled Substance: Any medication in DEA class I-V.

Prescription Monitoring Program (PMP): RCW 70.225 (2007) created Washington's PMP also known as Prescription Review. The program was created to improve patient care and to stop prescription drug misuse by collecting dispensing records for Schedule II, III, IV and V drugs, and by making the information available to medical clinicians and pharmacists as a patient care tool. Program rules, WAC 246-470, took effect August 27, 2011. The program started data collection from all dispensers October 7, 2011. It is accessed through https://secureaccess.wa.gov/public/saw/pub/submitRegister1.do

Pain includes:

- Acute pain: normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease; six weeks or less in duration.
- Subacute pain: continuation of pain that is six- to twelve-weeks in duration.
- Chronic pain: pain persisting beyond the usual course of an acute disease or healing of an injury, or which may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. Chronic pain is considered to be pain that persists for more than twelve weeks.

SCOPE AND APPLICABILITY

The Indian Health Service Indian Health Manual establishes the requirements for local policies for the management of chronic non-cancer pain among patients18 and over seeking care in Indian Health Service (IHS) facilities for chronic non-cancer pain in the ambulatory setting. This policy was established to minimize the adverse psychological

and physiological effects of unrelieved pain, promote appropriate opioid prescribing, and reverse the cycle of opioid pain medication misuse that contributes to the opioid overdose epidemic. This policy is based on the Guidelines for Prescribing Opioids for Chronic Pain (Centers for Disease Control and Prevention, 2016); and the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain (Federation of State Medical Boards, 2013)

The Washington Medical Commission adopted opioid prescribing rules on August 22, 2018, with an effective date of January 1, 2019.

These rules do not apply to palliative, inpatient hospital care, procedural medications and cancer related treatments. Children and adolescent patients should be treated based on weight of the patient and adjust the dosage accordingly.

Prescribing clinicians at Suquamish Health Division programs, including Wellness Clinic and Healing House, will follow all Indian Health Service standards and federal drug enforcement agency (DEA) regulations as well as Washington State Guidelines when using controlled substances in a treatment plan for patient/clients.

While marijuana is legal in Washington State, it is a federal DEA class I drug with no medical use. As a facility with federal funding, Suquamish Tribal Health Division will not prescribe or refer patients for medical marijuana treatment.

All Federal prescribers, contractors (that spend 50 percent or more of their clinical time under contract with the Federal Government), clinical residents and trainees are required to successfully complete the IHS Essential Training on Pain and Addictions within six months from the start of IHS employment. Completion of refresher training is required every three (3) years.

Link to training site:

https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/private/1302046856/1807444882/event_registration.html?sco-id=1807545646

Clinicians prescribing opioids in Washington must complete a one time, one hour continuing medical education course. It must be completed by the end of your first full CME reporting period after January 1, 2019, or it may be reported during the first full CME reporting period after getting license. Clinicians prescribing long-acting opioids should have a one-time completion of at least four hours of continuing education relating to this topic.

PROCEDURE

Prescribing clinicians will follow the best practice guidelines and maintain all monitoring standards for patients whose treatment plans include opioids.

Where applicable, validated assessment and monitoring tools, urine drug testing and copies of the guidelines in print or online, will be available for prescribing clinicians to use for the purpose of meeting this policy.

Prescribing opioids must be based on clear documentation of unrelieved pain. Prescribing clinicians will emphasize patient/client safety in prescribing and using opioids in treatment plans by meeting or exceeding Indian Health Service recommendations and federal DEA regulations within the scope of their practice and Washington State law and guidelines.

Generally, clinicians should prescribe immediate release (instead of long acting or extended release) opiods at the lowest effective dose and on an as needed (as opposed to scheduled) basis. They should carefully evaluate the risk benefit ratio before increasing dosage or frequency. Discontinuation of opiods should be considered if the benefits do not outweigh the risks.

Acute pain

Prior to issuing an opioid prescription for acute nonoperative pain or acute perioperative pain, the clinician shall:

1. Conduct and document an appropriate history and physical examination including screening for risk factors for overdose and severe postoperative pain.
2. Evaluate the nature and intensity of the pain or anticipated pain following surgery
3. Inquire about any other medications the patient is prescribed or is taking.
4. Consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate.
5. If opioids are deemed necessary for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient. The physician shall not prescribe beyond a seven-day (7) supply without clinical justification and documentation.
6. The clinician shall reevaluate the patient who does not follow the expected course of recovery and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.
7. Long-acting or extended-release opioids are not indicated for acute nonoperative pain.
8. Medication assisted treatment (MAT) medications must not be discontinued when treating acute pain, except as consistent with the provisions of WAC **246-919-975**.
9. If the physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain.

Subacute Pain

Prior to issuing an opioid prescription for subacute pain, the clinician shall assess the rationale for continuing opioid therapy as follows:

1. Conduct an appropriate history and physical examination.
2. Reevaluate the nature and intensity of the pain.

3. Screen the patient's level of risk for aberrant behavior and adverse events related to opioid therapy.
4. Obtain a biological specimen test if the patient's functional status is deteriorating or if pain is escalating.
5. Screen or refer the patient for further consultation for psychosocial factors if the patient's functional status is deteriorating or if pain is escalating.

The clinician treating a patient for subacute pain with opioids shall ensure that the following is documented:

1. The presence of one or more recognized diagnoses or indications for the use of opioid pain medication.
2. The observed or reported effect on function or pain control forming the basis to continue prescribing opioids beyond the acute pain episode
3. Pertinent concerns discovered in the PMP
4. An appropriate pain treatment plan includes maximizing nonpharmacological modalities and nonopioid therapy and only considering opiates if the benefits (in terms of pain and function) outweigh the risks
5. The action plan for any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued
6. Results of psychosocial screening or consultation
7. Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy, and mitigation strategies
8. The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable

Follow-up visits for pain control in 1-4 weeks after initiating opiods must include the following objectives or metrics to be used to determine treatment success if opioids are to be continued:

1. Change in pain level
2. Change in physical function
3. Change in psychosocial function
4. Additional indicated diagnostic evaluations or other treatments

Chronic Pain

Clinicians will review the treatment plan at reasonable intervals based on the individual circumstances of the patient, but at a minimum of every 3 months and immediately upon indication of concerning aberrant behavior and more frequently at the clinician's discretion.

During the periodic visit, the clinician shall review and document:

1. patient's compliance with any medication treatment plan
2. if pain, function, and quality of life have improved, diminished, or are maintained; and
3. if continuation or modification of medications for pain management treatment is necessary based on evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan
4. physical examination related to the pain

5. use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control
6. review of the Washington state PMP
7. if the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan

Co-prescribing
Clinicians cannot knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:

1. Benzodiazepines
2. Carisoprodol
3. Barbiturates
4. Sedatives
5. Nonbenzodiazepine hypnotics

PMP queries
Must be completed and pertinent concerns raised in review of PMP should be documented in patient record:

1. At the first refill or renewal of an opioid prescription
2. At each pain treatment transition phase
3. Periodically based on the patient risk level
4. For episodic care of a patient currently on opioids for chronic pain

Toxicology testing
When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

Side Effects and Harms
Before initiating opiods and periodically during treatment, clinicians should counsel patients regarding common opiods side effects as well as life threatening risks.

Naloxone
Clinicians will incorporate into the pain management plan strategies to mitigate risk, including considering offering naloxone and training to the patient or a family member when there are factors that increase risk for opioid overdose, such as:

1. Patients with sleep-disordered breathing; and /or respiratory disorders;
2. Patients using concurrent benzodiazepines;
3. Pregnant women;
4. Patients with renal or hepatic insufficiency;
5. Patients aged $\geq$ 65 years;
6. Patients with mental health conditions;
7. Patients with substance use disorder; and
8. Patients with prior history of opioid overdose.

Consider naloxone prescribing with all patients on chronic opioids prescriptions and highly recommended for patients that exceed 50 MME/day.

Consultation
Consultation with a Pain Management Specialist may benefit the following types of patients:

1. Patients with complex pain conditions with or without a clear source for their ongoing reports of pain;
2. Pregnant or potentially pregnant patients;
3. Patients with complex medical co-morbidities impacting their pain management;
4. Patients with history of alcohol or substance use disorders;
5. Patients requiring excess of 90 MME dose daily;
6. Patients requiring continued escalation of dosing for adequate pain relief; and
7. Patients scheduled for surgical interventions

Patient agreement, notification, secure storage, and disposal

1. The clinician shall use a written agreement (Controlled Substances Agreement) that outlines the patient's responsibilities for opioid therapy. This will be signed by patient and clinician at the time of first prescription and embedded or scanned into electronic health record.
2. Patients will be informed verbally and in writing (Controlled Substances Agreement) of the following information at the first issuance of a prescription for controlled substances and periodically thereafter.
    a. Risks associated with the use of controlled substances, including the risk of dependence and overdose, as appropriate to the medical condition, the type of patient, and the phase of treatment.
    b. Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments (including, where appropriate, complementary and alternative therapies; traditional medicine; culturally specific spiritual practices) whenever reasonable, clinically appropriate, evidence-based alternatives exist.
    c. The safe and secure storage of opioid and controlled prescriptions.
    d. The proper disposal of unused controlled medications including, but not limited to, the availability of recognized drug take-back programs.
    e. That the patient has the right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.
3. If the patient is under eighteen years old or is not competent, the discussion required by subsection of this section must include the patient's parent, guardian, or the person identified in the Suquamish Tribal Code and RCW **7.70.065**, unless otherwise provided by law.

Indications to taper or stop controlled substance prescribing

1. Patient request
2. Patient experiences a deterioration in function or pain

3. Lack of demonstrable clinical benefit of using controlled substance
4. Patient is noncompliant with the written agreement
5. Other treatment modalities are indicated
6. Fails to comply with medical evaluation of pain complaint: diagnostic tests requested (e.g., radiology tests, EMG, stress test) and referrals (e.g., neurology, neurosurgery, physical or occupational therapy, psychology, psychiatry)
7. There is evidence of misuse, abuse, substance use disorder, or diversion
8. The patient experiences a severe adverse event or overdose
9. There is unauthorized escalation of doses
10. The patient is receiving an escalation in opioid dosage with no improvement in their pain or function
11. Disorderly behavior in clinic: abusive behavior toward clinic staff, or disruptive behavior interfering with the care of other patients will not be tolerated and may result in discontinuation of controlled substance prescription and/or dismissal from clinic
12. Patient misses more than 3 (three) appointments (no shows) per rolling 12 monthe window without proper cancellation.

Electronic Prescribing and EHR/PMP Integration

1. The Suquamish Tribe Healing House and Wellness Clinics communicate prescriptions and prescription refills for Schedule II-V controlled substances to the pharmacy electronically via a federally certified electronic health records (EHR) system that is fully integrated with the Prescription Monitoring Program (PMP).
2. The PMP will be reviewed upon initial prescription of controlled substances and at least annually, as well as after any incidences of concern.

Resources

Safe disposal of opioid and other unused medication
Suquamish Police Department
18490 Suquamish Way Northeast
Suquamish, WA, 98392 (360) 598-4334
This Medicine Mail-Back Distribution *site provides free, postage paid mail-back disposal packages for residents to safely dispose of expired or unwanted medicines by mail.*

Patient information
https://wmc.wa.gov/resources/pain-management-resources/patient-pain-management-resources

https://depts.washington.edu/anesth/care/pain/telepain/mini-site/docs/UW-BenefitsRisks_TreatmentOpioids.pdf

References

Indian Health Manual Part 3, Chapter 30 - Chronic Non-Cancer Pain Management:
https://www.ihs.gov/ihm/pc/part-3/p3c30/#3-30.1E

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022
https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

https://wmc.wa.gov/resources/pain-management-resources

https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf
WAC 246-919-850 through 246-919-985
Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-850, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.