PURPOSE

To assure that DOP inmates with Chronic Pain are receiving high quality Primary Care for their condition.

POLICY

All DOP Primary Care Providers are to follow these guidelines when treating inmates. Deviations from these guidelines are permissible only on a case by case basis. When deviations are made they must be clearly documented in the medical record along with a clear explanation of the rationale for the deviation.

PROCEDURE

CHRONIC PAIN

Basic Premises

1. Chronic pain is a serious and prevalent problem in the DOP. When it is legitimately present it deserves treatment comparable to that available to patients outside of corrections. However, because of the unique character of the DOP patient population, chronic pain is frequently over reported and/or exaggerated by our patients. It is incumbent upon the Primary Care physicians and physician extenders who regularly treat these inmates that they carefully and correctly diagnose chronic pain. Free world community standards of care in this area may need to be modified to take into consideration the special needs and problems inherent in this population.

2. The initial evaluation and management of chronic pain is an integral part of the normal practice of primary care. As such the DOP expects that all physicians providing primary care to inmates should be able to do the initial evaluation and management of chronic pain and that the vast majority of chronic pain patients will be managed by primary care.

3. The first step in the management of chronic pain is a thorough evaluation for underlying serious or reversible causes of the pain. This however does not mean that chronic pain patients should be subjected to needless diagnostic testing. Such testing should be based on a reasonable expectation that it will significantly impact the therapeutic regimen. It should be done solely on basis of medical necessity without regard to patient/family demands and/or the legal concerns of the medical providers.

4. The second step in the management of chronic pain is to determine if the patients' complaints are amenable to chronic pain management. The DOP patient population has a high incidence of drug seeking and manipulative behavior. Patients should not be allowed to use chronic pain for inappropriate secondary gain. The primary care and mental health physicians who work with this population on a regular basis are the ones best suited to make the determination of whether or not the patient's complaints are authentic. Physicians with little or no correctional experience should not be expected to make this determination. Referrals to pain clinics should be limited to patients who might benefit from an invasive procedure, **not for comprehensive medical management.**

5. The use of chronic opioid therapy is a legitimate therapy that can be used in the management of chronic pain in the DOP. However it must be done with great care and only as a part of a comprehensive pain management

plan and after an aggressive trial of non-opioid therapy has been unsuccessful in controlling the patient's pain/disability. Inmates receiving chronic narcotics must sign a Chronic Opioid Therapy Agreement, agreeing to the appropriate use of these medications. Inmates, who after careful investigation are confirmed to have seriously violate the terms of their agreement, use their chronic pain to inappropriately manipulate the system, or in any way use their opioid in an illegal or inappropriate manner should lose their privilege to have opioids for the management of chronic pain and may be subject to disciplinary and/or legal actions.

6. Opioids may not be prescribed to non-hospice inmates on a chronic basis within the DOP except under the terms of the Chronic Pain Guidelines. Chronic opioid use is defined as the use of or prescribing of **more then 4 doses per week continuously for 2 or more months or for 4 months out of any 12 month period.**

Treatment Guidelines

1. The primary care provider should complete a careful and complete symptom focused history and physical examination **on all new chronic pain patients**. This should include the following:

   A. A detailed history of the pain, its intensity, duration, modifying factors, response to previous treatments, etc. The use of a pain diary by the patient may be useful in further delineating the pain history; also the willingness to do a thorough diary is a good indication as to the legitimacy of the symptoms. A complete past history of the pain including previous evaluations, injuries, surgical or diagnostic procedures. Whenever possible old medical records should be obtained.
      1. Attempt to categorize the pain as neuropathic or nociceptive
      2. Characteristics of **neuropathic** pain:
         a. Usually described as burning or shooting/stabbing
         b. Due to damage or dysfunction of the nervous system
         c. Common clinical settings: chronic pain in diabetic, postherpetic neuralgia, poststroke pain in the same distribution as the stroke, pain that follows a nerve distribution
         d. Physical findings: numbness or coolness of the skin in the same distribution as the pain, allodynia (sensitivity to non-noxious stimuli).
         e. Some researchers feel that all long-standing chronic pain has a neuropathic component
      3. Characteristics of **nociceptive** pain:
         a. Usually described as aching, throbbing, constant, sharp, dull
         b. Is due to tissue damage
         c. Common clinical settings: mechanical low back pain, sprains/strains, myofascial pain syndromes, fibromyalgia, inflammatory disorders
         d. Physical findings vary depending on the underlying etiology

   B. Do a functional assessment, evaluating how the patient's pain has interfered with his ability to work, to play, and perform ADLs (See appendix 2) and assess the patients overall level of physical conditioning.

   C. Past medical history of substance abuse, mental illness, or medical problems that might contribute to, or interfere with the treatment of the pain.

   D. Social history concentrating particularly on factors that may interact with or be affected by the patient's chronic pain. It should include occupation or DOP assignment, hobbies/sporting activities, tobacco and/or alcohol use, family relationships, and how the above have been affected by the pain (Studies have shown

that one of the major determinants of the prognosis of pain syndromes is the presence or absence of serious psychosocial problems).

E. Family history of mental illness, substance abuse, or related pain syndromes.

F. Complete examination of all organ systems involved in the pain syndrome.

G. Evaluate the validity of the complaints. The presence of any signs of **malingering**, such as the following should be documented:
   1. Gross exaggeration of symptoms.
   2. Aggressive or belligerent behavior
   3. Behavior outside of the examination room that greatly differs from the behavior demonstrated in the examination room as observed personally or by other staff including correctional staff.
   4. Non anatomic physical findings i.e.:
      a. Pressure on top of head increasing back pain.
      b. Straight leg raise response different between lying and sitting positions.
      c. Non dermatonal pattern of sensory loss.
   5. Objective findings of non-compliance.
   6. Failure to cooperate with treatment plan and/or diagnostic evaluations

2. Adjunctive evaluations

   A. Diagnostic testing as indicated by the above evaluation. **Avoid excessive or repeated unnecessary diagnostic testing.**
      1. Carefully evaluate prior diagnostic testing before doing any additional testing, obtain old records if necessary and possible.
      2. Diagnostic testing should be used to **confirm clinical suspicions** not as a primary means of making diagnoses.

   B. Before prescribing chronic opioid therapy evaluate the patient's risk for addiction using The Opioid Risk Tool (ORT) or similar rating tool. (see Table 1)

   C. Mental health evaluation – **Refer**:
      1. If significant comorbid **psychological disease** is present
      2. If the PCP **is uncertain** about the psychological status of the patient
      3. All patients who are **addicted or at high risk by ORT**(Opiod Risk Tool) for addiction prior to starting chronic opioid therapy
      4. Consider if patient is at **moderate risk** by ORT for addiction and opioid therapy is being considered

3. Establish a diagnosis and document it in the medical record

   A. A legitimate chronic pain syndrome with or without an identifiable underlying etiology i.e. migraine, osteoarthritis, fibromyalgia, etc.
   B. Malingering, substance abuse, or drug seeking
   C. Psychiatric either primary or secondary (comorbid)

4. Formulate a treatment plan based on the above diagnosis

   A. **Chronic pain** – proceed with treatment per the guidelines below
   B. **Malingering, substance abuse or drug seeking – no opioid treatment**, disciplinary action where appropriate, offer mental health referral for help in dealing with substance abuse
   C. **Psychiatric**
      1. Primary – refer to mental health for primary management, provide chronic pain management if mental health feels it is appropriate.
      2. Secondary – proceed with chronic pain management, and arrange for appropriate evaluation and treatment of comorbid mental illness.

5. Chronic pain treatment guidelines

   A. Overall guiding principles
      1. Use non-pharmacological treatment modalities wherever possible to reduce the need for medications.
      2. Increasing functionality is as important as decreasing pain, if not more important. **The primary goal should be to decrease disability.**
      3. Most treatment should generally be dosed around the clock not PRN.
      4. Individualize analgesic therapy
      5. Begin with a low dose of a simple, single-entity analgesic and titrate dose gradually to achieve effective pain relief
      6. Try combination therapy when the above is not successful
      7. Fully explain your diagnosis, treatment plan, and goals to the patient

   B. Where appropriate, start with therapy specific to the underlying disease (see related guidelines – Headache and Back Pain)

   C. Non-pharmacological treatment modalities
      1. Physical rehabilitation with functional goals
         a. Establish with the patient functional goals for reestablishing their ability to work, play, and perform activities of daily living
         b. Prescribe an aerobic conditioning program (i.e. walking)
         c. Develop a strength, flexibility, and balance program. Simple unit based exercise programs have been shown to be just as effective as more formalized ones. You may want to consider one or two visits to physical/occupational therapy to develop unit based exercise program.
         d. Set intermediate activity goals at each follow up visit to be accomplished by the next visit
      2. Psychosocial management with functional goals
         a. Depression is a frequent comorbidity with chronic pain and failing to recognize and treat depression appropriately will significantly interfere with the management of chronic pain
         b. When identified or suspected a prompt mental health consultation is indicated
         c. Inadequately managed or identified anxiety, personality disorders, and other major psychological disorders also interfere with the management of chronic pain and must be addressed.
      3. Cognitive behavior therapy (CBT)

a. CBT is considered one of the most effective ways of managing chronic pain. Patients are sometimes referred to a counselor skilled in this, however there are many CBT steps that can be implemented by the PCP. (See appendix 3)
b. Many researchers now feel that disordered thinking plays a major role in chronic pain. CBT attempts to correct this disordered thinking to give the patient a more positive outlook.

D. Pharmacologic Therapy:
1. Should be in addition to nonpharmacologic therapy not in replacement of it.
2. Using two or more agents from **different classes** often allows greater effectiveness with fewer side effects
3. However, multiple agents from the same class should be avoided, as this is rarely effective and often unduly increases the risk of side effects

6. Medications
A. Non-opioids
1. Acetaminophen – this is generally the safest analgesic and should usually tried first
a. Generally is more effective if dosed on a regular basis and not PRN
b. Maximum doses
1) no liver disease/not high risk for liver disease: 4.0 g per day
2) pre-existing liver disease/high risk for liver disease: 2.0 g per day
c. Generally should be continued even if started on more potent analgesics
d. Longer acting forms are preferred for chronic pain patients
2. NSAIDS –
a. High dose and/or prolonged therapy should be avoided in high risk populations i.e. >65, hypertension, liver or renal insufficiency, diabetes
b. Maximum analgesic effect is often obtained at doses **50 to 75% of the maximum** allowable dose. Higher doses generally only increase the anti-inflammatory effect, not analgesia, and significantly increase the risk of side effects.
c. In chronic pain management it is usually best to limit NSAID doses to 50 to 75% of the maximum dose (i.e. ibuprofen 400 to 600 mg TID, naproxen 250 to 375 mg BID)
d. Patients at high risk for GI complications should be given a H2 Blocker or PPI (omeprazole 20 qd) along with NSAID
e. Patients requiring low dose aspirin should avoid ibuprofen
f. Low dose aspirin therapy negates G.I. protective effect of celecoxib

B. Adjuvant drugs
1. Tricyclic Antidepressant
a. Are probably effective against pain particularly neuropathic, also are effective in reducing the frequency and severity of both tension and migraine headaches
b. May help control coexisting depression and anxiety
c. May be helpful in restoring sleep
d. Start low and go very slowly, over periods of weeks and months. Consider a starting dose of approximately 10 to 25 mg each night. Start even lower with elderly patients
e. Therapeutic range may be from 50 to 150 mg per day, it may be lower with elderly
g. Analgesia may take weeks or longer to develop

h. Baseline electrocardiography (ECG) is indicated in patients at risk for cardiac conduction problems
i. Tertiary amines (i.e. amitriptyline, imipramine) have greater anticholinergic side effects and may cause arrhythmia, orthostatic hypotension; therefore, these agents should not be used in elderly patients
j. Secondary amines (i.e. nortriptyline, desipramine) have fewer anticholinergic side effects, but should still be used cautiously in elderly patients.
k. Common side effects are sedation, dry mouth, constipation, urinary retention, may cause cardiac conduction defects, or arrhythmias

2. SSRI (**Requires** a mental health consultation and prescription from a psychiatrist)
   a. Most benefit may be due to decreasing anxiety and depression
   b. Start low, but push to the maximum tolerated dose that is at or below the maximum FDA approved dose

3. SSNRI (Requires a mental health consultation and prescription from a psychiatrist)
   a. Venlafaxine XR
      1) 75 mg no difference from placebo (at this level only effect on serotonin)
      2) 150 -- 300 mg superior to placebo (higher the dose, greater the norepinephrine effect)
   b. Duloxetine
      1) FDA approved for diabetic neuropathy and fibromyalgia
      2) Studies have shown a modest effect in these conditions
      3) Usual dose 60 mg per day, higher dose may confer additional benefit for some but is less well tolerated

4. Anticonvulsants

Medication	Initial dose	Max dose	Titration (fastest)	Side effects (some)	Contra-indications
Carbamazepine	100 mg BID	Titrate to intolerable side effects	100 mg Q 7 days	Sedation, dizziness, ataxia, confusion, nausea, liver toxicity, blood dyscrasia	Liver disease, bone marrow suppression, allergy to tricyclic compounds
Gabapentin[1]	300 mg QHS/BID	1500 mg QID	300 mg q7 days	Sedation, dizziness, confusion, edema, weight gain	
Pregablin[2]	50 mg TID	300 mg BID	150 mg q7 days	Sedation, dizziness, ataxia, edema, weight gain, thrombocytopenia	Avoid abrupt withdrawal, caution in elderly, renal dysfunction, III/IV CHF, history of angioedema

1. Non-formulary, normally will only be approved if at least two formulary agents have been prescribed and failed at max tolerated doses or had intolerable side effect
2. Non-formulary, normally will only be approved if gabapentin has been prescribed and failed at max tolerated doses or had intolerable side effects

5. Topical agents
   a. Analgesic Balm (Theragen Muscle Cream): may be helpful for musculoskeletal pain
   b. Capsaicin (Zostrix, Zostrix HP)
      1. May be helpful in both musculoskeletal pain and neuropathic syndromes particularly postherpetic neuralgia
      2. Can cause severe burning but most patients find tolerable after several days
   c. Lidocaine patches
      1. May be helpful in postherpetic neuralgia and other cutaneous dysesthesias
      2. Non-formulary, will only normally be approved if formulary agents have been prescribed and failed at max tolerated doses or had intolerable side effects

C. Opioids
   1. General considerations
      a. **Should only be considered after the following has been completed**:
         1) A careful and thorough evaluation of the patient's chronic pain syndrome by **the provider** (not RN)
         2) Failure to adequately control the patient's symptoms after an aggressive attempt using the above modalities
         3) Evaluation of the addiction potential using the **Opioid Risk Tool**
         4) Comprehensive discussion with the patient by **the provider** of the benefits and complications of opioid therapy
         5) Review by **the provider** and acceptance and signature by the patient of the **Chronic Opioid Analgesic Agreement** (see appendix 4)
      b. Opioid therapy **should never be the sole modality** used to treat chronic pain syndrome, and failure of the patient to cooperate with non-opioid therapy is sufficient grounds for **discontinuing opioid therapy**
      c. There is **no legal, professional, or ethical requirement** to treat chronic pain with opioids. Opioids should only be prescribed when the provider in their professional judgment feels that the benefits of opioid therapy out weigh its risks.
      d. Opioid therapy should always be initiated as a trial and needs to be frequently reevaluated
         1) Continued opioid therapy should be based on a **demonstration of improved functionality** not just improvement in reported pain control
         2) Initial opioid therapy should be reevaluated by the provider at a minimum of a monthly basis until a stable and effective regimen is established
         3) Once a stable regimen has been established it should be reevaluated by a **provider** at least **every three months** and by a **physician at least annually**

   2. Dosing Guidelines
      a. Chronic opioid therapy should be done on a regular schedule using a long-acting agent, PRN dosing should be avoided
      b. Methadone is the preferred long-acting opioid for the DOP. Refer to the separate dosing guideline for methadone.
      c. Generic long-acting morphine compounds are the preferred second line agents, but normally will only be approved if methadone has been prescribed and failed at max tolerated doses or had intolerable side effects
      d. All long-acting narcotics require prior approval by utilization review.

e. Opioid side effects
   1) Constipation
      a. Extremely common particularly when patient is on other anticholinergic agents and should be treated expectantly
      b. Increase fluids, dietary fiber, and consider the use of a bulk laxative in all patients
      c. Start on regular doses of an osmotic agent or a stimulant plus stool softener at the first signs of difficulty with bowel movements
      d. Ask about difficulties with bowel movements at every follow-up visit and instruct the patient to submit a sick call if he develops problems between visits
   2) Nausea/vomiting
      a. maintain adequate hydration
      b. try adjusting doses, and very gradually tapering
      c. give medications on a full stomach
      d. if associated with vertiginous symptoms consider meclizine
      e. if associated with early satiety consider metoclopramide
      f. in other cases consider dopamine antagonist, i.e. promethazine, metoclopramide, prochlorperazine, etc.
   3) Somnolence/Cognitive Impairment
      a. educate that this will often resolve or improve once the patient is on a steady regimen
      b. avoid dangerous situations until resolved
      c. if persistent after on a stable dose and good pain control is obtained try reducing dose by 25 to 50%

Appendix 1: **Opioid Risk Tool**

		F	M	#
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: 16-45	1	1	
4	History of pre-adolescent sexual abuse	3	0	
5	Psychological disease			
	Attention deficit disorder, obsessive-compulsive disorder, bipolar, or schizophrenia	2	2	
	Depression	1	1	
	Total score	X	X	

F = Female M = Male

Scoring

0-3 - Low Risk
4-7 - Moderate Risk
> 8 - High Risk

Appendix 2: **Functional Ability Questionnaire**

Instructions: Circle the number (1-4) in each of the groups that best summarizes your ability.
Add the numbers and multiply by 5 for total score out of 100.

Self-care ability assessment
1. Require total care: for bathing, toilet, dressing, moving and eating
2. Require frequent assistance
3. Require occasional assistance
4. Independent with self-care

Family and social ability assessment
1. Unable to perform any: chores, hobbies, driving, sex or social activities
2. Able to perform some
3. Able to perform many
4. Able to perform all

Get-up-and-go ability assessment
1. Able to get up and walk with assistance, unable to climb stairs
2. Able to get up and walk independently, able to climb one flight of stairs
3. Able to walk short distances and climb more than one flight of stairs
4. Able to walk long distances and climb stairs without difficulty

Lifting ability assessment
1. Able to lift up to 10 lb. occasionally
2. Able to lift up to 20 lb. occasionally
3. Able to lift 20-50 lb. occasionally
4. Able to lift over 50 lb. occasionally

Work ability assessment
1. Unable to do any work
2. Able to work part-time **and** with physical limitations
3. Able to work part-time **or** with physical limitations
4. Able to perform normal work

Functional Ability Score = ____

Appendix 3: **Cognitive-Behavioral Strategies for Primary Care Physicians**

• Ask the patient to take an active role in the management of his/her pain. Research shows that patients who take an active role in their treatment experience less pain-related disability

• Let the patient know you believe that the pain is real and is not in his/her head. Let the patient know that the focus of your work together will be the management of his/her pain. ICSI Patient Focus Group feedback included patient concerns that their providers did not believe them when they reported pain.

• Tell the patient that chronic pain is a complicated problem and for successful rehabilitation, a team of health care providers is needed. Chronic pain can affect sleep, mood, levels of strength and fitness, ability to work, family members, and many other aspects of a person's life. Treatment often includes components of stress management, physical exercise, relaxation therapy and more to help them regain function and improve the quality of their lives.

• Avoid telling patients to "let pain be their guide," whether it is stopping activity because of pain or taking medications or rest in response to pain.

• Prescribe time-contingent pain medications, not pain medications "as needed." Time-contingent medications allow a disruption in the associations between pain behavior and pain medication. The powerfully reinforcing properties of pain medicines are then not contingent upon high levels of pain and pain behavior.

• Schedule return visits on a regular schedule and don't let the appointments be driven by increasing levels of pain. Physicians are powerful reinforcers, too.

• Reinforce wellness behaviors such as increased activity or participation in an exercise program.

• Enlist the family and other supports to reinforce gains made towards improved functioning, too.

• Have patient involved in an exercise program or structured physical therapy.

• Assist the patient in returning to work. Do this in a stepwise fashion that is not dependent on level of pain.

• Fear of movement or fear of pain due to movement is a significant concern for many chronic pain patients. Inactivity or avoidance of movement leads to physical deconditioning and disability. Try not to rely on sedative or hypnotic medications to treat the fear many chronic patients show of activity or fear of increased pain. When chronic pain patients expose themselves to the activities that they fear, which simply means when they do the things they have been afraid of and avoiding, significant reductions are observed in fear, anxiety and even pain level *(Vlaeyen, 2002)*. If patient's fears are excessive, relaxation strategies may be helpful or referral for more formal and intensive cognitive-behavioral therapy may be necessary.

Appendix 4: Chronic Opioid Analgesic Agreement

A. If chronic opioids are going to be used, have patient sign a Chronic Opioid Analgesic Contract, and review the contract in great detail. This review must be done by the provider prescribing the opioid. Make certain that the inmate understands his/her responsibilities, particularly the clauses concerning misapplication and receiving narcotics from other providers. Make certain that the inmate understands that failure to comply with the terms of the contract can and will likely result in the loss of the privilege to be treated with chronic opioids. Each time there is a change in the primary provider for the patient a new contract needs to be completed specifying who the new primary provider is. This should occur no more then 5 working days after a prescription renewal is done for an inmate transferred to a new facility.

B. **Cancellation of Chronic Opioid Analgesic Contract**: Cancellation of the contract needs to be based solely on the medical judgment of the inmate's Primary Provider. Neither the provision of nor the withdrawal of Chronic opioids should be used as a bargaining chip or punishment. However, the inmate's failure to comply with the terms of his contract can be seen as an objective sign that he does not need Chronic Opioid Analgesics. Cancellation of the Chronic Opioid Analgesic Contract means only that the inmate's chronic pain will not be treated with opioids. He/she will still be afforded all other medically indicated treatments and he/she may receive short courses of acute narcotic analgesics for appropriate acute pain.

9/30/10

Paula Y. Smith, MD, Director of Health Services Date

SOR: Deputy Medical Director

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CHRONIC OPIOID ANALGESIC CONTRACT
FOR NON-HOSPICE ILL INMATES

I, _____, OPUS # _____, agree to fully cooperate with the chronic pain management that is prescribed by _____, my Division of Prisons medical provider. I understand that the program may contain a variety of different medications and other treatments and that it may include the use of opioid pain medications. Further I understand that to be eligible to continue to receive opioid pain medications I must comply with all the following:

1. Follow all DOP regulations
2. Be on time to all my appointments or have a written excuse from custody for being absent or late.
3. Comply with ***all*** treatments, medical tests, and evaluations including mental health evaluations prescribed by my medical provider.
4. If requested complete a pain diary.
5. Treat all medical personnel with respect and common courtesy.
6. Not take any pain medication, prescription or over the counter that the above named medical provider does not specifically prescribe to me. This specifically ***includes*** pain medications that might be prescribed to me by other medical providers.
7. Not misapply including barter, hoard, or sell the narcotics or any other medication that is dispensed to me.

I understand that failure to comply with the terms of this agreement could result in the suspension of all opioid pain prescriptions and/or disciplinary action. I further understand that the DOP medical staff will be the sole determiners of my compliance with the above conditions. I also understand that any opioid pain medications that I receive will be my sole responsibility. If they are damaged, lost, or stolen that they will not be replaced.

I have reviewed this agreement with the above named provider, had all my questions answered, and I voluntarily agree to abide by the above terms.

Signature _____Date _____

Witness _____

Printed name _____