KootenaiCareNetwork

# Acute Pain Management Clinical Pathway:

Primary Care Strategy

# Acute Pain Management Pathway– Primary Care Strategy

**Key Words:**

- acute pain;
- pain management;
- primary care

**Target Audience:**

This pathway applies to the following organizations:

- Kootenai Care Network, participating clinics
- Kootenai Health Ambulatory Clinics
- Kootenai Health Outpatient Services

**Objective**:

The purpose of this pathway is to provide an evidence based guideline for the treatment of acute pain patients. It is our goal that this pathway will:

- Improve patient safety
- Decrease the rate of opioid prescribing for adults (18 years or older) with diagnoses that do not warrant opioids.
- Decrease diversion of prescribed medication
- Promote evidence based, guideline adherent, and mechanisms cognizant pain management
- Promote prompt diagnosis, effective assessment and appropriate treatment of pain
- Facilitate discovery of comorbid conditions contributing to symptoms
- Improve standardization of pain treatment practices in order to make our expectations for our patients more transparent, improve accountability for patients, and increase consistency for staff protocols.

**Patient Population:**

This pathway provides the guidelines for management of acute pain, defined as any new pain which is expected to have a short duration and improve during the anticipated healing time.

**Patient inclusion criteria –**
This pathway covers diagnoses including but not limited to:

- Adult, non-cancer, acute and subacute pain (outpatient)
- Adult, non-cancer chronic pain patients experiencing unrelated acute pain, including withdrawal pain
- Adult, non-cancer chronic pain patients with acute pain exacerbation

**Rationale and Background**:

Misuse and abuse of prescription opioids is recognized second only to marijuana usage with opioid overdose now being recognized as the leading cause of accidental death in the United States. State governments, the Center of Disease Control (CDC), as well as third-party payer organizations have already begun to restrict and decrease the number of patients on high doses of opioids. Opioids are also recognized to contribute to significant adverse effects such as respiratory depression, allodynia, and hyperalgesia. These in turn contribute to further increases health risks for our patients.

Recommendations from multiple organizations, such as the CDC and Mayo Clinic, have documented that the majority of patients can and should be treated with the lowest effective dose of opioids. They also state that a majority of these patients will require no more than 90 morphine milligram equivalencies (MME) per day. It is also well documented that there is an opioid crisis not only in our country but also in our own community. This pathway is an attempt to begin to standardize pain management in our community and region. Multidisciplinary pain management will be the central theme to the treatment of pain. Multimodal therapies, motivational interviewing techniques, counseling and education will all be utilized as the primary treatment pathways. Opioids will be secondary and will only be a small component of patient's pain management.

## Recommendations for Primary Care Acute Pain Management

***Process:***

**I. Initial Assessment:** All patients have the right to safe and effective pain management applied with respect to cognitive and physical abilities, culture, ethnicity, age, and gender. The acute pain intake encounter will cover the following:

1. Review of records, if available, at the time of intake. If records are not yet obtained, get permission to release the records for review when they become available.

2. A set of resources to assist in the history taking on new pain management patients, or patients presenting with a new pain complaint, will be provided. This includes:
    a. **Prescription Monitoring Program (PMP) Screening for current or recent opioid use:** All physicians and NPs have the ability to sign up for both the Idaho and Washington Prescription Monitoring Program (PMP). In addition, CMAs can be given delegate access which in turn will promote a more effective workflow. Therefore, both the Idaho and Washington PMP database should be checked at all visits to ensure that prescriptions from other facilities are not being filled or that the patient is receiving early refills.
        i. Idaho PMP: https://idaho.pmpaware.net/login
        ii. Washington PMP: https://secureaccess.wa.gov/

    b. **Pain Inventory and Assessment (See addendum 1):** Assessment of the patient's pain, function, and wellbeing will be performed by the provider. The patient's self-report will be accepted as the most accurate measures of the current level of the patient's pain. This will include education regarding expectations of the patient's pain and will work with the patient to establish agreed upon goals. Also, during this visit the provider will educate the patient about Multidisciplinary pain management options. Based on goals and pain management options, an individualized pain treatment plan will be created with the patient which will assess for challenges and follow up schedule.

        i. The Brief Pain Inventory questionnaire (See Addendum 1).
        ii. The Assessment and Management of Chronic Pain Algorithms will also be utilized to identify and treat the source of the patient's pain (See Addendum 4).
        iii. Assessment of Vitamin D and iron levels. Low vitamin D and/or iron levels can contribute to an increase in some types of pain.

c. **Mental Status Assessment such as PHQ-9 (See addendum 2):** Completion of a mental status assessment such as PHQ9 is required at least annually for every patient. Please confirm that the patient has completed their annual PHQ-9 at the initial acute pain visit. If they have not completed a PHQ-9, complete one at the initial visit and any follow up visits as appropriate to identify any additional risks for the patient's treatment plan. This form may be completed by the patient either electronically before or upon arrival to the clinic or on paper upon arrival to the clinic. It will be reviewed by the provider and discussed with the patient during each visit to assess the appropriateness of the pain management plan.

d. **Opioid Risk Tool (See addendum 3):** If an opioid is prescribed for acute pain, the opioid risk tool should be used at the initial visit to identify the patient's risk for opioid addiction. If patient's risk score is high, score ≥8, it is recommended that no opioid therapy be prescribed based on safety of the patient.

**II. Multidisciplinary Pain Management Plan:** It is extremely important to stress to the patient the goals of pain management. Opioid therapy focuses on improvement of functional status and is only used for short-term use or in low dosages due to patient safety risks. Attempt to identify the root cause of the patient's pain should always be assessed and optimally treated before opioids are initiated or dosages increased whenever possible. Opioids will be started on a short-term basis and continuation of opioid therapy will be considered on a patient-by-patient basis. Such patients will then be enrolled in the Multidisciplinary Pain Management Care Program and will be treated according to the Multidisciplinary Chronic Pain Management Pathway.

1. **Non-Opioid therapy (See Addendum #4):** Therapies include but are not limited to:
   a. Pain Education and Counseling
   b. Lifestyle Modifications
   c. Physical Medicine and Rehabilitation
   d. Alternative/Complementary Therapies
   e. Interventional Pain Management Therapies
   f. Topical, oral, and injectable medication options

2. **Opioid therapy**: If narcotic therapy is deemed necessary, avoid prescribing more than 3 days' supply, totaling ≤ 50 morphine milligram equivalency (MME). If circumstances clearly warrant additional opioid therapy, a maximum of 7 days totaling ≤ 90 morphine milligram equivalency (MME) may be provided.
   a. **Example**: **<50 MME**= 10 tablets of hydrocodone-acetaminophen 5/325mg; 6tablets of oxycodone IR 5mg over a 3-day period.
   b. **Example**: **<90 MME**= 18 tablets of hydrocodone-acetaminophen 5/325mg; 12 tablets of oxycodone IR 5mg over a 7-day period.

3. **Opioid Refills**: It should be stressed to the patient that refills on opioid therapies will not be provided without a clinic visit and re-assessment of pain and function.

**III. Follow-up Assessment:** As appropriate per individual patient, assessments found in Addendums 1-3 should be repeated at each follow-up visit as described above. Continued monitoring for comorbid conditions affecting pain and appropriate treatment for these problems is highly recommended. This may include sleep disturbances, depression, PTSD, and strengthening.

Patients with comorbid or chronic conditions may not tolerate all appropriate multimodal therapies. Therefore, non-medication alternatives should be assessed at each visit. If a short-term opioid therapy was initially prescribed, follow up should be performed within 3-5 days in order to assess their pain management regimen as well as appropriate use of their pain medication. This follow-up may be done telephonically or face-to-face. If a patient continues to experience uncontrolled pain after 90 days of therapy, they should then be referred to and enrolled in a Multidisciplinary Chronic Pain Care Management program and managed according to the Multidisciplinary Chronic Pain Management Pathway.

**Acute Pain Management in Special Populations:**

I. **Complex Patients**: It is understood that there may be situations, or a unique clinical scenario, in which this pathway does not cover, or where the suggested pathway may not be appropriate. These situations should be noted, discussed, and documented in the electronic health record. A case review referral to the Multidisciplinary Pain Management Care Program may be utilized to help determine a Multidisciplinary pain management plan for such patients.

**Algorithm:** *See pages 2 to 5 of link*

https://www.icsi.org/wp-content/uploads/2019/01/Pain.pdf

**References/Supporting Evidence**:


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**Implementation & Education Items:**

**Implementation:** *(underlined titles are hyperlinks)*

- Addendum 1: Example: Brief Pain Inventory Example "To receive the BPI you must place an online order from their website at: symptomresearch@mdanderson.org"
- Addendum 2: Example: Screening Tool for Co-Occurring Mental Health Conditions: Mental Status Assessment
- Addendum 3: Example: Screening Tool for Substance Abuse: Opioid Risk Tool
- Addendum 4: Example: Pain Management Algorithm
- Addendum 5: Non-Opioid Treatment Options
- Addendum 6: Pain Etiology-Based Treatment Reference Chart

**Supporting Documents:**

- Magazine Stickers: Opioids
- Rack Cards: Chronic Pain, Medication Storage, etc.
- Standard patient education materials

**Kootenai Care Network Applications**

- Provision of Continuing Education

**Quality Metrics Plan**:

- Pending

**Quality Plan, Do, Study, Act (PDSA) Plan**:

The Kootenai Care Network will be responsible for ongoing review of the literature and for developing necessary modifications to the clinical pathway based on published or local best practices. The guideline will be formally reviewed annually. If any area is in need of improvement, a workgroup will utilize LEAN tools and methodologies to address any issues.

**Point of Contact:**
Created in collaboration with KCN Pain Workgroup, Shelly Rutledge, PharmD, and Kootenai Care Network Quality Committee.
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| **Approval By:** | **Date of Approval:** |
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# Addendum 5: Outpatient Non-Opioid Pain Management Options

## Oral, Injectable, and Topical Pain Management Options

| Oral Medications | Injectable Medications | Topical Medications |
|---|---|---|
| Scheduled: Acetaminophen every 4 hours (Max 4000mg per day) | Steroid injections | Topical NSAIDS (diclofenac gel) |
| Scheduled: Rotation of Acetaminophen and Ibuprofen Every 3 Hours | Epidural steroids | Topical capsaicin, salicylates, methol, camphor, etc. (Tiger Balm, SalonPas, Aspercreme, Biofreeze) |
| TCA's: Desipramine, Nortriptyline, Amitriptyline | | Lidocaine Patches, Gel, or Cream |
| SNRI's: duloxetine, venlafaxine, desvenlafaxine, milnacipran | | Nitroglycerin patches (for chronic tendinitis) |
| Anticonvulsants: gabapentin, pregabalin, carbamazepine | | Essential Oils |
| Muscle Relaxants/Antispasmodics: baclofen, cyclobenzaprine, tizanidine, carisoprodol, metaxalone, methocarbamol | | Diltiazem cream (for rectal fissures/spasms) |
| Tramadol | | |

## Alternative Pain Treatment Options

| Lifestyle Modifications that can Affect Pain Management | Therapy Options | Pain Counseling and Neurological Treatment Options | Alternative/Complementary Therapy Options |
|---|---|---|---|
| Address and stabilize sleep, psychological (depression), and weight conditions | Physical Therapy<br>Spinal Cord Stimulation<br>TENS | Cognitive Behavioral Therapy | Chiropractic |
| Smoking cessation | Occupational Therapy | Environmental Condition Modifications | Acupuncture |
| Blood Glucose Control | Osteopathic Manipulative Treatment (OMT) | Biofeedback | Reflexology |
| Body Movement Therapy: Exercise/Yoga | Fascial Distortion Model | Breathing Exercises<br>Distraction Techniques<br>Imagery | Massage Therapy |
| Nutrition: Identify triggers; eliminate inflammatory foods (wheat, dairy, gluten, soy, processed foods) | Nerve Ending Ablation | Music Therapy | Hot/Cold Therapy |

References: CDC Chronic Pain Management; Bonica's Management of Pain 4th edition; Mayo Clinic Acute and Chronic Pain; Academy of Multidisciplinary Pain Management; Institute for Clinical Systems Improvement; UpToDate Acute and Chronic Pain Tx Non-Cancer

Original: 01/2019

# Addendum 6: Pain Etiology-Based Treatment Reference Chart

| ACUTE Pain Mechanism-Based Treatment Options | | |
|---|---|---|
| **Neuropathic Pain** | **Alternative Treatment Options** | **Medication Options** |
| Post herpetic neuralgia | Soft diet<br>Cold Packs alternating with moist heat | Topical agents<br>NSAIDs<br>Antidepressants<br>Anticonvulsants |
| **Musculoskeletal Pain** | **Alternative Treatment Options** | **Medication Options** |
| Acute musculoskeletal pain | Exercise/movement<br>Physical Therapy | NSAIDs<br>Acetaminophen<br>Topical Agents<br>Muscle Relaxants |
| **Inflammatory Pain** | **Alternative Treatment Options** | **Medication Options** |
| Tendonitis | Physical therapy<br>Iontophoresis<br>Intra-articular injection | NSAIDs<br>Glucocorticosteroids<br>Topical Agents |
| Dental/Orofacial | Alternate moist heat and cold therapies<br>Dental consultation | NSAIDs and Acetaminophen<br>Topical anesthetic rinse<br>Chlorhexidine rinse<br>Bupivacaine injection |
| Temporomandibular Disorder | Soft diet<br>Cold packs alternating with moist heat<br>Physical therapy<br>Phonoophoresis<br>Dental appliances<br>Manual therapy<br>Cognitive behavioral therapy<br>Biofeedback<br>Hypnosis | NSAIDs<br>Anticonvulsants |

| Visceral Pain | Alternative Treatment Options | Medication Options |
|---|---|---|
| Headache/ Migraine | Hot/Cold Therapies<br>Essential Oils<br>Nutraceuticals | **Preventative Medications**<br>Propranolol<br>Tricyclics<br>Anticonvulsants<br>**Treatment Medications**:<br>Triptans<br>NSAIDs<br>Acetaminophen<br>Aspirin<br>Caffeine<br>Ergot derivatives |
| Non-Cardiac Chest Pain | GERD:<br>Dietary Modifications<br><br>Non-Cardiac Chest Pain:<br>Cognitive Therapy<br>Hypnotherapy | GERD:<br>H2 receptor antagonists<br>PPI<br><br>Non-Cardiac Chest Pain:<br>Tricyclics<br>SSRIs<br>Trazodone |
| Abdominal Pain | Lifestyle Modifications<br>Dietary Modifications | Treat underlying comorbidity, if present: stress, regulate bowel movements, psychological- depression, anxiety |
| Pelvic Pain | Acupuncture<br>TENS<br>Chiropractic<br>Osteopathic manipulations | Treat underlying psychiatric condition, if present |
| **Regional Pain** | **Alternative Treatment Options** | **Medication Options** |
| Dental Pain | Mouthwashes<br>Desensitizing toothpaste | NSAIDs<br>Non-opiate analgesics |
| Facial Pain | TMJ:<br>NSAID<br>Nonopiate analgesic<br>Physical Therapy | Sinus Pain:<br>Decongestants<br>NSAIDs<br>Topic agents<br><br>Periocular Pain:<br>NSAIDs<br>Nonopiate analgesics<br>Topical corticosteroids<br>Botox<br><br>Periauricular Pain:<br>NSAIDs<br>Nonopiate analgesics<br>Topical corticosteroids |

| | | |
|---|---|---|
| Neck and Arm Pain | Physical Therapy<br>Chiropractic | |
| Lower Extremity Pain | <u>Foot:</u><br>Arch support<br>Plantar inserts<br>Orthotic shoe inserts<br>Supportive shoes<br><br>Physical Therapy<br>TENS | NSAIDs<br>Acetaminophen<br>Nonopioid analgesics |
| Lower Back Pain- Acute | Lifestyle Modifications<br>TENS<br>Physical Therapy | NSAIDs<br>Acetaminophen |
| **Special Populations** | **Alternative Treatment Options** | **Medication Options** |
| Elderly | | NSAID + PPI<br>Nortriptyline<br>Duloxetine<br>Gabapentin or pregabalin |

| Chronic Pain Mechanism-Based Treatment Options | | |
|---|---|---|
| **Neuropathic Pain** | **Alternative Treatment Options** | **Medication Options** |
| Diabetic Neuropathy | | Anticonvulsants<br>Antidepressants<br>Topical Agents |
| Trigeminal Neuralgia | Soft diet<br>Cold packs alternating with moist heat | Anticonvulsants<br>Antidepressants<br>NSAIDs<br>Botox |
| Nerve compression/radicular pain | Physical rehabilitation<br>Cognitive behavioral therapy<br>Corsets and braces<br>Therapeutic injections<br>Interventional procures | Anticonvulsants<br>Antidepressants<br>Topical Agents |
| Chronic Neuropathy | TENS | Antidepressants<br>Anticonvulsants<br>Topical agents |
| Post Spinal Cord Injury | TENS<br>Physical rehabilitation | NSAIDs<br>Baclofen<br>Opioids<br>Anticonvulsants<br>Antidepressants<br>NMDA antagonist |

| Musculoskeletal Pain | Alternative Treatment Options | Medication Options |
|---|---|---|
| Diffuse non-specific myalgias/ Complex regional pain syndrome | Physical Therapy<br>Biopsychosocial interdisciplinary team approach<br>Cognitive behavioral therapy<br>Graded exercise<br>Massage Therapy | Topical agents<br>Acetaminophen<br>Antidepressants<br>Anticonvulsants |
| Chronic musculoskeletal pain | Physical Therapy<br>Mindfulness-based stress reduction<br>CBT<br>Hypnosis<br>Yoga/Tai-chi<br>Acupuncture<br>Healing touch<br>Aquatic therapy<br>Exercise<br>Manual therapies (neck & back pain)<br>TENS<br>Ultrasound | Acetaminophen<br>NSAIDs<br>Topical Agents |
| Fibromyalgia | Physical Therapy<br>Graded aerobic exercise<br>Heated aquatic therapy<br>Relaxation<br>Interdisciplinary management<br>CBT<br>Hypnosis<br>Healing touch/Qi-gong massage | Anticonvulsants<br>Antidepressants |
| **Inflammatory Pain** | **Alternative Treatment Options** | **Medication Options** |
| Arthritis, all types | Physical Therapy<br>Exercise<br>Aquatic therapy<br>Hypnosis<br>Intra-articular injection | Acetaminophen<br>NSAIDs<br>Glucocorticosteroids<br>Topical agents<br>DMARDs |
| Gout | Dietary modifications | NSAIDs<br>Antihyperuricemic agents |
| **Joint Pain** | **Alternative Treatment Options** | **Medication Options** |
| Osteoporosis | Exercise<br>Aquatic therapy<br>Intra-articular injection | Calcium + Vitamin D<br>Bisphosphonates<br>Acetaminophen<br>NSAIDs |

| Visceral Pain | Alternative Treatment Options | Medication Options |
|---|---|---|
| Headache/ Migraine | Hot/Cold Therapies<br>Essential Oils<br>Assess for TMJ | **Preventative Medications**<br>propranolol<br>**Treatment Medications**:<br>Triptans<br>NSAIDs<br>Acetaminophen |
| Abdominal Pain | Psychotherapy<br>Cognitive Behavioral Therapy<br>Hypnotherapy | IBS:<br>Tricyclic Antidepressants<br>SSRIs<br>Antispasmodics |
| Pelvic Pain | Physical Therapy<br>Acupuncture<br>TENS<br>Chiropractic<br>Osteopathic manipulations | Treat underlying psychiatric condition, if present |
| **Regional Pain** | **Alternative Treatment Options** | **Medication Options** |
| Dental Pain | Mouthwashes<br>Desensitizing toothpaste | NSAIDs<br>Non-opiate analgesics |
| Facial Pain | TMJ:<br>NSAID<br>Nonopiate analgesic<br>Physical Therapy | Sinus Pain:<br>Decongestants<br>NSAIDs<br>Topic agents<br><br>Periocular Pain:<br>NSAIDs<br>Nonopiate analgesics<br>Topical corticosteroids<br>Botox<br><br>Periauricular Pain:<br>NSAIDs<br>Nonopiate analgesics<br>Topical corticosteroids |
| Neck and Arm Pain | Physical Therapy<br>Chiropractic | |
| Lower Extremity Pain | Foot:<br>Arch support<br>Plantar inserts<br>Orthotic shoe inserts<br>Supportive shoes<br><br>Physical Therapy<br>TENS | NSAIDs<br>Acetaminophen<br>Nonopioid analgesics |

| | | |
|---|---|---|
| Lower Back Pain- Chronic | Massage Therapy<br>TENS<br>Exercise<br>Physical Therapy<br>Weight Loss<br>Chiropractic<br>Acupuncture<br>Lifestyle Modifications<br>Interventional Therapies | NSAIDs<br>Acetaminophen<br>Non-opioids<br>Muscle Relaxants<br>SSRI<br>Topical Analgesics |
| Lower Back Pain- Failed Back Surgery Syndrome | Cognitive Behavioral Therapy<br>Physical Therapy | Treat underlying psychiatric condition, if present<br><br>Corticosteroid Injection |
| **Special Populations** | **Alternative Treatment Options** | **Medication Options** |
| Elderly | | NSAID + PPI<br>Nortriptyline<br>Duloxetine<br>Gabapentin or pregabalin |
| **Opioid-Induced Pain** | **Alternative Treatment Options** | **Medication Options** |
| Withdrawal | Develop opioid taper schedule | Opioid<br>Buprenorphine analgesic or methadone with appropriate license |
| Hyperalgesia | Opioid reduction<br>Opioid rotation<br>Adjuvant medication<br>Hypnosis | Anticonvulsants<br>Antidepressants |
| Tolerance | Assess appropriateness of opioid medication<br>Adjuvant medication<br>Opioid rotation | Anticonvulsants<br>Antidepressants<br>Muscle relaxant for flare-up |

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Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell
UpToDate; Mayo Clinic