Chronic Pain Management Care Plan

Here are the guidelines The UAB Emergency Department uses to provide you with safe and effective care. We want to help you avoid problems with opioids by providing education to reduce the risk of opioid misuse and addiction.

- The UAB Emergency Department avoids using IV opioids (drugs given in the vein) unless there is an acute medical condition not related to chronic pain, such as a new injury or disease.

- The best place to get care for ongoing chronic pain is from a chronic pain specialist. The ED is not the right place for this care. The UAB Emergency Department can provide you with a list of clinic providers who manage chronic pain.
- The UAB Emergency Department does not refill opioids for chronic pain or provide new prescriptions for lost or stolen medications.

- The UAB Emergency Department does not use IV Benadryl or IV benzodiazepines (Valium, Ativan) for symptom control including itching or anxiety.

- The UAB Emergency Department does not perform repeated imaging studies (such as CT scans) unless there is an emergent reason. These imaging procedures put you at risk for radiation exposure. We only do these imaging procedures when an exam or lab test suggests that you may have a new, emergent medical problem.

- The UAB Emergency Department asks that you only obtain opioid prescriptions from your usual primary care clinic or provider**.** The UAB Emergency Department is part of a statewide program that actively monitors opioid prescriptions in compliance with Alabama policy.

- If you feel you may have a substance abuse problem, The UAB Emergency Department is happy to assist you in locating treatment programs for addiction.

UAB Emergency Department Chronic Pain Management Plan

**excludes management of acute sickle cell crisis

Initial Assessment	• Patients should be flagged for protocol use 1. Will flag by chronic pain diagnosis on problem list and/or ICD-10 code • ED Physician should access report from state Prescription Drug Monitoring Program to identify possible pattern of addiction
Treatment	• Treat pain initially with up to 2 doses of IV analgesia, reassessing pain after each administration, while doing workup for acute cause of pain. **If patient requires Benadryl for itching this should be administered PO, NOT IV** 1. If patient is still in pain and is able to tolerate PO, dose #3 should be PO 2. If able to tolerate PO dose and no acute indication for inpatient admission has been identified, patient should be provided resources for outpatient chronic pain follow up (via case management) and discharged home
Indications for Admission	Patients with known chronic pain diagnosis will be admitted to the hospitalist service after treatment per ED protocol if patient has an acute indication for admission as defined below: • intractable N/V • elevated enzymes (cardiac, lipase, etc) • abnormal imaging • abnormal vitals (specifically tachycardia, hypertension) • abnormal differential, increased bilirubin, increased reticulocyte count (SS) • elevated ESR, CRP
Discharge	If no acute indication for admission noted and patient able to tolerate PO, patient should be provided resources for outpatient chronic pain management and discharged home. ***Protocol Prescribing practice at discharge:*** • Prescribe no more than a 7 day supply (no more than 20 pills of low dose, short acting opioid unless circumstances clearly warrant more) • Do not prescribe long acting or extended release opioids unless this is a preexisting home medication (in which case prescribe no more than 3 day supply) • PCP follow up expected within 7 days of discharge as bridge to chronic pain clinic follow up (or f/u in chronic pain clinic if already established patient) ** (Plan should not be used for patients >65yo)

UAB Hospitalist Inpatient Chronic Pain Management Protocol

**excludes management of acute sickle cell crisis

<table>
<tr><td>Admission</td><td>Patients with known chronic pain diagnosis will be admitted to the hospitalist service after treatment per ED protocol if patient has an acute indication for admission as defined below:
• intractable N/V
• elevated enzymes (cardiac, lipase, etc)
• abnormal imaging
• abnormal vitals (specifically tachycardia, hypertension)
• abnormal differential, increased bilirubin, increased reticulocyte count (SS)
• elevated ESR, CRP

Admitting MD should access report from state Prescription Drug Monitoring Program (PDMP) or can consult pharmacy to access PDMP if unable to do so</td></tr>
<tr><td>Phase 1</td><td>• Increase home pain management regimen (long and short acting medications) by 20%;
• If no improvement in pain scores add IV pain medications q4h (offer, patient may refuse) x 12 hours while continuing workup for acute cause of pain (if IV medications indicated)
➢ Morphine 2mg (unless patient has allergy or renal failure), or
➢ Dilaudid 0.2mg
○ Can increase dosing if necessary (up to max dose morphine 8mg or dilaudid 3mg)
If patient requires Benadryl for itching this should be administered PO, NOT IV

If by the next MD rounds/assessment no acute cause for pain is identified and patient is tolerating PO, deescalate to phase 2</td></tr>
<tr><td>Phase 2

(Note: Phase 1 must be discontinued before initiating phase 2)</td><td>If no acute cause for pain has been identified or if workup is still pending treatment should deescalate to :
• No IV pain medications
• home pain management regimen (long and short acting medications) at phase 1 doses +
• Ice packs, heat packs and/or physical therapy as indicated

If pain still not adequately controlled can add the following medications based on pain score and risk factors:
<table>
<tr><th>Mild Pain (1-3)</th><th>Moderate Pain (4-6)</th><th>Severe Pain (7-10)</th></tr>
<tr><td>Tylenol 650mg (q4h scheduled)

OR
Gabapentin 300mg BID x1 day (then increase to TID scheduled)</td><td>Ibuprofen 600mg (q6h scheduled)

OR
Diclofenac 100mg PO x1, then 50mg TID (max dose 200mg in 1st 24h,</td><td>Oxycodone (q4 h offer, patient may refuse)

Moderate pain→ 10mg
Severe pain→ 20mg</td></tr>
</table></td></tr>
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	for neuropathic pain **OR Lidocaine patch **for localized pain	150mg/day thereafter) **OR** Toradol 10mg (q6h scheduled)	
Phase 3	If by the next MD rounds/assessment the workup for acute cause of pain remains negative, symptoms can safely be attributed to ongoing chronic pain • deescalate to home pain regimen • check prescription database for recent activity to identify possible pattern of addiction • Social work/Case Management referral to help schedule chronic pain follow up • Addiction medicine/Psychiatry assessment if concern for addiction and/or mental illness • reassure patient and provide education including expected management of chronic pain and warning signs that would require immediate medical attention		
Discharge	Protocol Prescribing practice at discharge: • Prescribe no more than a 7 day supply (no more than 20 pills of low dose, short acting opioid unless circumstances clearly warrant more) ***confirm whether insurance plan will cover lidocaine patch prior to prescribing as this is often not covered* • Do not prescribe long acting or extended release opioids unless this is a preexisting home medication (in which case prescribe no more than 3 day supply) • PCP follow up expected within 7 days of discharge as bridge to chronic pain clinic follow up (or f/u in chronic pain clinic if already established patient) o If patient is a PrimeCare patient there should be communication with the PCP (verbally, email, message center, or via discharge summary) ***(Plan should not be used for patients >65yo)*		

References

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