Lansing Area Consortium Emergency Department Chronic Pain and Dental Pain Practice Guidelines and Management

Goals:
1. Maximize patient safety.
3. Maintain some adaptability for individual case management.
4. Minimize inappropriate narcotic use.
5. Be consistent with State of Michigan Prescribing Guidelines and similar policies already implemented in Jackson, Battle Creek, Eaton Rapids.

Components:
1. Utilize current standard of care.
2. Define Chronic Pain syndromes and Chronic Emergency Department (ED) use.
3. Create the ability to analyze recurrent visits.
4. All ED providers will have a uniform management of chronic pain patients.
5. The ability for enhanced communication with primary care physicians and others regarding chronic pain patients seeking care in the emergency department.
6. Patients with chronic pain will receive non-narcotic pain medications as treatment; exceptions are to be rarely made and with direct contact with the patient’s primary care physician or pain management specialist.

Definitions:

1. **Chronic Pain**:
   - Chronic pain is defined as persistent pain, which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient’s well-being, level of function, and quality of life.
   - Treatment of chronic pain is multi-factorial and often requires psychological assessment, antidepressants, counseling, and physical therapy that which are unavailable in the emergency department.
   - Teamwork and empathetic listening in the development of a treatment plan are of critical importance.

2. **Chronic Pain Syndromes**:
   Patients who frequently visit the Emergency Department for treatment of:
   - Migraine Headaches
   - Chronic Back Pain
   - Pelvic / Ovarian pain
   - Dental Pain
   - Kidney Stone / Flank Pain
   - Fibromyalgia
   - RSD
   - Neuropathy
   - Other chronic musculoskeletal pain.

3. **Chronic ED use**:
   A patient with more than 2 visits in one month or greater than 6 visits a year.
Management of Chronic Pain Syndrome Patients:

1. **Review previous visits** and prior records for same or similar complaint.

2. Identify those **patients who define chronic ED use.**

3. All patients should have an adequate pain assessment that includes location of pain, intensity, quality, onset / duration, modifying factors and a general history and physical examination

4. Obtain a **detailed history regarding the patients current treatment:**
   a. Who manages your pain?—Identify the PCP.
   b. What is your PCP prescribing for your pain?
   c. Does anyone else prescribe pain medications?
   d. Do you have a pain contract with your PCP?
   e. What does your PCP prescribe for breakthrough pain?
   f. What have you taken for this pain already today and what have you tried at home, and what do you normally use for as needed pain?
   g. Did you drive here today?

5. **Explain to the patients** that chronic pain is a well-researched area and that chronic migraine, back pain, musculoskeletal pain, and neurologic pain is not treated with narcotics in the ED.

6. Opioids are rarely beneficial in the treatment of inflammatory or mechanical/compressive pain and are not indicated for chronic use in treatment of headaches. Due to their addictive nature, opioid distribution must occur from one source. For chronic pain, that source is their primary care physician.

7. **Providers should not feel compelled to prescribe opioids if it is against their honest judgment or if they feel uncomfortable prescribing the medication.**

8. The ED will not prescribe controlled substances for pain that is chronic, and therefore is more appropriately addressed by the patient’s primary care provider.

9. The ED provider will check the Michigan Automated Prescription System (MAPS) before prescribing a controlled medication for pain for patients with unclear history.

10. The ED provider may consider random drug screen prior to giving controlled substance for pain—this is to check for diversion, to check for drugs of abuse and test for presence of prescribed drug that the patient claims they are on. Any evidence of street drug use indicates non-compliance with opioid contracts. This has been well established at PCP offices.

11. The ED will limit the number of doses of controlled meds dispensed or prescribed. The numbers for pills dispenses should be 10 or less. This will often require changing the default number of tablets dispensed
12. For patients who are frequently seen in the ED for pain complaints and who have no established primary care provider, the ED case manager or social worker will work to help get that patient established with a regular provider.

13. **Explain to the patient** that they have chronic pain syndrome and that their physician should have *prescribed medication for them at home for break-through pain*. We in the ED view this as the *patient’s responsibility*.

14. **Explain to patients** that if they need *periodic opioid injections for break-through pain*, then we will need an *updated letter* from their physician managing their pain and we *need to know the drug and the frequency* that they may receive this treatment. Do not honor outdated letters. Contact the PCP directly. This information can be saved in the ED note for future reference.

15. **Explain to patients** that if they have been *dismissed* from a medical practice we will be able to assist them in obtaining a PCP to manage their chronic pain.

**Management of requests for refills for chronic pain medications:**

- The ED will not provide refills for chronic pain medications (lost prescriptions, need for after office hours or weekend refills, etc.)

- **Explain** that if the patient is treated as an outpatient for chronic pain syndrome and *if they run out of their medications, then it is their responsibility*. We will not refill any *narcotic medication* without the approval of their PCP.

- **Prescriptions** for narcotics and benzodiazepines that have been *lost or stolen* will not be refilled. Again, this is the *patient’s responsibility* keep their medications safe.

**Management of patients seeking refills for Acute medical conditions:**

- When patients come to the ED with *acute* medical conditions in which the emergency providers feels that it is appropriate to prescribe narcotic or sedating pain medication, these should be dispensed in very limited quantities. The amount of these medications will last only until the patient can see their PCP.

- Any patient who *returns* to the ED seeking refills will be given only *non-narcotic pain medications*. The ED will not continue to provide controlled medications for acute, treatable conditions.

- For patients continuing to return for these acute conditions appropriate referrals will be made to the PCP or subspecialist for definitive treatment. These are not patients with chronic pain syndromes.
Management of specific chronic pain syndromes:

1. For Migraine Headache patients, consider the following medications:
   1. Imitrex 6 mg subcutaneous
   2. Toradol IV/IM
   3. Reglan IV/IM
   4. Compazine IV/IM
   5. Vistaril IM
   6. Benadryl IM/IV
   7. Ativan IV/IM
   8. Norflex IM
   9. Decadron IV
   10. 1-2 liters IV fluid
   11. Occipital Nerve Block
   12. Osteopathic Manipulative Treatment

   • If the patient has any allergies to these medications, they can be substituted with zofran or benadryl or Tylenol PO or suppository if vomiting.
   • Caution for Imitrex in patients with hypertension.
   • Caution for NSAIDs in patients with renal insufficiency and/or history of GI Bleed.
   • Patients must have someone to drive them home if they receive any medications beside Toradol and Tylenol and Imitrex.

   • During history and physical, identify any red flags during exam on these patients. If there are any red flags during examination the patient will need further ED work up and evaluation:
     o For Headaches
       ▪ Fever
       ▪ abnormal vital signs
       ▪ elevated blood pressure
       ▪ change in severity or intensity or quality
       ▪ change in mental status
       ▪ syncope
       ▪ seizure
       ▪ neurological deficits
       ▪ visual changes
       ▪ neck pain
       ▪ abrupt onset
       ▪ other concerning history for atypical headache for patient.
2. For Chronic Back, Musculoskeletal or Neurologic pain patients, consider the following medications:
   1. Toradol IV/IM
   2. Flexeril PO
   3. Norflex IM
   4. Valium PO
   5. Motrin PO
   6. Osteopathic Manipulative Therapy

- If the patient has any **allergies** to these medications, they can be **substituted** with Norflex or Ativan or Tylenol.

- Patients **must have someone to drive them home** if they receive any medications beside Toradol and Tylenol.

- During history and physical, identify any **red flags during exam** on these patients. If there are any red flags during examination the patient will need further ED work up and evaluation:
  - For **Back Pain**
    - Fever
    - Recent invasive procedure to back (i.e. facet blocks, LP, etc.)
    - symptoms of compressive syndromes
    - urinary and incontinence and retention
    - bowel incontinence
    - focal weakness
    - paresthesias
    - erythema and warmth to the back
    - other concerning history for atypical exacerbation of pain for patient.

3. For Patients with Dental Pain

- **Any** Dental patients that do not have an abscess clinically should be given **non-narcotic pain medications** and appropriate **antibiotics**: *(Please refer to soft tissue infection guidelines for further antibiotic information)*
  1. Ibuprofen
  2. Naproxen
  3. Tylenol
  4. Penicillin
  5. Clindamycin

- **Explain to patients** that the ED will provide them with the **best care available** for their dental problem. Routine dental care such as; fillings, tooth extractions or root canals are **not** available in the ED.

- Dental patients with **abscess or facial swelling** may need **appropriate narcotics** and antibiotics.

- For **midlevel providers** regarding **dental blocks**: Unless there is **one clear tooth** that is causing the patient **significant distress** and this can be blocked with **local infiltration**, then dental blocks **should be withheld unless discussed** by the attending physician.
- **All Dental Pain patients** should be referred to their dentist as soon as possible. A list of local dentists and clinics should be provided as well.

- **Explain to the patient** that the ED has a **policy for non-narcotic pain control** for dental pain. For the **safety of our patients, narcotic medications are restricted by specific, strict guidelines.** Exceptions are for patients with definite abscess or facial swelling.

**EMTALA and Chronic Pain:**

- The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.

- The Emergency Medical Treatment and Active Labor Act (EMTALA) does not require the emergency medical provider to provide pain relief for patients that do not have an emergency medical condition. Once a medical screening exam determines patient does not have an emergency medical condition, there is no obligation under EMTALA to treat a patient’s pain in the ED.

- The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated that may be resultant of; or in result from an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition.
Appendix 1. An approach to chronic pain syndrome patients. (Adapted from several Studer
Group articles.)

The following are some phrases which will be helpful for managing ED patients presenting
with chronic pain syndromes or drug-seeking behavior

It is very important not to begin the conversation by telling the patient they are not getting
narcotics. When a patient tries to negotiate for more narcotics, tell the patients, "I am here to help
you, but I just can't do it with narcotics.”

For patients who have not-frequented the ED regularly but are exhibiting inappropriate
behavior or history concerning for drug seeking behavior

1. “It is important that we discover the cause of your pain rather than just treat it. Once I
understand what is causing your pain, I can give you something that can help reduce your
pain, and we can discuss some things that you can do at home which may help.”

2. “For this condition, I usually prescribe (insert non-narcotic drug name).”

3. “Usually, it is not possible to completely eliminate your pain, so our goal today is to
reduce it to a more tolerable level.”

4. “I do not feel comfortable giving you (insert name of medication they are requesting)
prescription for this condition, but I can give you a prescription of (insert medication
name) instead, which should also help make you feel better.”

5. “I’m sorry, but I will not prescribe this medication for you. I would be glad to prescribe
some of the other medications we have already talked about.”

6. “I acknowledge that you are having pain from (condition). A prescription for (non-
steroidal anti-inflammatory) can benefit you, as it can decrease the inflammation that is
causing your pain and make you feel better.”

For patients who have frequented the ED and are seeking treatment for chronic pain
syndromes:

1. “In looking over your medical records, I see that you have visited us various times over the
last (weeks, months).”

2. “It looks like you have received a number of narcotic prescriptions (or insert other class of
medication) for these visits from a number of different doctors, which concerns me.”

3. “I want to help you today, but I do not feel comfortable treating you with (insert name or
class of medication). I want to make you feel better and can offer you a number of
different treatment options, but none of them will involve giving you (insert name or class
of medication).”

4. “It is important that you follow-up with a primary care doctor who can take care of you
rather than getting care and prescriptions from many different doctors.”
5. “Let’s agree that after today, you will make every effort to see your own doctor for any follow-up, because your visits to us have become so frequent that our doctors will no longer be prescribing any narcotics (or insert other name or class of medication) for you.”

6. “The emergency department is not the best place to receive care for your chronic pain. Treating chronic pain is not what we do best here. You usually see a different doctor each time you come back to us. Patients with a chronic condition like diabetes or high blood pressure usually get better results when they see the same doctor for their condition. It’s the same for you and your chronic pain.”

7. “It is better to receive care from a single doctor who can get to know you well and build a trusting relationship with you. He or she can design a pain care plan that both of you agree to."

8. “I believe in having you work with a single physician to create a long-term strategy for managing your condition”
References:
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   Studer Group 2011.
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    Directors Group 2010.
11. Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the 