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Joint Policy Statement of the Kansas Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Chronic Pain

Section I: Preamble

The Kansas Legislature created the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to protect the public health, safety, and welfare. Protection of the public necessitates reasonable regulation of health care providers who order, administer, or dispense prescription medications. These Boards adopt this Statement to help assure the citizens of Kansas that it is the policy of this state to encourage competent comprehensive pain care. For chronic pain, such care is best provided by person-centered treatment teams, where they are available, in which disparate health care providers regulated by their respective boards work together in partnership with people with pain and their families to achieve optimal, patient- centered outcomes. This statement addresses issues that may be encountered by all team members, while guidelines issued by individual Boards and professional societies are appropriate to address issues related to particular professions.

Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment. All persons who are experiencing pain should expect the prompt and appropriate assessment of pain and function and the initiation of pain management, while retaining the right to refuse treatment. Health care professionals can decline to provide opioid pain medication if, in their professional judgement, this is not required and/or other modalities are thought to be more appropriate. The clinical decision to not treat chronic pain with opioid pain medication is an appropriate therapeutic decision and does not equate to inappropriate care. Reasonable suspicion of abuse of diversion constitutes grounds to refuse to prescribe opioid pain medication. This, too, does not constitute inappropriate care but

needs to be documented in the patient's medical record. Health care professionals who are not experienced in the management of chronic pain may also decline to treat patients with this condition, if good faith attempts are made to refer patients to other providers with more experience.

The experience of pain is always subjective, requiring that health care providers rely heavily on self-reported data in completing a pain assessment. The primary goal of pain management is to increase the individual's level of functioning to the greatest extent possible; functional improvement often correlates with reduced pain, but these two outcomes may be unrelated in some individuals. The exact goals of care and the treatment plan used to achieve those goals should be determined jointly by the patient, family, and the health care team.

The appropriate application of available treatment modalities in a manner supported by the best available evidence improves the quality of life for people with pain and reduces the morbidity and costs associated with inadequate or inappropriate pain care. All health care providers who treat people with pain, whether acute or chronic, and regardless of cause, should be knowledgeable about effective methods of pain treatment and indications for appropriate referral to other health care providers. The management of pain should include the use of both pharmacologic and non-pharmacologic modalities in an integrated biopsychosocial plan of care.

Prescribing, dispensing, or administering controlled substances, including opioid analgesics, to treat pain and improve function is considered a legitimate medical purpose for the use of these medications if based upon a sound clinical evaluation and treatment plan. As in all other areas of health care, it is incumbent upon providers to recognize the risks and benefits inherent in providing pain care, and to seek to optimize the risk-benefit ratio in formulating a plan of care. High-dose and/or long-term opioid therapy is associated with an increased risk of various adverse outcomes, which may include physical complications and substance misuse, abuse, diversion, overdose, and death. Health care providers authorized by law to prescribe, administer or dispense medications, including controlled substances, should recognize the risks associated with this type of therapy and take appropriate action to minimize such risks. These providers should be knowledgeable about the safe use of opioid analgesics; their role in an integrated, biopsychosocial treatment plan; risk factors for adverse opioid-related outcomes and ways to screen for them; and the signs and symptoms of substance use disorders. They also should understand that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

All boards have a duty to make an inquiry when they receive information contending that a licensed health care provider treated pain inappropriately. Proper investigation is necessary in order to obtain relevant information. A health care provider should not construe any request for information as a presumption of misconduct. Prior to the filing of any allegations, the results of the investigation will be evaluated by the health care provider's peers who are familiar with this and other relevant policy statements, as well as community standards of care. Health care providers who competently treat pain should not fear disciplinary action from their licensing boards.

The following guidelines are not intended to define a standard of care or best practice, but rather to communicate what the boards consider to be within the boundaries of professional practice. This policy statement is not intended to interfere with any healthcare provider's professional duty to exercise that

degree of learning and skill ordinarily possessed by competent members of that healthcare provider's profession.

Section II: Principles for treating chronic pain

The boards approve the following principles regarding health care professionals' responsibilities when evaluating the use of controlled substances for the treatment of chronic pain:

1. Assessment of the Patient

Pain and function should be assessed and reassessed as clinically indicated. Interdisciplinary communications regarding a patient's report of pain should include adoption of a standardized protocol for assessing pain. A complete pain assessment should evaluate not only the intensity of a patient's pain, but also the impact of that pain on the patient's physical, emotional, and social functioning, as well as expectations for treatment outcomes. A number of standardized instruments are available to assist in this assessment, and clinicians should consider their use [REFS]. Assessment also should include evaluation of the individual's risk of substance misuse and abuse, ideally involving use of an evidence-based standardized instrument [REFS]. If controlled substances are, or may be, part of the individual's plan of care, obtaining a prescription monitoring program report and baseline urine/serum/saliva drug screen are strongly encouraged.

2. Treatment Plan

A written treatment plan should be strongly considered for all episodes of pain care. Such a plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or treatments involving other health care professionals are planned. After treatment begins, the treatment plan, especially the medication regimen, should be adjusted to the individual medical needs of each patient. The plan may include specific directions for adjusting medication doses or schedules between evaluations by the prescriber. The plan may also include limiting the amount of opioid pain medication prescribed at a given time, with more frequent periodic reviews, to better assess potentially aberrant behavior. Other treatment modalities may be necessary, depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. If, in a healthcare provider's sound professional judgment, pain should not be treated as requested by the patient, the healthcare provider should discuss the basis for the treatment decisions with the patient and document the substance of this communication.

3. Informed Consent and Agreement for Controlled Substance Treatment

Each patient should have one health care provider or provider team who primarily coordinates the pain care plan. That provider retains the ultimate responsibility for obtaining informed consent to treatment from the patient. All health care providers share the role of effectively communicating with the patient so that he or she is apprised of the risks, benefits, side effects, and risk of addiction when using controlled substances to treat pain.

If controlled substances are part of the individual's pain treatment plan, use of a written controlled substance treatment agreement should be strongly considered. The purposes of such an agreement are to ensure clarity on the part of both the patient and the health care provider regarding the role of controlled substances in the overall treatment plan and to establish parameters governing their provision as part of a comprehensive treatment plan. Such an agreement should outline patient responsibilities, including:

- Submitting to testing of medication levels when requested;
- Limiting prescription refills only to a specified number and frequency;
- Requesting and receiving prescription orders from only specified health care providers;
- Using only one pharmacy or pharmacy chain for filling prescriptions;
- Storing medications securely, not sharing them with anyone else, using them only as directed, and disposing of excess supplies in a safe and effective manner; and
- Acknowledging reasons for which the drug therapy may be modified or discontinued (e.g., violation of agreement).

4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the course of treatment and new information about the etiology of the pain should be evaluated. Communication among healthcare providers is an essential part of reviewing the plan of care. The health care providers involved in providing pain care should evaluate progress toward meeting treatment objectives in terms of physical and psychosocial outcomes (e.g., ability to work or attend school; emotional, cognitive, and behavioral functioning; need for health care resources; activities of daily living; and quality of social life). Such periodic reviews should include an evaluation of the patient's current prescription monitoring program report, assessing for the presence of aberrant behaviors, determining safe function at home and at work while taking opioid medication, testing for medication levels, pill counts, and other monitoring techniques, at a frequency determined by the health care provider based on the patient's evaluated risk for substance misuse, abuse, and/or diversion.

If treatment goals are not being achieved despite medication adjustments and the use of other treatment modalities, the health care providers should reevaluate the diagnosis, the impact of non-opioid treatment modalities, and the appropriateness of continued controlled substance treatment. If it is determined that controlled substances are not providing expected benefits and/or are causing adverse outcomes, their doses should be tapered and/or discontinued, in a manner that minimizes the risk of producing withdrawal and appropriately treats any emerging symptoms of withdrawal. Other changes to the treatment plan, as indicated by the results of the evaluation, should be made as needed.

5. Consultation

The health care provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with co-morbid psychiatric disorders and those who are at risk for misuse or diversion of their medications. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder can be challenging, and extra care, monitoring, documentation, and consultation

with or referral to an expert(s) in the management of such patients may be appropriate. In addition, many patients with chronic pain may benefit from referral to providers with other areas of expertise, to develop a multimodality approach to pain control.

If there is reasonable suspicion based upon aberrant behavior, such as seeking refills earlier or frequent loss of medications or prescriptions, that patients are misusing or diverting controlled substances, the health care provider can refuse further treatment or make a good faith effort to refer the patient to another provider. These episodes of aberrant behavior and the rationale for refusing or transferring care need to be documented in the patient's medical record.

6. Medical Records

The medical record should document the results of the pain and functional assessments and contain pertinent information concerning the patient's health history, including previous treatment for pain or other underlying or coexisting conditions. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

The results of periodic reviews should be documented to assist in evaluating the patient's progress toward the goals set out in the plan of care. These reviews may include

- findings from the patient examination
- the prescription monitoring program report
- drug testing results
- results of consultations with, or treatments provided by, other health care providers

If a patient is not progressing as anticipated and the health care provider is contemplating changing dosages or medications, the rationale for these changes should be documented in the patient's medical record, along with an anticipated timeline for follow-up to assess the efficacy of the new treatment regimen.

7. Compliance with Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances within this state, the health care provider must be licensed according to the laws of this state and comply with applicable federal and state laws.

Section III: Principles for treating acute pain

[To be added]

Section IV: Definitions

For the purposes of these guidelines, these terms are defined as follows:

Aberrant behaviors associated with opioid medication drug abuse may include selling medications; obtaining medications from non-medical sources; forgery or alteration of prescriptions; injecting medications intended for oral use; resistance to changing medications despite deteriorating function or significant negative effects; recurrent episodes of prescription loss or theft; repeated violations of pain agreements; independently increasing dosing; repeatedly running short of medications and requesting early refills. Providers should be aware that some behaviors may initially appear to be aberrant, but may actually be part of the normal process of stabilizing a patient's pain condition.

Acute pain is the normal, predictable physiological response to a noxious chemical, thermal or mechanical stimulus and is associated with invasive procedures, trauma and acute illness. It is generally time-limited, and resolves as the identified cause resolves.

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to as "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction. Addiction must be distinguished from pseudoaddiction, which is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction

Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury. It may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over a period of months or years.

Diversion is defined as the intentional transfer of a controlled substance from authorized to unauthorized possession or channels of distribution.

Misuse (also called *nonmedical use*) encompasses all uses of a prescription medication other than those that are directed by a health care provider and used by a patient within the law and the requirements of good medical practice.

Opioid is any compound that binds to an opioid receptor in the central nervous system. The class includes both naturally-occurring and synthetic or semi-synthetic opioid drugs or medications, as well as endogenous opioid peptides.

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical dependence on a controlled substance is a state of biologic adaptation that is evidenced by a class-specific withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist. Physical dependence is an

expected result of extended opioid use. Physical dependence, by itself, does not equate with addiction.

Prescription Monitoring Program is a state-operated program that facilitates the collection, analysis, and reporting of information on the prescribing and dispensing of controlled substances. The Kansas Tracking and Reporting of Controlled Substances (K-TRACS) program employs electronic data transfer systems, under which prescription information is transmitted from the dispensing pharmacy to the Kansas Board of Pharmacy, which collates and analyzes the information, and makes it available to authorized parties.

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance is a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time. Tolerance is common in opioid treatment, has been demonstrated following a single dose of opioids, and is not the same as addiction.

APPROVALS

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Healing Arts, on the 12th day of August, 2016.

Terry L. Webb, D.C., President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Nursing on the 14th day of September, 2016

JoAnn Klaassen, RN, MN, JD, President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Pharmacy on the 3 day of November, 2016.

Chad Ullom, RPh, President