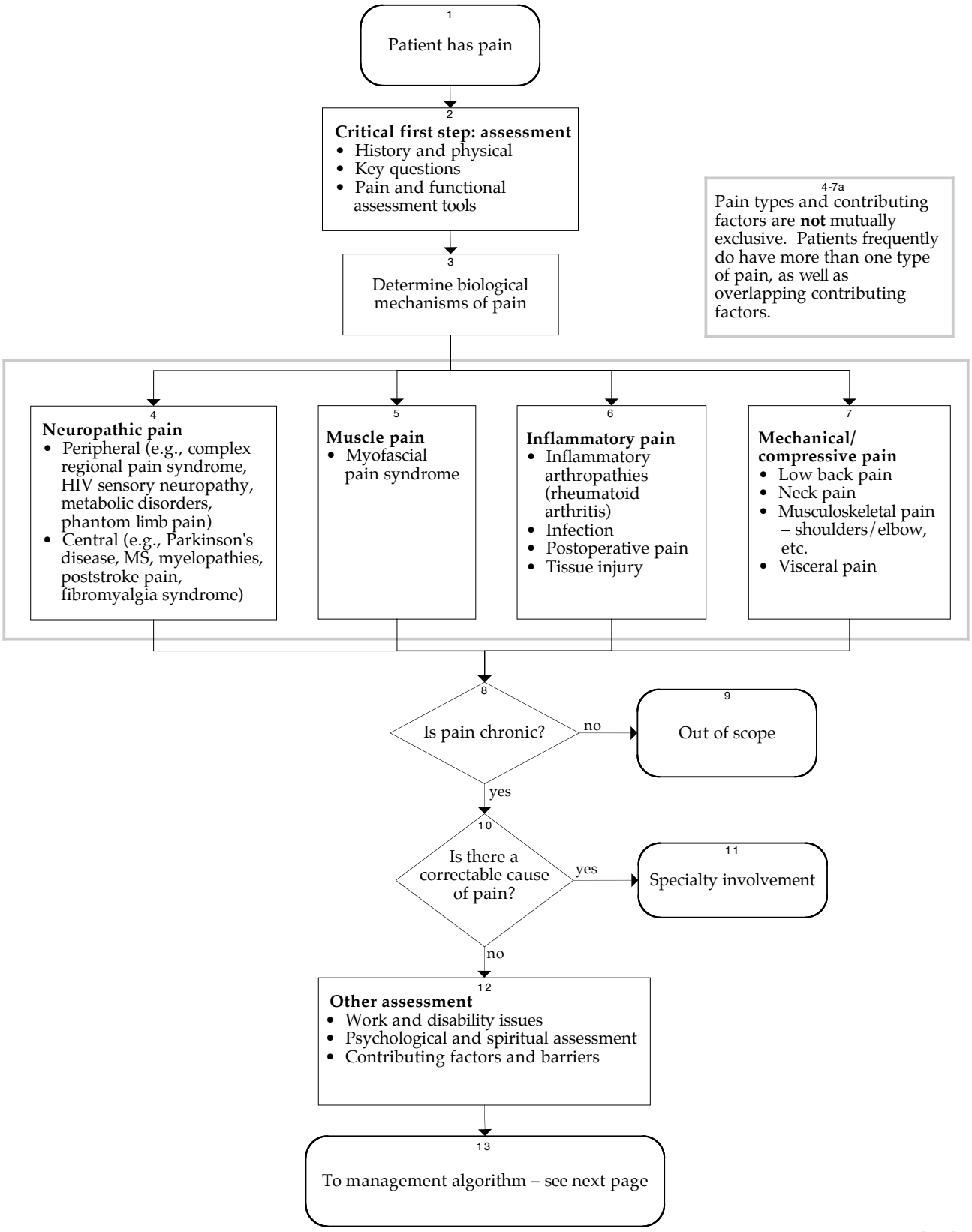
Implementation Tool:

Assessment and Management of Chronic Pain Guideline Summary

Assessment Algorithm

A = Annotation



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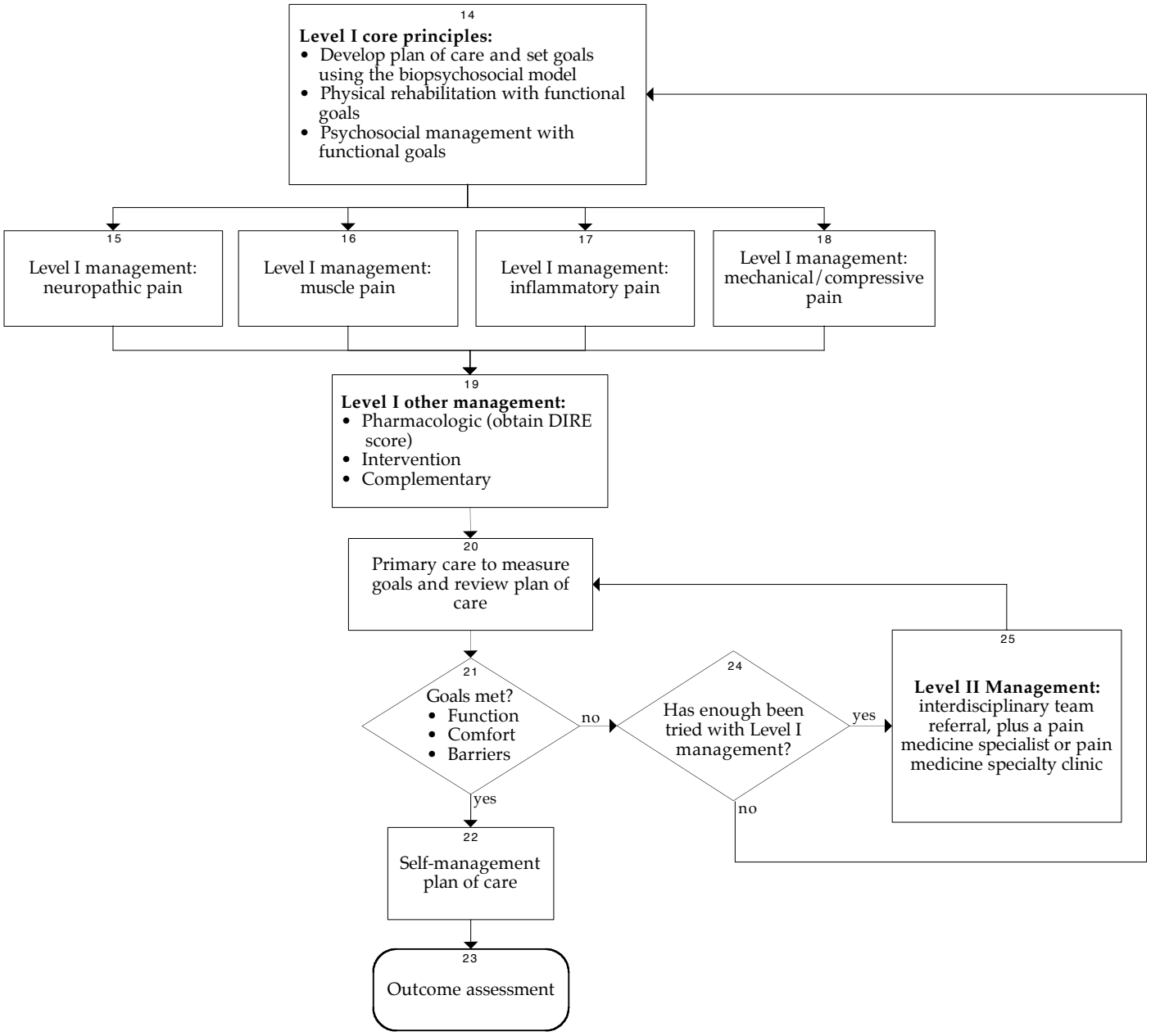
Management Algorithm

A = Annotation



Key Principles

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 *(Wisconsin Medical Society Task Force on Pain Management, 2004 [R])*. If the patient has not been previously evaluated, attempt to differentiate between untreated acute pain and ongoing chronic pain. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the cause of the chronic pain is warranted.

Assessment

- Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.
  - See the ICSI Chronic Pain guideline, Appendix A, "Brief Pain Inventory (Short Form)."
  - See the ICSI Chronic Pain guideline, Annotation #12, "Other Assessment," for examples of questions regarding behavioral health, chemical health, spirituality and occupational health.
- The goal of treatment is an emphasis on improving function through the development of long-term, self-management skills including fitness and a healthy lifestyle, in the face of pain that may persist.
  - A variety of assessment tools have been used in the medical literature for measuring, estimating or describing aspects of a patient's functional ability. See the ICSI Chronic Pain guideline, Appendix C, for an example.

Management

- A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors. Addressing spiritual and cultural issues is also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.
  - Empathetic listening is critical.
  - Recognize that the term "chronic pain" may elicit a highly emotional resonance with some patients.
  - Use diagnostic and anatomical terms.
  - Focus on improving function.
  - See the ICSI Chronic Pain guideline, Appendix D (or page 8 of this summary), "Personal Care Plan for Chronic Pain."
- Level I treatment approaches should be implemented as first steps toward rehabilitation before Level II treatments are considered.
- Medications are not the sole focus of treatment in managing pain and should be used when needed to meet overall goals of therapy in conjunction with other treatment modalities.
- Careful patient selection and close monitoring of all non-malignant pain patients on chronic opioids are necessary to assess the effectiveness and watch for signs of misuse or aberrant behavior.
- Review care plan and goals at every visit.

Key Implementation Recommendations

1. It is important to take both a clinical and an operational approach for successful implementation of this guideline.
2. Develop a process that allows patients with chronic pain to see a dedicated care provider who has an interest or expertise in chronic pain. The care provider is responsible for care management involving chronic pain in order to foster continuity while allowing the primary care physician to focus on medical diagnosis.
3. Develop a process for handing off patients to a dedicated chronic pain provider within the clinic.
4. Develop a process to work collaboratively with other care providers in prescribing opioids with shared patients (e.g., dentists, specialists).
5. Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
6. Develop a process for scheduling follow-up patient visits to deter drug-seeking behaviors with other care providers, for instance, support personnel calling patients to schedule follow-up appointments with a dedicated chronic pain physician.
7. Develop staff and physician training regarding the organization's process for treating patients with chronic pain that could include process of referrals to chronic pain provider within the system, follow-up visits, prescription refills and continuity of care.
8. Train a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestion for care providers from other disciplines include pharmacy, chemical dependency, neurology, home care, social work, physical medicine and rehabilitation, and physical therapy.
9. Determine population ICD-9 codes for data collection that is unique to patients with chronic pain in your facility. Examples of this would be:
    - low back pain
    - headache
    - neck pain
    - fibromyalgia
    - chronic pain
10. Identify multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care providers and are appropriate for the patient populations.

    Examples of pain assessment, functional assessment, and psychological assessment tools are, but are not limited to:

    - Brief Pain Inventory (BPI)
    - Functional Ability Questionnaire (FAQ5)
    - Oswestry Low Back Disability Index (refer to ICSI Adult Low Back Pain guideline)
    - PHQ-9

Examples of opioid and substance abuse assessment tools are, but are not limited to:

- CAGE and CAGE-AID
- Webster's Opioid Risk Tool (ORT)
- DIRE Tool
- Screener and Opioid Assessment for Patients in Pain (SOAPP®)
- Current Opioid Misuse Measure (COMM™)
- Prescription Drug Use Questionnaire (PDUQ)
- Screening Tool for Addiction Risk (STAR)
- Screening Instrument for Substance Abuse Potential (SISAP)
- Pain Medicine Questionnaire (PMQ)

Patient Focus Group: Key Learnings for Providers

- Patient experience is that limited education is done early on and patients do a lot of research on their own. Education is critical and includes setting realistic goals, providing education to patients about their disease state, explaining medications and also any interventional procedures. Well-informed patients will be able to take more responsibility for their care.
- Be aware that the term chronic pain may elicit a highly emotional response. Patients may feel discouraged that the pain will never go away despite their hope a cure will be found.
- Although patients would like a quick fix to their pain, frustration occurs when interventions that only provide temporary relief are found or utilized.
- Patients want to be included in the treatment plan. They are often proactive in seeking ways to alleviate or eliminate their pain. They may see several types of physicians and may have also tried to find relief from their pain in additional varieties of ways. **Teamwork and empathetic listening in the development of a treatment plan are critical.**
- When the physician acknowledges that chronic pain affects the whole person and really listens, patients are more likely to be open to learning how to live by managing their pain versus curing their pain.
- Most patients want to return to a normal routine of completing activities of daily living, (e.g., playing with children/grandchildren, going for a walk, and working within their limitations). The focus should be on improving function.
- Many patients have utilized a variety of interventions including medications and complementary therapies.

Cognitive-Behavioral Strategies for Primary Care Physicians

There are a number of cognitive-behavioral strategies that primary care providers can utilize to help their patients manage chronic 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.
- 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/their child when they reported pain.
- 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.

Opioid Management

Opioids have the potential to alleviate pain but also the potential for aberrant drug-related behavior, drug abuse, or misuse. Therefore, a single physician/provider should prescribe and supervise opioids used for chronic non-cancer pain. Often the primary care provider is best suited to do so based on knowledge of the whole person. Physicians should not feel compelled to prescribe opioids or any drug if it is against their honest judgment or if they feel uncomfortable prescribing the drug. Additionally, those who prescribe opioid pain medication should be aware of current federal and state laws and regulations related to the use of chronic opioid therapy.

Before prescribing an opioid and other potentially addictive medications, or medications of potential abuse or misuse, the work group recommends completion of a comprehensive biopsychosocial assessment. This should include pain history/examination plus administration of an opioid assessment tool to recognize potential risks of addiction, abuse or misuse, prior medical records, particularly pertaining to pain medications, should be reviewed before deciding to start chronic opioid pain medications.

Opioid assessment tools, such as the DIRE tool, determine a patient's appropriateness for long-term opioid management (see ICSI Chronic Pain guideline Appendix E, or page 9 of this summary).

General opioid management principles:

- If the physician is not the initial prescribing provider, it is important to be aware that he/she is not under any obligation to assume responsibility for prescribing without adequate communication and hand-off. Nor is it appropriate to prescribe chronic opioid medications when not aware of the patient's past medical history.
- Most patients with acute exacerbation of chronic pain don't require opioid pain medications, but if the primary care physician feels a short trial of opioid pain medication is necessary, consider writing a two-week supply of a short-acting medication. If the patient is not improving from a functional point of view, consider getting a consult from a pain specialist before writing a second prescription.
- Most pain specialists do not feel it appropriate to prescribe opioid pain medications at the first visit. The prescribing provider should not expect or assume the pain specialist will take over the care of the patient or management of opioid pain medications.
- Patients with aberrant drug-related behaviors or drug abuse/misuse should be tapered off the opioid pain medication. A referral to a chemical dependency program may be necessary.
- Patients who don't meet functional goals should be tapered off chronic opioid pain medications.

Follow-Up Considerations

Involvement of a pain specialist in the care of a patient with chronic pain occurs optimally when the specialist assumes a role of consultation, with the primary care provider continuing to facilitate the overall management of the patient's pain program. It is recommended that the primary care provider receive regular communications from the pain specialist and continue visits with the patient on a regular schedule, even if the patient is involved in a comprehensive management program at a center for chronic pain. The primary care provider should not expect that a consulting pain specialist will assume primary care of a patient unless there has been an explicit conversation in that regard between the consultant and the primary care provider. This is particularly true in regard to the prescribing of opioids: the primary care provider should expect to continue as the prescribing provider, and ensure the responsible use of the opioids through contracts, urine toxicology screens, etc. (the exception to this may occur with the admission of the patient into a opioid tracking program). Conversely, the consulting pain specialist should not initiate opioids without the knowledge and consent of the primary care provider.

Personal Care Plan for Chronic Pain

This tool has not been validated for research; however, work group consensus was to include it as an example of a patient tool for establishing a plan of care.

1. **Set Personal Goals**
   - ☐ Improve Functional Ability Score by _____ points by: Date _____
   - ☐ Return to specific activities, tasks, hobbies, sports...by: Date _____
     1. _____
     2. _____
     3. _____
   - ☐ Return to ☐ limited work/or ☐ normal work by: Date _____
2. **Improve Sleep** (Goal: _____ hours/night, Current: ____hours/night)
   - ☐ Follow basic sleep plan
     1. Eliminate caffeine and naps, relaxation before bed, go to bed at target bedtime _____
   - ☐ Take nighttime medications
     1. _____
     2. _____
     3. _____
3. **Increase Physical Activity**
   - ☐ Attend physical therapy (days/week _____)
   - ☐ Complete daily stretching (____ times/day, for ____minutes)
   - ☐ Complete aerobic exercise/endurance exercise
     1. Walking (____ times/day, for ____minutes) or pedometer (_____ steps/day)
     2. Treadmill, bike, rower, elliptical trainer (____ times/week, for ____ minutes)
     3. Target heart rate goal with exercise _____ bpm

     Strengthening
     1. Elastic, hand weights, weight machines (____ minutes/day, ____ days/week)
4. **Manage Stress** – list main stressors _____
   - ☐ Formal interventions (counseling or classes, support group or therapy group)
     1. _____
   - ☐ Daily practice of relaxation techniques, meditation, yoga, creative activity, service activity, etc.
     1. _____
     2. _____
   - ☐ Medications
     1. _____
     2. _____
5. **Decrease Pain** (best pain level in past week: ____ / 10, worst pain level in past week: ____ / 10)
   - ☐ Non-medication treatments
     1. Ice/heat _____
     2. _____
   - ☐ Medication
     1. _____
     2. _____
     3. _____
     4. _____
   - ☐ Other treatments _____

Physician name: _____ Date: _____

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DIRE Score: Patient Selection for Chronic Opioid Analgesia

The DIRE Score is a clinician rating used to predict patient suitability for long-term opioid analgesic treatment for chronic non-cancer pain. It consists of four factors that are rated separately and then added up to form the DIRE score: Diagnosis, Intractability, Risk and Efficacy. The Risk factor is further broken down into four subcategories that are individually rated and added together to arrive at the Risk score. The Risk subcategories are Psychological Health, Chemical Health, Reliability, and Social Support. Each factor is rated on a numerical scale from 1 to 3, with 1 corresponding to the least compelling or least favorable case for opioid prescribing, and 3 denoting the most compelling or favorable case for opioid prescribing. The total score is used to determine whether or not a patient is a suitable candidate for opioid maintenance analgesia. Scores may range from 7 at the lowest (patient receives all 1s) to 21 at the highest (patient receives all 3s).

For each factor, rate the patient's score from 1 to 3 based on the explanations in the right-hand column.

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R= Total of P+C+R+S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a good candidate for long-term opioid analgesia

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