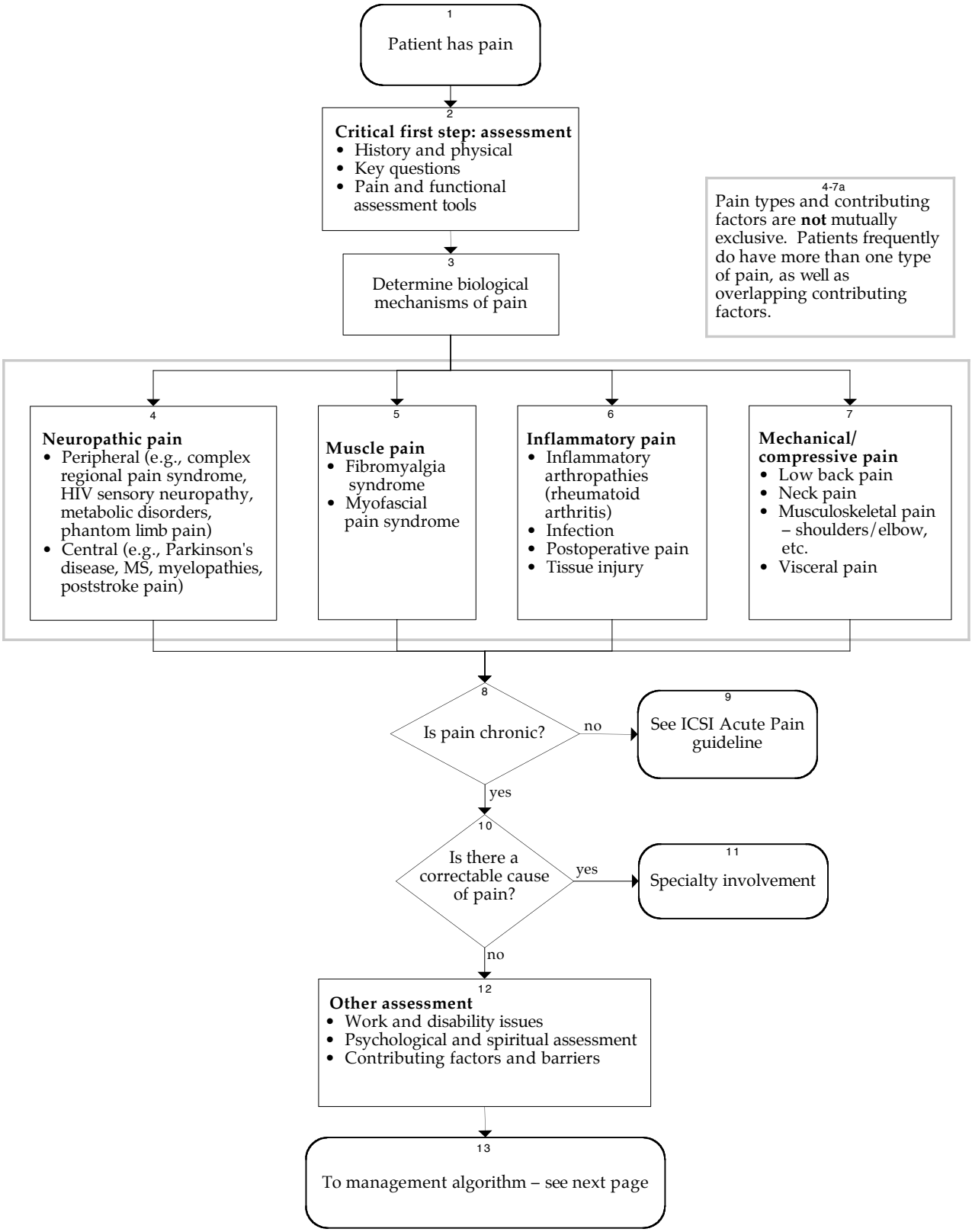
Implementation Tool:

Assessment and Management of Chronic Pain Guideline Summary

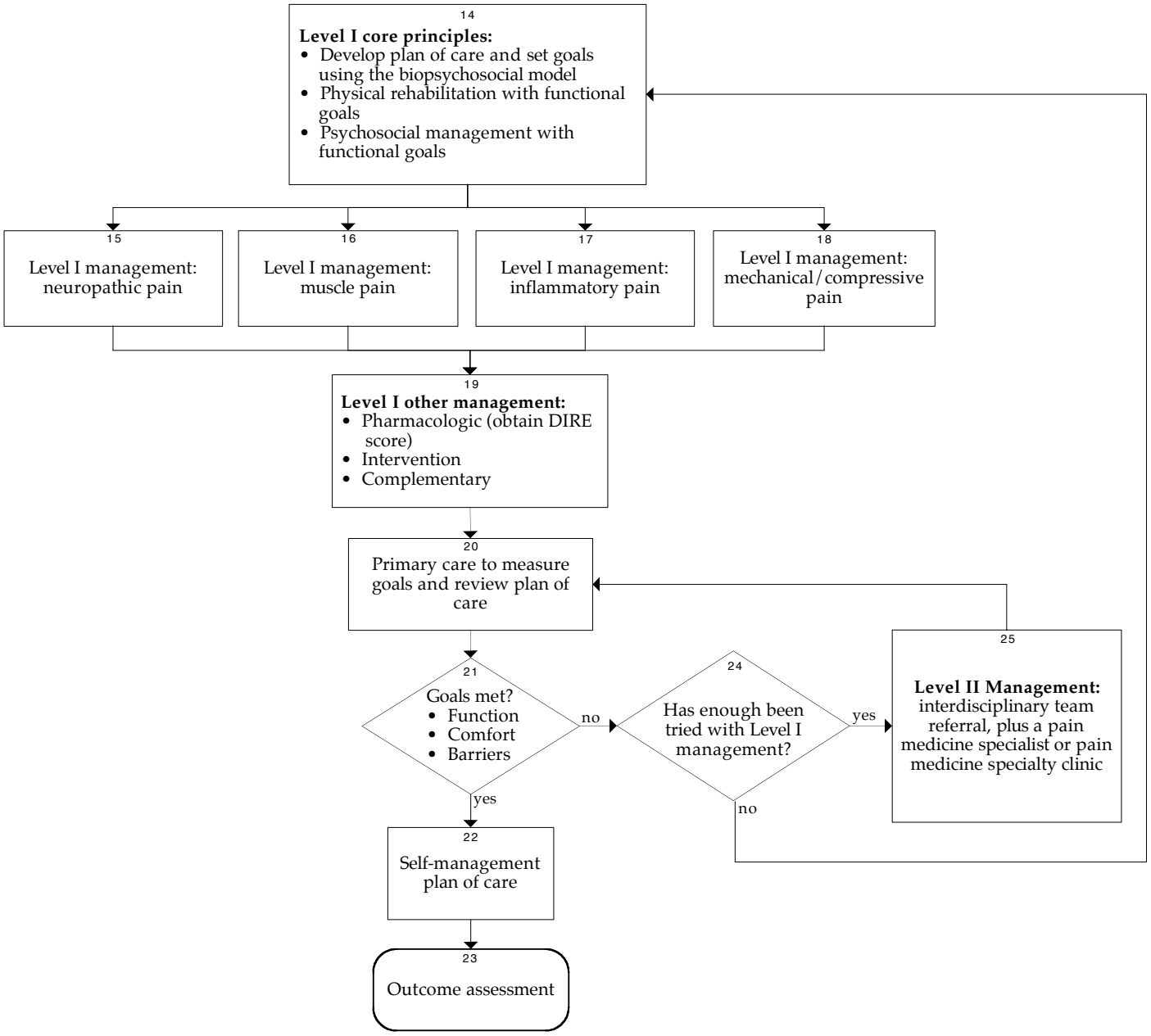
Assessment Algorithm

A = Annotation



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, 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.

The goals of treatment are an emphasis on improving function through the development of long-term, self-management skills including fitness and a healthy lifestyle.

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 ICSI Chronic Pain Guideline, Appendix A, "Brief Pain Inventory."
  - See ICSI Chronic Pain Guideline, Annotation #12, "Other Assessment," for example 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.
  - 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 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 ICSI Chronic Pain Guideline, Appendix D (or page 7 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 is necessary to assess the effectiveness and watch for signs of misuse or aberrant behavior.
    - Physicians should not feel compelled to prescribe opioids or any drug if it is against their honest judgement or if they feel uncomfortable prescribing the drug.
- Review care plan and goals at every visit.

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.

Patient Focus Group: Key Learnings for Providers

- 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.

Opioids: Important Considerations

Before prescribing an opioid, the work group recommends using the DIRE tool to determine a patient's appropriateness for long-term opioid management. See ICSI Chronic Pain Guideline Appendix E (or page 8 of this summary), "DIRE Score: Patient Selection for Chronic Opioid Analagesia."

When there is non-compliance, escalation of opioid use, or increasing pain not responding to increasing opioids, consider whether this represents a response to inadequate pain control (pseudoaddiction, tolerance, or opioid-induced hyperalgesia) or a behavioral problem indicating the patient is not a candidate for opioid therapy.

Physicians must bear in mind that opioids are not required for everyone with chronic pain. The decision to use or continue opioids depends on many factors including type of pain, patient response and social factors. Physicians must have the fortitude to say no to opioids when they are not indicated, and to discontinue them when they are not working.

Discontinuing of opioids is recommended when it is felt that they are not contributing significantly to improving pain control or functionality, despite adequate dose titration. It is recommended that the primary care physician discontinue when there is evidence of substance abuse or diversion. In these cases, consider referral to substance abuse counseling. It is recommended to not abruptly discontinue but to titrate off by decreasing dose approximately 10%-25% per week. When a patient is unable to taper as an outpatient, a clonidine patch or tablets, or referral to a detox facility are potential options.

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

     Strengthening
     1. Elastic, hand weights, weight machines (____ minutes per day, ____ days per 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 / 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: _____

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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