

 <p>Tier 3 Includes Henry Ford Medical Group</p>	Policy Name/Subject: Tier 3 - HFMG Primary Care Non-Cancer Pain Management Policy		Policy No:
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	Applies to: Tier 3		
	Business Unit: Henry Ford Medical Group		
	Site: HFMG		
	Department: Ambulatory Services		
	Category: Clinical		Current Approval Date: 3/1/2017
	Sub-Category: Ambulatory Services		Last Revision Date: n/a
	Owner: Chief Medical Officer Primary Care		Approver: HFMG Primary Care Division Head Group, P&T
	Related Policy/Procedure: CDC Guidelines, K15 Non Cancer Pain Management Policy		
Author: Dr Joseph Crow			
External Regulatory Requirement: CMS, DEA, Joint Commission			
Audience: All Employees			
Key Words: opioids			

Background: Opioids are highly effective medications for managing acute pain - **pain lasting less than 6 weeks**, but there is insufficient evidence that they effectively control chronic pain. Opioid abuse, diversion, and overdose have been on the rise, reaching epidemic proportions in recent years. Prevention, assessment, and treatment of chronic pain are challenges for health providers and systems. Primary care provider's account for a high percentage of prescription opioids dispensed.

Policy: This policy is intended to ensure that providers and patients consider the safest and most effective treatment for non-cancer, non-palliative¹, chronic pain (greater than 8 weeks). Providers have the obligation to keep patients safe, manage their pain as medically and socially appropriate, and reduce the risk of abuse, diversion, and overdose². To provide safe and effective pain management for our patients, the following evidence-based strategies will be used by all HFMG Primary Care providers.

1. To facilitate communication with staff and other providers, we will use the term "Chronic Pain Syndrome" under the problem list for all of our chronic pain patients and populate it with the smart phrase ".HFNARCOTICMANGEMENT"³ to document concerns and requirements. The Primary Care Provider is responsible for keeping this list up to date.
2. To ensure proper understanding with patients, we will use the HF standard "Patient and Healthcare Team Medication Management Agreement" and maintain an active, signed copy of the contract in the patient chart. If there is a change in medication, pharmacy, primary care physician, pain diagnosis, or other relevant issue must be updated and signed in the patients chart to be considered "active".

¹ Patients aged ≥ 18 years with chronic pain outside of palliative and end-of-life care. Palliative care is defined in a manner consistent with that of the Institute of Medicine as care that provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness.

² Definition of opioid use disorder (Reference A)

³ HFNARCOTICMANGEMENT (Reference C) Smart phrase

3. To assess ongoing need for opiates and compliance, chronic pain will be addressed at a visit on a regular basis (approximately twice per year) with the Primary Care Provider. If prescribing amounts > 90 MME⁴/day and/or concomitant benzodiazepine use, please consider more frequent intervals such as every 3 months.
4. To confirm opioids are providing clinically meaningful improvement, we will use a functional pain scale at each visit, such as a PEG (Pain, Enjoyment, and General Activities) scale⁵.
5. To screen for opioid risk of abuse, diversion, and overdose, we will review a Prescription Drug Maintenance Program (PDMP) report approximately every 12 months. In addition, periodic urine drug testing is recommended every 12 months (specific test used is at provider discretion).

Providers should continue opioid therapy only if there is clinically meaningful improvements in pain and function that outweighs the risk to patient's safety. If the patient violates their medication management agreement or is suspected of having an opioid use disorder, the provider may cease in giving any further opioid refills, may refer to a chemical dependency program⁶ and/or initiate the taper of opioid.

Reference A. Definition(s) Opioid Use Disorder (DSM-5)- Tool Kit

- 1) Taking more opioid drugs than intended.
- 2) Wanting or trying to control opioid drug use without success.
- 3) Spending a lot of time obtaining, taking, or recovering from the effects of opioid drugs.
- 4) Cravings opioids.
- 5) Failing to carry out important roles at home, work or school because of opioid use.
- 6) Continuing to use opioids, despite use of the drug causing relationship or social problems.
- 7) Giving up or reducing other activities because of opioid use.
- 8) Using opioids even when it is physically unsafe.
- 9) Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway.
- 10) Tolerance for opioids.
- 11) Withdrawal symptoms when opioids are not take

Reference B: CDC Prescribing Opioids for Chronic Pain Before Prescribing

1. **Assess pain and function:** use a validated pain scale
2. Consider if non opioids therapies are appropriate: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy
3. **Talk to patients about treatment plan:** set realistic goal for pain and function based on diagnosis, discuss benefits, side effect and risk, set criteria for stopping or continuing opioid, check patient understand of treatment plan.
4. **Evaluate risk of harm or misuse:** known risk factors, illegal drug use, prescription drugs for non-medical reason or history of substance abuse, check prescription drug monitoring program, urine drug screen to confirm presence of prescribed substance, medication interaction and avoid concurrent opioids and benzodiazepine whenever possible

When you prescribe

1. **Start low and go slow:** start with immediate release opioids at the lowest dose for the shortest therapeutic duration

After initiation of opioid therapy

1. **Assess, tailor and taper:** reassess benefits/risk within 1-4 weeks after initiation assessment. Assess pain and function and compare to baseline, continue opioids only after confirming clinically meaningful improvement in pain and function without significant harm, if over sedation or overdose risk then taper.

Treating overdose and addiction

1. **Screen for opioid use disorder** (if yes use Medication Assisted Treatment MAT)

⁴ MME (Morphine Miliequivalents) (Reference D)

⁵ PEG Scale (Reference E)

⁶ Chemical dependency program (Reference F)

Reference C. HFNARCOTICMANGEMENT- Pain Management Overview

1. Reason for Chronic Pain
2. Last Urine Tox Screen
3. Maps <1 yr. with date
4. Active narcotic contract in patient chart
5. PEG Score: baseline date, current date
6. Note/ goals of treatment

Reference D: MME (Morphine Miliequivalents)

- 1 mg Codeine = 0.15 MME (1 T#3 = 4.5 MME)
- 1 mg Hydrocodone = 1 MME (1 Norco = 5 MME)
- 1 mg Morphine = 1 MME
- 1 mcg Fentanyl = 2.4 MME
- 1 mg Oxymorphone = 3 MME
- 1 mg Oxycodone = 1.5 MME

Reference E: Compute the PEG score, add the three responses to the questions above, and then divide by three to get a final score out of 10.

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

1. What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

Reference F. Current as of March 2017 - SUD service offerings by location.- Tool kit

SUBSTANCE USE DISORDER SERVICE	BEHAVIORAL HEALTH LOCATIONS					
	Maplegrove Center	Dearborn (Westpark)	Detroit (OPF)	Clinton Twp. (Seville)	HFMC - Columbus (Novi)	HFMC - Troy
Residential rehabilitation (adults 18+)	X					
Residential detox services (adults 18+)	X					
Adult intensive outpatient program	X	X	X	X		
Adolescent intensive outpatient program (ages 13 to 17)		X				
Adult outpatient medical management (outpatient detoxification, medication assisted treatments and medical consultations for SUD issues)	X		X	X		
Adult outpatient therapy	X	X	X	X	X	X
Adolescent outpatient therapy	X	X				
Adult outpatient gambling addiction	X					
Early Recovery Group	X	X	X	X		
Family Support and Community Education	X					