Maine Chronic Pain Collaborative 2 (ME CPC2) Chronic Pain Management Change Package for Primary Care Practices

These 10 change components are intended to support enhanced safety and improved patient care for managing non-cancer chronic pain in the primary care setting.

(Note: for the purposes of this initiative, chronic pain is defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." – *International Association for the Study of Pain (IASP))*

Component 1: Leadership and Culture of Safety

1. Demonstrate leadership to build a culture of safety and use evidence-based practices in the team-based management of chronic pain.
    A. Formally adopt and commit to implement the elements of the ME CPC2 Chronic Pain Change Package.
    B. Provide ongoing education and support to identified care team members.

2. Set standards for care that establish and maintain structures for accountability and consistency in applying practice policy.
    A. Practice has written policies & procedures to ensure compliance with Board of Licensure in Medicine (BOLIM) Chapter 21 Regulations[1]
        a. Patient evaluation documented in medical record;
        b. Documented treatment plan:
            i. Consultation with the patient to determine their goals and what improved functionality means to them;
        c. Informed consent & patient agreement that includes
            i. Urine/serum medication levels screening when requested;
            ii. Pill count when requested;
            iii. Number and frequency of all prescription refills;
            iv. Reasons for which drug therapy may be discontinued (e.g., violation of agreement).
            v. Periodic review of PMP
            vi. Documented "exit strategy" or criteria for discontinuation; and
        d. Opioid prescribing evidence-based guidelines (periodic review of treatment efficacy).

[1] ME Board of Licensure in Medicine Chapter 21 – Use of Controlled Substances for Treatment of Pain, available at http://www.maine.gov/sos/cec/rules/02/chaps02.htm

Component 2: Team-based Approach to Care

1. Implement a team-based approach to care delivery model that includes expanded roles of non-physician providers and staff (e.g. nurse practitioners, physician assistants, nurses, medical assistants, social workers, substance abuse counselors) to improve clinical work flows.
    A. All team members can identify the goals of the approach, as well as their specific role and responsibilities, and enthusiastically draw upon the skills and experience contributed by members (and outside providers) representing different disciplines.
2. Provide education to team members on the ME CPC2 Chronic Pain Change Package and clearly identify the delegated roles of team members and, as appropriate, others in the practice.
3. Implement a proactive, pre-visit planning approach to the patient visit and use of team:
    A. PMP review by providers & sub-users (RNs, MAs);
    B. Regular review and maintenance of patient-provider agreement; and
    C. Follow up on consultations.
4. Establish a practice-wide substance abuse/addiction treatment process.
    A. Training is provided to clinical staff to increase awareness of substance abuse and treatment resources.
    B. The referral process, internal and/or external to the practice, is monitored and evaluated on a regular basis.

Component 3: Risk Stratification & Population Management

1. The practice has a process in place to identify and stratify patients across its population who are at risk for chronic pain and/or opioid misuse.

    A. The practice gives special consideration to the following populations in both the management of chronic pain and opioid prescribing:
        - Pregnant women / those receiving prenatal care;
        - Adolescents and young adults (ages 12 – 18); and
        - Patients with trauma history.

    B. Direct resources or care processes are identified to help reduce risk and increase prevention.
    C. Provide appropriate resources to patients.

Component 4: Comprehensive Assessment & Evaluation of Chronic Pain

1. Apply the evidence by adopting and systematically implementing evidence-based guidelines for the evaluation of chronic pain:
    A. Complete an assessment of daily living skills (ADLs) and functionality;
    B. Complete a comprehensive medical assessment of pain (including differential diagnosis/ assessment of trauma history); and
    C. Review potential use of analgesics and pharmacological interventions, adverse drug effects and aberrant drug behaviors and addiction risk, including:

- Screener and Opioid Assessment for Patients with Pain (SOAPP)[2], an assessment tool for new patients, and document the risk of misuse or diversion;
- Opioid Risk Tool (ORT)[3] (for patients already using opioids);
- Current Opioid Misuse Measure (COMM)[4] (for patients already using opioids); and
- D.I.R.E. Score[5]

Component 5: Comprehensive Approach to Co-Management of Chronic Pain

1. Review treatment modalities and consider use of complimentary therapies – e.g. behavioral health therapy, including cognitive behavioral therapy; physical therapy, occupational therapy, acupuncture, osteomanipulatory therapy (OMT), chiropractic therapy);
2. Develop a care plan that outlines the patient pain treatment agreement;
3. Establish a frequency of review of symptoms and response to therapy, along with risk factors; and
4. Communicate and document what will happen if the co-management agreement is broken.

Component 6: Mindful Approach to Initiating Opioids for Pain Control

1. Consider case review/ consultation with colleagues or peers.
2. Provide education to providers regarding the appropriate use of opioids.
3. Assess drug interactions that may have a significant impact on patient safety.
4. Provide education for new patients on opioid use and risk (informed consent).
5. Consider appropriate populations to utilize some or all of the following:
   A. Key points for providers to review;
   B. Risk addiction tools; and/or
   C. Evidence based guidelines.
6. Use an evidence-based, patient-centered approach when initiating opioid therapy.
   A. When starting opioid treatment with new patients, employ a limited trial of opioids
      i. (e.g. a 2 week trial) and jointly agree on an explicit exit strategy.
   B. Use a written informed consent agreement that includes specific goals for treatment and parameters for the exit strategy
   C. Assess implications of watchful waiting or holding off ("What happens if I don't do anything"?)
   D. Assess prescription impact and resulting patient behaviors.

Component 7: Safety First with Patients Receiving Opioid Therapy

1. Come to an agreed upon and understandable applied definition of Opioid Therapy (long term).

[2] SOAPP
[3] ORT
[4] COMM
[5] D.I.R.E. Score

A. Suggested definition: Patient using *any* dose of opioid on a daily basis (including Tramadol) by patient report or refill history (pharmacy report).

2. Assess drug:drug interactions that may have a significant impact on patient safety, including the use of benzodiazepines.
3. Employ an evidence-based approach to assess risk:
   A. Use morphine equivalent daily dose/dosage ceilings and a dosage table in the decision- making process.[6]
      a. In cases of 100 mg or greater daily dose: engage the patient in a plan to taper to a safe dose[7],[8] and assess whether the patient has reasonable indications for opiate use; evaluate contraindications; and
      b. Less than 100 mg daily dose: assess whether the patient has reasonable indications for opiate use and evaluate contraindications.
4. Provide education to patients on the keeping of opioids in the home and safe disposal.
   A. Provide information on community drug take-back (see Component 8).
   B. Provide information on disposal in the home (FDA Guidance).
      a. Include a list of medications that can be safely disposed of at home.

Component 8: Inclusion of Patients & Families

1. Engage patients and care givers as part of a comprehensive approach to managing chronic pain.
   A. Demonstrate understanding and empathy for the patient's condition and encourage his/her active participation in developing a treatment plan and evaluating results.
   B. Consider the distinction between "pain" and "suffering" and engage the patient his/her care givers in helping to assess patient functionality.
   C. Provide information and effective education tools to enhance patient and care giver understanding of effective chronic pain management (alternative modalities).
   D. Use informed consent to discuss impact of treatment.[9]

2. Assess risk to the family unit:
   A. With the assistance of CPC staff, consultants and partners, the practice works to identify tools to assess family risk and provides educational resources to the family regarding effective chronic pain management.

Component 9: Integration of Community & Clinical Resources

1. Connect with other members of the medical neighborhood to promote effective chronic pain management & safe prescribing.
   A. Connect with Emergency Departments and specialists in area to coordinate prescribing.

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[6] AMDG Dosing Guidelines
[7] Washington State Taper Calculator
[8] REMS Education
[9] Informed Consent Example

B. Connect with specialists to coordinate timely receipt of alternative therapies (e.g. physical therapy, occupational therapy, acupuncture, osteomanipulatory therapy [OMT], chiropractic therapy) for chronic pain management.

C. Connect with community-based organizations and programs to identify alternative resources (e.g. HMPs, AAAs, Chronic Pain Self-Management Program).

D. Connect with addiction services to establish timely referral and follow up process.

E. As appropriate, utilize the Maine Diversion Alert Program (DAP)[10]

F. Establish connection with local law enforcement resources (drug collection, lock boxes, etc.)

Component 10: Optimal Use of Health Information Technology (HIT) to Support Effective Chronic Pain Management & Safe Prescribing

1. Develop or maintain basic reporting and tracking capacity to identify and track patients with chronic pain (registry functionality).
2. Embed clinical decision support tools, including:
   A. Dose calculator
   B. Risk assessment
   C. Identification & tracking functions (automated follow up)
   D. Tapering calculator
3. Link EMR to Maine Prescription Monitoring Program (PMP)[11]

[10] Maine Diversion Alert Program

[11] Maine Prescription Monitoring Program