May 4, 2009


From: GUIDES (Guideline Utilization Implementation Development and Evaluation Studies)
William Chavey, MD
Van Harrison, PhD
Connie Standiford, MD

Subject: UMHS Clinical Care Guideline: “Managing Patients with Chronic, Non-terminal Pain, Including Prescribing Controlled Substances”

Key aspects.

General Issues
Multi-dimensional approaches should be used for evaluation and treatment. Consider the patient’s functional status, psychiatric comorbidities, social stressors and barriers to care. Treatment is more than medications.

Treatment goals must focus on realistic improvement of functioning at work, at home, with social contacts and in pleasurable pursuits. Complete analgesia (pain score of “0” is not possible for many patients).

Non-pharmacologic therapies (e.g., exercise, heat, psychotherapy, massage) should be initiated first.

Mood and psychiatric disorders should be actively managed per established clinical care guidelines, with psychiatry and/or pain psychology consultation for persisting symptoms.

Medications should be chosen based on presumed pain type and comorbidities, and should include adjuvant therapies such as tricyclics and SNRIs (e.g., duloxetine).

Follow up on patients with chronic pain at least every 3 months. Document progress toward functional goals.

Opioids – Special Issues
Assess patients for dependence and addiction risk prior to prescribing opioids. Patients considered for therapy with controlled substances must be monitored for misuse clinically, by checking a Michigan Automated Prescribing Service (MAPS) and a urine drug screen (at UM, DRUG COMP; the combined Drug6 [i.e. EIA] and GCMS).

When prescribing opioids:
Initial treatment with opioids should be on a trial basis and continued only if they help to achieve the documented goals. Stop them if not effective.
For patients requiring doses of short-acting opioids every day, consider switching to a long-acting opioid. Morphine ER is the preferred long-acting opioid. Methadone and buprenorphine are alternatives.

Avoid:
- Continuous short-acting opioids (such as Vicodin or Percocet)
- OxyContin (not long-acting, is expensive, has a “street” value, and a high potential for abuse)
- Simultaneous use of different opioids
- Prescribing large amounts of PRN medication. (PRN doses should be per month not per day.)

For ongoing opioid therapy:
A Controlled Substance Agreement (attached) should be reviewed, signed by patients, and imaged into CareWeb. In the Problem Summary List, under “Health Maintenance / Chronic Care Management” click the radio button for Controlled Substance Agreement and completion date; or if using Cielo, follow prompt.
At least once a year perform both:
- MAPS check [In the Problem Summary List, under “Health Maintenance / Chronic Care Management” use the radio button to indicate annual MAPS check has been completed, or if using Cielo, follow prompt.]
- Random urine comprehensive drug screen (at UM, DRUG COMP)
Appendices

A. 1. Outline of topics for initial evaluation of chronic pain
   2. Outline of topics for follow-up evaluation of chronic pain
B. Tools to assess pain disability
   1. Pain Disability Index (PDI)
   2. Oswestry Low Back Pain Scale
C. Patient-provider agreement for ongoing use of controlled medication
D. Oral opioid dosing equivalents and conversions
E. Ordering and interpreting urine drug tests
F. Discontinuing opioids
G. Example clinic policy regarding patients on long-term controlled substances

Patient education material.

HealthWise:

- Chronic Pain:
  [http://health.med.umich.edu/healthcontent.cfm?xyzpqabc=0&id=6&action=detail&AEProductID=HW_Knowledgebase&AEArticleID=cpain](http://health.med.umich.edu/healthcontent.cfm?xyzpqabc=0&id=6&action=detail&AEProductID=HW_Knowledgebase&AEArticleID=cpain)