Management of Chronic Pain and Addiction in the Primary Care FQHC Setting

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Working with communities to address the opioid crisis.

SAMHSA’s State Targeted Response Technical Assistance (STR-TA) Consortium assists STR grantees and other organizations, by providing the resources and technical assistance needed to address the opioid crisis.

Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

Funding for this initiative was made possible (in part) by grant no. 1H79TI080816-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Working with communities to address the opioid crisis.

-The STR-TA Consortium provides local expertise to communities and organizations to help address the opioid public health crisis.

-The STR-TA Consortium accepts requests for education and training resources.

-Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS) who is an expert in implementing evidence-based practices.

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Contact the STR-TA Consortium

To ask questions or submit a technical assistance request:

- Visit www.getSTR-TA.org
- Email str-ta@aaap.org
- Call 401-270-5900

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Objectives

- Discuss Pain Management in FQHCs
- Review Functional Treatment Model
- Review Rules and Regs
- Review Common Complications
- Review Management of these problems
Why Should You Do Pain Management

uptools your patients better including their co-morbid conditions

 Who knows the complicating factors related to pain involved with social determinants of health

 You have been trained in the use of the meds that SHOULD most commonly be used

 You have the better understanding of your patients medications and the potential for drug interactions

 Realistically, most pain mgmt clinics will delegate chronic medication mgmt to APRNs and/or PAs which is fine but your APRN/PAs as just as qualified.

 Therefore, it makes good clinical sense for the APRNs/PAs and physicians of your clinics to manage these patients and use pain mgmt as appropriate back-up
Results

Understanding those issues, APRN/PAs assisting primary care physicians with chronic pain mgmt is an attractive solution in providing this care to your patients in their home communities.

- It will provide better continuity of care.
- Closer monitoring.
- Reduced travel and wait times.
- Increased patient visits and a new revenue stream with ancillaries for your clinics.
- Most importantly, improved patient satisfaction and outcomes.
Treatment

- Evaluate the pain generator—why do they have chronic pain—don’t just cover up the pain.
- Understand that chronic pain is a chronic disease state and needs to be managed as such.
- May require use of subspecialty help at this stage—orthopedics, rheumatology…
- Treat the pain with non-opioid therapies as much as possible.
- Move to chronic opioid therapy only when non-opioid and non-pharmacologic therapies are inadequate.
Treatment

- Keep MMEs as low as possible always starting low and continue non-opioid therapies
- Use non-pharmacologic therapies such as PT, CBT, Chiropractic, interventional pain mgmt …
- Establish with patient the goals, objectives, and limitations at the beginning of treatment i.e keeping MMEs below 50
- Have the primary physician establish the care plan for pain mgmt
- Have APRNs/PAs co-manage these patients in close collaboration monitoring for complications of chronic opioid use and over all function
1. Primary Care Team of the patient manages the entire course of pain management

2. Primary Care Team of the patient initiates care and stabilizes and manages the patient with referral to a subject matter expert within the healthcare system should case become more complicated

3. Develop a subject matter expert (not a pain management specialist) within the system who will manage the patients requiring opioids or more complicated medical management using a board certified pain management specialist for the most difficult cases or when interventional pain mgmt is needed. Must keep percentage of patients on opioid therapy <50% of total patient population.
Goals and Objectives

- Goal is not to manage a pain scale number
- It is to improve function first and foremost
- The experience of pain should be improved
- Goal is to reduce suffering and improve quality of life
Non-opioid Medications

- NSAIDs if no gastric or renal issues
- Acetaminophen if no liver issues
- Neuroleptics/neuropathics such as gabapentin, tegretol, dilantin
- Lyrica- neuropathic that is in it’s own category
- SSRI-celexa, lexapro, zoloft   SNRI-effexor and cymbalta
- Tricyclics-elavil and nortriptyline
- Muscle Relaxers-zanaflex and baclofen
Opioids

- Butrans-transdermal low dose buprenorphine
- Tramadol
- Hydrocodone 1:1 MMEs
- Oxycodone 1.5:1 MMEs
Complications

- Tolerance and Dependence-need to discuss ahead of time that the plan will not allow continued escalation of MMEs
- Opioid Induced Hyperalgesic Syndrome- amplification of the pain signals at the level of the mid-brain causing an escalation in pain related to escalation of opioid dosing.
- Opioid Use Disorder (addiction)-potentially life threatening illness that must be addressed and refer for further care (hopefully within your own system)
- Unintentional Over Dosage- may be an outcome from all of the above
## Mississippi State Board of Medical Licensure Prescribing Rules Summary

### MSBML Prescribing Rules Summary:

<table>
<thead>
<tr>
<th>Acute Pain</th>
<th>Chronic Pain</th>
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<tbody>
<tr>
<td>- Recommended &lt; 3 days</td>
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<tr>
<td>- Max. 10 days, may give 1 additional (max 10 day) prescription</td>
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<tr>
<td>- Use lowest effective dose</td>
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<tr>
<td>- Recommend ≤ 50 MME daily</td>
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<tr>
<td>- Should not exceed 90 MME daily</td>
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<tr>
<td>- If &gt; 100 MME must be in pain clinic</td>
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<td>- Methadone for chronic pain only through pain clinics (by physician)</td>
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<tr>
<th>Benzodiazepines</th>
<th>Mississippi Prescription Monitoring Program (MPMP)</th>
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<tr>
<td>- Max 90 days per prescription</td>
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<tr>
<td>- Should not co-administer with opioids</td>
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<td>- Short term acceptable</td>
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<td>- Patients on chronic benzodiazepines and opioids should be gradually weaned off one or both</td>
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<td>- Chronic co-administration in rare, extreme circumstances</td>
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<tr>
<td>- All licensees must register with MPMP</td>
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<tr>
<td>- Must check on all opioid prescriptions for acute and/or chronic non-cancerous/non-terminal pain upon issuance</td>
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<td>- Must utilize the MPMP upon initial contact with new patients and at least every 3 months thereafter for all controlled medications other than opioids</td>
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<td>- Must document MPMP review (must include time from last check)</td>
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<tr>
<td>- FMP check not required for inpatients but must be checked if discharged on opioids</td>
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<tr>
<th>Exemptions</th>
<th>Pain Management</th>
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<tr>
<td>- Terminal/Cancer treatment</td>
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<tr>
<td>- Hospice patients</td>
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<td>- Inpatients (nursing home, rehab, hospitals, etc.)</td>
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<tr>
<td>- Prescriptions for Pseudoephedrine, Lomotil, Lyrica, Testosterone, and/or Amphetamines prescribed for patients under the age of 16 for the treatment of Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>- If ≥ 50% of patients receive controlled substances for chronic pain, must register as pain clinic</td>
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<td>- If advertises as pain clinic, must register</td>
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<tr>
<td>- Must check MPMP every time controlled substance prescribed</td>
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<tr>
<td>- Must see a pain management physician prior to initiating controlled substance</td>
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*MME = Morphine Milligram Equivalent*
Similarly, the complications discussed can and in my opinion, should be managed by those closest to the patient in need.

Realize that these patients are suffering and ill and need appropriate intervention.

This will most commonly require suboxone therapy in the outpatient setting which requires further training.

A medication assisted therapy program can easily be set up to provide high quality care within your healthcare network.
Model of Care

- Develop 1 or more physicians and APRN/PAs who have interest into your group’s subject matter experts (not addiction medicine specialists). Oftentimes, it will be the same providers that are your chronic pain experts.

- Have them undergo “waiver” training to become certified to prescribe buprenorphine (suboxone).

- Use our support via the STR-TA grant to help develop and launch your program in order to provide high quality care.

- As complications develop in your pain mgmt program, refer these patients to your own experts within your system which provides faster access to care and better continuity and collaboration.

- Watch your patients improve due to your good care.

- Eliminate all of the hassle patients currently endure in order to have access to MAT care.
You Will Not Be Alone

- STR-TA Grant technical assistance at the level you need in order to get started, further develop your program, and provide back up assistance
- Echo Project- under development to provide further teaching and case conferencing for those on the front lines with a team of experts on a weekly basis to help support your practice
- Collaboration with an addiction specialist to answer questions and to accept more complicated patients who aren’t doing well or who need inpatient care.
Thank You

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