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

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STR-TA Consortium

State Targeted Response Technical Assistance

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.

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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

- Who knows 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

Treatment Models

- 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

Rules and Regulations

Mississippi State Board of Medical Licensure Prescribing Rules Summary

MSBML Prescribing Rules Summary:	
Acute Pain	◦ Recommended < 3 days ◦ Max 10 days, may give 1 additional (max 10 day) prescription
Chronic Pain	◦ Use lowest effective dose ◦ Recommend ≤ 50 MME daily ◦ Should not exceed 90 MME daily ◦ If > 100 MME must be in pain clinic ◦ Methadone for chronic pain only through pain clinics (by physician)

Benzodiazepines	◦ Max 90 days per prescription
	◦ Should not co-administer with opioids
	  ◦ Short term acceptable
	  ◦ Patients on chronic benzodiazepines and opioids should be gradually weaned off one or both
	  ◦ Chronic co-administration in rare, extreme circumstances

Mississippi Prescription Monitoring Program (MPMP)	◦ All licensees must register with MPMP ◦ Must check on all opioid prescriptions for acute and/or chronic non-cancerous/non-terminal pain upon issuance ◦ Must utilize the MPMP upon initial contact with new patients and at least every 3 months thereafter for all controlled medications other than opioids ◦ Must document MPMP review (must include time from last check) ◦ PMP check not required for inpatients but must be checked if discharged on opioids
Drug Screening	◦ Point of Service Drug Testing must be done at least 3 times per calendar year when Schedule II medications is written for the treatment of chronic non-cancerous/non-terminal pain ◦ Applies also for Benzodiazepines for chronic medical and/or psychiatric conditions which are non-cancerous/non-terminal ◦ Inpatient treatment/hospice patients exempt
Exemptions	◦ Terminal/Cancer treatment ◦ Hospice patients ◦ Inpatients (nursing home, rehab, hospitals, etc.) ◦ 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
Pain Management	◦ If ≥ 50% of patients receive controlled substances for chronic pain, must register as pain clinic ◦ If advertises as pain clinic, must register ◦ Must check MPMP every time controlled substance prescribed ◦ Must see a pain management physician prior to initiating controlled substance

***MME = Morphine Milligram Equivalent**

Management of Complications of Opioids

- 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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