Tool Kit for Chronic Pain Management:

An Evidence Based/Team Based Model for Primary Care

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Sharon Mulvehill, MD

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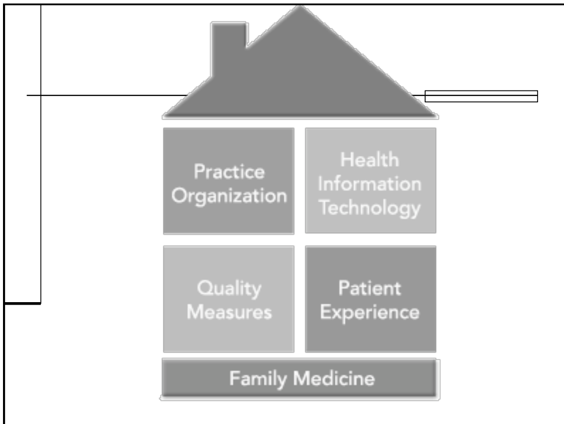
The Challenges

- Common complaint
- Complex HPI plus comorbidities
- Different types of pain in the same patient
- Providers have different educational backgrounds, perceptions, and values
- Treatment has risks associated - to the patient and to the public



RSH Philosophy

- Evidence based, team based **patient** care based on best available guidelines
- Support **providers** in providing complex and challenging patient care
- Provide care with an awareness for and protection of **public health**

RSH Tool Kit

- Complete evaluation of about 60 minutes
- Takes place over 3 or 4 visits
- Duties shared between nursing and provider and behavioral health
- No prescription until evaluation complete – prescribe based on a diagnosis (based on history and physical), risk assessment, patient centered care plan

Chronic Pain Visit #1

- Chronic pain identified as a complaint
- Urine Drug Screen collected
- Records release signed by nursing
- Brief Pain Inventory/Functional Assessment
- Provider verifies current medications and educates patient about plan

Patient Education

- Explain RSH uses national guidelines
- No rx until evaluation complete
- Family medicine scope of care
- Treatment is to improve function
- Chronic pain visits focus on chronic pain, other visits for co-morbidities

Chronic Pain Visit #2

- Complete HPI, PMH
- Review old records, summarize in medical record
- PHQ – depression screen
- ORT- risk tool for opioid prescribing
- Physical exam

Chronic Pain #3

- MD reviews information collected
- Diagnosis made regarding type of pain
- Medications selected, prescribed, documented, education provided
- CSA done if opiods prescribed
- Care plan - with behavioral health: sleep, stress, goals, exercise, rx

Chronic Pain Follow Up

- **Analgesia** – BPI
- **ADL's** – FAQ5
- **Aberrancies** – record reviewed for urgent visits, telephone calls, er visits
- **Adverse** effects of medication

- No changes in care plan - 1 to 3 month f/u
- Care plan changes – 1 month f/u

Chronic Pain – Urgent Care

- BPI
- Identify chief complaint – inadequate pain relief, missed appointment with pcp, did not schedule appointment, new injury
- Targeted physical exam
- Review care plan
- Reschedule with pcp, continue care plan

Risk Stratification

- Use of ORT to risk stratify patient into low, moderate, or high risk
- RSH will tx up to 120 MED's in low or moderate risk patients
- Referral – high ORT, high MED's, severe co-morbid psychiatric dz
- CSC – reviews referral patients on request for interim care plan, review difficult cases

Weaning Opiods

- Wean for lack of improvement in fxn, aberrancies, side effects
- Taper is for physical dependence, mental dependence lasts longer – more support
- No need to wean opiods for major aberrancies – forgery, selling drugs, substance abuse of rx or other drugs

2010/2011 Updates

- CDC, Washington State recomends referral if function not improved and 120 MED's reached
- Screening + follow up EKG - all patients on methadone, disclosure-potential of QT increase
- Washington State published article – 9X increase in OD risk with MED's >100MED/day
- FDA requires REMS – Risk Evaluation and Mitigation Strategy for LA opioids, provider ed
- State of Montana passes drug registry

Can you do this?

- Create a team, not a pain specialist
- Steal from the best and give credit- no need to invent anything,
- Learn the science of chronic pain treatment
- Adapt best practices to your setting
- Commit to excellance in: Patient care/ Provider support/Public safety

References

- Webster, L. Predicting Aberrant Behaviors in Opioid-Treated Patients. AAPM:6, Nov 2005 p432-442.
- Kral, L. Opioid Tapering: Pain-Topics.com: 2006
- Chou, R. Opioid Treatment Guidelines: The Journal of Pain: Volume 10 Feb 2009 p113-130.

Essential Websites

- icsi.org
- Agencymedicaldirectors.wa.gov
- http://www.agencymeddirectors.wa.gov/Files/DosingCalc.xls