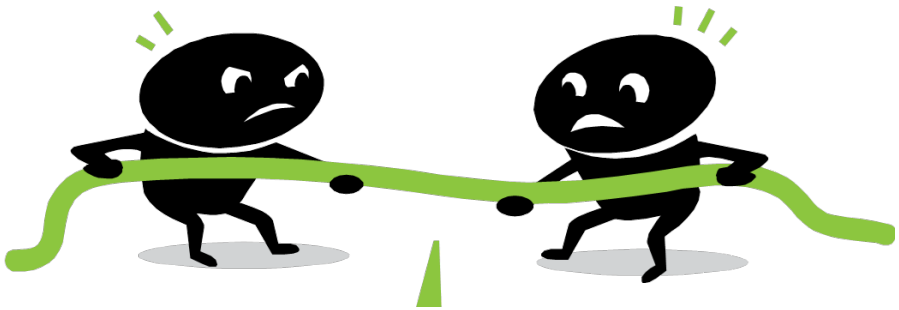


Chronic Disease Management for Pain: It CAN be done in primary care!

Sondra Adkinson, PharmD, DAAPM, CPE
Thomas B. Gregory, Pharm.D., BCPS, DASPE, CPE
Chris Herndon, PharmD, BCPS, CPE

Disclosures

- Adkinson:
  - Consultant, Krames Pt Education
- Gregory:
  - Nothing to disclose
- Herndon:
  - Consultant for Incline Therapeutics (expired)
  - Consultant for Premier Healthcare Alliance

Objectives

- Define chronic disease management
- Contrast policies, procedures, and risk mitigation strategies for use in the primary care setting
- List opportunities for easy to incorporate processes to streamline care of and communication to patients with chronic pain
- Discuss challenges to providing pain care in the primary care setting and balancing patient advocacy / public safety

We want this to be interactive!

- Microphones located in aisles
- Use your Twitter account: #PW2012CDM
- Use your cell phone by texting Poll Anywhere: TBD

What is CDM?

- "…a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."
- Proactive vs. reactive medicine

Congressional Budget Office. An analysis of the literature on disease management programs. 2004-10-13. Retrieved 2008-10-13.

Practice Background – Dr. Adkinson

- Veterans Administration
- – Clinical Pharmacy Specialist
- Outpatient chronic pain management clinic
- Interdisciplinary and consultative
- Menu of services – Medical, Interventional, Virtual, Pain School, Psychologist, Psychiatrist
- 90% consults from Primary Care

Practice Background – Dr. Adkinson

- Pharmacist led Opioid Renewal Clinic from 1999-2011 for Primary Care - CNMP
- Pain History on each new patient consult
- Counsel patients for related pharmacotherapy, pre procedure instructions, and at each clinic visit for medication reconciliation and MTM.
- Pain school coordinator and facilitator

Practice Background – Dr. Gregory

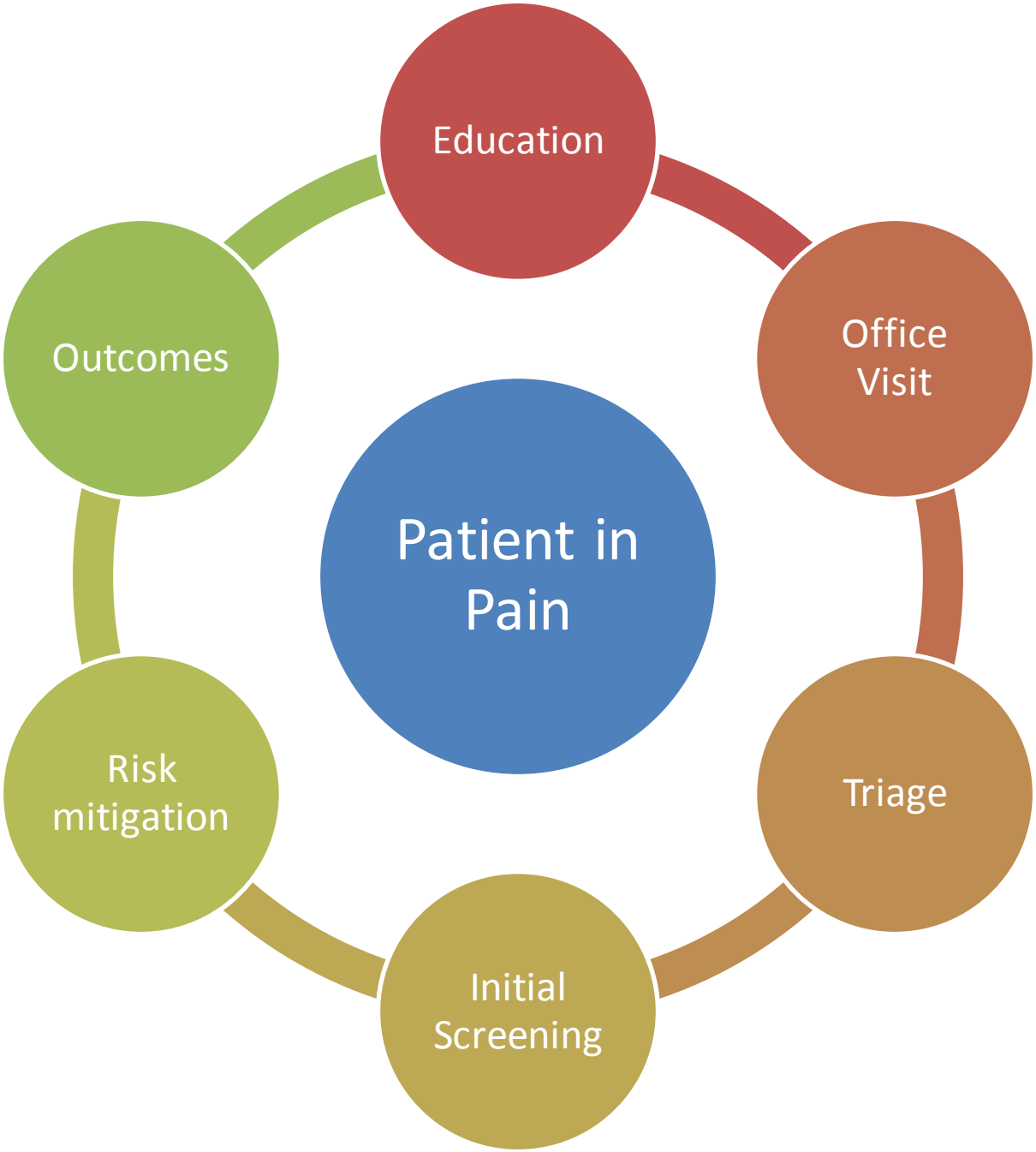
- Sickle cell population in an urban academic medical center
- Approximately 100 patients
- Team members
  - Medical Director
  - Nurse Practitioner
  - Social Worker
  - Psychologist
  - Pharmacist

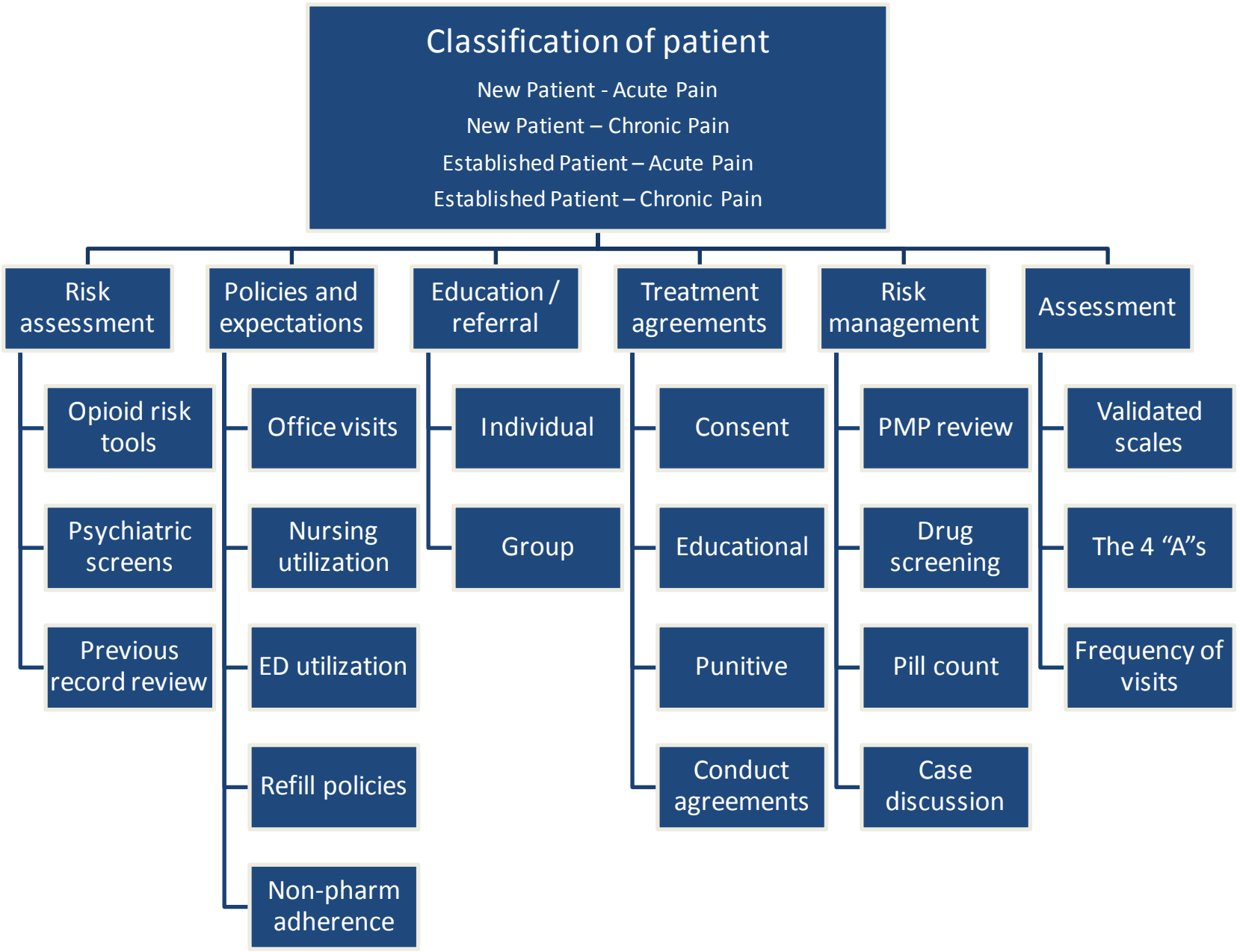
Practice Background cont.

- Primarily outpatient clinic patients
- Available for consultation if a patient is admitted to the hospital
- Opioid agreements and electrophoresis are required for all new patients to establish in the clinic

Practice Background Dr. Herndon

- Outpatient pain management within family medicine residency program
  - 50% of patients civilian, medically underserved and uninsured or state medicaid
  - 50% of patients USAF either active duty, dependents, or retired
- Multi-disciplinary evaluation and triage
- Pharmacist-led CDM
- Primary pain syndromes encountered
  - CLBP, Cervicalgia, FMS, OA, Migraine, CRPS, Chronic abdominal and pelvic pain


Education
Office Visit
Triage
Initial Screening
Risk mitigation
Outcomes
Patient in Pain



VAS: visual analog scale; NRS: numeric rating scale; BPI: Brief Pain Inventory; MPQ: McGill Pain Questionnaire; NPRS: Neuropathic Pain Rating Scale

Develop policies now!

- Seek input from all practice stakeholders
  - Medical assistants
  - Nurses
  - Lab techs
  - Providers
  - Institution patient advocacy
- Policies should address the following situations:
  - Acute pain with or without risk factors for abuse
  - ED or hospital follow-up appointments
  - New patient establishing care
  - Established patient transitioning from acute to chronic

Excerpt from BFHC draft policies

1. **New or established patient – Acute Pain**
   a. Prior to prescribing opioids or other controlled substances in classes II, III, IV, Illinois Prescription Monitoring Program shall be reviewed
   b. Chart documentation in progress note shall specifically describe intended duration of therapy
   c. All controlled substance prescriptions must be approved by an attending physician and ordered under an attending physician (for residencies) or other provider not in training.
2. **New or established patient – Chronic Pain**
   a. Requests for chronic maintenance therapy involving controlled substances in classes II, III, IV shall be declined until such time as previous providers medical records are provided
   b. Treatment agreement is executed between patient and provider
   c. Chart documentation in progress note shall specifically describe intended duration of therapy , ongoing necessity, and exit strategy
   d. Safe harbors documentation must include assessment of pain severity, change in activity level / functioning level, adverse effects, and aberrant drug taking behaviors or known risks (4 As of Pain)
   e. All controlled substances prescriptions must be approved by an attending physician and ordered under an attending physician
   f. Standing orders for random drug screening with random monitoring available to providers as well as team nurses
   g. Pill counts shall be implemented with patient requirement to bring all controlled substances to each office visit in original dispensing container
   h. Controlled substance prescriptions schedules II-IV require 72 hours notice prior to receipt of refill following request
   i. Refills shall be limited to 3 months duration between office visits

Big questions frequently encountered

- What if my patient seeks ED care and receives Rx
- What is my patient misses appointments
- Should I abruptly discontinue or wean opioids
- How many strikes is “enough” to dc patient
- Are all strikes the same
- Should I base care decisions on drug screen results
- How often should I see chronic pain patients
- Should I provide refills on non-CII prescriptions
- How high / how many times should I titrate opioids
- When should a patient be reprimanded for conduct
- How many times is “too many” for phone calls to clinic
- How much notice should be provided for refill requests

Audience and panel discussion

Questions or comments:

Twitter: #PW2012CDM

PollAnywhere (cellular): TBD

Risk Assessment

Is your practice equipped to handle this patient?

Opioid Risk Tool

Family history of substance abuse	**Female**	**Male**
Alcohol	1 point	3 points
Illegal drugs	2 points	3 points
Prescription drugs	4 points	4 points
Personal History of Substance abuse	**Female**	**Male**
Alcohol	3 points	3 points
Illegal Drugs	4 points	4 points
Prescription Drugs	5 points	5 points
Age (16 yrs to 45 yrs)	1 point	1 point
Preadolescent sexual abuse	3 points	0 points
Depression	1 point	1 point
ADD, OCD, Bipolar, or Schizophrenia	2 points	2 points

Low Risk 0 – 3 points, Moderate Risk 4 – 7 points, High Risk $\geq$ 8 points

Webster LR, Webster RM. Predicting aberrant behaviors in opioid treated patients. Pain Med 2005;6(6)432-42.

Other risk assessment tools

Acronym of tool[α]	Number of questions	Completion	Time to complete
SOAPP®-R	24 items	Self-report	< 10 minutes
DIRE	7 items	Clinician administered	< 5 minutes
ORT	5 items	Clinician administered	< 5 minutes
COMM	40 items	Self-report	< 10 minutes
CAGE	4 items	Either	< 5 minutes
PDUQ	42 items	Clinician administered	20 minutes
STAR	14 items	Self-report	< 5 minutes
SISAP	5 items	Clinician administered	< 5 minutes
PMQ	26 items	Self-report	< 10 minutes

α - SOAPP®-R (Screener and Opioid Assessment for Patient's in Pain-revised); DIRE (Diagnosis, Intractability, Risk, and Efficacy); ORT (Webster's Opioid Risk Tool); COMM (Current Opioid Misuse Measure); CAGE (Cut-down, Annoyed, Guilt, Eye-opener); PDUQ (Prescription Drug Use Questionnaire); STAR (Screening Tool for Addiction Risk); SISAP (Screening Instrument for Substance Abuse Potential); PMQ (Pain Medication Questionnaire)

Psychiatric Screens in Pain Mgmt

- Depression
  - Beck Depression Inventory?
  - Patient Health Questionnaire (short and long)
- Anxiety
  - Beck Anxiety Inventory
- Post Traumatic Stress Disorder (PTSD)
  - Trauma Screening Questionnaire
  - Primary Care PTSD Screen
- Bipolar
  - Mood disorder questionnaire

Audience and panel discussion

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PollAnywhere: TBD

Opioid or Pain Agreements

Are they for the patient's benefit, or yours?

Opioid agreement essentials

- Develop a policy regarding opioid prescriptions
  - Addresses early fills, lost or stolen medications, who can pick up the prescription, use of “on-call” number
  - One prescriber, one pharmacy, covering provider authorization
  - Needs to be given in writing, made part of the medical record
    - Informed consent
  - Periodic review of the policy with the patient
    - Required with certain REMS programs

Patient expectations

- Adherence to the treatment agreement language
  - Clean drug screen
  - Attend all clinic appointments on schedule
  - Refills are not “same day service”
  - Office staff are treated with respect
  - Adherence to non-opioid medications and non-pharmacologic therapy concurrent with opioids
  - Only get opioids from authorized provider

Provider expectations

- Will adhere to the opioid agreement in the clinic
  - Discusses with the patient goals, outcomes and all modalities used in pain management
  - Has an exit strategy regarding opioids if risks outweigh benefits
    - To taper off or not to taper off
  - Documentation includes periodic review for appropriateness of opioid continuation

Clinic staff expectations

- Screen all refill requests and assess for early refills
- Document all patient communication in the medical record
- Have clear chain of custody policy for
  - Giving patient's or patient representative hard copy of prescription
  - Urine or saliva drug screenings

Outcomes

- Documentation of clear goals of therapy
  - Pain score
    - Patient's pain diary
  - Activities of daily living
    - Increase or decrease in functionality
  - Opioid dose review
    - Long acting opioids with appropriate break through opioid dosing

Four A's of pain medicine

- Analgesia
  - Is the patient receiving appropriate or adequate pain relief
- Activity
  - Has the patient's overall functionality improved on opioids compared to non-opioid / no therapy
- Adverse effects
  - If present are they tolerable or should therapy be altered
- Aberrant behaviors
  - Patient risk stratification for appropriateness of opioid therapy

Resources

- Many template opioid agreements available online
- The policy within the clinic should be uniform and applicable to all patients in the practice
- Consistency and documentation are key to compliance with the policy

Audience and panel discussion

Questions or comments:

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PollAnywhere (cellular): TBD

Risk Mitigation

Can we really mitigate, or just reduce?

Opportunities for reduction in risk

- Prescription drug monitoring programs (PDMP)
- Refill records (not the same as PDMPs)
- Random drug screening
  - Ordering the correct screen
  - Chain of custody, point of care, and alternate samples
- Pill counts
  - Tips from the trenches
- Conferencing
  - Talk to dispensing pharmacist
  - Talk with nursing staff
- Family and/or friends?

Outcomes

How do we “make the grade”

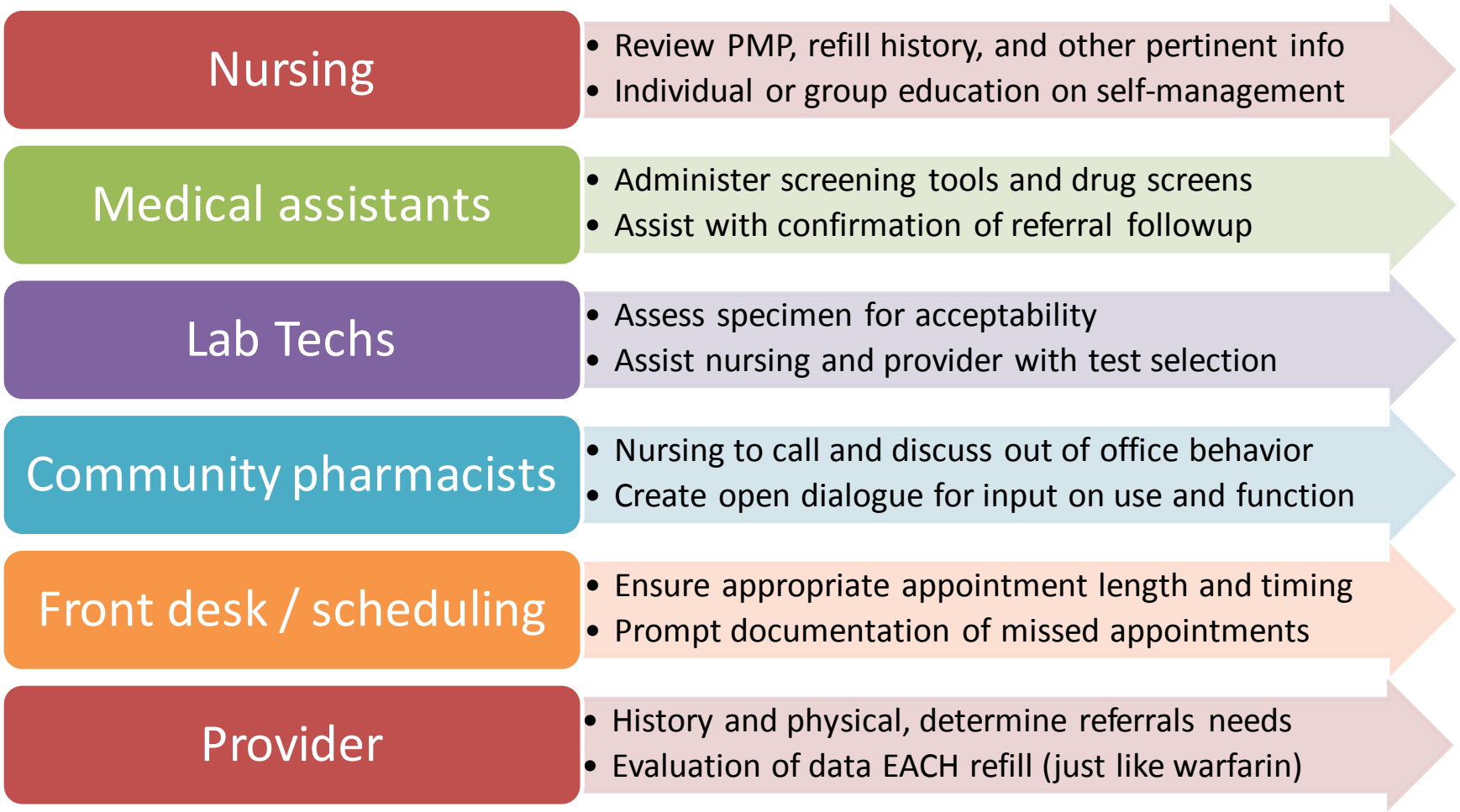
Outcomes assessment and accountability

- Multi-dimensional pain score
- Activity, but objectively
  - How many times to church
  - Activities documented in pain journal
  - Pedometer
- Weight loss
- Adherence with non-pharm recommendations
- Emergency department utilization

Use your whole team

Delegation

Proposed patient flow and responsibilities



Audience and panel discussion

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