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

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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

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
Patient in Pain

Education

Outcomes

Risk mitigation

Initial Screening

Triage

Office Visit
Classification of patient

New Patient - Acute Pain
New Patient – Chronic Pain
Established Patient – Acute Pain
Established Patient – Chronic Pain

Risk assessment
Opioid risk tools
Psychiatric screens
Previous record review

Policies and expectations
Office visits
Nursing utilization
ED utilization
Refill policies

Education / referral
Individual
Group

Treatment agreements
Consent
Educational
Punitive
Conduct agreements

Risk management
PMP review
Drug screening
Pill count
Case discussion

Assessment
Validated scales
The 4 “A”s
Frequency of visits

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
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

<table>
<thead>
<tr>
<th>Family history of substance abuse</th>
<th>Female</th>
<th>Male</th>
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</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>1 point</td>
<td>3 points</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td><strong>Personal History of Substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>5 points</td>
<td>5 points</td>
</tr>
<tr>
<td>Age (16 yrs to 45 yrs)</td>
<td>1 point</td>
<td>1 point</td>
</tr>
<tr>
<td>Preadolescent sexual abuse</td>
<td>3 points</td>
<td>0 points</td>
</tr>
<tr>
<td>Depression</td>
<td>1 point</td>
<td>1 point</td>
</tr>
<tr>
<td>ADD, OCD, Bipolar, or Schizophrenia</td>
<td>2 points</td>
<td>2 points</td>
</tr>
</tbody>
</table>

Low Risk 0 – 3 points, Moderate Risk 4 – 7 points, High Risk ≥ 8 points

Other risk assessment tools

<table>
<thead>
<tr>
<th>Acronym of toolα</th>
<th>Number of questions</th>
<th>Completion</th>
<th>Time to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOAPP®-R</td>
<td>24 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
<tr>
<td>DIRE</td>
<td>7 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>ORT</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>COMM</td>
<td>40 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
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<tr>
<td>CAGE</td>
<td>4 items</td>
<td>Either</td>
<td>&lt; 5 minutes</td>
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<tr>
<td>PDUQ</td>
<td>42 items</td>
<td>Clinician administered</td>
<td>20 minutes</td>
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<tr>
<td>STAR</td>
<td>14 items</td>
<td>Self-report</td>
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<tr>
<td>SISAP</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
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<tr>
<td>PMQ</td>
<td>26 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
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</table>

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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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

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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

Nursing
- Review PMP, refill history, and other pertinent info
- Individual or group education on self-management

Medical assistants
- Administer screening tools and drug screens
- Assist with confirmation of referral followup

Lab Techs
- Assess specimen for acceptability
- Assist nursing and provider with test selection

Community pharmacists
- Nursing to call and discuss out of office behavior
- Create open dialogue for input on use and function

Front desk / scheduling
- Ensure appropriate appointment length and timing
- Prompt documentation of missed appointments

Provider
- History and physical, determine referrals needs
- Evaluation of data EACH refill (just like warfarin)
Audience and panel discussion

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