Chronic Illness/Pain

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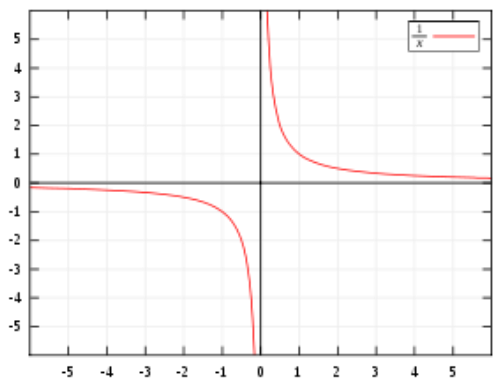
The Challenges

- Common complaint
- Complex history is the norm
- Patients often have many co morbidities
- Different types of pain can co-exist
- Some patients need referral
- Available therapies include real risks
- Real public health threat associated with tx

More Challenges

- Adequate evaluation requires time
- Providers have different educational backgrounds, perceptions, values
- These patients can be very challenging and sometimes frustrating
- Adverse events are traumatic and may leave providers unwilling to prescribe



What We Wanted

- Resource – someone who had improved their clinic care, used EBM, similar setting
- Education – similar educational experience for all faculty/residents
- Multidisciplinary change
- Team based care – nursing, BH, provider
- Everyone involved

How we did it

- Guest speaker "expert" at faculty retreat
- Core group got training – AMA, AAFP, Washington State Medical Directors
- Core group meetings
- PDSA
- Clinic roll out – all staff trained
- **Ongoing development, training, support**

What We Did

Committed to:

- Evidence based care based on best available guidelines
- Supporting providers in providing complex and challenging clinical care
- Providing care with awareness for and protection of public health

What We Came Up With

- A method to evaluate patients in a step wise fashion that included education and partnership
- A system to share the work with nursing so that visits became manageable
- A way to carry the information forward for ongoing care

Complete Evaluation

- Takes 60-80 minutes
- Structured over 3-4 visits
- Each visit has a list with shared duties between nursing and provider
- New patients – no rx until eval complete
- Est patients – rx if reasonable small amts until eval complete

Visit Number One

- Chronic pain is identified as a complaint
- Provider **educates** patient about how we evaluate and treat chronic illness/pain
- **Urine drug screen** collected
- **Records release** obtained by nursing
- Patient rescheduled with MD - **appt**
- **BFI/FA** completed

Patient Education

- Explain CHC uses national guidelines
- No rx until evaluation is complete
- Family medicine scope of care
- Treat to improve function
- Chronic pain visits focus on chronic pain, Treat pain for continuity patients only, other comorbidities and prevention addressed during other visits

Visit Number Two

- **Old records** are reviewed with the patient summarized in the record.
- **History** completed – BH sees patient if complex mental health history – either then or separate visit
- **PHQ** (nursing) – depression screen
- **ORT** (nursing) – opioid risk tool
- **Physical exam - MD**

Visit Number Three

- Accumulated information reviewed by MD
- **Diagnosis** is made regarding type of pain
- **Medications** selected with patient and prescribed, education provided
- **CSA** done if opioids selected
- **Care plan** constructed – MD/BH – focus on self mgmt/ improving function
- F/u in one month - **appt**

Patient Education

- No telephone refills
- Patient needs to schedule before running out of medications
- Discuss side effects and risks of medication
- Medications used to improve function

One Month Follow Up

- BPI/FA obtained – **analgesia, adl's**
- Medication regimen reviewed –**adverse effects**
- Record reviewed for **aberrancies**
- Care plan reviewed for success
- If no changes provider selects one to three month follow up, provides rx,
- If changes made one month follow up-**appt**

Urgent Care – Established Pt

- Causes: Increase in need, missed appointment, did not make appt
- **BFI/FA**
- **Care plan** review
- Targeted PE if indicated (be aware of new diagnosis)
- Reschedule with pcp **appt**, continue care plan, **Rx** if indicated by care plan

Referrals

- To pain specialist: High ORT, hx of aberrant behaviors, high MED's, failure to achieve functional improvement, sever psychiatric dz
- To CSC: Any of the above indications during referral process for care plan recommendations.
- Limit of 120 MED's, low or moderate ORT risk

Weaning opiods

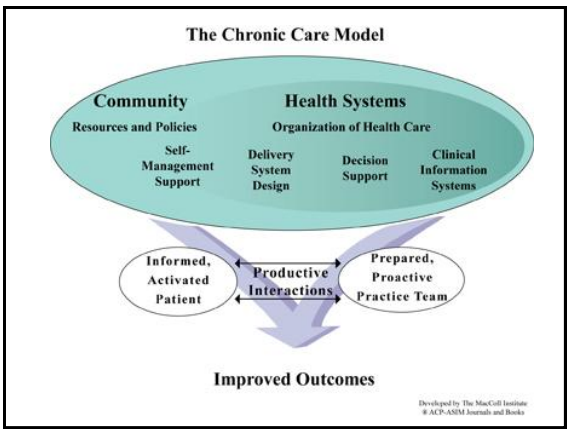
- Taper addresses physical dependence
- Mental dependence is more difficult, lasts longer. Use behavioral health support
- No need to wean opiods for major aberrancies: prescription forgery or tampering, selling prescribed medications, use of other recreational drugs (meth) –
- Treat symptoms and address the substance use.

Hot off the Presses - 2010

- CDC issues recommendation for referral if function not improved and 120 MED's reached.
- Washington State publishes article showing 9X increase OD risk with MED's >100/day Ann Int Med 2010, 152(2) 85-92.
- Screening and follow up EKG for all patients on methadone, disclose risk of QT prolongation and arrhythmogenic potential Ann Int Med 2009, 150

Can you do this?

- Find a champion, not a pain specialist
- Steal from the best and give credit – no need to invent anything,
- Learn the science of chronic pain Tx
- Adapt the best practices to your specific clinical setting
- Stay true to: excellent patient care, provider satisfaction, promoting public health



Appendices

- http://www.icsi.org/ Large pdf with comprehensive information, care plan, BPI/FA, guidelines, QA
- http://www.agencymeddirectors.wa.gov/ MED calculator, CME, guidelines
- http://www.amacmeonline.com/pain_mgmt/index.htm - CME
- http://www.aafplearninglink.org/Webcasts/Pain-managment/index.aspx - CME, tools

References

- Webster, L. Predicting Aberrant Behaviors in Opioid-Treated Patients. AAPM: Volume6 Nov2005 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