

Pain and Primary Care

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Management

Stepped Care Model

1. Primary Care

1. Routine assessment and management
2. Triaging to specialty care (e.g., substance use disorder treatment)
3. Behavioral health integration
4. Post-Deployment Clinics
5. System support
 1. Opioid Renewal Clinics
 2. Opioid – Decision Support System
6. Patient education program

2. Secondary consultation


1. Pain medicine, medical/surgical specialists, rehabilitation medicine, behavioral health, psychiatry/substance use disorder programs
2. Long term co-management, in some cases
3. Coordinated VISN level plan
4. Telehealth

Tertiary, Interdisciplinary Pain Care Centers

1. At least one site per VISN
2. CARF accreditation in five years
3. Services
 1. Comprehensive medical/psychological evaluations of veterans with complex conditions
 2. Evidence-based pharmacological, rehabilitation, and psychological interventions
 3. Coordinated interdisciplinary rehabilitation/recovery program
 4. Case management
 5. Focus on family/caregiver involvement

Primary Care

1. Routine screening, assessment, management, reassessment

 **Reminder Resolution: TEST PAIN SCREEN**

PAIN MANAGEMENT MAIN MENU

CLINICIANS

- Complete a CLINICIAN COMPREHENSIVE PAIN ASSESSMENT/PAIN HISTORY
- Complete a CLINICIAN PAIN REASSESSMENT & PAIN CARE PLAN
- Complete a COGNITIVELY IMPAIRED ASSESSMENT/REASSESSMENT & PAIN PLAN OF CARE
- Complete a CLINICIAN POST-OPERATIVE PAIN ASSESSMENT/REASSESSMENT
- Monitor OPIOID THERAPY

NURSING

- Complete a NURSING (RN) PAIN ASSESSMENT & PAIN CARE PLAN
- Complete a NURSING (RN) PAIN REASSESSMENT & PAIN CARE PLAN
- Complete a NURSING (RN) COGNITIVELY IMPAIRED ASSESSMENT/REASSESSMENT
- Complete a NURSING (LPN/NA) PAIN OBSERVATION/REOBSERVATION

APPLICABLE TO ALL

- Record a NUMERIC PAIN SCORE
- Complete PATIENT PAIN EDUCATION

[LINK to Pain Clinical Practice Guidelines](#)

[LINK to VA Pain Management Website](#)

Primary Care Competencies

1. Conduct of comprehensive pain assessment
2. Negotiating behaviorally specific and feasible goals
3. Knowledge/use of common metrics for measuring function
4. Optimal patient communication
 1. How to provide reassurance
 2. How to foster pain self-management
5. Conduct of routine physical/neurological examinations
6. Judicious use of diagnostic tests/procedures and secondary consultation
7. Assessment of psychiatric/behavioral comorbidities
8. Knowledge of accepted clinical practice guidelines
9. Rational, algorithmic based polypharmacy
10. Opioid management

ATHENA Opioid Therapy for Chronic Non-Cancer Pain

Feedback for researchers

Disclaimer: Complete clinical information may not be available to the Athena Opioid Therapy application herein displayed. Please use your clinical judgment to decide on the best therapy for this patient's chronic pain.

Summary Assessment **Orders: Urinary Drug Screens, Meds, Consults** Education & Agreements Documentation

Back to Recommendations

Recommendations for Chronic Pain

Cautions

- COPD
- Current or past drug-induced mental disorder
- Depression
- Age >=65 years

Patient data

Drug	Daily Dose	Start	End
hydrocodone/a...	20.0		
hydrocodone/a...	20.0		
hydrocodone/a...	20.0		
hydrocodone/a...	20.0		
hydrocodone/a...	20.0		

Treatment Checklist

- Conducted Pain Assessment
- Ordered a Urine Drug Screen
- Educated Patient to Call Ahead for Refills (7-10 days Before Running Out)
- Had Patient Sign Pain Management Agreement
- Documented Pain Assessment, UDS, Patient Education, Pain Management Agreement

Opioid Therapy Options

OPTION: Increase dosage of short-acting opioid (hydrocodone/acetaminophen)

OPTION: Switch from hydrocodone/acetaminophen to morphine SA

- Relative contraindications for hydrocodone/acetaminophen: Obstructive Pulmonary Disease, Drug Induced Mental Disorder, Depression
- Compelling indications for morphine SA: short acting rx for >2 months
- Relative contraindications for morphine SA: Obstructive Pulmonary Disease, COPD, Current or past drug-induced mental disorder, Depression
- Opioids are respiratory depressants and should not be used in the presence of hypercapnia and hypoxia on arterial blood gas determination.
- Formulation: morphine SA 15mg
Suggested schedule:
First week: 1 x 15 mg tab bid (30 mg/day)
Second week: 1 x 15 mg tab tid (45 mg/day)
Third week: 2 x 15 mg tab bid (60 mg/day)
Comments: Followup with patient by phone at end of 2-3 weeks. Titrate to level necessary for adequate pain relief.
- Tell patient not to dissolve, chew, or crush tablets.

OPTION: Maintain current therapy.

OPTION: Discontinue opioid therapy. Evaluate for opiate dependence. Click for taper schedule.

Tell patient not to dissolve, chew, or crush tablets.

Misuse Warnings

- Opioid hypoxia
- Opioid

Clinical Alerts

- Slow ini

Tools as drop down menus

Cautions

Patient data

Checklist

Patient specific guideline-based recommendations for opioid therapy, alerts if patient is high risk for misuse and more!

Mental/Behavioral Health Integration

1. Behavioral health specialists to conduct and document comprehensive pain assessments
2. Delivery of education and efforts to promote pain self-management (evidence-based psychotherapies; e.g., cognitive-behavior therapy/self-regulatory treatments)
3. Triaging role related to accessing psychiatric and substance use disorder treatment
4. Collaborative care and case management

Primary Care Provider Education

1. Existing resources

1. www.va.gov/pain_management
2. VA Pain List Serve
3. High Alert Medication Share Point site
 - <http://vaww.national.cmop.va.gov/HighAlertMedications/default.aspx>
4. PBM resources
5. On line training (general, opioid therapy, polytrauma)
6. Monthly teleconferences (1st Tuesday, 11 am eastern time; 30287#)
7. Cyberseminars

2. Planned conferences

1. February 24-26, 2009 (Ft. Lauderdale)
2. April 7-9, 2009 (Reno, NV)

Next steps

1. Statement of primary care provider competencies
2. Criteria/thresholds for referrals (i.e., standardized service agreements)
3. Case management model
4. Additional tools/resources
5. Education and training initiatives