County of Fresno
DEPARTMENT OF PUBLIC HEALTH

Health Advisory

June 1, 2021

Pain Management

The Fresno County Department of Public Health (FCDPH) is sharing this health advisory to primary care providers and other frontline clinicians as a refresher on fundamentals of pain management. Pain is a common and frequently chronic condition which can detract from health and wellness in a number of ways. Clinical evidence on therapies and interventions to help manage pain-- and prevent opioid use disorder-- has expanded in recent years. All clinicians who see patients with pain are encouraged to read this summary and understand some of the best practices for management of acute or chronic pain.

Background/ Situational Awareness

The closure of one of Fresno County's pain management clinics has resulted in uncertainty among patients as to when and where they will get their prescribed pain medication and medication assisted treatment for opioid use disorders.

Patients taking opioid or other controlled medications on a daily basis are at extremely high risk if they lose access to their regular prescriber, such as after a clinic closure. Patients must urgently be connected to a new provider before medications run out and withdrawal symptoms start. Withdrawal symptoms are usually severe, which can lead patients to seek out illicit drugs. Many illicit drugs are contaminated with fentanyl, and use can lead to accidental overdose death.

If you are contacted by a LAGS Clinic patient, please have them reach out to their Managed Care Plan, the doctor who prescribed their pain medicine, their primary care doctor, or their substance use disorder (SUD) treatment provider.

Here are questions you can ask to help direct them to care:

- **Have you called your insurance?**

CalViva	1 (888) 893-1569 TTY 711
Anthem	Call number on your member ID card
Covered California	1 (800) 300-1506

Categories of Health Alert Messages:

Health Alert: Conveys the highest level of importance; warrants immediate action or attention
Health Advisory: Provides important information for a specific incident or situation; may not require immediate action
Health Update: Provides updated information regarding an incident or situation; unlikely to require immediate action
Health Information: Provides general health information which is not considered to be of emergent nature

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- **Have you contacted your primary care doctor or established primary care with a clinic?**

Clínica Sierra Vista	(559) 457-5800
United Health Centers	1 (800) 492-4227
Valley Health Team	(559) 693-2462
Family Healthcare Network	(866) 342-6012

- **Have you contacted a Fresno County SUD access point?**

24/7 Access Line	(800) 654-3937
Urgent Care Wellness Center	(559) 600-9171
CRMC Bridge Program	(559) 250-4822

Program	Notes
County Access Line: mental health	https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx 24/7 intake line for mental health services
County Access Line: substance use disorders	https://www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx 24/7 intake line for substance use disorder treatment services
Medi-Cal Managed Care Plans	https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx County directory of Medi-Cal managed care plans
Buprenorphine Providers: including telehealth	Buprenorphine is an effective, safe alternative for patients on high-dose opioid medications. While comparable to morphine and oxycodone for pain control, the risk of overdose is a fraction of the risk of other opioids, without many side effects of other opioids. Buprenorphine treatment locator: https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator This CHCF publication lists telehealth providers that offer buprenorphine (some providers offer pain management and addiction treatment; others may only offer addiction treatment). The California Telehealth Resource Center lists telehealth specialty providers.
Emergency Department Bridge Program	Over 200 hospitals have programs in their emergency departments where patients may receive buprenorphine to bridge people to treatment, especially if they come in with withdrawal symptoms https://cabridge.org/impact/mat-sites/ www.cabridge.org
Methadone Maintenance (narcotic treatment program)	California directory of narcotic (opioid) treatment programs: https://dpt2.samhsa.gov/treatment/directory.aspx
Syringe Service Program	California directory: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_sepdirectory.aspx
Naloxone Access Site	Every patient taking opioids in any form on a daily basis, including those prescribed by a doctor, should have naloxone available in case of an overdose. Naloxone (Narcan) nasal spray can be used by family, friends, or a bystander to reverse an overdose and save a life. Naloxone is available on Medi-Cal, insurance plans, and can be available without a prescription.

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Capsule Summary

1. Pain management is determined primarily by whether pain is acute or chronic. Management of chronic pain should be individualized, patient-centered, and based on shared decision making and goals of treatment.
2. Pharmacological treatment of pain should use the lowest effective dosage for pain relief and functional improvement. Both pharmacological and non-pharmacologic treatments have shown to be effective in managing pain.
3. Management of chronic pain is covered by several different guidelines and systematic reviews with varying recommendations based on location and type of chronic pain. For example, this is the AAFP Pain Management Toolkit: https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/cpm-toolkit.pdf
4. Just as primary care providers can care for most patients with diabetes, chronic care providers should be prepared to care for most pain management patients. Primary care providers might also consider referral if a patient has risk factors such as taking >50 morphine equivalents each day, is prescribed multiple psycho-active medications or has a history of substance use disorder, if there are anomalies in their PDMP report or on drug testing, or if there are medico-legal questions related to pain and disability. Contact your patient's health plan to identify pain management specialists in your area.
5. In response to the opioid public health crisis, new guidance recommends non-pharmacologic and non-opioids as first-line therapies, when clinically appropriate. If an opioid is considered for treatment, the lowest effective dosage for pain relief and functional improvement should be used. Using non-opioid alternatives to pain medications is a smart strategy to prevent OUD from developing or worsening in our ED patients.
    a. The ACEP Managing Acute Pain (MAP) page has Dozens of ALTO (Alternatives To Opioids) techniques (also available as a smartphone app): https://www.acep.org/patient-care/map/
    b. the American Academy of Family Practice (AAFP) offers a comprehensive toolkit to help work through primary care workup and management of pain. https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/cpm-toolkit.pdf
6. An alternative to opioids useful both for pain and opioid use disorder is Suboxone. Suboxone (which is now offered in lower-cost generic formulations) contains both buprenorphine and naloxone.
    a. It is taken sublingually. If the patient attempts to reconstitute and then inject suboxone, the naloxone will precipitate sudden withdrawal.
    b. Buprenorphine is a mixed opioid agonist and antagonist, so it is effective in pain management, prevents opioid withdrawal, stops the cravings for opioids, and does not have the psychoactive effects of pure opioid agonists.
    c. Use of suboxone for opioid use disorder is called MAT (Medication Assisted Treatment).

7. Opioid use disorder is a chronic brain illness, characterized by periods of relapse. In this way it parallels many chronic medical conditions (such as epilepsy, hypertension, and COPD). Like these chronic illnesses, daily medications can prevent exacerbations and vastly improve quality of life even if a "cure" is not achieved.
8. Treatment with daily medications like buprenorphine for opioid use disorder is called "medication assisted treatment," or MAT. It is now considered a mainstream, standard of care strategy to initiate MAT in emergency medicine/ primary care settings so patients have immediate access to treatment.
9. Recent change to X-waiver registration will allow more practitioners to offer medication assisted treatment with home use of buprenorphine. This is considered the preferred approach to opioid use disorder for most patients.
    a. X-Waiver rules have changed—a course is no longer required.
    b. All you need is your DEA number, medical license number and 5 minutes.
    c. Once you get approved (can take 2-6 weeks) you will be able to make a profoundly positive impact on patients.
    d. A super helpful step-by-step instructions on how you can get your X-waiver can be found here: https://cabridge.org/resource/how-to-apply-to-get-your-x-waiver/
10. Naloxone/ Narcan saves lives, in the hospital, the ambulance and even in people's homes. Please give at-risk patients and families Narcan intranasal units for home use.
    a. Per California statute, Naloxone should be prescribed, and counselling provided to all patients who receive high doses of opioids or combinations of opioids with sedating medications.
    b. Because fentanyl is now found in every kind of street drug, (meth, cocaine, so-called Xanax, etc.) it is important to instruct and offer Narcan to users of ALL street drugs, regardless of their drug of preference or their motivation to stop using.
    c. A state grant allows clinics to provide free Narcan (intranasal naloxone, which otherwise would cost $150/unit). Please apply so your office or clinic can stock this medication. https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx
    d. CRMC Bridge Program also offers free naloxone from the ED. Call 559-250-4822.

Pain Management

Introduction

Pain management includes medications, restorative therapies such as physical therapy, interventions such as nerve blocks and trigger point injections, behavioral approaches, and complementary and integrative health approaches. A Department of Health and Human Services Pain Management Best Practices Interagency Task Force Report noted, "Because of an inadequate number of specialized pain physicians, PCPs are tasked with managing the majority of patients with painful conditions, often without adequate time and resources." (1)

Medications for Pain Management

This pain management advisory focuses on a primary care approaches to prescribing medications for pain management.

The Task Force notes, "In general, two broad categories of medications are used for pain management: non-opioids and opioid classes of medications. In response to the public health crisis resulting from the current opioid epidemic, there is a surge of interest in non-opioid pharmacotherapies for chronic pain. Non-opioid medications that are commonly used include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), antidepressants (e.g., serotonin-norepinephrine reuptake inhibitors [SNRIs], tricyclic antidepressants [TCAs]), anticonvulsants, musculoskeletal agents, biologics, topical analgesics and anxiolytics."

"Although effective for moderate to severe acute pain, the effectiveness of opioids beyond three months requires more evidence. A recent study demonstrated that treatment with opioids alone was not superior to treatment with trials of various combinations of non-opioid medications for improving pain-related function over 12 months…Opioid medications can be associated with significant side effects, including constipation, sedation, nausea, vomiting, irritability, pruritis, and respiratory depression. Opioid medications can be associated with OUD and can be diverted."

"Buprenorphine, an opioid medication that the FDA has approved for clinical use, is a partial agonist at the mu opioid receptor and therefore has a reduced potential for respiratory depression; it is thus safer than full agonists such as morphine, hydrocodone, and oxycodone. Buprenorphine also acts as an antagonist at the kappa receptor, an effect shown in experimental studies to reduce anxiety, depression, and the unpleasantness of opioid withdrawal. Buprenorphine is widely used and encouraged for treating patients with OUD and is approved for the treatment of pain."

(1) pmtf-final-report-2019-05-23.pdf (hhs.gov) U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html

Chronic Pain

CDC has identified 12 guidelines for prescribing opioids for chronic pain, "nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and review

prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone." (2)

(2) Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *JAMA.* 2016;315(15):1624–1645. doi:10.1001/jama.2016.1464
CDC Guideline for Prescribing Opioids for Chronic Pain

Medication Assisted Treatment for Opioid Use Disorder

Opioid use disorder is a chronic brain illness, characterized by periods of relapse. In this way it parallels many chronic medical conditions (such as epilepsy, hypertension, and COPD). Like these chronic illnesses, daily medications can prevent exacerbations and vastly improve quality of life even if a "cure" is not achieved. Treatment with daily medications for opioid use disorder is called "medication assisted treatment," or MAT. On April 28, 2021, the U.S. Department of Health and Human Services released Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder, which represent a partial rollback of the X-waiver. This change exempts physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives from certification requirements when treating up to 30 patients at one time with buprenorphine (or, in the acute care setting, limiting the number of active brief prescriptions to 30, with the understanding that prescriptions inactivate upon date of expiration).

Importantly, under these new guidelines, the x-waiver training course (which was 8 to 24 hours for prescribers) is no longer mandatory. For those who want to understand OUD treatment more fully, brief trainings and webinars are linked below. Providers can provide care to up to 30 patients at one time after submitting an application designated as a "Notice of Intent" to prescribe buprenorphine for opioid use disorder. In order to prescribe buprenorphine, health care practitioners who are licensed under state law and who are registered with the Drug Enforcement Administration (DEA) must apply for an "X waiver" through SAMHSA, at this website: http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php This online application process takes 5 minutes, and a step-by-step tip sheet is available here: https://cabridge.org/resource/how-to-apply-to-get-your-x-waiver/

Have your DEA and Medical License ready when you register. To apply, providers should check "Other" as under "CERTIFICATION OF QUALIFYING CRITERIA," then enter "practice guidelines" when prompted.

Both HHS and CDC note the advantages of MAT and buprenorphine for chronic pain management particularly when opioid use disorder is present, and the X-waiver allows clinicians to offer this relatively safe treatment regimen to their OUD patients.

For more information, see the FCDPH Opioid Use Disorder Update 637558891237670000 (fresno.ca.us)

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Evaluation of New Chronic Pain Patients

Chronic pain patients should be evaluated as any other patient presenting with a chronic condition. Primary care providers can and should provide the initial evaluation and management for chronic pain patients. Collect a careful pain history including onset, mechanism of injury, radiation, and prior treatments including physical therapy and behavioral interventions. Attempt to obtain information from prior health care providers including prior diagnostic studies, surgeries or recommendations for surgeries, referrals for related specialty care, and work-related restrictions if any. Document a focused physical exam that assesses potential anatomic and physiologic etiologies for the patient's pain, including if there is objective evidence of disease that is severe enough to justify the risks of opioid treatment.

Consider ordering additional laboratory and diagnostic studies in a step-wise fashion if not done previously and if patient is not responding as expected, or if the patients findings suggest a specific etiology that might require specialty evaluation, such as a frozen shoulder or radicular pain in the upper extremities. Routine diagnostic testing should be avoided as up to 50% of asymptomatic patients may have abnormal findings on MRI exams of the lumbo-sacral spine.

If the patient is currently on opioid treatment for chronic pain, the Prescription Drug Monitoring Program (PDMP) should be accessed to verify current opioid use and to assess if opioids are prescribed by multiple clinicians. If opioids are prescribed, the clinician must document that PDMP is reviewed at least every 3 months to verify that opioids are prescribed consistent with the clinician's treatment plan.

Do You Need to Continue Opioid Treatment for Chronic Pain Patients?

Health care providers are not required to continue a treatment regimen for chronic pain, but as with other chronic conditions, health care providers should be cautious in making major adjustments for patients they have less experience treating. If a health care provider is considering removing opioids from a patient's regimen, the health care provider must take special precautions to avoid precipitating withdrawal. For example, a taper for a patient on 4 Norco 10 mg tablets a day might be 3 tabs/day x 1 month then 2 tabs/day x 1 month, then 1 tab/day x 1 month, then 5 mg/day x 1 month then DC. A urine or serum drug test is recommended every 6-12 months for patients on chronic opioid treatment.

An alternative to opioids is suboxone. Suboxone contains both buprenorphine and naloxone. It is taken sublingually. If the patient attempts to reconstitute and then inject suboxone, the naloxone will precipitate sudden withdrawal. Buprenorphine is a mixed opioid agonist and antagonist, so it is effective in pain management, prevents opioid withdrawal, stops the cravings for opioids, and does not have the psychoactive effects of pure opioid agonists. Suboxone comes in a standard 8 mg buprenorphine/2 mg naloxone sublingual tab, that can be cut in quarters of half to facilitate initiation and proper dosage. Most patients require 1-3 sublingual tabs each day that can be taken together once daily. You do not need to taper patients off of buprenorphine, but you can taper and ultimately discontinue with

motivated patients. Tapering is not generally recommended because studies have shown higher rates of opioid-related complications amongst those who stop taking buprenorphine and then revert to using other opioids.

Should I Send Chronic Pain Patients to a Specialist?

Just as primary care providers can care for most patients with diabetes, chronic care providers should be prepared to care for most pain management patients. Similar to other chronic conditions, a primary care provider might refer if the patient's chronic pain is not improving on your treatment regimen, or if you identify an issue that requires specialty care, such as identifying spinal stenosis in an anatomic location that corresponds with the patients pain history. Primary care providers might also consider referral if a patient has risk factors such as taking >50 morphine equivalents each day, is prescribed multiple psycho-active medications or has a history of substance use disorder, if there are anomalies in their PDMP report or on drug testing, or if there are medico-legal questions related to pain and disability. Contact your patient's health plan to identify pain management specialists in your area.

References:

1. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm
2. https://www.aafp.org/family-physician/patient-care/care-resources/pain-management/aafp-chronic-pain-management-toolkit.html
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