Transcript Details
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Chronic Pain Management: The Family Practice Nursing Perspective

Mimi Secor:
Chronic pain costs The United States up to 635-billion dollars per year, which is more than yearly costs for cancer, heart disease, diabetes combined. In a 2012 institute of medicine report, chronic pain affects over 100-million Americans. Hydrocodone is the number one prescribed medication in The United States and pain is the number one diagnosis in primary care. You're listening to Reach MD on iHeart radio, the channel for medical professionals. Welcome. I'm nurse practitioner Mimi Secor your host.

With me to day is Brett Snodgrass, Nurse practitioner who will be discussing management of chronic pain. Ms Snodgrass is a board certified family nurse practitioner specializing in pain management and palliative care. She was the only nurse practitioner member of the Tennessee chronic pain task force charged with developing chronic pain guidelines for the state of Tennessee. She consults, teachers, speaks nationally, including at The American Association of Nurse Practitioners convention this past June and also at the recent American Academy of Pain Conference. She is also known as the NP mom. Brett is an award winning and popular blogger. Welcome Brett to Reach MD.

Brett Snodgrass:
Thank you so much Mimi. It's so nice to be here.

Mimi Secor:
Let's start with the basics. What is chronic pain and how does it differ from acute pain?

Brett Snodgrass:
That's of course the million dollar question. It truly is. Acute pain we all know. Acute pain occurs from an injury, an insult and suddenly you have pain associated with it. The mysterious chronic pain, is by definition pain that lasts greater than three months. So, any type of pain that results in having to be treated for the pain for more than three months is considered chronic pain.

In reality, chronic pain truly is pain that continues after an injury or that insult heals or the patient or the physician or the nurse practitioner, whomever they're seeing, the clinician says, "All right, it looks like you're good to go." And the patient says, "I'm still having pain." That often is what is associated with chronic pain and what we call chronic pain.

Mimi Secor:
Interesting. Why is it Brett that clinicians are so frustrated by patients who have chronic pain?

Brett Snodgrass:
I think part of the frustration comes with...ultimately as clinicians maybe it's a lack of knowledge base around treating chronic pain. The first thing that jumps in our minds is the use of opiates, whereas, there are many other therapies associated and available that you can use with chronic pain.
Of course, other frustrations come along in that you really can't measure chronic pain. There is not a lab test to draw, it's not like a hemoglobin A1C to see how they're doing. So, unfortunately you have to really just establish a rapport with the patines and talk to the patient to understand how they're feeling.

Then of course we do have patients that can be manipulative and that can turn people off and clinicians off to treating patients for chronic pain.

Mimi Secor:
That's another piece of what we have to learn how to deal with as professionals.

Brett Snodgrass:
Absolutely.

Mimi Secor:
What are some of the common myths about treating chronic pain that you encounter Brett?

Brett Snodgrass:
When talking to other clinicians or when teaching, I hear a lot of people say, "Well, they're all addicted. They're all addicted to this medicine and we've got to get them off. There's an addiction problem." While there can be an addiction problem, what we know is that addiction is phycologic. Are our patients tolerant to medicines? Absolutely. Addiction? Not necessarily. So, that can be a huge myth around the chronic pain patient.

Also, I have a lot of patients, and I remember even as a student being taught about chronic pain and I remember the number one thing I was told was, "If you have a patient come in knowing the exact dose of medicine, the exact medication, things along that line, then those people are drug seekers." In reality, I've turned that around and I talk about this anytime I speak, "If you were in chronic pain everyday then yes unfortunately you would know exactly the medication. You would probably know the dose and you would know what made you feel better and what made you able to cope with life, able to have a better quality of life," which is truly our goal in treating chronic pain.

Mimi Secor:
Good point. It sounds like a diabetic. They would know what medicine they're taking and they would know the exact does and the name.

Brett Snodgrass:
Absolutely. No different.

Mimi Secor:
What are some of the challenges though, literally even if you're an expert at this, in treating chronic pain.

Brett Snodgrass:
You truly feel some days like you're not winning the battle. You're truly doing so much legwork. There is a lot of legwork that is associated with treating chronic pain. You have to make certain that your charts are appropriate and your charting is very appropriate. This is no different than other diagnoses, but I think it's very scrutinized in chronic pain. We have to be so careful.

You have to frequently have the patients visit. So, you're seeing one patient more often. That can be a challenge to get them in, just too even get them in for that follow up as well as making certain that urine drug screens are done, making sure that you're checking a controlled substance monitoring database if available in your state. In most states it's now available. Making sure you're reviewing records and staying current with what's going on with the patient. Definitely challenges.

Mimi Secor:
How often are you yourself seeing patients that have chronic pain?

Brett Snodgrass:
Early on, I definitely see these patients monthly and sometimes every two weeks, it simply depends on what's going on with the patient. Then as we get a good treatment regimen, are the patients doing well? They're very functional, I often times will move them back to every two months, but what you have to consider with chronic pain is that you have to go by the rules and regulations of the state. So, sometimes that is mandated by the state. We usually say, "No more than every three months, but I will say I see them more frequently and usually only do a two month or less visit.

Mimi Secor:
Good to know. What are some of the nonopioid therapies that are available for patients suffering from chronic pain? We of course always want to know how affective they are.

Brett Snodgrass:
I love to talk about this part because it truly is, chronic pain the first thing your mind goes to is pain medication and opiates. There are so many things beyond opiates that we can try and we can use that are quite affective.

Physical therapy is one that we often times just dismiss and think, well that's probably not going to help them if they're having that much pain, that's only going to cause more pain. Physical therapy is wonderful. We have music therapy, hypnosis, acupuncture, yoga, exercise...all of those things are very good and truly have research to support the use of them with chronic pain. Then of course there are steps.

So, next a patient might be appropriate for an intervention such as an epidural block, pain stimulators, which are new and on the horizon

and being used more...surgical interventions where appropriate.

Then of course, let's move into what medicines we can use, this side of opiates. I would tell people not to forget about mood modulators, medications like duloxetine work wonderfully in pain management. Also anticonvulsants and then we all know nonsteroidal antiinflammatories where we can use those and then topical formulations have truly been on the horizon. They're getting more and more popular and if it's appropriate and an appropriate place, we can put a topical formulation it's very affective for the treatment of chronic pain.

Mimi Secor:
I know I always took those ThermaCare glue on, stick-on heater packs when I'm traveling because if you get the middle seat on an airplane, boy that can make a difference.

Brett Snodgrass:
Absolutely and it does. Even chronic pain patients often times we discount them and say, "Well, none of that would work because they're in chronic pain." Truly adding some of those things back in does actually help these patients. We can't forget those.

Mimi Secor:
Can that help you reduce the opioid prescriptions?

Brett Snodgrass:
That's always the goal.

Mimi Secor:
So, what about some pearls in prescribing opioids therapies Brett?

Brett Snodgrass:
I'd say my first pearl is definitely for anyone prescribing opiates to definitely, without a doubt, know their state regulations. Know what they can and maybe cannot do, what can and cannot be prescribed, and make certain you are following those. That can be very problematic if you are not. It's just important that you know what state regulations are.

Then I always push home the message of making certain your records reflect why you're prescribing an opiate. We wouldn't prescribe Lantus or Levemir or any other insulin to a patient with diabetes without probably having a hemoglobin A1C on that chart. That's no different for chronic pain.

Make certain there is an appropriate diagnosis and appropriate lab tests or appropriate radiological exams to affirm a diagnosis and to truly support, when you have to, using opiates.

Then also like we've just talked about, make certain that other alternatives are being tried. If they've been tried and failed, that may be appropriate, but make certain your chart reflects that and they have failed these alternatives. Then don't be afraid to refuse opiates if they're not appropriate for a patient.

If there is high risk to those patients and it's in primary care, those people need to be referred out. It's okay to say no, but then on the flipside, if it's appropriate to use an opiate then use an opiate.

Mimi Secor:
Do you get pushback Brett from pharmacists or other healthcare professionals when you're prescribing opioids?

Brett Snodgrass:
Being in my clinic, and I'm just now starting actually a pain clinic, in the state of Tennessee, there is such desperation to get people in to pain clinics and pain offices, that no, they're desperate for my services. But I've definitely heard things over the years.

I think as you become a prescriber, they get to know you, they know your practices, then of course it creates more affirmation for you prescribing those medications. So, maybe in the interim and early on I did receive some backlash from it, but not so much now.

Mimi Secor:
Good to know. Brett, more and more states are adopting guidelines on chronic pain, can you talk about this a little bit?

Brett Snodgrass:
Absolutely. As you talked about in the introduction, I was honored to be the only nurse practitioner on the chronic pain taskforce for the state of Tennessee. We were charged with creating guidelines and we were really following suit with Washington State and Utah. They have some great guidelines out there and we used them when we were developing our own. What I'm seeing is more and more states are going to be coming on board.

We have a problem. We have prescription drug abuse that's prevalent. We have overdose deaths that are on the rise and we have neonatal abstinence syndrome that just is so startling.

So, states are truly finding that they're' going to have to write some guidelines and some type of chronic pain guidelines or ways to guide treatment for patients. We're truly going to see more and more states follow suit over the coming months and years even.

Mimi Secor:
How do primary care clinicians and new nurse practitioners get more training in chronic pain management Brett?

Brett Snodgrass:
What's interesting to note, and this is truly across the board, we've looked at how much education everyone gets, med-school, nurse practitioner, physician assistant, on average we're finding that, throughout an entire curriculum of schooling, the average practitioner is coming out with about six to eight hours of education on chronic pain, which is very small.

Ultimately, it's the number one diagnosis, the number one complaint in primary care. It's the first thing they're truly hit with when they come into a primary care office. When they start working in primary care office, the first thing that a patient is going to complain about is pain.

So, truly there is some ill equipment of being able to treat these patients so, what do we do? I know that schools are looking into this and truly we're backtracking now in trying to create more education.

But I would say that the first thing, conferences are really finding a need and seeing a need American Association of Nurse Practitioners now has a pain track. They see a need. They need to see a need that these nurse practitioners are needing education.

Pain Week is a national pain conference for all disciplines and they just this year, and I'm actually speaking at it, have created their own NP track. So, it's really exciting. They see a need, they see that there is education there.

Then I'd also say, find a mentor and work with them or on the job training, those are very appropriate things and those are very helpful things. Sometimes you just need somebody to talk about something with or run something by somebody.

Then on the horizon, working with some other pain providers, we're talking about maybe actually creating some pain mentoring programs or even boot camps because what I'm hearing is, nurse practitioners truly don't know the nuts and bolts of treating chronic pain.

Mimi Secor:
Great suggestions. You've got plenty to keep you busy for a while there Brett. I'd like to switch gears in the last minute or so that we have, I would love for you to tell us a little bit more about your popular blog, the NP Mom. What are some of your hot topics? What's going on there with that? I love it when I receive it.

Brett Snodgrass:
Thank you so much. NP Mom was kind of created out of a little idea that I had, and the preface behind it is truly answers to questions patients always forget to ask. I know as a mom when I had babies and I would go see the pediatrician or the nurse practitioner whoever we were seeing, I'd leave and even as someone in healthcare, I'd leave and think I didn't ask...whatever. So, it truly evolved out of that.

Then I was able to make it into printable education sheets that anyone can go online and printout and use as reenforcement for their education in the office. There are so many topics. I've blogged on just about everything.

Recently the Ebola outbreak has been a hot topic so of course I had to weigh in on that and then...

Mimi Secor:
Yeah. I love that one.

Brett Snodgrass:
Some very popular ones have been vaccination debates, do we vaccinate? Do we not vaccinate? So, I did one on that.

Then of course, kind of dispelling myths about nurse practitioners, it's a very popular blog.

Then I've talked at length recently on concierge medicine. So, just whatever is going on and then I go as basic as hypertension and how to treat it, how to treat hyperlipidemia naturally.

So, it's definitely been a fun blog, fun to see evolve.

Mimi Secor:

Awesome. Fantastic. Keep up that great work. We love your blog.

Brett Snodgrass:
Good.

Mimi Secor:
We love your blog Brett and we love the work that you're doing. Thank you so much for being my guest today. It has been a pleasure talking with you.

Brett Snodgrass:
Thank you Mimi for having me.

Mimi Secor:
I'm nurse practitioner Mimi Secor and you are listening to Reach MD on iHeart Radio, the channel for medical professionals. Thank you for listening.