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The Consult

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# Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain

This comprehensive guideline provides clinical recommendations for all primary care clinicians for noninvasive treatment of acute, subacute and chronic low back pain in adults. The recommendations include guidance for nonpharmacologic treatments as well as for patients who do not respond to nonpharmacologic treatments. This guideline was developed in 2017 and is a current guide recommended by the Centers for Disease Control (CDC). In conjunction with this guideline, multiple appendixes summarizes findings for all pharmacologic, nonpharmacologic treatments and adverse events for chronic low back pain.

The American College of Physicians (ACP) developed the guideline using the ACP grading system on reviews of controlled trials and published systematic reviews.

This guideline is intended to be a resource for clinical practice. The goal of the guide is to help clinicians provide quality care for people who have chronic low back pain with the use of noninvasive treatment.

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# ADHD Monitoring Guidelines

Family physicians are frequently asked to evaluate and treat children who display attention or hyperactivity problems, for whom a combination of behavioral interventions and medications may be deemed appropriate. Individuals may respond better to one medication over another, and maximum benefit may require dosage titration, making follow up visits imperative.

Because stimulants might produce positive but suboptimal effects at a low dose in some children, the American Academy of Pediatrics (AAP) recommends titration to maximum doses that control symptoms without adverse effects rather than titration strictly on a milligram-per-kilogram basis. To increase compliance with follow up visits, providers should advise parents and children of the need for monitoring at regular intervals to effectively titrate medication doses.

During the initial titration phase, symptoms and side effects are ideally assessed weekly. An in-person visit for follow up assessment is recommended by the fourth week of medication titration to allow clinicians an opportunity to review response to varying doses, monitor adverse effects, track weight, height, heart rate and blood pressure.

With the recent pandemic, follow up assessments using the same timeline can be done either through in-person visits, phone, electronic portals, or other methods that are convenient for the family.

For maximum efficiency with virtual, telehealth or phone visits follow ups, it is suggested the following should be available to the patient at home.

- Bathroom scale to report weight
- Height measurement tool
- Thermometer
- Blood pressure monitor (most blood pressure monitors are relatively inexpensive and give heart rate as well)

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# Center for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain - United States, 2016

This comprehensive guideline was created to improve awareness between clinicians and patients about risks and benefits of opioid use for chronic pain, improve safety and efficacy with use and reduce risk with long term therapy. It provides clinical recommendations for all clinicians in primary care with prescribing opioids for chronic pain not related to cancer treatment, end of life care or palliative care.

Recommendations are addressed to determine the start or continuation of opioids, selection of opioid as well as dosage, duration, follow-up, discontinuation and finally assessing risk and harms with use of opioids. Included with this guideline is a quick reference box with concise information on prescribing opioids for chronic pain.

The CDC developed the guidelines using the GRADE framework and systematic review of scientific evidence from experts, peer reviews, the public and a federally charged advisory

committee. It is intended to be a resource for clinical practice. The goal of the guide is to help clinicians provide quality care for people who have chronic pain requiring the use of opioids.

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# Behavioral Health Committee

Network Health facilitates a Behavioral Health Committee. This committee focuses on access, quality and care coordination. It advocates for services which promote prevention, treatment, recovery and self-determination for members experiencing behavioral health and substance use disorders.

The committee reviews and provides input into policy development, quality indicators and service evaluation. It also serves as resource for the educational needs of providers and Network Health employees.

It is the committee's responsibility to provide a platform for behavioral health providers and advocates to address recommendations, questions and concerns directly with Network Health.

- Identify significant behavioral health integration challenges and recommend timely solutions.
- Identify areas of opportunity regarding member experience, care continuity, access and availability to behavioral health services through committee conversation, annual survey results, member/provider feedback and make recommendations, if applicable.
- Identify and advise on best practices for behavioral health care.
- Reports up to Network Health's Quality Management Committee.

This committee consists of participating providers, community advocates and Network Health clinical and operational leadership and staff. They work together to identify opportunities and barriers, assists in developing interventions to improve the quality of care members/patients receive and the continuity and coordination of care between members' behavioral health specialists and medical practitioners.

The group meets three times a year or more frequently as needed, uses National Committee for Quality Assurance (NCQA) standards and NCQA Healthcare Effectiveness Data and Information Set (HEDIS)measures to help guide this process.

If you are interested in becoming a Behavioral Health Committee member or would like more information on the Behavioral Health Committee, please feel free to reach out to the Quality Health Integration department at mzamost@networkhealth.com

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# Types of Bronchitis, Symptoms and Treatment

Bronchitis is an inflammation of the breathing tubes.  The tubes become swollen and make mucus.  This is what makes you cough. There are two types of bronchitis and each is treated in a different way.

Chronic Bronchitis - a cough with sputum that occurs every day due to exposure from irritants in the air such as pollen, dust or cleaners, smoking or secondhand smoke.

- If symptoms develop it is important to seek medical care as pneumonia is ta  serious risk especially if you have chronic conditions such as COPD, asthma, cystic fibrosis or heart failure.
- Treatment varies but can include antibiotics, steroids, oxygen or a combination of options.

Acute Bronchitis (chest cold) -  usually caused by a virus often following a cold or the flu.

- Avoid antibiotics if no other symptoms because they will not help your symptoms and the side effects outweigh the benefits.
- Home treatment includes rest, Tylenol or ibuprofen for fever, cough or cold medications over the age of 4, avoid smoking, drink plenty of fluids, honey for cough over 1 year old, steam from a shower, saline nasal rinses, clean cool mist humidifier for a stuffy nose.
- Symptoms resolve in a few weeks.

Symptoms for acute or chronic bronchitis include—

- Fatigue
- Cough with or without mucous
- Mild headache or body aches
- Wheezing with breathing or shortness of breath
- Sore throat
- Chest soreness

It’s time to seek medical care for acute or chronic bronchitis when—

- A cold lasts longer then 2-3 weeks
- Fever over 102 degrees F or fever for more than 5 days
- Cough that is bloody
- Mucus color changes
- Wheezing or shortness of breath

Sometime antibiotics may be prescribed if you have been sick for 14-21 days or if you have COPD, asthma, cystic fibrosis or heart failure.  Always take your medication exactly as it has been prescribed.

Bronchitis spreads the same way as a cold, through the air when someone sneezes or coughs. You can also transfer the germs by touching your eyes, nose, or mouth after you touch a contaminated service. Prevention is the best defense. Here are some ways to protect yourself from contracting bronchitis:

- Always get plenty of rest
- Avoid touching your face with dirty hands by washing your hands frequently
- Avoid others who are sick and stay at home if you are sick
- Cover your cough or sneeze with your elbow
- Don't smoke and avoid all forms of smoke and air pollutants
- Stay current with flu and pneumonia vaccines

Antibiotics are great for most infections but not acute bronchitis. By practicing healthy habits, getting your flu shot and following your provider recommendations will help you can have a bronchitis free winter.

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# Screening Needs for Patients Prescribed Antipsychotic Medications

Patients with schizophrenia and affective disorders have 1.5 to two times higher rates of diabetes and obesity when compared with the general population. Obesity, ethnic background, family history and certain medications increase these individual's risk of developing type 2 diabetes[1].

Second generation or "atypical" antipsychotics (SGAs) pose varying risks of metabolic effects, requiring the need to monitor weight, glucose and lipids. clozapine and olanzapine carry a high risk; risperidone and quetiapine carry a moderate risk; and aripiprazole and ziprasidone are associated with lower risk, although their side effects are not yet as well documented as older medications.

Baseline monitoring measures should be obtained before or, as soon as clinically possible after the initiation of any antipsychotic medication.

- Personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease
- Height, weight and BMI calculation
- Fasting plasma glucose
- Fasting lipid profile

Coordination with appropriate health care professionals may include.

- Nutrition and physical activity counseling for overweight or obese patients
- If appropriate, a weight management program addressing psychosocial needs
- Patient, family/caregiver education regarding treatment with SGAs and potential risks

Monitoring recommendations for individuals taking SGAs[2].

| | Weight | Glucose | Lipids |
|---|---|---|---|
| Baseline | X | X | X |
| At four weeks | X | | |
| At eight weeks | X | | |
| At 12 weeks | X | X | X |
| At four months | | X | |
| Quarterly | X | | |
| Annually | | X | |
| Every two - five years | | | X |

More frequent assessment may be warranted based on clinical status.

The HEDIS measure *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* focuses on individuals 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had an annual diabetes screening test (glucose or HbA1c meet requirement).

Please see the HEDIS 101 Guide for further information on this and other HEDIS measures.

[1] Hinds, Coutler, Hudson & Seaton. (2015). *Screening for diabetes in patients receiving second-generation atypical antipsychotics.* American Journal of Health-System Pharmacy. 2015; 72: S70-3.
[2] PL Detail-Document, Comparison of Atypical Antipschotics. Pharmacist's Letter/Prescriber's Letter. October 2012.

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# Controlled Substance Prescribing - Five Years of the Prescription Drug Monitoring Program (ePDMP) in Wisconsin

The **Wisconsin** Enhanced **Prescription Drug Monitoring Program** (ePDMP) is a tool to help combat the prescription drug abuse epidemic in **Wisconsin**. Its use by providers before prescribing a controlled substance became mandatory as of April 1, 2016.

According to the results of a retrospective review of the State of Wisconsin's PDMP database from April 2015 to March 2019, published in Pain Physician in June of 2020. Prior to the enforcement of the state's mandatory PDMP legislation, an average of 844,314 controlled substance prescriptions were written monthly. Following the implementation of the law, the average monthly total prescriptions written within the state decreased to 708,063, representing an average monthly reduction of 16.3% over-all, and a statistically significant reduction in opioid (23.0%) and benzodiazepine (16.3%) subgroups respectively.

While the effectiveness of mandatory use of the PDMP in decreasing the prescribing of controlled substances in the State of Wisconsin is clear and laudable, the results of a study published in Substance Abuse in March of 2021, which looked at data from three states including Wisconsin, found that there can be unintended consequences of state PDMPs, including under-prescribing for pain and physicians declining to see patients who are long term users of opioids.

A number of Network Health members with a controlled substance as one of their chronic medications when they transfer as a new patient to a physician in our network have shared with us their experience of abrupt discontinuation of the controlled substance medication by the new physician with little or no dialog.

We encourage all prescribers to engage in a transparent, non-judgmental dialog with any patient who comes to your practice taking a controlled substance prescribed by a previous provider. Here are steps to follow.

- Explain why the patient will not be able to continue receiving the medication long-term.
- Develop a plan to gradually wean the patient off the medication.
- Recommend and alternative approach to address the issue for which the medication was prescribed.

Thank you for your diligence in assuring that our members with acute and chronic pain receive the best possible care. The Wisconsin Medical Society webinar 'ALTERNATIVES TO OPIOIDS IN TREATING ACUTE AND CHRONIC PAIN', accessible at http://wisam-asam.com/event-4380266, is an excellent resource on this topic.

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