We support the health and well-being of the people living in our communities. Working together, we want to ensure that medical clinicians (physicians, physician assistants, nurse practitioners), other members of clinical care teams (nurses, medical assistants, community health workers, care navigators, BHCs) and others have access to the resources and support necessary to serve our communities, specific to chronic pain management.

**Alert:**

Our region is problem solving through the abrupt closure of Michigan Pain Consultants (MPC) pain management centers (three sites closed on June 13, 2024, Greenville and Holland sites closed on 6/28/2024, Grand Rapids site will close on August 30, 2024). These closures (from the Lake Michigan lakeshore through Grand Rapids, north of Big Rapids and south to Barry County) are resulting in over 50,000 patients scrambling for medical records, medical treatment and transition plans. Many patients are understandably afraid about disruptions in care if they are currently receiving opioids as part of their chronic pain treatment plan.

**Action:**

Given the regional (and national) shortage in pain management specialists, we know that these 50,000 patients cannot simply transfer to another specialty pain center. MPC is focusing its efforts on finding other pain specialists in the region who can receive patients referred for injection therapies and other procedural interventions for pain. Pain specialists in the region are working hard to receive and prioritize referrals, and rapidly expand their capacity to serve more patients. But this will take several months to achieve.

Approximately 8000 MPC patients are on medication therapy for their chronic pain. **There are not enough pain specialists in the region to assume management of this influx of patients for several months, and perhaps never. Therefore, primary care medical clinicians (PCPs) will inherit these patients – and their pain management plan.** PCPs must courageously step into this vacuum and serve our patients in our communities. While we all may not feel “comfortable” with the pain management plans our patients arrive with, we can rapidly gain competence to welcome, support and holistically manage these patients.

Please remember:

* + - * When patients suddenly lose access to their healthcare provider, they may feel they have no other options but to turn to other sources (including street drugs) to avoid withdrawal. As we (PCPs) receive and serve MPC patients, we will save lives.
      * We can “assume good intent” of MPC clinicians and their patient treatment plans.
      * We can verify patients’ prescribing history via the Michigan Automated Prescription System (MAPS). This collects information on all filled prescriptions for controlled substances and is a useful tool for medical clinicians to view a patient’s prescribing history in order to make informed clinical decisions.
      * Patients may not have access to their medical records; we may not have access to MPC records, but we have MAPS, the patient interview, and our internal clinical team.
      * Physical dependence alone does not constitute a substance use disorder.

As MPC patients seek medical management for their pain in primary care spaces, apply these best practices:

1. Continue opioid therapy for patients in transition.
2. Develop a patient-centered, individualized care plan.
3. Use caution when tapering opioid therapy.
4. Document patient care decisions.
5. Prescribe buprenorphine when appropriate.
6. ***Continue Opioid Therapy for Patients in Transition:*** In following CDC clinical guidelines for safe opioid prescribing, medical clinicians are encouraged to consider providing opioids to patients during transitions to avoid dangerous disruptions in care. While many medical clinicians may not have chosen to start opioids for a given chronic pain condition, stopping opioid therapy is different due to the physiological changes brought on by long-term opioid therapy. Stopping opioid therapy has been shown to increase illicit opioid use, emergency medical care utilization, mental health crises, medically attended overdose events, and death from overdose and suicide. It may be necessary and medically appropriate to continue opioid therapy, particularly if a patient will have a prolonged wait to see a pain management specialist. Whenever possible, discuss the patient’s history with their former medical clinician, complete baseline assessments of pain, review expectations for opioid prescribing, and start discussing treatment for opioid use disorder (OUD) if appropriate.
7. ***Develop a Patient-Centered, Individualized Care Plan:*** Develop an individualized plan in collaboration with the patient for continuing opioid therapy, tapering down or off of opioid therapy, or transitioning to buprenorphine to manage chronic pain. Engage the patient and include discussions around social issues and support, mental health services, alternative pain management strategies, and overdose risk. Consider the patient’s perceived risks and benefits of opioid therapy.

* Determine if the patient’s current treatment is still providing a clinical benefit. If not, consider an individualized tapering plan to reduce their symptoms of withdrawal.
* Providers may consider a benzodiazepine dose reduction plan or plan for treatment of benzodiazepine withdrawal.
* If new patients do not have naloxone already, consider co-prescribing naloxone to reduce the risk of opioid overdose death.
* Assess for Opioid Use Disorder (OUD) and collaborate with behavioral health clinicians and available resources.

1. ***Use Caution when Tapering Opioid Therapy:*** Medical clinicians should not abruptly discontinue or rapidly taper opioids in a patient who is physically dependent on opioid therapies. Safe tapers may take months to years to accomplish. Ensure patients understand the risks and benefits of dose maintenance versus dose tapering. Work with the patient to identify which medications to taper and how fast.
2. ***Document Patient Care Decisions:*** In investigations of medical clinicians around opioid prescribing where sanctions were levied, a majority of the time insufficient documentation violations were found.

Document the rationale for continuing or modifying a patient’s opioid therapy. Include descriptions of pain conditions, previous and current therapy, assessment of risk and evidence of OUD, and opioid stewardship measures. Comprehensive documentation benefits both the patient and the medical clinician and team.

1. ***Prescribe Buprenorphine when Appropriate:*** Buprenorphine has been shown to be a highly safe and effective treatment for pain management and OUD and is FDA-approved for both conditions. Buprenorphine reduces craving, withdrawal, and overdose risk, has low potential for misuse and diversion, and increases retention in care. Buprenorphine for pain has proven to be an effective and safe alternative for patients dependent on long-term opioid agonists. No additional DEA licensing (“X waiver”) is needed for medical clinicians to prescribe buprenorphine.

This fact sheet was adapted from: State of California—Health and Human Services Agency California Department of Public Health Newsletter of 9/7/2021. TOMÁS J. ARAGÓN, MD, DrPH*Director and State Public Health Officer*

**Support and Resources:**

* <https://www.youtube.com/watch?v=WTwZ76oPT3w> 6-minute video, Primer on Inheriting Patients on Opioids
* [Inheriting Patients on Opioids | CIAO (ciaosf.org)](https://www.ciaosf.org/inheriting-patients-on-opioids) – 63 minute video, and other resources in their toolkit contents.
* <https://www.cdc.gov/overdose-prevention/hcp/toolkits/2022-clinical-practice-guideline-partner-toolkit.html>
* FQHCs can also request technical assistance from [HRSA’s Bureau of Primary Healthcare](https://bphc.hrsa.gov/technical-assistance) and their Primary Care Association.
* <https://www.cdc.gov/overdose-prevention/hcp/trainings/tapering.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf>
* <https://www.scopeofpain.org/> Safe Competent Opioid Prescribing Education. Vast resources, and free CME.