Overcoming Barriers to Expanded Use of Non-Opioid Therapies to Manage Persistent Pain

CENTRAL OREGON AND GORGE SUMMIT TO REDUCE RX ABUSE

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REDMOND, OR
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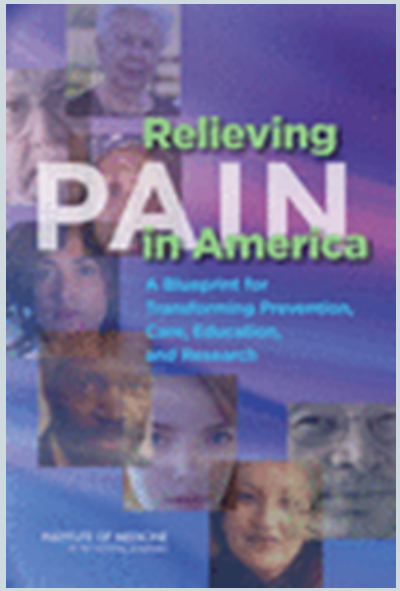
pra Progressive Rehabilitation Associates

Institute of Medicine Report 2011:

A cultural transformation in pain prevention, care, education and research

Chronic pain costs the nation up to $635 billion each year in medical treatment and lost productivity. *The 2010 Patient Protection and Affordable Care Act* required the Department of Health and Human Services (HHS) to enlist the IOM in examining pain as a public health problem.



In this report, the IOM offers a blueprint for action in transforming prevention, care, education, and research, with the goal of providing relief for people with pain in America.

In 1998 Federation of State Medical Boards issued new guidelines saying opioids could be essential for tx of chronic pain

VA 1999 and JCAHO 2000 pushed pain as the 5th vital sign

Regulators, doctors and patients misled into believing opioids safe and less addictive than other drugs

Now an average of 46 Americans die every day from prescription opioid overdoses and heroin deaths have more than doubled to 8,000 a year since 2010

Recently JAMA found a 19% decline in opioid prescriptions

Opiates, Mental Health and Chronic Disability

Interagency Guidelines on Prescribing Opioids for Pain 2015

- Little evidence to support long term efficacy of chronic opioid analgesic therapy (COAT) in improving function and pain
- Opioids have a short term analgesic effect and pain relief of about 30% State of the Art Review: Opioids for Low Back Pain, Deyo, Von Korff, Duhrkoop. BMJ 2015; 350:g6380
- Patients who use opioids for at least 90 days were greater than 60% more likely to be on chronic opioids in 5 years
- Overdose risk doubles at doses between 20-49 MED and increases 9x at doses of 100mg/day MED
- Adults with a history of depression, alcohol or other non-opioid substance use disorders are 3-5x more likely to receive COAT (Cicero, Wong, Tian, Lynskey, Todorov, Isenberg, 2009)
- Patients with substance use and /or psychiatric disorders are more likely to have complications from opioid use, misuse, abuse or overdose (Martin, Fan, Edlund, Devries, Braden, Sullivan, 2011)

New Draft Guidelines by the Centers for Disease Control and Prevention, September 2015

- National prescribing guidelines being proposed
- Precaution when increase opiates to 50 MSEQ
- Avoid increasing dosage >90 MSEQ
- Prescribe up to 3 days of opioids for acute flare up
- Consider co-prescribing nalaxone with risk factors
- Avoid prescribing opiates and benzos concurrently

2 Excellent Resources in Oregon

The Oregon Pain Guidance Group
http://www.southernoregonopioidmanagement.org

Oregon Pain Guidance (OPG) is a group of healthcare providers from Jackson and Josephine Counties in Southern Oregon, who are working together on standardizing community guidelines and best practices for treating patients with chronic pain.

Central Oregon Pain Guide 2015
http://www.copainguide.org/

Central Oregon PAIN GUIDE

Central Oregon resource on complex chronic non-cancer pain guidance to support healthcare professionals, patients and families

Oregon campaign to reduce dependence on and deaths from prescription opiates has many pieces Patient Education: Patient beliefs and expectations about LBP have a significant impact on outcomes

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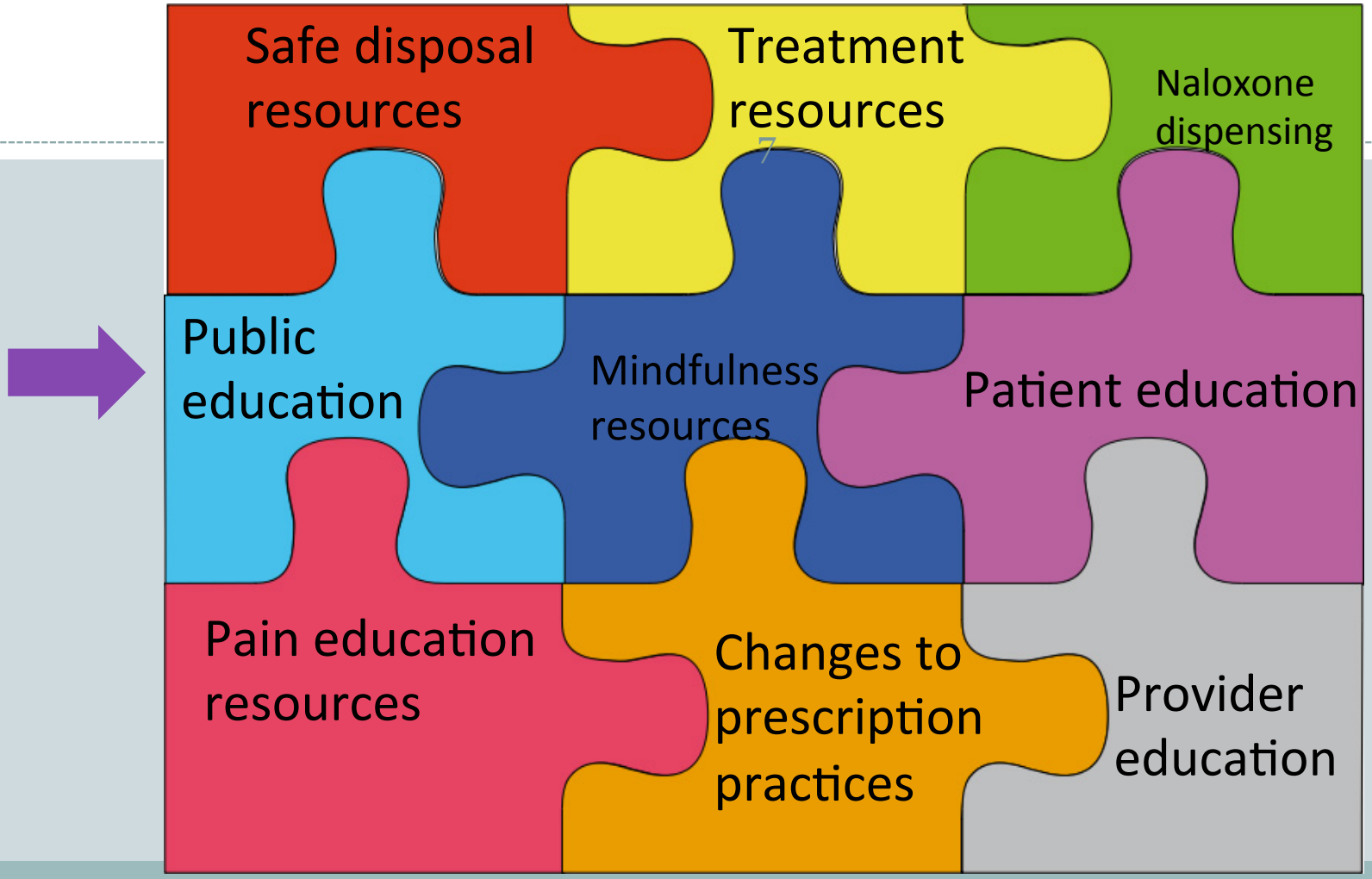
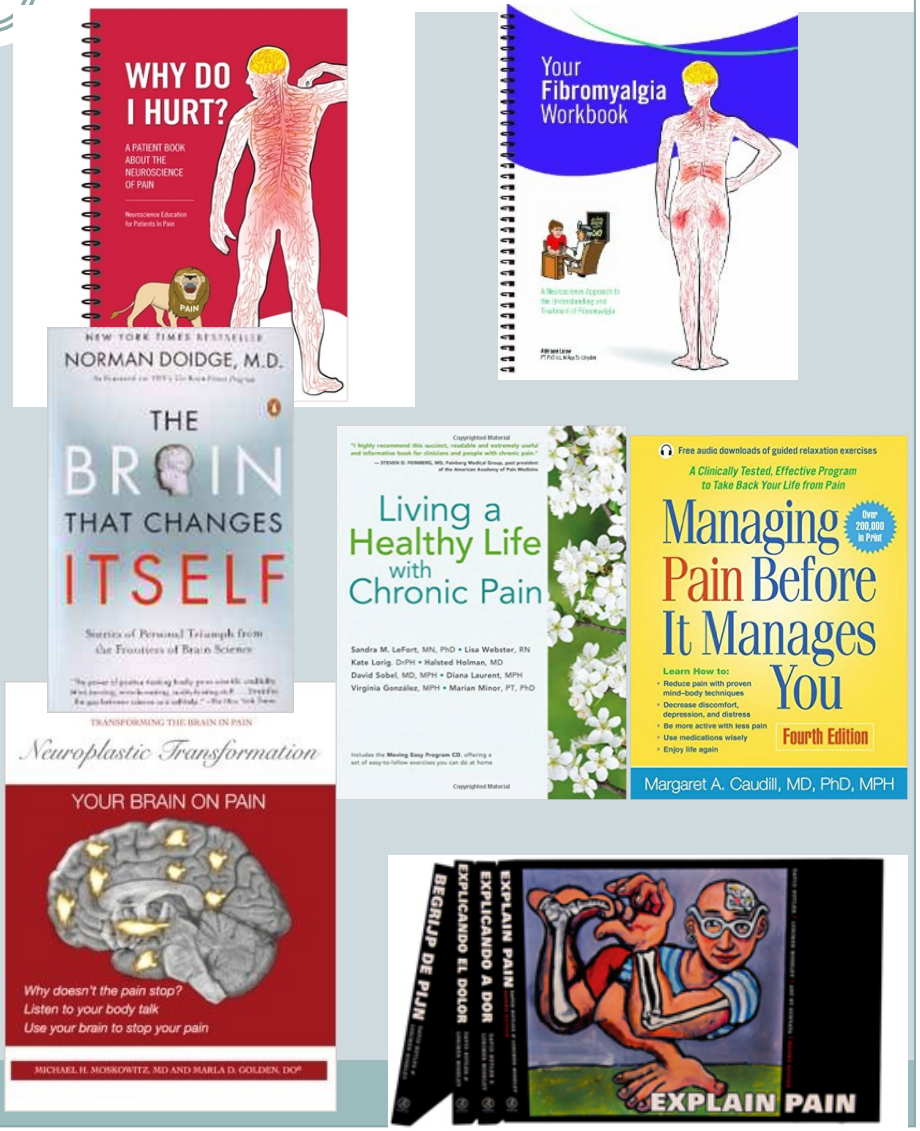


The Effect of Neuroscience Education on Pain, Disability, Anxiety, and Stress in Chronic Musculoskeletal Pain

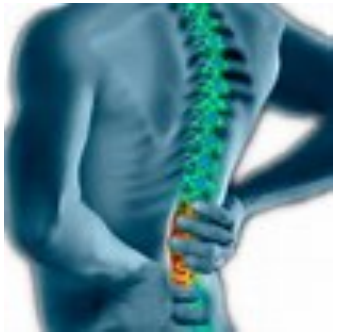
Adriaan Louw, PT, MAppSc, Ina Diener, PT, PhD, David S. Butler, PT, EdD, Emilio J. Puentedura, PT, DPT

Arch Phys Med Rehabil Vol 92, December 2011

- Conclusions: For chronic MSK pain disorders, there is compelling evidence that an educational strategy addressing neurophysiology and neurobiology of pain can have a positive effect on pain, disability, catastrophizing, and physical performance.



Pain = *an unpleasant sensory and emotional experience associated with actual or potential tissue damage (International Association for the Study of Pain)*



Acute Phase (< 2 weeks)

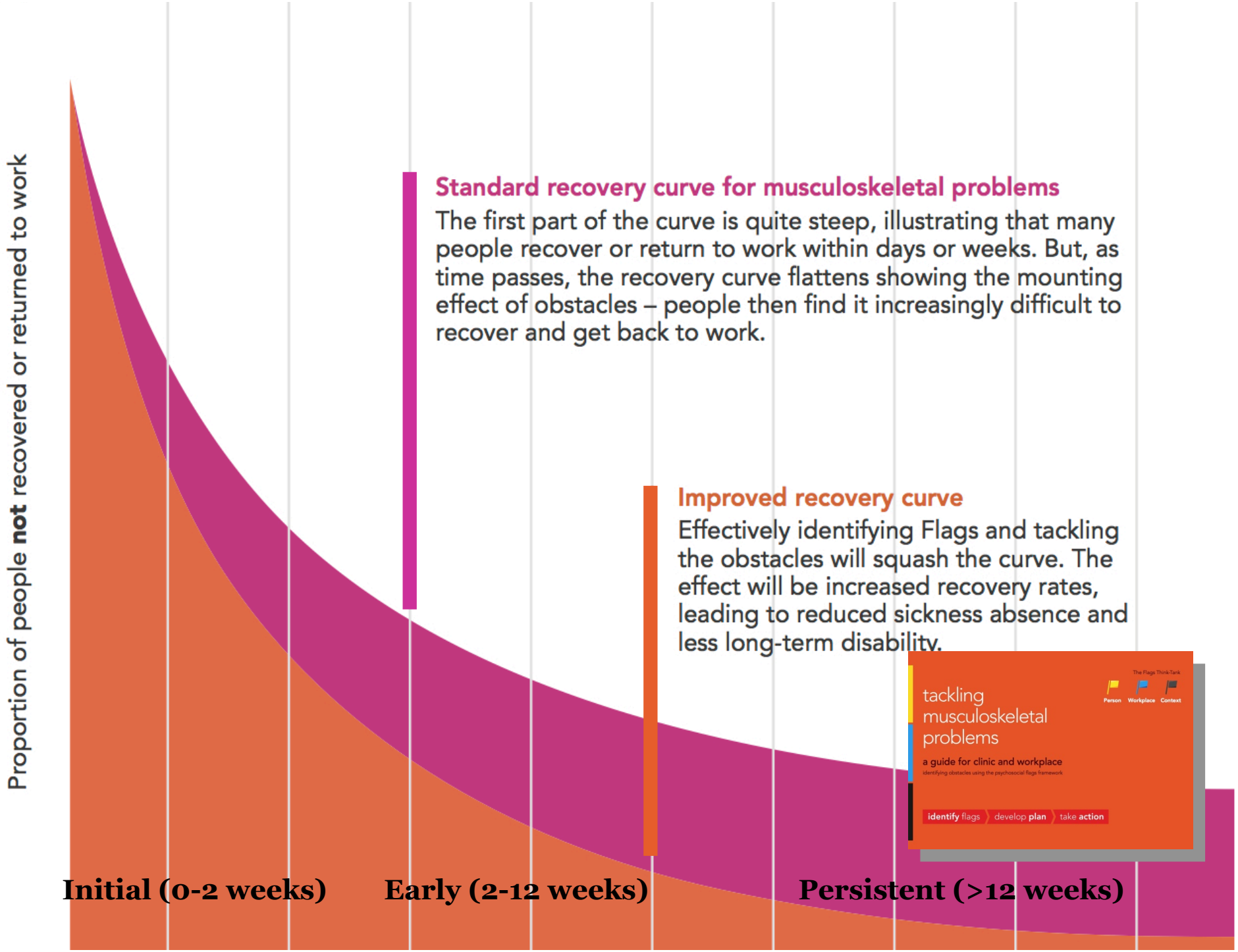
symptom relief, maintain activity, provide support
high proportion return to activity and work

Sub-acute (2-12 weeks)

develop plan for RTW/activity, healthcare and workplace accommodation, identify psychosocial obstacles, cease ineffective healthcare
optimal time to prevent the development of long term consequences including work loss

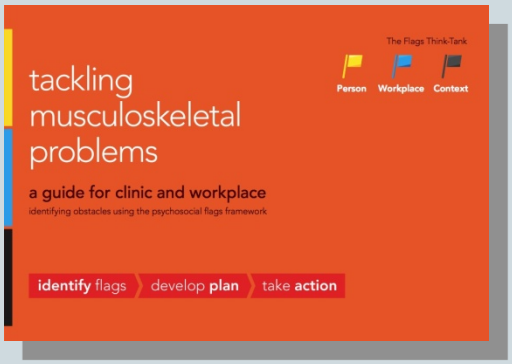
Chronic (> 12 weeks)

multidisciplinary approach, cognitive behavioral techniques, consider shifting goals, max RTW/activities
requires more resources and more difficult to achieve.


Proportion of people **not** recovered or returned to work
Standard recovery curve for musculoskeletal problems
The first part of the curve is quite steep, illustrating that many people recover or return to work within days or weeks. But, as time passes, the recovery curve flattens showing the mounting effect of obstacles – people then find it increasingly difficult to recover and get back to work.
Improved recovery curve
Effectively identifying Flags and tackling the obstacles will squash the curve. The effect will be increased recovery rates, leading to reduced sickness absence and less long-term disability.
tackling musculoskeletal problems
a guide for clinic and workplace
identifying obstacles using the psychosocial flags framework
The Flags Think-Tank
Person
Workplace
Context
identify flags
develop plan
take action
Initial (0-2 weeks)
Early (2-12 weeks)
Persistent (>12 weeks)

Red Flags Predicting Disability: A Biopsychosocial Approach

1. Catastrophizing
2. Fear of movement or re-injury
3. Expectations
4. Preoccupation with health
5. Worry and distress
6. Depression
7. Uncertainty
8. Extreme symptom report
9. Passive coping strategies
10. Serial ineffective therapy

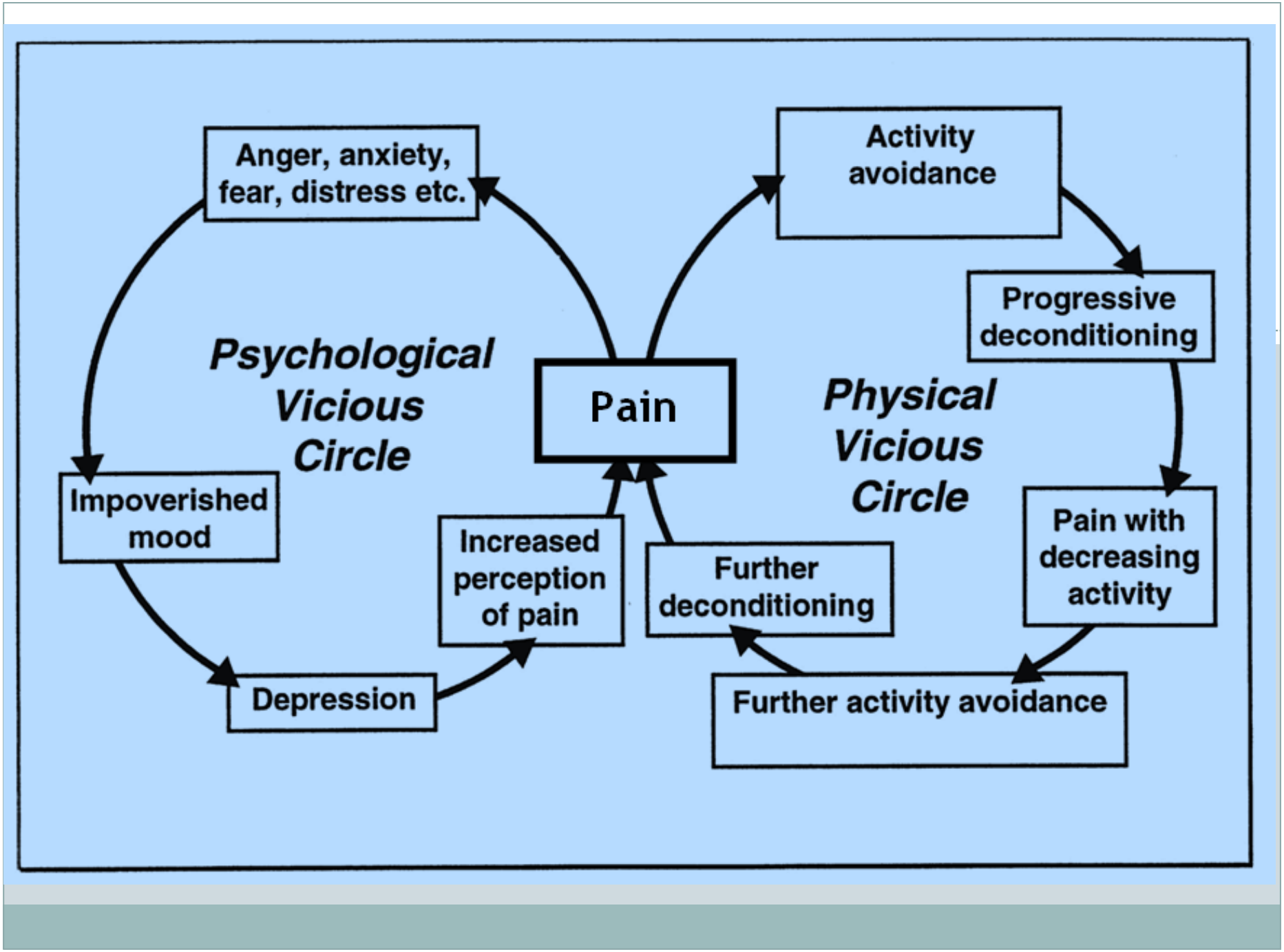


Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

Predictors of Persistent Disabling LBP

- Maladaptive pain coping behaviors
  - Fear avoidance (avoiding movement, activities)
  - Catastrophizing (excessive negative thoughts)
- Nonorganic signs (somatic focus)
- Functional impairment
- Low general health status
- Presence of psychiatric co-morbidities

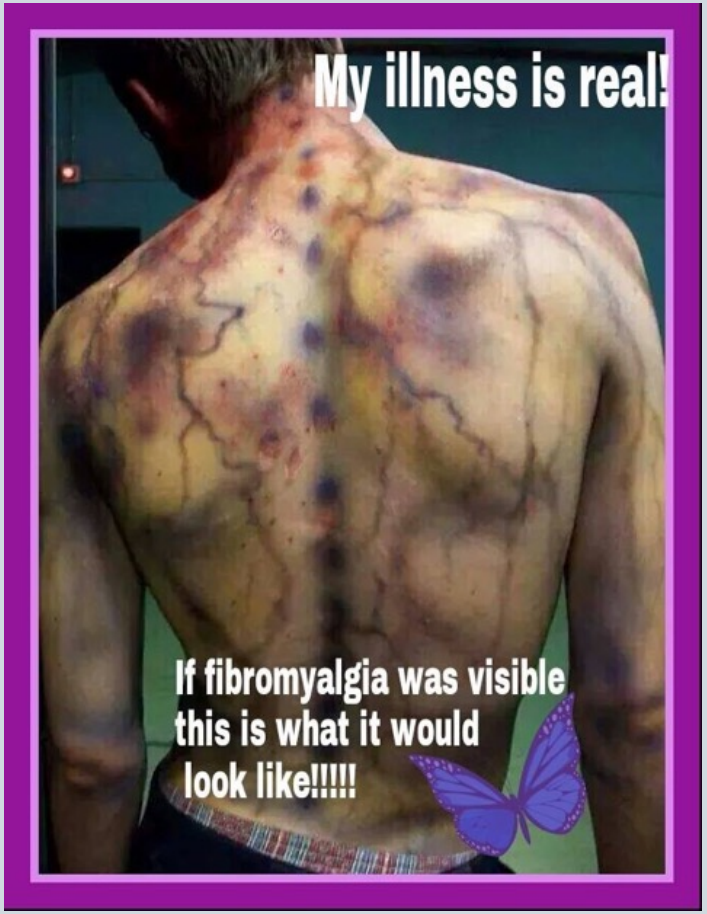
Chou, R., & Shekelle, P. Will This Patient Develop Persistent Disabling Low Back Pain? JAMA. April 7, 2010; Vol 303, No. 13, 1295-1302


Anger, anxiety, fear, distress etc.
Activity avoidance
Progressive deconditioning
Psychological Vicious Circle
Pain
Physical Vicious Circle
Impoverished mood
Increased perception of pain
Further deconditioning
Pain with decreasing activity
Depression
Further activity avoidance

Central Sensitization

- Centralization implies that peripheral nociceptive input might be responsible for some of a patient's pain but central nervous system factors likely amplify the pain. Volume control is set by levels of neurotransmitters.

- Central factors may result in fatigue, memory problems and sleep and mood disturbances probably because the same neurotransmitters that control pain and sensory sensitivity also control sleep, mood, memory and alertness (Phillips, Clauw. Arthritis Rheum. 2013;65(2):291-302).



Clauw, D.J. JAMA, April 16, 2014, Vol 311, No 15

"And with 10 being the highest, you're sure you're only at a 6?"

PEG – validated 3 item tool to assess pain intensity, interference with enjoyment of life and interference with general activity (Krebs, 2009)

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Interagency Guidelines on Prescribing Opioids for Pain 2015

Evidence Based Treatment for Chronic Pain

- Chronic pain self-management programs reduce the physical and psychosocial burden of chronic pain and reduce health care costs (Mann, Lefort, Vanderkerkhof, 2013)
- Evidence supports multimodal therapies to improve pain and function and reduce disability (Turk, 2002) (Gatchel, Okifuji, 2006)
- Multidisciplinary pain programs have strong clinical efficacy, cost-efficiency, and have been proven to improve function. Programs address the psychosocial and cognitive aspects along with physical rehabilitation.

Interagency Guidelines on Prescribing Opioids for Pain 2015

Expected Outcomes for Integrated Pain Care

- INCREASE FUNCTION and activity level
- Reduce pain
- Simplify medication / reduce opioids
- Graded physical exercise
- Reduce emotional distress, such as depression and anxiety (CBT)
- Increase self-management / coping skills
- Increase quality of life
- Teach self-regulation of psychophysical arousal
- Decrease inappropriate health care utilization
- RTW or meaningful activity

Non-pharmacological Options for Pain Management

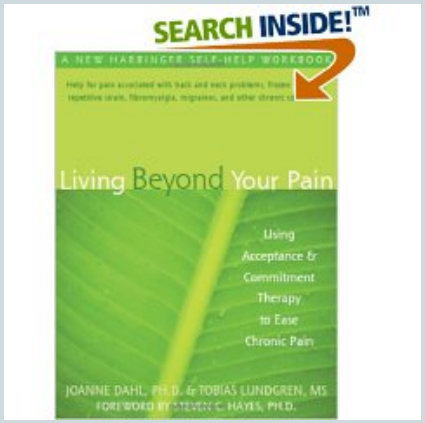
Interagency Guidelines on Prescribing Opioids for Pain 2015

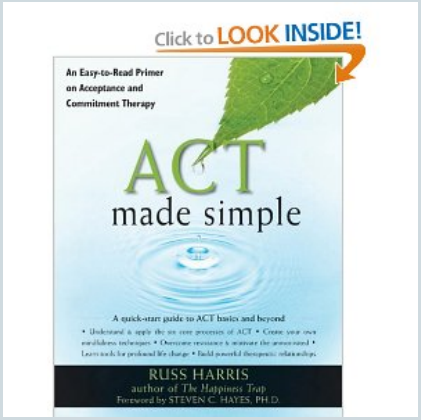
	Adapted from Argoff, 2009 & Tauben, 2015
Cognitive	Address distressing negative cognitions and beliefs, catastrophizing (pain coping characterized by excessively negative thoughts and statements about the future)
Behavioral Approaches	Mindfulness, meditation, yoga, relaxation, biofeedback
Physical	Activity coaching, graded exercise
Spiritual	Identify existential distress, seek meaning and purpose in life
Education (patient and caregivers)	Promote patient efforts aimed at increased functional capabilities

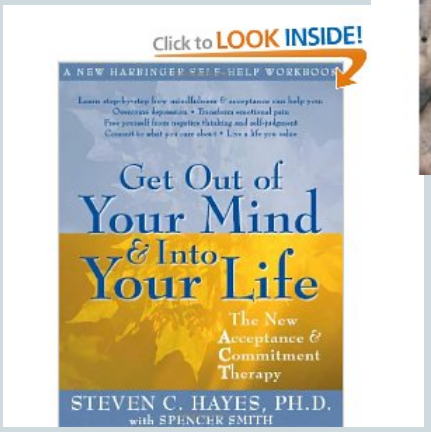
Self-Management Tools

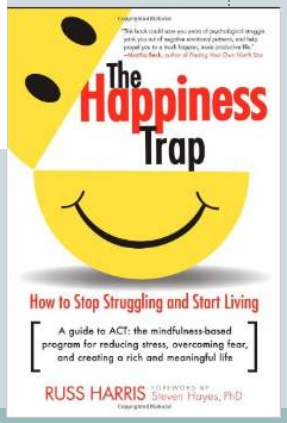
Common Cognitive Distortions to Address in Therapy	Cognitive Behavioral Therapy 
Catastrophizing	Magnifying the negative and anticipating the worst case scenario for events and experiences. "If my pain continues like this I'll end up in a wheelchair."
Selective Abstraction (Black and White thinking)	Attending to negative aspects of experiences and disqualifying the positive aspects. "If I can't keep up with my friends when we shop, then there is not pain in going with them."
"Should" statements	Expectations (often unrealistic) about what one should or must be able to accomplish. "I should be able to clean the house like I did before."
Overgeneralizing	Assuming that the outcome of one event inevitably applies to other or future events. "My pain always ruins my plans." "I'll never have a normal life again."

Acceptance & Commitment Therapy

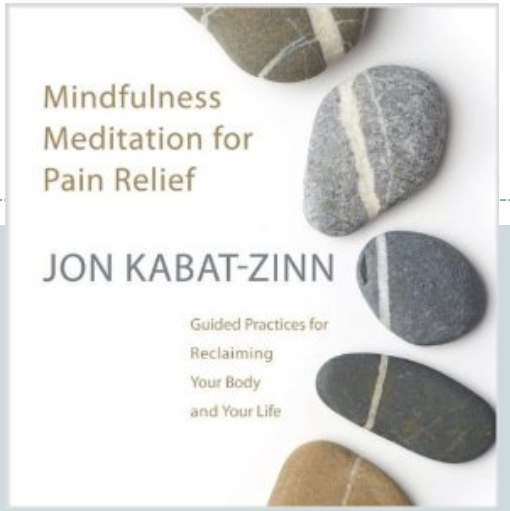




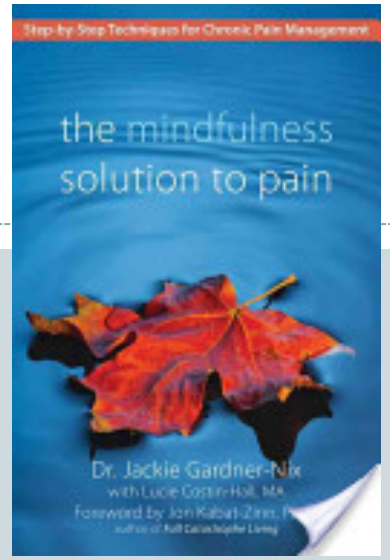




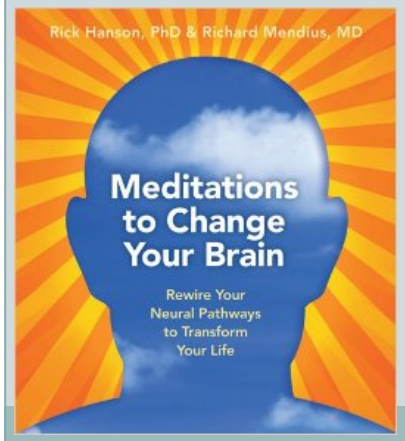
Goal of ACT is to help you live a rich, full, and meaningful life while effectively handling the pain that inevitably comes your way.



Mindfulness

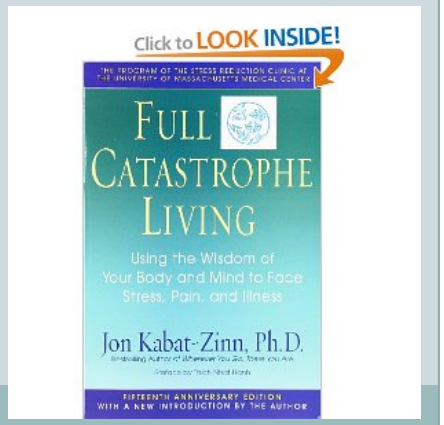


Mindfulness means paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally.



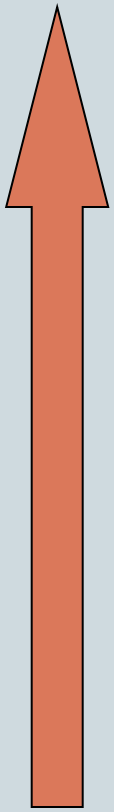
Jon Kabat-Zinn

From Segal, Williams, and Teasdale (2002)



Hierarchy of Pain Treatment Developed by WHO (2006)

finish



start

Nerve ablation
Implanted pumps
Spinal stimulation
Surgery
Behavioral treatments
Nerve blocks and other injections
Narcotics and other oral analgesics
Muscle relaxants
Physical and occupational therapy,
Chiropractic, Acupuncture
Non-steroidal anti-inflammatories
Over-the-counter medications

ABC's of Pain Relief and Treatment: Advances, Breakthroughs, and Choices. Dr. Tim Sams (2006)

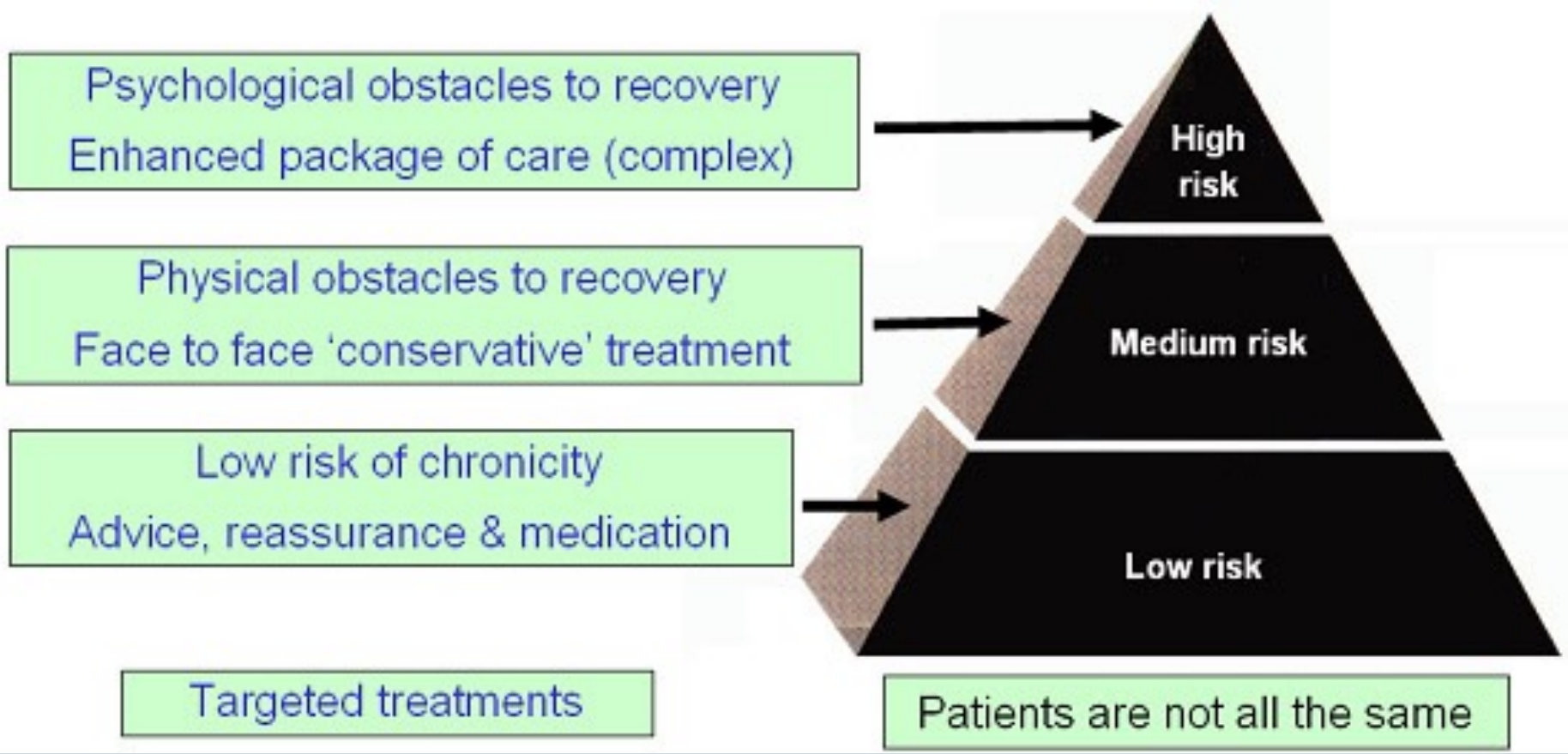
* Starting January 1, 2016 the Oregon Health Plan will begin providing reimbursement for alternative pain care for LBP *

http://www.oregon.gov/oha/herc/FactSheet/Back-policy-changes-fact-sheet.pdf

- Comprehensive integrated tx focused on the biopsychosocial needs of patient
- Added evidence based tx: Cognitive behavioral therapy, physical therapy, chiropractic manipulation, osteopathic manipulation, acupuncture, yoga
- Restricts or eliminates ineffective or harmful tx: long term opioid prescribing, unnecessary intervention
- Focus is to include medical, cognitive-behavioral, and psychoeducational interventions to increase function and quality of life
- Programs should address:
  - Managing comorbid conditions (sleep, PTSD…)
  - Fear and exercise avoidance, catastrophizing
  - Teach self-management skills (gentle exercise, relaxation, mindfulness)

LBP Patients Will Be Triaged Based on Biopsychosocial Issues Using the STarT Back Screening Tool

www.keele.ac.uk/sbst/downloadthetool/ or www.keele.ac.uk/sbst/onlinetool/



From the Bree Collaborative 2013

Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomized controlled trial

Lancet 2011; 378: 1560-71

- Compared the clinical effectiveness and cost-effectiveness of stratified primary care (intervention) with non-stratified current best practice (control)
- 851 patients were assigned to intervention (n=568) and control groups (n=283).
- Mean changes in the Roland Morris Disability Questionnaire were significantly higher in the intervention group at 4 months
- Stratified care was associated with a mean increase in generic health benefit and cost savings compared with the control group

The Oregon Pain Management Commission

- *The mission of the Commission is to improve pain management in the State of Oregon through education, development of pain management recommendations, development of a multi-discipline pain management practice program for providers, research, policy analysis and model projects.*

- <u>Goals for 2015:</u>

- Revise the 1 hour required pain management web-based module
- Review pain education curriculum for schools
- Provider survey to identify barriers to care for patients with pain
- Plan pain awareness event or drug take back event
- Review the delivery system models of care as relates to changes in healthcare and integration of pain tx into primary care

Upcoming PSO Meetings in Central Oregon

pain society of OREGON

- The Pain Society of Oregon offers CME credits for activities that advance healthcare professionals' understanding of and competency in treating pain

- Monthly meetings in Eugene, Portland, Central Oregon
- The Efficacy & Benefits of a Pilates-Based Approach in Physical Therapy For The Treatment of Low Back Pain
- October 22, 2015
- Erin Novelli, MPT

- Pain Standards Task Force Community-Wide Initiatives for Safe Prescribing
- November 19, 2015
- Kimberly Swanson, Ph.D

Worthwhile Resources for Providers and Patients

YouTube Videos on pain:

- Understanding Pain: What to do about it in less than 5 Minutes
- Brainman Chooses
- Brainman Stops His Opioids
- Back Pain by Mike Evans
- TED talk by Lorimer Moseley – Why Things Hurt
- Dan Clauw from UM – Chronic Pain – Is It All in Their Head (central sensitization)

Smart phone apps: IREHAB Back Pain, My Pain Diary, or Pain Free Back for the iphone

Exercise programs on YouTube from Bree Collaborative:
Exercises for lower back http://www.youtube.com/watch?v=u_alXoZ4774
Low back pain remedy stretching exercises http://www.youtube.com/watch?v=019f62bu364
Top 5 stretches to relieve low back pain http://www.youtube.com/watch?v=XNN3K2qj_LO
Yoga for back pain http://www.youtube.com/watch?v=aSthNvRxvaE

- Pain Society of Oregon
  - 541-345-7300 or 503-804-3072
  - www.painsociety.com
- Western Pain Society
  - 541-345-7300
  - admin@painsociety.com
  - www.ampainsoc.org/societies/wps/
- American Pain Society
  - http://www.ampainsoc.org/

Take Home Points

- Treatment and reimbursement for chronic pain is changing
- Screen for biopsychosocial issues
- Earlier intervention to other disciplines that provide evidence based/ outcomes oriented tx
- Know your community resources

- Catriona Buist, Psy.D.
- 503-292-0765
- Cat@progrehab.com
- Www.progrehab.com

pra Progressive Rehabilitation Associates