



SAMHSA-HRSA Center for Integrated Health Solutions

Treatment of Chronic Pain: Our Approach

**Today's webinar was coordinated by the National Association of
Community Health Centers, a partner with the SAMHSA-HRSA Center for
Integrated Health Solutions**



SAMHSA Initiatives

Chronic pain is a major challenge for clinicians as well as for the individuals who suffer from it. SAMHSA is dedicated to reducing prescription drug misuse and abuse including efforts to:

- Educate current and future prescribers regarding appropriate prescribing practices for pain and other medications subject to abuse and misuse.
- Educate the public about the appropriate use of opioid pain medications, and encourage the safe and consistent collection and disposal of unused prescription drugs

Additional resources are posted on the SAMHSA-HRSA Center for Integrated Health Solutions website including SAMHSA's new

- TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, and
- An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence



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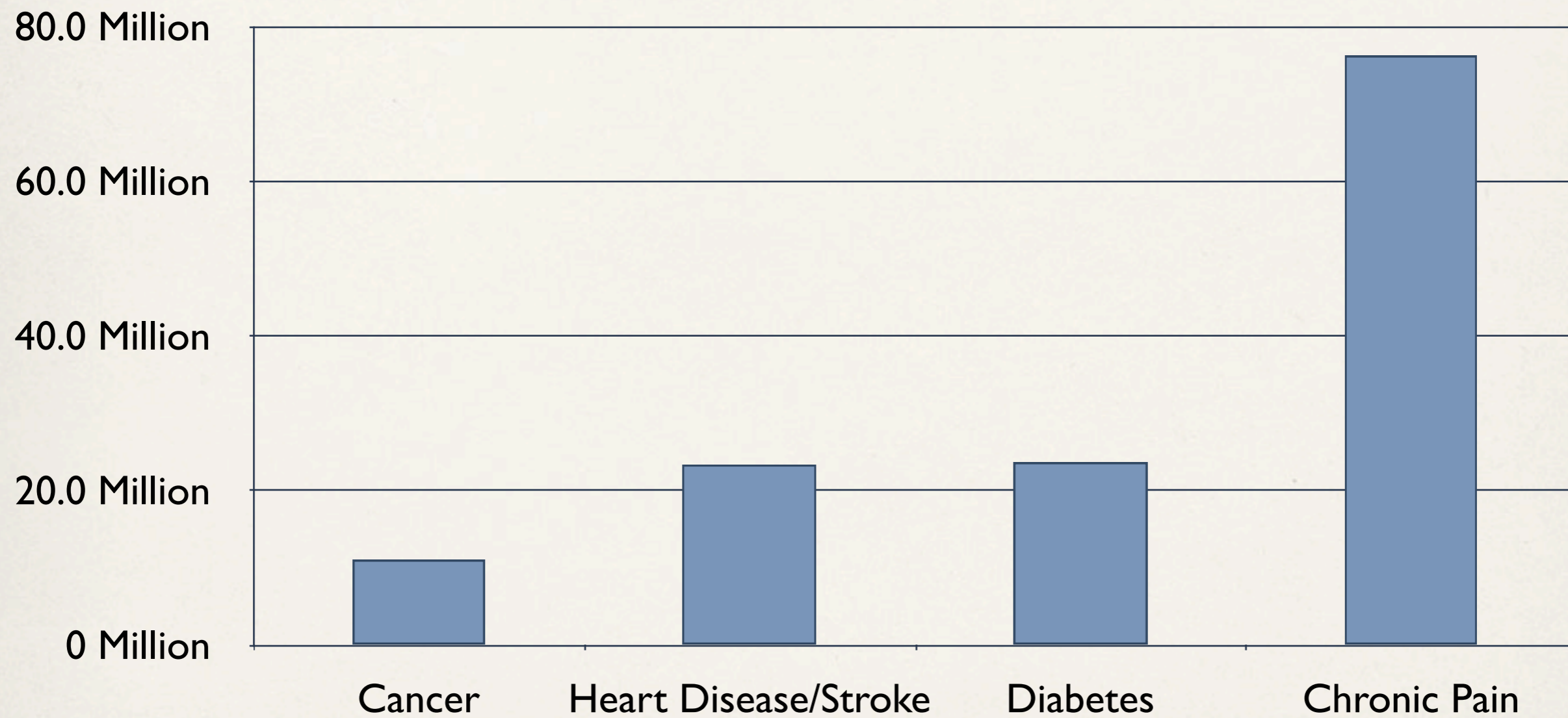


Pain

- ❖ The most common reason people go to the doctor



Chronic Pain



■ Patients

Pain

- ❖ A sensory and emotional experience associated with actual or potential tissue damage

Primary Care and Pain Treatment

- ❖ Frustration level
 - ❖ Patient pressure
 - ❖ Hospital pressure
 - ❖ No consensus on how to treat pain
 - ❖ Lack of education on how to treat pain

Obstacles to Treatment of Pain

- ❖ Disparities
- ❖ Disjointed, uncoordinated care
- ❖ Lack of consensus on how to treat pain

Obstacles to Treatment of Pain

Healthcare Professional Barriers	<ul style="list-style-type: none">• Inadequate knowledge• Inaccurate evaluation of pain• Legal issues for controlled substances	<ul style="list-style-type: none">• Concerns about addiction• Fears of respiratory depression• Pharmacologic tolerance• Pain management is a low priority
Patient Barriers	<ul style="list-style-type: none">• Underreporting pain• Fears that disease is worsening• Shifts focus from disease	<ul style="list-style-type: none">• Fears of addiction• Considered an “addict”• Poor compliance
Healthcare System Barriers	<ul style="list-style-type: none">• Inadequate reimbursement for healthcare center and/or patient	<ul style="list-style-type: none">• Regulatory requirements• Restricted availability of CDs from pharmacy• Pain management is a low priority

Obstacles to Treatment of Pain

- ❖ The experience of pain often carries a stigma within the health care system
 - ❖ Prevents early and aggressive intervention that could prevent chronic problems

Obstacles to Treatment of Pain

- ❖ Limited access to pain specialists
- ❖ Chronic pain treated in the ER
- ❖ Wrong medications to treat chronic conditions

Treatment of Pain

- ❖ Inappropriate care
- ❖ Unnecessary procedures
- ❖ Inappropriate prescribing
- ❖ Surge in prescription drug abuse

Treatment of Pain

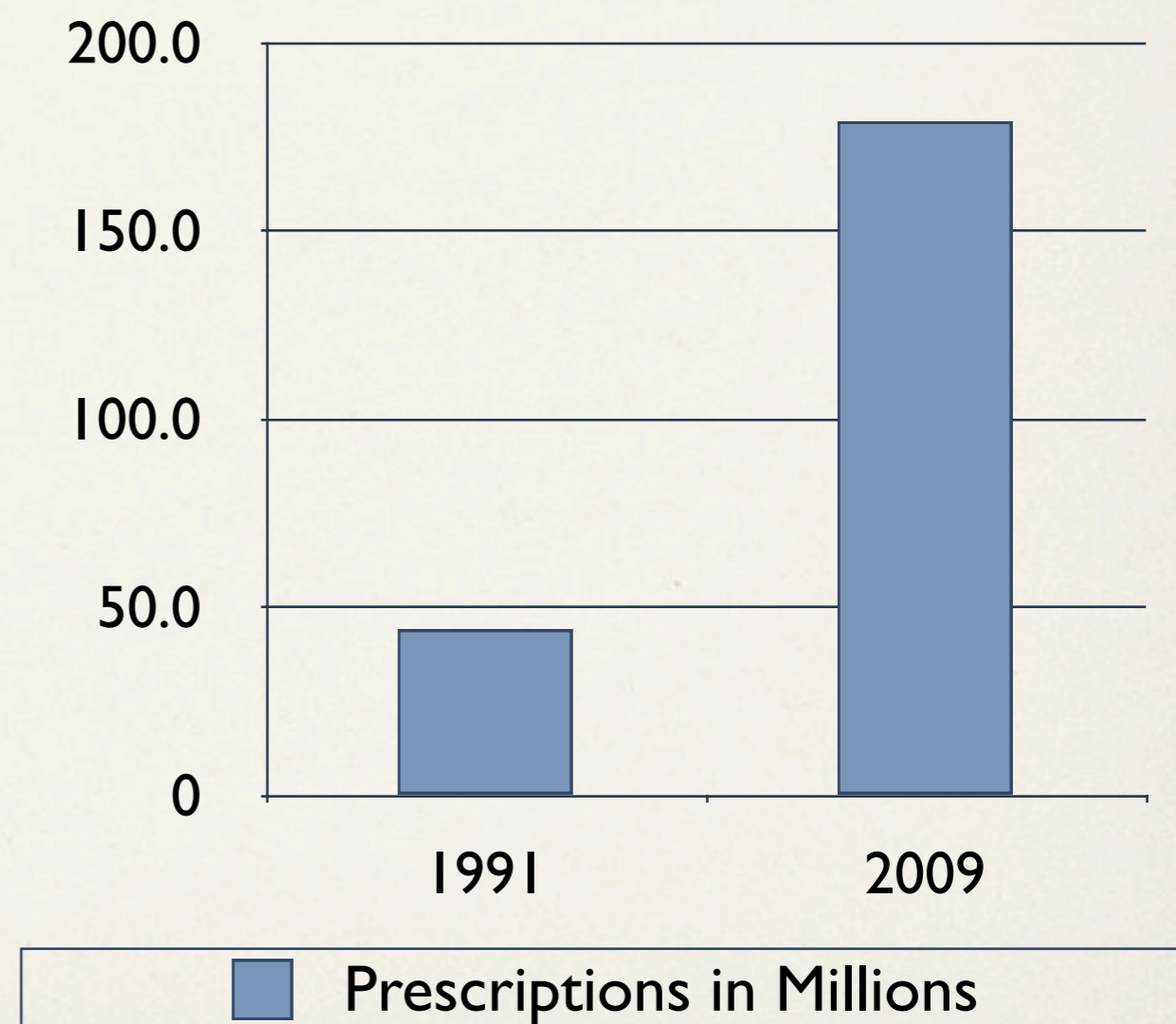
- ❖ Patients and physicians are conditioned that something can always be done

Treatment of Pain

- ❖ 220% increase in spinal fusion surgery between 1990 and 2000 for low back pain
- ❖ No clear indications
- ❖ No proof of efficacy

Treatment of Pain

- * Numbers of prescriptions of hydrocodone and oxycodone products filled in US pharmacies rose significantly from 1991 to 2009



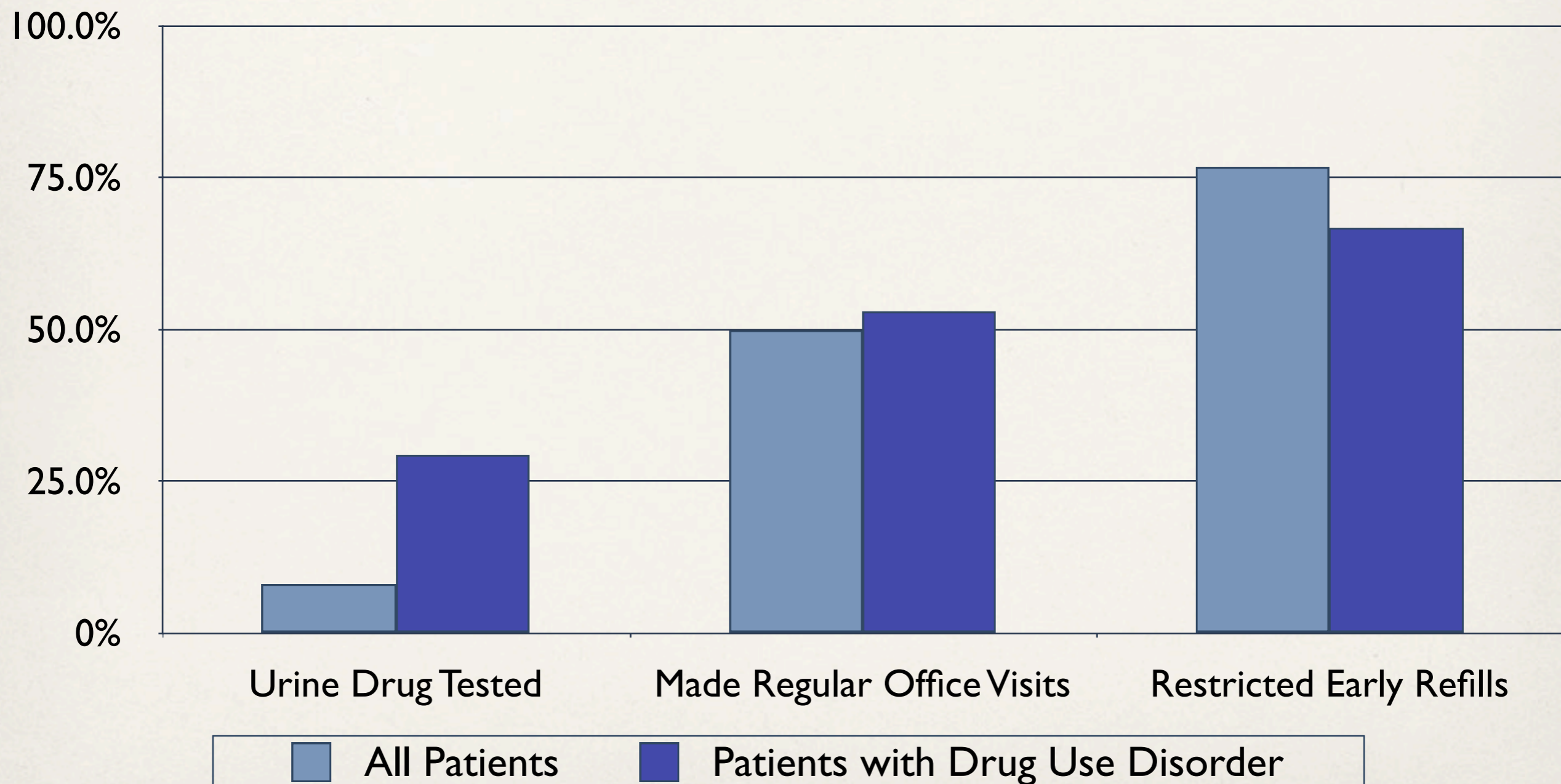
Opioids and Chronic Pain

- ❖ Not always the right answer for every patient
- ❖ Pain is not like appendicitis or hypertension
- ❖ Opioids are not without risk

Opioids and Chronic Pain

- ❖ Deaths from prescription narcotics now exceeds deaths from automobile accidents

Risky Opioids, Little Oversight



Treatment of Pain

- ❖ Important to reframe the issue of pain treatment
- ❖ Treatment of pain does not always equal prescription for opioids

Patient-Centered Pain Care

- ❖ Comprehensive and interdisciplinary approaches are the most effective way to treat pain
- ❖ A cultural transformation is needed to better prevent, assess, treat, and understand pain

Patient-Centered Pain Care

- ❖ A Biopsychosocial perspective
- ❖ “Patient-as-a-person”
- ❖ Sharing power and responsibility
- ❖ A “therapeutic alliance”
- ❖ “Doctor-as-a-person”

Patient-Centered Pain Care

- ❖ Pain is a chronic disease and should be treated as such
- ❖ Every patient should expect to have pain managed in a manner that translates the best evidence into appropriate treatments

Patient-Centered Pain Care

- ❖ Patients in pain should have access to a physician trained to evaluate and treat chronic pain
 - ❖ Patients who have not responded to the best practices in primary care
 - ❖ Patients needing sophisticated and / or complex treatment

Patient-Centered Pain Care

- ❖ Measurements
 - ❖ Self-reporting
 - ❖ History and physical examination

Patient-Centered Pain Care

- ❖ Team Approach
- ❖ Primary Care + Pain Specialist + Behavioral Health Specialist
- ❖ Communication among providers

Primary Care Physician

- ❖ Essential to coordinate care
- ❖ Treat underlying medical problems
- ❖ Healthy patients = easier to treat chronic pain

Co-morbidities and Chronic Pain

- ❖ Anxiety
- ❖ Depression
- ❖ Poor cognition
- ❖ Sleep disorders
- ❖ Cardiovascular disease
- ❖ Sexual dysfunction

Patient-Centered Pain Care

- ❖ Oswestry Disability Score
- ❖ Any previously performed diagnostic tests
- ❖ D.I.R.E Score
 - ❖ Diagnosis+Intractability+Risk+Efficacy

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R = Total of P + C + R + S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical copper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

___ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a candidate for long-term opioid analgesia

Multi-Disciplinary Approach

- ❖ Pharmacological
- ❖ Interventional
- ❖ Behavioral

Pharmacological

- ❖ Anti-inflammatory
- ❖ Anti-depressants
- ❖ Neuroleptics
- ❖ Opioids

Pharmacological



"Take two tons of aspirin
and call me in the morning."

- ❖ More is not always better

Pharmacological

- ❖ Regular assessment and documentation of the benefits of opioid therapy
 - ❖ There needs to be clear long term benefits

Pharmacological

- ❖ Frequent and regular office visits
 - ❖ Urine drug screens
 - ❖ No early refills
 - ❖ No over-the-phone prescribing

Pharmacological

- ❖ Re-attempt to treat underlying conditions
 - ❖ Underlying psychological issues
 - ❖ New physical problem

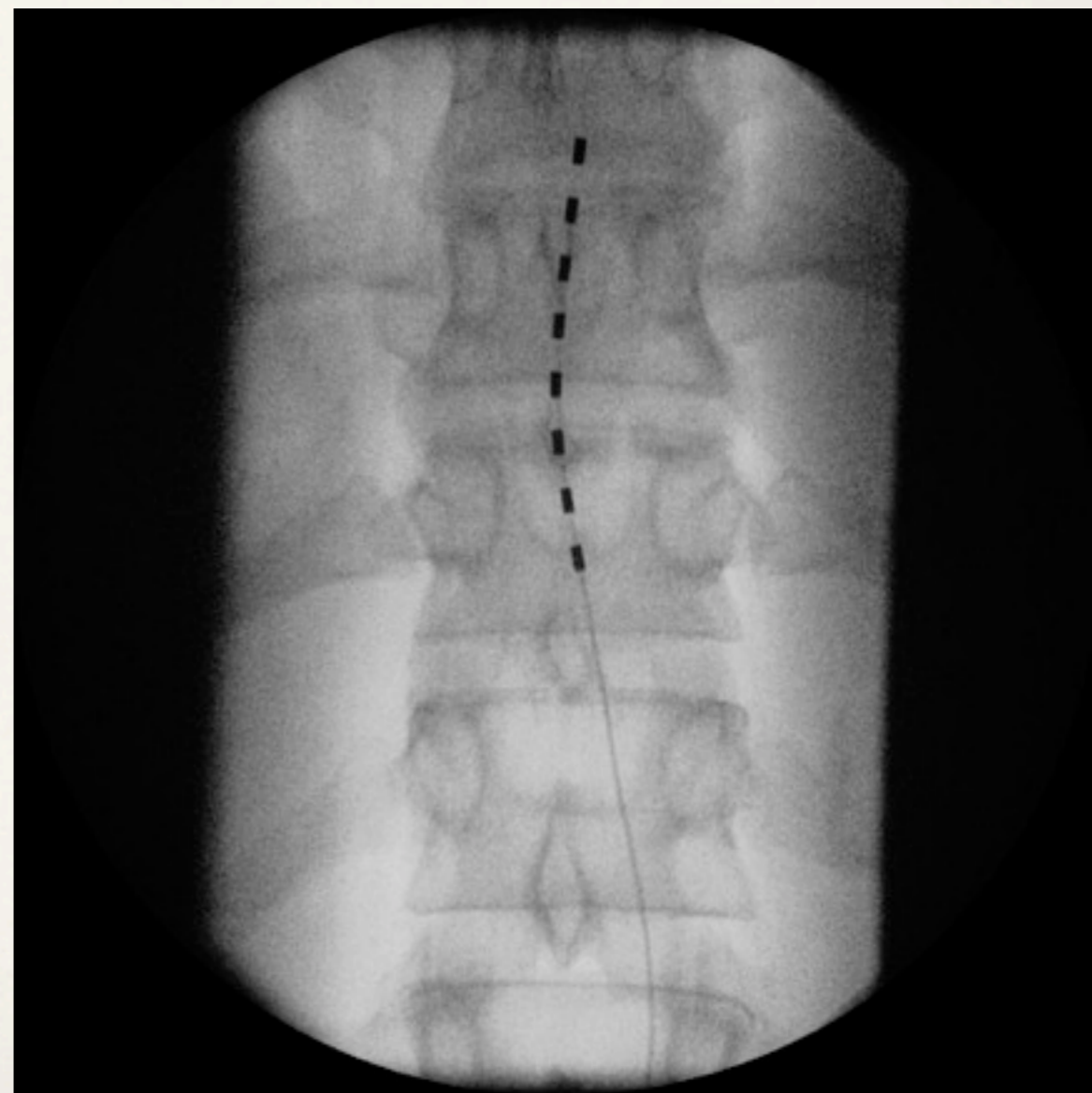
Pharmacological

- ❖ Long-acting vs. short-acting opioids

Interventional

- ❖ Exercise and / or physical therapy
- ❖ Pain relieving procedures
- ❖ Implantable devices
- ❖ Sensory nerve ablation

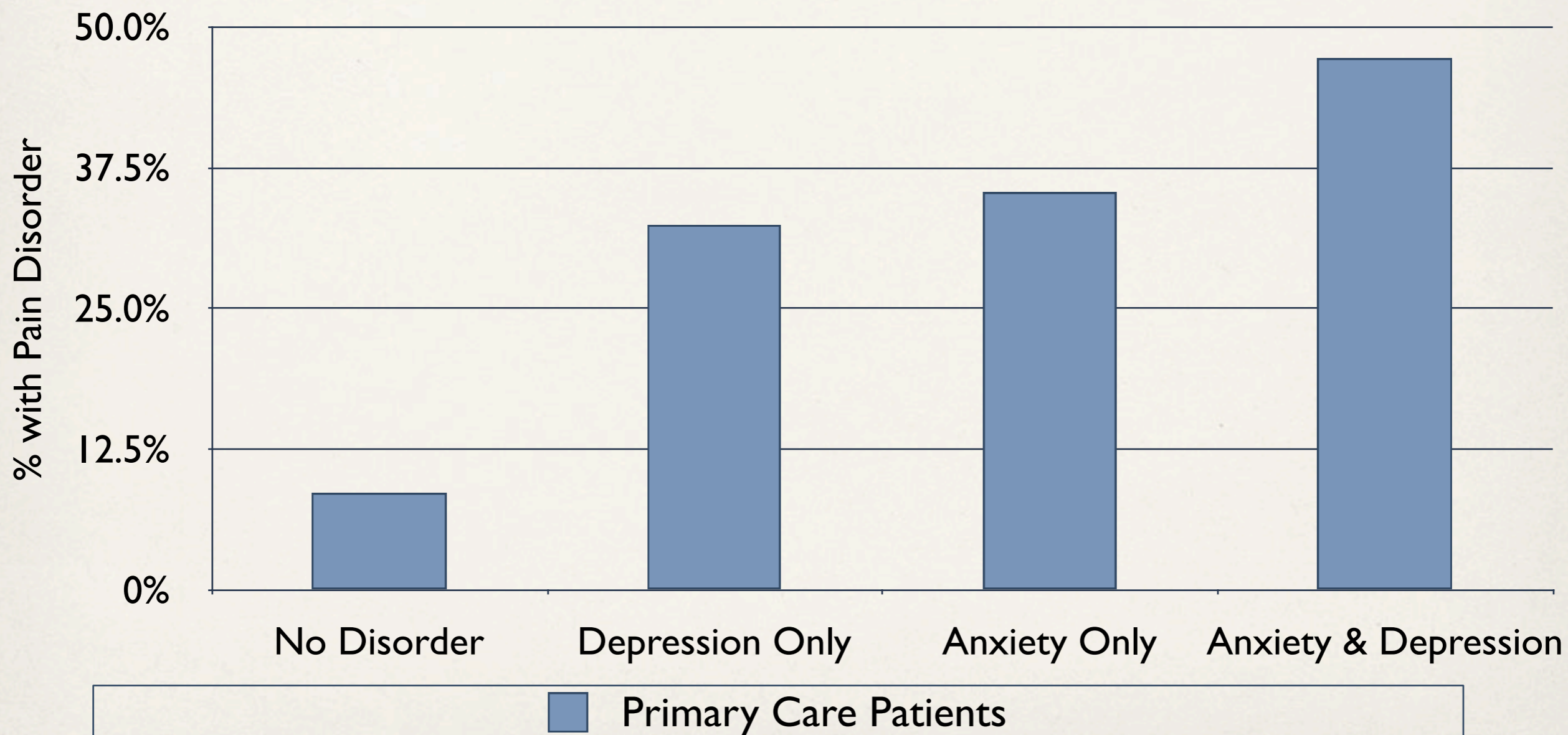
Interventional



Behavioral

- ❖ Life-style adjustments
- ❖ Counseling
 - ❖ Discuss with behavioral health specialist

Behavioral

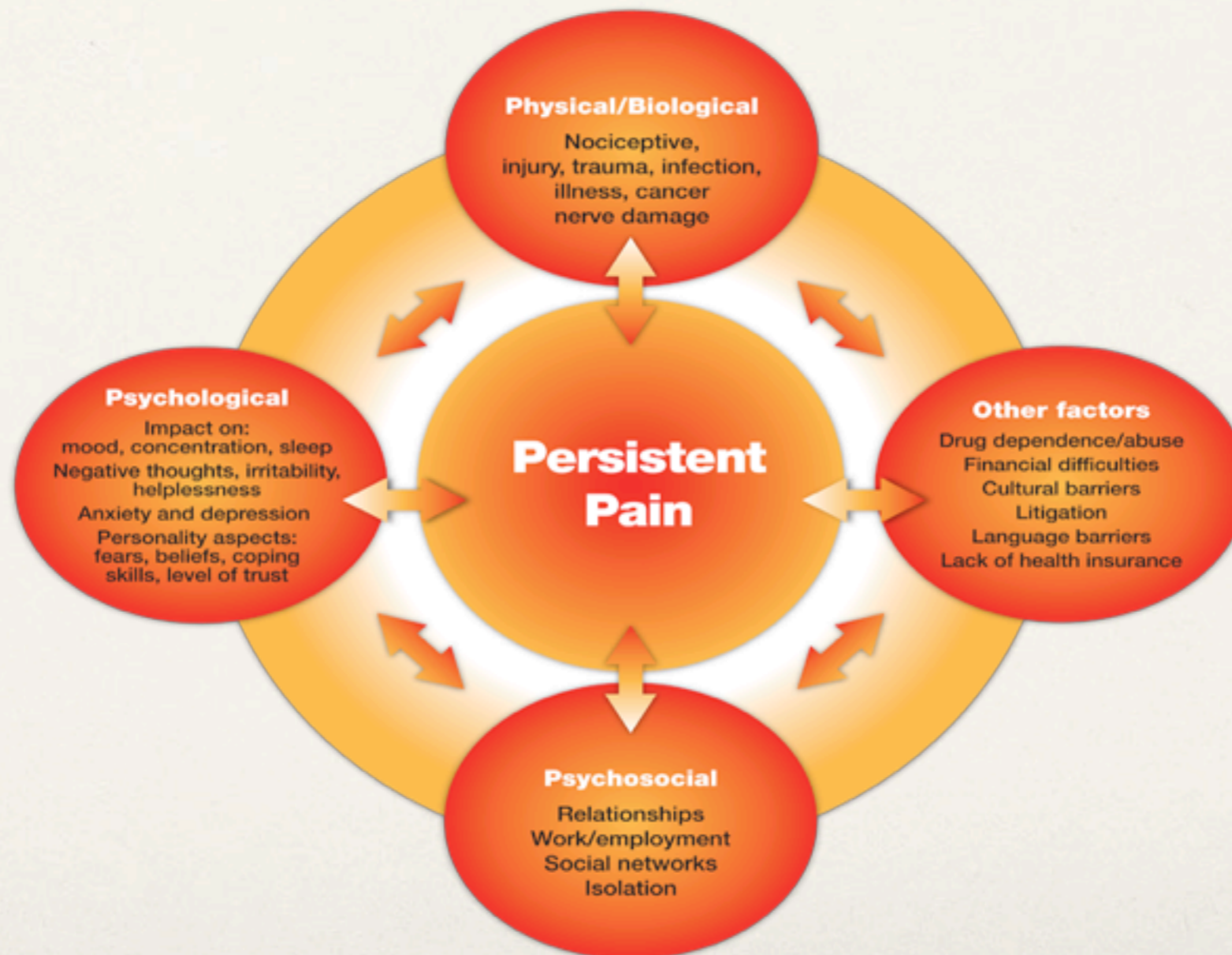


Behavioral

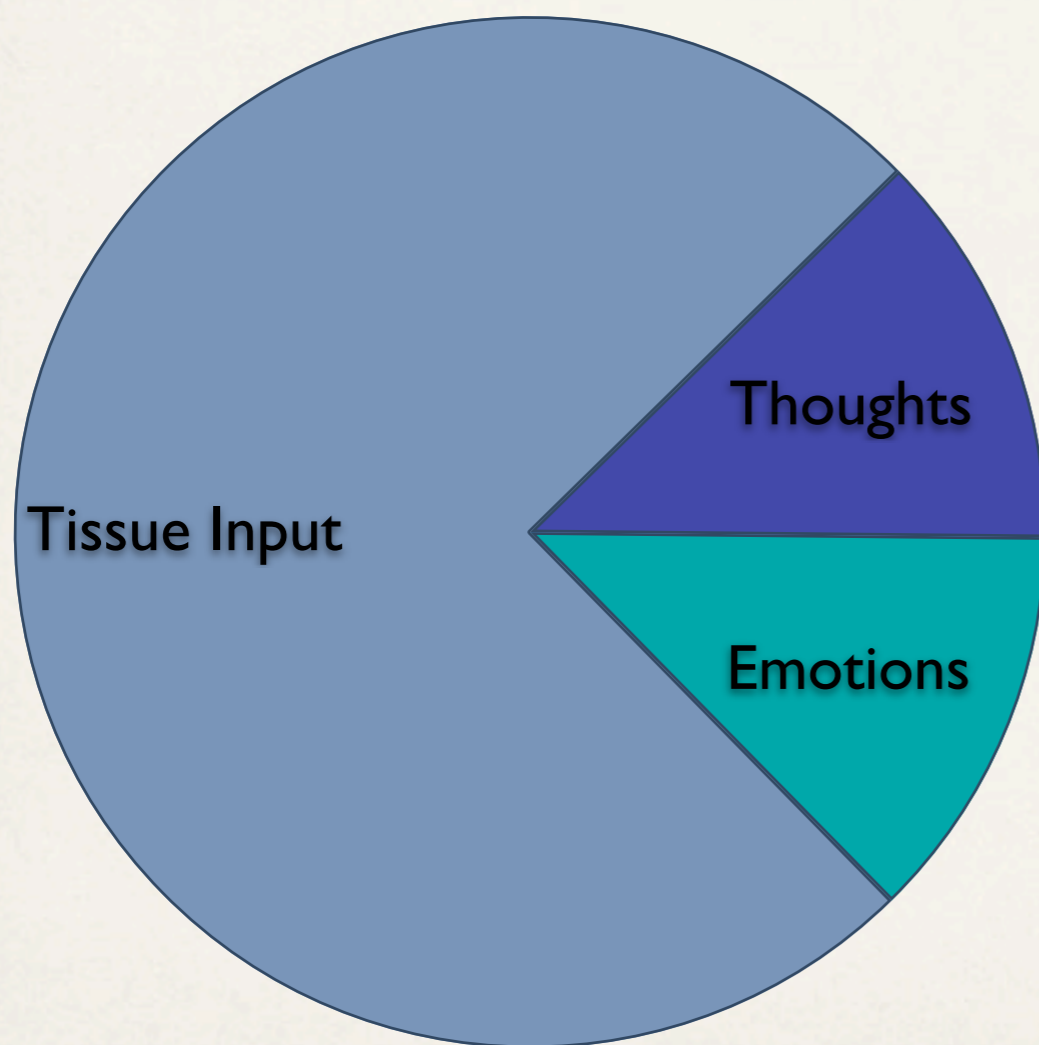
- ❖ Very important to have early behavioral intervention
- ❖ Mentally healthy patients = easier to treat chronic pain

Biopsychosocial Model

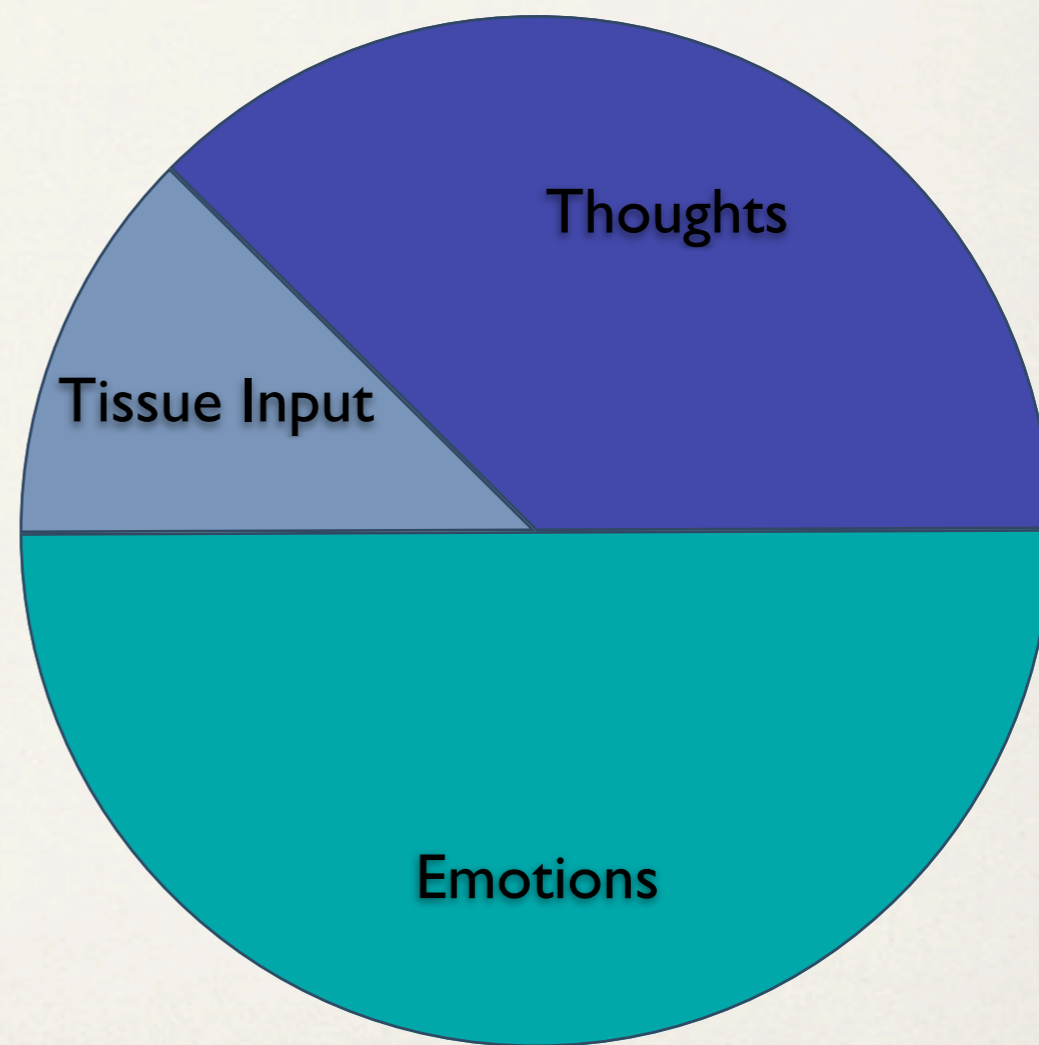
Figure 1: **The “biopsychosocial” model of pain**



Patient-Centered Care



Acute Pain



Chronic Pain

Biopsychosocial Impacts

- ❖ Misattributed Causality
- ❖ Feelings of Guilt
- ❖ Financial Stress
- ❖ Relationship Problems



Pain & Depression

- ❖ Pain and depression are closely related.
- ❖ Depression can cause pain — and pain can cause depression.
- ❖ Sometimes pain and depression create a vicious cycle in which pain worsens symptoms of depression, and then the resulting depression worsens feelings of pain.

Pain & Depression

- ❖ About 30% of patients with persistent pain conditions suffer from clinical depression related to their pain, and almost all persons will experience some mood changes.
- ❖ 75% of patients with clinical depression present to their doctors because of physical symptoms, including pain.
- ❖ People in pain who have symptoms of depression experience more impairment associated with pain than those who do not have depressive symptoms.

Behavioral Concepts

- ❖ Perception
- ❖ Suffering
- ❖ Recovery

Perception



INDIVIDUALITY

ALWAYS REMEMBER THAT YOU ARE UNIQUE. JUST LIKE EVERYBODY ELSE.

Perception

- ❖ It is true that there are some people who feel pain less acutely than others.
- ❖ It is true that there are some people who perceive pain to be pleasurable.
- ❖ Yet it is universally true, except for those with physical or neurological disorders, that people respond consistently to painful stimuli.

Suffering



- ❖ Unfortunately, psychological pain can persist long after the physical has been addressed

Suffering

- ❖ Suffering is an individual's basic affective experience of unpleasantness and the aversion associated with harm or the threat of harm.
- ❖ May include both physical and / or mental components – in varying degrees of intensity, from mild to intolerable.
- ❖ Drawing the distinction between pain and suffering is difficult, if not impossible, as the psychological impact of physical experience often amplifies its perception.

Recovery

- ❖ Relief vs. Function
- ❖ While some treatments may provide a degree of relief, they often come at the cost of a certain amount of functionality.
- ❖ Determining the willingness of a patient to sacrifice functionality for relief is essential, as primary goal of pain management is returning to previous levels of functionality

Resources

- ❖ Professional referrals for emotional / psychological issues to allow for comprehensive care of the patient.
- ❖ Developing relationships with behavioral health providers in geographic proximity will prove exceedingly valuable, and hopefully, decrease the stress of primary care providers

Resources

- * Consultants may help to more clearly streamline the diagnostic process, helping to make psychological / emotional diagnoses more of a primary consideration, when appropriate

Consultants/Referrals

- ❖ Consultants or providers are likely to be specific to the geographic area.
- ❖ Be aware of community resources (CHC, CMHC)

Realistic Recovery

- ❖ Assisting the patient to develop REALISTIC expectations of recovery is an essential part of the behavioral specialist's responsibility.
- ❖ Grieving loss of ability
- ❖ Inventory of current strengths and abilities
- ❖ Establishing a plan moving forward – not looking back
- ❖ Maximizing resources available

Realistic Recovery

- ❖ Realistic expectations
- ❖ Attainable goals
- ❖ Telling the truth
- ❖ Empathize



Treatment Goals

- ❖ Where will we be in 5 years?
- ❖ Develop a long-term plan
- ❖ Patient-physician ownership



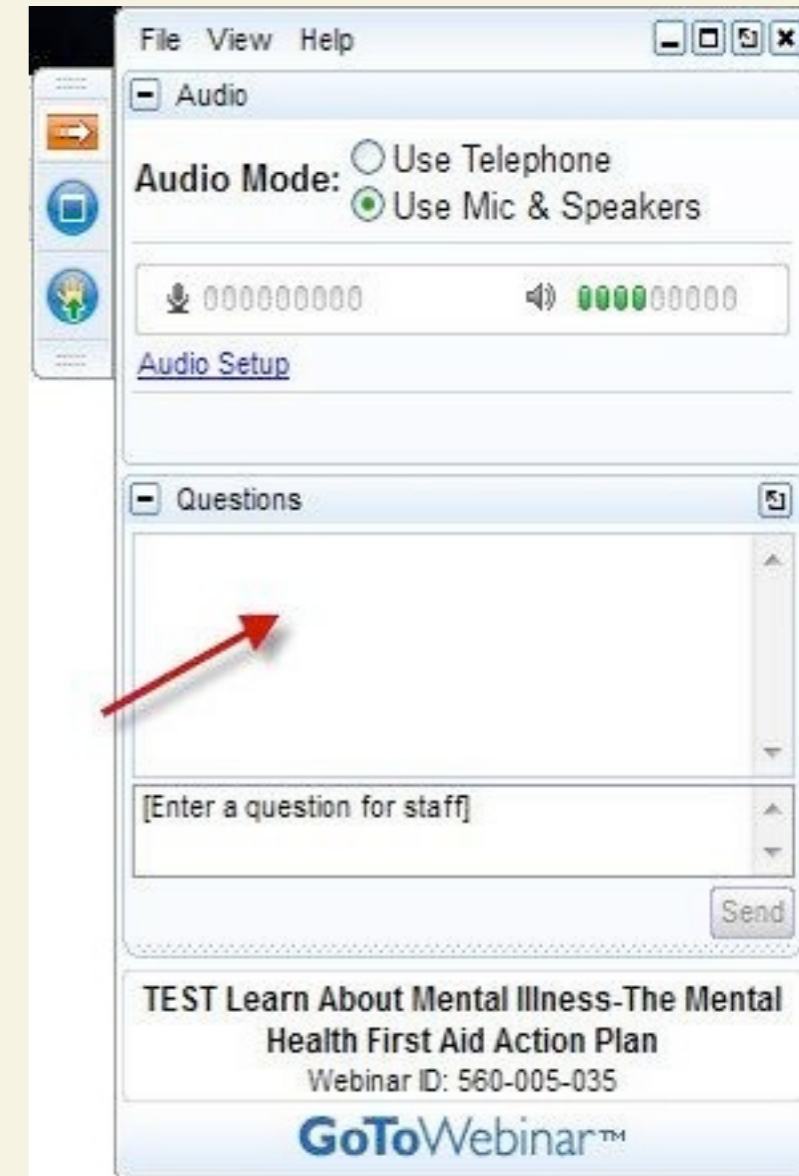
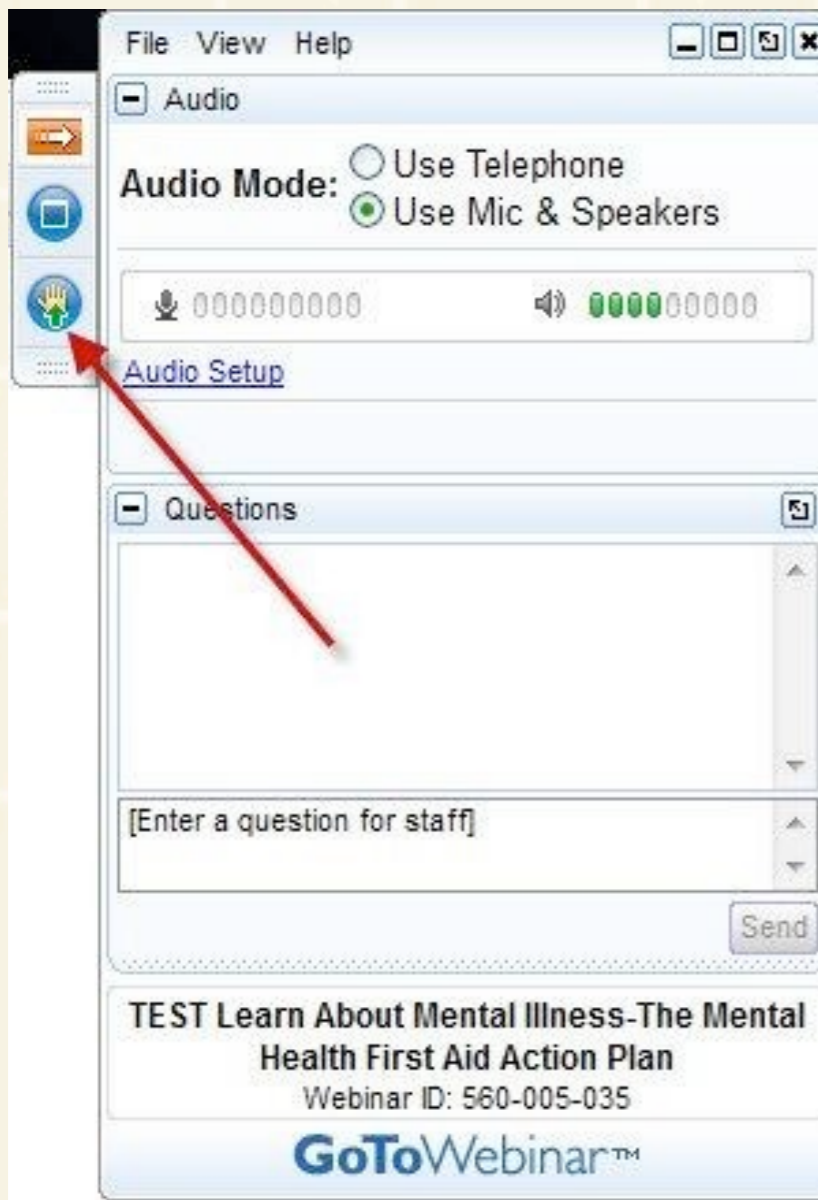
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Questions?

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the text box.





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Thank you for joining us today.



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