TREATMENT OF HIGH RISK AND COMPLEX CHRONIC PAIN: A REHAB APPROACH

Carolyn Buesgens, MA, RN-BC, ANP-BC
Minneapolis VAHCS

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Objectives

1. Define factors contributing to increased complexity and risk in patients with chronic pain
2. Explain the limitation of opioids as unimodal therapy for chronic pain
3. Describe a multimodal rehabilitation approach in addressing factors of high risk or complex chronic pain
Biopsychosocial model
Biopsychosocial Matrix

- Biological components
- Psychological components
- Social components
Case study

- 41-year-old man with chronic low back pain
- s/p lumbar epidural spinal injections and lumbar fusion
- 2011 EMG: No evidence of peripheral neuropathy of the LE
- Past history of Valium overdose and suicide attempts.
- Positive family hx substance abuse
- Mental health diagnoses: depression, anxiety disorder, opioid and alcohol dependence, mood disorder r/t medical condition.
- Poor activity tolerance on Methadone 90 mg daily (limited standing and sitting)
- Left his job two years ago
- Adjuvant medications: gabapentin, cyclobenzaprine, venlafaxine.
- Patient expressed desire to come off Methadone
- Non-pharmaceutical approaches: stress management classes, pain coping skills class, depression management skills, ACT classes.
- Physical therapy “didn’t work”
Factors increasing complexity and risk

- substance abuse
- addiction
- medical comorbidities
- number of pain complaints
- past functional history
- psychiatric issues
- concomitant rx for sedative-hypnotics and/or high dose opioid
Recent estimates suggest that pain and depressive disorder co-occur 30-60% of the time.

Anxiety disorders may be present 35% of the time among persons with chronic pain.

Pain and PTSD co-occur; 20-34% of persons with chronic pain meet criteria for PTSD; chronic pain is present in 45-87% of persons with PTSD.

Pain is present in 37-61% of patients seeking substance use disorders treatment.

Pain undermines effective treatment for depression, anxiety disorders, PTSD, and substance use disorders.
Indicators of complex chronic pain:

- When disability greatly exceeds what would be expected on the basis of physical findings alone,
- When patients make excessive demands on the health care system
- When patients persist in seeking medical tests and treatments that are not indicated
- When patients display significant emotional distress (e.g. depression or anxiety)
- When patients display evidence of addictive behaviors or continual non-adherence to the prescribed treatment regimen.

Adapted from Turk et al, 2010
Complex-chronic pain does not respond to our usual treatments (the “pain patients”)
- Syndrome encompasses a wide variety of painful conditions
- Pattern of declining function (in spite of progressively more aggressive, expensive, and risky medical treatments
- Unpleasant interactions.
- Dissatisfied customers.
- Medication adherence issues
- Overwhelmed and overwhelming

**Iatrogenesis** is a significant problem for this population!

A. Mariano
Seattle VA
Kirsh, KL, Passik, S; Exp Clin Psychopharm, 2008; 16(5)
Not all patients are good candidates for opioid therapy

Risk stratification is helpful in directing a course of treatment

- Low-risk
- Intermediate-risk
- High-risk
Screening Tools

- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients with Pain (SOAPP)
- Drug Abuse Screening Test (DAST)
- CAGE-AID
- STARS/SISAP
- Current Opioid Misuse Measure (COMM)
Opioids are such a big part of the problem, principally, because they are such a small part of the solution.”

Anthony Mariano, PhD
Seattle VAMC
High dose opioid use occurred in 2.4% of all chronic pain patients and in 8.2% of all chronic pain patients prescribed opioids long-term. The average dose in high-dose group was 324.9 (SD=285.1). The only significant demographic difference among groups was race with black veterans less likely to receive high doses. High-dose patients were more likely to have four or more pain diagnoses and the highest rates of medical, psychiatric, and substance use disorders. After controlling for demographic factors and VA facility, neuropathy, low back pain, and nicotine dependence diagnoses were associated with increased likelihood of high-dose prescriptions. High dose patients frequently did not receive care consistent with treatment guidelines; there was frequent use of short-acting opioids, urine drug screens were administered to only 25.7% of patients in the prior year, and 32.% received concurrent benzodiazepine rx, which may increase risk for OD and death

Morasco et al, 2010
Veterans with mental health diagnoses prescribed opioids, especially those with PTSD were more likely to have comorbid drug and alcohol use disorders; receive higher-dose opioid regimens; continue taking opioids longer; receive concurrent prescriptions for opioids, sedative hypnotics, or both; and obtain early opioid refills.

Seal et al, 2012
2012: A memorandum authored by the chief of staff launched the Opioid Safety Initiative limiting total daily opioid dose to < 200 MED


Primary Care Team training and education
Pharmacists and clinical psychologists closely aligned with each clinic
A chronic pain consult service was begun
Patient Pain Education Class started
Medicine Grand Rounds highlighting available behavioral pain programs
Tracking/performance measures
Percent Reduction in Number of Patients at 50+, 100+, 200+, 500+ and 1000+ MEQ/day
Minneapolis VA May 2011 - September 2012

-8%
-19%
-27%
-44%
-50%
Your patient does not have a right to opioids. They have a right to good care and appropriate treatment and in some cases, withdrawing or withholding opioids is ethically mandated.

A Mariano, PhD
Seattle VAMC
What else is there?
Key steps in Improving Management of High Risk and Complex Patients

Assessment
Identification of needs (and risk factors)
Chronic Pain Care Plan
Appropriate referrals
Ongoing Education
Individualized follow-up/monitoring
“Adequate primary medical treatment (of chronic pain) is really not possible without confronting the psychosocial dimension because the true healing skills are those of communication and care.”

Stuart and Lieberman (2002):
Role of primary care providers: Promoting self-management through collaboration

- **Validation** – much of the struggle with patients relates to our communication of doubt
- **Education** – the basis of effective long term care is a shared understanding of chronic pain
- **Motivation** – patients vary in their willingness to engage in self management
- **Activation** – primary clinical focus is on changing the way patients relate to pain

Mariano, PhD
Seattle VA
Disabling Beliefs

- Shared by patients who are overwhelmed by pain and providers who find these people overwhelming:
  - Belief that objective evidence of disease/injury is required for pain to be “real”
  - View of pain as the only problem, and which needs to be avoided at all costs
  - Expectation that urgent pain relief is the major goal of treatment
  - Overconfidence in medical solutions
  - Provider is the “expert” responsible for outcomes
  - Patient is helpless “victim” of underlying disease/injury
Chronic Pain Rehabilitation

- Optimal treatment paradigm
- Comprehensive assessment and individualized treatment plan
- Offer hope and help patient connect with their valued life
- End uncertainty
“Treating a pain patient can be like fixing a car with four flat tires. You cannot just inflate one tire and expect a good result. You must work on all four.”

Penny Cowan, Executive Director
American Chronic Pain Association
Psychological services for Chronic Pain

- Supportive therapies
- Cognitive-behavioral therapy
  - Re-conceptualizing of pain as problem to be solved
  - Coping skills training
- Behavioral Interventions
  - Altering pain-related communication
  - Behavioral activation
- Self-regulatory treatments
  - Biofeedback
  - Relaxation training (progressive muscle relaxation; autogenic training)
  - Hypnosis
Mindfulness based programs

- **ACT: Acceptance and Commitment Therapy**
  
  **Books:**
  
  

- **Mind-Body Skills**

  - cmbm.org

- **Mindfulness Based Stress Reduction**

  Kabat-Sinn, J. Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness.
Urgent and absolute pain relief, while it is an appropriate goal in acute and cancer pain, is an inappropriate goal in the treatment of chronic pain. It should not be the major focus of treatment.

A. Mariano, PhD
Seattle VAMC
The REHAB approach

Redefine the problem and the solutions
Expect some pain – but reject disability and suffering
Have a plan for bad days
Activate, Activate, Activate
Build a health and hopeful lifestyle
Missed opportunities to improve health and prevent further morbidity and disability

Address co-morbidities

- Sleep apnea
- Insomnia
- Obesity
- DM
- Smoking
“...the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.”

The Model Policy for the Use of Controlled Substances for the Treatment of Pain
Federation of State Medical Boards of the United States, Inc.
Medical Boards, 2004
References


- Guideline on Chronic Pain Assessment and Management. Institute for Clinical Systems Improvement (ICSI) *Copyright 2009*. 34
References

- Mariano, A. “Patient Chronic Pain Education: Taking self-management from the classroom to the clinic”
  https://www.visn23.portal.va.gov/min/SiteDirectory.. np. nd
- Robeck, I. Opioids: The good, the bad , the ugly. SCAN Echo presentation.
- SAMHSA. TIP 54: Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders. 2012. U.S. Department of Health and Human Services