Webinar Questions Asked by Attendees

Q #1: Is the Clinical Opiate Withdrawal scale published or available for others to use?

A: Here is a link to the questions that are on the scale, but we have modified it to fit our patient population. Specifically, we are not a buprenorphine clinic, but we have the questions useful. We intervene when the patients reach the "Mild" level of symptomatology. Intervention may include use of Clonidine, slowing down the taper, more detailed teaching on self-management skills such as anxiety management, distraction, sufficient hydration etc. This scale has not been validated in an out-patient chronic pain program as of yet.

https://docs.google.com/viewer?a=v&q=cache:c2p7WzgytMoJ:www.csam-asam.org/pdf/misc/COWS_induction_flow_sheet.doc+clinical+opiate+withdrawal+scale+cows&hl=en&gl=us&pid=bl&srcid=ADGEESiJe5xgUvlOHyjNrnj-cF4d_CFGVbhba7gf1baIzArzXm84gSWxyGToPZi8AaIVBQY8uJvsvWrRSfq4q8MMKIupfRNk53BbeQE2UsMumu7H6Fstc9EUeOOQS-MY97QcqiqUxIZY&sig=AHIEtbRtIVsYU3VljMWmwUgjzCxc1lUbZA

Q #2: In terms of drug therapy, is buprenorphine ever used to treat both the pain and the addiction?

A: We are not an Addiction program, so we are not licensed to initiate buprenorphine treatment. Our typical practice would be to taper the patients' own medications over a 10-12 day period or even longer if indicated.

Q #3: Can you explain SAMSHA more?

A: Substance Abuse and Mental Health Services Administration

In our program, we use the SAMSHA site to help locate substance abuse resources available for patients in their home area.

More information from their website: "SAMHSA was established in 1992 and directed by Congress to target effectively substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system. Over the years SAMHSA has demonstrated that - prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral

health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the Nation's health.

To accomplish its work SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities. The Agency's programs are carried out through its centers and offices:

SAMHSA Centers

- The Center for Mental Health Services (CMHS) which focuses on the prevention and treatment of mental disorders.| View Org Chart
- The Center for Substance Abuse Prevention (CSAP) which seeks to prevent and reduce the abuse of illegal drugs, alcohol, and tobacco. | View Org Chart
- The Center for Substance Abuse Treatment (CSAT) which supports the provision of effective substance abuse treatment and recovery services. | View Org Chart
- The Center for Behavioral Health Statistics and Quality (CBHSQ) which has primary responsibility for the collection, analysis and dissemination of behavioral health data. More information about CBHSQ *(formerly known as OAS)*.| View Org Chart"

http://www.samhsa.gov/

Q #4: Statistics do not support that acceptance of a label is indicative of success or reluctance to accept a label as indicative of failure... motivational interviewing may be used to bring an individual to a state of awareness which is indicative of successful change.

Did you experience resistance in the chemical dependency counselors in utilizing a non-judgmental, motivational interviewing approach?

A: Over time the techniques utilized by chemical dependency counselors has evolved, whereas the current evidenced based practice supports using motivational enhancement strategies to motivate patients for change. In treatment programs additional strategies may be used to help patients realize the consequences of their choices or behavior.

Change is always difficult. Staff initially seemed fearful of working with patients with substance abuse, perhaps related to lack of understanding, knowledge or confidence in their abilities to provide the best treatment. Reluctance might be a better term to use than resistance. However, as we provided a safe place to talk about their concerns and to provide them with education their fear lessened. Establishing regular meetings where we facilitated discussions and role playing the use of motivational enhancement statements seemed to be one of the

keys to this successful outcome. Joan and I also discussed now with this question, the simple fact that being "exposed" to a greater volume of these patients gave us the opportunity to hone our motivational interviewing skills.

Q #5: Please give more examples of neutral language.

A: Example 1

Patient continues to talk about pain. "I'm having a bad day today, my head is just pounding and I feel sick to my stomach."

Staff: "I'm so glad that you came to the program today. This might be a great time for you to try some of the new strategies you are learning. Is there someone in the program that you have connected with that might be a good distraction for you to visit with now? Or perhaps you could try 10 minutes of guided imagery in the quiet room?"

Example 2

Patient: "This is so awful, my pain is so much worse since I'm coming off of these medications. I think it is inhumane of you to make me suffer so."

Staff: "I can see that this is difficult for you right now. Let's talk about the process of how tapering medications works. ..(Educational opportunity)… During this time of medication tapers you will want to take care of yourself by eating well, making sure you are drinking enough water, stretching, practice some relaxation techniques, and being kind to yourself. It is normal to experience these physical symptoms along with some anxiety. It will get better. It is obvious to me that every day you are making an effort to use the new techniques you are learning. I noticed the other group members are going on to the next activity, you may want to join them."

Q #6: Do you have suggestions how to get insurance coverage for admission into the 3 week program, and what is follow up for those out of state patients who may not be able to attend aftercare program

A: We bill using medical IC 9 codes, along with health and behavioral codes. That seems to be effective for reimbursement. In addition, if we find that insurance companies are questioning the benefit of the program, we have sent them some literature (or links) to supporting literature of the effectiveness of comprehensive rehabilitative approaches for chronic pain. Unfortunately for some, it is just not a covered benefit and there is no way around it.

We offer a monthly Aftercare Program that consists of a 1 day refresher of stretches and relaxation with group topics focused on general program concept. Patients are encouraged to discuss challenges that they faced after returning home, along with sharing the concepts that they have been able to integrate into their life at home. Although we offer this monthly, our hope is that this is a transition point from patients seeking further medical work-ups, or even treatments for their pain problems, to a new approach of self-management. RN care coordinators help the patients identify a counselor within their local area to set up follow up appointments with prior to dismissal; patients are strongly encouraged to continue this therapy for at least 6 months. We like it best if the therapists are trained in Cognitive-Behavioral Therapy, but if that isn't possible, we make a phone call to the counselor to explain our approach. Ideally the patient is on the conference call as well

Q #7: Does your references list articles you mentioned about decreasing health care utilization by decreasing opioids.

A: No, we did not specifically address that. Here is are some more references that might be helpful.

Gatchel, Robert J. Okifuji, Akiko (2006). "Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain." *Journal of Pain.* 7(11):779-93.

Townsend, C.O., Kerkvliet, J.L., Bruce, B.K., Rome, J.D., Hooten, W.M., Luedtke, C.A. & Hodgson, J.E. (2008). A longitudinal study of the efficacy of a comprehensive pain rehabilitation program with opioid withdrawal: Comparison of treatment outcomes based on opioid use status at admission. *Journal of Pain* 6(2):75-83. PMID:15694873. DOI:10.1016/j.jpain.2004.10.009.

Q #8: Sometimes the Beast is not only the medications the patient is taking but the prescriber. Do you have suggestions on how to present concerns to the prescribing provider to encourage referral to a program such as yours?

A: Most health care providers are interested in best practice but may not have awareness of the positive outcomes of a rehabilitative approach for chronic pain. These provider "beast" likely believe that prescribing opioids is the best or only option for treatment. They do not want to be inhumane but are simply unaware. Just like patients move along the readiness to change continuum, so do we as providers. Offering non-judgmental education and support to these HCPs is best place to start. They will likely not turn down offers of your assistance in managing what is likely a complicated or challenging patient situation. We try using the same

motivational enhancement techniques (empathy, rolling with resistance, etc) with these "beastly" providers as we do with the patients.

Q #9: This is perhaps more of a topic for future webinar: How to treat patients that are in acute pain such as post injury or post-surgery, that have successfully recovered/in recovery from previous substance abuse? I realize there are nerve blocks that can bridge the pain level in some cases, but we have patients that refuse any pain meds post-surgery due to fear it may relapse them. So how best to handle these type situations. Thank you

A: It is appropriate and ethical to treat all patients for acute pain whether they have a substance abuse disorder or not. First of all, staffs need to understand and support this philosophy. Please refer to the "ASPMN Position Statement: Pain Management in Patients with Substance Use Disorders"

Most likely treatment for acute pain will include opioid analgesics. To help alleviate fear or anxiety about relapse, education needs to be done to help patients understand that time limited use of opioid analgesics is appropriate and recommended. If acute pain is not effectively managed, they may put themselves more at risk for relapse. A good strategy would be to have conversations with the patients to review their supportive resources (i.e sponsors, supportive friends, support groups) to connect with during this period of time.

Q #10: This was wonderful. I am proud to be a Mayo alum. In particular I like the emphasis on nonjudgmental language and designations. Here is my question: Have you as mental health professionals been approached by patients or vendors about use of Suboxone for treating pain (i.e., as a primary or secondary analgesic)?

A: Yes, but we have evidence to show that our rehabilitative approach is very successful along with the tapering of analgesics. There are special licensure requirements for using Suboxone; we are not able to initiate this treatment, but we can taper them off of this medication if they were prescribed this prior to coming to our program. We do, however, taper most of these people off of this medication, as that is our program rehabilitative philosophy.

Q #11: Do you utilize the Prescription Monitoring Program to help track patients seeking meds from multiple prescribers?

A: Yes. As a part of the admission process our pharmacist will seek out information from the Prescription Monitoring Program. Of course there are limitations, as now all states utilize this program, and we serve patients from around the country.