CHRONIC PAIN MANAGEMENT

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Disclosure

I am a consultant to Millennium Health
Pre-Test Questions

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Walking the Tightrope of Pain Management

- Adverse Events
- Misuse
- Death
- Addiction
- Diversion
- Abuse

Pain Management
Getting to the Other Side by Using Balanced Pain Management

• Reducing pain and improving functioning are critical, but must be accomplished in a safe and appropriate manner

• Optimal care for the person with pain = delivering safe, effective treatments across the healthcare continuum—and ensuring that people with pain can access that care

• Mirrors the usual criteria for inclusion of medications in pharmacy benefit plans:
  • Efficacy
  • Safety
  • Cost
Two Major Public Health Problems

• Prescription opioid abuse:
  • 12.5 million non-medical users per year
  • $70-120 billion cost per year
  • 16,000-19,000 overdose deaths per year

• Chronic pain:
  • >100 million with chronic pain, ~25-39 million with daily chronic pain, ~10 million disabled
  • $560-635 billion cost per year
  • Suicide risk doubled
    • 39,500 suicide deaths in 2011
    • ~26,000 were people with chronic pain
Not A Zero-Sum Game

Often, it feels like any attempt to prevent prescription opioid abuse must be accomplished by reining in prescribing, potentially increasing pain and decreasing function.

Similarly, it often seems as though any effort to improve pain management must involve increased prescribing, which could, in turn, lead to more adverse outcomes.

I believe this mis-states the case, and that it is possible to address both problems without adversely affecting either—by providing balanced pain management.
Asking the Right Questions

To get the right answers, we have to ask the right questions
The Right Question about Opioids for Chronic Pain

The wrong question is, “Should we use opioids to treat chronic pain?”

The right question is, “In which patients should we use opioids, at what doses, for how long, with which adjunctive treatments, and with what precautions?”
In September 2014, NIH sponsored a two-day “Pathways to Prevention” workshop on The Role of Opioids in the Treatment of Chronic Pain

- Extensive evidence review was carried out prior to the meeting
- After the meeting, an unbiased panel developed a report regarding the risks and benefits of using opioids to treat chronic pain

The key conclusion:
- There is “insufficient evidence for every clinical decision that a provider needs to make regarding use of opioids for chronic pain.”

Question: If that’s the case, then how do we find our way out of the mess we’re in?
Revisiting the Role of Opioids for Chronic Pain

- Careful, judicious use of opioids with both pain relief and patient safety in mind is appropriate in pain management. They are necessary, but we need other tools as well:

  “Within the context of an integrative model of care, the Academy recognizes the effectiveness of opioids as part of a comprehensive treatment plan for some people who experience chronic pain. When prescribed judiciously by clinicians who are well educated about prescribing these medications, and taken as directed by patients who are well informed about these medications, opioids may be useful in reducing pain and restoring function.”
Appropriate Treatment for Chronic Pain

• Appropriate treatment for chronic pain is multimodal, including interventions like exercise, pacing activities, medication – not just opioids, because there may be others that work better

• This kind of treatment focuses primarily on improving function, rather than focusing on pain intensity

• Use of multiple types of treatment should reduce reliance on opioid analgesics as a primary means of treating pain

• Multiple barriers exist to providing this type of care for chronic pain
Key Recommendations from CDC Guideline

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).
Key Recommendations from CDC Guideline

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to $\geq 50$ morphine milligram equivalents (MME)/day, and should avoid increasing dosage to $\geq 90$ MME/day or carefully justify a decision to titrate dosage to $\geq 90$ MME/day (recommendation category: A, evidence type: 3).
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ($\geq 50$ MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4).
Additional Safety Strategies to Consider

- Check the PDMP before starting a course of treatment with any controlled substance, and periodically during that course of treatment.
- Conduct urine drug test prior to starting a course of treatment and periodically thereafter.
- Education the patient about safe storage and disposal of controlled substances.
- Consider periodic unannounced pill counts.
- Educate the patient about synergistic effects of other CNS depressants, especially alcohol.
- Consider completing a patient-prescriber agreement.
Non-Pharmacological Pain Treatments Recommended by Multiple Guidelines

- There has been a spate of new guidelines and policy statements issued over the past couple of years.
- Many of these recommend non-pharmacological pain treatments as first-line therapy for chronic pain.
- These include:
  - CDC Guideline for Prescribing Opioids
  - American College of Physicians back pain guideline
  - US Surgeon General’s “Turn the Tide” campaign
- The Joint Commission’s proposed revision of its pain management standards also would require hospitals to promote non-pharmacological treatment for pain.
The Biopsychosocial Model of Chronic Pain

• The biomedical model works well for acute pain, but fails miserably when it tries to explain chronic pain
• This model considers all disorders to be caused by the presence of a pathogen or absence of a vital substance
• For chronic pain, neither of these applies in many (most?) cases
• Chronic pain etiology is complex and can result from myriad chronic medical conditions
• A model that considers biological, psychological, social, and spiritual aspects of the individual’s experience is much more useful in understanding chronic pain and guiding its treatment.
The Biopsychosocial Model: What’s on Your Plate?

Areas of Functioning

- Cell/System Physiology
- Anatomy
- Mechanics
- Cognition
- Emotion
- Behavior
- Social
- Spiritual

“Psycho-”

“Bio”
Restoring Balance

• A comprehensive pain assessment considers all of these factors, and determines the extent to which each is responsible for each person’s pain experience.

• This is why people with the same diagnosis may have very different experiences of pain.

• Interventions follow the assessment, and need to be considered in terms of three factors:
  • Which areas of function are affected
  • How much each area is affected
  • The valence of the effects

• A truly integrated intervention plan considers these in aggregate for all interventions.
# Areas of Impact for Some Common Pain Interventions

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- ★ Minimal Impact
- ★★ Moderate Impact
- ★★★ High Impact
NCCIH Review of Complementary Treatments for Pain

- Review of 105 US-based randomized controlled trials from the past 50 years
- Focused on seven approaches for five painful conditions:
  - Back pain
  - Osteoarthritis
  - Neck pain
  - Fibromyalgia
  - Severe headaches and migraine
- Examined the balance of positive, negative, and neutral studies of each of the seven techniques for each of the five painful conditions
NCCIH Review of Complementary Treatments for Pain

• Found support for use of the following:
  • Acupuncture and yoga for back pain
  • Acupuncture and tai chi for osteoarthritis of the knee
  • Massage therapy for neck pain (with adequate doses and for short-term benefit)
  • Relaxation techniques for severe headaches and migraine

• Weaker evidence for:
  • Massage therapy, spinal manipulation, osteopathic manipulation for back pain
  • Relaxation approaches and tai chi for fibromyalgia
“If all you have is a hammer, every problem looks like a nail.”

*Abraham Maslow*

- The biopsychosocial model recognizes the need to use multiple tools to fix the broken system that results in chronic pain.
- Unfortunately, the system that provides those tools also is broken. We need more tools. This requires:
  - More basic medical education content for “traditional” students.
  - Extensive continuing education for licensed providers.
  - Available providers of non-medication treatments.
  - Access to referral networks for those providers.
  - Adequate reimbursement for those providers.
Patient Self-Management Strategies

• There are a number of things that people with chronic pain can do to help themselves.

• These include:
  • Weight loss
  • Exercise/conditioning
  • Proper nutrition
  • Good sleep habits
  • Regular relaxation practice
  • Maintaining positive social connections

• Patients need to feel empowered, and treating them as members of the pain care team can help achieve that
Patient Safety Best Practices

- Pursue a balanced, multi-disciplinary approach to providing pain care
- Individualize treatment plans for each person with pain—there is no cookbook, and one size doesn’t even fit most
- Decrease opioid prescribing by incorporating multimodal analgesia
- Use safety measures based on your assessment of the patient’s risk.
- For all patients, emphasize proper use, storage, and disposal; educate people with pain, family members, other loved ones and caregivers
A Final Word

• Medical professionals, especially those specializing in pain management, want to be part of the solution that enables us to provide pain care that is both safe and effective
• In part, we need to better use some tools we already have
• In part, we need some additional tools to effectively treat both acute and chronic pain in ways that don’t exacerbate prescription drug abuse and other adverse outcomes
• We need to assert our appropriate role in developing solutions that promote balanced pain management, on behalf of ourselves and the people with pain for whom we care
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Thank you for your attention