Psychosocial Approaches in Chronic Pain Management: from Chaos to Stabilization

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Course Objectives

• Relate an *appreciation* and *sensitivity* for the impact of psychosocial issues on the chronic pain patient

• Explain the use of “*Find, Engage, Treat and Measure*” as a useful systematic response in chronic pain management

• Discover community resources specifically for this population
  – FUSE: Frequent Utilizers System Engagement
Key Take Away Points

• It is easier to *prevent* opioid addiction then to *treat* it
• Engaging chaotic chronic pain patient through community and health system collaboration
• Use of Medical Home for stabilization of chronic pain patients
• Change conversation away from pain to *functionality* and *normalization* (Kristy’s story)
How Did We Get Here?

Opioid Prescriptions Dispensed by Retail Pharmacies—United States, 1991–2011

Number of Drug Overdose Deaths Involving Opioid Pain Relievers and Other Drugs
United States, 1999–2010

- Any opioid analgesic
- Specified drug(s) other than opioid analgesic
- Only non-specified drug(s)

CDC, National Center for Health Statistics, National Vital Statistics System.
Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–

[Graph showing trends in opioid sales, overdose deaths, and treatment admissions from 1999 to 2010]
Drug Overdose Death Rate, 2008, and Opioid Pain Reliever Sales Rate, 2010

Kg of opioid pain relievers used per 10,000
Age-adjusted rate per 100,000

What Age Group Has The Highest Drug Overdose Death Rate?

• A. 15 - 24
• B. 25 - 34
• C. 35 - 44
• D. 45 - 54
• E. 55 - 64
• Over 65
Drug Overdose Death Rates by Age—United States, 1999–2010

CDC, NCHS, National Vital Statistics System.
Is the Drug Overdose Death Rate Higher For Men or For Women?
Every 3 minutes, a woman goes to the emergency department for prescription painkiller misuse or abuse.

Women between the ages of 25 and 54 are most likely to go to the emergency department because of prescription painkiller misuse or abuse.

SOURCE: Drug Abuse Warning Network, 2010. (Suicide attempts are included for the cases [0.3% of total] whose opioids were combined with illicit drugs in the attempt.)
How Did We Get From Here…

Extra Strength

MAGNESIUM SALICYLATE
PAIN RELIEVER

RELIEVES BACKACHE PAIN

24 CAPLETS
Centers for Disease Control and Prevention

• Vital Signs, July 2013
  – Prescription Painkiller Overdoses
  – http://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/index.html
  – A growing epidemic, especially among women
  – About 18 women die every day of a prescription painkiller overdose in the US

• Morbidity and Mortality Weekly, July 2013
  – Overdoses of Prescription Opioid Pain Relievers and Other Drugs Among Women — United States, 1999–2010
  – http://www.cdc.gov/mmwr/
  – Opioid overdose deaths in women in the United States increased 5-fold from 1999 to 2010
  – During the same time period, the risk of opioid pain reliever (OPR) deaths in men increased 3.6 times
  – More than 6,600 deaths in 2010
A Comparison of Common Screening Methods for Predicting Aberrant Drug-Related Behavior Among Patients Receiving Opioids for Pain Management

- **SOAPP**: Screener and Opioid Assessment for Patients with Pain
- **DIRE**: Diagnosis, Intractability, Risk and Efficacy Inventory
- **ORT**: Opioid Risk Tool

- 48 patients, previously discontinued from treatment
- Pain Management Center in Tennessee
- Type I Patients - positive drug screen
- Type II Patients - pattern of missed appointments
- All patients had completed screening tool prior to initiation of treatment.
## Results

Sensitivity values for measures of risk for aberrant drug-related behavior

<table>
<thead>
<tr>
<th>Measure</th>
<th>Entire Sample</th>
<th>Type 1 Discontinued Patients</th>
<th>Type 2 Discontinued Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Interview</td>
<td>0.77</td>
<td>0.76</td>
<td>0.79</td>
</tr>
<tr>
<td>SOAPP</td>
<td>0.73</td>
<td>0.82</td>
<td>0.50</td>
</tr>
<tr>
<td>ORT</td>
<td>0.45</td>
<td>0.44</td>
<td>0.43</td>
</tr>
<tr>
<td>DIRE</td>
<td>0.17</td>
<td>0.09</td>
<td>0.36</td>
</tr>
</tbody>
</table>

Combining the clinical interview with the SOAPP increased sensitivity to 0.90
The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?
2. How often do you smoke a cigarette within an hour after you wake up?
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?
4. How often have any of your close friends had a problem with alcohol or drugs?
5. How often have others suggested that you have a drug or alcohol problem?
6. How often have you attended an AA or NA meeting?
7. How often have you taken medication other than the way that it was prescribed?
8. How often have you been treated for an alcohol or drug problem?
9. How often have your medications been lost or stolen?
10. How often have others expressed concern over your use of medication?
Are Opioids Effective in Treating Pain?

- Yes: for acute and cancer-related pain
- Maybe: chronic pain
- Hence: The Great Divide
On one side is the pervasive public health issue of chronic pain, in which patients are "stigmatized, marginalized, and blamed," for conditions such as lower back pain, that are beyond their control and for which they desperately need effective treatment.
On the other side is a full-blown epidemic — the misuse and abuse of the very same prescription painkillers needed to treat the chronic pain, which, as detailed in one alarming report after another, is taking a heavy toll on society.

Pain Experts Confront the 'Great Divide' on Chronic Opioids
Nancy A. Melville
Sep 10, 2013
Dr. Ballantyne cited a large study from Denmark comparing 228 opioid users with 1678 non-opioid users (Pain. 2006;125:172-179).

"The opioid users reported more severe pain than non-opioid users, worse self-rated health, higher levels of inactivity, higher unemployment, higher health utilization, and poorer quality of life."

Pain Experts Confront the 'Great Divide' on Chronic Opioids
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Why Wait?

90% of pain complaints do not meet criteria of serious pain for which some people argue that opioids should be restricted to and not for the use of “moderate” pain.

90% of pain complaints:
- Axial low back pain without a pathoanatomic diagnosis
- Fibromyalgia
- Headache

Jane C. Ballantyne, MD, FRCA Professor of Anesthesiology and Pain Medicine University of Washington CDC’s Primary Care and Public Health Initiative October 24, 2012
Serious Pain

- Clear pathoanatomic or disease basis
- Underlying cause is disabling
- Cannot be improved by primary disease treatment or lifestyle changes
- Goal of pain treatment is comfort
- All other treatments (best effort) have failed
So today, we want to begin to make your lives a little bit easier...

by discussing ways to bring Stability out of Chaos
IW: Case Example

- November 2012: ED 47 woman
- H/O endometriosis, on Lupron
- 2 day worsening of chronic lower abdominal pain
- Past h/o peritonitis remotely with endometrioma rupture
- *She has recently stopped going to her primary care because of the agreements about the cause and care of her pain*
- Led to increased ED, Acute Care and Psychiatric hospitalizations (LOS: 3 Psych Hosp: 1/6-3/6, 4/19-5/21, 6/15-6/24 all 2013)
Intervention: Engagement

A new way to:

Assess psychosocial aspects of pain
AND
Establish a consistent, caring, and trusting relationship

Through the use of:

Warm hand off
Community case management
Communication
Community Collaboration

• FUSE: Frequent Utilizers Systems Engagement
  – Bringing together clinicians for coordinated care between health system and the community agencies

• SOAR: Social Security Disability – Outreach, Advocacy, Recovery
  – Trained representative imbedded within the medical home structure –
  – Hospital / Community SOAR collaborative
Specialty Care Coordinator:
I spoke with Neurology this afternoon who indicated to me that Ms. J. has six missed appointments with their office - (4/16/13, 4/26/13 and 6/10/13 - Office visits, as well as EEG's for all three dates). Before we move forward with authorizing her referral to Neurology, could you Karen, please follow-up with this patient?

Care Manager:
I see that she her depakote (seizure med) levels were low a month ago, and her dose was increased. She was supposed to follow-up here and have a second blood draw and she has not done any of this. Very complex patient with chronic abdominal pain issues, and hx of polysubstance abuse (including a violated pain contract from our office) and mental health issues. Will have a conversation with her hopefully later today to investigate the missed appointments, and to also encourage her to take her meds and get her repeat blood levels done. Will schedule for a co-visit with her PCP and me next week.

Will advise on how to proceed following this - thank you!
• University of Michigan Complex Care Bi-Monthly meeting
  – 2\textsuperscript{nd} Monday: any case manager can present complex care in unified format
  – 4\textsuperscript{th} Monday: Agency presentation

• St. Joseph Mercy Health Monthly Case Management Meeting
  – Case managers from both hospital system
  – Case managers from local health plan
  – Shelter provider
  – Medical homes

• IW was discussed at community case management meeting
Bringing Them Home

• Establish consistent mutual respect relationship within established clinical guidelines
• Talk about / teach about concerns, pain medications, practice policies
• Introduce team concept: other members of treatment team
• One provider with goal of increased functionality, which leads to increased stabilization
Medical Home Strategy

• Getting ready for chronic pain patients
• Ahead of time: set up schedule for pain patients…set up ongoing slot/protocol for pain patient, especially new patients and patient education materials
• Clinical team setting
  – Physical therapist – imbedded within the medical home…
  – Nursing / Medical Assistants
  – Social Work / Neuro Psychological Services
  – Nutritionist
  – Functional Capacity Evaluation
Within the Medical Home

- On the day of the appointment
- Use of huddles
- Changing the language of the clinicians within the huddle…
- Within Academic Internal Medicine: Instead of: “Oh your 11 o’clock will need a UDS…” to: (think about functionality…do we know what pt’s functional goal was from last visit)”
Engaging with the Patient

• Tell me how you got here….”My friend brought me”…what does that tell you

• Shows genuine interest and breaks the pattern of previous formal assessments...Showing genuine interest is building the relationship, and you need to build the relationship, because as the Chief Medical Officer of St. Joseph Mercy Health system stated recently “we are going to have to have some hard discussions…”
“As you already know, you have a complex disease, which impacts you daily…and we can treat you…

I want to tell you about our general approach…

I want to get to know you and so would like to see you often …so we can discover what is and is not helpful in restoring your functionality”
Clinical Questions

• “What would you like to be able to do, that you are not doing now?”
• Begin to plan with your patient a strategy, have a plan, begin to set idea of outcomes
• Goal is to quickly get them to normalization
• Screening tools
Shared Medical Appointments

- Shared Medical Appointments for persons with chronic pain
- Support group dynamics to foster goal of normalization, functionality
- Combination of psychosocial needs and medical concerns
- Pain prescriptions are provided

http://www.youtube.com/watch?v=F2-jvE5Ns
Wisdom From Ballantyne and Carey

- Expect it to be time consuming and resource heavy
- Chronic pain is never simple – approach holistically
- Measurement based care is the gold standard – set and assess functional goal, with using confidence ladder, re-assess next visit
It is easier to prevent opioid addiction than to treat it

Prevent....Screen and Teach, Teach, Teach
If You’re Not Comfortable, Don’t Treat

Hopefully the beginning trust you have established will carry them through this difficult transition.

If not, maybe they are not ready for primary care… and that is okay.

Do not change your practice, be respectful, be safe, and document.
From Chaos to Stabilization
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REMARKABLE CARE.