Managing Long Term, Non-Cancer Pain With or Without Opioids

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The Institute of Medicine Report 2011:
A cultural transformation in pain prevention, care, education and research

Chronic pain costs the nation up to $635 billion each year in medical treatment and lost productivity. The 2010 Patient Protection and Affordable Care Act required the Department of Health and Human Services (HHS) to enlist the IOM in examining pain as a public health problem.

In this report, the IOM offers a blueprint for action in transforming prevention, care, education, and research, with the goal of providing relief for people with pain in America.

The Bree Collaborative for Spine/Low Back Pain (Nov 2013)
www.hta.hca.wa.gov/bree.html

- LBP is the leading cause of disability in the US as of 2010.

- The Robert Bree Collaborative was established in 2011 to provide a forum in which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care in Washington State.

- LBP was one of the first topic area due to the variation in diagnosis and tx of LBP, high utilization rates for expensive modalities that have not been show to improve health outcomes

Watch Your Back
Rick Deyo, 2014 (OHSU)

- Use of MRI scans, opioid medications, injections and invasive spine surgery have all grown by several hundred percent

- Fewer medical interventions may produce better results

- Approximately 50% spine fusions in US are unnecessary

- Often tx focuses on unrealistic “fix” for pain

- Exposes the current approach to back pain, along with the profit motives and conflicts of interest behind many tx

Trends in Spine Fusion Surgery, U.S.
Source: National Inpatient Sample (from Deyo)

Changes in Financial incentives? (from Deyo)
NC BCBS made decision not to cover lumbar fusions for DDD or herniated discs.
Reducing Unnecessary Cost and Iatrogenic Effects of our Healthcare System

- In Washington State successful completion of a CARF* accredited Structured Intensive Multidisciplinary Program (SIMP) is required prior to lumbar fusion or disc replacement, unless there is back instability
- Provider should refer to SIMP if 3 months of conservative therapy fail to relieve pain or restore function to an acceptable level

(CARF = Commission on Accreditation of Rehabilitation Facilities)
http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/Lumbarfusion.pdf

In 1998 Federation of State Medical Boards issued new guidelines saying opioids could be essential for tx of chronic pain
VA 1999 and JCAHO 2000 pushed pain as the 5th vital sign
Regulators, doctors and patients misled into believing opioids safer and less addictive than other drugs
Now an average of 46 Americans die every day from prescription opioid overdose and heroin deaths have more than doubled in 10 years since 2000
Recently JAMA found a 19% decline in opioid prescriptions

Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

Estimated Opioid Expenditures, Adults With Spine Problems: 1997-2006, MEPS

Increase in Expenditures, 1997-2006: 660%
Due to both volume and price

$246 Million

$1.9 Billion

Interagency Guideline on Prescribing Opioids for Pain
Developed by the Washington State Agency Medical Directors’ Group (AMDG) in collaboration with an Expert Advisory Panel, Actively Practicing Providers, Public Stakeholders, and Senior State Officials.
www.agencymeddirectors.wa.gov

Oregon Opioid Initiative Partnership (From Lisa Millet)
Goals of the Oregon Opioid Initiative Partnership from Public Health Division of Violence Prevention Program (from Lisa Millet)

- Decrease drug overdose deaths
- Decrease prescription drug overdose hospitalization
- Decrease prescription drug overdose emergency department visits
- Increase use of medication assisted treatment for opioid use disorder
- Decrease opioid misuse
- Decrease health care costs

Prescription Opioid Overdose Deaths, Hospitalizations & Misuse from Oregon Public Health Division of Violence Prevention Program (from Lisa Millet)

- Deaths in 2014: 154 Oregonians died (prescription opioids)
- The rate of opioid deaths declined 40% between 2006 and 2014
- Hospitalizations in 2013: 330 Oregonians were hospitalized
  - Cost of care was $9.1 million
  - 4,300 hospitalized patients had opioid use disorder diagnosis
- Misuse: An estimated 212,000 Oregonians self-reported non-medical use of prescription pain relievers in 2012-13

Opiates and Chronic Disability

- Little evidence to support long term efficacy of chronic opioid analgesic therapy (COAT) in improving function and pain
- Patients who use opioids for at least 90 days were greater than 60% more likely to be on chronic opioids in 5 years
- Overdose risk doubles at doses between 20-49 MED and increases 9x at doses of 100mg/day MED
- “It is time to collectively lower expectations and prescribe these drugs less readily, to fewer patients, at lower doses, and for shorter periods.” Juurlink DN, et al. JAMA 2013; 309: 879

New Draft Guidelines by the Centers for Disease Control and Prevention, September 2015

- National prescribing guidelines being proposed
- Precaution when increase opiates to 50 MSEQ
- Avoid increasing dosage >90 MSEQ
- Prescribe up to 3 days of opioids for acute flare up
- Consider co-prescribing nalaxone with risk factors
- Avoid prescribing opiates and benzos concurrently

Interagency Guidelines on Prescribing Opioids for Pain 2015

Opioid Overdose & Prescribed Daily Dose Hazard Ratios for serious overdose, adjusted for depression, comorbidity, demographics, sedative-hypnotics (data from Dunn)

- Dunn KM. Van Korff M. Ann Intern Med 2010; 152: 85
- Sediative-hypnotics: 3x risk

Morphine Equivalents

Interagency Guidelines on Prescribing Opioids for Pain 2015

Opiates and Mental Health

- Patients with substance use and /or psychiatric disorders are more likely to have complications from opioid use, misuse, abuse or overdose (Martin, Fan, Edlund, Devries, Braden, Sullivan, 2011)
- Adults with a history of depression, alcohol or other non-opioid substance use disorders are 3-5x more likely to receive COAT (Cicero, Wong, Tian, Lynskey, Todorov, Isenberg, 2009)
Side Effects of Chronic Opioid Therapy

- Inhibition of endogenous sex hormone production resulting in hypogonadism & infertility
- Immunosuppression
- Falls and fractures older
- Neonatal abstinence syndrome
- QT prolongation with methadone
- Sleep disordered breathing
- Addiction
- Sexual dysfunction
- Opioid induced hyperalgesia (increased pain sensitivity)
- Hyperkatalesia (emotional dysregulation)
- Constipation
- Cognitive impairment
- Sedation
- Difficulty initiating urination
- Death due to respiratory suppression

State of the Art Review: Opioids for Low Back Pain
Deyo, Von Korff, Duhrkoop. BMJ 2015; 350:g6380

- Opioids to not seem to expedite return to work in injured workers or improve functional outcomes of acute back pain in primary care
- Opioids have a short-term analgesic effect and pain relief of about 30%
- Recommend strategies to reduce risk include more selective prescription of opioids and lower doses, use of prescription monitoring program, avoidance of co-prescription with sedative hypnotics and reformulations that make drugs more difficult to snort, smoke, or inject

Guidance for Primary Care Providers on Safe and Effective Use of Opioids for Chronic Non-cancer Pain

- Establish an opioid treatment agreement
- Use PDMP (prescription drug monitoring program)
- Screen for:
  - Depression (PHQ-9)
  - Prior or current substance abuse (ORT, SOAPP-R, DIRE or CAGE-AID)
- Use random urine drug screening judiciously:
  - Shows patient is taking prescribed drugs
  - Identifies non-prescribed drugs
  - Do not use concomitant sedative-hypnotics, benzos, or MJ
- Track pain and function to recognize tolerance (2-Question tool)
- Seek help if dose reaches 120 mg MED, and pain and function have not substantially improved

The Oregon Pain Guidance Group (OPG)
http://www.southernoregonopioidmanagement.org

- Oregon Pain Guidance (OPG) is a group of healthcare providers from Jackson and Josephine Counties in Southern Oregon, who are working together on standardizing community guidelines and best practices for treating patients with chronic pain. An improved quality of life for people with chronic pain can be achieved when patients and their families work closely with their healthcare providers. This website provides educational information, news, community resources, and upcoming events for both the public and healthcare providers.

Central Oregon Pain Guide 2015

http://www.copainguide.org/

Central Oregon resources to support providers, patients, and families

CENTRAL OREGON & GORGE SUMMIT TO REDUCE RX ABUSE WEDNESDAY, OCTOBER 14, 2015
8:30 a.m. - 4:30 p.m.
Deschutes County Fairgrounds | Redmond, OR

We will develop a Regional Action Plan to move discussion into action and create momentum for statewide change. The action plans will include strategies for:

- Reduce the number of pills in circulation
- Educate patients and the public better
- Dispose of unused and unwanted pills
- Improve and expand access to comprehensive treatment services
Patient Education: Patient beliefs and expectations about LBP have a significant impact on outcomes

- Back Pain Mass Media Campaigns
- Back Pain, Don’t Take It Lying Down, Victoria, Australia (97-99)
- Working Backs Scotland (2000-03)
- Active Back, Norway (2002-09)
- Back@It, Alberta, Canada (2005-08)

Oregon campaign to reduce dependence on and deaths from prescription opiates has many pieces
Samantha Kaan, samantha.kaan@multco.us (503) 349-5931

- Safe disposal resources
- Treatment resources
- Naloxone dispensing
- Public education
- Mindfulness resources
- Patient education
- Pain education resources
- Changes to prescription practices
- Provider education

Definition of Pain

Pain: an unpleasant sensory and emotional experience associated with actual or potential tissue damage (International Association for the Study of Pain)

- Acute Pain < 3 months
- Chronic Pain > 3 months

Acute Phase (< 2 weeks)
Symptom relief, maintain activity, provide support high proportion return to activity and work

Sub-acute (2-12 weeks)
Develop plan for RTW/activity, healthcare and workplace accommodation, identify psychosocial obstacles, cease ineffective healthcare optimal time to prevent the development of long term consequences including work loss

Chronic (> 12 weeks)
multidisciplinary approach, cognitive behavioral techniques, consider shifting goals, max RTW/activities requires more resources and more difficult to achieve.

Red Flags Indicating Need for Further Patient Evaluation

- Presence of neurological deficit(s)
- History of malignancy
- New signs and symptoms of underlying disease
- Sudden increase in severity or nature of previous pain complaint
- Unexpected results from UDS
- Wounds that don’t heal within normal time expectations
- Evidence of adverse side effects from current tx regimen

*Interagency Guidelines on Prescribing Opioids for Pain 2015*
Adapted from Taubon, 2015
Red Flags Predicting Disability: A Biopsychosocial Approach

1. Catastrophizing
2. Fear of movement or re-injury
3. Expectations
4. Preoccupation with health
5. Worry and distress
6. Depression
7. Uncertainty
8. Extreme symptom report
9. Passive coping strategies
10. Serial ineffective therapy

PEG – validated 3 item tool to assess pain intensity, interference with enjoyment of life and interference with general activity (Krebs, 2009)

1. What number best describes your pain on average in the past week?
   0 1 2 3 4 5 6 7 8 9 10
   No pain = Pain as bad as you can imagine

2. What number best describes, during the past week, pain has interfered with your enjoyment of life?
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere = Completely interferes

3. What number best describes, during the past week, pain has interfered with your general activity?
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere = Completely interferes

Interagency Guidelines on Prescribing Opioids for Pain 2015
Non-pharmacological Options for Pain Management
Interagency Guidelines on Prescribing Opioids for Pain 2015
Adapted from Argoff, 2009 & Tauben, 2015

Cognitive
Address distressing negative cognitions and beliefs, catastrophizing (pain coping characterized by excessively negative thoughts and statements about the future)

Behavioral Approaches
Mindfulness, meditation, yoga, relaxation, biofeedback

Physical
Activity coaching, graded exercise

Spiritual
Identify existential distress, seek meaning and purpose in life

Education (patient and caregivers)
Promote patient efforts aimed at increased functional capabilities

When to Refer to Behavioral Health
- Depression, anxiety, PTSD
- Social, interpersonal and intimate activities limited by the fear of pain
- Multiple and varied tx have not been satisfactory to the patient
- Patient views their role in tx as passive and put their lives on hold until the providers fix the pain
- Escalation of medications without increase in fcn
- When downtime exceeds uptime
- Self-appraisals and beliefs that they are unable or helpless to resume a modified normal life because of the pain

Predictors of Persistent Disabling LBP
- Maladaptive pain coping behaviors
  - Fear avoidance (avoiding movement, activities)
  - Catastrophizing (excessive negative thoughts)
- Nonorganic signs (somatic focus)
- Functional impairment
- Low general health status
- Presence of psychiatric co-morbidities

Chou, R., & Shekelle, P. Will This Patient Develop Persistent Disabling Low Back Pain? JAMA. April 7, 2010; Vol 303, No. 13, 1295-1302
Self-Management Tools


Body Mechanics

Sleep Hygiene

Explain Pain

- Explain Pain by David Butler and Dr. Lorimer Moseley is an evidence-based book designed for therapists, patients, and students. It answers the most common questions asked by pain sufferers: ‘why do I hurt?’ and ‘what can I do for my pain?’ Written in simple language that anyone can understand, it encourages patients to move better and research shows that they will have less pain once they have understood its underlying causes.

The Graded Motor Imagery Handbook for CRPS
Moseley, Butler, Beames, Giles (2012)

- Designed for both clinicians and pain sufferers, The Graded Motor Imagery (GMI) Handbook offers a novel three-stage synaptic exercise process for neuropathic pain using left/right discrimination, imagined movements and mirror therapy to explore the representation of body parts in our brains and how these may be affected by injury.
An astonishing new science called "neuroplasticity" is overthrowing the centuries-old notion that the human brain is immutable. In this revolutionary look at the brain, psychiatrist and psychoanalyst Norman Doidge, M.D., provides an introduction to both the brilliant scientists championing neuroplasticity and the people whose lives they’ve transformed. From stroke patients learning to speak again to the remarkable case of a woman born with half a brain that rewired itself to work as a whole, *The Brain That Changes Itself* will permanently alter the way we look at our brains, human nature, and human potential.

"The neurons that fire together, wire together."

"Pain is normal – living in pain is not. Chronic pain is commonly due to an extra-sensitive nervous system and how the brain processes information from the nerves. Understanding more about the neuroscience of pain has been shown to allow patients to hurt less, exercise more and regain control of their lives. "Why Do I Hurt?" teaches patients the science of pain in approachable language with metaphors, examples and images.

**CONCLUSIONS:** FOR CHRONIC MSK PAIN DISORDERS, THERE IS COMPELLING EVIDENCE THAT AN EDUCATIONAL STRATEGY ADDRESSING NEUROPHYSIOLOGY AND NEUROBIOLOGY OF PAIN CAN HAVE A POSITIVE EFFECT ON PAIN, DISABILITY, CATASTROPHIZING, AND PHYSICAL PERFORMANCE.

Shrink the Pain Map by Flooding the Brain Using Positive

- Beliefs and Thoughts
- Images
- Smell (peppermint blocks release of Substance P)
- Touch
- Sound (Brain Music – low frequency sounds)
- Memories
- Soothing Emotions (serenity, relaxation, empathy, attunement, gratitude, happiness, and love)
- Movement (connects brain and body)
- Pleasure (citris oils evoke pleasure circuits)

From Neuroplastic Transformation, Moskowitz and Golden, 2013
**Fibromyalgia A Clinical Review**
Clauw, D.J. JAMA, April 16, 2014, Vol 311, No 15

- Reviewed FM literature from 1955-2014
- FM is a constellation of symptoms characterized by central nervous system pain amplification with concomitant fatigue, memory problems and sleep and mood disturbances.
- Evidence based tx for FM: education, exercise, CBT, tricyclics, SNRIs, and gabapentinoids

**Central Sensitization**

- Centralization implies that peripheral nociceptive input might be responsible for some of a patient’s pain but central nervous system factors likely amplify the pain. Volume control is set by levels of neurotransmitters.
- Central factors may result in fatigue, memory problems and sleep and mood disturbances probably because the same neurotransmitters that control pain and sensory sensitivity also control sleep, mood, memory and alertness. (Phillips, Clauw. Arthritis Rheum. 2013;65(2):291-302).

**Diagnosing and treating chronic musculoskeletal pain based on the underlying mechanisms**, Daniel J. Clauw.
Best Practice and Research Clinical Rheumatology 29 (2015) 6-19

<table>
<thead>
<tr>
<th>Peripheral Neuropathic</th>
<th>Peripheral (nociceptive)</th>
<th>Central neuropathic or “centralized” pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammation or mechanical damage in tissues</td>
<td>Damage or dysfunction of peripheral nerves</td>
<td>Characterized by central disturbance in pain processing (diffuse hyperalgesia/allodynia)</td>
</tr>
<tr>
<td>NSAID, opioid responsive</td>
<td>Responds to both peripheral and centrally active pharmacological therapies</td>
<td>Responsive to neuroactive compounds altering levels of neurotransmitters involved in pain transmission</td>
</tr>
<tr>
<td>Classic examples: Osteoarthritis, Rheumatoid arthritis, Cancer pain</td>
<td>Diabetic neuropathic pain, Post-herpetic Neuralgia</td>
<td>Classic examples: Fibromyalgia, Irritable bowel syndrome, TMJ, Tension headache</td>
</tr>
</tbody>
</table>


- Opioids are not recommended for use in treating tension-type headaches (Bendtsen, Evers, Mitsikostas, Sandrini, Schoenen, Eur J Neurol 2010)
- The American Academy of Neurology in its Choosing Wisely campaign, recommends not using opioids or butalbital for treatment of migraine, except last resort (Langer-Gould, Anderson, Armstrong, Neurolog 2013)

**The Response Systems**

- Depression
- Mood swings
- Cell death in the hippocampus
- Memory changes
- Poor tissue healing
- Weight gain
- Altered immunity

(From Explain Pain, 2003)
Factors That Improve our Immune System

- An ability to develop coping skills
- The perception of the stressor
- Health perceptions
- Social interactions
- Medical support system
- Belief systems
- Exercise
- Humor
- Intimacy
- Diet

People don’t hurt if they have something better to do. W. Fordyce, Ph.D.

Mindfulness

Mindfulness means paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally.

Jon Kabat-Zinn

From Segal, Williams, and Teasdale (2002)

Biofeedback

- Diaphragmatic breathing
- Stress management through relaxation
- Muscle tension reduction
- Heart rate variability

I phone apps:
  - Breathe2Relax
  - Breath Pacer

Cognitive Behavioral Therapy

- "CBT is based on the premise that perceptions and observable displays of pain are influenced by complex interactions between environmental events and individuals' emotional, physiological, behavioral, and cognitive responses. Effective interventions for chronic pain must address the emotional, cognitive, and behavioral dimension of pain, and must also help patients become active participants in learning new methods of responding to their problems." Gatchel, R. J., & Turk, D.

Common Cognitive Distortions to Address in Therapy

<table>
<thead>
<tr>
<th>Distortion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophizing</td>
<td>Magnifying the negative and anticipating the worst case scenario for events and experiences. “If my pain continues like this I’ll end up in a wheelchair.”</td>
</tr>
<tr>
<td>Selective Abstraction (Black and White thinking)</td>
<td>Attending to negative aspects of experiences and disqualifying the positive aspects. “If I can’t keep up with my friends when we shop, then there is not pain in going with them.”</td>
</tr>
<tr>
<td>“Should” statements</td>
<td>Expectations (often unrealistic) about what one should or must be able to accomplish. “I should be able to clean the house like I did before.”</td>
</tr>
<tr>
<td>Overgeneralizing</td>
<td>Assuming that the outcome of one event inevitably applies to other or future events. “My pain always ruins my plans.” “I’ll never have a normal life again.”</td>
</tr>
</tbody>
</table>
Acceptance & Commitment Therapy

Goal of ACT is to help you live a rich, full, and meaningful life while effectively handling the pain that inevitably comes your way.

Values Exercise in ACT or Pie of Life

ACT Resources

- The unwanted party guest (acceptance - metaphor to cope w/ difficult or unwanted experiences) http://www.youtube.com/watch?v=VYht-guymF4
- Mind - struggling with internal hijackers (troublesome thoughts trying to hijack your life) http://www.youtube.com/watch?v=VYht-guymF4
- Dormer on the hunt https://www.youtube.com/watch?v=VYht-guymF4
- Dr. Kevin Vowels 8 session group model of using Acceptance and Commitment Therapy in the Interdisciplinary Rehabilitation of Chronic Pain.

Motivational Interviewing (Miller and Rollnick, 2009)

- A collaborative person-centered process (using warmth, genuine empathy, and acceptance) to engage client, elicit change talk and evoke motivation to make positive changes from the client. Ex.
  - "How might you like things to be different?"
  - "How does ______ interfere with things that you would like to do?"

Hierarchy of Pain Treatment Developed by WHO (2006)

start

Nerve ablation
Implanted pumps
Spinal stimulation
Surgery

Behavioral treatments
Nerve blocks and other injections
Narcotics and other oral analgesics
Muscle relaxants
Physical and occupational therapy,
Chiropractic, Acupuncture
Non-steroidal anti-inflammatories
Over-the-counter medications

finish

Evidence Based Treatment for Chronic Pain:

- Chronic pain self-management programs reduce the physical and psychosocial burden of chronic pain and reduce health care costs (Mann, Lefert, Vanderkloet, 2013)
- Evidence supports multimodal therapies to improve pain and function and reduce disability (Turk, 2002) (Gatchel, Okifuji, 2006)
- Multidisciplinary pain programs have strong clinical efficacy, cost-efficiency, and have been proven to improve function. Programs address the psychosocial and cognitive aspects along with physical rehabilitation.

Interagency Guidelines on Prescribing Opioids for Pain 2015
Expected Outcomes for Interdisciplinary Programs

- **INCREASE FUNCTION** and activity level
- Reduce pain
- Simplify medication / reduce opioids
- Graded physical exercise
- Reduce emotional distress, such as depression and anxiety (CBT)
- Increase self-management / coping skills
- Increase quality of life
- Teach self-regulation of psychophysical arousal
- Decrease inappropriate health care utilization
- RTW or meaningful activity

Case Presentation: AJ

50 y/o Native American man
DOI: 6/29/09
JOI: Veneer Superintendent

INJURY: WORKING IN PLYWOOD MILL, SLIPPED ON SLIPPERY FLOOR INJURING L KNEE

TX: 2011 CARTILAGE GRAFTING PROCEDURE, 2012 TOTAL L KNEE REPLACEMENT (TOTAL 4 KNEE SURGERIES)

POST SURGERY DX: GRADE 4 CHONDROMALACIA OF THE TROCHLEA AND MEDIAL FEMORAL CONDYLE

PAST HX: MENSISCUS TEAR IN 1999

Other health issues: HTN, hyperlipidemia, IBS, GERD

Smoker for 40 years 1ppd

Wt 322

Poor sleep 2-4 hours a night

Hx of depression

+ Trauma hx

Not worked since injury, NOT applied for SSDI

17 IMEs since injury (SIMP denied by ins 2 years ago)

Lives with supportive S/O

4 grown kids, 20 grands (poor relationship with 1 kid)

+ grandkids, golf, bowling

2015 Back Pain Group & Prioritized List Changes
Effective Jan 1, 2016 for OHP

- COMPREHENSIVE INTEGRATED TX FOCUSED ON THE BIOPSYCHOSOCIAL NEEDS OF PATIENT
- ADDED EVIDENCE BASED TX: COGNITIVE BEHAVIORAL THERAPY, PHYSICAL THERAPY, CHIROPRACTIC MANIPULATION, OSTEOPATHIC MANIPULATION, ACUPUNCTURE
- RESTRICTS OR ELIMINATES INEFFECTIVE OR HARMFUL TX: LONG TERM OPIOID PRESCRIBING, UNNECESSARY INTERVENTION

Cochrane Reviews for Various Therapies


From the Bree Collaborative 2013

**STarT Back Screening Tool**

- Developed at Keele University in 2008
- 9-item tool
- Q about radiating leg pain, pain in the shoulder or neck, restricted walking, dressing, fear avoidance, anxiety, pessimistic patient expectations, low mood and bothersomeness
- All of the items were validated predictors for poor back pain outcomes
- Divides patients into 3 risk categories for development of persistent, disabling back pain (low, medium or high)
- Empirically proven to improve outcomes
- Recommended to use tool no later than the 3rd visit to identify pts not likely to respond to routine care

Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomized controlled trial

*Validated Tools for Screening and Assessment (* = most commonly used in primary care)*

- PHQ-9 (depression) *
- GAD-7 (anxiety) *
- Pain Self-Efficacy Scale
- Pain Anxiety Symptoms Scale
- Pain Disability Questionnaire
- PHQ-15 (somatic focus) *
- Oswestry (LBP disability)
- Neck disability Index
- PCL-C (PTSD Checklist)
- PC-PTSD *
- Fear Avoidance Beliefs Questionnaire
- Tampa Scale of Kinesiophobia
- Pain Catastrophizing Scale
- Pain Disability Index
- Brief Pain Inventory
- Multi-dimensional Pain Inventory
- CAGE Adapted to Include Drugs (CAGE-AID)
- Alcohol Use Disorders Identification Test (AUDIT)
- Opioid Risk Tool *
- Screener and Opioid Assessment for Patients with Pain-Revised (SOAP-R)
- Current Opioid Misuse Measure (COMM)
- SIBRE
- The Berlin Questionnaire (sleep)
- STOP-Bang (sleep apnea)
- Pain, Enjoyment of Life, General activity (PEG) *
- 2- Item Chronic Pain Scale *
- StarTTrack Tool *
- Functional Recovery Questionnaire

The Oregon Pain Management Commission

- The mission of the Commission is to improve pain management in the State of Oregon through education, development of pain management recommendations, development of a multi-discipline pain management practice program for providers, research, policy analysis and model projects.

Goals for 2015:
- Revise the 1 hour required pain management web-based module
- Review pain education curriculum for schools
- Provider survey to identify barriers to care for patients with pain
- Plan pain awareness event or drug take back event
- Review the delivery system models of care as relates to changes in healthcare and integration of pain tx into primary care
The Pain Society of Oregon offers CME credits for activities that advance healthcare professionals’ understanding of and competency in treating pain.

- Monthly meetings in Eugene, Portland, Central Oregon
- The Efficacy & Benefits of a Pilates-Based Approach in Physical Therapy For the Treatment of Low Back Pain
- October 22, 2015
- Erin Novelli, MPT
- Pain Standards Task Force Community-Wide Initiatives for Safe Prescribing
- November 19, 2015
- Kimberly Swanson, Ph.D

Upcoming PSO Meetings in Central Oregon

Evidence Based Guidelines

- American College of Physicians and the American Pain Society (APS) published a joint clinical guideline in 2007 to address the dx and tx of LBP – Bree Collaborative recommends adoption of ACP/APS guidelines in primary care settings in Washington
- American College of Occupational and Environmental Medicine Institute of Medicine (IOM)
- American Medical Association (AMA)
- Agency for Healthcare Research and Quality (AHRQ)
- American Society of Interventional Pain Physicians (ASIPP)
- Institute of Clinical System Improvement (ICSI)
- North American Spine Society (NASS)

American Chronic Pain Association

www.theacpa.org

- A person with pain is like a car with 4 flat tires.
- The right medicine might fill one tire. Biofeedback, physical therapy, counseling, pacing, nutritional counseling and other modalities are a few ways to fill up our tires.
- Living a full life with pain requires an active role in the recovery process.

Resources for patients and providers

http://livingwell.doh.wa.gov/workshops

- This 2015 book is designed to help manage pain so people with chronic pain can get on with living a satisfying, fulfilling life, and includes the Moving Easy Program CD. This book and CD are the companion resources to the Chronic Pain Self-Management workshop. Available at bookstores or from the publisher

Resources on Opiates and Opiate Reduction for Chronic Pain

- Substance Abuse and Mental Health Services (SAMHSA) Providers’ Clinical Support System for Opioids (PCSS-O) and Providers’ Clinical Support System for Medication Assisted Treatment (PCSS-MAT) for treatment issues. Expert physicians are available to assist with questions or concerns about opioid tapering and assessment and treatment of substance use disorders.

Dr. Beth Darnall's book and CD

Emergency Department Guidelines for Opiate Prescribing

- The Washington Chapter of the American College of emergency Physicians (WA-ACEP) has developed a set of guidelines that outline good prescribing practices for ED providers
- http://www.washingtonacep.org/painmedication.html

Interagency Guideline on Prescribing Opioids for Pain, 2015
Worthwhile Resources for Providers and Patients

YouTube Videos on pain:
- Understanding Pain: What to do about it in less than 5 Minutes
- Brainman Chooses
- Back Pain by Mike Evans
- TED talk by Lorimer Moseley – Why Things Hurt
- Dan Clauw from UM – Chronic Pain – Is It All in Their Head (central sensitization)

Smart phone apps: My Pain Diary, or Pain Free Back for the iPhone

Exercise programs on YouTube from Bee Collaborative:
- Low back pain remedy stretching exercises
- Top 5 stretches to relieve low back pain
- Yoga for back pain

Treatment for chronic pain is changing

Screen for biopsychosocial issues

Earlier intervention to other disciplines

Know your community resources

Take Home Points

• Treatment for chronic pain is changing
• Screen for biopsychosocial issues
• Earlier intervention to other disciplines
• Know your community resources

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CENTRAL OREGON & GORGE SUMMIT TO REDUCE RX ABUSE WEDNESDAY, OCTOBER 14, 2015
8:30 a.m. - 4:30 p.m.
Deschutes County Fairgrounds | Redmond, OR

We will develop a Regional Action Plan to move discussion into action and create momentum for statewide change. The action plans will include strategies to:
- REDUCE THE NUMBER OF PILLS IN CIRCULATION
- EDUCATE PATIENTS AND THE PUBLIC BETTER - DISPOSE OF UNUSED AND UNWANTED PILLS
- IMPROVE AND EXPAND ACCESS TO COMPREHENSIVE TREATMENT SERVICES

Resources

- Pain Society of Oregon
  - 541-345-7300 or 503-984-3072
  - www.painsociety.com
- Western Pain Society
  - admin@painsociety.com
  - www.amapainsoc.org/societies/wps/
- American Pain Society
  - http://www.amapainsoc.org/

http://www.noigroup.com/
http://www.thehappinesstrap.com/
http://www.unstuck.com/
http://movebeyondpain.com/
www.Chronicpainnetwork.com
http://painconsortium.nih.gov
http://www.psychologytools.org/pain.html
http://www.healthyworkplace/pain-management/5a/slide55-line-back-pain-symp/ved-visit_5a foes_6043214
http://www.pain-in-a.com/archived-webinars
http://www.healthyworkplace.wa.gov/Pages/OpioidGuidelines.aspx
http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Opioids/default.aspx