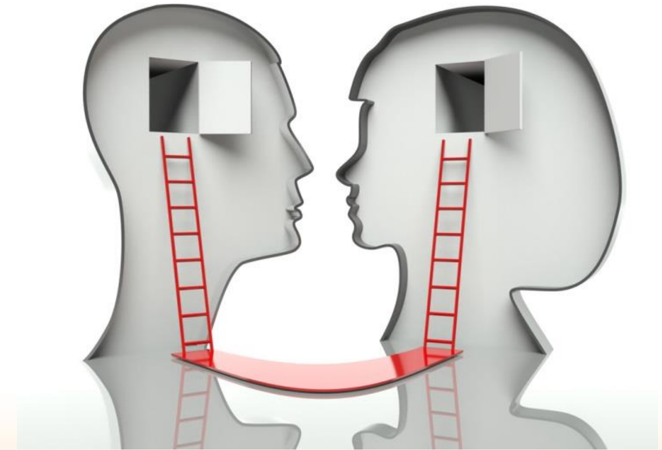
Welcome!

New Perspectives on Pain and Trauma: Conversations and Care Plans



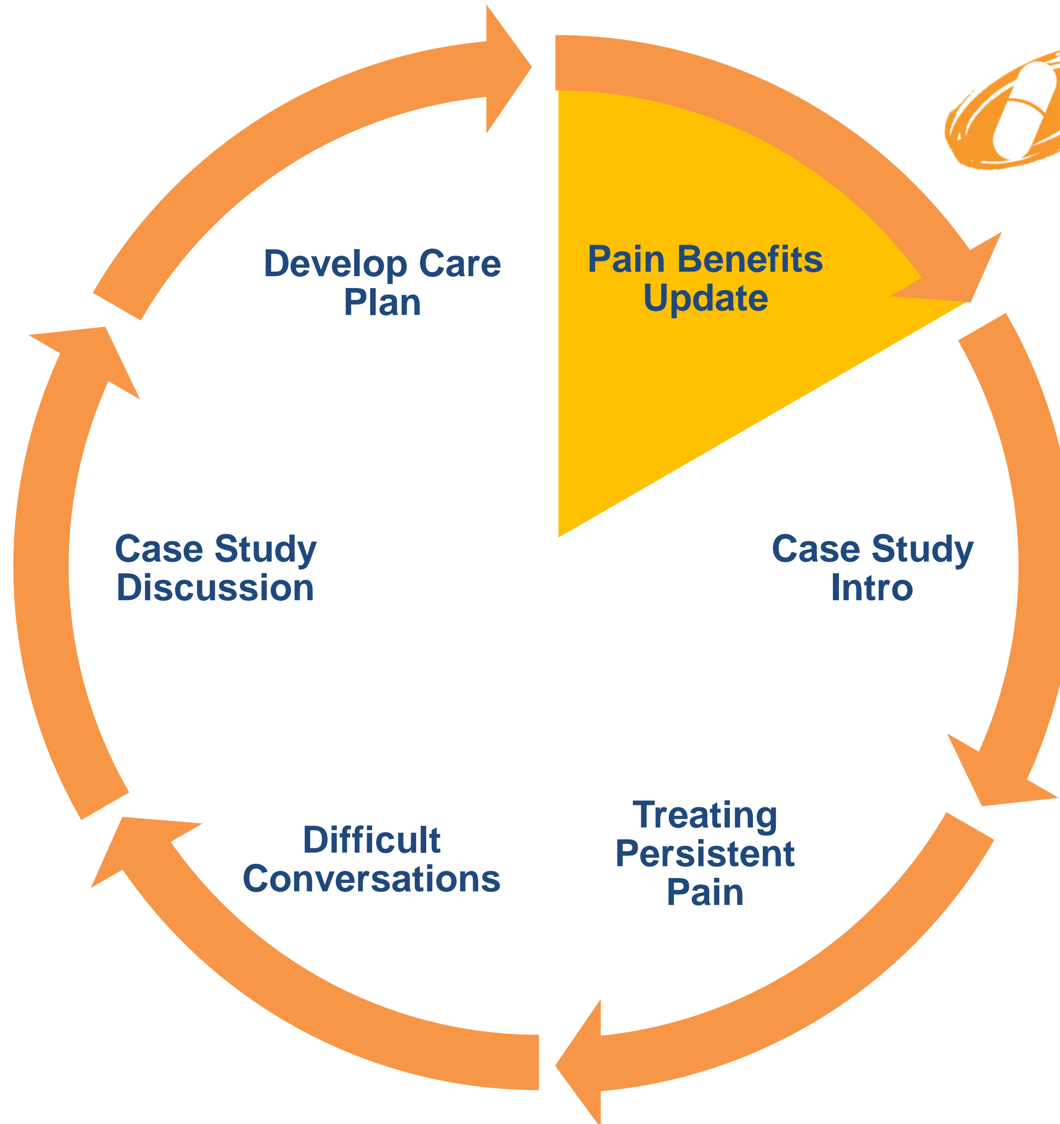
CareOregon Pharmacy

Today's Agenda

- Welcome and Introduction – 8:00
- Opioid Benefits Update – 8:05
- Case Study Introduction – 8:20
- Treating Persistent Pain – 8:30
- **Break – 9:30**
- Difficult Conversations – 9:45
- Case Study Group Discussion – 10:45
- Develop & Review Care Plan – 11:00
- Q&A Segment – 11:20

Objectives

- Review opioid benefit changes, current trends in opioid utilization and non-opioid options for managing pain
- Increase your ability to have trauma-informed conversations about controlled substances
- Understand the important role of movement and activity in dealing with pain recovery
- Develop effective care plans to help with pain recovery



MEDS Ed

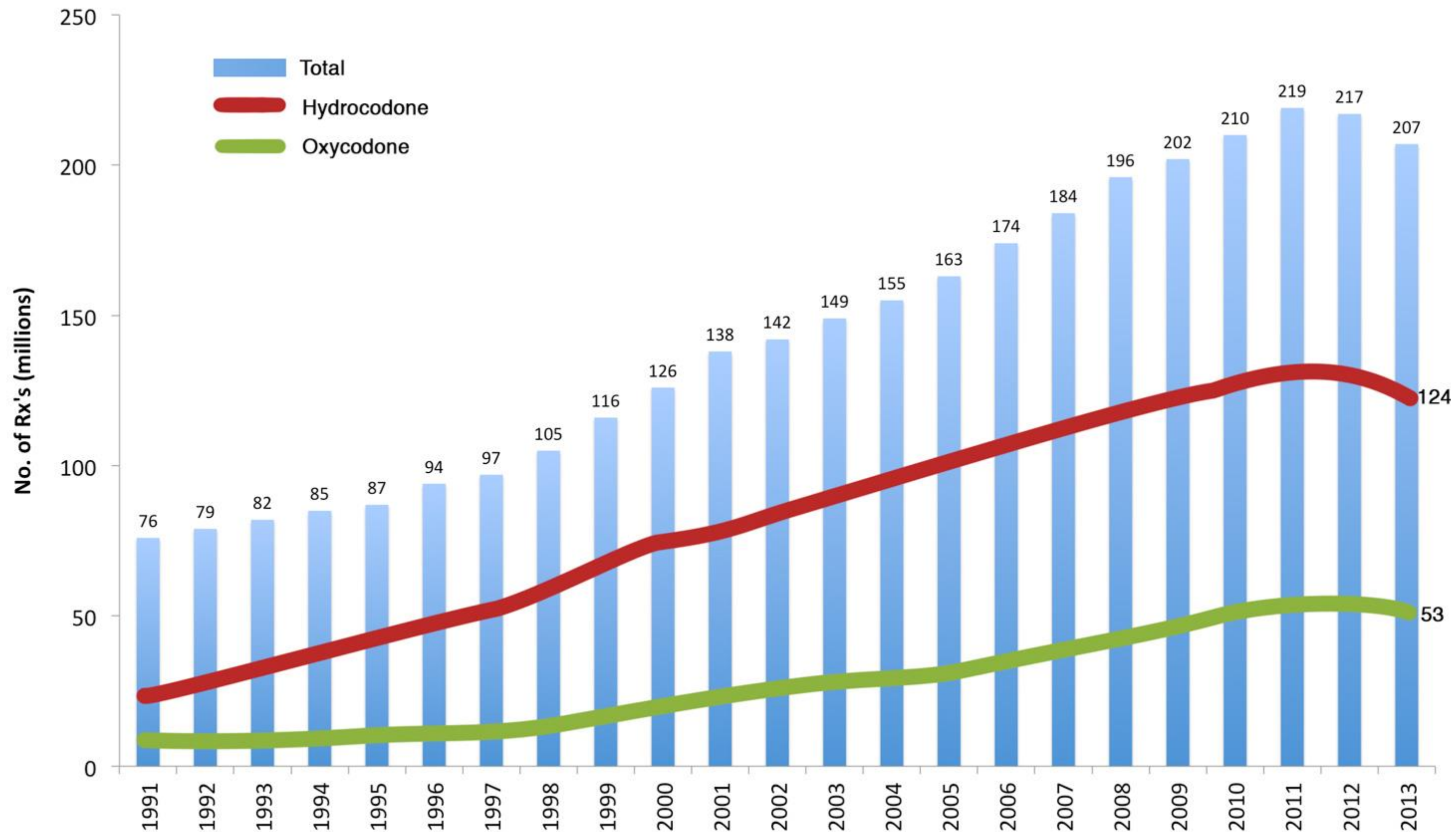
CareOregon Pain Management Benefits

Cassandra Miller, PharmD, MS
PGY-1 Managed Care Pharmacy Residents
CareOregon

Objectives

- Explain current trend in opioid utilization
- Describe Oregon Health Authority opioid changes
- Outline plan level changes
- List non-opioid options

Understanding the Opioid Epidemic



- Mid 1990s – pressure of providers to prescribe opioids and treat pain
- JCAHO adopted the "5th vital sign"
- Chronic pain designated ICD-9 code

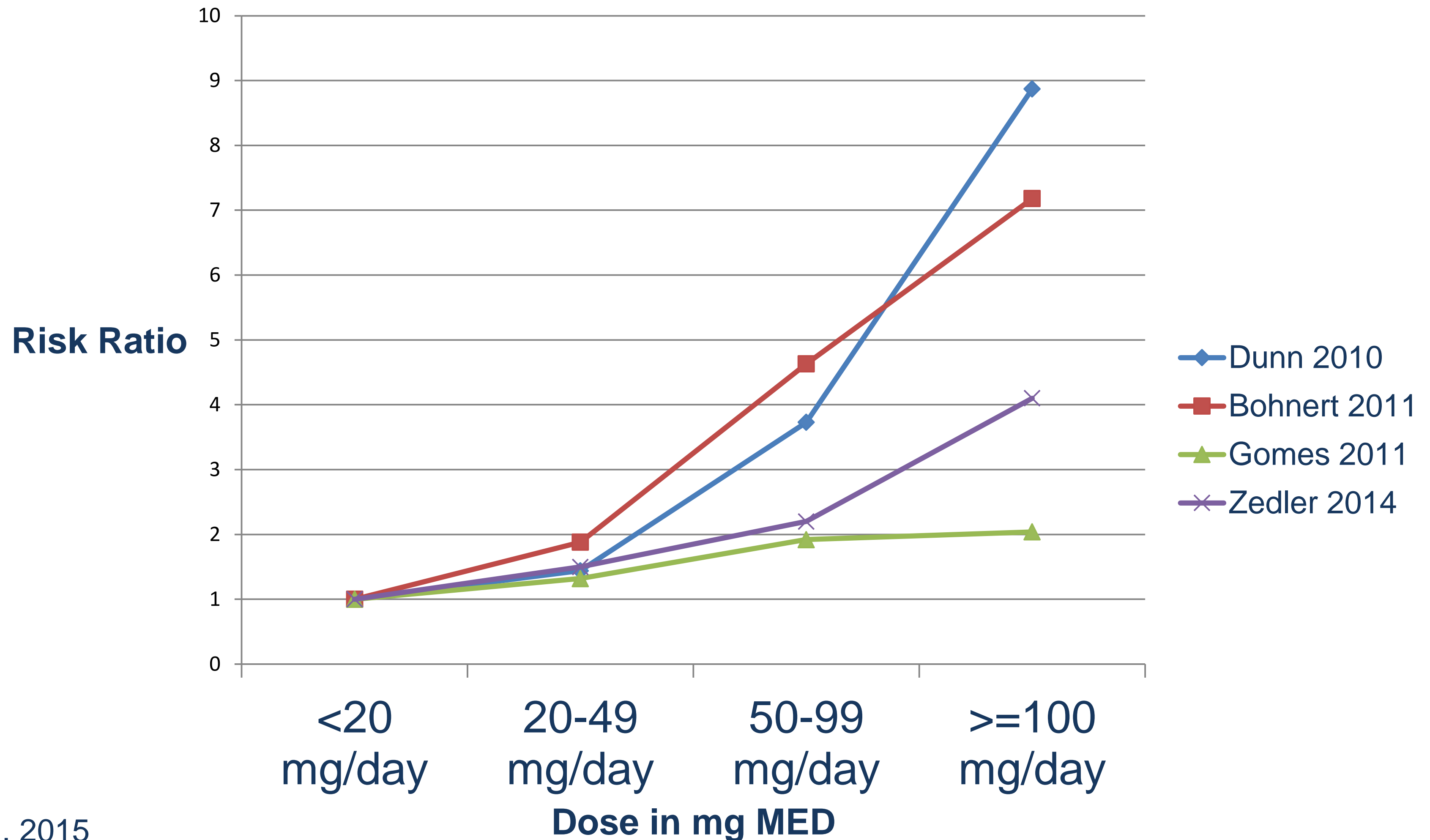
NIH, 2014

Evidence of Effectiveness of Chronic Opioid Treatment

The Agency for Healthcare Research and Quality's (AHRQ) recent draft report, "The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain," found **insufficient data on long term effectiveness to reach any conclusion, and "evidence supports a dose-dependent risk for serious harms."**

AHRQ 2014; Chou et al, Annals Int Med, 13 Jan 2015
Slide Adapted from Dr. Gary M. Franklin MD MPH

Risk of Overdose – 4 Studies



AMDG, 2015

Morphine Equivalent Dose (MED) or Morphine Milligram Equivalents (MME)

- http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm
- As MED increases, risk for adverse events including death increases exponentially
- When switching between opioids, use 75 to 50% of the MED
  - Hydrocodone: morphine- 1:1
  - Oxycodone: morphine- 1:1.5
  - Methadone: complex, escalating, risky

Opioid Agent	Approximate Equianalgesic Dose
Buprenorphine	0.4 mg
Codeine	200 mg
Fentanyl transdermal	12.5 mcg/hr
Hydrocodone	30 mg
Hydromorphone	7.5 mg
Methadone chronic	4 mg
Morphine	30 mg
Oxycodone	20 mg
Oxymorphone	10 mg
Tapendtadol	75 mg
Tramadol	300 mg

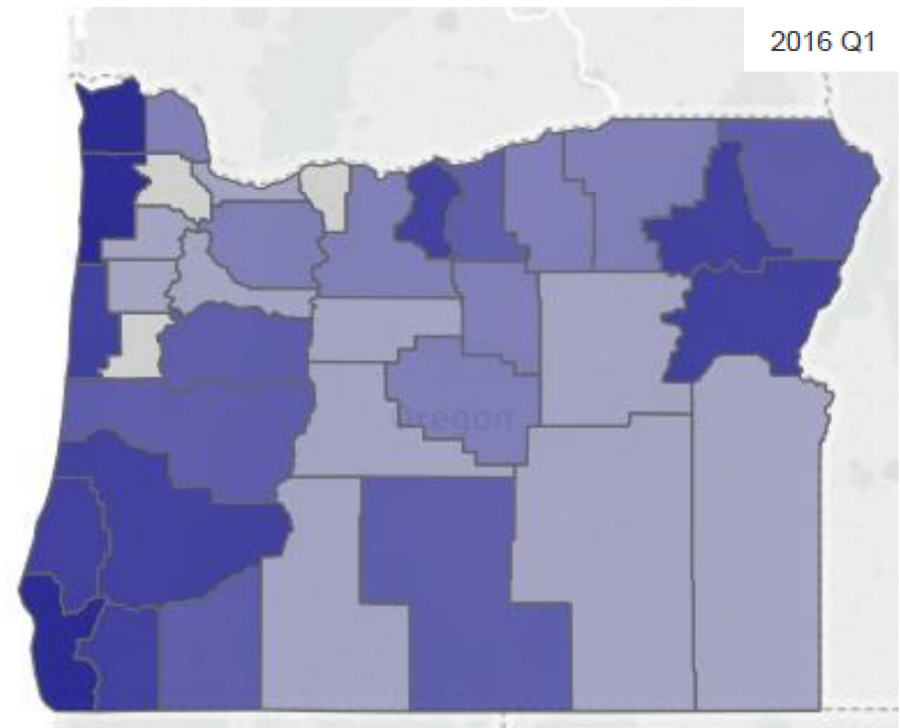
OPG guidelines, 2016

State Opioid Prescribing

>120MED Individuals per 1,000 Residents

Top Counties for Risky Prescribing (>120MED)

1. Curry
2. **Tillamook**
3. **Clatsop**
4. Sherman
5. Union
6. Baker

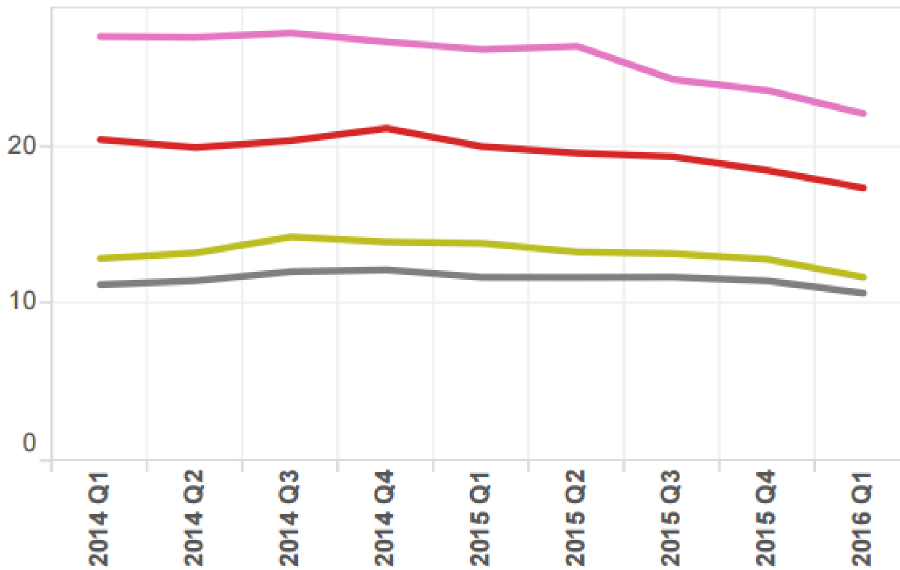


Map Scale

OHA Prescribing Data dashboard, 2016

State Opioid Prescribing

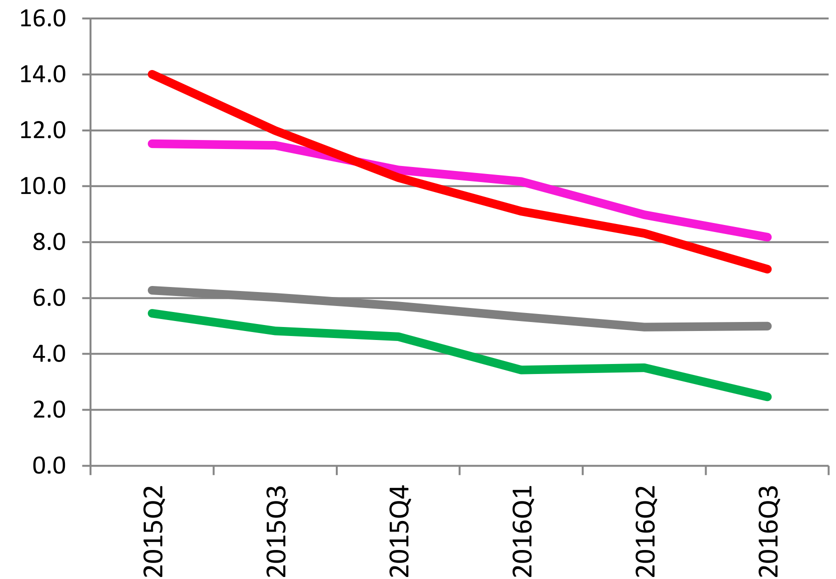
>120MED Individuals per 1,000 Residents



Clatsop, Tillamook
Multnomah, Clackamas, Washington
Jackson
Yamhill

OHA Prescribing Data dashboard, 2016

>120 MED individuals per 1000 adult CareOregon members



ColPac
JCC
YCC
HSO

CareOregon®
MEDS Ed

OHA Coverage Changes for Chronic Low Back Pain

- State and federal guidelines limit the use of opiate pain medications
  - Lack of evidence that opioid use improves patient lives
  - Increased accidental deaths and overdose
- Established restrictive changes on opioid management
  - Increase coverage for conservative treatments while limiting opioid prescribing for conditions of the back and spine

Guideline Note (GN) 60 Criteria for Opioid Use in Back Pain

Only acute injury, acute flare of chronic pain, after surgery

Up to 6 Weeks

- ✓ Each Rx limited to 7 days
- ✓ Short acting opioids only
- ✓ Must fail/contraindication to NSAIDs, APAP, muscle relaxers
- ✓ Not at high risk for opioid misuse/abuse
- ✓ Plan to keep active and consideration of evidence-based therapies (GN 56)

6 weeks – 90 days

- ✓ Must show 30% functional improvement

> 90 days

- Not covered except for taper process

GN 60 Opioid Taper Timeline for Back Pain

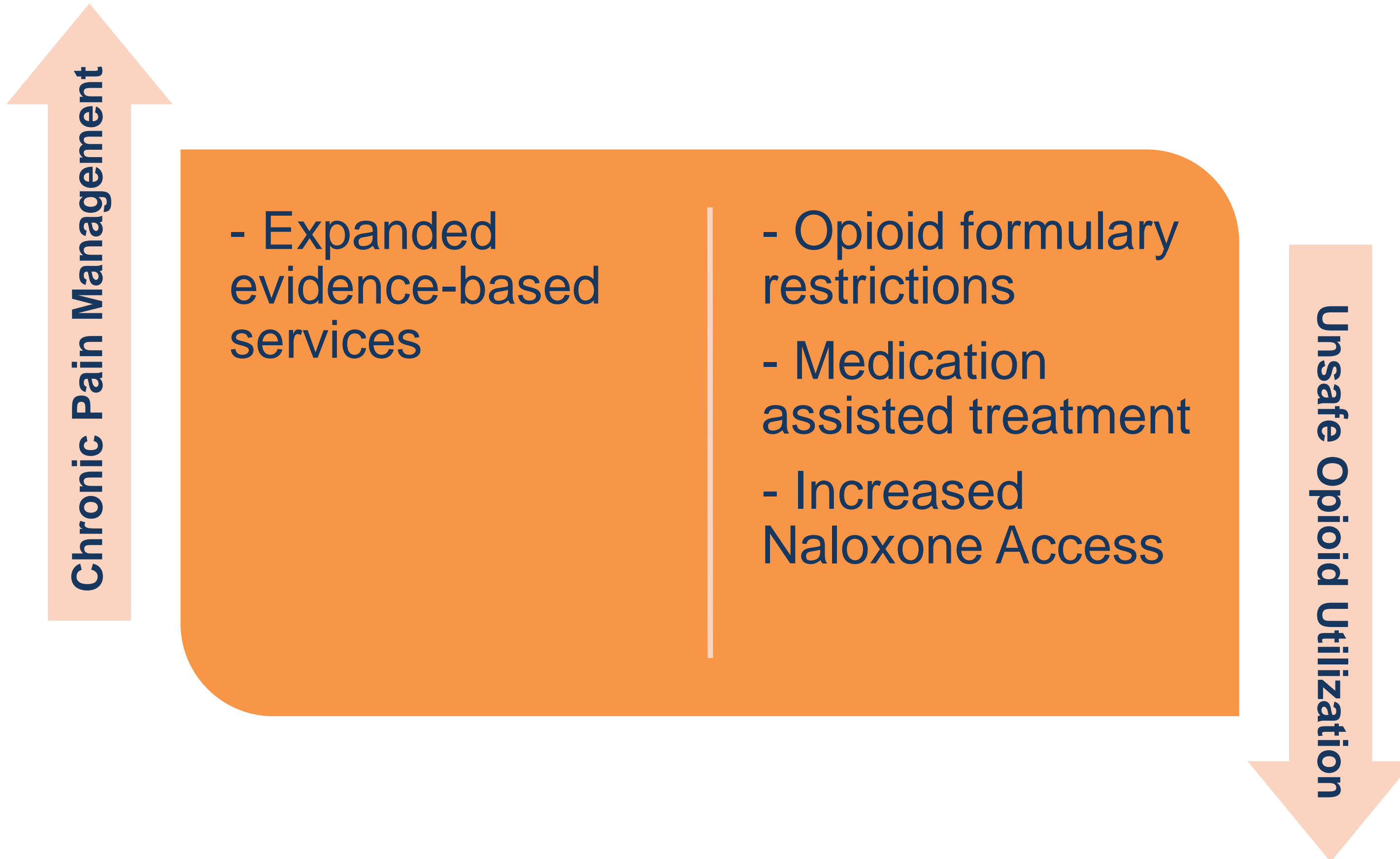
Opioid medication coverage ends on **12/31/16** for patients on long-term opioid therapy as of 7/1/16

1/1/17 – 12/31/17 Continued coverage of opioid medication must include

1. **Taper plan** and
2. **Nonpharm treatment strategies**

1/1/18 Deadline for the end of opioid therapy

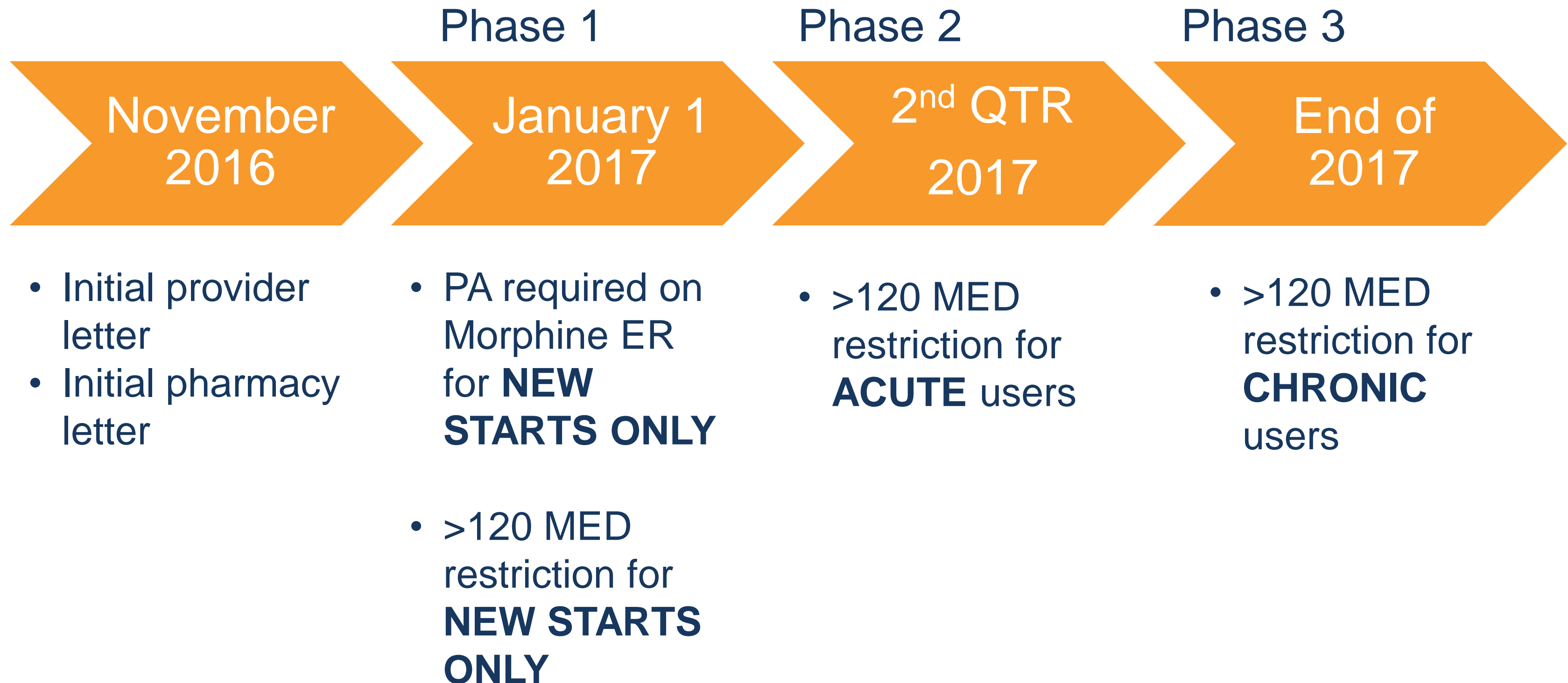
CareOregon Strategy



CareOregon Opioid Benefit Changes

1. Prior Authorization all strengths morphine ER
2. Quantity limit on all short acting opioids to 120 mg MED maximum per day per claim

CareOregon – Opioid Benefit Timeline



CareOregon Nonpharmacological Treatment

Intervention	PA Required
Acupuncture	No
Chiropractic Care	Yes
Physical Therapy	Yes

Up to 30 sessions per year of any combination of above services for back pain

Formulary Non-Opioid Alternatives

- Acetaminophen
- NSAIDs
- Carbamazepine
- Gabapentin/Lyrica*
- Topical capsaicin
- Topical lidocaine gel
- SNRIs and TCAs

*PA required: Indications limited to Diabetic Peripheral Neuropathy (DPN), neuropathic pain associated with spinal cord injury, or Postherpetic Neuralgia (PHN)

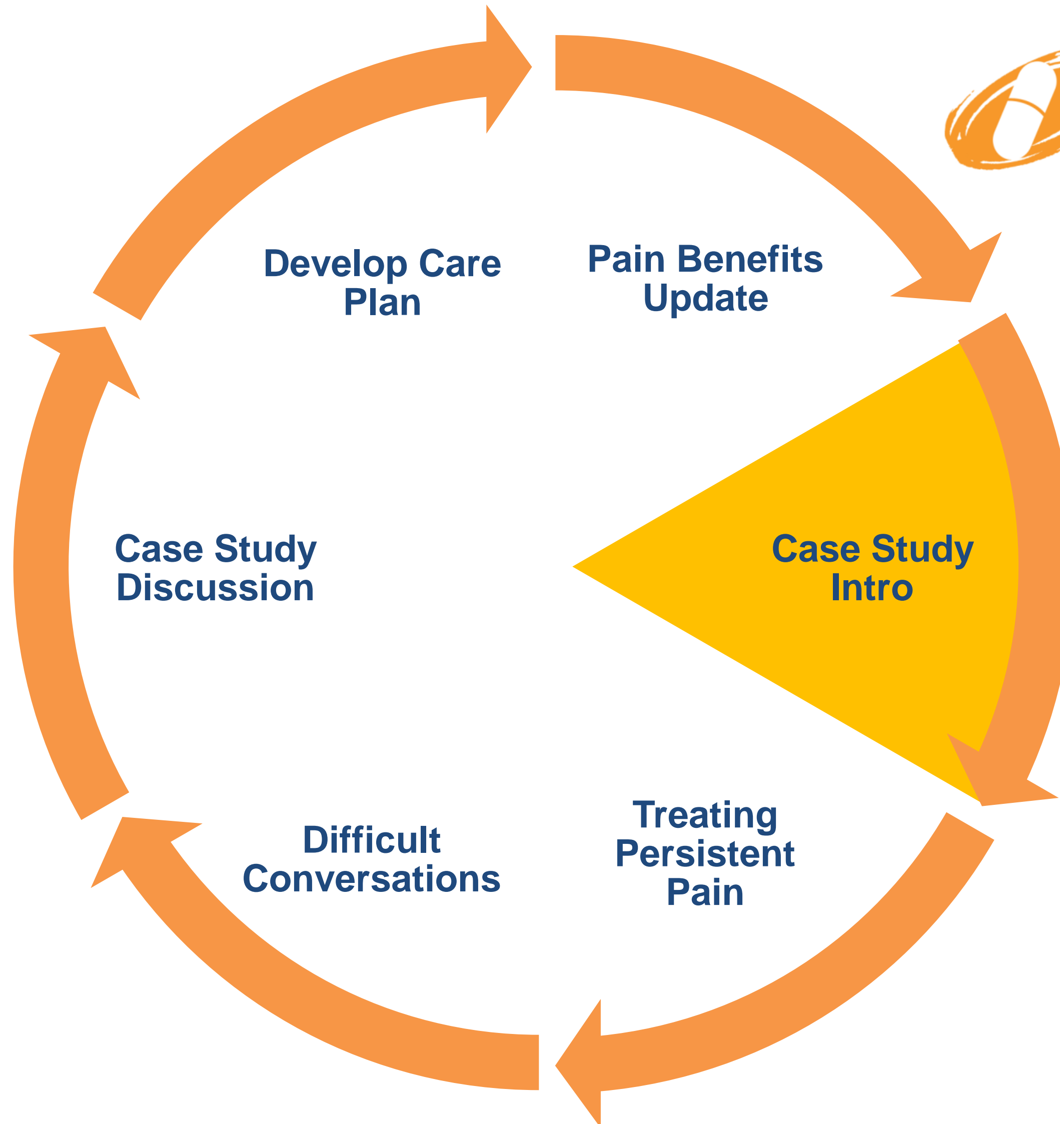
Future Considerations

- Phase out all chronic morphine ER use
- Lower QL MED threshold

  120 MED → 90 MED → 50 MED

FAQ

- See FAQ: Opioid Benefit Changes for additional information
- CDC handouts
  - MED/MME calculation
  - Nonopioid treatments for chronic pain



MEDS Ed™

Case Study Introduction

Lydia Anne M Bartholow, DNP, PMHNP, CARN-AP

Old Town Clinic, Central City Concern

Case Study: *Meet Laney*

Laney

- TBI, PTSD, MDD, Persistent Low Back Pain
- Both Opiates for pain and Benzodiazepines for anxiety
- HX at MMT Clinic
- Past Psychiatric TX primarily meds, no therapy
- Lives alone in SRO-like apartment
- Community in her building
- Pain with walking. Uses a walker a friend loaned her
- Loves her dog, Chloe

Laney's Pain Story

Pain Presentation:

Lower back pain, spreading in area across lumbar bilateral and left lower thoracic area, hard to tell where it is sometimes, worse with cold weather. Worse with walking

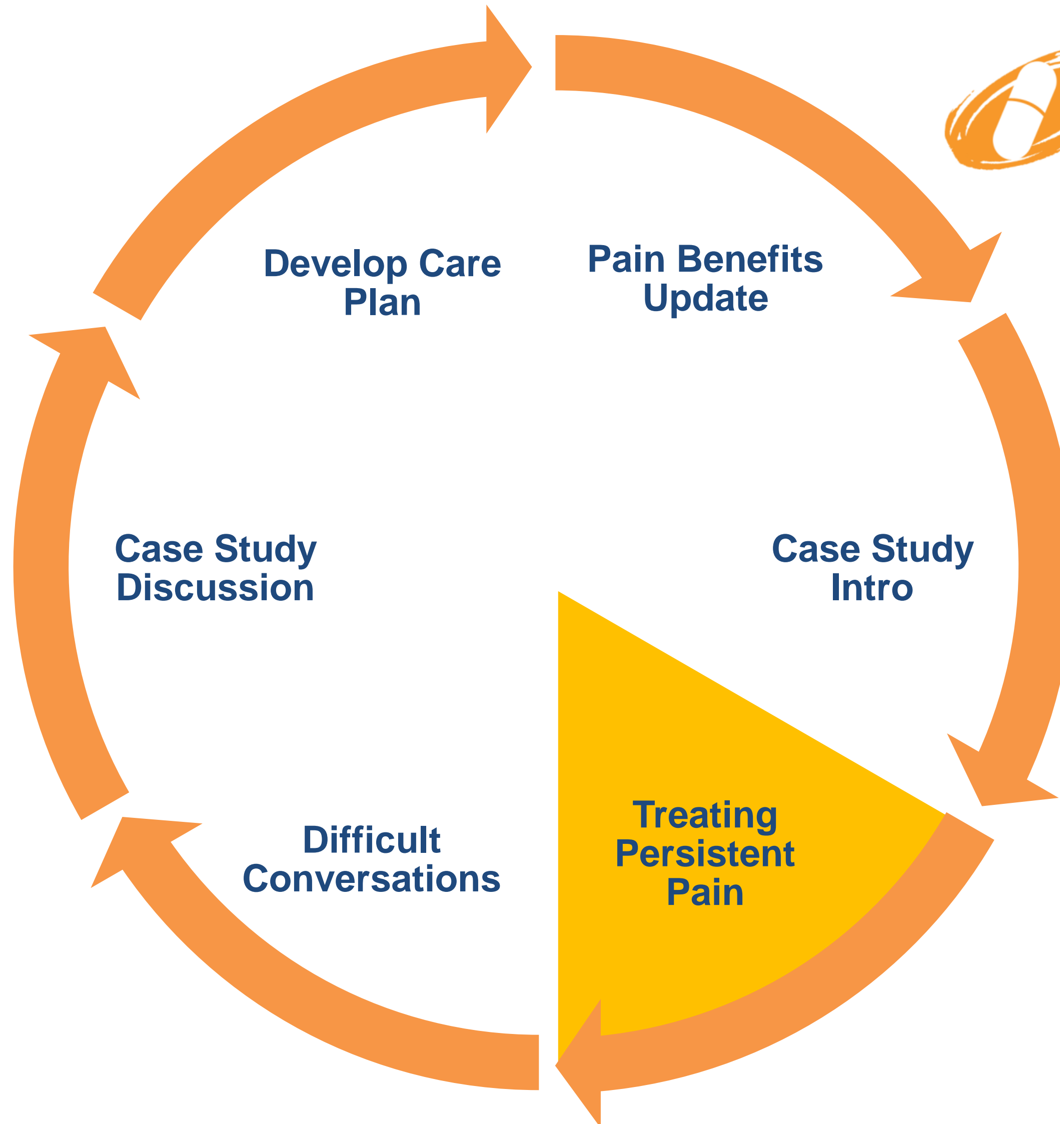
Testing:

X-Rays 2012: Moderate degeneration at L3-5 bilateral facets
No MRI but Laney is requesting this

Concern that something terrible is about to happen when she experiences pain

No HX of PT, OT 2/2 transportation challenges & insurance

Using ED roughly every 2 months



MEDS Ed™

Treating Persistent Pain Doesn't Need to Be Painful

Nora Stern, MSPT

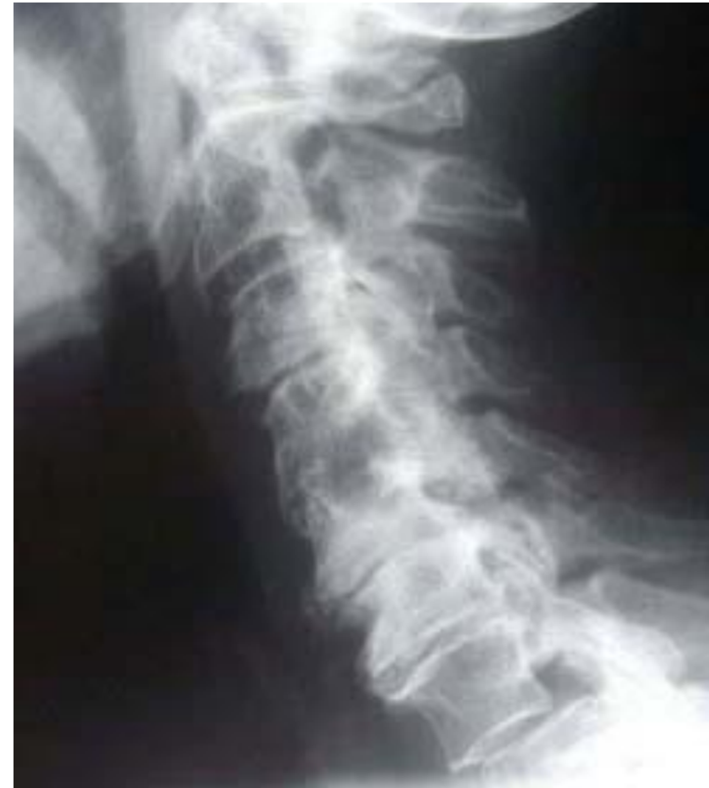
Providence Persistent Pain Project

Context and Meaning

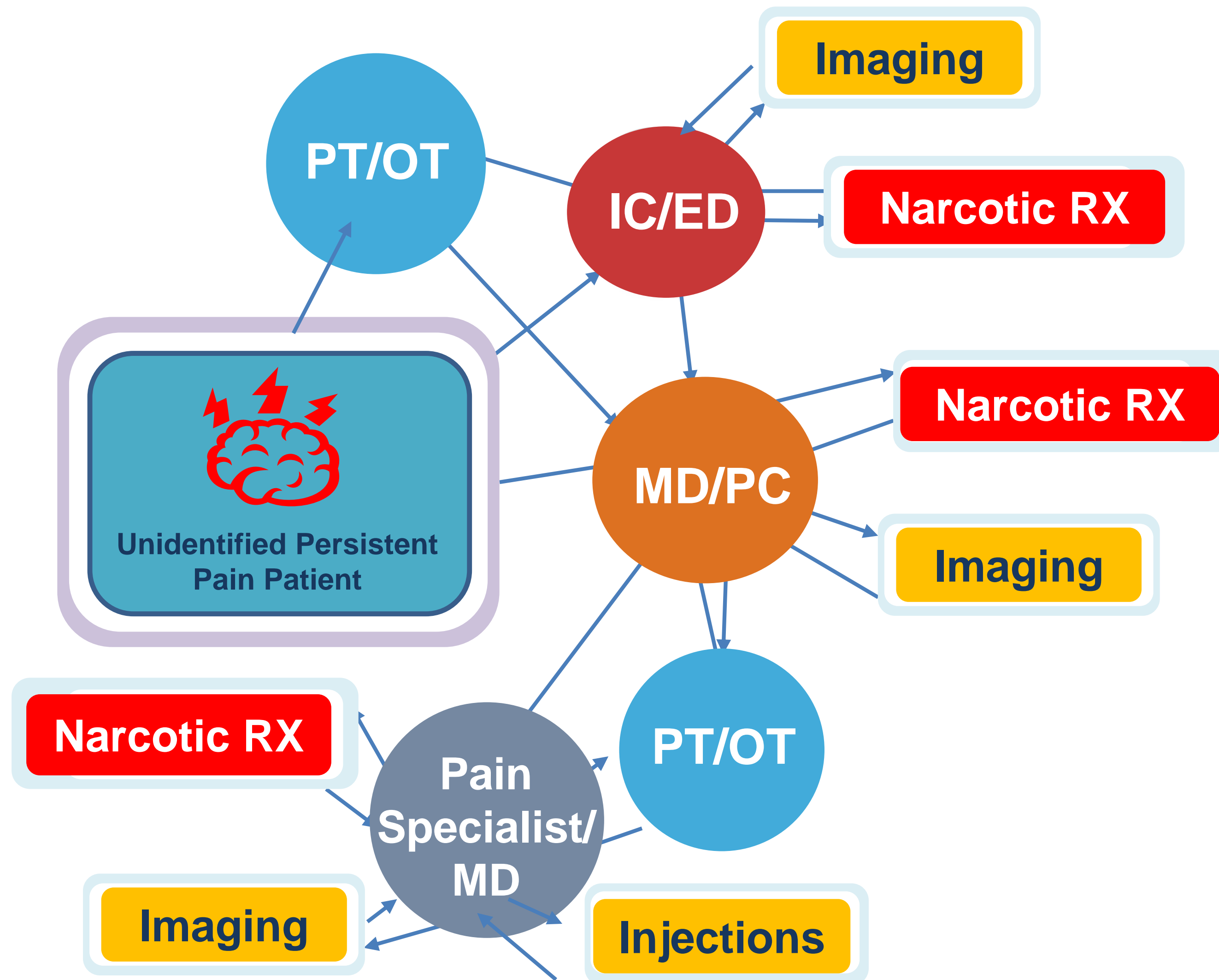
Childbirth vs. Trauma

Old Model

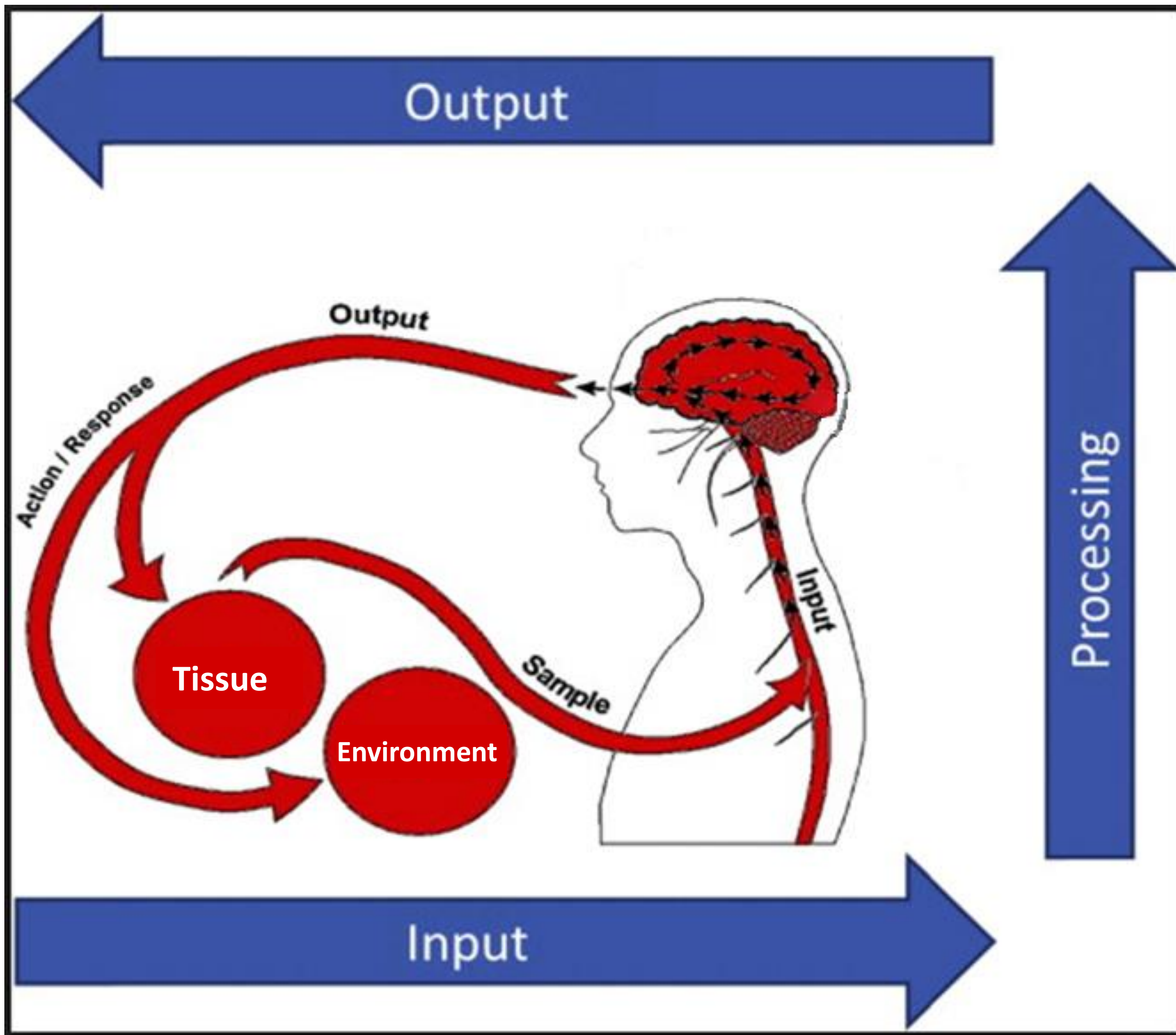
Pain = Tissue Damage



Where we've been…



Copyright (C) 2016 Providence Health & Services



Copyright (C) 2016 Providence Health & Services

Pain as an emergent rather than linear process

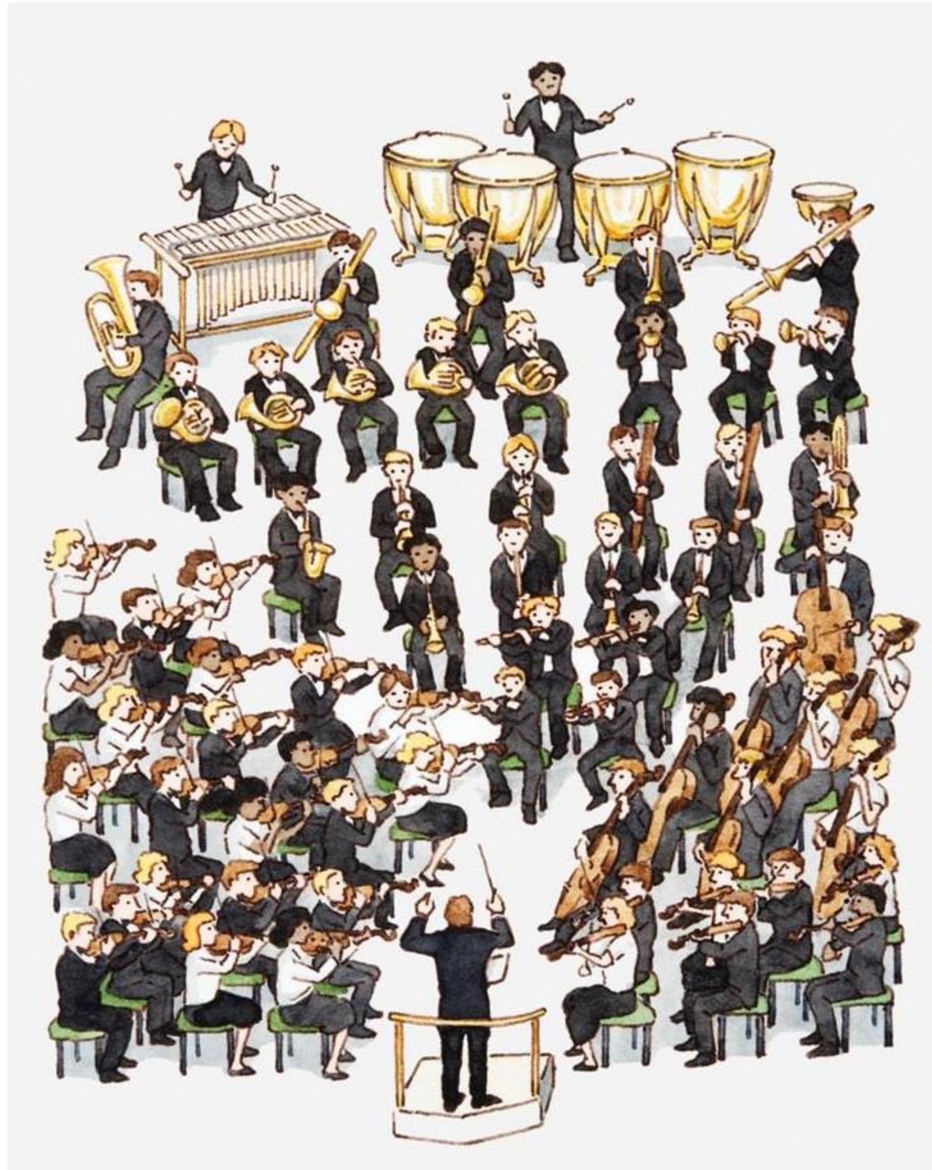


Схема на градски транспорт София

Цена на билет - 1 лв.

GRADSKI.net.TC

Януари 2009

Легенда

- Автобусна крайна спирка 6
- Тролейбусна крайна спирка 6
- Трамвайна крайна спирка 6
- Автобусна линия със спирка
- Тролейбусна линия със спирка
- Трамвайна линия със спирка
- Надземна метролиния със спирка
- Подземна метролиния със спирка
- Надземна метролиния в строеж със спирка
- Подземна метролиния в строеж със спирка
- Дипломатическо посолство на :

Георги Ехларов
Транспортен Институт
Технически Университет Карлсруе, Германия

Relaese : 21.1

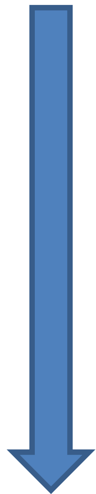
Internet : www.trafik.bg.tc

copyright © reg.Nr.2236 Всички права запазени.

Никоя Част от това издание не може да бъде възпроизвеждана с каквато и да е цел, в какъвто и да е формат и с каквито и да е средства , нито да се превежда на друг език без писмено съгласие на автора.

Pain Response Changes Based on Threat Value

Pain Education as a Treatment Intervention



Decrease in pain rating

(Van Oosterwijck et al 2011, Meeus et al, 2010, Ryan et al, 2010, Moseley, 2002, 2003, 2004)

Decrease in fear of re-injury

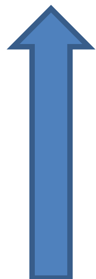
(Van Oosterwijck et al 2011, Moseley, 2002, 2003)

Decrease in pain catastrophizing

(Meeus et al, Moseley 2004, Louw et al 2011, Arch Phys Med Reh Systematic review)

Decrease in utilization of services postoperatively

(Adriaan Louw, PhD, PT, et SPINE Volume 39, #18)



Increase in function

(Van Oosterwijck et al 2011, Moseley, 2002, 2003, , Louw et al 2011 Arch Phys Med Reh Systematic review**)**

Increase in mobility

(Moseley and Hodges, Clin J Pain. 2004 Louw et al Physiotherapy J, 2011)

Pain education decreases utilization 45%

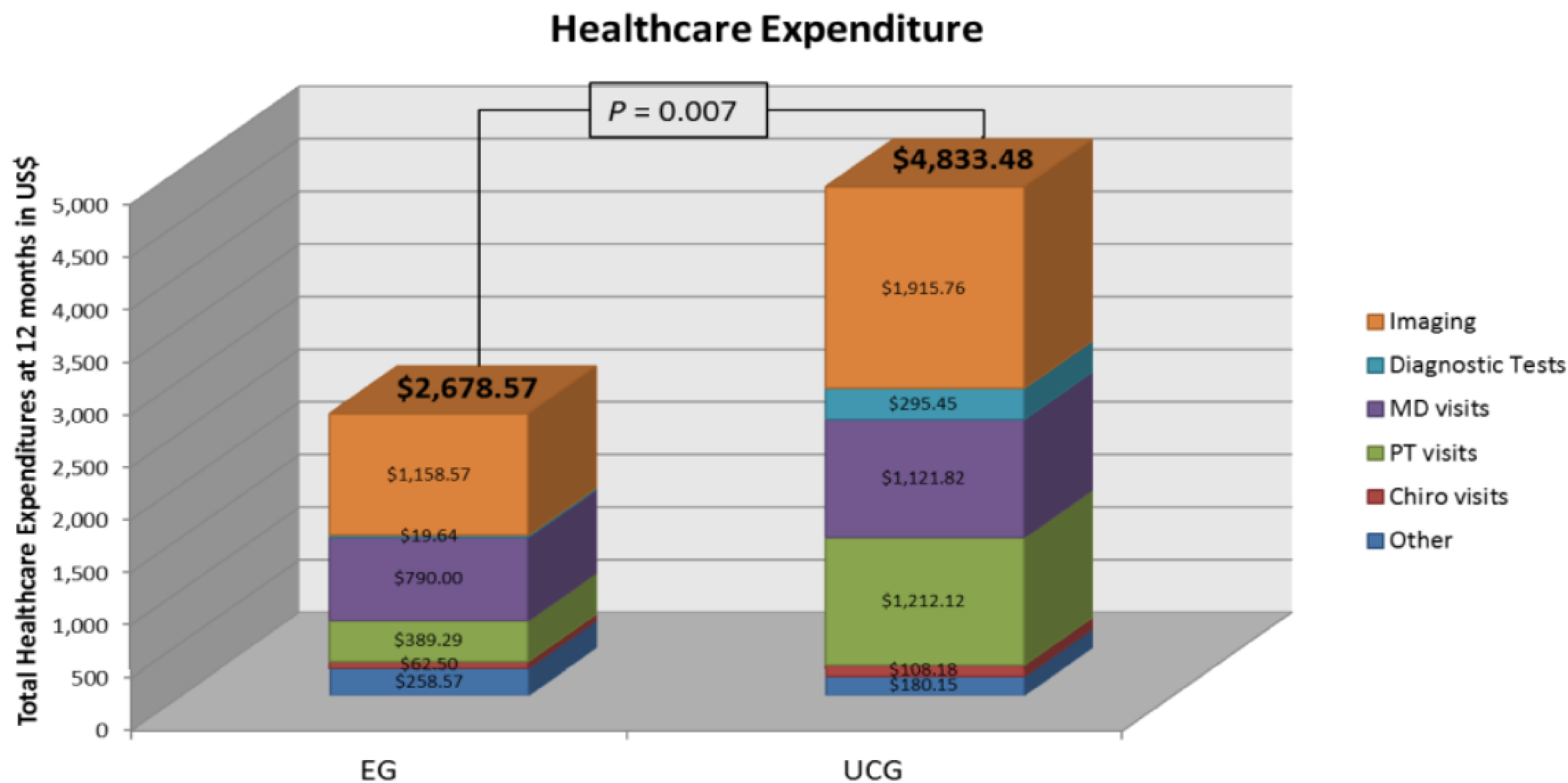


Figure 6. Comparison of total health care utilization (in US$) between the EG (n = 28) and control group (UCG) (n = 33) at 12 months post-lumbar surgery. Imaging = radiographs, magnetic resonance imaging, computed axial tomography, and myelography; diagnostic tests = blood tests and nerve conduction tests; MD visits = surgeon, family physician, or other physician. UCG indicates usual care group; EG, experimental group.

Preoperative Pain Neuroscience Education for Lumbar Radiculopathy: A Multicenter Randomized Controlled Trial With 1-Year Follow-up, Spine, 39 (18), 15 Aug 2014
Louw, Adriaan PhD, PT*,†; Diener, Ina PhD, PT†; Landers, Merrill R. DPT, PhD, PT‡; Puentedura, Emilio J. DPT, PhD, PT*,‡

Copyright (C) 2016 Providence Health & Services

Changes in the nervous system with pain

Copyright (C) 2016 Providence Health & Services

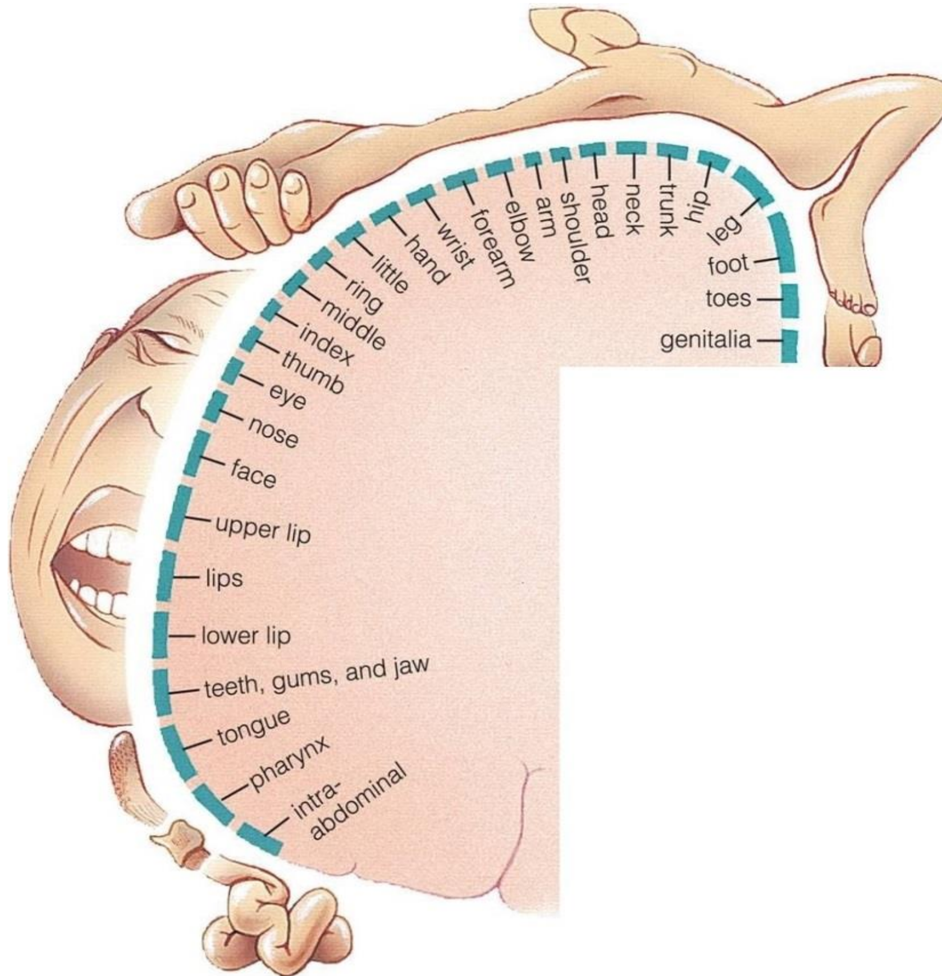
Sensitization at neuron

Changes in neuron sensitization

Copyright (C) 2016 Providence Health & Services

Sensory Cortical Changes

Sensory Cortical Changes



G.L. Moseley / Pain 140 (2008) 239–243

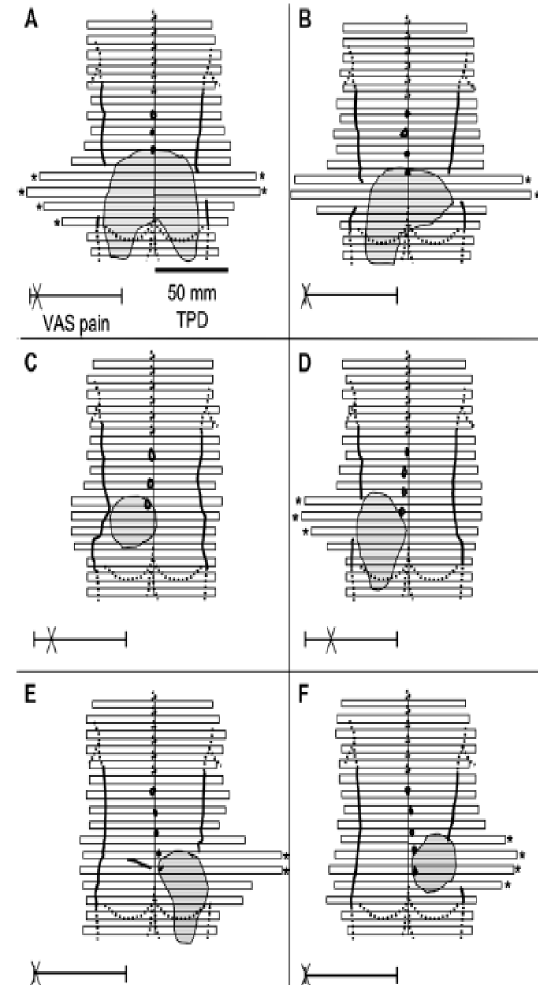


Fig. 1. Patient data: TPD threshold, normal distribution of pain, and body image. Two-point discrimination threshold (TPD) was assess

Disinhibition:
Brain Processes Become Coupled with Pain Response

Acute Injury: experience Fewer brain processes involved in pain

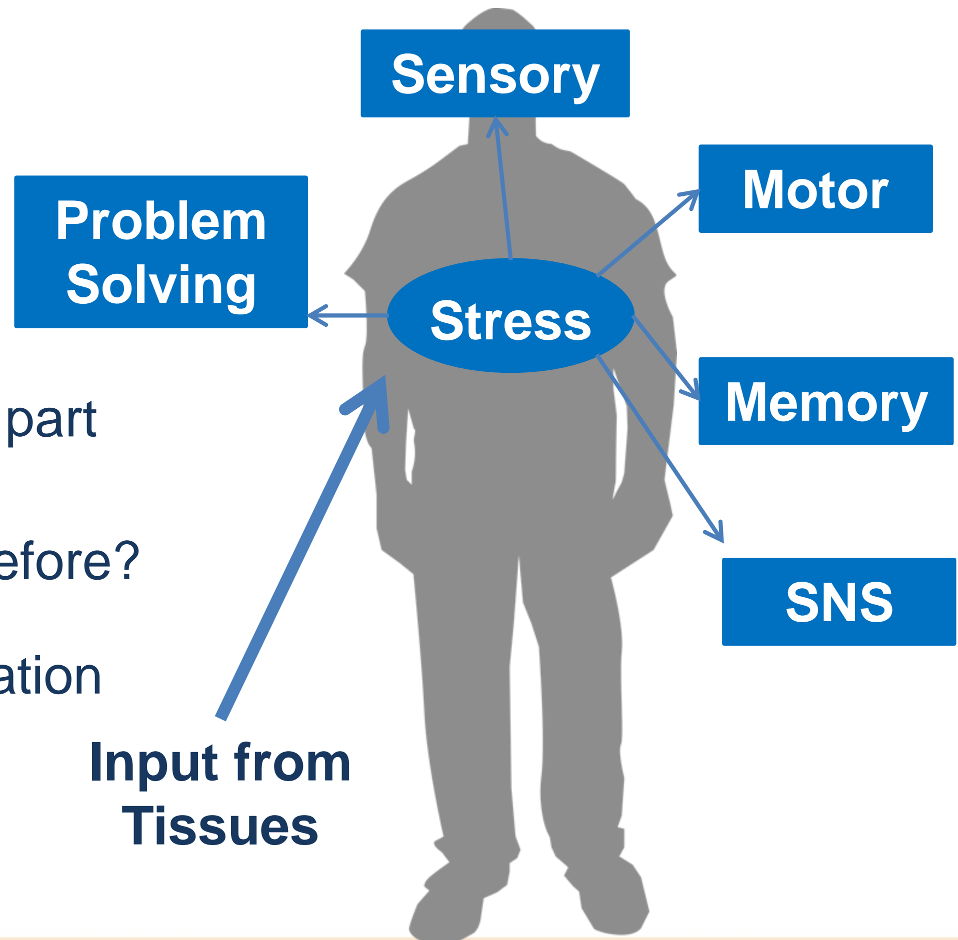
Stress response activates autonomic nervous system

Sensory cortex: identify body part

Memory: has this happened before?

Problem-solving: assess situation

Motor: acts to protect



Persistent Pain: More pain functions coupled with pain response

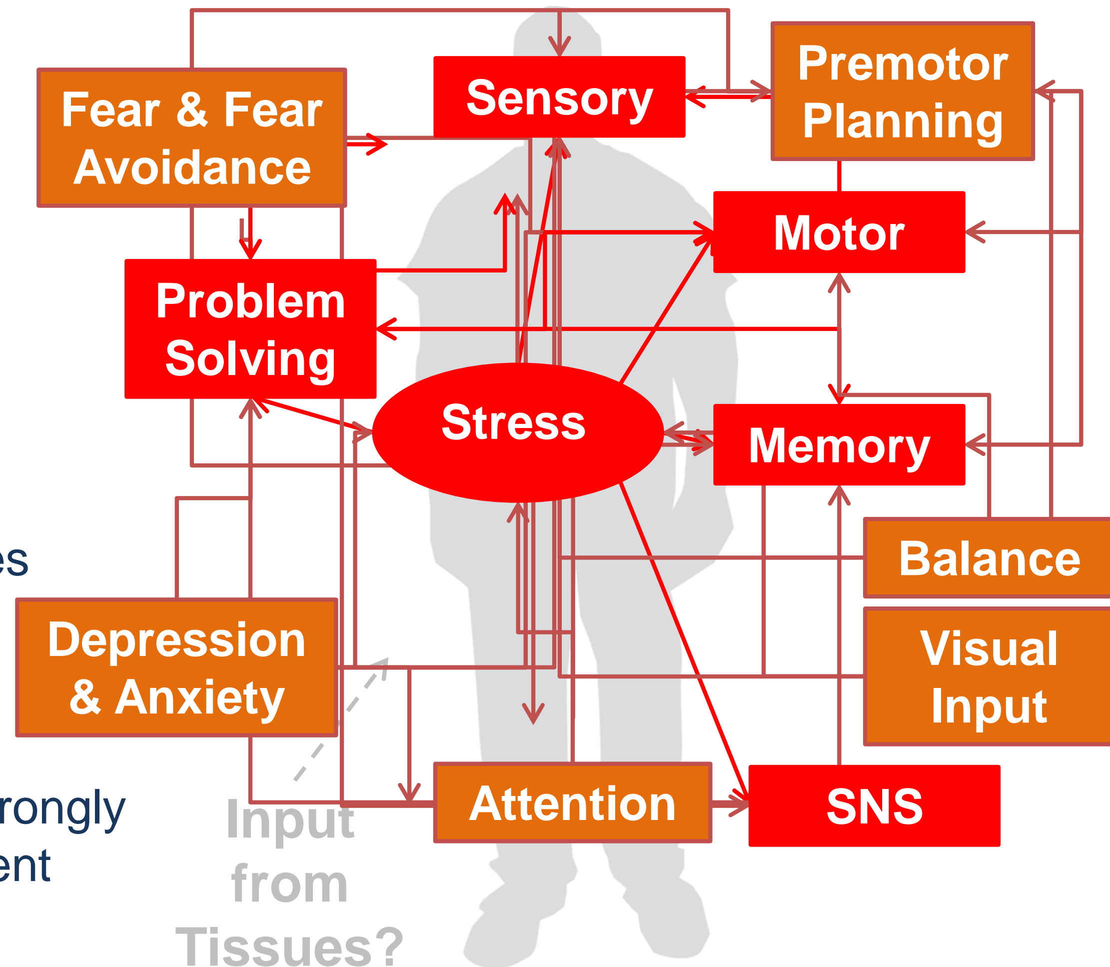
Premotor planning: expecting pain with movement, preparing for movement evokes pain

Attention: centrality of pain in one's life

Fear & Fear Avoidance: associates pain with harm, avoids movement

Balance and Visual Input

Depression, anxiety & trauma: strongly associated with increase in persistent pain



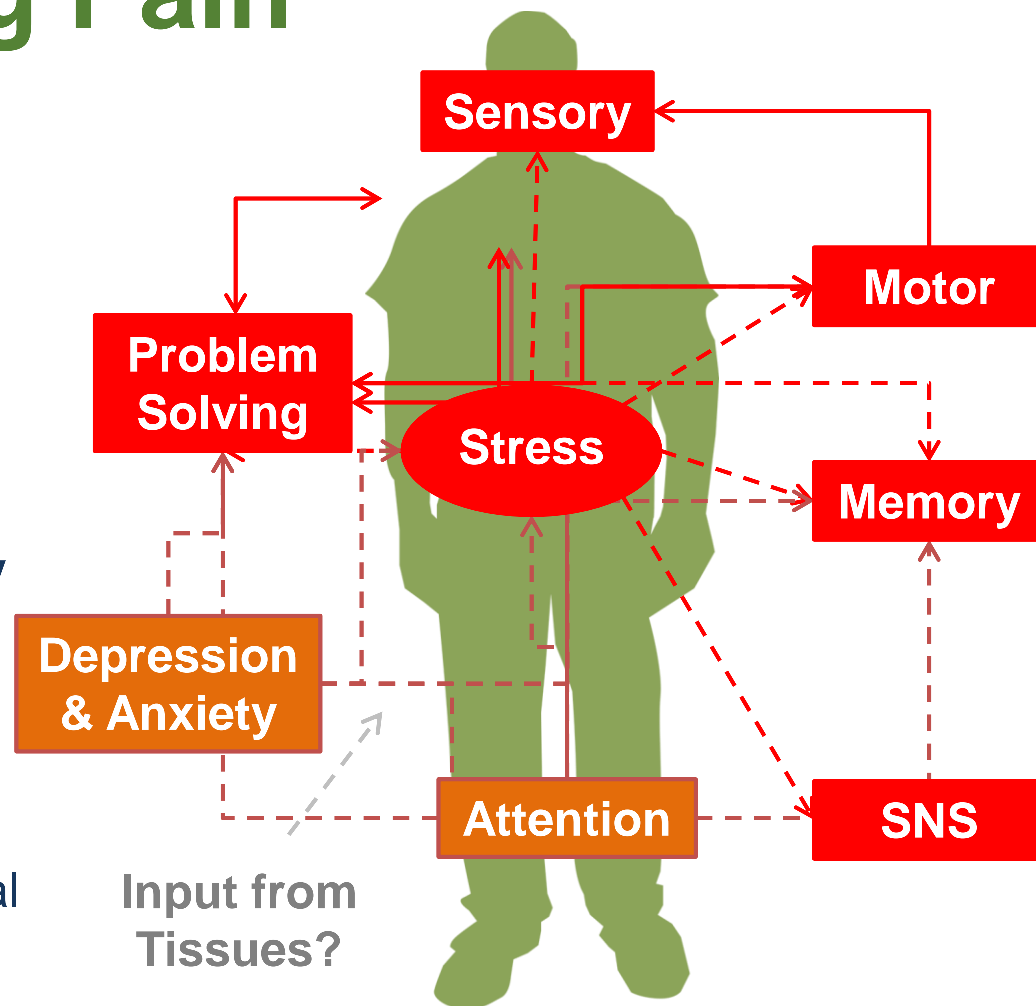
Possible Changes Through Understanding Pain

Problem Solving: Understanding pain, problems and solutions differently

Quieting stress response

Addressing depression, anxiety and trauma and validating their role in the pain experience

Understanding fear avoidance and beginning to return to physical activity



Imbalance of Arousal

Copyright (C) 2016 Providence Health & Services

Threat or Trauma

Immediate Response SNS Activation

Survival:
↑ HEART RATE
↑ RESPIRATION
↑ BLOOD TO MUSCLES

Maintenance:
↓ DIGESTION
↓ SLEEP
↓ REPRODUCTION AND SEX DRIVE
↓ IMMUNE FUNCTION

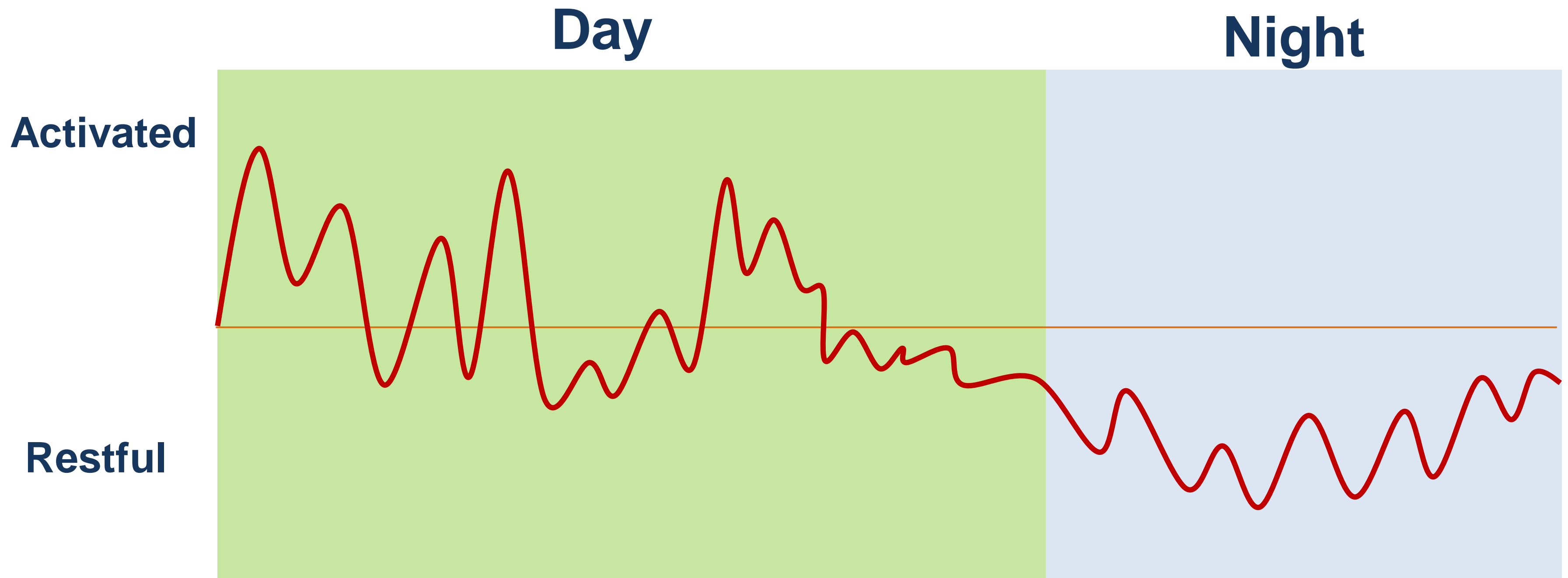
Sense of Safety:
Return to Homeostasis
(Balance of SNS and PNS)

Sense of Ongoing Threat
- System Left Turned On
- Chronic Stress

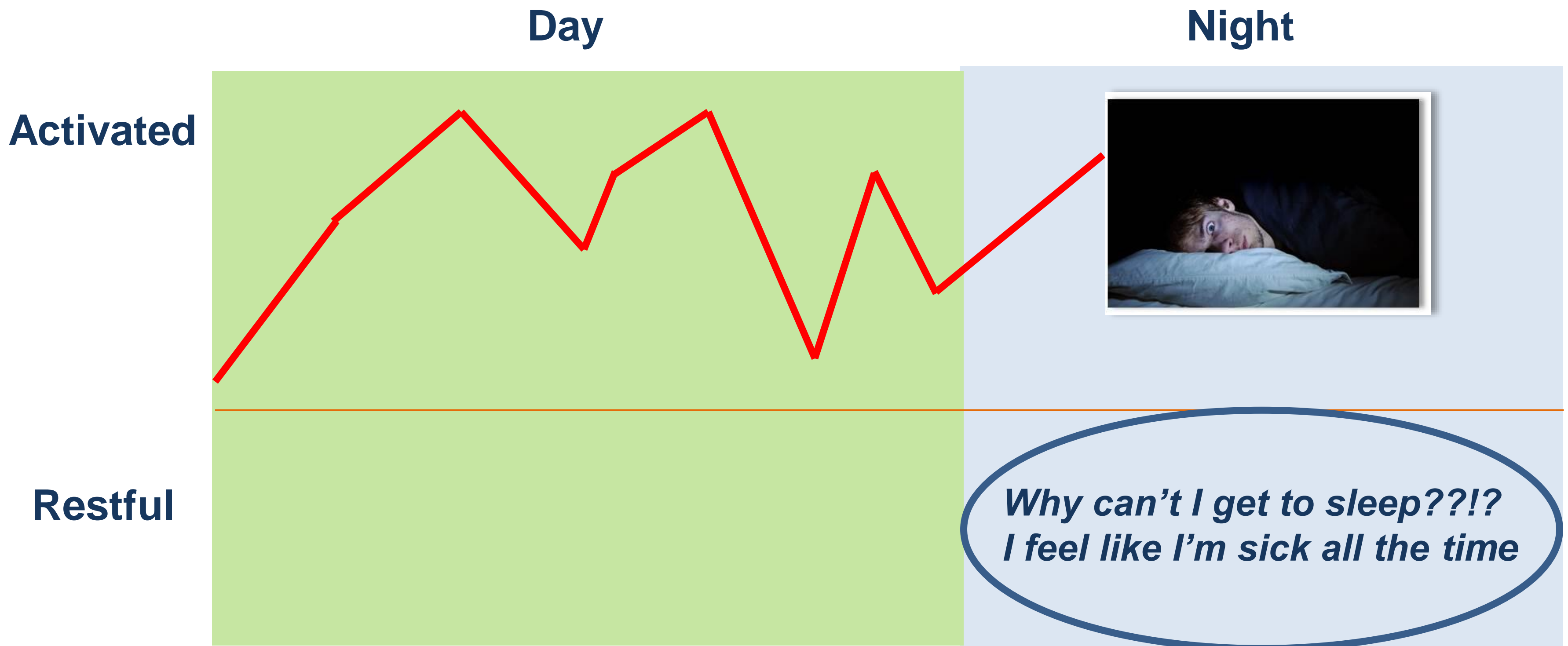
Sapolsky, R, "Why Zebras Don't Get Ulcers,"
Phys Ther. 2014 Dec;94(12):1816-25. doi: 10.2522/ptj.20130597. Epub 2014 Jul 17.
Chronic stress, cortisol dysfunction, and pain: a psychoneuroendocrine rationale for stress management in pain rehabilitation.
Hannibal KE[1], Bishop MD[2]

CareOregon®
MEDS Ed™

When things are in balance



Imbalance affects sleep, digestion and pain



Pain catastrophizing

Irrational negative forecasting of future events regarding pain

Fear Avoidance

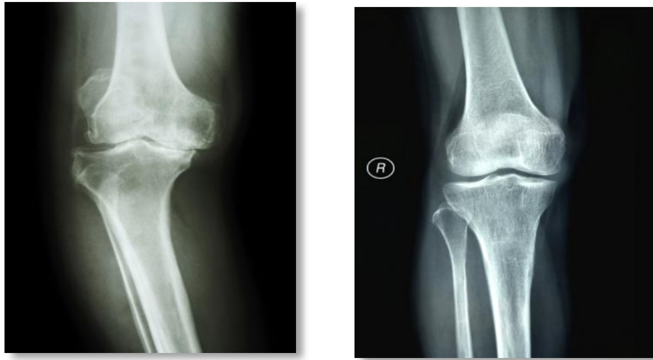
Avoidance of activities associated with pain due to beliefs that the pain itself is harmful

Key Points

- Pain is a multi-dimensional experience
- All pain is real pain
- Nociception is neither necessary nor sufficient for pain
- **PAIN ≠ HARM**

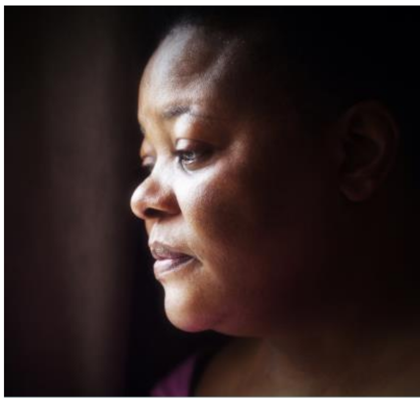
Adapted from material from G. Lorimer Moseley: Understand and Explain Pain course material 2010

THREAT!



MRI and X-Ray results

Fear of movement

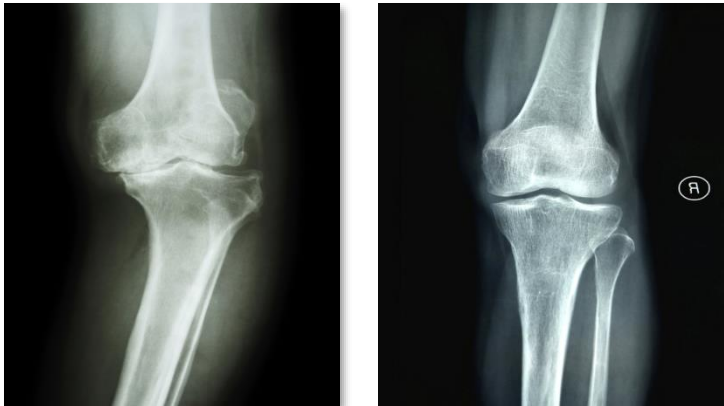


Struggles in living with pain

Medication is the only thing that can help me

Safety and Hope

Understand pain



Kisses of time

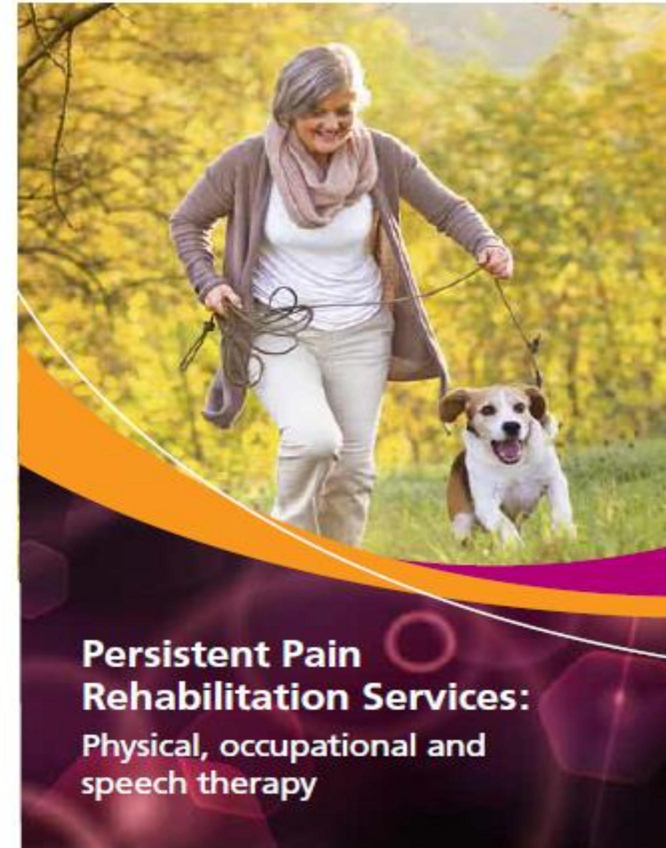
Quiet your worry

Sore, but safe

Bring some FUN back in your life!

Providence Rehab Services Persistent Pain program

- Pain education
- Relaxation training
- Retraining body sensing
- Pacing to return to activity



Understanding pain:
With knowledge comes power

Pain Education –

Now Available Online!

Did you know?
When people understand how pain happens, their level of pain can decrease!

Providence Pain Education will help you:
- Learn how pain develops and the important body-brain pain connection
- Learn how your own actions and thoughts can relieve your pain and help you return to a life you can enjoy.
- Practice simple calming techniques you can use to decrease stress and quiet pain.

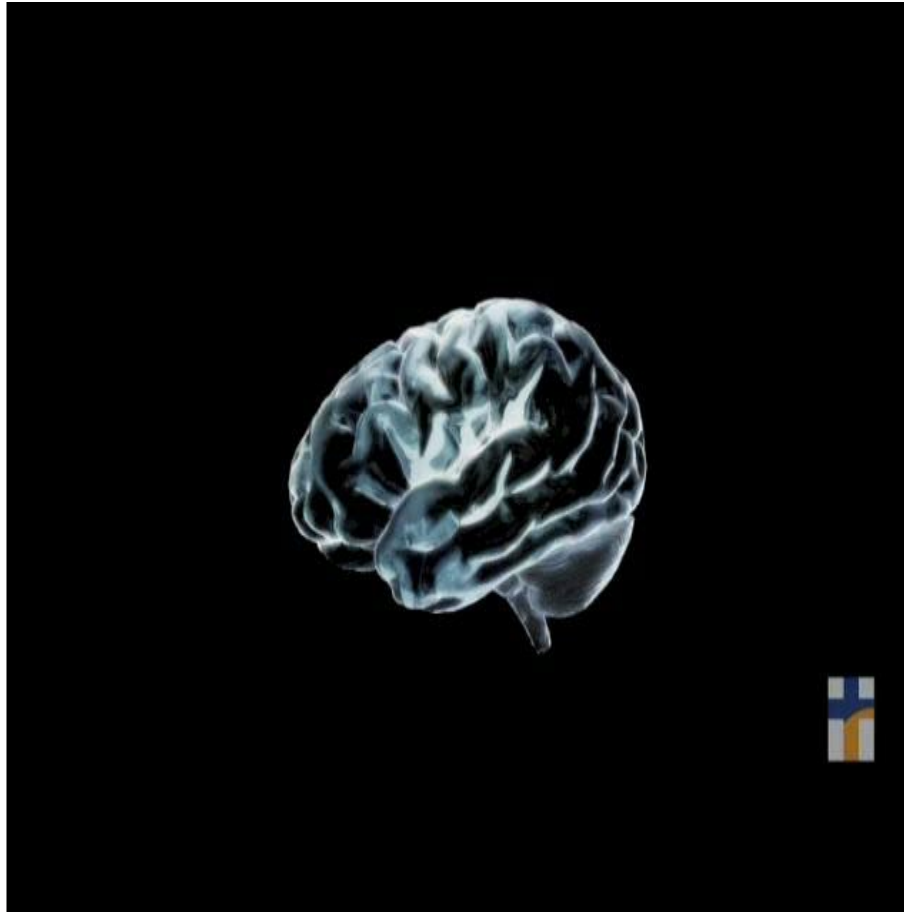
Two options:
- **Live, two-hour in-person group class** taught by pain experts at various locations throughout Oregon. You may bring a family member or caregiver at no extra charge.
- *Now available:* **Online class**: A live, interactive two-hour webinar, taught by the same pain experts, will be available April through June. You can attend using a computer, smart phone or tablet, from anywhere you have an internet connection.

Cost:
- **Current Providence Rehabilitation Services patients:** No cost
(NOTE: Providence Rehab patients must call to register: 503-574-6595)
- **Providence Health Plan members:**

Oregon Health Plan:	No cost
Medicare Advantage:	Eligible for no cost based on Health & Wellness benefit
Personal/Open Option:	$20 copay
PHP-"Administered by":	10% discount

Providence Rethinking Pain Toolkit

Persistent Pain – Clip 1



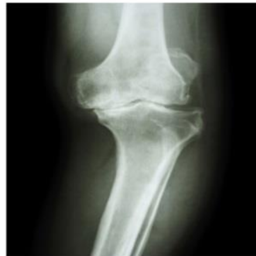
Persistent Pain – Clip 2

Clinician prompts on the back

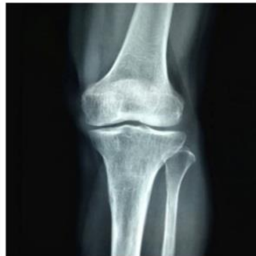
Rethinking Pain

A picture doesn't tell the whole story

These images show X-rays of two knees. On the left, we see severe degeneration of the joint, and on the right, we see a healthy knee.



Up to half of people with severe arthritis in the knee have no symptoms.



Ten percent with no arthritis on an X-ray have severe pain!

Pain ≠ Harm

Copyright © 2016
Providence Health & Services

This image shows an xray that has severe degeneration on the left, and a normal xray on the right. Multiple studies have looked at people with test results like X-Rays and MRI, which show moderate to severe changes like degeneration in the joint surface, and disc herniations, and have found that often people actually don't feel pain even though their test study is abnormal.

In one study, roughly half of people with severe arthritis in the knee had no symptoms and 10% with no arthritis on X-Ray have severe pain!!

Which is why I can say that whether or not you have something that shows up on an X-Ray does not tell us whether you will have more or less pain. There is a lot more to it than that. This also means that having a "bad" X-Ray does not necessarily mean you will have worse pain, and on the other side, you can have significant pain that can't be explained by an X-Ray because some people have totally normal X-Rays and still have significant pain.

The Good News: "Your pain is real, regardless of what the X-Ray or other test shows, AND there is a lot that you can do to change your pain, either way. The video I'd like you to watch can help explain a bit more."

References:

Brinjikji, W., et al "Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations," AJNR Am J Neuroradiol 36:811–16 Apr 2015 www.ajnr.org

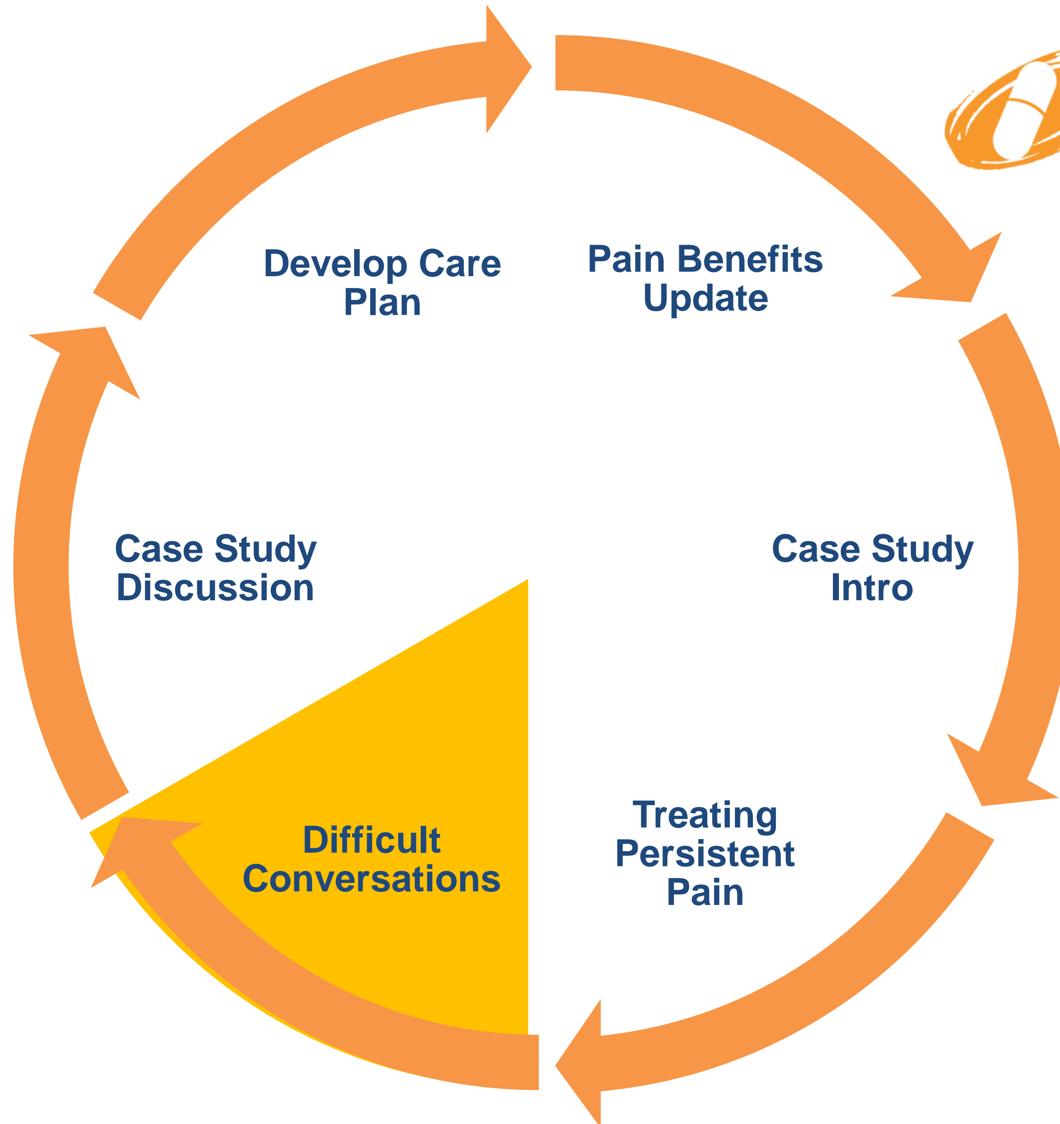
Creamer, P., and Hochber, M.C., "Why does osteoarthritis of the knee hurt sometimes," British Journal of Rheumatology 0886 Vol 36 No 7, 1997 p 726-7

Teraguchi M, et al. "Prevalence and distribution of intervertebral disc degeneration over the entire spine in a population-based cohort: the Wakayama Spine Study." Osteoarthritis Cart., 2014;22:104–10

Patient says:	Threat	Safety
I'm worried about my x-rays.	Your x-ray looks pretty bad.	Half of people with joint degeneration have no pain.
I can't do _____. It's too painful.	You'd better avoid that then.	Because your system has gotten too good at protecting you, that pain does not mean that you are causing yourself harm. Let's talk about slowly introducing activity a little at a time.

Please hold questions – thanks!

eak



MEDS Ed™

Difficult Conversations

Lydia Anne M Bartholow, DNP, PMHNP, CARN-AP

Old Town Clinic, Central City Concern

CareOregon®

MEDS Ed™

Skill Building

- Patient centered
- Boundaries and self-protection
- Trauma informed Care

Trauma-Informed Care

- Universal precautions
- TIC asks that we not re-traumatize patients
- TIC asks that we change systems, including systems of communication, in order to provide best care
- Also prioritizes provider well being

Trauma-Informed Care

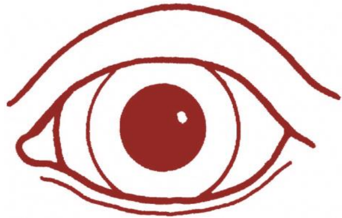
- The likelihood that chronic pain and addictions patients have experienced trauma is high
- The pathophysiology of trauma includes CNS dysregulation

Basic Neurobiology of Trauma

Initial signs and symptoms of the stress response:

(aka fight, flight or freeze or HPA axis)

Blurred vision



Muscle tension

nausea

Inability to focus/ think straight

Increased heart rate

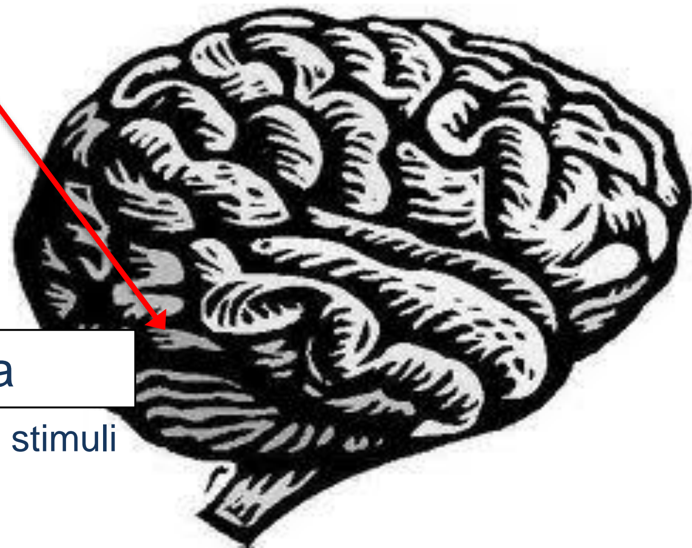
Increased blood pressure

Sweaty palms

shaky

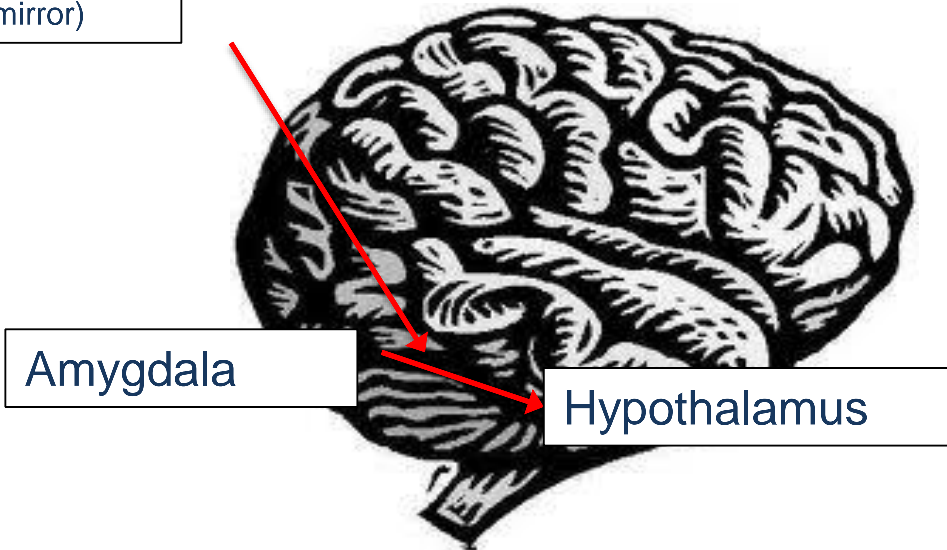
Thoughts of impending doom

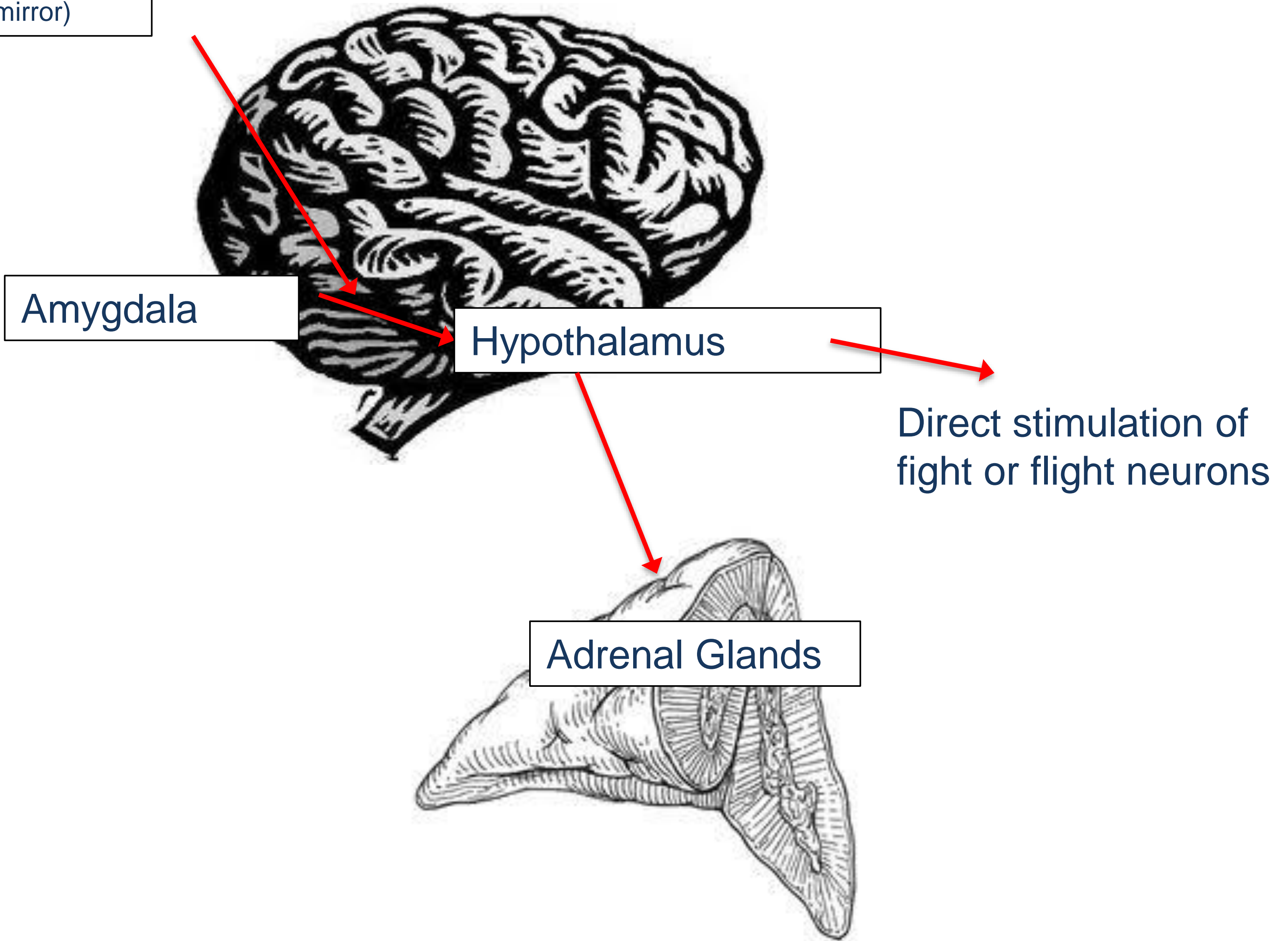
Stressor or Threat:
(cop in rearview mirror)

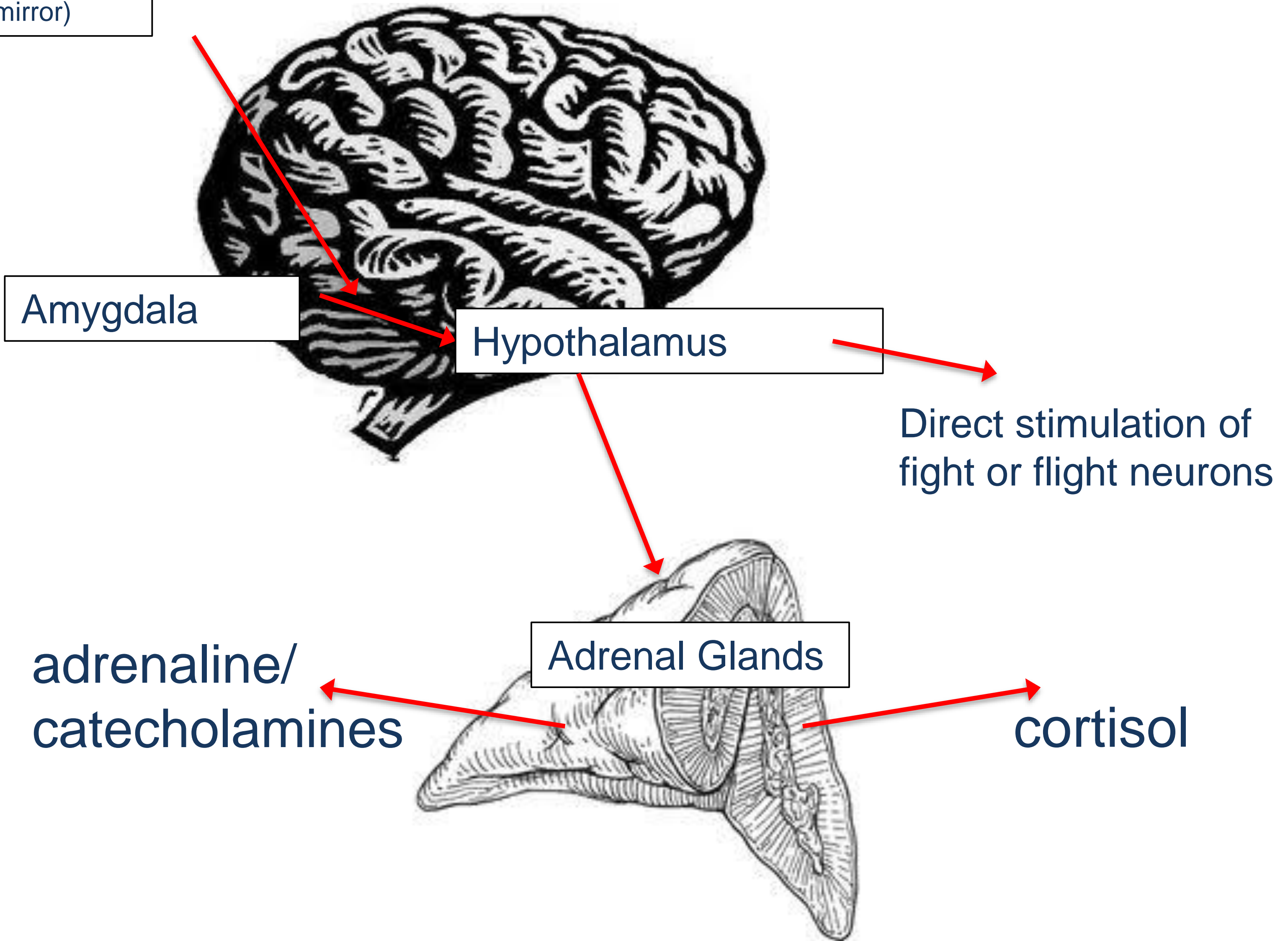


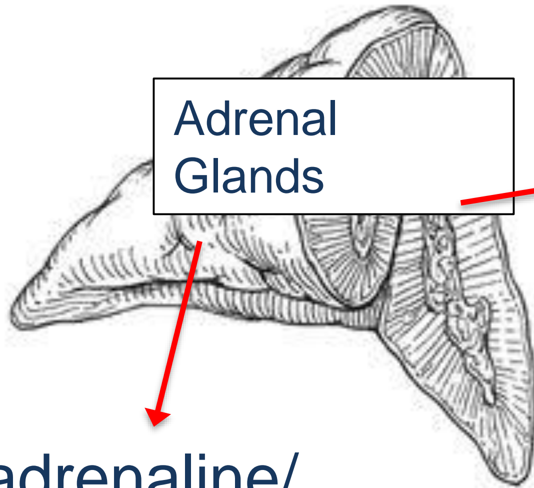
Amygdala

attaches fear to stimuli


Stressor or Threat:
(cop in rearview mirror)
Amygdala
Hypothalamus


Stressor or Threat:
(cop in rearview mirror)
Amygdala
Hypothalamus
Direct stimulation of fight or flight neurons
Adrenal Glands


Stressor or Threat:
(cop in rearview mirror)
Amygdala
Hypothalamus
Direct stimulation of
fight or flight neurons
Adrenal Glands
adrenaline/
catecholamines
cortisol

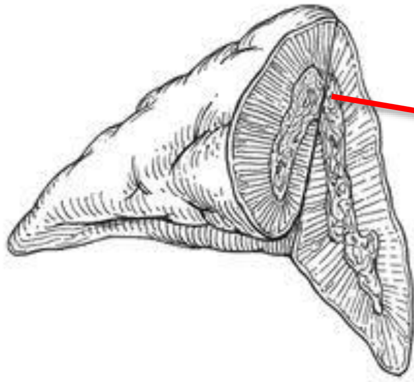


adrenaline/
catecholamines

-- muscle contractility
-- increased HR
-- increased BP
-- blow flow away from stomach
-- blow flow away from brain
-- blood flow to vital organs
-- increased blood sugar
-- sweat

cortisol

-- immune system suppression/dysregulation
-- water retention
-- high blood sugar
-- muscle breakdown
-- increased gastric juices



Affects of long term cortisol…

-- immune system suppression/dysregulation =

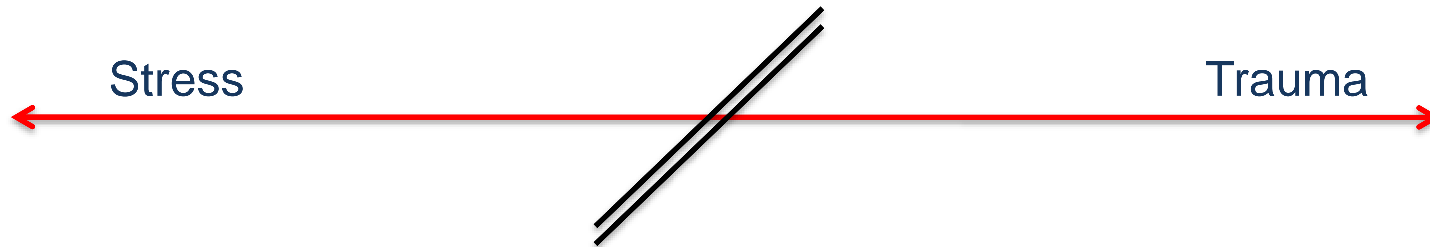
-- water retention =

-- hyperglycemia =

-- fat redistribution =

-- decreased GI system integrity =

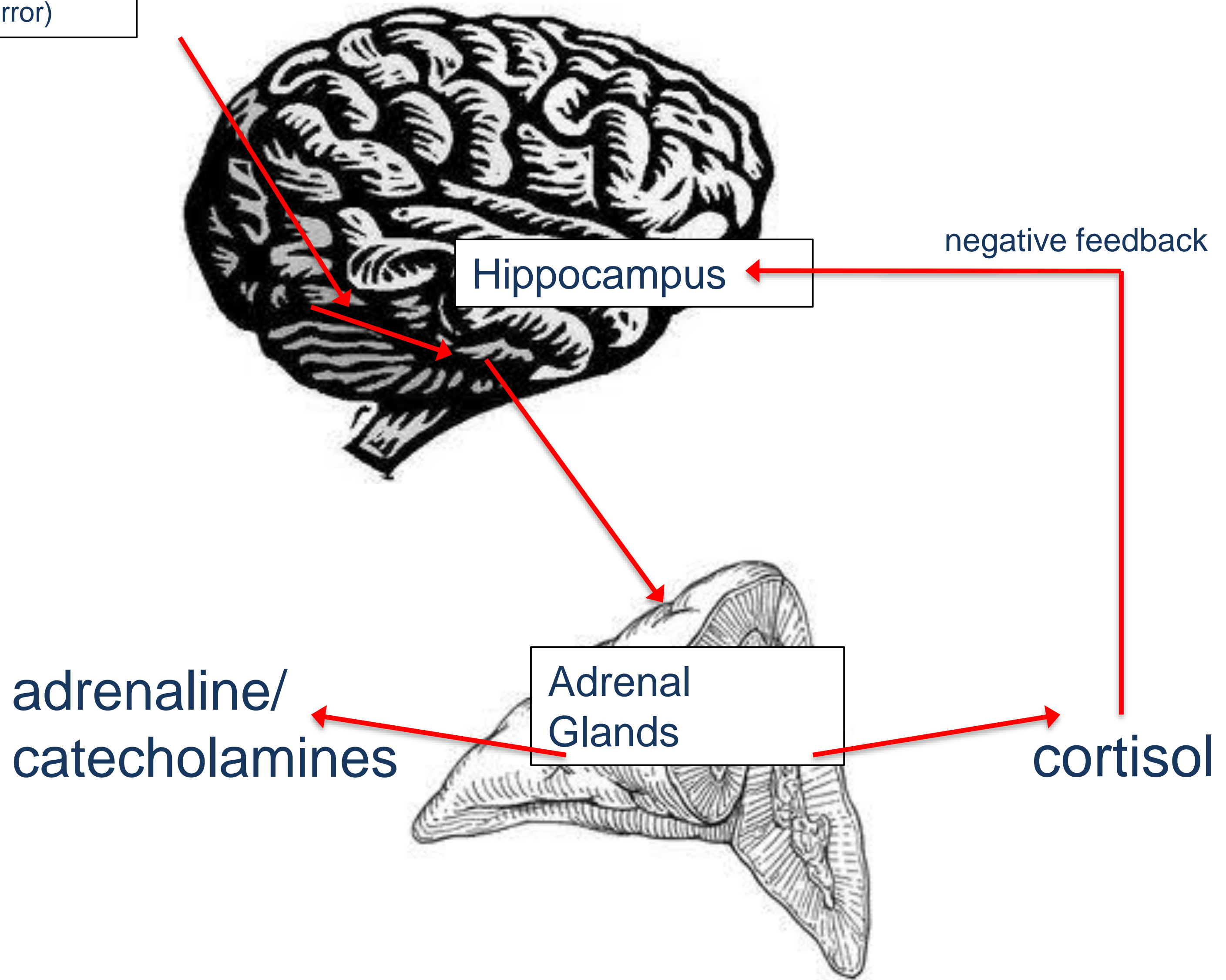
-- decreased serotonin (for some people) =

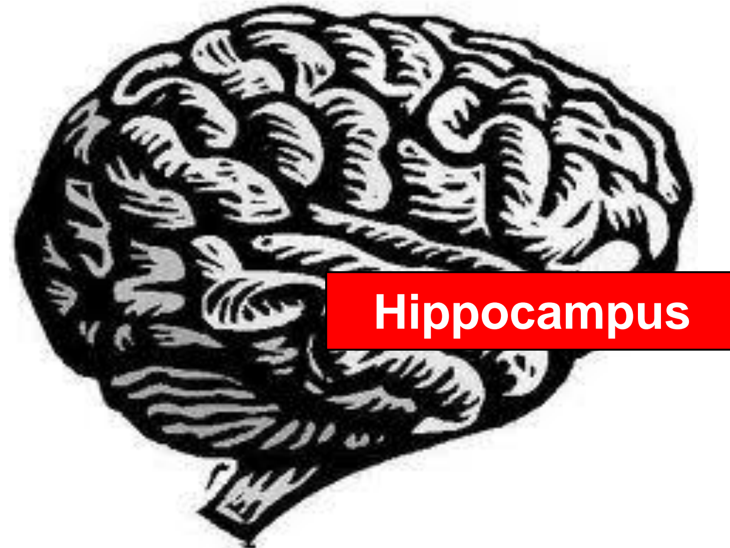


Trauma is:

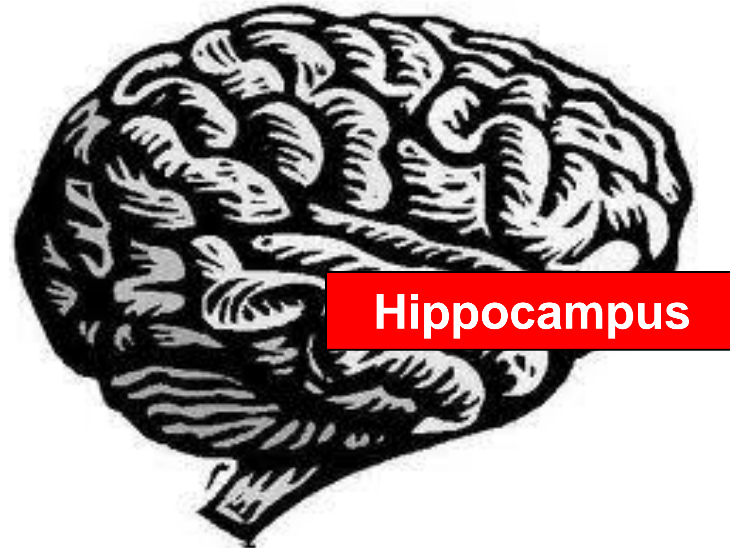
- inescapable powerlessness
- a “blow out” of your fight or flight system
- “The result of exposure to an inescapably stressful event that overwhelms a person’s coping mechanism” – Bessel Van der Kolk

Stressor or Threat:
(cop in rearview mirror)





- Helps regulate systemic cortisol levels – informs the body when cortisol is too high and says “stop making that stuff!” (think of it like a thermostat)



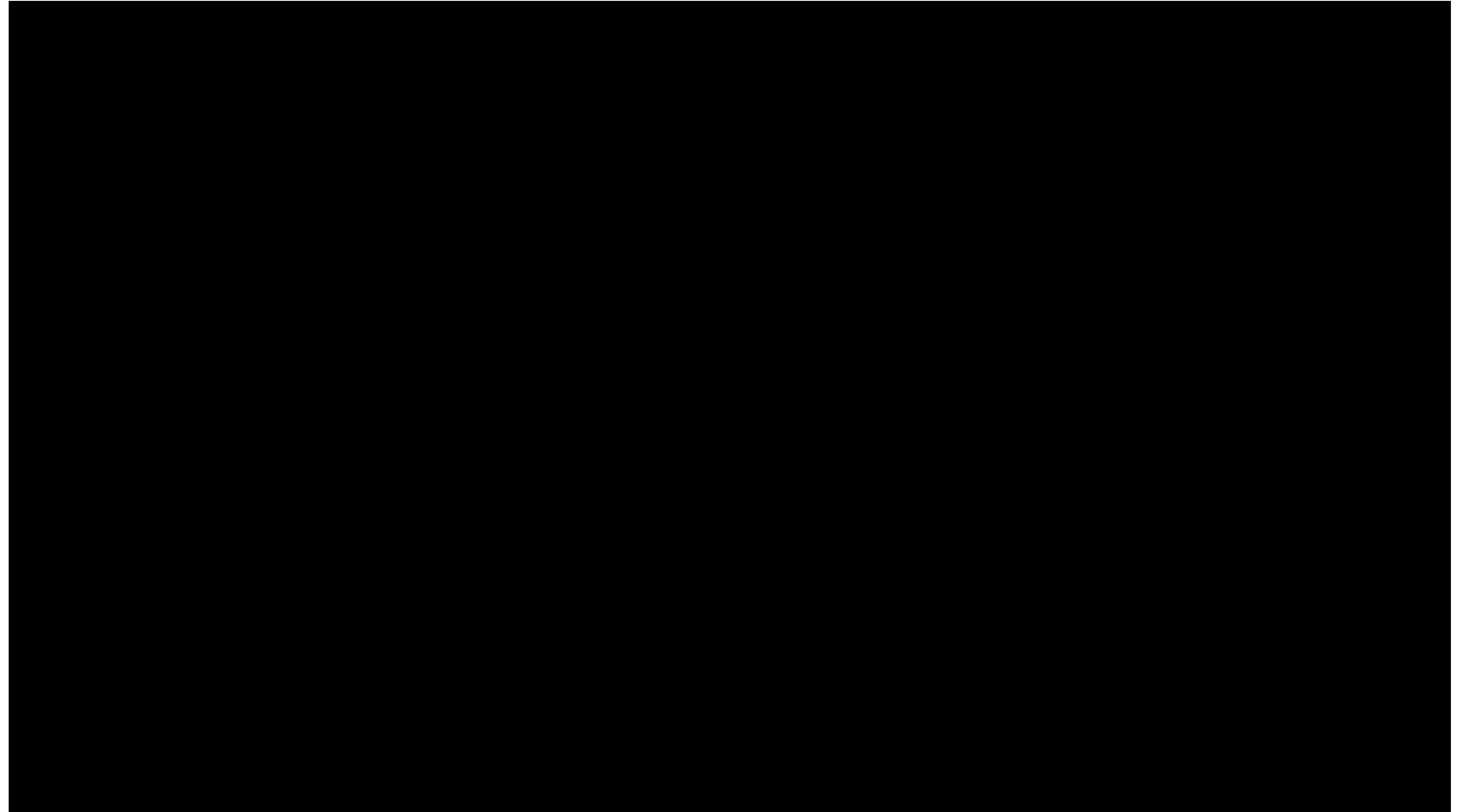
The Hippocampus is responsible for:

1. Fear and anxiety regulation
2. Anger regulation
3. Allowing your prefrontal cortex to override old brain
4. Sleep regulation
5. Organizing memories
6. ***Experience of pain***

Provider Complaints

Why do *you* hate to work with patients taking opiates?

In case you don't remember what this is like…



Patient Complaints

According to our **Patient Experience Coordinators at Jackson Care Connect**, patients stated they were unhappy because:

- they were made to feel like they **did something wrong**
- they were **made to feel like a criminal** or **drug addict**
- they **felt punished**
- they felt like they were being **talked down to**
- they **didn't understand** why they were being **forced** to make these changes
- we **didn't have concern for their pain**, only our policy

Used with permission from Laura Heesacker, LCSW at Jackson Care Connect

Skill Building

- Actively and explicitly involve your patients in decisions that affect their care – treat them as valued **partners** and part of their care team
- Emphasize your **concern for the patient's safety**
- Reiterate your primary objective – to **support them** and to help them **safely and effectively manage their pain**
- **Provide context for the opiate epidemic, and how this translates to their care**

Used with permission from Laura Heesacker, LCSW at Jackson Care Connect

The Backdrop of This Conversation

- Can you control the lighting?
  - Dim the lights
- Can you control the seating arrangement?
  - Sit!
  - Sit perpendicular
- Transparency:
  - Controlled substance agreements and contracts
- Make decisions before you go into the exam room

VEMA

- ***Validation**: Providing reassurance vs communicating doubt*
- ***Education**: Providing realistic treatment expectations and current understanding of Complex Chronic Pain*
- **Motivation**: Facilitating self-management understanding that patients willingness to engage in self-management will vary.
- **Activation**: Negotiating behaviorally specific/feasible goals, primary clinical focus is on changing the way patients react to pain.

Anthony J. Mariano, PHD Puget Sound VA Health Care

VEMA & EPE/Motivational Interviewing

- ***Validation: Providing reassurance vs communicating doubt***
  - *Validate hard feelings*
  - *Assuage doubt*

- ***Education: Providing realistic treatment expectations and current understanding of Complex Chronic Pain***

  - ***Elicit:*** *“Would it be okay if I told you about…?”*
  - ***Provide education:*** *“Research shows…”*
  - ***Elicit feedback:*** *“So, what does this mean for you?”*

And if this fails…
OR
if you are dealing with Addiction?

- Stay in the medical expert roll
- Emphasize concern and condition
- Speak to what is behind a patient's comment, not to the comment itself
- Speak to what you know to be true; trust your science

Used with permission from Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine

What to say to…?

- Are you accusing me of being an addict?”
  - *I have never accused anyone of diabetes but I’ve diagnosed them with it and that is what I am trying to now, diagnose.*

- “Don’t label me as a druggie”
  - *I have no interest in labels at all, I am interested in helping people who are struggling with medical problems, such as addiction.*

- “So you’re basically saying that I’m a junkie.”
  - *I’m saying that addiction is a medical problem that responds to treatment not a problem of bad morals or behavior*

Used with permission from Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine

How to respond to…?

- "Do you want me to lose my job, do you want me to be on the street?"
  - *I want you to have safe and effective pain control and it is my medical opinion that your current medicine won't give you that*.
- "Do you have pain?"
  - *I want to every minute of our time today to talk about your pain management plan.*
- "I wish you could feel my pain."
  - *I know you're suffering and I'm sure that we can work together to reduce pain, so you don't have to suffer*

Used with permission from Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine

And if they threaten you…?

- “I heard it’s illegal for you to let me go into withdrawal.”
  - *Withdrawal is uncomfortable but not life-threatening, I can prescribe you medicines to help with the withdrawal symptoms.*

- “I’ll just go and use heroin.”
  - *I certainly hope you don’t because you know that I don’t think any type of opiate will help your pain.*

- “Don’t bother with any other meds, I’ll just kill myself.”
  - *I need to ask you some more questions about your thoughts about suicide.*

- “I’m getting a lawyer.” “I’m calling KGW.”
  - *You do what you feel is right, of course. That’s what I’m doing for you, too.*

- “You have a family, don’t you, doc?” – Call the police

Used with permission from Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine

Boundaries make everyone feel safer!

- "Opiates are off the table. How would you like to spend our office visit today?"

- "There is nothing you can do or say to make me prescribe you opiates/increase your dose/give you an early refill"

Used/modified with permission from Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine

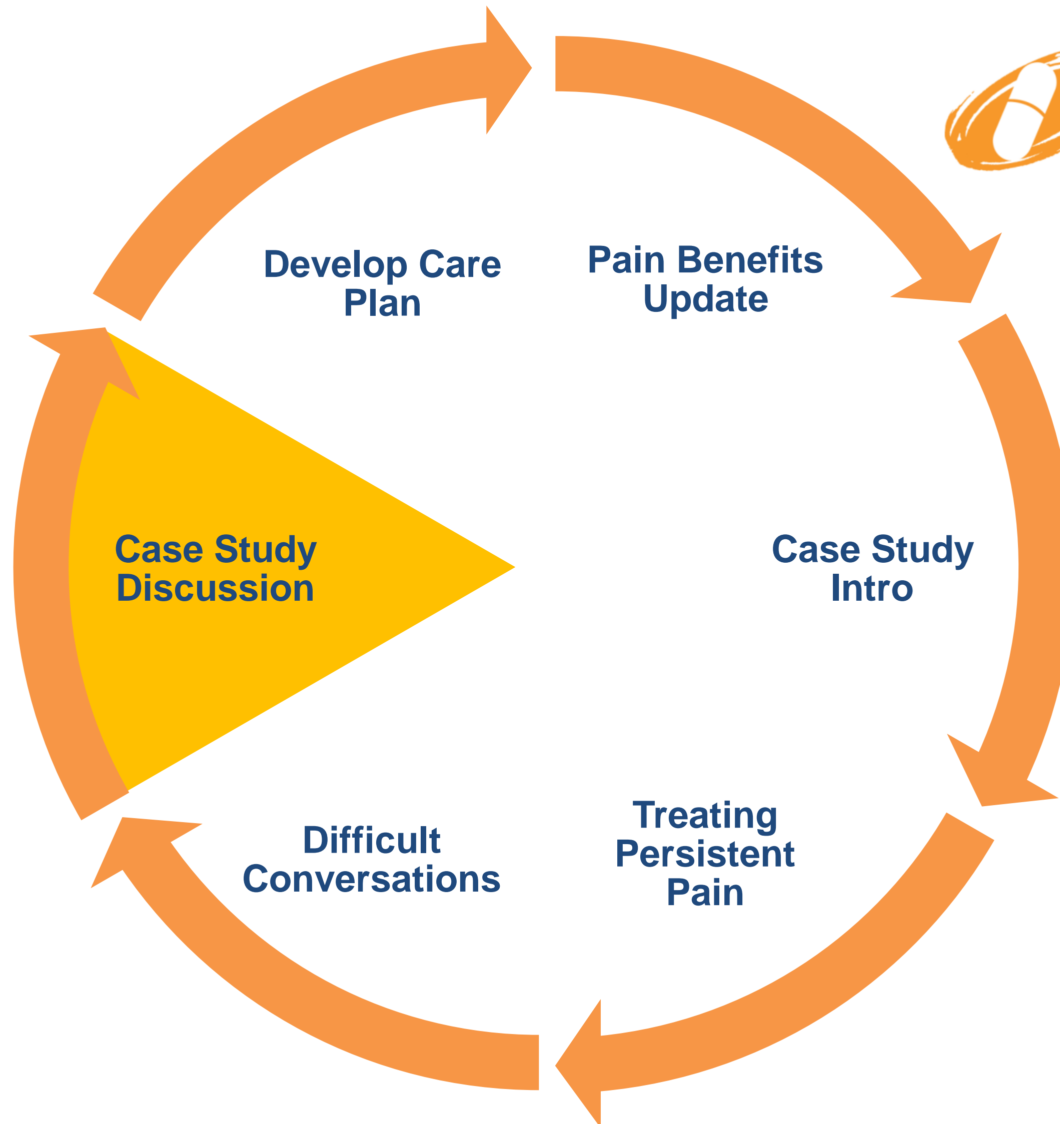
Wrap-up

Safety!

Concern!

Medicine!

Trauma-informed!



MEDS Ed™

Case Study: *Laney*

Laney

- TBI, PTSD, MDD, Persistent Low Back Pain
- Both Opiates for pain and Benzodiazepines for anxiety
- HX at MMT Clinic
- Past Psychiatric TX primarily meds, no therapy
- Lives alone in SRO-like apartment
- Community in her building
- Pain with walking. Uses a walker a friend loaned her
- Loves her dog, Chloe

Laney's Pain Story

Pain Presentation:

Lower back pain, spreading in area across lumbar bilateral and left lower thoracic area, hard to tell where it is sometimes, worse with cold weather. Worse with walking

Testing:

X-Rays 2012: Moderate degeneration at L3-5 bilateral facets
No MRI but Laney is requesting this

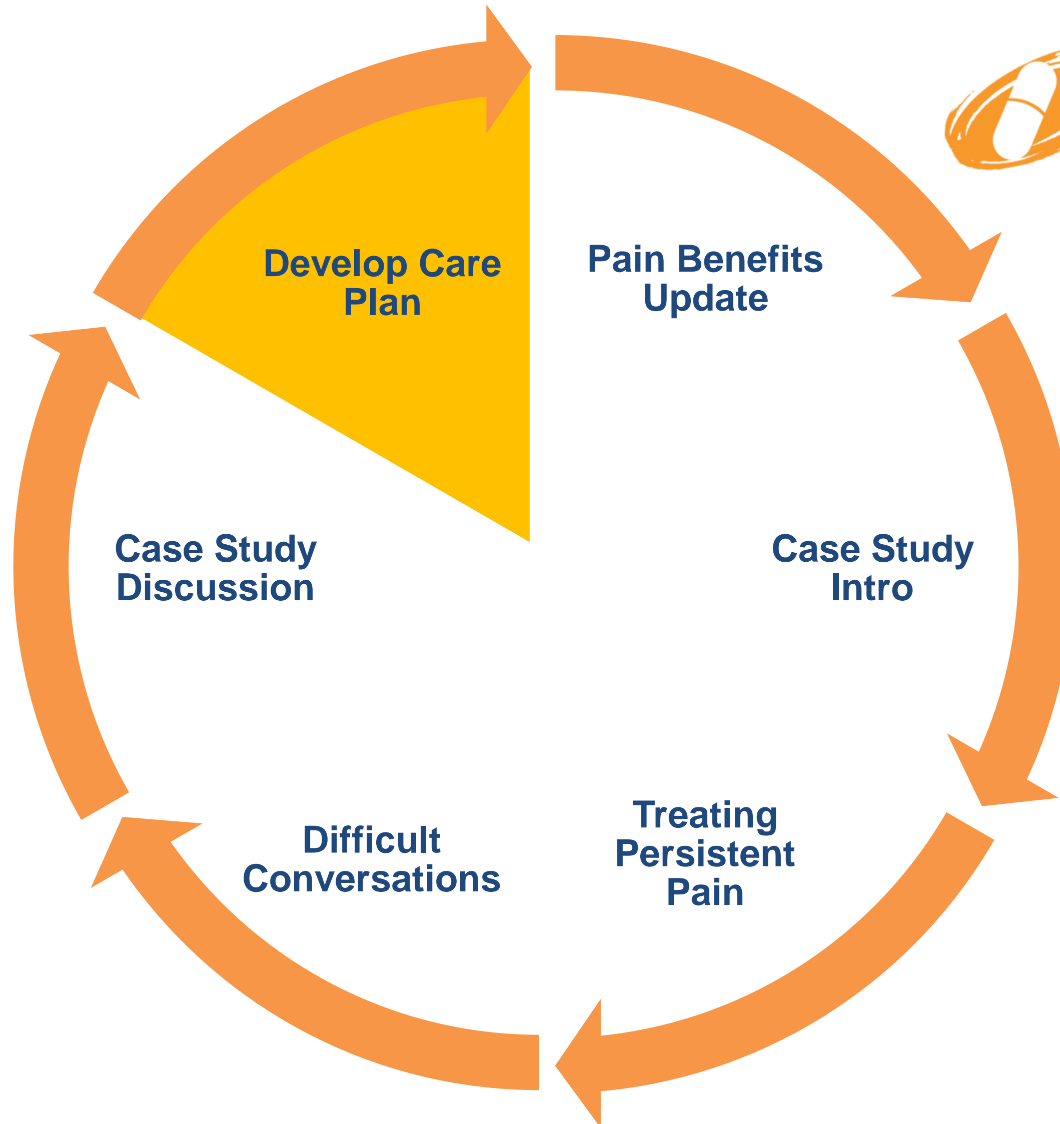
Concern that something terrible is about to happen when she experiences pain

No HX of PT, OT 2/2 transportation challenges & insurance

Using ED roughly every 2 months

Laney's Sensitization Picture

- Increased nerve sensitivity
- Sensory cortical changes
- Increase coupling of brain functions w/pain
- Imbalance of arousal



MEDS Ed™

Questions

Stay Tuned For More MEDS Ed Opportunities in 2017!

Thank you!