CHRONIC PAIN, MENTAL HEALTH, AND ADDICTION

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.
SPEAKER DISCLOSURES

✓ No financial conflicts of interest
✓ Grant funding from:
  • NIH Pain Consortium award: UW Center of Excellence in Pain Education
  • AHRQ: Team-Based Safe Opioid Prescribing in Primary Care
  • CDC: CDC Opioid Guidelines-Clinician Outreach and Communication Activity: Webinar Series (contract
OBJECTIVES

1. List challenges facing pain care in the midst of an opioid paradigm shift, overdose and addictions epidemic.

2. Describe training and support necessary for a “pain champion” to introduce a collaborative care model across an inter-professional provider and administrative team.

3. Defend how pain tele-mentoring advances a model and system of pain practice that will improve non-opioid centric pain care and opioid misuse, abuse, and addiction.
Pain is complex, as a biopsychosocial phenomenon... and as a clinical practice and educational topic
Chronic Pain Care Today

Complaint of “chronic pain” has led to over reliance on opioid Rx with poor health care outcomes and frequent misuse.

- Chronic pain is **challenging** to treat effectively and **distresses** health systems, providers and patients
- Poor chronic pain care has caused **significant harm** to the patient
- Unintended and often unrecognized **expense** for the health system.

Chronic Pain Care Today

• Poorly managed primary care of pain due to lack of provider knowledge and limited access to non-drug treatment strategies leads to:
  • 200,000 deaths in US since 1999, toll continues to rise...
  • Institute of Medicine reports: 116 Million Americans have chronic pain...
  • ...at a cost of $650 Billion annually

Every year, 16,000 people die from overdose and 500,000 come to Emergency Departments due to over-use of opioid pain medications in the US
Health System Burdens of Pain

• 12-fold increase in poor self-rated health status and diagnosis of chronic pain.
• Pain conditions lead 35 most common primary diagnosis groups at ambulatory care visits.
• 30-50% of patients on opioids for chronic non-cancer pain present with an active substance use diagnosis.
• 50% of community-dwelling elderly people and as many as 80% of nursing home residents experience chronic pain.
• Poorly managed pain related care, especially over-reliant on opioids in the primary care setting would be expected to increase in-hospital care complexity.

98% of Pain Care by Non-specialists

Chronic pain is mostly cared for and best managed in the primary care “medical home” setting, but when PCP’s need help:

- Access to multidisciplinary pain consultation is both scarce and difficult to access, especially so for non-metropolitan, rural, and remote communities; and very often for minorities and those reliant upon government sponsored health care.

Daubresse Med Care 2013; Bodenheimer JAMA 2002; Tait Am Psychologist 2014
Current state: “Flying Blind”

PCPs (!) Are Suffering “Pain Related Distress”

- Medical Schools “Pain” teaching: Median of 7 hours
  - 66% uncomfortable treating chronic pain
- 81.5% med school & 54.7% residency education “poor” or “not leading to competency”

Nurse Practitioners & Physician Assistants:
- Adequacy of pain training: 0.5 on a scale of 0 to 4.

Mezei et al 2011; Elman et al 2011; Corrigan et al 2011, Fishman 2012

IMAGE: rlv.zcache.com
PCPs: “Haven’t Got The Time For Pain”

1. Short appointment times (<15 - 20 min)
2. 70% of visits include pain-related discussions
   - Mean duration of ≤ 6 min (<1/3 of total visit time)
3. Crowded encounter agenda
   - Average of 7 clinical problems/visit
4. “Guideline pressure”
   - Recommended preventative services need >7 hrs/day
5. Limited access for frequent follow-ups
6. Adherence monitoring
   - Disrupts patient/provider relationship and workflow
7. Limited & often no access to multidisciplinary pain care
8. Long-term opioids the “de facto” pain treatment

Abbo 2008; Buckley 2010; Dosa & Teno 2010; Gallagher 2004; Hill 1996; Von Korff 2008
What about the “Chronic Care” Model?

- Coordinated, collaborative care
- Evidence-based clinical monitoring
- Effective patient self-monitoring and self-management support
- Planned preventive interventions
- Stepped and timely care follow-up tailored to need and severity

Wagner EH, et al. Milbank Q 1996
Coleman et al. Health Affairs 2009
Stellefson et al. Prev Chronic Dis 2013
Miller et al. Med Care 2013
Design: Cluster randomized controlled trial.

Intervention: 2-session clinician education program, patient assessment, education & activation, symptom monitoring, feedback & recommendations to clinicians, & facilitation of specialty care.

Main Outcome Measures: Changes over 12 months in pain-related disability, pain intensity, and depression.

**Conclusion:** Collaborative intervention resulted in modest but statistically significant improvement in a variety of outcome measures.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (95% CI)</th>
<th>3 mo</th>
<th>6 mo</th>
<th>12 mo</th>
<th>Δ From Baseline to 12 mo (95% CI)</th>
<th>P Value b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roland-Morris Disability Questionnaire for pain</td>
<td>14.6 (14.3 to 14.9)</td>
<td>14.0 (13.3 to 14.7)</td>
<td>13.8 (13.4 to 14.2)</td>
<td>13.3 (12.9 to 13.7)</td>
<td>-1.4 (-2.0 to -7.1)</td>
<td>.004</td>
</tr>
<tr>
<td>Treatment as usual</td>
<td>14.5 (14.0 to 15.0)</td>
<td>14.4 (13.8 to 15.1)</td>
<td>14.4 (13.7 to 15.1)</td>
<td>14.3 (13.6 to 15.0)</td>
<td>-0.2 (-0.8 to 0.4)</td>
<td></td>
</tr>
<tr>
<td>Chronic Pain Grade Intensity</td>
<td>67.4 (65.4 to 69.3)</td>
<td>65.6 (63.5 to 67.7)</td>
<td>63.3 (61.0 to 65.6)</td>
<td>63.2 (60.7 to 65.7)</td>
<td>-4.7 (-6.9 to -2.5)</td>
<td>.01</td>
</tr>
<tr>
<td>Assistance with pain treatment</td>
<td>66.0 (64.3 to 67.8)</td>
<td>68.0 (66.1 to 70.0)</td>
<td>66.3 (64.1 to 68.4)</td>
<td>65.6 (63.3 to 67.9)</td>
<td>-0.6 (-2.6 to 1.5)</td>
<td></td>
</tr>
<tr>
<td>PHQ-9 for depression (n = 148)</td>
<td>14.4 (13.4 to 15.5)</td>
<td>12.8 (11.3 to 14.3)</td>
<td>12.0 (10.6 to 13.5)</td>
<td>10.6 (9.1 to 12.1)</td>
<td>-3.7 (-4.9 to -2.0)</td>
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</tr>
</tbody>
</table>
## Chronic Pain Treatments

### “Comparing” Effectiveness

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Extrapolated Averages of Reduction in Measures of Pain Intensity or Pain Bothersomeness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>≤ 30%</td>
</tr>
<tr>
<td>Tricyclics/SNRIs</td>
<td>30%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>30%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>≥ 10+%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10-30%</td>
</tr>
<tr>
<td>CBT/Mindfulness</td>
<td>&gt;30-50%</td>
</tr>
<tr>
<td>Graded Exercise Therapy</td>
<td>N/A</td>
</tr>
<tr>
<td>Sleep restoration</td>
<td>&gt; 40%</td>
</tr>
<tr>
<td>Hypnosis, Manipulations, Yoga</td>
<td>“+ effect”</td>
</tr>
</tbody>
</table>

BIOPSYCHOSOCIAL TREATMENTS FOR CHRONIC PAIN?
EVIDENCE IS YES! ...since 1969

- **Efficacy of Behavioral Management & CBT:**

- **Efficacy for Multidisciplinary Chronic Pain Programs**
Are Chronic Pain Programs Treatment & Cost-Effective?

Evidence is overwhelmingly: **YES!**

*Focus Article*

Evidence-Based Scientific Data Documenting the Treatment and Cost-Effectiveness of Comprehensive Pain Programs for Chronic Nonmalignant Pain

Robert J. Gatchel* and Akiko Okifuji†

J Pain 2006

“**This review clearly demonstrates that CPPs offer the most efficacious and cost effective, evidence-based treatment for persons with chronic pain.**”

“**Unfortunately, such programs are not being taken advantage of because of short-sighted cost-containment policies of third-party payers.**”

70% reduced direct costs, 40% reduced disability costs.

AND:
Deschner & Polatin (2000); Feuerstein & Zostowny (1996); Gatchel & Turk (1999); Okifuji et al (1999); Turk & Burwinkle (2005); Turk & Gatchel (1999); Wright & Gatchel (2002); Sanders et al (2005).
Opioid Prescribing Practice: “The Allure of Opioids”

1. They make patients happy (at least initially).
2. They are very portable and available in the most remote sites.
3. Insurance covers them better than any other pain treatment.
4. The signed prescription closes the visit.

Courtesy Mark Sullivan, MD, PhD
Total Outpatient Prescriptions of ER Opioids, by Specialty
1991-2008

4 OUT OF 5 HEROIN USERS ABUSED PRESCRIPTION OPIOIDS FIRST
Opioid Deaths by County 2000 - 2013
Total deaths = 7834

1 Dot = 1 death attributed to any opiate in the 14-year period
Data suppressed when count is 1 to 4

Data from Center for Health Statistics, Washington State Department of Health.
Map created by Alcohol & Drug Abuse Institute, Univ. of Washington.
Residents who died outside Washington excluded.
Dots are randomly allocated within counties.

Slide courtesy of C. Banta-Green
Opioid Overdose Risk by MED*

Risk of Adverse OD Event

Risk Ratio

Dose in mg MED

<20 mg/day  20-49 mg/day  50-99 mg/day  >=100 mg/day

9-fold increased risk

Point of deflection

Dunn 2010
Bohnert 2011
Gomes 2011
Zedler 2014

*Morphine Equivalent Dose
Washington State Opioid Prescribing Laws
Guideline Adherent Care

1999: (WAC 246-919-830)
“No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.”

“2876” 2010 (WAC 246-840-460)
• Specifies education and guideline use
• Sets dose limit <120 mg MED above which pain specialty consultation needed
• Requires access to specialty care when pain/function not improved, or high risk
• Requires measurement-based care: Pain, Function, Mood, Risk
• Tracks opioid Rx adherence
• Excludes: acute pain, surgical pain, palliative care, cancer pain

WAC-Washington Administrative Code
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

Achieving Guideline Compliant Care
Prescription Opioid and Heroin Overdoses
Washington State 1999-2013

Assessing risk and addressing harms

1st Diagnose: then, treat!!
- Bup/NlX
- MMT

Need more buprenorphine providers trained!!!

Source: C. Banta-Green WA State Department of Health
Opioids for **Chronic Pain**

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

**Conclusion:** Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.
• When to initiate or continue
• Selection, dosage, duration, follow-up, and discontinuation
• Assessing risk and addressing harms
“Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians...”

Centers for Disease Control and Prevention MMWR March 15, 2016; 65:p23

- “...tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence.”

- **Offer in a “nonjudgmental manner”**... “the **opportunity** to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.”

- “**empathically review benefits and risks** of continued high-dosage opioid therapy” and “offer to **work with the patient to taper** opioids to safer dosages”

- “**very slow opioid tapers as well as pauses** in the taper to allow gradual accommodation to lower opioid dosages.”

- Be aware that **anxiety, depression, and opioid use disorder “might be unmasked by an opioid taper”**
UW TelePain
A service for community-practice providers to increase knowledge and skills in chronic pain management

UW TelePain sessions are collegial, audio/video-based conferences that include:

1. Didactic presentations from the UW Pain Medicine curriculum for primary care providers.
2. Case presentations from community clinicians.
3. Interactive consultations for providers with a multi-disciplinary panel of specialists.
4. Education in use of guideline-recommended measurement-based clinical tools to improve diagnosis and treatment effectiveness.
5. Follow-up case presentations to track outcomes and optimize treatments for ongoing care of your patients.

UW TelePain sessions for community health care providers are held each Wednesday, noon to 1:30 p.m.

You are invited to present your difficult chronic pain cases or ask questions, even if you don’t present a case.
The expertise of the UW TelePain Panel spans pain medicine, internal medicine, anesthesiology, rehabilitation medicine, psychiatry, addiction medicine, and nursing care coordination.

Learn more about these sessions on the UW TelePain website
http://depts.washington.edu/anesths/care/pain/telepain/

Questions?
telepain@uw.edu

To register:
Download and complete the registration form and fax it to 206-221-8259. Form location http://depts.washington.edu/anesths/care/pain/telepain/TelePain-Participant-Reg-Form.pdf

UW Medicine
PAIN MEDICINE
Washington State Health Care Authority

Are CME credits available? Yes.
The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
The University of Washington School of Medicine designates this live activity for a maximum of 7.5 AMA PRA Category I Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session 1.5 credits)

Clinicians: caring for patients with complex pain medication regimens? We’re behind you.

UW Medicine
Pain and Opioid Consult Hotline for Clinicians
1-844-520-PAIN (7246)

UW Medicine pain pharmacists and physicians are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (excluding holidays) to provide clinical advice at no charge to you.

Consultations for clinicians treating patients with complex pain medication regimens, particularly high dose opioids:

- Interpret Washington State Prescription Monitoring Program record to guide you on dosing
- Individualized opioid taper plans
- Systematic management of withdrawal syndrome
- Evaluate/recommend non-opioid/adjuvant analgesic treatment
- Triage and risk screening
- Individualized case consultation for client care and medication management
- Explain/Review Center for Disease Control and Prevention (CDC) opioid guidelines: https://www.cdc.gov/mmwr/volumes/65/mm6501e1.htm
- Will help identify and refer to other resources:
  - Evaluation of Substance Use Disorder, Washington Recovery Help Line 1-866-789-1511
  - Local pain clinics for patient referrals: www.doh.wa.gov/Emergencies/PainClinicClosures/PainClinicAvailability
  - UW TelePain Services: Available Wednesdays noon to 1:30 p.m. http://depts.washington.edu/anesths/care/pain/telepain

UW TelePain
Pain & Opioid Hotline

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UW TelePain
Improving Primary Care Pain Competency and Access to Experts

• Weekly case based learning sessions
• Guideline-adherent care
• Evidence-based practice

• Interactive discussions
• Continuing Medical Education
• Opioid & Addiction education/training

Contact Information: Telepain@uw.edu

Just-in-time interactive consultations with a team of interprofessional pain experts
UW TelePain™ Clinician Educators

• Expert UW Multidisciplinary Pain Faculty
  • (Direct Primary Care Provider -to- Pain Consultant Panel)

- Internal Medicine/Pain Medicine (Primary Care)
- Family Medicine (Primary Care)
- Addiction Medicine (Primary Care)
- Pharmacy
- Psychiatry
- OB-Gyn (Women’s Health/(Primary Care)
- Psychology & Social Work
- Rehabilitation Medicine
- Anesthesiology
- Nursing

...And planning for our future healthcare workforce:
• Students of Medicine, Nursing, Pharmacy, Psychology, & Social Work
• Residents/Fellows (all specialties welcomed)
Measure Pain Reliably and Multidimensionally

…and at every pain related encounter
UW TelePain™
Proven Performance

• Since March 2011:
  • **May 2017: 300th session**
  ✓ Total attendance: >10,500
  ✓ Average attendees/session: 30+
  ✓ Unique attendees: >1500+
  ✓ Unique locations: 300+ (22 US States, + Canada)

Educational Consultation
Outreach to WWAMI-region:

> 600 consultations (free)
> 1100 hrs of Cat 1 Pain didactic content
<table>
<thead>
<tr>
<th>Course Title</th>
<th>Description</th>
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<tbody>
<tr>
<td>Common Pain Disorders in Primary Care</td>
<td>Prescription Monitoring Programs: Access, Use &amp; Response</td>
</tr>
<tr>
<td>Pain Functional Assessment</td>
<td>Urine Drug Testing: Use, Interpretation and Response</td>
</tr>
<tr>
<td>Anxiety and Pain: Assessment and Treatment</td>
<td>Opioids and “MED” Calculation</td>
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<tr>
<td>Exercise and Chronic Pain</td>
<td>Non-Surgical Options for Management</td>
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<tr>
<td>Motivational Interviewing &amp; Goal Setting</td>
<td>Painful Disability: Care and Management</td>
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<tr>
<td>Methadone</td>
<td>PTSD and Pain: Assessment and Treatment</td>
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<td>Cognition</td>
<td>Pain in Pregnancy</td>
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<td>Medications</td>
<td>Taking a Pain History: The Pain Interview</td>
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<tr>
<td>Pain Functional Assessment</td>
<td>“CAM”: Integrative Medicine in Pain</td>
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<td>Painful Disability: Care and Management</td>
<td>Sleep and Pain</td>
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<td>Addiction Diagnosis &amp; Treatment</td>
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<td>Exercise and Chronic Pain</td>
<td>Medical Marijuana</td>
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<tr>
<td>Methadone</td>
<td>Pain in Children and Adolescents</td>
</tr>
<tr>
<td>Cognition</td>
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ACHIEVING GUIDELINE COMPLIANT PAIN CARE
Role of Tele-mentoring

• Team approach with “Pain Champion(s)”
  • Embedded Pain expertise
• Shared clinic policies and assessment tools
• Consensus for a pain “standard of care”
• Focus on functional gains
• Address opioid safety and efficacy
• Defined referral processes

• Emphasis on a multimodal treatment approach
• Address substance use disorders and have care and referral options
  • Buprenorphine “waivered” providers
• More efficient visits
• Patient self-management strategies
  • Web-based programs
• Effective follow-up planning
Pain, at a Point of Equilibrium (!!!!)

Any Questions??

Crawford, The New Yorker 2015
REFERENCES (1)


REFERENCES (3)

REFERENCES (4)