



**UW PACC**

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

# 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.



# Chronic Pain Care Today

(1)

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.

Sullivan MD, Howe CQ. Opioid therapy for chronic pain in the United States: promises and perils. Pain (IASP) 2013;154:S94-S100.

# Chronic Pain Care Today

(2)

- 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

CLINICAL needs case:

# Transformation of Practice

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  
Krebs 2008; O’Rourke 2007; Upshur 2006; Von Korff 2004.

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  $\leq 6$  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.**

Measure	Mean (95% CI)				Δ From Baseline to 12 mo (95% CI)	P Value <sup>b</sup>
	Baseline	3 mo	6 mo	12 mo		
<b>Main Outcomes</b>						
Roland-Morris Disability Questionnaire for pain Assistance with pain treatment	14.6 (14.3 to 14.9)	14.0 (13.3 to 14.7)	13.8 (13.4 to 14.2)	13.3 (12.9 to 13.7)	-1.4 (-2.0 to -7.1)	.004
Treatment as usual	14.5 (14.0 to 15.0)	14.4 (13.8 to 15.1)	14.4 (13.7 to 15.1)	14.3 (13.6 to 15.0)	-0.2 (-0.8 to 0.4)	
Chronic Pain Grade Intensity Assistance with pain treatment	67.4 (65.4 to 69.3)	65.6 (63.5 to 67.7)	63.3 (61.0 to 65.6)	63.2 (60.7 to 65.7)	-4.7 (-6.9 to -2.5)	.01
Treatment as usual	66.0 (64.3 to 67.8)	68.0 (66.1 to 70.0)	66.3 (64.1 to 68.4)	65.6 (63.3 to 67.9)	-0.6 (-2.6 to 1.5)	
PHQ-9 for depression (n = 148) <sup>c</sup> Assistance with pain treatment	14.4 (13.4 to 15.5)	12.8 (11.3 to 14.3)	12.0 (10.6 to 13.5)	10.6 (9.1 to 12.1)	-3.7 (-4.9 to -0.24)	.003
Treatment as usual	14.4 (13.5 to 15.3)	14.0 (12.8 to 15.3)	13.2 (12.0 to 14.5)	13.2 (11.9 to 14.5)	-1.2 (-4.9 to -2.4)	

# Chronic Pain Treatments

## *“Comparing” Effectiveness*

Extrapolated averages of reduction  
in measures of *Pain Intensity*  
or *Pain Botheredness*

- Opioids:  $\leq 30\%$
- Tricyclics/SNRIs: 30%
- Anticonvulsants: 30%
- Acupuncture:  $\geq 10^{+}\%$
- Cannabis: ? 10-30%
- *CBT/Mindfulness*:  $>30-50\%$
- *Graded Exercise Therapy*: N/A
- *Sleep restoration*:  $> 40\%$
- *Hypnosis, Manipulations, Yoga*: “+ effect”

Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp Hypnosis 2007.

# BIOPSYCHOSOCIAL TREATMENTS FOR CHRONIC PAIN?

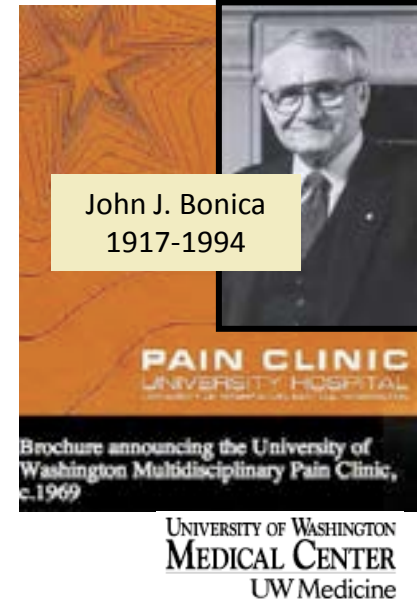
EVIDENCE IS YES! ...since 1969

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

- Astin, et al (2002); Keefe & Caldwell (1997); Bradley (2003); Brox et al. (2003); Burns, et al (2003); Chen et al (2004); Cutler et al. (1994); McCracken & Turk (2002); McGrath & Holahan (2003); Morley et al (1999); Okifuji et al (2007); Pincus et al (2002); Roberts et al (1980); Spinhoven et al. (2004); Turner et al (2006); Vlaeyen & Morley (2005); Weydert, et al. (2003)

- **Efficacy for Multidisciplinary Chronic Pain Programs**

- Aronoff 1983; Becker et al (2000); Flor et al (1992); Gatchel & Okifuji (2006); Gatchel et al (2007); Guzman et al (2001); Lande & Kulich (); Lang et al (2003); Linton et al (2005); Loeser 1991; McAllister et al (2005); Okifuji (2003); Robbins et al (2003); Skouen et al (2002); Turk (2002).



# 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

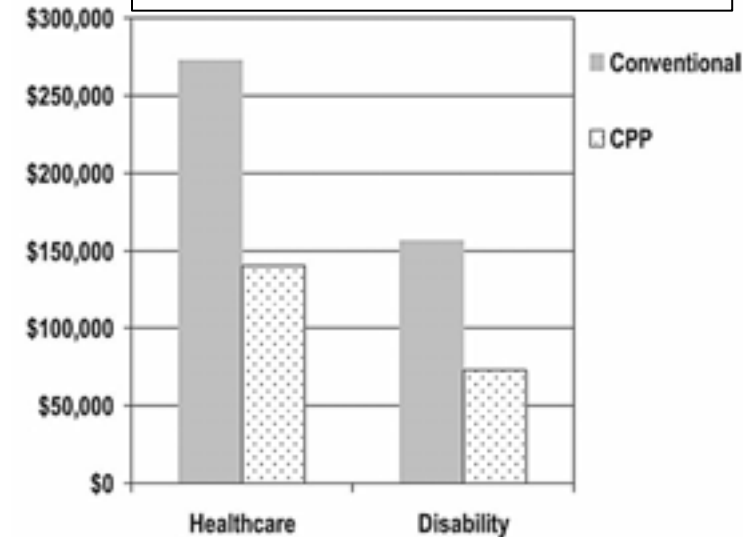
Robert J. Gatchel\* and Akiko Okifuji†

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:

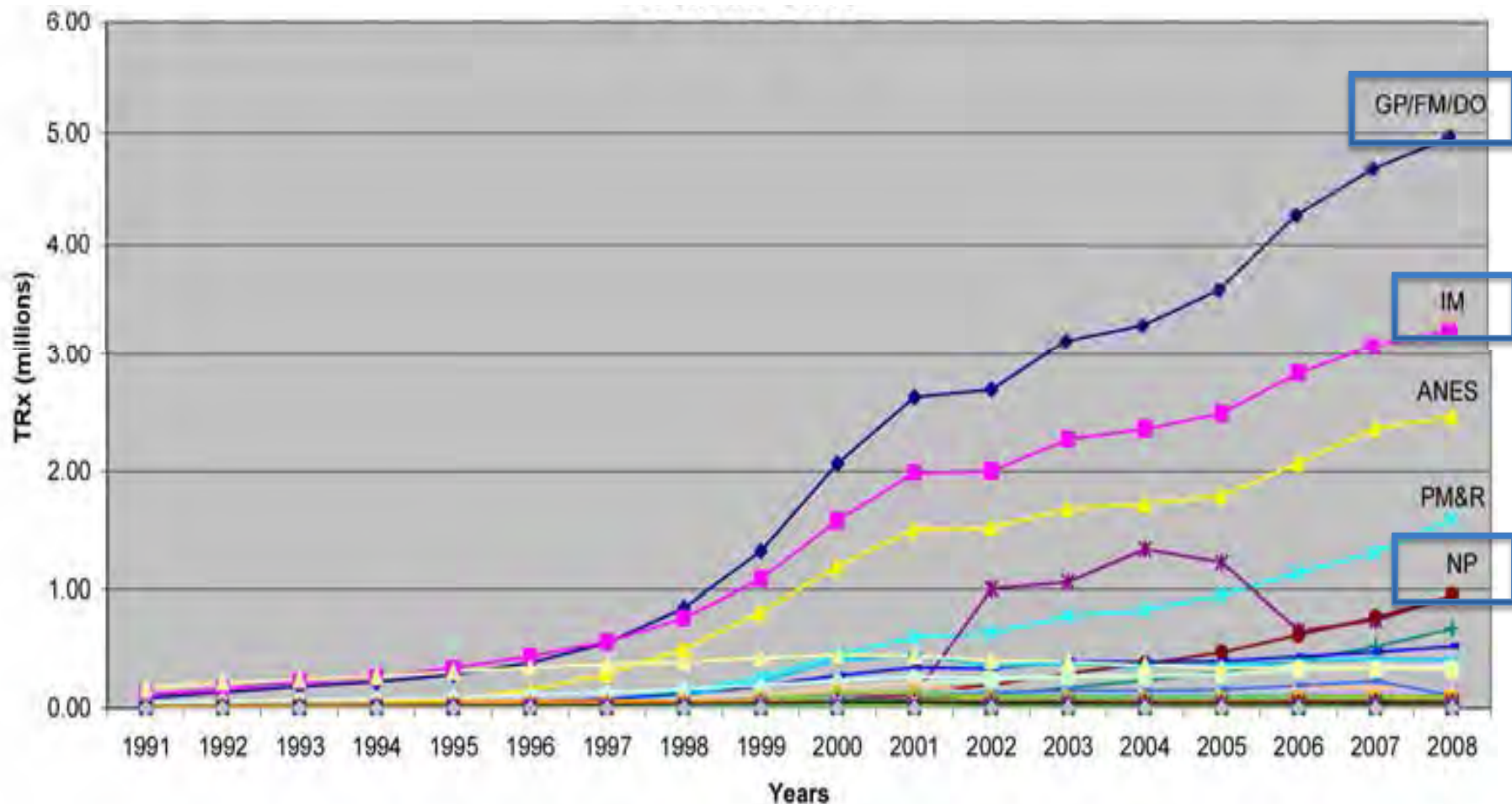
## *“The Allure of Opioids”*

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.

# Total Outpatient Prescriptions of ER Opioids, by Specialty

## 1991-2008

SDI, Vector One: Nationale. Extracted 12/2009

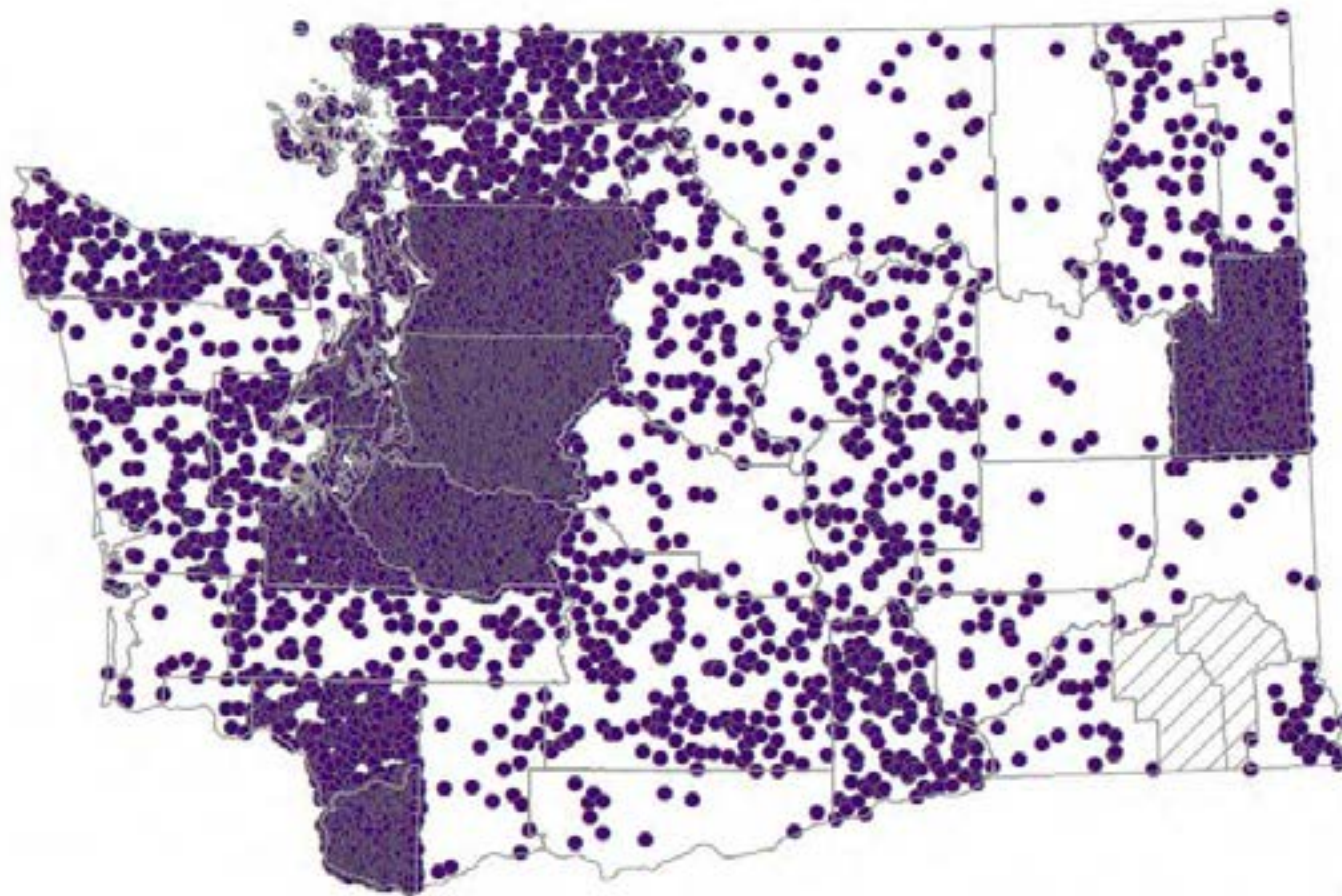


**4 OUT OF 5**  
**HEROIN USERS**  
**ABUSED**  
**PRESCRIPTION**  
**OPIOIDS**  
**FIRST<sup>4</sup>**



# 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

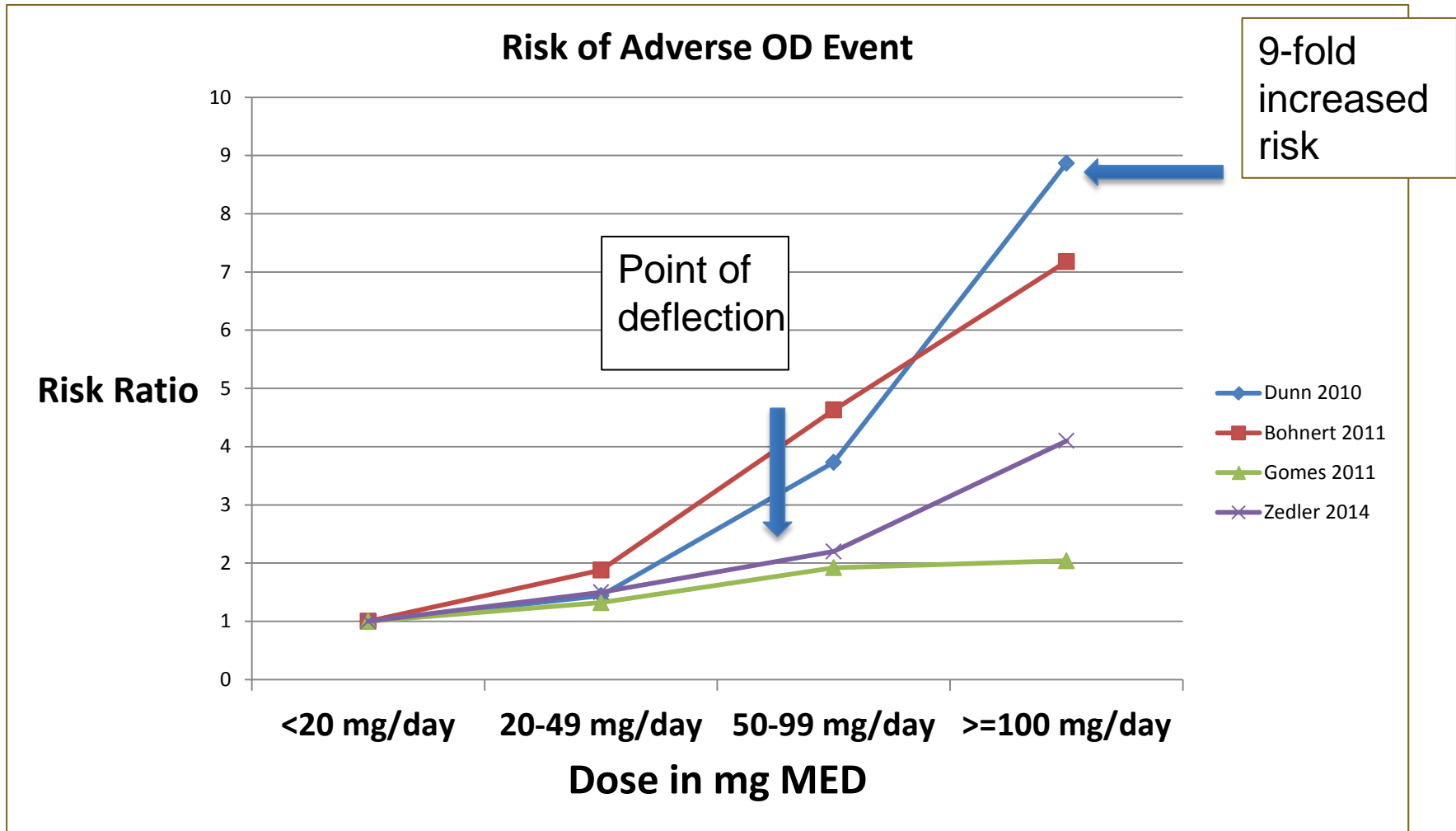
Slide courtesy of C. Banta-Green

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.

UNIVERSITY of WASHINGTON

**ADAI** Alcohol & Drug Abuse Institute

# Opioid Overdose Risk by MED\*



\*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

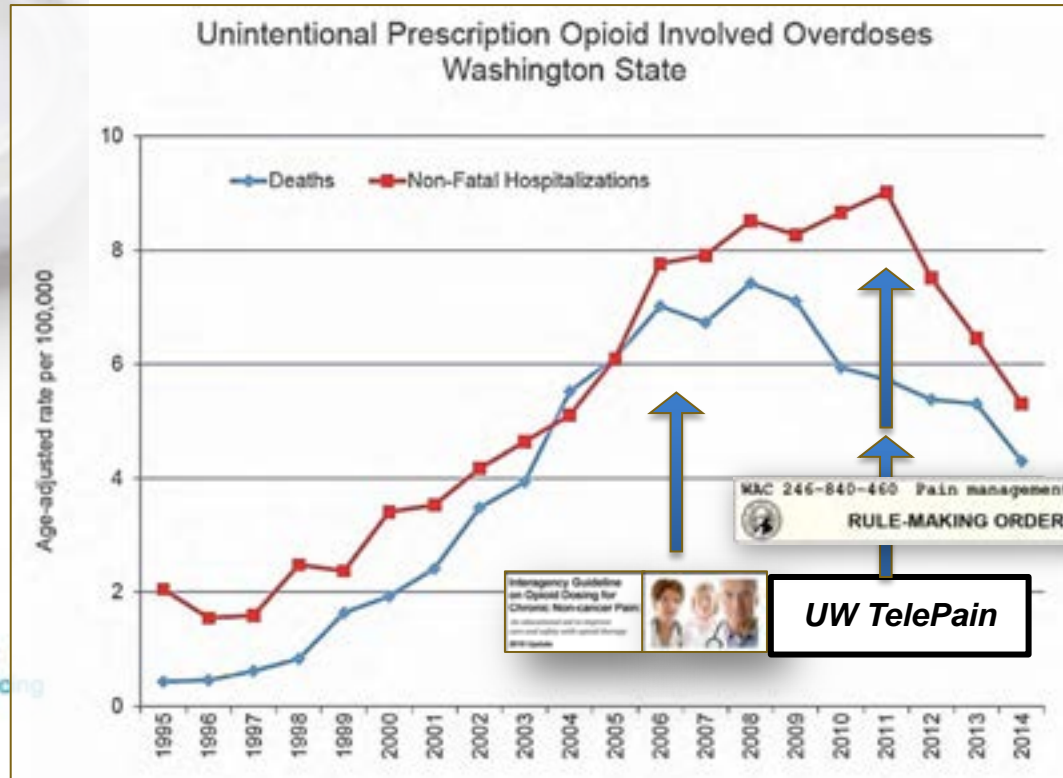
Written for Clinicians who Care for People with Pain  
3rd Edition, June 2015



## 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](http://www.agencymeddirectors.wa.gov)



**AMDG** agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

Written for Clinicians who Care for People with Pain  
3rd Edition, June 2015

**Achieving Guideline Compliant Care**

NIH Pain Consortium  
Centers of Excellence in Pain Education



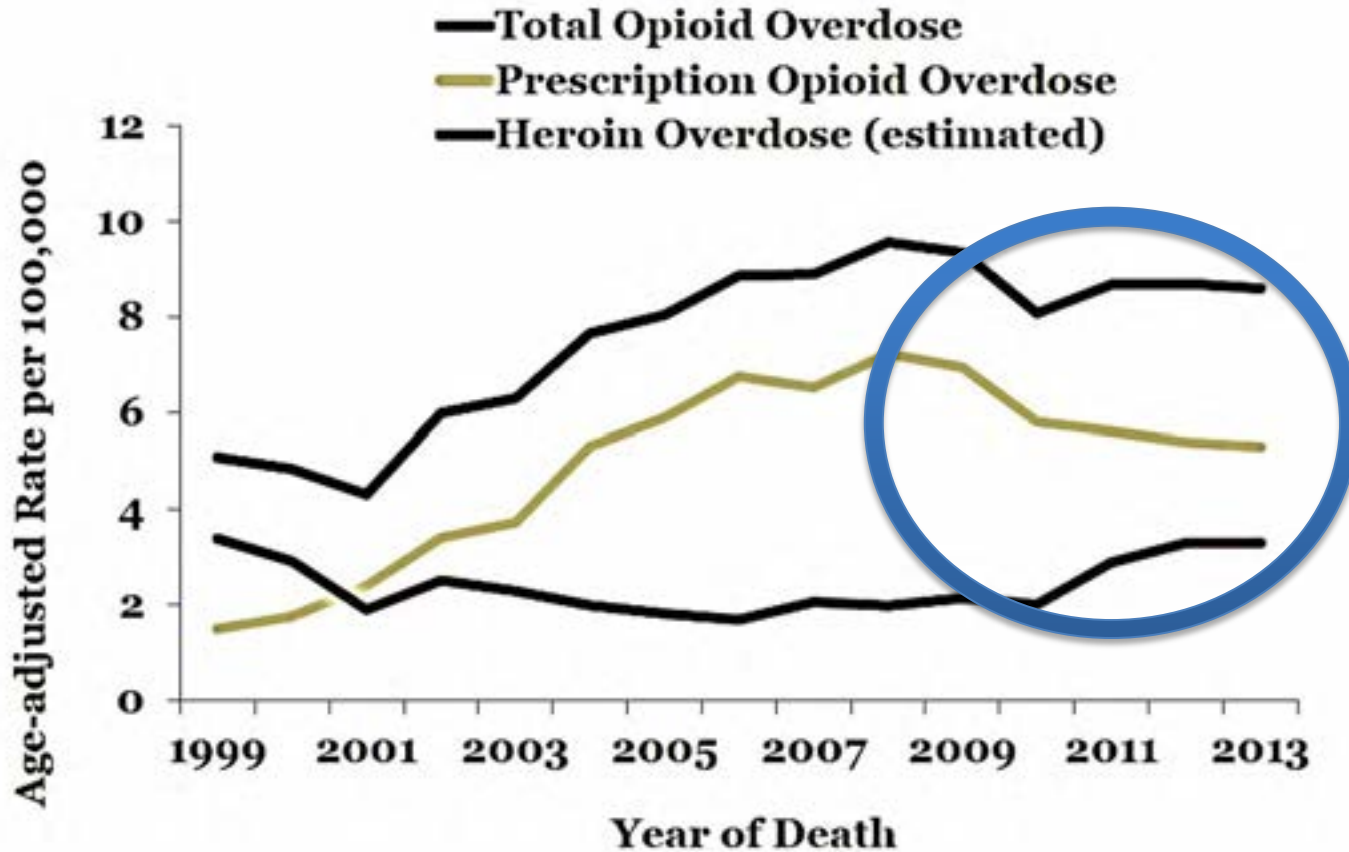
Centers  
Excellence  
AMERICAN PAIN SOCIETY  
Award Recipient 2010

**UW PACC**

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# Prescription Opioid and Heroin Overdoses

Washington State 1999-2013



Assessing risk and addressing harms

1<sup>st</sup> Diagnose: then, treat!!

- Bup/Nlx
- MMT

Need more buprenorphine providers trained!!!



# Opioids for Chronic Pain

REVIEW

Annals of Internal Medicine

## 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.

Annals of Internal Medicine • Vol. 162 No. 4 • 17 February 2015



# Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain  $\geq 3$  months, excluding cancer, palliative, and end-of-life care

Centers for Disease Control and Prevention

# MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 65

March 15, 2016

## CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



### CHECKLIST

#### When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

#### If RENEWING without patient visit

- Check that return visit is scheduled  $\leq 3$  months from last visit.

#### When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If  $\geq 50$  MME/day total ( $\geq 50$  mg hydrocodone;  $\geq 33$  mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid  $\geq 90$  MME/day total ( $\geq 90$  mg hydrocodone;  $\geq 60$  mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals ( $\leq 3$  months).

### EVIDENCE

#### EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

#### NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated.

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

#### EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP):

Check for opioids or benzodiazepines from other sources.

#### ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores. CDF% improvement from baseline is clinically meaningful.

- Q1: What number from 0–10 best describes your pain in the past week?  
0 = “no pain”, 10 = “worst you can imagine”
- Q2: What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?  
0 = “not at all”, 10 = “complete interference”
- Q3: What number from 0–10 describes how, during the past week, pain has interfered with your general activity?  
0 = “not at all”, 10 = “complete interference”



U.S. Department of  
Health and Human Services  
Centers for Disease  
Control and Prevention

TO LEARN MORE  
[www.cdc.gov/od/odasr/preventing/guideline.htm](http://www.cdc.gov/od/odasr/preventing/guideline.htm)

March 2016

- 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/anesth/care/pain/telepain/>

**Questions?**

[telepain@uw.edu](mailto:telepain@uw.edu)

**To register:**

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



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/rrrr6501e1.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](http://www.doh.wa.gov/Emergencies/PainClinicClosures/PainClinicAvailability)
  - UW TelePain Services: Available Wednesdays noon to 1:30 p.m. <http://depts.washington.edu/anesth/care/pain/telepain>



**Pain & Opioid Hotline**

**UW TelePain**



# 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](mailto:Telepain@uw.edu)



**Just-in-time interactive consultations with a team of interprofessional pain experts**



Registration Form

Connecting to UW TelePain Sessions

Zoom via PC, Mac, Linux, IOS, or Android:

<https://zoom.us/j/359845443>

## UW TelePain Case Conference

Wednesday, February 22, 12:00 PM - 1:30 PM PST

Addiction Treatment Overview

Speaker: [Pam Pentin, MD](#)

Panelists: [David Tauben, MD](#), [James Robinson, MD](#), [Mark Sullivan, MD](#), [Suzanne Rapp, MD](#)

# UW TelePain™ *Clinician Educators*

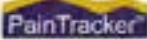
- **Expert UW Multidisciplinary Pain Faculty**
  - *(Direct Primary Care Provider -to- Pain Consultant Panel)*
    - **Internal Medicine/Pain Medicine (Primary Care)**
    - **Family Medicine (Primary Care)**
    - **Addiction Medicine (Primary Care)**
    - **Pharmacy**
    - **Psychiatry**
    - **OB-Gyn (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

...& at every *pain related* encounter



University of Washington

Below is a list of locations of pain. In the first column, please indicate one or more areas where you have felt pain over the past week. In the second column, please indicate the ONE location of your most severe pain:

LOCATION	ANY PAIN? (√ ALL THAT APPLY)	WORST PAIN? (√ ONE ONLY)
Head		
Neck		
Chest		
Stomach		
Back		
Arm		
Hand		
Buttocks		
Genital/Urinary		
Leg		
Knee		
Foot		

Please rate your pain by filling in the circle of the one number that best describes your pain on the average in the last week?

0    1    2    3    4    5    6    7    8    9    10  
 No Pain Pain as bad as you can imagine

Fill in the circle of the one number that describes how, 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

**Enjoyment of life**


0    1    2    3    4    5    6    7    8    9    10  
 Does not interfere Completely interferes

**Falling asleep**

0    1    2    3    4    5    6    7    8    9    10  
 Does not interfere Completely interferes

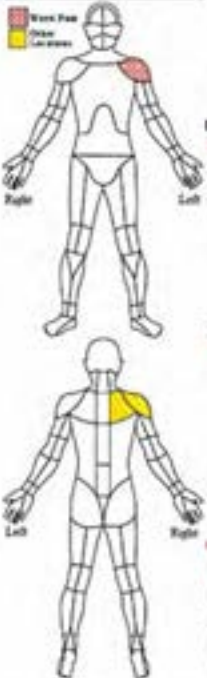
**Staying asleep**

0    1    2    3    4    5    6    7    8    9    10  
 Does not interfere Completely interferes



ORT Score: 18 (0-24) ⚠ ASSET-C: 6 (0-12) ⚠ PHQ-9: 18 (0-27) ⚠ SI: 3 (0-11) ⚠ PTSD: 2 (0-4) STOP: 0 (0-4)	Patient Reported Current Treatments --- Injection: T162014, 3112014, T1730014, T1840014 --- Started Physical Therapy: No start of physical therapy reported --- Started Behavioral Therapy: T100014, 31140014
---	--

Problems: Low  
Concerns: High ⚠  
Helpfulness: No  
Taper: Yes



**Pain Interference & Interference**

Legend: Pain Intensity (black line), Interference (red line)

Session	Pain Intensity	Interference
7/12	10	10
7/15	10	10
7/19	10	10
7/22	10	10
7/26	10	10
7/29	10	10
8/2	10	10
8/5	10	10
8/9	10	10
8/12	10	10
8/16	10	10
8/19	10	10
8/23	10	10
8/26	10	10
8/30	10	10
9/2	10	10
9/6	10	10
9/9	10	10
9/13	10	10
9/16	10	10
9/20	10	10
9/23	10	10
9/27	10	10
9/30	10	10

**Depression**

Legend: PHQ-9 (black line), GAD-7 (red line)

Session	PHQ-9	GAD-7
7/12	18	18
7/15	18	18
7/19	18	18
7/22	18	18
7/26	18	18
7/29	18	18
8/2	18	18
8/5	18	18
8/9	18	18
8/12	18	18
8/16	18	18
8/19	18	18
8/23	18	18
8/26	18	18
8/30	18	18
9/2	18	18
9/6	18	18
9/9	18	18
9/13	18	18
9/16	18	18
9/20	18	18
9/23	18	18
9/27	18	18
9/30	18	18

**Sleep Initiation & Maintenance**

Legend: Sleep Initiation (black line), Sleep Maintenance (red line)

Session	Sleep Initiation	Sleep Maintenance
7/12	14	14
7/15	14	14
7/19	14	14
7/22	14	14
7/26	14	14
7/29	14	14
8/2	14	14
8/5	14	14
8/9	14	14
8/12	14	14
8/16	14	14
8/19	14	14
8/23	14	14
8/26	14	14
8/30	14	14
9/2	14	14
9/6	14	14
9/9	14	14
9/13	14	14
9/16	14	14
9/20	14	14
9/23	14	14
9/27	14	14
9/30	14	14

**ODI & Important Activity Difficulty**

Legend: ODI (black line), Important Activity Difficulty (red line)

Session	ODI	Important Activity Difficulty
7/12	80	80
7/15	80	80
7/19	80	80
7/22	80	80
7/26	80	80
7/29	80	80
8/2	80	80
8/5	80	80
8/9	80	80
8/12	80	80
8/16	80	80
8/19	80	80
8/23	80	80
8/26	80	80
8/30	80	80
9/2	80	80
9/6	80	80
9/9	80	80
9/13	80	80
9/16	80	80
9/20	80	80
9/23	80	80
9/27	80	80
9/30	80	80

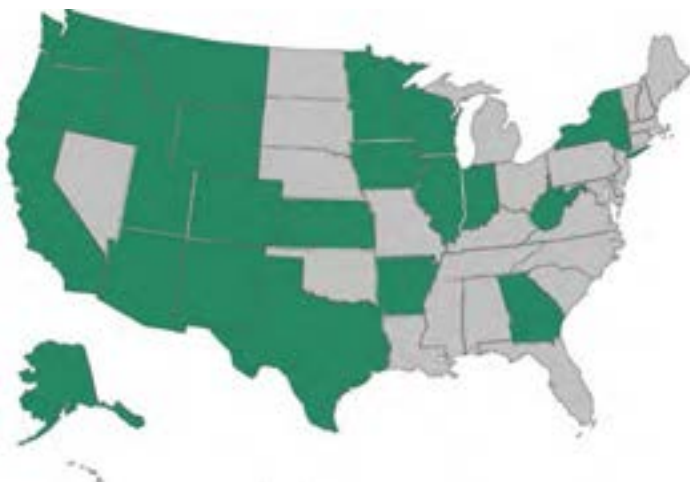
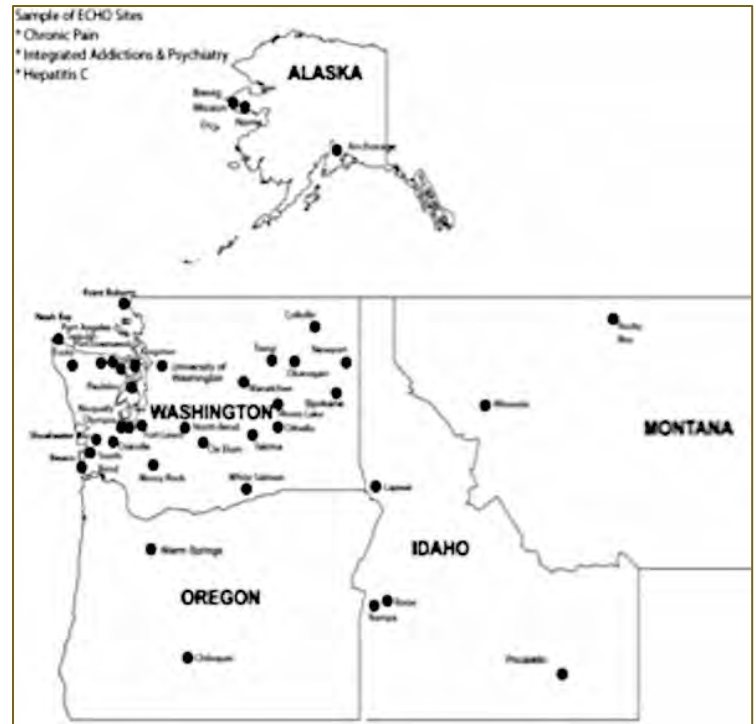
PT NO: GRANTHAM, JACK  
DOB: 1974-07-31 SEX: F

UW Medicine  
Northwest Medical Center - Northwest Hospital & Medical Clinics  
Safety Medical Center - UW Medical Center  
University of Washington Physicians - Seattle, Washington  
PainTracker  
Page 1 of 2  
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# 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



# UW TelePain “Lecture Format” Curriculum

Common Pain Disorders in Primary Care	<b>Prescription Monitoring Programs: Access, Use &amp; Response</b>
Pain Functional Assessment	<b>Urine Drug Testing: Use, Interpretation and Response</b>
Anxiety and Pain: Assessment and Treatment	<b>Opioids and “MED” Calculator</b>
Exercise and Chronic Pain	<b>Non-Opioid Pain Management</b>
Motivational Interviewing & Goal Setting	<b>Non-Opioid Pain Management</b>
<b>Methadone</b>	<b>Non-Opioid Pain Management</b>
<b>✓ FDA-REMS*</b> compliant opioid prescriber curriculum	<b>Non-Opioid Pain Management</b>
<b>✓ “Suboxone®”**</b> training & continuing active clinical support	<b>Non-Opioid Pain Management</b>
<b>✓ AMDG &amp; CDC Guidelines</b> adherent practice	<b>Non-Opioid Pain Management</b>
<b>Depression and Pain: Assessment and Treatment</b>	<b>“CAM”: Integrative Medicine in Pain</b>
<b>Extended Release and Long Acting Opioids</b>	<b>Sleep and Pain</b>
<b>Addiction Assessment</b>	<b>Addiction Diagnosis &amp; Treatment</b>
<b>Opioid Drug Diversion</b>	<b>Medical Marijuana</b>
	<b>Pain in Children and Adolescents</b>

**Bold font** indicates FDA-REMS Compliant content

\*FDA Risk Evaluation and Mitigation Strategies

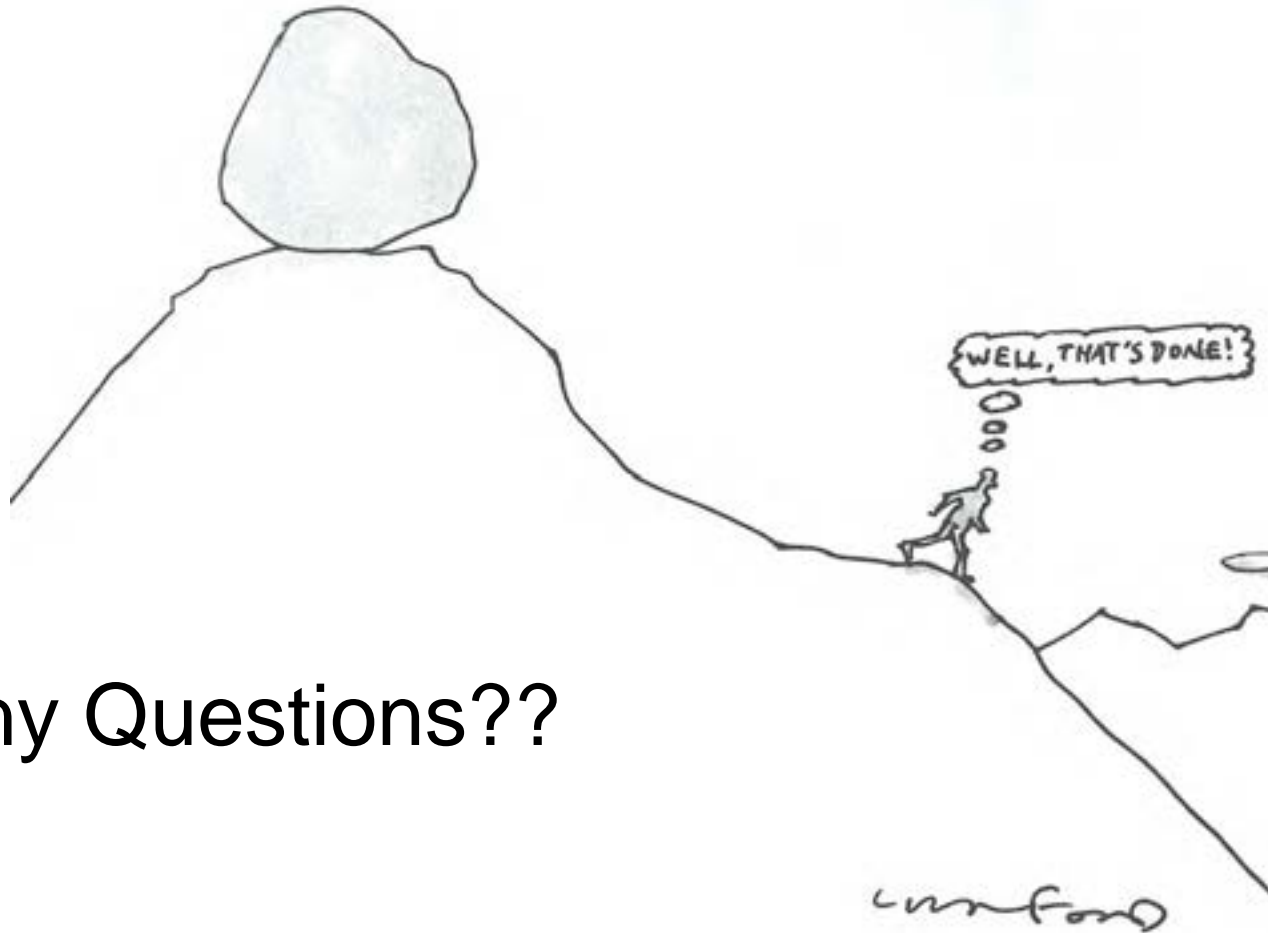
\*\*Buprenorphine/Naloxone

# 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??

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