Opioid Abuse Prevention Symposium

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Objective

• Describe self-management as it relates to chronic pain and the opioid epidemic
• List 2 active treatments for chronic pain that are supported by evidence
• Discuss barriers and opportunities for implementing a whole person approach to chronic pain in the US healthcare system
Two Converging Public Health Crises

Chronic Pain

Opioid Crisis
2011 NAM Report:

- > 100 million Americans report having chronic pain
- $560-635 billion annual costs associated with chronic pain (direct medical costs and lost productivity)

Source: Social Security Administration
Credit: Lam Thuy Vo / NPR
Chronic Pain and Transformation of the Care Model

• Biomedical Care Model
  • “Find it and Fix it” approach
  • Assumes a 1:1 correlation between physical pathology and pain
  • Patient is passive victim of identifiable disease and doctor is responsible for urgent and complete pain relief
  • Focus on passive treatments that are done TO the patient
  • 1980s-2000s
  • Created a care system that is fragmented, costly, risky, and ineffective
Cultural Transformation to a Biopsychosocial Care Model

- Biopsychosocial Care Model
  - Focus on care of the **whole person**
    - Treat the person who has pain rather than focus on painful tissue
  - Address social, psychological, and biological components of pain
  - Focus on improving function
    - Create physical, mental, social, spiritual health
  - Patient is activated center of care team
  - Focus on **self-management** and **active treatments** that depend on active patient participation
3 Sections with 17 Recommendations regarding opioid use for chronic pain
1 Recommendation regarding use of opioids for acute pain
Provider and Patient Summaries and Pocket Card

1. Initiation and Continuation of Opioids
2. Risk Mitigation
3. Type, Dose, Follow-up, and Taper of Opioids
4. Opioid Therapy for Acute Pain
Recommendation 1

a) We recommend against initiation of long-term opioid therapy for chronic pain.

b) We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments.

c) When pharmacologic therapies are used, we recommend non-opioids over opioids.
What is locus of control?

- External vs Internal
- “What are you going to do to fix my pain?” vs “what can I do to start managing my pain?”
Active vs Passive therapies

- Passive therapies are therapies that someone else does TO the person with pain
  - Medications
  - Shots
  - Surgery
  - Massage
  - Acupuncture
  - Chiropractic

- Active therapies require effort of the person with pain and are not dependent on professionals
  - Exercise/movement
  - Application of coping skills
  - Setting goals and taking actions to work towards goals
  - Engaging in enjoyable, social, work, and volunteer activities
Evidence for Low Back Pain Therapies

- **Medications**
  - Limited evidence for short term benefit

- **Injections**
  - Limited evidence for very short term benefit of unclear clinical significance

- **Surgery**
  - Discectomy may provide benefit in well-selected pts with radiculopathy and prolapsed disc
  - Symptomatic spinal stenosis may benefit from surgery, however interdisciplinary rehabilitation is preferred
  - Failed Back Surgery Syndrome incidence may be up to 40%

Evidence for Low Back Pain Therapies

• Biopsychosocial rehabilitation\(^1\)
  • Small improvement in long term pain and disability
• Cognitive Behavioral Therapy\(^2\)
  • Moderate improvement in pain and disability
• Exercise\(^2\)
  • Moderate improvement in pain and disability

(1) Kamper 2014 (2) Chou 2007
Treatment of comorbidities

• Optimized **treatment of depression** and pain self-management can improve pain in chronic MSK pain (Kroenke, *JAMA*, 2009)

• **Weight reduction** can lead to improvement in pain and pain related disability (Narouze, *Reg Anesth Pain Med*, 2015)

• **Improved diabetic control** can lead to improvement in neuropathic pain

• **Improvement in sleep** can lead to improvement in wellbeing and pain
Implementation
Barriers

• Episodic
• Single discipline
• Short term focus
• Disease focus
• Reductionism
• Single treatment focus:
  • procedures or opioids

Future Directions

• Longitudinal
• Team based
• Long term focus
• Wellness and Prevention
• Whole Person + environment
• Multimodal focus:
  • Self-management + biopsychosocial treatment plan
Reimbursement

• Value **cognitive work** (time spent with patients) equally to procedural work
• Provide reimbursement for **pain psychological services**
• Provide economic **incentives to provide integrated interdisciplinary care**
• NPS: Tailor payment to promote and incentivize high-quality, coordinated pain care through an integrated biopsychosocial approach that is cost-effective, value-based, patient-centered, comprehensive, and improves outcomes for people with pain.
Focus on Treatment Teams

- Focus on functions rather than disciplines
  - Case Manager (RN, SW)
  - Movement therapy (PT, RT, KT, yoga therapist, etc)
  - Behavioral therapy (psychologist, counselor)
  - Health Coach (LPN, RN, RD, non-licensed)
  - Addiction provider with ability to prescribe Medication Assisted Treatment
  - PCP – medical provider (MD/DO, NP, PA)
- May require virtual teams (ideally linked by care manager)
- Shared Medical Appointments
- Treatment and Education Groups
- Integrated Interprofessional Pain Rehabilitation
References


