WELCOME – where are we coming from?
Mental Health; Medical Health; Education

PLEASE QUIET CELL PHONES

NEW INFORMATION – FUNDING Chronic Pain

Hot Off The Presses

"SUPPORT for Patients and Communities Act" [H.R. 6] on Non-opioid treatment of pain pass the US Senate 10/15/18 98 to 1.

AREAS: PREVENTION; TREATMENT: WORKFORCE & SPECIAL POPULATIONS

Prevention

- Requires CMS to issue guidance to states on Medicaid coverage of non-opioid treatment and management of pain, including non-pharmacological therapies;
- Requires the Department of Health and Human Services (HHS) to issue a study within one year of best practices, coverage policies, and payments to providers related to the use of multi-disciplinary non-opioid treatments for acute and chronic pain management under Medicare, and to develop an action plan on recommended changes to Medicare and Medicaid policies and payments to prevent opioid addiction and improve access to medication-assisted treatment;
- Requires HHS to issue guidance to Medicare-participating hospitals on pain management strategies, including education of non-opioid pain management treatments and authorizes award grants to hospitals and emergency departments to test or develop alternatives to opioids for pain management.
- Requires HHS to convene technical expert panels to make future recommendations.

Treatment

- Requires states to cover medication-assisted treatment (MAT) under Medicaid, including methadone and all other FDA-approved drugs used in MAT, and counseling and behavioral treatment, beginning 10/1/2020.
- Gives states option for temporary Medicaid coverage of residential treatment for substance use disorder, up to 30 days per year
- Authorizes CMS to test the use of incentive payments to clinical psychologists and other behavioral health providers for the use of electronic health records (EHR) technology;
- Establishes Medicare coverage of services provided by opioid treatment programs, including individual and group therapy with a psychologist or other authorized mental health professional, under a bundled payment system, and authorizes a 4-year demonstration project
- Establishes coverage of telehealth services under Medicare and guidance re: Medicare for patients to receive treatment in their own homes for substance use and co-occurring mental disorders, for those patients with a substance use disorder.
- Strengthens federal agency reporting requirements on private sector health plan compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

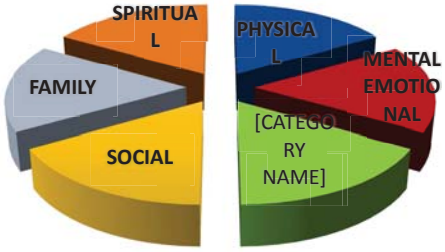
Workforce

- Supports expansion of the substance use treatment workforce through a new, targeted loan repayment program & by extending eligibility for National Health Service Corps loan repayment assistance to providers working in schools and other community-based settings.
- Requires the establishment of Regional Centers of Excellence in Substance Use Disorder Education for improving health professional training resources with respect to substance use disorder prevention, treatment, and recovery.
- Requires HHS to establish a competitive grant program funding at least 10 Comprehensive Opioid Recovery Centers to provide a full continuum of treatment and recovery services, including residential rehabilitation, community-based and peer recovery support services, job training and placement assistance, and to conduct training and outreach to educate the public and professionals on substance use disorders and respond to community needs;

Special Populations

- Authorizes the CDC to support state efforts to collect data on **adverse childhood experiences**, and creates an interagency task force to promote best practices to identify, prevent and mitigate the effects of trauma on children and families;
- Establishes grant program to increase student access to evidence-based trauma support services, and requires HHS to disseminate resources to early childhood providers working with youth on ways to recognize and respond to early childhood trauma;
- Requires HHS to develop guidance to states on identifying funding for family-focused residential substance treatment programs, and authorizes grants to help states develop, enhance or evaluate family-focused treatment programs;
- Supports services for pregnant and postpartum women, creating a new funding stream to states for implementing "plan of safe care" provisions in the Child Abuse Prevention and Treatment Act (CAPTA), & requiring development of educational materials on pain management during pregnancy; & research on Neonatal Abstinence Syndrome
- Allows states to cover inpatient and outpatient services at residential pediatric recovery centers for infants with neonatal abstinence syndrome and requires HHS to issue recommendations on financing under Medicaid and CHIP for parents with substance use disorders and infants with neonatal abstinence syndrome.

Effective Intervention for Chronic Pain
Behavioral Treatment of Chronic Pain



James Keyes, Ph.D., ABPP
University of Washington Clinical Instructor

I have no Conflicts of Interest to report!

Disclaimer:

“Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professions standards. “

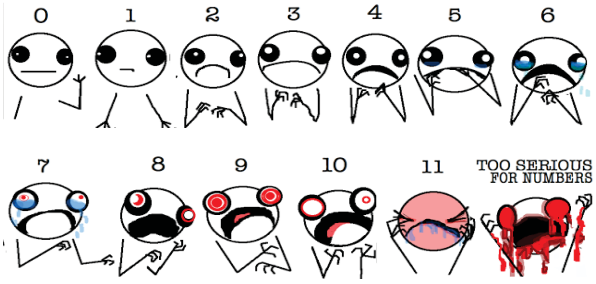
WHERE ARE YOU AT TODAY? – Self Assessment

Oswestry Questionairre
Anxiety / Depression / Wellness
YOU NEED for this information in your practice

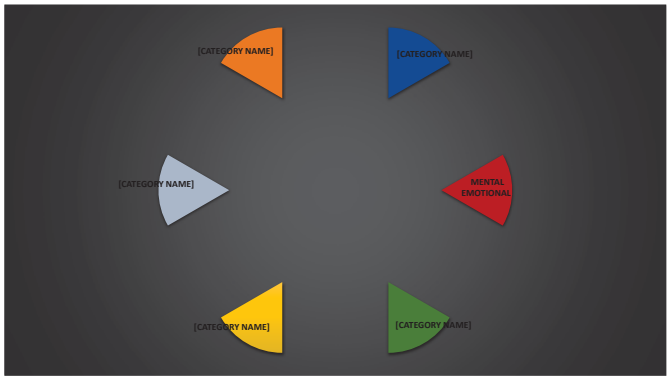
ARE YOU WILLING TO SHARE WITH OTHERS HERE?

PHQ-9	**OSWESTRY Disability Scale**
Rate 0,1,2,3 (None, Some, Mod, Sev)	**Pain intensity**
1. Little Interest or pleasure doing things	**I have no pain at the moment**
2. Feeling down, depressed, hopeless	The pain is very mild at the moment
3. Trouble falling or staying asleep	The pain is moderate at the moment
4. Feeling tired; Little energy	The pain is fairly severe at the moment
5. Poor Appetite; or Too Much	The pain is very severe at the moment
6. Feeling bad about yourself; guilt	The pain is the worst imaginable at the moment
7. Trouble concentrating simple things	**Personal care**
8. Moving Slow or Speeded	I can look after myself normally without causing extra pain
9. Thoughts of death / self-harm	I can look after myself normally but it causes extra pain
	It is painful to look after myself and I am slow and careful
	I need some help but manage most of my personal care
	I need help every day in most aspects of self-care
	I do not get dressed, I wash with difficulty and stay in bed
➢ **REMIND ME – Bernie Siegel, MD**	**Sitting**
Love, Medicine & Miracles – How does he talk with patients about pain?	I can sit in any chair as long as I like
	I can only sit in my favorite chair as long as I like
	Pain prevents me sitting more than one hour
	Pain prevents me from sitting more than 30 minutes
	Pain prevents me from sitting more than 10 minutes
	Pain prevents me from sitting at all

How do you RATE YOUR PAIN (0-10)?
ALTERNATIVE version



THE WHOLE PERSON APPROACH TO CHRONIC PAIN



Chronic Pain – A nationwide problem

U.S. Incidence of Chronic Pain overall is 31% (apx. one in three).
Greater than all other (single) healthcare conditions.

Chronic Pain	100 Million Americans	Institute of Medicine
Diabetes	26 Million Americans	American Diabetes Association
Coronary Heart Disease	16 Million Americans	American Heart Association
Cancer	12 Million Americans	American Cancer Society

Healthcare costs annually range $560 billion - $635 billion

Lost productivity based on 3 estimates:

- Days of Work missed (from $11.6 to $12.7 billion)
- Hours of Work lost (from $95.2 to $96.5 billion)
- Lower Wages (from $190.6 billion to $226.3 billion).

Types / Areas of pain presentation:

Area of (Chronic) Pain	US Population
Low Back Pain	27%
Severe Headache / Migraine	15%
Neck Pain	15%
Pelvic Pain	14%
Carpal Tunnel Pain	8%
Facial / Dental Pain	4%
Abdominal Pain	3%

Small Group Discussion

WHAT exactly makes the difference between Acute Pain and Chronic Pain?

Acute vs. Chronic Pain - Definitions

Chronic Pain is currently defined as:

- Someone experiencing pain greater than 4-12 weeks, or
- Pain that is not healing as expected.

BUT…

Newer approaches to try and help patients improve more quickly and effectively talk about:

The IASP Definition of Chronic Pain has expanded to include ALL factors which might affect the experience of Chronic Pain:

An unpleasant sensory and ***emotional*** experience associated with actual or potential tissue damage, or described in terms of such damage.

IASP Taxonomy - International Association for the Study of Pain 12/14/17

Overview

- Case Examples (Functional vs. Dysfunctional)
- Looking at a "Framework" for how to view Function
- Where to Start? – Where is the most likely Shift?
  - SHORT ANSWER: If you can get a patient with chronic pain doing ANYTHING different, you've changed the context; meaning or experience of their pain.
- Physical Arenas – you need to know!
- Mental / Emotional Arenas – most familiar
- Purpose
- Social
- Family & Spiritual

Functional Means Different things



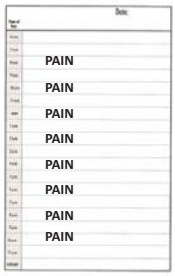
…functional

Dysfunctional Might mean Different Things

Under Activity

Over (doing) Activity

Functional vs. Dysfunctional –
Are there things outside of a pain focus at home?



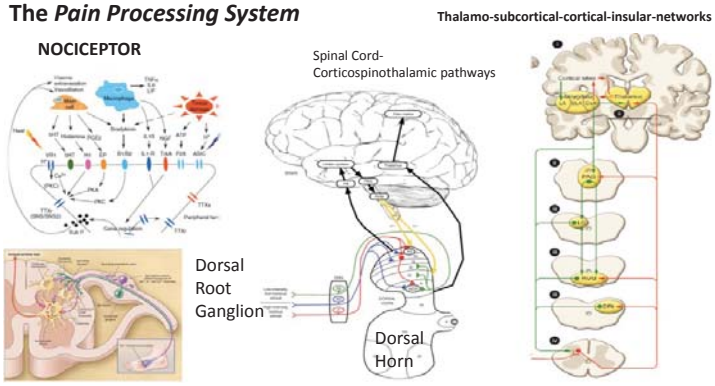
Coincidental to Chronic Pain, the DSM Epistomology

Factors more likely associated with Mental Illness and Pain

- Female > Male (once out of childhood)
- Age of Onset (Majority start at or after adolescence)
- Precursor factors (Genetic; Social Learning; Abuse / PTSD)

- Women report more severe levels of pain; more frequent pain, and pain of longer duration than men. Henschke, N., Kamper, S.J., & Maher, C.G. (2015).
- Adolescent levels approach those of adults.
- Pain remains a serious problem in older age, with prevalence in adults over 65 at 25-76%, and in those in residential care ranging from 83-93%.
- **Incidence on those with PTSD diagnosis is 2.7x higher than typical.**

The *Pain Processing System*

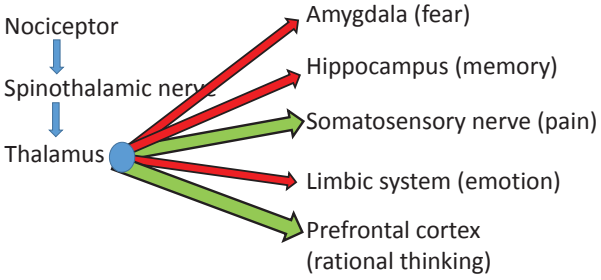


From: D'Mello 2008, Mendell 2003, Ossipov 2010

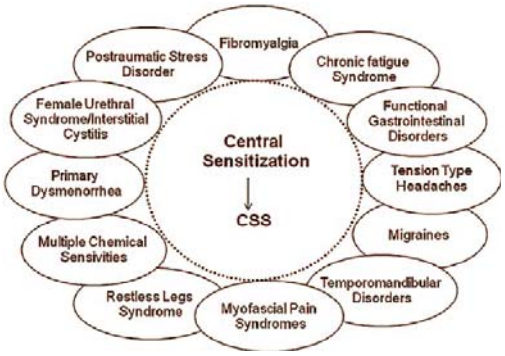
Steps of Pain Signals

- Initial Injury / Insult of some type: PAIN is meant to serve a purpose!
- Nerve or chemical signal is sent toward brain (Nerve type?)
- Local chemical agents released at the site (prostaglandins & Substance P) as well as hormonal / chemical changes in brain
- Note in pictures – not only is the sensory path stimulated, but transfer centers (thalamus) and **affective centers of the brain (Limbic System) are all stimulated.**
- Then, messages relay back to the area of injury, surrounding muscles/bones (MOVE) and sometimes other hormonal releases are present in the dorsal root area of the spine.

Pain Pathways (in Central Sensitization)



Central Sensitization thought related to:



Central Sensitization - Summary

In Summary

It causes real pain due to scrambled signals in the brain

Therapy is the only thing that helps

ACES – Adverse Childhood Experiences scale KP SD

Significant Events Studied:

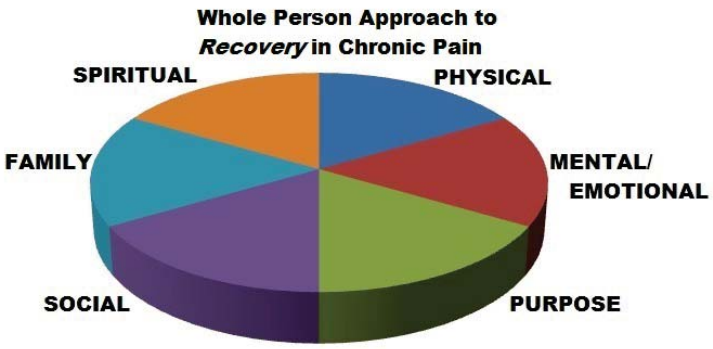
- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- Alcohol/ drug abuser in home
- Incarcerated household member
- Someone with Mental Illness
- Mother is treated violently
- One or No parents
- Emotional or Physical neglect

64% with 1; 12% > 4

Robust Correlation:

- Depression, Suicide Attempts
- Multiple Sex partners & STD's
- Smoking / Alcoholism
- Cognitive / Emotional Impairment
- Adoption of risky health behaviors
- Disease, Disability & Social Problems
- Early Death
- Chronic Pain Disorders

Issue becomes RESILIENCE



Case Examples

1. 55 year old partnered LPN sent to see me with Chronic LBP, Arthritis, daily narcotic use; and recent loss of job due to number of days absent from work. Not engaged in exercise, not going to social encounters, mildly depressed (long-term issues of abuse/ neglect in family), caring for partner who is disabled / often bed-ridden.

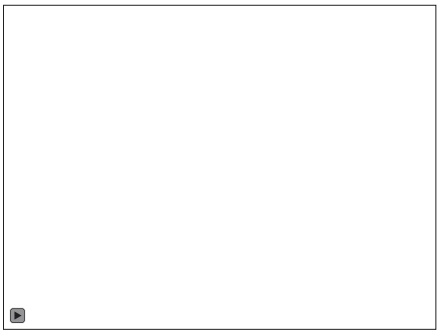
2. 60 year old married Teacher sent to see me following lack of progress in recovery for fractured metatarsal. Loss of function included – not at work, not engaged in regular hiking (favorite hobby), requesting 2nd (3rd?) opinion on next steps for foot. Still doing some exercise; Still socializing; Not on pain medications but took recommendation and started on anti-depressants. *However,* between referral/1st visit and 2nd visit 2 months later - she returned to work part-time, took a vacation trip with husband, and review with podiatry gave final "bad news" no more to do with foot.

Where to start?

Case 2 ("Functional") – Already doing 2 types of exercise*, already socializing, already returned to purposeful activity, improved mood following antidepressant and return to some work. With this type of patient, the goal can be "enriching what's there".

Case 1 ("Dysfunctional") - Have to get a sense of her history: What worked for her in the past?, Where does she take pride?, How does she see your role in assisting? Can you use "Motivational Interviewing" to get her to choose some place to start that is different than her ususal?

VIDEO



SMART GOALS

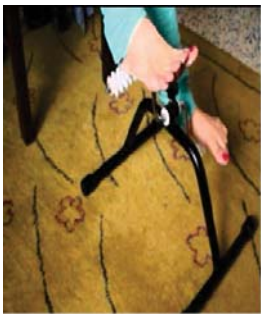
- **S**pecific and significant
- **M**easurable and meaningful
- **A**chievable and action-orientated
- **R**ealistic and reasonable
- **T**imely / time-limited

- Define the GOAL (Who, What, Why)
- Can you track PROGRESS?
- Is it a reasonable goal, Action based
- Is the goal relevant, worthwhile / consistent with the person's needs?
- What's the time limit for trying?

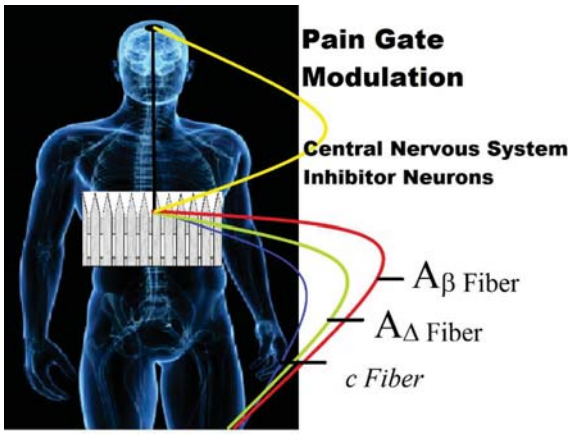
Physical – YOU have to know

- Type of injury (simply – Bone, Muscle/Tendon (soft tissue) or Nerve?
- How long since date of injury? (Centralization of Pain)
- What medications? (Research on TCA's, Development of "Tolerance")
- How is sleep? Have to be sleeping (Address mental & physical parts)
- *3 areas of exercise (in order): Aerobic; Stretches; Strengthening
- Areas of Overlap - *Behavioral Activation* for depression; *Desensitization* to fear of activity; Demonstrating *Reframed Cognitions* about their condition (disabled?); Restarting *Self-Efficacy; Physical changes to release of neurotransmitters.*

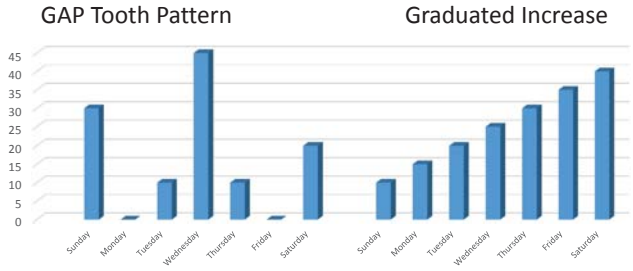
Physical Activities


Use the GATE THEORY of Pain to help.



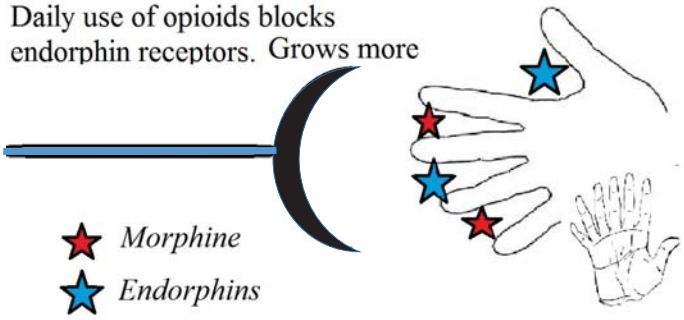
PACING -Need to Discuss & Practice Pacing with patients who have chronic pain over and over, like they never had learned this self care.



MEDICATIONS for PAIN (Pain Killers)

- Opioid Receptor Blockers (Buprenorphine; Methadone)
- Opioid Medications (Morphine; Hydromorphone; Fentanyl)
- Atypical's (TCA's; Anticonvulsants; Other)
- Muscle Relaxants (Flexeril; Methocarbanol; Soma; Tizanidine*; Baclofen*)
- Topical Agents (Analgesics: Icy Hot; Biofreeze; Capsacian)
- OTC Analgesics (Aspirin; Acetaminophin; Naproxen; Ibuprofen)

PROBLEM with daily use of Opioid Medicines



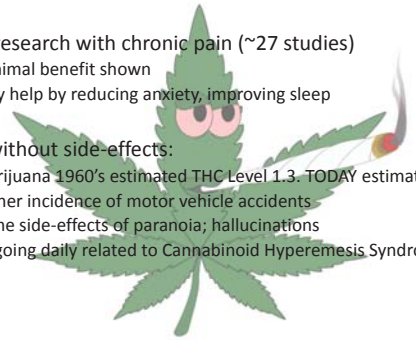
??March 2018 - Opioids no more effective than OTC medications for chronic osteoarthritis pain??

Krebs, E.E., Gravely, A., Nugent, S, et. al (2018). Effect of Opioid vs Non-opioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain. *JAMA (319,* 9): 872-882. doi:10.1001/jama.2018.0899

RANDOMIZED CONTROL STUDY; N=240 (somewhat small); 3.4 point decrease in pain on 0-10 Pain Scale vs. 3.3 point decrease after 12 month's trial. MEANINGS?

Marijuana

- Little research with chronic pain (~27 studies)
  - Minimal benefit shown
  - May help by reducing anxiety, improving sleep
- NOT without side-effects:
  - Marijuana 1960's estimated THC Level 1.3. TODAY estimated 8.5
  - Higher incidence of motor vehicle accidents
  - Some side-effects of paranoia; hallucinations
  - Ongoing daily related to Cannabinoid Hyperemesis Syndrome



OTHER MEDICATIONS / SUBSTANCES

What about other medications or substances?

Have you heard about CBD's? Not pot; won't get you high but it can…

What about Ketamine Withdrawal Programs from Opioids; just 1 week..

New Non-Opioid Medication will help with your pain…

In my work with patients, I advocate "Self-Management" not external management approaches. What about these "newer / better" tools? Does they fit a self-management approach?

Mental / Emotional
– where *we* have most experience

- Motivational Interviewing – ADD in MI to whatever approach you use.
- Evidence base of CBT – both Activation AND Changing Beliefs
- Research on decreasing paired anxiety associated with activity (Do it with them!)
- PACING, PACING, PACING
- Research on magnification of pain signals related to depression and anxiety – sometimes we cannot change the pain, but *can* change the things *worsening* the pain.
- Relaxation Examples and In-Vivo Practice
- Role of hypnosis for functional and dysfunctional individuals here.
- Humor

Two EBT models for Chronic Pain

John Otis - Treatments that Work	**VA - CBT for Chronic Pain**
1. Pain education	1. Assessment
2. Breathing	2. Treatment orientation
3. PMR and imagery	3. Goal setting
4. Aut. neg. thoughts	4. Exercise and pacing
5. Cognitive restruct.	5. Relaxation
6. Stress	6. Pleasant activities 1
7. Pacing	7. Pleasant activities 2
8. Pleasant activities	8. Cognitive coping 1
9. Anger	9. Cognitive coping 2
10. Sleep	10. Sleep
11. Relapse	11. Discharge planning

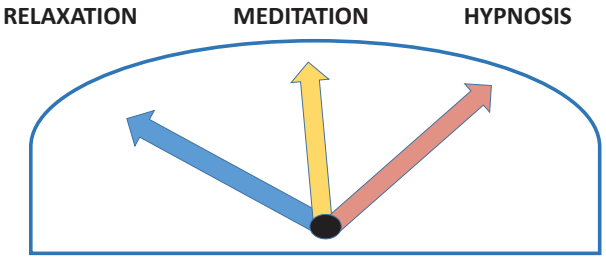
PAIN IS NOT OBJECTIVE

Study of 2000 ”NORMAL” individuals over 35 MRI Revealed “abnormal” results in 2/3 of their backs. ASKED how many have back pain, only 15% indicated that as a symptom. OFTEN, the place they indicated pain was different than the “objective” problem was noted.

CONTEXT of Pain

- Football Player in HS Championships with broken leg
- Violinist with a cut on his Left Hand vs. Dancer with cut on Left Hand
- Meaning of WORDS: Age related change vs. Degenerative Disc Disease
- No Name for it = Worse Distress; NAME it = Better sense of control
  (Neuromuscular Sensitivity Disorder)
  WHEN patients continue to “search” for another answer,
  that is often a “warning sign” that emotions are in charge of pain.

Continuum of Relaxation, Meditation, Hypnosis



Hypnosis

See about becoming "certified" American Society of Clinical Hypnosis

Hypnosis is "evidence based" for chronic pain

- Analgesia [Numb; Cooling; Warming]
- Warming Hands/ Feet [Migraine / Autogenic Training]
- Dissociation [Positive use of ignoring a wiring problem]
- Time Distortion [Time before/ after the problem better]
- Changing Cognitive / Affect about pain
  - (Increased Exercise; Control; Less Distress when noticed)

What is "self-hypnosis?" How do patients practice?

Purpose

- Used to be called work – until I started dealing with 75 year olds.
- The feeling you are contributing to something bigger than you helps!
- Other feedback loops –
  - Routines of Activity , Social Learning Theory (Bandura); Social Engagement; Accomplishment; Feeling their body.
  - Re-learning NOT to overdo (Fibromyalgia)
- Helping set reasonable expectations (e.g., volunteer 2 hrs. 2x weekly)
- Setting expectations / ability to be at work, creating success

Social

- Tendency to withdraw, or have pre-morbid difficulties in social life makes this area one that is absolutely necessary to review.
- Schedules (Pacing) of interaction (not none, not overdoing)
- Re-learn appropriate ways of interacting (not all about disability)
- HOW do you respond when someone asks: "How are you doing?" (Humor)

Teach Assertiveness

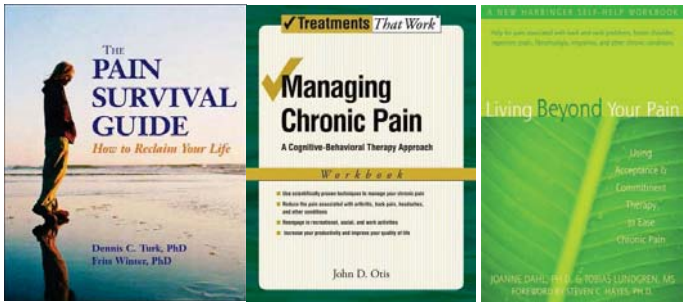
Spiritual & Family

My EHR does not have a stock phrase ('smartphrase') for these two individualized areas

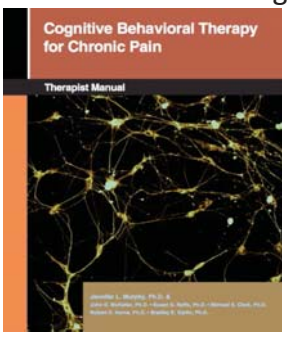
- **SPIRITUAL**– like purpose, ways of connecting to something *larger*
- We *KNOW* that mindfulness, relaxation, and similar are helpful
- Catholic Nuns – Same effect from Rosary as Progressive Relaxation on their body and mental state.

- **FAMILY** – Too MUCH or too little?
- Boundaries, Assertiveness, Healthy Communication
- Healing from Childhood neglect or trauma

Resources - Books



Veteran's Administration Paid Researched Program



SAMHSA Presentation Pain

Specific Treatment Factors?

Pain Class was 2x/ week for 6 weeks. The CARF Pain Program Daily 4 weeks.
Most "Effective" shift after the "Evaluation Session" for pain program - ??
Most Effective Tool? Schedule; Exercise; Relaxation (SELF-Managed)
Self vs. Other directed care seems quite important.
Likelihood of Functional Improvement – Lower than other areas (30%?)
Set provider expectations accordingly
Can you create a "*virtual team*" to work on these issues?

Questions?

- What / How will you put this information into practice next week?
- Motivational Interviewing - Modeling