Tailoring Complex Pain Treatments: Strategies for Working With Providers

Graves Owen, MD, Paradigm Medical Director

Steven Moskowitz, MD, Paradigm Senior Medical Director

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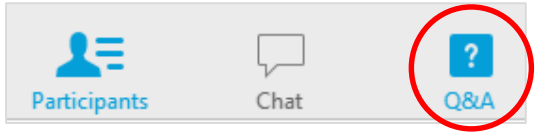

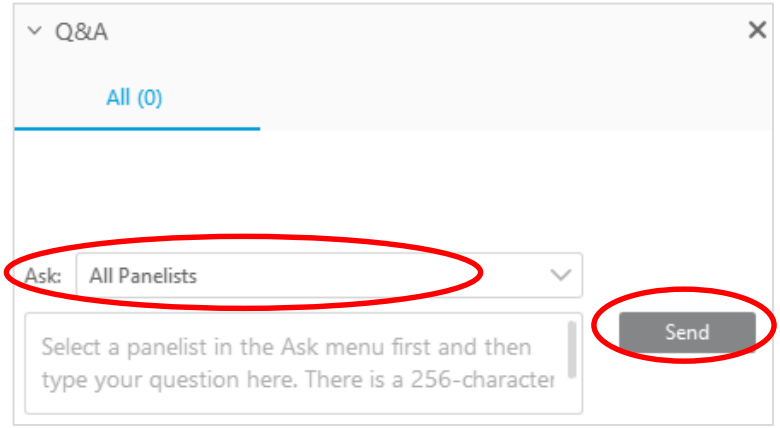

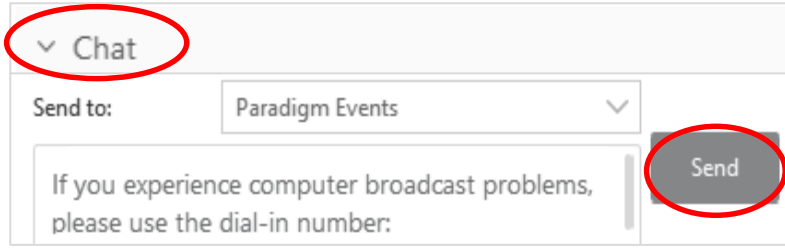

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Today's Learning Objectives

1. **Identify** common psychosocial factors that cause delayed recovery
2. **Discuss** how to summarize psychosocial observations to have meaning to a provider
3. **Learn** effective strategies to encourage treating physicians to incorporate psychosocial factors into treatment
4. **Understand** how to account for psychosocial needs when a provider will not participate

Today's Speakers

Graves Owen, MD
Paradigm Medical Director

- Head of Medicine, Texas Pain Rehabilitation Institute
- Past-president, Texas Pain Society
- Peer reviewer on pain medicine, American Academy of Pain Medicine
- Chairman of the Board, Texas Pain Foundation

Steven Moskowitz, MD
Paradigm Senior Medical Director

- Leads Paradigm's pain program
- Physiatrist with 30 year experience chronic pain, neurological rehabilitation
- 30 years experience in managed care and program development
- Certified in Managed Care Medicine

Overview

Psychosocial Factors Always Play a Role in Delayed Recovery

These factors should inform treatment approach

Biomedical model: Attributes disease to biological factors.

Management: Endless diagnostics, drugs and surgical interventions.

Biopsychosocial model: Disease outcome based on interaction of factors.

- ***Biomedical***: physical, ongoing tissue injury
- ***Psychological***: mood, personality, behavior, beliefs, coping
- ***Social***: cultural, familial, socioeconomic, vocational

Management: Rehabilitation, health literacy, adjustment, compliance, self-care.

Source: Engel George L (1977). "The need for a new medical model: A challenge for biomedicine". Science. 196: 129–136.

What is Pain? What is Suffering?

- ***Pain***: an unpleasant sensory and emotional experience with actual or potential tissue damage or described in terms of such damage
- ***Suffering***: distress, perceived hardship
- Some people express severe pain/suffering beyond actual or potential tissue damage

Suffering out of proportion to pain often reflects a poor ability to cope with adversity

What is Disability Perception?

An individual's perceived degree of disability

Disability perception does not always correlate with physical pathology.

It can strongly correlate with unstable psychosocial issues.

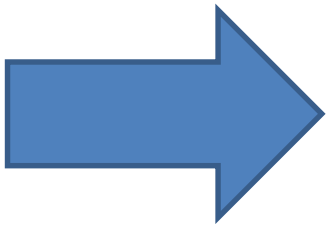
Psychosocial Comorbidities Magnify Perception of Pain and Disability

Which leads to pain behaviors

Dramatic suffering

+

Magnified disability perception



Unstable psychosocial behavior

Most Predictors of Poor Outcome/Chronicity Are Psychosocial

- Maladaptive coping behaviors[1]
- Nonorganic signs[1]
- Functional impairment[1]
- General health status
- Presence of psychiatric comorbidities[1]
- Previous work injury with extended lost time[2]
- History of substance abuse
- Family history of being on compensation
- Chronic opioids
- Geographic factors/providers[2]

Sources:
1. Chou et al. Will this patient develop persistent disabling low back pain? JAMA 2010;303(13):1295-1302.
2. Early Predictors of Chronic Work Disability, A Prospective, Population-Based Study of Workers, With Back Injuries

Incidence of Psychosocial Comorbidities

What are some of the "missed" psychosocial issues we need to share with the physician?

Chronic pain syndrome

- 80% depressed
- 70% anxiety/panic attacks
- 30-60% personality disorders
- 35% incidence of addiction
- Majority with maladaptive coping strategies

Source: Manchikanti et al. Pain Physician 2013; Owen et al. Evidence based PM for the PCP in press

Physicians Often Poorly Account For Psychosocial Issues

Pain is treated as a vital sign. Suffering is not recognized.

Physicians commonly underestimate the degree of psychosocial comorbidities in their pain patients unless psychometric testing is performed.

-Daubs, et al. J Bone Joint Surg AM. 2010

Patients complaining of severe pain and disability are at greatest risk of aberrant drug-taking behaviors.

This is why mental illness is strongly associated with opioid use for pain.

Those reporting the greatest pain and disability are most likely to be prescribed opioids.

Not Adequately Accounting For Psychosocial Factors Has Consequences

Impact on outcomes

Opioids for suffering rather than pain (chemical coping)

Back surgery for non-specific lower back pain

Spinal cord stimulators for failed back surgery

Goals Of Addressing Psychosocial Issues With Treating MDs

Foster optimal outcomes

Addressing psychosocial issues - especially suffering:

- **Improves function**
- **Reduces healthcare utilization**
- **Optimizes RTW**

Avoid undo compensability of psychosocial issues by:

- **Limiting treatment to psychosocial issues related to general medical condition**
- **Cognitive behavioral therapy approach**
- **Using health and medical codes**

A Word About Psychometric Testing

Sometimes more in-depth psychosocial information is needed

Screen for:

- Depression
- Anxiety
- Maladaptive coping behaviors (catastrophizing, fear-avoidance, injustice, disability conviction)
- Substance Use Disorders (family/personal history)
  - Alcohol, licit/illicit drugs, nicotine

Biomedical Model Fails the Chronic Pain Patient

And frustrates the clinician

Biomedical model can frustrate clinicians:

- Most physicians are provided little training in addressing psychosocial issues
- The medical system rewards procedures/discourages extra time with the patient

Biomedical model leads doctors to offer pain interventions, even when unlikely benefit:

- Patients reporting the greatest pain and disability are provided the most diagnostic testing, the most procedures, and the most medications- with few positive results
- Those at greatest risk of misusing opioids are most likely to receive and continue use

How Can You Communicate Better With Physicians?

Understand How Doctors Process Information

So they can better receive your information

Doctors:

- Make quick, fact-based decisions
- Value autonomy, especially clinical autonomy
- Prefer data-based arguments and learning
- Focus on the best interests of the patient and his or her family
- Seek rewards intrinsic (providing high quality care) and extrinsic (earning money)
- Struggle with the optimal way to be resource efficient and effective

Source: http://www.impact-advisors.com/implementation/doctor-doctor-effectively-communicating-physicians-part/

Let’s Look At How Psychosocial Issues Hide In Plain Sight

Case Study

Claimant Mr. B Walks Into A Pain Medicine Office

46-year-old male injured worker with DOI 4/17/2015

- **Diagnosis:**
  - Degenerative disc disease, L5 and S1 radiculopathy, failed back syndrome, opioid induced constipation and hypogonadism
- Complains of left leg numbness and pain and back pain: 8/10
- **Comorbidities:**
  - Obesity, ADD, prior rotator cuff repair, possible alcohol abuse
- **Medications**:
  - Lyrica, OxyContin 20 mg, 6 per day; fentanyl patch 25 mcg every 48 hours (MEDD 240 mg); Xanax .5 mg, 3 per day, Relistor, Testosterone patch
- **Treatments:**
  - Laminectomy L4-5, repeat laminectomy L4-5 and L5-S1, fusion L4-S1. he has had multiple ESI, facet injections and facet neurotomy (radiofrequency)
- IW remains out of work. He drives a motorcycle and works on cars. He has three children under 12 and his wife also has chronic pain
- He is interested in additional medications or surgery to help his pain

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Four Levels of Communication

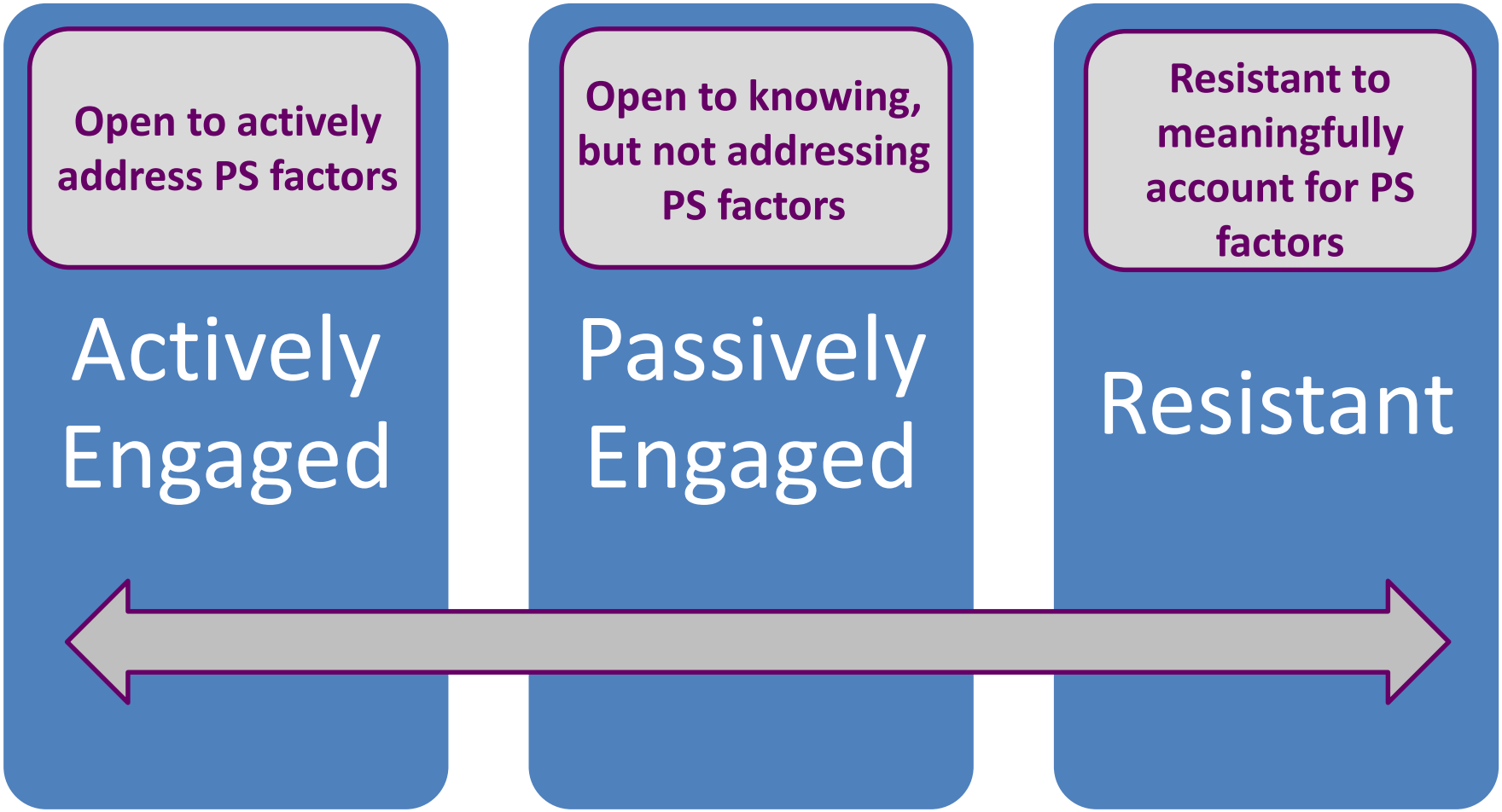
SOAR to Better Outcomes with Different Physician Types

1. **S**hare Information
   - Share psychosocial information you know about the IW
2. **O**ffer Assistance
   - Offer to help get more valuable psychosocial data, such as CBT eval
3. **A**rrange alternate solutions
   - Suggest or arrange second opinions, pain program, physician change
4. **R**esist and Adjudicate
   - UR, IME, litigation with back-up of psychosocial model

Three Levels of Physician Engagement

How To Communicate Better With Physicians

Determine the physician's level engagement with psychosocial issues



If Mr. B Has An Actively Engaged Physician

Share psychosocial information you have about the injured worker

- **The actively engaged physician tends to:**
  - Take a comprehensive history of Mr. B
  - Include broad psychosocial history
  - Focus on function, activity
  - De-emphasize VAS
  - Address pain behaviors head on
  - Educate IW about non-bio pain issues

He emphasizes Mr. B's PT and home exercise program. He resists medication escalation.

Your Intervention:

SHARE information you have

- Past history: prior injuries, substance history, premorbid med list
  - First report
  - ED note
  - Consults
- Potential functional inconsistencies
  - Avocational activities
- Unrealistic goals
- Recent psychosocial assessment findings

If Mr. B Has An Passively Engaged Physician

Offer assistance.

- **The passively engaged physician tends to:**
  - Take a comprehensive history
  - Take a cursory psychosocial history
  - Emphasizes VAS
  - Cursory focus on function, activity
  - May notice pain behaviors, but not their impact on pain reporting

After hearing about Mr. B's pain rating of 8/10, he orders an MRI. Enumerates a number of medication and interventional treatment options. Willing to discuss rehabilitative options. May let Mr. B drive the care plan.

Your Intervention:

Offer assistance

- A CBT assessment
- Other psychosocial support
- Rehabilitative services such as specialized PT, pain program
- Information on latest guidelines on opioid risk
- Pre-visit MD conference or summary

Psychosocial Interventions

Evidence-based psychotherapeutic treatments:

- Cognitive Behavioral Therapy
- Mindfulness-based therapies
- Psycho-education
- Family/caregiver interventions
- Self-help tools/apps
- Coaching

If Mr. B Has A Resistant Physician

Arrange alternatives

- **The resistant physician tends to:**
  - Take a comprehensive history
  - A cursory psychosocial history
  - Heavy focus VAS
  - No meaningful functional measures
  - Ignores pain behaviors
  - Drives care to medication changes and escalating interventional care
  - Often does not let CM into the room

After hearing about Mr. B's pain rating of 8/10, orders several diagnostic tests. Prescribes a number of medication changes and interventional treatment options. Providers a video on spinal cord stimulators.

Your Intervention:

Arrange Alternatives

- Address liability and risk concerns
- Work with claims professional
- Educate IW
- Identify new provider
- Arrange second opinions
- Consider Pain programs

Resist and adjudicate

- UR
- IME
- Enforce Standard of Care
- Ethics issues

Enforcing Standard of Care (SOC)

What would a reasonable and prudent physician do?

- First, do no harm
- Look to evidence-based literature
- Exhaust conservative evidence-based treatments
- Use sound medical judgment

Failure to exhaust conservative evidence-based treatments prior to higher-risk or non-evidence-based treatments is a breach in the SOC and unethical.

Summary

Summary

- Psychosocial issues are **ubiquitous** in complex pain
- Though obvious to us, they **may be less apparent** to treating physicians
- Physicians are **often poorly trained** in responding to psychosocial issues
- Communicating psychosocial concerns to physicians requires understanding of **how to engage** the individual physician
- **Case managers and adjustors can help physicians** manage psychosocial issues

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https://www.surveymonkey.com/r/complexpainstrategies

Tip: If your work computer has blocked Survey Monkey, access the link via your home computer.

Question and Answer Session

Submit your questions in the Q&A panel on the right of your screen.

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