- Why should I even bother to treat chronic pain?
- If my patient doesn't abide by my rules I will fire them from my practice.
- I don't have time to provide behavioral support, and insurance won't pay for it.

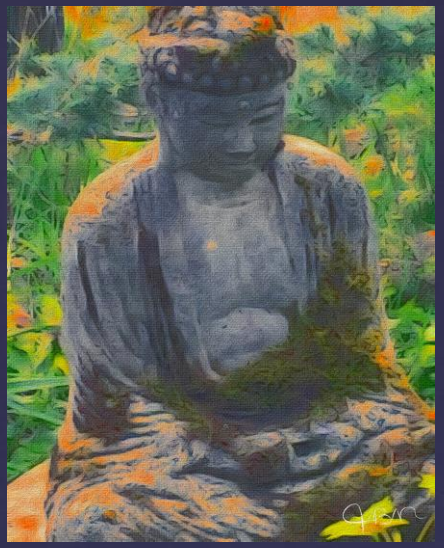
These are challenging patients

- Why bother? Pain is a part of the human condition and it is an essential part of caring for patients.
- Fire them? Your patients will become your colleague's patients, and perhaps yours again some day. You can educate them and help them even if you don't provide medication.
- No time? It is easier than you think.
- Insurance won't pay? Yes they will!

Maybe I just won't treat Chronic Pain?

- We don't do radical mastectomies for breast cancer any more.
- We don't routinely remove a child's tonsils.
- We don't treat ulcers with a bland diet.
- And we don't use opioids to treat complex, chronic, non-cancer pain.

Best practices change as we learn more:



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Behavioral Health Consultant
April 23, 2015

Compassion-Based Patient Conversations

“Pain Sucks Mom!”

Tyree Heesacker, Age 18

Compassion

- Compassion
  - Sensitivity to suffering
  - Motivation to help
- Begins by how we approach suffering and pain
  - Do we turn away
  - Do we stay

  We belong to a Genetic Lottery-we will **all** exp. Pain
  - Being human = Pain in life
  - We are shaped by our human experiences

- We used to call it, “The Difficult Conversation”
- How we think of things determines how things turn out
- “When we change the way we look at the things, the things we look at change” W. Dyer

The Safety Conversation

Disabling beliefs

Shared by patients who are overwhelmed by pain **and** providers who find these people overwhelming:

- Belief that objective evidence of disease/injury is required for pain to be "real"
- View of pain as the only problem
- Expectation that urgent pain relief is the major goal of treatment
- Overconfidence in medical solutions
- Provider is the "expert" responsible for outcomes
- Pt. is helpless "victim" of underlying disease/injury

- It is impossible to help patients with complex chronic pain if you share these beliefs
- Your efforts to help by providing short-term solutions and urgent pain relief will likely make long-term problems worse

What you believe matters..

Why is treating Complex Chronic Pain so hard?

- Conceptual burdens: biomedical model v.s. psychosocial model
- Unrealistic goals and expectations
- Dependence, Misuse, Abuse, Addiction? –Dr. Jane Ballantyne's article in PAIN-2015
- Trauma? Ted Talk-Nadine Burke Harris: How childhood trauma affects health across a lifetime
- "Blind spots"-Dr. K and Women who Cry-TEAMS identification

"Get Rid of Pain"

The Natural Response to Pain

- "Its important to keep fighting this pain."
- Endorsed as "Always True" or "Almost Always True" by 92% of patients

McCracken, Vowles, & Eccleston, 2004, *Pain*

Treatment Outcomes

Over 10 published studies showed Improvements

- Pain
- Disability
- Distress (i.e. Depression, Anxiety)
- Healthcare Utilization
- Physical Performance
- Work & School Attendance

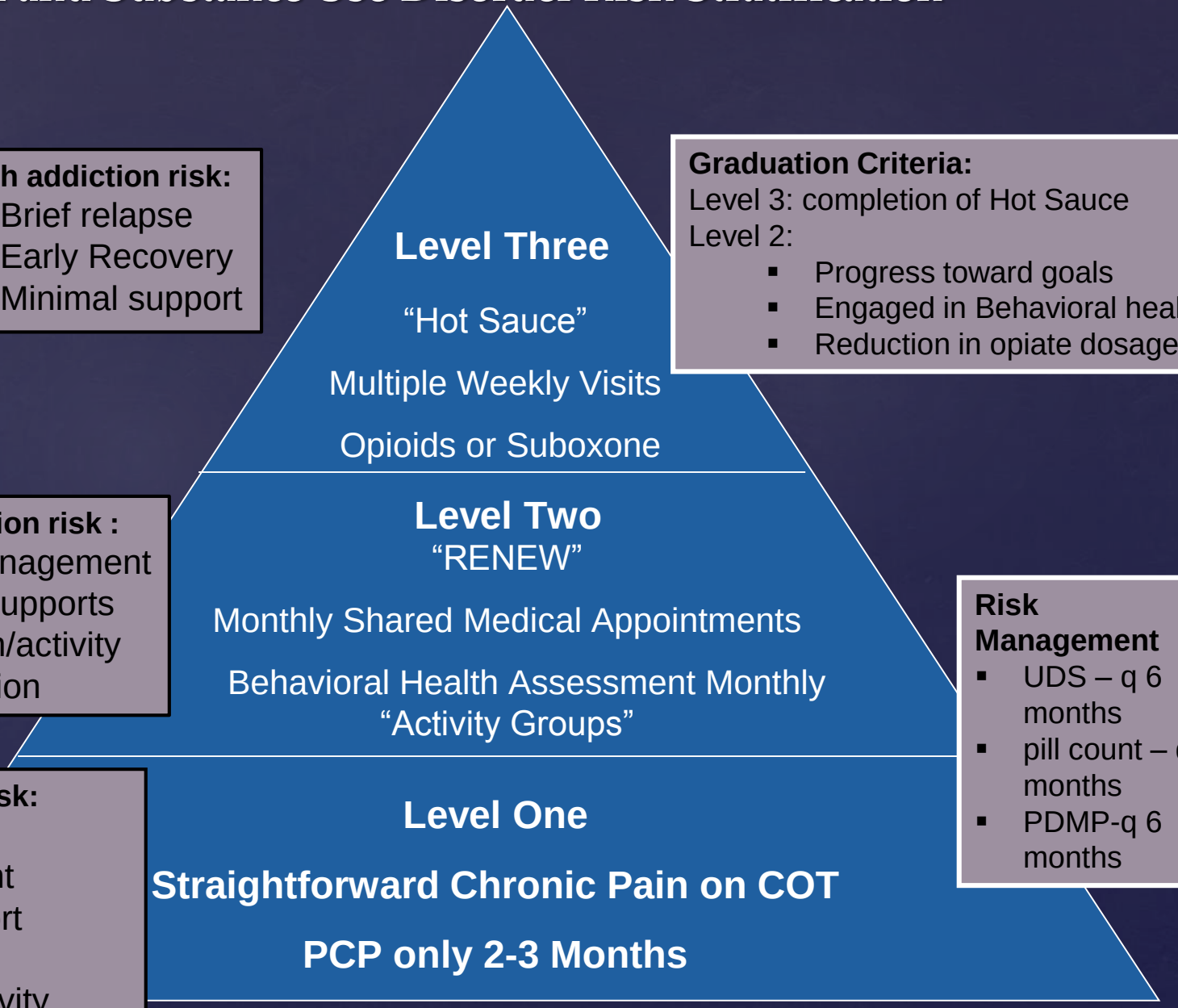
Tx =Application of concepts:

- Acceptance
- Mindfulness
- Values-based action

Dahl et al., 2004; McCracken et al., 2005; 2007;
Vowles et al., 2007a; 2007b; 2008; 2009; Wicksell et al., 2007, 2008, 2009.

Chronic Pain Recovery Pyramid

Chronic Pain and Substance Use Disorder Risk Stratification



High addiction risk:
- Brief relapse
- Early Recovery
- Minimal support

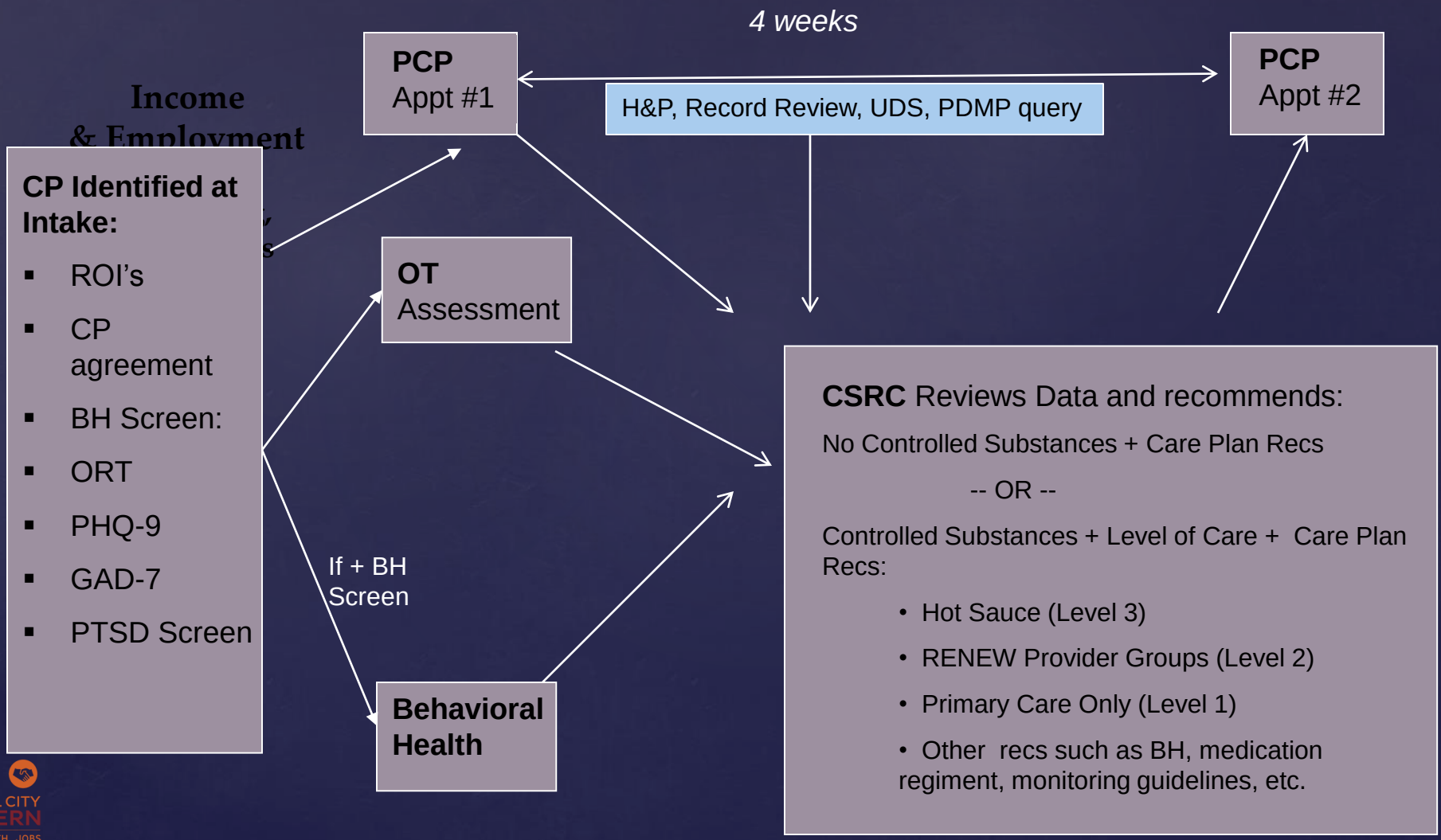
Graduation Criteria:
Level 3: completion of Hot Sauce
Level 2:
- Progress toward goals
- Engaged in Behavioral health
- Reduction in opiate dosage

Moderate addiction risk :
- Low self-management
- Low social supports
- Low function/activity
- Hx of addiction

Risk Management
- UDS – q 6 months
- pill count – q 6 months
- PDMP-q 6 months

Low addiction risk:
- Good self-management
- Good support
- Good function/activity

Chronic Pain and Substance Use Assessment Map



CENTRAL CITY CONCERN
HOMES HEALTH JOBS

It is about safety!

This is not a sting operation!

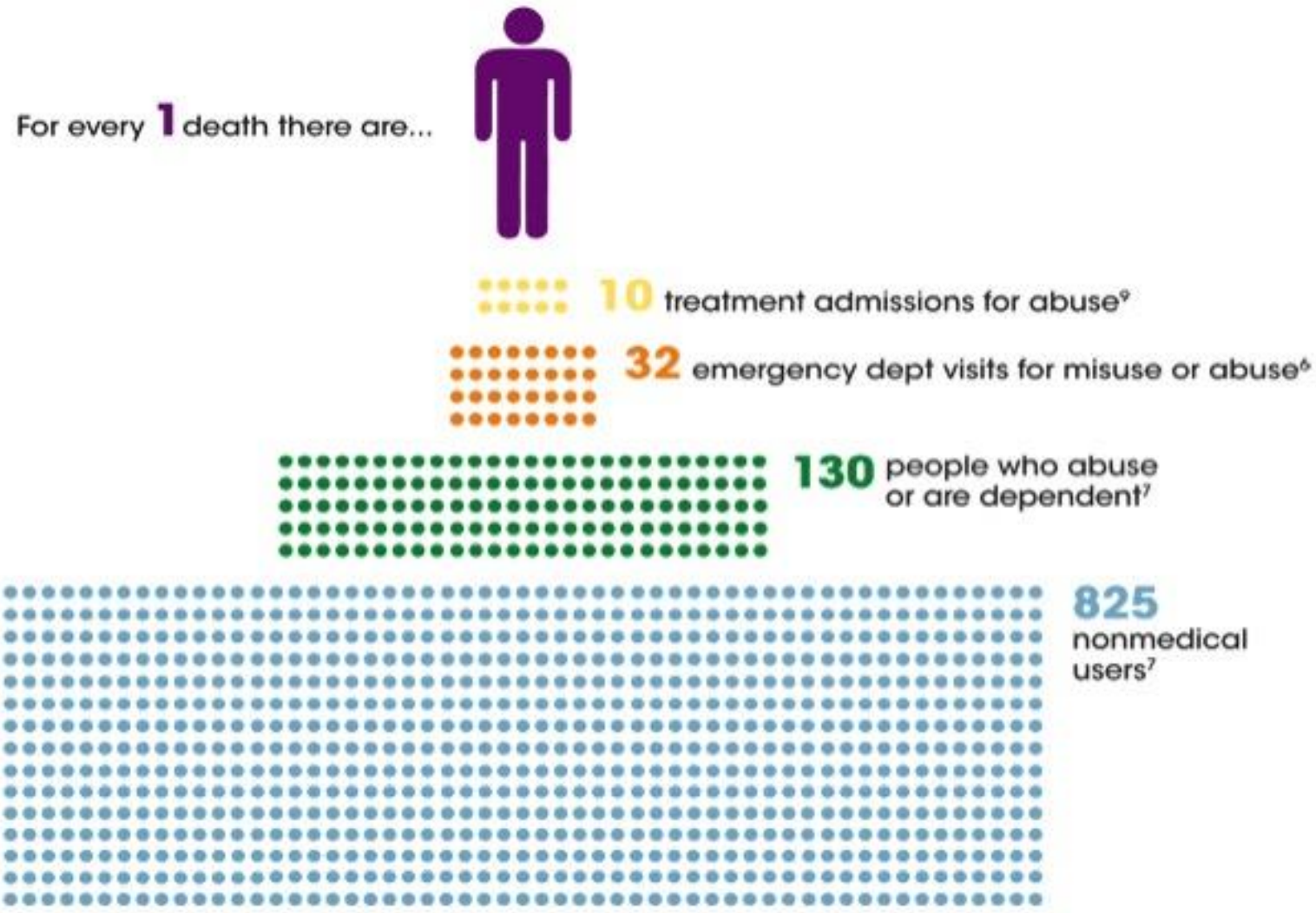
- As you begin to implement guidelines:
  - You will get blamed
  - Patients will threaten to leave
  - You may want pts to leave
- Patients can lose **COT Privileges** vs. getting fired from clinic

Beware of the Unintended Consequences…of increasing COT safety

DEATH
ADDICTION
MISUSE/ABUSE
DIVERSION

Be aware of Unintended Consequences of prescribing COT

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, 2011



We can expect relapse and slip-ups, plan for it, even predict it…

The patient/provider/clinic relationship can almost always be saved

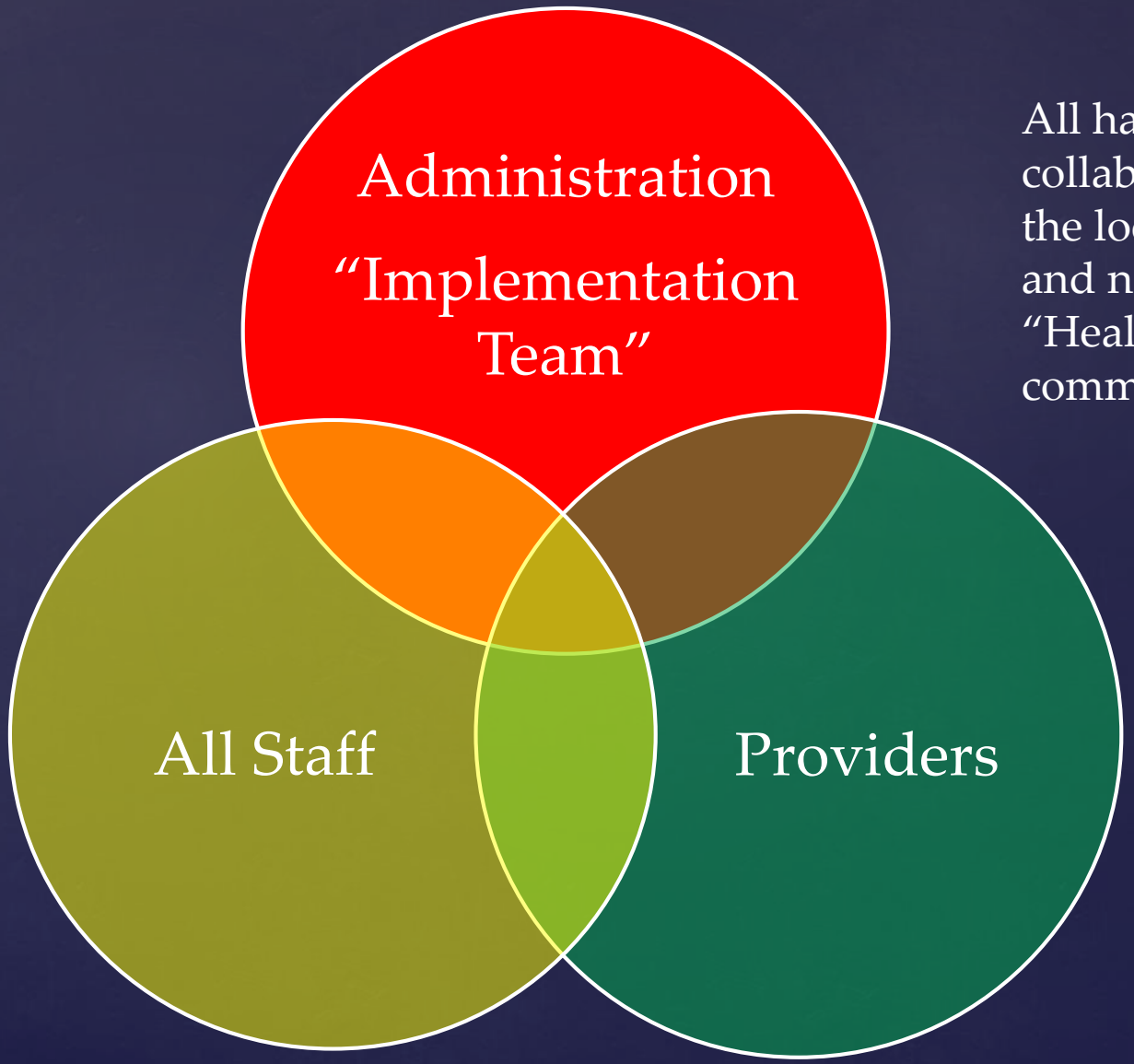
{ Bad Behavior…

{ Good Person…

Separate the Person from the Behavior

Fear and Ambivalence often look like Resistance

Implementing OPG Guidelines



All happening in collaboration with the local, state, and national "Health" community

- You are telling me to X (exercise, go to therapy, etc.), I am telling you that without the pills I can't even get out of bed"
- "You know this means I wont be able to go to work, is that what you want, for me, to lose my job"
- "Taking these pills is the only way I can manage to take care of my children, you do understand that you are taking their mother/father away from them?

First line negotiations:

- “Are you saying you are just going to let me suffer?”
- “You have no idea how much pain I am in. You are not in my body.”
- “This isn’t fair, you promised you wouldn’t reduce my medications, and you are going back on your word”

Second Line Negotiations

- “Do you want me to go get drugs from the street?”
- “Well, I am just going to go to the ER”
- “I will be finding another provider, who believes me and cares!”

Desperate Negotiations/Threats

- “Survival skills are so fine tuned it feels like manipulation”
- Even the most confident providers can be left questioning themselves and not sure what is “The Right Thing” to do
- We can loose sight of what is in the patients “best and safest” interest

Anxiety Provoking…

{ 

Compassionate Management…

- Pause and consider your values (stand in them)-
  - To practice safe medicine,
  - To do no harm
  - Practice best practices
  - Alignment with your colleagues, community, and/or practice
  - Be clear on the outcome you hope to reach (3 choices you can live with)
- Decide if you will "hold the line"
- Beware of hesitation it is ripe for "negotiation”

Before going in the room (slow, deep breath):

- Elicit patient perspective on how "chronic pain" care is going
- Share your concerns, framed around safety
- Ask patient to relay back understanding and clarify misconceptions
- Identify a shared goal if possible
- Set limits/clarify boundaries

While in the room (soft hands, fingers touching):

Helpful Hints…

- Speak slowly and keep it simple
- If your intent is to take something away, have something to offer…(your relationship)
- Believe in their capacity to…(say it)

- It is unreasonable that you will be able to "talk the patient into being "ok" with the changes.
- Be flexible with what is a successful outcome (it is ok for pt to have whatever emotion).
- Possibly, "no changes need to be made today"
- Give breaks from tapers (Dr. H-one freebie)

Helpful Hints…

Helpful Hints…

- MA call pt for a ck up, no matter what happens in the exam room, even if the pt "fires" you
- Ask your patient what they are the most concerned about, don't assume you know

Helpful Hints…

- Don't be defensive, it escalates emotion
- Make a statement about the patients experience, e.g. "The look on your face tells me you are afraid, is that the right?"
- Share control, it models collaboration, and empowers patients to make changes
- Consider giving pt 3 options
- Let pt choose where to start

- Focus on function not pain; it permits progress despite ongoing pain.
- State how much you care for your patient (especially when trauma is involved-safety)
- Reconsider the language you and your pt use to describe their condition (L. Mosely)
- Relay your confidence in their capacity to make the changes being (Michelle's #1)

Helpful Hints…

- “You seem X (upset, anxious, fearful, scared), by what I have said.”
- “You seem pretty X”

Reflection

- "It is understandable that you feel X …
- This is a lot of information; it would be understandable if you were experiencing X …
- "I believe that you are in **real** pain and you have every right to X (find a new provider, go to the ER, get your RX from the streets, neighbor, etc.) **and** I hope that you will continue to let us care for you".

YOU DON'T HAVE TO AGREE TO EXPRESS UNDERSTANDING

Validation

- “I’m sure it has ben difficult to keep going to your provider and have these tug-o-wars about a prescription”
- “I do not want you to suffer, I care about you, I am confidant that you are capable of making the adjustments I have outlined.”
- Be with your patient in their pain, avoid the impulse to “fix” or “do” or “say” anything
- Lean in..Literally (Dr. H-hand over the heart)
- Instead of speaking, hand the crying patient a tissue.

Support…

- “It seems like we have reached an impasse.”
- “You and I have very different views on how to best manage your pain”
- “At this point maybe we can agree to disagree, why don’t you take some time to consider the options we have discussed and next week when you come in we will start”

Identify the Impasse

What you <u>will</u> do:

- "I'd like to be your provider and continue to help you with your pain, despite our disagreement"
- "I certainly do not want you to X (stay in bed, not go to work, neglect children), and due to the safety reasons I have outlined, it is important for us move forward with treatment adjustments."
- It is understandable you are angry, you can raise your voice with me, AND if you decide to that behavior out of this room and threaten our staff…

Clarify Boundaries…

What you won't do:

- "Prescribing more of this medicine is something that is not in your best, long term interest. I cannot continue ."
- "Unfortunately I will not be able to X (raise the dose, give you an RX, etc), I would like you to consider the non-narcotic treatment options we discussed, I hear you have tried them in the past with no success, I am asking you to consider trying them again.

Clarify Boundaries…

When you say “no”, you may:

- Question your judgment even if you are doing the right thing
- Feel you have failed as a provider
- Feel your behavior is unethical
- Feel, mean, unsupportive, and uncaring

Manage your reactions…

Consider looking at your patient's behavior through the lens of "dependence" and/or "Trauma":

- It is normal for patients to have heightened emotional reactions, fear of the pain as well as withdrawal.
- It is the role of the provider to take charge and safely guide the patients treatment

Manage your reactions…

- Breathe, Self-talk, talk to a colleague who shares your philosophy
- Gather strength from your core beliefs
- Let your values and core principals of practicing good and safe medicine guide your practice, this will ease your way as you embark on these challenging conversations

Learn to Soothe Yourself...

Further Resources…

- www.scopeofpain.com/tolls-resources
- www.agencymeddirectors.wa.gov/guidelines.asp
- www.cdc.gov/primarycare/materials/opioidabuse/index.html
- www.supportprop.org/index.html

OregonPainGuidance.org

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