# Ouch! What We Do Today May Hurt Us Tomorrow.

*Avoiding Pain Management Program Pitfalls*

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## Objectives

- State Current Pain Management Definitions
- Identify Barriers to Successful Outcomes
- Develop Proactive Strategies to Attain Optimal Pain Management Results

## Chronic Pain is about people, not disease

- I know families who are spending every dime to get their loved ones sober.
- Nothing seems to work. It's easy to blame the victims and write it off as a "hillbilly problem".
- There's a culture of addiction in eastern Kentucky now.
- Just taking one drug away won't erase that.

Watts (2007) "KY town grapples with OxyContin Addiction", Youth Radio, *NPR*, October 10,

## Not just Pain > 6 months

- Duration-longer than 3-6 months
- Deconditioned-due to inactivity
- Depression-secondary to the chronic pain
- Disability-fostered by the system
- Drugs-NSAIDs, antidepressants, antiseizure, opioids, etc. (Good polypharmacy versus Bad polypharmacy)
- Biopsychosocial aspects of pain

## Primary Care Failure

- For soft tissue injuries lasting > 3 months someone is missing the root cause
- Psychosocial risk factors are greatest predictor for soft tissue injuries transitioning from Acute to Chronic Pain
- Interventions, Functional Capacity exams have historically been the focus of PCP exams in the first 3 months of MSK injury

Menzel (2007)
Geisser (2003)

## Primary Care Referrals

- Pain is chief complaint preventing RTW
- Ongoing and escalating interventions without organic cause or constantly changing diagnoses
- Failed conservative treatment
- Surgery is not considered
- Pain is ~6 months post DOI

## Inappropriate candidates

- Severe physical handicap or active co-morbid that prevents treatment
- IW not receptive to psychological interventions
- Significant BPS co-morbid that prevents rational thought or intentional behavior
- Severe alcohol or illicit drug use that prevents in-patient treatment

## Purpose of Ideal CP Program

- Diagnose
- Cure (if possible)
- Restore function
- Educate/Support
- Prevent

## Purpose of Ideal CP Program

- Biopsychosocial
- Interdisciplinary
- Functional Restoration

## Looks do Matter

**Interventional**

- Invasive procedures
- Goal is to remove the pain
- Promises of pre-injury state of health
- Biomedical model
- Heavy use of polypharmacy
- Continued quest to find "the problem"

**Biopsychosocial**

- Varied reasons for pain
  - Biological
  - Psychological
  - Sociological
- Functional restoration
- Health is not the absence of disease
- Holistic model

## Looks do Matter

**Multidisciplinary**

- Many providers as consultants
- Each looks at their specialty and how to diagnosis and treat identified problems
- Management is difficult at best
- Third party manager is often required to coordinate care and communicate amongst the different orders/providers

**Interdisciplinary**

- Is highly structured and time limited
- Has concurrent daily care consisting of:
  - Rehab services
  - Psychological
  - Social and vocational services
  - Medical professionals
  - Biofeedback professionals
- Has longitudinal outcome data

Stanos & Houle, 2006, *PM&R Clinics of North America, 17, 435*

## Looks do Matter

Pain Alleviation

- Medical treatment of pain generators
  - Medications
  - Injections
  - Stimulators
- Modalities and treatments that lack outcomes and/or treatment plans
  - Physical therapy
  - Passive treatments
- May lead to over utilization of services

Functional Restoration

- Increase physical functioning
- Improve pain-coping skills
- Setting of formal goals and objectives that when met are expected to allow RTW
- Behavior modification techniques to allow IW work through stressors

## "Good" Pain Programs

- Interdisciplinary approach
- Focus on functional restoration
- Incorporate behavior modification
- Return claimant to productive lifestyle
- Reduce long-term disability due to pain/injury
- Work with CCM/NCM to promote RTW
- Liaison between primary treating provider and claimant

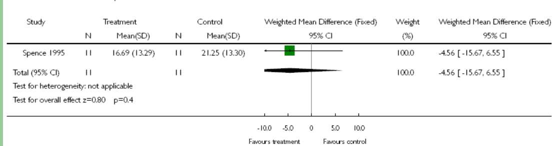
## "Good" Pain Programs

- "Quality of care is the problem, not managed care"
- Quality problems classified by IOM:
  - Overuse
  - Underuse
  - Misuse

## "Bad" Chronic Pain Programs

- No mission/No goals
- Non-coordinated treatment by multiple providers, and/or does not involve the primary treating physician
- Lack of evidence-based medicine
- Limited treatment focus ("when all you have is a hammer…")
- Excessive passive treatment modalities, multiple injections, excessive use of narcotic or sedative medications
- Exclusion of psychosocial aspects of chronic pain and work injury

## Do BPS interventions really work?



**Analysis 06.02. Comparison 06 Applied relaxation versus waiting list, Outcome 02 self-monitored pain 8 weeks**

Review: Biopsychosocial rehabilitation for upper limb repetitive strain injuries in working age adults
Comparison: 06 Applied relaxation versus waiting list
Outcome: 02 self-monitored pain 8 weeks

| Study | Treatment N | Treatment Mean(SD) | Control N | Control Mean(SD) | Weighted Mean Difference (Fixed) 95% CI | Weight (%) | Weighted Mean Difference (Fixed) 95% CI |
|---|---|---|---|---|---|---|---|
| Spence 1995 | 11 | 16.69 (13.29) | 11 | 21.25 (13.30) | | 100.0 | -4.56 [ -15.67, 6.55 ] |
| Total (95% CI) | 11 | | 11 | | | 100.0 | -4.56 [ -15.67, 6.55 ] |

Test for heterogeneity: not applicable
Test for overall effect z=0.80 p=0.4



**Biopsychosocial rehabilitation for upper limb repetitive strain injuries in working age adults (Review)**
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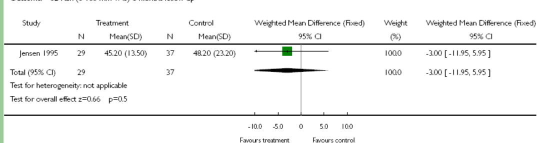
## Psychologist onsite vs consult



**Analysis 01.02. Comparison 01 Psychologist contact setting versus psychologist coaching setting, Outcome 02 Pain (0-100 mm VAS) 6 months follow-up**

Review: Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults
Comparison: 01 Psychologist contact setting versus psychologist coaching setting
Outcome: 02 Pain (0-100 mm VAS) 6 months follow-up

| Study | Treatment N | Treatment Mean(SD) | Control N | Control Mean(SD) | Weighted Mean Difference (Fixed) 95% CI | Weight (%) | Weighted Mean Difference (Fixed) 95% CI |
|---|---|---|---|---|---|---|---|
| Jensen 1995 | 29 | 45.20 (13.50) | 37 | 48.20 (23.20) | | 100.0 | -3.00 [ -11.95, 5.95 ] |
| Total (95% CI) | 29 | | 37 | | | 100.0 | -3.00 [ -11.95, 5.95 ] |

Test for heterogeneity: not applicable
Test for overall effect z=0.66 p=0.5



**Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults (Review)**
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## Barriers to Successful Outcomes

- Predisposition or multiple disorders
- Program specifics or availability
- Timing or lack of funding or support

## Barriers: Predisposition or Multiple Disorders

- Studies have identified that both affect and cognition increase pain chronicity
- Dissatisfaction with work
- Deconditioned patient due to inactivity

## Barriers: Program Specifics or Availability

- Geography
- Availability of trained specialists
- Impatient vs. outpatient program access
- Competing philosophies
- Medical treatment outside of evidence based guidelines

## Case Management

- Identification of appropriate candidates 3-6 months post DOI
- Proactive management
  - Not monitoring, not shotgun interventions
- Include team (IW, ER, PCP, RN, PT, Ergo)

Faucett, McCarthy (2003)

Doctors pour drugs, of which they know little, to cure disease of which they know less, into human beings of whom they know nothing."

- Voltaire (d. 1724 AD)

## References


- Chassin(1998) The Urgent Need to Improve Health Care Quality ", JAMA, September 16th.
- Faucett, J & McCarthy,D (2003). Chronic Pain in the Workplace. *The Nursing Clinics of North America, 38*(3), 509-23
- Geisser, M., Robinson, M, Miller, Q. & Bade, S (2003). Psychosocial factors and funcitonal capacity evaluations among persons with chronic pain, *J of Occupational Rehabilition, 13*(4), 259-76
- Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Biopsychosocial rehabilitation for upper limb repetitive strain injuries in working age adults. *Cochrane Database of Systematic Reviews* 2000, Issue 3.
- Karjalainen K,Malmivaara A, van TulderM, Roine R, JauhiainenM,HurriH, Koes B.Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. *Cochrane Database of Systematic Reviews* 2003, Issue 2.
- Menzel, N (2007). Psychosocial factors in musculoskeletal disorders, *Critical Care Nursing Clinics of North America, 19*(2), 145-53
- Stanos, S. & Houle, T. (2006). Multidisciplinary and Interdisciplinary Management of Chronic Pain. *PM&R Clinics of North America*, 17, 435-450
- Watts (2007). KY town grapples with OxyContin Addiction, *Youth Radio, NPR*, October 10