

PROVIDER'S GUIDE TO EFFECTIVE PAIN  
MANAGEMENT

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Durham Veterans Affairs Health Care System | VISN 6 Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC)

A Presenter's Guide

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## **VISN 6 Mid-Atlantic MIRECC**

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## Important information about this guide

*This section will provide the presenter with a brief introduction to chronic pain management, explain how to deliver the associated training materials, and will provide some technical guidance.*

### Background

These pain management training materials are a unique educational contribution to the field, as they were thoughtfully developed by an interdisciplinary team of pain specialists. Contributing specialties include anesthesiology, nursing, pharmacy, physiatry, primary care, psychiatry, and psychology. The result is a well-informed training that addresses pain management using a biopsychosocial approach to pain care.

### Introduction

Chronic pain disorders are a critical health problem for Veterans, affecting almost half of Veterans seen in the VA (Kerns et al., 2003). As many as 50% of male and 75% of female Veterans report pain in a primary care setting (Murphy et al., 2014) which can negatively impact emotional and physical well-being, cognition, quality of life, and functional abilities, and increase the risk for suicide (Office of the Army Surgeon General, 2010). In addition, chronic pain disorders are extremely challenging to treat safely and effectively, as pain frequently co-occurs with other physical and mental health problems.

Although most pain conditions are treated in primary care settings, primary care providers (PCPs) may not feel adequately prepared to handle chronic pain disorders. PCPs identify several barriers to providing optimal care, including significant knowledge deficits in pain management education and training, pessimistic expectations for effective pain relief and generally unfavorable views of patients with chronic pain disorders. These factors too often result in suboptimal or inappropriate pain management. PCPs are often uncertain about risk/benefit tradeoffs in initiating and/or continuing chronic opioid therapy and are concerned about the potential for opiate misuse. Unfortunately, the net result is that many patients with chronic pain conditions do not engage in less-invasive treatments; instead, pain symptoms are managed with a single pharmacological modality that have contributed to a surge in opiate-related overdoses.

In response, the VA recently issued pain management directive VHA 2009-053, advocating for concurrent development of Patient Aligned Care Teams (PACT), implementation of Stepped Pain Care, and integration of Behavioral Medicine into Primary Care. Locally, PACTs have been successfully implemented into the Durham VA Health Care System (DVHCS)'s primary care setting and Behavioral Medicine providers are now present in primary care settings. This project's initial aim was to address the VHA 2009-053 directive by providing patients and providers at the DVHCS with information and education to help them better understand chronic pain, its impact, and provide *multimodal* treatment options to be used early and in a stepped care fashion.

### **Mission**

With successful implementation of this project at the local level, our project aims have expanded to developing and distributing this package (i.e., PowerPoint presentation and Presenter's Guide) to medical providers in VA facilities nationwide to help increase access to chronic pain education for Pain Care Providers. This package was developed for providers with varying levels of familiarity with chronic pain and behavioral pain management. It includes basic background information on all topic areas and contains a list of references and suggested readings for continuing education. Our primary goal is to assist presenters in successfully and competently delivering the presentation to providers who treat patients with chronic pain. We put an emphasis on encouraging providers to help Veterans become active in their own healthcare through positive behavior change and improved communication with medical providers.

### **Target Audience**

The target audience for this project includes providers who are treating patients with chronic non-cancer pain and who are responsible for providing targeted education and guidance for patients to better self-manage their chronic pain condition.

### **Organization**

There are three separate modules to this Presentation Guide and accompanying slide deck. Given time constraints of VA primary care providers, our site has chosen to deliver each module in three, 60-minute intervals (during the lunch hour on different days). If there is sufficient time, all three modules can be delivered in a single day (which we have also done during various pain-related educational retreats). However the presenter chooses to deliver this information, we suggest that the didactic portion be delivered first (by a Health Psychologist and a medical doctor of any pain management specialty), followed by the case vignette discussions, and then the provider case discussions (actual patient cases presented by attendees for discussion with the interdisciplinary team panel). We recommend the interdisciplinary team panel be comprised of the following specialists with pain management expertise: Primary Care, Health Psychology, Pharmacy, and either Psychiatry or Anesthesiology.

This Presenter's Guide is organized by presentation slide. Below each slide is an overview of the slide's purpose followed by background information the user will find helpful to effectively deliver the presentation. A more condensed version in addition to some helpful hints for presentation are provided in the "notes" section of the companion slide deck. The presentation begins by defining chronic pain and describing its impact, shifts to outline effective pain management strategies, and concludes with recommendations for improved communication with patients, including difficult conversations.

## Technical Considerations

*Duration to Deliver:* Each module (total of 3) will require 60 minutes to complete. The modules are meant to be an overview of effective pain care management for providers. You may consider exploring whether this training would meet criteria for continuing medical education (CME). In collaboration with our academic affiliate, Duke University Medical Center, the Durham VA has been able to offer “Joint Credit” for these trainings, which includes CME, continuing nurse education (CNE), and Accreditation Counsel for Pharmacy Education (ACPE).

*Power Point Presentation Set Up:* Details on how to set up the power point presentation can be found [here](#). If you find that the speaker notes are being displayed to the audience you can quickly swap the presenter view and slide view monitors. To do this, on the task bar at the top of Presenter view, select **Display Settings**, and then select **Swap Presenter View and Slide Show**.

## **The presenter is encouraged to be familiar with key definitions and aspects of pain management**

*This section will provide the presenters with some key definitions that will help facilitate the presentation and discussion with attendees.*

### **Key Definitions**

When referenced in this guide and associated presentation, the term “pain” will refer to chronic non-cancer pain, as defined by the International Association for the Study of Pain (IASP), unless otherwise stated. Slide content will assist presenters in teaching the distinction between acute and chronic pain. Pain associated with malignancy will not be a focus of the current presentation or Presentation Guide.

Acute Pain: Acute pain is time limited and typically lasts for a few weeks and can happen for many reasons. It's usually caused by something specific, such as a surgery, a back injury, or a sprained ankle, and goes away after the body has healed, usually within 3-6 months.

Biopsychosocial Model: The current and most widely accepted model to understand and treat pain. It views chronic pain through a framework that considers physical, psychological, and social factors that may collectively influence a patient’s clinical presentation and attempts to address many of these factors as opposed to just one.

Central pain: Pain that results from damage to or dysfunction of the central nervous system and can be caused by stroke, tumors, multiple sclerosis, epilepsy, brain or spinal cord trauma or Parkinson’s disease.

Chronic Pain: Pain that continues after an injury is healed and persists for more than 3-6 months. Chronic pain is much more complicated than acute pain. Chronic pain can impact mood, lifestyle, and overall well-being.

[Cognitive Behavioral Therapy for Chronic Pain \(CBT-CP\)](#): CBT-CP is an approach rooted in the development of a strong therapeutic relationship that encourages clients to adopt an active, problem-solving approach to cope with the many challenges associated with chronic pain (Burns et al., 2015 in Murphy et al., *Cognitive behavioral therapy for chronic pain among veterans: Therapist manual*. Washington, DC: U.S. Department of Veterans Affairs).

Explicit Bias: Attitudes and beliefs about a person or group on a conscious level.

Gate Control Theory of Pain: A model that proposes that pain signals come from the pain location and can be modified. A “gate” in the spinal cord can be opened or closed; therefore, the experience of pain can be exacerbated or minimized by addressing particular stimuli.

Healthcare Disparities: Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention (IOM, 2002).

Implicit Bias: Attitudes and stereotypes that operate below conscious awareness and without intentional control.

[Motivational Interviewing/Motivational Enhancement](#): Evidence-based strategies to enhance one’s motivation for change. The process explores reasons to change unhealthy behaviors and addresses ambivalence, which is common during any change process.

Neuropathic pain: Pain that occurs where there is nerve damage. Neuropathic pain is often described as shooting, burning, or tingling.

Nociceptive pain: Pain that is caused by damage to body tissue based on input by specialized nerves called nociceptors. Nociceptive pain is generally musculoskeletal and described as aching pain.

Non-opioid analgesics: Medications unrelated to natural or synthetic opioids which are used to treat pain. Nonsteroidal anti-inflammatory drugs (NSAIDs), which includes aspirin, ibuprofen, and naproxen, are commonly used non-opioid analgesics.

Opioid analgesics: Opioid analgesics or narcotics are compounds that bind to opioid receptors in the brain. Common opioids include morphine, hydrocodone, oxycodone, codeine, and methadone. Opioids produce effects centrally and are associated with high rates of misuse and physiological dependence.

Stepped pain care: Stepped pain care provides the framework requiring the progressive addition of resources based on complexity, treatment response, medical and mental health comorbidities, and risk to patients. It begins with low intensity interventions and progresses through a series of increasingly intensive interventions.

[Opioid Safety Initiative \(OSI\) Stratification Tool for Opioid Risk Monitoring \(STORM Risk Reviews\)](#): A predictive model to estimate the risk of opioid-related adverse outcomes. STORM uses

a real-time data dashboard to present individual patients' level of risk, as well as patient-specific clinical risk factors.

Morphine Milligram Equivalents (MME): The calculation of the relative potency of the opioid in the commercial container by multiplying the total active opioid ingredient in a drug by the equivalency factor for the drug published by the Centers for Disease Control and Prevention or as determined by rule of the board of pharmacy.

Primary Care Mental Health Integration (PC-MHI): PC-MHI integrates mental health staff into each PACT, allowing the care team to provide services for depression, anxiety, PTSD, and substance use without requiring a separate consult with mental health providers outside of the PACT clinic area

Visceral pain: Pain that results from the activation of nociceptors of the thoracic, pelvic or abdominal viscera (internal organs). Visceral nociceptors are sensitized by inflammation, stretching, or tension.

**Additional resources to be familiar with:**

The VA has several websites with educational information on chronic pain.

1. For Patients:
  - a. [https://www.va.gov/PAINMANAGEMENT/Veteran\\_Public/CHRONIC\\_PAIN\\_101.asp](https://www.va.gov/PAINMANAGEMENT/Veteran_Public/CHRONIC_PAIN_101.asp)
  - b. <https://www.myhealth.va.gov/mhv-portal-web/ss20180620-understanding-acute-chronic-pain>
  - c. [https://www.va.gov/PAINMANAGEMENT/Veteran\\_Public/index.asp](https://www.va.gov/PAINMANAGEMENT/Veteran_Public/index.asp)
  
2. For Providers:
  - a. <https://www.va.gov/PAINMANAGEMENT/Providers/index.asp>
  - b. <https://www.va.gov/painmanagement/>

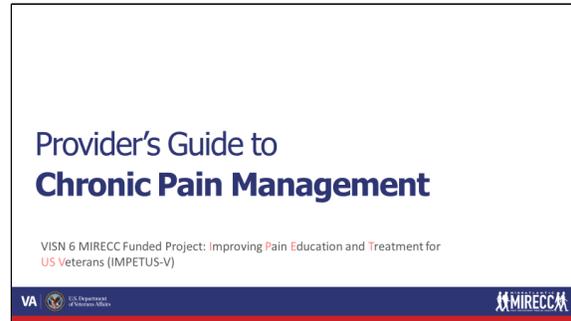
## **Useful information needed to effectively present these materials**

*This section will provide the presenter with detailed information to present the materials in the companion slide deck. An image of each slide is presented in the right top corner of the page with relevant content in the text below. The goal of each slide is presented to the left of the slide image. Some sections will include additional images and recommended links for further reading. Speaker notes are also included in the companion slide deck. The speaker notes are generally not as detailed as the information in this guide, but should provide sufficient guidance, particularly if the presenter is knowledgeable of the topics presented. Recommended specialists for each portion of the didactic modules are indicated in the companion slide deck. Briefly, a Clinical Health Psychologist is recommended to deliver the material on slides 1-10 and 20-27. A physician with pain management expertise is recommended to deliver the material on slides 11-19.*

# Didactics: Module 1

## Slide 1

*Goal: Introduction slide to allow for a brief welcome of attendees to class, including orienting them to purpose of presentation and class guidelines. This time can be used to introduce the speakers and ask for cell phones to be silenced. Presenters may wish to add a disclaimer slide, and mention the uniqueness of this class, as it was developed from an interdisciplinary perspective.*



*Background:* A Clinical Health Psychologist is recommended to deliver the materials on slides 1-10.

## Slide 2

*Goal: Communicate the goals for the presentation and provide a general outline of areas covered.*



*Background:* The goals for Module 1 include an explanation of the biopsychosocial approach to chronic pain care, a discussion about functional assessments and case conceptualization, the importance of clinical documentation, barriers to pain care management, and a brief discussion about effective communication strategies.

Module 2 will consist of case vignettes for discussion, and the 3rd and final module will be an opportunity for providers to bring their own cases for discussion.

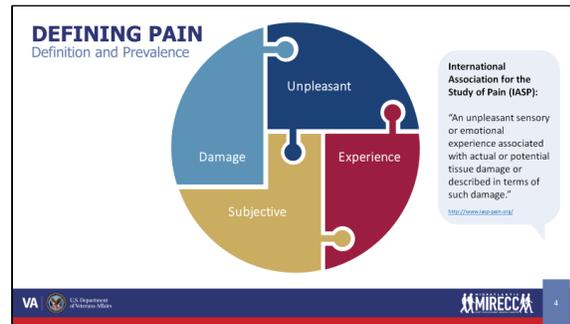
## Slide 3

*Goal: Transition slide.*



## Slide 4

*Goal: Develop an understanding of the accepted definition of pain, and what may contribute to an individual's unique pain experience.*



*Background:* Chronic non-cancer pain is a symptom of many diseases (e.g., arthritis, diabetic neuropathy, past traumatic injury), and often occurs in the absence of any specific underlying diagnosis. Chronic pain is unfortunately a common experience for many people in this country – National Health Interview Survey (NHIS) data demonstrates that approximately 11% of adult Americans experience chronic pain (NIH, 2015). In male Veterans seen in VHA, however, estimates are higher. As many as 50% of male Veterans have chronic pain conditions (Kerns et al., 2003). Pain affects approximately 50 million Americans, and as many as 41% will report that their pain is not well controlled (Nicholson, Ross, Weil, et al., 2006). The costs related to treatment and lost productivity range from \$70 to \$100 billion annually (Gatchel & Turk, 1996; Gatchel & Mayer, 2000).

The International Association for the Study of Pain (IASP, Merskey and Bogduk, 1994) defines pain as *an unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage*. The IASP definition of pain is important both for what it states and what it doesn't state. "Sensory or emotional experience" could perhaps have been better phrased "and/or". What is critical to recognize is that pain does not have to be sensory but can be additionally or exclusively emotional. Carefully teasing out the sensory and emotional components of chronic pain will allow for better diagnosis and treatments, which may be very different for sensory vs. emotional pain, even if the latter is expressed in terms of the former.

"Experience" is an important word in this definition, as pain is experienced differently. Pain is by its nature perceived through the experience of the patient; it is subjective, and there are no lab tests or imaging studies that can quantify or measure pain. Numerical scales, visual analog scales, verbal descriptors, and even pain behaviors are all merely tools used to help the patient communicate his/her experience. Seen in this light, it is easy to understand why a patient observed surreptitiously may appear comfortable, while the same patient when engaged face-to-face may exhibit pain behaviors.

"Associated with actual tissue damage" is easy to understand as injuries typically hurt. "Potential tissue damage" points out the protective function of pain: most mechanisms of injury cause pain *before* tissue is damaged. For example, heat sufficient to cause a burn injury typically causes pain prior to causing injury. This pain serves as an aversive stimulus that tends to cause the organism to remove itself from the source of potential injury.

“Described in terms of such damage” highlights the experiential nature of pain. Were there an objective measure of pain one would not need such descriptors. Because pain is an experience without objective measure, people must communicate their experience by analogy to previous experience. Because certain types of injury are nearly ubiquitous, the pain associated with such experiences serves as common ground between speaker and the listener. Thus, we have descriptors such as “burning pain” and “stabbing pain.”

What the IASP definition of pain doesn't state is as important as what it does state. It nowhere makes a distinction between “real” pain and other types of pain. Pain is what the patient experiences it to be. Of course, there can be (and are) instances of deception. Trust by both patient and provider is critical to assessment of pain. Providers are dependent on the patient to provide information regarding their pain. While outside observers can confirm or deny certain manifestations of pain thereby strengthening or weakening the patient's description, the patient is the sole authority regarding the pain itself. Unless the provider can trust the patient, s/he cannot assess the patient's pain. At the same time, the patient must trust that the provider believes them lest the patient augment the story to convince the provider that s/he really is having pain. Such augmentation, if misinterpreted will lead to a recursive loop of misstatements and mistrust.

[\*The IASP website\*](#) contains many helpful resources regarding education, information regarding pain schools/camps, pain scale references, and translated resources.

## Slide 5

*Goal: Distinguish between acute and chronic pain and describe the key differences between these two types of pain.*

Acute Pain	Chronic Pain
Lasts less than 6 months	Lasts more than 6 months
Symptom (of tissue damage)	The "problem" vs. symptom
Expected to go away	No cure / Focus on function
Useful signal something's wrong	Signal is no longer helpful
Rest often recommended	Rest can make things worse
Minimal (short-term) life disruption	Major (long-term) life disruption

*Background:* While acute pain and chronic pain share a similar vocabulary, they are different conditions and require different treatment approaches.

The simplest way to distinguish between chronic and acute pain is based on time. The specific amount of time chosen is somewhat arbitrary and may be different in different contexts. In this example, we use 6 months. A strict time definition is very precise but may not be accurate. For example, is there really much difference between pain of 5 months and 29 days' duration vs. 6 months? Despite such limitation, a time-based definition may be very useful in certain instances, like determining inclusion criteria for a research study. In such a case, the clarity and repeatability of a strict time definition may be desirable.

Acute and chronic pain are different conditions and the differences go beyond merely time. For example, acute pain is generally associated with a sympathetic autonomic response, which generally extinguishes over time. Thus, a stubbed toe usually results in increased heart rate and blood pressure, while chronic back pain does not. Just as a person's hypertension should not be attributed to a chronic pain condition, the lack of a sympathetic autonomic response should not be interpreted as evidence against the existence of a chronic pain condition.

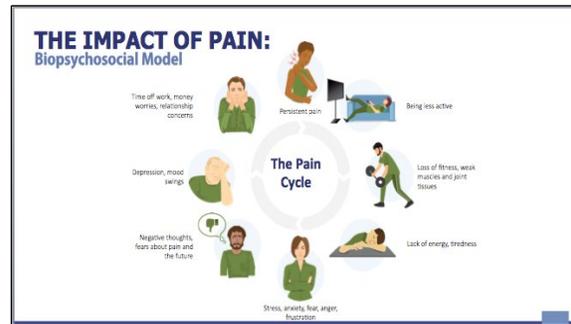
Acute pain is generally caused by some physical process. While a person's psychological state can significantly modify pain perception (for example, a gunshot wound experienced in battle may not begin to hurt until the soldier has reached the relative safety of an aid station), it is rarely the cause of acute pain. In contrast, chronic pain can result from psychological mechanisms. Nonetheless, the pain experienced is real and should be validated. As alluded to regarding the IASP's definition of pain, there is no difference in the legitimacy of pain caused by physical or psychological reasons. There are however, crucial treatment differences. Just as a femur fracture will not be well treated with psychotherapy, back pain due to psychic conflict is unlikely to benefit from surgery. Again, taking care to look for and distinguish between the sensory and emotional components of pain has critical treatment implications. Care must be made when treatment includes opioid medications as these medications have effects on both sensory (nociceptive) pain, and emotional pain.

One major difference between acute and chronic pain is that acute pain serves a physically protective biological function while chronic pain does not. For example, a burn hurts and signals the organism to avoid the heat source, thus avoiding or limiting injury at the time. The ongoing pain during the healing process signals the organism to limit further injury. Finally, memory of the pain signals the organism to avoid similar situations in the future. It is through the experience of acute pain that we learn the association between hurt and harm.

In contrast, chronic pain has essentially outlived its protective function and ceases to be the symptom of a disease but rather becomes the disease itself. In fact, by altering body mechanics, limiting exercise, etc., it can become the cause of ongoing dysfunction and more pain, leading to a vicious cycle. In this case, pain no longer leads to an avoidance of harmful or potentially harmful behaviors, but in fact causes harmful behavior (either directly or indirectly by causing the avoidance of healthful behaviors). Restoration of function and health then involves not only treatment of the sensation of “hurt” but also a relearning of the relationship between “hurt” and “harm.”

## Slide 6

*Goal: Describe the persistent/chronic pain cycle and explain how pain impacts and is impacted by mood, thoughts, and behaviors.*



*Background:* The chronic pain cycle demonstrates the interplay between chronic pain and all domains of life (physical health, emotional health, social/family, work, etc.). This is a specific and visual cycle of the biopsychosocial model. It's not “just” about the pain; rather, the life dysfunction that the patient attributes to the pain, that is at the center of effective treatment.

The persistent/chronic pain cycle is important to providers for several reasons. First, it reminds the provider that persistent pain is not simply a biological experience, but rather a cycle with multiple influences. Conceptualizing a Veteran's persistent pain symptoms in this manner, is a way to directly apply the biopsychosocial model of chronic pain. In addition, it gives providers various avenues to help intervene and break the pain cycle without the initiation of or increased use of medication. For example, behavioral activation and pleasant activity scheduling can be used for patients who are withdrawn and not engaging in activities they enjoy and psychologically-informed physical therapy can help patients address a fear of movement and better discriminate the difference between “hurt” and “harm.” This pain cycle graphic can also be used as an educational tool to help patients understand how their pain is influenced by thoughts, feelings, and behaviors. Ultimately, the persistent pain cycle needs to be broken.

The pain cycle graphic in the slide deck also reveals the perpetual nature of chronic pain. Painful conditions can result in reduced activity. Sometimes this is due to the pain associated with certain movements, but other times it is related to fears of harming oneself more (i.e., increasing pain or injury). When one becomes less active, the body loses fitness—muscles weaken, and joints become stiffer. As a result, stamina is lost, and individuals feel more tired and experience low energy. Negative emotions and thoughts often accompany these negative moods, such as “I can't do anything when I have pain like this.” One may often worry about their pain and how it will affect them in the future and may begin avoiding friends/family and any activities that involve movement because it hurts to move. The combination of negative mood, reduced activity, and less or no time with friends/families or engagement in meaningful activities leads to distress (such as depression, mood swings) and increased disability, which in turn increases the pain experience.

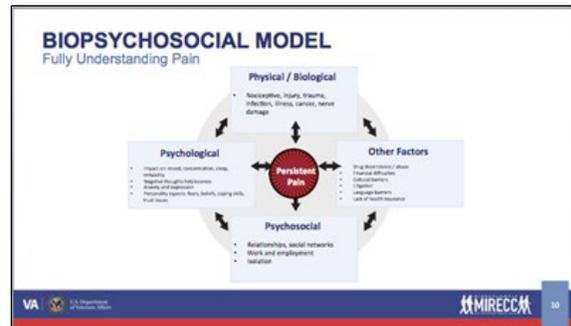
## Slide 7

*Goal: Transition slide*



## Slide 8

*Goal: Explain the biopsychosocial model for pain, each factor, and talk about its application to pain treatment in stepped care.*



*Background:* The biopsychosocial model is a broad view that attributes disease outcome to the intricate, and variable, interaction of biological factors (e.g., genetic, biochemical), psychological factors (e.g., mood, personality, behavior patterns, cognitive style, etc.) and social factors (e.g., cultural, familial, socioeconomic, environmental, etc.). The biopsychosocial model shifts the conceptual focus from “disease” to “illness.” “Disease” is described as an altered condition that results from the disruption of normal physiological systems and is considered to be an “objective, biological event” that should be “cured.” Illness; however, is used to refer to the “subjective experience” associated with disease states that is characterized by the unique interaction between biological, psychological, and social factors (Turk & Monarch, 2002).

The biopsychosocial model was first introduced in medicine by Engel (1977). In this seminal publication, he highlighted that as medical illness becomes more chronic in nature, psychosocial “layers” (e.g., illness behavior, taking on the “sick role”) often emerge to complicate assessment and treatment. Engel proposed 4 dimensions related to the idea of pain: 1) nociception (physiological components associated with sensory input such as nerve fibers), 2) pain, 3) suffering, and 4) pain behavior. Suffering and pain behaviors are viewed as negative psychological/emotional responses to nociception or pain.

The earliest models (1800s through early 1900s) of pain focused on understanding the biological or pathophysiological aspects of pain, with an emphasis on separation of mind/body. In the 1960s, Melzack and Wall (1965) proposed an integrative model (The Gate Control Theory of Pain), which emphasized the significant role that psychosocial factors play in the perception of pain. The authors claimed that the “gate” controlled the frequency and intensity of signals to the central nervous system (CNS) by modulating the amount of afferent impulses from the periphery to the transmission cells (T-cells) of the dorsal horn of the spinal cord. This is done through inhibitory processes at the neuronal level. The model also suggests that higher level cortical functions (including psychological phenomena) can contribute to the gating mechanism and therefore the patient’s subjective experience of pain. For example, negative states (e.g., anger, hopelessness) and maladaptive behavior patterns (e.g., poor eating, smoking or drug use, poor sleep, sedentary lifestyle) would be expected to amplify the experience of pain, while strategies focused on coping and stress reduction (e.g., diaphragmatic breathing, behavioral activation, pacing, safe exercise promotion) would act to “close” the gate.

The biopsychosocial model has led to the development of the most therapeutic and cost-effective interdisciplinary pain management programs and increases the likelihood for the patient with

chronic non-cancer pain to regain function and experience meaningful improvements in quality of life. In contrast to a biomedical model, which views pain as a disease or objective biological event, the biopsychosocial model of pain considers the whole person and all experiences in the evaluation and management of their chronic illness (pain). Providers should be very familiar with this model and are encouraged to view this model as the basic context in which to provide optimal care. In the management of chronic illnesses such as chronic non-cancer pain, the most effective care will be achieved by addressing patient needs at all three levels: biological, psychological, and social.

### **Biopsychosocial Model and Pain Assessment:**

The biopsychosocial model is broadly accepted as the most successful model to date for understanding chronic non-cancer pain; however, it is not possible to break pain down into discrete elements (physical, psychosocial, etc.). Rather, pain as an illness is conceptualized as a complex manifestation of attributes across domains (psychological, social, physical, etc.), and the interplay of these factors is thought to directly impact a patient's perception of pain (frequency, severity, intensity) and associated disability. Consistent with this conceptualization, biopsychosocial approaches to pain assessment should focus on comprehensive measures: physical, psychological, social, cognitive, affective, behavioral, and the interactions between these domains (e.g., relationship between psychosocial/emotional stress and hormone elevations from hypothalamic-pituitary-adrenal system).

### **Biopsychosocial Model and Levels of Care in Pain Management (Acute and Chronic):**

As noted earlier, the biopsychosocial model highlights the idea that chronic illnesses (e.g., pain, diabetes, asthma) cannot be cured; rather, the focus of treatment is on management (i.e., improved function, reduced disability, improved quality of life). Tailoring treatment to meet the unique needs of a given patient, based on their unique presenting concerns (biological, physical, social, psychological, environmental, socioeconomic, cognitive, etc.), is essential to producing optimal outcomes. Depending on the circumstances and duration of the presenting complaint, different levels of care will be emphasized and patient education (medication compliance, recovery process, normalizing health anxiety, etc.) is often helpful for both acute and chronic pain conditions.

In a subset of the population, recovery following an acute injury will be impaired by psychosocial issues that compound the impact of the physical injury. In these cases, secondary care can provide more integrated rehabilitation/treatment by using an interdisciplinary team focused on reducing physical deconditioning and the impact of psychological barriers that impede recovery. This level of care might ideally incorporate an emphasis on behavioral pain management interventions, which are typically readily available in VA medical facilities (e.g., primary care psychology, health psychology). Some patients, unfortunately, do not respond well to primary or secondary care approaches. Often, this is due to a complex interplay of psychosocial factors that impair a patient's ability to fully benefit from traditional treatment approaches. In these cases, tertiary care may be appropriate, which focuses on intensive care aimed at functional restoration. This type of care involves an interdisciplinary team (e.g., PCP, psychiatrist, psychologist, physical/occupational/recreational therapist(s), disability case manager) and focuses on development of a comprehensive care plan intended to assist the patient in regaining mobility and function. Emphasis is also given to stress coping skills training. Often, patients requiring tertiary care have developed a dependency on opioid medications and may require detoxification during inpatient care.

## Slide 9

*Goal: Explain why the biomedical approach to chronic pain management is problematic (as described by Anthony Mariano, PhD).*



**Background:** The biomedical approach to pain care addresses pain as a unidimensional problem in which providers treat patients using multiple modalities (medications, injections, surgeries) in order to “cure” their pain. That is, providers “do something” to their patients. In contrast to the biopsychosocial model where the experience of chronic pain is conceptualized as a complex interaction of biological, psychological and social factors and the focus is on “management” of the condition rather than cure.

For broader contextualization, we are providing some background on the growth and implementation of “Pain as the 5th Vital Sign” and how an emphasis on the biomedical model as a unidimensional approach to pain care resulted in unintended consequences. In the mid 1990’s The American Pain Society strongly advocated for the concept of “Pain as the 5th Vital Sign” (American Pain Society, 1995). This concept was put forth based on the premise that pain conditions were not adequately evaluated during doctor’s visits and hospital stays. In 2001, the Joint Commission released “Pain Management Standards” which required all providers to query about pain and indirectly helped advance “Pain as the 5th Vital Sign.” In 2009, the VHA also introduced a Pain Management Strategy that required pain evaluation using a numerical rating scale. Although a patient’s satisfaction with pain care does not always reflect appropriate pain management, patient satisfaction surveys soon became more widely utilized for pain management, and in some cases patient satisfaction became linked to financial incentives within hospitals. During this time, opioids were being heavily marketed for the treatment of chronic pain, and some providers felt substantial pressure to prescribe opioids to patients with chronic pain. Although opioid use increased patient satisfaction, it also resulted in increased opioid-related adverse events. Moreover, this biomedical approach using opioid medications to treat chronic pain did not improve treatment outcomes. In 2016, the American Medical Association dropped “Pain as the 5th Vital Sign.” To assess and treat chronic pain more effectively, a biopsychosocial approach to pain care was introduced, using interdisciplinary approaches with multi-faceted assessment tools. This approach still assesses pain intensity ratings but is expanded to include functional domains. Functional interference from pain may include sleep, mood, social engagement, and other generalized or specific functional talks. The medical system is currently transitioning from a biomedical to a biopsychosocial approach to chronic pain care. This transition has resulted in challenges for both patient and providers about pain care expectations.

### **Biomedical Approaches to Pain Care Management:**

The slide for discussion is an explanation of how the biomedical approach applied to chronic pain can go wrong. It begins with both patient and provider hopeful that a medical intervention will treat

or cure their pain, and ends with distrust, frustration, and ultimately the patient firing the provider and moving on to begin the cycle again with another provider.

The cycle starts off HOPEFUL, when patients and providers share disabling beliefs and believe that medical solutions are possible if the pain is “real.” However, standard biomedical treatments fail because they are not sufficient in managing pain as an “illness” vs. “disease”. When pain doesn’t improve, providers begin to DOUBT patients have legitimate problems. The more providers doubt, the more patients increase demands for *validation and relief*. Providers may view patients as a “problem” and that don’t have a “real medical problem,” but rather they are unmotivated, seeking secondary gain, over-utilizing, or drug seeking. Similarly, patients are frustrated and see the provider as the “problem” who is uncaring and incompetent and perhaps withholding treatment due to fear.

This general mistrust of the medical system & VA specifically results because patients and clinicians are making decisions based on the biomedical model, which is inadequate and leads to disabling beliefs such as:

- a. The belief that objective evidence of disease/injury is required for pain to be ‘real’
- b. The view of pain as the *only* problem
- c. The expectation that urgent pain relief (alleviation) is the major goal of treatment
- d. Overconfidence in medical solutions
- e. The belief that the provider is the “expert” and therefore responsible for outcomes
- f. The belief that the patient is “victim” and helpless in managing his/her concerns
- g. Pain as the “identity.” This is the view that a person is a “pain patient” vs. “person/patient *with* pain (amongst lots of other characteristics).”

Providers are left with few choices other than to repeat what has already been done or escalate medications (type and/or dose). Thus, the dyad enters the HOPELESS Phase. Providers give up or give in.

*Give in:* One may provide treatments that are not clearly empirically driven, or that one doesn’t believe in. These are non-rational treatments that reinforce erroneous beliefs in medical solutions and expose people to unnecessary and excessive risk.

*Give up:* Concluding that there is nothing to offer and rejecting the patient. Patient moves on to a new doctor and the cycle is perpetuated, beginning with increased frustration and stressful presentations from/by the patient.

### SOLUTION: BREAK THE CYCLE

Redefine the problem: Chronic pain is not just a disease, but a breakdown in the process of caring for patients. Patients and providers blame each other rather than question erroneous assumptions about pain and treatment or reflecting on errors in thinking/beliefs/biases. Patients often repeat the same process with another provider as he/she is rejected from clinics/teams.

Redefine the solution: Treatment should support the patient as a person, while challenging their belief that pain is the major problem and that medical interventions are the only appropriate solution. The patient-provider relationship is of paramount importance.

Provider tools include:

1. *Effective communication:* including ongoing assessment of the pain “problem” AND contributing factors related to patient self-management behaviors.
2. *Education:* educating the patient about the biopsychosocial model and working collaboratively with patients to help them better manage their pain. We want the patient to share responsibility for setting goals, be accountable for outcomes, and become an active participant in their care and rehab. This is referred to as *collaborative self-management*, a VA strategy/policy in Primary Care/PACT teams. [Whole Health](#) strategies can also be useful for patients to evaluate what they value about their own health to help them develop health behaviors consistent with these values.
3. *Motivational interviewing and motivational enhancement:* Use these skills to help patients engage or move toward change-behavior. Expect resistance and ambivalence; it’s a part of the process.

## Slide 10

*Goal: Explain the VA Stepped Pain Care Model and outline the role and involvement of the PACT team, clinicians, etc.*



*Background:* The VA first proposed using a stepped-care model in 2009 when it was recognized that managing chronic pain required a shift from a biomedical treatment model to a biopsychosocial model. This coincided with the development and growth of the Patient Aligned Care Team (PACT) in primary care that provided opportunities for greater involvement of additional clinicians in patient care. The most recent versions of the stepped-care model stress the importance of patient self-management in **Step 1**.

**Step 2** stresses full utilization of treatment possibilities included in the PACT team model. The Mental Health – Primary Care Integration team supports availability of group and individual psychological management in the PACT setting. Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) and Post-Deployment Teams help to address special needs of these populations as they relate to individual care plans for those veterans. Expanded roles of nurses and pharmacists in the PACT teams for group classes and medication management are additional ways to help patients with chronic pain.

As the complexity of a patient’s pain management plan increases, additional resources may be needed, introduced in **Step 3**. Referrals to Multidisciplinary Pain Medicine Specialty Teams, Physical Medicine and Rehabilitation, Behavioral Pain Management, or Mental Health/Substance Use Disorders may be appropriate for patients with more complex chronic pain conditions.

Finally, **Step 4** includes referral to Interdisciplinary Pain Centers, Interventional Pain Clinics, or a Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited pain rehabilitation program (which may be necessary for some patients with chronic pain who have multiple comorbidities and increased risk for treatment failure and harm from continued reliance on high-dose opioid analgesics/concomitant mental health disorders). Some of these patients may be candidates for more advanced pain management techniques such as spinal cord stimulators or more advanced interventional pain management techniques to relieve pain that is refractory to other treatments.

## Slide 11

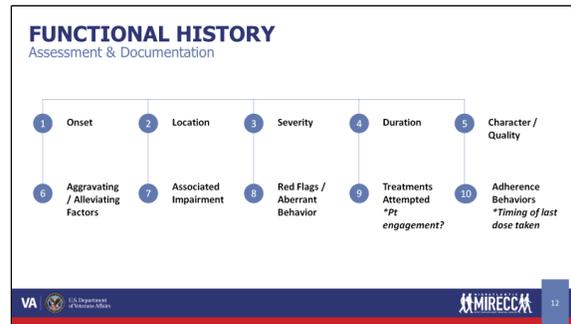
*Goal: Transition Slide.*

*Speaker Switch: Internal Medicine, Anesthesiology  
or Psychiatry (slides 11-19)*



## Slide 12

*Goal: Explain the functional history assessment and how this should inform providers in their treatment approach. Emphasize importance of documentation.*



*Background:* A functional history is a more comprehensive assessment of the items that should already be assessed and documented in a typical History of Present Illness. This allows the provider to understand the functional impairments that the patient attributes to their painful state. Asking the patient for specifics of their pain [e.g., “whole body” pain may mean post-stroke pain, physical manifestations of psychological distress, or multifocal musculoskeletal pain (polytrauma)] will allow the provider to make informed decisions about their approach to pain treatment.

Assessing for pain-related impairment should also include:

- a. Mobility: community, ambulation (+/- assistive device), distance, frequency
- b. Activities of daily living: dressing, bathing, grooming, meal preparation and feeding, driving, schedules/planning/medication management
- c. Social history: patient’s location, living situation, vocation, and avocational pursuits.

This helps the provider and patient mutually set focused goals for pain treatment and reasonable timeframe for improvement. Functional history and patient centered goals should be documented in the patient encounter. This will allow the patient and provider to review progress (and barriers to achievement) and adjust treatment options on subsequent encounters. In addition, it may assist the provider in documentation of medical decision-making for pain treatment.

Validated measures for pain impairment may be helpful in tracking patients over time:

- a. [Defense and Veterans Pain Rating Scale](#)
- b. Brief Pain Inventory
- c. Oswestry Disability Index
- d. RAND-36

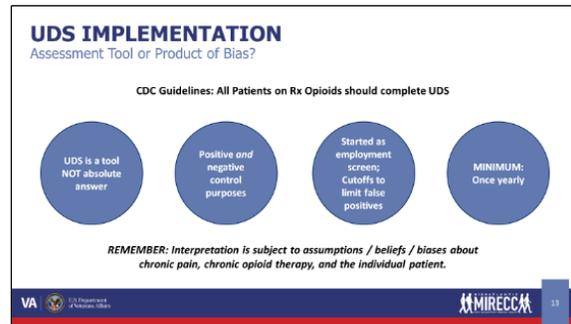
Physical examination is based upon history taking:

- a. History allows clinician to form a differential diagnosis. If there are multiple pain complaints, it can help clinician and patient prioritize which painful issues should be addressed at the current visit.
- b. Tests (including physical examination maneuvers) allow the clinician to narrow the differential diagnosis and form a treatment plan
- c. An organization mnemonic for physical examination for pain can be repeated for as many body regions as needed.
  - IPROMSS: Inspection, Palpation, ROM, Strength, Special tests (neurologic tests and tests for specific injury processes [e.g., Anterior drawer for ACL tears])

\*Common elements for documentation of opioids for pain can be found on the [CDC website](#).

## Slide 13

*Goal: Outline appropriate use of urine drug screen (UDS), explain its purpose and limitations.*



*Background:* Under current VA policy, UDS is required annually for all patients who are prescribed opioids for >90 days (except for patients with cancer pain and receiving hospice care). While annual UDS is required, more frequent screening may be indicated depending on the clinical condition. The provider's state licensure may also have specific requirements when prescribing controlled substances and it is up to the provider to review their individual requirements.

It is important to understand what a UDS is and what it isn't. It is a tool that provides information for clinical decision-making. It is not a gold standard that answers all questions about how (or if) a patient is using his/her opioids.

The typical UDS was developed as an immune-assay based screening test for employment purposes to detect illicit drug use. Reporting limits were chosen to limit false positives. Therefore, reporting limits are set relatively high, giving up some sensitivity in exchange for increased specificity. When these tests are applied to patients prescribed chronic opioids, they are being used somewhat outside of their original design parameters. Not only is the pre-test probability of opioid in the urine entirely different from what was assumed when developing the test, the end-user's value judgment (as to the desirability of false positive vs. false negative result) may be entirely different. In addition, low cost is desirable in a screening test, and certain compromises may have to be made to achieve that goal. For example, the screening test used at DVAMC is relatively insensitive to oxycodone and completely insensitive to fentanyl. It is critical to understand the specifics of the test used at your institution.

Once the limitations of the screening test are understood, the patient variables must be considered. For example, a UDS for opioids may or may not be positive in a patient who is prescribed PRN (as needed) medication, depending on when s/he took the medication and his/her individual metabolism. Once the limitations of the test and the patient variables are understood, one must understand what the purpose of the testing is and how one's assumptions, beliefs, and biases affect interpretation of the test results.

The UDS serves both negative and positive control purposes. That is to say, the reason for testing involves both providing evidence that the patient is taking the prescribed medication and that s/he is not taking certain other medications. Establishing a baseline level during opioid therapy can aid in the interpretation of future UDS results.

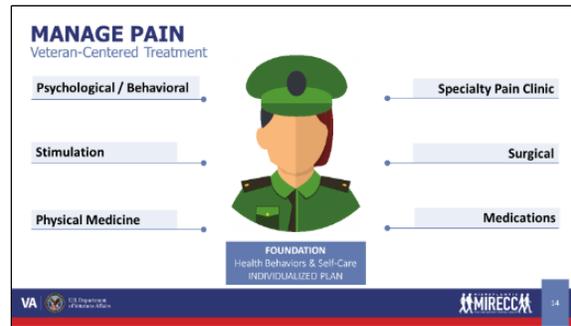
The purpose of the negative control is to detect the presence of certain illicit or co-prescribed substances. Take for example a positive cocaine screening test and examine how assumptions, beliefs, and biases may affect the interpretation of this. If the patient openly admits to using cocaine, one may (reasonably) assume this test result represents a cocaine metabolite in the urine. If the patient presents in a way that is atypical of a cocaine user, the provider might believe the test to be a false positive and order a confirmatory test. One's biases can affect not only the interpretation of a particular result, but also how to proceed with that result. For one provider, a positive cocaine test may be indication of a treatable substance use disorder, while for another, the same result may be an indication to stop all treatment with opioids.

The purpose of the positive control is to provide confirmation that the patient is taking the prescribed medication. As discussed above, the test was not designed for this and may not work well in this capacity. For example, a person taking one oxycodone a day is highly unlikely to show a positive opioid UDS with the DVAMC test. In fact, a positive result in this case is quite likely to be indicative of the use of other opioids. In contrast, a person prescribed 100mg of morphine twice a day should almost certainly test positive. Between these two extremes there are many patients who could be expected to have either a positive or a negative screening result. It is in these cases that one's interpretation is dependent on the patient context (to include compliance history, SUD history, early refill history, etc.) and is particularly subject to assumptions, beliefs, and biases.

Understanding cutoff values, detection times and false-positive results is vital when interpreting UDS results. Immuno-assays should be considered presumptive and clinical judgement, patient history, and collaborative information should be used to determine if confirmatory testing is needed. Gas chromatography/mass spectrometry (GC-MS) is considered the standard in confirmatory testing and can identify specific molecular structures and quantities. It is recommended for positive results.

## Slide 14

*Goal: Explain the 6-step conceptualization of chronic pain care*



*Background:* Treatment *must* be tailored to meet the needs of the individual, based on individual characteristics, and should emphasize collaborative self-management, pacing, shift in thinking (ability VS. disability focus), accountability, improved adherence, and health behavior promotion that emphasizes functional improvements valued by the patient. At the foundation of all chronic pain management is the engagement of the patient. Patients are empowered to engage in their own self-care and positive health behaviors.

One method of conceptualizing chronic pain management is to consider classifying intervention techniques into one of six general categories. These categories are intended for *practical utility* rather than for scientific purposes (e.g., should radiofrequency ablation be classified as an injection or a surgery? It doesn't matter how any specific treatment is classified so long as the approach is organized and consistent). Effective pain management is rarely achieved with single-agent or even single-category treatment; the provider should expect to utilize multiple modalities to maximize benefit and minimize risk.

Psychological measures: Treatment of the psychological or behavioral components of chronic pain as well as any psychiatric comorbidities is critical to long-term pain management success—both for the patient and the provider. One behavioral intervention that should be taken with every patient at the first encounter is to set realistic expectations for treatment and expectations for the management, rather than a cure of the chronic pain condition.

Several psychological or behavioral intervention strategies may reduce the experience of pain by improving pain coping and self-management skills training. Patients may find pain relief through treatments such as guided imagery, progressive muscle relaxation, self-hypnosis, or meditation. These treatments can be inherently empowering to patients, providing sense of control and self-efficacy. Pain-specific cognitive behavioral therapy for chronic pain can also be very useful for helping patients to learn pain coping skills. Skills training is valuable since few chronic pain conditions can be eliminated, therefore most individuals benefit from learning strategies to live more successfully despite some degree of persistent chronic pain. Personality traits and cognitive processing styles such as [pain catastrophizing](#) can be identified and addressed in cognitive or cognitive behavioral treatments for pain. Those who exhibit catastrophic thinking will tend to be unnecessarily high utilizers of the health care system and effective treatment can have benefit for both the patient and the provider.

Additionally, symptoms of depression, grief, anxiety, trauma, and interpersonal conflict may manifest as physical complaints and chronic pain. These forms of pain are every bit as real as pain from an obvious physical cause such as a broken leg. Thus, careful evaluation of psychosomatic disease is essential and can facilitate appropriate treatment. Cognitive-Behavioral Therapy is often recommended, and Mindfulness-Based Stress Reduction and Acceptance and Commitment therapies are also used as alternatives to CBT (Veehof et al., 2016). However, those who perceive psychological stress as somatic symptoms may be reluctant to agree to psychological or psychiatric evaluation or treatment. Thus, providers may consider alternative methods to treat the patient's experience of pain such as medications (e.g., antidepressants).

Physical Measures: This category is listed second because many conditions can be caused or exacerbated by altered body mechanics. If a patient receives pain treatment and then returns to his/her lifestyle from before treatment, the same pain is likely to return. Exercise (with or without the help of a therapist), stretching, heat, cold, massage, yoga, weight loss, etc. all may be helpful. While not always applicable, it is often helpful to directly explain to the patient that effective pain management almost always requires the participation of the patient; the injections, pills, and other biomedical interventions can best be thought of as ways to help the patient make the changes that improve the painful condition. Collaborative management, including integrated care with a health psychologist or other MH provider skilled at working with patients with chronic health conditions, can be helpful in addressing some of these issues (e.g., weight management, compliance issues).

Particularly with exercise, there is likely to be some acute increase in pain or new pain when first starting. This is perfectly normal, expected, and predictable; therefore, the patient should be warned of this beforehand. Working with a good physiatrist and/or physical therapist will help the patient learn to distinguish between hurt and harm and help him work through the hurt, avoid harm, and eventually derive benefit.

Additional physical measures include adaptations to accommodate alterations in the patient's function. Physical and Occupational Therapists can evaluate patients for braces (e.g., knee brace or carpal tunnel splint), assistive mobility devices (e.g., wheelchairs, walkers, canes), and adaptive equipment (e.g., raised toilet seats, adaptive feeding, bathing, and dressing utensils) and train them on use.

Stimulation: TENS (transcutaneous electrical nerve stimulation) can be helpful and carries few risks or side effects. While it is difficult to predict whether TENS will be helpful in most situations, it is of such low risk that it should be tried aggressively. TENS does seem to be particularly effective for chest wall pain. Spinal cord stimulation should be considered in select cases.

In addition, there is growing interest in the study and use of electroceuticals not classified as TENS for pain reduction and functional improvement. Current limitations include little or no specific clinical studies, small studies lacking scientific rigor, limitations in the FDA approval process, and cost versus insurance coverage.

Injections: Trigger point injections, joint injections, epidural steroid injections, and facet injections are rarely curative, but in many cases can provide effective pain relief of several months' duration. Such relief can be very helpful for treatment of pain exacerbation (for example, to avoid increasing

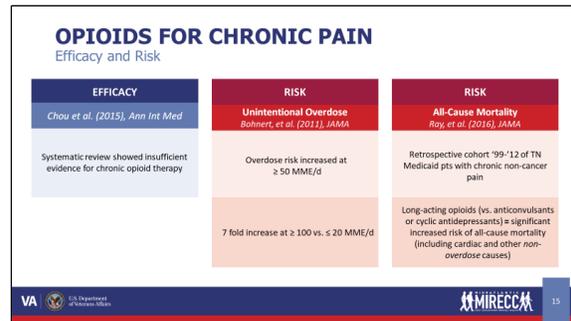
opioid analgesics) or for treatment for specific time periods (patient has a vacation with lots of walking planned or has a family reunion coming up for which he wants to be particularly active). Perhaps the best use for injection therapy is to provide analgesia so that the patient can better participate in the physical measures that will ultimately provide improvement of the underlying condition.

Surgery: Patients with chronic pain often have unrealistic hopes for a surgical cure to their problem, and if they search long and hard enough, will often find someone willing to operate. While surgery is often the definitive treatment (e.g., joint replacement) for both the underlying condition and the chronic pain, not every or even most painful conditions will respond favorably to surgical intervention. Because surgery carries significant risk, a conservative approach is prudent.

Medications: Medications are listed last because they are often thought of first. Tricyclic Antidepressants (TCA), Serotonin-Norepinephrine Reuptake Inhibitors (SNRI), Non-steroidal Anti-inflammatories (NSAID), steroids, immunomodulating agents, muscle relaxants, anticonvulsants, all may be helpful either alone or in combination. Combinations of moderate doses of drugs with different side effects and mechanisms of action are often better-tolerated and/or more effective than large doses of single agents. Opioids are at most *part* of an effective pain management regimen and deserve special caution because of the associated risks.

# Slide 15

*Goal: Review the risks and benefits of long-term opioid therapy and emphasize the importance of reviewing current literature on the topic*



**Background:** To help make an evidence-based-medicine approach to the decision of whether to start/continue a patient on opioids for chronic non-cancer pain, it is important to review the literature on chronic opioid therapy risks and benefits. This slide summarizes what the literature tells us about chronic opioid therapy benefit, which is that there is so far no evidence base for prescribing chronic opioid therapy. It might be effective, but it has not been studied, so we do not really know.

There is substantial and dose-dependent risk associated with chronic opioid therapy, which must be weighed against each individual patient’s demonstrated benefit (since there is no research to describe expected benefit). Of note, an additional finding in the 2016 study was that death was especially likely during the first 30 days of opioid therapy, highlighting the importance of carefully discussing risks with patients and families before starting any new opioid prescription. The referenced studies from the slide are summarized below:

### **Efficacy of Chronic Opioid Therapy (Annals of Internal Medicine: Chou, 2015):**

This was a systematic review of the risks and benefits of chronic opioid therapy. Of 4209 studies considered, 40 met criteria for inclusion. There were no studies at that time addressing long term outcomes: “No study of opioid therapy versus placebo, no opioid therapy, or non-opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, or quality of life.” The authors’ concluded that there was insufficient evidence to support chronic opioid therapy for chronic non-cancer pain.

In contrast to lack of evidence for opioid efficacy, there is mounting evidence that chronic opioid therapy has significant risks:

### **Unintentional Overdose (JAMA: Bohnert, et al., 2011)**

This is a case-cohort design study comparing a cohort of all patients who died from opioid overdose deaths with a random sample of patients prescribed opioids. The notable finding in this study was that overdose risk increased significantly at 50mg/d MME or greater, and there was a dose-response relationship as the dose increases further, with doses higher 100mg/d MME showing substantial risk.

### **All-Cause Mortality (JAMA: Ray, et al., 2016)**

This is a retrospective cohort looking at mortality rates of patients prescribed different classes of pain medicines. The notable finding from this study is that long-acting opioids were associated with increased risk of all-cause mortality compared to other classes of pain meds.

Commonly reported side effects associated with opioid use can include sedation, dizziness, nausea, vomiting, constipation, physical dependence, tolerance, and respiratory depression (Benyamin et al., 2008). Sedation, dizziness, nausea, and respiratory depression tend to diminish with time; however, constipation does not. Less commonly occurring side effects can include delayed gastric emptying, hyperalgesia, immunologic and hormonal dysfunction, muscle rigidity, and myoclonus (Benyamin et al., 2008). These less common side effects may be dose dependent.

\*[CDC's Total Daily Dose of Opioids Calculator](#)



## Slide 17

*Goal: Explain the official CDC guidelines for opioid management.*

The slide is titled "2016 CDC GUIDELINES Opioids in CNCP Management". It contains three main sections of text:

- Continue opioid only if clinically meaningful improvement in pain AND function that outweighs risk(s) to patient safety.**
- Avoid increasing dose to ≥90 MME/day or carefully justify decision**
- Reassess evidence of benefit/risk when considering increasing dose to ≥50 MME/day**

On the right side, there is a pink box titled "Patients already Rx ≥90 MME/d:" with two bullet points:

- Including transferred / inherited patients
- Opportunity to re-evaluate utility of continued use at higher dose given evidence of link between dose & risk (OD and all-cause mortality with long-acting)

At the bottom, there is a footer with logos for VA, the U.S. Department of Health and Human Services, and MIRECC, along with the number 19.

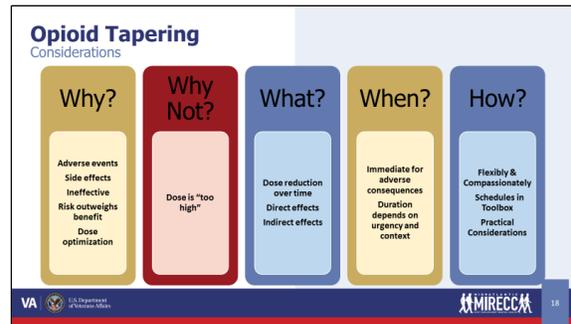
*Background:* The 2016 CDC Guidelines for opioid therapy were developed primarily with the intent to improve the safety and effectiveness of pain treatments, as well as to reduce risk associated with long-term opioid therapy such as opioid use disorder, overdose and death. Updates contain new/updated recommendations:

In the updated guidelines, *pain intensity* and *function* are both important outcome measures to determine the effectiveness of chronic opioid therapy. A dose of 50 MME/day is considered the point where risks are more significant, therefore benefits and risks should be considered carefully before exceeding that dose. Doses of 90MME/day or greater should be avoided, **or if prescribed must be carefully justified**. This does not mean that a patient currently on 90MME/day or more should be weaned down or tapered off without patient-specific cause; rather, weaning should be discussed and implemented if *individual* risk of opioids at a particular dose exceed *individual* benefit. Evaluation of risks and benefits should consider the patient's circumstances and values.

The updated 2016 "CDC Guideline for Prescribing Opioids for Chronic Pain" emphasizes the use of low or moderate doses when opioids are being prescribed. Functional benefit (instead of just pain scores) as the measure of whether the opioid therapy is effective for each patient is also emphasized. Except in unusual circumstances in which functional improvement is not possible (i.e., certain spinal cord injuries), patients should demonstrate functional improvement (after starting opioid use or increasing dose) to justify continued use.

## Slide 18

*Goal: Provide considerations for opioid reduction and tapers.*



*Background:* Opioid tapers and reductions should be made in collaboration with the patient. A thoughtful and compassionate approach to changes in opioid medication is important for both emotional and physical comfort of the patient. Details are discussed below:

**WHY:** “Why” is the basis from which all tapering decisions must be made. It informs all other choices. Why should providers consider tapering down or off opioids for chronic pain management? Examples include:

- Patient has experienced a critical adverse event and it is reasonable to expect this has a significant likelihood of happening again
- Patient is experiencing bothersome side effects
- Medication is not effective
- Risk outweighs benefit
- Dose optimization

It is equally important to know **WHY NOT** consider an opioid taper. The most common inappropriate reason to consider an opioid taper is “the dose is too high.” While there is no specific dose that is universally “too high”, higher doses do carry increased risk and one should always strive to use the lowest effective dose. Doses higher than 90 MME require particular care. 90 MME is NOT an arbitrary maximum allowable level, is a level at which risk appears to reach an inflection point. It is common that patients above this level are not having great functional improvement (were opioids tremendously effective for that patient, it is likely his/her dose would not have been escalated). Careful documentation of rationale for using higher doses should be made. It is far better to think of tapering in such cases as an experiment to determine whether the same or better analgesia can be achieved at a safer, lower dose.

From a practical standpoint, unless a patient is troubled by an adverse effect, starting a discussion regarding opioid tapering with “your dose is too high” is rarely ideal and predictably leads to an adversarial interaction. From the patient’s perspective the dose is not causing harm and the longer he has been on that dose, the less reason he must believe it is dangerous.

**WHAT:** A taper is a dose reduction spread over time (rather than done abruptly) which is intended to minimize the adverse effects of opioid dose reduction. Adverse effects must be thought of broadly and are not limited to the direct effects of opioid dose reduction. In fact, the direct effects (opioid withdrawal) are generally short lived, self-limited, and while perhaps profoundly unpleasant,

are not lethal. Conversely, the indirect effects of opioid dose reduction can have long-reaching and serious consequences. These indirect effects can include:

- Social effects: job, marriage, etc.
- Patient-provider relationship: to include individual provider and system as a whole
- Substitution of non-prescribed substances.

While a provider should not allow a patient to be pressured into prescribing opioids with the threat of resorting to non-prescribed substances, it is a potentially lethal reality that a proportion of patients will resort to use of non-prescribed substances if their prescribed opioids are discontinued carelessly. If a patient initiates this discussion, the provider should consider the patient at particularly high risk. There are multiple reasons why a patient may be so resistant to the suggestion of opioid dose reduction that substituting non-prescribed substances are considered. Reasons include SUD, uncontrolled pain, and palliation of non-pain symptoms. Seeking the input of specialists is prudent in such cases.

**WHEN:** Consideration of WHAT a taper is (a way to minimize adverse effects of opioid dose reduction) and WHY a taper is being considered will inform the decision of WHEN to initiate a taper and over what time period to perform the taper. Immediate adverse or potential adverse direct drug effects argue for starting a taper immediately-soon. Conversely, no immediate adverse or potential adverse direct drug effects argue for taking adequate time to minimize adverse indirect effect. Duration depends on urgency and context. Examples may clarify the principles:

- 1) A patient's caregiver reports that new in recent weeks, every time she takes a dose of morphine, she falls asleep and yesterday, it was very hard to wake her up for dinner. Outside of a terminal care scenario where the principle of double effect may apply, such a case would give cause for immediate dose reduction. Implementation of additional risk mitigation strategies such as a naloxone rescue kit would also be indicated as would investigation into the cause of this change in response to a previously well-tolerated dose. Admission to hospital may be justified.
- 2) A provider is taking over care of a patient has been prescribed 200mg MME for the past 10 years by a provider who has retired. The patient has not had any adverse effects from this treatment and by all measures has done well. The new provider feels very strongly that this dose is too high and wishes to initiate a taper. He considers that the increased risk at higher doses is a population statistic and this individual patient has thus far remained in the portion of the population that has not experienced adverse direct effects and it is reasonable to believe that barring a change in his circumstances he will likely continue to safely use his present dose of opioid. The sense of urgency he feels in reducing the dose is due to understandable discomfort prescribing such a high dose and not due to immediate risk to the patient. Recognizing the importance of establishing a trusting relationship, chooses to begin the conversation by asking how effective the treatment is for the patient and offers that there are additional treatments that can be added that may provide even more relief. He explains that these newer, safer treatments are sometimes working so well that people can reduce their opioid, but that is not something to consider just yet. The patient leaves

relieved that his new provider wants to help him with his pain and at the next visit wishes to discuss the risks of opioids that he has been hearing about.

**HOW:** In an urgent taper, technical considerations of direct effects dominate the decision-making process. The technical aspects of opioid tapering are relatively straight forward and schedules exist in the VHA Pain Management Academic Detailing Services [toolbox](#). There are practical considerations of dose increment and relative proportion. In a non-urgent taper, consideration of indirect effects become relatively important. A taper is most likely to go well for both the patient AND the provider if it starts from a place of established trust and proceeds flexibly and compassionately. For example, if the provider wishes to taper by 10% every other week but the patient is tolerating it poorly, is there benefit to slowing down to a monthly or even longer pace? If the patient expresses that he has had a particularly challenging month at work and at home and doesn't feel ready for another reduction, is it harmful to hold steady for a few months, giving the patient some control and autonomy in this sphere of his life when other areas are challenging him?

A patient should be explicitly informed that with a dose reduction, s/he will experience a TEMPORARY increase in pain. Just as he experienced a TEMPORARY decrease in pain with each increase but eventually and inexorably required higher and higher doses to control his pain, s/he will feel an increase in pain before the pain again drops to its new baseline at a lower, safer dose. Finally, the question of benefit must be addressed frankly. In a climate where providers feel increasingly under pressure to reduce the amount of opioid they prescribe, it is sometimes difficult to recognize when the perceived benefit to the provider outweighs the actual benefit to the patient.

## Slide 19

*Goal: Refer to Slide 14 to review a comprehensive approach to pain care.*

The slide is titled "BIOPSYCHOSOCIAL PAIN CARE: The Comprehensive Approach". It is divided into two main columns. The left column is titled "Formulate Your Global Plan for Treating Whole Patient" and is further divided into "Psychological / Behavioral" and "Physical Measures". The right column is titled "Options for Referral / Management" and lists various referral options. At the bottom, there are logos for VA, the U.S. Department of Veterans Affairs, and MIRECC, along with the number 29.

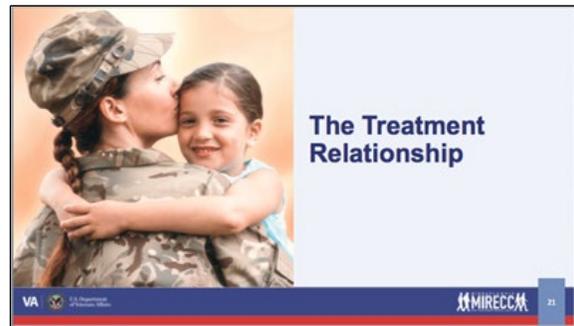
Formulate Your Global Plan for Treating Whole Patient	Options for Referral / Management
<p><b>Psychological / Behavioral</b></p> <p>Behavioral pain management is not just "the last resort"</p> <ul style="list-style-type: none"><li>• Primary history or secondary to pain</li><li>• Playing a role in compliance concerns?</li><li>• Substance / Alcohol Use Disorders?</li></ul>	<ul style="list-style-type: none"><li>• General Mental Health (Psychology and / or Psychiatry)</li><li>• Health Psychology (pain, obesity management, etc.)</li><li>• Substance Use Disorder Clinic for addiction concerns</li><li>• Diabetes</li><li>• Pain Clinic</li><li>• PM/BAO, physical medicine, mobility support, PT/OT/RT, acupuncture, chiropractic, etc.</li></ul> <p><b>DIPIC E-Consult for PCP managing pain:</b></p> <p>Refer Consult → Pain Consult (229) → DIPIC Interdisciplinary Pain Management E-Consult Recommendations (925)</p>
<p><b>Physical Measures</b></p> <ul style="list-style-type: none"><li>• Stimulation</li><li>• Specialty Pain Care (injections)</li><li>• Surgery</li><li>• Pharmacotherapy – pharmacy consult?</li></ul>	

*Background:* In some cases, specialty Mental Health referral may be needed to properly address presenting comorbidities; however, it is important to utilize your own embedded team. If an issue is outside of the provider's scope of expertise or comfort level, referrals may be required. Consultation with the PC-MHI team (Primary Care-Mental Health Integration) psychologists, psychiatrists, mid-level providers, and social workers can help prevent unnecessary specialty referrals, and may result in more timely service to the patient. The PC-MHI team can provide treatment support for primary MH concerns, help assess a patient's need for specialty referral (e.g., patient with primary presenting concerns such as PTSD and/or alcohol/substance use), and may offer specialty pain management support (e.g., CBT for Chronic Pain).

## Slide 20

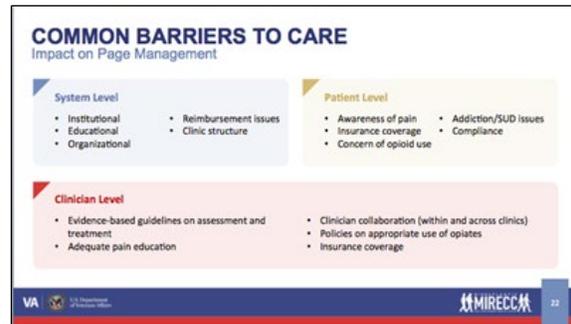
*Goal: Transition slide.*

*Speaker Switch: Health Psychology (slides 20-27)*



## Slide 21

*Goal: Identify and explain common barriers to care on the system, patient, and clinician level*



*Background:* Identifying barriers to effective pain care is essential to improve pain management. There are three major sources of potential barriers: the health care system, the patient, and the clinician.

On a system level, institutional policies designed to make prescribing and administration of opioid analgesics safer may have the unintended effect of restricting access to these analgesics. Formulary restrictions may limit analgesic choices. Policies for automatic stop orders designed to prevent ongoing administration of controlled substances prescribed for acute pain might result in interruptions of the same agents when being used for cancer-related chronic nociceptive pain. Inadequate or inconsistent education of administrators and supervisors about resources needed to provide good pain care is another common problem. Lack of administrative support for staff education and training in pain management may also be a barrier. From an organizational standpoint, the lack of a strong inter-professional and multidisciplinary oversight committee for pain management may lead to lack of coordination of activities, policies, and procedures for pain care. Reimbursement for non-pharmacological pain management modalities may be limited or unavailable depending on insurance plan coverage. Some non-pharmacological or newer, more expensive medications might require prior authorization procedures. Finally, clinics are frequently structured to accommodate many patient visits per day with as little as 10-15 minutes spent with each patient. Pain care is often one of several chronic or acute problems that must be addressed in a short period of time. Models that allow for more inter-professional interaction between patients, including nurses, pharmacists, psychologists, and primary provider (physician, physician assistant, or nurse practitioner) could provide more opportunities for pain care.

Patients seeking pain care may present barriers to their own care. One common problem is an individual patient's awareness of their pain. Patients with longstanding chronic pain might have markedly impaired function but not associate their chronic pain and use of pain medications as contributors to functional decline. In addition, stoicism or lack of stoicism related to reporting pain or pain intensity is highly individual. Patients with neuropathic pain describe symptoms that are not common pain symptoms such as burning, numbness, tingling or itching. Insurance reimbursement issues such as whether the insurance covers a specific treatment and the deductible/copy will also affect the patient.

With increasing media coverage of prescription drug overdoses, patients may have a fear of opioid use or a fear of becoming addicted to opioids. Conversely, patients with prior or concomitant substance use disorders have a greater risk for developing an opioid use disorder. Patients might also be resistant to complying with or adhering to treatment plans, taking medication in ways other

than prescribed, skipping required urine drug screening, forgoing physical therapy exercises, or missing appointments with the psychologist for group or individual sessions.

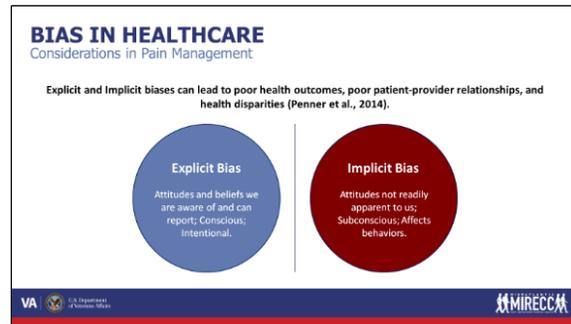
Clinician-level barriers include the relative lack of a strong clinical evidence for pain assessment and treatment, especially for chronic non-cancer pain. Nonetheless, there are several evidence-based and expert opinion-based practice guidelines that were recently released. The Centers for Disease Control (CDC), the American Pain Society, and the American Society for Clinical Oncology were among the organizations that released new guidelines. A 2007 evidence-based guideline on diagnosing and treating low back pain was vetted with new research findings. Recent studies reveal that there is poor adherence to evidence-based guidelines for managing chronic non-cancer pain. Better education for clinicians in pain management starting during professional education programs and continuing into post-graduate training and beyond is important to assure that clinicians learn and incorporate up-to-date, evidence-based practices into their own professional practices. This may be reinforced through professional collaboration within and across clinical settings. Finally, there is a need for improvements in insurance coverage for non-pharmacological, evidence-based treatments for chronic non-cancer pain, including various physical medicine techniques, acupuncture, and psychological techniques such as cognitive-behavioral therapy.

These are some examples of the factors that make effective pain management difficult:

- On the “System Level,” primary care clinics are not set up well to deal with pain management, with brief appointments (20-30minutes) every six months standard, which is often insufficient time to manage complex pain, especially when there are competing interests (diabetes, hypertension, heart disease, medication reconciliation, clinical reminders) to be addressed during the visit.
- On the “Patient Level,” patients often underestimate the psychological aspects of chronic pain, have unrealistic expectations of pain management, and struggle to take an active role in their pain management.
- On the “Clinician Level,” there is substantial pressure by organizations (VA, CDC, State Medical Boards) to limit opioid use. Prescribers often feel lack of support when making difficult decisions contrary to patient’s wishes, often with limited ability to refer to pain clinics, and with arguably vague guidelines on how to approach pain management dilemmas in the clinic. Insight and awareness regarding implicit biases is also needed.

## Slide 22

*Goal: Explain different types of explicit and implicit biases for both patients and providers*



*Background:* All of us have biases (patients and providers) that are important to recognize because they can have significant negative clinical impacts and they contribute to health disparities. The perception of provider biases and discrimination is associated with many deleterious psychological and physical health outcomes. Specifically, provider bias and discrimination are associated with delays in seeking care, mistrust in provider/system, poor patient satisfaction, patient stress, poor adherence to treatment, and lack of continuity of care.

**Bias in Communication:** Given the importance of patient-provider communication due to its predictive association with treatment adherence (Zolnieriek & Dimatteo, 2009), it is important to better understand biases in communication. Factors contributing to poor communication include implicit and explicit biases.

There are several other types of biases providers should be aware of, including but not limited to:

- Bias against weight/obesity: 53% of overweight/obese patients report inappropriate comments from their doctors (Puhl & Brownell, 2006) and 50% of providers viewed obese patients as awkward, unattractive, ugly and non-compliant (Foster et al., 2003).
- Bias against sexual orientation (LGBTQ): 25% of lesbian women delay pap screening due to fear of discrimination in clinical care (Tracy et al., 2010); 25% of sexual minority patients in VA avoid seeking care due to concern about stigma (Simpson et al., 2013).
- Bias against race: Race-based discrimination results in poor patient satisfaction, poor adherence to physician recommendations, poor general health and mental health.

Less studied scientifically but reported on anecdotally is the impact of patient bias on providers. Discrimination based on race, sex, gender, age, religion, and sexuality can impact the psychological and physical well-being of the provider and can also lead to disparities in health care via a rupture in rapport. According to a recent WebMD survey (2017), approximately 59% of physicians report having experienced discrimination from patients. Many of these providers also report that their patients requested another provider based on a cultural variable (e.g., race). Unfortunately, there is little direction or guidance on how to rectify situations like these. Some scholars suggest top-down efforts aimed at educating and training faculty members on ways to address patient bias. Additional recommended reading: Tweedy, 2015.

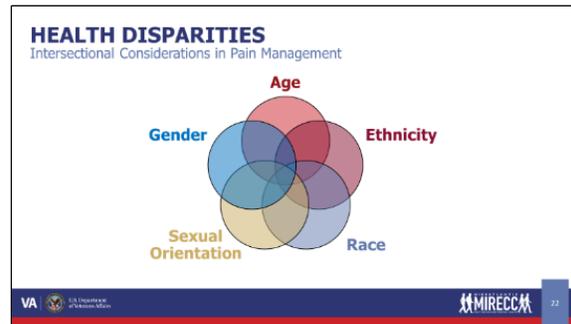
Some biases are explicit, such as attitudes and beliefs we have about a person or group on a conscious level. Others are implicit, such as attitudes and stereotypes that operate below conscious awareness and without intentional control. Explicit biases are easy to recognize and thus address. However, implicit biases require effort to identify, recognize, and evaluate.

Left unchallenged, implicit biases can surface without awareness, particularly during times of fatigue, sleep deprivation, stress, time pressure, multi-tasking, etc. These are times when we are not paying attention to our biases, and we are likely to be on “auto-pilot.” These biases can then, in turn, influence our behaviors.

There are several websites that test implicit attitudes. Here is one that can be used to explore biases: <https://implicit.harvard.edu/implicit/selectatest.html>

## Slide 23

*Goal: Explain how biases in treatment, as mentioned in the previous slide, can lead to health disparities between sexes, ages, and ethnicities. Give examples*



**Background:** The Institute of Medicine’s (IOM) definition of health disparities is, “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (Stith and Nelson, 2002, p. 32). Importantly, disparities can occur due to other factors such as gender, socioeconomic status, and sexual orientation as well (Fredriksen-Goldsen et al., 2014; Joynt et al., 2013; Weber & Parra-Medina, 2003).

**Race/Ethnicity/SES:** It is well documented that as a result of biases, certain racial, ethnic, and socioeconomic groups are more likely to receive poorer quality pain care and management (NIH, Disparities in Pain Care). For example, Black Americans are less likely than White Americans to receive analgesic medication for pain, and primary care providers are more likely to underestimate pain severity in Black Americans compared to other sociodemographic groups (Joynt et al., 2013). In addition, Black patients are more likely to be referred for substance abuse assessment, receive more urine drug screens, and receive fewer referrals to pain specialty clinics (Hausmann et al., 2013). There is literature also documenting disparate pain treatment for Latinx (e.g., Bonham, 2001). For example, Latinx patients with long bone fractures are also less likely to receive pain medication than non-Hispanics in an emergency medical setting (Todd et al., 1993, 1994). People with incomes below poverty line are more likely to report pain, and opioids are more likely to be prescribed to those with the highest socioeconomic status in the Emergency Room (IOM, 2011; Joynt et al., 2013).

**Sex/Gender:** Chronic pain prevalence is higher in women than men, although women may be at risk of under-treatment of pain. Gender biases likely play a role in some pain-related health disparities. For example, studies that ask providers to evaluate vignettes of fictional patients tend to reference psychosocial factors more often (Hamberg et al., 2002), make more non-specific diagnoses (Hamberg et al., 2002), and are more likely to recommend antidepressant medications for women than analgesic medications (Hirsh et al., 2014). With respect to pain treatment, women also respond differently than men to interdisciplinary pain treatment programs and are more likely than men to utilize complementary and alternative modalities for pain management.

Gender-informed pain care is important. In addition to the gender differences mentioned, other considerations include mental health comorbidities and specific needs of women of child-bearing age and pregnancy, during menopause, and postmenopausal. Hormonal changes play a role in pain intensity and can impact weight and increase several painful conditions.

**Sexual Orientation and Gender Identity:** Sexual minorities are at higher risk for some pain conditions (Cochran and Mays, 2007; Roberts et al., 2013; Sandfort et al., 2006; Katz-Wise et al., 2015) and for pain-related functional impairment (Case et al., 2004) than heterosexual individuals. Reasons for this increased risk may be explained by greater risk for depression and minority stress (Meyer, 2003) which results from prejudice and discrimination. Some scholars have also noted that childhood abuse might play a role in pain disparities between sexual minorities and heterosexual individuals (Roberts et al., 2013). However, the research on sexual minorities and specific pain-related health disparities are not yet clear. One contributing factor to increased risk for pain could be related to limited access to health care, as sexual minorities are twice as likely to be unemployed or uninsured compared heterosexuals (Charlton et al., 2018). The research on transgender patients and pain-related health disparities is also not clear. Based on existing health disparities research, it can be surmised that transgender patients may be at-risk for pain disparities. For example, compared to other sexual minorities, transgender patients are less likely to have health insurance (U.S. Department of Health and Human Services, 2013). In addition, knowledge and awareness regarding transgender health issues plays a significant role in the healthcare experience of transgender patients.

**Intersectionality:** While understanding the various health disparities experienced by different minority groups, an intersectional lens (how identities overlap) is of utmost importance to fully understand patient's lived experiences. For example, a gay Black woman's experience will be different compared to a Black woman.

## Slide 24

*Goal: Explain the VEMA framework for interviewing patients*



**Background:** This framework for interviewing is meant to be used to develop and maintain productive patient-clinician relationships. Anthony Mariano developed the VEMA tool, which can be used for navigating difficult conversations. VEMA stands for Validation, Education, Motivation, and Activation. It uses fundamental principles from Motivational Interviewing to validate the patient's experience so they can effectively hear new information and engage in the change process. Dr. Mariano recommends the following when communicating with patients:

**Validation:** People need to feel validated about their experience. Until they do, they won't be able to move forward in the process of accepting change or receiving new information. The patient's experience can be validated by reflecting emotional response. Providers do not have to agree with the patient's perception, but they do need to validate their pain experience and recognize that the patient's pain is real.

**Educate:** Patients with chronic conditions such as pain should have realistic expectations about improvement. In addition, these expectations should be discussed in terms of best-practice guidelines which include risk/benefit of specific treatments. Educational information may begin with non-opioid based modalities.

**Motivate:** Motivational Interviewing strategies can be used to help patients move toward self-management strategies. The use of open-ended questions can be used to help the patient develop an agenda and make a collaborative plan moving forward.

**Activate:** Work together with the patient to set goals and actively create opportunities for the patient to take control of establishing their own action plan. Active involvement in action planning will increase the likelihood of engagement and action-taking.

\*VEMA comes from Anthony J. Mariano, PhD Clinical Psychologist, Pain Service VA Puget Sound Health Care System

### **Further Resources:**

[professional.oregonpainguidance.org/online-resources/difficultconversations/](https://professional.oregonpainguidance.org/online-resources/difficultconversations/)

## Slide 25

*Goal: Explain the stages of change that lead to opportunity and action*



*Background:* This slide is to introduce the concept of motivation when considering behavioral changes. Motivation is an internal, unstable, and therefore changeable state: Internal + Unstable = Changeable.

Ambivalence is normal when contemplating more adaptive behavioral changes. Sliding between stages is also expected, *even with highly valued targets.*

### **Stages of Change Model (Prochaska and DiClemente)**

**Precontemplation** - In this stage, people do not intend to act in the foreseeable future. People are often unaware that their behavior is problematic or produces negative consequences, and often underestimate the pros of changing behavior, placing too much emphasis on the cons of changing behavior.

**Contemplation** - In this stage, people are intending to start the healthy behavior in the foreseeable future. People recognize that their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both. Even with this recognition, people may still feel ambivalent toward changing their behavior.

**Preparation (Determination)** - In this stage, people are ready to act within the next 30 days. People start to take small steps toward the behavior change, and they believe changing their behavior can lead to a healthier life.

**Action** - In this stage, people have recently changed their behavior and intend to keep moving forward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors.

**Maintenance** - In this stage, people have sustained their behavior change for a while and intend to maintain the behavior change going forward. People in this stage work to prevent relapse to earlier stages.

## Slide 26

*Goal: Describe how to facilitate productive conversations with patients to increase their functioning and motivation.*

**MOTIVATE**  
What's the Target?

**Rarely are People 100% Unmotivated**

- Listen for values and fears
- Discuss discrepancies Between goals & behaviors
- Your job ≠ policing bad behavior or convincing

**Primary Goal = Functional Improvement**

- Significant individual difference in how this is defined
- Emphasize the patient's values
- Identify behavioral goals that map onto **valued** functional targets

Sellsch, Miller, & Butler (2008)

VA U.S. Department of Veterans Affairs MIRECC 27

*Background:* Rarely are people 100% unmotivated to change. We can use strategies to better understand where they are and to help facilitate change behaviors. Motivational Interviewing is a collaborative conversation to strengthen a person's own motivation for and commitment to change (Miller and Rollnick, 2009).

Facilitating a conversation using the MI “spirit” involves the following:

- 1) A collaborative partnership, a relationship built on shared understanding
- 2) An evocative approach to help patients identify their own motivations and capacity for change (instead of simply telling a patient what to do and why)
- 3) Honoring patient's autonomy, recognizing that change lies in the hands of the patient

### MI “RULE”:

*Resist the righting reflex* – Most practitioners have the desire and knowledge to fix situations in order to help their patients. However, a natural human tendency is to resist attempts by others to make one change. A clue that an interaction is not going well is if you and your patient find yourselves on opposite sides of the argument for change (for and against). It is best if you guide your patient to articulate arguments for change, which makes change more likely. Consider yourself a tour guide.

*Understand your patient's motivations* – People perform actions because they can (efficacy expectation) and because they think the action is worth doing (outcome expectation). Ambivalence about change is a normal part of the change process. To understand what the patient is motivated by, explore the patient's perceptions of benefits/drawbacks of making a change versus maintaining the status quo. Elicit discrepancies. Ask your patient why they would want to make a change and how they might do it.

*Listen to your patient* – This conveys empathy and provides you with important information about how the patient feels about change. Empathy involves seeking to understand another person's perspective, thoughts and feelings without judgment. This does not mean that you agree with the behavior. When patients feel understood, they are more open to discussion about change. Reflect what the patient is saying to communicate your understanding and allow the patient to clarify as needed. Choose what you reflect/summarize depending on how you would like to guide the conversation, including both resistance talk and change talk.

*Empower your patient* – The patient is the consultant on his/her own life. Utilizing a collaborative stance will help the patient feel more invested in treatment and more likely that they will follow through. Offer options from which the patient can choose. Express hope for the future in which change is possible.

***Aspirations for Behavior Change (ABCs)*** – Patient vs. provider-defined is critical to foster motivation for change

Explore the patient's perceptions of benefits and drawbacks of making a change versus status quo. Questions that can be elicited:

- What are the advantages of doing X? What is the downside / what might make it hard?
- What do you think will happen if you don't change anything / stay on the current path?
- Develop discrepancy between current behavior and future goals.

Depending on what stage of change the patient is in, the following open-ended questions can be helpful to stimulate change talk:

- Why do you want to work on your pain? (Desire)
- How might you go about increasing your physical activity? (Ability)
- What do you see as the benefits of X? (Reasons)
- How important is it for you to? (Need)
- What will you do to help you achieve? (Commitment)
- What are you considering doing? (Activation)
- What have you already done? (Taking steps)

Expect resistance to change: patients want YOU to change. They want medical solutions that they believe are possible. They do not want to change themselves. View resistance as a product of the patient/provider interaction, rather than a characteristic of the patient. Do not argue – instead, change strategies. People may be more ready for one adaptive behavior than another. For example, begin a walking program but do not lower opioid regimen.

If the patient says, "I can't because of pain" and believes their pain must be relieved before any positive change can occur, this will maintain the focus on urgent pain relief and is responsible for the iatrogenic cycle. Patients can, but they will not. Explore reasons why (short term benefit, long term costs) and create discrepancy between contradictory statements a patient makes about where they want to go and their continuation of maladaptive behaviors. Identify barriers and strategies to address barriers. The goal is to educate and inform, not to persuade. Roll with the resistance and reflect back concerns, reframe problem, or shift topics.

## Slide 27

*Goal: Summarize information presented in the didactic module*



*Background:* The topics covered during today's presentation included an explanation of the biopsychosocial approach to chronic pain care with an emphasize on motivational enhancement strategies to facilitate behavioral change, a discussion about functional assessments and case conceptualization, the importance of clinical documentation, barriers to pain care management, and a discussion about effective communication strategies.

This training addressed some of the common complexities and challenges of effective chronic pain management, particularly in the VA Health Care System. We hope that we have provided a substantial amount of information that providers can use in their own clinical practice and ultimately increase their confidence in providing pain management care.

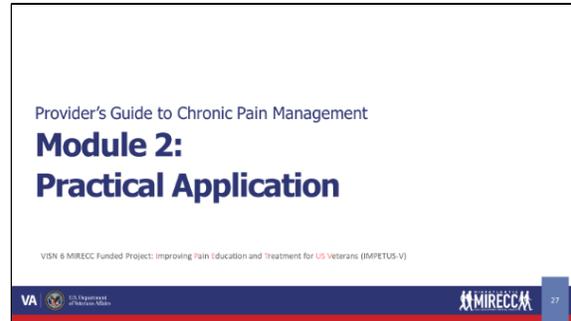
There are two more components to this training, both of which involve practical application of common situations. The next hour will be devoted to discussion of clinical vignettes. The final hour will be an opportunity for providers to bring their own cases to discuss with a team of pain experts.

# Vignettes: Module 2

## Slide 28

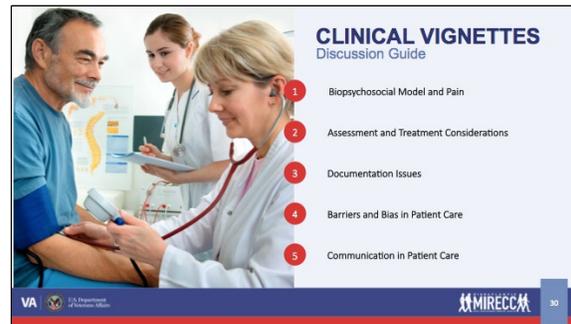
*Goal: Transition slide*

*Speaker: Full Interdisciplinary Panel*



## Slide 29

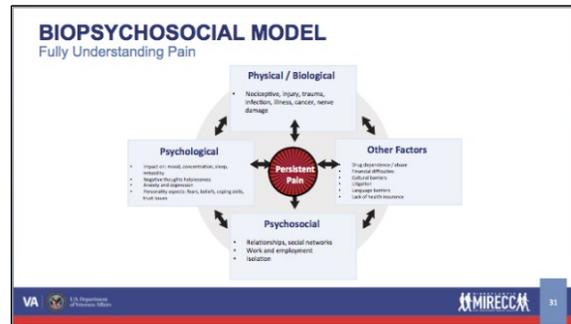
*Goal: Transition slide*



*Background:* This session will be spent discussing several clinical vignettes. Encourage attendees to recall the didactic training portion of this training, and conceptualize each case using the biopsychosocial model. Consider functional assessments and treatment considerations, barriers to care the patient may be facing, as well as individual and patient biases. Also, consider what will be important to document in the electronic health record. Finally, consider effective communication strategies.

## Slide 30

*Goal: Review the biopsychosocial model*



*Background:* This is the biopsychosocial slide presented earlier. Recall that persistent or chronic pain is a complex interaction of physical/biological, psychological, and psychosocial factors. Also recall why the biomedical model is not the most effective treatment strategy for chronic illnesses like chronic pain conditions.

The biomedical model fails for chronic pain. Stages of this unproductive cycle are re-listed below:

**Hopeful:** Belief that medical solutions are available if the pain is “real.”

**Doubtful:** Standard biomedical treatments fail because they are not sufficient in managing pain “illness” vs. “disease.” Providers doubt that patients have “legitimate” pain. Patients become frustrated from lack of validation and doubt their provider’s ability to help “fix” their pain.

**Hopeless:** Providers give up or give in.

*Give in:* One may provide treatments that are not clearly empirically driven, or that s/he doesn’t believe in. These are non-rational treatments that reinforce erroneous beliefs in medical solutions and expose people to unnecessary and excessive risk.

*Give up:* Concluding that there is nothing to offer and rejecting the patient. Patient moves on to a new doctor and the cycle is perpetuated, beginning with increased frustration and stressful presentations from/by the patient.

# Slide 31

*Goal: Conceptualization of a patient with chronic pain*

**CASE 1:**  
UDS Issues / Discussing UDS Results



46-year-old Black American male combat Veteran, service connected (50%) for PTSD and back injuries. Unemployed secondary to pain condition. Patient is status post motor vehicle accident 10 years ago with whiplash and back strain, and complains of low back pain (LBP) since military due to "lifting and training". Chronic LBP for over 15 years, currently with unclear etiology. Pt describes pain as constant and debilitating, radiating pain through right hip to calf.

**Treatments:** Methadone (5mg tid), Hydrocodone (10mg q6hrs PRN); status post L5/S1 Hemilaminectomy/Discectomy (2010) and lumbar epidural steroid injections (minimal benefit). Frequent ED visits for pain (injections, supplemental opioids).

**UDS:** Negative for all substances.

VA U.S. Department of Veterans Affairs MIRECCA 30

*Background:*

**Anesthesiology Perspective:** Methadone is detected on Durham VAMC Urine Drug Screens (UDS) as a specific item. Hydrocodone metabolites are well detected as part of the general opiate line. Why is his UDS negative? Is he not taking it? Is he taking more than prescribed and running out? Is he hiding illicit substance use by providing a urine specimen that is not his? Irrespective of the UDS result, it appears that the patient is not deriving great benefit from the opioids (unemployed due to pain). Why does he continue to take opioids? Is this addiction? Is this a pseudo addiction (undertreated pain)? Does the opioid help somewhat with his PTSD symptoms? Is he diverting the opioids as a means of earning a living? Some combination of the above? Examine your own biases as you answer these questions.

**PCP PERSPECTIVE:** I am concerned that this patient is going down a bad path. He's unemployed; is he active? What is he doing all day? Why is he supplementing opioids in the ER? Is his PTSD undertreated, exacerbating his pain? Has methadone prescriber had clear discussion with patient over opioid safety (including need to get opioids from only one provider)? If I am his primary care provider, I'm thinking about these general issues, but the two issues I have to address today are (1) coming up with plan to deal with pain flares and setting firm boundaries against getting supplemental opioids in ER for his chronic pain; (2) what is the reason for this unexpected UDS result?

If the patient is unable to use opioids safely, he is at higher risk for bad outcomes, and opioids may need to be discontinued. Getting opioids in the ER for chronic pain is not a safe or sustainable pain management plan. Discussing what leads him to these ER visits may shed some light on what is happening (PTSD? Consistently undertreated pain? Craving more opioids? Overdoing activity?) and help develop an alternative treatment plan.

The UDS results are concerning if he is overusing opioids and runs out prior to UDS, but it is difficult to reach a certain conclusion. Methadone needs a specific test at our VA, and it is unclear from this narrative if this was part of the UDS ordered. It is also possible that qualitative UDS results can be negative even when hydrocodone and methadone are being taken as prescribed. If possible, the urine sample (which our lab holds for 14 days) should be re-run for specific methadone and hydrocodone quantitative levels.

**PHYSIATRY PERSPECTIVE:** Patient has had pain since he was about 30 years old, worsened with a motor vehicle accident around age 35. What type of employment did he have, and what currently does he do all day? Does he have a family and what is the care structure? Does he have a

daily routine and how does he manage his activities of daily living? What is his walking, sitting, and standing tolerance? Do the medicines help him do any of these tasks better or longer? Does he have any exercise routine? From a goal setting perspective, what would the patient like to accomplish that is limited by his back pain and what are barriers to care? Has he had any prior physical therapy treatments and if so, what was his engagement, treatment, and response? In addition, he has right hip to calf pain and prior surgery to his back and prior injection to his lumbar spine- it is a possibility that the target was wrong. Sacroiliac joint pain can cause radiating symptoms in the same distribution and would be unaffected by the prior treatments.

**PHARMACIST PERSPECTIVE:** There is no mention that adjuvant medications were ever tried. I suggest a trial of gabapentin titrated to at least 1800 mg a day and possibly up to 3600 mg a day if it is effective. Alternatively, venlafaxine titrated to at least 150 mg a day or duloxetine titrated to 60 mg a day could be considered. General recommendations for treating moderate to severe neuropathic pain is combination therapy with a gabapentinoid (gabapentin or pregabalin) with either a TCA (amitriptyline, nortriptyline, etc.) or an SNRI (duloxetine or venlafaxine) (Finnerup et al. 2015), though I would not recommend a tricyclic antidepressant first line in this case due to the interaction with methadone [both drugs prolong QT interval (QTc)].

Methadone has been widely associated with QT interval (QTc) prolongation and potentially torsade de pointes (tachycardia), however, is often the result of multiple factors, including hypokalemia, structural heart disease, and combination with other medications with such effect (Krantz et al. , 2009).

At DVAMC, methadone should be detected in a UDS, and 40 mg/day of hydrocodone might be detected. Before speaking to the patient, the next step is to have the lab recheck the same urine sample with specific assays for methadone and hydrocodone and their metabolites. The specific tests have lower thresholds and may be positive. If one or both tests remain negative, the provider should discuss the results with the patient.

**BEHAVIORAL MEDICINE PERSPECTIVE:**

I am wondering if he is engaged with Mental Health for his PTSD symptoms. Are these symptoms effectively managed? Is he possibly using opioid medication to manage his PTSD symptoms? There are other, much more effective treatments for PTSD, and I'd like to discuss those with him, including the possibility of exposure-based therapies. I would also want to make sure he has a naloxone kit for an accidental opioid overdose. I also wonder if he has any other comorbid psychiatric diagnoses, such as depression and/or anxiety. Again, there are effective treatments for all these disorders if he is using medication to treat depression and anxiety symptoms. Similarly, I wonder about his function. Is he engaging in activities that enjoys? Is he doing any activities? What about positive (or negative) health behaviors? Does he have a strong social support network? I would consider some behavioral activation strategies to facilitate engagement, and perhaps referral for psychologically-informed Physical Therapy. We would also want to explore whether the patient is diverting or mis-using medication. Frequent trips to the ED for pain treatments could suggest his pain is undermanaged, but it could also suggest diversion, or a substance use problem. We could uncover an Opioid Use Disorder which would require referral to Substance Use Disorder treatment.

## Slide 32

*Goal: Explain the perspective of each specialty on UDS implementation*

**PROPER UDS IMPLEMENTATION**  
Knowledge is Power

Drug	POS on Opioid Screen?
Morphine	YES
Codeine	YES
Hydrocodone*	YES*
Hydromorphone	Likely
Oxycodone	Unlikely
Methadone	NO
Fentanyl	NO
Tramadol	NO

**Frequency Should Match Pt-Specific Risks**

- MINIMUM = ONCE YEARLY

**Primary Options at DVAMC:**

- Drugs of abuse (methadone now included)
- Extensive panels (use selectively):
  - \*PAIN MGT, Opiates
  - \*PAIN MGT, Drug Screen

**What Does UDS Tell Me?**

- Don't overestimate utility of the UDS!

VA  MIRECC  33

*Background:* The urine test is only one of many facts that should be considered when making decisions about opioid prescribing. Understand the technical limitations of the urine test used at your site. Always bear in mind that the information a urine test provides is limited to the presence or absence of a substance (within the detection limits) and says nothing about the patient actions that caused that result. Base discussions on what you know (“The urine test didn’t show any methadone in your urine”) rather than what you may believe (“you aren’t taking your methadone”).

## Slide 33

*Goal: Conceptualization of a patient with chronic pain*

**CASE 2:**  
Taper / Discontinue Opioid?



70 year-old White American male, divorced, unemployed, Vietnam Veteran, 100% service connected for various medical diagnoses and PTSD. On active duty, stepped in a hole and injured right knee and lower back, and complains of chronic low back pain worsening over the past 10 years. Remote history of Alcohol Use Disorder (AUD), treated in outpatient substance use disorder (SUD) clinic 5 years ago. Mostly sedentary, states "I don't like people so I just sit home and watch TV."

**Treatments:** Physical therapy twice, now refused because of worsening pain with movement; Oxycodone 120 MME/d for more than 15 years.

What assumptions come up? Missing data?

VA  U.S. Department of Veterans Affairs  33

*Background:*

**ANESTHESIA PERSPECTIVE:** We don't know what the patient was being treated for in SUD clinic; this would be helpful information. The amount of oxycodone he is prescribed is enough that he is not really taking it PRN. Would he be better off on a long-acting opioid? What benefit is he having from the opioid he is taking?

**PCP PERSPECTIVE:** This is a complicated presentation. Why is he really on opioids? My first concerns are that this patient may be using oxycodone to escape emotional distress, not to treat chronic pain. Would be good to know if he is drinking any alcohol now, and if he is receiving treatment for PTSD. How functional is he now compared to 15+ years ago before the oxycodone? If he is less functional now than he was back then, his pain management treatment plan is not working. He's on a relatively high opioid dose and given CDC Guidelines recommend weaning down below 90 MME when possible, it is important to initiate this conversation with the patient today, reviewing in detail potential risks and asking patient about perceived benefit of current opioid regimen. At this point I don't have enough information to feel a wean down/off opioids is mandatory, but dose increase is not indicated.

**PHYSIATRY PERSPECTIVE:** What movement makes his pain worse? Is it untreated knee OA pain that is affecting his back? Is it worsening back pain and if so, where along the back hurts? Some patients describe "back pain" but then point to their buttocks; others describe "hip pain" but then point to their lumbar spine. With a history of Alcohol Use Disorder, could this patient have hip joint femoral head avascular necrosis that is presenting as "back pain" but is really located in the buttock?

In addition, I would like to know this patient's prior level of function (ambulation, activities of daily living), and level of function now that he is complaining of worsening pain with movement. What was PT working on? Did the patient feel he had a therapeutic relationship with the therapists? What did the patient find was beneficial versus painful in physical therapy?

What image does this "70-year-old divorced unemployed" man invoke? What is the reality? Does he have family, or does he have to care for himself? What care needs does he have, and what are his goals?

**PHARMACIST PERSPECTIVE:** AUD history presents risks for problems with other substances. I would like to know whether this veteran still uses alcohol or if he has remained abstinent. PTSD may not be adequately treated, and this does interact with our ability to manage this veteran's pain. Sedentary lifestyle likely does not help this veteran's pain and might be

exacerbated by high-dose (per CDC definition) chronic opioid therapy. Pain begs for a diagnosis to allow for better targeting of pharmacologic and non-pharmacologic therapies. It would be important to check for adverse reactions of opioid therapy, check UDS and Prescription Drug Monitoring Program (PDMP). If this Veteran is getting worse and not better on chronic opioids, a long, slow taper could be considered to determine if the opioids are still having a positive effect or if they are just contributing to problems and causing side effects. It would also be important to rule out hyperalgesia due to opioid therapy in this patient. If this patient now has Opioid Use Disorder (OUD) he could be a candidate for buprenorphine therapy. Addition of adjuvant pain medications could improve efficacy of opioid analgesics. Opioid rotation might be useful if the liver is functioning well (liver function tests within normal limits). Some opioids, specifically, morphine and codeine are heavily metabolized by the liver. Also, if actively consuming alcohol, combination products with acetaminophen should not be considered.

When discussing this it is important to let learners know that while taper or discontinuation could be considered, continuation of chronic therapy at current dose might still be appropriate.

#### **BEHAVIORAL MEDICINE PERSPECTIVE:**

It is not clear if the Veteran's PTSD is well managed, or if he is currently receiving treatment for it. It's possible that his current opioid medication regimen is being used to manage his PTSD symptoms in addition to symptoms of chronic pain. He is currently isolating from others ("don't like people, so I sit at home and watch TV") so I'd like to know more about that. Is he depressed? Is he seeing a mental health provider? Could he benefit from additional psychotropic medications and/or psychotherapy? He could probably learn better pain coping skills and develop a better understanding how his mood impacts his pain and vice versa. Behavioral activation and motivational interviewing/enhancement approaches are likely warranted. I wonder if his medications are managing his pain effectively, as he is isolating, and refusing physical therapy due to increased pain. Should he be on reduced opioids? Perhaps he's experiencing hyperalgesia. He would certainly need a naloxone kit. I also want to assess for suicidal ideation, and learn more about any history of suicide attempts, current plan or ideation.

## Slide 34

*Goal: Conceptualization of a patient with chronic pain*

**CASE 3:**  
Aberrant Behavior



54 year old Black American female, single, unemployed for medical disability, 70% service connected. Chronic history of diffuse body pain, and intermittent flares in low back and bilateral lower extremity. Chronic history of mental health treatment, with diagnoses of Borderline Personality Disorder and Major Depressive Disorder. At least 1 psychiatric admission (8 yrs ago) for suicidal ideation. Followed by psychiatry (sertraline), intermittent compliance.

**Treatments (pain):** Hydrocodone (5mg q6 hrs PRN) x 15yrs. Pre-visit UDS positive for benzodiazepines and cocaine.

*Gut reaction? Cultural Considerations? What do you still need to know?*

VA U.S. Department of Veterans Affairs MIRECCA 33

### *Background:*

**ANESTHESIA PERSPECTIVE:** At first, I see what seems to be an essentially hopeless case on all fronts and I doubt I or anyone else can help her. Then I see a patient who, for a variety of reasons (race, gender, borderline personality disorder, drug use (both prescribed and illicit), and disease state of chronic non-specific pain), is at high risk for being dismissed and disregarded by the medical profession. This makes me a bit more optimistic! At the very least I can try not to dismiss or disregard her. I can review her past evaluations and examine her to look for things that may have been missed. Nothing in her history suggests interventional techniques will be appropriate so I have the luxury of time to sit and listen to her. There is great therapeutic value to patients with chronic pain in feeling heard and believed even when there is no biomedical treatment available.

The UDS shows several controlled substances. The cocaine is inherently illicit and as there is no mention of a benzodiazepine (BZD) prescription, this may well be illicit as well. SUD is treatable so I am relieved to have something concrete to offer in a referral to the subject matter experts.

The concomitant use of opioid and BZD is concerning as it presents an increased risk of adverse events, particularly respiratory depression. The cocaine puts her in contact with the illegal drug trade, so I have some concern that the prescribed opioids have potential to end up in that market. If I am prescribing the opioid, my first instinct is to stop prescribing to reduce the opioid-BZD risk. I consider that she has been prescribed opioid for 15 years. Is the cocaine and BZD new or is merely newly recognized? If I stop the prescribed opioid will she use her contacts in the illegal drug trade to substitute a more dangerous opioid? My course of action depends on the answers to these questions and the patients' willingness to address her SUD. I do not want to passively maintain the status quo; I do want to be circumspect about any changes that may destabilize an already marginally functioning patient.

**PCP PERSPECTIVE:** My initial reaction is concern for unacceptably high risk, that I am making things worse by prescribing opioids that this patient may be misusing or trading for illicit substances, and/or that she may be combining opioids and BZD in unanticipated and likely inconsistent ways. I would like to engage her in a conversation on how to most safely manage her pain while engaging in health-promoting behaviors; this is likely to include weaning off opioids and referring for SUD evaluation.

**PHYSIATRY PERSPECTIVE:** I would like to know the time course of her symptoms. What led to her medical disability, and what was the time course of her body pains? What does her home situation and self-care needs look like, and what goals does she have? Are there any triggers to her

body pains and flares of pain in her back and legs? Has she had an evaluation to look for other biomedical causes of pain such as autoimmune disease (as there is concern for race and gender bias and undertreatment of symptoms)? Does she have any daily routine and what are her barriers to treatment? Her case description hints towards fibromyalgia, but as that is a diagnosis of exclusion, to jump to it initially and not complete a thorough history and physical examination would be premature.

**PHARMACIST PERSPECTIVE:** This veteran is at high risk for opioid misadventures! This veteran's multiple mental health problems make her pain symptoms complicated to manage. BZD and opioids do not play well together, and cocaine exposes this veteran to illicit drug use and the potential for obtaining additional non-prescribed substances. The pain described sounds like it could be fibromyalgia which does not generally respond to the use of opioids. Stopping opioids abruptly with the offer of medications to ease any withdrawal symptoms might be an appropriate course of action but could lead to the veteran buying opioids to replace them on the street. Inpatient admission for withdrawal of all substances (opioids, BZD and cocaine) could be warranted if the veteran is willing to participate in an inpatient program and transition to lifelong management. Management of pain with adjuvant agents that have less potential for misuse or abuse is advisable.

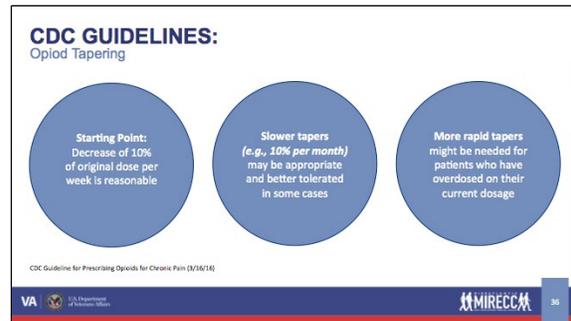
This veteran is currently in an unsafe situation and we should not be perpetuating that. Tapering one drug at a time is the best course and starting with the opioid is probably somewhat easier than dealing with the BZD. Patients with suicidal ideation may threaten suicide if opioid therapy is stopped and some patients may act on the threat. Offering multiple options and strong support with excellent documentation and the support of mental health and other members of this patient's care team is essential.

**BEHAVIORAL MEDICINE PERSPECTIVE:**

This is an opportunity for providers to assess their own potential for bias. This patient has been diagnosed with Borderline Personality Disorder and has a history of hospitalization for suicidal ideation. In addition, she may have a Substance Use Disorder, and could be diverting her opioid medications and purchasing cocaine and benzodiazepines. These are all situations in which provider biases may emerge and could result in suboptimal treatment (e.g., health disparity). Once potential biases have been assessed (and hopefully challenged!) it is important to be able to understand the patient's vantage point; likely hx of trauma, chaos, and challenges in interpersonal relationships. I would explore whether this patient has been engaged in Dialectical Behavioral Therapy (DBT) and I would use these DBT strategies/skills to discuss in the context of chronic pain management. I also would address the cocaine and the BZD in the UDS and explore whether SUD treatment has been tried in the past, and possibly recommend now. I would also ensure that she has a naloxone kit for possible overdose. I would take care to validate what is valid, which is her experience of chronic pain, suffering, and emotional distress. Her pain is real. I would be mindful to her prior psychiatric admission for suicidal ideation and express a genuine interest in supporting her. I would assess for current suicidal ideation and explore her current engagement with mental health treatment (Psychiatry and Psychology). She may be a good candidate for Cognitive Behavioral Therapy for Chronic Pain, as well as other non-opioid, non-pharmacological therapies.

## Slide 35

*Goal: Present the official CDC guidelines for opioid tapering*



*Background:*

Tapering Guidance:

- The 2016 Opioid prescribing guidelines contain advice as to how to wean patients off opioids.
- Generally, decreasing by 10% of the original dose per week is a good place to start.
- Slower tapers over many months may be appropriate for patients on long-term chronic opioids.
- When risks are more substantial, faster tapers may be appropriate.

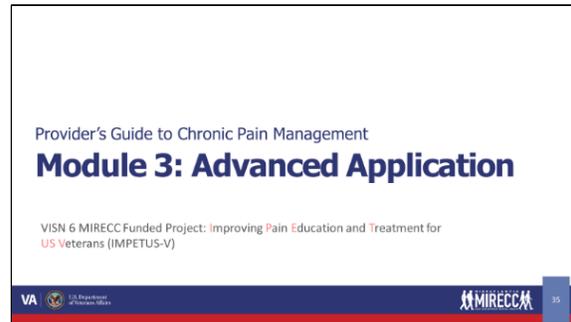
Often prescribers feel uncertain about how to best wean patients off opioids. These guidelines give some helpful suggestions. Ultimately, there usually needs to be negotiation between prescriber and patient to agree on a tapering schedule. It is okay to pause the taper at times if needed, but additional opioids should generally not be used to help ameliorate any type of withdrawal during the taper. Few patients get to their current dosage overnight and reduction will, likewise, take time. Reduction is not an end to itself, but rather a means to an end: if a patient is not deriving benefit from the opioid, continuation of opioid is pointless and potentially risky (both to the patient and potentially to society); certainly, the risk/benefit ratio approaches infinity the lower the benefit. Tapering may reveal previously unrecognized benefit from the original opioid dose. For example, the patient continues to report 10/10 pain but sees a decrease in function as the opioid is tapered.

# Case Discussion: Module 3

## Slide 36

*Goal: Introductory slide*

*Speaker: Full Interdisciplinary Panel*



## Slide 37

*Goal: Indicate the purpose of the module is to discuss individual provider cases. A brief review of previously presented information will be provided for case contextualization and conceptualization.*



## Slide 38

*Goal: Present guidelines and helpful phrases for negotiating a change in treatment plan with the patient*

**DIFFICULT CONVERSATIONS**  
Considerations in Opioid Management

When benefits no longer outweigh risks, consider discontinuation of opioids.

Ruptures are often part of treatment. Emphasize you will not abandon patient.

*"I cannot responsibly continue to prescribe opioids because I feel that they are causing you more harm than good."*

*"I remain committed to working with you to manage your pain."*

You may not always agree.

Offer referrals (if appropriate).

*"I understand your point. We may have to agree to disagree on this."*

*"I'd like us to bring in a colleague of mine for more support."*

Consider options for care, including opioid replacement therapy and SUD referral for opioid dependence cases.

VA U.S. Department of Veterans Affairs MIRECCA 38

*Background:* Decisions regarding starting/continuing/ending opioids are more emotionally charged than most other medication prescribing decisions, but ultimately these decisions still boil down to assessment of risk/benefit ratio. When the risk or harm outweighs the benefit – just as true for insulin or warfarin as for oxycodone – then the medicine needs to be discontinued. It is best to negotiate this change in treatment plan *with the patient*, but often agreement is not possible, and the patient weaned off opioids will be unhappy about the decision. When we reach a point where we cannot agree, patients will sometimes panic, become angry, or even abruptly leave the exam room. Providers may feel anxious, like they have failed, or feel angry at the patient. It's important to keep in mind that rupture is sometimes part of the treatment relationship. Because we value freedom and autonomy, patients have the right to express disagreement and/or walk out of a visit. Disagreement is not necessarily a problem, assuming the patient is not demonstrating aggressive/threatening behaviors. One of the most critical factors to achieve is to facilitate the patient's ability to feel comfortable coming back for a future visit and knowing that we will be there ready to work with them. So, although agreement may not be possible today, providers can emphasize intention to maintain commitment to the patient's care; *"I am still committed to continue working with you to manage your pain. We can work on this together."*

Providers do not have to prove addiction or diversion. Providers cannot prove pain. Trust, compassion, realistic evaluation of risk to both the patient and society taken in context of their own assumptions, beliefs, and biases, are the art of medicine. It is useful to keep the conversation very patient-centered when having these difficult conversations. Patients may become upset, blaming the provider or the clinic/institution for not caring, for worsening pain, for making life unlivable, for making withdrawal unbearable. Focusing on patient safety, staying patient-centered is what should have led to the decision to discontinue the opioid, and it is also likely the most rational and genuine way that providers can approach these patient discussions. Continue to affirm commitment to work with the patient (this is especially important in the VA clinics, where patients often have no choice except to keep coming back to same clinic, same provider), and do not forget about mental health referrals if needed for anxiety/depression/hopelessness, substance use disorder clinic if opioid addiction/dependence is suspected, or ER if describing acute suicidality. Sometimes there is need to discontinue opioids at the first visit, though in general, these conversations seem to go better once the treatment relationship has strengthened over multiple visits.

## Slide 39

*Goal: Explain the critical elements for documentation of patient history and treatment*

**DOCUMENTATION**  
Critical Elements

1. Diagnosis
2. Treatments Tried & Associated Outcomes
3. Documents & Forms (OIC, PDMP, OTRR)
4. Functional Impact and Analgesia
5. Adverse Effects
6. Aberrant Behavior
7. Urine Drug Screen
8. Functional Goal(s) of Treatment
9. Plan – Continue Current (non-medication) Treatments (List These)

CPRS TEMPLATES: Templates Shared Templates >  
ACS > PAIN Management +/- OPIOID

VA U.S. Department of Veterans Affairs MIRECC 40

*Background:* All of the information in this slide is important to document in the electronic healthcare record. Pain treatment effectiveness documentation is critical for all chronic pain management. There are specific elements of additional documentation that are required for [opioids](#). If medications are not effectively treating symptoms, alternative treatments should be considered. The effectiveness of chronic pain treatments is measured by functional outcome. If patients are functioning well, then the benefit of their current opioid medication regimen may outweigh the risk. This should be clearly documented in the chart.

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