NUTS AND BOLTS OF INTEGRATIVE PAIN MANAGEMENT: USING THE WHOLE TOOLBOX

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The HGTV Model of Pain Management

In some ways, treating pain is like remodeling a house:

- First, you need to do a survey of the house to identify strengths and weaknesses
- Next, you need to sit with the homeowners and learn what works, what doesn't, and what it is that they want after the remodel
- Then, you bring your toolbox and get to work, and you enlist the homeowners to help you
- You might do all the work yourself, but you also might need to call a plumber or an electrician
- Along the way, you are likely to find that your plans need to be altered, and some things that are desired have to be abandoned
- In the end, you have a home that is more functional and better meets the needs of the homeowner

The HGTV Model of Pain Management

- Pain management begins with a complete assessment of the patient
- Goals of care should be jointly determined by the clinician and the patient
- A variety of treatments should be used, and the patient is part of the treatment team
- You can manage the pain yourself, or you might need to involve a specialist
- In applying those treatments, there will be inevitable problems (side effects or lack of efficacy) that will necessitate changing the plan, and some goals may need to be changed
- In the end, successful treatment helps the patient achieve improved function and meet his/her goals

Chronic Pain is a Complex Biopsychosocial/Spiritual Condition

- The biomedical model works well for acute pain, but fails miserably when it tries to explain chronic pain
- Chronic pain etiology is complex and can result from myriad chronic medical conditions—or no medical condition at all
- A model that considers biological, psychological, social, and spiritual aspects of the individual's experience is much more useful in understanding chronic pain and guiding its treatment
- This model explains why people with the same diagnosis may have different experiences of pain

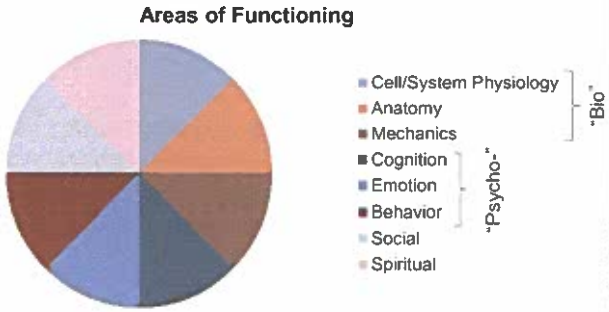
One Graphic Depiction of the Model

Treatment targets impacting one sphere may have indirect bearing on a different sphere

Treatment selection must consider both direct and indirect effects

These are some, but not all, of the things that need to be assessed

The Biopsychosocial Model: What's on Your Plate?



Restoring Balance

- A comprehensive pain assessment considers all these factors, and estimates the extent to which each is responsible for each person's pain experience
- Interventions follow the assessment, and need to be considered in terms of three factors:
  - Which areas of function are affected
  - How much each area is affected
  - The valence of the effects
- A truly integrated intervention plan considers these in aggregate for all interventions

Optimal Treatment for Chronic Pain

- Optimal treatment for chronic pain is multimodal, including a variety of biological, psychological, social, and spiritual interventions
- This kind of treatment focuses primarily on improving function, rather than focusing on pain intensity
- Using multiple types of treatment should reduce reliance on opioid analgesics as a primary means of treating pain and provide better results overall
- Multiple barriers exist to providing this type of care for chronic pain

Policy Responses to the Opioid Crisis

- Unfortunately, most of the policy responses to the opioid crisis—from legislatures, government agencies, and private payers—have focused on limiting the use of opioids
- In essence, if opioids are the hammer in the toolbox, we're being told:
  - What size hammer we can use (dose)
  - How many times we can hit the nail (days' supply)
  - To try using a different tool, even if it is hard to find and outside the homeowner's budget
- We haven't been provided with more tools, leaving us wondering what to do if we can't use the hammer

Comprehensive Integrative Pain Care

Comprehensive Integrative Pain Management includes biomedical, psychosocial, complementary health, and spiritual care. It is person-centered and focuses on maximizing function and wellness. Care plans are developed through a shared decision-making model that reflects the available evidence regarding optimal clinical practice and the person's goals and values.

Consensus definition:
Inaugural Integrative Pain Care Policy Congress, 2017

Proposed Areas of Impact for Some Common Pain Interventions

Intervention	Physiology	Anatomy	Mechanics	Cognition	Emotion	Behavior	Social	Spiritual
Opioids	***			**	**			
NSAIDs	***		**	*				
Pall XRT		***	**	***		*		
Massage	**		**		**		**	
Psycho-therapy	*			***	**	***	**	
Meditation	**			**	**			**
Ice/Heat	*	*	***					
Education				***	**	**		
Prayer				**	**		**	***
Tai chi			***	**	**		**	**

* Minimal Impact ** Moderate Impact *** High Impact

AHRQ Systematic Review, 2018

- Conducted systematic review of noninvasive, nonpharmacological treatment for chronic pain
- Few high-quality studies
- Long-term evidence was sparse
- Several interventions may improve pain or function 1 to 12 months after completion of therapy
- Most effects were small
- No evidence of harms
- Additional evidence needed on sustainability of effects on function and pain

AHRQ Systematic Review, 2018

Interventions that improved function and/or pain for at least one month:

- Chronic low back pain:
  - Exercise
  - Psychological therapies (primarily cognitive-behavioral therapy)
  - Spinal manipulation
  - Low-level laser therapy
  - Massage
  - Mindfulness-based stress reduction
  - Yoga
  - Acupuncture
  - Multidisciplinary rehabilitation

AHRQ Systematic Review, 2018

Interventions that improved function and/or pain for at least one month:

- Chronic neck pain:
  - Exercise
  - Low-level laser therapy
  - Alexander Technique
  - Acupuncture
- Knee osteoarthritis:
  - Exercise
  - Ultrasound

AHRQ Systematic Review, 2018

Interventions that improved function and/or pain for at least one month:

- Hip osteoarthritis:
  - Exercise
  - Manual therapies
- Fibromyalgia
  - Exercise
  - Cognitive-behavioral therapy
  - Myofascial release massage
  - Tai chi / Qigong
  - Acupuncture
  - Multidisciplinary rehabilitation

AHRQ Systematic Review, 2018

Interventions that improved function and/or pain for at least one month:

- Chronic tension headache:
  - Spinal manipulation

What Is the Metric for Success in Pain Management?

- The most commonly monitored variable is pain intensity
- Second most commonly monitored is probably global functioning
- These two metrics present challenges
  - Pain intensity can be difficult to move in many cases of chronic pain
  - Global functioning is subjective and impressionistic

Determining the Overall Goals of Care

- Currently, most common is probably a focus on pain intensity:

- This is where we went wrong with the JCAHO 2001 Standards on pain management
- In chronic pain, pain intensity has little correlation with objective outcome measures—and little correlation with patient satisfaction

Determining the Overall Goals of Care

- There has been movement toward a global measure of function:

- This is a better measure, and can (partially) be measured objectively—at least, in the physical realm
- It is still largely subjective and may be challenging for patients to report reliably

There Is Little Consensus on Optimal Outcome Measures

- Patients, left to their own devices, will generally focus on pain intensity
- Many experts point to function as the optimal outcome
- The CDC guideline, followed now by many others, recommends that opioid treatment be continued only if the patient shows improvement in BOTH pain AND function

An Alternative to Pain and Function

- In many clinicians' experience, pain and function can be poorly correlated in people with chronic pain
  - It is possible to see improvement in pain when the patient has no hope of ever gaining function
  - It is possible to see improvement in function when the patient reports no significant change in level of pain intensity
- In comments to CDC regarding their guideline, AIPM suggested that the optimal metric is "progress toward mutually determined goals of care" that are set by the clinician and the patient, working together

What If We Asked What the Patient Wants?

Care plans are developed through a shared decision-making model that reflects the available evidence regarding optimal clinical practice and the person's goals and values.

What if we asked this question?:

"Your pain prevents you from doing a lot of things you want to do. We need to pick 2 or 3 things to work on first. If we are successful in treating your pain, what are 2 or 3 things that you would like to do, but can't do now?"

The Patient's Role As A Member of the Pain Management Team

- It is important for patients to be treated as members of the pain management team, along with the clinicians
- This communicates to the patient that he/she has a role to play
  - Highlights use of self-management strategies to improve outcome
  - Diminishes sense of helplessness, gives sense of agency
  - Teaches the patient to be an observer of the right kinds of outcomes
- Begins with determining the goals of care

Person-Centered Goals of Care

- Allowing the person to choose the goals of care provides a sense of agency
- These goals should be more intrinsically motivating than other goals we might impose
- Can be set up in a basic goal attainment scaling paradigm—for instance:
  - 0 is where the patient is now on this measure
  - 5 or 10 is the goal set by patient and clinician
  - Intermediate behaviorally-defined points are set to help measure progress

Goals of Care Should Be Jointly Determined

- Clinicians need to have input in determining goals of care
  - Can serve as a reality check if patient wants an unrealistic goal
  - Can suggest goals that other patients have found useful
  - Can help ensure that the goal is measurable
- Patients need to have input in determining goals of care
  - Can determine what they most want to achieve if their condition improves
  - Can also have input on what is a realistic goal
  - Can become invested in a goal that they helped determine

SMART Goals

- Goals set in conjunction with patients should be SMART goals
- SMART goals are:
  - **S**pecific
  - **M**easurable
  - **A**greed-upon/**A**ttainable
  - **R**ealistic
  - **T**angible

Goal Attainment Scaling

- GAS is a method of scoring the extent to which a patient's individual goals are achieved in the course of an intervention. In effect, each patient has their own outcome measure but this is scored in a standardized way as to allow statistical analysis.

https://www.kcl.ac.uk/ltsm/research/divisions/cicelysaunders/attachments/Tools-GAS-Practical-Guide.pdf

How To Set Goals with A Patient

- Try to avoid setting goals based on pain intensity
- Focus on specific areas of function for goal development
- Ask the patient what 3-4 things he/she would hope to be able to do if pain management is successful
- State these as SMART goals and back-fill the measurement scales

An Example

- Patient: "I want to be able to spend more time with my granddaughter"
- SMART goal: "You want to be able to walk your granddaughter to school every morning (four blocks round-trip total)"
- Scale:
  - 0 = unable to walk one-half block
  - 2 = able to walk one-quarter block and back
  - 4 = able to walk one-half block and back
  - 6 = able to walk one block and back
  - 8 = able to walk one and one-half blocks and back
  - 10 = able to walk two blocks and back (four blocks round-trip total)

Monitor and Reward Progress

- At each visit, assess the patient's progress toward the mutually-determined goals
- A graphic representation of progress is often very helpful
- Positive reinforcement for progress is absolutely necessary
- If possible, arrange for someone else to provide reinforcement, as well
- Warn the patient not to expect linear improvement: it's usually "two steps forward, one step back"; manage lapses
- Plan for a special reward when patient achieves the goal

The Rest of the Treatment Plan

- Interventions can be grouped by the eight categories previously described
- They should include interventions for which the patient is responsible
- Whenever possible, interventions designed to be implemented or aided by the patient's support system also should be included
- Use of motivational interviewing may be necessary to increase buy-in and adherence to the plan

What Does Integrative Pain Management Look Like in the Ideal World?

The key is to use an interdisciplinary team to deliver patient-centered comprehensive integrative pain care

- Interdisciplinary, not multidisciplinary
  - Multidisciplinary is a hub-and-spoke model: PCP talks to a variety of team members; team members don't communicate with each other
  - Interdisciplinary requires communication among all team members; everyone talks to everyone else, ideally at the same time
- Key team members +/- additional specialists evaluate patient and confer with each other and with patient
- Goals of care are set jointly by patient and healthcare team

Key Team Members

- Physician: Often one of the following:
  - Physical medicine and rehabilitation
  - Anesthesiology
  - Neurology
- Nurse: Key team member, coordinates team activity
- Behavioral health professional: Ideally a psychologist, but social workers and counselors can fill the role, too
  - Note different skill sets; may need more than one role here
- Physical therapist
- Occupational therapist

Additional Team Members

- Nutritionist
- Personal trainer
- Patient navigator
- Chaplain
- Complementary and integrative therapists
  - Chiropractor
  - Acupuncturist
  - Massage therapist
  - Yoga therapist
  - Others, as available and as needed

Thank you