Department of Defense (DoD)
Opioid Prescriber Safety Training (OPST) Program:

Stepped Care Model for Pain

Presenter

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Summarize ways to collaborate with patients to create pain treatment goals that are achievable and relevant to the patient.
2. Analyze how to refer and connect appropriate patients with chronic and acute pain for cognitive behavioral therapy for pain.
3. Recognize indications for prescribing Naloxone to patients.

Treatment Goals in the Stepped Care Model (SCM) for Pain

Collaborate with patients to impact the following pain treatment goal areas:

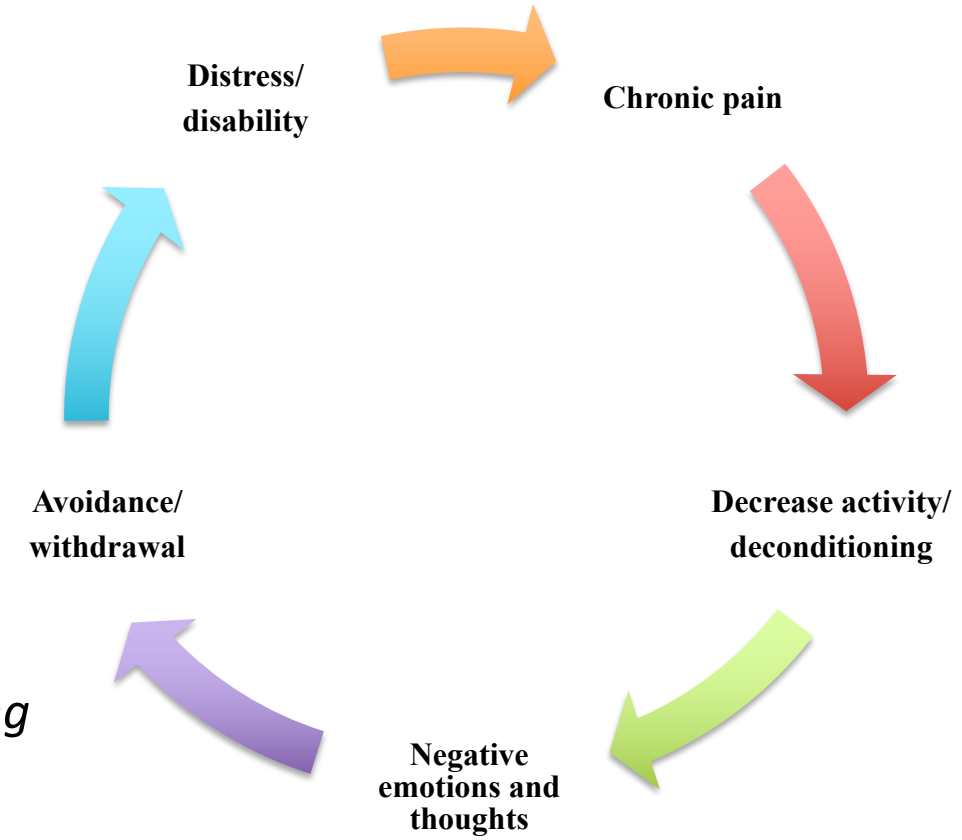
- Prevent chronic pain.
- Improve function and well-being.
    - Manage (not eliminate) pain.
    - Decrease pain interference.
    - Improve level of functioning and quality of life.
- Increase activity level, reduce inactivity/deconditioning.
- Decrease co-morbidities (depression, anxiety, insomnia, etc.).
- Understand and address biopsychosocial contributors to pain.
- Incorporate alternatives to medications and safer prescription practices.

Incorporate short-term SMART goals in working toward the long-term goal.

The Pain Cycle

THE COSTS OF INACTIVITY:

- More pain
- Poorer physical fitness
- Less time with family and friends
- Depressed mood or increased irritability
- Lower self-esteem
- Increased strain on relationships
- Decreased quality of life



Contrast this with readiness and achieving pain treatment goals.

(Beehler et al, 2017)

Defense and Veterans Pain Rating Scale (DVPRS)

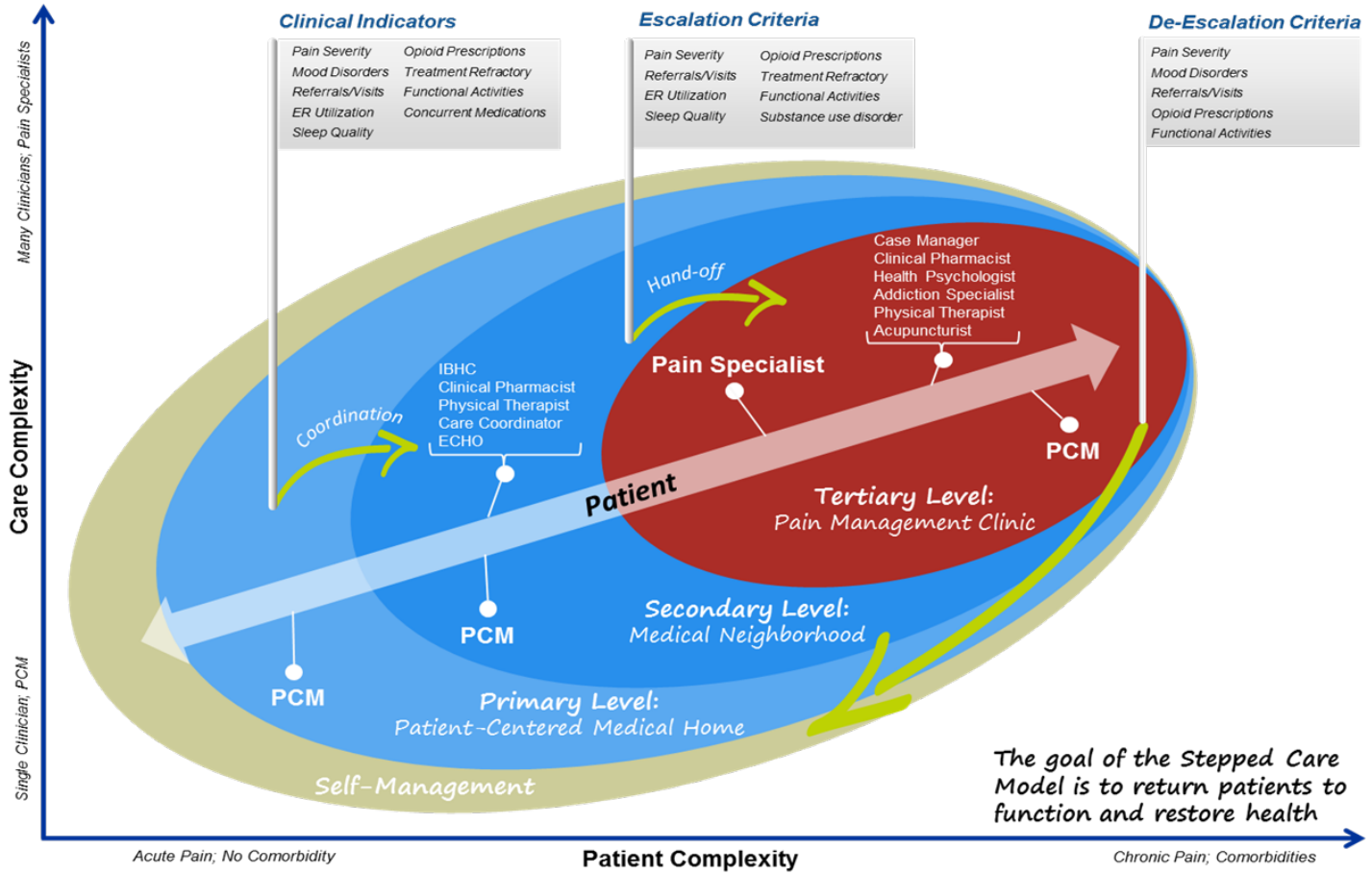
- DVPRS is the standard pain rating scale for the Military Health System (MHS).
- DVPRS has 2 parts:
  - Two pain intensity questions that are completed on all patients.
  - Four supplemental questions measuring impact of pain on activity, sleep, mood and stress and that are completed on:
    - Patients with pain ratings of 4 or above.
    - Patients not responding to the expected course of recovery.
    - Secondary level appointments.
- A copy of the scale must be available for the patient to see each time it is used.

(Defense and Veterans Pain Rating Scale, 2016)

Why Use the DVPRS?

Defense and Veterans Pain Rating Scale (DVPRS) Video

Stepped Care Model for Pain



"Medically Ready Force…Ready Medical Force"

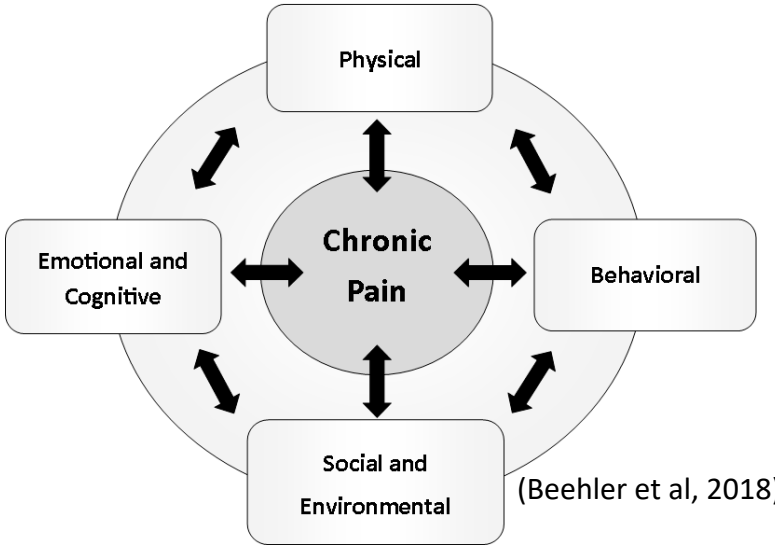
Flexibility within the SCM

- Movement between levels is not always linear.
- Movement between levels does not occur in a specific timeline.
- All care should begin with a biopsychosocial assessment used for case conceptualization and to guide level appropriateness.

Collaborate to Develop a Structured, Comprehensive Treatment Approach

The treatment approach should reflect the complex biopsychosocial nature of the pain experience and may include:

- Physical activity/movement.
- Diet and lifestyle changes (smoking, drinking, food, activity, sleep).
- Patient's resources and supports.
- Thoughts and emotions impacting mood and stress levels.
- The deeper meaning of pain and surrounding personal story.
- Non-pharmaceutical physical and behaviorally-based treatments.
- Safer medication approaches when used.



(Beehler et al, 2018)

(Beehler et al, 2017)

The Importance of Education, Self-Management, and a Team Approach

Essentials of Good Pain Care Video

Roles in Secondary Level or Patient-Centered Medical Home (PCMH) Neighborhoods

The PCMH may have one or more of the following available:

- Behavioral health consultant
- Integrated clinical pharmacist
- Physical therapist
- Physical therapist.
- Dietician or nutrition expert.
- Chiropractor.
- Military Treatment Facility (MTF) or community resources, e.g., massage therapy, yoga or tai chi classes.
- Provider with complementary and integrative health and medicine (CIHM) expertise in managing pain (e.g., acupuncture, osteopathic manipulative treatment, etc.).
- Pain Extension for Community Healthcare Outcomes (ECHO) support.

Providers should know what is available in and outside of their MTF, and make patients aware of their options for treating pain.

Spotlight: Behaviorally-based Treatments

- Veteran A/DoD Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain:
  - "Strong for" recommendation for cognitive behavioral therapy (CBT) due to moderate quality evidence.
  - "Weak for" recommendation for mindfulness-based stress reduction (MBSR).
  - Benefits of CBT and MBSR outweigh harms or burdens to the patient.
- Numerous reviews support efficacy of CBT, as compared to usual care and wait-list in a variety of specific types of chronic pain.
  - Small to medium effects on pain intensity, catastrophizing, and mood.
  - Small effects on pain-related disability and activity interference.

(VA/DoD Diagnosis and Treatment of Low Back Pain Work Group, 2017)
(Ehde et al, 2014)

Behavioral Health Consultants (BHCs) Intervention: Overview of Brief CBT for Chronic Pain (CBT-CP)

For chronic pain: Behavioral Health Consultants (BHCs) use a brief CBT-CP protocol of three-seven, 20-30 minute appointments. Modules (appointments) include:

- Education and goal identification.
- Activities and pacing.
- Relaxation training (two appointments).
- Cognitive coping (two appointments).
- Pain action plan.

(Beehler et al, 2017)

BHC Intervention: Brief CBT for Acute Pain (CBT-AP)

- What should prompt you to refer a patient with acute pain to the BHC?
  - Pain catastrophizing.
  - Fear-avoidance beliefs or behavior.
  - Depressive symptoms.
  - Other concerning psychosocial factors
- BHCs use a brief CBT-AP protocol of up to five, 20-30 minute appointments. Modules (appointments) include:
  - Assessment, Engagement, Education.
  - Fear of Movement and Activities.
  - Relaxation.
  - Cognitive coping (two appointments).

(Psychological Health Center of Excellence., 2018)

BHCs Support Treatment of Pain in a Variety of Ways:

- Biopsychosocial assessment.
- Brief cognitive behavioral therapy (CBT) for chronic pain.
- Brief CBT for acute pain (particularly for patients with depression, fear of movement/avoidance, catastrophizing, psychosocial stressors, etc.)
- Behavioral activation.
- Skills training for intense pain episodes.
- Trouble-shooting barriers in adhering to PCMH team's treatment plan (self-management, medications).
- Addressing co-morbid concerns (e.g., sleep, mood symptoms, risk, nutrition and other health behaviors).
- Following-up with the patient in continuity consultation for "boosters."

(Hunter et al, 2017)

Role of Integrated Clinical Pharmacist, 1 of 2

- All pharmacists can dispense Naloxone according to DHA-Procedural Instruction (DHA-PI) 6025.07 guidelines.
- Embedded clinical pharmacists consult with PCMs to:
  - Give recommendations related to pain medications (e.g., appropriateness of medication and dosing, interactions, side-effects, medication adherence, and eligibility for Naloxone).
  - Provide recommendations regarding a comprehensive treatment plan for pain.

Role of Integrated Clinical Pharmacist, 2 of 2

- Privileged clinical pharmacists can:
  - Provide medication therapy management of non-opioid pharmacotherapy, perform limited physical assessments, prescribe appropriate non-opioid pharmacotherapy, and order/interpret relevant laboratory tests.
  - Provide medication therapy for opioid pharmacotherapy; design and monitor opioid tapers; order and interpret urine drug tests; and provide patient education on opioid informed consent, sole provider agreements, Naloxone use, and safe medication disposal. Some privileged clinical pharmacists can prescribe opioid pharmacotherapy (including opioid tapers) and perform auricular acupuncture.

Collaborate with Patients for a Well-Developed Pain Treatment Plan

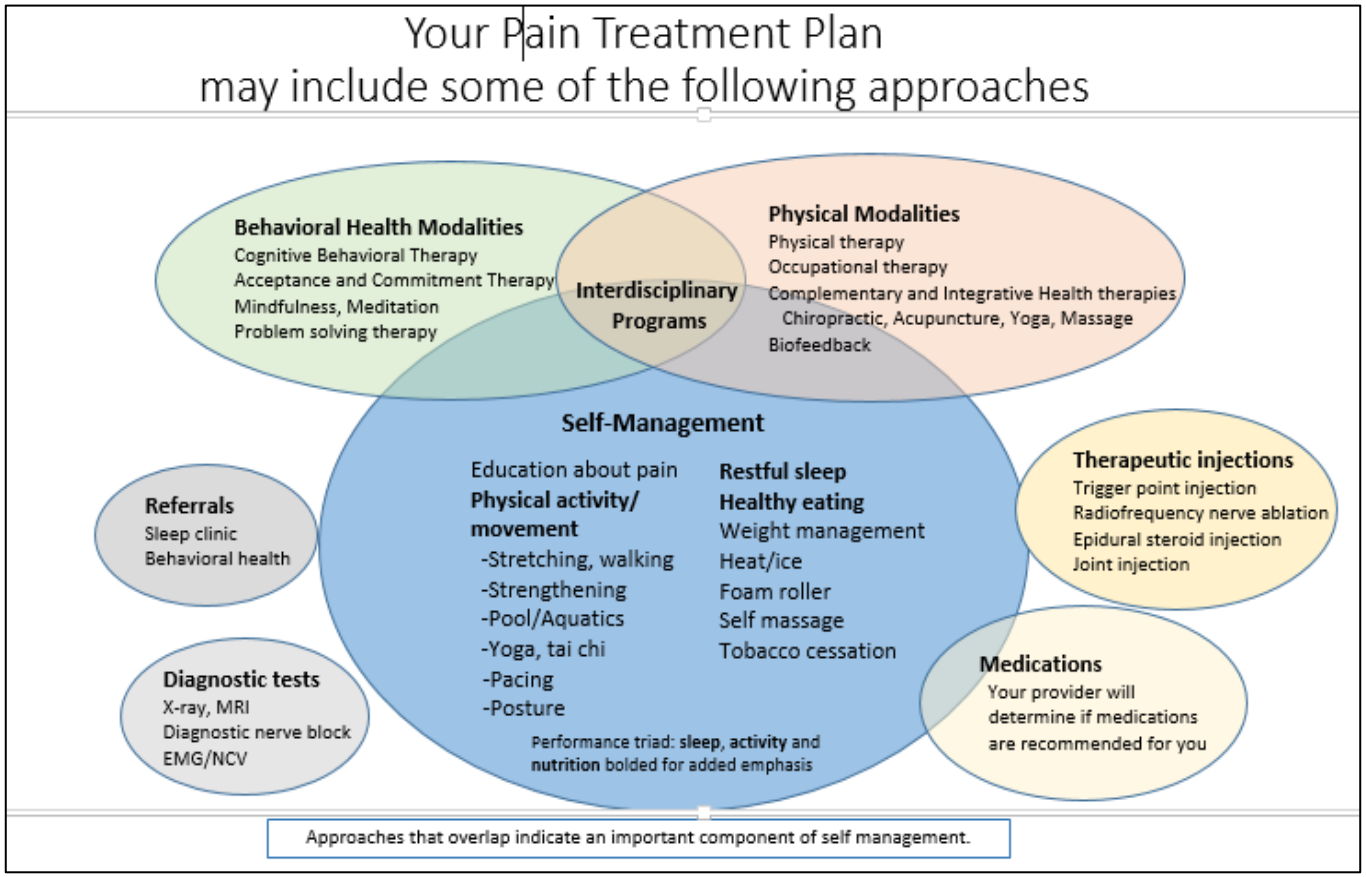


Figure courtesy of Dr. Diane Flynn (2018)

Summary: Overview of Provider Actions in the Treatment of Pain

- Complete a biopsychosocial assessment (history, exam, labs/rad as needed).
- Provide pain education (e.g., pain cycle) and support self-management with the aid of the self-management trifold and pain exit handout.
  - Collaboratively determine long-term broad pain treatment goals.
  - Identify factors that impact the pain experience to inform short-term goals.
  - Use long-term treatment goals and identified factors that impact the pain experience to collaboratively determine short-term goals.
- Collaboratively develop a comprehensive treatment approach that includes other team members in the secondary and tertiary levels as appropriate.
- If opioids are used, include lower risk prescription practices and other methods of risk reduction.

Team Approach Example: Opioid Education Naloxone Distribution

Indications for Naloxone include (only need one):

- Long-term opioid therapy (any 90 days over the last 180)
- Morphine equivalent daily dose (MEDD) of 50 or above
- Risk Index for Overdose or Serious Opioid-induced Respiratory Depression (RIOSORD) score above 32
- Co-prescription of opioids and benzodiazepines
- Additional indications include a substance use disorder, alcohol use, a mental health disorder, and other patients at high risk of experiencing an overdose.

How might the greater military health system team work together to create opportunities for opioid education and Naloxone distribution?

Key Takeaways

1. Collaborate with patients to create and impact appropriate pain treatment goals.

2. Use the DVPRS including supplemental questions when indicated as part of a biopsychosocial assessment of pain.

3. Include other team members in a comprehensive pain treatment plan that addresses biopsychosocial factors, includes non-pharmacologic treatments, supports self-management, and minimizes risks.

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