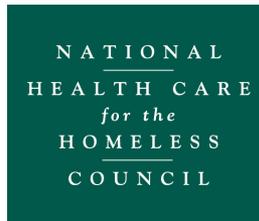


# Welcome

## Chronic Pain Webinar

September 26, 2011

We will begin promptly @ 1PM EST



Event Host

**Barbara Wismer, MD, MPH**

Tom Waddell Health Center/Homeless Programs

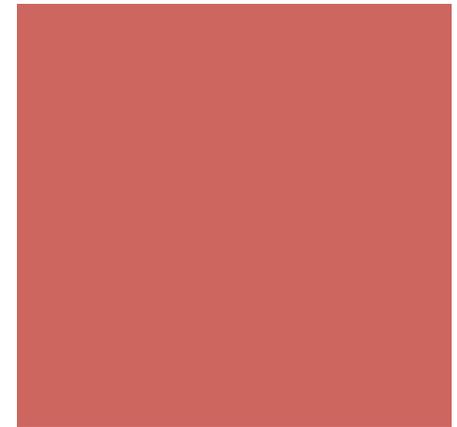
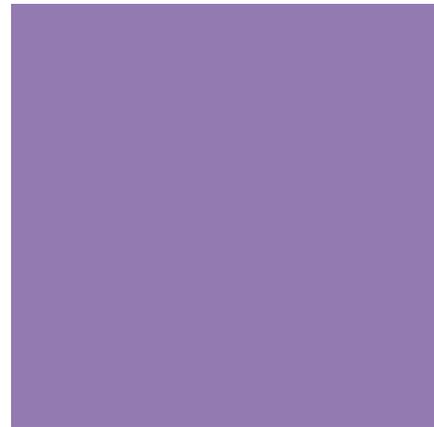
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## Adapting Your Practice:

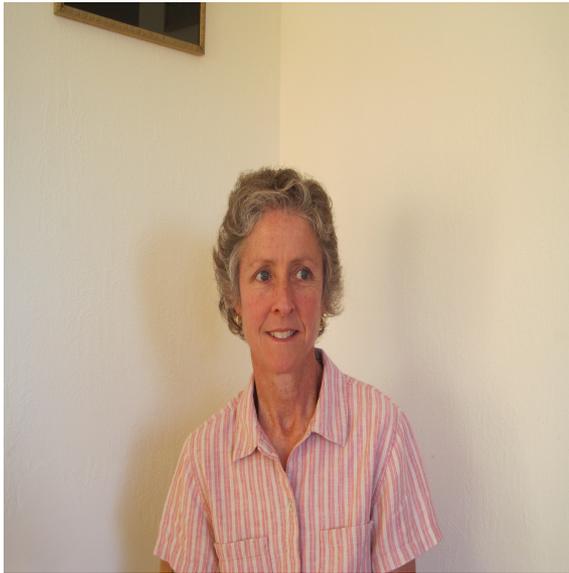
# Recommendations for the Care of Homeless Adults with Chronic, Non- Malignant Pain

September 26, 2011





# Presenters



## Barbara Wismer, MD, MPH

- Physician at Tom Waddell Health Center/ Homeless Programs in San Francisco Dept. of Health
- Board Certified in both internal and preventive medicine



## Rachel Solotaroff, MD, MS

- Medical Director at Central City Concern
- Assistant Professor at Oregon Health and Science University
- Oversaw transformation of Old Town Clinic into a PCMH



# Roadmap

- Background/Context
- Approach to the individual
- Model of care
- Q & A



# Chronic Pain - Background

- National news – rising tide of opioid overdose deaths
- Historical backdrop – under treatment of pain
- HCH Clinicians’ Network priority
  - National survey revealed clinicians lacked resources for optimal pain management, lacked access to non-pharmacological pain interventions, were uncomfortable prescribing opioids



# Chronic Pain + Homelessness

- Homelessness increases risk of chronic pain, exacerbates suffering, makes pain management more complicated – for example:
  - More frequent injuries + assaults
  - Less optimal + timely treatment
  - Exposure to the elements
  - More frequent behavioral health problems
  - Difficulty keeping appointments
  - Lack of safe place to store medications

# + History

- “Focus primarily on fostering a therapeutic alliance at the initial encounter, recognizing that this may be the only opportunity to engage a homeless patient in ongoing care.”

# + History

- “Ask about physical and mental health (including history of traumatic brain injury/ substance use), history of chronic pain, and living situation (including residential stability).”

# + History

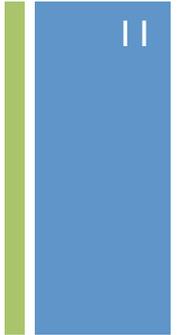
- Allow patients to tell their story + feel heard non-judgmentally
- Build confidence that you have their best interest in mind
- Help them understand that pain management involves comprehensive health care



# History

- Clarify what your setting can offer (e.g., one-time urgent care visit to comprehensive continuity primary care clinic with access to specialists)
- Specify pace of evaluation (usually several visits)
- Clarify whether or not + when opioids can be prescribed (after evaluation complete)

# + History - Tips



- Start with general questions, e.g., “How long have you been in this city?” “Where are you from originally?”
- Tailor the substance use history; explain relevance: “Information about your drug + alcohol use can really help me figure out what is the safest + most effective treatment for you.”



# History - Tips

- Attend to the patient's mood + your own emotional reactions; respond to frustrated or hostile patients with acknowledgement + interest: “I hear how frustrating it's been to have this pain + try to find relief. Tell me more about how it began.”
- Inquire about factors related to homelessness that may cause or exacerbate pain; change as able.



# Physical Exam

- “Defer the physical examination to the 2<sup>nd</sup> visit, if needed; or keep the initial exam focused on the area of concern. Perform serial focused exams as tolerated (if needed). Look for evidence of occult alcoholism or addiction.”



# Physical Exam

- “Practice Trauma-Informed Care during the physical examination + in all patient encounters, recognizing that individuals who are homeless are likely to have experienced some form of previous trauma.”
  
- Continue to develop trust + rapport.

# + Physical Exam - Tips

- Explain what a comprehensive visit will entail.
- Ask permission to perform exam each time; explain what you are going to do before touching the patient.

# + Plan + Management

## “Universal Precautions” Approach

### ■ Rationale

- High rates of substance abuse/ dependence
- Increased risk of opioid misuse, abuse, diversion
- Difficulty detecting misuse, abuse, diversion

### ■ Approach

- Ongoing assessment, including function, “aberrant” behavior
- Additional structure, e.g., treatment agreements, urine drug testing

# + Plan + Management

- Develop functional improvement goals, with patient
- Include self management techniques (pacing, relaxation, stress management) + physical activity/exercise
- Include behavioral health plan

# + Plan + Management

- Choose non-opioid medications based on etiology of pain, co-morbid conditions, medications, + other factors
- Add a trial of opioids when indicated
- Make plan for safe storage of medications, if prescribed



# Plan + Management

- When prescribing opioids:
  - Written treatment plan
  - Patient/provider agreement
  - Informed consent
  - Multidisciplinary care team
  - Consistent non-judgmental approach to behaviors outside the treatment plan
  - Routine vs as-needed urine drug tests
  - Follow up based on stability + risk



# The San Francisco Experience

- San Francisco Department of Public Health Primary Care Clinic Policy:
  - “Aberrant drug-related behavior in the use of controlled substances in the treatment of chronic non-malignant pain”
- Purpose
  - Defines uniform, minimum standard across sites for monitoring, responding to + documenting aberrant drug-related behavior



# The San Francisco Experience

- Aberrant drug-related behavior is an umbrella term that includes behaviors that may result from:
  - Abuse
  - Diversion
  - Misuse
  - Pseudo-addiction
- These overlap with behaviors resulting from chaos/vulnerability of homelessness



# The San Francisco Experience

- Monitor for aberrant behavior
- Aberrant Behavior Checklist – examples:
  - Refill request earlier than expected
  - Report of lost or stolen prescriptions/medications
  - Missing appointments with provider
  - Presenting to clinic intoxicated or under the influence of drugs
  - Abusive or threatening behavior toward staff
  - Altering or stealing a prescription

# + The San Francisco Experience

- Get urine drug test on initiation of therapy then at least yearly on ALL patients
  - Pill counts may be substituted or added
- Evaluate (including differential diagnosis) + respond to each episode of aberrant behavior
- Document review of treatment plan + agreement with each episode of aberrant behavior
- Mandatory documented peer review for repeated aberrant behaviors



# The San Francisco Experience

- Responses to aberrant behavior might be:
  - Monitor more closely
  - Dispense medications in smaller quantities
  - Require substance use treatment
  - Taper off controlled substances
  - Talk with patients and/or colleagues



# Model of Care

- Multi-disciplinary teams
- Utilize chronic disease care management model:
  - Stratify by complexity and risk
  - Patients “graduate” to each new level
  - Establish goals and outcomes for each level
  - Utilize care manager and registry to track patients and outcomes



# Background

## ■ Approaches to chronic pain with history of addiction:

- Integrated, structured care
- Close monitoring
- Multi-disciplinary teams
- Adjunct Therapies
  - Cognitive Behavioral Therapy
  - Physical training
  - Other analgesics
  - Meditation
  - Acupuncture



Chou 2009; Jamison 2010; Gourlay 2009; Wiedemer 2007; Savage 2008; Chelminski 2005,



# Background

- Reports of programs elsewhere for opioids in high-risk groups:
  - Experimental group with close monitoring (UDS, compliance check-lists) and individual and group MI compared to standard treatment.
    - Found reduction in misuse
    - Did not measure functional or quality of life outcomes
  - 3-month trial of integrated care with psychiatrist, pharmacists, PCP.
    - 32% still had “serious misuse”
    - Reduction in mean pain and depression scores



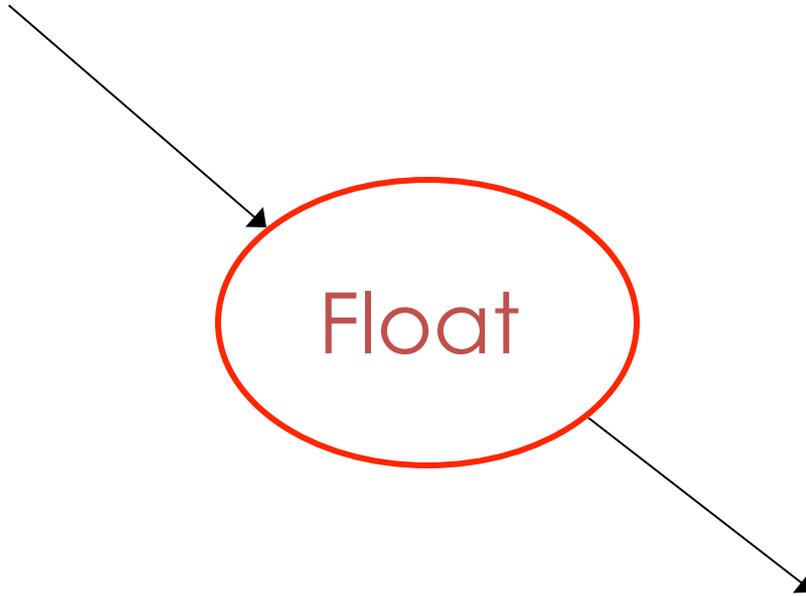
# Background

- Reports of programs elsewhere for opioids in high-risk groups:
  - VA program: multi-disciplinary team with close oversight by NP, pharmacist
  - Support from psychiatrist, rheumatologist, addiction psychiatrist, neurologist, orthopedists
  - Emphasized early recognition and effective management of co-occurring disorders
  - 45% adherence

+

# Background

Spin



Integrate

# + Chronic Pain Recovery: Mission and Goals

- ⦿ Recovery and Lifestyle changes
  - Seeks to provide access to new techniques
  - Education and access to enable new choices
  - Mindfulness
- ⦿ The program responds to a need in the clinic community for support for patients with chronic pain, recognizing that those with a history of addiction often have legitimate pain, and attempting to avoid under-treatment of pain.



# Program: Hot Sauce

- Hot Sauce:
  - Group counseling for high-risk patients with chronic pain taking prescribed narcotics for their pain.
  - Lead by alcohol and drug counselor
  - 12 weeks
  - Weekly or bi-weekly 1-on-1 sessions with A&D counselor
- Goal: support these patients in taking prescribed meds appropriately and improving their quality of life.
  - New outlook regarding pain
  - Create community where people with a common problem (pain) learn to discuss their experiences dealing with pain, hope, and over-coming obstacles
- Not for those with active addiction or early recovery



# Program: Hot Sauce

- Hot Sauce Lite:
  - Follow-up program for those who have completed Hot Sauce Spicy
  - More emphasis on other modalities for managing pain
    - Chi Gong
    - Stretching
  - Relatively less emphasis on recovery work



# Program: Hot Sauce

## Curriculum topics:

- What is addiction?
- Self-care techniques
- Building a support network
- Methods of de-escalating cravings
- Improved standard of life (raising the bar)
- Pain physiology
- Relapse Prevention
- Handling stress
- Cycle of change
- Adhering to the Controlled Substance Contract
- The client-doctor relationship
- Spiritual outlook options



# Program: Hot Sauce

- Who Hot Sauce is for:
  - Many have less than a year of continuous clean-time
  - Many years of active addiction
  - Many have multiple treatment episodes
  - Those who stay have a relationship with clinic and an interest in staying in the community



# Program: Hot Sauce

- Hot Sauce Goals:
  - Adherence to controlled substances agreement
  - Engagement with behavioral health (if indicated)
  - Progress toward self-identified goals



# Program: Occupational Therapy Groups

- Purpose:
  - Provide Occupational group therapy for patients with chronic pain
  - Streamline monthly chronic pain visits
  
- 1.5 hour visits, once a month
  - Group Occupational Therapy
  - Individual 10-15 minute focused appointment with PCP
  
- Bi-weekly outreach by OT or OT Student



# Program: OT Group Curriculum

- Back Health
- Body Mechanics
- Communication Skills
- Nutrition
- Relaxation
- Sleep
- Home Safety/Maintenance & fall prevention
- Energy Conservation & Pacing
- Stress Management
- Cognitive Behavioral Therapy for chronic pain & Advocacy
- OPEN FOCUS/meditation
- Envisioning You (Tai Chi and Vision Boards)
- Leisure Exploration



# Program: OT Groups

- OT Goals:
  - Reduction in Centrality of Pain Score
  - Engagement with behavioral health (if indicated)
  - Progress toward self-identified goals
  - 10% reduction in opiate dosage



## Program: CSRC

- Controlled Substance Review Committee:
  - Alcohol and Drug Counselor
  - Medical Doctor
  - Mental Health Nurse Practitioner
  - Behavioral Therapist (Qualified Mental Health Professional)
  - Occupational Therapist



# Program: CSRC

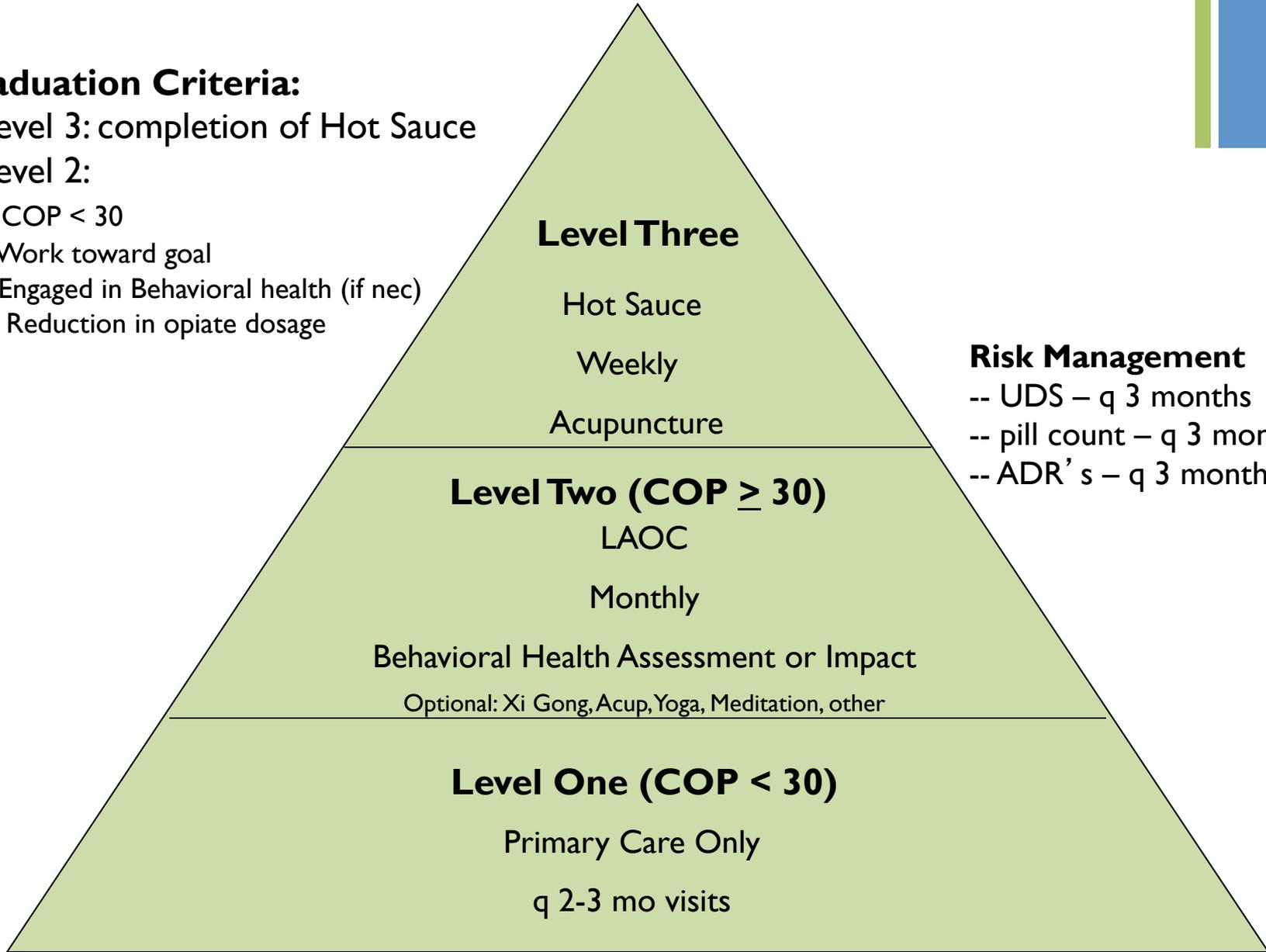
- Controlled Substances Review Committee
  - Review cases
  - Multiple perspectives (so referrals are appropriate from a variety of therapeutic perspectives)
  - Make referrals to Hot Sauce, OT groups, other individual providers
  - All new opiate starts are referred to CSRC



# Chronic Pain Recovery Pyramid

## Graduation Criteria:

- Level 3: completion of Hot Sauce
- Level 2:
  - COP < 30
  - Work toward goal
  - Engaged in Behavioral health (if nec)
  - Reduction in opiate dosage

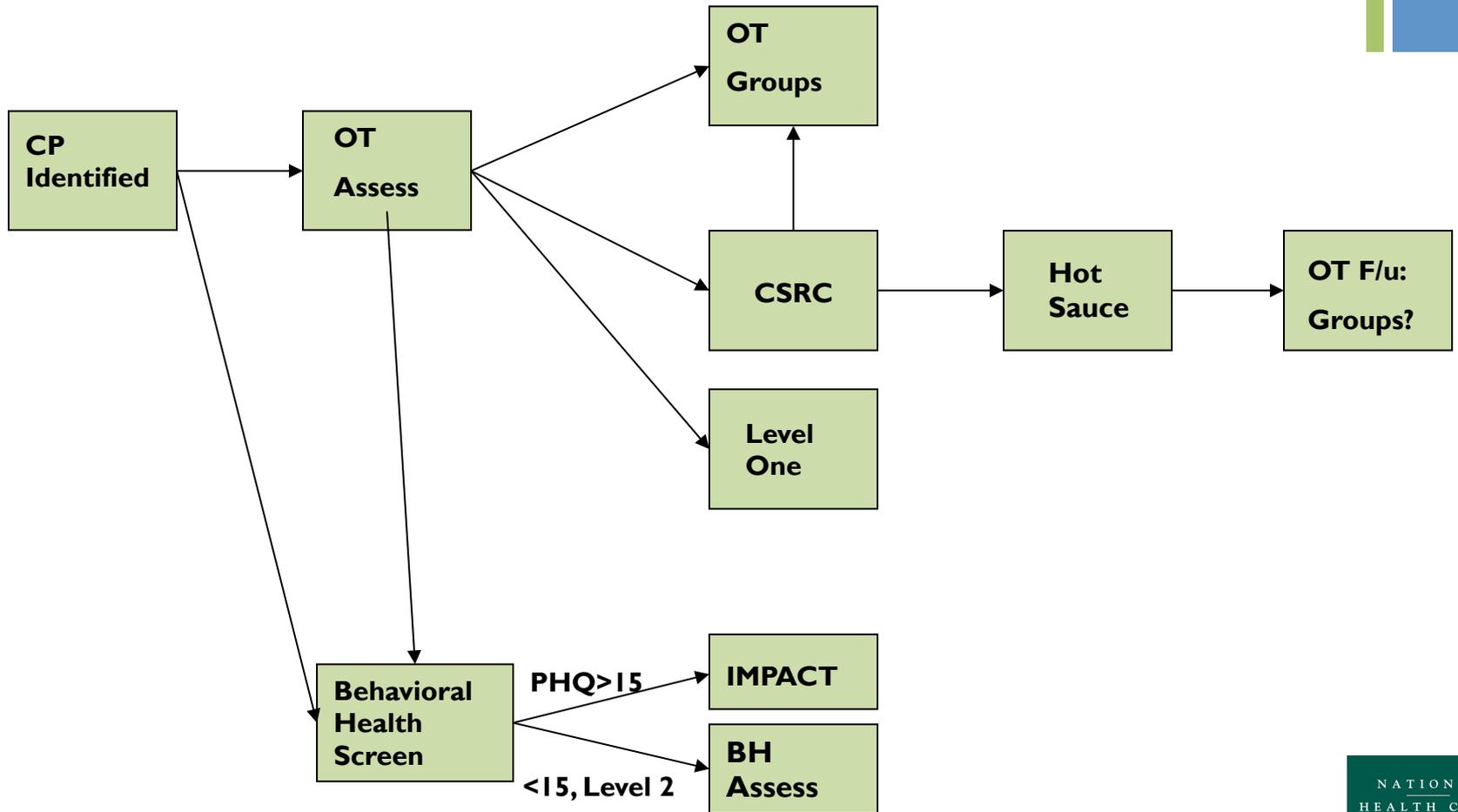


- ### Risk Management
- UDS – q 3 months
  - pill count – q 3 months
  - ADR's – q 3 months



# Chronic Pain Recovery Program Initiation

## Road Map





# Provider Feedback

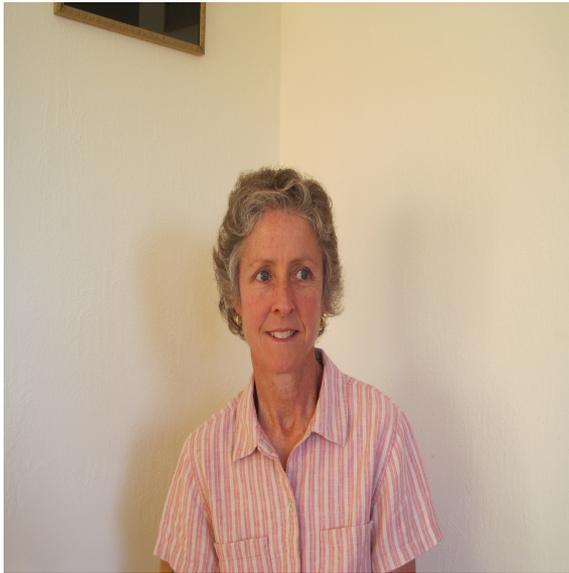
- Feel that no longer “going it alone”
- Patients taking more responsibility for their pain management
- Successful while enrolled in Hot Sauce
- “Feels like the right thing to do”
- “Patients seem brighter”
- Seem to appreciate “community and continuity”

# + Chronic Pain Recovery Program: Outcomes

- Safety:
  - UDS
  - Violations
  - Pill counts
  - Reduced opiate dose
- Quality of Life
  - Centrality of Pain
- Goals
  - Self-identified
  - Quantitative
  - progress
- Provider Outcomes:
  - Practice satisfaction
  - Provider competence in pain management
- Sustainability (clinic operations)
  - Decreased phone calls related to pain meds
  - Decreased PCP visits for chronic pain
  - Increased diversity of provider panels



# Questions & Answers



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# Resources

To access the full report of *Adapting Your Practice: Recommendations for the Care of Homeless Adults with Chronic Non-Malignant Pain* visit the National HCH Council's website at:

<http://www.nhchc.org/clinicalresources/ChronicPainManagement.pdf>

For more information on other clinical practice adaptations, please visit the Council's clinical resources page for a full list:

<http://www.nhchc.org/clinicalresources/practiceadaptations.html>

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