CHILDREN IN PAIN

PLUS: OPIOIDS AND PREGNANCY

Also in this Issue
• Medication Selection for DPN
• Self-Management Approaches
• Fitting into a New Practice

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opioid overuse has led to federal, state, and local ini-
tiatives to reduce its serious consequences on health
and healthcare costs. Yet, patients with chronic pain
face an immense burden. Given the adverse effects on their
mental, physical, and social wellbeing, they often live with
a diminished quality of life, functional limitations, and loss
of productivity.2,3

Despite the complexity of chronic pain, at least half of all
patients receive their healthcare from a primary care clini-
cian. This raises a striking conundrum since primary care
practitioners (PCPs) have been found to harbor negative
attitudes toward patients with chronic pain, driven by a sense
of insufficiency in addressing this patient compliant;4–6 this
hesitancy may be explained at least in part by limited training
in pain management.6

The challenge faced by PCPs in managing chronic pain
has been hampered further by limited resources, especially
among low-income patients who are under- or uninsured. As
shown in recent studies led by Turner, et al, managing these
patients has been made all the more difficult because their
families and friends have a limited understanding of chronic
pain conditions.7

In one study, a representative sample of Hispanics who did
not have a diagnosis of chronic pain were surveyed from five
southwestern states; only 12% of respondents said they “knew
a lot” about chronic pain.8 This small group was more likely
to endorse the need for pain medications to manage pain at
increasing doses. This belief reflects a common acceptance
of relying on opioids and other prescription medications to
treat chronic pain conditions that may respond at least as well
to multimodal, non-pharmacologic interventions to control
pain and reduce the myriad negative effects on daily living.

Self-Management of Chronic Pain in Primary Care
A multimodal approach may meet a multitude of needs.

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Turning to Biopsychosocial Approaches to Manage Chronic Pain

Employing a biopsychosocial model to pain management in the primary care setting would introduce PCPs to a valuable conceptual framework that captures biological, somatic, cognitive, and affective dimensions of chronic pain. This approach has the ability to positively address “central pain processes” and amplify its negative effects on activities of daily living, interpersonal relationships, social expectations, work history, and social support/isolation.9,10

To effectively address the multidimensional effects of chronic pain, patients need self-management training about behaviors, strategies, and activities that may help to control the destructive effects of pain on their quality of life. Use of self-management methods have proven highly effective for people with diabetes mellitus, a similarly complex condition, and has become a well-accepted component of diabetes care, covered by insurance.11 Diabetes self-management training, for example, typically involves certified trainers and a team-based approach.11-15 To date, this disease approach has not been implemented broadly to assist patients with chronic pain to more effectively manage this severely disabling condition, even as its value has been recognized by the Institute of Medicine, which defines self-management of chronic pain as involving the following:16

- Adhering to medical treatment
- Managing personal, family, and social roles and responsibilities through cognitive and behavioral strategies
- Managing emotional consequences of conditions associated with chronic pain.

Successful self-management requires the patient to develop a mastery of transferable skills and strategies for many aspects of living with chronic pain, such as: goal setting, activity pacing, relaxation, thought challenging, positive self-reinforcement, self-monitoring, problem-solving, decision-making, and resource identification.17-30

A review of 46 randomized controlled trials of pain self-management education identified these common components: psychological training, lifestyle modification, pain education, physical activity, and mind-body therapy.31 Each component has the potential to transform primary care pain management by providing efficient, affordable approaches that can be integrated into clinical practice. Further, recent guidelines from the Centers for Disease Control and Prevention and the US Department of Health and Human Services’ National Pain Strategy endorse multimodal, non-pharmacologic interventions as first-line treatment for chronic pain.32,33 The following hypothetical case demonstrates the challenges patients may face without this training.

Patient Case: “I’m stuck, what else can I do?”

John D is a 44-year-old Hispanic male married for 15 years to Violet. They have two teenage sons. John and Violet own a busy restaurant. However, John injured his lower back in an accident at home. After three months on acetaminophen and ibuprofen, he visited his PCP who found no neurologic impairment upon examination. The PCP prescribed cyclobenzaprine and Tylenol with codeine (60 mg every 4 to 6 hours). The PCP also referred John for physical therapy (PT). He returned to the office one month later for a follow-up appointment. He reported running out of the prescribed medications and being “too busy” to go for a PT consultation. His PCP administered a steroid injection in the lumbar spine that provided temporary relief, renewed his opioid prescription, and ordered an MRI, which revealed no abnormalities. Over time, however, John continued to report disabling pain, and asked for stronger medication for pain relief, which the PCP refused. John exhibited frustration, as did his wife, who accompanied him on visits and complained about her husband’s inability to function at work or to help with the children. When the PCP suggested that John see a pain specialist, both he and his wife indicated that they did not have the financial means for this type of care and needed to continue to receive their care at the primary care practice.

Discussion

This hypothetical case demonstrates the limited options available to manage common cases of chronic pain in the primary care setting. Until recently, the usual solution has been to continue to prescribe opioids.34 However, John’s situation makes an excellent case for offering multimodal, self-management chronic pain training in primary care.

Primary care providers faced with a growing number of chronic pain patients often report feeling “stuck,” with limited options for their patients. Ideally, education and training could be made accessible in the primary care setting to help patients like John learn to function better with their pain and to reduce the cycle of complaining and reliance on increasing medication as the only solution.

Non-pharmacologic, Self-Management Approaches for Chronic Pain

Expert guidelines for non-pharmacologic interventions are backed by strong evidence from randomized trials of the beneficial effects of structured exercise, Cognitive Behavioral Therapy (CBT), and complementary/alternative therapies, in contrast to well-known risks of long-term opioid therapy.18,34-45 However, a combination of approaches is likely needed because no single self-management strategy has consistently
Patients may need to build self-confidence to gain readiness to initiate pain self-management.

demonstrated strong short-term effects or sustained long-term benefit for chronic pain. Barriers to multimodality care include financial support and an inadequately trained workforce in primary care settings.

To meet this growing need for a viable pain management program implementable in the primary care setting, a team of healthcare professionals set out to develop and test a multimodal, integrative self-management program to serve a low-income predominantly Latino community. A primary driver for this model was its efficacy in other clinical practices with a similar demographic of low-resource patient populations with limited access to affordable extended services.

Design and Implementation of the Living Better Beyond Pain Program

The Living Better Beyond Pain (LBBP) self-management program was designed in response to several community-based studies by Turner, et al, to address the unmet needs of low-income Hispanic patients who suffer from chronic pain. The program encompasses 30-minute low-literacy PowerPoint educational presentations that cover eight self-management strategies that are actionable at home. These include:

- Understanding the physiology of chronic pain and the need for goal setting
- Stretching and exercise, supplemented by training in appropriate physical activities
- Meditation and mindfulness
- Massage techniques
- Healthy eating plan
- Keys to sleep hygiene
- Management of setbacks
- Maintenance planning to incorporate these activities long-term.

A randomized trial of the LBBP curriculum was conducted over six months. Patients with chronic pain were randomized to receive the LBBP either individually in meetings with a trained community health worker in clinic or in groups in the community with lectures from content experts (n = 111 subjects; 53 in the clinic arm and 58 in the community arm). There was no control arm as clinic directors wished to help their disabled patients.

At 6 months, both study arms demonstrated significant improvement in measures of physical, cognitive, and psychological function (refer to the full published studies for details). Thus, this study offers support for the feasibility and efficacy of a low resource self-management program to be provided to primary care patients who would otherwise lack access to this training.

Exploring Additional Self-Management Approaches for Pain in Primary Care

For practices looking to start a self-management program for chronic pain patients, there are several other options to explore that may be feasible to access, as described below.

Building Pain Self-Efficacy

Patients with chronic pain may need to build self-confidence in order to gain readiness to initiate pain self-management to improve their function. By employing brief motivational interviewing skills, the PCP and/or allied healthcare team may be able to guide patients to work through their ambivalence following SMART – Specific, Measurable, Attainable/Achievable, Realistic, Time-limited – tips to move patients to a readiness to embrace self-care.

The US Substance Abuse and Mental Health Services Administration (SAMHSA) addresses some ways to implement support-based SMART goals while employing effective Motivational Interviewing techniques. See www.integration.samhsa.gov/clinical-practice/motivational-interviewing.

Since physical therapy is often expensive, and usually covered by insurance only short-term, SMART goal setting further aims to foster adoption of exercising and/or stretching into the patient’s daily routine. The patient is encouraged to start by defining simple movement goals that evolve to build duration and intensity after initial successes.

The focus is on building the patient’s level of physical activity. The emphasis is to encourage slow, steady progress in achieving one exercise at a time to improve function in patients with chronic pain. These activities may involve:

- Stretching: focus on exercises that increase flexibility, loosen tight/stiff muscles, and improve range of motion
- Strengthening: focus on exercises that build stronger muscle (eg, wall pushups or bicep curls)
- Cardiovascular: focus on light to moderate aerobic exercises (eg, walking, swimming, or bike riding).

Stress Management

By working with a behavioral health provider in clinic or community setting, patients can be taught to identify stress
triggers. As a result, they gain an understanding of the processes through which muscle tension disrupts relaxation and sleep, leading to an increase in pain and diminished function. There are several approaches to assist patients in managing stress and depression, including CBT and acceptance and commitment therapy (ACT). These approaches have been shown in many studies to be effective for patients with chronic pain. Even when the patient does not have the desire to work with a professional in behavioral medicine, patient education focused on stress management in the context of chronic pain may be very useful and can be accessed online through the American Psychological Association website (see www.apa.org/helpcenter/pain-management.aspx).

**Step-by-Step Treatment Algorithms/Clinical Pathways**

Clinical pathways have been designed to assist primary care practices to employ evidence-based treatments for chronic pain. Creating clinical pathways that rely on non-pharmacological approaches to chronic pain care may be implemented in team-based care to provide education and support to promote self-management concepts for patients with chronic pain. Figure 1 offers an example of an algorithm/clinical pathway for the primary care setting.

Importantly, the move away from a reliance on prescription opioid therapy must be accompanied by practical approaches to pain care that are relatively easy to implement in the primary care setting. The best strategy for long-term pain management is one of promoting self-management aimed at increasing function for the long-term. By learning about and adopting daily methods to self-manage, patients will gain the ability to engage in multiple activities and adopt strategies that will improve their daily living.

Introducing and testing effective programs and strategies, particularly for low-income populations with limited access to pain care resources, is still rudimentary and needs to receive financial support from policymakers and payers. Nevertheless, integrated, multimodal non-pharmacological approaches to chronic pain management are needed for all patients with chronic pain conditions, regardless of socioeconomic status.

**Figure 1**: A chronic pain algorithm for behavioral interventions in primary care (printed with permission of creator Donald McGeary, PhD, ABPP, Reference 53).
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