The 2016 ASPMN Jean Guveyan Lecture

Caring for People with Pain: Understanding the Past and the Present In Order to Shape the Future

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The Problem

- Unrelieved pain is a public health crisis\(^1\)
- National Pain Strategy, 2016; IOM, 2006
- Opioid misuse, abuse and overdose is a public health crisis\(^2\)
  - Centers for Disease Control and Prevention (CDC), 2016
- Sometimes the two are addressed as if they are the same problem – they are NOT!
- Well intended efforts to address prescription drug abuse place a heavy burden on people who benefit from opioids and use them responsibly as part of a comprehensive treatment plan\(^3\)
- Unintended consequences of efforts to curb abuse and misuse of opioids are significant for people with pain\(^3\)

- Conflict of Interest Disclosure
  - Ani Parseghian, BSN has no conflicts of interest to report
  - Carol P. Curtiss, MSN, RN-BC is owner of Curtiss Consulting

The problem of pharmaceutical drug abuse

- Late 19th century (1800’s)
  - Morphine and cocaine were non-prescription and used widely
  - "Solution"
  - Increased education of physicians, supply side restrictions, "junkies"
  - Harrison Narcotics Tax Act of 1914 made these drugs prescription only
- 1920’s-1970’s
  - Shift to use of tightly regulated barbiturates (1906) and amphetamines (1930)
  - "Solution"
  - Increased education, restrict these drugs to prescription only
- 2016
  - New “epidemic” of prescription drug abuse
  - "Solution"
  - Education, restricted access

- "Those who can not remember the past are condemned to repeat it”
  - Philosopher George Santayana

The Past

AVOID OPIOIDS whenever possible
The Past
- Meperidine was the drug of choice for severe pain – often combined with hydroxyzine (Vistaril®) or promethazine (Phenergan®) and only when pain was really bad
- Morphine was saved until the very end of life
- The health care provider was the expert on pain and pain relief
- We told patients to “wait until it was time”
- Tolerate as much pain as you can...
- Fear of addiction was common and prevented people from taking ANY medication for pain
- Children did not receive analgesia for painful procedures and for pain in general

The Past
- The use of touch, direct observation, range of motion, positioning, humor (but not too much), non-pharmacologic interventions, and use of therapeutic self was common – that’s pretty much all we had
- Pain was not a priority
- People suffered tremendously and needlessly
- Health care providers attitudes and beliefs became ingrained and passed onto new generations
- Clock watching
- Knowing the name of the medication that works
- Fear of addiction
- Avoid opioids

The Past: New Models for Pain
- Gate Control Theory
- Painful stimuli travel from the periphery to the central nervous system.
- Non-painful stimuli can activate large diameter nerve fibers to close the “gate” to diminish painful input and suppress pain
- Thoughts, feelings & motivation may either open or close the gate
- Fear, anxiety, depression open the gate → pain
- Positive thoughts, decreasing fear etc. close the gate → less pain

The Recent Past
- Opioids Used Liberally

Efforts to Make Pain Visible
- “Pain is whatever the patient says it is, occurring whenever the patient says it does, 1968”
- Lobbies in D.C. to improve pain management, 1984
- Begins WHO State Pain Initiatives, 1984-86
- Lobbies TJC to screen for pain and with Pat Berry, drafts TJC standards
- “Nursing owns pain.”, 2011
Unintended consequences

- Prescribing freely without adequate pain assessment
- Integrating multimodal plans
- Knowledge of each drug’s characteristics, dosing, strengths, relative potency to morphine, adverse events, & cautions
- Written goals for treatment outcomes
- Reassessment before renewals
- Prescribing controlled-release/long acting or continuous basal rates to opioid naïve persons
- Health care provider self misuse/abuse/diversion
- Lack of patient and public education about treatment options, risks and benefits of ALL therapies, safe storage, handling and disposal of medications

The Present

Overdoses of Opioids & Benzodiazepines

But how many of these are people with pain versus people using opioids as their choice for recreational use?

Increases in abuse of prescription drugs

- Individuals experimenting with drugs perceived prescription drugs to be “safer” than street drugs.
- Opioids widely prescribed
  - Primary care providers prescribe 70% of the opioids in the U.S.¹
- When prescription drugs became harder to obtain, many, including adolescents, turned to heroin as a cheaper and easier to obtain alternative¹

   (Dr. Volkow is the director of the U.S. National Institute on Drug Abuse [NIDA])

Sources Where User Obtained Drugs for Non-medical Use, 2010-2011

www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm#1

The Present: Yet another extreme shift

Don’t Use Opioids
The Present: What we know…

- Pain reshapes the CNS
- Unrelieved acute pain increases the risk for developing persistent (chronic) pain
- Pain ruins lives
- Persistent pain effects ALL aspects of a person’s life
- Access to competent care for persistent pain is challenging
- Many people take opioids responsibly and do not show signs of addiction or misuse
- Addiction occurs in only a small percentage of persons who are exposed to opioids – even among those with pre-existing vulnerabilities

1. Volkow, ND & McLellan AT. (2016). NEJM 374(13): 1253-1263 (Dr. Volkow is the director of the U.S. National Institute on Drug Abuse [NIDA])

The Present: Where we are…

- Efforts are underway to diminish pain as a priority
- The person with unexplained pain is suspect
- Opioids have become the enemy
- Guidelines recommend first-line strategies that are not usually covered by health insurance
- Barriers to access to care and interventions are frequent
- Health care providers receive little education regarding pain management

The Present: A View from a New Graduate

Ani Parseghian, BSN

The Present

- Magnitude of the pain problem:
  - Consequences of untreated pain
  - Undertreated pain
- Causes:
  - Inadequate skills to assess and treat pain
  - Unwillingness to believe patient reports
  - Lack of time, expertise, and perceived importance of pain assessments
  - False concepts of addiction and tolerance
- Concern:
  - Issues aren’t addressed in a timely manner
  - Non-adherence to practice guidelines by medical professional

Going forward…

What needs to happen from a student’s perspective:

- Hiring more nurses so each nurse’s patient load is lower
- Having specialized pain team or nurses to implement treatments according to each patient
- Teaching nurses, in all areas of nursing how pain assessment is a very important part in caring for the patients well being
From the more experienced..

- “God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the knowledge to know the difference”
  ~Reinhold Niebuhr
- “Imagine that was your family member in front of you, would you walk away as they are wincing in pain?”
  ~Simmons College Nursing Professor

Challenges to Pain Management Today

- “Asking patients about pain causes overprescribing... Focusing on satisfaction leads to bad medicine... Eliminate pain questions”
  American College of Emergency Physicians, 4/2016
- “Remove pain as a 5th vital sign... Eliminate it from professional standards and usage so it can’t be used against physicians...”
  J Sellers on behalf of NY State delegation at AMA national meeting, 6/2016
- “Exempt cancer patients from opioid rules”
  Policy Statement, American Society of Clinical Oncology, 5/2016

The Present: Critical Times

- 28-31% reduction in prescriptions for opioids given to injured workers
- Pain specialists are overwhelmed with new patients
- First time opioid prescriptions limited to 7 day Supply for all new patients
- National Pain Strategy is released
- Opioid prescriptions are reduced by 23% in the past year
- Companies plan to cut opioid use among U.S. customers by 75%

The Present: Complex Problems

- Restriction of prescription opioids has caused a shift to heroin and other street drugs
- “We are in a state of pseudo-prohibition in regards to opioids and patients will needlessly suffer from lack of access to pain care...”
  Rose Januzzi, DNP, RN-BC, FNP ASPMN List Serve 6/27/16
- Climate of mistrust between patients and the healthcare team
- The most current CDC and NIDA stats are 2014
- Multiple studies look at the success in decreasing prescribing rates but few published studies have looked at the effect of reduced prescribing on people with pain
- Published reports suggest the use of cannabis in place of opioids.
- Yet, we know far less about cannabis than opioids.

The Voices of People with Pain

- “Everyday we hear news on either drug overdose deaths or addiction. They tug at our hearts. But where are the stories of pain patients? Where is my husband’s voice who lived stoically for over 20 years with chronic pain?”
- “Most pain patients wouldn’t think of selling medication because they need it just to get through the day, yet HCPs are suddenly decreasing doses in spite of the consequences”
- “Being treated like a medical pariah is becoming an increasingly common experience. The stigma of being addicts has been dumped on those of us with chronic pain”
- “I would throw my pain meds away in a heartbeat if I could get pain to a manageable level.”

Pain is the number one reason people seek health care

- A primary MD’s Referral Note to Pain Specialist...
  “DR has been under my care for many years and has been on many regimens for the management of her chronic post-cervical fusion pain. These have included opioids as well as adjuncts. Currently, my colleagues and I are in the process of discontinuing prescribing opioids to patients under 65 years of age. The lack of consensus in the profession about the efficacy of opioids in chronic non-cancer pain makes it difficult to justify the use of opioids in primary care practice. Having said that, I think DR has done better on opioids than without them.”
- A colleague’s experience...
- What’s a person with pain to do???

1. Physician & wife of spouse with chronic pain
2. Patient with persistent pain in an email to the Massachusetts Pain Initiative, 2016
3. Paula Kenney (chronic pain patient), Cape Cod Times, 4/2016
4. Patient with chronic pain
A voice ended too soon

“...After two surgeries he fought the constant pain of his degenerative spinal condition with Oxycontin which, for 13 years, allowed him to work in his landscaping business and live some semblance of normal life. In July his new medical plan cut off the drug and suggested a psychiatrist in lieu of narcotic pain management. In September, unable to stand the constant, excruciating pain, Bill bought a gun and ended his life…”

Sacramento Bee Obituaries September, 2014
William John Jay "Bill" Hays

Voices in Support of People with Pain

- "The vast majority of pain meds are prescribed by competent caring prescribers, dispensed by caring pharmacists and end up in the hands of those who desperately need these drugs to perform everyday functions we take for granted"
  - John Burke at www.painnewsnetwork.org; Past national President of the National Association of Drug Diversion Investigators & past Commander of the Cincinnati Police Dept’s Pharmaceutical Diversion Unit

- "I have seen first hand that patients who have their opioids decreased to ineffective levels due to the current environment of dose reduction turn to street/illicit drugs out of desperation. Recent guidelines do not acknowledge those who are responsible with their medications"
  - Ann Marie Harootunian, MSN; Pain management nurse practitioner in written comments to CDC Guidelines

- "Judge the treatment, not the patient"
  - Dan Alford, MD; Primary care physician and coordinator of Boston University’s Safe and Competent Opioid Prescribing Education Program (SCOPE)

Voices in Support (cont’d)

- "Providers are no longer prescribing and are referring to us. There are many patients being abandoned and taken off their pain meds who are suffering. We have a long waiting list of people who need pain management, but they have to wait."
  - Pain management nurse working in an urban pain clinic

- "There is an imbalance between those who provide care and those who need assistance"

Guidelines for Pain Management

- Evidence Based Practices and Best Practices
  - Make decisions about the care of an individual patient
  - Responses vary based on genetics, gender, prior sensitizations, psychosocial aspects, meaning, litigation, job etc. Individualize ALL therapies to account for our differences

AHROQ Report, 2014:
Long-term Opioid Treatment for Chronic Pain

- Except for the use of buccal fentanyl (> placebo - moderate SOE), all key questions of this AHRQ report resulted in strength of evidence reported as insufficient or low with regards to
  - Effectiveness and comparative effectiveness, harms and adverse events, dosing strategies, risk assessment and mitigation strategies, function, QOL, and outcomes greater than 1 year related to pain,
  - No randomized trials exist of risk of abuse, addiction and related outcomes in patients with chronic pain prescribed opioid therapy
  - In 10 uncontrolled studies, estimates of opioid abuse varied substantially even after stratification by clinical setting (0.6%-14.4%)

- Other results based on single studies of varying quality

Best Practices for Prescribing Opioids for Chronic Pain

- Conduct a physical exam, pain history, past medical history and family/social history
- Establish treatment goals
- Consider all treatment options, weighing benefits and risks
- Start opioids with the lowest effective dose
- Use urine drug testing when appropriate
- Implement pain treatment agreements
- Monitor pain/treatment progress. Document. Use greater vigilance at higher doses
- Use safe and effective methods for discontinuing opioids
- Use data from Prescription Drug Monitoring Programs

Federation of State Medical Boards, 2013; Centers for Disease Prevention and Control (CDC)

“Use the lowest, effective dose for the shortest effective duration without compromising analgesia”

Emphasize “effective” not “lowest”

Published Guidelines: Dose Limit Recommendations

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<th>APS/AAPM</th>
<th>CDC</th>
<th>VA/HID</th>
<th>York State</th>
<th>Canadian</th>
<th>NYS</th>
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<td>&gt; 500 MME/day monitoring</td>
<td>Caution at any dose, increase monitoring at &gt; 15 MME/day. Avoid increasing &gt; 50 MME/day</td>
<td>Refer or consult &gt; 200 MME/day</td>
<td>Consult for &gt; 150 MME/day</td>
<td>Reassess for &gt; 200 MME/day</td>
<td>Reassess for &gt; 150 MME/day</td>
<td>Consider consult &gt; 91 MME/day</td>
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CDC Guidelines (2016): “The evidence is not as robust as we’d like”
Thomas Friedman, Director, CDC 3/16/2016

MAJOR pain management practice changes are being made based on weak evidence!

“The absence of evidence is not evidence of absence”
Carl Sagan, astronomer

“When Bad Evidence Happens to Good Treatments”
Dan Car, MD in Regional Anesthesia & Pain Medicine, 2008

Act NOW

to be sure the pendulum comes to rest in the middle where it belongs so opioids remain safe and effective options for people with pain who benefit from them while we prevent misuse and abuse whenever possible

Appropriate Use of Opioids
Prevention of misuse, abuse and diversion

Opioids are not the enemy-
The disease of addiction and unmanaged or poorly managed pain are!

Act now to achieve a balance.
Shaping the future of pain management

I believe that nurses will solve the mysteries of pain given their patient-centered focus and broad knowledge base, including an understanding of human responses, environmental influences, and the context of pain to the person’s everyday life.

Patrick Wall’s personal communication to Paul Arnstein
In: Core Curriculum for Pain Management Nursing, 2010

“Our lives begin to end the day we become silent about things that matter”

Martin Luther King

What can YOU do now…?

For Patients
- Within the health care system
  - where you work or with broader reach
- Within your community
  - To influence legislative/regulatory proposals
    - Locally, regionally and nationally
- Other options
  - Do what needs to be done to make “pain management nursing and yourself the voice of reason”¹

¹. Adapted from Barbara St. Marie, personal communication, July 2016

National Pain Strategy, 2016

- A coordinated national plan from the U.S. Dept of Health and Human Services aimed at achieving a system of care in which all people receive appropriate, high quality & evidence-based care for pain
- “Importance of self-care and inter-professional treatment”
- A system of patient-centered pain prevention and management based on a biopsychosocial model of care that allows access to the full spectrum of treatment options
- Reduce disparities and improve quality of care for vulnerable, stigmatized and underserved populations
- Improve professional, patient/family and public education in pain management
- Improve patient self-management strategies
- Encourage evaluation of risks and benefits of current treatments
- Conduct research to identify how to provide individual-based care
- Support and push for implementation! Talk with your Congressmen and women


Addressing prescription drug abuse and addiction is critical

- Reduce stigma on people who suffer from substance use disorders (SUDs)
- Screen for, identify, refer and treat people with SUDs
- Community-based overdose prevention (naloxone)²
- Improve access to mental health care
- Improve access to treatment for SUDs, including medication assisted treatment²
- Provide broad and prolonged education for providers
  - Opioids were dispensed to 91% of patients after overdose¹
  - 7% had repeated overdose¹
- Provide broad and prolonged education for patients and the public


Advocating for effective pain care is critical

- Reduce the stigma of people with persistent pain
- Differentiate these patients from those with SUDs
- Provide broad and prolonged education of providers, patient and the public
  - Pre and post licensure, for prescribing privileges, in continuing education, academic detailing
- Emphasize the importance of multi-modal team-based care
- Mandatory REMS in broad-based pain management for prescriptive authority?
- Patient and public education about the risks/benefits of ALL treatments
- Evaluate the risks and benefits of ALL treatments on an individual basis
- Identification and referral of those patients with coexisting pain and SUDs
- Change payer practices that do not cover or limit number of visits for non-pharmacologic or self-care strategies and thus, encourage prescribing
  - PT/OT, counseling, mind-body practices, acupressure, acupuncture, music and art therapies, and other integrative care

All pain management is based on individual responses

Comprehensive assessment & multi-modal plans work best. Almost never are medicines ALONE the answer

Move from a one-size-fits-all approach to one that looks at individual factors like age, comorbidities, function, effects of pain, physical abilities, support system, access to care
To have pain is to have certainty. To hear about pain is to have doubt…

Elaine Scary, *The Body in Pain*
- Improve our assessment skills…
- Continue to ask about pain
- Listen to the story, appreciate the experience of the patient, offer empathy, encouragement and hope, accept self report and assess, assess, assess!

"Tell me about your pain in a way that I can feel it too"

Claire Sampson, RN - Pain Management Nurse

Supporting Patient Self-Care
- Patient Activation
  - Having the knowledge, confidence and skills to take care of one’s health & health care
  - The greater patient involvement in care, the better the outcomes.
- Strategies used by top clinical provider performers using coaching & motivational interviewing
  1. Emphasize patient ownership (here to coach you, not make you better)
  2. Maintain a partnership with the patient – create goals, strategies
  3. Identify small, detailed feasible steps
  4. Schedule frequent follow-up to support, cheer success and problem solve
  5. Let patients know you care about them
- Strategies used by bottom clinical performers
  - Telling patients negative outcomes if they didn’t adhere or change


Patient, Family & Community Education
- Risks of unrelieved pain
- What to report and to whom
- Risks of non-medical use of opioids
- Risks and benefits of opioid therapy
  - Self and others
- Importance of taking medications as instructed
- Safe storage
  - Total possession of medication at all times (locked boxes/safes)
  - At home, work, during recreational activities and when traveling
- Safe disposal
  - 4 in 10 stored pills for later use. Only 23% returned or disposed of left over meds
  - Household strategies, take-back programs


Educating Providers: Are Opioids the Right Choice?
- FOR THIS PATIENT…
  - Are other interventions as effective?
  - Are opioids appropriate for the condition & the individual?
  - Are opioids a part of a multi-modal plan?
  - Are there specific written goals?
  - What is the patient’s risk to abuse opioids?
  - Do benefits of a trial of opioids outweigh the risks?
  - Is there an exit plan before beginning therapy?
  - Does the patient improve with opioids?
  - Are goals being met?
  - Am I prescribing quantities that match anticipated need?
  - Is there a plan for follow-up and reassessment?

Educating Providers: Opioid Therapy Risk Management Tools

Positive Patient/Provider Relationship
- Written Agreements
- Conversations
- Risk Screening Tools
- Multi-modal Plans
- Online Drug Testing

Universal precautions

PMP: Prescription Drug Monitoring Programs; also known as PDMP

Shaping the Future: Have the moral courage!
- Challenge clinical pain practices that are not multi-modal
- Be at the table when policies, procedures, rules and regulations are made
- Educate, educate, educate
- Advocate at work, local, regional, state and national levels to assure the voices of people with pain are heard and they are not marginalized
  - Access to competent pain care
  - Insurance coverage for non-pharmacologic and integrative strategies
  - Balanced laws and regulations
  - Increase quantity and quality of research about pain and SUDs
  - Conduct studies that evaluate the effects of regulatory and reimbursement changes on people with pain
  - Study best practices for managing persistent pain
  - Promote cross-fertilization of researchers in collaborative studies
• “Pain is an emergency for the person experiencing it regardless of the urgency of the underlying pathology. I believe we must apply the science and art of pain relief as if a life depended on it. Certainly the quality of life does.”

• “Every health care provider has an ethical responsibility to do all that is possible to insure that all people with pain have access to comprehensive assessment and an individualized plan for care.”

• “No one should be consumed with despair because of our failure to consider every resource available to us. Be a voice of reason.”