OSC|12
Ohio Safety Congress & Expo

WELL AT HOME. SAFE AT WORK.

655 Interdisciplinary CARF Accredited Chronic Pain Programs

Glenn Swimmer, Ph.D. and Edward Covington, MD

Wednesday, March 28, 2:30 to 3:30 p.m.

Ohio | Bureau of Workers' Compensation

Interdisciplinary CARF Accredited Pain Programs:

An Alternative to Opioids And
Useful for Early Intervention to Avoid PTD

Edward C. Covington, MD
Director, Neurological Center for Pain, Cleveland Clinic
Founder, Chronic Pain Rehabilitation Program

Glenn I. Swimmer, Ph.D.
Director, Paincare of Northwest Ohio
President, Stresscare Behavioral Health, Inc.

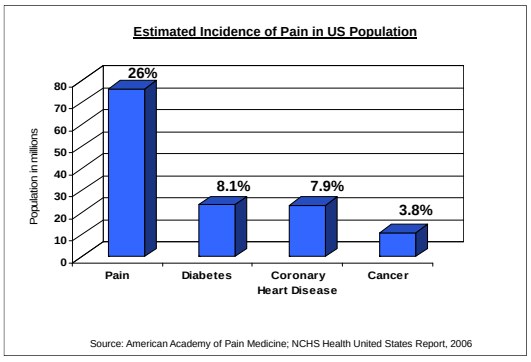
Dr. Covington has directed comprehensive pain programs since 1979
Dr. Swimmer since 1984

Community Prevalence Of Chronic Pain

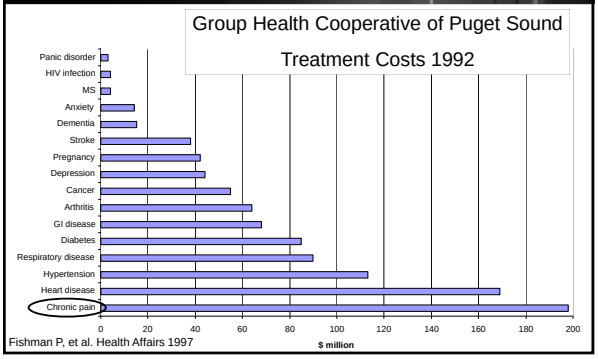
- Representative sample of US adults
  - N = 27,035 responses of 35,718
- Point-prevalence of chronic pain = 30.7%
  (95% CI, 29.8–31.7)
  - Half of those had daily pain
- Average intensity was severe (≥ 7/10)
- Low household income and unemployment were significant correlates
- 89% reported duration ≥ 1 year

Johannes CB et al. J Pain 2010;11(11):1230-1239.

Pain Affects More Americans Than Diabetes, Heart Disease and Cancer Combined



Costs of Chronic Pain



Fishman P, et al. Health Affairs 1997

"Five percent of people with back pain disability are estimated to account for 75% of the costs…"

Frymoyer, J.W, Cats-Baril Wl. Orthop Clin North Am 1991;22:263-71

Impact of Chronic Pain

- Direct treatment costs
  - Healthcare costs for diagnosis & treatment
  - Drugs & therapies
  - Other medical costs
- Loss of work time & productivity
- Depression and other psychological impact
- Impact on overall enjoyment of life
- Impact on family / primary caregiver

Overall chronic pain results in an average loss of 4.6 hours per week in productivity and costs employers between $100 - $150 billion annually

Source: American Academy of Pain Medicine

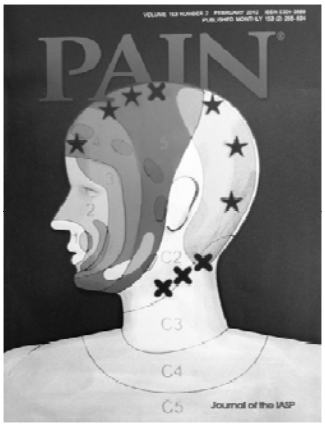
Traditional Biomedical Approach to Pain

Pain is symptom of underlying pathology and always has specific causes

Treat with:
- Local anesthetics
- Nerve blocks
- Surgery

Resulting In:
- Longer hospital stays
- Increased rates of re-hospitalization
- Increased outpatient visits
- Decreased ability to function fully

Gatchel RJ , Okifuji A. J Pain 2006;7(11):779-793



Surgery

Recognition of lumbar disc herniation as a surgically treatable condition dates to 1934.

Mixter WJ, Barr JS. N Engl J Med 211:210-215, 1934

Spinal Surgeries

- An estimated 1.2 million spinal surgeries are performed in the U.S. each year

  "Unnecessary Spinal Surgery Will Waste Billions In 2009." Emaxhealth: Daily Health News. Web. 9 Jan 2009.

- As of 2006 there were an estimated 500,000 spinal fusions per year in the U.S.

  Abelson, R. New York Times, 30 December 2006;9.

Effectiveness of Spine Surgery

- Lumbar Discectomies
  - On average 33% are unsuccessful with 10% reoperation rate

  Hoffman RM et al. J Gen Intern Med 1993; 8(9): 487-496

- Lumbar Fusion
  - On average, 25-35% are unsuccessful
  - Lower success rates with more levels fused and with instrumentation

  Turner JA et al. JAMA 1992; 268(7):907-911

Failed Back Surgery Syndrome (FBSS)

40% of patients may fail to have long-term relief after a first surgery

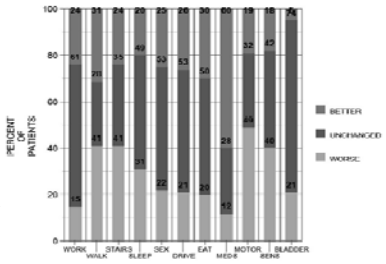
Reasons:

- Inadequate diagnosis
- Improper patient selection
- Inadequate decompression
- Recurrent herniation
- Secondary instability or related degenerative changes
- Inadequate fusion or pseudoarthrosis
- Complications (eg. arachnoid fibrosis)
- Psychosocial factors

North RB, Campbell J, et al. Neurosurgery 28(5) 1991:685-691

FBSS

Surgical Outcomes



- Impairment by pain in daily activities usually unchanged
- Overall, changes were often as favorable as they were unfavorable
- Analgesic intake was reduced in most cases
- Neurological function (strength, sensation, bladder and bowel control) worsened more often than it improved

North RB, Campbell J, et al. Neurosurgery 28(5) 1991:685-691

Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain

Chou R, et al. Spine: 2009;34(10):1066-1077

Outcomes

- Benefits of fusion vs. nonsurgical therapy are only demonstrated in a narrow group of patients
  - ≥ moderately severe pain or disability
  - Unresponsive to nonsurgical therapies for ≥ 1 year
  - No serious psychiatric, medical, or other risk factors for poor surgical outcomes
- In persistent disabling radiculopathy due to herniated disc or persistent and disabling leg pain due to spinal stenosis, surgery offers moderate *benefits, which appear to decrease over time*.

Chou R, et al. Spine: 2009;34(10):1066-1077

Outcomes

- For persistent /disabling radiculopathy due to herniated disc, open discectomy and microdiscectomy :
  - Moderate short-term (6 -12 weeks) benefits compared to nonsurgical therapy
  - Differences in outcomes in some trials are diminished or absent after 1 -2 years.
- Patients tend to improve substantially with or without discectomy.

Chou R, et al. Spine: 2009;34(10):1066-1077

Outcomes

- Most surgical patients do not experience an "excellent" or "good" outcome.
- Early complications occur in up to 18% of patients who undergo fusion in randomized trials.
- Insufficient evidence exists to determine whether instrumented fusion improves outcomes, and additional costs are substantial.

Chou R, et al. Spine: 2009;34(10):1066-1077

Criteria For Grading The Strength Of Evidence And Making Treatment Recommendations

Strength Of Evidence

Good Consistent Results From Well Designed, Well Conducted Studies

Fair Evidence Is Sufficient To Determine Effects On Health Outcomes, But The Strength Of The Evidence Is Limited

Poor Evidence Is Insufficient To Assess Effects

Criteria, Continued

Recommendation

A-Strongly Recommends That Clinicians Consider Offering The Intervention To Eligible Patients

B- Recommends That Clinicians Consider Offering The Intervention To Eligible Patients

C- Make No Recommendations For Or Against The Intervention

D-Recommends Against Offering The Intervention

E- Insufficient Evidence To Recommend For Or Against The Intervention

Level of Evidence for Interdisciplinary Rehabilitation, Injections, and Surgery for Patients with Nonradicular Low Back Pain

Intervention	Condition	Level of Evidence	Net Benefit	Grade
Interdisciplinary Rehabilitation	Nonspecific Low Back Pain	Good	Moderate	B
Intradiscal Steroid Injection	Presumed Discogenic Pain	Good	No Benefit	D
Fusion Surgery	Nonradicular Low Back Pain	Fair	Moderate vs. Standard Nonsurgical Therapy, No Difference Intensive Rehabilitation	B
Facet Joint Steroid Injection	Presumed Facet Joint Pain	Fair	No Benefit	D

Chou R, et al. Spine: 2009;34(10):1066-1077

Level Of Evidence, Continued

Intervention	Condition	Level Of Evidence	Net Benefit	Grade
Epidural Steroid Injection	Nonspecific Low Back Pain	Poor	Unable To Estimate	I
Radiofrequency Denervation	Presumed Facet Joint Pain	Poor	Unable To Estimate	I
Radiofrequency Denervation	Presumed Discogenic Pain	Poor	Unable To Estimate	I
Spinal Cord Stimulation	Nonspecific Low Back Pain	No Trials	Unable To Estimate	I
Intrathecal Therapy	Nonspecific Low Back Pain	No Trials	Unable To Estimate	I

Chou R, et al. Spine: 2009;34(10):1066-1077

Recommendations for Persistent, Nonradicular LBP

- Consider intensive IPRP with a cognitive/behavioral emphasis
  - Similar in effectiveness to fusion
  - Strong recommendation, high-quality evidence
- Facet injections, prolotherapy, and intradiscal injections are not recommended
  - There is no convincing evidence that injections and other interventional therapies are effective.
  - Injections are not recommended because trials consistently found them to be no more effective than sham therapies.

Chou R, et al. Spine: 2009;34(10):1066-1077

During the decade between 1997 and 2006:

- Facet blocks increased 543% (Medicare beneficiaries)

Manchikanti L et al. Pain Physician. 2009; 12:9-34

Recommendations, Cont.

Surgical decision-making should include specific discussion about:

- Intensive interdisciplinary rehabilitation as a similarly effective option
- The small to moderate average benefit from surgery
- The fact that most patients who undergo surgery do not experience an optimal outcome

Chou R, et al. Spine: 2009;34(10):1066-1077

- Uncontrolled studies:
  - Rehabilitation alone may result in excellent outcomes even after surgery has been advised.

Weber, H. Spine 1983;8:131-139

Hoffman RM et al. J Gen Intern Med 1993;8:487-496

- With rare exceptions, lumbar spine surgery is elective

Deyo RA et al. Involving Patients in clinical Decisions: Impact of an Interactive Video Program on Use of Back Surgery. Medical Care 2000; 38(9): 960.

- In patients with herniated discs the primary benefit is accelerated relief of sciatica; outcomes after 3 years are similar with or without surgery

WEBER, H. LUMBAR DISC HERNIATION: A CONTROLLED, PROSPECTIVE STUDY WITH TEN YEARS OF OBSERVATION. SPINE 1983;8:131-139
HOFFMAN RM, WHEELER KF, DEYO RA. SURGERY FOR HERNIATED LUMBAR DISCS: A LITERATURE SYNTHESIS. J GEN INTERN MED 1993; 8(9): 487-496

IPRP Should Be Considered as an Alternative to Spine Surgery

- Patients:
  - With moderate or high level of psychosocial risk factors
  - Uncertain about whether to have surgery
  - With unrealistic outcome expectations
  - With comorbid physical problems, such as diabetes, obesity, etc.

Block AR, Guyer, RD. Chronic Pain Management, 65. 2007

Opioids

Chronic Opioid Therapy Slows Pain Recovery?

- Danish Health Interview Survey
- N = 2354, Non Cancer Pain
  - Interview in 2000 and questionnaire + F/U in 2005
- Annual incidence new chronic pain was 2.7%
- Annual recovery from chronic pain 9.4%
- Odds of recovery from chronic pain were almost 4 times higher among individuals not using opioids vs using opioids
- Strong opioids associated with poor health-related quality of life.
  - Sjøgren P et al. Clin J Pain 2010; 26(9):763-769

The Opioid Problem

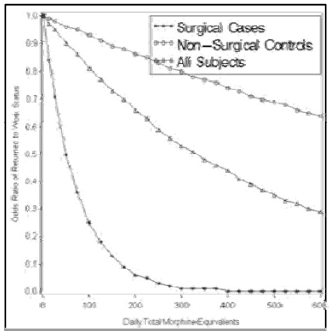
- Well known
  - Odds of recovery from chronic pain were almost 4 times higher among those not using opioids vs using opioids
  - Strong opioids associated with poor Health Related Quality Of Life

Sjogren Petal. Clinical J Pain 2010; 26(9): 763-769

Total Morphine Equivalents as Predictor of Return to Work

- Historical Cohort Study
- Workers' Compensation Subjects with lumbar fusion
  - 725 fusion cases
  - 725 WC controls with LBP
- Main Outcomes:
  - RTW status 2 years after DOI or date of surgery

Nguyen TH, ET AL. Spine 2010 AUG 23. [EPUB AHEAD OF PRINT]

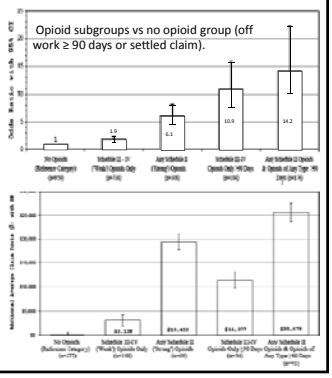


In LBP – Work Loss, Claim Costs

- Workers Compensation Fund Of Utah
- 2/3 of the market
- DOI 1/1/02 – 6/30/05
- 122,530 Workers filed claims
- N=2005 non surgical LBP

- Compared opioid vs non-opioid users
  - Work loss
  - Claim costs

Volinn E et al. Pain 2009;142(3):194-201

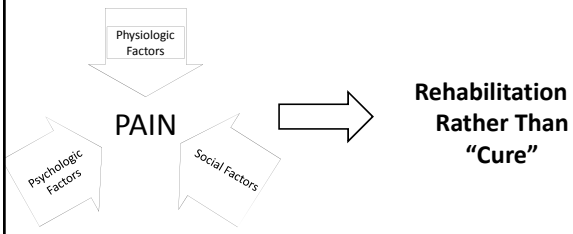


Interdisciplinary Pain Rehabilitation Programs (IPRP)

Not all pain can be abolished by surgery, injections or medication and often there is no fixable underlying problem

Ballantyne, J.C. Chronic Pain Management 49-64. 2007

Rehabilitation Approach To Pain



Chronic pain typically fails to respond well to a single medication, procedure or therapy, but requires a comprehensive program (CPP) that addresses all aspects of this complex condition

Gatchel RJ , Okifuji A. J Pain 2006;7(11):779-793

Traditional Biomedical Model

When the pain goes away then I can…

- Have a life
- Go back to work
- Be a good spouse, parent, friend

Rehabilitation Model

Resume life now and, while you may still have pain it won't run your life.

Pain Rehabilitation Approach

- Focused on improved function
- Pain is the last thing to improve
- Treatment involves re-activation:
  - Exercise
  - Self-management
    - Biofeedback
    - Relaxation training
    - Cognitive coping
    - Cognitive-behavior therapy
    - Goal setting
    - Stress management
  - Education
  - Vocational counseling
    Medication management
  - More exercise!

What Is An Interdisciplinary Pain Rehabilitation Program?

Multidisciplinary Care Model	Interdisciplinary Care Model
Patient is recipient of care; passive	Patient is at the center of care; proactive
Two or more specialists	Team of specialists
Independent therapeutic goals	Collaborative therapeutic goals
Chain of command approach and style	Egalitarian approach and style
Independent roles	Overlapping roles
Limited intercommunication	Frequent intercommunication

Stamos, S. Practical Pain Management, 2006: A-e

CARF (Commission On Accreditation Of Rehabilitation Facilities)

- Provides outcomes-focused, coordinated, goal-oriented interdisciplinary team services.
- Measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

The Team

- Medical director
- Psychologist
- Social worker
- Counselors
- Vocational counselor (CRC)
- Chemical dependency counselor
- Occupational therapist
- Certified occupational therapy assistant (COTA)
- Physical therapist
- Physical therapy assistant (PTA)
- Massage therapist
- Aquatics specialist
- Biofeedback technician
- Nurse
- Health educator
- Claimant
- Claimant family member

Interdisciplinary Pain Rehabilitation Components

- Medications
- Education
- Reconditioning PT/OT
- Detoxification / Weaning
- Biofeedback / Relaxation Training
- Operant Conditioning
- Psychotherapies
- Chemical Dependence Treatment
- Vocational Assessment / Counseling
- TENS
- Nerve Blocks

Treatment Targets

- Function
  RTW, play, socialization
- Affect
- Inappropriate health care utilization
- Medication overuse
- Demedicalize claimant
- Pain

IPRPS FOCUS ON DEMEDICALIZING

Acute Pain Is A Symptom

Chronic Pain Is A Disease

A Symptom You Cure. A Disease You Manage, e.g. Heart Disease, Diabetes, Etc.

"Chronic pain is clearly a disease of the person, not simply the body."

Schatman ME, Chronic Pain Management: Guidelines For Multidisciplinary Program Development. 2007

What Is Pain Coping?

Pain Coping

Active pain coping
Belief in one's competence to control pain

- Results in less severe pain & higher levels of functional activity
- Self-efficacy (SE) belief that one can perform a task or obtain a desired outcome
  - Requires patient participation in a treatment setting that facilitates learned control over pain

Roth RS et al. Published Online; 16 November 2011

Pain Coping, Cont.

Higher SE for pain:

- Increased functional ability and adjustment to pain
  Marks R. Efficacy Theory And Its Utility In Arthritis Rehabilitation: Review And Recommendations. Disab Rehabil. 2001; 23:271-280
- Mediates relationship between pain and disability
  Costa Lcm Et Al. Self-efficacy Is More Important Than Fear Of Movement In Mediating The Relationship Between Pain And Disability In Chronic Pain. Eur J Pain. 2011;15:213-219
- Associated with lower pain intensity
  Keefe Fj Et Al. Self-efficacy For Arthritis Pain: Relationship To Perception Of Thermal Laboratory Pain Stimuli. Arthritis Care Res. 1997: 10:177-184
- Less severe pain-related distress and disability
  Dolce Jj Et Al. The Role Of Self-efficacy Expectancies In The Prediction Of Pain Tolerance. Pain. 1986; 27:261-272

Pain Coping

- Acceptance-Based Therapy
  - Redirects patients from controlling pain to focus on valued activities and acceptance that they can still participate in life and achieve goals
  - Associated with decreased pain, disability and depression
- Fixation on unattainable pain relief:
  - Increases feelings of helplessness, defeat and disillusionment

Pain Coping, Cont.

- Surgery, injections require little patient participation
- Instill view that eradication of pain is effortless and without patient responsibility or ongoing management
- When they fail, the prior promise of pain relief under conditions of passivity and dependency enhance the difficulty of reorienting patient to the need for self-directed involvement in coping with enduring pain.

Roth RS et al. Translational Behavioral Medicine 2012; 2(1):106-116

Pain Coping

Passive coping is associated with

- Poor adjustment to pain
  - More severe pain
  - Greater functional impairment
  - Work disability
  - Current & future depression
  - Lower self esteem

Kerns RD et al. PAIN 1997,72:227-234

Victim Or Victor?

If It's To Be It's Up To Me

Hurt ≠ Harm (Kinesophobia)

Weaning of Opioids, Benzodiazepines and Other Scheduled Medications in the Context of Interdisciplinary Pain Rehabilitation

Medical Issues in Opioid Maintenance

- Potential Benefits
  - Analgesia
  - Function
  - Quality Of Life
- Risks
  - Toxicity
  - Functional Impairment
  - Addiction / Physical Dependence
  - Hyperalgesia

Opioid Research vs Usual Practice

Research

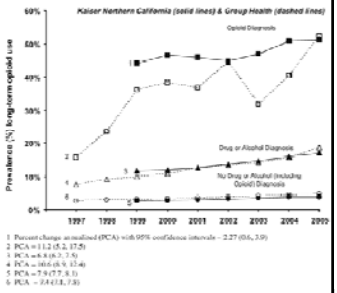
- Perfect patients
- ~ 6 months rx
- Low-moderate doses
- No additional controlled substances
- Tightly controlled rx by experts

Usual Practice

- Comorbid substance use, psychiatric illness, poorly explained pain
- Years of rx
- Moderate – high doses
- Combined with benzodiazepines, Soma, sedatives, stimulants
- Loose supervision by non experts

In Practice –
Patients at Highest Risk Receive the Most Drugs

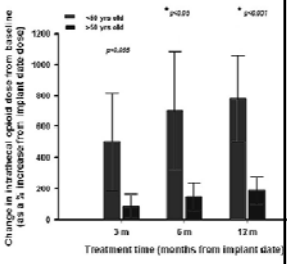
- N = 4 million
- Prevalence of long-term opioid use for CNMP by drug or alcohol diagnosis and opioid diagnosis in the prior 2 years.
- Individuals with SUDs:
  - Higher dose regimens
  - Received more days supply
  - More likely to receive short and long-acting schedule ii opioids
  - More likely to receive 180+ days of sedative-hypnotics
- Similar patterns were again significant (p<0.0001) when comparing persons with an opioid use disorder to those without an opioid use disorder.



Constance M et al. Pain 145 (2009) 287–293

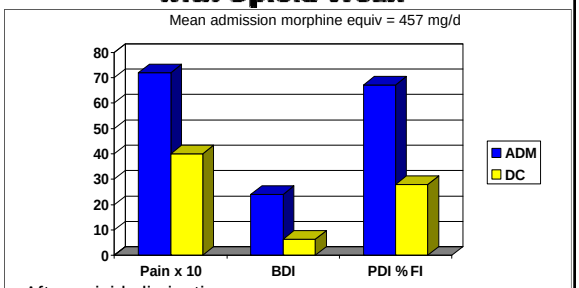
Change in Intrathecal Dose by Age
1 Year after Implant

- 135 chronic noncancer
- Divided into ≤ 50, >50 Y.O.
- Similar pain at 1 year
- Dose escalation 750% vs 195%
- Oral opioids
  - Decreased in the older (140 to 62 mg/day P < 0.001
  - No change in younger(128 to 105 mg/D P=0.65



Hayek SM, et al. Pain Medicine 2011; 12: 1179–1189

Chronic Pain Rehabilitation Program with Opioid Wean



After opioid elimination:
- 3 had increased pain
- 42 had pain reduction

Covington EC, unpublished data

What Do These Studies Have in Common?

- All were performed with opioid failures
- It is not surprising to find that patients are better when taken off a drug that wasn't working

Opioid Induced Hyperalgesia

- Poorly understood, but
- Varies with opioid
  - Less with methadone?
- Varies with individual
  - Mouse model demonstrates genetic propensity varies
    - De-Yong Liang. Anesthesiology 2006; 104:1054–62
- Depends on CCK activation of descending facilitatory tract

"Downhill Spiral"

Does chronic opioid use lead to a downhill spiral?

- Retrospective study: n=243 consecutive patients
- Answer – yes, but…
- Association between poor status and opioid use disappeared when controlled for BZs
- Benzodiazepine use was associated with:
  - Functional impairment
  - Healthcare utilization
  - Depression
  - Pain
- Effects were small
  - Ciccone DS, et al. *J Pain Symptom Manage.* 2000;20:180–192.

Bz Use Predicts Opioid Use More Than Does Pain

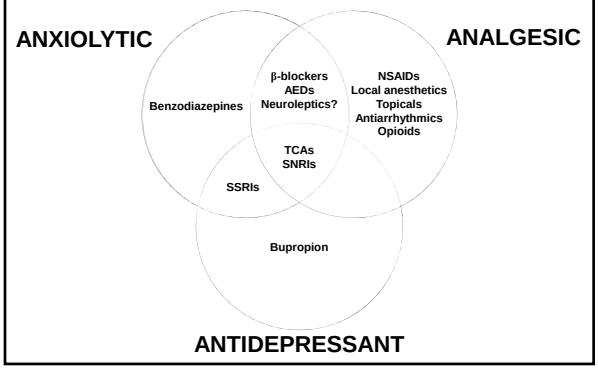
- N = 17,074 who were opioid free in 2000–2001
- Linked to Norwegian prescription database during 2004–2007
- OR for moderate-high prescription frequency of opioids for previous bz users was 7.7
- Bz use was stronger predictor of opioid use than pain
- Benzodiazepine users had more disability, CV disease and musculoskeletal pain

Skurtveit S. Pain Medicine 2010; 11: 805–814

My Conclusions re Benzodiazepine Use in Pain

- Bz use disorders comprise a very small portion of addictive disorders
  - Despite the fact that 12% of adults and 40% of pain patients use or have used them
- Many (most?) addicts, with or without chronic pain, use bzs
- Bzs probably do not help pain, and they impair function
- Patients usually don't escalate doses
  - But they can't stop
- Are they addicted?
  - Tolerance, dependence, inability to stop, no misuse
  - Consequences? They attribute to pain, others attribute to opioids, but some portion of impairment is likely bz-related.

Parsimonious Polypharmacy



Our Strategy

- Assumptions
  - If opioids are not a clear asset, they are probably a liability and should be stopped
  - Functional restoration is a primary metric for benefit
  - Almost no chronic pain patient should receive long term benzodiazepines, Soma, or non-benzodiazepine hypnotics
- We focus on alternate medications + behavioral management to improve comfort, function, and quality of life

Weaning Addictive Substances

- FDA
  - It is "weaning" if medications were prescribed for therapeutic purposes
  - It is "detoxification" if medications were taken illicitly for recreational purposes
- There are no studies to demonstrate the optimal strategy for weaning opioids or sedatives
  - It's like sharing cookie recipes
  - Everyone thinks theirs is best

Weaning

- Opioids and sedatives are usually eliminated in 12-14 days
- Patients are typically surprised to find that they are better
  - "It's like coming out of a fog"
  - "I feel like I'm myself again"
  - "My thinking is clearer"
  - "My energy is back"
- If addiction is present and craving a problem
  - Suboxone therapy
- If clear deterioration in pain/function off opioids and absence of addiction
  - May resume low dose opioids with no allowance for escalation

DIFFERENCES: IPRPS & CD PROGRAMS

Differences Between Interdisciplinary Pain Programs and Detox/Chemical Dependency Programs

- Chronic pain patients don't identify themselves as addicts, regardless of opioid use and respond poorly to referral to chemical dependency program
- If forced to go to chemical dependency program, often get "you can make me go but you can't make me get anything out of it"
- Chemical dependency programs don't offer injured worker enough in the way of skills and techniques to replace the medication

Differences, Cont.

- IPRP offers weaning of medication, physical rehabilitation, vocational counseling and coping skills targeted for pain.
- Injured worker more likely to feel they are in the right place in IPRP vs with end stage alcoholics, IV drug users, people who have lost everything due to addiction (chemical dependency program)

IPRP Does Not Involve a Psych or Abuse/Dependence Allowed Condition

The Appropriate Place for Chemical Dependency Programs for Injured Worker

Case Example

Paulette:

Registered nurse. "Med-surg" floor nurse. Family history of alcoholism. She and husband were frequent THC smokers before injury.

Her drug of choice "OC". She "doctor shopped" x 2. Bought OxyContin from a "friend" and was $40,000 in debt because of her addiction.

The Appropriate Place, Cont.

Comment: with Paulette, the primary problem is addiction. Her pain problem is secondary. She needs chemical dependency treatment.

With most injured workers the primary problem is chronic pain. If opioids are an issue the IW needs an interdisciplinary pain rehabilitation program while being weaned.

Indicators For IPRP

Who Requires Iprp?

- Thoroughly evaluated
  - Pain as well understood as possible
  - No definitive treatment is reasonable
  - Rehab effort is safe
    - Inflammatory arthritis, Crohn's, pancreatitis pain treated when inactive

Indicators for Interdisciplinary Rehabilitation

- Intractable pain
  - Absence of viable medical / surgical solution
- Inordinate functional impairment
- Iatrogenic addiction
- Motivated to work a rehabilitation / coping program vs passive "fix me" approach or can be "hooked" into active/self management approach

BWC Indicators

BWC: Injured Worker Eligibility Indicators

- IW…EXCESSIVE pain behaviors disproportionate to the compensable injury or condition
- IW has not responded to traditional medical treatment
- It is recommended IW be referred to BWC certified CARF accredited program… the ideal time frame… six months to three years, but referrals should not be limited to those time frames.

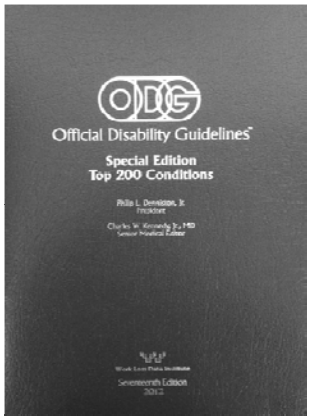
(NOTE: NOT DIAGNOSIS DRIVEN LIKE ODG)

Eligibility Indicators, Cont.

- No acute medical problems, medically stable
- IW… significant emotional distress…
- IW… goal of RTW if appropriate. If no RTW goal… expectation of cost savings

BWC Fee Schedule & Codes

	BWC UCR
W1001 – Evaluation (P.T., O.T., Psych And Medical) Full Interdisciplinary Report	$600
W1000 – Per Diem	$500
W1002 – Four Hours Or Less	$250



Chronic Pain Programs – Procedure Summary (ODG)

"It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition."

Denniston, Philip L., ed. *Official Disability Guidelines.* Corpus Christi, TX: Work-Loss Data Inst., 2012. Print.

Criteria for Interdisciplinary Pain Management Programs

Medically necessary when:

- An adequate and thorough evaluation has been made
- Previous methods of treating the chronic pain have been unsuccessful
- The patient has significant loss of ability to function independently resulting from pain

Denniston, Philip L., ed. *Official Disability Guidelines.* Corpus Christi, TX: Work-Loss Data Inst., 2012. Print.

Criteria, Cont.

- …Surgery not clearly warranted
- …Motivation to change …willing to forego secondary gains…

Denniston, Philip L., ed. *Official Disability Guidelines.* Corpus Christi, TX: Work-Loss Data Inst., 2012. Print.

Criteria, Cont.

Comment:

- Secondary gain issue could be applied to <u>any</u> treatment

Denniston, Philip L., ed. *Official Disability Guidelines.* Corpus Christi, TX: Work-Loss Data Inst., 2012. Print.

Chronic Pain Programs, Early Intervention – ODG

- Recent suggestions:
  - IPRPs have a place in treatment prior to the development of permanent disability
  - Perhaps no later than 3 - 6 months after a disabling injury.

Outcomes

Outcome Data: Return To Work Rates

Study	Comprehensive Pain Program	Control
Bendix Et Al, 1996	64 (%)	29 (%)
Deardorff Et Al, 1991	48	0
Duckro Et Al, 1985	71	33
Feuerstein Et Al, 1993	74	40
Finlayson Et Al, 1986	65	44
Guck Et Al, 1985	75	25
Hazard Et Al, 1989	81	29
Hildebrandt Et Al, 1997	62	N/A
Mayer Et Al, 1987a	87	41

Outcome Data: Return to Work Rates, Cont.

Study	Comprehensive Pain Program	Control
Pfingsten Et Al, 1997	63	N/A
Roberts & Reinhardt, 1980	77	5
Sachs Et Al, 1990	63	42
Sturgis Et Al, 1984	29	14
Tollison Et Al, 1989	56	27
Tollison, 1991	57	20
Tyre Et Al, 1994	86	N/A
Vendrig Et Al, 2000	65	N/A
Average	**66(%)**	**27(%)**

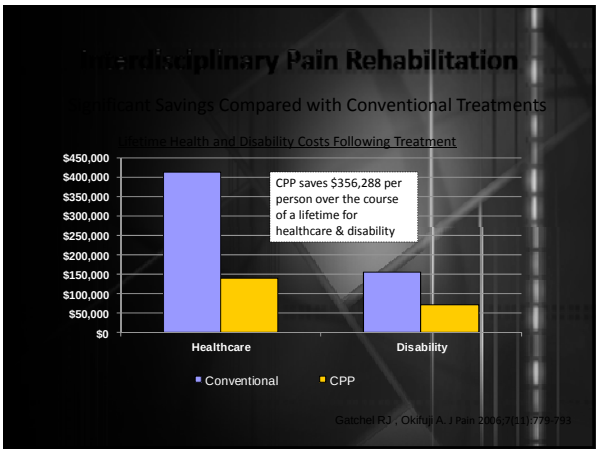
Gatchel And Okifuji (2006)

Outcome Data: Healthcare Utilization Cost Comparisons Study Results

	Costs (Millions)		
Treatment	Interdisciplinary Pain Centers	Surgical	Conventional
Initial Treatment	$142.8	$158.4	$457.8
Subsequent Surgery	$25.3	$88.7	$44.3
1-year Post Treatment (Medical)	$197.1	N/A	$457.8
Lifetime Disability	$1,835.3	N/A	$4,226.8
Total	$2,200.4		$5,186.4

*Medical Treatment Excludes Surgical Procedures.
N/A Indicates Data Not Available For Estimates. Modified From Lawrence Eribaum Associates.

(Stamos, S. Evaluating Interdisciplinary And Multidisciplinary Approaches To Chronic Pain Mangement. Practical Pain Management Ce & Accredited Monograph, 2006: A-e)

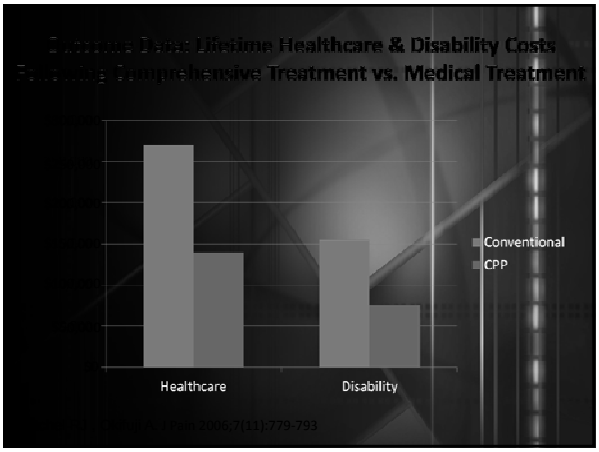


Cost Effectiveness of IPRPS vs Alternatives

IPRPS Are…

- 12 times more cost effective than conventional care
- 17.5 times more cost effective than spinal cord stimulation
- 30 times more cost effective than surgery

Okifuji, et al. Outcomes Following Multi-disciplinary Pain Treatment. in: Block A, et al., eds., Handbook Of Pain Syndromes: Biopsychosocial Perspectives. Mahwah, NJ: Erlbaum; 1999:77-98



Three decades of research has consistently documented the therapeutic superiority of multidisciplinary pain treatment compared to less comprehensive therapies or single-modality interventions

Roth RS et al. Translational Behavioral Medicine 2012; 2(1):106-116

"…Chronic pain management has been empirically demonstrated, beyond a doubt, to be a clinically effective and cost-efficient approach… to the treatment of chronic pain…"

Schatman ME, Chronic Pain Management: Guidelines for Multidisciplinary Program Development. 2007

WHY AREN'T THERE IPRPS ON EVERY CORNER?

"The Allure Of A Cure"

IPRP Can't Offer Cures

•30+ years of research leads to serious doubts that we can eliminate chronic pain simply by altering physiological pain pathways

Geisser, M., R. Roth, and D. Williams. "The Allure of a Cure." *The Journal of Pain* 7.11 (2006): 797-99. Print.

How to Use IPRPS To Cut Costs and Prevent PTD

Identify the 5 - 10% at Risk

High Risk for Chronicity

- Loss of employment > 4 weeks (ODG)
- Previous medical history of delayed recovery (ODG)
- Response to treatment falls outside of established norms for dx. (ODG)
- Poor response to single modalities
- Opioid use (high doses)
- Multiple "scheduled" drugs in addition to opioids (e.g. benzodiazepines)
- Passivity

CARF Accredited IPRPs: To Prevent "Chronification" As An Alternative To Opioids

Preventing Chronification:

1. We collaborate and create a "new normal"

   -"Operation prevent PTD" "Operation P.C. (prevent chronification)"

   Accept: from time of injury we are in a battle for hearts and minds.

   Assign someone internally so within the first 3-6 months high risk claimants are identified. It's like with a CVA – get to hospital in first 3 hours.

*Joos B et al J Negat Results Biomed. 2004;3:1

IPRPS And MMI

Carf Accredited Programs Have Two Important Areas Of Contribution:

A) Early intervention per ODG guide

"Intervention as early as 3 to 6 months past injury may be recommended…"

"It is now being suggested that there is a place for interdisciplinary programs at a stage in treatment prior to the development of permanent disability, and this may be no later than 3 to 6 months after a disabling injury…"

Contributions, Cont.

B) Decreasing or eliminating opioid use while increasing function

- No psych claim or chemical dependency claim needed or created!

Interdisciplinary Pain Rehabilitation Programs (IPRP) Summary

- Improved function and RTW status
- Reduction in pain and pain related disability
- Reduced ER visits due to pain
- Reduced hospital admissions due to pain
- Reduced medical and disability costs
- Better lives for a lot of people
- Represent what should be #1 option for preventing chronification and for opioid weaning

Can You Think Of One Claimant In Need Of An IPRP?

If You Can, Locate a Good IPRP

Key Points

- Acute pain is A symptom. Chronic pain is A disease. You manage it.
- Chronic pain is a disease of the person, not simply the body
- Chronic pain is best treated in an IPRP

Unproven Conclusions Based On 35 Years Of Chronic Pain Work

- Most acute pain is nociceptive – orthopedic, inflammatory, ischemic, etc
- Most chronic pain is neurological – primarily central and peripheral sensitization
- The vast majority of disability is psychosocial
- Therefore, repeated peripheral treatments for chronic pain typically fail
  - Lysis of adhesions, repeated laminectomies/fusions, epidural steroid injections

More Unverified Conclusions

- The last 35 years
  - An explosion of knowledge re: the neurophysiology of pain
  - An explosion in treatments – blocks, stimulators, intrathecal analgesia, chronic opioids, disc replacements
  - A man who hurts his back at work in 2012 is no more likely to return to work or recover function than a man in 1970
  - However, he'll spend a lot more doing it
- Chronic opioids help a minority of patients feel better
  - >50% of "ideal subjects" drop out after 6 months
  - They impair function in many patients, especially if young, on high doses

CARF/JCHO Accredited Interdisciplinary Pain Rehabilitation Programs in Ohio

Cleveland Clinic Pain Rehabilitation Program
9500 Euclid Ave
Cleveland, Oh 44195
Phone: 216-636-5860

Cleveland Clinic Children's Hospital For Rehabilitation
2801 Martin Luther King Dr.
Cleveland, Oh 44104
Phone: 216-448-6400

Hire/Prowork
360 South Main Street
Dayton, Oh 45402
Phone: 937-208-2065

Paincare of Northwest Ohio
3425 Executive Pkwy #230
Toledo, Oh 43606
419-531-3500

Ohio Health Workrehab
223 East Town Street
Columbus, Oh 43215
Phone: 937-208-2065

Pain Solutions Network
1325 Kemper Road
Cincinnati, Oh 45246
Phone: 513-671-7246

Contact Information

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  216-636-5860
  WWW.CLEVELANDCLINIC.ORG/CPRP
- Glenn I. Swimmer, Ph.D.
  Director, Paincare Of Northwest Ohio
  President, Stresscare Behavioral Health, Inc.
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  Www.Paincarenwo.Com

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