Interdisciplinary CARF Accredited Chronic Pain Programs

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

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

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


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

Costs of Chronic Pain

Group Health Cooperative of Puget Sound

Treatment Costs 1992

- Pain disorder
- Stroke
- Dementia
- Respiratory disease
- Diabetes
- GI disease
- Arthritis
- Cancer
- Heart disease
- Depression
- Anxiety
- Chronic

Futran J et al. Health Affairs 1997


Estimated Incidence of Pain in US Population

“Five percent of people with back pain disability are estimated to account for 75% of the costs...”


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

Source: American Academy of Pain Medicine

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


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.

Spinal Surgeries

- An estimated 1.2 million spinal surgeries are performed in the U.S. each year
- As of 2006 there were an estimated 500,000 spinal fusions per year in the U.S.

Effectiveness of Spine Surgery

- Lumbar Discectomies
  - On average 33% are unsuccessful with 10% reoperation rate
- Lumbar Fusion
  - On average, 25-35% are unsuccessful
  - Lower success rates with more levels fused and with instrumentation
  Turner SA 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

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


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

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.
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.


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.


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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Condition</th>
<th>Level of Evidence</th>
<th>Net Benefit</th>
<th>Grade</th>
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<tr>
<td>Interdisciplinary Rehabilitation</td>
<td>Nonspecific Low Back Pain</td>
<td>Good</td>
<td>Moderate</td>
<td>B</td>
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<tr>
<td>Intradiscal Steroid Injection</td>
<td>Presumed Discogenic Pain</td>
<td>Good</td>
<td>No Benefit</td>
<td>D</td>
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<tr>
<td>Fusion Surgery</td>
<td>Nonradicular Low Back Pain</td>
<td>Fair</td>
<td>Moderate vs Standard Nonsurgical Therapy, No Difference</td>
<td>B</td>
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<tr>
<td>Facet Joint Steroid Injection</td>
<td>Presumed Facet Joint Pain</td>
<td>Fair</td>
<td>No Benefit</td>
<td>D</td>
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</table>


Level Of Evidence, Continued

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Condition</th>
<th>Level Of Evidence</th>
<th>Net Benefit</th>
<th>Grade</th>
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</thead>
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<td>Nonspecific Low Back Pain</td>
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<td>Unable To Estimate</td>
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<tr>
<td>Radiofrequency Denervation</td>
<td>Presumed Facet Joint Pain</td>
<td>Poor</td>
<td>Unable To Estimate</td>
<td>I</td>
</tr>
<tr>
<td>Radiofrequency Denervation</td>
<td>Presumed Discogenic Pain</td>
<td>Poor</td>
<td>Unable To Estimate</td>
<td>I</td>
</tr>
<tr>
<td>Spinal Cord Stimulation</td>
<td>Nonradicular Low Back Pain</td>
<td>No Trials</td>
<td>Unable To Estimate</td>
<td>I</td>
</tr>
<tr>
<td>Intrathecal Therapy</td>
<td>Nonradicular Low Back Pain</td>
<td>No Trials</td>
<td>Unable To Estimate</td>
<td>I</td>
</tr>
</tbody>
</table>


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.


During the decade between 1997 and 2006:

- Facet blocks increased 543% (Medicare beneficiaries)

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


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


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, Gayer, 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.
  - Sjogren Petal. Clinical 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
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]

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


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

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

When the pain goes away then I can...
- Have a life
- Go back to work
- Be a good spouse, parent, friend

Gatchel RJ, Okifuji A. J Pain 2006;7(11):779-793
Resume life now and, while you may still have pain, it won’t run your life.

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
- Patient is recipient of care; passive
- Two or more specialists
- Independent therapeutic goals
- Chain of command approach and style
- Independent roles
- Limited intercommunication

Interdisciplinary Care Model
- Patient is at the center of care; proactive
- Team of specialists
- Collaborative therapeutic goals
- Egalitarian approach and style
- Overlapping roles
- Frequent intercommunication

Stamos, S. Practical Pain Management, 2006: A

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.

“What 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

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**Pain Coping, Cont.**

Higher SE for pain:

- Increased functional ability and adjustment to pain
  

- Mediates relationship between pain and disability
  

- Associated with lower pain intensity
  

- Less severe pain-related distress and disability
  
  Marks R et al. The role of self-efficacy expectation in the prediction of pain tolerance. Pain. 1986; 27:261-272

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**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

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**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.

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**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

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**Victim Or Victor?**

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

Potential Benefits
– Analgesia
– Function
– Quality Of Life

Risks
– Toxicity
– Functional Impairment
– Addiction / Physical Dependence
– Hyperalgesia

Medical Issues in Opioid Maintenance

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.

Change in Intrathecal Dose by Age 1 Year after Implant

- 135 chronic noncancer
- Divided into ≤ 50, >50 Y.O.
- Similar pain at 1 year
- 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)


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

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

Chronic Pain Rehabilitation Program with Opioid Wean

Mean admission morphine equiv = 457 mg/d

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

Covington EC, unpublished data
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.

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

- 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.

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 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

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: 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)

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.”

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

Comment:

• Secondary gain issue could be applied to any treatment

Outcomes

Criteria, Cont.

• ...Surgery not clearly warranted
• ...Motivation to change ...willing to forego secondary gains...

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.

Outcome Data: Return To Work Rates

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<tr>
<th>Study</th>
<th>Comprehensive Pain Program</th>
<th>Control</th>
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<tr>
<td>Bendix Et Al, 1996</td>
<td>64 (%)</td>
<td>28 (%)</td>
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<tr>
<td>Deardorff Et Al, 1991</td>
<td>48 (%)</td>
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<td>Duckro Et Al, 1985</td>
<td>71 (%)</td>
<td>31 (%)</td>
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<tr>
<td>Feuerstein Et Al, 1993</td>
<td>74 (%)</td>
<td>40 (%)</td>
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<tr>
<td>Finlayson Et Al, 1986</td>
<td>66 (%)</td>
<td>44 (%)</td>
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<tr>
<td>Guck Et Al, 1985</td>
<td>75 (%)</td>
<td>25 (%)</td>
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<tr>
<td>Hazard Et Al, 1989</td>
<td>81 (%)</td>
<td>29 (%)</td>
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<tr>
<td>Hildebrandt Et Al, 1997</td>
<td>62 (%)</td>
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<tr>
<td>Mayer Et Al, 1987a</td>
<td>87 (%)</td>
<td>31 (%)</td>
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Interdisciplinary Pain Rehabilitation

Significant Savings Compared with Conventional Treatments

Outcomes Data: Return to Work Rates, Cont.

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<tr>
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<tr>
<td>Pfingsten Et Al, 1997</td>
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<td>Sachs Et Al, 1990</td>
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<td>Sturgis Et Al, 1984</td>
<td>29</td>
<td>14</td>
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<td>Tollison Et Al, 1989</td>
<td>56</td>
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<td>Tollison, 1991</td>
<td>57</td>
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<tr>
<td>Tyre Et Al, 1994</td>
<td>86</td>
<td>20</td>
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<td>Vending Et Al, 2000</td>
<td>65</td>
<td>N/A</td>
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<tr>
<td><strong>Average</strong></td>
<td><strong>66(%)</strong></td>
<td><strong>27(%)</strong></td>
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Gatchel And Okifuji (2006)

Outcome Data: Healthcare Utilization Cost Comparisons Study Results

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<th>Treatment</th>
<th>Interdisciplinary Pain Centers</th>
<th>Surgical</th>
<th>Conventional</th>
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<td>Initial Treatment</td>
<td>$142.8</td>
<td>$138.4</td>
<td>$457.8</td>
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<tr>
<td>Subsequent Surgery</td>
<td>$25.3</td>
<td>$88.7</td>
<td>$491.8</td>
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<td>1-year Post Treatment</td>
<td>$197.1</td>
<td>N/A</td>
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<td>(Medical)</td>
<td></td>
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<tr>
<td>Lifetime Disability</td>
<td>$1,835.3</td>
<td>N/A</td>
<td>$4,226.8</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$2,200.4</strong></td>
<td>N/A</td>
<td><strong>$5,666.4</strong></td>
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*Medical Treatment Excludes Surgical Procedures.
N/A Indicates Data Not Available For Estimates. Modified From Lawrence Eribaum Associates.


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


Outcome Data: Lifetime Healthcare & Disability Costs Following Comprehensive Treatment vs. Medical Treatment

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

“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

“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


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
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…”

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: 216-636-5660

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
Phone: 419-531-3500

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

Ohio Health Workrehab
1326 Kemper Road
Cincinnati, OH 45246
Phone: 513-671-7246

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