

The Management of Chronic Pain; Caught Between a Rock and a Hard Place: The Case for a Renewed Focus on Provider, Patient, and Payer Education

Talal W. Khan,^{1,*} and Farnad Imani²

¹Department of Anesthesiology and Pain Medicine, University of Kansas Medical Center, Kansas City, United States

²Pain Research Center, Department of Anesthesiology and Pain Medicine, Iran University of Medical Sciences (IUMS), Tehran, Iran

*Corresponding author: Talal W. Khan, 3901 Rainbow Boulevard, Mail Stop 1034, Kansas City, Kansas, 66260. Tel: +98-9135883315, Fax: +98-9135883365, E-mail: tkhan@kumc.edu

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1. The Burden of Chronic Pain

Chronic pain is a significant public health burden. This affliction affects at least 10 percent of the world's population with an additional 10 percent developing various forms of debilitating chronic pain every year (1). The 2010 global burden of disease report places back pain as the leading cause of years lost to disability (2). Upon further review of this report, it becomes apparent that eight of the top 12 conditions responsible for global disability, which include low back pain, neck pain, arthritis, other musculoskeletal conditions, migraines, anxiety, depression, and drug use disorder, are conditions associated with chronic pain.

The Department of Health and Human Services (HHS), National Institutes of Health (NIH) requested the Institute of Medicine (IOM) to address the current state of pain research, care, and education and to explore and make recommendations for the advancement of the science related to the field. The IOM report released in 2011 estimates that approximately 100 million suffer from chronic pain (3). Admittedly, the number of people actively seeking care for this complex disease does not reach 100 million. However, many people live with the burden of chronic pain, which may wax or wane during their lifetimes. According to various estimates, 20 - 30 million individuals experience chronic pain to such a degree that it erodes quality of life and the ability to work while forcing them to actively seek care for this condition. Access to providers with the skills necessary for appropriate evaluation and management of pain is limited. The majority of sufferers seek care with their primary care providers, many of whom are primarily in a rural setting in the state of Kansas. These providers often lack the additional resources needed for the appropri-

ate evaluation and management of chronic pain patients presenting with complex behavioral manifestations and functional limitations. Without the proper care, patients are unable to break out of the vicious cycle of increasing pain, limited function, and generalized deconditioning.

2. CDC Guidelines for the Prescription of Opioids for Persistent Non-Cancer Pain

Juxtaposed against this scourge of pain is the epidemic of opioid abuse. Deaths related to the abuse of prescription and non-prescription opioids reached a new crest in 2014 with 165,000 fatalities, the highest rates of overdose among people aged 25 - 54 years (4). It will come as no surprise that the sales of prescription opioids have also quadrupled from 1999 - 2012 (5). Whereas prior to the 2000s it was widely believed that risk of addiction was low in chronic pain populations, recent data has revealed that as many as 1 in 4 individuals treated with prescription opioids for long term non-cancer pain in primary care settings may struggle with addiction (6). In light of these concerns, the Centers for Disease Control (CDC) released guidelines for the prescription of opioids for persistent non-cancer pain (Table 1) (7). Many of the proposed guidelines promote the development of a treatment plan with a stepped up approach to opioid therapy, i.e., the exploration of alternatives and attempts at ensuring compliance and utilization of available prescription monitoring resources. However, some controversial approaches may lead to the unintentional consequence of reduced patient access to providers while still giving patients access to medications that allow them to maintain some quality of life and reasonable function.

Table 1. CDC Recommendations for Prescribing Opioids for Chronic Pain Outside Active Cancer, Palliative, and End-of-Life Care^a

Determining When to Initiate or Continue Opioids for Chronic Pain
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
Assessing Risk and Addressing Harms of Opioid Use
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

^aAll recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

3. National Pain Strategy

Recognizing the burden of chronic pain, the US congress provided a mandate to the NIH to evaluate and make recommendations “to increase the recognition of pain as a significant public health problem in the United States” (8). The NIH contracted with the IOM, which developed a report calling for the development of a comprehensive population health-level strategy to lead a cultural transformation in pain prevention, care, education, and research (3). The National Pain Strategy is the result of HHS requesting the Interagency Pain Research Coordinating Committee (IPRCC) to oversee the development of such a strategy. The National Pain Strategy provides a focus on six key areas:

- Population research

- Prevention and care
- Addressing disparities in care
- Service delivery and reimbursement
- Professional education and training
- Public education and communication

Through this broad focus, the National Pain Strategy envisions a decrease in the incidence and prevalence of acute, chronic pain across the life span from pediatric through geriatric populations, including end-of-life care. Those suffering pain would receive timely access to comprehensive care tailored to their biological, psychological, and social needs based upon evidence and efficacy delivered in a patient-centric manner. Chronic pain is a complex disease and a significant public health burden, therefore considerable efforts need to focus on recognition of risk factors as well as mitigation, prevention, and self-

management strategies.

This bold vision will need champions at the national, regional, state, and local levels. Disparities in care, in areas such as population research, may require large coordinated research infrastructures. Public and professional education, on the other hand, could be accomplished through the efforts of small groups working together toward the aims of better care for chronic pain patients through prevention, comprehensive assessment, and evidence-based interdisciplinary care. Outlined below are some efforts at the local and regional level in the state of Kansas.

4. Kansas Partnership for Pain Management

The Kansas partnership for pain management is a multidisciplinary group comprised of individuals from family medicine, anesthesiology/pain medicine, psychology, emergency medicine, pathology, psychiatry, nursing, education, pharmacy, chiropractic groups, bioethics, and various state and federal agencies that studied Kansas healthcare provider and Kansas healthcare related agency concerns regarding the assessment and management of chronic pain. This assessment revealed almost unanimous concern regarding the need for pain management education. A comprehensive statewide, multi-year, multi-tiered collaboration aimed at improving practice performance for the assessment and management of chronic pain was developed. The program envisioned an inaugural statewide foundational conference followed by 1-2 day primary care intensives and quality/performance improvement (QI) projects at the practice level. The first phase of the plan was completed with a conference in Wichita, Kansas, in November 2014. Attendance was excellent with a diverse group of 265 healthcare providers. The conference utilized patient interviews, discussions, role play, video vignettes, and case presentations. Ninety-five percent of attendees strongly agreed that course objectives were met. The group is now focused on planning the next stages of pain education in the form of intensives in two additional areas in the state of Kansas. The intensives will include recruitment of primary care practices in the target areas, a lecture program reviewing the foundational elements of pain assessment and management, and the development of online modules for pain-related quality improvement projects at the practice level (9).

5. Project ECHO Kansas

Chronic pain is a complex disease. Patients suffering from pain need access to specialty care and education for

this complex health condition. Unfortunately, there are not enough specialists in the field of pain management to provide care for everyone who suffers from pain, especially in rural and underserved communities. Project ECHO is a learning and guided practice model that seeks to empower and educate providers in remote areas through a hub-and-spoke knowledge-sharing network led by experts through multi-point videoconferencing (10). Many different versions of project ECHO exist around the country and focus on various chronic diseases, one of which is chronic pain. The Kansas project ECHO for chronic pain is in the pilot stage. The goal is to reach a select group of primary care practices scattered across the state and utilize the ECHO model to enhance practice knowledge of the assessment and management of chronic pain, provide teleconference access to experts in the field, and to assist them in developing staged quality improvement projects to achieve the aims of improvement in the management of the patient in pain.

6. Conclusion

Pain is one of the most common reasons for seeking medical care. Many Kansans will experience pain during the course of their lives; some will go on to develop chronic debilitating pain. The appropriate use of opioids will likely continue to be a widely used modality along a spectrum of other treatment options ranging from self-management techniques, other pharmacological agents, functional and psychological rehabilitation, various surgical and minimally invasive interventions, and complementary and alternative options to advanced pain techniques. While the national pain strategy aims to shed more light on the public health crisis of pain as a disease, the CDC guidelines may result in the unanticipated consequence of reduced access to primary care providers who are willing to explore appropriate opioid therapy for the right patient at the right time for the right reasons after other modalities have been considered and patient and provider goals have been discussed. Thus patients find themselves caught between a rock and a hard place. Those who had been able to maintain meaningful lives through the responsible use of opioids, after exhaustion of other options, are being tapered off their medications or encouraged to find another provider willing to take over these prescriptions. It is through the education of patients, providers, and healthcare organizations that we will be able to better navigate the turbulent waters of the recognition of pain as a complex biopsychosocial disease requiring the appropriate treatment. This task will include balancing the appropriate utilization of opioids, when and if necessary, to curb

and ultimately eliminate fatalities related to overdoses of this class of medication.

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Footnote

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