Two Sides of the Same Coin

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We have no relevant disclosures
Objectives

• Describe common “Difficulties” of Providers/teams and Patient/Families

• Learn the 5 Foundational Components of both the Art of Difficult Conversations and the Art of Living with vs. Struggling with Chronic Pain

• Participate in experiential exercise to reinforce listening and validation skills
Who is in the Room?
Enter this 10 digit phone number here.
Enter "opg1" in this box.
You've joined Jim shames' session (OPG1). When you're done, reply LEAVE
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This message appears here

Enter answers here.
Send text to: 1-747-444-3548

- Text Message: OPG1
- Then type in your response to the question (A, B, C, etc)
To show this poll

1. Install the app from pollev.com/app
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What makes it Difficult?
(Provider/Team)

- Being with **suffering** and feeling **helpless**
- **Discomfort** with expressed emotions/guilt/shame
- Reduced Patient **satisfaction**
- Conversations take more **time**
- Not enough team **support**
- **Not enough** “effective” non-opioid tx options
- Pt won’t agree to non-opioid tx
- Don’t “buy” the research on safety/efficacy (**Non-Believer**)
- Disbelief that “my” **patient is misusing/abusing**
- **Lack of clear dx** (e.g. SUD/Mental Health/Centralized Pain)
Send text to:
1-747-444-3548

• Text Message: OPG1
• Type 1 or 2 words to describe what you believe about chronic pain patients
To show this poll

1. Install the app from pollev.com/app
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What is a Difficult Conversation?

One that elicits **uncomfortable** emotions within both parties (Provider-Team and Patient-Family)
Anxiety (on both ends!)

Difficult Conversations are anxiety provoking and can threaten the medical provider/team sense of competence as a healers and trigger negative emotions such as:

– Anger
– Frustration
– Fear
– Helplessness
Different Sides of the Same Coin

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Provider/Team Perspective: Art of Difficult Conversations

RELATIONSHIP AS A RESOURCE: Leverage the relationship you have with your patient, E.g. “This is a work-in-progress, nothing has to change today, we are a team.”

REALISTIC EXPECTATIONS: Practicing safe and effective pain care requires that you set realistic boundaries. E.g. Your patient might leave upset, if you are holding the line in a compassionate and supportive way...this is still a win.

VALUE IDENTIFICATION: What is motivating you to have this conversation? E.g. Alignment with medical board, safety, best practice medicine, etc. Stand in your values.

BELIEFS AND CONFIDENCE: Be confident that your patient can live a full life alongside their pain. Believe in yourself that you can walk this path with your patient.

WILLINGNESS TO FEEL UNCOMFORTABLE: Consider modeling for your patient by relaxing your hands, softening your jaw, deepening your breath, and feeling into the discomfort. Mirror neurons are real and effective!

Patient/Family Perspective: Art of Living vs. Struggling Against Persistent Pain

RELATIONSHIP AS A RESOURCE: Encourage your patient to leverage their relationships with their family/support system. E.g. “What do you think your family/support system would say about your struggle with pain?”

REALISTIC EXPECTATIONS: Help your patients understand the limitations of various pain treatment modalities. E.g. Patients often look to be cured by prescription opioids, procedures and surgeries leaving them with unmet expectations.

VALUE IDENTIFICATION: Ask your patients, “What is important to you and why is life worth living”. Patients can make their change be in the service of their values.

BELIEFS AND CONFIDENCE: Support your patient in understanding how beliefs and thoughts impact feelings and behaviors. E.g. You might say to your patient, “you can be safe but sore”.

WILLINGNESS TO FEEL UNCOMFORTABLE: Identify with your patient that doing new things, such as movement, tapering, etc. will likely feel uncomfortable but that “hurting does not equal harm”.

5 Foundational Components

1. Relationship as a Resource
2. Realistic Expectations
3. Value Identification
4. Beliefs and Confidence
5. Willingness to Feel Uncomfortable
A Model for Treatment

Improved willingness to have the experience of pain

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More frequent engagement in valued activity over the longer term

= 

Progress

American Psychological Association, Society of Clinical Psychology (Div. 12), Research Supported Psychological Treatments: Chronic Pain - Strong Research Support, Depression - Mixed anxiety Modest Research Support
Gripe and Treasure Hunt!
Can Patients Successfully Taper w/o BH?

Yes! JAMA Internal Med-Published 2/2018 Beth Darnall, PhD, et. Al

A substantial fraction of patients at a clinic with no behavioral Support available, successfully tapered down/off high dose opioids with supportive relationship of MD and a book (see References)
Expectation (75%) vs Reality (30%)

Patient Expectation

Medical Reality
Actual Pain Relief with Opioids for Chronic Non-Cancer Pain is about 30%

*Opioids in chronic non-cancer pain: systematic review of efficacy and safety.*
Kaiso E, Edwards JE, Moore RA, McQuay HJ
Pain Clinic, Department of Anaesthesia and Intensive Care Medicine, Helsinki University Central Hospital, P.O. Box 340, FIN 00029 HUS, Finland.
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**Abstract**
Opioids are used increasingly for chronic non-cancer pain. Controversy exists about their effectiveness and safety with long-term use. We analysed available randomised, placebo-controlled trials of WHO step 3 opioids for efficacy and safety in chronic non-cancer pain. The Oxford Pain Relief Database (1950-1994) and Medline, EMBASE and the Cochrane Library were searched until September 2003. Inclusion criteria were randomised comparisons of WHO step 3 opioids with placebo in chronic non-cancer pain. Double-blind studies reporting on pain intensity outcomes using validated pain scales were included. Fifteen randomised placebo-controlled trials were included. Four investigations with 120 patients studied intravenous opioid testing. Eleven studies (1025 patients) compared oral opioids with placebo for four days to eight weeks. Six of the 15 included trials had an open label follow-up of 6-24 months. The mean decrease in pain intensity in most studies was at least 30% with opioids and was comparable in neuropathic and musculoskeletal pain. About 80% of patients experienced at least one adverse event, with constipation (41%), nausea (32%) and somnolence (29%) being most common. Only 44% of 388 patients on open label treatments were still on opioids after therapy for between 7 and 24 months. The short-term efficacy of opioids was good in both neuropathic and musculoskeletal pain conditions. However, only a minority of patients in these studies went on to long-term management with opioids. The small number of selected patients and the short follow-ups do not allow conclusions concerning problems such as tolerance and addiction.
<table>
<thead>
<tr>
<th>Treatment</th>
<th>Reduction (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>≤ 30%</td>
</tr>
<tr>
<td>Tricyclics/ SNRIs</td>
<td>30%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>30%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>≥ 10+%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10-30%</td>
</tr>
<tr>
<td>CBT/Mindfulness</td>
<td>≥ 30-50%</td>
</tr>
<tr>
<td>Graded Exercise Therapy</td>
<td>variable</td>
</tr>
<tr>
<td>Sleep restoration</td>
<td>≥ 40%</td>
</tr>
<tr>
<td>Hypnosis, Manipulations, Yoga</td>
<td>“+ effect”</td>
</tr>
</tbody>
</table>

PEG Pain Screening Tool

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.
What to do When You Have a Difficult Day

CHRONIC PAIN IS CYCLICAL, THESE DAYS DO HAPPEN, REMEMBER THEY ARE TEMPORARY. THE FOLLOWING SUGGESTIONS FOR A TOOL KIT FOR YOU TO HAVE HANDY WHEN YOU ENCOUNTER A PARTICULARLY DIFFICULT DAY.

• Magazines/Books
• Comics
• Crafts – simple, one hour projects
• Funny movies
• Games
• Pictures – remember the good days
• Gift cards – to restaurants or movies, to us to get out of the house as a distraction
• Journal
• Travel planner – looking to the future to get through today
• Small pieces of candy
• Cards – written to you, or blank ones to write
• Fun socks, ugly sweater, funny t-shirt
• Mindfulness or meditation tools – podcasts, phone apps, or coloring books
• Favorite music
• Movement videos – gentle yoga, tai chi, or stretching
• Essential oils – lavender
• Tea – chamomile
• Bath bombs
• Heating pad or ice packs

TODAY WAS A DIFFICULT DAY.
BELIEVE THAT TOMORROW WILL BE A BETTER DAY.

MICHELLE MARIKOS, PPS - MICHELLEMARIKOS@GMAIL.COM
Tapering Information and Withdrawal kit

Symptoms of opioid withdrawal include anxiety, nausea, vomiting, or abdominal pain. While symptoms can be severe, they aren’t life-threatening.

Anything that is not considered normal - is normal during a taper/ withdrawal.

Symptoms include but not limited to

Pain areas: in the muscles, achy all over
Gastrointestinal: diarrhea, vomiting, or nausea
Whole body: restlessness or sweating, chills, goose bumps, hot flashes
Mood: general discontent or anxiety, agitation, irritability
Eyes: dilated pupil or watery eyes,

Also common: cramping abdominal pain, women may start their menses, fast heart rate, excessive yawning, goose bumps, insomnia, or tremor, restless legs, allergy like symptoms, sneezing, fatigue, fuzzy head, flu like symptoms, dehydration

What to have in your kit

Imodium- or other anti diarrhea
Pepto-Bismol- for stomach discomfort and nausea
Gatorade/ Pedi lite- for dehydration
Aspirin/ Ibuprophen- for aches and flu like symptoms

Frequently Asked Questions

Why do these symptoms happen?
How will my taper work?
How long will my symptoms last?

Michelle Marikos, PPS - MichelleMarikos@gmail.com
The Elevator Speech

Chronic Opioid Therapy for chronic non-cancer pain is not as safe or effective as we were once lead to believe.

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• We don’t need to make any changes today
• Change can be challenging
• We can go very slow
• I will be by your side along the way
• I am confident that you can make these changes.
• Do you want to talk about these changes today or schedule a time for next week?

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• Lembke, A (2016). Drug Dealer, MD How Doctors were Duped, Patients Got Hooked and Why it’s So Hard to Stop, John Hopkins University Press
• WEBSITES:
  • www.Oregon.gov/oha/hpa/csi-pmc/pct (Oregon Pain Management Commission-Pain Management Commission)