Practical Tools for Psychologists Offering Pain Psychology Services:

Dress Up as a Pain Psychologist and Get Treats

In a Nutshell

- Pain psychology is not a bad area in which to practice;
- Pain psychology services are desperately needed by many healthcare professionals;
- Pain psychology basics are not that hard to learn;
- There are subsets of pain psychology practice, offering you some choice about what kind of work you'd like to do.
- If you want more referrals, more revenue and a new interesting area of practice, then consider adding pain psychology to your practice repertoire.

Introduction to the Speaker

- Ted Jones, Ph.D. has been a licensed clinical psychologist for more than 30 years.
- He has worked full-time in the area of pain psychology for the last 15 years.
- In 2013 he was named Pain Educator of the Year by the American Society of Pain Educators.
- He is the current President of the Tennessee Pain Society.
- He is on the Governor's Chronic Pain Guidelines Task Force.
- His pain practice was named a Clinical Center of Excellence by the American Pain Society, the only pain practice in Tennessee to receive this award.

HIGH DEMAND FOR PAIN PSYCHOLOGY

Is Chronic Pain Common?

- Surveys estimate chronic pain prevalence somewhere between 30% and 50%.
- Prevalence of chronic pain is higher than heart disease, diabetes and cancer – combined.
- Pain is most common complaint of military personnel returning from Iraq and in the general veterans' population.

And recently…

- In 2014, as part of the Governor's "Prescription for Success" initiative, all boards who oversee prescribers have adopted new guidelines for treating chronic pain.
- These guidelines apply to all healthcare providers who are treating chronic pain with opioids, not just pain clinics.
- End of life care is excluded.
- So a patient who is being prescribed even a few tramadol or hydrocodone a month for more than three months is covered under these guidelines. That's a huge number of patients and providers

Highlights for Psychologists

- “The possible presence of co-occurring mental health disorders should be considered when deciding whether to initiate a trial of opioids. Screening should occur for disorders such as depression, anxiety and current or past substance abuse and, if present, these should be addressed in the creation of a treatment plan.”
- “Benzodiazepines should be generally avoided in combination with chronic opioid therapy. When the opioid dose reaches 120mg MEDD and the benzodiazepines are being used for mental health purposes, the provider shall refer to a mental health professional to assess necessity of benzodiazepine medication.” (not necessarily a psychiatrist).

And…

- “The prescriber shall assess the patient’s risk for misuse, abuse, diversion and addiction prior to initiating opioid therapy” (using a validated risk assessment tool, and a provider’s judgment is not a validated tool).
- Patients on opioid doses of 120mg MEDD or greater shall be referred to a pain specialist for a consultation and/or management.

This is a national trend

- Federation of State Medical Boards' report.
- July 2013. "Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain."
- Expectations of good care:
  - Opioid risk assessment
  - Screen for depression
  - Screen for substance abuse
  - Address co-occurring mental health disorders

For Your Reference

- TN Chronic Pain Guidelines:
  http://health.state.tn.us/Downloads/ChronicPainGuidelines.pdf
- Federation of State Medical Boards report (2013)
  https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain_policy_july2013.pdf
- List of certified pain clinics in Tennesseehttps://health.state.tn.us/HCF/Facilities_Listings/facilities.htm
- And calculating Morphine Equivalent Daily Dose (MEDD):
  http://agencymeddirectors.wa.gov/mobile.html

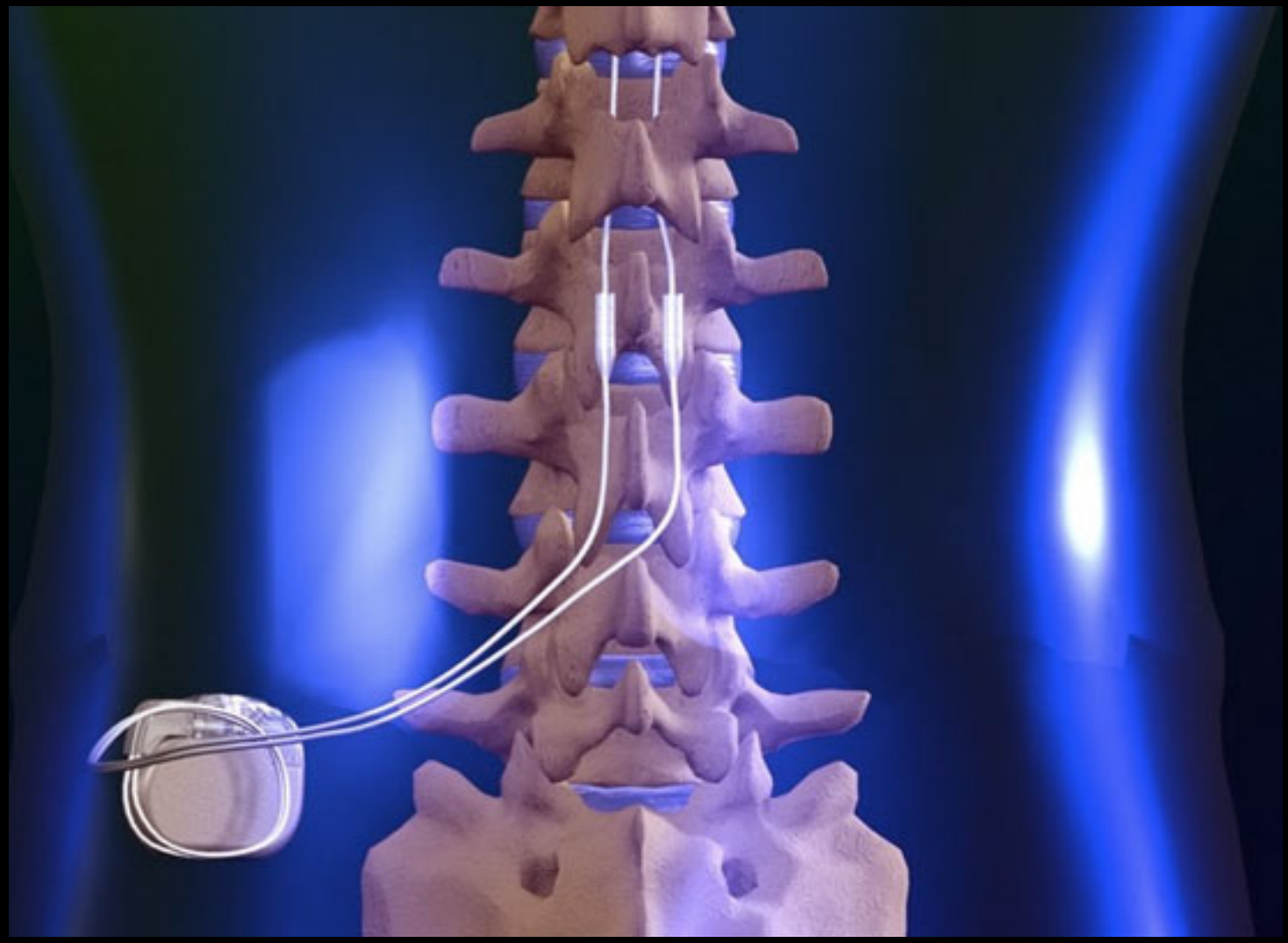
So…

- There are a large number of people who have chronic pain.
- Medical providers are being prodded / pushed to use psychologists (or other mental health providers) to help them:
  - with medication choices
  - with treatment in general.

Interventional, Pharmaceutical, “Self-help” (Skills)

THE THREE GENERAL AREAS OF NEED

INTERVENTIONAL TREATMENT



Spinal cord stimulators are being recommended for more patients and at earlier stages of treatment.

Physicians need us here.

- Central nervous system factors (significant MH problems, secondary gain issues) can override the effectiveness of a SCS.
- Most insurers require a formal psychological evaluation before a trial of a SCS is undertaken.
- It has become the standard of care to request a psychological evaluation on all patients before a trial of a SCS.
- Interview, MMPI-2 and a pain catastrophizing scale is the usual test battery.
- Patient are cleared for a trial or asked to address the central factors first (not cleared).

Practice issues

- Psychological testing can bring in significant revenue.
- Getting authorizations for the testing is the biggest hurdle; knowing whom/where to call.
- Many insurance plans have a presurgical exclusion to MH benefits so it is often billed to the medical side of the insurance.
- Psychologist Andrew Block has written the most about presurgical evaluations. He has a specific testing and scoring protocol.
- You really don't need to interpret the MMPI-2 in any significant fashion.
- If you are going to do these you should get testing materials and Block's book on the topic.

By the way…

- There was a time when implanted pain medication pumps were a somewhat common method of treatment.
- Reimbursement for the medication in the pump has fallen dramatically.
- So while physicians are still well reimbursed for implanting pumps, there are few physicians will fill the pumps (monthly).
- So it is not a good treatment option currently.
- Sometimes you may be asked to do a presurgical evaluation for a pain pump. Just so you know.

PHARMACEUTICAL TREATMENT

How Should Chronic Pain Best Be Treated?

- Some physicians and providers opine that no patient should be treated with opioids for more than six months; that there are no studies that show that opioids are helpful in the long run.
- PROP: Physicians for Responsible Opioid Prescribing
- Multidisciplinary pain treatment (MDPT) used to be hailed as the best way to treat pain, and it is still the standard of care in some areas of the country.
- It usually loses money, and the number of MDPT programs has been steadily declining over the last 20 years.
- Most chronic pain now is treated by PCP's and outside of MDPT programs.

Validated Opioid Risk Assessment

- And opioids are used. Sometimes a little. Sometimes a lot.
- Opioids is the chemical name. Narcotics is the legal and colloquial name. Cocaine is a narcotic. Opioids is what we are really talking about.
- So if opioids are going to be a major player in a pain patient's treatment, providers are being required to use some sort of validated risk assessment tool:
- Something to estimate the risk that a patient will misuse, abuse, divert or become addicted to the opioids.

Common Risk Assessment Tools

- BRI (Brief Risk Interview)
- BRQ (Brief Risk Questionnaire)
- DIRE (Diagnosis, Intractability, Risk, Efficacy score)
- ORT (Opioid Risk Tool)
- PMQ (Pain Medication Questionnaire)
- SOAPP (Screener and Opioid Assessment for Patients with Pain)
- SOAPP-R (Screener and Opioid Assessment for Patients with Pain – Revised)

Brief Risk Interview

- Jones (2013 and in press) has shown that the BRI outperforms questionnaires overall and has the best sensitivity of all risk assessment measures (best identifies the ones who misuse medications).
- The questions for the patient are easily embedded in a standard psychosocial interview, and takes little extra time.
- It is especially helpful for psychologists a, because it is an interview, it promotes visits to psychologists. This allows for psychologists to engage with the pain patient and opens the potential for education and more visits.

Risk Assessment overall

- Whether you use the BRI or a paper and pencil risk assessment tool, psychologists should be knowledgeable about the risk assessment issue.
- Prescribers will often be asking the question “What is this patient’s risk for opioid misuse?” (Low-High, Low-Medium-High, or L-LM-M-MH-H-VH classification system).
- This rating directly impacts (or should) monitoring of the patient, like how often a UDT is done.
- It can also affect the choice of opioid medication that is prescribed.

Other Pharmacological Input

- Some pain physicians will want psychologists to weigh in with other information that is relevant to prescribing.
- Would this person benefit from an antidepressant?
- Referral to a psychiatrist?

“SELF-HELP” OR PSYCHOLOGICAL TREATMENT

How can psychologists help pain patients?

- The five skills all chronic pain patients need:
  - Understanding
  - Accepting
  - Calming
  - Balancing
  - Coping
- Traditionally we have been strong in two of these (relaxation and CBT).
- This framework is a little broader.

1 - Understanding – the core ideas

- Chronic pain is more than tissue damage.
- Pain gates affect how much signal gets to the brain.
- Central processes influence how much pain is felt,
- and how the pain is interpreted cognitively and emotionally (pain versus suffering).
- Behavioral interventions can be very helpful for chronic pain as well.
- So psychology is vital in the treatment of chronic pain.

Examples

- The mystery of phantom limb pain
- The even greater mystery of Chronic Regional Pain Syndrome (CRPS – formerly known as RSD)
- On MRI's the same areas light up with both pain and negative emotions.
- Central nervous system factors are deeply interwoven with the experience of pain.

Understanding that

- Hurt doesn’t mean harm.
- Usually pain means danger.
- In chronic pain this is not the case.
- Chronic pain is – usually – a broken fire alarm. Learning to ignore it, and not be concerned that something is physically wrong.

Basically

- There are three kinds of pain (from the consumer perspective):
  - Nerve
  - Joint (inflammation)
  - Muscle
    - Spasms (Charlie horses)
    - Tension
    - Referred pain (deep soreness)
- This framework helps patients understand and cope with their pain

2 - Accepting

- CBT (after some knowledge about the condition)
- Adapting mentally to the significant change that has occurred in one's life in all areas.
- Grief and loss.
- "Where do I go from here?"
- It is likely not all-encompassing or immutable (maladaptive thoughts).
- Mindfulness and ACT (Acceptance and Commitment Therapy)
- There are workbooks for patients and therapists if you want help or structure for addressing this.

3 - Calming

- Decreasing stress: diaphragmatic breathing
- Increasing calming: relaxation
- Classic stuff, though I don’t use Jacobson’s PMR. Pain patients are usually already tight and tension increases pain.
- Body scan, guided imagery, biofeedback…

4 - Balancing

- A general term for a variety of issues that all involve daily activities and creating a lifestyle that is sustainable and adaptive.
- One large issue is activity pacing. Not overdoing it (and then expecting opioids to bail them out of increased pain).
- But also keeping moving. Decreasing “fear avoidance.”

And

- Sleep hygiene is important and often affected.
- Setting priorities, time management, should's versus wants….
- Assertiveness comes into play.
- Overall, adapting to "the new you."
- And getting spouses and family to adapt as well.

5 - Coping

- Things a patient can do to cope with pain (besides take an extra pill).
- Ice, TNS, leg elevation
- OTC creams and rubs
  - Menthol
  - Capsacin or camphor
  - Anti-inflammatory
- Distraction is a key coping tool
- I get much mileage out of the “hand in the box” exercise.

Myofascial pain

- Much ignored
- Easy to address
- Trigger points
  - Heat
  - Pressure
    - Trigger point injection
    - Massage
    - Thera-cane / Back Buddy

I’m considering this. Hmmm…..

LOGISTICAL ISSUES TO CONSIDER

Questions to ask yourself

- Full-time or part-time?
- Which pieces: Evaluations? Treatment? Both?
- Should I locate inside a doctor's office?
- Testing: How to get authorizations?
- Bill using MH codes and/or bill with Health & Behavior codes?
- Group and/or individual therapy?
- Short-term and/or long-term treatment?

Marketing

- Who needs me?
  - Do you know someone already?
  - Who is “a pain doctor”?
    - ABMS certified
    - AMPM certified
    - Other certifications
  - Specialties:
    - Anesthesiologists
    - Neurologists
    - Physiatrists
    - Psychiatrists
    - Neurosurgeons

And….

- Who is a reputable pain doctor?
- Harder to discern.
- Pain clinic list. TN Website.
- A pain clinic is a practice in which at least half of the patients are being prescribed scheduled medications for a pain condition for at least 90 days.

Current Hot Button Issues in the Field

- Prescribing of opioids. To whom, how long, how much, what kind, what other treatments should be offered or demanded.
  - PROP says “no opioids for more than six months.”
- UDT’s. The current driving monetary force in the field. More than any assessment or treatment service.
- Interventional treatments. In the office and in the OR. What to offer. To whom. How many to do.
- Who should own a pain clinic?
- Who should be medical director of a pain clinic?

The Intractable Pain Act

The TN Intractable Pain Act (2001)

- “A patient suffering from severe chronic intractable pain should have access to proper treatment of his or her pain.”
- “Opiates can be an accepted treatment for patients in severe chronic intractable pain…”
- “A patient who suffers from severe chronic intractable pain has the option to choose opiate medication for the treatment of the severe chronic intractable pain as long as a physician has first determined that such treatment is appropriate and medically necessary ….

Controversy

- Some feel it pushes opioids or is interpreted as a patient having a right to opioids.
- There is political movement to repeal or amend the IPA.
- The American Cancer Society reportedly will oppose changes, while many others will push for an amendment or repeal.

QUESTIONS AND DISCUSSION

Thank
You!