Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

SAMHSA
Substance Abuse and Mental Health Services Administration

Managing Chronic Pain in the Patient Centered Medical Home Webinar Series

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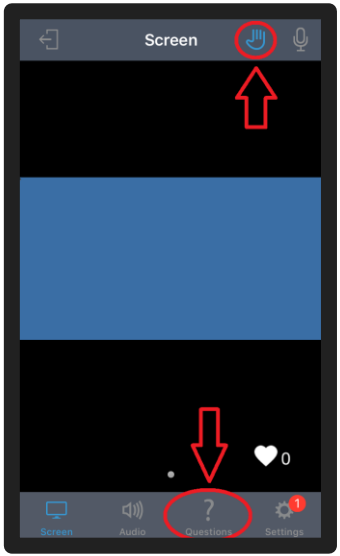
Tyler Brown, PsyD, Medstar National Rehabilitation Hospital
Chase Grosse, PsyD

UNMC | MUNROE-MEYER INSTITUTE
BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

Asking Questions

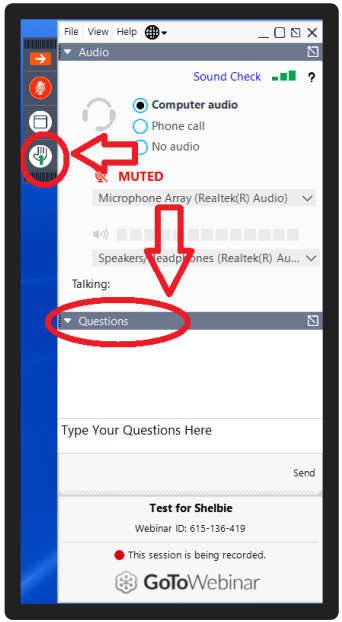
Mobile



Option 1: Raise your hand to ask a question aloud.

Option 2: Type your question in to have it read for you.

Web



We, Drs. Clarke, Klepper, Grosse & Brown, have no financial, personal, or professional conflicts of interest in this training titled “Managing Chronic Pain in the Patient Centered Medical Home Webinar Series”.

Evaluation and follow up

- At the end of this session, you will be asked to complete a brief evaluation sent via email.
- Because this event is federally funded, we are required to ask about participants' satisfaction with our services.
- To maintain our funding, we are required to get 80% follow-up.
- We greatly value your feedback and participation in the survey!!

What is the Mid-America MHTTC?

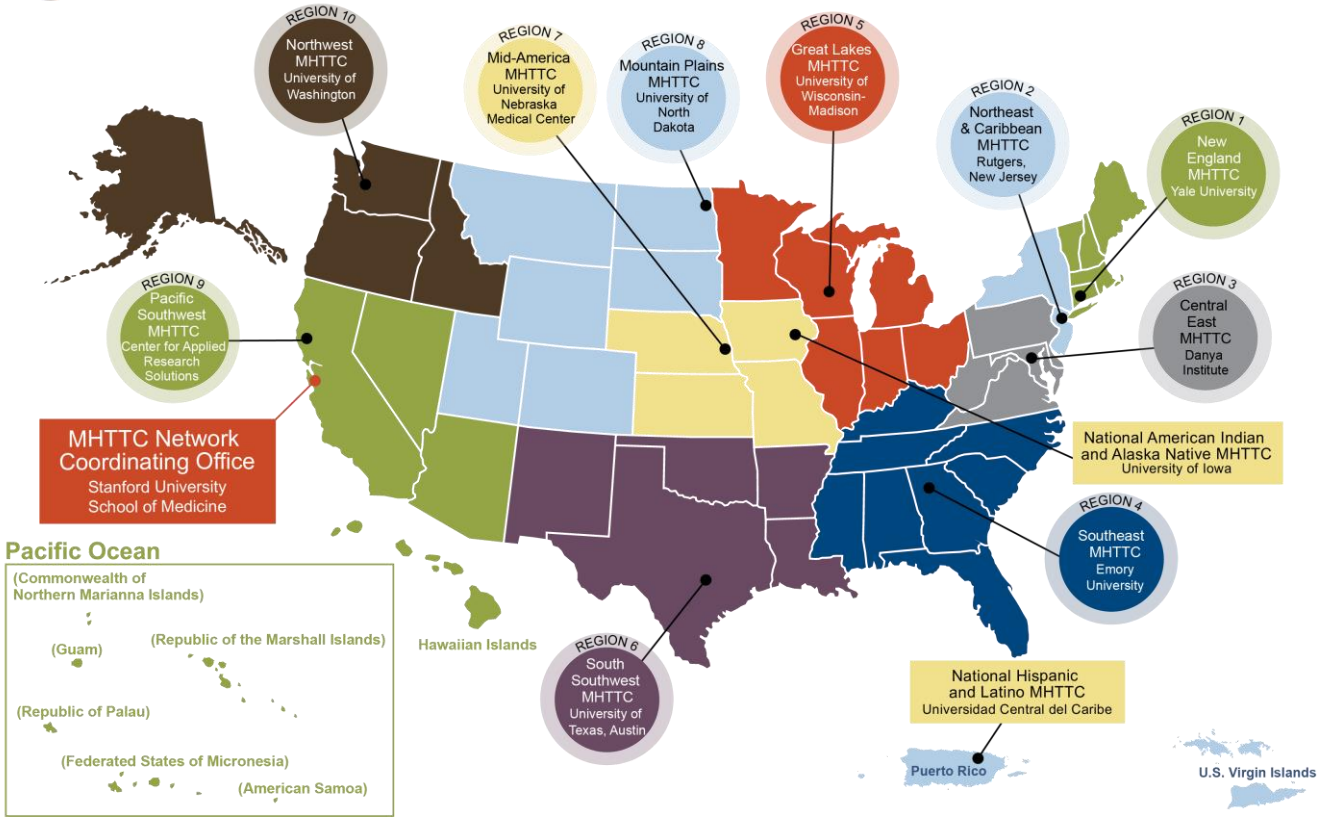
- Funded by the Substance Abuse and Mental Health Services Administration
- Five-year grant of $3.7 million
- Awarded to Dr. Joseph Evans at the Behavioral Health Education Center of Nebraska (BHECN) at University of Nebraska Medical Center
- Serves to align mental health systems and professional competencies with evidence-based practices
- Operates in Missouri, Iowa, Nebraska, and Kansas
- Provides free/low cost training and technical assistance on a variety of topics germane to effective mental health practice

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



Mid-America MHTTC Team

Brandy Clarke:
Project Director

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MHTTC Services

Training Levels

- Universal: Conference presentations, newsletters, brief consultation
- Targeted: Online courses, webinar series, focused knowledge-sharing, short-term training, replication guides
- Intensive: Ongoing relationship between the TTC program and agency receiving services

Outcomes

- Universal: Increased reach of information and tools about evidence-based practice
- Targeted: Increased motivation to use and apply specific interventions
- Intensive: Policy and program changes with implementation of interventions by users

Specialized Training Topics

- **Integrated behavioral health in primary care**
- School mental health
- Serious mental illness
- Behavioral health workforce development

Integrated Care Program

Brandy Clarke, PhD
Project Director

Rachel Valleley, PhD
IC Program Director

Holly Roberts, PhD
Faculty Trainer

Christian Klepper, PsyD
IC Program Coordinator

Eryn McMaster, PhD
Faculty Trainer

Integrated Behavioral Health in Primary Care

MHTTC staff have 20+ years of experience integrating behavioral health into primary care in 40+ rural, suburban, and urban sites

Training and TA in Integrated Care

QUALITY INDICATORS OF INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

EVIDENCE-BASED BEHAVIORAL HEALTH INTERVENTIONS FOR CHILDREN AND ADULTS APPLIED IN INTEGRATED CARE SETTINGS

TECHNICAL ASSISTANCE ON IMPLEMENTATION OF INTEGRATED CARE

ONLINE COURSES FOCUSED ON INTEGRATED CARE AND SPECIAL TOPICS IN PEDIATRIC AND ADULT SERVICES (IN DEVELOPMENT)

Introductions

Dr. Tyler Brown is a second-year postdoctoral fellow at Medstar National Rehabilitation Hospital in Washington, DC. He completed his Psy. D. in Clinical Psychology at Mercer University in Atlanta, GA. Dr. Brown has six years of supervised experience working in psychology with an emphasis on rehabilitation and health related issues including chronic pain, spinal cord injury, amputation, stroke, multiple sclerosis, and brain injury. Dr. Brown is a licensed Psychology Associate in the District of Columbia and recently Licensed Psychologist in the state of Virginia. He is also a member of the APA Division 22 Rehabilitation and Division 38 Health Psychology organizations.

Dr. Grosse graduated from Mercer University. He completed an internship in health service psychology at the University of Texas at Tyler Health Sciences Center. He completed his fellowship in Clinical Health Psychology at Ascension Genesys Hospital in Grand Blanc, Michigan. Throughout his graduate and training programs, Dr. Grosse has focused on integrating behavioral health, including behavioral pain management, into medical settings and training medical residents and fellows.

Actionable Goals

- Describe why behavioral treatment for chronic pain is important
- Differentiate between acute and chronic pain
- Describe the evolution of conceptualizations of pain and pain management
- Utilize models of pain to gain personal understanding and convey meaning to patients and providers

Cost and Prevalence of Chronic Pain

- Pain is estimated to cost between $560-635 billion annually
- Most common reason people seek medical care
  - Up to 80% of all medical visits involve chronic pain (Van Dorsten, 2018).
  - In 2007, despite making up about 4.6% of the total world population, the United States accounted for 81% of oxycodone and 99% of hydrocodone use (Volkow, 2014)

Provider Training

Physicians receive little training in pain management unless they seek training.

Psychologists have a similar lack of tracking.

Training

Not in the core curriculum

80% of U.S. medical schools have sessions as part of a course – approx. 9 hours

92% of Canadian medical schools have sessions

Veterinarians vs. Physicians

Acute vs. Chronic

Acute pain – short-term, usually in the presence of tissue damage and is self-limited

Chronic malignant pain – associated with cancer or other progressive disorders

Chronic non-malignant pain – tissue injury that is non-progressive or healed and "longer than normal healing process"

Traditional Model – Biomedical

- “Diseases are expressions of a discoverable disease process and that there is a reliable connection between pathological changes and clinical features.”
  - Depersonalized
  - Reductionistic
- Predictable and linear relationship between identifiable tissue damage and the report of pain (Quintner et al., 2008)

Modern Model – Biopsychosocial

- Pain is much more than sensory input.
- “Overall health reflects a high level of intra- and intersystemic harmony. Such harmony may be disrupted at any level, at the cellular, at the organ system at the whole person or at the community level. Whether the resulting disturbance is contained at the level at which it is initiated or whether other levels become implicated is a function of that system's capacity to adjust to change.”

Biopsychosocial Assessment

Cognitive: Rumination, catastrophic thinking, managing expectations

Emotional: Sadness, worry, anger, fear

Behavioral: Isolation, over/under sleeping, diet, withdrawing from activity and life

Environmental/Social: Fina ncial stress, marital discord, reinforcement

Theories of Pain

Gate Control Theory

Loeser's Model of Pain

Fear Avoidance Model

Theories of Pain – Gate Control Theory

The spinal cord serves as a gate

Certain things "open" the gate, thus increasing signals

Stress/tension

Boredom/directed attention

Inactivity

Certain things "close" the gate, thus inhibiting signals

Relaxation and positive emotion

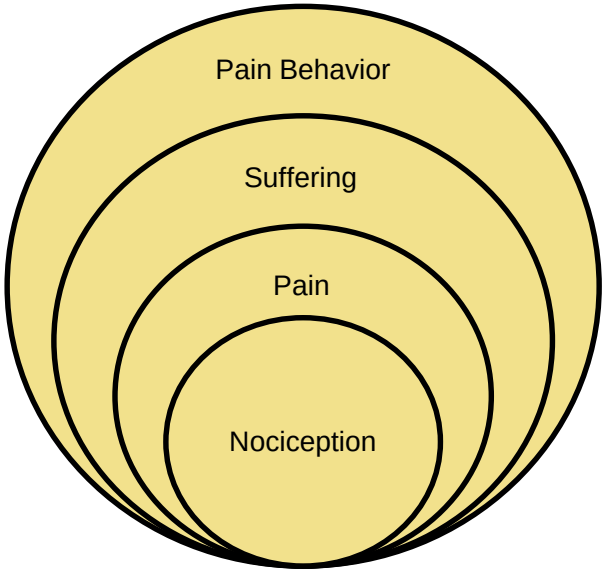
Distraction/mindfulness

Activity

Sleep

Competing sensations (heat, pressure, etc.)

Theories of Pain – Loeser's Model



Theories of Pain – Loeser's Model

Nociception

Biological reaction to tissue damage, injury and/or inflamation

Pain

Perception resulting from the processing of sensory information

Begins at the dorsal horn into the CNS

Suffering

Affective response to the perception of pain

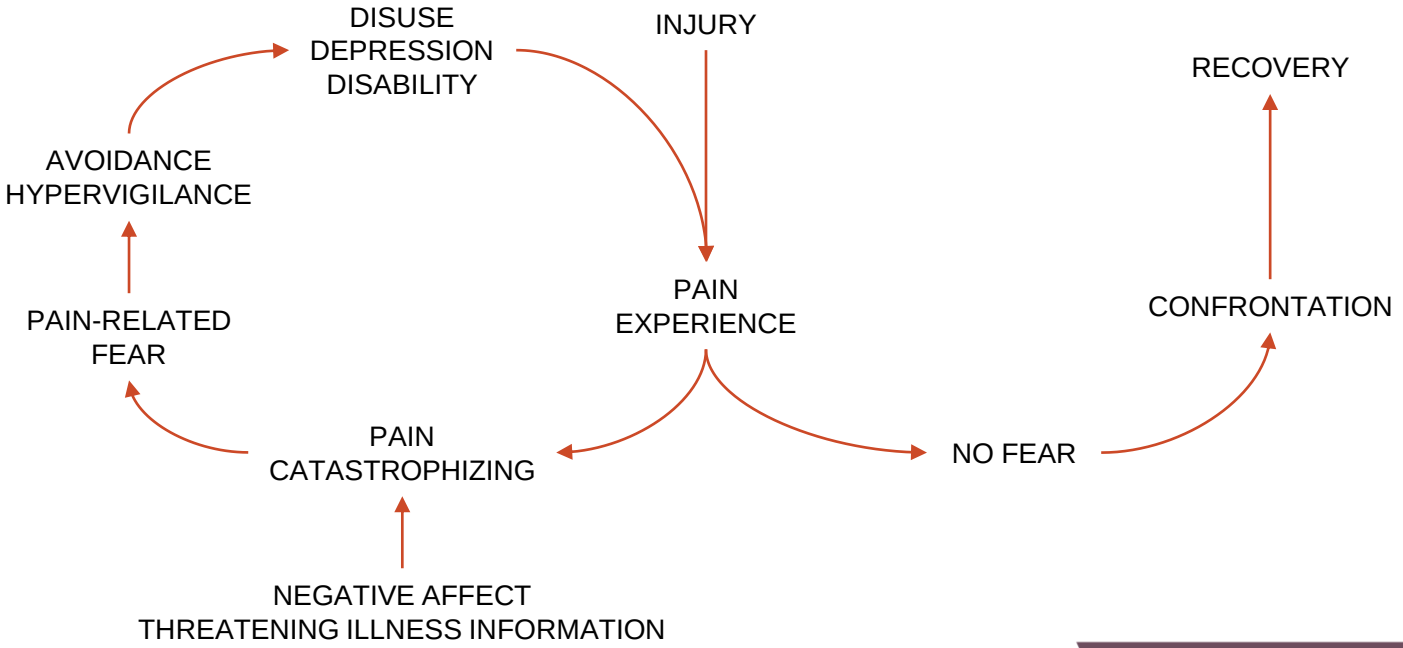
Pain Behaviors

The observable results of suffering due to pain

Grimacing, guarding, restricted activity, seeking medical treatment

Experienced or anticipated

Theories of Pain – Fear Avoidance Model



Theories of Pain – Fear Avoidance Model

Helps significantly predict pain-related disability in low-back pain patients (Robinson, 2006; Swinkels-Meewisse et al., 2006; Jensen et al., 2010).

Associated with greater pain ratings, attention to pain, self-reported disability, depression, pain behaviors, and poor coping (Keefe et al., 2004; Swinkels-Meewisse et al., 2006).

The Changing Landscape of Behavioral Pain Management

Persistent pain

- Can define pain due to inflammation
- A more useful term to replace chronic pain
- Relatable for patient (Robinson, 2018)

Function over cure

- Pain is natural
- How to live a life worth living
- More in the intervention module

Psychosocial Role in Pain

Pain Catastrophizing

- “An exaggerated negative orientation toward pain stimuli and pain experience” (Sullivan et al, 1998)
- Catastrophizing accounts for up 31 percent of variance in pain ratings (Sullivan et al., 2001).
- Associated with “greater disability, increased use of health care services, increased use of pain medications, increased pain behaviors, and increased recovery time during postsurgical rehabilitation.” (Robinson & O’Brien, 2010).

Expectations of Treatment

Psychosocial Role in Pain

- Psychosocial factors that can be predictors of development of chronic disability (Turk & Okifuji, 2001)
  - Psychiatric diagnosis
  - Adaptive attitudes
  - Perceived lack of social support
  - Heightened emotional reactivity
  - Job dissatisfaction
  - Substance abuse
  - Compensation status

Behavioral Health Provider's Role

Expectation management and patient education

Assessment and diagnosis of comorbid psychological distress, coping, and maladaptive behavior

Treatment for cognitive, affective, and behavioral components of the pain experience

Assessment of risk for medication abuse

Assessment of candidacy for surgical intervention such as spinal cord stimulator

Co-management with other providers to maximize outcomes

Interdisciplinary Care

Across meta-analytic studies, siloed approaches to treatment often produce modest results at pain reduction at best (Turk, Wilson, & Cahana, 2011).

Meta-analyses on interdisciplinary treatment for pain have demonstrated effects as good or superior to unidimensional treatments (Hoffman, Papas, Chatkoff, & Kerns, 2007; Flor, Fydrich, & Turk, 1992).

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