REDUCING RISK IN PAIN MANAGEMENT

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DISCLOSURES

- Dr Dekker has no financial nor professional conflicts of interest to disclose…
- Contents of the lecture are for educational purposes.
- Dr Dekker does not represent any federal organization and his opinions are simply his opinions for this educational program

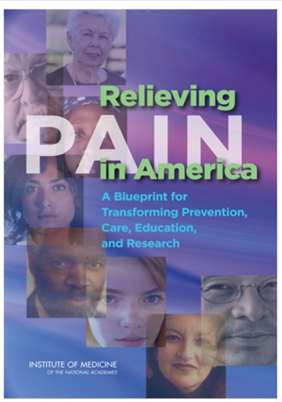
OBJECTIVES

- 1) Identify 2021 impact of Chronic Pain
- 2) Be aware of Chronic Pain Treatment overview
- 3) Know Multidisciplinary Treatment Approaches
- 4) Implement Non-Pharmacologic Treatment Modalities
- 5) Understand how we got here

CHRONIC LOW BACK PAIN

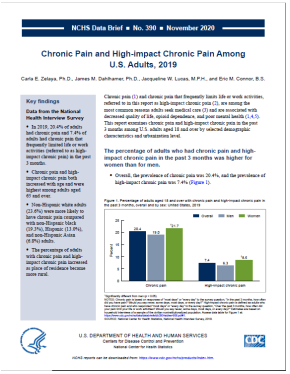
- **Low back pain** is the most common (27%) complaint, followed by severe headache or migraine pain (15%), neck pain (15%) and facial ache or pain (4%).
- 28% of adults report limited physical activity due to LBP, as compared to 10% of adults who do not report LBP.
- Adults reporting low back pain were **three times as likely to be in fair or poor health and more than four times as likely to experience serious psychological distress** as people without low back pain.

National Centers for Health Statistics, Chartbook on Trends in the Health of Americans 2006



Institute of Medicine (IOM) Report (2011)

- The financial burden of chronic pain exceeds those of cancer and heart disease combined.



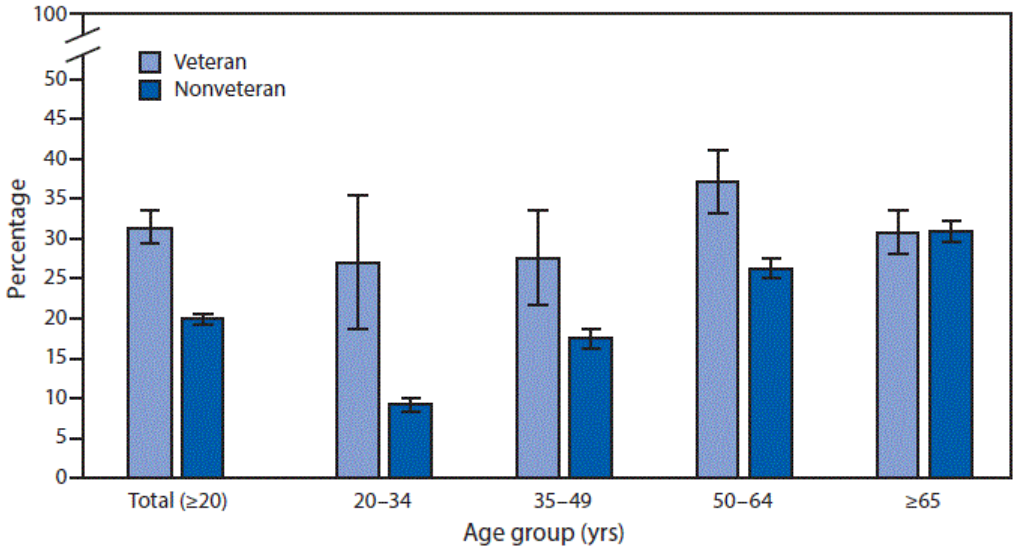
2019 National Health Interview Survey (NHIS) (2020)

- 20.4% of adults in the US had **chronic pain** in 2019, and
- 7.4% had **high impact chronic pain,** defined as chronic pain that frequently limited life or work activities.
- Groups with higher rates of high-impact chronic pain include women, those over 65, Non-Hispanic white adults, and those in rural locations.

National Academies Press http://www.ncbi.nlm.nih.gov/books/NBK91497/; Zelaya CE et al. NCHS 2020 Nov https://www.cdc.gov/nchs/data/databriefs/db390-H.pdf

Chronic pain is more common in Veterans than non-Veterans.

- In a national survey, **31.5% of Veterans vs. 20.1% of non-Veterans reported experiencing chronic pain in the past three months.**
- Chronic pain was defined as pain on most days or every day in the past three months.
- Veterans of all age groups except those ≥65 years of age were significantly more likely than non-Veterans of the same age group to experience chronic pain.



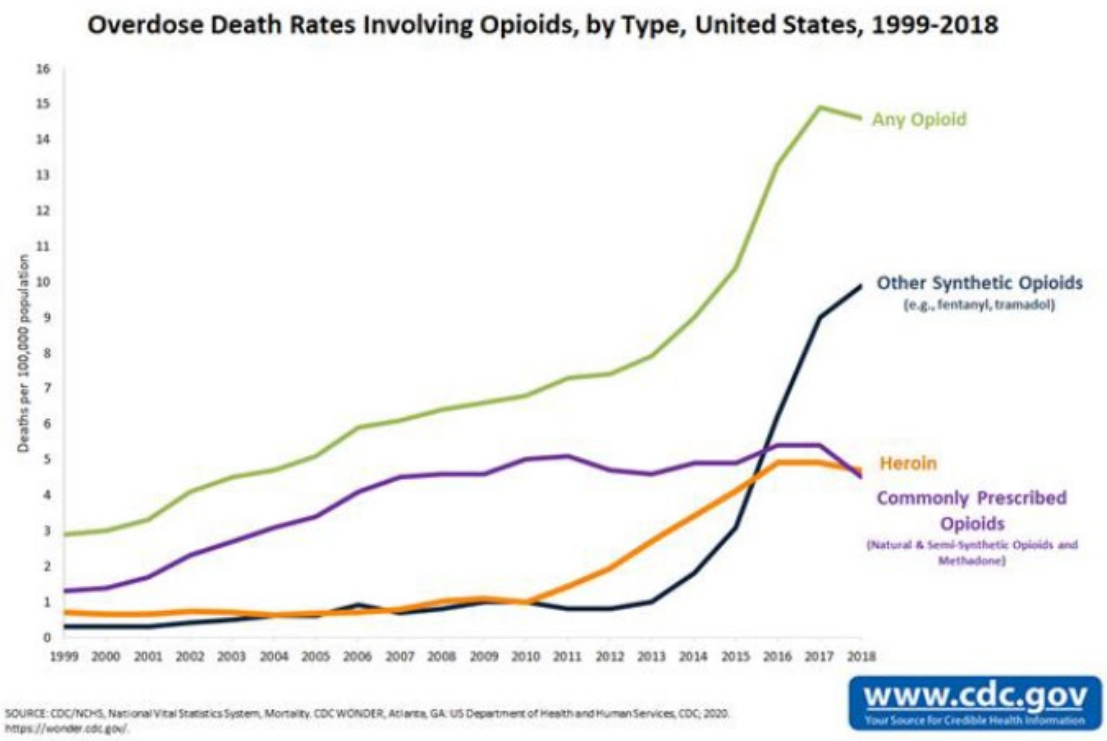
QuickStats: Percentage of Adults Aged ≥20 Years Who Had Chronic Pain, by Veteran Status and Age Group — National Health Interview Survey, United States, 2019 (cdc.gov)

The VA 2018-2024 Strategic Plan included Pain Management and Opioid Safety in the list of Focus Areas.

- The co-occurrence of pain and mental health conditions often result in high impact pain.
- Pain, medical and/or mental health comorbidities are often related to military service and require Veteran-specific expertise.
- Veterans are at higher risk for harm from opioid use and accidental poisoning than non-Veterans.
- Pain is the most common factor among Veterans who die by suicide, and there is a close correlation between pain intensity, suicide risk and death rates.
- **Pain care requires a systematic coordination of medical, psychological and social aspects of health care (integrated care).**

https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf; Ashrafioun et al., J Pain. 2019 Jul;20(7):852-859 https://pubmed.ncbi.nlm.nih.gov/30690167/

Overdose Deaths due to Synthetic Opioids on the Rise



https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf

In the past several years, the relative contribution of drug type to overdose deaths has changed: initially primarily **prescription opioids**, then also **heroin** and more recently **synthetic opioids** (such as carfentanil).

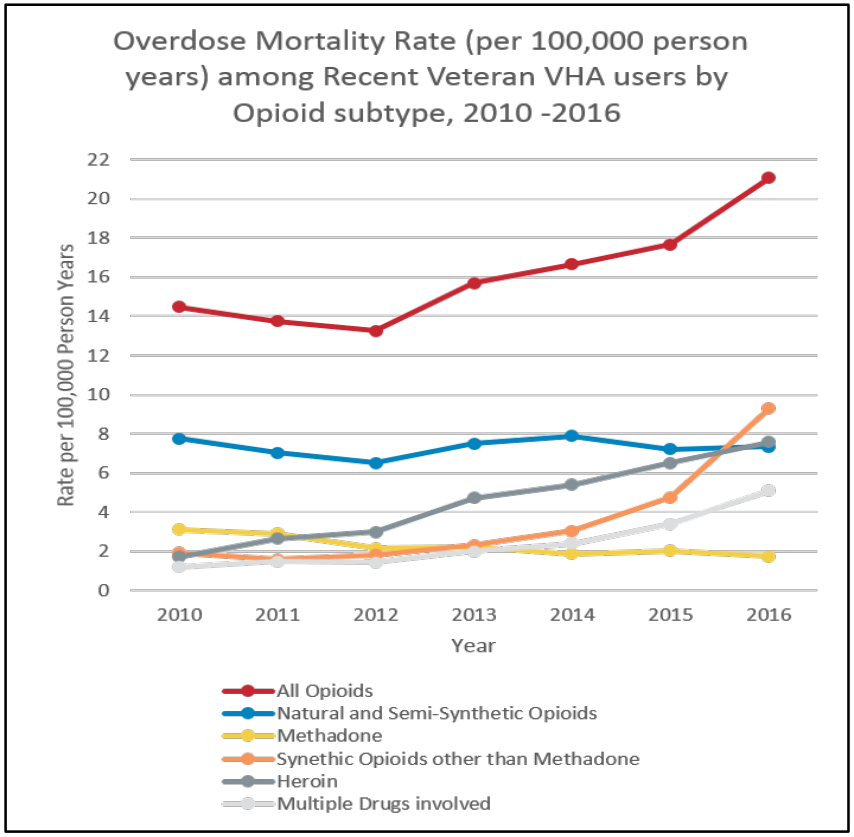
Now, **polysubstance** use is common, such as the combination of opioids with sedatives and/or stimulants.

Veterans are at Elevated Risk for Death due to Overdose

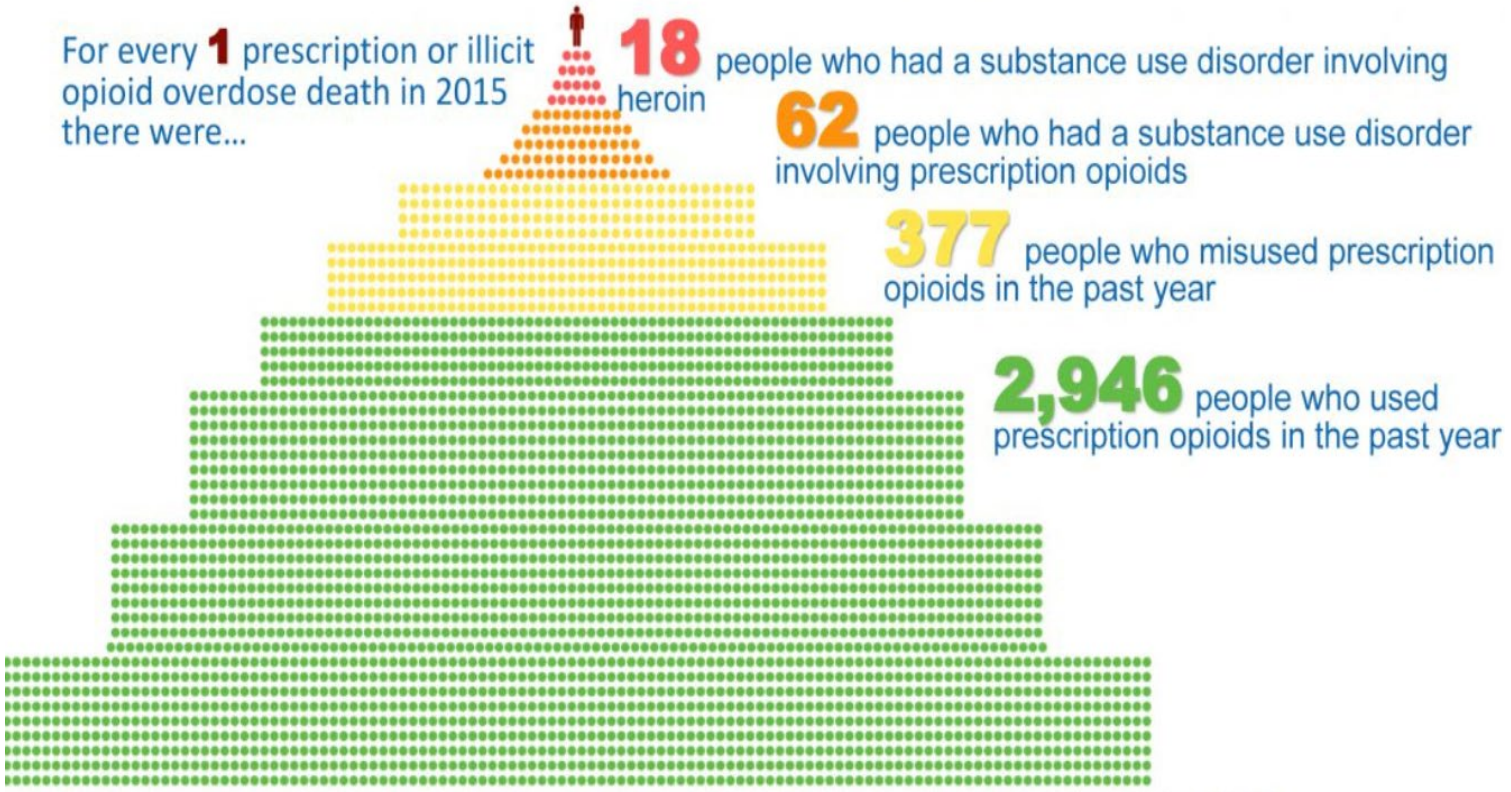
- 6,485 Veterans receiving care in VHA died from an opioid overdose between 2010 and 2016, with increasing rate over that time period.

- **In 2016 alone there were 1,271 deaths of Veterans in VHA, or 3.5 per day.**
  - This is 1.5x greater than the general population opioid overdose mortality rate.*
  - 62% of VHA Veteran overdoses involved opioids.

**This equates to a mortality rate of 21.1/100,000 among VHA Veterans and 13.3/100,000 in the general population.*

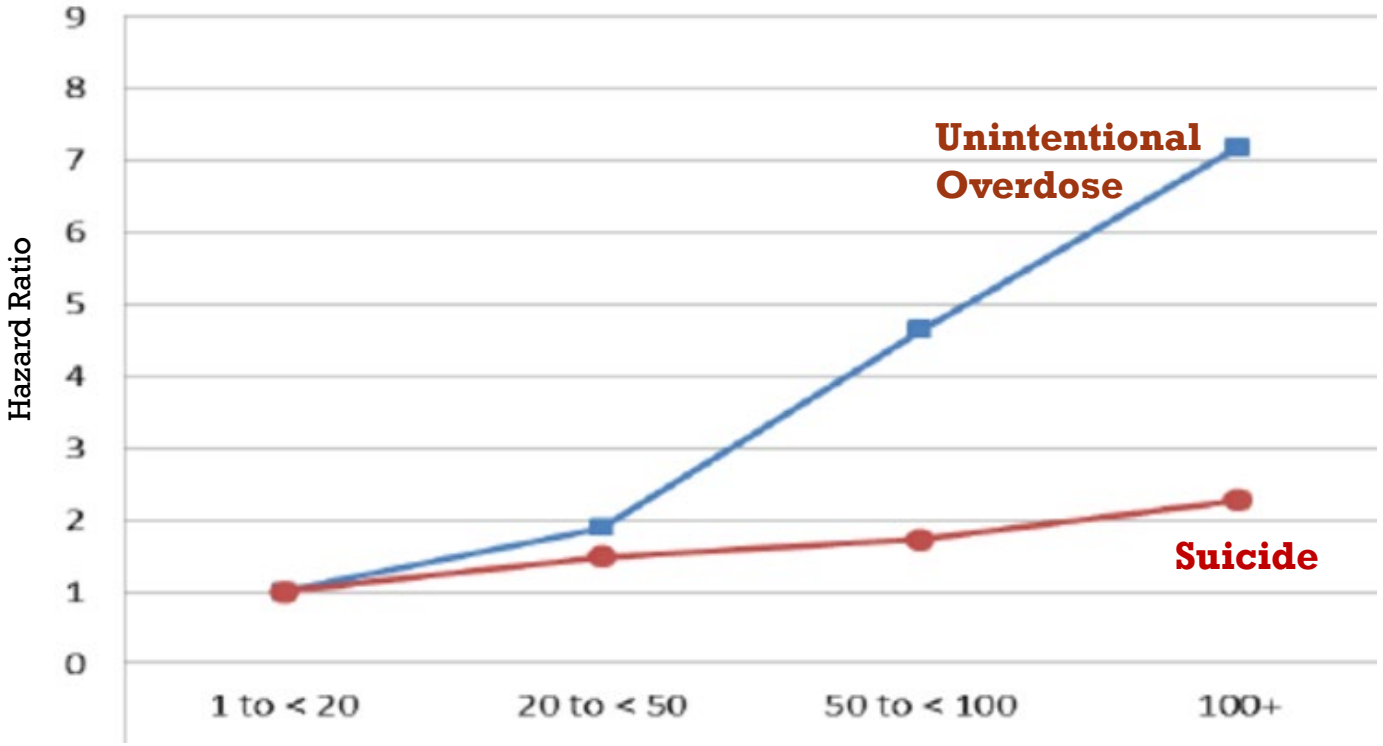


Data from Lin LA et al. *Am J Prev Med. June 2019;* https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#page=1



Results from the 2015 National Survey of Drug Use and Health https://www.cdc.gov/media/releases/2017/a1203-hargan-fitzgerald-infographic-508.html

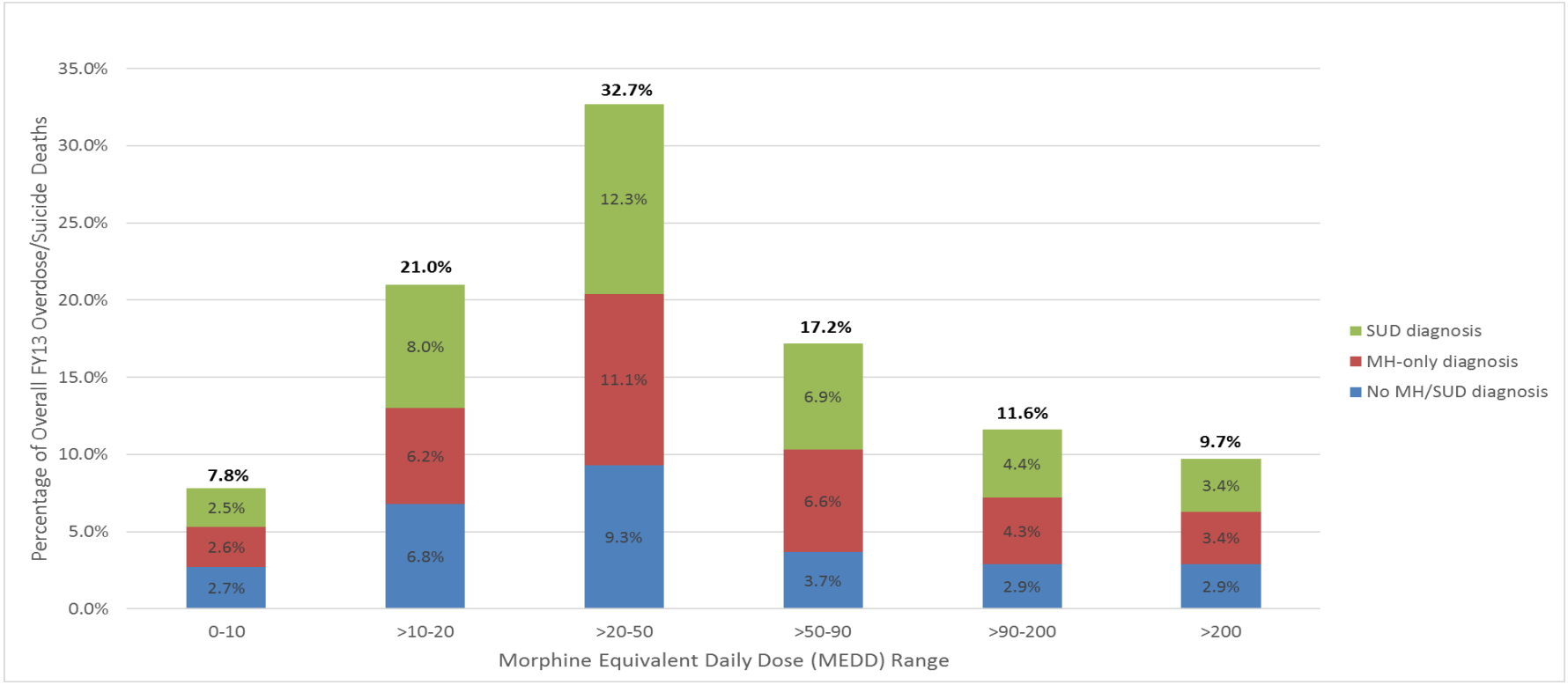
Opioid Dosage and Risk of Death (Patients with Chronic



Multiple studies demonstrate **higher doses carry higher risk of opioid-related death**.

- This may in part reflect the **prevalence of mental health comorbidities** in patients with chronic pain.

- Bohnert AS et al. JAMA 2011 Apr 6 https://pubmed.ncbi.nlm.nih.gov/21467284/; Igen MA et al. Opioid Dose and Risk of Suicide. Pain. 2016 May https://pubmed.ncbi.nlm.nih.gov/26761



Analysis of FY2013-2014 VHA data.

Of the Veterans who died from overdose/suicide:

- Almost **4/5** were **prescribed < 90 Morphine Equivalent Daily Dose** (MEDD).
- Almost **3/4** had **Mental Health diagnosis (including Substance Use Disorder)**
- More than 1/2 had MH/SUD diagnoses and were prescribed < 90 MEDD.

Unpublished Data from the Patient and Family Education Resource Center (PERC).

Risk Factors Include:

- Opioid prescription, including:
  - Dose and Duration
  - Type (Extended-Release/Long-Acting forms)
- Interaction with other medication/drugs, such as sedative hypnotics

Prescribing factors

- Medical comorbidities (e.g., chronic pulmonary disease, sleep apnea)
- Mental health comorbidities (e.g., depression, bipolar disorder)
- Substance Use

Patient factors

Park et al. J Addict Med 2016 https://pubmed.ncbi.nlm.nih.gov/27525471/

- **Chronic pain in Veterans is more common, and more often severe** than in the general US adult population.
- **Mental health comorbidities often result in high impact**, or severe **pain**.
- **Pain is the most common factor among Veterans who die by suicide.**
- Veterans are 1.5x as likely as the general population to die from an opioid overdose.
- **Higher dosages carry higher risk of opioid-related death**; however, **no dose is completely safe**.
- **Risk factors for Opioid Use Disorder (OUD) and overdose** include:
  - Higher dosages
  - Extended-release/longer-acting forms
  - Drug-drug interactions, such as with sedative-hypnotics (e.g., Benzodiazepines)
  - Medical comorbidities such as sleep apnea
  - Mental health comorbidities
  - Substance use

First, a Definition

In 2020, the International Association for the Study of Pain (IASP) Task Force Reconvened for the first time since 1979 to develop an updated definition of pain:

OLD Definition:

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage **or described** in terms of such damage."

NEW Definition:

"An unpleasant sensory and emotional experience associated with, **or resembling** that associated with, actual or potential tissue damage."

IASP
International Association for the Study of Pain

Pain is Now Recognized as:

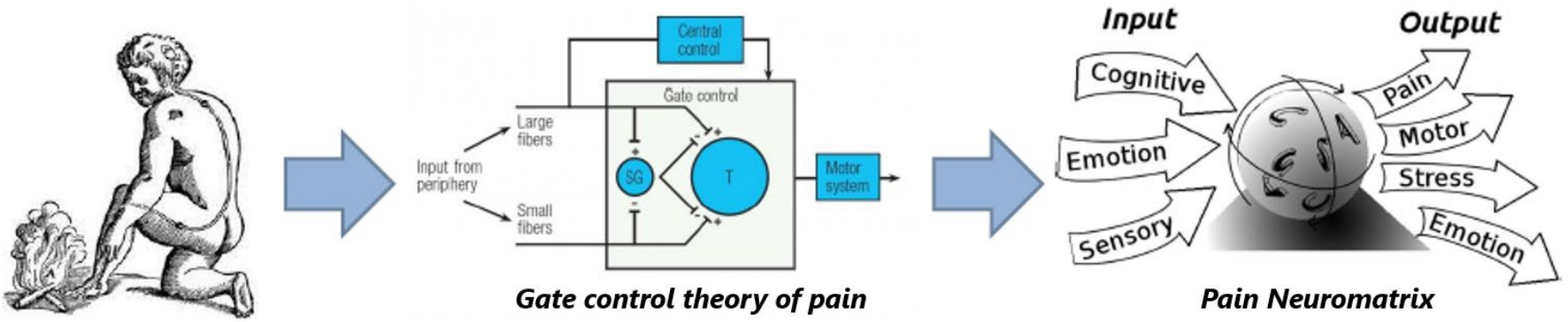
- A different phenomenon from nociception.
- Influenced by biological, psychological and social factors.
- An experience that is learned throughout the life course.
- **A personal experience to be respected regardless of objective evidence of tissue damage.**

https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ItemNumber=10475

Visualizing the Mechanisms of Pain

Our framework for the underlying mechanisms of pain has evolved from basic nociception in the 17th century to Gate Control Theory (1965) to the Neuromatrix model involving the input and output of interacting domains (2012).

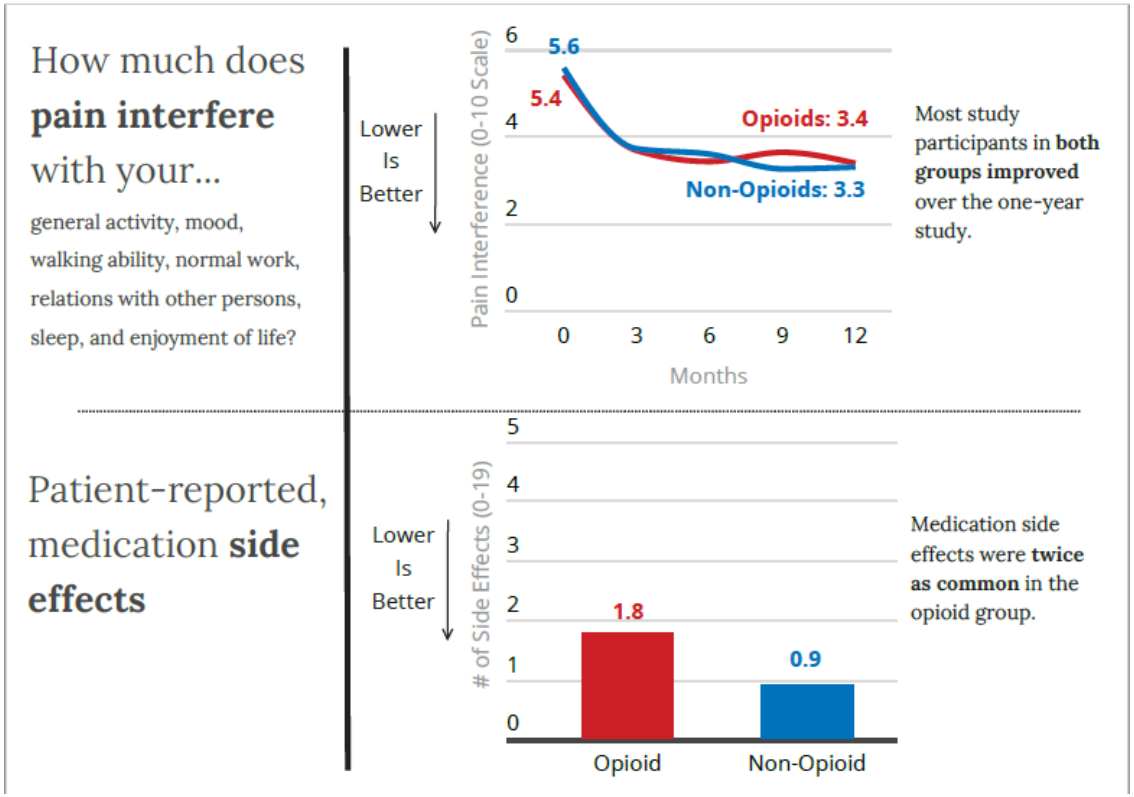
From Nociception to Pain Neuromatrix



Descartes 1664; Melzack and Wall, Science 1965;150(3699):971-9
https://pubmed.ncbi.nlm.nih.gov/5320816/; Leung J Prim Health Care 2012; 4(3):254-8
https://pubmed.ncbi.nlm.nih.gov/22946077/

The SPACE Randomized Controlled Trial (2018)

Among 240 VA patients with long-term back, hip, or knee pain treated for 12 months, **opioids did not work better than non-opioids for chronic pain and resulted in twice as many side effects.**



Krebs et al. JAMA 2018 https://pubmed.ncbi.nlm.nih.gov/29509867/

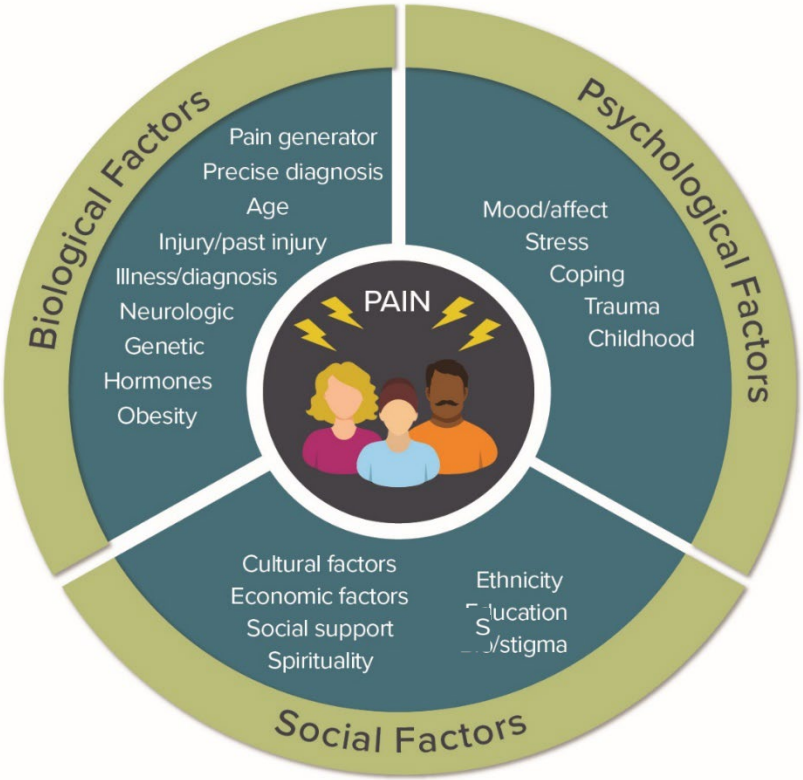
Shift **TOWARDS multimodal and integrated team-based pain care** (biopsychosocial interdisciplinary care) and **AWAY FROM opioid therapy** for non-end-of-life pain management

- There is **no completely safe opioid dose threshold** for which there are no risks for adverse outcomes.
  - Even short-term use of low-dose opioids may result in addiction.
- Any initial, **short-term functional benefit will likely not be sustained** in most patients.
- There is a concern that prolonged use of opioids, especially in higher doses, may lead to central sensitization and increase in pain over time (**opioid-induced hyperalgesia**).
- **Patients on opioids may experience a functional decline in the long-term**, measured by factors such as return to employment.

https://www.healthquality.va.gov/guidelines/Pain/cot/; https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf; Lee et al. Pain Physician 2011 https://pubmed.ncbi.nlm.nih.gov/21412369/; Hoffman et al. JAMA Neurol 2017 https://pubmed.ncbi.nlm.nih.gov/28531306/

- **Key Components:**
- Biological Factors (e.g., diagnosis, age)
- Psychological factors (e.g., mood, stress)
- Social factors (e.g., social support, spirituality)

- **Goals:**
- Improve the experience of pain
- Enhance physical functioning
- Promote activities of daily living
- Increase quality of life (QoL)



https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf


Treatment Refractory
Comorbidities
Complexity
Risk
Tertiary Interdisciplinary Pain Centers
Advanced diagnostics & therapeutic interventions; CARF accredited interdisciplinary pain rehabilitation program (IPRP)
STEP 3
Specialty Care
Interdisciplinary pain management clinics/teams, Interdisciplinary pain rehabilitation program (IPRP)/Functional restoration program; Behavioral Pain Management; Rehabilitation Medicine; Mental Health/SUD Programs
STEP 2
Patient Aligned Care Team (PACT) in Primary Care
Assessment and management of common pain conditions; Mental Health Integration (PCMHI) incl brief CBT for pain; Assessment and treatment of OUD (office-based); Physical therapy; Occupational therapy; Kinesiotherapy; Chiropractic Care, Expanded care management; Pharmacist pain clinics; Pain schools; Complementary and Integrative Health (CIH) modalities incl. Battlefield acupuncture (BFA); Whole health coaches; Peers
STEP 1
Foundational: Patient/Family/Caregiver Learning and Self Care
Nutrition/weight management; Exercise/conditioning; Ice & stretch; Sufficient sleep; Mindfulness meditation/relaxation techniques; Engagement in meaningful activities; Family & social support; Safe environment/surroundings

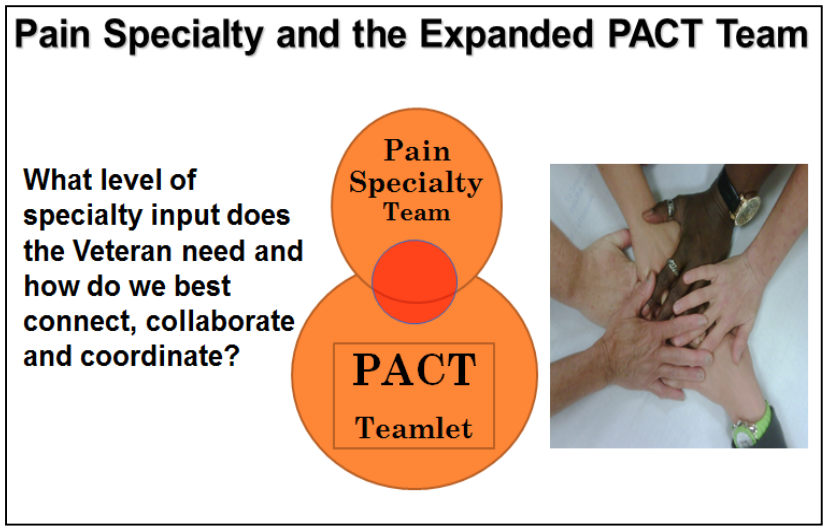
Person-centered pain care: Whole Health

- **Foundational** to the **Stepped Care Model for Pain Management** is **self-care/self-management** that takes a broad approach consistent with "Whole Health" care.

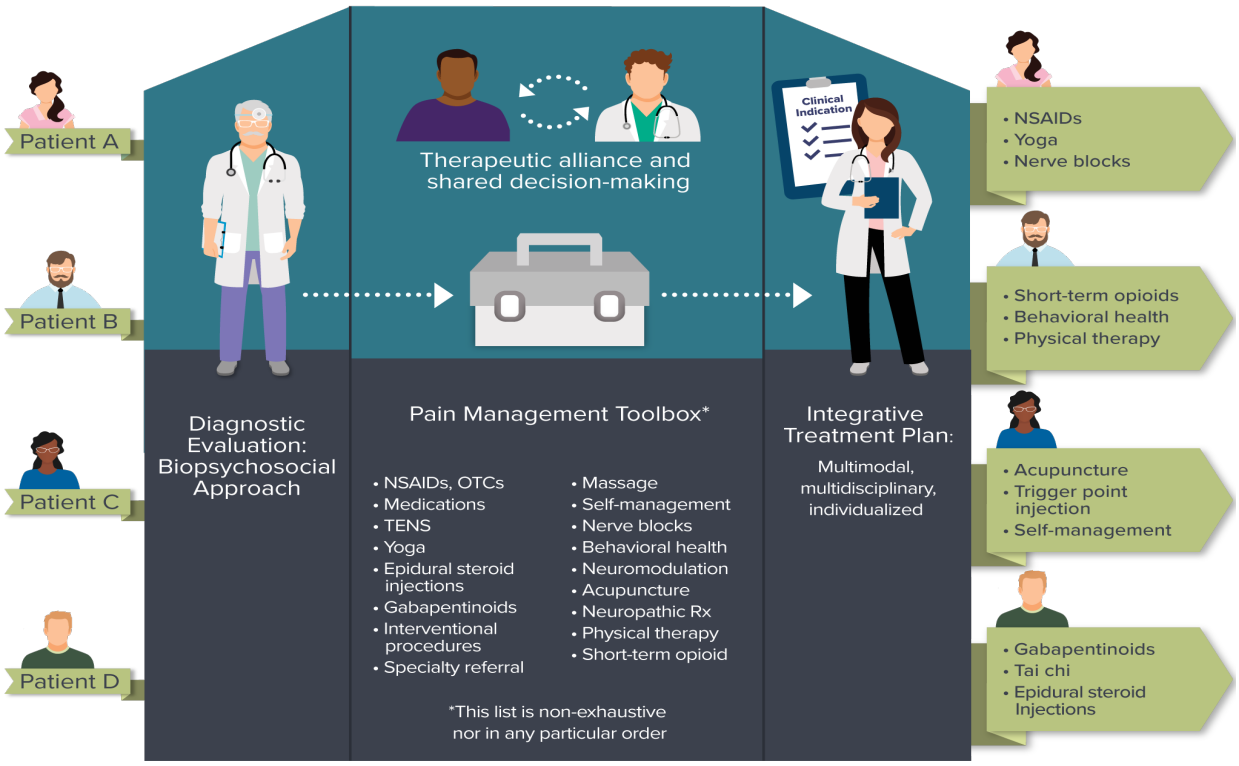
The **Patient Aligned Care Team (PACT) in Primary Care** is the **Medical Home** with integrated Mental Health services and direct access to pain care modalities.

A **Pain Management Specialty Care Team** is available at all facilities to support Veterans and their Primary Care teams.

Providers from **PACT and Specialty Care work collaboratively** and coordinate pain care across service lines.



- Individualized, patient-centered care is best achieved through:
  - Diagnostic evaluation
  - A biopsychosocial approach
  - Access to needed treatment approaches
- Producing an individualized, patient-centered treatment plan requires a strong patient-clinician relationship:
  - Mutual trust and respect
  - Empathy
  - Compassion



https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

Integrated Collaborative Pain Care that is Patient-Centered

- **Pain** has been **redefined as being a complex personal experience** and is influenced by biological, psychological, and social factors (**biopsychosocial model**).
- Pain care in VHA is **moving away from the use of opioids** and **towards multimodal, interdisciplinary pain care** that takes a "**Whole Health**" approach in order to provide individualized care.
- **Foundational** is **self-care/self-management.**
- The **Patient Aligned Care Team (PACT) in Primary Care** is the **Medical Home** with integrated Mental Health services and direct access to pain care modalities.
- The **PACT team and Pain Management Teams/Specialty Care work collaboratively** and coordinate pain care across service lines.

CHRONIC PAIN TREATMENT

- 1) Medications: Oral, Topical, Intrathecal
- 2) Modalities: PT/OT, Acupuncture, Microcurrent, TENS, OMT
- 3) Exercise, Rehab, Weight-Loss: PT, Dietitian
- 4) Interventional: Superficial, Joint, Selective Nerve Root, Sympathetic Chain, ESI, RF, Cryotherapy, SCS, Intrathecal Pumps
- 5) Behavioral Health: Psychiatry, CBT, Biofeedback, Mindfulness, Support Groups
- 6) Complementary/Alternative Care/Body Work

MEDICATIONS:

- Medications typically include NSAIDS, Acetominophen, Anticonvulsants, SNRIs/SSRIs/MAOIs, TCAs, NMDA antagonists, Corticosteroids, Viscous Supplements, anesthetic patches, Muscle Relaxants, Homeopathic agents, Biologics, MAT, Naltrexone and Opiates
- **Future**: non-classical (NOP) opioid receptor agonists?, CB2 agonists?, medical marijuana?

NON-OPIATE TREATMENTS

- Cognitive Behavioral Therapy (**CBT**)
- Exercise therapy, diet and weight management
- 1st line and 2nd line options: acetaminophen and NSAIDs; gabapentinoids, SNRI's, and TCA's
- Topical modalities and interventional treatments
- Multimodal/Multidisciplinary **approaches** have favorable response vs single modalities

NON-OPIATE RISKS

- **Acetaminophen** toxicity thresholds between 2-4000mg.
- **NSAID** precautions with both COX1 and COX2 inhibitors. Be wary of long-term concerns for **cardiac, CKD, anticoagulants**.
- **Gabapentinoids** – risk associated with fall, dizziness relative to dose initiation and titration
- **SNRI** – loading and taper strategies, rare incidence of Serotonin Syndrome.
- **TCA's** – Cardiac and dizziness related risks
- **Corticosteroids** – Hormonal and Glucose precautions
- **Lidocaine Analogs** – Cardiac and Toxicity risks
- **Muscle Relaxants** – Fatigue, Fall risks

GOALS OF TREATMENT

- **1)** Improve quality of life, function, and performance of ADL's.
- **2)** Ensure safe and reasonable treatment for underlying condition(s).
- **3)** Maintain clear rationale for utilization based on patient's risk factors and response.
- **4)** Encourage autonomy, coping and healthy lifestyle choices to improve long-term outcomes.

OBJECTIVES

- Will patient be able to reasonably perform routine work and family obligations?
- Will patient transfer, walk, and routinely exercise? Will patient remain sedentary?
- Will patient be able to reliably perform ADL's and executive functioning without significant harm to self?
- Will patient commit to behavioral modification and interventions when appropriate?

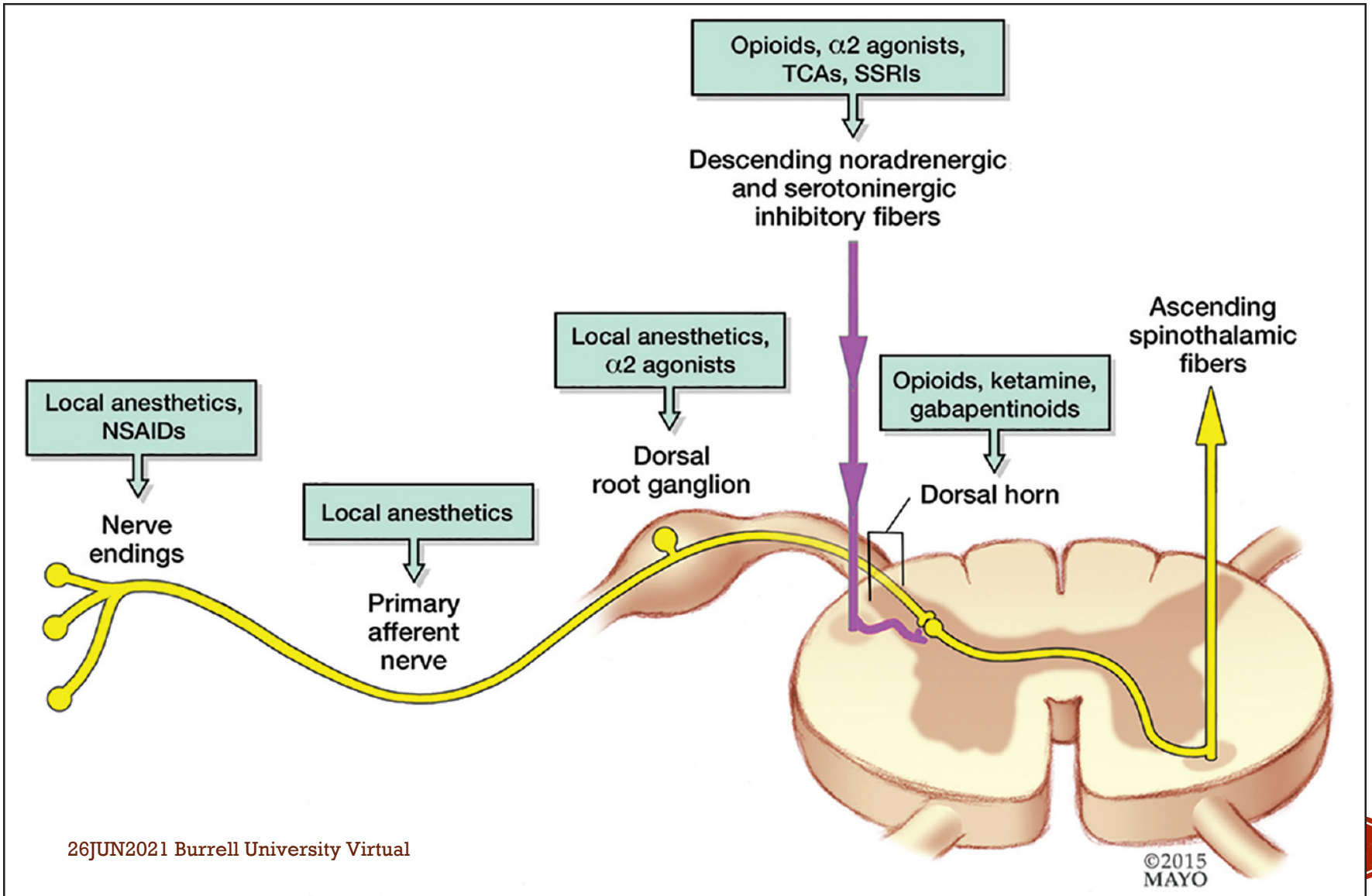
DOCUMENTATION

- Assess and document the signs and symptoms consistent with pain and dysfunction.
- Describe the setting and provocative activities that lead to complaints.
- Be descriptive with findings: What type of pain: myofascial, joint, facet, radicular, spastic, neuritic and correlate findings on exam with ROM, strength evaluation and special testing.
- Tailor plan based on objective complaints 1st line

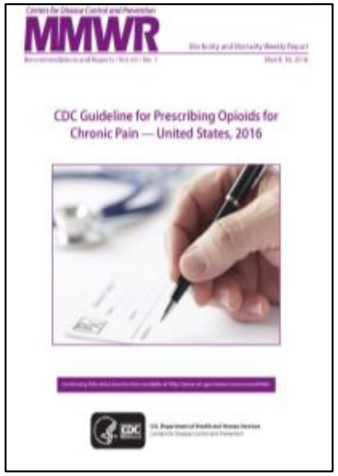
PAIN AND NOCICEPTION

- the sensory nervous system's response to certain harmful or potentially harmful stimuli
- Nociceptors have a certain threshold that require a minimum intensity of stimulation before they trigger a signal to axons which further travel to the spinal cord or brain for further modulation.

NOCICEPTIVE PATHWAY AND



"Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with **insufficient evidence to determine long-term benefits** versus no opioid therapy, though evidence suggests risk for **serious harms that appear to be dose-dependent**."



"Clinical decision-making should be based on a relationship between the clinician and patient, and an understanding of the patient's **clinical situation, functioning, and life context**."

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

VA/DoD CPG Includes 18 Recommendations, Organized In Four Topic Areas:

1) Initiation and Continuation of Opioids

- "**We recommend against initiation of long-term opioid therapy.**"
- "We recommend **alternatives** to opioid therapy **such as self-management strategies** and other **non-pharmacological treatments**."
- "When pharmacologic therapies are used, we **recommend non-opioids over opioids**."
- **Recommendation against opioid therapy** in patients <30 years of age, in patients with active substance use disorder, or **in combination with benzodiazepines**.

https://www.healthquality.va.gov/guidelines/Pain/cot/

2) Risk Mitigation

- Recommendation to use risk mitigation strategies, including **Informed Consent, Urine drug testing, Prescription Drug Monitoring Program (PDMP), Overdose education and Naloxone prescribing.**
- Assess for **Suicide risk.**
- Evaluate benefits and risks **at least every 3 months.**

https://www.healthquality.va.gov/guidelines/Pain/cot/

3) Type, Dose, Follow-up, and Tapering of Opioids

- If prescribing opioids: **use the shortest duration and lowest dosage.**
- **No dosage is absolutely safe**; strong recommendation against increasing opioid dosage >90 MEDD.
- **Avoid long-acting opioids for acute pain, as PRN, or upon initiation** of opioid therapy.
- Opioid dose **reduction should be individualized** to the patient.
  - For **OUD**, offer **medication treatment (m-OUD)**.

4) Opioid Therapy for Acute Pain

- **Acute pain:** use alternatives to opioids; use multimodal pain care, **if using opioids prescribe for ≤3-5 days.**

https://www.healthquality.va.gov/guidelines/Pain/cot/

- **The VA/DoD CPG recommends against *initiation* of long-term opioid therapy**, i.e., new starts should be avoided.
- Alternatives to opioid therapy, such as non-pharmacological treatments, are preferred for pain management. Non-opioids are preferred over opioid medications.
- **Risk mitigation strategies** include **Informed Consent, Prescription Drug Monitoring Program (PDMP) queries, Urine Drug Testing (UDT), and Overdose Education and Naloxone Distribution (OEND)**.
- **Avoid combination with benzodiazepines**, if possible.
- Risks and benefits should be **reevaluated at least every three months**.
- If prescribing opioid medications, the dose and duration should be minimized as no dose is free of risk.
- For Opioid Use Disorder (OUD), provide **access to Medication for OUD (m-OUD).**
- **For acute pain**, use alternatives to opioids, if feasible. **If using opioids prescribe for ≤3-5 days.**

OPIATE PRESCRIBING

- Opioids are commonly prescribed for chronic pain despite poor empirical evidence of long-term efficacious relief.
- In 2012, 259 million prescriptions were written for opioids, enough for one bottle per adult American.
- CSPMP monitoring in Arizona has documented a 35% drop in opioid prescribing in AZ
- All prescribers are being followed
- New regulations implemented 26APR2018
- DEA has full visuals on CSPMP
- All states became interactive in 2020 (MO)

National Institute on Drug Abuse. (2015). Drugs of Abuse: Opioids

LONG-TERM ADVERSE EFFECTS

1) Addiction/Tolerance/Dependence (risks)

2) Opioid-Induced Endocrinopathy: suppression of hypothalamic-pituitary-gonadal axis via inhibition of GnRH. Most notable changes to **sex-hormones and Vitamin D-25-OH**

3) Hyperalgesia Syndrome/Sensitization: Increased pain as a result of long-term opioid use generally different from original injury (difficult to diagnose). Pain may gradually normalize with decrease in opiate. This may be more pronounced wind-up phenomenon with **Fibromyalgia.**

4) Respiratory Suppression in Apneic Disorders, COPD

5) Depression/Anxiety/Sleep Disorders

American Academy of Pain Medicine (AAPM) 29th Annual Meeting. Poster 135. Presented April 11, 2013.

RISK STRATIFICATION

- Rates of nonmedical prescription opioid use were greatest among **white** and **Native American men** in the Midwest and West, with annual incomes less than $70,000, previously married, and with a **high school-level education or less.**
- Prescription opiate use disorder are linked to a variety of mental health disorders: **PTSD**, borderline, schizotypal, antisocial personality, persistent and **major depressive disorder**, and **Bipolar I disorder**.

SAFETY

- Safe and effective opioid therapy for chronic pain requires clinical skills and knowledge in both the principles of opioid prescribing and on the assessment and management of risks associated with **opioid abuse, addiction, and diversion**
- **Veterans have a higher risk ratio**

CONSIDERATIONS TO ASK

- Is it medically reasonable to initiate or continue current regimen?
- If so, for how long at current dosage?
- Is it safe?
- Are their long-term concerns?
- Is there evidence of Aberrant Drug-Related Behaviors?
- Are supportive and evidence-based treatments being *continually* trialed?

CDC OPIATE PRESCRIBING GUIDELINES

- Opioids are **not** first-line for chronic pain.
- If opioids are used, they should be combined with **nonpharmacologic therapy** and **nonopioid pharmacologic therapy**
- Establish and measure goals for pain and function with each assessment and **track accountability/progress.**
- Prescribe the lowest effective level, practicing caution with dosing **>50 MME/day**, and **document justification** for dosing **>90 MME/day**.
- Prescribe no more than needed for acute pain. Utilize **Opiate Risk Tools** and documented pain agreements.

USDHHS, CDC, Guidelines for Prescribing Opioids for Chronic Pain 2016

2016 CDC RECOMMENDATIONS

- Frequently reassess risk of harm and risk factors; taper or discontinue as appropriate. Be prepared to address **common opiate-related adverse effects.**
- Utilize **PDMP(CSPMP)** and toxicology routinely.
- Avoid/minimize **benzodiazepine** and opioid prescribing whenever possible. Utilize **multidisciplinary teams.**
- Be prepared to offer or refer for **MAT** with buprenorphine or methadone in combination with behavioral therapy for high-risk patients.
- Practice extreme caution with **methadone**, never rotate/initiate higher than 10mg PO TID due to variable pharmacokinetics.

PURPOSE OF THE GUIDELINES

- To provide recommendations on opiate prescribing for chronic pain (adults with pain lasting > 3 months) outside of active cancer treatment, palliative care, and end-of-life care for primary care clinicians and serve as a **relative safety and documentation standard.**

RELEVANCE OF CURRENT GUIDELINES

- Improve the communication of benefits and risks of opioids for chronic pain amongst patient's and clinicians.
- Improve the safety and effectiveness of pain treatment.
- Hopefully reduce the morbidity and mortality of long-term opioid therapy.
- Help recognize appropriate referrals or initiation for Medication-Assisted Treatment.

TAPER STRATEGIES

- Taper slow enough to minimize symptoms and signs of opioid withdrawal.
- **10%** decrease per week is reasonable starting point; however individualized care and psychosocial support should be endorsed.
- **10%** decrease per month may be better tolerated in long-term opiate patients. Methadone slower.
- **Rapid tapers** may be more appropriate with recent overdose or suspected **Aberrant Drug-Related Behaviors. 89% of AZ 2016 deaths**
- **Consider MAT** if taper intolerable or pregnancy.

PDMP MONITORING

- Evaluate whether there **are multiple providers, early refills, high dosages, or dangerous combinations** at higher risk for overdose.
- Every prescription to every 3 months.
- **Practice caution** with out-of-state patients or limited access scenarios.
- **Consider medication counts.**

PATIENT DISCUSSION

- Discuss information and confirm patient awareness of all prescriptions.
- Review medications and safety risks. MME assessment.
- Reinforce patient agreement and monitoring needs.
- Discuss care with other providers when appropriate. Coordinate goals
- Evaluate possibility of Substance Use Disorder, misuse, abuse, or diversion.

BEHAVIORAL HEALTH SUPPORT

- Comprehensive pain-management plans can decrease the physical and emotional impacts of chronic pain and better suit patient care needs.
- Stress-reduction techniques, work with a cognitive behavioral therapist (CBT), relationship counselor or pain support group.
- Talking to others in addition to the provider about chronic musculoskeletal pain can help ease the pain symptoms.

PRACTICE PITFALLS

- Establish ground rules and stick to them with a documented Pain Agreement.
- Avoid complete cloning of charts
- Do not blindly continue high-risk regimen without succinct and transparent plan and justification on each visit.
- Do not allow frequent early-refills.
- Minimize management of high-risk patients without coordination with pain management, psychiatry, and/or addiction.
- Do not have erroneous delays in mailouts.

OSTEOPATHIC MANIPULATIVE TREATMENT

- **Key Points:**
- **1)** Spine and peripheral structures behave as an interconnected unit, (ie – myofascial trigger points as a result of poor posture, somatovisceral or viscerosomatic reflexes)
- **2)** Diagnosis and assessment are based upon 10 distinct regional structures, palpatory TART findings (Tenderness, Asymmetry, Restriction, Temperature), and segmental diagnoses.
- **3)** Correction of underlying somatic dysfunctions can optimize the self-healing mechanisms and relieve pain.
- **4)** OMTs are believed to modulate the neural/vascular, lymph, and chemotactic load of nociception via central and peripheral mechanisms.

OMT CONSIDERATIONS

- The role for manual modes of therapy such as OMT has been documented for acute, subacute, and chronic LBP.
- OMT provides statistically significant and clinically relevant pain improvement in patients with chronic pain as further manifested by the decreased need for prescription rescue medication
- Trial of OMT may be useful before progressing to other more costly or invasive interventions in the medical management of patients with chronic neck and LBP.

Bronfort, Haas, Evans, Bouter. Efficacy of spinal manipulation and mobilization for low back pain and neck pain. *Spine J.* 2004; *4*:335-356.
Prinsen , Hensel, Snow. OMT associated with reduced analgesic prescribing and fewer missed work days in patients with low back pain:. *J Am Osteopath Assoc.* 2014;*114*(2): 90-98

CONTROVERSIES

- Limits on MME
- Many MAT providers but few prescribers
- Cost and effectiveness of Residential Treatment Care
- Effectiveness of Sober Living Homes
- Naloxone distribution
- Buprenorphine diversion
- SAMHSA and DEA dropping required XDEA training
- Requirements of BC Pain Medicine Consultation for Opioids over 90 MME

WHERE TO WE GO FROM HERE

- Recognize those in need
- Support NM and AZ efforts to increase providers able to prescribe MAT (SAMHSA recent drop of XDEA requirements)
- Realize that treating addiction is complex and multidisciplinary
- Remove Stigma of addiction
- Decriminalize the diagnosis of substance use disorder to maximize acceptance to treatment
- Realize this is a moving target as new substances of abuse are coming
- Enhance use of the community services

THANK YOU, QUESTIONS?

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