

PAINS

PROJECT

TRANSFORMING THE WAY PAIN IS PERCEIVED, JUDGED AND TREATED



POLICY BRIEF

NEVER ONLY OPIOIDS:

THE IMPERATIVE FOR EARLY INTEGRATION OF NON-PHARMACOLOGICAL APPROACHES AND PRACTITIONERS IN THE TREATMENT OF PATIENTS WITH PAIN.



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INTRODUCTION: The Imperative for Non-Pharmacological Approaches and Practitioners in Pain Treatment

Former U.S. Army Surgeon General Eric Schoomaker, MD, PhD, has characterized the military's advanced engagement of complementary and integrative approaches and practitioners as "the imperative for integrative medicine in the military."¹ This urgency came even as integrative practices are already embedded in military medicine. By 2012, 120 military facilities offered 275 complementary and alternative medicine programs producing 213,515 visits for active duty military members.²

Shortly thereafter, the director of the National Institutes of Health's National Center for Complementary and Alternative Medicine, Josephine Briggs, MD, announced an NIH working group involving Schoomaker on integrative pain strategies for the military, declaring that "opioids alone cannot be the answer."³

The perception of an "imperative" for using non-pharmacological strategies in the military begs a major policy question. Is there an imperative for integrative health and medicine for treatment of pain in the civilian population?

In 2010 with the passage of the Patient Protection and Affordable Care Act (ACA), Congress recognized the impact of complementary and alternative medicine (CAM) -- a term that includes meditation, acupuncture, chiropractic care and naturopathic treatment, among other things. While CAM is mentioned in various parts of the ACA, two sections specifically call attention to this integrative, bio-psychosocial approach. Section 2706 requires that insurance companies “shall not discriminate” against any health provider with a state-recognized license. Section 5101 includes licensed complementary and alternative medicine providers and integrative health practitioners in its definition of health professionals in the “health care workforce.”

“This is a unique, historic moment to capitalize on what we know works to effectively treat pain. It marks the beginning of a cultural shift in how health care is practiced in the military.”⁴

— Former Army Surgeon General Lt. Gen. Eric B. Schoomaker, MD, PhD, 2009

There is a distinct need for balance in the twin public health crises of prescription drug abuse and inadequately-treated chronic pain. The Institute of Medicine has declared pain a major public health challenge.⁷ Simultaneously, deaths related to prescription medications soared 400% in women and 265% in men in a decade.⁸ Every year, prescription opioids contribute to 17,000 deaths; NSAIDs and acetaminophen send another 80,000 people to the ER;⁹ and NSAID use is associated with increased risk of GI bleeds, impaired renal function, and cardiovascular death. Opioids have become problematic street drugs among our youth.¹⁰ Immeasurable personal costs of chronic pain are linked to \$300 billion in additional health care costs and \$335 billion in lost productivity.¹¹ Multiple non-pharmacological approaches, methods and practitioners with evidence to support their inclusion should be considered important tools in addressing these public health challenges.

Ellen: A Patient's Story

Ellen* is a 46-year old, college-educated African American female with a history of severe migraines beginning at age 22. She is married with one child and runs a part-time consulting business, working from home. She suffers migraines lasting several days, three-to-four times a month, and her work schedule varies with the frequency and severity of her headaches.

Ellen was seen at a pain management center in the past year, where she was offered medication and a facilitated support group. She has had medications, including opioids, prescribed, but she tries to avoid these unless absolutely necessary. She doesn't like the side effects and cannot perform her work as effectively. Chronic pain has negatively affected her relationships with her family. While she used to enjoy dancing with her husband and working in her garden, with her headaches she seldom feels she can now.

When she can, Ellen attends the support group for people living with chronic pain. After hearing a success story about an integrative approach to managing fibromyalgia pain, Ellen decided to investigate non-pharmacological options. She began getting a massage twice a month for three months. She felt noticeably more relaxed and aware of how she was sitting at the computer after the first month. Her massage therapist recommended yoga or Pilates for self-care between sessions. She chose yoga, took a series of classes, and practiced postures at home, especially when she noticed feeling stressed.

After reading about mindfulness, Ellen began morning walks and used this time to practice deep breathing and being fully present. She already avoided certain foods as headache triggers, and talked with a nutritional consultant about an anti-inflammatory diet. With her family's support, they all began eating more vegetables, fruit and fish, less processed foods, sugar and artificial sweeteners, and eliminated soda.

After three months, Ellen had fewer, less severe migraines, and noticed her stress sooner. She more often managed her headaches with OTC medications, and only occasionally used prescription medication. She spent more time in the garden, her mood improved, and she was able to work more productively and engage more positively with her family. She continues to add to her repertoire of self-care strategies, gets a massage about once a month, practices yoga and mindfulness, attends her support group, and eats more healthfully.

Ellen had the personal resources and determination to investigate her options, explore, and make positive changes. Every patient living with chronic pain should have education about, and access to, non-pharmacological treatment options and knowledgeable practitioners who can guide them in creating an individualized plan of care that includes complementary, integrative, and self-care options.

* Ellen's story is a composite of several real individuals who participated in a University of Virginia study of people living successfully with chronic pain: <http://www.medicine.virginia.edu/community-service/centers/wisdom/home>.

Indeed, we have an imperative to immediately engage in a thorough exploration of how to implement non-pharmacological approaches to improve pain treatment. The time is right. Values-based changes in payment and team-based methods in the delivery of care support engagement. The current evidence base, advanced practices and the military can guide us. This policy brief outlines the issues and opportunities and recommends solutions.

Evidence to Support Optimal Integrative Treatment

Research into non-pharmacological care is vastly underfunded on the federal level compared to industry funding for drugs and high cost procedures. Despite this disparity, present evidence is more than sufficient to support integration of these strategies and providers in multiple settings.

“Ideally, most patients with severe persistent pain would obtain pain care from an interdisciplinary team.”

— IOM Blueprint

Most current health care is not based on optimal evidence, and research typically takes one to two decades to be implemented in practice.⁵ The medical director of the University of Pittsburgh Medical Center shared a sobering perspective when he said that “only about a quarter of what we do has strong evidence, and we only do that about half the time.”⁶

Our tangled relationship to evidence is particularly problematic in optimal treatment of people with pain. We have agents, such as analgesics, with multiple studies showing they suppress pain symptoms. At the same time, new evidence is growing that prolonged use of these agents can worsen these very symptoms and poses substantial risks.^{7,8} These risks may be exacerbated by the concept of neuroplasticity, the functional, chemical and anatomical changes in the nervous system that can take place in response to pain. This concept of neuroplasticity highlights the importance of psychological factors in the central processing of pain and provides an explanation for how

non-pharmacological approaches may work to reduce the intensity of the pain experience.

Non-pharmacological approaches pose no such risk, and there is substantial evidence to support their use. In fact, the evidence base for non-pharmacological approaches to pain management was sufficient 15 years ago for the Joint Commission’s 2000 mandate on pain to include “non-pharmacological approaches.”⁹ Evidence has grown considerably since then. The American College of Physicians and American Pain Society includes multiple non-pharmacological practices in their low back pain guidelines.¹⁰ The NIH has published information on evidence levels for diverse complementary and integrative interventions.¹¹ *Pain Medicine* devoted a recent issue to the evidence for patient engagement.¹²

While the military is building non-pharmacologic approaches and practitioners into multiple practices,¹³ few civilian settings have implemented practices that include significant opportunities to break the analgesic-pain cycle. Present evidence is more than sufficient to support early use of non-pharmacological strategies, including complementary and integrative care, in real-world settings.

Widening the Circle of the Integrative Pain Workforce

The Institute of Medicine concludes that “ideally, most patients with severe persistent pain would obtain pain care from an interdisciplinary team.”

The report singles out “psychologists or other mental health professionals, rehabilitation specialists, and/or complementary and alternative medicine [CAM] therapists).” Yet the report also notes that primary care doesn’t customarily include these specialists.

Care providers and patient-created teams in specialized pain centers frequently include integrative practitioners and/or therapies. The growth of these licensed fields is tied to consumer interest in non-pharmacological approaches. Pain-related conditions are the dominant force in growing consumer use of chiropractic, acupuncture and Oriental medicine, naturopathic medicine, and massage therapy. Together, these total over 380,000 licensed practitioners. An estimated 3,000

medical doctors and 1,000 nurses have been educated to competency-based standards in integrative or holistic medicine. Pain was viewed as the most effective treatment area in a survey of health system integrative medicine centers.²¹

These practitioners are already part of the nation's workforce and provide services to many who live with chronic pain. They are also formally included in an as yet unfunded portion of the Affordable Care Act, Section 5101, the National Health Care Workforce Commission. In this patient-centered era, policy on research and practice should proactively include integrative health practitioners.

“Non-Discrimination in Health Care” Fosters Non-Pharmacological Options

Lack of reimbursement is a major barrier to the optimal inclusion of non-pharmacological approaches in the treatment of people with pain. Licensed practitioners with skills in non-pharmacological or integrative approaches are often not covered providers. Patient choice, practitioner referrals, and health system employment are constrained.

Depending on interpretation and implementation, Section 2706 of the Affordable Care Act, “Non-Discrimination in Health Care,” may move us toward lowering this barrier. The section was included in response to requests from a consortium of 13 organizations of licensed and certified integrative health professionals with expertise in treating people with pain conditions, the Integrative Healthcare Policy Consortium, and also by the American Chiropractic Association.

Section 2706 is the subject of considerable debate nationally and in the states. The AMA House of Delegates resolved to overturn it. The national Blue Cross Blue Shield Association and some other insurers have responded affirmatively. Many insurance commissioners are disregarding it. Three federal agencies including the Department of Health and Human Services essentially dismissed the section. However, the U.S. Senate Appropriations Committee has twice told these agencies their actions violate Congressional intent.

Some Resources for Evidence on Non-Pharmacological Approaches

Guidelines

Pain Management Standards (Joint Commission on Accreditation of Healthcare Organizations, 2000)

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline (American College of Physicians and the American Pain Society, 2007)

Other Resources

Chronic Pain and Complementary Health Approaches: What You Need to Know (NIH National Center for Complementary and Alternative Medicine)

Are Self-Care Complementary and Integrative Therapies Effective for Management of Chronic Pain? A Rapid Evidence Assessment of the Literature and Recommendations from the Field. (Pain Medicine, 2014)

Clinical Update: A Holistic Model of Care (International Association for the Study of Pain, 2014)

Clinicians' and Educators' Desk Reference on the Licensed Complementary and Alternative Healthcare Professions (Second Edition, 2013)

Clinical Update: Chronic Pain Management – Measurement-based Step-Care Solutions (International Association for the Study of Pain, 2012)

“Overall, CAM users had lower average expenditures than nonusers (\$3,797 versus \$4,153). Their outpatient expenses were higher, but offset by lower expenses for inpatient care and imaging. People who had the heaviest disease burdens accounted for the highest levels of savings, an average of \$1,420.”²²

— IOM Blueprint

Since 1996, Washington State has been an experiment for coverage of licensed complementary and alternative medicine practitioners. The law that forced inclusion has been compared to Section 2706. Research has found lower average costs from covered users of these practitioners compared to non-users.²³

Maturation of Licensed Integrative Health Professions

Profession	Accrediting Agency Established	US Dept. of Education Recognition	Recognized Schools or Programs	National Exam Created	State Regulation	Total Licensed Practitioners
Acupuncture and Oriental medicine	1982	1990	61	1982	44	28,000
Chiropractic	1971	1974	15	1963	50	72,000
Massage therapy	1982	2002	88*	1994	48	280,000
Naturopathic medicine	1978	1987	7	1986	18	5,500

* Only includes those schools accredited through the specialized accrediting agency for massage therapy, the Commission on Massage Therapy Accreditation. Source: Updated from the Clinicians and Educators Desk Reference on the Licensed Complementary and Alternative Healthcare Professions. Academic Consortium for Complementary and Alternative Care (2013)

Notably, patients with the heaviest disease burdens accounted for the most significant savings.

Yet application and implementation that follows Congressional intent will stimulate opportunities for wider implementation and support patient choice.

“The Joint Commission would significantly increase health system exploration of non-pharmacological treatment by beginning to score non-pharmacological approaches in pain treatment.”

Roles for Accreditors and Certification Agencies

Under-implementation of non-pharmacological approaches results from multiple cultural, economic, educational and systemic barriers. The military has an advantage in engaging course corrections. Leaders can quickly marshal forces. For instance, when the Veteran’s Administration decided its practitioners should be knowledgeable about integrative options, they quickly created an online course. Attendance was mandated. Awareness spread. Culture shifted.

Mandating courses to promote public health is not uncommon. There are many examples of requiring

continuing education on a particular subject for licensure or recertification such as for HIV, ethics, cultural competency, and CPR.

Authoritative responses to pressing imperatives are powered by accreditation agencies for academic institutions and for hospitals and outpatient settings. Certification organizations for health professionals can similarly prompt practice shifts.

In a patient-centered era, mandated requirements can bridge the chasm between biomedical approaches, i.e., prescription pain medications, nerve blocks, surgeries and other interventional approaches, and the bio-psychosocial approaches promoted by complementary and alternative medicine. Bridging this chasm can help change the way pain is perceived, judged and treated.

Non-Pharmacological Approaches

Physical modalities

- ☐ Acupuncture
- ☐ Chiropractic and Osteopathic manipulation
- ☐ Massage therapy, hydrotherapy, and aromatherapy
- ☐ Physical therapy
- ☐ Trigger point therapy
- ☐ Occupational therapy

Relaxation and Mind/Body therapies

- ☐ Meditation, guided imagery, Reiki, music therapy
- ☐ Psychological therapies



Movement-based therapies

- ☐ Yoga, dance, exercise, aquatic therapy
- ☐ Tai chi and qi gong
- ☐ Movement education and postural awareness such as Alexander Technique, Feldenkrais, Egoscue Method, and Trager

Creative Arts Therapies

- ☐ Art, drama, dance, music and poetry therapy

Nutritional counseling

- ☐ Dietary changes and weight loss
- ☐ Learning to shop for and prepare healthy meals
- ☐ Identifying food sensitivities that cause inflammation

Strategies for Self-Care

- ☐ Learning to cope with the emotional and social consequences of pain
- ☐ Topical pain relievers (non-pharmacological)
- ☐ Participation in support groups and social support generally
- ☐ Mindfulness, meditation, guided imagery and contemplative practices
- ☐ Self-massage and partner massage
- ☐ Exercise

- ☐ Spending time in nature and engaging in other pleasurable or personally meaningful activities

Because licensed complementary, integrative and mental health practitioners are often trained in multiple non-pharmacological modalities, their inclusion into team-based care is an efficient method for increasing patient access to non-pharmacological approaches.

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"Never Only Opioids"

is the 5th in a series of briefs profiling policy issues important to improving chronic pain care.

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This policy brief is a product of the Pain Action Alliance to Implement a National Strategy (PAINS) in collaboration with the Academic Consortium for Complementary and Alternative Health Care (ACCAHC) and the Center for Practical Bioethics. ACCAHC participation was funded by an unrestricted grant from the NCMIC Foundation.

Funded by US Cancer Pain Relief Fund

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