Pain Management Part 2 – Therapy – Non-Opioid Care Guide

September 2018

SUMMARY

GOALS

- ✓ Pain will be treated in a systematic, step-wise approach based on comprehensive assessment and planning
- ✓ Improve function; facilitate participation in rehabilitative efforts; reduce sense of suffering
- ✓ Avoid injury/complications by iteratively considering risks and benefits

ALERTS

- Attitudes about managing pain require socioeconomic, cultural, and religious sensitivity. Therefore, the method in which care is delivered is equally as important as the care itself.
- Non-pharmacologic therapies and non-opioid therapies are preferred for managing chronic non-cancer pain.

DIAGNOSTIC CRITERIA

See CCHCS Care Guide: Pain Management Part 1—Assessment for guidance on identifying types of pain and formulating a differential diagnosis. This care guide does not cover cancer, hospice, or palliative care pain management.

EVALUATION/TREATMENT

[See CCHCS Care Guide: Pain Management Part 1—Assessment for details on conducting a full assessment.] Pain is a multidimensional experience. Pain management is most effective when a biopsychosocial model and a multimodal approach are used together. Each patient has different needs and it is essential they play an active role in their own pain management program. A Stepwise Approach to Chronic Pain Management[1] shows the gradual progression necessary to create an individualized program for your patient.

Step 1: Self-Management

- Recommended first line treatment for all chronic pain patients.
- There are a host of tools and techniques available to providers that can be used to assist patients with the management of their chronic pain.
- Patients are much more likely to embrace self-management strategies if they are taught how to do things rather than being told "you need to learn to live with it."
- The pain treatment paradigm is changing and the focus is "now on a biopsychosocial model of pain care"[1] (See page 4).
- After completing your patient assessment (See CCHCS Care Guide: Pain Management Part 1 — Assessment), you should be able to suggest several "self-management activities"1 to help your patient start their self-management process.
- Be sure to introduce concepts such as, the mind-body connection, the importance of physical activity, sleep hygiene, healthy eating, relaxation techniques, etc. (See page 5 and Patient Education page PE-1). As providers we need to address our patient's pain, but with a shift toward "using a whole-health approach to improve quality of life and increase functional status."[1]

Step 2: Non-Pharmacologic Therapies (See pages 6-7)

Physical Therapy (PT)

- Therapeutic exercise (graded and progressive with coaching)
- Range of motion, stretching and strengthening
- Gait and balance retraining
- Soft tissue, joint, and spinal mobilization
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Mobility aids

Behavioral Therapies

- Cognitive Behavioral Therapy (CBT)
- Psychotherapy
- Dialectical Behavioral Therapy

- Support groups
- Motivational Enhancement Therapy (MET)

Step 3: Non-Opioid Pharmacologic Therapy (See pages 8-9 & 11-12)
- Recommended for patients who continue to have intolerable pain impacting function, despite incorporating Steps 1 and 2.
- Selections of non-opioid therapy (agent trials) should be based on type of pain (i.e., somatic vs. neuropathic pain).
- Other Agents: Corticosteroids, muscle relaxants, topical anesthetics, etc.

Step 4: Procedures/Interventions (See page 10)
Interventional techniques ranging from trigger point injections, intra-articular injections, spinal interventions, and surgery may be beneficial in select cases (consider them based on clinical findings and differential diagnosis).

MONITORING

- Monitor functional status and progress toward patient goals.
- Encourage patient to complete the pain log (see Patient Education, PE-2 & 3 attachments on Lifeline) before each visit to track functional impact.
- Schedule prudent follow-up visits that are timed appropriately for the stage of treatment (i.e., ranging from 1-4 weeks for new agent trials, to 3-6 months for stable patients without changes to management plan).