

Interdisciplinary Management of Chronic Pain in Managed Care

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Summary

Patients who develop chronic pain can be difficult to manage. The factors perpetuating pain in these patients have to be treated. Thus, chronic pain must be dealt with from a biopsychosocial perspective. Many chronic pain patients will benefit from multidisciplinary and interdisciplinary approaches.

Key Points

- Pain is multifactorial and complex.
- It is important to understand why the chronic pain patient has pain.
- Many psychological factors determine why chronic pain persists.
- Chronic pain leads to changes in the brain that perpetuate the process.
- Multidisciplinary and interdisciplinary teams can be used to effectively manage chronic pain patients.
- A balanced biopsychosocial assessment and treatment plan is needed to manage many chronic pain patients.

EXHIBIT 1 OUTLINES THE CRITERIA FOR success in managing a patient with chronic pain.¹ The different stakeholders in this process have different goals that may be in conflict. The workers compensation program wants the patient to return to work. The managed care plan wants health care utilization and costs decreased. The health care provider wants the patient to have functional improvement with good patient satisfaction and few adverse effects of medications. The patient just wants pain relief. Although it is a difficult journey, success is possible with these patients.

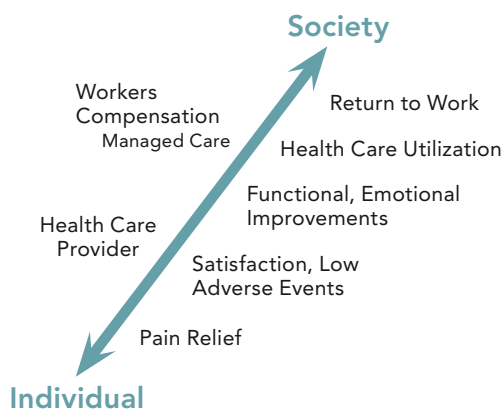
Patients many times come to the chronic pain specialist thinking they have failed and nothing is going to help them. Thus, it is important to understand chronic pain patients and why they have reached this point. Pain is multifactorial and complex. When pain becomes chronic, positive and negative adaptations, and psychological issues add to the physiological and structural causes of the pain syndrome. The interplay of physical, functional, emotional, psychological, social, and spiritual aspects

of patient well-being has supported the development of interdisciplinary approaches to treatment. Meeting the needs of patients in pain requires a broad spectrum of disciplines, knowledge, skill, experience, and creative thought.

Pain is perceived as a threat or damage to one's biological integrity. Response to pain is a normal physiologic response; unfortunately with chronic pain, this response gets out of control. Suffering is perceived as a threat or damage to the self. Patients seek treatment because they are suffering and this suffering changes who they are.

Chronic pain changes the person – it affects behavior, identity, and cognition. If these effects are not dealt with, successful pain management will not occur. Chronic pain patients are demoralized from continuing their quests for relief, and are in a state of medical “limbo.” They have been to many doctors and had many treatments, and begin to doubt themselves. Everything in their lives revolves around their pain problems. The person is changed from being an active patient to a more passive patient.

Exhibit 1: Criteria for Success



Reference:1

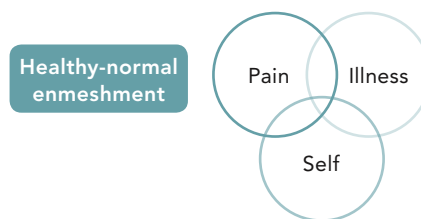
Exhibit 2 shows a healthy normal overlap between pain, illness, and self.² This is the person with a short-term problem such as a knee replacement. There is currently pain but the self-component is maintained. In the chronic pain person, the pain, self, and illness are overlapped, and enmeshed much more.

In a biomedical model, pain is a sensory event reflecting underlying disease or tissue damage. Once the stimulus resolves, so does the pain. This model works for acute pain but not for chronic pain. With chronic pain, the nervous system changes and becomes sensitized. Unfortunately, treating pain still revolves around the biomedical model in many ways. Clinicians use objective tests to try and define the source of the pain, and solve it without addressing the changes to the nervous system and the patient's psychological issues.

The gate control theory explains chronic pain better (Exhibit 3).³ This theory says pain can be modulated at the spinal cord level. According to this theory, the whole nervous system is affected. There are certain areas of the brain that are responsible for pain perception and modulating the whole experience. The thalamus is important for pain perception, and the dorsolateral prefrontal cortex is important for modulating affect. If the patient is anxious or depressed, the ability of the brain to control pain is blunted. MRI brain studies have shown high rates of degeneration in the brains of patients with chronic pain.

Chronic pain patients have an excess of pain behavior and relative absence of well behavior. They also have dysfunctional attitudes, beliefs, and expectations about pain and disability. In these patients, the factors that maintain pain are different

Exhibit 2: Enmeshment and Pain



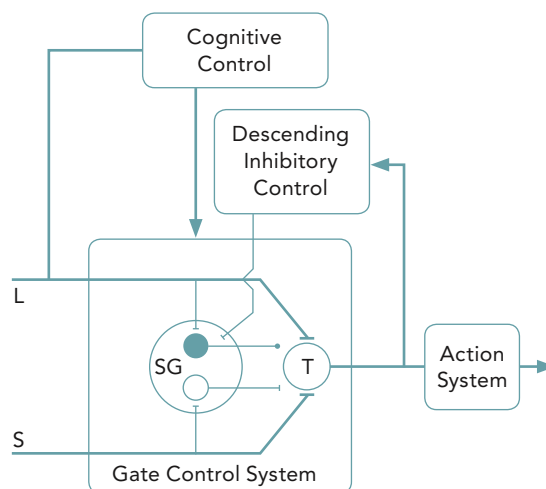
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from those that start the process. The management of chronic pain should focus on a biopsychosocial understanding of chronic pain. This approach takes into account the biophysiology, maladaptive pain behaviors, coping, emotional distress, and the impact of pain on the person, family, and workplace.

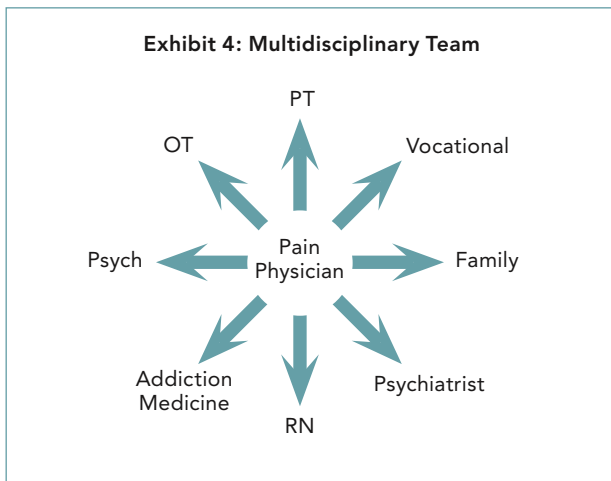
Patients will require different medical team approaches for management. The acute pain person can be managed with a parallel practice approach. The majority of pain patients will be managed adequately and will not develop psychosocial and behavioral issues. The approximately 10 percent of pain patients who develop psychological and behavioral issues, and typically consume 80 percent of the pain management health care resources, belong in a more comprehensive management program.

A multidisciplinary team can be used to effectively manage certain chronic pain patients. Patient care is planned and managed by a team leader and leadership is often hierarchical. One or two individuals on the team direct the services of a range of team members. The team members have individual goals and make independent decisions.

Exhibit 3: Gate Control Theory



Reference: 3



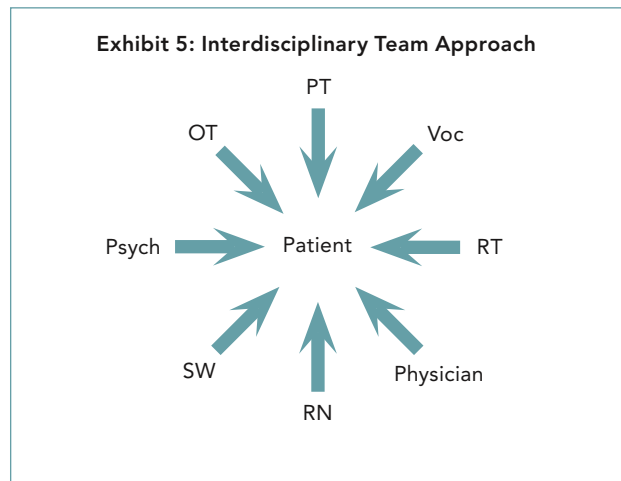
About 80 percent of pain practices function in this model (Exhibit 4).

Some chronic pain practices use an interdisciplinary approach (Exhibit 5). With this approach the patient is the center. Team members work together toward a common goal and make collective therapeutic decisions. There is communication and consultation with other team members, facilitated by regular, face-to-face meetings. Interdisciplinary teams possess a combination of skills that no single individual demonstrates alone. Thus, the team is able to achieve more than the sum of the individuals involved.

One example of an interdisciplinary management program is at the Rehabilitation Institute of Chicago. The Center For Pain Management conducts both formal assessments (psychological/behavioral, operant issues, and physical variables) and informal assessments (self efficacy, fears, pain-related anxiety, readiness to change, treatment expectancies) for each patient. The goals of this program are to decrease pain intensity, increase physical activity, decrease reliance upon pain medication, improve psychosocial functioning, return the patient to leisure pursuits and work, and reduce utilization of health care services. The pain team works to re-conceptualize the patients' pain, foster optimism and combat demoralization, encourage active patient participation and responsibility, provide specific training in specific skills, and encourage feelings of success, self-control, and self-efficacy. During a four-week, eight-hours-per-day program, the phases of treatment include education, skills training, skills application, and relapse prevention. The purpose of a pain program is to move patients away from a chronic sick role to a healthy role.

Conclusion

Management of the chronic pain patient requires a balanced biopsychosocial assessment and treatment



plan. The ultimate goal is to move the patient to closure. To achieve this goal, there has to be consistent communication between all stakeholders – patient, providers, employer, and insurer. Additionally, to prevent the development of chronic pain, managed care may have to identify those patients with fear, anxiety, low self-efficacy, depression, or other factors, and get them to psychological treatment earlier. **JMCM**

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References

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