The Role of Nonpharmacological Approaches to Pain Management: A Workshop

Chester “Trip” Buckenmaier, MD, COL US Army (Ret)
Director, Defense and Veterans Center for Integrative Pain Management
Professor Anesthesiology
Uniformed Service University

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Disclosures

• The presenter has no relevant financial relationships or conflicts of interest.
• No discussion of off-label use of drugs or devices.
• The presentation is the personal opinion of the presenters and does not reflect the official views of the Department of Defense or any other Federal Agency.
• Provide recommendations for a MEDCOM comprehensive pain management strategy that is holistic, multidisciplinary, and multimodal in its approach, utilizes state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.
  • Army Pain Management Task Force Charter; signed 21 Aug 2009

• Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research
  • June 2011
Military Installations Located Near US Counties With High Opioid Prescribing Rates and TRICARE Enrollees

Opioid prescribing rates are per 100 people for both county-level and military installation-level data

Data pulled from DoD Carepoint Opioid Registry on 11/28/2018
County Population 2016 Estimates
MTF prescribing rate based on average number of total enrollees per month of FY2016
Opioid Risk Percentile weighted based on proportion of TRICARE enrollees in the county and county opioid prescribing rates
Facility level prescribing rates of opioids and naloxone based on distinct patients seen from 12/1/2017 to 08/01/2018

Cumberland County, NC
Population: 327,127
TRICARE Enrollees: 19%
Opioid Prescribing Rate: 86

AMC Womack-Bragg
• Facility Opioid Prescribing Rate: 33
• % High Risk Patients: 3%
• % High Risk Dispensed Naloxone: 8%

Craven County, NC
Population: 103,445
TRICARE Enrollees: 22%
Opioid Prescribing Rate: 111

NH Camp Lejeune
• Facility Opioid Prescribing Rate: 25
• % High Risk Patients: 2%
• % High Risk Dispensed Naloxone: 2%

Okaloosa County, FL
Population: 201,170
TRICARE Enrollees: 22%
Opioid Prescribing Rate: 85

AF-H-96th Med Group-Eglin
• Facility Opioid Prescribing Rate: 34
• % High Risk Patients: 3%
• % High Risk Dispensed Naloxone: 2%

Esambia County, FL
Population: 315,187
TRICARE Enrollees: 11%
Opioid Prescribing Rate: 113

NH Pensacola
• Facility Opioid Prescribing Rate: 52
• % High Risk Patients: 4%
• % High Risk Dispensed Naloxone: 4%

Clay County, FL
Population: 208,311
TRICARE Enrollees: 12%
Opioid Prescribing Rate: 87

NH Jacksonville
• Facility Opioid Prescribing Rate: 51
• % High Risk Patients: 6%
• % High Risk Dispensed Naloxone: 3%

Madison County, AL
Population: 356,967
TRICARE Enrollees: 6%
Opioid Prescribing Rate: 114

AHC Fox-Redstone Arsenal
• Facility Opioid Prescribing Rate: 50
• % High Risk Patients: 5%
• % High Risk Dispensed Naloxone: 1%

Wichita County, TX
Population: 131,838
TRICARE Enrollees: 7%
Opioid Prescribing Rate: 105

AHC Reynolds-Sill
• Facility Opioid Prescribing Rate: 44
• % High Risk Patients: 5%
• % High Risk Dispensed Naloxone: 6%

Dorchester County, SC
Population: 153,773
TRICARE Enrollees: 8%
Opioid Prescribing Rate: 101

AHC Moncrief Jackson
• Facility Opioid Prescribing Rate: 32
• % High Risk Patients: 2%
• % High Risk Dispensed Naloxone: 4%

Clay County, FL
Population: 356,967
TRICARE Enrollees: 6%
Opioid Prescribing Rate: 114

Madison County, AL
Population: 356,967
TRICARE Enrollees: 6%
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AHC Fox-Redstone Arsenal
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Another epidemic: Cholera

London, 1854: Cholera, John Snow and the Broad Street Pump
Both the idea that chronic pain could be effectively and safely managed with opioids and the principles of opioid pain management were based on the successful use of these drugs to treat acute and end-of-life pain. That success was based on the “titrate to effect” principle: the correct dose of an opioid was whatever dose provided pain relief, as measured by a pain-intensity scale.
DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITY**:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
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2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**:

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</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
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3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**:

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</thead>
<tbody>
<tr>
<td>Does not affect</td>
<td>Completely affects</td>
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4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**:

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</thead>
<tbody>
<tr>
<td>Does not contribute</td>
<td>Contributes a great deal</td>
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A new take on an old scale...

If clinicians focus on improvements in patient physical and emotional function for pain management, integrative health can compete with traditional pharmacologic approaches to pain.

This is the cultural change the DoD is working to effect within its medical systems by adopting the DVPRS as the DoD pain scale.