

Opioid Guidelines and Their Implications for Occupational Therapy

Niccole Carpenter Rowe, BA, COTA/L
Pain Consultants of East Tennessee
Knoxville, Tennessee

Kimberly Lowe Breeden, MS, OTR/L
Pain Consultants of East Tennessee
Knoxville, Tennessee

This CE Article was developed in collaboration with **AOTA's Rehabilitation and Disability Special Interest Section**.

ABSTRACT

This article provides information about recent federal guidelines regarding prescribing opioids and treating chronic pain, to help occupational therapy practitioners improve treatment related to chronic pain as well as better promote occupational therapy's distinct role in achieving the objectives in the guidelines.

LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Recognize the implications of national guidelines regarding treating chronic pain that affects the delivery of occupational therapy services
2. Describe the biopsychosocial model for chronic pain management using an interdisciplinary approach
3. Differentiate between opioid use disorder and chronic pain

INTRODUCTION

In the United States, more than 116 million individuals are dealing with chronic pain (Seth et al., 2018). In 1991, advocacy for improved treatment for pain began (Tsang et al., 2008). One result of these efforts may have been the inadvertent rise in prescription opioid overdose deaths by more than four times from 1999 to 2016 (Seth et al., 2018). In response to this crisis, government and health-regulating entities have created guidelines regarding the prescription of opioid pain relievers. These regulations have affected not only health care providers, but also people with chronic pain, often leading to their frustration, anger, confusion, and concerns about treating their pain.

DEFINING THE RELEVANT TERMS

An *opiate* is the alkaloid that occurs naturally in opium and is derived from the opium poppy. An *opioid* is a product that binds to the same receptors as opiates. *Synthetic opioids* are those that are chemically manufactured, whereas *semi-synthetic opioids* are

chemical modifications to naturally occurring opium alkaloids. The term *opioid* is commonly used to include the whole family of legal and illicit opioids and opiates. Prescription opioids are most commonly used for treating pain and include opiates, synthetic opioids, and semi-synthetic opioids (see Table 1 on p. CE-2).

Because of media attention to the increasing cases of opioid abuse and addiction, some patients with pain may be concerned that they will inevitably become addicted if they take opioids. For others, it might be merely the stigma associated with taking prescription opioids that prevents them from considering this option. As Carol Levy (2018) states in an editorial about her resistance to taking opioids despite her chronic pain: "They'll think I am an abuser or an addict."

Long-term opioid use does not necessarily lead to physical dependence, which is distinct from addiction disorder (National Institutes of Health, 2011). The Centers for Disease Control and Prevention (CDC; 2016) defines long-term opioid use as "use of opioids on most days for more than 3 months" (p. 8). *Physical dependence* is the process by which the body adapts to a specific drug and manifests "drug-class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist" (Corsini & Zacharoff, 2011).

Addiction is:

[A] disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. (American Society of Addiction Medicine, 2011, p. 1)

Too often, people are not aware of the differences in individuals' adaptations to a drug and its connection to drug addiction. For prescribers, the challenge is to ensure safety with medication use and to minimize the risk of addiction. One way to do this is to assess and monitor for *aberrant behaviors*, which are any medication-related behaviors that depart from strict adherence to the prescribed plan of care. These behaviors include *abuse*, which is using a drug for nonmedical purposes; *diversion*, which is intentionally removing a medication from legitimate distribution, including sharing it with friends or family members or selling it on the street; *misuse*, which is taking medication in a way other than how it was prescribed (possibly

Table 1: Brand Name and Generic Versions of Various Types of Opioids

Type of Opioid	Brand Name	Generic
Opiates	MS Contin Duramorph	Morphine
		Codeine
Semi-synthetic	Hysingla ER Zohydro ER	Hydrocodone
	OxyContin Roxicodone	Oxycodone
	Dilaudid	Hydromorphone
	Opana Numorphan	Oxymorphone
	Butrans	Buprenorphine
Synthetic	Nycynta	Tapentadol
	Methadose Dolophine	Methadone
	Demerol	Meperidine
	Actiq Duragesic	Fentanyl
	Ultram	Tramadol
	Darvon	Propoxyphene
Combination Drugs	Percocet Roxicet	Acetaminophen and oxycodone
	Targinq	Oxycodone and naloxone
	Lortab Vicodin	Hydrocodone and acetaminophen

unintentionally, such as forgetting to take it or taking it incorrectly); and *overdose*, which is taking a lethal or toxic amount of a medication.

HISTORY AND PREVALENCE OF THE OPIOID CRISIS

In the early 1990s, the American Pain Society began to advocate for new quality assurance standards for acute and cancer pain. These standards were based on an editorial in the *Annals of Internal Medicine* that promoted using opiate analgesics for treating pain, and stating that the risk of addiction was low. This determination was based on a single study (Baker, 2017). As a result, in 2000, the Joint Commission required all patients to be assessed for pain (Morone & Weiner, 2013). Congress then declared a “Decade on Pain Control and Research,” from 2001 to 2011. After these and other public health efforts, there was an increase in not only prescribing opioids, but also in reports of misuse, addiction, and overdose deaths (U.S. Department of Health and Human Services [HHS], 2016).

RECENT GUIDELINES

Concerns over the increase in adverse events from prescription opioids, along with an agenda to improve pain care, have led to many federal government, state government, and health care agencies publishing guidelines for prescribing opioids and treating pain. This article discusses four recent guidelines, including their background, purpose, and recommendations relevant to occupational therapy practitioners.

Relieving Pain in America (2011)

In 2010, the Patient Protection and Affordable Care Act charged HHS with examining pain as a public health problem in the United States in partnership with the Institute of Medicine of the National Academies (IOM; 2011) to determine how pain was being researched, treated, and discussed in the United States. The IOM published the result of this collaboration, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, in 2011. This document provides

Earn .1 AOTA CEU (one contact hour and 1.25 NBCOT PDU). See page CE-8 for details.

recommendations to transform how health care providers understand, assess, treat, and prevent pain, including calling for another set of guidelines to be developed that provides a “comprehensive, population health-level strategy for pain prevention, treatment, management, education, reimbursement, and research” (IOM, 2011, p. 7).

National Pain Strategy (NPS; 2016)

The Interagency Pain Research Coordinating Committee (IPRCC) created the *National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain* at the request of the HHS to develop strategies and further recommendations based on the initial findings of *Relieving Pain in America*. The NPS seeks “to reduce the burden of pain for individuals, their families, and society as a whole” (IPRCC, 2016, p. 6). For each of its objectives, the NPS identifies short-, medium-, and long-term strategies; federal stakeholders in the objective; possible collaborators to achieve the objective; and metrics for determining whether the objective has been reached.

Guideline for Prescribing Opioids for Chronic Pain (2016)

Although the previously discussed guidelines considered a broad view of the problem of pain in the United States, the CDC determined a need for specific guidelines regarding prescribing opioids and created the *Guideline for Prescribing Opioids for Chronic Pain* in 2016. Note that the CDC’s guidelines consider primary care physicians as the target audience. The CDC addresses the treatment of chronic non-malignant pain and does not address malignant, palliative, or end-of-life treatment. The CDC guidelines seek to “improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy” (Dowell et al., 2016, p. 1).

Opioid Analgesic REMS Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients With Pain

In early 2018, the U.S. Food and Drug Administration (FDA) released the *Opioid Analgesic REMS Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients With Pain* as a way to address the opioid epidemic by reducing new addiction. The FDA’s blueprint outlines the development of educational programs for health care providers to increase their understanding of the risks associated with opioids, treatment options for pain management, and guidelines for when to prescribe opioids. The blueprint guides education regarding opioid misuse and abuse so health care providers can use better strategies to reduce it (FDA, 2018). Note that the FDA wants all health care providers involved in pain management to complete educational programs laid out in the blueprint. Occupational therapy practitioners may consider pain treatment as a specialty area, but many routinely address pain management with clients.

Guideline Recommendations for Safer Prescribing Practices

The FDA and CDC focus on reducing risks associated with prescribing opioids. The FDA (2018) believes that health care practitioners should have an understanding of alternate pharmacologic (non-opioid) and non-pharmacological treatments for pain so opioids are considered when those alternate treatments are inadequate. The CDC states that these alternate treatments are preferred for chronic pain over opioid medication.

There are also specific recommendations for actions to be taken if opioids are prescribed. The CDC states that the prescriber should follow up with the patient within 4 weeks of initial prescription or if there is a change in dosage. During that follow-up, the prescriber should reassess the patient’s function, pain, and quality of life; monitor side effects; and check for signs of aberrant behaviors or misuse (Dowell et al., 2016). For long-term opioid prescriptions, the CDC recommends a reassessment at least every 3 months. The FDA does not specify reassessment frequency, but states that reviewing patient goals and pain should be periodic and providers should be reviewing adverse events at each patient visit (FDA, 2018). The FDA considers the following to be relevant when considering adverse events: medication errors, overdose, labeled warnings for the drug, and common unpleasant drug reactions. The FDA also identifies key safety strategies to be considered when prescribing opioid medications, including safe storage, proper disposal of used (e.g., patches) and unused opioids, and driving and work safety of the patient (FDA, 2018). The CDC also recommends safe storage and proper disposal, and it notes that health care providers must consider a patient’s cognitive limitations, including whether a caretaker can safely manage prescriptions (Dowell et al., 2016).

The FDA and the CDC recommend using urine drug screens to monitor for potential risks for misuse or abuse. The urine drug screens should be done before prescribing and then be considered at least annually (Dowell et al., 2016). The FDA recommends that health care providers be familiar with urine drug screens and use them as needed. The screen typically assists providers in determining the presence of any prescribed drugs in a patient’s system, which provides data for monitoring adherence to the treatment plan. The presence of illicit substances or other controlled substances, such as benzodiazepines, can help prescribers make clinical decisions that will limit the risks associated with prescribing opioids for the patient (Dowell et al., 2016).

Screening tools that evaluate risk factors for misuse or abuse may also be part of the treatment process. These include the Opioid Risk Tool, the Screener and Opioid Assessment for Patients with Pain, and the Brief Risk Interview. The CDC does not specifically recommend decision making based on screening tools because evidence shows they may not accurately classify patients (Dowell et al., 2016). The CDC recommends caution when considering prescribing opioids and to not overly rely on these tools. The CDC does recommend questioning patients regarding current drug and alcohol use. However, the FDA recommends the use of screening tools

during the initial evaluation of a patient who has pain, but they do not refer to any specific tool.

Another way for prescribers to determine a patient's risks for opioid use is to use state prescription drug monitoring programs (PDMP), which are databases that track prescriptions written for controlled substances in a state (Haffajee et al., 2015). The CDC recommends that PDMPs be reviewed at the initiation of opioids and up to every 3 months, if the prescribing is long term. The FDA recommends that the PDMP be checked on initial evaluation of the patient, at the start of prescribing opioids for acute pain, and for ongoing pain management through the use of opioid analgesics.

The CDC and FDA also discuss differences in prescribing opioids for acute versus chronic pain, including specific recommendations regarding short- versus long-term prescribing.

Occupational Therapy Considerations Regarding Regulations for Safer Prescription Practices

Most occupational therapy clients on long-term opioid therapy will be required to provide periodic urine samples for screening. Occupational therapy services should consider the clients' ability to complete toileting, complete toilet transfers, manage collecting the samples, manage the collection containers, and accurately report all current medications to lab personnel. Increased monitoring for the safe use of opioids requires clients to make frequent office visits, which may include pill counts. For community-dwelling clients, occupational therapy practitioners should address functional mobility as well as transportation to ensure safe compliance with scheduled appointments. To have accurate pill counts, medication management should be addressed to ensure that clients are adhering to their prescribed regimens. Medication management could consist of "negotiating with the provider for a prescription, filling the prescription at the pharmacy, interpreting complicated health information, taking the medication as prescribed, and maintaining an adequate supply of medication for ongoing use" (American Occupational Therapy Association, 2017, p. 7112410025p1). Ensuring medication management may include assessing and treating cognition and/or executive function, fine motor coordination, vision, health literacy, and the effectiveness of current strategies.

Health literacy is a consideration not only for managing medication, but also for ensuring that patients fully understand the expectations and requirements that are often specified in medication agreements, including guidelines on alcohol consumption, filling prescriptions from other providers, and driving. Occupational therapy practitioners should also ensure that clients understand the information their prescribing provider issued regarding the risks of intentional or unintentional misuse of opioid medications.

Assessment and training for toileting, mobility, medication management, and health literacy are not just valuable services that occupational therapy practitioners can provide to their clients, but these valuable services also assist prescribing providers. Communicating the results of evaluations to physicians,

nurse practitioners, and physician assistants can allow them to better determine the safest treatments for clients and ensure they adhere to the recommendations for opioid therapy.

Guideline Recommendations for Non-Pharmacological Interventions

All the opioid guidelines touch on the recommendation that non-pharmacological treatments should be considered for treating chronic pain, as these treatments typically provide fewer risks than opioid analgesics. The CDC states that non-pharmacological therapy is preferred for treating chronic pain, with the CDC's guidelines discussing evidence-based treatments such as cognitive-behavioral therapy, physical therapy, exercise therapy, multidisciplinary therapy, and interventional approaches such as injections. The CDC guidelines only mention occupational therapy once, for addressing posture as a disease-specific symptom for someone with pain. The FDA provides the following examples of non-pharmacological treatments: psychological, physical rehabilitation, and surgical approaches, with recommendations that health care practitioners have knowledge of these treatments, including evidence to support their use. The IOM and IPRCC take a broader view by discussing the need for more pain treatments that are evidence based, with recommendations for more data, research, and funding to obtain this evidence. The IOM (2011) notes that patients should be educated about strategies to "prevent, cope with, and reduce pain" (p. 8). It also identifies the lack of funding for non-pharmacological treatments, such as interdisciplinary practice, psychosocial services, and rehabilitative services, as a barrier to adequate pain care. The IPRCC seeks to improve the care and prevention of pain through treatments that are evidence based and use a biopsychosocial model. It states the need for a benefit-to-cost analysis for the current evidence-based treatments. It also recommends initiating research to develop strategies for treating and preventing pain, and using insurer reimbursement to promote using best practice guidelines from the results of the research (IPRCC, 2016).

Self-managing pain is discussed in three of the guidelines. The IPRCC recognizes self-management programs as evidence based, but with limited implementation as a treatment for pain (IPRCC, 2016). The NPS believes these programs are important enough to include an objective focused on nationwide development.

Relieving Pain in America also makes specific recommendations for self-managing pain, with a focus on educating those with pain and their families on self-management techniques, including benefits, risks, and costs (IOM, 2011). The FDA also recognizes self-management as an effective treatment approach for those with pain.

The guidelines recognize interdisciplinary treatment for chronic pain as evidence based and cost effective. *Relieving Pain in America* states, "the comprehensive, interdisciplinary approaches to pain assessment and treatment ... appear to work best in managing chronic pain" (IOM, 2011, p. 45). It also recognizes the limited number of facilities offering this approach, and that this approach is not promoted through reimbursers. An interdisciplinary approach to pain involves evaluation, diagnosis, and creation of a care plan through multiple specialists. The

plan should address all the dimensions of the pain experience, including biological, psychological, and social (IOM, 2011). The NPS calls for interdisciplinary care to be defined and evaluated to promote consistent application and use in interdisciplinary care of those with pain (IPRCC, 2016).

Occupational Therapy's Role in Providing Non-Pharmacological Interventions

Relieving Pain in America describes chronic pain as “a distinct pathology, causing changes throughout the nervous system that often worsen over time. It has significant psychological and cognitive correlates and can constitute a serious separate disease entity” (IOM, 2011, p. 3). It states that acute pain “is of sudden onset and expected to last a short time. It usually can be linked clearly to a specific event, injury, or illness” (IOM, 2011, p. 33). The CDC, IOM, and IPRCC recommend that treatment for chronic pain include interdisciplinary or multidisciplinary and biopsychosocial approaches. The Biopsychosocial Model of Pain (BMP) describes pain and disability as “a complex and dynamic interaction between physiological, psychological, and social factors that can perpetuate, and worsen, one another, resulting in chronic and complex pain syndromes” (Gatchel et al., 2014, p. 120). Biopsychosocial treatment approaches aim to managing pain instead of effecting a cure by addressing all factors at the same time. Proponents recognize that the individual experience is unique and recommend interdisciplinary services (Gatchel et al., 2007). Note that the terms *multidisciplinary* and *interdisciplinary* are used interchangeably in much of the literature. The BMP describes *multidisciplinary* as the delivery of services by several health care providers pursuing separate goals who do not take into account the contributions of other disciplines and with limited communication. *Interdisciplinary* services are provided by multiple disciplines with greater coordination of services, constant daily communication among professionals, shared common rehabilitation philosophy, and active patient involvement (Gatchel et al., 2014). The BMP recommends interdisciplinary care over multidisciplinary care.

Treating chronic pain using the biopsychosocial model can include various health care providers, such as physicians, nurse practitioners, physician assistants, psychologists, psychiatrists, behavioral specialists, occupational therapy practitioners, physical therapy practitioners, massage therapists, nurses, vocational counselors, and recreational therapists.

Occupational therapy may not be specifically recommended in many of the guidelines, but that does not diminish the distinct value of occupational therapy services in treating individuals with chronic pain. Because of their training in psychosocial interventions, occupational therapy practitioners are distinctly qualified to provide a notable amount of evidence-based, non-pharmacological interventions for treating chronic pain.

Relieving Pain in America states that self-management is “almost always the first step in a person’s journey to relieving pain” (IOM, 2011, p. 117). It notes that self-management programs should educate patients about their condition to help them become active

participants in their pain treatment. Based on the chronic care model, self-management programs like cognitive-behavioral therapy work to engage patients in active problem solving and decision making, developing good health resources, and taking action to manage their own pain (IOM, 2011). Self-management encompasses the very principles stated in the overarching statement of the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.): “Achieving health, well-being, and participation in life through engagement in occupation” (AOTA, 2014, p S4). Using a self-management approach enables occupational therapy practitioners to most effectively direct and carry out treatments that promote active client participation in pain management.

The CDC, IOM, and IPRCC also recommend relaxation training, coping strategies training, and/or stress reduction. Relaxation training focuses on identifying and then purposefully working to decrease tension in the body. Relaxation interventions may include teaching diaphragmatic breathing, progressive muscle relaxation, visualization, and stretch-based relaxation. Jon Kabat-Zinn (1994), the creator of Mindfulness Based Stress Reduction (MBSR), defined mindfulness as “paying attention in a particular way: on purpose, in the present moment and non-judgmentally” (p. 7). For most clients, completing a certification course in MBSR is not feasible, but they can be trained in many mindfulness techniques to assist in coping with their pain, such as guided meditation, walking meditation, quiet meditation, and mindfulness during activities.

Guideline Recommendations for Function-Related Goals

The FDA and the CDC discuss the importance of functional goal setting when creating a treatment plan for someone with chronic pain. The FDA recommends health care practitioners use functional assessment scales as part of the initial patient evaluation. They recommend that providers, such as physicians or nurse practitioners, establish functional goals in the initial treatment plan to be reviewed with the patient. The CDC addresses the need for creating treatment goals, including those that address the effect of pain on the individual’s, and that these goals should be created before starting opioid therapy. This will assist the prescriber in reassessing whether the benefits, including improvement in function, outweigh the risks associated with the opioid medication. The CDC (2016) provides examples of functional goals, such as “walking the dog or walking around the block, returning to part-time work, attending family sports, or recreational activities” (p. 20). The NPS doesn’t specify creating functional goals, but it does state that outcome measures used to treat pain should include physical, psychological, emotional, and social aspects of the patient’s function. Determining changes in functioning as part of a pain evaluation may foster more consistent results across various populations (IOM, 2011).

Occupational Therapy's Role in Functional Goal Setting

Most prescribing providers do not have the time or assessment tools to comprehensively assess the effects of pain on the lives of

their clients. In describing her experience, one client said, “I’m rather easily upset if I try to do more, because as I’ve said, I’ve been exhausted and burnt out, and for several years I’ve been living like a stretched piece of elastic; at the maximum of my capacity” (Werner et al., 2004, p. 1039).

Occupational therapists’ skills in determining current performance in the occupations of ADLs, IADLs, sleep, socialization, leisure and/or recreation, work, and school help them provide additional valuable information regarding client factors (including body functions, body structures, and values and/or beliefs), performance skills, performance patterns, contextual factors, and environmental factors that can help guide realistic, objective, and measurable functional goals for the individual with chronic pain (AOTA, 2014). It is equally important that we inform prescribing providers of how occupational therapy can benefit them during this process.

Guideline Recommendations for Client-Centered Treatment

The NPS states that outcomes should be client centered and include patient goals and reported measures. These outcomes should be included in the assessment and treatment plan. *Relieving Pain in America* found that “pain care must be tailored to each person’s experience,” as pain is subjective and has many factors for each individual (IOM, 2011, p. 161). The CDC encourages functional goals to be patient centered. It recommends that prescribers involve the patient when deciding whether to initiate or continue opioids, making a “mutual decision” regarding the treatment (CDC, 2016, p. 20). The CDC states that the relationship between the patient and the health care provider should be the basis for all clinical decision making for pain treatment, and the “unique needs of each patient” should be considered when providing care (CDC, 2016, p. 2).

EDUCATION RECOMMENDATIONS

Educating Health Care Providers

The FDA (2018) REMS strategy outlines the content for continuing education materials. Many health care professions and curriculums lack in-depth education for understanding pain and caring for those who have pain (IPRCC, 2016). The IPRCC has two objectives related to health care provider education. One recommends that core competencies for caring for people with pain be developed and reviewed for licensure and certification. The other suggests creating a centralized source for education materials that provide comprehensive instruction about effectively treating those who have pain. The CDC identifies primary care clinicians reporting insufficient training for prescribing opioids as one of the rationales for creating its guidelines. *Relieving Pain in America* voices concern about the discrepancy between current knowledge regarding pain and current treatment being provided, and recommends major portions of health care curriculums provide training regarding pain and its complexity.

The IOM calls for more collaboration among all health care practitioners when treating someone with pain. One of their

focus areas is for primary care clinicians to work more closely with pain specialists in many health care disciplines. Primary care clinicians are often the first access points to health care for someone in pain. Increasing the primary care clinician’s knowledge about pain and its complexity, along with improving their collaboration with pain specialists, may lead to providing the most evidence-based prevention, assessment, and treatment of pain.

Educating the Public and Patients With Pain

Relieving Pain in America calls for expanding education programs “to transform patient and public understanding of pain” (IOM, 2011, p. 10). This will help to promote actions at both a personal and community level to prevent injuries, advocate for appropriate pain treatments, and support policies that seek to improve the treatment and prevention of pain (IOM, 2011). Clients should be educated about their condition and options for treatment. Family members should also be educated, if appropriate. *Relieving Pain in America* identifies 12 “essential patient education” topics, including self-management techniques, types of health care providers that may be able to assist, and patients’ inherent right to pain care (IOM, 2011, p. 182). It recommends that patient education should consider age, health literacy, cultural factors, and the patient’s experience.

The FDA recommends that health care practitioners educate patients on 21 topics, including pain management expectations; treatment options; adherence to the treatment plan, including prescribed dosing; risks of opioids, including adverse events; common side effects; safe storage and disposal of medications; and the use of naloxone in case of an opioid overdose (FDA, 2018). The CDC guidelines report a patient lack of knowledge about opioids, and that clinicians do not always effectively communicate with patients about this topic (CDC, 2016). The CDC also lists important talking points for educating patients before initiating opioid use, with many of the points overlapping with the FDA recommendations.

Relieving Pain in America also discusses the rationale and recommendations for educating the general public, including assisting in preventing pain and increasing awareness of self-management techniques for managing pain, advocacy for better policies and treatment, and community action to prevent injuries. When the guidelines were published in 2011, the IOM was concerned that there were no large-scale public campaigns for pain education from either government or private agencies.

Revising Reimbursement Policies

Payer reimbursements may be affecting the care of patients with pain. *Relieving Pain in America* states that interdisciplinary care is often not covered, or reimbursement is limited. This is also frequently true for evidence based psychosocial and rehabilitative care for pain treatment (IOM, 2011). During primary care visits, reimbursement policies make lengthy one-on-one interviews and more treatment time difficult, even though such interviews are often required to appropriately treat pain (IOM,

2011). *Relieving Pain in America* calls for establishing “quality-of-care standards incorporating principles of biopsychosocial, interdisciplinary, multimodal pain care or evidence on the clinical effectiveness of different modalities” to assist with encouraging payers to support these practices (IOM, 2011, p. 49). The NPS states that costs of therapies can vary, but nonpharmacological treatment often costs more than generic medications. Another factor may be that medications can be taken with little disruption to daily routines, whereas nonpharmacological treatments often occur at appointments during work hours (IPRCC, 2016). The NPS recommends that the model for pain care be changed from fee-for-service to a client-centered model that provides incentives for prevention as well as collaborative care for someone who has pain (IPRCC, 2016).

The CDC does recognize that nonpharmacological therapies are not always covered by payers, which may limit a patient’s ability to pursue them. The CDC also does not recommend a solution, other than pursuing low-cost options for exercise that the patient might have access to. This solution does not address lack of access to a skilled service like occupational therapy.

Research Regarding Pain

The CDC, IOM, and IPRCC find that one of the largest barriers to appropriate, effective pain treatment is research. The CDC repeatedly states that their recommendations are based on the latest research, but that “the clinical scientific evidence informing the recommendations is low in quality” (CDC, 2016, p. 34). The NPS and *Relieving Pain in America* both dedicate full sections to research and the need for improvements, with the NPS voicing concern over insufficient data about prevalence, onset, effect, and outcomes of pain. This lack of evidence impedes decision making regarding policies and practices for pain care (IPRCC, 2016). *Relieving Pain in America* calls for research findings regarding pain and its treatment to be more quickly integrated into patient care, and recommends that new research should be pursued for better diagnosis and treatment. This would include research and collaboration in multiple areas of medical science, including physiology, cognition, and psychology. In 2017, the IPRCC published the *Federal Pain Research Strategy*, which outlines a long-term strategic plan for research regarding pain, its complexity, and how to best assess and treat it.

Focus on Prevention

The guidelines all note the importance of pain prevention. *Relieving Pain in America* states that prevention is one of the most important outcomes when considering the cost of pain to the individual and the public. The NPS states, “Preventable causes of acute and chronic pain should be identified and addressed throughout the health care delivery system” (IPRCC, 2016, p. 23).

Preventing adverse events related to opioids is another area addressed. The FDA and CDC discuss specific remedies, such

as dosing, titration, and tapering, to help clinicians reduce risk when prescribing and to help determine whether the benefits of opioids outweigh the risks for a particular patient. The NPS and *Relieving Pain in America* only discuss addiction and adverse events related to opioids as a rationale for recommendations such as health care provider training, whereas the CDC and FDA discuss opioid use disorder (OUD) more directly. The FDA recommends that health care providers check their patients who are taking opioids for signs of misuse, abuse, and OUD. These providers should understand how to begin appropriate interventions, including referrals, if an OUD is suspected. The CDC guidelines make very similar recommendations. Appropriate language that reduces stigmatizing or blaming should be used (FDA, 2018).

A patient named Elaine explained an experience that demonstrates this need for nonjudgmental care:

I asked a doctor one time, “What am I doing that’s wrong?” And he says, “You present like a drug addict.” And I’m, like, what? Because I’m in so [much] pain, I need something to help me. And because of saying that, it makes me a drug addict rather than a woman who’s in pain. (Buchman et al, 2016, p. 1399)

Occupational Therapy’s Role in Addressing the Public Health Crisis

These guidelines recommend better education to those with pain, the public, and health care professionals. Educating patients to the physiological, psychological, and sociological factors of pain perception, pain persistence, and the functional implications of chronic pain is a fundamental component of self-management and should be part of the treatment of chronic pain. Although many disciplines can provide pain education, occupational therapy practitioners are distinctly prepared to also determine an individual’s specific learning needs and modify teaching strategies in response to those needs. Occupational therapy practitioners are trained in facilitating individual education, group education, and using multimodal learning strategies that improve active engagement and enhance learning. This leads to an opportunity to advocate for occupational therapy’s distinct value in addressing opioid use.

Occupational therapy practitioners may also consider participating in public health programs that provide education about the BMP as well as the distinct role occupational therapy has in providing services within this model. In response to the recommendations, occupational therapy practitioners can contribute to solving the opioid public health crisis by advocating for greater training in treating chronic pain in current occupational therapy educational programs.

As stated earlier, most of the guidelines do not mention occupational therapy specifically. To promote greater recognition of the value of the profession in updated versions of the guidelines and similar publications, more research on the effectiveness of

occupational therapy services in treating chronic pain is needed. Simon and Collins (2017) are helping with this effort with their recent findings on the effectiveness of Lifestyle Redesign® interventions in improving occupational performance and satisfaction, as well as health-related quality of life.

CONCLUSION

Occupational therapy practitioners can provide more effective treatment to individuals with chronic pain if there is a better understanding of the recommendations. This can also help practitioners promote the distinct value of occupational therapy services to prescribing providers, payers, policy makers, and the public. Part of occupational therapy's value includes the distinct qualifications to provide treatment interventions within a biopsychosocial model, as recommended in the opioid use guidelines. This enables occupational therapy practitioners to better assist those with chronic pain in better self-managing their condition. 🌐

REFERENCES

- American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl. 1), S1–S48. <https://doi.org/10.5014/ajot.2014.682006>
- American Occupational Therapy Association. (2017). Occupational therapy's role in medication management. *American Journal of Occupational Therapy*, 71, 7112410025p1–7112410025p20. <https://doi.org/10.5014/ajot.2017.716S02>
- American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction*. Retrieved from https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=a8f64512_4
- Baker, D. W. (2017). *The joint commission's pain standards: Origins and evolution*. Oakbrook Terrace, IL: The Joint Commission.
- Buchman, D. Z., Ho, A., & Illes, J. (2016). You present like a drug addict: Patient and clinician perspectives on trust and trustworthiness in chronic pain management. *Pain Medicine*, 17, 1394–1406. <https://doi.org/10.1093/pm/pnv083>
- Centers for Disease Control and Prevention. (2016). *CDC guideline for prescribing opioids for chronic pain: Promoting patient care and safety*. Retrieved from https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf
- Corsini, E., & Zacharoff, K. L. (2011). *Definitions related to aberrant drug-related behavior: Is there correct terminology?* Retrieved from <https://www.painedu.org/definitions-aberrant-drug-related-behavior/>
- Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain—United States, 2016. *Morbidity and Mortality Weekly Report*, 65(No. RR-1), 1–49. <https://doi.org/10.15585/mmwr.r6501e1>
- Gatchel, R. J., McGeary, D. D., McGeary, C. A., & Lippe, B. (2014). Interdisciplinary chronic pain management: Past, present, and future. *American Psychologist*, 69, 119–130. <https://doi.org/10.1037/a0035514>
- Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: Scientific advances and future directions. *Psychological Bulletin*, 133, 581–624. <https://doi.org/10.1037/0033-2909.133.4.581>
- Haffajee, R. L., Jena, A. B., & Weiner, S. G. (2015). Mandatory use of prescription drug monitoring programs. *JAMA*, 313, 891–892.
- Institute of Medicine of the National Academies. (2011). *Relieving pain in America: A blueprint for transforming prevention, care, education, and research*. Washington, DC: National Academies Press.
- Interagency Pain Research Coordinating Committee. (2016). *National pain strategy: A comprehensive population health-level strategy for pain*. Retrieved from https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf
- Interagency Pain Research Coordinating Committee. (2017). *Federal pain research strategy*. Retrieved from https://iprcc.nih.gov/sites/default/files/iprcc/FPRS_Research_Recommendations_Final_508C.pdf
- Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. New York: Hyperion.
- Levy, C. (2018, June 8). The pained life: An open letter to President Trump. *Pain News Network*. Retrieved from <https://www.painnewsnetwork.org/stories/2018/6/8/an-open-letter-to-president-trump>
- Morone, N. E., & Weiner, D. K. (2013). Pain as the fifth vital sign: Exposing the vital need for pain education. *Clinical Therapeutics*, 35, 1728–1732.
- National Institutes of Health. (2011). Opioids and chronic pain. *NIH Medline Plus*, 6(1), 9.
- Seth, P., Rudd, R., Noonan, R., & Haegerich, T. (2018). Quantifying the epidemic of prescription opioid overdose deaths. *American Journal of Public Health*, 108, 500–502.
- Simon, A. U., & Collins, C. E. R. (2017). Lifestyle redesign for chronic pain management: A retrospective clinical efficacy study. *American Journal of Occupational Therapy*, 71, 7104190040p1–7104190040p7. <https://doi.org/10.5014/ajot.2017.025502>
- Tsang, A., Von Korff, M., Lee, S., Alonso, J., Karam, E., Angermeyer, M. C., ... Watanabe, M. (2008). Common chronic pain conditions in developed and developing countries: Gender and age differences and comorbidity with depression-anxiety disorders. *Journal of Pain*, 9, 883–891. <https://doi.org/10.1016/j.jpain.2008.05.005>
- U.S. Department of Health and Human Services. (2016). *National pain strategy: A comprehensive population health-level strategy for pain*. Retrieved from https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf
- U.S. Food and Drug Administration. (2018). *FDA's opioid analgesic REMS education blueprint for health care providers involved in the treatment and monitoring of patients with pain*. Retrieved from <https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm>
- Werner, A., Isaksen, L. W., & Malterud, K. (2004). "I am not the kind of woman who complains of everything": Illness stories on self and shame in women with chronic pain. *Social Science & Medicine*, 59, 1035–1045. <https://doi.org/10.1016/j.socscimed.2003.12.001>

How to Apply for Continuing Education Credit

- To get pricing information and to register to take the exam online for the article **Opioid Guidelines and Their Implications for Occupational Therapy**, go to <http://store.aota.org>, or call toll-free 800-729-2682.
- Once registered and payment received, you will receive instant email confirmation.
- Answer the questions to the final exam found on pages CE-9 & CE-10 by **August 31, 2020**.
- On successful completion of the exam (a score of 75% or more), you will immediately receive your printable certificate.

Final Exam

Article Code CEA0818

Opioid Guidelines and Their Implications for Occupational Therapy

August 2018

To receive CE credit, exam must be completed by August 31, 2020

Learning Level: Intermediate

Target Audience: Occupational Therapists and Occupational Therapy Assistants

Content Focus: Professional Issues; Occupational Therapy Interventions

1. **Because of the rising number of individuals dealing with chronic pain, advocacy for the improvement of pain treatment began in 1991. A potential unforeseen consequence of the efforts to reduce chronic pain appears to be:**
 - A. Increased use of alternative pain relief therapies, such as acupuncture.
 - B. A decrease in the number of chronic pain cases.
 - C. An increase in the number of opioid overdose deaths.
 - D. A decrease in the number of prescriptions written for opioids.
2. **Morphine and codeine are generic types of opiates.**
 - A. True
 - B. False
3. **Addiction disorder and physical dependence are two possible outcomes of opioid use. Physical dependence is correctly associated with which one of the following statements:**
 - A. It is a disease of the brain reward circuitry.
 - B. It occurs when the body adapts to a specific drug and can produce withdrawal symptoms.
 - C. It does not occur with use of synthetic opiates.
 - D. It includes various aberrant behaviors, such as sharing medication with family members.
4. **The U. S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) focus on reducing risks associated with opioid prescriptions by recommending safer prescribing practices. Which one of the following is *not* a recommendation of these two agencies?**
 - A. Use urine drug screens to monitor for potential risks of prescribing the opioid.
 - B. Opioid use should be considered after non-opioid treatments are found not effective.
 - C. Opioid use should be considered after non-pharmacological alternative treatments are found to be inadequate.
 - D. After prescribing opioids, occupational therapy practitioners should follow up with the client within 1 week for reassessment.
5. **The FDA recommends using screening tools to evaluate risk for misuse or abuse of opioids during the initial assessment. Which of the following are possible screening tool options?**
 - A. Multiple Pain Reliever Risk Tool, Screener and Opioid Assessment for Patients with Pain, and the Brief Risk Interview
 - B. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, and the Brief Lifestyle Risk Interview
 - C. Opioid Risk Tool, Physical Dependence Screener and Addiction Assessment for Patients with Pain, and the Brief Risk Interview
 - D. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, and the Brief Risk Interview
6. **Because of new recommendations for prescribing and monitoring the use of opioids for individuals with chronic pain, occupational therapy practitioners can be important team members based on which of the following?**
 - A. The need for the client to always self-administer medications, even if fine motor difficulties are present; manage clothing for urine tests; and organize transportation to frequent doctor visits
 - B. The need for the client to comply with urine testing, attend increased number of follow-up prescriber visits, and have medication management capabilities
 - C. The need for the client to negotiate with the provider for a prescription, to have intact cognition, and to conduct the required daily pill count
 - D. The need for the client to comply with urine testing, accurately report all medications being used to lab personnel, and have daily check-ins arranged through the locale senior center to ensure ongoing home safety

7. Occupational therapy services are helpful not only for the client, but also for the prescriber. Which one of the following is an important service that occupational therapy practitioners can provide to opioid prescribers?
- A. Ensure that clients are on time for all follow-up appointments
 - B. Ensure that clients bring a knowledgeable friend or family member to follow-up visits
 - C. Assess and communicate results of ADL abilities, medication management abilities, home safety, and cognitive status
 - D. Assess and ensure that patients possess intact upper body strength and coordination
8. At this time, the CDC recommends occupational therapy only as a possible non-pharmacological intervention to include:
- A. Injections of corticosteroids
 - B. Posture as a disease specific symptom
 - C. Cognitive-behavioral therapy
 - D. Exercise therapy
9. Interdisciplinary or multidisciplinary and biopsychosocial approaches to pain management are recommended through the National Pain Strategy (NPS). Biopsychosocial treatment approaches aim to manage pain instead of finding a cure. Which of the following facts is *not* true about biopsychosocial treatment approaches?
- A. They address all or multiple factors at the same time
 - B. They recognize that the individual experience is unique
 - C. They describe pain and disability as complex and dynamic interactions among physiological, psychological, and social factors
 - D. They're based on an approach promoted by occupational therapists in the *Framework*
10. Which one of the following CDC and/or NPS recommended approaches to chronic pain management is *not* an approach occupational therapy practitioners would likely use?
- A. Cognitive-behavioral therapy
 - B. Relaxation training
 - C. Mindfulness-based stress reduction
 - D. Prescription drug monitoring program
11. The FDA and CDC recommend using functional patient goals as a means of:
- A. Ensuring that the patient is cured of their chronic pain.
 - B. Ensuring that the profession of occupational therapy is part of the interdisciplinary team.
 - C. Assisting the prescriber in determining whether the benefits of opioids outweigh potential risks.
 - D. Creating a more practitioner-centered approach to care.
12. Opioid guidelines make all of the following system-wide recommendations *except*:
- A. Educate health care providers and focus on preventing pain.
 - B. Educate the public and patients with pain and research regarding pain.
 - C. Control the cost of non-opioid medication options and research on medications.
 - D. Revise reimbursement policies.

Now that you have selected your answers, you are only one step away from earning your CE credit.



[Click here to earn your CE](#)