BEYOND COGNITIVE BEHAVIORAL THERAPY:
Exploring the Use of Acceptance and Commitment Therapy in the Treatment of Chronic Pain in Older Adults
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BY SUSAN THOMPSON PHARMD, BCPP, CPE
GOODBYE 2015, HELLO 2016!

Did you make any New Year’s resolutions? Have you already abandoned them? If you have, you’re not alone. According to Forbes, 40% of us make resolutions, but only 8% see those resolutions to their goal.

The authors of our Painview articles are goal-setters and goal-meeters. I find them inspiring. For example, our certified pain educators: They manage to find time in their already busy lives and careers to study and add “CPE” to the letters already after their name. Our last Painview issue, all about the CPE credential, was highly regarded. In this issue we reconnect with 3 former CPE Profile interviewees to catch up and ask follow-up questions.

A new feature in this issue is the Pain Diary. Written by Susan Thompson, a CPE Profile in our last issue, the Diary is a day-to-day look at patient misconception, practitioner misunderstanding of pain management, and how a new CPE actually uses what she’s learned. It’s also sad and funny.

How can one not be inspired by Shaina Smith. Despite a diagnosis of fibromyalgia, myofascial pain, hypermobility, and Ehlers-Danlos syndrome, she works (as the Director of State Advocacy and Alliance Development for the U.S. Pain Foundation), volunteers, and loves to laugh. After getting to know her a little better in the Pain Perspectives column, you may hope to someday meet in person, and laugh along with her.

Amanda Rae Comstock tells us about acceptance and commitment therapy, explains how it differs from cognitive behavioral therapy, and explores how it works well for older adults in chronic pain.

Urine drug testing is a staple in assessing adherence to medications. However, as Brooke Mueller writes, there is a “gap in providers’ abilities to accurately interpret drug test results.” Her hands-on, real-life examples of test results and the questions they bring up may help avoid misinterpretation.

What’s your day-to-day pain management story? Do you have questions for our experts? Or perhaps you want to offer advice or share some information? Contact me at editor@paineducators.org. I’d love to hear from you.

—HOLLY CASTER

NEW CPEs

Verna Bain MD CPE
Esther Bernhofer PHD, RN-BC, CPE
Kevin Fantich PHARMD, CPE
Kelly Franks Henderson PHARMD, CPE
Susan Janicke DNP, CPE
Kathleen Kelly PHARMD, CPE
Jennifer Pruskowski PHARMD, BCPS, CGP, CPE
Beyond Cognitive Behavioral Therapy:
Exploring the Use of Acceptance and Commitment Therapy in the Treatment of Chronic Pain in Older Adults

By Amanda Rae Comstock PsyD

INTRODUCTION

The population group aged 65 years and older is increasing rapidly. Among this population, up to half will report to medical professionals experiencing chronic pain. Unlike the better known Cognitive Behavioral Therapy, which implements the use of control based strategies for pain management, Acceptance and Commitment Therapy (ACT) focuses treatment on acceptance and an openness to experience pain. Therefore, instead of focusing on the logic or semantics of painful thoughts and sensations, ACT explores the way in which thoughts and beliefs have a direct impact on an individual’s functioning. This study describes the application of this behavioral psychotherapy to the treatment of older adults experiencing chronic pain. Chronic pain is frequently associated with attempts to control unwanted thoughts, feelings, and sensations. As ACT is a therapeutic method that is designed to reduce avoidance behaviors, it may be a treatment that is particularly suited for older adults with chronic pain.

Chronic pain is a prevalent and common condition that can result in substantial impairment in the quality of life in older adults. It is estimated that in the United States by the year 2050, 20% of the population will be over the age of 65. Currently, among this age group, 50% to 50% report experiencing some type of chronic pain. In fact, following infectious illnesses, pain is one of the most common presenting symptoms within primary care.
centers. As our aging population continues to grow, managing chronic pain in older adults will continue to be a major challenge to healthcare providers.

COGNITIVE BEHAVIORAL THERAPY

Virtually all psychotherapy research on pain has involved the implementation of Cognitive Behavioral Therapy (CBT). CBT, in practice, focuses on the reduction of symptoms with a variety of psychological and physiological disorders. CBT was developed to impact 3 domains in treatment:

1. In the cognitive area, patients are taught cognitive restructuring techniques that aid patients to identify and challenge overly negative pain related thoughts and replace them with more adaptive coping thoughts. For individuals in pain, common thoughts such as "I can not do anything when I am in pain" would be refuted and patients would be asked to provide evidence of times this thought was false.

2. In the behavioral domain, the therapist teaches techniques such as behavioral scheduling, social skills, and assertiveness training. These skills are taught in order to change behavioral malfunctioning or maladaptive behaviors (e.g., staying at home when in pain) that may lead to or further contribute to pain symptoms.

3. CBT impacts the physiological domain by teaching distraction techniques such as imagery and relaxation that divert attention away from severe pain episodes through calming one's body. Through these techniques, the patient learns how to implement coping skills during exposure to situations that may cause pain or distress.

Through the exploration of the individual in these 3 domains, the patient is able to identify, reality-test, and correct distorted ideas and dysfunctional beliefs underlying cognitions and behaviors regarding one's pain. The patient is then able to think and act in a realistic and positive manner about his or her psychological or physical problems. Consequently, they experience a reduction in symptomology.

CBT is a therapeutic approach that has been researched and utilized as a treatment option for pain in later life. However, despite some research stating its effectiveness, CBT with the elderly remains underutilized, and evidence for its efficacy with older adults has had inconsistent results. Research has found that with older adults, therapeutic techniques based on control, such as CBT, tend to be maladaptive as older adults often feel a low sense of self-efficacy as their lifestyles change. As a result, CBT's approach to maintain control over thoughts and sensations can lead to a greater likelihood of disability or distress from attempting to control uncontrollable dimensions such as disability or pain.

ACCEPTANCE AND COMMITMENT THERAPY

ACT is effective with a wide range of clinical disorders including depression, obsessive compulsive disorder, workplace stress, anxiety, posttraumatic stress disorder, anorexia, and drug abuse.

“Unlike CBT, the goal of ACT is not to reduce symptoms or cognitive distortions; instead the focus is to increase one's willingness to experience emotions and physical sensations as they occur without trying to alter or correct them.”
As ACT gains further empirical support, it is vital to discuss the possible benefits to its use in the treatment of pain in older adults.

As a therapeutic approach, ACT is designed to dissuade experimental avoidance, defined as an unwillingness to experience negative thoughts, feelings, and physical sensations such as pain. When individuals have a high level of experimental avoidance, negative coping mechanisms such as suppression or avoidance are utilized in order to cope with psychological or physiological distress. ACT methods are used to decrease a patient’s use of these escape strategies. Through increasing one’s acceptance and willingness to experience these sensations, the individual learns how to engage in activities that were previously avoided. Unlike CBT, the goal of ACT is not to reduce symptoms or cognitive distortions; instead the focus is to increase one’s willingness to experience emotions and physical sensations as they occur without trying to alter or correct them.

**THE ROLE OF EXPERIMENTAL AVOIDANCE IN OLDER ADULTS WITH PAIN**

The literature supports the idea that avoidance and escape strategies play a critical role in the experience and maintenance of pain. Cognitively, individuals in pain often engage in thought suppression in an attempt to reduce painful thoughts or sensations, but ignoring these experiences or trying to adopt positive thinking patterns regarding pain may lead to an opposite effect. The attempt to control or avoid painful thoughts, feelings, or sensations can increase both the frequency and distress associated with them. As a consequence, the individual may experience a decline in mood or self-esteem at the inability to achieve the intended positive or altered mindset.

In order to avoid these consequences, ACT utilizes cognitive defusion, a skill which assists in fostering a mindful and accepting posture toward negative cognitive content regarding psychological or physiological pain. From the ACT perspective, it is not the content of these negative thoughts associated with pain that are problematic. Instead, it is one’s personal and emotional responses to the pain and these thoughts. Through the use of cognitive defusion, patients learn to view their thoughts as just thoughts, which are separate from one’s self and have no personal meaning. Through defusion, patients are able to shift their perspective to identify themselves as more than just a sum of their thought content or physical ailments. Therefore, ACT weakens the literal meanings of language until they no longer impact the patient’s behavior. For example, the phrase “I’m a patient with pain" may be personally associated with constant pain, complaints, loss of functioning, not feeling like a whole person, excreta. With defusion work, the patient is able to state, “I’m a patient with pain” without the additional associations previously associated with it. One example of an ACT metaphor that is used to help patients achieve cognitive defusion is the exercise *Leaves on a Stream*. This exercise instructs the patient to close his/her eyes and come in contact with the present moment by listening to his/her breath, heartbeat, and the sounds within the room. The patient is then told to imagine a leaf floating down a stream. As the patient thinks, he/she is told to place each thought on a leaf and watch it float away. Through this metaphor, the patient is taught to view his or her thoughts as they are, without additional emotion. Exercises such as *Leaves on a Stream* help remove personal meaning from thoughts, which previously would have caused an emotional or behavioral reaction.

The flexibility and detachment achieved through defusion skills can be highly beneficial for older individuals with chronic pain. Through defusion, older individuals are able to focus on behavioral changes in areas of their life that are important while being in contact with thoughts that are painful or highlight their self-doubt. Without the necessity of altering negative thoughts or sensations, especially those that are difficult to change (such as aging or pain), the individual is able to come in contact with these cognitions while still engaging in behaviors that enhance their quality of life.

Through the process of willingly engaging in thoughts, feelings, memories, or sensations whether they are positive or painful, the individual practices acceptance. Acceptance is the process of embracing experiences in order to engage more fully in life. Similar to defusion skills, acceptance does not label situations as good or bad, nor in the treatment of pain identify that pain is okay. Instead, acceptance is about being open to the idea that pain fluctuates in intensity and, instead of trying to control it, understanding that it’s more beneficial expending that energy into building the life one wants to live. In older adults, this concept is significant: there are going to be aspects of one’s life that, due to pain or aging, will be unpleasant and uncomfortable and one can still engage in the pursuing the life one wants. This allows an older adult to increase feelings of self-efficacy and the belief that one does have control over his or her behaviors and environment.

**VALUES BASED ACTION**

One of the challenges of pain at any age is that no one is willing or desires to experience pain. Thoughts such as “If I did not have pain I could live the life I want to” or “If I wasn’t too old, I could do more things” are common. ACT is explicitly directed towards teaching skills to accept these thoughts and assisting patients towards values or aspects they want in their life. Within therapy, patients are directed to examine their life and to acknowledge the ways they have participated in avoidance—perhaps by not engaging in previously pleasurable activities due to the fear of increased pain, negative thoughts, or worries. For older adults, common avoidance experiences include not attending important social events such as weddings or family reunions due to the concern or thought that they might experience pain. It is well known that older adults already experience significant life changes and loss of career, friends, health, or feelings of self-efficacy.

In order to enhance one’s quality of life and move towards one’s values, the patient along with the therapist examines whether
attempts at pain alleviation have moved an individual toward or away from valued life directions. With patients who experience chronic pain it is often found that life goals have been on hold for a long time or there is a mindset that they are too old or have too much pain to even try. In order to identify values, patients describe what they want their life to look like in various domains such as romantic relationships, family, spirituality, physical health, and interests. Exercises such as having a patient write about what he or she would like to hear said about them at their funeral or 100th birthday can be used to develop more clarity on their values. A life review, commonly used in psychotherapy for older adults, can be easily adapted to values work, exploring what areas have been consistently important throughout a lifespan.

COMMitted ACTION

Following the identification of values, a patient proceeds to engage in committed action: the process of identifying ways to live by identified values, even if it becomes painful or uncomfortable. This is completed by the identification of small behavioral changes in the areas of acknowledged values. For example, if a patient identifies family as a value, their goal may be to call one member of the family a week to talk and increase communication. Barriers to goals are explored and identified. For psychological barriers especially related to pain, additional ACT skills can be employed during this process, such as acceptance skills, mindfulness (being in the moment) exposure, or defusion skills. All goals identified within committed action can be customized with the limitations that an older individual with pain may have. Common factors such as declining socioeconomic status, loss of a loved one, or transportation concerns can be explored through effective problem solving and exploration of different solutions such as community resources and acceptance work. This process is almost identical to CBT techniques such as exposure, skills acquisition, and goal setting.

SUMMARY

ACT’s main goal is to allow for a meaningful life, while allowing acceptance of the pain that comes with living. The aim of this therapeutic approach in pain work is to transform the patient’s relationship with negative thoughts and sensations so that the patient will no longer perceive these thoughts as being

“Through the process of willingly engaging in thoughts, feelings, memories, or sensations whether they are positive or painful, the individual practices acceptance... embracing experiences in order to engage more fully in life.”
debilitating or a disability. Through the process of acceptance, values work, and committed action the individual can alter their experience of pain. ACT may be a particularly beneficial therapeutic approach in the treatment of chronic pain with older adults because of its strong emphasis on individual values, which can be applied and implemented in any life stage. In addition, its focus on defusion allows individuals to avoid becoming debilitated by negative thoughts or painful sensations through engaging in the life they want to live. Through implementing ACT methods in the treatment of chronic pain in older adults, rather than overtaxing their mental resources on attempting to control their pain sensation and psychological distress related to pain, there is a strong possibility that patients will experience an increase their quality of life through spending more time focusing on their individual values.

Resources
During the 4-week double-blind period, in patients with

* Adverse reactions occurring in ≥ 1 % of patients receiving RELISTOR

Adverse reactions in adult patients with opioid-induced constipation

regimen of 12 mg once daily.

administered less frequently than the recommended dosage

constipation and chronic non-cancer pain receiving opioid analgesia.

Non-Cancer Pain

Opioid-Induced Constipation in Adult Patients with Chronic

be directly compared to rates in the clinical trials of another drug and

adverse reaction rates observed in the clinical trials of a drug cannot

profile when using RELISTOR in such patients. Monitor for adequacy of

and/or reduced analgesia. Take into account the overall risk-benefit

in patients treated with RELISTOR. Patients having disruptions to the

Opioid Withdrawal

Severe or Persistent Diarrhea

for the development of severe, persistent, or worsening abdominal pain;

with these conditions or other conditions which might result in impaired

Cases of gastrointestinal perforation have been reported in adult

obstruction, due to the potential for gastrointestinal perforation.

Non-Cancer Pain

Information for complete product information.

12 mg once daily and at an incidence greater than placebo.

Hot Flush 3% 2%

Diarrhea 6% 2%

Flatulence 13% 6%

Diaphoresis, flushing, malaise, pain. Cases of opioid withdrawal

General Disorders and Administrative Site Disorders

Gastrointestinal

The rates of discontinuation due to adverse events during the

without adequate relief of opioid-induced constipation, or cases of

Opioid-induced constipation was also evaluated in a 48-week,

placebo-controlled trials in adult patients with opioid-induced

to establish a relationship between these events and RELISTOR.

investigators reported 4 myocardial infarctions (1 fatal), 1 stroke

12 mg once daily

Placebo

bromide for 13 weeks, adverse clinical signs such as convulsions,

Safety and effectiveness of RELISTOR have not been established

in nursing infants.

It is not known whether RELISTOR is present in human milk.

benefit justifies the potential risk to the fetus.

rabbits at doses up to 20 times and 26 times, respectively, the

In healthy subjects, a subcutaneous dose of 0.30 mg/kg

(dependent upon renal function). The use of RELISTOR in patients

renal impairment. Dose reduction by one-half is recommended in

patients with severe renal impairment (creatinine clearance less

or effectiveness were observed between these patients and younger

65-74 years (79 methylnaltrexone bromide, 39 placebo) and a total

In the double-blind studies, a total of 118 (14%) patients aged

Geriatric Use

Older adults (≥ 65 years), especially those with severe renal impairment,

but greater sensitivity of some older individuals cannot be ruled out.

patients, and other reported clinical experience has not identified

SAFETY

You are encouraged to report negative side effects of

inadequate relief of opioid-induced constipation, or cases of

Opioid-Induced Constipation was also evaluated in a 48-week,

no placebo-controlled trials in adult patients with opioid-induced

placebo controlled trials in adult patients with opioid-induced

adverse reaction, may occur while taking RELISTOR, including sweating,

Opioid Withdrawal

Advise patients with advanced illness receiving RELISTOR for

Advise all patients to:

Advise patients to discontinue RELISTOR and to promptly seek

• Be within close proximity to toilet facilities once RELISTOR

• Inject one dose every other day, as needed, but no more

recommendations described in the RELISTOR Instructions for Use.

or thigh. Do not inject at the same spot each time (rotate

frequently than one dose in a 24-hour period.

The safety and effectiveness of RELISTOR in patients with

tremors and labored breathing were observed, and the juvenile

undeveloped blood brain barrier.

bromide for 13 weeks, adverse clinical signs such as convulsions,

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Are You Missing Something?

Urine Drug Testing in Pain Management

By Brooke Mueller PharmD

INTRODUCTION

CLINICAL DRUG TESTING CAN BE a very useful tool in assessing a patient’s adherence to their medication regimen by confirming the presence of prescribed medications and/or detecting the presence of unauthorized substances. However, studies suggest a knowledge gap in providers’ abilities to accurately interpret drug test results, and the consequences of misinterpretation are potentially serious. Misinterpretation may lead the clinician to a false sense of assurance that there is appropriate use of the prescribed medication, particularly opioid analgesics, and that substance misuse does not exist. It can also have negative consequences for the claimant, secondary to false accusations of misuse, including:

- Loss of access to opioid analgesic therapy
- Damage to the provider-patient relationship
- Painful and possibly dangerous opioid analgesic withdrawal
- Difficulty receiving appropriate therapy from future providers

Therefore, full knowledge of the capabilities and limitations of drug testing and monitoring is necessary to utilize this vital
tool to its full potential. The following cases demonstrate potential nuances in the interpretation of urine drug test results that could affect the plan for the patient.

**CASE 1: DAVE**

**DAVE IS A 57-YEAR-OLD MAN** with chronic low back pain, including a neuropathic component. He was prescribed OxyContin® 60 mg CR and duloxetine 30 mg to treat his pain. As part of his provider’s policy to randomly urine drug test any patient on chronic opioid therapy, Dave was asked to provide a urine sample during his last office visit. The sample was sent to the lab for confirmatory testing (Table 1).

**Table 1: Dave**

| Test Date: | April 13, 2015 |
| Prescribed Medications: | OxyContin 60 mg CR, Duloxetine 30 mg |

**Results**

<table>
<thead>
<tr>
<th>Test</th>
<th>Test Method</th>
<th>Test Outcome</th>
<th>Measured Results (ng/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>80,115</td>
</tr>
<tr>
<td>Noroxycodone</td>
<td>LC-MS/MS</td>
<td>NEGATIVE</td>
<td></td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>LC-MS/MS</td>
<td>NEGATIVE</td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>LC-MS/MS</td>
<td>NEGATIVE</td>
<td></td>
</tr>
</tbody>
</table>

*LC-MS/MS = liquid chromatography tandem mass spectrometry*

**Which of the results, if any, are inconsistent with Dave’s medication therapy?**

At first glance, the only concern might be the absence of duloxetine. Depending on the laboratory, the oxycodone result might not be flagged as inconsistent due to the presence of the parent medication. However, the absence of the metabolites, noroxycodone and oxymorphone, might warrant further investigation. Possible reasons for detecting a parent drug in the absence of its metabolites might be due to the patient’s individual metabolism or their taking the medications just prior to urine collection.

Because of the unusual results, the lab’s toxicologist was consulted for more insight. The toxicologist agreed that the results were not typical and suggested the specimen validity tests (SVT) be reviewed. Unfortunately, SVT had not been included with the original order; however, the toxicologist was able to add an order for this panel on the sample that had not yet been discarded.

The SVT measures certain urinary characteristics, such as creatinine, pH, and specific gravity, as well as detecting the presence of oxidants in the urine.1 This is one of the most effective ways to detect adulteration or dilution, a well-known problem with urine drug testing, where a urine specimen is tampered with to intentionally alter the testing results. The revised report, including the SVT, was generated (Table 2).

**Table 2: Dave**

**Specimen Validity Results**

<table>
<thead>
<tr>
<th>Test</th>
<th>Measured Result</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine (mg/dL)</td>
<td>0</td>
<td>&gt;20 mg/dL</td>
</tr>
<tr>
<td>Oxidant (mcg/mL)</td>
<td>10</td>
<td>&lt;200 mcg/mL</td>
</tr>
<tr>
<td>pH</td>
<td>6.1</td>
<td>4.5–9.5</td>
</tr>
<tr>
<td>Specific gravity</td>
<td>1.000</td>
<td>1.003–1.050</td>
</tr>
</tbody>
</table>

These SVT results show a specific gravity equivalent to water, as well as abnormal creatinine. With this information, in addition to the confirmed lack of duloxetine, “pill scraping” should be considered. Pill scraping is where patients scrape a portion of their pill(s) into the urine sample in an effort to appear compliant with their current treatment regimen. This will lead to a type of false-positive on the point-of-service test; however, quantitative testing can identify the specific opioid analgesics and confirm metabolites, which will indicate if the medications were actually ingested or just scraped or shaved into the sample.2

Specimen substitution and pill shaving were discussed with Dave. Because an opioid treatment agreement was not in place between the provider and the patient, Dave was given a second chance. The results from the random urine drug test performed the following quarter are in Table 3.
**Table 3: Dave**

Test Date: August 24, 2015  
Prescribed Medications: OxyContin 60 mg CR, Duloxetine 30 mg

<table>
<thead>
<tr>
<th>Test</th>
<th>Test Method</th>
<th>Test Outcome</th>
<th>Measured Results (ng/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>22,198</td>
</tr>
<tr>
<td>Noroxycodone</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>219</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>LC-MS/MS</td>
<td>NEGATIVE</td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>LC-MS/MS</td>
<td>NEGATIVE</td>
<td></td>
</tr>
</tbody>
</table>

Specimen Validity Results

<table>
<thead>
<tr>
<th>Test</th>
<th>Measured Result</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine (mg/dL)</td>
<td>4</td>
<td>&gt;20 mg/dL</td>
</tr>
<tr>
<td>Oxidant (mcg/mL)</td>
<td>0</td>
<td>&lt;200 mcg/mL</td>
</tr>
<tr>
<td>pH</td>
<td>3.7</td>
<td>4.5–9.5</td>
</tr>
<tr>
<td>Specific gravity</td>
<td>1.002</td>
<td>1.003–1.050</td>
</tr>
</tbody>
</table>

Are there any concerns with Dave’s most recent urine drug test results?

While duloxetine is still missing from the urine, one of oxycodone’s metabolites is now present. In addition, while the specimen validity results do not indicate the sample was water, it does appear the sample has been tampered with.

A call to the laboratory toxicologist for more information about the SVT results revealed the ratio between noroxycodone and oxycodone was not consistent with what is typically seen. The ratio indicated Dave provided a small urine sample, which allowed for detection of the metabolite. In addition, the creatinine, pH, and specific gravity suggested the sample was diluted with an acidic diluent and, again, a portion of the oxycodone tablet was scraped into the specimen in an attempt to produce a consistent test result. This attempt at deception indicated the patient was trying to hide the presence of a nonprescribed and/or illicit substance or trying to cover up nonadherence with the prescribed medication.

**CASE 2: JENNIFER**

JENNIFER IS A 43-YEAR-OLD WOMAN who experienced a work-related crush injury in February 2007. As part of her treatment, Jennifer was prescribed hydromorphone 8 mg and methadone 10 mg for pain. Following the pain practitioner’s policy to urine drug test everyone on chronic opioid therapy, Jennifer was asked to submit a urine sample. The results are displayed in Table 4.

```
The manufacturing of opioid analgesics may produce process impurities. These impurities may contribute to unexpected or false-positive results . . .
```

**Table 4: Jennifer**

Test Date: September 10, 2015  
Prescribed Medications: Hydromorphone 8 mg, Methadone 10 mg

<table>
<thead>
<tr>
<th>Test</th>
<th>Test Method</th>
<th>Test Outcome</th>
<th>Measured Results (ng/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydromorphone</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>1,374</td>
</tr>
<tr>
<td>Methadone</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>5,013</td>
</tr>
<tr>
<td>EDPD</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>3,934</td>
</tr>
<tr>
<td>THC</td>
<td>LC-MS/MS</td>
<td>POSITIVE</td>
<td>13</td>
</tr>
</tbody>
</table>

Specimen Validity Results

<table>
<thead>
<tr>
<th>Test</th>
<th>Measured Result</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine (mg/dL)</td>
<td>167</td>
<td>&gt;20 mg/dL</td>
</tr>
<tr>
<td>Oxidant (mcg/mL)</td>
<td>21</td>
<td>&lt;200 mcg/mL</td>
</tr>
<tr>
<td>pH</td>
<td>5.7</td>
<td>4.5–9.5</td>
</tr>
<tr>
<td>Specific gravity</td>
<td>1.019</td>
<td>1.003–1.050</td>
</tr>
</tbody>
</table>

EDDP = a methadone metabolite

When questioned on the positive THC result, the patient claims it was secondary to incidental exposure from a going away party she attended the week before urine collection.

Is this explanation a possibility?

A study conducted by Cone et al examined the effect of marijuana
smoke exposure on drugfree participants. The urine of nonsmoking participants was analyzed by GC-MS (gas chromatography mass spectrometry). Maximum concentrations by GC-MS for nonsmokers ranged from 1.3 to 57.5 ng/mL, but room ventilation substantially reduced exposure levels. These results demonstrate that extreme cannabis smoke exposure can produce positive urine tests at commonly utilized cutoff concentrations. However, positive tests are likely to be rare, limited to the hours immediately postexposure, and occur only under environmental circumstances where exposure is obvious, such as hot-boxing. Hot-boxing is the act of smoking marijuana, or another drug, in an enclosed area to which no outside air can enter. This practice maximizes the effect of the marijuana through both first and second hand smoke. When a patient claims incidental exposure as the cause of a positive THC result, the deliberate act of hot-boxing should be considered.

**CASE 3: RICK**

RICK IS A 61-YEAR-OLD MAN with chronic shoulder pain. As part of his treatment, he was prescribed oxycodone IR 10 mg and oxycodone ER 80 mg for pain. Following the random drug testing policy of the pain practice, Rick provided a urine sample during his most recent office visit. The results of the in-office immunoassay (IA) test are in Table 5.

**Table 5: Rick**

**Test Date:** October 5, 2015

**Prescribed Medications:** Oxycodone IR 10 mg, Oxycodone ER 80 mg

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test</strong></td>
</tr>
<tr>
<td>Opiates</td>
</tr>
<tr>
<td>Oxycodone</td>
</tr>
<tr>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Amphetamines</td>
</tr>
<tr>
<td>THC</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
</tbody>
</table>

Do these results warrant further investigation?

Immunoassay test results have been reported to return up to 50% false results, depending on the drug class. Immunoassay screens in general are quite susceptible to crossreact with other drugs and produce false-positive results. In addition, results falling below cut-off levels will produce false-negative results. Most IA screens for opiates are primarily targeted to detecting morphine, hydrocodone, codeine, 6-acetylmorphine (metabolite of heroin), and hydromorphone. Because they are typically not sensitive enough to detect oxycodone, the oxycodone assay is utilized to detect oxycodone and oxymorphone.

Due to these issues, there is debate regarding when to send screening test results for confirmation. Some experts state that each and every result should be sent for confirmation, while others argue that only disputed results should be submitted. In Rick’s case, it was office policy to submit any positive results for confirmation. The laboratory confirmatory results are in Table 6.

**Table 6: Rick**

**Test Date:** October 5, 2015

**Prescribed Medications:** Oxycodone IR 10 mg, Oxycodone ER 80 mg

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test</strong></td>
</tr>
<tr>
<td>Hydrocodone</td>
</tr>
<tr>
<td>Oxycodone</td>
</tr>
<tr>
<td>Noroxycodone</td>
</tr>
<tr>
<td>Oxymorphone</td>
</tr>
</tbody>
</table>

**Specimen Validity Results**

<table>
<thead>
<tr>
<th>Test Validity</th>
<th>Measured Result</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine (mg/dL)</td>
<td>157.5</td>
<td>&gt;20 mg/dL</td>
</tr>
<tr>
<td>Oxidant (mcg/mL)</td>
<td>36</td>
<td>&lt;200 mcg/mL</td>
</tr>
<tr>
<td>pH</td>
<td>5.5</td>
<td>4.5–9.5</td>
</tr>
<tr>
<td>Specific gravity</td>
<td>1.020</td>
<td>1.003–1.050</td>
</tr>
</tbody>
</table>

**Is the hydrocodone result inconsistent with Rick’s current pain medication regimen?**

While Rick was not prescribed a hydrocodone product, hydrocodone is a known impurity of oxycodone products. The manufacturing of opioid analgesics may produce process impurities. These impurities may contribute to unexpected or false-positive results, even utilizing liquid or gas chromatography coupled with mass spectrometry. Allowable limits have been established for these impurities by the industry. In order to appropriately evaluate a drug test, the reader must be aware of positive results caused by medication impurities.

After further evaluation, it was determined the ratio of hydrocodone to oxycodone in the urine sample falls within the expected range for this impurity ratio; however, illicit hydrocodone use should not be completely ruled out.
SUMMARY

Urine drug monitoring can be a very useful tool to assess patient compliance by confirming the presence of prescribed medications and detecting the presence of unauthorized substances. However, to fully take advantage of the value, providers should ensure results are accurately interpreted. As these cases show, it is important to examine the full clinical picture and consider all possible reasons for each result, expected or unexpected. When in doubt, the laboratory’s toxicologist and/or a clinical pharmacist should be consulted to clarify the results.

Brooke Mueller, PharmD, is a Clinical Pharmacist Supervisor at Helios in Tampa, Florida.

References:
I LOVE TO LAUGH, AND one of my favorite things to do is to make my fellow pain warriors giggle—because there so many reasons for us not to laugh. So fair warning: If you meet me at an advocacy event, a healthcare conference, or a lobbying day, no matter how serious the subject, I will not hesitate to make you double over with laughter.

And if you're a pain patient or pain management practitioner, odds are good you will meet me at some point, because I am passionate about advocating for the needs and rights of patients with pain—and that advocacy work takes me to countless events around the country, both in person and online.

THE ORIGINS OF ADVOCACY

Before I became Director of State Advocacy and Alliance Development for the U.S. Pain Foundation, I was active in local government; I'm currently serving my second term on the Board of Selectman in my town of Thompson, Connecticut. I believe everyone deserves to have their voice heard, a belief that also served me well when I was news director of a local radio station.

While I’ve always believed in giving voice to my community’s issues, my personal pain journey has hugely amplified my passion for service and advocacy. In 2010, shortly after the birth of my son, Landon, I developed relentless joint pain. I figured it was an aftereffect of a difficult childbirth, but as months passed, the pain only increased.

On the urging of my mother-in-law, Ellen Smith (Co-Director of Medical Marijuana Advocacy for U.S. Pain Foundation), I started pursuing answers. Ellen also urged me to consider volunteering...
Pain advocacy is a slightly selfish pursuit for me, because on any given day, it distracts me from my own health issues. It also provides me with a sense of balance...

with U.S. Pain Foundation. She reasoned it was a way for me to help others while also gaining the support I craved for myself—and wow, was she right.

Visits to multiple healthcare providers yielded some diagnoses: fibromyalgia, myofascial pain syndrome, hypermobility. They also resulted in the prescription of a medication cocktail that caused so many secondary symptoms (including tachycardia, which was scary, and bouts of itchy hives all over my body) that it was almost impossible to care for my son.

A year after developing my first pain, I still was nowhere near relief, and I felt devastated. I couldn’t hold my child for very long. I had trouble chasing him around the yard, and even wrangling a diaper bag. I was in my mid-20s, and no one in my circle of friends had chronic pain. I felt like no one understood the struggle I was facing, along with my husband, Tim, to raise a child while coping with a barrage of crippling symptoms. This pain was no joke.

THE PERSONAL IS POLITICAL

I had to do something—I couldn’t accept leading such a limited life. Under the care of my primary care physician, I pursued a more holistic pain management approach and eventually weaned off medication. Tim was right there by my side, joining me for juice fasts and joking about unusual dietary changes and other lifestyle modifications that turned out to be oh-so-helpful. As I began to feel relief, I also increased my advocacy work.

Pain advocacy is a slightly selfish pursuit for me, because on any given day, it distracts me from my own health issues. It also provides me with a sense of balance—a big-picture view of my experience and my place in the world. Advocacy work helps me process what it means to be a patient, and it has helped me define my new normal.

Eventually, I joined the staff of U.S. Pain Foundation, heading up the state ambassador program, which identifies and trains pain patients how to lobby for fair legislation and patients’ rights. It’s hard work; many of our ambassadors have never been politically active and don’t understand the need for their personal involvement until they speak to a legislator face-to-face and watch how their story creates meaningful dialogue and change. We put enormous effort into training our volunteer state ambassadors so they can advocate with confidence.

One of my proudest moments so far was when step therapy legislation passed in Connecticut in 2011, removing one obstacle for pain patients who seek relief. (Step therapy is an insurance practice that requires the least-expensive drug in a medication class to be prescribed first, no matter what the prescribing doctor knows will work for a patient—resulting in the limitation of patients’ options, delay of treatment, and potential worsening of the condition.) By showing our faces at the state capitol and committee meetings—by sharing our personal stories—we helped make politics more personal.

SERVICE AS A DAILY PURSUIT

The life of a pain patient is so hard. We face societal discrimination, stigma around pain medications, enormous costs for care, a crazy array of ever-changing symptoms, isolation. Every day is a true struggle. We may know our healthcare providers are trying their best; we may feel compassion and love from our friends and family. But it’s not enough. Pain persists. We lack relief.

There is so much work to be done to help pain patients feel more supported, understood, connected and cared for—and I don’t believe that goal is out of our reach.

I don’t think I’ll ever stop doing advocacy work. I still live with chronic pain every day; I was recently diagnosed with Ehlers-Danlos Syndrome, hypermobility type, and I continue to develop ways of coping. Service keeps me feeling grounded and connected with my community.

Daily acts of advocacy are invaluable for me to continue my pain journey with some sense of meaning. At the end of each day, I know I’ve helped others and participated in a movement that’s far bigger than myself, and that’s inspiring. Each little victory brings me enormous joy.

So if we meet at conference or educational summit, get ready: I’m passionate, and I’m going to talk your ear off. And we’re going to share a few laughs. We’ll connect, and find a way to work together—because I know that if you’re reading this, you care.

About This Column
Curated by Jenni Prokopy of ChronicBabe.com, this year-long series offers first-person patient perspectives on a variety of pain-related topics.
Jennifer Gansen
Jennifer Gansen, PT, DPT, CPE, is currently the Supervisory Physical Therapist at the Veterans Program, Atlanta VA Outpatient Clinic in Decatur, Georgia.

THE PROFILE

PV: What motivated you to become a healthcare professional?
JG: Most of my childhood was devoted to trying to beat my brothers at any sport. At some point, I realized sheer determination isn’t enough to sustain ambition for a career as an athlete. I wondered, what distinguishes elite athletes, musicians, dancers, and martial artists from the rest of us? And what factors interfere with realizing our full potential? Physical therapy (PT) was a natural fit for this inquiry, with a focus on optimizing movement and human performance.

PV: Why did you choose to focus on pain management?
JG: Pain is the most common factor that interferes with function and human performance. Early in my career, I provided PT as part of a multidisciplinary hospital based intensive pain management program. I loved the holistic perspective of the program and the opportunity to learn from other disciplines. The experience also highlighted the limitations of a biomedical approach to pain treatment. This frustration, combined with my interest in tai chi, led to exploration of integrative medicine and neuroplasticity, especially somatic education (the Feldenkrais Method®). I joined a research team at the VA in Cleveland, Ohio, that included MDs, PTs, and engineers. We developed innovative multimodal interventions to improve walking and arm function after stroke through neuroplasticity. Then I left clinical work entirely and spent 3 years in a somatic education training program.

During this time, I experienced a health crisis that challenged everything I thought I knew about myself. All of a sudden, I went from spreading my wings and soaring through life to being curled up on the ground in a panic. I spent a year caught up in a whirlwind of anxiety, fear, and resentment. I catastrophized. I focused on what I could not do. And the frustrating part was that I knew conceptually what was happening, that I just had to work through it, but I felt powerless to do so. There was no “snapping out of it.” No one could do it for me and I resented anyone who tried to help. It required an arduous process of figuring out my new “normal” by establishing new limits and routines and slowly adding challenges. Moshe Feldenkrais understood this process and the importance of resiliency in health. He said, “Health is measured not by the capacity to stay standing, but by the ability to be knocked down and then return to standing.”

Six years ago, I returned to clinic work in VA primary care, where my health crisis paled in comparison to the challenges faced by many veterans. Prevalence of persistent pain in veteran populations is estimated around 50% in males and 75% in females. For veterans, being knocked down by pain and trauma is often complicated by comorbidities like PTSD, TBI, and substance abuse. The return to standing process requires that same arduous establishing of new limits and routines and slowly adding challenges. It requires an understanding and respect for the complexity of our nervous system protecting through pain. And it requires reconceptualization of “normal” for individuals dedicated to a culture of elite performance and physical and mental toughness in service to our country.

I specialize in pain because I believe in the power and possibility of resiliency. I work for the VA because no one has taught me more about honor, integrity, and resiliency than our nation’s veterans. I feel privileged to learn from an elite group about rising to meet life’s challenges.

PV: Why did you decide to pursue the Certified Pain Educator credential? How has it helped you in your professional life?
JG: When I started in VA primary care, the Veterans Health Administration pain directive and programs like pain school were being rolled out to the field. My work emphasizes treating “issues with the tissues” while recognizing the important role of the nervous system in pain through multimodal interventions and optimizing conditions for neuroplasticity. This drew some interest from national VA pain leadership, and I was invited to attend the PAINWeek National Conference in 2012.

Being exposed to a multidisciplinary perspective at a conference for frontline practitioners was a steep learning curve. Much of the information presented was new to me. The breadth and depth of information included sleep, diet, immune and endocrine systems, medications, and mental health issues. The CPE credential helped me focus on how the information could be applied to
my work in VA primary care. It provided a framework for organizing and connecting the information. The emphasis on effective learning and education strategies opened my eyes to the importance of going beyond what information I needed to know to include how it should be integrated.

Achieving the CPE credential opened up a network of multidisciplinary professionals and resources. I’ve integrated this experience into my individual treatment plans, group interventions, case review committees, and national initiatives. I’ve also realized that physical therapy is underrepresented in the pain community and needs to contribute to the conversation. Butler and Moseley’s textbook Explain Pain and related research into the important role of the nervous system in all pain dominates PT conferences and publications. A quiet revolution is brewing in PT, with an approach to pain beyond treating issues with the tissues. A great example involves the treatment of chronic regional pain syndrome (CRPS). Systematic reviews by Daly and Bowering support the effectiveness of graded motor imagery (GMI), a 3-stage treatment including mirror therapy that aims to gradually engage cortical motor networks without triggering the protective response of pain. Current research is directed at applying these concepts to a wide range of other debilitating pain conditions. The CPE provides an avenue for integrating information like this into a multidisciplinary forum.

PV: Why would you recommend the CPE credential to others?

JG: Just to be clear, my opinions about the CPE are solely my own. In achieving this credential, I have identified myself as someone who is part of a community. That has opened doors to collaborations and conversations and resources that I never could have imagined, both within the VA and beyond. With 50% of veterans receiving care outside the VA system, fostering this type of exchange is critical to VAs mission to serve those who have served. The CPE fills a unique and vital niche: bringing frontline practitioners from various backgrounds together to improve treatment of persistent pain.

References

FOLLOW-UP QUESTIONS

PV: In your CPE Profile, you mentioned that the credential “provided a framework of organizing and connecting the information.” Can you tell us more about that?

JG: Pain is really complex. Effective evaluation and treatment by frontline practitioners requires a commitment to in-depth learning within one’s discipline that connects to a biopsychosocial/spiritual framework. In achieving the CPE, I reached beyond my professional training to figure out how my approach to chronic pain relates to the big picture. In doing so, I’ve gained an even deeper understanding of my role as a physical therapist.

PV: What do you do differently now than you did before?

JG: I actively seek out perspectives and knowledge from multidisciplinary sources.

PV: Is it a direct result of your CPE training?

JG: Participation in PAINWeek opened my eyes to the need to reach beyond my professional training; the CPE provided an avenue to do so.

“ Participation in PAINWeek opened my eyes to the need to reach beyond my professional training; the CPE provided an avenue to do so.

PV: In a perfect world, how would you see yourself fully utilizing your CPE?

JG: I’ve recently transitioned to the Empower Veterans Program, an initiative of the Atlanta VA, directed by Dr. Michael Saenger. This innovative, multidisciplinary biopsychospiritual approach to complex chronic pain allows me to fully realize my vision of a CPE, as a member of a patient centered team with a shared goal of safe and efficacious care.

PV: Is there anything else you’d like to say about the CPE, pro or con?

JG: While the content defining the CPE must reflect evolving knowledge and paradigms, especially regarding the important role of the nervous system, the intention and design of the CPE fills an important void—bringing frontline practitioners together to promote optimal care for individuals with chronic pain.

Sarah A. Palyo

Sarah A. Palyo, PhD, CPE, is currently the Clinical Director of the Intensive Pain Rehabilitation Program and Clinical Director of the Integrated Pain Team, Mental Health Service (116B), at the San Francisco VA Medical Center in California.

THE PROFILE

PV: What motivated you to become a healthcare professional?

SP: I have always had an interest in human behavior and understanding why we do what we do. Psychology seemed like a perfect fit for me, and as I was completing my graduate training, I realized that direct clinical work was exciting, challenging, and highly personally rewarding. My clients allow me into their lives, at some of their most difficult times, and I have the privilege of assisting them through their struggles and seeing them succeed.

PV: Why did you choose to focus on pain management?
SP: Early on in my career I was working mostly in the area of posttraumatic stress disorder (PTSD), and I realized that chronic pain was quite prevalent in this population. I became interested in the intersection of the 2 conditions and did some research in that area. It wasn’t until later that I began working with clients who have chronic pain, and I began to recognize the enormous challenges many of them face and the great potential for them to have a good quality of life through self-management and lifestyle changes. When the opportunity to take a job building an interdisciplinary pain management program for the San Francisco VA Healthcare System came up, I took the leap into full time work in pain management. I have never regretted that decision; pain management is a challenging and dynamic field that encourages the interdisciplinary team approach to healthcare that I so enjoy.

PV: Why did you decide to pursue the Certified Pain Educator credential? How has it helped you in your professional life?

SP: A good colleague and pharmacist told me about the CPE credential and at first I was a little intimidated by the idea of pursuing it. My training and experience is in pain psychology; could I obtain the breadth of knowledge needed to obtain the CPE? Yet, I also wanted to challenge myself to become a better pain educator. Well, like everything else that I’ve achieved in pain management, I approached this challenge as a team with my pharmacist and physical therapist colleagues. We studied together, attended PAINWeek together, and pushed each other to practice in pain management at the top of our scopes. Through this process I gained a great deal of knowledge about the management of pain and how to educate others about it. It has not only improved my confidence in my practice but also in my efforts to educate patients and colleagues about pain.

PV: Why would you recommend the CPE credential to others?

SP: The process you go through to obtain the CPE emphasizes educational/instructional techniques as well as basic pain knowledge. Even if you are an expert in one area of pain management, this credential ensures you are skilled in the ability to teach others about pain and how to best manage it. I believe that kind of emphasis in your practice can improve patient care, help you collaborate with interdisciplinary colleagues, reduce burn-out, and improve job satisfaction.

PV: Finally, from your past experiences as a PAINWeek participant, what would you say to your colleagues about the value of attending PAINWeek?

SP: Whenever someone asks me about what good training/educational opportunities there are for pain management, the first thing I tell them is to attend PAINWeek. PAINWeek offers the frontline clinician education about the basics of pain management, updates on the newest research in pain, practical approaches to improving your practice, ideas about how to improve how you approach pain education, and a chance to learn from experts representing a variety of disciplines.

FOLLOW-UP QUESTIONS

PV: Can you tell us more about how you manage pain, on an average day with a patient?

SP: The first thing I do with a patient is educate them about chronic pain and the importance of self-management in the treatment of their pain. I then work with patients on their thoughts and behaviors in order to approach and engage in activities that are meaningful to them. We explore the “unhealthy” thoughts that support avoidance of activity and challenge these thoughts so that they no longer have so much power over people’s actions. We work on approaching activities differently, through skills like pacing and scheduling, so engagement in those activities is a more positive experience and not so punishing. I encourage social activities and explore ways that people can re-engage in their communities. I teach relaxation and mindfulness techniques that support a healthy nervous system. None of these skills can take away all the pain, but through the consistent use of them, people can have a different experience of pain, change their relationship with their pain, and have a better quality of life.

PV: You mentioned in your profile that, through the process of studying with your colleagues, you “gained a great deal of knowledge about the management of pain and how to educate others about it.” Can you tell us more?

SP: I take every opportunity to speak formally to providers, patients, and families through groups, classes, and seminars. One example of this is the San Francisco VA’s SCAN-ECHO (Specialty Care Access Network—Extension for Community Healthcare Outcomes) Pain Program, which is a monthly video teleconference lead by a team of multidisciplinary pain management experts who interact with a frontline clinician.* Each month, we provide a didactic presentation and then offer consultation on a question that was submitted by someone from our community of learners. Serving on this panel allows for far-reaching education, oftentimes to clinicians who are working in rural settings or in settings without access to pain management specialists. Also, I must highlight that sometimes informal consultation is the best and most practical form of education. I try to be accessible to my colleagues for consultation, and every chance I get, I take the opportunity to provide education about chronic pain.

PV: In a perfect world, how would you see yourself fully utilizing your CPE?

SP: In a perfect world, there would always be enough time to provide more education to patients, family members, and colleagues. I feel so lucky that I
already have the freedom to engage in many of these activities, and, over time, I have seen more of my colleagues develop their roles as educators. Education is treatment, and I can envision a world in which our healthcare system starts with education, before anything else, in the treatment of chronic pain.

PV: Is there anything else you’d like to say about the CPE, pro or con?

SP: The CPE credential allows providers to make a concerted effort to refocus their practice on education about pain. It is not only beneficial for the individual clinician, but it represents a culture change in health care when comes to the treatment of pain. I hope in the future, the CPE continues to gain acknowledgment and attention from healthcare systems that are trying to improve their approach to pain management.

*Editor’s note: for more information about SCAN-ECHO, see Painview Vol. 10/No. 2.

Kate Schopmeyer

Kate Schopmeyer, PT, DPT, CSCS, CPE, is Physical Therapy Program Coordinator, Pain Management, at SFVAHCS and Pain Committee Co-Chair, San Francisco VA Medical Center in California.

THE PROFILE

PV: What motivated you to become a healthcare professional?

KS: My mother was a nurse, and she encouraged me to pursue a career in the healthcare field. With this in mind, I joined the athletic training team in college, and the faculty there taught me to assess and treat acute pain conditions, while also encouraging me to pursue a career in physical therapy. My graduate education solidified my interests in health care, and the more I learned about the complexity and capacity of the human body, the more my motivation to be a lifelong learner grew.

PV: Why did you choose to focus on pain management?

KS: There is a tremendous need to advance the knowledge and understanding of pain, especially as we discover the limitations of traditional approaches to treating chronic pain conditions. I have always been one to seek out new challenges, and the opportunities for learning in this field are endless. The more we educate ourselves, the better we can do by our patients.

PV: Why did you decide to pursue the Certified Pain Educator credential? How has it helped you in your professional life?

KS: Pain management truly is a specialty that is not yet recognized in the professional organizations for physical therapists, and I believe it should be given this recognition. There are so many advanced clinicians in my field who are doing inspiring work in pain management. My hope is that I can contribute to the momentum by using this credential to elevate the conversation about pain and change the way PTs approach treatment of chronic pain conditions. I felt that earning the CPE credential would allow me to initiate more educational opportunities for others working in health care.

PV: Why would you recommend the CPE credential to others?

KS: Having a credential that is nationally recognized can help to spotlight the need for further pain education in the US. It is important that many different disciplines combine their efforts so that people living in pain hear a consistent message about their condition. Getting the CPE is one major step toward this type of change in the healthcare field.

PV: Finally, from your past experiences as a PAINWeek participant, what would you say to your colleagues in physical therapy about the value of attending PAINWeek 2014?

KS: I would strongly encourage my colleagues in physical therapy to attend the PAINWeek conference for many reasons. Most continuing education conferences target one discipline or one specialty clinical skill. PAINWeek offers a rare opportunity for clinicians to interface with many other professionals across the healthcare domain who are all on the forefront of pain management in the US. The participants are genuinely excited about learning and sharing their knowledge with others. Successful pain treatment plans must include interdisciplinary or multidisciplinary approaches, and having the chance to learn how other clinicians are delivering services as pain specialists is priceless. Physical therapists are in a unique position to execute the concepts put forth by the experts in pain medicine—such as the benefits of exercise, the importance of mind-body connection, the magic of facilitating neuroplasticity—and if we PTs have the chance to engage in the conversation directly, I believe that everyone will benefit, especially our patients!

“Challenging people’s long-held beliefs about pain is no easy task, and I find that having the CPE credential brings more credibility to my teaching points.”
FOLLOW-UP QUESTIONS

PV: In your original CPE Profile you said, “My hope is that I can contribute to the momentum [of inspiring work done in pain management] by using this CPE credential to elevate the conversation about pain and change the way PTs approach treatment of chronic pain conditions.” Do you feel you have, indeed, elevated the conversation? If yes, how?

KS: Since I earned my CPE, I feel that I have indeed elevated the conversation about pain and pain management treatments. I deliberately steer conversations about pain away from a strict biomedical model and use the biopsychosocial approach to summarize patient cases and prepare treatment plans with my colleagues. Whether I am teaching patients about pain or updating colleagues about pain research, I incorporate principles of adult learning to explain modern pain science concepts such as neuroplasticity, neuroimmune responses, cognitive maladaptation, and motor/sensory cortical reorganization. Challenging people’s long-held beliefs about pain is no easy task, and I find that having the CPE credential brings more credibility to my teaching points. By preparing for the CPE credentialing examination, I gained important knowledge about how to effectively teach individuals and groups; ultimately this leads to better clinical outcomes.

PV: Has being a CPE allowed you to initiate more educational opportunities for others working in health care?

KS: I have been asked to present at several venues outside of my clinical setting based on my knowledge of pain and treating persistent pain conditions. My confidence in accepting these invitations has increased because of my CPE credential.

PV: Do your coworkers understand exactly what a CPE is? Is there a way we can better get the message out there?

KS: I have been approached by several physical therapists within my professional online network who are interested to learn about how to earn a Certified Pain Educator credential. They often do not know how to find information about the credentialing process, but consistently tell me that they believe this credential would facilitate better opportunities for them within their work environments.

PV: In a perfect world, how would you see yourself fully utilizing your CPE?

KS: I would like to teach a broader audience about pain and the nervous system, so that we can truly change the focus and direction of pain care in the United States. I love what I do for a living, and there are also substantial challenges to my work as a physical therapist, simply because all clinicians trying to treat pain do not speak in the same terms or follow the same research regarding pain. A CPE could afford more opportunities for me to branch out and spend more time teaching—but then I would have to spend less time treating patients in pain and it’s difficult to have competing priorities!

PV: Is there anything else you’d like to say about the CPE, pro or con?

KS: We are living in exciting times in the world of pain treatment, and I expect to see a dramatic shift over the next 10 years in formal pain training both at the institutional level and for professional continuing education courses. Being knowledgeable and skilled in educating patients and clinicians about pain will be an asset for any professional working in the field of pain management. I would encourage more healthcare professionals to consider obtaining a CPE!

“When it comes to the value proposition of the American Society of Pain Educators for primary care practitioners, I consider the Certified Pain Educator credential to be sort of a driver’s license for managing pain in a primary care setting. I highly recommend it as something that frontline practitioners seek and obtain.”

—KEVIN L. ZACHAROFF MD, FACIP, FACPE, FAAP

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Susan Thompson  PharmD, BCPP, CPE

**Dr. Thompson was the CPE Profile in the last issue of Painview. Here she gives us a glimpse into her daily work life in her Pain Diary.**

**ENTRY**—A nurse asked me today, “How can you tell if a patient is REALLY in pain?” The patient was using an unusually large amount of IV hydromorphone. I responded, “How can you tell a patient is REALLY experiencing itching? They tell you they itch, they scratch their skin, they may or may not have hives, they may or may not have a condition or are taking a medication that causes itching.” You take their subjective report and look for etiology to select the appropriate treatment. They may truly have itching but I wouldn’t give large doses of IV Benadryl to a 90-year-old demented patient with a prostate the size of a grapefruit. He may get some topical hydrocortisone or ice instead. Point is pain can be treated with many tools.

**ENTRY**—Applied for the “Pain Specialist” position at my hospital today. I gave a presentation of methadone induction with pregnant women to the staff as part of the interview process. I was surprised by how many people came to the presentation. This topic still seems very mysterious to my colleagues. Good opportunity to practice my teaching skills with peers.

**ENTRY**—One of the biggest reasons for poor postop pain control I have come across with spinal surgery patients is the mismatch with their expectations. I often ask, “Well what did the surgeon tell you to expect after surgery?” They either cannot recollect the conversation or had the belief that once they had surgery they would have no pain. If I spend the time to **really listen to their story**, I can usually identify where the cognitive mismatch occurred and help them to process what is going on with their body. I can explain that some new pains they may be feeling acutely postop (like radicular pain) are not uncommon once the spinal cord compression has been relieved. It doesn’t mean the surgery was “not successful” as sometimes they fear. With appropriate intervention with neuropathic pain medications and reassurance that this “new pain” usually resolves with healing, the patient is able to successfully manage pain and participate in the activities needed for their recovery. Also this helped to remind me to get the whole story.

**ENTRY**—Decided to review our hospital’s Patient Controlled Analgesia order set. Our pain team has not had much guidance on how to convert a patient’s home opiate regimen to continuous rates when they are started on PCA. Reviewed multiple resources and there are **definitely no good guidelines** for opiate tolerant patients. Some references suggest converting the entire home regimen into a continuous rate and give large boluses (1/4 of hourly rate) only up to about 4 times per hour. Other references give different percentages and recommendations. The team and I have decided to look at some retrospective PCA data from our hospital.

**ENTRY**—Had a spina bifida patient, status post foot amputations, stage 4 decub sacral ulcer. I ended up getting him a diverting colostomy to keep fecal matter out of his wound. He went
“One of the **biggest reasons** for poor postop pain control I have come across... is the mismatch with [patient] expectations. They...had the belief that once they had surgery they would have **no pain**.”

through acute renal failure from vancomycin, then had his surgical colostomy site dehisce with evisceration. I was managing his pain with morphine PCA. He was depressed. We had to stop his antidepressants because he ended up on linezolid for his infection which interacted with his amitriptyline and SSRI. All I could think of, every time I worked with him, is there doesn’t seem to be much I can do to ease his suffering any more than I have with medications. So, I decided that every day I saw him I was going to tell him a new joke. Every day I would rattle off a joke—some were met with laughter, others with comments like, “Don’t quit your day job, lady,” but it established a relationship between us. He knew I was thinking about him (by looking up the jokes) and acknowledging that life wasn’t being very fair to him right now. It showed him I was going to do my best by helping him through it.

**ENTRY**—The powers that be always warn us not to “medical babble” at patients but I have to be reminded every so often. The terms I most get busted for using with the assumption that patients know what I’m talking about are: PO (apparently this isn’t as blatantly obvious to the lay public as I assume it is), titrate (almost always met with a deer in the headlights look when I mistakenly use that word), taper (right up there with titrate).

**ENTRY**—I was called by the ICU manager to come assess a postop patient who had uncontrolled pain all night despite a morphine PCA. When I reviewed the pump data, I noted that the RN inadvertently increased the continuous rate on the PCA from 0.5 mg/hour to 2 mg/hour instead of increasing the demand dose from 1 mg to 2 mg. This gave me an opportunity to review the order, set guidelines with her, and review how to program the pump.

**ENTRY**—It’s not all about pain management: on the foot of this patient’s bed I noticed a box that said, “Tactical Solutions Gear,” [Editor’s Note: TSG is a gun and ammunition and accessories company.] Since I am no novice to firearms, I picked up the box, thinking, I wonder if this is an EOtech optic or something. Nope, it was a silencer. I pointed out to the patient’s family member that although I was truly impressed that he could afford the fees for the license and the firearm silencer, the hospital (due to federal regulations) frowns on bringing firearms or silencers on the campus. I mentioned to the ICU manager that there was no extra charge for my firearms assessment: it was just included pro bono in my pain assessment.

**ENTRY**—Some days it’s a silencer, and some days it seems like all I do is measure pain and poop. Pain and poop. Pain and poop. Darn opiate induced constipation. ☹️

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