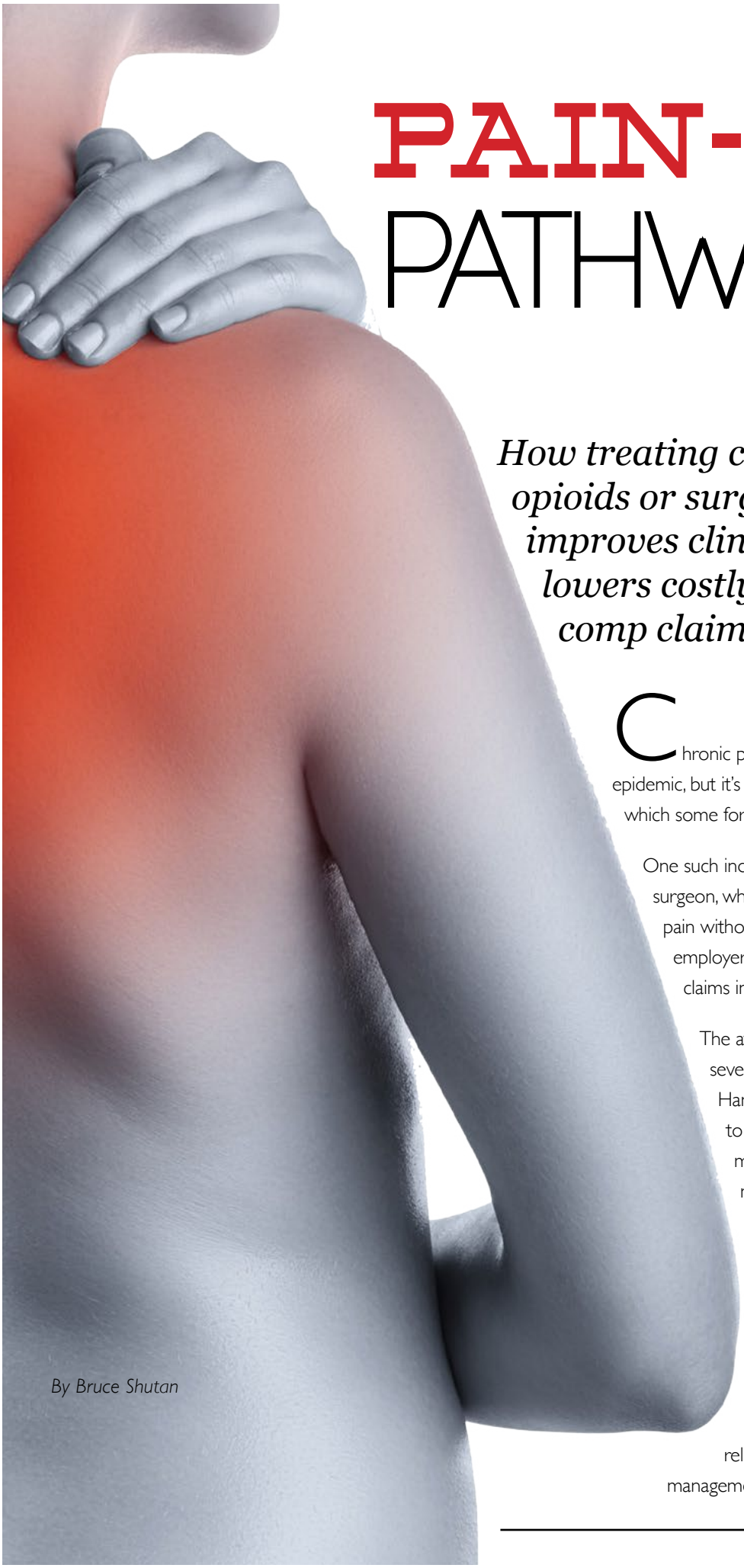

PAIN-FREE PATHWAYS

How treating chronic pain without opioids or surgery in most cases improves clinical outcomes and lowers costly medical and work comp claims

By Bruce Shutan

Chronic pain fuels the nation's troubling and costly opioid epidemic, but it's also part of a gray area in medical treatment for which some forward-thinking clinicians are trying to add clarity.

One such individual is David Hanscom, a renowned spine surgeon, who's helping thousands of patients treat chronic pain without highly addictive opioids or surgery and saving employers on costly group medical and workers' comp claims in the process.

The average life span of someone with chronic pain is seven years shorter on average than those without it, Hanscom reports, adding that the impact is estimated to be similar to terminal cancer. "My goal is to bring modern neuroscience research into mainstream medicine," he says.

His book, "Back In Control: A Surgeon's Roadmap Out of Chronic Pain" (Vertus Press), and a self-directed care program serve as valuable resources. The recommended road to recovery includes an awareness of the neurological nature of pain, which is an embedded memory, as well as getting seven hours of uninterrupted sleep, stress relief, physical conditioning, meditation, medication management and a positive outlook on life.

After seeing too many lives ruined by unnecessary spine surgery, Hanscom strongly believes that 70% of all back surgeries should never happen and says they simply create more pain and complications for those who are already in pain. Research shows that 80% of patients who follow a self-care program that's based on his own experience with chronic pain are pain free within three to six months and cancel their spine surgeries.

"What Dave does is nothing short of a miracle," John Shervey, a safety and work comp consultant, says of his friend, Hanscom. *"But he has a never-ending supply, and the only way I can see that you can be effective in doing that is working on the front end and trying to get motivated people."*

What's puzzling to Tom Lagen, M.D., a physician who specializes in coordinating returns to work for work comp claimants, is determining why a subset of claimants with a herniated disk or nerve compression experience so much pain vis-à-vis others with the same issue who do not. "That's the real difficulty of this," he says.

How the brain processes pain

Cracking the code on chronic pain requires new approaches to treatment. "There is a fundamental lack of understanding about the nature of pain and that it is occurring in the brain," explains Jennifer Christian, M.D., an occupational medicine physician in clinical practice for Multi-Dimensional Medical Care LLC, adding that the kind of disabling chronic pain that ruins a life is rarely due solely to the medical condition itself.

Industry experts note that the body sends messages to the brain that are interpreted as pain and the way the brain responds to incoming stimuli is actually what produces pain. This can increase or decrease the distress and disruption of normal life activities that pain produces.

Moreover, certain risk factors make it more likely that the brain's reaction to incoming stimuli will result in chronic pain. There are now methods to systematically detect the presence of risk factors, as well identify as the specific nature of those risks.

However, today's conventional thinking about chronic pain management is rooted in "an intuitive, informal, unstructured and disorganized method of risk assessment," according to Christian, who's also president of Webility Corporation, a consulting firm, and was a board member of the American Chronic Pain Association.

The entire bio-psycho-socio-economic (BPSE) context in which an injury begins and unfolds has a profound impact on the health outcome, she says, particularly for musculoskeletal conditions, depression and anxiety. "The fact that workers' compensation tries to ignore nonmedical issues means the system is ignoring the things that are driving outcomes," she adds.

Data show that between a quarter and half of all doctor visits involve common symptoms that have no pathological basis, Christian notes, describing the phenomenon of medically-unexplained physical symptoms.

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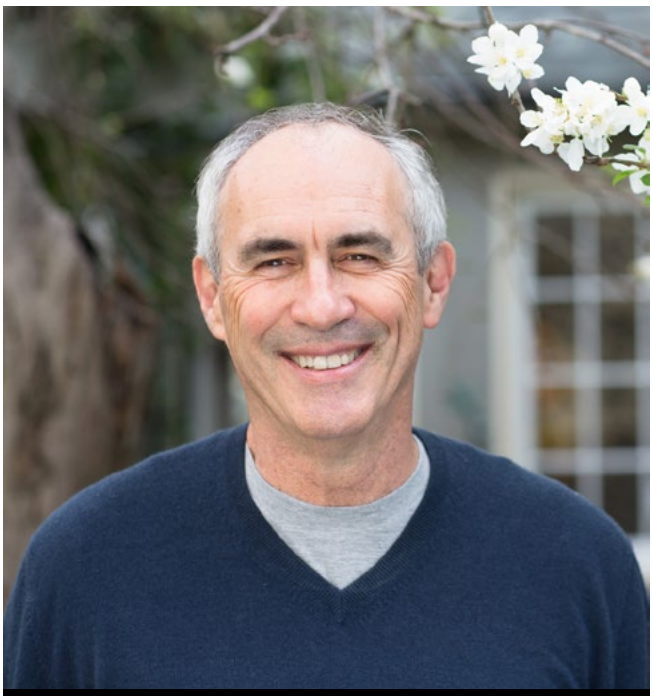

David Hanscom

In other words, physicians can't find any evidence of disease to explain low back pain, migraines, stomachaches, chest pain, etc., nor have the doctors been trained to deal with patients whose symptoms have no anatomical basis. Sometimes doctors "medicalize" these benign symptoms by assigning a diagnosis when they are actually being caused by an emotion, stress, mental conflict or even a memory.

Opioids are not the only effective way of treating acute pain, says Christian, who's heartened that surgical specialties are pondering alternatives for treating "real agony." If more than a 100 million Americans live with chronic pain, according to the Institute of Medicine, she believes it's "morally bankrupt" for providers and insurers not to suggest alternatives.

The good news is that the brain's processes can be altered so that pain becomes less bothersome and not such an obstacle to daily functioning and the ability to participate fully in life. Since the brain is neuroplastic, which means it is constantly changing, she says it can be intentionally remodeled. Once learned patterns become clear, the brain can be retrained to do something different. That may involve developing new thought patterns or practicing new behaviors.

Complicating comp claims

Triggers of chronic pain include a number of factors such as sleep, stress, physical conditioning and one's outlook on life, Hanscom explains. The body responds to anxiety with stress chemicals, muscle tightness, a racing heartbeat, etc.

It's odd and disturbing that workers' comp will pay easily for CAT scans, procedures, surgeries and injections, but they won't pay for mental health resources, which actually is the diagnosis," he adds.

With more than three decades of experience as a spine surgeon, Hanscom became active in the work comp system for about 15 years in Washington State. Injured workers are at the mercy of a claims examiner who's not qualified to make medical decisions, he opines. Their expectation is they'll be taken care of them when, in fact, he says they're often harassed and threatened.

As if being out of work wasn't stressful enough, Hanscom says it's compounded when work comp claimants must wade through a perverse system that doesn't treat the underlying source of pain. Feeling like a victim, many work comp claimants become angry and frustrated. He also says spine surgery, injections, opioids and random physical therapy don't work for chronic pain.

Surgery on work comp claimants is only about half as successful as those who haven't filed a claim, Hanscom says. Why so? He cites as the chief culprit for exacerbating pain a sustained, stress-chemical assault associated with anger over the way they're treated. He says there are nearly 30 symptoms of an adrenalized nervous system that cause migraines, ringing of the ears, fibromyalgia-type symptoms, back pain, neck pain, anxiety and insomnia.

His approach includes "expressive writing" of thoughts that are immediately discarded, which he says nearly 1,000 research papers have shown will change the nervous system. Decreasing the body's adrenaline levels and releasing pent-up anger can pave the way to a pain-free life. Also noting that the antithesis of anger is play, Hanscom points out how critical it is, along with the power of forgiveness, to help injured workers manage or end their chronic pain.

Given the work comp system's regulatory patchwork, some states are having more success than others when it comes to managing chronic pain. For example, Hanscom lauds the

leadership of Daniel Bruns, a clinical health psychologist who was instrumental in Colorado becoming the first state to mandate a biopsychosocial medical treatment model for work comp. The effort has led to substantial annual savings totaling hundreds of millions of dollars, he adds.

In contrast, he castigates the approach in Washington for "actually promoting treatments that hurt people and actively withholding the correct treatments." Hanscom has worked extensively with a health plan in the state to establish guidelines for when spine surgery should be considered in rare cases and why surgical outcomes in the work comp population are almost always less successful than the general population.

A research paper presented in Baltimore in 2014 suggests that "only 10% of surgeons are assisting the known risk factors that adversely affect outcomes before actually recommending or doing the surgery," according to Hanscom.

Behavioral health assessment flaws

Cautioning against a cookie-cutter approach, Christian says a formulaic program like "detect biopsychosocial risk and refer to cognitive behavioral therapy" will be ineffective if it focuses on symptom relief rather than the specific obstacles perpetuating distress and impeding functional recovery in that particular individual's life.

Her concern is behavioral health providers who have not had training in how the body works, the neuroscience of pain, and BPSE model of physical sickness and disability could end up as unwitting enablers of unnecessary distress, as well as over-impairment and functional disability.

Christian and a group of physician-psychologist colleagues wrote a patient education brochure called "If Opioids Have Not Relieved Your Chronic Pain." The material plainly states a powerful message usually omitted in educational materials: opioids are not the right treatment if they haven't enabled people to resume a normal rhythm of life and get their life back on track.

While serving as president of the Alaska State Medical Association in 1992, Christian says the American Medical Association undertook an initiative to improve pain treatment. At that time, the AMA was aware that acute pain was being under-treated and that chronic pain was being over-treated. Sadly, she says, the latter thought got lost in the rush and led to a national crisis involving opioids.

Christian started noticing that the costliest work comp claims include those with poor outcomes due to persistent disabling symptoms, especially chronic pain, despite long-term, high-dose opioids. She became convinced that their lives had been ruined by the narrow bio-medical care model and lack of access to a wide array of resources to manage pain and live good lives. So, she designed a small program to help these claimants take back control of their lives and partnered with an excess work comp carrier to pilot the effort.

In a phone call with claims adjusters who had identified some injured workers as

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potential candidates for the program, she shared findings from conversations with the first group of candidates. She expressed sadness that none had known there are alternatives to pills, shots, or surgery. To her dismay, the claims adjusters said they also weren't aware of other methods.

Christian's self-care model empowers individuals to manage symptoms and improve the quality of their lives rather than creating additional diagnoses and sending them off to other health care specialists. This is partially due to administrative lack of access to mental health care, but also that most psychotherapists are ill prepared to deal with disabling chronic pain.

Ounce of prevention for pound of cure

When injuries occur, it's critical to immediately assess the damage and gain an accurate view of someone's pain level. For example, Shervey says an injured worker who conveys a pain level of eight on a scale of 1-10 "ought to be lying on the floor pounding on the ground" vs. having a discussion. In some cases, he warns, people with chronic pain may have had it "way before accidents" and have personalities that are susceptible to conflicts, which if allowed to fester, could send their case into litigation.

There's a need to recognize faulty pain signals from an individual's periphery, Lagen explains, and over time, develop new neural pathways or circuitry that rewire the brain. "It's a difficult process and not a lot of these workers will buy into it," he cautions. "They keep thinking that there's a medical solution to everything."

Adds Christian: "We have to stop chasing symptoms and start chasing a resumption of the normal rhythm of life," noting that learning ways to relieve one's symptoms will move chronic pain into the recesses of the brain where it's no longer the center of attention.

In the end, prevention is the best form of treatment, according to Shervey, who believes improving stay-at-work or return-to-work processes will steer work comp claimants away from the proverbial slippery slope. That means engaging employees in the process and soliciting their suggestions for workplace safety, as well as keeping well-intended service providers from enabling patients to stay in the system longer than necessary.

"Rather than trying to put the egg back together, I'm trying to keep the egg from falling," he says. *"Now, if the egg does fall, then you have to pursue these proactive steps very quickly."*

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for 30 years.