Collaborative Care for Chronic Pain in Primary Care: Overcoming Patient, Provider, Data, and System Challenges in Implementing the Pragmatic Trial

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PPACT Overview

**AIM:** Coordinate and integrate services feasible/sustainable in primary care for helping patients adopt self-management skills to:

- Manage chronic pain
- Limit use of opioid medication
- Identify exacerbating factors amenable to treatment

**DESIGN:** Cluster (PCP)-randomized PCT (106 clusters, 273 PCPs, 851 patients)

**ELIGIBILITY:** Chronic pain, long term opioid tx (*prioritizing high utilizers of primary care, ≥120 MEQ benzodiazepine use*)

**INTERVENTION:** Behavioral specialist, nurse case manager, PT, and pharmacist team; 12 week core CBT + adapted movement groups

**OUTCOMES:** Pain (3-item PEG), opioids, pain-related health services, and cost
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<tr>
<th>Barrier</th>
<th>Level of Difficulty</th>
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<td>Enrollment and engagement of patients/subjects</td>
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<td>Engagement of clinicians and Health Systems</td>
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<td>5 = extreme difficulty</td>
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- Enrollment and engagement of patients/subjects: 3 → X
- Engagement of clinicians and Health Systems: X → 1
- Data collection and merging datasets: X → 3
- Regulatory issues (IRBs and consent): X
- Stability of control intervention: X → 3
- Implementing/Delivering Intervention Across Healthcare Organizations: X → 3
Challenges: Enrollment and Engagement of Patients

- **Issues of continued importance**: Scrutiny on opioid prescribing → rapidly changing treatment landscape → confusion, fear, anger about care; chronic pain stigma and history of treatment failures

- **Other issues**: Tenacity of biomedical treatment model for pain and missed opportunity to apply chronic disease model / rigid study design

- **Group orientation sessions**: ↑ patient receptivity & intervention and assessment adherence but higher recruitment bar and staff intensive

- **Hindsight is 20/20**: relaxing design features included to prevent “contamination” would have helped (timing of patient enrollment, flexibility in group attendance)
Challenges: Engagement of Clinicians / Implementing & Delivering across HCSs

- **Issues of continued importance**: Staffing (implementation within an evolving primary care model re: nurse and behavioral specialists; also who is HCS willing to give time from?)

- **Other issues**: Design not able to capitalize on PCP learning (& brevity of intervention availability seen as “research business as usual”); challenged to leave staffing support in place; opioid-driven urgency for system-wide treatment change

- **Hindsight is 20/20**:
  - Better designs? Participant level randomization or – if time and resource feasible and baseline pain PROs routinely available – stepped wedge
  - Ask less of staff (development of new skill set) & pull more of intervention online (newer tailored technology driven options)
Other Challenges

• **Merging data sets**: KPH reluctance to share medical health record numbers (despite sharing PHI) consequently requiring cumbersome multi-step crosswalk design and limiting central QA and assist options.

• **(In)stability of usual care**: Opioid tapering efforts continue to accelerate (Spring 2016 CDC primary care prescribing guidelines), often addressed by simultaneous poorly coordinated and shallow clinical initiatives.
• **PRO Integration**: KP-wide instrument change that increased clinical utility and scientific rigor; scalable infrastructure for routine PRO delivery – health care systems interested in broader adoption

• **Model for staff training**: Despite little foundational training, full proficiency in intervention delivery (& skills valued by health plan); flexible training model; shift in understanding of chronic pain and self-efficacy for helping patients to manage

• Numerous individual success stories with very complex chronic pain patients and chronic pain fatigued clinicians

• Interest / commitment to sustain PPACT intervention in whole or part
Overarching Lessons Learned

• Challenging the status quo requires persistent and deep *vertical* health care system partnership

• With timely and clinically important research questions expect dynamic practice environment and sense of urgency

• Health care systems still need assist for routine collection of patient reported outcomes such as pain

• Framework of change, communications, choices for design and assessment should be as native to health care system as able

• For chronic pain, mind/body split still deeply embedded in the “behavior” of health care systems