

Multi-disciplinary chronic pain management in primary care: paradox or paradigm?

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Goal for today's talk

- Share what we have learned about embedding complex interventions in primary care
 - Data derive from ethnographic formative evaluation
 - What are the implications for research on chronic pain and other complex conditions?
 - What are the implications for implementation and dissemination if our intervention proves successful?
 - Understand findings within the context of ongoing Collaboratory learnings about clinician engagement

CONTEXT

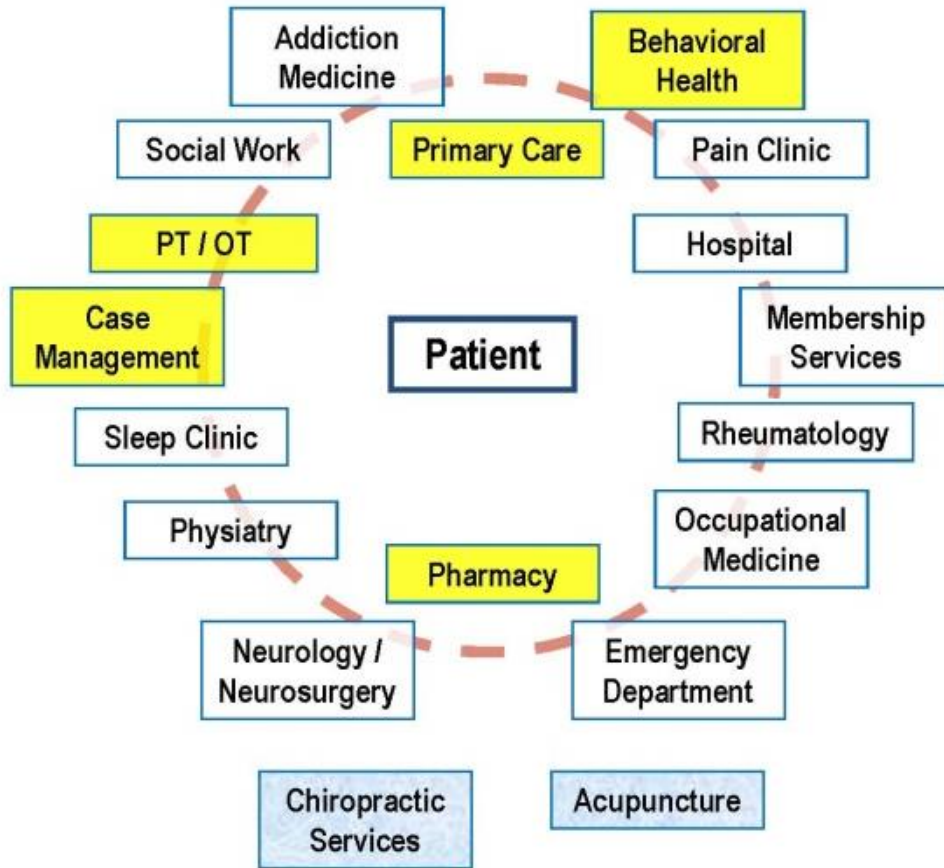
KPNW clinical leadership asked researchers: Help us implement and evaluate best practices in chronic pain management for the most complex* patients in primary care practice.

How do we keep our primary care providers from burning out and leaving the health care system?

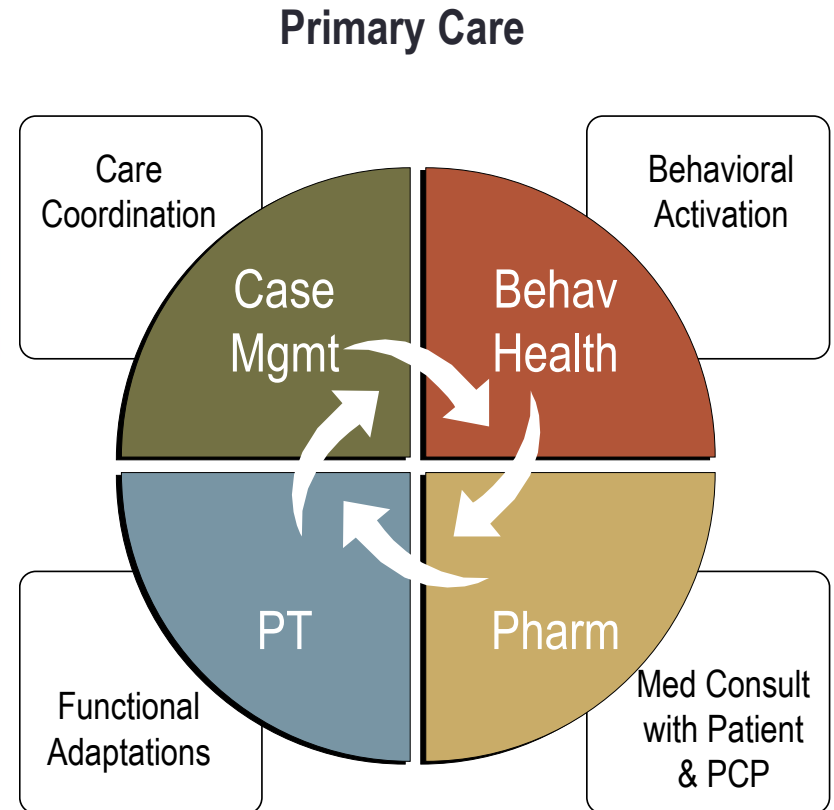
What do we do with the patients who “belong to everyone and no one?”

* Those on higher dose chronic opioid therapy with substantial medical and mental health comorbidity

Pain Management in Usual Care



Interdisciplinary Pain Management Embedded in Primary Care



Intervention Description

Patient Identification / Referral

Comprehensive Intake Evaluation by Care Manager Team (CMT), Including Nurse, Behavioral Specialist, & Physical Therapist, & Pharmacy Consultant

CM Communicates Patient Specific Treatment Plan to PCP

PCP Referral for Ancillary Services & Follow-up Communication

Case Management Follow-up

Periodic re-evaluation & revision of treatment plan at mid and end of program

Individual coaching contacts (as needed)

Group Series (12 sessions; 2 hours every week)

- PCP Component:**
- Brief, 1 page summary of intake & discharge assessment provided to and discussed with PCP
 - Dashboard of all assessment info documented in chart (linked from problem list)
 - Weekly progress notes from PPACT interaction with patient
 - **PCP expected to make outreach call to patients at program onset (template to guide PCP communication with patient)**

Intervention ~4 months in duration

Overall Study Aim and Approach:

- Coordinate and integrate services for helping patients adopt self-management skills for managing chronic pain, limit use of opioid medications, and identify exacerbating factors amenable to treatment that are feasible and sustainable within the primary care setting

Design:

- Cluster-randomized pragmatic clinical trial
- Between 150-200 PCPs will be randomized (102 clusters)
- 1,000 + patients

Eligibility:

- Patients with chronic pain on long term opioids (prioritizing high utilizers of primary care, ≥ 120 MEQ, benzodiazepine use)

How is Kaiser Permanente (KP) Similar or Different to National Health Care Landscape?

- Integrated delivery system; provides both care and insurance
- PCP-Specialty care relationship may be different than in many other contexts but represents model of care that is increasingly being emulated
 - Physicians are salaried; physician reimbursement is not RVU-based
 - Shared responsibility for a defined population
 - Complex patients managed within primary care as much as possible
- Each region of KP has somewhat different organization, different existing pain care services (e.g., focus/comprehensiveness & longevity of program)
 - Three KP regions in trial have implemented intervention somewhat differently

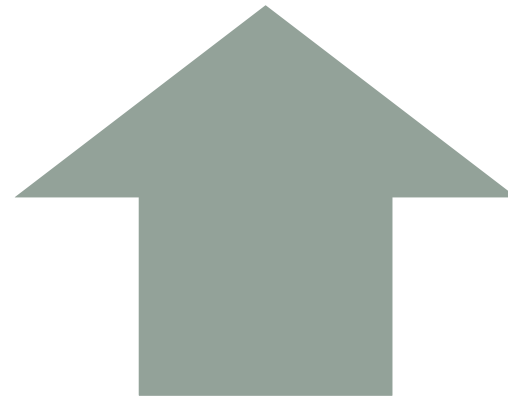
We will describe a paradox:



Primary care is the most logical setting for treating medically complex chronic pain patients

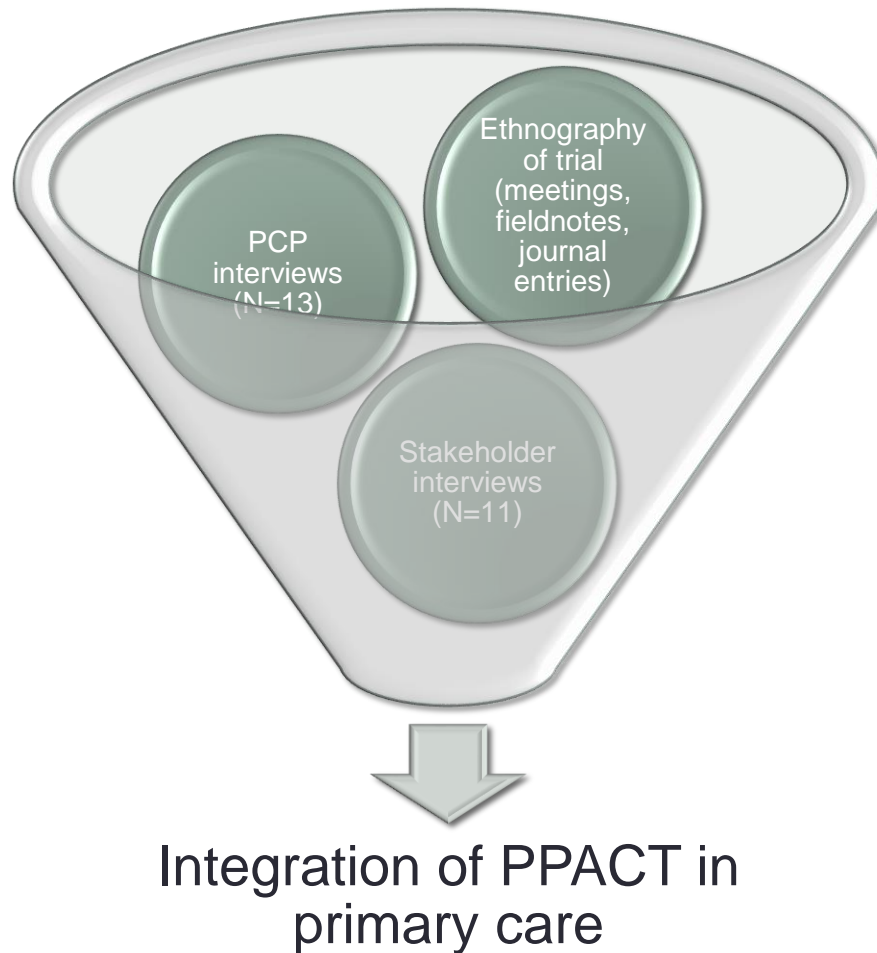


The structure, process, and staffing of primary care make implementation of best-practice interventions for these patients extremely challenging



FORMATIVE DATA

Data sources: Ongoing Formative Evaluation



Note: PCP Interviews just starting in Hawaii and Georgia

PCP PERSPECTIVES

PPACT reinforces and supports PCP goals

- Consistent messaging reinforcing provider goals re: non-pharmacological options for pain management
- Facilitates effective communication with patients; patients are receptive to discussing options for pain management
- Patients feel empowered to engage in non-pharmacologic options

“When patients hear the message from different sources... not just the PCP, it just drives home the point a lot more and reinforces it. So PPACT has helped, essentially reinforce what we’ve been trying to tell patients... [that] pain medication is only going to help a certain percentage of your pain.”

“A lot of them had grown some confidence that they could manage it without medication.”

“[My patient] got a sense that there was a lot more substance to the non-pharmacologic approach... more research and more evidence... so she’s very open to it now.”

PPACT reinforces and supports PCP goals

Where does a program like PPACT belong?

- Who “owns” this program? Primary care? Complex chronic pain program housed in specialty care?
- In targeting the most complex patients, both primary care and specialty care usually need to be involved
- PCPs recognize that existing services for acute pain and less complex chronic pain are insufficient for their most complex patients
- How do you staff/train/oversee a multi-disciplinary team that spans so many departments?
- The program exists in a “crowded space” where many initiatives are targeting opioid problem. This breeds confusion about PPACT

Where does a program like PPACT belong?

PRIMARY CARE

"It seems like it really should be at least some sort of extension of primary care, because we're the only ones who do long-term pain management...we have pain specialists but they won't follow people long term for pain. It's all put on us."

"It would have to exist in the primary care clinics, where there's the most traffic... and... the integration of care [is] easier... Meaning you would have a PCP onsite and a behavioral health specialist onsite. And all the people on the team would be in one place."

SPECIALTY CHRONIC PAIN CARE

"It's too involved. It's too demanding. You don't have enough [primary care] providers... given the number of pain [patients]... They utilize a lot of resources, just because of the nature of the condition... if you want to free up your primary care providers there should be a separate department that just manages chronic pain, which is comprehensive."

"We really need a comprehensive, chronic pain program, for those patients who have chronic pain... They can be discharged when they're stable, back to their PCPs... I just think the same way we have a comprehensive diabetes management program, you know, and a comprehensive CHF program, right? That's the way I think we should have a chronic pain management program."

There is no obvious best way to communicate with providers about individual patients within the EMR

- Workflow & workload place enormous constraints on providers' attention
- Tried to design a user friendly tool to communicate with providers within the EMR
- Providing this summarized, multi-disciplinary evaluation at the beginning and end of trial does not necessarily provide the information to PCPs when it is most useful
- Emailing/messaging providers about specific actionable concerns works well, but does not provide the “big picture” required for co-management

“Unless we were specifically alerted to look in this place... there’s way too much noise in the chart”

– PCP, about reviewing a PPACT report



ORGANIZATIONAL LEADERSHIP PERSPECTIVES

Leadership recognizes the value of providing these services in primary care setting, but approach varies.

KPNW: Can we fit multidisciplinary pain treatment into existing organizational structures and initiatives?

- Team-based care (social work/nurse case management)
- Behavioral/mental health services
- Pain specialty services
- Opioid tapering

KPHI: Implement an adapted version of PPACT ASAP

Primary care is “the first line for a lot of these treatments. [PCPs] will see a lot of these patients early.”

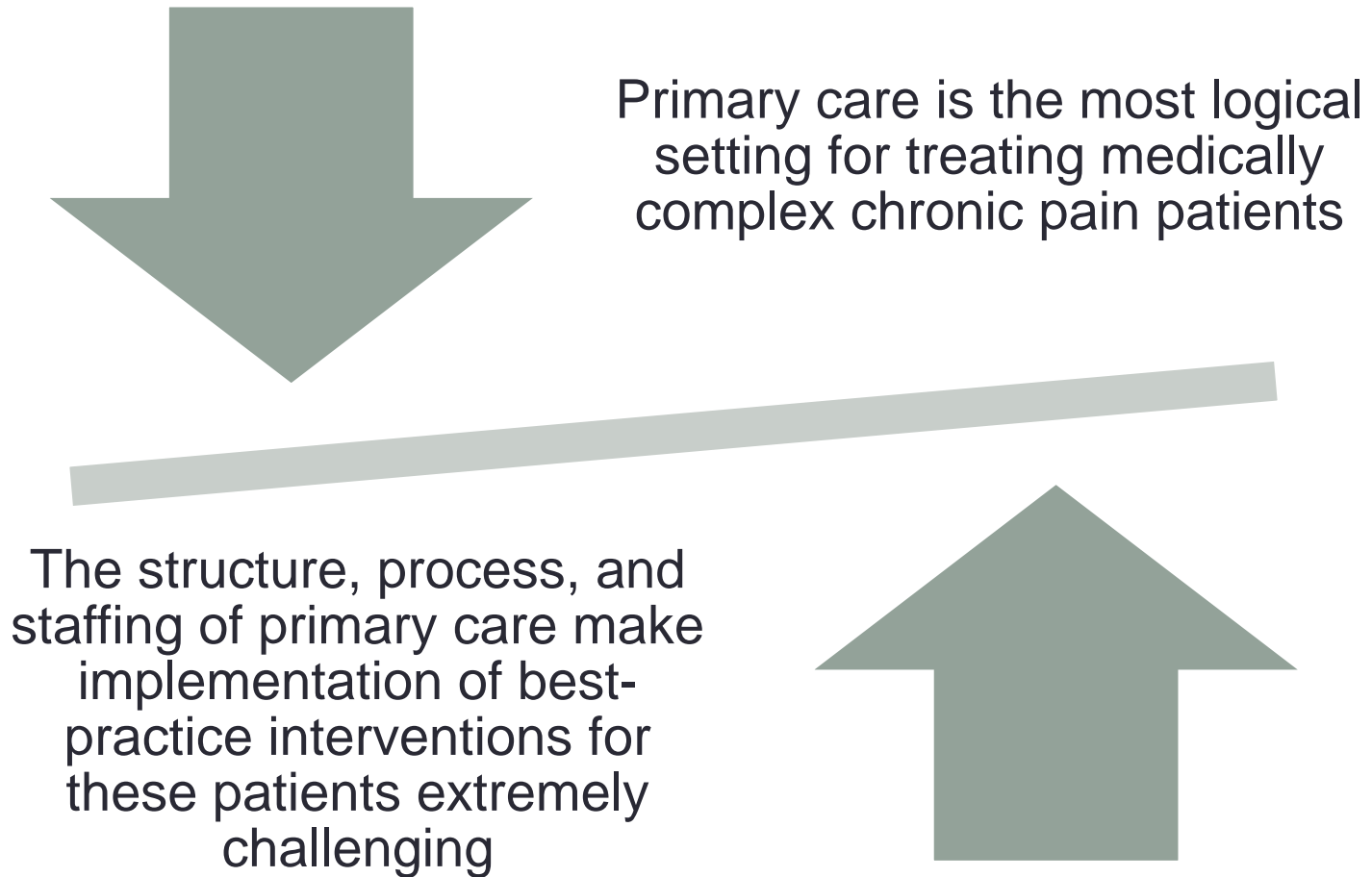
Sustainability

- Can't wait 5 years for a business case – we have to act now
- Intervention components likely to be “evaluated” and implemented piecemeal
- Multidisciplinary care isn't a new idea – it's failed before
- Staffing is a major challenge
- Integration in primary care is essential

“A lot of times, it ends up being more of a financial reason that [multi-disciplinary care] doesn't maintain itself, or even being able to find people to consistently be able to participate or run this kind of program. That has probably been the problem sort of universally.”

*“So the hope is... we hike patient satisfaction because their needs are being addressed by **the right professional at the right time, available in primary care**”*

The paradox



DISCUSSION

What happens for other complex chronic conditions?

Congestive
Heart
Failure

Diabetes

Anti-
coagulation

What makes chronic pain different?



Summary & Discussion: How can research help to transform the paradox into a paradigm change?

- Leaders & PCPs are telling us: systems are not yet ready for the vision of care that both they and researchers are aiming for
- **Provocation: If health systems must modify best-practice interventions that researchers are being funded to develop, do we need to reframe the role and responsibility of research in bringing about care improvement?**
- Should we be funding more organizational research?
- How much can interventions “ask” of PCPs?
- Should we measure as an outcome the *relationship* between the PCP and the patient because that is what will endure after the intervention ends?