Best Practices for Integrated, Patient Centered Care for Chronic Pain

Daren Anderson, MD
VP/Chief Quality Officer
Community Health Center, Inc.
Director, Weitzman Institute
Associate Professor of Medicine
Quinnipiac University
The Weitzman Institute

Committed to improving primary care for underserved populations by promoting research, training, education, and innovation
Chronic pain affects approximately 100 million Americans\(^1\) and costs more than $635 billion in medical treatment and lost productivity\(^2\).

- Majority of patients with pain seek care in a primary care setting\(^3\).
- Primary Care Providers express low knowledge and confidence in pain management and receive little pain management education\(^3\).
- Opioids are heavily relied on for pain management in primary care.
- Prescription opioid overdose is a major and growing public health concern.
How Doctors Helped Drive the Addiction Crisis

Richard A. Friedman  NOV. 7, 2015

There has been an alarming and steady increase in the mortality rate of middle-aged white Americans since 1999, according to a study published last week. This increase — half a percent annually — contrasts starkly with decreasing death rates in all other age and ethnic groups and with middle-aged people in other developed countries.

So what is killing middle-aged white Americans? Much of the excess death is attributable to suicide and drug and alcohol poisonings. Opioid painkillers like OxyContin prescribed by
Oxycodone Consumption (mg/capita) 1980-2013
CDC: Drug Poisoning Death Rates

Figure 1. Age-adjusted drug-poisoning and opioid-analgesic poisoning death rates: United States, 1999–2011

Notes: The number of drug-poisoning deaths in 2011 was 41,340, and the number of drug-poisoning deaths in 2011 involving opioid analgesics was 16,917. Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db156_table.pdf#1.

## Sources of Opioid Analgesics

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>% Distribution</th>
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<tbody>
<tr>
<td>Emergency department</td>
<td>39%</td>
</tr>
<tr>
<td>Primary care office</td>
<td>31%</td>
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<tr>
<td>Medical specialty office</td>
<td>13%</td>
</tr>
<tr>
<td>Surgical specialty office</td>
<td>10%</td>
</tr>
<tr>
<td>Hospital outpatient department</td>
<td>7%</td>
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</table>

How Did We Get Here?

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"And with 10 being the highest, you're sure you're only at a 6?"
Providers
Well-intentioned medical providers wished to alleviate suffering and improve quality of life for those with chronic pain.

Industry
PhRMA wished to develop and market new medications that treated pain and generated profits.

Patients
Patients with unrecognized and untreated substance use disorder and emotional pain processing related to trauma or mental illness.
Opioid-addicted patients are like beach balls at a rock concert...
And Primary Care needs to catch the ball
“The mission of Project ECHO is to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes.”

Dr. Sanjeev Arora, University of New Mexico
Weitzman ECHO Learning Community
Since Jan 2012
Weitzman Institute
ECHO Learning Network

- 119 Practices
- 405 ECHO Sessions
- 1475 Case Presentations
- Primary care providers from 20 States
Key Elements of an ECHO Session

Case Presentations
- 2-3 Cases per ECHO session
- Co-presented by PCP and BH Provider
- Complex cases
- Multi-disciplinary consultation available
- Valuable for discussion and teaching
- Total time = 1.5 hours

Didactic Presentations
- 1 per session
- Focused and topical
- By expert faculty
- Total time < .5 hour
Integrative Pain Center of Arizona

Bennet Davis, MD, Founder IPCA
Anesthesiology, orthopedics, and Pain Medicine

Cela Archambault, Ph.D., Founder IPCA
Clinical Psychology, Health Psychology and Pain Management

Jennifer Schneider, MD, Ph.D.
Internal Medicine, Addiction Medicine and Pain Management

Amy Kennedy, PharmD, BCACP
Clinical Assistant Professor at the Univ. of Arizona College of Pharmacy and Clinical Pharmacist

Kathy Davis, RN, ANP-C, Founder IPCA
Primary care, pain management

Ancillary staff: Chinese medicine, rehabilitation/occupational medicine, nutrition
Pain ECHO Curriculum

- Monthly core session with second optional session
Faculty Profile

Latest Forum Entries

Resource for Colorado Providers - The Impact of Marijuana Legalization on Public Policy
Dr. Jennifer Schneider, Project ECHO Pain Faculty, recently shared a new publication discussing the...
Forum: General Discussion
Each case recorded and indexed
Key cases condensed and edited

ECHO ID 200227
36y M w/ peripheral neuropathic pain in lower extremities due to DM. HepC+, meth use, smoker. On max gabapentin & still has pain. What are the next steps in improving pain control? Would you bother changing to Lyrica or add other adjuncts to current regimen?
Clinical Pearls Digest

Analgesic Discogram
posted 12 minutes ago by Dan Wilensky

Can inject the disc diagnostically. If it resolves the pain substantially (vs. with injection of a non-involved disc as control) then that identifies the disc as the pain source and may guide treatment.

Annular tear -- significance
posted 14 minutes ago by Dan Wilensky

"Lots of sensory nerves if it reaches the outer covering of the disk. Plenty of tears hurt, plenty don't.

"Opioid Monotherapy is not OK"
posted Mar 6, 2014, 9:03 AM by Dan Wilensky

A patient was presented who just wanted to stay on Vicoden, worked 12 hours a day....no time for PT....no interest in other meds. They didn't say that ongoing Vicoden was wrong, but that as "monotherapy" Vicoden will permit this person to live a lifestyle which is bad for his pain syndrome. If he doesn't work on it, it's not going to improve....and the Vicoden may work now, but it's not going to keep working for 10 years, for 20 years.
Best Practices in Pain Evaluation and Treatment for Primary Care Providers

What is Pain?

Bennet Davis, M.D.

Psychological Aspects Affecting Pain

Psychosocial Assessment at the Specialty Level

Cela Marie Archambault, Ph.D.

Cela Marie Archambault, Ph.D.
Resource Library

• Tools for implementing pain care best practices
• Patient and practice assessments
• Community generated resources
52 yo female with hx of lumbar spine decompression surgery 6 years ago and continued stenosis and pain with radiculopathy and neuropathy. Hx of left hip pain on MRI shows left gluteal tear and surrounding muscular atrophy Tried and failed Physical therapy. Hx of osteoporosis and gets reoplast once a year Tried and failed fentanyl patches with pain management and does not want to go back on this medication Currently on MS contin 15mg 2 tabs BID and Percocet 7.5 TID, Gabapentin 800 mg TID, Voltaren gel PRN and ibuprofen PRN for pain relief.

My plan: Rererefer to pain management, rerefer to physical therapy, obtain most recent lumbar MRI to assess if patient needs to see orthopedic surgeon again, goal is to decrease her narcotics doses that she came to me on Questions: [1] What further management can I offer this patient? [2] For gluteal tear, is PT contraindicated as this was a concern? [3] Any other recommendations. Thank you!

Hello! Dr [ ] here.

Physical therapy is the ticket for the gluteal tear. Not contraindicated at all. If there is a complete tear of the tendon and there is really nothing that can be done other than improve the mechanics of the hip using surrounding muscles. The patient will need to be very compliant with home exercise program, this is the kind of thing that people need to work on at least 4 days a week with her home exercise program.

You didn't mention weight, if the patient is overweight, that weight loss will help quite a bit with hip mechanics and reduce the chance of degenerative disease related to the dysfunction of the hip muscles.

As far as exercise, cardiovascular exercise might include pool therapy when this is available if it is available and recumbent bike that sort of thing. That is going to be very important for protecting the hip and the back as well.

I would suggest that before you make the goal of decreasing narcotics use for a goal for transitioning to an aggressive lifestyle medicine-based program that includes exercise, weight loss if indicated, improving sleep. It is always best to do that before you start focusing on the opioid unless the opioid is causing severe side effects that need to be addressed through a decrease or unless you were concerned about misuse or diversion of the opioid. These are not big doses. One small change might be to change to 30 mg twice a day of MS Contin and eliminate the Percocet, or 15 mg 3 times a day and eliminate the Percocet. Regardless of the FDA labeling, MS Contin often does not last 12 hours, i.d. dosing is the most common dosing regimen United States, consequently.
Make sure to set concrete functional goals. What is it she is not able to do that she would like to do? What is she able to do but not as well as she would like to? Use those to measure progress. Not changes in medication doses - although reduction in medication does can be a secondary outcome measure.

Finally, reviewing the MRI to see if there is persistent or recurrent nerve root compression that might relate to leg pain/sciatica is a good idea. It may be that you're pain medicine consultant (we want to get away from using the phrase "pain management" because that is often connotes pharmacotherapy and pulses back to talking about pills instead of the things we want to talk to patient about) can do epidural injections, and if there is severe stenosis, he might refer for surgical evaluation if the patient is interested. However, a good lifestyle medicine plan that includes exercise, working on sleep, weight loss, smoking cessation (generic recommendations since I don't know this patient well) needs to be established first. A great reference for how to prep your patient for surgery (and how to recognize a patient who isn't ready) can be found on page 212 of Dr. David Hanscom's book "Back in Control" http://www.amazon.com/Back-Control-surgeons-roadmap-chronic/dp/0988272903.

Please let me know how helpful this is!
Pain-Related Knowledge

- Maine Interventionists – Post-ECHO: 188
- Next Steps Interventionists – Post-ECHO: 169
- Maine Interventionists – Pre-ECHO: 166
- Next Steps Interventionists – Pre-ECHO: 157

Max Score = 250
Pain-Related Self-Efficacy

Next Steps Interventionists – Post-ECHO

Maine Interventionists – Post-ECHO

Maine Interventionists – Pre-ECHO

Next Steps Interventionists – Pre-ECHO

Ideal Score = 7.0
### Study Period

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<tr>
<th></th>
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<tr>
<td><strong>Total Patients</strong></td>
<td>3357</td>
<td>4477</td>
<td></td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Opioid Rx</td>
<td>1610</td>
<td>1966</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>90+ Days Opioid</td>
<td>763</td>
<td>924</td>
<td>0.023*</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td></td>
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<tr>
<td>Pts w/ a CHCI BH Visit</td>
<td>816</td>
<td>1292</td>
<td>&lt;0.001*</td>
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<tr>
<td>Chiropractic</td>
<td>2</td>
<td>48</td>
<td>&lt;0.001*</td>
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<tr>
<td>Physiotherapy and Physical Therapy</td>
<td>658</td>
<td>1035</td>
<td>&lt;0.001*</td>
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<td>Neurological and Orthopedic Surgery</td>
<td>590</td>
<td>748</td>
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<tr>
<td>Rheumatology</td>
<td>122</td>
<td>137</td>
<td>.16</td>
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</table>

*Chronic pain patients of providers who were here for all 3 years.*
Prescriptions with Morphine Milligram Equivalents (MME) >=120

- Measure 1: 189
- Measure 2: 157

6/2/14-9/15/14
7/21/15-10/20/15
Thank You

Daren Anderson, MD
VP/ Chief Quality Officer
Community Health Center, Inc.,
Director, Weitzman Institute
Daren@chc1.com
860.347.6971 ext.3740