

Transforming Pain Care in Missouri's FQHCs

CMK4

Monday, Aug 25
3:00 PM - 4:30 PM
Coronado D

2014 Community Health Institute (CHI) & EXPO
Manchester Grand Hyatt San Diego
San Diego, CA
August 22 – 26, 2014



NATIONAL ASSOCIATION OF

Community Health Centers

TRANSFORMING PAIN MANAGEMENT IN MISSOURI FQHC MEDICAL HOMES

Missouri Primary Care Association
Community Health Institute
San Diego, CA
August 25, 2014

RELIEVING PAIN

- Institute of Medicine Report published in 2011 – *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*
- Recommendation 2-1 "Improve the collection and reporting of data on pain."
- Recommendation 3-3 "Provide educational opportunities in pain assessment and treatment in primary care."

HISTORY AND PARTNERS

- Pain Management Program developed at Community Health Center of Central Missouri, Jefferson City
 - Kari Haake, MD – pain specialist
 - Rich Lillard, PsyD – behavioral health
 - Katie Friedebach, MD – family physician
 - Alan Stevens – CEO
- Pain Action Alliance for a National Strategy (PAINS)
 - Center for Practical Bioethics, Kansas City, MO
- MO HealthNet Division – Missouri Medicaid
- University of Missouri-Columbia – potential

LOOKING FOR MONEY

- Tried to include chronic pain in ACA Section 2703 Primary Care Health Home Medicaid State Plan Amendment
- State Medicaid Director told us we didn't know enough and didn't have enough capacity
- Applied in partnership with PAINS for CMMI
- Applied to Pfizer Independent Grants for Learning and Change program

WE FOUND A LITTLE BIT

- CMMI application was not funded
- Received funding from Pfizer's Independent Grants for Learning and Change program to pilot transformation at five Missouri Community Health Centers – all are Level 2 or 3 NCQA Patient Centered Medical Homes
- State Medicaid Director sharing in cost of contract to aggregate Medicaid claims data for same five Missouri Community Health Centers

DEFINITION OF PAIN

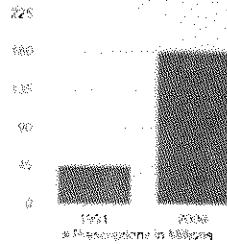
- A sensory and emotional experience associated with actual and potential tissue damage

COMMON TREATMENT

- Pain pill = pain treatment
- Pain treatment is an afterthought or is avoided at office visits
- Co-morbidities that can make pain worse are often ignored

PAIN & OPIOIDS

- Numbers of prescriptions of hydrocodone and oxycodone products filled in US pharmacies rose significantly from 1991 to 2009



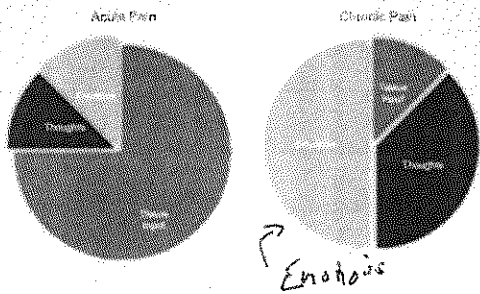
PAIN & OPIOIDS

- Deaths from prescription opioids now exceed deaths from automobile accidents – CDC, 2012
- Between 1999 and 2010, deaths from opioids increased more than five-fold in women – CDC, 2013

MISCONCEPTIONS

- All pain patients are drug seekers.
- Drug-seeking patients exhibit drug-seeking behaviors infrequently. (Grover, 2012)
- Providers and patients do not understand the difference between acute and chronic pain.

THERE IS A DIFFERENCE



*Emotions & Thoughts more involved
in chronic pain*

CHALLENGES

- Providers/organizations may not know who their pain patients are
 - Pain greater than 3 months = chronic pain
 - Patient on medications, automatic refills
- May need specialist referral
- Are co-morbidities being addressed?
- May need to try something different

GOALS

- Improve quality by establishing agreed-upon standards of care for treating chronic pain patients in each practice
- Increase provider satisfaction surrounding the treatment of chronic pain patients
- Increase patient engagement and improve patient experience in the area of chronic pain

TREATING CHRONIC PAIN

- Identifying pain patients leads to:
 - Patient safety
 - Right treatments at the right time
- More is not necessarily better
- High dosages = danger
- Concurrent medication risks



"Take two tons of aspirin and call me in the morning."

Pain Champion → Someone who is following the pain pts

Know who your pain pts are

Pts with sleep apnea → big risk for death

→ Need to pull a report (look @

Sens' pts, coding, etc)

GUIDING PRINCIPLES

- Incorporate bio-psychosocial approach into treatment of chronic pain patients
- Utilize the patient-centered approach to the treatment of pain patients
- Leverage Patient Centered Medical Home structure

PATIENT-CENTERED APPROACH

- Bio-psychosocial perspective
- "Patient-as-a-person"
- Sharing power and responsibility
- A "therapeutic alliance"
- "Doctor-as-a-person"

April 2014 | March 2015

PATIENT-CENTERED PAIN CARE

- Team Approach
- Primary Care + Pain Specialist + Behavioral Health Specialist
- Communication among providers and staff
- Utilize data and measures
- Engage leadership
- Community and social supports

Team based Care

Guidelines implemented to help MDs

THE HEALTH CENTER STORY

- Getting Started – Engaging Leadership
- Putting the Pieces Together - Primary Care + Pain Specialist + Behavioral Health Specialist
- Building the Team - Communication among providers and staff – consistent messaging
- Managing Payer Mix - Utilizing Data and Measures
- Connecting to Community and Social Supports

BIO-PSYCHOSOCIAL

- Biological, psychological, and social factors, all play a significant role in human functioning in the context of disease or illness
- Differs from the bio-medical approach

Figure 19.12.1111

BIO-PSYCHOSOCIAL

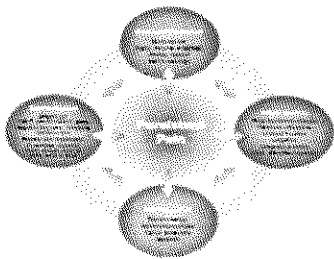
- Began in the late 1970s and early 1980s
- Patient-centered care is a product of the bio-psycho-social model

Figure 19.12.1111

The referral to an external organization is never enough
It is not kept.

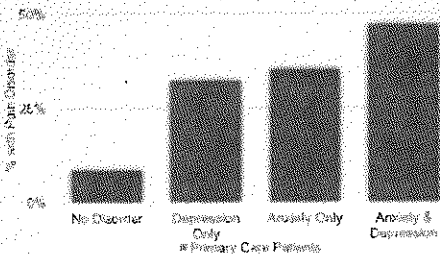
BIO-PSYCHOSOCIAL

Figure 19.12.1111 The "biopsychosocial" model of pain



pain → ↓ activity → ↓
social level → ↑ depression

PAIN & MENTAL ILLNESS



Source: Cleveland Clinic, 2007

PAIN & MENTAL ILLNESS

- In an undertreated mentally ill patient, it can be difficult to treat pain.
- Non-opioid substance abuse is the strongest predictor of opioid abuse/dependence. (Edlund, 2007)
- 50% of patients with pain have co-morbid psychiatric conditions. (Marfins, 2011)
- Mood disorders increase risk of opioid abuse.

SUBSTANCE ABUSE

- 51% of those who met criteria for a substance use disorder at some point in their life also met criteria for mental disorder at some point
- Possible explanation: individuals use psychoactive substances to self-medicate painful or disturbing psychiatric symptoms

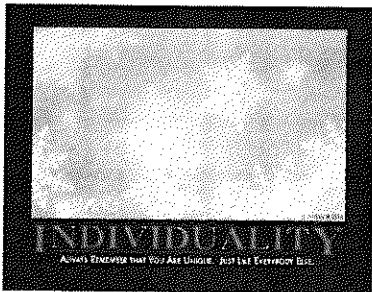
PSYCHOLOGICAL TRAUMA

- Increased risk of chronic pain with history of childhood sexual abuse (Wurtele, 1990)
- Increased risk of substance abuse (Dube, 2005)

PSYCHOLOGICAL CONCEPTS

- Perception
- Suffering
- Recovery

PERCEPTION



*Always remember that you are
unique. Just like everyone else.*

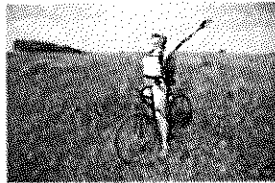
SUFFERING

- Unfortunately, psychological pain can persist long after the physical pain has been addressed



RECOVERY

- Relief vs. function
- Realistic expectations



*You can't tell a pt. that they'll
get back to 100%*

CHRONIC PAIN AS CHRONIC ILLNESS

- Chronic illness treatment methods adapt to chronic pain care
- Additional screening
- Who is the best provider to manage this patient?
- Primary care vs. specialists vs. behavioral health

5 STEP APPROACH TO PAIN PATIENTS

- 1 - Determine if pain is acute or chronic
- 2 - Perform PEG scale
- 3 - Perform substance use and depression screens
- 4 - Perform opioid risk assessment
- 5 - Address positives, develop treatment strategies

STEP ONE

- Determine if pain is acute or chronic
- Chronic pain is pain that has lasted longer than three months, even if the pain is an acute exacerbation

STEP TWO

- Perform the PEG scale
- Pain intensity
- Enjoyment of life
- General activity

1. What number best describes your worst pain during the past week?	
0	Not at all
1	Mild
2	Moderate
3	Severe
4	Very severe
5	Worst imaginable

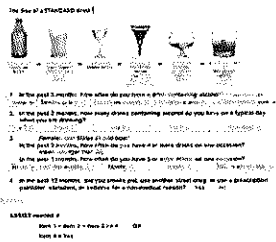
2. What number best describes how much you enjoyed your usual activities during the past week, even if you had pain?	
0	Not at all
1	Mild
2	Moderate
3	Severe
4	Very severe
5	Worst imaginable

3. What number best describes how much you did your usual activities during the past week, even if you had pain?	
0	Not at all
1	Mild
2	Moderate
3	Severe
4	Very severe
5	Worst imaginable

Intensity is an average over the past week.

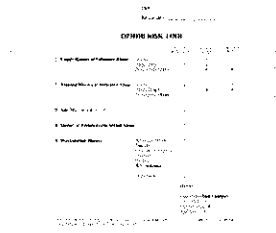
STEP THREE

- Screening
- Alcohol
- Drugs
- Depression



STEP FOUR

- Opioid Risk Assessment



STEP FIVE

- Address positives, develop treatment strategies
- Move away from reflexively prescribing pain medications
- Perform in-depth alcohol, drug, and depression screening

AUDIT

Alcohol screening questions (ASQ)
 The purpose of this questionnaire is to identify patients at risk of alcohol-related problems. It is not a diagnostic tool. If you suspect a patient has an alcohol problem, refer them to a specialist.

Sex	Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Interpretation:
 0-3: Low risk
 4-7: Moderate risk
 8-15: High risk
 16-19: Very high risk

Section 2: Further questions

If you have answered 'yes' to any of the questions in Section 1, you should answer the questions in this section.

Question	Yes	No
1. Do you drink alcohol?		
2. How often do you drink alcohol?		
3. How much alcohol do you drink on each occasion?		
4. Do you ever have 4 or more drinks on one occasion?		
5. Do you ever get drunk?		
6. Do you ever feel the need to have a drink?		
7. Do you ever feel guilty about your drinking?		
8. Do you ever have a drink in the morning?		
9. Do you ever feel unable to cut down on your drinking?		
10. Do you ever have a drink because you are stressed or nervous?		
11. Do you ever have a drink to relax or to get a drink?		
12. Do you ever have a drink to help you sleep?		
13. Do you ever have a drink to help you feel better?		
14. Do you ever have a drink because you are bored?		
15. Do you ever have a drink because you are lonely?		
16. Do you ever have a drink because you are depressed?		

DAST

Drug, Tobacco and Alcohol Dependence Questionnaire (DAST-10)

This questionnaire is used to identify patients at risk of drug, tobacco and alcohol dependence. It is not a diagnostic tool. If you suspect a patient has a dependence problem, refer them to a specialist.

Question	Yes	No
1. Do you ever feel a strong desire or urge to use drugs, alcohol or tobacco?		
2. Do you ever spend a lot of time trying to cut down on your use of drugs, alcohol or tobacco?		
3. Do you ever use drugs, alcohol or tobacco to relieve stress or tension?		
4. Do you ever use drugs, alcohol or tobacco to relax or to get a drink?		
5. Do you ever use drugs, alcohol or tobacco because you are bored or lonely?		
6. Do you ever use drugs, alcohol or tobacco because you are depressed?		
7. Do you ever use drugs, alcohol or tobacco to help you feel better?		
8. Do you ever use drugs, alcohol or tobacco to help you sleep?		
9. Do you ever use drugs, alcohol or tobacco because you are stressed or nervous?		
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18. Do you ever use drugs, alcohol or tobacco because you are depressed?		
19. Do you ever use drugs, alcohol or tobacco to help you feel better?		
20. Do you ever use drugs, alcohol or tobacco to help you sleep?		

PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

This questionnaire is used to identify patients at risk of depression. It is not a diagnostic tool. If you suspect a patient has depression, refer them to a specialist.

Question	1	2	3	4
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Losing interest in hobbies and pastimes				
4. Feeling tired or having no energy				
5. Trouble concentrating				
6. Thinking about death or suicide				
7. Feeling nervous, anxious or on edge				
8. Not sleeping well				
9. Loss of appetite or overeating				

PAIN DIAGNOSIS

- Thorough history and physical
 - Past medical history
 - including psychiatric history
 - substance abuse history
 - significant co-morbidities
- Identify cause of pain and associated conditions
- Diagnostic tools (imaging studies, diagnostics tests)
- Physical signs and symptoms
- Assess patient psychological fitness, since pain and psychological conditions can be closely associated

Where does it hurt?

Don't accept "All over" as an answer

Poorly controlled diabetics are @ risk for chronic pain. Control the DM will improve pain relief.

Repeat imaging studies, a 10yr old MRI means nothing

Address the pts psychological stress, stress causes physical reactions

PAIN TREATMENT

- Acute Pain
 - Treatment of the underlying pathology will likely improve the pain
- Chronic Pain
 - Use the 5 step approach
 - Know when to refer

ROLE OF SPECIALISTS

- Care coordination
- Support for primary care providers
- Exploring mini-pilot with University of Missouri-Columbia to use Project ECHO remote specialist support model

MULTIDISCIPLINARY PAIN THERAPIES

- Pill does not always equal pain relief
- Patient satisfaction actually goes down with more pain medications
- Interventional (injections, nerve stimulation, physical therapy)
- Alternative (yoga, meditation, massage, prayer)
- Behavioral
- All available therapies should be encouraged by the team
 - primary care providers, community support workers, therapists, family members

Why do this? Improve Pt & Provider
Satisfaction
Empower on improving Pt function

Pts want a plan & want
someone to listen to them.

ADVICE/TIPS

- Patients want a plan and want someone to listen to them
- Patients living with chronic pain are unique and a one-size-fits-all approach rarely works
- Know who your chronic pain patients are
- Don't treat to pain scale; look at patient function and quality of life
- No one can be 100% pain free (unless under general anesthesia)
- Patients can manage pain, improve function and have some enjoyment of life

Chronic Pain Pts.

• Improve Safety

• Medication Mgt Agreement

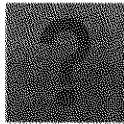
• Urine drug Analysis

• Tracking Pts

• Don't treat to pain scale

• Look @ pt function / quality of life

QUESTIONS?



Pt. may have pain

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3 Visit

Controlled Substance Committee

Must F/O with

Group Sessions