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
  - Karl 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

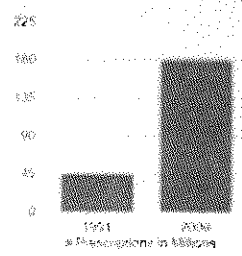
- A sensory and emotional experience associated with actual and potential tissue damage

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



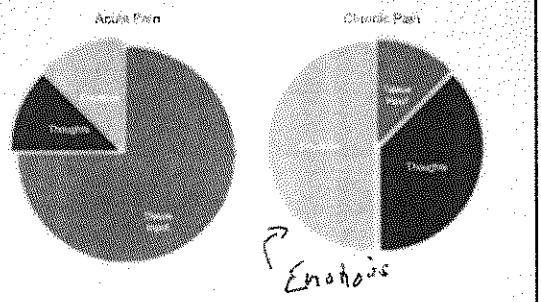
PAIN & OPIOIDS

- 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 (Lupke Suicide 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"

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

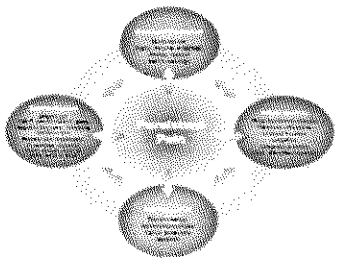
BIO-PSYCHOSOCIAL

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

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

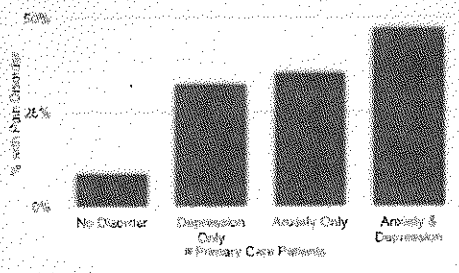
BIO-PSYCHOSOCIAL

The "biopsychosocial" model of pain



pain → ↓ activity → ↓ social level → ↑ depression

PAIN & MENTAL ILLNESS



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. (Martins, 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

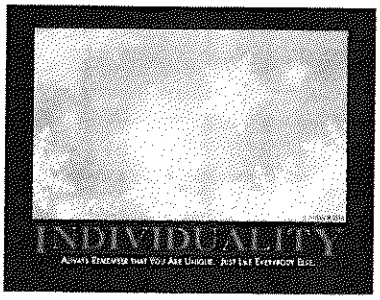
PSYCHOLOGICAL TRAUMA

- 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

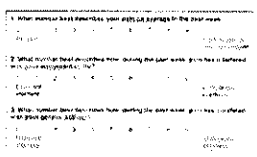
1- Determine if pain is acute or chronic
2 - Perform PEG scale
3 - Perform substance use and depression screens
4 - Perform opioid risk assessment
5 - Address positives, develop treatment strategies

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

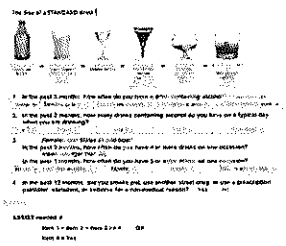
- Perform the PEG scale
  - Pain intensity
  - Enjoyment of life
  - General activity



Intensity is an average over the past week.

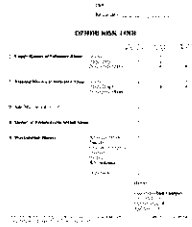
STEP THREE

- Screening
  - Alcohol
  - Drugs
  - Depression



STEP FOUR

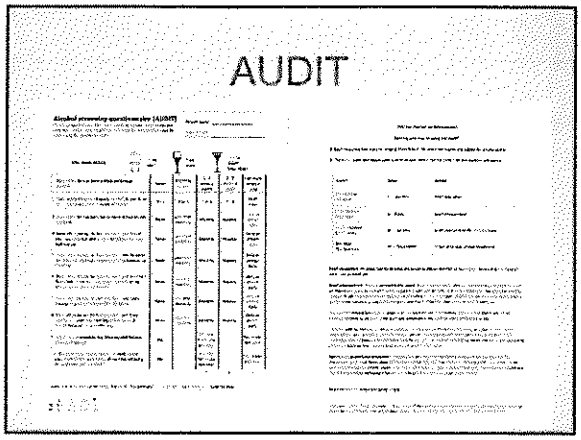
- Opioid Risk Assessment



STEP FIVE

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

AUDIT



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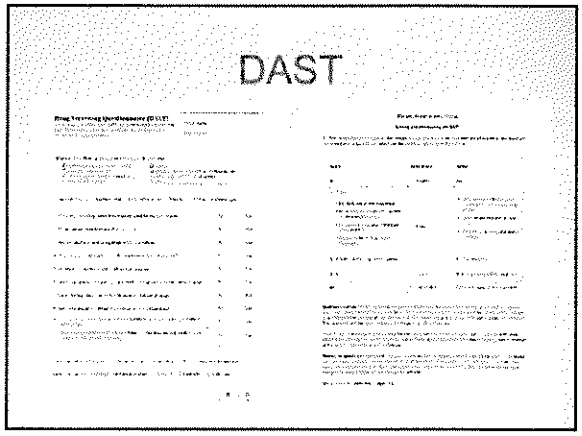
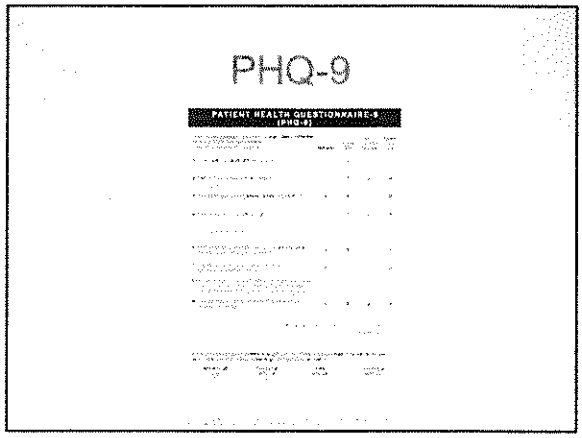


PHQ-9



PAIN DIAGNOSIS

- Thorough history and physical
  - Past medical history
    - including psychiatric history
    - substance abuse history
    - significant co-morbidities
- Identify cause of pain and 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.

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

Repeat imaging studies, a 10 yr old MRI means nothing

Address the pt's psychological fitness, stress causes physical reactions

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 to this? Improve Pt & Provider satisfaction
Emphasis on improving Pt function.

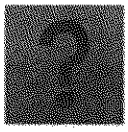
Pts want a plan & want someone to listen to them.

ADVICE/TIPS

- Patients want a plan and went 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
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