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BEST PRACTICES IN PAIN evaluation and treatment for PRIMARY CARE PROVIDERS

Bennet Davis, M.D.

Help people live healthier lives
Get the diagnoses right
Pay attention to lifestyle and social issues that affect health
Be patient centered: Match the treatment and the patient
Reduce unnecessary care
Improve safety
Reduce costs of healthcare
Elevate the healthcare system to the next level

Attributes of Best Practice Pain Care

These should be pursued now (we will teach to these!)

In the future these will become critical for success

- Practice evidence based and outcomes driven - Safety & function
- Offer individualized care with focus on the patient's best interests over the long term.
- Integrate Behavioral with Medical into assessment, decision-making, and treatment
- Integrate Lifestyle Change into daily practice
- Use a Multimodal approach – CAM, chiropractic, pharmacology, procedures all individualized
- Coordinate care - team approach

The best practices that follow promote excellence in each of these 6 attributes

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The 9 Best Practices were designed to meet these criteria

- Promote value in our health care system (lower cost, better outcomes)
- Embrace a commitment to patient centered care
- Remain relevant despite progress in knowledge and technology
- Be relevant to a wide range of health care professions
- Reflect current consensus in pain curricula, and
- Inspire change in training of healthcare professionals
- Be easily adapted based on variations in the context of care delivery: cultural, ethnic, socioeconomic, and gender
- Facilitate better health care policy
- Be transferable to other health conditions
- Describe behaviors that can be measured

BEST PRACTICES IN PAIN EVALUATION AND TREATMENT for PRIMARY CARE PROVIDERS

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The first 4 competencies are about patient centered care: care that is customized to the individual and well coordinated:

#1: Become Expert at Patient engagement

Patient engagement
Why?

- Less unnecessary care
- Greater patient and provider satisfaction
- Better adherence to treatment plans

Osborn L International Perspectives on Patient Engagement: Results from the 2011 Commonwealth Fund Survey J Amb Care Mgmnt 2012; Vol 35(2): 118-128

Patient engagement
Why?

Because “pain management” is a combination of what we do for the patient and *what the patient does for themselves*: Diet, exercise, stress management, smoking cessation, pacing activities.

Patient engagement
How are we doing?

A recent national survey found that only 23% of people adopted new health behaviors in the last 5 years. The remaining 77% were divided this way:

- 12% wanted to be passive recipients of care
- 29% felt they did not have the facts to understand their provider's recommendations
- 36% had "some facts" but lacked the confidence and skills to act on them

Hibbard JH, Health Serv Res 2007; 43: 1443-1463

Patient engagement
How?

- Educate and promote health literacy
- Provide a sense of control, engage the patient in decision-making (shared decision-making)
- Provide access to health information

Coulter A Patient Engagement: What Works? J Amb Care Mngmnt 2012; 35(2): 80-89

Patient engagement
How? Build a healing relationship

- Respect the patient's time
- Be responsive in communications
- Make care very accessible
- Pursue exceptional customer service in the clinic
- Identify all your customers and communicate accordingly
- Help patients understand their costs, and make it affordable
- Discover the patient's frustrations and become part of the solution

#1: Patient engagement
#2: Put the Patient at the Center (individualize their care)

Put the Patient at the Center
IOM Definition

Health care that establishes a partnership among practitioners, patients, and when appropriate their families to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.

Institute of Medicine The National Health Care Quality Report 2001

Put the Patient at the Center
How are we doing?

- 1/3 of respondents said their providers sometimes, rarely or never tell them about treatment options or involve them in decision-making.
- 2/3 of respondents said the when going to their provider with an illness they left without "answers to important (to them) questions".

Schoen C Primary Care and Health System Performance; Adult's Experiences in Five Countries Health Affairs Web Exclusive Oct 28, 2004: w4-487 w4-503

The Patient at the Center

We need to leave this concept behind- where its all about the treatment and the people that do it:

Replace with this: Patient at the Center:

Sleep
PATIENT

PT and Exercise
PATIENT

Injections
PATIENT

Surgery
PATIENT

Counseling and Stress management
PATIENT

The provider and the provider's interests and bottom line.
The health plan and its contracts and networks.
The hospital and its bottom line.

Medications
PATIENT

Mental health treatment
PATIENT

Diet
PATIENT

Massage
PATIENT

Acupuncture
PATIENT

Smoking cessation
PATIENT

Patient-at-the-center is a great concept, but how do we do it?

#3 Live care coordination, build a truly integrated care team around the patient

Sleep medicine

PT and Exercise

Injections

Surgery

Simplified relationship between patient and careteam

Counseling and Stress management

Medications

Pat

Patient liaison – the provider chosen to be the primary contact for the team

Mental health treatment

Diet

Massage

Acupuncture

Smoking cessation

"Care coordination is a key strategy to improve the effectiveness, safety, and efficiency of the American health care system"

Institute of Medicine Priority Areas for National Action: Transforming health Care Quality 2003

#1: Patient engagement

#2: Put the Patient at the Center

#3 Live care coordination, build a truly integrated care team around the patient

#4: Know who the patient is

CC: Knee pain, bad degeneration of the joint on x-ray

- Treat inflammation (injection – maybe prolotherapy/PRP, NSAID oral and/or topical, diet)
- Rest and protect (brace?)
- Exercise/stretching and more to improve joint function (consider non-weight bearing exercise for arthritis patients)

CC: Knee pain, bad degeneration of the joint on x-ray+BMI 35

- Treat inflammation (injection – maybe prolotherapy/PRP, NSAID oral and/or topical, diet)
- Rest and protect (brace?)
- Exercise/stretching and more to improve joint function (consider non-weight bearing exercise for arthritis patients)
- Weight loss

CC: Knee pain, bad degeneration of the joint on x-ray +PTSD from abuse HX

- Treat inflammation (injection – maybe prolotherapy/PRP, NSAID oral and/or topical, diet)
- Rest and protect
- Exercise/stretching and more to improve joint function
- Treat anxiety aggressively
- Cognitive behavioral therapy to alter central nervous system pain processing (Somatic experiencing plus general CBT)

CC: Knee pain, bad degeneration of the joint on x-ray +Addiction disorder

- Treat Addiction disorder first

CC: Knee pain, bad degeneration of the joint on x-ray +Diversion of oxycodone

- No meds
- Cannot establish a therapeutic relationship
- Coordinated with ERs and PCPs

5 patients: same "problem"?

- Yes, same problem if we look at patients "the traditional way" - - - arthritis of the knee
- And same treatment if all we do is ask "where does it hurt?", Then do a 3 minute knee exam, and take x rays.
- *Completely different* treatment if we understand who the patient is
- *Completely different* outcomes (as in BETTER) if we know who the patient is and adjust treatment accordingly

Know who the patient is
How?

- Ask about the patient's environment
- Ask about what a "day in the life" is like
- Integrate behavioral health assessment into your medical assessment
  - Screening, and when indicated based on the screening
  - Formal Behavioral Health evaluation when needed
- Stratify risk
  - StarT – risk that striaghtforward tx will fail
  - Opioid tools – ORT and others

What evidence raises "know your patient" to a Best Practice level recommendation?

Evidence that psychosocial issues, not the medical elements of the HPI and PMH, are the leading cause of failure of back pain treatment

Prospective study looked at factors that predicted failure of medical therapy plus stabilization training and manual therapy in a national health service database over 5 years.

- Depression, anxiety, generalized somatic complaints, poor life control topped the list
- Concluded: "Psychosocial differences seem to be the important determinants for treatment outcome"

Niemisto L J Rehab Med 2004 May; 36(3):104-9

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#1: Patient engagement

#2: Put the Patient at the Center

#3 Live care coordination, build a truly integrated care team around the patient

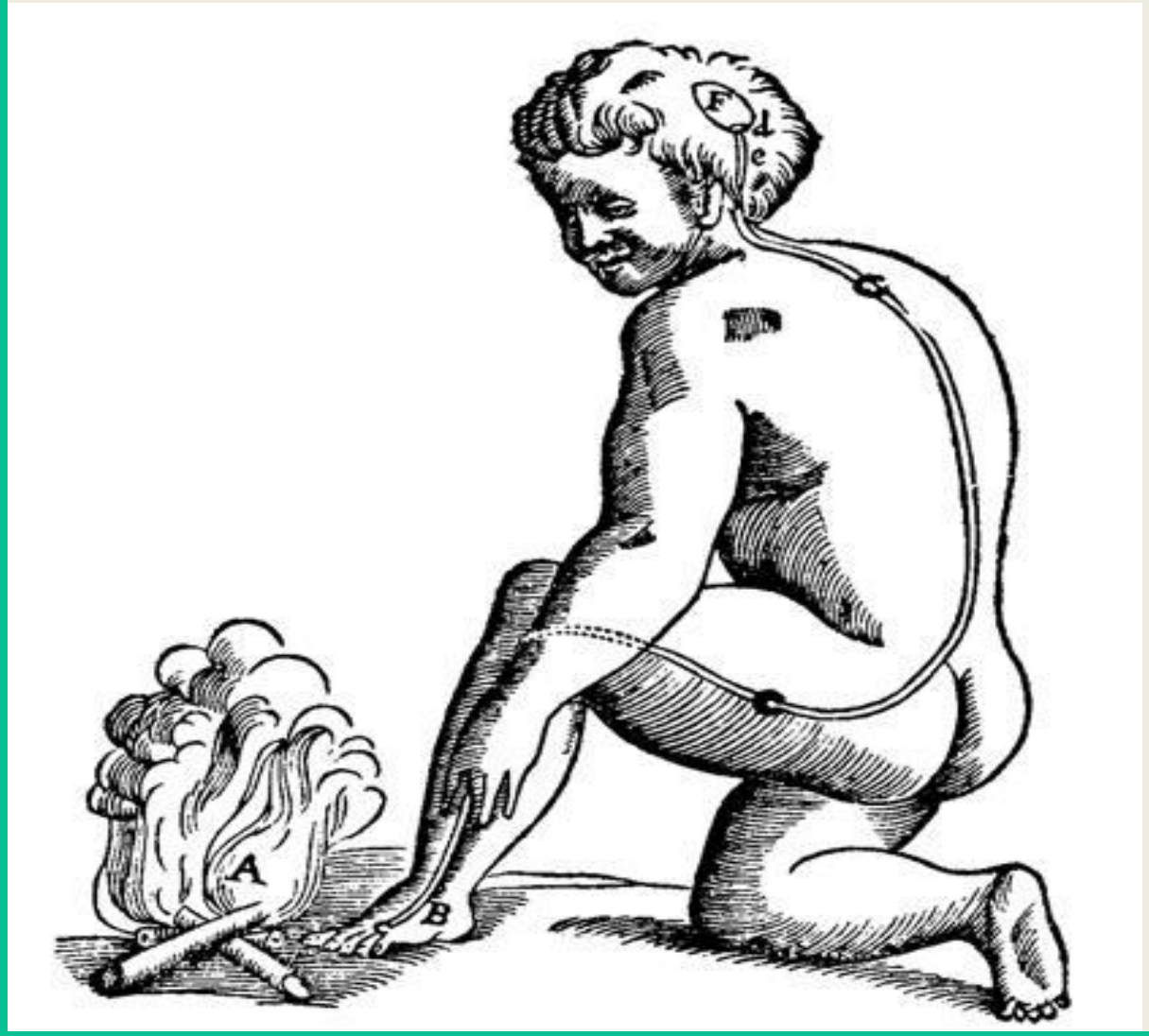
#4: Know who the patient is

#5: Understand what pain is

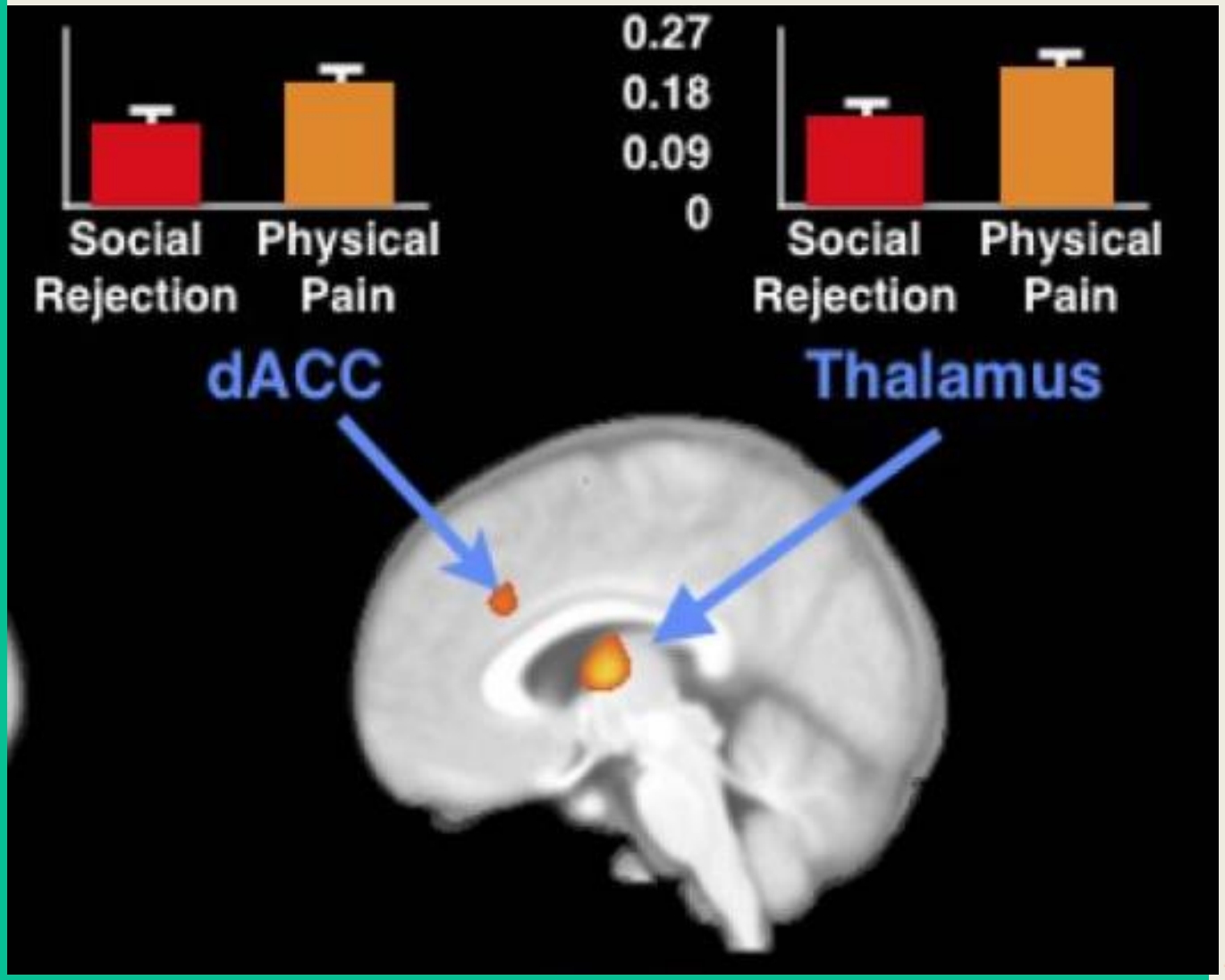
Modern neuroscience has changed far more than we providers – time to catch up because once we catch up, our whole approach changes. For the better.

A lot better.

Renee Descartes conceived of the pain sensing nervous system this way in the 17th Century



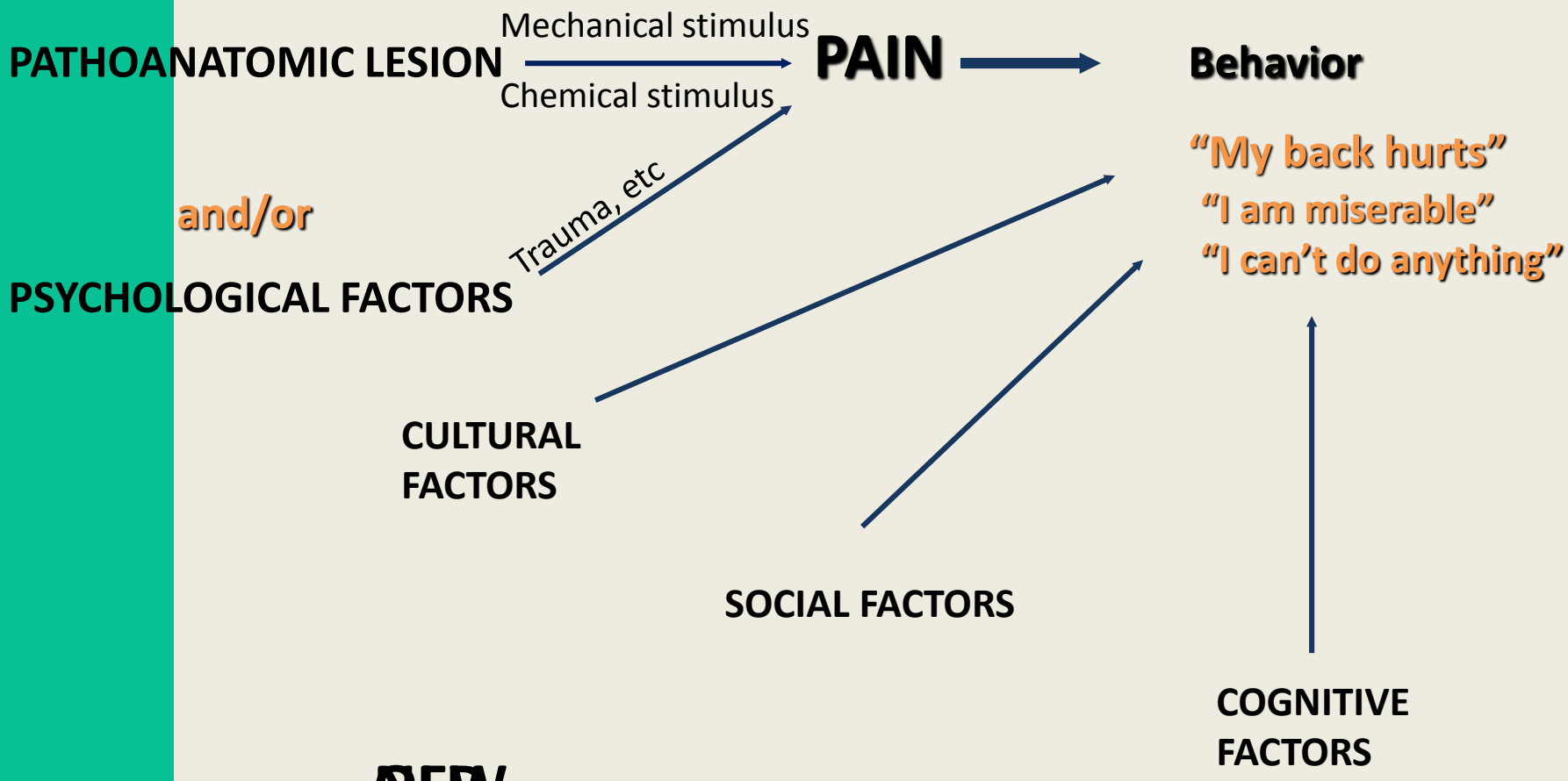
Overlap between brain activity in response to heat pain vs social rejection: SAME!

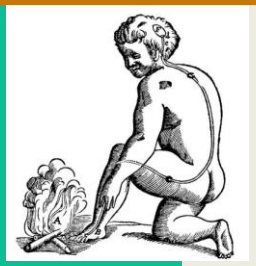


IASP updated definition of pain
(This is from **3** years ago)

Many people report pain in the absence of tissue damage or any likely pathophysiological cause; usually this happens for psychological reasons. There is usually no way to distinguish their experience from that due to tissue damage. If they regard their experience as pain, and if they report it in the same ways as pain caused by tissue damage, it should be accepted as pain. This definition avoids tying pain to the stimulus. Activity induced in the nociceptor and nociceptive pathways (the wiring of the nervous system) by a painful stimulus is not pain, which is always a psychological state, even though we may well appreciate that pain most often has a physical cause. - IASP 2011

The change in thinking embodied by the newer IASP definition of pain has led us to formulate a new approach





What is Pain: ACUTE PAIN, NO PSYCHOLOGICAL OR OTHER ISSUES

Painful Stimulus
(burn left foot)

Sensory processing
Of pain stimulus

Emotional processing
Of pain stimulus

Emotional Distress and
unpleasantness

PAIN and DISABLITY

"Ow, my foot's ON FIRE!"

Pain in a patient with psychological factors that change everything

Pain Stimulus (trauma, inflammation, heat, etc)

DEPRESSION, TRAUMATIC EXPERIENCE (WAR, ABUSE, DISASTER), ETC

Altered Sensory processing

Sensory processing Of pain stimulus

Emotional processing Of pain stimulus

Emotional Distress and UNPLEASEANTNESS

PAIN and DISABILITY

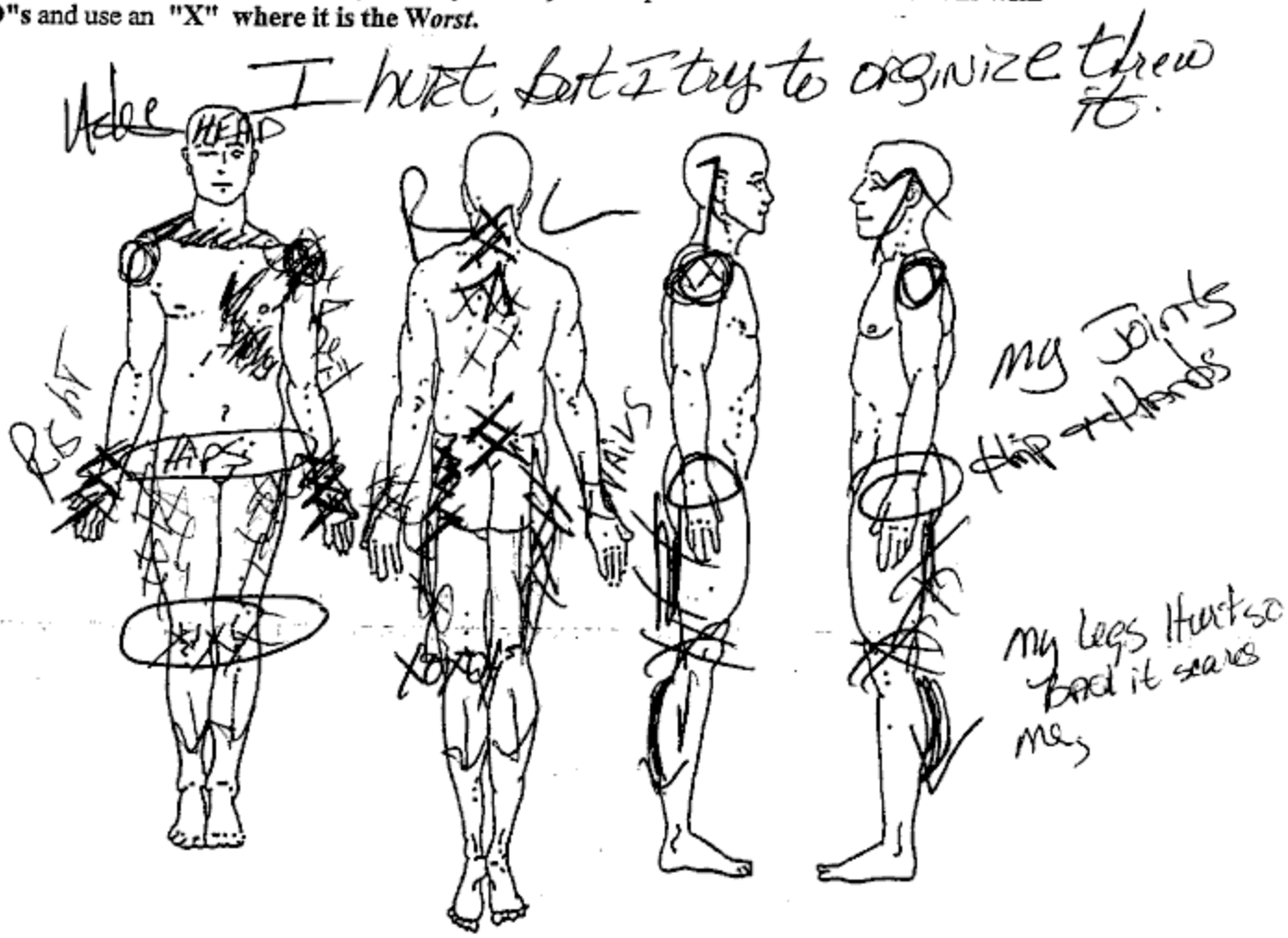
PAIN and DISABILITY

The next two slides describe a patient who was caught up in a hostage situation 3 years ago. She was unharmed – physically.

She presented to IPCA in referral from her PCP with complaints of 3 years of diffuse pain that was not responding to opioid at high doses.

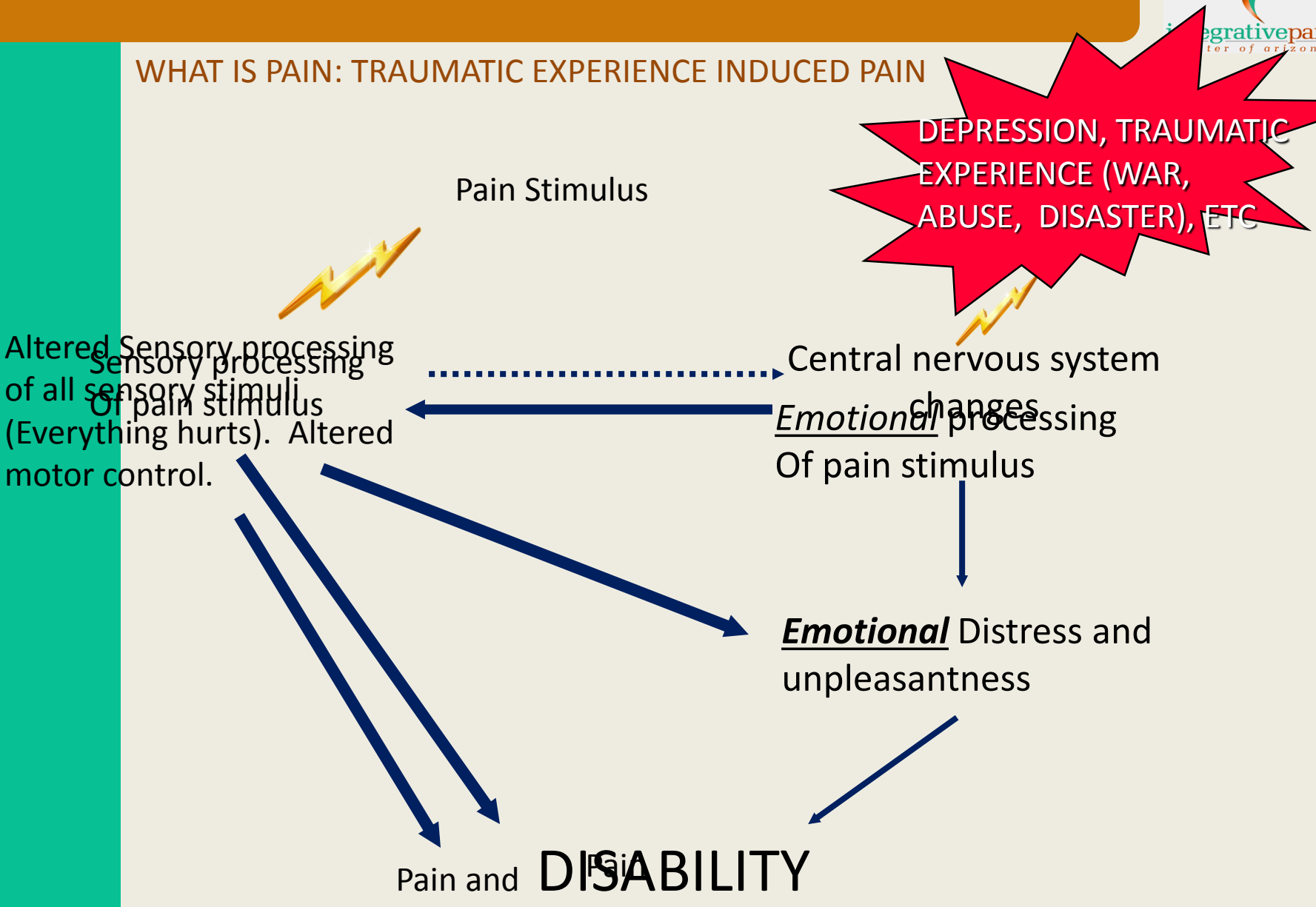
Referring diagnosis was “fibromyalgia”

Please fill in the "Pain Diagram" below to let us know where your pain is and where it hurts the worst. Shade or color the areas on your body where you feel pain. Mark **Severe Locations with "O"s** and use an **"X" where it is the *Worst*.**



13. Circle *all* words that describe your pain. (Circle ...

WHAT IS PAIN: TRAUMATIC EXPERIENCE INDUCED PAIN



Which statement best describes "Pain?"

a. Is always the consequence of tissue pathology.

b. Is a psychological state, always.

c. Is made up if the patient's response seems out of proportion to the tissue pathology and is always the consequence of tissue pathology.

d. Can occur without tissue pathology and is a psychological state, always.

#1: Patient engagement

#2: Put the Patient at the Center

#3 Live care coordination, build a truly integrated care team around the patient

#4: Know who the patient is

#5: Understand what pain is

#6: Use (and document) function to assess pain severity and treatment outcomes

Why is "evaluate function" and "use function as your pain treatment endpoint" worthy of mention in a Best Practice discussion?

First: Because we don't do it

76 audiotaped primary care back pain visits:

- 13.2% asked if the patient had taken time off work for back pain
- 14.5% asked if back pain interferes with work
- 10.5% asked if back pain interferes with social activities
- 19.7% asked if back pain interferes with activities such as driving, walking, etc.

TURNER JA, SPINE; 23: 463-469 1998

Why is "evaluate function" and "use function as your pain treatment endpoint" worthy of mention in a Best Practice discussion?

Second: because…

- Disability is the accepted measure of disease severity, adopted by the W.H.O. in 1996 as the "Disability Adjusted Life Year"
- Disability due to pain is the best way to measure pain severity
- Disability is why our patients come to us
- Disability is what our patients want us to reduce
- Disability costs money – patients, health plans, employers, government, military, etc

The patient's perspective on pain

Disability!

- 74% of patients indicated that they had significant interference with work
- 83% of patients rated receiving information on what could be done to return to normal activities as quickly as possible as "very/extremely important"

TURNER JA, SPINE; 23: 463-469 1998

And

Pain scales and pain related disability do not necessarily correlate well, meaning we need to track disability separately

In a formal study of the correlation between pain and disability, the relationship was week, with correlation coefficient of 0.3-0.4

Waddell G, Spine; 17: 617-628

Final comment: Why measure function?

Chronic opioid therapy for non-malignant pain is unsafe unless there are clear functional goals identified.

#1: Patient engagement
#2: Put the Patient at the Center
#3 Live care coordination, build a truly integrated care team around the patient
#4: Know who the patient is
#5: Understand what pain is
#6: Use function to assess pain severity and treatment outcomes
#7: Lifestyle Medicine is the foundation of pain medicine

Lifestyle Medicine for Pain

- Stress reduction
- Sleep
- Healthy diet and weight management
- Exercise
- Smoking cessation

Sample evidence for Lifestyle based recommendations

- Epidemiologic studies show that smoking is a risk factor for chronic pain
- Smoking has been identified as a major factor related to failure of back pain treatment

1. Shi Y Anesthesiology 2010 Oct;113(4):977-92
2. Behrend C Journal of Bone and Joint Surgery, 2012

Exercise

"Exercise therapy is effective (level A) at decreasing pain and improving function in adults with chronic low-back pain, particularly in populations visiting a healthcare provider. In adults with subacute low-back pain there is some evidence that a graded activity program improves absenteeism outcomes, though evidence for other types of exercise is unclear." (61 studies)

Hayden J "Exercise therapy for the treatment of non-specific low back pain" *Annals of Internal Medicine* 2005 May 3;142(9):776-85.

#8: Be proficient in primary care level in evaluating pain (history, basic psychosocial screening, and musculoskeletal and neurological examinations) in documentation, in risk assessment, and monitoring pain medications

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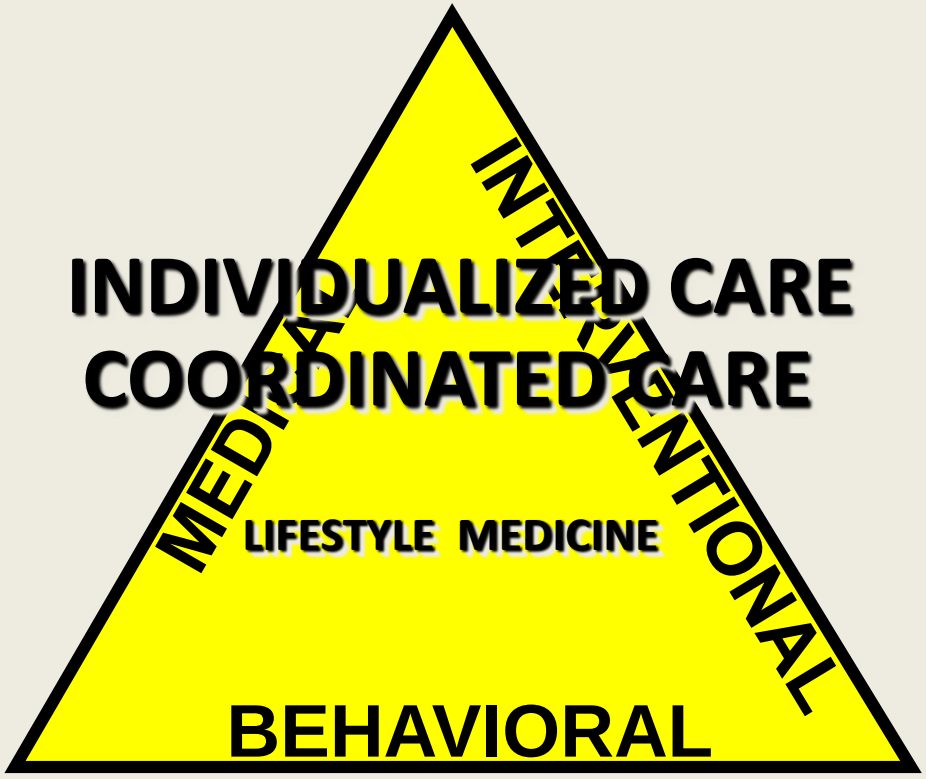
#9: Know when to refer, and to whom, for what.

- Get the right help before conditions become chronic.
- Understand the difference between interventional, medically focused, and interdisciplinary pain clinics.
- Develop relationships with physical therapists, chiropractors, massage therapists and other ancillary providers who are interested in helping you diagnose and manage – who are interested in being part of a team.
- Use training and support resources such as ECHO and teleconsulting

BEST PRACTICE IN EVLAUATION AND TREATMENT OF PAIN

A well-coordinated care team that understands the patient and engages the patient in individualized care through a healing relationship to help the improve function and stay well



A HEALING RELATIONSHIP BETWEEN PATIENT AND THE ENTIRE HEALTH CARE TEAM