Primary Care-Based Behavioral Treatment for Long-Term Opioid Users with Chronic Pain: PPACT Sustainability Learnings and Healthcare System Insights

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The “Ask” from KP leadership / impetus for the trial…

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

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

- Brief visits
- Complicated patients
- Gaps in coordination with specialty care
- Measurement and alert fatigue
- Limited pain treatment options

Policies/guidelines
- NCQA, State Medical Boards, DEA opioid prescription mandates
- Changes in expectations
- Shifting marijuana laws & policies
Pain Management in Usual Care

Primary Care
- Pain Clinic
- Hospital
- Membership Services
- Rheumatology
- Occupational Medicine
- Acupuncture Chiropractic Services
- Physiatry
- Sleep Clinic
- Neurology / Neurosurgery
- Social Work
- Case Management

Pt/OT

Interdisciplinary Pain Management Embedded in Primary Care

Behavioral Health Coach:
- Goal setting & Lifestyle Changes

Nurse:
- Care Coordination

Pharmacist:
- Medication Review

Physical Therapist:
- Improved Movement

Primary Care
**PPACT Overview**

**AIM:** Integrate interdisciplinary services into primary care to help patients adopt cognitive behavioral therapy (CBT) based self-management skills to:
- Manage chronic pain (decrease pain severity / improve functioning)
- Limit use of opioid medication
- Identify exacerbating factors amenable to treatment

*Focus on feasibility and sustainability*

**DESIGN:** Cluster (PCP)-randomized PCT (106 clusters, 273 PCPs, 850 patients)

**SETTINGS:** KP Georgia, KP Hawaii, KP Northwest

**ELIGIBILITY:** Mixed chronic pain conditions, long-term opioid tx (prioritizing ≥ 90 MME, benzodiazepine co-use, high utilizers [≥ 12 visits in 3 months])

**INTERVENTION:** Core 12-week CBT + yoga-based adapted movement groups led by behavioral specialist / nurse case manager, 2 physical therapy patient consultations (intake & mid-treatment), pharmacist medication review; PCP support

9,998 EHR identified potentially eligible patients invited

4,715 Patients not screened; cluster enrollment quota reached

5,283 Screened for eligibility (53% of invited)

Excluded:
- 2,706 Declined (51% of screened)
- 1,345 Barriers to in-person groups (25%)
- 121 Did not meet pain eligibility (2%)
- 260 Other ineligible (5%)

851 Enrolled (16% of screened)

433 Randomized to PPACT intervention
Follow-up assessments:
- 3 months – 86%
- 6 months – 88%
- 9 months – 85%
- 12 months – 84%

417 Randomized to usual care
Follow-up assessments:
- 3 months – 88%
- 6 months – 87%
- 9 months – 86%
- 12 months – 84%
PPACT Outcomes

Smith D, et al. Medical Care 2022
Sustaining PPACT

KPNW (and KPWA) – Uptake of shorter variant
- 3-5 sessions delivered by primary care-integrated behavioral health providers
- Challenge: Sustaining adequate therapist training/support; competing priorities and needing teams to support generalist needs

KP Hawaii – Malama Ola adaptation
- Challenge: LOTS of content and few visits

KP Georgia – No direct uptake
- Regional focus on health care system restructuring at study conclusion

Broad psychoeducation approaches with brief and limited contacts are common
PPACT Implementation Learnings

Patient/clinician experience and story critical – Positive clinical and cost outcomes important but not enough to drive sustained adoption

Logistic feasibility can “make or break” – Embedded primary care w/frontline staffing and group formats unrealistic for sustained delivery of sufficiently potent intervention

For highly stigmatized conditions, standard “study recruitment” insufficient to enroll those in need, undercutting potential impact for both patients and their PCPs

The “why” of health care system’s needs should guide planning and can morph over time – Iterative HCS communications and recalibration critical for success