



AN INTERVIEW WITH DR. LYNN DEBAR

**Principal Investigator,
Primary Care-based Collaborative
Care for Chronic Pain (PPACT) Trial**

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Dr. DeBar, a senior investigator at the Kaiser Permanente Center for Health Research in the Northwest, provided an update on the Primary Care-based Collaborative Care for Chronic Pain (PPACT) Trial at the April 2015 Collaboratory Steering Committee Meeting ([view slides](#)).

Background

At Kaiser Permanente Northwest, the associate director of patient quality and safety, and the chiefs of internal medicine, family practice, mental health, addiction medicine, and pain formed a working group to answer this question: How do we better manage patients with chronic pain who are on long-term opioid treatment? Primary care providers don't have the time or the training to actively promote alternatives to opioid treatment, and these patients use a lot of health care services, bounce from provider to provider, and belong to everybody and nobody at the same time.

Patients with chronic pain on long-term opioid treatment belong to everybody and nobody at the same time. We need a way to rigorously evaluate what will help them.

The working group approached Dr. Lynn DeBar, who suggested they design a study across multiple health care systems and write a grant for the NIH Health Care Systems Research Collaboratory. They involved the Georgia and Hawaii regions of Kaiser, which added diversity not only of patients but also of healthcare systems, because each system has developed and evolved in a unique manner.

Design

They developed the Primary Care-based Collaborative Care for Chronic Pain (PPACT) Trial to coordinate and integrate services for helping patients adopt self-management skills for managing chronic pain, limit use of opioid medications, and identify exacerbating factors amenable to treatment that are feasible and sustainable within the primary care setting. They are prioritizing patients who are on high doses (morphine equivalent dose ≥ 120 mg), on concurrent opioid and benzodiazepine, have a high utilization of primary care services (> 12 outpatient contacts / 3 months), or are nominated by their primary care provider (PCP).

After a patient is identified, a care manager team (nurse, behavioral specialist, physical therapist, and pharmacy consultant) evaluates the patient and communicates a patient-specific treatment plan (1-page summary) to the PCP. Other elements of the program include group sessions (goal setting, problem solving, yoga-based adapted movement, skills training, relaxation and imagery), individual coaching (to move patient toward goal attainment and coordination of services), periodic re-evaluation and revision of treatment plan, and encouraging the PCP to refer the patient for relevant ancillary

services. Randomization is at the level of the PCP, and the team anticipates enrolling 200-300 PCPs, with a total of approximately 1,200 patients anticipated to be enrolled. They have identified and trained individuals across the three regions who will staff the interventions, and have begun to fully implement the trial with rolling enrollment, with 88 PCPs and 266 patients enrolled.

Challenges

Sustainability. One of the biggest challenges is the tension between doing rigorous evaluation and building in sustainability. The healthcare systems needed this yesterday, but the team is still randomizing, and half the patients aren't getting the intervention. There is a real desire to see the data to determine if patients are reducing their emergency room and opioid use. For healthcare systems to invest heavily in sustaining this intervention, they want evidence that it works, and that creates tension.

Stability of control intervention. The control is usual care, but because there is such a desire to reduce opioid use, healthcare systems routinely perform internal experiments and have overlapping initiatives. The long-term implications of this are great because we need answers to this meaningful clinical question, but we compete for resources with the other initiatives, and need to collect information about what usual care is at each site, how it is changing, and how it relates to our study. Our control is not controlled. We can't control it. That's a big challenge.

Clinician Engagement. Although PCPs have been broadly enthusiastic and grateful for support, this intervention is challenging because it is new and requires a different clinical skillset to harmonize the support of the patient's self-care efforts with traditional treatments.

Patient Engagement. Helping patients and family members be more active in their care is not easy. These are patients who often perceive themselves as having had "failed" treatment at one or more times in the past and frequently feel stigmatized by those they interact with in the health care system. Such patients are often not

convinced that they can make changes in their lifestyle or day-to-day self-management efforts to improve the quality of their lives, and are consequently frequently anxious about having their opioids taken away or reduced. Some patients perceive (and health care providers often implicitly reinforce) that if they receive medications, injections, or surgeries then their pain is considered "real," whereas behaviorally focused care is often received suspiciously as a sign that providers think the pain is in the patients' head.

Patient-Reported Outcomes (PROs). PROs were not embedded into the system in a way that would enable us to pull the data from the EHR. We needed to build infrastructure, processes, and additional resources into the system to gather this information.

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Advice for the UH2 projects

1. When focusing on clinical issues considered critical and urgent, nothing is static. Everything is moving all the time. Everything is new in this hybrid between clinical care and pragmatic research. Resilience is required.
2. Adopt systems and processes that are native to the healthcare system whenever you can. At the various Kaisers, there are systems, processes, and project managers for change initiatives and quality improvement, and I wish we had substantively partnered with them earlier on in the process.
3. Be cognizant of what makes your research question a timely one, because the answer to this question portends challenges in implementation. Do we need this because there is a lack of existing services? If so, then the politics are simple. But if there are services that may or may not meet the needs of existing patients, then close work with the stakeholders is required.

Key goals

In early 2016, we're going to implement this more fully in Hawaii, and will expand our model for identifying and training staff in the Northwest.

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