Collaborative Care for Chronic Pain in Primary Care: Overcoming Patient, Provider, Data, and System Challenges in Implementing the Pragmatic Trial

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<thead>
<tr>
<th>KP Research Centers</th>
<th>KP Operations / Clinicians</th>
<th>Other Study Investigators</th>
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<td>Ashli Owen-Smith</td>
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PPACT Overview

**AIM:** Coordinate and integrate services feasible/sustainable in primary care for helping patients adopt self-management skills to:

- Manage chronic pain
- Limit use of opioid medication
- Identify exacerbating factors amenable to treatment

**DESIGN:** Cluster (PCP)-randomized PCT (*106 clusters, 273 PCPs, 851 patients*)

**ELIGIBILITY:** Chronic pain, long term opioid tx (*prioritizing high utilizers of primary care, ≥120 MEQ benzodiazepine use*)

**INTERVENTION:** Behavioral specialist, nurse case manager, PT, and pharmacist team; 12 week core CBT + adapted movement groups

**OUTCOMES:** Pain (3-item PEG), opioids, pain-related health services, and cost
<table>
<thead>
<tr>
<th>Barrier</th>
<th>Level of Difficulty</th>
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<tr>
<td></td>
<td>1</td>
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<tr>
<td>Engagement of clinicians and Health Systems</td>
<td></td>
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<tr>
<td>Data collection and merging datasets</td>
<td>X</td>
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<td>Regulatory issues (IRBs and consent)</td>
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<tr>
<td>Stability of control intervention</td>
<td>X</td>
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<tr>
<td>Implementing/Delivering Intervention Across Healthcare Organizations</td>
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1 = little difficulty
5 = extreme difficulty
Challenges: Enrollment and Engagement of Patients

• **Issues of continued importance**: Scrutiny on opioid prescribing → rapidly changing treatment landscape → confusion, fear, anger about care; chronic pain stigma and history of treatment failures

• **Other issues**: Tenacity of biomedical treatment model for pain and missed opportunity to apply chronic disease model / rigid study design

• **Group orientation sessions**: patient receptivity & intervention and assessment adherence but higher recruitment bar and staff intensive

• **Hindsight is 20/20**: relaxing design features included to prevent “contamination” would have helped (timing of patient enrollment, flexibility in group attendance)
Challenges: Engagement of Clinicians / Implementing & Delivering across HCSs

- **Issues of continued importance:** Staffing (implementation within an evolving primary care model re: nurse and behavioral specialists; also who is HCS willing to give time from?)

- **Other issues:** Design not able to capitalize on PCP learning (& brevity of intervention availability seen as “research business as usual”); challenged to leave staffing support in place; opioid-driven urgency for system-wide treatment change

- **Hindsight is 20/20:**
  - Better designs? Participant level randomization or – if time and resource feasible and baseline pain PROs routinely available – stepped wedge
  - Ask less of staff (development of new skill set) & pull more of intervention online (newer tailored technology driven options)
Other Challenges

• **Merging data sets**: KPH reluctance to share medical health record numbers (despite sharing PHI) consequently requiring cumbersome multi-step crosswalk design and limiting central QA and assist options

• **(In)stability of usual care**: Opioid tapering efforts continue to accelerate (Spring 2016 CDC primary care prescribing guidelines), often addressed by simultaneous poorly coordinated and shallow clinical initiatives
...and Successes

- **PRO Integration**: KP-wide instrument change that increased clinical utility *and* scientific rigor; scalable infrastructure for routine PRO delivery – health care systems interested in broader adoption

- **Model for staff training**: Despite little foundational training, full proficiency in intervention delivery (& skills valued by health plan); flexible training model; shift in understanding of chronic pain and self-efficacy for helping patients to manage

- Numerous individual success stories with very complex chronic pain patients and chronic pain fatigued clinicians

- Interest / commitment to sustain PPACT intervention in whole or part
Overarching Lessons Learned

• Challenging the status quo requires persistent and deep *vertical* health care system partnership

• With timely and clinically important research questions expect dynamic practice environment and sense of urgency

• Health care systems still need assist for routine collection of patient reported outcomes such as pain

• Framework of change, communications, choices for design and assessment should be as native to health care system as able

• For chronic pain, mind/body split still deeply embedded in the “behavior” of health care systems