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

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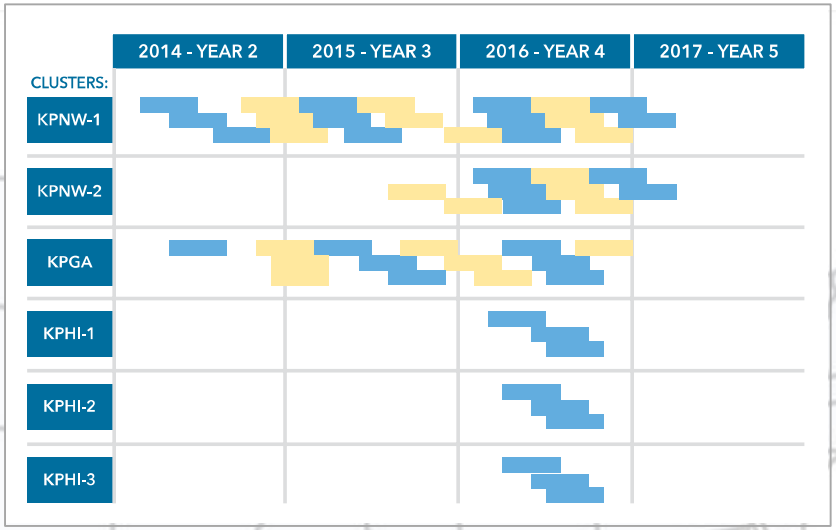

PPACT Overview

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

Barriers Scorecard

Barrier	Level of Difficulty				
	1	2	3	4	5
				X →	X
Engagement of clinicians and Health Systems				← X →	
Data collection and merging datasets		X	→ X		
Regulatory issues (IRBs and consent)		X			
Stability of control intervention				X →	X
Implementing/Delivering Intervention Across Healthcare Organizations			X	→ X	

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