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Using Technology to Transform Pain Care in Primary Care

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Quinnipiac University

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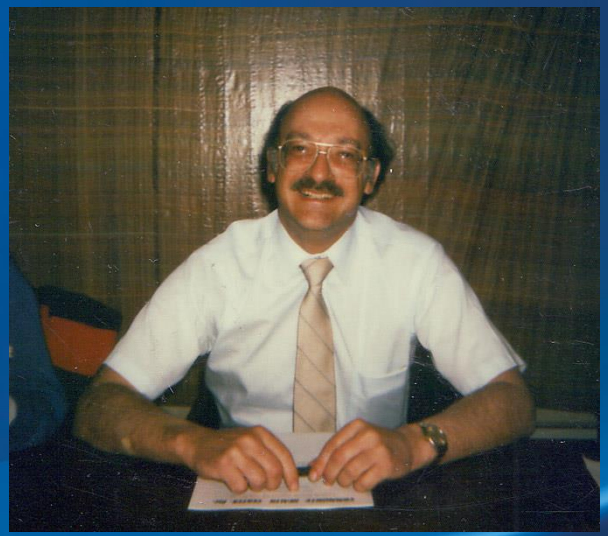
The Weitzman Institute

Committed to improving primary care for underserved populations
by promoting research, training, education, and innovation

The Mission…

…to inspire innovation through research, education, and quality improvement to ensure that effective, efficient and equitable primary care is available to all.



Research


Do you want to quit smoking?
Do you have Medicaid Insurance?
Do you want the chance to earn up to $350?
Call to sign up today for this research study
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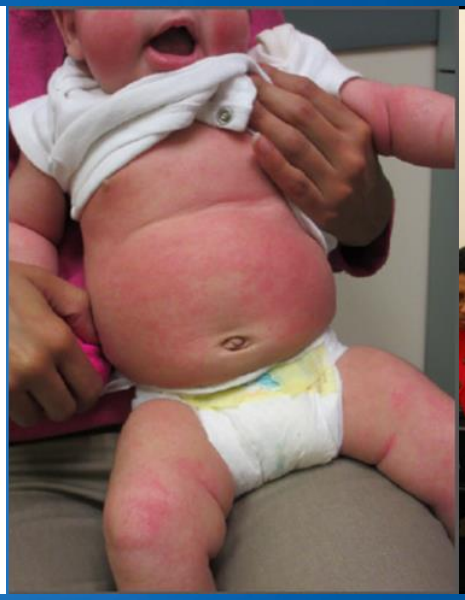
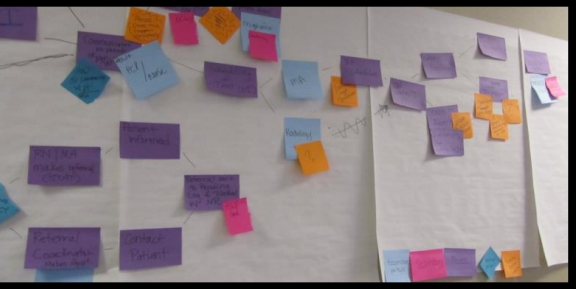
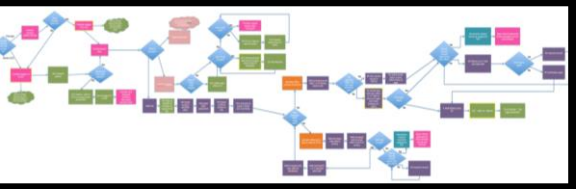
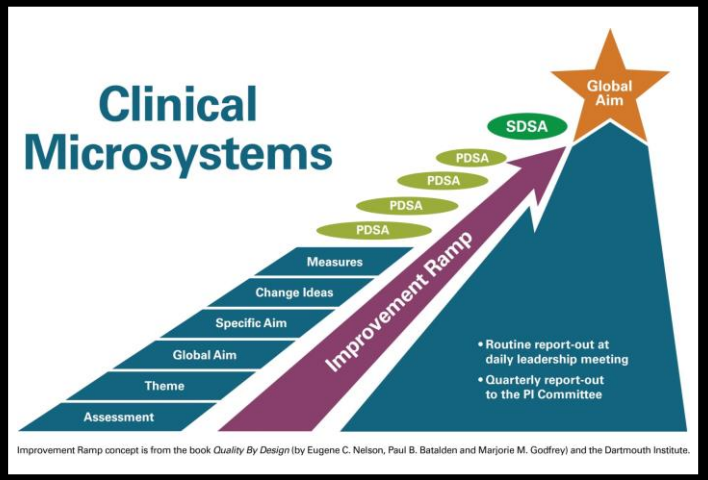
Rewards to Quit is a research study sponsored by:
Community Health Center, Inc.
Weitzman Quality Institute
HUSKY HEALTH





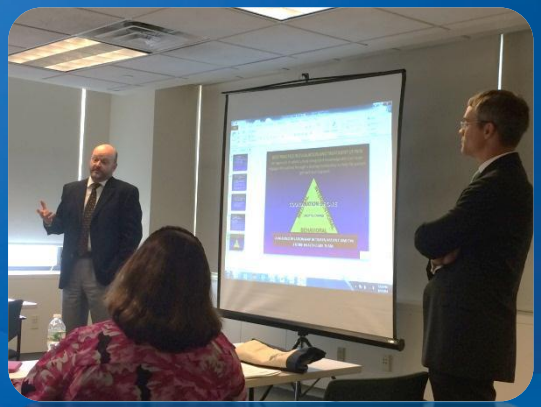


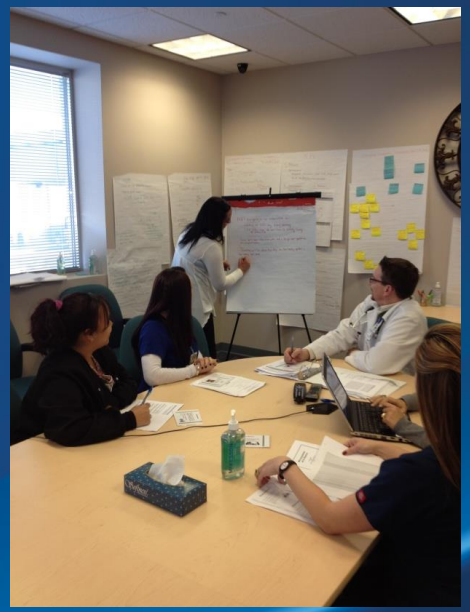


Quality Improvement

Leading National Improvement Collaboratives

- Chronic Pain Improvement Collaborative
- Team-based Care Collaborative
- LGBT Health Collaborative





Our National Academic Partners

Background

- Chronic pain affects approximately 100 million Americans[1] and costs more than $635 billion in medical treatment and lost productivity[2]
- Majority of patients with pain seek care in a primary care setting[3]
- Primary Care Providers express low knowledge and confidence in pain management and receive little pain management education[3]
- Opioids are heavily relied on for pain management in primary care
- Prescription opioid overdose is a major and growing public health concern

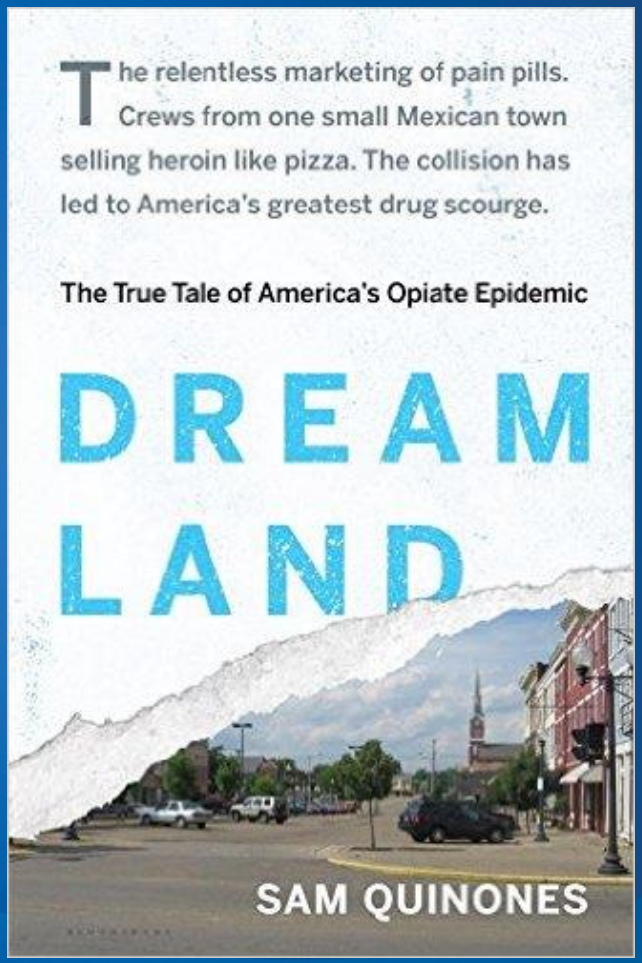
SundayReview | CONTRIBUTING OP-ED WRITER

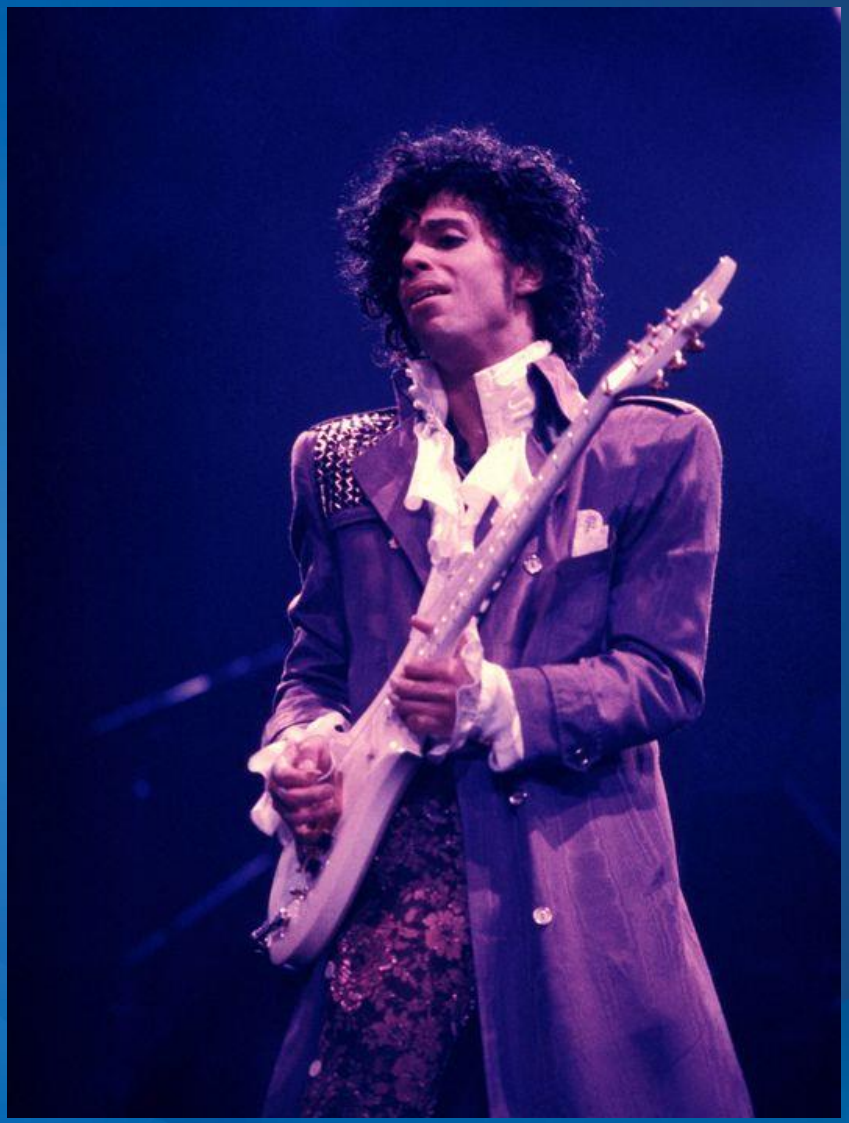
How Doctors Helped Drive the Addiction Crisis

Richard A. Friedman NOV. 7, 2015

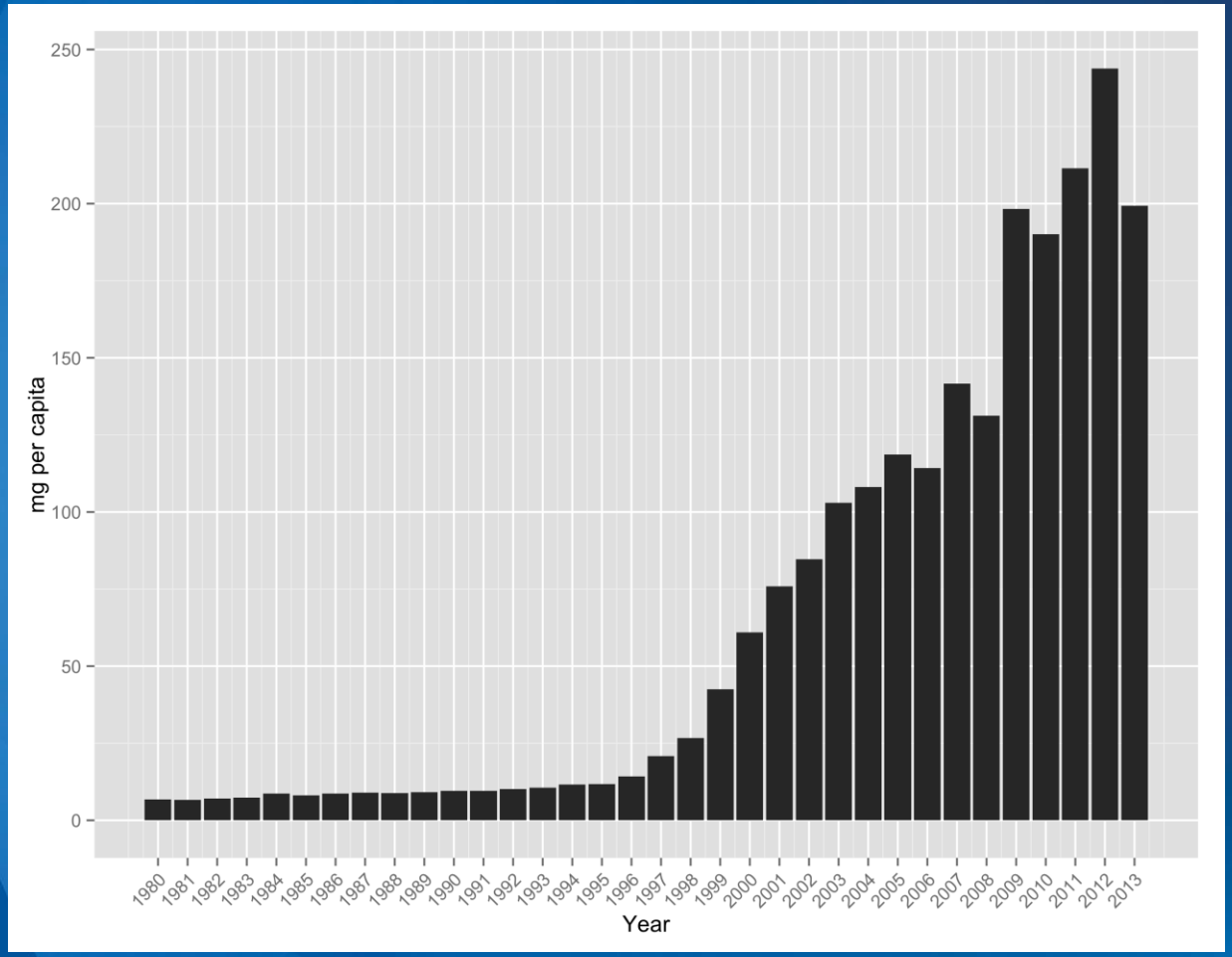
THERE has been an alarming and steady increase in the mortality rate of middle-aged white Americans since 1999, according to a study published last week. This increase — half a percent annually — contrasts starkly with decreasing death rates in all other age and ethnic groups and with middle-aged people in other developed countries.

So what is killing middle-aged white Americans? Much of the excess death is attributable to suicide and drug and alcohol poisonings. Opioid painkillers like OxyContin prescribed by


The relentless marketing of pain pills. Crews from one small Mexican town selling heroin like pizza. The collision has led to America's greatest drug scourge.
The True Tale of America's Opiate Epidemic
DREAM LAND
SAM QUINONES

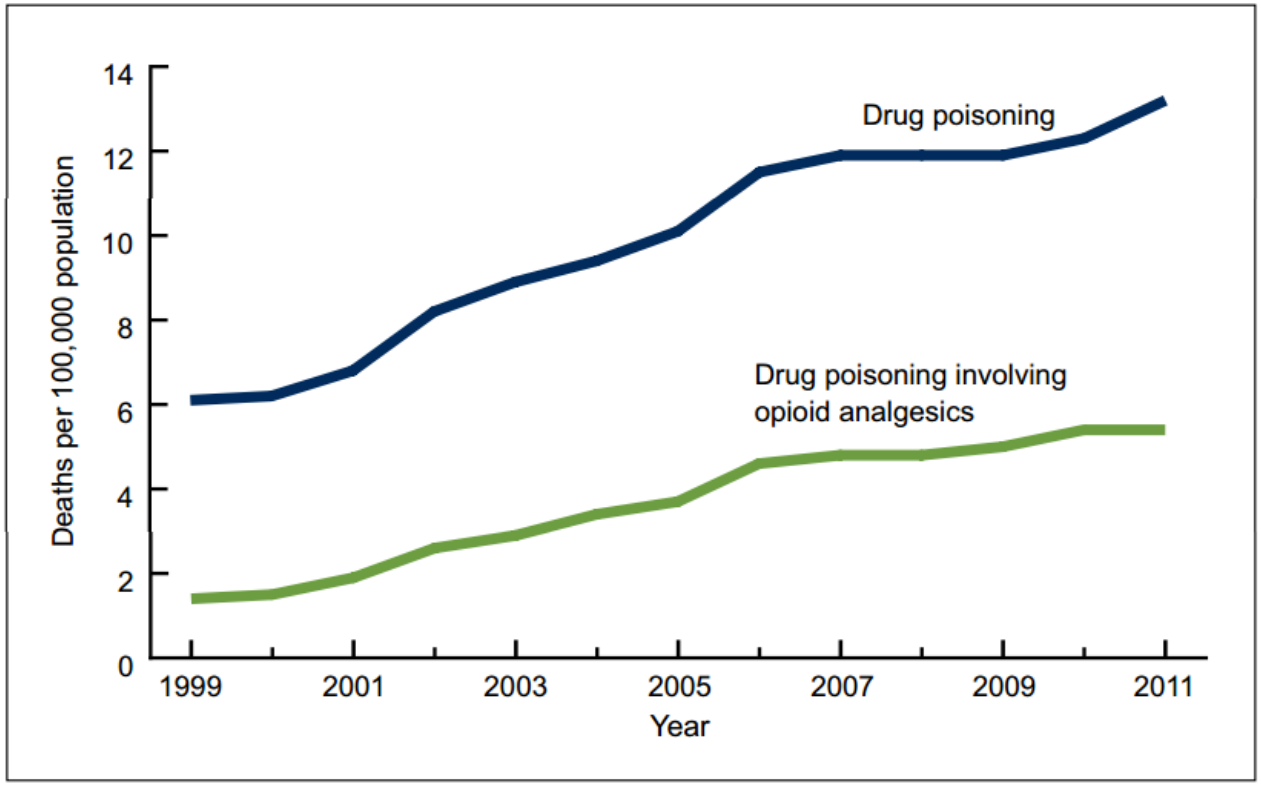


Oxycodone Consumption (mg/capita) 1980-2013



CDC: Drug Poisoning Death Rates

Figure 1. Age-adjusted drug-poisoning and opioid-analgesic poisoning death rates: United States, 1999–2011



NOTES: The number of drug-poisoning deaths in 2011 was 41,340, and the number of drug-poisoning deaths in 2011 involving opioid analgesics was 16,917. Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db166_table.pdf#1.
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality File.

Sources of Opioid Analgesics

Setting Type	% Distribution
Emergency department	**39%**
Primary care office	**31%**
Medical specialty office	**13%**
Surgical specialty office	**10%**
Hospital outpatient department	**7%**

Source: National Center for Health Statistics. Medication therapy in ambulatory medical care: United States, 2003-04

Pain patients are like beach balls at a rock concert…

And Primary Care needs to catch the ball

TOOLS AND STRATEGIES TO HELP PRIMARY CARE PROVIDERS MANAGE PAIN

Moving Knowledge, Not Patients

PROJECT ECHO®

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inspiring primary care innovation

Project ECHO

"The mission of Project ECHO is to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes."
Dr. Sanjeev Arora, University of New Mexico

Weitzman ECHO Learning Community

Since Jan 2012

PROJECT ECHO®

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inspiring primary care innovation

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PROJECT ECHO®

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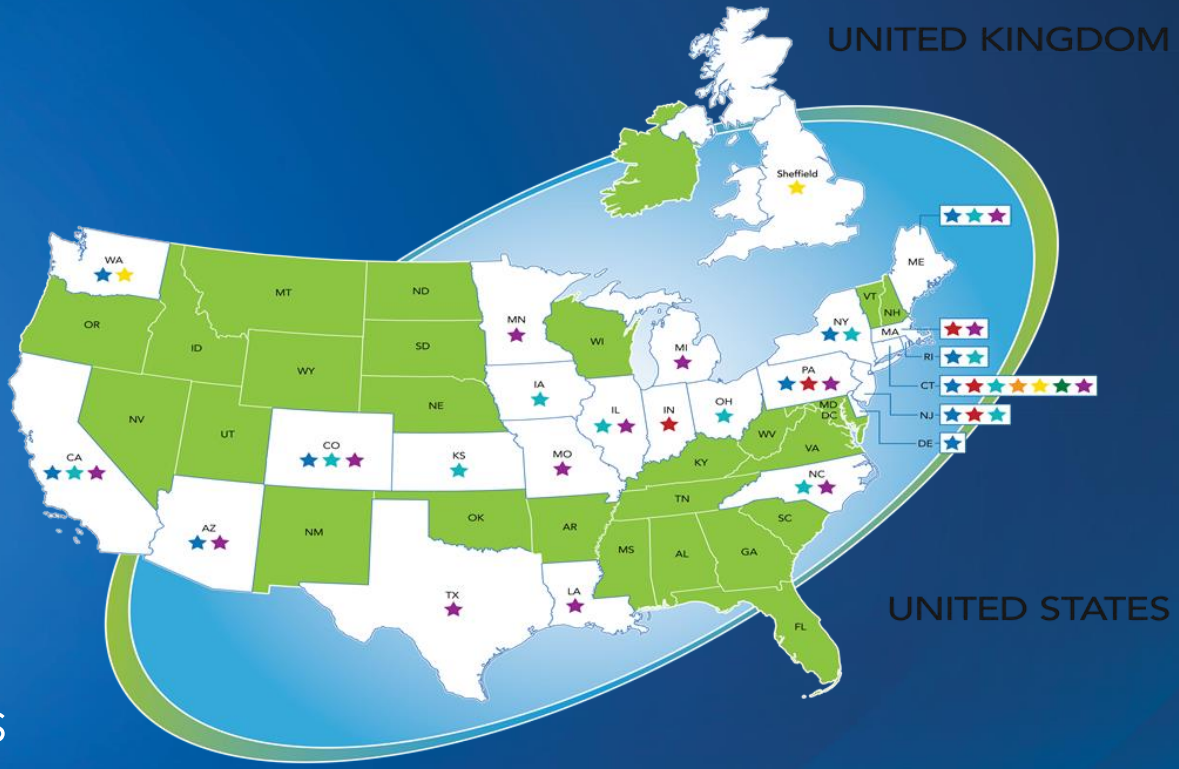
Weitzman Institute ECHO Learning Network

- 119 Practices
- 405 ECHO Sessions
- 1475 Case Presentations
- Primary care providers from 23 States

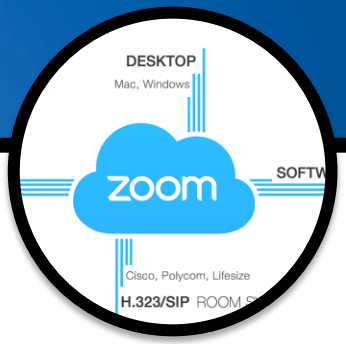


- Project ECHO® Pain
- Project ECHO® Hepatitis-C/HIV
- Project ECHO® Buprenorphine
- Project ECHO® Pediatric and Adolescent Behavioral Health
- Project ECHO® Quality Improvement
- Project ECHO® Complex Care Management
- Project ECHO® LGBT Health

Technology requirements

Webcam/ Computer iPad/ Smartphone for End-Users

Video Conferencing System for ECHO Team



Cloud-based Teleconferencing Platform (Zoom©)

Recorded/ Catalogued Sessions

Streaming Sessions

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Integrative Pain Center of Arizona

Bennet Davis, MD, Founder IPCA
Anesthesiology, orthopedics, and Pain Medicine

Cela Archambault, Ph.D., Founder IPCA
Clinical Psychology, Health Psychology and Pain Management

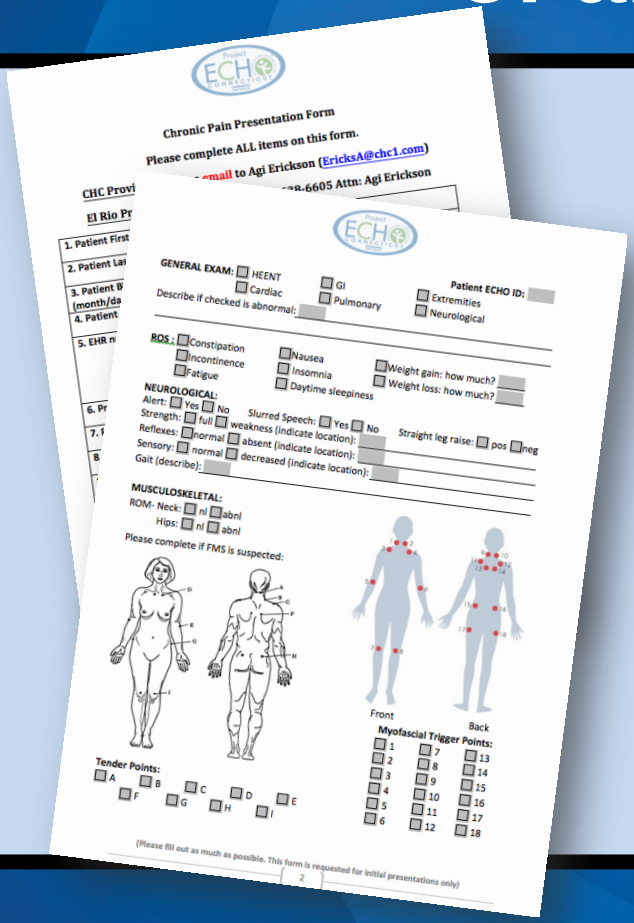
Jennifer Schneider, MD, Ph.D.
Internal Medicine, Addiction Medicine and Pain Management

Amy Kennedy, PharmD, BCACP
Clinical Assistant Professor at the Univ. of Arizona College of Pharmacy and Clinical Pharmacist

Kathy Davis, RN, ANP-C, Founder IPCA
Primary care, pain management

Ancillary staff: *Chinese medicine, rehabilitation/occupational medicine, nutrition*

Key Elements of an ECHO Session



Case Presentations

- 2-3 Cases per ECHO session
- Co-presented by PCP and BH Provider
- Complex cases
- Multi-disciplinary consultation available
- Valuable for discussion and teaching
- Total time = 1.5 hours

Didactic Presentations

- 1 per session
- Focused and topical
- By expert faculty
- Total time < .5 hour

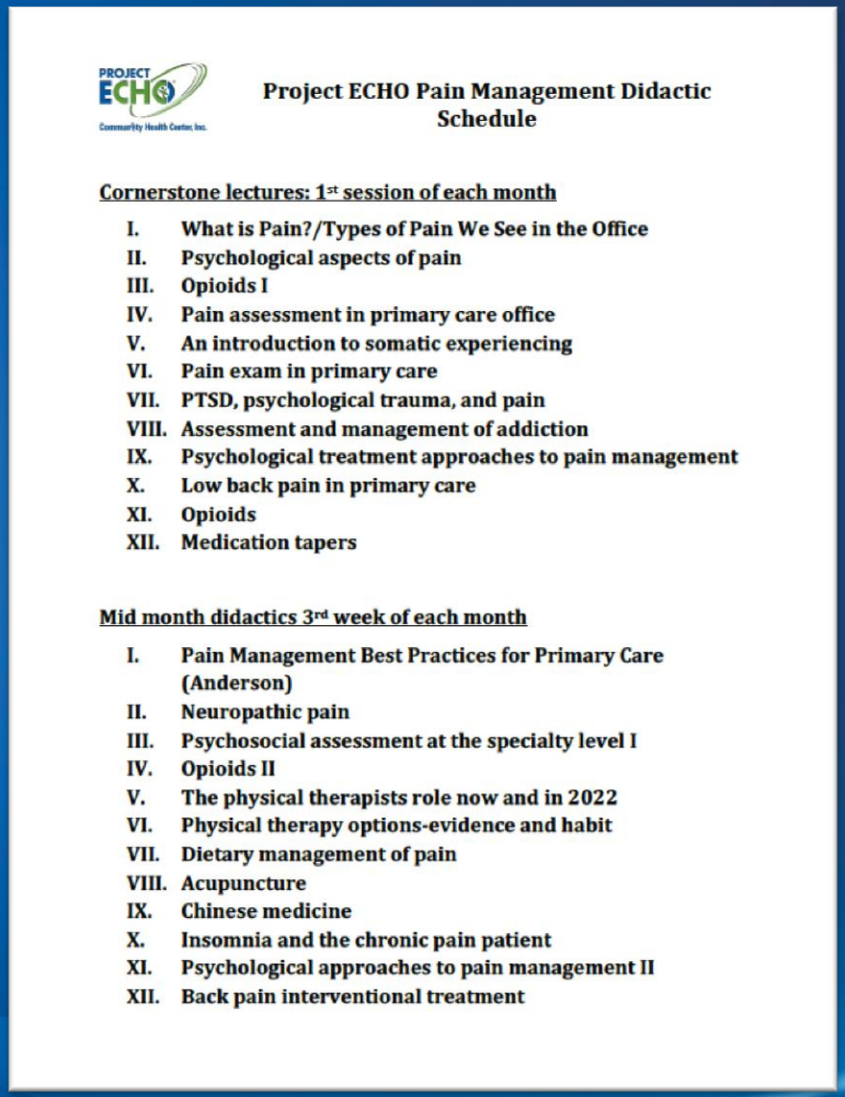
Integration of Medical and Behavioral Health

- Primary care providers and behavioral health providers encouraged to attend sessions and co-present
- Didactic lectures on medical and behavioral health topics with emphasis on how to integrate the two at the primary care level
- Care plan recommendations include BH and medical recommendations

integrative pain center of arizona

Pain ECHO Curriculum

- Monthly core session with second optional session



PROJECT ECHO
Community Health Center, Inc.

Project ECHO Pain Management Didactic Schedule

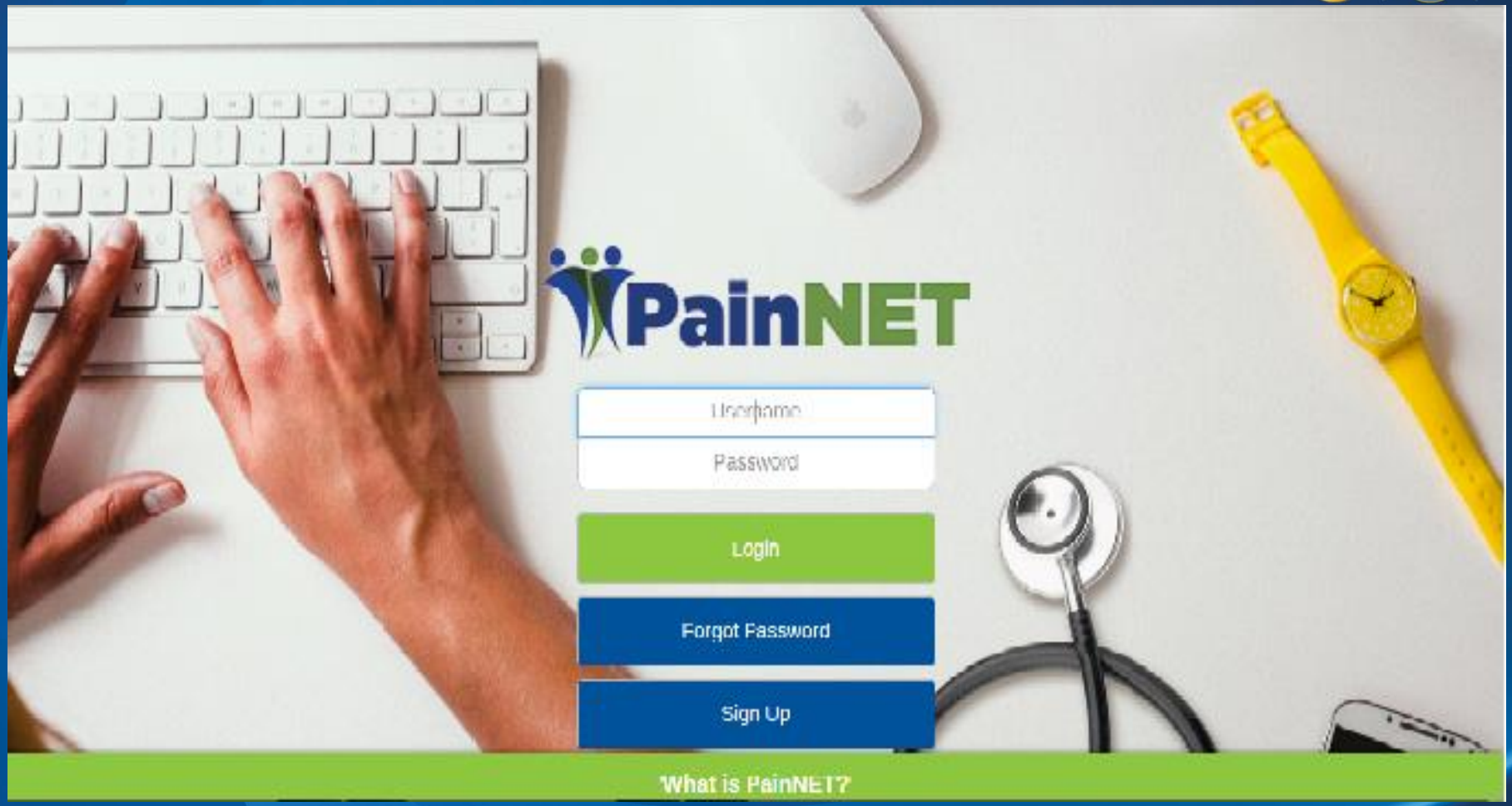
Cornerstone lectures: 1st session of each month

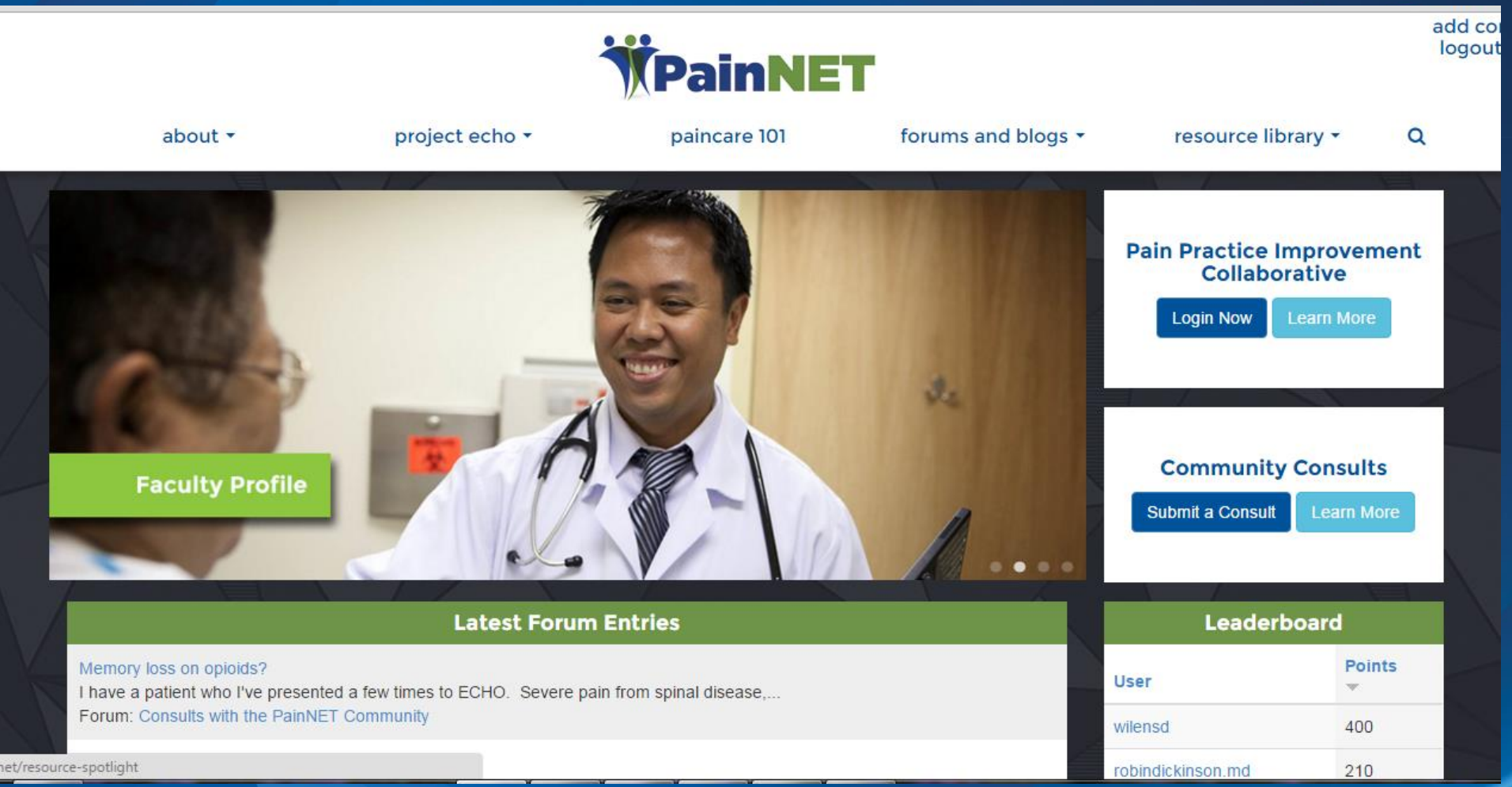
I. What is Pain?/Types of Pain We See in the Office
II. Psychological aspects of pain
III. Opioids I
IV. Pain assessment in primary care office
V. An introduction to somatic experiencing
VI. Pain exam in primary care
VII. PTSD, psychological trauma, and pain
VIII. Assessment and management of addiction
IX. Psychological treatment approaches to pain management
X. Low back pain in primary care
XI. Opioids
XII. Medication tapers

Mid month didactics 3rd week of each month

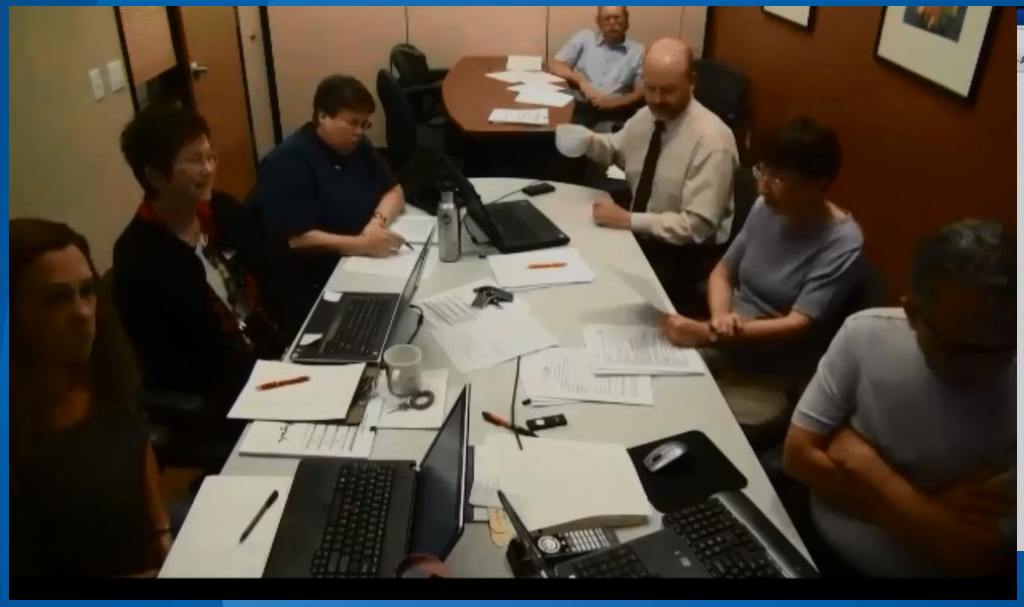
I. Pain Management Best Practices for Primary Care (Anderson)
II. Neuropathic pain
III. Psychosocial assessment at the specialty level I
IV. Opioids II
V. The physical therapists role now and in 2022
VI. Physical therapy options-evidence and habit
VII. Dietary management of pain
VIII. Acupuncture
IX. Chinese medicine
X. Insomnia and the chronic pain patient
XI. Psychological approaches to pain management II
XII. Back pain interventional treatment

PainNET


PainNET
Username
Password
Login
Forgot Password
Sign Up
What is PainNET?


PainNET
add co
logout
about
project echo
paincare 101
forums and blogs
resource library
Faculty Profile
Pain Practice Improvement Collaborative
Login Now
Learn More
Community Consults
Submit a Consult
Learn More
Latest Forum Entries
Memory loss on opioids?
I have a patient who I've presented a few times to ECHO. Severe pain from spinal disease,...
Forum: Consults with the PainNET Community
Leaderboard
User
Points
wilensd
400
robindickinson.md
210

Each case recorded and indexed
Key cases condensed and edited



STarT Back Screening Tool Website / Online Tool

Keele STarT Back Screening Tool	No	Yes
Has your back pain spread down your leg(s) at some time in the last 2 weeks	●	○
Have you had pain in the shoulder or neck at some time in the last 2 weeks	○	●
Have you only walked short distances because of your back pain	●	○
In the last 2 weeks, have you dressed more slowly than usual because of back pain	●	○
Do you think it's not really safe for a person with a condition like yours to be physically active	○	●
Have worrying thoughts been going through your mind a lot of the time	○	●
Do you feel that your back pain is terrible and it's never going to get any better	○	●
In general have you stopped enjoying all the things you usually enjoy?	○	●

Overall, how bothersome has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much
○	○	○	●

ECHO ID 200227

36y M w/ peripheral neuropathic pain in lower extremities due to DM. HepC+, meth use, smoker. On max gabapentin & still has pain. What are the next steps in improving pain control? Would you bother changing to Lyrica or add other adjuncts to current regimen?

- about
- project echo
- paincare 101
- forums and blogs
  - clinicians' corner
  - discussion forums
  - community consults
- resource library
- search

Forums and Blogs

See what our community has to say!

Clinicians' Corner

Informative blog posts from a variety of specialists and primary care providers.

Chiropractic Evaluation and Management of Cervicogenic Headaches
Cervicogenic headache is a specific type of headache that originates from the cervical spine and is typically chronic in nature. Diagnostic criteria for... **read more**

Negative emotional reactivity to daily

Discussion Forums

A general forum to share thoughts and questions with the PainNET community.

Dr Doerwalt's questions/commentary
In regards to this announcement from the CDC: http://www.cdc.gov/mmw
Forum: General Discussion
2 replies

What to do if you have concerns about someone's prescribing?
I just got off the phone with a pharmacist about a pain patient I fired for violating his contract...

Community Consults

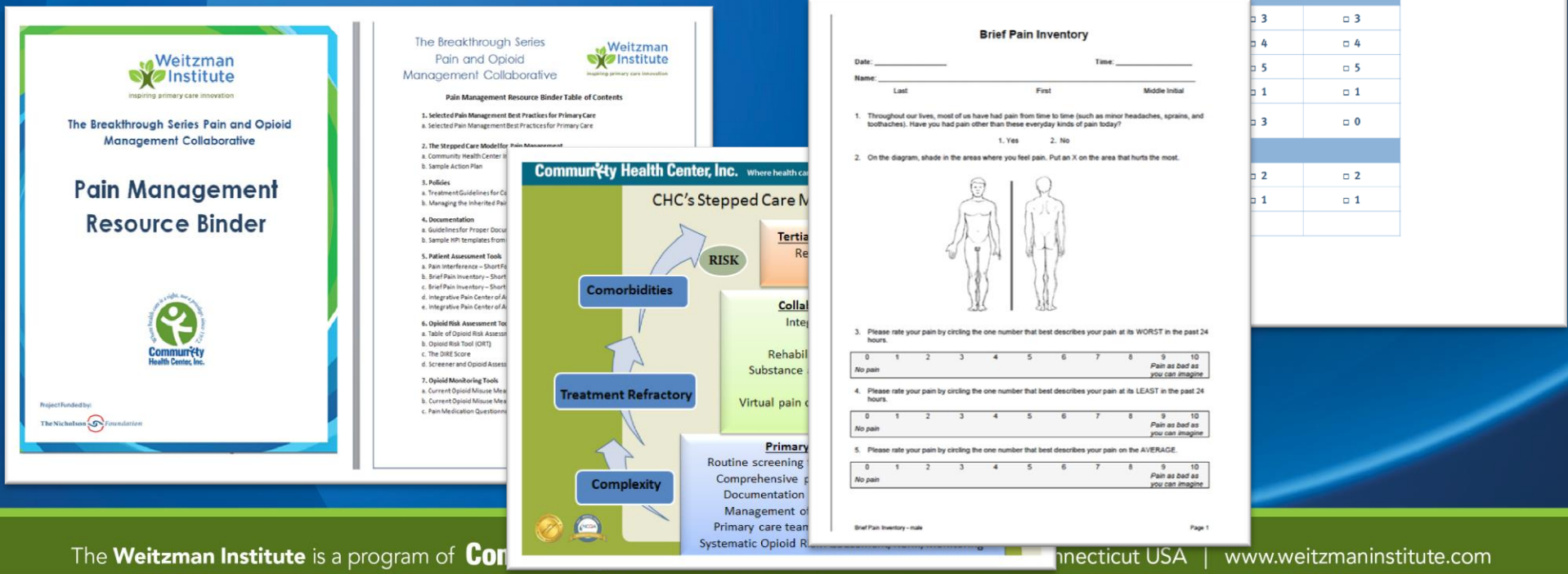
A page to post your case-related questions for feedback and recommendations.

Memory loss on opioids?
I have a patient who I've presented a few times to ECHO. Severe pain from spinal disease,...
Forum: Consults with the PainNET Community

Pain Management for Diabetic Neuropathy
65 y/o AA male w/ a hx of ESRD (on dialysis x 3/wk), diabetic neuropathy, Hep C (advanced fibrosis...
Forum: Consults with the

Resource Library

- Tools for implementing pain care best practices
- Patient and practice assessments
- Community generated resources




COMMUNITY
ECONSULT
NETWORK

Community eConsult Network

Pain Management eConsult

continued

10/21/2015 01:33 PM

52 yo female with hx of lumbar spine decompression surgery 6 years ago and continued stenosis and pain with radiculopathy and neuropathy. Hx of left hip pain on MRI shows left gluteal tear and surrounding muscular atrophy Tried and failed Physical therapy, Hx of osteoporosis and gets reclast once a year Tried and failed fentanyl patches with pain management and does not want to go back on this medication Currently on MS contin 15mg 2 tabs BID and Percocet 7.5 TID, Gabapentin 800 mg TID, Voltaren gel PRN and ibuprofen PRN for pain relief

My plan: Rerefer to pain management, rerefer to physical therapy, obtain most recent lumbar MRI to assess if patient needs to see orthopedic surgeon again, goal is to decrease her narcotics doses that she came to me on Questions: [1] What further management can I offer this patient? [2] For gluteal tear, is PT contrindicated as this was a concern? [3] Any other recommendations. Thank you!

Hello! Dr [redacted] here.

Physical therapy is the ticket for the gluteal tear. Not contraindicated at all. If there is a complete tear of the tendon and there is really nothing that can be done other than improve the mechanics of the hip using surrounding muscles. The patient will need to be very compliant with home exercise program, this is the kind of thing that people need to work on at least 4 days a week with her home exercise program.

You didn't mention weight, if the patient is overweight, that weight loss will help quite a bit with hip mechanics and reduce the chance of degenerative disease related to the dysfunction of the hip muscles.

As far as exercise, cardiovascular exercise might include pool therapy when this is available if it is available and recumbent bike that sort of thing. That is going to be very important for protecting the hip and the back as well.

I would suggest that before you make the goal of decreasing narcotics use for a goal for transitioning to an aggressive lifestyle medicine-based program that includes exercise, weight loss if indicated, improving sleep. It is always best to do that before you start focusing on the opioid unless the opioid is causing severe side effects that need to be addressed through a decrease or unless you were concerned about misuse or diversion of the opioid.These are not big doses. One small change might be to change to 30 mg twice a day of MS Contin and eliminate the Percocet, or 15 mg 3 times a day and eliminate the Percocet. Regardless of the FDA labeling, MS Contin often does not last 12 hours, t.i.d. dosing is the most common dosing regimen United States, consequently.

Pain Management eConsult

cont'd

Make sure to set concrete functional goals, what is it she is not able to do that she would like to do? What is she able to do but not as well as she would like to? Use those to measure progress, Not changes in medication doses - although reductionin medication dosecan beA secondary outcome measure.

Finally, reviewing the MRI to see if there is persistent or recurrent nerve root compression the that might relate to leg pain/sciatica is a good idea. It may be that you're pain medicine consultant (we want to get away from using the phrase "pain management" because that is often connotes pharmacotherapy and pulses back to talking about pills instead of the things we want to talk to patient about) can do epidural injections, and if there is severe stenosis, he might refer for surgical evaluation if the patient is interested. However, a good lifestyle medicine plan that includes exercise, working on sleep, weight loss, smoking cessation (generic recommendations since I don't know this patient well) needs to be established first. A great reference for how to prep your patient for surgery (and how to recognize a patient who isn't ready) can be found on page 212 of Dr David Hanscom's book "Back in Control" http://www.amazon.com/Back-Control-surgeons-roadmap-chronic/dp/0988272903 .

Please let me know how helpful this is!

Pain Practice Improvement Collaborative

Goals:

- Provide support to practice teams for implementing best practices for pain care
- Provide expanded QI education and training for participating sties
- Develop measures for assessing quality of pain care and use them to track and measure success

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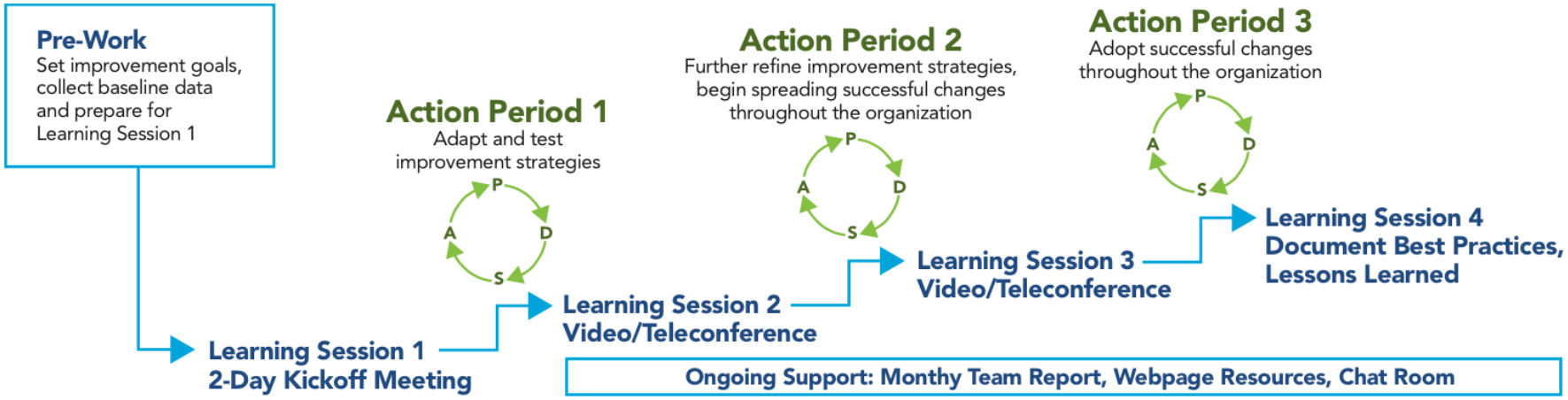
Institute for Healthcare Improvement Breakthrough Series Collaborative

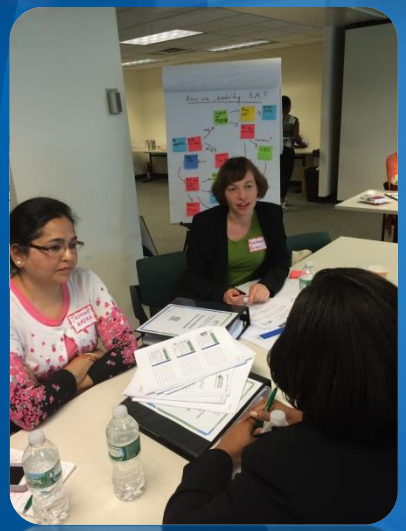
Participants (10-100 teams)

Schematic for the Breakthrough Series Pain Management Collaborative



Dissemination: Publications, Congress, etc.

Purpose of BTSC:



- Engage frontline teams in practice redesign
- Systems-level mechanism to implement best practices for pain management and buprenorphine prescribing in primary care
- Provide basic QI training
- Enhance the impact of Project ECHO
- Encourage partnerships across FQHC sites in promoting learning and best practice adoption

Monthly Team Reporting Template

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				Mandatory Measures - Chronic Pain									Mandatory Measures - Chronic Opioids								
			Best practice	Use a template or standard pain assessment form for all pain management visits			Provide pain management education material to all patients with chronic pain			Refer all patients with chronic pain and any substance abuse or mental health issues to behavioral health			Require a signed Opioid Agreement/contract for all patients receiving Chronic Opioid Therapy (COT)			Require periodic urine toxicology screening test for all patients receiving Chronic Opioid Therapy (COT)			Check the state prescription drug monitoring program (PDMP) prior to each pain management visit for all patients receiving Chronic Opioid Therapy (COT)		
			Measure	Number of patients in POF-chronic pain who have a completed pain assessment form or template at their most recent pain management visit			Number of patients in POF-chronic pain who have documentation in the chart of having received pain management educational material at least once in the past year			Number of patients in the POF-chronic pain with any behavioral health or substance abuse diagnosis who have been referred to a behavioral health provider in the past year			Number of patients in the POF-chronic opioids with a signed opioid agreement in the chart			Number of patients in the POF-chronic opioids with documented urine toxicology screening test results in the past three months			Number of patients in the POF-chronic opioids with documentation in the chart that the PDMP was checked at the last pain management visit		
	POF - Chronic Pain*	POF - Chronic Opioids**		# PCPs	Total # Pts Meeting Criteria	% Goal Achieved	# PCPs	Total # Pts Meeting Criteria	% Goal Achieved	# PCPs	Total # Pts Meeting Criteria	% Goal Achieved	# PCPs	Total # Pts Meeting Criteria	% Goal Achieved	# PCPs	Total # Pts Meeting Criteria	% Goal Achieved	# PCPs	Total # Pts Meeting Criteria	% Goal Achieved
Jul-14						#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
Aug-14						#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
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Dec-14						#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
Jan-15						#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
Feb-15						#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
Mar-15						#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

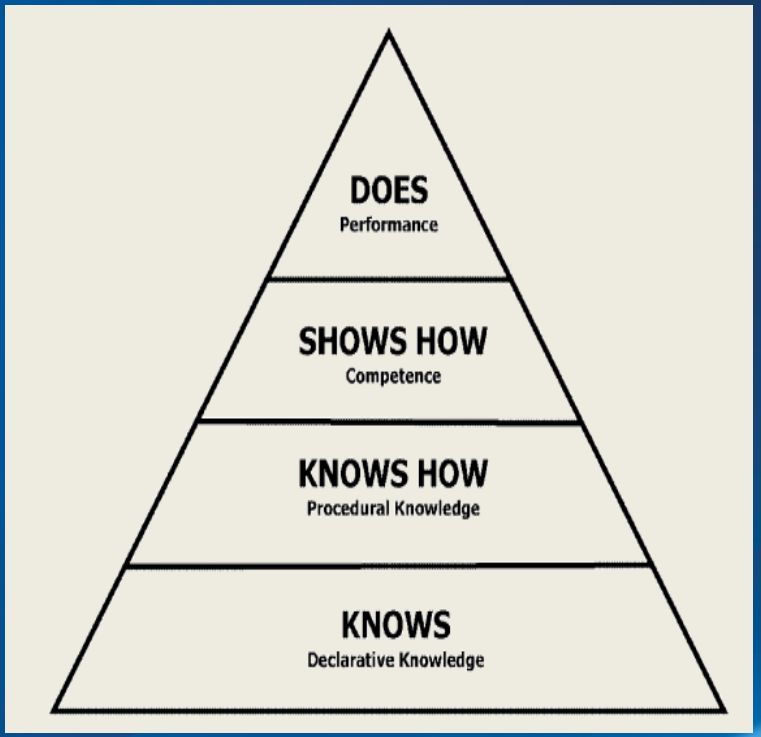
*POF Chronic Pain = Patients with a painful condition causing pain on all or most days, that lasts for >90 days
** POF Chronic Opioids = Patients receiving chronic opioid therapy (COT), defined as one or more opioid prescriptions for 90 days or more, in the past year

				Optional Measures - Prescribing Practices									Optional Measures - Care Coordination								
			Best practice	Track PCPs' % panel on opioids (PPO) and evaluate variation in prescribing practices			Monitor and minimize the co-prescribing of benzodiazepines, stimulants and opioids			Monitor and minimize the use of supratherapeutic doses of opioids (>120 ME)			Morning huddles to review upcoming pain care needs			Medical assistants review state PDMP, opioid agreement needs, utox screens			Utilize nurses to help coordinate care for patients with pain		
			Measure	% Panel on opioids is being tracked for each participating PCP and a process has been established to analyze this data and respond to variations			Co-prescribing of benzodiazepines, stimulants and opioids is being tracked for each participating PCP and a process has been established to analyze this data, and flag inappropriate co-prescribing			Use of supratherapeutic doses of opioids (>120 ME) is being tracked for each participating PCP and a process has been established to analyze this data, and flag supratherapeutic doses (> 120 ME)			Morning huddles are held each day between PCPs and other members of the clincial team to identify pain management care needs for the day			Medical assistants or other members of the care team review the state PDMP before each PCP visit with a patient being prescribed chronic opioids and review the patient's chart to determine whether opioid agreement or utox have been completed			Nurses or other members of the care team assist PCPs in assuring that patients with chronic pain receive referrals to specialist providers, receive instructions on how to take medications properly, sign yearly opioid agreements, and complete random utox screenings		
				# PCPs	Implemented (Y/N)	Date Implemented	# PCPs	Implemented (Y/N)	Date Implemented	# PCPs	Implemented (Y/N)	Date Implemented	# PCPs	Implemented (Y/N)	Date Implemented	# PCPs	Implemented (Y/N)	Date Implemented	# PCPs	Implemented (Y/N)	Date Implemented

EVALUATION

Moore's framework

- Conceptual model for planning and assessing continuous learning for medical providers
  - Levels of Assessment
    - Participation
    - Satisfaction
    - Learning
    - Performance
    - Patient Health
    - Community Health



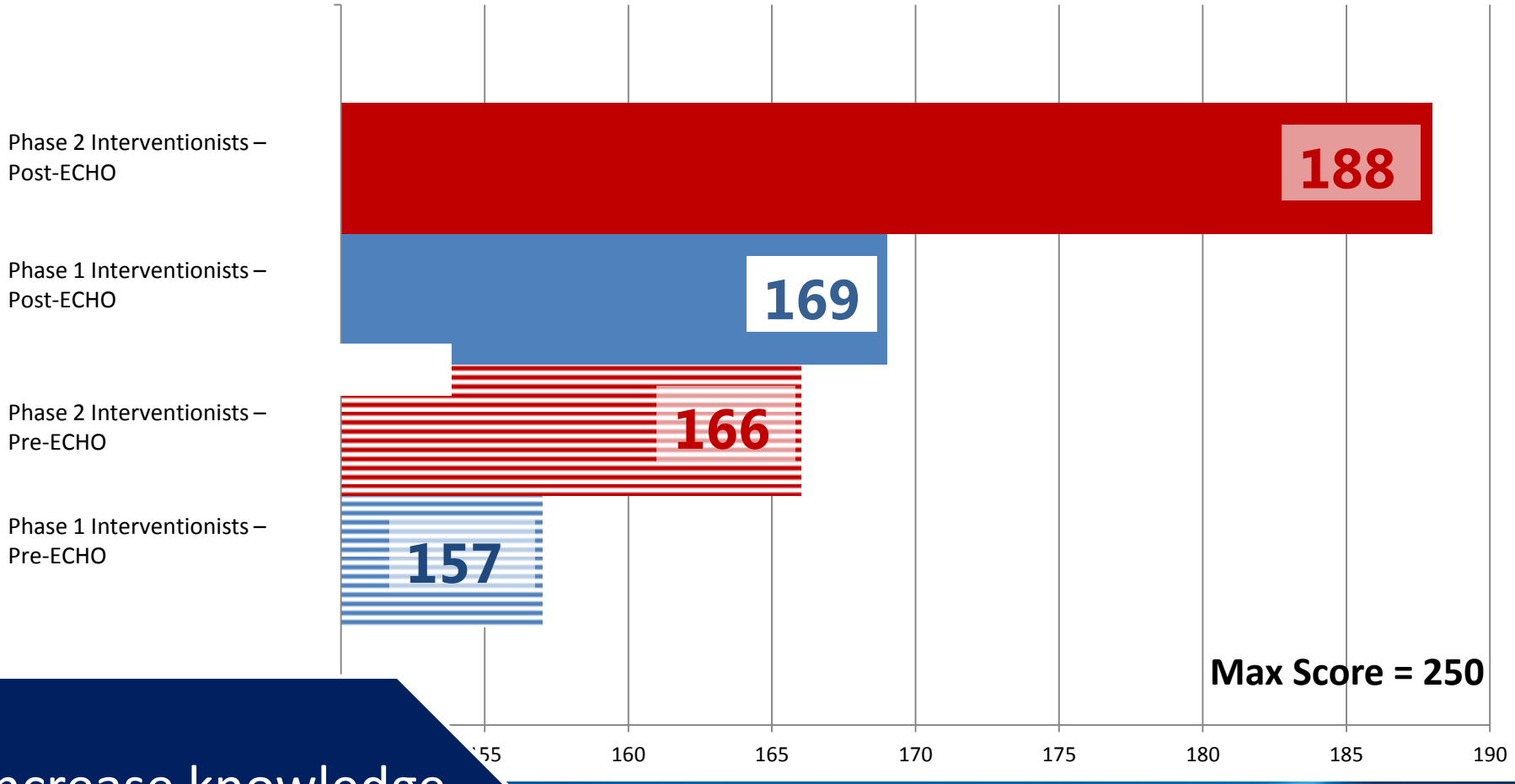
Moore DE, Green JS, Gallis HA. Achieving desired results and improved outcomes: integrating planning and assessment throughout learning activities. J Contin Educ Health Prof. 2009; 29(1):1-15.

Evaluation Framework for ECHO/Collaborative

Level	Element	How Element is Assessed
1	Participation	Operational data on ECHO sessions - # sessions held, %attended, #cases heard, #cases presented
2	Satisfaction	Provider satisfaction survey on CME form – were expectations about content and delivery met?
3a 3b	Learning: Declarative Knowledge Learning: Procedural Knowledge	Pre- and Post- Surveys measuring changes in provider attitudes and knowledge re: content area of ECHO sessions
4	Competence	Pre- and Post- Surveys measuring changes in competence and self-efficacy re: content area of ECHO sessions
5	Performance	Pre-ECHO and Post-ECHO Practice Assessment completed by Chief Clinical Officer Chart review data audit of provider treatment practices, documentation and follow-up, monthly collaborative measures reports
6	Patient Health	Chart review, monthly collaborative key measures reports, assessment of claims data (i.e. service utilization)
7	Community Health	Analysis of population health data and reports (i.e. claims data analysis, data from state and local public health databases)

ECHO/Collaborative Impact Model

PCP Knowledge Scores Pre-Post ECHO



Increase knowledge

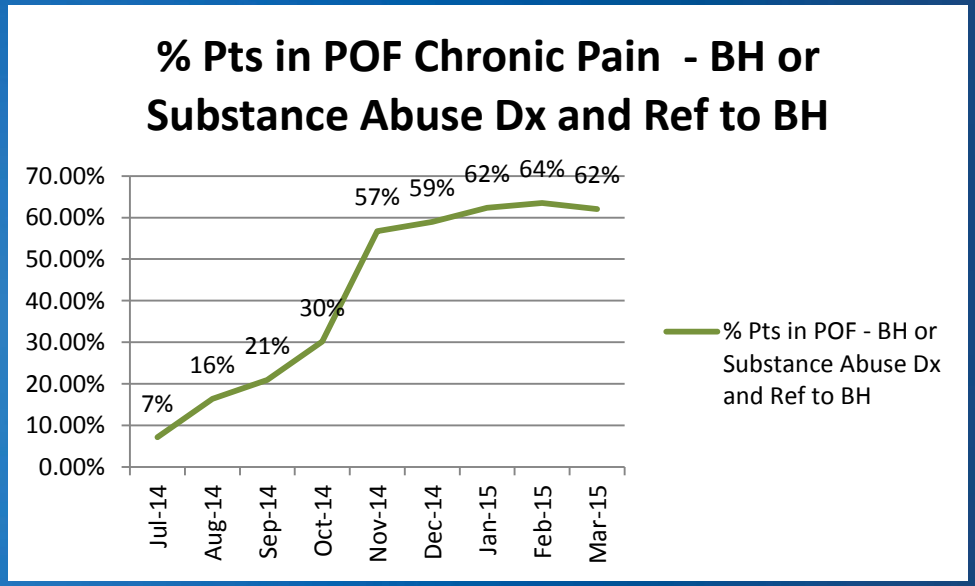
Changes in Practice

	Pre-ECHO	Post ECHO
Functional assessment documented*	14%	60%
Documented pain re-assessment*	40%	65%
Visit with behavioral health**	29%	34%
Prescribed any opioid **	49%	45%

Increase knowledge → Change practice

*Source: Chart review, phase 2
**Source: 2yr follow up EHR data phase 1 practices

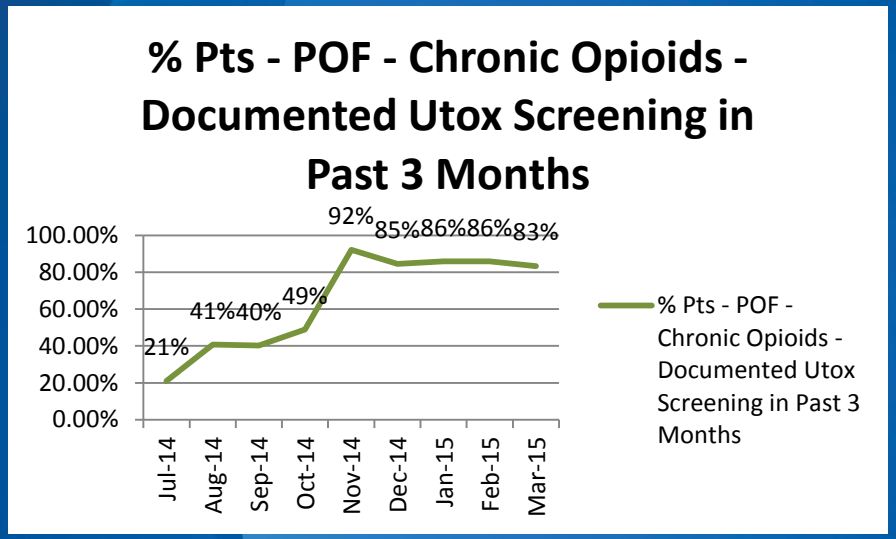
Chronic Pain Best Practices: Behavioral Health Co-Management

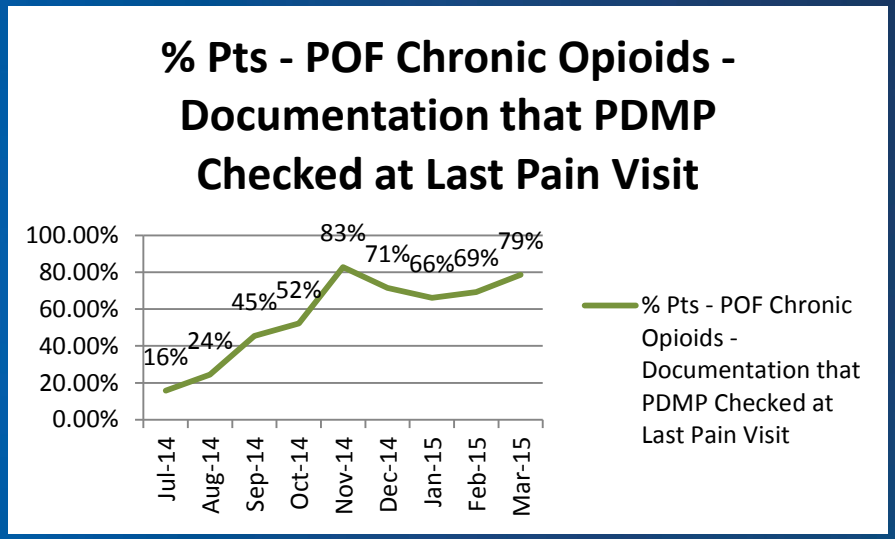


Total # Pts in POF Chronic Pain w/ Behavioral Health or Substance Abuse Diagnosis who were referred to Behavioral Health Treatment.
Max: **67**

Increase knowledge → Change practice

Chronic Pain Best Practices – Chronic Opioid Monitoring





Total # Pts in POF Chronic Opioids w/ Signed Opioid Agreement in Chart: Max: **71**

Total # Pts in POF Chronic Opioids w/ Documented Prescription Drug Monitoring Program Check at Last Pain Visit: Max: **66**

Increase knowledge → Change practice

FIML estimates		Changes: 2014-2012				Diff. Changes	
N= 5,402 (2,907; 2,495)		ΔControl		ΔIntervention		d = (ΔI -ΔC)	
		Avg/%	SE	Avg/%	SE	d(Δ)	p
	Age (Avg)	2.098	0.015	2.104	0.018	0.006	.799
Visits	Avg/year	-0.616	0.169	-0.499	0.201	0.117	.655
Opioids	Any Opioid Rx	-3.3%	1.7%	-4.4%	2.0%	-1.1%	.681
Mental health	Pts w/BH Visit on site	-0.7%	1.6%	5.7%	1.9%	6.4%*	.010
Pain referrals	Physical Therapy	-10.7%	2.0%	-1.5%	1.6%	9.3%*	<.001
	Pain management	5.8%	1.3%	-0.7%	1.4%	-6.4%*	.001
	Physical Med and Rehab	-2.6%	1.1%	-5.9%	1.5%	-3.3%†	.080
	Surgery (neuro or ortho)	-0.7%	2.0%	-8.3%	2.1%	-7.6%*	.009
	Rheumatology	-1.3%	0.8%	-1.5%	0.9%	11.7%	.655

Thank You

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