Enhancing Chronic Pain Management by Resident Physicians through Standardized Curriculum and Clinic Workflows

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Conflict of Interest

- I have no financial relationships/conflicts of interest to disclose

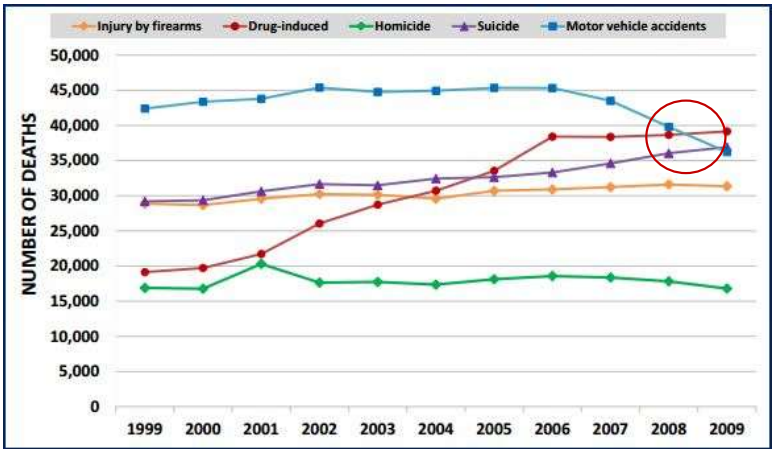
Learning Objectives

- Discuss one residency program's adoption of a standardized curriculum for management of chronic, non-cancer pain in primary care
- Recognize the role of clinic workflow in supporting curricular change
- Explore opportunities for change in your curriculum and clinic processes

The Problem

- 1995: the "5th vital sign"
- 1996: OxyContin promoted for non-cancer pain
- 1997-2003: OxyContin prescriptions grew from 670,000 → 6.2 million (half written by primary care docs)
- 2007: Purdue pleads guilty to misbranding, pays $600 million
- 2008-2009: the "tipping point"

The Problem



Source: "Prescription Painkiller Overdoses in the US." CDC Vital Signs, November 2011 http://www.cdc.gov/vitalsigns/PainkillerOverdoses/;

The Problem

- Also in 2007, back at our residency program:
  - No curriculum/standards/guidelines
  - No workflow
  - Confusion
  - Frustration
  - Risk
- By 2012, new leadership = new opportunity

The Charge

- Develop standardized, evidence-based curriculum for evaluation of chronic pain
- Create clinical environment within which to deliver curricular care to patients
- Vision: resident obstetric practice

The Effort

- January 2013-August 2013 (curriculum committee):
  - Goals set
  - Literature review
  - Curricular development
  - Peer review/approval of curriculum (handout)
- August 2013-April 2014 (process improvement):
  - Workflow development
  - Policy review and updates
  - EMR templates, hardware purchases/upgrades

Residency Curriculum

- Objectives-based
- Measureable
  - **Required** REMS PGY-2 (catchup PGY-3)
    - www.scopeofpain.com
    - Faculty: earn Part 2 MOC credit!
  - **Required** SAM: chronic pain
- Delivered to residents and patients
  - EMR templates
  - Clinical practice expectations

The Curriculum: Fundamentals

- Patient as the center of care
  - Include patient in care plan
  - Assess understanding of condition
  - Educate regarding illness at every visit
  - Overall goal: empower patient, set realistic expectations
  - Focus on “patient safety” as key component
- Quantify pain
  - Written instruments are essential
  - History must be standardized

The Curriculum: Fundamentals

- Understand mechanism
- Understand patient risk profile
  - Low risk – appropriate for family medicine
  - Intermediate risk – appropriate with stricter follow up rules
  - High risk – "not appropriate for family medicine practice"
- Understand/negotiate patient goals
  - Pain tolerability – NOT "pain free"
  - Improved physical/psychosocial function
- Realistic expectations
  - Patient responsibilities – PT, others
  - Physician options/limitations

The Curriculum: Fundamentals

- Treatment as a negotiation
  - Goal: relief sufficient *to improve function*
  - Multimodal non-opiate therapy is first
  - Complementary therapies must be used as appropriate
  - Opiate treatment is a *trial of therapy* (communicate!)
    - Opiates not appropriate for every patient
- Focus on function, not pain
  - Physical function
  - Effect on biopsychosocial factors

The Plan: Goals

- Maintain balance between safety and relief
- Standardize visits
  - Focus on function, not pain score
  - Solution: brief pain inventory
- Document risk assessment (at-a-glance decisions)
  - Opiate Risk Tool
  - CAGE-AID questionnaire
- Standardize clinic workflows (offloading providers)
  - Prescription Monitoring Database review/documentation
  - Controlled Substance Agreements
  - Urine Drug Screening
  - Patient-completed self-assessments

Limitations on Resident Practice

- PGY-1 may not see chronic pain for first 6 months
- Residents must present all patients taking controlled substances for chronic pain
  - Brief history, including likely etiology
  - Follow up: whether functional status better, worse, or stable
  - Patient risk category
  - Current morphine equivalent dose
  - Patient compliance with care plan
  - Results of OBNDD
  - Results of last UDS, if available

Limitations on Resident Practice

- Resident prescriptions initially limited to < or = 100mg morphine equivalent daily (now follow CDC/FDA guidelines)
  - Defined by approved calculation tool
  - Not negotiable
    - Resident with DEA
    - “grandfathered” patient
- Residents may not prescribe
  - Methadone
  - Suboxone
  - Soma (carisoprodol)

The Plan: Measurement

- Project 1: how many patients do we have on controlled opioids?
- Project 2: are we compliant with 100 mg MEQ daily limit? (refined after CDC guideline, then FDA guideline)
- Project 3: have we reduced “walk-in” refill requests?
- Project 4: have we increased patient satisfaction with care?
- Project 5: have we improved resident satisfaction with curriculum/comfort level in treating patients?

The Plan: First Cycle

- Staff:
  - Gathered data on refill requests (creating registry)
  - Used registry to alert schedulers
  - Began scheduling follow ups as “COAT”
  - Gave patients “heads-up” letters (mail, during refills)
  - Changed communication scripts
- Admin:
  - Identified standardized history and risk assessment forms, created new agreements
  - Began provider training/buy-in

The Effort

- June 2014:
  - Staff training
  - Faculty retreat – refinement and approval
- July 2014:
  - Letters to patients
  - Staff/Resident training
- August 2014: LAUNCH
- October 2014: first curricular visits
- January 2015: All patients transitioned (?)
- Summer-Fall 2015: reviewed and modified

The Clinic Visit (Handout)

- Prior to COAT designation:
  - Patient requests treatment for chronic pain
  - "Initial COAT" visit scheduled
    - » 30 minutes
    - » Full assessment done, treatment plan developed with attending
    - » If appropriate for opiate trial:
      - Agreement signed
      - Nursing staff enter agreement into EHR
      - Clerical staff add "pop-ups" (ID PCP, agreement signed)

The Clinic Visit (Handout)

- COAT Visit
  - Prior to visit:
    - » Clerical staff gather history forms
    - » Patient completes during check in
    - » Nursing staff confirm PMP report and print for provider
  - During visit:
    - » Resident performs periodic review in context of office visit
    - » Resident presents every patient to attending; exceptions:
      - Resident has DEA on file
      - Resident has completed REMS and SAM trainings
      - Resident is in good standing and cleared by PD

Plan-Do-Study-Act

2015-present:
- Added PMP to workflow
- Identified need to respond to CDC
- Broadened referral base

2012-2013:
- Identify problem
- Set goals

2015-2016:
- Further consolidate
- Respond to CDC
- Mechanism-based treatment guidelines

2014-2015:
- MEQ reduction
- CGCHAPS
- Functional assessment
- Address unexpected outcomes

2013-2014
- Objectives-based curriculum
- Standardized assessment
- System redesign
- Pilot project - Franklin

Successes

- Patient registry
  - 2013: ~500 estimated patients receiving opioids?? (based on 90 day refill review)
  - 2015: ~225 patients in COAT registry
    - » ~109 – resident PCP
    - » ~118 – faculty PCP
- Clinic processes
  - 2013: nothing existed
  - 2015: COAT clinic process in place, working towards consistency
    - » No refills at same day appointments (unless PCP, safety check done and appropriate)
    - » No guarantee of script at initial appointment
  - Late-2016: achieved process consistency

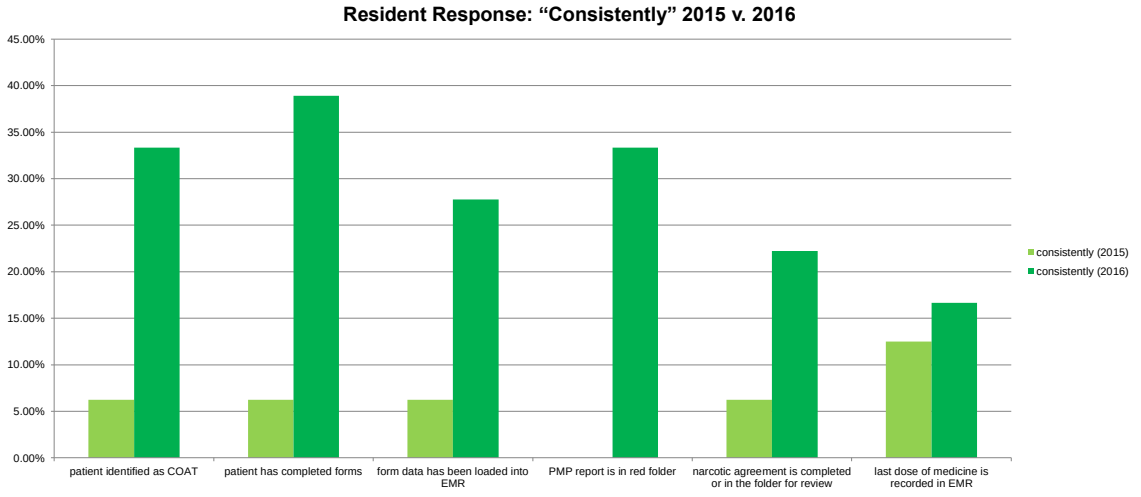
Successes

- Curricular structure:
  - 2013: no required curriculum
  - 2014: curriculum inconsistently applied
  - 2015: additional faculty education, edict from residency division
  - 2016: relative consistency
- EMR Documentation:
  - 2013: none existed
  - 2014: launched, inconsistently loaded
  - 2015: education program for staff, faculty, residents
  - End-2015: consistently loaded, inconsistently used by physicians
  - 2016: re-education of faculty and residents (work in progress)

Challenges – and a Caveat

- Outlier patients
  - 1 addiction specialist in system
  - Access to pain management for high risk patients (some success)
- Faculty inconsistency
  - Familiarity with/application of guidelines
  - Faculty clinic vs. residents' clinics
- Caveat
  - Largest physician group in Oklahoma (600+ physicians)
  - May not be applicable to smaller systems/more rural settings

Feedback – Clinic Workflow Consistency



Feedback - Curriculum

- Resident survey (16/36 responded, 9/12 PG3)
  - 6% "well prepared" to determine pathophysiology of pain (80% agree they've had any instruction)
  - 18-30% "well prepared" to determine treatment plans (60-70% agree they've had any instruction):
    - 25% - non-pharmacologic therapy
    - 18% - non-opiate pharmacologic therapy
    - 18% when to start opiates
    - 12% indications/contraindications to opiates

Feedback - Curriculum

- "Well prepared"
  - Stratifying risk for abuse/diversion: 12%
  - Determining when to increase opiates: 12%
  - Determining when to wean/taper/change opiates: 6%
  - Taught "a little" or "a good deal": 50-60%

Feedback - Instructors

- "Attending understands curricular guidelines"
  - 25% inconsistently
  - 62% pretty often
  - 13% consistently
- "Attending is consistent with curricular guidelines" (same result)
- "Attending makes use of available curricular resources in T box"
  - 6% never
  - 37% inconsistently
  - 44% pretty often
  - 13% consistently

Thank You

- Discussion?

The Risk Assessment – Opioid Risk Tool

- Measures risk factors associated with substance abuse potential:
  - Personal/family history of substance abuse
  - Age
  - History of preadolescent sexual abuse
  - History of psychological diseases, esp
    - Bipolar
    - Major depression
    - Schizophrenia
    - Attention deficit disorder
    - Obsessive-compulsive disorder

Source: Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005;6(6):433.

The Risk Assessment – Opioid Risk Tool

- Stratifies patients into 3 categories of risk for substance abuse
  - Low: 0-3 points
  - Moderate: 4-7 points
  - High: >8 points
- Validation study: 185 consecutive new patients to a pain clinic given the tool
  - Followed for aberrant behaviors for 12 months
  - Low risk: 94.4% displayed NO aberrant behavior on opioids
  - High risk: 90.9% displayed aberrant behavior

Source: Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005;6(6):433.

The Risk Assessment

- It's in "Initial Visit" document
- Modifiable – since patients can fib

Today's CAGE score: 1
In the last three months:
- have you felt you should cut down or stop drinking or using drugs? **no**
- has anyone annoyed you by telling you to cut down/stop drinking or using drugs? **yes**
- have you felt guilty or bad about how much you drink or use drugs? **no**
- have you been waking up wanting to have an alcoholic drink or use drugs? **no**

Today's ORT score: 5 **Risk:** Moderate Risk
Do you have a family history of substance abuse?
Alcohol: **yes**
Illegal Drugs: **no**
Prescription Drugs: **no**

Do you have a personal history of substance abuse?
Alcohol: **no**
Illegal Drugs: **no**
Prescription Drugs: **no**

Please select your age group: 26-45

Do you have a history of being sexually abused? no

Have you ever been diagnosed with one of the following conditions?
Attention Deficit Disorder: **yes**
Obsessive Compulsive Disorder: **no**
Bipolar: **no**
Schizophrenia: **no**
Depression: **yes**

EMR: How to Find Data – Today's HPI

History Of Present Illness
How did you arrive today? cane
Is this a work related injury? yes
Has it been reported to your employer? no
Is legal action or an insurance settlement pending? no

Chief Complaint
Location of pain? left side
Headache: no
Neck pain: yes
Abdominal/Pelvic pain: no
Upper back pain: yes
Lower back pain: yes
Tailbone pain: yes

Pain Quality: crushing, aching, gnawing, stabbing, burning, pins and needles sensation

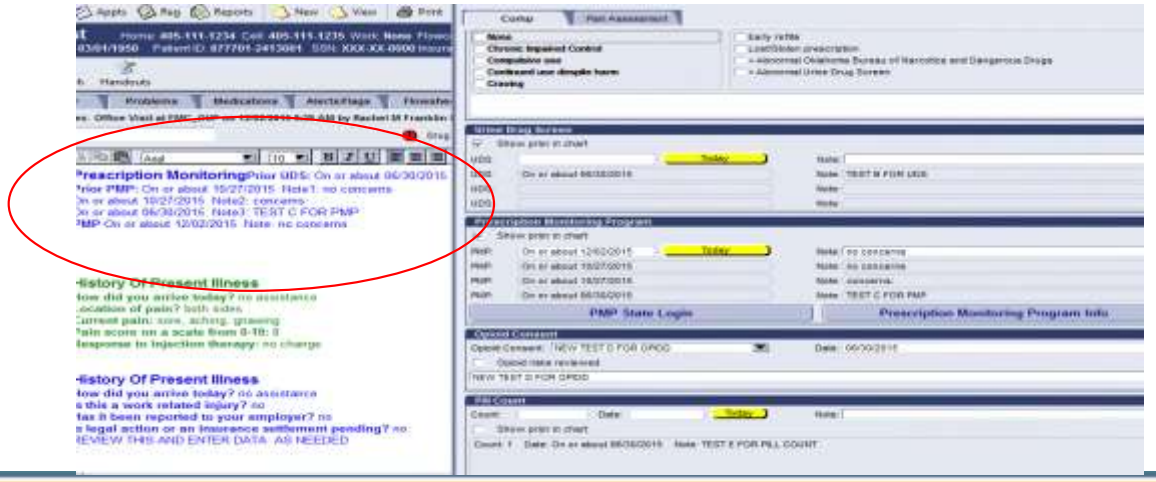
Pain score on a scale from 0-10: 10
Are you experiencing the problem now? yes
How long have you had the pain? months

Factors which aggravate the pain: climbing stairs, overhead lifting, running/jogging, reaching up, lying on/touching the affected area, walking, physical activity, stress, coughing, standing, sneezing

Factors which relieve the pain: none identified

Previous Treatments and Effect
Chiropractic Care: no change
Injection Therapy: no change
Massage Therapy: no change
Physical Therapy: no change
Home Exercise Program: worse
Prescription Medication: non-effective
OTC Medication: non-effective

EMR: PMP Check – office visit



Please…

Complete the session evaluation.

Thank you.

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