

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

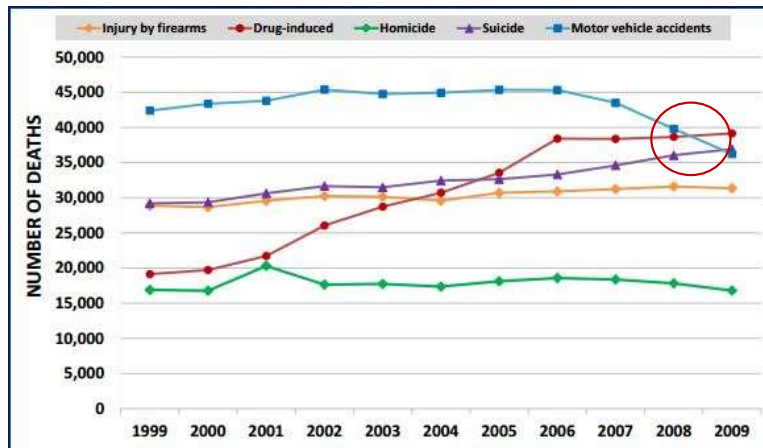
Learning Objectives

- 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/;](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

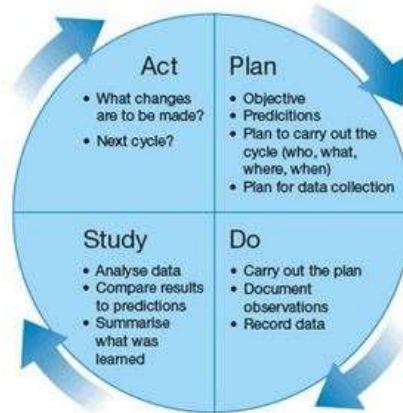
Plan-Do-Study-Act

2015-present:

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

2014-2015:

- MEQ reduction
- CGCHAPS
- Functional assessment
- Address unexpected outcomes



2012-2013:

- Identify problem
- Set goals

2015-2016:

- Further consolidate
- Respond to CDC
- Mechanism-based treatment guidelines

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

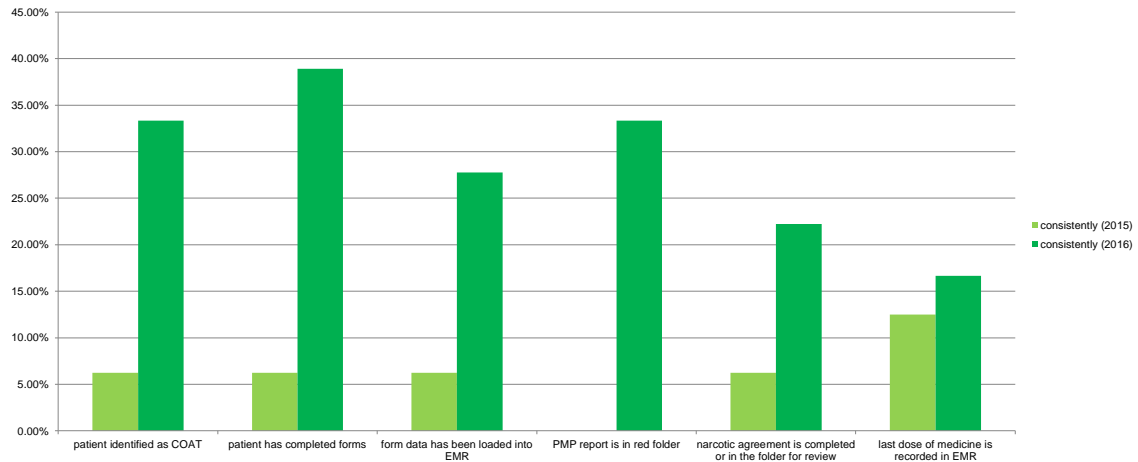
- Curricular structure:
 - 2013: no required curriculum
 - 2014: curriculum inconsistently applied
 - 2015: additional faculty education, edict from residency division
 - 2016: relative consistency
- EMR Documentation:
 - 2013: none existed
 - 2014: launched, inconsistently loaded
 - 2015: education 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

Resident Response: “Consistently” 2015 v. 2016



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.

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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

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EMR: PMP Check – office visit

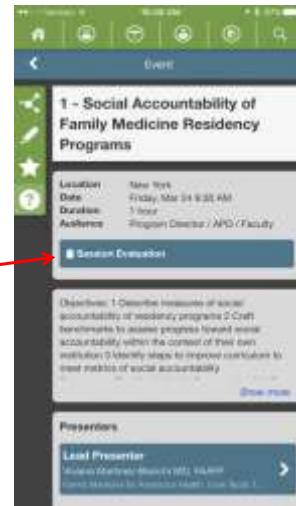
The screenshot displays an EMR interface with a 'Prescription Monitoring' section highlighted by a red circle. The interface includes a patient header, a navigation menu, and a main content area. The 'Prescription Monitoring' section shows a table of drug screens with columns for drug name, date, and status. The table contains two entries: 'PMP' on 05/03/2015 and 'PMP' on 05/02/2015. The 'PMP' on 05/03/2015 entry is highlighted in yellow. The 'PMP' on 05/02/2015 entry is also highlighted in yellow. The 'PMP' on 05/03/2015 entry has a status of 'TEST B FOR UDS'. The 'PMP' on 05/02/2015 entry has a status of 'TEST C FOR PMP'. The interface also includes a 'PMP State Login' button and a 'Prescription Monitoring Program Info' link. The 'Open Content' section shows a list of open content items, including 'NEW TEST B FOR UDS' and 'NEW TEST B FOR UDS'. The 'All Content' section shows a list of all content items, including 'NEW TEST B FOR UDS' and 'NEW TEST B FOR UDS'. The interface also includes a 'Print' button and a 'Close' button.

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Please...

Complete the
session evaluation.

Thank you.



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