

C.A.R.E.S AllianceSM Chronic Pain Toolkit Project

This brief is a summary of the C.A.R.E.S AllianceSM practice-based toolkit project conducted in nine primary care practices by the American Academy of Family Physicians National Research Network.

Executive Summary

- Family Medicine physicians and practices are interested in improving chronic pain care and are excited to use streamlined, EHR-ready, team care-oriented tools to support the delivery of “best care” medicine to patients with chronic pain.
- Practice-based activities indicate that the chronic pain tools could achieve desired outcomes. Patients did not report problems or concerns with the tools they were asked to complete, and practice staff could include the tools during routine visits with little disturbance to the practice’s workflow.
- Quantitative data collected via an e-survey from Family Medicine physicians provides a profile of attitudes, current practices and self-identified needs to support caring for patients with chronic pain.
- Qualitative data collected from interviews and focus groups reveals five important themes that characterize (and reinforced quantitative findings) current attitudes, practice patterns and opportunities for improving care to patients with chronic pain.

Rationale and Design

The Chronic Pain Toolkit project explored clinician perceptions, attitudes and readiness to use tools designed to screen, support, treat and monitor adult patients with chronic pain, with an emphasis on patients prescribed opioid medications for their non-cancer pain condition(s). The aims of the study were to review and refresh items in the C.A.R.E.S AllianceSM toolkit and to review the literature to replace any tools that needed to be updated or modified. Each tool received individual attention with a priority on distilling the most essential, practical elements in a streamlined, easy-to-use format. Further, the entire toolkit was assessed for comprehensiveness, redundancies and clarity to encourage use in the context of busy primary care practices.

The project design had three key elements to achieve the study’s aims. First, we retained an expert group to advise the research and offer guidance on risk management, patient advocacy and clinical aspects of pain care. Second, an electronically administered survey collected practicing physicians’ perspectives about chronic pain and measured their readiness to use a toolkit. The survey also collected physician opinions and attitudes about taking care of patients with chronic pain. The third element of the project and the most intensive arm of the study was to work with primary care practices to test the acceptability and implementation of specific tools from the toolkit during the course of routine clinic operations. This arm used a rapid cycle approach that involved ongoing engagement of a lead physician and site coordinator with feedback to the study team.

Expert Panel Guidance

Experts in medicine, law, ethics, pharmacy and chronic pain care provided their review of the existing C.A.R.E.S AllianceSM toolkit, highlighting areas that needed to be updated given the current science. For example, diverse but relevant areas to the topic of chronic pain such as urine drug screening procedures and the emerging importance of early childhood adverse events as contributing factors to adult health highlight the need for some tool modifications in the toolkit. The panel also guided the team to recognize and modify the orientation of the toolkit in ways that would stress the importance of partnering with patients to achieve meaningful outcomes. Because chronic pain requires trust and an ongoing, open dialogue between clinicians and patients, skills to achieve these healing relationships – wedged within the constraints of limited visit time and other pressing priorities – was an important dimension of the work tasked to the project team. Both prescriber and patient must negotiate chronic pain care in a setting of increased diversion, suspicion, misuse and oversight due to the escalating abuse of opioid and other medications prescribed for pain management. To the extent possible, the expert panel encouraged framing the project and the toolkit in ways that could provide a rational, balanced, risk-mitigating and practical approach for clinicians that will contribute to de-stigmatizing both the prescriber and patient.

Prescriber Attitudes, Behaviors and Resource Needs

An online survey collected information from fifty prescribers about their approach and routine care of patients with chronic pain. Questions to evoke underlying biases, concerns not often given voice in daily practice and honest examination of procedures used in the practice provided essential information to the project team. The sample is not representative of all Family Medicine prescribers, but responses were extremely consistent and likely indicate generally held opinions. The table below shares the results of the survey.

Question/Domain	Percent
Attitudes	
Agree that chronic pain patients are a source of frustration	92
Agree that stress occurs between office staff and physicians due to caring for patients with chronic pain	64
Agree stress occurs between physicians (because of differences in how they practice and care for patients with chronic pain)	67
Report they find their clinical work rewarding	78
Report they experience a strong connection to their patients	97
Report they are confident in their ability to provide skilled care	83
Agree that providing skilled care is a high priority	92
Behaviors	
Agree that they are influenced by experiences with addicted patients	81
Report that less than ¼ of the time do patients they treat become addicted	61
Agree that they are influenced by fear of contributing to dependence	86
Report they are influenced by fear of regulatory agencies	53
Resources	
Report they conduct pain assessments more than ¾ of the time	28
Report they use pain monitoring tools more than ¾ of the time	14
Report they are satisfied with the resources available to treat chronic pain	50

The responses to these questions directly influenced attention to specific tools and to the approach planned for structured interviews and focus groups in the implementation arm of the study. For example, the relatively high level of stress reported among and between clinicians and staff was an area identified for further examination. The study team reasoned that the extent to which the clinical team allows variation to commonly encountered problems would likely contribute to instability of relationships, erosion of mutual trust and differential uptake and use of the toolkit. Knowing that the issue of addiction and prior experiences with patients contribute to physicians' behavior also was important. This information encouraged the study team to develop questions to probe participants in the implementation arm to learn whether tools in the toolkit helped reduce fear or mitigate concerns. The extent to which the tools could open discussions and permit prescribers to simultaneously assess a patient 's risk of addiction while sharing their concerns prior to prescribing opioid medication and during their care was essential and valuable information to achieve the study's aims.

Practice Implementation and Use of Chronic Pain Toolkit

While the study team was revising and streamlining the toolkit, primary care practice recruitment for the implementation arm began. The goal was to include a variety of practices – rural, urban, residency training sites, etc., and to include geographic diversity as well. The bases for these choices are that there are substantial differences in regional and state-level prevalence of drug misuse, diversion and topic relevant programs (e.g., prescription monitoring programs) as well as anticipated small area practice variation that could influence results. Nine practices, 18 practice champions and approximately 45 clinicians agreed to participate in the implementation arm of the study (see table below for practice type and location).

Practice Type	Rural	Suburban	Urban
Federally Qualified Health Center	Ahoskie, NC Hays, KS		Cleveland, OH
Primary Care Solo/Group	Indiana, PA Strasburg, PA	Bristol, CT Waco, TX	Kansas City, KS
Residency Training Site		Cheyenne, WY	

All practices began the study using the same patient assessment tool but afterwards, could choose to try any or all of the other tools in the toolkit. Every practice chose at least one additional tool to implement, and a number of them rotated their adoption of tools on a routine (e.g., biweekly) basis. Simply trying to adopt a tool with or without prior experience or a standing quality improvement team offered insight to the practice about issues of care, documentation and workflow. For one week at the beginning of the study and one week in the final phase of the project, each practice conducted a card study. A paper, perforated card with information provided by the physician and separately by the patient served as a cross-sectional “snapshot” of dyad-specific care issues that informed the project. Practices mailed the cards back to the NRN study team for reassembly and analysis.

A study team member established routine communications following the day/time preference of each site. During calls, the study team member checked in with the lead site coordinator and/or lead physician to learn how things were going at the practice, to ask about barriers or facilitators affecting the use of a particular tool and to hear directly from these individuals about their views on whether the tools were working as designed within routine workflow. The study team reviewed data collected from these calls during weekly team meetings, and discussions about what was shared stimulated additional follow-up questions and monitoring plans on specific issues. These positive relationships improved the quality of data collected and created an ongoing opportunity to talk about topics that the prescribers and staffs wanted to discuss. These topics included cases of opioid misuse, challenges they faced using pain contracts and their discomfort with selecting patient candidates for random urine drug screening. These conversations led directly, in at least one practice, to a change of protocol that the team did not anticipate. The physician recognized that his current practice used subjective criteria to identify patients for urine drug screening. He changed practice procedures immediately to include a non-routine but monthly time during which all patients prescribed opioid and related medications would be asked to participate in screening. According to this physician, the change he instituted came directly from the study’s request to examine the issue and discuss the ramifications of practice policy on provider responsibilities and patient care.

To augment telephone interviews and check-ins, the team conducted three focus groups with physicians, advanced practice registered nurses and nurse QI leaders in two participating practices. Focus group questions reflected the same topics of interest for the overall study. In all three cases, the focus group was the first time participants had openly discussed these topics with one another. Many of them commented on how they had made assumptions about other clinicians’ attitudes or care and prescribing patterns within the practice. Further, they were able to share their common frustrations, suggestions for improvements and they volunteered to introduce the topic as a priority among other ongoing quality improvement initiatives.

The card study did not detect significant change from baseline through the later phase of the study. What this may mean is that the introduction of tools and modifications to practice workflows for patients prescribed opioids and related medications for chronic pain was undetectable and did not interfere with the provision of care. It also may mean that elapse time between the two data collection periods may not have been sufficient to measure changes.

Practice Themes

Throughout the study, the research team accrued themes based on how often topics, issues and solutions were offered among the participating sites. As these themes emerged from the content analysis of interviews and focus group discussions, each one was reviewed with the lead practice physician and site coordinator for validation and/or modification. The follow list provides the salient themes derived from the practices’ experience using the toolkit:

1. Chronic pain care is complex, and because of this, reminders and checklists are important devices that can assist them in ensuring the collection of comprehensive information needed for planning and care. Above all, such reminders and checklists need to be extremely brief and direct.
2. Idiosyncratic application of procedures that depend on subjective patient characteristics runs the risk of unfairly (and unscientifically) “profiling” individuals in ways that may have negative healthcare consequences. Participants requested practice-wide recommendations to avoid profiling.
3. Improving care highly depends on integrating tools into the Electronic Health Record (EHR) and deploying health care team members at the “top of their licensure” in order to be time- and cost-efficient. Failure to account for ease of integration into an EHR platform in their opinion would severely limit uptake and adoption of the tools in the toolkit.
4. Patient education needs to be literacy appropriate and move beyond typical print materials into other modalities such as videos that can be offered during office visits or be available through patient portals. Patient education is essential, but the time to accomplish effective information exchange, answer questions and provide anticipatory guidance is limited. If material could be deployed using computers, tablets, kiosks, and accessed either during clinic or at home, participants in the study would recommend them and build in expectations for their use.
5. Physicians want and need continuing education in short, easy-to-use formats that permit them to augment their knowledge of chronic pain and medication issues to improve patient care. Prescribers must increase their awareness and knowledge commensurate with the changing and challenging times, but to do so they need developers who understand that their time is limited to accomplish these goals. Providing information in sequential small packets that they can focus on during lunch, or listen to when driving between sites of care, would be ideal.

Summary

Findings from this pilot study affirm that some family medicine clinics lack standard protocols and processes that may put patients and prescribers at risk when treating chronic pain. With limited resources designed to fill the gaps, many physicians feel frustration. Prescribers and practice staffs found the tools introduced and tested during this study to be valuable, not only because they directly assist in ensuring comprehensive care for patients with chronic pain, but also because they enabled meaningful discussions about this very complex and difficult area of primary care delivery. One of the most valuable insights gained during interviews with participating clinicians was that the use of some of the tools stimulated novel conversations with their patients. Opening the dialogue about aspects of behavioral health was important, and one critical area of need is training and guidance on how to handle these conversations. Suggestions to address this include trainings on how to review screening results, discussion of quality of life issues and the collection of family and childhood behavioral health history that affect recommendations of therapeutic options and the use of pain medications for treatment.

Practices request better resources for patients, and they want them to be available online and in a variety of formats. Practices without access to behavioral health specialists and those located in resource-poor communities struggle to address the comorbid conditions that complicate chronic pain care. Concerns about medications used to treat chronic pain should be matched with commitments to integrate other health expertise to provide a comprehensive biopsychosocial model of care. Until the workforce and payments align with providing “best care” medicine, Family Medicine physicians say that they will continue to struggle to meet the needs of their growing population of patients with chronic pain.