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NMF-GE Project Summary
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Chronic Pain Management in an Ambulatory Setting

“The unreasonable failure to treat pain is viewed worldwide as poor medicine, unethical practice, and an abrogation of a fundamental human right.”(1)

Background

What is Chronic Pain?

Chronic pain is one of the most frequent reasons for physician visits, one of the most common reasons for medication use, and a major cause of work disability. Although improvement may be possible, for many patients, a cure is unlikely. Chronic pain can become so debilitating that it affects every aspect of a person’s life—the ability to work, to go to school, to perform common tasks, or to maintain friendships and family relationships. (2)

Chronic pain is defined as pain that lasts for three months or more or lasts longer than would be expected with “normal healing” from an identifiable cause. Chronic pain can be the result of an underlying disease or medical condition, however many cases of chronic pain have no identifiable cause. Pain associated with a known disease state may persist in a continuous state, may recur after the disease itself has been cured, or may worsen as the disease progresses. Chronic pain may also occur as a response to tissue inflammation and injury or to an injury or as the result of medical treatment when unresolved acute pain evolves into chronic pain. (2)

Common sources of chronic pain include migraine and recurring headaches, arthritis or other joint pain, fibromyalgia, irritable bowel syndrome, trauma or postsurgical pain, low back pain, or other musculoskeletal disorders as well as pain caused by chronic diseases such as cancer, stroke, and diabetes.(2)

Scope of the Problem

According to the Institute of Medicine (IOM), approximately 100 million U.S. adults—more than the number affected by heart disease, diabetes, and cancer combined—suffer from chronic pain. The annual economic cost of chronic pain in the United States is estimated to be between \$560-635 billion due to direct medical costs (\$261-300 billion) and lost productivity (\$297-336 billion) attributable to pain. The federal Medicare program bears one-fourth of U.S. medical expenditures for pain; in 2008, this amounted to at least \$65.3 billion, or 14 percent of all Medicare costs. In total, federal and state programs—including Medicare, Medicaid, the Department of Veterans Affairs, TRICARE, workers' compensation, and others—paid out \$99 billion in 2008 in medical expenditures attributable to pain. (2)

Most people with chronic pain have multiple sites of pain, with musculoskeletal pain, notably low back and joint pain, as the most common cause. Low back pain is responsible for the largest proportion of chronic pain, accounting for 28.1 percent of individuals 18 and over reporting pain within the last three months. Knee pain was the second most common cause at 19.5 percent and severe headaches or migraine third at 16.1 percent.(2, 3)

Who is at Risk?

While pain prevalence increased between 1999-2004 across all age groups, sexes, income levels, and most races, certain factors are associated with an increased prevalence of chronic pain(4). Nonmodifiable risk factors associated with chronic pain include a genetic predisposition toward chronic pain, female gender, minority race and ethnicity, English as a second language, and increased age. Other factors associated with the development of chronic pain include lower education level, lower income, history of physical or sexual abuse and other traumatic events,

serious illness or injury, history of hospitalization, obesity, low levels of fitness, lack of social support, accumulated stress, overuse of joints and muscles, job dissatisfaction, development of chronic disease, and possibly geographic location, cognitive impairment, and a past military history. While several factors predispose an individual to chronic pain and increase frequency of pain, several protective factors have been implicated in being inversely related to pain status. Examples of protective factors include engaging in moderate physical activity, controlling weight, avoiding injuries, receiving pre- and postsurgical analgesia and monitoring, and having personality traits such as resilience and positive affect.(2)

The Intervention

The GE-NMF Program

While there is no single, universally accepted definition of the medically underserved, this population can be characterized as those who do not have adequate access to healthcare services. They share one or more of the following characteristics: they may be poor and/or uninsured, have limited English language proficiency, lack familiarity with the healthcare system, or live in locations where health providers are not readily available. Members of ethnic and racial minority groups are not by definition “underserved,” but are disproportionately found among this population. (5)

The Primary Care Leadership Program (PCLP) encourages improvement of healthcare through leadership, innovation, and promotion of best practices, of which the use of evidence-based medicine is key. Using these ideals, a Chronic Pain Policy was developed at an ambulatory clinic in the underserved city of Jackson, Mississippi.

The Clinic

Central Mississippi Health Services, Inc. is a federally-qualified health center (FQHC) located in Hinds County in Jackson, Mississippi. Mississippi experiences some of the worst health outcomes in the nation, with chronic pain being no exception. Hinds County residents experience higher rates of unemployment and poverty, poor physical and mental health, lack of health insurance, and a higher population to physician ratio, almost double that of the national average. (6)

Central Mississippi Health Services, Inc. (CMHS) provided a unique opportunity for intervention in chronic pain management as the clinic cares for a population at high risk for chronic pain. The majority of patients served at CMHS are ≥ 65 years of age (56.3%) and African-American (96.2%). Most patients are below the federal poverty line (75.2%) and are uninsured or on Medicare and/or Medicaid (55.5%).(7) As discussed previously, age, race, income level, and lack of health insurance are factors associated with the development of chronic pain.

The Role of Primary Care

The American Academy of Family Physicians (AAFP) has defined primary care as “healthcare provided by physicians and health professionals specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern.” Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses. Primary care is performed and managed by a personal physician collaborating with other health professionals, and utilizing consultation or referral as appropriate. Primary

care provides an opportunity for patient advocacy in the healthcare system, provides cost-effective care through coordination of healthcare services, and promotes effective communication with patients, encouraging partnership with the patient in his or her healthcare.

(8)

In a study by Breuer et al(9), primary care physicians were found to be involved in the treatment of 52 percent of chronic pain patients in the United States, a finding that emphasizes the importance of effective pain management in a primary care setting. The principles embodied in primary care are essential to the effective management of chronic pain and a central focus of the commitment of Central Mississippi Health Service, Inc. to effective pain management for its patients.

Methods

The Chronic Pain Policy at CMHS was developed to meet both clinic and national chronic pain management goals. The Committee on Advancing Pain Research, Care, and Education at the Institute of Medicine listed several recommendations regarding management of patients with chronic pain in the document “Relieving Pain in America”(2). These recommendations, along with the goals of the Chronic Pain Committee at CMHS, were included in development of the Chronic Pain Policy.

Research on current best practice and national guidelines for the management of chronic pain was conducted prior to meeting with the Chronic Pain Committee. A meeting was then arranged to discuss goals of the Chronic Pain Policy, present current best practice and available resources for pain management, and expectations of the committee. A pain policy was drafted and reviewed by all members of the committee. Input from committee members was used to

revise the policy and a final copy of the policy was submitted to the committee members and CEOs for approval and an implementation date of July 31, 2012 was agreed upon.

The Policy

Consistent with the goals of the IOM and CMHS, this policy was developed to improve the quality of life of all patients with chronic pain by using evidence-based medicine to control pain, minimize the use of narcotics, and minimize staffing time and resources. This policy was not intended to replace clinical decision making nor does it provide recommendations on management or treatment plans for patients. Rather, this policy establishes a guideline for the operation of the Chronic Pain Committee at CMHS, a method through which providers may refer patients to the committee for evaluation, and standards to which the committee will be held to.

Chronic pain is defined by CMHS as any pain persisting for three months or more. Any provider who feels unable to effectively manage a patient's pain may refer them to the Chronic Pain Committee for evaluation. Although not required, it is recommended by the committee that any patient who is currently on chronic opioid therapy for pain be referred to the Chronic Pain Committee for evaluation.

The Chronic Pain Committee will meet with all referred patients within two weeks of referral. Any delay in meeting must be documented by the Chronic Pain Committee in the patient's chart and in committee records with an explanation of the reason for delay. Prior to review by the committee, a patient must complete the following screening questionnaires, as decided by the pain committee, including but not limited to: the Screener and Opioid Assessment for Patients with Pain (SOAPP), the Opioid Risk Tool (ORT), and/or the Diagnosis, Intractability, and Risk Efficacy (D.I.R.E) Score.

A meeting will be arranged during which the committee will meet with the patient and review the patient's medical records, completed questionnaires as requested, and pain history, including but not limited to, a history of any relevant injuries or medical conditions, including psychiatric conditions, and a history of patient or family substance abuse, including a history of all patient medications, past and current. The committee will then discuss all available options for pain management with the patient based on current best practice and available resources. Any patient whose pain management issues are felt to be beyond the scope of the clinic will be referred to a pain management clinic after review by the Chronic Pain Committee.

After case review, a Chronic Pain Management Contract will be made between the committee and the patient; this contract will be drafted by the Chronic Pain Committee and signed by at least two committee members and the patient. This contract may include agreements related to, but not limited to, random drug screening and dismissal from care by the Chronic Pain Committee for noncompliance including, but not limited to, missed appointments, drug-seeking behavior, or the sale or distribution of prescription medications. A signed copy of this contract will be provided to the patient and will be placed in the patient's medical record.

If chronic opioid therapy is decided upon for pain management, the patient will also be required to sign the Consent for Chronic Opioid Therapy and/or Long-term Controlled Substances Therapy for Chronic Pain Agreement, as well as complete the Pain Assessment and Documentation Tool and Current Opioid Misuse Measure (COMM) on subsequent visits.

Any patient who does not adhere to the contract agreed upon may be considered for dismissal by the committee, to be determined on a case-by-case basis. All patients have the right to one appeal to the committee regarding dismissal under which the committee will have the authority to decide whether to pursue dismissal or allow for continuation of the patient contract.

The Chronic Pain Committee will be held to standards of performance as described in the Chronic Pain Policy, including quarterly meetings during which random chart reviews of chronic pain patients under the care of CMHS will be conducted. The committee will also conduct an annual review of the Chronic Pain Policy and will update the policy accordingly. The committee will provide all CMHS staff with copy of the most current version of the Chronic Pain Policy, will notify staff of any changes to the policy, and will be available for questions and interpretations regarding the content of this policy. Staff training opportunities on chronic pain and chronic pain management will be organized by the committee and provided as CME to the staff of CMHS as available.

Consistent with current guidelines and the agreed upon scope of the Chronic Pain Committee, management of cancer pain, pain at the end of life, acute pain, postsurgical pain, labor pain, or chronic non-cancer pain in children and adolescents is beyond the scope of the committee and should be managed by the individual provider at CMHS who is responsible for the patient, by a specialist collaborating in the care of the patient, or through referral to a pain management clinic.

This policy must be approved by the CMHS Chronic Pain Committee and CEOs Dr. Robert Smith and Dr. Obie McNair. Any changes made to this policy must be approved by both parties prior to implementation.

Conclusion

Discussion

The Institute of Medicine recently developed recommendations to improve the care of people who experience pain and the training of healthcare providers who treat them, highlighted

in its most recent brief on chronic pain in the U.S, “Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research”. These guidelines and recommendations were used to guide discussions with the Chronic Pain Committee and were included in development of the Chronic Pain Policy at CMHS.

Recommendation 3-1 and 3-6 (2) from the IOM encourages healthcare providers to promote and enable self-management of pain and to perform consistent and complete pain assessments of those presenting for treatment. Central Mississippi Health Services, Inc. utilizes the patient-centered approach in its policy of medical management and this approach extends to that adopted by the Chronic Pain Committee. Using a patient-centered approach, the Chronic Pain Policy encourages patient participation in active management of their condition and provides an outline for the management of chronic pain patients. By completing a full history and physical of each patient, including a focus on factors commonly related to chronic pain, the patient will be encouraged to share their experience and goals of treatment. Several validated questionnaires will be used to assess risk factors for chronic pain, symptomology of chronic pain, and treatment management, ensuring a complete and consistent assessment prior to treatment.

Specific questionnaires regarding mental health symptoms will be included, as an estimated 40 to 50 percent of patients with chronic pain have mood disorders. The interrelationship between chronic pain and depression will be emphasized during assessment and management, as unrelenting pain is an important cause of and contributor to depression and anxiety, disability, and a reduced quality of life (2, 10, 11). Patients are further encouraged to take responsibility for their pain through open discussions, frequent meetings, and the development and use of treatment and/or opioid contracts with the committee. In a study of

primary care clinics, three-fifths of patients adhered to such contracts over two years of follow-up (2, 12).

Recommendations 3-3 and 4-2(2) address education regarding chronic pain management in healthcare providers involved in primary care. A survey (13) conducted at community clinics, found that, of 111 primary care practitioners, including physicians and midlevel providers, most felt inadequately prepared to treat pain and had low satisfaction with providing pain care. Despite nearly 40 percent of adult appointments involving people with chronic pain complaints, these providers rated the adequacy of their training for pain management as a 0.5 on a scale from 0 (inadequate) to 4 (fully adequate). The Chronic Pain Policy encourages the Chronic Pain Committee to take responsibility of this matter and organize opportunities for Chronic Pain Committee members and other providers at CMHS to participate in CME activities related to chronic pain and its management.

The IOM supports collaboration between primary care providers and pain specialists, including referral as appropriate, as stated in Recommendation 3-4(2). The Chronic Pain Policy encourages CMHS healthcare providers and the Chronic Pain Committee to develop partnerships with nearby pain clinics and refer patients that they feel need treatment beyond what can be provided by the committee. By the committee following the treatment of such patients, a patient-centered approach is maintained and discussions regarding treatment and management of the chronic pain patient can occur.

Best practices

Significant cost savings may arise through strategies used to reduce the prevalence and burden of chronic pain. Better management of acute pain, in order to avoid the progression to

chronic pain, may decrease economic costs through workers' compensation, lost productivity, and lost tax revenues. Preventing and effectively managing health problems and social issues associated with chronic pain may decrease the rates of several chronic illnesses and the additional burden these hold on the chronic pain patient. Through patient and provider education on chronic pain management, unnecessary diagnostic tests and procedures can be avoided and more cost-effective, personalized methods of treatment can be utilized and incorporated into practice. By monitoring the progress of patients on opioids and performing regular assessment of behavior that may indicate abuse, opioid addiction can be addressed at its initial stages. As other medications are used more effectively and other forms of treatment successfully supplement medication use, the economic costs related to opioid addiction and overdose may start to decline.

References

1. Brennan F, Carr DB, Cousins M. Pain management: A fundamental human right. *Anesthesia & Analgesia* 2007; 105: 205-221.
2. Committee on Advancing Pain Research, and Education. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Board of Health Sciences Policy, editor. Washington, D.C.: Institute of Medicine; 2011.
3. CDC Chartbook, Special feature on death and dying. Hyattsville, MD; 2010.
4. CDC. National Health and Nutrition Examination Survey. IOM; 1999-2004.
5. Scholar Orientation: Background, Primary Care in the U.S., Health & Underserved Populations. GE-NMF PCLP; 2012.
6. Scholar Orientation: Sites, Demographics & Health Data by City. GE-NMF PCLP; 2012.
7. CMHS. Uniform Data System (UDS). Jackson, MS; 2011.
8. Physicians American Academy of Family Physicians. Primary Care. 2012.
9. Breuer B, Cruciani R, Portenoy RK. Pain management by primary care physicians, pain physicians, chiropractors, and acupuncturists: A national survey. *Southern Medical Journal* 2010;103(8):738-747.
10. Bair M, Wu J, Damush TM, Sutherland JM, Kroenke K. Association of depression and anxiety alone and in combination with chronic musculoskeletal pain in primary care patients. *Psychosomatic Medicine* 2008;70(8):890-897.
11. Gureje O. Comorbidity of pain and anxiety disorders. *Current Psychiatry Reports* 2008;10:318-322.
12. Hariharan J, Lamb G, Neuner J. Long-term opioid contract use for chronic pain management in primary care practice: A five-year experience. *Journal of General Internal Medicine* 2006;22(4):485-490.
13. Upshur C, Luckmann R, Savageau J. Primary care provider concerns about management of chronic pain in community clinic populations. *Journal of General Internal Medicine* 2006; 21(6):652-655.