OPTIMAL PAIN MANAGEMENT IN PRIMARY CARE VIA INTERPROFESSIONAL COLLABORATION: A DNP PORTFOLIO

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Introduction of Clinical Practice Issue: *Definition of Chronic Pain*

- Chronic pain is any pain condition lasting more than 12 weeks, and is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage.
- Chronic pain accounts for more than 80 percent of all medical visits and is associated with major psychiatric disorders and emotional suffering.
- 116 million Americans adults experience chronic pain, costing the U.S. up to $635 billion each year in medical treatment and lost productivity.
- Many of chronic pain patients receive insufficient pain treatment because of a lack of adequate pain management in primary care. This is partly due to a lack of knowledge among the Primary Care Providers (PCP), limited pain management insurance benefits, and regulatory barriers that prevent legitimate pain patients from getting adequate treatment.

Practice Question: *Investigate the Concept Of Chronic Pain in Primary Care and Explore Effective Interventions*

- A multidisciplinary approach, including conventional medicine, complementary and alternative (CAM) treatment options, and behavioral interventions, is essential to treat chronic disease along with chronic pain, anxiety and depression.
- Addressing chronic pain in conjunction with primary care concerns is possible with "shared visits" or "group visits."
  - Shared visit: One patient has a visit with one PCP and one CAM/Behavioral Health provider to address a primary care concern and chronic pain.
  - Group visit: A group of patients with similar health concerns have a visit with multiple PCPs, CAM providers, and Behavioral Health providers to address their common primary care concern and chronic pain (e.g. patients with diabetes and chronic pain).

Project Aims: *Understanding and Treating Chronic Pain Using the Biopsychosocial Model*

- The concept of chronic pain is a biopsychosocial phenomenon in which biological, psychological and social factors interact with one another, and can interfere with the experience of living with chronic pain.
- As a philosophical model, the biopsychosocial model helps understand how suffering from a disease (objective biological phenomenon) and illness (subjective experience of the patient who has the disease) are affected by multiple factors, and affects various factors. At the practical level, the model contributes to exploring the patient's subjective experience, and views the patient as an active partner in the relationship with the provider.
- The social determinants such as socioeconomic stability, education, social structure, access to health care, and the environment affect an individual's state of health. Therefore, there is a need to explore a new care delivery model that would use a multidisciplinary approach to addressing, treating and managing chronic pain in primary care.

Treatment Options: *A Collaborative Model*

- The biopsychosocial approach alleviates the patients' pain, helps the patients explore their feelings and develop healthy coping skills.
- This model of care places the patient in the center of the plan, engages the patient in their treatment options, and encourages collaboration with the different members of the health care team.
- The program emphasizes participatory decision-making and family-centered care.
- A mental health provider offers support to the patients who are struggling with the pain, teaches ways to accept a tolerable amount of pain, and helps them learn healthier ways to cope with limitations.
- CAM treatment options supplement the medical treatment of chronic pain.
- Shared/Group visits allow for PCP(s) to address the patient(s) medical concerns with conventional therapies, and the CAM/Behavioral Health provider(s) offer additional treatment options.

Multidimensional Care
It's More Than Medications

**Adapted from: Multidimensional Care. Boston University School of Medicine*

Case Study: *A Group of Patients with Diabetes and Pain. A grant received from Care Oregon Coordinated Care Organization*

- Oregon City Medical is a primary care clinic in Oregon, providing shared visits to patients with chronic pain and uncontrolled diabetes (HgA1c > or = 8), to address blood glucose control and the psychosocial aspects of their conditions.
- PCPs and licensed clinical social workers (LCSW) collaborated to address the psychosocial aspects of diabetes and chronic pain.
- 32 patients were offered the shared visit model. 23 of the 32 patients have had one or more shared visits with LCSWs, many have had multiple shared visits.
- The patients were screened for depression using the PHQ9, and SBIRT for substance abuse. LCSWs provided brief interventions to the patients during shared visits addressing depression and other psychosocial factors. The primary care team and the LCSWs met regularly to address the needs of each patient. These needs commonly included: socioeconomic barriers, lack of transportation, access to information related to their chronic disease, lack of motivation, and depression.

Results:

The project was successful in reaching the one year goals:

- Better compliance with drug screenings and pain medication regimes.
- Total reduction of 4% in HgA1C values.
- Outcome measures indicated a 50% decrease in the no-show rates.
- Increase of shared visits with this subpopulation from 0% to 73%.

Feasibility: *Coding and Billing*

- Group visits require the participation of a larger number of patients and providers, therefore, are more feasible for clinics with more than 5000 patients. Shared visits are more feasible in clinics with less than 5000 patients, as fewer patients and providers are needed to participate.
- When PCP and CAM/Behavioral Health providers spend prolonged visit time face-to-face with the patient counseling/coordinating care, the following code can be used: 99354
- The following CPT codes can be used in addition to standard E&M codes in primary care (e.g. 99214)
  - G0396-7: Alcohol abuse and assessment
  - G0436-7: Smoking/tobacco cessation and counseling
  - G0444: Annual depression screening
  - G0447: Face-to-face behavioral counseling for obesity
  - G0108: Diabetes self-management service (individual)
  - G0109: Diabetes self-management service (group)

Conclusion:

- Chronic pain is a significant public health issue, and is complex due to biopsychosocial interactions.
- A multidisciplinary approach using shared/group visits can effectively allow patients to address their primary care concerns and chronic pain with a PCP, CAM provider, and behavioral health provider.
- Prolonged visit time codes and additional screening/counseling codes allow for medical providers to be compensated for additional services provided to patients, making it a financially sustainable model.

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