

CONFERENCE ABSTRACT

Integrated Team Assessment and Patient Perspective Pain Paradigm in Primary Pain Care Pain Management: a new language for provider-provider and provider patient communication

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Introduction: The opioid crisis has highlighted the needs for more effective pain management. Integrative|multidisciplinary pain programs are effective, but are not widely available. A native Alaskan primary care (PC) group had successfully implemented an opioid reduction and MAT programs, but were unsuccessful sustaining an integrated pain program. A new approach was piloted by addressing three issues: 1) patient reluctance to go behavioral health due stigmatization; 2) the need for a care paradigm whose language helped integrate PCs, rehabilitation services (RS), behavioral health (BH) and nurse providers around the patient and their care ROADMAP; 3) the limitations in teaching and care-coordination resources to support patient self-management.

Practice change: Three strategies addressed the above issues: 1) BH came to the RS department where they joined a pain specialist, nurse, and physical therapist for a team history, clinical evaluation and patient collaborative decision-making; 2) a Patient Perspective Pain Paradigm (PPPP) was developed and unified providers with their patient in their joint assessment of pain's five components (PFC) and in the development of a care plan balanced between active and passive therapies; 3) BH offered care management and education to helped patients follow their care ROADMAP through the phases of illness to living well.

Aim & theory: Our aim was to change care from a provider-centered|episode-based process, to a patient-driven|performance-based process that looked at five components of pain and taught self-management.

Population & target: Patients and representatives, PC providers, BH directors and therapists, RS director and therapists, a specialty consultant and board director contributed to the pilot program development serving one clinic.

Timeline: Tasks accomplished between May 2018 to May 2019 were: setting goals based on the system's strategic plan; assessing needs; delivering BH pain-care in the RS department; creating care ROADMAP templates for patients; modifying scheduling, documentation and billing templates; selecting screening questionnaires; scaling the care management service.

Highlights: Referred patients were hesitant, but afterwards they: 1) felt heard and became engaged in their own care; 2) gained new insights about the components to their pain; 3) agreed to participate in the BH groups; 4) care management became financially viable and scalable because of BH involvement.

Sustainability & transferability: Important factors for sustainability will be: 1) Access to TeleMed pain care in remote villages; 2) Centralization and standardization of BH care management to support patients and care teams; 3) Standardization of post-acute and chronic pain evaluations allowing personalized care ROADMAPS.

Conclusions: Integrated care teams helped patients feel heard, appreciate the comprehensive evaluation framework, and engage with their self-management opportunities around: movement-function, inflammation, nervous system sensitization, autonomic visceral activation, and cognition patterns. They committed to an active greater than passive care plan and a ROADMAP to lead them through illness phases: crisis to self-confidence; acceptance to living well.

Discussion: Problem areas implementing an integrated pain evaluation program included: scheduling, billing, interprofessional communication, patient reluctance and care-management discontinuity. Nearly all chronic pain patients meet BH diagnostic criteria necessary for CM services.

Lessons learned: Collaborative development needs to fit within the organization's structure and payor regulations.