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Initiative Aims to Lighten Primary Care's Chronic Pain Overload

By Tyler Smith

It seems a simple situation. A patient visits a primary care provider (PCP), complaining of chronic pain that interferes with activities of daily living. The PCP writes a prescription for a narcotic analgesic, or opioid, such as hydrocodone. The patient fills the prescription for the medication, which relieves the pain.

Peter Smith.

It's a scenario that has played out millions of times over the past decade, and now society is paying the price. The well-intentioned prescription writing, encouraged by federal pain control guidelines, and newer, more potent medications, has helped to fuel a national epidemic of addiction to prescription painkillers and drug overdoses. The number of such medications dispensed in the United States has quadrupled since 1999 – as have the number of deaths from overdoses, according to the Centers for Disease Control and Prevention. The CDC reports that 16,000 people died from prescription painkiller overdoses in 2013 alone.

The stark stats might point the finger of responsibility at PCPs, some of whom certainly have overprescribed prescription painkillers. But the real story is far more complicated, said Peter Smith, MD, associate professor of Family Medicine and assistant dean for clinical affairs with the University of Colorado School of Medicine. The avalanche of prescriptions is the consequence of a tsunami of chronic pain patients for PCPs, Smith said.

He points out that the ratio of chronic pain patients to physicians specializing in pain treatment is 30,000-to-1, and most of them focus on interventional procedures. That leaves most patients to seek help from PCPs, who are not trained to manage chronic pain.

"The problem has landed in the lap of PCPs," Smith said. With resources in pain management, substance abuse disorders, and behavioral health relatively scarce, and PCPs under pressure to see more and more patients, it's little wonder that many PCPs turned to writing prescriptions for opioids. Colorado, Smith added, is one of the leading states for opioid abuse and opioid-related deaths and "ground zero for a national epidemic."

Nipping a budding problem. It's difficult to quantify the problem at University of Colorado Hospital's primary care clinics, Smith said, but he noted that a recent database review found 8,000 to 10,000 patients who had received three or more refills for prescription opioids in the past 13 months. Some of those were for palliative care and cancer patients, he acknowledged, but the number is nevertheless cause for concern, Smith said.

He's part of a broad effort to address the problem. A Primary Care Oversight Committee project jointly funded by UCH and University Physicians, Inc., is working to broaden management of chronic pain in the primary care clinics and improve the quality and safety of patient care.

The committee's work has yielded standardized training for PCPs in managing chronic pain and being aware of the risks of opioid use.

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The training includes online modules developed by the Colorado School of Public Health as well as monthly telehealth case conferences with a multidisciplinary team of specialists. Providers will have guidelines for managing patients with chronic pain and access to a host of online resources. The website will also include information for patients, Smith said.

Patricia Pade.

Additionally, the group worked with the Epic team to create a tool that automatically converts a patient's chronic pain medication dose to the maximum daily equivalent dose of morphine. It then calculates a risk score that displays in a note to providers. A longer-term project goal is to create a registry of opioid patients to help providers develop an understanding of their characteristics and ensure that those at high risk of addiction get therapy in addition to their primary care, Smith said.

Addressing addiction. That help includes services at UCH's AF Williams Family Medicine Clinic. Patricia Pade, MD, program director for CU's Addiction Medicine Fellowship, leads a clinic for chronic pain medication patients prescribed opioids who are at moderate to high risk of addiction and overdose. Shandra Brown Levey, PhD, director of integrated clinical behavioral services for the Department of Family Medicine, provides behavioral health care for many patients referred by PCPs, including those with chronic pain.

Pade called the mountain of painkiller prescriptions and the social problems that have resulted "a complex issue" that goes back to the 1990s.

"Patients were prescribed a lot of opiates with little evidence of the good they would do them," she said. "Nobody knew what would happen five, six, ten years out, and now people are struggling. The problem is that PCPs are in the least position to deal with it, but they are stuck with managing the problem."

Many of the patients Pade sees in her half-day clinic at AF Williams are taking painkillers with a daily equivalent morphine dose of 100 milligrams, an amount that substantially increases the risk of overdose. The primary goal is to help these patients taper off opioids to a safer range. Pade said data on some 180 patients taking opioids show that the clinic helps to reduce the equivalent morphine dose an average of 90 milligrams.

The clinic also helps patients find alternatives for managing their pain. One frequently used is buprenorphine, a medication used to treat opioid dependency as well as relieve pain while alleviating withdrawal symptoms, Pade said. Non-medical treatment, such as physical therapy, is another valuable technique for relieving pain safely. As an additional precaution, the clinic trains patients and their loved ones to use naloxone, a substance that can reverse the effects of an opioid overdose.

Shandra Brown Levey.

But clinical expertise alone is not always enough to manage patients reliant on chronic pain medications, Pade said. She noted that many patients at moderate risk for overdose have comorbidities that increase their vulnerability, including depression, previous addiction, and simply being young. In October, Pade said, the Center for Dependency, Addiction and Rehabilitation (CeDAR)

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at UCH will open an addiction medicine program that includes psychiatric services and intensive counseling.

Plans are to use hospital expansion to extend care beyond the walls of AF Williams and CeDAR, added Steve Millette, CeDAR's executive director. "As UCH consolidates its multiple Boulder-based specialty clinics into one location next year, the hope and plan is that the integration and collaboration between addiction medicine and primary care started at AF Williams will be replicated in our new Boulder location," he said.

Behavioral change. At AF Williams, PCPs can also call in behavioral health specialists on-site. Brown Levey, a clinical psychologist, said her role is to support providers treating patients who have issues with pain and addiction as well as other behavioral difficulties, such as depression, anxiety, and health behavior change needs.

An encounter typically involves the PCP giving a quick presentation of the issue to Brown Levey, who then meets with the patient. After that discussion, Brown Levey circles back with the PCP to discuss possible behavioral treatment options. Brown Levey often also works with the patient and the provider in the room at the same time, providing an opportunity for team-based patient care.

The roots of chronic pain are complex, Brown Levey said, with physical and emotional factors often intertwined. "I try to elicit conversations with patients," she said. A seemingly simple back-and-forth conversation can yield valuable information about the times and situations when a patient's pain typically flares.

"I try to plant seeds about what the patient can do and how to help manage the pain and improve functioning," Brown Levey said.

Among other therapeutic options for patients, Brown Levey leads a monthly pain support group. It focuses on helping patients to identify barriers to pain management and teaching them to better manage pain and improve functioning with strategies based on breathing, meditation, and mindfulness.

"The group is also an opportunity for patients to meet with people who understand the problem and learn how to do better and to help each other," Brown Levey said. A key goal, she added, is to help patients single out something of value that their pain prevents them from doing – say attending a granddaughter's soccer game – and guide them in deciding how to address the issue.

Integrating care. More broadly, Brown Levey said, her team's work at AF Williams is important as a "bridge service" to introduce patients to the mere idea of seeking behavioral health care, which still carries a stigma for many. When it is appropriate, the clinic can help to transition patients to a long-term provider, such as the CU Depression Center or UCH's Outpatient Psychiatric Clinic.

For Smith, the problem of managing chronic pain reflects the long-time fragmentation of care in the U.S. health care system, which as a rule still separates medical and behavioral health care rather than integrating them and allowing providers to develop unified treatment plans.

"Like diabetes, chronic pain is a medical condition with a behavioral component and socioeconomic component," Smith said. "It doesn't address the problem to bite off little pieces of it. I would love for all our primary care practices to have the kind of services AF Williams offers its patients."

Nor can the problem of chronic pain addiction be written off as one that affects only certain groups of people, Smith said.

"As physicians, we've seen it in many different contexts," he said. "Addiction is an equal-opportunity problem that affects people in all walks of life. Human addictive behavior knows no boundaries."