Collaborative Care

An Effective Way to Manage Patients with Chronic Pain

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- Concert Health co-founder and Special Advisor, Advocacy and Research
- 20 years of non-profit leadership, clinical and administrative operations for larger teams
- 20 years of building high-performing Collaborative Care teams
- Industry speaker & consultant (AIMS, NCBH, SAMHSA)

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- Directs integrated behavioral health services for a multi-site, not-for-profit, primary care practice system in Central New York (Cayuga Health)
- General psychiatrist by licensure with additional training and experience in integrated psychiatric consultation
- Leadership and clinical experience in integrated and specialty-care psychiatric models across community, military, and college health environments
- Speaking experience includes regional (Cornell University, Cayuga Health) and national level (CFHA) engagements

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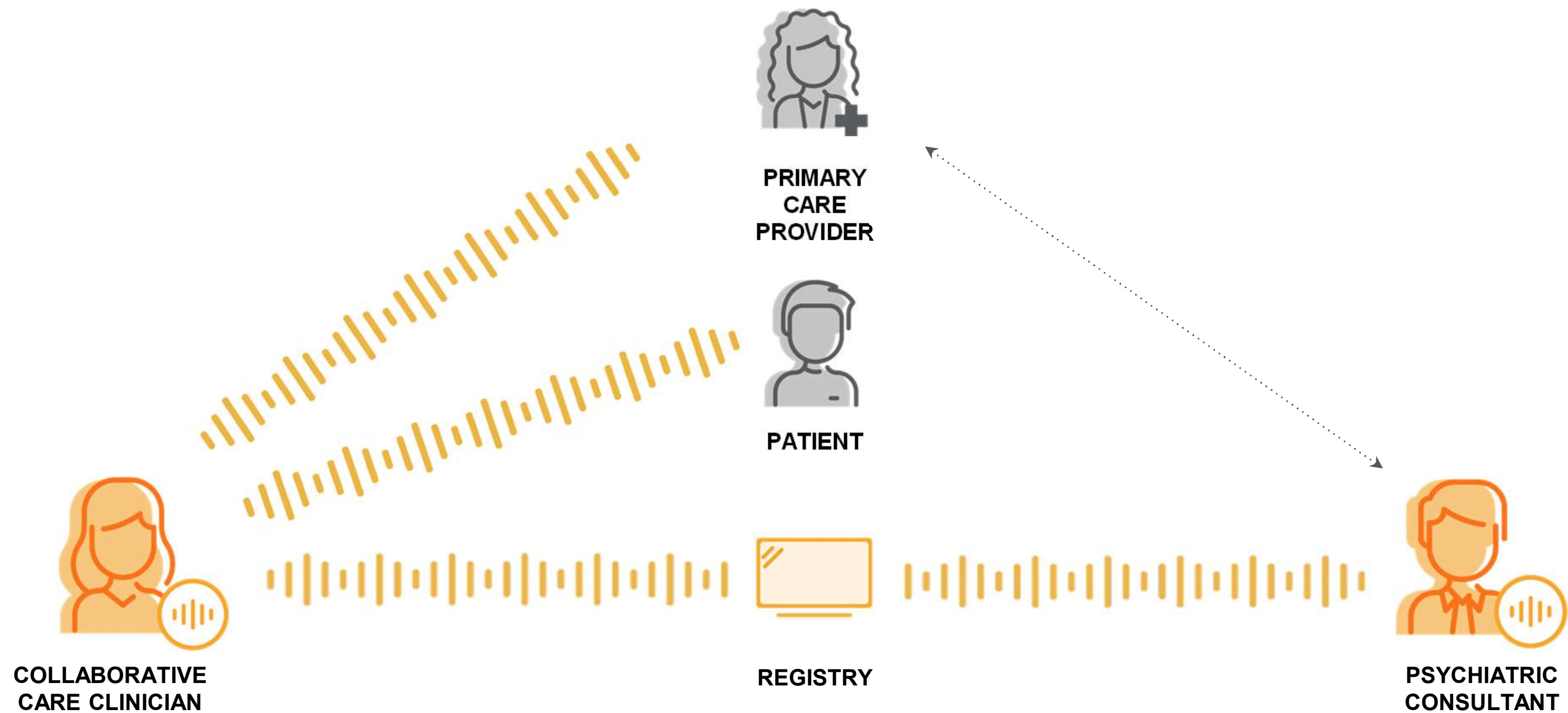
Turnkey Approach to Collaborative Care



Source: Diagram adapted from the AIMS Center at the University of Washington's visual representation of the Collaborative Care Protocol

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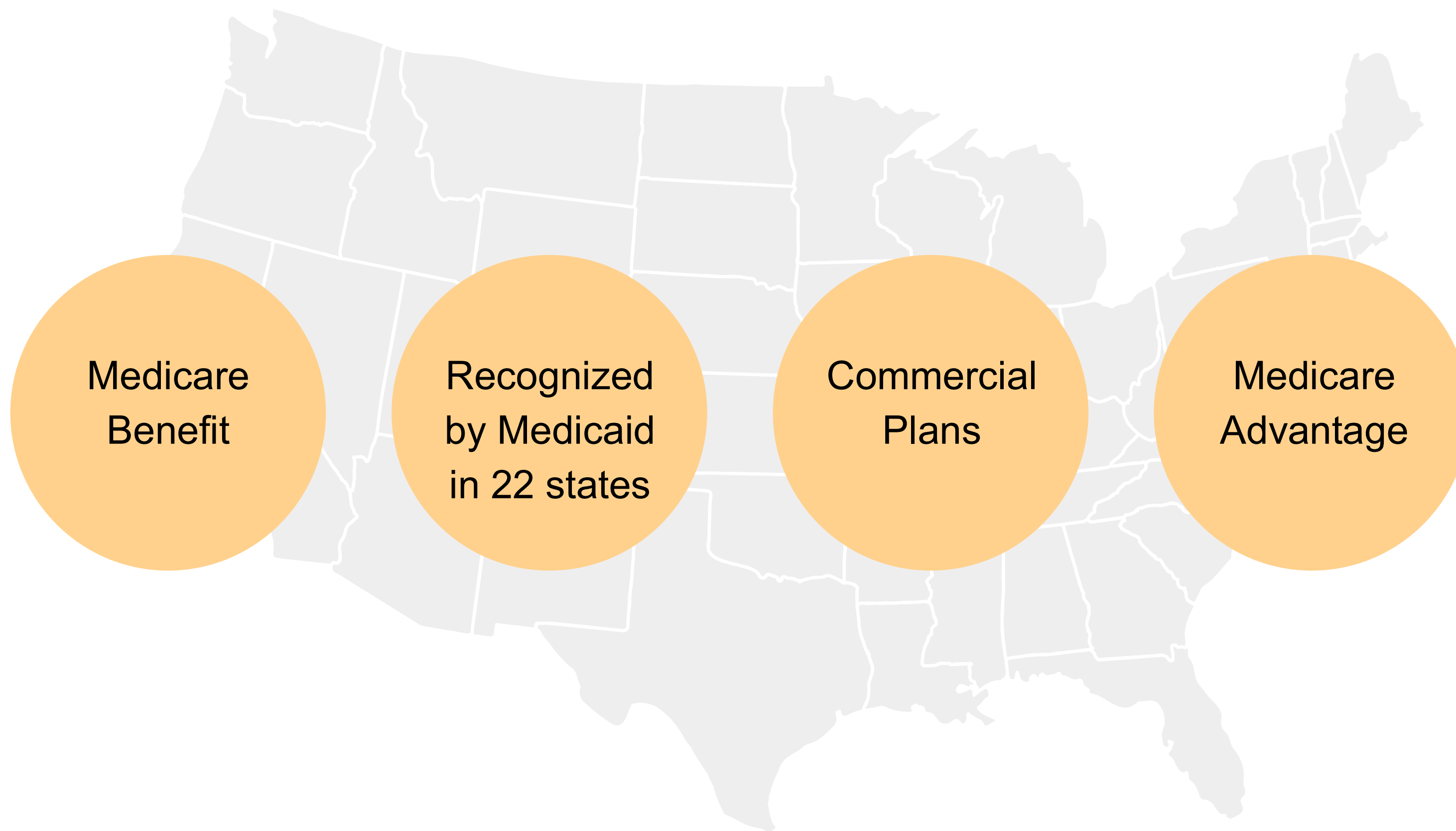
Collaborative Care Reimbursement



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Core Principles of Collaborative Care

Patient-Centered Care

Primary care and mental health providers collaborate effectively using shared cared plans.

Crisis Access and Expertise

Concert's team is trained in suicide safer-care techniques. Phone tree to provide you real-time support when you don't feel safe letting your patients leave the clinic.

Population-Based Care

A defined group of patients is tracked in a registry so that no one falls through the cracks.

Treatment to Target

Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

Evidence-Based Care

Providers use treatments that have research evidence for effectiveness.

Accountable Care

Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.

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Treatment Choices

Evidence-Based Practices

Talk Treatment/Therapy

Cognitive behavioral interventions, problem solving treatment, dialectical behavioral approaches, etc.

Behavioral Activation

Increase adaptive behaviors, re-establish routines, troubleshoot barriers

Medication Adherence

Support patients with prescription regimen

Symptom Monitoring

Tracking thoughts, feelings, screening scores

All choices are clinical interventions, and they can happen repeatedly!

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Behavioral Health, Functionality, Opiates

- Collaborative care should be part of “rx” for patients experiencing chronic or acute pain
- Team-based care is considered a “best practice” for pain patients
- Behavioral activation for functionality
- Overdose safety planning
- Co-morbid behavioral health conditions

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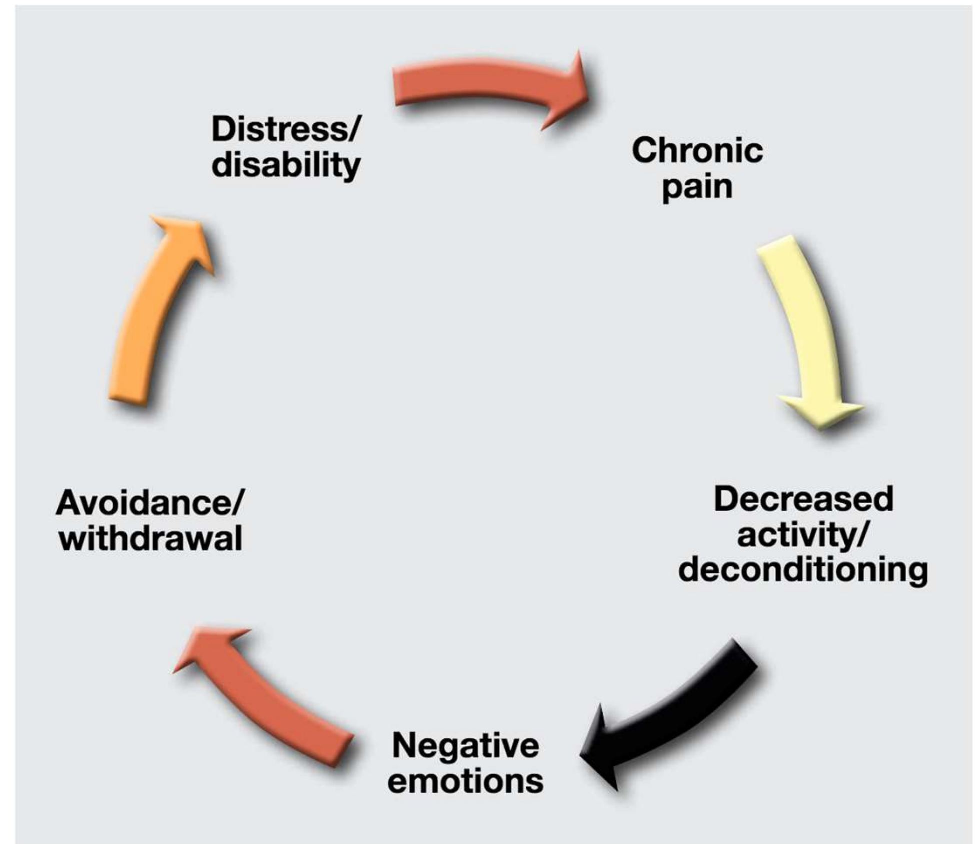
Collaborative care brings core components to patients

- Psychoeducation
- Behavioral activation
- Pleasure principles
- CBT/ replacing cognitions
- Collateral “care team”
- Focus on function
- Recognize pain/grieving loss
- Pain/sleep/mood



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Collaborative care helps change the discussion around pain

- Help to move the focus from pain and changing the experience of pain in control to putting the patient "in driver's seat"
- Is talking about pain helping or is it a "reminder"?
- If pain were not "in charge" what would you like to do today?
- Are there things you used to do that you would like to do again?
- Is there something specific you would like to change?
- Working with collaterals on changing language

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Chronic Pain and Suicide

- Nearly 1 in 10 suicide deaths in the United States are associated with chronic pain.[1]
  - More than 25 million adults (11.2%) in the US experience some level of **daily pain**, while 10.5 million (4.6%) suffer from **significant pain every day**
  - Suicide currently ranks as the 10th leading cause of death in the US

- Patients with chronic pain often exhibit risk factors for suicide, including **coexisting psychiatric conditions** like depression and anxiety, as well as **access to opioid medications** commonly used for chronic pain management[2,3]

[1] Petrosky et al., 'Chronic pain among suicide decedents, 2003 to 2014,' 2018.
[2] Okifuji & Benham, 'Suicidal and self-harm behaviors in chronic pain patients,' 2011.
[3] Hassett et al., 'The risk of suicide mortality in chronic pain patients,' 2014.

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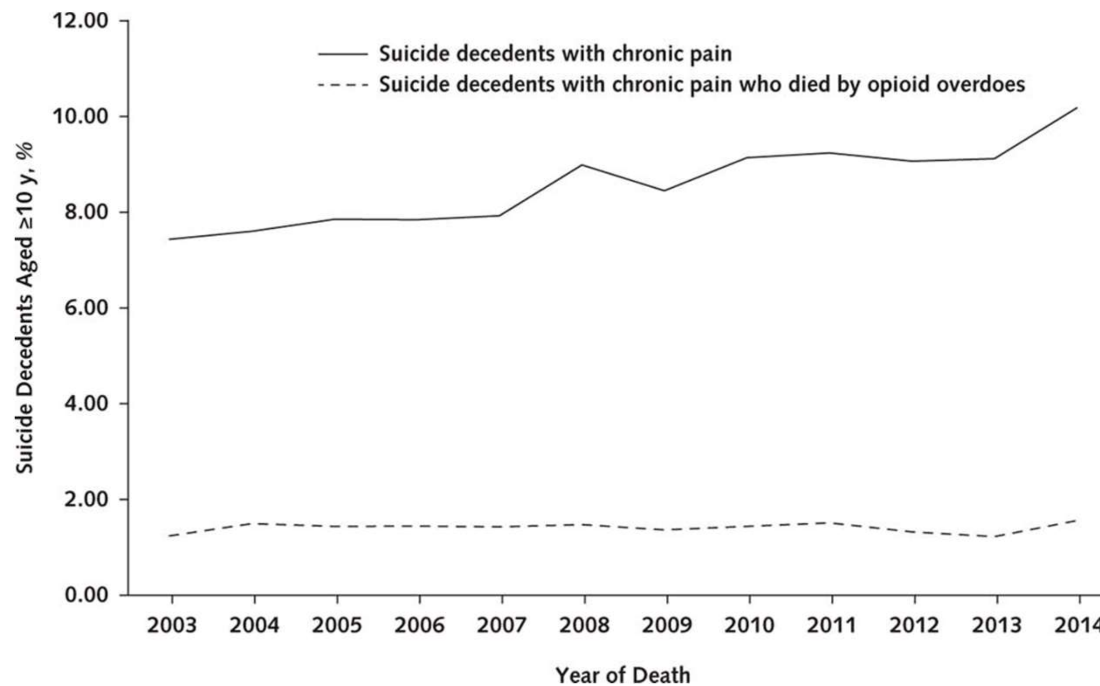
Percentage of suicide decedents with chronic pain aged 10 years or older, by year, in 18 states—NVDRS, 2003–2014



Retrieved from "Chronic Pain Among Suicide Decedents, 2003 to 2014: Findings From the National Violent Death Reporting System" by E. Petrosky, R. Harpaz, K. A. Fowler, M. K. Bohm, C. G. Helmick, K. Yuan, and C. J. Betz, 2018, *Annals of Internal Medicine, 169*(7):448-455. Copyright 2018 by American College of Physicians.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________ DATE: ______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns ___ + ___ + ___

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL ___

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	___
Somewhat difficult	___
Very difficult	___
Extremely difficult	___

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DURATION

- Two weeks

SEVERITY

- Frequency
- Intensity

***Consider individual AND total scores
***Consider changes in scores across time

IMPACT

- Clinically-significant emotional distress
- Dysfunction

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add columns		+	+	
TOTAL:				

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Core symptoms of depression

Neurovegetative symptoms

Thoughts of being better off dead or of self-harm

Ask questions that are in bold.

Ask Questions 1 and 2	Past Month YES	Past Month NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you had any actual thoughts of killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, go directly to question 6		
3. Have you been thinking about how you may do this? *e.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.*		
4. Have you had these thoughts and had someintention of acting on them? *as opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Lifetime	
	Past 3 Months	
If **YES** to question 6, ask: **Was this in the past 3 months?**		

Schedule Follow-Up

Address Lethal Means, Safety Planning, Schedule Follow-Up

Evaluate Hospitalization, Address Lethal Means, Safety Planning, Schedule Follow-Up

Suicide Safer Care: Suicide Prevention in Primary Care

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Treatment Considerations

- Caution with pain medication interactions with common psychotropic medications
  - Serotonergic agents: muscle relaxants, opioids, tripans
  - Overuse of NSAIDS, especially with SSRIs / SNRIs (risk for bleeding, especially GI bleeds)
- Clinical pearls: Consider the fewest number of agents with crossover benefits for comorbid conditions

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Treatment Options for Chronic Pain

This table outlines different classes of medications and non-pharmacological treatments with indications for use in chronic pain. While pain management is a major issue in the United States, the evidence is still limited, especially for non-pharmacologic treatments. Long-term studies for almost all treatments are lacking. Please note that this table is provided as an overview and should not be considered as a guideline for specific management.

Table C. Management Considerations Based on Pain Type: Acute vs. Chronic Pain

Characteristics	Acute Pain	Chronic Pain
Duration	Normal healing duration; <3-6 months	Prolonged duration >6 months
Function	Physiologic (protective)	Pathologic (non-protective)
Cause	Acute illness, injury, trauma, surgery or other medical procedure	Injury, chronic illness, cancer, may have no indefinable pathology
Characteristics	Usually nociceptive; sharp, localized, sudden/gradual onset	Usually a combination of nociceptive and neuropathic, dull, aching, generalized, persistent
Treatment options (non-inclusive list no in any particular order)	Nonsteroidal anti-inflammatory drugs (NSAIDS), acetaminophen, opioids, nerve bocks, ketamine, muscle relaxants, pain-reducing modalities (e.g., immobilization, heat/cold, and elevation), graded exercise of the affected body area, physical therapy. Opioids are not recommended for acute low back pain.	Non-opioid analgesics, physical therapy, cognitive behavioral therapy, rehabilitation, exercise, integrative medical therapies (e.g., yoga, relaxation, tai chi, massage, and acupuncture), opioids on a case-by-case basis
Goals of treatment	Pain Resolution + Resolve underlying cause: - Facilitate recovery - Reduce pain - Minimize side effects - Prevent chronic pain	Pain Control + Restore function: - Restore function (physical, emotional, social) - Decrease pain (e.g., treat underlying cause, minimize medication use) - Correct secondary consequences (e.g., maladaptive behavior)

Table D. Pharmacologic Treatments

Class of Medication	Indications[a]	Magnitude of Benefit[b]	
		PAIN	FUNCTION
NSAIDs (topical or oral)	Low back pain, asteoarthritis, inflammatory arthritis, acute musculoskeletal (MSK) pain	Small to noderate	None to small
Acetaminophen	Acute MSK pain	Small	None
Antidepessants	Diabetic peripheral neuropathy, fibromyalgia	Small	None
Anticonvulsants	Diabetic peripheral neuropathy, fibromyalgia	Small to moderate	None (neuropathic pain) Small (fibromyalgia)
Opioids	Acute MSK pain, chronic pain, neuropathy	Small to no benefit[c]	Small to no benefit[c]
Non-Pharmacologic Treatments			
Therapy	Indications[a]	Magnitude of Benefit[b]	
		PAIN	FUNCTION
Exercise	Low back pain, neck pain, knee and hip osteoarthritis, fibromyalgia	Small to moderate	Small to moderate
Cognitive Behavioral Therapy	Low back pain, fibromyalgia	Small to moderate	Small to moderate
Massage/Acupuncture/ Spinal Manipulation	Low back pain, fibromyalgia, chronic headache, neck pain	Small to moderate	Small to moderate
Yoga/Tai Chi	Low back pain, fibromyalgia	Small	Small (fibromyalgia) Moderate (low back pain)

a. Summary of treatments and indications pulled from recent guidelines and evidence reviews as outlined above (references 3, 4, 6, 7)

b. Magnitude of benefit compared to harms of treatment; will vary based on type/location of pain

c. Not considered first line treatment for most indications

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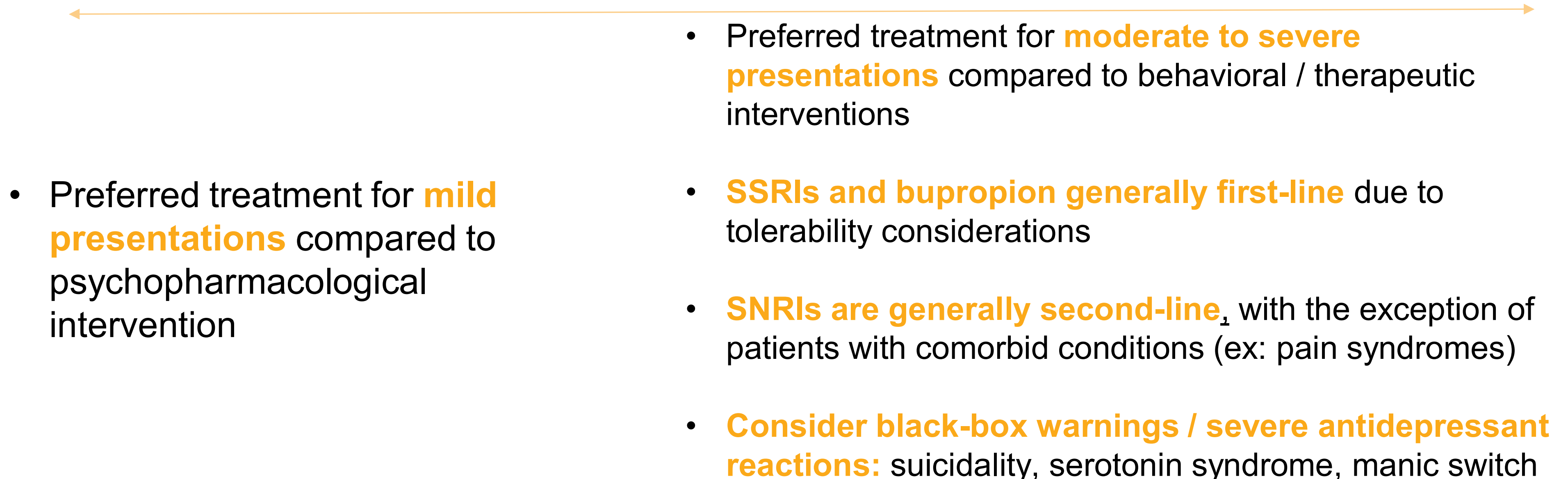
Depressive Disorder Treatment Considerations



*****EXPANDED BENEFITS FOR COMBINATION THERAPY / PSYCHOTROPIC TREATMENTS**

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Clinical pearls for treating depression with SSRIs / SNRIs

Ensure adequate time AND dosing with consistent adherence

Consider that tolerability complaints are a common cause of early treatment drop-out

Consider second and third-line treatment options ONLY AFTER adequately exhausting first-line options

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SSRI / SNRI Pearls

Selective Serotonin Reuptake Inhibitors (SSRI)	Serotonin and Norepinephrine Reuptake Inhibitors (SNRI)
SSRIs generally first-line for comparative tolerability > efficacy for depressive and anxiety disorders	Comparative advantages for efficacy with treatment-resistant symptoms and comorbid presentations with pain, cognitive, and vasomotor symptoms • Greater tolerability risks for GI upset, hypertension, and insomnia
Consider impact of disorder on target dosing: • Depressive Disorders: Lower dosing increments advantages • Anxiety Disorders: Higher dosing increment advantages	Comparative benefit for anxiety symptoms at lower dosing increments compared to SSRIs
Preferable for "increased negative affect" (depressed mood, guilt, fear / anxiety, hostility, irritability, loneliness)	Preferable for "decreased positive affect" (depressed mood, loss of happiness, loss of energy, decreased alertness)

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Adult Unipolar Depression Medication Algorithm for Primary Care

Unipolar Depression Diagnoses:

(1) Presentation consistent with a depressive disorder

(2) *Consider rule-outs:* medical, substance, medication, another psychiatric condition (ex: Bipolar)

(3) Ensure moderate to severe disorder

(4) Consider individual and family characteristics

First-Line Medication Trial
Greater emphasis on tolerability
Utilize lowest effective dose

First-line Considerations
Escitalopram (Lexapro) and sertraline (Zoloft) generally have the best tolerability of SSRIs and lower risk for drug-drug interactions

Bupropion (Wellbutrin) particularly tolerable for sexual function and weight management but no ideal for seizure risks, prominent anxiety, or elderly

Non-response or inadequate response?
Ensure adequate trial, assess adherence, confirm diagnosis

Tolerable medication with partial response
Consider augmenting approaches (after or in conjunction with behavioral interventions)

No response and/or intolerable side effects:
Consider switching agents

If patient presents with comorbid pain
Consider duloxetine (Cymbalta), venlafaxine (Effexor)

Consider psychotherapy in conjunction **at any point**

Case Example

- 37-year-old female treated for chronic pain and “treatment-resistant depression” in primary care
- She was recently assessed by rheumatology one month ago and has been newly diagnosed with fibromyalgia
- Rheumatology recommended low-impact physical exercises and referrals to PT/OT, but the patient declined these recommendations due intolerable pain when exercising
- She has multiple medication trials of SSRIs over the last 5 years, with no trials lasting longer than a month due to tolerability problems
- Her PCP recommends her to collaborative care (CoCM)

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Resources

- Building Bridges: Six Steps to Improve Integrated Pain Care (pcdc.org)
- AAFP Chronic Pain Management Toolkit | AAFP

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Q&A

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Thank you.