Chronic Pain Clinical Pathway Outline

1. Identification of Patients for Chronic Pain Pathway
   
   a. Criteria for inclusion into chronic pain pathway: Patients who meet the following criteria should be asked to attend an IBHC appointment as part of standard, evidence-based team healthcare:
      
      i. Patients enrolled in the one-provider program (i.e., only one provider is prescribing narcotic medications)
      ii. Patients who have signed a pain agreement
      iii. Patients who have taken narcotic medications for a pain condition for 3 months or more
      iv. Patients with a diagnosis of a chronic pain condition (e.g., ankylosing spondylitis, costochondritis, fibromyalgia, complex regional pain syndrome, headaches, rheumatoid arthritis, osteoarthritis, lupus, chronic low back pain, degenerative disc disease, irritable bowel syndrome)

   b. Process for identification: Multiple methods should be used to identify chronic pain patients for referral to the IBHC.
      
      i. Morning huddle review of PCM patient roster
      ii. Identification of patient by nurse/tech during screening for PCM appointment
      iii. Identification of patient by PCM during PCM appointment
      iv. Patient self-referral
      v. Referral of patient by other
      vi. Proactive booking by nurses who oversee HEDIS metrics for “patients on persistent medications,” if applicable
      vii. PCMs or nurses refilling any anti-inflammatory or analgesic medications for chronic pain, especially narcotics
      viii. Monthly data pull from AHLTA or Care Point (e.g., chronic pain diagnosis in last 12 months, new prescription for chronic pain treatment with narcotic pain medication, those on narcotic pain medication for 4 months or greater, those with new narcotic prescription because previous narcotic prescription decreased in effectiveness)

2. Methods of Linking Identified Patients with the IBHC
   
   a. During a PCM appointment with a patient who meets any of the inclusion criteria, the PCM, nurse, and/or other designated team member ensures the patient receives a same-day appointment with the IBHC following the PCM appointment (warm handoff) or schedules a future IBHC appointment.
   
   b. If patients are identified through data pull from AHLTA or Care Point:
      
      i. PCMH nurse or technician calls patient to schedule a future IBHC appointment. 
         *Uses standard pathway telephone script.*
      ii. PCMH nurse, technician, PCM, or IBHC may also send secure email to encourage an IBHC appointment.
c. If patient refuses to see the IBHC, a team member (PCM, nurse, technician) may ask the IBHC to review the available medical record and information from the PCM, and document recommendations for care based on available medical data.

3. First IBHC Appointment
   a. Administer PEG [pain intensity (P), interference with enjoyment of life (E), and interference with general activity (G)] outcome measure for pain (available in the IBHC TSWF form; also see attachment “PEG Scale”)
   b. Biopsychosocial functional assessment questions specific to pain management:
      i. Pain symptoms  
      ii. Location of pain in the body  
      iii. Onset, frequency, duration of pain  
      iv. Subjective ratings of pain intensity on a 0-10 scale (10 = “the most excruciating pain you have ever experienced” and 0 = no pain)  
         i. Average rating over last 2 weeks  
         ii. Worst pain level in the last 2 weeks  
         iii. Lowest pain level in the last 2 weeks  
         iv. Current pain level  
      v. Factors associated with increases and decreases in pain  
      vi. Relevant medical conditions that relate to pain  
      vii. Pain medications and patterns of use (e.g., taking on fixed schedule or “prn”- as needed; taking more or less than prescribed; taking more over time to get same effect, etc.)  
      viii. Any psychosocial changes that coincided with the onset of symptoms  
      ix. Biopsychosocial assessment of functioning across multiple domains of life functioning

c. Intervention Options: There are numerous evidence-based interventions for improving chronic pain management. The IBHC and patient should collaboratively select the intervention(s) that are most appropriate given the nature of the patient’s difficulties as well as readiness for change. Possible interventions include:
   i. Education  
      i. Distinction between acute and chronic pain (see Handout 1 “Acute versus Chronic Pain”)
      ii. Limitations of medical technology in identifying some causes of pain and in eliminating chronic pain
      iii. Importance of self-management, and functioning/quality of life as the goal for pain management (i.e., unrealistic to set goal of eliminating pain) (See Handout 7 “Medical versus Self-Management”)
      iv. Gate control theory of pain (factors that open and close gate; See Handout 2 “Gate Control Theory of Pain”)
      v. Biopsychosocial factors involved in chronic pain (See Handout 5 “Understanding Chronic Pain”)
   ii. Use of pain diary to monitor and identify patterns in pain/activities/emotions
   iii. Activity pacing (See Handout 3 “Activity Pacing with Chronic Pain” and Handout 4 “Pacing Yourself to Increase Valued Activities”)
   iv. Behavioral activation (See Handout 4 “Pacing Yourself to Increase Valued Activities”)


v. Relaxation training (See Handout 8 “Relaxation Posture,” Handout 9 “Cue Controlled Relaxation” and Handout 10 “Diaphragmatic Breathing”)

vi. Strategies to manage intense pain episodes (See Handout 6 “Steps for Managing Intense Pain Episodes”)

vii. Questioning unhelpful thinking (See Handout 6 “Steps for Managing Intense Pain Episodes”)

viii. Identifying, monitoring, and decreasing pain behaviors (grimacing, limping, using one’s body in an unbalanced way in order to mitigate pain)

ix. Stretching or appropriate physical activity daily

x. Healthy nutrition and sleep; other self-management strategies (heat/cold packs; hot baths or showers)

xi. Adherence to pain medication prescriptions

xii. Monitoring/using assisted ambulatory devices (canes, walkers, scooters) appropriately

xiii. Develop recommendations for PCM (e.g., recommend referral to physical therapy or occupational therapy; recommend patient be considered for single prescriber program; recommend PCM initiate written pain contract, recommend referral to specialty behavioral health, etc.)

4. Follow Up IBHC Appointments
   a. Recommended follow-up interval:
      i. The time between appointments with the IBHC will vary depending on the IBHC’s assessment of the patient’s readiness to change, their ability to successfully make changes with self-management approach, and the nature of the intervention selected.
      ii. For many patients the follow-up interval is between 2 to 4 weeks

   b. Recommended number of IBHC appointments:
      i. 2 to 4 IBHC appointments may be sufficient for some patients to improve and maintain aspects of their chronic management.
      ii. Other patients may benefit from continuity consultation (more than 4 appointments) to maintain the changes needed best overall management. For patients receiving continuity consultation, consider the following structure:
         1. Initial phase of consultation: 4 appointments, spaced at 2 week intervals
         2. Continuity consultation:
            a. Appointments with IBHC at more spaced intervals (e.g., monthly, every other month, quarterly).
            b. Consider alternating monthly appointments with IBHC and PCM
            c. If seeing a patient more than 4 times, ensure patient progress is made and documented. Clearly document rationale for continuity consultation in each note, and space out the appointments at increasing intervals (e.g., once per month or once per quarter). Consider referral to specialty behavioral health if indicated.

   c. Assessment at follow-up IBHC appointments:
      i. BHM-20
      ii. PEG
      iii. Reassess pain severity levels (0-10 scale) and factors related to any changes