Group 17 IPE Pain Conference with UNE Students of the Colleges of Pharmacy, Physical Therapy, Social Work, and Osteopathic Medicine

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Mercy Pain Clinic Program Background

Chronic pain is a serious health problem that continues to grow in prevalence. A study based on the 2008 Medical Expenditure Panel Survey indicated that chronic pain affects about 100 million adults in the United States, with an estimated annual cost that ranges from $560 to $635 billion. Current medical education on pain management is extremely limited, which in part leads to insufficient pain care by post-graduate health care providers. The program "Supervised Student Chronic Pain Clinic" is designed to help train health professional students to improve their abilities and provide them with experience in interprofessional practice and chronic pain management. The current study serves as a pilot study that will help us to evaluate the feasibility and the effectiveness of this "supervised interprofessional student clinic" approach.[1]

Patient Overview

Chief Complaint: Our patient is a woman in her 50s referred to the pain clinic for initial evaluation by her primary care physician. She presents with a diagnosis of fibromyalgia and a history of intolerance to many medications. Previously, physical therapy and psychotherapy had to be cut short due to lack of insurance. She has also tried numerous medications in the past and has had side effects with all, preventing use.

Patient's Goals:
To find a holistic approach to pain management

The Interprofessional Approach

The team met prior to patient intake to understand types of pain, pathology, and intersections with physical and mental traumas. Importantly, the pain clinic does not necessarily measure success by eliminating pain; instead, they engage with the patient from a model of accepting chronic pain while improving quality of life in the Acceptance and Commitment Therapy (ACT) framework. No single profession can address quality of life because such a measurement is inherently holistic- encompassing pathology, mechanics, chemistry, and social determinants of well-being. Together, the interprofessional team worked through differential diagnoses and various treatment modalities. They then presented recommendations to the patient and collaborated on a meaningful treatment plan.

Social Work

The patient lives in rural Maine with a "very supportive" partner. She enjoys gardening which is one of her value-added activities shrunk by chronic pain (others include cooking, family time, dancing, and hiking). Because of her ease identifying committed actions, I anticipate she will react very well to ACT approaches; she was invested in the referral to the Pain Clinic psychologist. She did not immediately identify mental health as a tactic to manage pain although she has had positive experiences with a therapist in the past.

Potential barriers to care include out-of-pocket costs and needing to take unpaid time from work. She notes improvement with an anti-inflammatory diet but was unable to afford that diet due to recent illness and time away from work.

Pharmacy

The patient was placed on an extensive list of drugs for both her pain and pre-existing conditions - posing an increased risk for side effects and drug interactions. Patient's primary pain medication is a muscle relaxer taken twice daily during flare of pain, then return to 1-2 by mouth at bedtime as needed. Topical NSAID was placed on hold during therapeutic trial of oral NSAID. The patient reported having good outcomes while on the muscle relaxer, however, she was afraid that the drug might lose efficacy over time. She also expressed no interest in starting a new drug and preferred to work with a physical therapist. In addition, she reported that the muscle relaxer worked but she feared that these effects would wear off overtime.

Osteopathic Medicine

The patient presented with a long history of pain symptoms, onset since childhood and progressively worsened from incidents of physical trauma including a car accident. She pursued surgical interventions including a lumbar fusion which resulted in paresthesias in one of her legs and minimal improvement of low back pain. The patient was under long term care of a chiropractor with relief from gentle manipulation. Given her adverse reactions to many medications and previous temporary relief from joint injections and manipulation, physical interventions appeared to be a starting point for treatment. Based on these history and physical findings, we recommend osteopathic manipulative medicine as a treatment option.

Physical Therapy

The patient had attended physical therapy sessions before, but remained in pain and was unable to continue care due to lack of insurance. Patient reported her previous physical therapy consisted primarily of stretches and was likely not functional for modulating her pain. A well-informed therapist, in combination with information and treatment provided by a physician, could guide the patient through therapeutic exercises, stretches, mobilizations, postural adjustments, and lifestyle modifications to aid pain mitigation stemming from her cervical spine, sacroiliac joints, and feet.

Patient Appointments

Appointment 1: The main goal of the first patient appointment centered around information gathering and a physical examination. During the 60 minute interview, we gathered an updated medication list, persistent problems, and a more thorough social history. In between appointments 1 and 2, the team would discuss with Dr. Hull potential treatment plans to implement in appointment 2.

Appointment 2: Due to the holistic goals of the patient, we decided to discuss with her the possibility of an anti inflammatory diet, mindfulness, physical therapy, and psychotherapy. The patient presented with a flair of pain. We opted for treatments that would rapidly reduce the flair; a sacroiliac joint injection under fluoroscopy and possibly pursuit of nerve blocks and, if diagnostic, radiofrequency ablation. We increased her muscle relaxer and started an oral NSAID to try and reduce the acute pain. The patient was agreeable to set up a pain psychology appointment.

Appointment 3: Due to COVID-19, neither the injections nor the PT were able to be initiated, although the patient is in the process to start therapy over telehealth.

Interprofessional Work in the time of COVID-19

In mid March of 2020 our interprofessional team, along with the rest of the country, faced a new challenge in completing our outlined goals; the arrival of the highly infectious SARS-CoV-2 causing the illness of COVID-19. What felt like overnight, the world shifted into a new daily reality of social distancing. Our team transitioned to virtual communication with a heavy reliance on email and the video chatting platform Zoom to complete our project. These Zoom meetings were a different form of the familiar round table sessions we were used to, but we quickly found our flow in returning to our focus; Patient 17 and how this virus would affect her care. Communication over Zoom came with accidentally muted mics, wifi drops, and some talking over each other, but it also allowed for the freedom to meet more times than we likely would have without this situation. We brainstormed what each profession could provide over telemedicine, as well as the limitations. At this time, a pain psychology appointment over video chat for our patient is in development, which we as a group are hopeful will provide support to our patient. The value of communication with each other and with our patient was felt to be an important consideration of interprofessional work in the time of COVID-19.

COVID-19 and Harm vs. Hurt Prioritizing Pain Care

Pain allows our body to detect tissue injury, prevent injury, hasten healing, and is essential for survival. According to this tissue damage model, as the tissues heal the pain will decrease, reflecting the resolution of the threat to the body. A person experiencing chronic pain has a mismatch between the potential or actual tissue damage, and the pain signals being interpreted by the brain. Well after the healing time has completed and damage no longer exist, their body continues producing pain signals. The pain they are experiencing ceases to relate to the harm imposed on the body. A key aspect of the Pain Clinic is to educate patients that hurt does not always equal harm. With the COVID-19 threat, many medical centers have begun to prioritize only emergency care when there is immediate harm to the patient. Unfortunately for patients experiencing chronic pain, the pain they may be feeling (no matter how severe) does not qualify as causing harm. Since the physical interventions that would normally be provided to alleviate pain (osteopathic medicine, injections,physical therapy etc.) cannot be accessed, we had to change our priorities for the care of Patient 17. Our focus has shifted to emphasize patient education and counseling that can be completed via telehealth.

Outcomes

By working in an interprofessional group, it allowed us to start this patient on a multifaceted treatment program that works within the patient's goals and lifestyle. An integrated, patient-centered, interprofessional approach to care addresses many aspects of a patient's life that affect their well-being, including social factors, mental health, physical health, and access to health care.

Acknowledgements

[1] Taken from consent form for Effectiveness of educating medical professionals in managing chronic pain patients through a "supervised student inter-professional pain clinic", a case study" by Ling Cao, MD PhD, Associate professor, Department of Biomedical Sciences, College of Osteopathic Medicine 8/29/12.