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Overcoming Fears, Frustrations, and Competing Demands: An Effective Integration of Pain Medicine and Primary Care to Treat Complex Pain Patients

In the United States, the number of pain specialists is insufficient to manage the tens of millions of patients suffering from chronic pain. Also, multidisciplinary pain clinics are on the "endangered list" and not widely available. Therefore, most patients with pain are being managed in the primary care setting. Primary care providers (PCPs) encounter patients daily with chronic pain and its attendant comorbidities, but may lack the knowledge, experience, and time to tackle all the complexities involved—frustrating both patients and providers. PCPs have become increasingly aware of research documenting the undertreatment of pain, but feel unprepared to adequately address this public health problem because of their limited training in pain and addiction medicine [1], and are inexperienced in the nuances of using opioids, treatment agreements, and urine drug tests.

Time pressures are faced routinely by PCPs. While these pressures are not unique to primary care; juggling a variety of competing demands by PCPs is unique and may be particularly onerous [2]. In addition to addressing patients' acute complaints and concerns at a particular visit, PCPs are expected to manage several comorbid chronic diseases (diabetes mellitus, hypertension, heart disease, and many others), provide preventative care (cancer screening and vaccinations), offer counseling and education, order indicated laboratory and radiographic tests, refer to appropriate specialists, and stay attuned to a variety of quality of care indicators. Pain management is just one of the many items on this crowded agenda, and PCPs often feel as if they have too much to accomplish during the standard 15 minutes clinic visit. As a result, critical tasks such as comprehensive pain assessments and use of tools such as opioid agreements and urine drugs testing may not be implemented. Hariharan et al. [3] described their experience with opioid agreements in an academic primary care setting. PCPs placed patients on opioid agreements only 4% of the time and less than half (45%) ever had a urine drug screen ordered during the 5 years under study.

Despite the publication of several national guidelines and consensus statements detailing the appropriate use of opioids for chronic pain, PCPs continue to fear regulatory scrutiny and sanction and worry about fostering prescription drug abuse and addiction. These fears have been heightened by several additional issues: 1) recent media reports of criminal prosecutions involving physicians convicted of manslaughter from prescribing opioids; 2) data showing rising rates of unintentional deaths related to methadone and fentanyl use; and 3) research showing that opioid misuse and aberrant behaviors are common in primary care [4,5]. Still opioids are gaining wider acceptance by PCPs and are being prescribed more frequently [6], despite lingering questions of their long-term effectiveness [7]. However, PCPs prescribe opioids for "at risk" (i.e., those with past or present history of substance use disorder) patients with much trepidation and specifically want assistance in this context.

In this issue, Wiedemer et al. [8] describe the development and evaluation of an innovative opioid renewal program for "at risk" patients with chronic pain requiring opioids. The intervention consisted of regular assessments and monitoring by a clinical pharmacist and a nurse practitioner working together as a liaison between PCPs and a multidisciplinary pain team. In addition, PCPs were trained in the use of opioid agreements and random drug testing. Outcomes included patients' adherence to opioid agreements and urine testing, provider behavior and satisfaction, and pharmacy costs.

Of 335 patients referred to the program, 171 (51%) had documented aberrant behaviors (e.g., positive urine screen for illicit drugs) and 164 (49%) entered the program because of complex management issues (i.e., history of substance use disorder, need for opioid titration or rotation). In those with documented aberrant behaviors; 38% self-discharged from the program; 13% were referred for addiction treatment; and 4% had consistently negative urine testing for prescribed

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opioids and were weaned off. Of the patients with a history of substance use disorder or other "complexity" (i.e., need for opioid titration or rotation or previous problem with PCP over opioids) but no documented aberrant behaviors, all were adherent to the program. PCPs use of opioid agreements increased fourfold and random urine drug testing increased substantially over the study period. PCPs expressed high levels of satisfaction with the program and significant pharmacy savings were shown. An important issue not addressed in the study is whether patients in the program showed improvements in pain or function.

The findings by Wiedemer et al. highlight several issues relevant to pain management in the primary care setting. First, the study demonstrated how a team of front-line providers, clinical managers, pharmacists, and researchers can effectively develop, design, and evaluate an intervention tailored to address a local clinical problem. Second, the intervention targeted the management of primary care patients with chronic pain with a high potential for opioid misuse and abuse—a frequent dilemma for PCPs who may feel ill-prepared in this situation [1]. Third, the intervention showed the benefit of integrating pain management services into primary care. And finally (and maybe most importantly), the intervention provided training, support, and structure that were reassuring to PCPs and helped alleviate both their fears related to opioid management and some time burdens.

This study is a welcome addition to the scant literature focused on pain management in primary care. In a similar study, Chelminski et al. [9] conducted a prospective cohort study to evaluate a disease management program for primary care patients with chronic pain on opioids and demonstrated significant improvements in pain, disability scores, and depression symptoms at 3-month follow-up. The authors concluded that these improvements resulted from their systematic approach to pain management and attention to comorbid depression. While both studies lacked a comparison group and findings need to be confirmed in controlled trials, both were impressive for their rigorous development and evaluation in a real-world, primary care settings.

Future efforts need to more effectively integrate pain and addiction medicine into the primary care setting [10]. PCPs are the current workhorses in delivering chronic pain care; yet they do not necessarily relish this role without the guidance and back-up from pain specialists. Some promising areas for future research include nurse case management interventions, stepped care approaches [11], or other collaborative care models [12].

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