Center for Health Experience Design
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Addressing the Opiate Crisis through Better Pain Assessment

About Us

MHQP

MHQP has a 21-year history of effectively bringing together representatives from across the medical ecosystem (large system providers, affiliated and independent physician groups, all of the large insurers, and patients of different backgrounds) to develop groundbreaking measures in the areas of health care quality, patient experience, patient-reported outcomes and practice variation. Its multi-stakeholder governance and infrastructure allows for broad representation, rapid dissemination of findings, accelerated change in practice patterns and experienced measurement of those changes.

Mad*Pow

Mad*Pow is a strategic design consultancy that leverages the psychology of motivation to create innovative experiences and compelling digital solutions that are good for people and good for business. For almost 20 years, our passionate and creative team has thrived on collaborating with our clients to create experiences and programs that are designed to deliver both social impact and financial return.

Thanks

Cigna®

Many thanks to Cigna for their partnership and funding for Phase 1

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Background

When it comes to pain, doctors and patients often have a hard time partnering with each other. We're not much good at talking about how much it hurts, or understanding the reasons it won't go away, or building the trust it takes to navigate together through the complex, ambiguous landscape of pain.

Too often, these dysfunctional conversations lead to the over-prescription and overuse of opioids—and ultimately to the destruction of individual lives, families, and communities across the country.

Challenge

How might we improve conversations between **clinicians** and their **patients suffering from serious pain** to enhance the ways in which they **assess and understand pain** in the **outpatient** setting?

Approach

Using a human-centered and evidence-based design process, we drew together the different stakeholders involved in assessing pain, including patients, their families, physicians and other healthcare professionals. Each of these stakeholders offered key perspectives into the ways in which we respond to pain: how we experience it, assess it, and treat it.

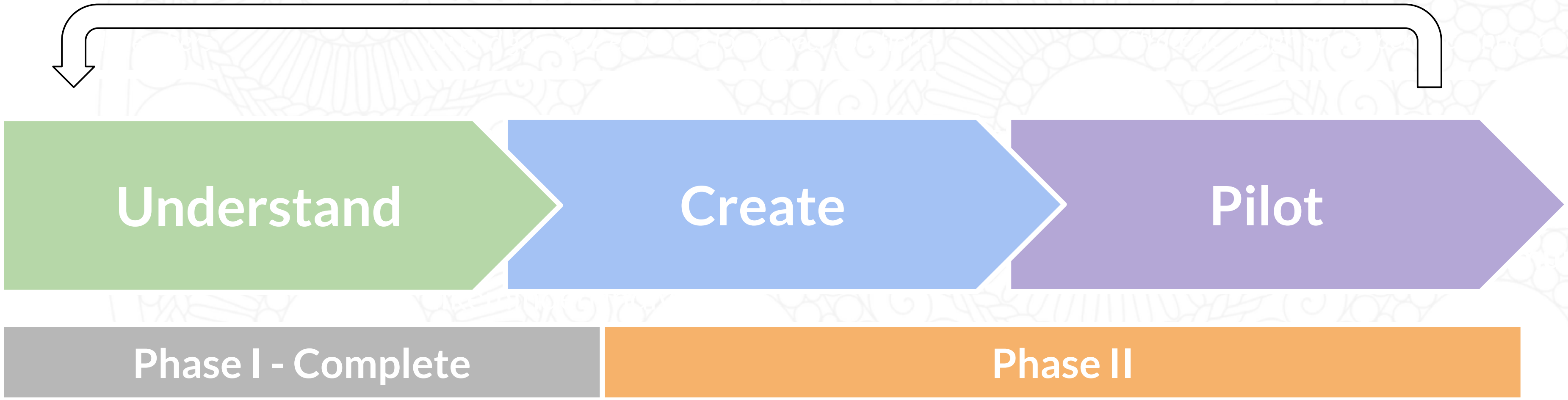
This deeper understanding of the patient-clinician interaction provided a foundation for broader, prevention-based approaches to pain that may prove more powerful than regulatory solutions such as limits to the number of pills a physician can prescribe.

Activity

Background research including:

- Professional literature review
- Expert interviews including pain specialists, journalists, medtech investors, substance abuse counselors
- Stakeholder research including people suffering from acute pain, and those suffering from chronic pain, PCPs, surgical specialists, VA physicians, integrative pain managers, physical therapists, nurses, pharmacists, and payors
- Co-design workshop with representatives from each stakeholder group
- Summarized findings and recommendations for future Phase 2

Project Status



Immersive Research

25+ Interviews: Patients, PCPs, Pain Specialists, Advocates, Surgeons, Nurses, Researchers, Payors, Pharmacists…

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“Big-Picture” Pain Challenges

Physiological	Pain in fundamentally subjective	Pain is commonly complex	Pain is poorly-understood
Interpersonal	Doctor expected to “just fix it”	Patients with pain often isolated, confused, fearful	Clinical interactions are rushed, cold, surface
Systemic	Patients have limited access to multi-modal care	Healthcare system designed to provide acute care	Reimbursement policies support consultation, education poorly

Patient with Acute Pain: Insights

Key Unmet Needs

Help me get relief from this pain - it's scary.

Help me get back to my life quickly.

Help me feel listened to and not rushed.

Help me get the care that's right for me, not some generic, one-size-fits-all approach.

Help me avoid getting addicted - I've heard so much about the trouble people are getting in.

Help me feel sure this won't last forever.

Help me feel like I'm in the care of someone who is an expert, and can get to the root cause of my pain quickly.

Barriers to Satisfaction

- Clinicians aren't aware of full range of treatment options.
- Patients lack access to complete range of treatment options (e.g. not covered, can't afford copay).
- Clinicians "don't have time" to patiently consider full patient story.
- Pain is inherently difficult to measure; pain scale reduces complex experience to a number.
- Clinicians treat "every patient as a suspect," harming patient trust.
- Patients not proactive in managing own health due to "receive from expert" health culture.

(Mal)adaptive Behaviors

- "Doctor shops" until clinician can be found who will give desired Rx.
- Experiments with wide range of specialist clinicians until one can figure out the "real cause" of pain.
- Uses acupuncture because "it really works," accepts burdensome out-of-pocket expense.
- Enlists wife for help being accountable for responsible dosing and timing of opioid Rx.
- White-knuckles the pain for three days until it fades on its own.
- Switches to heroin when opioid refill refused due to clinician fear of abuse.

Primary Care Provider: Insights

Key Unmet Needs

Help me get through my significant patient load quickly.

Help me maintain my reputation as a competent, trustworthy professional.

Help me know whether this patient is trying to fool me to sell or misuse drugs.

Help me ensure I don’t get my patients addicted - I’ve sworn an oath to do no harm and could lose my license.

Help me stay current with every new pain treatment I can offer my patients.

Help me avoid the burden of disruptive, emotional patients on my practice.

Help me get rid of difficult cases without feeling like I’m abandoning my patient.

Barriers to Satisfaction

- Pain can be overwhelmingly complex to treat.
- Pain is difficult to describe, and pain scales infrequently give clinicians specific, actionable information.
- Financial pressures “force” PCPs to allocate minimal time to a patient.
- PCPs are trained to play the role of “expert”; it’s difficult to admit error or course-correct.
- Pain patients can be emotional, abusive, and difficult to confront.
- PCPs are given very limited training in treating pain.
- Public attention on the opioid crisis has brought intense scrutiny onto PCP prescribing practices.

(Mal)adaptive Behaviors

- Dreads chronic pain patient visits, strategizes to minimize disruption.
- Resists prescribing opioids before milder treatments attempted.
- “Gives in” to patient demands.
- Avoids implementing accountability measures like opioid contracts and urine tests because it involves confronting patients and signals distrust.
- Asks questions about functional impact of pain to understand role pain plays in patient’s real life.
- Leads off new patient consultation with frank conversation about pain.
- Ensures every pain patient receives education regarding risk of opioids.

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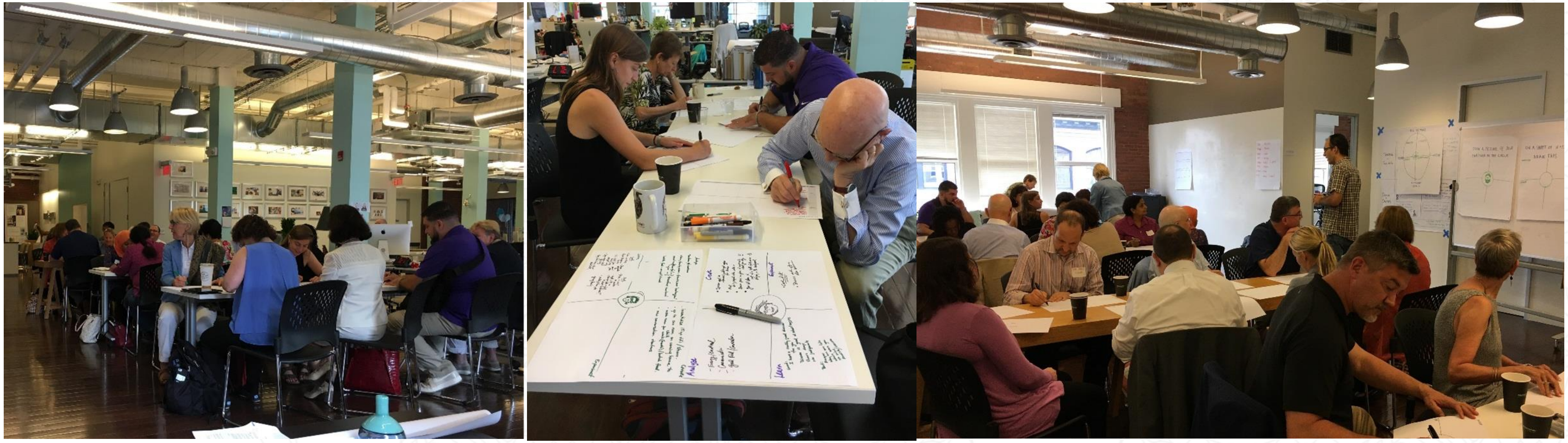
Ideation Through Collaboration

Using knowledge gained from the Research phase, our next step was to bring together representatives from across the various stakeholder groups to have them work together to identify the key points of intersection for the challenges they face and hone in on the areas of opportunity.



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ILLUSTRATED JOURNEYS

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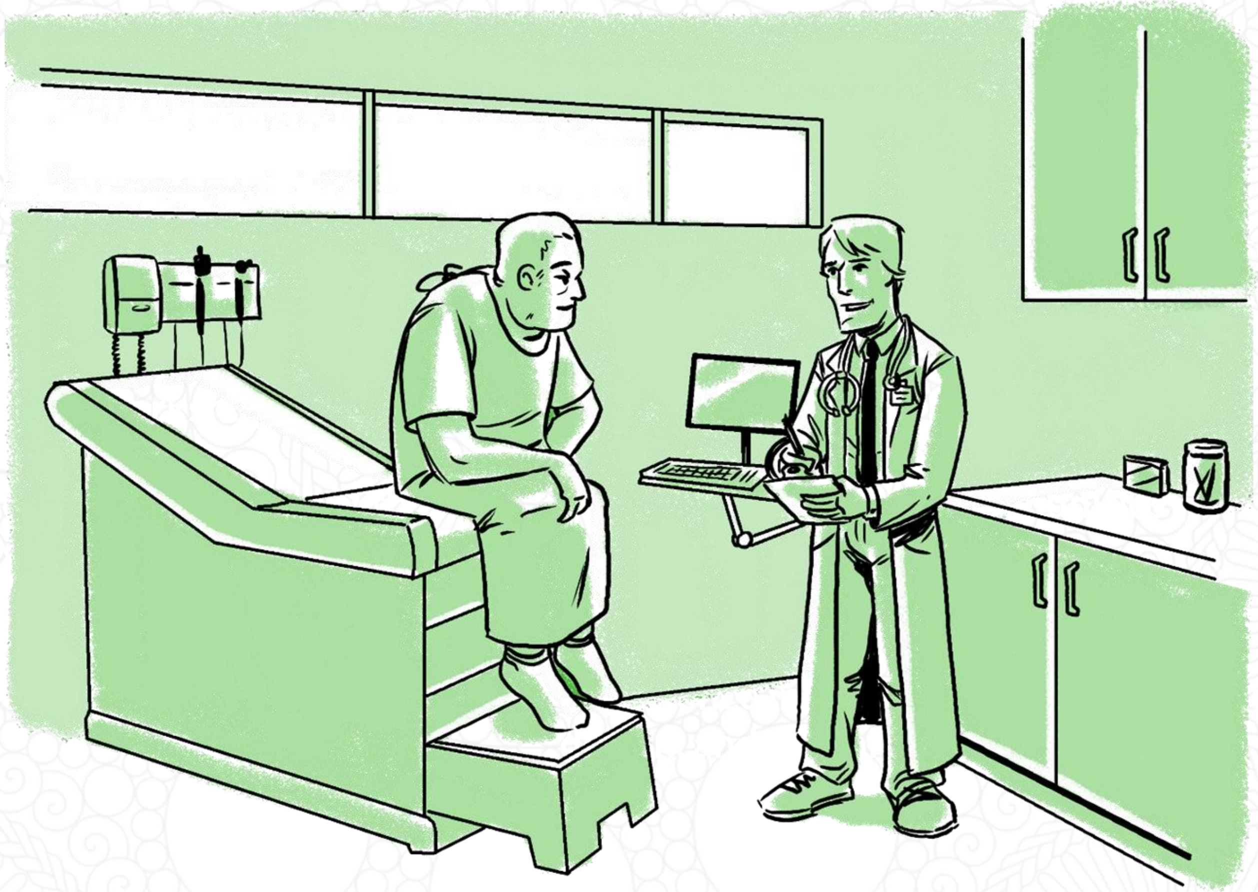
Patient Meeting with PCP

In instances of complex and chronic pain, patient-physician interactions are often marked by mistrust on both sides. Patients struggle to prove that their pain is “real,” and deal with increasing scrutiny of their motivations, while physicians are worried about the consequences of giving patients powerful opioids--or of being deceived by those seeking opioids for abuse or diversion. As a consequence, these relationships are often strained.



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Patient Meeting with Nurse

Nurses are a consistent para-clinical touchpoint for patients with complex and chronic pain, and may offer opportunities for less-rushed, deeper interactions that yield insights into psycho-social dimensions of a patient’s experience.

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Patient and Pharmacist

Most patients primarily interact with pharmacists in a retail context where they can seem little more than just another cashier (e.g. prescription pickup at CVS). But pharmacists are trained to provide real care about complex pharmaceutical issues to complicated human beings. Given the right opportunities, they could become more substantial contributors to a care team.

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Patient and Payor

Many patients with chronic and complex pain have mixed experiences with insurance companies, which often act to enable or obstruct care options. However, their central coordinating role and ability to see/understand an individual patient journey as well as that of a population, gives payors a unique opportunity to enable interactions between stakeholders who may not closely coordinate in patient treatment.

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Patient with Friends/Family

Patients suffering from complex or chronic pain can feel severely isolated; however, while friends and family can provide life-saving support for a patient with complex or chronic pain, they themselves also feel the real burden of long-term illness. These people are able to offer critical care, and be “on the same team” as a patient in need... if their own needs are considered as well.

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Five Key Findings

1. Pain is not well understood which leads to fear and uncertainty
2. There can be a lack of trust between patients, providers and payors which contributes to suffering
3. There are many barriers to successful pain assessment conversations including a dearth of training and tools
4. Policy and payment issues create barriers to appropriate treatment
5. Setting mutual goals and encouraging empowerment and hope for patients are often crucial missing approaches in care delivery

1 Pain is not well understood, which leads to fear and uncertainty

"I have no idea what to do so I am going to keep suggesting the same 'solutions'."

- We do not deeply understand the pathology or etiology of pain – there is a lack of knowledge and agreement about what works, and what may work is different for different people and at different times.
- Chronic pain can be a life-threatening condition that reduces life expectancy on its own and should be viewed as a disease
- There is tremendous stigma around patients with pain, particularly "invisible pain" such as lower back pain – people start doubting the legitimacy of such pain and the person suffering if it is not "seen"
- Ongoing pain and its treatment has an uncertain course for a given patient and this can lead to treatment that is frustrating and inadequate

2 There is a lack of trust between patients, providers, and payors which contributes to suffering

"Both patients and clinicians are often guarded about interactions – patients feel dismissed and clinicians are frustrated and feel hoodwinked by drug seekers."

- Patients who are seeking care have often been to multiple providers and are frustrated that nothing has helped them
- Patients often have complicated histories (impacted by socio-economic status, motivators, resiliency) and it takes time and skill to understand what is really going on
- Providers wrestle with whether the harm of opioid prescribing outweighs the benefit for a given patient
- Providers have concerns about building a profile as "drug (opioid) giver"

3 There are many barriers to successful pain assessment conversations including a dearth of training and tools

“These conversations require a skillset that many doctors do not have in their toolbox.”

- Many providers do not have the time and do not have the skills required to capture the relevant history
- How do we help support provider's clinical empathy when they have not received enough training in care for pain?
- We must consider how different doctors approach problems (recognizing differences)
- What are the questions to find out what a patient’s life is like? How do questions get asked, and how do answers get treated?
- Financial incentives are not in place to prioritize clinicians to spend time with patients to make successful pain assessments

4 Policy and payment issues create barriers to appropriate treatment

"Why do we blindly follow the rules when patients are clearly in pain?"

- Clinical protocols that clinicians follow (e.g. one script and referral to PT) often do not achieve results for patients
- Medical policy that drives benefits coverage favors pharmaceutical and procedural interventions over alternative interventions based on existing peer review research
- Clinical protocols patients are asked to follow are not achieving optimal results
- New laws, regulations and policies are focused on preventing opioid prescribing rather than promoting appropriate prescribing of opioids and other treatment alternatives
- There is a lack of communication among payers, providers and patients around information sharing leading to lack of coordination of care

5 Setting mutual goals & encouraging agency and hope for patients are crucial missing approaches in care delivery

“We can learn from Edward Trudeau about the care of people with tuberculosis – ‘to cure sometimes, to relieve often, to comfort always’.”

- Patients need hope to be open to possibilities
- We should enable patients to advocate for themselves
- Patients can learn to live with pain, but it is important to clarify that the patient is more than their pain
- Do people understand that pain management is not a quick fix and an ongoing project between patients and caregivers?
- We need to understand how to set up patient and health care provider as partners, supported by the ecosystem that includes payers and policy makers
- There is great value in setting goals: e.g. focus on functional relief so you can do what you want to do and return to a sense of self

PROPOSED SOLUTIONS FOR PHASE 2 AND NEXT STEPS

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Three Potential Approaches

Based on input from the workshop, following are three potential approaches which are being considered for Phase 2 of this initiative:

1. Improve Provider Assessment Skills
2. Create a ”Playbook” for Patients
3. Increase the Evidence, Distribution of Evidence, and Effective Ways to Treat Pain

Phase 2: Create the Tools

Phase 2 would involve the creation of **tools** to help guide pain assessment conversations. These tools would feature **patient and physician facing and training modules** with a form or discussion guide that gets filled out to create a common baseline of knowledge. Areas that the tools could touch on include:

- Education about social neuroscience underlying many of the behaviors seen with chronic pain
- Establishing context for patient reporting of pain and how it impacts patients' lives
- Offering patients a sense of partnership through their pain journey
- Expectation setting on severity and duration of pain
- Exposure of treatment options with associated risks and benefits
- Education about how to spot addiction and overdose and what to do about it

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Phase 2: Prototype and Test

To gauge the effectiveness of the tools, we will prototype and test them with patients, doctors and other providers to ensure that a viable solution has been created. The phase will involve various partners from health systems, government organizations, and other relevant experts to ensure the solution will be both effective and scalable.

By the end of Phase 2, we will have tested tools that can then be fully built out and brought to pilot during Phase 3.

We are seeking sponsors and collaborators for both Phase 2 and Phase 3.

YOUR QUESTIONS AND COMMENTS?

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