

# Interprofessional and Integrative Pain Management

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Project ECHO Pain

# Disclosure

- No Conflict of Interest
- Nothing to Disclose

# Objectives

1. To understand the difference between interdisciplinary, integrative and interprofessional and traditional models of care
2. To learn about the four core competences of interprofessional education
3. To understand why to model of interprofessional pain management is important to patients suffering with moderate to severe chronic pain

# Case Example

- **Physician Assistant-** Presenting the Case
- “ My patient, J.T. is a 62 year old rancher living in Northern New Mexico. His chief complaint is chronic low back pain with pain radiating down his right leg. J.T. requests additional opioid pain medication because of worsening pain. He is also interested in other non-pharmacological modalities due to relieve his pain.

# Case Example (Cont)

- **Past medical history** includes a 20 year history of low back pain, depression, high blood pressure and diabetes. Past surgical history is significant for 2 surgeries to his low back in the past 5 years. J.T. is not interested in further operations.
- **Social History** reveals: J.T. is married, with 5 grand-children. He is a recently sober from a long history of alcohol abuse, but denies using any illicit substances. J.T. is currently working part-time, but this is very difficult because his pain is becoming increasing more severe.

# Case Example (Cont)

- **Review of Systems** include: difficulty sleeping at night due to the pain, and occasional constipation.
- **Medications** include: gabapentin 600 mg tid, morphine sulphate long-acting 60 mg tid, oxycodone short-acting 10-15 mg qid prn-pain, and trazadone 100 mg at night. He is now asking for more oxycodone because of the pain”.

# Case Example (Cont)

- His examination reveals muscle spasm in his middle and low back, difficulty touching his toes and his straight leg raise exam is negative bilaterally. Neurologically, his strength appears full in this lower extremities. His deep tendon reflexes are absent at the patellar and trace at the ankles. Babinski responses are equivocal”.

# Neurologist

- **Neurologist:**
- “It is important to first discuss the differential diagnosis for this patient. This will help all of our participants with understanding next steps should any further work-up needed. My differential diagnosis includes: worsening degenerative changes in his lumbar spine with spinal stenosis, myofascial pain of the paraspinous muscles of his low back, and opiate induced hyperalgesia”.

# Internist

- **Internist:**

- “It is imperative to rule-out any other causes of worsening middle and low back pain, such as compression fracture(s), abdominal aortic aneurysm and organ disease and dysfunction such as referred pain from the kidney and pancreas. Plain Films of the spine can rule out compression fractures, which present with point tenderness. An abdominal aortic aneurysm can be assessed best with an abdominal ultrasound. An MRI of the abdomen would help in ruling out renal and pancreas involvement. Please remember that these radiology studies only need to be obtained if the clinical exam is suggestive of other causes”.

# Chiropractor

- **Chiropractor:**
- “As a myofascial specialist, I would consider ruling out myofascial involvement as the cause of this patient’s pain escalation. J. T. may have referred pain from his latissimus dorsi, quadratus lumborum, and other paraspinous muscles that can cause tremendous spasm. Since J. T’s employment involves much physical labor, it is possible that he has overused his muscles”.

# Addiction Psychiatry

- **Addiction Psychiatrist:**
- “Although J.T is now sober from alcohol, he is taking high amounts of opiate analgesics, which act as central nervous system depressants, similar to alcohol. Given that he is asking for increasing doses of opiates for pain relief, it is important to be very careful to rule out any aberrant behaviors that may be developing in this patient.

# Addiction Psychiatry (Cont).

- I would consider J.T increasing his frequency of your visits with you with pill counts. Because J. T is also depressed, it is important to treat the depression as well as pain. Finally, it is important to make sure that he is sleeping adequately, but I am glad that he is not taking benzodiazepines, because his opiate dose is so high that respiratory depression could be a significant risk”.

# Physical Therapy

- **Doctor of Physical Therapy:**
  - “J.T. may benefit from a physical therapy evaluation. Rehabilitation techniques such as improving his flexibility, decreasing his spasticity through stretching, and strengthening his core muscles may significantly improve his pain control without medications”. \*
- Adapted from The Pain Practitioner vol 22, (1), 2012, 47-49, Katzman, J, Comerci, G, Duhigg, D, Daitz, D**

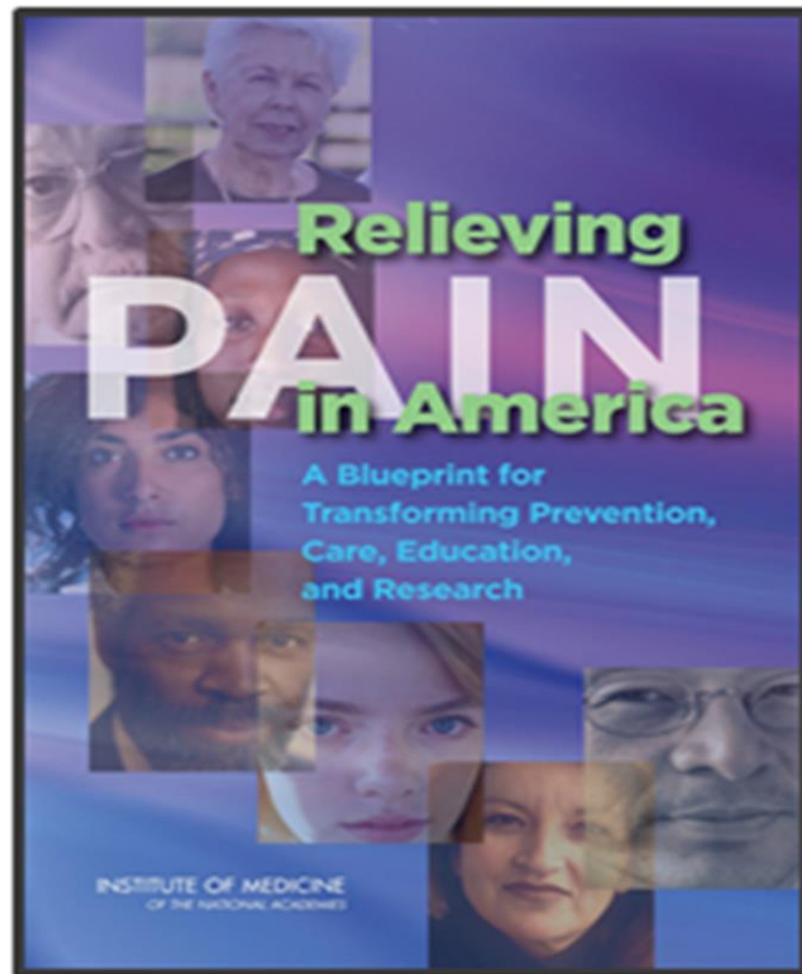
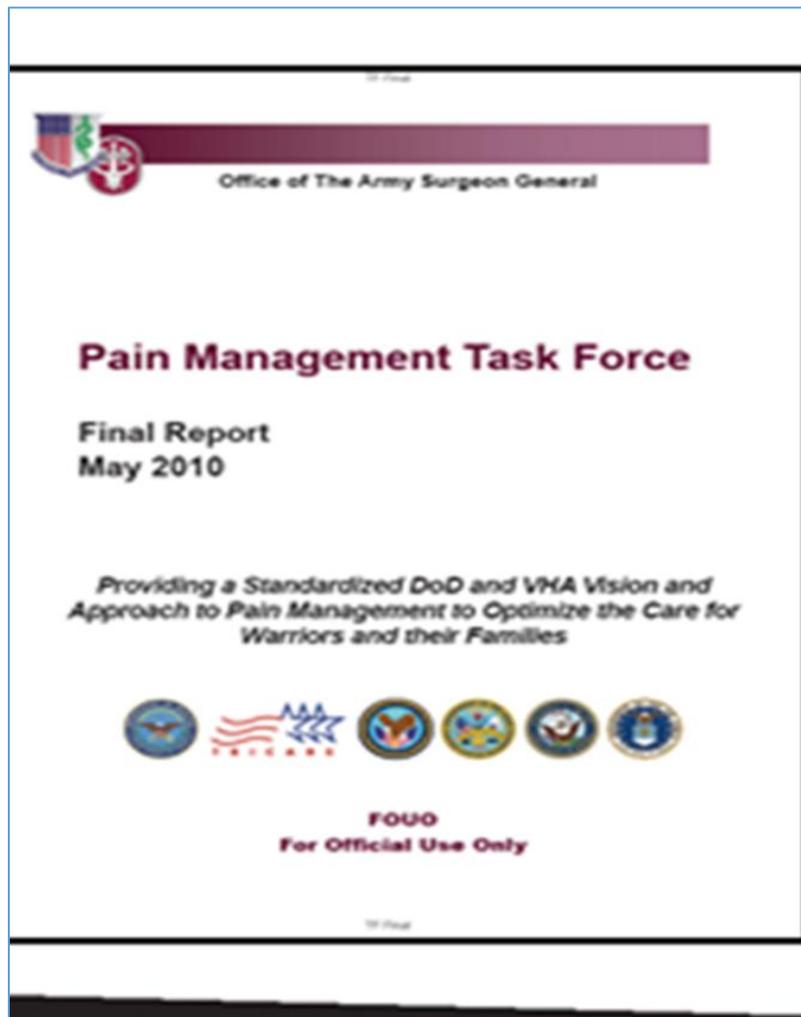
# Clinician Pharmacist

- **Pharmacist:**
- “J. T. is currently taking about 240 mg/day of opiates. It is quite possible that he is experiencing opiate induced hyperalgesia, a mechanism caused by central sensitization. By lowering his dose slowly, or changing the specific formulation of opiate through incomplete cross-tolerance, the patient’s pain may likely improve”.

# Gaps in Pre-Licensure Pain Education

- Most Healthcare professionals lack the pre-licensure pain education needed for post-graduate patient care
- Knowledge, Self-Efficacy and Attitudes
- Medical, Nursing, Pharmacy, Dentistry, etc.
- It is unrealistic for clinicians to follow standards for which they have received insufficient training

# DoD and IOM Reports



# Coordination of Care

- Institute of Medicine Report recognized that Primary Care clinicians need:
  - 1- increased pain education
  - 2- improved coordination of care with pain specialists
  - 3- and acknowledged that primary care clinicians are on “front lines” in care for patients suffering with chronic pain

# Interdisciplinary Pain Care

- Allows several specialists examining and/or discussing individual patients in a comprehensive team-based approach

# Integrative Pain Care

- Includes alternative and complementary approaches to augment traditional medical approaches to pain management
- Now considered best practices pain care

# Interprofessional Education

- Cultural Shift among academic institutions globally over the last decade
- Interprofessional education and collaborative practice model instrumental to the success of quality integrative pain management
- Examples of Conditions requiring HIGH levels of coordinated care:
- Chronic Pain, Psychiatric/Addiction, Diabetes

# World Health Organization

## Definition of Interprofessional Education

“ When students from two or more professions learn about, from, and with each other to enable effective collaborative and improve outcomes”.

# Interprofessional Core Competencies

- 2010, WHO developed “ Framework for Action on Interprofessional Education and Collaborative Practice” for pre-licensure trainees
- Four core competencies developed in 2011:
  - 1- values and ethics
  - 2- roles and responsibilities
  - 3- interpersonal communication
  - 4- teams and teamwork

# Project ECHO Pain

- Example of Interprofessional and Integrative Pain management
- Began in 2009 as a mechanism to “expand the capacity to provide best practices” chronic pain management and safer opioid prescribing to primary care clinicians caring for patients in rural and underserved regions.
- An interdisciplinary Pain Team (Hub) uses a video-conferencing platform with case based learning and didactics to educate Primary Care (Spokes)

# Conclusion

- Both interdisciplinary and integrative approaches to chronic pain management are now considered best practices
- Interprofessional education (IPE) and collaborative practice geared toward the practice of integrative pain management as essential for delivering quality patient care

# Conclusion

- Integrative approaches to best practices pain management include complementary and alternative treatments (CAM) that are now recognized world-wide as effective treatments for many types of pain.
- The interprofessional collaborative practice model allows a diverse group of healthcare professionals with unique knowledge and skills to function as a team with the patient as the center of the team.

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