Collaborative Care for Pain:
Improving Chronic Pain Care in the Workers’ Compensation Setting

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Disability Prevention is Critical

At 3 months: Chronic pain and higher risk of long-term disability coincide

Percent of injured workers still on time loss

Time loss duration (months)

Adapted from Cheadle et al. Am J Public Health 1994; 84:190–196
Long-Term Goals

• Prevent transition from acute/subacute to chronic pain
• Reduce the impact of chronic pain on work disability
  – Promote early and sustained RTW
  – Improve function at work & reduce re-injury
  – Prevent long-term disability
• Promote high-quality evidence-based health care
• Improve coordination and integration of care

How can L&I best provide resources to attending providers (APs) who are treating injured workers who have chronic pain and potential for long-term disability?
Mission-Critical Components

1. High-risk injured workers identified systematically and early
2. Care coordinator with identified lead responsibility at all times
3. Accessible stepped-care options with clear eligibility criteria
4. Provider/employer communication and RTW-focused activities integrated with traditional health care delivery
5. Best practices and incentives align with desired outcomes
6. Health care providers supported with accessible resources
7. Quality improvement processes to
   – Identify and pilot best practices and incentive structures
   – Assess provider and patient experience and satisfaction
8. Adequate information systems and decision support
Intervention Timeline

Injury occurs: 0-6 weeks  **Acute Pain**

- Report of accident ≤ 2 days
- Employer-provider communication
- Activity prescription form
- Assess risk factors for long-term disability

~ 6-12 weeks  **Subacute Pain**

- Activity coaching (PGAP)
- Graded exercise (PT)

~ 12 weeks  **Chronic Pain**

- Multidisciplinary pain clinic (SIMP)
- Collaborative care for chronic pain
What is Collaborative Care?

• Active care management for an eligible patient panel via integrating physical and mental health care
• Regular structured brief interventions (weekly)
• Use of patient-centered communication techniques to promote engagement
• Regular assessment: functional and psychosocial status, pain, depression, anxiety, insomnia, meds
• Regular clinical expert review & tx recommendations
• Regular documentation of clinical status & outcomes
Collaborative Care Manager

• Engage and support injured worker in treatment
• Provide direct patient-centered services
• Communicate clinical expert recommendations to AP
• Support medication management by AP
• Track referrals, treatment, and clinical improvement
• Facilitate changes in treatment if no improvement
• Coordination with health care & RTW team:
  – AP and other health care providers or specialists
  – COHE health services coordinator
  – PGAP coach, vocational rehab counselor, claims manager
How to Adapt for Injured Workers

• No existing WC-based collaborative care model for chronic pain and/or behavioral health
• RTW is not a standard collaborative care outcome
• Many facets of existing collaborative care models can be adopted/adapted for this new model
• Broader impact than symptom treatment, affects long-term functioning within a community
• Could enable effective health care delivery for injured workers with chronic pain and/or behavioral health issues that interfere with successful RTW
Collaborative Care Team

- Attending provider
- Injured worker
- Employer
  - Vocational rehab
  - Other resources
- Collaborative care manager
- Supervising clinical expert
- Care coordination supervisor
- Other resources
Thank you!