#35 Utilizing a novel asynchronous focus group approach to understand and prioritize challenges of physicians managing patients with chronic pain

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INTRODUCTION AND PURPOSE

Chronic pain is a major public health problem in the United States that has been estimated to affect up to a third of Americans. As physicians are becoming more aware of the impact of pain on their patients' quality of life, continued evidence is emerging about the risks associated with current standards of care, including opioids. Physicians must be kept up-to-date on the latest findings and standards in chronic pain management in order for them to provide optimal care to their patients while minimizing potential risks. Further, new modalities of pain treatment are being developed with lower abuse profiles, but these emerging therapies may allow patient self-injection, which will necessitate physicians use different patient education strategies. Well-designed continuing medical education (CME) programs offer a valuable tool for addressing the educational needs of physicians managing patients with chronic pain. In order to better understand the barriers and challenges faced by these physicians, and to inform development of upcoming CME programs, two asynchronous focus group (AFG) sessions were conducted using an asynchronous modified Delphi technique via online surveys, with one session focusing on chronic pain associated with osteoarthritis (CPOA), and the other on chronic low back pain (CLBP).

METHODOLOGY

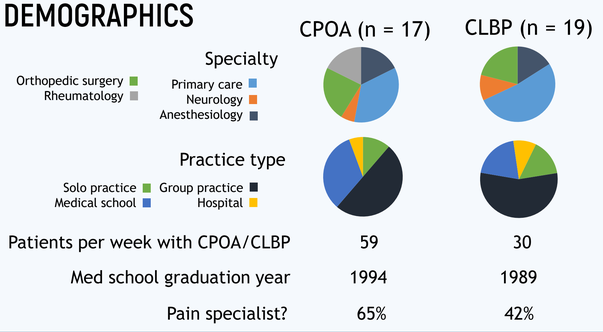
Invitations to online surveys were distributed during May-June 2017 to a random sample of rheumatologists, orthopedic surgeons, neurologists, primary care physicians, and anesthesiologists. Inclusion criteria: US-practicing and actively managing at least 15 patients with chronic pain per week.

PHASE 1: Physicians generated lists of barriers they and their colleagues face in the management of chronic pain, which were then compiled.

PHASE 2: The same group of physicians were asked to identify and rank the 3 most significant barriers in their practice and the 3 best addressed by CE from the compiled list.

The barriers for each question were categorized into themes and an overall score was calculated for each theme based on ranked priority. A weighted score was calculated for each theme by dividing the summed prioritization scores of the barriers assigned to that theme by the total number of individual barriers in the theme.

DEMOGRAPHICS



RESULTS – CHRONIC PAIN ASSOCIATED WITH OSTEOARTHRITIS

COST AND INSURANCE
- Insurance coverage prevents access
- High patient out-of-pocket costs
- Insurance barriers to specialist care

LACK OF EFFECTIVE TREATMENT
- No good disease modifying osteoarthritis medication options
- Hylan injections are basically placebo
- Steroid injections don't give relief/cause further damage
- Lack of duration of relief for interventional procedures
- Arthroscopy not beneficial in arthritic knees or hips
- Lack of effective long-term medications
- Limited classes of effective pain medication options
- Young age limiting surgical options
- Route of administration

COMORBIDITIES
- Not all patients are surgical candidates due to comorbidities
- Comorbidities limit multiple treatments

LACK OF EVIDENCE-BASED GUIDELINES

PATIENT-SPECIFIC COMPLICATIONS
- Obesity that arises from lack of healthy lifestyle choices
- Patients have unrealistic expectations for pain control
- Patient inability/unwillingness to exercise
- Patient adherence
- Patient social isolation and poor support system
- Patient expectation of pain management

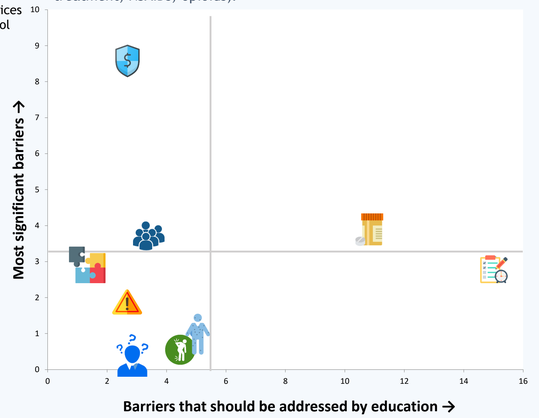
SAFETY/RISK ISSUES
- Safety concern of medication
- Potential for dependence/tolerance
- Restriction by pharmacy to dispense meds
- Risk of addiction

INHERENT COMPLEXETIES OF PAIN
- A lack of appreciation of the body's capacity to heal
- Poor understanding of the mechanism of OA
- Multiple locations of pain
- Subjectivity of pain assessment

PHYSICIAN FRUSTRATION

SIDE EFFECTS OF MEDICATION

What are the barriers to effectively managing moderate-to-severe chronic pain associated with osteoarthritis of the hip or knee for patients who have not responded to the current standard of care (ie, nonpharmacologic treatment, NSAIDs, opioids)?



RESULTS – CHRONIC LOW BACK PAIN

COST AND INSURANCE
- Lack of insurance coverage for alternative treatments
- Cost of therapy
- Financial concerns regarding other treatment modalities
- Insurance approval for physical therapy
- Insurance approval for testing when needed

LACK OF EFFECTIVE TREATMENT
- Lack of medical evidence for therapies
- Non narcotics not effective
- Poor surgical candidates
- Lack of effective/safe oral meds
- Tolerance to long-term and high-dose opioids
- Avoiding invasive surgical procedures
- Commonly unsuccessful surgical options

COMORBIDITIES
- Comorbidities such as obesity, smoking
- Psychological conditions complicating the picture

RISK OF ADDICTION

PATIENT-SPECIFIC COMPLICATIONS
- Weight loss
- Patient expectations
- Patient hesitancy for non-traditional measures
- Patient unwillingness to engage in physical activity
- Patient motivation
- Patient compliance

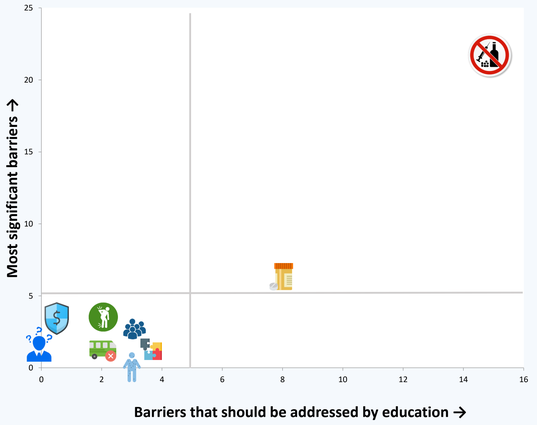
ACCESS ISSUES
- Lack of effective pain specialists in area
- Getting patients into regular physical therapy
- Lack of transportation

INHERENT COMPLEXETIES OF PAIN
- Work related injury
- Job modifications
- Lack of an objective measure to evaluate pain

LACK OF CLINICIAN FAMILIARITY

SIDE EFFECTS OF MEDICATION

What are the barriers to effectively managing moderate-to-severe non-radicular, chronic low back pain for patients who have not responded to the current standard of care (ie, nonpharmacologic treatment, NSAIDs, opioids)?



EDUCATIONAL IMPLICATIONS

The identified barriers to effectively managing moderate-to-severe CPOA for patients who have not responded to the current standard of care were a lack of effective treatment options and a lack of pain guidelines, both of which may be addressed by CME.

The barriers to effectively managing moderate-to-severe non-radicular CLBP most important for education to address were a lack of effective treatment options and risk of addiction.

Addiction risk is more concerning for clinicians in the management of CLBP than in CPOA.

Lack of effective treatment was a common barrier indicated by both focus groups. As pain assessment is limited by subjective measures of analgesic response and a lack of objective measures, continued research is needed to help clinicians understand how medications are or are not benefitting their patients.

Barriers such as cost/insurance issues are often viewed as significant, but not appropriate for education. However, innovative education can address challenges with insurance companies and payors. In addition, CME may be used to educate such decision-makers on the effect of clinical advances on patient outcomes.

CME often addresses patient-related difficulties, identified as a common barrier. Effective patient-directed resources may assist with collaborative decision making, patient-provider communications, unrealistic treatment expectations, and adherence.

These focus group sessions did not specifically detail the types of education clinicians are looking for to address the specific barriers. Further research may be needed to understand specific preferences for managing key issues commonly faced by pain clinicians.

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