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 familiar with the many issues surrounding patients with chronic pain on their patients’ quality of life, continued evidence is emerging about the risks associated with treating these patients, including opioids. Physicians must be kept up-to-date with the recent research and development that can provide optimal care to their patients while minimizing potential risks. Further, new modalities of pain management 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. With the increasing availability of chronic pain management programs, these 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 (FG) sessions were conducted using an asynchronous moderated 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).

RESULTS – CHRONIC PAIN ASSOCIATED WITH OSTEOARTHRITIS

**COST AND INSURANCE**

- Insurance coverage affects access
- High patient out-of-pocket costs
- Insurance barriers to specialist care

**LACK OF EFFECTIVE TREATMENT**

- No good drugs modifying osteoarthritic arthritic indications
- Hijack injections are basically placebo
- General analgesics don’t give relief/cause further damage
- Adherence not beneficial in osteoarthritic knees or hips
- Lack of effective non-invasive media

**LACK OF EVIDENCE-BASED GUIDELINES**

- Limited access to current surgical candidates due to comorbidities
- Comorbidities limit multiple treatments

**COMORBIDITIES**

- Asymptomatic in surgical candidates due to comorbidities
- Comorbidities limit multiple treatments

**PATIENT-SPECIFIC COMPLICATIONS**

- Risk of ineffective pain specialists in one
- Patients frequently experience pain control
- Patients typically unwilling to exercise
- Patients adhere

**INHERENT COMPLEXITIES OF PAIN**

- Lack of appreciation of the body’s capacity to heal
- Poor understanding of the mechanism of pain
- Lack of multiple locations of pain
- Limited capacity to plan

**SIDE EFFECTS OF MEDICATION**

- Poor management of pain

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 (e.g., nonpharmacologic treatment, ISADs, opioids)?

**RESULTS – CHRONIC LOW BACK PAIN**

**COST AND INSURANCE**

- Insurance coverage affects access
- High patient out-of-pocket costs
- Insurance barriers to specialist care

**LACK OF EFFECTIVE TREATMENT**

- No good drugs modifying chronic low back pain for patients who have not responded to the current standard of care
- Hijack injections are basically placebo
- General analgesics don’t give relief/cause further damage
- Adherence not beneficial in chronic low back pain or hips
- Lack of effective non-invasive media

**LACK OF EVIDENCE-BASED GUIDELINES**

- Limited access to current surgical candidates due to comorbidities
- Comorbidities limit multiple treatments

**COMORBIDITIES**

- Asymptomatic in surgical candidates due to comorbidities
- Comorbidities limit multiple treatments

**PATIENT-SPECIFIC COMPLICATIONS**

- Risk of ineffective pain specialists in one
- Patients frequently experience pain control
- Patients typically unwilling to exercise
- Patients adhere

**INHERENT COMPLEXITIES OF PAIN**

- Lack of appreciation of the body’s capacity to heal
- Poor understanding of the mechanism of pain
- Lack of multiple locations of pain
- Limited capacity to plan

**SIDE EFFECTS OF MEDICATION**

- Poor management of pain

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

EDUCATIONAL IMPLICATIONS

The identified barriers to effectively managing chronic pain are those that have not been addressed by current CLBP and CPOA. The barriers to effectively managing moderate-to-severe non-radiular CLBP most important to address are 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 benefiting 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 chronic 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-provided communications, unrealistic expectations, and physician-related expectations and treatment. These focus group sessions did not specifically detail the types of education clinicians are looking for to address the physician barriers. Further research may be needed to understand specific preferences for managing key issues commonly faced by patients.

**METODOLOGY**

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

**PHASE 1: Physicians generated lists**

Physicians were asked to identify and rank the 3 most significant barriers in their practice and the 3 best addressed by CE programs.

**PHASE 2: Physician Barrier Prioritization**

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**

<table>
<thead>
<tr>
<th>CPOA (n = 17)</th>
<th>CLBP (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Specialty</td>
</tr>
<tr>
<td>Orthopedics</td>
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</tr>
<tr>
<td>Rheumatology</td>
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<tr>
<td>Medical school</td>
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</tr>
<tr>
<td>Patients per week with CPOA/CLBP</td>
<td>Patients per week with CPOA/CLBP</td>
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<td>59</td>
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<tr>
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<td>1989</td>
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<tr>
<td>Pain specialists</td>
<td>Pain specialists</td>
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<tr>
<td>65%</td>
<td>42%</td>
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</tbody>
</table>

**DISCLAIMERS**: This research was supported by Teva Pharmaceuticals and Regeneron Pharmaceuticals, Inc. Anne Marie Delmatteo is an employee of Regeneron Pharmaceuticals, Inc. All other authors have nothing to disclose. For more information on this study, please contact Greg Salinas, PhD at greg.salinas@ceoutcomes.com.

PRESENTED AT PAINWeek 2017, September 5-9, 2017, Las Vegas, NV