Group Medical Visits for Chronic Pain

UVM Project ECHO
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Intentions

- Review the rationale and value for the use of group medical visit for individuals experiencing chronic pain;
- Describe the format of the group medical visit used at the Comprehensive Pain Program;
- Review successes and challenges with our use of the group medical visit.
What is a group medical visit?

- Medical Care
- Education
- Peer support

- 10 - 12 Participants (up to 20)
- 60 - 120 minutes
- Closed vs. Open format
Quadruple Aim -
Improved Population Health Outcomes

- Unclear, but may improve access to care for underserved communities
- Variation in program design makes this assessment challenging
- Implementation at scale

Quadruple Aim
Improving Patient Experience

- Qualitative literature
  - Patient satisfaction
  - Decreased isolation
  - Peer support
- Shifts in patient-clinician power dynamics
- Peer engagement

Kirsh et al. BMC Health Serv Res 2017; 17:113
Quadruple Aim – Reducing Cost of Care

- Diabetes
- Prenatal care

- Shift from fee-for-service to value based care/capitated payments

Wan et al. Diabetes 2018; 67(Supplement1)
Gareau et al. Matern Child Health J 2016; 20: 1384-1393
Rowley et al. Matern Child Health J 2016; 20: 1-10
Quadruple Aim

Improve Clinician Experience

- High levels of practitioner satisfaction
Group Medical Visits for Individuals Experiencing Chronic Pain

- Isolation
- Condition often invisible to others
- Stigma
- ‘Othered’ in traditional medical system
- Entrenched in relationship to their pain and their treatment
Goals of the Group Medical Visit - CPP

- Provide access to medical providers in a different paradigm
- Create an environment which fosters reflection and openness
- Create space for openings
- Increase self-efficacy and self-agency
- Develop Trust
  - Among participants
  - Between participants and co-facilitators
- Go “deeper than the symptom”
  - Enhancing self agency and self efficacy
  - Transforming transactional approach
Outcome Priorities

Group Medical Visit - Comprehensive Pain Program

- Eight weeks
- Two hours
- Co-facilitation, Laurel Audy RN
- ‘Closed’ Cohort
- Limited Didactic Presentations
- Conjointly with COMPASS/ACT
- 1:1 with clinician
Four Pillars

- Mindfulness
- Movement
- Self-compassion
- Spirituality

In the Service of...

- Self-Efficacy
- Self-Agency
- Connection
- Self-Esteem
Structure

- Status forms
- Mindfulness
- Check-in
- Break
- Experiential
- Meta
STATUS FORM

NAME: ___________________________ SESSION #: _________
DATE: __________________________

1. What home practices did you do this past week? (Circle)
   - Meditation
   - Body scan
   - Journaling
   - Movement
   - Mindful eating
   - Other: _______________________

2. How would you rate your pain today?
   - No pain
   - Worst pain imaginable
     0 1 2 3 4 5 6 7 8 9 10

3. Do you need to see the medical provider privately today?
   - No / Yes

4. Did you visit a healthcare provider since our last group visit?
   - No / Yes

5. Did you visit the emergency room or urgent care since our last group visit? 
   - No / Yes

6. Have any of your medications changed since our last group visit? 
   - No / Yes

7. Any other concerns?
“Somewhere in this process you will come face-to-face with the sudden and shocking realization that you are completely crazy. Your mind is a shrieking gibbering madhouse on wheels barreling pell-mell down the hill utterly out of control and hopeless. No problem. You are not crazier than you were yesterday. It has always been this way and you just never noticed. You are also no crazier than everybody else around you. The only real difference is that you have confronted the situation they have not.”

— Bhante Henepola Gunaratana
Check-in

- Highlights/Lowlights of the week
- Experience/Recommendations re therapies
- Debrief last session
- Group Read
Experiential

- Sensitized CNS
- Nutrition in Chronic Pain
- Pain and my sense of self
- Pain in the context of my family
- Art as therapy
- Suffering and Happiness
- Pain, Medicine, and Me
- Next steps
Break

- Facilitator Check-in
- Check-in with participants - questions/concerns/medical issues
- Participant Connection
Prevalence of Stigmatization and Poor Self-esteem in Chronic Pain Patients

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Abstract

Objective: Stigma and poor self-esteem (defined as the internalized cognitive, emotional, and behavioural impact of others’ negative attitudes on a person) are associated with many chronic health conditions and have indirect but strongly negative implications for clinical prognosis. We sought to estimate the prevalence of perceived stigmatization and self-esteem in chronic pain patients and its relationship with general health markers.

Methods: All adult patients (n=160, >16 years old, chronic pain >3 months) completed a set of validated questionnaires: Stigma Scale for Chronic Illness (SSCI), Rosenberg’s Self-esteem Scale (RSSE); Hospital Anxiety Depression Scale (HADS); Brief Pain Inventory short form (BPI); and the General health survey (SF12v2). Data was recorded using Microsoft Excel and analyzed using SPSS.

Results: The mean pain intensity score (Visual analogue score (VAS)) was 6.1 ± 1.7, 77% of patients (123/160) had a lowered self-esteem (RSSE score=17.2 ± 4.5) with a mean SSCI score of 50.8 ± 19.0 (normal range 24-120). An inverse relationship between (a) stigmatization and self-esteem (Pearson correlation, r=-0.6, p<0.001) and (b) self-esteem and pain interference (r=-0.48, p<0.001) was identified. A positive correlation between stigmatization and anxiety (r=-0.28, p<0.05) and an inverse relationship between self-esteem and depression existed (r=-0.34, p<0.05).

Conclusions: A high prevalence of stigmatization was identified in individuals experiencing chronic pain and a significant correlation exists between the type of stigma experienced, the level of pain intensity and other psychological factors including self-esteem, anxiety, and depression.
You hold in your hand an invitation: to remember the transforming power of forgiveness and loving kindness. To remember that no matter where you are and what you face, within your heart peace is possible.

—Jack Kornfield
Compassion
By Miller Williams

Have compassion for everyone you meet, even if they don't want it. What seems conceit, bad manners, or cynicism is always a sign of things no ears have heard, no eyes have seen. You do not know what wars are going on down there where the spirit meets the bone.

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The Power of the Group

“Being involved in the Path Program was the first time I've ever been in a group setting for anything medically or therapeutically. I've never gone down that path before. I think that adds a layer of vulnerability and it can be kind of intimidating, but I don't think that the experience would have been so meaningful without having that connection. I mean, you're in a group of people who all know deeply and in their own body what you're feeling when you talk about pain and suffering. No matter how much your family, loved ones, friends want to identify with that. It's different when you're not having to wade through that every day...”
“...and then boom, you get this whole group of people who want everyone to get better. You have that same mindset and they know what it’s like and they know what it’s like to have setbacks and they just understand it without having to work at understanding it. That connection and that community feeling, I think it made me feel normalized instead of marginalized. That’s huge when you can’t find a place to feel like you’re okay or within the scope of normal and that changes when you find a group that you can talk to and be vulnerable that will also lift you up”
And where exactly is the medicine here?
Challenges

- Upfront work - Recruitment/Screening
- Reluctance to participate in group
- Co-facilitation
- Facilitation Style - Group Empowerment
- Billing
Logistics

- Consent
- Outcome measurement
- Billing
- Documentation