Assistance with Pain Treatment (APT): A collaborative intervention for pain and depression in primary care

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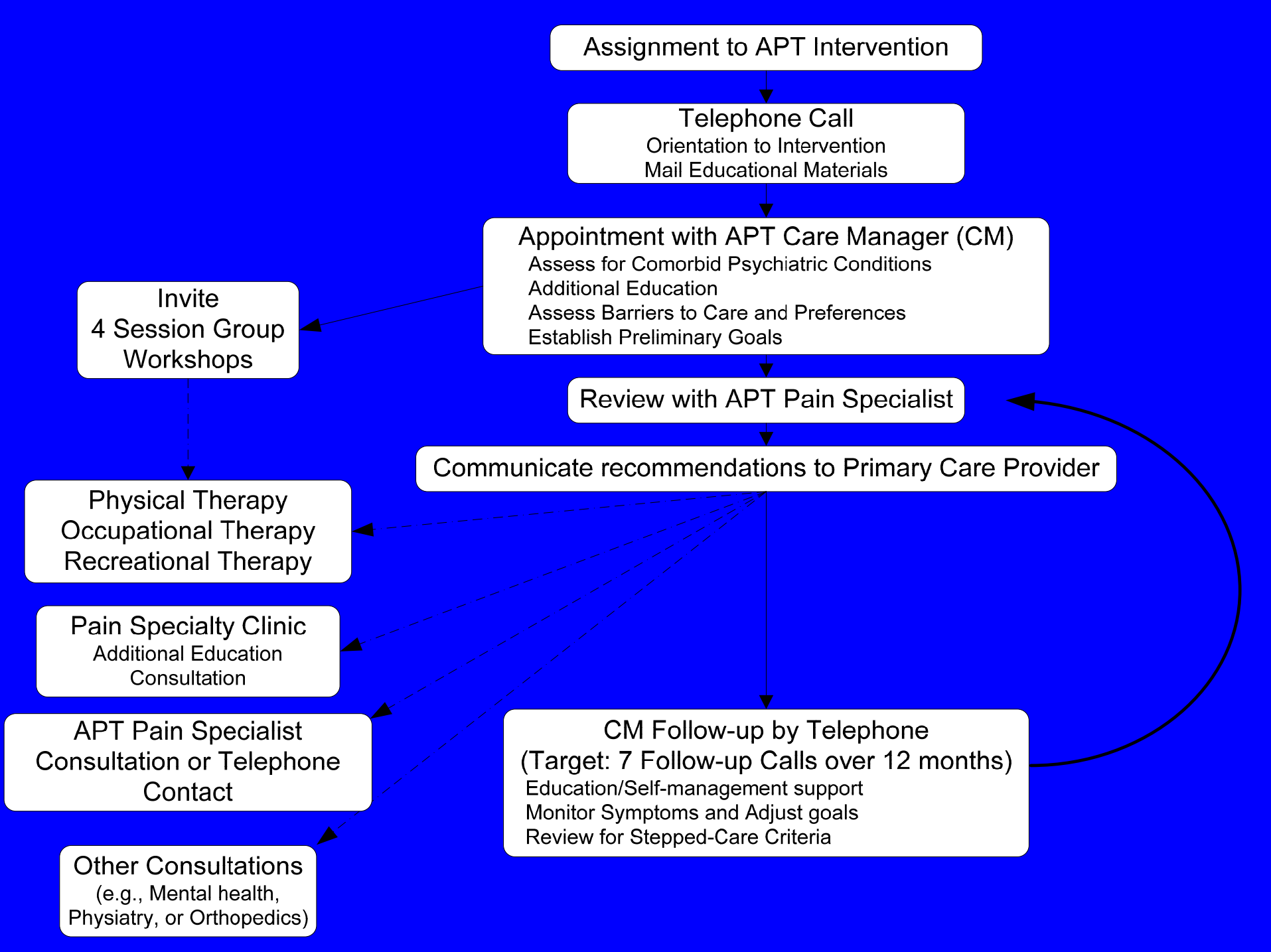
Portland VA Medical Center

10/14/08

Assistance with Pain Treatment (APT)

MAIN CONCEPTUAL COMPONENTS:

- Chronic illness model and stepped care
- Biopsychosocial framework—focus on function; target comorbid depression
- Evidence-based approaches
  - Multidisciplinary
  - Behavioral/Activating interventions
  - Education in self-management
  - Monitor adherence and outcomes

Intervention team

- Full-time Psychologist Care Manager (though could be delivered by nurse)

- Up to 1 day/week Physician Pain Specialist

- Provider education (incl. communication skills) and orientation to <u>primary care providers</u>

- Evaluated & monitored <u>patient</u> progress, offered feedback and recommendations to providers

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│  Assignment to APT Intervention │
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│          Telephone Call         │
│    Orientation to Intervention  │
│    Mail Educational Materials   │
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┌──────────────────────────────────────────────┐
│    Appointment with APT Care Manager (CM)     │
│   Assess for Comorbid Psychiatric Conditions  │
│   Additional Education                         │
│   Assess Barriers to Care and Preferences      │
│   Establish Preliminary Goals                  │
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Invite
4 Session Group
Workshops

Physical Therapy
Occupational Therapy
Recreational Therapy

Pain Specialty Clinic
Additional Education
Consultation

APT Pain Specialist
Consultation or Telephone
Contact

Other Consultations
(e.g., Mental health,
Physiatry, or Orthopedics)

Review with APT Pain Specialist

Communicate recommendations to Primary Care Provider

CM Follow-up by Telephone
(Target: 7 Follow-up Calls over 12 months)
Education/Self-management support
Monitor Symptoms and Adjust goals
Review for Stepped-Care Criteria

RCT of APT vs. Treatment as Usual
(Dobscha et al. 2008)

- 401 patients, 42 primary care providers
- One VAMC, 5 clinics (2 rural)
- Patients recruited from primary care
- Key patient characteristics
  - 32% worked prior 12 months
  - 65% currently receiving disability payment
  - Mean of 15 years of pain
  - 37% with substantial depressive sx (PHQ$\geq$10)
  - 17% with PTSD
  - 16% with + alcohol misuse screens

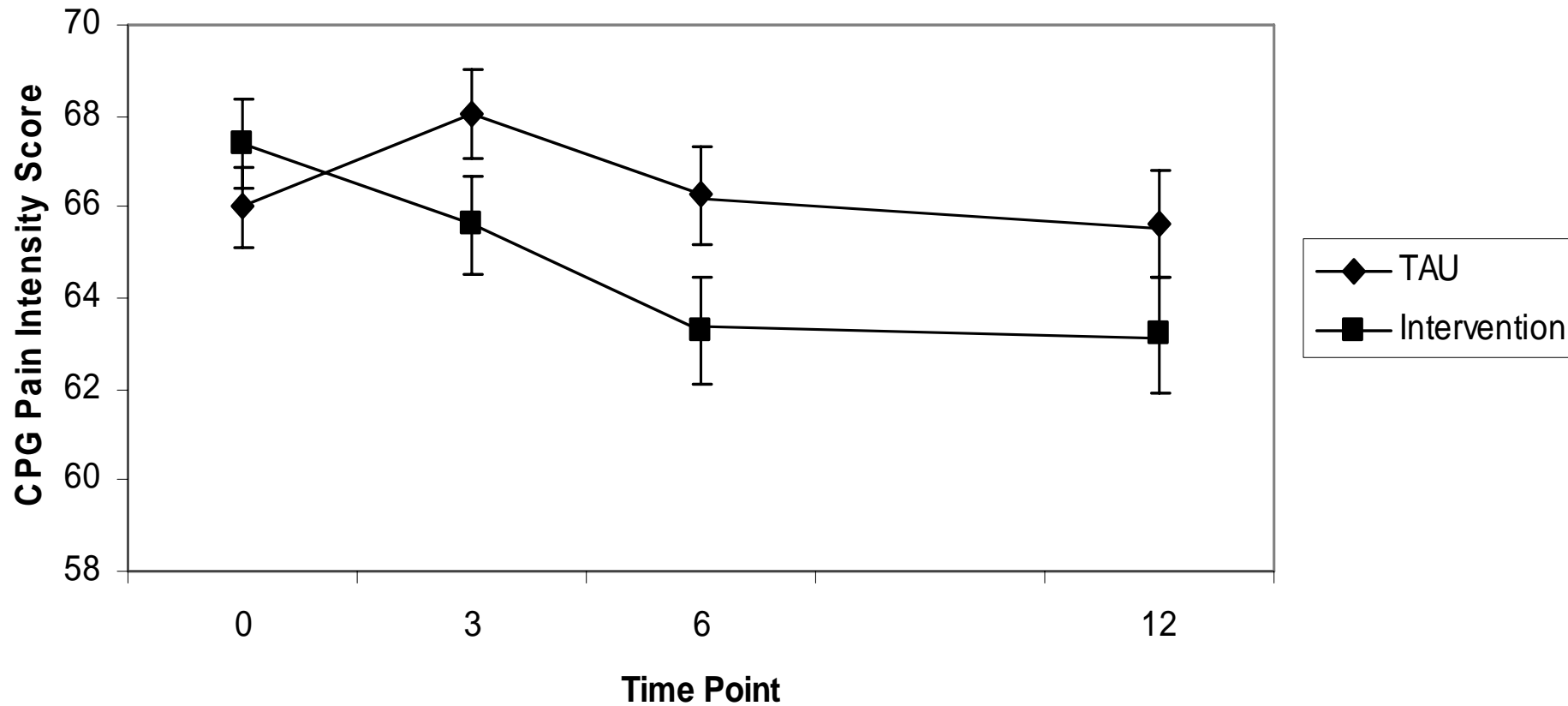# Roland-Morris Score Change over Time (Primary Outcome), n=401

Roland-Morris Score Change Over Time
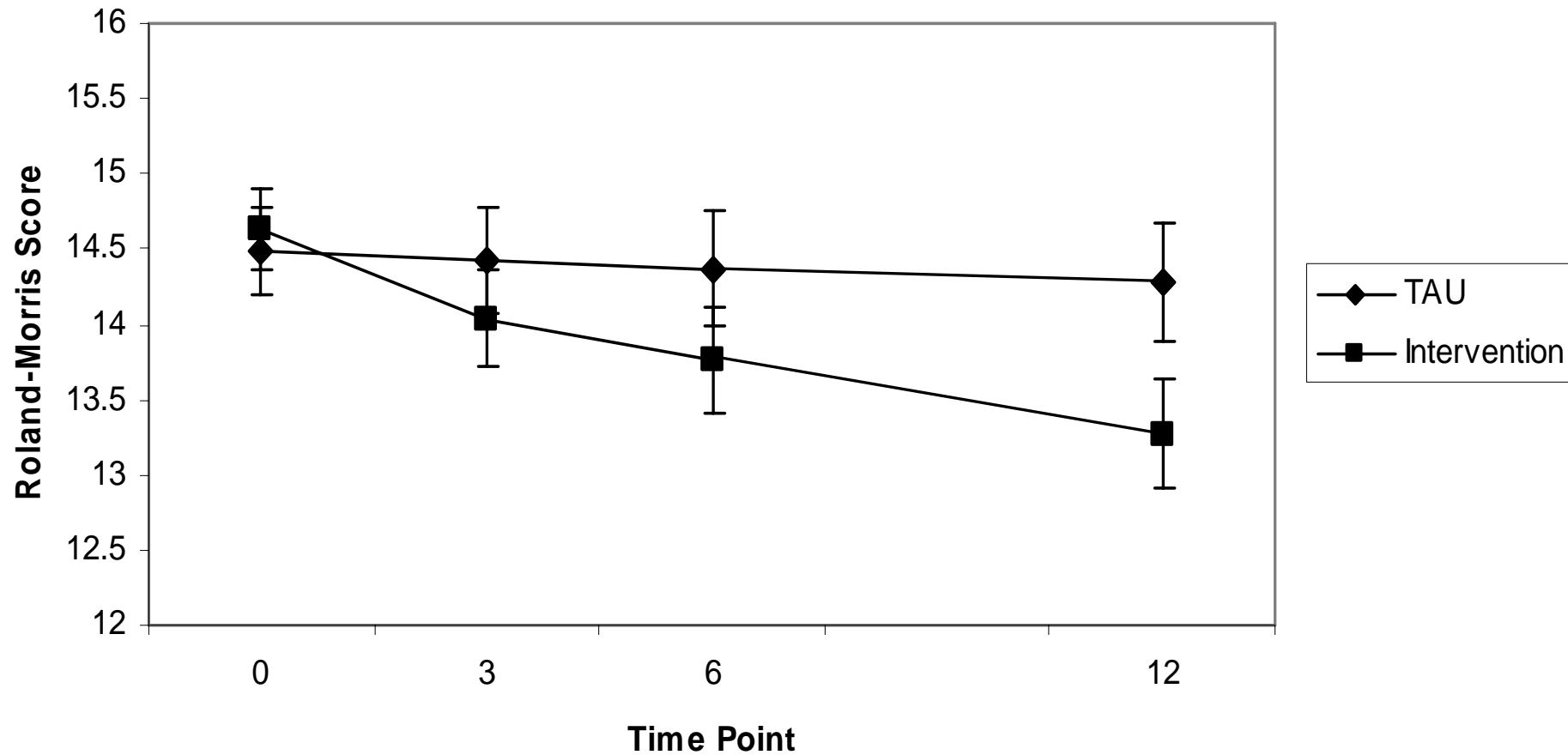
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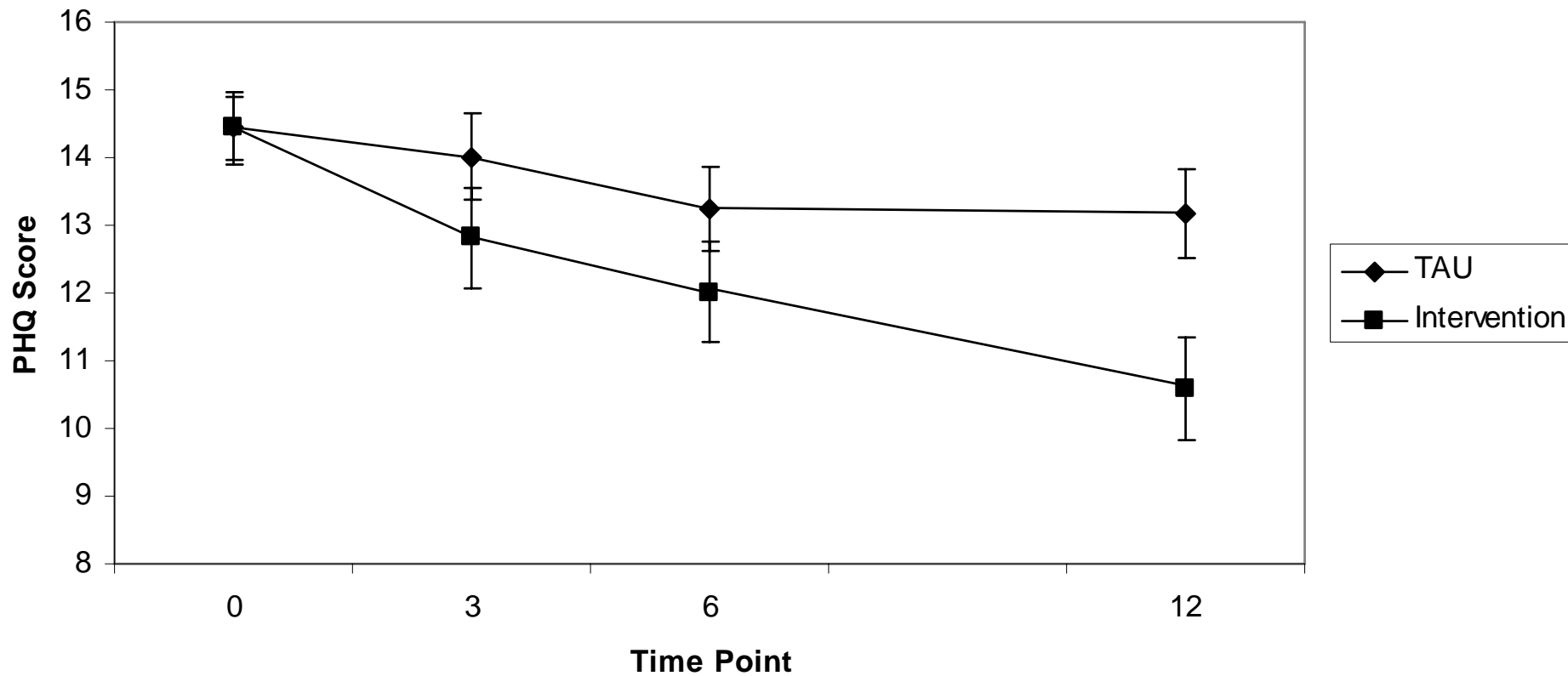
CPG Pain Intensity Score Change over Time, n=401

p=.014

PHQ-9 Score Change over Time
(Among Those with baseline PHQ ≥ 10), n=148

PHQ Score Among Those With PHQ GE 10 at Baseline

p=.003

Other selected outcomes

	TAU	APT
NNT: 30% reduction RMDQ	14%	22%
If opioid prescribed, any long acting	18%	31%
Antidepressant, any prescribed	39%	53%
NSAID/acetaminophen, any prescribed	39%	62%
Global impression of change past 6 months (lower scores better)	6 mo: 4.5 12 mo: 4.4	6 mo: 3.6 12 mo: 3.7

Satisfaction with intervention

- Clinicians:
  - 95% reported using feedback from the APT intervention team half or more of the time
  - 80% reported that APT had somewhat positive or highly positive impact on patient outcomes.

- Patients (4 months):
  - 76% agreed/strongly agreed APT overall helpful
  - 82 and 84% agreed/strongly agreed follow-up contacts with APT CM and MD helpful

Summary of Findings

- Collaborative care is feasible
- Resulted in improvements in a number of measures:
  - Pain disability
  - Pain intensity
  - Depression severity
  - Patient-rated Global impression of change
  - Indicators of guideline recommended care
- Clinicians and patients satisfied with intervention