The MDT approach to Pain Management

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Describe my experience of leading a MD chronic pain service

Hope to convince you why a MD approach to chronic pain works

Stimulate some thoughts on how you could manage your patients and possibly take aware the inspiration and aspiration to influence your local pain services

• Multidisciplinary – what exactly are we talking about?
• Pain services – national and local drivers
• east Kent pain service – an interdisciplinary approach
• Operational and clinical models
• Elements that make up the service
• How it all fits together – in practice
• Future developments
• Patient pathways
• Outcomes
• Summary
**MULTIDISCIPLINARY**

Combining or involving several disciplines or professional specialisations in an approach to a topic or problem.

**COLLABORATIVE**

Produced by or involving two or more parties working together:

**INTEGRATED**

in which many different parts are closely connected and work successfully together

**INTERDISCIPLINARY**

Relating to more than one branch of knowledge:  
*an interdisciplinary care pathway*
Ten Principles of good interdisciplinary team work - Nancarrow et al. (2013)

1. Identifies a **leader** who establishes a **clear direction and vision** for the team, while listening and providing support and supervision to the team members.
2. Incorporates a **set of values** that clearly provide **direction** for the team’s service provision; these values should be visible and consistently portrayed.
3. Demonstrates a team culture and interdisciplinary atmosphere of **trust** where contributions are valued and consensus is fostered.
4. Ensures appropriate **processes and infrastructures** are in place to uphold the vision of the service (for example, referral criteria, communications infrastructure).
5. Provides **quality patient-focused services** with documented outcomes; utilizes feedback to **improve** the quality of care.
6. Utilizes **communication strategies** that promote intra-team communication, collaborative decision-making and effective team processes.
7. Provides sufficient team **staffing** to integrate an appropriate mix of skills, competencies, and personalities to meet the needs of patients and enhance smooth functioning.
8. Facilitates **recruitment** of staff who demonstrate interdisciplinary competencies including team functioning, collaborative leadership, communication, and sufficient professional knowledge and experience.
9. Promotes **role interdependence** while respecting individual roles and autonomy.
10. Facilitates **personal development** through appropriate training, rewards, recognition, and opportunities for career development.
National and Local Drivers for Chronic Pain Services

National drivers
• Pain summit 2011
• Putting Pain on the Agenda (July 2012)
• Pain Management Services: Planning for the Future Guiding clinicians in their engagement with commissioners (November 2013)
• SIGN Guidelines for chronic pain (2013)
• FYFV (October 2014)

Local drivers
• CCG demographics
• Commissioning priorities and intensions
East Kent Community Pain Service

- Long standing secondary care pain service
- 2006-2007 Community Pain Service started
- Very successful, good outcomes, high patient satisfaction
- Recognised nationally as an innovative community chronic pain model

BUT

- Isolated in the health economy
- 2 separate pain services – hospital and community
- Duplicate referrals - 42% of referrals to community service came from hospital service (multiple first assessments)
- Increased overall demand
- So a new collaborative model brought the hospital and community services together
Multi-disciplinary chronic pain services
2009 – east Kent collaborative referral point introduced

Completed referral received

Chronic Pain Referral Point – EK

sent electronically for clinical triage

Triage outcome actioned

Choice

Community Chronic Pain

Secondary Care

Other services

Reject to referrer

48 Hrs

48 hrs
Community Chronic Pain Service

- Referral accepted
- Patients complete pain self efficacy questionnaire
- Majority of patients attend introductory group
- Full assessment & management plan
- Physiotherapy clinic
  - Graded exercise
  - Desensitisation
  - Mirror therapy
- Acupuncture
- Tai Chi
- Alexander Technique
- CNS Clinic
  - Tens review
  - Med review
  - Healthy lifestyle management
  - Discharge planning
- Majority of patients attend ½ day pain education session
- PMP – face to face or on-line
- 1 to 1 Psychology
- Discharge - Long term self management plan
- Patient initiated re-access

Graded exercise programme

Excellent care, healthy communities
Who?

Specialist doctor
Nurses
Physiotherapists
Psychologists
Alexander Teachers
Tai Chi Instructors
Health Trainer
Admin team
Operational management team

Secondary care – consultants and CNSs
GPs
Pharmacy services
Mental Health Services
Drug and Alcohol Services
HWB
Voluntary agencies
Support groups
Employment support
Who does what?

Triage – Senior clinical group – 9 clinicians
Secondary care Consultant Anaesthetists and community pain senior clinicians who undertake 1st assessments – nurses / specialist doctor

Patients complete pain self efficacy questionnaire and book into introductory group – admin

Introductory group – currently delivered by nurse
But can be delivered by psychologist / physiotherapist / specialist doctor - set format – key skills

Full assessment & management plan
Nurses / Specialist doctor
Psychologist / Physiotherapist
Who does what?

CNS Clinic
- Tens review
- Med review
- Healthy lifestyle management
- Discharge planning

Majority of patients attend ½ day pain education session
- Psychologist – Physio - Nurse

PMP – face to face or on-line
- Psychologist – Physio - Nurse

Physiotherapy clinic
- Graded exercise
- Desensitisation
- Mirror therapy
- Healthy lifestyle management
- Discharge planning
- Physio

1 to 1 Psychology
- Psychologists

Alexander Technique
- Alexander Teacher

Acupuncture
- Nurse – Physio - Doctor

Tai Chi
- Tai Chi Instructor

Discharge - Long term self management plan – ALL
- Usually Nurse – but can be Doctor – Physio - Psychologist

Patient initiated re-access
- Clinician that best knows the patient

Graded exercise programme
- Physiotherapist – Health trainer

Excellent care, healthy communities
So how does this all fit together?
This can be a challenge:

Interdisciplinary health care teams face a set of challenges that are not necessarily encountered by other types of teams such as unidisciplinary or non-health care teams.

These challenges include the contentious nature of sharing professional roles and expertise, planning and decision-making, while delivering quality patient care within complex contexts.

Ten Principles of good interdisciplinary team work - Nancarrow et al. (2013)
We all need to face the right way!

Kent Community Health
NHS Foundation Trust

Excellent care, healthy communities
Referral point – collaborative and multidisciplinary

Referral and Triage

• One point for east Kent – 5 CCGs
• Clear referral guidelines
• Standard triage guidelines
• Communication channels internally
• Standard Communication externally
• Quarterly meetings – clinical admin and managerial input
• Leadership roles identified

Wider Health Economy

Referrers
– GPs and practice secretaries
- Orthopaedics / other services
Commissioners
CCG pharmacy leads
Mental health services
Turning Point
Key services looking after patients who cannot attend core service
Community Pain Service –
Multidisciplinary, interdisciplinary, collaborative and integrated

Community

Pain

Service

One patient pathway

Clear roles

Shared goals

Leadership

Communication

Trust

Role
interdependence

Shared vision
and values

Excellent care, healthy communities
Service development and business planning

- RAISING PROFILE
- MANAGING DEMAND
- INTEGRATED CARE
- NEW OPPORTUNITIES

- PRISON HEALTH

- LOCAL PRIORITIES
  - Prescribing

- CORE BUSINESS

- EDUCATION
- PATIENT ENGAGEMENT
- INCOME GENERATION

Outcomes focused
This 61 year old lady was seen in the Community Chronic Pain clinic today. This was a referral to our service, with the problem of **low back pain**. She was accompanied by her husband.

She has had low back pain since a fall approximately 13 years ago. She used to attend the Secondary Care Pain clinic. They transferred her to us in 2011, and we transferred her back in 2012, as she requested more interventions. Since that time, she has had more interventions, which unfortunately has not been helpful.

Today her pre-assessment clinic form’s body map, however, painted the picture of widespread body pain and all areas of the body have been shaded in. On questioning, she confirmed that over the past approximately 6 months, she has had widespread body pain and not just pain in her lower back any more. This was associated with a time of particular strife in the family.

The muscles are burning and stinging and aching all the time. Whenever she is being hugged, this is very painful. Associated with this, she has noticed severe fatigue, a terrible sleeping pattern, headaches and her one temporomandibular joints is painful. She has also got Irritable Bladder and Bowel. All of these symptoms are associated with her fibromyalgia and indeed she was tender over 17 out of 18 classic tender spots today.
Other medical problems/medication:

Meniere’s disease with Tinnitus and Vertigo, requiring bilateral hearing aids. She needs both Cinnarizine 15mg TDS, as well as Betahistine 16mg TDS. For her IBS she takes Alverine 60mg TDS. As prevention of UTI, she takes Trimethoprim 100mg once per day. I understand she has seen Urology.

She has Hypothyroidism requiring a high dose of Levothyroxine 200mcg per day. She has been prescribed Duloxetine for her mood, 60mg once per day. She does think it was helpful for her mood. I understand she has tried a higher dose of 120mg, but found that she was too sleepy on it.

For acid reflux she takes Lansoprazole 30mg once per day and Domperidone 10mg 3 x per day.

She is still experiencing a lot of menopausal symptoms, currently on HRT gel sachets. I have asked her to discuss perhaps the pump bottle of Estrogel gel with you as perhaps this will enable her to take a slightly higher dose if required.

She takes supplements in the form of Cod Liver Oil and a multivitamin/mineral preparation. From the way that she filled in her form, I was unclear if she was taking Orlistat related to obesity, or if she was actually allergic to Orlistat.

She scored 4 on a Falls Risk Assessment and may need referral to a Falls Clinic if our future modalities are not helpful. In general she makes use of her mobility scooter outdoors. She is allergic to Elastoplast, Silicone and an unknown antibiotic.
Current pain-related medication consists of:

Paracetamol 2 tablets, 4 x per 24 hours, which is actually of no help to her pain.

Capsaicin cream (?strength) that she uses for the burning pain in her feet and it is helpful.

Diclofenac gel 3 x per day to the painful joints, which is helpful.

A recent prescription of Naproxen 250mg TDS, which is not making any difference and is increasing her GIT symptoms.

Codeine, Buprenorphine and Tramadol were trialled and discontinued due to nausea and sleepiness. She also trialled Gabapentin and Pregabalin in the past and these were discontinued due to rashes.
We started by discussing the role of the Community Chronic Pain Clinic and its biopsychosocial approach. Our aim is to get a patient to a point of self-management, together with their GP. To this end we look at medication reviews, non-pharmacological therapies and education/psychological therapies. Patients do not remain with us indefinitely. We discussed the differences between the services offered by the Secondary Care Pain clinic and that of the Community Chronic Pain clinic.

We then discussed the difference between nociceptive and neuropathic pain, or central sensitization. We discussed the difference between analgesia for nociceptive pain, and adjuvant medication (for instance certain anti-depressants and certain anti-convulsants) for neuropathic pain/central sensitization.

We discussed the pathophysiology of Fibromyalgia in detail. She now understands that as a central pain syndrome, this would be treated similarly to neuropathic pain. Fibromyalgia patients often respond poorly to opiates, as they seem to develop defective and diminished opiate receptors. Please note Fibromyalgia is a diagnosis by exclusion. The local Rheumatology Department advises the following blood tests: FVC/U&E/LFT/TFT/ESR/CRP/CPK/ANF/Vitamin D. If there is any doubt about diagnosis, please rather refer to Rheumatology.
After discussion we agreed on the following plan:

She will stop **Naproxen and Paracetamol**, as neither of these have proven to be helpful. She could perhaps keep a small stock in her bathroom cupboard to take during times of flare-up, if it proves itself to be useful in that circumstance.

She will start trying **Capsaicin cream** on some of the other painful joints, not just her feet.

She will start attending our specially adapted Tai Chi classes, as these can help with mobility, balance, breathing and relaxation. She/he was given the necessary paperwork.

In the past, she has not attended any Pain Education, therefore I have listed her for an introductory Pain Education Session, with view to later attending a Pain Management Programme. Of note is that she only scores 9 out of 60 on a Pain Self-Efficacy Questionnaire, which would indicate low confidence in her abilities to manage her life in pain.

She has been issued with printed information on: Falls Prevention, Fibromyalgia, our Support Groups, Body Temperature Control information.

She will be reviewed by her Clinical Nurse Specialist in approximately 3 months.
Pain Self Efficacy Questionnaire (PSEQ) M.K.Nicholas (1989)

Please rate how **confident** you are that you can do the following things **at present**, despite the pain.

1. I can enjoy things, despite the pain.

2. I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.

3. I can socialise with my friends or family members as often as I used to do, despite the pain.

4. I can cope with my pain in most situations.

5. I can do some form of work, despite the pain. (‘work’ includes housework, paid and unpaid work).
6. I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.

7. I can cope with my pain without medication.

8. I can still accomplish most of my goals in life, despite the pain.

9. I can live a normal lifestyle, despite the pain.

10. I can gradually become more active, despite the pain.

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Patient feedback:

Thank you to all members of this team!! Helping people cope with chronic pain! Well done, and wow what a service!! God bless x

Service is professional and is patient focused, you feel as though you have time and are given attentive time and confident advice.

Excellent understanding and really sound advice and treatment life changing thank you.

Absolutely great to have this clinic to help us. The staff are very knowledgeable and extremely helpful.

I feel a weight has been lifted off my shoulders at last someone who listened and understood how I feel and the pain I'm in.
So is a multidisciplinary / interdisciplinary approach to pain management effective?

- Our staff think so
- Our commissioners think so
- Our outcomes say so
- Our patients think so – a patient’s response
So what can I do?

- The patient
- Long term outcomes – the bigger picture
- Enhance skills and knowledge
- Build local networks
- Use national resources
- Influence commissioning plans
- Learn from others
- Plans and aspirations
- Collaborative – Multidisciplinary – Interdisciplinary
Thank you – Any questions?