

Patient Experiences With Integrated Pain Care: A Qualitative Evaluation of One VA's Biopsychosocial Approach to Chronic Pain Treatment and Opioid Safety

Global Advances in Health and Medicine

Volume 8: 1–8

© The Author(s) 2019


Article reuse guidelines:

sagepub.com/journals-permissions

DOI: 10.1177/2164956119838845

journals.sagepub.com/home/gam



Natalie Purcell, PhD, MPA^{1,2} , Kara Zamora, MA^{1,2},
Carolyn Gibson, PhD^{1,2}, Jennifer Tighe, MSPH¹,
Jamie Chang, PhD^{1,3}, Joseph Grasso, PhD¹, and
Karen H Seal, MD, MPH^{1,2}

Abstract

Background: Mounting concern about the risks and limited effectiveness of opioid therapy for chronic pain has spurred the implementation of novel integrated biopsychosocial pain care models in health-care systems like the Department of Veterans Affairs (VA). However, little is known about patient experiences with these new care models.

Objective: We conducted a qualitative study to examine patient experiences with a pain care model currently being disseminated at the VA: interdisciplinary, integrated pain teams (IPTs) embedded in primary care.

Method: We interviewed 41 veterans who received care from VA's first IPT to learn how working with the team impacted their pain care and quality of life. We asked about their overall experience with IPT, what worked and did not work for them, and what changes they would recommend to improve IPT care.

Results: The interviews revealed a wide spectrum of patient experiences and varying perspectives on the extent to which the new model improved their pain and quality of life. Thematic analysis shed light on factors impacting patients' experiences, including pretreatment goals and expectations as well as attitudes toward opioids and nonpharmacological treatments.

Conclusion: We discuss the implications of our findings for national efforts to implement biopsychosocial pain care, and we offer recommendations to promote patient-centered implementation.

Keywords

chronic pain, opioids, integrated care, biopsychosocial care, patient experience, patient satisfaction, qualitative research

Received December 20, 2018. Accepted for publication February 27, 2019

Introduction

In the United States, reliance on opioids for chronic pain care has contributed to an overdose epidemic that claims thousands of lives annually.^{1–3} Opioid-related deaths have increased by 200% since 2000,⁴ prompting the declaration of a national public health emergency in 2017.⁵ Beyond overdose risk, long-term prescription opioid use has concerning side effects that can decrease quality of life and daily functioning.⁶ Today, there is significant evidence of harm, but little evidence supporting the effectiveness of opioid therapy for long-term chronic pain treatment.^{7–11}

Patients are often dissatisfied with conventional pain care and its reliance on opioids. Many report that,

despite treatment, chronic pain continues to affect their health, relationships, happiness, and quality of life.^{12–14}

Patients often describe frustrating relationships with the providers treating their pain, citing power struggles, and conflicts surrounding treatment decisions.^{15–20}

Communication about opioids can be particularly

¹San Francisco VA Health Care System, San Francisco, California

²University of California, San Francisco, San Francisco, California

³Santa Clara University, Santa Clara, California

Corresponding Author:

Natalie Purcell, San Francisco VA Health Care System, 4150 Clement Street, Building T-31, San Francisco, CA, 94121, USA.

Email: Natalie.Purcell@va.gov



tense, and patients often report feeling like providers are not listening to them or view them as addicts rather than human beings in pain.

Today, most chronic pain care is delivered in primary care settings, prompting recent efforts to introduce new pain care models into primary care.^{21–25} A growing body of evidence now documents the safety and efficacy of multiple integrative and nonpharmacological modalities in improving pain symptoms, quality of life, and functioning.²⁶ These modalities include psychological and behavioral therapies, exercise and movement therapies, and manual therapies, ideally delivered in combination with one another and alongside pharmacological treatments.

Studies suggest that integrated pain care models can effectively reduce patient reliance on opioids,²⁴ improve pain-related functioning,²⁴ and improve primary care providers' experience.²⁵ Indeed, emerging best practices and clinical guidelines increasingly recommend multimodal, biopsychosocial care as the gold standard for chronic pain treatment.^{26–31} However, it is not yet clear whether integrated care models also improve patients' care *experience*.

In the current study, we examined patients' experiences with an integrated pain care model embedded in Department of Veterans Affairs (VA) primary care and currently being implemented across multiple sites in the national VA health-care system. We conducted semi-structured qualitative interviews to explore patients' overall experiences and satisfaction and to identify factors affecting their perspectives on integrated, multimodal pain care.

Methods

Setting

The present study (approved by the University of California, San Francisco Institutional Review Board) is part of a larger quality improvement research initiative evaluating implementation of an integrated pain team (IPT) care model throughout the San Francisco VA Health Care System—a public health-care system serving over 40,000 U.S. military veterans. Participating campuses included an urban VA medical center; 2 small, urban outpatient campuses and 3 small, rural outpatient campuses.

Intervention

The IPT care model^{24,25} provides integrated, interdisciplinary chronic pain care within VA primary care settings. Primary care providers refer patients with complex chronic pain to IPT, often due to concerns about opioid safety, opioid misuse, and/or co-occurring mental health diagnoses. Referred patients see IPT's medical provider,

psychologist, and pharmacist as a unified interdisciplinary team. All providers are present for the initial visit and, as appropriate, follow-up visits. During these visits, the team educates patients about chronic pain, medication safety, and a biopsychosocial approach to pain management. The team works with each patient to optimize a personalized pain care plan that addresses pain symptoms, improves quality of life, and reduces opioid risk. IPT takes over pain-medication prescribing and often initiates and oversees opioid tapers for patients in their care. IPT care plans typically include behavioral interventions and psychotherapy and emphasize self-management strategies. Additionally, the team provides information about and coordinates referrals to ancillary and complementary health services, including physical therapy and acupuncture.

At San Francisco VA, patients average 3 to 4 visits with IPT over 2 to 3 months before returning to primary care for pain management. However, the number and frequency of visits vary significantly based on patient needs and preferences.²⁵ Veterans served by the urban medical center and its nearby campuses see IPT primarily through in-person visits with some telephone follow-up. Veterans served by rural VA clinics see IPT primarily through video-teleconferencing with telephone follow-up.

Design

We used a qualitative study design to evaluate patients' experiences with IPT, inviting those who received IPT care to participate in a telephone interview after completing at least 3 IPT visits.

Measures

We developed a semistructured interview instrument comprised of questions about: (1) veterans' overall experience working with IPT, (2) IPT's impact on their pain care and quality of life, and (3) what did and did not work well in the IPT care model. Across all areas, we solicited patient concerns and recommendations to inform future iterations of the model.

Participants

Eligible participants included veterans with chronic pain diagnoses who enrolled in IPT care at San Francisco VA and completed at least 3 IPT visits. Patients were excluded if they had untreated serious mental illness or were actively suicidal or homicidal. All eligible veterans ($n = 84$) were invited to participate via a letter from the study team and a follow-up telephone call to those who did not return an "opt-out" postcard.

Interviews were completed for 41 veterans (response rate = 49%, see Table 1). Participants were predominantly male (66%), white (66%), and middle-aged

Table 1. Characteristics of the Sample (n = 41).

Demographic Characteristics	Participants, n (%)
Age, in years (mean)	58
Gender	
Male	27 (65.85)
Female	14 (34.15)
Race	
White	27 (65.85)
Black/African American	6 (14.63)
American Indian/Alaskan Native	1 (2.44)
Hispanic	1 (2.44)
Asian	1 (2.44)
Multiracial/Other	4 (9.76)
Military service-connected disability	26 (63.41)

(mean age 58 years). Military service-related disabilities were documented for 63% of participants.

Procedures

Study team members trained in qualitative assessment conducted all interviews via telephone. Interview times typically ranged between 30 and 60 min. All interviews were audio-recorded for analysis.

Analytic Strategy

We used a qualitative analysis technique developed for rapid health services research.³² Using our semistructured interview guide, we created an analytic matrix template organized by topical area. Guided by the interview audio-recordings, we populated a matrix for each interview, summarizing interview content for all topical areas and transcribing participant quotations illustrating each summary. To ensure reliability, at least 2 analysts completed a matrix for each individual interview and compared their findings for consistency. The team then used these matrices to identify and organize recurring themes and to prepare a description of each theme. To ensure validity, authors NP, KZ, and CG each reviewed the matrices and independently identified themes. We met routinely during the analysis phase to reconcile the results of our analyses, to confirm that all central themes had been identified, and to ensure consensus around the description of each theme.

Results

Patient interviews revealed a wide spectrum of experiences with IPT care. To illustrate this range of experiences and to identify the factors driving them, we present themes across 3 domains: (1) Interdisciplinary Treatment Model, (2) Treatment Planning and Communication, and (3) Treatment Results and Impact.

Interdisciplinary Treatment Model

Patients referred to IPT enter a multimodal care-planning process with an interdisciplinary team of providers who meet together with the patient at the same time. Many patients described this interdisciplinary care model as both efficient and beneficial. They liked seeing multiple clinicians with pain expertise in a single appointment primarily because the team could address various clinical needs and questions at once and follow a cohesive treatment plan. One patient observed:

That's never been something that I've ever had in a medical facility—trying to facilitate a solution for me where more than one person came into a room with their different expertise and collaboratively worked together to promote higher understanding, and I think that's what's really benefitted me.

Several veterans noted that receiving care from an interdisciplinary team meant they did not need to waste time requesting referrals or making appointments to see different specialists. As one patient said, "Having them all together let us all get it taken care of at one time."

However, not all patients favored the interdisciplinary model. Even after working with the team for months, many could not differentiate the IPT providers or recall their individual roles. Some felt that IPT's interdisciplinary model added unnecessary complexity: "It's just taken the same thing and made it more confusing for me," observed one veteran. Dealing with "one provider is better than five," commented another.

Other patients noted that having multiple clinicians in the room could feel awkward. The team-based visit structure could leave them feeling outnumbered, intimidated, and less inclined to engage. "You can feel a little ganged up on," noted one veteran. A few patients shared mixed feelings about the presence of a mental health provider. Some preferred to keep that aspect of their care private or felt that mental health care was not helpful for their pain. "To me, talking about it doesn't help," shared one veteran, "Obviously, my pain depresses me."

Treatment Planning and Communication

A primary goal of IPT is to actively engage patients in personalized care planning. However, patients provided varied and, at times, conflicting perspectives about their communication with IPT and their involvement in the care-planning process.

On one end of the spectrum, many patients felt that their personal goals were truly reflected in their care planning. "They found out what my life is about and what is important to me," explained one veteran, "I got to decide what I really wanted to work on, kind

of what my goals were...It was tailored for me.” Patients frequently noted that the team listened carefully to them and addressed their questions and concerns, often more so than in their usual health-care experiences. “I felt like they heard me,” shared one veteran, “When I told them ‘this is who I am, and this is what I do’... they weren’t trying to put a round peg in a square hole.” Multiple patients valued the collaborative nature of the care-planning process. “It’s a two-way conversation, not a one way conversation, so it worked really well for me,” shared one veteran.

Patients often spoke of how important it was to feel that the team members cared about them as human beings, investing time and attention to meet their needs:

They *care*, and that’s the biggest part...I think it’s genuine...That gives a guy kind of a shot in the arm, if you will. It gives me more incentive, because they become part of my team and I don’t want to let them down.

In some cases, having someone to talk to about their pain met an otherwise unmet need for connection and validation. “I think it’s honestly given me confidence on managing my own pain and making decisions for myself,” shared one veteran.

However, not all patient experiences were positive. Some regarded the team with suspicion, worrying that, if they answered questions about their pain and opioid use honestly, they would be labeled an addict and have their medications taken away. “You have to tell them what they want to hear, or you’re in big trouble, trust me,” affirmed one veteran, “I feel like I’m doing something illegal every time I take a pain pill...I’m scared to death of what to say to them.”

Some patients felt that opioid dose reduction was IPT’s singular “agenda” from the start. As one veteran put it, “They just want to get the medications down, take them away from me and that’s their goal.” To patients who shared this view, IPT was not personalized pain care but rather a mechanism to implement new VA policies around opioids. “I don’t feel that they necessarily had my welfare as number one,” shared another veteran, “I believe their main concern was just getting me off of drugs.” The perceived discrepancy between what IPT espoused (multimodal care options, patient-driven treatment planning) and the care they felt they received (focused on opioid dose reduction) left some patients feeling misled and dissatisfied. These veterans described the team’s claims about personalization and choice as a “joke” or a “charade.” The most distressed and unhappy patients said that IPT had treated them like “junkies” or “drug addicts.”

Interviewed patients often referenced the national opioid crisis, describing IPT as a part of VA’s effort to

rein in the use of opioids to prevent abuse and overdoses. As one veteran put it, “Everybody is running so scared behind Vicodin and whatever, that they’re more concerned with that than trying to address someone’s pain...it’s headline news.” When patients mentioned the opioid crisis, some took pains to explicitly differentiate themselves from its victims:

I saw on the news this morning...a million or whatever people died in 2016 from opioid addiction or overdoses, but that’s not me. I think each one of us should be taken individually.

Patients’ perspectives on the national opioid crisis—and their own relationship to it—thus shaped their impressions of and feelings about IPT.

Treatment Results and Impact

IPT aims to improve pain, quality of life, and functioning with an explicitly multimodal approach, including a range of nonpharmacological and behavioral strategies. However, when we asked patients to reflect on how their treatment plans changed during their time with IPT, nearly all cited opioid reduction or elimination as the most significant change.

Some felt that this change had a clear, positive impact, resulting in greater energy, less grogginess, and a renewed ability to engage in valued activities and relationships. Explained one veteran:

Since I don’t do as much morphine, I’ve started to get myself back out and doing things I had stopped doing... I [had] completely quit fishing and stuff and now I’ve got it back to where I’ll go fishing once a week, and just trying to be a little more of an active person.

Like him, many patients reported that IPT’s changes to their medication regimen had a positive impact on their pain and quality of life. For some, it was truly life-changing:

It’s really definitely changed how I kind of carry myself, I don’t feel like I’m a decrepit...aging, old woman, I feel like, okay, I have a new lease on life.

However, other patients described worsening pain as their opioid medications were reduced or changed, sometimes severely curtailing their functioning and quality of life. “I’m spending half the time in the emergency room curled up in the corner,” complained one veteran, “The VA ruined my life.” Many of these patients said that opioids had been the only effective means of treating their pain, and they felt that the negative impact of opioid reduction was not offset by any alternative

treatments or positive effects. Some expressed a sense of desperation and resignation: “I just don’t know what to do about the pain except live with it I guess . . . I’m at a loss.”

Although most patients described adjustments to their opioid regimen as the most significant change in their treatment plan, several also described adding nonpharmacological and integrative treatment modalities to their care plan. The changes most often mentioned were behavioral strategies including stress reduction, mindfulness, activity pacing, and use of heat and ice. Experiences with these modalities varied among interviewees, but many found a few strategies they considered helpful. The addition of acupuncture was frequently described as a significant, if temporary, source of relief, and some found acupuncture to be truly life-changing. Others mentioned exercises and physical therapy as helpful additions to their care plan.

However, not all patients felt that behavioral strategies and integrative modalities made an appreciable difference. Some doubted their effectiveness or found them impractical. Several patients said that IPT offered them nothing that they had not tried before:

They’ve suggested a thousand different things, but . . . I’ve done so many different things. I’ve tried all the things you can imagine, including acupuncture, acupressure, physical therapy . . . There’s nothing that they could suggest to me that I can think of that would be different, or new.

It is notable that, although multimodal care-planning is central to IPT’s mission, many interviewed patients were not able to cite any nonpharmacological changes or additions to their treatment plan.

Drivers of Patient Experience

The factor that most clearly shaped patients’ overall IPT experience was whether they wanted to reduce their opioid use. Patients who came to IPT with a goal to reduce or stop opioids generally welcomed the team’s support in this endeavor. These patients often spoke warily of opioids, saying things like, “you don’t want to get hooked on that stuff,” and using words like “dope” and “chemicals” to describe the medications. Other patients made no negative comments about opioids but came to IPT with some interest in learning about alternatives and safety considerations; they, too, often reported positive IPT experiences. However, very little satisfaction was reported among patients who believed that opioids were the *only* effective treatment for *their* pain—i.e., “there just isn’t any other medication out there.”

Patients’ preexisting opinions about behavioral and integrative treatment options also appeared to shape their IPT experience. Those who noted that they were already open to or excited about “holistic” or nonpharmacological approaches to pain care tended to be the most positive about IPT care. Others had little experience of these modalities but were interested and open to them; among these patients, many were satisfied with what IPT had to offer. By contrast, several dissatisfied IPT patients expressed general skepticism about the effectiveness of behavioral, integrative, and nonpharmacological approaches in addressing their pain, even dismissing them as “holistic this and that.”

Other veterans were open to developing multimodal treatment plans but felt let down by the options available to them. For example, women with childcare responsibilities sometimes felt it was not realistic for them to participate in groups or follow recommendations regarding rest and pacing. As one veteran put it, “Some of their recommendations would have been great for the general patient population at the VA [older men], but they were just lousy for someone who has to take care of young children.” Similarly, patients in rural areas often felt like they did not have access to the same community-based resources as patients near urban campuses.

Patients’ experiences with IPT were also shaped by how much control they felt they had in treatment planning. Patients who felt that their own treatment goals were driving the process tended to have positive experiences and reported more substantive and effective changes to their treatment regimen. However, when patients saw tapering opioids as IPT’s sole or primary goal, they often felt less in control, less invested in encounters with the team, and less satisfied with both IPT’s process and outcomes. “The end game was already defined,” explained one dissatisfied veteran, “A couple times I said, ‘why are we having these meetings when you already knew what you were gonna do before you even met me?’”

The manner in which patients were referred to IPT was also important. Patients who perceived IPT as an additional choice available to them tended to be open to working with the team and thankful for this option, even if they were not always satisfied with the results. Patients who were referred to IPT by their providers without a discussion of their options tended to believe the referral was a matter of policy rather than a choice and often had more negative experiences.

Finally, the outlook that patients brought with them appeared to shape to their overall experience in IPT. A number of interviewed veterans spoke cynically about the possibility of healing from pain, and those patients were seldom happy with their IPT experience. “I’ve tried everything else [and] it’s never worked,” said one veteran, “and the medication only works so much,

then after that I'm going to end up—I have to take more medication.” In contrast, patients who felt hopeful about the possibility of improvement tended to be more positive in their descriptions of the IPT care process and its outcomes. An extant sense of motivation and engaged optimism tended to generate the most positive IPT experiences. One veteran exemplified this attitude when he said:

I think it's up to each one of us to get in touch with our own bodies, and figure out how to work around what we have. And it's just a matter of deciding, 'do you want to live, or are you gonna give up?' And I'm a grandpa, and I've got horses and I've got a pet dog, and I've got a good life, and I'm not ready yet, so I'm gonna figure it out. And these young people listen to me and they work with me and I'm encouraged that I can do this... I'm hopeful.

Discussion

There is mounting evidence that integrated, biopsychosocial care models like IPT can reduce pain, improve functioning, and reduce opioid-related risk.^{21–24} However, less is known about the impact of these care models on patients' experience. Our findings point toward several ways that health-care institutions can promote patient-centered care and improve patients' experience when implementing integrated, biopsychosocial pain care models.

First, our findings show the importance of transparency at the foundation of the pain care relationship. The patients we interviewed were well aware of the sociopolitical context undergirding VA's shift toward integrated and nonpharmacological pain care. They knew that teams like IPT are, in part, a response to the national opioid crisis. Many arrived with preexisting impressions, including fears and concerns about their medications being taken away. One approach that teams like IPT might consider is to prioritize transparency about this context from the start—not only referencing the opioid crisis but also acknowledging that health-care policies and practices contributed to, and helped create, that crisis.^{33,34} Care teams can explicitly acknowledge this and simultaneously convey awareness that each patient is an individual with unique needs that are not reducible to social trends or statistics. Doing so respects patients' knowledge about the broader context while creating space for them to voice their unique concerns and needs. Such frank discussions might help lift the cloud of suspicion and distrust that some patients felt in their encounters with IPT.

Second, our findings suggest that engagement in any pain care intervention should be an informed choice

among meaningful alternatives. We found that patients who felt that they *chose* to work with IPT were often able to build positive, collaborative relationships with the team and felt like active, engaged drivers of their own care. This was seldom the case for patients who were referred without first having a discussion about options with their primary care provider. To facilitate informed choices about pain care, providers and patients should have opportunities to learn about the structure, aims, and potential benefits of available options, as well as evidence of their impact. Teams like IPT might consider offering recurring open informational sessions or orientations for patients so they can better understand the care model and ask questions before deciding to engage.

Third, patients' attitudes when they enter an intervention like IPT may shape their receptivity to the model and their satisfaction with treatment outcomes. Primary care providers may wish to informally assess patients' current attitudes toward opioids, nonpharmacological pain treatment, and the care system as a whole before making specific pain care referrals. Some patients may benefit from additional education or coaching to improve their readiness for specific pain care interventions. Alternately, care models like IPT could be modified to better facilitate the attitude shifts needed for successful engagement. Possible changes that warrant further exploration include adding preliminary motivational interviewing sessions and/or increasing visit frequency and treatment duration.

Fourth, our findings show the importance of expanding the menu of available integrative and nonpharmacological treatment options to meet the needs of a diverse patient population. We learned that the options currently available to IPT patients were not readily accessible to all, and accessing them could pose particular challenges for some patients, such as those with childcare responsibilities and rural residents. The more treatment options that teams like IPT can offer, the more likely they will be to meet the needs of a diverse patient population.

Limitations

Our interviews were limited to IPT patients within one VA health-care system, and our findings may not be generalizable to nonveteran patients or to patients receiving care at other VA facilities. Selection bias may have affected our results as the perspectives of patients who participated could differ in significant ways from those who chose not to. The experiences of some patient groups, such as young veterans of the wars in Iraq and Afghanistan, were less well represented in our findings. Also, our methodology may not have captured changes in patient perspectives and experiences with continued

IPT involvement beyond the 3-visit minimum required for participation.

Despite these limitations, this study has many strengths. For a qualitative interview-based study, our sample was large ($n = 41$), and our response rate (nearly 50%) was robust. Our sample was reasonably diverse with respect to race and gender and included patients living throughout a large geographical area encompassing urban, suburban, and rural locations.

Conclusion

As the VA and other health-care systems work to adopt integrated, biopsychosocial approaches to pain care, they can learn from the experiences of patients served by IPT. Introducing biopsychosocial care options and adopting integrated care models can facilitate an improved patient experience but does not guarantee it. Even good faith efforts to practice patient-centered care may not *feel* patient-centered to everyone served, especially when tied to institutional imperatives like opioid risk reduction. To build pain care models that leave patients feeling respected and well cared for, care teams must be attentive to the range of personal and institutional factors that can shape patients' experiences, continually seeking ways to serve patients in their individuality and diversity.

Authors' Note

The authors are employees of the Department of Veterans Affairs, but this paper reflects their own views and not the views of the Department of Veterans Affairs. The authors alone are responsible for the content of this article.

Acknowledgments

The authors wish to thank the clinicians on the integrated pain team at the San Francisco VA Health Care System, including nurse practitioner Caitlin Garvey, psychologists Payal Mapara and Erin Watson, pharmacists Christina Tat and Elizabeth Son, psychiatrist David Villasenor, and primary care provider Wilson Fong.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded by the Quality Enhancement Research Initiative, Department of Veterans Affairs. The funder was not involved in the study design; the collection,

analysis and interpretation of data; the writing of the report; or the decision to submit the article for publication.

ORCID iD

Natalie Purcell  <http://orcid.org/0000-0002-0582-9235>

References

1. Atluri S, Sudarshan G, Manchikanti L. Assessment of the trends in medical use and misuse of opioid analgesics from 2004 to 2011. *Pain Physician*. 2014;17:E119–E128.
2. Centers for Disease Control. Prescription opioid overdose data. Centers for Disease Control Injury Center. <https://www.cdc.gov/drugoverdose/data/overdose.html>. Published December 16, 2016. Accessed March 2, 2017.
3. Katz J. Drug deaths in America are rising faster than ever. *The New York Times*. <https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html>. Published June 5, 2017. Accessed April 20, 2018.
4. Rudd RA, Seth P, David F, Scholl L. Increases in drug and opioid-involved overdose deaths: United States, 2010–2015. *MMWR Morb Mortal Wkly Rep*. 2016;65:1445–1452.
5. United States Department of Health and Human Services. HHS acting secretary declares public health emergency to address national opioid crisis. HHS.gov. <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html>. Published October 26, 2017. Accessed April 20, 2018.
6. Benyamin R, Trescot AM, Datta S, et al. Opioid complications and side effects. *Pain Physician*. 2008;11(2 Suppl):S105–S120.
7. Krebs EE, Gravely A, Nugent S, et al. Effect of opioid vs nonopioid medications on pain-related function in patients with chronic back pain or hip or knee osteoarthritis pain: the SPACE randomized clinical trial. *JAMA*. 2018;319(9):872–882.
8. Kuehn BM. AHRQ: little evidence for opioids in managing long-term chronic pain. *JAMA*. 2014;312(12):1185.
9. Manchikanti L, Kaye AM, Kaye AD. Current state of opioid therapy and abuse. *Curr Pain Headache Rep*. 2016;20:34.
10. Sjøgren P, Grønabæk M, Peuckmann V, Ekholm O. A population-based cohort study on chronic pain: the role of opioids. *Clin J Pain* 2010;26(9):763–769.
11. Eriksen J, Sjøgren P, Bruera E, Ekholm O, Rasmussen NK. Critical issues on opioids in chronic non-cancer pain: an epidemiological study. *Pain*. 2006;125(1–2):172–179.
12. David Michaelson & Company, LLC. *Voices of Chronic Pain: A National Study Conducted for American Pain Foundation*. Middletown, CT: American Pain Foundation; 2006.
13. McCarberg BH, Nicholson BD, Todd KH, Palmer T, Penles L. The impact of pain on quality of life and the unmet needs of pain management: results from pain sufferers and physicians participating in an Internet survey. *Am J Ther*. 2008;15(4):312–320.
14. Dueñas M, Ojeda B, Salazar A, Mico JA, Failde I. A review of chronic pain impact on patients, their social environment and the health care system. *J Pain Res*. 2016;9:457–467.

15. Frantsve LME, Kerns RD. Patient–provider interactions in the management of chronic pain: current findings within the context of shared medical decision making. *Pain Med.* 2007;8(1):25–35.
16. Kenny DT. Constructions of chronic pain in doctor–patient relationships: bridging the communication chasm. *Patient Educ Couns.* 2004;52(3):297–305.
17. Matthias MS, Krebs EE, Bergman AA, Coffing JM, Bair MJ. Communicating about opioids for chronic pain: a qualitative study of patient attributions and the influence of the patient–physician relationship. *Eur J Pain.* 2014;18(6):835–843.
18. Upshur CC, Bacigalupe G, Luckmann R. “They don’t want anything to do with you”: patient views of primary care management of chronic pain. *Pain Med.* 2010;11(12):1791–1798.
19. Jonsdottir T, Gunnarsdottir S, Oskarsson GK, Jonsdottir H. Patients’ perception of chronic-pain-related patient–provider communication in relation to sociodemographic and pain-related variables: a cross-sectional nationwide study. *Pain Manag Nurs.* 2016;17(5):322–332.
20. Werner A, Malterud K. It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Soc Sci Med.* 2003;57(8):1409–1419.
21. Dorflinger L, Moore B, Goulet J, et al. A partnered approach to opioid management, guideline concordant care and the stepped care model of pain management. *J Gen Intern Med.* 2014;29(4):870–876.
22. Dorflinger LM, Ruser C, Sellinger J, Edens EL, Kerns RD, Becker WC. Integrating interdisciplinary pain management into primary care: development and implementation of a novel clinical program. *Pain Med.* 2014;15(12):2046–2054.
23. Wiedemer NL, Harden PS, Arndt IO, Gallagher RM. The opioid renewal clinic: a primary care, managed approach to opioid therapy in chronic pain patients at risk for substance abuse. *Pain Med.* 2007;8(7):573–584.
24. Seal K, Becker W, Tighe J, Li Y, Rife T. Managing chronic pain in primary care: it really does take a village. *J Gen Intern Med.* 2017;32:931–934.
25. Purcell N, Zamora K, Tighe J, Li Y, Douraghi M, Seal K. The integrated pain team: a mixed-methods evaluation of the impact of an embedded interdisciplinary pain care intervention on primary care team satisfaction, confidence, and perceptions of care effectiveness. *Pain Med.* 2017;19:1748–1763.
26. Kligler B, Bair MJ, Banerjee R, et al. Clinical policy recommendations from the VHA state-of-the-art conference on non-pharmacological approaches to chronic musculoskeletal pain. *J Gen Intern Med.* 2018;33(Suppl 1):16–23.
27. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *JAMA.* 2016;315(15):1624.
28. Kerns RD, Krebs EE, Atkins D. Making integrated multimodal pain care a reality: a path forward. *J Gen Intern Med.* 2018;33(Suppl 1):1–3.
29. Becker WC, DeBar LL, Heapy AA, et al. A research agenda for advancing non-pharmacological management of chronic musculoskeletal pain: findings from a VHA state-of-the-art conference. *J Gen Intern Med.* 2018;33(Suppl 1):11–15.
30. Hylands-White N, Duarte RV, Raphael JH. An overview of treatment approaches for chronic pain management. *Rheumatol Int.* 2017;37(1):29–42.
31. Cheatle MD. Biopsychosocial approach to assessing and managing patients with chronic pain. *Med Clin North Am.* 2016;100(1):43–53.
32. Hamilton AB. Qualitative methods in rapid turn-around health services research. In: presented at the Health Services Research & Development Cyberseminar; December 11, 2013. http://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=780. Accessed June 3, 2016.
33. Van Zee A. The promotion and marketing of oxycontin: commercial triumph, public health tragedy. *Am J Public Health.* 2009;99(2):221–227.
34. Katz N. Opioids: after thousands of years, still getting to know you. *Clin J Pain.* 2007;23(4):303–306.