

## Pain Management Design Group 2

10/01/18

**Participants:** Alyssa Harrington, Randolph Trowbridge, Helena Hilario, Pano Yeracaris, Shaina Smith, Mark Schaefer, Ronald Preston, Doug Olson, Stephanie Burnham, Alice Ferguson, Ellen Bloom, Rebecca Andrews, Robert Zavoski

### Purpose of Design Group:

PCM Goals:

1. Support patient-centered, coordinated care and a better patient experience.
2. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed
3. Expand care teams and improve access outside the traditional office visit
4. Double investment in primary care over five years through more flexible payments
5. Reduce total cost of care while protecting against underservice

Pain Management Design Group:

1. What are the elements of an effective pain management model that all practices should invest in?
2. What elements of pain management should the network provide but only a subset of practices or providers deliver?

### What We Heard in Session 1:

Consumer Input, Questions and Concerns

1. Important to ensure alternative and preventative therapies are accessible
2. Multipronged approach that includes education is needed
3. Need to look at overcoming cost and transportation barriers
4. Need reimbursements for providers for longer appointments
5. CDC guidelines are inefficient and have resulted in unintended consequences and unnecessary prescribing. Should take caution if following these guidelines. Recommend looking at FDA guidelines that will be released soon.
6. Need to ensure all services for pain management are in-network and covered by insurance
7. Need for more resources for providers to prescribe affordable medications for chronic pain.

Questions: Anything to add?

- Consumers on phone?
  - Consumer: Nothing so far
  - Consumer: The necessity of an educational component (for patients and providers).

### What We Heard in Session 1:

1. CT should undertake multi-pronged approach to pain management that aligns with National Pain Strategy and focuses on prevention
2. All primary care providers should have training on basics of pain prevention and management
3. Begins with proper management of acute pain and preventing progression to chronic pain
4. Expanded care teams are needed to coordinate care, provide motivational interviewing, assist with lifestyle interventions, and address behavioral health issues
5. Provide access to lifestyle interventions and alternatives to opioid treatment, such as physical therapy, behavioral health interventions, acupuncture, mindfulness, etc.
6. All primary care providers should have access to e-Consults with pain management specialists
7. Subset of primary care providers should specialize in chronic pain management
  - a. Need access to Project Echo learning and guided practice model
8. Establish CT Center of Excellence resource/comprehensive pain center to refer complex patients

Question: Anything to add?

- No comments

#### **Draft Concept Map for Pain Management.**

- FHC: We are focused on those elements most pertinent to the primary care delivery model

#### **Questions for Discussion**

1. What elements of this diagram would you change? What is missing?
2. Which elements of pain prevention and management should all primary care practices be responsible for? Which should be for a subset of primary care practices?
3. How would PCP specialization in pain management be defined?
4. How should MAT be incorporated into this model or should it be a separate capability?
5. Are there other resources the network needs to provide to support this capability?
6. Is this approach missing any components for primary care delivery?

#### **Questions/Comments**

- Provider: Think you did a great job. The whole organization for this has been one of the best things I've seen so far in terms of providing structure, but "God is in the details". The details are where this will all lie.
  - What about the very basic primary care need?
    - I think the biggest idea is 80% of all pain goes away if you do nothing within the first 8 weeks
    - To know pain itself is not a diagnosis, its just a symptom, makes the concept of evaluating pain more complex.
  - There must be an educational process that goes into this for the primary care providers that do not normally deal with pain daily.
    - There should be a center of excellence in the state and have that be the educators → this is a great way to start your evaluation of a pain situation
- FHC: We will assess whether this is something that needs further treatment.
- Provider:

- Depending on prior history of managing pain, everyone has a protocol they go through, and I don't think those protocols are accurate.
- Everyone could use a refresher course. Maybe we can create an objective model and start out on the right foot
- The term education is important from a patient point of view.
- Back pain affects 85% of the population in the US, but there are areas in the world where only 5-8% of the population is affected
- FHC: A provider brought up preventive care in primary care and what all practices should provide.
- Provider: Must define this population: people with acute pain transitioning to chronic pain
  - Once someone develops acute pain syndrome, we need to make sure there is a recognized bundle that is taught to primary care providers that patients can be engaged with (exercise, meditation, physical therapy, and so forth)
  - Make sure patients and their families are supported
  - Do everything possible to keep them from going into chronic pain
- Provider: Screening for things like depression & diseases; teaching patients how to deal with stress is key
  - Occupational literature can be a resource
  - Some generics go to all kinds of pain, but first must consider what is necessary for prevention and preventing acute from going to chronic
- FHC: What about the routine care?
  - Provider:
    - Primary care does so much, you can't force them to do everything.
    - There will always be some practitioners not interested in doing a lot in pain
    - The ones that are receptive and want to do a better job should be educated
    - You can't force doctors to do this.
- OHS: What do others think?
  - Provider: There are certain primary care doctors that don't want anything to do with chronic pain management
    - There's an opportunity to bump patients up to a different type of treatment
    - The Advanced Network should ensure that someone can do this to keep patients from bumping up, otherwise, not a smart use of resources
- OHS: COE is the only thing providing support for primary care. The advanced primary care physicians provide ongoing care, or do they provide a consult?
  - Provider: People at the AN primary care chronic pain level are going to have to refer to a PCP because there are a limited number of pain specialists or COEs of pain management that can accommodate the large number of pain patients that need to be seen.
  - A lot of this involves prescribing. There will not be enough of the folks in the top two boxes shown for prescribing. Sending them back to the PCP would be good to educate PCPs and embrace the concept of a patient-centered medical home.
- Provider: Agreed. The COEs can be a resource to primary care doctors. There are so many patients with pain, and they will have to be referred.
- OHS: The Center of Excellence would play a critical role getting to that
  - Add something to this chart that articulates the role of the subset and the general community of primary care providers (show an ongoing supportive role)

- Provider: I can't tell you how many times I've seen patients move into chronic pain where it could have been prevented, so assessment ability is important and where to direct patients if a doctor can't handle the patient. Most problems are mechanistic, so we must have a simple model at the beginning to look at the mechanism to shut off the whole process.
- Expert: This has been a rich discussion. I would suggest we specify that team-based care is also in the routine care for acute and chronic pain. You want to assess and make sure there is no significant danger or injury (hopefully with a good physical exam and history).
  - Red flags=imaging
  - You don't want providers assessing chronic pain, ruling out significant injury, and instructing patient to just take some ibuprofen or some Tylenol
- Provider: I received 20 phone calls this morning of people who need acute visits. I know we are focused on this from a chronic pain standpoint, but if we expect this to be treated then we might have to give people different ways of accessing care (i.e. telemedicine) because right now, it's hard for people to get in to see their primary care provider. We want people with acute pain assessed correctly and quickly.
- OHS: In isolation, I don't think we would have much success with this. The bundled payment the PRC is working on will help. What is needed from a coverage or payment perspective? There should be coverage for things like acupuncture (the kinds of care team partners needed in diverse care teams). Do we have to have some other category of care team member that is specific to acute and chronic pain?
- Provider: I refer people in a team-based model all the time, and I use the same people for pain management that I've used for other things.
- Expert: PT + OT = there's a lot of potential. I don't think it's realistic to have it in primary care, but you'd want it in a care-coordinated, highly-valuable way (companion training for members of the care team and if you have it in the same building that's great)
  - There is this Rhode Island chiropractor called Primary Low Back Pain, run by chiropractors and physical therapists, and they do an assessment before patients go to an ortho
- Provider: Nutritionists play into pain management highly.
- OHS: Let's make sure our BH clinicians have a full range of expertise.
- Provider: Pharmacy and social work can help get people into systems that maybe we can't right now (like affordable programs for acupuncture)
  - Being housed in one area is nice in terms of comprehensive billing
- OHS: Tie to other work groups, helps people to understand the efficiency of the care team as a flexible means to accomplishing better care
- OHS: Today what really matters is what is on the printed page and at the 30,000-foot level; it is a reasonably comprehensive statement of the problem
  - Should we specifically call out addiction?
- OHS: Next year: we can get more nuanced and articulate more thoroughly what we are after
- FHC: Right now, we have a separate doctor that talks about medication-assisted treatment (MAT) as a subset of this and OHS mentioned calling out addiction, what are people's thoughts on including this on the model?
- Payer: You essentially have two treatments there.

- Provider: Not necessarily people who have just addiction, but there are people who have addiction and chronic pain. You must have the option to treat people who become dependent on medication doctors have given them.
- Provider:
  - We would only use MAT for those with opioid disorders.
  - There is a growing group of people who have every qualification to be on both, from a Medicaid point of view.
- Payer: There is a subset of PCPs with a subset in pain training, and there are some mixed messages here that could be cleaned up a bit.
- Expert: It's nice to have your PCP doing it to ensure a continuity of the relationship (maybe this belongs somewhere else, like medication-assisted treatment).
- Payer: May want to outline examples of specialized training such as acupuncture. There are also several people out there who claim to be specialists in pain management who aren't
  - FHC: If we go with specialized training in pain management, are there standards that we would recommend or special training to be considered advanced in pain management?
  - Provider: If you're a PCP, you're required to try and treat everything. It's difficult to layer something on top of PCPs to prove they're pain management specialists (you can go to a program and get certified, but should not have to prove certification to do this)
- OHS: Have subset on the left and a split rectangular box (subset who does MAT and one is a subset that does the other and add the point about expertise in BH interventions)
- OHS: It does make sense to keep MAT visible as part of the continuum.
- Consumer: Is it possible for us to get this as a one-pager to weigh in with more comments?
  - FHC: Will send revised diagram and revised capability requirement 10/2
  - This will be reviewed by the Practice Transformation Task Force Oct 9<sup>th</sup>
- Provider: Setting general standards for education (specify number of hours or additional hours of training that would qualify someone as one of these higher PC specialists)
- Consumer: I see patient education and awareness under preventive care. I would think education would apply to all levels.
- Provider: Patients don't know their recovery (time is a big factor).
- Consumer: Important to remember outside factors on the insurance side.
  - FHC: This is something we could capture as a recommendation.
- Consumer: Different insurance protocols doctors must participate in to make sure their patient is getting the medication prescribed in a timely manor and then to make sure continuity of care with the limitation's insurers put on physical therapy, etc. Some plans have limits and others do not. Some limitations are placed on mental health as well.
- FHC: Making recommendations on insurance side too makes a lot of sense.

#### **Next Steps:**

- FHC will revise the diagram and get it back to attendees for feedback by 10/3 or 10/4
- Then, based on feedback, will revise again and send to PTF on Oct 9<sup>th</sup>. Then, will circle PTF recommendations back to group.
- Provider: When you get the recommendations from today, I know the PTF may ask for more detail, so if you think there are opportunities to provide that it may be helpful.

