

Primary Care Modernization Project Capability Summary Pain Management

Meeting Notes and Feedback from Design Group Meetings are attached at the end of this document.

Definition of the Capability: Integrated approach to preventive, routine and advanced care management of acute and chronic pain in primary care, with support from Centers of Excellence in pain management.

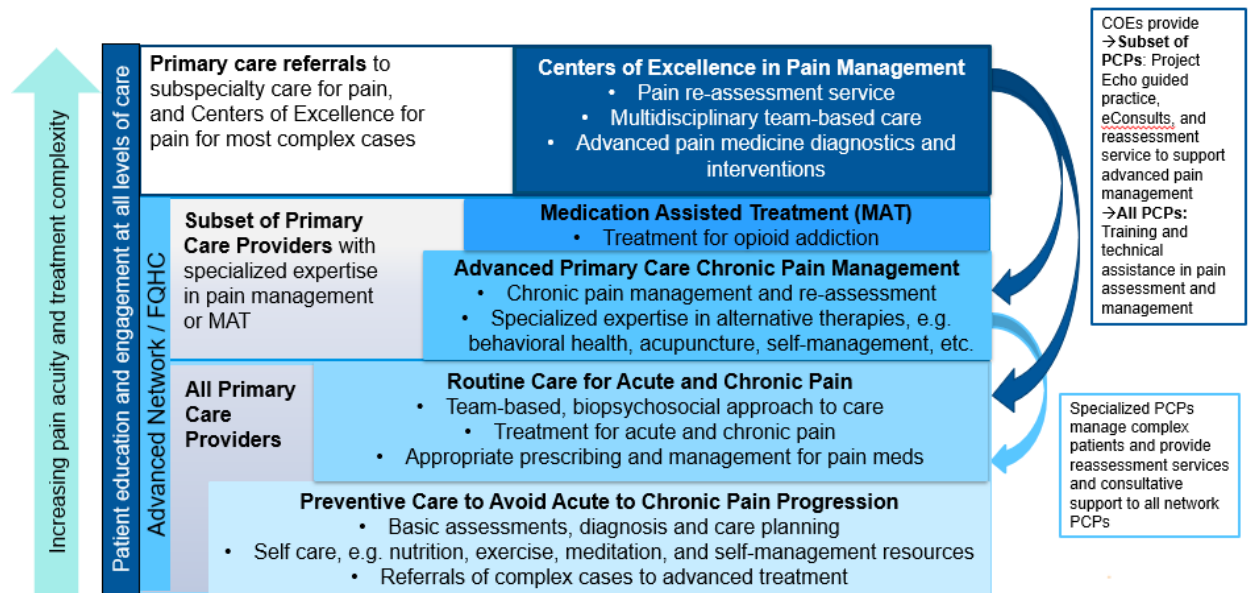
Goal of the Capability¹: Increase PCP capacity and resources to improve prevention of acute pain to chronic pain, management of chronic pain to avoid opioid dependence, and treatment for opioid addiction.

Consumer Input, Questions, and Concerns for Implementation:

- Important to ensure alternative and preventative therapies are accessible
- Multipronged approach that includes education is needed
- Need to look at overcoming cost and transportation barriers
- Need reimbursements for providers for longer appointments
- 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.
- Need to ensure all services for pain management are in-network and covered by insurance and address limitations on medications and interventions like physical and occupational therapy, behavioral health services, etc.
- Need for more resources for providers to prescribe affordable medications for chronic pain
- Patients and providers need education in pain assessment and management
- Patient education about pain management should be provided at all levels of care, not just as part of preventive care

¹ While pain management should be situated within larger public health initiatives, capability requirements focus on those aspects of a pain management strategy that pertain to primary care.

Primary Care Modernization – DRAFT Concept Map for Pain Management



Summary of Capability

● Responsible

◆ Needs Infrastructure

Type of Service in the Model	Provided by:		
	All Practices	Subset of Practices	Network
Preventive care to prevent progression of acute pain to chronic pain (via in-office visit or telemedicine)	●		
Patient education on pain management at all levels of care	●	●	
Basic assessments and diagnosis to establish appropriate care plan and treatment if needed	●		
Routine care for patients with acute and chronic pain (via in-office visit or telemedicine)	●		
Team-based, biopsychosocial approach to pain management that promotes patient activation and self-management	●	●	
Appropriate prescribing and management for pain medication	●		
Access to training and technical assistance for assessing pain, routine care, appropriate prescribing, medication management	●		◆ ●
Access to clinical decision support tools and web and phone-based self-management resources for patients	●	●	◆ ●
Subset of primary care providers develop expertise in advanced chronic pain management through Project Echo training and practice experience		◆ ●	◆ ●
Subset of primary care providers trained in Medication Assisted Treatment to treat patients with opioid addiction		●	●

Access to Centers of Excellence in pain management for referral of most complex cases			●
Re-assessment services and support from expert subset of primary care providers and Centers of Excellence in pain management		●	●
Access to data and analytics to identify opioid users and track pain treatment	◆	◆	●◆

Capability Requirements Based on Design Group Recommendations

Across all levels of care, payment model options support pain management approaches that:

- Aim to improve availability of clinical decision support tools for clinicians at the point of care, patient activation, care coordination and access to multimodal care.
- Incorporate patient education that aims to destigmatize and address misperceptions of chronic pain, risks and benefits of pain treatment, safer use of pain medications, risks of opioid use
- Use a team-based, biopsychosocial approach that encourages patient activation and engagement, care coordination, and addressing barriers to self-management and treatment. Care team members are cross trained to support pain management goals.
- Promote routine availability of patient self-management resources and tools, such as mobile phone apps, phone-based interactive voice responses and web-based tools.
- Allow for longer visit times for clinicians to adequately address patients with pain management needs

All Primary Care Providers provide the following services within primary care, which may be provided through in-office visits or telemedicine where appropriate²:

- **Preventive Care to Avoid Progression of Acute Pain to Chronic Pain**
 - Basic assessments and care planning: PCPs and care teams are trained to assess pain and determine if further treatment is needed and develops a plan to support patients and families in preventing transitions to chronic pain. This may include access to clinical decision support tools at the point of care, screenings for other conditions such as depression, assessing how patients deal with stress, and helping patients develop self-care routines or access occupational or physical therapy.
 - Self-care interventions such as nutrition and weight management, exercise and conditioning, sufficient sleep, and mindfulness, meditation, and relaxation techniques, etc. (National Pain Strategy)
- **Routine Care for Acute and Chronic Pain**
 - Ongoing assessments and care planning: For patients with ongoing and chronic pain, assess pain level and screen for high impact chronic pain (enduring participation restrictions because of pain) and develop a plan that addresses biological, psychological and social effects of pain on the patient (National Pain Strategy).

² The Practice Transformation Task Force has provisionally recommended telemedicine capabilities for all primary care practices.

- Team-based approach to pain management³: Proposed expanded care teams can be cross-trained to support pain management goals such care coordination, motivational interviewing, medication, lifestyle interventions, and behavioral health issues. Care team members provide education to patients on pain self-management, medication (if applicable), and encourage patient activation and engagement in care plans for managing pain. Care team members ideally include:
 - Care Coordinators: perform a care continuum process that assesses, plans, implements, coordinates, monitors and evaluates options. Care coordinators helps patients engage as active participants individualized care plans for pain management and use communication and available resources to promote quality, cost-effective outcomes.
 - Behavioral health clinicians: address psychosocial effects on pain and may provide Cognitive Behavioral Therapy to help patients cope with chronic pain.
 - Community Health Workers (CHWs): connect patients to affordable services such as acupuncture, chiropractic services, physical and occupational therapy and integrative medicine. CHWs also address social determinants of health needs, socioeconomic disparities and other barriers to care that may contribute to pain or impede self-management or access to treatment. For example, CHWs may help patients with transportation and child care needs for getting to appointments.
 - Nutritionists/dieticians: assist patients in dietary choices that support treatment of pain.
 - Medical Assistants: trained in simple techniques and exercises to help patients manage pain, may also help coordinate care with alternative treatment providers.
 - Nurses: trained in pain self-management techniques, assist with routine care, may do simple medication reconciliation
 - Pharmacists: Conducts comprehensive medication reviews for pain medication, conduct medication reconciliation, provide comprehensive medication management, provide medication monitoring and care coordination across multiple prescribers and pharmacies, and tailored medication action plans for patients with chronic pain.
- Appropriate prescribing and medication management: Follow guidelines for appropriate prescribing. The National Pain Strategy recommends following guidance included in the FDA Blueprint for Prescriber Education that is part of the FDA-approved Risk Evaluation and Mitigation Strategy for Extended-Release and Long-Acting Opioid Analgesics.
- Referrals to Medication Assisted Treatment as needed

³ The Diverse Care Teams design groups is considering these care team members to be included in the payment model for all networks. The Adult Behavioral Health Integration design group specifically recommended integrated behavioral health in all primary care practices, including a dedicated care coordinator with expertise in behavioral health and a behavioral health clinician (psychologist, LCSW, APRN).

- Referrals to specialized subset of primary care providers with expertise in advanced chronic pain management and Centers of Excellence in pain management for complex cases for patients with complex chronic pain and treatment needs.

Subset of Primary Care Providers specialize in advanced primary care pain management

- Project Echo: Receive advanced training through Project Echo guided practice in advanced chronic pain management provided by Centers of Excellence in pain management
- eConsults: Access to eConsults with Centers of Excellence in pain management for complex cases and ongoing training in advanced chronic pain management.
- Expertise in pain medication management: Help guide non-specialized PCPs in pain medication management, appropriate prescribing and avoiding opioid addiction
- Expertise in comprehensive chronic pain management therapies and multimodal care: Specializations in interdisciplinary approaches to pain management and alternative or multimodal therapies, such as behavioral health therapies (e.g. Cognitive Behavioral Therapy), acupuncture, meditation, massage, physical and occupational therapy, integrative medicine, and self-management programs to manage multiple aspects of the patient's causes of pain and treatment.
- Re-assessment services: Provide re-assessments of patients with chronic pain and refer back to routine care with patient's regular PCP as appropriate, with ongoing guidance.
- Specialization is based on PCP receiving advanced training in pain management and building experience and expertise in chronic pain management through practice.

Subset of Primary Care Providers specialize in Medication Assisted Treatment (MAT): Specialized training in delivering MAT for patients with opioid addiction, who may also suffer from chronic pain and developed addictions from taking opioids for chronic pain management.

Networks have MOU with Center of Excellence, which provide:

- Advanced pain medicine diagnostics and interventions for patients with complex chronic pain using a multidisciplinary, team-based approach
- Training and technical assistance for basic pain management assessment and routine care for all primary care providers
- Provide training and resources for patient self-management and recommended patient technology assisted tools, such as mobile phone apps and web-based resources.
- Project Echo guided practice to a subset of primary care providers specializing in advanced chronic pain management
- eConsults to a subset of primary care providers with specialized expertise in pain management
- Re-assessment services to all primary care practices

Networks provide data and analytics to practices to:

- Identify patients with or at risk for opioid use disorder to provide interventions such as Medication Assisted Treatment
- Track pain prevalence and treatment across populations and identify disparities in pain assessment and treatment and overprescribing in vulnerable populations

Other Design Group Recommendations

- Beyond primary care delivery, there is a need for reforms that support access to treatment and affordable insurance coverage for:
 - Alternative therapies such as acupuncture, physical therapy, occupational therapy, etc.
 - Pain medications as prescribed
- Beyond primary care delivery, there is a need for broader public education that helps destigmatize pain.

Understanding the Need

The Problem:

One in five adults suffer from chronic pain (Dahlhamer, et al., 2018). Primary care practices report difficulty trying to manage patients' chronic pain in a manner that reduces pain, minimizes opioid addiction, and treats addiction when it occurs. Contributing factors include lack of access to well-trained providers offering multidisciplinary, behaviorally-oriented approaches and too heavy of a reliance on opioid medications, which can lead to addiction. Current payment models also do not support the development of systems that connect patients with cognitive behavioral therapy and physical therapy or with less traditional approaches such as chiropractic care and acupuncture, all of which have shown promise in improving the lives of patients with chronic pain (Ehde, Dillworth, & Turner, February-March 2014) (Mao & Dusek, June 2016).

Proven Strategy:

Name: Integrated Pain Management in Primary Care

Definition: Interdisciplinary approaches, particularly those employing a biopsychosocial framework, have produced the most effective results for preventing and managing pain and preventing opioid abuse. These approaches combine medication with behavioral strategies that support patients in managing the pain and developing coping skills that lead to a more positive mindset. These approaches combine a variety of therapeutic modalities and typically rely on teams of physicians, behavioral specialists, nurse case managers, and others (DeBar, et al., April 2016).

Approaches vary but shared attributes of well-functioning integrated pain management include shared philosophy, mission, objectives across the care team and patient; patient and family centered approaches with clear roles; integrated, evidence-based approach tailored to the patient's needs and designed to achieve common goals agreed to by the patient and care team; and frequent and effective, direct, clear, and reciprocal communication amongst team members including primary care providers (Turk, et al.).

Integrated pain management care delivery models will be most effective if situated within a larger statewide strategy for addressing pain prevalence, including public health interventions, public campaigns that raise awareness and reduce stigma, population health research that identifies evidence-based approaches to pain prevention and treatment and approaches to reduce disparities, establishment of standards, guidelines and systems that reduce opioid prescribing, and changes to insurance design to ensure consumers have affordable coverage for pain medications, behavioral health services and alternative treatments such as acupuncture, physical therapy, etc.

Intended Outcomes:

- Improved patient experience and outcomes related to pain and disability
- Provide a more comprehensive approach that recognizes psycho-social need
- Reduce iatrogenic causes of addiction

Consumer Input, Questions, and Concerns for Implementation:

- Lack of services that account for physical and mental health connection

- Consumers need support managing chronic conditions like chronic pain. Support services should try to include educational components to empower patients and caregivers, and free and low-cost solutions when possible
- Consumers would like more training and tools to manage chronic conditions
- Important to ensure alternative and preventative therapies are accessible
- Multipronged approach that includes education is needed
- Need to look at overcoming cost and transportation barriers
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- 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.
- Need to ensure all services for pain management are in-network and covered by insurance and address limitations on medications and interventions like physical and occupational therapy, behavioral health services, etc.
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Health Equity Lens: While research is lacking about the impact of integrated pain management on health disparities, it cannot be overlooked the potential harm that could result from implicit/unconscious bias. Pain management approaches need to consider how to address disparities in care. For example:

- Team based approaches to pain management that include Community Health Workers can help address barriers to care and social determinants of health that contribute to health disparities
- Changes to insurance design to ensure consumers have affordable coverage for pain medications, behavioral health services and alternative treatments such as acupuncture, physical therapy, etc. may address socioeconomic disparities
- Access to data and analytics that track pain prevalence and treatment across populations can identify disparities in pain assessment and treatment and overprescribing in vulnerable populations

Implementing the Strategy

Example Scenario: Patient presents with chronic pain. Following detailed history and screening for risk of addiction, PCP uses CDC guidelines to determine whether to prescribe opiates and if so, appropriate quantity and dosage. Care team connects patient with additional resources as appropriate, such as cognitive behavioral therapy, physical therapy, acupuncture and chiropractic care.

HIT Requirements: None required, though access to a common electronic health record would facilitate information sharing across care team members. Decision support tools can also help identify patients at higher risk for opiate addiction.

Implementation Concerns:

- Chronic pain can be complex and entrenched. Success should focus on increased function, reduced catastrophizing and improved coping.
- Integrated treatment for chronic pain will likely be more expensive to provide than a prescription. A payment mechanism to address these costs will be needed.
- Strong support for frontline staff is critical to success and is important to reduce the increased burden on provider time.
- Integrated behavioral health and diverse care team members to address social needs will be necessary.
- There is widespread disagreement about the opioid prescribing guidelines released by the CDC. Allowing providers to choose from a menu of prescribing guidelines may be necessary.
- Consistent messaging from diverse care team members about the need to try other treatment methods increases patient interest and confidence.
- There remains skepticism among some specialists that PCP offices can be sufficiently trained to manage the most complex chronic pain patients (McMullen, Elder, & DeBar, October 2016).
- Appropriately staffing these programs is a “major challenge.” (McMullen, Elder, & DeBar, October 2016). Collaborative efforts between primary care and “specialty” practices that deploy more advanced and integrated approaches will result in better outcomes.

Impact

Aim	Summary of Evidence
<i>Health promotion/prevention</i>	Comprehensive pain management aims to prevent opioid addiction through proper management of opioid prescribing and treatment when needed, and alternative therapies to opioid use.
<i>Improved quality and outcomes</i>	Among 240 randomized patients in the SPACE Randomized Clinical Trial patients at Veterans Administration facilities with chronic pain, those treated with medications other than opioids (acetaminophen and anti-inflammatory drugs) did significantly differ on pain-related function over 12 months versus those treated with opioids. Patients treated without opioids reported less intense pain and fewer adverse medication-related symptoms. (Krebs, et al., 2018) A meta-analysis of 65 studies found that interdisciplinary pain management programs that incorporate medication management, physical exercise, cognitive behavioral training, and decreasing impact of pain on function resulted in a 20% average reduction in pain (Clark, 2000).
<i>Patient experience</i>	Addressing patient “catastrophizing” is key to integrated approaches to manage chronic pain and a predictor of patient satisfaction, which is also a predictor of adherence to treatment protocols. Therefore, using integrated approaches to pain management can improve patient satisfaction and adherence. (Hirsh, 2004).
<i>Provider satisfaction</i>	Primary care physicians reported inadequate training for, and low satisfaction with, delivering chronic pain treatment. They

desired more patient-centered approaches to pain management and the skills and colleague relationships necessary to implement (Upshur, Luckmann, & Savageau, 2006). One physician noted: "These can be very challenging patients and I can get to end of my own set of ideas for treatment. It takes some of the weight of pain management off the individual PCP, gives fresh outlook on the patient and freshens a sometimes stale treatment plan." (Dorflinger, et al., 2014)

Lower Cost

A study of 17,600 patients found persons who had been involved in interdisciplinary treatment programs for pain management would spend \$280 million less for medical costs including surgery in the year following treatment those treated conventionally (Clark, 2000).

**Please complete the survey on this capability [here](#).

APPENDIX

Learning from Others

Case Study: Project ECHO in Community Health Centers (CHCI) Investigators evaluated impact of Project ECHO Pain videoconference learning sessions on pain management in two Federally Qualified Health Centers (FQHCs), one in Connecticut, Community Health Center Inc. (CHCI), and one in Arizona, El Rio Community Health Center (El Rio). Through this model PCPs attended 48 sessions during 2013, where providers' pain-related knowledge and self-efficacy were evaluated and EHR data was used to evaluate opioid prescribing and specialty referrals. The opioid prescription and referral patterns were then compared to those who did not receive the videoconference Project ECHO training.

Results:

- Medical and behavioral health providers attended an average of 82.4% of offered videoconference sessions
- The KP50 knowledge survey revealed a 7.9% increase in intervention group provider knowledge compared to a 2.9% increase in control group provider knowledge after participating in sessions
- PCPs were more likely to use opioid agreements and were less likely to worry about patients becoming addicted to opioids post intervention
- Providers in the intervention group had a greater reduction in chronic pain patients treated with opioids post intervention as compared to the control group
- Average number of opioid prescriptions per patient with pain increased less for providers in the intervention group when compared to the control group
- Providers in the intervention group increased referrals to behavioral health and physical therapy while decreasing referrals to surgical subspecialists following a year of ECHO training as compared to the control group

Lessons Learned:

- Case-based learning via video conference was able to change clinician behavior in adherence to protocol (use of opioid agreements), referral patterns, and prescription of opioids
- Project ECHO provides a new avenue for continuing medical education, particularly for chronic pain management (Anderson et al., 2017)

Case Study: Chronic Pain and Addictions ECHO (CHCACT) The Community Health Center Association of Connecticut (CHCACT) has launched learning sessions for fifty Connecticut health center staff and providers in August 2018 through its Chronic Pain and Addictions ECHO project. The CHCACT Project ECHO specialist panel, including a physician, nurse practitioner, and PharmD from the University of Connecticut, will conduct two sessions per month with health center teams. Deidentified case presentations will be made by health center staff on common clinical scenarios and then cases will move into more complex and challenging scenarios. The specialist panel will guide health center teams to learn from their experiences, build confidence in complex patient care, join supportive peer networks, and learn and develop best practice guidelines (CHCACT, 2018).

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Primary Care Modernization Pain Management Design Group Session 1: 9/13/18

Summary of Design Group Feedback:

- Approach should align with National Pain Strategy recommendations
- Approach needs to be multi-pronged and broader than just managing patients with chronic pain to prevent opioid addiction (a small percentage of patients with pain) and include:
 - Upstream public health interventions
 - Training in medical school curriculums
 - Public education about stigmatization of pain and pain prevention
 - Education for providers on scope of problem
 - A focus on preventing acute pain, development of chronic pain and opioid treatment
 - Approaches for managing acute pain
 - Lifestyle interventions and alternatives to opioid treatment, such as physical therapy, behavioral health interventions, acupuncture, mindfulness, etc.
- Care teams are needed to coordinate care, provide motivational interviewing, assist with lifestyle interventions, and address behavioral health issues
 - Care team members may include social workers, nurses, and psychologists
 - Need additional workforce to fill gaps
- Insurance needs to cover alternative therapies to opioid medication
- For primary care providers that treat chronic pain:
 - CDC guidelines for safe prescribing, quantity and dosing guidelines have many unintended consequences and are not the gold standard.
 - FDA is releasing more flexible guidelines that may be useful for primary care
 - Providers need access to Project Echo training and eConsults but this is not enough. Providers also need places to refer complex patients for treatment
 - Providers need data to identify patients who are on opioids
 - System, payment and training needs to support alternative treatments to medication
 - All providers should have basic training in pain management

Consumer Input, Questions, and Concerns for Implementation:

- Important to ensure alternative and preventative therapies are accessible
- Multipronged approach that includes education is needed
- Need to look at overcoming cost and transportation barriers
- Need reimbursements for providers for longer appointments
- 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.
- Need to ensure all services for pain management are in-network and covered by insurance
- Need for more resources for providers to prescribe affordable medications for chronic pain
- Patients and providers need education in pain assessment and management
- Patient education about pain management should be provided at all levels of care, not just as part of preventive care

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Design Group Notes

Summary of Approach

- a. All primary care providers:
 - i. Adhere to opioid medication management practices including CDC safe prescribing, quantity and dosing guidelines
 - ii. Assess and treat acute and chronic pain, with access to eConsults for specific clinical scenarios
 - iii. Refer to MAT providers within network as needed
- b. Subset of primary care providers within network:
 - i. Enroll in Project Echo training program for comprehensive chronic pain management for specific expertise in managing chronic pain
 - ii. Specialize in MAT for patients with opioid use disorder
- c. Practices refer to Centers for Excellence for complex pain management cases
- d. Centers of Excellence provide access to education, eConsults, Project Echo, direct patient care

Discussion

- Consumer: Educational component is broad but needed. A decrease in barrier to access → looking at overall costs and transportation needs. Also, looking at reimbursements for providers for people with longer appointments.
- Comprehensive Chronic Pain Management in Primary Care
- All primary care providers:
 - Adhere to opioid medication management practices including CDC safe prescribing, quantity and dosing guidelines
 - Assess and treat acute and chronic pain, with access to eConsults for specific clinical scenarios
 - Refer to MAT providers within network as needed
- Subset of primary care providers within network:
 - Enroll in Project Echo training program for comprehensive chronic pain management for specific expertise in managing chronic pain
 - Specialize in MAT for patients with opioid use disorder
- Practices refer to Centers for Excellence for complex pain management cases
- Centers of Excellence provide access to education, eConsults, Project Echo, direct patient care
- Provider: Are you including pediatric practices?
 - FHC: This is adult practices.
- Consumer: Are these recommendations or are these already in place?
 - FHC: These are recommendations

- Consumer: From the patient community: we have found so many inefficiencies with CDC guidelines and have been looking to FDA; CDC guidelines have produced negative health outcomes in patients (they are more like mandates than guidelines)
 - FHC: Are there specific parts or areas that should be addressed?
 - Consumer: Just a misconception of dosage, limits, and dispensing. The recommendations get skewed. A lot of the 7- and 5-day limits are also being applied to chronic pain.
 - Consumer: Will double check with national director and will pass along info to FHC.
- Provider: As a PCP who does a lot of acute and chronic pain→ most PCPs do not feel comfortable treating chronic pain. If it's a complicated patient, you are left holding that patient. A comprehensive pain center would help this. The eConsult through Echo is limited. In our state, it's a real challenge to get our Medicaid payments at pain centers.
- Chronic pain center for kids→ there are no places for them to transition to.
 - FHC summary: 1. CDC guidelines are not the end all and be all for what to follow for chronic pain and there needs to be caution; 2. More support for primary care providers; 3. We need to go beyond Echo and eConsult; 4. Needs to be a chronic pain center to send patients
- For people who are uncomfortable with prescribing opioids, leaning on the CDC guidelines is complicated
- Provider: There seems to be a conflation of strategies around improving pain management-> opioid issues are the tail of the dog. I am concerned about the focus. Today, the CDC published a report on chronic pain and how it affects daily functioning in about 8% of the population. Poor management of acute pain leads to chronic pain issues. CDC should not be held accountable for guidelines to treating chronic pain.
- OHS: Some commenters are inflating eConsults with Project Echo, and different techniques for providing care. eConsults supports more than just chronic pain but also co-occurring psychiatric conditions. An eConsult is not a patient-specific consultation.
- OHS: If you were to modify the Comprehensive Chronic Pain Management in Primary Care slide, how would you modify?
 - Provider: This is a public health problem, but it's interesting to see the way we treat pain in America vs. other counties.
 - Provider: Every PCP is treating and managing people with chronic pain, but if 20% of the population has chronic pain (it's the number one complaint heard by PCPs) they share responsibility in addressing this problem.
- OHS: Assess and treat acute and chronic pain is really using every possible method other than opioids and then to provide experts to eConsults.
- OHS: It's clear we shouldn't be looking to CDC for guidelines, but we can be vaguer about the guidelines. We completely sidestep the magnitude of the transformation that will elevate today's garden variety primary care to achieve acceptable standard in every PCP in Connecticut.
- Provider: We agreed primary care needs to be done in a more comprehensive manor. Looking at prevention and healthcare management, all of this takes time. To do primary care right and a lot of lifestyle management (for pain or for anything else) takes time.

- Provider: If we are talking about state dollars, we can take a lead from other countries that have focused on public education and media campaigns (Don't Take Back Pain Lying Down in Australia) to encourage people to understand pain; An investment in public messaging
- Provider: A multipronged approach is important. Emphasizing getting PCPs to assess pain and educate their patients...We want to redesign a system that is supporting PCPs in their interactions with patients
- Provider: As a rehab doctor for 30 years, a preventive component is important. I see lots of people who are being managed by primary care physicians, and the patients have never been referred to a chronic pain specialist. We are missing getting to the root causes of problems.
 - FHC summary: A multipronged approach, we are missing the upstream piece: prevention. This focus on medication is further down the line but is also important.
- Provider: Using evidence to guide this strategy within the National Pain Strategy. Primary Care Providers are managing pain, but there are only a couple of medications to manage pain that are covered by a patient's insurance.
 - It's not just the problem of paying for specialists, but it's the limited workforce as well.
 - OHS: We are trying to solve the workforce issue and trying to improve performance of accountable care organizations. How do we get them to a higher standard of practice? Payment points: we are proposing to double the investment of the healthcare dollar and are looking for payers to reallocate hundreds of millions of dollars (more easily said than done). There is no reward for an accountable care organization to manage chronic care well, so we are trying to learn how to deal with Medicare, Medicaid, and certain shared-savings employers. Value-based insurance design may provide us with a lever. What this design group can do is provide us with an outline for our strategy over the next year and doing so will increase the likelihood that Medicare will do this.
- FHC: UConn Health Comprehensive Pain Management
 - Provider: The idea of investing in a Center of Excellence at UConn is a great idea, but what's missing is the whole integration of behavioral health and mental health.
 - It is multi-disciplinary
 - Provider: Let's not emphasize psychiatry. We really need psychologists.
- OHS: May need different payment models for different teams. Are there core lifestyle or interventions (like the mindfulness point, stress management, etc.) that would lead us to suggest we should build into the payment model for every ACO to dedicate some resources to those kinds of services (so you don't have to go to the UConn Center of Excellence)
 - Those kinds of resources would be great for so much more than primary care → social work or psychology are great adjuncts to primary care team
 - Also, nursing
- Provider: With Advanced Care Network → I would like to get some expert training and education, but we are going to have to present a business model that demonstrates the upside to investing resources in this...Most pain centers will not prescribe narcotics and will only perform procedures. They will need to offer the multidisciplinary approach for the PT that is affordable
- Consumer: Ensuring that all these services would be in-network is important. Ensuring insurance companies continue to cover for those services is important as well.

- How obtainable would this new facility be for the population?
- FHC: Alternative therapies and preventative therapies are needed as well.

Questions for Discussion

- FHC: Is chronic pain management something that all networks should be required to participate in?
 - Provider: This should be up to the practice.
 - Provider: All networks-absolutely. All practices-unreasonable.
 - The CDC just asked what we did here was distributable to PCPs in practice...at least the starting basics don't take long. Not all PCPs are in love with the thought of treating chronic pain
 - There are ways to make things like acupuncture not a money loss.
 - FHC: Basic things all providers should be trained in, but chronic pain management would be a specialty within a practice or be a provider's interest
- Provider: On a claim's perspective, we know how many people are on chronic opioids.
 - FHC: We can give this data to the practices, so they can identify their patients and measure that.
- FHC: Medicated Assisted Treatment-it sounds like this would be a subset within a network
- As a PCP who does chronic pain and prescribes opioids, I think people like me should be trained. It's more than just taking the 8 hours off from work to do the training though.
- We don't have enough PCPs doing this right now.
- Provider: We need to set benchmarks that advanced network medical leadership will agree to. Many private practice providers will resist for fear of "overwhelming" their practices with opiate users. There needs to be a maximum number that will then allow practices to electively close their practices to this therapeutic approach.
- Expert: Using the care team to help with pain management is important and the training is obvious. It's much more than taking the 8-hour course. With appropriate training, you can start to use other members of the care team.

Primary Care Modernization Pain Management Design Group Session 2: 10/1/18

Summary of Design Group Feedback:

- Primary care providers and teams need to be trained in how to assess and diagnosis pain and determine appropriate care plan and treatment path
- Preventive care in primary care should focus on preventing progression from acute to chronic pain and supporting patients and families in following care plans that prevent this
- Use team-based, biopsychosocial approach to pain management
- Proposed expanded care teams can be cross-trained to support pain management goals such as care coordination, motivational interviewing, medication, lifestyle interventions, and behavioral health issues
- Care may be provided through in-office visits or telemedicine visits where appropriate (aligns with telemedicine capability)
- Subsets of primary care providers with expertise in advanced pain management and Centers of Excellence will need to provide re-assessment and consultative support to all PCPs in the network to handle routine care of patients with pain. There are not enough providers who specialize in pain management to handle all patients.
- Subsets of PCPs with expertise in pain management are determined based on training, practice experience and expertise
- A subset of PCPs should have expertise in Medication Assisted Treatment, which is related to pain management for patients with pain and opioid addiction, but a separate diagnosis and skillset.
- Patient education on pain management occurs across all levels of care and should aim to destigmatize chronic pain
- Beyond primary care delivery, need reforms that support affordable insurance coverage for alternative therapies such as acupuncture, physical therapy, occupational therapy, etc. and pain medications as prescribed

Additional Consumer Input, Questions, and Concerns for Implementation:

- Need to ensure all services for pain management are in-network and covered by insurance and address limitations on medications and interventions like physical and occupational therapy, behavioral health services, etc.
- Patients and providers need education in pain assessment and management
- Patient education about pain management should be provided at all levels of care, not just as part of preventive care

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

Design Group Notes

- 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 9th
- 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 9th. 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.