

Pain Management Design Group 1

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Purpose of Design Group:

- FHC: What are we trying to achieve?
- Consumer Needs
 - Support managing chronic pain. Support services should try to include educational components to empower patients and caregivers, and free and low-cost solutions when possible.
 - Primary care services that account for physical and mental health connection
 - Mental health services that are easy to access and free of stigma
 - Addiction services and long-term recovery support
 - Adequate behavioral health services. High turn-over rates of psychiatrists and other behavioral health team members affects people's ability to recover
 - Patients should not have to "prove" a certain level of illness or addiction to receive access to services

Questions for discussion: What are we missing?

- 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 countries.
 - 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.

Summary:

- Need for more upstream interventions
- Prevention
- Education of providers and patients
- Diverse care teams who can address behavioral health issues
- Connect people to care coordination