

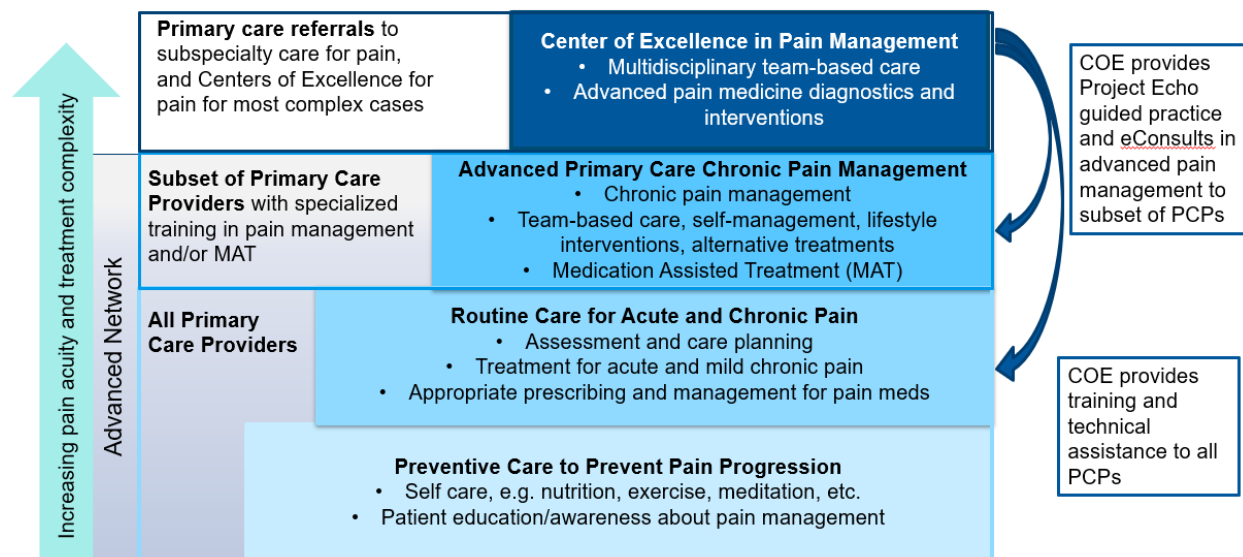
Primary Care Modernization Project Capability Summary Pain Management

Meeting Notes and Feedback from Design Group Meetings are attached at the end of this document, including consumer input, questions and concerns.

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

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

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 and patient education to prevent progression of injury to acute pain, and progression of acute pain to chronic pain	●		
Routine assessments and care planning for patients with acute and chronic pain	●		
Appropriate prescribing and management for pain medication	●		

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.

Access to eConsults, training and technical assistance	●		◆●
Subset of primary care providers provide advanced pain management through Project Echo training		●	●
Subset of primary care providers trained in Medication Assisted Treatment		●	●
Access to Centers of Excellence in pain management for referral of most complex cases			●
Access to data and analytics to identify opioid users and track pain treatment	◆	◆	●◆

Capability Requirements

- **All Primary Care Providers** provide the following services within primary care:
 - **Preventive care:**
 - Self-care interventions to prevent acute pain and progression of acute pain to chronic pain through injury prevention, such as nutrition and weight management, exercise and conditioning, sufficient sleep, and mindfulness, meditation, and relaxation techniques, etc. (National Pain Strategy)
 - Patient education on stigmatization and misperceptions of chronic pain, risks and benefits of pain treatment, safer use of pain medications, risks of opioid use
 - **Routine Care for Acute and Chronic Pain**
 - **Assessment:** Assess pain level and screen for high impact chronic pain (enduring participation restrictions because of pain). Development of a care
 - **Care Planning:** Develop a plan that addresses biological, psychological and social effects of pain on the patient (National Pain Strategy).
 - **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.
 - **Consultations:** Access eConsults with pain management specialists and subspecialists as needed
 - Referrals to Medication Assisted Treatment as needed
 - Referrals to primary care providers trained in advanced chronic pain management and Centers of Excellence in pain management as needed
- **Subset of Primary Care Providers specialize in advanced primary care pain management**
 - **Project Echo:** Train providers through Center of Excellence in pain management Project Echo model
 - **Team-based care:** Interdisciplinary care team for chronic pain management includes nurses, care coordinators, behavioral health providers, and providers of alternative

- therapies and integrated medicine to manage multiple aspects of the patient's causes of pain and treatment.²
- **Self-management programs:** Team-based self-management programs help patients with pain develop the appropriate skills and provide education and resources to play an active role in managing their pain.
 - **Care coordination:** Care coordination with alternative therapies such as physical therapy, acupuncture, integrative medicine, lifestyle interventions, and behavioral health services.
 - **Subset of Primary Care Providers specialize in Medication Assisted Treatment (MAT):**
Specialized training in delivering MAT for patients with opioid addiction
 - **Referrals to multidisciplinary Centers of Excellence in pain management:** Primary care providers refer patients with complex chronic pain and treatment needs to multidisciplinary pain centers who can provide advanced pain management interventions.
 - **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, technical assistance, and eConsults on basic pain management for all primary care providers
 - Re-assessment services through in-person, eConsults or Project Echo
 - Project Echo training to subset of primary care providers in network for advanced primary care pain management
 - **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

² The Adult Behavioral Health Integration design group has recommended integrated behavioral health in all primary care practices, including a dedicated care coordinator with expertise in behavioral health and a behavioral health provider (psychologist, LCSW, APRN).

Understanding the Need

The Problem:

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
- 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

Health Equity Lens: Insufficient research on the impact on health equity

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>	<p>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)</p> <p>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).</p>
<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)
<i>Lower Cost</i>	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

Design Group Notes

Participants: Vinayak Sinha, Linda Green, John Freedman, Alyssa Harrington, Ellen Bloom, Andrew Selinger, Randolph Trowbridge, Robert Zavoski, Rebecca Andrews, Doug Olsen, Ronald Preston, Shaina Smith, Robert Kerns, Pano Yeracaris, Mark Schaefer, Bob Kerns, William Zempsky

PCM Overview: What are we trying to achieve?

1. Consumer Needs
 - a. 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.
 - b. Primary care services that account for physical and mental health connection
 - c. Mental health services that are easy to access and free of stigma
 - d. Addiction services and long-term recovery support
 - e. Adequate behavioral health services. High turn-over rates of psychiatrists and other behavioral health team members affects people's ability to recover
 - f. 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?

2. Shaina Smith: Educational component is broad but needed. A decrease in barriers 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

- 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
- e. Bill: Are you including pediatric practices?
 - i. FHC: This is adult practices
- f. Shaina: Are these recommendations or are these already in place?
 - i. FHC: These are recommendations

- g. Shaina: 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)
- i. FHC: Are there specific parts or areas that should be addressed?
 - ii. Shaina: 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.
 - iii. Shaina: will double check with national director and will pass along info to FHC.
 - iv. Rebecca Andrews: 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.
 - v. Chronic pain center for kids, there are no places for them to transition to.
 - vi. 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
 1. For people who are uncomfortable with prescribing opioids, leaning on the CDC guidelines is complicated.
 2. Bob Kerns: 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.
 3. Mark Schaefer: 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. eConsult is not a patient specific consultation.
 - vii. Mark Schaefer: If you were to modify the Comprehensive Chronic Pain Management in Primary Care slide, how would you modify?
 1. Rebecca: This is a public health problem, but it's interesting to see the way we treat pain in America vs. other countries.
 2. Bob Kerns: 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.
 3. Mark Schaefer: Assess and treat acute and chronic pain is really using every possible method other than opioids and then to provide experts to eConsults.
 4. Mark Schaefer: It's clear we shouldn't be looking to CDC for guidelines.
 5. Rebecca: We agreed primary care needs to be done in a more comprehensive manner. 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.
6. Bob Kerns: 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
 7. Bob Kerns: A multiprong 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
 8. Randolph-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.
 9. 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.
 10. Doug Olsen: 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 patient's insurance.
 - a. It's not just the problem of paying for specialists, but it's the limited workforce as well.
 - b. Mark Schaefer: 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 in primary care 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. 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.
- h. FHC: UConn Health Comprehensive Pain Management
- i. Bob Kern: 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 and needs to be further emphasized
 1. It is multi-disciplinary approach.
 2. Bob Kern: Let's not emphasize psychiatry because we really need psychologists.
 - ii. Mark Schaeffer: 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?

1. 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.
 - a. Also nursing.
2. Andy Selinger: 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 (which is sad) ...Most pain centers will not prescribe narcotics and will only perform procedures. They will need to offer the multidisciplinary approach that is affordable.
3. Shaina: Ensuring that all these services would be in network is important → will my insurance company continue paying for those services? i.e. How obtainable would this new facility be for the population?
4. FHC summary: Alternative therapies and preventative therapies are needed as well.

Questions for Discussion

3. FHC: Is chronic pain management something that all networks should be required to participate in?
 - a. Randolph: This should be up to the practice.
 - b. Dr. Selinger: All networks absolutely. All practices absolutely unreasonable and not.
 - c. The CDC just asked what we did here was distributable to PCPs in practice... the starting basics don't take that long... Not all PCPs are in love with the thought of treating chronic pain.
 - d. There are ways to make acupuncture and things like that not a money loss
 - e. FHC summary: 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.
 - f. Doug Olson: On a claim's perspective, we need to know how many people are on opioids and give this data to the practices, so they can identify their patients and measure that.
 - g. FHC summary: Medicated Assisted Treatment: it sounds like this would be a subset within a network.
 - h. As a PCP who does chronic pain and does prescribe opioids → training is good, but it's more than just taking the 8 hours off from work to do the training.
 - i. We don't have enough PCPs doing this right now.
 - i. Dr. Selinger: 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
 - j. Pano: Using the care team to help with MAT 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