Current Updates in Pain Management:

Reflections from Leaders Promoting Cultural Change in Pain Management at State and Federal Levels

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Former CMO
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Alliance to Advance Comprehensive Integrative Pain Management

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Opioid Crisis: HHS Strategy and Advancing Pain Management

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Immediate Past Chief Medical Officer
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Chair, Pain Management Best Practices Task Force
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Alliance to Advance Comprehensive Integrative Pain Management (AACIPM) Presentation 2020

Latest: Pain in the U.S. (CDC, 2018)

- **50 million** American adults suffer from **chronic pain** daily or almost daily

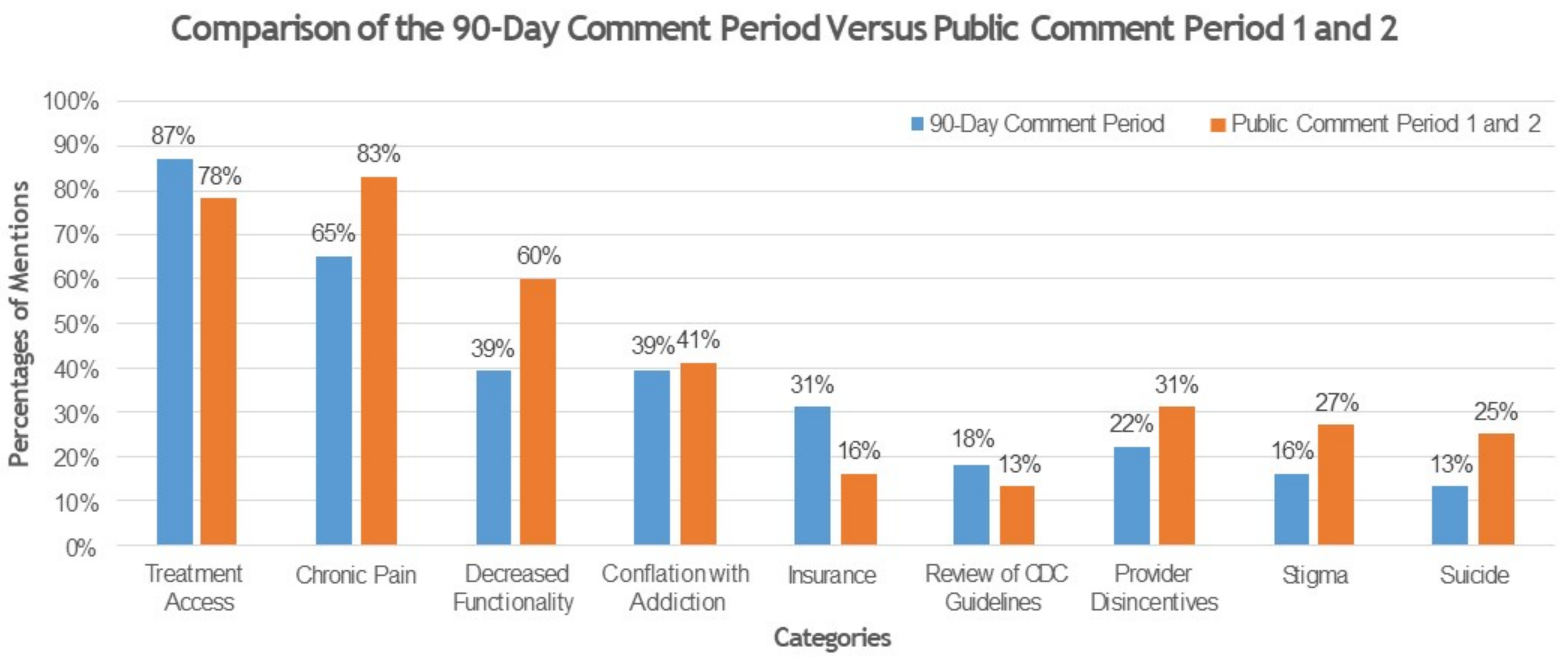
- **19.6 million** American adults have **high-impact** chronic pain

January 2019

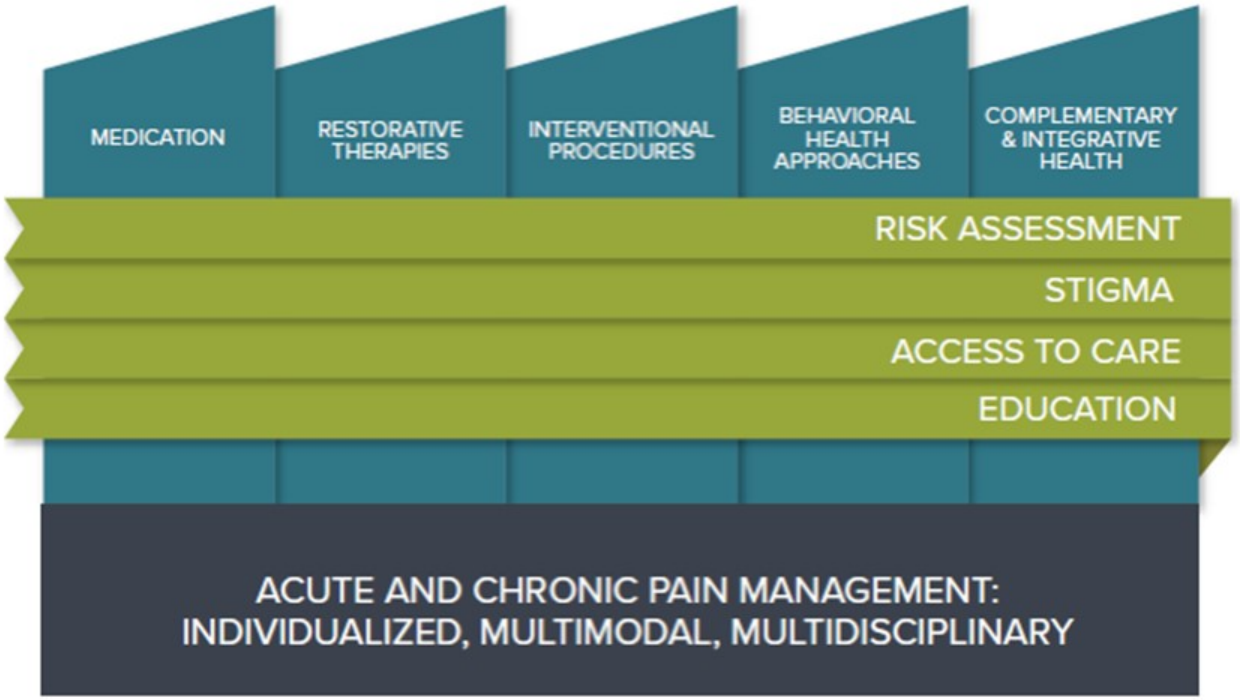
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Pain Management Best Practices Inter-Agency Task Force Gaps and Recommendations Overwhelmingly Passed

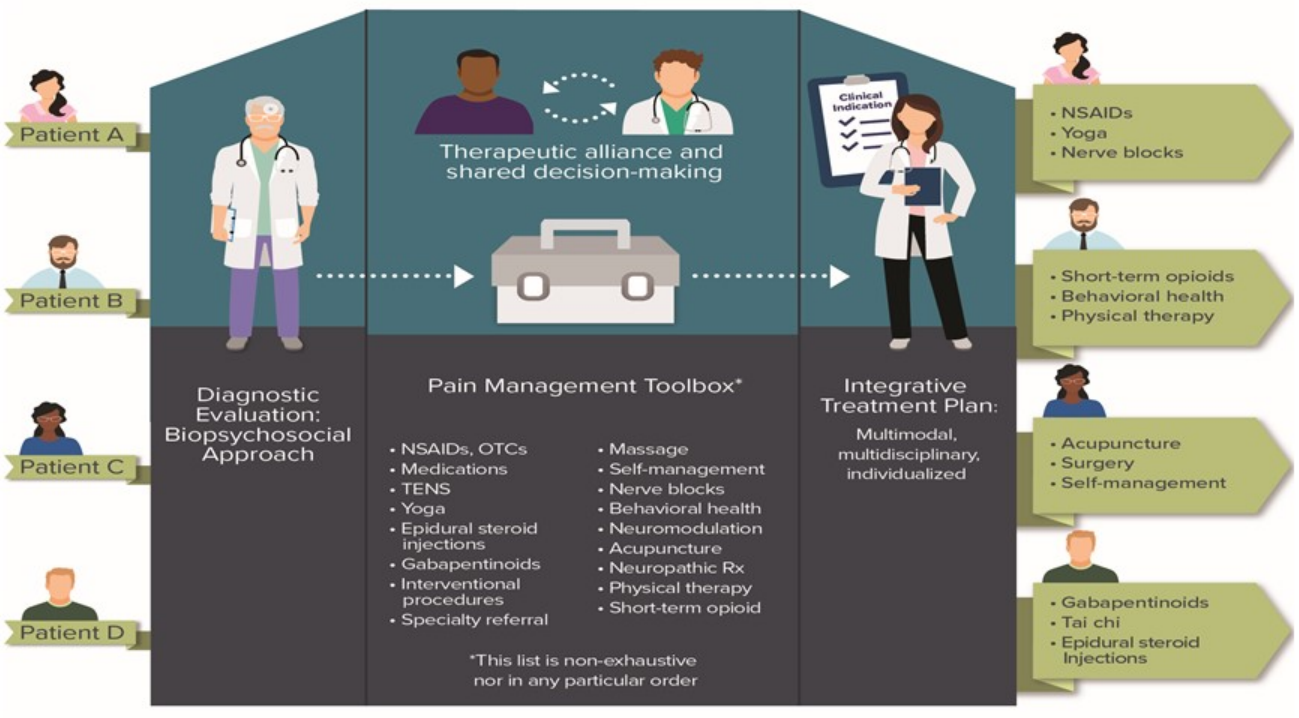
Public Comments to the Task Force



Pain Management Task Force Overview



Individualized Patient Care:
Diagnostic Evaluation
Multidisciplinary (as indicated) Treatment Plan



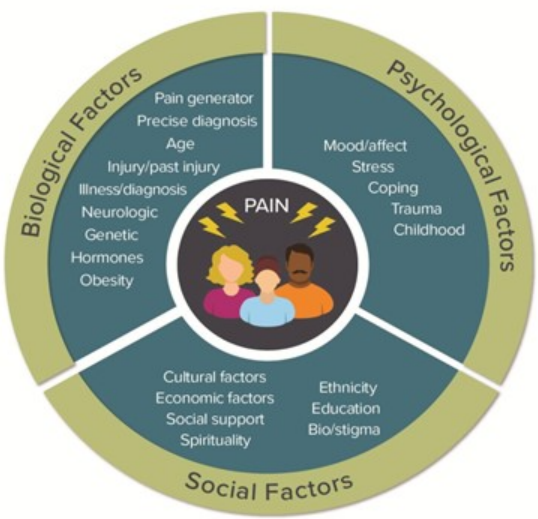
Approach to Pain Management:
The Biopsychosocial Model of Pain Management

Key components of the **biopsychosocial model**:

- Biological Factors (e.g. diagnosis, age)
- Psychological factors (e.g. mood, stress)
- Social factors (e.g. social support, spirituality)

Aim to improve:

- Overall pain experience
- Physical functioning,
- Activities of daily living
- Quality of life (QOL)



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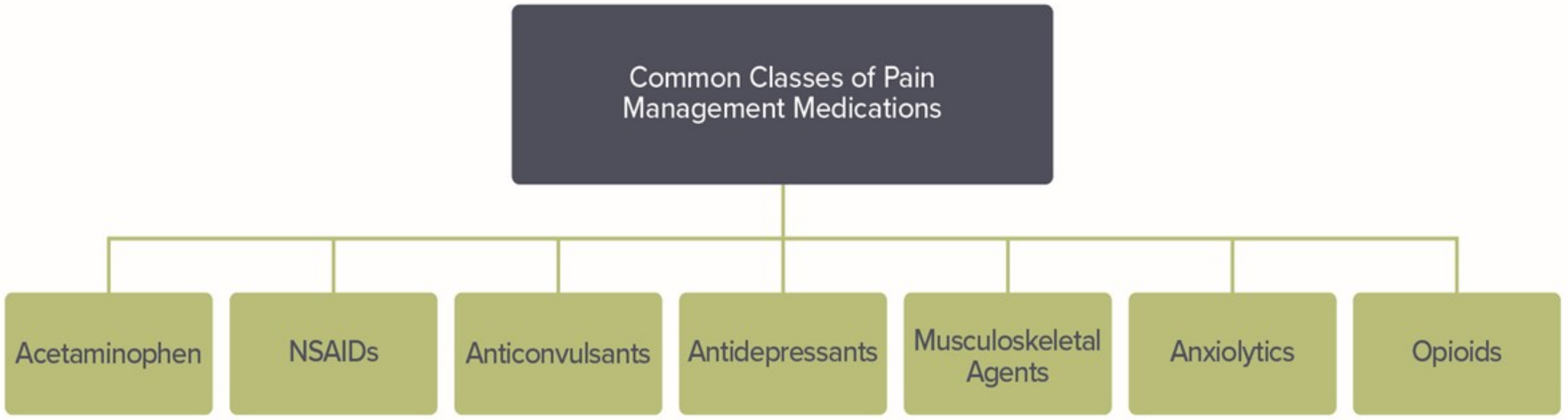
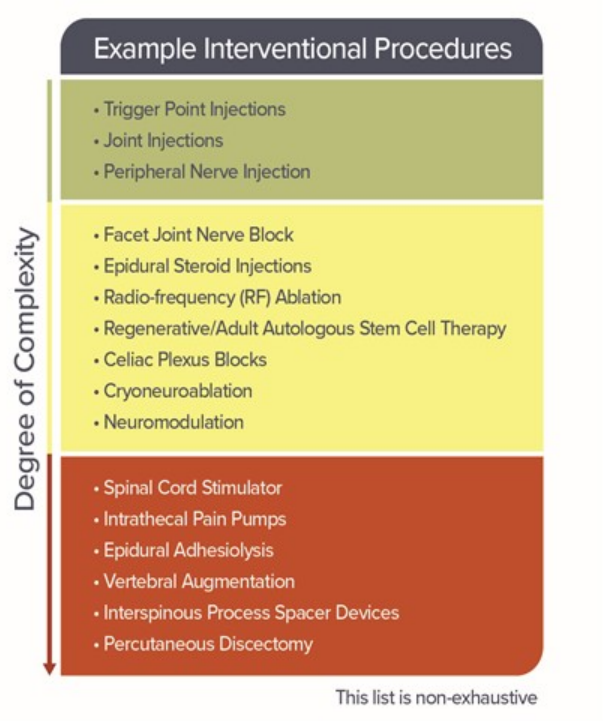
Medication Approaches to Pain Include Opioid and Non-opioid Options

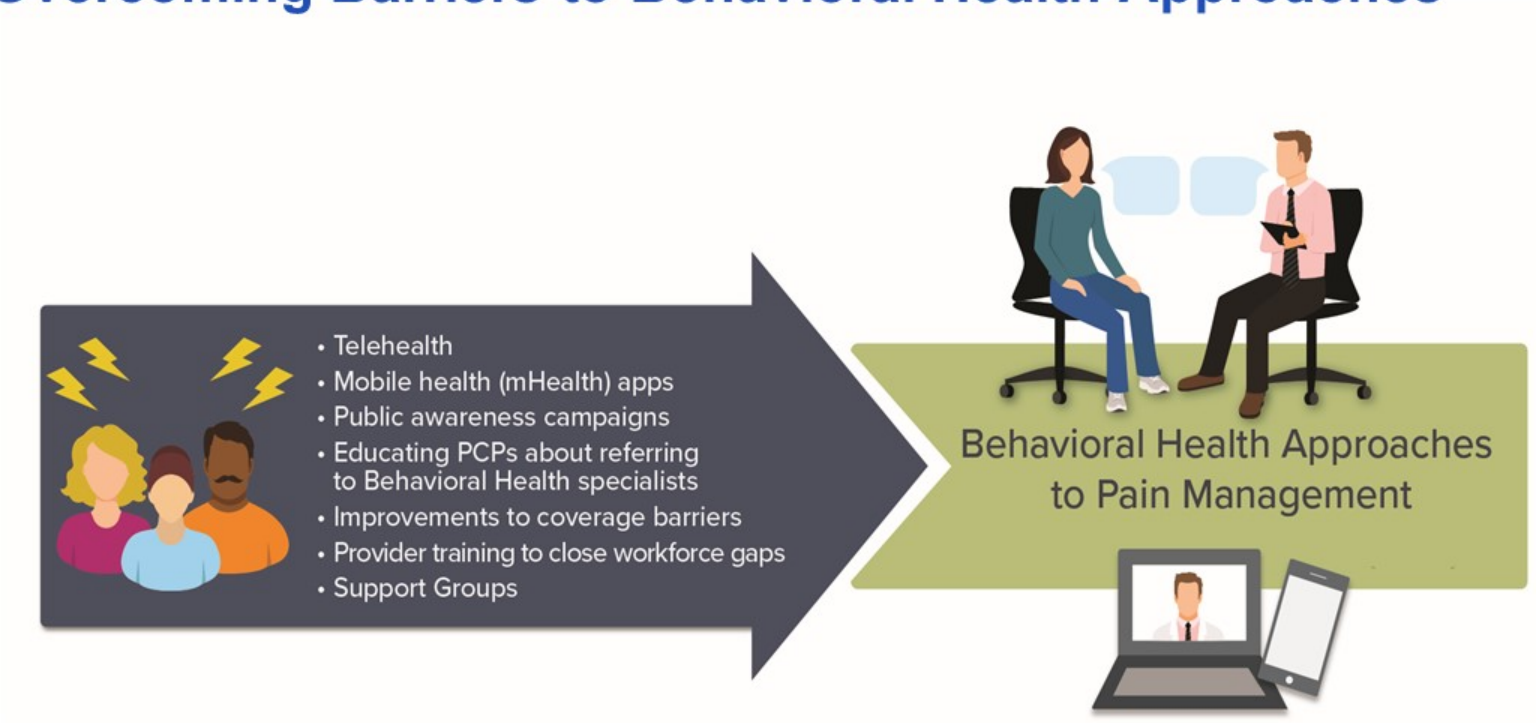


This list is non-exhaustive

Interventional Procedures Vary by Degree of Complexity and Invasiveness



Overcoming Barriers to Behavioral Health Approaches



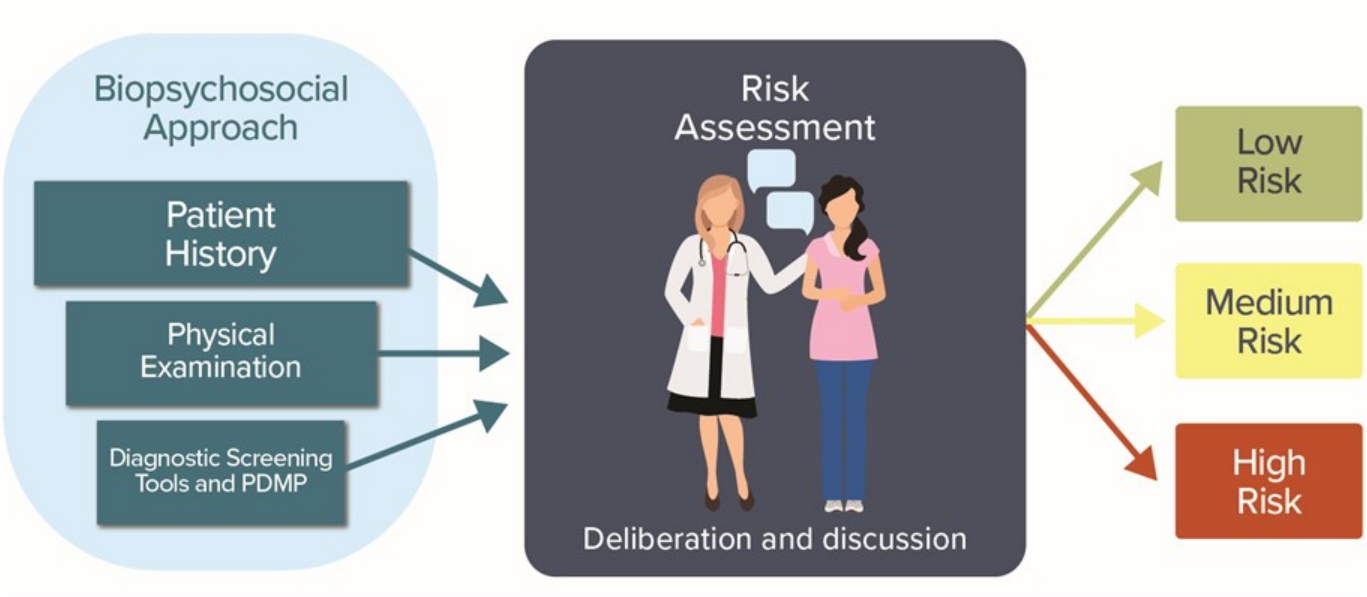
Complementary and Integrative Health Approaches

This list is non-exhaustive

Innovative Delivery Systems, Research, and Special Populations

- **Innovative** solutions: e.g. telemedicine, tele-mentoring, mobile apps
- **Research** needed: mechanisms of pain, preventive measures, innovative medical devices and medications
- **Special populations:** pediatric, women, older adults, American Indians/Alaskan Natives, active duty soldiers/veterans, sickle cell disease (as an example of a chronic relapsing condition)

Risk Assessment for Risk-Benefit Analysis



Public Comments to the Task Force Affirm the Barriers Stigma Creates

I have gone through, and exhausted all of the other drug and non-drug treatment options over the past 13 years. Still, I have pain. I hate that I am being treated like a drug abuser when I am just trying to make my life more manageable on a daily level. I try to participate in being part of our family, making a contribution to society, but it's hard. Not everyone who needs pain relief is an abuser.

- April 2019

How can a person be in pain for many years, unable to do the things he or she used to do without becoming depressed? Why does everyone assume the person was depressed or anxious first? Try having a serious heart condition knowing if you go to an ER for chest pain with or without extremely high blood pressure they probably will think you are seeking drugs

- June 2018

My wife has Cervical Spinal Stenosis with Myelopathy. She was forced to taper in January of 2018. Within one month she was bed ridden and had talked to her employer explaining why she may have to quit her accounting job. I can't tell you how demoralizing this experience has been. We were immediately treated like second class citizens, accused of seeking drugs and the reason for the crippling, illicit, drug epidemic taking place on our streets.

- January 2019

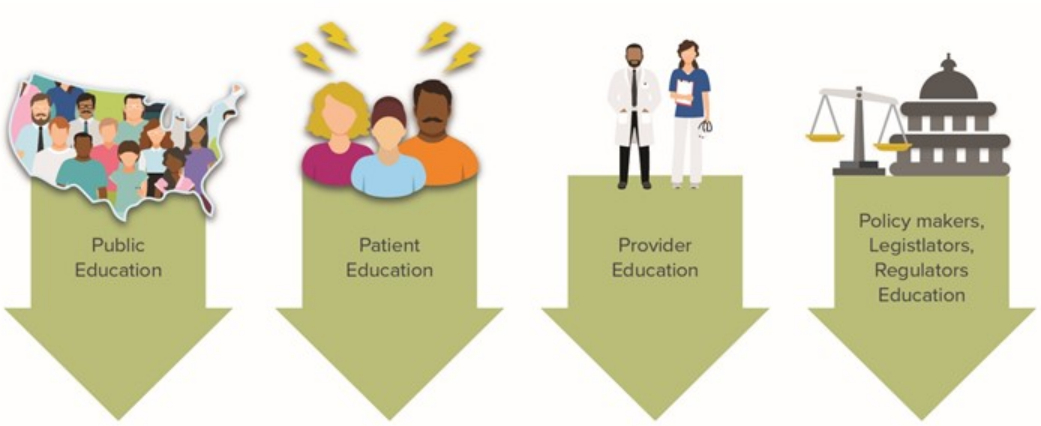
I was sent to a doctor after the last pain clinic in my county closed. He yelled at me, shamed me, and dehumanized me right in of front two other people.

- September 2018

I understand the abuse of pain meds, but not all of those who deal with chronic pain abuse them. I have always abided by pain contracts, been willing to submit UAS and yet still have had some pain doctors treat me as an addict because of the number of years I have been on pain meds. Trust is vital between a pain patient and their physician.

- May 2018

Education Is Critical to the Delivery of Effective Patient-Centered Pain Care and Reducing the Risk Associated With Prescription Opioids



+ Effective, patient-centered care
+ Optimize patient functional outcomes
+ Appropriate use of pain medication
+ Eliminate stigma
+ Reduced risk through risk-benefit assessment

Access to Care

Improved Insurance Coverage and Payment

Barriers

- Covered services further **limited** through prior authorization, condition requirements, visit limits and referral requirements
- Non-pharmacological treatments for pain –
  - Commonly covered – e.g. PT/OT
  - Limited coverage – e.g. acupuncture, behavioral health interventions
- Insurance Coverage for Complex Pain Management Situations
- Shortage of pain specialists

Needs

- More time and resources for assessment and multimodal treatment plan
- Align payer guidelines with current clinical guidelines, including non-opioid pharmacologic therapies
- Complex management of pain code

Innovative Virtual Delivery Systems – Electronic Mediums

- **Telemedicine: Has moved ahead at WARP speed:**
- **Reimbursement improved with recent CMS actions**
- **Various platforms – and facetime, zoom, phone**
- **Tele-mentoring:** procedural guidance of one professional by distance
- **Project ECHO:** (Extension for Community Healthcare Outcomes) - method of tele-mentoring healthcare professionals underserved areas to improve the care of common, chronic, complex medical conditions.
- **Mobile Apps and Devices**

RECOMMENDATIONS CDC UPDATE AND EMPHASIZE

- Better quality data for long term opioids
- Identify sub-population that may benefit from LT opioids
- Consider patient variables that affect pain and opioids
- Opioid tapering guidelines
- Opioid/benzo have increased risk: therefore need pain/addiction specialty
- Appropriate duration of therapy- start with guidelines but ultimately treating clinician is last determinant with patient
- Develop/update acute pain guidelines for common surgical procedures
- Partial refill system

Concerns about Forced Tapers and Patient Abandonment due to misapplication and misinterpretation

- **FDA Safety Announcement, April 9, 2019**

  FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

  (https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes)

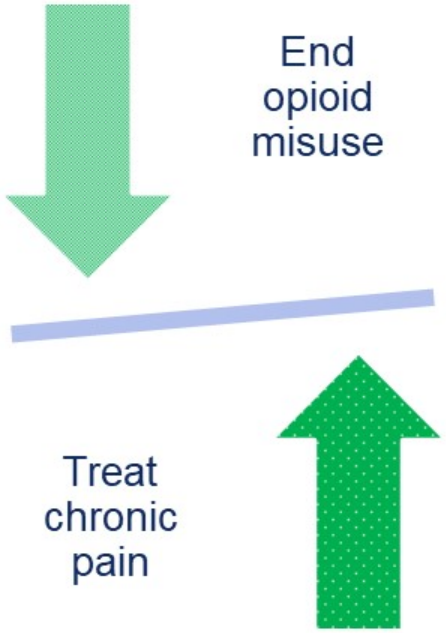
- **CDC NEJM Perspective, April 24, 2019**

  No Shortcuts to Safer Opioid Prescribing

  (https://www.nejm.org/doi/full/10.1056/NEJMp1904190)

Goal: "Strike a Balance" and address both public health crisis

- Important to balance the need to end the devastating effects of opioid misuse while also ensuring that pain patients can work with their doctors to develop an integrative pain treatment plan that **optimizes measurable function outcomes, quality of life, and productivity.**



Letter from Senator Bill Cassidy

"Tools like the *Pain Management Best Practices Inter-Agency Task Force Report* should be seen as a resource to better equip the DEA and other key stakeholders while seeking to combat the opioid crisis. Empowering the registrant community with instruction in best practices will serve those in need of medication who are combating pain in the acute and chronic period. This should prove to be a help as we all seek improvement of the patient's well-being and overall improved function."

Thank You

Dr. Vanila M. Singh, MD MACM

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https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf

https://www.hhs.gov/blog/2019/05/10/patient-centered-care-is-key-to-best-practices-in-pain-management. HTML

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U.S. Department of Veterans Affairs
Department of Veterans Affairs
Office of Patient Centered Care and
Cultural Transformation

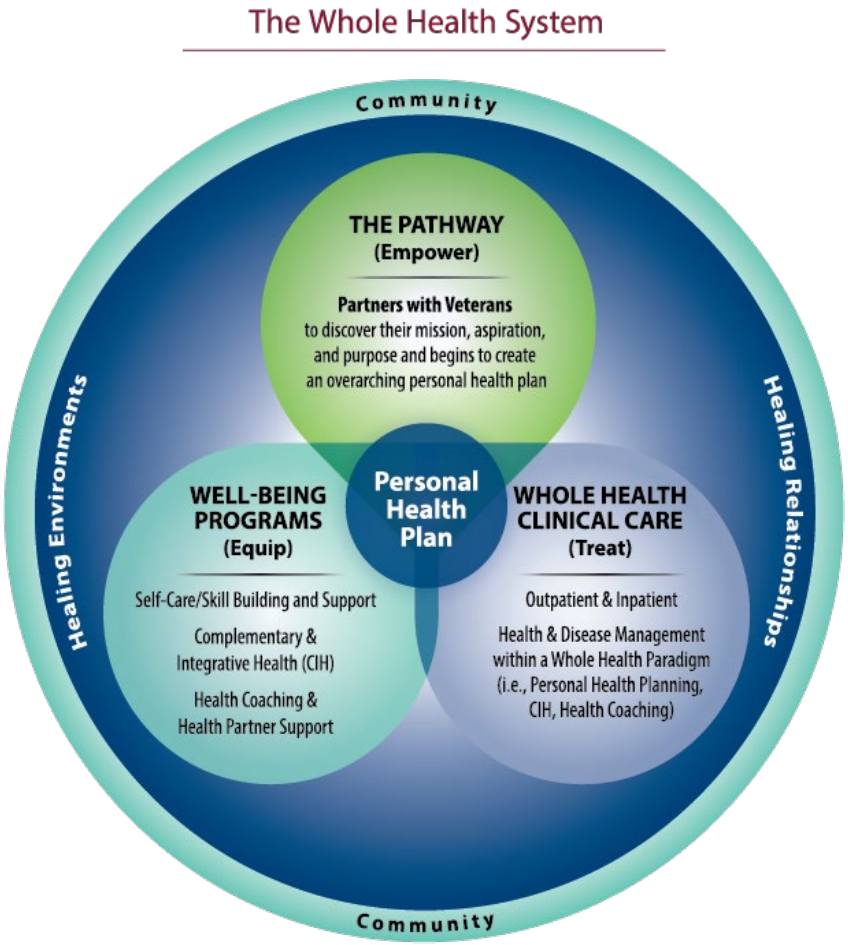
Whole Health for Life

THE WHOLE HEALTH APPROACH FOR PAIN: OUTCOME DATA FROM THE WHOLE HEALTH FLAGSHIPS

Benjamin Kligler MD MPH
Acting Executive Director
Office of Patient-Centered Care & Cultural Transformation
Veterans Health Administration

Whole Health
is an approach
to health care that
empowers AND equips
people to take charge
of their health and well-being,
and live their life to the fullest.

The Whole Health System



Strategy 2.1.4:Emphasizing Veterans' And Their Families' Whole Health & Wellness

- VA will significantly improve Veteran health outcomes by shifting from a system primarily focused on disease management to one that is based on partnering with Veterans throughout their lives and focused on Whole Health. VA will provide *personalized, proactive, patient* driven health care to empower and equip Veterans to take charge of their health, well-being, and to adopt healthy living practices that deter or defer preventable health conditions.

- A Whole Health system focuses not only on treatment but also on self-empowerment, self-healing, self-care, and improvements in the social determinants of health.

- How will we know we have arrived? Veterans have a good quality of life, defined by presence of positive emotions in daily activities, participation in society, satisfying relationships, and overall life satisfaction.

Congressional Support is Strong

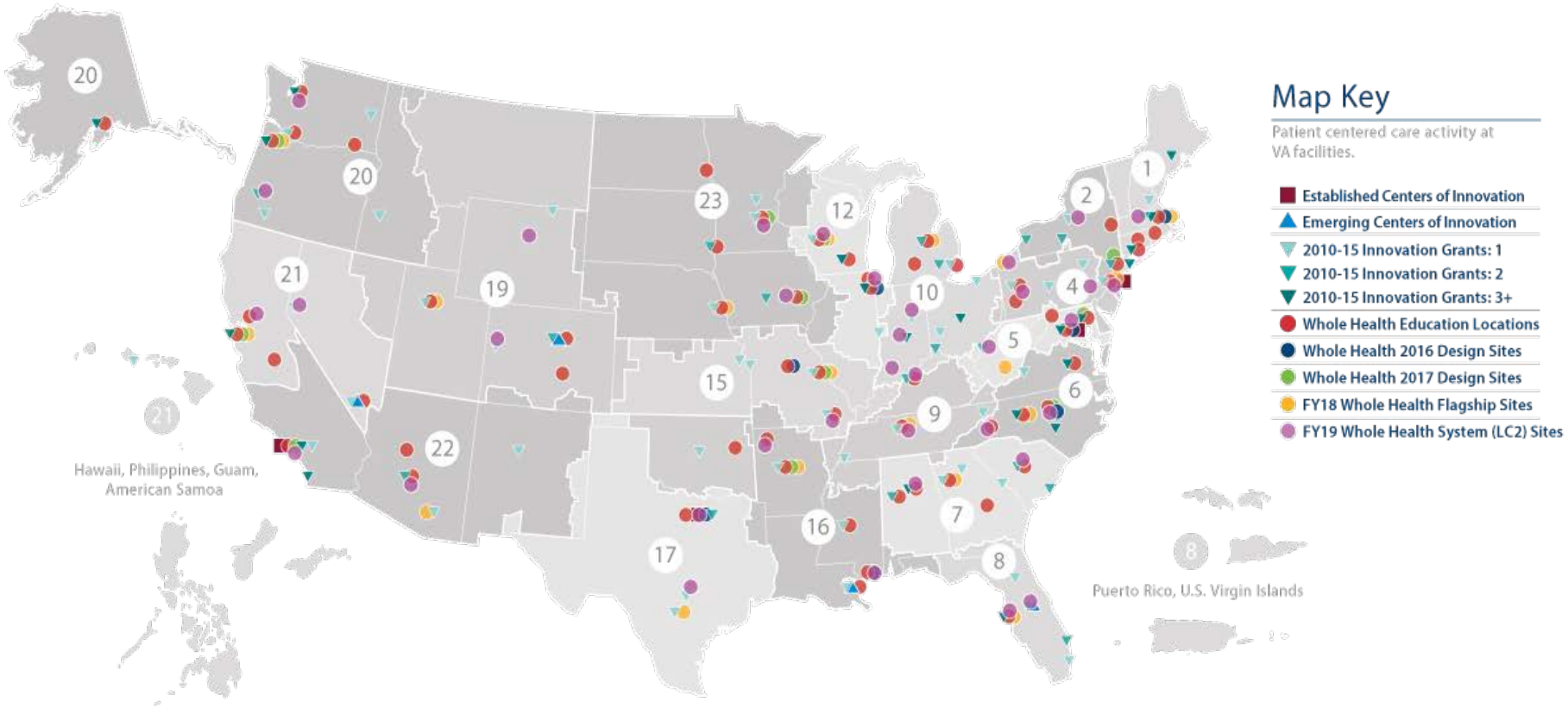
Comprehensive Addiction and Recovery Act (CARA) of 2016

- Complementary and Integrative Health (CIH)
  - Expansion of Research & Education on and delivery of CIH to veterans
  - Pilot program on integration of CIH and related issues for Veterans and family members of Veterans.
    - Minimum of *15 geographically diverse sites*; including at least 2 polytrauma rehab centers = 18 Flagship sites
  - By July 2020, a final report is due to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives.

HVAC and Appropriations Committee's support continues

https://vaww.infoshare.va.gov/sites/OPCC/SiteAssets/SitePages/IHCC-home/2017%20CIH%20Plan_CARA%20932.pdf

Whole Health Reach To Date



Whole Health System of Care Evaluation

Whole Health System of Care Evaluation – A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites

Prepared by:
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EPCC Center for Evaluating Patient Centered Care in VA
QUERI Partnered Evaluation Initiative

Live Whole Health.

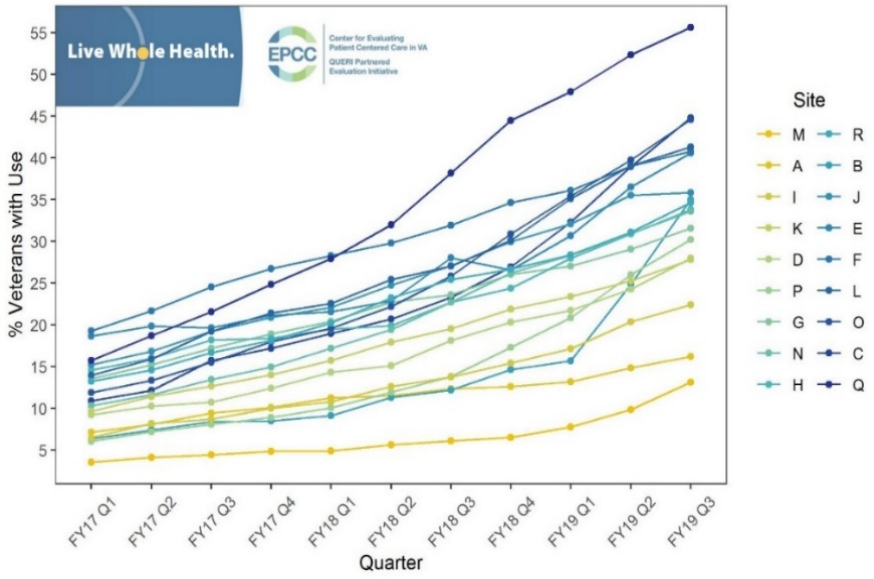
VA HEALTH CARE Defining EXCELLENCE in the 21st Century

Funding for this report was provided by the Department of Veterans Affairs:, Office of Patient-Centered Care and Cultural Transformation, and Quality Enhancement Research Initiative (PEC13-001). The views in this paper are the views of the authors and do not represent the views of the Department of Veterans Affairs or the United States Government

Categories of Whole Health Services Use

Whole Health Service Category	Services included
Complementary and Integrative Health (List 1) **Chiropractic care**	Chiropractic care Massage Whole body acupuncture & Battlefield acupuncture Yoga Tai Chi Meditation Biofeedback Guided Imagery Hypnosis
Core Whole Health	Personal Health Planning Peer-led Whole Health Groups Whole Health Pathway services Whole Health Coaching Whole Health Educational Groups

Utilization: 31% of Veterans with chronic pain engaged in some WH services across the 18 sites (Q3FY19).



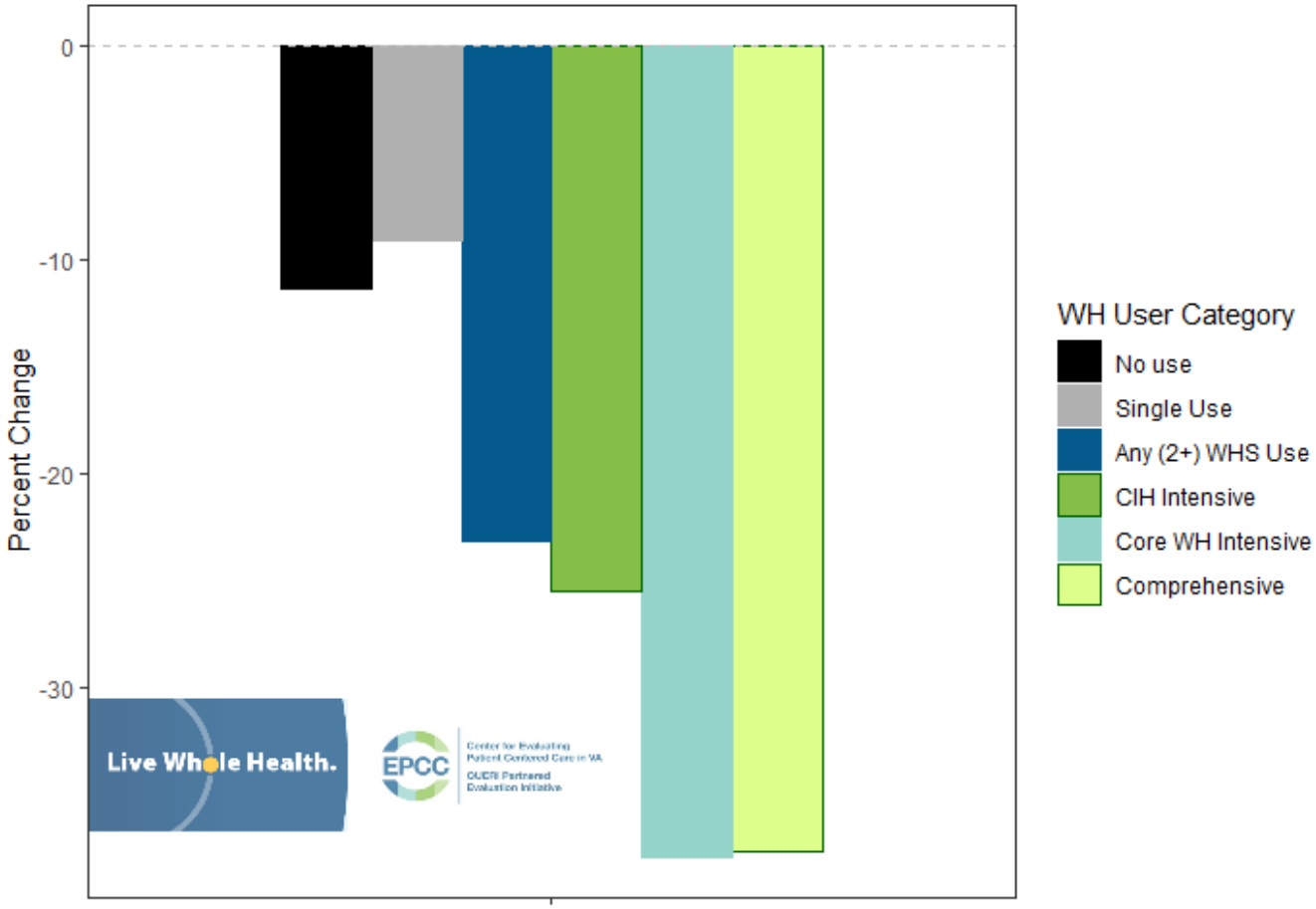
Changes in WHS Utilization Among Veterans with Chronic Pain

- At 1 flagship site, engagement = 55%
- Expectation: 44% Veterans with chronic pain will engage in WH services by the end of 2020.
- Increases in utilization since 2017:
  - Veterans with chronic pain: 193%
  - Veterans with MH diagnoses: 211%
  - Veterans with chronic conditions: 272%
- CIH utilization:
  - 26% of Veterans with chronic pain
  - Includes services delivered in the community
  - Increasingly being delivered within VA

PRELIMINARY FLAGSHIP OUTCOMES: VETERAN IMPACT

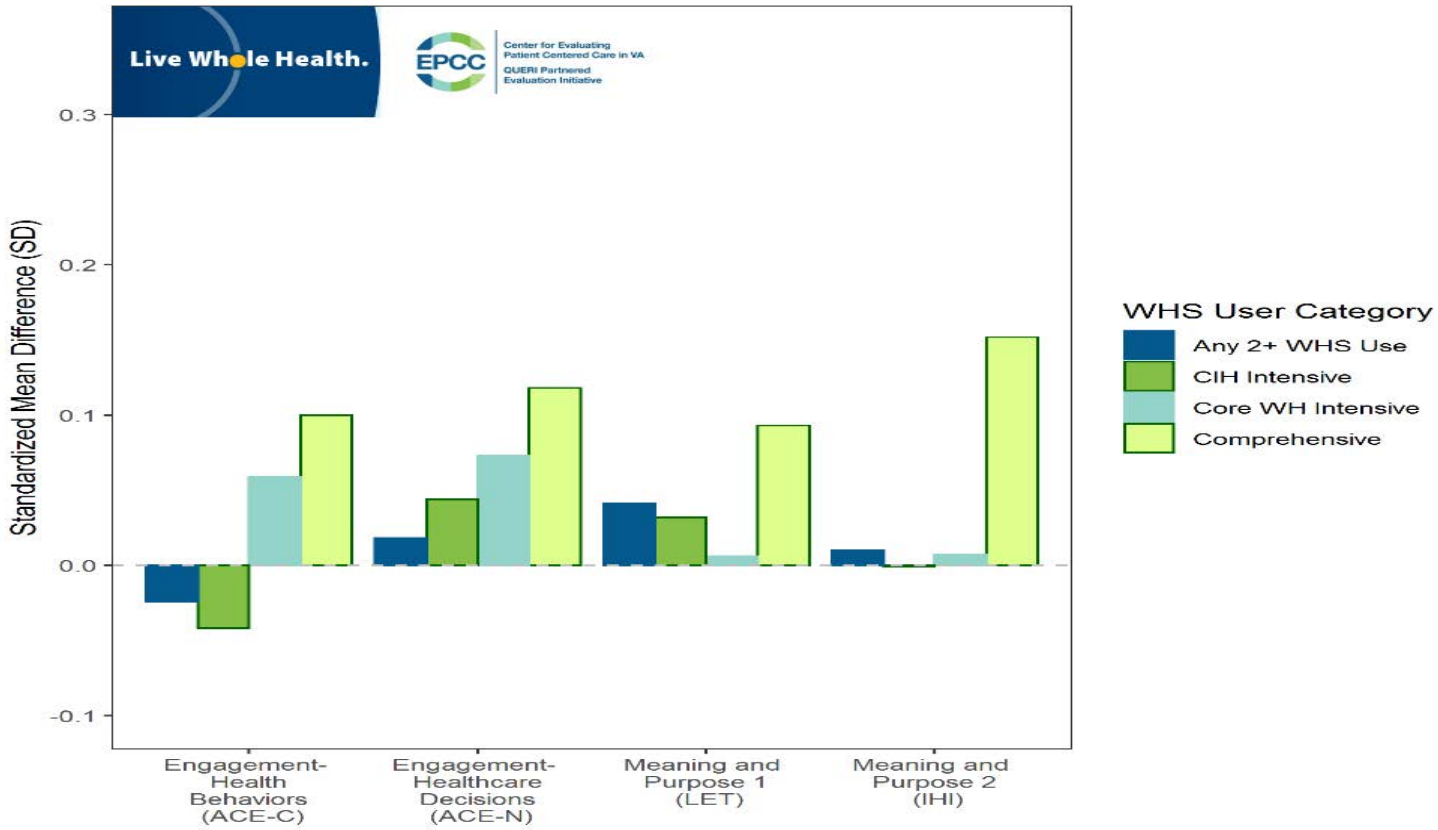
- Impact on Veterans
  - Whole Health had a positive impact on reducing opioid use among Veterans.
    - There was a threefold reduction in opioid use among Veterans with chronic pain who used WHS services compared to those who did not. Opioid use among comprehensive WH users decreased 38% compared with an 11% decrease among those with no WH use.
  - Findings on Veteran-reported outcomes from our Veterans Health and Life Survey are preliminary, however compared to Veterans who did not use any WHS services, Veterans who used WHS services demonstrate trends towards improvements in patient-reported health and well-being outcomes. These early findings show improvements over a 6-month period and are promising for the future.
  - Compared to Veterans who did not use WH services, Veterans who used WH services reported:
    - Greater improvements in perceptions of the care received as being more patient-centered.
    - Greater improvements in engagement in healthcare and self-care.
    - Greater improvements in engagement in life indicating improvements in mission, aspiration and purpose.
    - Greater improvements in perceived stress indicating improvements in overall well-being.

PRELIMINARY FLAGSHIP OUTCOMES: OPIOID UTILIZATION



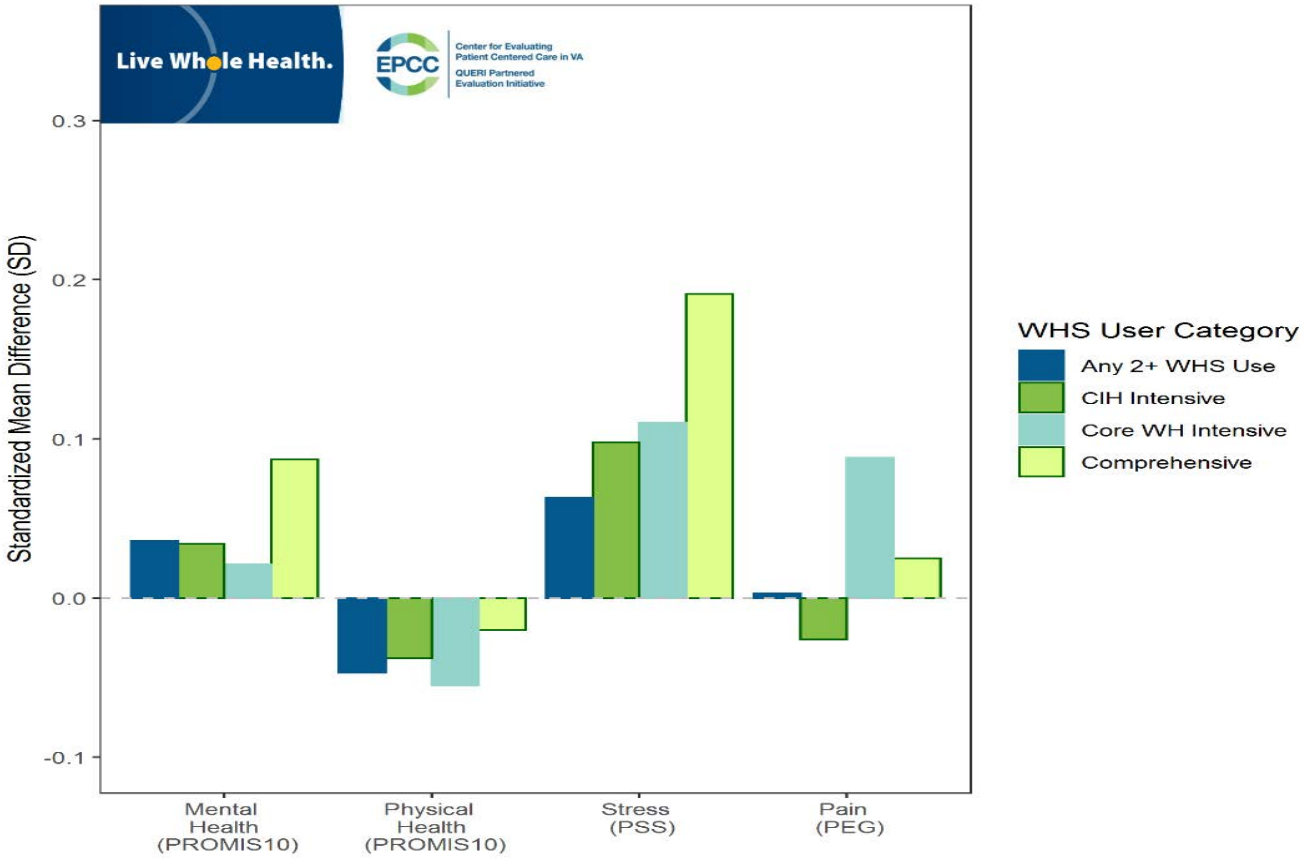
Change in opioid use by WH user category for Veterans with chronic pain (n=114357)

PRELIMINARY FLAGSHIP OUTCOMES: VETERAN ENGAGEMENT



Association between changes in Veteran engagement and meaning and purpose and WHS service use compared to no use group (n=3266).

PRELIMINARY FLAGSHIP OUTCOMES: WELL-BEING



Association between changes in Veteran well-being and pain, and WHS service use compared to no use group (n=3266). *Note that any negative SD represents a relative change compared to the non-user group. All measures did improve across all groups.*

PRELIMINARY FLAGSHIP OUTCOMES: EMPLOYEE IMPACT

- Impact on Employees
  - Employee involvement in provision of WH expanded from 2018-2019 in all sites.
  - Variation exists in different clinical areas, with the greatest uptake in primary care, mental health, rehabilitation, and home/community care.
  - Employees who reported involvement with WH also reported:
    - Their facility as a ‘best place to work’
    - Lower voluntary turnover
    - Lower burnout
    - Greater motivation
  - **Facilities with higher employee involvement in WH had higher ratings on hospital performance, as measured by Strategic Analytics for Improvement and Learning (SAIL).**
  - **Facilities with higher employee involvement in WH had higher ratings from Veterans on receiving patient-centered care as measured in the Survey of Healthcare Experiences of Patients (SHEP).**

Why It Matters

Whole Health began my journey to joy, I am a changed person. I no longer need my cane. The Whole Health group has become my family. My neurologist says he doesn't need to see me anymore!"

J.H., 52 year old Male

"I have lost 33 pounds. I go to FIT class, nutrition class, Battle-field acupuncture, and regular acupuncture. My wife says I have a positive attitude now! And my diabetes is under control, blood pressure down and lipids good. I see my primary care doctor much less"

R.C., 71 year old Male

I used to drive over the Mississippi River Bridge, to Jefferson Barracks VA, and think about jumping every time. The whole health system has helped me explore my purpose, find ways to use nutrition to reduce my pain, and use iRest and Tai Chi to get moving again. Now I drive over that bridge and think about tomorrow…. I have hope"

K. H., 37 year old Female

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#AACIPM

AACIPM Symposium

Innovation in Person-centered Pain Management

Reflections from Leaders Promoting Cultural Change

May 13, 2020

Cindy Steinberg
National Director of Policy & Advocacy
U.S. Pain Foundation
Policy Council Chair
Massachusetts Pain Initiative
Leader, Boston-area Pain Support Group

Life with Chronic Pain
The Typical Patient Experience

- We have heard the PMTF and VA ideal models of chronic pain care
- *But, what is the reality for most patients?*
- People with pain struggle to find care; especially the past few years
- Pain sufferers typically see at least 4 -5 practitioners before they find help; could take years
- Most treatment options are inadequate or ineffective
- Often not believed; practitioners lack empathy
- Stigmatized as if having chronic pain is something to be ashamed of
- Often labeled “doctor-shopper” or “drug seeker” ; treated in a demeaning, dismissive manner

The Typical Patient Experience

- Care is fragmented, lacks coordination, struggle to piece treatment together on your own
- Most practitioners & patients lack understanding that chronic pain is a disease itself w/ no cure
- Often takes years to learn that managing it requires combining therapies specific to individual
- Constantly confront access barriers: cost, lack of reimbursement, doctors fears, long wait for pain specialists, referrals required

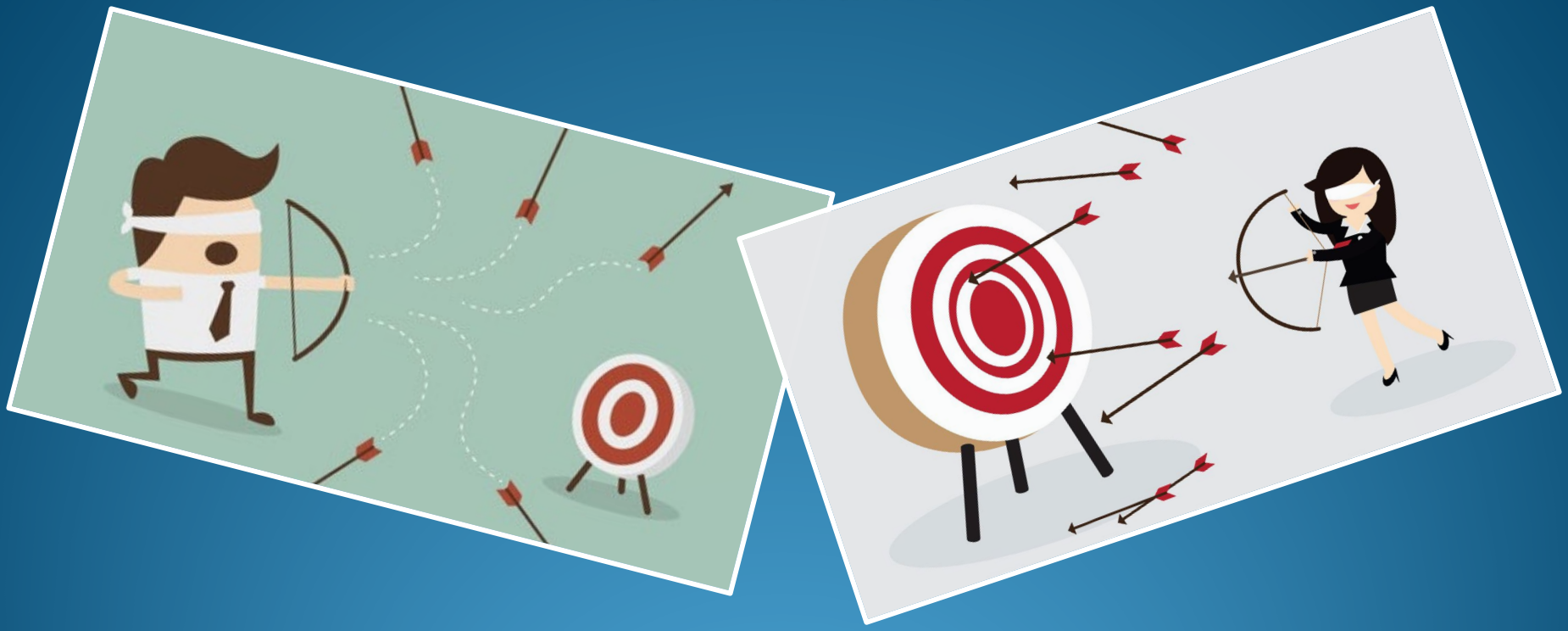
The Typical Patient Experience

- Meanwhile, chronic pain is devastating your life
- Feel like a trapped prisoner in your own body
- Tortured 24/7 with no means of escape
- Often cannot work, socialize, sleep, engage in pursuits you enjoy
- Relationships suffer, lose self-esteem, friendships
- Become isolated

Roller Coaster of Chronic Pain Treatment: Hope & Disappointment

- Torturous route “roller coaster” of trial & error investing time, money & energy to find a way to lessen the pain
- Research & try treatments, try to stay hopeful—only to have hopes dashed

State of the Art of Pain Treatment Then….and Now



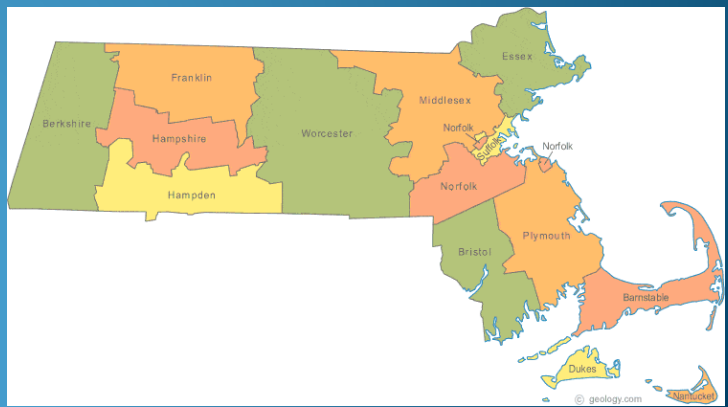
- Doctors blindfolded, trying different treatments in the hopes of hitting the target
- A lot of misses & occasionally something helps

Confronting Reality of Improving Pain Care

- Involves pushing against an entrenched h/c system w/ many barriers to integrative care
- Barriers include:
  - Physician's lack understanding of integrative model of pain care
  - Physicians lack time required to spend w/ patients
  - Insurers generally do not cover complementary therapies
  - Insurer PBM practices delay treatment (eg. Step Therapy, prior authorization, non-medical switching)

Incremental Change is Possible
(with persistence & patience)

- An example from Massachusetts
- Lawmakers in sessions from 2013 – 2016 writing bills attempting to severely limit or ban opioid prescribing
- Constantly on the defensive until 2017 when switched to offense
- Argued since taking away opioids, we must give people w/pain other options; insurers unwilling to do this on own
- Drafted a bill w/ lawmaker to require insurers to cover other pain management services



Bill included following requirements:

- Pertained to all public and private carriers in the Commonwealth
- Carriers must “provide adequate coverage and access to a broad spectrum of pain mgmt services”
- PM plan shall be a component of carrier accreditation subject to approval
- Carriers shall distribute educational materials to providers about PM plan
- And post information about plans on public websites
- DOI to publish standards & guidelines for PM services & assess network adequacy

Path from Bill Language to Pain Care Change

- Worked to get bill language into larger opioid bill
- Enacted as part of CARE Act signed by Governor, Aug, 2018 *(one of several pain mgmt provisions included)*
- DOI issues draft guidance Dec, 2018
- Far short of legislative intent; requires one alternate medication & one alternate non-med treatment
- We commented on Guidance & had calls with Deputy Insurance Commissioner
- Final Guidance issued Aug, 2019; requires 2 alternate medications & 3 non-med treatment modalities

Path from Bill Language to Pain Care Change

- Pain mgmt plans due to DOI Oct 31, 2019
- Plans to take effect with provider contracts & consumer materials by Jan 1, 2020
- Oct 3, 2019 BC/BS of MA announced will cover acupuncture for pain; up to 12 visits w/ no PA starting Jan 1!
- Announcement didn't mention required to do this but it made me smile
- Requested copies of all pain mgmt plans & will be following up on that
- Progress slow, enacting law just 1st step, someone has to be on it but nevertheless progress toward goal of multidisciplinary pain mgmt!