Comprehensive Integrative Pain Management (CIPM)
Employer Advisory Board
Midwest Business Group on Health
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Summary Overview

Introduction: Problem/Purpose

Pain is 90% of the reason people go see doctors. It is a complex problem that rarely has a simple solution. To further complicate this, how we deliver health care has taken a huge departure from what health truly is about. We are losing site of optimizing people's function and well-being. In fact, people suffering from pain are also experiencing mental health conditions and poor quality of life – 30% – 50% of people with chronic pain have depression or anxiety while 25% have insomnia. Integrating care and addressing biological, psychological, and social needs has a positive impact on quality of life.

Acute and chronic pain is a matter of public health. The importance of viewing pain through a public health lens allows one to understand pain as a multifaceted, interdisciplinary problem for which many of the causes are the social determinants of health. Social determinants are conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Healthy People 2020 developed a "place-based" organizing framework, reflecting the five key areas of social determinants of health include:

- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and Built Environment

When developing a strategy for comprehensive and integrative pain management, it is important to look at an individualized approach that is focused on the right treatment/therapy for the right individual at the right time. This includes a focus on the whole person and getting to the root of the cause of the pain.

Providing comprehensive integrative pain management is complex and difficult to achieve in a siloed system of healthcare. In the clinical examples of this approach to care, outcomes include improved function and quality of life while decreasing overall costs and use of pharmacological treatments. Because this is not well understood or easy to implement for employers, the Midwest Business Group on Health and the Alliance to Advance Comprehensive Integrative Pain Management decided to convene an advisory board of employers, who make decisions regarding health insurance for their employees and their families, to offer advice about the utility of CIPM and how to advance its adoption as a standard of care for pain.

What is Comprehensive Integrative Pain Management (CIPM)?

The Pain Policy Congress 2017 brought together 50 organizations and agreed upon this common definition of CIPM:

Comprehensive Integrative Pain Management includes biomedical, psychosocial, complementary health, and spiritual care. It is person-centered and focuses on maximizing function and wellness. Care plans are developed through a shared decision-making model that reflects the available evidence regarding optimal clinical practice and the person's goals and values.

The "spiritual care" component is about people being connected to meaning and purpose – to a sense of what they value. When you lose that, you lose a sense of motivation and drive. The terms "meaning" and "purpose" are good words to use in place of "spiritual."

Looking at Terminology: Alternative, Complementary, Integrative, Integrated

During the focus group, terminology was discussed, and this is some of the themes that were discussed. In the world of integrated pain management, there is a hierarchy of terms that often creates confusion and furthers the mindset that these approaches are not as good as current standard traditional care. The word "alternative" implies moving away from standard care to use an alternative therapy. "Complementary" is often seen as complementing mainstream care and has been viewed as an improvement over alternative, but it still implies that it's not necessary or is something done on the side. The term "integrative" is looked at as complementary but evidence based. Using terminology like complementary and integrative are viewed as a positive shift that may help employers sell programs internally.

It was noted that from a payer perspective, it would be most helpful to take all these words out and just say pain management. Then there is no discerning whether an approach is alternative, complementary or integrative – those words tend to confuse. Ideally you could say that you will cover the most effective pain management you can, regardless of what therapy it is. Sometimes that will include other types of therapy. From a payer perspective, this may avoid senior leaders asking, "Why are we covering these alternative treatments rather than traditional pain management?"

Additionally, all players (employers, pharmacy benefit management, health plan) must understand the particular medical terms and pharmacological options or the discussion gets lost in the terminology. At some point, discussions have to get down to very specific needs to cover actual medical and pharmacological therapies.

Why Employers are Paying Attention

Here are comments from employers attending the Advisory Board meeting:

A huge area of concern for employers is how to handle the opioid addictions and do it in a way that is safe for all employees. It's important for me to make sure we get the integrated pain management taken care of.

This is a pain management crisis. We need to look at this from the perspective of comprehensive care, not managing a single intervention or single prescription

This is not just an opioid issue – it's a pain management issue. We're on the right road with the integrative approach.

We only have so many hours in a day and dollars to spend, so we have to judiciously allocate resources to areas that are the biggest challenges. We are interested in learning about alternatives to pain management and if/how what we're doing in the US will have applications for employees outside of the US. We generally don't cover a lot of alternative therapies and I'm interested in whether that should change and how we should position this (what to pay for, what not).

Employers who haven't embraced alternative therapies are probably missing the boat (e.g. productivity, presenteeism, depression component). I'm excited to hear about integrated opportunities.

We want to be able to help pull it all together (integrative medicine, behavioral health) and have a case for it – it's hard to prove worth.

The solutions we find don't always fit in a small organization. The challenge is bringing large employer strategies to a small company.

There is a lot of discussion around find it and fix it quickly. Many will say the opioid misuse/overuse crisis has been confounded by that. The health care system and the fragmentation around how things are paid for have forced quick fixes or less expensive fixes. If paired with quality outcomes, people start to see it differently.

Network and finding good providers and quality referrals is an issue that is very location dependent and especially challenging if you are rural. The main issue is how to find good providers – how to take a data driven approach that's not proprietary to an insurer and make that information publicly available.

Comments from other participants included:

For the past couple of years, we have been working on how to best support employees through prevention, treatment and recovery. Through this, it has become apparent that the pain management piece of this puzzle needs to be defined.

My goal is to convince people who pay the bills that integrated medicine/pain management is in their financial interest versus simply the right thing to do. You either generate revenue or you're a cost saver – you have to show you save money. This is a different paradigm and it is the future.

Evidence is based on the risk involved. If you weigh the risk versus the benefit and there is minimal risk and potential benefit, you need less evidence. Integrated pain management is cost effective plus it's great patient satisfaction/patient experience.

There is a need for greater access to nonopioid pain care. In the public policy world, everyone talks but no one does. We need to see best practice examples to share and help state medical societies adopt best practices instead of just having policy discussions around the issue.

Policy efforts have been focused on decreasing prescribing of opioids and that has been successful. However, this hasn't resulted in better outcomes in pain management and often it's gotten worse because many primary care physicians report they aren't comfortable providing quality care for pain management with so few resources available. We need to focus on quality outcome measures for pain management. We also need to understand access and utilization of evidence-based non-pharmacologic treatments.

There are important commonalities between people with chronic pain, mental health disorder and substance use disorder – all benefit from a whole person, biopsychosocial approach to care; there are many comorbidities, complexities and overlapping conditions; and these patients are often marginalized and stigmatized. Patient-centered care is important.

Starting in medical school, physicians are poorly trained on different options. In practice, issues are not around integrative, complementary, or whole person – instead they are around the benefits of a particular therapy.

What's Working

UnitedHealth Group

Most of the money and pain volume in MSK is back and neck, and a lot of it is routine orthopedic problems that are non-fracture and non-surgical. Recent research shows the trajectory/outcomes for back pain depends more on whose office the patient stumbles into first versus their underlying condition. The front door patients go through has a dramatic impact on total cost, which is a function of imaging, injections and opioid use.

The current system is structured backwards. Approaches including spinal imaging, spinal injections, surgery and medications are generally placed at the front door and other therapies (complementary, alternative, integrative) are used if these interventions are not working. Spinal imaging and spinal injections represent 50% of all low value care in our system, are the most commonly paid for approaches and have fewer barriers.

Guidelines for managing back pain are crystal clear (from the American College of Physicians, Lancet). Therapies recommended for frontline treatment are manipulation, manual therapy, exercise, acupuncture, yoga and/or over the counter NSAIDS. These are not complementary and not integrating with medical care delivery – they are the primary preferred front door treatments for back pain. If a patient isn't progressing, then they get a more in-depth surgical consult and possibly imaging and some of the medications.

UHG, an employer of 300,000, adopted this benefit plan design and we are actively driving patients to this kind of care model. We eliminated out-of-pocket costs to go down this path for our 5 million fully insured book of business. Benefit plan design offers pathways to high performing networks and search tools that rank order providers best aligned with guidelines. There is an algorithm behind the scenes to help get people connected in a way that respects individual's preferences and is not dictatorial. We want to help more patients access pathways that are best aligned with the guidelines, offer a great consumer experience and drive lower cost of care.

In terms of consumer sentiment, the net promoter score for chiropractic and physical therapy is around 92%, whereas the medical provider score is often 60% - 70%. Any way we come at this, the patient experience is compelling. We are seeing a significant impact on return to function when chiropractic and physical therapy are used, and these professions are doing the best job of systematically measuring this. Medical doctors aren't systematically collecting outcomes that scale and can be rolled up in this way (some individual systems are doing it).

The variable we need to be concerned about is the different medical options positioned as a front door for back pain are not aligned with the guidelines and are exposing patients to extreme variability in practice.

Scripps Center for Integrative Medicine
Chronic pain does not travel alone – 30% – 50% of chronic pain patients have depression or anxiety and 25% have insomnia. We need to recognize that when we triage patients between silos, we will not likely impact their quality of life. There is a need for clinical care models and other interventions that simultaneously address the complexity and interrelationships of multiple chronic conditions.

High Impact Chronic Pain (HICP) is defined as having pain most/every day in the previous three months with at least one related activity limitation. The patient has become sensitized to the point where everything is amplified. Compared to lower impact chronic pain, those with HICP have twice the annual per person health care costs, four times the rate of opioid use, and five times the morphine equivalent daily dose.

Multiple studies show that underlying issues including metabolic, diabetes, weight management and cholesterol issues are big drivers of pain. If exercise, diet and well-chosen passive care models (not self-care), can be incorporated into a treatment plan, outcomes may be a lot better.

IDEA Trial (2013): An 18-month randomized trial of 450 osteoarthritis subjects
This is one of the largest trials that looked at changing the trajectory of inflammation through lifestyle approaches (diet, exercise or combination) using a group format. Results showed that although people lost barely any weight, they had 25% - 50% increase in function and a systemic reduction in inflammation on blood markers. Ultimately, an attempt to lose weight and make lifestyle changes is more important than the actual weight lost, and the group mentality and format were very important to success.

Group Medical Visit Model
Group medical visit is a model that can be confusing and cumbersome when you consider bringing multiple providers together. However, among providers who are frustrated with the current system and interested in this, many see this model as an attempt to empower patients to act on their own, leading to more empowerment than just what happens in a typical exam room.

We put a package together that brought many of the therapies that are often fragmented together for a 12-week program. This included weekly visits with health professionals including a dietitian, exercise physiologist and a mindfulness teacher. It was billed as a group medical visit.

A big part of creating this model is education. We know the tools that are important, but providers don't feel confident talking with patients. We created a 6-hour course which we have since brought to 400 providers (primary care to specialists) in an attempt to change their confidence. After the course, surveys showed that low confidence was increased two to three times. This impacts the conversation between physicians and patients, even if it's a short conversation that brings diet into the discussion.

Acupuncture and Neuropathic Pain
There have been a lot of articles about how acupuncture is not just treating pain, but also the intensity of common comorbidities such as sleep, fatigue, depression and anxiety. This is very unrecognized. Employers often worry that expanding acupuncture to their whole system will cause a significant negative impact financially. This may be true if you are only looking at pain. If you are looking at overall quality of life function, the emerging model is showing how these integrated well-chosen therapies can be beneficial overall. Systems outside of the US (e.g. Taiwan) have expanded acupuncture offerings and actually improved health care spending.

A good middle ground is to triage patients as soon as they come in for the first visit. Primary care physicians can be taught to do a quick survey (Keele survey) to try and determine if a patient is headed for chronic pain and if so, that's who gets the full portfolio (PT, acupuncture). Long term there is data that shows this can reduce cost. A recent study looking at high-impact chronic pain showed that integrative therapies for the most part are cost effective/cost saving. Keep in mind that most savings come when high-impact patients are identified and get interventions early in the process.

Whole Health Model of Care (VA)
The Whole Health System is a health care delivery model designed to:

- Empower: Focuses on social determinants and exploring what matters most; gives people a place to think about what motivates them to get better and be pain free
- Equip: Give them self-care skills and approaches
- Treat: Clinical care from Whole Health clinicians

Components of health and well-being include:

- Working your body (energy and flexibility)
- Surroundings (physical and emotional)
- Personal development (personal life and work life)
- Food and drink (nourishing and fueling)
- Recharge (rest and sleep)
- Families, friends and coworkers (listening and being heard)
- Spirit and soul (growing and connecting)
- Power of the mind (relaxing and healing)

Me + self-care + professional care + community resources = whole healthcare

We don't use clinicians to drive the "empower" piece – we use peer-driven groups and other low-cost resources throughout the system, including health coaching. There is a lot of evidence behind their effectiveness. When managing behavior change, it's often better to have a health coach who can allow a patient time to process their challenges and barriers.

You have to shift the entire workforce in their thinking and bring in providers who understand the skills of motivational interviewing and who are looking at connecting people to the right resources. Ultimately, you get to the place where clinicians are delivering this type of care across the continuum – setting shared goals with patients, determining where the evidence-based approaches are and developing the self-care skills.

In the Whole Health system of care, there are multiple entry paths for chronic pain and a patient doesn't need a physician to start. We have partners, who function like navigators, who bring people in and start to define what is important to the individual, what areas they want to work on, and an awareness/support if they need a clinician. This is a huge shift away from a physician-driven model.

Outcomes
For the last two years, we have been evaluating 18 sites that are deploying the full model of care. All sites have made progress in implementing this model and transforming how clinicians deliver care. Thirty-one percent of veterans with chronic pain engaged in some Whole Health service across the 18 sites. Since 2017, there has been a 193% increase in utilization by veterans with chronic pain, 211% by patients with a mental health condition, 272% by patients with a chronic condition.

These are all interrelated – we are treating the whole person. If we don't educate providers, they will do the next easiest thing. When we do it comprehensively, we see a threefold reduction in opioid use (38%). This is incredibly striking and exciting information (cost reduction, improved quality of life). Those not using Whole Health decreased opioid use by only 11%. Although pharmaceutical costs increase with Whole Health users, they increase far less than non-Whole Health participants and the general population.

Involvement in providing Whole Health was associated with important employee outcomes:
- Reported their facility as "best place to work"
- Lower burnout and voluntary turnover, greater motivation

Duke University Multidisciplinary Collaborative Care for Spine-Related Disorders
Vision: To empower patients, clinicians and populations with the knowledge and tools they need to ensure that people-centered, multidisciplinary, value-based, evidence-informed spine care is provided to the right person at the right time.

Foundational care represents the beginning of the patient health care trajectory. Its population health emphasis is consistent with the National Pain Strategy's call for prevention strategies in pain management and aligns well with value-based health care delivery models (e.g. ACOs).

Foundational Care Level One: Self-care – patient education on nutrition, mindfulness, physical activity and the current guidelines recommended for treatment of back pain, including prevention or how to deal with it early on

Foundational Care Level Two: Facilitated Self-Care – evidence-based treatments that are self-managed by the patient but either require or are enhanced by a trained professional; includes cognitive behavioral therapy, yoga, tai chi, instructed exercise and weight loss classes

Individualized Care – patients who remain in pain after a course of self-care/facilitated self-care or are not suitable candidates for Foundational Care due to the nature of their pain or co-morbidities; involves co-managed spine care between PCPs and Primary Spine Practitioners providing incentives for patients to consider chiropractic and physical therapy.

Our research has looked at models of care and what happens when you integrate chiropractic care with the primary care model. Medical doctors are open to this but feel that the practitioners they work with are the only good ones. Doctors often experience relief, e.g. after referring a patient to a chiropractor, because they can focus their time on things they know and can make a difference. Clinicians don't have to be co-located. The patient has an exam by both clinicians and knows they are working together on the study.

Specialized Care – patients who are not responding to individualized care who request fast tracking to a specialist. They are well vetted and are much more likely to be surgical candidates.

Washington State Health Benefit Exchange
BREE Recommendations on Collaborative Care for Chronic Pain

The BREE Collaborative was founded in 2011 with many different stakeholders. Their focus is on recommendations on topics that have high variability in care, high cost or poor outcomes. This is their summary on collaborative care for chronic pain:

- Support patient self-management in the context of a biopsychosocial model
- Acknowledge the high number of people with unmet need due to gaps in or lack of comprehensive care
- Focus on primary care as the medical home for acute and chronic pain treatment and management through a systems-based approach
- Build off the Washington State Agency Medical Directors Group Guideline on Prescribing Opioids for Pain and the Centers for Disease Control and Prevention Guidelines on Prescribing Opioids for Chronic Pain to recommend evidence-informed opioid prescribing
- Focus on goals of improved function, increased quality of life and greater patient autonomy rather than a primary focus on pain relief

Five Focus Areas

1. Patient Identification and Population Management – identify patients with persistent pain with life activity impacts; use functional tracking tools (versus ones only tracking pain) and recommend patient reported outcomes
2. Care Team – provide one central point of contact for the patient, use a standard workflow and create a plan of action including a support system
3. Care Management – coordinate the collaborative care process including facilitation of care team access; identify resources and interventions for patients and facilitate referrals if needed; manage medication; do proactive outreach using an RN, social worker, pharmacist
4. Evidence-Informed Care (trauma-informed, medication-assisted care if needed) – develop and improve pain management skills; offer conventional medical treatment options e.g. NSAIDs as first line of treatment rather than opioids; address pain amplifiers such as sleep problems; use

integrative health practices (e.g. massage, acupuncture, spinal manipulation), and movement and body awareness strategies

5. Supported Self-Management – empower patients by focusing on abilities, preferences, assets and less on deficits and dysfunctions; identifying goals for resuming life activities and addressing barriers; pain education including understanding of the cycle of pain, pain and anxiety; work on shift from reactive to proactive thinking; identify/offer diverse resources for patients

Questions from Participants/Employers/Advisors

The injection piece is so common, and it is common for surgery to occur when not indicated. Are we saying do all of the other things first and if they don't work consider the injection or surgery if indicated?

The system is generally placing the "avoid" category of interventions (injections, surgery, medications) at the front door and thinking about using other therapies (complementary, alternative, integrative) if these interventions are not working. The system is structured backwards today, and we need to get the sequencing correct.

The biggest hurdle is that surgery, medications, and injections are easy and don't result in call backs to physicians. From a payer perspective, we make it easy to give meds and send patient on their way. From a provider perspective, they can see more patients. How do we get here without some massive overhaul of health care system?

Employers have the most vested interest but are not at the table. We rely on the physicians to make the right call, but we know they generally don't all of the time. We need policies instead of guidelines and the plan design has to be there. You have to go back to the carriers and ask: What is the appropriate level of control that gives people access to what they need? What is the appropriate review process for individualized care beyond that? There will always be some abuse. From an employer perspective, we have to balance ensuring that those who need the care get it, but not opening the flood gates at the same time.

How does the copay work?

As a payer, we (UHG) took patient out-of-pocket deductibles and co-pays down to zero to help patients with back pain. As a provider we're trying to scale and develop these truly integrated practices that have all of the services available geographically at multiple access points.

We use step therapy on the pharma side. Why not on the medical side?

Health plans have gotten in the way and contracting with providers also plays a role. We would have to get health plans to change the way they deliver care. There are competing incentives – generic opioid fills don't cost much money and injections are quick. Even though they are more expensive and quality questions abound, they are less expensive than, for example, unlimited PT throughout the year. There are cost containment protocols that employers demand.

How much analysis has been done on the demographics of those who have surgery versus use non-surgical options?

Barriers can play a role and include copays, lost work and childcare. They have started to do some work on thorough informed consent – if you sit down with a patient and clearly show the risks and benefits, patients are much more likely to opt out of surgery.

Closing Remarks

When participants were asked for takeaways and/or what the Advisory Board should focus on next, they responded:

I need to go back and ask good questions of my carriers, e.g. what they are doing in this space, what we are covering, what should we cover, what they are doing to promote this kind of activity. I also will look at my plan design to see what's covered.

Presenter's comment: That's a great idea, and just encourage you to explore the way the covered treatments were understood and coordinated as part of standard care, if they weren't highly utilized. Meaning, some plans have treatments covered but underutilized and say no one wants to use them, but in fact, it's because there is lack of understanding of their value, or perhaps their aren't adequate trained providers in the network.

We're trying to achieve integration/collaboration – very few are doing this well. I believe that, over time, we will find a group of providers who will crush the market as we see employers trying to pivot to those who can demonstrate outcomes. Some will lag and stay with fee-for-service that won't equate to outcomes we see here.

Look at how can we boil this down and bring forward three actionable steps that MBGH employer members can leverage.

To advance this before the plans and carriers are ready, we may need to create a navigator process, then get the word out to our employees proactively. We don't have enough leverage to make it happen in every market, so until it's available everywhere, we need to have a way to start to make it happen.

I agree with the idea of a pain navigator and providing an individualized pathway to manage overall pain. This gives the member something to lean on. If the patient is educated, they can ask the right questions of their provider.

I plan to clean up and rewrite my SPD.

Want to have a detailed conversation with my EAP – they may be my navigator instead of buying the service from another vendor. They already do great research when an employee calls in. We would need to appropriately train them and educate employees about how to use the resource.

We are hosting a collaborative vendor session, including compensation, equity, health/medical. Integration and a well-being/whole person approach will be the focus. We will be challenging our partners with this. We have carved out vendors, so what does integration mean in this situation. Our top of mind is challenging what we can control.