Transcript from AACIPM Fall Symposium

Behavioral Health as Part of Comprehensive Pain Care and Payment Design - November 12, 2020

51 minute transcript - accompanying video can be found here.

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Interactive Discussion: Connecting Social Determinants of Health and Solutions to Advance Integration of Behavioral Health, Integrative Health, and Primary Care

Stephen Gillaspy, Moderator (00:03):

All right. Well, thank you so much for that, Ruth. I hope everyone is back from break. We're going to go ahead and get started with the next section, which is going to be an interactive discussion connecting social determinants of health and solutions to advance integration of behavioral health, integrative health and primary care. So I want to start this off with saying we've heard about the importance of an interdisciplinary team of providers and pain care. We know that this pandemic has illuminated with even more clarity the challenges in accessing evidence-based quality care for all. So with that said, we're going to start off with Natalie Middaugh. Let me go ahead and give you just a little bit of background information about Natalie. She is the Community Health Program Manager at the Kentuckiana Health Collaborative, a nonprofit multi stakeholder organization that works to improve the health status and healthcare delivery system in greater Louisville, Kentucky, and southern Indiana. So with that said, I'm going to turn it over to Natalie.

Natalie Middaugh, Panelist (01:22):

Thank you for the introduction. As you said, my name is Natalie Middaugh. I'm the Community Health Program Manager with the Kentuckiana Health Collaborative or KHC for short. And it's an honor to be here, a part of this discussion today and share a little bit more about what our organization and our partners have been doing to improve behavioral health in our region. We bring together healthcare stakeholders of all kinds, including payers, providers, purchasers, policymakers, nonprofit organizations and patients. And a lot of our work is really led under the premise that as we are all part of the problems in healthcare, we must all be a part of the solution.

Natalie Middaugh, Panelist (02:03):

So for over 15 years, we've convened healthcare stakeholders underneath this premise to really advance our key organizational priorities of building healthier communities, improving healthcare quality and making healthcare more affordable. Our investment in behavioral health really began in 2017 at the height of the opioid epidemic. Seeing the impact of substance use

and mental health on their employees and their families, our employer members came together and gave us a call to action.

Natalie Middaugh, Panelist (02:32):

So the same year, the KHC partnered with the Kentucky Opioid Response Effort, also known as KORE, which is a federally funded program from the Substance Abuse and Mental Health Services Administration through the Kentucky Department for Behavioral Health and Intellectual Disabilities. This program really seeks to expand and sustain a comprehensive and equitable recovery oriented system of care to help in ending the opioid epidemic. The KHC and our partners at KORE realize not only the impact that substance use and mental health was having on employer business operations and employee well being but also the potential for employers to be a significant agent of change in remedying these issues. So with this recognition, and we have been engaged in a multi year partnership that has leveraged employer influence through a variety of educational and data initiatives.

Natalie Middaugh, Panelist (03:24):

Next slide, please. Thank you. So our educational initiatives have included a variety of resources as well as learning collaboratives. Our first development was in the spring of 2019 and was our employer toolkit around opioids in the workplace.

Natalie Middaugh, Panelist (03:43):

And what this was, a resource that really detailed for employers best practices around data analytics, benefit design and workplace policies for them to support their employees who are being impacted by substance use. And our focus here really started around opioid and substance use disorders but we quickly realized that it was also necessary for us to place equal focus on mental health and pain management as upstream approaches to curbing the opioid epidemic. And our thinking really shifted from encouraging a universal decrease of opioids to rather advancing comprehensive evidence-based pain management that may include opioid prescribing and tapering in a way that decreases opioid-related harms, while also ensuring that people who are experiencing pain are receiving appropriate care. With this realization, we later updated this resource to include best practices for employers around pain management through benefit design and data analytics.

Natalie Middaugh, Panelist (04:45):

The second major development in our educational initiatives was the formation of an employer cohort to focus on opioid misuse and pain. This group consisted of 22 employers who represented 23% of commercially insured Kentuckians. This group convene over a six month period to dive deep into the recommendations that were presented in the employer toolkit and really explore what their implementation looked like in their workforce, what were the successes or the challenges that they were seeing in putting these recommendations into action. Lastly, an ongoing initiative at the KHC is the formation of our work site addiction group, which is a multi stakeholder group that has been convening for over two years that continuously shares and collaborates around trends, innovations and challenges that respective organizations are seeing around behavioral health.

Natalie Middaugh, Panelist (05:37):

And now I'll go ahead and move on to the next slide to share a little bit more about how these educational efforts have been supported by multiple data initiatives focused on healthcare quality and health outcome data. Behavioral healthcare does not have the same quality outcome metrics available, such as there are for other conditions, such as diabetes or hypertension. And the KHC has really made it a focus of ours to figure out how we can measure these outcomes in our current landscape, while also working towards advancing the potential for measuring the outcomes and identifying optimal care.

Natalie Middaugh, Panelist (06:15):

So the opioids in the workplace toolkit provides metrics for employers to utilize health plan claims data to understand their trends and outcomes around the prevention, treatment and recovery of substance use disorders, mental health and pain management, and subsequently evaluate benefit and service offerings. To complement these metrics, the KHC partnered with IBM Watson Health to help develop state and national benchmarking data so that employers could compare their own claims data and evaluate where they stand in comparison to these trends over time.

Natalie Middaugh, Panelist (06:50):
Second, although the KHC does not produce community level data on our own, we do incorporate it heavily into our work, including metrics around the incidence of overdose deaths and prevalence of behavioral health conditions. This data also provides important information around who is experiencing these outcomes in our community. By breaking down this information by race, age, gender, socioeconomic status, geography and other important demographics, we are better prepared to ensure that our response and actions are equitable and not reinforcing existing disparities.

Natalie Middaugh, Panelist (07:26):

Moving on to some of our broader data initiatives, for the last 16 years, the KHC has led the way around healthcare quality measurement and transparency through consolidated measurement reports. These reports allow for a comparison to local and state averages and benchmark scores on the quality of care patients receive on a variety of ambulatory care indicators. The KHC is the only organization in our region that combines commercial, Medicaid and Medicare Advantage data for quality reporting. This data allows us to see where we have improved or haven't improved as a community in these key indicators of quality healthcare.

Natalie Middaugh, Panelist (08:08):

The metrics included in these reports are decided by the Kentucky Core Healthcare Measures Set. This set consists of 38 primary care measures that were identified by a panel of experts, representing consumers, providers, payers and purchasers from across Kentucky as highest priority for driving health improvements through measurement alignment.

Natalie Middaugh, Panelist (08:29):

On the next slide, you can see the five categories that are included in the set: preventative care, behavioral health, pediatric care, chronic and acute conditions and costs and utilization.

On the slide here, I've highlighted the six behavioral healthcare metrics that are included in the set. You'll notice that although a variety of metrics around conditions related to pain are included in the set, there are no metrics directly related to outcomes around pain. In our experience, standardized metrics for outcomes specific to pain management are not readily available. And I know we're happy to see that AACIPM is making measurement of these outcomes a focus in their work.

Natalie Middaugh, Panelist (09:10):

So moving on to the next slide, I have told you a lot about what our organization has facilitated. And now I want to move in to a little bit more about how our employer partners have responded and facilitated these changes within their organizations. So first, substance use, mental health and pain are all often misunderstood conditions that are accompanied by stigma. Our employers have really emphasized that in order to enact any change, whether it be around workplace policies, culture or benefit design, that organizational buy in and leadership buy in is key to change.

Natalie Middaugh, Panelist (09:49):

To facilitate this buy in, employers have really worked to challenge the stigma within their leadership as well as their employee population and educate the group around a number of key messages. Some of these key messages have included the fact that addiction is a chronic brain disease and not a moral failing, that mental health is just as important as physical health and something that we all have to maintain and take care of, and also expanding perspectives on what pain management looks like.

Natalie Middaugh, Panelist (10:21):

And we know that in order to educate and challenge this stigma, that these messages have to be passed down to employees in the form of words, resources and behaviors, and that the employer must really embody these messages to help produce a supportive work environment.

Natalie Middaugh, Panelist (10:40):

Second, you probably got the gist that KHC is a big fan of data. And one of the reasons that is is because we know that data is one of the most powerful tools that an employer has in their toolbox to really understand their population. We know that a number of challenges exists for employers in accessing their data. But through our work over recent years, we've really seen employers begin to look at their data more critically, and evaluate these trends and use that information to inform their benefit offerings, as well as their workplace culture and policies. We've seen employers establishing new relationships with data vendors and engaging their health plans in more transparent conversations on accessing their data.

Natalie Middaugh, Panelist (11:23):

We've also seen employers heavily engaged in ensuring that their employees are experiencing equitable care and outcomes. There are significant treatment disparities that exist around substance use, mental health and pain management. Our employers have really been on the forefront of discussions around ensuring that equity is at the center of healthcare delivery, and also looking through this lens for their employer population to ensure that the messaging and

workplace resources that they're providing, such as through their EAP, are promoting culturally responsive and equitable care for their employee populations.

Natalie Middaugh, Panelist (12:05):

Lastly, and this is kind of an all encompassing action of our employers, but they're really collaborating with their healthcare partners. And by bringing employers into the healthcare system, they are more prepared to connect their knowledge, the healthcare system challenges and therefore identify what their role is in remedying these challenges. By continuously engaging in conversations with healthcare partners, our employers are more informed around issues of behavioral health integration, shortages of mental health professionals, network adequacy challenges as well as challenges and successes around the expansion of telehealth. We found this to be particularly important during the time of COVID-19, as our healthcare system as well as our employers are undergoing so many rapid changes.

Natalie Middaugh, Panelist (12:52):

So all that said, I think a big message here is that this is really a long game for employers, and we've been at it for over three years and have seen great strides in how employers are thinking about and approaching behavioral health in their workforces and through their health and wellness offerings. This continues to pick up steam, and I only see this trend accelerating due to the significant impact that we are seeing COVID-19 have on behavioral health. And with that, I will turn it back over. Thank you.

Denise Giambalvo, Moderator (13:29):
Thank you, Natalie. We really appreciate the work that KHC continues to do as a sister coalition, and on behalf of the rest of our coalitions across the country, we really appreciate how you continue to move this along for all of us. So as we think about the needs related to the prevalence of qualified providers and racial inequities in our systems, it is important to mention some relevant topics that address improving overall well being. Health coaching and patient navigation are two important topics that have positive impact when caring for people with chronic pain, yet access is limited for many. Dr. Wolever, you direct the Osher Center for Integrative Medicine at Vanderbilt and Vanderbilt's health coaching program. Can you clarify for participants today what health coaching is and is not as it relates to clinical care and health plan coverage?

Ruth Wolever, Panelist (14:33):

Thank you so much, Denise. I hope I can clarify that. So let me say that I am a licensed health psychologist as well as a national board certified health coach and I've been working on helping people better understand what health coaching is and isn't. So that's where I want to start today. Coaches do not diagnose and they do not treat but they play a really key role in helping people enact desired changes or key parts of their treatment plan that are super challenging for chronic pain patients. This tends to be things like the need for more physical activity and movement, managing stress and doing a number of things that help to calm the nervous system, building social support, et cetera.

Ruth Wolever, Panelist (15:26):

So next slide, please. The methodology that coaches use is a set of communication skills that when packaged in a certain way has been demonstrated to support patients in enacting the change that they wish to enact. So it's a heavy use of really good active listening, of reflecting back what they're hearing and acknowledging patient's strengths, in provoking insight with key kinds of questions. And really importantly, and different than most other people on the healthcare team, the path forward is driven by the client and what the client wants to do.

Ruth Wolever, Panelist (16:12):

In most professions, including health psychology, the path forward is driven heavily by the professional as well as the patient. So when I'm wearing my psychologist hat, I'm thinking as I'm talking to the person, I certainly use all of these communication tools also. But I'm thinking as a psychologist, what is the picture here and what does it mean in terms of a skills deficit or a perceptual deficit that the person might need to help better manage their chronic pain?

Ruth Wolever, Panelist (16:47):

When I'm working as a health coach, I'm not thinking from the perspective of assessment and what the person might need to get somewhere. I'm thinking from the perspective of what is the person saying they want to do based on what they've learned that their treatment plan should be, and then I'm helping them to enact that.

Ruth Wolever, Panelist (17:07):

Next slide. So coaching uses a lot of visioning and linking changes that are needed to personal values of the patient. It's a very facilitative process, it is non directive. And sometimes this is hard to understand unless you've been in either driver seat or passenger seat for both roles, but I am going to try to help make it more clear.

Ruth Wolever, Panelist (17:34):

Next slide, please. So most of the healthcare roles that we have, and certainly health education and psychotherapy, particularly clinical psychology, come out of the biomedical model, where the problem is that people are looking for is a pathology of some sort. And the idea is to focus on fixing that problem, often motivated by fear or a desire to free for example, the person from pain. And the healthcare professional is an expert in a content area as well as the process to help somebody get better. So there's a lot of look at an assessment like what is the problem and what needs to happen here to get it fixed, and the objective is really to restore a person to their premorbid level of functioning.

Ruth Wolever, Panelist (18:31):

But health coaching comes out of a whole different research base. It's a learning or developmental paradigm, which works from the perspective of what an individual's goals are, what achievement or attaining those goals is actually possible for them. So the focus is more on optimal performance, and the motivation is more about happiness, growth, contentment, personal meaning, linking values to particular behaviors that are needed. And the coach is much more an ally of equal stature. It's a non hierarchical approach. And the questions that are

asked are much more about how do you want to move forward? What is it you'd like to do? The client, the objective is really to move the client to achievement of whatever they've articulated.

Ruth Wolever, Panelist (19:30):

Next. So what has happened in the field is that a lot of people have done a lot of different things and called them coaching. But there's huge heterogeneity, a lot of different, a lot of variability. So a group of us started working together 10, 11 years now, ago, to get clear on a uniform job definition for health coaching. Even a lot of coaching companies themselves are doing different things and calling it coaching, but it's only been in the last few years that there is a consistent job definition emerging. It's important to have a consistent job definition because that's what will allow appropriate scope of practice, that will allow and clarify best practices to be defined, allow the accumulation of a rigorous evidence base that clarifies what actually works and what doesn't work, and what are the mechanisms of it. And then the uniform job definition can also help people to develop practice guidelines and training standards.

Ruth Wolever, Panelist (20:32):

Next slide. So the definition for health and wellness coach that is supported by the National Board for Health and Wellness Coaching arose from a systematic review that a team of us did and published in 2013, and a job task analysis that we led to clarify what it is that coaches do and what they don't do. And the job task analysis itself was then up leveled by National Board of Medical Examiners, who formed a partnership with this nonprofit group to add input from subject matter experts in training and education of coaches.

Ruth Wolever, Panelist (21:16):

Next. So this is just a quick snapshot of a job task analysis, the things I've called out in purple here or tried to call out in purple are things that are really different than other professions, including psychotherapy. So for example, there's the creation of an ideal vision, there is exploring a person's readiness to move toward that vision and helping them to look at patterns. There's not interpretation of patterns or interpretation of beliefs, like there is in psychotherapy, but there is the asking of questions so that individuals themselves can see how their patterns may be impacting them.

Ruth Wolever, Panelist (22:07):

Next slide. The National Board for Certification and Health and Wellness Coaching started. We gave the first exam in 2017. We now have about 3,200 nationally board certified coaches. We have close to 100 training programs that have been approved to graduate people that are eligible to sit for the exam. And the completion of that approved training program is really important because it covers all the clear tasks of job task analysis and trains on scope of practice as well.

Ruth Wolever, Panelist (22:45):

Next slide. The exam is given twice a year. And when we first formed, we tried to get all the players on the same field. And so originally, there was a 30 hour training process and particular practical skills had to be delivered and tested on. That has been up leveled. It's now a 75 hour training process at a minimum and the practical skills assessment is much more complex.

Ruth Wolever, Panelist (23:16):

Next slide. So I want to just underline that there is now this standard that has emerged and it is the only national standard that was developed by 75 different stakeholder organizations, and it is in contrast to patient navigation. Patient navigation is also a hugely important role, but it's different. It grew out of critical gaps that were observed starting in the 90s between the finding of a suspicious, something that looked to be potentially cancerous and the acquisition of diagnosis and treatment. Subsequently, the scope of practice for navigation has expanded across the continuum from prevention through to survivorship.

Ruth Wolever, Panelist (24:05):

Next slide. What navigators do is help address barriers to timely care. This is not what coaches do. What navigators do is help people that have access barriers about finances, insurance coverage, communication barriers, working the system barriers, and often there is an emotional component to it.

Ruth Wolever, Panelist (24:32):

Last slide please. So what I hope you take away is that there's a difference in psychotherapy and coaching and navigation and a little more clarity, hopefully on the different roles. All three roles are hugely important in the treatment of folks with chronic pain. This is the specialty that we have at the Osher Cnter for Integrative Medicine at Vanderbilt and we have these people all on our team. Coaching is used to really support patient activation to engage in the behavioral changes that are needed that come from a treatment plan, but that are driven by the patient. And there is a lot of data that supports the ability of coaching to help boost self confidence, encourage people's persistence, and create a really positive atmosphere wherein they feel empowered. Thank you.

Stephen Gillaspy, Moderator (25:36):

Thank you so much for that great overview of health coaching and helping distinguish the difference between health coaching and patient navigation as well as psychotherapy. So thanks so much. We're going to move on to our last speaker, which is going to be Dr. Seidner. He is the Chief Medical Officer at The Hartford, where he has direct experience with success of integration of behavioral health and primary care for pain. So with that backdrop of the pandemic, we'd like to kind of pick your brain about what is important for participants to understand about the impact of social determinants of health, patient reported outcomes when working to advance integration of primary care with behavioral health and other evidence-based non-pharmacological therapies for people with acute and chronic pain.

Adam Seidner, Panelist (26:37):

Thank you, and good day, everybody. So we'll walk through this and one other slide, but there's a number of things we have to understand is that the primary need for a person is to feel secure, respected and cared for. Only about a third of patients agree providers take the time to understand their needs and explain treatment options. And so that's primarily in the traditional or biomedical, biopsychosocial model that medicine has been aimed to diagnose, treat and/or cure and alleviate symptoms, but really the integrative care much more powerful. Yes, it looks at

relieving symptoms and restoring wellness as well as helping patients in process of self healing. So this coaching and health goal attainment is critical as part of all of that, and we have to understand that there are protective factors as well as risk factors that individuals have.

Adam Seidner, Panelist (27:36):

So the biopsychosocial model has been expanded by Dr. Fricton out of the University of Minnesota. And we have to recognize, I think, first and foremost that we can prevent the individual who has acute or subacute pain from developing chronic pain, using multimodal models and the integrative approach is an excellent way to achieve that, and there's been many studies looking at post surgical, post trauma models to achieve that.

Adam Seidner, Panelist (28:07):

So with that, it's a difficult time. COVID is a difficult time for everybody. But it's a difficult time for any person who's ill, who's managing a chronic disease, who's undergoing surgery, who's got some work-related injury or illness. And so with all of that, there's increased anxiety and stress. And we just need to remember that stress is a modifiable and important factor. It's modifiable. So how do we get there? It's important to view the whole patient.

Adam Seidner, Panelist (28:41):

So this is where we get into the biopsychosocial model, the expansion that I mentioned from Dr. [inaudible 00:28:47] on the human systems approach, which gives a lot more granularity. And one way is to bring this all together, an integrative approach. If you adopt that, you're able to look at the behavioral health and bring together that primary care, as well as bringing in evidence-based non-pharmacologic treatment.

Adam Seidner, Panelist (29:08):

And so one of the things that I look at as a payer is claim severity. So how can I predict claim severity? And so I'll look at clinical risk factors and people are familiar with those, their comorbidities, issues of diabetes, body mass index, tobacco use, but all of that comes together as well but doesn't explain all the severity. So I think we need to really expand our model, which again, the human systems approach does, but look specifically at the social determinants of health. And that really has been able to give us much more insight as we look at and try to understand what an individual may need to be successful and really achieve the greatest function and functionality that they can.

Adam Seidner, Panelist (30:01):

And so remember, as we walk through, there's the psychosocial issues. And so how do we understand that patient and how do we approach the mental health, behavioral health issues? One of the things I'll say is we've talked a lot about various different clinicians and interventions. But also remember that we're in the digital age and there's digital therapeutics that are now available that need to be thought about as we move forward with all of this, which again may be impacted by that person's social economic status, whether they have access. We've talked about, and other speakers have talked about whether an individual is going to have access to this, but re-SET-O is now a prescribed digital therapeutic for people with substance use disorder, for opioid use disorder. There's other programs out there for sleep, such as Sleepio.

Adam Seidner, Panelist (30:59):

So we have to be sensitive to the social and economic aspects of individuals as we move forward. That also goes to the telemedicine, telerehab, telebehavioral health that we're looking at. So it's important also, I think, to bring in the pharmacologist, even though we're looking at a lot of non pharmacologic, they are an asset as well. So all the stakeholders need to be engaged so that we can make sure that if there's high risk drugs involved, whether they be opioids or combined with a muscle relaxant or combined with a benzodiazepine, that we make sure that individual isn't harmed in any way.

Adam Seidner, Panelist (31:45):

And I spoke already of some of the comorbidities, but not being able to really predict how severe an individual's going to be moving forward. So some of the things to look at relative to social determinants of health, again that's social and economic. So what is the economic stability of the individual? Do they have food access? Is there food insecurity? What's their education level? Is there issues with regard to health or medical literacy that need to be addressed? Generally, what's the physical environment? Is there any concern around household security, housing security and household density as part of that?

Adam Seidner, Panelist (32:30):

So as we move forward with some of the areas that we're dealing with, COVID-19 in particular, we're seeing the inequities impact these populations as well. And we see this in the work comp world, as well as in our group benefits work, which is short and long term disability as well. So as we move forward, case managers, which are traditionally the adjusters, what we've done is to move them to become advocates to really look at the patient or the employee from an employee centric view, in total, and really to make sure that they're displaying and engaging in empathy.

Adam Seidner, Panelist (33:19):

Next slide, please. So the empathy really will do a number of different things. It will decrease anxiety, it can decrease stress. We have health coaches as well. It's all voluntary. If a claimant wants to engage with them, a person wants to engage with them. And really, I think some of the areas that have been important to think about as we partner with various different individuals and other stakeholders and the patients themselves is coverage and reimbursement, which you've talked intermittently about through the sessions today.

Adam Seidner, Panelist (33:58):

And so we have engaged in alternative payment models with providers just to make sure that they have enough freedom to be able to provide the care that they deem appropriate for their patient, with minimal interference from us as a payer. And just remember other things that all the clinicians are doing is they're helping define and deliver coping skills and strategies to the people. And so they're able to help with this fear and fear avoidance, which some people may have or catastrophic thinking on psychological and social issues, as well as any perceived injustice that may have if they've sustained an injury from a work exposure.

Adam Seidner, Panelist (34:49):

So with all of that, there are a number of resources that are available that I think all need to be aware of and be able to provide to individuals based on their needs as I mentioned, whether it be the medical conditions, but particularly for their social determinants of health, and what their needs are going to be and to get there, I think this integrative approach, a proactive approach, a patient centric approach is the way that we're able to achieve that. And that's it, Amy.

Stephen Gillaspy, Moderator (35:31):

So one question I wanted to pose to the panel members, when we talk about reimbursement and codes, that really focuses on the traditional fee for service venue. I think we all know that the future is going to be advanced payment models or alternative payment models and more value-based care. So I have two questions. One is just to get people to kind of respond to what do you think value based care might look like in regards to pain management. And I think the next part of that goes into what might be some of the metrics when we think about paying. I know one of the panel members earlier on mentioned that there are not really established metrics for pain. So does that look at functioning and things like that. So just wanted to throw that question out there for panel members.

Adam Seidner, Panelist (36:29):

This is Adam. I can start, and then turn it over to other panel members for their thoughts. I think first and foremost, we need to understand that even the value based payment model isn't the endpoint that we need to be at. We need to have a patient centric payment reimbursement model. And so for folks that aren't familiar with all of the different models, Harold Miller has the Center for Healthcare Quality and Payment Reform that's out there and talks about all the different types of reimbursements and what worked best looking at underutilization, overutilization, and also the responsibility that the clinicians have as we move forward.

Adam Seidner, Panelist (37:13):

So it will be a hybrid model. There may be some services that are underutilized that fee for service would be the answer for. There's other services that may be taken care of under a bundled payment, and they're used appropriately. So we just want to make sure that the right amount of service is given to that individual. And remember, the issue is not necessarily a goal. The goal should be to care for each person the right way, not necessarily the same way. And so that is the importance I think of all the things we've talked about from the health coaching, the cognitive behavioral therapy, mindfulness, motivational interviewing, and something that hasn't come up is something called shared decision making, to really understand the expectations of your patient, and understand what intervention is going to work best for them.

Stephen Gillaspy, Moderator (38:19):

I think that's right on track. In fact, I wonder if Amy, probably the idea came up, she's going to start marketing t-shirts with that slogan on it that patients don't need to be treated the same way but the best way. So that's a great comment. Natalie, do you want to comment on the value based care?

Natalie Middaugh, Panelist (38:42):

Yeah, sure thing. So I'll start with the second part of your question because I mentioned earlier, the difficulty in measuring quality outcomes around pain, and also speak to this from the provider perspective and... or I'm sorry, employer perspective, and some of the challenges that we ran into when we were looking at what claims data should employers be looking at to evaluate the quality of care that their patients are receiving. We know pain is often a symptom rather than a condition. And when we're looking at data, employers often look at that by condition and outcome. So there was a disconnect there with linking pain itself with any claims data, and just yeah, similar track with the quality metrics, we typically abide by metrics that are nationally standardized, usually HEDIS measures and the metrics just aren't there for pain and from my understanding, it is the similar problem and they haven't been decided upon. And so looking at those outcomes you mentioned, quality of life, functional assessment, and I think it's all of the above. I think we need to consider all of these things in identifying what that value is.

Ruth Wolever, Panelist (40:10):

I could add to the measurement piece. The NIH has put 120 million plus into the development of what are called PROMIS measurements, patient reported outcomes measurement information system or something. So they're free to everybody. And the whole idea was that, because there were lots of different ways to measure, lots of independent different scales for depression, for pain, for fatigue, et cetera, they went through a very complicated process of figuring out using item response theory, a particular way of using the minimal question numbers you can use to get at an answer. It's a long winded explanation. But suffice it to say that using the PROMIS pain measures would be actually a really useful tool. It's a patient centered approach, and there's great validation behind it.

Denise Giambalvo, Moderator (41:08):

Thank you. So I'll just jump in with a little bit of commentary. So the shared decision making, which is certainly where we see all of this moving, we talk more and more about the importance of that and putting things back in the physician's hands and expanding that beyond this. So other clinicians besides physicians, I want to make sure that we don't forget about the pharmacists and their role. So as we talk about integrative pain management, it doesn't mean that the drugs aren't being used. And many forget the key role that a pharmacist plays in this decision making process.

Denise Giambalvo, Moderator (41:52):

And then Dr. Wolever, thank you so much for how you laid out the difference for therapy, behavioral therapy versus health coaching, and then the role of the navigator. And so as we think about bringing the metrics in and identifying value, so quality for what you're paying and how disparate and disruptive our system can be in terms of trying to get integrative care, how do we bring that together? So not everyone can go to a Vanderbilt. So how do we have more navigators? What's the answer to this? And is part of it how the payment model is set up to drive that?

Ruth Wolever, Panelist (42:57):

So I definitely think part of it is the payment model? And I don't have the answer to Adam's good point. I think it's going to be a little of this and a little of that. He said it much more articulate than that, but it's going to be a mixture of models. I think we have a lot to learn still about triage processes, and who's really needed to do what. And the challenge in that is that some of the things that help us figure it out are not covered in the traditional fee for service model like case conferences. Somebody was making that point earlier. So the communication part is the most crucial part in terms of all the multiple disciplines really, truly working together as opposed to just sending reports to each other. Yeah, I don't know the answer. But at least we're certainly preaching to the choir. We're all singing the same song here.

Denise Giambalvo, Moderator (44:06):

Yeah, yeah, which is a good start and moving this discussion on, I think that's how we get to the answer. Adam, do you have anything additional you'd like to add?

Adam Seidner, Panelist (44:20):

Well, again, I think we as the clinicians, as a part of this, need to be at the table with the payers because the payers will come in with their metrics and what outcome measures they want to look at, which may be very different based on if you're a group health carrier versus a work comp carrier, property and casualty. So all of you need to understand that they'll come in with their outcome measures, but you need to come in with what you think is appropriate as well. And remember that as we talk about function as well as quality of pain and how well it's been managed, that there are some validated instruments out there that can be used to really measure the function of that individual, and that's really I think what we're looking at is how functional can this individual be. They may still have some pain, but they still may be able to function much better because of the interventions that you're providing.

Denise Giambalvo, Moderator (45:20):

Sure, I can speak to that because I broke my radial a year and a half ago and my wrist. And so through that physical therapy, they kept running tests, how was my flexion and strength and all those things. So yeah, even though they said I was back to fully functioning, I wasn't feeling that way. I can't argue with the numbers. Natalie, I know that it took you a couple of years to bring those stakeholders together so that I'm talking about bringing the providers in, and getting everyone to talk on those measures. Do you want to share a little more about that?

Natalie Middaugh, Panelist (46:10):

Yeah, sure thing. And so yeah, as I mentioned, it's been a long game bringing all of these groups together. And I mentioned earlier that we started around substance and opioid use disorder, which really we had a community case for bringing these stakeholders together. Not to shortchange us but it didn't take a lot of convincing that some work needed to be done. And really our journey through increasing our focus on mental health as well as pain management, came from this group. By bringing this group together, we were able to really dissect the subsequent issues that we saw were playing in into opioid and substance use disorder. And we really continued on that journey.

Natalie Middaugh, Panelist (46:58):

As I mentioned a couple times with COVID-19, just seeing the rapidly changing landscape around healthcare, how people are accessing behavioral health, the changing regulations, the changing regulations around payment and how people are experiencing those things, we continue to adapt and reform our mission and our work based on the feedback that we're receiving from the stakeholders. So it really is just so crucial to have all those players at the table, particularly seeing the army, we really lead through the employer position. So keeping the employer engaged with the other stakeholders has really been effective and reaching consensus on the changes that we need to see.

Denise Giambalvo, Moderator (47:49):

Thank you. I'm not seeing additional questions. If there are more questions, please submit them. Stephen, do you have anything you want to ask?

Stephen Gillaspy, Moderator (48:00):

Well, I was just going to say, I know we've got just a couple, maybe two minutes. So I didn't know if any of the panel members kind of wanted one last shot to kind of parting thoughts or take home messages before we wrap things up.

Adam Seidner, Panelist (48:19):

This is Adam. Just one other thing to raise awareness on is during any of these stressful times, when someone's ill, not working, or going through a pandemic, we really need to assess the interpersonal safety of the patients. So we know that after catastrophic events, there's an increase in domestic violence and abuse, and all of that, all the social determinants of health, which I quickly outlined, really could lead to either an engagement or disengagement with regard to the treatments that are being recommended. And so the compliance adherence aspect is critical to all of this. So again, just going back, patient centric, person centric approach, and really understanding the whole person is critical.

Ruth Wolever, Panelist (49:13):

Yeah, I'll just piggyback on that. Samantha Rafie I think is her last name, and I were having this chat dialogue, that the whole person perspective is so important, because as opposed to there being a mental and a physical side, and then insurance not being responsible for the social side, or like these artificial divides, we of course all know that that's what they are. They're artificial divides. And the one thing that we see in coaching all the time is that even if a person isn't ready to do the particular thing that all the providers agree is the most important thing, they're always ready to do something to improve their wellbeing. For a lot of people, it might be manage stress, it might be shift a relationship, it might be something along the social determinants of health, but people are always ready to do something. And so if we open it wider, then they gain some traction doing something and get some self efficacy, and some more confidence going that they can impact their world and that success then breeds success. So just really underlining the importance of the whole person whole being.

Denise Giambalvo, Moderator (50:34):
Natalie, any parting thoughts?

Natalie Middaugh, Panelist (50:37):

Yeah, well I'll just add right on to that, people want to be healthy, and it's our responsibility as health stakeholders to make sure that people have access to the options that promote their optimal health. So I think that's the consensus of this whole conversation and the message that we are going to take away.

Denise Giambalvo, Moderator (51:01):

Thank you. I think that Amy, you want to come back in?