Duke MARGOLIS CENTER for Health Policy

Duke Orthopaedic Surgery
Duke University School of Medicine

Part 3 of a 4 Part Series

CASE STUDY | October, 2021

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Exemplary Integrated Pain Management Programs:

People's Community Clinic Integrative Pain Management Program (PCC IPMP)

SUMMARY

Background

The Integrative Pain Management Program (IPMP) is based within People's Community Clinic (PCC), a Federally Qualified Health Center (FQHC) in Austin, Texas. The IPMP was established in 2018 after grant funding from the Health Services & Resources Administration (HRSA) was provided to expand mental health services and address the opioid epidemic.

Care Delivery Approach

The IPMP aims to treat pain and improve patients' functioning and quality of life while reducing the use of pain medication and other substances. The program, and PCC more broadly, equips patients with the necessary skills to manage their pain and advocate for themselves and their care needs. The IPMP care team includes primary care physicians, social workers, yoga therapists, acupuncturists, attorneys, and a nutritionist.

Results to Date

Program staff described that benefits of the IPMP can be challenging to measure directly, especially while the IPMP is relatively new, but preliminary outcomes data and patient feedback have been promising. Findings from interviews with patients indicated that the IPMP has contributed to improvements in quality of life, diminished stress, increased self-efficacy, and new skills to cope with and manage pain. The IPMP has also experienced steadily increasing demand and patient volume since inception.

Key Features of the Program

- **An approach to care that promotes and supports relational health.** Program staff noted that many patients' experiences with pain are rooted in trauma, so the IPMP aims to holistically address the root of these experiences and work towards personal and interpersonal rehabilitation. This approach involves building trusting relationships among patients and providers, fostering a sense of community and belonging within the program, and providing a safe space for patients to try new things (e.g., food, movement, relationships, or simply practicing receiving care from another person).
- **Medical-legal partnership (MLP).** The IPMP has attorneys on staff to assist patients with health-harming legal and social needs, such as financial strain, housing instability, or food insecurity. When legal needs are identified during new patient intake or by another provider, the IPMP attorneys conduct legal intake interviews and can provide patients with counsel, legal representation, and/or assistance with systems navigation to address these needs.
- **Group medical visits.** The IPMP offers group medical visits in English and Spanish based on an eight-week curriculum, which covers information including nutrition and anti-inflammatory diets, stress and trauma, health-harming legal needs, exercise and movement, and sleep. These groups have been impactful for patients as they learn from one another and learn more about options for managing their pain.
- **Community-based partnerships.** The IPMP has partnered with local organizations in the community, including a non-profit law firm, yoga therapy providers, and a school of integrative medicine to help provide integrative services to patients.

Challenges with Implementation

The IPMP's largest challenge is financing. Since services are primarily supported through grants, the IPMP has limited capacity to sufficiently expand services to match patient demand. At present, many of their services have long waitlists. Reimbursement challenges have also limited the IPMP's ability to expand. However, the IPMP has worked creatively within these constraints to offer a variety of integrative services through partnerships with community-based organizations. In the future, the IPMP hopes to build sustainability for the program through additional grant funding or an alternative payment model.

IPMP Details

Location: Austin, TX
Website: https://www.austinpcc.org/our-programs/adult/integrative-pain-management-program/

CASE STUDY

TABLE 1. Overview of Pain Management Program

Organizational Description	The IPMP is based in PCC, an FQHC. As an FQHC, PCC receives HRSA funding to provide care in medically underserved areas. PCC sees approximately 20,000 patients per year. Currently, over 130 patients are enrolled in the IPMP.
Pain Management Services Offered	Acupuncture, behavioral health counseling, exercise, group medical visits, primary care, nutrition, substance use treatment, yoga therapy, and legal aid for health-harming legal and social needs.
People Served by the Model	Most IPMP patients are underinsured or uninsured. 86% of PCC's patients have incomes below 200% of the federal poverty level. Many patients have experienced substantial trauma (related to adverse childhood experiences, racism, discrimination, and poverty). 84% of PCC's patients are Latinx, and many patients are immigrants or refugees. 61% of PCC patients are best served in a language other than English (predominantly Spanish).
Key Innovations	Approach to care that promotes and supports relational health; medical-legal partnership; group medical visits; community-based partnerships.
Local Market and Context	The IPMP operates in Austin, TX, which has a population of over 950,000 people.
Evolution and Buy-In	PCC's culture and holistic model of care helped to generate buy-in for the IPMP. A physician champion worked to integrate existing services to treat pain more comprehensively, and services have expanded over time with additional funding.
Financing & Infrastructure	The IPMP is mostly grant-funded. Two HRSA grants, which are ongoing, have provided the necessary funding for program development, infrastructure, and staff. Some services, including nutrition and MLP, are covered by PCC's general fund. The IPMP also receives some funding from private foundations.
Implementation Challenges	Challenges with reimbursement and expansion of services
Results and Key Outcomes	Increased demand and patient volume; positive patient feedback

Historical Context

PCC was founded in 1970 by a team of volunteer physicians and nurses to provide accessible and affordable care to uninsured and medically underserved patients in the Austin area. From the beginning, PCC's culture has been grounded in partnering with patients to provide holistic health care and health education. In 2012, PCC was designated as an FQHC, allowing them to receive federal funding to provide care. This designation aligned with PCC's existing culture and values, as FQHCs generally provide holistic care and integrate medical care with other services, such as behavioral health and wraparound services.

Before the IPMP was created, PCC offered some integrative services, including acupuncture, nutrition, behavioral health, and medical-legal services for pain-related and non-pain-related care. Acupuncture has been offered at PCC since 2003 through a partnership with the AOMA Graduate School of Integrative Medicine, also based in Austin. In 2013, PCC partnered with the Texas Legal Services Center, a nonprofit law firm, to begin an MLP to better address upstream social and legal factors that influenced patients' health.

"People's has always looked beyond just the very clinical, [and the idea] that we take care of what's in the four walls and nothing else. We go beyond that. We have all these programs because we believe in a more holistic model of care, that you have to look at all the elements in someone's life to really understand what's causing their illnesses, but also to lead them to optimal health and wellbeing."

In 2017, PCC received a HRSA grant that provided funding to expand access to mental health and substance abuse services, with a particular emphasis on addressing the opioid epidemic. Although few PCC patients were using opioids at the time, the medical staff recognized that many patients had a significant risk of developing opioid dependency if it was the only option for treating pain, due to the prevalence of trauma and other mental health conditions. PCC decided to build an opioid prevention program that would provide patients with evidence-based non-opioid treatment options, aiming to mitigate opioid prescribing. PCC hired a physician to build the program and the physician recognized that although PCC was already providing a range of services that could impact behavioral health and pain, these services were provided separately. This physician became the champion of the IPMP. Based on previous experience with providing integrative medicine to address pain in medically underserved populations, the physician worked to better integrate the clinic's existing services to treat patients' pain and its root causes.[1]

"I think the nice thing about an FQHC is that there is already this understanding of integration of services because we are supposed to be integrating medical and behavioral health and dental at the very minimum, but we always have a lot of wraparound services, too. So when you're just saying ..." let's add in yoga therapy, let's add in acupuncture, it's not that hard of a sell, especially if there's data or evidence around it. So it made it easier, I think, to say, 'Let's just bring these in.'"

PCC's leadership was supportive of the proposal to create the IPMP as it fit within PCC's holistic approach to care. As an FQHC, at least 51% of PCC's board members must be patients; one of the board members had participated in an IPMP group medical visit and was able to generate additional buy-in for the program by talking about it with the rest of the board and leadership. The physician champion highlighted the importance of multidisciplinary work, as each member of the care team brings value to patient care.

"You cannot overvalue the importance of having leadership that's backing this kind of initiative. I think the other thing is champions … you have to get buy-in from the people on the ground, because otherwise, you're telling very busy practitioners who are already trying to do this immense job… to consider this."

Program Details

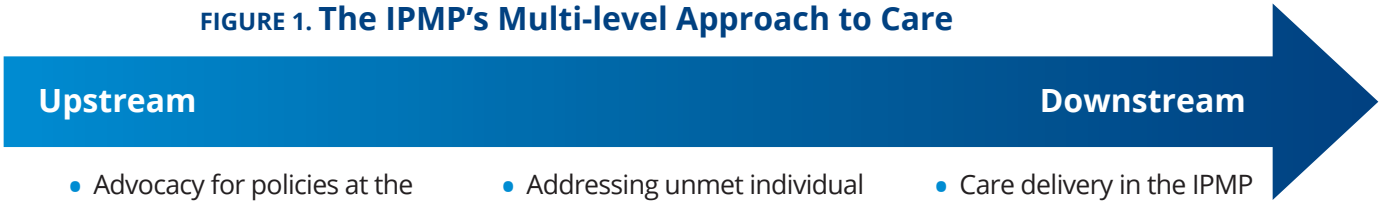
The IPMP aims to help patients manage chronic pain and improve functioning and quality of life while reducing the use of pain medication. The IPMP also works to build patients' senses of self-advocacy ("representing one's own interests within the health care decision-making process") and self-efficacy ("belief in one's capacity to manage their pain"). The IPMP is structured to empower patients to choose the services they want to engage in. **Table 2** outlines the IPMP Theory of Change model, which outlines the strategies, targets, and ultimate goals of the program.

The majority of patients served by the IPMP are uninsured or underinsured, and many patients have experienced substantial trauma related to adverse childhood experiences, racism and discrimination, and/or poverty. Program staff noted that many patients' experiences with pain are rooted in trauma, so the IPMP aims to holistically address the root of these experiences and work towards personal and interpersonal rehabilitation. This approach involves building supportive and trusting relationships among patients and providers; fostering a sense of community and belonging among patients in the program; empowering patients to make choices about their care; and providing a safe space for patients to try new things, including new modalities of pain treatment.

"I think that the design of this program reflects our shared view that physical and emotional/spiritual pain are not separate categories, and that we can contribute to our patients' healing (and our own) by fortifying our sense of belonging in this community – starting with our small IPMP community… these ideas undergird the program design and are reflected in the services we've chosen to offer and the manner in which we do so."

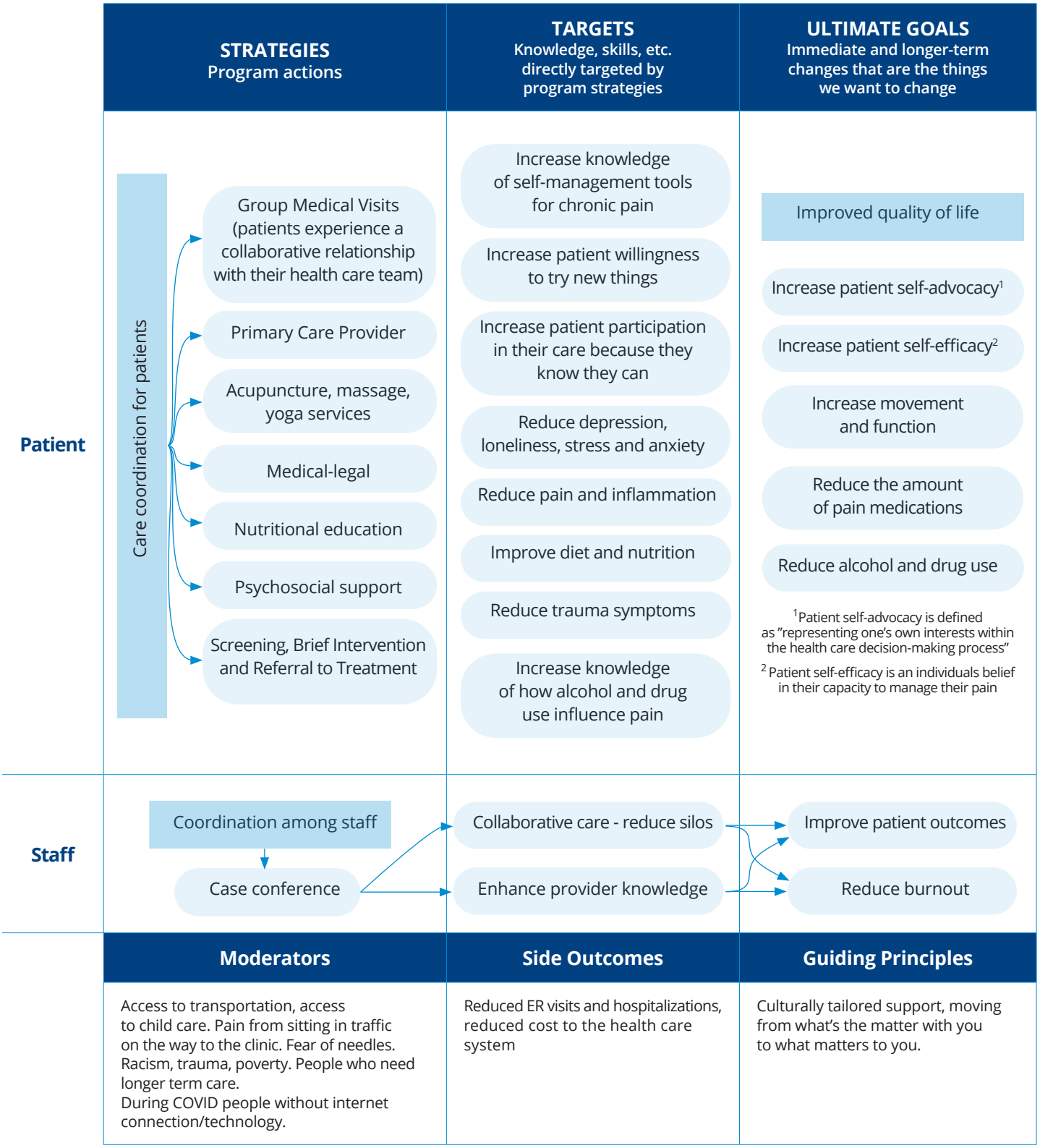
The IPMP also takes a multi-level approach to care. The delivery of medical and integrative services represents the downstream approach, while connections to necessary social and legal services through the MLP address more upstream factors. Staff work to make the clinic feel like a safe and welcoming space for all patients; services are not denied based on patients' insurance status, legal status, or ability to pay. The IPMP's multi-level approach also includes an intentional advocacy component. To address policy-level upstream factors that influence health, staff at the IPMP (and PCC more broadly) advocate for local, state, and federal policies that impact their patient populations.[2] For example, PCC staff advocated against Medicaid work requirements, recognizing that the policy would create additional barriers for patients with disabilities.[3] Interviewees noted that these health advocacy activities have also benefited staff by offsetting some of the burnout and stress associated with their clinical work. **Figure 1** visualizes this multi-level approach to care.

FIGURE 1. The IPMP's Multi-level Approach to Care



- Advocacy for policies at the city, state, and national levels that impact health
- Addressing unmet individual social needs (through medical-legal partnership)
- Care delivery in the IPMP
- Approach to care that supports and promotes relational health

TABLE 2. IPMP Theory of Change



The Theory of Change was developed using the IDEAS Impact Framework, which was originally developed by the Center on the Developing Child in partnership with the University of Oregon Center for Translational Science, and the University of Washington College of Education.[6,7]

"Our integrated program is truly integrated. So it's not just a referral network. It means that if someone is in a group medical visit, for instance, or in one of the education sessions, that these ideas [about social needs] are all incorporated at the point of those services, and then enter case conferences as well."

The IPMP has expanded over time with additional funding and patient demand. Currently, IPMP providers include primary care physicians, social workers, yoga therapists, acupuncturists, attorneys, and a nutritionist. **Figure 2** lists the services offered at the IPMP.

FIGURE 2. Pain Management Services Offered

- Acupuncture
- Behavioral health counseling
- Exercise
- Group medical visits
- Medical-legal partnership
- Primary care
- Nutrition
- Substance use treatment
- Yoga therapy

Medical-Legal Partnership

An innovative aspect of the IPMP is its MLP, which aims to address legal and social needs that impact patients' experiences with pain and their overall health. There is promising evidence that providing legal assistance to patients can reduce unnecessary health care utilization and spending.[4] PCC has had at least one full-time staff attorney since 2013, and have since brought in additional attorneys and paralegals to help with the MLP part time.

Across the country, MLPs aim to address issues through the "I-HELP™" model of understanding health-harming legal needs: income and insurance, housing and utilities, education and employment, legal status, and personal and familial stability.[5] At the IPMP, many patients experiencing chronic pain seek assistance from the MLP with applying for disability benefits and accommodations. The MLP can go beyond advocating for patients by providing counsel, legal representation, and assistance with systems navigation to meet legal and social needs, such as housing and food assistance, and public and disability benefits. The legal assistance provided by the MLP can greatly decrease patients' stress and facilitate improved engagement in care.

"The medical-legal team is so important in this because if [patients] are getting evicted, they're not going to focus on whether or not they're eating healthy."

In the electronic health record (EHR), the MLP legal team records "legal diagnosis codes," "legal acuity level codes," and legal outcomes based on standardized national and state systems, which are shared with other IPMP providers. Practitioners on the ground have been supportive of the MLP to help them address non-clinical contributors to pain, and feel comfortable with referring patients with legal and social needs. Interviewees described that adding the responsibility for meeting patients' social needs onto practitioners, who lack adequate training and time, would have been unsuccessful. Having members of the care team who are trained experts at addressing patients' legal needs, which often overlap with social and medical needs, has been critical to the IPMP's overall success.

"Our clinicians know that they need to ask about the home and that they don't have to be afraid to ask about the home because we have experts who are ready to deal with that on site."

* For additional information about PCC's MLP, see Using the Law to Inform Empowered Patient Care in Austin and Bringing Lawyers Onto the Health Center Care Team to Promote Patient & Community Health.

Provision of Care

Patient Referral and Conditions of Care

There are multiple entry points for patients to receive care at the IPMP. The IPMP has had a full-time care coordinator since 2019 who manages the program and patient referrals. Referrals to the IPMP have primarily been generated through word of mouth to limit demand due to current capacity and funding. Other providers at PCC also stated that they appreciate being able to refer their patients experiencing pain to an internal resource. Moving forward, the IPMP staff is working to conduct more outreach regarding the program in the neighborhoods surrounding the clinic.

When patients are referred to the IPMP, the care coordinator reviews their medical records to ensure they have chronic rather than acute pain. Patients who participate in the IPMP must also have a behavioral health diagnosis, with common diagnoses including anxiety, depression, post-traumatic stress disorder (PTSD), and attention-deficit/hyperactivity disorder (ADHD). Many patients have significant complex trauma related to early attachment relationships with caregivers, which impacts their experiences with pain and medical care. The care coordinator then contacts referred patients who qualify for the program to describe program details, review services offered, and explain how these services can address pain. During this intake call, patients can indicate the services they are interested in, and the care coordinator helps to schedule their appointments. Once patients have started receiving care through the IPMP, their providers can refer them to additional services as they see fit, or patients can self-refer. The care coordinator continues to follow up with patients who are in the program to ensure continuity of care.

The frequency of IPMP visits and length of time in the program tend to be individualized. Patients can generally continue to receive services as long as a provider deems it is necessary. Due to capacity limitations, yoga therapy and acupuncture services are generally provided to a patient for eight weeks, at which point a provider will reassess the patient and determine whether to continue services. If patients are interested in continuing services long-term, providers are able to refer patients to a variety of services in the community. When patients are referred to the IPMP, staff clearly state that the program staff do not prescribe medications. Beyond this, the IPMP does not set any strict requirements or expectations related to adherence to treatment or substance use.

Group Medical Visits

Group medical visits, while optional for patients, are a defining feature of the IPMP. Groups are structured in eight-week cohorts and are offered in both English and Spanish. A physician, a social worker, and a nutritionist co-facilitate the groups and use a flexible curriculum that begins with basic information about pain and the body. From there, each group of patients can choose additional topics to discuss from a menu of options, including nutrition and anti-inflammatory diets, stress and trauma, health-harming legal needs, exercise and movement, and sleep.

There is substantial evidence for the impact of group medical visits on pain and related outcomes, and they can be especially helpful in increasing access to integrative services for underserved populations.[8, 9, 10] IPMP staff noted that group medical visits often serve as a "gateway," leading patients to become more interested in trying additional IPMP services. Group medical visits also facilitate peer-to-peer learning and social connection, allowing patients to learn from one another's experiences with pain and strategies for managing it.

Community Partnerships to Deliver Integrative Services

The IPMP has partnered with existing organizations in the community to provide some integrative services not traditionally billed to insurers, such as acupuncture and yoga therapy. These services are particularly important to uninsured patients who face barriers to accessing specialty providers. These partnerships have developed relatively organically from PCC's longstanding community-based approach and through direct outreach to organizations in the community who are doing relevant work. The IPMP pays the AOMA Graduate School of Integrative Medicine for four hours of an acupuncturist's time to provide one-on-one sessions with patients. The IPMP also has a financial contract with Sundara Yoga Therapy, a community-based organization, to provide bilingual and bicultural yoga therapy to IPMP patients five hours per week. The yoga therapists are trained to address

chronic pain and guide patients through movement and breathing exercises. The IPMP refers patients seeking long-term services to additional community partners.

Care Coordination and Provider Communication

Multidisciplinary care coordination is key to the IPMP's success, and requires program staff to spend time building relationships with patients. The work of the care coordinator is critical to ensuring continuity of care. Program staff noted that many patients are unsure that the IPMP will be able to help them, but having the care coordinator following up with them and maintaining communication keeps patients engaged in their care plan. One provider also observed that having this support system within the IPMP helps some patients advocate for themselves and their needs.

When the program was first implemented, program staff noted that they had to figure out how to best communicate with each other. One method was to have all members of the care team on the same EHR to allow for referrals and two-way communication. Early on, the IPMP staff worked with the PCC IT department to adapt the existing EHR system to enable data collection from integrative providers and services.

In addition, all IPMP providers meet weekly for case conferences to discuss clinic updates, resolve issues, and review patient cases. These conferences have helped develop a sense of shared responsibility for patient care across the entire care team. During case conferences, the team works to identify and address barriers to care, often resulting in additional referrals to clinical or social services to address patients' pain-related needs.

"One of the things that we have discovered through this program is that it is uplifting to work with vulnerable people in a way that doesn't ask any of us to be anything more than what we've trained for and the sum of our experiences … there's so much power in setting us all alongside each other and saying, "I'll do my part and you do your part. Now, let's put this together into one plan that recognizes we're … working with a whole person. So why wouldn't we address their needs as a whole team?"

Outcomes Measurement and Program Evaluation

The IPMP collects a variety of data to inform care decisions and demonstrate program effectiveness. See **Table 3** for a summary of measures used. PCC has an evaluation and quality team that analyzes these data to determine which services are making an impact on patients and how these services are operating. Prior to the COVID-19 pandemic, patients would complete measurement forms at each clinic visit. With the transition to providing services virtually, collecting this data has been challenging; at present, the care coordinator walks through each measure with patients over the phone. IPMP staff are exploring options for further streamlining data collection and analysis.

Measurement to Improve Clinical Care

The IPMP collects a variety of data to measure patients' pain levels, psychosocial well-being, and social determinants of health over time. The IPMP's care coordinator assesses patients' psychosocial wellbeing using depression and anxiety scales and a quality of life metric called the "Flourishing Measure" every three months, which have shown particular promise for demonstrating impacts on longer-term health outcomes.[11] PCC also developed a shareable social determinants of health screening tool in English and Spanish to better understand patients' health-harming legal and social needs. For each item on the tool, PCC's community health workers can make connections to corresponding clinical or community resources to address these needs. This tool is given to patients at intake and every twelve months. These measures are recorded in the EHR to inform clinical decision-making. See **Table 4** for more details on the information captured by the social determinants of health screening tool.

TABLE 3. Overview of Measures Used

Measure	Description	Components	Collection	Use
PCC Pain Rating Scale	Adapted from the Defense and Veterans Pain Rating Scale	Four questions that assess pain, functioning, stress, and sleep	Collected in EHR at each visit	Patient screening and clinical decision-making
PHQ-9	Patient Depression Questionnaire	Assesses severity and frequency of symptoms of depression	Collected in EHR at intake, 3 months, 6 months, 9 months, and 12 months	Patient screening and clinical decision-making
GAD-7	Anxiety Questionnaire	Assesses severity and frequency of symptoms of anxiety	Collected in EHR at intake, 3 months, 6 months, 9 months, and 12 months	Patient screening and clinical decision-making
Flourishing measure	Developed by the Human Flourishing Program at Harvard University	Assesses various domains of flourishing or well-being, including: happiness and life satisfaction, mental and physical health, meaning and purpose, character and virtue, close social relationships, and financial and material stability	Collected in EHR at intake, 3 months, 6 months, 9 months, and 12 months	Patient screening and clinical decision-making
Social determinants of health screening tool	Developed by People's Community Clinic	Assesses patients' access to food, transportation, housing, and other resources; sense of safety; social services needs	Collected in EHR at intake and every 12 months	Patient screening and clinical decision-making
Physical health measures	Blood pressure, BMI, A1C		Collected in EHR	Patient screening and clinical decision-making
Post-group questionnaire	Developed by People's Community Clinic	Assesses patients' feedback and knowledge, including what patients like and dislike about group visits; changes in knowledge after participation; lifestyle changes they intend to make	After group medical visits	Quality improvement

Adapted from CMS AHC, Health Begins, Health Leads, and PRAPARE

TABLE 4. PCC Social Determinants of Health Screening Tool Components

Domain	Response Options
Future Preparedness. *Do you need help getting any of the following?*	A checking/savings bank account; job or job training; a GED; high-speed internet; preschool for your 3- to 5-year old child; English classes for you or a family member; financial aid for college; none of the above
Food Access. *In the past year, have you worried that you would run out of food?*	Yes; no; we don't have enough food right now
Housing. *Do you have problems with any of the following?*	Losing your housing; mold or water leaks; lead paint/pipes; bugs or rodents; unclean water; broken or no smoke detectors; broken heat or air conditioning; none of the above
Finances and Income. *Do you need help getting any of the following?*	Food stamps (SNAP); WIC; welfare/cash assistance (TANF); veterans' benefits (VA); free tax help, especially if you work or have kids; lowering your debt/improving your credit score; I was recently denied one of these and want help; none of the above
Utilities. *In the past year, have you had trouble paying your bill?*	Yes; no; my gas, water, or electric is shut off right now
Transportation. *Do you miss medical appointments because you have no way to get there or it is hard to get there?*	Yes; no
Neighborhood. *Do you feel unsafe doing any of the following?*	Being in your yard/on your sidewalks; using your local parks; visiting your local library; calling the police; shopping at your grocery store; going to your school or your child's school; waiting at your local bus stop; none of the above
Community. *Would you like information about any of the following?*	Voting (registering, where to go, etc.); volunteering; getting an ID; joining affordable sports activities (youth; adult); joining social clubs (youth; adult; senior); none of the above

"It is really promising for us to … be able to say, "We may not have shown a change in these classic measures of clinical outcomes, but we're showing this, which we think is linked to these longer-term health outcomes."

The IPMP also collects information about patient experiences in the program. At the end of each group medical visit cohort, patients are given a post-group questionnaire that asks for their feedback and assesses changes in their knowledge following the group. Patients are asked to report any changes they foresee making in their lifestyles. The data from these questionnaires can inform subsequent referrals to services and also improve group medical visits for other patients.

At the clinic level, the IPMP tracks which services are used and how often to have an accurate understanding of current and future needs.

Measurement to Demonstrate Effectiveness

To date, outcomes data collected in the IPMP has been promising, but the number of patients who have consistently engaged in the program and had outcomes data collected has been relatively small, making it difficult for the evaluation and quality team to draw reliable and generalizable conclusions. To demonstrate program success to their funders, the most important metric is the number of patients enrolled in the program. Their grants do not require them to report on any specific outcomes.

"The magic of the program is, in part, that it is choose your own adventure … there's so many factors that it becomes very hard to quantitatively measure what's going on … because everybody's journey is different."

To offset some of the costs and challenges associated with quantitatively evaluating the IPMP, a local medical student has been conducting qualitative interviews with patients. Findings from these interviews have indicated that the integrative care provided by the IPMP has helped to improve quality of life and diminish stress, even for patients with persistent pain. Patients who participated in both group medical visits and behavioral health counseling reported the largest improvements to quality of life. All interviewees also indicated that the IPMP provided them with new skills to cope with and manage pain and increased self-efficacy. Interviewees reported that group medical visits helped them feel empowered and understood by fostering a sense of belonging among people living with pain. Interviews also suggest that most of the IPMP's targets and goals are being met. Program staff hope that combining quantitative and qualitative data as the program continues to grow can more clearly demonstrate the effectiveness of the program.

Financing and Infrastructure

Important sources of funding for the IPMP are two HRSA grants. In 2017, PCC received an Access Increases in Mental Health and Substance Abuse Services (AIMS) grant from HRSA, which provides ongoing funding for the IPMP. The initial funding from this grant was used to start the IPMP; half was used for IPMP staff salaries, and the other half went towards building infrastructure for the program. PCC received additional funding from HRSA in 2019 through an Integrated Behavioral Health Services (IBHS) grant, which was used to expand many of the IPMP's non-pharmacological therapy. This grant allowed the IPMP to offer yoga therapy and group medical visits, and provided funding for a full-time care coordinator and full-time substance use counselor. Both grants allow some services, including acupuncture and yoga therapy, to be offered to patients at no cost. The IPMP also receives some funding from Central Health, the local hospital district, as well as private foundations.

While grant funding has covered most of the IPMP's costs to date, this model is not necessarily sustainable for the program's future operations and growth. Challenges related to reimbursement have limited the IPMP's ability to expand services and hire certain types of providers. As a result, patients encounter long waitlists for some services. The IPMP has limited options to expand the number of services and providers, in large part because they are grant funded and not covered by patients' insurance. FQHCs are also subject to limitations on billable providers and services. For example, acupuncturists and nutritionists in FQHCs are not able to bill for their services in some states, including Texas. Providers are also not reimbursed for their time spent in weekly case conferences or in group medical visits that do not involve a physician having an individual visit with a patient.

"Challenges are still there, especially around reimbursement … we have 90 people on a waitlist for acupuncture right now, because we only offer it two half-days per week. And so how do you expand these services if they're not covered? I mean, our grants will only take us so far."

"And so at the end [of group medical visits], I usually ask, "Who needs to see the doctor?"... And one of the patients was like, 'I was feeling really bad before I came to the group and I was feeling like I needed to see you, but I feel much better now just having gone to the group ... I don't need to see you anymore.' ... and so to me, that's great, and that's the way it should be. Now, the problem is my productivity takes a hit. We can't bill for that patient."

For years, the IPMP leadership has expressed interest in pursuing an alternative payment model, but little traction has been made thus far. The IPMP has had some conversations with the county about developing a capitated model, but these conversations have stalled since the onset of the COVID-19 pandemic. Several of the private foundations that have provided funding to the IPMP are also interested in improving the sustainability of the program.

In the meantime, the IPMP leadership has worked creatively to expand services. The IPMP has partnered with existing organizations in the community to provide integrative services, such as acupuncture and yoga therapy. The IPMP has considered using linked visits, where a billable practitioner links with a non-billable practitioner to facilitate reimbursement and provider collaboration. Staff are also considering charging patients a small fee for certain services to facilitate expansion, with a caveat that as an FQHC, they cannot deny services to patients who are unable to pay. Some staff noted they were still wary of hindering access to care for low-income patients by imposing fees.

TABLE 5. Barriers and Facilitators to Implementation

Contextual Factors	Barriers	Strategies
Institutional	Provider communication and integration	Including all providers in EHR; weekly case conferences
Local Market	Barriers to patient access to health and insurance and health care services	Staff participation in advocacy efforts; connections to community-based services
Regulatory	Challenges with billing and reimbursement for some providers and services	Partnerships with community-based services; advocacy for reform to support additional services

Impacts of COVID-19

Although the COVID-19 pandemic has limited in-person visits at PCC, the IPMP has been able to deliver many of its services virtually, including behavioral health, acupuncture, yoga therapy, nutrition, and group medical visits. Virtual group medical visits have generally had fewer participants compared to the in-person groups before the pandemic. The IPMP had planned to begin offering massage therapy in early 2020, but the COVID-19 pandemic made it difficult to add and offer this service virtually.

Program staff noted that for some patients, especially patients who experience significant pain, COVID-19 has not created an additional barrier to care because telehealth is more convenient than traveling to receive care. However, staff also noted that some patients have limited access to the Internet, computers, or a quiet space to participate in visits, making it difficult to engage in virtual services.

Recommendations and Future Directions

During interviews, IPMP staff provided key recommendations for others wanting to develop and implement similar IPM programs, which included:

- **Recognizing the importance of relational health.** An approach to care that prioritizes building trusting relationships and providing secure opportunities to try new things can help address the root causes of patients' experiences with pain (which are often trauma-related) and promote relational health.

"If care doesn't take relational harm into account and into healing, then people's ability to receive care and have different experiences with people won't change."

- **Hiring a care coordinator early on.** The IPMP's care coordinator has been critical to managing referrals and helping patients navigate through the program.

"It's so complex and there are so many pieces … you need a care coordinator."

- **Prioritizing collaborative provider relationships.** The collaborative relationships among IPMP providers are unique and critical to success. Program staff described that many patients see medical settings as a hierarchy, and the IPMP is different; all providers play an equal role in contributing to patients' health. The multidisciplinary nature of the program helps patients to get a variety of perspectives and a more holistic view of their experiences with pain. The team-based approach to care also helps providers learn from one another, reduce burnout, and increase satisfaction.

"I feel like that is what we attribute our most success to – all playing an equal role in helping the patient or promoting the patient's health and wellbeing."

- **Building on community partnerships.** Working with trusted organizations in the community can help expand service offerings and address health-harming legal and social needs.

"We would never have had [yoga therapy] if we hadn't just reached out, just cold called people … reaching out to the folks in your community that are doing things already."

Moving forward, program staff described their plans to expand staff and services. The IPMP plans to hire additional support for care coordination, and is working to offer massage therapy soon. Program staff are also interested in continuing to strengthen its data collection and evaluation efforts and achieve financial sustainability. More broadly, program staff are interested in expanding this model of care to treat other complex conditions, such as diabetes and hypertension, to benefit more of PCC's patient population.

Acknowledgements

This project is part of the Duke School of Medicine Opioid Program portfolio, a grant funded by the Duke Endowment and administered through the Duke Department of Population Health Sciences. The Opioid Program portfolio projects are designed to save lives and reduce the harmful impact of opioids in North Carolina through the development, implementation, and/or evaluation of sustainable, system-level interventions.

We would like to thank the People's Community Clinic staff who participated in interviews and informed this case study.

About the Duke-Margolis Center for Health Policy

The Robert J. Margolis, MD, Center for Health Policy at Duke University is directed by Mark McClellan, MD, PhD, and brings together expertise from the Washington, DC policy community, Duke University and Duke Health to address the most pressing issues in health policy.

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For more information about this case study, please contact Trevor Lentz at Trevor.Lentz@duke.edu.

For information about this project, including other publications and case study reports, please visit https://healthpolicy.duke.edu/projects/integrated-pain-management-lessons-north-carolina-health-systems-and-beyond

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