Duke MARGOLIS CENTER for Health Policy
Duke Orthopaedic Surgery
Duke University School of Medicine

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Exemplary Integrated Pain Management Programs:

University of New Mexico Pain Consultation and Treatment Center (UNM Pain Center)

SUMMARY

Background

The University of New Mexico Pain Consultation and Treatment Center (UNM Pain Center) opened in December 2011 in response to high rates of prescription opioid deaths in New Mexico.

Care Delivery Approach

The Pain Center provides personalized pain care to patients with a focus on supporting and coordinating with pain care in primary care settings, extending the capacity for pain care across the state through Project ECHO, and coordinating with integrative therapies. The care team includes anesthesiologists; a neurologist and headache specialist; family medicine providers who are myofascial experts; advanced practice providers (APPs), including nurse practitioners and physician assistants; physical therapists (PTs); chiropractors; pharmacists; a licensed counselor (LCPC); psychologists; and an addiction psychiatrist.

Results to Date

One marker of success is the level of access to pain care, with the Pain Center seeing over 10,000 patients per year. While the Center is reviewing more pain-specific measures of patient impact, it has seen improvements in patient satisfaction, specifically the likelihood that patients would recommend the practice. Interviewees expressed that the Pain Center's provider outreach and education efforts have likely had the largest impact in growing the Center.

Challenges with Implementation

The Pain Center faced a variety of challenges during implementation, including limited resources and cultural challenges associated with establishing a multidisciplinary team.

Key Features of the Program

- **Connections to primary care providers.** The Pain Center only accepts referrals from primary care providers (PCPs), acting as a "consultation clinic" focused on patients with moderate to severe pain and high-impact pain. The goal of the Pain Center is to stabilize the patient's pain and return them to their PCP for ongoing care.
- **Care for medically underserved communities.** The Pain Center is a regional destination for pain care in the Southwest. The Pain Center educates community providers about pain management via Project ECHO, effectively extending their reach into many underserved communities. The Pain Center also has a local physician champion who is well-known in the community and committed to outreach.
- **Commitment to provider education.** In addition to Project ECHO, the Pain Center runs a Pain Medicine Fellowship Program for UNM trainees in Family Medicine, Physiatry, and other disciplines.

UNM Pain Center Details

Location: Albuquerque, NM
Website: https://unmhealth.org/services/pain-management/

CASE STUDY

TABLE 1. Overview of Pain Management Program

Organizational Description	The Pain Center is within the academic medical center affiliated with the University of New Mexico (UNM), which is the only academic medical center in the state.
Pain Management Services Offered	Behavioral medicine (individual and group therapy), biofeedback, chiropractic care, dry needling, interventional therapies, medication management, physical therapy
People Served by the Model	The Pain Center sees over 10,000 patients per year from a large geographic area, including across New Mexico and surrounding states.
Key Innovations	Connections to primary care providers; expanding access to care for medically underserved communities; commitment to provider education
Local Market and Context	The UNM Pain Center is the only large interdisciplinary program in New Mexico and in the Southwest US more broadly.
Evolution and Buy-In	To generate support from UNM Health System leadership, it was critical to demonstrate that the Pain Center could lead to downstream cost benefits and reductions in the number of chronic pain patients seeking care in the hospital. The Pain Center had to overcome departmental silos to bring providers together from across the academic medical system.
Financing & Infrastructure	UNM provided a block of funding to help establish the Pain Center. The UNM Health System provides some ongoing funding to the Center, including salary support for key positions. Facility fees and procedures have helped to generate revenue.
Implementation Challenges	Limited resources in the state make it difficult to treat patients in a timely manner; bringing together providers from across the health system; reimbursement
Results and Key Outcomes	The Pain Center has established itself as a key resource in the state. Center staff have been able to demonstrate downstream reductions in health care utilization and costs and increased patient satisfaction.

Historical Context

The physician who became the champion of the UNM Pain Center worked as a headache specialist in the UNM Neurology Department, and in collaborating with colleagues across the UNM Health System, recognized the need for professionals from multiple departments to come together to more effectively treat chronic pain. Providers from across the health system shared that they struggled with effectively managing care for patients with chronic pain, leading to long wait times in their clinics. A small group of providers worked for eight years to generate support for the Pain Center before it was established in December 2011. The main barrier to garnering support for the Pain Center was demonstrating its value; in the beginning, health system leadership did not see how the proposed Center could be financially sustainable.

Several types of information were helpful for gaining leadership buy-in for the proposed Pain Center. The providers spoke with patients, third-party payers, and providers across the state to learn about their needs. They heard from these stakeholders that a comprehensive pain program could add value to people from across the state. Further, the providers planning for the Pain Center analyzed how the Center would lead to downstream savings within the health system by routinely treating chronic pain as opposed to more emergent care provided in the emergency department, urgent care, or the hospital. Growing state and national attention to opioid use and chronic pain also helped to generate buy-in. In June 2011, the Institute of Medicine released a report highlighting opioid use and chronic pain as public health crises. Opioid overdose is a significant and longstanding problem in New Mexico, with prescription opioids being the leading cause of all overdose deaths.

Once buy-in was achieved, the next challenge was how to structure the Pain Center given that pain requires multidisciplinary care. While the Pain Center was implemented in the Neurosurgery Department, the organizing providers had to work diligently to bring together providers and staff from Family Medicine, Internal Medicine, Neurosurgery, and Anesthesiology across the hospital, physician group, and academic group of UNM. The challenge was that all providers had different management systems, reporting structures, and departments. Department and clinical chairs were key in establishing a "united front" and generating support for the Center within their departments. Providers and staff actively worked to overcome these differences and create an integrated team. The Center has expanded with additional services being added over time, including pharmacy, chiropractic care, and pain support groups.

Program Details

The Pain Center is located in a single physical location in Albuquerque, NM, and it is the only large interdisciplinary integrative pain program in New Mexico. The Pain Center is a regional provider for pain care in the Southwest US, serving patients from New Mexico and surrounding states such as Texas, Colorado, and Arizona. The majority of patients served by the Center are on Medicaid, the primary payer for approximately 33% of residents in the state. A large proportion of the patients seen in the Center identify as Native American or Hispanic, and the Pain Center works very closely with the Indian Health Service to deliver care to patients from federally-recognized tribes. Many patients in the Center also have co-occurring substance use and/or have had traumatic experiences. Given people's needs, the Pain Center seeks to provide care that recognizes the interconnectedness of physical pain and other life experiences.

"Patients really look to us for this unique specialty care need."

One defining feature of the Pain Center is its focus on collaboration with PCPs. From the beginning of the program, patients are required to have a PCP to receive services and the Center only accepts referrals from primary care. Importantly, the Center emphasizes that the PCP must be someone who actually has a relationship with that patient, not simply a provider of record. This requirement allows the Center to act as a consultation resource, with the goal of seeing patients that have moderate to severe high-impact pain and returning them to their PCPs for ongoing care once pain-related needs have stabilized. This criterion has also helped to ensure sustainability of the Center given its limited capacity.

"If we just kept taking referrals from everybody... we would have drowned."

To date, the Pain Center has refrained from taking referrals from the emergency department, trauma clinic, or other non-PCP referral sources within UNM. If the Pain Center does receive internal referrals, staff ask for a referral from the patient's PCP. The PCP referral requirement also helps to ensure continuity of care between a patient's local provider and pain specialists in the Pain Center. Despite these parameters, patients can come back to the Pain Center whenever they need. This approach has the secondary effect of training PCPs on what types of care may be most effective for their patients, since the plan of care is always communicated back to the PCPs.

The Pain Center has two co-medical directors (one neurologist, one pain psychologist), which helps with workload distribution given the extensive reach of the Center within the community. The Center has multiple provider types including anesthesiologists; a neurologist and headache specialist; family medicine providers who are myofascial experts; advanced practice providers (APPs), including nurse practitioners and physician assistants; physical therapists (PTs); chiropractors; pharmacists; a licensed counselor (LCPC); psychologists; and an addiction psychiatrist. Anesthesiologists primarily focus on interventional procedures. The Pain Center also has full-time APPs, pharmacists, PTs and psychologists. Most physicians in the Pain Center are part-time.

In addition to services offered directly through the Pain Center, patients also have access to a number of integrative, non-pharmacological services through the UNM Center for Life. The Center for Life opened around the same time as the Pain Center and offers acupuncture, nutrition services, medical massage, mindfulness-based stress reduction, and other general integrative medicine services. The Center for Life is a medical group clinic and only accepts fully insured patients or those that are able to pay out of pocket. As a result of high out-of-pocket costs and lack of insurance coverage, these services are not accessible to many people. Some patients are referred to integrative services within the community if they don't have insurance and/or cannot afford services at the Center for Life. For instance, many patients are referred to community acupuncture, which is popular in New Mexico and available on a sliding scale. Community acupuncture is an affordable, group-based approach to delivering acupuncture for a variety of conditions, including pain management.

Many patients seen in the Pain Center have been on opioids for years upon entry to the program. While providers in the Pain Center do occasionally prescribe opioids, the Center does not accept patients for that purpose. Instead, Pain Center providers partner with patients to help them comfortably wean off of opioids. The prescription and management of opioids is left to patients' PCPs, which helps to mitigate demand for entry into the Pain Center. Due to high rates of opioid use disorder (OUD) in New Mexico, the Pain Center collects information on substance use history and buprenorphine prescribing during intake to identify the potential need for OUD prevention and management.

"If we're talking about medication management, we see ourselves as consultants on that issue, not as a place to send someone to get their prescriptions. And that's a big distinction."

"The team really works with each other to reduce the opioids whenever appropriate and do it in a way that we're not throwing our patients into a situation where they go to the street out of desperation because they're in so much pain."

Clinician pharmacists have a unique and critical role in the Pain Center, particularly related to opioid weaning and management. New Mexico has a broad practice act for pharmacists which allows them to collaborate with other health care providers in clinical settings.

In the Pain Center, clinician pharmacists independently see patients to aid in medical management of their pain and provide education on non-opioid pharmacological management options. A common goal is to get patients, particularly those who are currently on opioids, to expand their definition of "pain medications" beyond opioids. To see a clinician pharmacist, patients are required to see a physician or advanced practice provider first. The clinician pharmacist commonly reinforces the importance of behavioral health and promotes behavioral interventions to complement medical management. The clinician pharmacists' role in educating patients also frees up time for anesthesiologists to work at the "top of their license" by focusing on the delivery of interventional treatments.

"We are just the opposite from a traditional interventional pain program. We don't just do opioids and injections. Our goal is actually just the opposite."

Beyond providers' clinical roles, many Pain Center staff are involved in advocacy work related to pain and substance use in New Mexico. For example, the Center was instrumental in passing state legislation that set educational standards for providers who work with pain and prescribe opioids.

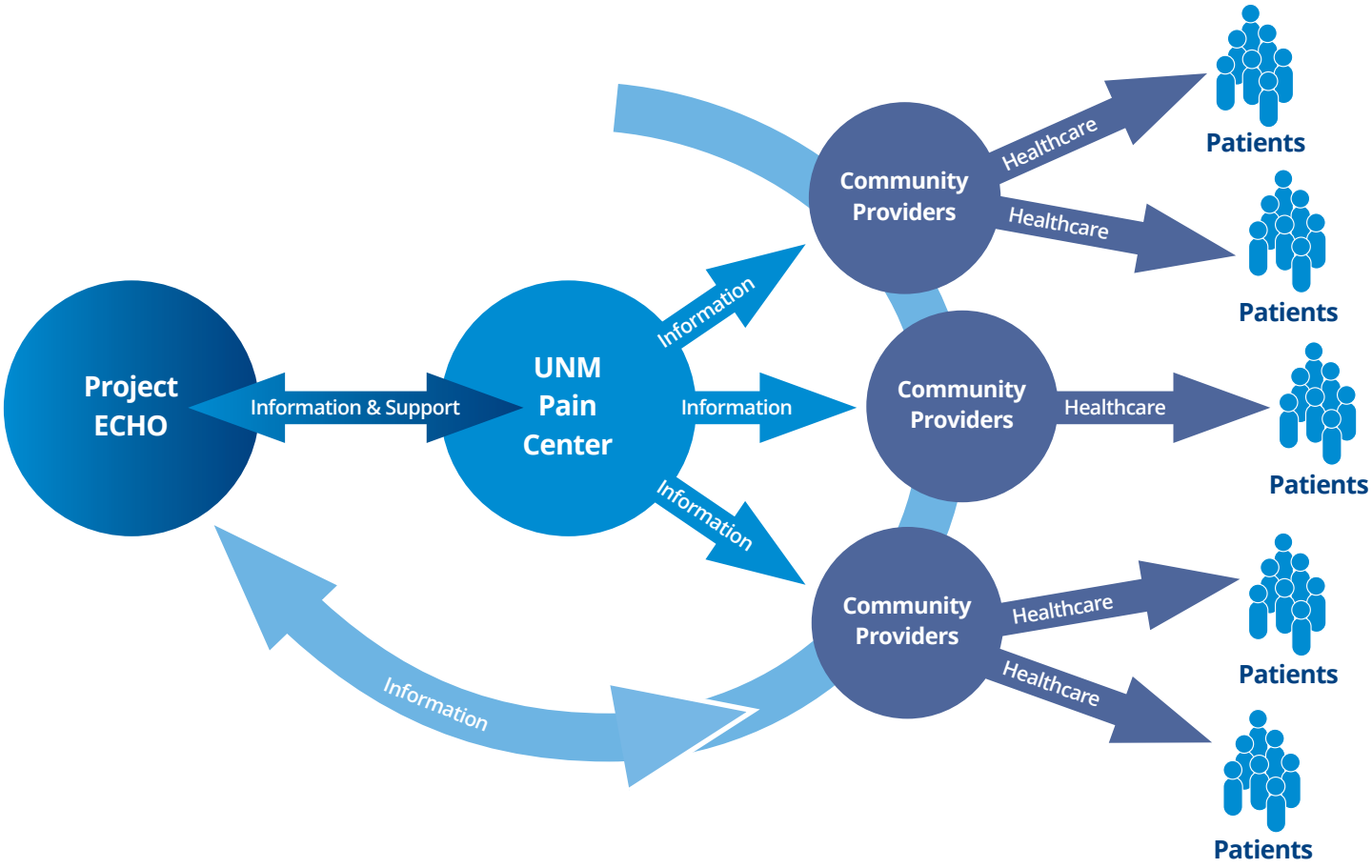
"I think the goal has always been: let's not work in one spot … a lot of health care, we require the patients to come to us, and I think that's great and that's helpful. But I think if you want to make a bigger impact, you also have to go out and engage the community and the other spheres of influence that make a big difference on the patients that we see."

Provider Education

In addition to direct patient care, the Pain Center also facilitates provider outreach and education through Project ECHO (Extension for Community Health Outcomes). The Project ECHO Program for Chronic Pain started in 2008. Designed as a hub and spoke model, it enables UNM providers (hub) to educate clinicians across the region (spokes) on best practices for pain management through didactic and case-based training **(Figure 1)**. Project ECHO participants include providers in many rural and medically underserved areas, as well as independent practitioners, Federally Qualified Health Centers (FQHCs), and multispecialty groups throughout the Southwest. Project ECHO has a year-long didactic curriculum that includes conferences on substance use, Centers for Disease Control and Prevention (CDC) guidelines on pain management and opioid prescribing, nonpharmacological therapies, pain throughout the lifespan, trauma-informed care, and non-opioid pharmacological therapy. In addition to providing didactic material, the ECHO program also provides a conduit for referral and consultation. If ECHO providers present cases that are urgent, UNM providers can give recommendations and/or get them seen in the Pain Center.

UNM also offers a Pain Medicine Fellowship Program for physicians, which was approved by the Accreditation Council for Graduate Medical Education (ACGME). Started in 2013 and housed in Anesthesiology, the program trains three to four new fellows per year. Trainees come from various subspecialties, including anesthesiology, physical medicine and rehabilitation (PM&R), palliative care, and family medicine. Like Project ECHO, this program focuses on educating trainees in evidence-based management of pain. Over half of the residency-trained fellows remain in New Mexico to provide care following the program. Outside of the fellowship program, family medicine and pharmacy trainees and residents also have rotations in the Pain Center to learn about pain management.

FIGURE 1. How Project ECHO and the UNM Pain Center Interact with the Community to Amplify Care



"New Mexico is a pretty rural state, so we have a lot of providers out there practicing pain management because they have to, but they might not have the same kind of expertise or backgrounds that maybe the experts here do. So to be able to impart that knowledge and have kind of an ongoing consultation with folks that might not have the resources that we do, I think really spreads the wealth … I think that's the biggest impact."

Provision of Care

Patient Referral and Conditions of Care

The Pain Center has developed a streamlined referral process that aims to schedule patients for their initial visit within a week of receiving their referral from primary care. A core team of six Pain Center physicians screen each referral and make a recommendation for which provider they see first. The patient's initial evaluation commonly involves a comprehensive assessment by an APP or physician. The intake process is standardized with an eight-page intake form. Information collected during the intake process includes pain management modalities patients have previously tried, which modalities have worked or not worked, medication history, treatment preferences, expectations, and goals for treatment. During this intake process, the provider explains the Pain Center's team-based approach to care, discusses all of the non-medication interventions and pharmacological interventions that are known to address pain, and helps the patient to identify which service(s) may be most appropriate **(Table 2)**. The provider then sets up follow-up appointments for patients' specified treatment(s). Most patients will receive multiple services at the Pain Center. Care may be either delivered by one of the many providers housed within the Pain Center, or for some integrative services, such as acupuncture, patients may be referred to providers at the Center for Life or in the community.

> *"Ideally we see [patients] and then like the hub of a wheel, begin to refer them out to different groups in our pain clinic"*

While many patients do receive pharmacological and interventional care, the majority of the care delivered in the Pain Center is through psychology and physical therapy. The Center employs three physical therapists with training in how to deliver pain neuroscience education and psychologically-informed approaches to rehabilitation. One goal of physical therapy is to de-emphasize the biomedical model of pain. The clinic is intentionally devoid of anatomical models and diagrams, and instead displays artwork with abstract depictions of neurotransmitters and nervous system structures. The physical therapy initial evaluation is comprised mostly of discussion and education, helping the patient to understand that pain is complex, individualized, and real. Many patients have had negative experiences with physical therapy in the past (i.e., it has caused more pain or hasn't helped) and few have ever been educated on the physiological mechanisms of pain. The initial evaluation presents an opportunity to explain pain and discuss why physical therapy provided in the Pain Center is different from traditional physical therapy. Physical therapists will also use quantitative sensory tests such as pain pressure threshold and two-point discrimination testing to better understand a person's level of pain processing. These measures are commonly repeated later in treatment to assess any changes. In addition to pain education, treatment will often consist of activity pacing, graded exercise, and guided imagery. Modalities are used as appropriate and include dry needling, neuromuscular electrical stimulation, and transcutaneous electrical nerve stimulation

TABLE 2. Services Offered

Interventional Pain Management Services	Integrative Pain Management Services
• Steroid injections	• Physical therapy
• Nerve blocks	• Biofeedback
• Minimally invasive surgery	• Dry needling/trigger point injections
• Nerve stimulation	• Chiropractic care
• Pain pumps	• Behavioral medicine (individual and group therapy)
• Radiofrequency	• Medication management

(TENS). Treatment sessions are generally 60 minutes. Physical therapy is commonly incorporated alongside injections (e.g., trigger point or epidural). In terms of behavioral health, the Pain Center offers group as well as individualized therapy. Currently, there are no strict boundaries on the number of treatments or sessions a patient can receive; however, most patients receive no more than eight visits of physical therapy.

"We have to convince our patients that this isn't like the PT they did that hurt them. This is different."

Care Coordination and Provider Communication

To improve coordination, the Pain Center uses care coordinators and a social worker that shares time with the neurology and neurosurgery clinic. Because these services are stretched thin, care coordinators are not used in every case. Providers routinely collaborate on patient care, which occurs organically and is facilitated by provider co-location. Case conferences are held twice a month, where providers from different disciplines can discuss complex cases. These conferences include providers that work in the Pain Center and providers from the broader UNM Health System such as interventional radiologists, surgeons, and physiatrists. The degree of care coordination is largely dependent on need, as not all patients require multiple coordinated services.

"I think they're getting a nice combination of modalities that work for them, but we don't necessarily collaborate intensively on everyone. A lot of people come in and get routine care and they do well and I think that's the more typical experience."

"It is important to have a consistent message about the nature of pain across all providers"

Outcomes Measurement and Program Evaluation

Program evaluation metrics are based on traditional Institute for Healthcare Improvement (IHI) metrics, including wait times for third available appointment. These access measure results tend to fluctuate seasonally and are influenced by the number of available pain fellows in the program. The Pain Center also uses modified Press Ganey surveys and the CAHPS® Clinician & Group Survey (CG-CAHPS) to evaluate patient satisfaction with the Pain Center. From fiscal year 2020 to fiscal year 2021, the likelihood of patients recommending the Center increased from 89% to 92.1%.

To evaluate progress and outcomes associated with clinical care, patients receive the Brief Pain Inventory (BPI) at each visit **(Table 3)**. This allows providers to track pain interference over time and in response to treatment. At intake, patients also complete the PHQ-9 and GAD-7 to measure depression and anxiety symptoms, respectively. These measures are only re-administered as needed. Patients with co-occurring substance use will also complete the Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R) and Current Opioid Misuse Measure (COMM), which are designed to identify patients who may be misusing their prescription opioids.

TABLE 3. Overview of Measures Used

Measure	Description	Components	Collection	Use
Brief Pain Inventory	Pain interference measure	Assesses the severity of pain and its impact on functioning	Each visit	Patient screening and clinical decision-making
Patient Health Questionnaire (PHQ-9)	Patient Depression Questionnaire	Assesses severity and frequency of symptoms of depression	At Intake	Patient screening and clinical decision-making
General Anxiety Disorder (GAD-7) Assessment	Anxiety Questionnaire	Assesses severity and frequency of symptoms of anxiety	At Intake	Patient screening and clinical decision-making
Pain Catastrophizing Scale (PCS)	Pain catastrophizing measure	Evaluates levels of rumination, magnification, and helplessness regarding pain	At physical therapy initial evaluation; follow-ups as needed	Patient screening and clinical decision-making
Patient Specific Functional Scale (PSFS)	Function and goals	Assesses patient-specific abilities and goals	At physical therapy initial evaluation; follow-ups as needed	Patient screening and clinical decision-making
Press Ganey **Survey; CAHPS® Clinician & Group Survey (CG-CAHPS)**	Patient satisfaction	Experiences with providers and staff in primary care and specialty care settings		Program success to leadership and quality improvement
Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)	Opioid screen	Helps determine how much monitoring a patient on long-term opioid therapy might require	At intake (as appropriate)	Patient screening and clinical decision-making
Current Opioid Misuse Measure (COMM)	Opioid screen	Identifies patients who may be misusing their prescription opioids	At intake (as appropriate)	Patient screening and clinical decision-making

Financing and Infrastructure

The Pain Center began with a dedicated block of funding from UNM. To garner UNM's support, the founders of the Pain Center conducted several studies to demonstrate that the Center would lead to downstream savings that would accrue back to UNM over time. For example, through an analysis of existing patient data (using International Classification of Diseases (ICD)-9 codes and chronic pain diagnoses for patients presenting in the emergency department) they found that the Pain Center would have reduced UNM costs if patients had been seen at the Pain Center instead of the emergency room.

They conducted similar counterfactual studies across different parts of the health system, projecting what savings might be realized based on reduced service utilization for a variety of departments. They also forecast average patient cost by conducting root cause analysis and forecasting what a typical patient who might be consulted in the UNM Pain Center might need.

"That's when the light bulb came on that we need to look at this from a different perspective. Not necessarily as a revenue stream, but more of … a clearly needed service that can help us all indirectly by channeling these patients into the right resources at the right time, and freeing up all of these other expensive resources to do the work they're supposed to do. And that's when an investment in this kind of program started to make sense for all parties concerned, because they saw the backside benefits of creating the service. It would in turn elevate the performance of their own individual services."

The Department of Neurosurgery in the UNM School of Medicine is the cost center for the Pain Center, serving as the financial management center. The hospital allocates funding to the department, and the department then "purchases" faculty time from other departments in the School of Medicine. The revenue from multi-disciplinary faculty members at the Pain Center accrues to the Neurosurgery Department, which is then re-allocated back to the Pain Center to cover overhead costs or additional faculty time beyond what the hospital allocation covers. This is critical to the Pain Center's success, helping align siloed funding streams into one dedicated center. As one stakeholder noted, *"If incentives aren't aligned, it's very difficult to get everybody to collaborate."*

UNM also provides additional resources to help sustain the Pain Center. First, they provide infrastructure for the Center, creating a physical space that can support multiple services, including a large room for exercise and pain support groups. Second, UNM provides salary support for key personnel, supporting staff time from multiple different departments. This funding is partially offset by earnings from facility fees. In addition, interventional procedures like injections contribute to some funding, though this is a small portion of revenue. However, overall resources are limited, particularly since many patients are uninsured or on Medicaid. Other policies, like limitations on multiple visits in one day, pose financial challenges.

Impacts of COVID-19

The COVID-19 pandemic led to several challenges, including issues with staffing, disrupted in-person weekly interdisciplinary conferences, and paused efforts to implement a new functionality assessment. At the onset of the pandemic, the physical space the Pain Center operated in was repurposed for pandemic response efforts. As a result, patients from the Pain Center began presenting in the hospital and emergency room instead.

"The good that came out of it is the services that this pain clinic provides to the community and to the organization become very well known."

A silver lining from the pandemic is the rapid expansion of telehealth. Telehealth visits have been helpful for patients who live several hours away or have financial hardship, and have helped increase access and reduce patient no-shows. However, not everyone in the state has Internet access.

TABLE 4. Barriers and Facilitators to Implementation

Contextual Factors	Barriers	Strategies
Institutional	Funding flows are often misaligned and fragmented; cultural tensions across disciplines	Created a dedicated cost center that manages all of the revenue and costs for the Pain Center, breaking down funding siloes; co-location and weekly case conferences
Local Market	Staffing shortages	Project ECHO; pain fellowship program
Regulatory	Providing multiple services to a patient on the same day and getting reimbursed	Financial assistance from the university

Recommendations and Future Directions

The experiences of the Pain Center provide several lessons for other programs seeking to get off the ground, as summarized in the following recommendations:

- **Build parameters to manage capacity.** Pain Center staff noted the importance of being realistic about the number of referrals a program can handle. If a program accepts more referrals than capacity, it will lead to backlogs or limited service for patients in the program. Rather, a more focused referral strategy was critical for the Pain Center's ability to deliver services in a timely manner to the patients in the Center.
- **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."

- **Facilitate connections to multidisciplinary providers.** The Pain Center leveraged existing providers to build and staff its program and referred to community providers when internal capacity was not available.

"In terms of what you put together, every pain clinic is going to look different based on who's around and who can do it... You want to have a conduit to [the types of clinicians not available within your program]. You want to have a place you can send [your patients] if [that specialty of type of clinician is] not in your clinic."

- **Encourage a team culture with respect across the team.** Creating a team culture that values the expertise and contributions of each provider can help overcome departmental silos and better facilitate integrated team-based care, which has downstream benefits for patients. Team-based care can also help to distribute workload and facilitate buy-in among providers.

"It's really the relationship building and communication that allows us to be a healthy system, and that healthy system translates to its patients."

- **Show the impact of the program for improving care across the entire organization.** To generate buy-in, the Pain Center showed how the program would meet the needs of its patients, improve care across clinical departments, and overall reduce downstream emergent care. While there were financial considerations that had to be considered by the organization's leadership, other considerations were also important in gaining leadership buy-in, such as combating the opioid crisis in the state.

"I'd advise [people interested in establishing an integrative pain program] to look at it from a critical service perspective, not from a financial perspective. And I would ask that health system to take a hard look at whether or not there is enough need and enough demand to support creating a service like this. The finances will take care of themselves in other ways, but don't look at the finances primarily. Don't look at it from a revenue generating perspective, because if you do that, there's not going to be too many programs that get off the ground."

Future Directions

The UNM Pain Center is actively planning for growth as they move into their second decade of service to New Mexicans and the Greater Southwest. The Pain Center leadership remains very pleased with faculty retention in the Center, and plans to recruit a diverse team of interprofessional and integrative clinicians to the program as well. Additionally, the leadership team has goals of 1) creating satellite clinics in rural and underserved regions of New Mexico, 2) improving reimbursement for integrative services, and 3) continuing to work with partners at Project ECHO, the UNM substance use clinic, New Mexico's primary care clinicians, and the New Mexico Governor's Council for Pain and Opioid Misuse.

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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