Innovation in Equitable, Whole Person, Multimodal Pain Management

AACIPM's 2022-23
Innovation & Progress Series
Pain and Self Care Awareness
#RightCareAtTheRightTime

Alliance to Advance
Comprehensive Integrative
Pain Management

October 3 | 11:00AM-12:30PM CDT

Moving to Panel Discussion

Co-Moderators

Amy Goldstein, MSW
Director, **Alliance to Advance Comprehensive Integrative Pain Management**

Robert Kerns, PhD
Yale University
Director, **NIH/DOD/VHA Pain Management Collaboratory**

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Panelists

Kate Nicholson, JD
Founder & Director
National Pain Advocacy Center

Denise Giambalvo
Director of Purchaser Strategies
Washington Health Alliance

David Elton, DC
VP, Musculoskeletal R&D
Optum Labs

Daniel Blaney-Koen, JD
Senior Legislative Attorney
American Medical Association

Ben Kligler, MD, MPH
Director, Office of Patient Centered Care and Cultural Transformation
Veterans Health Administration

Thank You

Primary sponsor for the AACIPM Initiative is:

The David and Lura Lovell Foundation

Special thanks to the fiscal sponsor for this project, The Pain Community

The Pain Community
Serving Patients, Caregivers, Providers

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AACIPM

AACIPM is not an organization. It is a nimble, grant-funded initiative born from past advocacy efforts of the American Academy of Pain Management and later called the Academy of Integrative Pain Management. AACIPM is a multi-stakeholder collaborative.

Stakeholders: People with Pain | Payers | Purchaser | Healthcare Providers | Academia | Government Agencies | Advocates

Outputs: Strategic Digital Communication | Policy Advocacy | Education & Awareness | Coordinated Responses

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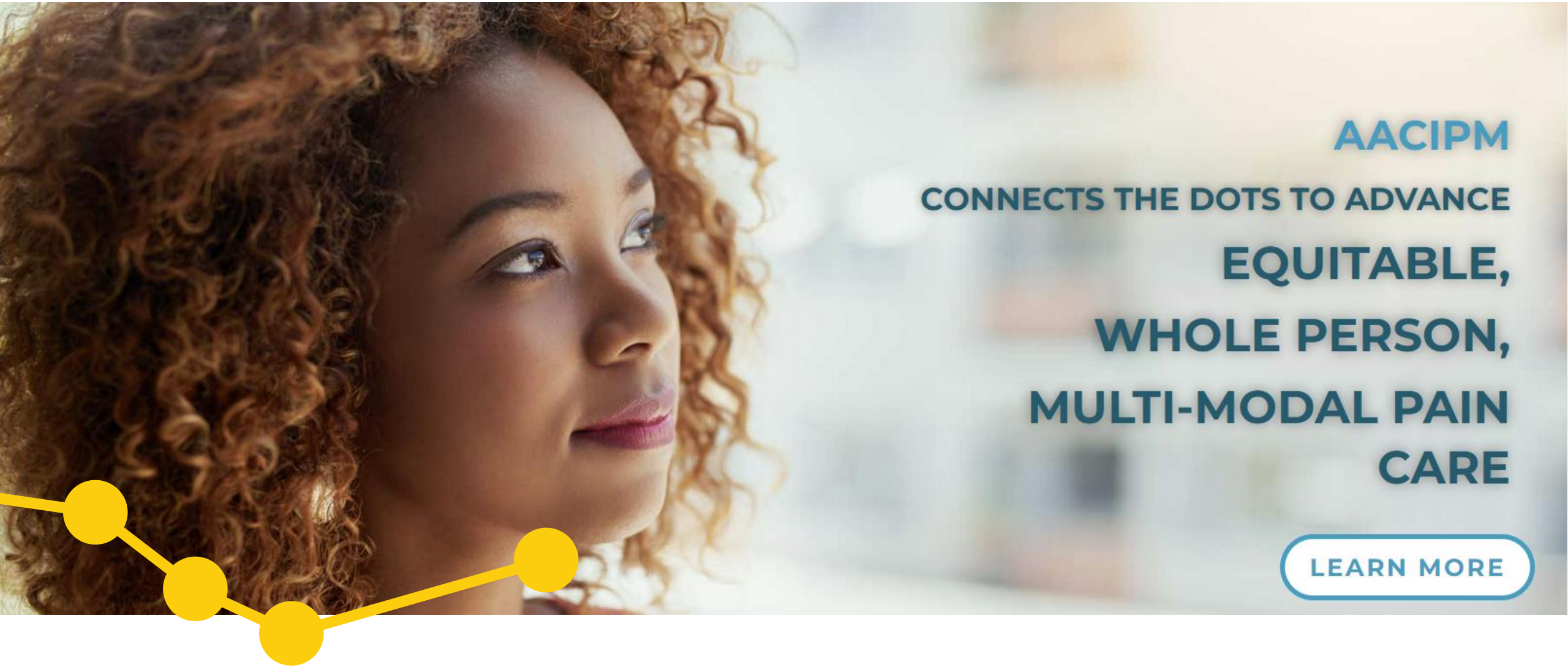


WHY WE NEED AACIPM

Chronic pain is the #1 cause of disability globally.

1 in 6 Americans lives in pain every day.

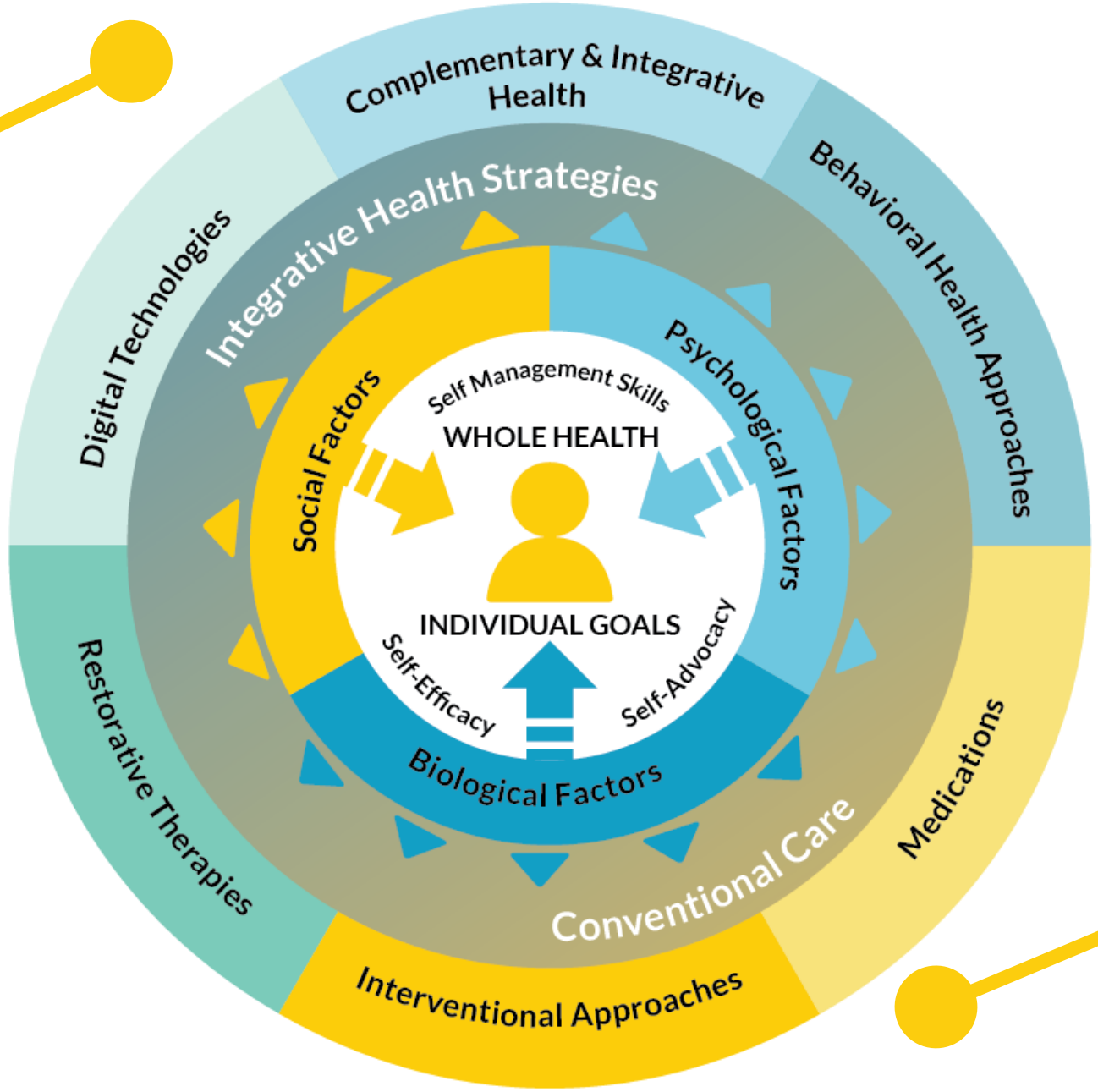
635

Billion in Expenses
& Lost Productivity

Nearly 20 million Americans have pain that prevents life activities and work.

Whole Person-Centered Pain Management

Cross-Cutting Factors
Trauma-Informed Care
Education
Risk Factors
Stigma
Access to Care



Alliance to Advance Comprehensive Integrative Pain Management

https://painmanagementalliance.org/what-is-cipm/

CIPM TOOLBOX

Alliance to Advance Comprehensive Integrative Pain Management

IMPORTANT FACTORS

Trauma-Informed Care
Education
Risk Assessment
Stigma

SOCIAL FACTORS

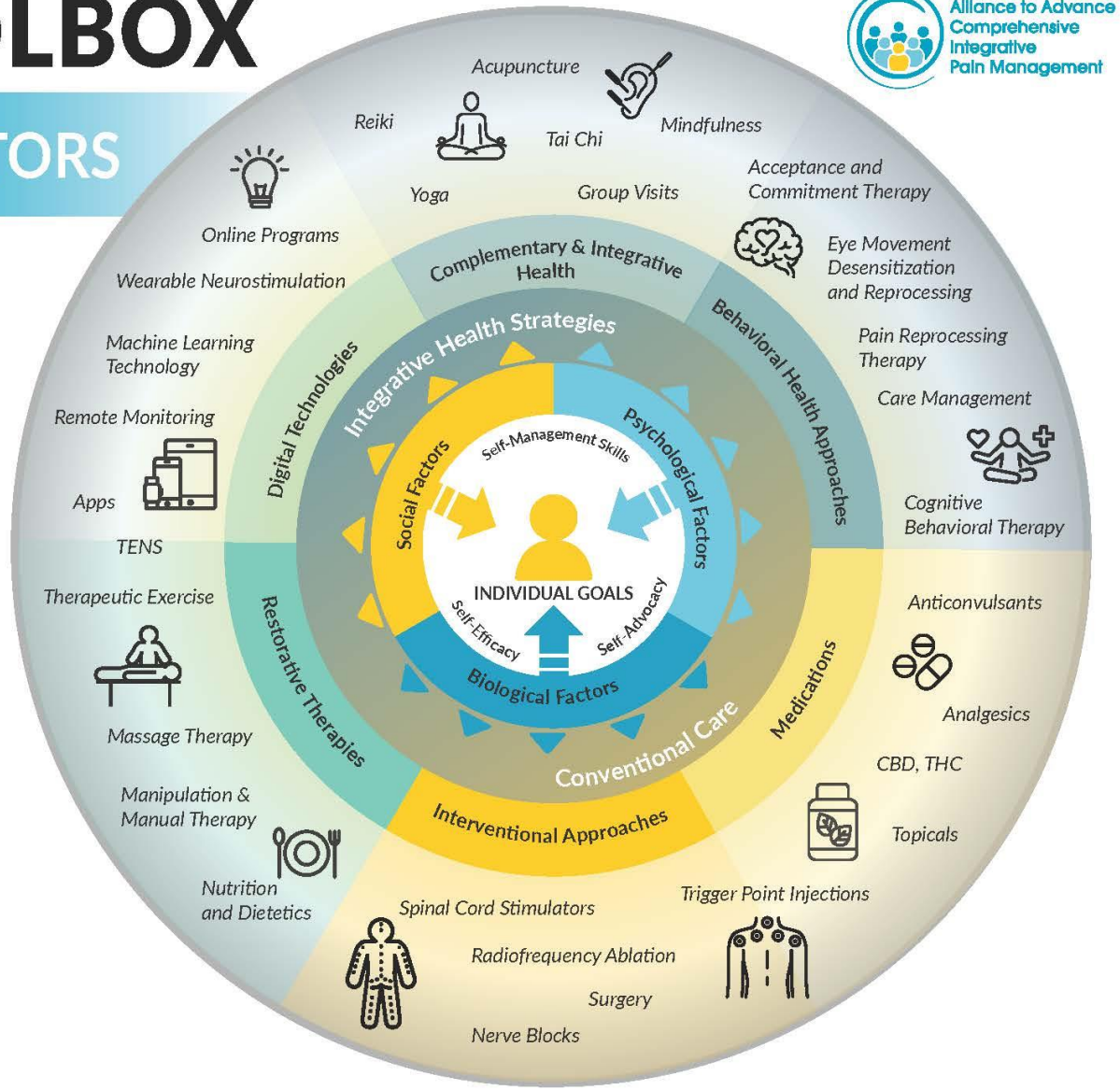
Environmental
Stigma
Cultural
Racism
Discrimination
Housing
Transportation
Food Security

PSYCHOLOGICAL FACTORS

Mood
Stress
Coping
Trauma
Isolation

BIOLOGICAL FACTORS

Age
Injury/Past Injury
Illness/Diagnosis
Neurologic
Genetic
Hormones
Nutrition
Metabolic Health



AACIPM offers this visual tool to illustrate and increase awareness of the various therapies that may be a part of whole person, multidisciplinary, multi-modal, evidence-informed, integrative pain management. This does not represent an exhaustive list of interventions, and not all interventions will be covered, covered without limits and/or without patient out-of-pocket cost." Most services must be provided by a licensed or credentialed health care provider or community-based service provider.

CHALLENGES

Why is Evidence-Based, Guideline-Concordant, Multimodal Care **Not Accessible** for Many People, Especially Those who are Underserved?

Misperceptions & Stigma

Lack of Awareness/Education

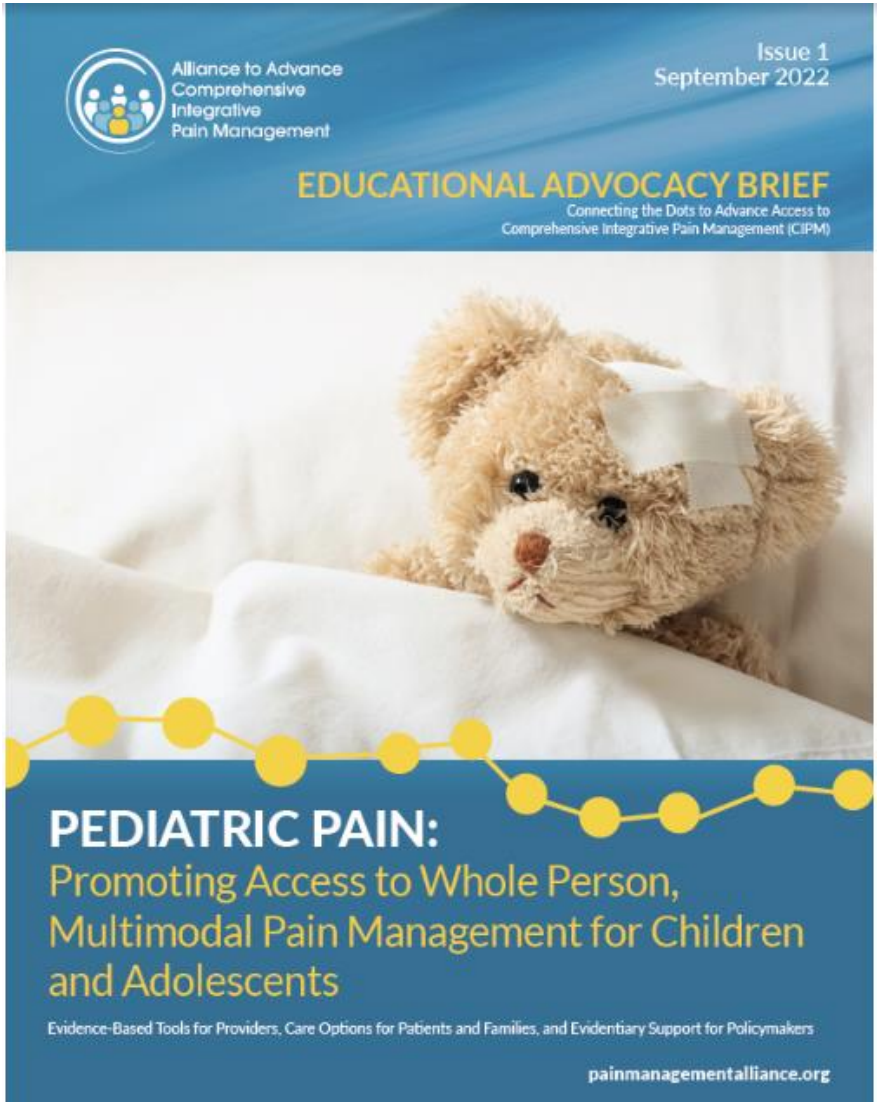
Business Case Data Disagreement

Workforce Supply & Demand

Misaligned Financial Incentives

Integration & Cultural Incompatibilities

Example: AACIPM's Newly Released Brief 9.30.22



There is a well-established link between mental health and chronic pain. Untreated pain has been shown to worsen depression, and depression often worsens pain.[8] Moreover, multiple studies have shown that adverse childhood experiences (ACEs) often result in negative health effects in later life, including a much greater risk of developing chronic pain.[9] Most individuals have experienced at least one ACE (57.8%) with 21.5% experiencing 3+ ACEs.[10] While ACEs are typically defined to include physical and sexual abuse, neglect, humiliation, and parental separation, or incarceration, ACEs may also encompass other undefined negative conditions or experiences occurring during childhood—which may well include a life-altering pandemic, particularly when associated with specific negative consequences.

About one in five experience more than 3 adverse childhood experiences (ACEs)... and ACEs often result in negative health effects in later life, including a much greater risk of developing chronic pain.

Undertreated childhood pain can lead to lifelong health issues and financial burdens. Long-term exposure to severe pain without adequate treatment has negative long-term consequences, including increased morbidity and mortality, predisposing undertreated young people to lifelong harms. Further, the long-term effects of ACEs have been shown to have long-term effects on development, negative adult psychological and physical health outcomes, risky health behaviors, healthcare utilization, and associated high societal and familial financial burdens.[11] What's more, the early introduction of opioids in childhood can lead to the development of opioid use disorders in adulthood.[12] However, research has shown that factors associated with the development of chronic pain and related disability are modifiable, meaning it is imperative that we treat children early to help them avoid negative lifelong consequences.[13]

Action Requested by End of 2022: Review, Feedback, Suggestion for Webinar

Examples – Collective Responses to HHS

CMS Takes Action on AACIPM Recommendations Regarding Bundled Payments for Integrative Pain Management

In an exciting turn of events, the Centers for Medicare and Medicaid Services (CMS) have released a draft of the Physician Fee Schedule for 2023 for public comment—

CMS.gov
Centers for Medicare & Medicaid Services

and it is clear that the collective efforts of AACIPM and its member organizations on the 2022 PFS have been highly influential in the development of the 2023 PFS!

AACIPM Submits Second Response to AHRQ on Integrated Pain Management Programs Systematic Review

On June 21, AACIPM submitted a collective response to AHRQ

Alliance to Advance Comprehensive Integrative Pain Management

https://painmanagementalliance.org/2021/06/30/aacipm-submits-second-response-to-ahrq-on-integrated-pain-management-programs-systematic-review/

AHRQ Agency for Healthcare Research and Quality

Three years after its initial release, the CDC recognized the chaos and harm it inadvertently created with its guideline and released a statement advising against the misapplication of their guideline and offering further clarifications. A year later, CDC established a new Opioid Workgroup and plans to complete updates to their guideline by the end of 2021, because, “Despite the best intensions [sic], they have seen barriers and challenges in implementing the guideline’s strategies. Unfortunately, some policies and practices derived from the guideline have been inconsistent with and often go beyond its recommendations.”

It is our hope that AHRQ will not add to the body of confusing and low-quality evidence, but rather, will set a new standard for basing findings upon high-quality evidence, or, at the very least, being explicitly clear when making a statement based upon low quality evidence.

Today's Agenda and Enduring Materials

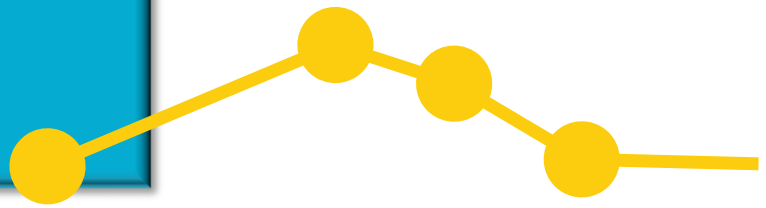
To reserve time for presenters, please note the presenters' bios and slides can be found at https://painmanagementalliance.org/innovation-webinar

11:15-12:00 – Individual brief presentations

12:00-12:25 - Q&A Discussion

12:25-12:30 – Closing Remarks

CONNECT THE DOTS



This session will discuss innovation along with some barriers – and opportunities – from the provider, patient and payer levels.

We will spur potential action steps to increase integration of complementary and integrative approaches for the millions of people in need of quality pain care.

Share your Engagement using **#AACIPM**

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LinkedIn: **linkedin.com/company/aacipm**

Co-Moderator

Robert Kerns, PhD

Director, **NIH/VA/DoD Pain Management Collaboratory**

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pmc painmanagement collaboratory

The NIH-DOD-VA Pain Management Collaboratory: Pragmatic trials of integrated models of care and nonpharmacological approaches for pain management

Robert D. Kerns, Ph.D.
Yale University

www.painmanagementcollaboratory.org

National Pain Strategy

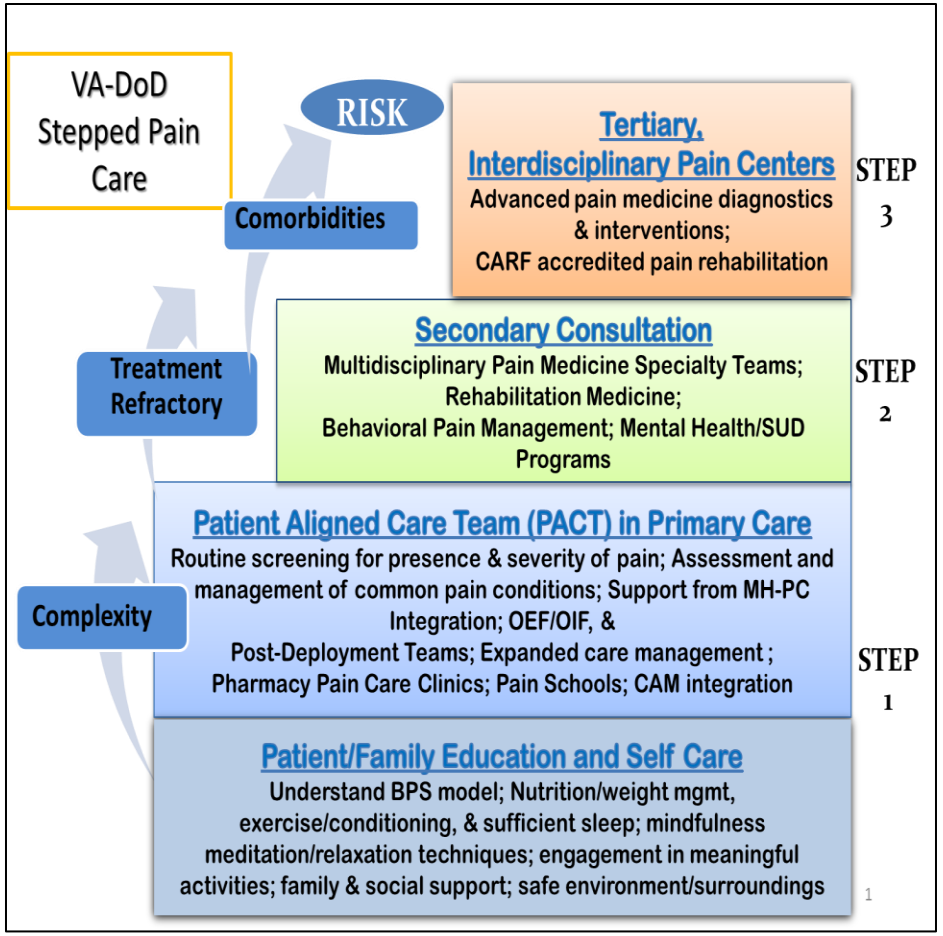
The Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services. (2016). *National Pain Strategy.* Washington, DC.

Framework

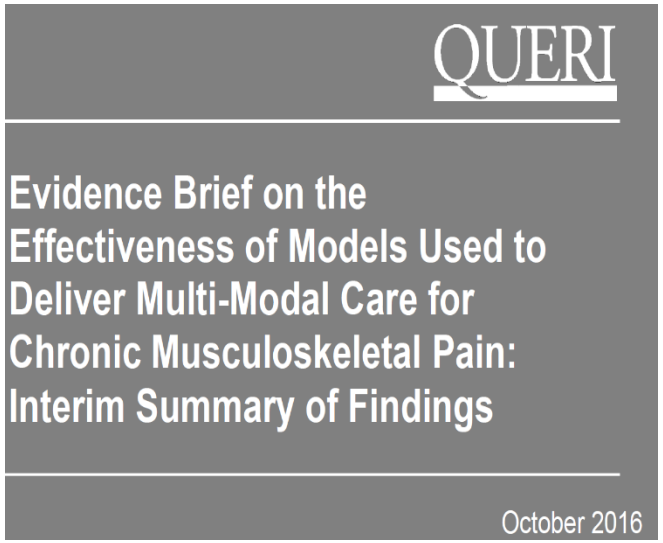
- Many challenges exist for access to quality pain care, which is often:
  - not based on best evidence.
  - not team based.
  - limited to pharmacological treatment offered by one primary care practitioner or to procedure-oriented and incentivized specialty care.
- More quality research is needed on the effectiveness of pain interventions, integrated care, models of care delivery, and reimbursement innovations.
- We need more effective methods to disseminate research findings and incentives to incorporate them into clinical practice.
- Current reimbursement practices complicate development of a population-based approach, which would use integrated, interdisciplinary, patient-centered teams.

Models of Pain Care

- Stepped-Care
- Stratified Care
- Matched Care
- Collaborative Care
- Care management
- Integrated care/
  co-located care
- Telecare
- Technology-facilitated
- Peer-delivered/ informal caregivers
- “Whole-health” care

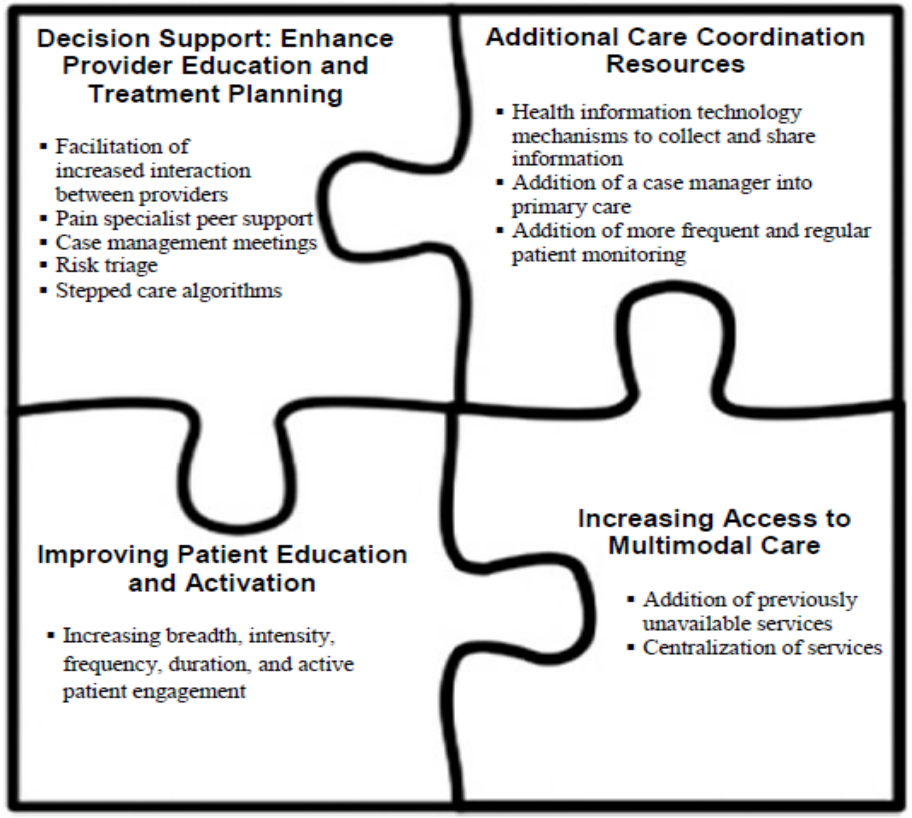


What's the evidence?



Peterson et al. (2018). Effectiveness of models used to deliver multimodal care for chronic musculoskeletal pain: A rapid evidence review. *Journal of General Internal Medicine, 33,* S71-S81.

11 articles (10 studies) included
Most were RCTS of fair-good quality (3 poor)
Most had 12-month follow-up (range 6-18)
Most used usual care control
Baseline mean pain 5.1-7.7 on 10-point scale
9 diverse models of care delivery



What are the barriers to expanding clinical use of evidence-based models (patient/provider/facility/system)?

- Cultural adherence to a biomedical model
  - Entrenched beliefs about effectiveness of certain treatments
- Complexity of biopsychosocially-informed models of care
- Stigma and skepticism about nonpharmacological approaches
- “Silos”— prevent effective communication across teams
- Lack of availability and access
- Within health care organizations - Lack of leadership support; needed at all levels
- Perverse financial incentives

Gap between evidence and practice

- Growing evidence to support integrated, coordinated, multimodal and interdisciplinary models of pain care that incorporate evidence-based nonpharmacological approaches that support patient activation and pain self-management

- Significant organizational/systems, provider and patient-level barriers to timely and equitable access to these approaches

- Pragmatic Clinical Trials (PCTs) provide an opportunity to address this gap

NIH-DOD-VA Pain Management Collaboratory

$81 Million investment over six years

Sponsors:

- **NIH:** National Center for Complementary and Integrative Health, National Institute for Neurological Disorders and Stroke, National Institute of Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, National Institute of Child Health and Human Development, National Institute of Nursing Research, Office of Behavioral and Social Sciences Research, Office of Research on Women's Health
- **DOD:** Clinical Rehabilitative Medicine Research Program, Military Operational Medicine Research Program
- **VA:** Health Services Research & Development Service, Office of Research and Development

Key objectives:

- Support investigators to do the necessary planning and pilot testing to demonstrate that they can effectively implement the proposed pragmatic trial
- Conduct pragmatic clinical trials to evaluate whether integrated models of care and non-pharmacological approaches to pain management are effective when delivered in the setting of the Veterans and/or military health care systems (VA and MHS)
    - Why pragmatic studies?
        - Emphasizes generalizability of results and protect rigor
        - Answer questions that inform VA and MHS about what services to make available to patients with pain throughout their systems
        - Results may inform other health care systems about nonpharmacological treatments for pain management

12 Pragmatic Clinical Trials

J. Fritz/D. Rhon:
SMART Stepped Care Management for Low Back Pain in Military Health System (NIH)

A. Heapy/D. Higgins:
Cooperative Pain Education and Self-management: Expanding Treatment for Real-world Access (COPES ExTRA) (NIH)

K. Seal/W. Becker:
Implementation of a Pragmatic Trial of Whole Health Team vs. Primary Care Group Education to Promote Non-Pharmacological Strategies to Improve Pain, Functioning, & Quality of Life in Veterans (NIH)

Burgess:
Learning to Apply Mindfulness to Pain (LAMP) (DOD)

S. George/S.N. Hastings:
Improving Veteran Access To Integrated Management of Chronic Back Pain (AIM-BACK) (NIH)

D. McGeary/J. Goodie:
Targeting Chronic Pain in Primary Care Settings Using Internal Behavioral Health Consultants (DOD)

S. Taylor/S. Zeliadt:
Complementary and Integrative Health for Pain in the VA: A National Demonstration Project (VA)

B. Ilfeld:
Ultrasound-Guided Percutaneous Peripheral Nerve Stimulation: A Non-Pharmacological Alternative for the Treatment of Postoperative Pain (DOD)

C. Goertz/C. Long:
Chiropractic Care for Veterans: A Pragmatic Randomized Trial Addressing Dose Effects for cLBP (NIH)

M. Rosen/S. Martino:
Engaging Veterans Seeking Service-Connection Payments in Pain Treatment (NIH)

S. Farrokhi/C. Dearth:
Resolving the Burden of Low Back Pain in Military Service Members and Veterans (RESOLVE Trial) (DOD)

T. Lovejoy/B. Morasco
Tele-Collaborative Outreach to Rural Patients with Chronic Pain: The CORPs Trial
(NIH)

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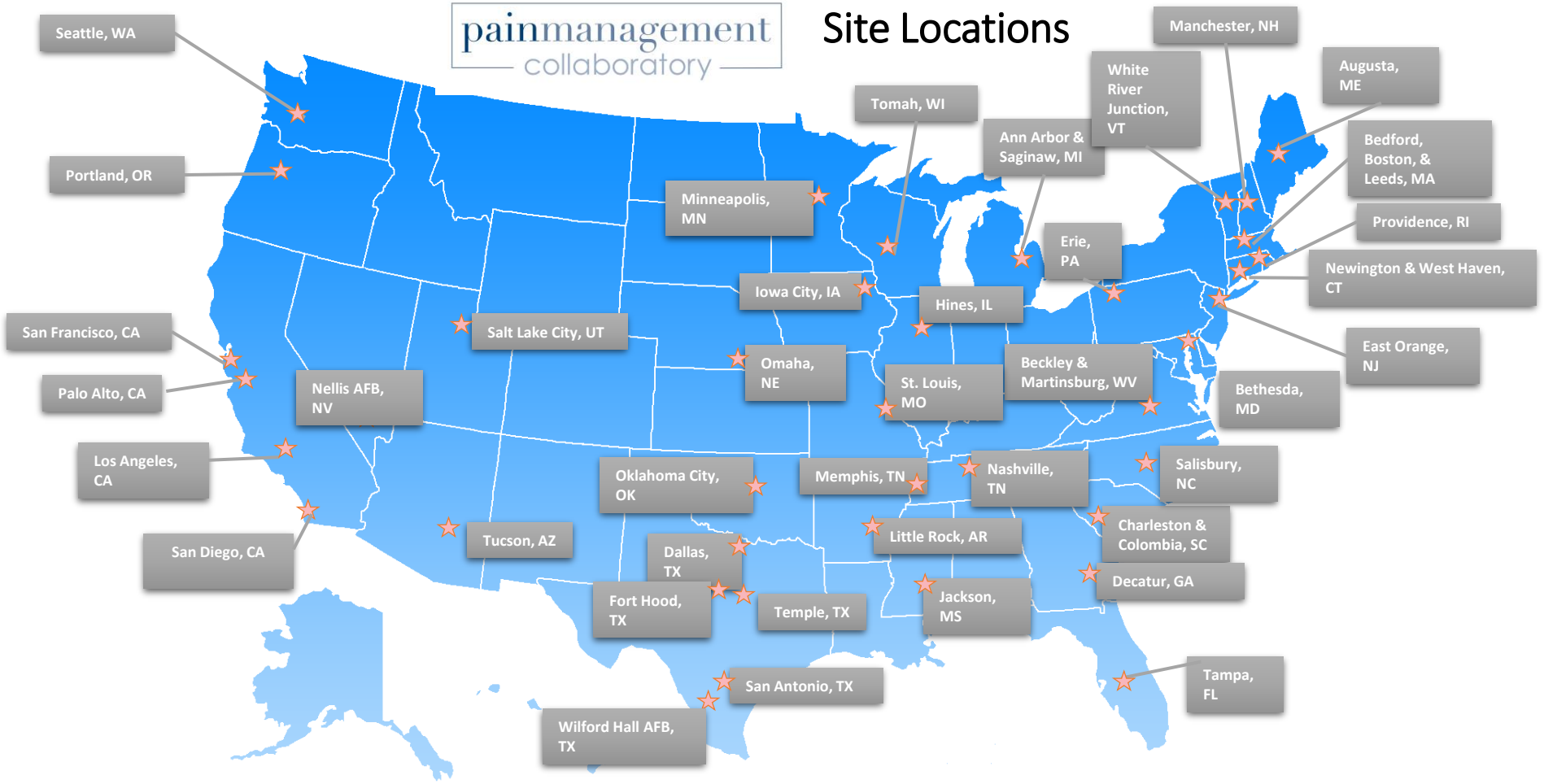
Site Locations



Other NIH and VA pain (and opioid) research initiatives

- NIH Helping to End Addiction Long-Term (HEAL)
  - 2018 launch; $2 Billion by July 2022; approx. 600 projects
  - Integrative Management of chronic Pain and Opioid use disorder for Whole Recovery (IMPOWR; Becker, Fiellin, Barry)
  - Multilevel Interventions to Reduce Harm and Improve Quality of Life for Patients on Long Term Opioid Therapy (MIRHIQL; Becker, Edmond)
- VHA Health Services Research and Development Service
  - Pain/Opioid Consortium (CORE; Heapy, Becker, Krebs)
  - Role of nonpharmacologic pain treatments in safe and effective opioid tapering in chronic pain (Black)
- Pain, Opioid Therapy, and PDMP (PMOP) Program Evaluation
  - Evaluation of Pain Management Teams (Edmond, Relyea)

Thanks!!

Robert.kerns@yale.edu

www.painmanagementcollaboratory.org

Follow me on Twitter: @Drbob52

Kate Nicholson, JD

Founder & Director

National Pain Advocacy Center

Alliance to Advance Comprehensive Integrative Pain Management

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Kate Nicholson, JD

- Executive Director, National Pain Advocacy Center.
- NPAC takes no industry funding. Other disclosures: CDC Opioid Workgroup.
- 30-year career in health-related civil rights. Previously at USDOJ.
- Person with lived experience of pain.

NPAC

NATIONAL PAIN ADVOCACY CENTER

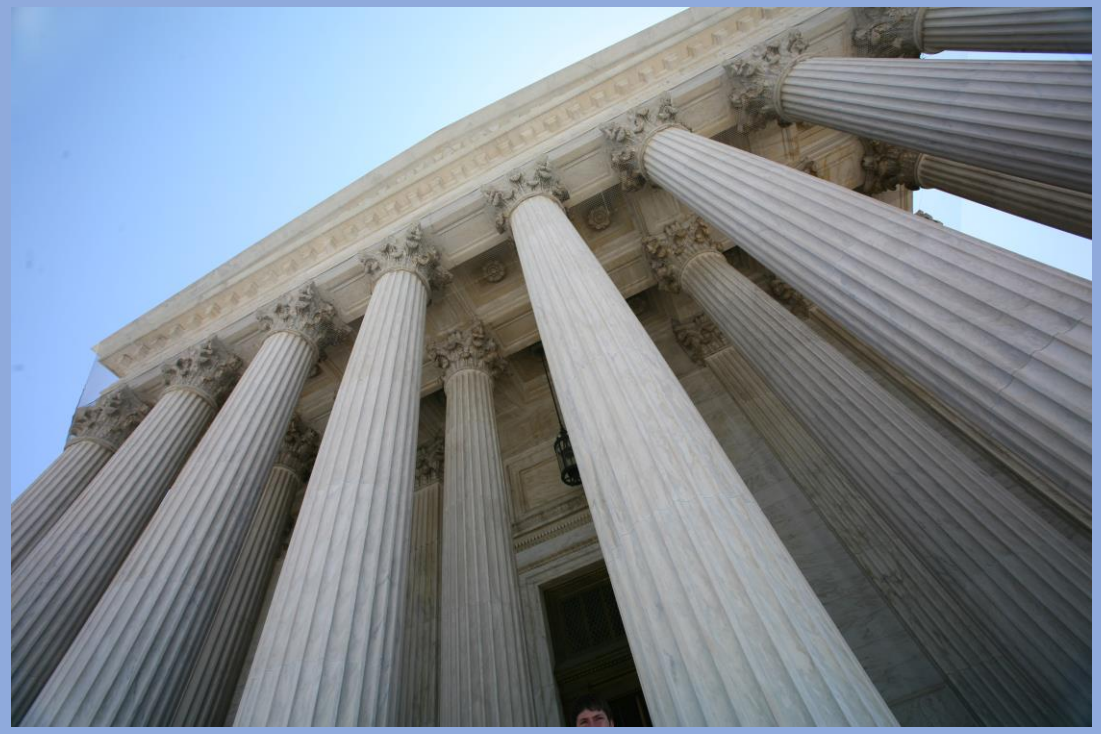
Pain Prevalence, Consequence, Cost

50 million Americans, or about 1 in 6, **live in pain** every day or almost every day.

Nearly **20 million** have pain **severe** enough to regularly prevent them from engaging in basic life activities.

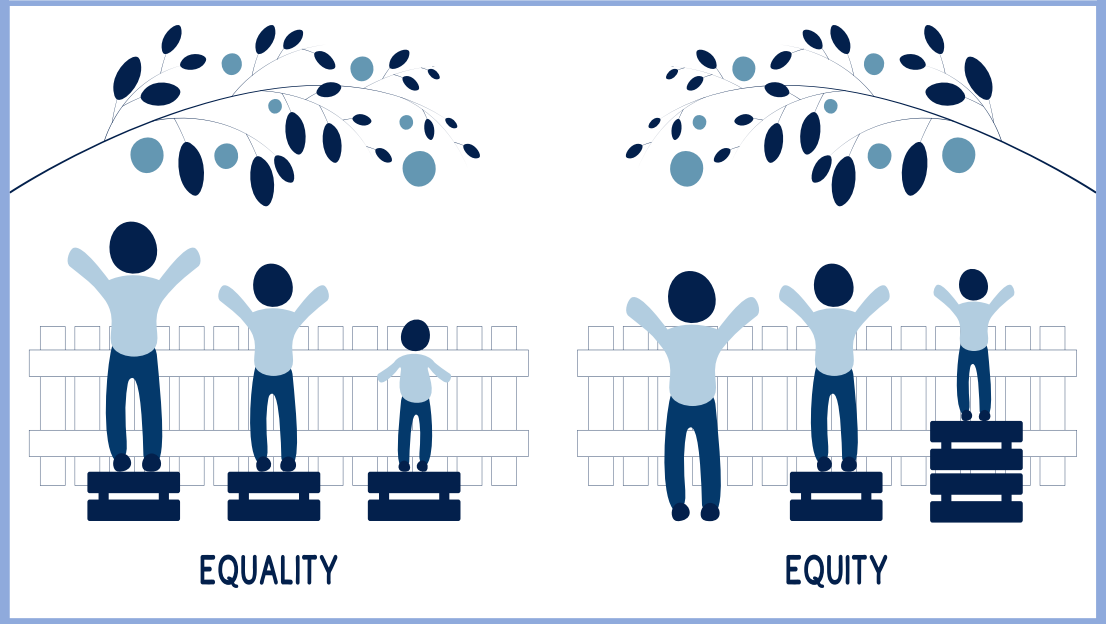
Pain is the chief cause of **long-term disability**.

US spends **$700 billion each year** (adjusted for inflation) in lost productivity and health costs.



Equity & Disparities: Defining Terms

Equity ≠ Equality. Equity may require treating people differently for a level playing field.



Disparities: *avoidable* differences in health status among groups.

Inequities: *avoidable and unjust* differences in health status & distribution of health resources (policies/structures).

Social Determinants of Health: *nonmedical factors* affecting health outcomes. Where people are born, live, work; social, political & economic forces.

Overwhelming Data

- Significant disparities based on race, ethnicity, disability, gender, LGBTQIA+ status, LEP, etc., exist across the healthcare ecosystem: in insurance coverage, access to care, quality of care, health outcomes, mortality rates, inclusion in biomedical research, among other things.

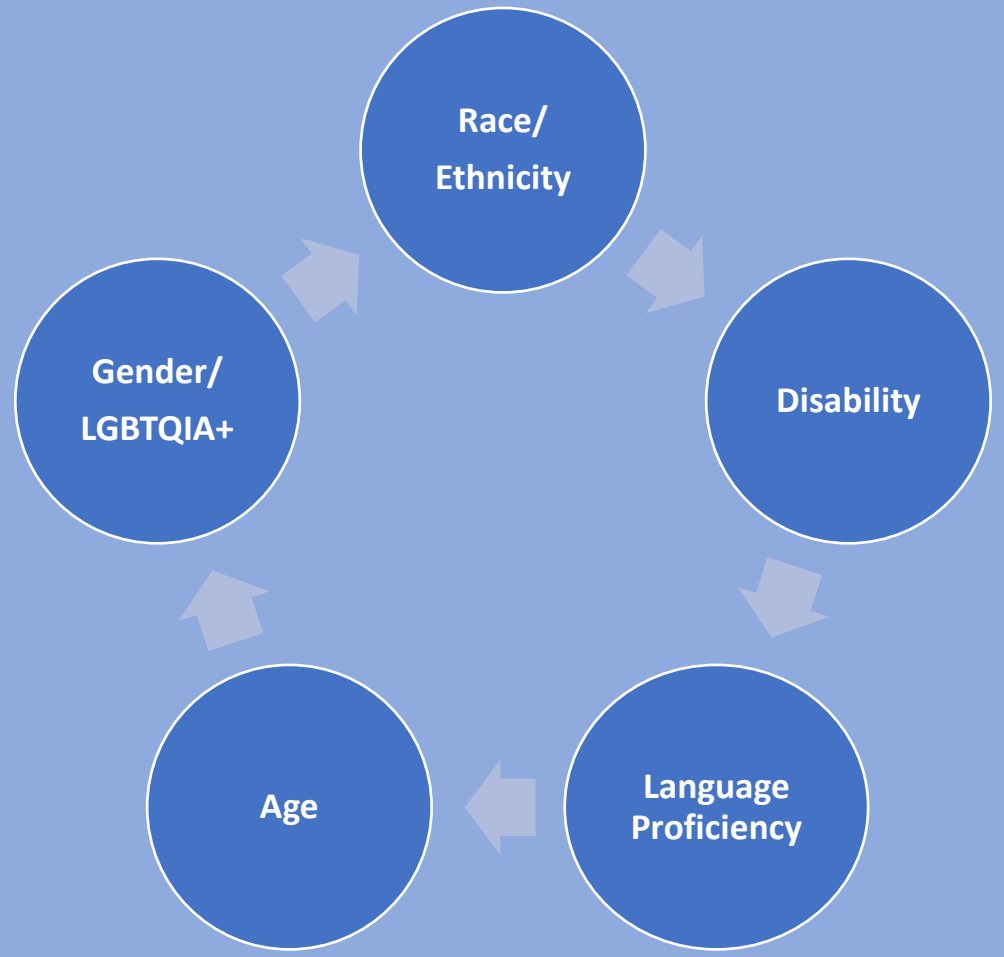
- HHS OCR Proposed Rule on Discrimination in Healthcare implementing sec. 1557 of the ACA mentions studies on bias in pain re: race/ethnicity, gender, and age. https://www.federalregister.gov/documents/2022/08/04/2022-16217/nondiscrimination-in-health-programs-and-activities *See also* https://nationalpain.org/resources-rights-and-disparities.

- The same document notes people with disabilities face substantial health barriers, including provider bias regarding the quality of their lives, the tendency of providers to substitute their judgments for patients' preferences, and a greater likelihood of being denied treatment.

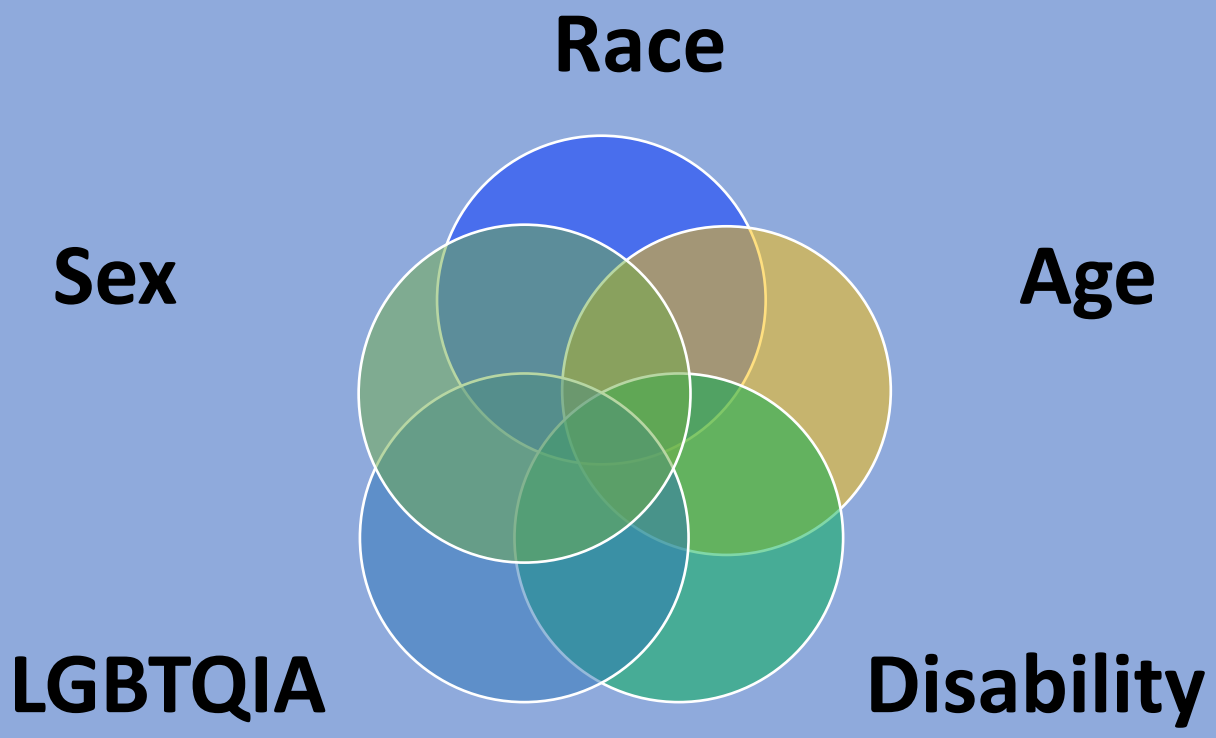
All Major Pain Policies Acknowledge Disparities.

All recognize inequity, bias & discrimination.

All approach the problem in terms of **unitary categories**.



Intersectionality & Whole Person Health



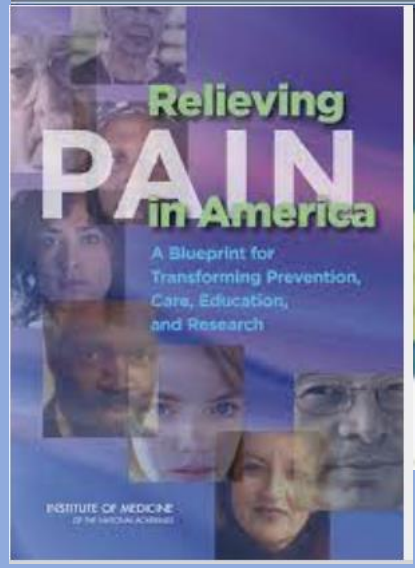
You might have a Latinx teenager who is transgender and disabled, for example.

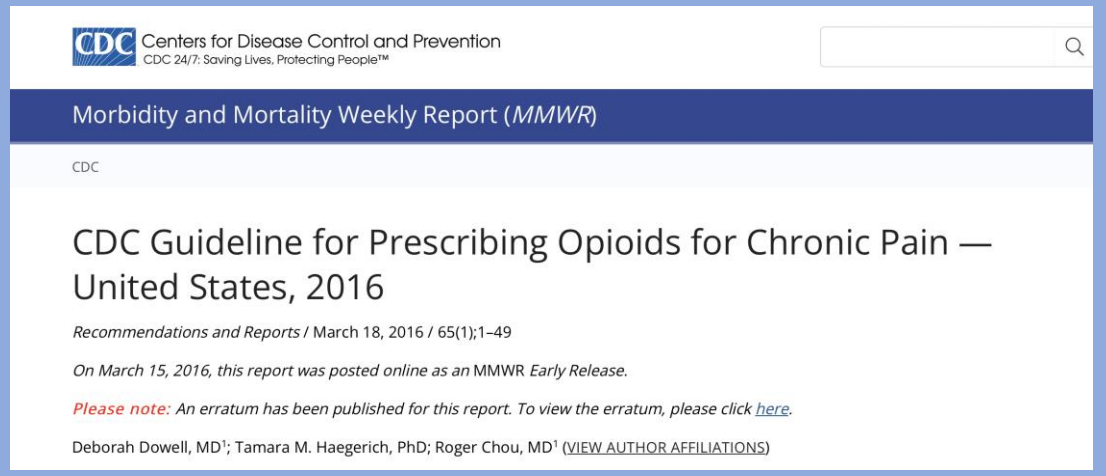
When we focus on a category like race, we often mythologize a universal experience.

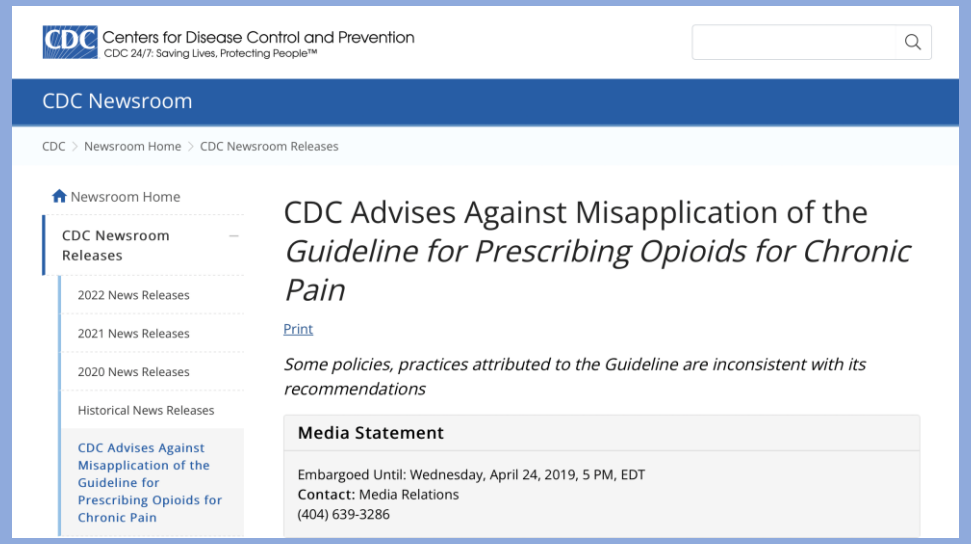
Those who fall outside familiar prisms or stereotypes are invisible (Crenshaw).

Example: We know pain disparately affects people as they age. We know there is bias based on race. There is little research on pain in aging Black men.

Policy: No Implementation/Strict Implementation







Access to Care

Pain Patients Who Take Opioids Can't Get in the Door at Half of Primary Care Clinics

"Secret shopper" study finds stigma is highest against those who say their last doctor stopped prescribing opioids to them.

Lagisetty, PAIN 2021; Lagisetty. JAMA Open Netw. 2019.

8 to 13 Million Americans (at least prior to 2016) take opioids long term for pain. Mojtabai R. Pharmacoepi. Drug Saf. 2015. Kroenke PAIN 2019.

81% of providers reluctant to treat people already taking opioids. Quest Diagnostics, 2019.

Tapering is associated break down of healthcare relationships. Perez, JGIM, 2020.

Patient Safety

Uptick in opioid discontinuation as safety measure, often abrupt, often requiring emergency medical services. Fenton, JAMA Open Netw 2019. Neprash, JGIM 2021. Mark, JSAT 2019.

Discontinuation increases risk of overdose and suicide 3-to-5-fold. Oliva, BMJ 2020. James, J Gen Int Med 2019. Hallvik, PAIN 2021.

Even destabilizing dose increases risk, which can last more than 2 years, occurs in patients with no known misuse/OUD, and occurs **regardless of the pace of tapering**. Glanz, JAMA Open New 2019. Agnoli, JAMA 2021. Fenton, JAMA Open Netw. 2022. Larochelle, JAMA Open Netw. 2022.

Statistical correlation of tapering with race and gender. Fenton, JAMA Open Netw. 2019.

In Summary

An **intersectional approach** suits **Whole Person Health**.

Access is essential: We can't improve pain if people don't have regional or economic access to treatment.

(Many years I have spent more out of pocket on health care than on housing.)

Equity is a cornerstone: Preferencing treatments for pain that are not fully covered or available may compound existing disparities.

Ben Kligler, MD, MPH

Director, Office of Patient Centered Care and Cultural Transformation

Veterans Health Administration

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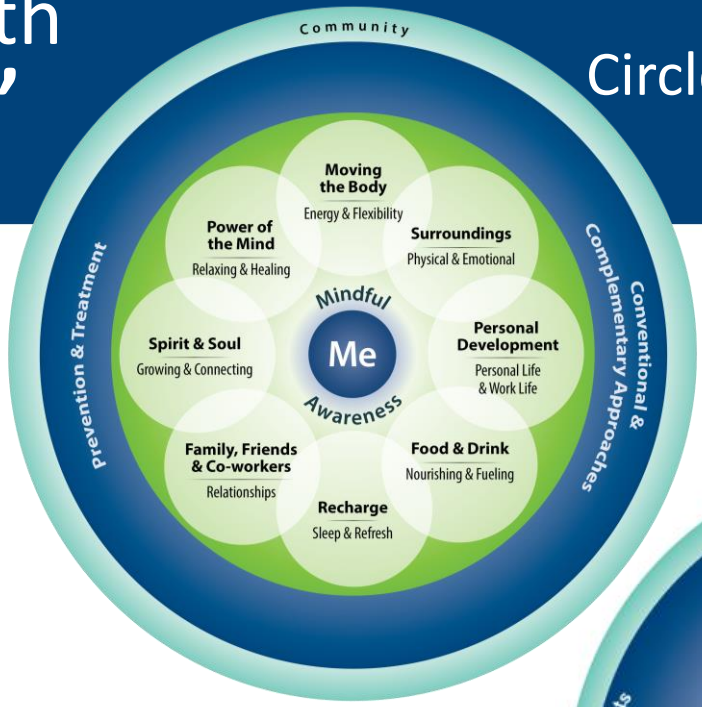
WHOLE HEALTH IN THE VETERANS HEALTH ADMINISTRATION

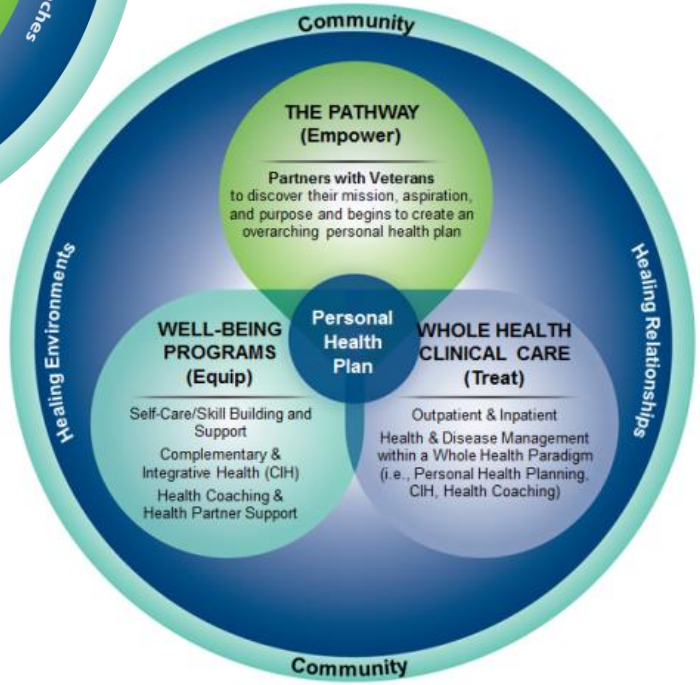
BENJAMIN KLIGLER MD MPH
EXECUTIVE DIRECTOR
OFFICE OF PATIENT CENTERED CARE & CULTURAL TRANSFORMATION
VETERANS HEALTH ADMINISTRATION

Moving from "What's the Matter with You?" to **"What Matters to You?"**

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



Circle of Health



Whole Health System

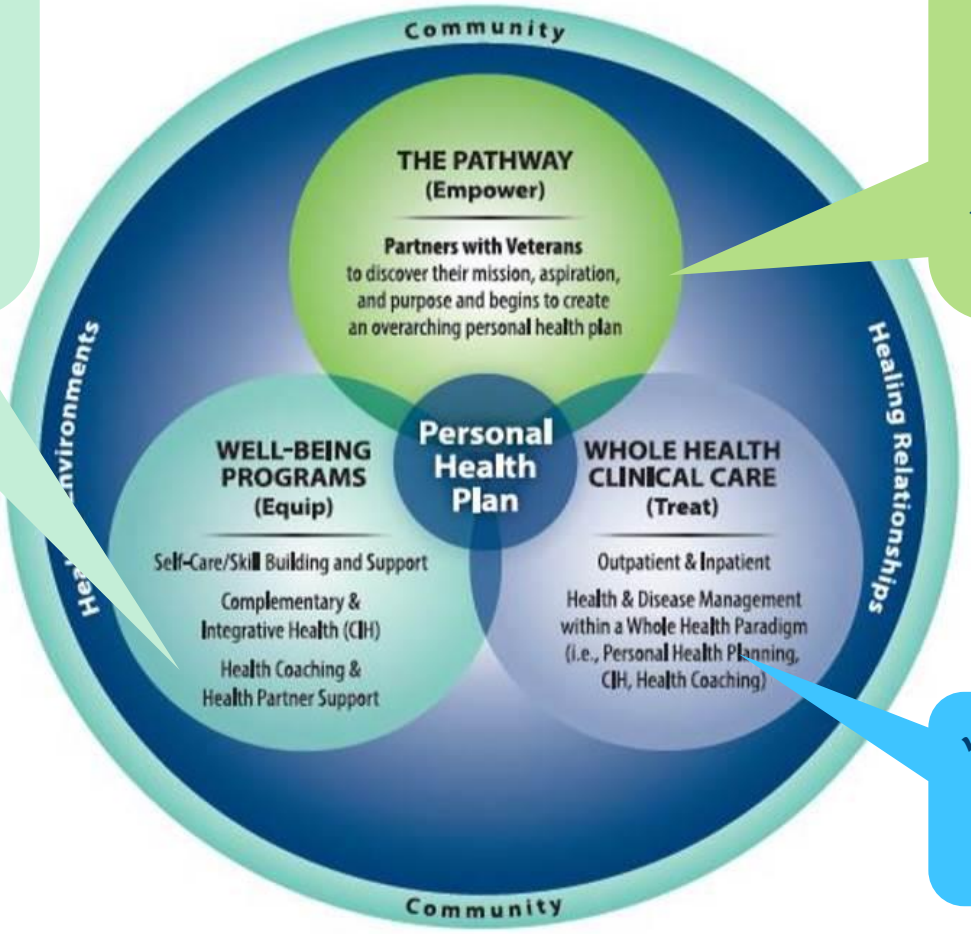
Live Whole Health.

VA U.S. Department of Veterans Affairs
Veterans Health Administration

Whole Health = Health Care Transformation

The Whole Health Model is a balance of 3 pillars that when combined will help drive the continued success of the transition to personalized, proactive, patient-driven care

- ✓ Encourage self-care
- ✓ Decrease reliance on provider delivered care
- ✓ Complementary and Integrative Health Approaches



- ✓ Engage Veterans in their Mission Aspiration Purpose (MAP)
- ✓ Veteran Partners, Whole Health Coaches

- ✓ Cultural transformation of how clinical health care is delivered

VA STRATEGIC PLAN 2022-2028

2022 – 2028 VA Quadrennial Plan: VA Plans, Budget, Finances, and Performance

- STRATEGIC OBJECTIVE 2.2: (Tailored Delivery of Benefits, Care and Services Ensure Equity and Access) VA and partners will tailor the delivery of benefits and **customize whole health care and services for the recipient at each phase of their life journey.**
  - ***Implementing Strategy 2.2.2: (Whole Health) VA empowers employees to deliver high-quality whole health care that equips Veterans and supports their health and well-being by addressing what matters to them most.***

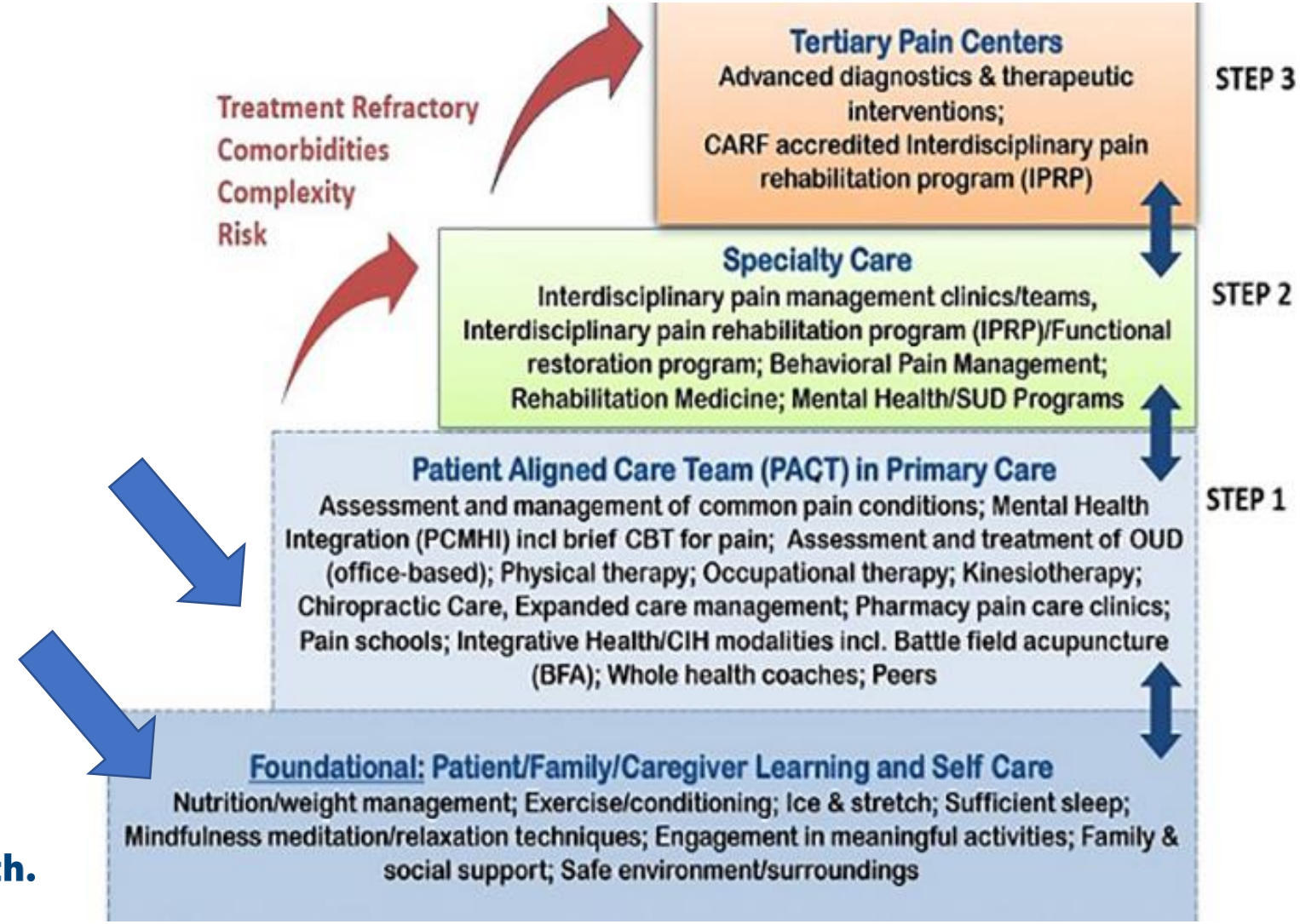
WHOLE HEALTH OUTCOMES: CONGRESSIONALLY MANDATED FLAGSHIP EXPERIENCE

Center for Evaluating Patient Centered Care in VA
QUERI Partnered Evaluation Initiative

- Opioid use among comprehensive WH users with pain decreased 38% compared with only an 11% decrease among those with no WH use.
- Decrease in downstream utilization of invasive spine procedures of 20-40% over 18 months in Veterans with chronic low back pain
- Veterans with a mental health diagnosis who began using Whole Health had a 2.3 times probability of being engaged in evidence-based psychotherapies 12 months later as those not using Whole Health.
- Black and women Veterans appear to be most/more interested in Whole Health services
- Veterans with chronic pain who used WH services reported:
  - Greater improvements in engagement in healthcare and self-care.
  - Greater improvements in engagement in life indicating improvements in mission, aspiration and purpose.
  - Improvements in quality of physical and mental health

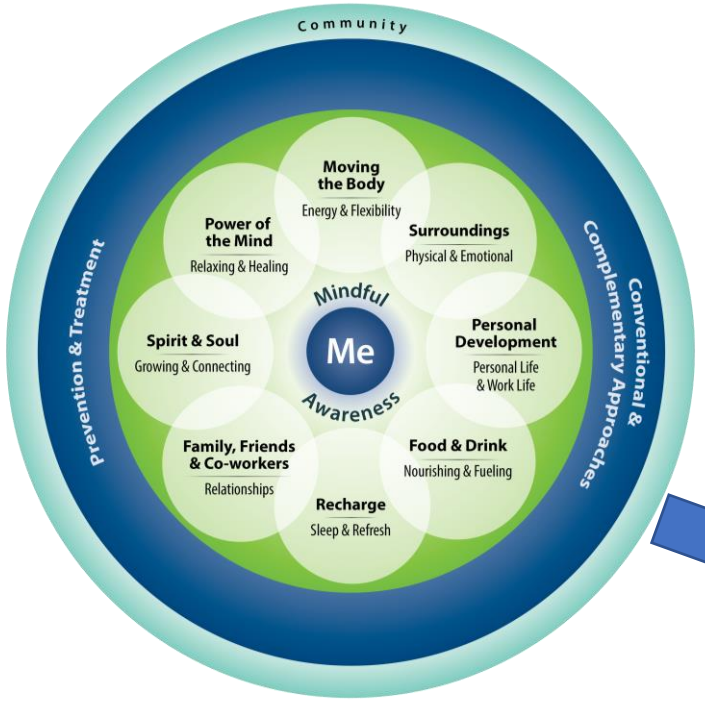
Whole Health System of Care Evaluation – A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites (Feb 2020): WHS Flagship Pilot Outcome Report

Whole Health is fully integrated in the VA Stepped Care Model of Pain Management

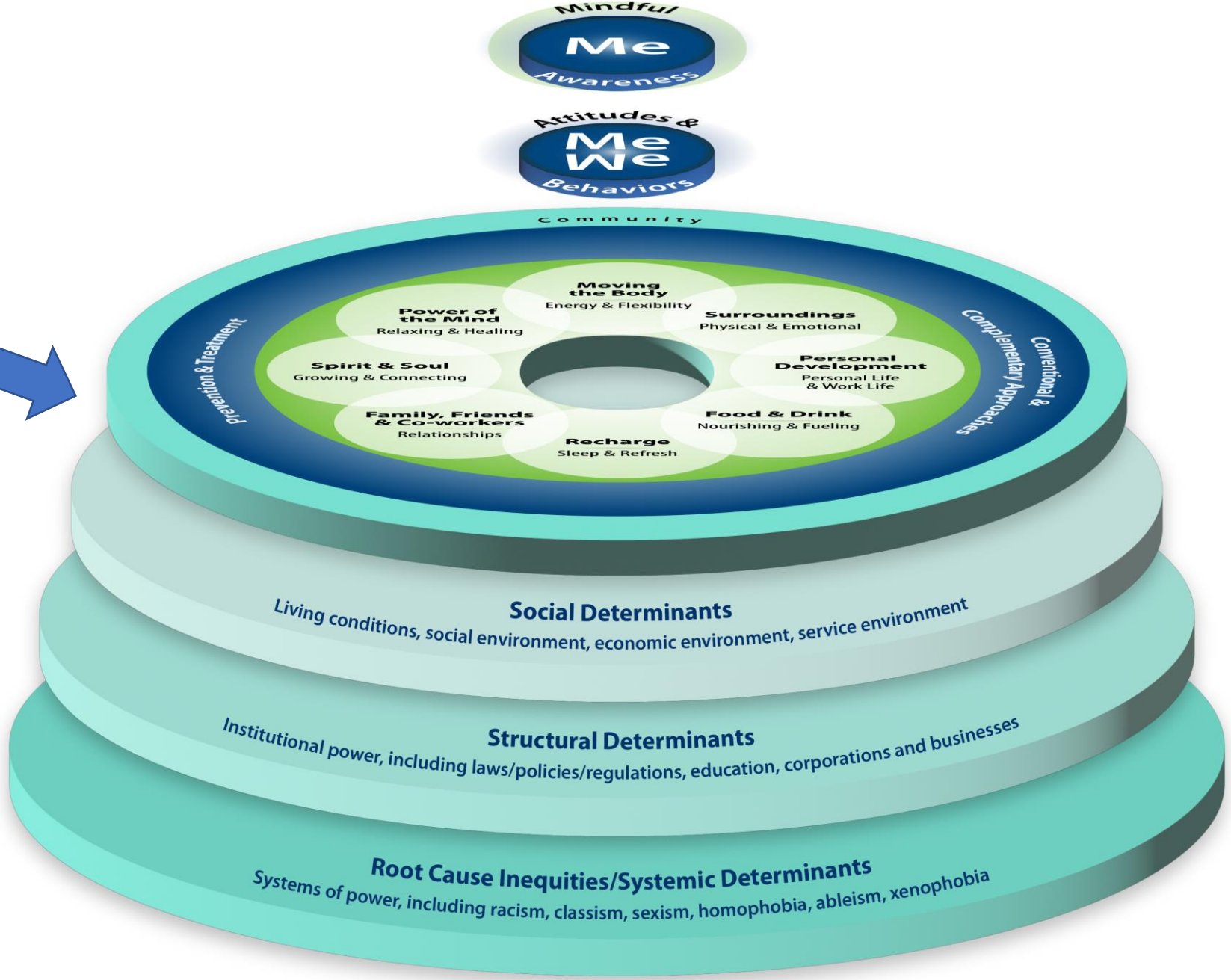


Live Whole Health.

U.S. Department of Veterans Affairs
Veterans Health Administration



WHOLE HEALTH AND STRUCTURAL DETERMINANTS



David Elton

VP, Musculoskeletal R&D

Optum Labs

Alliance to Advance Comprehensive Integrative Pain Management

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Geographic disparities in spine care

Association with health care provider availability and population measures of race, ethnicity, and deprivation

October 3, 2022
AACIPM Webinar (excerpts from 11/6 APHA presentation)
Virtual

Dave Elton, DC david.elton@optum.com
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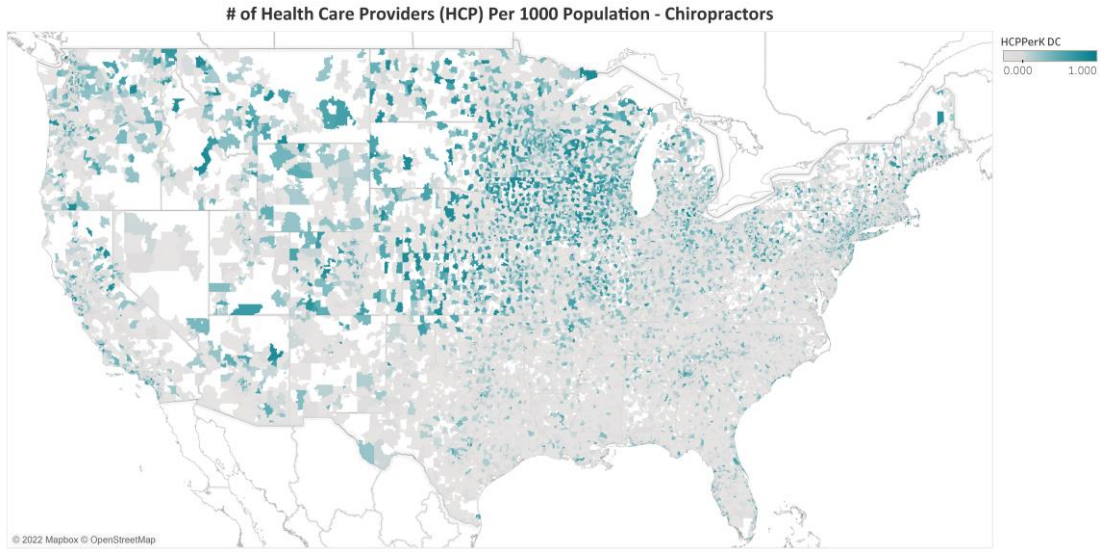
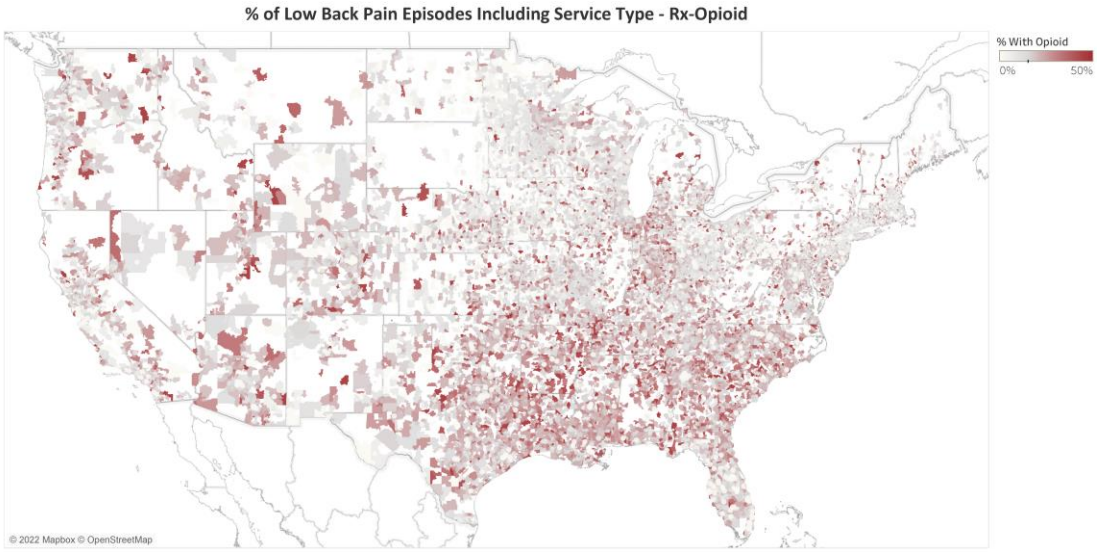




About the study

https://www.medrxiv.org/content/10.1101/2022.08.15.22278722v1

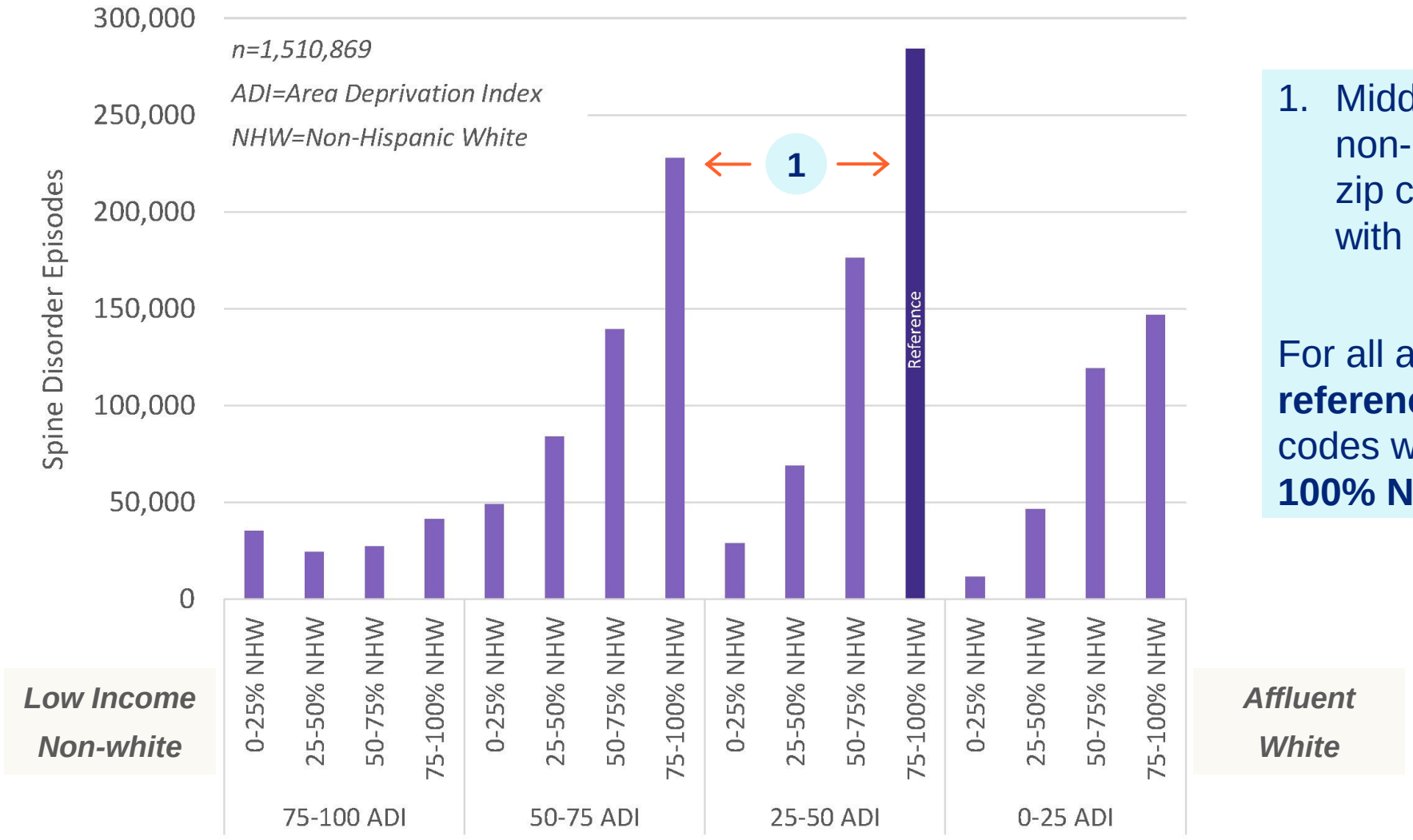
Commercially insured individuals with a complete episode of **low back or neck pain** in **2017-2019 (pre-COVID)**

1,534,280 episodes associated with **1,075,204** individuals living in **29,318** zip codes

17 types of health care provider (HCP) and **14** types of health care services

5-digit zip code population demographic data; **2018** Census Bureau ACS Survey, **2017** IRS tax statistics, **2019** University of Wisconsin Neighborhood Atlas Area Deprivation Index

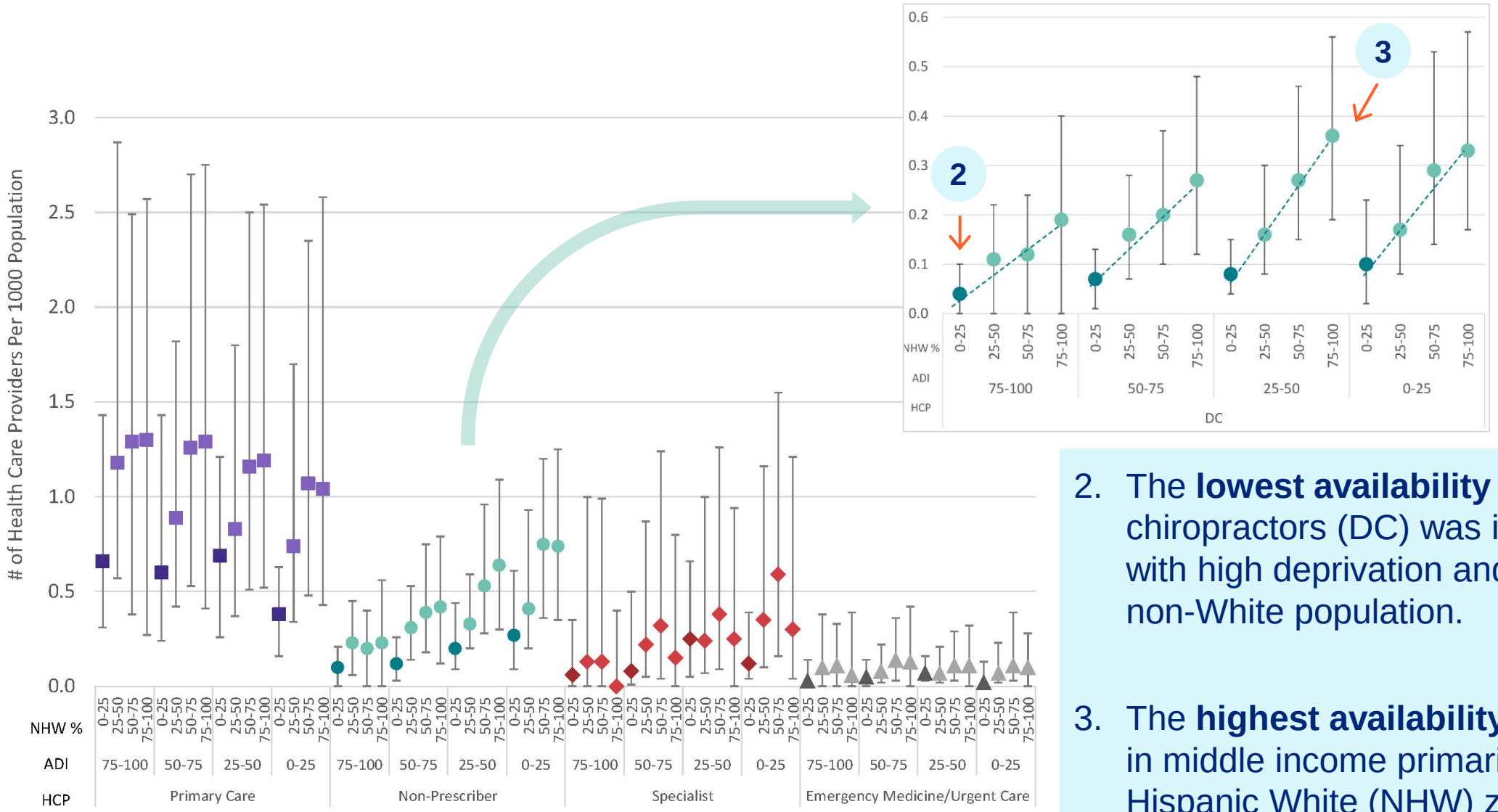
Zip code segmentation and spine disorder episode volume



1. Middle income, primarily non-Hispanic White (NHW) zip codes were associated with most episodes.

For all analyses, we selected the **reference segment** as zip codes with **25-50 ADI and 75-100% NHW** population

Health care providers (HCP) per 1000 population



2. The **lowest availability** of chiropractors (DC) was in zip codes with high deprivation and a primarily non-White population.

3. The **highest availability** of DCs was in middle income primarily non-Hispanic White (NHW) zip codes

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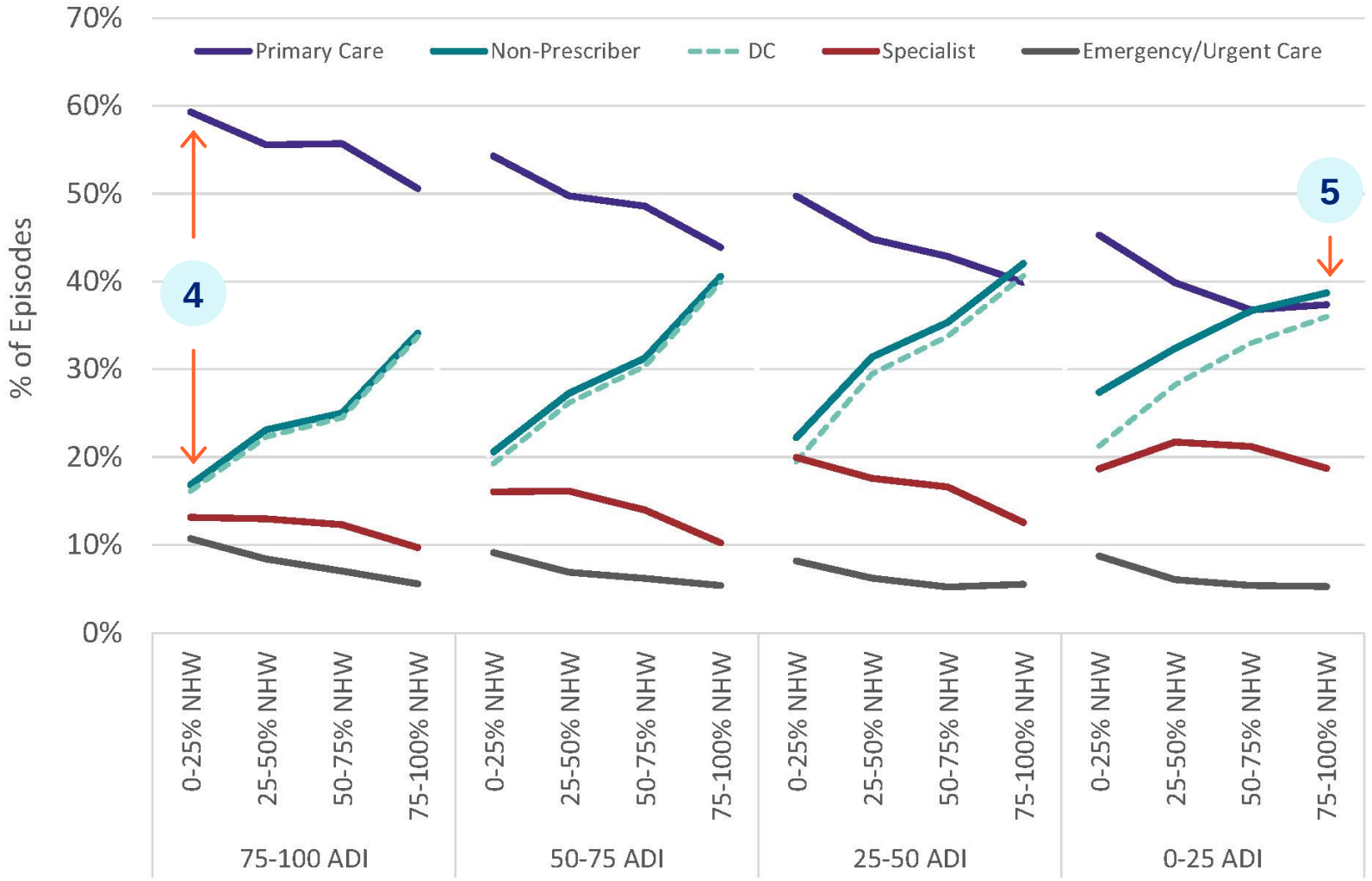
Type of HCP initially contacted by an individual with a spine disorder



4. Individuals in **low income, non-white zip codes**, are most likely to initially contact primary care, and **less likely to contact a non-prescriber**.

5. In **affluent, white zip codes**, individuals are **more likely to contact a non-prescriber than primary care**

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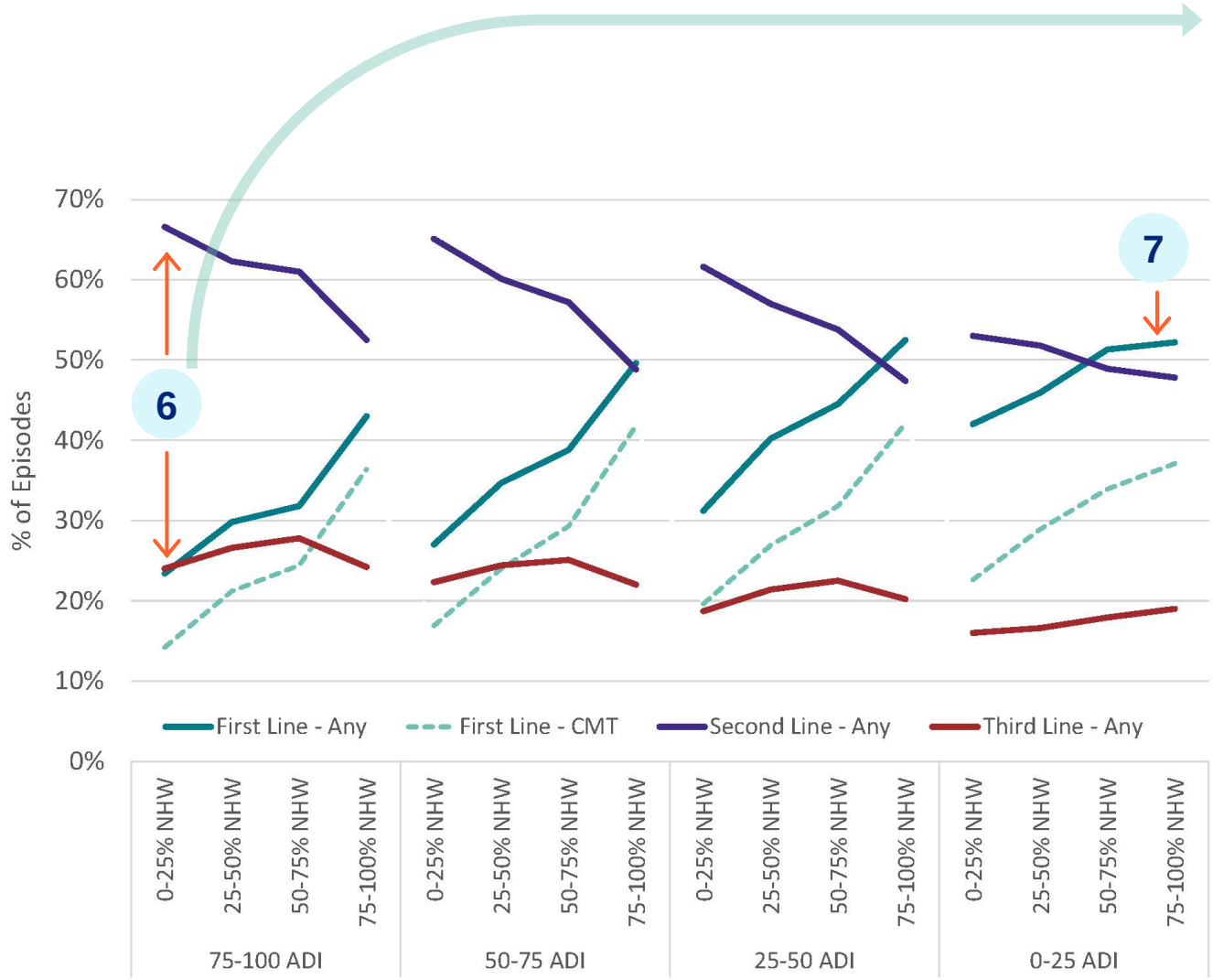
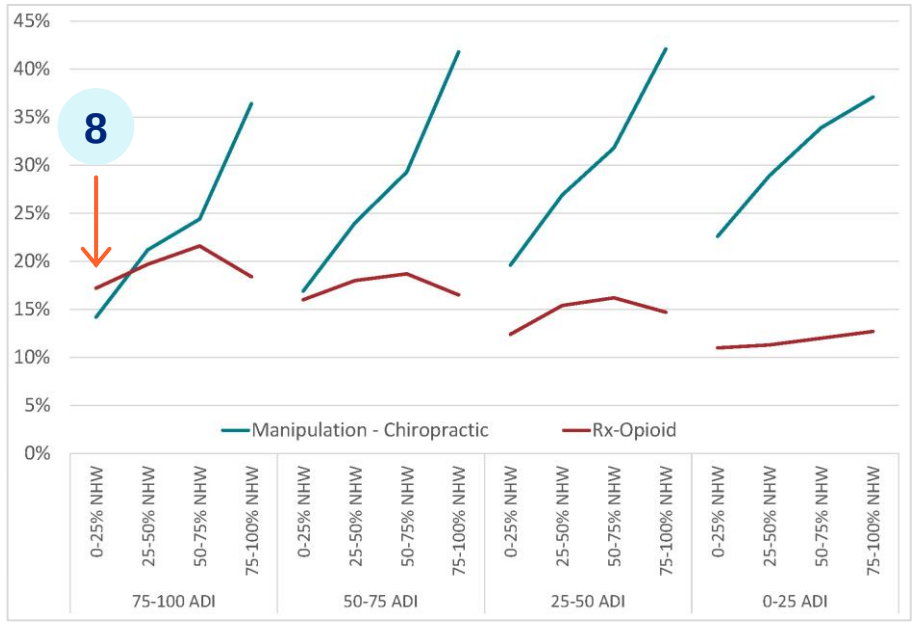
Services provided for spine disorders





6. Individuals in low income, non-white zip codes are more likely to receive second- or third-line services than first-line services.
7. In high income, white zip codes, individuals are more likely to receive a first-line service than a second-line service, and infrequently receive a third-line service.
8. Individuals in low income, non-white zip codes are more likely to receive a prescription opioid (**17.2%** of episodes) than chiropractic manipulative therapy (**14.2%**)

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Conclusions

Geographies characterized by **high deprivation and high % non-white population** have the **lowest availability of the types of health care provider (e.g., DC, PT, LAc) offering guideline concordant non-Rx treatment options**

Not surprisingly, these geographies are associated with **greater use of primary care and the emergency department** resulting in primary Rx management, including **greater use of prescription opioids**

Translation opportunity is **addressing barriers to increasing availability of and access to non-Rx treatment options** in these geographies

- financial viability of traditional solo or small practice models
- workforce diversity

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Questions for other panelists

How do we improve guideline concordance and value in:

low income, non-white zip codes with **sparse/no access** to guideline recommended non-Rx, non-interventional and hands-on types of health care providers (e.g., DCs, PTs, and LAcs)?

affluent, non-Hispanic white zip codes with an **abundance of all types** of health care providers?

What's next

Commercial and **Medicare Advantage** insured individuals with a complete spine disorder episode in **2019-2021**

Impact of COVID, addition of Medicare

17 types of health care provider and **17** types of health care services

Additional Rx classes (gabapentins, benzodiazepines, oral steroids), lab, DME

Census Block Group or zip+4 population demographic data; **2020** Census Bureau ACS Survey, **2019** IRS tax statistics, 2019 University of Wisconsin Neighborhood Atlas Area Deprivation Index, University of North Carolina Chapel Hill **Health Literacy**

Finer grain of population factors

Provider race/ethnicity

Explore individual-provider racial concordance preferences

Denise Giambalvo

Director of Purchaser Strategies

Washington Health Alliance

Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

Acute Low-Back Pain Implementation Collaborative – Funded by Arnold Ventures

Denise Giambalvo
Director of Purchaser Strategies
Washington Health Alliance
October 3, 2022

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

Mission and Vision

The mission of the Washington Health Alliance is to build and maintain a strong alliance among purchasers, providers, health plans, and consumers **to promote health and improve the quality and affordability of the health care system in Washington state**.

Our vision is that physicians, other providers and hospitals in Washington will achieve **top 10% performance in the nation** in the delivery of equitable, high quality, evidence-based care and in the reduction of unwarranted variation, resulting in a significant reduction in the rate of medical cost trend.

Diverse Stakeholder Membership

Health Waste Calculator Top Low-Value Services

Measure	WA State	A	B	C	D	E	F	G	H
Annual EKG or cardiac screening in individuals who are low-risk and without symptoms (M)	1	1	1	2	3	1	1	2	2
Opiates for acute low back pain (H)	2	2	2	1	1	5	4	1	1
Antibiotics for acute URI and ear infections (L)	3	4	4	4	2	2	2	3	3
Pre-operative baseline lab studies prior to low-risk surgery in healthy individuals (L)	4	5	5	3	5	3	3	4	4
PSA screening for prostate cancer in men (M)	5	3	3	10	4	4	5	5	5
Imaging tests for eye disease (L)	6	6	8	5	6	6	7	10	9
Too frequent cervical cancer screening in women (M)	7	7	7	7	10	8	8	9	7
Routine general health checks in adults 18-64 (L)	8	9	9	15	7	7	9	8	8
Screening for vitamin D deficiency (L)	9	8	6	6	8	9	6	6	6
NSAIDS prescribed for adults with hypertension, heart failure or chronic kidney disease (M)	10	10	11	8	9	11	11	11	10
Imaging for low back pain within 6 weeks of diagnosis (M)	11	11	10	11	11	10	10	7	11
Too frequent colorectal cancer screening adults 50-74 (L)	14	13	16	9	19	15	12	22	16

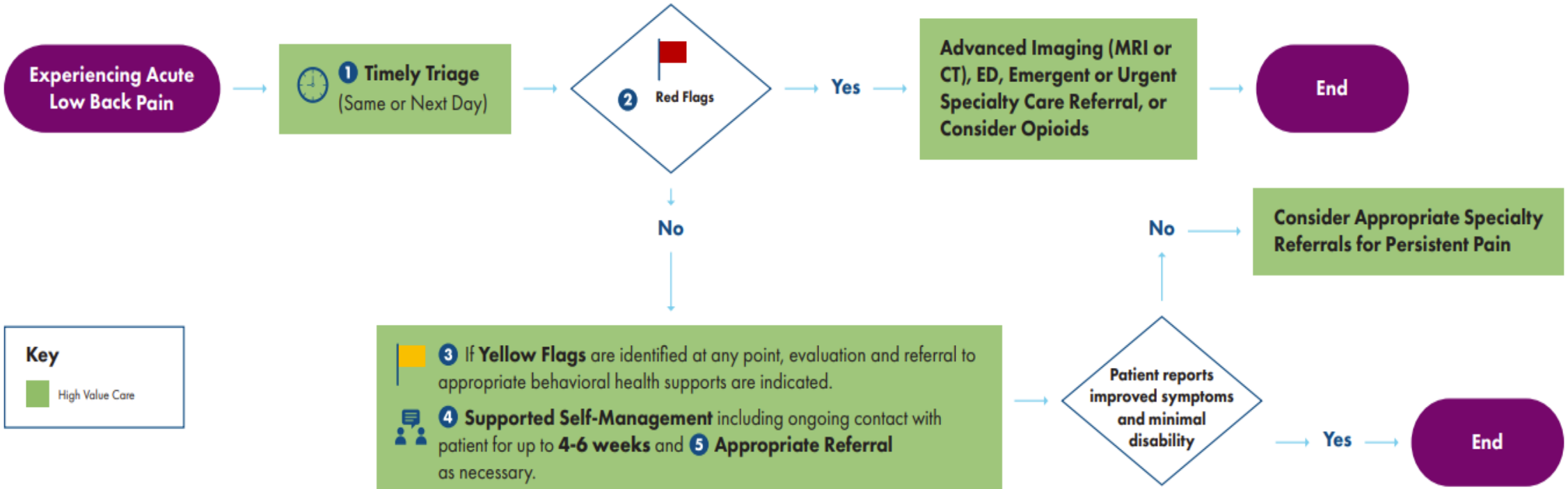
WASHINGTON HEALTH ALLIANCE

LOW BACK PAIN Implementation Collaborative

Advancing Equity in Acute Low-back Pain Care

Acute Low Back Pain Care Pathway

Common Goal — Decreased Use of: Advanced Imaging, Emergency Department (ED), Opioids and Surgery as First Interventions



Actions for Equity

Employers

- Implemented programs with zero co-pay and 24-hour access to triage

Providers

- Created educational materials in multiple languages
- Practicing shared-decision making
- Championed new legislation that would include coverage for Chiropractic care for all adults in WA
- Increased timely triage with trained clinicians who provide supportive self-management

Health Plans

- Worked to expand coverage for evidence-based alternative therapies
- Deployed bilingual navigators focused largely on communities with limited English proficiency

Daniel Blaney-Koen, JD

Senior Legislative Attorney

American Medical Association

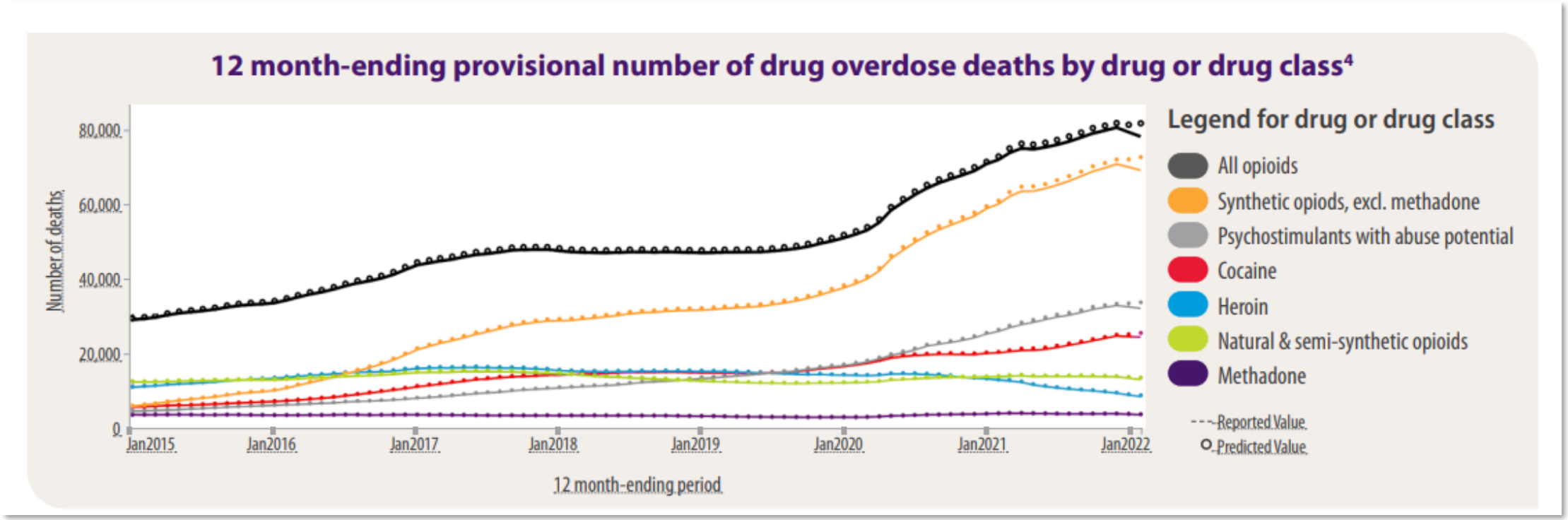
Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

Advocating for patients with pain

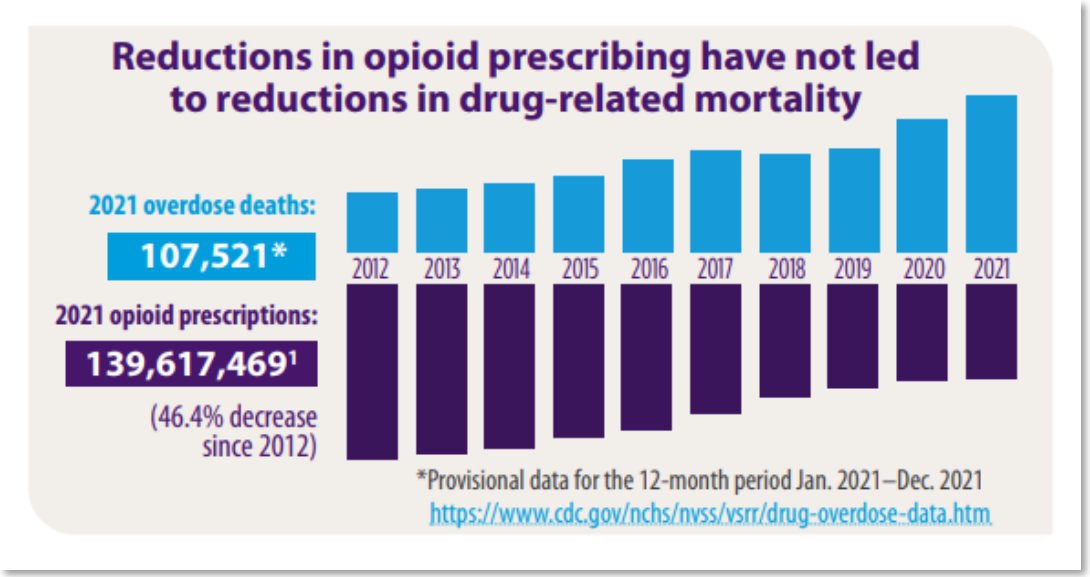
Daniel Blaney-Koen, JD
October 2022

The nation's drug overdose and death epidemic continues to worsen



Policy intervention 1: Restricting Rx opioids has not reduced drug overdose or death

- 2016 CDC opioid prescribing guidelines recommended restricting opioid Rxs to 3-7 days and less than 90 daily MME
- More than half of states have laws/regs restricting opioid Rxs along with payers, pharmacies
- Since 2012, opioid prescriptions have decreased 46.4 percent
- Since 2012, MME has decreased 57.2 percent



The AMA strongly agrees with CDC …

This clinical practice guideline is not

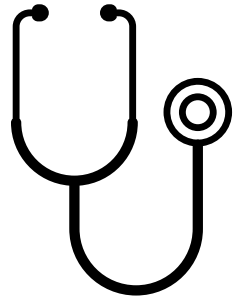
- A replacement for clinical judgment or individualized, person-centered care
- Intended to be applied as inflexible standards of care across patients, and/or patient populations by healthcare professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or discontinuation of opioids for patients
- A law, regulation, and/or policy that dictates clinical practice or a substitute for FDA-approved labeling

Policy intervention 2: Mandating PDMPs has not reduced drug overdose or death

Year	Drug-related overdose deaths, US	Opioid prescriptions dispensed from retail pharmacies, US	Prescription drug monitoring program queries, US
2012	41,502	260,464,735	
2013	43,982	251,770,763	
2014	47,055	244,484,091	61,462,376
2015	52,404	227,807,356	86,096,259
2016	63,632	215,998,653	136,643,036
2017	70,237	192,696,190	295,347,288
2018	67,367	168,858,135	449,497,610
2019	70,630	153,966,961	744,943,531
2020	91,799	143,389,354	908,269,727
2021	107,270	139,617,469	1,138,346,812

What's happened since the 2016 CDC Guideline?

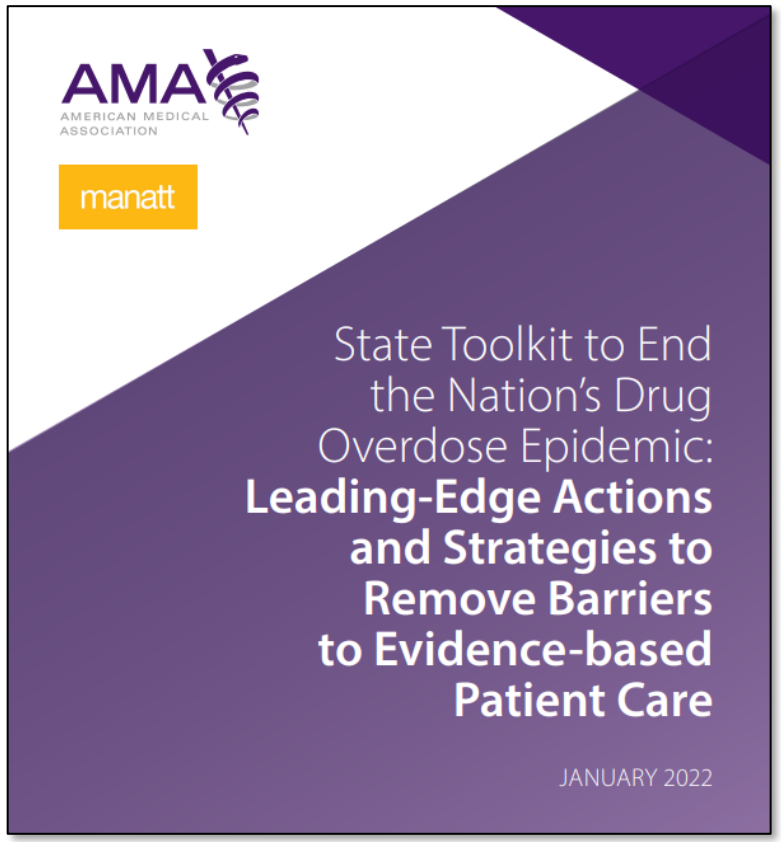
- Pressure to terminate and taper opioid therapy
- Increased stigma and scrutiny when opioid therapy indicated
- No meaningful increase in access to non-opioid therapies
- Continued challenges in access to integrative, multimodal pain care
- Continued inequities in pain care
- Increased frustration, pain and suffering



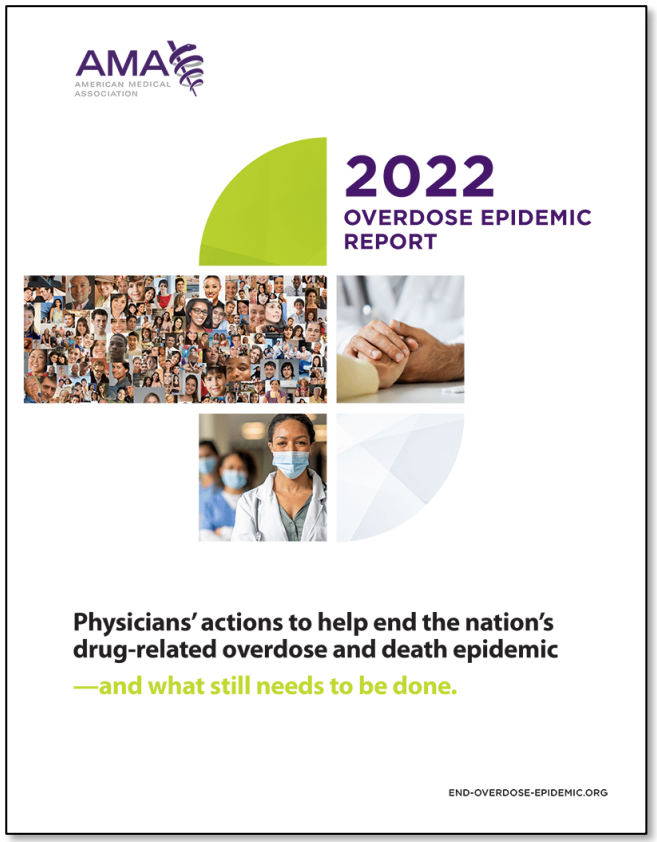
We all have a role to play to help patients with pain (a non-exclusive list)

Physicians	Implement foundational training in medical schools
	Advocate for policies that rescind the 2016 CDC opioid prescribing guideline
	Treat patients with pain with care and compassion
Payers	Remove all vestiges of the 2016 CDC guideline from coverage and utilization policies
	Increase access to affordable, accessible non-opioid pain care options
	Ensure networks include sufficient numbers of multispecialty pain care professionals
Employers	Review benefit design to ensure adequate networks of multispecialty pain care professionals
	Support patients' SDOH to access individualized pain care treatments
	Advocate for policies that support individualized pain care decisions by pain care professionals
Policymakers	Rescind all vestiges of 2016 CDC opioid Rx guideline numeric thresholds from statute and rule
	Enforce the primacy of state licensure authority and prohibit payer or pharmacy intrusions
	Review networks and formularies to ensure access to wide spectrum of pain care options

Recent AMA resources, best practices



https://end-overdose-epidemic.org/wp-content/uploads/2022/02/AMA-Manatt-Health-Toolkit-Resources-January-2022_f_FOR-WEB-FINAL.pdf



https://end-overdose-epidemic.org/wp-content/uploads/2022/09/AMA-Advocacy-2022-Overdose-Epidemic-Report_090622.pdf

Questions?

Moving to Panel Discussion

Co-Moderators

Robert Kerns, PhD
Director, **NIH/VA/DoD Pain Management Collaboratory**

Amy Goldstein, MSW
Director, **Alliance to Advance Comprehensive Integrative Pain Management**

Alliance to Advance Comprehensive Integrative Pain Management

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Closing Remarks

Amy Goldstein
Director
Alliance to Advance Comprehensive Integrative Pain Management (AACIPM)

Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

Thank you for joining

We hope you've been inspired by this webinar. Watch for the next webinar in this series.

Please share your feedback – Amy@PainManagementAlliance.org

You can find the slides, recordings and more on AACIPM website:

https://painmanagementalliance.org/innovation-webinar