Innovation & Progress Series

Realities, Research & Rethinking Person-Centered Integrative Pain Management

Alliance to Advance Comprehensive Integrative Pain Management

January 25, 2023 | 11:30 AM-1:00 PM CDT

Innovation & Progress Webinar Series

Amy Goldstein

Director

Alliance to Advance Comprehensive Integrative Pain Management (AACIPM)

Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

Why This Webinar Today

- The use of integrative care has been increasingly recommended by policymakers at local, state, and national levels.
- Most pain-related clinical guidance points to early use of non-pharmacological and team-based therapies, yet extensive challenges affect coverage and access, especially for those who are underserved.
- People with pain want access, but deep disconnects remain around misperceptions, current research, clinical practices, business case and more.
- Awareness and advocacy is a key lever for change. We believe connecting different stakeholder perspectives together will bring improved awareness and spark more advocacy opportunities.

Panelists

Dan Clauw, MD
Director, Chronic Pain & Fatigue Research Center
University of Michigan

Nicole Golding, MD, FAAPMR, CHCQM
Medical Director, Health Services
American Special Health

Ravi Prasad, PhD
Clinical Professor & Director of Behavioral Health
Dept. of Anesthesiology & Pain Medicine, UC Davis

Bethany Ranes, PhD
Research Scientist

Keaton Schmitz
Third-Year Medical Student &
Fibromyalgia Patient

Important Note – Your Expertise Really Matters

- AACIPM includes participation across more than 75 stakeholder organizations, including many different healthcare provider perspectives.
- https://painmanagementalliance.org/engage/aacipm-participants/

- Pre-Webinar Poll: What attracted you most to this webinar?
- Post-Webinar Poll: What would you have liked to see included in this or future webinars?

Please use the chat feature to share "other" answers so we can capture your input.

AACIPM

AACIPM is not an organization. It is a nimble, grant-funded initiative.

AACIPM is a multi-stakeholder collaborative connecting people with pain, payers, purchasers, providers, academia, government agencies, advocates and more. We align around keeping people with pain at the center.

Focus: Connecting the dots to advance equitable, whole person, multimodal, guideline-concordant care.

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

Alliance to Advance
Comprehensive
Integrative
Pain Management

AACIPM CONNECTS THE DOTS TO ADVANCE EQUITABLE, WHOLE PERSON, MULTI-MODAL PAIN CARE.

Advocating for Integrative Health Care at the Federal Level
A Success Story – Physician Fee Schedule 2023

- CMS implemented new codes for Integrative Pain Management Services, changing payment structures to support team-based care. Effective Jan. 1, 2023.
- The codes (HCPCS G3002 and G3003) pertain to chronic pain lasting longer than three months, and may be billed by a physician or other qualified health practitioner, and cover a variety of services which advance integrative care, including, in part:
  - ***ongoing communication and care coordination between relevant practitioners*** furnishing care (e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care), and
  - ***facilitation and coordination*** of any necessary behavioral health treatment.

New codes came after years of sustained advocacy.

https://painmanagementalliance.org/2022/11/30/cms-creates-new-pain-management-codes-heeding-advice-of-aacipm/

Advocacy Had a Vital Impact

Without collective advocacy efforts, the well-intentioned CMS codes would have been riddled with unintentional negative consequences.

How Can You Help?

Promote awareness & implementation to ensure patients and providers benefit from the new codes:

- Providers must be educated as to the existence and utility of the new codes.
- The codes must be properly utilized to provide CMS with follow-up data.

While the CMS example may sound complex, it was simply the ***input we received from different healthcare providers about their unique experiences*** with patient care (e.g., billing, access) that made a difference. AACIPM combined multi-stakeholder perspectives into one cohesive letter.

Capture Your Experiences. Collect Your Own Data.
Share Your Stories. Promote Implementation. Get Involved!

Thank You

Special thanks to the primary funder for this project:

The David and Lura Lovell Foundation

Thank You

Special thanks to the fiscal sponsor for this project:

Why do 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

Multimodal Care is the Gold Standard but **Not Accessible** for Many, Especially Underserved Persons

CIPM TOOLBOX

Alliance to Advance Comprehensive Integrative Pain Management

IMPORTANT FACTORS

Trauma-Informed Care
Education
Risk Assessment
Stigma

SOCIAL FACTORS

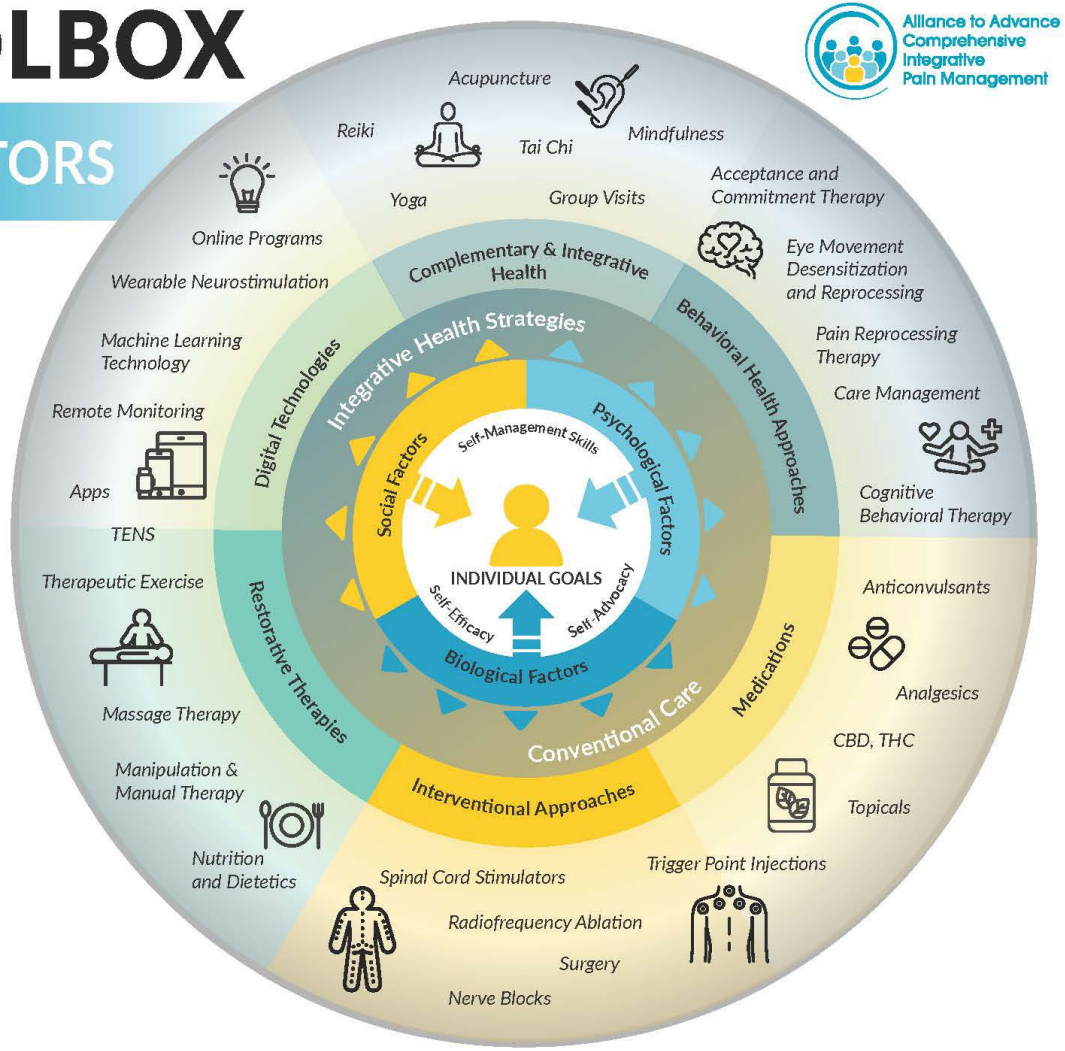
Environmental
Stigma
Cultural
Racism
Discrimination
Housing
Transportation
Food Security

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.

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

CHALLENGES

Why is evidence-based, guideline-concordant, multimodal care **inaccessible** for many people, especially those who are underserved?

EQUITY

Misperceptions & Stigma

Lack of Awareness/Education

Business Case Data Disagreement

Workforce Supply & Demand

Misaligned Financial Incentives

Integration & Cultural Incompatibilities

EQUITY

Dan Clauw, MD

Director, Chronic Pain & Fatigue Research Center

University of Michigan

Alliance to Advance Comprehensive Integrative Pain Management

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Re-Thinking Catastrophizing . . .

as well as a lot of other dogma in the pain field

Daniel J. Clauw M.D.

dclauw@umich.edu
Professor of Anesthesiology, Medicine (Rheumatology), and Psychiatry
Director, Chronic Pain and Fatigue Research Center
The University of Michigan

Disclosures

- Consulting
  - Pfizer, Tonix, Theravance, Zynerba, Samumed, Aptinyx, Daiichi Sankyo, Intec, Regeneron, Teva, Lundbeck, Virios
- Research support
  - Pfizer, Cerephex, Aptinyx
- Litigation – testified against opioid manufacturers in State of Oklahoma, Florida

Destroyed Dogma

- Catastrophizing and negative affect are traits that predispose individuals to develop chronic pain
- Chronic pain is due to ongoing peripheral nociceptive input from damage/inflammation to peripheral tissues and/or nerves
- Complementary and Alternative therapies should be considered as such

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AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Arthritis Care & Research
Vol. 72, No. 8, August 2020, pp 1096–1103
DOI 10.1002/acr.24000

Stability of Measures of Pain Catastrophizing and Widespread Pain Following Total Knee Replacement

Emma C. Lape,[1] Faith Selzer,[2] Jamie E. Collins,[2] Elena Losina,[3] and Jeffrey N. Katz[2]

Objective. Pain catastrophizing and widespread pain are predictors of pain chronicity/severity. Gaps remain in our understanding of the extent to which each is a stable (trait) or dynamic (state) variable. We undertook this study to assess the stability of each variable from before to after total knee replacement (TKR) and whether changes are explained by pain improvements.

Methods. We used data from a prospective study of TKR recipients ages ≥40 years. Questionnaires included body pain diagrams assessing widespread pain, the Pain Catastrophizing Scale (PCS), and the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) pain subscale. We divided subjects into widespread pain groups (0 versus 1–2 versus ≥3 pain regions) and into low and high PCS score groups (<16 versus ≥16). We assessed changes in group membership from pre-TKR to 12 months post-TKR, then compared these changes between subjects with most and least WOMAC pain improvement.

Results. A total of 176 subjects completed scales at both time points; 64% were female, the mean age was 66 years, and baseline median WOMAC pain score was 40. In all, 71% of subjects in the high PCS score group improved to join the low PCS score group at follow-up. While 73 subjects (41%) changed widespread pain group, they were similarly likely to worsen and to improve. We found a statistically significant positive association of improvement in WOMAC pain score with improvement in PCS score ($r = 0.31$), but not widespread pain ($r = –0.004$).

Conclusion. The PCS score reflects state-like aspects of catastrophizing that diminish along with pain. In contrast, widespread pain scores worsened and improved equally often, regardless of knee pain relief. The findings urge caution in interpreting PCS score and widespread pain as trait measures in musculoskeletal research.

Pain and Catastrophizing in Patients With Rheumatoid Arthritis

An Observational Cohort Study

Ezra M. Cohen, MD, Robert R. Edwards, PhD,† Clifton O. Bingham, 3rd, MD,‡ Kristine Phillips, MD, PhD,§ Marcy B. Bolster, MD,|| Larry W. Moreland, MD,¶ Tuhina Neogi, MD, PhD,# Wendy Marder, MD,** Alyssa Wohlfahrt, BA,†† Daniel Clauw, MD,‡‡ and Yvonne C. Lee, MD, MMSc††*

From the *Division of Immunology, Boston Children's Hospital; †Department of Psychiatry, Brigham and Women's Hospital, Boston, MA; ‡Division of Rheumatology, Department of Medicine, Johns Hopkins University, Baltimore, MD; §Division of Rheumatology and Immunology, Vanderbilt University Medical Center, Nashville, TN; ||Division of Rheumatology, Allergy and Immunology, Massachusetts General Hospital, Boston, MA; ¶Division of Rheumatology and Clinical Immunology, University of Pittsburgh, Pittsburgh, PA; #Sections of Clinical Epidemiology and Rheumatology, Department of Medicine, Boston University School of Medicine, Boston, MA; **Department of Rheumatology, University of Michigan, Ann Arbor, MI; ††Department of Rheumatology, Immunology and Allergy, Brigham and Women's Hospital, Boston, MA; and ‡‡Department of Anesthesiology, University of Michigan, Ann Arbor, MI.

Ethics Approval and Consent to Participate: The Partners Institutional Review Board approved this substudy (2015P001817), as well as the overall CPIRA study (2013P000951). The institutional review boards of each participating site also approved the parent study. Written informed consent was obtained from all participants in CPIRA.

Competing Interests: C.B. has served as a consultant to Eli Lilly, Janssen, and UCB regarding patient reported outcomes assessment. M.B. reports funding from Eli Lilly for a clinical trial as well as trainee funding from Amgen. D.C. has received consulting fees from Pfizer, Eli Lilly, Nuvo, Cerephex, Tonix, Abbott, Forest Labs, Johnson & Johnson, Merck, Purdue Pharma, Sammumed, Zynerba, Astellas Pharma, Williams & Connolly LLP, and Therevance. He has also received research support from Pfizer, Cypress Biosciences, Forest, Merck, Nuvo, and Cerephex. Y.L. has received a research grant from Pfizer and has stock in Express Scripts. All other authors report no competing interests.

Funding: The CPIRA cohort was funded by NIH grant AR064850. E.C.'s work was conducted with support from Harvard Catalyst | The Harvard Clinical and Translational Science Center (National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes of Health Award UL1 TR001102) and financial contributions from Harvard University and its affiliated academic health care centers. The content is solely the responsibility of the authors and does not necessarily represent the official views of Harvard Catalyst, Harvard University, and its

Background: The aims of this study were to define changes in catastrophizing that occur with initiation of a new disease-modifying antirheumatic drug (DMARD) and to examine the relationship between changes in Clinical Disease Activity Index (CDAI) and changes in catastrophizing.

Methods: Participants in an ongoing multisite, observational study completed the Pain Catastrophizing Scale (PCS) before and 12 weeks after DMARD initiation. We used multivariable linear regression models to examine the association between changes in CDAI as the exposure and change in pain catastrophizing as the outcome. We also assessed the relationship between changes in each component of CDAI and change in PCS, using multivariable linear regression models.

Results: Among the 165 rheumatoid arthritis patients with data on CDAI at both time points, CDAI decreased from 22 to 11.5 on a 76-point scale ($p < 0.0001$) after 12 weeks. Pain intensity decreased from a median of 5 to 3 on a 10-point numeric rating scale ($p < 0.0001$), and catastrophizing decreased, from 16.0 to 12.0 on the 52-point PCS ($p = 0.0005$). Among the 163 with complete data for the regression analysis, changes in CDAI were positively correlated with changes in catastrophizing (standardized $\beta = 0.19$, $p = 0.01$). Of the components of the CDAI, change in assessor global score was most strongly associated with changes in catastrophizing (standardized $\beta = 0.24$, $p = 0.003$).

Conclusions: Pain catastrophizing decreases, in conjunction with disease activity, after initiation of a new DMARD. These findings provide support for catastrophizing as a dynamic construct that can be altered with treatment directed at decreasing inflammatory disease activity and pain.

Key Words: rheumatoid arthritis, pain, catastrophizing, disease activity

(*J Clin Rheumatol* 2019;25: 232–236)

Research Paper

PAIN®

Neurobiological antecedents of multisite pain in children

Chelsea M. Kaplan[a,*], Andrew Schrepf[a], Ishtiaq Mawla[b], Eric Ichesco[a], Kevin F. Boehnke[a], Adriene Beltz[c], Emily Foxen-Craft[d], Michael P. Puglia II[a], Alexandre Tsodikov[e], David A. Williams[a,b,f,g], Afton L. Hassett[a], Daniel J. Clauw[a,f,g], Steven E. Harte[a,b,g], Richard E. Harris[a,b,g]

Abstract

Altered brain structure and function is evident in adults with multisite chronic pain. Although many such adults trace their pain back to childhood, it has been difficult to disentangle whether central nervous system alterations precede or are consequences of chronic pain. If the former is true, aberrant brain activity may identify children vulnerable to developing chronic pain later in life. We examined structural and functional brain magnetic resonance imaging metrics in a subset of children from the first 2 assessments of the Adolescent Brain and Cognitive Development Study. Children (aged 9-10) who were pain free at baseline and then developed multisite pain 1 year later (n = 115) were matched to control children who were pain free at both timepoints (n = 230). We analyzed brain structure (cortical thickness and gray matter volume) and function (spontaneous neural activity and functional connectivity). Results were deemed significant at the cluster level $P < 0.05$ false discovery rate corrected for multiple comparisons. At baseline, children who subsequently developed multisite pain had increased neural activity in superior parietal /primary somatosensory and motor cortices and decreased activity in the medial prefrontal cortex. They also exhibited stronger functional connectivity between the salience network, somatosensory, and default mode network regions. No significant differences in the brain structure were observed. Increased neural activity and functional connectivity between brain regions, consistent to that seen in adults with chronic pain, exist in children before developing multisite pain. These findings may represent a neural vulnerability to developing future chronic pain.

Keywords: Multisite pain, Children, fMRI, Functional connectivity, Risk factors

To date no longitudinal studies have examined symptoms in pain-free children that presage a new, multisite manifestation of pain in the future. We hypothesized that female sex, sleep problems and heightened somatic complaints at baseline would be associated with the risk of developing new multisite pain one year later.

Methods

Symptom assessments were completed by parents of youth (ages 9-10) enrolled in the ABCD study. Multivariate logistic regression models focused on children who developed multisite pain one year later (n=322) and children who remained pain-free (n=4014).

Results

Female sex (OR=1.29; 95% CI=1.02, 1.64; p=0.03), elevated non-painful somatic complaints (OR=1.20; 95% CI=1.09, 1.32; p<0.001), total sleep problems (OR=1.24; 95% CI=1.12, 1.38; p< 0.001), and attentional issues (OR=1.18; 95% CI=1.05, 1.32; p<0.004) at baseline were associated with new multisite pain one year later. Baseline negative affect was not associated with new multisite pain.

Destroyed Dogma

- Catastrophizing and negative affect are traits that predispose individuals to develop chronic pain
- Chronic pain is due to ongoing peripheral nociceptive input from damage/inflammation to peripheral tissues and/or nerves
- Complementary and Alternative therapies should be considered as such

Mechanistic Characterization of Pain

Variable degrees of any mechanism can contribute in any disease

	Nociceptive	Neuropathic	Centralized/Nociplastic
Cause	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
Clinical features	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
Screening tools		PainDETECT	Body map or FM Survey
Treatment	NSAIDs, injections, surgery, ? opioids	Local treatments aimed at nerve (surgery, injections, topical) or CNS-acting drugs	CNS-acting drugs, non-pharmacological therapies
Classic examples	Osteoarthritis Autoimmune disorders Cancer pain	Diabetic painful neuropathy Post-herpetic neuralgia Sciatica, carpal tunnel syndrome	Fibromyalgia Functional GI disorders Temporomandibular disorder Tension headache Interstitial cystitis, bladder pain

Chronic Pain 2

Nociplastic pain: towards an understanding of prevalent pain conditions

Mary-Ann Fitzcharles, Steven P Cohen*, Daniel J Clauw, Geoffrey Littlejohn, Chie Usui, Winfried Häuser*

Lancet 2021; 397: 2098–110

See Comment page 2029

This is the second in a Series of three papers about chronic pain

*Contributed equally

Department of Rheumatology and Alan Edwards Pain Management Unit, McGill University, Montreal, QC, Canada (M-A Fitzcharles MBChB); Department of Psychiatry and Behavioral Sciences and Department of Anesthesiology and Critical Care Medicine, Neurology and Physical Medicine and Rehabilitation at

Nociplastic pain is the semantic term suggested by the international community of pain researchers to describe a third category of pain that is mechanistically distinct from nociceptive pain, which is caused by ongoing inflammation and damage of tissues, and neuropathic pain, which is caused by nerve damage. The mechanisms that underlie this type of pain are not entirely understood, but it is thought that augmented CNS pain and sensory processing and altered pain modulation play prominent roles. The symptoms observed in nociplastic pain include multifocal pain that is more widespread or intense, or both, than would be expected given the amount of identifiable tissue or nerve damage, as well as other CNS-derived symptoms, such as fatigue, sleep, memory, and mood problems. This type of pain can occur in isolation, as often occurs in conditions such as fibromyalgia or tension-type headache, or as part of a mixed-pain state in combination with ongoing nociceptive or neuropathic pain, as might occur in chronic low back pain. It is important to recognise this type of pain, since it will respond to different therapies than nociceptive pain, with a decreased responsiveness to peripherally directed therapies such as anti-inflammatory drugs and opioids, surgery, or injections.

Introduction

occur in isolation or as a comorbidity in individuals with

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RESEARCH
EDUCATION
TREATMENT
ADVOCACY
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Available online at www.jpain.org and www.sciencedirect.com

Overlapping Chronic Pain Conditions: Implications for Diagnosis and Classification

William Maixner,[*,†] Roger B. Fillingim,[‡] David A. Williams,[§] Shad B. Smith,[*,†] and Gary D. Slade[*,¶,‖]

*Center for Pain Research and Innovation, ¶Department of Dental Ecology, ‖Department of Epidemiology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
†Center for Translational Pain Medicine, Department of Anesthesiology, Duke University, Durham, North Carolina.
‡Pain Research and Intervention Center of Excellence, University of Florida, Gainesville, Florida.
§Chronic Pain and Fatigue Research Center, Department of Anesthesiology, University of Michigan, Ann Arbor, Michigan.

Abstract: There is increasing recognition that many if not most common chronic pain conditions are heterogeneous with a high degree of overlap or coprevalence of other common pain conditions along with influences from biopsychosocial factors. At present, very little attention is given to the high degree of overlap of many common pain conditions when recruiting for clinical trials. As such, many if not most patients enrolled into clinical studies are not representative of most chronic pain patients. The failure to account for the heterogeneous and overlapping nature of most common pain conditions

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- Complementary and Alternative therapies should be considered as such

Evidence Based Medicine

Prepared for: Agency for Healthcare Research and Quality
Prepared by: Pacific Northwest Evidence-based Practice Center, Portland, OR
Investigators: Andrea C. Skelly, Ph.D., M.P.H., Roger Chou, M.D., Joseph R. Dettori, Ph.D., M.P.H., M.P.T., Judith A. Turner, Ph.D., Janna L. Friedly, M.D., Sean D. Rundell, Ph.D., D.P.T., Rongwei Fu, Ph.D., Erika D. Brodt, B.S., Ngoc Wasson, M.P.H., Shelby Kantner, B.A., Aaron J.R. Ferguson, B.S.

Key Messages – I

Interventions that improved function and/or pain for ≥one month

- **Low back pain:** Exercise, psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation (MDR)
- **Neck pain:** Exercise, low-level laser, mind-body practices, massage, acupuncture
- **Knee osteoarthritis:** Exercise, cognitive behavioral therapy (CBT)

Key Messages – I

Interventions that improved function and/or pain for ≥one month

- **Hip osteoarthritis**: Exercise, manual therapies
- **Fibromyalgia:** Exercise, CBT, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, MDR
- **Tension headache:** Spinal manipulation
- Some interventions did not improve function or pain.
- Serious harms were not observed with the interventions.

Conclusions

Trials identified subsequent to the earlier report largely support previous findings—namely that exercise, multidisciplinary rehabilitation, acupuncture, CBT, mindfulness practices, massage, and mind-body practices most consistently improve function and/or pain beyond the course of therapy for specific chronic pain conditions.

Additional research, including comparisons with pharmacological and other active controls, on effects beyond the immediate post-treatment period is needed, particularly for conditions other than low back pain.

Nonpharmacological Therapies are similar to those for any Chronic Pain State

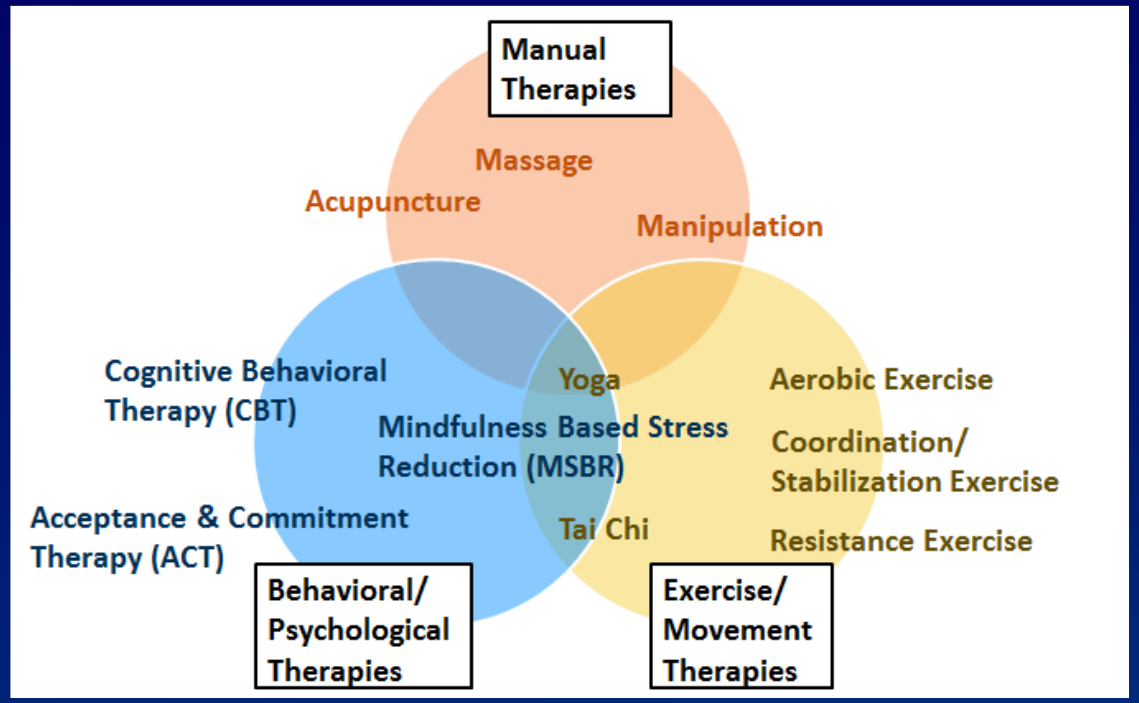
Strong Evidence	▪ Education ▪ Aerobic exercise ▪ Cognitive behavior therapy
Modest Evidence	▪ Strength training ▪ Hypnotherapy, biofeedback, balneotherapy, yoga, Tai Chi ▪ Neuromodulation ▪ Acupuncture, chiropractic, manual and massage therapy
Weak Evidence	▪ Trigger point injections
No Evidence	▪ Doing nothing

Modified from Clauw *JAMA*. 2014

Non-Pharmacological Pain Treatments in VHA

VA State of the Art Conference Nov. 2016: Evidence-based non-pharmacological approaches for MSK pain management

- Evidence to support CIH and conventional therapies.
- Provision of multi-modal therapies accessible from Primary Care.



VHA Directive 1137: Advancing Complementary and Integrative Health (May 2017)

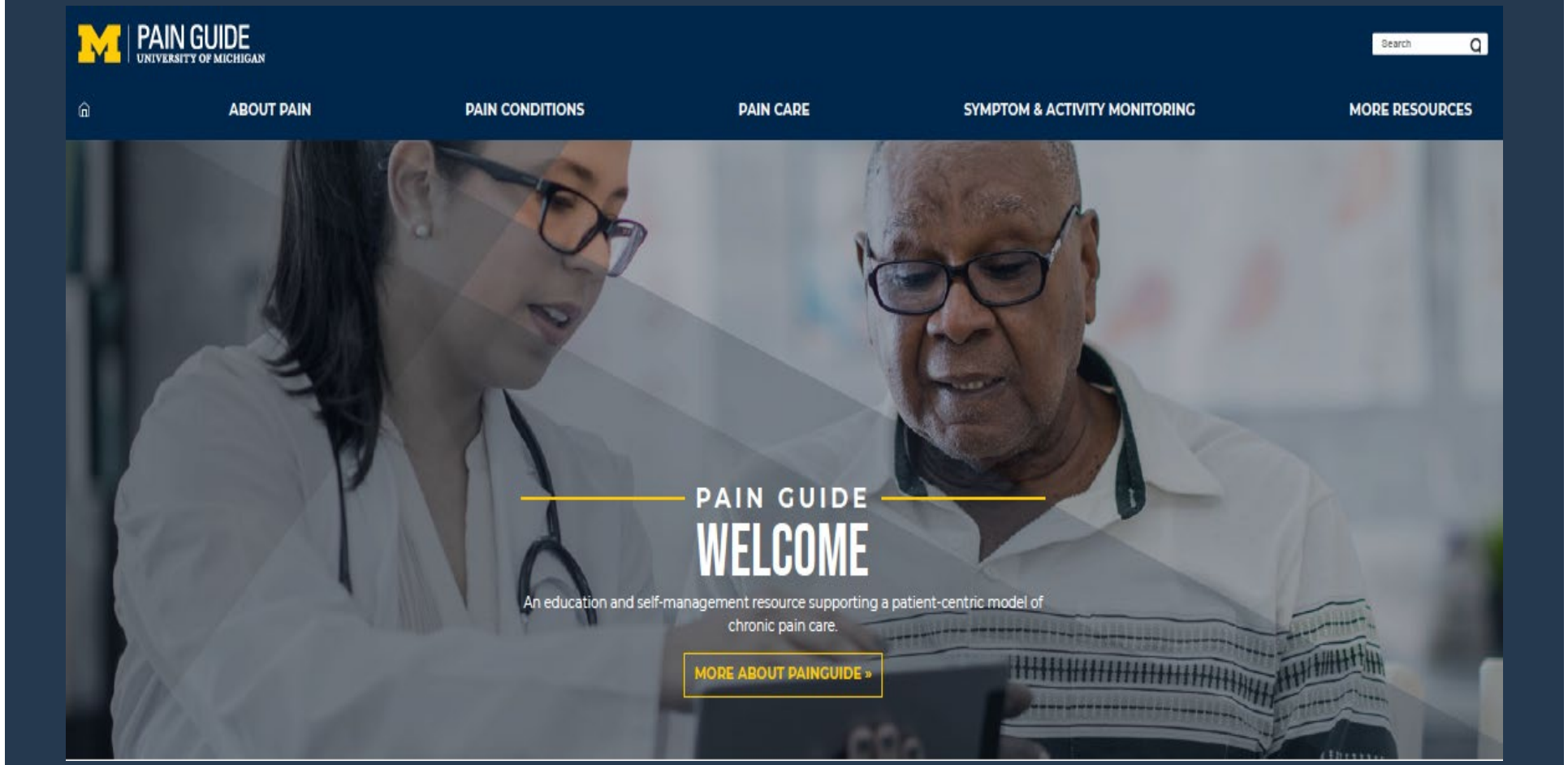
- List 1: Approaches with published evidence of promising or potential benefit.
  - Acupuncture
  - Massage Therapy
  - Tai Chi
  - Meditation
  - Yoga
  - Clinical Hypnosis
  - Biofeedback
  - Guided Imagery

Chiropractic Care was approved as a covered benefit in VHA in 2004 and is part of VA whole health care.
To be made available across the system, if recommended by the Veteran's health care team.

www.fibroguide.com

- Program features 10 CBT modules:
  - Understanding Fibromyalgia
  - Being Active
  - Sleep
  - Relaxation
  - Time for You
  - Setting Goals
  - Pacing Yourself
  - Thinking Differently
  - Communicating
  - Fibro Fog

- In a RCT of 118 FM patients comparing the earlier version of this website plus usual care, to usual care alone, Williams demonstrated statistically significant improvements in pain (29% in the WEB group had 30% improvement in pain vs 8% in usual care, p=.009) and function (i.e., 31% in WEB-SM had .5 SD improvement in SF-36 PF vs. 6% in standard care, p<.002) Williams et. al. Pain. 2010;151(3):694-702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WELCOME
An education and self-management resource supporting a patient-centric model of chronic pain care.
MORE ABOUT PAINGUIDE »

Self Care

Exercise

Exercise, when done safely, can benefit you physically and mentally. It helps prevent deconditioning of muscles which is often associated with more pain. Studies find that exercise is one of the most beneficial approaches to managing pain.

Learn more >

Pacing

People with pain often "over do" resulting in pain flare ups. Pacing can allow activities to get accomplished safely, without flare-ups, and in a manner that conserves energy (i.e., with less fatigue).

Learn more >

Nutrition & supplements

Eating a healthy diet has many benefits for everyone; however there may be some specific benefits for pain sufferers. The examination of pain and diet is an emerging literature.

Read nutrition & supplements tips >

Relaxation

Teaching the body to relax can both diminish muscle tension and decrease stress. To work properly, regular practice is needed so that the body learns a rhythm of relaxation and can relax on your command. Less tension and less stress can lead to decreased pain intensity.

Learn more >

Reframing

What we think influences how we feel and how much pain we experience. Sometimes negative thoughts become automatic and make us feel worse. Learning to reframe our thinking in realistic terms that challenge negative automatic thinking can help diminish pain intensity.

Learn more >

Managing Emotions

Emotions are integral to the production of pain. You cannot have pain without emotions. Thus anything we can do to alter the emotional content of one's brain will influence pain. Better management of stress can influence pain as well as engaging in pleasant activities. The pleasant activities will help diminish pain intensity.

Learn more >

Communication skills

Conflictual social relationships with family, friends, doctors, and employers can make pain worse. Alternatively, these same relationships can be used constructively to make pain better. Communication skills can help make social relationship work in your favor.

Learn more >

Sleep

Pain and Sleep are closely related such that poor sleep can make pain worse. These are a number of behavioral sleep strategies that can be used to get a more refreshing night's sleep.

Learn more >

Acupressure

Like acupuncture, which uses needles, acupressure is an ancient treatment that uses the pressure of one's own finger on the skin so as to help re-balance the flow of energy through the body as a means of reducing symptoms such as pain.

Learn more >

Sprituality

The belief in something "bigger," "more powerful," or "more knowledgeable" than oneself has been key to many individuals being able to successfully deal with pain. Spirituality may refer to a specific religious belief or it can be any belief that provides a source of strength and comfort to the individual with pain.

Learn more >

Ergonomics/Posture

How you sit, stand, transition and lift can either make pain worse or allow you to function even with pain. This section offers help in optimizing how you interact with your environment in ways that don't exacerbate pain.

Learn more >

Resilience

We often focus on fixing what is broken but we can't lose sight of our personal strengths that help us get through challenging times. Finding our sources of resilience can be a valuable tool for reducing pain and living a quality-filled life.

Learn more >

PAIN CARE

- Self Care
- **Professional Care**
  - Medications
  - Therapies
  - Devices
  - Procedures

Bethany Ranes, PhD

Research Scientist

Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

A Neuroscience-Novice Explanation

PAIN IN THE BRAIN

Dr. Bethany Ranes
Research Scientist and Brain Geek
CSO for Healing Track

Today's Session

10-MINUTES TO UNDERSTAND THE NEUROSCIENCE OF PAIN

- How is pain a brain issue?
- New directions and the emergence of brain-based therapies
- Opportunities and challenges

How is pain a brain issue?

IN A HEALTHY PERSON, THE EXPERIENCE WE CALL PAIN HAS TWO PRIMARY COMPONENTS..

BOTTOM-UP

TOP-DOWN

How is pain a brain issue?

IN A HEALTHY PERSON, THE EXPERIENCE WE CALL PAIN HAS TWO PRIMARY COMPONENTS..

BOTTOM-UP: THE SIGNAL FROM THE BODY TO THE BRAIN WHEN DAMAGE OCCURS (ALSO CALLED "NOCICEPTION")

How is pain a brain issue?

IN A HEALTHY PERSON, THE EXPERIENCE WE CALL PAIN HAS TWO PRIMARY COMPONENTS..

TOP-DOWN: THE BRAIN'S AUTOMATIC RESPONSE TO NOCICEPTION - WHAT WE AS HUMANS THINK OF AS "FEELING PAIN"

How is pain a brain issue?

THESE TWO SIGNALS ARE RELATED, BUT ARE **INDEPENDENT** FROM EACH OTHER...

...SO NOCICEPTION DOESN'T ALWAYS CAUSE PAIN, AND PAIN DOESN'T ALWAYS INCLUDE NOCICEPTION

How is pain a brain issue?

IF PAIN IS HAPPENING WHEN THERE IS NO DAMAGE IN THE BODY TO FIX, THEN HOW DO YOU "FIX" IT?

PAIN WITHOUT DAMAGE: A NEW WAY OF THINKING

NEUROSCIENTISTS FOUND THAT MANY PEOPLE WITH NON-STRUCTURAL PAIN HAVE **HYPERCONNECTIVITY BETWEEN THE AMYGDALA AND THE BRAIN'S PAIN PROCESSING CENTERS** (1,2)

INTERESTING NOTE: THIS CONNECTION IS NATURALLY STRONGER IN WOMEN THAN MEN (3)

IN ENGLISH, THIS MEAN THAT THE BRAIN HAS LEARNED TO ASSOCIATE **DANGER, NEGATIVE EMOTIONS, AND PAIN**

WHEN STRESSFUL OR SCARY SITUATIONS OCCUR, THEY ACTIVATE THE **SAME TOP-DOWN PAIN SIGNALS THAT ARE ACTIVATED BY NOCICEPTION**

IN OTHER WORDS, THE EXACT SAME PAIN IS FELT AS THOUGH DAMAGE WERE OCCURRING

BRAIN-BASED THERAPIES

FOCUSED ON CHANGING THE **TOP-DOWN SIGNALS** RATHER THAN THE BOTTOM-UP SIGNALS

Through a process that is similar to exposure therapy (which is used by therapists to extinguish fears), brain-based techniques are designed to reinforce that the body is undamaged during pain-provoking situations

BRAIN-BASED THERAPIES

BASED ON THE ASSUMPTION OF **NEUROPLASTICITY**

AKA, brain-based therapies apply the neuroscience finding that says connections between parts of the brain can be adjusted (what can be learned can be **un-learned**) because the brain is designed for constant updates and changes throughout our lifetime

BRAIN-BASED THERAPIES

INITIAL STUDIES HAVE SHOWN THAT **BRAIN-BASED THERAPIES CHANGE THE CONNECTIONS OF THE BRAIN'S PAIN CENTERS**

- They can reduce the hyperconnectivity from the amygdala (1)
- They can also increase connectivity to the prefrontal cortex (which helps slow down the activation from the amygdala) (4)
- They demonstrate dramatic pain relief for those who respond (4, 10, 11)

AWESOME! IT SOUNDS LIKE THE PERFECT PAIN CURE!

...NOT SO FAST...

OPPORTUNITIES AND CHALLENGES

BRAIN-BASED THERAPIES **DON'T ADDRESS DAMAGE**

In fact, for the exposure therapy to work, there cannot be structural damage in the body (a fear of bears is pretty legit when a bear is actually chasing you). While it is still a debate among pain providers, the good news is that scientists believe that a large portion of chronic pain is non-structural. For example, studies have estimated that approximately 85% of chronic back pain have no definitive structural cause. (4, 5, 6, 7, 8, 9)

OPPORTUNITIES AND CHALLENGES

BRAIN-BASED THERAPIES **ARE NEW AND STILL BEING TESTED**

Since they are are new approach to pain treatment, brain-based therapies don't yet have as much research to back them up as more established therapies like CBT. Early studies show a lot of promise (4, 10, 11), but findings still need to be replicated over and over again, and we need to learn more about who responds to them and who does not.

OPPORTUNITIES AND CHALLENGES

BRAIN-BASED THERAPIES **CAN BE DIFFICULT TO ACCESS**

Most doctors have limited training in neuroscience and even less training on the science of pain (on average, most med schools offer fewer training hours on pain than veterinary schools!) (12); so training providers on new brain-based therapies will take time. Insurance usually does not yet cover brain-based therapy, so costs can be an issue.

Resources to Learn More

THE WAY OUT
ALAN GORDON & ALON ZIV

UNLEARN YOUR PAIN
HOWARD SCHUBINER

HIDDEN FROM VIEW
ALLAN ABBASS & HOWARD SCHUBINER

CURABLE
WWW.CURABLEHEALTH.COM

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6) MAHER, C, ET AL. (2017). NON-SPECIFIC LOW BACK PAIN. *LANCET, 389*(10070), 736-747.

7) VLAEYEN, JWS, ET AL. (2018). LOW BACK PAIN. NT REV DIS PRIMERS, 4(1), 52.

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8) HENSCKE, N, ET AL. (2009). PREVALENCE OF AND SCREENING FOR ERIOUS SPINAL PATHOLOGY IN PATIENTS PRESENTING TO PRIMARY CARE SETTINGS WITH ACUTE LOW BACK PAIN. *ARTHRITIS RHEUM, 60*(10), 3072-3080.

9) DEYO, RA, ET AL. (2001). LOW BACK PAIN. *N ENGL J MED, 344*(5), 363-370.

10) LUMLEY, MA, ET AL. (2017). EMOTIONAL AWARENESS AND EXPRESSION THERAPY, COGNITIVE-BEHAVIORAL THERAPY, AND EDUCATION FOR FIBROMYALGIA: A CLUSTER-RANDOMIZED CONTROLLED TRIAL. *PAIN, 158*(12), 2354-2363.

11) YARNS, BC, ET AL. (2020). EMOTIONAL AWARENESS AND EXPRESSION THERAPY ACHIEVES GREATER PAIN REDUCTION THAN COGNITIVE BEHAVIORAL THERAPY IN OLDER ADULTS WITH CHRONIC MUSCULOSKELETAL PAIN: A PRELIMINARY RANDOMIZED COMPARISON TRIAL. *PAIN MEDICINE, 21*(11), 2811-2822.

12) FIRTH, S (2016). MEDICAL SCHOOLS BOOST PAIN MANAGEMENT EDUCATION. MEDPAGE TODAY, 04-FEB 2016, HTTPS://WWW.MEDPAGETODAY.COM/PUBLICHEALTHPOLICY/MEDICALEDUCATION/56025

Ravi Prasad, PhD

Clinical Professor & Director of Behavioral Health

Dept. of Anesthesiology & Pain Medicine, UC Davis

Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

Realities, Research, & Rethinking Person-Centered, Integrative Pain Management

RAVI PRASAD, PHD

CLINICAL PROFESSOR

DIRECTOR OF BEHAVIORAL HEALTH

DEPARTMENT OF ANESTHESIOLOGY AND PAIN MEDICINE

UCDAVIS HEALTH | SCHOOL OF MEDICINE

Pain in Context

- US Department of Health & Human Services/CDC (11/2020)
  - 20.4% of the US population has chronic pain
  - 36.4% of these individuals have high-impact chronic pain
  - Chronic pain is most prevalent in women, individuals over 65, and non-Hispanic white adults
  - Prevalence higher in more rural areas

Zelaya CE, Dahlhamer JM, Lucas JW, Connor EM. Chronic pain and high-impact chronic pain among U.S. adults, 2019. NCHS Data Brief, no 390. Hyattsville, MD: National Center for Health Statistics. 2020.

Comprehensive Integrative Pain Management

Primary goal:

Help patients learn to live with pain

Pain Management

Pain Management

LIFE

Family Friends Work School

Sports Leisure Self-care Music

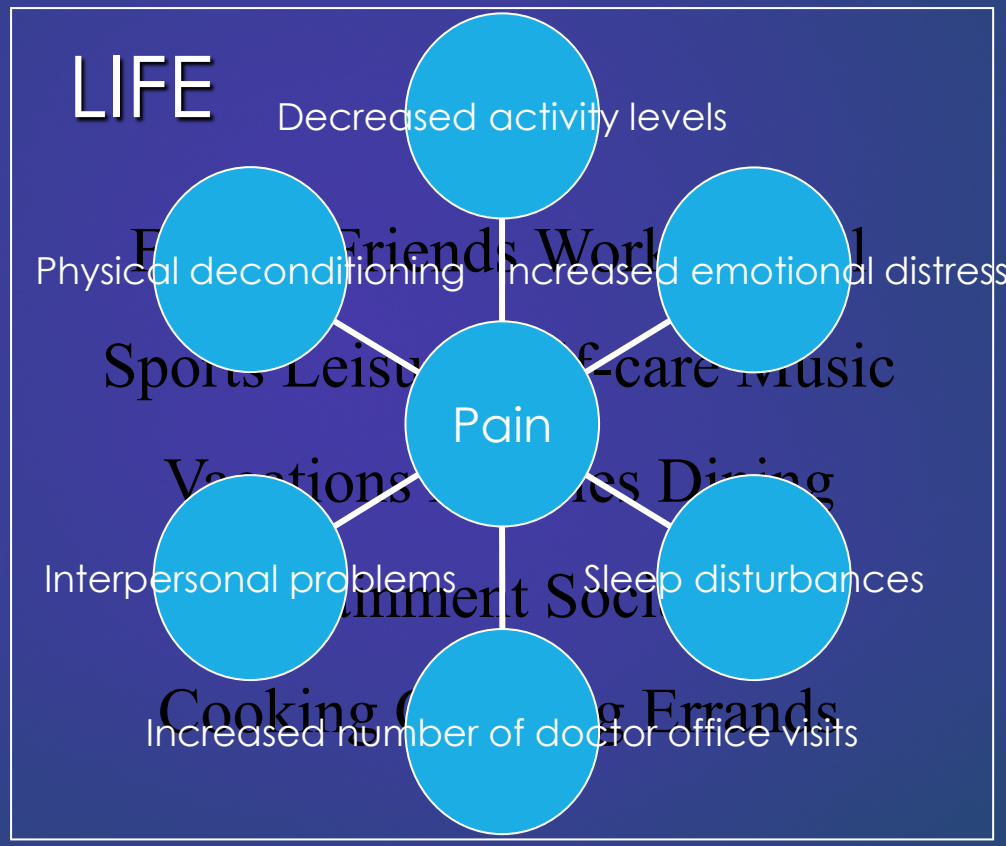
Vacations Hobbies Dining

Entertainment Socializing

Cooking Cleaning Errands

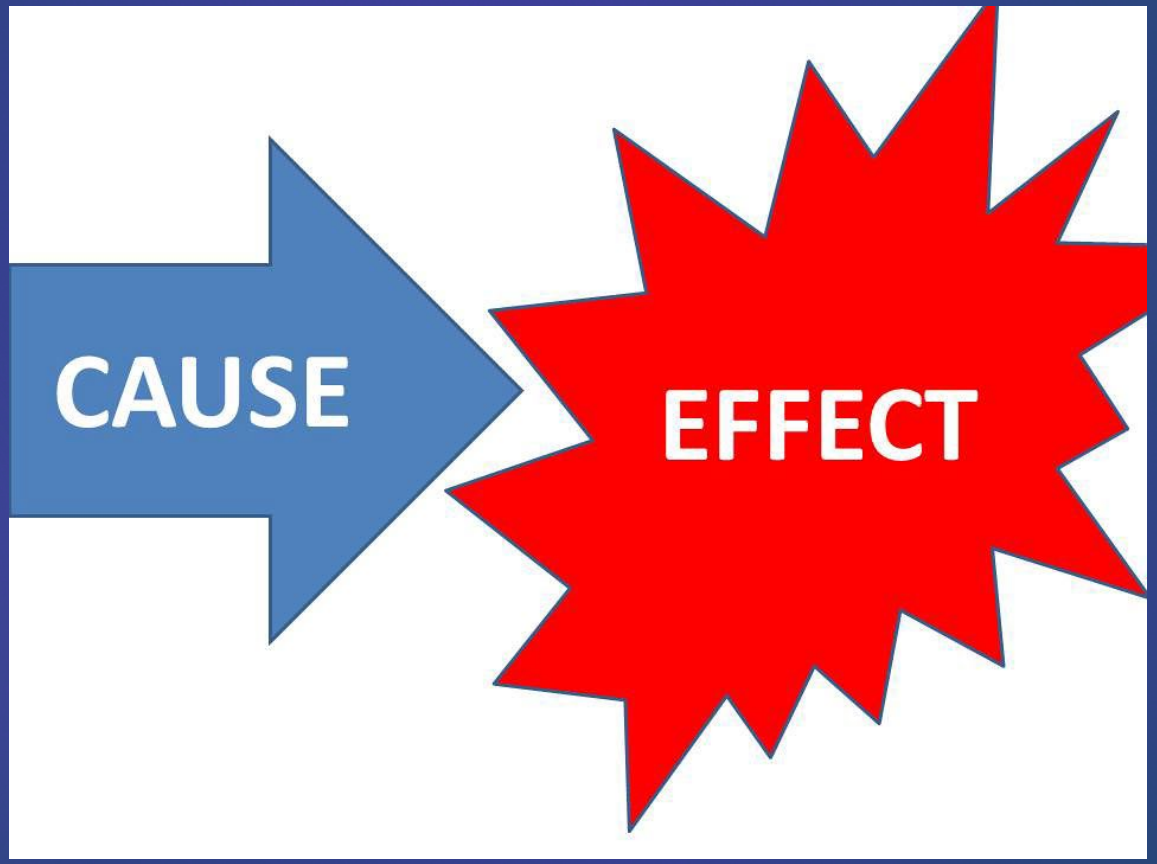
Pain Management

Pain Management

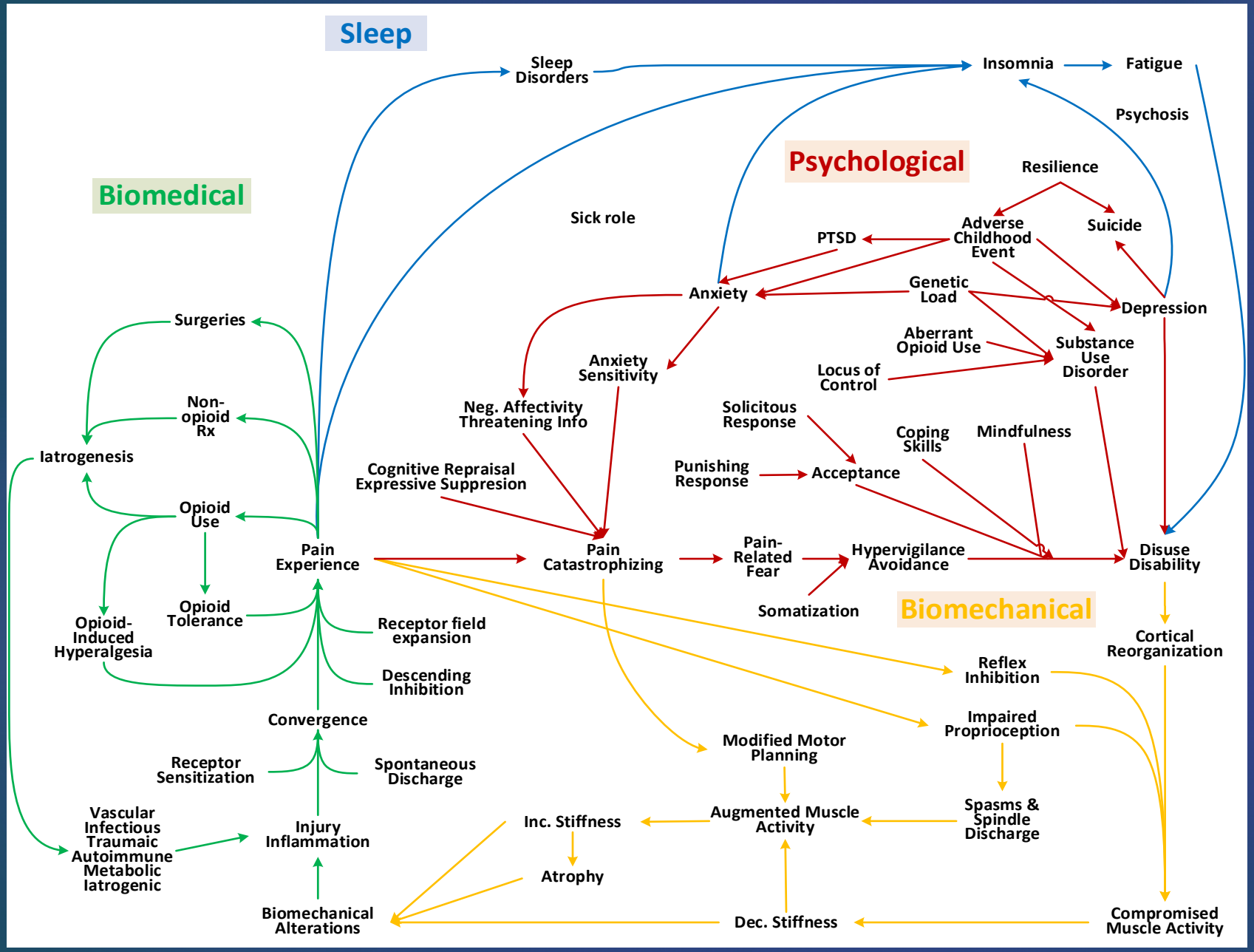


Pain Management

What causes pain?



Extended Pain Cycle



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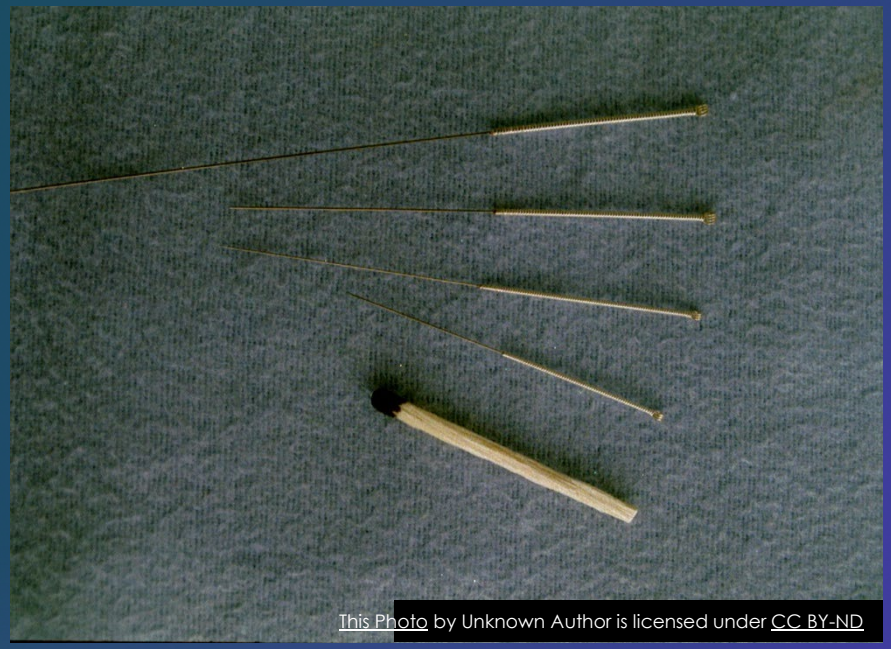
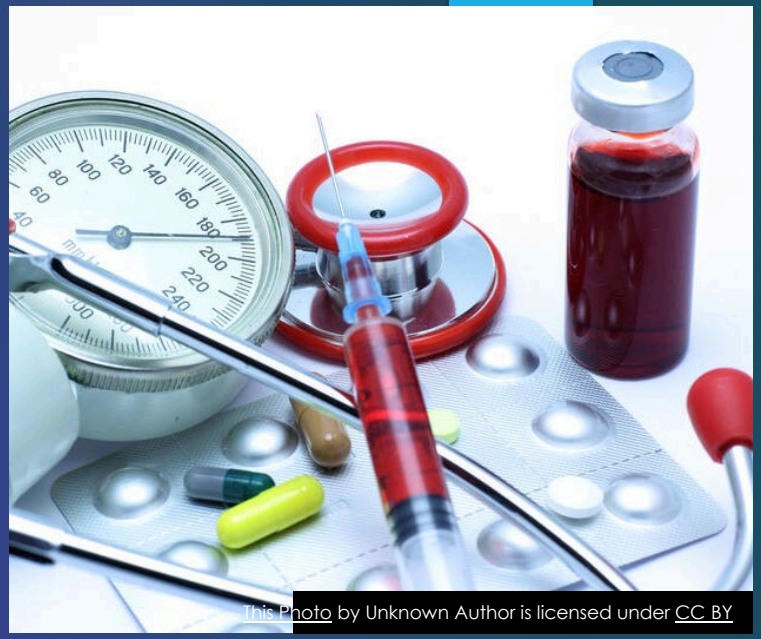
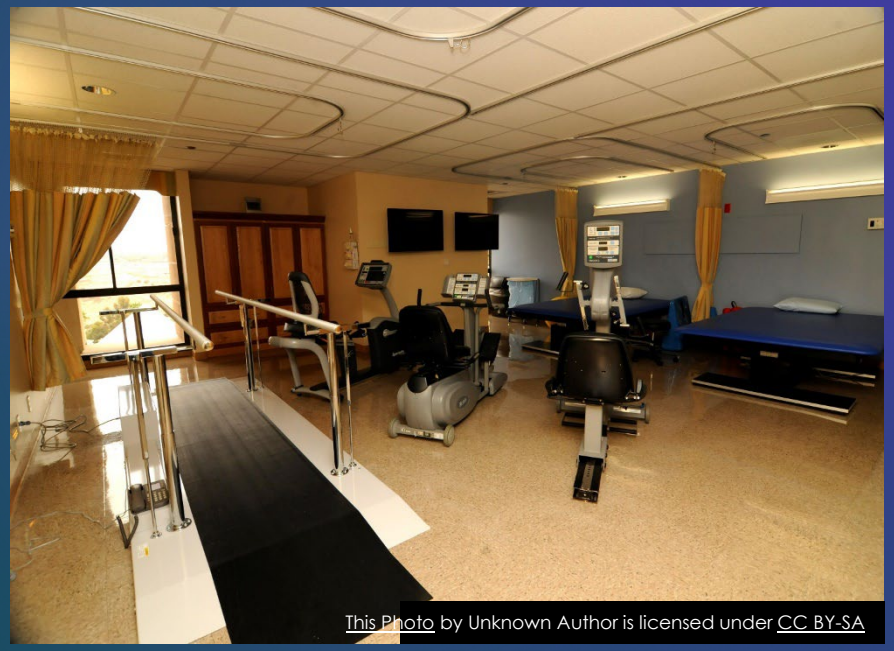
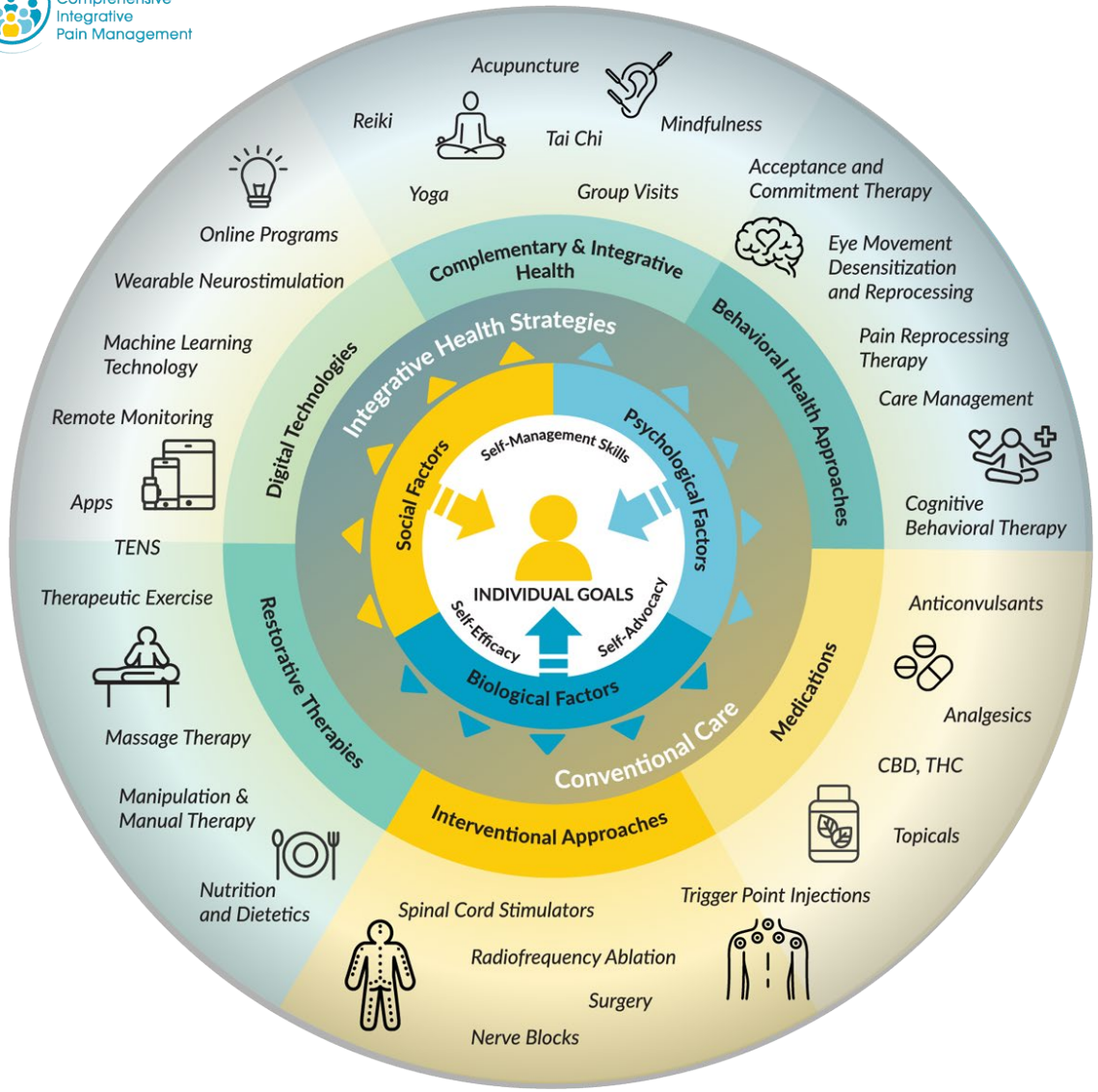






Pain Treatment

Alliance to Advance Comprehensive Integrative Pain Management



Comprehensive Integrative Pain Management

Cognitive Behavioral Therapy (CBT)

- Three primary components:
  - Helping patients understand how thoughts/behaviors can influence their experience of pain and their ability to impact this relationship
  - Teaching patients pain management coping strategies
  - Helping patients apply coping strategies and maintaining use of said skills over time

Keefe FJ. 1996. Cognitive behavioral therapy for managing pain. Clin. Psychol. 49(3): 4–5.

Empirically Validated Treatment

- Linton & Andersson (2000)
  - Randomized control trial (n=213)
  - All patients received regular primary care tx + Minimal Treatment (information pack, pamphlet) or 6-session CBT treatment.
  - Assessments administered at pretest and 12-month follow-up
  - Risk for developing long-term sick absence decreased 9x in CBT group
  - CBT participants had decreased medical utilization compared to increase in other groups

Empirically Validated Treatment

- Linton & Nordin (2006)
  - 5-year follow-up of Linton & Andersson (2000) study, also used supplemental records from the National Insurance Authority
  - 97% completed follow-up questionnaire
  - CBT group had significantly less pain, higher activity, better quality of life, and better general health compared to Minimal Treatment Group
  - Risk of long-term sick leave 3x higher in the non-CBT group
  - CBT group had significantly less lost productivity costs

Other Literature Findings

- 373 CPRP participants (3 week)
- ~57% on opioids at admission
- Assessments at admission, discharge, and 6-month (70% return rate; pain severity, depression, psychosocial functioning, health status, pain catastrophizing)
- Pain severity and depression higher in opioid users at admission
- Significant improvement on all variables at discharge, 6-month follow-up regardless of opioid status

Townsend, CO, Kerkvliet, JL, Bruce, BK, Rome, JD, Hooten, WM, Luedtke, CA, Hodgson, JE. (2008). A Longitudinal Study of the Efficacy of a Comprehensive Pain Rehabilitation Program with Opioid Withdrawal: Comparison of Treatment Outcomes Based on Opioid Use Status at Admission. Pain, 140(1): 177-189.

Other Literature Findings

- 705 (600 completed) outpatient interdisciplinary program participants
- Opioid group tapered with cocktail
- Opioid group improved same as more than non-opioid group (pain severity, catastrophizing, sleep, treatment satisfaction, pain-related functioning domains)

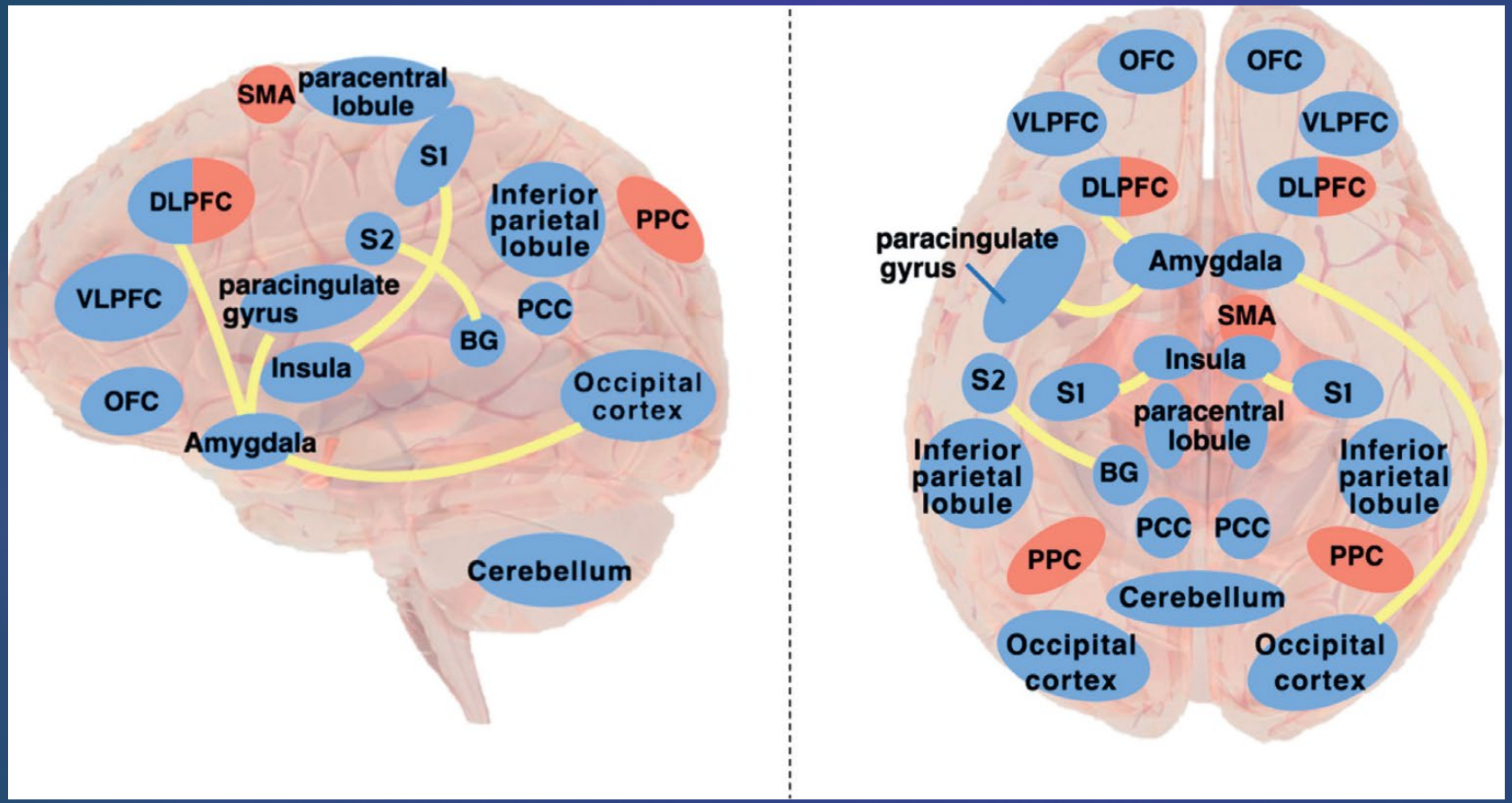
Murphy, JL, Clark, ME, Banou, E (2013). Opioid Cessation and Multidimensional Outcomes After Interdisciplinary Chronic Pain Treatment. Clin J Pain, 29(2): 109-17.

Neuroplastic Associations

- Imaging studies following CBT reflect changes in activity and/or gray matter volume of the following brain regions:
  - Dorsolateral prefrontal cortex
  - Orbitofrontal cortex
  - Ventrolateral prefrontal cortex
  - Posterior cingulate cortex
  - Amygdala

Bao, S., Qiao, M., Lu, Y., & Jiang, Y. (2022). Neuroimaging Mechanism of Cognitive Behavioral Therapy in Pain Management. *Pain research & management*, *2022*, 6266619. https://doi.org/10.1155/2022/6266619

Neuroplastic Associations



Structural changes

Functional changes

Bao, S., Qiao, M., Lu, Y., & Jiang, Y. (2022). Neuroimaging Mechanism of Cognitive Behavioral Therapy in Pain Management. *Pain research & management*, 2022, 6266619. https://doi.org/10.1155/2022/6266619

Neuroplastic Associations

- RCT comparing CBT to pain education shows fMRI changes in limbic and prefrontal regions following participation in the former
  - CBT participants noted significant improvements in pain and self-efficacy for coping with chronic pain
  - Imaging findings correlated with clinical outcomes observed
- Overall, structural changes/activation are associated with:
  - Enhanced pain control
  - Cognitive reassessment
  - Altered perception of stimuli

Shpaner, M., Kelly, C., Lieberman, G., Perelman, H., Davis, M., Keefe, F. J., & Naylor, M. R. (2014). Unlearning chronic pain: A randomized controlled trial to investigate changes in intrinsic brain connectivity following Cognitive Behavioral Therapy. *NeuroImage. Clinical*, *5*, 365–376. https://doi.org/10.1016/j.nicl.2014.07.008

Bao, S., Qiao, M., Lu, Y., & Jiang, Y. (2022). Neuroimaging Mechanism of Cognitive Behavioral Therapy in Pain Management. *Pain research & management*, *2022*, 6266619. https://doi.org/10.1155/2022/6266619

Beyond CBT

Evidence Based Psychological Treatments for Pain

- Acceptance and commitment therapy
- Mindfulness based interventions
- Emotional awareness and expression therapy
- Biofeedback

Real-World Applications

- UC Davis Pain Center
  - Wide range of specialties represented
  - Integration with other departments within the system
    - Primary care
    - Neurology
    - Oncology
    - Integrative medicine
  - Pain coping skills intervention to assist with opioid reduction

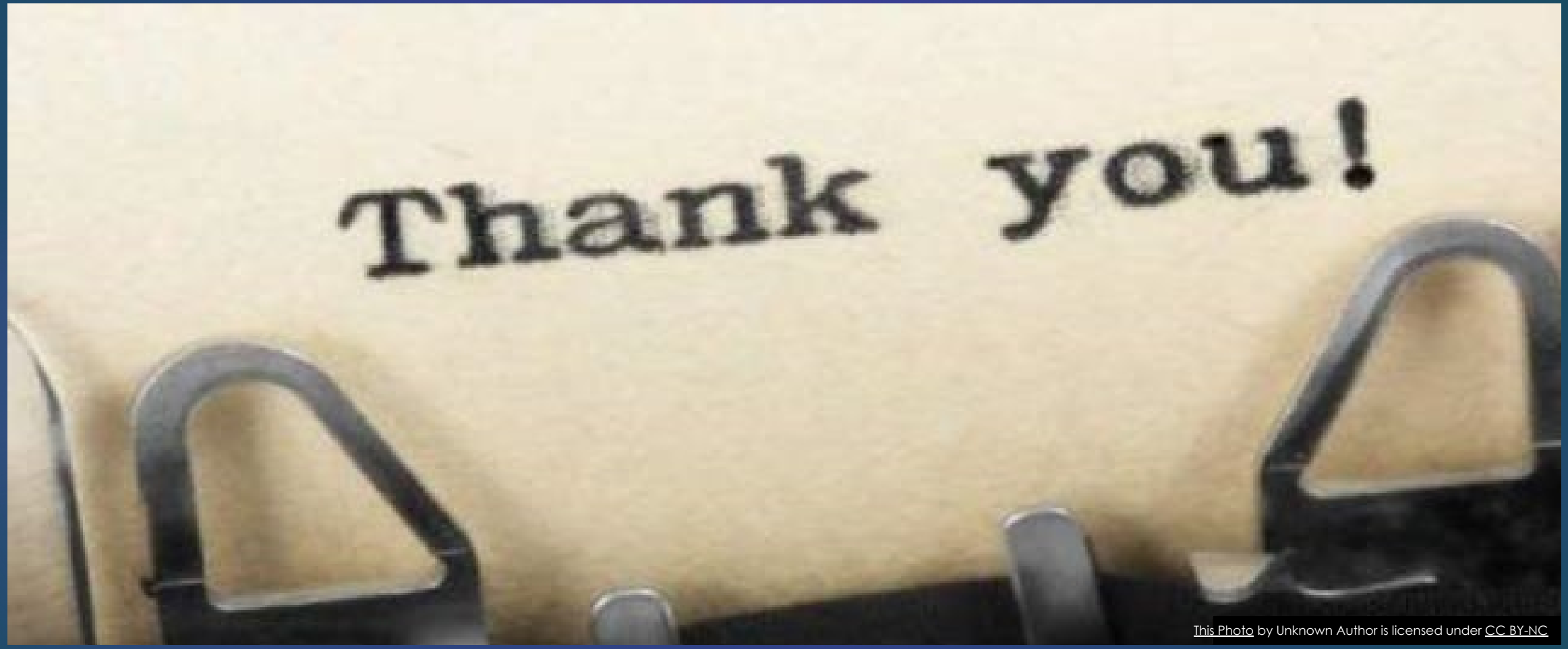
Impact of Telehealth

- Expanded clinical reach
- Not the panacea that many believed it might be

Conclusions

- Treatment for chronic pain conditions focus on maximizing functioning and improving quality of life
- There are a wide range of evidence-based psychological treatments for pain
- Chronic pain is a multifactorial experience; thus, a truly integrated, interdisciplinary approach is necessary to maximize treatment outcomes
- It is important for all members of the interdisciplinary team to reinforce the approaches being used by their colleagues to promote patient engagement

Email: drprasad@ucdavis.edu Twitter: @RaviPrasadPhD



Keaton Schmitz

Third-Year Medical Student &
Fibromyalgia Patient

Alliance to Advance Comprehensive Integrative Pain Management

#AACIPM

A Patient Experience

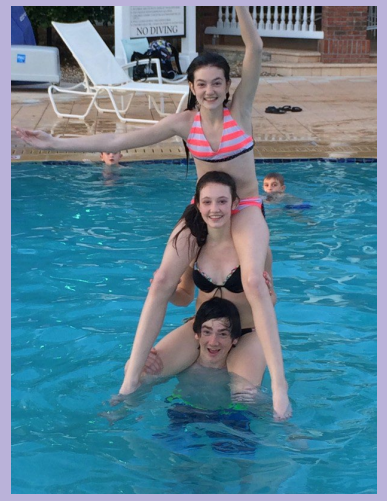
Keaton Schmitz
MS-3 OUWB School of Medicine
B.S. Chemical Engineering

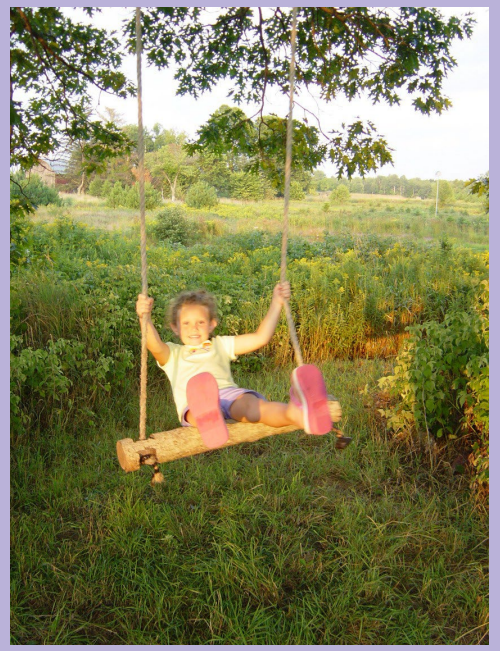
Agenda

a) Patient History
    a) Past Medical History
    b) Social History
    c) History of Present Illness
b) Problems Encountered in Care & Solutions
    a) Undertreatment
    b) Mistrust
    c) Lack of Knowledge

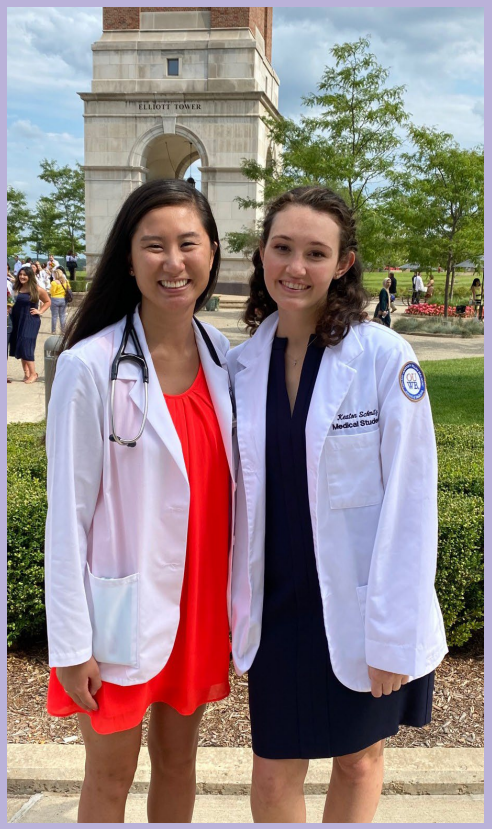
Past Medical History

1. Accident Prone





Social History



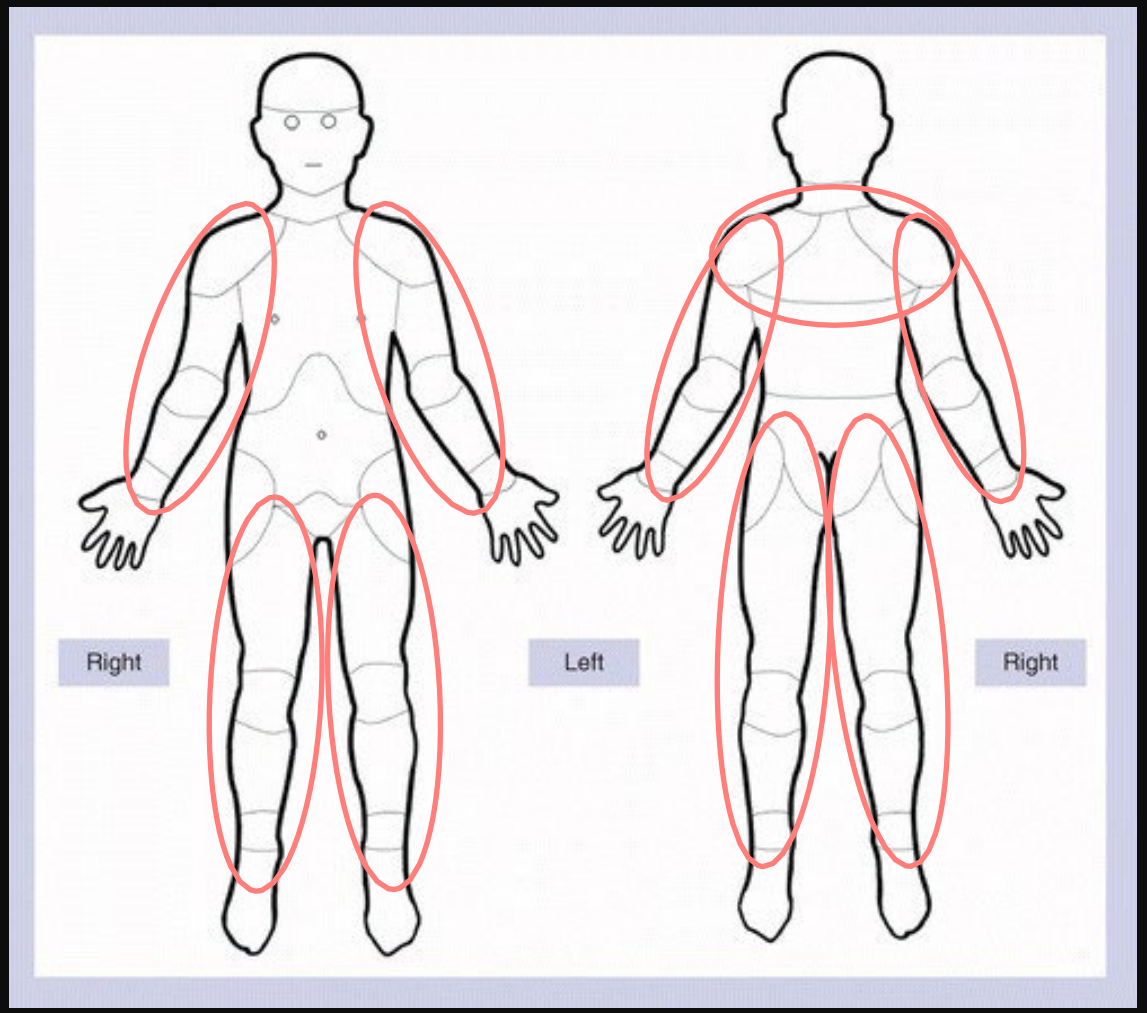
History of Present Illness

Disease Onset

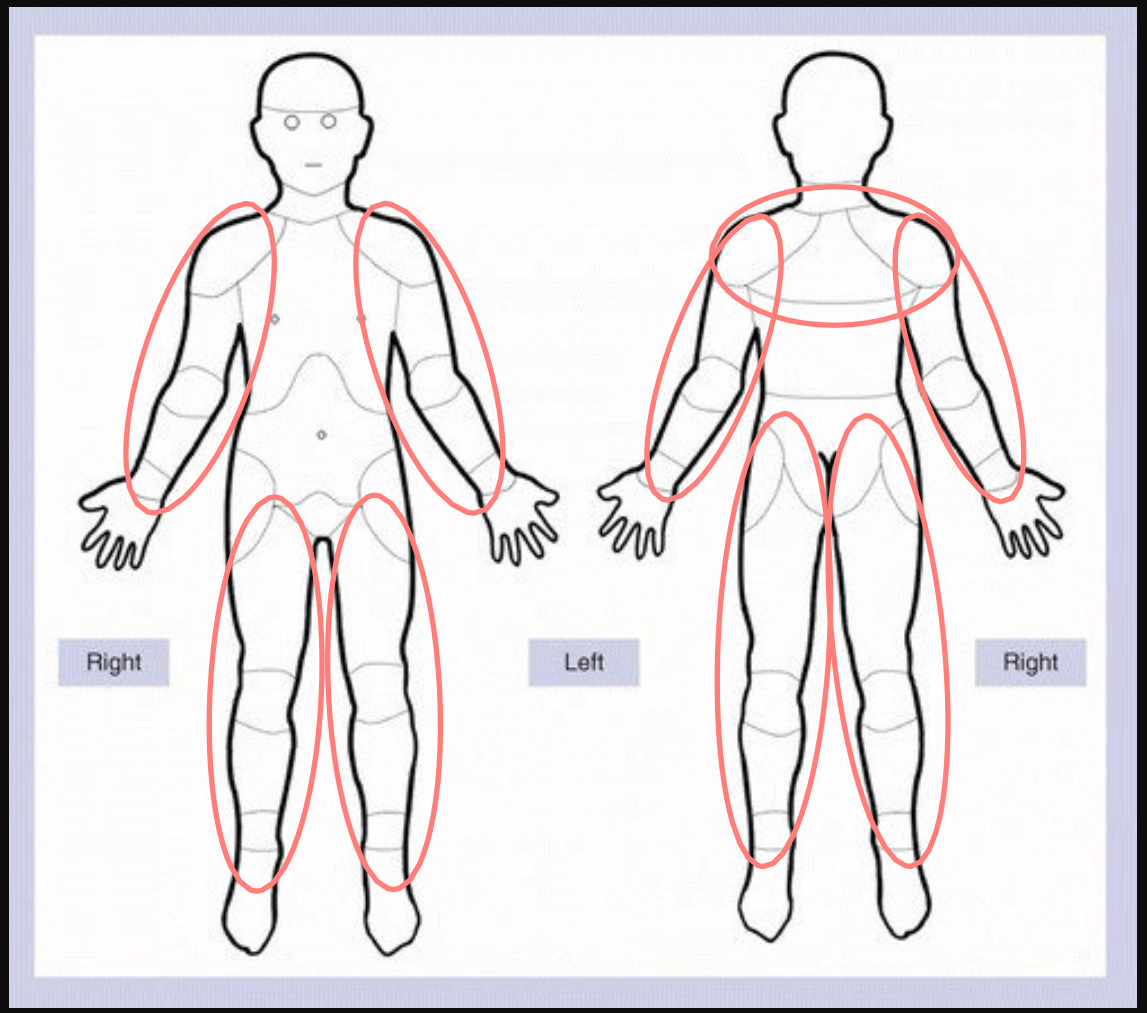
- October 2020: Two-week flu-like illness
- Pain!
- August 2021: Fibromyalgia Diagnosis

Chief complaint: Muscular Pain

Chief complaint: Muscular Pain



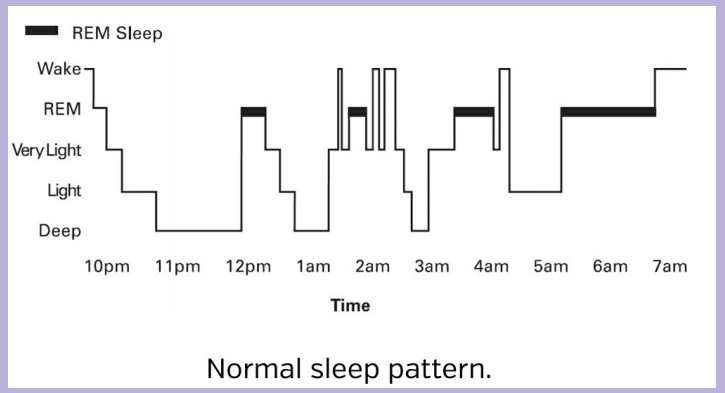
Chief complaint: Muscular Pain



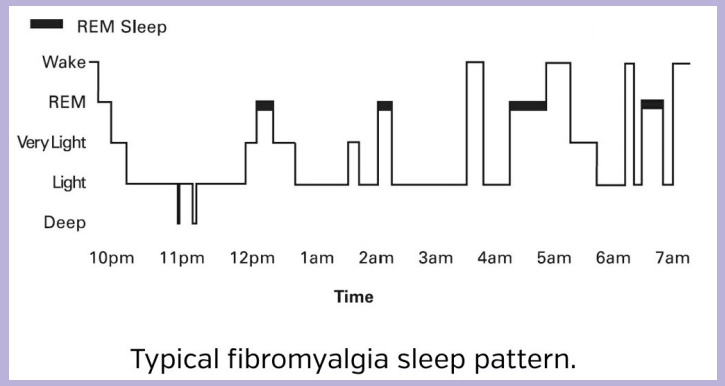
Life Effects of Chief Complaint and Pertinent S

1. Pain
   - Impaired work
     - Off days” could not be planned and were spent writhing in pain
   - Impaired activities of daily living & leisure
   - Unable to exercise

2. Poor sleep & Fatigue
   - Fewer hours to work/leisure in a day



Normal sleep pattern.



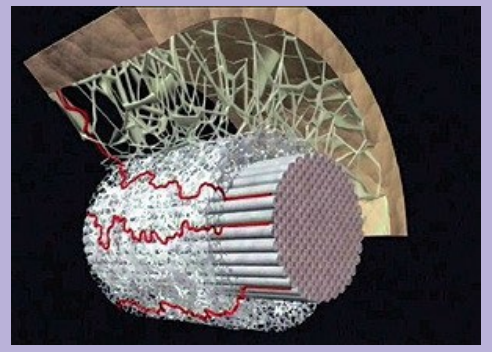
Typical fibromyalgia sleep pattern.

Problems and Solutions for Current Treatment

Problem	Solutions
Undertreatment	1) Integrated Care Teams 2) Suggest Complementary & Integrative Treatment Options
Mistrust	1) Validate 2) Address: Pain and Functionality/Goals 3) Be aware of Unconscious Bias
Lack of Knowledge	1) Medical Education 2) Research

Problem: Undertreatment
Solution: Suggest Complementary & Integrative Treatment Options

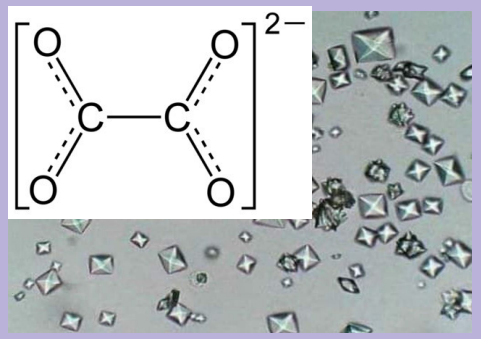
Lavender Essential Oil



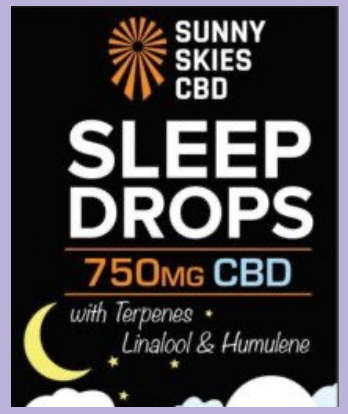
Myofascial Therapy

Infrared Heated Yoga

Prayer & Meditation

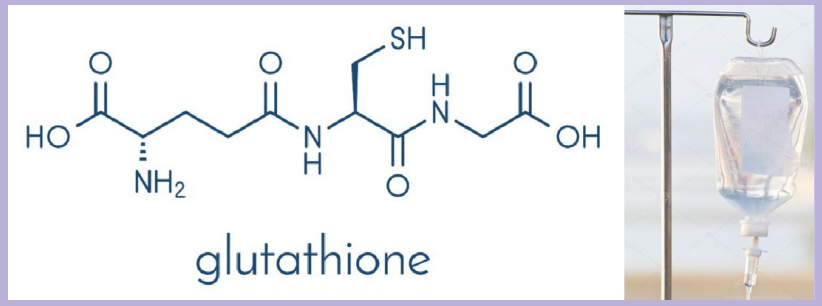


Low Oxalate Diet



CBD

Vagal Nerve Stimulator



IV Glutathione

Problems and Solutions for Current Treatment

Problem	Solutions
Undertreatment	1) Integrated Care Teams 2) Suggest Complementary & Integrative Treatment Options
Mistrust	1) Validate 2) Address: Pain and Functionality/Goals 3) Be aware of Unconscious Bias
Lack of Knowledge	1) Medical Education 2) Research

Problem: Lack of Knowledge
Solution: Education and Research

Fibromyalgia	Most common in females 20–50 years old. Chronic, widespread musculoskeletal pain associated with "tender points," stiffness, paresthesias, poor sleep, fatigue, cognitive disturbance ("fibro fog"). Treatment: regular exercise, antidepressants (TCAs, SNRIs), neuropathic pain agents (eg, gabapentin).

Problems and Solutions for Current Treatment

Problem	Solutions
Undertreatment	1) Integrated Care Teams 2) Suggest Complementary & Integrative Treatment Options
Mistrust	1) Validate 2) Address: Pain and Functionality/Goals 3) Be aware of Unconscious Bias
Lack of Knowledge	1) Medical Education 2) Research


Got A Lotta Bad Days Still Commin' Our Way
But A Sweet Ever After
Wind And Waves Breaking Over Our Walls
But the Ship, It Don't Shatter
The Real Life Lesson By A Life Well Lived Is
You Lose What Don't Matter
But The Sun's Coming Up On the Stairway to Heaven
In the Sweet Sweet Ever After

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Nicole Golding, MD, FAAPMR, CHCQM

Medical Director, Health Services

American Special Health

Alliance to Advance Comprehensive Integrative Pain Management

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PATIENT-CENTERED INTEGRATIVE CARE

NICOLE GOLDING, MD, FAAPMR, CHCQM

MEDICAL DIRECTOR, HEALTH SERVICES

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257
Health Plans

49.6M+
Members

Health Plan Value Proposition

10 – 56%
Reduction in costs

97%
Compliance with 189 Performance standards

97%
Patient satisfaction

70
NPS Client Score

Clinical Network:
Clinical Outcomes and Satisfaction

Improved Clinical Outcomes

Was the ASH practitioner successful treating your primary condition?

	AGREE OR STRONGLY AGREE
Chiropractic	96%
Acupuncture	91%
PT/OT	92%
Massage Therapy	96%
Naturopathy	96%

High Patient Satisfaction

86% ASH members rate their provider best-of-the-best

vs

79% US population rate their provider best-of-the-best

98% Patient Satisfaction

- Received all the care they felt was needed: **94.4%**
- CMS-Level Grievance or Appeals: **0**

cahps® Surveys and Tools to Advance Patient-Centered Care

CG-CAHPS Data collected by NCQA certified: SPH Analytics

Clinical Coaching:
Member Satisfaction & Net Promoter Score

Digital Coaching

43
NET PROMOTER SCORE

95%
SATISFIED TO VERY SATISFIED

57
OVERALL NPS

Live Coaching

62
NET PROMOTER SCORE

Google 41

SAMSUNG 47

intel 50

charles SCHWAB 52

WESTIN HOTELS & RESORTS 59

Low Back Pain for Five Years

49-year-old; Female Considering Surgery

Bjornarra, J, etal; Effects of a Remotely Delivered Cognitive Behavioral Coaching Program on the Self-Rated Functional Disability of Participants with Low Back Pain; *Pain Management Nursing*; August 2021.

Herniated Discs, lumbar

Cohort: 3 [MRI 72148]

BASELINE (T-1)

ODI:	**28.9 (moderate)**
PAM:	4 (activated)
SPS:	20.0 (significant)

PAST TREATMENT

Tried Acupuncture; Massage; Heat.

Discussed Surgery with HCP

RESULT (T-2)

ODI: 15.6 (minimal)*

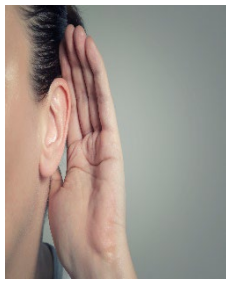
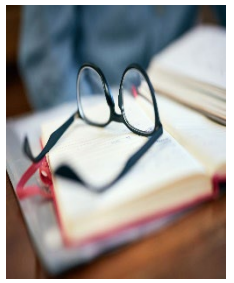
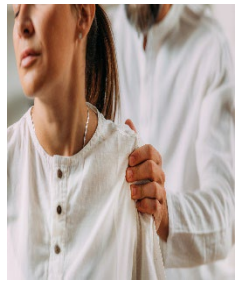
Decided to not pursue surgery or other invasive treatments

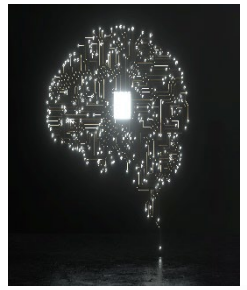
FUNCTIONAL IMPROVEMENT

- Standing longer in the classroom without constant pain
- Confident in how to move safely
- Traveling again (longer drives in car and took a cruise)

"I WAS ABLE TO DANCE ON THE CRUISE! I WAS HAVING SO MUCH FUN I FORGOT ABOUT THE PAIN."

Navigation Coaching

- Physician makes referral to ASH pain management program (Navigator Coach)
- Members average 1–2 navigation sessions with Navigator Coach
- Navigator Coach:
  - Listens. Develops an understanding of the **patient's current needs**. Introduces benefits available.
  - **Identification of provider**(s) near member and answers questions @ **chiropractic, acupuncture, therapeutic massage**
  - Engages member and informs them about **support** (call us at any time)
  - ID if they have website access and discuss **resources**
  - Coordinates **scheduling member with RN coach for Pain Management coaching**
  - Sets date when outreach phone call will be made to **follow-up** on progress
  - **Educates about Cognitive Behavioral Coaching** and value of learning new ways to address pain

Coaching Focus: 6 Domains of Cognitive Behavioral Coaching

Coaching that motivates and educates (*cognitive*) individuals about the connection between thoughts and actions; helping participants through active engagement (new *behaviors* and reframed thinking) to approach recovery and functional activity in a more effective manner.

Being Active
Overcoming fear avoidance behavior

Getting Motivated
Learning about treatment decisions and taking action to manage pain

Understanding My Options
What are evidence-based options (unbiased information)

Reframing How I Think About Pain
What is pain telling me and how to respond

Taking Care of Me (Self-Care)
What can I do myself; learning to *want* to do it

Getting the Help I Need
Maximizing doctor-patient relationships; taking ownership of care plans

Patient Advocacy & Quality Assurance: Sociological Aspects

SDoH?

Is the participant currently safe?

Is coaching appropriate for the participant?

Clinical status and goals?

Internal Resources:

- Multi-disciplinary QA team
- PharmD, Physician, and Social Worker
- RN coaching
- Extensive online resource library

External Referrals:

- Referring Provider
- Case Management
- Equipment needs
- Other resources

Regular monitoring of patient status during live coaching intervention

Medicaid Integrative Pain Management Program Components

Eligibility: Medicaid population, on opioids, with Low Back Pain

- Learned - better to open to anyone, no matter medications or location of MSK pain

Health Plan

- Referred by health care provider or Health Plan Case Management

Navigation coach

- helps with choosing a provider, explaining program, and scheduling with RN coach

ASH Network Providers:

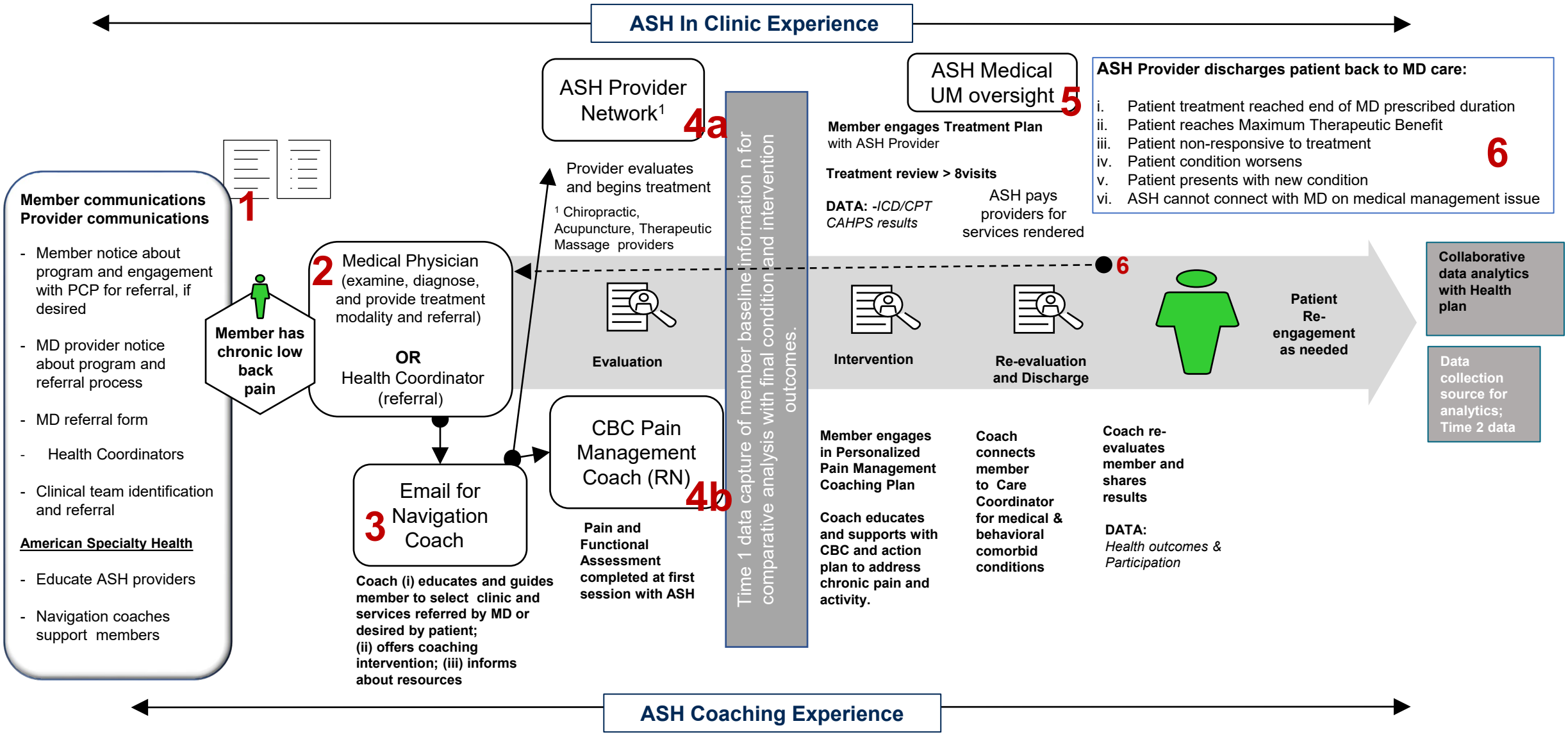
- Chiro, Acupuncture, Massage Therapy and ASH does medical necessity review

RN Pain management coaching program

- Cognitive Behavioral Coaching, Lifestyle modifications, and educational resources

Quality Assurance oversight / medical oversight through ASH

- Referrals to case management at Health Plan as needed.


ASH In Clinic Experience
ASH Provider Network[1]
4a
ASH Medical UM oversight
5
ASH Provider discharges patient back to MD care:
i. Patient treatment reached end of MD prescribed duration
ii. Patient reaches Maximum Therapeutic Benefit
iii. Patient non-responsive to treatment
iv. Patient condition worsens
v. Patient presents with new condition
vi. ASH cannot connect with MD on medical management issue
6
Member communications
Provider communications
- Member notice about program and engagement with PCP for referral, if desired
- MD provider notice about program and referral process
- MD referral form
- Health Coordinators
- Clinical team identification and referral
American Specialty Health
- Educate ASH providers
- Navigation coaches support members
1
Member has chronic low back pain
2 Medical Physician (examine, diagnose, and provide treatment modality and referral)
OR
Health Coordinator (referral)
3 Email for Navigation Coach
Coach (i) educates and guides member to select clinic and services referred by MD or desired by patient; (ii) offers coaching intervention; (iii) informs about resources
Provider evaluates and begins treatment
[1] Chiropractic, Acupuncture, Therapeutic Massage providers
CBC Pain Management Coach (RN)
4b
Pain and Functional Assessment completed at first session with ASH
Time 1 data capture of member baseline information n for comparative analysis with final condition and intervention outcomes.
Member engages Treatment Plan with ASH Provider
Treatment review > 8visits
DATA: -ICD/CPT CAHPS results
ASH pays providers for services rendered
Evaluation
Intervention
Re-evaluation and Discharge
Patient Re-engagement as needed
Member engages in Personalized Pain Management Coaching Plan
Coach educates and supports with CBC and action plan to address chronic pain and activity.
Coach connects member to Care Coordinator for medical & behavioral comorbid conditions
Coach re-evaluates member and shares results
DATA: Health outcomes & Participation
Collaborative data analytics with Health plan
Data collection source for analytics; Time 2 data
ASH Coaching Experience

66 F w/Low Back Pain, Hx drug addiction wanting to avoid alcohol & Tramadol

Uses a walker and ibuprofen

Takes care of her 2 dogs

ISSUES

Not interested in coaching at first but entered after speaking with navigator coach

Was not on opioids - trouble getting into program initially

Friends wanted her to get opioids to sell – she refused

Spinal stimulator hurting her

TREATMENT- ACUPUNCTURE

"Acupuncture very helpful – it feels like it is getting to the root of pain."

 # SESSIONS

5

COACH CHAMPIONED

Staying off alcohol
Setting her up with Acupuncture

Finding more healthful ways to deal with LBP – pacing, ergonomics, spine sparing movements; opioid management

Helping her talk to her providers and ask questions

Referred to Health Plan case management

MONTHS

3

SELF ADVOCACY & CASE MANAGER

Restarted Physical Therapy as well

Helped get her appt with pain specialist.

PT wrote a note @problems with stimulator

Sched. w/ primary doctor – given BP machine & BP has been normal

Obtained new walker

VISUALIZING A FUTURE

Goal - walk her dog on the beach

Spinal Stimulator removal surgery is scheduled

Thinking about getting a part time job

"MORE OPTIMISTIC OUTLOOK ON LIFE AND FEELS SHE IS GETTING STRONGER."

42 F w/Low Back Pain, Radiculopathy (leg pain), Schizophrenia on Oxycodone

Welfare, food stamps

In WW, lost weight, stopped d/t cost

Case mgr sets up all appointments

ISSUES

Pain affects mood

Uncomfortable making appointments independently

Mind can go blank

Doctor will not prescribe additional pain meds -> stress

Wants to lose weight

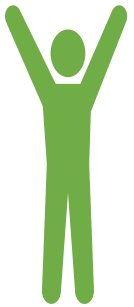
Worried @ arm pain

TREATMENT

Chiropractic treatment – 8 sessions for shoulder and low back pain – both better.

COACH CHAMPIONED

Helped her remember/ cont. point system



Inflammatory foods – read article on website

- Reduced white rice, then cut,
- Reduced salad dressing
- Rating more vegetables,
- Eating brown bread
- Drank more low-fat milk

Brainstormed how to feel more full
Drinking more water

Mindful movement and abdominal core bracing – watched video

SMART goals with sleep

Self care

 # SESSIONS

7

MONTHS

6

SELF ADVOCACY

Asked doctor to be referred to pain specialist – given Rx instead, talked to doctor that it was not working.

Prepared for MD visit to discuss arm pain, sleep, walking, how far should walk safely. Red flags reviewed to discuss.

What techniques providers suggest to work on mood – certain music

Talked to family about supporting diet

CASE MANAGER

Finances sometimes a barrier to cost of healthy food

Obtained a new care manager

LOST 3-5 POUNDS, HAS STRATEGY TO COPE WITH LOW BACK PAIN FLARE, STOPPED USING OXYCODONE

Person Centered Approach
INTEGRATIVE plus INTEGRATED

- Can program flex to address **where person is in their journey**?
- Design vs implementation differences demands **expectation management**.
  - **Staff and processes** need to be flexible, adaptable, and pivot!
  - **Sharing** info with patients about roles and contractual connections to share (HIPAA)
  - Program supports the **Biological, Psychological, and Social factors**
- Complex populations = messiness
  - Needs help with **self advocacy, self- efficacy, self-management, and system advocacy**
  - Some need basic living support (SDOH), support for social situations, and medical support while addressing pain
  - Be prepared for unexpected, urgent acute referral response (e.g. QPR; infection; etc.)
- **INTEGRATIVE** pain management solution provides *complimentary medicine specialties, educates about pain and lifestyle, but also changing their perspective (reframing)* AND ALSO identifies *significant medical management* opportunities.
- Our goal was to drive a great outcome; we learned that a patient centered integrative program demands effective **INTEGRATED** care for all a person's health concerns, including providing a safety net.

It isn't easy but it is possible!

QUESTIONS?

THANK YOU

Approach to Opioid Education

- Identify current opioid use during initial intake
- Encourage responsible opioid use through education on risks and appropriate use
- Foster realistic expectations for pain relief
- Educate on evidence-based opioid alternatives appropriate for the condition
- Support participant in discussing opioid use and alternatives with their provider
- Make appropriate referrals to Health Plan Case Management if nurse coach identifies a potential safety issue or participant discloses addiction or misuse/abuse
- Decrease reliance on opioids by providing education and encouraging self-care behaviors

Cognitive Behavioral Coaching Techniques

Coaching that motivates and educates (*cognitive*) individuals about the connection between thoughts and actions; helping participants through active engagement (new *behaviors* and reframed thinking) to approach recovery and functional activity in a more effective manner.

Core Cognitive Behavioral Concepts

- **Personalized,** structured learning experience
- Become **aware** of the **pain cycle** and what pain means
- Create **productive actions** aligned with new thought patterns
- Challenge **self-limiting** automatic thoughts
- Learn **new responses** to pain (reframe reactions to pain sensations)
- **Practice** until new thoughts and behaviors become the norm

Q&A

RESOURCES

https://painmanagementalliance.org/innovation-webinar-2

This link includes the slides along with other resources related to this topic.

THANK YOU

More Information About AACIPM

- **Email:** amy@painmanagementalliance.org
- **Website:** painmanagementalliance.org
- **Sign up** for our monthly newsletter and announcements at bottom of any webpage
- **Hashtags:** #aacipm #cipm
- **Twitter:** @aacipm
- **LinkedIn:** https://www.linkedin.com/company/aacipm

Alliance to Advance Comprehensive Integrative Pain Management

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