A Multistakeholder Discussion:
Exploring Equitable, Scalable,
Value-Based Pain Care Delivery

Alliance to Advance Comprehensive Integrative Pain Management

U.S. PAIN FOUNDATION

December 7, 2023
12:00 PM-2:00 PM
Welcome and Thank You for Joining

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

Cindy Steinberg
Director of Policy & Advocacy
U.S. Pain Foundation

#AACIPM
AACIPM CONNECTS THE DOTS TO ADVANCE EQUITABLE, WHOLE PERSON, MULTI-MODAL PAIN CARE.
People with Pain Remain at the Center of Pain Care
We stand behind this foundation to check ourselves and our participants during all discussions.

Harmonizing Input into Accelerated Action
AACIPM was formed in early 2019 as a unique multistakeholder collaborative uniting patients, payors, providers and policymakers.

Where the Rubber Meets the Road – Scaling Value-Based Pain Care
We curate examples of person-centered pain care to educate stakeholders, promote targeted research, and change practice and payment designs.

No one can do this alone.
ABOUT THE U.S. PAIN FOUNDATION

Our mission: to empower, educate, connect, and advocate for individuals living with chronic pain, as well as their care partners and clinicians.
U.S. PAIN FOUNDATION PROGRAMS

- Federal & State Policy & Advocacy Program
- INvisible Project
- Support Groups
- Pediatric Pain Program
- Medical Cannabis
- Living Well With Chronic Pain booklets
- Spanish materials
- Surveys
- Building Your Toolbox
Advocacy Priorities

● Promote movement toward individualized, integrated, multidisciplinary pain care as best practice

● Work to improve access to a full range of therapies for chronic pain including integrative & complementary modalities, restorative therapies, behavioral approaches, interventional procedures including innovative medical devices and novel therapeutics.
What are the Pain Realities?

Chronic pain is the #1 cause of disability globally.

1 in 6 Americans lives in pain every day.

Multimodal Pain Care is the Gold Standard but Not Accessible for Many, Especially Underserved Persons
CIPM TOOLBOX

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

**CHALLENGES**

- Misperceptions & Stigma
- Workforce Supply & Demand
- Lack of Awareness/Education
- Misaligned Financial Incentives
- Business Case Data Disagreement
- Integration & Cultural Incompatibilities
The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in US
Nearly 90M Americans rely on its health care benefits
NHE has been growing and accounts for about a fifth of the Gross Domestic Product (GDP).
CMS wants to change the way healthcare providers are paid
They want to recognize and reward care that is coordinated, that encourages good communication between health care providers and their patients, and that eliminates redundancy or care that is proven to be ineffective.

Innovation Center Strategic Objective 1: Drive Accountable Care

Aim:
Increase the number of people in a care relationship with accountability for quality and total cost of care.

Measuring Progress:
• All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
• The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
1.21.20 – CMS announced it will cover up to 12 acupuncture visits for CLBP

This has presented exciting opportunities and numerous challenges.

• Utilization is low.

• Driving down payment rates.
  – Licensed acupuncturists (LAc) have mainly private paying patients from affluent zip codes.
  – Low reimbursement, paperwork do not incentivize LAc participation in insurance.

• In Social Security Act, LAc are not a “qualified provider” which means they are not a Medicare-approved provider for reimbursement.

• Licensed acupuncturists have the most extensive training to provide this care.
New CMS/Medicare Chronic Pain Management Billing Codes

• Congress directed CMS to work with the HHS Pain Management Best Practices Task Force (PMTF) to improve pain management

• Many recommendations in the PMTF report were directed at CMS to encourage and reimburse for coordinated, comprehensive pain management

• CMS proposed & then finalized in Nov 2022 Physician Fee Schedule Final Rule that starting Jan 1, 2023 Medicare will create two specialized billing codes for Chronic Pain Management
New CMS/Medicare Chronic Pain Management Billing Codes

Codes require comprehensive pain management to include:

- Diagnosis
- Assessment & Monitoring
- Use of a validated pain rating tool
- Development, revision & maintenance of individualized care plan
- Medication management
- Pain & health literacy counseling
- Crisis care
- Care coordination of physician, NP, PA with other therapists including behavioral health, PT, OT, complementary & integrative approaches, etc.
New CMS/Medicare Chronic Pain Management Billing Codes

Intent of new codes to improve pain care by:

• Paying physicians to spend more time with patients on a monthly basis
• Requiring recommended best practice steps in comprehensive chronic pain management
• Emphasizing an individualized treatment plan integrating a number of treatment modalities
• Paying lead healthcare practitioner to coordinate care
We asked some stakeholders...

**Primary Care & Pain Specialists:** Generally not aware of these codes, not discussing their use. CMS has done little to publicize & educate on the use of these codes.

**Coding/ Billing Expert:** “We have an NP who treats a lot of chronic female pelvic pain and asked about these codes. My research shows it would actually hurt financially to use in many situations. For example - pt has an office visit every month that includes management of her chronic pelvic pain (35 minutes of clinician time is noted.) Assuming the requirements of documentation are there, I can bill G3002 OR E/M 99214. I suppose there are some circumstances these new codes would be helpful, but it's not in mine.”

**Physician doing integrative pain care:** “I do not have the billing, coding or regulatory compliance background to be able to advocate for use of these codes. I am being told they are less reimbursement than what we are already using.”
Financial Disincentive

New G Codes (G3002/G3003) Have Lower Reimbursement than Existing E/M Codes Being Used

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<th>Year</th>
<th>CPT</th>
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<td>112</td>
<td>$30.19</td>
<td>$25.93</td>
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</tbody>
</table>

Source PFS National Payment Amount File | CMS
Samuel “Le” Church, MD, MPH, CPC, CRC, FAAFP
Family Physician
AAFP Member
Changing Physician Led Practice Patterns

Samuel L Church, MD, MPH, CPC-I, FAAFP
Synergy Health, Inc
The Quintuple Aim in Healthcare Delivery

Triple Aim 2007
- Improved Patient Outcomes
- Better Outcomes
- Lower Costs

Quadruple Aim 2014
- Clinician Well-Being

Quintuple Aim 2018
- Health Equity
Barriers to Learning and Implementing New Knowledge

• Habits of “lower-value” – “higher-cost” care
• Competes with time with patients
• Non-optimized new tools
• Competition with current payment models
• Workforce shortages
• Management support
Health Care Change is S....L....O....W....

• Need to “unlearn” (some) old knowledge
• Motivations for changing health care delivery practices
  • Intrinsic motivating factors (personal satisfaction, use of qualifications)
  • Extrinsic factors (salary, career opportunities)
  • Providing high quality care
• Value-based care challenges – requires buy-in from team
Experience with Chronic Care Management Codes
Karen Johnson, PhD
Vice President, Practice Advancement
American Academy of Family Physicians

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The Questions

1. Your background and role
2. What is your experience using CMS pain-related codes for person-centered care?
3. Why was your model of care developed?
4. What healthcare providers/therapies are included?
5. How does your model integrate with the patient’s overall care?
6. Are there outcomes you can share?
7. If your model is scalable, how is that working?
Tobias Moeller-Bertram
CEO, SAVAS Health
President, VitaMed Research, LLC
THE SAVAS SOLUTION
Unitized Transdisciplinary Care
A Novel Technology Driven Value-Based Care Delivery Model

Dr. Kayode Williams
Johns Hopkins School of Medicine

Dr. Tobias Moeller-Bertram
CEO Savas Health

Scalable, Value-Based Care Delivery for People with Pain
December 7, 2023
5/50 PROBLEM: 5% OF PATIENTS COUNT FOR 50% of COST

United States Health Spending

IN BILLIONS

Complex Condition Health Spending (shown in red)
Patients with Chronic Pain are in the 5% of patients with complex conditions that consume 46% of healthcare spending (~$2 Trillion annually).

All Other Health Spending (shown in blue)

Source: Institute of Medicine. “Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research.”
**THE CHALLENGE:**

**SUPPLY/DEMAND MISMATCH**

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**Physician Supply and Demand Through 2032**

<table>
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<tr>
<th>NATIONAL PHYSICIAN SHORTAGE BY 2032*</th>
<th>WE PREDICT A SHORTAGE OF</th>
<th>46,900-121,900</th>
<th>INCLUDING A SHORTAGE OF</th>
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<tr>
<td></td>
<td>PRIMARY CARE PHYSICIANS</td>
<td>21,100-55,200</td>
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<tr>
<td>GREATEST CONTRIBUTORS TO THE SHORTFALL</td>
<td>SPECIALISTS</td>
<td>24,800-65,800</td>
<td></td>
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<tr>
<td></td>
<td>SURGICAL SPECIALISTS</td>
<td>14,300-23,400</td>
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**Physician Training Completion**

| IT TAKES | 7-15 YEARS FOR A PHYSICIAN TO COMPLETE THEIR TRAINING, SO WE MUST ADDRESS THIS SHORTAGE NOW. |

**Federal Support for GME**

| CAPS ON FEDERAL SUPPORT FOR GRADUATE MEDICAL EDUCATION (GME) | HAVE BEEN EFFECTIVELY FROZEN SINCE 1997 AND SHOULD BE RAISED. |

**Resident Physician Shortage Reduction Act**

| THE AAMC SUPPORTS THE RESIDENT PHYSICIAN SHORTAGE REDUCTION ACT OF 2019 (S. 348, H.R. 1743), WHICH ADDS 15,000 RESIDENCY SLOTS OVER 5 YEARS. |

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**Figure 6:** Spending by employers on individuals with chronic diseases is nearly quadruple that of healthy individuals while spending on individuals with complex chronic diseases is eight times higher

Average annual per capita spending 2013-15 for individuals with employer-based insurance

- Healthy: $1,320 (1X)
- Chronic: $4,668 (3.5X)
- Complex chronic: $10,830 (8.2X)

**Source:** PwC Health Research Institute analysis of Medical Expenditure Panel Survey data for individuals with employer-based insurance. 2017-18.

Note: Consumers with chronic disease have problems afflicting a single body system such as hypothyroidism or require uncomplicated disease management. Consumers with complex chronic disease have one or more chronic diseases that afflicts their systems under complicated disease management. Additionally, note that the percentage of the population with employer-based plans is nearly 57%. The other 29% are either individuals with a mental illness or whose primary care or specialty care provider is located in a rural area. The remainder are covered by Medicare or managed care organizations.


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= Reduced Access to Care
THE SAVAS SOLUTION

UNITIZED TRANSDISCIPLINARY CARE (UTC)

1. SOLVES SUPPLY/DEMAND MISMATCH
Team of providers plans and delivers care to groups of patients
Care planning driven by real-time data

2. SOLVES INCREASED COSTS
Leverages technology to match complex patients with care needed
Bundled payment de-risks cost explosion for payor

3. PROVIDES MEASURABLE VALUE
Technology driven automated outcome reporting
Proven improvement of clinical outcomes and cost savings

4. SOLVES SCALABILITY AND REPRODUCIBILITY OF CARE DELIVERY
Technology driven platform aligns provider behavior
Software based care system enables scalability


www.savashealth.com
THE SCALABLE SOLUTION
Technology Driven Value-Based Care

EFFICIENCY MATRIX: Match SUPPLY With DEMAND

VIRTUAL
Combined
IN PERSON

GROUP OF PATIENTS
TEAM OF PROVIDERS

GROUP OF PATIENTS
SINGLE PROVIDER

SINGLE PATIENT
TEAM OF PROVIDERS

SINGLE PATIENT
SINGLE PROVIDER

ACCESSIBILITY
COMMUNITY

SIMPLICITY
COMPLEXITY

ASSEMBLAGE

+ DEMAND
+ SUPPLY
PROGRAM STRUCTURE

Patient Centered

Provider Team delivers care in one location

Patient Needs based treatment planning

Cost Sensitive: Healthcare utilization pre-post analysis

Outcome Driven: 10 standard measures (Emotional, Physical, Other)

Patient Satisfaction important outcome

www.savashealth.com
• Medical Service Line
  • Doctors, Addiction Specialists, Interventional Pain Specialists, Nurse Practitioners, & Physician Assistants
• Behavioral Service Line
  • Psychologists, Social Workers, & Cognitive Behavioral Specialists
• Physical Reconditioning Service Line
  • Physical Therapists, Massage Therapists, Fitness Instructors, Yoga, & Tai Chi Masters
• Alternative Care Service Line
  • Acupuncturists, Dietitians, & Nutritional Therapists

TRULY INTEGRATED MEDICINE
THE UNIT

Each Unit begins with a SCRUM

1) Nurse Care Coordinator
2) RN Care Manager
3) Medical Provider
4) Psychology Provider
5) Nutrition Provider
6) Physical Reconditioning Provider
7) Chiropractor
EMOTIONAL OUTCOMES

Subjective Pain Catastrophizing and Depression decreased significantly.

Data tested for distribution by Shapiro-Wilk test followed by Wilcoxon signed-rank test with list wise exclusion of missing data and presented as Median +/- interquartile range, ***p < 0.001.
Subjective Pain Intensity and Interference, as well as Disability (OSWESTRY) decreased significantly.

Data tested for distribution by Shapiro-Wilk test followed by Wilcoxon signed-rank test with list wise exclusion of missing data and presented as Median +/- interquartile range, ***p < 0.001.
Global impression of change increased significantly.

Data tested for distribution by Shapiro-Wilk test followed by Wilcoxon signed-rank test with list wise exclusion of missing data and presented as Median +/- interquartile range, ***p < 0.001.
SAVAS HEALTH (DCPI) ROI PERFORMANCE:

External Three Year UCSD Analysis of Behavioral Health Integration, Integrated Complex Care (BHICCI) programs of which SAVAS HEALTH was the identified as the “Multispecialty Clinics” showed that SAVAS HEALTH outperformed the other 28 BHICCI sites significantly in reducing:

Inpatient Costs by $225 PMPM

Total Cost of Care by $150 PMPM (“All Services”)
THANK YOU
Josh Plavin, MD, MPH, MBA
Associate Medical Director
Comprehensive Pain Program
Osher Center for Integrative Health at UVM

#AACIPM
Comprehensive Pain Program
Osher Center for Integrative Health at the University of Vermont

Josh Plavin, MD, MPH, MBA, Associate Medical Director, Comprehensive Pain Program
Assistant Professor of Family Medicine & Psychiatry, Larner College of Medicine
“To understand pain as a universal life experience, and to understand chronic pain as a particular form of suffering which may also hold an opportunity for growth, increased wisdom, and wellness.”

CPP Mission Statement
Changing the Paradigm

• “What’s the Matter?”
  “What Matters to You?”

• Curing/Healing

• Patient/Participant
Participant Experience - Programs

PATH Program

BCBSVT/Medicaid Bundle

- PCP copay x 4
- 16 weeks duration, 8-12 pts.
- Weekly groups
  - First 8 weeks – ACT
  - Second 8 weeks – MGV

- Care Alliance Group
- Alumni Group

- Individual offerings
  - Clinical Hypnosis
  - EMDR
  - Medical Consult
  - Nutrition Consult
  - Psychologically-Informed Physical Therapy
  - Occupational Therapy
  - Health Coaching
  - Acupuncture
  - Massage/Craniosacral Therapy
  - Reiki

- Group offerings
  - EMDR 101
  - Kitchen Conversations/Culinary Medicine
  - MedEd – Cannabis 101
  - SleepWell Program
  - Yoga
Participant Experience - Programs

COMPASS Program
(FFS - not BCBSVT/Medicaid)

- 12 weeks in duration – 8-12 pts
- Weekly group
  - Acceptance and Commitment Therapy
  - Your Pain Protection System
  - Nutrition Overview

- Individual Offerings – FFS visits
  - Clinical Hypnosis
  - EMDR
  - Medical Consult
  - Nutrition Consult
  - Physical Therapy (Psychologically Informed)
  - Occupational Therapy

- Group Offerings – Optional
  - EMDR 101, introductory class
  - Kitchen Conversations/Culinary Medicine (free)
  - MedEd: Cannabis 101 (free)
  - Sleep Well Program (6-week program)
  - Yoga Classes (virtual, free)
  - Care Alliance Group (free)
An Integrative, Transdisciplinary Team

- Integrative Intake Review
- Midpoint Review
- Informal Encounters
Comprehensive Pain Program PATH Outcomes Measures

Survey Instruments:
- Pre/Post for pilot
- Goal 6 & 12 month in future
- Defense and Veterans Pain Rating Scale (DVPRS)
- PEG scale (interference of: pain (P), enjoyment of life (E), and general activity (G))
- Patient-Reported Outcomes Measurement Information System (PROMIS®)–29
- Brief Resilience Scale
- Self-Compassion Scale
- Chronic Pain Acceptance Questionnaire 8
- Health Confidence Scale

Financial and Utilization measures:
- 18 months of continuous coverage, 12 months pre and post intervention
- Medical PMPM
- RX PMPM
- Medical & RX PMPM (total cost of care)
- Musculoskeletal diagnostic related group PMPM
- Interventional Pain PMPM
- Pain Management RX PMPM (opioids)
- ER visits/1000 both total and pain related
Comprehensive Pain Program Outcomes

Patient’s Self Identified Pain Assessment (PEG)

- *Average pain in the last week*
  - Pre: 5.77
  - Post: 4.56
  - $P < .001$

- *Interference with life enjoyment*
  - Pre: 6.13
  - Post: 4.11
  - $P < .001$

- *Interference with general activity*
  - Pre: 6.2
  - Post: 4.31
  - $P < .001$

*Statistical Significance is based on a paired T-test with a p-value below 0.05*
Comprehensive Pain Program Outcomes

PROMIS – 29

* Pain Interference  * Physical Function  * Fatigue  * Sleep Disturbance  * Anxiety  * Depression  * Social Roles and Activities

* All SS at P<.001

* Statistical Significance is based on a paired T-test with a p-value below 0.05
Comprehensive Pain Program Outcomes

BCBSVT Per Member Per month Cost Data 12 months Pre and Post

<table>
<thead>
<tr>
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<th>Pre PMPM</th>
<th>Post PMPM</th>
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<tbody>
<tr>
<td>Medical</td>
<td>$1,901.34</td>
<td>$1,582.06</td>
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<tr>
<td>Rx</td>
<td>$628.58</td>
<td>$486.27</td>
</tr>
<tr>
<td>Medical + Rx</td>
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<td>$2,068.32</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>$688.70</td>
<td>$479.21</td>
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</table>

- Pre PMPM Medical: $1,901.34
- Post PMPM Medical: $1,582.06
- Pre PMPM Rx: $628.58
- Post PMPM Rx: $486.27
- Pre PMPM Medical + Rx: $2,529.92
- Post PMPM Medical + Rx: $2,068.32
- Pre PMPM Musculoskeletal: $688.70
- Post PMPM Musculoskeletal: $479.21

Decreases:
- Medical: 17%
- Rx: 23%
- Medical + Rx: 18%
- Musculoskeletal: 30%
Comprehensive Pain Program Outcomes

Average ER Visits/1000 Pre and Post Intervention

- Any Diagnosis Pain Related Diagnosis
  - Pre Visits/1000: 706.6
  - Post Visits/1000: 249.6
  - Reduction: 65%

  - Pre Visits/1000: 287.9
  - Post Visits/1000: 93.6
  - Reduction: 67%
Thank You
Chris Knackstedt
Founder, Tellus Wellness
Managing Director, ValueIQ, LLC
Complementary Care Wellness Program
For Employer Sponsored Healthcare
The Questions

1. Your background and role
2. What is your experience using CMS pain-related codes for person-centered care?
3. Why was your model of care developed?
4. What healthcare providers/therapies are included?
5. How does your model integrate with the patient’s overall care?
6. Are there outcomes you can share?
7. If your model is scalable, how is that working?
The Team

Donna Goldin Evans  Chris Knackstedt  Lance Luria, MD,FACP,ABOIM
CO-Founder/CEO  CO-Founder  Chief Medical Officer

• Co-Founders: 30+ years of large health system and health plan experience. Co-created ValueIQ, successful consulting firm focused on transition to value-based healthcare.

• Clinical team led by Chief Medical Officer with experience managing integrative medicine programs that included Wal-Mart and Bass Pro. Documented significant year one savings using complementary medicine.

• CPO/CTO who created and scaled national B2B SaaS compliance-driven platforms.
The Problem
(Why our Model of Care was Developed)

Employers who self-fund their health benefits need solutions that improve well-being while moderating costs, and are of value in recruiting and retaining employees.
The Solution
Tellus Wellness Complementary Medicine Program Includes

Acupuncture  Nutrition  Massage  Chiropractic  Naturopathic

• **Digital Platform** guides members with health issues to care options using evidence-based clinical rules.

• **Curated and Credentialed Providers** who have cleared background checks and been reviewed and approved by on-staff medical professionals.

• **Innovative Provider Payment Process** yields most provider payments in 24 hours from the employee health benefit plan.
Digital Platform

Tellus Wellness Complementary Medicine Platform
Why?

Complementary Care Program: Unique In Marketplace

FOR EMPLOYERS

• Differentiator in the talent market via a low cost investment in your people

• Reduces traditional medical and related cost spend

FOR EMPLOYEES

• One-stop digital portal provides up-to-date information on complementary medicine, guidance to treatment options

• Fast access to experienced and credentialed providers

Research shows that “...workers receiving the most varied health and well-being benefits are the most positive about their employers, their jobs and their ability to afford the healthcare they need...” Mercer, Health on Demand, 2023 Report.
Program Impact

2022 Case Study
Mid-West Manufacturing Company - 1600 Plan Members

Overall, **chronic conditions cost** the pilot program company $5.08 million per year.

Members using Tellus Wellness providers had a **29% cost decrease** compared to the previous year as compared to a 7% increase without Tellus Wellness.

**Members using Tellus Wellness providers incur less cost**, only $186 per member per month (pmpm) versus $298 pmpm total costs for members using non-Tellus providers.

**Members using Tellus Wellness providers had 50% less incidence of large claims and ER visits** compared to members using non-Tellus Wellness providers for similar conditions.
Summary

Employers need to **enhance the benefits** provided to their employees to support recruitment and retention — and do so without meaningfully increasing cost of benefits.

Complementary care expands options and has the potential to **lower cost** —often with better outcomes.

Tellus Wellness has developed innovative technology to **guide members using evidence-based clinical protocols**.

Innovative **disruptive payment process** (most payments 24 hours).

**Curated and credentialed** Tellus Wellness provider network.

Business development, initially **focused on employers who self-fund benefits** — including other channels (e.g. integrated health systems, 3rd party administrators, health insurers, retail).
David Elton, DC
Co-Founder, Arete Healthcare
CEO, Arete Networks

#AACIPM
Exploring Equitable, **Scalable**, Value-Based Pain Care Delivery

Scalable = *economically viable*

12/07/2023

dave@arete.healthcare

Arete Healthcare

[Link: www.arete.healthcare]
Should I have become a Great Clips stylist?

Evidence-based inflation adjusted reimbursement (if DCs were reimbursed for evaluations and exercise like PTs)

Actual reimbursement for 20 minutes in the clinic
11 minutes in the chair

- This is not intended to single out CMS or Great Clips, CMS price transparency made this possible and Great Clips is fantastic
- PTs in 2022 - 22k left practice, 12k joined | 9 out of 10 graduates have >$150k in student debt

In pursuit of economic viability “integrative” practices are evolving to “cash” practice, for which affluent, primarily white zip codes are the target market, increasing disparities in management of pain.
Maybe not.....if I could be reimbursed for an evaluation
Thesis for improving economic viability

• Independent, hands-on, and highly personal “integrative” practices are:
  • Essential to a well-functioning healthcare system
  • Fragmented, isolated, and under-served by technology, resulting in:
    • Reimbursement that is unchanged in >20 years and barely sustainable
    • Hard to be “integrative” if your technology doesn’t integrate
    • Fewer patients benefitting from CIPM than current guidelines suggest should be happening

• To improve economic viability “integrative” practices must adopt:
  • Modern, interoperable technology
  • Organizational design prevalent in medicine
    • Achieve economies of scale of larger group while preserving benefits of independent practice
    • Geographic distribution to provide convenient access, including under-served communities
    • Participate in value-based contracts

More research, expanded coverage, new codes at low reimbursement, larger networks, and demonstration projects, while well intended, do not address the barriers to economic viability.
Integration Model – Employed and Physically Embedded

**Medical Group, ACO, etc**

- **Comprehensive “integrative” health services**
- **Comprehensive medical and mental health services**

**Person With Pain**

**Strengths**

- **Convenient**
  - All services in one place
- **Collaborative**
  - Referrals, communication, and co-management are straightforward through use of the same EHR

**Weaknesses – barriers to scale**

- **Access limited to:**
  - Individuals living close to facility
  - Appointment availability of a small number of “integrative” providers
- **Lose $ for the entity**
  - Low revenue per square foot
  - Use and occupancy and administrative allocation may exceed revenue generated
  - Atypical RCM, credentialing, and contracting
Integration Model – *Outsourced and Physically Embedded*

- **Strengths**
  - Convenient
  - Collaborative
    - Assuming interoperable EHRs
  - Potential to be profitable as a separate entity
    - Same low revenue per hour per square foot
    - Use and occupancy and administrative allocation better aligned with revenue
    - RCM, credentialing, and contracting are handled by entity with expertise and focus

- **Weaknesses**
  - Limited access
  - Two scheduling processes
Integration Model – *High Value Network Using Common EHR*

**Strengths**
- **Convenient**
  - all services in one place if needed
- **Collaborative**
  - All embedded and external providers use the same interoperable EHR
- **Potential to be profitable as a separate group**
- **Clinically Integrated Network** of practices:
  - Convenient access for all individuals
  - Participate in value created ensuring viability

**Weakness**
- **Two scheduling processes**

**Outcomes**
- 1000s of referrals
- Reimbursement 50% premium to market
Mindfulness Break

Isabel Roth, DrPH, MS
Research Assistant Professor
Program on Integrative Medicine Department of Physical Medicine and Rehabilitation
University of North Carolina at Chapel Hill

#AACIPM
Take a moment
Moving to Panel Discussion

Co-Moderators

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

Cindy Steinberg
National Director of Policy and Advocacy
U.S. Pain Foundation

#AACIPM
Panelists

Samuel “Le” Church, MD, MPH, CPC, CRC, FAAFP
Family Physician
AAFP Member

Karen Johnson, PhD
Vice President, Practice Advancement
American Academy of Family Physicians

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Please use Q&A to submit a question
We were pleased to see CMS activate new pain codes effective January this year. You have a lot of experience with chronic care management and principle care management codes.

- First, is there a role in pain management for these codes?
- Are there any lessons from the Chronic Care Management program space that we could apply to these new codes or to comprehensive pain management in general?

Patient-centered outcomes are central to true value-based care.

- What outcome measures are you using?
- How have your outcomes changed in your current models of care compared to past care?

Scalable can mean different things to each person asked. Some excellent clinics say their model is scalable but it’s difficult to replicate easily across a large number of patients.

- Do you believe your model is scalable?
- Can you say more about scaling care and if that has affected the way you’ve built your current program?
THANK YOU

More Information About AACIPM

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• Website: painmanagementalliance.org
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