

Transcript from AACIPM Fall Symposium

Behavioral Health as Part of Comprehensive Pain Care and Payment Design - November 12, 2020

40 minute transcript - accompanying video can be found [here](#).

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- Robin Kahn, Director, Health & Benefits, Willis Towers Watson
- Yvette Colón, PhD, ACSW, LMSW, Assoc. Professor, Eastern Michigan, University School of Social Work
- Ravi Prasad, PhD, Director, Behavioral Health Services and Clinical Professor, Department of Anesthesiology and Pain Medicine, University of California, Davis School of Medicine
- Joseph T. (Tom) Norris, Jr. Lieutenant Colonel, U.S. Air Force, Retired

Interactive Discussion: Key Issues that Impact Patient, Clinical and Payor Interests

Denise Giambalvo, Moderator (00:00):

Well, thank you, Tom, for sharing your story. I wish I could say I've never heard a story like that before, but I have. And I'm just so happy that today you're getting the care that you deserve. I did notice a few comments in the chat, and I just wanted to note that one was that people aren't aware of the care that's out there and that's so very true. And we know that there's a very low literacy around healthcare benefits and it has absolutely no relation to intellect. We have a very complex healthcare system. We've made it very difficult for people to navigate and it's one of the contributing problems to integrative care.

Denise Giambalvo, Moderator (00:52):

So now I'd like to introduce our first speaker on our next panel. So I am pleased to introduce Ms. Robin Khan. Robin, we're going to start with you to give us a sense of what employers as purchasers of healthcare for about half of the covered lives in the US, are challenged with when it comes to pain management and behavioral health. And although Robin and I have known each other for a number of years, I am going to let her tell you a bit about herself and her role in employer-based healthcare before she goes into her presentation. Thank you Robin.

Robin Kahn, Panelist (01:31):

Thanks Denise. My name is Robin Khan, I'm a director in our health and benefits practice at Willis Towers Watson in Chicago. The focus of my work is with employers in the area of wellbeing and the concept of integrated wellbeing. There are many who think, "Oh, wellness, that must mean platforms like Limeade or Virgin Pulse." And that couldn't be further from the truth. So a lot of what we do is helping employers recognize that by putting their employees in the center, they have the ability to help them with all aspects of their lives.

Robin Kahn, Panelist (02:17):

And so when we look at the slide here, you'll see you have the individual in the center and an understanding that there's a connection between physical, emotional, financial, and social wellbeing. We've talked about this already. Stress exacerbating physical, financial exacerbating emotional, social impacting emotional. All of these are connected, and there's significant data demonstrating how challenges in one area often relate to challenges in others. So employers

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have been working on putting solutions in place to help their employees navigate this crazy healthcare system that we have, but the tools aren't enough. All of this needs to be grounded in a total rewards perspective. It's not just the healthcare benefits, but compensation, career, what's the culture? Do we have the leadership and the involvement in the community? And what is my work environment to support being able to thrive?

Robin Kahn, Panelist (03:32):

And this is where the challenge only gets worse. If we go to the next slide, employers prior to 2020 were focused on solving the larger problems. What do we do about weight management? What do we do about making sure we have the right behavioral health network? Are people ready to retire? What do I do about diabetes and cancer and my high cost claimants? Now, as we look at the last seven or eight months, those issues haven't gone away. In some respects, they've worsened, and there's new elements that were never considered before. Working age parents are dealing with virtual learning challenges for children, caring for a loved one that may need additional help, but yet now they can't leave to care for that person.

Robin Kahn, Panelist (04:35):

We're seeing increases in loneliness and isolation and the impact that that is having on people potentially from a substance abuse perspective or domestic violence. And add on top of that, this world of financial uncertainty for those that lost their job or a family or spouse that lost his or her job, what does that do? How is that impacting the individual? And we say, well, what does the employer have to do with all of this? But the employer is the linchpin to helping all of their employees get the care they need so that they can be happy, healthy, connected, and able to do their jobs.

Robin Kahn, Panelist (05:23):

So when we look at what this really means and go to the next slide, some of the data, almost every single employee is feeling some level of anxiety due to the coronavirus. And now we're seeing 40%, almost half of the US adult population, struggling with mental health or substance abuse. The interesting thing about this statistic though is that's those who have actually admitted that there's a challenge. There's not necessarily the psychological safety for people to raise their hands and say, "I need help." Definitely not from their employer. And when we look at financial struggles, the link between financial health and physical health is very strong. If I'm struggling financially, I may cut back on a gym membership or time to exercise or what I choose to eat, because maybe I think I can only afford the less healthy options.

Robin Kahn, Panelist (06:37):

And while we look at everything that's going on, stress and anxiety are normal reactions to the world around us today. But it also not only just impacts all of us generally, but for those that already have chronic pain, it's only making things worse. So what is an employer to do? And the challenge that employers face now, if we can go to the next slide, is that the employer is that glue around all of their employees, but they have so many different partners that they work with to deliver that care to their employees because they can't know what any individual is dealing with on a daily basis. So they have their various carriers for medical, dental, pharmacy vision. They've got their disability and life insurance carriers. They've got retirement partners to help make sure that people are hopefully saving money for retirement.

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Robin Kahn, Panelist (07:49):

And then we get into this wellness area where they will provide solutions or healthy options at work, but the interesting thing is you see this behavioral health kind of stuck between those two. Sometimes the behavioral health carrier will be the same as the medical carrier seeking care [inaudible 00:08:08] look in a connected way at both medical care and behavioral care, sometimes it's not. EAP solutions, Denise mentioned just one of them earlier. How does that fit into all of this? Because now you've got a separate solution, how do you then connect all of the dots, let alone help people like Lieutenant Colonel Norris find the right care? If I need help, who do I call? Where do I begin? How do I know that just because they're in network, that they're the best solution for me? So unfortunately, there's no single solution a lot of times for the individuals and not for the employer either. Thanks.

Stephen Gillaspay, Moderator (09:05):

Robin, thanks so much for those insights into all the many things that employers are struggling with to provide the right care. We're going to pivot now. We're going to pivot back to Dr. Prasad. So I'm going to throw this out here for Dr. Prasad. So now that we've have a better sense and some insights of what purchasers of healthcare are managing when trying to provide quality care with consistent outcomes at affordable costs, can you help us understand the standards and competencies necessary to effectively provide behavioral health interventions to people with chronic pain? And then if time permits, talk a little bit about what type of training or experience does a behavioral health provider need to have to work effectively in a disciplinary pain team. Dr. Prasad.

Ravi Prasad, Panelist (10:01):

Sure. Thank you for the question. I think it's an important question. And I'll try to address all of what you asked altogether in my response here. So first, how do we define a specialist? How do we define somebody who's a pain psychologist or a pain behavioral health specialist? I can tell you a story anecdotally. There was a individual who was on an insurance panel or a patient who was referred to a pain psychologist. They called their insurance company and they asked for people that specialize in pain. And so they contacted a particular clinician on the insurance panel who was a psychologist, and that psychologist experience with pain was that they treated a person for depression, but they also had arthritis.

Ravi Prasad, Panelist (10:51):

Now the arthritis wasn't necessarily an identified part of their treatment, depression was the primary treatment, but they label themselves as a pain specialist because they treated somebody who had arthritis. But the overwhelming practice that this person has was treatment of depression, treatment of anxiety in adults, specifically people that were going through relationship issues, but one of their patients had arthritis that they knew about. And so they checked a box with their insurance carrier saying that they had a specialization in pain.

Ravi Prasad, Panelist (11:22):

From my perspective, I think that that's a significant disservice to the individuals who are living with pain. Pain is an invisible disease. In many cases, we're not able to see what's happening with the person who's living with pain. We can't tell from going into the supermarket who is a person who is living with pain and who's not. It's a very isolating experience that takes a significant physical and emotional toll on folks. We know from the literature that's out there that behavioral interventions can be immensely helpful in helping people restore a higher level of quality of life and a higher level of functioning in their lives, but to the person living in pain, they

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don't necessarily possess this knowledge. They don't read our medical journals and things along those lines to know that this is a treatment pathway that can have viable results.

Ravi Prasad, Panelist (12:10):

So when they get referred to a psychologist or a behavioral health specialist for pain, they can have a lot of trepidation about that. There can be a lot of questions about why am I being sent to such a specialist? Do you think that this is all in my head? Do you think that I'm just making this up? And so there is a lot of stigma, there's a lot of doubt and skepticism that the person has to overcome. But then when they go to a person who truly doesn't have expertise in managing pain, then all of that has been overcome and they're not going to get the help that they necessarily need.

Ravi Prasad, Panelist (12:41):

So we need to make sure that the folks that people are being sent to possess the skills necessary to help the population, but what are those skills? I've always advocated that a good pain, health and behavior specialist needs to understand a little bit about the pain medicine, a little bit about the pain PT, and a little bit about the role of complimentary and integrative therapies. We need to make sure that we don't go beyond the scope of our practice, but we need to understand all those disciplines. Just like a good pain physician needs to understand all the other disciplines, a good pain physical therapist, a good pain acupuncturist, we all need to understand what the other disciplines bring to the table and how they integrate to help move a person's life forward with pain. But what are these skills that we need?

Ravi Prasad, Panelist (13:27):

And in this next slide, we illustrate how core competencies start to be something that's emerged as a way to help define what these are. About seven years ago, Dr. Fishman, who's a colleague of mine here now at UC Davis, and a number of other individuals spanning different professions across different disciplines, so across psychology, veterinary medicine, different disciplines in pain, nursing, physical therapy, came together to identify what are the core competencies that a person working in this field needs to have at the pre-licensure level.

Ravi Prasad, Panelist (14:02):

And so last year, Dr. Laura Wandner, myself, Dr. Ramezani, Malcore, and Kerns, we applied these competencies that were developed to the field of psychology. And there were four pillars that were identified recognizing the multi-dimensional nature of pain which is again, appreciating all the different biopsychosocial factors that go into the experience of pain, understanding pain assessment and measurement, understanding of the different components involved in pain management, and understanding clinical care, appreciating how context influences pain.

Ravi Prasad, Panelist (14:38):

So we applied this to our field of psychology, but we recognized that there was a number of challenges that still exist. So on the next slide, we realized that for people to get some of this training, oftentimes it may occur in training programs, such as fellowship programs. I completed a APA accredited... Or I created APA accredited fellowship program in pain psychology at my previous institution and I completed a fellowship program in pain management as well, but the thing is these programs are few and far between. They're not readily available to all folks. There's not as many pain psychology programs as there need to be compared to the need for pain

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psychologists in the community. And so given the pervasiveness of pain, we're not reaching enough people.

Ravi Prasad, Panelist (15:23):

And moreover, what we recognized is there needs to be more access to basic pain knowledge among all the psychologists who are out in the field. The reality is given the pervasiveness of pain, and I mentioned at the very start of my opening remarks today that one in five people are living with pain, well, there's a good likelihood that if somebody presents for psychological intervention, even if pain isn't the identifying factor, pain is maybe a good part of what that person's experiencing. So it's important for all psychologists to have an understanding of the basic fundamental aspects of pain management and not necessarily become experts where they have expertise in all those four pillars that we identified, but know enough to know how to guide a person and know when to refer.

Ravi Prasad, Panelist (16:10):

So quite simply, for example, I'm not a PTSD specialist, but I know enough about PTSD to understand what questions to ask to do an assessment, I understand what types of things may be indicated to help with PTSD treatment, and I also know when I need to refer to a PTSD specialist. And it's important for us to be able to provide that same level of education to psychologists. And so in collaboration with APA, Dr. Gillaspay and other colleagues, we created a curriculum that was meant to be delivered at a state by state basis to all the psychologists through workforce training program. And it was a curriculum developed by our incoming president, Dr. Jennifer Kelly, Dr. Dan Bruns, a private practice psychologist in Colorado, to try and provide this education to all psychologists, recognizing that people aren't necessarily going to be able to get that fellowship level training.

Ravi Prasad, Panelist (17:04):

So there are specific skills that people need to have in order to be able to do this work competently, and our goal is to be able to provide both guidance around what those specific skills are, but then also provide broad training so people understand how they're able to help this large and growing population.

Denise Giambalvo, Moderator (17:30):

Thank you for kicking us off with that fabulous information on the need for behavioral health and the expansion of it in pain management. Oh dear, I just... If someone could just let me know, are you still hearing me because I just lost power?

Robin Kahn, Panelist (17:52):

Yes, we can hear you Denise.

Yvette Colón, Panelist (17:53):

Yes.

Denise Giambalvo, Moderator (17:54):

Okay, I lost visual, but that's okay. I can go on. So Dr. Prasad, we do have some questions for you in the chat. And so just to let people know who have submitted questions, we will hold those till the panel has completed. It is now my pleasure to introduce Dr. Colón. Thank you for being a part of our panel. I am particularly interested in hearing comments from you about standards

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and competencies for social workers for pain management, and I'm hoping you'll also get to address behavioral health providers have a role in pain management, even if the patient does not have a diagnosable mental health condition.

Yvette Colón, Panelist (18:45):

Well, thank you very much for the lovely introduction. And I am really honored to be here with all of my colleagues across the country working very hard on behalf of people with chronic pain. I do want to clarify one thing. Although I am at Eastern Michigan University, we do not have a school of medicine. I am a faculty member in the School of Social Work, and I am also a clinical social worker in private practice, which is where I see the folks who have chronic pain. So as you have been hearing from all of us, especially Lieutenant Colonel Norris, a lot of work has been done in the last 20, 25 and more years to support effective pain management and to support integrative pain management, but unfortunately, the current climate towards improving care for people with chronic pain in this country really continues to be very complicated. Next slide, please.

Yvette Colón, Panelist (19:50):

Part of the issue is that care is fragmented. And I'm going to speak specifically from perspectives in my own discipline. The people I work with often do not know that social workers can help with pain or that they are trained in interventions that can address the difficulties that they have with pain. They have issues with insurance coverage, they're not quite sure what care employer-based coverage pays for, I work with a number of patients who have Medicaid who find the system very, very complicated. And that means if the patients are confused, then access to care is often reduced. They don't know where to go, they don't know the appropriate providers beyond doctors and nurses who can help them directly with their pain care.

Yvette Colón, Panelist (20:45):

Training has been inconsistent. In all the time that I have been in the pain world, I have seen a lot of efforts, including the curricula that Dr. Prasad spoke about in terms of psychologists, physical therapists, doctors, nurses, social workers as well, and other health professions, those curricula have been available, but not consistently implemented. They're implemented not at all in social work. I happen to live in a state... I'm in Michigan. I happen to live in a state that requires pain management continuing education for social work licensure. There are lots of other states that are doing social work continuing education around addressing opioid use disorder, the intersection of pain management and substance use as a way to prepare social workers to meet the needs of people with very complicated issues, not only pain issues, but also social issues, practical challenges, et cetera.

Yvette Colón, Panelist (21:58):

And so there are curricula available, but it hasn't gotten to the people that it needs to get to at least, certainly not in social work. In all of my social work training, I did not have any content on pain management, including in my death and dying elective, right? And so there's a really important opportunity that we can all take to promote the continued education of social workers and other professions.

Yvette Colón, Panelist (22:32):

It's interesting to think about teletherapy now. It's been around for really long time. And certainly there is research that shows the efficacy of different forms of virtual therapy, telephone, VR, virtual reality, video teletherapy, et cetera. During the pandemic, we've seen teletherapy

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reimbursement expanded, but we don't know what's going to happen next year or when the pandemic... When we're out of this very difficult time. Certainly, teletherapy, video therapy, and I do EMDR through video therapy with existing clients to very good effect, we can adapt some of our interventions to working through teletherapy in a way that is supportive to clients, especially those people with chronic pain who have difficulty physical challenges for whom getting to our offices might pose a difficulty. How much better might we be able to support them if we're able to continue over the long run be able to provide teletherapy services? So it's complicated for practitioners who work outside of the health care, any kind of healthcare setting. Next slide, please.

Yvette Colón, Panelist (23:57):

Because unless... And I will just speak to social work, unless social workers are working in some kind of a healthcare setting, a DSM-5 diagnosis is required for the person to access and get therapeutic benefits for social work services, reimbursement for clinical social work services. It becomes an ethical challenge, and this is part of the conversation that I've been in for a while, an ethical challenge to confront the idea that we have to give somebody a DSM-5 diagnosis simply for them to be able to get their social work services paid for. Not every chronic pain patient comes to us already with a diagnosis that would still be appropriate to use. That might be an area that we look at to challenge the fragmentation even up clinical social work, clinical psychology reimbursement if we were able to work with people who had chronic pain without having to give them a specific diagnosis, right?

Yvette Colón, Panelist (25:06):

And so it becomes difficult to think about the challenges for someone with just chronic pain and then add all of the complications that my colleagues have talked about, the spiritual, psychological, family, practical, employment challenges as they try to navigate all of this. Next slide, please.

Yvette Colón, Panelist (25:31):

And I know that we might be coming back to this issue, but to think about the intersection of mental health, chronic pain, and opioid use to think about how the commonalities and the differences among these communities, absolutely requires integrated individualized care to think about the commonalities, especially around stigma. Opioid misuse is stigmatized. Having chronic pain continues to be stigmatized for a lot of people. It becomes so important to think about a whole person approach and to try to provide a whole person perspective in the middle of a fragmented landscape. Next slide please.

Yvette Colón, Panelist (26:20):

And so I'll be back in a little bit, but right now, I want to turn it back to Dr. Prasad to talk about the challenges in providing behavioral health services for pain.

Ravi Prasad, Panelist (26:39):

Thank you so much. So we certainly faced a number of challenges in delivering these services, one of which is what I call the treatment of last resort, which is oftentimes folks will refer individuals to whether it be psychologists, social workers, after they've not been successful with all the other treatments. They've tried physical therapy, they've tried injection therapies, different medication trials, these haven't resulted in long-term amelioration and symptoms, and then they get sent to the behavioral health specialist. And the reality is that this is something that's not going to necessarily result in the outcomes that we want because again, we ideally want to

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have all the services integrated where we have the medical care, the physical therapy, the behavioral health, the complimentary integrative services, all of these working in concert with one another. That's where we tend to get the best outcomes. So this is one of the challenges that we faced.

Ravi Prasad, Panelist (27:33):

And one of the areas that we... One of the things that we do to try to help address this is education. So a lot of times, doing talks like these, speaking to different pain groups, physician groups, things along those lines to try to help provide insight into how to make referrals to behavioral health early on in care and starting the education process. We heard from Lieutenant Colonel Norris some of the challenges he had, and much of that revolved around being connected to some of the services early on, or rather not being connected to some of these services early on. So this is one of the challenges that we have.

Ravi Prasad, Panelist (28:09):

Another deals with access issues. And there was a question that was posted in the chat related to do we have an understanding of why it is that pain, the prevalence of chronic pain is higher in some of the rural areas? And there's not a very clear definitive information as to why this is the case, but we could certainly understand that perhaps limited access to care as we get to more rural areas can be impacting why we have a higher prevalence in these regions. And as I pointed out in my answer that I gave in the chat, I don't know if I replied to the entire group or just to the individual who asked the question, but it'll be interesting to see if there are shifts in this over the course of time as we implement more telehealth across the board where we're able to have a broader reach.

Ravi Prasad, Panelist (28:56):

I can say that anecdotally speaking just from my experiences here at UC Davis, the classes that we're running, the interventions that we're doing right now, we're reaching a much broader range of people because of the telehealth services than what we were doing before when they were all in-person and people would have to physically come in-person to the classes. Now I would say a large number of people that are participating in our behavioral health interventions are folks in the northern regions of the state in the Sierra Foothills and the Central Valley, folks who otherwise wouldn't be availing themselves for these services.

Ravi Prasad, Panelist (29:30):

Competencies and training, which we already talked about, can be an issue where people don't have... The clinicians themselves may not have the appropriate training or expertise to work with this population. And then we also have issues related to reimbursement where we have challenges with getting reimbursed for services, inconsistency in the reimbursement for services, or different types of services that aren't reimbursed at all. There was another question in the chat about comprehensive case conferences. And there are some domains where this can get covered. For example, in the workers' comp industry, we know that some of these can be covered, but it's not a pervasive thing. It's not regularly covered as a part of standard care quite yet. And so there are groups that are working to try to improve this to try to address this. Next slide please.

Ravi Prasad, Panelist (30:21):

So there's a wide range of different behavioral health services that are available as has already been mentioned. We have cognitive behavioral therapies, acceptance and commitment

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therapy, emotional awareness and expression therapy, biofeedback training, mindfulness-based stress reduction. And all of these are evidence-based treatments. These aren't things that we just came up with and said, "Okay, this might keep a person busy if they're living with pain," but there's good, robust evidence in different domains of pain that show that these things can be effective. All right, we move on to the next slide please.

Ravi Prasad, Panelist (30:54):

What we found is that these different therapies have shown that they can result in improvement in functioning, reduction in affective distress, reduction in medication usage, reduction in disability, and reduction in pain intensity. Even though our overall goal is to improve functionality and improve quality of life, what we often find as a byproduct of people successfully implementing some of the behavioral approaches to pain management is that we do actually see reduction in pain intensity as well. So the next slide please.

Ravi Prasad, Panelist (31:26):

So how do we deliver these services? What's the mechanism of action for providing these different types of treatments and what are the ways that we build for them? Well, we can provide these in either an individual or a group based format, and what we typically use are health behavior assessment and intervention codes. And what these are, these are codes that are specifically created to address psychological and behavioral factors as they affect a physical health condition. And in this case, the physical health condition is a chronic pain condition. What's nice about the health and behavior codes is that these don't require a psychiatric diagnosis. Whereas a lot of the psychiatric codes require a psychiatric diagnosis in order to get reimbursed, health and behavior codes should not require a psychiatric diagnosis for us to get reimbursement because these services are being delivered specifically for a medical condition.

Ravi Prasad, Panelist (32:22):

I've taken the liberty of writing down the CPT codes that are used and what the descriptions are, and these were all actually changed within this past year. We have had a modification in what the codes are, what the descriptions are. The initial evaluation and assessment used to be a time-based code, but now whether it's a 45 minute evaluation or a 90 minute evaluation, it's the same code that gets reimbursed with the same number of RVUs. Individual interventions and group-based interventions have a certain code for the first 30 minutes, and then each 15 minute increment after that, there's a different code that's used for that.

Ravi Prasad, Panelist (33:02):

So these are the types of codes that we use for our behavioral health treatment, but we still face challenges. Even though we've got these different codes that we can use, these codes that are available to us, we face challenges with getting the reimbursement in a timely fashion. There are some times where a person may use a health and behavior codes, but they still get pushback from the carrier saying that, well, you need to have a psychiatric diagnosis, even though these codes were designed specifically to eliminate that particular need. So it's still somewhat of an uphill battle. And what I'm happy to say is that we have great advocacy on the part of American Psychological Association to help address these things. Dr. Gillaspay and his group, when people encounter some of these challenges, they say, "Well, please let us know what these issues are and we'll try to address them as best as we can." And so we use this advocacy to try to help improve the coverage for these services one group at a time. But it is a challenge, but each day we live another day to keep fighting that battle.

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Yvette Colón, Panelist (34:20):

Thank you Dr. Prasad. I don't want to repeat some of the things that you talked about regarding evidence-based practice, but I will emphasize the idea that all of these evidence-based practice have a lot of information. Some of them are a little bit newer in terms of using them for pain management, but even the newer ones are very promising in terms of helping people manage their pain through different behavioral health interventions. Certainly, EMDR, even though not all pain is trauma related, has a role. CBT, medical or clinical hypnotherapy has been found to be very effective for helping people manage their pain. Acceptance and commitment therapy, next slide, and all of the mindfulness-based practices, mindfulness-based stress reduction, psychoeducation, family therapy, support groups, group therapy, all of these are wonderful tools in the toolboxes of anyone who is helping provide behavioral interventions for people with pain. Next slide please.

Stephen Gillaspy, Moderator (35:32):

So I know that we're running a little short on time. We're supposed to have our break at 1:20. I did want to throw out one question to our panel members and also to Colonel Norris. My question, Dr. Prasad touched upon telehealth as possibly one way to make sure that more people can access providers with specialty in pain management. So I'm just curious, from Robin and from a payer perspective, and then also from Lieutenant Norris, what do other people think as far as is telehealth this great potential to provide better access, easier access to pain specialists?

Tom Norris, Panelist (36:35):

Well, I could start. I think it's great, and with all the people that I am... Sorry, with all the people I'm in contact with through my support groups, everybody is on board with telehealth. The basic advantage they see is they don't have to go through all the turmoil of going from their homes to the doctor. And they've gotten that not only is the experience better, but they feel like the doctor's actually talking to them rather than, and it's a usual complaint, the doctor's talking around them while he's filling out the forms. Does that help answer your question?

Stephen Gillaspy, Moderator (37:23):

So I think that's great. Robin, any thoughts from the employer perspective?

Robin Kahn, Panelist (37:31):

Yeah, we know that employers sometimes struggle knowing that their members don't always have access to some of the specialists in a given geography. So by adding telehealth, it now may not matter how far away the best specialist is. So it takes that geographic challenge out of the equation for the member.

Stephen Gillaspy, Moderator (38:01):

Any other comments from the panel in regards to telehealth?

Yvette Colón, Panelist (38:09):

I will just say that telehealth from my perspective has been extremely beneficial to the patients I work with, but we are also still challenged by patients who don't have the technological capacity to be able to do that. We live in a world... All of our work is now on Zoom, but not every potential client has the ability to participate in teletherapy. And so there's another area that we could be advocating for.

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Ravi Prasad, Panelist (38:41):

And to piggyback on what Yvette just said, in addition to the technological literacy and being able to participate in these interventions, there's also a financial impact too. For a number of people, the only device that they have to get online with the internet is their smartphones, and they may have limited data and such. And so if we're talking about having people participate in a 90 minute class or something along those lines, they may have data limitations, things along those lines where they incur a higher extra costs that we don't necessarily appreciate. So there's a number of other issues that start to come up where even though there's a lot of advantages of being able to reach people, whether it be technical literacy or other financial implications, can still present factors that make this a limited intervention for many individuals still.

Stephen Gillaspay, Moderator (39:34):

Thanks for everyone's input and great comments. I think at this time, we'll turn it back over to Amy.

Amy Goldstein, AACIPM (39:53):

Okay, hopefully you can hear me. Give me a thumbs up if you can. Excellent. Thank you. I'm toggling between computer and phone here with some fun technical difficulties. So thank you so much to all of the panelists. And we now have our break for 10 minutes. And please make sure you're back in 10 minutes so you don't miss Dr. Ruth Wolever's five minute mindfulness exercise before we begin again at 1:35 Eastern. So thanks to everyone, and we'll see you in a few minutes.