Improving Access to Care for Patients Taking Prescription Opioids for Chronic Pain

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Introduction

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- PCP and research investigator at Ann Arbor VA and U-M
- No conflicts of interest
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Today's objectives

Review opioid epidemic and unintended consequences for patients with pain

Describe chronic pain and prevalence

Describe multimodal treatment and its availability

Describe major barriers to accessing multimodal pain treatment

Discuss potential solutions

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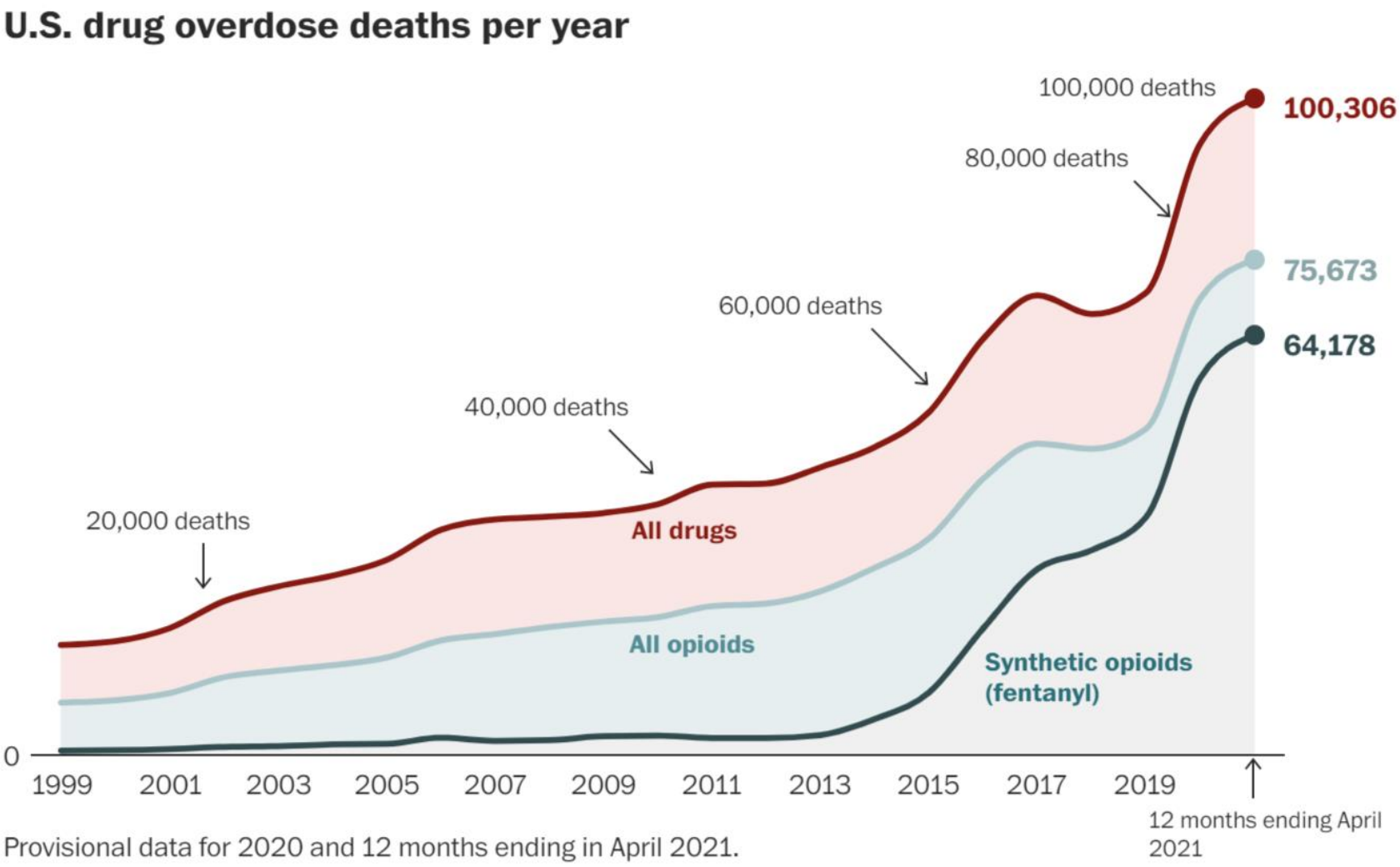
We are in the middle of an overdose epidemic

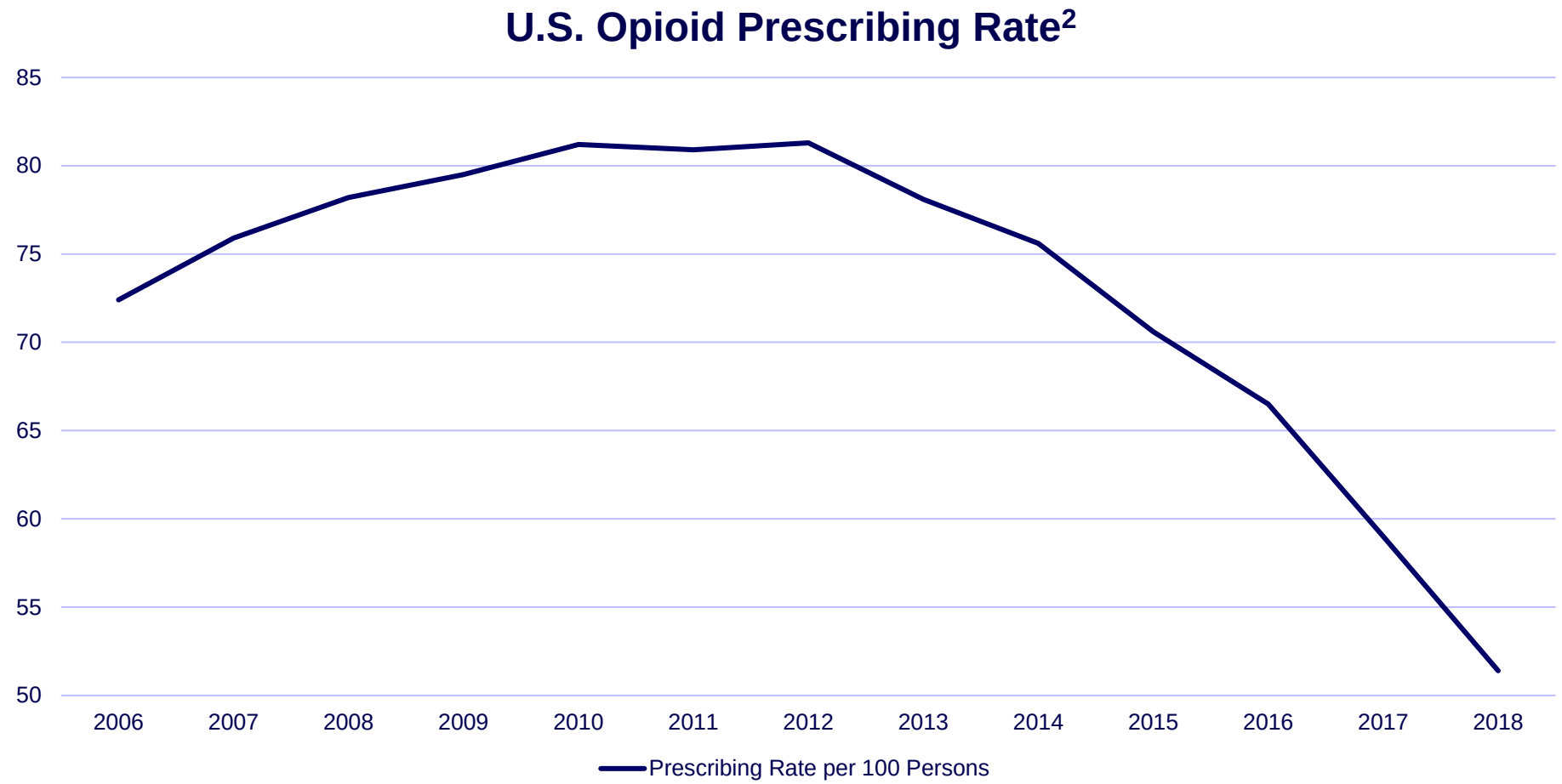


[1] Keating 2021

Many responses to the epidemic

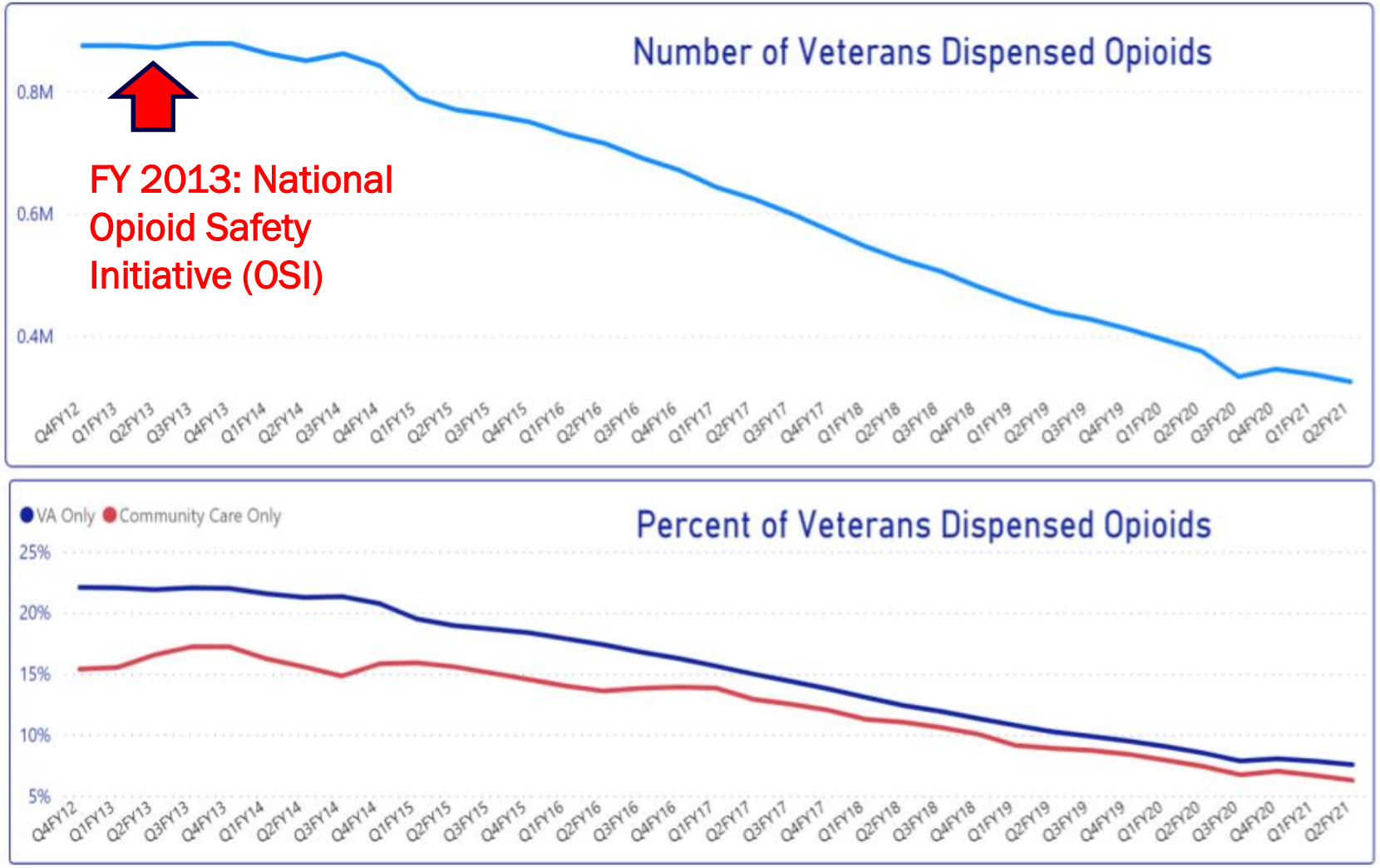
Supply	Prevention	Treatment	Harm Reduction
Lower the supply of illicit & Rx drugs	Prevent initial prescription drug use	Reduce barriers to treatment	Public health laws for people not in treatment
• Drug trafficking laws • International efforts to limit opioids/illicit drug trade • Criminalizing possession	• CDC guidelines • PDMPs • Insurance dosing limits • Safe medication take-backs	• Provider training and workforce development • Expanding treatment coverage • Improved coordination	• Overdose reversal drugs • Good Samaritan laws • Safe injection sites

As a result, prescribing is at a 10-year low



[2] CDC Injury Center. U.S. Opioid Prescribing Rate Maps. 2020.

VA opioid prescribing has decreased 63% since 2012



[3] Sandbrink et al. 2021.

Restrictive prescribing can lead to unintended consequences for patients with pain

PAIN REEXAMINED

The New York Times

Good News: Opioid Prescribing Fell. The Bad? Pain Patients Suffer, Doctors Say.

Doctors and insurers are using federal guidelines as cover to turn away patients, experts tell the C.D.C. and Congress.

CDC Clarifies its Opioid Prescription Guideline

Laura Mills
Researcher
@lauraphylmills

Many have questioned these restrictions

- New guidelines serve a purpose but fail to protect patients who need long term opioid therapy (LTOT) for pain[4]
- Physicians ask CDC to investigate deaths linked to pain patients losing access to pain medicine[5]
- Patients 'orphaned' as doctors discontinue pain treatment[6]
- Mandates requiring nonconsensual dose reductions not justified[7]
- AMA has called on the CDC to revise the 2016 guidelines to protect patients with pain[8]

[4] Kertesz, et al. 2019
[5] Hamilton. 2017.
[6] Grinspoon 2019.
[7] Kertesz, et al. 2020
[8] AMA urges CDC to revise opioid prescribing guideline. 2020.

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What does chronic pain look like?

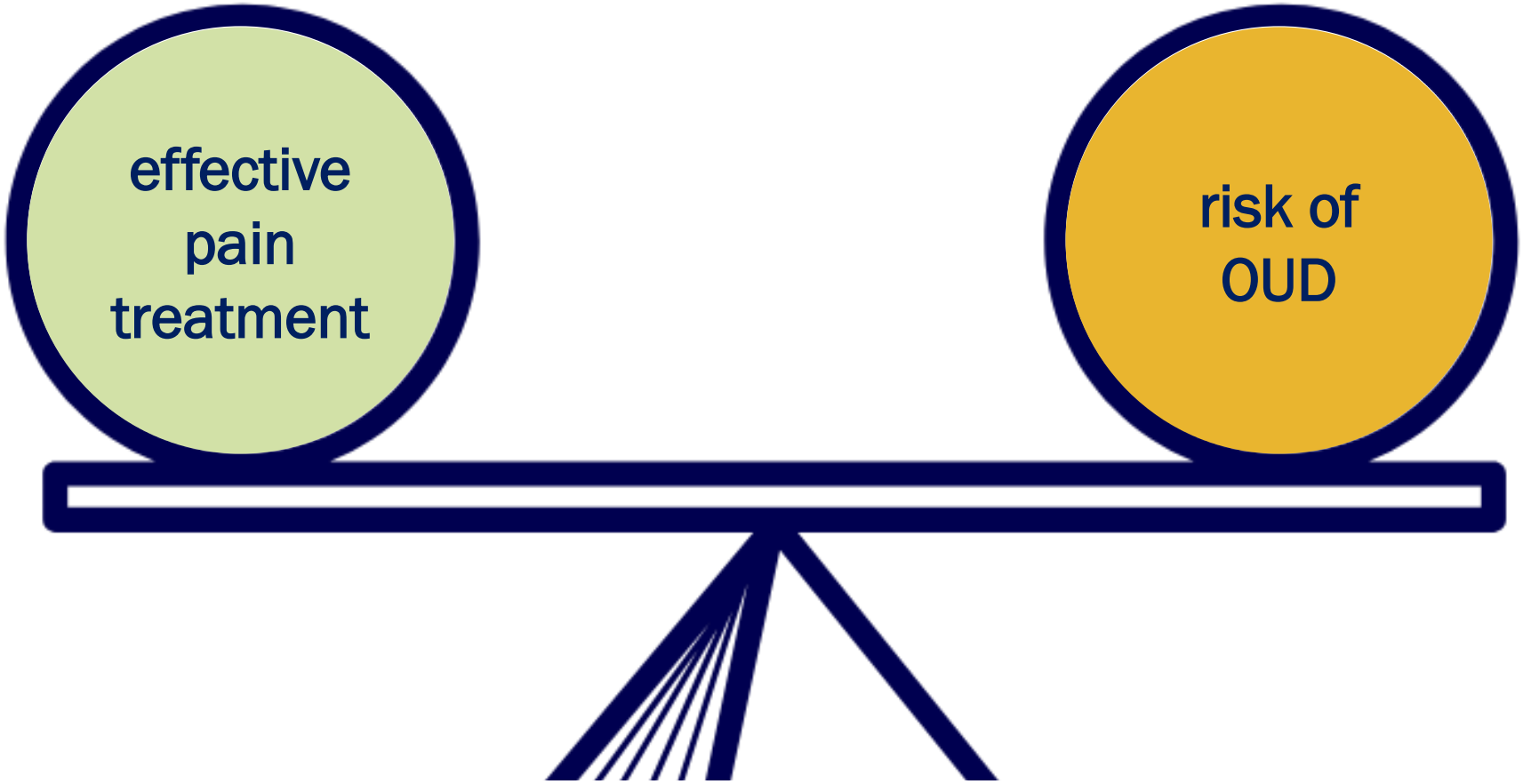
Meet Mr. B

- 55 yo male with back pain due to a car accident, limited mobility
- **Been to ER twice in the past year reporting extremely severe pain**
- Hydrocodone has helped to control his pain and independence for the past five years

Meet Mr. B

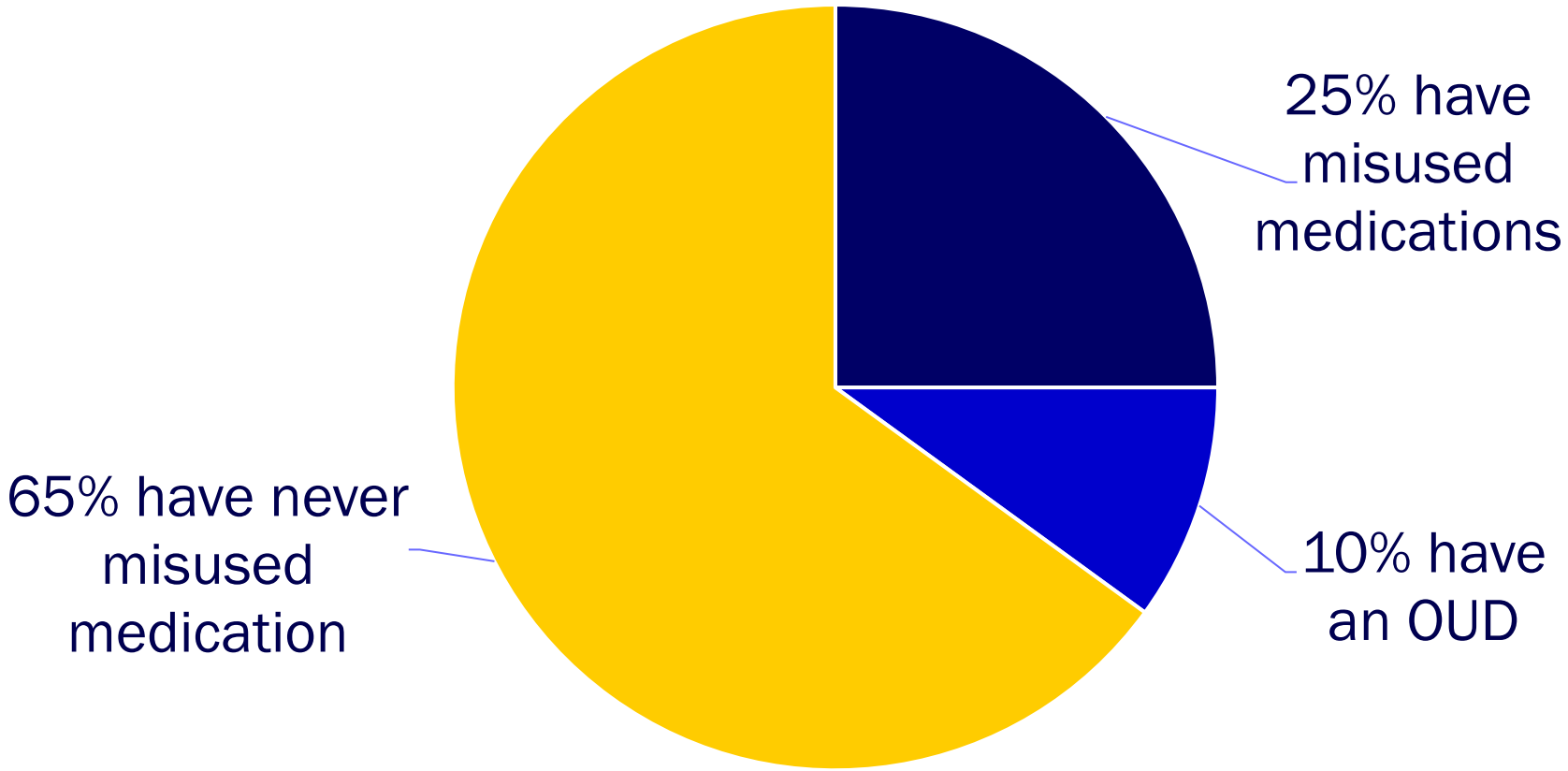
- Now needs **higher** dose, but PCP wants to reduce dosage citing the CDC guidelines and new policies
- Mr. B becomes **upset** but agrees to lower dose
- **Next month, goes to ER** reporting increased pain and trouble completing daily activities

Why does Mr. B's experience matter?



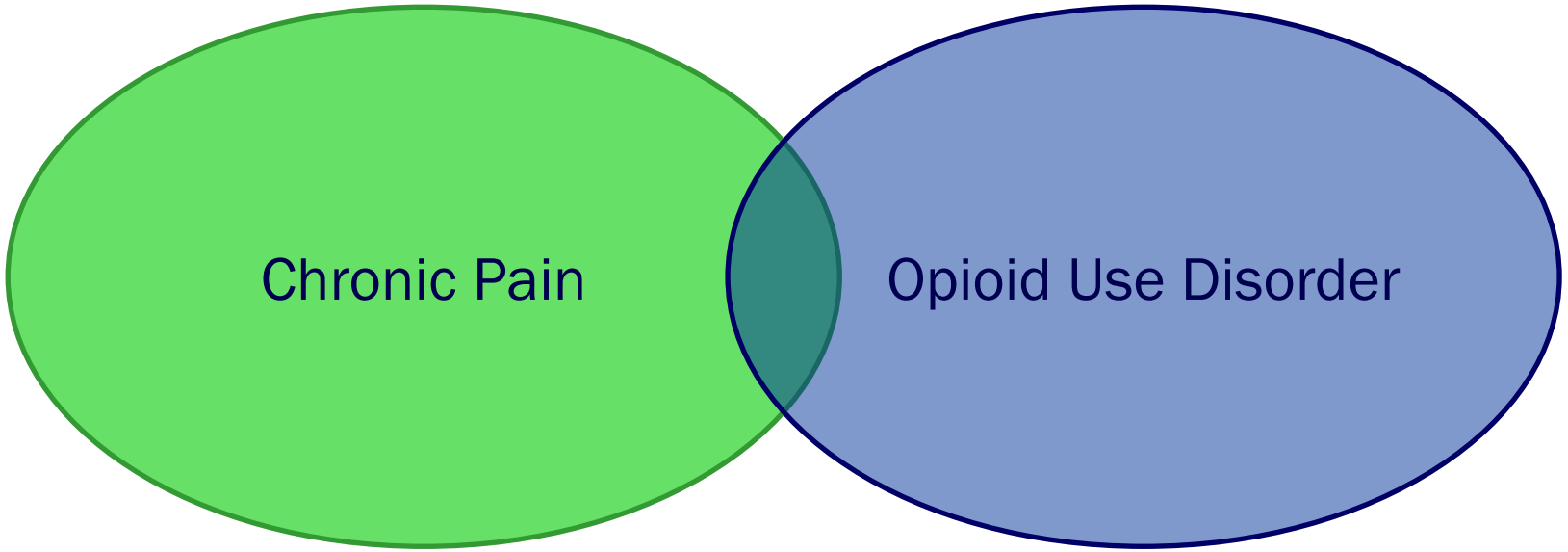
Most chronic pain patients don't misuse opioids

Of chronic pain patients prescribed opioids



[9] Vowles et al. 2015.

Manage pain while preventing OUD



Focus on managing the patient's chronic pain while preventing potential OUD

How widespread is chronic pain & opioid use?[9]

100 million

American adults experience chronic pain — more than the number affected by heart disease, diabetes and cancer combined

5 million to 8 million

Rely on opioids for long-term pain management

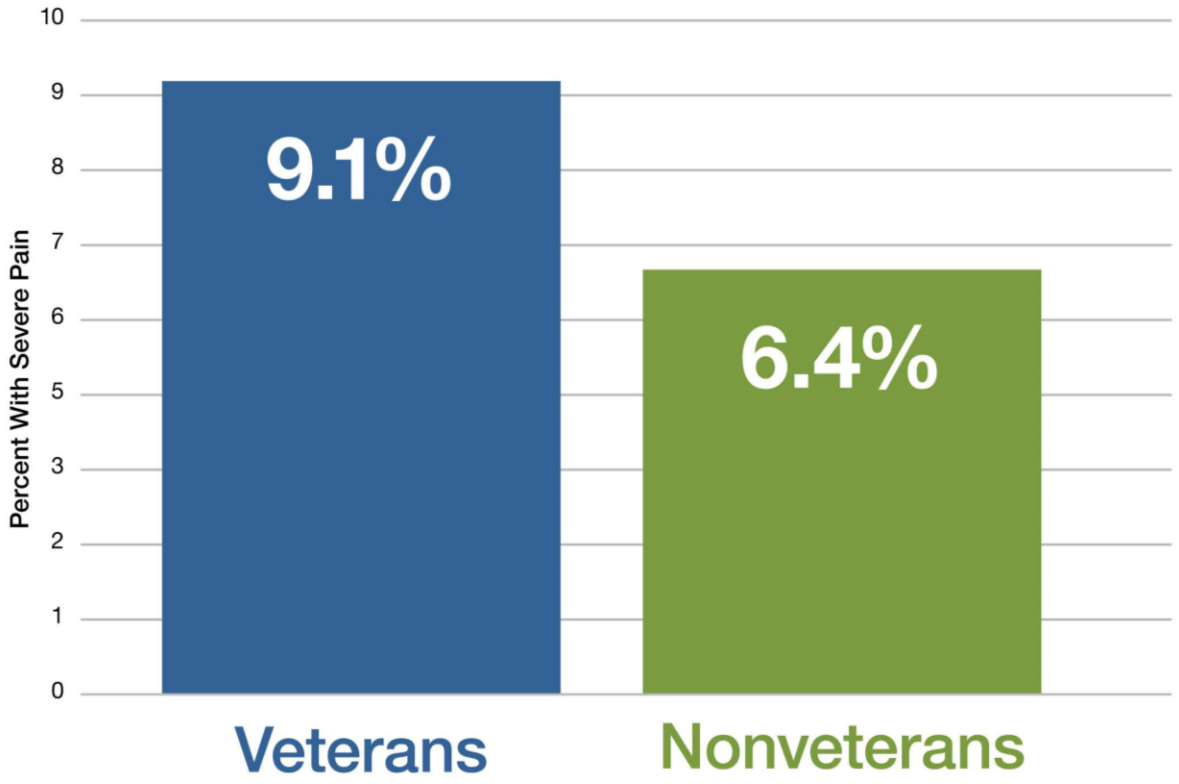
[10] Joy. The Cost of Chronic Pain. 2017.

Chronic pain is more prevalent among veterans

Severe Pain in Veterans

Analysis of Data From the National Health Interview Survey (NHIS)

Severe Pain: Veterans vs Nonveterans



[11] Nahin 2017.

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How do experts say chronic pain should be treated?

How should chronic pain be treated?

Medications

+

Behavioral Health Approaches

+

Restorative Therapies

+

Complementary and Integrative Health

+

Interventional Approaches

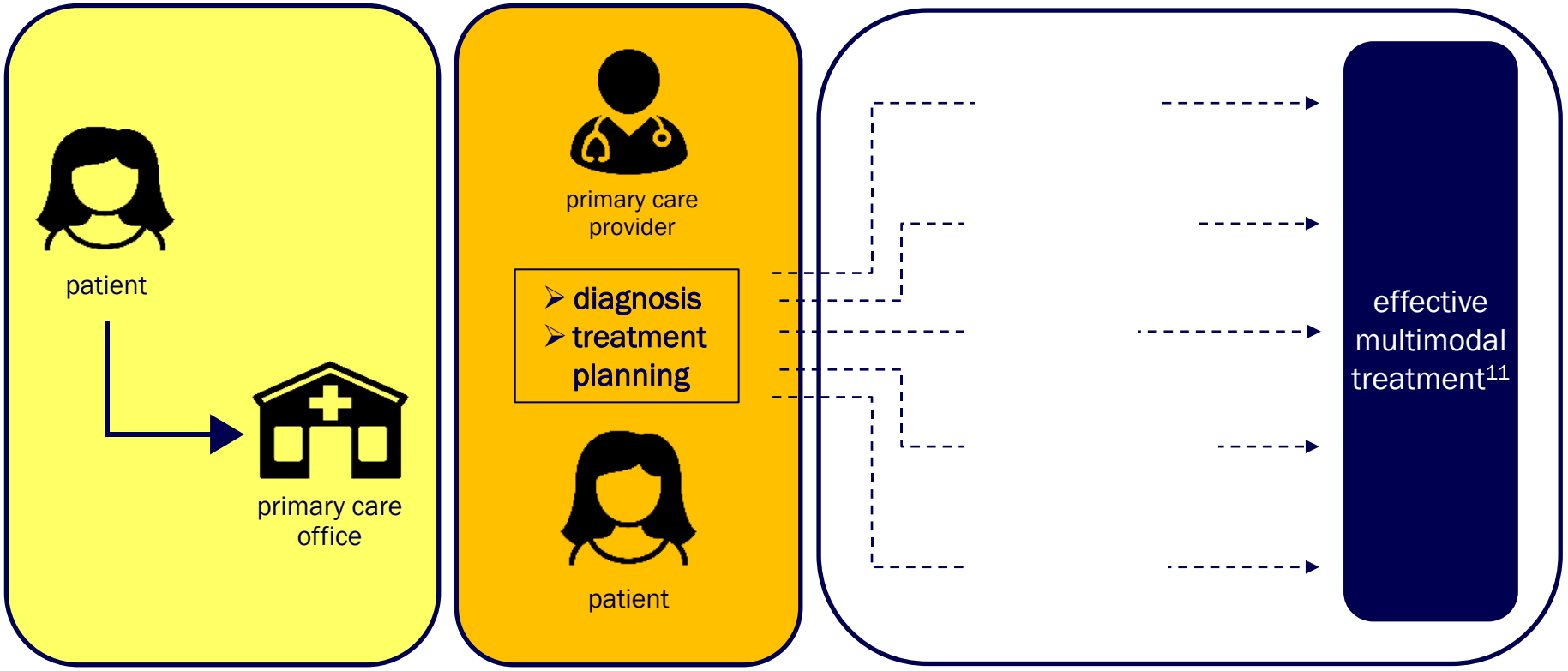
=

Effective Multimodal Treatment[12]

[12] U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report. 2019.

How do patients access this level of care?

Conceptual Model of Treatment Access



[13] Slat et al. 2021.

Can patients with chronic pain on opioids *actually* access multimodal pain treatment through primary care?

“Secret Shopper” Study

Methods:

- Call clinics to assess whether patients on long-term opioids have access to scheduling new primary care appointments.
- We did this by simulating a patient needing an appointment
- Method used in prior studies of healthcare access to reduce response bias

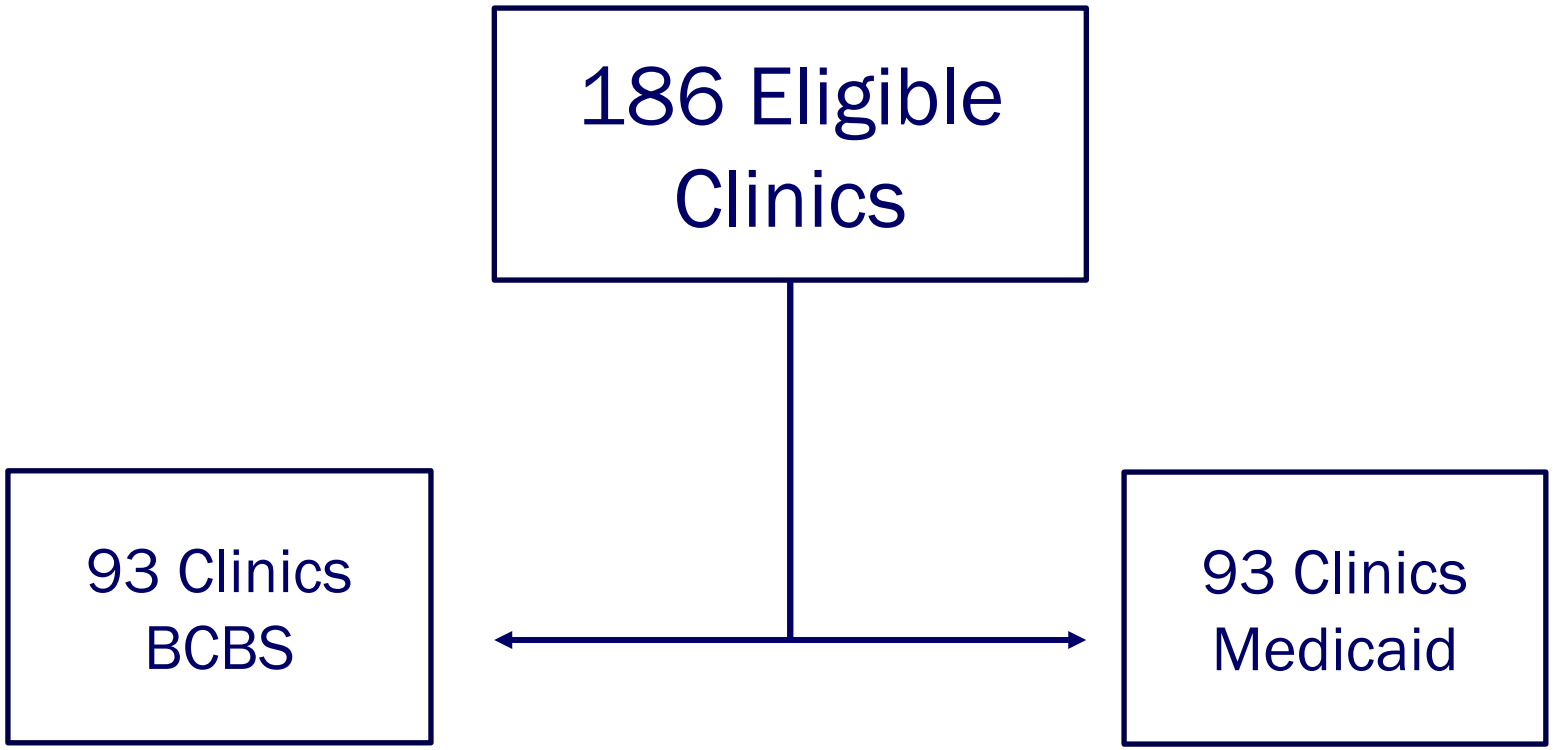
Step 1

Called 667 Michigan primary care clinics, asked about:

- Type of prescribers
- Insurances accepted
- Appointment availability
- Whether their providers use medications to treat OUD

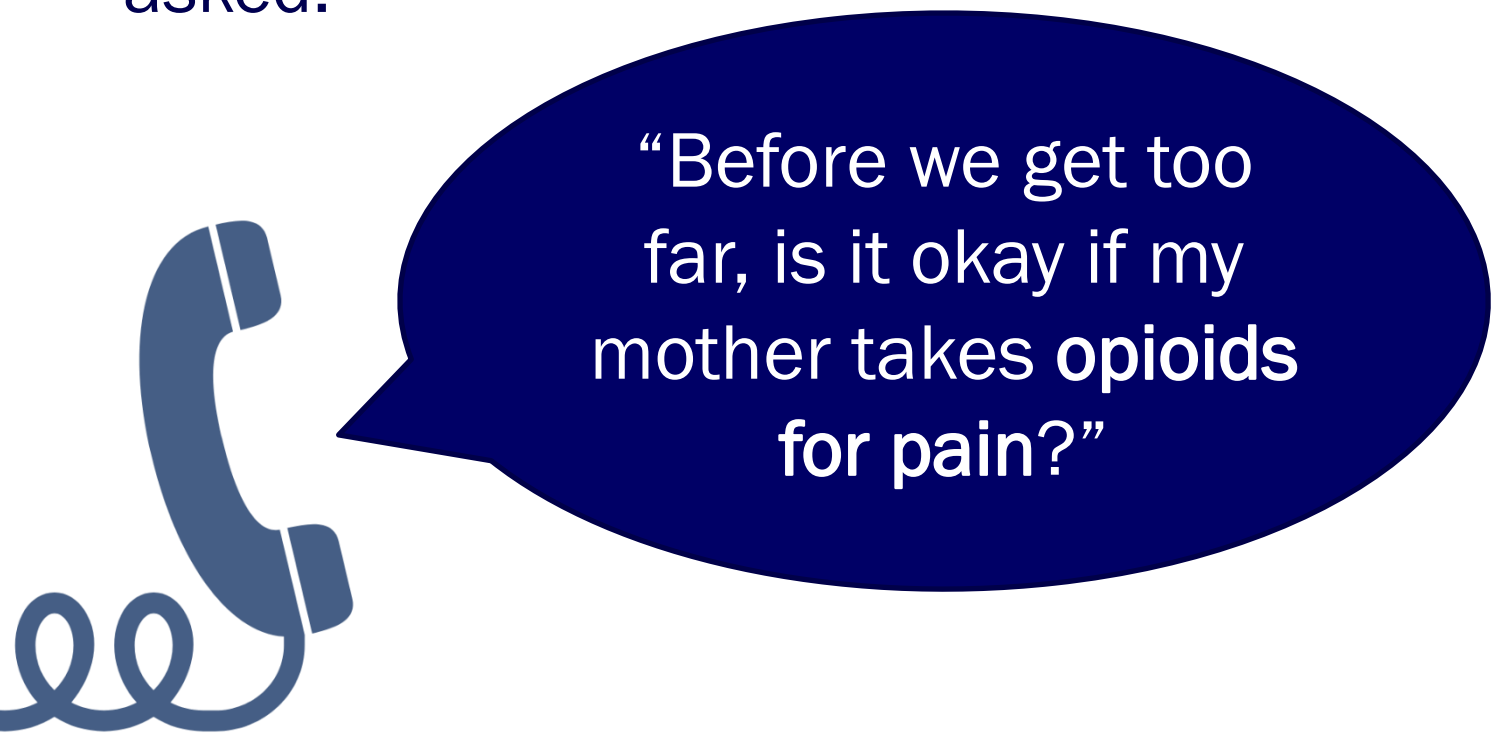
Step 2

Randomized clinics to a simulated patient with either private or Medicaid insurance type



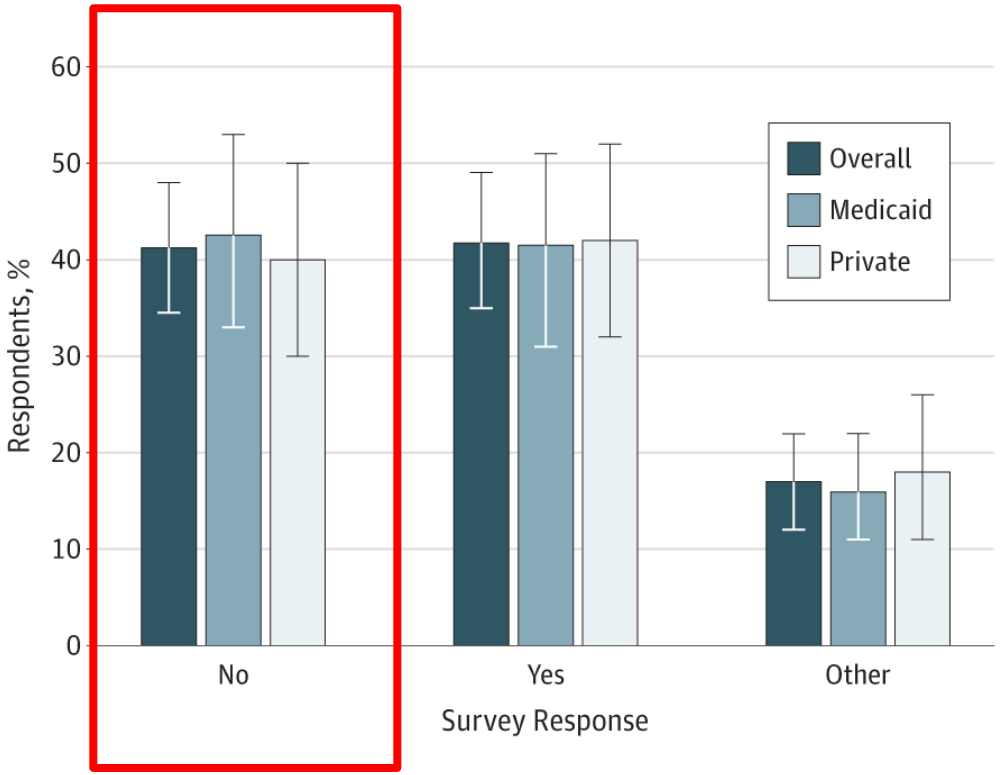
Step 3

- RAs called each clinic trying to request a new appointment for their mother who had chronic pain
- They revealed their mother's health insurance and asked:



The data is discouraging

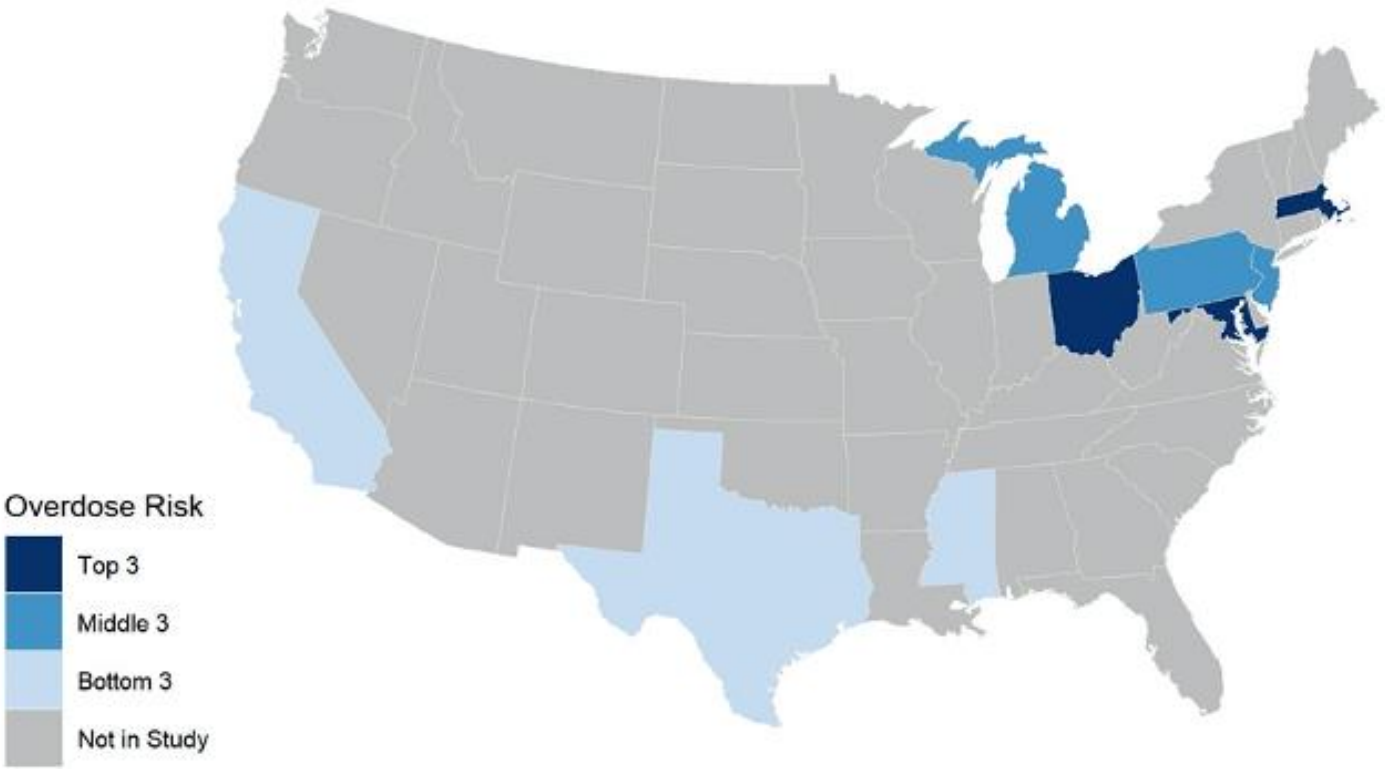
41% of MI primary care clinics won't accept new patient with chronic pain on opioids[14]



[14] Lagisetty et al. 2019.

Is this happening elsewhere too?

We expanded our study to include 8 additional states based on overdose death rates[15]



Does the reason for needing a new patient appointment matter?

[15] Opioid Overdose Deaths by Race/Ethnicity. Kaiser Family Foundation. 2020.

Does patient scenario affect the outcome?

Called each clinic twice to schedule a new patient visit

I've been taking Percocet for years, but…

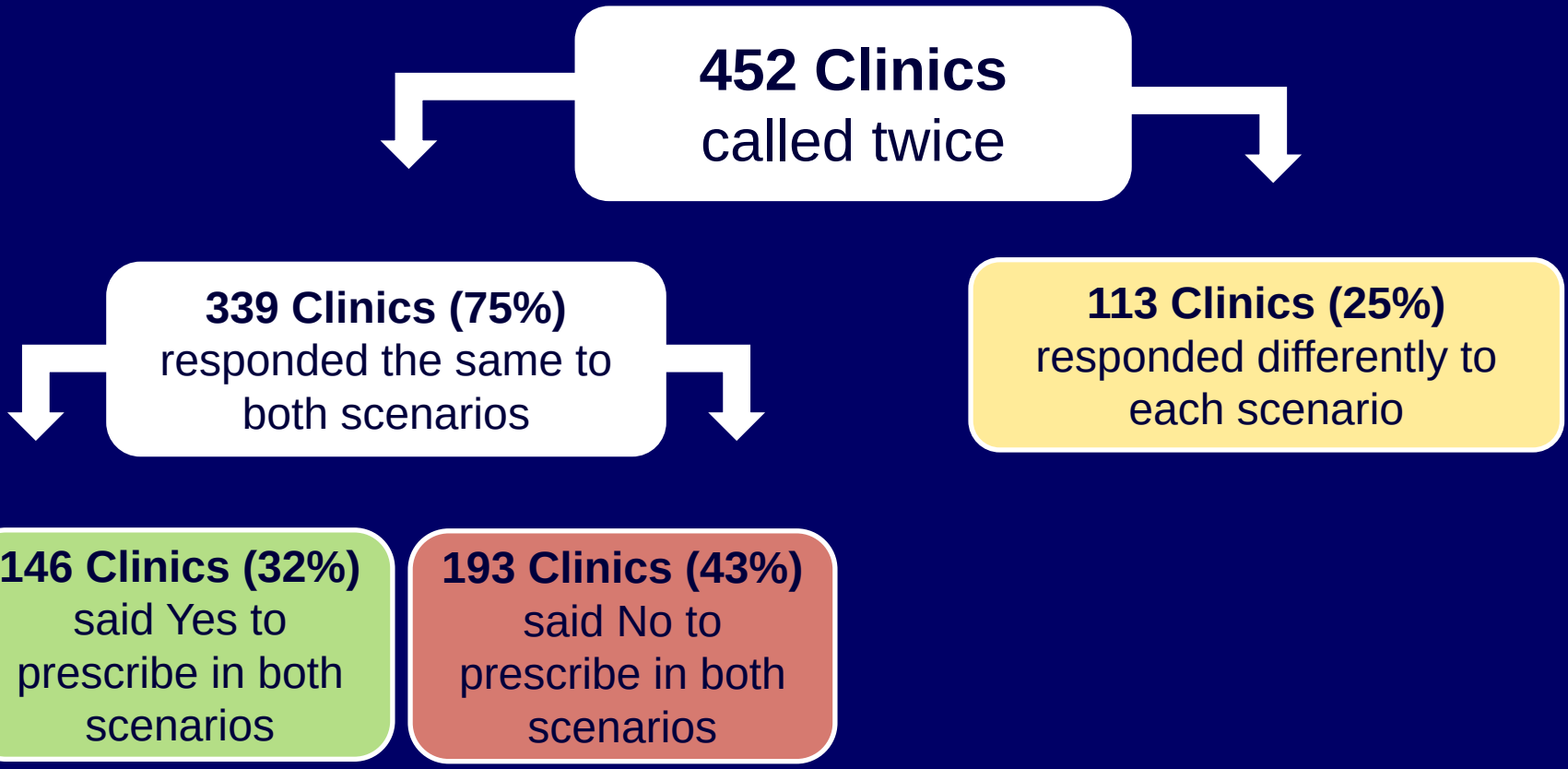
SCENARIO 1

my doctor just retired.

SCENARIO 2

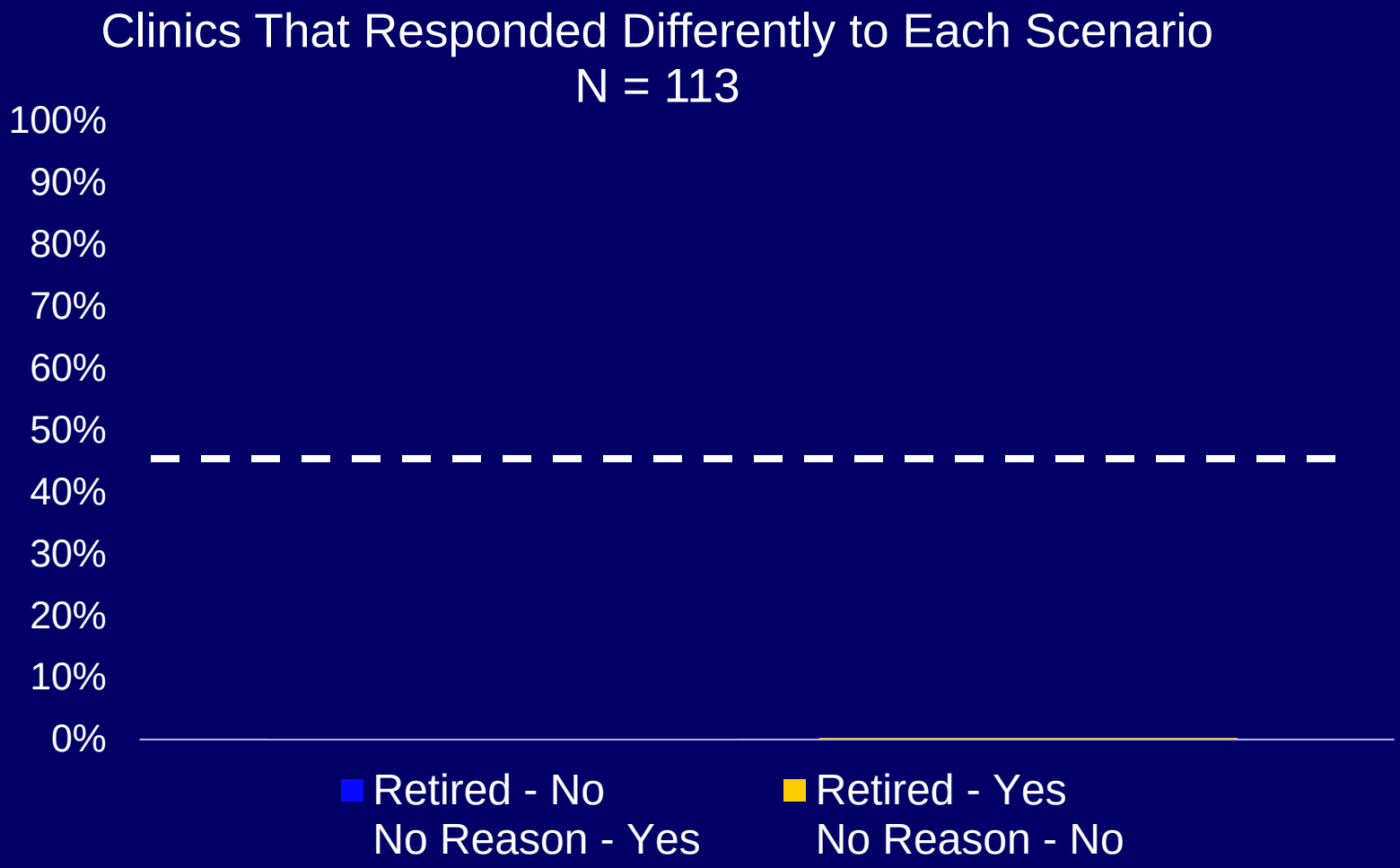
my doctor just stopped prescribing it for me.

Reason for needing an opioid Rx affects access[16]



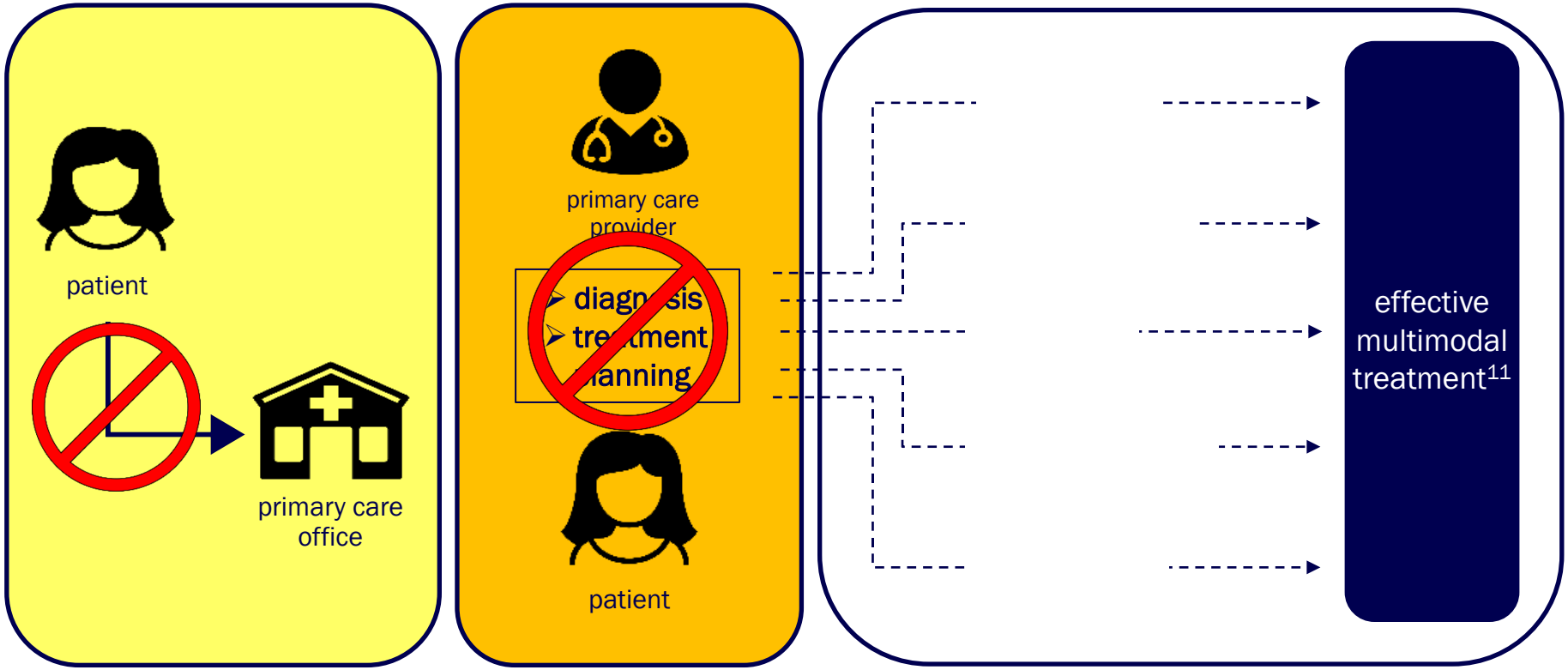
[16] Lagisetty et al. 2020a.

Reason for needing an opioid Rx affects access[16]



[16] Lagisetty et al. 2020a.

Breakdowns in effective multimodal pain care



[13] Slat et al. 2021.

If patients can access primary care, can they also access specialty pain care?

Do pain clinics offer multimodal treatment?

Called 366 pain clinics posing as a patient on long-term opioid therapy seeking care

Asked about:

- Insurances accepted
- Referral requirements
- Treatments offered

Many pain clinics have restrictive acceptance policies

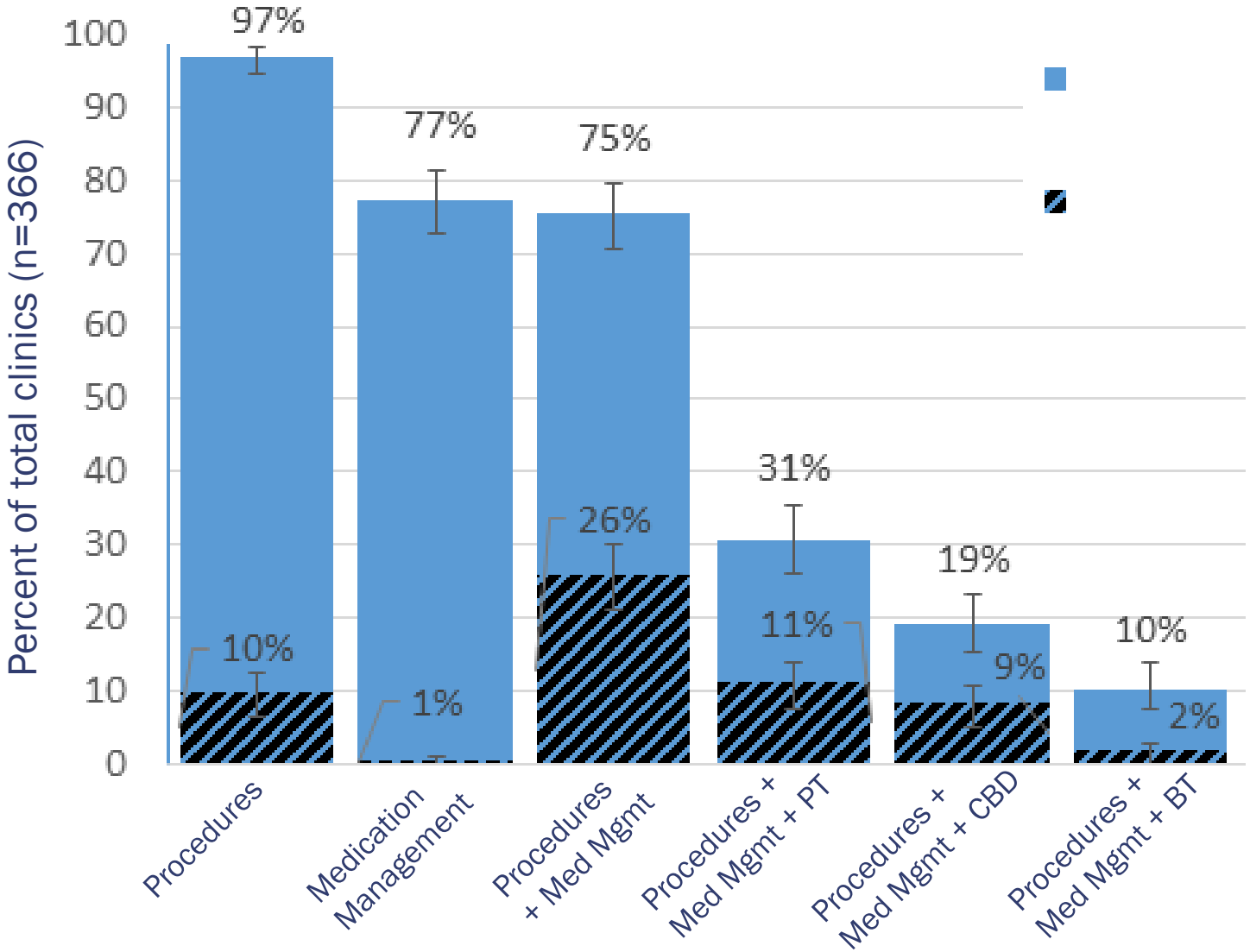
Roughly half (48%) of pain clinics **did not accept Medicaid**

Over half (51%) **required a referral** before accepting new patients

An additional 23% **required a referral based on insurance type**

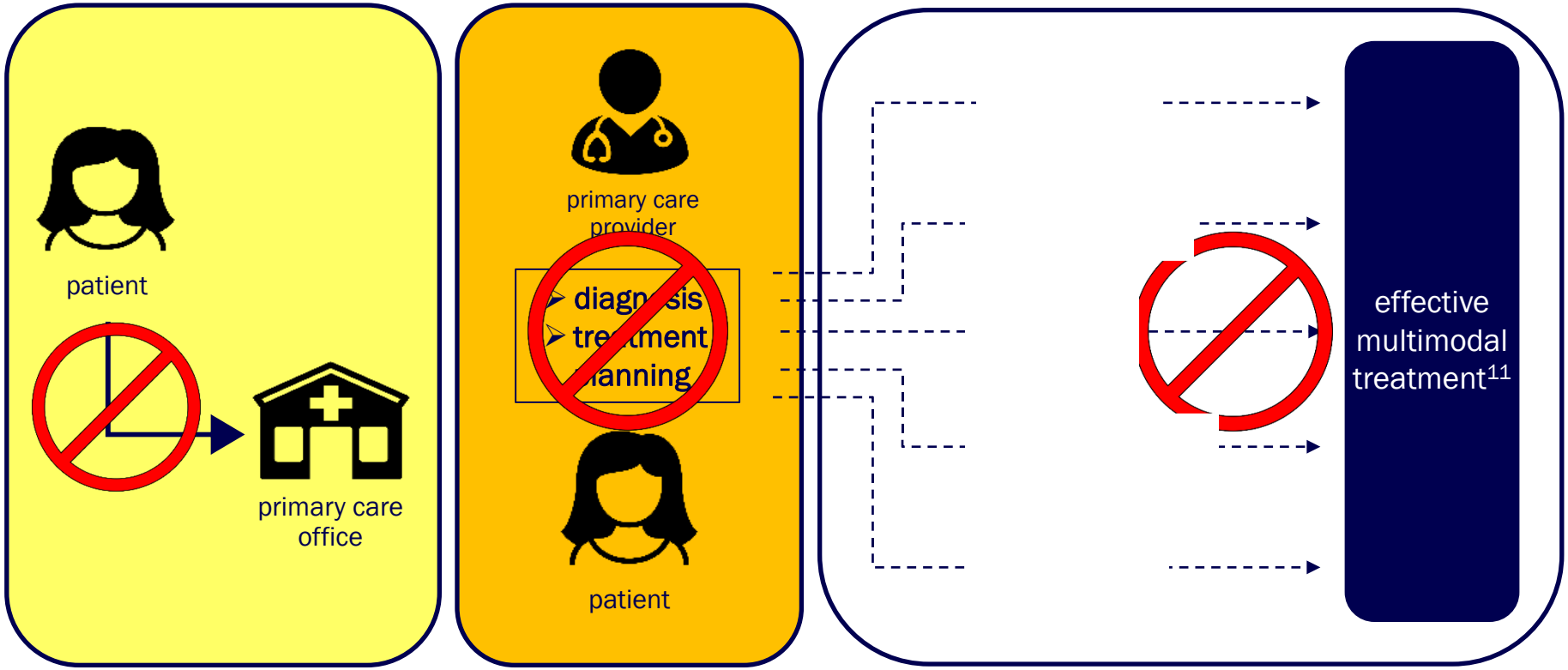
[17] Lagisetty et al. 2020b.

Multimodal treatment is rare



[17] Lagisetty et al. 2020b.

Breakdowns in effective multimodal pain care



[13] Slat et al. 2021.

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Why is this happening?

Primary Barriers to Pain Care

Primary Barriers to Pain Care

1. Policy

1. Policy

State and insurer policies around opioid prescribing ***add significant administrative burden and fear of litigation***, which reduce providers' willingness to treat this patient population

Prescribing Policies and Guidelines

CDC Guidelines (2016)[18]	State of MI Requirements[19]	VA Practices
	- "Start Talking" Form - Review MAPS for each patient - Follow-up care (long term commitment) - Sanctions for noncompliance	- Urine toxicology screens - Performance feedback comparing prescribing to peers

[18] CDC Guideline for Prescribing Opioids for Chronic Pain. 2016.
[19] Opioid Resources- Information for Prescribers. 2020.

How does policy affect treatment?

Kertesz et al. describe policy mandates and metrics as creating a problem of "dual agency" for physicians

Regulatory success: reducing opioid prescribing to combat the opioid epidemic

Clinical success: providing appropriate care to individual patients, which may sometimes include opioid medication

What does a physician do when opioids are effective for their patient?

[20] Kertesz, et al. 2020

What did we hear from clinic staff & providers during our interviews?

"

The DEA has scrutinized everything.

Extra time and paperwork involved in trying to get meds approved.

Plus the legal environment is such that we are cautious about writing anything.

"

[13] Slat et al. 2021.

Policies affect practice

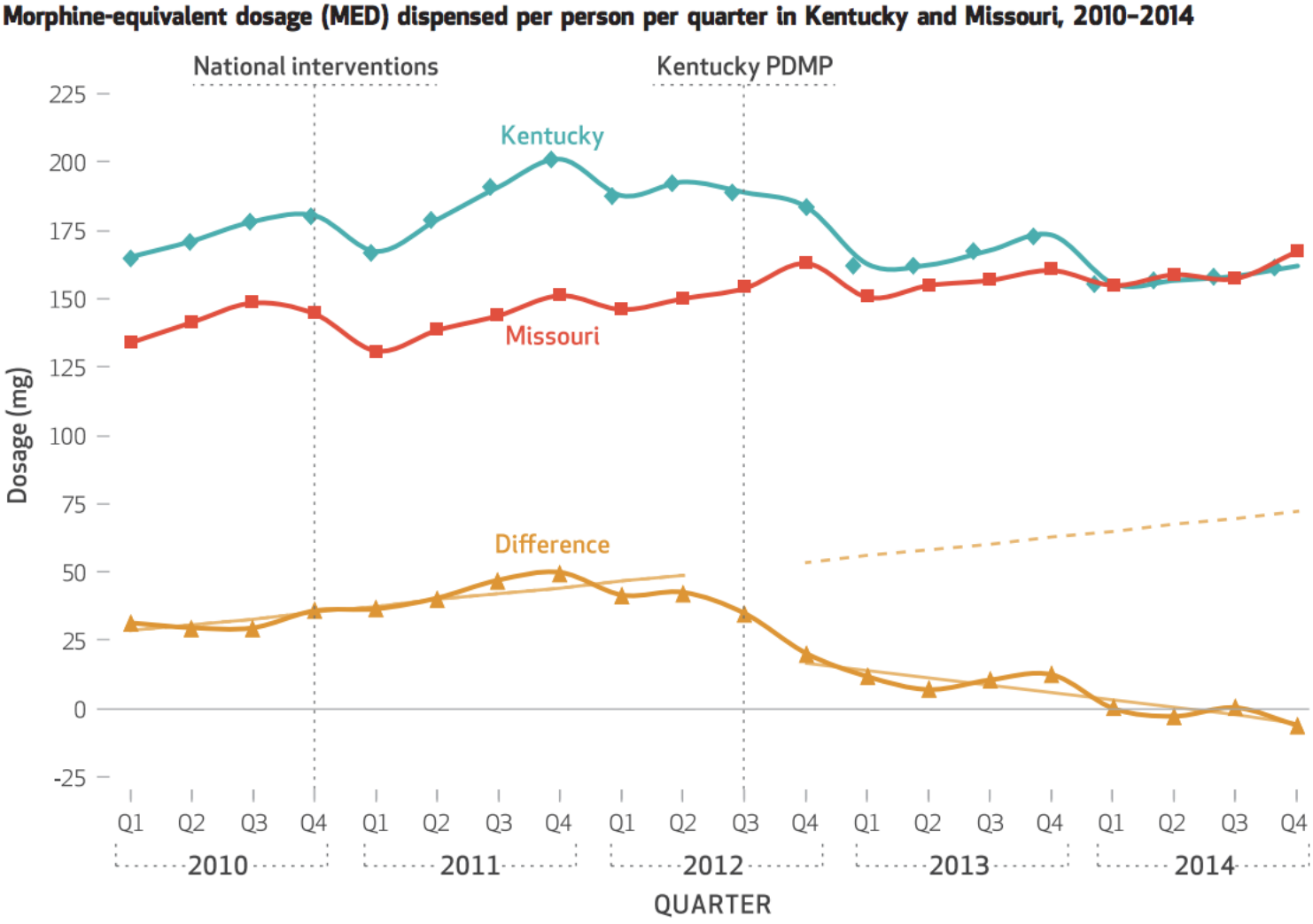
58% of providers changed their practice due to the 2016 CDC Guidelines[21]

43% elected not to treat patients with chronic pain[21]

Physicians fear liability if they prescribe opioids[22]

[21] NCMB Licensee Survey. 2018.
[22] Nadeau. 2015.

Robust PDMPs reduce opioid dosages



[23] Haffajee et al. 2018.

Insurance plans aim to reduce opioid Rx

Interviews with insurance plan executives show efforts focused around reducing opioid prescribing rather than promoting comprehensive pain strategies

Provider-level interventions

- Training and education
- Written warnings
- Removal from plan network

Patient-level interventions

- Pain contracts
- Limit patients to 1 provider & 1 pharmacy

[24] Lin et al. 2018.

These policies may be effective

BCBSM reported decreased opioid prescribing:

- "From 2012 through 2017, the number of opioid prescriptions went **down 32%**"
- In 2019, there were **850,000 fewer opioid pills prescribed** than in 2014

[25] A look at Blue Cross' efforts to address opioid epidemic. 2020.

Opioid utilization policies reduce prescribing

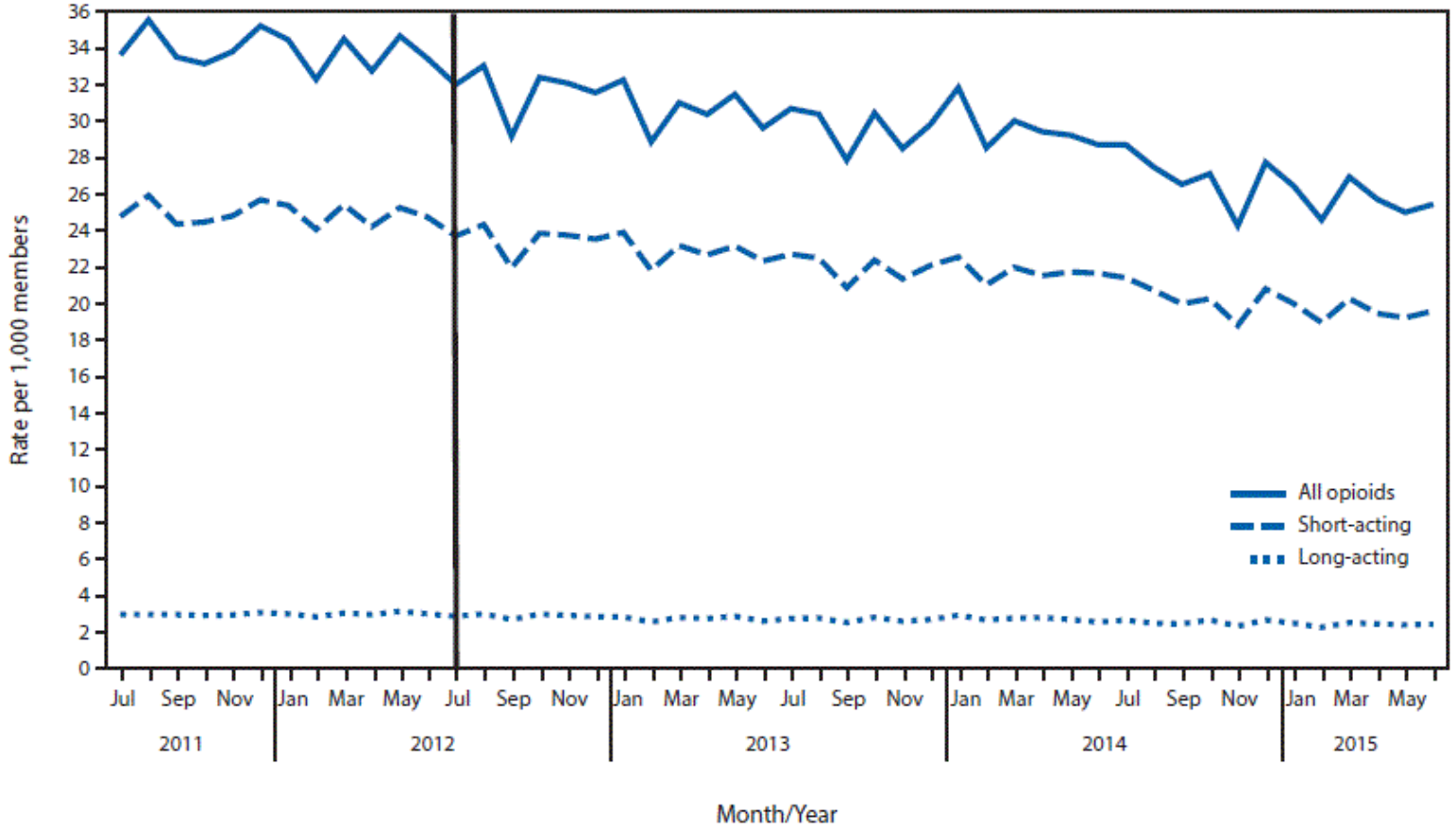
BCBS of MA implemented an ‘opioid utilization policy’ requiring

- Signed treatment agreement between patient & provider
- Prior auth for a new opioid Rx
- Use of one pharmacy for all opioid Rxs
- Dose and duration limits

[26] Garcia. 2016.

Opioid utilization policies reduce prescribing

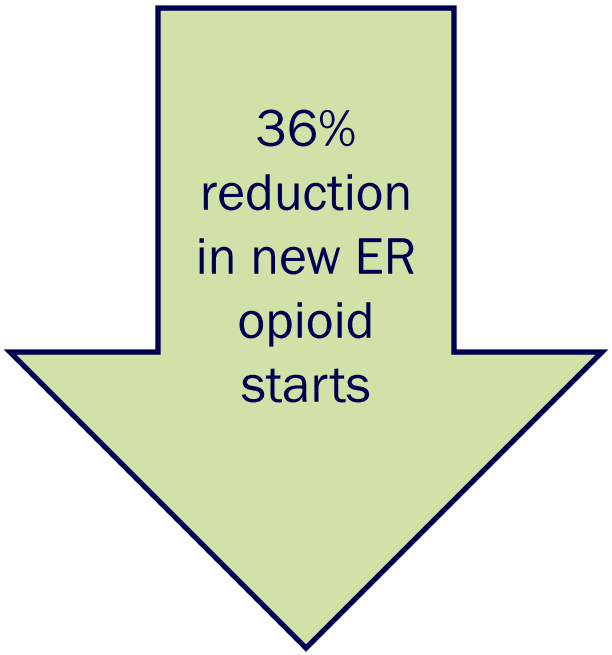
Average monthly prescribing rate for all opioids decreased 14.7%[24]

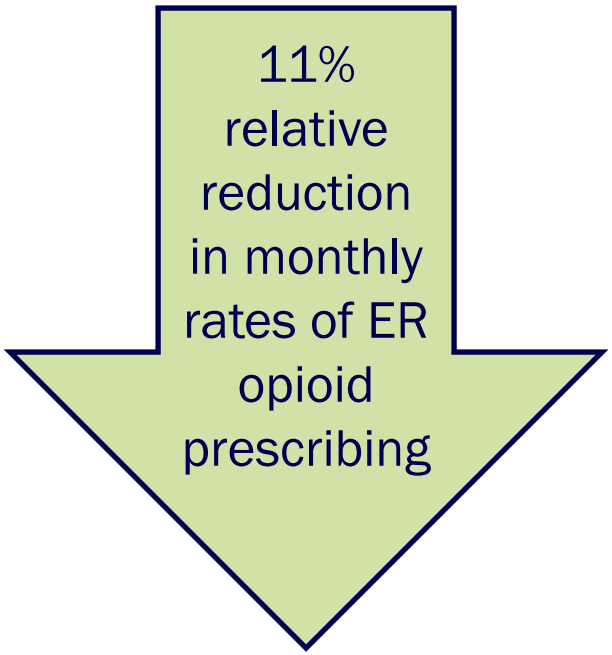


[26] Garcia. 2016.

Prior auth's alone have mixed results

BCBS of CA required prior authorization for extended release (ER) oxycodone





[27] Barnett et al. 2018.

Expert perspectives

American Medical Association

- Urged regulators/policymakers to reevaluate policies[28]

Centers for Disease Control

- Advised against misapplication of 2016 Guidelines[29]

[28] National opioid policy roadmap highlights state efforts on epidemic. AMA. 2020.
[29] Dowell et al. 2019.

Primary Barriers to Pain Care

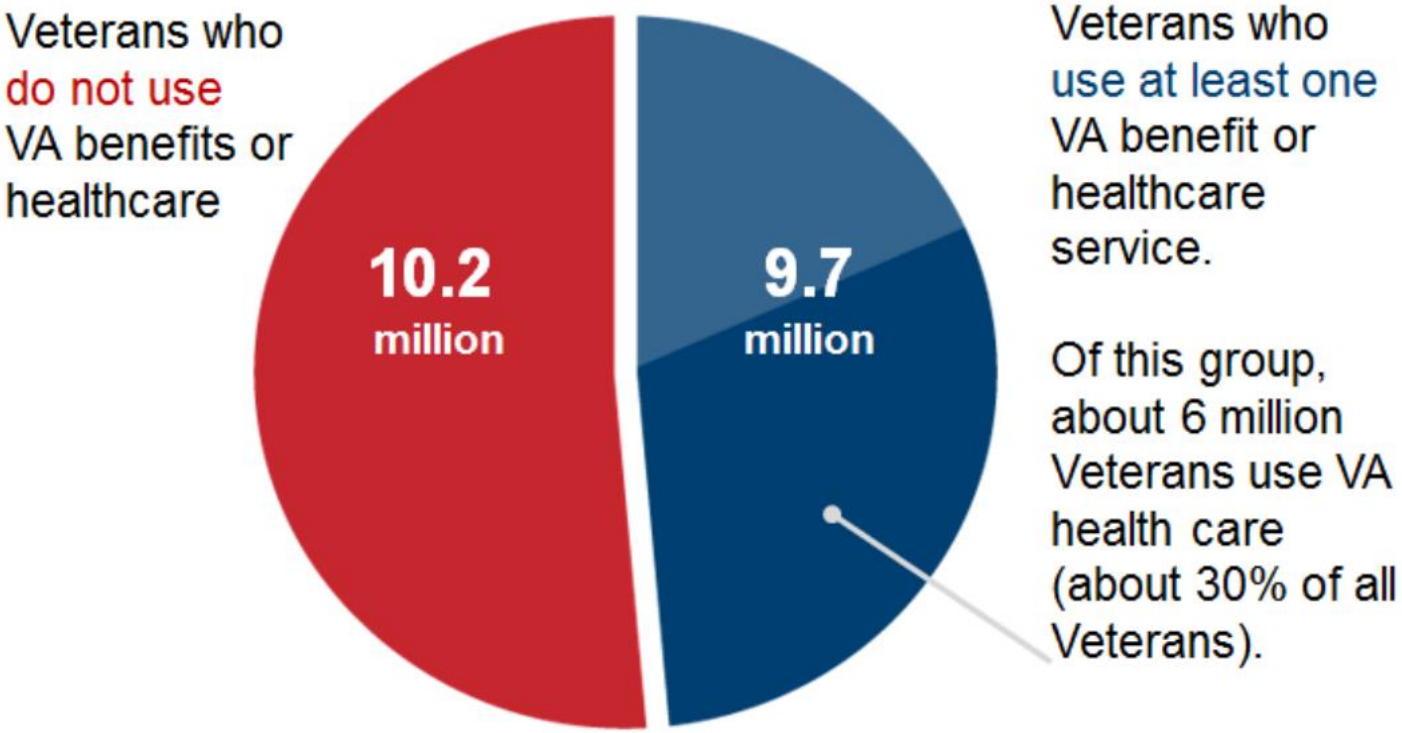
1. Policy

2. Payment

2. Payment

Current coverage and reimbursement structures provide **little compensation or coverage for pain management strategies**

Many veterans are privately insured or co-managed



[30] Sandbrink et al. 2021.

How does payment affect treatment?

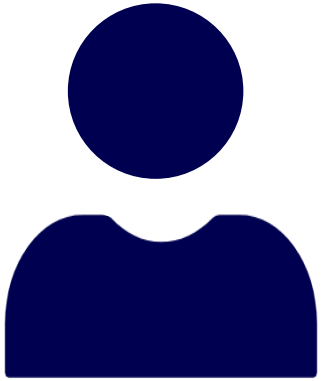
Less likely to provide certain treatments

Less likely to accept certain insurance

Higher out of pocket costs

Longer wait times

Provider



Patient

What did we hear from clinic staff & providers during our interviews?

> I just don't have time for the conversation.

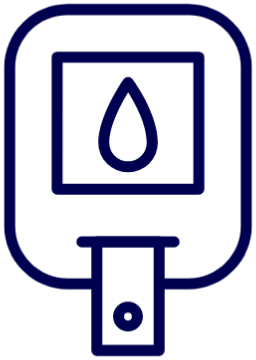
> It kind of gets us out of [having to accept the patient] if the insurance isn't going to pay for it.

> We have quite a few Medicaid patients and a lot of pain management providers don't necessarily take that, so it's a long time for them to get in.

[13] Slat et al. 2021.

Too little time to cover everything

PCPs have only < 20 mins per visit for all topics



[31] NAMCS/NHAMCS- Web Tables. 2020.

Wide variation in pain treatment coverage

- 90% of all public & private insurance plans cover physical & occupational therapy and chiropractic but visit limits and prior authorizations were common for these treatments[32]

- Review of Essential Health Benefits by state[33]
  - <10 states cover acupuncture, massage, or biofeedback
  - Zero cover mindfulness-based stress reduction (MBSR), tai chi, and yoga

[32] Heyward et al. 2018.
[33] Bonakdar et al. 2019.

Expert perspectives

US Dept. of Health & Human Services

- Current payment structures incentivize interventional procedures and monotherapy, impeding an interdisciplinary approach[12]

American Medical Association

- Recommend changing reimbursement structures to adequately reimburse time-intensive, high-quality care[28]

Assoc. of State and Territorial Health Officials

- States should evaluate pain treatments covered by Medicaid to update policies where needed[34]

[12] U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report. 2019.
[28] National opioid policy roadmap highlights state efforts on epidemic. AMA. 2020.
[34] Improving Access to Nonopioid Pain Management. 2018

VA pain care coverage

- CARA (2016) expanded complementary and integrative health offerings at the VA
- Treatments include:
  - Acupuncture
  - Biofeedback
  - Massage therapy
  - *Tai Chi*
  - Yoga
  - Meditation

[35] U.S. Department of Veterans Affairs .“Complimentary and Integrative Health”. 2021.

Primary Barriers to Pain Care

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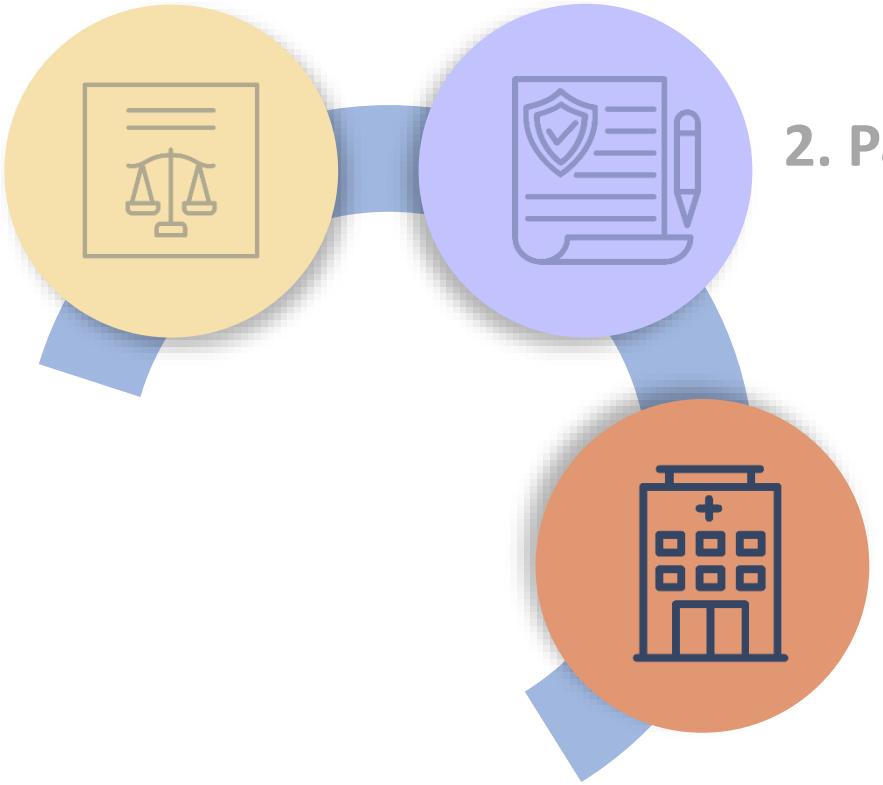


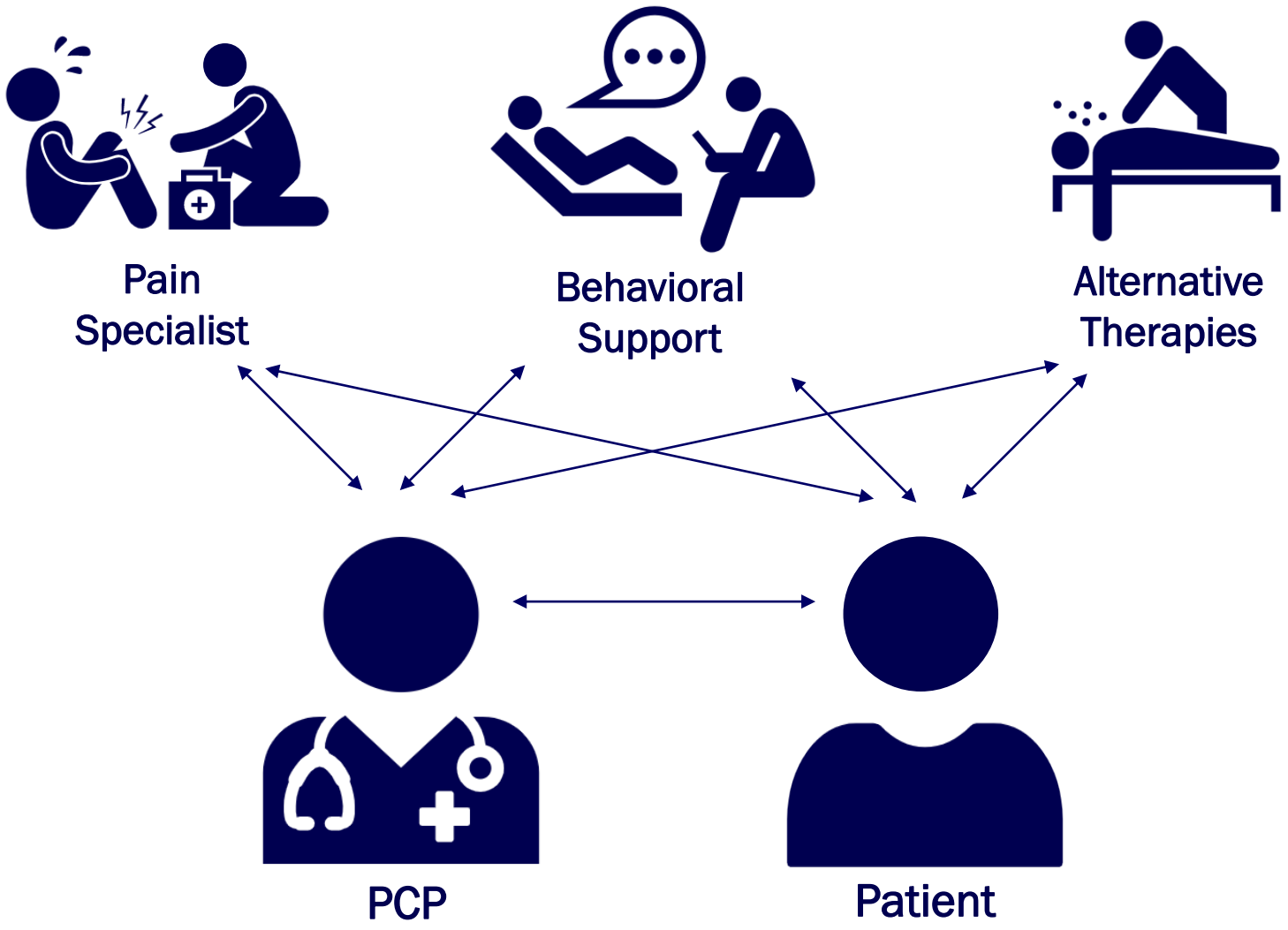
2. Payment

3. Care Coordination

3. Care Coordination

Lack of coordination between providers leads to gaps in receiving multimodal, effective pain care and additional burden on the patient to manage multiple opinions and treatment plans

How does care coordination affect treatment?



Care coordination in the VA

VA Patient-Aligned Care Team (PACT)[36] and Stepped Care Model (SCM)[37]

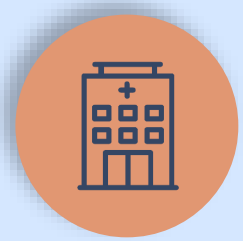
Step 1: Patient-Aligned Care Team
- Primary care setting
- Screening, plan, first-line treatments, and education

Step 2: Specialty Care
- Interdisciplinary team
- Pain medicine, rehabilitative medicine, and behavioral health

Step 3: Interdisciplinary Pain Centers
- Advanced diagnostics and interventions
- Integrated SUD treatment

[36] Veterans Health Affairs. PACT Roadmap for Managing Pain. 2018
[37] Kerns, et al. 2011.

What did we hear from clinic staff & providers during our interviews?



"Our new policy is we don't do pain management."

"There are not enough counseling agencies…that deal with chronic pain as well as mental illness."

"Chronic pain is a multi-system issue that requires a primary care physician, a pain specialist, and a [psychotherapist] for their mental health. We are talking about three things here."

[13] Slat et al. 2021.

Other research supports these claims

- Pain clinics throughout US are scarce[38]
- Pain clinics are underrepresented in rural areas[39]
- Many pain clinics do not offer ‘multidisciplinary’ care[17,38]
- Only 20 VAs have interdisciplinary pain programs as of 2019[40]

[17] Lagisetty et al. 2020b.
[38] Tompkins et al. 2017.
[39] Breuer et al. 2007.
[40] Murphy et al. 2021.

Expert perspectives

US Dept. of Health & Human Services

- Current fragmentation of pain care limits best practices and patient outcomes[11]

American Medical Association

- Enhance access to multidisciplinary, multimodal pain care, including non-opioid and non-pharmacologic pain care options[28]

[12] U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report. 2019..
[28] National opioid policy roadmap highlights state efforts on epidemic. AMA. 2020.

Primary Barriers to Pain Care

4. Stigma

Stigma around chronic pain and addiction make it difficult for this patient population to find a primary care doctor or receive quality care when they do

What is the role of stigma?

Disbelief of pain[41,42]

Illegitimacy of opioid therapy[45]

Assumption of addiction[43,44]

[41] De Ruddere, Craig. 2016.
[42] Matthias et al. 2010.
[43] McCradden et al. 2019.
[44] Antoniou et al. 2019.
[45] McCaffery, Pasero. 2001.

What did we hear from clinic staff & providers during our interviews?

> Mental illness overlying the use of chronic pain medicines.

> Unseemly, I guess. You know, patients that are kind of drug seeking, that have had a lot of issues.

> Now, that's really going back to the point that I made that most chronic pain do not need opioids. They need care for pain.

[13] Slat et al. 2021.

Stigma manifests in several ways

‘Opiophobia’ by providers and patients limits options for pain treatment

Estimation of pain severity affects whether opioid use is viewed as legitimate or not

Opioid use for pain is generally accepted for short-term, but not long-term, treatment

Lack of trust from providers toward patients using opioids for any reason

[43] McCradden et al. 2019.

Expert perspectives

US Dept. of Health & Human Services

- Stigma is both a barrier to effective care and risk factor for behavioral health issues like depression[12,33]

US Pain Foundation

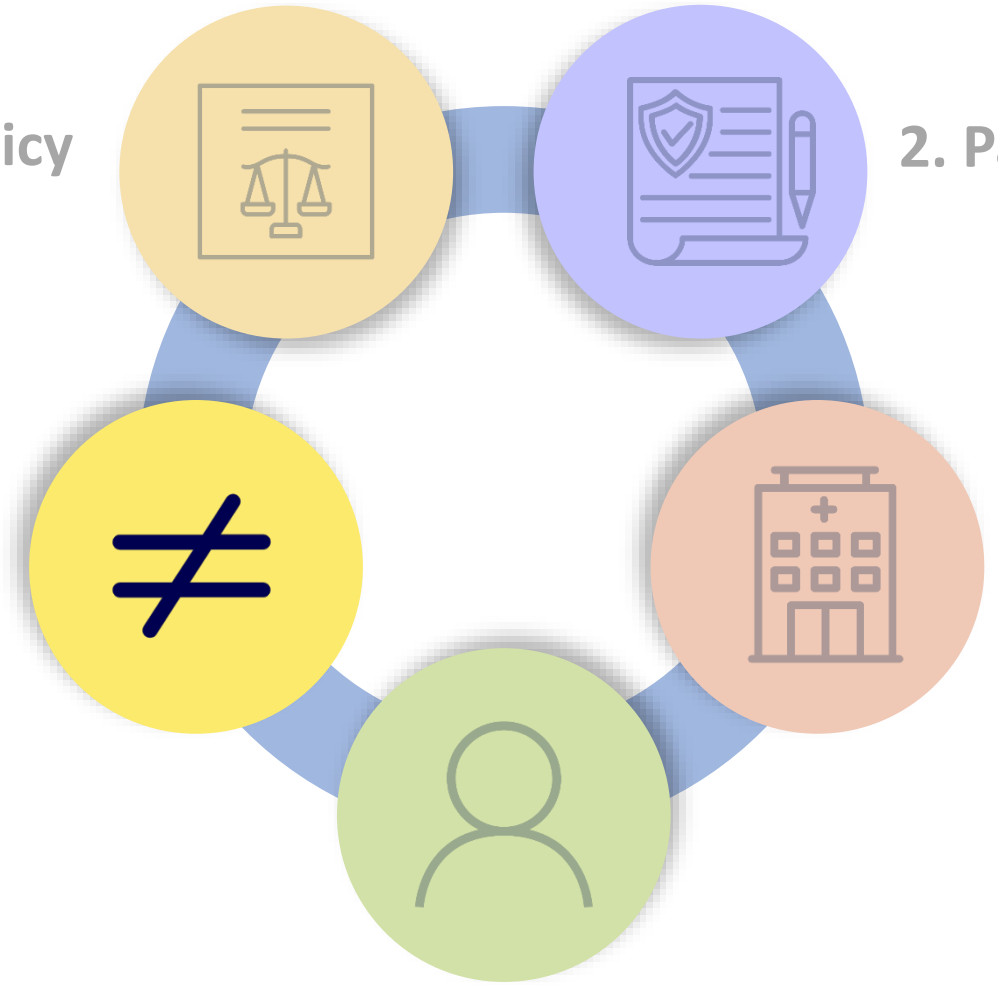
- Patients living with pain deserve support, not stigma[46]

American Chronic Pain Association

- Supports educating the public about the impacts of chronic pain to counter stigma and misperceptions[47]

[12] U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report. 2019..
[33] Bonakdar et al. 2019.
[46] Virtual Advocacy Action Center- U.S. Pain Foundation. 2020.
[47] Pain Awareness Toolkits. ACPA. 2020.

Primary Barriers to Pain Care



Definition

Differential pain treatment provided to patients based on their race

Reduced access to health care

- Impoverished individuals and minorities are more likely to be uninsured or underinsured than non-minorities and those with greater incomes
- Racial and ethnic minorities have reduced access to health care in general and specialty care in particular
- Pharmacies located in minority neighborhoods are less likely to carry sufficient analgesics than those in white neighborhoods

[48] National Institute of Neurological Disorders and Stroke. Disparities in Pain Care.

Differences in dosing and wait times

Blacks and Hispanics:

Are less likely to receive an opioid medication than Whites[49-52]

Receive **lower doses** of pain medications[51]

Experience **longer wait times** to receive pain medication[52]

49. Pletcher, et al., *JAMA,* 2008
50. Meghani, et al. *Pain Medicine,* 2012
51. Cleeland, et al. *Ann Intern Med.* 1997
52. Epps, et al. *Pain Manag Nurs,* 2008

Clinic referral & management differences

Black patients are also more likely to have:

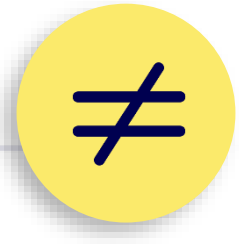
More referrals for substance use disorder assessment

Fewer referrals to pain specialists

Increased urine drug tests

[53] Hausmann et al. 2013.

Why does this happen?



Racial and ethnic minorities more likely to experience **miscommunication** and **misinterpretation** about pain with medical providers

Some doctors still **choose to believe that pain levels are lower** for Blacks than Whites or that minorities are '**drug seekers**'

Physicians are **more likely to underestimate the amount of pain** that African Americans are experiencing

54. Shavers, et al. *J Health Care Poor Underserved.* 2010

Recommendations for addressing disparities

American Chronic Pain Association recommends:

- Creating tools to consistently communicate symptoms to promote better understanding between patient & provider
- Increasing requirements for pain management education for providers
- Providing clear standards of care that must be adhered to

[55] Cowan, P. Confronting Disparities in Health Care. 2008

Today's objectives

Review opioid epidemic and unintended consequences for patients with pain

Describe chronic pain and prevalence

Describe multimodal treatment and its availability

Describe major barriers to accessing multimodal pain treatment

Discuss potential solutions

Expert panel

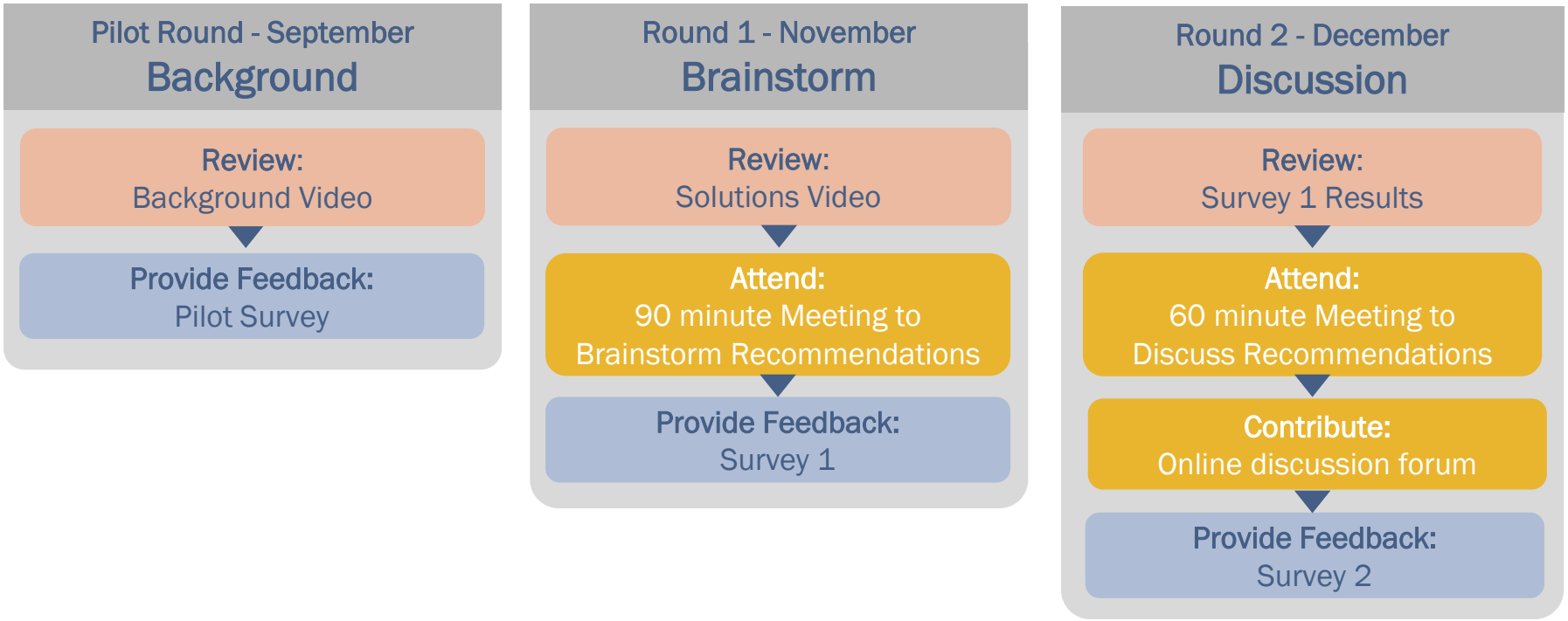
- Convened stakeholders from across Michigan Nov 2020 - Jan 2021
- Modified Delphi method[56]
  - Iterative rounds of surveys completed anonymously by experts
  - Survey results presented to the group between rounds to reach convergence of opinion

[56] Fitch et al. 2001.

OBJECTIVE:

Create a prioritized list of recommendations to reduce treatment access barriers for patients taking prescription opioids for chronic pain

Panel Timeline

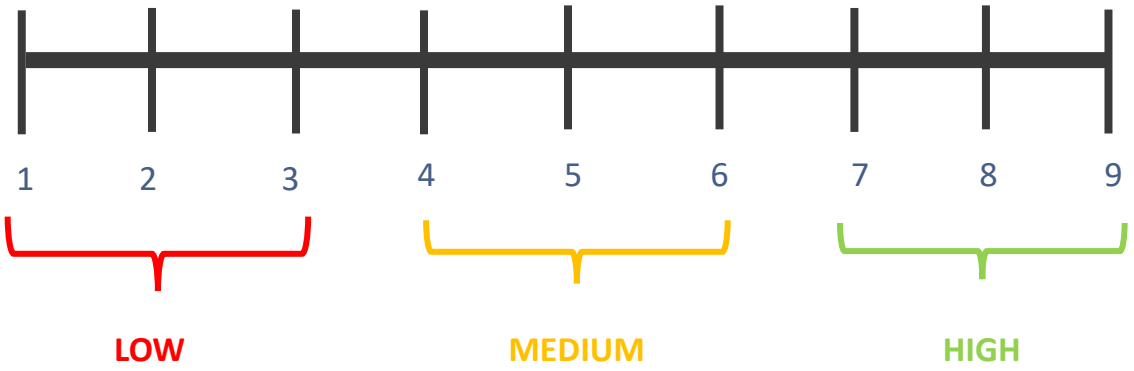


Ratings

- 3 metrics to consider:
  - **Feasibility** - The extent to which a proposed recommendation is within stakeholder control and could attract the political and financial support necessary for implementation
  - **Impact** - The extent to which, if implemented, a proposed recommendation would improve access to effective pain care for patients taking opioids for chronic pain
  - **Importance** - The extent to which stakeholders should prioritize implementing this recommendation

Ratings

- Each recommendation was rated on feasibility, impact, and importance on a 9-point Likert scale:

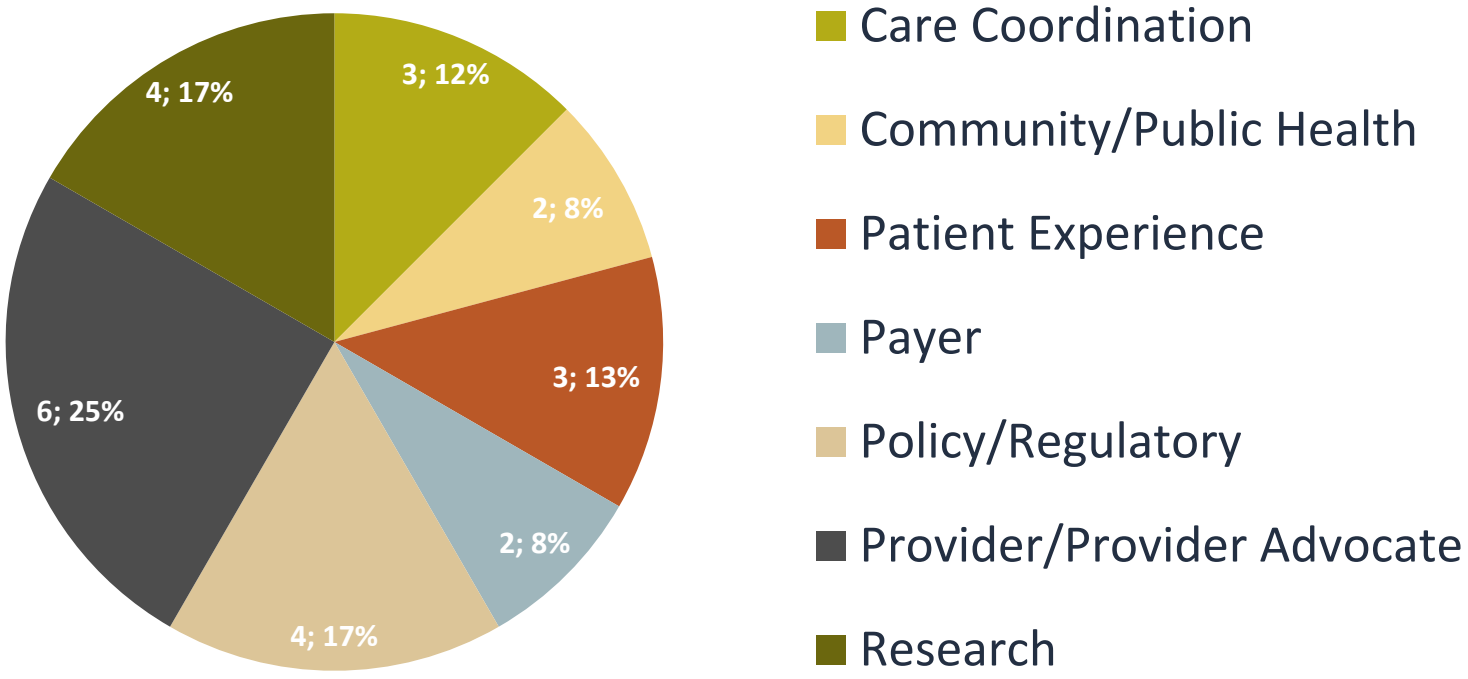


Rankings

- Ranked by implementation priority
- Rankings averaged to produce final prioritized list

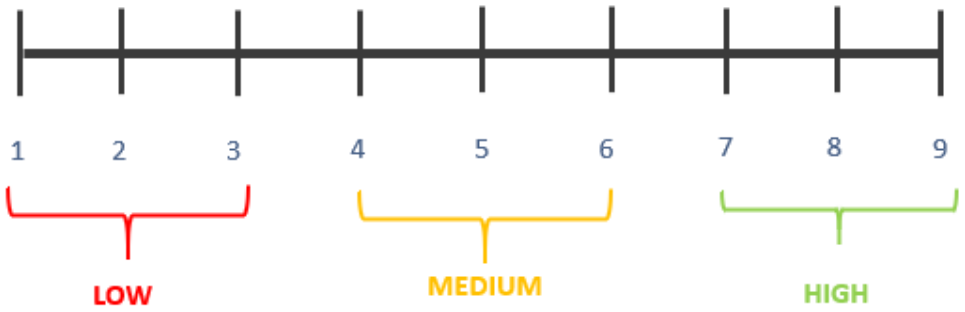
Panel Composition

24 panelists:



Recommendations and Ratings

- 11 final recommendations
- Median ratings were moderate – high:
  - Feasibility: 5.5 - 7
  - Impact: 5 - 8
  - Importance: 5.5 - 9

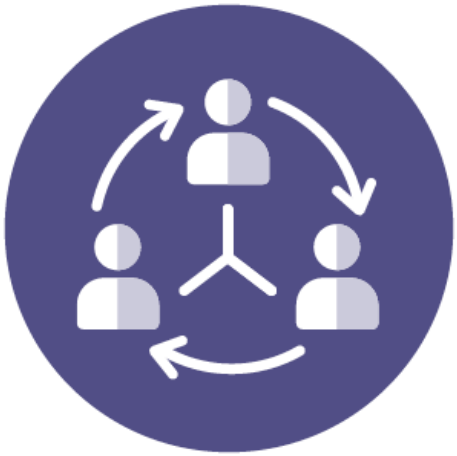


Improving care models through reimbursement reforms

- 3 recommendations, including the top two:

  1. Increase reimbursement for the time required to treat chronic pain

  2. Establish coordinated care models to bundle payment for multimodal pain treatment



Enhancing Provider Education

- 4 recommendations
- Emphasis on non-pharmacologic care and reducing stigma towards opioid dependence and OUD

Addressing racial disparities in care

- 4 recommendations
- Focus on reducing the impact of provider bias, e.g. through standardized protocols and implicit bias training

In conclusion…

- What we've been doing isn't addressing the epidemic: despite decreases in opioid prescribing, deaths keep rising
- And substantial barriers to care exist for patients with pain – maybe the pendulum has swung too far?
- But there's little appetite for repealing these deprescribing policies

So… where to from here?

A way forward?

Some combination of:

- Restructuring reimbursement models
- Improving provider education around pain and addiction
- Addressing racial inequities in care

...could meaningfully improve access to care

Thank You

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