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
- This work was funded by the Michigan Health Endowment Fund
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

**U.S. drug overdose deaths per year**

- **20,000 deaths**
- **40,000 deaths**
- **60,000 deaths**
- **80,000 deaths**
- **100,000 deaths**

Provisional data for 2020 and 12 months ending in April 2021.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics

1. Keating 2021
## Many responses to the epidemic

<table>
<thead>
<tr>
<th>Supply</th>
<th>Prevention</th>
<th>Treatment</th>
<th>Harm Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower the supply of illicit &amp; Rx drugs</td>
<td>Prevent initial prescription drug use</td>
<td>Reduce barriers to treatment</td>
<td>Public health laws for people not in treatment</td>
</tr>
<tr>
<td>• Drug trafficking laws</td>
<td>• CDC guidelines</td>
<td>• Provider training and workforce development</td>
<td>• Overdose reversal drugs</td>
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<tr>
<td>• International efforts to limit opioids/illicit drug trade</td>
<td>• PDMPs</td>
<td>• Expanding treatment coverage</td>
<td>• Good Samaritan laws</td>
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<tr>
<td>• Criminalizing possession</td>
<td>• Insurance dosing limits</td>
<td>• Improved coordination</td>
<td>• Safe injection sites</td>
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<td>• Safe medication take-backs</td>
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</table>
As a result, prescribing is at a 10-year low

U.S. Opioid Prescribing Rate\(^2\)

VA opioid prescribing has decreased 63% since 2012

FY 2013: National Opioid Safety Initiative (OSI)

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3 Sandbrink et al. 2021.
Restrictive prescribing can lead to unintended consequences for patients with pain

The New York Times


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
@laoraphymills
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\(^8\)

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\(^4\) Kertesz, et al. 2019  
\(^6\) 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?

effective pain treatment

risk of OUD
Most chronic pain patients don’t misuse opioids

Of chronic pain patients prescribed opioids

- 65% have never misused medication
- 25% have misused medications
- 10% have an OUD

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?®

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

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

9.1% Veterans 6.4% Nonveterans

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

How do patients access this level of care?

Conceptual Model of Treatment Access

1. Patient visits primary care office
2. Primary care provider
   - Diagnosis
   - Treatment planning
3. Effective multimodal treatment

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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

186 Eligible Clinics

93 Clinics
BCBS

93 Clinics
Medicaid
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:

  “Before we get too far, is it okay if my mother takes opioids for pain?”
The data is discouraging

41% of MI primary care clinics won’t accept new patient with chronic pain on opioids\textsuperscript{14}

\textsuperscript{14} Lagisetty et al. 2019.
Is this happening elsewhere too?

We expanded our study to include 8 additional states based on overdose death rates\textsuperscript{15}

Does the reason for needing a new patient appointment matter?

\textsuperscript{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\textsuperscript{16}

452 Clinics called twice

339 Clinics (75\%) responded the same to both scenarios

146 Clinics (32\%) said Yes to prescribe in both scenarios

193 Clinics (43\%) said No to prescribe in both scenarios

113 Clinics (25\%) responded differently to each scenario

\textsuperscript{16} Lagisetty et al. 2020a.
Reason for needing an opioid Rx affects access\textsuperscript{16}

Clinics That Responded Differently to Each Scenario

\textbf{N} = 113

\begin{itemize}
  \item Retired - No
  \item Retired - Yes
  \item No Reason - Yes
  \item No Reason - No
\end{itemize}

\textsuperscript{16} Lagisetty et al. 2020a.
Breakdowns in effective multimodal pain care

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

- Diagnosis
- Treatment planning

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Why is this happening?
Primary Barriers to Pain Care

1. Policy
2. Payment
3. Care Coordination
4. Stigma
5. Racial Disparities
Primary Barriers to Pain Care

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

<table>
<thead>
<tr>
<th>CDC Guidelines (2016)(^{18})</th>
<th>State of MI Requirements(^{19})</th>
<th>VA Practices</th>
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<tbody>
<tr>
<td></td>
<td>“Start Talking” Form</td>
<td>- Urine toxicology screens</td>
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<tr>
<td></td>
<td>Review MAPS for each patient</td>
<td>- Performance feedback comparing prescribing to peers</td>
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<tr>
<td></td>
<td>Follow-up care (long term commitment)</td>
<td></td>
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<tr>
<td></td>
<td>Sanctions for noncompliance</td>
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</tr>
</tbody>
</table>

\(^{18}\) 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?
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.”

Policies affect practice

- 58% of providers changed their practice due to the 2016 CDC Guidelines\(^\text{21}\)
- 43% elected not to treat patients with chronic pain\(^\text{21}\)
- Physicians fear liability if they prescribe opioids\(^\text{22}\)

\(^{21}\) NCMB Licensee Survey. 2018.
\(^{22}\) Nadeau. 2015.
Robust PDMPs reduce opioid dosages

Morphine-equivalent dosage (MED) dispensed per person per quarter in Kentucky and Missouri, 2010-2014

- National interventions
- Kentucky PDMP

Kentucky
Missouri
Difference

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%\textsuperscript{24}
Prior auth’s alone have mixed results

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

- 36% reduction in new ER opioid starts
- 11% relative reduction in monthly rates of ER opioid prescribing

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.

Veterans who do not use VA benefits or healthcare: 10.2 million

Veterans who use at least one VA benefit or healthcare service: 9.7 million

Of this group, about 6 million Veterans use VA health care (about 30% of all Veterans).

How does payment affect treatment?

- Provider: Less likely to provide certain treatments, Less likely to accept certain insurance
- Patient: Higher out of pocket costs, Longer wait times
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."

Too little time to cover everything

PCPs have only < 20 mins per visit for all topics
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\(^\text{12}\)

**American Medical Association**
- Recommend changing reimbursement structures to adequately reimburse time-intensive, high-quality care\(^\text{28}\)

**Assoc. of State and Territorial Health Officials**
- States should evaluate pain treatments covered by Medicaid to update policies where needed\(^\text{34}\)

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\(^{28}\) 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

Primary Barriers to Pain Care

1. Policy
2. Payment
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?

- Pain Specialist
- Behavioral Support
- Alternative Therapies

PCP

Patient
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

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\(^{36}\) Veterans Health Affairs. PACT Roadmap for Managing Pain. 2018
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.”

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\(^{40}\)

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\(^{17}\) 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\(^ {28}\)


\(^{28}\) National opioid policy roadmap highlights state efforts on epidemic. AMA. 2020.
Primary Barriers to Pain Care

1. Policy
2. Payment
3. Care Coordination
4. Stigma
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\textsuperscript{41,42}

Assumption of addiction\textsuperscript{43,44}

Illegitimacy of opioid therapy\textsuperscript{45}

\textsuperscript{41} De Rudder, Craig. 2016.
\textsuperscript{42} Matthias et al. 2010.
\textsuperscript{43} McCradden et al. 2019.
\textsuperscript{44} Antoniou et al. 2019.
\textsuperscript{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.”
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\(^{47}\)


\(^{33}\) 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

1. Policy
2. Payment
3. Care Coordination
4. Stigma
5. Racial Disparities

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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
Differences in dosing and wait times

Blacks and Hispanics:

- Are less likely to receive an opioid medication than Whites\textsuperscript{49-52}
- Receive lower doses of pain medications\textsuperscript{51}
- Experience longer wait times to receive pain medication\textsuperscript{52}

\textsuperscript{49} Pletcher, et al., \textit{JAMA}, 2008
\textsuperscript{50} Meghani, et al. \textit{Pain Medicine}, 2012
\textsuperscript{51} Cleeland, et al. \textit{Ann Intern Med}. 1997
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

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.

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
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Expert panel

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

\textsuperscript{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

Pilot Round - September
- Background
  - Review: Background Video
  - Provide Feedback: Pilot Survey

Round 1 - November
- Brainstorm
  - Review: Solutions Video
  - Attend: 90 minute Meeting to Brainstorm Recommendations
  - Provide Feedback: Survey 1

Round 2 - December
- Discussion
  - Review: Survey 1 Results
  - Attend: 60 minute Meeting to Discuss Recommendations
  - Contribute: Online discussion forum
  - Provide Feedback: Survey 2

Provide Feedback:
- Pilot Survey
- Survey 1
- Survey 2
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:

1. LOW
2. MEDIUM
3. HIGH
Rankings

• Ranked by implementation priority
• Rankings averaged to produce final prioritized list
Panel Composition

24 panelists:

- **Care Coordination**: 4; 17%
- **Community/Public Health**: 2; 8%
- **Patient Experience**: 3; 13%
- **Payer**: 6; 25%
- **Policy/Regulatory**: 4; 17%
- **Provider/Provider Advocate**: 2; 8%
- **Research**: 3; 12%
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

Mentors & Collaborators
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Steve J. Bernstein
Mark C. Bicket
Erin Fanning Madden
Victoria Powell
Goodarz Golmirzaie

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