PainWeek®

Rebalancing Pain Medicine: Improving Care Through a Wider Lens

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Disclosure

- Nothing to disclose

Learning Objectives

- Distinguish between the multidisciplinary and interdisciplinary models of chronic pain management
- Identify the weaknesses of “siloed” chronic pain care
- Describe practice patterns that will be more “balanced,” thereby resulting in better patient outcomes and more personal satisfaction with their pain practices

Balance

- "Equipoise between contrasting, opposing, or interacting elements"

&

- "An aesthetically pleasing integration of elements"

Merriam-Webster Dictionary. Available at: https://www.merriam-webster.com/dictionary/balance

- Irrespective of which definition one chooses, that American pain medicine has become unbalanced is irrefutable
- And "balance" appears to be becoming more distant in our rear-view mirrors….

Balance

- 1847 – AMA founded, and its Code of Ethics addressed the need to balance:
  - The needs of patients
  - Quality of care
  - Ethical standards for physicians
  - The covenant of trust that binds them all together in the patient/physician relationship

American Medical Association. Code of Ethics;1847.

- Easy to balance when cost containment and quality guided care rather than serving as sources of controversy

Seward PJ. Health Aff (Millwood). 1997;16(3):195-197.

Balance

- 1910 – The Flexner Report called for medical education and practice to become more scientific

Flexner A. Medical Education in the United Sates and Canada. Washington, DC: Science and Health Publications, Inc.; 1910.

  - Yet few are aware that later in his career, Flexner made the earliest calls for medicine to become more interdisciplinary, and education to balance science and the humanities

Flexner A: I Remember. New York, Simon & Schuster Inc; 1940.

- Biopsychosocial pain medicine
  - Has its roots in Engels' biopsychosocial approach to psychiatry, an effort to balance the biomedical vs. psychological argument in psychiatry

Engel GL. Science 1977;196:129-136.

Balance

- Unidimensional biological, psychological, and social models lack explanatory power for complex phenomena seen in medicine

Swisher SN. Psychosom Med. 1980;42(1 Suppl):113-121.

  - And what could be more complex than chronic pain?
- IASP definition:
  - Lasts or recurs for longer than 3 months
  - An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage

Raja SN, et al. Pain. 2020;161(9):1976-1982.

Disease vs. Illness

- Critical concept in understanding the biopsychosocial model
- "Disease" – Refers to an objective bodily event that involves disruption of specific body structures or organ systems caused by pathological, anatomical, or physiological changes
- "Illness" – Refers to a subjective experience or self-attribution that a disease is present, resulting in physical discomfort, emotional distress, behavioral limitations, and psychosocial disruption

Mechanic D. Illness behavior: an overview. In: McHugh S, Vallis TM (eds). Illness Behavior: A Multidisciplinary Model. New York: Plenum Press, 1986;101-110.

Disease vs. Illness

- Biomedical model – emphasizes disease
- Biopsychosocial model – emphasizes disease and illness

- "Illness strikes men when they are exposed to change"

  -Herodotus

- "It is much more important to know what sort of patient has a disease than what sort of disease a patient has"

  -William Osler

Biopsychosocial Model of Chronic Pain

- Waddell (1987) – Suggested that we need to:
  - Treat patients rather than spines
  - Treat low back disability as an illness rather than low back pain purely as a disease
  - Distinguish signs of stress and illness behavior from those of physical disease

Waddell G. Spine 1987;12:632-644.

- Considers the “dynamic and reciprocal interaction between biological, psychological, and sociocultural variables that shapes the person’s response to pain”

Turk DC, Flor H. Chronic pain: a biobehavioral perspective. In: Gatchel RJ, Turk DC (eds.). Psychosocial factors in pain: Critical perspectives. New York: Guilford Press, 1999;18-34..

Biopsychosocial Model of Chronic Pain

- Why do we need biopsychosocial models of assessment and treatment?
- Unimodal models don't work!!!!!
  - "The history of pain medicine is replete with failures of the biomedical model"

Gallagher RM. Med Clin N Am. 1999;83:555-583.

- Failure to address the psychosocial components of chronic pain leads to almost guaranteed inadequate care

Turk DC, et al. Can J Psychiatry 2008;53:213-223.

Vranceanu AM, et al. J Bone Joint Surg Am. 2009;91:2014-2018.

Bendelow G. Virtual Mentor 2013;15:455-459.

Ushida T. J Orthop Sci. 2015;20:958-966.

Treating the "Illness of Chronic Pain"

- The heuristic value of the biopsychosocial model is best demonstrated through interdisciplinary chronic pain management

Gatchel RJ. Am Psychol. 2004;59:795-805.

- Yet with insurers' refusal to pay for them and hospitals' refusal to lose revenue by keeping them going, they've essentially gone away
  - Over 1000 programs in the US in 1999, 38 (???) today

Anooshian J, et al. Psychosomatics 1999;40:226-232.

Schatman ME. In: Schatman ME (ed.). Ethical Issues in Chronic Pain Management. New York: Informa Healthcare;2007;43-62.

Schatman ME. In: Ballantyne JC, et al. (eds). Bonica's Management of Pain, 4th Edition. Philadelphia: LWW,; 2010;1523-1532.

Schatman ME. Pain Med. 2011;12:415-426.

Schatman ME. Pain: Clin Updates 2012:20(7):1-5.

Treating the Illness of Chronic Pain

- What arose as the interdisciplinary programs shut down?
  - Is it a coincidence that the opioid crisis began just as interdisciplinary programs began to “go away”?

Schatman ME. In: Peppin J, Coleman J, Dineen KK, Ruggles A (eds.). Pain and Prescription Drug Diversion: Healthcare, Law Enforcement, and Policy Perspectives. New York: Oxford University Press, 2018:204-218.

- The “war on opioids” provided an opportunity for other “pain specialists” to grab a progressively larger market share
  - And to throw our pain care system further into imbalance
  - This imbalance is not helping our patients
  - And is anything but “interdisciplinary”

“Interdisciplinary” vs. “Multidisciplinary”

- Terms are often used interchangeably
- This is a mistake….
- “Multidisciplinary” simply means numerous disciplines
- “Interdisciplinary” means that they’re actually working together
- Multidisciplinarity is often simply a money-maker….but not particularly effective

Gatchel RJ, et al. Am Psychol. 2014;69:119-130.

- Disintegrated multidisciplinary care is overrated….

Are “Pain Clinics” Interdisciplinary?

- Study of 46 facilities in North Carolina that advertised themselves as “pain clinics”
- Multidisciplinarity criterion was inclusion of a medical physician, registered nurse, physical therapist, and mental health specialist
- Only 7% were determined to be multidisciplinary

Castel LD, et al. *Spine* 2009;34:615-622.

- Even a pill mill can advertise itself as “interdisciplinary”…..

What is a "Pain Clinic"?

- IASP released definitions in 2009:
  - "A pain clinic may be large or small but it should never be a label for an isolated solo practitioner"

International Association for the Study of Pain. Pain clinic guidelines. Available at: https://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1471

- "Pain clinic" is not a protected term…..nor a clearly defined one
- The most common types of pain clinic are single modality, "which reference the use of narcotics within the clinic"

Andraka-Christou B, et al. Subst Abuse Treat Prev Policy. 2018;13:17.

What is a “Pain Clinic”?

- This has likely changed since the authors collected their data in 2017
  - How favorably would DEA and state medical boards look at pain clinics that solely prescribed opioids today?
  - They’d likely be deemed “pill mills”, be shut down, and licenses revoked
- Negative as well as positive consequences of shutting down “opioid clinics” in underserved areas such as Appalachia have been empirically established

Roberson PNE, et al. J Appalach Health 2020;2(4):26–36.

What is a “Pain Clinic”?

- What has replaced the “opioid clinics”?
- What SHOULD replace the opioid clinics?
- According to HHS:
  - Need for all classes of treatments: medication, restorative, interventional, behavioral, and complementary & integrative approaches in single settings

U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html

- Medication – Are clinics specializing in non-traditional opioid pharmacological approaches viable alternatives?

What is a “Pain Clinic”?

- “High-Risk Pain Clinics” are proliferating
  - Purportedly to treat patients suffering from OUDs and chronic pain with buprenorphine/naloxone

Kaski S, et al. J Clin Med. 2021:10:973.

  - But too often buprenorphine is becoming the “first stop” for those with severe intractable pain, even without OUDs, if they’re deemed “at risk”

Ehrlich AT, Darcq E. Recommending buprenorphine for pain management. Pain Manag. 2019;9(1):13-16.

  - Without an iota of quality long-term evidence for efficacy

Schatman ME, et al. Ann Intern Med. 2020;172:293-294.

  - Why not conflate safety with analgesic efficacy if it meets anti-opioid agendas? 😳

Other Oral Analgesics

Other Oral Analgesics

- Dental research on analgesia “created a monster”
  - Dentists were overprescribers of opioids for years

Dhadwal S, Kulich RK, Monga P, Schatman ME. Dent Clin N Am. 2020;64(3):491-501.

  - Resulting in research demonstrating that combinations of acetaminophen and ibuprofen could be as effective for treating short-term, mild to moderate post-procedural pain

Moore PA, Hersh EV. J Am Dent Assoc. 2013;144(8):898-908.

  - FDA indication for acetaminophen is for “mild to moderate pain”

https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/204767s000lbl.pdf

  - FDA indication for ibuprofen is for “mild to moderate pain”

https://www.accessdata.fda.gov/drugsatfda_docs/label/2007/017463s105lbl.pdf

Other Oral Analgesics

- FDA warning on ibuprofen: Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals

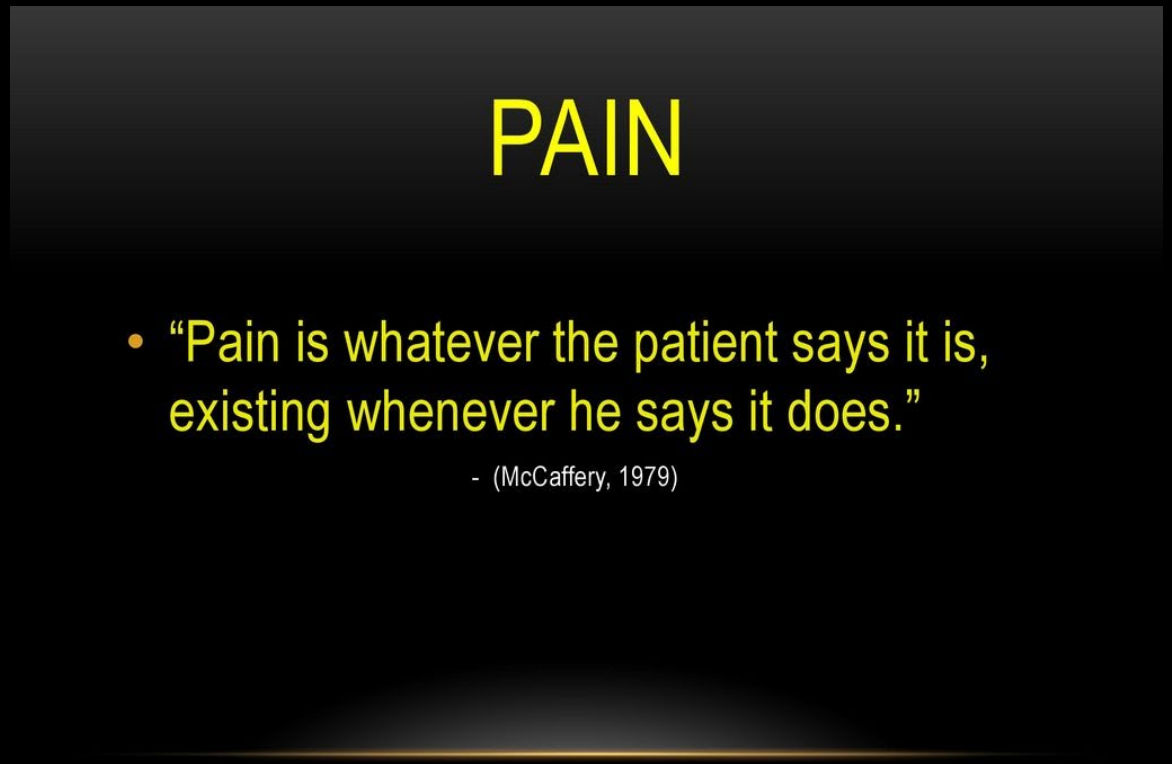
https://www.accessdata.fda.gov/drugsatfda_docs/label/2007/017463s105lbl.pdf

- How was this extrapolated to severe, chronic pain?!?!
- Any data?
- Only the dubious SPACE study suggests that nonopioids were as effective as opioids in the treatment of moderate to severe chronic pain
  - Authors failed to mention how many of the subjects had severe pain

Krebs EE, et al. JAMA. 2018;319(9): 872–882.

Pearl #1 for Rebalancing Pain Medicine

- Believe our patients when they tell us that their pain is severe!



“Restorative” Pain Treatment

- Refers to physical therapy, occupational therapy, therapeutic exercise
- Systematic reviews support its efficacy for:
  - Fibromyalgia

Garijo IH, et al. J Back Musculoskelet Rehabil. 2021[Epub ahead of print].

  - Myofascial pain

Ahmed S, et al. J Exerc Rehabil. 2018;14(6):902-910.

  - Spinal pain

Hernando-Jorge A, et al. Rehabilitación (Madr). 2021;55(1):49-66.

Restorative Pain Treatment

- ❖Chronic non-specific low back pain

Niederer D, Mueller J. PLoS One. 2020;15(1):e0227423.

- ❖Chronic non-specific neck pain

Amiri Arimi S, et al. Am J Phys Med Rehabil. 2017;96(8):582-588.

- ❖Osteoarthritis

Skelly AC, et al. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Apr. Report No.: 20-EHC009.

- ❖Pediatric rheumatoid disease

Nijhof LN, et al. Rheumatol Int. 2018;38(11):2015-2025.

- Efficacy through numerous individual RCTs also identify painful conditions for which restorative therapies appear beneficial

Restorative Pain Treatment

- And then there's the benefit of no or minimal negative iatrogeneses
- What's the catch?
  - Insurance caps the amount of physical therapy that enrollees can access
  - More treatment translates to better outcomes in chronic pain conditions

Lieberz D, et al. Eval Health Prof. 2020[Epub ahead of print].

  - Results in deterrence of patients from seeking care from a restorative care and/or limiting provider referrals

Carvalho E, et al. N C Med J 2017;78:312–314.

Restorative Pain Treatment

- Calls are being made to get MSK pain patients into restorative care earlier to reduce opioid exposure

George SZ, Goode AP. Pain Rep. 2020;5(5):e827.

- Commercial insurers are not likely to be impressed
  - Irrespective of data demonstrating that restorative care reduces costs

Lentz TA, et al. BMC Health Serv Res. 2018;18(1):648.

- PT practices are becoming less likely to accept Medicaid

Curry EJ, et al. JSES Int. 2021;5(3):507-511.

- Not being able to provide an adequate amount of PT and OT results in moral distress among therapists

Goddard D. Phys Occup Ther Geriatr. 2021[Epub ahead of print].

Restorative Pain Treatment

- Low-income patients and those of color are less likely to access restorative therapies for chronic pain

Iverson MD, et al. Phys Ther. 2018;98(8):670–678.
Khoja SS, et al. Arthritis Care Res. 2020;72(2):184–192.

- Lack of restorative treatment among low-income patients is associated with greater use of opioid pain medications
  - This is exacerbated by an inability to self-manage restoratively due to an inability to afford gym memberships

Turner BJ, et al. Arch Phys Med Rehabil. 2017;98(11): 2111–2117.

- Caveat – PT-guided exercise has a strong evidence-basis, yet surveys point to high rates of use of electrical modalities, which the evidence shows are ineffective

Foster NE, et al. Lancet. 2018;391:2368-2383.

Pearl #2 for Rebalancing Pain Medicine

- As long as insurers can get away with limiting access to restorative pain treatment – even with its evidence-basis for clinical efficacy and cost-efficiency – chronic pain patients will continue to be undertreated

Interventional Pain Treatment

- Are “drill mills” becoming the new “pill mills”?
  - 2009 – Deyo and colleagues noted a 629% increase in Medicare expenditures for epidural steroid injections over the previous decade

Deyo RA, et al. J Am Board Fam Med. 2009; 22(1):62–68.

    - Authors pointed out that European and American guidelines, based on systematic reviews, concluded they do not reduce the rate of subsequent surgery
    - And that facet joint injections with corticosteroids appear no more effective than saline injections
  - Vastly overutilized in the US due to profit motivation

Epstein NE. Surg Neurol Int. 2015;6(Suppl 14):S383-387.

Interventional Pain Treatment

- Recent editorial: “As interventional pain specialists, we have a long history of early and overzealous adoption of procedures that initially appeared promising, but over time failed to live up to the early optimism”

Zhao Z, Larkin TM, Cohen SP. Pain Med. 2020;21:655–658.

- To suggest that interventional approaches “don’t work” is ludicrous
  - The field includes such a wide variety of interventions
  - The key is to use them judiciously
  - As simply “opioid-sparing”, they’re not established as an answer
  - And improved guideline adherence is desperately needed

Foster NE, et al. Lancet. 2018;391:2368-2383.

Interventional Pain Medicine

- The issue is not merely the need for more judicious use of interventional procedures
  - Integration of interventional pain medicine into evidence-informed multimodal systems is imperative
  - Pain medicine continues to become progressively more siloed in its spirit and practice, and pertains not only to interventionalists

Tick H, et al. Explore. 2018;14(3):177-211.

Eisenberg GM. Rheum Dis Clin N Am. 2019;45:53–66.

  - Isolated practice makes little sense, as large, multispecialty groups have more bargaining power with insurers.

Weeks WB, et al. Health Aff (Millwood). 2010;29(5):991-997.

Interventional Pain Medicine

- Guidelines for interventional pain medicine are plentiful
  - Yet, they're all about procedures as monotherapies, addressing discreet interventions in isolation

Tousignant-Laflamme Y, et al. J Pain Res. 2017;10:2373–2385.

  - The personal and environmental factors that might influence reports of pain and perceived or actual disability are ignored
    - Example: Pain and depression share some biological processes and both prompt maladaptive neuroplastic changes in the CNS

Doan L, et al. Neural Plast. 2015;2015:504691.

    - So why would an interventionalist ever perform a procedure without depression being addressed?

Interventional Pain Medicine

- Do injections do anything to alter the maladaptive behaviors, cognitive distortions, and environmental factors that perpetuate chronic pain?

Martel MO, et al. Pain. 2010;151(2):330-336.
Shaw WS, et al. Best Pract Res Clin Rheumatol. 2013;27(5):637–648.
Gatchel RJ, et al. J Orthop Sports Phys Ther. 2016;46(2):38-43.

- Do interventional procedures in isolation help improve function?
  - Perhaps to an extent in some patients
  - But not as well as multimodal approaches

Solutions to Siloed Interventional Pain Care

- Proposed model in interventional pain management to incentivize physicians to make their care more multimodal

Heres EK, et al. Pain Med. 2018;19:910-913.

  - ❖Interesting idea, but not likely outside of academic medical centers interested in quality improvement
  - ❖Hospital corporations are interested in maximizing revenue
  - ❖Interventional pain medicine will remain a cash cow
  - ❖Until we move into a “pay for performance” paradigm

- “Interventional pain management….will probably suffer the most under the new affordable health care law and regulatory burdens”

Manchikanti L, et al. Pain Physician 2012;15:E27-E52.

Pearl #3 for Rebalancing Pain Medicine

- Interventional pain medicine has its place, but only as an aspect of integrated multimodal chronic pain management. Interventionalists are in for a hard time should they remain siloed, which is becoming progressively more common.

Behavioral Pain Management

- Perhaps the cornerstone of the interdisciplinary chronic pain management programs of yesteryear…..
- Historically the territory of pain psychologists

Fordyce WE, et al. Arch Phys Med Rehabil. 1973;54(9):399-408.

- Long history of insurance refusing to pay

Sharfstein SS. Am J Psychiatry. 1978;135(10):1185-1188.

Bao Y, et al. Psychiatr Serv. 2003;54(5):693-697.

  - Managed care was particularly challenging
    - 2-4 sessions to treat severe depression in the context of chronic pain was ludicrous

Behavioral Pain Management

- Then came the Mental Health Parity Act
  - 1996 Act – Full of loopholes
  - Applied only to large employer-sponsored group health plans
  - Did not address treatment limits

Goodell S. Health Aff Health Policy Brief, April 3, 2014. https://www.healthaffairs.org/do/10.1377/hpb20140403.871424/full/

- Several progressive states passed acts with genuine parity
- 2008 - Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA)
  - Provided actual parity, other than exempting group plans that did not already offer mental health coverage

Dave D, Mukerjee S. Health Econ. 2011;20(2):161-183.

Behavioral Pain Management

- Affordable Care Act took that last loophole out of the Mental Health Parity and Addiction Equity Act
  - Actual parity was achieved, behavioral services now fully covered
- But good luck in trying to find a trained pain psychologist…
  - Efforts have been made to educate the public and the mental health community about the imperative of training more pain psychologists

Darnall BD, et al. Pain Med. 2016;17(2):250–263.
Darnall BD, Carr DB, Schatman ME. Pain Med. 2017;18:1413-1415.

  - No evidence of any progress….

Behavioral Pain Management – Other Options

Journal of Pain Research

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EDITORIAL

The Problem (and the Answer?) to the Limited Availability of Pain Psychologists: Can Clinical Social Workers Help?

This article was published in the following Dove Press journal:
Journal of Pain Research

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Matthew G Fortino [1,3,4]

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Introduction

American chronic pain medicine has been in a state of crisis for many years, with the overall quality of care continuing to deteriorate. In a 3-part series published in 2008, Giordano and Schatman discussed this crisis,[1–3] elucidating the notion that chronic pain care would not reach its potential if we failed to emphasize multidisciplinary care focused on the needs of patients. More than a decade later, it is quite apparent that our warnings were not heeded. Much of this failure has been related to the devolution of the "profession" of pain medicine to the "business" of pain medicine,[4] which has been due to numerous factors. These have included, but not necessarily been limited to, the malevolent dominance of the health insurance industry,[5,6] progressive corporatization,[7] fraudulent marketing,[8] indus-

Behavioral Management of Pain

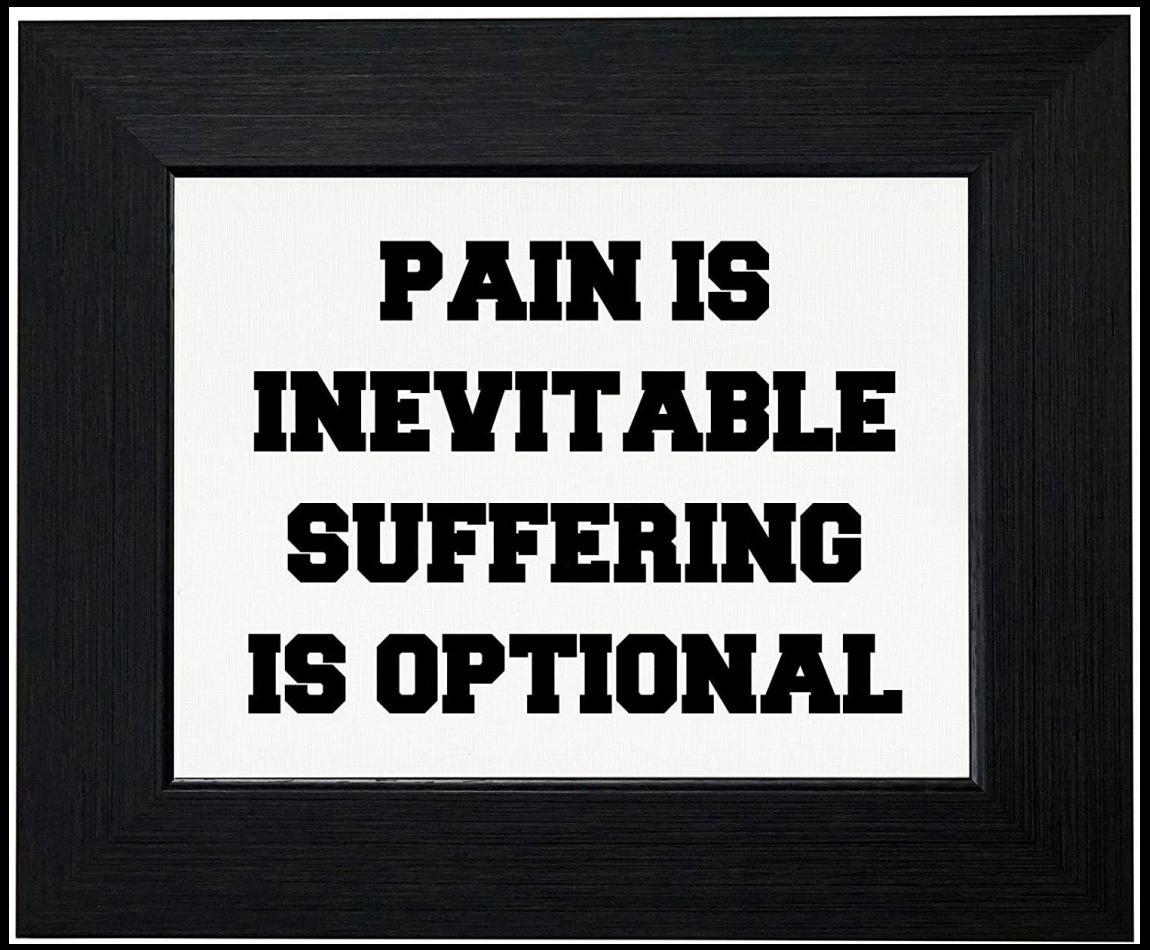
- It works!!!
  - Not a “cure”, but a group of treatments that improves emotional status and quality of lives, and results in more adaptive behavioral responses to pain
- Treatments include:
  - Operant conditioning (manipulating reinforcers)
  - Cognitive therapy (challenging/reframing cognitive distortions)
  - Acceptance and Commitment Therapy (ACT)
  - Mind-Body Approaches (progressive relaxation, diaphragmatic breathing, mindfulness, self-hypnosis training, biofeedback)
- All about active self-management rather than passive tx

Behavioral Management of Pain

- Other concerns:
  - Many patients are passive, and thus want passive treatment
  - Psychologists seen by some patients as the enemy, as an approach that's not "opioid-sparing" but "opioid-eradicating"
    - Some pain psychologists are members of the teams responsible for draconian, involuntary tapers
  - Untrained, unqualified therapists may call themselves "pain psychologists"
    - Unprotected term
    - Too often provide destructive treatment, not understanding the nuances of chronic pain

Pearl #4 for Rebalancing Pain Medicine

- Behavioral management of pain is effective, particularly in terms of reducing pain's behavioral and emotional sequelae. Until we train sufficient numbers of non-psychologist behavioral health professionals, quality services will be almost impossible to access, resulting in unbalanced chronic pain management, which should be biopsychosocial.



CAM and Management of Pain

- Defining CAM or “integrative medicine” is difficult to do
  - Some lists oddly include well-accepted behavioral treatments
  - Evidence-bases for many are not impressive, unless the research is done specifically in CAM journals as opposed to medical journals
  - Systematic review data on safety, efficacy and efficiency are all over the map, making it impossible to evaluate them accurately

Houzé B, et al. Prog Neuropsychopharmacol Biol Psychiatry. 2017;79(Pt B):192-205.

  - Insurers exploit this lack of clarity in the literature by simply refusing to cover CAM treatments, for the most part
  - Patients dissatisfied with traditional biomedical approaches continue to flock to CAM providers

CAM and Management of Pain

- Even though most LBP Guidelines include CAM, the quality of recommendations for CAM are weaker than for overall recommendations

Ng JY, Mohiuddin U. Eur Spine J. 2020;29(8):1833-1844.

- Higher SES associated with practitioner-guided CAM use, while low SES patients more likely to use of self-guided, free CAM

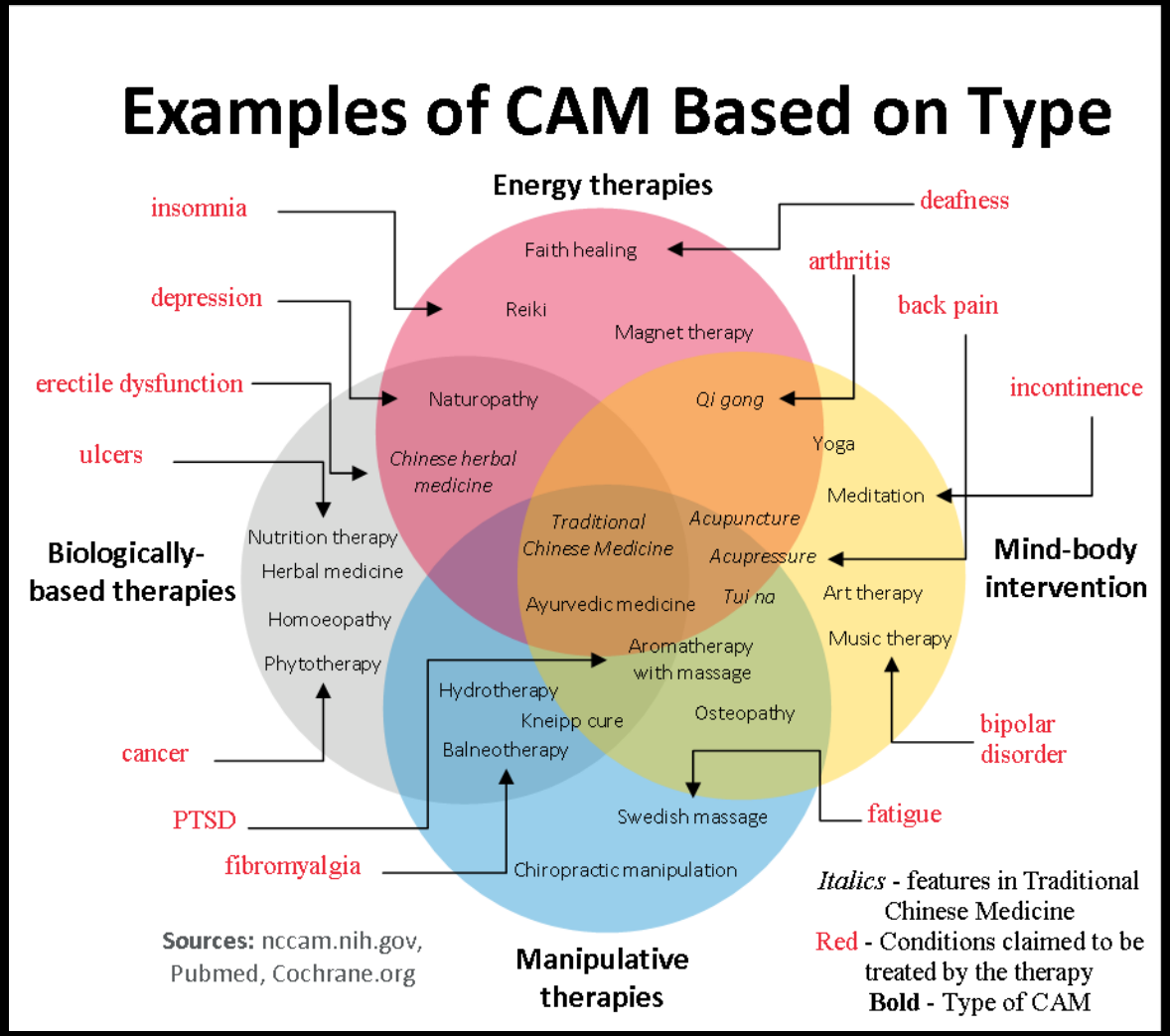
Ludwick A, et al. Pain Manag Nurs. 2020;21(2):142-150.

- 2017 data from National Center for Health Statistics:
  - 14.3% of US adults use yoga
  - 14.2% use meditation
  - 10.3% use chiropractic

Clarke TC, et al. NCHS Data Brief, No. 325, November, 2018. https://www.cdc.gov/nchs/data/databriefs/db325-h.pdf

Pearl #5 for Rebalancing Pain Medicine

- Some CAM treatments for some patients with chronic pain may be effective in some cases, but the empirical literature on their safety, efficacy and efficiency makes evaluation impossible. Insurers love this lack of clarity and conveniently use it as an excuse not to pay. Higher SES patients continue to access CAM treatments, irrespective.



Recommendations and Conclusions

- 2019 HHS reported noted the need for all classes of chronic pain treatments: medication, restorative, interventional, behavioral, and complementary & integrative approaches in single settings
  - Many chronic pain patients receive all of these, to varying degrees, but in a multidisciplinary rather than a coordinated interdisciplinary manner
  - The profit motive, particularly among insurers, is the primary cause of lack of coordination
  - This lack of coordination translates to a lack of balance

Recommendations and Conclusions

- And the lack of balance translates to unacceptable quality of chronic pain care
  - And needless suffering for countless millions of patients
- The Patient-Centered Medical Home (PCMH) is a framework for coordinated care first described in 1967 for treating children with chronic diseases

Pediatric records and a 'medical home'. Standards of Child Care. Evanston, IL: American Academy of Pediatrics; 1967.

- Applied to chronic pain patients in 2011, as it was noted that med students, residents, and physicians all saw them as "challenging"
  - Patient AND provider satisfaction were found to increase when applied

Evans L, et al. Fam Med. 2011;43(10):702-711.

Recommendations and Conclusions

- The model is interdisciplinary, with the PCP serving as the “hub of the wheel”
- Most feasible in a multispecialty medical center – as specialists are needed
  - Should not ALL medical care of complex patients ideally be provided in such settings? 🤔
- Proposed as a framework for reducing prescription opioid abuse and diversion by patients

Cheatle MD, et al. Transl Behav Med. 2012;2(1):47-56.

- Outcomes data, including for cost-efficiency, should be collected

Pryzbylkowski P, Ashburn MA. Anesthesiol Clin. 2015;33(4):785-793.

Recommendations and Conclusions

- Data suggest that the PCMH approach has also been effective in VAMCs

Kay C, et al. J Pain Res. 2018;11:1779-1787.

- But what about in independent private practice?

- Multispecialty group development should be a goal for practitioners who don't want to work for hospital corporations or in the public sector
  - Theoretically, they have more bargaining power with insurers

Weeks WB, et al. Health Aff (Millwood). 2010;29(5):991-997.

- Although likely not needed, as insurers are progressively embracing PCMH models, given the data on their cost-efficiency

Saynisch PA, et al. Med Care. 2021;59(3):206-212.

Recommendations and Conclusions

- CMS appears to be supportive of PCMH models, although some individual states' Medicaid programs have been resistant

Wilson EK, et al. J Gen Intern Med. 2020;35(11):3181-3187.

- But these programs will come around

- PCMHs reduce disparities in health care

Swietek KE, et al. J Gen Intern Med. 2020;35(8):2304-2313.

- These disparities are yet another force contributing to the unbalancing of pain medicine

Ghoshal M, et al. J Pain Res. 2020;13:2825-2836.

Recommendations and Conclusions

- PCMH models of chronic pain management will make treatment more biopsychosocial & BALANCED
- All that's required is that providers have the courage to step outside of their silos
- Remember – some silos are nuclear…..

THANK YOU