CARILION CLINIC
PAIN MANAGEMENT
2331 Franklin Rd | Roanoke VA 24014
selakhan@carilionclinic.org | 818-720-4860

February 16, 2018

Office of the Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200
opioids@finance.senate.gov

Dear Mr. Orrin G. Hatch,

We appreciate the opportunity to help inform your Committee on measures that may mitigate the development of opioid use disorder (OUD). We represent Carilion Clinic Pain Management in Roanoke, Virginia serving the southwest communities of our state that have been most affected by the opioid epidemic. We offer an integrative and comprehensive pain management service over a seven-hospital academic healthcare system. In our professional opinion, **we are less so in an opioid epidemic, but rather an epidemic of chronic pain**.

Below, please find our responses to your eight questions:

1. How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing Opioid Use Disorder?

Pain is hardly ever purely a physical phenomenon outside of the lab or operating room. Patients in chronic pain require attention to psychological, behavioral, social, and economic factors in addition to their physical states. This realization has led to the birth of an interdisciplinary team-based approach to chronic pain whereby team members and the patient are partners and collaborators towards functional goals. Treatment decisions are a shared process and made by consensus, there is collective accountability, and member roles complement each other. Through this integrated paradigm, chronic pain patients undergo coordinated care for the mind, body, and soul using pain medications, interventions, psychology, psychiatry, nutrition, nurse-based education, and integrative/complementary therapies.

The efficacy of interdisciplinary programs for pain has been well documented in the literature (see Turk for a review). The cost-effectiveness of such programs are also well studied and demonstrate reduced pain-related clinic visits in a HMO setting (Caudill et al., 1991), reduced subsequent hospitalization and surgeries (Turk & Okifuji, 1998), and pharamaceutical cost savings (Clark, 2009). In fact, opioids made up the majority of pharmaceutical costs at admission, and were the largest percentage cost decline at discharge with a 98% reduction (Clark, 2009). The lifetime savings of interdisciplinary programs for healthcare and disability is $356,288 per person compared to traditional medical therapy for chronic pain

(Gatchel & Okifuji, 2006). Unfortunately, many third-party payors still refuse to reimburse for chronic pain interdisciplinary programs and integrative therapies despite proven clinical efficacy and cost-savings.

The evidence base for the use of complementary and alternative medicine (CAM) in chronic pain management is on the rise. CAM therapies which include movement therapy, massage therapy, acupuncture, yoga, aromatherapy, and acupuncture are viable and efficacious non-opioid methods to minimize the risk of developing OUD. Unfortunately, there is neither consistent nor wide-spread insurance coverage for evidence-based CAM therapies for painful conditions including Medicare and Medicaid. Currently, CAM therapies are limited to patient's who can afford to pay out of pocket (Fleming et al., 2007) which is promoting further health inequity.

2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?

The most significant barrier to the use on non-pharmaceutical therapies for chronic pain is cost. CAM therapies are much less costly than traditional medicines, however, are not reimbursed by most medical insurances and the majority of the patients cannot afford to pay out of pocket. Additionally, there are certain conditions where the evidence-base for CAM is in its infancy. The limited use of non-pharmaceutical therapies when clinically appropriate is made worse by the lack of physician education on CAM therapies.

Without clearer evidence for quality outcomes and cost-effectiveness, some policymakers may be understandably hesitant to support some complementary non-pharmacological pain management therapies. Even when complementary services are explicitly recommended in practice guidelines, insurers have acknowledged the need for more research although they have not assisted with funding to facilitate studies (Dorr & Townley, 2016). There is an urgent need for healthcare provider, administrator, and policymaker education on CAM therapies and increased funding for CAM research projects on chronic pain.

3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening assessment, and treatment for OUD and other SUDs to improve patient outcomes?

Behavioral modification incentives can be used by Medicare and Medicaid to remove barriers and/or create incentives to ensure beneficiaries receive evidence-based prevention, screening assessment, and treatment for OUD and other substance use disorders (SUDs) to improve patient outcomes. These incentives range from offering points redeemable for rewards to monetary incentives. Additionally, to encourage participation from providers, the state can provide continuing medical education credits to them (Baltic, 2015). CMS can facilitate wellness programs that produce measureable and achievable patient outcomes involving evidence-based prevention, screening assessment, and treatment for OUD and other SUDs. These wellness programs must have great awareness, adequate incentives, and appropriate program tracking and evaluation of through randomized control trials that include cost-effectiveness analyses (Baltic, 2015). Nonetheless, these wellness programs can only be successful if barriers are likewise addressed (i.e. financial, cultural, access) (Healthy People 2020, 2018). For payment incentives to be beneficial, CMS can focus on what efforts are being expected of the recipients participating in the

programs and what is costing those recipients in order to participate. Overall, CMS can require multidisciplinary and interprofessional involvement in steering programs including public and population health to remove barriers and create incentives for beneficiaries.

4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?

There are changes to Medicare and Medicaid prescription drug program rules that can mitigate the risk of OUD and SUDs all the while promoting access to safe and appropriate opioid prescriptions. These changes include a national prescription drug monitoring program. Currently, statewide electronic databases gather information from pharmacies on dispensed prescriptions for controlled substances. Notably, not all statewide systems interoperate, there are inconsistencies state-by-state of who has access and what is reported, and the entire VA health-system is missing. Also, the CDC has developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings (CDC, 2017). Furthermore, the Virginia Board of Medicine has regulations from July 2017 on Drug Laws for Practitioners. Lastly, the National Council for Prescription Drug Programs has formed a strategic alliance with Experian Health to create a database incorporating patient demographic information and universal patient identifiers (Stember, 2017).

5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

In order to educate health professionals who have "high prescribing patterns of opioids", a system to monitor opioid prescribing practices must be in place. On a state level, these are prescription drug monitoring databases. The intent of the monitoring program should not be punitive. The worst situation can be that physicians drop a great deal of their opioid prescribing due to monitoring while not offering efficacious substitutions for pain management. This potential phenomenon may further doctor-patient mistrust and the feeling of abandonment, Further, it will lead to poorly controlled pain, may drive some illicit drug use, and ultimately burdens the entire system as these patients will seek care through other providers (usually through high-cost services like emergency care).

Simply reporting individual versus aggregate opioid usage data to healthcare providers may influence total prescriptions by the "nudge effect". However, a structured prevention and education strategy starts off with a baseline knowledge of pain -- what we refer to as "Pain 101". We are collaborating with the Department of Defense and the Defense and Veterans Center for Integrative Pain Management on this integrated curriculum that is intended not only for fellow providers, but patients and the community at large to elevate the discussions beyond media portrays of abuse and addiction, but the larger conversation around pain – self management, process of chronification from acute pain, multi-modal treatment options, and a focus on functional restoration.

6. What can be done to improve data sharing and coordination between Medicare, Medicaid and state initiative such as prescription drug monitoring programs?

In a nutshell, federal and state agencies need to interoperate and share data to tackle this nationwide and almost uniquely American epidemic.

7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

The traditional strategy of treating OUD is through:

- Access to naloxone for opioid overdoses
- Medication assisted treatment that combines medication with counseling and other therapies using these medications:
    - Methadone,
    - Buprenorphine,
    - Naltrexone
- Coverage for a wide range of treatment services including:
    - inpatient detoxification
    - partial hospitalization,
    - outpatient – follow up, PT , psychiatrists /psychologist, massage, acupuncturist,
- Case/care management

The best way to treat chronic pain is through interdisciplinary and interprofessional programs using integrative and comprehensive pain modalities. These include medications, injections, nutrition, physical activities, education, and integrative modalities. Central to this type of plan are the seven dimensions of wellness (physical, emotional, intellectual, occupational, social, spiritual and environmental), while changing the focus from pain relief to functional restoration. That is, restoring the activities that pain has prevented, rather than simply focusing on a number (e.g. reducing 10/10 pain to 4/10 without any real functional impact). These programs should be supported by research and education across the learning continuum (evidence-based pain medicine). We operate such a program in southwest Virginia called Carilion Clinic Pain Management in an area that has three of the top five cities with the highest opioid prescriptions per capita in America. Allow us to describe one successful patient story:

> We had a middle-aged man visit our program. The patient had been disabled by chronic headaches most of his adult life and saw virtually every local pain provider and neurologist. He was amongst the "walking dead" muted by chronic opioids. Accompanied by his wife, he felt more "informed" and "empowered" to manage his painful condition after his visit than his previous years/decades of care combined. With his wife of 20 years at the bedside and despite the blunting effects of opioids, the man wept profusely -- in a moment of catharsis, his tears symbolized a cleanse where his body was finally free from the rapture and curse of narcotics and his mind now working in partnership with our team. That can be called true "value"-based care.

8. What human services efforts (including specific programs or funding design models) appear to have effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

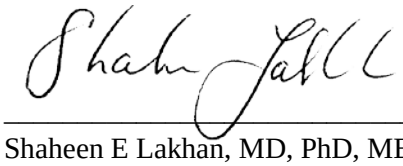
Colorado Medicaid implemented a policy change that limited the quantity of short-acting opioids that could be filled through the Medicaid benefit to no more than 4 tablets per day, or 120 tablets in 30 days.

Four types of prior authorizations (PAs) to allow tablet quantities above this limit were available as part of policy implementation. All PA requests required either prescriber or pharmacy initiation. Lifetime PAs were permitted for patients with sickle cell disease or terminal illness (e.g. cancer, receiving hospice or palliative care services) (Saggs, 2017).

In conclusion, we support the use of interdisciplinary pain management coupled with integrative/complementary approaches as non-invasive, efficacious, and cost-effective means to combat the opioid epidemic (aka epidemic of chronic pain).

Please feel free to reach out to us for any further input or discussion. Thank you.

Sincerely,



Shaheen E Lakhan, MD, PhD, MEd, MS, FAAN
Chief of Pain Management, Carilion Clinic
Adjunct Professor of Neuroscience, Virginia Tech

Contributors: Rachel Huddleston, MSN, RN-BC; Kanisha Nash; Shama Patel; Sunny Pydah, MBA; Harka Thapa; Tendai Ushe, BSN, RN-BC.

References

Baltic, S. (2015). Medicaid incentives worth the effort? Managed Healthcare Executive. 25(8):30-32.

Caudill M, Schnable R, Zuttermeister P, Benson H, Friedman R (1991). Decreased clinic use by chronic pain patients: response to behavioral medicine intervention. Clin J Pain. 7(4):305-10.

Centers for Disease Control and Prevention (CDC) (2017). CDC Guideline for Prescribing Opioids for Chronic Pain. Retrieved from https://www.cdc.gov/drugoverdose/prescribing/guideline.html

Clark ME. (2009). Cost-effectiveness of multidisciplinary pain treatment: are we there yet?. Pain Med. 10(5):778-9.

Dorr, H., Townley, C. (2016). National Academy for State Health Policy (NASHP). Chronic Pain Management Therapies in Medicaid: Policy Considerations for Non-Pharmacological Alternatives to Opioids. Retrieved 2018, from https://nashp.org/wp-content/uploads/2016/09/Pain-Brief.pdf

Fleming S, Rabago DP, Mundt MP, Fleming MF. (2007). CAM therapies among primary care patients using opioid therapy for chronic pain. BMC Complement Altern Med. 7:15.

Gatchel RJ, Okifuji A. (2006). Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain. J Pain. 7(11):779-93.

Healthy People 2020 (2018). Social determinants of health. Office of Disease Prevention and Health Promotion. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Saggs, K. (2017). Opioid Use for Pain Management after Implementation of a Medicaid short-acting opioid quantity limit. J Manag Care Spec Pharm. 23(3):346-354.

Stember, L. A. (2017). Lee Ann Stember, President National Council for Prescription Drug Programs. Chain Drug Review, 39(1):123.

Turk, D. (n.d.). Interdisciplinary Pain Management. Retrieved 2018, from http://americanpainsociety.org/uploads/about/position-statements/interdisciplinary-white-paper.pdf

Turk, D.C., Okifuji, A. (1998). Treatment of chronic pain patients: Clinical outcomes, cost- effectiveness, and cost-benefits of multidisciplinary pain centers. 10(2):181-208.