Pain Management Center of Excellence Model for
Reducing Members at High Risk for Opioid Overdosing and Preventing Those on the Path for High Risk

In order to address the opioid crisis and out-of-control costs associated with treating chronic pain, we propose that health plans incentivize a team based approach to evaluation and treatment of complex chronic pain patients. Pain care as usual in the Arizona medical community is:

1. Focused on procedures or medications, or sometimes a combination of both. It does not include evaluation of psychosocial factors that may interfere with good outcomes treating pain, evaluation of the social context of the patient, or co-treatment of behavioral factors along with medical and procedural management.
2. Directed by 1 provider who usually directly benefits financially from specific pain therapies recommended by that provider. In addition to creating a conflict of interest, current research shows that the "1 provider evaluation and decision-making model" produces a contextually appropriate care plan only 22% of the time when the patient has both medical and behavioral comorbidities[1]. Such comorbidities are ***always*** present in the complex pain patients who will make up the treatment population for this program.

The team based approach we propose brings together the medical, behavioral, and physical therapy core expertise that the literature clearly supports as important for treating complex chronic pain in a shared decision-making model that equally weights all providers' input and creates decision-making transparency not possible in the 1 provider model. The contextually appropriate care plan the team produces, and the integration of behavioral medical and physical treatment the team pursues, are requirements for effective treatment of behavioral health and physical comorbidities that together undermine efforts to safely taper opioids.

1. Define the population

- Members who have had chronic pain for > 3 months; and
- Members who have >20 MEDDs in the CSPMP (the CDC recommends referring opioid patients to specialists at 50 MEDD; the CSPMP only calculates the known dispensed and does account for the overwhelming number of people who are "self-medicating" for unchecked mental health reasons and taking more than their prescribed daily dosage – a parameter of 20 MEDDs, in conjunction with the medical and behavior evaluations described below, will not only catch the visible "high risk" members already in excess of 100 MEDDS, but it will also catch the "at risk" population using 50-100 MEDDs and ***prevent the path*** to high cost, high risk outcomes); and
- Members with a positive psychosocial screen using a standardized measurement tool (NSDUH identifies these members at elevated risk for misuse and abuse and self-medicating behaviors; NIDA and SAMHSA identifies them as vulnerable populations at elevated risk for accidental overdosing)
- Members with no active addiction disorder (i.e., those needing referrals out to MAT)

2. Define the exact services to be used within the COE
The following services would need to have a gold card on prior authorization for the COE to make this model successful; model would run per patient over a 6 month treatment cycle

- Initial medical and behavioral health evaluation with MD
- 2 follow up evaluations with MD
- 1 Physical therapy evaluation
- 6 follow ups with nurse practitioner for medication

[1] Listening for What Matters: Avoiding Contextual Errors in Health Care. Weiner S, Schwartz A. Oxford University Press 2016

- 6 Cognitive Behavioral Therapy session
- 12 acupuncture/chiropractic sessions
- 12 somatic experiencing sessions
- 10 physical therapy visits
- 3 urine drug screens

3. Estimated number to be served in one year

- 100 in Tucson (estimated 4 per week)
- 100 in Kingman (estimated 4 per week)

4. Proposed method of how to pay for it

- Case rate bundle of $6,934 per member (see chart below for cost breakout)
- The estimated case rate does not include procedures, (e.g., epidural injections, MRI, X-rays; imaging, non UDS lab testing) or consults with other specialty providers. These should be minimal, but they are idiographic to individual cases and hard to estimate on a case rate basis and would need to be paid as FFS.
- The shared decision-making model where the core team have input on whether a procedure is even needed cuts down on over-utilizing unnecessary procedures typically seen in "big block" clinics.

5. Projected total costs and cost savings

- COE Model: 200 members x $6,934 = $1,386,800
- Current Pain Management Model: 200 members x $35,000 (average yearly cost for the current status quo of multiple meds and over utilization of procedures) = $7,000,000
- Cost savings = $5,613,200

TEAM BASED PAIN CARE PROPOSAL: BUNDLED CORE SERVICES			
	Population:	>20 MED, pain >3 months, Postitive psychosocial screen	
	Duration:	6 months	
	SERVICES	COST	
1	**Behavioral Pain medicine in pain COE**	1299	
2	**Physician in pain COE**		
	eval	300	
	2 follow up visits*	200	
3	**NP medical management in pain COE**		
	6 follow up visits	600	
4	**Somatic Experiencing****		
	12 visits	1200	
5	**Accupuncture or Chiropractic**		
	12 visits	1200	
6	**Physical Therapy**		
	eval and 12 visits	1135	
7	**Team Conference x 1 (TDR***)**		
	BH	50	
	MD/NP	50	
	PT	50	
	PCP	100	
8	**Urine Drug Screening (x3 at 250 per test)**	750	
	Case rate	**$ 6,934**	For: 6 months treatment to includeMedical, BH, PT evaluation, 2 FU with MD, 6 FU with NP for meds, 6 CBT sessions, 12 accupuncture sessions, 12 SE sessions, PT 10 visits, TDR to include PCP BH MD NP physical therapist, and Urine drug screening.
	* to review testing, etc		
	** https://www.ncbi.nlm.nih.gov/pubmed/28585761		
	***http://www.ipcaz.org/transdisciplinary-rounds-program/		