

**Improving Access to Primary and  
Pain Care for Patients Taking  
Opioids for Chronic Pain in Michigan:  
Recommendations from an Expert Panel**

**July 2021**



## ACKNOWLEDGEMENTS

This project was funded by the Michigan Health Endowment Fund. We are deeply grateful to our panelists for their thoughtful, sustained engagement and to our facilitators for leading such rich discussions. We would also like to thank the following organizations, which provided invaluable guidance: the Institute for Healthcare Policy and Innovation at the University of Michigan, the Michigan Primary Care Association, and the Michigan Department of Health and Human Services. Finally, we would like to thank the researchers and research staff who contributed to this report.

## DISCLAIMER

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## SUGGESTED CITATION

Lagisetty, P., et al. (2021). *Improving Access to Care for Patients Taking Opioids for Chronic Pain in Michigan: Findings from an Expert Panel*. Retrieved from <https://dx.doi.org/10.7302/1699>.

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## EXECUTIVE SUMMARY

This multidisciplinary expert panel was convened to generate recommendations to address the limited access to care that patients experience when taking opioids for chronic pain. Recent policies and guidelines instituted to reduce inappropriate opioid prescribing have had unintended consequences for the 5-8 million patients taking long-term opioid therapy for chronic pain in the U.S. As providers discontinue prescribing and turn away patients dependent on opioids, this population faces limited access to both primary and pain-related care. The root causes of this access issue can be attributed to several overarching barriers, including new opioid-related policies, payment models, a lack of care coordination, stigma, and racial biases.

Over multiple rounds of deliberation, the panel brainstormed possible solutions, considering feasibility, impact, and importance, and ultimately ranked their final recommendations in order of implementation priority. The final list included 11 recommendations, from which three overarching themes emerged:



### **Improving care models to better support patients with chronic pain**

Three recommendations involved improving care models, including the top two: increasing reimbursement for the time needed to treat complex chronic pain and establishing coordinated care models that bundle payments for multimodal pain treatment.



### **Enhancing provider education and training**

Four recommendations involving provider education efforts received slightly lower rankings and included training on biopsychosocial factors of pain care and clarifying the continuum between physical dependency and opioid use disorder.



### **Implementing practices to reduce racial biases and inequities**

The remaining four recommendations address racial biases and inequities, ranging from standardizing pain management protocols to reduce bias to increasing recruitment and retention of providers from underrepresented racial minorities.

Throughout the process, panelists emphasized the interconnectedness of their proposed solutions, and indicated that multiple approaches are likely needed to meaningfully improve access to care for this patient population. Importantly, though this panel was convened in Michigan, and its expertise grounded in Michigan's healthcare ecosystem, there are millions of patients taking opioids for chronic pain across the country, and reports of limited access to care are not unique to Michigan. Consequently, there may also be opportunity to apply these recommendations more broadly, in other states and at multiple levels of the United States healthcare system.

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# 1. INTRODUCTION

## 1.1 BACKGROUND: UNINTENDED CONSEQUENCES

Drug-related overdoses continue to climb in the U.S., with an estimated 90,000 deaths in 2020,<sup>1,2</sup> despite a decades-long, nationwide effort to limit and reverse rising numbers of opioid-related deaths. In recent years, numerous states have passed laws to combat opioid-related harms by reducing inappropriate prescribing. These laws require specific clinical practices, such as mandatory checks of prescription drug monitoring programs, and place strict limits on dosages and durations prescribed.<sup>3</sup> The enactment of these policies has been associated with declines in opioid prescribing,<sup>4</sup> but many stakeholders have expressed concern that such broad efforts may also be unintentionally leading providers to restrict ethical care for patients receiving long-term opioid therapy (LTOT) for chronic pain. As a result, these patients may face inappropriately rapid tapering or discontinuation of their dosages and uncontrolled pain.<sup>5,6</sup> Though there has been significant attention and funding directed to preventing and improving care for patients with opioid use disorder (OUD), there has been relatively less attention paid to these “forgotten” patients with chronic pain on LTOT.

Nationally, an estimated 5-8 million adults receive LTOT to treat chronic pain.<sup>7</sup> In response to state and federal laws that limit and sanction opioid overprescribing, some physicians have reduced or stopped prescribing opioids. This has been associated with reports of patients—who have developed physical dependence on opioids—struggling to find new providers willing to treat them.<sup>8,9</sup> Recent studies, both in the State of Michigan and nationally, have found that over 40% of primary care clinics would not accept a new patient who was taking opioids for chronic pain.<sup>10,11</sup> This situation can be emotionally distressing, both for patients, who may confront withdrawal and uncontrolled pain without being able to find a new provider, and physicians, who may feel ill-equipped to provide care to patients taking opioids for chronic pain.

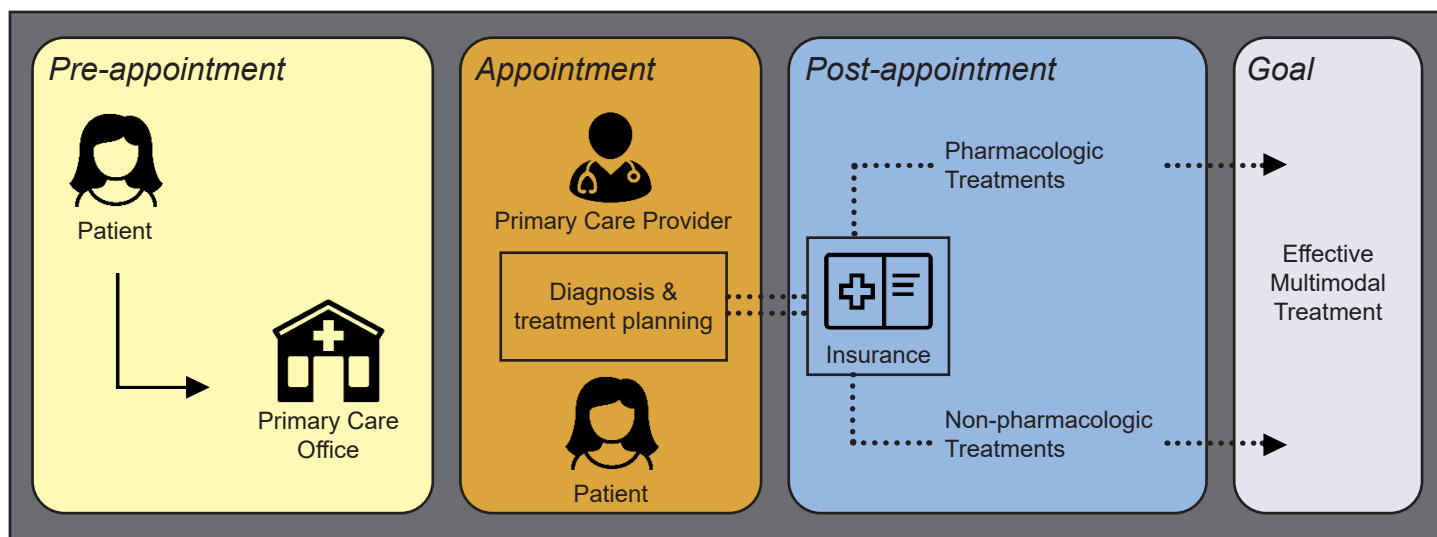
Below is an example of how barriers to care might arise for a patient receiving long-term opioid therapy:

*Mrs. Smith, a 65-year-old, started receiving oxycodone for a back injury 7 years ago and is now taking high doses. She also has co-morbid depression and diabetes that are managed by her primary care clinic. Dr. Johnson is concerned that Mrs. Smith may be misusing her prescriptions because she calls frequently to request early refills. Mrs. Smith, however, attributes requesting early refills to her worsening pain, which led her to take more than the prescribed number of pills.*

*Dr. Johnson feels that he does not have the time or skills to safely manage Mrs. Smith’s opioid prescription for her pain and states that he will no longer prescribe opioids to Mrs. Smith. Mrs. Smith feels abandoned and frightened by this decision. She calls two primary care clinics to see if she can find a new doctor and is notified that they are not taking new patients on opioids. She calls a pain clinic and is told that they do not have openings for patients who “need pills” and are only accepting new patients with a referral for procedures like injections. She does not seek behavioral health support, such as addiction services, because she does not identify herself as having a substance use disorder.*

Patients with pain also face barriers to receiving non-opioid pain treatments, such as behavioral health and non-pharmacologic pain care. According to a 2019 report from the US Department of Health and Human Services, ideal pain care is multimodal, involving a combination of medications, behavioral health care, restorative therapies (e.g. physical therapy), complementary and integrative health, and interventional approaches (e.g. injections).<sup>12</sup> Unfortunately, many patients do not have ready access to this full range of treatments. In a study of pain clinics in Michigan, 48% did not accept Medicaid and 51% required a referral before accepting new patients.<sup>13</sup> Obtaining a referral could prove particularly difficult for a patient population that struggles to secure primary care appointments, as has been found of patients on LTOT.<sup>10,11</sup> Even with an appointment, only 10% of pain clinics offered a combination of interventional approaches, medication management, and behavioral therapy.<sup>13</sup> With challenges in finding primary care doctors and limited pain care services available even with a referral, many patients taking opioids for chronic pain are likely not receiving appropriate, effective, timely, or high-quality care.

The progression through primary care to specialty pain care can be visualized using the following figure (adapted from Slat et al. 2021).<sup>14</sup>



**Figure 1.** Conceptual model showing a patient's progression through primary care, adapted from a recent qualitative study of patient and provider experiences.<sup>14</sup>

## 1.2 BARRIERS TO CARE

The lack of access to care arises out of the interaction between several complex and interrelated factors, which can be described as five overarching barriers:

### Policies

Government and payer policies around opioid prescribing add significant administrative burden and fear of litigation, which may reduce providers' willingness to treat this patient population.<sup>8,15</sup> For example:

- ▶ In Michigan, a provider must educate patients about possible risks, obtain a signed "Opioid Start Talking" form, and check the Michigan prescription drug monitoring program) before prescribing an opioid medication.<sup>16</sup> The state licensing board has authority to sanction providers found to be in violation of state policies.
- ▶ The largest private insurer in Michigan requires prior authorization when an opioid prescription exceeds a specific daily dosage threshold<sup>17</sup> and limits opioid prescriptions to a 30-day supply.<sup>18</sup> (In Michigan, patients without such insurance-mandated limits can receive up to a 90-day supply of opioids, though federal law prohibits refills, necessitating frequent renewals.<sup>19,20</sup>)

### Payment Models

Current coverage and reimbursement structures provide insufficient provider compensation or insurance coverage for multimodal pain management, disincentivizing the provision of comprehensive, effective care and restricting patient access.

- ▶ Primary care appointments typically last less than 20 minutes.<sup>21</sup> Providers say they do not have time in a primary care appointment to fully address complex issues, such as chronic pain and opioid management, or to coordinate multidisciplinary care.<sup>14</sup>
- ▶ Reimbursement for procedural treatments, like injections, tends to exceed reimbursement for physical therapy or other non-pharmacologic alternatives like massage and acupuncture. Furthermore non-pharmacologic alternatives can often require multiple lengthier visits. This incentivizes the provision of pharmacotherapy and interventional procedures,<sup>12,22</sup> and it likely contributes to a workforce shortage of providers of alternative pain therapies. Moreover, many insurance plans do not cover alternative therapies, such as acupuncture or biofeedback, which are prohibitively expensive for patients to pay for out-of-pocket.<sup>23,24</sup>



## Lack of Care Coordination

A lack of coordination between providers leads to gaps in effective pain care and places additional burden on the patient to manage multiple opinions and treatment plans.<sup>12</sup>

- In many care settings, pain management is not provided through a coordinated and multidisciplinary model. For example, specialty pain clinics are scarce in the US, and many do not offer multidisciplinary care.<sup>13,25</sup> Instead, care is fragmented, multiplying the difficulty and cost patients face in accessing multimodal treatment.
- Lack of provider communication may result in redundant, insufficient, or incoherent treatment plans.<sup>14</sup>

## Stigma

Stigma around chronic pain and substance use disorders (SUD) make it difficult for this patient population to find a primary care doctor or receive quality care when they do.

- Patients with chronic pain describe providers not believing their accounts of pain<sup>26</sup> or assuming that the patient is experiencing SUD, particularly when patients are taking opioids.<sup>27,28</sup>
- Providers can be reluctant to take on patients with suspected SUD. In a multistate study, primary care clinics were less willing to accept a new patient taking opioids for chronic pain if their history was suggestive of misuse than if their previous physician retired.<sup>11</sup> Though some patients do experience comorbid pain and SUD, turning patients away does not effectively treat either condition.

## Racial Inequities

Patients experience inequities in pain treatment depending on their race or ethnicity.<sup>29</sup>

- Some doctors believe that there are lower pain tolerances among nonwhite patients than among white patients and underestimate the amount of pain that patients of color experience.<sup>30</sup> This is also reflected in unequal pain care: Black and Hispanic patients are less likely to receive opioid medication,<sup>31,32</sup> are more likely to receive lower doses of pain medication,<sup>33</sup> and experience longer wait times than white patients.<sup>34</sup>
- Non-white patients are also more likely to be perceived as “drug seeking” when pursuing pain-related treatment,<sup>30</sup> which likely contributes to inequities in care. Black patients, compared to white patients, receive more referrals for SUD assessment, fewer referrals to pain specialists, and increased urine drug testing,<sup>35</sup> potentially indicating increased provider suspicions of SUD.

These overlapping barriers arise from multiple facets of the existing healthcare system. **In order to provide more equitable and ethical care to patients taking opioids for chronic pain, these barriers must be considered and addressed by numerous stakeholders and participants in the healthcare system.** To begin this process, we convened an expert panel of stakeholders from across the State of Michigan to generate a set of recommendations that could address these barriers and improve access to care for patients taking opioids for chronic pain.

## 2. APPROACH

To identify possible avenues to address the above barriers, we convened a panel of 24 experts from across the State of Michigan between September 2020 and January 2021. The panel represented a broad range of perspectives, including policymakers, insurers, providers, patient advocates, and researchers (see full list on p. 2). Figure 2 shows each panelist’s primary identification.

The panel was organized using the RAND UCLA modified Delphi process, which has components of both the nominal group technique and Delphi process.<sup>36</sup> Due to the coronavirus pandemic, the panel was conducted virtually, convening for two synchronous meetings with background materials and surveys sent before and after meetings (see Figure 3).

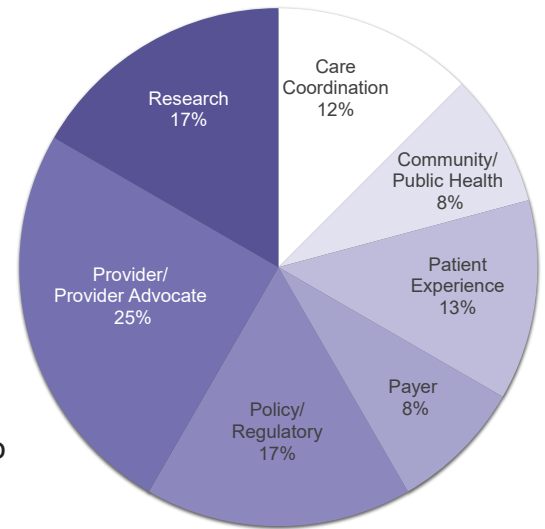
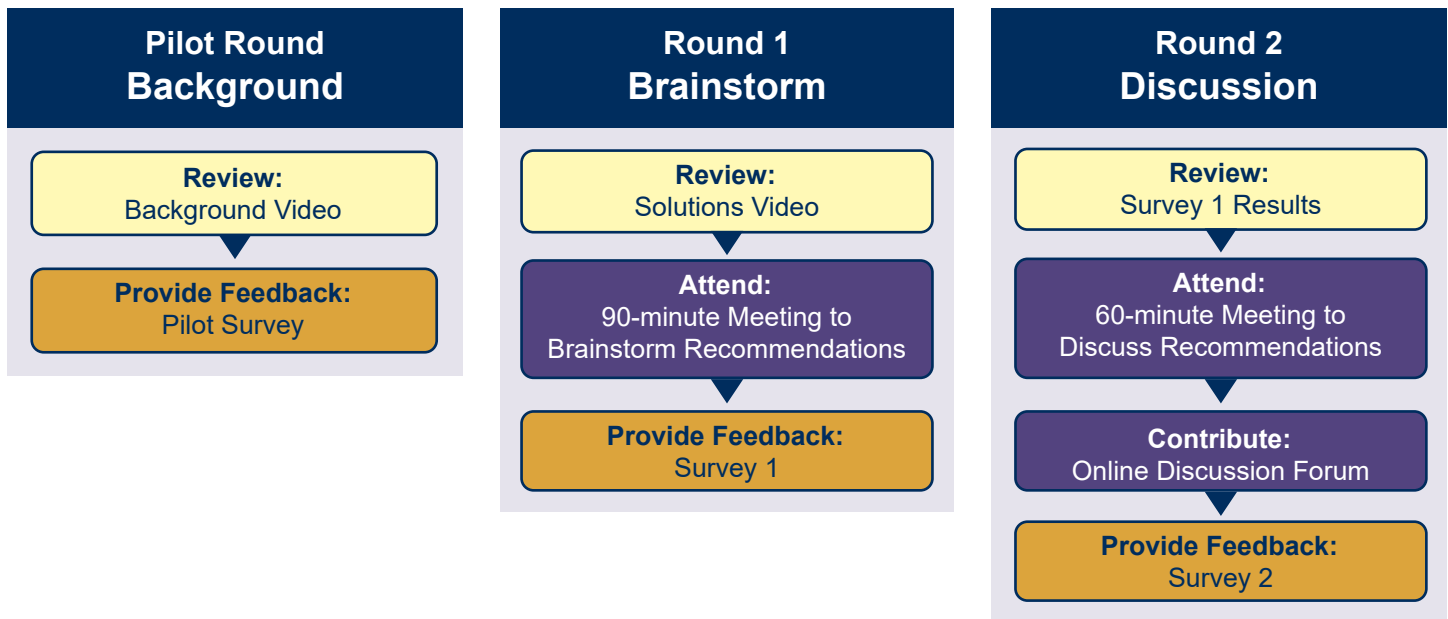


Figure 2. Composition of the expert panel.

### Pilot Round: Background

Prior to the first meeting, panelists were sent two video briefs presenting 1) background information on barriers to multimodal care ([click here to view on Youtube](#)) and 2) possible solutions to these barriers that have been implemented in Michigan or elsewhere ([click here to view on Youtube](#)). They were also surveyed on the scope and aims of the panel. At this stage, panelists overwhelmingly affirmed that access to care was an important issue. They also recommended the addition of a specific barrier around racial inequities in care, which was not initially part of the background materials, and endorsed the importance of the other four identified barriers: policy, payment models, lack of care coordination, and stigma.

Figure 3. Structure of the Modified Delphi panel.



## Round 1: Brainstorm

At the first meeting, the panel was divided into five groups with each group asked to brainstorm on one of the barriers to long-term opioid therapy (LTOT) care noted above (i.e., policy, payment models, lack of care coordination, stigma, and racial inequities). These sessions were facilitated by study team members. Each group was then asked to develop a set of recommendations related to policies, interventions, or research questions that would address the identified barriers to care. For each recommendation, the responsible group was to provide the entire panel information on: (1) how the recommendation would address the barrier; (2) who or what populations would the recommendation serve; and (3) the major challenges (e.g., feasibility, cost) or potential negative outcomes that might arise from implementing the recommendation.

Following the meeting, the panel independently rated the feasibility, impact, and importance of each of the 15 initial recommendations on a 9-point Likert scale, with scores of 1-3 defined as a low rating, 4-6 a moderate rating, and 7-9 a high rating. These characteristics were defined as follows:

### 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

## Round 2: Discussion

Panelists then participated in a second virtual meeting. At this meeting, they received a list of all Round 1 recommendations with an average importance score of 6 or greater (n=13; Recommendations B and C in Appendix were excluded from further consideration). For each recommendation, panelists could see the distribution of scores for each critical area (i.e., feasibility, impact, and importance) as well as their personal rating from Round 1. They discussed each recommendation again, both during the second virtual meeting and on a multi-day online discussion board following the virtual meeting. After this round of discussion, 3 recommendations which overlapped in content and scope were consolidated into a single recommendation (see Recommendations D, F, and J in Appendix). Finally, panelists independently rated the final 11 recommendations on feasibility, impact, and importance a second time and ranked all recommendations in order of implementation priority.

Upon completion of the final rating and ranking, the research team noted similarities in the objectives and mechanisms of the 11 final recommendations and grouped them into three thematic domains. To describe the relative prioritization of these three thematic domains, the research team pooled and averaged all panelist rankings for the recommendations within each theme.

### 3. PANEL RECOMMENDATIONS AND FEEDBACK

The panel ultimately generated 11 recommendations that could potentially improve access to care (see Table 1). The panelists' median scores of recommendation feasibility ranged from 5.5 - 7, impact from 5 - 8, and importance from 5.5 - 9. All median scores fell at or above the midpoint of the rating scale (5), which suggests that the panel considered all recommendations to be moderately to very feasible, impactful, and important. The panelists' priority rankings for each recommendation were averaged to yield the final ranked list, and recommendations were grouped into three thematic domains (see thematic groupings in Table 1 on the following page):

#### 3.1 THEMES



##### **Improving care models to better support patients with chronic pain**

Three recommendations involved improving care models, including the top two: increasing reimbursement for time needed to treat complex chronic pain (#1) and establishing coordinated care models that bundle payments for multimodal pain treatment (#2). On average, recommendations in this theme received the highest priority rankings (pooled average rank = 4.2/11).



##### **Enhancing provider education and training**

Four recommendations focused on provider education and included training on biopsychosocial factors of pain care (#3) and clarifying the continuum between physical dependency and opioid use disorder (#5). These recommendations received slightly lower priority rankings (pooled average rank = 6.2/11).



##### **Implementing practices to reduce racial biases and inequities**

The remaining four recommendations address racial biases and inequities (pooled average rank = 7.2/11), ranging from standardizing pain management protocols to reduce bias (#7) to increasing recruitment and retention of providers from underrepresented racial minorities (#8).

### 3.2 RANKINGS

**Table 1.** Final list of recommendations in order of priority ranking, with median ratings of feasibility, impact, and importance. Colors indicate thematic domain as follows:

Blue: Improving care models	Yellow: Provider education	Orange: Addressing racial bias and inequities		
Final Rank	Recommendations to Improve Access to Care	Median Rating		
		Feasibility	Impact	Importance
1	Establish reimbursement models for chronic pain to provide appropriate compensation for all care providers, such as psychologists, physical therapists, physician assistants, nurse practitioners, social workers, and physicians, who treat and manage patients with complex pain.	6	8	9
2	Create a collaborative/integrated care model expanding upon the existing Michigan Medicaid Health Home model to include patients with chronic pain who are publicly and privately insured.	6	8	7.5
3	Train members of the clinical team, such as social workers, to help address biopsychosocial factors and ongoing management of chronic pain treatment.	7	7	7
4	Improve dissemination of evidence related to multimodal and non-pharmacological treatments for pain and their effectiveness to encourage expanded insurance coverage.	7	6.5	7
5	Deliver an educational curriculum that explains the continuum between addiction and physical dependency on long-term opioid therapy for chronic pain to all personnel who interact with patients (providers, clerical staff, etc.) to encourage appropriate patient-centered care and reduce stigma.	7	6	7
6	Improve education on multimodal and non-pharmacological therapies for chronic pain management (and chronic pain in general) for healthcare providers, including both at the level of health professional school and continuing medical education.	7	6	7
7	Implement standardized pain management protocols that include mandatory reporting to provide more objective data on pain management across races and ethnicities.	5.5	6	6
8	Increase recruitment and retention of providers from underrepresented racial and ethnic minorities across clinical duties (e.g., physicians, nurse practitioners, social workers) including by providing appropriate financial compensation and incentives if practicing in under-resourced communities.	6	8	8
9	Make providers aware of how Michigan's prescription drug monitoring program data is used in investigating and disciplining providers.	7	5	5.5
10	Develop implicit bias training to improve patient-provider communication around pain.	7	6	6
11	Evaluate and describe where individuals belonging to minority racial and ethnic groups prefer to receive health-related information and community institutions they look to for support in healthcare decisions.	7	7	6.5

## 3.2 DETAILED DESCRIPTIONS AND DISCUSSION SUMMARIES

Recommendations are described in greater detail below, including a one-sentence overview, a more detailed recommendation description that panelists collaboratively generated, and a researcher-written summary of the panel's discussion. The language of each recommendation summary and description was developed through iterative discussions and reflects the collective perspective and expertise of the panel. Expert panel discussion summaries provide information about the main topics considered while the panel created and reviewed each recommendation.

### **1** Establish reimbursement models for chronic pain to provide appropriate compensation for all care providers, such as psychologists, physical therapists, physician assistants, nurse practitioners, social workers, and physicians, who treat and manage patients with complex pain.

**Detailed Description:** Visits for chronic pain are often complex and require significantly more clinical time than other conditions. Currently, members of pain-related care teams (e.g. clinical pharmacists, nurses, social workers) do not receive reimbursement specifically for their services, and physicians and other billable providers can be reluctant to manage patients with chronic pain because it is so time-intensive. Different reimbursement models, such as value-based reimbursement and billing modifiers, may incentivize the provision of time-intensive and personnel-intensive care, from both physicians and other care team members, and lead to increased access to quality, full-team care.

**Discussion Summary:** During the panel discussion, there was some concern about the difficulty of reaching a common understanding of what types of coverage increased “value” and that the meaning of “value” could differ between stakeholder groups (e.g. patients and insurers). Similarly, some panelists thought insurers might be reluctant to increase reimbursement due to the cost or would want robust evidence of cost-effectiveness. Interestingly, panelists with insurance expertise were more confident than other panelists that insurers would, in fact, be willing to shift their existing reimbursement structures to drive provider behavior change.

## 2 Create a collaborative/integrated care model expanding upon the existing Michigan Medicaid Health Home model to include patients with chronic pain who are publicly and privately insured.

**Detailed Description:** Currently, patients may not be encouraged to pursue non-pharmacologic treatment modalities or be counseled on whether opioid medications are effective or safe long term (tolerance/dependence). In the existing Michigan Medicaid Opioid Health Home model, which is funded through Michigan Medicaid and focused on treating patients with opioid use disorder (OUD), patients are provided intensive support, including case management (for more information on Michigan Opioid Health Homes, [click on this link](#)). Patients are presented with all available resources and treatment options at one time and provided support in navigating integrated care across multidisciplinary providers (e.g. transitional care and referral to community and social services). Interested health systems and providers can apply for Health Home designation status to receive funding to support these staff, such as a director, behavioral health specialist, and peer recovery coach. The panel recommended expanding the existing model in Michigan to include patients with chronic pain, which has been included as a qualifying condition for Medicaid-funded health home care models in at least 5 states (Iowa, Missouri, New York, South Dakota, and Washington).<sup>37,38</sup> This would ensure that these multimodal therapies are easily accessible before the patient becomes physically dependent on opioids.

**Discussion Summary:** Panelists noted that private payers could fund similar structures to expand this care model further. Noted challenges with this recommendation included securing funding from public or private insurers, having an adequate workforce to staff the model, and needing different types of providers in a care team (e.g. physical therapists) to provide pain-focused care that the current OUD-focused model does not utilize.

## 3 Train members of the clinical team, such as social workers, to help address biopsychosocial factors and ongoing management of chronic pain treatment.

**Detailed Description:** This would address prescriber concerns about being unable to adequately support and monitor patients using long-term opioid therapy from a physical and mental health perspective. These additional staff would provide support for ongoing pharmacologic treatments, such as opioid therapy, as well as non-pharmacologic treatments, such as behavioral interventions. When appropriate, these team members could also identify and refer patients to address issues such as housing and behavioral health concerns.

**Discussion Summary:** Panelists did note that training and, where necessary, hiring these staff members could pose a challenge to implementation, particularly within existing reimbursement models that do not typically cover such assistance. Therefore, this recommendation is closely related to Recommendation #1 in that the staff, once trained in managing biopsychosocial factors, must also be reimbursed for their time.

## 4 Improve dissemination of evidence related to multimodal and non-pharmacological treatments for pain and their effectiveness to encourage expanded insurance coverage.

**Detailed Description:** Insurers are more likely to provide coverage and increase reimbursement for services that are evidence-based and cost-effective. Therefore the objective of this recommendation is to disseminate information regarding the efficacy of multimodal and non-pharmacologic treatments to insurers to potentially improve coverage for such treatments.

**Discussion Summary:** Initially, there was some disagreement among panelists as to whether evidence of treatment effectiveness already exists in systematic reviews and whether the existing data is robust. However, upon further discussion, there was agreement that the existing evidence base needs to be conveyed to insurance companies to inform coverage changes. There was some concern that some non-pharmacological treatment modalities can be quite expensive, and insurers may be unwilling to cover these high-cost treatments even with evidence of effectiveness. Similarly, panelists voiced hesitancy about the transparency of insurers' cost-effectiveness determinations. Finally, several panelists brought up persistent disbelief among providers as to the effectiveness of these treatments, which could potentially limit engagement even with increased coverage. Ultimately panelists felt that there may be a knowledge gap more so than a lack of evidence for such treatments, and the evidence therefore needs to be relayed to insurers to encourage expanded coverage.

## 5 Deliver an educational curriculum that explains the continuum between addiction and physical dependency on long-term opioid therapy for chronic pain to all personnel who interact with patients (providers, clerical staff, etc.) in order to encourage appropriate patient-centered care and reduce stigma.

**Detailed Description:** Providers, staff, and even patients may equate prescribed opioid treatment with addiction because of a lack of knowledge about the differences between addiction and physical dependence. Some providers who prescribe opioids appropriately have suggested that they feel stigmatized or judged by their colleagues. Within electronic medical records systems, patients prescribed long-term opioid therapy may incorrectly be labeled as having an opioid use disorder (OUD). An educational intervention that explains the differences between physical dependence and addiction and the harms of incorrect assumptions can address these stigmatizing ideas. This could also clarify best practices for patients who have comorbid OUD and chronic pain.

**Discussion Summary:** There was some concern among panelists that this type of educational intervention could be too simplistic, and, in trying to categorize patients as having either pain or OUD, ultimately further stigmatize patients with OUD. This stigma could then potentially manifest, counterproductively, as worse pain care for patients who have *both* pain and OUD. Furthermore, panelists acknowledged that it can be challenging to develop and implement effective educational campaigns that reduce provider stigma and change behavior.



**6 Improve education on multimodal and non-pharmacological therapies for chronic pain management (and chronic pain in general) for healthcare providers, including both at the level of health professional school and continuing medical education.**

**Detailed Description:** Providers may not have a solid understanding of the efficacy of non-pharmacological treatments and how to guide patients towards these treatments. By educating providers on how to diagnose chronic pain, the treatment options, and how to use them effectively, more treatment modalities could be provided in more care settings outside of specialty pain clinics. This educational intervention would not only apply to physicians but to all members of the care team. This could help address misconceptions and stigma about patients with chronic pain, especially around disbelief of pain or assumptions of addiction.

**Discussion Summary:** Panelists did note that these existing attitudes and misconceptions are deeply entrenched and could be difficult to overcome. Also, it could be difficult to design effective and comprehensive curricula because pain management is often quite complex and individualized.

**7 Implement standardized pain management protocols that include mandatory reporting to provide more objective data on pain management across races and ethnicities.**

**Detailed Description:** Systematic protocols, such as screening and management checklists, may reduce individual provider biases in pain treatment and variation across providers. Mandatory reporting of treatment data may increase data transparency with respect to racial outcomes and demonstrate potential areas for improvement.

**Discussion Summary:** Panelists noted that developing and implementing these protocols would require financial resources, and it can be challenging to design protocols that are directive enough to provide consistent care without being so rigid as to be misapplied in inappropriate treatment situations.

## **8 Increase recruitment and retention of providers from underrepresented racial and ethnic minorities across clinical duties (e.g., physicians, nurse practitioners, social workers) including by providing appropriate financial compensation and incentives if practicing in under-resourced communities.**

**Detailed Description:** Patients from minority racial and ethnic groups often feel more comfortable and experience less racial discrimination when treated by a provider of the same race. However, there is concern about the limited representation of racial minorities among providers who treat this patient population. This problem is multifactorial and includes both recruitment of people from underrepresented racial minority groups into health professional programs and retention of health professionals from underrepresented racial minorities working in areas with limited healthcare resources. This would be addressed by first recruiting more providers from underrepresented racial minorities into health professional programs. Once trained, it would also be important to support and incentivize these providers to practice in communities that face racial bias and disparities in care.

**Discussion Summary:** Panelists noted that it could be challenging to secure consistent funding for incentive programs, and the effectiveness of recruitment efforts could be limited by ongoing disputes over affirmative action.

## **9 Make providers aware of how Michigan's prescription drug monitoring program data is used in investigating and disciplining providers.**

**Detailed Description:** Michigan's prescription drug monitoring program is an online database providers use to keep track of prescriptions for controlled substances. There is currently confusion about how and when prescription data are used to investigate and possibly sanction providers. Both physicians and patients have noted that providers are fearful of being sanctioned for prescribing opioids. By clarifying when and how prescription data are actually used in licensing investigations, an awareness campaign may reduce provider fears of sanction, and therefore reduce inappropriate under-prescribing. This awareness intervention will focus specifically on how this data is monitored with respect to legal consequences for providers and not be focused on general use of the platform. Reducing provider reluctance to treat this population will consequently increase access to providers for patients receiving long-term opioid therapy.

**Discussion Summary:** Some panelists felt that this would not be effective because there has already been extensive provider training about how to use Michigan's prescription drug monitoring program, and additional efforts to clarify its use could add administrative burdens to prescribing, further limiting patient access to care. It is also unclear whether increased awareness around actual data use would change provider perceptions about the legal ramifications of opioid prescribing or consequent willingness to prescribe.

## 10 Develop implicit bias training to improve patient-provider communication around pain.

**Detailed Description:** Implicit bias training would help address cultural barriers in patient-provider communication. Reducing provider bias and improving communication may make health services seem more accessible to patients from racial and ethnic minority groups, and may thereby improve treatment outcomes.

**Discussion Summary:** Panelists recognized that these trainings can become a “checkbox” for organizations, and may not be effective in their implementation or intended outcomes. Also, developing and implementing these trainings would require an investment of health system resources.

## 11 Evaluate and describe where individuals belonging to minority racial and ethnic groups prefer to receive health-related information and community institutions they look to for support in healthcare decisions.

**Detailed Description:** As a first step to improve healthcare engagement with racial and ethnic minority communities with limited access to healthcare resources, more research is needed to identify trusted anchor institutions and preferred information delivery mechanisms. With this data, community outreach and treatment education efforts can then be tied to and focused on these trusted institutions (e.g churches).

**Discussion Summary:** Panelists noted this type of data could be challenging to collect, and both the initial research and any resulting implementation strategies would require funding. There was some disagreement among panelists as to whether the initial evaluation of how to disseminate healthcare-related information was necessary. Some argued that funding should instead be invested directly into engagement efforts, and that there was already sufficient information about effective engagement channels.

## 4. DISCUSSION

As stakeholders consider these recommendations, it is worth noting that policies and interventions similar to those the panel recommended have been implemented in other contexts. Examples are provided below:



### Improving care models to better support patients with chronic pain

On restructuring care models, five states—Iowa, Missouri, New York, South Dakota, and Washington—currently list some type of chronic pain as a qualifying condition for their Medicaid Health Homes, granting patients in those states access to a more coordinated care model.<sup>37,38</sup> Colorado has increased Medicaid coverage of non-opioid pain management, including by increasing reimbursement rates for physical therapy, which led to more physical therapists accepting Medicaid and more physical therapy services rendered to patients.<sup>39</sup> Oregon has added coverage for acupuncture, chiropractic services, osteopathic manipulation, cognitive behavioral therapy, and physical therapy for Medicaid beneficiaries with back and neck pain, affecting approximately 50,000 Oregonians.<sup>40</sup> In Michigan, private insurers have used modifiers, a billing increase tied to providing “additional” care, to drive provider behavior change around opioid prescribing. Blue Cross Blue Shield of Michigan successfully used this tool to encourage surgeons to counsel patients about opioid pain management and prescribe fewer opioids after surgery. The program resulted in surgeons counseling patients and reducing opioid prescribing in 70% of eligible surgeries.<sup>41</sup> It is possible private insurer modifiers may also be used to reorient chronic pain care to better align with evidence-based multimodal treatment approaches.



### Enhancing provider education and training

In the realm of provider education, many states, including Michigan, already mandate continuing medical education credits in pain management for maintaining licensure, though qualifying trainings are often limited in scope and duration, emphasizing addiction risks and providing little guidance on multimodal care.<sup>42</sup> At the health professional school level, medical schools in the United States have historically offered very limited pain care curricula,<sup>43</sup> though several medical schools, such as Johns Hopkins and the University of Washington,<sup>44,45</sup> have recently increased their curricular offerings around pain management in recognition of this educational gap.



### Implementing practices to reduce racial biases and inequities

To address racial inequities in health care, Michigan’s Department of Licensing and Regulatory Affairs has just instituted a new rule mandating 1 hour of implicit bias training

per year for healthcare professional licensure.<sup>46</sup> However, this new implicit bias training requirement is not specific to pain- or addiction-related care, and, as the requirement has not yet gone into effect, its impact on pain-related care remains to be seen. A recent study indicated that personally-tailored implicit bias training can reduce racial biases in chronic pain treatment by engaging providers in perspective-taking exercises (e.g. imagining the impact pain has on a patient's life) with real-time feedback.<sup>47</sup> At the federal level, the Biden administration recently announced its intention to address racial inequities in substance use disorder treatment, including by identifying data gaps to target unmet treatment needs and identifying culturally competent and evidence-based practices, but these priorities have not yet been enacted, and they do not encompass inequities in pain care.<sup>48</sup> Regardless, these existing efforts provide valuable context for possible future efforts to address racial inequities in care, both in Michigan and elsewhere.

Importantly, though this panel was convened in Michigan, and its expertise grounded in Michigan's healthcare ecosystem, there are millions of patients taking opioids for chronic pain across the country, and reports of limited access to care are not unique to Michigan. Consequently, there may also be opportunity to apply these recommendations more broadly, in other states and at multiple levels of the United States healthcare system. Indeed, panelists consistently emphasized that, because the lack of access to care arises out of so many contributing causes, there are correspondingly many options for a wide range of stakeholders to improve it.

## **5. CONCLUSION**

Our multidisciplinary stakeholder panel felt that improving access to care for patients taking opioids for chronic pain is a pressing, complex issue. Patients' access is limited by five overlapping barriers: policies, payment models, a lack of care coordination, stigma, and racial bias and inequities. The panel generated 11 final recommendations to address the different facets of this issue, concluding that numerous possible solutions could and ought to be implemented. Broadly, their recommendations encourage implementing new care models for chronic pain, enhancing provider education and training, and addressing racial biases and inequities in care. We hope these findings provide valuable guidance to stakeholders and policymakers, both in Michigan and elsewhere, as they work to improve access to care for this population.

## RESEARCH CONTRIBUTORS

We would like to acknowledge the following research faculty staff who contributed to this report.

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## APPENDIX

Original 15 recommendations following Round 1 meeting. Note that Recommendations B and C were removed from consideration before Round 2, and Recommendations D, F, and J were ultimately combined into a single recommendation.

- A. Educate providers about how the Michigan Automated Prescription System (MAPS) data is used in investigating and disciplining providers.
- B. Enact legislation to separate information in MAPS regarding patients with acute pain vs. chronic pain in order to reduce the administrative burden of current MAPS policies.
- C. Educate pharmacists about opioid prescribing policies and limits to reduce uncertainty and differences in care between pharmacies.
- D. Establish value-based care models for chronic pain, with appropriate compensation for the physicians and care teams who treat and manage patients with complex pain.
- E. Conduct and disseminate a systematic review of evidence related to non-pharmacological treatments for pain and their efficacy.
- F. Incentivize providers through payment reform (e.g., insurance payments) to educate patients on the disease progression of chronic pain to facilitate reaching a treatment plan.
- G. Create a collaborative/integrated care model expanding upon the existing Michigan Medicaid Health Home model to include patients with chronic pain who are publicly and privately insured.
- H. Improve education on multimodal therapies for chronic pain management (and chronic pain in general) earlier on in the education of healthcare providers, at the level of health professional school.
- I. Deliver an educational curriculum that explains differences between addiction and physical dependency on long-term opioid therapy for chronic pain to all personnel who interact with patients (providers, clerical staff, etc.).
- J. Increase reimbursement for evaluating patients with chronic pain across provider types (e.g. MDs and advanced practice providers (APPs), such as physician assistants and nurse practitioners).
- K. Train members of the clinical team, such as social workers, to help address biopsychosocial factors and ongoing management of chronic pain treatment.
- L. Increase recruitment and retention of providers of color across clinical duties (e.g., MD, NP, SWs) especially in underserved communities.
- M. Implement standardized pain management protocols that include mandatory reporting to provide more objective data on pain management across races and ethnicities.
- N. Develop implicit bias training to improve patient-provider communication around pain.
- O. Evaluate and describe where BIPOC individuals prefer to receive health-related information, and community institutions they look to for support in healthcare decisions.