
**Report to
The Vermont Legislature**

**Nonpharmacological Approaches to Treatment of Chronic Pain:
Status Report and Recommendations**

January 15, 2015

In Accordance with Act 75, *An Act Relating to Strengthening
Vermont's Response to Opioid Addiction and Methamphetamine Abuse*,
Sections 14(d)(2) and 14a.

Submitted to: House Committees on Health Care and on Human
Services; Senate Committee on Health and Welfare

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Introduction and Overview

In 2013, the Vermont General Assembly passed Act 75, *An Act Relating to Strengthening Vermont's Response to Opioid Addiction and Methamphetamine Abuse*. Among other initiatives, the Act created a Unified Pain Management System Advisory Council (UPMSAC) with membership from a broad range of professions knowledgeable about the treatment of chronic, non-cancer related, pain. Section 14(a) of the Act defines the purpose of the Council as advisory to the Commissioner of Health on matters relating to the appropriate use of controlled substances in treating chronic pain and addiction and in preventing prescription drug abuse. Section 14 (d)(2) further charges the Council with evaluating the use of nonpharmacological approaches to the treatment of chronic pain, including the efficacy and cost-effectiveness of using complementary and alternative therapies such as chiropractic, acupuncture and massage. The Act required the Department of Health (VDH) to submit a report on its findings in January, 2014, and a subsequent report on any additional recommendations emerging from the work of UPMSAC.

The initial 2014 report presented an overview of the historical uses of Complementary and Alternative Medicine (CAM) and the growing awareness that many of these approaches to treating pain have a legitimate role in augmenting traditional medical treatment. The report reviewed the types of research that have been conducted and discussed the increasing interest in finding efficacious alternatives to prescribing opioids to manage chronic pain. The report can be accessed at <http://legislature.vermont.gov/assets/Documents/Reports/295935.PDF>. The Act also called for a subsequent status report on this work. This brief report responds to that charge of Act 75.

During 2014, UPMSAC members who expressed interest in working on these issues were consulted about how Vermont could make progress toward greater use of CAM, now often referred to as Integrative Medicine because it is often used with, and integrated into, traditional medical treatment protocols. There is general agreement that progress is needed to remove some of the existing barriers to offering individuals integrative care. Insurance benefit and payment policies have traditionally not covered non-medical treatment, leaving individuals with chronic pain to pay privately for any non-medical treatments they pursue. This has created access barriers for individuals who have limited discretionary income. Insurance coverage for medications, however, creates subtle incentives to rely upon opioids for managing chronic pain. The current public health challenge of the increasing prevalence of opioid dependence and addiction is evidence that alternatives to the reliance on opioids must be available and affordable for people experiencing chronic pain.

In the case of chiropractic it is not introducing a new covered benefit but simply making the copay more affordable so that the benefit can be accessed by more individuals.

Reducing the chiropractic copay to the PCP level would remove some barriers to access by making it more affordable.

It is important to note that although the phrase *prescribing opioids to treat chronic pain* is used in the literature and in Act 75, opioids rarely treat pain. Rather, opioids help people manage chronic pain and resume functionality in daily living by chemically binding to opioid receptors in the nervous system and reducing neuronal excitability in the pain carrying pathways¹. This management of pain, albeit effective and necessary in many cases, carries the risk of dependence, addiction, diversion and the innumerable life problems that stem from these risks. The public health challenge is to minimize these risks by finding alternatives to sole reliance on opioids for managing pain. In fact, the literature suggests that some alternative treatments such as physical therapy, cognitive-behavioral therapy and yoga might play a greater role in actually treating various types of chronic pain.

It is important to note that this interest in the potential for nonpharmacological interventions to decrease reliance on the use of opioids to manage pain is but one of many policy strategies Vermont is pursuing to address opioid dependence and addiction. The Department of Health is currently promulgating several rules intended to address the prescribing of opioids. The first is an amendment to the current rule for the Vermont Prescription Monitoring System (VPMS). The proposed amendment would require additional situations in which prescribers of scheduled drugs would have to query VPMS prior to prescribing the medications. A new proposed rule governing the prescribing of opioids, also required by Act 75, would require a prescriber to document the consideration of use of nonpharmacological alternatives for treating chronic pain.

The Department of Health discussions with UPMSAC members and others about nonpharmacological alternatives to the increasingly heavy reliance on opioids to manage chronic pain has captured the attention of others concerned about the risks inherent in opioid use.

Discussion with Green Mountain Care Board and Staff: Payment Reform Opportunities

Payment reform involving how health care is paid for is not only a key component of health care reform but also a fundamental charge of Vermont's Green Mountain Care Board (GMCB) and the federal State Innovation Model grant project currently underway in the state. There is general consensus that the way in which health services have traditionally been paid has created many perverse incentives that may not lead to the most effective or efficient care. The fee for service system has encouraged the use of quick interventions that may have short-term effects without long-term positive outcomes. Experts in pain management acknowledge that the nature of chronic pain is such that it often leads to psychological, family, social and economic and occupational problems that also need to be addressed in a treatment system. Because the current fee-for-service payment system pays for some discrete services and not other others, the system incentivizes providers to perform the services for which payment is ensured, i.e. prescriptions. Time-consuming assessments and interventions that address the complexities of chronic pain are

¹ <http://www.drugs.com/drug-class/narcotic-analgesics.html>

typically not reimbursed. Payment reform is intended to address these inherent perverse incentives by focusing on payment for outcomes and the interventions that lead to positive outcomes.

As part of the work called for by Act 75, discussions with selected members of the GMCB and their staff focused on how, in recognition of the risks of using opioids for chronic pain, Vermont could build into its payment reform strategies coverage for the use of evidence-based integrative care for treating pain. There was general interest in the legitimate need for such a strategy, but an acknowledged lack of relevant data for Vermont to project the costs and benefits of pursuing this strategy. The VDH was encouraged to explore the possibility of a pilot project to test out the efficacy and cost-benefit of including coverage of CAM in a future Green Mountain Care benefits plan.

The Department of Vermont Health Access Interest: Performance Improvement Project

The Vermont Department of Health Access (DVHA), Vermont's State Medicaid Agency, receives federal matching funds to provide Medicaid-covered health services to eligible Vermonters. A condition of receiving these federal matching funds from the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) is that DVHA conduct methodologically-sound Performance Improvement Projects (PIPs) and report the findings to CMS.

Many Vermonters who are experiencing chronic pain have Medicaid coverage, and DVHA shares the concern that the prescribing and covering of opioids may not be the most effective way to treat chronic pain in a way that returns patients to functionality. Aware of the Act 75 charge to explore non-pharmacological alternatives to treating chronic pain, DVHA leadership expressed their interest in and commitment to developing a PIP to examine this issue. Once implemented, the results of such a PIP could provide the GMCB data with which to project the costs and benefits of covering a specified range of integrative therapies to people with chronic pain.

DVHA has an interest in and commitment to addressing the appropriate treatment of chronic pain. Recently, the agency has engaged with Center for Health Care Strategies on a multi-state learning-collaborative, with Vermont's primary goal being a focus on the treatment of chronic pain. The focus of the collaborative is on a program referred to as ECHO™ (Extension for Community Healthcare Outcomes). The model is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their

own communities. Project ECHO is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people where they live.

The ECHO™ model™ does not actually “provide” care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub. Originally developed at the University of New Mexico, the model has been expanded from one condition and one geographical area to multiple disease processes and is now being modeled across the country. DVHA is working with the Blue Print to develop a further understanding of the model, capacity and costs of a replication program that would focus on the treatment of Chronic Pain.

Recommendation:

The Department of Vermont Health Access has expressed a willingness to lead a Performance Improvement Project to offer selected and covered integrative health services to Medicaid-eligible Vermonters with a diagnosis of chronic pain. These services would be offered for a defined period of time to determine if treatments that are alternative or adjunctive to prescribing opioids are as effective, or more effective, than the sole prescribing of opioids for returning individuals to social, occupational and psychological functionality. The PIP should include:

- A small advisory group of pain-management specialists familiar with current science on what CAM treatments are evidence-based for specific conditions.
- Specific PIP eligibility requirements regarding the specific cause or site of chronic pain and the evidence-based recommendations about which CAM treatments may be efficacious for treating that pain.
- Input and involvement from the Commissioner of Health or designee to promote consistency with other state policy initiatives designed to reduce the reliance on opioid medications for managing chronic pain.
- Communication with the Green Mountain Care Board Members about the design and results of the PIP.