October 2019
The Care Redesign Series:
Structures for Chronic Pain Management
TheAcademy

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Introduction

As the healthcare landscape continues to evolve, health systems are grappling with a myriad of financial, technical, clinical, and consumer demands. New payment and delivery models, novel technologies, and changing patient expectations are all driving health systems to reimagine how they deliver care.

Care redesign is the process of reengineering the delivery of clinical care at the system level with the following strategic goals:

- Improving quality and outcomes
- Increasing operational efficiency
- Reducing clinical variation
- Managing the total cost of care

Chronic pain management (CPM) is a field that exhibits substantial clinical care variation both within and across health systems. Reflective of the challenges in CPM, healthcare economists estimate that chronic pain costs the United States up to $635 billion each year.[1] In 2019, The Academy's report, **Chronic Pain Management at America's Leading Health Systems**, established the national state of CPM as ineffective and identified that coordinated organizational structures were a notable gap in health systems' pain management strategies.[2]

As Leading Health Systems (LHS) reevaluate their approach to CPM, they are particularly focused on developing the organizational structures and clinical processes needed to drive CPM care delivery. This report aims to identify the current organizational structures underlying CPM care delivery across LHS and how those structures support, or hinder, effective CPM.

Perceived Effectiveness of US Healthcare System's Treatment of Patients with Chronic Pain, 2011–2018

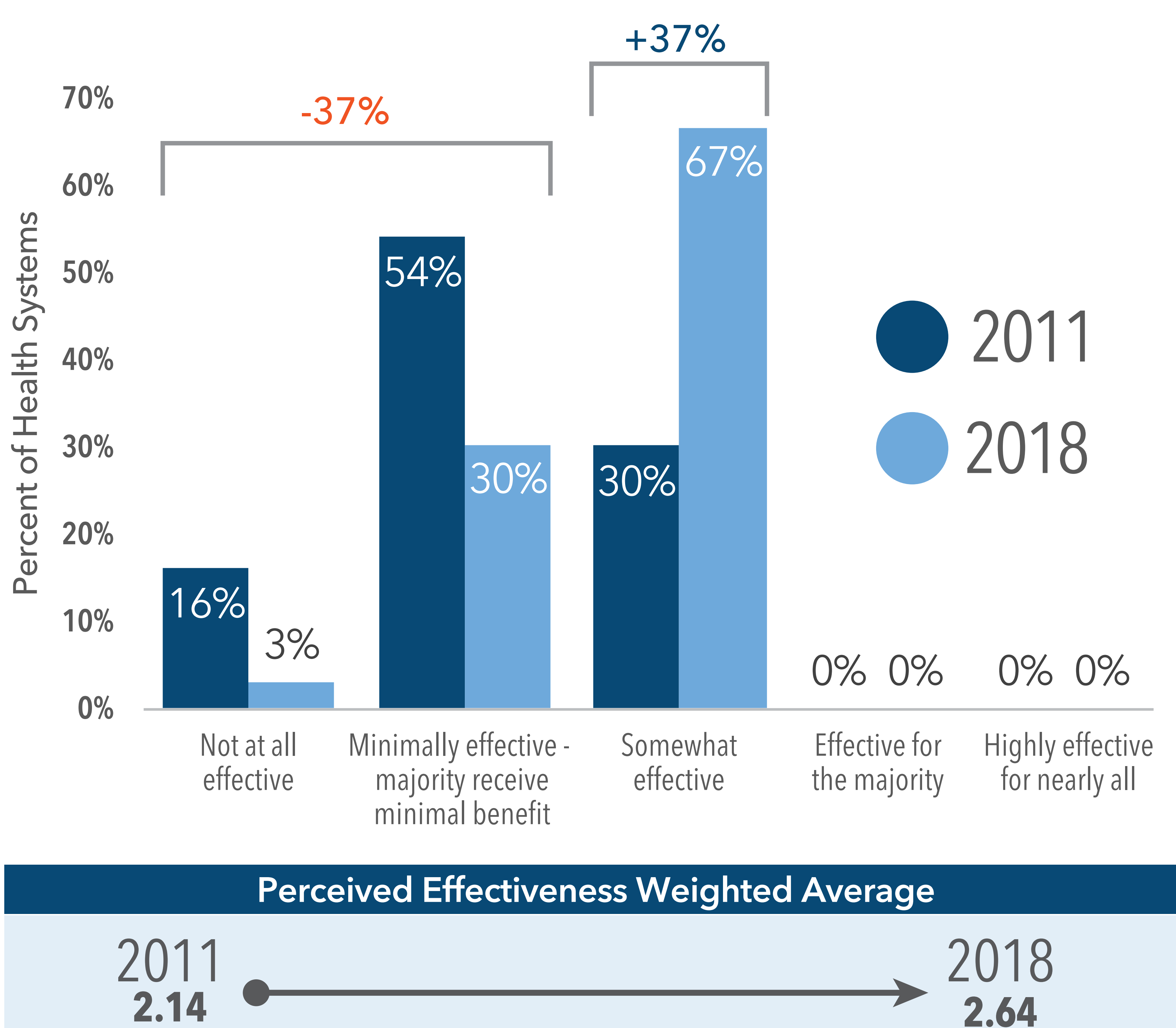

Figure Note: How effectively do you believe the US healthcare system treats patients with chronic pain? N=30. Source: Chronic Pain Management at America's Leading Health Systems. The Academy. 2019.

[1] Gaskin DJ, Richard P. The Economic Costs of Pain in the United States. In: Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington (DC): National Academies Press (US); 2011.

[2] Chronic Pain Management at America's Leading Health Systems. The Academy. 2019.

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Perspectives Represent Significant Share of US Healthcare Market

Insights from 12 Senior Executives Across 8 Unique Leading Health Systems

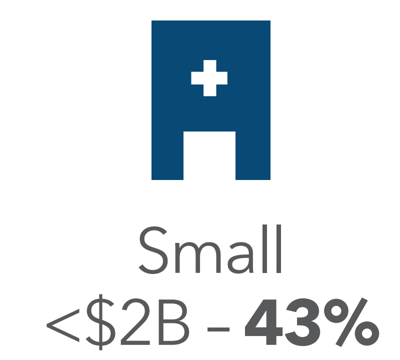
79
Hospitals

997K
Inpatient Admissions

$4.3B
Average Net Patient Revenue

$5.4B
Average Total Operating Revenue (TOR)

Health System Size (NPR)



Small
<$2B – **43%**

Medium
$2–5B – **29%**

Large
>$5B – **29%**

Respondent Roles

- Chief Medical Officer (CMO)
- Medical Director, Behavioral Health
- Regional Medical Director
- Addiction Medicine Specialist
- Director, Chronic Pain Treatment Programs
- Advanced Practice Nurse
- Pharmacy System Director
- Director of the Screening, Brief Intervention, & Referral to Treatment

Note: All data and findings included in this report are reflective of survey responses from executives at leading health systems. The sample size remains consistent throughout the report, in which qualitative insights from 12 executives provide perspectives for 8 unique health systems. For additional methodology details, see page 33 of this report.

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Key Findings

1

Structure

All health systems have some form of a centralized pain management committee, but few (33%) have well-defined objectives, clearly delineated roles and responsibilities, and firm accountability mechanisms to maximize the effectiveness of their initiatives.

2

Initiatives

Data-driven initiatives (100%) and expansion of non-pharmacological therapies (83%) are the most common intervention strategies health systems use to address pain management. Other strategies include education (71%) and community outreach (67%). Notably, the focus of these initiatives is often related to opioid-specific interventions.

3

Challenges

Provider education, particularly with respect to overcoming industry norms and behaviors, is the most frequently cited (71%) barrier to successful implementation of pain management initiatives. Additional hurdles include resource constraints (67%), gaps in the patient care continuum (67%), and reimbursement (50%).

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Current State of Chronic Pain Organizational Structures

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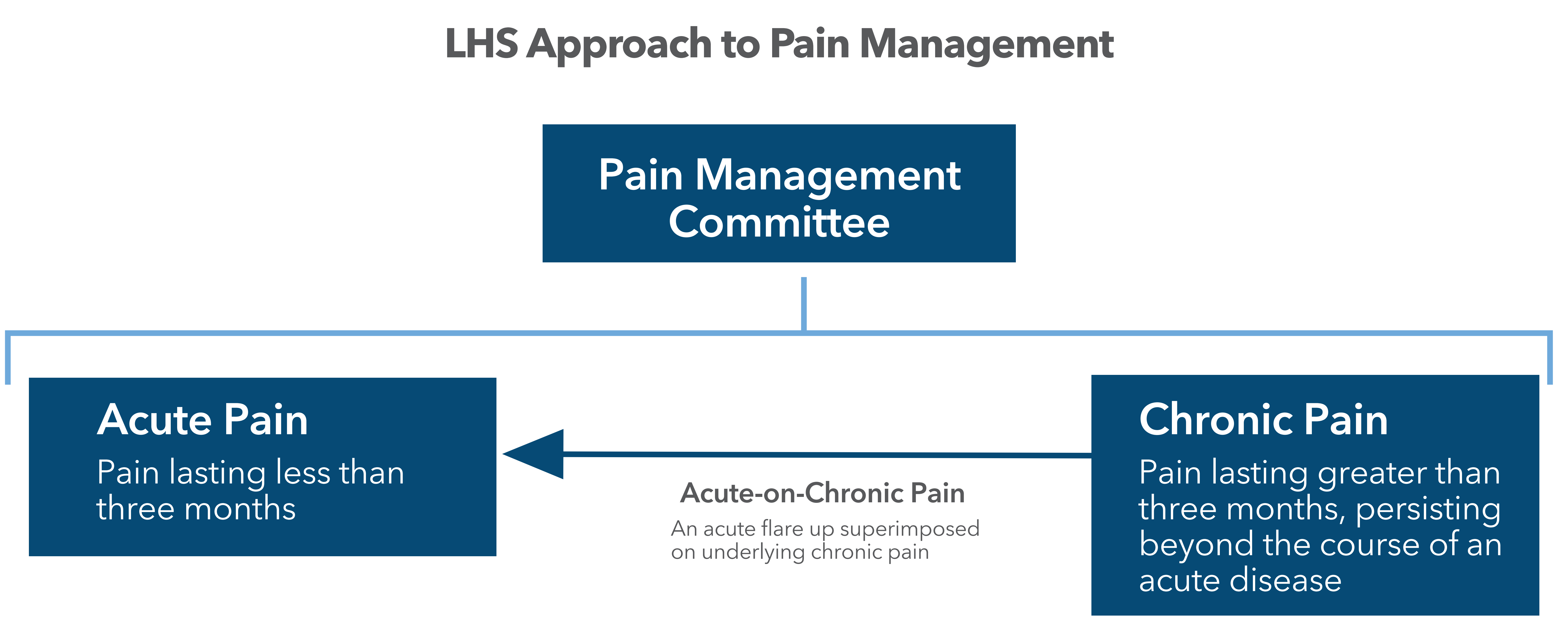
Chronic Pain Addressed within Broader Pain Management Structures

Pain Management Structure

All LHS (100%) have created some form of Steering Committee or Task Force to address pain management at the corporate level. These structures are designed to address pain management across the organization, and incorporate strategies for various settings, specialties, and types of pain.

Reflective of this structure, chronic pain is commonly addressed as part of organizations' broader approach to pain management. Rather than have multiple committees for acute and chronic pain, health systems are aiming to address pain holistically, recognizing the overlap in pain management across settings.



"The reality of the issue is so complex and interconnected. We don't have a specific chronic pain service line. We don't differentiate out pain."

– Chief Medical Officer, Medical Group

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Opioid Management is the Primary Focus

"Chronic pain usually means chronic opioid treatment. It is almost impossible to differentiate at this point. Our current [pain] structure falls within a larger penumbra of opioid reduction strategies."

– Chief Medical Officer, Medical Group

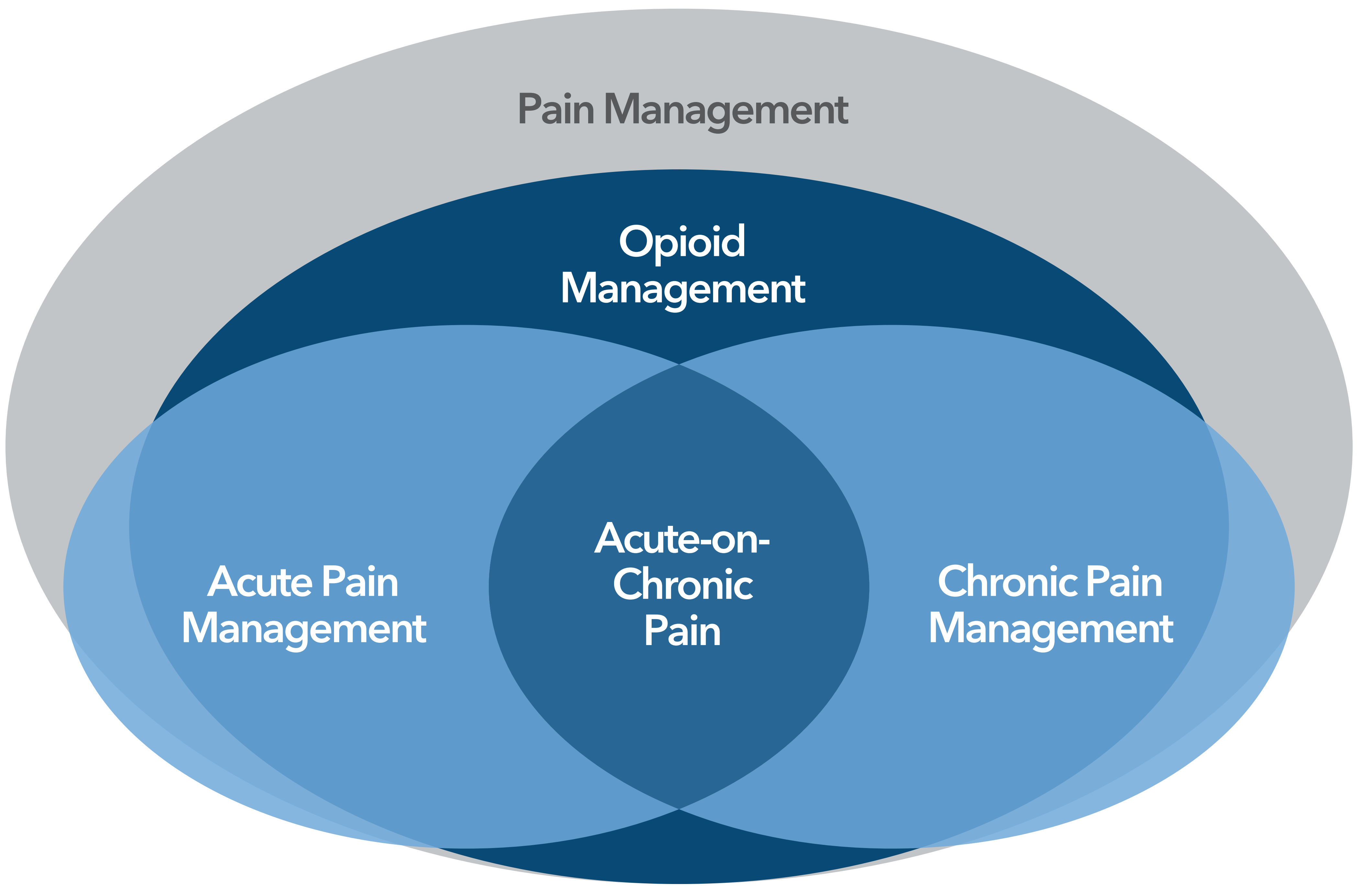
Most LHS Focus on Opioids

Reflective of the impact of the opioid crisis, most pain steering committees were developed with a focus specifically toward opioid management. This is particularly true for health systems operating in states that have been particularly affected by the opioid epidemic or states which have prioritized opioid response through state-based laws and regulations.

LHS Are Struggling with CPM Treatment Post-Opioid Crisis

In a limited resource environment, health systems are often choosing to focus their steering committees, initiatives, and capabilities on opioid response.[1] This is compounded by the fact that chronic pain has historically been treated with opioids; thus, health systems are struggling to distinguish between addressing chronic pain and managing opioid dependence. Newer strategies health systems are implementing to manage pain (i.e. alternative therapies) are often driven by a desire to reduce opioid prescribing rates. Few health systems have expanded the scope of their opioid steering committees to focus on redesigning the health system's approach to chronic pain management more broadly.

Opioid Management Represents a Majority of Pain Management Strategies



[1] Chronic Pain Management at America's Leading Health Systems. The Academy. 2019.

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Pain Management Sub-Committees Manage Distinct Workstreams

Pain Committee Structures Vary

Across health systems, there is no standard organizational structure for pain management. However, most (67%) health systems have appointed sub-committees or workgroups within the corporate Steering Committee to manage workstreams for discrete pain management issues. Sub-committees or workgroups generally fall into three categories:

- Care setting (e.g., primary care, inpatient, emergency department)
- Specialty area (e.g., surgical, pediatrics, behavioral health)
- Functional task (e.g., prescribing guidelines, education)

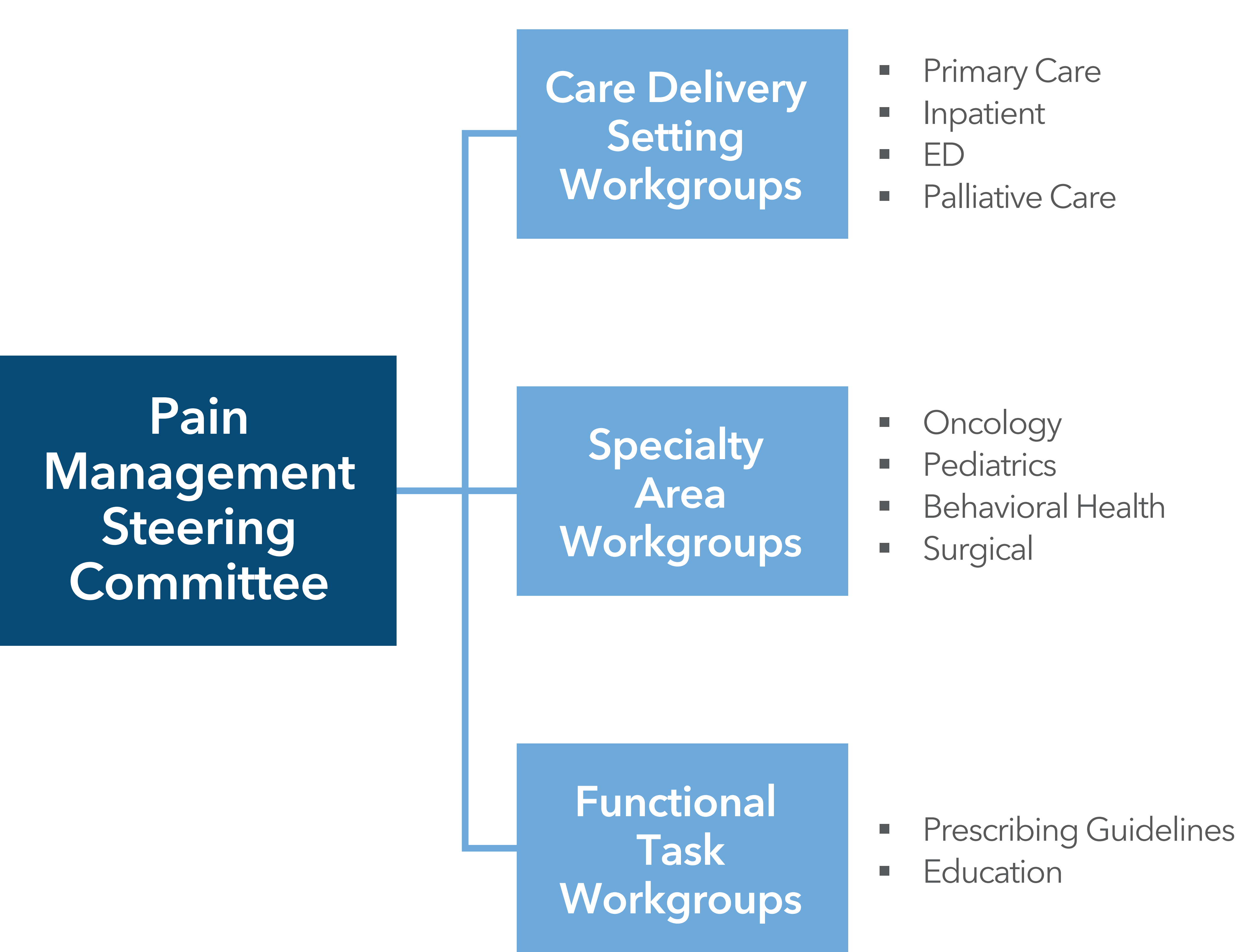
The ubiquitous existence of pain management committees across LHS signals a commitment to taking action on pain management. However, in practice, these committees encounter several challenges to their ability to both implement and sustain progress on their initiatives.

"When we started this a year and a half ago, the first thing we did is identify stakeholders. Then we divided up into workgroups." – *Medical Director, Addiction Medicine and Pain Management*

Chronic Pain Typically Siloed in the Ambulatory Setting

Chronic pain is most commonly addressed within sub-committees focused on the ambulatory setting, such as primary care. However, health systems rarely indicate having strategies or initiatives specifically for chronic pain beyond those focused around opioid management.

Pain Management Committee Structures



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Some Functions Under-Represented on Committees

Multidisciplinary Committees Address Pain Management from All Perspectives

Multidisciplinary pain management committees ensure that health systems are taking a holistic view of the patient, and considering a patient's care journey throughout their system. This is particularly critical for chronic pain patients who may require more frequent touch points with the system and longer-term care.

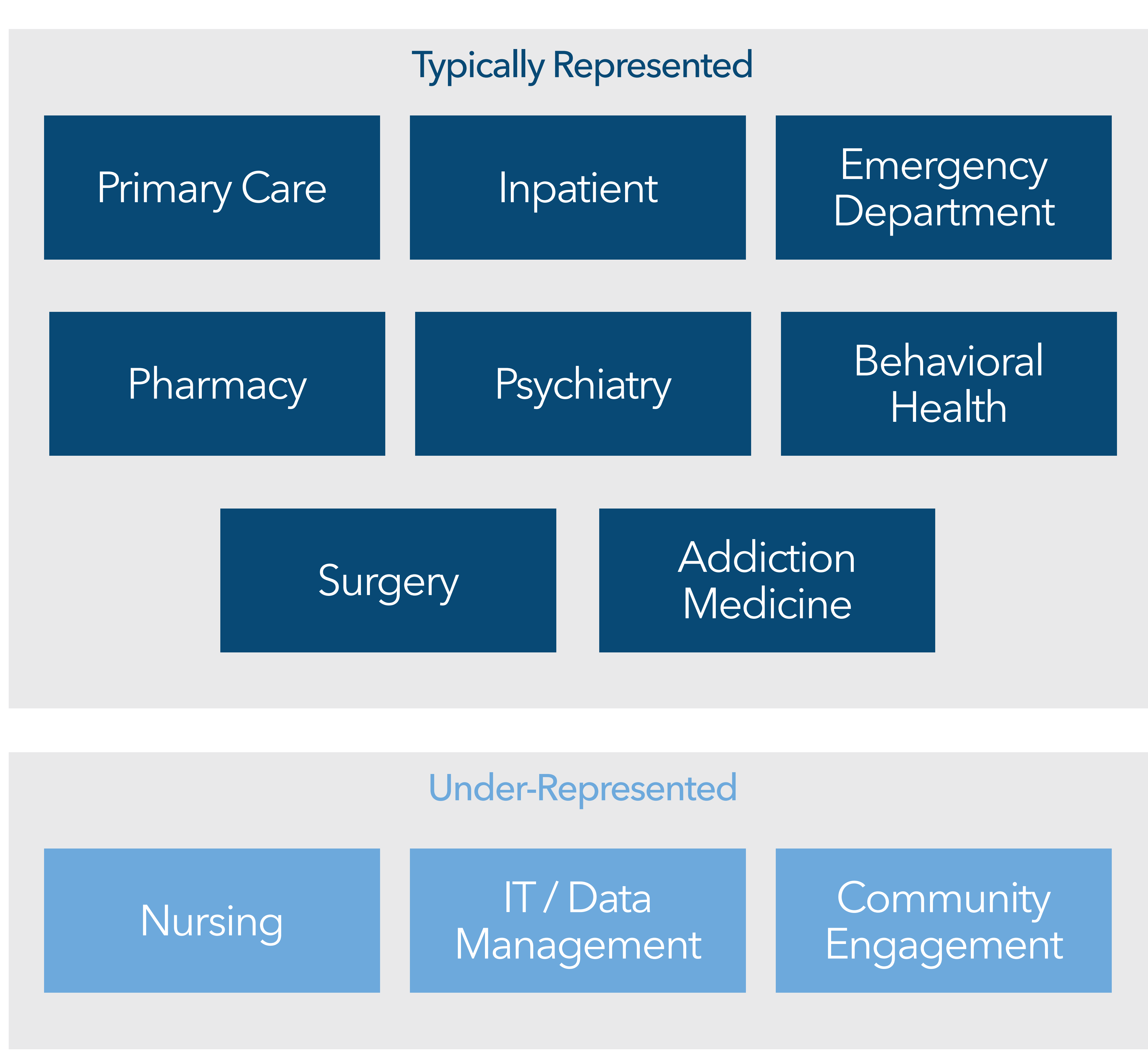
Health systems typically have some combination of the following departments represented on their pain management committees: primary care, inpatient, ED, pharmacy, psychiatry, and behavioral health.

A Few Under-Represented Committee Members Can Add Significant Value

Though less frequently represented on pain management committees, nurses, data management personnel, and community engagement liaisons play critical roles in the treatment of pain patients – both chronic and acute.

- **Nursing:** Nursing clinicians often have better exposure and more consistent access to patients and are well-positioned to lead implementation of direct patient initiatives.
- **Data:** Data management (e.g. those involved with EHR-related initiatives or prescribing dashboards) have access to valuable patient and provider-level data, and can help committees document the progress of their goals.
- **Community Engagement:** Including a dedicated community engagement liaison on the committee will serve the purpose of keeping an open dialogue with critical community partners (e.g., schools, law enforcement).

Illustrative Multidisciplinary Committee Representation



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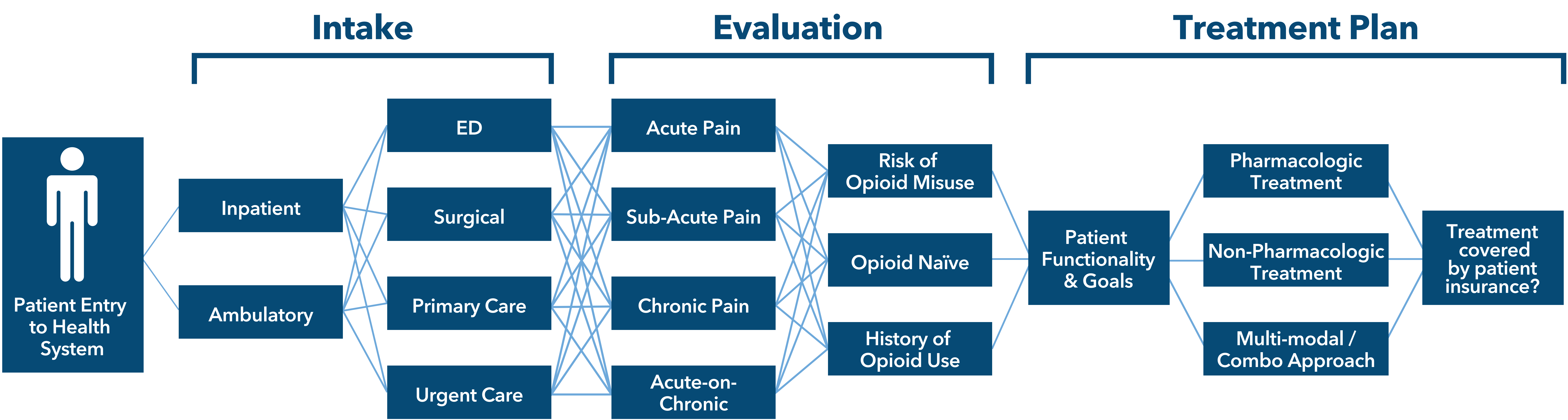
Pain Spectrum Complexity Complicates Treatment



Limited Resources Impede Navigation of Pain Management

Pain management requires the assessment of many factors, which clinicians often do not have sufficient time or resources to evaluate during the patient encounter. Reflective of the challenge of this complexity, two-thirds (67%) of health systems report struggling to allocate finite resources across the pain management spectrum to meet the needs of a diverse patient population. Given the challenge of segmenting pain management approaches, few health systems have defined a distinct workstream around CPM. Most often, health systems are dedicating their limited resources to opioid-related initiatives.

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Unclear Objectives Limit Committee Effectiveness

Few Committees Have Well-defined Objectives

The complexities of defining and treating pain management significantly complicate a health system's ability to assign clear-cut objectives, roles, and accountability to its committee and committee members. Just 33% of LHS' report having clear objectives and accountability for their workstreams. Additionally, it makes it difficult for health systems to define success.

Consequences of ill-defined objectives, roles, and accountability include poor coordination across departments and workgroups, low or inconsistent physician engagement in initiatives, and lack of accountability for meaningful progress.

Additionally, those with well-defined objectives tend to be focused more narrowly around acute pain or opioid management, rather than chronic pain.

Consequences of Unclear Objectives in Pain Management Committees

Poor Coordination (e.g., departments working in silos)

"Are the different entities across our organization aware of what's happening outside of their silo? Often the answer is no." *– Medical Director, Addiction Medicine and Pain Management*

Low Engagement (e.g., inconsistent provider participation)

"We struggled with engagement and participation. I don't think its for lack of interest. There are a lot of competing priorities, and a lack of understanding of what needed to happen." *– Program Manager, Pain Management*

Limited Accountability (e.g., no responsibility for outcomes)

"A lot of work is happening independently around various hospitals – too dispersed for anyone to be responsible for it at a committee level." *– Director SBIRT, Division of General Internal Medicine*

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Most Have Broad Goals, Few Have Measurable Objectives

Striving for Measurable Objectives

While several health systems have committee goals, few reported measurable objectives and accountability mechanisms. Similarly, health systems reported uneven division of responsibilities across workgroups and sub-committees, with some individuals or departments dedicating significantly more time to program implementation than their committee peers.

- Commonly, one or two pain management "champions" emerged as organic or appointed leaders to spearhead pain management initiatives across the system. Each of those individuals cited struggles with sustaining provider engagement as a barrier to implementation.

Committees Must Determine Specific Objectives

To ensure success, pain management committees can outline specific, measurable objectives for their initiatives (e.g., increase % of patients receiving functional pain assessment from 50% to 80% over next six months). Likewise, committees can strive to delegate ownership of each objective to a subset of committee members and designate a project schedule for members to report out on their progress.

Health systems which define specific goals, roles, and accountability mechanisms are more successful at achieving objectives and measuring progress over time.

Key Questions for Pain Management Committees

- What are the committee's specific, measurable objectives?
- How frequently should the committee meet?
- Should the committee be ongoing, or project-based?
- What is a realistic time commitment from committee members?
- How will our committee define success?
- How will the committee be held responsible for outcomes?
- Are responsibilities delegated appropriately across committee members?

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Defined Objectives & Accountability Critical to Success

	Health Systems in Early Organizational Stages Cite Challenges…	… While Systems with More Mature Initiatives Experience Success
Setting Objectives	"It's August and we don't yet have our objectives in place for 2019. The intent was for it to be a very multidisciplinary group to drive the work. I'm not sure it's meeting its own objective." – Program Manager, Pain Management	"We set a goal of reducing opioid prescribing across the enterprise by 40%. We've done it in the ED and in surgery. We are really proud of that. It's fairly new, we've only been doing it a year. Now that we've done that, we're shoring up other types of resources." – Medical Director, Behavioral Health
Delegating Responsibilities	"Our approach is decentralized. It's just myself – the only pain clinical specialist. No one else does pain management. It is very fragmented… It would be nice to have a system approach." – Clinical Nurse Specialist	"We started a steering committee in 2016 to understand drivers of the opiate crisis. We used a modified IHI driver diagram to break the problem down and created interdisciplinary workgroups with SMART goals associated with the drivers. Then we selected leads who report out at our task force meetings – it's an opportunity for cross collaboration and to hear status reports on the projects generated from the goals." – Director, SBIRT
Documenting Progress	"How do we know if we're doing it right? We don't have outcome metrics yet." – Chair, Department of Psychiatry	"We developed an opioid-tapering protocol. It's built into our EMR. We can identify patients who are in withdrawal, acute, sub-acute, chronic. Once we get them off pain medicine, we send them to our comprehensive pain center. It's new but going well. We have the data – we're tracking them." – Medical Director, Behavioral Health

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Care Transitions Hindered by Workstream Silos

"Care transitions are the biggest challenge. It requires a lot of good communication."
– Chair, Dept of Psychiatry / Medical Director, Behavioral Health

Due to the complex nature of pain management, few to no health systems report having clear processes for managing patient care across departments. Poor communication between departments poses risks such as: duplicative or unnecessary care, missed opportunities to intervene on a patient's behalf, or lost information between patient handoffs.

In the absence of reliable care coordination, health systems may struggle to properly care for patients with chronic pain who may require continued services across the care continuum.

LHS Focused on Eliminating Care Gaps

Notably, most LHS recognize the importance of smooth transitions for patients experiencing chronic pain, and are actively working to fill gaps in their care continuum.

Though most health systems do not have formalized protocols for handling care transitions, several health system executives shared anecdotal examples of coordinating across departments to ensure that individual patients received appropriate care.

- For instance, one medical director shared an example of working directly with an anesthesiologist to discuss a patient's medication regimen and develop a care plan before and after the patient's major surgery.
- Additionally, health systems are aiming to leverage the EHR to facilitate data transfer and smoother transitions of care across settings.

For health systems with early-stage pain management programs, future initiatives may include formalizing guidelines and processes for transitioning patients with chronic pain across care settings.

"We're trying to look at all of the handoffs on the care continuum so patients have smooth handoffs and aren't falling through the cracks. It's the holy grail. We don't have a vision yet for how to get there and how we can use our EHR to help us in that regard.

To be successful in this space, you have to recognize the complexity. There are multiple stakeholders and it takes a big effort to get everyone talking and on the same page." – *Medical Director, Addiction Medicine & Pain Management*

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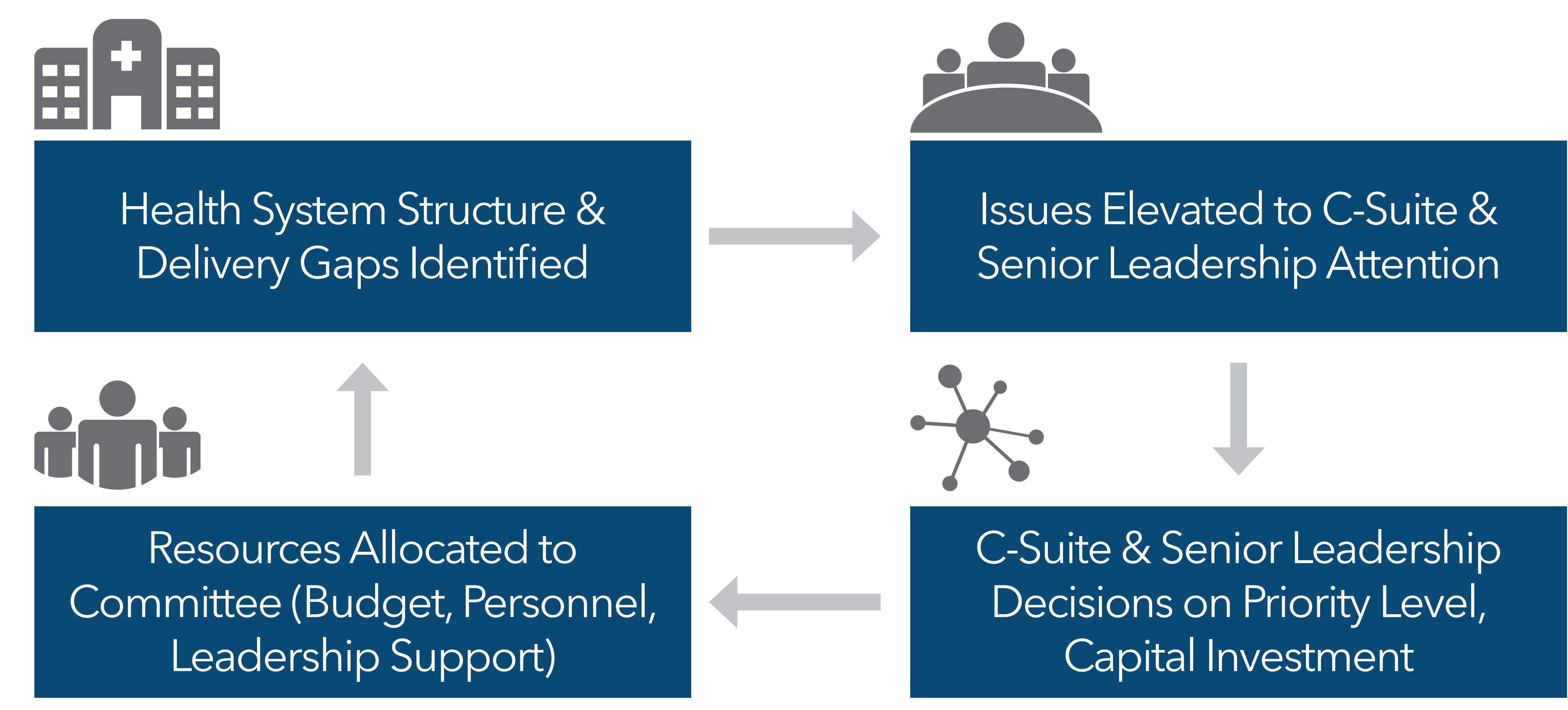
Initiatives Require Leadership Support and Dedicated Resources

Senior Leadership Buy-in Bolsters Initiatives' Success

Pain management leaders commonly cite C-suite or senior leadership buy-in as critical to the success of health systems' pain management programs. Likely, this is due to the resource-intensive nature of pain management interventions from both a budget, personnel, and technical standpoint.

Without the dedicated support of a health system's senior leaders, and a realistic budget for initiatives, committees are limited in their ability to make meaningful progress. Data-driven initiatives in particular (e.g., prescribing dashboards, new EHR workflow processes) may require capital investments to implement. Health systems willing to allocate senior leaders' time to program oversight, and a budget line-item for pain management initiatives, may see greater returns on their investment.

Optimal Pain Management Workflow



"The opioids task force is a system-level C-suite initiative. All of our activities are supported and overseen by our C-suite and CEO. There's a lot of attention and engagement on this. The C-suite is expecting us to come up with the strategies to address these issues."
– Chair of Psychiatry / Director of Chronic Pain Management Program

"We had a committee in the past, but what we lacked was administrative support. It was a lot of volunteerism on the part of interested providers. Now, if we identify a significant gap in our system, we have the privilege of taking it to higher level leadership to ask for help."
– Medical Director, Pain Management & Addiction Medicine

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Pain Management Intervention Strategies

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Primary Focus Areas for Pain Management Initiatives

Data-Driven Initiatives	"We targeted those physicians and divisions prescribing the most to get a handle on where our potential opioid problem is from the prescribing side. We're also looking at patients that come in that could be potential abusers of opioids." – *Director, Division of General Internal Medicine / Medical Director and Chair, Opioid Management Steering Committee*
Non-pharmacological Therapies	"We have a relaxation and well-being "menu" with items to help patients feel better. Staff may be too busy to remember to offer it, but it gives the patients some control over their care." – *Program Manager, Pain Management*
Education	"We have a sub-committee for education. It's critical from the perspective that we wanted to educate not only our own staff, but also develop a strategy for community outreach which is important for our patients." – *Senior Director, Pharmacy System Innovations*
Community Engagement	"We are involved with training various community groups – first responders, police departments in our area and throughout the state. We also go to universities and schools. We are involved in "Train the Trainer" programs. " – *Senior Director, Pharmacy System Innovations*

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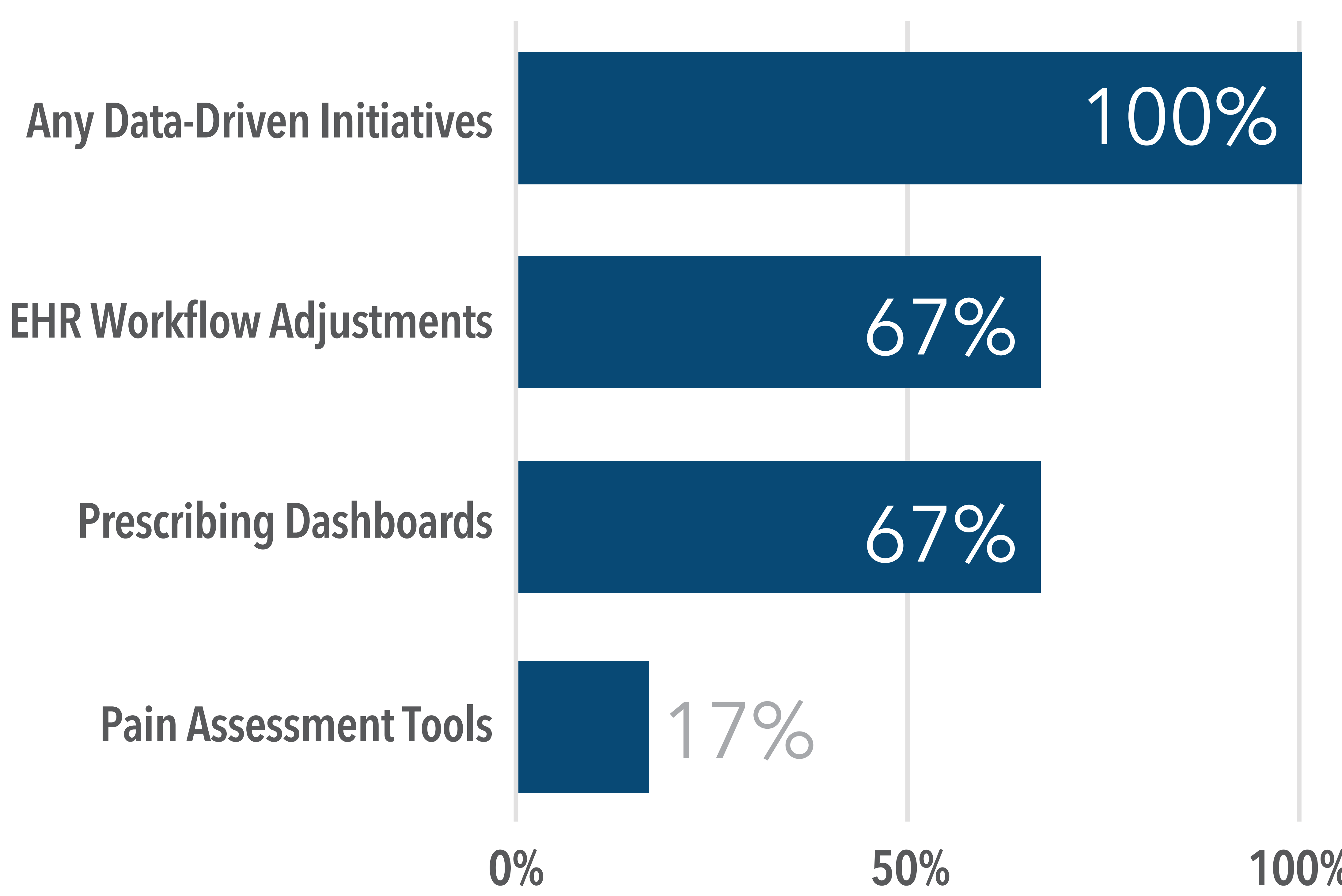
Leveraging the EHR to Support Data Analysis

Health systems view the EHR as a tool to support implementation of pain management initiatives (e.g., prescribing protocols, pain assessment documentation), and are increasingly focused on leveraging EHR data to understand, address, and manage chronic pain among their patients. All participating health systems reported using data-driven pain management initiatives, and many remain focused on building out additional tools in the EHR to capture and assess additional data.

Use of Data-Driven Management Initiatives Among LHS



Prescribing Dashboards

The majority (67%) of health systems rely on prescribing dashboards to target clinician prescribing and address inappropriate prescribing patterns

EHR Workflow Adjustments

Two-thirds (67%) of health systems reported making adjustments to their EHR workflows to begin capturing data on pain-related metrics

Pain Assessment Tools

Fewer (17%) health systems are using supplemental pain assessment tools to evaluate patient pain levels; increasingly, health systems are moving toward patient functionality assessments as opposed to pain intensity rankings

For health systems focused more on opioid response, risk assessment tools are a common method for estimating a patient's risk of opioid misuse

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Non-Pharmacological Therapies Complement Pharmacological Treatment

Integrating Non-Pharmacological Therapies

Most LHS (83%) report early initiatives to integrate non-pharmacological therapies as a part of offering comprehensive CPM treatment options for patients where appropriate. The goal of non-pharmacological therapies is to provide patients relief from chronic pain through methods personalized to their preferences and pain management goals. Non-pharmacological therapies may be used as a complement to or in place of traditional pharmacological interventions.

Examples of non-pharmacological interventions include treatments such as acupuncture or massage, movement-related activities such as yoga or tai chi, calming therapies such as aromatherapy or music therapy, medical marijuana, and others. Non-pharmacological therapies may reduce debilitating effects of chronic pain and offer more sustainable, patient-centered treatment solutions.

Implementing Non-Pharmacological Therapies

Most health systems are still in the early stages of implementing non-pharmacological therapy initiatives. However, few organizations are evaluating the uptake and success of these programs. Additionally, executives cite challenges on securing clinician buy-in around some alternative therapies. Data on the progress of these initiatives may become available as clinician mindsets shift to wider acceptance of these interventions and health systems integrate therapies into formal protocols and guidelines.

Clinicians Consider Key Questions about Newer Non-Pharmacological Therapies

Is it evidence-based?

Education may be required to help providers understand the evidence-based value of non-pharmacological therapies, particularly since these therapies may not have been included in traditional medical school training.

Do we have the resources to provide this?

Health systems may have resource constraints which impede their ability to provide a menu of "wellness services;" they may need to partner with community groups to provide access to these services for patients.

Will it be covered by the patient's insurance?

Non-pharmacological therapies may not be covered by patient's health plans – complicating both the coordination and reimbursement of services.

"We had a long conversation with leadership on what would be an easy and low-resource option we could bring in. Aromatherapy came to mind – it's easy to implement, low resource requirements, and relatively inexpensive. There is a flow sheet in EPIC to capture data on how well it's being utilized. Patients really liked that we offered it."

– Program Manager, Pain Management

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Education Is a Broadly Deployed Strategy

Education Represents a Low-Resource, High-Yield Intervention

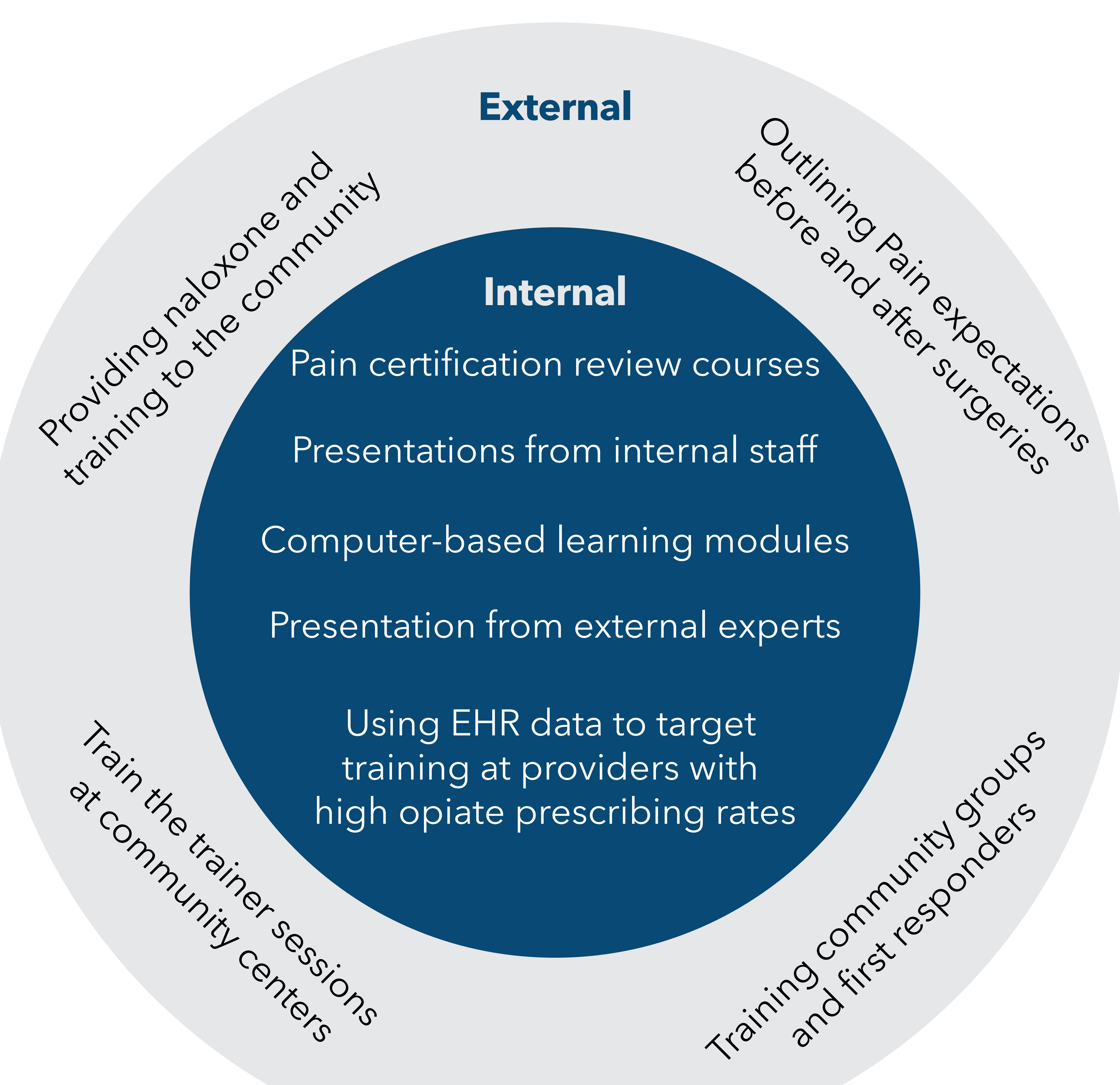
Nearly all health systems (71%) reported using internal and external education as their first-line intervention around pain management. This is likely due to both the need for education and the accessibility of the intervention – education is often less resource intensive than other strategies which may require workflow changes, technical overhauls, or high-touch engagement with external stakeholders.

External education targets both patients and their families, and typically focuses on risk factors, management, and safe storage & handling. Clinicians have seen some success simply recommending that patients try alternatives to opioids.

Internal Education Can Be Tailored to Maximize Engagement

Internal education efforts target clinicians and leverage data to illuminate prescribing patterns and highlight appropriate methods for treating pain management. In the course of their pain management education, providers may be required to learn new ways of treating pain (e.g., by integrating alternative therapies, such as yoga), or "unlearn" previously taught prescribing behaviors (e.g., assessing a patient's risk before prescribing opiates).

One executive described a shift in her health system's approach to education: initial efforts to educate clinicians through formal training (i.e. PowerPoint presentations) resulted in low engagement. Now, the health system uses a discussion-based education model, informally explaining to clinicians why the treatment plan selected may or may not be effective after patient encounters.



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Many Engage Community Stakeholders to Broaden Impact

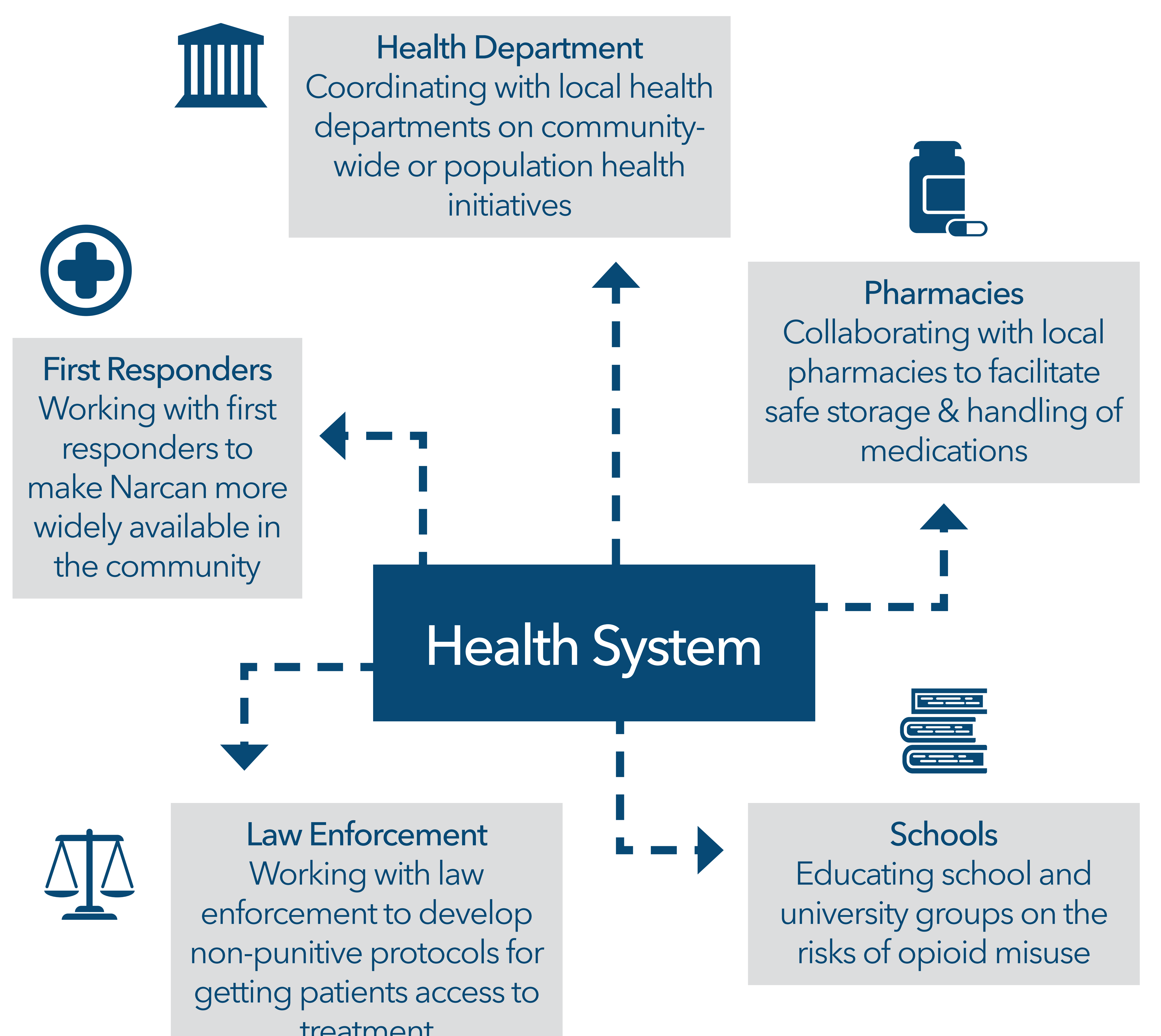
Looking Beyond the Health System

In order to treat patients more holistically and recognizing the scope of pain management extends far beyond the four walls of the health system, organizations are increasingly looking beyond the clinical setting to connect patients to resources. Engaging other community stakeholders also allows health systems to approach pain management from the population health level.

Forging Partnerships with the Community

A majority (67%) of health systems have initiated community outreach or forged community partnerships with the goal of meeting the patient's needs in their community and taking a broad view of patient care. As health systems shift their focus from opioid management to broader pain management, including chronic pain, new community-based partnerships may emerge to reflect the needs of a distinctly different target population (e.g., patient advocacy groups.)

"The system is very concerned about the opioid epidemic and has been in discussions with the county and state, and other non-profits operating in this space to look at opportunities for collaboration. We kick off a public awareness campaign in September that culminates in a community conference event." – *Chair of Psychiatry / Director of Chronic Pain Management Program*



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Measuring Success in Pain Management

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Newer Pain Assessments Emphasize Patient Goals

LHS Re-Think Pain Management Assessment Methods

In The Academy's recent assessment of chronic pain management, 59% of health systems said their current pain assessment methods were "somewhat effective."[1] Many pain management leaders expressed interest in ongoing efforts to revamp their current pain assessments. Underpinning these efforts is an acknowledgement that traditional pain assessments which emphasize pain intensity or severity do not appropriately capture patient-specific pain goals.

Newer Assessment Methods Consider Patients' Quality of Life Goals

Increasingly, physicians are starting to incorporate patient functionality into their new success methodology. This dialogue encourages patients to discuss their quality of life goals (e.g., ability to perform basic tasks), rather than focusing narrowly on the intensity or severity of their pain.

New pain assessment tools focused on functionality may reflect a patient's mood, stress levels, sleep cycle, and ability to participate in activities that are important to them. This type of information will also help providers determine which treatment regimen will be most effective, including non-traditional therapies.

- New pain assessments may also require dialogue between clinicians and their patients to set realistic expectations and goals. For instance, clinicians may need to work with patients to transition from goals such as "I'd like to be pain-free" to "I'd like to be able to participate in moderate exercise."

As health systems begin to embrace non-traditional pain assessment tools, they will need to figure out how to incorporate these metrics into their standard processes and workflows.

"We were focused on pain intensity (i.e., how bad does it hurt) but that's not the most important piece of information. What really matters is how that impacts your ability to walk, eat, breathe. In May, we included a functional pain scale.

The next thing we did was change the verbiage in our chart to "What is the patient's realistic pain goal?" We added questions in our flow sheet to ask about aggravating and alleviating factors for pain."

– Program Manager, Pain Management

[1] Chronic Pain Management at America's Leading Health Systems. The Academy. 2019.

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Integrating Non-traditional Metrics of Success

Leveraging Outcome vs. Process Metrics

Most health systems are focused on outcome metrics (e.g., pain intensity, patient satisfaction), however, many of them are acute pain focused (e.g., length of stay, readmissions). Health systems are considering ways to integrate CPM metrics into their dialogue, although many note challenges in identifying appropriate metrics.

Health systems with more mature pain management strategies also incorporate structure and process metrics (e.g., availability of non-pharmacological alternative therapies to offer patients, whether patient goals are considered for treatment plans) in addition to standard outcome metrics. Developing structure and process metrics may help health systems with defining success in their approach to CPM.

Success Metrics Across Early-Stage and Mature Pain Management Programs

	Early-Stage	Mature
Health System	▪ Length of stay ▪ Readmissions ▪ Patient satisfaction	▪ Population pain literacy ▪ Integration of non-pharmacological therapies into protocols
Patient	▪ Pain intensity ▪ Risk assessment ▪ Satisfaction	▪ Functionality ▪ Patient goals ▪ Quality of life ▪ Social determinants of health
Provider	▪ Prescribing patterns	▪ Non-pharmacological therapy recommendations ▪ Compliance with guidelines

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Challenges to Pain Management Program Implementation

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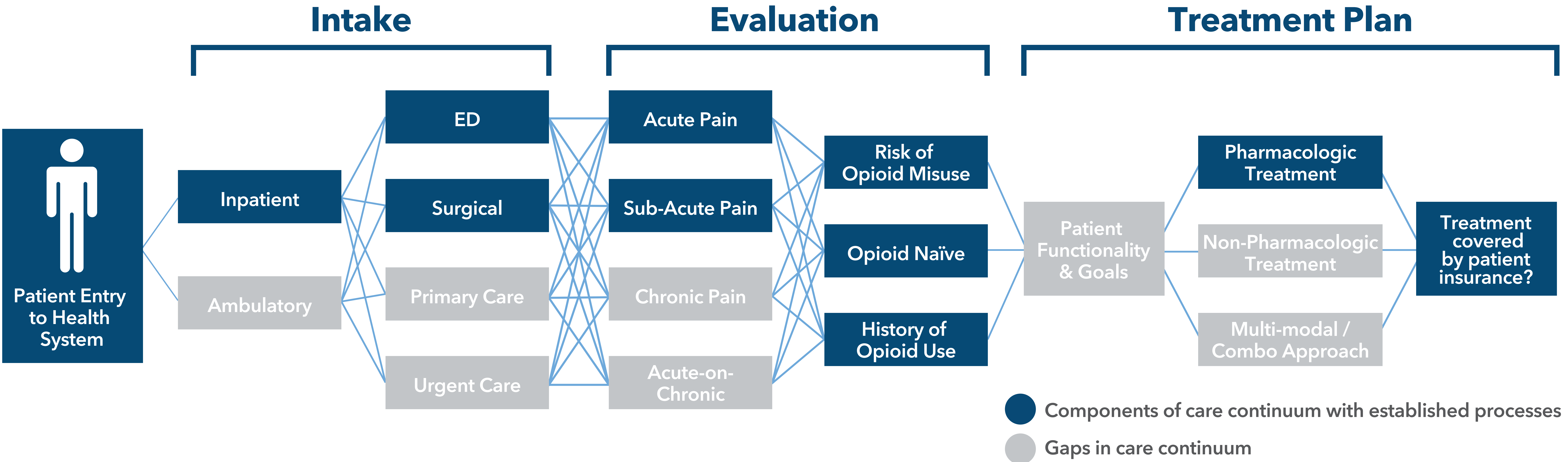
Gaps in Care Continuum Need to Be Filled



Smooth Coordination and Streamlined Processes Are Essential

Given the many stakeholders involved in pain management, coordinated efforts are essential to maximize limited resources and ensure positive patient outcomes; particularly for chronic pain patients, who require ongoing consultation and treatment to manage their pain.

Many LHS cited known gaps in their care continuum; often, internal resources are unevenly distributed, leaving breaks in the patient care continuum. Several health systems cited ongoing work or intentions to strengthen capabilities in departments with existing care gaps. As health systems build out their resources across the care continuum, they can develop formal processes for patient handoffs between departments. Implementing a pain registry – a real-time database of patients reporting pain – can also help health systems track patient encounters across their health system.

Ultimately, open communication and smooth handoffs across departments positions health systems to make progress on pain management initiatives by better understanding how patients are engaging with their system and providing them access to the right resources at the right time.

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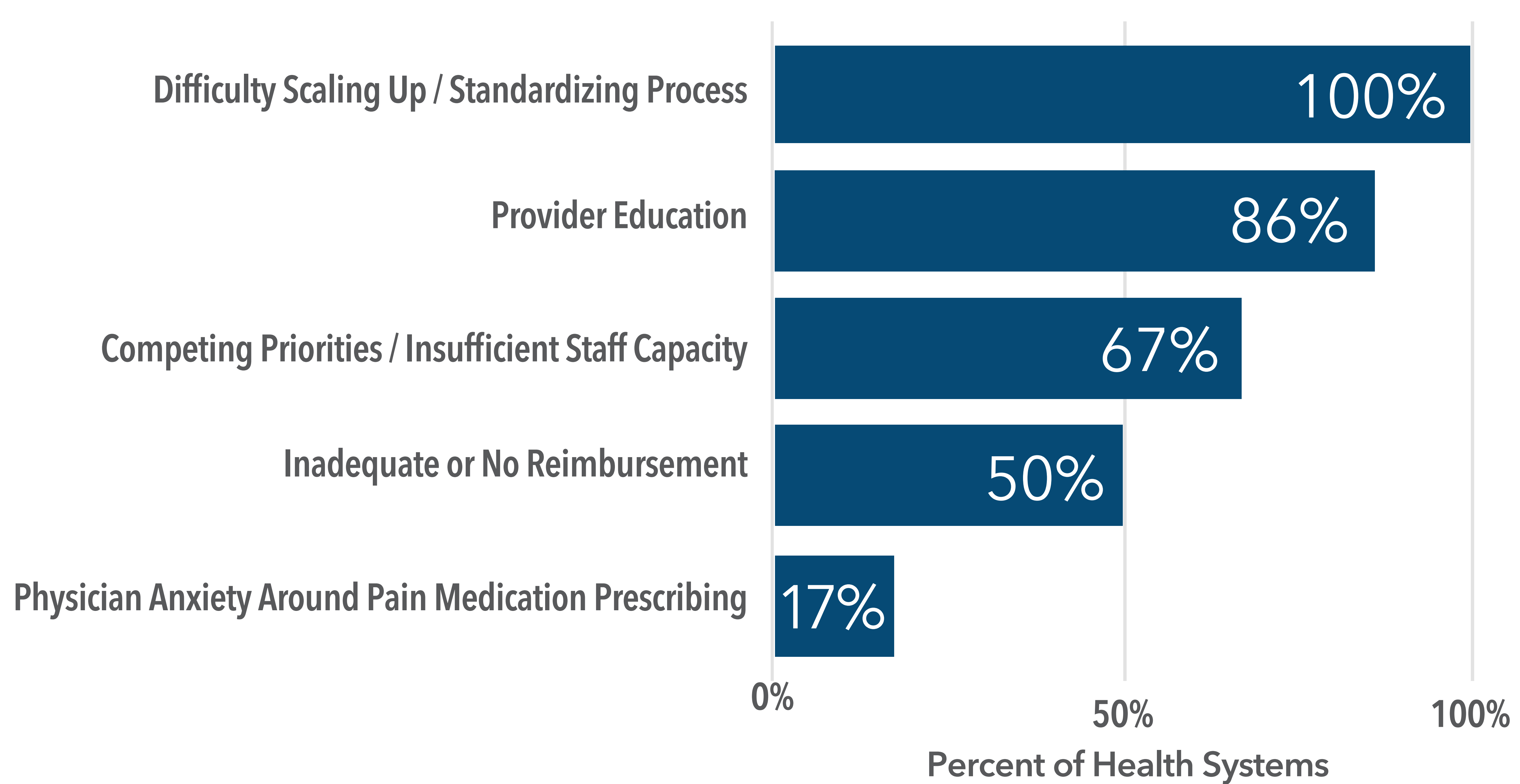
Insufficient Resources Threaten Progress on Initiatives

Challenges to Implementation and Sustaining Progress

Though most health systems have a structure in place for addressing pain management, insufficient internal resources create challenges to implementing initiatives and sustaining progress. Resources may also be unevenly distributed between inpatient and ambulatory care.

LHS cite the following challenges as the most frequent barriers to progress:

- Difficulty "scaling up" initiatives or standardizing processes across the system (100%)
- Provider education / new techniques contradict industry norms (86%)
- Competing priorities / insufficient time for staff to engage (67%)
- Inadequate or no reimbursement for newer treatment options (50%)
- Physician anxiety around pain medication prescribing (17%)



"One of the things I run into frequently is lack of time for PCPs. They don't have the ability to manage or dedicate time to these patients." – *Chair of Psychiatry, Director of Chronic Pain Treatment Program*

"My job is to do the discovery, research and development of the solution. I try to implement the solution, but always hit barriers – competing priorities, not the right time, we didn't budget for this." - *Program Manager, Pain Management*

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Notable Challenges Measuring CPM Outcomes

Pain Assessment Documentation

Eighty-eight percent of health systems track the documentation of pain assessments within 24 hours of admission.[1] However, high rates of pain assessment do not necessarily reflect the appropriateness of the assessments or their effectiveness for chronic pain patients.

Measuring chronic pain specifically presents several challenges to health systems, including:

- Whereas acute pain is often resolvable in the near-term, chronic pain does not necessarily have a clear end point
- Existing pain assessments tend to focus on pain severity, which does not reflect the total pain burden over time
- Due to historical prescribing patterns, chronic pain is almost inextricably linked to chronic opioid treatment

On the whole, health systems are applying pain assessments inconsistently across the spectrum of care and often do not have appropriate assessment tools to document the nuances of chronic pain

"Getting beyond acute pain management issues and into chronic pain, it becomes difficult to know what the metrics should be and what the model of care should include." *– Chair of Psychiatry, Director of Chronic Pain Management Program*

"The real problem is the population of high utilizers, highly distressed, who fail lots of symptomatic treatments. Primary care and others do not feel capable of managing them and they end up on multiple opioids of polypharmacy because PCPs don't know what to do with them. They require psychiatric care for anxiety, substance abuse, personality disorders… the healthcare system is not equipped to deal with them." *– Director of Chronic Pain Management Program*

[1] Chronic Pain Management at America's Leading Health Systems. The Academy. 2019.

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Ongoing Education Necessary for All Stakeholders

"We don't want to become punitive. We need to be better informed and compassionate around pain management." – *Director, Division of General Internal Medicine / Medical Director and Chair, Opioid Management Steering Committee*

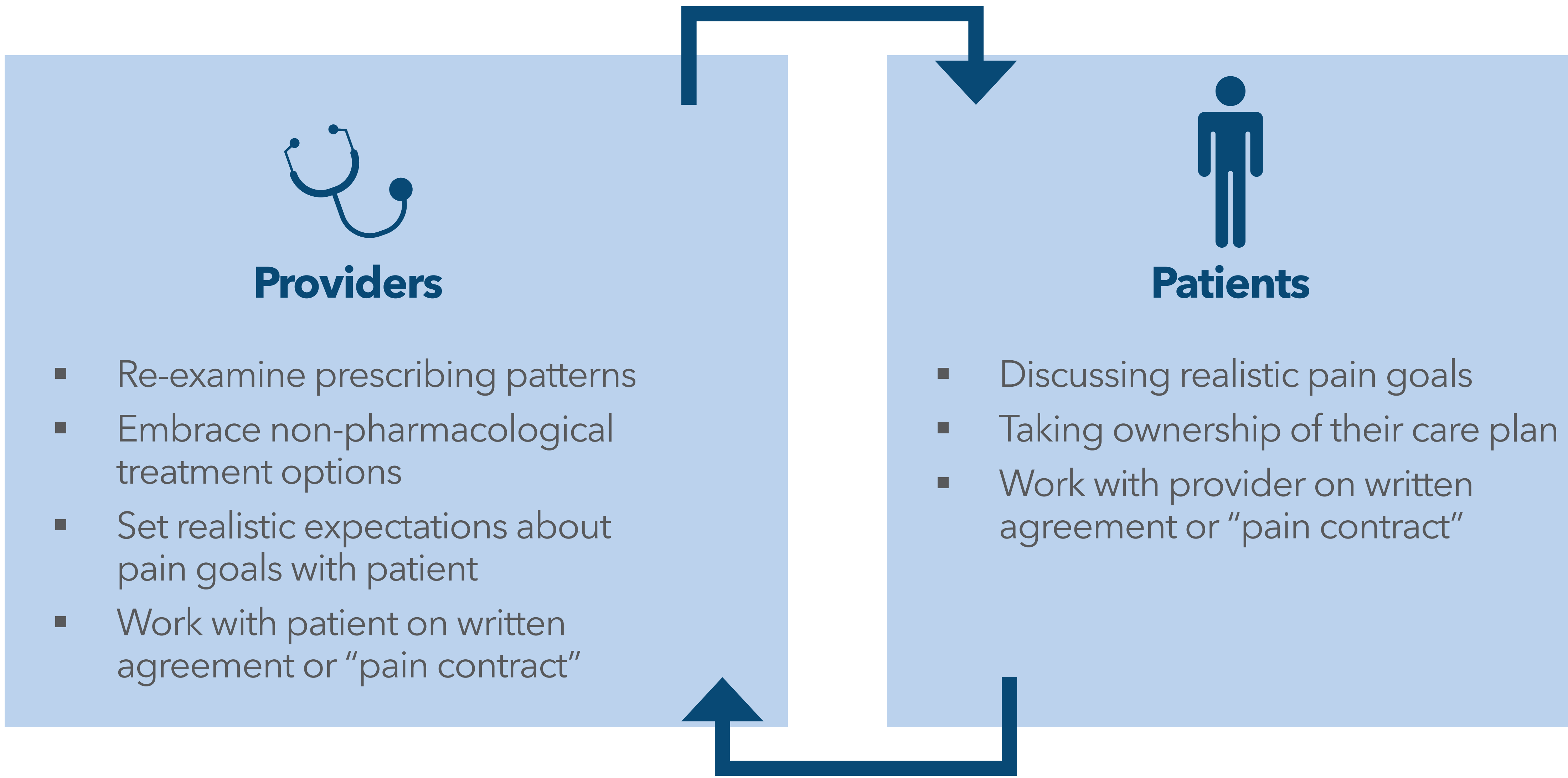
"They are worried about their license and state and federal regulations. I routinely see prescribers prescribing over the counter products to treat chronic pain when that's not appropriate." – *Chair, Psychiatry and Director of Chronic Pain*

Goals of Future Pain Management Education

Education is the most frequently cited strategy health systems are using for pain management, and ongoing education will be necessary for both providers and patients. To date, education efforts have focused primarily on appropriate prescribing patterns. Goals of future education efforts may include:

- **Changing culture:** Providers may need to unlearn behaviors they have previously learned or were taught in their medical school education (e.g., around prescribing) and embrace newer, non-traditional treatment options (e.g., aromatherapy).
- **Reducing stigma:** Health systems are increasingly focused on reducing stigma and changing the dialogue around pain management, as well as re-thinking approaches to compassionate care. This includes reducing provider stigma around prescribing pain medications, which many providers are reluctant to do as states crack down on prescribing.
- **Setting expectations:** Providers may need to work with patients to shift pain-related expectations. Goals of being completely pain free may be unrealistic, but together patients and providers can form a plan for better pain management and day-to-day functionality.

Being Better Informed Will Allow Providers and Patients to Work Together on Pain Management



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Future Outlook

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Robust Organizational Structures Drive Success in CPM

Across LHS, there is a great deal of variation and ambiguity in organizations' approach to pain management. Few health systems have developed the organizational structures necessary to facilitate scaling pain management initiatives across the organization – resulting in a disjointed care continuum and poor effectiveness. Additionally, health systems are challenged in developing strategies to address acute and chronic pain in concert. This ambiguity results in significant variation in the effectiveness of pain management, and in particular chronic pain, across and within health systems.

More mature health systems, with robust organizational, leadership, and accountability structures, were more often able to execute on their defined objectives. Without clear organizational structures, health systems will be challenged in successfully implementing and scaling key initiatives across the enterprise and sustaining progress.

Characteristics of Mature Organizational Structures for CPM

1. There is buy-in and **support among the health system's C-suite and senior leadership** for pain management initiatives to ensure system prioritization, accountability, and appropriate resource dedication.
2. The pain management committee scope extends beyond achieving singular initiatives (e.g., opioid targets, prescribing guidelines for acute pain in the ER) to **develop a holistic strategy integrating chronic and acute pain strategies across the continuum of care**, while facilitating transitions of care between settings.
3. Pain management committees and workgroups have defined **measurable objectives, metrics of success, and strong accountability mechanisms** by which to achieve and sustain success.

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Methodology

In August 2019, The Health Management Academy conducted a qualitative assessment with senior Leading Health System executives regarding chronic pain management. The 12 total respondents represent 8 unique health systems. Respondent roles included Chief Medical Officer, Medical Director -- Behavioral Health, Regional Medical Director, Addiction Medicine Specialist, Psychiatrist, Pain Management Nurse, Pharmacy System Director, and Emergency Medicine Physician. The responding health systems have an average Total Operating Revenue of $5.4 billion and own or operate a total of 79 hospitals.

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TheAcademy

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500+ C-suite Executives

2,000+ Health System Leaders

66% Inpatient Admissions

62% Outpatient Visits

67% Total Physicians

62% Total Operating Revenue

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The Academy extends its appreciation to Pfizer for its for the financial support for the Structures for CPM assessment.

[1] https//:www.pfizer.com/about/leadership-and-structure/company-fact-sheet

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