Reevaluating Low Back Pain Care to Help Address the Opioid Epidemic

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Since there are many contributors to the patient's experience of chronic pain, **a "one-size fits all" treatment approach does not exist.** Effective management of pain may demand a multimodal and multidisciplinary assessment and treatment plan.

Longer-term comparative studies are needed regarding non-opioid, pharmacological, non-pharmacological, and interventional procedures (and how they might be combined) to build upon the current evidence-base about what treatments work best for which types of pain patients, and expected outcomes over time.

Change is Needed

Across different categories of musculoskeletal (MSK) pain, chronic low back pain (cLBP) is among the most common nonmalignant disorders associated with prescribed opioid use in primary care.[1] Studies have shown that patients with cLBP are more likely to use illegal drugs (e.g., marijuana, cocaine, heroin, methamphetamine).[2] Additionally, cLBP has become a leading driver of health care costs in the United States, with estimates of total expenditures on the diagnosis and management of low back pain nearing $90 billion.

In light of the nation's opioid epidemic, health insurance providers, clinicians, and patients are increasingly evaluating non-opioid treatments as a first-line option for the cLBP. In the past, common treatments for low back pain have included opioids or steroid injections, depending on the severity of the pain. However, in recent years, research has emerged showing limited efficacy of these interventions for long-term resolution of chronic low back pain.[3,4,5] With a commitment to improving individual and population health and reducing the risk of opioid dependence, health plans and

On an average day, at least 78 people will die from an opioid-related overdose, 3,900 people will use a prescription opioid outside of legitimate medical purposes, and 580 people will try heroin for the first time.[1]

1 https://www.ncbi.nlm.nih.gov/pubmed/11929502
2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5002230/
3 http://annals.org/aim/fullarticle/2643842/patient-outcomes-dose-reduction-discontinuation-long-term-opioid-therapy-systematic
4 https://www.researchgate.net/publication/7994701_The_Updated_Cochrane_Review_of_Bed_Rest_for_Low_Back_Pain_and_Sciatica
5 http:\\aahp.org\share\sys\users\rvenkataraman\Opioids\Back Pain\[2] http:/annals.org/aim/article-abstract/2430207/epidural-corticosteroid-injections-radiculopathy-spinal-stenosis-systematic-review-meta-analysis

clinicians have also been investigating innovative solutions driven by real-world best-practices and evidence produced in controlled clinical trials.

To investigate cLBP care further, America's Health Insurance Plans (AHIP) convened a group of health insurance providers over the last year to discuss strategies to improve access to non-opioid approaches to lower back pain. The organizations came together to discuss the barriers to treatment of cLBP with an emphasis on non-opioid treatments and potential strategies to address those barriers. Input from several medical societies has also been incorporated.

This paper outlines the current landscape and identifies opportunities for multi-sector collaboration.

Current Landscape & Challenges

Pain is subjective and chronic pain is complex. Chronic pain is a multidimensional experience that, like other chronic conditions, may have multiple contributors. Each person's pain experience and suffering is unique and influenced by several variables, making it difficult to assess, diagnose, and treat in many patients. Individuals who seek ongoing care for low back pain may present to the clinician as acute, subacute, episodic, or chronic. And patients may have other chronic conditions, or a combination of symptoms related to different kinds of MSK pain (e.g., a patient with an acute knee injury with recurrent low back pain who also has chronic fibromyalgia), that may need to be addressed in the context of their treatment plan. Since there are many contributors to the patient's experience of chronic pain, a "one-size fits all" treatment approach does not exist. Effective management of pain may demand a multimodal and multidisciplinary assessment and treatment plan where goals may include reducing pain, restoring function, cultivating wellbeing, and/or improving quality of life. Additionally, clinicians should consider the patient's history with opioid medications, other substances, and/or illicit drugs to assess their potential risk for developing a substance use disorder (SUD). Pain treatment should consider a patient's individual functional capacity and treatment goals. Treatment should also factor in the patient's other physical and mental health conditions, as well as whether the patient has a history of substance use, which might impact their diagnosis and treatment plan.

Patients may have expectations to be "pain free." Clinicians and other health care providers who treat patients with cLBP provide a valuable service when they engage in shared decision-making with patients. As part of these conversations with patients and their families, clinicians may need to ask about the patient's expectations, set goals with the patient, and explain that chronic pain management may not result in a "pain free" experience but may lead to significantly improved functionality and quality of life. Health insurance providers and clinicians should collaborate toward better systems of care to improve whole-person, integrated pain care that is based on the best available evidence.

Build consensus on what constitutes effective pain care for cLBP and how it can be measured. There are a multitude of clinical guidelines and other policies available recommending pain treatment practices for cLBP, but there is little consensus on how to define or measure effective pain care. Further complicating the landscape are the varied, and sometimes conflicting, guidelines and policies issued by specialty societies, academic institutions, and government entities, making the guidelines impractical for implementation. Health insurance providers, clinicians, and other health care professionals would benefit from a thorough evaluation of these policies to determine which are effective. In the meantime, clinicians and their patients would benefit from practical, easy-to-follow guidance to help identify which interventions (or combination of interventions) are most likely to improve outcomes for the patient given the existing evidence base. *(Note: "Best available" evidence must be used judiciously within the concept of "first do no harm." As research becomes more precise in its description of effective patient outcomes, patients, clinicians, and insurance providers will gain more clarity regarding different cLBP treatment options).*

More research is needed on all forms of pain management treatments. Some reliable and available evidence exists for treatment of cLBP, but it is limited in specificity, and clinicians may not be aware of the different non-opioid treatment options that may be appropriate. Longer-term comparative studies are needed regarding non-opioid, pharmacological, non-pharmacological, and interventional procedures (and how they might be combined) to build upon the current evidence-base about what treatments work best for which types of pain patients, and expected outcomes over time (e.g., a year or more).

While some complementary and integrative therapies have been identified in guidelines and systematic reviews[6] as potentially useful adjunct or replacement therapies for traditional pain management treatments, further long-term research is needed. These therapies might include, but are not limited to, physical therapy, manipulation, acupuncture, cognitive behavioral therapy, and mindfulness-based stress reduction. These therapies may be safer than medications or invasive procedures, and patients may need to devote considerable effort to obtain meaningful benefits. As patients have less access to opioids, there must be an effort to ensure patients have access to other forms of pain relief. For these interventions specifically, research is needed to better understand how patients with cLBP will benefit.

Research continues to emerge regarding the effectiveness of nonsteroidal anti-inflammatory drugs (NSAIDs) for patients with cLBP. Evidence has shown that NSAIDs, some of which are available over the counter, are more effective that opioids for treating chronic pain.[7] As a result, many organizations have endorsed guidelines recommending that physicians consider opioid therapy as a last option for treatment, and only for patients who have failed other therapies.[8]

Better training and tools are needed. Clinicians and care team members need additional training, tools, and support to understand which non-opioid interventions might be best suited for which types of cLBP patients, the combination or sequence of interventions, the number of attempts and visits that are appropriate for the patient based on their diagnosis and current symptoms, what to do next if that number has been reached, and the most appropriate provider of those interventions. Additional resources and support are also needed to help patients, employers, policymakers, caregivers, health insurance providers, and the public better understand the characteristics of a pain treatment model and the benefits and risks of available interventions. As this body of evidence develops, guidelines and policies should undergo timely and appropriate review to ensure new evidence can be incorporated.

The social determinants of health play a critical role in pain care. Many factors such as health insurance coverage status, access to transportation, type of employment, language, physical and cognitive disabilities, and other factors impact an individual's health care. Clinicians and health insurance providers should consider how these characteristics may impact pain care and strive to convey information as clearly and simply as possible to help patients understand their treatment options and make an informed choice that works best for them. As we consider treatment options for cLBP and other forms of MSK pain, it is important to evaluate the patient's current coping strategies and symptoms of stress or distress in order to best recommend an appropriate treatment.

Collaborative Opportunities to Address Challenges/Gaps

1. **Develop an easy-to-use repository of existing evidence-based clinical guidelines, toolkits, and recommendations in a central library that clinicians can reference for issues related to cLBP management.** This repository should also highlight best practices where a multidisciplinary approach to pain care has been implemented with good outcomes. This resource may be helpful for clinicians to assess, diagnose, and identify an effective pain care plan for patients that can be evaluated for outcomes, and adjusted as appropriate over time. Further, access to well documented best practices information may inform future resource needs for health systems, hospitals, and health plans to consider.

2. **Build consensus on how to measure effective pain care.** Evidence-based outcome measures regarding cLBP care will help clinicians, patients, and health insurance providers monitor progress in managing pain. Standardized measures for cLBP care might include: validated patient-reported outcomes, frequency of long-term opioid prescriptions, emergency department visits for patients presenting with persistent cLBP, use of imaging to diagnose and treat cLBP, use of non-opioid pharmacologic and nonpharmacologic options, pain specialist visits, injection treatments, improved quality of life for people with cLBP, improved functional capacity for patients with chronic pain, and validated patient satisfaction measures.

6 https://effectivehealthcare.ahrq.gov/topics/nonpharma-treatment-pain/research-2018
7 https://jamanetwork.com/journals/jama/article-abstract/2673971
8 https://www.acponline.org/acp-newsroom/american-college-of-physicians-issues-guideline-for-treating-nonradicular-low-back-pain

3. **Design and test alternative payment models in cLBP treatment to align incentives for patient-focused, coordinated, evidence-based pain care that is linked to agreed-upon outcomes.** This may help define the optimal care team, integrated case management, incentives for care coordination, reimbursement, physician integration with allied health providers who are supporting a holistic care plan (such as physical therapists, chiropractors, and others), as well as current and potentially new billing codes to support care coordination, the ability for alternative practitioners to bill, and physician oversight of allied health practitioners.

4. **Improve coordination among pain management specialists, allied health professionals, and primary care, particularly for patients with complex conditions, and identify the lead clinician or health care professional ultimately responsible for chronic pain management.** Appropriate documentation and electronic health records that support information sharing among the care team and with the patient will help ensure care coordination. Allied health professionals (e.g., physical therapy, chiropractic, therapeutic massage, yoga, tai chi) may need to meet certification or accreditation standards in order to be a part of established networks for patient referrals and patient access.

5. **Better disseminate and follow existing evidence-based guidelines while building more precise recommendations for the use of non-opioid interventions.** Some evidence is available, but more is needed to build the evidence base including additional comparative effectiveness research studies that evaluate first-line treatments of cLBP. The goal is to effectively disseminate the available evidence on what treatment or combination of treatments works best for which type of cLBP, for what types of patients, and for what time intervals. The development of a repository of guidelines, toolkits, and recommendations may be helpful to accomplish this goal.

   In the meantime, while research continues to develop and provide additional clarity, patients need support and clinicians need resources to help with effective clinical decision making. Use of currently available tools will benefit both patients and practitioners. Currently, some tools exist that attempt to streamline and clarify the decision-making process. In 2017, the VA and DoD released their Clinical Practice Guideline for the Diagnosis and Treatment of Low Back Pain. Their toolkit provides clear and comprehensive evidence-based recommendations for improving patient outcomes. There may be opportunities for clinicians, health insurance providers, and other health care professionals to better disseminate and share existing resources.

6. **Develop and/or better disseminate patient-focused resources (e.g., toolkits, webpages, fact sheets on what to expect and how to engage) about different cLBP treatment options, including an emphasis on the importance of engaging patients as early and as consistently as possible.** Resources could include:

   a. An overview of MSK pain and cLBP pain;

   b. Descriptions of treatment options and their risks and benefits;

   c. Information about setting treatment goals; and

   d. Descriptions of the different types of clinicians who can provide services including their expertise and credentials (e.g., pain specialist, anesthesiologist, psychologist, licensed clinical social worker, therapist, physical therapist, occupational therapist, licensed acupuncturist, neurosurgeon, orthopedic surgeon, physical medicine and rehabilitation, pain psychologist, chiropractor).

   Patient-focused materials should provide information on safe self-care and watchful waiting options when these are clinically appropriate related to the management of cLBP and the occasional acute flare up of pain.

Vision for a Future State

Change is needed, but it might not be easy. It will take time, commitment, and multi-stakeholder collaboration. AHIP is committed to making tangible changes and playing a role in educating stakeholders and disseminating information that may be useful.

As we move from routinely prescribing opioids for cLBP, stakeholders all have a role to play to ensure patients receive effective pain care. This includes patient education and empowerment, as well as increased efforts to support improved functionality and quality of life. Both clinicians and health insurance providers together will need to manage the new realities of a comprehensive, integrated, patient-focused pain management approach. The importance of the behavioral health and education components of cLBP management cannot be overemphasized.

Clinicians will collectively need to build their knowledge of cLBP treatments; this may require additional training to understand which interventions are most appropriate for which patients, based on available and emerging evidence. Allied health professionals will need to adopt a collaborative, team-based care management approach within their training and culture. As additional research becomes available, health insurance providers will need to refine coverage policies to ensure patients can access safe, effective, appropriate, and efficient care, delivered by qualified practitioners. These changes represent a cultural transformation that will take time and impact all stakeholders across the health ecosystem and will entail significant investments in knowledge development and dissemination.

A future state of cLBP will entail a "whole-person" approach, where evidence-based treatment pathways have been clarified and simplified to support multi-disciplinary clinical teams in a variety of settings. In this future state, guidelines would be translated into easy-to-use operational models, where clinicians can follow resources that recommend specific interventions for patients based on their individual type of pain, how they present, their other medical and/or mental health conditions, their goals and values, and socio-economic and other relevant factors. Patients and clinicians would engage in shared decision making to discuss options in the context of the patient's goals and values (e.g., current and desired functionality), and develop an individualized treatment plan supported by a review of available options. This would be enabled by a more robust evidence base; an appropriate set of quality metrics; incentive models that encourage coordinated team-based care; and supported with critical infrastructure to seamlessly share information, monitor progress on the treatment plan, and adjust as needed to achieve the agreed upon goals.