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Current Concepts in Physiatric Pain Management

Controlling the Midfield: Treating Patients With Chronic Pain Using Alternative Payment Models

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Abstract

The entire American health care system is turning upside down, except for the parts that aren't— yet. For physiatrists who manage pain problems, the future is complex. The usual challenge of treating these devastating and costly problems that cannot be measured physiologically is compounded by the requirement to do so in a health care system that doesn't know what it wants to be yet. Payment, regulation, and the very structure of practice are changing at a pace that is halting and unpredictable. Nonetheless, knowledge about some structures is necessary, and some themes almost certainly emerge. I propose that the role of the pain physiatrist is best understood through a soccer analogy. Whereas the casual spectator of the past might note the goals scored by surgical colleagues and shots missed by primary care partners, sophisticated health care systems of the future will learn that the pain game is won by creating a strong physiatry midfield. Physiatrists can reach to the backfield to help primary care with tough cases, send accurate referrals to surgeons, and reorganize the team when chronic pain complicates the situation. Current and emerging payment structures include insurance from government, employers, or individuals. Although the rules may change, certain trends appear to occur: Individuals will be making more choices, deductibles will increase, narrow groups of practitioners will work together, pricing will become important, and the burden on primary care colleagues will increase. Implications of each of these trends on pain medicine and specific strategy examples are addressed. A general concept emerges that, although procedure- and activity-based practice is still important, pain physiatrists can best prepare for the future by leading programs that create value for their health care system.

Recently the best-performing accountable care organization in the United States suffered financially because it succeeded too quickly in moving away from the fee-for-service model [1]. The practice of pain medicine is also moving toward but not quite approaching value-based care. This article looks at the way forward, focusing on building resiliency that will serve pain physiatrists and their patients best in the current world and in the future.

A major framework of this discussion will be reflected in the soccer adage, "Control the midfield" (Figure 1). The reality is that physiatrists are midfield players. We don't score big financially or clinically as often as our offense-minded surgical colleagues do, nor do we often take on the role of the primary care "defense players" who block all types of bad things from happening but often cannot advance the patient to full success. Midfield players must have a holistic perspective on the field, certain technical skills unique to the midfield, and the judgment required to redirect the flow of the game. By taking a critical look at the flow of patients back and forth from primary care to surgical care, the PM&R pain physician can find important unmet needs. Vision, skill, and flexibility create resilience, or the ability to respond optimally to any challenge. This position of resilience is the reason why PM&R might lead pain management in the future.

New Pressure to Control the Midfield

The role of PM&R pain physicians has always been in the midfield. However, changes in health care mean that the midfield is becoming more important than ever. This discussion must begin with a brief review of some models of care that many readers are familiar with.

In the past, fee-for-service medicine was the primary model of payment. In this model, the provider is paid more for doing more regardless of the outcome. Patients may access fee-for-service medicine through an insurer or by paying out of pocket. Insurers attempt to

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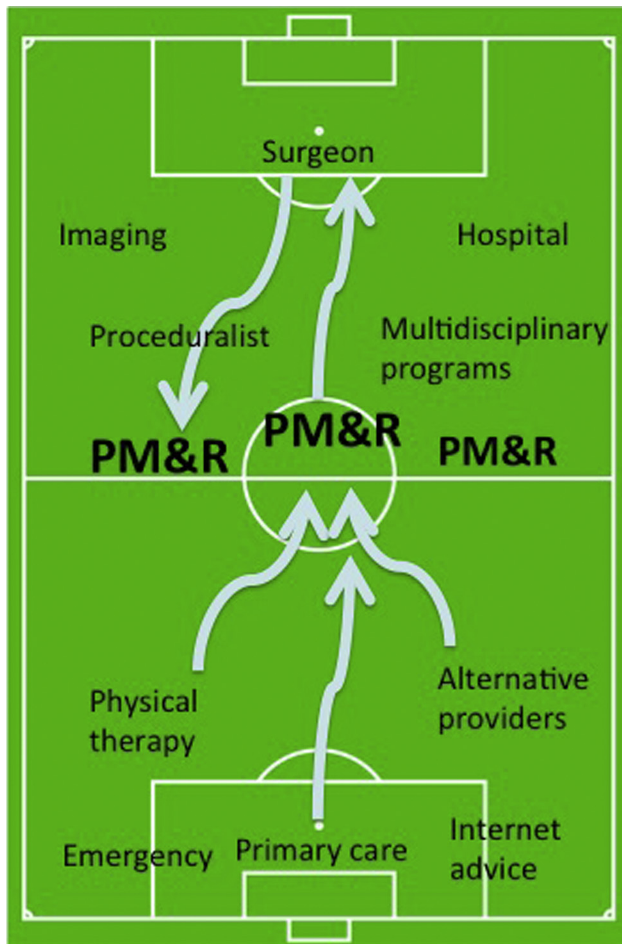

Figure 1. The pain management playing field. PM&R is a midfield player critical in managing patients who fail to respond to primary care, handing off appropriate patients for expensive and invasive interventions, and managing patients who fail to respond to or do not qualify for these expensive or invasive interventions.

control costs in fee-for-service medicine by discounting physicians' usual fees, restricting access to certain clinicians, tests, and treatments, and assigning case managers to expensive cases.

Health maintenance organizations are special types of insurance in which specialist physicians are still typically paid more for doing more. However, access to specialists is restricted to those referred by a primary care physician. Often the primary care groups assume some risk, making them "gatekeepers" who are given incentives not to refer. Many health maintenance organizations allow patients to bypass primary care physicians for services such as optometry, podiatry, psychology, or chiropractic.

In preferred provider organizations, patients have access to a panel of providers who are favored (preferred) by the insuring organization. Often treatment by non—primary care specialists involves either a referral from primary care or an extra charge.

Accountable care organizations, or ACOs, are groups of physicians, hospitals, and others who band together to take on a contract for care of a population of Medicare beneficiaries. The federal government has structured the ACO system in such a way that a number of specific requirements and quality metrics are in place. These requirements and ACO payment to organizations have evolved and will continue to do so. As ACO organizations mature, they better understand their own cost structure and learn how to control quality and cost. This new business sophistication has resulted in some ACOs forming "ACO-like" contracts that take on the risk of a population insured by private companies.

The patient-centered medical home is a concept driven by the idea that care can be improved by having a primary care physician and a team of others as needed take overall responsibility for the patient's health. This model encourages creative use of various allied health providers and community services to optimally manage chronic disease. The Center for Medicare and Medicaid Services recently approved a $42 case management fee; however, with copays and other strings attached, this dollar amount does not yet appear to have drastically changed practice.

Back to the soccer game. On the defensive side, primary care physicians are asked to cover more and more lives, so they strive for efficiency. Yet their skill set in managing pain is often less than optimal, with documented gaps in diagnostic testing and treatment for pain [2]. In addition, the roles of primary care physicians often are being filled by allied health professionals. These professionals range from nurse practitioners and physician assistants, who have less pain education than do most physicians, to physical and occupational therapists, who may have more training pertinent to pain than many primary care physicians. The gaps are also being filled by alternative practitioners, exercise clubs, Web sites, smartphone apps, and online telemedicine consultations. Pain physicians need to influence these groups and sometimes take over when the pain physician has more to offer.

An important way to influence these groups is to step outside of the daily grind of the isolated pain practitioner and try to help our colleagues. One example is the FastBack emergency department triage program [3]. To improve care in the emergency department, the investigators first looked at the complex reasons why back pain care went bad in emergency departments. They provided an equally complex network of help involving patient questionnaires that drove treatment, physician education and protocols, and rapid access to physical therapy and PM&R physicians for appropriate cases. The campaign resulted in an 80% drop in "bounce back" cases (ie, patients who returned to the emergency department within 30 days), with increased detection of dangerous disease, more appropriate medication use, and increased referrals to PM&R and physical therapy. It was a win-win-win-win situation for the emergency department, therapists, PM&R physicians, and patients.

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