Clinical Utilization Review Board (CURB)
January 15th, 2020

PRESENT:
Board: Thomas Connolly, DMD; Nels Kloster, MD; Michael Rapaport, MD; Valerie Riss, MD

DVHA Staff: Katie Collette, RN; Scott Strenio, MD (moderator); Christine Ryan RN; Jenna Cebelius, MPH

Absent: Anne Goering, MD; Elizabeth Newman, MD; John Matthew, MD; Joshua Green, ND

HANDOUTS

- Agenda - Projected
- Minutes – November 2019
- Meeting schedule 2020
- CURB Recommendation Process Document
- CURB Attendance Request Document

CONVENE: Dr. Scott Strenio convened the meeting at 6:35 pm.

1.0 **Introductions and Acknowledgments**
All present introduced themselves. Also in attendance were guests Oleg Neaga, fiscal agent for DXC Technology, and Jay Persico, national account executive for Neurocrine Biosciences.

2.0 **Review and Approval of Minutes**
While reviewing minutes, Dr. Connolly mentioned that it is very helpful to have the minutes forwarded ahead of time. A plan was made to send past meeting minutes up for review to board members a couple of weeks in advance.

Dr. Rapaport noticed one grammatical error to be corrected. Otherwise no additional comment on minutes. However, as quorum was not reached, no motion to approve the minutes could happen. November and January minutes will be brought to the next CURB meeting for approval.

3.0 **Old Business**

Updates on Past Initiatives, Prior Topics, and Discussion
Update – Quality Measures – Group

While reviewing the past minutes, Dr. Connolly brought up a discussion item from last meeting regarding quality measures for providers. He asked about hurdles/data collection that providers and technicians must overcome and asked about the existence of checklists for them to submit for evaluation for certain quality measures by different payors. He discussed with Katie and Dr. Rapaport existing quality measures ranking providers amongst their peers by size or percentage.

Dr. Strenio responded with updates on discussions DVHA has been engaging with Blue Cross Blue Shield about aligning data collection from major payors in order to have comparable quality metrics between payors, relying on the underlying belief that physicians do not practice differently based on what insurance their patients have.

Dr. Connolly connected this to the evolving medical home model, commenting on particular tiers in the medical home spectrum that have expectations about what information they collect across their tier and the spectrum overall. Dr. Strenio mentioned that in the past, different data were collected for different purposes, and at different intervals, making this difficult. He discussed that going forward this information would ideally pass through Vermont Information Technology Leaders (VITL), and explained that DVHA had recently shifted from an opt-in model, where patients had to proactively consent to having their data shared from this master database, to an opt-out model, where they now have to revoke consent for their data to be utilized. Dr. Strenio said that it is expected that data access will increase from around 30% to around 80-90%, if the opt-out approach is continued in this legislature. There was some further discussion between providers about this approach – overall, they seemed in favor of opt-out, provided recipients are made aware and have it clearly explained to them what their data will be used for upon enrollment. Dr. Riss mentioned this approach being helpful for folks registering, since the opt-in model can be rather intimidating if it's just a checkbox indicating that the recipient consents to their data being shared with the state.

There was further discussion about what VITL is – the providers present had not yet accessed it to look up a patient. It was determined that there may be room for improved usability with VITL in the future.

Update –Tobacco Cessation – Dr. Strenio

Dr. Strenio provided an update on the work DVHA is conducting around use of incentives for things such as smoking cessation. DVHA is looking to include incentive use in 2022 Global Commitment to Health Waiver, which is the waiver that allows Vermont Medicaid flexibility in the ways in which Medicaid dollars can be spent. DVHA also has been having discussions w/ OneCare Vermont around incentive use in the pregnant population.

4.0 **New Business**

Comprehensive Pain Program – Dr. Jon Porter

Dr. Porter began his presentation with an introduction of both himself and the program. He is a family physician by training and is now the medical director of the Comprehensive Pain Program associated with UVMMC in South Burlington. When the program began, there was no facility, and no program, just a few legacy patients from the former pain program who were on 800-1800 MMEs for their pain - so Dr. Porter and his team had to start from scratch.

Dr. Porter presented some statistics on the prevalence of chronic pain in general, and high impact pain (chronic pain that has affected some major life function). He told the group that there is an inverse relationship between chronic pain and socioeconomic status, and that it disproportionately affects women, persons of color, and anyone with early adverse childhood events or trauma. Dr. Porter discussed how individuals with chronic pain are often very isolated, in large part due to the stigma associated with opiate use, high rates of depression and anxiety, poor sleep, multiple medical procedures, and being othered by the medical system. He discussed the emotional taxation of a visit on both the patient and the clinician, given the current transactional system of pain treatment. He went on to explain that this transactional approach, which works well for someone with acute pain or sickness, stems from the language used to describe pain. The issue with looking at chronic pain on a scale of 1-10, as we do acute, temporary pain, is that practitioners are operating on the assumption that the pain level can be reduced to zero. This sets up a situation where this very complicated patient comes in for a 20 minute visit saying, "I'm in pain, do something," a clinician operating with a very limited arsenal of interventions and medications they themselves can administer, which may not work, which then leaves the clinician exhausted and the patient feeling unseen, and still in pain.

Patients in the program are asked to find a more apt word to define their experience with chronic pain, as it affects so many facets of their life. Dr. Porter reports that the word they arrive at most often is 'suffering,' which facilitates the deeper dive into both helping them feel less alone by connecting to the human condition and reframes how we look at and treat their pain. When the cohorts of comprehensive pain program begin, they are asked to describe what their pain makes them do, how it makes them feel, and are then asked how many of those things medication can address; which, often, isn't most of them. So, the program then moves the conversation away from curing, but to healing, which is where the transdisciplinary approach comes in.

Over the past two years, using input from those initial legacy patients who agreed to participate, they developed a transdisciplinary program centered on patient agency, efficacy, and autonomous participation. Every week, all practitioners at the program sit down to discuss each patient, share ideas and observations, and strategize about approaches. On staff, there is a half time psychiatrist, full time psychologist, full time social worker (both of these individuals can do EMDR, and the psychologist hypnotherapy), a case worker, two nurse practitioners (one of whom is a yoga instructor), a RN (who is also the reiki practitioner), and interventional anesthesiologist, and the medical director – Dr. Porter.

The program is eight weeks long and centered on groups. This is an evidence-based approach used in mental health and substance abuse fields. It is considered an episode of care – each participant enters the program, and attends two group sessions a week, with additional therapies such as yoga, acupuncture, nutrition programs, PT/OT, massage therapy, and mindfulness movement. Dr. Porter and the RN facilitate group medical visits for status updates, reports of ER visits, and patient requests. There is a second group that is acceptance commitment therapy based, run by the psychologist or the social worker, depending on the day. They have a Care Alliance Group that meets three times over the episode of care at weeks 2, 5, and 8. There is also an orientation. These groups are to let folks at home know about what's happening in-program to

facilitate the transition of this approach back to the medical home, when it's time. There are alumni groups that currently meet once a month, to maintain connection to the program, and touch base about the continuation of the supportive framework for the patients, and the primary care providers. They are finding that participants tend to find the program very intensive, but helpful.

Patients are referred by a primary care physician, a neuropathologist, rheumatologist, or therapist. The program's registered nurse performs an outreach call to determine candidacy and explain what the financial implications of their participation will be. Then the participant comes in for an intake visit performed over two sections; the first by the psychologist or social worker, the second by a nurse practitioner or Dr. Porter. This order is to emphasize that this program isn't just about finding the right medicine, but that the approach is heavily psychologically based. After these assessments, the providers meet to discuss what approaches the think might work best for that individual, and the participant is presented with this list at orientation, and they choose what they want to try.

The location for the program was also designed from scratch. The goal was to create an environment that itself felt therapeutic, homey, comfortable. The waiting room has comfortable chairs, there's a large kitchen where nutrition and cooking classes are taught. There is a movement space that can accommodate classes of up to ten people and a teacher, and a therapy room where a participant might come for body work like massage therapy, reiki, or acupuncture.

Once the program was designed and ready to go, the team had to figure out funding, money from UVM being in absentia. Because a lot of these therapies aren't covered individually by some insurances, they explored alternative payment models; particularly, bundled payments. They explored it with Blue Cross Blue Shield, and DVHA. At the time, DVHA was not in a place to offer bundled payments, but Blue Cross Blue Shield, was. Thus, the full treatment episode of 8 weeks, two groups, multiple therapies, is available only to BCBS subscribers. The Comprehensive Pain Program receives a certain dollar amount per participant for the 8-week episode, for the alumni, and for the Care Alliance Group. The individual participant is responsible for their plan equivalent of two primary care visits; one at the beginning, and one at four weeks. Dr. Porter reports that, in terms of program costs, these services are low intensity costs – so, the hospital bails them out for less than the cost of one epidural injection.

Both the integrative service program design, and bundled payment model, has drawn a lot of attention nationally. Dr. Porter's program has now been running for long enough that they'll soon be able to start looking at financial impact to evaluate cost effectiveness and profitability. They're also measuring outcomes for the participants – the program administers a battery of questionnaires and scales and pre-, post-, and six months out from the treatment episode. The packet records function over a range of domains, as well as trending utilization of various services.

The program focuses on four pillars – compassion, mindfulness, movement, and spirituality. This latter pillar not in the sense of choosing a denomination, but instead, here you are in this mortal

life; it's a tough place – how can we help you, how do you want to be in this space, and how do you want to move forward? This is to enhance the self-efficacy and agency of the participant in working with a very challenging disease. The program's goal is to try a new paradigm, since the current one has been causing significant harm.

Dr. Rapaport responded to the closing statement by discussing how many providers use opiates as a last resort and consider it harmful.

Dr. Porter continued the discussion by commenting on how the fee for service payment model, the burdens of primary care, and limited services covered by insurances and scopes of practice, the default had been for many years to turn to the prescription pad. This, coupled with fraudulent medication marketing of the 90's-2000's, and some absence of critical thinking as a profession, has inspired this sort of paradigm as having a restorative element, to do better by patients.

Dr. Riss asked if back to function employment status and relationship statuses were included in the outcome measures. Dr. Porter reported that they were, demographically. He also pointed out that since their current cohorts are BCBS providers, the majority are already and still working. Folks wishing to participate who do not have BCBS have limited access to groups and classes, but all of the other therapies are billed as fee for service to their insurance.

Dr. Riss also asked if participants must have a certain level of dysfunction to qualify for the program, and if any consideration had been given to early intervention for high risk patients. Dr. Porter told the group that anyone with three months of pain that has in some way interfered with their life is eligible – the idea being to ultimately shift this treatment upstream, before people become legacy patients, and deeply entrenched in their pain.

Dr. Rapaport inquired after the issue of filing for disability coming up (which, Dr. Porter told us, is left up to the decision of the medical home, but the program is willing to offer support in when asked), connecting it back to his own practice. When GIA forms are filled out, in order to get disability financial assistance for patients, there's an onus to indicate that the patient is incapable of doing anything, which is dehumanizing, limiting, and frustrating for provider and patient both. Unfortunately, an 8 week program can't necessarily address this issue to its fullest, but they're already considering another program level for those who have completed the first, who might need a longer program to build supports that establish a sustainable post-program mode of change.

There was some discussion from Dr. Kloster and Dr. Rapaport, as well as Dr. Porter, about managing opioid prescriptions. Overall it was felt that 8 weeks is too short a time span to address dosage tapering and that the program focuses so heavily on re-establishing trust in a marginalized patient accustomed to treatment being centered on tapering of opioid dosage, sometimes unexpectedly, that it wasn't an appropriate environment for that. It was also discussed that tapering, or switching to alternative medications like suboxone, can be destabilizing for the patient.

Christine Ryan and Dr. Porter discussed the alumni group. It's run by the psychologist or the social worker, depending, features some sort of movement therapy, connects alumni, and any difficulties that come up in the return to the medical home.

Dr. Strenio commented that it is probably important to intervene early with this type of program with chronic pain patients before they define life in terms of pain with the goal of the patient identifying and obtaining from the program alternative pain treatment approaches that are effective enough for them that can then actively work with their prescriber to work to reduce/taper the MME dose. It may be for chronic pain patients reducing MMEs/tapering opiate dosage is negatively associated with because opiates are the one tool they have known for dealing with the chronic pain. Therefore the comprehensive pain program may allow patients an opportunity to identify alternative treatments that are effective to some degree for their pain and so then they may be able to consider reducing MMEs because they feel supported by the other tools they have been able to identify to help with the pain.

Dr. Strenio discussed the important role providers/prescribers play to emphasize the gravity of opiate treatment and incorporate this mindset into treatment and practice. Dr. Porter emphasized that the goal of the program is to enhance self-efficacy for patients by providing avenues that are effective and not harmful as soon as possible in course of care. It may be unrealistic to expect that patients that have been on very large MME dosages will ever be able to be completely tapered. It is important to be diligent about surveillance with this subset of the population.

Dr. Riss discussed that chronic pain patients may become frustrated because they feel that the only tool they are being offered is medication, and to have another tool is one patients are likely interested in but may not have access to. She also noted practitioners, particularly outpatient and subspecialty providers, would be very interested in potentially utilizing the comprehensive pain approach with patient as almost a quid pro quo where they meet the patient where they are in regard to opiate need but work with the patient to develop a trial care plan approach to include requirement of participation in a comprehensive pain program in tandem with the opiate treatment in an effort to provide the patient with other pain treatment options that are effective for them.
Dr. Porter discussed that part of what the patient comes away with is knowledge of what is effective for them. Challenges that need to be addressed with chronic pain patients include working with the patient to identify how the pain can be approached so that is does not become their life while the reality will always remain that pain will likely always be a part of their life, but to have tools that make the pain tolerable. Dr. Porter discussed that part of the program is that it provides the patients with the time and space to think about what they are doing around their pain and to reflect. Dr. Porter brought up that if we really wanted to take a proactive approach to comprehensive pain treatment, we would work on addressing things like Adverse Childhood Experiences and how to keep individuals from being exposed.

Dr. Rapaport discussed that this identifies an opportunity to reduce medical expenses which would be to increase the funding to early childhood education. Dr. Riss spoke up that there should be more investment into the foster system.

Dr. Rapaport asked if the comprehensive pain program was something that DVHA wanted to consider as a benefit option for Medicaid members. Dr. Kloster asked if most of the modalities offered through the comprehensive pain program would not be covered under a fee for service payment system. Dr. Rapaport discussed that some patients may not be open to this type of program. Dr. Porter reported that this is a challenge and one of the program tracts works to address this through the initial screening process. When resistance to the alternative program is identified in a patient during the prescreen process, these patients are able to work with the social worker that has expertise in motivational interviewing and they find they are often successful in supporting the patient to participate in the program.

Dr. Riss commented it would be interesting to require participation in volunteer work as part of the program and opiate prescribing to measure if social engagement/participation was improved for those patients that feel isolated. Dr. Connolly commented it may be akin to developing a multistep program to address chronic pain patients to increase engagement and optimize connection. Dr. Riss commented that this might be helpful with the elderly population.

Dr. Strenio discussed that Blue Cross has utilized the bundled payment for the comprehensive pain program. DVHA considered the bundled payment because this would allow trial of whichever of the modalities the patient and provider decide might be effective for the patient but does not open each modality option individually to each member. The thought was that this would promote a more comprehensive evaluation with a transdisciplinary approach. DVHA did put out an RFP two years ago and received several responses however funding was not allocated for the program. DVHA would like to continue pushing for funding for this type of service for Medicaid members.

Dr. Rapaport discussed that expanding a patient's understanding of pain can make a big difference. The overlap with addiction is significant and the approach similar in that how do you change a patient's perception that they can indeed do something else and change their outlook on life. He discussed that comprehensive plans might be beneficial to other conditions as well e.g. diabetes where a comprehensive approach might be more beneficial than a piecemeal approach.

Dr. Connolly discussed that this comprehensive pain program is different in that it is not a program to manage addiction so much as it is a program to provide psychosocial support for people with comprehensive pain. Dr. Kloster and Rapaport discussed that chronic pain patients and patients with substance use disorders are often in the same group. Dr. Kloster discussed that the comprehensive approach seems to be directed more at improving quality of life. Dr. Rapaport followed by saying the earlier these types of interventions, the better for improved patient outcomes.

Brattleboro Retreat

Dr. Strenio echoed Secretary Mike Smith's comments about Brattleboro having a struggling business model and the State's commitment to working with Brattleboro to keep the resource available. Conversations are being held around operational practices and transparency.

Discussion:
Dr. Riss verbalized the importance of having a plan in place particularly for the pediatric population. Dr. Rapaport reported that Valley Vista is no longer accepting methadone patients. Dr. Kloster explained that this was related to the fee for certification for opioid treatment program (OTP) which is the designation necessary to dispense methadone. He discussed that they did not have enough of a volume of patients requiring methadone treatment to make that cost effective to be an OTP. Dr. Kloster noted the Serenity House has expanded their number of beds.

CURB Engagement

Christine Ryan reviewed that over the last couple of CURB meetings we've had robust conversations. We want to continue to actively think of what the CURB can do more of and what DVHA can continue to bring to the group for discussion. The members were encouraged to continue to bring relevant and current clinical issues to the meeting for discussion. Dr. Riss asked if it would be possible to receive the agenda and a summary of any available background information including any relevant data more in advance – maybe a couple of weeks prior to the meeting. Additionally, Dr. Riss asked if updates on topics discussed during the meetings could be provided if there are actions or work is completed between the meeting discussion and the later meeting.

5.0 **Additional Discussion**

Codes No Longer Covered by Medicaid – Unspecified Codes
Dr. Riss asked about an issue she noted that her group at UVM was running into around non coverage of codes. This was related to the unspecified codes. DVHA will bring this information to the next meeting.

Budget
DVHA's overall budget has decreased with fewer people on Medicaid. DVHA will bring more budget details after conclusion of the legislative session.

Adjournment – CURB meeting adjourned at 8:41 PM

Next Meeting

March 15, 18th 2020
Time: 6:30 PM – 8:30 PM
Location: Albany College of Pharmacy and Health Sciences