Access to Multimodal Pain Management for Patients with Chronic Pain: an Audit Study

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INTRODUCTION

An estimated 50 million Americans experience chronic pain.[1] To address the complex biopsychosocial aspects of chronic pain and minimize the risks associated with opioid therapy, governmental agencies recommend "timely, early consultation with pain specialists" and a coordinated multimodal approach to pain management.[2] Effective multimodal care includes medications, restorative therapies, procedures (e.g., joint injections), and behavioral therapy.[2] However, there are concerns that patients with chronic pain, and particularly those receiving opioid therapy, may not have sufficient access to pain specialists, or to the full range of recommended treatments.[2] This research sought to quantify access to pain management services for patients receiving opioid therapy for chronic pain.

METHODS

The study used the "secret shopper" audit methodology during July 2019–September 2019.[3] The pain clinics were sampled from IQVIA OneKey, a frequently updated healthcare database listing over 9.6 million practitioners, and were drawn from 9 states with varying rates of opioid overdose deaths (Table 1).[4]

Research assistants (RAs) called clinics posing as a patient on long-term opioid therapy (LTOT) seeking care. RAs asked about clinic size, providers available, treatments offered, insurances accepted, referral requirements, wait time for a new patient appointment, and providers' willingness to prescribe opioids, assist with opioid tapering, and/or use buprenorphine to manage pain. Descriptive statistics were produced in R, version 3.5.3 (R Foundation for Statistical Computing). The University of Michigan Institutional Review Board deemed this study not regulated.

RESULTS

Of 422 specialty pain clinics with working numbers, 366 (86.7%) were included after exclusions: being unreachable in 3 attempts ($n = 35$), not accepting new patients ($n = 10$), and other reasons (e.g., not serving a general adult population) ($n = 11$).

Of these 366 clinics, 48.1% did not accept patients with Medicaid. Additionally, 54.9% required a referral before accepting patients, and another 23.2% reported that referral requirements varied by insurance. The median wait time for a new appointment was 9 (IQR 4–17) days.

Nearly all clinics (97.0%) performed interventional procedures and 77.3% managed pain medications; at over a third (36.3%) of clinics, one or both of these were the *only* services offered. Physical therapy was offered by 38.3%. A quarter (25.1%) offered cannabinoid products, including THC and/or CBD, in the 8 states where cannabinoids were legal ($n = 355$). Opioid tapering was offered at 246 clinics (67.2%), 105 (42.7%) of those reported having a buprenorphine provider on staff. Only 12.8% offered behavioral therapy. Multimodal treatment was rare: only 10.4% of clinics offered a combination of procedures, medication management, and behavioral therapy (Fig. 1).

DISCUSSION

This study indicates many barriers to and gaps in care at pain clinics. Almost half of pain clinics did not accept Medicaid, and many required primary care physician (PCP) referrals. Only two-thirds of clinic schedulers responded affirmatively when probed if their providers assist with opioid tapers, and the median appointment waiting period was 9 days. As more patients with chronic pain are transitioned off opioids by their PCPs and PCPs are increasingly unwilling to accept new patients on LTOT,[3] these access barriers and a 9-day wait time could lead to unintended harms such as worsened pain, withdrawal symptoms, or transition to non-prescribed opioids.

Furthermore, few pain clinics offered behavioral therapy, which can improve pain-coping skills and address maladaptive behaviors commonly associated with pain-related disability.[2] Interestingly, more clinics offered cannabinoid products than offered behavioral therapy, despite evidence for cannabinoids as a treatment for chronic pain being less robust than that for behavioral therapy.[5] The observed focus on procedural treatments and lower rates of medication management and behavioral therapy may be particularly unhelpful to patients with comorbid substance use disorders.

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Table 1 Clinic Attributes: Treatments Offered and Barriers to Care

States (3 state mean of age-adjusted opioid overdose death rate per 100k people (4)) ($n = 366$)	*n* (%)
High rates of opioid overdose death (mean 33.2 deaths per 100,000)	91 (24.9%)
Massachusetts	9 (2.5%)
Maryland	36 (9.8%)
Ohio	46 (12.6%)
Medium rates of opioid overdose death (mean 21.5 deaths per 100,000)	108 (29.5%)
Michigan	38 (10.4%)
New Jersey	30 (8.2%)
Pennsylvania	40 (10.9%)
Low rates of opioid overdose death [mean 5.6 deaths per 100,000]	167 (45.6%)
California	84 (23.0%)
Mississippi	11 (3.0%)
Texas	72 (19.7%)
Services offered ($n = 366$)	*n* (%: CI)
Medication management	283 (77.3%: 72.8–81.3%)
Procedures	355 (97.0%: 94.7–98.3%)
Physical therapy	140 (38.3%: 33.4–43.3%)
Behavioral therapy	47 (12.8%: 9.8–16.7%)
Cannabinoids (including THC and/or CBD)†	89 (25.1%: 20.2–29.0%)
Complementary alternative medicine‡	31 (8.5%: 6.0–11.8%)
Chiropractic	25 (6.8%: 4.7–9.9%)
Other	50 (13.7%: 10.5–17.6%)
Willingness to manage tapering opioids ($n = 366$)	*n* (%: CI)
Yes	246 (67.2%: 62.6–72.1%)
No	67 (18.3%: 13.7–23.2%)
Do not know/no response	53 (14.5%: 9.8–19.4%)
Buprenorphine prescribing, among clinics indicating "yes" to opioid taper ($n = 246$)*	*n* (%: CI)
Yes	105 (42.7%: 36.2–49.7%)
No	78 (31.7%: 25.2–38.7%)
Do not know/no response	63 (25.6%: 19.1–32.6%)
Referral required ($n = 366$)	*n* (%: CI)
Yes	201 (54.9%: 49.7–60.3%)
No	80 (21.9%: 16.7–27.3%)
Depends on insurance	85 (23.2%: 18.0–28.6%)
Medicaid accepted ($n = 360$)*	*n* (%: CI)
Yes	187 (51.9%: 45.9–56.5%)
No	173 (48.1%: 42.1–52.7%)
Wait time, among clinics offering an appointment date ($n = 192$)*	Median (IQR)
Days	9 (4–17)

**Excluded clinics did not respond or did not receive the prompt. Percentages are based on the provided n value*
†Percentages were calculated for only the clinics in states where some form of cannabis derivative is legal (i.e., full legalization, medical legalization, or CBD oil only)
‡For example, cupping and/or acupuncture

Barriers to providing multimodal care likely include inadequate reimbursement for behavioral therapy and other non-procedural treatments, lack of trained providers, and opioid-related stigma.[2] Limitations to this study included only contacting pain clinics from the IQVIA database, and in 9 states, which may not be representative of all pain clinics. In addition, information was provided by front desk staff, who may be unaware of some services. However, this

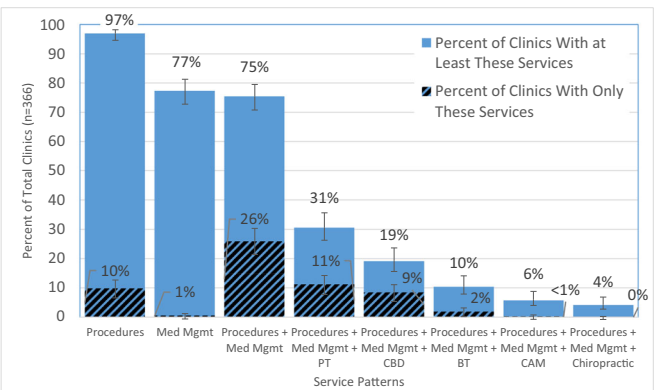

Figure 1 Percentage and 95% CI of select service patterns offered exclusively and in combination with additional services. This graph presents selected service patterns. Service patterns are presented both exclusively [diagonal] (e.g., "Procedures + Med Mgmt" are clinics that *only* offer those two services and no others) and non-exclusively [solid bars]. Med Mgmt, medication management; PT, physical therapy; CBD, any cannabinoid or cannabis derivative (e.g., CBD oil); BT, behavioral therapy; CAM, complementary alternative medicine (e.g., cupping, acupuncture).

is consistent with the information real patients receive. Thus, while timely multimodal specialty care may be the ideal treatment model, it is currently unavailable to the majority of patients.

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Compliance with Ethical Standards:

The University of Michigan Institutional Review Board deemed this study not regulated.

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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