Pain Management and Spine Rehabilitation Strategic Plan

Envisioned Future:

In the future… physiatrists are recognized as the preferred providers for Pain Management and Spine Rehabilitation care. Timely physiatric assessment and management, when utilized early in the care continuum, may effectively treat acute pain and injury, and reduce the severity and chronicity of pain-related conditions. Pain Management and Spine Rehabilitation physiatrists develop, direct, and administer comprehensive multi- and interdisciplinary rehabilitation programs based on a patient-centered biopsychosocial model of care. They help people manage acute and chronic disabling pain conditions, with the emphasis on maximizing physical and psychosocial function, and quality of life.

Pain Management and Spine Rehabilitation physiatrists are able to provide breadth and depth of clinical care in this field. Their expertise includes pharmacologic management, prescribing restorative therapies, injection therapies, and minimally invasive procedures. Physiatrists help to coordinate behavioral health, patient education, and complementary and integrative therapies. Physiatrists bring unique skills to pain management including their ability to diagnose underlying pain conditions and manage patients over their continuum of care, adapting treatment plans as necessary.

Physiatrists are good financial stewards in the value-based health care system, resulting in decreased health-related costs for patients with pain and spine care needs. Both primary care providers and specialists refer patients with a spectrum of pain conditions and spinal related disorders to Pain Management and Spine Rehabilitation physiatrists.

Physiatric care incorporates best evidence and emerging technologies. Pain Management and Spine physiatrists demonstrate the value of physiatric-led multi- and interdisciplinary care teams through patient-reported and functional outcomes data, and comparative effectiveness research. Pain Management and Spine Rehabilitation physiatrists are seen as the optimal “go to” providers early and throughout the continuum of care, and are uniquely equipped to provide the most optimal, safe and efficient patient-centered care.

High-Level Goals:

High Priority Goals:

A. Detail models of Pain Management and Spine Rehabilitation (PSR).
    1. Define the expertise and core competencies of PSR physiatrists that strongly align with value-based care systems
    2. Explore how to deliver PSR services including integrating physiatrists within care referral pathways

a. Cultivate critical relationships with providers such as primary care and specialty providers.
b. Demonstrate how PSR expertise can provide value to insurers/payors and decision makers within and outside care pathways.
c. Explore opportunities to provide a wide range of pain management and spine rehabilitation services to comprehensive groups and referring providers.
d. Explore the positioning of PM&R in future employer or self-insured groups, demonstrating that a subset of patients can be treated with more cost- effective care vs. surgical care.
e. PSR physiatrists develop comprehensive care plans, effectively integrating injection therapies and other minimally invasive procedures, supported by best evidence, value, and outcomes data.
f. Further explore the practice area's use of new treatments and technologies including orthobiologics, pharmaceuticals, multidisciplinary rehabilitation, novel interventional spine techniques, and alternative and complementary treatments.

B. Educate external stakeholders on the expertise of PSR physiatrists to increase market penetration
    1. Identify and prioritize external stakeholders.
    2. Promote an understanding among stakeholders of what PSR physiatrists do and how they add value.
        a. Establish a more consistent view of the role of PSR in the MSK/pain care continuum, as current understanding varies regionally and system by system, with some viewing PSR physiatrists as interventionalists only or excluding PSR physiatrists from the pain or MSK care pathways.
        b. Pursue strategic relationships with other associations and physician networks to generate knowledge and demand for best practices in pain management and spine rehabilitation.
    3. Create resources to help PSR physiatrists craft stronger relationships with primary care physicians (PCP), orthopedic and neurosurgeons, urgent care and emergency care providers.
        a. Develop resources that can help educate stakeholders that PSR physiatrists will see patients early in the course of treatment, with emphasis on non- operative care. These resources may also address incorrect assumptions that spine and joint problems are immediately considered an "orthopedic problem" whereas PSR physiatrists can/should be known as the Spine/MSK "first line" and triage experts.
        b. Create and provide frameworks for pain management to provide value to the patient, PCP (or other physician group), and system.
        c. Provide resources that help PSR physiatrists to establish and lead interdisciplinary pain management teams, providing comprehensive biopsychosocial assessment and management, behavioral health and addiction medicine.

C. Set a standard for training (in residency, fellowship and in practice) that will advance the knowledge and skills of physiatrists to meet the needs of future pain management and spine rehabilitation models
    1. Develop a pain management and spine rehabilitation scope of practice.
        a. Identify unique skillset and practice approaches of PSR physiatrists.
        b. Pursue the new ACGME rules regarding pain fellowships to create more PSR physiatrist-led training

i. Consider capacity within existing pain fellowships and/or need for a PSR-led pain fellowship.
ii. Develop physiatry led standards for pain fellowships and advocate for the number of physiatrist-led fellowships to increase.

2. In residency and fellowship training, increase emphasis on pharmacologic management (including opioid and nonopioid), biopsychosocial training, biomechanical assessment, team management, and proper triage.
    a. Advocate for modifying training curriculum.
    b. Prepare academic faculty to teach/train this new curriculum.
3. Update education available for physiatrists in practice to prepare for future models of pain management and spine rehabilitation.
    a. Increase exposure to pharmaceutical management, biopsychosocial training, and biomechanical assessment.
    b. Provide education regarding new techniques or procedures to continue adding to PM&R's "toolkit," when supported by research evidence.
        i. Create digital learning and in-person resources.

Intermediate Goals:

D. Explore reimbursement models for comprehensive pain and spine rehabilitation.
    1. Advocate for best practices including risk adjustment and carveouts where appropriate. (Note: work with care pathways, payers, and models in Goal A can be leveraged in this goal area as well)
    2. Establish PSR physiatrists as having a prominent voice and position in bundled care models.
    3. Advocate for appropriate reimbursement for E/M.
    4. Advocate for increased coverage and reimbursement for multi and interdisciplinary care programs supported by evidence-based care.
    5. Address telemedicine reimbursement including coverage for routine visits that do not require a hands-on physical assessment.
    6. Address burden reduction including time and energy spent doing peer-to-peers, paperwork, etc.
E. Create educational pathways to prepare physiatrists to embrace, lead and practice in the new PSR models highlighting value-based care.
    1. Practice Management Skills:
        a. For those who need or choose to diversify their practice, create training on how to transition from a solo/small practice to integrating with PCPs and larger health delivery systems.
        b. Create educational programs to help physiatrists implement outcome measurement, collecting basic data, and how to leverage that data.
        c. Ensure practice management education prepares physiatrists for current and future models and helps physiatrists understand the urgency related to preparing for value-based care.
    2. Leadership skills including:
        a. PSR physiatrists need to have a seat at the leadership/administrative table (and leadership skills) to affect reasonable distribution of the financial pie.
        b. Develop leaders in PSR that are prepared to be leaders of health systems, directing care, and advocating for physiatrists to be leaders of multidisciplinary care.
        c. Address the need for advocacy training including how to network and public

speaking.

d. Provide information on how to leverage teams to ensure the "full PM&R toolbox" is readily available.

F. Train and leverage Advanced Practice Providers (APPs) to support physiatrists to fulfill PSR models and meet workload expectations/requirements.

G. Address critical health policy and regulatory barriers to model adoption.

1. Physiatrists need to level the playing field with pain anesthesia at various stages
    a. GME
    b. Credentialing
    c. Access to patients
2. Address restrictions on opioid prescribing
    a. Current metrics are centered around volume of prescribing (reducing overdoses, tapering, etc.) but not quality of prescribing (valuing comprehensive patient-centered care).
    b. Add PSR physiatrists' voice to national opioid discussions.

Future Considerations:

H. Document/demonstrate the value of Physiatry to Primary Care though registry and data

1. Share research showing outcomes
2. Utilize Registry, creating new measures as needed
3. Comparative effectiveness research

**Disclaimer: Elements of plans marked "strategy" are not firmly defined for all areas and need to be explored with committees where assigned.