Introduction to Dr. James Friedkin and chronic pain care

So wonderful to have Doctor James for Dinan today. He's a professor at the University of Minnesota, the School of Dentistry. And, my gosh, I think that what we're about to go through has blown my mind.

And I hope it blows yours, because talk about an industry leading innovative technique addressing chronic pain. But truly, truly get to getting to the root and not just talking about medications and stuff like that.

So Doctor Friedkin's got 35 years of full time experience in health care and research and teaching, with a focus on the field of chronic pain. And he's developed something called pact, which we're going to get into a little bit later on.

And, and this is I think this is something that's really going to change the world, and this is what I wanted to him to be on our digital summit. So, Jim, great having you here.

Thank you very much. Chang, it's a pleasure to be here and to share with some of my experiences over the, the years of working with chronic pain patients, actually, since about 1978.

Oh, wow. I started. So, yeah, I mean, obviously you've been doing this for for a while, but let's let's talk about let's talk about some some pain points here for, for a lot of doctors.

So it doesn't matter what specialty a lot of doctors and it doesn't matter. It's primary care or orthopedics, dermatology, rheumatology whichever one it is taking care of of patients in chronic pain requires a lot, from the doctors, from the staff, from, from the family members and communication.

And it just requires a lot. And I and I feel like those people with chronic pain are kind of brushed off. You see this in the emergency room, right? Right.

See this, an inpatient. Even the only place I feel like the a chronic pain patient is welcome is in hospice. That's like the only place where it's like, welcome home.

Welcome in. Right. And so let's let's try to change that for a bit. But but let's, let's let's kind of categorize like you categorize some of these patients with chronic pain.

Like what kind of patients are they in. How should we do anything about it. Well, it's very interesting. The whole sort of population with chronic pain.

The youngest patient I had was about, five years old. So, neck pain dropping. The oldest one has been 96. So chronic pain has a potential impact for any age group within the population.

And of course, I do have patients who are probably more above the age of 60 or so. But that doesn't mean that all people, cannot develop, a pain condition that that it persists.

Who chronic pain affects and why it becomes persistent

Now, one of the interesting studies or multiple studies that I found was, well, when a person has an acute injury, what's the percentage of patients that persist, have pain that persists and lasts beyond five years?

Take a guess. I don't know. 50. Yes 50%. Okay. So that means and when you have acute pain that lasts at least a month. Yeah. It's at least with our current health health care system, it will last beyond five years.

Now there's reasons for that. And that's what we have to figure them out. You know, I feel like whenever we would

just talk about pain in general, you know, it's really not just about the subjective feeling of pain, right?

There's so many things that come with it, like the socioeconomic status, the social determinants of health, their financial situation and stuff like that.

And I just I just don't think it's what we were trained to, to deal with. You know, or we were trained, we weren't trying to deal with it in the appropriate way.

So, you know, how do you how do you have, how do you have a system where it's more like patient centered when you're dealing with chronic pain patients?

Well, it's a challenge in our current health care system because, we don't have time. I mean, how do you evaluate a whole person or other aspects of their, of their sort of risk factors that drives chronic pain?

How do you evaluate evaluate them, identify them, and then, of course, address them in the context of your treatment program. And within our current health care system, health care system, it doesn't really allow for the time to do that.

And so we have to develop other tools for which to do that. And it's critical to really identify those patient centered factors that drive chronic pain.

So what I'd spent the last ten years doing is really researching the literature to identify what are the factors that drive acute to chronic pain, and are they risk factors, or are they sort of a lower number of protective actions that you do, and how do they contribute to and how do they categorized?

And in terms of the and that's one of the areas that I've studied very carefully and developed a course, for patients, for providers, at the University of Minnesota, it's called, Preventing Chronic Pain, a human systems approach to kind of present that.

And it's, part of a course called coursera.org. It's a free course. And it helps kind of sort out all of those risk factors. But then of course, when you know what they are being practical about identifying them and implementing something to help support the patient and change them is the complicated factor.

Well, it's also got to work in business too, right? Because, you know, from a primary care standpoint at least, it's the average, the average time a doctor spend of a patient on one on one is about 7.5 minutes.

Right. And so, you know, we we laugh at that. But unfortunately that that is that is the median time. Right. And so and believe it or not, it's about 30 minutes on documentation per seven minutes of, of of spending time with the patients so that that's, that's, that's a big issue.

So I think that, you know, before, you know, electronic medical records, written documentation is relatively easy. And you do spend a lot of time with the patient.

Now, a lot of it's kind of typing in front of the patient, you know, unless you have a scribe. And then, you know, trying to treat someone with needs in 7.5 minutes, not only is it impossible, I think is doing a big disservice, to the patients.

And what are what what field you're in. And so obviously we have to get some help here, right? Obviously. Yeah. So, so, so from a primary care standpoint and this is usually what we primary care docs do.

So referred to pain management physical therapy occupational therapy and maybe some chiropractic or acupuncture work is you know we're into that sort of stuff right.

But I and I feel like there's a lot of like these services are more like, done for you rather than you do the work.

Patient-centered care, time constraints, and the need for coaching

And in my field of integrative medicine, a lot of it is a lot of this is about empowerment and coaching through and everything. Right. And so I don't think that our medical system is necessarily set up for that coaching side, especially when I see somebody on 7.5 minutes.

But even so, we do we do want to see this patient for 1530, you know, 60 minutes. That the business model has to it has to be there. Right. And so, and so the whole the whole reason I'm talking about this is because we're, we're missing something.

And I think that that's health coaches because that's really what you develop. So you can you sort of walk us through what did you have. What do you what do you have in mind like this master plan is your is your solution for this chronic pain issue?

Well, that's a very good question and very good discussion too, because, you know, primary care is where it begins. I mean, somebody has an acute injury.

They go to primary care first. Back pain, neck pain, headaches, draw pain. And an interesting study at Mayo Clinic found that two thirds of all visits are all patients that are go to primary care are related to pain conditions.

So that is really their majority of the practice. And when you spend 5 to 10 minutes with them, it's hard to identify anything beyond just physical diagnosis now.

100% of my patients have a physical condition that's causing their pain. Most of the time it's called myofascial pain. It's a it's a muscle related pain.

And complicated by joint problems like arthritis or disc disorders. And so when they have those conditions, that's what's focused on. And usually it's it's so easy to write a script.

And that leads to the opioid crisis multiple medications. I've seen most of my patients or many of my patients have at least 10 to 20 prescriptions given to them.

The average the number of years that a patient has pain prior to seeing is about five. And of course, prescriptions is the way to go. And then when you have 5 to 10 minutes that's a problem.

So somehow we have to figure out how to transform that visit. Not taken more time, but how do you really engage the patient within a, within a, some type of, program that is an extension of your care that allows the patient to really understand not just the physical problem, but also those lifestyle or patient centered factors that are driving that.

You know, and that's that's really the key. And so we have developed a strategy for which to allow that with a simple phrase. And this is a phrase that, all primary care doctors need to provide their patients and specialists also.

And it's very simple. I'm happy to treat you. This is what you tell patients. However, it's more effective long term if we also train you to reduce the causes of your pain.

Are you interested? That does two things. It shifts the paradigm. It starts putting the responsibility to some extent on the patient to improve their condition.

So that's that's one thing. And you know that it's training and things like that. And it's more effective long term. And then it shifts the paradigm from the physician to the patient.

And that also opens the whole door to the patients. And really I have the ability to manage my pay. And when they have that ability, and when they have that, that shift in paradigm, it's not about taking the drugs.

It's not about some passive treatments which do help. They do help. And we don't recommend stopping that. But we also have to implement a training program, a support program.

And that's where telehealth coaching comes in. Does that make sense? Absolutely. So so you said something, earlier was talking of asking the patients, we have something that you may be able to do, to activate lifestyle metrics that is able to positively reduce or control your pain.

And so, and so, so and then, you know, the next phrase is probably the most important one is are you interested? And. Right. Yeah. And and now, you know, the patients, they're, they're in the cockpit on their own plane.

You know, they're the one flying like you're not the one flying for me. And then I said, there's, multiple other, interviews is, you know, we're we're we're doctors.

Have to be, for patients now is not to play the hero role, but have the patients be their own heroes. And to do that, you have to switch from a doctor being the hero to the doctor being a guide.

And I think, you know, in our practice, when we started health coaching, we became guides and the health coaches became even bigger guides for the patient.

Now there's empowerment that that really happens. I think the the structure of our of our vernacular is just absolutely crucial. In, in the patient interaction.

And I'll tell you what, I and I swear half the time, you know, we get, we get pain scores and pro data for patients. And half the time, like the patients are in less pain leaving your office because they have some level of certainty that there's something to be done.

So I think so, yes, yes. In fact, if you look at the randomized clinical trial. So I spent about five years doing systematic reviews of all randomized clinical trials for all pain treatments.

The PACK model and how it works

And interestingly enough, you know, medications, physical therapy, chiropractor, you know, patients, self care, surgery, injections. It it was really surprising the results of that.

What we found essentially was that every treatment worked above and beyond placebo to some extent, usually about 10%. And some of them are longer terms.

Most of them are short term effects because that's all you can really do in a clinical trial. So but was interesting that the nonspecific therapeutic effect of the interaction between you, the patient and the treatment, that belief system had the biggest effect.

So it's called the placebo effect. But you know we don't like to call it that. I like to call it the nonspecific therapeutic effect of a relationship of caring for somebody else.

Now that has a big impact. Treatment has a big impact. But what we found to be the most effective treatment of everything was self-management, was the patient's belief in self-efficacy of how they can control the pain themselves.

And that shift in paradigm, doesn't our health care system doesn't allow that to happen very often. But with that simple phrase, I'm happy to treat you, but it's more effective long term if we also train you to reduce the causes of your pain.

Are you interested? That simple phrase shifts the paradigm, and then, of course, they say yes. That's what makes most doctors nervous that, oh no, I've got to figure out how to train them.

Or at least involve them in a program to do that. And, and that's what we've, we've developed as a very simple transition to, well, we have a solution for you if you're interested and willing.

But if they say no, it's actually on them, you know, and, you know, we talk more patient. It does not want to be part of the program at this time in the documentations.

Let's follow you up next month. We will reach out back back out to you to see if you want to incorporate into this. And that's something that's really work for our practice and other different, you know, coaching systems within our practice.

But, well, let's rewind for something here because. Yes. Well, there's an acupuncturist, so I have to mention this. You said that most of your piece, or 100% of patients have a pain.

That's from a physical source. And most of it's the mile stash, right? A mile fast is probably the most common word that comes out of my mouth on a daily basis.

Me too. So, so, so for, for and for those of you who aren't really trained in this, the the mile. Sasha produces the most placebo effects in clinical drug trial history.

And, and I'll tell you why. So there's a, there's studies showing that those patients with end stage, lung cancer, have better mortality in hospice than they do with aggressive therapy.

And it's not because it's not because chemo and radiation isn't the necessarily work, but because their, their threshold of pain is less the, their it's, they're, they're mile fast, if you will, is a lot more relaxed.

So when you translate that into other disease states and disorders, we see a lot of patients with Ehlers-Danlos syndrome. So EDS in this autonomy and Pots.

And so it's same thing as the mouth as well. When you give them, when you give them a some sort of sense of certainty, like a verbal sense of certainty that, hey, you're probably going to be okay, but it requires this and you're in the driver's seat.

And so when they take upon themselves to become empowered, their pain scores is drop. And so and so I think there's already more power in words. And there are in prescription just off the bat.

But at the same time, if you have a whole program that's dedicated to it, like we do for a lot of your stuff in our facility, it's a home run and it gets you like five star reviews, like on Google, like it's there's nothing better than then closing the loop on on those type of patients.

Well guess what the patients said. No, we'll check with them again. And when they're ready, the they'll be ready. But we're not necessarily tied to the outcome.

We're tied to the fact that we have this for them. When you're ready, you're ready. And that's the guidance mentality rather than the heroes mentality.

So I truly appreciate, you know, what you're what you're saying here. So let's go. Let's go into the program. Let's go into the pack program. Because, you know, you showed me a file earlier that had all this data on it.

And so let's, let's, let's give a short version of that to the audience. And, and by starting with what what is what is pack stand for well packed stands for it's packed personalize activated care and training.

And I'm, half researcher and half pain specialist. And so I do and I was trained in both dental school as well as a medical school pain management anesthesiology program.

So I've got kind of this, this, sort of land. And then I've also have a advanced degree in research. And so as a

professor at the University of Minnesota, I've had, lots and lots of NIH grants to really support looking not only at the longitudinal factors that drive chronic pain, but NIH did fund the development of a platform, called the Pack program, that provides a very simple strategy for which to implement patients into a robust pain management training program with telehealth coaching.

And, it makes it so easy to implement that, as part of your routine care. And it kind of extends my care into the patient's life. And the coaching aspect of it is very critical because, again, it's part of that nonspecific therapeutic effect of a relationship between you and the patient and the coaching the patient.

And it has a very powerful effect and helping guide the patient to achieving their goals by making the lifestyle changes that they really need to make.

And so the program involves, several components. There's a technology platform that's equivalent to an electronic health record. We call it a patient engagement platform.

And it's like any H. R. Only it's for the patients. Yeah, it's for us and for billing and things like that. A Pep or a patient engagement platform is really for the patient to be engaged in this comprehensive sort of strategy for which to what we call transform them, or transformative care.

And so what we did in the clinical trials or in the study, the longitudinal studies and the review of the literature is try to identify all of those risk factors that drive acute, chronic pain and all aspects of our life.

Then we developed a risk assessment based on all of those. We tested it out on 1500 patients as part of this course on Coursera. They all took it. We looked at the correlations between that risk factor and the severity of pain and the and the persistence of pain.

So we validated this risk assessment. So that's one piece of it. So what the patient does and what the doctor does is say I'm happy. If the patient's interested they can just simply enroll them in this platform.

It takes about 30s. And it does. The doctor does do. It's usually the staff that does that or the front desk. And then they first thing they do is take a pain and risk assessment to really understand that person and the whole person, not just their physical condition and diagnosis.

So there's that. There's the risk assessment component. Then there's risk reduction training program. So for every risk factor there's a brief 5 to 10 minute micro lesson on okay here's the problem.

Here's why it's a problem. Like say for instance, something as simple as clenching your teeth or tensing your shoulders or sitting at a computer all day long, or stressors or anxiety, I mean, all aspects of life.

And I'll go into that in the second and all the different areas of pain. But that training then provides them some really quick lessons, because nobody wants to spend a half hour on the computer listening to they really want to get to the information.

So these are micro learning, micro lessons. Then based on that risk assessment, the coach there's the third part of the program is the coaching. And so they schedule that first visit with the coach.

And the coach provides orientation on trying to understand why there are patient centered factors that play a role in these pain cycles that perpetuate pain over time.

And so it helps to clarify what they need to do and helps them set their goals like it's not just always about reducing their pain, but it's about reducing the impact that the pain has on their life.

It's actually more important if they can't work or they're not able to take care of their family. It's like they want to do or they can't go out for a walk, it just hurts too much.

That impact and their coping skills is also critically important. So it helps them set the goals, the broad goals, and then guide them and support them in achieving those goals.

So those three parts risk assessment, risk reduction, training, telehealth, coaching all occurs outside of the doctor's office. And it's a then then the doctor will see the patient and other months they've already gone through a couple coaching sessions, some lessons.

They ask them about how are you doing in your self-care? And, that patient talks about it. Usually they rave about their health coach, because everybody loves health, coaches health and wellness coaches.

And and it's not about reversing the negative. It's about implementing protective actions. So healthy habits and calming practices and developing mindful pauses throughout the day.

So you just simply pay attention to what you're doing. It's about implementing really positive protective actions versus that just versus reducing risk factors, because that naturally happens when you implement healthy habits every day.

So those three things are put into a program we call the pack program. Very simple, easy to implement. But then the patient is engaged in something outside of the clinic that really helps transform their lives.

And we call this model where you do training with treatment using technology and telehealth, coaching all these, as transformative care. It starts with Te also.

So it's kind of a acronym. So so in year more than three decades of experience with, with pain. How how do you see this impact America. Like just tell me what your, your vision is for, for this program.

Well, it kind of goes back to your original discussion and point about the business model. Obviously, the business model drives practice to some extent.

So we collaborated with the health plans, you know, Blue Cross Blue Shield, UnitedHealthCare, Aetna, you know, all the large health plans in Minnesota as well as, nationally to really say, okay, we have a model of transformative care that we really believe strongly.

If you want to stop the opioid crisis and really reduce chronic pain, you know, chronic pain patients costs 20 to $40,000 per year to the health plans and to employers.

I mean, there are the big elephant in the room of health care. So getting back to the business model then is how do we get reimbursed for implementing this program?

Business model, reimbursement, and scaling transformative care

And we tried a variety of different CPT codes, and they didn't get reimbursed because they were generally provided by mid-level providers and reimbursed at a relatively low level. And it wasn't really cost effective and physicians could not implement this.

So we went to a model where one of the the CPT codes that we found works really well and was recommended by the health plans to use was 99409. Now, that is a little bit of an unusual color because it's about substance misuse.

And so, preventing substance misuse but preventing chronic pain. So we broadened that concept so that nine nine, 409 could be reimbursed. And so the platform is designed to when the coach has a visit or there's a risk assessment that a billing sort of form is set up the PDF form and the billing team for that clinic then can just simply download it every week and, and add that to the providers sort of services that they provided.

And it gets filled to the insurance coverage. So that business model, which is relatively simple in the billing staff, seemed to, you know, do it quite well and it adds revenue to that primary care or specialty provider.

And so we have found that we're able to generate a net revenue for the provider to implement transformative care. So, you know, you can do blocks and injections and things like that.

And that adds, you know, revenue. And it does help patients for sure. But if you also add a transformative care, the packed program into that, it generates a net additional net revenue.

And it supports for a little bit of additional time that is provided by the by the health professional. So we believe that that model is when it's a triple win.

So the patients benefit because they get better. The health professionals benefit because it extends their care in the patient's life and they get reimbursed in a positive net revenue.

And the third thing is really important, since pain patients cost 20 to 40,000 per year because they get ongoing treatments. We have found that this decreases health care utilization considerably and improves and reduces health care costs considerably.

So, we believe that triple when you know, it's health professionals health plans and the particularly the patient will drive use of this. And we're just at the beginning stages in the first year that it's an interesting thing.

When you brought up the business model, I think it's important to recognize that. So you can can't do anything without the business model. You can't skill anything without the business model.

And something like this that's really catered towards the patient decreases, cost overall of healthcare expenditure. I mean, the payers got got to see this as a win.

So I'm glad. You know, the Blue Cross Blue Shield who referred is recommended using these these goals. But now I think we're hey we're in 2021. So 2021 lots lots of CPT.

Changes came out 2022 even more because they released those those in July. So I had a chance to take a look at them. So now we're, we're also in a lot of physicians are in digital health as well.

And we also have the opportunity of being reimbursed for digital communication. So whether it's, you know, messaging, secure messaging, text messaging, phone calls, checking phone calls, you know, CMS has has brand new safety codes for this.

And so I think there is a way where we can improve, the more touch points for the chronic pain patients, through, you know, not just the, the, you know, the substance use counseling or screening code.

We'll also all these different things that are engaged, you know, together to, to to formulate a very, you know, cool and structured way to, to deal with, chronic pain is actually very similar how we deal with other chronic conditions as one that is, you know, chronic pain, but most chronic conditions have some pain associated with it.

So it's pretty all, all encompassing. So I think that if we if I understand this, then this is really this, these visits, these assessments, and, and the touch points are, are really taken on a digital platform outside of the doctor's office.

And so what is what do you think? Are are there any negative impacts to the workflow of a of a doctor's office at this point? Well, one of the the questions that always comes up by patients that's really important is is this reimbursed.

And so does my insurance cover it. Yeah, all the time. And so one of the issues that we have frequently is that the that when we bill it out, we fill out the coaching, we fill out the risk assessment.

And that's usually done on a monthly basis. And it's billed under the provider's name. And so patients kind of and it's, and it lists it as sort of preventing substance misuse.

And so one of the, you know, red flags that come up is I don't have a substance problem. I'm not an alcoholic. You know, it's just going to get on my record that I'm doing this.

And so yeah, I can see that. Yes, it brings up questions. And so what we do at the initial consent form within this is explain that to them and explain that this is not a red flag for you.

It's not going to to necessarily make people think that you have a substance misuse problem. So part of that is just the upfront consenting form that the staff typically does when they enroll them in the program.

And, and the vast majority of patients really don't have any problems with that. You know, but there are some patients who do have substance abuse problems.

And so we really work with them. That's one of the major lessons. And one of the criteria for billing that nine, nine, 4 or 9 is to use a risk assessment that identifies whether or not there are any substance, misuse or substance concerns at all.

So it's all part of that, initial assessment, form to really help us identify, the other issue that comes up sometimes in terms of, the red flag is that is that some providers, you know, really have a hard time shifting that paradigm because they, for instance, they their revenue is generated by injections, blocks, interventions, things like that.

And so, but we've been able to because there's a net revenue, we've been very successful in integrating, this program with treatments such as nerve blocks and injections, interventions, even surgery, when surgery is needed, because it does improve the outcome of surgery.

And that's what most surgeons want to make sure they do, is we want to have these treatments have not only a short term effect, but a long, long term effect.

And let me tell you a story about, a patient that I saw, a couple of years ago. He was 81 years old, and he was, the CEO of one of the major corporations.

And then he retired when he was 65, and I was treating his wife and his daughter, and he was happened to be in the room at the same time. And they were doing so well with lifestyle changes and, and some of the treatments that we provided.

So he came up to me afterwards and says, I wonder if you could help me. He's 81. I've had headaches, neck pain, shoulder pain, jaw pain for the past 65 years.

Every day, every day since he was age 16, he says. I don't know if you can do anything about it. Nobody has ever been able to help me. So of course I said, well, we have a very comprehensive program.

And yes, if we can reduce the causes of your pain, it's going to improve. And some of the treatments will help too. So let's do that. So I worked with him for about two months or so.

And he had dramatic improvement because he was tensing his shoulders, clenching his teeth, really doing a lot of factors that drove, you know, drinking lots of caffeine and wasn't sleeping very well.

There's just a number of factors, that he reduced his headaches and pain from every day to about once every two weeks. And when he came in, it was interesting after those two months and he's better.

He was so angry. And I said, well, why are you so angry? You should be delighted. He says, you know, why hasn't the health care system or somebody in health care taught me these things when I was, you know, 20 years ago or ten years ago or 30 years ago?

Yeah. And that's, that's, you know, a story that just sort of hits home that how important these factors are. And patients really engage in it. And doctors need to know that, that they it will improve their outcomes dramatically by

integrating patient centered transformative care as part of their treatment plan.

Just routinely. You know, you're absolutely right, especially with a lot of the interventional is kind of listening to this, pro data or a patient reported outcome data is absolutely crucial to obtain, you know, you want to be able to to make sure you're doing the right things.

But when are you able to, accelerate on the improvements of your patients? Your outcome data is going to go drastically of your your you know, you get better reviews on on, on social media or on Google.

You're going to have much less poor, perception of burnouts in your practice. And, now with that, I mean, I think about like, how many people can truly help in a shorter amount of time and, and even without, you know, doing anything, anything different.

Each phone call that comes in to your office is going to also shift. It's not going to be a lot of people who are chronic pain and upset. It's going to shift to a lot less of that, more people who are empowered.

And I've seen this transform, even within my own practice. And just because of the delivery, the value that we have, the coaching and stuff like that.

And so it makes such a impactful, journey for the patients, for yourself, and even for your, for for your staff as well, you know, so much so that you think and talk about your patient that says you yes, peers that no one's told them is, you know, decades ago.

Patient empowerment, case examples, and lessons learned

Well, we get that every day and so. Well, no one is really, you know, told me about this, understood about this and so and so I why what do you think that this exists currently?

Because because we talked about we talked about the social emotional health. We talked about how each primary care visits seven half minutes. We already covered all that stuff.

We talked about how there's there's, there's decreased engagement because of insurance reimbursement practices and stuff like that. And then we talked about just really the expectations of a patient and the value that a doctor traditionally has brought to a patient has been the power of a pin or a prescription.

Right. But what why else do you think, is causing this trend? And what paradigm shift within, within medicine itself needs to switch. So that doesn't this doesn't continue anymore?

Well, I think that of course, the biomedical model has been very successful for acute problems and for cancer. And and, you know, very serious problems.

But what we're seeing is an epidemic of chronic illness within our country. And I think that the model of the called the chronic illness care model is a model that has been promoted for the last 20 or 30 years, but difficult to implement as part of routine care.

And so I don't really you know, I think that all health professionals generally are very, very sincere, caring. They really want the patients to get better.

And, and so we want to measure those outcomes. And we do that as part of the pack program also. So every month the patient fills out kind of a progress assessment to see how they're doing.

And then you can look at the dashboard and you can see how the pain is improving or staying the same. So you can identify red flags or other problems.

And of course the health coach tracks all this stuff too. So provider has access and so does the health coach. And

so I think the biomedical model, there's a lot of pressure to shift the paradigm to a broader model.

That's a whole person. And we understand that there are social determinants of health or emotional determinants of health. They're behavioral determinants of health.

There's cognitive environmental like for instance environmental factors are the number one initiating onset factor for pain is car accidents or other types of accidents.

In our studies we've done and others shown that, almost 40% of patients begin their chronic pain problem with some type of accident. And so there I think that there is a shift towards more transformative care.

And as long as the health plans get on board and are willing to reimburse it so that there is a net revenue for the providers, what you're going to see is a gradual transition to a broader transformative care model where you do treatments and training using technology and telehealth coaching.

And that model, I think, is something that is primary care, specialty care, like we have a group of orthopedic surgeons who are very interested in using this model, pain specialists, chiropractors, physical therapists.

It's it's a model that really is very easy to adopt and easy to implement, and, and to be generally reimbursed for. And so we we're hoping we're at this point right now where we want to provide more national implementation.

And that's of course, why it's a pleasure to to work with you today and, and to have this conversation. Yes. Because we, we think it's a model that really, everybody's looking for and it's just a matter of making it so that it's one easy to implement.

And secondly, it's reimbursed. And patients adopted and are interested in my and my patients. We had in our clinical trials, we did a randomized clinical trial of it.

And we've done a case series of 500 patients in it. And the vast majority 90% of the patients say, yes, I'm interested. Wow. What do you think it's what do you think?

It's 90%. I seem just it seems to be like unnaturally high for, for a patient by. And what do you think it's that high. Is it the delivery of the value or what is it?

It is when you explain it, sit down in two minutes to explain the pain cycle that here's here's the physical condition you have myofascial pain or arthritis or disc problems or neuropathic pain or neurovascular pain.

So here's your physical condition. And that's causing these symptoms. But what is causing those physical symptoms that continue like that. And then I say it's the it's the strain on the tissues, whether it's clenching or tensing or repetitive strain or posture that really causes the tissues to have peripheral sensitization.

And then what causes that more are the stressors within your life. And that's from physical stressors, emotional stressors social stressors environmental.

They contribute to more strain. They convert to more. And physical sensitization which contributes to more symptoms. And then you get into this pain cycle and it just continues in vast majority patients say, oh, that's me.

And I have a little diagram that I've shown that. And it takes two minutes to kind of describe it. And then they say, that's me. And I say, well, you know, we're happy to these are things under your control, the stresses and strains.

We can't change that for you, but we can train you to do it. We're going to treat this condition and it's going to provide you some relief. And they love that.

But then for long term success, you really have to turn to learn what you need to do. So explaining it like I just did in two minutes to you is not it doesn't take much time.

Patients are totally engaged and they say yes, well then they ask the question, is this reimbursed? And then I say yes. In general it is. Yeah. So I mean, that's the powerful I think it's all in the delivery. Right.

So you know that you have so much buy in because, because I think you establish intention like I want you to do. Well, you start with education mean that here's something that you might not know, but I think is a bit of a special for you.

The third most important point is that there's something we can do about it. And here it is. And it's all organized into this little, little box right here.

Right? It's whether or not you want to really open this gift box or not, this point, and put them into that position where they're they're the ones, you know, taking the box and opening it.

And, and I think that's true with the, with most, most patient care, especially in chronic pain, because these people are living in daily doubts, they're hiding their symptoms, they're shamed or their symptoms ashamed of themselves. They don't want to tell people about it.

So they're not used to opening up about it. And the minute that they they that you establish a connection, they show some vulnerability. It's natural that they're they're guarded.

But the minute that you give them the fact that, hey, this is within your hands and then they take it within their hands, all of a sudden that vulnerability just becomes empowerment.

And I think that's the most powerful thing we can experience as, as, as doctors. And in general, you know, and so that's really what, what makes me get up every morning so.

Well. And I have another case that's an interesting case, similar to the 81 year old gentleman. And this was a seven year old girl, and she was there with her parents, her mother, and, she had, you know, headaches right here.

She had headaches back here. And this is seven years old and you really do get headaches. And so, of course, we ran through all the neurologic tests and diagnostic tests were ruled out.

Anything serious. And it was you know, these muscles were tender. Everything was tender back here. So I asked her a simple question. I said, do you ever find yourself bringing you're touching your teeth during the day?

And she steps back and she said, yeah, I do that all the time. Aren't I supposed to? She thought, plunging her teeth all the time and tensing these muscles and the neck is something that she should just do.

So I said, no, that's not that. That drives your headaches right now. And so she says, oh my gosh. I mean, that's all I need to do. So I saw her one time a month later, all her headaches, neck pain, jaw pain was gone in one just with one conversation where she's seven, so she's seven years old.

Yeah, seven years of age. Wow. So it can happen to all ages and it it's so impactful when patients understand and realize and then grasp that oh my gosh, the I'm doing these things every day and sometimes they can't control like for instance, if they're working on the computer all the time, shrugging their shoulders, tensing their teeth and things like that, you know, this entire work is really stressful.

Sometimes it's very difficult to change it. And that's where the coach comes in. So they help facilitate simple changes that allow them to really achieve the release that they want long term.

That's interesting stories. That's fascinating. My daughter's seven. So I can kind of relate. As a parent you know, especially seeing that and and maybe as a parent saying, oh, here's some, you know, children's Tylenol or whatever like that.

And not really getting to the root cause. And it's, it's, it's emotional thing, not being a parent of a seven year old.

And and it it's emotional thing being, being a son of elderly patients who are going through pain as well.

And so I think that the there's, there's eventually there's not just going to be the patient, it's gonna be family by and it's going to feel really good when the other family members are really, really thinking you for the things that you're truly impactful on.

So. Well, this has been such a such a great talk. And I really want to close it up by, by asking, very probing questions that I never prepare any of my summit speakers for knowing what you know today.

What is something that you wish you knew maybe when you when you first started practicing and figuring people out in chronic pain, what what is the most valuable lesson that you know now, you can tell yourself maybe 35 years ago.

Hey, this this is something you should know. What is it? Yeah, that it's always a good question, you know, and, as, as you evolve in your understanding, it becomes broader, broader understanding.

And I have to admit, you know, many years ago, when I was training as a pain specialist, there was this focus just on that intervention. There was also because it was an acupuncture clinic, which is interesting.

Also, it's in the Department of Anesthesiology at UCLA. I was exposed to kind of the Chinese strategy of acupuncture, which when you do acupuncture, you talk to the patient about lifestyle factors, but still it was an interventionist type of clinic.

And as I evolved over the years and then looked at all the research that drove acute to chronic pain, I wish I had known this knowledge, you know, about the broader that that 80% of a patient's success is really based on what they do.

20% is what I do, and I wish I had known the clinical trials, the systematic reviews, all this, research on acute to chronic pain risk factors. I wish I had known that.

Well, let's see, 40, 40 years ago. Well, 40 years ago. That's great. And so. But now I think it's time to, really make an impact, nationwide and bring something that's been studied.

And this is a NIH, originally NIH funded study, to the masses. And it's really time to, to really tackle the opioid crisis as well, and, and create some, some true positivity in a business model that's, that's actually scalable, rather than something that is just very kind of ethereal and out there.

So I want to congratulate you on, on, helping bring impact and everything that you've learned over the last 40 years. And that's to the masses. And, and I think that for those for those doctors who are listening to this, you to create impact is is not the same as creating a service.

Creating service is done for you, which is interventions. And creating impact is the power of empowerment, which is a very different conversation. So the more, the more operating systems within the health care system that creates impact and empowerment, the better the outcomes will be.

And that's truly what's going to be absolutely changing in the pandemic era, if you will, of practicing medicine. So, thank you. And and that closes on.

And thank you, Jim, for being on. It's been an absolute pleasure talking to you. Yes. And that's why when you mentioned impact, yeah, that's why the acronym PAC, which is really interesting packed is a packed with the patient.

So it has secondary impacts also. So pact for pain the model. So I really appreciate your all the innovative work that you're doing and well thank you.

And in bringing you know, a broader, broader model of care to all of us, I really appreciate the and on and thank you I thank you. Thank you for watching everyone.