NORTHWESTERN HEALTH SCIENCES UNIVERSITY

A Policy Statement from Northwestern Health Sciences University

Enhancing Pain Care: The Case for Complementary and Integrative Health Services within Federally Qualified Health Centers

Executive Summary

Federally Qualified Health Centers (FQHCs) have a critical role in providing pain management treatment to underserved populations that is safe and consistent with clinical best practices. Acute and chronic pain diagnoses are more prevalent within vulnerable populations and often compound existing barriers to health and disease management, employment, community engagement, and overall quality of life. Expanding access to complementary and integrative health (CIH) services, such as chiropractic care, acupuncture, massage, and mind-body treatments, provides a nonpharmacological approach to pain management within FQHCs that aligns with current clinical practice guidelines.

Offering CIH services on-site within FQHCs presents a significant opportunity to expand reach and build workforce adequacy. For individuals experiencing pain, the provision of these services decreases pain and disability, and reduces the need for high-cost invasive procedures and risks associated with opioid prescriptions. Integrating CIH services into FQHC clinical care pathways provides a readily available alternative to opioid prescribing and alleviates the burden of common pain complaints on primary care teams. At the facility level, CIH services contribute to an integrative and person-centric care delivery model that emphasizes stepwise care, providing the right care, to the right person, at the right time. As low-cost, high-value services, the inclusion of CIH interventions in FQHCs favors innovations within healthcare financing such as alternative payment models (APMs). Costs for staffing CIH providers can also be offset through traditional fee-for-service arrangements. Additionally, the use of grant funding, such as the opioid settlement fund or state block grants, offer pathways to support implementation.

Recommendations to Stakeholders:

- **Prioritize Adherence to Clinical Practice Guidelines for Pain Management**
- **Include CIH Providers Within FQHCs**
- **Build Referral Networks to CIH Services Not Offered On-Site**
- **Credential CIH Physician-Level Providers to Full Scope**
- **Provide Interprofessional Education and Care Coordination**
- **Collect and Report Data on CIH Utilization and Outcomes**
- **Pursue Grant Opportunities to Support CIH Integration**

Purpose

To assist Federally Qualified Health Centers (FQHCs) in addressing the needs of their patients, this white paper presents the framework whereby a FQHC can improve pain care delivery through the integration of complementary and integrative health (CIH) providers, such as doctors of chiropractic, acupuncturists, naturopathic physicians, and massage therapists.

Pain is a Persistent Problem

Pain, including back and neck pain, is among the most prevalent and disabling health conditions in the United States, impacting nearly all adults throughout one's lifetime.[1] For nearly 25% of adults, this condition develops into a chronic complaint that affects how an individual lives, works, and plays.[2] Furthermore, the burden of chronic pain disproportionately impacts individuals and populations with greater exposure to adverse social determinants of health. High-impact chronic pain—defined as pain that severely limits one's daily life or ability to work—further compounds these inequities, making it both a priority for health care providers and a challenge for society.[3] FQHCs play a vital role in meeting the pain needs for such vulnerable populations.

Industry-leading clinical practice guidelines from the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and the American College of Physicians (ACP) emphasize the use of nonpharmacological interventions as first- and second-line approaches for treating spine pain. These guidelines advocate for evidence-based nonpharmacological therapies such as spinal manipulation, acupuncture, massage, and mind-body treatments (e.g. yoga, tai chi) to address both acute and chronic spine pain.[4] These treatments are routinely used within CIH disciplines, including doctors of chiropractic, acupuncturists, massage therapists, and naturopathic physicians.[5]

Yet, adherence to these clinical practice guidelines and the integration of CIH providers remains a challenge. For decades, back pain was the most common condition that initiated opioid prescriptions in the United States, which fueled the early stages of the opioid epidemic.[6] Although the rate of prescription opioids has decreased from national highs, a recent study of health insurance claims data showed that 20% of individuals with acute back pain are still prescribed an opioid, against the recommendations of medical guidelines.[7] Individuals prescribed opioids for pain face a 21–29% risk of misusing opioids and an 8–12% chance of developing opioid addiction.[8] The ongoing regularity of prescribing opioids for pain poses a continued risk to patient health. This risk is magnified for Medicaid beneficiaries, as this population is more likely to receive opioid prescriptions than those on commercial insurance.[9] Furthermore, adequate pain management for individuals in recovery of substance use disorder, and for those who prefer non-medication options, often lack access to evidence-based alternatives.

Expand Access with CIH Workforce

Despite growing recognition of the benefits of nonpharmacological approaches for pain management and overall wellbeing, access to (CIH) providers remains limited, particularly in historically marginalized and medically underserved areas.[10] FQHCs routinely serve these communities and are well-positioned to bridge this gap. However, chiropractic care, the most commonly utilized CIH service, is available at only 10% of the nation's FQHCs, leaving an overwhelming majority of patients with limited or no access to these essential services.[11]

FQHCs that have CIH providers integrated have recognized significant advantages for patients, FQHC provider teams, and overall clinic efficiency. Patient surveys consistently demonstrate high satisfaction rates among those receiving treatment from CIH providers.[12] These positive outcomes are corroborated by feedback from FQHC providers and administrators. A study of FQHCs employing doctors of chiropractic revealed that incorporating chiropractic care reduced the burden on primary care physicians in addressing musculoskeletal complaints. Co-location of chiropractic services was reported to increase patient access, decrease patient wait times, enhance care coordination, and create efficient internal referral processes. CIH providers, with their specialized expertise in musculoskeletal pain management, effectively alleviate the clinical workload associated with common pain complaints, thereby enabling primary care providers to concentrate their efforts on addressing other comorbidities that impact patients' overall health status. Similarly, this on-site integration reduces "leakage" that can negatively influence patient outcomes, care coordination, and facility revenue.

CIH supports Substance Use Disorder Services

Beyond the broad improvements to patient care, integrating CIH is particularly helpful for supporting care of complex healthcare needs, such as co-occurring chronic pain and a history of substance or opioid misuse. In 2023, FQHCs reported providing substance use disorder services to nearly 300,000 patients and medications to over 200,000 patients with opioid use disorder.[13]

Notably, many of these patients also have co-occurring chronic pain, and research indicates that unmanaged pain can increase the risk of illicit drug use.[14] For these individuals, CIH providers play a crucial role in delivering essential care to help manage their pain effectively, thereby reducing risks for drug recurrence. With many FQHCs delivering care to this patient population, improving chronic pain treatment to include integrated CIH providers can supplement or support existing OUD/SUD treatment teams to effectively address the complex relationship between substance use and co-occurring health conditions, including chronic pain.

At Scenic Bluffs Community Health Centers (WI), the incorporation of CIH services is a key strategy within their recovery-focused care model. An administrator described how CIH therapies are leveraged to support individuals participating in the medication-assisted treatment (MAT) program: "Our chronic pain program is specifically referring people—helping people cut back on their opioid addiction by using acupuncture, chiropractic, massage, and therapy."

Similarly, a doctor of chiropractic practicing at Spectra Health (ND) emphasized the role of nonpharmacological care in mitigating risks associated with medication use: "Our medical director wants those [chronic pain] patients to see the chiropractor more often, because what commonly happens is by the end of their prescription, if they've had a lot of pain, then they use their replacement medication more often."

These examples underscore the critical role of CIH services in advancing comprehensive recovery within FQHCs. By managing pain through nonpharmacological approaches, FQHCs not only improve pain outcomes but also support appropriate medication use, reduce recurrent drug misuse, and strengthen overall care coordination. This integrated model reflects a necessary shift toward addressing pain and substance use disorders as interconnected challenges, requiring coordinated, patient-centered strategies to achieve lasting recovery and improved quality of life.

Administration and Financing

Incorporating CIH services into a clinic's care model advances not only patient outcomes and care coordination but also can positively contribute to revenue and production.

Per Federal Regulations 42 CFR 405.2412(a), FQHCs are eligible to credential doctors of chiropractic at the physician level. Qualifying visits to a doctor of chiropractic are eligible for the bundled payment prospective payment system (PPS) methodology for reimbursement. This PPS rate can provide consistent revenue generation for the clinic. For non-physician level CIH providers, traditional fee-for-service reimbursement can be utilized. Either pathway provides CIH providers an ability to generate revenue and contribute to clinic expenses.

For FQHCS utilizing various alternative payment models or those shifting towards value-based care models, CIH providers could be uniquely positioned to support clinics by delivering high-value clinical services, especially to complex chronic pain patients. The early use of CIH services leads to reductions in hospitalizations, lower prescription drug costs, and prevention of unnecessary diagnostics.[15] By transitioning from lower value services to higher value services, the facility can create care pathways that efficiently align with value-based care agreements.[16]

For additional consideration, FQHCs and stakeholders could leverage their professional and political networks to facilitate grant funding for expanding CIH care.[17] At the state level, this could occur through grant awards that provide FQHCs with funding to expand CIH offerings. Alternatively, grant opportunities funded through the opioid settlement fund can support the initial costs associated with incorporating or expanding CIH offerings.[18]

Conclusion

The impact of chronic pain represents a challenging and costly situation for patients and communities. Through the integration of CIH services into FQHCs, patients can better manage the impact of their pain. Similarly, FQHCs choosing to deliver CIH services can better meet the needs of their patients through integrating these high-value services.

Recommendations to Stakeholders:

Prioritize Adherence to Clinical Practice Guidelines for Pain Management

Adopt and implement clinical care pathways that align with established pain management guidelines from the CDC, WHO, and ACP by prioritizing nonpharmacologic therapies as first- and second-line treatments for musculoskeletal pain.

Include CIH Providers Within FQHCs

Integrate CIH providers (e.g. doctors of chiropractic, licensed acupuncturists, massage therapists, and naturopathic physicians) on-site within FQHCs to expand access to evidence-based, nonpharmacological pain care.

Build Referral Networks to CIH Services Not Offered On-Site

Develop referral pathways with trusted community-based CIH providers to ensure continuity of care when services cannot be delivered within the FQHC.

Credential CIH Physician-Level Providers to Full Scope

Credential doctors of chiropractic at the physician level when eligible to maximize reimbursement opportunities under the Prospective Payment System (PPS).

Provide Interprofessional Education and Care Coordination

Facilitate regular interprofessional training for clinical teams about CIH modalities and establish care pathways that promote quality care coordination for patients.

Collect and Report Data on CIH Utilization and Outcomes

Systematically collect and analyze data on CIH services, including patient-reported outcomes, access, opioid prescribing rates, and service utilization, to measure clinical and financial impacts of CIH integration.

Pursue Grant Opportunities to Support CIH Integration

Leverage local, state, and federal grant opportunities—including opioid settlement funds, state block grants, and targeted public health initiatives—to pilot, expand, or sustain CIH services within FQHCs, especially in communities disproportionately affected by chronic pain and substance use.

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