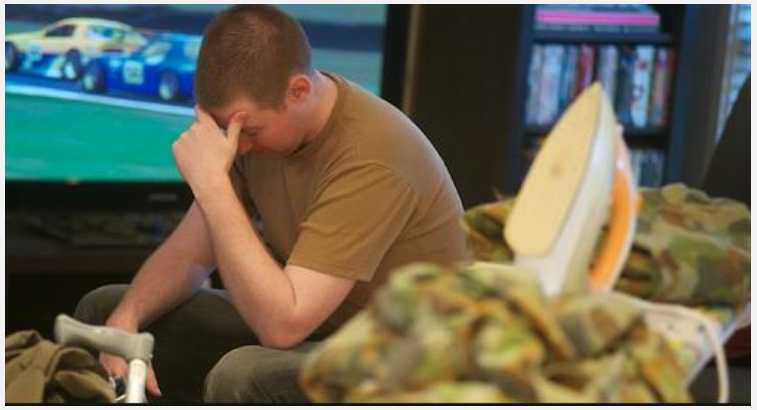

Delivering Integrated Pain Care to Veterans

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Disclosure

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between Dr. Dobscha (or his spouse) and any for-profit company in the past 24 months that could be considered a conflict of interest.

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Outline/Timeline

- 2009:
  - VA research on collaborative/stepped pain care
  - VHA adopts stepped-care model
- 2010-present:
  - Key contextual changes in VHA
  - Recent examples in practice—demo projects
  - Selected research in progress
- Present: Overview of current state and next steps

A Few Definitions

- Integrated Care
  - Multidisciplinary approach
  - Interfaces with and supports primary care
  - Not Integrat*ive* care (or CAM) though may incorporate
- Collaborative Care
  - Team-based
  - Population-based
  - Measurement-based
  - Key components
    - Self-management support
    - Delivery system redesign (addition of care management)
    - Decision support
    - Clinical information system facilitation

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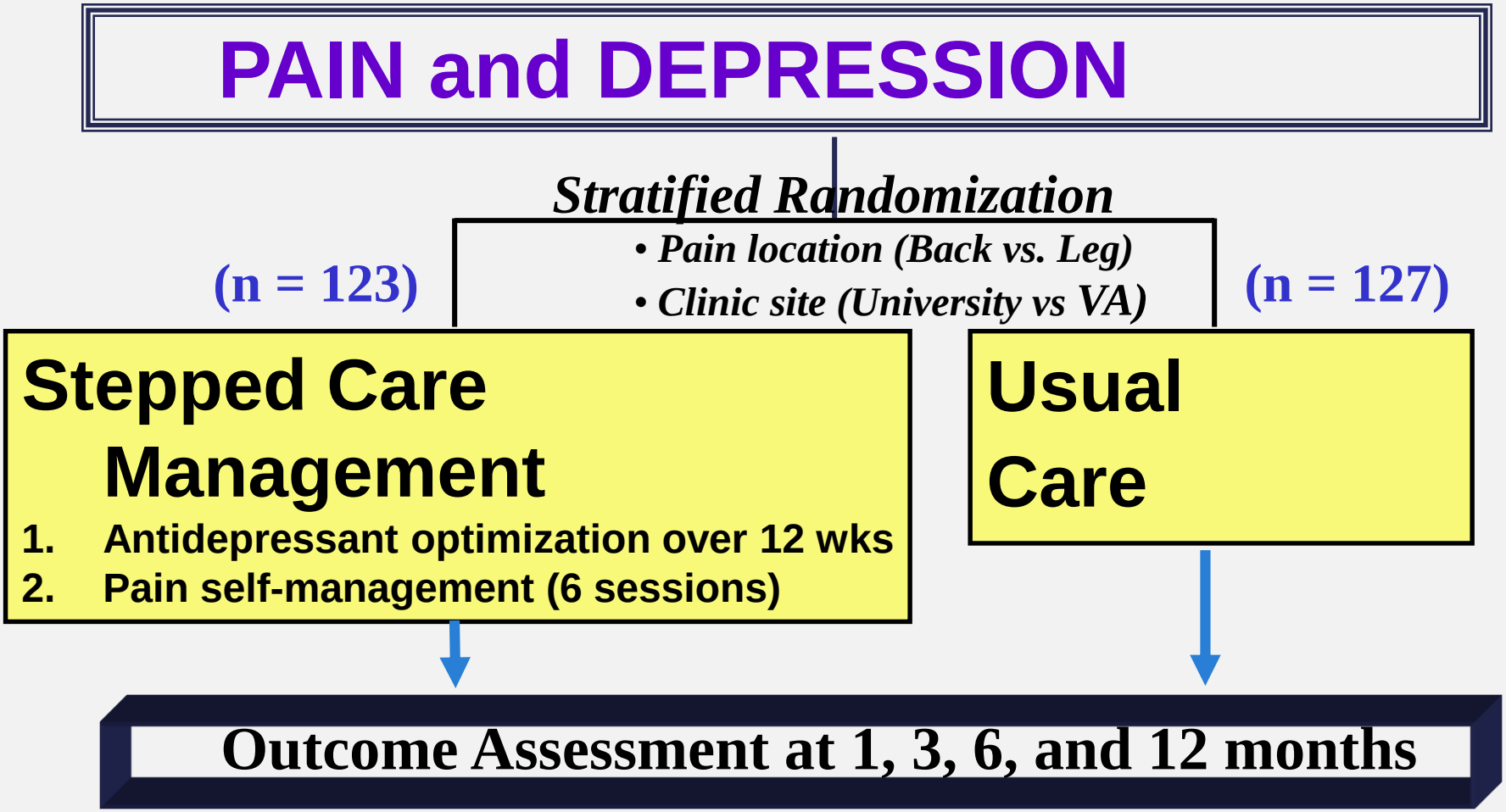
Stepped Care for Affective disorders and Musculoskeletal Pain (SCAMP) (Kroenke et al 2009)

- RCT of stepped-care intervention for pain and depression in patients with musculoskeletal pain and depression versus TAU
- 5 VA & 6 University primary care clinics
- 250 patients
- Intervention showed significant improvements in:
  - Depression severity
  - Reductions in pain intensity and disability
  - Global improvements in pain

SCAMP Trial Design



SCAMP Pain Self-Management Program
(example components)

- Education – pain; vocabulary; red flags;
- Identifying /modifying fears and beliefs
- Goal-setting and problem-solving
- Exercise – strengthening; aerobic; etc.
- Relaxation; deep-breathing;
- Handling pain flare-ups
- Working with clinicians and employers

Study of the Effectiveness of A Collaborative Approach to Pain (SEACAP) (Dobscha et al 2009)

- Cluster randomized RCT of collaborative intervention vs TAU at single VA facility
- 401 patients; 46 primary care clinicians
- Intervention showed modest improvements:
  - Pain disability
  - Pain intensity
  - Depression severity
  - Patient-rated global impression of change
- Clinicians and patients satisfied with intervention

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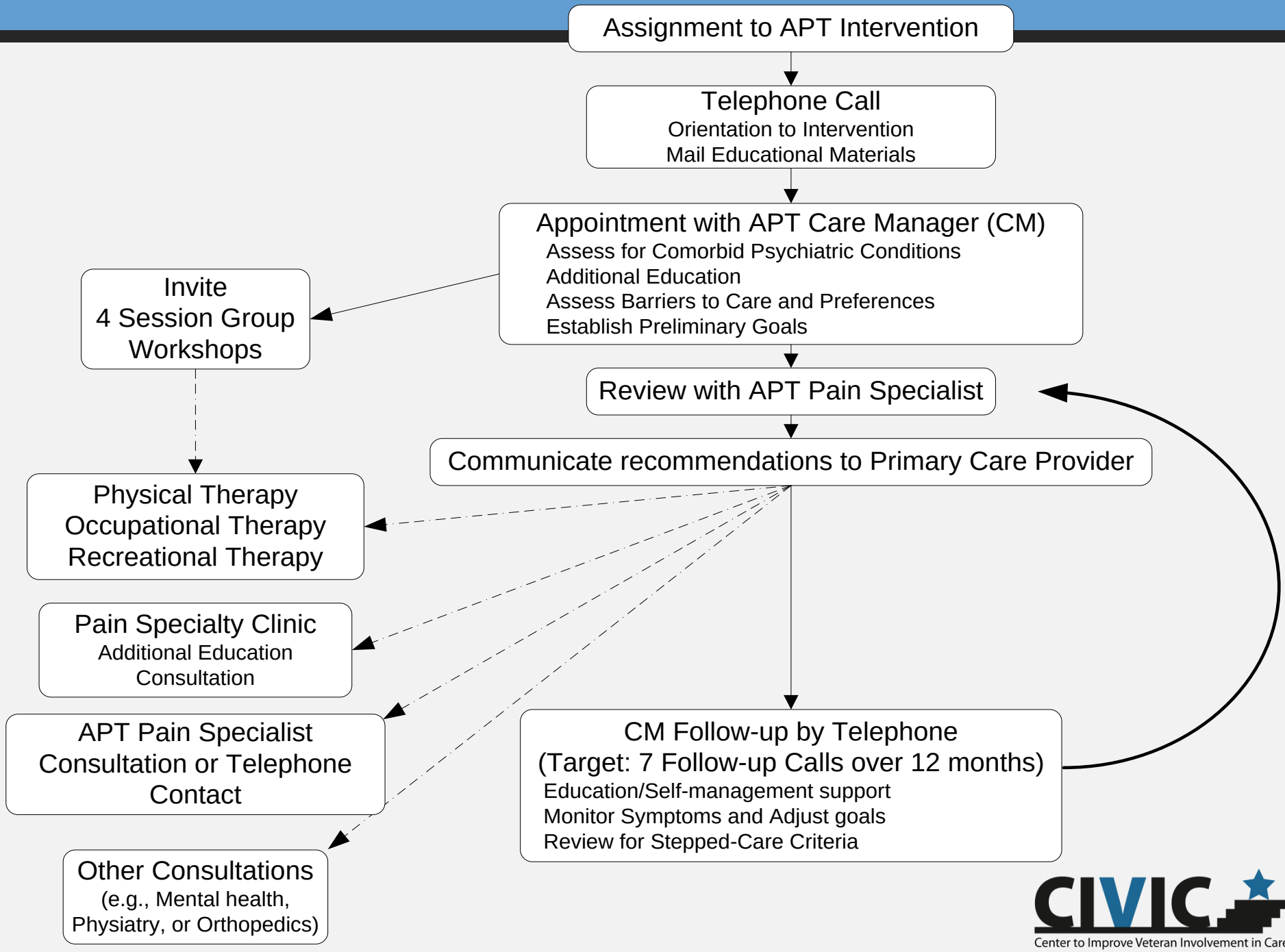

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Some Lessons Learned

- Many patients who chose to participate in this study already felt skilled in self-management
- Group workshop was inefficient
- Clinicians highly variable in response/interaction with team
- Intervention was somewhat expensive
  - Formal cost analysis: $364 per Pain-Disability Free Day (based on RMDQ scores) (Dickinson et al 2010)
  - 1.0 FTE Care manager treated 180 patients at a time at peak—yet 6,000 – 20,000 primary care patients might potentially be eligible
- Most effects had decayed by 36 months post-intervention

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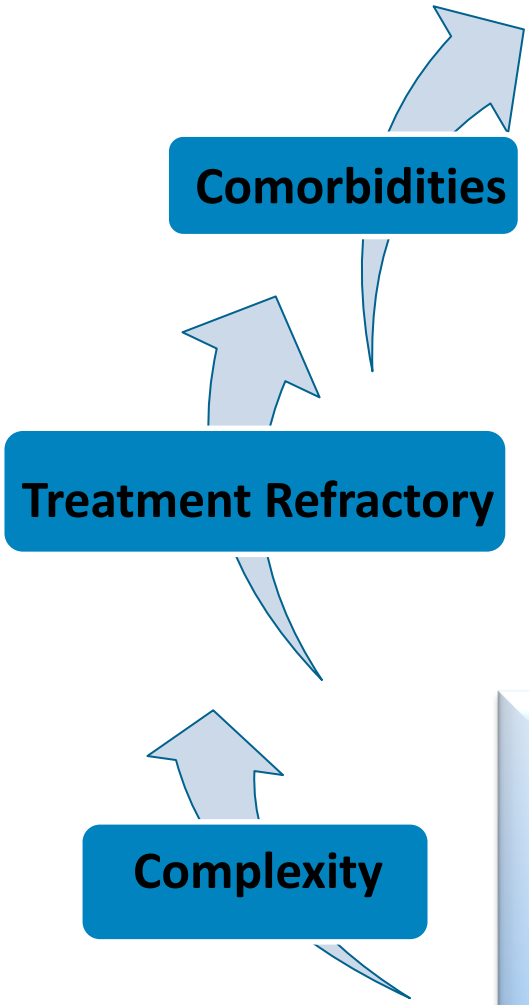
Stepped Care Model for Pain Management



RISK

STEP 3

Tertiary Interdisciplinary Pain Centers
Advanced diagnostics & interventions
Commission on Accreditation of Rehabilitation Facilities accredited pain rehabilitation
Integrated chronic pain and Substance Use Disorder treatment

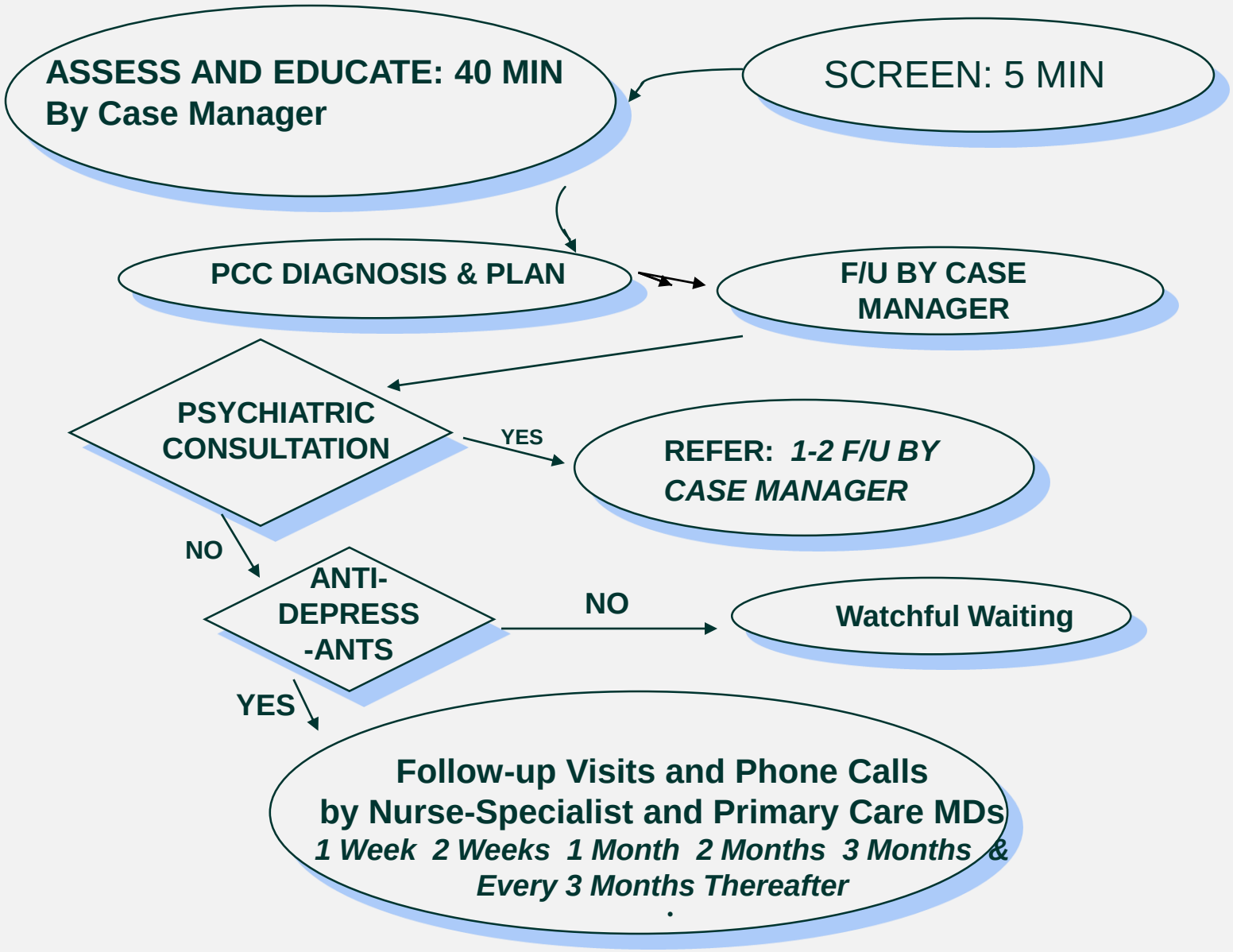
STEP 2

Secondary Consultation
Pain Medicine
Rehabilitation Medicine
Behavioral Pain Management
Interdisciplinary Pain Clinics
Substance Use Disorders Programs
Mental Health Programs

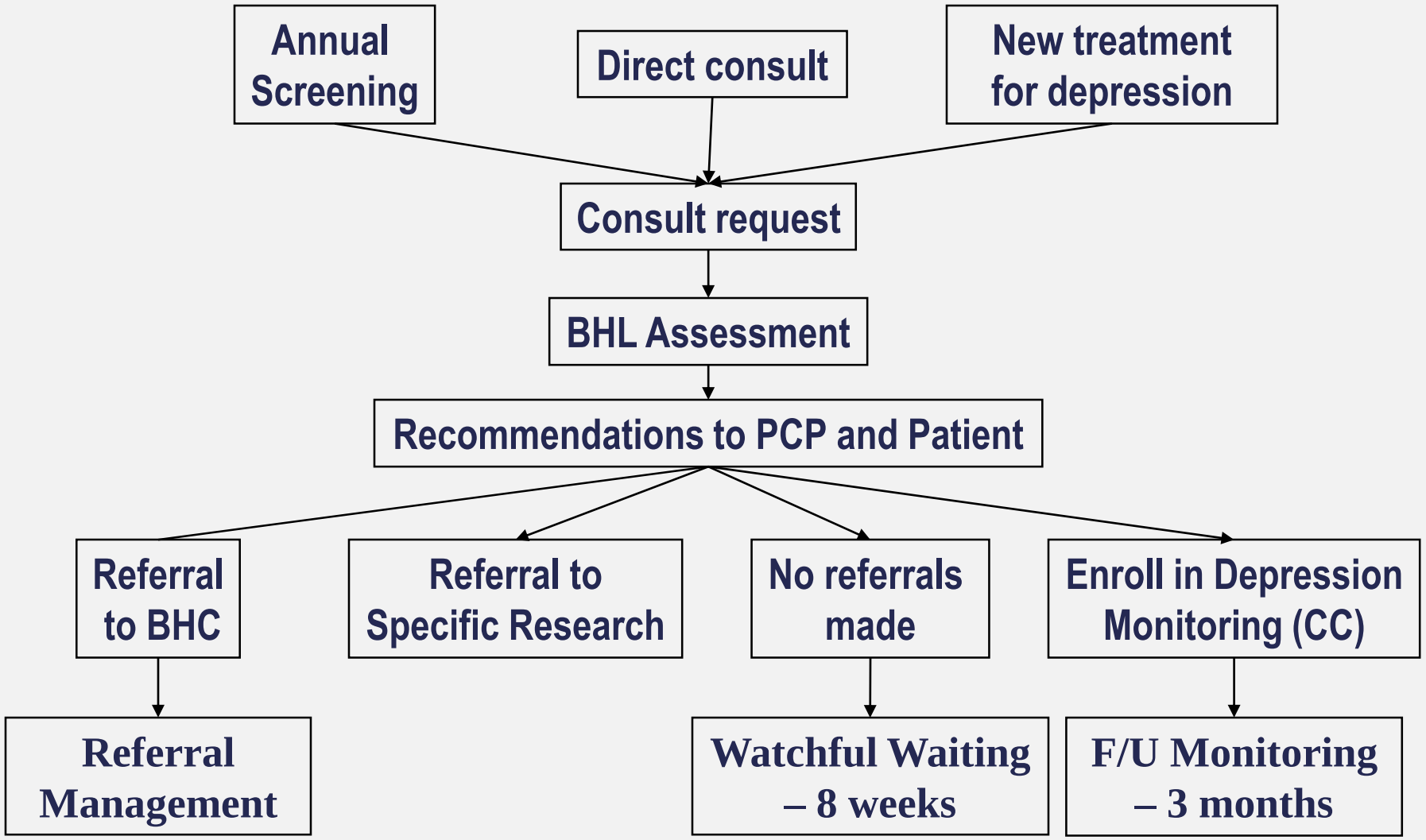
STEP 1

Primary Care/Patient Aligned Care Teams (PACTs)
Routine screening for presence & intensity of pain
Comprehensive pain assessment
Management of common acute and chronic pain conditions
Primary Care-Mental Health Integration, Health Behavior Coordinators, OEF/OIF/OND & Post-Deployment Teams
Expanded nurse care management
Clinical Pharmacy Pain Medication Management
Opioid Pain Care and Renewal Clinics

Context: Rollout of VA TIDES



Behavioral Health Lab (Oslin 2004)

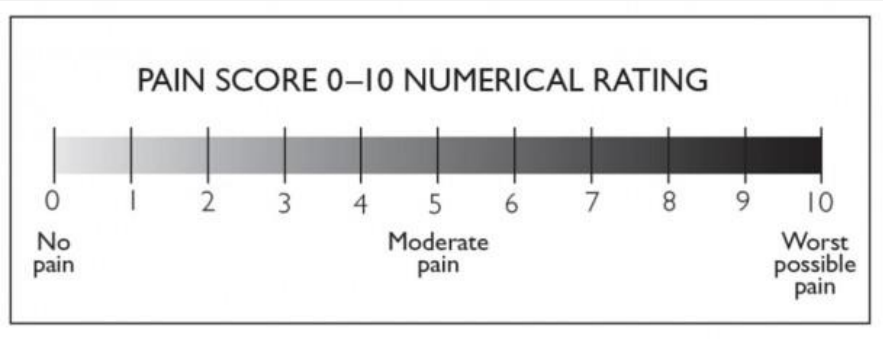


Introduction of Patient Aligned Care Teams

ehealth Development

- Telehealth:
  - Clinic-based video telehealth
    - Pretty wide-spread
    - Some projects with treating pain
    - Group and individual
  - Video to Home
    - Still getting off the ground
    - At least one project doing individual pain work
- Office of Connected Care
  - MyHealtheVet/secure messaging
  - VA App store
    - ACT Coach; Mindfulness Coach; Move! Coach

Measurement



- 1998 VA Adoption of Pain as the 5th Vital Sign
  - NRS is administered by staff at most outpatient visits
- Discussion about change in pain measure to PEG
- Some research using IVR and mobile apps for pain data
- There are considerable IT barriers to sending patient generated data directly to patient EHRs
- Mental Health measurement-based care initiative in progress
- Opioid Crisis: Development of Opioid Risk prediction tools
  - STORM (Stratification Tool for Opioid Risk Management)
  - OTRR (Opioid Therapy Risk Report)

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Recent examples in VA practice

- Psychologists have been embedded in primary care settings
  - Familiar with TIDES principles
  - Assist with pain assessment/consultation; integration of pain care with other mental health care
  - Many have had training in *CBT for chronic pain*:
    - (10) 1-hour sessions
    - 148 Veterans who participated in CBT-CP showed pre-post improvements in catastrophizing, pain interference, QOL (Stewart et al 2015)
    - Over 500 VHA clinicians trained to date

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Integrated Pain Program—West Haven

(Dorflinger LA, Ruser C, Sellinger J, Edens EL, Kerns RD, Becker WC. Pain Medicine. 2015)

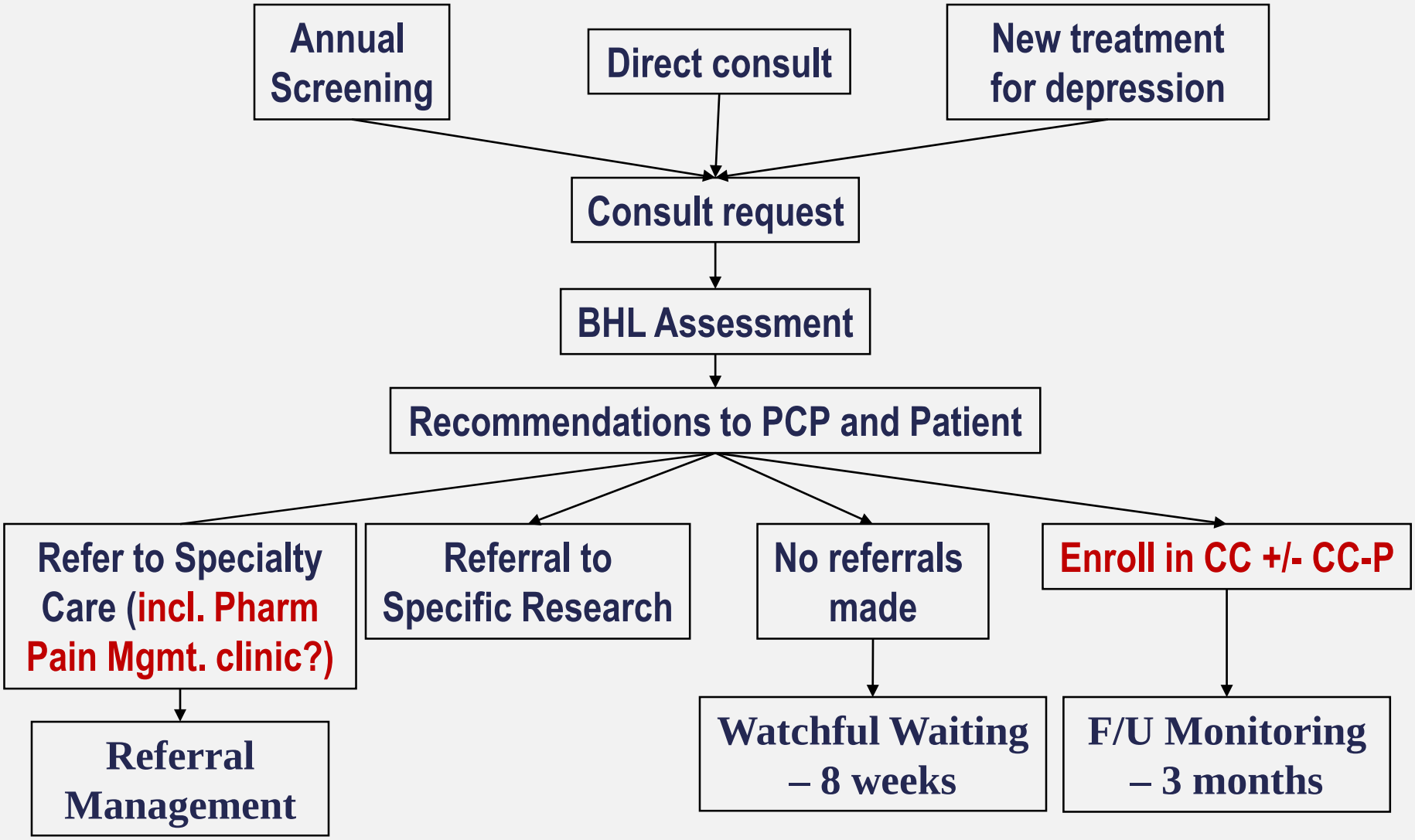
- Integrated Pain Clinic
  - ½ day per week clinic in primary care setting
  - Physical therapist; physiatrist; health psychologist; nurse care manager
  - One time assessment plus NCM coordinates after visit

- Opioid Reassessment Clinic
  - ½ day per week in primary care
  - Same staffing + addictions ANP, buprenorphine-certified prescribers
  - Longitudinal co-management of patients from IPC when concerns related to safety/efficacy/risk related to opioids
  - Takes over opioid prescribing from primary care clinicians

Opioid Reassessment Clinic evaluation (Becker et al 2017)

- Data from first 87 referrals over 2 years
- Patients:
  - 84% with SUD histories
  - 70% with concerns about current misuse of opioids
- Outcomes
  - Length of treatment in ORC: 137 days
  - 22% of patients with SUD engaged ion addictions treatment
  - Mean decrease in MED was 33.4mg
  - 91% had UDS
  - Able to hire NCM which signaled institutional commitment
  - Mean patient treatment satisfaction; 1-5 Likert scale, 3.8 (sd=1.3)

Collaborative Care for Pain—Philadelphia VA



BHL-CC-P

- Extends model of BHL/collaborative care: offer patients with comorbid pain additional assistance with pain
- Acute and Chronic pain modules
- Motivational interviewing
- Patient-centered workbooks and supplemental education
- Pain monitoring
- Works with Supervising Clinician to provide feedback for primary care clinicians
- Complex patients referred to range of services—might include opioid renewal clinic

BHL-CC-P—preliminary outcomes (Helstrom, under review)

- 160 patients randomly assigned to CC-P vs traditional CC
- 3 month interventions; evaluated over 6 months
- Both groups showed modest reductions in pain intensity and interference and other clinical outcomes
- No significant differences between the groups

- Barriers:
  - Engaging patients in the program—biopsychosocial approach
  - Keeping clinicians up to date on program and the treatment model

Pharmacy Pain Management Clinic—Philadelphia VA (Wiedemer NL, et al. *Pain Med*. 2007;8:573-584)

Procedure

- 1 FTE Clinical Pharmacist +NP
  - Added .5 FTE clin pharm to assist with high dose tapers
- Eligibility
  - High Risk/High complexity
  - Work-up & Pain Diagnosis
  - Baseline Urine Drug Test
  - *Imed Informed Consent*
  - *State PDMP*
  - *OEND – Naloxone Safety Kits & Education*
- PCP CONTINUES TO BE RESPONSIBLE TO PRESCRIBE OPIOID

Strategies

- Individualized Treatment Plan
  - High Risk: Recent & Frequent Aberrancy
  - Moderate Risk: Intermittent Aberrancy
  - Low Risk: Remote Aberrancy
- Frequent Visits
- Prescribing opioids on short term basis

  i.e. weekly or bi-weekly
- Random UDT
- Pill Counts
- Co-management with addiction services

Pharmacy Pain Management Clinic evaluation

- 335 patients
  - Of 171 with aberrant behaviors, 45% adhered to OTA; 13% referred to addiction treatment; 4% who had (-) UDS & weaned from opioids
  - Others adhered to OTAs and had regular UDS's
- Barriers
  - Pharm D can't write directly for prescriptions
  - Lack of resources for non-pharmacologic treatments including integrative medicine, tertiary rehab program (getting better now)
  - Doesn't work great with CBOCs (clinics at a distance from main medical center)—substantial problems with coordination
  - (May be highly dependent on this particular, very experienced/skilled Pharm D)

Additional research coming out of Indianapolis group…

Trial	PI	N	Fund-ing	MEDS	BE-HAV	TELE-CARE	KEY TREATMENTS
SCAMP	KK	250	NIH	✓	✓	+	Antidep + Self-Mgt
INCPAD	KK	405	NIH	✓		++	Analgesics
SCOPE	KK	250	VA	✓		++	Analgesics
ESCAPE	MB	240	VA	✓	✓	+	Analgesics + CBT
CAMEO	MB	260	VA	✓	✓	+	Opioids vs. CBT
SPACE	EK	240	VA	✓		+	Opioids vs Analges
CAMMPS	KK	294	VA	✓	✓	++	Analges +Mood Rx
POYSE	MB	300	VA		✓		Exercise vs. Yoga
ECLIPSE	MM	215	VA		✓	+	Peers with Pain
TOMCATT	MB	460	VA		✓		Massage

Opioid Management Practice Concerns—Oversight Report for Veterans Affairs Office of Inspector General *05/31/2017 08:00 PM EDT*

- OIG conducted an inspection to evaluate allegations regarding opioid management practices at the John J. Pershing VA Medical Center, Poplar Bluff, MO…We found that a provider lacked knowledge of safe and effective methods for tapering patients' opioids. We substantiated that opioid prescriptions were written for patients without documentation of an opioid risk stratification tool such as ORT…We substantiated that some providers did not consistently use UDS, order confirmatory tests to evaluate for diversion, or further evaluate UDS results that were suggestive of urine tampering for the patients reviewed. We substantiated that some patients did not have signed informed consents prior to initiating long-term opioid therapy for pain.

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Morasco et al—in progress

- RCT of multifaceted intervention (Improving Safety of Opioid Prescribing [ISOP]) vs. usual care.
- Aims to determine if ISOP enhances measures of safety; impacts clinician-patient relationship and measures of pain
- Nurse Care Manager
  - Assesses patients—discuss safety of opioids and approaches to minimize/screen for misuse
  - Maintains registry—tracks opioid related events
  - Facilitate use of OTAs, UDS and PDMP and subsequent actions
  - Naloxone kits
  - Facilitates decision support for clinicians; other care coordination
- 148 patients enrolled to date
- Big barrier: Consultant vs. more active role—PCPs not acting on recs, or forgetting to act on recs

Summary—current state

- The positives:
  - A number of interesting demonstrations and models
  - Components often integrated with primary care activities/space
  - Often team-based approaches
- The not-so-positives:
  - Many sites don't have any of these components
  - Almost no demonstrations are implementing most of the CoCM
    - Philadelphia closest to having model program
    - Measurement based approaches frequently absent
  - Challenges engaging with primary care clinicians in light of competing demands
  - Ongoing challenges in accessing non-pharmacologic options

How do we get to where we want to go?

- More support is needed for model, in particular for system redesign and decision support elements of CoCM
  - Care management capacity—care coordination
  - Local pain expertise (EBPs and Pain medicine)—decision support
- Optimize technology
  - Patient generated data—interface with EHR
  - Patient education and self-management support
- Training for new roles and models of care
  - Population-based approaches
  - Integration of data into practice
- Increase access to and evaluate outcomes of use of psychological/behavioral therapies; exercise/movement therapies; manual therapies

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