Engaging Veterans Seeking Service-Connection Payments in Pain Treatment

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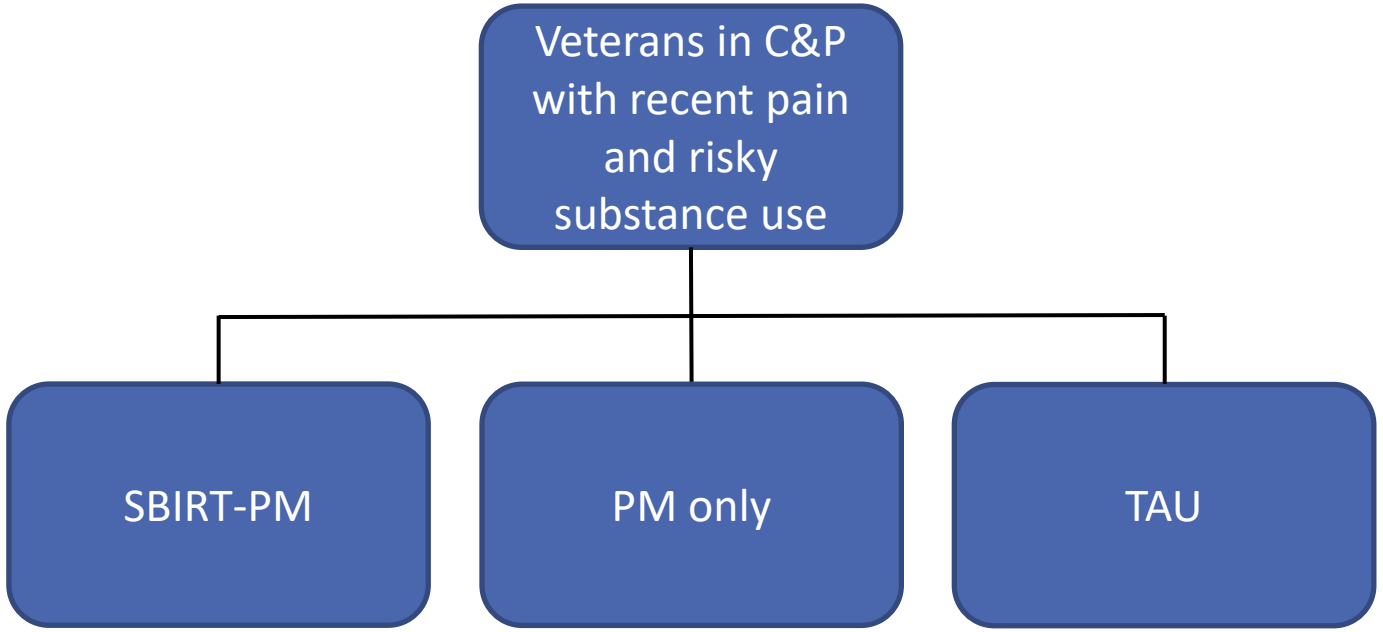
NCCIH/NIDA U24AT009769 and UH3 AT009758

C&P as an Intervention Opportunity for Pain Management

- Over half of post-9/11 Veterans have a musculoskeletal disorder. Comorbid substance misuse is common.
- In FY 2018, 989,835 awards were made for lumbosacral or cervical sprain
- 71,197 new claims for these conditions awarded during FY 2018.

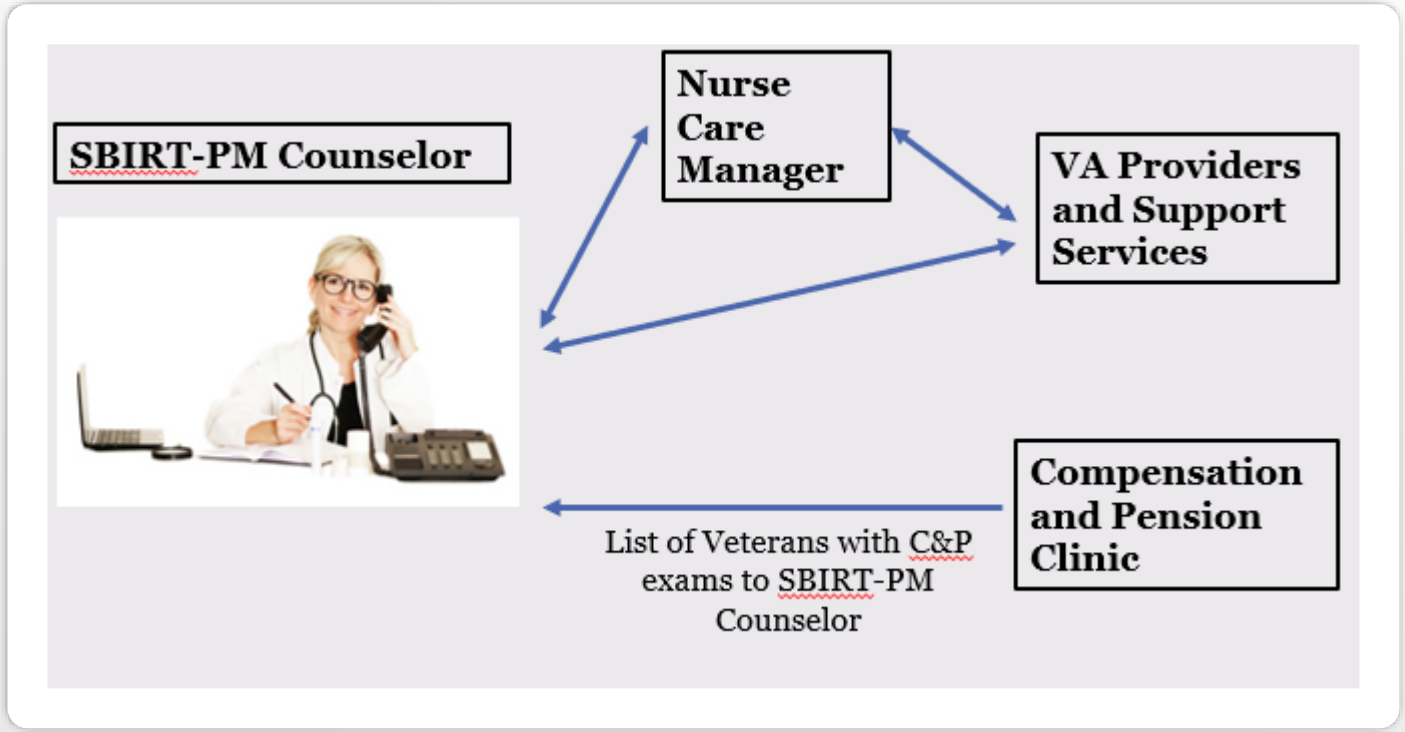
Screening, Brief Intervention and Referral to Treatment – Pain Management (SBIRT-PM)



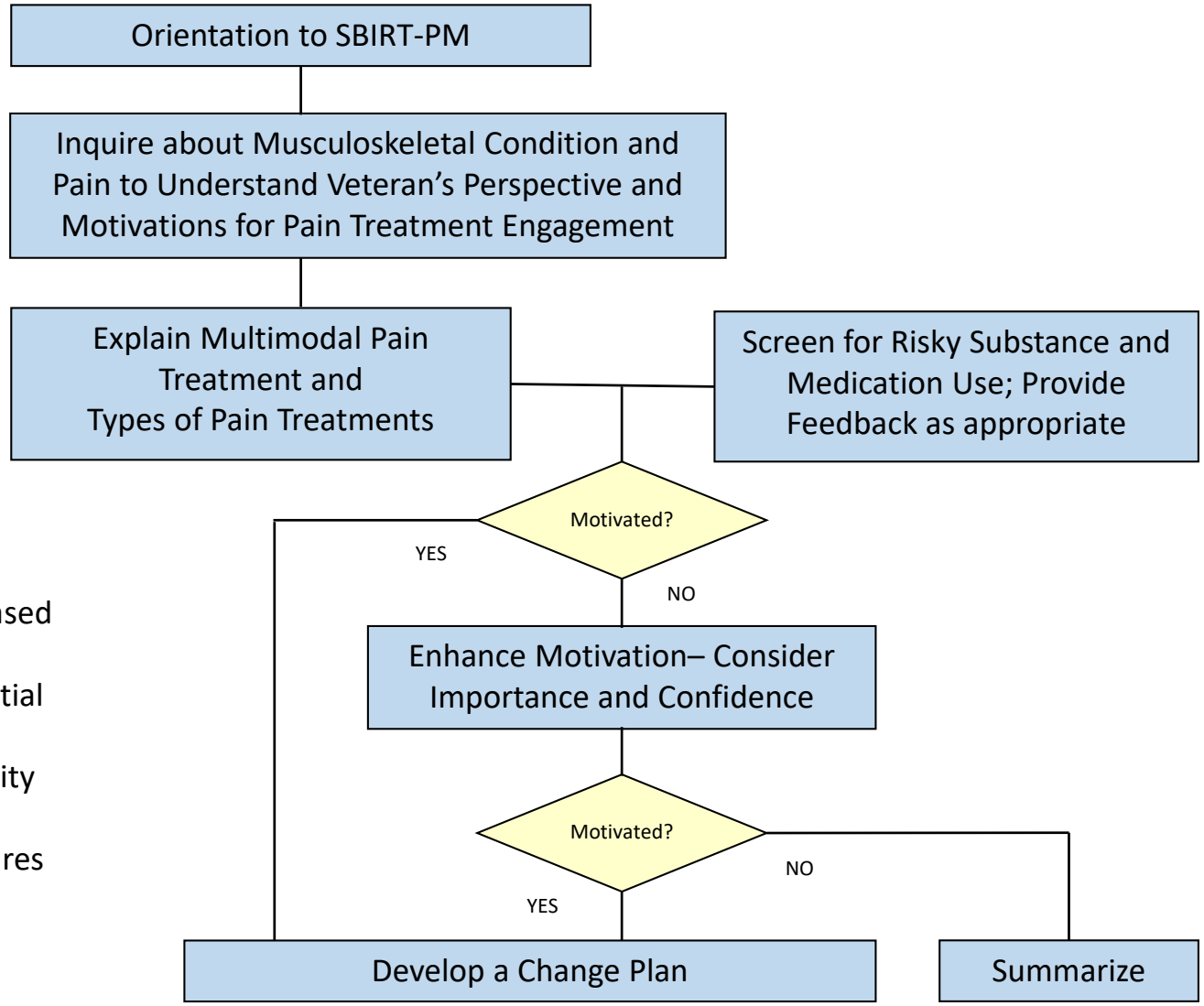
Rosen MI, Becker WC, Black AC, et al. Brief Counseling for Veterans with Musculoskeletal Disorder, Risky Substance Use, and Service Connection Claims. *Pain Med* 2019;20:528-542.

The Idea


New England VISN
Maine VAHCS
Manchester VA
White River Junction
Bedford VA
Central Western Mass
Boston VA
Providence VA
VA Connecticut


SBIRT-PM Counselor
Nurse Care Manager
VA Providers and Support Services
Compensation and Pension Clinic
List of Veterans with C&P exams to SBIRT-PM Counselor

4-Session SBIRT-PM



Key Features

- Motivational Interviewing-based
- Delivered by phone
- Describes how to conduct initial and follow-up sessions
- Details pain services per facility
- Details emergency and mandated reporting procedures

Two Phase Project

Preparatory (Years 1-2)

- Understand pain services at sites
- Understand access to pain care from C&P
- Determine feasibility of trial and acceptability of SBIRT-PM

Pragmatic Trial (Years 4-6)

- 8 VA medical centers
- N = 1100 participants with MSD-related pain conditions
- Mixed methods to evaluate effectiveness of SBIRT-PM and barriers and facilitators to implementing SBIRT-PM using a regional hub-and-spoke implementation strategy (hybrid type I)

The Team

VACHS	Role
Christina Lazar	Study Director
Kate Gilstad-Hayden	Biostatistician
Brenda Fenton	Senior Biostatistician
John Sellinger	Co-I/Health Psychology, pain expert
Paul Barnett	Consultant/Health Economist
Qing Zeng, Yijun Shao	Co-I/Natural Language Processing and medical informatics
Linda Adamczyk	RA
Jessenia Medina	RA
Karen Ablondi	Research Coordinator
Lisa Navarra	SBIRT-PM Counselor
Kimberly Ross	SBIRT-PM Counselor

Other Sites	Site PI	Role/Expertise
Central Western MA	Brad Brummett	C&P examiner
Boston	Dianna Higgins	Health Psychology, pain expert
Bedford	Tu Ngo	Health Psychology, pain expert
Providence	Thomas Reznik	Primary Care Provider, pain expert
White River Junction	Paul Holtzheimer	Psychiatrist, depression researcher
Manchester	Alicia Semiatin	Health Psychology, pain expert, now MH Service Line Director
Maine	Stapley Zimmerman Schimelman	ACOS Research, Primary Care Leadership

Key Stakeholders

Group	Participants
VISN1 Leadership	VISN Director, MH Lead, Research Lead
VISN1 Clinical Trials Network	CTN Director, Research Coordinator
VISN1 Pain Council	Clinical pain experts from across New England region
PRIME Center	Research pain experts
New England MIRECC	Research dual diagnosis experts
Veterans Engagement Board	Veterans with MSD
VHACO Patient Centered Care and Cultural Transformation	Executive Director
VBA Medical Disability Examination Office	Director

Preparatory: 1

Understand pain services at sites

Pain Medicine, 21(5), 2020, 970–977
doi: 10.1093/pm/pnz341
Advance Access Publication Date: 30 December 2019
Original Research Article

PRIMARY CARE & HEALTH SERVICES SECTION

Pain Care in the Department of Veterans Affairs: Understanding How a Cultural Shift in Pain Care Impacts Provider Decisions and Collaboration

Kristin Mattocks, PhD,[*,†] Marc I. Rosen, MD,[‡,§] John Sellinger, PhD,[‡,§] Tu Ngo, PhD,[¶]
Brad Brummett, PhD,[*] Diana M. Higgins, PhD,[‖,‖‖] Thomas E. Reznik, MD, MPH,[**,††]
Paul Holtzheimer, MD [‡‡,§§] Alicia M. Semiatin, PsyD [¶¶] Todd Stanley, DO [‖‖] and Steve Martino, PhD[‡,§]

- 39 VA providers (primary care, mental health, pain management, and C&P) from the 8 VISN medical centers
- Semi-structured telephone interview
- Qualitative analysis or transcribed interviews informed by grounded theory methodology
- Prominent themes identified related to providers' experience with coordination of pain care in VISN facilities

Results:

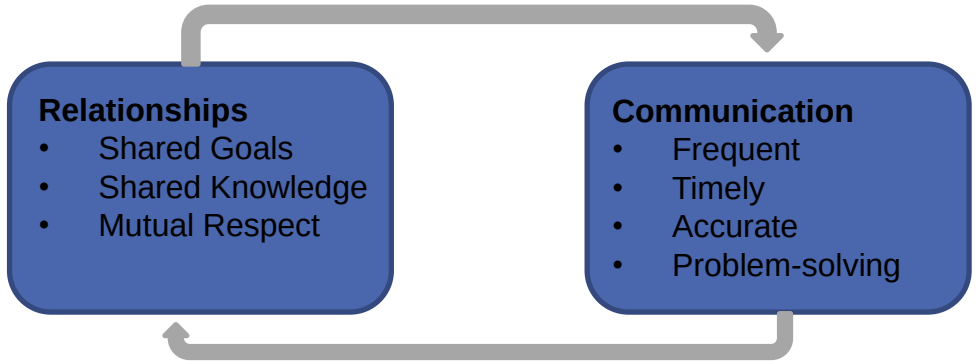
- The culture of VA pain care has changed dramatically with greater focus on nonpharmacological approaches
- Wide range of multimodal pain treatment options at VISN facilities
- Many providers are unaware of the full range of treatment options
- Most facilities have no clear pain treatment pathways
- VA multidisciplinary teams generally work together to ensure that veterans receive coordinated pain care
- Veteran preferences for care may not align with existing facility resources and complicate the pain care pathways

Preparatory: 2

Understand access to pain care from C&P

Access to Pain Care From Compensation Clinics: A Relational Coordination Perspective

Marc I. Rosen, MD; Steve Martino, PhD; John Sellinger, PhD; Christina M. Lazar, MPH; Brenda T. Fenton, PhD; and Kristin Mattocks, PhD (2020), Federal Practitioner, 37 (7), 336-342.



- Workgroups that communicate with each other well relate to each other well
  - And vise versa
- Higher relational coordination helps workgroups achieve common goals.

- Staff from four workgroups (primary care, mental health, pain management, and C&P) at each of the VISN medical centers completed a relational coordination survey.
- Surveys asked, vis a vis each other group, about:
  - Communication
  - Response to problems providing services
  - Sharing goals
  - Knowledge and respect for respondent's job function

TABLE Relational Coordination Composite Scores for Workgroups[a]

Workgroups Evaluated	Total Surveys, No.	Mean (95% CI)	Surveys Excluding Workgroup Members, No.	Mean (95% CI)
Compensation and pension	66	2.21 (2.01-2.42)	59	2.09 (1.91-2.27)
Primary care	66	3.49 (3.34-3.64)	50	3.38 (3.22-3.55)
Pain management	66	3.78 (3.61-3.96)	34	3.53 (3.25-3.81)
Administration	66	2.86 (.093-4.78)	55	2.84 (2.63-3.05)

[a]Relational coordination survey scores range from 1 to 5.

Some C&P examiners see their role as purely forensic

"We don't have an ongoing therapeutic relationship with any of the patients,"

"We see them once; they're out the door. It's forensic. We're investigating the person as a claimant, we're investigating it and using our tools to go and review information from 30, 40 years ago."

"Because we are doing the forensic stuff that tends to take the major part of our visit, but I certainly spend a little time with the Veteran talking to them about what their personal life, who they are, what they do, what they've done, they're going to do to kind of break the ice between us. Then at the end, I will make some suggestions to them. I'm comfortable doing that."

Results:

- C&P providers coordinated less with other workgroups than other workgroups coordinated with each other.
- Most VA staff interpret the emphasis on evaluative rather than therapeutic examinations to preclude attempts to engage Veterans into pain treatments.
- Some C&P sites tried to engage Veterans in pain treatment.
- Suggestions for improving relational coordination included
  - Providing an intervention to increase treatment referrals
  - Forging more integration between C&P and administrative groups responsible for enrolling eligible Veterans in VA care (e.g., having C&P clinicians more familiar with Eligibility process)
  - Conducting in-house rather than contract C&P exams

More privatization of C&P exams. More need for outreach to Veterans at C&P?

United States Senate
WASHINGTON, DC 20510

November 20, 2020

The Honorable Robert Wilkie
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Wilkie,

We write today to express grave concerns regarding the Department of Veterans Affairs' (VA) decision to privatize the Compensation and Pension (C&P) programs within the Veterans Health Administration (VHA), eliminating the associated VA personnel conducting these exams and leaving the examination of veterans' disabilities in the hands of private contractors at a potentially enormous cost to American taxpayers. We were alarmed to learn that VA's vision for the future of the C&P program is to fully utilize private contractors to take over the VA personnel's workload, which we believe has the potential for serious long-term negative impacts on the services and benefits provided to our nation's veterans.

...

Preparatory: 3

Evaluate Feasibility and Acceptability

Sellinger JJ, Martino S, Lazar, et al. (under review). The acceptability and feasibility of screening, brief intervention, and referral to treatment for pain management among New England veterans with chronic pain.

- Study enrolled 40 Veterans (5 from each of the VISN medical centers)
  - Post 9/11 era
  - Scheduled to have compensation examination for MSD condition
  - Reported average pain rating of at least 4 on NRS over prior week
  - Had received <3 nonpharmacological pain treatment modalities in past 12 weeks
  - Had access to a phone
- Provided up to 4 sessions of SBIRT-PM within hub-and-spoke delivery system.
  - Counselors trained in SBIRT-PM and oriented to C&P and VA healthcare services
  - Supervised monthly (2 audio recorded sessions reviewed per counselor)
- Completed baseline and 12-week assessments and semi-structured interview about counseling process
  - Pain - BPI, Pain Medications, Nonpharmacological Modalities
  - Substance Use – ASSIST, Nail Clippings
  - Other – PHQ-9, interview about counseling experience and perceptions of pain services

Results:

- Recruitment rate from screening was 14%
- Retention at 12-week assessment was 90%; dropout was distributed across sites
- 80% received at least one SBIRT-PM session, with half receiving at least three
- SBIRT-PM was acceptable in that it:
  - Increased awareness of pain services
  - Helped participants connect to care
  - Counselors were supportive attentive to Veterans' pain experiences
- Outcomes
  - BPI pain intensity and interference scores showed little change, though mean pain intensity was somewhat higher than interference (5.1 vs. 3.7)
  - Nonpharmacological pain service use increased from baseline to week 12
  - Two thirds reported risky substance use with little change over 12 weeks, with the exception of self-reported risky alcohol use, which dropped from 33% to 17%
  - Participants reported mild depressive symptoms; 15% and 11% at baseline and week 12 respectively endorsed suicide thoughts item on PHQ-9

Pragmatic Trial

Specific Aims:

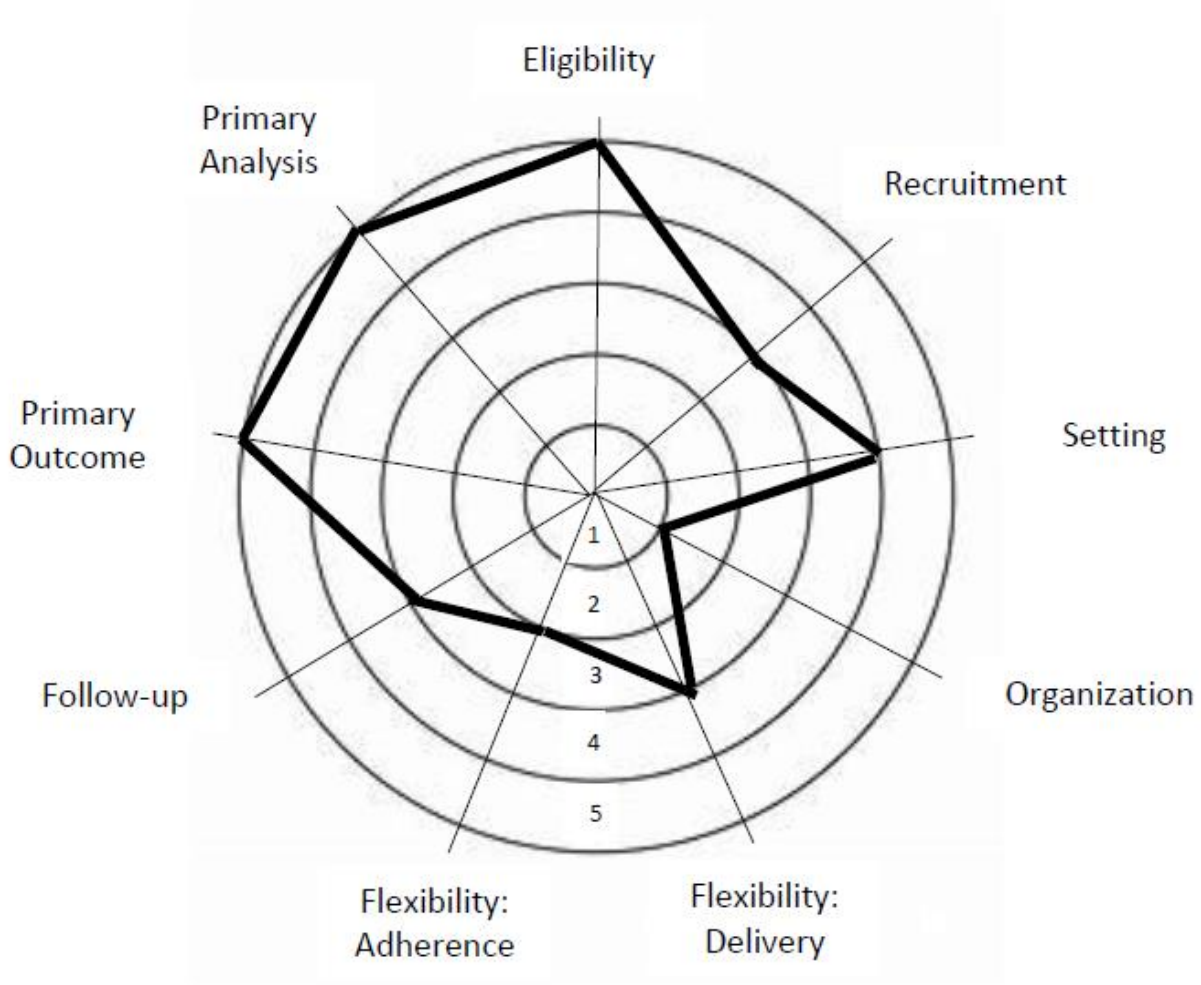
1. To determine if SBIRT-PM is more effective than UC in reducing pain severity, and secondarily reducing pain interference with life activities and overall pain and increasing nonpharmacological pain management service utilization and health-related quality of life

2. To determine if SBIRT-PM is more effective than UC in reducing the number of misused substances requiring intervention, and secondarily reducing use severity for individual substances

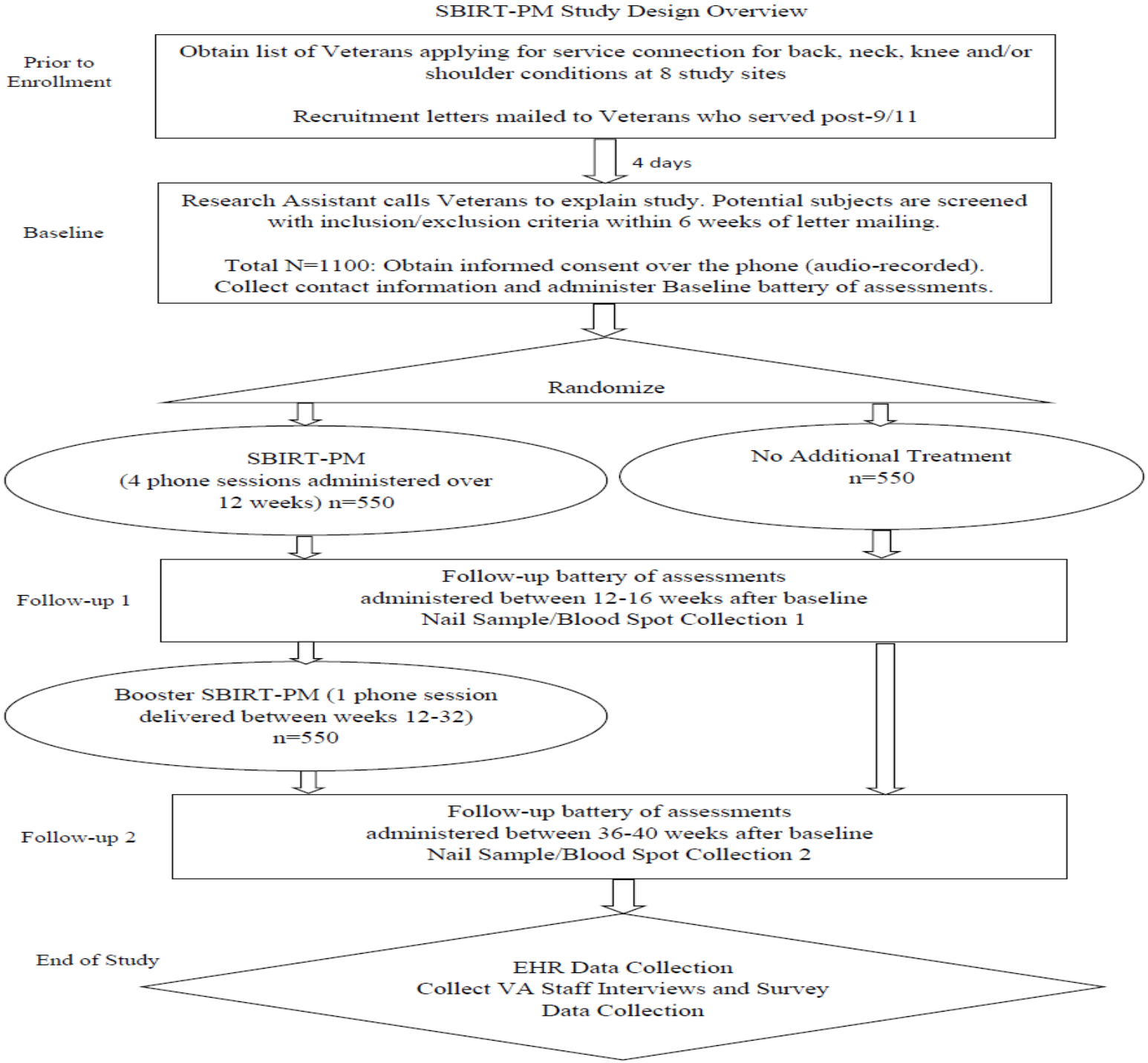
3. To determine the cost-effectiveness (VA health system and societal perspectives) and budget impact of SBIRT-PM relative to UC .

Pragmatic Trial

PRECIS-2 Figure

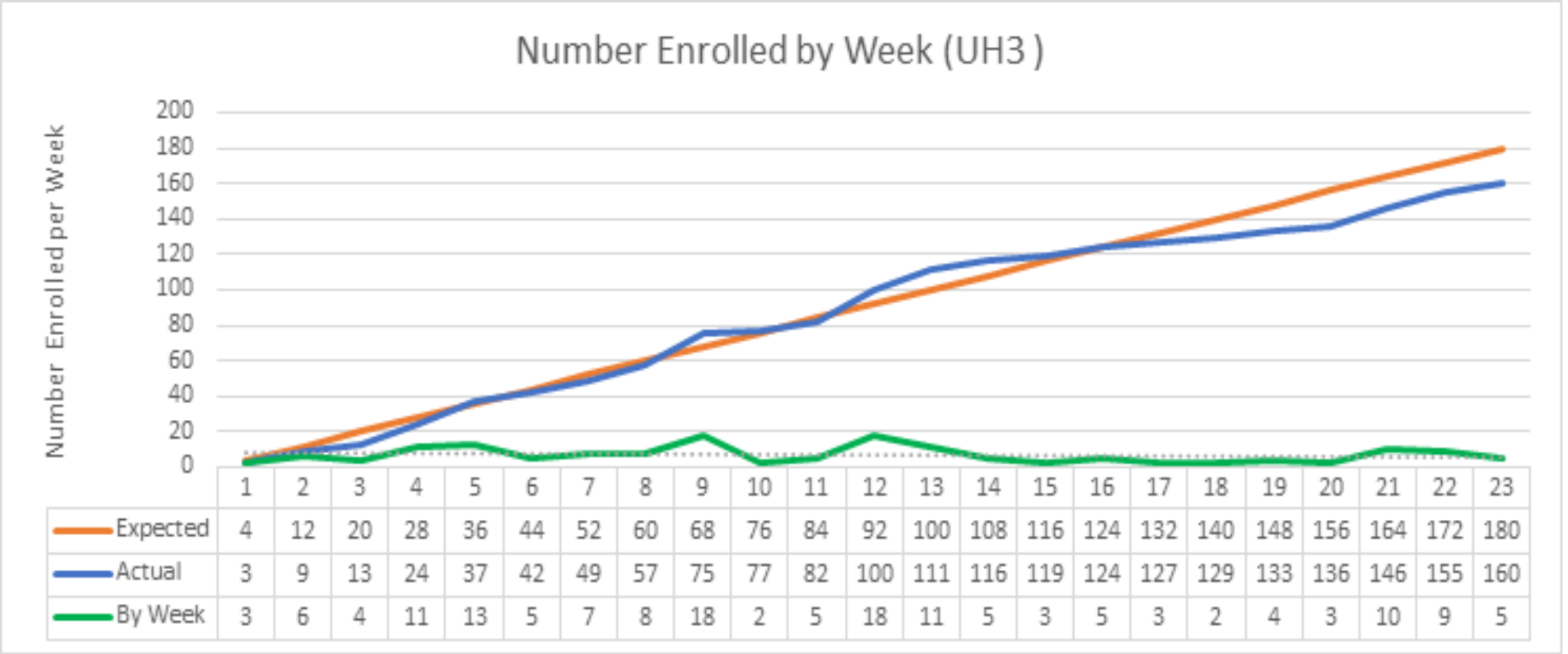


Pragmatic Trial



Pragmatic Trial

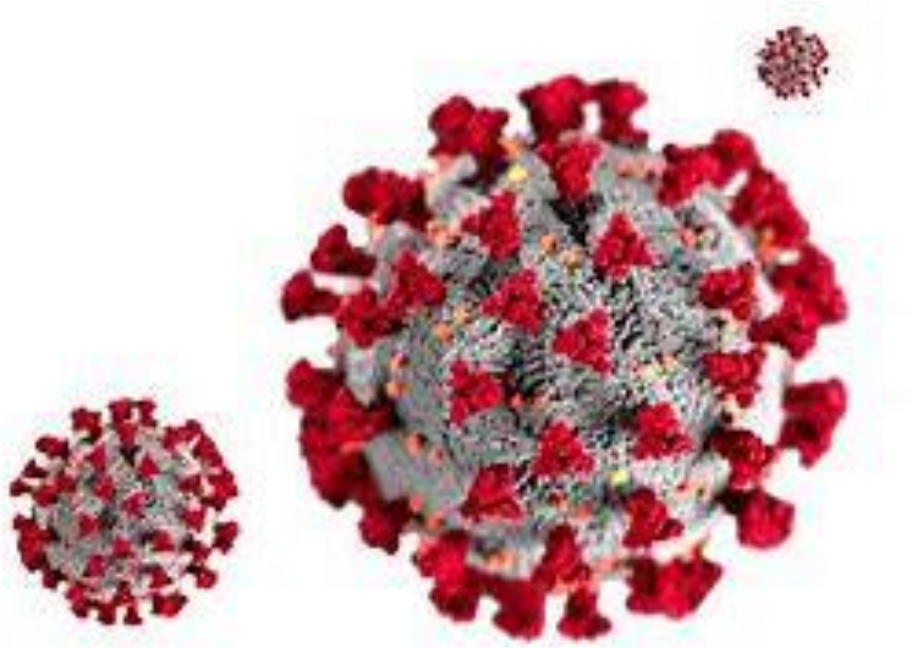
Life was good…
October 2019 – March 2020



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Expected	4	12	20	28	36	44	52	60	68	76	84	92	100	108	116	124	132	140	148	156	164	172	180
Actual	3	9	13	24	37	42	49	57	75	77	82	100	111	116	119	124	127	129	133	136	146	155	160
By Week	3	6	4	11	13	5	7	8	18	2	5	18	11	5	3	5	3	2	4	3	10	9	5

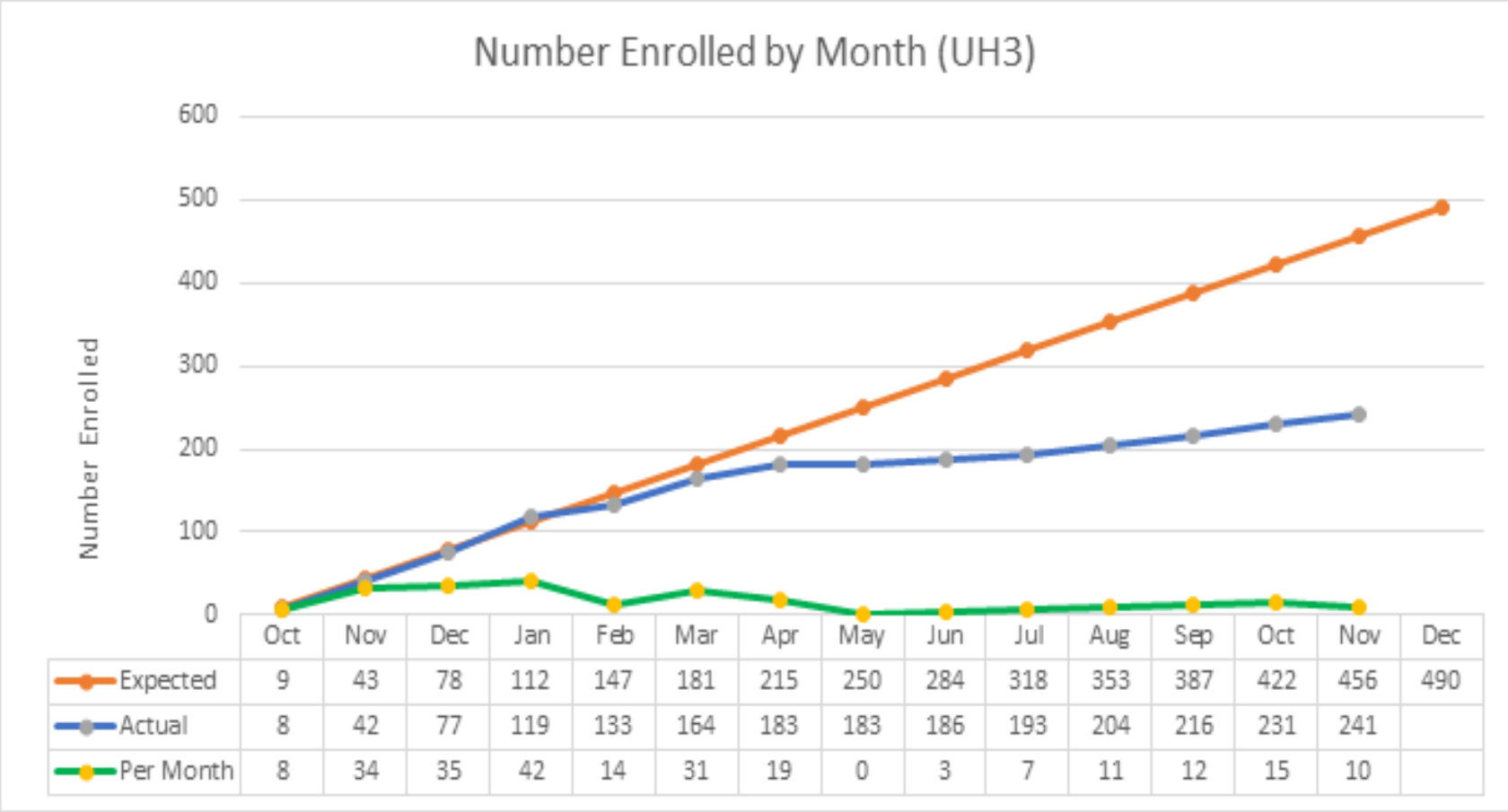
Pragmatic Trial

… and then COVID-19 hit



Pragmatic Trial

Now life is complicated
October 2019 – Nov 2020



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Expected	9	43	78	112	147	181	215	250	284	318	353	387	422	456	490
Actual	8	42	77	119	133	164	183	183	186	193	204	216	231	241	
Per Month	8	34	35	42	14	31	19	0	3	7	11	12	15	10	

Pragmatic Trial

What did we do?

1. Added a 5th counseling session between weeks 12-32
2. Updated SBIRT-PM to include more virtual and self-help pain care options and coordinated with Site-PIs to understanding shifting landscape of services
3. Allowed for counselor discussion of pandemic-related stressors as they related to Veterans' chronic pain and risky substance use
4. Implemented COVID-19 questionnaire to get at Veterans' perspective of impact of pandemic on access to health care and social determinants of health; serially administered at baseline, 12- and 36-week assessments
5. Implemented a quarterly pain service availability assessment (not offered, reduced, full access, virtual [yes/no])

Pragmatic Trial

What did we do?

6. Analyzed C&P recruitment process pre- and during pandemic
   - Much less potentially eligible Veterans due to stalled/reduced C&P claims being filed and fewer exams being scheduled
   - Contacted greater percentage of Veterans post pandemic, but greater percentage of them are not interested in participating
   - Recruitment rate has dropped from about 14% to 11%
   - Considering use of swag and small reimbursement with recruitment letter
7. Developed plans to deal with complications to data analysis as COVID impact is a time-varying covariate; data from COVID-19 Questionnaire and pain service availability survey likely will be used in analyses.

Cost Estimation (led by Paul Barnett)

- Costs assessed for activities needed to replicate SBIRT-PM :
  - identifying and recruiting eligible Veterans
  - preparing for counseling, delivering counseling, following up and referrals
  - training and supervision.
- Micro-cost estimates will be based on study data:
  - SBIRT-PM encounters
  - staff reports of time spent
  - data on labor cost and overhead from the VA National Data Extracts (NDE) of the Managerial Cost Account (MCA) system.
- Cost of VA MSD-related care
  - Sources: MCA system, the claims data of the VA Community Care program (Program Integrity Tool and Fee Basis Claims System), and patient self-report.
- Cost of non-VA MSD-care
  - Sources: Self-reported quantities of pain treatments used and VA costs, or published estimates of unit costs per treatment service.
- Cost of care will be measured from the date of randomization until the end of the 36-week follow-up.

MSD-specific Cost Estimation

- Inpatient treating specialty extracts (TRT) identify costs of each inpatient service that was used:
  - Acute medical stay
  - Rehabilitation
  - Acute surgical stay
  - Mental Health
  - Domiciliary
  - Long-term care
- Which inpatient stays (DISCH) are MSD-related decided based on:
  - Principal diagnosis – diagnosis responsible for admission to hospital
  - Primary diagnosis – most serious (resource intensive) diagnosis during the stay
  - Placeholder principal/primary diagnosis – assigned outside of MCA production system; working to understand how this is different and if it is useful

MSD-specific Cost Estimation

- Outpatient costs include 4 mutually exclusive categories (based on stop code):
  - Emergency care for MSD conditions
  - Surgical care for MSD conditions
  - Other care for MSD conditions
  - All other care
- Outpatient care attributed to MSD conditions if:
  - Outpatient visit with primary diagnosis “M” code
  - Radiology/Prosthetics/Laboratory visit
    - +/- 14 days of outpatient visit with a primary diagnosis “M” code OR
    - MSD CPT code in RAD record
    - MSD HCPCS code in PRO record
- Medication costs are attributed to MSD condition based on standardized description of drug

Questions or Comments

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