The Pain Services Evaluation Program: A Partnered Evaluation

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Co-Principal Investigators

Disclosures & Acknowledgements

- The contents do not represent the views of the U.S. Department of Veterans Affairs or the United States Government.
- We have no conflicts of interest to report.
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Background

- **What is the Pain Services Evaluation Program?**

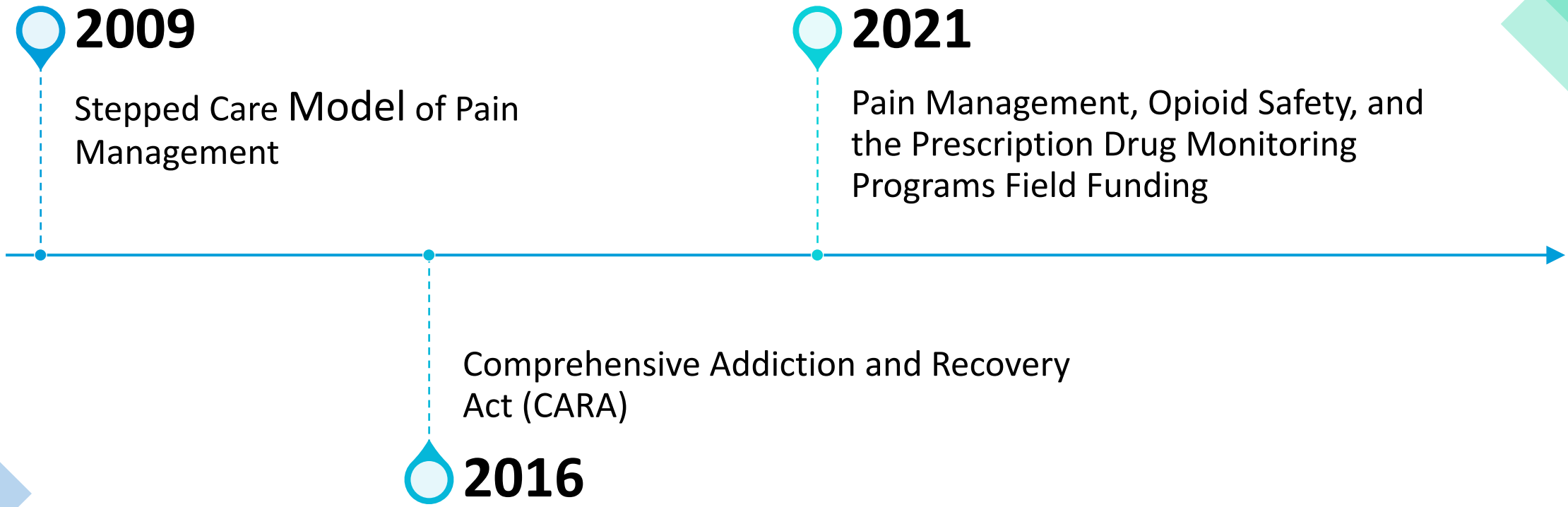
  Began in FY21, a partnered evaluation between:

  - Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP)
  - Pain, Research, Informatics, Multi-morbidities and Education (PRIME) Center

- **Goal**

  To understand services provided in pain specialty care throughout VHA, with an emphasis on the structure and functions of pain management teams.

Background


2009
Stepped Care Model of Pain Management
2021
Pain Management, Opioid Safety, and the Prescription Drug Monitoring Programs Field Funding
Comprehensive Addiction and Recovery Act (CARA)
2016

Stepped Care Model of Pain Management

Provides a framework for effective treatment of pain by emphasizing an individualized approach to pain management informed by Veteran

Foundational Step, Self-Management. VHA supports self-management through the systematic provision of educational and supportive interventions designed to strengthen Veterans' skills and confidence in the management of their health conditions, thus promoting wellness and well-being, including nutrition/weight management, sleep, and exercise. It supports the Veteran regarding stress management, relaxation and mindfulness skills building, stress management and abstinence from substance use. Specifically, for self-management of pain symptoms, these approaches involve acquiring knowledge and management strategies to minimize pain symptoms and improve self-efficacy and quality of life

Step One, Primary Care. Requires the development of competent Patient Aligned Care Team (PACT) to assess and manage common pain conditions. To accomplish this, Primary Care requires the availability of system supports, family and patient education programs, collaboration with integrated mental health care providers within the PACT.

Step Two, Specialty Care and Collaborative Co-Management. Requires timely access to an interdisciplinary PMT providing specialty care in pain management, pain medicine, behavioral health, physical medicine, and rehabilitation, polytrauma programs and teams, outpatient and inpatient pain management, and palliative care teams.

Step Three, Tertiary Pain Management Programs. Requires advanced pain medicine diagnostics and pain rehabilitation programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

2016 Comprehensive Addiction and Recovery Act (CARA)

Mandates that each VHA facility designate a pain management team (PMT), an interdisciplinary team of providers. A fully staffed Pain Management Team (PMT) must include, at a minimum, members fulfilling all of the following roles:

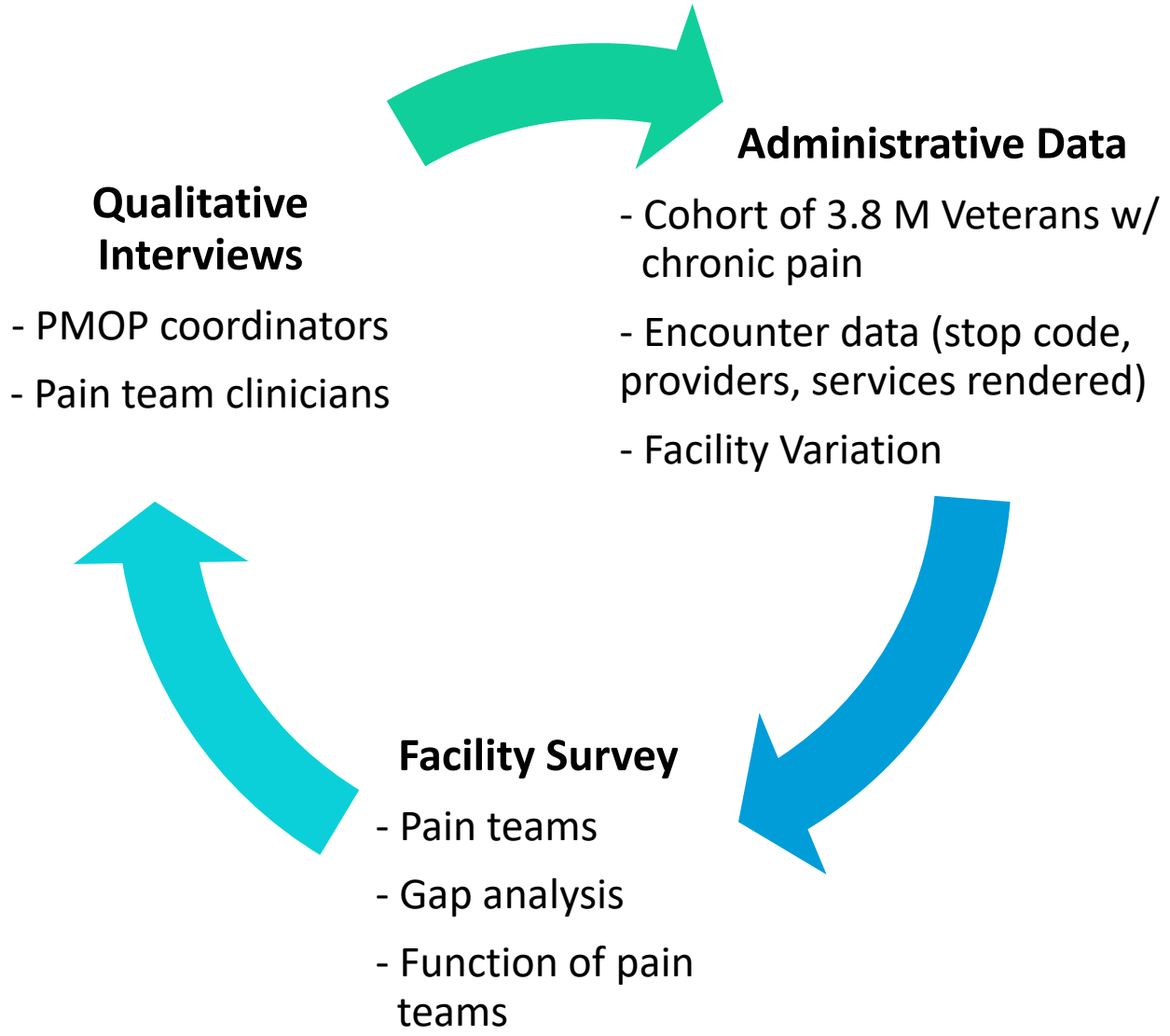
1. Medical Provider with Pain Expertise
2. Addiction Medicine expertise to provide evaluation for Opioid Use Disorder (OUD) and access to Medication-Assisted Treatment (MAT)
3. Behavioral Medicine with availability of at least one evidence-based behavioral therapy
4. Rehabilitation Medicine Discipline

2021 PMOP Funding Initiative

Provides funding for dedicated staffing at VISNs and facilities to assure oversight, reporting and coordination of pain care and opioid stewardship programs and initiatives.

1. Sustained (recurring) funds for staffing:
   - A. VISN and Facility PMOP Coordinators:
     1. VISN PMOP Coordinator funding equivalent to 1.0 FTE
     2. Facility PMOP Coordinator funding equivalent to 1.0 FTE
   - B. VISN and Facility Pain Point of Contacts (POCs)
     1. VISN Pain POC funding equivalent to 0.25 FTE
     2. Facility Pain POC funding for 0.25 FTE
   - C. Facility Primary Care/Patient Aligned Care Team (PACT) Pain Champ
     1. VISN Primary Care funding equivalent to 0.25 FTE
     2. Facility PACT Pain Champion funding equivalent to 0.25 FT
2. Temporary funding for expansion of Veterans' access to clinical pain care services
3. Funding to VISNs for allocation across facilities

Understanding the State of Specialty Pain Care at VA



Program Goals for FY22

Conduct a retrospective evaluation of VHA pain specialty care from Oct 1, 2018 - Sept 30, 2021

- Focused on encounter data to understand VHA pain specialty care services, including number of visits, services rendered, clinicians involved, and coding practices
- Evaluate trends in coding practices for pain specialty care (e.g., use of stop codes, CHAR4 codes, etc.) and changes in coding during the pandemic (e.g., due to the use of virtual care).

Develop and disseminate a facility-level survey to understand functions of pain management teams.

Use qualitative data to understand the needs and functioning of pain management teams.

Pain Services Evaluation Program Staff

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- **Funder and Consultants:** Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP)

Accomplishments to Date

Goal		Activities to Date	Data Sources
1a	Retrospective evaluation of pain specialty care from October 1, 2018 - September 30, 2021.	Developed cohort; examined encounter data and pain services	Administrative data
1b	Evaluate trends in coding practices for pain specialty care.	Began evaluation of trends in coding practices related the use of stop code 420 and changes during COVID	Administrative data
2	Develop and disseminate a facility-level survey to understand function of pain management teams.	Worked with PMOP to develop PMOP Gap Analysis, disseminate, and analyze data.	Facility-level survey
3	Use qualitative data to understanding pain management teams and enhance information gathered by administrative and survey data.	Conducted in depth qualitative interviews with 4 VISNs (13 pharmacists, 3 psychologists, 6 clinicians)	Qualitative interviews

Administrative Data

- Retrospective evaluation focused on encounter data to:
  - Understand pain services across VHA, including number of visits, services rendered, and clinicians involved
  - Evaluate trends in coding practices for pain specialty care and changes in coding during the pandemic (e.g., due to the use of virtual care).
- Primary analysis focused on stop code 420
- Categorized other specialty pain care stop codes of interests with stakeholder input

Cohort Definition

- Defined as all Veteran VHA patients with at least two outpatient encounters, within 18 months of each other (between October 1, 2018 and September 30, 2021) that included two similar ICD-10 pain diagnostic codes
- Cohort of 3,837,005 Veterans with chronic pain
- This represented 76% of the ~5 million Veterans with at least one pain diagnosis during this period.

Cohort Demographics:
Compared to the total VA patient population, the cohort had a slightly higher percentage of women Veterans, Black Veterans, and Veterans with >=50% service-connected disability.

Grouping Variable	Cohort	Total VA
Age	59.4	60.7
Sex		
Male	89.2%	90.8%
Female	10.8%	9.2%
Race*		
White	70.5%	70.9%
Black	19.8%	16.9%
AAPI/Native American/Multiracial	4.0%	3.8%
Missing	5.7%	8.4%
Hispanic Ethnicity*		
No	92.6%	93.4%
Yes	7.4%	6.6%
Rurality		
Urban	65.6%	66.2%
Rural	33.0%	32.4%
Highly Rural	1.2%	1.2%
Missing	0.2%	0.2%
Service Connected		
<50%	23.6%	28.7%
>=50%	47.7%	39.0%
Not specified	28.7%	32.3%

What are the most common stop codes used during encounters with a pain diagnosis?

Top 5 most frequently used stop codes across VHA during visits with a pain diagnosis

Stop Code	Visit Count (primary or secondary)
PHYSICAL THERAPY	4156775
PODIATRY	2334315
Surgery	2018708
PAIN CLINIC	1868473
Mental Health	1351016

Which pain services saw the most patients for pain?

Top 5 stop codes associated with highest number of unique patients during visits with a pain diagnosis

Stop Code	Number of Unique Patients
PHYSICAL THERAPY	996998
PODIATRY	734488
Surgery*	725064
PROSTHETICS/ORTHOTICS	475510
PM&RS	435736

Which stop codes are associated with the greatest number of visits per patient?

Top 5 stop codes associated with highest number of visits per patient during visits with a pain diagnosis

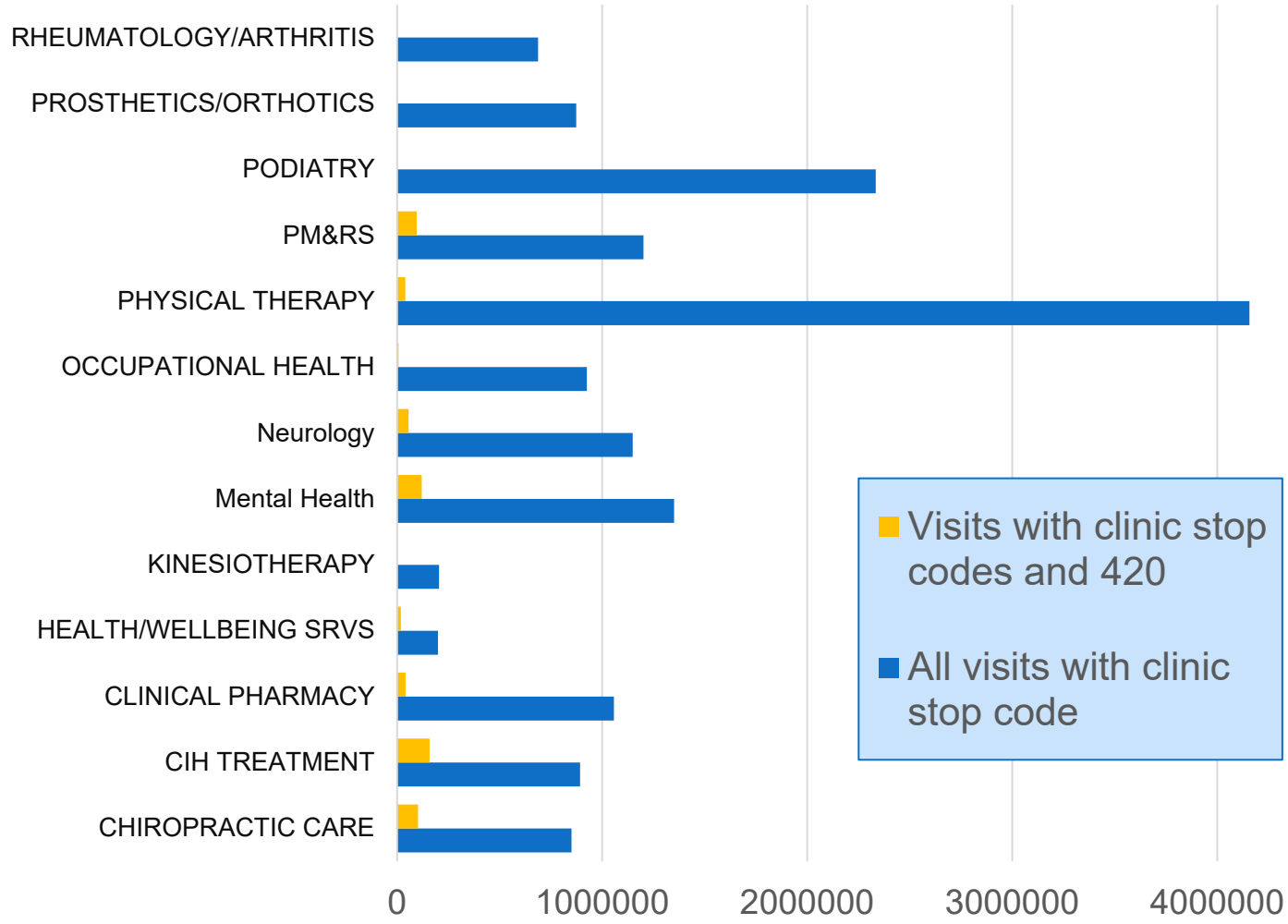
Stop Code	Visit Count	Number of Unique patients	Average visits per unique patient
Spinal cord injury	141178	18456	7.65
CIH TREATMENT	892554	149088	5.99
RECREATION THERAPY SERVICE	115123	19804	5.81
CHIROPRACTIC CARE	850249	152930	5.56
PAIN CLINIC	1868473	365948	5.11

Findings: Evaluation of Pain Clinic Use

TYPES OF ENCOUNTERS	%
% of total encounters with a PAIN CLINIC code (420)	3.2%
% of encounters of interest with a PAIN CLINIC code (420)	10.5%
% of total encounters with a PAIN CLINIC code (420) in the primary position	3.0%
% of encounters of interest with a PAIN CLINIC code (420) in the primary position	9.0%

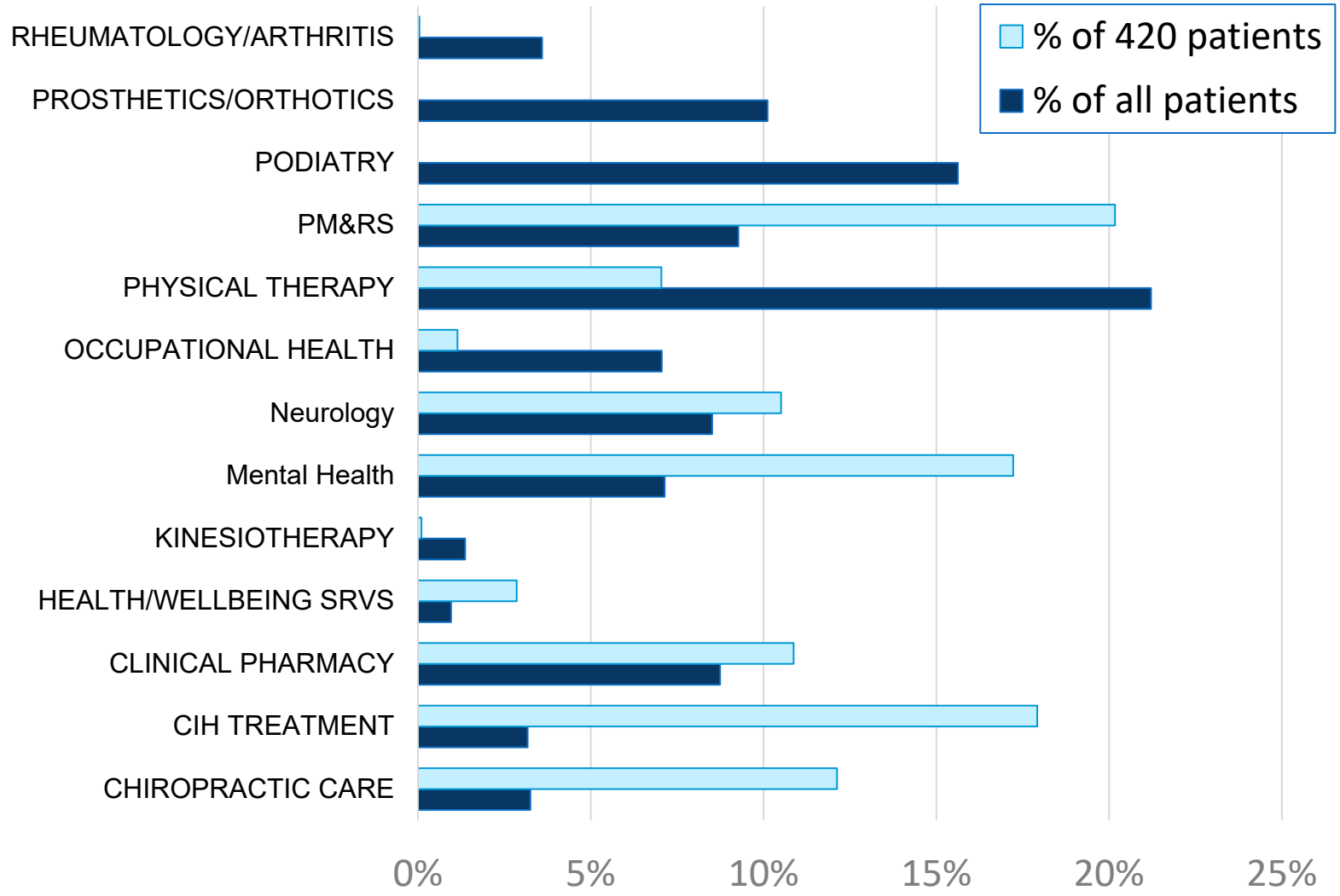
Use of Pain Clinic Stop Code with other Pain Service Codes

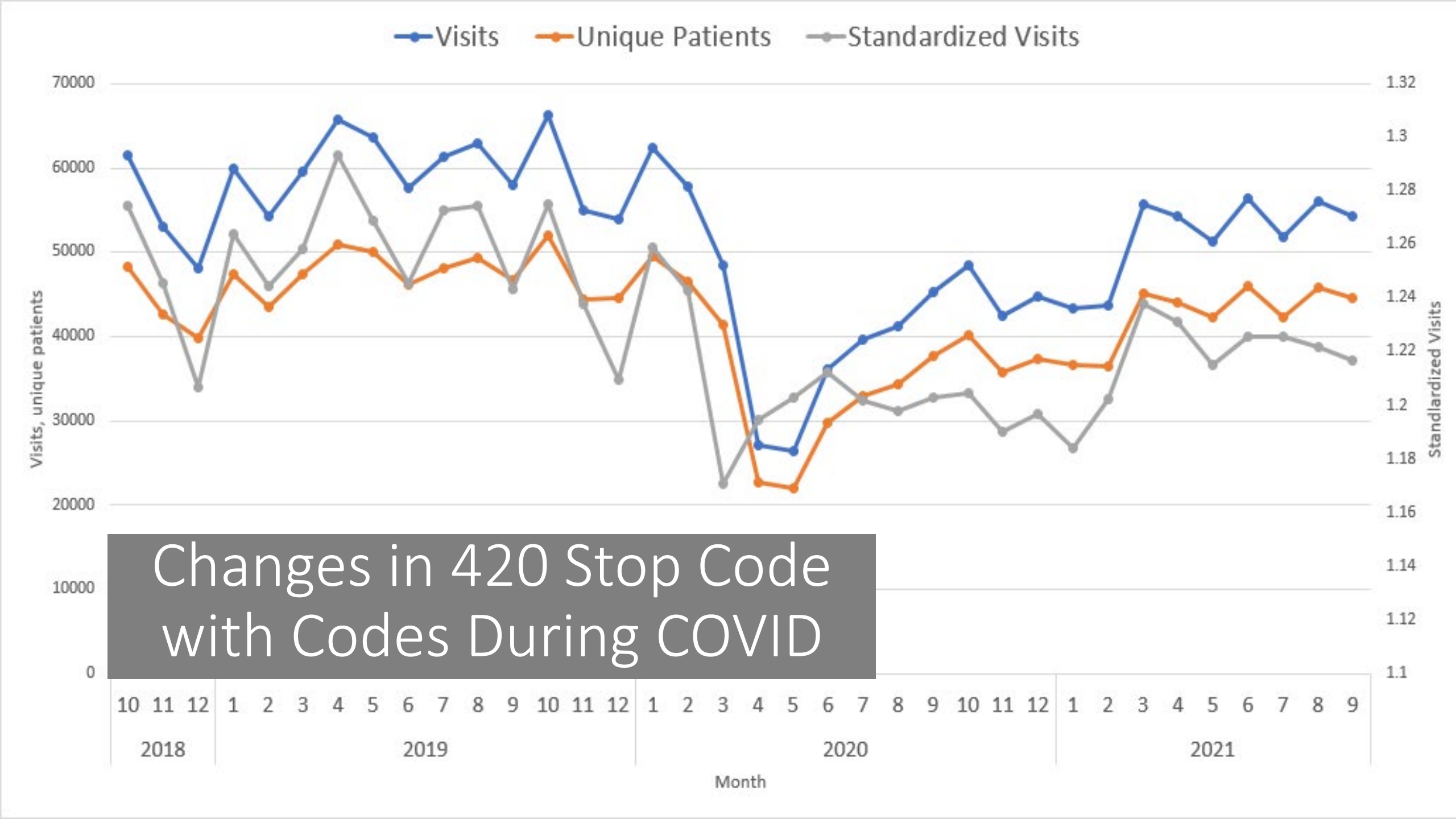
When patients with chronic pain receive treatment, at how many visits is 420 used with other stop codes?



How does our definition of a cohort change what pain services appear common compared to using 420 stop codes?

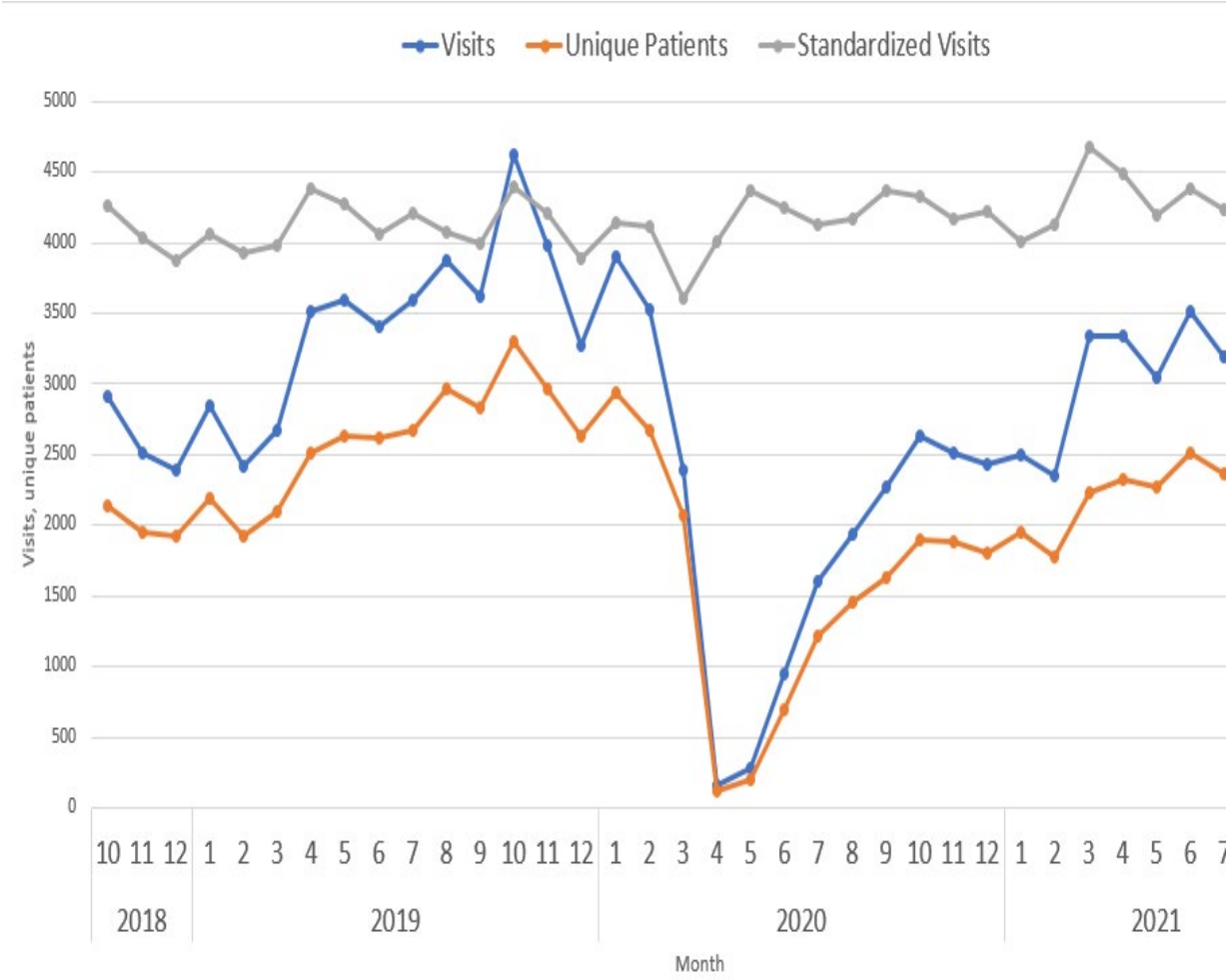
When patients with chronic pain visit clinics of interest, what % appear to each type of clinic?



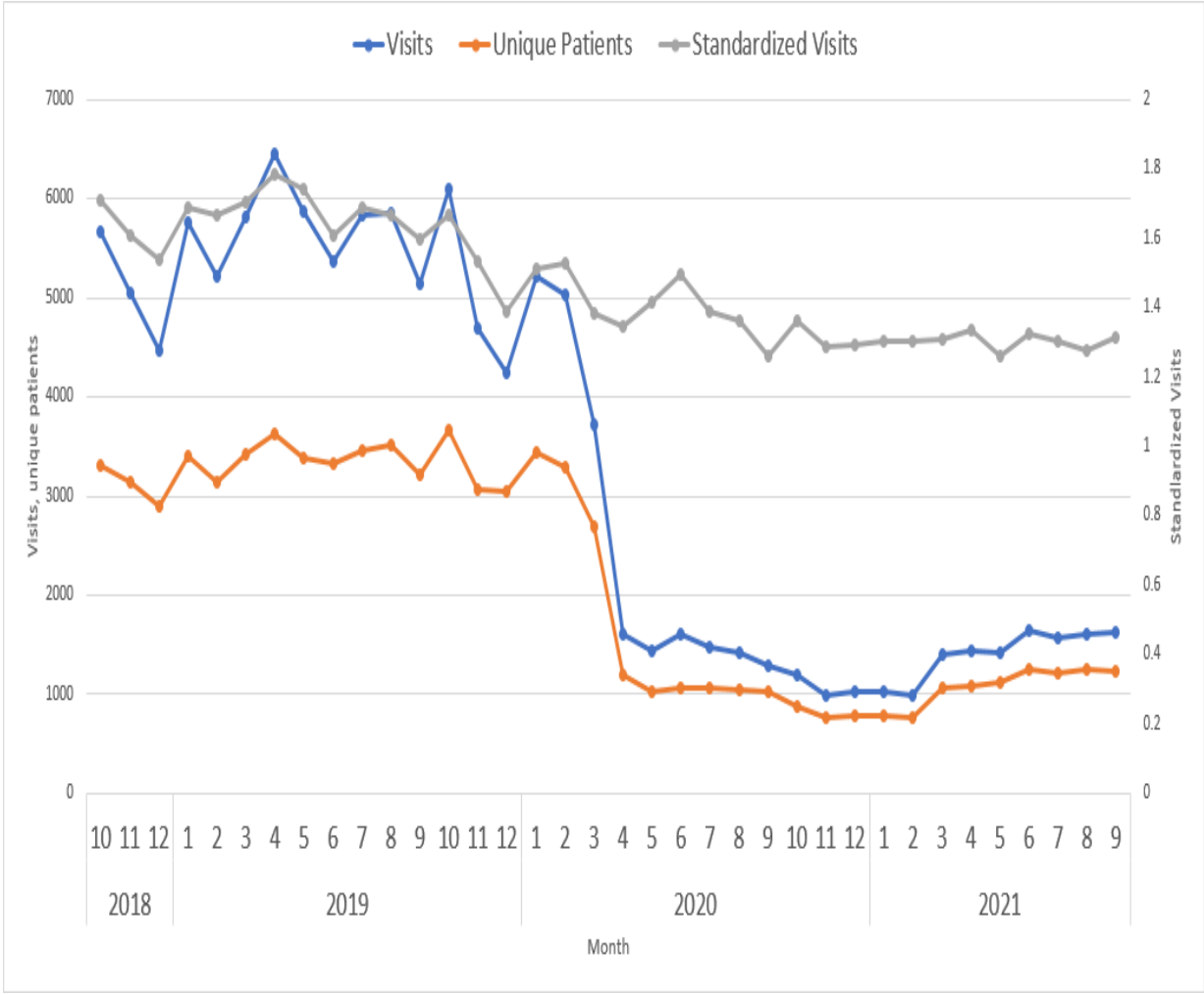


Changes in 420 Stop Code with Codes During COVID

Chiropractic Care



Mental Health



Facility-Level Survey

- Focus on pain management teams (PMTs) as defined by CARA legislation, including staffing, services provided, and barriers to optimal functioning
- Developed with stakeholder input
- Distributed in Spring 2022

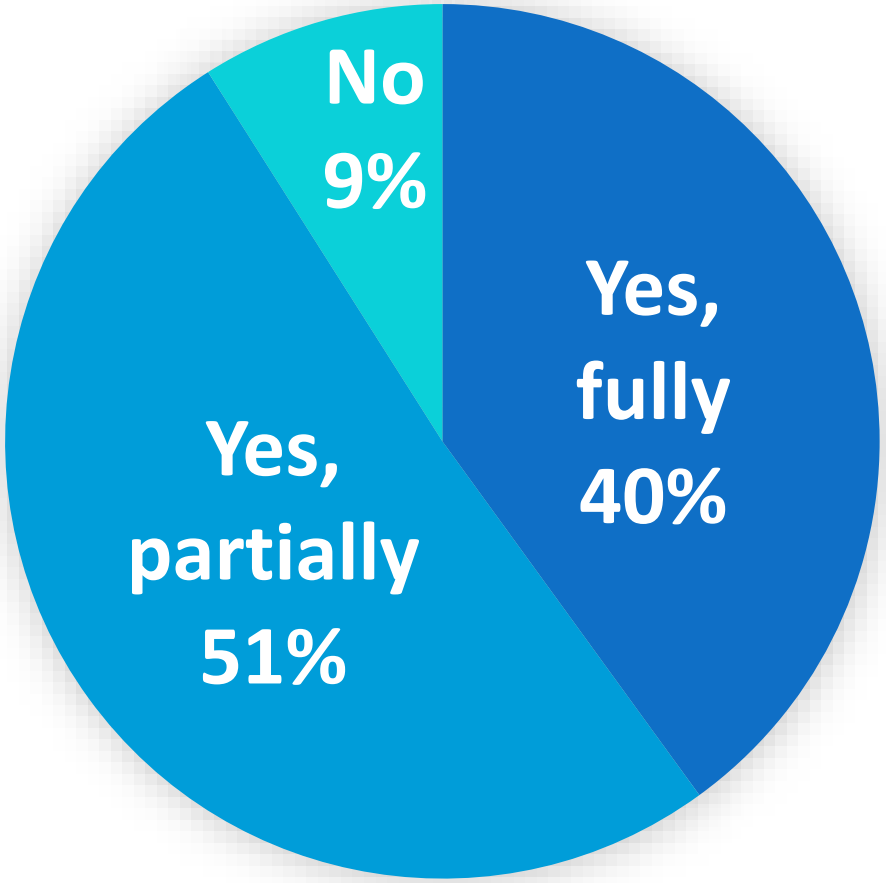
Objectives

1. Describe the implementation status of the Stepped Care Model of Pain Management (SCM-PM);
2. Understand the implementation status of PMTs as defined by CARA;
3. Describe the activities of PMT, including the availability of pain specialty care services, functions, patterns of communication, the number of patients evaluated per month, e-consultations, and follow-up appointments;
4. Understand variations in PMT structure, such as location, service line, and referral patterns; and,
5. Identify barriers to PMT implementation

Methods

- Developed with stakeholder input, designed to align with previous surveys (i.e., HAIG, internal audit) to aid comparison; pilot tested by PMOP coordinators
- Distributed via REDCap in Spring 2022 to all VHA facilities
- Distributed to PMOP Coordinators or Pain POCs
- Survey data were combined with data about facility size, complexity, and rurality from VHA's Corporate Data Warehouse and information from the 2019 HAIG

PMT Staffing



	Complexity					
	High		Medium		Low	
	n	%	n	%	n	%
Fully staffed	41	45%	10	48%	5	19%
Partially staffed	48	52%	7	33%	16	62%
No	3	3%	4	19%	5	19%

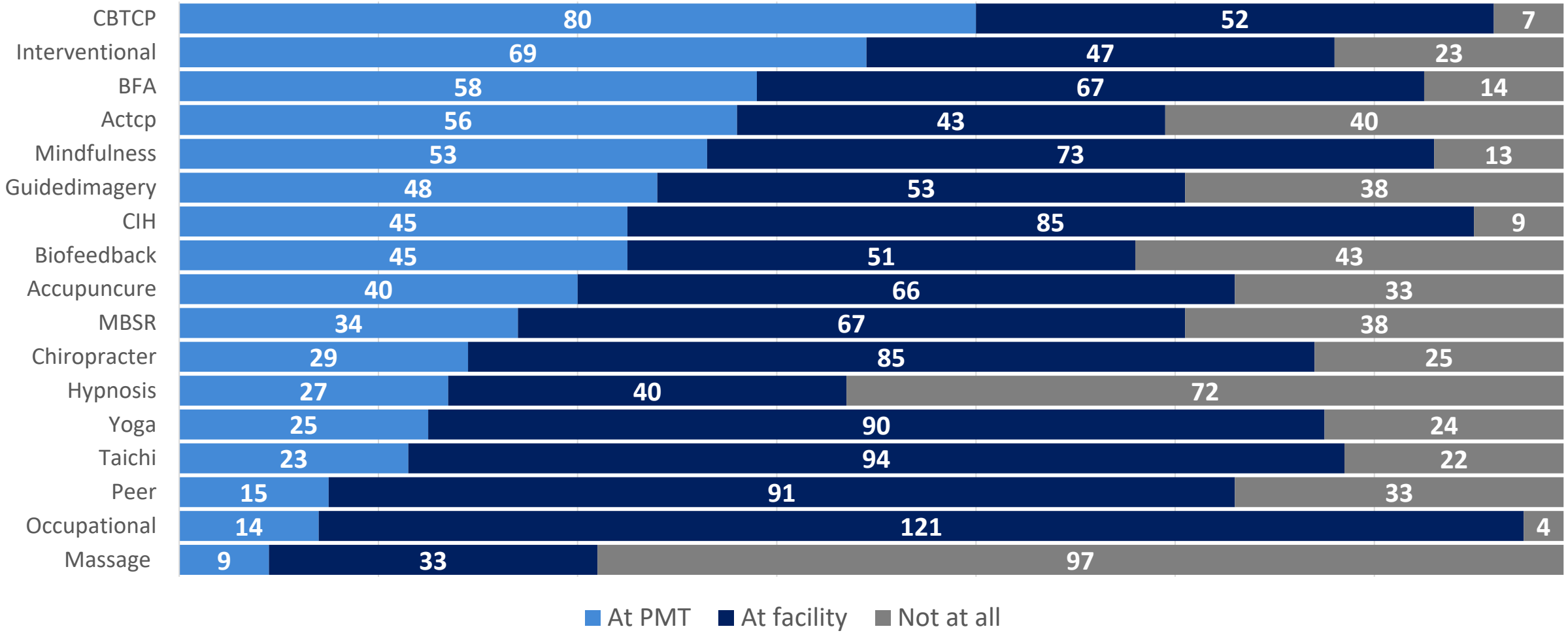
PMT Clinical Staff Characteristics

PMT Clinical Staff	Overall	
	n	%
Medical provider with pain expertise (n=134)	121	90.3
Medical provider with opioid prescription oversight (n=123)	103	83.7
The medical provider has a DEA X waiver (n=124)	97	78.2
Addiction medicine provider (n=132)	89	67.4
Addiction medicine provider has DEA X waiver (n=106)	85	80.2
Addiction medicine provider uses the DEA X waiver (n=106)	80	75.5
Behavioral medicine provider (n=133)	110	82.7
Rehabilitation medicine provider (n=132)	109	82.6
Other team members (n=130)	65	50.0

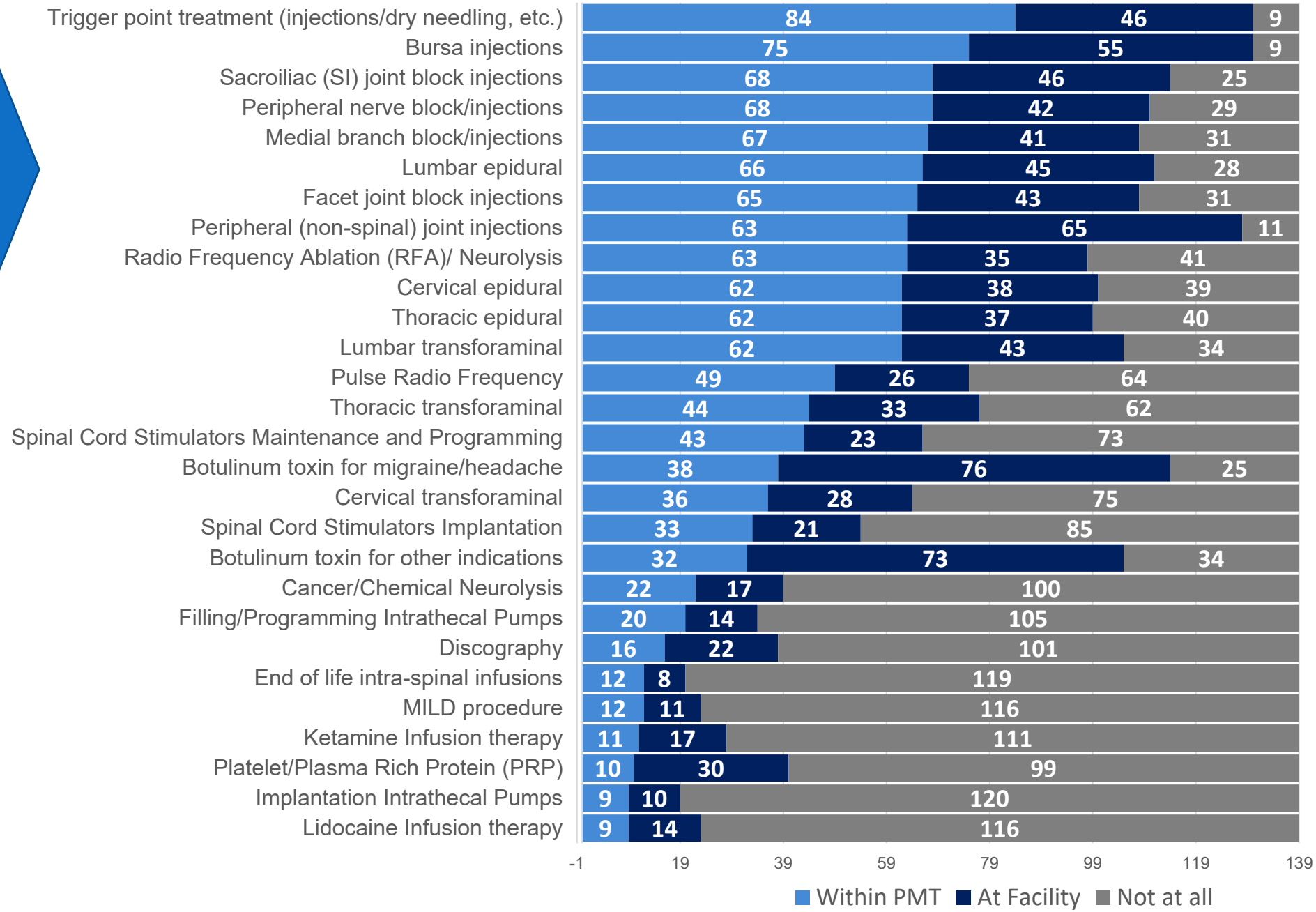
PMT Functions

	Overall		Fully Staffed (n = 56)		Partially Staffed (n = 71)	
	N	%	N	%	N	%
Provides e-consultation	112	88.2%	51	91.1%	61	85.9%
Provides in-person evaluations for pain medication management (may/not include opioids)	110	86.6%	49	87.5%	61	85.9%
Provides in-person follow-up visits (e.g., monitoring/prescribing of pain medication)	106	83.5%	49	87.5%	57	80.3%
Provides in-person evaluations of patients with ongoing opioid prescriptions	105	82.7%	48	85.7%	57	80.3%
Provides in-person evaluations of patients with complex pain conditions	104	81.9%	50	89.3%	54	76.1%
Issues prescriptions of pain medications for patients (actual prescribing by PMT member)	98	77.2%	49	87.5%	49	69.0%
Provides telehealth follow-up visits (e.g., monitoring/prescribing of pain medication)	96	75.6%	43	76.8%	53	74.6%
Provides telehealth evaluation for new patients	85	66.9%	40	71.4%	45	63.4%
Provides case/care management	72	56.7%	36	64.3%	36	50.7%
Provides immediate consultation for assistance with prescriptions	68	53.5%	33	58.9%	35	49.3%
Provides inpatient pain consultation	57	44.9%	29	51.8%	28	39.4%
Provides palliative care	17	13.4%	6	10.7%	11	15.5%
Oversees a patient's primary care (e.g., functioning as a PMT and a PACT)	9	7.1%	3	5.4%	6	8.5%
Others	34	26.8%	20	35.7%	14	19.7%

Pain Services



Interventional Pain Services



PMT Coding

Primary stop code	N	%
420 (Pain clinic)	98	88.3
160 (Pharmacy)	5	4.5
201 (PM&R)	2	1.8
323 (Primary Care)	2	1.8
533 (Psychology)	2	1.8
159 (Secondary code with CIH)	1	0.9
697 (E-consults)	1	0.9

PMT Barriers to Implementation

Barriers to implementation	Overall		Rural		Urban	
	N	%	n	%	n	%
Staff recruitment issues	103	74.10	12	70.6	90	74.4
Staff retention issues	70	50.36	10	58.8	60	49.6
Difficulty getting protected time for clinicians to spend on PMT functions	48	34.53	11	64.7	54	44.6
COVID-19	46	33.09	5	29.4	41	33.9
Members do not operate as an integrated team	46	33.33	6	35.3	40	33.1
Insufficient existing recourses	45	32.37	8	47.1	37	30.6
Have never been able to fill specific disciplines	33	23.74	5	29.4	27	22.3
PMT does not effectively collaborate with Primary Care	25	17.99	2	11.8	22	18.2
Member(s) identified do not fully engage	18	13.04	3	17.6	15	12.4
Other barriers	48	34.78	5	29.4	43	35.5

Survey Limitations

- Point-in-time survey in a rapidly changing environment
- Survey data were self-reported from facility PMOP coordinators or Pain POCs.
- Some items were missing responses.
- Responses were completed primarily by facility PMOP coordinators, some of whom were new to their position.
- Some respondents were asked to submit their responses to their leadership for review before finalizing their survey. This may have impacted the qualitative and quantitative feedback, especially regarding leadership.

Qualitative Interviews

- Aim to interview at least two clinicians per facility at a minimum of ten facilities
- Goal is to understand how pain management teams (PMTs) function at a range of VHA facilities (e.g., high- and low-functioning, facility complexity, geographic region)
- Interview guide explores topics such as typical patient flow, perspectives on team functioning, and perceived leadership support
- Preliminary findings are from 22 interviews across 4 VISNs

Qualitative Interviews: Findings

Secret-sauce to high functioning teams

Respect among providers, communication, bi-directional feedback

Recruitment, retention, and attrition

Facilities struggling with hiring/onboarding, attrition, and space; hiring is a time-intensive process

Measuring success

Reduction in opioid use is objective and trackable, but measures of function and self-care are needed

“Secret Sauce”

- “Communication and I think the expectation for like bi-directional feedback… I think most of us are at a level that if we hear one another say something that we don’t feel is quite right or quite consistent with the pain neuroscience [then] I think we are comfortable enough that we’ll say, ‘that’s not really my understanding’…keeping each other honest in a respectful way.”

- “[We have] been working together as a team for so long, so that like, continuity of providers and staff on our team has really helped, like the way we build relationships and institutional knowledge of those, too, I think takes so much time and so it's been really valuable. I think all of us have really good relationships with mental health leadership and primary care leadership.”

Recruitment & retention

- A lot of my time is spent on spending some of our funding before the end of the fiscal year…we are about tripling our staff, so working on getting those [positions] posted, hired, interviews…all those things are challenging."

- "Mainly our HR is backlogged like [by] 8 months or 9 months and so we have all of this funding…we have all these [positions] that we're trying to hire for… we would be able to see meaningful change once we get these people on board…we have the funding…."

- "I would say that [the PMT] has definitely suffered definitely attrition [for a while] …we had a very good pain psychologist that was with us consistently and had been for a couple years and then we lost her to another VA and we were not able to back fill that position until just in the past year."

Recruitment & retention

- “This where our real pain management journey began. We expanded that pain management in primary care clinic, Medical Practice Pain Clinic, into what we're currently called, the Integrated Pain Team, or IPT, and we began kind of our stepwise expansion to the CBOCs and our facility. And so that was really exciting. We are growing the team, really kind of honed our interdisciplinary model.”

- “ I haven’t seen the changes yet…the funding, of course, will be helpful and I think with the funding is coming an expansion**.”**

Measuring Success

- “I don't even know how you could measure this, but I love the whole health idea. And what we don't do is incorporate or measure people who have successfully seen an acupuncturist or have started a yoga program or have started meditation, or all the other things that are involved in self-care that we know are so important for long term pain control.”

- “I mean, we're measuring (Veterans) taking less opioids, yes, that's objective. But how functional are they? (If a Veteran’s) functional goal was to walk to the mailbox or to play with their grandkids…have they met their goal and/or how far along are they.”

Next Steps

- Follow up staffing survey
- Partner with PMOP to iteratively develop and refine definitions for and indicators of pain management team functioning
- Evaluate facility-level variations in pain specialty care services
- Evaluate uptake, application, and impact of newly funded PMOP initiatives
- Assess need for other initiatives to support pain management teams

Thank you!