

# The Integrated Pain Clinic: Facilitating Coordinated Care Within the Stepped Care Model

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# Poll Question #1

- What is your role in chronic pain care?
  - Primary Care Provider
  - Nurse
  - Psychologist
  - Pain Specialist (M.D., D.O., APRN)
  - Other

# Stepped Care Model

- VHA Pain Management Directive (2009-053) calls for a stepped care approach to pain management.
- Stepped Care - *“a strategy to provide a continuum of effective treatment to a population of patients from acute pain caused by injuries or diseases to longitudinal management of chronic pain diseases and disorders that may be expected to persist for more than 90 days, and in some instances, the patient’s lifetime.”*

# VA Stepped Pain Care

## Tertiary, Interdisciplinary Pain Centers

Advanced diagnostics & interventions  
CARF accredited pain rehab  
Integrated chronic pain and SUD treatment

STEP  
3

Comorbidities

## Secondary Consultation

Pain Medicine  
Rehabilitation Medicine  
Behavioral Pain Management  
Multidisciplinary Pain Clinics  
SUD Programs  
Mental Health Programs

STEP  
2

Treatment  
Refractory

## Patient Aligned Clinical Team (PACT)

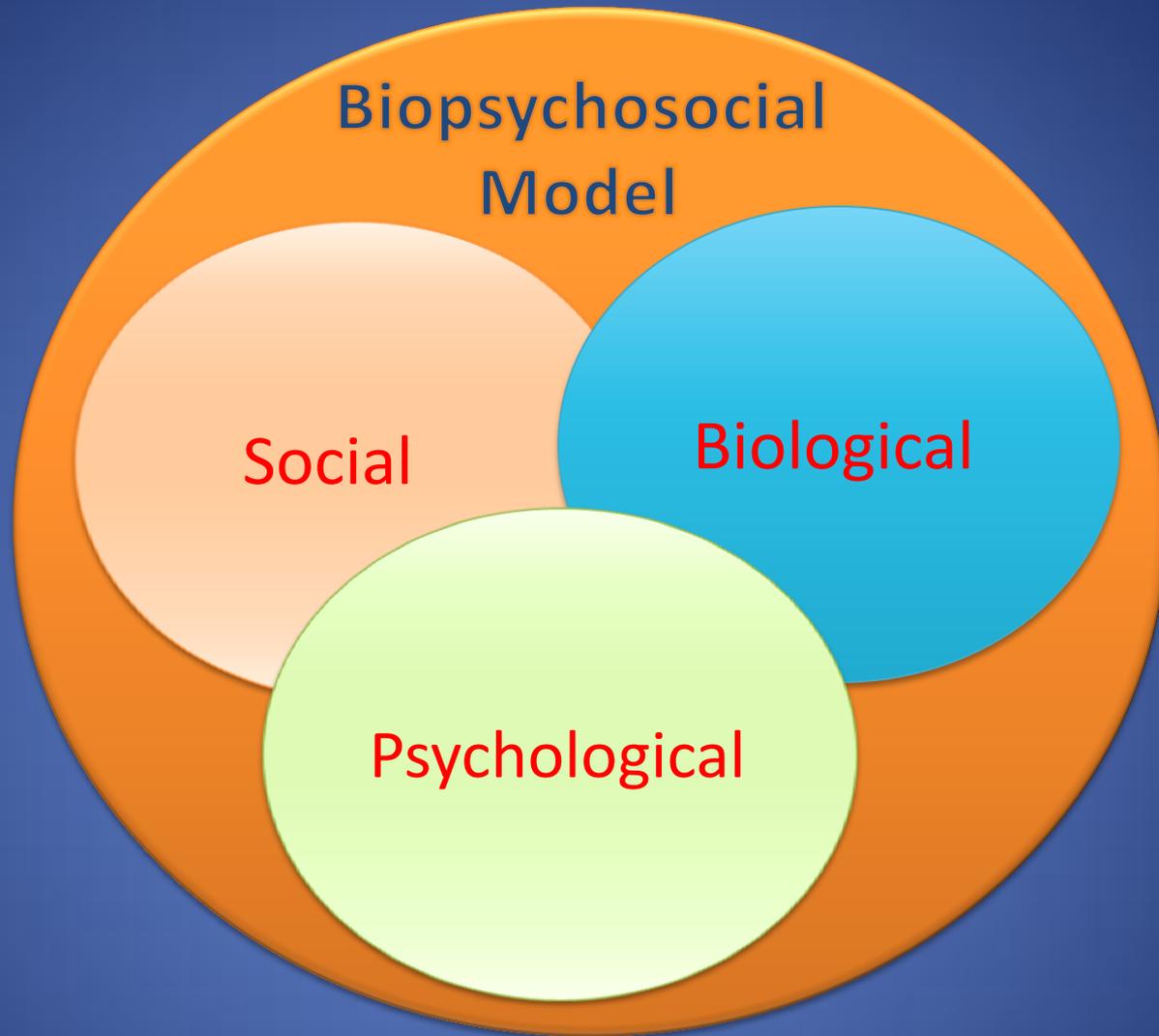
Routine screening for presence & intensity of pain  
Comprehensive pain assessment  
Management of common pain conditions  
Support from MH-PC Integration, OEF/OIF, & Post-Deployment Teams  
Expanded care management

STEP  
1

Complexity

# Biopsychosocial Approach

- The chronic pain experience, and an individual's capacity to cope with it, are best understood as an interaction of biological, psychological, and social variables.
- Empirical findings support the efficacy of multimodal treatment approaches.
- The absence of a coordinating structure with the healthcare system can make adoption of this approach somewhat challenging



We must understand the *“person with pain.”*

# Poll Question #2

- At your facility, where do you encounter the biggest problems with implementation of the Stepped Care Model?
  - Step 1 (Primary Care)
  - Step 2 (Specialty Care)
  - Movement between Steps
  - Coordination of care between Steps

# Local Implementation Challenges

- Chronic pain prevalence rates as high as 50% among Veterans.
- Chronic pain management presents numerous challenges for primary and specialty care providers
  - Time demands
  - Patient demands/Patient Advocate complaints
  - Diagnostic uncertainty
  - Difficulty engaging patients in empirically supported interventions
  - Engaging support of specialists
  - Medication management (escalating doses, aberrant use)
  - High-risk management (comorbid substance abuse, pseudo-addiction, psychiatric instability)

# Problem Manifestation

- Consult process has become center stage for these challenges.
- Review of local pain-related consult data helped to quantify these challenges.
- Data review included consults placed from primary care to specialists for pain-related issues.

# Review of Consult Data

- We examined pain-related consults to 5 specialty pain clinics over a one-year period
  - Pain Medicine
  - Neurology Pain
  - PT
  - Bone and Joint
  - Pain Rehab School
- Of approximately 4,400 consults placed, 42% were cancelled or discontinued

# Reasons for Cancelled & Discontinued Consults

- Consult deemed inappropriate by specialist
- Appropriate consults, but due to high level of complexity, best triaged to an interdisciplinary setting
- Premature consults
- Patients did not follow through/No Showed
- Patients expressed disinterest in service
- Pain care assumed by another service

# Bottom Line...

- High levels of discontinued/cancelled consults:
  - Are a source of frustration for referring providers, specialists, and patients
  - Reflect a lack of coordination of care
  - Should push us to think about the problem more broadly
    - What are the systems issues?
    - What is happening at the patient-system interface?
    - How can we better organize our resources to improve these outcomes?

# Primary Care Providers' Perspective

- Local project examining implementation of the Stepped Care Model.
- One study focused on PCPs' perceived barriers and facilitators to effective pain management.
- Qualitative study, posed the questions:
  - Describe some barriers that you feel limit your ability to manage chronic pain?
  - What are some of the negative aspects about caring for patients with chronic pain?

# Barriers to Chronic Pain Management

- Systems domain
  - Difficulty exploring all elements of the biopsychosocial model
  - No forum to discuss challenging patients with specialists
  - Difficulty coordinating treatment modalities
- Personal/Professional
  - Clinical quandaries/diagnostic dilemmas
  - Fear of missing something
- Interpersonal domain
  - Lack of collaboration with specialists
  - Rejected consults
  - “Ownership” of pain issue
  - Difficult patient-provider interactions
  - Patients unwilling to accept referrals for certain services (PT, CBT)

# Identified Need: Bridging the Steps



# Systems Redesign

- **Rapid Process Improvement Workshop (RPIW)**
  - An improvement process that brings together a team of staff from either various departments or a single department to examine a problem, eliminate wastes, propose solutions, and implement changes.
- A day-long RPIW was facilitated by our local Quality Management Department
  - Trained systems redesign specialists

# Rapid Process Improvement Workshop

- Goals:

1. Improve patient flow between Primary and Specialty Care settings (Steps 1 & 2).
2. Enhance coordination of pain care between Primary and Specialty Care, and between Specialty Care settings.
3. Increase engagement of patients with chronic pain in multimodal therapies with emphasis on rehabilitation and self-management.

# RPIW Process

## Voice of Customer (Voc)

Patients: Patient Center  
 long term is short term

- Pain Relief
- Pain Meds
- Freedom/Flexibility of treatment
- Trust order of pain
- Afraid of making changes
- Want change - what to do
- Want life back - better function
- Want answers - why pain?
- Want someone to listen to them
- Want connection / human connection

IPC - appropriate  
 ample time/resources  
 to address/connect w/pt  
 education/coordination w/ specialty evaluation  
 lag time/wait time treatment

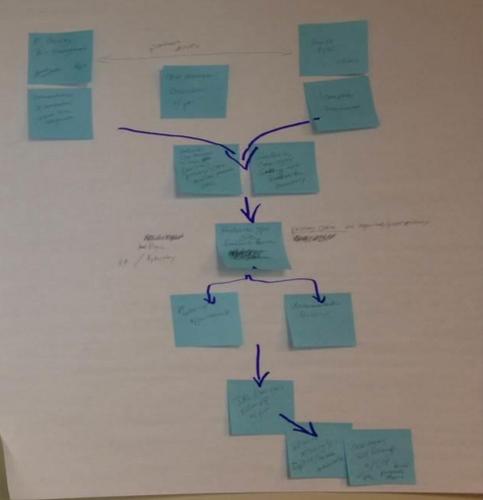
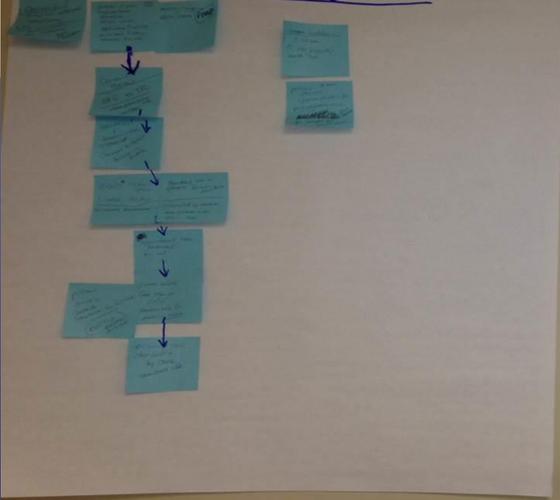
Safety for patient  
 resources - mental health behavioral  
 clear mission/role of IPC ownership  
 patient population complex pain  
 communication and education of primary care

Primary Care - appropriate  
 ample time/resources  
 to address/connect pt  
 effective communication education/understanding  
 agendas differ beyond pain

Obstacles by other departments  
 barriers  
 Safety for patient reduce churning  
 trust patient duration  
 balance of pt care  
 Clear mission/role of IPC  
 PAC Team framework  
 IF pt refuses IPC recommendation  
 what next?



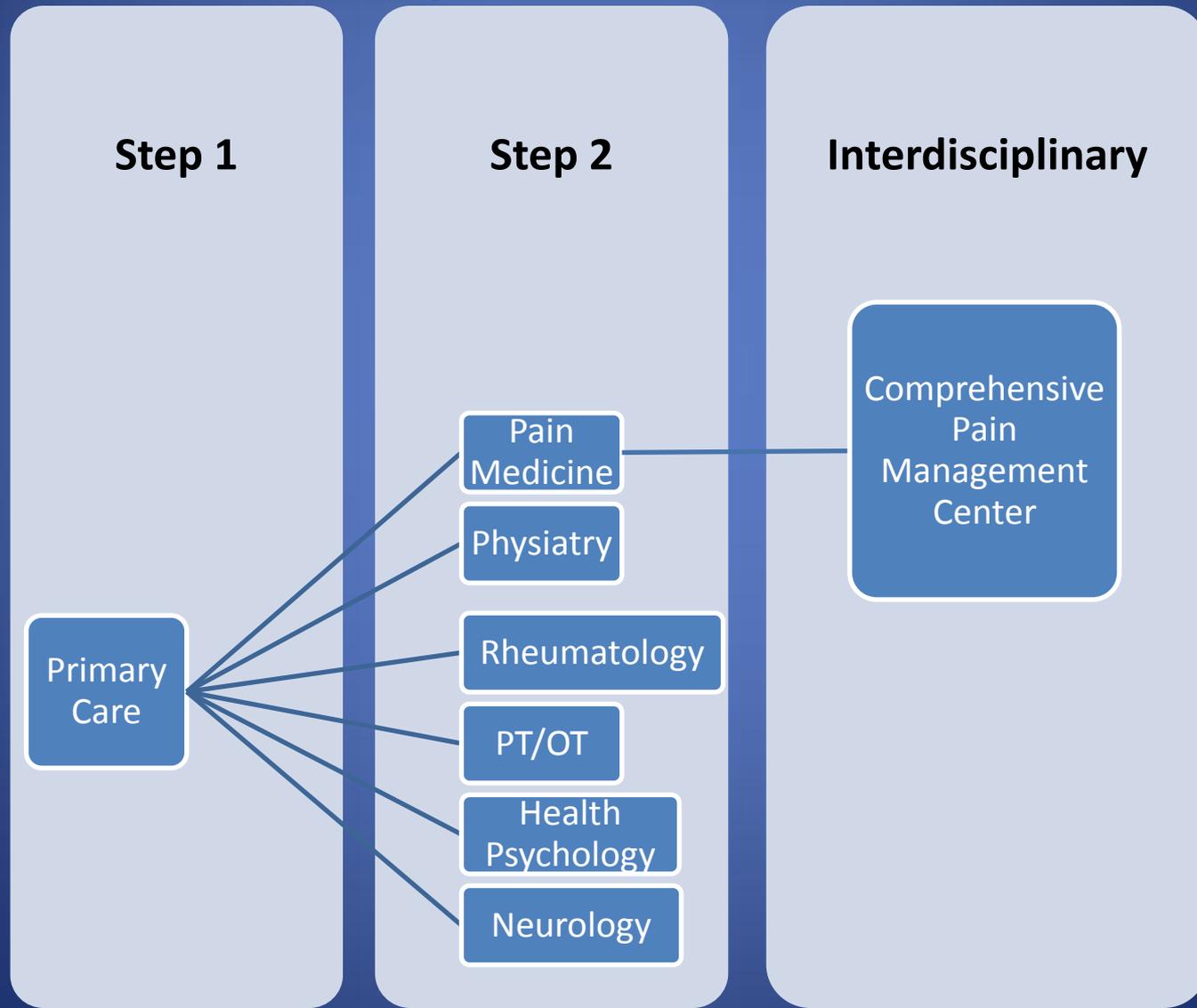
## Future State



# RPIW: Disciplines Represented

- Primary Care
- Pain Anesthesiology
- Clinical Health Psychology
- Psychiatry/Addictions
- Neurology
- Physiatry
- Physical Therapy
- Chiropractic
- Rheumatology
- Interventional Radiology
- Pharmacy
- Quality Management
- Research

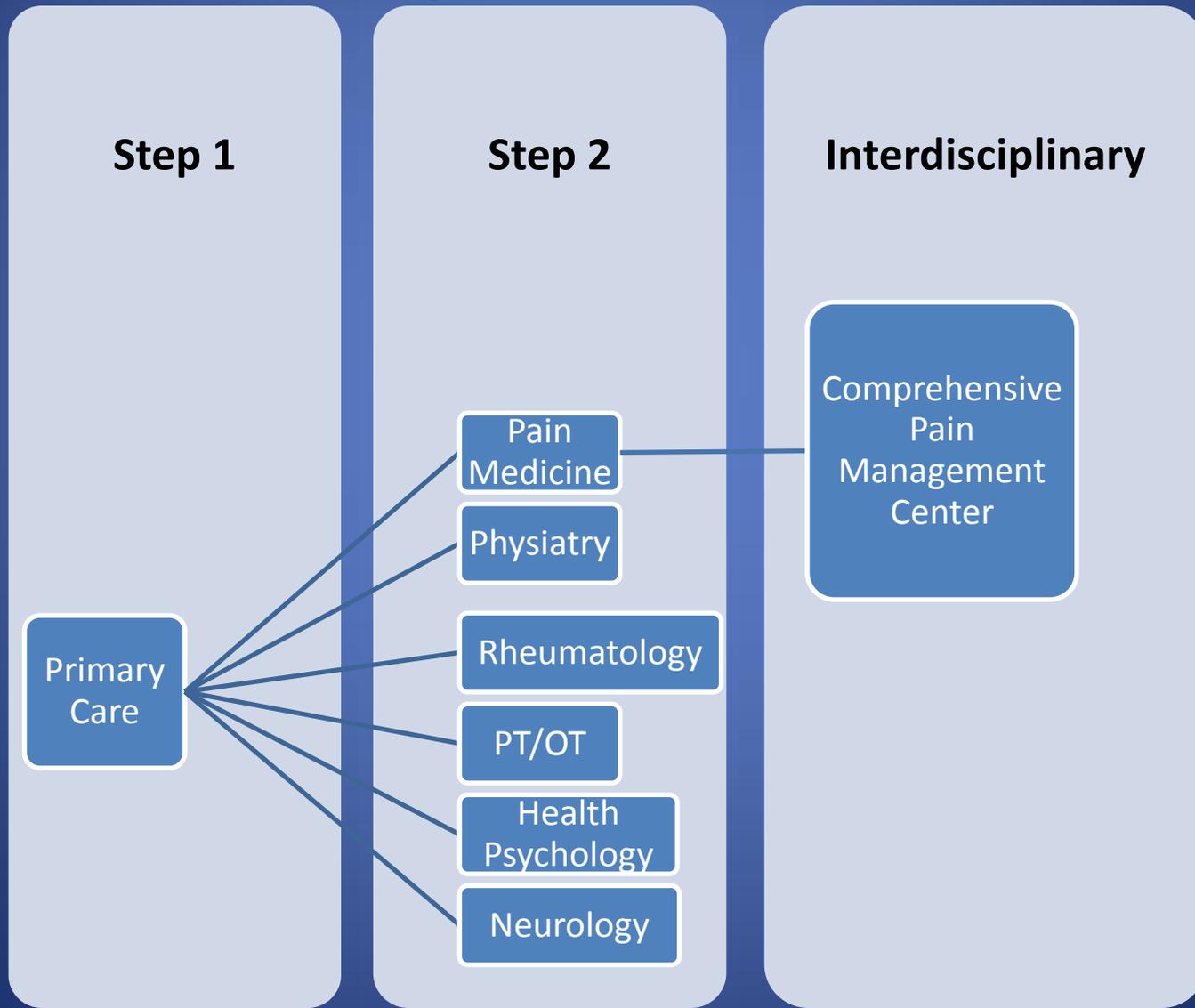
# Old Model: Comprehensive Pain Management Center



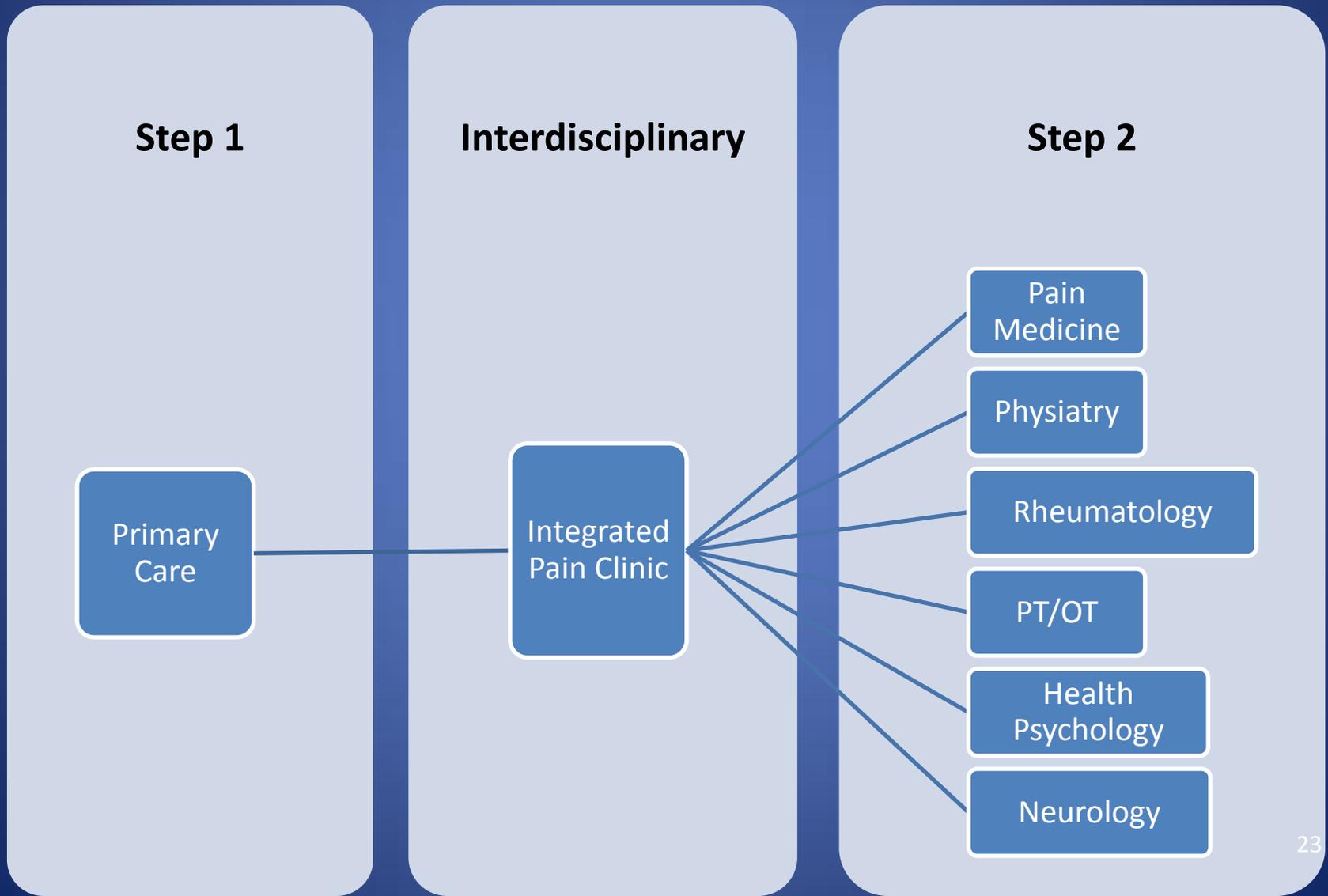
# Comprehensive Pain Management Center

- Was not addressing the “gap” between primary and specialty care.
- Became reserved for a select few patients who made it through the specialty consult process.
- Was delivering a service that in many cases was too late for the Veterans we were evaluating, or was not well received (e.g., focus was primarily on opioid management)

# Old Model: Comprehensive Pain Management Center



# New Model: Integrated Pain Clinic



# Goals of Integrated Pain Clinic

- Simplify pain referral process for primary care
- Increase early access to interdisciplinary consultation, assessment and intervention
- Promote early access to rehabilitative and self-management approaches
- Facilitate multimodal treatment approaches
- Enhance access to key specialists, including mental health and substance abuse, to ensure safe and effective use of opioids

# Integrated Pain Clinic (IPC)

- Interdisciplinary assessment within primary care setting
- Brings the biopsychosocial perspective
  - Assessment of pain and the Veteran with pain (putting pain in context)
- Typical referral questions:
  - Concerns about escalating opioids, opioids as monotherapy
  - Seeking validation of current plan of care (e.g., reducing opioid regimen)
  - Diagnostic clarification
  - Assistance identifying additional treatment options
  - Enlisting Veteran in an multidisciplinary or multimodal approach to chronic pain management

# Integrated Pain Clinic (IPC)

- Assessment team:
  - Clinical Health Psychology
  - Physiatry
  - Physical Therapy
  - Pain Anesthesiology
- Additional consultants:
  - Pharmacy
  - Addiction Psychiatry
  - Primary Care Pain Specialist

# Clinic Flow

- 8:30-9:00 Check-in; questionnaires
  - 9:00-9:30 Pain Anesthesiology
  - 9:30-10:00 Physiatry
  - 10:00-10:30 Health Psychology
  - 10:30-11:00 Physical Therapy
  - 11:00-12:00 Team meeting
- 
- 4 patients rotate through all providers

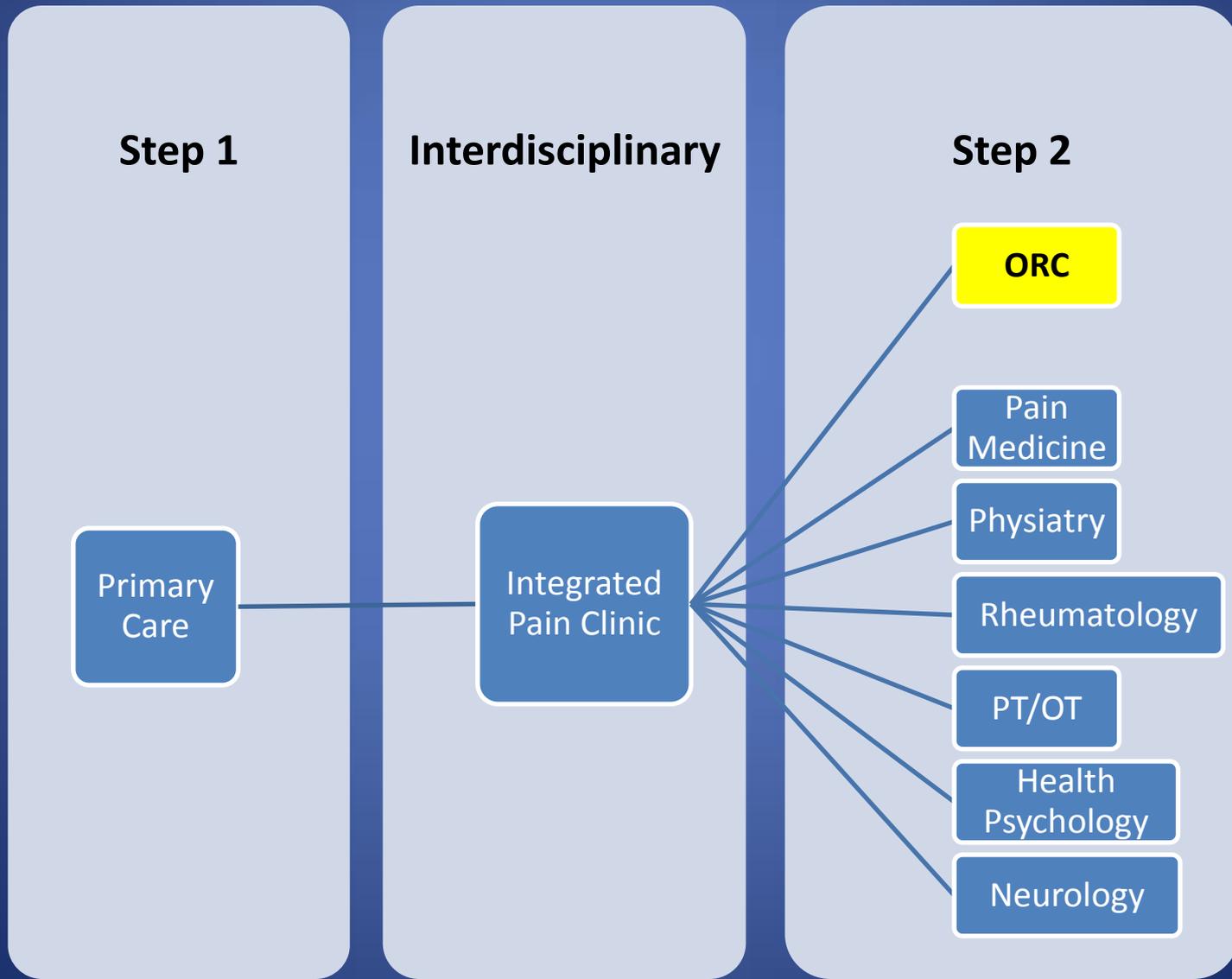
# IPC: Interdisciplinary Team Meeting

- Providers summarize findings
- Group discussion on assessment and treatment recommendations
- Input from consultants (Psychiatry/Addictions, Pharmacy)
- Involvement of PACT members (team meeting and curbside consultation)
- Plans made for “downstream” referrals: PT, Health Psychology, Physiatry, Pain Anesthesia, Opioid Reassessment Clinic, and other relevant specialists

# Integrated Pain Clinic (IPC)

- Serves as Step 1.5 in the Stepped Care Model
- Enhances PCP access to and communication with specialists
- Helps to triage patients to the right specialists at Step 2 in a more efficient manner
- Provides a pathway to our opioid monitoring clinic for Veterans deemed to be on opioid regimens that put them at risk

# New Model: Integrated Pain Clinic



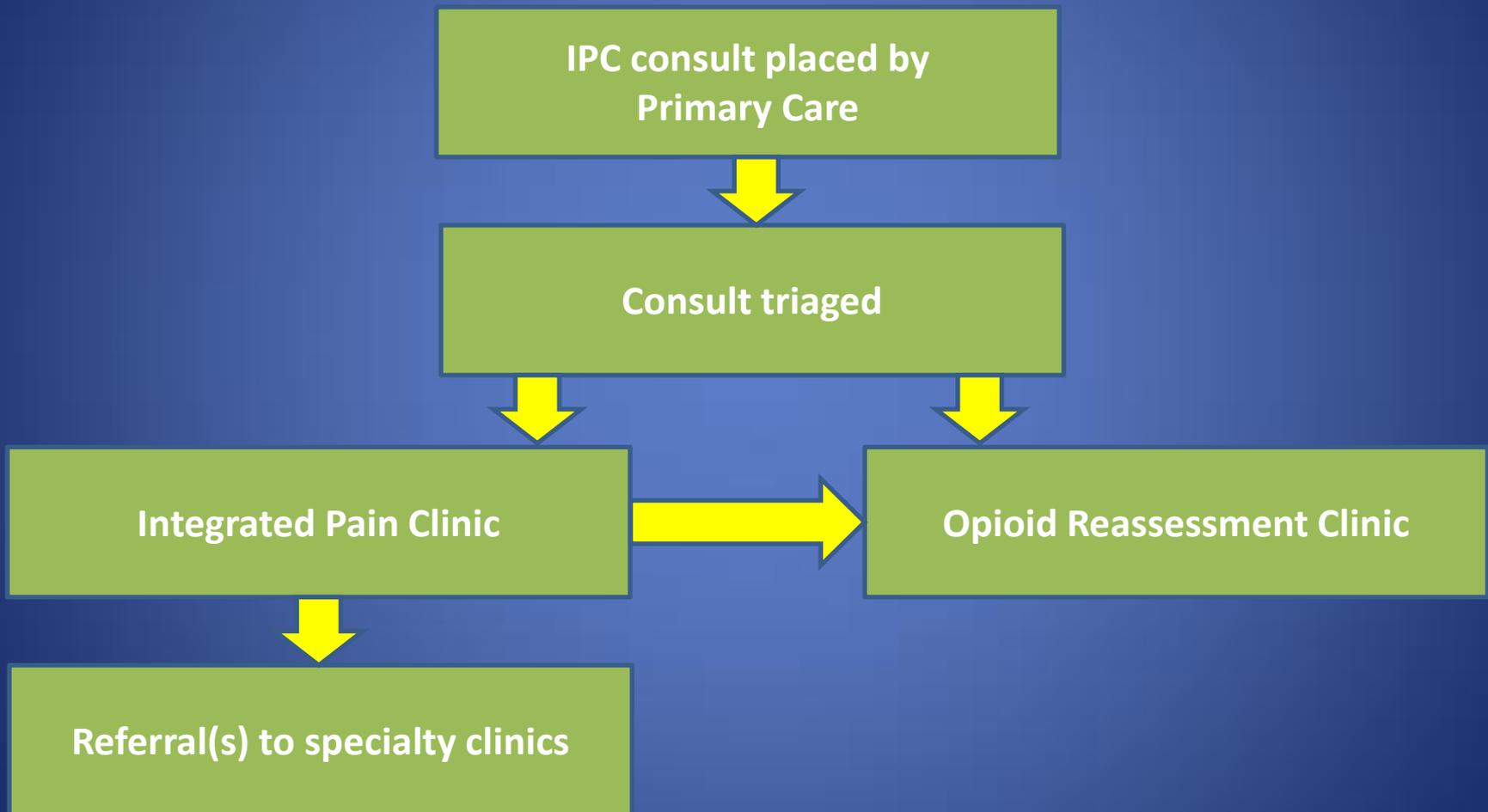
# Opioid Reassessment Clinic (ORC)

- *Embedded in Primary Care* → For IPC patients in whom opioid misuse or safety is the primary issue:
  - **Further addiction-related assessment**
  - **Structured, monitored opioid prescribing for typically 3-6 months**
  - **Motivational enhancement, contingency management targeting multimodal pain treatment engagement**
  - **Facilitated transition to addiction treatment including within ORC**

# ORC Steps

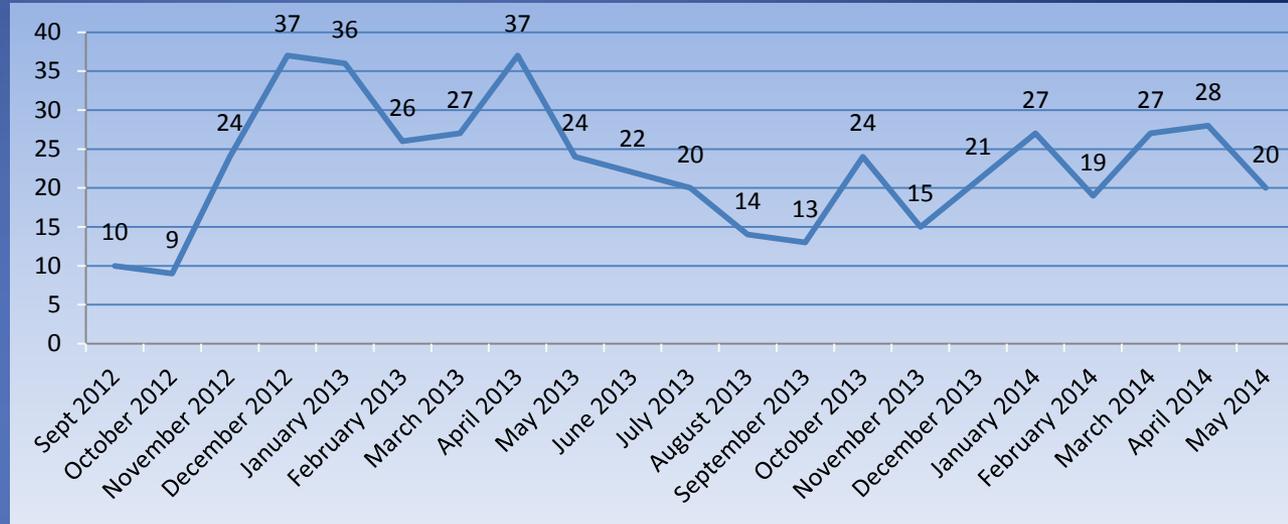
- Primary Care Pain Specialist (PCPS) discusses case with IPC and PACT
- APRN performs structured chart review
- New patient appointment :
  - Team discussion led by APRN
  - In-depth Addiction Psychiatrist assessment (40 min)
  - PCPS assessment (40 min)
  - Team discussion (30 min)
  - Team wrap up/treatment planning with patient (20 min)
- Follow up visit:
  - APRN or MD or both
  - Health Psychology
  - Team discussion

# Pathways to IPC and ORC



# IPC Early Outcomes

Chart reflects the number of consults per month to the IPC since the clinic opened. Data reflects early adoption of the model and sustained utilization.



N = 34 patients	Pre-IPC visit	Post-IPC visit
# of distinct specialists seen by the sample	71	117
# of collective visits made to specialists	174	333
Average # of specialists seen per patient	2.09	3.44
Average # of specialty care visits per patient	5.11	9.79

Table reflects impact of IPC consultation on increasing patient engagement in multimodal pain care, including number of specialists seen and the number of follow-up visits made to those specialists.

# Some issues still needed to be addressed

- Limited utilization of IPC by providers in our Community Based Outpatient Clinics (CBOCs)
- Lack of support for overseeing implementation of IPC treatment plans
  - Treatment plan was put back on PCP for implementation and follow-through
- Missed opportunities
  - Patient no shows = waste of resources

# Systems Redesign – Take two!

- Received a grant from the VA Office of Specialty Care Transformation, with focus on
  - Multidisciplinary teams
  - Care coordination
  - Primary and Specialty Care integration (Specialty Care Neighborhood)
- Our primary goals:
  - Increase CBOC provider access to the IPC through use of videoconferencing
  - Add nurse case management services to assist patients, PCPs, and specialists with implementation of IPC care plans

# Two More RPIWs

- February and June, 2014
- Helped us to identify inefficiencies in our process (“missed opportunities”)
- Developed strategies for moving toward our stated goals



# IPC Updates

- Nurse Case Manager
  - New addition to our clinic
  - NCM responsible for pre-clinic phone screening, and post-clinic follow-up with patients and providers to facilitate implementation of the IPC treatment plans/recommendations.
- Installed videoconferencing equipment in our clinic which we will use to connect with CBOC providers while their patients are in IPC
- Redesign of clinic flow to promote efficiency

# New Clinic Flow

- 8:30 Check-in; questionnaires
- 8:30-9:30 Pain Anesthesiology & Health Psychology
- 9:30-10:30 Physiatry and Physical Therapy
- 10:30-11:30 Nurse Case Manager; questionnaires
- 11:30-12:30 Team meeting
- Patients see all providers; but now the team rotates

# Successes to Date

- Marked reduction in cancelled consults
- Improved communication between PACT and specialists facilitated by shared space and integrated approach
- Increased utilization of VACT's wide array of multimodal pain treatment options
- Timely addiction treatment/referrals
- PACT providers perceive improved support, increased satisfaction with process
- We are tackling many of the barriers to chronic pain management cited by our PCPs

# Lessons learned

- Implementation of the Stepped Care Model, and application of the biopsychosocial approach, can be challenging – even with a wealth of specialty care resources available
- If you perceive there to be flaws in your own system/process, it is likely that others see it the same way. Developing a forum for perspective sharing and joint problem solving is key.
- Interdisciplinary care is essential for tackling the complexities of chronic pain

# Lessons learned (cont.)

- Get to know your Quality Management team, and utilize the various systems redesign tools available to help you figure out how to improve your process
- Investing time up front can pay dividends over time (improved patient flow, increased patient and provider satisfaction, etc.)
- Systems redesign is never done (Plan-Do-Study-Act)

# Staff Acknowledgement

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## QM Staff

- Jill Wellner, MA, MPH



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# Questions/Comments?

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