Dr. Masheb: Good morning everyone, and welcome to today’s cyberseminar. This is Dr. Robin Masheb, Director of Education at the Prime Center of Innovation at VA Connecticut, and I will be hosting our monthly pain call entitled Spotlight on Pain Management. Spotlight on Pain Management is a collaboration of the Prime Center, the VA National Program for Pain Management, the NIH-VA/DoD Pain Management Collaboratory, and the HSR&D Center for Information Dissemination and Education Resources, or CIDER. Today’s session is Virtual Chronic Pain Care, Current State and Future Directions. I’m pleased to introduce today Dr. Frank and Dr. Scorsone. Dr. Joseph Frank is a core investigator for the VA HSR&D Denver-Seattle Center of Innovation for Veteran-Centered and Value-Driven Care. He’s also Director of VA Eastern Colorado Chronic Pain and Wellness Center and Associate Professor of the University of Colorado School of Medicine. And also with us is Dr. Krista Scorsone, who is a VA Advanced Health Services Research and Development Fellow at the VA Denver-Seattle Center of Innovation for Veteran-Centered and Value-Driven Care.   
  
Our presenters are going to speak for approximately 45 minutes, and we will have a 15-minute Q&A. Please feel free to write your questions in the panel, and I will fielding them to our presenters. Also on our call today, we have Dr. Bob Kerns, who is Director of the NIH-DoD/VA Pain Management Collaboratory and professor at the Yale School of Medicine. He will be on our call today and can take any questions that are related to policy at the end. I’m also hoping that we have Dr. Friedhelm Sandbrink with us. He is a neurologist and VA National Program Director for Pain Management and Director of Pain Management in the Department of Neurology at Washington, D.C. VA Medical Center. And with that, I’ll turn it over to our presenters.

Dr. Scorsone: Good morning, and thank you for joining us for the presentation today. I’m going to turn it over at this time to Dr. Frank to begin our talk.

Dr. Frank: Great. Thanks, Dr. Scorsone, and thank you so much for having us this morning and for those introductions. We’ll start with a quick statement that we have no financial disclosures. That today we’ll discuss research and quality improvement initiatives funded by VA Health Services Research and Development, the VA Office of Rural Health, and the National Institutes of Health. The views expressed in today’s presentation don’t necessarily reflect the position or policy of VA, government, or any other university organization.   
  
So the objectives for our presentation today are to present a framework for assessing impact and potential of technology-based virtual care. To describe two pilot studies of bundled virtual care interventions for Veterans with chronic pain. And to discuss future projects and future needs for virtual chronic pain care.   
  
So this is the Spotlight on Pain Management cyberseminar, and so most of you are here because this is a topic of interest, and so I think that this background will be familiar to many of you. So we’ll keep it brief and dive into the presentation itself. But noted here is that chronic pain is common and can substantially limit quality of life. In a 2016 national survey, an estimated 20%, or 1 in 5 of U.S. adults lived with chronic pain, and 8% of U.S. adults had high-impact chronic pain. Among a national cohort of Veterans prescribed long-term opioid medications for chronic pain, more than 2/3 of these Veterans reported that their quality of life was either fair or poor. Additionally, chronic pain care can be risky and is often costly. And I’ll also add that chronic pain care is often not as effective as we would like it to be. In that same cohort study of Veterans prescribed opioid medications, more than half of Veterans surveyed rated the effectiveness of their chronic pain care as fair or poor. And finally, for many, use of technology is growing, especially since and during the COVID-19 pandemic, and technology has an important role to play in improving chronic pain care.   
  
One key way that virtual care has grown in recent years is to a dramatic expansion in the different types of technologies that are now available in heath care. And I think it’s helpful to start by recalling a prior model of heath care, one that consisted almost entirely of brick and mortar clinics and in-person care. Patients and providers would meet together in a clinic room to exchange information. They’d part ways and meet again in weeks or months. The patient at this meeting might have involved travel over some distance, difficulty parking, a wait in the waiting room, etc., etc., and each of these technologies layered onto that have dramatically changed how patients and providers interact. We now have heath care via telephone, video, text, apps on our phones. Patients can review their health data with patient portals and contact their providers by secure messaging. Other technologies include interactive voice response, wearable devices, at-home monitoring, and even virtual reality. And while understanding the available technologies is helpful, we would today like to propose a framework that focuses not just on the technologies themselves but rather on the impact of technology-based virtual care for patients, for providers, and for our VA approach to chronic pain care.   
  
So today, we’ll use this framework of six Cs to assess the impact of virtual care. Now while this is not a comprehensive list, we hope this can capture important ways that virtual chronic pain care can complement, extend, and improve patient/provider interactions and chronic pain care. We’ll return to these six C’s throughout the presentation as we go forward today.  
  
So the first is Communication, using phone, video, and secure messaging to improve and also often increase sharing of information bidirectionally between patient and provider. Next is Connection, and here we’re thinking about improving access to care for patients for whom geography, maybe a work schedule, or caregiving obligations might otherwise be barriers to in-person care during the Monday to Friday, 9-5 hours that clinics often lead. The third C is Collaboration. For chronic pain care, this impact refers to patients’ ability to collaborate as participants in their own care, and the potential for technology to support self-management, provide pain education, and enhance patient engagement. Next is Collection—or if you’ll allow us, data collection. This is your PROs, or patient-reported outcomes. And these patient-reported outcomes in chronic pain care really define effectiveness. Whether the outcome is pain severity, function, quality of life, or mood, we really need to better learn from patients, to hear from patients, how they measure these key goals in chronic pain care. Additionally, PGHD is another acronym here, or patient-generated health data, which can provide important feedback to patients and data for providers. The fifth C on the list here is Community, in the form of online forums or virtual mutual aid groups that can be supported by technology, and these have certainly expanded greatly during the COVID-19 pandemic. And lastly, Combination. So it’s important to remember that these impacts don’t occur in isolation and can be combined to improve patient experience with virtual care. And the other way of thinking about combination is thinking about virtual care in combination with all other types of care including face-to-face and in-person care. Our patients don’t use individual technologies in isolation day to day, and our virtual care interventions should really aim to meet people where they’re at in terms of their technology use.   
  
Again, we’ll revisit these impacts as we review two bundled virtual care interventions in today’s presentation. But first, we’ll discuss the impact of chronic pain care for type of technology that many of us currently have in our pocket, our purse, a bag nearby, or maybe sitting right beneath our hand as we tune in for this presentation, and that’s the technology of the smart phone app. And for this, I’ll turn it over to Dr. Scorsone.

Dr. Scorsone: Yes, thank you, Dr. Frank. To review the current state of pain management apps, a 2019 systematic review aimed to evaluate the contents of smart phone apps providing pain management strategies for people with chronic pain. The authors of this study conducted a systematic search of the Apple store and Google Play store including apps that were designed for people with pain, provided information on self-management strategies, and were available in English. The app quality was assessed using the 23-item Mobile App Rating Scale, and app contents were evaluated using the 14-item Self-Management Support Checklist, which included items such as pain education, behavioral management, exercises, relaxation, and distraction techniques, among others.   
  
Of the apps screened, 19 apps met inclusion criteria, with meditation and guided relaxation being used most frequently as the self-management strategies in these apps, with self-monitoring of symptoms as a frequently featured function. And few apps had features that facilitated social connection and/or communication with other clinicians or providers. No apps were found to provide culturally tailored information. And while two of the apps were validated to show improved health outcomes, none were tested in people living with chronic pain.   
  
Now to give you a sense of two of the apps that were included in this review, the first is highlighted here on this slide, which is the app Curable. And this was found to have a large number of items that foster self-management of pain symptoms. But at this time, Curable requires individuals to pay for use of this app.   
  
SuperBetter was another app highlighted in this study that uses Gamefully method, which is a framework that brings psychological strength to the mindset of game play. This also was found to have a large number of items to foster self-management, and this app is available free of charge. So it has the potential for use as an intervention to complement face-to-face pain care.   
  
I’d now like to present some VA apps for health, and they include things such as Mindfulness Coach, Live Whole Health, Pain Coach, Annie app for Veterans, as well as the COVID Coach.

Dr. Frank: And then, Dr. Scorsone, I’ll just add that shown here on the right is a screenshot for the development of the next generation of the Pain Coach app. And so for folks who have used the current version of Pain Coach, there is underway a process of developing a new and improved version of Pain Coach which will offer a few novel features including clinical integration—or at least the opportunity for clinical integration—but also an opportunity for Veterans to have control over how they share their data, which data they share, with a goal of making this an improved experience for Veterans. And so we met with the Office of Connected Care team last week to learn more about this, and we’re excited to hear that this is expected to become available in 2022. So more to come with next generation Pain Coach.  
  
And then from there, what we’d like to do is transition from our review of pain management apps to think about two pilot studies of bundled virtual care interventions that our team here in the Denver Center of Innovation have worked on, collaborated on recently and moving forward. We’ll present today one project titled Video Collaborative Pain Management, or VCPM. Now we’re going to use this term bundled. By bundled, we’ll be referring to interventions that bring together multiple technology-based components in a single clinical intervention. And shown here on the left are four key components from the VCPM, and we’re going to return to these key components as we review this clinical program.   
  
But a little bit of background on VCPM. This was a project funded by VA HSR&D as part of a COVID rapid-response funding opportunity early in 2020. It started in late 2020 and ran for about nine months, finishing up this past summer. There were two VA sites involved, our colleagues in VA Connecticut as well as our team at VA Eastern Colorado. Veterans were eligible to participate in VCPM if they were prescribed long-term opioid medications at a moderate-to-high dose defined as 50 morphine equivalents or greater. And in Colorado, we used an additional eligibility criteria of reaching out to Veterans with a rural residence in Colorado.   
  
So what I’ll do next is walk us through these components and provide just a little bit more information about what the bundled virtual care intervention looked like. And first is to share two images here of our Veteran-centered mailing. And so this was partnered with Proactive Outreach. We partnered with our VISN 19 Academic Detailing team. They led the graphic design to develop what were intended to be Veteran-centered relatively engaging mailed brochures. And then the proactive outreach piece was a follow-up call from our team, and in both sites—in Connecticut and Denver—we moved during the project to have that be a Veteran peer making that initial proactive outreach call.   
  
The next component I’ll highlight is the clinical pharmacist evaluation. We focused on this being virtual when possible and recommended to Veterans that we would offer an at-home video evaluation using VA Video Connect. We provided technical support when needed and also conducted phone visits for Veterans who preferred phone or who were unable to connect by video. The pragmatic clinical pharmacist assessment was based on the collaborative care management approach that has been tested in a number of VA trials and included individualized assessment of benefits and harms of long-term opioid therapy; a recommendation for dose reduction, discontinuation, or switch to buprenorphine if indicated when benefits no longer outweighed harms; as well as optimization of nonpharmacologic, nonopioid pain treatment. And I’ll say it’s this third number here that included a few key self-management support resources that we developed as part of this project, and the first was to partner with the Office of Connected Care and put together a brochure titled here Your VA Virtual Pain Care Guide. And so this was intended to be made available for Veterans who are interested in learning more about—you see at the top—My Healthy Vet and VA Video Connect to improve connection with their care teams as well as the apps that Dr. Scorsone highlighted to think about collaboration and self-management. As part of this project, we also partnered with a \_\_\_\_\_ [00:16:25] group called Moving Pictures in Connecticut to develop video-based testimonials from Veterans with experience with buprenorphine. Toward the end of the talk today, we’ll add links for both of these resources so people can check these out on their own.  
  
And then too, the brief results of our VCM project. You see in the top left here that our teams in Connecticut and Colorado outreached a total of 133 eligible Veterans as part of this project. And it was a total of 44 Veterans who completed the initial virtual clinical pharmacist visit. So that’s about 1 in 3 of the Veterans who we initially outreached. Among the group who completed that initial virtual visit, it was a smaller number still, 19 Veterans, who engaged in longitudinal care with the clinical pharmacist and medical provider as appropriate. So that 14% is of the overall outreached sample. And then not the focus of today’s talk, but I’ll also note that there was a little more than half of this group who engaged in longitudinal care who did trial a transition of medications from a full agnonist opioid to buprenorphine, and 9 of these 11 continued the buprenorphine at 3-month followup.   
  
And then to say a little bit more about what that 3-month followup looked like. A team member in both Connecticut and Colorado contacted Veterans by phone 3 months after their baseline visit with the clinical pharmacist to assess their experience with the program. We also asked questions about their experience with COVID. And I think interestingly, as this was funded as a COVID rapid-response project, it was about 50:50, that 53% reported reduced access to care during COVID and the other 47% reported that COVID had not substantially impacted their access to care. Among 16 Veterans who received longitudinal virtual chronic pain care followup and completed our full 3-month survey, the majority reported that they found the intervention to be successful. So we asked them to rate this on a scale from 0 to 10, and had an average of about 7. We asked if they’d recommend the program to a friend, and that number was 7.6 out of 10. And then we also assessed satisfaction with the virtual care components, this time on a 5-point scale, and found that there was good satisfaction at a mean of 4.3 out of 5.   
  
So now what we’d like to do is revisit these four components, discuss lessons learned, and think in terms of the types of impact that we laid out earlier. So for communication, there was limited reach of our mail-based resources. We were not able to determine whether the brochure never arrived, whether it wasn’t opened or read, or was simply forgotten among everything else that arrived in a Veteran’s mailbox. On the other hand, we received a strong positive response to the Veteran-to-Veteran telephone outreach component of the intervention. For connection, as noted, there was low uptake of longitudinal care in this pragmatic voluntary clinical program. For collaboration with self-management resources, there was limited integration. And I think in hindsight, this was really a feature of the timeline on which the project rolled out and that we were developing these resources as the intervention was moving ahead, and so there really is an important opportunity to assess Veterans’ feedback on these resources as we continue VCPM going forward. And then finally, there was not a focus on community in this particular bundled virtual care intervention, but this gap led to the first of three active projects that I’d like to briefly preview based on these lessons learned in VCPM.  
  
Now to do this, what we’re going to do is add some additional components to this list on the left. So you’ll see that we have the same four components from VCPM up top, but now we’ve added four additional components. And those include virtual groups, automated symptom monitoring, interactive voice response, and text messaging. And so we’ll revisit this menu of virtual care components as we talk about each of several projects, including the second project that we’re going to feature in more detail.   
  
The first project that is an outgrowth of our VCPM work is shown here in a flyer in which we are actively recruiting for a Veteran-to-Veteran Group Support for Rural Veterans with Chronic Pain program. This has been funded by the VA Office of Rural Health and will feature a few of the key components from VCPM including that Veteran-to-Veteran proactive outreach and self-management support, with a key difference here of a core feature involving virtual groups in which Veterans can both facilitate and participate in groups with other Veterans living with chronic pain.   
  
The second project that I’ll briefly highlight uses a different combination of these components here on the left. So as part of our QUERI-funded center called the Quadruple Aim QUERI based here at VA Eastern Colorado, we will compare two bundles of these interventions on the left, the first being Veteran-to-Veteran peer coaching in groups in the form of self-management support in virtual groups, and we’ll compare that to peer coaching plus VCPM. And so we’re taking different combinations of these bundles and comparing them for Veterans in a trial that will specifically target Veterans receiving community care pain management and start patient recruitment next year.   
  
And then the third of three studies that I’ll highlight is an NIH-funded center based at Yale University and VA Connecticut funded by the HEAL Initiative, and the title shown at the top here which is a specific funding initiative called Integrative Management of Chronic Pain and OUD for Whole Recovery, or IMPOWR. So the Pain CHAMP trial as part of this center at Yale and VA Connecticut will compare a very similar intervention to VCPM versus VCPM plus an interactive voice response–delivered cognitive behavioral therapy–based self-management program. Some on the call may be familiar with the COPES program created and evaluated to date by Dr. Alicia Heapy and team there at VA Connecticut. And so we’re partnering these two distinct bundles to compare in a national VA trial. Eligibility for this criteria will be Veterans with chronic pain and evidence of opioid use disorder or opioid misuse. I will note that site recruitment is underway, and so if you’re at a VA site and this trial sounds interesting to you, we’d love to have you join us. So please reach out directly and we can give you more information on this study.   
  
Which then brings us to the second pilot study that we’d like to describe in more detail, and for this next study, I will hand it back over to Dr. Scorsone.

Dr. Scorsone: Thank you, Dr. Frank. Earlier this year, our team received a Rapid Start Funding award from the Pain/Opioid Consortium of Research funded by the Department of Veterans affairs, the Veterans Health Administration, Office of Research and Development, and HSR&D. And the funding will support a 1-year pilot study and will use a pragmatic design, attempting to leverage VA resources to deliver virtual care intervention to Veterans in a novel way.   
  
Specifically, we propose to use Annie, the VA text messaging app, to support the self-management of chronic pain by providing Veterans with health-related motivational messages. The Annie app is named after Lieutenant Annie G. Fox, who is pictured here on this slide. She was the first woman to receive the Purple Heart for combat.   
  
Our team of researchers partnered with the VA Annie protocol development team to develop an Annie chronic pain protocol that will be used specifically for this pilot study. And the protocol has two components. First, enrolled Veterans will receive a message from Annie every Tuesday asking them to report back with their pain levels over the past week by responding to three questions. And second, enrolled Veterans will then receive a message from Annie each Saturday, and this message will contain information about self-management of pain, providing them with an attached video link.   
  
And on the next slide, you can see here an example of one of the pain survey questions that we’ll be using in our Annie protocol. And on this slide, this is an example of one of the motivational videos that we’ve included in our Annie protocol, and it actually links out to one of the whole health videos that are available.   
  
I would like to acknowledge and thank the members of the Pain/Opioid Core Veteran Engagement Panel for their willingness to meet with our team, for reviewing our protocol, and for providing us with feedback.   
  
For this study, in addition to the Annie chronic pain protocol, enrolled Veterans will be asked to participate in a qualitative interview to explore their experiences using Annie, to track pain-related function and self-manage their pain symptoms, and also to foster Veteran engagement and partnership. We have two Veteran collaborators who are a part of our study team.   
  
So lessons learned so far. You know, the Annie text messaging virtual care intervention has a lot of potential. It fosters communication and Veteran collaboration and/or self-management of their symptoms, and also with the potential for data collection. However, there are some limitations that we’ve learned about, and that is really that Annie at this point in time is primarily a one-way communication tool. It cannot answer the Veteran back with individualized responses, and it also doesn’t have the capacity to remember what a Veteran reported previously, and in this case, that may be changes in pain level from week to week. And also, responses that get texted back don’t get sent directly to any specific VA providers. So these are some potential limitations that we’re working with. However, for future directions, we’re hoping to incorporate in broader dissemination of Annie protocol for self-management of pain. We also would like to adapt the protocol to support self-management of related conditions. And you may recall that the whole-health videos that we’re using in this protocol, although they’re not designed for pain, we found that they fit really well for self-management as well as motivational messaging, so building on that. And we also hope to advance clinical integration with pain management teams and specifically integrating this protocol into the VA Eastern Colorado Chronic Pain and Wellness Center.   
  
And I’d like to turn it back over to Dr. Frank for some concluding remarks.

Dr. Frank: Thanks so much, Dr. Scorsone, and I think we’ve covered a lot of ground. We’ll conclude but then hopefully have plenty of time to hear from our other panelists and hopefully answer questions that the group may have. And to summarize what we’ve talked about today, we’ll propose to the group that when considering the impact of virtual care technologies, to think about the six C’s. We’ve linked to a few of our ongoing projects to think about the ways that connection and collaboration and collection and community can all make an impact for a Veteran’s experience, for how usable and acceptable these technologies are, how helpful they are for care teams. And I really want to make the point that combination of these modalities is key, both between virtual care technologies—so that these interventions can be flexible and be tailored to individual Veterans’ needs and goals with these technologies—and I think, importantly, in combination with the pain management teams that we have at our VA facilities. And we highlighted two studies and several future studies and trials, and I think it’s exciting to note that multiple VA clinical trials and quality improvement initiatives are under way, and these will examine implementation of bundled virtual care interventions. We hope people will reach out to us directly for questions or with interest in collaborating. And with that, what we’ll do is acknowledge all the collaborators that have gone into these multiple pieces, both our team at the Denver-Seattle Center of Innovation, the VCPM team in Connecticut, and certainly the other collaborators across VA that have made this work possible. We appreciate everybody’s time this morning and look forward to your questions.

Dr. Masheb: Thank you so much, Dr. Frank and Dr. Scorsone. These are amazing projects, and I’m sure everybody is really impressed with how you’ve worked to integrate so many different technologies in combinations and are working with investigators in a number of different sites to be able to take pieces of things that have been tested and put them together in new ways. So kudos to you. We have a number of higher-level questions about the six C’s and whether that was an idea that came from something else or was that something you specifically developed for this project. Maybe you can talk a little bit more about theoretically how you put this together.

Dr. Frank: Well, I appreciate that question. I’m going to zoom back to the slide here. I think this came from Dr. Scorsone and I in thinking about these projects in preparation for this presentation, looking for common themes and connections, and so this has a lot of work to do to identify what’s missing, to identify where these are helpful. But this is our original list for this presentation, so certainly interested in the audience’s and the greater VA chronic pain care communities’ thoughts on if this can be useful and how we can use it as a framework for thinking about future bundled care intervention. It fit well with these projects that we’re working on today, and hopefully we can apply it to future project development going forward.

Dr. Masheb: Yeah, I’m super excited about this framework, and I think that this could be used in other health areas across the VA because these are obviously really important things in terms of—especially in the VA—collaboration, using the community, and data collection, making sure that we’re trying to test out things that are evidence based and getting that feedback. So this is really interesting, and congratulations on even just putting this together and coming up with it. We did have a specific question about one of the C’s, the collection one. Is there an easier method of gathering data other than My Healthy Vet attachments? You know, it seems like a big thing here too is the collection of data because of some of the limitations of Annie.

Dr. Frank: Great. Thanks for that. Dr. Scorsone, maybe I’ll keep my comments brief and then see if you have additional thoughts based on your work with Annie so far. I think it’s worth noting that the question alludes to an attachment in a My Healthy Vet message. And I’ll just note that to think through that process, that’s probably a Veteran opening an electronic document, sometimes even receiving a paper document and completing it by hand, and then finding a way to take a picture of it or scan it, and attach it to a secure message and send it. So I think it is worth acknowledging that these technologies have opportunities for impact. I think we could probably think about this list in a similar way that is it opportunities for inefficiency, opportunities for growing pains as we learn how to do these things better, because that process is certainly familiar to our clinical team here in Denver, and I think the impact here is data collection of the right outcomes from the right Veterans on time. And so we’ve mentioned some of the drawbacks, some of the limitations currently to Annie. I think I’ll note that there are VA teams working on sustainable, integrated, feasible systems. I think the one that comes to mind is an announcement I saw just last week of a system that goes by the acronym of PETALS, P-E-T-A-L-S, based out of the team at VA Ann Arbor. That’s designed specifically for patient-reported outcome collection. I think the one other opportunity that I’ll note—but it may not be readily available for many VA teams—are other survey tools like Qualtrics or Survey Monkey. You know, those can require management and cost which is not always going to be readily available in real-time clinical care. And again, I’ll note that one example of the PETALS platform—which is just now launching, looking to next year—but identify that the goal of any of these is collecting information in a way that doesn’t keep care teams from focusing on other tasks in addition to collection by taking up a lot of time and energy, and so that’s really the north star here, is to make data collection efficient and useful. Dr. Scorsone, from your work on Annie so far, are there other thoughts that you would add to that about those current limitations but goals for data collection?

Dr. Scorsone: Yeah, absolutely. Thanks, Dr. Frank. We are in the preliminary phase right now of just rolling out this pilot Annie protocol, but as part of the work for this pilot study, our team will be looking to create and develop a study database for the data collection that comes in through the Annie app, and so I expect that we’ll be working through that in the coming months. But there is no streamlined process right now for tracking the collection of that data, and so that’s part of the work that we will be doing. Thanks for that question.

Dr. Masheb: Yeah, data is collection is very complicated. We also have a question about community, and can you maybe elaborate a little bit more on ways in which you’re trying to facilitate things with the community?

Dr. Frank: Certainly. And I’m going to move back to the slide which I think describes one of our projects that’s just getting started with funding from the Office of Rural Health, and that is intended to be proactive in reaching out to Veterans in rural communities living with chronic pain to help them connect with other Veterans sharing that experience. And so I think what is hopefully a theme in this presentation is we’re taking advantage of existing technologies, using VA Video Connect for groups, which is, I suspect, a way that many of our clinical teams across VA have transitioned from in-person groups during the pandemic and are allowing Veterans to connect remotely using VA Video Connect. I think one key aspect of this program which I’ll highlight—which I think is an innovation we’re very excited about—is training Veterans as part of this project to serve as the facilitators. And so sort of taking one step away from a typical VA clinical group program in the direction of mutual aid, mutual support, in which the agenda and the facilitation is really led by Veterans who themselves have lived experience with chronic pain. And so I think that’s just one example. The other example I’ll just note, from Dr. Scorsone’s presentation about pain management apps, to say that certainly online forums or apps where people can connect and chat and share experiences certainly hold promise. And from the systematic review that Dr. Scorsone presented, there was not robust capacity for that community building in current apps, and so this would be a very VA-focused way to aim for Veterans. And I think as part of this project, we’ll need to keep an eye on broader developments and ways that technology can support community building and chronic pain care.

Dr. Masheb: We have some more questions about Veteran data, so I’ll just go back to the C, Collection. Can you talk a little bit about the CBT-i Coach app and whether data might be able to be uploaded in that in a way that the provider can see that, or is there also any movement in terms of IVR that once that data is there, that participants can see that?

Dr. Frank: Thanks for that question. I think importantly identifying existing technologies as platforms that are already asking Veterans to share data as part of their experience with the app, and in the case of CBT for insomnia, CBT-i Coach, or for interactive voice response, and I think making that next step to take those data and get them to a place where they can be shared with a care team, shared with other people for whom it can help improve care. I’ll admit that I don’t have a great deal of experience with the CPT-i Coach. I’ll just note two things. One is that we highlighted a next-generation pain coach, and I think the key goal in that app will be the capability to share data with care teams and have Veterans feel like they are in control of what’s being shared and when. And so I think what we heard from the Office of Connected Care last week was a key goal in that next generation app is just what the questioner was asking about here. And then I’ll just note that I mentioned a program, again, based at VA Ann Arbor called PETALS, and I think from the update I heard from their team, and some others may have seen, this is starting just here recently. This isn’t the place in virtual care where I can consider myself an expert. I do think that transition of connecting the app at the fingertips of the Veteran and the distance between what they’re sharing and what actually enters the health record in VA does sound like it’s a technical challenge but one that increasingly teams in VA are getting over. I’ll admit that…one final comment to the question about IVRs, and I’ll just have to give credit to the team at Yale and VA Connecticut for all the work they’ve done with COPES. I highlighted a trial called Pain CHAMP, shown here, which will use the COPES protocol. And certainly I’m happy to connect the audience with folks who know this IVR-delivered self-management program better than I do to ask specific questions about COPES.

Dr. Masheb: That’s great. I just was doing a little search on PETALS at VA Ann Arbor, and it looks like this is a VA HSR&D initiative designed to serve as a resource to investigators nationally who need to secure a compliant VA platform for developing and deploying text messaging or SMS and automated calls like IVR as part of research studies with Veteran patients. So it seems at this point that this is a resource that they’re trying to make available to investigators to do the type of research that you are presenting here. And I would hope that there’s a longer-term plan that this would be data that clinicians and even patients could access as well.

Dr. Frank: Thanks so much for that.

Dr. Masheb: Yeah, very exciting.

Dr. Frank: That’s an important current step, an important next step.

Dr. Masheb: Yes. Let me turn to Dr. Bob Kerns and see if you have any thoughts about these projects and where things are at the VA in terms of virtual treatments for chronic pain.

Dr. Kern: Sure. I’ve typed several things and then keep screwing up while I’m trying to listen attentively. This is just a great presentation that helps inform me about, you know, it brings the broader scope of all of this work that’s happening—much of it VA HSR&D funding and support—together to help improve access to pain care and particularly to support Veterans around their adaptive pain self-management. That brings me to actually a fundamental question that I’d ask anybody, but I’ll put Joe and Krista on the spot, which is about the definition for the scope of pain self-management or adaptive self-management itself. I’ve been involved in many policy discussions way back to the IOM Committee on Blueprint for Transforming Pain Care in America, the National Pain Strategy. We all use the term pain self-management, but it’s never been quite clear to me that we have our arms around what do we really mean by that. What are the priorities that are specifically related to supporting management of pain—and by the way, doesn’t it vary depending on the specific painful condition—but to what extent does pain self-management extend out to other health risk behaviors such as tobacco use, nutrition/diet, overweight/obesity, alcohol and substance use disorders, etc.? And then, even more broadly, I think as we’ve become…a lot of research is zooming on social determinants of health and social determinants of chronic pain and \_\_\_\_\_ [00:45:50] chronic pain, to what extent does this model or framework that you’re employing really more broadly accommodate to those health risk behaviors? So anyway, it’s a question about the definition of self-management. How do you use science to inform your priorities within this context, how are you trying to deal with the chronic pain isn’t chronic pain isn’t chronic pain varied conditions, and then this whole domain of health risk behavior, and then broadly, social determinants of health.

Dr. Frank: Thanks so much for that question, Bob. Dr. Scorsone, I wonder if you’d like to start off. This has come up with our Veteran collaborators as part of the project you’re leading as well as a little bit of our discussion with the Pain/Opioid Core Veteran Engagement Panel, thinking about what Veterans think of that term pain self-management. I wonder if that is a good place to start in responding. Would you like to summarize our conversations thus far with our Veteran collaborators, Dr. Scorsone?

Dr. Scorsone: Absolutely. And thanks again for that question. You know, the term itself, self-management of chronic pain, has come up as a word that can be perceived in many different ways. You know, in some cases, even the perception that self-management puts blame on the individual living with symptoms from day to day, right? You have pain because you’re not self-managing symptoms well enough. And so that’s sort of one perception that came from our collaboration and our discussion with Veteran Engagement Panel but also our collaborators. And this has led us really to think about self-management of symptoms as being an integral part of chronic pain management care regardless of where a Veteran may be. And this makes me think of our discussion, Dr. Frank, about the VA stepped-care model and how we think of self-management of pain symptoms being integral to care regardless of where a Veteran is on the hierarchy of VA stepped-care model. So whether it’s self-care being integrated into whatever is in primary care all the way on up through specialty care, we see self-management as being integral. Dr. Frank, did you want to add anything?

Dr. Frank: Yeah, I think that’s really helpful, and I’ll just add a couple comments. One from our conversations with our Veteran collaborators and from the Pain/Opioid Core Veteran Engagement Panel is that I think I found in those conversations that the Veterans were able to speak about self-management for themselves and their fellow Veterans in ways that would be distinct from how I think a VA clinician could recommend self-management. We heard a recommendation when it comes to the Annie app protocol, clicking on links, watching videos. I think one of the Veterans on the panel noted that well, if a Veteran is not in a place where there are able to spend three or five minutes with a video, then, you know, that’s a level of effort that’s going to be required. And I think that message coming from a peer, coming from a Veteran, can bring us back to that C for Community and the importance of hearing from others, sharing with others that would be a difficult message for me as a physician to communicate for the reasons that, Krista, you just described.   
  
And then I’ll just add one other comment, and then, Bob, circle back to your question about social determinants of health. I think that one other comment is that we have really I think found ourselves moving toward VA’s whole-health resources and several of these projects. I think for some of the reasons, Bob, that you alluded to about the ways that self-management cuts across health conditions, health behaviors, we’ve certainly found that this approach fits quite well with chronic pain but also doesn’t limit the conversation to pain management in a way that can I think be a useful place to start in thinking about self-management.   
  
And then finally to your question, Bob, about social determinants of health, I think this is a really important one that self-management sort of can assume access to certain, you know, types of places to go for a safe walk. It can assume access to foods that can impact health and weight and activity. And so that’s a really important comment. And I think we started with a systematic review of apps, and Dr. Scorsone noted that none of the apps surveyed included any culturally tailored information, and that may connect to tailored information that is responsive to social determinants and other barriers. And so that’s a real gap and I think an important one for us to keep an eye on as we’re thinking about how these interventions get bundled and who we might miss and whose access might not actually be improved the way we are aiming for. So I appreciate that question, Bob.

Dr. Kerns: Thank you very much. I’ll just say really great answers, great response. It’s complicated, and taking your approach to engaging Veterans, in helping to inform priorities—what they believe are important priorities within this broader domain—I think in doing that in an ongoing way is very, very important. The other thing by way of…I put a couple of citations in the chat about other self-management apps that have been developed specifically for Veterans, and that reminds me just more broadly of how rapidly things are changing, you know, how rapidly the science is emerging in this area. And so your efforts and others’ to bring it all together and keep moving forward in this integrative fashion in the way that you’ve described here just seems to me to be very exciting and right on target. So thank you.

Dr. Masheb: Yes, I just want to echo Dr. Kern’s words that the way you’ve integrated this and collaborated both with other researchers and with Veterans and being engaged is really so impressive. It’s really incredible. Thank you so much for this work. Maybe I could just put a question to the two of you about if you had a wish of something that would be helpful for you in terms of moving this work forward and something that would help researchers to do a better job, what might that be?

Dr. Frank: That’s a great question. Dr. Scorsone, would you be interested in going first and then I can try and follow up?

Dr. Scorsone: Yes, sure. That’s a really great question, and I don’t know that I have a straightforward answer and/or request for that. I think that the VA has so many existing resources. I think sometimes it can just be challenging to know what’s there, what’s already being used, what’s been done, so that you don’t have to reinvent the wheel. But where I’m going with that is that there’s already so many great resources and technologies that exist, so it’s just, for me, the process of leveraging these existing resources to provide innovative care meeting Veterans’ needs.

Dr. Frank: Well, I’ll just echo that. I think a request to the audience if you or colleagues are interested in any of these technologies or programs, I guess the request would be to reach out to us. We’ve put in the time to try and understand how they work, what they do, and to learn from the people who are developing them and managing them, and so if we can help others avoid reinventing these particular wheels, we’d be happy to try. And then the one other request I would add is I think it comes back to a couple of questions about data collection and to note that it’s increasingly clear to me that we just can’t know how effective chronic pain care is in VA unless we ask Veterans and I think moving in the direction of really feasible, usable, and hopefully scalable ways of hearing from Veterans. It’s going to be very important, and I think one of the ways we’ll get there is by understanding that that information is just so vital and probably won’t be free. And we need to consider ways to build into our research projects ways to help engage Veterans and understand that we’re asking them to take their time to tell us how we’re doing and to compensate them accordingly in research studies and to think about ways we can make this as engaging and easy for Veterans going forward so that we continue to hear from them on how we’re doing so that we can improve both in research studies but more broadly in VA chronic pain care.

Dr. Masheb: Thank you so much, Dr. Frank and Dr. Scorsone. This was a wonderful presentation. Thank you to our audience for attending today and for writing in with some great questions that made for a really interesting discussion. Thank you to Dr. Bob Kerns for participating in that discussion. And Heidi Schlueter, I probably don’t do justice to all the hard work you do to make these cyberseminars available to our audience, especially all of our clinicians and researchers and policymakers who are invested in doing this work in chronic pain. Just one more reminder to hold on for another minute or two for the feedback form. If you’re interesting in downloading the PowerPoint slides from today, you can do go the reminder email you received this morning for the link to the presentation. If you’re interested in slides from our past sessions, you can search on VA cyberseminars archive and use the pull-down menu to find Spotlight on Pain Management past sessions. We will be sending out registration information around the 15th of the month for our next talk, and we hope to see you there or at a future HSR&D cyberseminar. Thank you everybody, and have a wonderful day.

Unidentified Female: Thank you.

Dr. Frank: Thanks so much, everybody.

Dr. Scorsone: Thank you.

Dr. Masheb: Thank you.