Robin Masheb: Thank you, Maria. Good morning, everyone, and welcome to today’s cyberseminar. This is Dr. Robin Masheb – excuse me – 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 titled “The Pain Services Evaluation Program: a Partnered Evaluation.”   
  
I’m very pleased to introduce our presenters for today; Dr. Sara Edmond and Dr. Mark Relyea. Dr. Edmond is a clinical health psychologist investigator in the Pain Research Informatics Multi-Morbidities and Education – or PRIME Center of Innovation – at VA Connecticut, and an assistant professor in the Department of Psychiatry at Yale School of Medicine.   
  
Dr. Edmond is the co-PI of the Pain Services Evaluation program. Her work focuses on improving the delivery and uptake of evidence-based non-pharmacologic treatments for chronic pain.  
  
Dr. Mark Relyea is a community psychologist at VA Connecticut and associate research scientist at the Yale School of Medicine. Dr. Relyea is the co-PI of this program, as well. He focuses on health services research and understanding how to prevent and respond to harassment in healthcare facilities.  
  
Our presenters will be speaking for approximately forty-five minutes and we’ll be taking your questions at the end of the talk. Feel free to send them in using the question panel on your screen. If anyone is interested in downloading the slides from today, go to the reminder email you received this morning and you’ll be able to find a link to the presentation.   
  
Immediately following today’s session, you will receive a very brief feedback form. We appreciate you completing this as it is critically important to help us provide you with great programming.  
  
Also on our call today to respond to any questions related to policy are Dr. Bob Kerns, Director of the NIH-DOD-VA Pain Management Collaboratory, and professor at the Yale School of Medicine.   
  
Also, we have with us Dr. Jennifer Murphy, who’s a clinical psychologist and Director of Pain Management for VA’s Central Office.   
  
And with that, I’m going to turn it over to our presenters.

Mark Relyea: Thank you all for having us today. I’m actually going to turn off my video for now and we’ll turn it back on when we start the question period.  
  
So, before we get started, just a few disclosures. Our contents do not represent the views of the US Department of Veterans Affairs or the US government. We have no conflicts in interest to report.  
  
We would like to particularly acknowledge and thank the Pain Management Opioid Safety and Prescription Drug Monitoring Program – hereafter, I’ll refer to it as PMOP – Program Office for supporting this work.   
  
To provide you with some background, the in-service evaluation program is a partnership between the PMOP office and the Office of Specialty Care Services that’s partnered with the Pain Research Informatics Multi-Morbidities and Education PRIME Center to evaluate specialty pain services provided nationally across the VA.  
  
The goal of the Pain Services Evaluation Program is to gain a better understanding of services provided in pain specialty care throughout VHA, including facility-level variations and gaps in care.   
  
In particular, this project is us to better understand the structure and functions of pain management teams, as defined by CARA, we’ll get into in a little bit, and provide information about strengths and growth areas of facility pain management teams.  
  
The mission of the Pain Service Evaluation Program is to support the development of best practices for evaluating, implementing, sustaining high-quality pain care throughout VA and to assist PMOP in evaluating the impact of PMOP initiatives toward pain management.   
  
And the overall objectives of the service evaluation are to develop and refine measurement approaches for tracking indicators of high-quality pain care, evaluate the impact of PMOP initiatives and policies on pain care throughout VHA, and support PMOP in the development and implementation of best practices.  
  
So, to help understand the state of pain care at VA, it’s important to know a few of the major mandates and funding initiatives that help shape the current state of pain care and pain teams, including the stepped-care model of pain management, the Comprehensive Addiction and Recovery Act – CARA – and the 2021 PMOP funding initiative. And although there have been other initiatives, these are some of the large ones and we’ll briefly describe each of these.  
  
In 2009, VHA instituted a stepped-care model of pain care as a strategy to provide a continuum of effective treatment from acute pain caused by injuries or diseases to longitudinal management of chronic pain.  
  
The stepped-care model is four steps, which includes a foundational step that involves supporting self-management and supportive interventions to help veterans develop the skills and confidence to manage pain and improve quality of life. And this can involve a variety of strategies, anything from nutrition to stress management.   
  
Step one involves a patient-aligned care team to manage common pain conditions.   
  
Step two involves a pain management team that provides specialty care, and we’ll get into the requirements of pain management team in a moment.  
  
Step three involves pain medicine diagnostics in a Harvard-accredited rehabilitation program.  
  
In 2016, the CARA created several mandates for VHA, including the designation of a pain management team at all facilities and the full implementation of the stepped-care model.   
  
So, under CARA, each VHA facility must have an interdisciplinary pain team that has a minimum of four roles; a medical provider with pain expertise, and addition medicine provider, a behavioral medicine provider, and a rehabilitation provider.  
  
To enable facilities to meet these prior mandates and ensure dedicated staffing for pain services and teams; in 2021, PMOP released a funding initiative for recurring funds for VISNs and facilities to hire PMOP coordinators, points of contact, and pain champions, as well as to provide temporary funding for expansion of veterans’ access to clinical pain care services.  
  
To accomplish the goal of understanding the state of pain specialty care at VHA, our evaluation uses a mixed-methods approach, which includes qualification research with pain team members, a diverse range of facilities, an administrative data cohort of veterans with chronic pain, and a VHA-wide facility survey of pain teams.  
  
More specifically, we collaborated with stakeholders at PMOP to come up with various goals in FY22. The first goal was to conduct a retrospective evaluation of VHA specialty care from October of 2018 to September of 2021 to cover some of that period directly before, during, and after the height of the pandemic, which is focused on counter data to understand VHA pain specialty care services including number of visits, services rendered, clinicians involved, and coding practices. With this data, we’re evaluating trends in coding practices for pain specialty care and changes in coding during the pandemic.  
  
Next, we developed and disseminated a facility-level survey to understand the structure and function of pain management teams in FY22. And lastly, using qualitative data to understand more about pain management team needs, functioning, and flow.  
  
We’re hoping to use this data over the next federal year to develop definitions and metrics of high- and low-functioning pain teams and pain clinics.  
  
To accomplish these tasks, we’re grateful to have a large diverse team with expertise in qualitative methods, data management, informatics and analysis, and content experts in pain.   
  
So, to date, we’ve developed and analyzed this cohort of veterans with chronic pain, performed a facility-level survey of pain management teams, and performed qualitative interviews with pain management teams at four visits. And we’ll go into each of these more in depth.  
  
So, for administrative data, we’ve developed and analyzed a cohort of veterans with chronic pain. We’ve used this administrative data to develop a better understanding of services to provide pain specialty care and coding practices to examine the volume of the work such as number of encounters with pain specialty care, how pain specialty care encounters are being coded, and what kind of care is being provided.   
  
Because many VHA encounters involve care that may not be specific to pain such as primary care or diagnostic tests, throughout this presentation, we’ll occasionally use the term “stop codes of interest,” which refer to codes that we, through discussion with PMOP stakeholders, have deemed likely to represent care primarily focused on pain.   
  
These stop codes of interest include physical therapy, podiatry, in-clinic, mental health, physical medicine, rehabilitation services, neurology, clinical pharmacy, occupational therapy, complementary and integrative health treatment, prosthetics and orthotics, chiropractor care, rheumatology/arthritis, telephone rehab and support, kinesiotherapy, and health and wellbeing services. You can see it’s a variety of different common services for pain.  
  
So, to create our cohort, we defined our cohort as all VHA patients that had at least two outpatient encounters within eighteen months of each other during that time period. That included two similar ICD-10 pain diagnostic codes. This produced a cohort of about 3.8 million veterans with chronic pain and this represented about 76% of the 5,000,000 veterans that have at least one chronic pain diagnosis during this period.  
  
Our cohort had similar demographics to the total VA population, in general; yet, it had a slightly higher percentage of women veterans, Black veterans, and veterans with greater than 50% service-connected disability.   
  
We looked at pain services that were common in a few different ways. And here, we have the top five most common stop codes during encounters with pain diagnosis. And as we see, the most common stop code across encounters was physical therapy. And this information is useful to identifying commonly used services for pain care as a whole; yet, it slightly biased towards services that have more visits or that occur at more facilities or at larger facilities.  
  
We next look at which pain services saw the most patients for pain. And this information on pain clinics shows which patients have been – which services patients are be more likely to use. And we see the physical therapy also saw the highest number of unique patients.  
  
Next, we looked at which stop codes were associated with the greatest number of visits per patient. And this data show that many clinics that reach relatively fewer patients were more intensely used, such as spinal cord injury. And although that 420, which is the pain clinic stop code, had the fifth-highest level visits per patients, it had the highest number of unique patients out of these top five.  
  
The next charts are really trying to look and understand the 420 pain clinic stop code use to see how common it was. And find that at diagnosis with – encounters with a pain diagnosis, the pain clinic 420 stop codes were the fifth most commonly used stop code and were used about by 96% of stations. Yet, in contrast with this code, it accounted for a small percentage of both the total encounter to the pain diagnosis – about 3% – and encounters involving only stop codes and addressed at about 11%.  
  
And then, we’ve next looked at when the pain clinic stop code was used with other pain service codes to see when these two were used together as part of the pain clinic – pardon – in conjunction with the pain clinic. And we see that although 420 codes were the fifth most commonly used stop code, you can see here it was seldom used in combination with other pain service stop codes. So, the table shows that less than 50% of stations used the 420 codes in combination with the clinics of interest stop code.  
  
Similar to the table above, we then looked at how definition of our cohort would change what pain services appeared common compared to using 420 stop codes because some previous studies have tried to look at kind of a cohort to find what people are using the 420 stop code.  
  
And therefore, we see here, similar to the table above, 420 stop codes were rarely used in combination with other codes. Therefore, the 420 code misses a lot of pain specialty visits if those occurred outside of the pain management team.   
  
Yet, as the 420 is mandated for a pain management team, it makes 420 potentially very useful for identifying patients seeing pain management teams; yet, less useful overall for capturing the total chronic pain population.  
  
So, the previous slides were limited because we took an overall picture from 2018 to ’22. And so, then, we turned to try and look at the change in the use of stop codes over time and the impact of COVID. And as we might expect, the number of patients and visits dropped during COVID and then, climbed slowly back up, while the number of visits per patient for each service remained about the same.  
  
However, we see that it looks like when you look at services in combination with the 420 stop code, that COVID had a different impact on services. It really appears to be – look like differences with services performed in person than ones with telehealth.   
  
So, just to give you two examples; we see here that chiropractor care with 420 dropped during the pandemic and looks like it rebounded following the lowest point of pandemic. Whereas mental health appears to have dropped and not rebounded. However, we know that mental health services did not stay low following the pandemic. So, we believe that as telehealth and coding switched, some practices dropped the use of 420.  
  
So, in summary, it looks like the 420 code appears better for identifying patients seeing pain teams than for identifying chronic patients overall. Yet, the use of the stop code to identify the services and – whereas competing stop codes – that means some services, particularly those with higher telehealth use that might be working more closely with the pain team might be undercounted if only looking at that 420 code.  
  
Now, I’m going to turn it over to my colleague, Sara Edmond, to talk about the facility-level survey and our qualitative data.

Sara Edmond: Thanks, Mark. So, yes. Next, we are going to talk about the facility-level survey, which focused primarily on pain management teams as defined by CARA legislation.   
  
One of the primary goals of this survey was to understand the structure and function of these pain management teams including staffing, services provided, and barriers to optimal functioning.  
  
More specifically, the objectives of this survey and the subsequent analyses were to; one, describe the implementation of the stepped-care model of pain management. Two, understand the implementation status of pain management teams as defined in CARA. Three, describe the activities of pain management team, including the availability of pain specialty care services, function, patterns of communication, how many patients they evaluated per month, how many e-consultations they were doing, and followup appointments. Or understand variations in pain management team structures such as their location, their service line, and referral pattern. And finally, identifying barriers to implementing pain management teams.  
  
We developed this survey using past surveys of pain care such as the HAIG and the 2019 internal audit, and we kept all the questions as similar as we could when possible in order to aid comparison.  
  
We also pilot-tested this survey with a few contacts like local pain points of contacts and PMOP coordinators.   
  
And then, the survey was distributed in VA REDCap in spring 2022 to all VHA facilities. The survey went to PMOP coordinators and pain points of contact and PMOP coordinators were instructed to complete the survey with input from other staff at their facility such as the pain POCs.  
  
Facilities were given approximately three weeks to respond and by May 2022, we had 100% participation.   
  
So, next, I will highlight just a few of our preliminary findings. First, as you can see here, while the majority of facilities report having a pain team, only 40% of them report that their pain team is fully staffed; that is, that they have each of the four required goals represented.   
  
You can also see that low-complexity facilities appear to be less likely to have a fully-staffed team. And just as a reminder, the “fully-staffed” was defined as the four roles that Mark outlined earlier so, a pain medicine provider, an addiction medicine provider, behavioral medicine, and rehabilitation.  
  
Next, you can see some of the initial data we received regarding staffing. So, the role most often missing from these teams was an addiction medicine provider, which is missing at almost one-third of facilities.  
  
We also asked facilities to report who else is on their pain team beyond those four required roles and a lot of people do have other providers. And some of the team members reported most commonly were acupuncturists, nurses, case managers, chiropractors, dieticians, social workers, whole health coaches, care specialists, and yoga instructors.  
  
We also asked facilities to report the functions that their PMTs were engaging in. And this list of functions was designed to mirror previous surveys. I know this is a little bit small but hopefully, you can see here that the majority of teams are providing a consultation, in-person evaluations, and followup visits.   
  
However, teams that were only partially staffed were, in general, less likely to offer most of these functions.   
  
We also asked facilities to report on what pain services were available; both within their pain team, meaning a patient could access this service as part of being seen by the pain team. And at their facility, more broadly, meaning the service was available at their facility but it wasn’t part of the care provided within that pain team. Cognitive behavioral therapy for chronic pain, interventional pain care, and battlefield acupuncture were the most services offered within the team.  
  
We also asked facilities which interventional pain services were available at their team and at their facility in a similar manner.   
  
Now, as Mark mentioned earlier, during encounters with a pain diagnosis, pain clinic 420 stop codes were the fifth most commonly used stop code and they were used by most facilities. Yet, encounters with a 420 stop code account for only a small percentage of encounters that are coded with a pain-related diagnosis as the primary reason for the visit.  
  
So, conversely, in our survey, we asked facilities what is the way that the clinic that you use for your PMT is coded. And you can see here that 88% of facilities say that the clinic that they use for PMT evaluations uses 420 as the primary stop code.  
  
Finally, we asked about implementation barriers. The most commonly reported barriers to implementation of pain teams are staff recruitment and retention, though difficulty getting protected time and lack of team integration are also a relatively common problem.  
  
We asked about COVID-19, as well, and COVID was reported as a barrier by about one-third of facilities.  
  
So, this survey has several important limitations I want to note. One is that this is a point-in-time survey in a rapidly changing environment. We know that PMOP was rolling out more funding initiatives to the field to help pain teams be more fully staffed in the process of doing this survey. So, we know that some of these results are probably already outdated from the spring.  
  
Survey data was self-reported from facility PMOP coordinators for pain POCs. And so, what those facility PMOP coordinators know and how much they’re talking to other members of their facility to get information is unknown.  
  
We did have some items with missing responses. And responses – it’s also, I think, important to note that some of these facility PMOP coordinators were relatively new to their position, which might have limited their ability to answer.   
  
And finally, some respondents were asked to submit their responses to either a facility or VISN leadership before reviewing –for review before finalizing the survey. And that might’ve impacted the qualitative and quantitative feedback, especially regarding questions about whether or not they feel like leadership is hindering implementation.  
  
So, next, I’m going to tell you a little bit about the qualitative work that we’ve done to date. So, our goal for fiscal year ’22 is to conduct interviews with at least two clinicians per facility at a minimum of ten facilities. And we selected facilities using an integrative approach with stakeholder input.   
  
And so, here, we’ll share preliminary findings from twenty-two interviews conducted across four VISNs.   
  
The interview guide explored how facility pain management teams function such as descriptions of typical patient flow, the roles and responsibilities of pain management team members both within and outside the pain team, perspectives on the team functioning, and perceptions of reasons for the team being successful or team challenges.  
  
So, today, I’ll talk about three preliminary themes. First is insights into the secret sauce that helps teams function well. Second is recruitment, retention, and attrition problems. And third is perspectives on how to measure success.  
  
For our first theme, clinicians felt like the secret sauce to being a high-functioning pain team was to have respect among providers, good communication, and a culture of bidirectional feedback.   
  
We also heard from teams without a rigid hierarchy; that they felt like not having a rigid hierarchy was important to have a good team dynamic.   
  
We have a couple of quotes to illustrate what we’ve heard. “Communication – and I think the expectation, for like bidirectional feedback. I think most of us are at a level that if we hear one another say something 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.”  
  
Another clinician said, “We’ve 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 it 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.”  
  
For our second theme, facilities reported struggling with hiring and onboarding, attrition and space. And they also noted that hiring is a very time-intensive process. One clinician even noted that it took over two years to hire for one position after a job was posted.   
  
And here are some of the quotes we heard there. “A lot of my time is spent on some of our funding before the end of the fiscal year. We’re about tripling our staff so, work on getting those positions posted, hired, interviews; all of those things are challenging.”  
  
Another clinician said, “Mainly, our HR is backlogged by like eight or nine months. And so, we have all this funding, we have all these positions we’re trying to hire for. We would be able to see meaningful change once we get these people onboard. We have the funding.”  
  
And then, “I would say that the PMT has definitely suffered from attrition for a while. We had a very good pain psychologist that was with us consistently, and had been for a couple of years. And then, we lost her to another VA and we weren’t able to backfill that position until just the past year.”  
  
At the same time, we did hear that facilities were enthusiastic about funding from PMOP and the potential impact that it would have on their team. One clinician said, “This is where our real pain management journey began. We expanded that pain management into the primary care clinic, medical practice pain clinic, into what we’re currently calling the ‘integrated pain team’ or ‘IPT.’ And we began kind of our stepwise expansion into the CBOCs in our facility. And so, that was really exciting. We’re growing the team, kind of honed in on this interdisciplinary model.”  
  
Another clinician said, “I haven’t seen the changes yet. The funding, of course, will be helpful and I think with the funding coming, an expansion.” So, lots of optimism.  
  
For our last theme, we heard attention between what is easily measured, such as reduction in opioid use, and what might be more valuable to measure in the eyes of the clinician such as function and engagement with pain self-management.  
  
So, one clinician said, “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 who started a yoga program or started meditation or all of the other things that are involved in self-care that we know are so important for long-term pain control.”  
  
Another clinician said, “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? Or how far along are they?”  
  
So, some of our next steps with this work include a followup staffing survey to clarify some of the findings from the initial facility-level survey. And I think as Mark mentioned earlier, partnering with PMOP to iteratively develop and refine definitions for, and indicators of, pain management team functioning, using administrative data to evaluation facility-level variations in pain care, evaluating the impact of these new PMOP funding initiatives, and assessing the need for other initiatives for PMOP to consider in the future.  
  
So, we are so grateful for the opportunity to have started on this work in the past year and we’re excited to continue collaborating with PMOP for this upcoming you. And thank you; I think we’re ready for questions and reflections.

Robin Masheb: Thank you so much to our presenters. This is amazing. So exciting to see the work that you’re doing to help us better understand, at the system level, how things are functioning for our patients who are struggling with chronic pain.   
  
You know, I’m wondering how does this information now not just kind of get reported but how does it get put into action?

Sara Edmond: I know Dr. Murphy and Dr. Sandbrink are on the call though I don’t know if Dr. Sandbrink can speak. I don’t know if, Dr. Murphy, if you have – if you want to say anything first.

Jennifer Murphy: So, first, I just wanted to say thank you for working with us through this period and, also, really helping us to do – learn a lot of the things – you know, many of these things, you kind of – it’s like when you’re a clinician, you sort of think things are true [laugh]. But until you actually take a closer look and look at the data, you don’t know as much about what is happening.   
  
And so, this is just incredibly valuable to see the depth of information that you were able to gather here. So, it’s just really helpful to us in understanding better. And I also really appreciate the qualitative information and getting the input from the most important people, the people who are on this call, who are on the ground, doing the work, and just make so many great points about there’s certain things we can track more easily but what are the meanings behind those things, right?  
  
And so, these are all questions that are actually really important to us. And so, I think as far as next steps, a lot of this, in terms of action, you know, we’re trying to do more around making changes with the 420 stop codes and ensuring that pain care is better tracked across our system and this information is really helping us to make those changes and support why we’re asking people to make those changes. Which can sometimes be cumbersome, irritating. But in the long run, really does us all good to see where pain care is happening and who is doing it.  
  
And then, also, you know, I mean, just in terms of, again, action around a lot of these things, a priority for us is really trying to move beyond some of what we’ve captured here and better define function, right?  
  
So, yes, you may have a team, you may have part of a team, you may have – but what does that really mean? You know, what does that mean functionally? What does that mean to the patients? What does “high-functioning” mean, right? We just had a big meeting last week and that’s definitely a priority for us.  
  
So, a lot of this is really at the heart of what’s motivating our work and priorities. And some of it seems like things we should already know, right? But we’re still trying to sort out and define those things.  
  
So, you know, I know we just really appreciate having the partnership with PRIME and being able to work on these things and learn more about it.

Sara Edmond: Thank you so much.

Robin Masheb: Is there anything maybe that you could speak to, Mark or Sara, that was surprising to you in the findings that you didn’t know? Because I know the two of you have been so involved in this work in a myriad of ways and, you know, for the first time, being able to look at this systematically at a national level. Or, you know, the group of collaborators who you’re working with kind of said, “Oh, my goodness, this is so surprising to us and we didn’t know.”   
  
Or do you feel like it validated things that you had a sense were going on? Maybe you could speak to some of those different things.

Sara Edmond: Sure, thank you for that question, Robin. I think for me, you know, one of the hats I wear is pain team psychologist. And so, there is a lot of what we found here that was, as Jen said, sort of validating and resonated with me as what my experience was or what my sense of things were.  
  
I think one of the things that was most striking for our qualitative team was as they went around interviewing clinicians and pain management teams in four different VISNs at many – several different facilities – those facilities varied wildly, in terms of how their pain teams are structured, what kinds of services they’re offering, what their struggles are.  
  
And so, we actually had to go back and revise our interview guide and sort of help the qualitative interviewers maybe understand the potential breadth of what a pain team could look like. Like almost needed two different interview guides for some of our questions to understand.  
  
And so, I think, you know, the first time I trained at a VA, someone told me, you know, “If you’ve seen one VA, you’ve seen one VA.” And I think that is – I’ve learned that that’s very true. And even though we have this national office to support pain management and pain management teams and we have these directives and guidance about how it should be done; how we’re actually able to implement that in each facility varies quite a bit.  
  
And to me, that speaks to the need to have really tailored plans on how to help teams. Because what helps Team A might not resonate at all with Team B because their setup is different, their resources are different, the problems that they’re facing are really, really different.

Robin Masheb: I can imagine that that’s really exciting, Sara, and I know that Friedhelm Sandbrink wants to jump in. But with the ubiquity of telehealth and being able to provide care anywhere, I’m sure that there’s more conversations about; how can you help those facilities that are not as well-structured as some of these other facilities and kind of, you know, maybe in a centralized way, have resources to be able to fill in those gaps.   
  
But I’ll give Dr. Sandbrink a moment to respond, probably to that question and a lot of other thoughts he has on the presentation.

Friedhelm Sandbrink: Yeah, thank you. Thanks, everybody, for joining in and, particularly, obviously, Sara and Mark. Thank you for putting all the data together.  
  
So, you know, as I’m speaking for the PMOP program – and Jen already has filled in a lot – I just would like to add on that this is really incredibly helpful for us to understand where we are coming from, right? In 2019, you had our HAIG study and the internal audit. And now, with our funding enhancement, we have moved forward.  
  
But as you pointed out, Sara, this is a point of time where we are actually transitioning.   
  
I think one of the few things – one of the many things – that I’ve learned here, among others, from what you point out is that, you know, we had a good sense that there is often a relatively heterogeneous understanding – a wide variety of understanding – of what these pain management teams may consist of.  
  
But I think you also see very clearly here that the functioning is very different, right? And it confirms our concerns that so many facilities do not have a pain team that has all the providers in place that are needed.  
  
And you know, it’s a relatively low bar to have four providers who cover these four different functions when, you know, if you think especially of the larger facilities, you have to have a significant higher number of staff to truly fulfill the need of the veterans.  
  
And the second issue is the integration of these key members, right? You know, you went through the slides that show what is available within the team and what is available outside of the team. And it’s interesting that so much of the intervention of pain care is considered, you know, at so many – about half of the facilities – really doesn’t happen in the pain team; it seems to be happening outside. And that, in itself, shows that there is a lack of integration here, right? I mean, interventional pain care should not be done in isolation. It has to be connected with other modalities. It gets better if it’s connected with physical therapy that is done afterwards and with behavioral therapies.  
  
And I’d just concerned that if you don’t integrate this better and truly make, for instance, our interventionist part of our team, at least in a functional way – they may be in a different service alignment but they have to be functionally part of this expanded pain management team – as well as others. All the different modalities that we have that we won’t really bring the best care forward.  
  
So, I think this is something that I’m taking from this. Again, thanks for the great data. That really gives us a better ability to move forward.

Robin Masheb: I see Dr. Bob Kerns also on our call. I don’t know whether you wanted to make some comments, Bob? [Pause]

Bob Kerns: No, I think, you know, from that perspective, thinking back to when I was in Friedhelm’s role, you know, what a wonderful blessing it is to have these kinds of data and to start the – have the resources, really, not only to build the teams but to, you know, at least at this point, set the platform for ongoing evaluation/quality improvement.  
  
So, I love taking a look at this. I think, you know, fundamentally, there continue – you know, when I was involved in Friedhelm’s role, the issue of encouraging, supporting, cajoling, etc., of people to use the 420 stop code was a challenge. It sounds like the penetration has been great but that there’s still a lot of slippage there.  
  
Ultimately, I guess I’d love to know a little more about the authority the Friedhelm is wielding in that regard. Because historically, it’s been my understanding that the use of stop codes is at the VISN, or even facility, level. And so, how much authority is there from a top-down approach to try to encourage people to use the 240 stop code? Because a lot of these data hinge on that, I think.  
  
So, anyway, it’s just a wonderful enterprise and I’m delighted to see this progress report.

Friedhelm Sandbrink: Yeah. Thank you, Bob. And in fact, we have realized the same thing; that the limitations in regard to the correct use of the stop code, it becomes most apparent and obvious when you do the telehealth visits, right? Suddenly, these visits in pain clinics seem to be all dropping off, the 420 ones, because they’re not properly coded and, you know, they’re maybe in second position and then, telehealth took it over.  
  
So, we have new guidance in that regard and we have a general agreement now that includes other program offices, including pharmacy and behavioral health, that if these services – whether that’s mental health services for behavioral pain care or whether it’s medical management by pharmacists – if they are delivered as part of a pain clinic, of the pain management team, if their focus is in the clinical setup of pain care, that they must have that 420 in primary. I think we’ve finally got an agreement about that and I think this will give us much more solid data.  
  
And we are currently asking everybody this – the beginning of this fiscal year – if they haven’t switched it over, those clinics, that they are properly set up now. That obviously is primarily true for anybody who’s still within our legacy CPRS. With Cerner, everything gets a little bit more challenging but, hopefully, we find a system there, as well.

Bob Kerns: So, one more point about that. I think continuing to push on this front but, you know, much more broadly, you know, the developing of structured databases that are providing structured data to understand more about what’s actually – you know, who’s doing what. You know, I’m a psychologist. Challenges related to identifying veterans who are receiving an evidence-based psychological treatment approach for chronic pain would be a great adventure. It would be a great asset.  
  
So, the question is; beyond structured data, though, is there any thought at this point of even trying to bring informatics and machine learning to bear on this to try to, I guess, realize that ultimately, there’s still going to be limitations with structured data. So, is there an opportunity for trying to get into unstructured data using natural language process and machine learning and so forth? It seems like, ultimately, that’s going to be needed to drill down – overcome the barriers of just relying on structured data.

Friedhelm Sandbrink: Yeah, absolutely. I think we will have to do that. And I think especially when you come and you would like to understand, obviously, as we want to do, what is the success of all our interventions, right? Are the patient getting functionally better, right? Where is our pain care expansion? Where is that going from the patient side and their quality of life? We have to find a better way of pulling this from the data. That may also mean the patient-reported outcomes, hopefully. This will happen in the next year, as well, if we get truly self-reported data that can integrate it into the chart.   
  
Just one notice in this regard, though; I think the priority for us to get the structured data correct, as everybody, I think, seems to know, the new requirement for bookable hours is actually resulting in that opportunity to get better data, right? I mean, providers are much more now carefully assessed in their roles and that they are mapped appropriately for what they do. This is all part of this better understanding of the accountability that comes from the larger VHA. This is not from Pain or Specialty Care, also, specifically. But it does support us in our assessment of actual care delivery.  
  
And hopefully, in the next – actually, within a few months, we will have actually a much better structured system in place.

Robin Masheb: Related to that, in terms of another direction, we have a question from the audience about whether there’s a plan to do qualitative interviews with veterans about their experiences. Everybody’s shaking their head; is that a yes?

Jennifer Murphy: Well, so, I think we all acknowledge the importance of that and the value of having the veteran experience. And I think this preliminary work that we’ve done during this first year is really trying to understand the lay of the land and what’s going on from an administrative perspective and, also, like clinical – like what is being offered.  
  
We don’t have that built into our plan yet but I do think that’s something that we’ve all thought about moving forward is; what is the best way to get the veteran perspective on this? It might be reaching out to patients served by pain teams, specifically, if we can identify them. Or it might be using advisory groups like the Pain and Opioid CORE’s Veteran Engagement Panel.

Robin Masheb: Thank you.

Bob Kerns: Could I ask one more question that is, I think, timely and indirectly relevant? I’m wondering what the plans are – any potential effort to try to promote the use of the, I think – I don’t even know if it’s out yet or soon to be out – care coordination codes that CMS are promulgating to try to, I guess, incentivize to a coordination?

Friedhelm Sandbrink: Yeah, so, you know, I think the care coordination is really a challenge, right? It even starts with us not necessarily having a good way of documenting the workload associated with team meetings. I think our CPT code that we use is rather limited. Often, it is used more broad than, you know, is really applicable, especially as you discuss patients that you may not have seen in-person. Yet, when you cannot use this code that many use of us.  
  
So, that in itself is a problem; how do we document the coordination. Unless we give people credit for the work that there is, it’s going to be a challenge. And I think we have to look at all the different avenues of how to do this well, including what CMS suggests of how to integrate and coordinate.  
  
And it isn’t just within the team. In particular, it’s also the coordination between the pain team and the other stakeholders; in particular, Primary Care and Mental Health stakeholders. Because often, our efforts overlap so much. And unless we do this in a coordinated fashion, bring in the Primary Care as part of the expanded pain team, or see the pain clinic as part of the expanded PACT effort to try to deliver comprehensive care, I think we will fail. We cannot do this in isolation for PMTs.

Jennifer Murphy: I’ll just add that I wasn’t – we haven’t fully finished analyzing all of our qualitative data and I only presented a few preliminary themes. But I do know that there were other themes about the value of care coordination, or how challenging it might be for a team; they had care coordination at one point and then, that person left and how hard it was for that team to feel like they were functioning as a team without care coordination.   
  
So, I do think there is wide recognition of the importance of that. But as Dr. Sandbrink said, like a lot to figure out about how best to implement that in places that have not yet implemented it.

Bob Kerns: For this new proposed billing code – I guess I’ll call it that; I don’t know if that’s the proper CMS language – around care coordination, you know, I think first of all, our advocates within CMS – I think of Dr. Shari Ling who’s the Deputy CMO, is just all over this and really an advocate for our community, the pain community.  
  
So, I think this is, you know, their intention to take a step – an important step – toward being able to incentivize care coordination and then, document it when it occurs.   
  
As I understand it, listening to many groups, there’s been some concern that it is a physician-only code. You know, the AMA and others are supporting the idea of a physician-led team and care coordination.   
  
So, I think in the VA, that may be a challenge because I’m guessing that there are teams that aren’t necessarily physician-led that are – you know, where somebody else is in that role of the care coordinator or navigator and so forth.  
  
But anyway, I do think that paying attention to this and looking at that code – and maybe if the will is there within VA to try to promote the use of that code, it could be advantageous in this regard.

Jennifer Murphy: Yeah. I just wanted to say thank you for bringing that up, Bob, because it’s a great point and it’s absolutely something that, to me, is kind of the future and the direction that we need to go in. And so, having the support behind potentially using this code; how can it be applied? We definitely talked about ways that we can sort of focus on pain care coordination and perhaps – you know, there are already sites doing a good job so, identifying those sites and maybe trying to start out with more of a pilot model but something that then could be rolled out in a more widespread fashion.  
  
But it seems like it’s – you know, I mean, as you know, it’s just the complexity of the care really requires something like that. But it has been so hard to get there.   
  
But we’ve definitely talked about that a lot this past year and recognize the importance of it. So, it’s great to kind of see it coming together, right? In the private sector, as well, and in CMS to try to help us maybe achieve – make some movement on that specifically around pain care.

Bob Kerns: I guess, you know, there are just so many things. First of all, I appreciate exactly what you just said, Jen. And the implied thing is I think in the pain world, even internationally, what’s going on in the VA is looked as a model to be emulated. So, the more we can learn – and not just learn for our internal purposes but disseminate what we’re learning as we go – is really going to be important.  
  
In this regard, of course, VA has a large proportion of – our population over 65 that is Medicare-eligible. And so, I think Dr. Ling and others in CMS are really looking for – or, you know, like the VA – maybe even in some of these analyses to isolate the over-65 group because it potentially has important broader implications for CMS. And then, of course, downstream of the private sector or the non-public section.   
  
So, that’s also – you know, of course, the priority is care for veterans. But I do think keeping your – you know, on the lookout in your vision is, you know, how can the lessons learned through this important partnered evaluation, how can it inform practice in the community?

Jennifer Murphy: No, it’s a great point, and one we can actually take back and we discuss again. We have, you know, Dr. McMullen who’s part of our team – she has history with CMS – and Dr. Ling. And that’s something, you know, that we could definitely look towards even focusing again on an older population.   
  
Having the coding is so important because it’s kind of something we’ve focused less on but it’s like the heart of things when it comes to generalizing what we do, or showing how to do something well. It can only really translate into the community if we have a way to document it and make sure that it’s paid for.   
  
So, it is a huge opportunity so, we should definitely follow up on that.

Bob Kerns: I’m guessing there may be other questions in the chat. I just want to put a plug for dissemination activities, specifically. It seems that this partnership is – one of the strengths is the potential of people that are accustomed to writing papers and getting it out into the scientific or other literature.  
  
So, I’d wonder, actually, either now or later, I’d be curious to learn a little more about your plans around how to use this to spearhead broader dissemination activities. We’re learning a lot and it really is valuable to the field, more broadly.

Robin Masheb: We do have one other question in the chat, which is; are there plans to look at care in the community and how that interacts with VA-based care?

Sara Edmond: Yeah, and thank you for that question. We know that care in the community impacts care coordination and that it’s used in differing amounts and for different types of services at different facilities.   
  
I know we did just take a small look at some of that data. Maybe – I don’t want to put you on the spot, Mark, but can you recall what we’ve looked at so far with care in the community?

Mark Relyea: Yeah. I don’t think we’ve – we haven’t looked at it much. We looked at it briefly just for the reasons stated; we realize how important it is.  
  
So, I think it’s something we definitely might be interested in looking at more but I think we’re kind of in the formative stages of figuring out exactly what we would look at and what the most important questions and valuable questions would be to look at there.

Robin Masheb: Thank you. Thank you so much for this talk and sharing your work. And thank you to our panelists who also contributed for us to have a larger picture of what’s happening with this program evaluation. It is so exciting for the VA and I know it’s been something that everybody’s been waiting for for a long time.   
  
Thank you to our audience for writing in with some great questions and attending today. If everybody could just hold on for a minute or two, you’ll receive the feedback form. I’d just like to invite everybody to our next cyberseminar, which will be the first Tuesday of the month at 11:00 a.m. and you should be receiving information about it about the 15th of the month.   
  
So, thank you, everybody. Thank you to CIDER for assisting with putting this program together, as always. Have a good afternoon, everybody.

Jennifer Murphy: Thank you.

Robin Masheb: Take care.

Maria: When I close the meeting, you’ll be prompted with a survey form. Please take a few minutes to fill that out. We really do count and appreciate your feedback. Have a great day.