Friedhelm: There are really great efforts going on both in clinical care as well as in research. Many, many different stakeholders are involved. Obviously primary care, specialty care, mental health, pain management in particular. Really many of those activities are coordinated with the National Pain Program but certainly not all of it. And it would be too much here to really talk about the many different initiatives that we have.

But putting the framework out for what we are dealing with right nigh primarily is the implementation of the Comprehensive Addiction and Recovery Act which first became law in July 22, 2016 almost a year ago. I was asked to provide a little bit of the background about the CARA legislation as we are implement it in the VA and how are we going along with this. The CARA while it talks about Comprehensive Addition and Recovery Act, it really speaks a lot about pain management and the opioid safety, opioid risk mitigation strategies. It fits actually quite nicely into our national pain management strategy towards implementing the stepped care model and the biopsyschosocial model of pain care.

I will talk a little bit in particular about opioids OSI systemwide, opioid safety initiative, implementation systemwide as part of the CARA efforts. Then in particular about the pain teams that we are now mandating at all facilities to be compliant with CARA. And implementation of the stepped care model. And lastly, just a few other things in regard to CARA such as the expansion for the integrated health modalities.

There are really nine tiles. It’s a very comprehensive legislation. And it’s a Title IV that is specifically for the VA and that’s what is known as a Jason Simcakoski Memorial and Promise Act named after Jason Simcakoski who passed away in an overdose of several medications including opiate medication, actually while admitted to a hospital in the VA system. There are 54 specific milestones of deliverables in the current legislation. We’ve now completed 28 of those. And the implementation in central office is under specialty care. Larry Myer is leading that. Jenny Perry is helping us from the office of strategic integration and then pain management with again many stakeholders being included. In regard to the opioid safety initiative, many of those medication strategies that we have been implementing since 2012, 2013 which is when we expanded the OSI nationwide, are really further emphasized and truly are mandated to be implemented everywhere in our system.

It talks about and I don’t really want to go through all of this, but it talks about a greater VA and DOD collaboration which we do through our health executive committee and our pain management workgroup. One specific requirement already was also ongoing when the CARA legislation was passed that this if you have an updated clinic of practice guideline for opioid therapy which was in February 2017 that we published that. It mandated provide education about opioids for filling also the presidential memorandum. We had more than 99% of our providers trained. Improvements to our dashboards, opioid therapy risk report in particular and the STORM which we are promoting nationwide now. P&P directives were issued in regard to the opioid overdose education in the Naloxone distribution. You see here that how successful we have been with more than 80,000 prescriptions issued. But our current legislation requirement that there’s no co-payments for this. So we’ve eliminated all the co-pays, not just for the medication but also for the training of the patients and their caregivers in this regard.

In regard to pain pills, the current legislation mandates that the director of each medical facility designates a pain management team responsible for coordinating and overseeing pain management therapy for patients experience acute and chronic pain with non-cancer origin. With that in mind, how are we going to implement this? It’s short and specific. It basically says that we and secretary of the VA has to decide what is the standard of these pain teams. In that regard the national pain program office program with primary care, mental health and addiction medicine developed the standards that were then agreed for by the national leadership council and that we’ve now issued to all facilities. I will talk about those in a moment.

Really, we need to understand the coordination between the different stakeholders is most essential. We are not issuing a number of FTEs that have to be available at the sites or the specific functions that have to be accomplished for implementing pain management at the facilities. There is great flexibility of how it is being done locally including for instances at VISN supported hubs. Maybe through some form of \_\_\_\_\_ [00:05:22] can support other facilities to do so to get there so that these teams are implemented nationwide.

At this point, the requirement for the pain teams is within one year of the Act so it’s July 22 coming up. We are just in the process of getting the field reports from all the medical centers with the appropriate signatures by the medical center directors. Where we are in regard to our pain management teams and in the stepped care model implementation. These are the official requirements that we’ve issued.

The function of the interdisciplinary pain team has to include the ability to evaluate patients with complex pain conditions and actually follow them up. Clearly the step is a way from just being a one-time consultation. We actually have to have a way to see these patients in followup in the specialty care setting if it is appropriate for the complexity of the patient. We are also including specifically the ability to make medication management recommendations and implement the actual prescribing in those pain teams. Again, going away from just consultation, going away from often, we have a number of pain clinics, we just didn’t do medication prescribing. They didn’t do opioid recommendations. They basically limiting themselves to certain modalities whether it’s behavior modalities for instance or the intervention care.

Then we’ve incorporated also the opioid safety initiative reviews as a mandated function of these pain teams knowing that why these have been mandated already since 2013, since rollout. They were about a third, possibly more than a third of the facilities who just don’t really have high functioning opioid safety initiative, OSI review teams.

In addition, nowadays the OSI reviews actually are changing their character. We have now our dashboards who can truly check off the risk mitigation strategies. Is PDM checked? Is urine checked? Is the informed consent in place? We don’t’ really need the team to do that anymore. Our technology has move forward. But what we need to do at this point is truly have a safety review of the patient. Where are they in regard to their mental healthcare? Just as much as we take opioids away, is this patient still tied in? We don’t want the patients to disengage because somehow we felt opioid prescribing was not appropriate due to safety concerns and we take medication away. What’s happening with the patient? We need to keep them in our system. We need to prevent them from starting to use illicit drugs or possibly worse.

In regard to the pain management team specifically we said at the minimum the composition of the pain management team has to include a medical provider with pain expertise, addiction medicine expertise has to be incorporated into these pain teams. Very much being aware of the risks in regard to opioid medication tapering and patient’s patient with opioid use disorder requiring access to MAT, medication assisted treatment. Behavior medicine is mandated to be included at least one of the evidence based behavior therapies that were also identified at the SODA and rehabilitation medicine needs to be incorporated.

In regards to the other additional pain team recommendations, those were not mandated through the national leadership council. We would like to see them mandated but they were not mandated in part due to concerns that not all in our facilities may be able to comply at this point. But these are obviously a number of other recommendations that we have and that are really part of our larger stepped care model of pain management that you see there. I don’t really need to read those all to you.

The other aspect that CARA mandates is full implementation of the stepped care model systemwide. Part of the field survey that we’re doing at this point is that medical centers have to certify how much are they in compliance with each of these steps of the stepped care model. And if they are not 100% in compliance, full compliance, what will their corrective action be to get there? So every facility who is not in full compliance with the stepped care model basically has to issue an action plan now. That is being collected at this point and by July 22, hopefully next week, we will have a summary report in this regard.

But as you know, the stepped care model has changed over time. I think you all know very much about it and we clearly have put an emphasis on patient family education and pain self-care now as a foundation for both primary care and secondary and tertiary care.

Other topics in regard to CARA I think in particular I want to mention the expansion of the complementary integrated health modalities. We will have eight demonstration sites. CIH expansion in regard to implementation, education of providers and research is mandated through the CARA legislation. We will have one site that will be specifically designated as a CIH expansion site within each VISN. It will be a model also to study how successful can the CIH implementation be in order to help with pain management and opioid reductions.

With that in mind really, as we are putting out these pain team requirements and the stepped care model, what we still have open questions about is how do we put all these different stakeholders together. You know primary care, specialty care, mental health, addiction therapy, CIH, you see them. How do we make them talk to each other? And how do we make them work collaboratively so that we are actually efficient in what we are providing? Not everything, and this is really where the CARA legislation comes from, not everything can be done in primary care. In fact, the CARA legislation originated in part because they felt that primary care providers were possibly overburdened or not specifically trained well enough for the highest complexity patients. And primary care providers often report that the challenge that they have in their practice may be in particular, the complex pain patient especially as it comes to opioid prescribing. The CARA legislation was implemented in part, then we got to the pain teams, to help somebody else who can help the PCP and the PAC team.

How do we make that possible? How do we make this efficiently so that we don’t throw basically everything at every patient and see what sticks? How do we do this in a way that is actually cost effective and manageable for us?

Moderator: Fantastic. So I’ll maybe have you take a question or two. In the meantime, if there are cards filled out, will people send them towards the aisle and I’ll come collect them.

Friedhelm: I need questions about CARA, pain teams, pain specialty teams. Yes.

Steve Pizer: I have a question. I’ll just try to use the mic here. You just sort of, you finished, maybe I should turn this on. Is it on? So one of the last things you said

Friedhelm: Briefly introduce yourself and where are you coming from?

Steve Pizer: I’m Steve Pizer. I’m chief economist at Partnered Evidence-based Policy Resource Center.

Friedhelm: Thank you.

Steve Pizer: One of the last things you said was how do we do this in a cost-effective way. And you know we very often do better when we have interdisciplinary teams and people are getting a lot of attention and they respond well to that. But as an economist, I worry about how much that costs. So we’re now asking all the sites to stand up these teams and what can you tell us about the resources that are involved in doing that and what are you hearing back from the field as they try to do that?

Friedhelm: Yeah, we did a preliminary gap analysis this spring to try to see what facilities are. Most of the facilities, the majority of facilities have already pain management teams in place. It is really, we’re not starting \_\_\_\_\_ [00:14:18]. We have these pain teams at probably two-thirds of the facilities already implemented. I think it’s very similar to diabetes care which is chronic disease model. Patients with heart failure. Where the majority of prescribing of the medication, majority of coordination truly has to be in primary care. But again, for the highest complexity patients, there has to be a way to get somebody else to help. We don’t intend these pain teams although the CARA legislation more or less mandates that we have pain teams that can take over prescribing that’s part of the legislation. Because it does mandate that the for the patient for the provider who has issues with prescribing, that they have somebody else, a pain team, that they can send the patient to.

On the other hand, we understand it not as a taking over. We really understand it as a collaborative model where the pain team will or somebody designate and within the pain team will work collaboratively with the primary care provider to give them just as much support as they need in order to implement this. You know, I can give you hopefully very soon when we have our reports back from facilities the needs we know and where we are. Clearly, I think it’s not a secret that many sites are not there. Unfortunately, the CARA legislation when it was issued initially did not have any funding associated with it. A little bit of extra funding then was designed in subsequent legislation but it is greatly insufficient in order to implement the pain teams as the law actually mandates.

Barbara Bokhour: Barbara Bokhour. I’m from the Bedford Boston COIN. I am also the Director of the Center for Evaluating Patient Center Care leading the evaluation for the Office of Patient Center Care, \_\_\_\_\_ [00:16:21] 18 and 18. This is really important because pain is obviously at the core of that evaluation as well. But I actually have a question talking about the integrated health part is really important and this issue of offering something else. I think when we talk about messaging and communicating with patients, there’s a real risk in putting up a sign saying we’re going to try to reduce opioid use because patients are going to get really nervous. What am I going to get instead? I’m just going to have all this pain. It actually came up in a … my colleague Jimmy Fix has been doing some interviews with patients with HIV lately and she brought this to me yesterday. A patient saying they’re telling me they’re going to take away my opioids, but I need them. And so we know that there are alternative and thinking about how to present those alternatives. If we start messaging that we’re going to decrease opioid use in the VA and veterans get word of, get hold of it and they say you mean you’re not going to treat my pain anymore. So I think it’s a really, I guess it’s a question of how do you do that? How do we actually frame the broad scale communication around opioid use and people do want to decrease it? A lot, some of the new vets don’t want to go on the medications. I will say that we had a vet recently tell us, one of our veteran consultants for our research program, saying you know in the field, veterans are getting opioids and they’re getting more and more so they can go back out in the field and fight some more. So how do we balance all of these pieces so that when they come in and we’re trying to get them off of these medications, that we’re really going to help the? That we’re creating alternative programs to help them manage their pain. That was a very long way around to ask about how do we communicate.

Friedhelm: I think, Barbara, I mean obviously that touched on the lap of we talked a little bit earlier already. I think patients are more open now towards implementing a long-term care plan that they feel often, similar to the example of providers. Or that is actually provided by Will’s patient, right? But you know they often fear and they understand better that opioids are not the way to go for the long-term. If you ask the patient, they typically tell you yes, I want to come off but not today. [laughter] Right? I mean that is usually what we get. It is this threshold that we need to step over, to make them actually comfortable about it and actually entice them in whatever way it is.

For some patients it really, I think, Alicia, as you pointed out, we have to find out what they may be interested in. If you recommend exercise, we don’t tell them what exercise to do. We tell them hey, that is important. Which one would you like to do? I think that’s the same as we start with integrated \_\_\_\_\_ [00:19:23]. What would fit your personal desires? What we as a system have to do is that we provide the access and make it easy. And we motivate them to get there. That might be for, we also strategize. We’re trying to get it away from these bridging therapy. We didn’t formally talk about this concept that we have temporary measures such as acupuncture or chiropractic care. Which are modalities delivered by a healthcare provider but are not self-management. They are really good only for the temporary measure such as why we are getting a patient motivated to come off opioids. Eventually though we want to go to active self-management for the long-term. We cannot provide acupuncture weekly for the next five years. We have to have limits. We have to get away from these modalities that we might find appropriate for the temporary use while we are transforming the individual’s pain care but we have to truly gear it towards a whole health approach that is active self-management.

Moderator: Sure. We have no written questions. Everyone is just going to bring the questions up front to the mic I guess. Questions for the whole panel.

Tara: Hi, I’m Tara, and I’m from West Haven. One thing you mentioned with the stepped care model was the emphasis on patient and family education that’s now being inserted and you also just mentioned that we need in the long-term to think about active self-management. One struggle that I have seen with that is that is very hard to measure and capture and to know are we doing a good job of that. Are our patients actually doing those things? I’m curious if any of you have thoughts on how we can capture that in the healthcare system?

Alicia: That’s a difficult question [laughter] to ask. I would say to step back more broadly and think about this is something that has come up for us is how can we more effectively measure outcomes at the point of care. We know that the information that we get is around current pain. Which we know is not as reliable as average pain. We have opioid medications and we have some treatment use. So I feel that we’re trying to promote a message of function. We want people to function well despite pain but we don’t measure function. And if we don’t ask them about function, then they see through that. They see that what really drives the system is what’s your pain score. So I think at the very least understanding outcomes around function for even the various initiatives. Is OSI, is CARA making an impact on patient reported function when they come in? At the very least we need to have a better understanding of that as an outcome.

Friedhelm: You know I think in regard to outcome measurements, really one goal that we should have between, and I think this is where the partnership of HSR&D is really so important, is to align our outcome measurement that we use in clinical care as well as what might be suitable to researchers. If we can be successful to align outcome measurements across our system, even if you just have a minimal set, a data set that will be used everywhere, I think it would be huge. Obviously, it would have access to clinicians to compare facilities from a QM standpoint but it would just a huge data trove I think that researchers could access if it were standardized across the system. We are working on that obviously. Going away from a self-report of the patient is really what is so challenging. How do we measure function beyond you have the \_\_\_\_\_ [00:23:33] obviously and many primary care settings may use it or other people, the defense of veterans pain rating scale? There’s the quality of life scale from the American Chronic Pain Association and probably forgetting lots of other really good simple tools but most of them are really self-reports. How do we make it more objectively? I think that’s one of the challenges that we have. And in particular, how can we go and measure some other domains in the simplest way that makes it standardized across the system.

Moderator: So I’m going to ask a question, going to take moderator’s prerogative here and ask a question of the whole panel. And that is just so I think you’ve really illustrated well and I think most people in this room are aware how rapidly the landscape is changing here in terms of policy, mandates, public opinion, all these things that we’re responding to right now in the pain and opioid world. We all know that health services research evolves at a different pace sometimes than policy needs to evolve at or that the administration needs to move at. My question, really for all three of you, is how can we in research make our work relevant, useful in a time like this? Are there ways that we can ensure that the findings we have actually mean something when they’re ready to be published and aren’t just old news by that time? [laughter] It’s a hard question. It’s a hard question.

Friedhelm: One thing that we have now is that clinically we actually have a lot more dashboards now that we use for our monitoring of providers. We become less reliant on the research community to give us a number in regard to specific and in regard to like what is the number of prescriptions that the VA has issued. We can look that up, to basically up to last quarter. What is the number of PDMP checks? Or informed consents? Or things that like that that we can easily measure. But we obviously need research to answer the more concerning questions in many ways which is as we implement all these changes, what is the true outcome of our patients? As we reduce opioids, which patients do successfully and which ones are challenged? How can we address the concern about potentially this concerning, when a patient with chronic pain and mental health conditions is on opioid medication, possibly has PTSD and history of substance use? The patients who have these complex situations, they’re probably are not the same and the guidance shouldn’t be the same as somebody who doesn’t have all those co-morbiditities. Or maybe the way how we approach it in order to do it more safely and preventing illicit drug use and overdoses and suicide has to be different than somebody who can step back and basically be more cooperative and for them it’s easy to adhere to our treatment recommendation. That’s where research needs to help us. To understand better what are the intricacies, beyond our dashboards.

Moderator: Thank you. Will or Alicia?

Will: I think it’s a question I struggle with a lot. I think Andy Tobin has helped me understand the value of deciding when a topic is worthy of QI and maybe does it need to go through, you’d have a vigorous informed consent protocol. If you’re implementing a well established, efficacious treatment and you’re wanting to understand how to get broader uptake, that’s a QI study and could be executed in that manner and shouldn’t be burdened down by essentially making people sign consent for care that they’re going to receive anyway. I kind of adopted that approach to a certain extent and it’s been helpful to move things forward in the work that I do.

Brian Hertzog: Sorry, I didn’t want to block the camera back there. Brian Hertzog, internal medicine provider at Hines. One of the partners with Houston. As I provider, I find … Sorry, now I’m currently working in the Office of Access to Care, central office. Having practiced back in Hines and thinking about this, I just wonder about the forthcoming requirements or thoughts from you guys about what might additionally be required beyond the committee? What we struggle with is a big one and I think some sites are struggling with is the fact that the committees require to spend is fantastic but when my patient needs to receive alternative therapies, they’ve got to go to the community. It’s not something inside the VA. It seems like something we should have. I wonder about why we’re not yet requiring, if you will, mandating is the meaner term I guess, but requiring certain sites within networks to offer these alternative strategies in advance of paying for them to be received in the outside where we can’t monitor the quality or potentially the objective effectiveness of them. And even still the broadness of all the different places our patient can go to get these therapies. We’re not sending them to Dr. Jones, the acupuncturist. We’re sending them to Dr. Jones, Dr. Smith and all these other people that are closer to where that patient lives. Beyond the committee, I just wanted to get your thoughts on the forthcoming potential, forthcoming requirements really on the access to care side for our patients to get these kind of alternative therapies, approaches in advance of just being sent out to the community where we can’t really monitor who’s doing what. And the cost? The economist, the gentleman that spoke about that. That was fabulous. I think the answer is right there in terms of what we could do internally but I don’t know that we’ve gone there yet with the research capabilities that we have. Thanks.

Friedhelm: I guess this question is more for me. [laughter] No, I think we understand obviously that access to CIH is hugely, important and it probably needs to be outside and inside. Because patients live far away. If you require somebody to come or if you would like for it to be delivered consistently and weekly intervals, ideally it’s done close to home. Certain modalities for CIH are certainly not as easily implemented over telehealth as maybe a behavioral health option would be. But in that regard, we have for instance, have had the requirement of offering chiropractic care, spinal manipulation for long time in the VA. And any facility that doesn’t have it at the site, needs to offer it in the community and has done that on key basis long before we had our choice system.

I think we have some experience in that regard but as you’re pointing out, in general I think we understand and would strongly support to have these modalities available at the sites where they can integrate and collaborate with the primary care providers and can be accessed right from the primary care. And they’re feedback.

I think we know, for instance, that somebody who is maybe getting certain modalities within the system and with communication with a provider who maybe delivers it such as spinal manipulation, that it often … we are able to maybe limit it beyond what is truly needed. It’s a little bit easier to get the feedback. So I think we would certainly support it in that regard.

As part of CARA, there is this integration and expansion of integrative health modalities. So I talk about this 18 model sites, demonstration sites, in addition though the integrative health coordinating centers certainly promote the expansion of integrative health systemwide. It’s also part of CARA. It maybe isn’t quite so obvious because we can’t name the sites where it happens. But I think we strongly support the expansion of access to CIH modalities.

As Alicia mentioned, the SODA, the state of the art conference, and we have the different modalities and behavioral care, behavioral health, exercise, movement therapies, then the more integrated modalities, spinal manipulation and acupuncture, really want at least one modality of each of these subcategories to be available at each site. Again, this is where the model of VISN supported hubs might come in as we talk about pain teams. The same would be applying for CIH.

Moderator: Yes.

Christian Helfrich: Christian Helfrich from VA Puget Sound Arling City where … and I wanted to pitch a letter, a question to the panel, in particular that a recent neighbor in observation \_\_\_\_\_ [00:33:17] a few days ago outside VA twice as long as \_\_\_\_\_ [00:33:23]. Dr. Shulkin is giving priority to increased access to community care. Anyway, we’ve got some emerging research indicating that when a patient comes back to the VA on a prescription, providers are more reluctant to take a patient off of that medication, a med that they themselves put on it. So there’s some implications there for how not only for how frequently patients are going to be put on these risky therapies but also the challenge presented by taking those patients on. I wonder if you guys have any thoughts about steps that can be taken systematically as an integrated healthcare system to monitor patient’s coming back on those therapies?

Moderator: So I’ll repeat the question in brief. Essentially the question is about community care and the observation that patients seem to be more likely to be prescribed opioids in care in the community than they are in VA. What are the system implications? How can we respond both to the increased prescribing and also potentially to the challenges in terms of taper or discontinuing therapies started elsewhere? Harder to stop once it’s started. Does that cover it? Yes, okay. Will, go first on this.

Will: Sure, thanks for the question, Christian. So I think something I have been exploring is we put all this emphasis at the point of care, the provider is supposed to be checking the prescription drug monitoring program database and then they’re supposed to know exactly what to do with it. It’s a lot to ask at that interface. Something I’ve been talking to Joe Francis and others about, could we not batch. Our facility could look at all the prescriptions that our veterans are receiving and we have done some preliminary looks at this and sure enough, there are pockets of outside prescribers who are serving or treating or doing something to a lot of our veterans. Can we intervene on them on ways that are patient centered and ethical? Because you’re absolutely right. There is overlap. There is dual care. And the quality control of what’s going on outside is in my view, suspect in a lot of cases. Might we use our integrated services to buff what’s going on with our patients in the community.

Friedhelm: You know pain management including opioid prescribing if that’s appropriate, is chronic disease management. It’s like diabetes and hypertension care. And we should not I think in general freebase or choice out essential primary care activities such as diabetes care. Why would we want to send out opioid prescribing? I think the reality that has happened speaks to the point that some primary care providers were truly not able to do it on their own. And if they did not have a pain team at the facility or somebody that they can go to who helped them, they were afraid they were left alone and then they take the next step which is sending patients out.

What I often heard from primary care providers is like I don’t want you in the pain specialty to take over my patient. But if you just meet them once, and reinforce my message, and then we can do it together. You just help me to do this and implement this. I think as we put up our pain teams, that is really the point behind it. We would not have to have these patients who where the provider and the patient don’t really know how to move forward here. Whether it’s a misunderstanding on the patient side of what is really the best care for them or whether it is on the provider side of how do I find enough time or whatever the effort is or the energy to implement this in this case.

On the other hand, I think there is a general understanding that if we have community care prescribing, the facility is responsible for what’s happening. I mean a lot of the pain prescriptions, I mean the opioid prescriptions, actually filled at the VA pharmacy because community care providers, choice providers write the prescription, but we fill them. With that in mind, I think really opioid prescribing as part of the larger pain management in general which usually is done in the PACT environment, should be done within the VA system inside by VA providers.

Moderator: So we are in the last five minutes here. I think what I’m going to do is just ask our panel for any closing thoughts. This has been a great conversation. I think it’s excellent, it’s really great to see so many people here who are doing pain related research in VA. I just think the room will fill even more in the future because one thing that is clear is that there will be more funding for pain related research in VA. Any final thoughts from the panel in terms of making that relevant to practice, policy and operations in VA?

[laughter]

Friedhelm: Just from my side. You think about what you’re going to say. I think we obviously from the pain policy side, we have strong interests to work with the research community. I really want to invite you to reach out. If you have questions where we can help you, if you have suggestions, I think we are more than open to hear your thoughts and work with you. In this regard, I want to emphasize that pain care is much more than opioids. We talked a lot about opioids today but this is so much more about it. It’s more than integrated health and opioids which was really most of the topic that we had. I think within that spirit I want you to think big and to be creative, and you as researchers are obviously that. We are open to your big ideas as we move forward for pain care. I think we have a unique, actually, we have a new chance, a new chance in the VA. We have pain teams probably better than most other systems. I think we should utilize that to the best possible, both for research, knowledge gathering as well as obviously for the benefit of our patients.

Alicia: I just want to follow on with Friedhelm said. A lot of what we’ve been talking about is we have this system that has a lot of resources, but it’s often very difficult to coordinate and it’s often very difficult to move efficiently and to have information flow to the right places. I think if we can think big as Friedhelm said, and leverage the integrated nature of our care, whether it’s through technology to allow the geographic projection of evidence based care, whether it’s universal methods or messages, so that we really can start to treat pain like the chronic condition that we believe it is. I don’t think we’re there yet. The other thing is we have the opportunity in having this large system but it’s also the challenge. So how do you build a system that supports our activities, that makes it easy to do the right thing. I think that’s where we’re missing and we could potentially make a lot of progress. We know what we want people to do and how do we build in practices with technology or other methods to allow people to do what we want them to do.

Will: I’m going to leave it there. [laughter]

Moderator: And I always think the secret to a successful presentation is finishing a few minutes early so thank you to the panel. [applause] Thank you to the great questions.