CMS 2024 Quality Conference

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Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Chronic Pain: Getting People the Care and Services They Need

Monday, April 8, 2024

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Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

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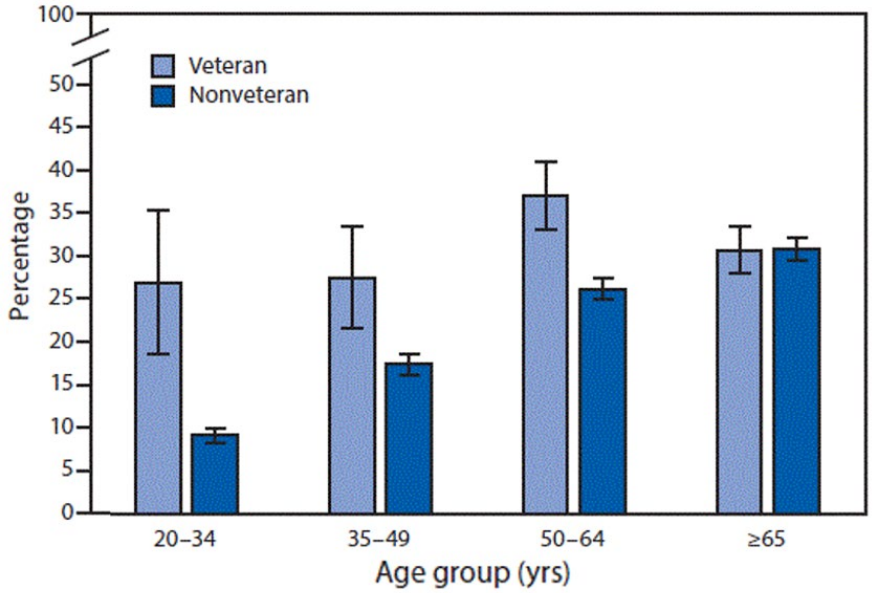
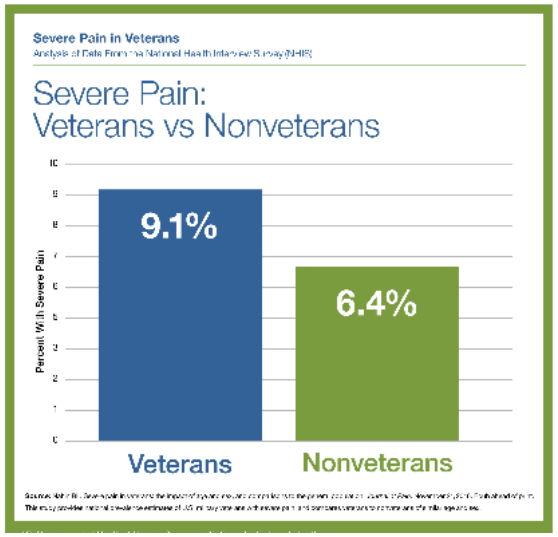
Prevalence of Pain Among Veterans

Chronic pain is more common and more often severe in Veterans than non-Veterans

- In a national survey, 31.5% of Veterans vs. 20.1% of non-Veterans reported experiencing chronic pain in the past 3 months
  - Chronic pain defined as pain on most days or every day
  - Veterans of all age groups except those ≥65 years of age were more likely than non-Veterans to experience chronic pain.



QuickStats: Percentage of Adults Aged ≥20 Years Who Had Chronic Pain, by Veteran Status and Age Group — National Health Interview Survey, United States, 2019 (cdc.gov)



- Severe pain in 9.1% of Veterans
  - 40% more common than in non-Veterans
  - Pain that occurs “most days” or “every day” and bothers the individual “a lot”

National Health Interview Survey Nahin RL, Journal of Pain 2017; https://www.nccih.nih.gov/health/pain/veterans

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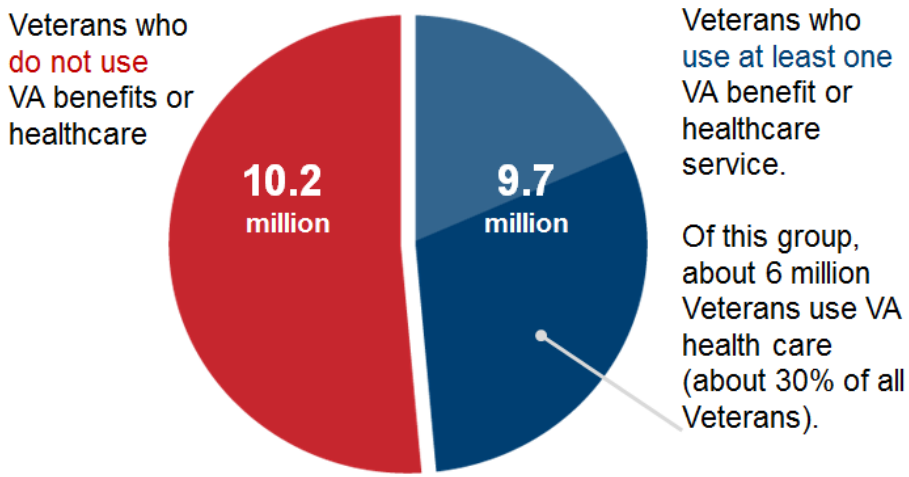
Veterans Health Administration (VHA) Veterans with Chronic Pain Conditions



Pain diagnoses

- Back pain 27%
- Neck or other joint pain34%
- Migraine 5%
- Neuropathy 3%
- Fibromyalgia 1%

MH and SUD diagnoses

- Depression 19%
- Anxiety 10%
- PTSD 14%
- Bipolar disorder 2%
- Alcohol use disorder 8%
- Opioid use disorder 1%
- Other SUD 5%

Veterans in VHA

- **1 in 3 with chronic pain diagnosis**
- **1 in 5 with persistent pain**
- **1 in 10 with severe persistent pain**

VHA Veterans enrolled in Primary Care
2,095,938 Veterans with incident chronic pain

Frank et al. Pain Med. 2019

VHA Veterans with Pain Specialty Care (1)

- 6 million Veterans in Primary Care
- 2 million with at least one pain diagnosis
- About 120,000 Veterans had at least one visit to a pain specialty clinic (2012 data)
  - 5.8% of Veterans with pain condition attended a pain clinic in VHA
  - Pain clinic users had higher rates of muscle spasms, neuralgia, neuritis, radiculitis, and fibromyalgia, as well as major depression and personality disorders
  - Patients in pain specialty clinics had more difficult-to-treat pain conditions and comorbid psychiatric disorders, used more outpatient services, and received more opioid medication

  ➔ **Importance of the inclusion of mental health care in the specialized treatment of chronic pain**

Arout et al. Pain Medicine 2017

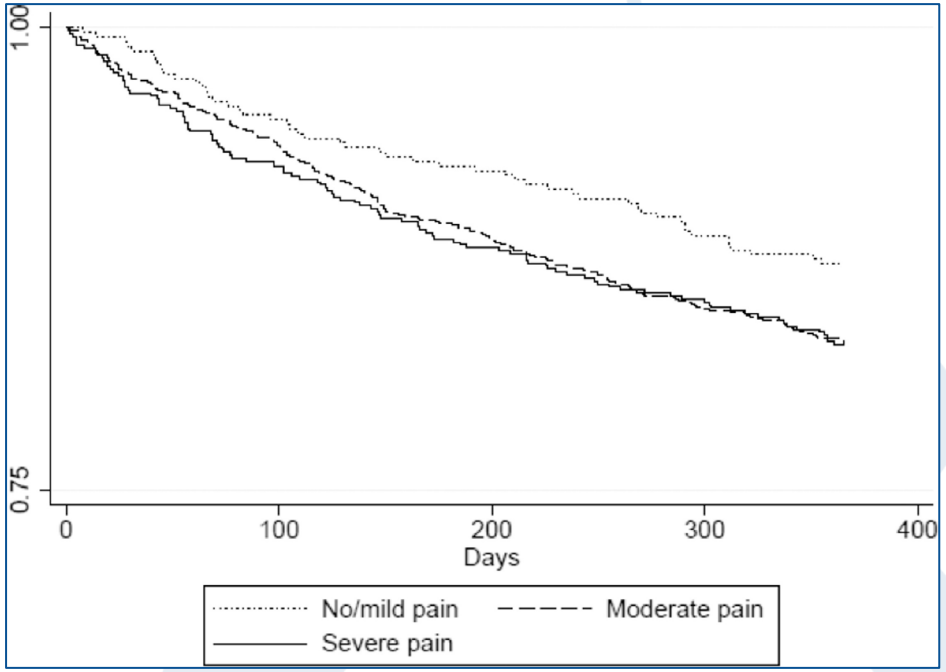
Rates and Correlates of Pain Specialty Clinic Use Nationally in the Veterans Health Administration - PubMed (nih.gov)

Veterans with Chronic Pain are at High Risk for Suicide

Severity of Pain Predicts Suicide Risk

- Suicidality in patients with chronic pain is common: one third contemplate or attempt suicide, with an almost three-fold increased risk for suicide attempts compared to the general population.
- There is a direct correlation between pain intensity, suicide risk and death rates.
- VA's "Behavioral Autopsy Program" reports pain as the most common risk factor among Veterans who die by suicide.
- Risk factors include pain severity, use of opioid therapy, substance use disorder(s), depression, and possibly recent discontinuation of opioids, among other factors.

Survival Estimates for Suicide Attempts After the Index Visit, by Pain Intensity



Veterans with higher pain intensity had lower survival rates than those who had mild pain or no pain.

https://blogs.va.gov/VAntage/67708/va-study-uncovers-link-pain-intensity-suicide-attempts/; Ashrafioun et al. J Pain 2019 Jul;20(7):852-859 https://pubmed.ncbi.nlm.nih.gov/30690167/

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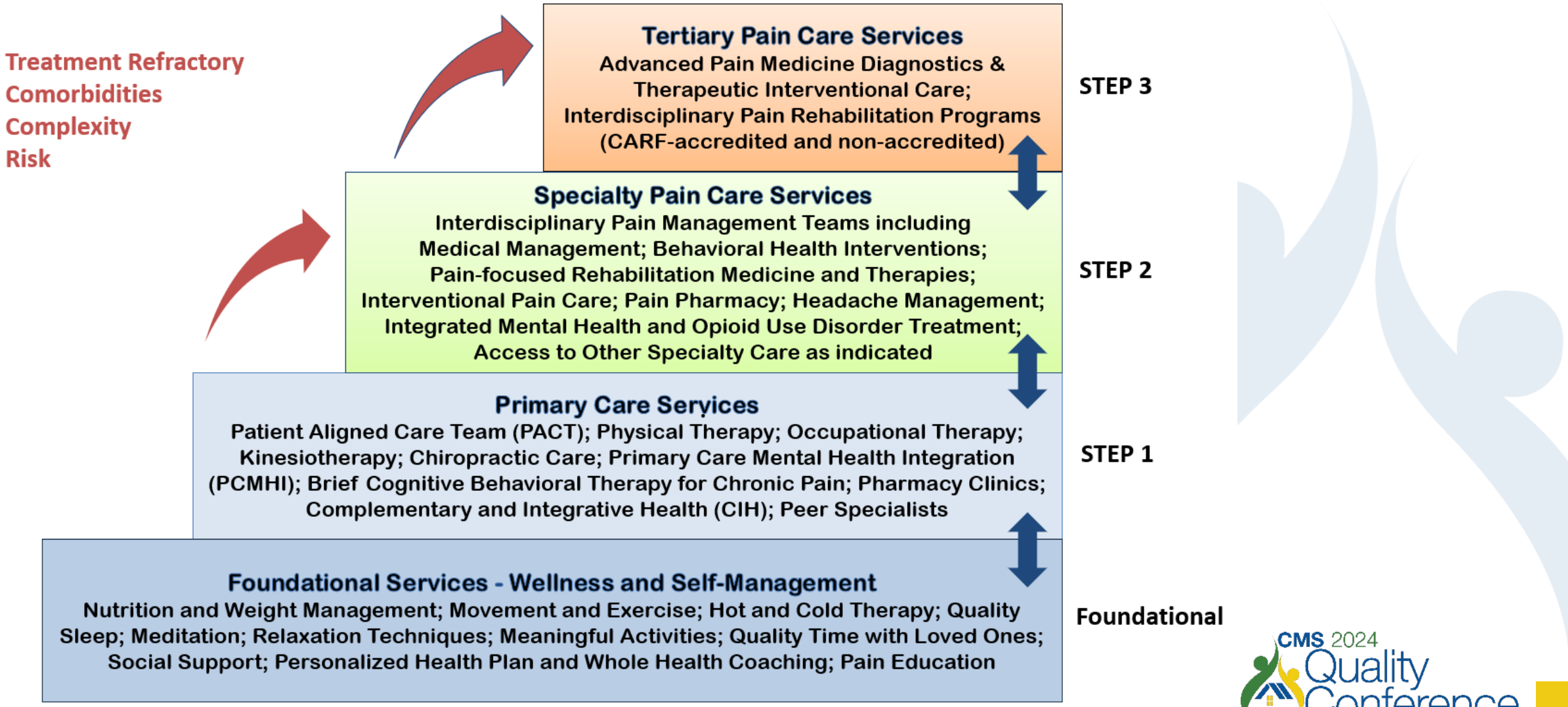
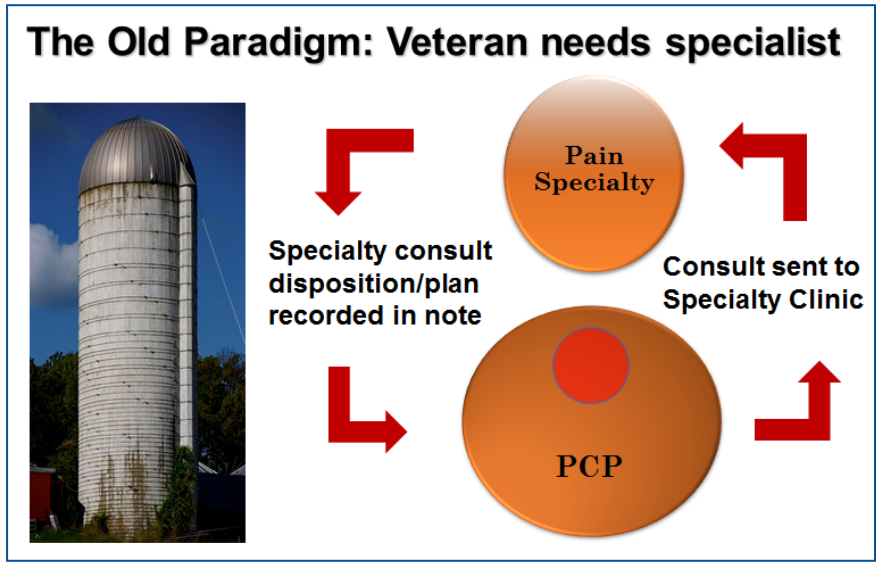
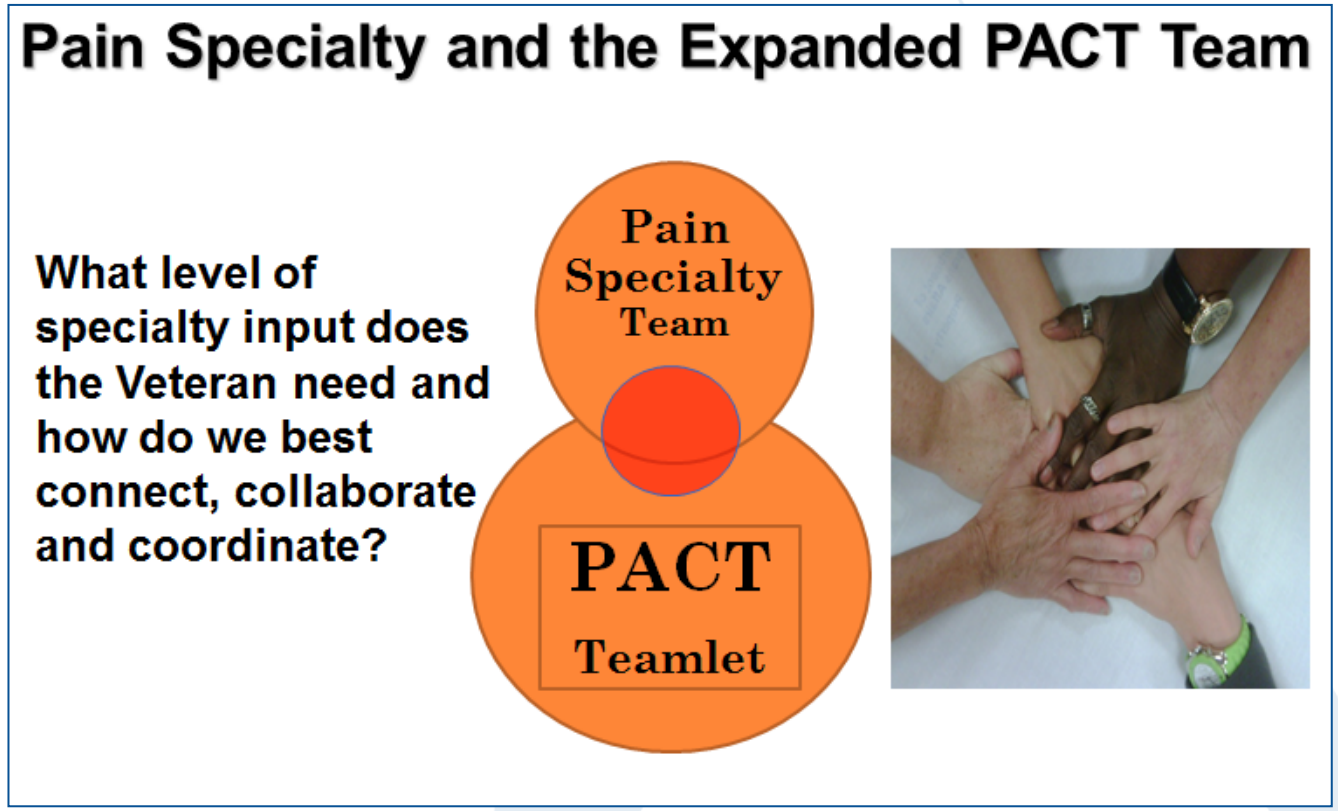
Stepped Care Model for Pain Management (SCM-PM)



Collaborative Pain Care between Primary and Specialty Care





VHA Pain Management Teams at All Facilities

Comprehensive Addiction and Recovery Act (CARA) 2016

- Full implementation of the Stepped Care Model for Pain Management
- Pain Management Teams (PMT) at all VHA facilities are *"responsible for coordinating and overseeing pain management therapy for patients experiencing acute and chronic pain"*
  - *Administrative/operational functions*
  - *Clinical functions: Pain Clinic*

Minimum Composition of the PMT in the Pain Clinic:

- **Medical Provider with Pain Expertise**
- **Addiction Medicine expertise** for evaluation of Opioid Use Disorder (OUD) and access to Medication for OUD (MOUD)
- **Behavioral Medicine** with at least one evidence-based behavioral therapy.
- **Rehabilitation Medicine** discipline.
- Optional team members include Interventional pain, Nursing, Case/Care manager, Pharmacist.

Pain Management Team Care: Biopsychosocial, Collaborative, Whole Health

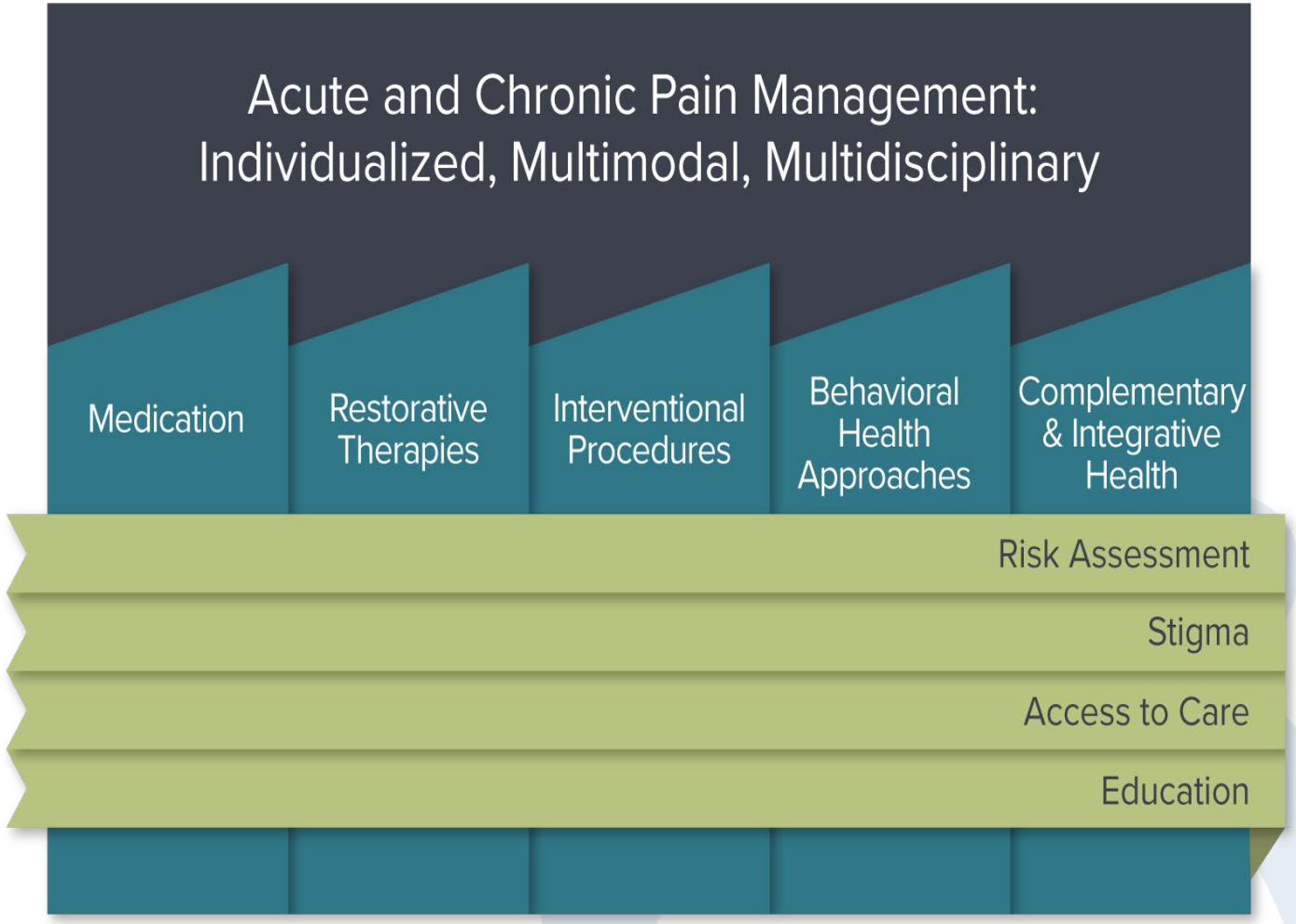
Key components of the biopsychosocial model:

- Biological factors (e.g. diagnosis, age)
- Psychological factors (e.g. mood, stress)
- Social factors (e.g., social support, spirituality)

Aim to improve:

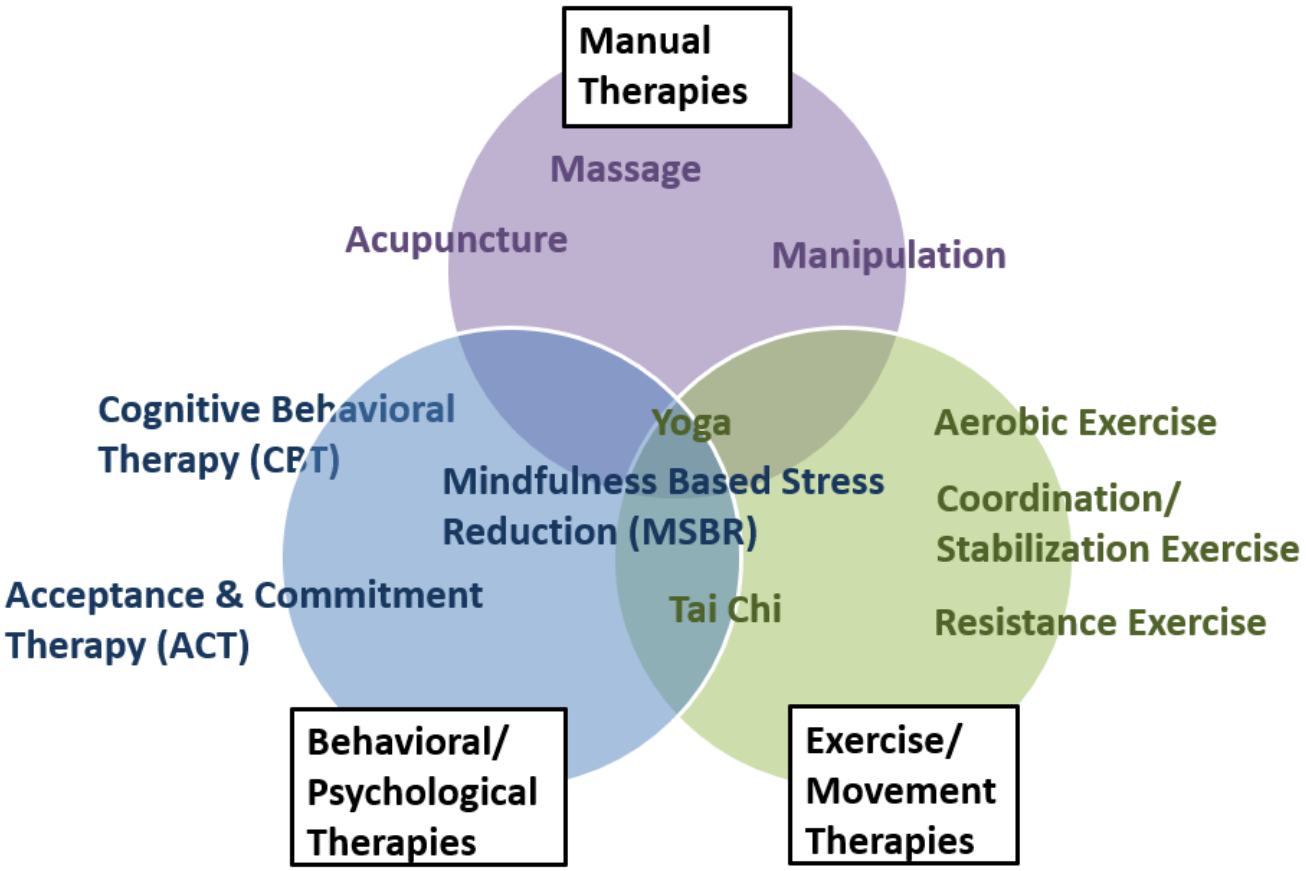
- Overall pain experience
- Physical functioning
- Activities of Daily Living
- Quality of life

Five major treatment approaches, cross-cutting factors



HHS Pain Management Interagency Best Practices Task Force Report
https://www.hhs.gov/ash/advisory-committees/pain/index.html

Nonpharmacological Pain Treatments in VHA



VA State of the Art Conference, 2016

Nonpharmacological approaches for musculoskeletal pain

Kligler et al. J Gen Intern Med. 2018

- **Chiropractic Care**
  - Approved as a covered benefit in VHA in 2004 and is part of VA whole health care.
- **Acupuncture**
- **Massage Therapy**
- **Meditation**
- **Yoga**
- **Clinical Hypnosis**
- **Biofeedback**
- **Guided Imagery**

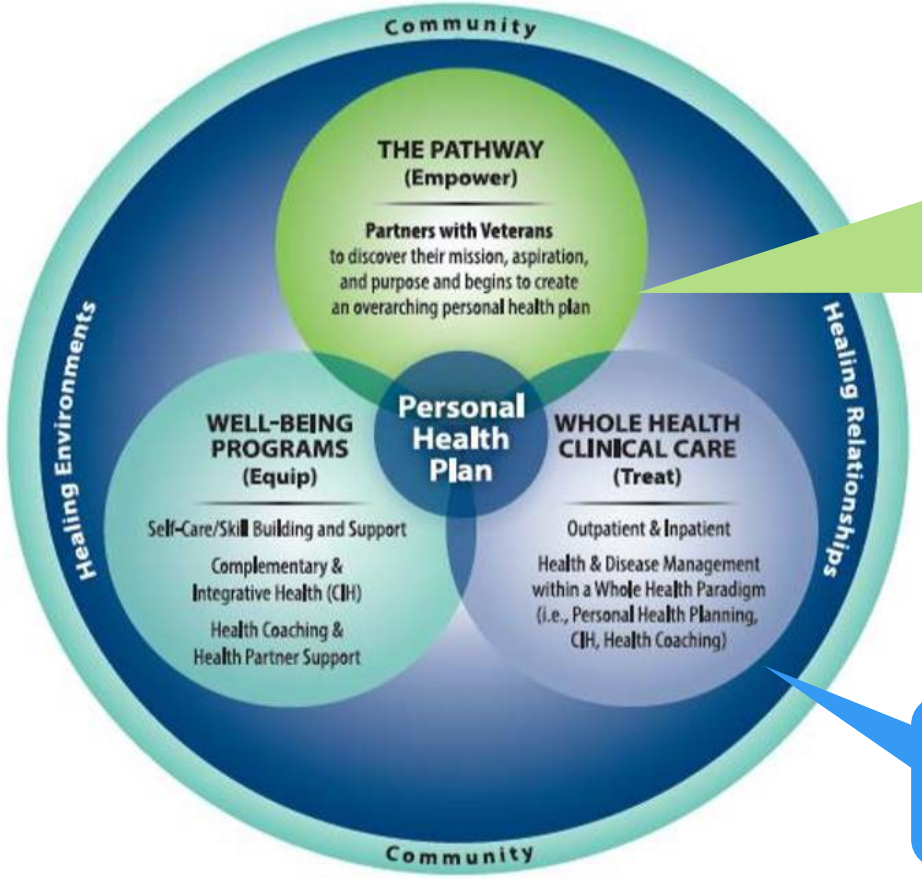
VHA Directive 1137: Advancing Complementary and Integrative Health (2017)

The Integrative Health Coordinating Center (IHCC) serves as an up-to-date resource for approved CIH services.

VHA Veterans with Pain Specialty Care (2)

The Whole Health Model is a balance of three pillars which when combined will help drive the continued success of the transition to personalized, pro-active, patient-driven care

- ✓ Encourage self-care
- ✓ Decrease reliance on provider delivered care
- ✓ Complementary and Integrative Health Approaches



- ✓ Engage Veterans in their Mission Aspiration Purpose (MAP)
- ✓ Veteran Partners, Whole Health Coaches

- ✓ Cultural transformation of how clinical health care is delivered

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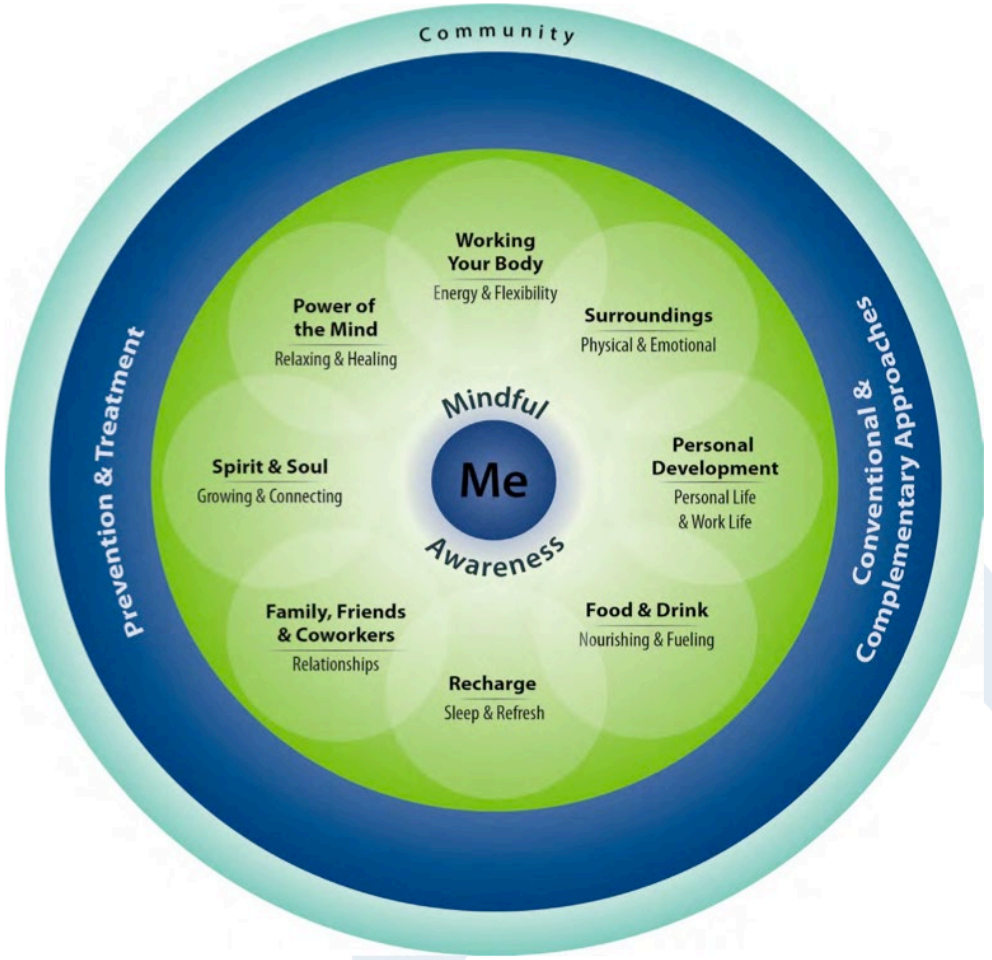
The Circle – a Tool for Assessment

***Whole Health* is an approach to health care that empowers and equips people to take charge of their health and well-being, and live their life to the fullest.**



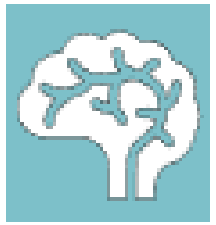
- How might these be interconnected?
- How might these affect your health?
- What are your strengths?
- Where are you?
- Where would you like to be?

Stepped Care for OUD Treatment

- **Medication for Opioid Use Disorder (MOUD)**
  - Buprenorphine/naloxone
  - Methadone
  - Naltrexone
- **Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative** (since 2018)

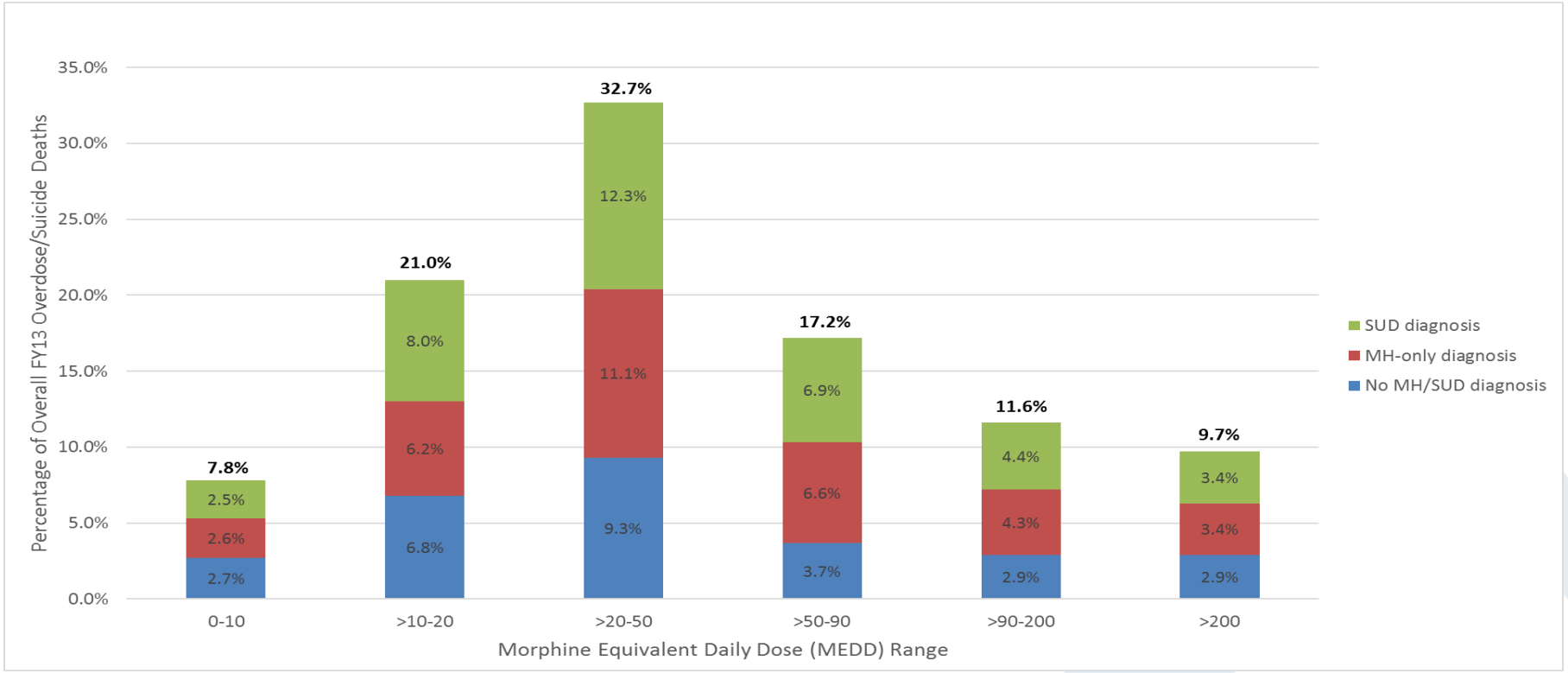
Innovative Expansions in Pain Management Teams: PMOP-Focused Initiatives

AMP
ACTIVE MANAGEMENT OF PAIN



- **MMPMT = Medication Management in Pain Management Teams**
  - 75 sites approved for funding
  - CPP + APRN or PA supporting medication management and risk mitigation
- **AMP = Active Management of Pain**
  - 59 sites approved for funding
  - Behavioral Health Provider + PT delivering specific group-based treatment protocol
- **WHCPMT = Whole Health Coaches in Pain Management Teams**
  - 29 sites approved for funding
  - Whole Health Coach embedded in Pain Clinic
- **MHI PC = Mental Health Integration in Pain Clinics**
  - 44 sites approved for funding
  - Mental health clinician embedded in Pain Clinics
  - Partnership with OMHSP

Overdose/Suicide Mortality in Veterans Using Opioid Analgesics (VHA)



Of the Veterans who died from overdose/suicide:

- Almost 4/5 were prescribed < 90 Morphine Equivalent Daily Dose (MEDD).
- Almost 3/4 had a mental health diagnosis (including Substance Use Disorder)
- More than 1/2 had MH/SUD diagnoses and were prescribed < 90 MEDD.

Data reflects Veterans on opioid analgesic therapy in 2013/14

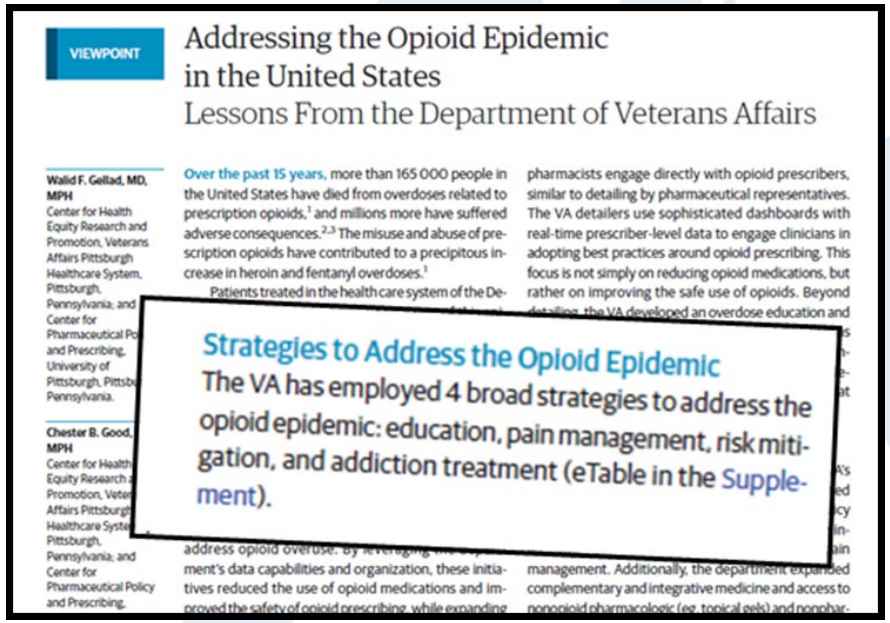
Unpublished data from PERC, Office of Mental Health and Suicide Prevention (OMHSP), VHA

The VA Opioid Safety Initiative (OSI)

OSI was piloted in 2012 and expanded nationally in 2013

- **OSI Aims**
  - Reduce over-reliance on opioid analgesics for pain management
  - Safe and effective use of opioid therapy when clinically indicated

- **Comprehensive OSI strategy including:**
  - Provider education; academic detailing
  - Access to non-pharmacological modalities, incl. behavioral and CIH modalities
- **OSI Dashboard**
  - Totality of opioid prescribing visible within VA
  - Provides feedback to interested parties at VA facilities regarding prescribing parameters


VIEWPOINT

Addressing the Opioid Epidemic in the United States

Lessons From the Department of Veterans Affairs

Walid F. Gellad, MD, MPH

Over the past 15 years, more than 165 000 people in the United States have died from overdoses related to prescription opioids,[1] and millions more have suffered adverse consequences.[2,3] The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.[1]

Patients treated in the health care system of the De-

pharmacists engage directly with opioid prescribers, similar to detailing by pharmaceutical representatives. The VA detailers use sophisticated dashboards with real-time prescriber-level data to engage clinicians in adopting best practices around opioid prescribing. This focus is not simply on reducing opioid medications, but rather on improving the safe use of opioids. Beyond

Strategies to Address the Opioid Epidemic

The VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment (eTable in the Supplement).

address opioid overuse. By leveraging the

ment's data capabilities and organization, these initiatives reduced the use of opioid medications and improved the safety of opioid prescribing, while expanding

management. Additionally, the department expanded complementary and integrative medicine and access to

Gellad, Good, and Shulkin. JAMA Intern Med. 2017

VA Opioid Safety Initiative: OSI Parameters and Policies (selected)

OSI Dashboard

1. Opioid use overall, and long-term opioid use
2. Opioid and benzodiazepine co-prescribing
3. High dose ≥ 90 MEDD
4. New starts for Long-Term Opioid Therapy (LTOT, i.e., ≥ 90 days)
5. Urine Drug Testing (for LTOT) at least annually and more often, if clinically indicated

<u>Other OSI parameters/risk mitigation strategies (implementation/guidance year):</u>

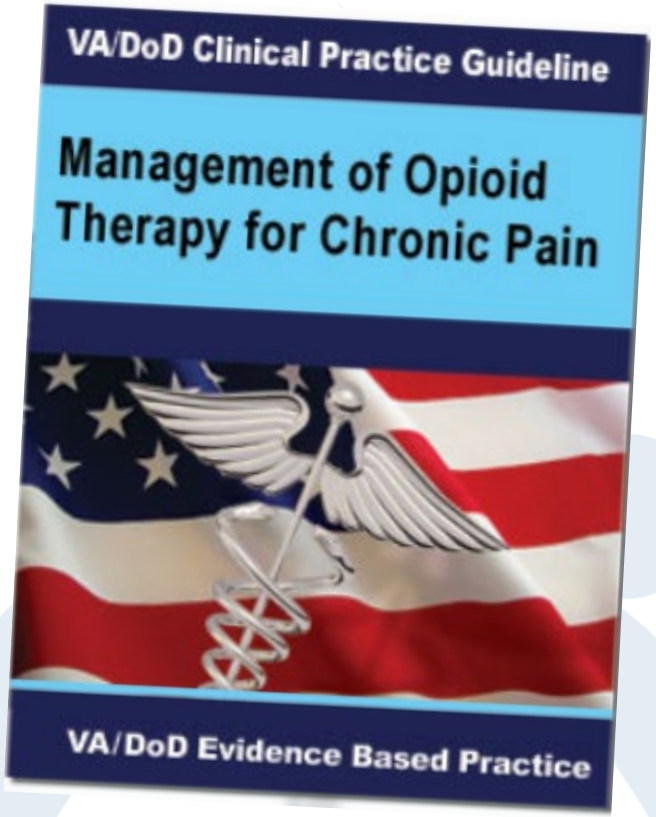
- Informed consent (2014) for pts on LTOT (90 d)
- PDMP checks (2016) at initiation and at least annually for all controlled medications if > 5 d supply
- Overdose education and naloxone distribution (2014) broad inclusion, no cost to Veterans
- Timely f/u within 1-4 weeks after dosage change, and at least q3 months to review care (2017)
- OSI Risk Reviews based on STORM (2018) optimize care of pts with very high risk for OD/suicide, and assess risk prior to initiation of opioid therapy

VA/DoD Clinical Practice Guideline for Opioid Therapy

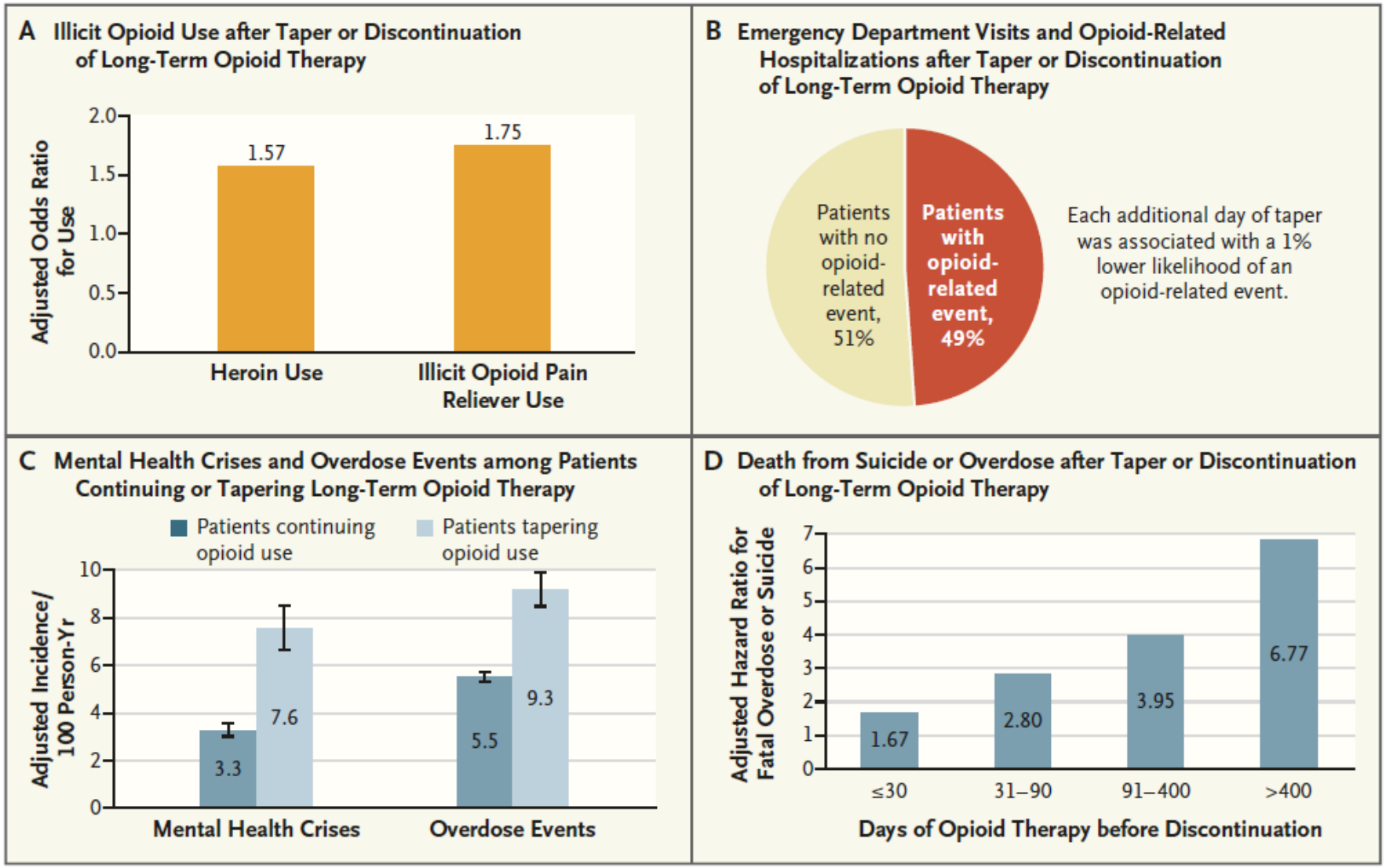
Recommendation 5.

For patients receiving daily opioids for the treatment of chronic pain, we suggest the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse. (Weak for | Reviewed, New-added)

“While the Work Group found insufficient evidence regarding the comparative effectiveness of buprenorphine and other full agonist opioids for the management of chronic pain, because of its superior safety profile as a partial agonist at the mu opioid receptor, there is reason to consider buprenorphine a first line agent in adults with chronic pain compared to scheduled dosing of moderate to high dose full agonist opioids.”



VHA Veterans with Pain Specialty Care



Data from Coffin et al., Mark and Parish, Agnoli et al. and Oliva et al.

Inherited Patients Taking Opioids for Chronic Pain — Considerations for Primary Care | NEJM

Coffin PO and Barreveld AM

NEJM Perspective Feb. 17, 2022

Among patients who have their long-term opioid therapy discontinued or tapered:

A) Increased risk of illicit opioid use

B) High incidence of emergency department visits and opioid-related hospitalizations

C) Increased incidence of mental health crises and overdose events

D) Increased risk of death from suicide or overdose

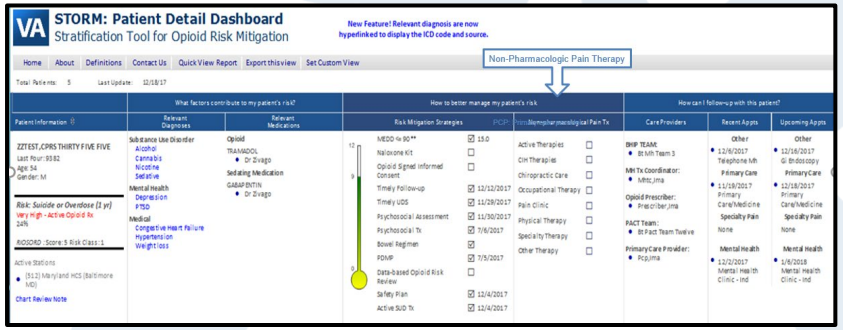
Data-based Risk Reviews of Opioid Exposed Veterans

- Systematic review of the clinical care of patients at high risk for overdose or suicide
- Interdisciplinary membership to include Primary Care, Pain specialty, MH, SUD programs
- 20-30% of patients with overdoses are estimated to be intentional/suicidal
- Veterans to be reviewed:
  - prescribed or recently discontinued opioid analgesic medications or recently had non-fatal overdose

  and
  - STORM dashboard identifies Veterans at very high risk
- Other high risk: dosage, opioid/benzodiazepine combination, etc.
- Care coordination across services
- Recommendations are entered into the electronic health record

Oliva et al. Psychol Serv. 2017

Stratification Tool for Opioid Risk Mitigation (STORM)

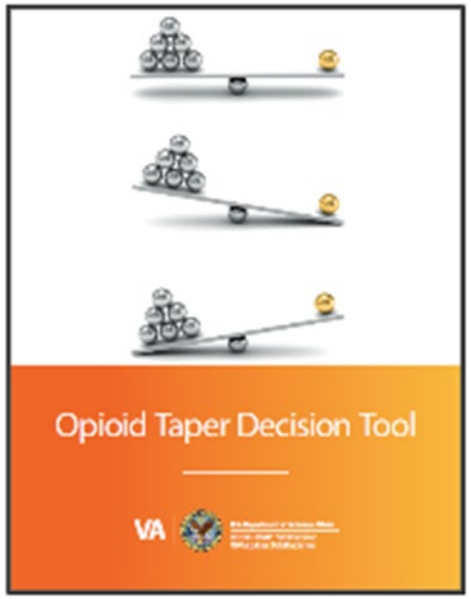


Approaching Opioid Tapering

- **Integrated Approach With Patient Buy-In and Active Participation**

  - When tapering is clinically indicated due to risks outweighing benefits, providers should seek patients' active buy-in by providing education and by using motivational interviewing.
  - Assess patient needs and address patient concerns including psychological factors.
  - Goal is to improve function and long-term outcomes.
  - Slower, more gradual tapers (e.g., ≤ 10% per month) are often better tolerated than more rapid tapers, with pauses as needed.
  - Sudden interruption of opioid prescribing (rapid tapers or discontinuations) should be avoided, with few safety exceptions.
  - VHA Opioid Taper Decision Tool issued (2016) Most commonly, tapering will involve dose reduction of 5-20% every 4 weeks.
  - F/u is recommended within 1 to 4 weeks after dosage adjustment

Academic Detailing: Opioid Taper Decision Tool (2016)



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Tara McMullen, PhD, MPH

Associate Director Opioid Safety, Veterans Health Administration

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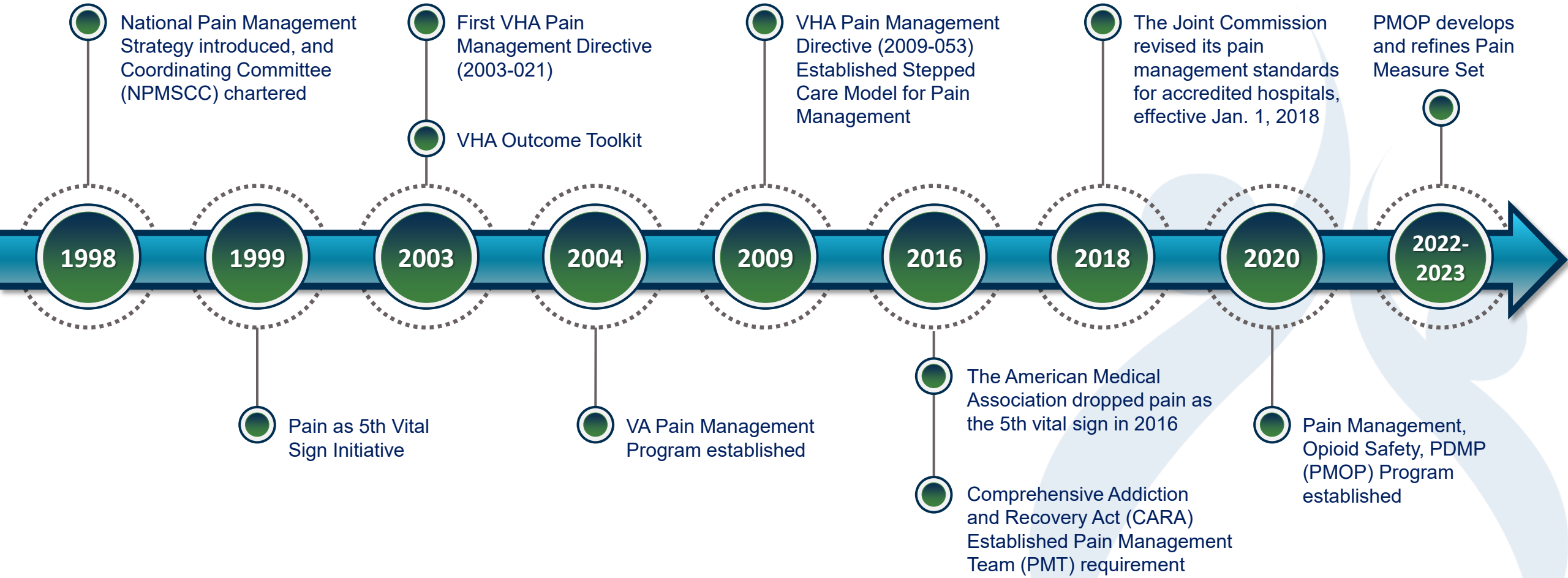
Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP) Measure Set

VHA Pain Management and Assessment Timeline



Pain as the 5th Vital Sign Initiative

Phrase coined by physician from Johns Hopkins in 1996 in the hope that “pain [is] assessed with the same zeal as other vital signs” and promoted by the American Pain Society.

The VHA Pain as the 5th Vital Sign initiative established routine screening, assessment, and documentation of a plan for pain reduction.

- Mandated screening for pain using pain Numeric Rating Scale (0-10).
- Documentation of present pain intensity (i.e., “pain score”) for all patients.
- Completion of a comprehensive pain assessment, as clinically indicated, for patients reporting a significant level of pain.
- Documentation of the comprehensive pain assessment, the plan for improved pain management, and a timeframe for reassessment.

Excerpt from: Take 5:Pain as the 5Th Vital Sign Toolkit, VHA, October 2020

Why Measure? (1)

- Biopsychosocial
  - Moving beyond a “pain score” only approach (i.e., Pain as the 5th Vital sign)
  - Screening and assessment in multiple domains assist in better understanding pain and its meaning
  - Assessing pain from a biopsychosocial framework means gathering Veterans’ information across multiple domains to best understand their individual needs

- Patient-centered
  - Allows Veteran to have an active voice in their care
  - Decreases delays to “best fit” care for each unique Veteran
  - Promotes conversations that align with Veteran priorities

Why Measure? (2)

- Efficient
  - Increased information means more accurate and efficient treatment planning
  - Identify the most appropriate external consults and engagement of pain team members
  - Collected electronically to minimize the burden on providers

- Veteran Population Health Awareness
  - Allows collection of standard information for Veterans with pain across the enterprise to assist in characterization and understanding of the population
  - Build a database to help identify trends and Veteran needs

Introducing the PMOP Pain Measure Set

- Used expert consensus (e.g., IMMPACT, NIH HEAL, VHA Workgroup) to identify measure domains

- Identified measures based on:

  - Subjective health status
  - Psychometric characteristics
  - Brevity and assessment burden
  - Feasibility of electronic administration
  - PMOP and SME consensus

What Will We Measure?

DOMAIN	MEASURE	# ITEMS
Subjective Health Status	Self-Rated Health (SRH)	1
Pain Intensity/Interference	Pain Intensity, Interference with Enjoyment, Interference with General Activity (PEG)	3
Self-Efficacy	Pain Self-Efficacy Questionnaire, 2 item (PSEQ-2)	2
Unhelpful Pain Thoughts (Pain Catastrophizing)	Concerns About Pain, 2 item (CAP-2)	2
Sleep	Sleep Quality Scale (SQS)	1
Depression	Patient Health Questionnaire, 2 item (PHQ-2)	2
Anxiety	Generalized Anxiety Disorder, 2 item (GAD-2)	2
General Well-Being	Well-Being Signs Tool (WBS)	3
	TOTAL	**16**
Perceived Treatment Impact	Patient Global Impression of Change (PGIC) Scale *FOLLOW UP ONLY*	1
	TOTAL	**17**

PMOP Pain Measure Set: The Items (1)

Self-Rated Health	
1.	In general, would you say that your health is: Excellent, Very good, Good, Fair, or Poor
PEG-3	
2.	What number best describes your pain on average in the past week, where 0 is no pain and 10 is the worst pain you can imagine?
3.	What number best describes how, during the past week, pain has interfered with your enjoyment of life where 0 is does not interfere and 10 is completely interferes?
4.	What number best describes how, during the past week, pain has interfered with your general activity where 0 is does not interfere and 10 is complete interferes?
Pain Self-Efficacy (PSEQ-2)	
Please rate how confident you are that you can do the following things, despite the pain. Answer choices: 0 is not at all confident, and 6 is completely confident	
5.	I can do some form of work, despite the pain (work includes housework and pain and unpaid work).
6.	I can live a normal lifestyle, despite the pain

PMOP Pain Measure Set: The Items (2)

Concerns about Pain (CAP-2)	
7.	In the past week, how often did you have the following thought when you were in pain: "My pain is more than I can manage." Answer choices: never, rarely, sometimes, often, always
8.	In the past week, how often did you keep thinking about how much it hurts? Answer choices: never, rarely, sometimes, often, always
Sleep Quality	
9.	During the past week, how would you rate your sleep quality overall? Answer choices: 0 = terrible, 1/2/3 = poor, 4/5/6 = fair, 7/89 = good, 10 = excellent
PHQ-2 and GAD-2	
Over the past two weeks, how often have you been bothered by any of the following problems? Answer choices: Not at all, several days, more than half the days, nearly every day	
10.	Feeling nervous, anxious or on edge
11.	Not being able to stop or control worrying
12.	Feeling down, depressed, or hopeless
13.	Little interest or pleasure in doing things

PMOP Pain Measure Set: The Items (3)

Well-Being Signs Tool
For these questions, please consider the most important things that you do, or wish to do, in your daily life. This might include having a job, spending time with family and friends, participating in leisure-time activities, or managing your health or finances, for example. *If you are not sure which response to choose, please make your best guess.* *Over the past three months, what percentage of the time have you been:* *Answer choices: 0 (none of the time) to 10 (all of the time)*
14. Fully satisfied with how things are going in these aspects of life
15. Regularly involved in all aspects of life that are important to you?
16. Functioning at your best in aspects of life that you do participate in?

PMOP Pain Measure Set: The Items (4)

FOLLOW UP ONLY

Patient Global Impression of Change (PGIC)

Since the start of (INTERVENTION), my overall pain is…

1 – Very much improved
2 – Much improved
3 – Minimally improved
4 – No Change
5 – Minimally worse
6 – Much worse
7 – Very much worse

When Will These Measures Be Collected?

- PMOP Pain Measure Set is administered for intake in pain clinic and can be repeated during and at the end of an episode of care, including:
    - New Consultations/Referrals
    - Re-evaluation at Follow-up

- For patients followed in the pain clinic, recommend reassessment at least once per year

- **Patient Global Impression of Change item only administered after a treatment intervention or episode of care

Who Will Collect Measures?

- Almost anyone on the Pain Management Team!

- Link can be generated and sent by a variety of PMT members including physicians, behavioral health providers, pharmacists, physical therapists, nurses, care coordinators, social workers, and more

How Will We Get This Information?

- Strong focus on minimizing the burden to both providers and patients *by using an electronic collection*

- BHL Touch:
  - Collects data directly from the Veteran with minimal time investment needed
  - Allows for data collection anywhere with easily accessible link (e.g., at a Veteran home, in the clinic waiting room)
  - Is already in use and available to all in VHA
  - All PMOP Pain Measure Set items are available

- PMOP will provide educational webinars and support in coming months for the use of BHL Touch

CMS 2024 Quality Conference

Resilient and Ready Together

Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Scott Lawrence, DC

CMS Quality Improvement and Innovation Group, Senior Advisor

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THANK YOU AND DISCUSSION

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