REIMAGINING THE CARE TEAM

Examples Of Telehealth-Enabled Team-Based Care Implementation: Pain Management

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Clinical Resource Hub (CRH) Basics

- Each VA network established a CRH as a response to the Mission Act of 2018
- A repository of virtual clinical and support staff
  - Clinical Pharmacist Practitioners (CPP), Primary Care Providers (PCPs), Psychologists, Psychiatrists, RNs, Social Workers, Physical Therapists, Surgeons, Specialty Care Providers, etc.
- CRHs support VA medical centers (VAMCs, 170) and their associated outpatient sites of care via a telehealth hub and spoke model, to improve Veteran access to care
  - Vacancies due to retirement or difficult to recruit areas
  - Extended leave coverage
  - Services are not available or easy to reach within VA or in the community
CRH TelePain Prescriber Model Data

1.0 FTE Pain CPP
0.25 FTE Behaviorist
0.2 FTE Pain X-Waiver Physician Champion

*NorthWest CRH Pain Team

Fiscal Year (FY) 2020
200 Veterans managed via telehealth

30 Veterans evaluated for Suboxone and 17 initiated

69 Veterans Reviewed
1 to 19% Opioid Reduction (n=9)
20 to 49% Opioid Reduction (n=15)
≥ 50% Opioid Reduction (N=38)
No Opioid Reduction (N=7)

*Service initiated Q1FY20 and provides primarily pain medication management, MOUD, and CBT-P. Lack of RN or Clinical Tech results in CPP spending ~25% time with Spoke and Hub care coordination activities. CPPs have prescriptive authority, under a scope of practice (VA version of collaborative practice agreement).
The reach of specialty pain care increased from 11.1% to 16.2% in the pre- to post-TelePain periods (OR: 1.37, 95% CI: 1.26-1.49).

**Stepped Care Model for Pain Management (SCM-PM)**

- **SCM-PM** is required by the 2016 Comprehensive Addiction and Recover Act (CARA) Legislation

- 58% of VAMCs lack fully implemented Step 1 Pain Care and 49% lacked Step 2 Pain Care (2019 Healthcare Analysis and Information Group Survey)

- CRH TelePain programs implemented in FY2022 to improve Veteran access to Step 2 pain care via an interdisciplinary virtual team approach

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**1. PRIMARY**
- Initial assessment and ongoing management of common pain conditions

**2. SECONDARY**
- Specialty pain care, typically consultative a la carte approach based on what services may be indicated for the patient

**3. TERTIARY**
- Advanced specialty pain care, typically provided through a dedicated interdisciplinary pain center or program

**FOUNDATION FOR ALL STEPS**
- Self care and management
- Support from family, caregivers, and other supportive community members
CRH Step 2 Care Pain Management Teams (PMT)

### Pain/Addiction Specialty Practitioner(s)
- Medical history
- Assessment
- Diagnosis (Pain, OUD)
- Treatment plan
- Suicide Risk
- Care needs
- High risk review

### Pain Pharmacist Practitioner
- Med management (prescriber)
- OUD treatment
- Opioid tapers
- OEND
- PDMP, UDS
- High risk review
- Suicide Risk

### Nurse Care Manager/ Nursing
- Patient education
- Ensure labs, appts, screenings
- Visit triage
- Care Coordination

### Rehabilitation Medicine
- Physical, Occupational Therapy
- Other Multimodal
- Patient instructions

### Behavioral Health
- Psychosocial assessment, plan
- Case management
- Psychotherapy
- Suicide Risk

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**12 CRHs Implementing PMT in FY22**
Ranging from 5 to 19 FTE/team
The Patient’s Journey Through the Clinical Resource Hub (CRH) TelePain Program

There are many reasons why a provider may choose to refer a patient to the CRH TelePain Program, including, but not limited to:
- The patient has complex chronic pain or requires specialty pain care
- The patient’s local facility lacks the capacity to deliver specific pain care services
- The provider feels unable to address the patient’s chronic pain
- The provider is concerned about the patient’s opioid use or suspects that the patient may have an opioid use disorder (OUD)

After the patient’s provider chooses to refer the patient to the CRH TelePain Program, they can choose to place an interfacility consult (IFC) directly to a CRH TelePain Program or indirectly via their local RCT.¹

When indicating reason for referral, consider the following scenarios, which would make the patient a good candidate for CRH TelePain:
- Does the patient need interdisciplinary pain care?
- Is opioid use an issue?

The CRH TelePain triage team at each hub should develop their own inclusion/exclusion criteria to accept or reject a referral. Criteria could include:
- Patient is willing to engage in biopsychosocial pain care
- If the provider is concerned with patient’s opioid use AND patient is willing to discuss opioid safety and steps moving forward

The goal of the intake session is for the patient to leave with a multimodal treatment plan. The CRH TelePain team could conduct initial intake in several different ways, depending on provider availability and staffing. Ideally, the patient would meet with all members of the CRH TelePain team (i.e., MD/medical, psych/psych, PT/thera., etc.) together during intake to bolster interdisciplinary care.

During intake, the CRH TelePain team should facilitate and produce a plan in collaboration with the patient.

Each patient’s plan should be tailored to their individual needs, as indicated during the intake session. We recommend starting with a minimum of one movement-based therapy and one psychological or behavioral therapy. Recommendations will depend on the availability of treatments at each site, but may include:
- Comprehensive pain medication management
- Psychotherapies (e.g., cognitive behavioral therapy, acceptance and commitment therapy, mindfulness meditation)
- Movement therapies (e.g., Tai Chi, qigong, adaptive yoga, exercise)
- Manipulation (e.g., massage, acupuncture, chiropractic) if available in person at spoke site

Once the IFC is accepted by the CRH TelePain triage team, the CRH TelePain scheduler (e.g., MSA) schedules the patient’s initial intake session.

TeleHealth Technician assists patient with obtaining VA/ICD or setting up for intake session, if needed

The referring provider and patient attend the initial TelePain intake session together, if possible.

Each CRH TelePain Program should determine their own criteria for transition planning of patients from the CRH TelePain Program back to spoke sites. Factors that might influence transition planning may include:
- Is the patient getting an opioid prescription from a spoke site provider at the time of warm hand-off?
- Does the patient feel satisfied with care and feel as though their pain is well-managed?
- How long has the patient been in the TelePain program? We expect that 6-12 months in a TelePain program will be sufficient for most patients.

Key personnel descriptions on the back of this page

a. For sample interfacility consults, please visit the Clinical Resource Hub SharePoint Site: Clinical Consults
b. VA’s Office of Veterans Access to Care (OVAC) Referral Coordination Team (RCT) will be the only IFC referral type available on Center

c. Acute suicide risk as indicated by the Columbia-Suicide Severity Rating Scale (C-SSRS) may also be a potential reason that spoke site providers/teams do not recommend a patient for CRH TelePain. It is generally recommended that these patients receive a comprehensive suicide risk assessment before entering specialty care. However, if comprehensive suicide assessment is unavailable at the spoke site, CRH TelePain teams can still consider accepting referrals from these patients if it is deemed that interdisciplinary pain care would help the patient.

Patient has complex chronic pain and scheduled appointment with spoke site provider

Patient accepts or modifies TelePain team’s treatment plan and starts attending treatment sessions

Patient transitions from the CRH TelePain Program back to the spoke site for care maintenance
Key Takeaways and Next Steps

- TelePain Care improves access to specialized pain care and MOUD
- Interprofessional TelePain Care Teams benefit underserved areas and may improve health equity
- A mixture of on-site care (labs, procedures, CIH therapies) and telehealth care (diagnosing, evaluation, medication management, behavioral therapy) is optimal for a multi-modal approach to specialized pain care
- CDC 2022 Guideline Update: *In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other context makes follow-up visits challenging), follow-up assessments that allow the clinician to communicate with and observe patient through telehealth modalities may be conducted.*
- VA CRH Interprofessional TelePain Teams are in their infancy. Anticipate this model will add to the evidence needed to support the delivery of comprehensive pain care via telehealth