IMPLEMENTATION OF PREVENTION AND CARE

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Stepped Care Model for Pain Management

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Disclosures

- Research funding: NIH, VA, Consortium of MS Centers
- No other funding relevant to this presentation
- Retired from VA in January 2016; continued funding from VA via an Inter-Personnel Act (IPA) Agreement with Yale
- My presentation was not vetted by VA and the content does not represent the official policy or position of the VA
VA-DoD Stepped Pain Care

RISK

Comorbidities

Tertiary, Interdisciplinary Pain Centers
- Advanced pain medicine diagnostics & interventions;
- CARF accredited pain rehabilitation

Secondary Consultation
- Multidisciplinary Pain Medicine Specialty Teams;
- Rehabilitation Medicine;
- Behavioral Pain Management; Mental Health/SUD Programs

Patient Aligned Care Team (PACT) in Primary Care
- Routine screening for presence & severity of pain;
- Assessment and management of common pain conditions;
- Support from MH-PC Integration; OEF/OIF, & Post-Deployment Teams;
- Expanded care management;
- Pharmacy Pain Care Clinics; Pain Schools; CAM integration

Patient/Family Education and Self Care
- Understand BPS model;
- Nutrition/weight mgmt, exercise/conditioning, & sufficient sleep;
- Mindfulness meditation/relaxation techniques;
- Engagement in meaningful activities; family & social support;
- Safe environment/surroundings
2014 Healthcare Analysis and Information Group (HAIG) Pain Management Survey

• Comprehensive survey regarding implementation of VA policy regarding pain management, including implementation of the Stepped Care Model of Pain Management
• Survey conducted in November 2014
• 100% facility response (n=141)
To what extent has your Facility/HCS implemented Step One (Primary Care) of pain care?

This question refers to the following specific components:

- Advanced training in the biopsychosocial model of pain management for all primary care providers,
- Primary care-based behavioral health providers, and PACT team members;
- Full implementation of integrated behavioral health in primary care;
- Dedicated resources (including personnel) to opioid monitoring and safety initiatives in primary care;
- Ongoing pain education/self-management programs available to all patients.

Full implementation, all components are fully implemented: 31%
Partial implementation, some components well established, others not yet fully implemented: 38%
Early implementation in progress, most components not yet fully implemented: 23%
In planning stage for implementation: 7%
Not at all: 1%
Top five most frequently available pain management services in Primary Care

• Medication management: 91%
• Patient Education Programs: 65%
• Psychological Consultation/Assessment: 49%
• Cognitive-Behavioral Therapy: 30%
• Supportive Psychotherapy: 30%
Integrated Primary Pain Care


**Integrated Pain Clinic**
- Core team:
  - Clinical Health Psychologist
  - Pain Medicine Specialist
  - Physiatrist
  - Physical Therapist
- Comprehensive interdisciplinary pain assessment
- Integrated pain management plan
- Feedback and recommendations to primary care team

**Opioid Reassessment Clinic**
- Core team:
  - Addiction Psychiatrist
  - Internist with addiction specialty
  - Mental Health Nurse Practitioner
  - Clinical Health Psychologist
- Interdisciplinary opioid management for high risk patients
- Increased intensity and frequency of monitoring
- Medication Assisted Treatment, as appropriate
- Co-management with primary care up to six months
To what extent has your Facility/HCS implemented Step Two (Consultation by Pain Medicine Specialty Team) of pain care?

This question refers to the following components:

- **Timely availability of the full range of specialists including pain medicine, rehabilitation medicine, pain psychology, and addiction psychiatry;**
- **Availability of short-term co-management by pain medicine specialty teams and addictionology/mental health for complex or high-risk patients;**
- **Inpatient acute pain and palliative care consultation.**

Full implementation, all components are fully implemented: 28%
Partial implementation, some components well established, others not yet fully implemented: 40%
Early implementation in progress, most components not yet fully implemented: 14%
In planning stage for implementation: 10%
Not at all: 8%
Specialty and Tertiary Care

Specialty Pain Clinics (from HAIG survey)
- Multidisciplinary Pain Centers: 17%
- Multidisciplinary Pain Clinics: 55%
- Pain Clinics: 28%

Specialty Pain Clinics (from Workforce and Workload Report):
- All VISNs and 124/141 (88% have a pain clinic)
- Capacity continues to grow by approximately 8% each year

Complementary and Integrative Health Approaches (from HAIG survey): 88%

Commission for the Accreditation of Rehabilitation Facilities (CARF):
- All 18 VISNs have at least one CARF accredited pain rehabilitation program
Characteristics of Pain Specialty Clinic Utilization
doi: 10.1093/pm/pnw206

• 122,240 of 2,025,765 patients with pain diagnoses (5.79%) attended pain specialty clinics.
• Pain clinic users had higher rates of:
  – Muscle spasms, neuralgia, neuritis, radiculitis, and fibromyalgia
  – Major depression and personality disorders.
• Veterans attending a pain clinic received more opioids than those not attending (10.4 vs 6.7 prescriptions, respectively)
• No substantial differences in other factors.
Comprehensive Addiction and Recovery Act (CARA)

- **Strengthening of Joint Working Group on Pain Management of the Department of Veterans Affairs and the Department of Defense**: This section proposes various ways that the VA and DOD joint Pain Management Working Group can improve collaboration.

- Pain management teams are to be established at each facility; in support of the Opioid Safety Initiative

- Mandates compliance with the Stepped Care Model

- **Pilot Program on Integration of Complementary and Integrative Health and Related Issues for Veterans and Family Members of Veterans**: This section establishes a pilot program within HHS to determine the feasibility of whether complementary and integrative health programs could add to the existing system of pain management and other health care services for veterans.
Thanks!

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Implementation of the National Pain Strategy Listening Session

Integrated Pain Care Efforts in the DoD

Chester ‘Trip’ Buckenmaier III, MD COL (ret), MC, USA Director, DVCIPM

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Up to 35% of wounded soldiers addicted to drugs

Medical officials estimate that 25% to 35% of about 19,000 ailing soldiers assigned to special wounded-care companies or battalions are dependent on drugs — particularly prescription narcotic pain relievers, according to an Army inspector general’s report made public last year.

The report also found that these formations, known as Warrior Transition Units — created after reports detailed poorly managed care at W Army Medical Center — have become costly way stations where ill, injured or wounded soldiers can wait more than a year for a medical discharge.

Some soldiers have become so ill from the delays in leaving the Army that doctors, nurses and other medical staff say they have been in their offices and threatened, or had their private cars damaged or tires flattened, the report says.

“I’m very concerned about folks and their personal safety,” says Army Col. Darryl Williams, commander of Warrior Transition Units, of those allegations. “I’m going after that really, really hard.”

Williams, however, called into question findings about high rates of drug addiction and dependency, saying these percentages were base estimates made by case managers and nurses working with troops, and are not statistically valid.

Most case managers and nurses interviewed by investigators said 25% to 35% of soldiers in warrior units “are over-medicated, abusing pain medication and have access to illegal drugs.”

They said most soldiers arrive in the units with narcotics provided by battlefield doctors or military hospitals. They also said a few soldiers who come out of pocket and may be raising legal and illegal drugs.


Troops reportedly popping more painkillers

WASHINGTON — Narcotic pain-relief prescriptions for injured U.S. troops have jumped from 30,000 a month to 50,000 since the Iraq War began, raising concerns about the drugs’ potential abuse and addiction, says a leading Army pain expert.

The sharp rise in outpatient prescriptions paid for by the government suggests doctors rely too heavily on narcotics, says Army Col. Chester “Trip” Buckenmaier III, of Walter Reed Army Medical Center in Washington.

By 2005, two years into the war, narcotic painkillers were the most abused drug in the military, according to a survey that year of 10,140 servicemembers.

Among Army soldiers, 4% surveyed in 2005 admitted abusing prescription narcotics in the previous 30 days, with 10% doing so in the last 12 months. Researchers said the results may have been skewed by respondents mistakenly referring to legal use of pain medication. A 2008 survey has not been released.

“Your don’t have to throw narcotics at people to start managing pain,” says Buckenmaier, who pioneered technology that eases the pain of wounded soldiers.
VA and DoD Pain Collaboration:

DVPRS: New Pain Rating Scale

JPEP: Joint Pain Curriculum

Joint Acupuncture Training Project

Pain and Opioid Prescribing Safety Videos

Video Tele-Mentoring

Stepped Care Model

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Defense and Veterans Pain Rating Scale (DVPRS)

• **Goal:** Recalibrate Standardized Pain Assessment
  Move from a single focus on pain intensity to an assessment (and discussion) on function and bio-psychosocial impact of pain

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**Defense and Veterans Pain Rating Scale**

- **Mild (Green)**
  - 0: No pain
  - 1: Hardly notices pain
  - 2: Notice pain, does not interfere with activities
  - 3: Sometimes distracts me

- **Moderate (Yellow)**
  - 4: Distracts me, can do usual activities
  - 5: Interrupts some activities
  - 6: Hard to ignore, avoid usual activities

- **Severe (Red)**
  - 7: Focus of attention, prevents doing daily activities
  - 8: Awful, hard to do anything
  - 9: Can't bear the pain, unable to do anything
  - 10: As bad as it could be, nothing else matters

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**DoD/VA Pain Supplemental Questions**

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITY:**
   - 0: Does not interfere
   - 1: Completely interferes
   - 2: Doesn't interfere
   - 3: Somewhat interferes
   - 4: Moderately interferes
   - 5: Substantially interferes
   - 6:完全ly interferes
   - 7: Extremely interferes
   - 8: Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP:**
   - 0: Does not interfere
   - 1: Completely interferes
   - 2: Doesn't interfere
   - 3: Somewhat interferes
   - 4: Moderately interferes
   - 5: Substantially interferes
   - 6: Completely interferes
   - 7: Extremely interferes
   - 8: Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD:**
   - 0: Does not affect
   - 1: Completely affects
   - 2: Doesn't affect
   - 3: Somewhat affects
   - 4: Moderately affects
   - 5: Substantially affects
   - 6: Completely affects
   - 7: Extremely affects
   - 8: Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS:**
   - 0: Does not contribute
   - 1: Contributed a little
   - 2: Contributed a lot
   - 3: Contributed much
   - 4: Contributed a great deal

| 1: Understanding Pain Introduction                                                                 |
| 2-1: Pain and Societal Impacts of Pain and Understanding Pain                                      |
| 2-2: Pain Terminology, Taxonomy, and Physiology                                                    |
| 2-3: DoD/VA Pain Care Delivery Systems, Assessment of Pain                                       |
| 3-1: Assessment of Pain                                                                            |
| 3-2: Assessment Tools                                                                             |
| 4-1: Acetaminophen, NSAIDS and Opioid Basics                                                       |
| 4-2: Anti-epileptics,                                                                              |
| 5-1: Chronic Opioid Therapy (COT) Risk Evaluation and Mitigation                                  |
| 5-2: Chronic Opioid Therapy Dose Reduction and Discontinuation                                     |
| 6-1: Behavioral Management of Chronic Pain – Treatment LMG                                        |
| 7-1: Physical Based Therapeutic Approaches to Pain MGT                                              |
| 8-1: Integrative Pain Medicine                                                                     |
| 9-1: Pain Medicine Specialty Care                                                                  |
| 10-3: Transitional and Chronic Low Back Pain                                                       |
| 11-1: Shoulder Pain                                                                               |
| 11-2: Hip Pain                                                                                    |
| 11-3: Knee Pain                                                                                   |
| 12-1: Myofascial, Connective Tissue, and Fibromyalgia Pain                                         |
| 13-1: Central Neuropathic Pain                                                                    |
| 13-2: Peripheral Neuropathic Pain                                                                  |
| 14-1: Headache Pain                                                                               |
| 15-1: Visceral Pain                                                                               |
| 16-1: Psychological and Psychiatric Conditions Related to Pain                                     |
| 16-2: Sleep and Pain                                                                              |
| 16-3: Substance Use Disorder                                                                      |
| 17-1: Geriatric Pain                                                                              |
| 17-2: Palliative and Oncologic Pain                                                                |
| 18-1: Women Pain Related Issues                                                                   |
| 18-2: Opioids and Pregnancy                                                                       |
| 18-3: Pelvic Pain and Women                                                                        |
Pain Education Videos

- Understanding Pain
- Medication Take Back Pain Assessment
- Chronification of Pain
- Essentials of Good Pain Care
- Safe Opioid Prescribing and Tapering
- Pain Outcomes (PASTOR)
- Stepped Pain Care Model
Pain Exam Videos
-included in JPEP curriculum download

- Exam: Back Pain
- Exam: Shoulder Pain
- Exam: Neck Pain
- Exam: Knee Pain
- Exam: Hip Pain
INTERDISCIPLINARY PAIN MANAGEMENT CENTER (IPMC): Serves as hub for pain management synchronization for designated MTFs within RMC. Provides pain management specialty referral/consultation services, patient and provider education, and coordination of research initiatives.

Primary Care Pain Champion - Designated member of PCMH team responsible to provide enhanced pain management in the medical home. Pain management education, training, and practice standards; linked to a designated IPMC for support.

ECHO TELEMENTORING: Weekly CME awarding educational activity hosted by IPMCs for PCPC and WTC primary care providers.

IPMC
- Ft Benning
- Ft Campbell
- Ft Carson
- Ft Drum
- Ft Eustis
- Ft Huachuca
- Ft Irwin
- Ft Jackson
- Ft Lee
- Ft Knox
- Ft Leonard Wood
- Ft Meade
- Ft Polk
- Ft Riley
- Ft Richardson
- Ft Sill
- Ft Stewart
- Ft Wainwright
- Ft Leavenworth
- West Point

PCPC in PCMH
- Schofield Barracks
- Grafenwoehr
- Katterbach
- Vicenza
- Vilceck
- Wiesbaden

ECHO
- Ft Gordon
- Ft Bragg
- TAMC
- LRMC
- WRMC
Stepped Care Model of Pain Management

Figure 1: The VA's stepped care model of pain management.
Comprehensive Pain Management

- Evidence-Based Complementary and Alternative Therapeutic Modes
  - Acupuncture
  - Biofeedback
  - Yoga
  - Meditation

- Standardizes Pain Management Services at echelons of care across our Medical Treatment Facilities: Team-Based

- Provides optimal quality of life for Soldiers and patients with acute and chronic pain
Teaching Our Own
Advancing Evidence-Based Complementary & Integrative Practices and Consensus Guidelines

Pain Medicine

Volume

Are Active Self-Care Complementary and for Management of Chronic Pain? A Review of the Literature and Recommendations

The Official Journal of the American Academy of Pain Medicine

The official journal of the American College of Physicians

Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians

Clinical Guideline

May 2017

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May 2017

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Noninvasive, Nonpharmacological Treatment for Chronic Pain: Planning a review of the evidence

Elisabeth Kato, MD, MRP
May 11, 2017
AHRQ Mission

AHRQ Works: Building Bridges Between Research and Practice

BUILDING BRIDGES BETWEEN RESEARCH AND PRACTICE
AHRQ EPC Program

- Established in 1997
- Supports 13 academic/research organizations
- Provides independent and unbiased synthesis of evidence
- Partners with external organizations to promote evidence-based decisions
Objective 1: Characterize the benefits and costs of current prevention and treatment approaches

- Incorporate the most effective and cost-efficient treatments into practice guidelines and other best practices efforts.

- Systematic review of the evidence on Noninvasive, Nonpharmacologic Treatments for Chronic Pain (AHRQ, CDC, ASPE)
EPC Program Systematic Review Process

**Topic Refinement**
- Refine questions (population, interventions, comparators, outcomes) based on input from end users of review
- Post draft Key Questions for public comment via Web

**Draft Report**
- Develop protocol based on EPC Program Methods Guide and technical expert input
- Conduct review
- Post draft report public comment via Web and submit to peer review

**Final Report**
- Revise draft report based on public and peer review comments
- Post final report
- Publish manuscripts based on report

You are here
Population: Five chronic pain conditions

- Back pain
- Neck pain
- Osteoarthritis
- Fibromyalgia
- Tension headache
Interventions

1. **Exercise** (e.g. PT, supervised exercise, home exercise, group exercise)
2. **Psychological therapies** (e.g., cognitive behavioral therapy, biofeedback)
3. **Physical modalities** (including traction, ultrasound, TENS, etc.)
4. **Manual therapies or manipulation**
5. **Mindfulness/meditation practices**
6. **Mind-body practices** (e.g. Yoga, Tai Chi, Qigong)
7. **Acupuncture**
8. **Functional restoration training**
9. **Multidisciplinary/interdisciplinary rehabilitation**
Comparators

A. Control
  • sham treatment
  • no treatment
  • waitlist
  • attention control
  • usual care

B. Pharmacological therapy
  • non-opioid
  • opioid

C. Exercise (biofeedback for headache)
Outcomes

Primary efficacy outcomes
- Function/disability
- Pain

Harms and adverse effects

Secondary outcomes
- Psychological distress
- Quality of life
- Opioid use
- Sleep quality
- Health care utilization
Modifiers

Do estimates of benefits and harms differ by

- Age
- Sex
- Comorbidities (e.g., emotional or mood disorders)?
Analytic framework

Adults with low back pain, neck pain, osteoarthritis, fibromyalgia, headache

**Interventions**

Primary Outcomes
- Function/disability
- Pain

Secondary Outcomes
- Psychological distress
- Quality of life
- Opioid use
- Sleep quality
- Health care utilization

Intervention-related harms

Age, sex, co-morbidities
Next steps

Protocol now available at:

September 2017: Draft Report posted for comment

December 2017: Final Report posted

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Questions or feedback?