

IMPLEMENTATION OF PREVENTION AND CARE

Dr. Richard Ricciardi, Agency for Healthcare Research and Quality

Dr. Robert Kerns, Yale University

Dr. Chester “Trip” Buckenmaier, Department of Defense

Dr. Elisabeth Kato, Agency for Healthcare Research and Quality

Stepped Care Model for Pain Management

Robert D. Kerns, Ph.D.

Yale University

VA Connecticut Healthcare System

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

STEP
3

Treatment
Refractory

Secondary Consultation

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

STEP
2

Complexity

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

STEP
1

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

Dorflinger, L.M., Ruser, C., Sellinger, J., Edens, E.L. Kerns, R.D., & Becker, W.C. (2014). Integrating interdisciplinary pain management into the primary care setting: An early phase implementation study. *Pain Medicine, 15*, 2046-2054.

Integrated Pain Clinic

- Core team:
 - Clinical Health Psychologist
 - Pain Medicine Specialist
 - Psychiatrist
 - 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

Arout, C. et al. Pain Medicine 2017; 0: 1–9

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.

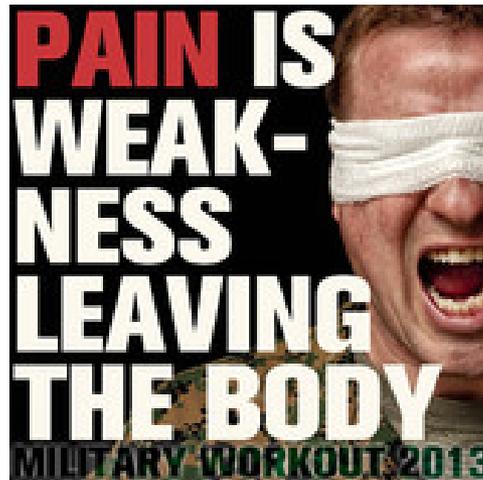
Thanks!

Robert.kerns@yale.edu

Robert.kerns@va.gov

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

Up to 35% of wounded soldiers addicted to drugs

Updated 1/28/2011 6:36 PM | Comments [46](#) | Recommend [3](#)

E-mail | Save | Print

By Gregg Zoroya, USA TODAY

Medical officials estimate that 25% to 35% of about 10,000 ailing soldiers assigned to special wounded-care companies or battalions are or dependent on drugs — particularly prescription narcotic pain relievers, according to an Army inspector general's report made public Tue

The report also found that these formations known as Warrior Transition Units — created after reports detailed poorly managed care at [W: Army Hospital](#)— have become costly way stations where ill, injured or wounded soldiers can wait more than a year for a medical discharg

Some soldiers have become so irate about 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.

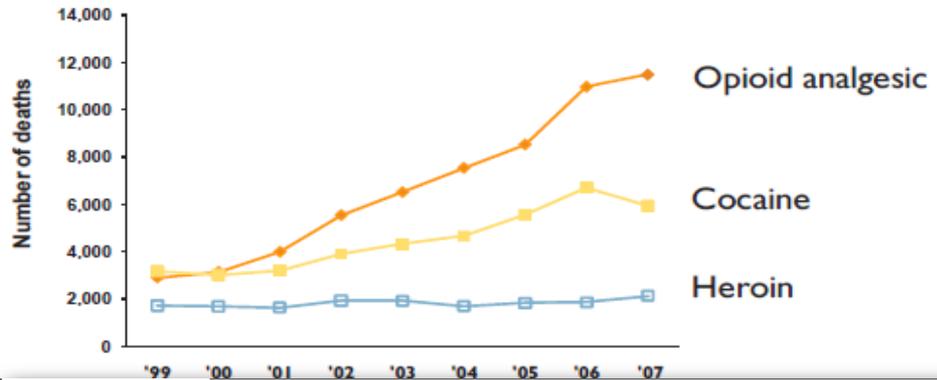
Most case managers and nurses interviewed by investigators said 25% to 35% of soldiers in warrior units "are over-medicated, abuse pre and have access to illegal drugs."

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

About three out of four soldiers in the warrior units either leave the Army or active duty, the report says

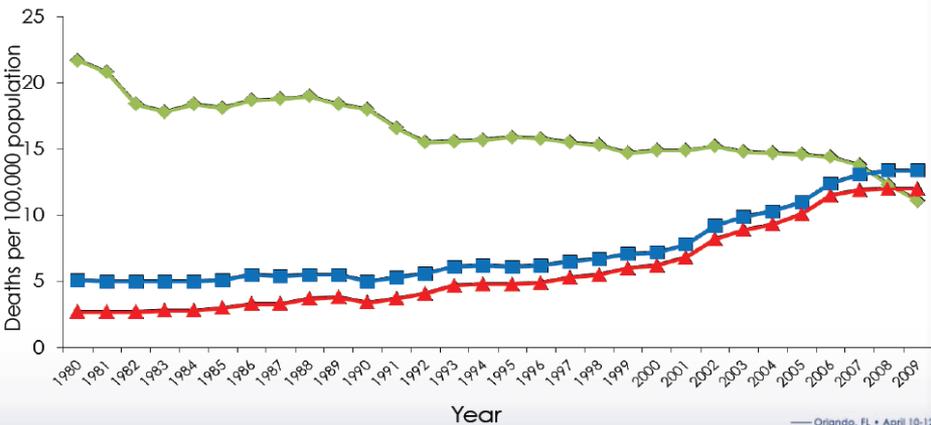
In 2007, the number of deaths involving opioid analgesics was 1.93 times the number involving cocaine and 5.38 times the number involving heroin.

Figure 2: Unintentional drug overdose deaths by major type of drug, United States, 1999-2007



Motor Vehicle Traffic, Poisoning, and Drug Overdose Death Rates: United States, 1980-2009

◆ Motor Vehicle Traffic
 ■ Poisoning
 ▲ Drug Poisoning



Troops reportedly popping more painkillers

Posted 5h 8m ago | Comments [20](#) | Recommend [2](#)

E-mail | Save | Print | Reprints & Permissions | [RSS](#)

By Gregg Zoroya, USA TODAY

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 16,146 servicemembers.

MORE: Prescription drug abuse hits Mo. Army unit hard

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.

FIND MORE STORIES IN: [Washington](#) | [Virginia](#) | [Iraq](#) | [Pentagon](#) | [Missouri](#) | [Marine Corps](#) | [Walter Reed Army Medical Center](#) | [Department of Veterans Affairs](#) | [Fort Leonard Wood](#) | [Afghanistan-era](#) | [Warrior Transition Units](#)

"You don't have to throw narcotics at people to start managing pain," says Buckenmaier, who pioneered technology that eases the pain of wounded soldiers.

[Mix it](#)
 Other ways to share
[Yahoo! Buzz](#)
[Digg](#)
[Newsvine](#)
[Reddit](#)
[Facebook](#)
 What's this?

VA and DoD Pain Collaboration:



DVPRS: New Pain Rating Scale



Pain and Opioid Prescribing Safety Videos



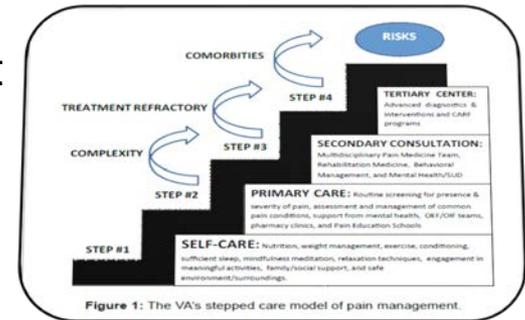
JPEP: Joint Pain Curriculum



Joint Acupuncture Training Project



Video Tele-Mentoring



Stepped Care Model

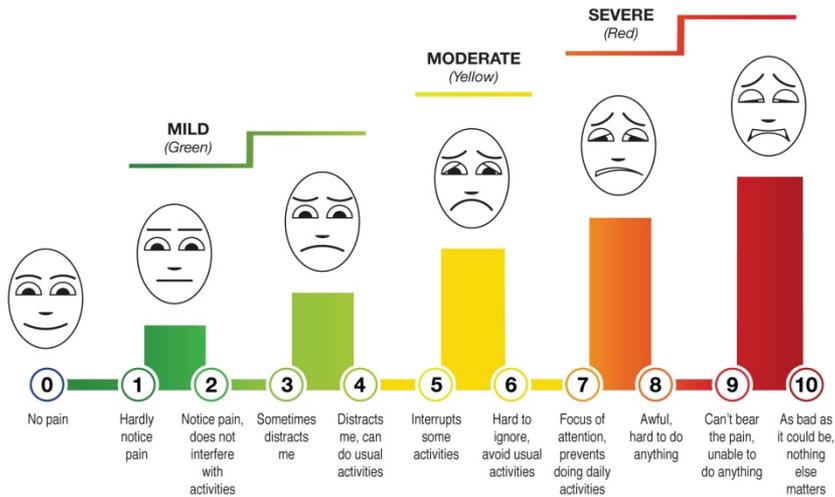


Defense and Veterans Pain Rating Scale (DVPRS)

- 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

Defense and Veterans Pain Rating Scale



v 2.0

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 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**:

0 1 2 3 4 5 6 7 8 9 10
Does not affect Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**:

0 1 2 3 4 5 6 7 8 9 10
Does not contribute Contributes a great deal

*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. *Ann Acad Med Singapore* 23(2): 129-138, 1994.

v 2.0

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,

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

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

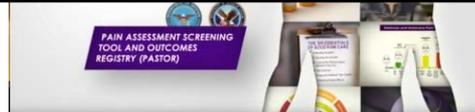
18-2: Opioids and Pregnancy

18-3: Pelvic Pain and Women

Pain Education Videos



Safe Opioid Prescribing and Tapering



Pain Outcomes (PASTOR)¹⁹



Stepped Pain Care Model

Pain Exam Videos

-included in JPEP curriculum download



Exam: Back Pain



Exam: Shoulder Pain



Exam: Neck Pain



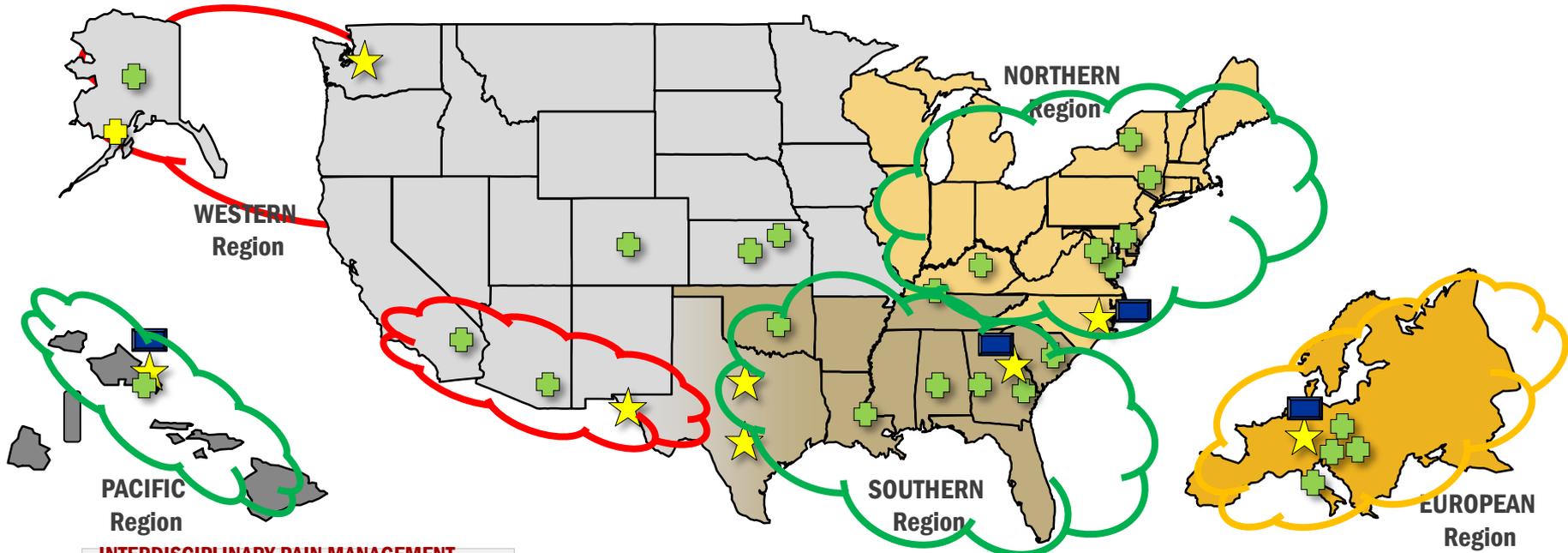
Exam: Knee Pain



Exam: Hip Pain



ARMY | Pain Management ECHO Network



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 Gordon
- Ft Hood
- Ft Bliss
- Ft Lewis
- Ft Sam Houston
- Landstuhl
- Tripler
- Ft Bragg



PCPC in PCMH

- 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



ECHO

- Schofield Barracks
- Grafenwoehr
- Katterbach
- Vicenza
- Vilceck
- Wiesbaden
- Ft Gordon
- Ft Bragg
- TAMC
- LRMC
- WRMC

Stepped Care Model of Pain Management

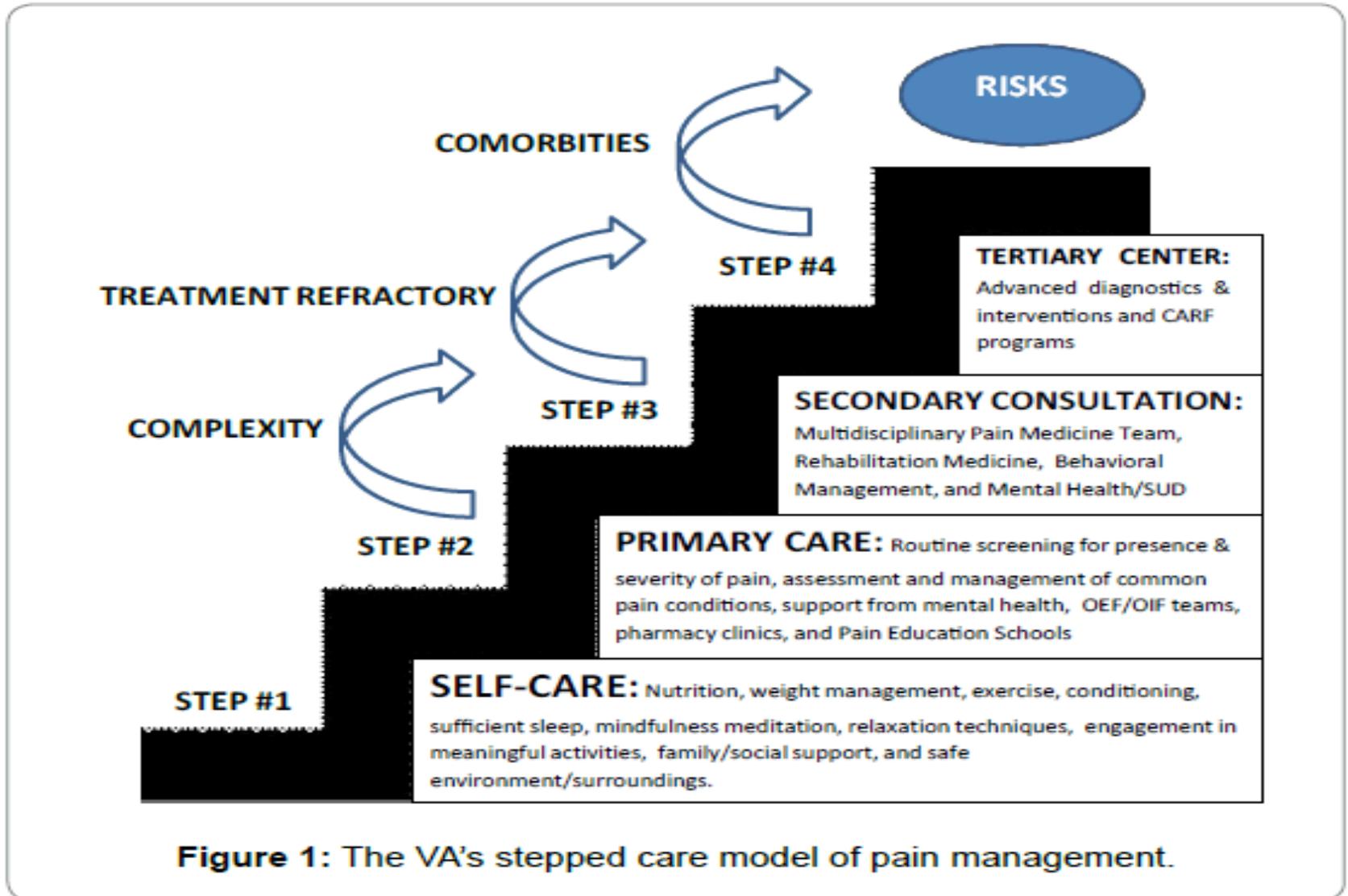


Figure 1: The VA's stepped care model of pain management.

Comprehensive Pain Management

Interdisciplinary

➤ 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

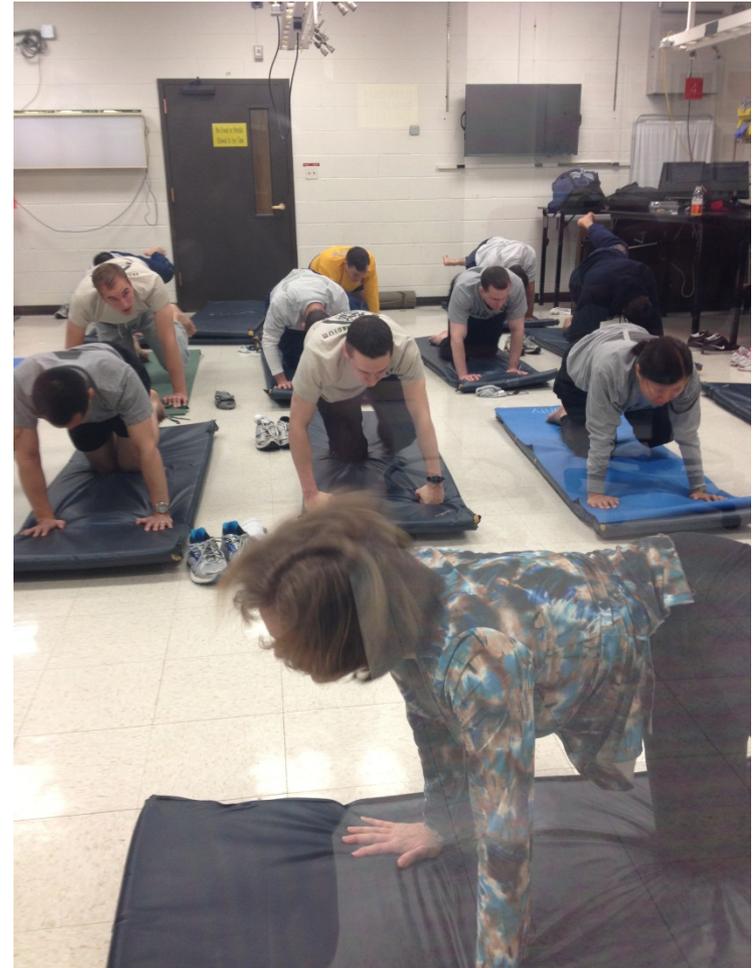
➤ Provides optimal quality of life for Soldiers and patients with acute and chronic pain

Holistic



Multimodal

Teaching Our Own





Advancing Evidence-Based Complementary & Integrative Practices and Consensus Guidelines



ACP American College of Physicians™
Leading Internal Medicine, Improving Lives

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

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; and Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians*

CLINICAL GUIDELINE

Description: The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations on noninvasive treatment of low back pain.

Methods: Using the ACP grading system, the committee based these recommendations on a systematic review of randomized, controlled trials and systematic reviews published through April 2015 on noninvasive pharmacologic and nonpharmacologic treatments for low back pain. Updated searches were performed through November 2016. Clinical outcomes evaluated included specific and overall function, improvement in health-related quality of life, reduction in work disability and return to work, global improvement, number of back pain episodes or time between episodes, patient satisfaction, and adverse effects.

Target Audience and Patient Population: The target audience for this guideline includes all clinicians, and the target patient population includes adults with acute, subacute, or chronic low back pain.

Recommendation 1: Given that most patients with acute or subacute low back pain improve over time regardless of treatment, clinicians and patients should select nonpharmacologic treatment with superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence), if pharmacologic treatment is desired, clinicians and patients should select nonsteroidal anti-inflammatory drugs or skeletal muscle relaxants (moderate-quality evidence). (Grade: strong recommendation)

Recommendation 2: For patients with chronic low back pain, treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence). (Grade: strong recommendation)

Recommendation 3: In patients with chronic low back pain who have had an inadequate response to nonpharmacologic therapy, clinicians and patients should consider nonpharmacologic treatment with nonsteroidal anti-inflammatory drugs as first-line therapy, or tramadol or duloxetine as second-line therapy. Clinicians should only consider opioids as an option in patients who have failed the aforementioned treatments and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients. (Grade: weak recommendation, moderate-quality evidence)

Ann Intern Med. doi:10.7326/M16-2367
For author affiliations, see end of text.
This article was published at Annals.org on 14 February 2017.

See also:
Related articles 1
Editorial comment 2
Summary for Patients 3
Web-Only
CME quiz

* This paper, written by Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; and Mary Ann Forciea, MD, was developed for the Clinical Guidelines Committee of the American College of Physicians. Individuals who served on the Clinical Guidelines Committee from initiation of the project until its approval were Mary Ann Forciea, MD† (Chair); Thomas D. Denber, MD, PhD† (Immediate Past Chair); Michael J. Barry, MD†; Cynthia Boyd,



U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality

Advancing Excellence in Health Care • www.ahrq.gov

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





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





The National Pain Strategy

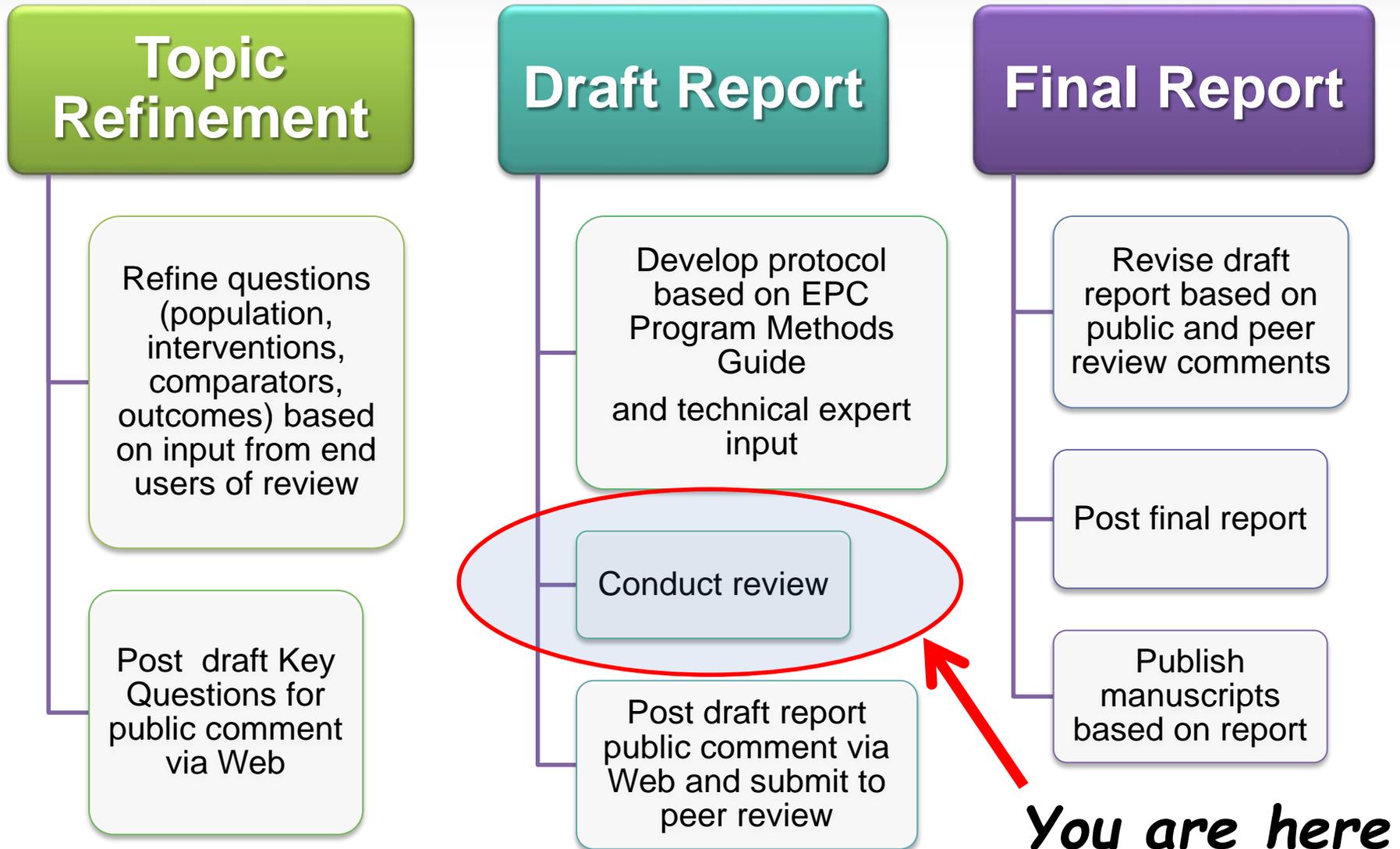
Action Plan Area: Prevention and Care

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



Population: Five chronic pain conditions



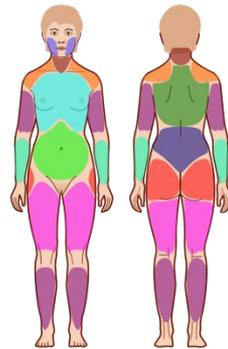
Back pain



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

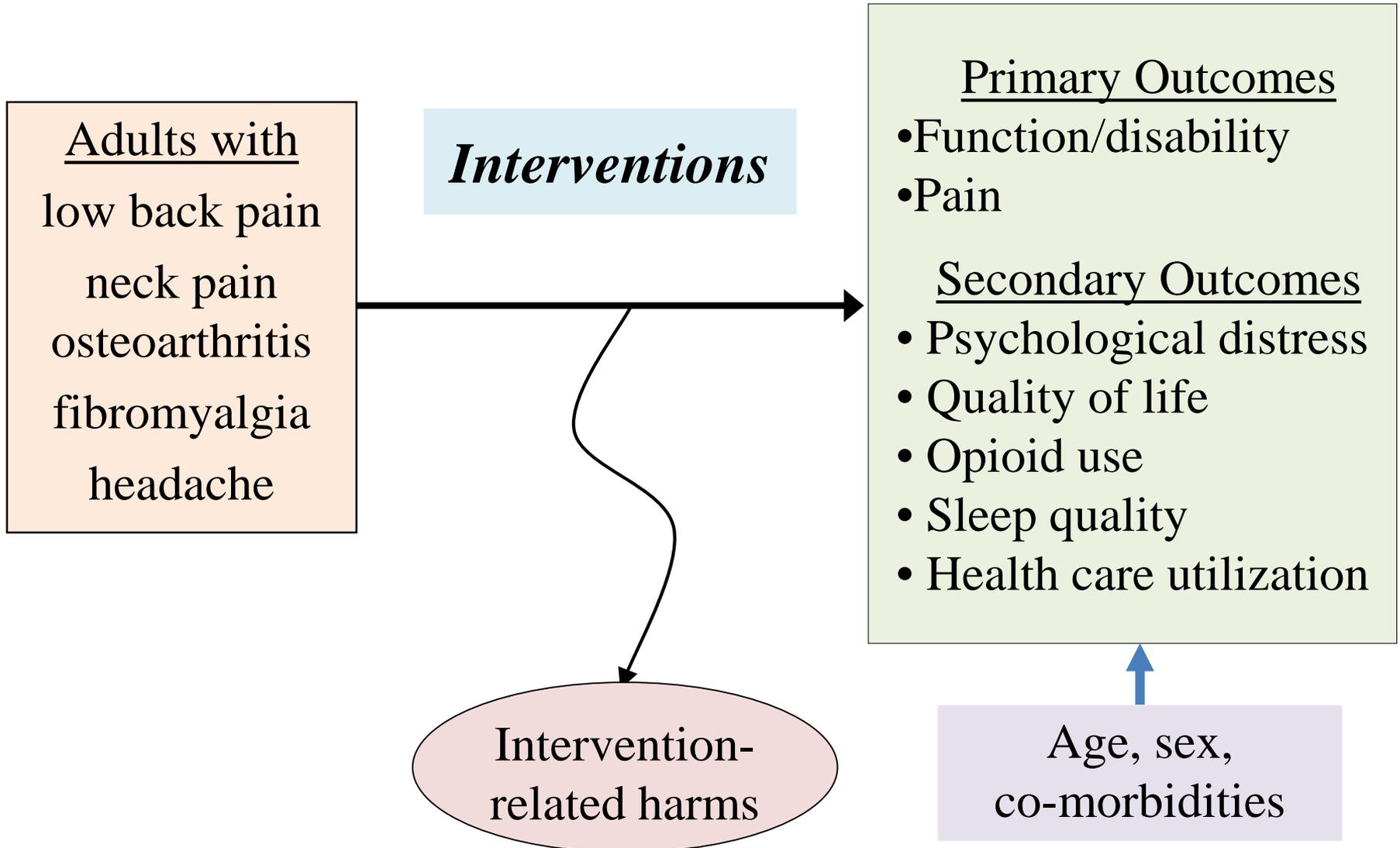


Modifiers

Do estimates of benefits and harms differ by

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

Analytic framework





Next steps

Protocol now available at:

<https://effectivehealthcare.ahrq.gov/ehc/products/661/2470/nonpharma-treatment-pain-protocol-170426.pdf>

September 2017: Draft Report posted for comment

December 2017: Final Report posted

For more information contact:

Elisabeth Kato: elisabeth.kato@ahrq.hhs.gov

Richard Ricciardi: richard.ricciardi@ahrq.hhs.gov

or signup for email updates at **effectivehealthcare.ahrq.gov**



Questions or feedback?