

Transforming Post-Deployment Care

Transforming Pain Care

Transforming Health Care

Researchers as Team Mates

Stephen C Hunt MD MPH

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HSR&D CyberSeminar

March 5, 2013

Poll Question #1

- What is your primary role in VA? (128 character limit for the question)
 - student, trainee, or fellow (60 character limit for each answer choice)
 - clinician
 - researcher
 - manager or policy-maker
 - Other

Up to five answer options. Can be “select one” or “select all that apply”

Poll Question #1

- Do you have a role in PACT? (128 character limit for the question)
 - Teamlet member (60 character limit for each answer choice)
 - Expanded PACT member
 - manager or policy-maker
 - Other

Up to five answer options. Can be “select one” or “select all that apply”

HSR&D

Health Services Research and Development

...research that underscores all aspects of VA healthcare: patient care, care delivery, health outcomes, cost, and quality as well as critical issues for Veterans returning home from Iraq and Afghanistan with conditions that may require care over their lifetimes.

Within VA HSR&D, researchers focus on identifying and evaluating innovative strategies that lead to accessible, high quality, cost-effective care for Veterans and the nation

Transforming Post-Deployment Care



We knew that the health risks of combat were many...



...and that the health impacts were prevalent...

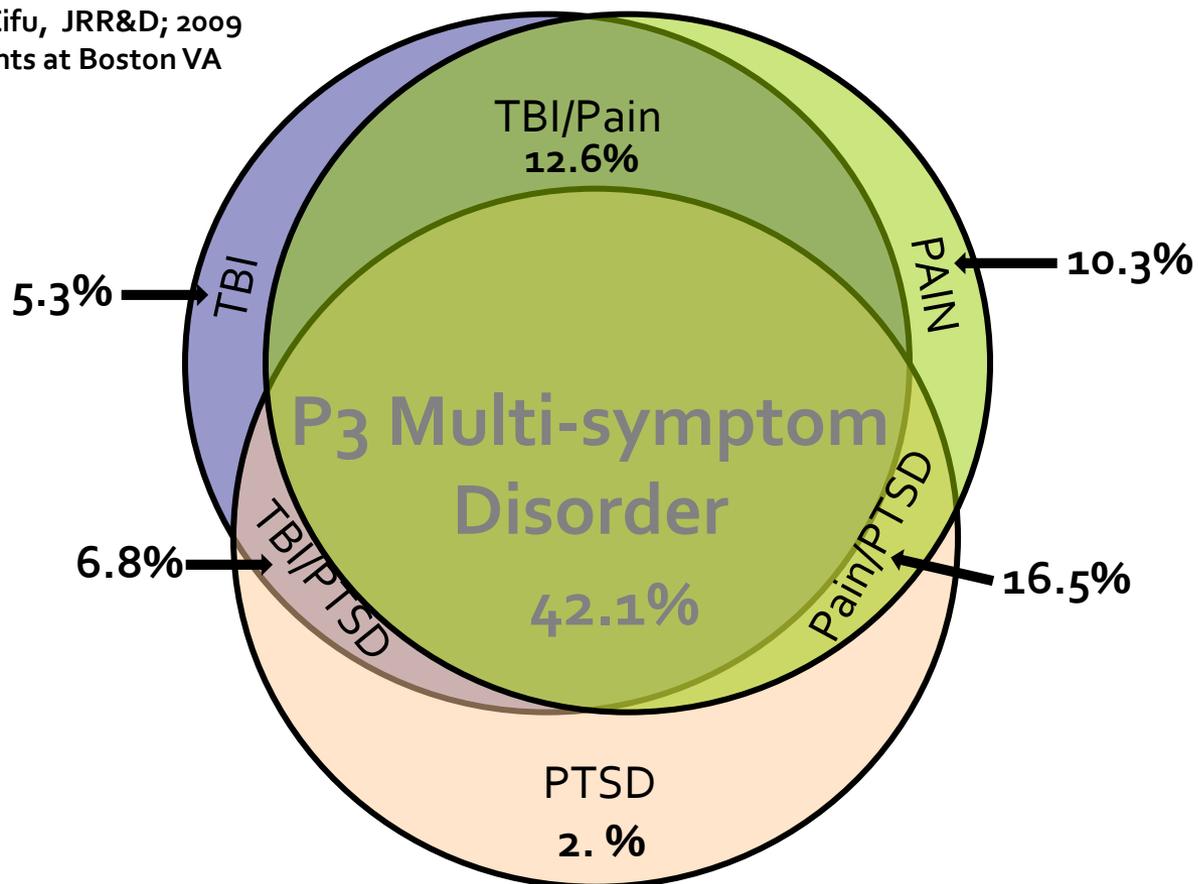
1,557,026 of the 2.5 million deployed, are separated and eligible for VA

56 % (866,182) have been seen in VA between FY02 and October 1, 2012

- Musculoskeletal 57.5%**
- Mental disorders 53.6%**
- Symptoms/signs 52.8%**
- Nervous system (hearing) 45.8%**
- GI (dental) 36.2%**
- Endocrine/Nutrition 33.3%**
- Injury/Poisoning 29.0%**
- Respiratory 26.5%**

...and complex...

Lew, Otis, Tun, Kerns, Clark, & Cifu, JRR&D; 2009
Sample = 340 OEF/OIF outpatients at Boston VA



Overall prevalence:
Pain 81.5%
TBI 68.2%
PTSD 66.8%

Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: Polytrauma clinical triad

Henry L. Lew, MD, PhD;^{1-3*} John D. Otis, PhD;⁴ Carlos Tun, MD;¹⁻² Robert D. Kerns, PhD;⁵ Michael E. Clark, PhD;⁶ David X. Cifu, MD⁷

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Abstract—This study examines the prevalence and coprevalence with which returning Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans were reporting symptoms consistent with chronic pain, posttraumatic stress disorder (PTSD), and persistent postconcussive symptoms (PPCS). The medical records of 340 OIF/OEF veterans seen at a Department of Veterans Affairs Polytrauma Network Site were comprehensively reviewed. Analyses indicated a high prevalence of all three conditions in this population, with chronic pain, PTSD, and PPCS present in 81.5%, 68.2%, and 66.8%, respectively. Only 12 of the veterans (3.5%) had no chronic pain, PTSD, or PPCS. The frequency at which these three conditions were present in isolation (10.3%, 2.9%, and 5.3%, respectively) was significantly lower than the frequency at which they were present in combination with one another, with 42.1% of the sample being diagnosed with all three conditions simultaneously. The most common chronic pain locations were the back (58%) and head (55%). These results underscore the complexity of the presenting complaints in OIF/OEF veterans and support the importance of a multidisciplinary team approach to assessment and treatment.

Key words: brain injuries, explosions, Iraq, military personnel, pain, posttraumatic stress disorder, rehabilitation, veterans, war, wounds and injuries.

INTRODUCTION

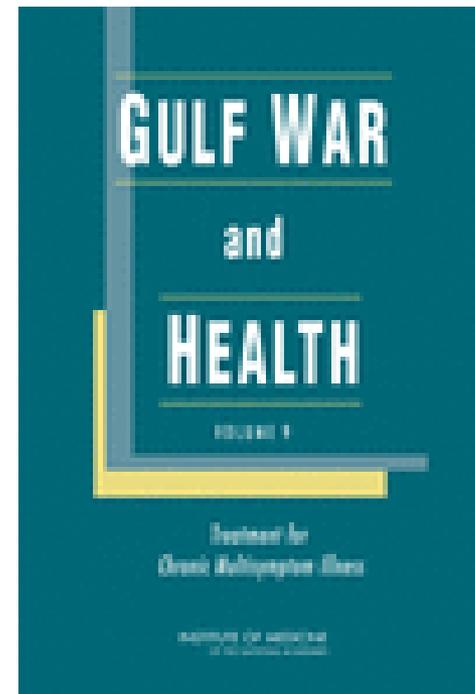
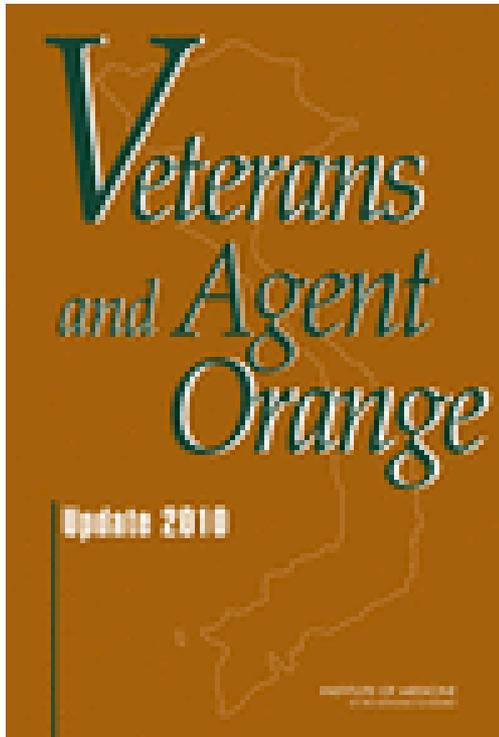
Advances in battlefield medicine and protective armor for the torso have led to a higher percentage of soldiers surviving physical injuries that would have been fatal in prior conflicts [1-3]. Many of these injuries sustained from the current conflict in the Middle East have been described as "polytrauma," defined by the Veterans Health Administration (VHA) as "two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability." While the concomitant injuries accompanying traumatic brain injury (TBI) may be manifold, including fractures, amputations, burns, spinal cord injury, eye injury, and auditory trauma.

Abbreviations: OEF = Operation Enduring Freedom, OIF = Operation Iraqi Freedom, PNS = Polytrauma Network Site, PPCS = persistent postconcussive symptoms, PRC = Polytrauma Rehabilitation Center, PTSD = posttraumatic stress disorder, TBI = traumatic brain injury, VA = Department of Veterans Affairs, VHA = Veterans Health Administration.

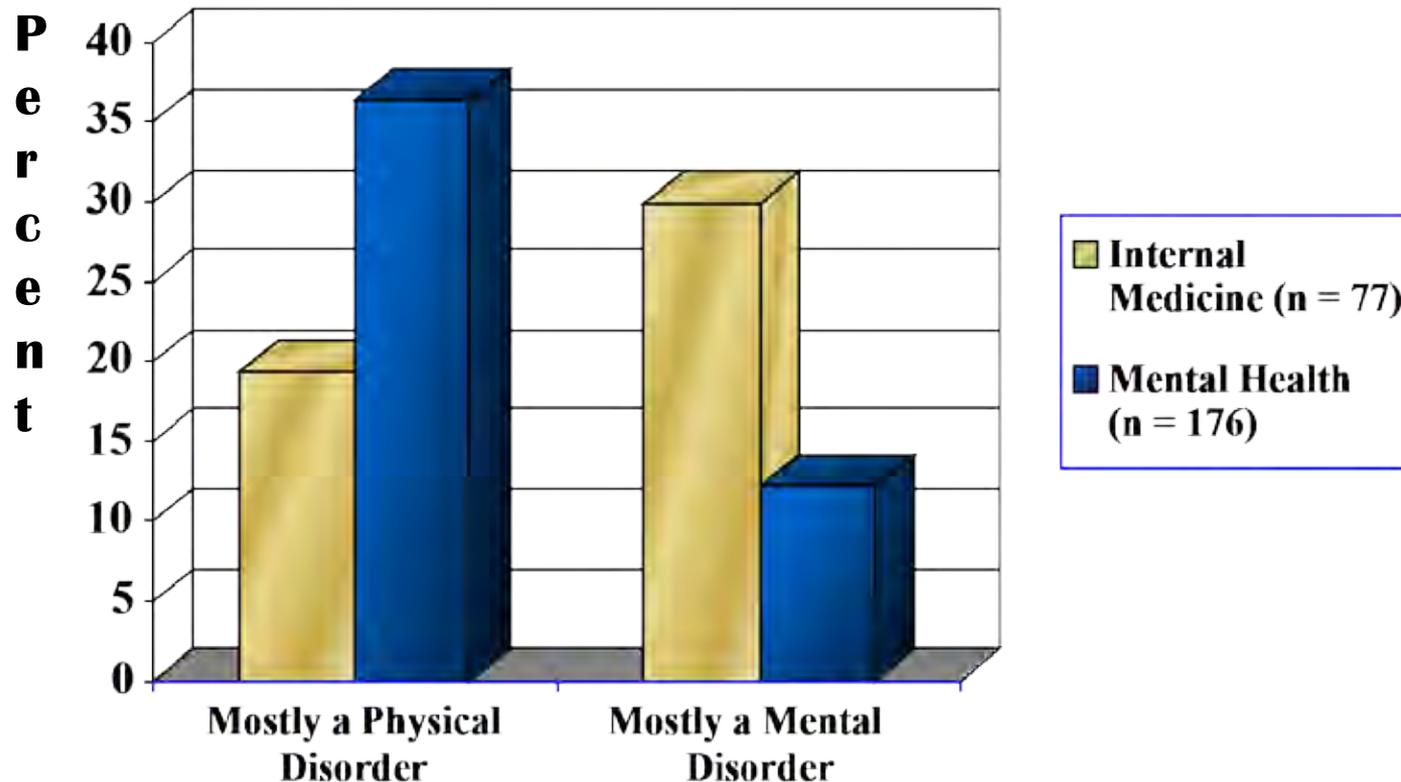
*Address all correspondence to Henry L. Lew, MD, PhD; Chief, PM&R Service, VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA 02130; 617-323-7700; fax: 857-203-5680. Email: henry.lew@va.gov

DOI:10.1682/JRRD.2009.01.0006

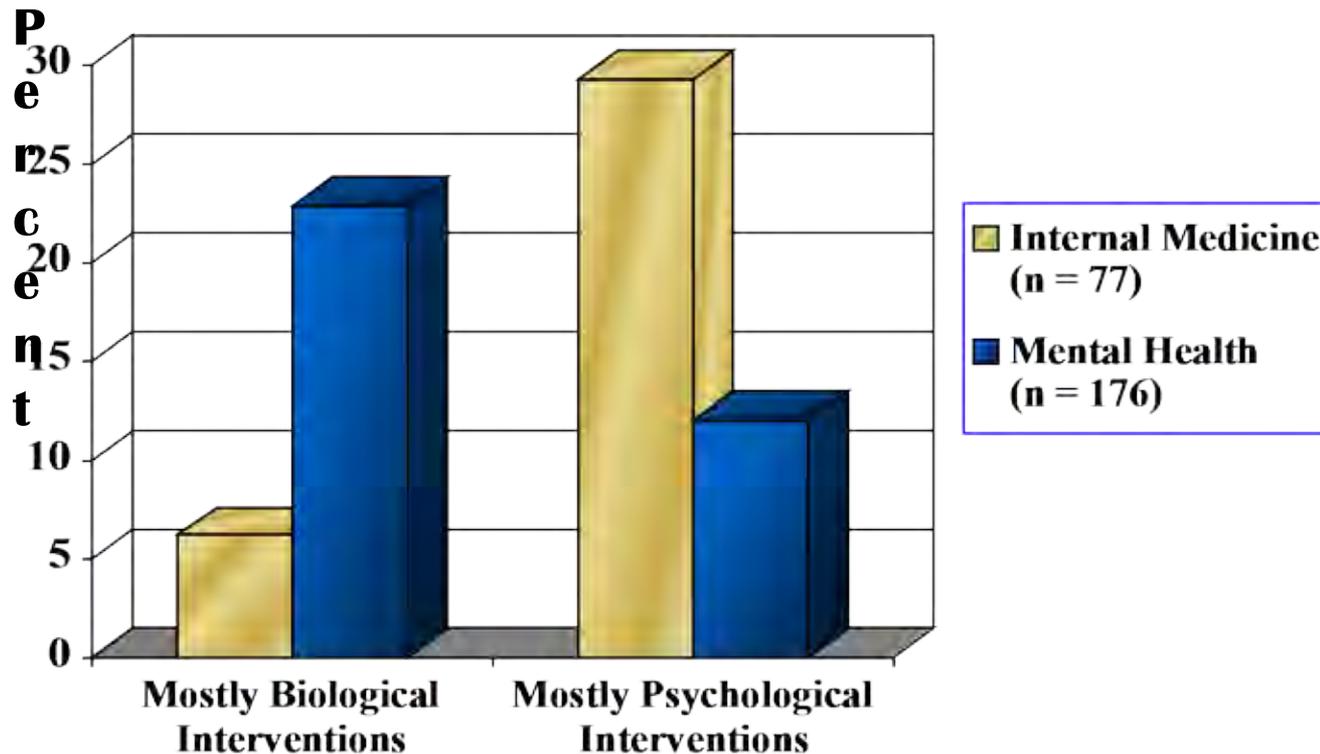
We had learned a great deal from our experiences with Veterans from earlier conflicts...



Rate the degree to which you believe "Persian Gulf Illness" is:



**Rate the degree to which you believe
"Persian Gulf Illness," in general,
is most effectively treated by:**



Beliefs May be More Similar Than Previously Thought

43%

of Gulf War Veterans with CMI seen at the WRIISC report that the nature of their illness is both **physical** and **psychological**.

Presented by the **VA War Related Illness and Injury Study Center (WRIISC)**

We knew that there were
physical
risks and impacts of combat...

injury

temperature

diet

toxic agents

multiple immunizations

noise

sleep deprivation

austere conditions

infectious agents

blast wave/head injury

We knew that there were
psychological
risks and impacts of combat...

anticipation of combat

combat trauma

non-combat trauma

separation from family/home

deprivation

We knew that there were
psychosocial
risks and impacts of combat...

Marital/parenting issues

Social functioning

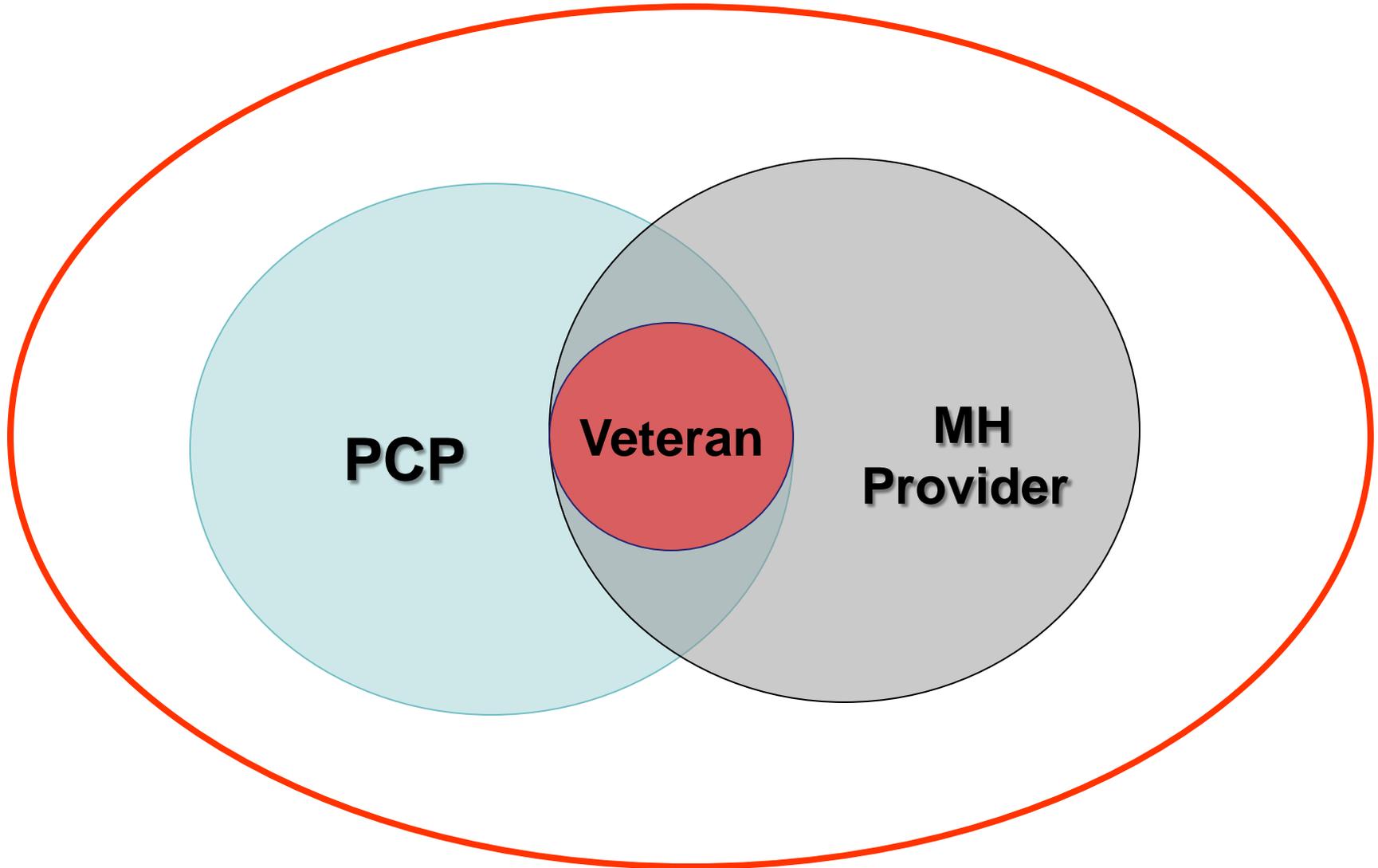
Occupational/financial concerns

Risk of re-deployment

Spiritual / existential

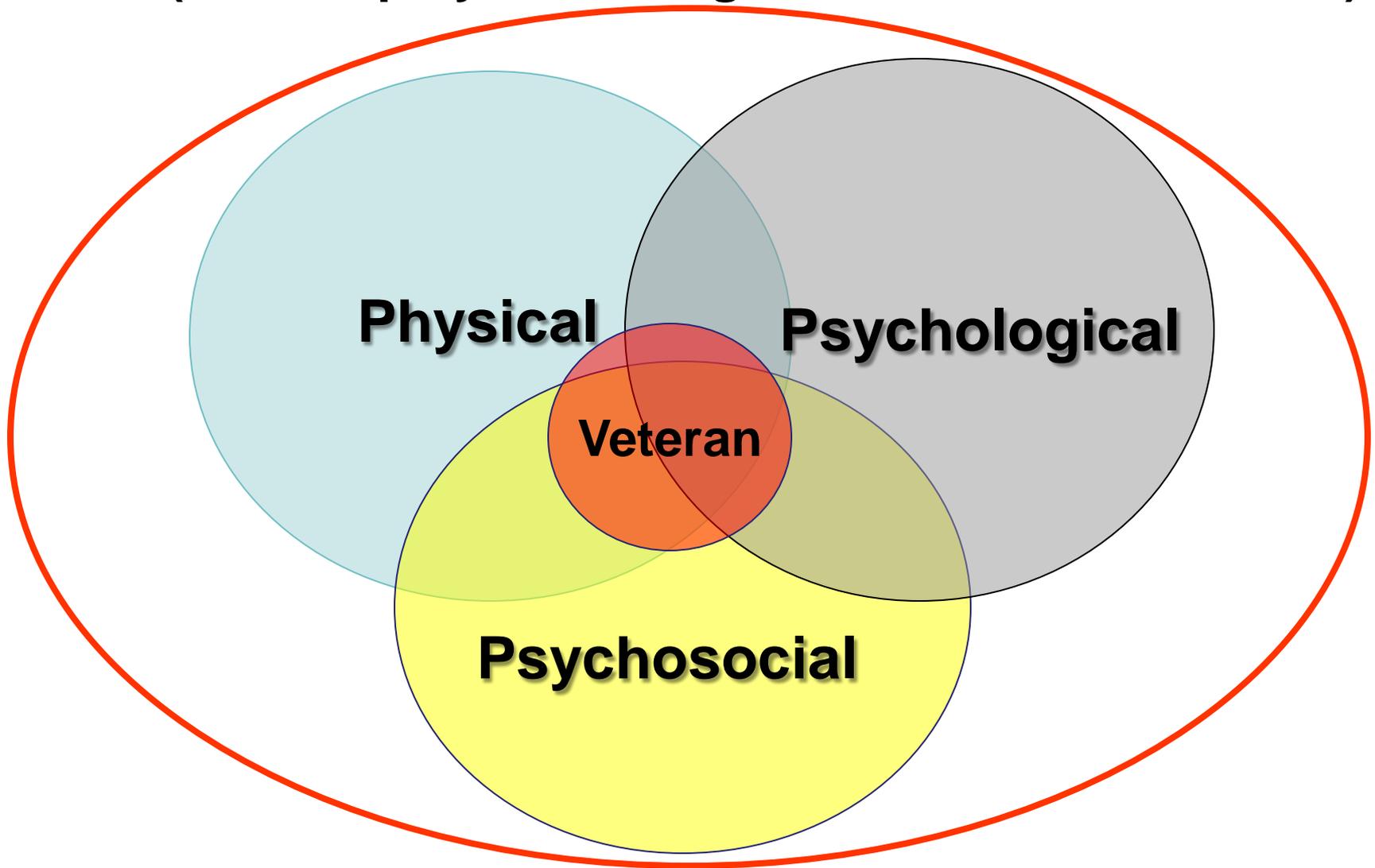
Primary Care-Mental Health Integration

(Primary Care Mental Health Integration Initiative 2007)



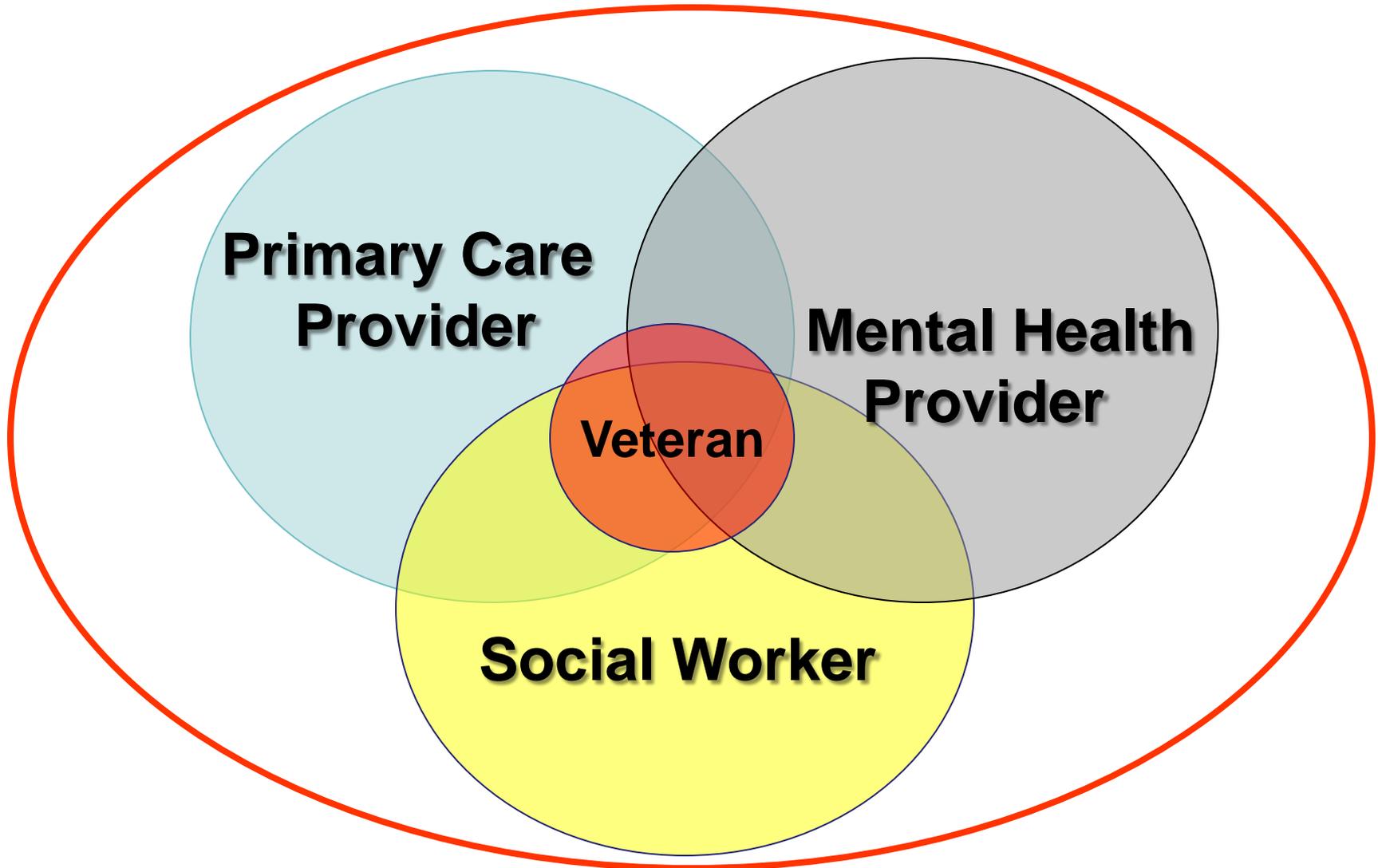
**We used the research literature, the data,
the lessons learned to create a model...**

PDICI (Post-Deployment Integrated Care Initiative 2008)



Integrated Post-Combat Care

PDICI (Post-Deployment Integrated Care Initiative 2008)



**MAJORITY OF OEF/OIF VETERANS RECEIVE THEIR INITIAL
PRIMARY CARE CLINICAL EVALUATION WITH THE...**

OEF/OIF Post Deployment Clinic	54%
OEF/OIF Primary Care Cohort	34%
General Primary Care Clinic(s)	12%

AS PART OF THE INITIAL CLINICAL EVALUATION PROCESS FOR OEF/OIF VETERANS...

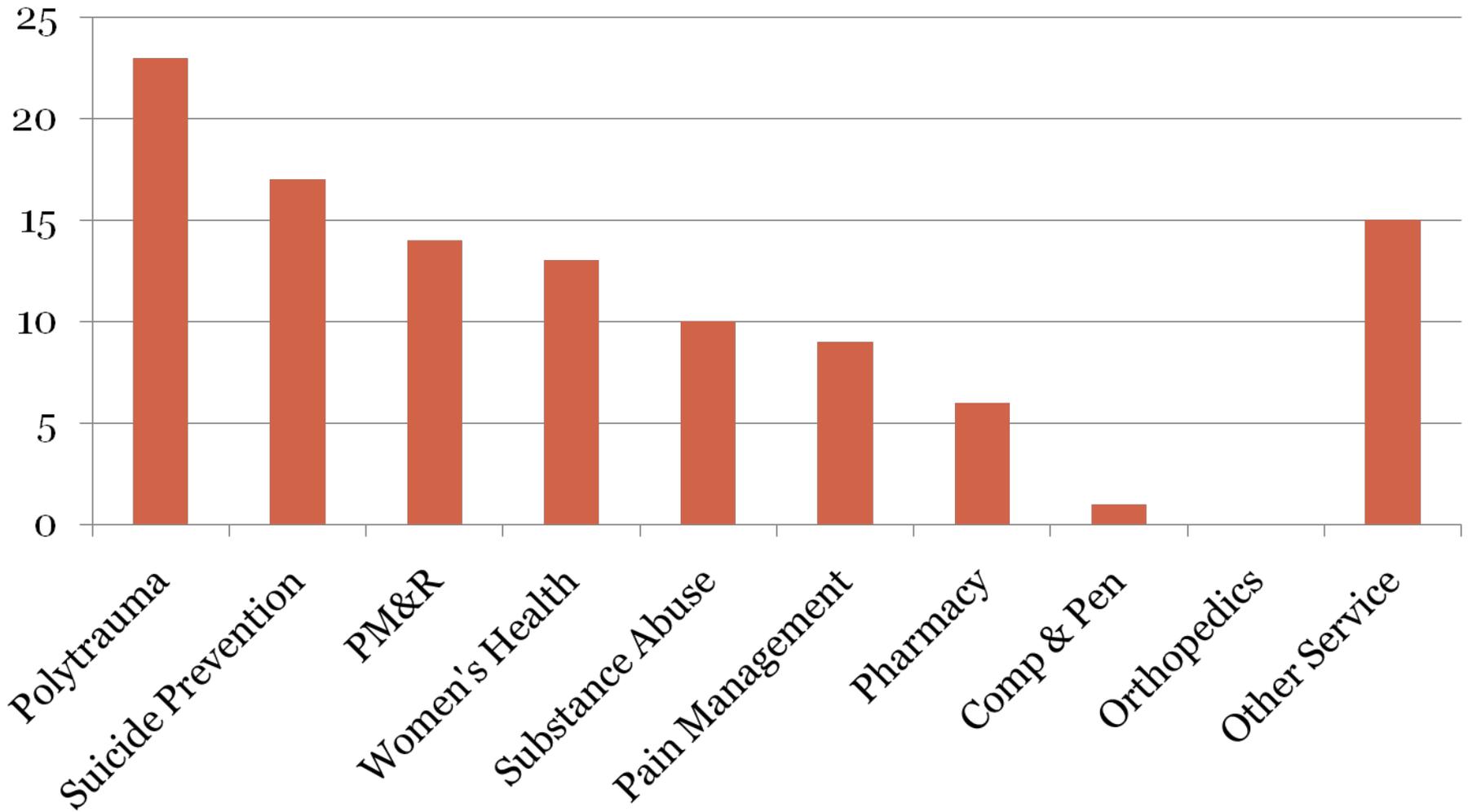
...a mental health specialist typically conducts a separate evaluation and/or combat stress assessment

48%

...a social worker/case manager typically conducts a separate evaluation

87%

Providers from these Services regularly attend formal meetings to discuss OEF/OIF Veteran care



Integrating Mental Health and Primary Care Services in the Department of Veterans Affairs Health Care System

Antonette M. Zeiss · Bradley E. Karlin

Published online: 21 February 2008
© U.S. Government 2008

Abstract Integrating mental health care in the primary care setting has been identified in the literature as a model for increasing access to mental health services and has been associated with enhanced clinical and functional patient outcomes and higher patient satisfaction. The Department of Veterans Affairs (VA), which operates the nation's largest integrated health care system, has taken a leadership role in creating a health care system in which mental health care is provided in the primary care setting. This article examines VA's efforts and progress to date in implementing evidence-based models of integrated mental health services nationally in community based outpatient clinics, home based primary care, and outpatient primary clinics at medical facilities. Psychology plays an important role in this progress, as part of an overall interdisciplinary effort, in which all professions are crucially important and work together to promote the overall well-being of patients.

Keywords Primary care · Mental health · Veteran's Affairs

of Veterans Affairs (VA) that plans, has oversight of funding, and evaluates health care service provision to veterans. Significant efforts have been made in the last year and a half to accomplish this goal, and continued efforts are underway. Integration of mental health care in the primary care setting is a goal for VHA for the same reasons as in other health care settings. While there are a large number of reasons to prioritize this change in the health care system, five particularly important reasons stand out.

First, patients prefer it—most selectively take mental health problems to their primary care providers, and they often express the preference that mental health care be provided in that setting (e.g., Areán et al., 2002; Chen et al., 2006). Second, mental health problems are often missed or misattributed to physical illness in primary care, particularly with older patients (Karlin & Fuller, 2007; Tai-Seale et al., 2005). Integrating mental health care in primary care can significantly increase detection and diagnostic accuracy. Third, patients are more likely to

Reducing Barriers to Mental Health and Social Services for Iraq and Afghanistan Veterans: Outcomes of an Integrated Primary Care Clinic

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BACKGROUND: Despite high rates of post-deployment psychosocial problems in Iraq and Afghanistan veterans, mental health and social services are under-utilized.

OBJECTIVE: To evaluate whether a Department of Veterans Affairs (VA) integrated care (IC) clinic (established in April 2007), offering an initial three-part primary care, mental health and social services visit, improved psychosocial services utilization in Iraq and Afghanistan veterans compared to usual care (UC), a standard primary care visit with referral for psychosocial services as needed.

DESIGN: Retrospective cohort study using VA administrative data.

POPULATION: Five hundred and twenty-six Iraq and Afghanistan veterans initiating primary care at a VA medical center between April 1, 2005 and April 31, 2009.

MAIN MEASURES: Multivariable models compared the independent effects of primary care clinic type (IC versus UC) on mental health and social services utilization outcomes.

KEY RESULTS: After 2007, compared to UC, veterans presenting to the IC primary care clinic were significantly more likely to have had a within-30-day mental health evaluation (92% versus 59%, $p < 0.001$) and social services evaluation [77% (IC) versus 56% (UC), $p < 0.001$]. This exceeded background system-wide increases in mental health services utilization that occurred in the UC Clinic after 2007 compared to before 2007. In particular, female veterans, younger veterans, and those with positive mental health screens were independently more likely to have had mental health and social service evaluations if seen in the IC versus UC clinic. Among veterans who screened positive for ≥ 1 mental health disorder(s), there was a median of 1 follow-up specialty mental health visit within the first year in both clinics.

CONCLUSIONS: Among Iraq and Afghanistan veterans new to primary care, an integrated primary care visit further improved the likelihood of an initial mental health and social services evaluation over background increases, but did not improve retention in specialty mental health services.

KEY WORDS: veterans; mental health; health services utilization; primary care.

J Gen Intern Med

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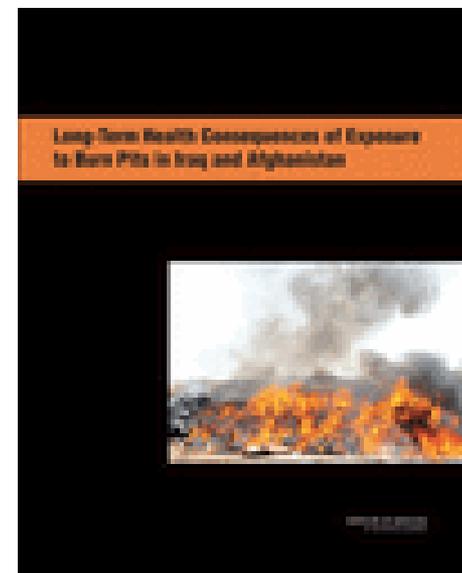
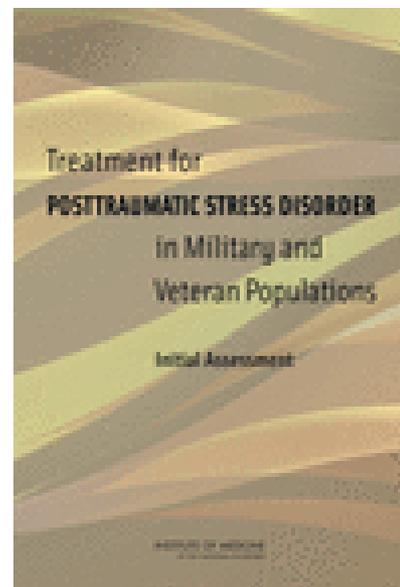
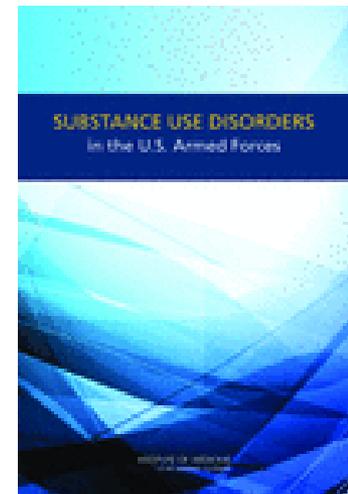
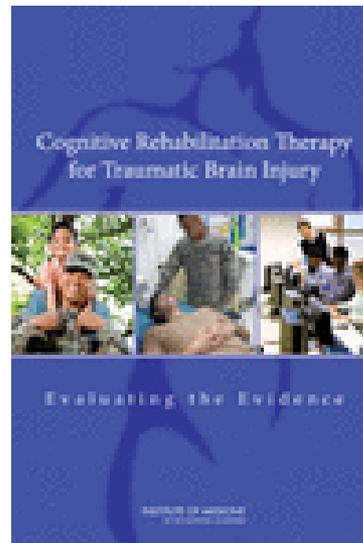
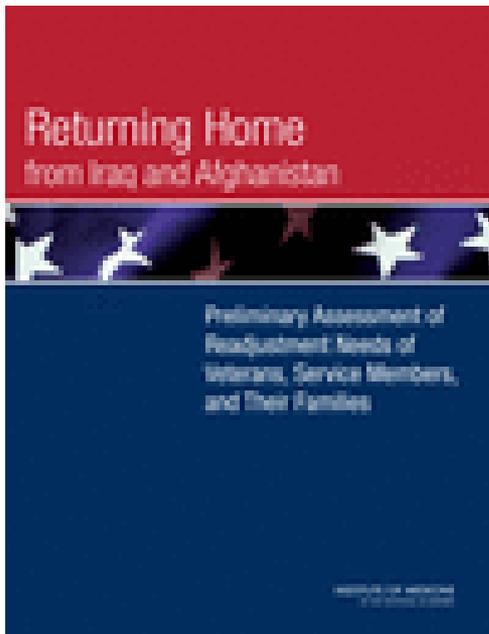
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INTRODUCTION

Approximately 2 million American men and women have served in the conflicts in Afghanistan (Operation Enduring Freedom, OEF) and Iraq (Operation Iraqi Freedom, OIF)¹. The prevalence of mental health disorders has steadily increased: between 18.5% and 42% of OEF/OIF veterans are estimated to suffer from deployment-related mental health problems²⁻⁴. Further, mental health diagnoses in this population are typically comorbid with other mental and physical disorders⁵⁻⁸, resulting in a significant public health burden⁹⁻¹².

Despite population-based mental health screening by the military and VA¹³, most OEF/OIF veterans with mental health problems, including posttraumatic stress disorder (PTSD), do not access or receive an adequate course of mental health treatment^{3,4,14,15}. OEF/OIF veterans continue to report numerous barriers to mental health care, most notably stigma^{4,14,16,17}. Nevertheless, OEF/OIF veterans with mental health disorders have significantly higher rates of primary care utilization than those without mental health disorders^{18,19}.

In response, priorities were identified for VA primary care nationally²⁰, some of which were operationalized at the San Francisco VA Medical Center (SFVAMC) in April 2007. These included: (1) monitoring rates of VA post-deployment mental health screening, (2) same-day mental health evaluations of veterans screening positive for PTSD and depression, and (3) limits on wait times for initial mental health appointments. In addition, on April 1, 2007, the SFVAMC OEF/OIF Integrated Care (IC) Clinic was established which offered integrated, co-located primary care, mental health and social services as



CME Available for this Article at ACOEM.org

Health and Exposure Concerns of Veterans Deployed to Iraq and Afghanistan

Drew A. Helmer, MD
Marycarol Rossignol, DNSc
Melissa Blatt, BS
Ritu Agarwal, MS
Ronald Teichman, MD
Gudrun Lange, PhD

Learning Objectives

- Identify, in this retrospective chart review and interview study of 56 veterans deployed to Iraq or Afghanistan, those organ systems about which they were most concerned and their most prevalent mental health problems.
- Recall those types of exposure, environmental and other, about which the veterans reported being most concerned.
- Relate the investigators' impressions of the severity of the veterans' concerns and the possibility of possible long-term adverse health effects.

Abstract

Objective: We report the clinical concerns of US veterans of Operations Iraqi Freedom and Enduring Freedom evaluated at the New Jersey War-Related Illness and Injury Study Center (NJ WRIISC) between June 2004 and January 2006.

Methods: We conducted a retrospective chart review of veterans' health and exposure concerns. **Results:** Veterans ($n = 56$) reported an average of 4 (standard deviation [SD] = 2.1; range, 0–9) physical health concerns, and 2.7 (SD = 2.3; range, 0–10) exposure concerns. The majority of veterans (55%) had a mental health concern, most commonly, posttraumatic stress disorder. The most common exposure concerns were depleted uranium, multiple vaccinations, and poor air quality. Greater proportions of Reserve veterans reported genitourinary concerns and exposure to smoke from burning trash than active duty veterans.

Conclusions: Veterans of military operations in Southwest Asia have deployment-related health and exposure concerns that will need to be addressed by their ambulatory care physicians. (J Occup Environ Med. 2007;49:475–480)

With US military personnel actively engaged in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) since 2001, interest is high in health protection and the effects of combat and other deployment experiences on the long-term health of military personnel. Several processes are in place for surveillance of health and exposure concerns,¹ providing invaluable information about the population health, but not as much is known about the care of individual veterans of these deployments.

For example, all deployed US service members complete the post-deployment health assessment (PDHA) immediately on their return to the United States from deployment overseas. Between January 2003 and March 2006, on the PDHA forms, 22% of active and 40% of Reserve component respondents reported “medical/dental problems” during deployment. Also, approximately 5% of both groups reported “mental health concerns,” and about 16% indicated “exposure concerns.”² In addition, several surveys of military personnel have provided important information about health and expo-

Medical Service Utilization by Veterans Seeking Help for Posttraumatic Stress Disorder

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Hayden B. Bosworth, Ph.D.

Steven C. Grambow, Ph.D.

Tara K. Dudley, M.Stat.

Jean C. Beckham, Ph.D.

Objective: Posttraumatic stress disorder (PTSD) has been associated with higher rates of health complaints and medical conditions diagnosed by physicians, yet research examining the relationship between PTSD and health care utilization has been limited. This study compared the health service use of veterans with PTSD to that of help-seeking veterans without PTSD. The relationship between severity of PTSD and service utilization was also examined.

Method: Data were collected from 996 veterans seeking an evaluation at a Veterans Affairs (VA) Medical Center specialty PTSD clinic in the southeastern United States between March 1992 and September 1998. Data included sociodemographic characteristics, severity of PTSD, and disability status. The outcome variable, VA health service utilization, was prospectively assessed 1 year from the date of the initial PTSD assessment.

Results: Although the use of VA mental health services by patients with PTSD was substantial (a median of seven clinic stops), these patients used more services in general physical health clinics that provided predominantly nonmental health services (a median of 18 clinic stops). Negative binomial regression models revealed that younger veterans with PTSD had greater health care utilization than those without PTSD who also sought services. Greater severity of PTSD was related to higher rates of mental and physical health service use among veterans without a service-connected disability.

Conclusions: PTSD is associated with substantial health service use. The results highlight the importance of increased collaboration between primary care and mental health specialists, given that patients with PTSD are more likely to receive treatment in nonmental health clinics.

Gulf War Veterans' Health: Medical Evaluation of a U.S. Cohort

Seth A. Eisen, MD; Han K. Kang, DrPH; Frances M. Murphy, MD; Melvin S. Blanchard, MD; Domenic J. Reda, PhD; William G. Henderson, PhD; Rosemary Toomey, PhD; Leila W. Jackson, PhD; Renee Alpern, MS; Becky J. Parks, MD; Nancy Klimas, MD; Coleen Hall, MS; Hon S. Pak, MD; Joyce Hunter, MSN; Joel Karlinsky, MD; Michael J. Battistone, MD; Michael J. Lyons, PhD; and the Gulf War Study Participating Investigators*

Background: United States military personnel reported various symptoms after deployment to the Persian Gulf during the 1991 Gulf War. However, the symptoms' long-term prevalence and association with deployment remain controversial.

Objective: To assess and compare the prevalence of selected medical conditions in a national cohort of deployed and nondeployed Gulf War veterans who were evaluated by direct medical and teledermatologic examinations.

Design: A cross-sectional prevalence study performed 10 years after the 1991 Gulf War.

Setting: Veterans were examined at 1 of 16 Veterans Affairs medical centers.

Participants: Deployed ($n = 1061$) and nondeployed ($n = 1128$) veterans of the 1991 Gulf War.

Measurements: Primary outcome measures included fibromyalgia, the chronic fatigue syndrome, dermatologic conditions, dyspepsia, physical health–related quality of life (Short Form-36 [SF-36]), hypertension, obstructive lung disease, arthralgias, and peripheral neuropathy.

Results: Of 12 conditions, only 4 conditions were more prevalent among deployed than nondeployed veterans: fibromyalgia (de-

ployed, 2.0%; nondeployed, 1.2%; odds ratio, 2.32 [95% CI, 1.02 to 5.27]); the chronic fatigue syndrome (deployed, 1.6%; nondeployed 0.1%; odds ratio, 40.6 [CI, 10.2 to 161]); dermatologic conditions (deployed, 34.6%; nondeployed, 26.8%; odds ratio, 1.38 [CI, 1.06 to 1.80]), and dyspepsia (deployed, 9.1%; nondeployed, 6.0%; odds ratio, 1.87 [CI, 1.16 to 2.99]). The mean physical component summary score of the SF-36 for deployed and nondeployed veterans was 49.3 and 50.8, respectively.

Limitations: Relatively low participation rates introduce potential participation bias, and deployment-related illnesses that resolved before the research examination could not, by design, be detected.

Conclusions: Ten years after the Gulf War, the physical health of deployed and nondeployed veterans is similar. However, Gulf War deployment is associated with an increased risk for fibromyalgia, the chronic fatigue syndrome, skin conditions, dyspepsia, and a clinically insignificant decrease in the SF-36 physical component score.

Ann Intern Med. 2005;142:881–890.

www.annals.org

For author affiliations, see end of text.

*For a list of the Gulf War Study Participating Investigators, see the Appendix (available at www.annals.org).

GULF WAR

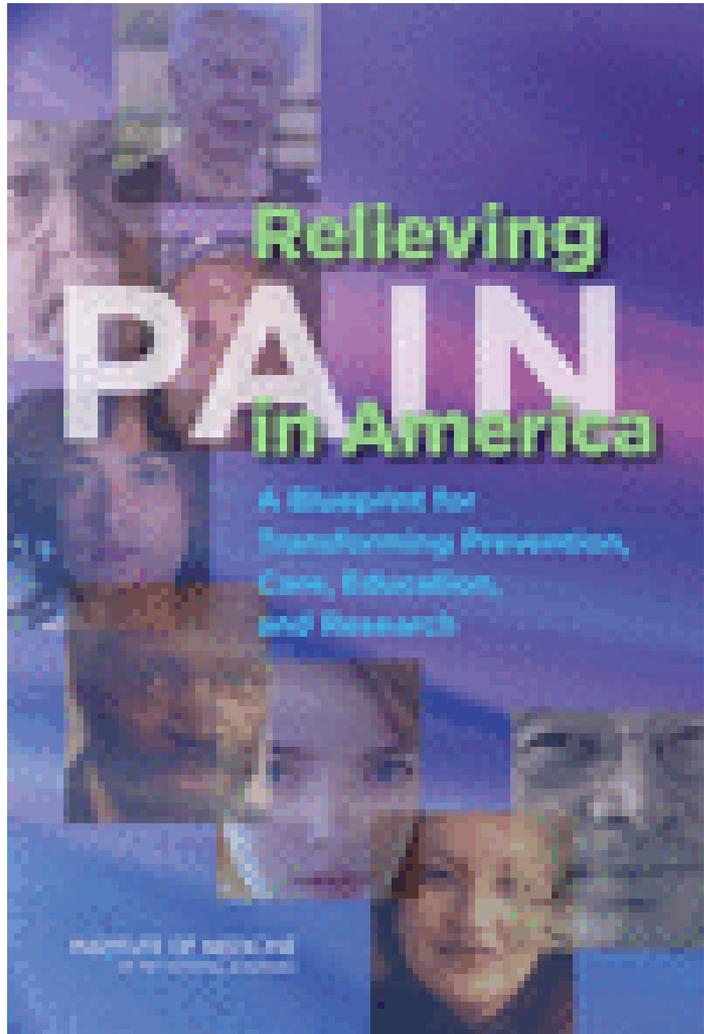
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HEALTH

VOLUME 9

*Treatment for
Chronic Multisymptom Illness*

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES



An examination of the relationship between chronic pain and post-traumatic stress disorder

John D. Otis, PhD; Terence M. Keane, PhD; Robert D. Kerns, PhD

Department of Veterans Affairs (VA) Boston Healthcare System, Boston, MA; VA Connecticut Healthcare System, West Haven, CT, and Yale University, New Haven CT

Abstract—Chronic pain and post-traumatic stress disorder (PTSD) are frequently observed within the Department of Veterans Affairs healthcare system and are often associated with a significant level of affective distress and physical disability. Clinical practice and research suggest that these two conditions co-occur at a high rate and may interact in such a way as to negatively impact the course of either disorder; however, relatively little research has been conducted in this area. This review summarizes the current literature pertaining to the prevalence and development of chronic pain and PTSD. Research describing the comorbidity of both conditions is reviewed, and several theoretical models are presented to explain the mechanisms by which these two disorders may be maintained. Future directions for research and clinical implications are discussed.

Key words: anxiety, avoidance, chronic pain, post-traumatic stress disorder, vulnerability.

pain. Importantly, interest in the relationship between chronic pain and its comorbid conditions has had a significant impact on the field of pain research and has contributed to improvements in the delivery of treatment.

While some chronic pain conditions may have an organic etiology and develop gradually over time, other conditions may develop because of an injury sustained in a traumatic event such as a motor vehicle accident (MVA), work-related injury, or participation in military combat. Most recently, there has been burgeoning interest in the relationship between pain and post-traumatic stress disorder (PTSD). Clinical practice and research indicate that the two disorders frequently co-occur and may interact in such a way as to negatively impact the course and outcome of treatment of either disorder. Despite this recent interest, a review of the relevant literature indicates that neither empirical studies investigating theoretical models to explain the comorbidity of the two



Mental Health Diagnoses Associated with Opioid Prescription, High-Risk Use, and Adverse Outcomes among OEF/OIF Veterans

CITATION:

Seal K, Shi Y, Cohen G, Cohen B, Maguen S, Krebs E, and Neylan T. Association of Mental Health Disorders with Prescription Opioids and High-Risk Opioid Use in Veterans of Iraq and Afghanistan. *JAMA* March 7, 2012; expected publication date. **Embargoed until March 6, 3:00pm Central time.**

BACKGROUND:

Nationwide, the prescription of opioid analgesics has nearly doubled since 1994, owing to greater recognition of the importance of treating pain. At the same time, rates of prescription opioid misuse and overdose have increased sharply, and prescription opioids are now a leading cause of death in the U.S. OEF/OIF Veterans with pain and PTSD who are prescribed opioids may be at particularly high risk for prescription opioid misuse given the high co-occurrence of substance use disorders among Veterans with PTSD. This retrospective cohort study examined the impact of mental health disorders, particularly PTSD, on risks and adverse clinical outcomes associated with prescription opioid use among OEF/OIF Veterans. Using VA data, investigators identified 141,029 OEF/OIF Veterans who received ≥ 1 non-cancer pain-related diagnoses within one year of entering VA healthcare – from 10/05 through 12/08, with follow-up through 12/10. [This timeframe was chosen to minimize shifts in opioid prescribing patterns in VA as the joint VA/DoD clinical practice guideline for the management of opioid therapy was released in 2003 and was not updated until May 2010.] The main outcome assessed was the independent association of mental health disorders, particularly PTSD, on patterns of opioid prescription, associated risks, and adverse clinical outcomes (e.g., accidents and overdose) within one year of receiving a pain-related diagnosis.

FINDINGS:

- Among OEF/OIF Veterans with pain, mental health diagnoses, especially PTSD, were associated with an increased risk of receiving opioids, high-risk opioid use, and adverse clinical outcomes.
- Compared to those without mental health diagnoses, Veterans with PTSD who were prescribed opioids were more likely to receive higher-dose opioids (16% vs. 23%), receive two or more opioids concurrently (11% vs. 20%), receive sedative hypnotics concurrently (8% vs. 41%), and to obtain early opioid refills (20% vs. 34%).
- Receiving prescription opioids (vs. not) increased risk for serious adverse clinical outcomes for Veterans (10% vs. 4%) across all mental health categories and was most pronounced in Veterans with PTSD.
- Of the 141,029 Veterans with pain diagnoses, 15,676 (11%) received prescription opioids for ≥ 20 consecutive days; 77% of which were prescribed by VA primary care providers. Veterans with PTSD and mental health diagnoses excluding PTSD were significantly more likely to receive opioids for pain (18% and 12%) compared to Veterans without mental health diagnoses (7%).

LIMITATIONS:

- Findings are based on administrative data only from VA-enrolled OEF/OIF Veterans with pain.

AUTHOR/FUNDING INFORMATION:

This study was partly funded by HSR&D. Drs. Seal and Maguen are part of HSR&D's Program to Improve Care for Veterans with Complex Comorbid Conditions, San Francisco. Drs. Maguen and Krebs were supported by HSR&D Career Development Awards.



Department of Veterans Affairs
Veterans Health Administration
Office of the Assistant Deputy Under Secretary for Health for Policy and Planning



PAIN MANAGEMENT IN VHA SURVEY

2010

September 2010

Clinical Practice Guideline

Management of Opioid Therapy for Chronic pain

May, 2010

Transforming Veterans Pain Care

Implementation of the Pain Directive

1. Education of Veterans
2. Education and training of Teams
3. Establish primary care Pain Champion, pain resource providers, pain teams (pain resource nurse, pain resource pharmacist, pain psychologist)
4. Development of non-pharmacological modalities
5. Strengthen capacity for connecting the specialists with the PACTs: e consult, ECHO/SCAN, telephone consult services, Office Communicator
6. Instituting safe opioid prescribing (universal precautions, opioid surveillance)
7. Metrics/dashboards to monitor and maintain pain care

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Transforming Veterans Pain Care

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Transforming Veterans Pain Care

Implementation of the Pain Directive

1. Education of Veterans
2. Education and training of Teams
3. Establish primary care Pain Champion, pain resource providers, pain teams (pain resource nurse, pain resource pharmacist, pain psychologist, BH support/HBC)
4. **Development of non-pharmacological modalities**
5. Strengthen capacity for connecting the specialists with the PACTs: e consult, ECHO/SCAN, telephone consult services, telehealth, Office Communicator
6. Instituting safe opioid prescribing (universal precautions, opioid surveillance)
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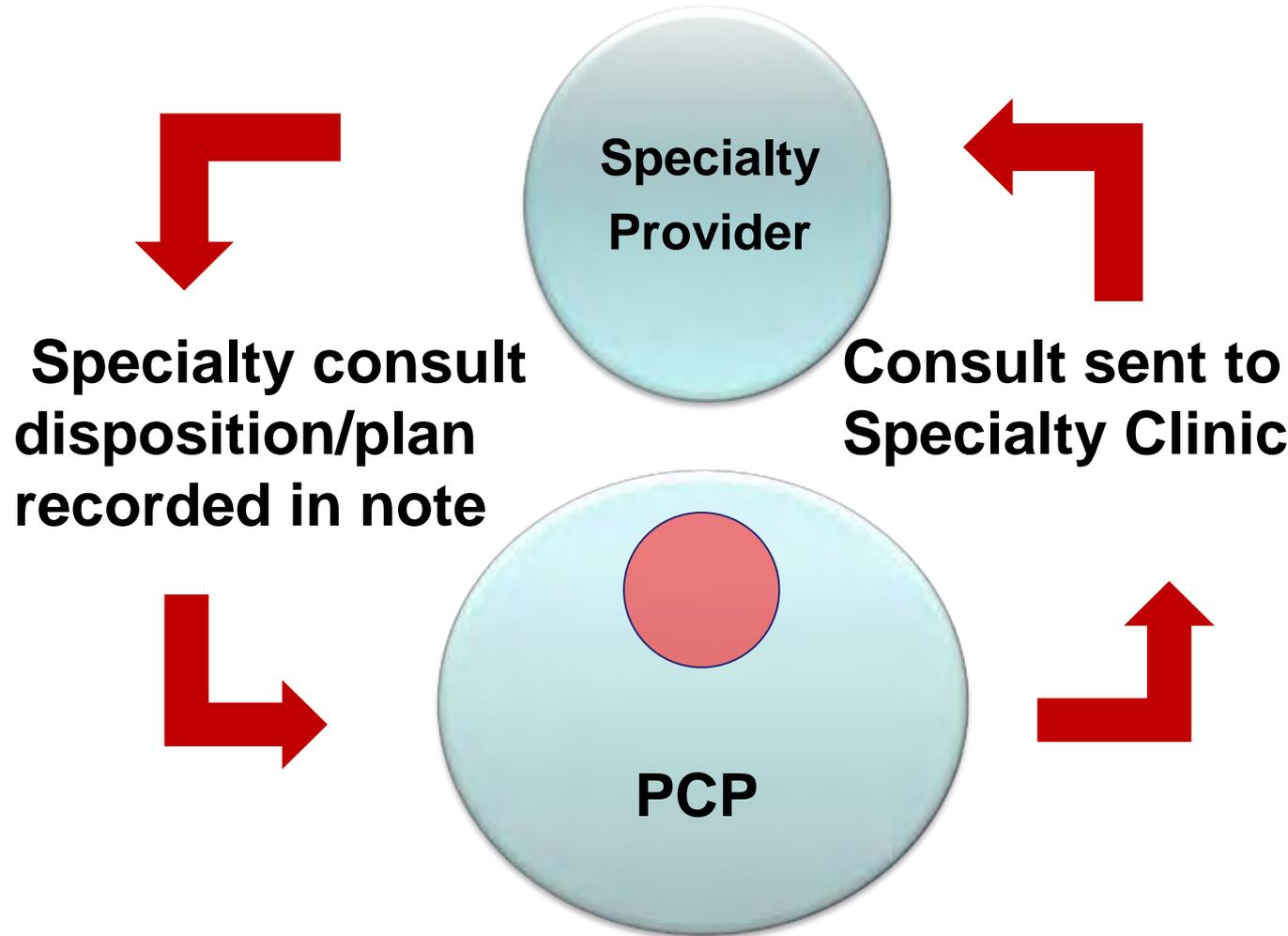
Transforming Veterans Pain Care

Implementation of the Pain Directive

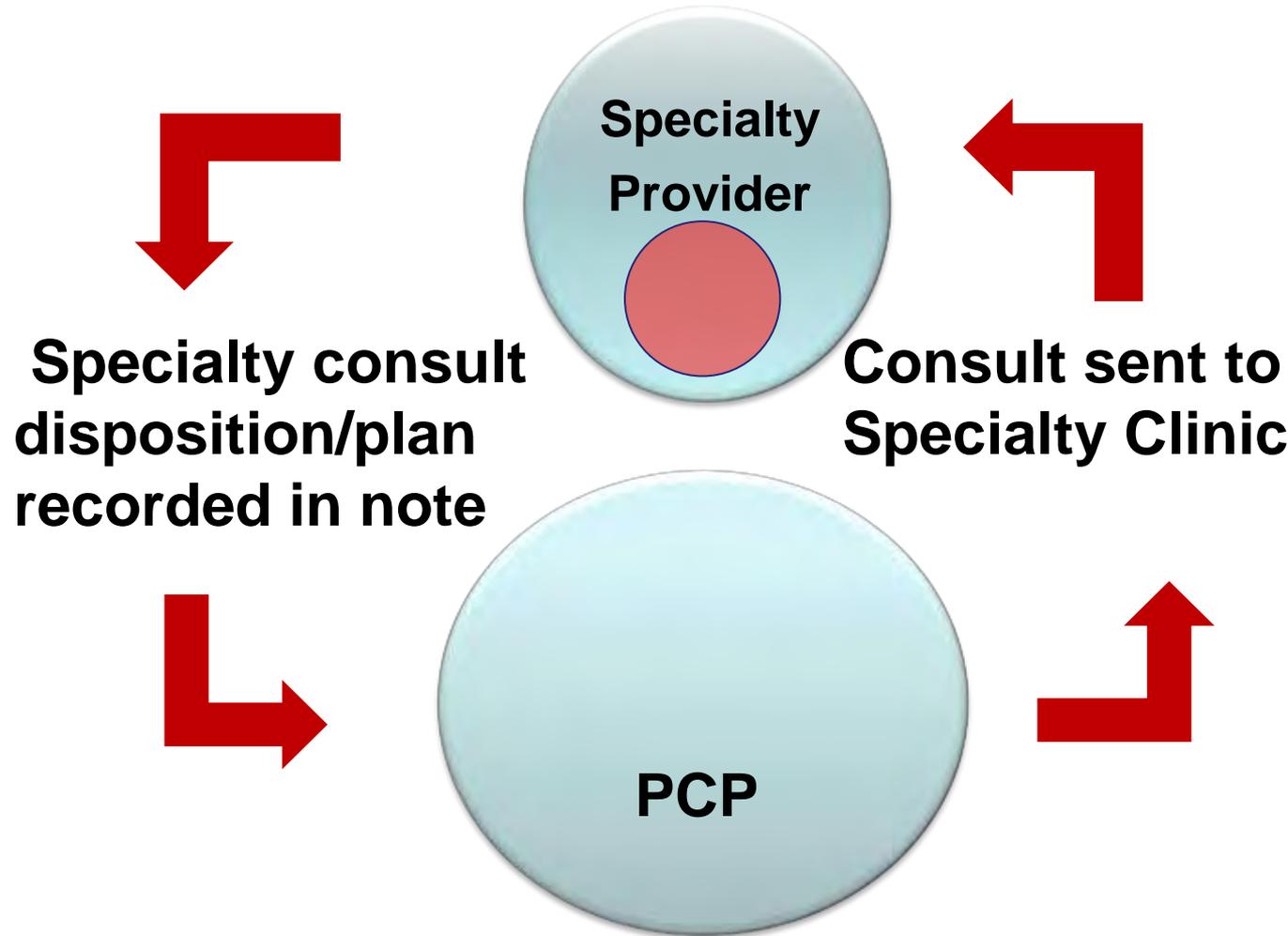
1. Education of Veterans
2. Education and training of Teams
3. Establish primary care Pain Champion, pain resource providers, pain teams (pain resource nurse, pain resource pharmacist, pain psychologist)
4. Development of non-pharmacological modalities
5. Strengthen capacity for connecting the specialists with the PACTs: e consult, ECHO/SCAN, telephone consult services, Office Communicator
6. Instituting safe opioid prescribing (universal precautions, opioid surveillance)
7. Metrics/dashboards to monitor and maintain pain care

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The Old Paradigm: Veteran needs specialist

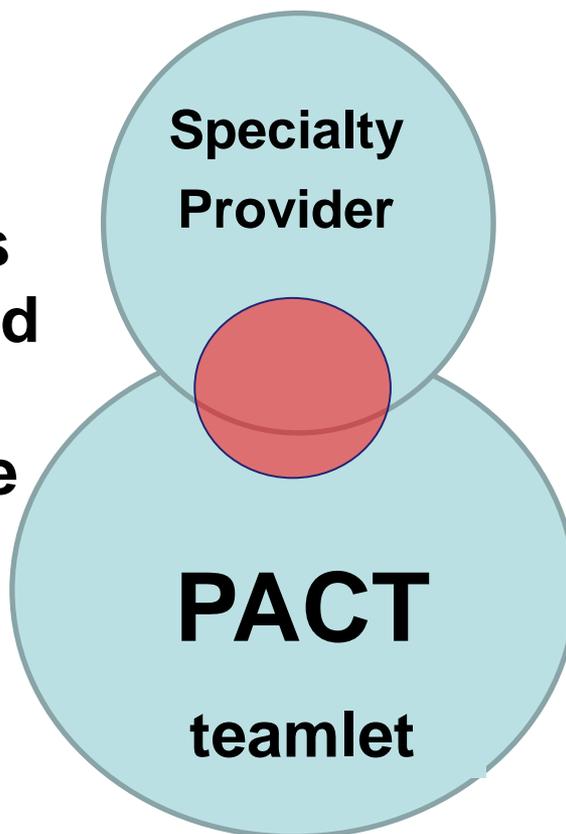


The Old Paradigm: Veteran needs specialist



The Pain Specialist and the Expanded PACT Team

What level of specialty input does the Veteran need and how do we best connect, collaborate and coordinate?

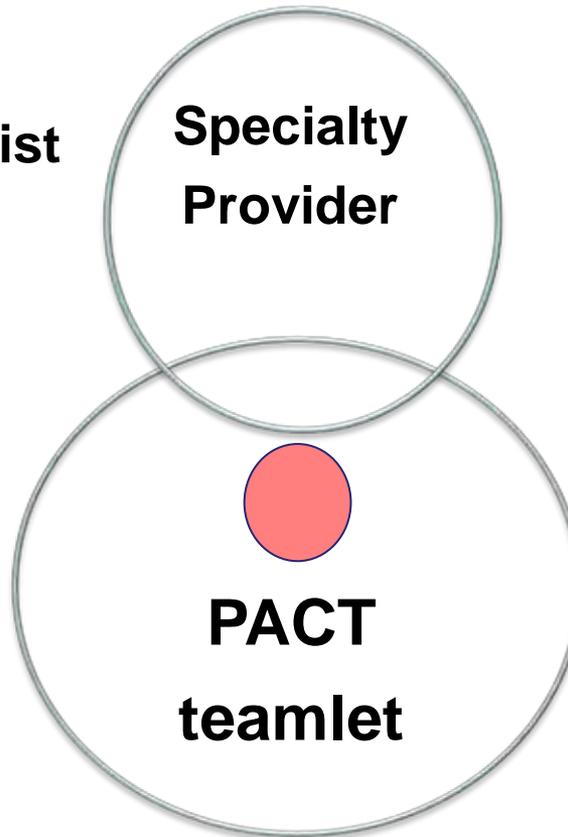


The Specialist and the Expanded PACT Team

Level 3:

Veteran and PACT team need input from specialist but not necessarily a Veteran visit with the specialist

- f/u on Pain assessment
- Pain/PTSD/other co-morbidity



Team function:

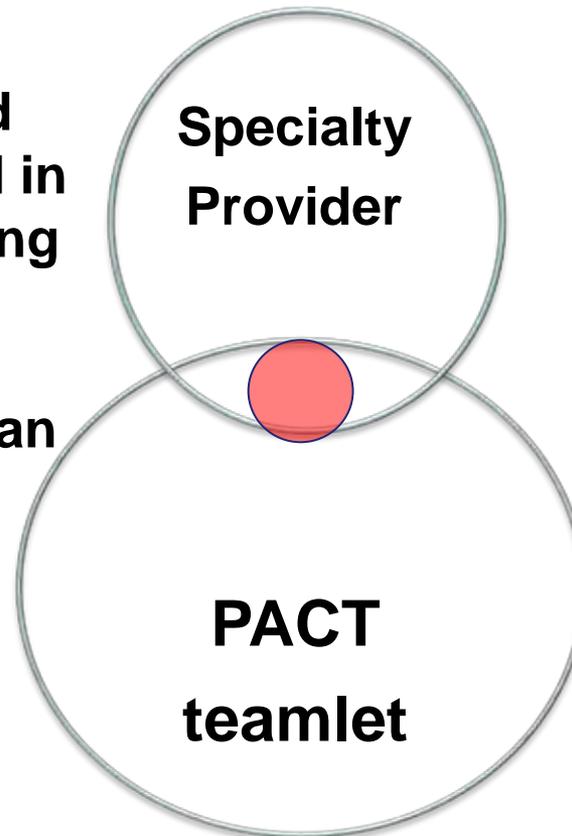
- Documentation on over-arching treatment plan
- Non-visit consult note
- Specialist has direct communication with team:
 - Tele-conference
 - SCAN
 - Office Communicator day of visit

The Specialist and the Expanded PACT Team

Level 2:

Veteran needs specialized care that is best delivered in a more collaborative setting

- Pain with/without PTSD
- rehab/pain issues
- Health recovery rehab Plan
- CBT, brief behavioral interventions



Team function:

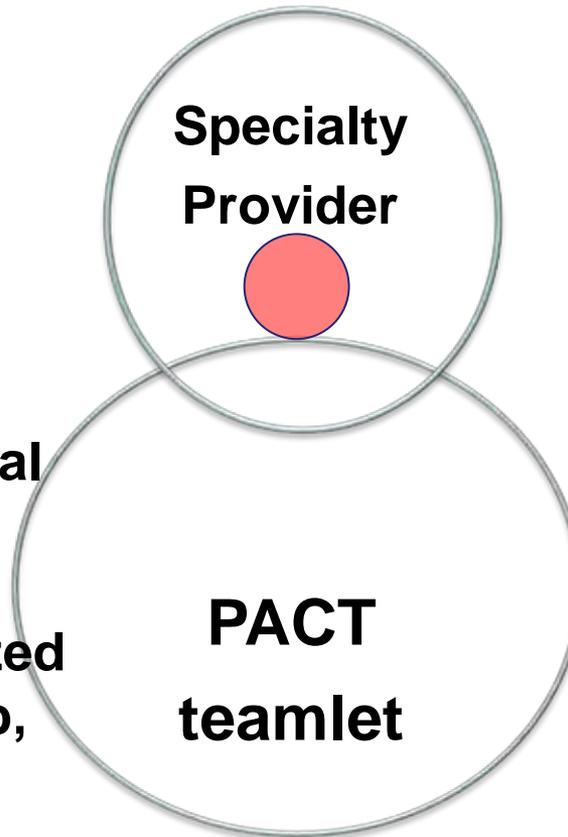
- Documentation on over-arching treatment plan
- Specialist has direct communication with PCP:
 - Telephone call
 - Secure e mail/text
 - OC on day of visit
- Specialist attends team meeting
- Coordination of care through specialty clinic care manager and PACT RN Care Manager

The Specialist and the Expanded PACT Team

Level 1:

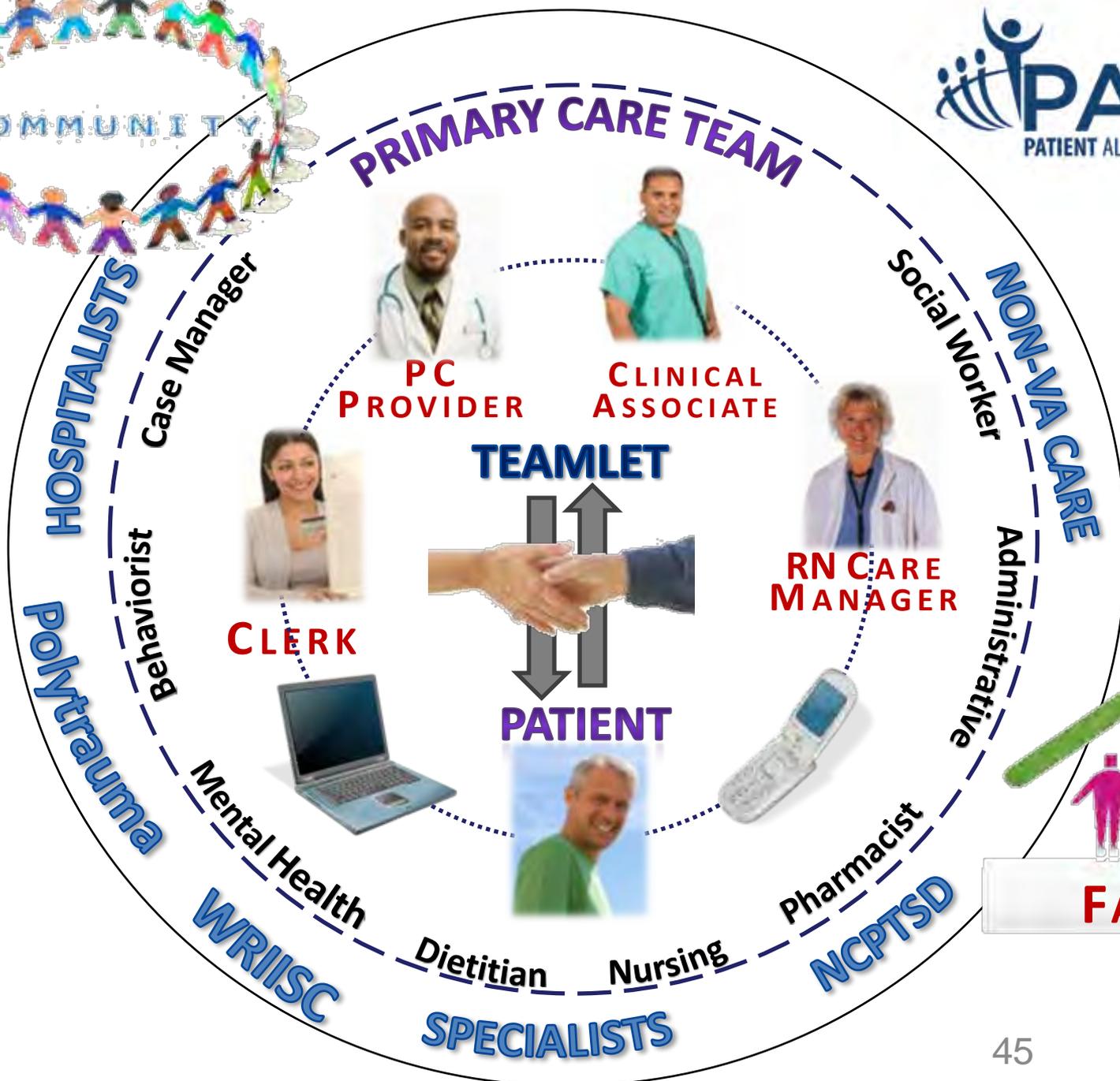
Veteran needs highly specialized cares that will be delivered in the specialty setting:

- Moderate/severe chronic pain
- Need for interventional pain care
- High/moderate levels of general or specialized rehab, cognitive rehab, OT, speech tx

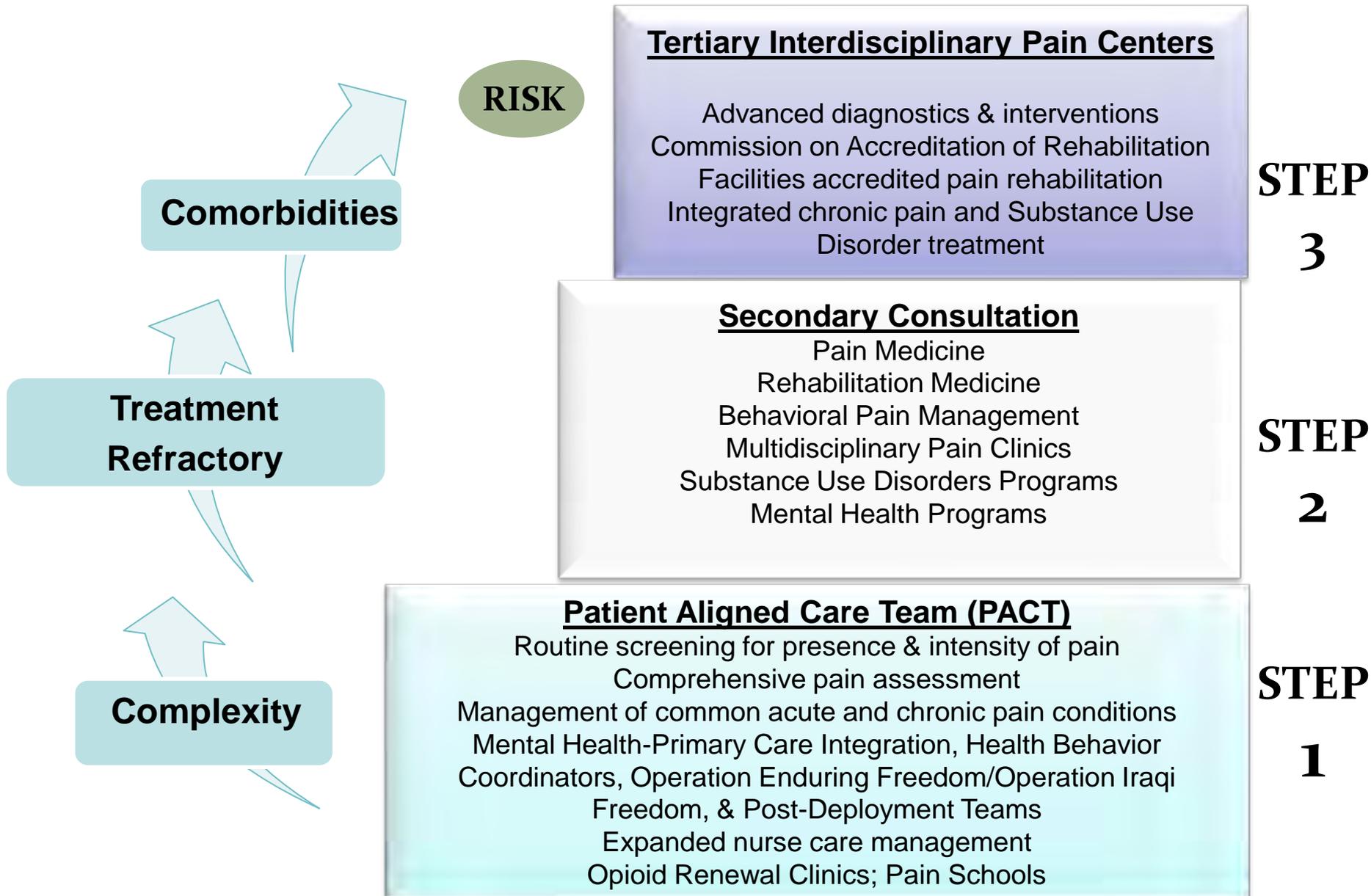


Team function:

- Contact between specialist and PCP
- Documentation on over-arching treatment plan
- Coordination of care through specialty clinic care manager and PACT RN Care Manager



Stepped Pain Care



Transforming Veterans Pain Care

Implementation of the Pain Directive

1. Education of Veterans
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Transforming Veterans Pain Care

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7. **Metrics/dashboards to monitor and maintain pain care**

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August 2012

Commentary

Transforming Pain Management Services for Veterans

Robert D. Kerns, Ph.D., Pain Research, Informatics, Medical Comorbidities, and Education (PRIME) Center, VA Connecticut Healthcare System

In a recent report, "Relieving Pain in America: A Blueprint for Transforming Pain Prevention, Care, Education, and Research," the Institute of Medicine (IOM) asserted that pain is a significant public health problem and estimated that as many as 100 million Americans experience persistent pain at a cost of as much as \$635 billion in treatment costs and lost productivity.¹ The report invites the Department of Veterans Affairs (VA) to join with other agencies to transform care of persons with pain, to educate and train providers and consumers of pain management services, and to conduct more pain research. The IOM specifically calls on agencies such as VA to improve its collection and use of data to support this transformation. Among its recommendations for research, the report encourages increased support for interdisciplinary research, longitudinal research, and training of pain researchers. The report emphasizes the development of strategies to minimize disparities in pain care, and it identifies Veterans of military service as one of several vulnerable groups. The VA provides a unique laboratory in which to conduct effectiveness and implementation research required for this transformation.

Pain Management – A Top Priority

In late 1998, the former Under Secretary for Health, Kenneth Kizer, launched the VA National Pain Management Strategy to provide a system-wide standard of care to reduce suffering from preventable pain. Support for the Strategy has served to elevate pain management as a top priority within VA, and to spark innovation in the planning and provision of high-

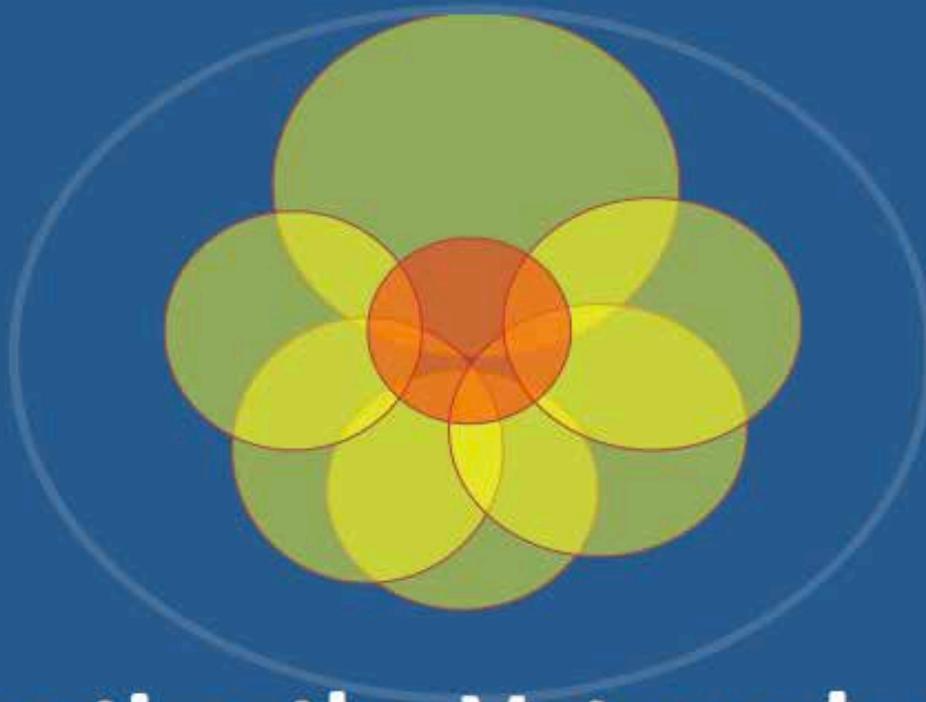
quality pain care. Among the several primary goals of this initiative is an explicit emphasis on promoting pain-relevant research. Data documents a strong and growing commitment to funding pain-relevant research through the intramural research program of the Office of Research & Development (ORD). In Fiscal Year 2011, ORD invested \$11.4 million in support of 36 investigator-initiated research projects and career development awards for early career investigators. The Health Services Research & Development Service (HSR&D), in particular, continues to invest in and strengthen its pain research portfolio with particular attention to research that promises improvement in the organization, delivery, safety, and equity of pain management services. A national Pain Research Working Group (PRWG), comprised of over 75 scientists and scholars, plays a key role in advancing VA's pain research agenda and in promoting its impact. Special topic issues of leading scientific journals including the *Journal of Rehabilitation Research and Development*, *Pain Medicine*, *Translational Behavioral Medicine*, and *Clinical Journal of Pain* highlight some of the important contributions of PRWG members. A monthly "Spotlight on Pain Management" seminar series offered through a partnership among the Pain Management Program Ofcice, the HSR&D's Pain Research, Informatics, Medical Comorbidities, and Education (PRIME) Center, and the Center for Information Dissemination and Educational Resources (CIDER) supports the shared interests of VA's research, practice, and policy communities in advancing National Pain Management Strategy.

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PACT

Veteran centered, team based,
coordinated care



Creating the Veteran's team

Transforming Veterans Pain Care

Current Projects

1. Current HSR&D Projects and Initiatives (CREATE)
2. Opioid Safety Initiative
3. Joint DoD/VA Pain Education Project (JIF JPEP)

2013: The Year of Pain Care

Transformation of Veterans Health Care



**Veteran
Centered,
Team
Based**



**Care based on
continuous
healing
relationships**

**IOM 2001
Crossing the Quality Chasm**

**Care is
customized
to individual's
needs and
values**



**Power
resides
with the
patient**



HSR&D Webinar

March 5, 2013

QUESTIONS ?

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Transforming Post-Deployment Care

Transforming Pain Care

Transforming VA Health Care

Researchers as Partners