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Commentary

Transforming Pain Management Services for Veterans

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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 document 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 56 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 promotes 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" webinar series offered through a partnership among the Pain Management Program Office, 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.



Director's Letter: Health Services Research Must Prove Its Value Now

Health care issues facing the VA are similar to those facing the nation: dramatic increases in health care cost, health care of modest quality, wide practice variation and inequities, and overutilization.

The coming health care budget squeeze and the competitive challenge resulting from expanded health care benefits for the Veteran and his/her family under the Affordable Care Act require that VA provide health care of unequalled QUALITY and VALUE. The time is now for health services researchers to unequivocally demonstrate the importance of our contributions to Veterans' health. To facilitate success, attention to six areas is required.

- **Expand the Concept of the Research Team.** The concepts of program/operations and patient stakeholder engagement in research, as embodied in the CREATE and COIN programs, must be extended to all research efforts.
- **Speed Research.** Stakeholders must be engaged at the outset of research to ensure speedy implementation of products, and experienced investigators must direct the IRB process. For critical, nearly-fundable projects, HSR&D will substitute the rapid SDR (Service Directed Research) revise-and-review approach for the semi-annual 'revise and resubmit' process.
- **Ensure Focused Research Objectives.** Research can no longer be undertaken simply because data is handy and the research questions 'interesting.' Projects must be undertaken within the scope of a broader vision that emphasizes generalizable principles, models, and acquisition of new knowledge that moves the field measurably forward.
- **Adopt Health Care Informatics Technologies.** Investigators must gain a working knowledge of VINCI's data and data sharing, applications, and computational abilities. Because informatics will be a core component of health services research, every investigator must become familiar with natural language processing (NLP) and understand the concepts and applications of 'big data.'
- **Share Methodology and Outcomes Knowledge.** Investigators must routinely share their research methodology (e.g., statistical code, tools) and products (e.g., data, registries) with colleagues under guidelines that respect individual efforts and intellectual property.
- **Intensify Mentoring.** Mentoring is the responsibility and requirement of every investigator.

Our research environment is stronger than ever. We have VA leadership support, a substantial budget, a vast health care database, a strong informatics program, outstanding investigators, the freedom to transparently study issues, and the ability to implement evidence based results. We must now demonstrate that we can contribute value to Veterans' health.

Seth Eisen, M.D., M.Sc.

Director, HSR&D

The Role of Health Services Investigators

VA health services investigators have played instrumental roles in advancing the theoretical and empirical foundations for core pain management policies and clinical practice guidance as established in VA's Pain Management Directive (2009-053).² For example, investigators have published empirical tests of integrated and collaborative care models in the primary care setting that support the establishment of a Stepped Care Model of Pain Management (SCM-PM) as the single standard of pain care for VA. The SCM-PM provides the ability to assess and treat pain in primary care settings by integrated Patient Aligned Care Teams (PACTs), while maintaining the capacity to escalate treatment options to include specialized care and interdisciplinary approaches to pain care, if necessary. The SCM-PM can similarly be applied for pain management in other settings, including management of acute pain in inpatient settings, management of pain in specialty mental health and substance use disorders treatment settings, and management of pain in the context of palliative and hospice care. VA health services investigators continue to conduct high-impact work in each of these settings.³

Other high priority areas in which health services research has already had considerable impact on policy and practice can be cited. Promoting equitable access, safety, and effectiveness of opioid therapy for the management of chronic pain has emerged as a particularly important challenge. Several teams of VA investigators collaborate with VA patient care and operations partners to ensure that policies and practice guidance are informed by strong science. Development and evaluation of alternative treatment approaches such as behavioral interventions that promote adaptive pain self-management is another area of interest and importance.

As emphasized in the IOM report, VA is uniquely positioned to provide leadership in the development of comprehensive registries, databases, and quality improvement efforts that can have widespread impact on pain management within and outside VA. Particularly

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Response to Commentary

VA Pain Management and Research: From Good to Great

Kurt Kroenke, M.D., VA Center of Excellence for Implementing Evidence-Based Practice, Indianapolis, Indiana

In his 2001 book, *Good to Great*, James Collins describes characteristics that distinguish a merely “good” company from a competitor who moves beyond “good” to become a “great” market leader. VA efforts to advance our understanding and management of pain over the past 15 years are well-articulated by Kerns in the lead commentary article for this issue of FORUM. At the same time, actions that might further solidify and strengthen clinical care and research related to pain management warrant our attention.

Since launching its National Pain Management Strategy in 1998, the VA has witnessed substantial strides in pain clinical care and research. The Pain Research Working Group, Pain Management Program Office, and PRIME Center have all played pivotal roles in advancing VA’s pain research agenda through special topic issues in scientific journals, a monthly webinar series on pain management, and other initiatives. Numerous projects centered on pain have been funded by the Office of Research & Development. The VA Pain Management Directive issued in 2009 provides comprehensive policy and implementation procedures for elevating the standards of care for pain management across all VA facilities. The 2011 Institute of Medicine report was a milestone in bringing national attention to the importance of pain and, moreover, in highlighting the potential role of the VA as a lead agent.

Steps toward Becoming “Great”

According to Kerns, the 1998 VA National Pain Management Strategy “has served to elevate pain management as a top priority within the VA.” However, as of 2011, pain had not yet risen to being one of the official HSR&D Priorities for Investigator-Initiated Re-

search. Ascending to this top tier would signify that pain has truly “arrived” as an HSR&D research priority. A second step would be to provide targeted money for pain research, similar to the request for application issued by the NIH when it identifies areas of particular importance. Congress passed the National Pain Care Policy Act in 2003, which declared the first decade of the 21st century as the “Decade of Pain Control and Research.” However, from 2003 to 2007, NIH funding for pain research declined sharply—an average of 9 percent per year.¹ Thus, the lip-service Congress paid to pain research was not heeded by the NIH. While VA ORD has been more supportive of pain research according to Kern’s figures, pain-targeted research announcements would further accelerate the research agenda. Other steps might include funding of a pain QUERI and support of multi-center pain trials through the Cooperative Studies Program.

Quality Chasms in Pain Care

Nowadays, quality gaps in the care of specific diseases are often identified and targeted for quality improvement initiatives as well as clinical research. Until the past few decades, pain has been sufficiently ignored that some of the gaps are more like chasms. The appropriate use of opioid analgesics remains one of the great divides. The pendulum swings between highly restrictive and more liberal usage. While we await the results from currently funded studies, disparate guidelines from various organizations complicate practice.² Even the universal vs. selective use of opioid contracts and urine drug screens are debated by experts. A second major gap is measurement which, paradoxically, is not resolved by

VA’s Pain as the 5th Vital Sign initiative.³ First, it is unclear the single 0 to 10 rating of current pain initially developed for acute pain, often in hospitalized patients, performs as well in assessing and monitoring chronic pain. Second, frequent feedback of pain scores to busy clinicians without having systems-based interventions in place is analogous to the inadequacy of depression screening in the absence of systems in place to provide adequate monitoring, treatment adjustments, and specialty support. Integration of pain care constitutes a third chasm. Because pain is ubiquitous across diseases and central to many specialties, pain care can be coordinated by primary care clinicians and Patient Aligned Care Teams (PACTs), but cannot be disarticulated from multiple other practice settings. Also, pain management relies more on patient report and less on laboratory testing than many other medical disorders, making pain particularly well-suited to tele-care management. Other important gaps include Veterans’ acceptance of and access to behavioral treatments for pain; the appropriate and efficient use of highly-specialized pain programs; effective provider-patient communication regarding pain; and reduction in excessive imaging and other diagnostic testing, and disability determinations in Veterans with chronic pain.

In the past 15 years, the clinical care and research in Veterans with chronic pain has advanced considerably. For the VA to move from “good” to “great” and assume the mantle of leadership encouraged by the Institute of Medicine report, parity of pain with other medical and mental disorders will be paramount.

References

1. Bradshaw, H. et al. “Trends in Funding for Research on Pain: A Report on the National Institutes of Health Grant Awards Over the Years 2003 to 2007,” *Journal of Pain* 2008; 9:1077-87.
2. Von Korff, M. et al. “Long-term Opioid Therapy Reconsidered,” *Annals of Internal Medicine* 2011; 155:325-8.
3. Lorenz, K.A. et al. “How Reliable is Pain as the Fifth Vital Sign?” *Journal American Board of Family Medicine* 2009; 22:291-8.

Research Highlight

Improving Opioid Prescribing Practices

Jodie A. Trafton, Ph.D. and Eleanor T. Lewis, Ph.D., both with the VA Palo Alto Center for Health Care Evaluation, Substance Use Disorder QUERI, and Office of Mental Health Operations Program Evaluation and Resource Center, Menlo Park, California

Opioids are prescribed at high and increasing rates in the United States both within and outside VA; over 23 percent of VA patients received an opioid prescription in FY10. Opioids are considered a core pain management tool, but long-term effectiveness of opioid therapy for chronic pain is untested, and opioid use is associated with a number of serious risks, including death from unintentional overdose or suicide, sedation-related accidents, and medication interactions. The VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain (CPG) outlines care practices designed to reduce the risks and increase the effectiveness of opioid therapy. But guideline recommended practices are not consistently followed.

HSR&D/QUERI has supported several studies designed to inform and support VA efforts to improve the safety and effectiveness of opioid therapy for chronic pain. We describe studies that focused on three strategies for improving the quality of opioid therapy in VA: 1) improve point-of-care clinical decision-making around opioids by providing CPG-based patient-specific recommendations, tailored data, and tools to primary care providers; 2) increase understanding of patient experience and behaviors around opioid therapy to develop better methods of communicating with patients and managing their opioid-related risks; and 3) develop measures of adherence to CPG-recommended practices for opioid therapy to identify variation in clinical practice, and motivate and guide quality improvement efforts.

Improving Point-of-Care Clinical Decision Support

Primary care clinicians report feeling inadequately trained to deliver safe and effective pain management, but are being increasingly relied upon to treat chronic pain and are frequent prescribers of opioid therapy. To support primary care clinicians in opioid prescribing, we

iteratively developed and tested a computerized decision-support system based on the CPG and the core ATHENA-Decision Support System software architecture. Development of ATHENA-Opioid Therapy (OT) involved operationalization of the CPG content with key CPG authors, design of a graphical user interface with pain and primary care clinic staff input, and lab-based and in-clinic usability testing with providers.¹ ATHENA-OT includes patient-specific alerts and instructions on how to change prescriptions, filtered and highlighted opioid-relevant patient-data, and tools to facilitate CPG-recommended practices. Usability and implementation evaluation suggested a need for methods to coordinate PACT and specialty team-based management, increase prioritization of good pain management practices, and support clinician communication around emotion-laden topics.

Understanding Patient Behaviors and Experience

To understand and identify risk factors for patients using opioid medications in problematic ways, we conducted structured interviews with 191 Veterans who had at least one opioid prescription in the last year. Pain and physical functioning, prescription drug use, substance abuse history, and mental health conditions were assessed. Findings confirmed previous research identifying existing substance use and mental health problems as risk factors, but also identified novel and straightforward approaches to address behaviors in patients to improve opioid use. For example, clinicians prescribe—and patients use—different strategies for taking opioid medications. Symptomatic use of opioid medications—in response to pain or distress—was most common, but associated with worse pain-related mental health. Patients who used opioid medications on a schedule reported better pain-related mental health. While literature has focused on patient overuse of opioids, in our

sample, problematic underuse of opioid medications was more prevalent (20 percent) than overuse (9 percent).² Lastly, most patients saved their extra medications, and roughly one-third reported borrowing or sharing opioid medication at least once. These findings suggest new interventions, including modifying prescription instructions and monitoring use and disposal of medication that could improve safety and effectiveness.

Motivating and Guiding Opioid Therapy Quality Improvement

A team of VA leadership, clinicians, and measurement experts developed metrics to assess CPG adherence using VA administrative data.³ These metrics assess use of care practices to improve opioid safety and effectiveness including use of urine drug tests, managing patients with substance use disorders in addiction specialty care, avoiding co-prescription of sedative medications, avoiding sole reliance on opioid therapy for pain management, and serious adverse events. Some practices vary widely across VA facilities; for example, while urine drug testing is conducted routinely at some facilities others rarely use this practice. Other measures indicate non-optimal, but relatively consistent practice patterns across facilities, such as co-prescribing sedative and opioid medications. These measures are being monitored by VA Central Office and emphasize the need for development and targeting of effective interventions to improve opioid prescribing practices.

Together, these studies have increased our understanding of the current challenges and strengths of VA pain management practice. Findings suggest opportunities for quality improvement and development of new interventions to improve safety and effectiveness of opioid prescribing.

References

1. Trafton, J.A. et al. "Evaluation of the Acceptability and Usability of a Decision Support System to Encourage Safe and Effective Use of Opioid Therapy for Chronic, Non-Cancer Pain by Primary Care Providers." *Pain Medicine* 2010; 11(4):575-85.
2. Lewis, E. et al. "Reasons for Under-use of Prescribed Opioid Medications by Patients in Pain." *Pain Medicine* 2010; 11(6):861-71.
3. Midboe, A.M. et al. "Measurement of Adherence to Clinical Practice Guidelines for Opioid Therapy for Chronic Pain." *Translational Behavioral Medicine* 2012; 2:57-64.

Research Highlight

Post-Deployment Pain: Musculoskeletal Conditions in Male and Female OEF/OIF Veterans

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Musculoskeletal conditions are among the most common diagnoses of men and women Veterans returning from deployment. Studies of Persian Gulf War Veterans as well as Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans show that diseases of the musculoskeletal system are the most frequent diagnoses in cumulative reports of both inpatient and outpatient encounters. Musculoskeletal injuries sustained during training or active duty may go on to cause chronic persistent pain, which is emerging as a highly prevalent and clinically important problem among the population of OEF/OIF Veterans.

More than 200,000 women have now been deployed in support of the wars in Iraq and Afghanistan, representing up to 15 percent of the armed forces. Like their male counterparts, female soldiers are subjected to the many physical stresses of war. Although still excluded by law from participating in combat, women are serving in a variety of roles where they come under direct fire. Additionally, women soldiers carry heavy loads, wear gear originally designed to fit men, and participate in strenuous physical training.

Because research in the civilian sector has demonstrated that women are more likely to report painful musculoskeletal conditions than men, and to report more severe and longer lasting pain than men, we hypothesized that women Veterans might be at particular risk for the development of chronic musculoskeletal pain. In a series of studies, we utilized VA administrative data to examine pain and musculoskeletal conditions in male and female Veterans after deployment.

HSR&D Studies Reveal Differences

Our HSR&D-funded study initially examined medical and mental health conditions in men and women Veterans who utilized VA care within one year after return from deployment. Our study population was composed of Veterans from the VA's OEF/OIF roster provided by the Defense Manpower Data Center-Contingency Tracking System Deployment File. Data from the OEF/OIF roster was linked with the VA National Patient Care Database, Decision Support Systems, and the Corporate Data Warehouse. We evaluated records for 19,520 female and 144,292 male Veterans, using previously validated diagnostic code groupings, and found that back problems, joint disorders, and musculoskeletal conditions were among the most frequent diagnoses for both men and women.¹

In a second study, we evaluated pain numeric rating scores, which are recorded along with vital signs at each clinical encounter in VA. We evaluated records for all male and female Veterans who had one year of observation after the end of their last deployment. Results indicated that 60 percent of both men and women were assessed for pain. Men (44 percent) were more likely to report pain than women (38 percent), but among those with pain, women were more likely to report moderate to severe pain than men.²

A third study examined the prevalence of back, musculoskeletal, and joint conditions in female compared to male Veterans in years 1-7 after return from deployment. For each year of analysis, we limited the sample to Veterans who had an encounter during that year. We used previously validated diagnostic code groupings for back problems, joint disorders, and musculoskeletal/connective tissue disorders, and counted only those conditions that were coded

at least once for an inpatient stay, or twice for an outpatient visit. For both male and female Veterans, the prevalence of painful musculoskeletal conditions increased each year after deployment. After adjustment for significant demographic differences, women were more likely than men to have back problems, musculoskeletal problems, or joint problems and the odds of having these conditions increased each year for women compared to men in years 1-7 after deployment. Among patients who had been seen in VA for 7 years, 20 percent of women (compared to 17 percent of men) had back problems; 12 percent of women and 10 percent of men had musculoskeletal conditions; and 19 percent of women and 17 percent of men had joint problems.³

Further Research Needed

The growing difference in prevalence of painful musculoskeletal conditions between women and men over time may represent a difference in the chronicity of musculoskeletal problems sustained during military service, a difference in the incidence of newly reported pain between men and women over time, or a difference in the effectiveness of treatment. Compared with men, women may face challenges in pain treatment such as stigmatization, misunderstanding, and gender bias. These factors may be particularly important in the VA health care system where most pain treatment protocols have been developed for a largely male population. Further research will be critical to determine factors leading to development of chronic pain so that prevention and treatment protocols can be tailored to meet the needs of women Veterans.

1. Haskell, S.G. et al. "The Burden of Illness in the First Year Home: Do Male and Female VA Users Differ in Health Conditions and Healthcare Utilization," *Women's Health Issues* 2011; 21-1:92-7.
2. Haskell, S.G. et al. "Pain Among Veterans of Operations Enduring Freedom and Iraqi Freedom: Do Women and Men Differ?" *Pain Medicine* 2009; 10(7):1167-73.
3. Haskell, S.G. et al. "The Prevalence of Painful Musculoskeletal Conditions in Female and Male Veterans in 7 Years After Return from Deployment in Operations Enduring Freedom/Operation Iraqi Freedom," *Clinical Journal of Pain* 2012; 28(2):163-7.

Research Highlight

Painful Truths About Pain Screening

Karl A Lorenz, M.D., M.S.H.S. VA Palliative Care Quality Improvement Resource Center (QUIRC), VA Greater Los Angeles Healthcare System, and Erin E. Krebs, M.D., M.P.H., Minneapolis VA Health Care System

Recognizing the importance of pain, VA has, for over a decade, routinely required staff to assess and document the intensity of pain using the 5th Vital Sign, a 0 to 10 numeric rating scale (NRS). The patient's report is central to efforts to relieve pain, but pain of equal intensity can accompany a range of human experiences—from the torture of metastatic cancer to the joy of childbirth. Can a simple measure of pain intensity inform efforts to manage pain effectively?

How Informative of the Patient Experience is “the 5th Vital Sign”?

The HELP-Vets Study found that the NRS measure of current pain intensity was only moderately accurate for chronic disabling pain measured with the Brief Pain Inventory (BPI). HELP-Vets evaluated the variability and clinical usefulness of pain screening at random outpatient encounters in the VA Los Angeles and Long Beach Healthcare Systems (March 2006 - June 2007) at 19 oncology, cardiology, and primary care clinics in three large urban Southern California counties. HELP-Vets targeted the screening experience with baseline surveys of clinic-based physician and nursing staff followed by post-encounter patient and physician surveys to characterize each encounter combined with chart reviews.¹

Reasons for suboptimal performance of the NRS included the chronicity of pain in primary care and the lack of fidelity in scale administration. Substituting a rating of average pain over the past week significantly improved sensitivity for clinically important pain. HELP-Vets also found that staff used informal queries (e.g., “Is your knee good today?”) rather than the NRS in about 50 percent of cases; this practice was associated with pain underestimation. Although direct patient reports could avoid errors related to fidelity in scale use, clinicians tended to docu-

ment more severe, and possibly more actionable pain, suggesting the importance of comparing clinician-documented and patient-reported approaches.

Why Doesn't the 5th Vital Sign Lead to Better Management?

HELP-Vets informs why the linkage between pain assessment and improved care is missing. Busy providers noted pain score information in two-thirds of encounters but acted on moderate to severe pain with augmented management in only 15 percent of cases.² Knowledge, as well as attitudes and skills, proved important—including physicians' perception of the accuracy of nurses' pain reports. The most commonly cited reasons not to act on the NRS value included that the patient preferred not to change his/her approach (56 percent); everything has been done (35 percent); and the patient is not experiencing pain (26 percent).

A VA CDA-funded qualitative study of primary care opioid management identified additional concerns about pain assessment. Patient interviews identified a strong theme that physicians did not want to listen to patients' pain experiences and did not understand the effect of pain on patients' lives. Patients felt the NRS lacked meaning and did not accurately reflect their experience of chronic pain; for example, “this business about what kind of pain are you feeling from 1 to 10, I don't do real well with that because I don't know how do you rate what's a 1 and what's a 10, you know.” Several participants indicated that the NRS detracted from individualized treatment of patients, by reducing their experience to a number. As one stated, “I mean, just a question like, ‘tell me something in your daily life, how your pain affects it.’ That would be the most beautiful question in the world.”

Our research suggests that assessment of pain intensity alone will not likely change practice. Pain assessment that incorporates more patient-centered information (such as pain-related impairment), and that allows clinicians to assess response to therapies might facilitate individualized care. Furthermore, screening needs to be meaningfully linked to management, and needs to include a focus on high value clinical conditions and expanded options, especially non-pharmacologic approaches, for management.

What Should We Do Next?

HELP-Vets identified approaches to routine pain assessment that may be more informative than the NRS, including a three-item measure that includes assessment of emotional and physical pain interference, the PEG.³ We plan to evaluate the PEG versus the NRS, as well as compare clinician-documented versus patient-reported approaches directly in a multi-site randomized controlled pain assessment trial, the Effective Screening for Pain (ESP) Study. ESP will query clinicians about how to improve the pain assessment process—including linkage of pain assessment to management—and explore prototype approaches and tools to facilitate the assessment-management link.

In summary, measurement is a necessary but not sufficient step to improving patients' pain. Pain measurement can be improved, especially by incorporating information about pain-related functional interference to inform individualized goals. Additionally, the assessment-management link must be strengthened, which will require better access to non-pharmacologic treatment. Pain is one of various patient-centered symptom concerns, so learning how to systematically improve care for Veterans living with pain should inform a more humanistic, quality of life-centered VA health care system.

References

1. Lorenz, K.A. et al. “How Reliable is Pain as the Fifth Vital Sign?” *The Journal of the American Board of Family Medicine* 2009; 22:291-8.
2. Zubkoff, L. et al. “Does Screening for Pain Correspond to High Quality Care for Veterans?” *Journal of General Internal Medicine* 2010; 25:900-5.
3. Lorenz, K. A. et al. “Exploring Alternative Approaches to Routine Outpatient Pain Screening,” *Pain Medicine* 2009; 10: 1291-9.

HSR&D and QUERI Hold National Meeting

“Transforming Veteran Healthcare through Partner-Oriented Research” was the theme of the 29th VA Health Services Research and Development Service (HSR&D) and Quality Enhancement Research Initiative (QUERI) National Meeting. Hosted by HSR&D’s Center for Health Services Research in Primary Care, located in Durham, N.C. the meeting was held from July 16-19, 2012 in National Harbor, Md. Meeting participants selected among 121 peer-reviewed, highly rated scientific paper sessions, 40 workshops, and 146 posters on vital healthcare issues, such as: chronic disease management (e.g., heart disease, hypertension, diabetes), mental health, substance use disorders, telemedicine, women Veterans’ healthcare needs, patient-aligned care teams (PACTs), and deployment-related health issues (e.g., traumatic brain injury, PTSD, chronic pain), to name a few.

Partners in Research

Many of the studies highlighted during the meeting depend upon partnerships between HSR&D and QUERI and other VA programs and offices, such as the Office of Informatics and Analytics, Patient Care Services, and the Office of Information & Technology. This year’s theme emphasized HSR&D’s commitment to increase high-quality, high-priority, partner-aligned research aimed at better meeting the needs of Veterans and the VA healthcare system. Research/operations partnerships will ensure continuous improvement and optimal delivery of healthcare for Veterans, so that research is more responsive to the prioritized needs of the organization—and the findings are more likely to be implemented and sustained in practice.

National Meeting Highlights

The Honorable Robert A. Petzel, M.D., Under Secretary for Health, presented the Under Secretary’s Award for Outstanding Achievement in Health Services Research to Elizabeth Yano, Ph.D., M.S.P.H., Director of HSR&D’s



Robert A. Petzel, M.D., Under Secretary for Health, and Elizabeth Martin Yano, Ph.D., M.S.P.H., recipient of the 2012 Under Secretary’s Award for Outstanding Achievement in Health Services Research.

Center for the Study of Healthcare Provider Behavior. Dr. Yano exemplifies high achievement in health services research, impact of research on healthcare, and contribution to the care of Veterans. “Her career has made an indelible mark on VA research, policy, and clinical operations,” stated Dr. Petzel. “Through her research, Dr. Yano has led significant scientific development in two newly formed scientific fields—organizational epidemiology, and the study of women Veterans and their care in VA. She has also carried out innovative work on VA primary care settings and their organizational characteristics.”

Madhu Agarwal, M.D., M.P.H., Deputy Under Secretary for Health for Policy and Services, presented Seth Eisen, M.D., M.Sc., Director of HSR&D, with the Under Secretary for Health’s Exemplary Service Award for his



Madhu Agarwal, M.D., M.P.H., Deputy Under Secretary for Health for Policy and Services and Seth Eisen, M.D., M.Sc., Director of HSR&D, recipient of the Under Secretary for Health’s Exemplary Service Award

“outstanding leadership and dedication to the Veterans Health Administration, HSR&D, and to the Veterans we serve.” Dr. Agarwal spoke about Dr. Eisen’s important research, including his work in developing the Vietnam Era Twin Registry and his continued involvement in a national study of Gulf War Veterans and their families, as well as the progress he has fostered with VA’s IT and health informatics infrastructure. She also remarked on his guidance of HSR&D regarding its “increasing engagement with clinical and operations partners with the goal of improving the impact of health services research on areas of importance to our Veterans and to our system.”

Other meeting highlights included a Partnership Panel with two operations/research partner pairs that described their experiences and challenges in implementing innovations in VA healthcare; a plenary presentation on the “Direction for Implementation Science: Methods, Models, and Measures” by Russell Glasgow, Ph.D., Deputy Director of Implementation Science at the National Cancer Institute; and a session on “Engaging Operations Partnerships” that was led by Jeff Murawsky, M.D., Network Director, VISN 12, which was followed by lively participant interaction and debate.

State of the Service

In his address to plenary attendees, Dr. Eisen emphasized that the time is NOW for HSR&D to prove its value to VA. To ensure continued success, he told HSR&D researchers that they need to engage both Veterans and stakeholders at the outset, speed and focus research, utilize informatics, and intensify mentoring. In his QUERI overview talk, David Atkins, M.D., QUERI Director, spoke about several of the program’s recent accomplishments; for example, the development of toolkits to improve care for lung and colorectal cancers. He also emphasized the importance of partnerships in QUERI’s success, including collaborations with VERC (Veterans Engineering Resource Center), My Health-Vet, and VA System Redesign, to name a few QUERI partners.

Visit the meeting website at www.hsrd.research.va.gov/meetings/2012/ for presentation slides and other meeting information.

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Translating research into quality health care for Veterans

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important are efforts targeting highly prevalent conditions such as musculoskeletal disorders and headache; high cost conditions such as low back pain and trauma-related pain; chronic pain and mental health comorbidities, especially post-traumatic stress disorder, substance use disorder, and depression; and conditions known to be associated with disparities and differences associated with age, gender (including gender specific disorders), and race/ethnicity. Finally, the use of these databases to identify explanatory and causal factors associated with the transition from acute to chronic

pain and to develop interventions to reduce this likelihood is another particularly high priority.

References

1. Institute of Medicine. 2011. *Relieving Pain in America: A Blueprint for Transforming Pain Prevention, Care, Education and Research*. Washington, D.C.: The National Academies Press.
2. Veterans Health Administration. 2009. *VA Pain Management Directive (2009-053)*. Washington, D.C.: Department of Veterans Affairs.
3. Kerns, R.D. et al. "Implementation of the Veterans Health Administration National Pain Management Strategy." *Translational Behavioral Medicine* 2011; Vol. 1, 635-43.

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