DoD and VA Pain Management:

Strategies and Collaboration in the midst of the national epidemic of opioid overuse, misuse and diversion

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Disclosures

• The presenters have no relevant financial relationships or conflicts of interest.
• No discussion of off-label use of drugs or devices.
• The presentation is the personal opinion of the presenters and does not reflect the official views of the Department of Veterans Affairs or any other Federal Agency.
Objectives

At the conclusion of these presentations, attendees will be able to:

• Demonstrate knowledge of the changing paradigm of pain management that has occurred over the last 18 years

• Explain the unintended consequences related to the historical reliance on numeric rating scale (NRS) for pain assessment and treatment; to include relationship with the nation’s epidemic of opioid overuse, abuse, and overdoses

• Understand the priorities and strategies within the DoD and VA pain management strategies and initiatives

• Explain the DoD implementation plan for the Stepped Care Model of Pain Management and
DoD Pain Management Strategy and Initiatives

"Is this too much pressure?"

Chester ‘Trip’ Buckenmaier III, MD
COL (ret), MC, USA
Director, DVCIPM
Pain Management Task Force Report

- Provide recommendations for a MEDCOM comprehensive pain management strategy that is holistic, multidisciplinary, and multimodal in its approach, utilizes state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.

  » Army Pain Management Task Force Charter; signed 21 Aug 2009

Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research

  » June 2011, Institutes of Medicine
### Pain Mgt Task Force Findings (2010)

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>RESOURCES</th>
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</thead>
</table>
| - Integrative Pain Management (Tripler Army Hospital, Hawaii, and Naval Hospital San Diego)  
- Acute Pain Medicine (Walter Reed Army Medical Center)  
- Interventional Pain Medicine (Military Medical Centers) | - Warrior Transition Command Medication Policies  
  - Sole Provider  
  - Medication Reconciliation  
  - WTU Pharmacist  
  - Embed Pain Mgt Resources in WTU  
- VA Stepped Care Model |

### EDUCATION

- Primary Care Providers feel they are ill-prepared to handle “pain patients” and look to move them to specialty care ASAP  
- Lack of common orientation to pain among medical staff  
- Lack of common orientation to pain among Patients

### RESEARCH

- Need to improve translational research for pain management  
- Current research not fully leveraging the interest/capabilities power of clinicians in research  
- We are not able to track sufficient “actionable” pain data for our patients

### CAPABILITIES

- Lack of predictable pain management capabilities across our MTFs  
- Lack of standardization not unique to MEDCOM or DoD  
- Lack of non-medication modalities for pain mgt  
- Overwhelming majority of Providers not satisfied with pain management care received in network

### RESOURCES

- Many Providers not aware of Clinical Practice Guidelines for pain management  
- Clinical Practice Guidelines are not “user friendly”  
- MEDCOM not fully leveraging IM/IT capabilities to influence/optimize pain mgt practice  
- Need improved pain assessment tool  
- The perception of working in a system that asks for "A" (quality/satisfaction) but rewards "B" (productivity)
Evolution of Federal Medicine Pain Management & Opioid Safety

**Mandate/Organizations**
- **Army/DoD Pain Mgt Task Force**
- **Institute of Medicine: IAW Affordable Care Act**
- **NIH Interagency Pain Research Coordinating Committee**
- **NCCIH National Advisory Council**
- **DoD PMWG Chartered**
- **DoD Battlefield Pain Mgt CPG**
- **2009 - 2010**
- **2011 - 2012**
- **2013**
- **2014 - 2015**
- **2016 - 2018**

**Products/Deliverables**
- **VHA Pain Mgt Directive : 2009-053**
- **Pain Management Task Force Report**
- **IOM “Pain in America” Report**
- **MHS Policy Comprehensive Pain Management**
- **Army Comprehensive Pain Management Campaign**
- **NACCIH WG Report: Strengthening Collaborations w/ DoD and VA on CIH Pain Therapies**
- **NCCIH/DoD/VA Pain Research Collaboratory**
- **MHS Pain Clinical Support Service Chartered**
- **Presidential Memorandum: Prescription Med and Heroin Abuse**
- **Comprehensive Addiction and Recovery Act (CARA)**
- **CDC: Opioid Guidelines**
- **DoD/VA Opioid Clinical Practice Guideline**
- **NHS National Pain Strategy**
- **Pres Memo Directed: DoD Opioid Prescriber Training**
- **DHA PI: Pain Mgt and Opioid Safety**
- **DVCIPM designated as DoD CoE for Pain Mgt FEB 2016**
- **DoD/VA Opioid Clinical Practice Guideline**
- **Army Comprehensive Pain Management Campaign**
- **Navy Comprehensive Pain Management Program**

**Institute of Medicine: IAW Affordable Care Act**

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**DoD PMWG Chartered**

**DoD Battlefield Pain Mgt CPG**

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DHA Pt: Pain Mgt and Opioid Safety

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- Comprehensive Addiction and Recovery Act (CARA)
Another epidemic: Cholera

London, 1854: Cholera, John Snow and the Broad Street Pump
In 1803, Sert turner, a German pharmacist, identified and isolated the main ingredient of opium, Morphine. He called this alkaloid "Morphia" after Morpheus, the Greek God of Dreams. The name "Morphine" is now used instead of Morphia because of the standard that all alkaloids end in "-ine".
MHS Pain Management Priorities and Initiatives

**Improved Measurement:** Develop/Deploy
New Pain Scale that emphasizes improvements in function and quality of life (DVPRS)

**Standardize Pain Education:** Joint Pain Education Project (JPEP) developed common DoD/VA Pain curriculum

**Non-medication Pain Treatments:** Expand access to non-medication (non-opioid) pain treatments (Acupuncture, Yoga, Massage.....)

**Embrace Best Practices:** Adapt ECHO to increase capacity of MTFs to deliver quality pain care without on-site pain specialists

**Improve transitions of care:**
Align DoD and VA pain resources and strategies via HEC PMWG

**Promote New Pain Paradigm:** Developing educational products for patients and providers

**Evidenced Based Medicine:** Implement tiered pain management (VA Stepped Care Model)

**Improve External Collaborations:**
Establish research collaborations with academic medical centers

**Improve Provider Tools:**
Pain Assessment Screening Tool and Outcome Report (PASTOR)
“It’s now four years since I lay in the dirt, near death, on the side of the road in Fallujah. I’m grateful for all I have, and proud of the things I’ve accomplished.

In the end though, I don’t measure how far I’ve come by goals achieved, or academic degrees earned, or running trophies won. For me, what counts is that pain no longer rules my life.”

–Derek McGinnis

Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families
www.exitwoundsforveterans.org   American Pain Foundation
In 2008, there were 14,800 prescription painkiller deaths.¹

“Medicine is not a science; it is empiricism founded on a network of blunders.”
— Emmet Densmore (1837-1911)

TRICARE Enrollees

County-Level Percentage of TRICARE Enrollees
US Country Prescriptions 2016
Opioid Prescribing Weighted by Proportion of TRICARE Enrollees.

County-Level Opioid Prescribing Rate Weighted by Proportion of TRICARE Enrollees
Notes:
Only counties that had an opioid rx rate >100 per 100 people were selected. Then, weighted the data with the % of TRICARE enrollees. By selecting only the high rx counties, this ensures that the risk rate is not due to an extremely large TRICARE population.

• The highest-risk counties included:
  • 1. Okaloosa County, Florida (Duke Field, Eglin AFB and Hurlburt Field)
  • 2. Cumberland County, North Carolina (Fort Bragg)
  • 3. Montgomery County, Tennessee (Fort Campbell)
    4. Onslow County, North Carolina (Marine Corps Base, Camp Lejeune)
  • 5. Hardin County, Kentucky (Fort Knox)

Conclusion: We do not know how the external civilian environment impacts opioid use for service members and their family members. However, we have some ideas of where to start examining risk and resilience factors, especially the environmental factors extending beyond the boundaries of an MTF.
Why it matters?

Elements of Performance for LD.04.03.13

2. The hospital provides nonpharmacologic* pain treatment modalities.

* Nonpharmacologic strategies have previously been defined as: physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and physical therapy), relaxation therapy, and cognitive behavioral therapy.
What should we measure?
Most commonly used tools to measure pain in both civilian and military medicine settings are the 11-point, 0-10 Numeric Rating Scale (NRS) and Visual Analog Scale (VAS).

**NRS – Numeric Rating Scale**

**VAS - Visual Analog Scale**

Example: “What is your pain on a scale of 0 to 10”

Documented issues related to use and perception of the value of NRS/VAS Pain Scales:

- Inconsistently administered
- Subjective and with no functional component
- Tendency to focus providers and patients on “chasing zero”, often leading to unintended consequences of over-medication
- Although recorded in patient medical records, considered to have little value by clinicians at all levels
Both the idea that chronic pain could be effectively and safely managed with opioids and the principles of opioid pain management were based on the successful use of these drugs to treat acute and end-of-life pain. That success was based on the “titrate to effect” principle: the correct dose of an opioid was whatever dose provided pain relief, as measured by a pain-intensity scale.
Many Other Validated Scales are Available

1. What number best describes your pain on average in the past week:
   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>No pain</td>
<td>Pain as bad as you can imagine</td>
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2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

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<th>8</th>
<th>9</th>
<th>10</th>
</tr>
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<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
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3. What number best describes how, during the past week, pain has interfered with your general activity?

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PEG Scale

IPT – Iowa Pain Thermometer

FPS-R - Faces Pain Scale Revised
2010 Pain Management Task Force
Requirements for Revised Pain Scale

1. Validated: able to measure pain intensity AND bio-psychosocial/functional impact

2. Objective and able to evaluate treatment effectiveness

3. Practical and adaptable to multiple clinical settings and scenarios throughout the continuum of care
   (e.g. battlefield, transport, Combat Support Hospital, primary care, medical center, pain medicine specialty services)

4. Adaptable for integration into DoD and VHA electronic health record and registries

5. Standardized into all levels of medical training across all roles of care
   (e.g. useful for the medic, nurse, Primary Care provider, pain researcher and the pain management specialist)

6. Consistent with other validated pain research tools
# DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITY**:
   - 0 (Does not interfere)
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10 (Completely interferes)

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**:
   - 0 (Does not interfere)
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10 (Completely interferes)

3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**:
   - 0 (Does not affect)
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10 (Completely affects)

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**:
   - 0 (Does not contribute)
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10 (Contributes a great deal)


V 2.0
1. **Validated:** Measures pain intensity AND biopsychosocial and functional impact of pain (*sleep/stress/mood/activity*)

   *Pain Medicine. 2012:14;110-123*

2. **Improved objective components** to evaluate treatment effectiveness
   - *Provides greater insight on treatment progress and focus on function improvement*

3. **Adaptable to multiple clinical settings** and scenarios throughout the continuum of care and research
   - *e.g. battlefield, transport, Primary Care, specialty services*

4. **Adaptable for integration** into DoD/VHA EHR and registries
   - *Incorporated into Essentris, PASTOR, PCMH AIMs Forms*

5. **Consistent with current validated pain research tools** (*NRS, VAS, FPS-R*)

Download DVPRS at: [http://www.dvcipm.org/clinical-resources/pain-rating-scale](http://www.dvcipm.org/clinical-resources/pain-rating-scale)
A new take on an old scale…
RESEARCH ● OUTCOMES REGISTRY ● CLINICAL DECISION TOOL

• Web application served from MAMC
  – Clinical Assessment
    • Using validated computer adaptive testing (CAT) PROMIS instruments
  – Clinical Report/Decision Tool
    • Longitudinal pt pain/function/alert data in concise format
  – Patients Enter Information Prior to Appointments
    • Using the web capable device of their choice
PASTOR Clinical Report

- Pain Mapped by Region
- Clinical Alerts
- Patient Defined Goals

System went live on 14 June 2018
• Gen population percentile indicator

• Color Coding on each graph
Biopsychosocial Model of Chronic Pain

Biological
- Physical symptoms (sleep, sex drive, appetite)
- Hormone dysregulation
- Neuroplastic changes
- Autonomic and sensory changes
- Endocrine and immune dysregulation
- Motor reduction or pattern changes

Psychological
- Motivation alterations
- Emotion dysregulation
- Executive dysfunction
- Changes in attention
- Memory/learning impairments
- Altered perceptions

Social
- Reduced occupational role
- Reduced social role
- Social isolation
- Communication problems
- Alterations in empathy

Pain Intensity
Pain Interference

Treatment targets impacting one sphere may have indirect bearing on a different sphere.

Treatment selection must consider both direct and indirect effects.
Yoga for Chronic Lower Back Pain

- Participants randomized:
  - 8 weeks (12 sessions) individual yoga practice
  - treatment-as-usual (control)
- PROMIS, DVPRS, RMDQ @ Weeks 0, 4, 8, 13, & 26

RESTORE Yoga group reported early improvements, which maintained for full 6-months. Note, analyses corrected for multiple comparisons across four outcomes and five time points, therefore, the present findings are interpreted as preliminary.
When controlling for multiple comparisons, the RESTORE group had a higher proportion participants reporting clinically meaningful change at post-treatment for all outcomes, and for 6-month symptom burden.
"It is more important to know what sort of person has a disease than to know what sort of disease a person has." ~ Hippocrates (460-377 B.C.)
Show me the data…

“If the camel once gets his nose in the tent, his body will soon follow.” – Arabian Proverb
Pain Management and the Opioid Safety Initiative in VHA

Friedhelm Sandbrink, M.D.

National Program Director for Pain Management, Specialty Care Services
Director Pain Management, Washington DC VA Medical Center

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Overview

• Background
  – Pain crisis
  – Opioid crisis
  – Overdose and suicide risk

• Pain care transformation in VHA
  – Opioid Safety Initiative - overview
  – Non-pharmacological pain care
  – Pain Management Teams

• CARA legislation
  – Opioid Safety Initiative - data
  – Opioid Use Disorder (OUD)
Prevalence of Pain in Veterans (US population)
National Health Interview Survey

Chronic pain is more common in Veterans than in non-veterans and more often severe.

- 66% of Veterans vs. 56% of non-veterans with pain in prior 3 months
- Severe pain in Veterans is 40% more common than in non-Veterans
- Most common pain conditions: musculoskeletal pain (joint 44%, back 33%, neck 1%)

Severe Pain
Pain which occurs "most days" or "every day" and bothers the individual "a lot,"

Severe Pain in Veterans
Analysis of Data From the National Health Interview Survey (NHIS)

Severe Pain by Age: Veterans vs Nonveterans

Severe Pain by Sex: Veterans vs Nonveterans
Chronic pain in Veterans receiving care in VHA is often severe and in the context of mental health comorbidities.

– 60% of Veterans from Middle East conflicts with chronic pain, up to 75% in women Veterans.
– More than 2 Mil Veterans with chronic pain diagnosis (In 2012, 1/3 on opioids).

– MH and Pain conditions increased in prevalence from 2008 to 2015.
– Increase in pain scores/pain severity.

Pain in Veterans (in VHA):
1 in 3 with chronic pain diagnosis
1 in 5 with persistent pain
1 in 10 with severe persistent pain
Pain Management and Opioid Safety as Foundational Services

- Pain severity and co-concurrence with mental health comorbidities result in high impact pain.
- Pain, medical and/or mental comorbidities are often related to military service and/or require Veteran-specific expertise.
- Veterans are at higher risk for harms from opioids/accidental poisoning than non-veterans.
- “The most frequently identified risk factor among Veterans who died by suicide was pain” (2015, 2017).
- Integrated care: systematic coordination of medical, psychological and social aspects of health care

VHA: Pain Management and Opioid Safety is included in the list of “Foundational Services”
Overdose Deaths Involving Opioids: 3 Waves

1) Natural and semi-synthetic opioid deaths increased 4-fold from 1999 to 2011; Methadone rate increased 6-fold from 1999 to 2007
2) Heroin death rate increased over 5-fold since 2011
3) Synthetic opioid (excluding methadone) death rate increased more than 6-fold from 2013 to 2016

"Bleak New Estimates in Drug Epidemic: A Record 72,000 Overdose Deaths in 2017"

The New York Times Aug 15, 2018
By Margot Sanger-Katz

- Rise of around 10% since 2016
- Higher than HIV, car crashes or gun deaths
- Dominant factor is the changing drug supply (more deadly).

* Provisional counts for 2017, not yet finalized.

Opioid Overdoses as the Tip of the Iceberg

For every 1 prescription or illicit opioid overdose death in 2015 there were...

- 18 people who had a substance use disorder involving heroin
- 62 people who had a substance use disorder involving prescription opioids
- 377 people who misused prescription opioids in the past year
- 2,946 people who used prescription opioids in the past year

Results from the 2015 National Survey of Drug Use and Health, as reported by
Risk factors are related to:
- Opioid prescribing
- Interaction with other medication/drugs
- Medical comorbidities
- Mental health comorbidities

“Opioid dosage was the factor most consistently analyzed and also associated with increased risk of overdose. Other risk factors include concurrent use of sedative hypnotics, use of extended-release/long-acting opioids, and the presence of substance use and other mental health disorder comorbidities.”

Review of 15 articles published between 2007 and 2015 that examined risk factors for fatal and nonfatal overdose in patients receiving opioid analgesics.
Mortality of all causes: HR 1.64 for LA opioids

Overdose deaths

HR 7.18-8.9 for MME > 100 mg/d

**Opioid use disorder**

Long-term opioids (> 90 d)

- Low dose 1-36 mg/d MME: HR 15
- Medium 36-120 mg/d MME: HR 29
- High > 120 mg/d MME: HR 122

3x ↑ risk of OUD

Up to 122x ↑ risk
Veterans: Risk Factors for Overdose/Suicide

Odds Ratios for Overdose/Suicide-Related Events

Opioid type, tramadol = reference
- Long-acting 1.5x
- Chronic, short acting 1.1x
- Acute, short acting 1.1x
Risk increased slightly with increasing MEDD
- e.g., 120 MEDD would increase modeled risk by about as much as a PTSD or AUD diagnosis

STORM Analysis: Oliva et. al. Psych. Services 2017

Medical comorbidity
- Benzo: 1.4
- HIV: 2.2
- Ecl. Dis.: 2
- Liver dis: 2.2
- Other Neuro: 2.1
- PTSD: 2.6
- Depression: 4.8

Psychiatric comorbidity
- Bipolar: 5.8
- Other MH: 5.7
- AUD: 5.3
- Stimulant: 8.1
- OUD: 8

SUD
- Sedative UD: 11.2
- IP MH Tx: 16.6
- Detox: 18.5
- OD/suicide: 23.1

Healthcare utilization
Almost 4 out of every 5 patients who died from overdose/suicide were prescribed doses < 90 MEDD
Almost 3 out of every 4 overdose/suicide deaths were among patients with MH/SUD diagnoses
More than 1 out of every 2 deaths were among patients with MH/SUD diagnoses prescribed < 90 MEDD
Paradigm Shift in Pain Care

- **Paradigm shift away from opioid therapy** for non-end-of-life pain management.
  - There is no completely safe opioid dose threshold below which there are no risks for adverse outcomes.
  - Even a short-term use of low dose opioids may result in addiction.
  - Realization that any initial, short-term functional benefit will likely not be sustained in most patients.
  - Prolonged use of opioids, especially in higher doses, may lead to central sensitization and increase in pain over time (*Opioid Induced Hyperalgesia*).
  - Patients on opioids may actually experience a functional decline in the long term, measured by factors like returning to employment.

- **Paradigm shift towards multimodal and integrated team-based pain care** (*biopsychosocial interdisciplinary care*)
The VA Opioid Safety Initiative (OSI) expanded nationally in FY 2013.

• **OSI Aims**
  - Reduce over-reliance on opioid analgesics for pain management.
  - Safe and effective use of opioid therapy when clinically indicated.

• **Comprehensive OSI strategy includes**
  - Provider education; Academic Detailing.
  - Access to non-pharmacological modalities, incl. behavioral and complementary integrative health (CIH) modalities.

• **OSI Dashboard**
  - Totality of opioid use visible within VA.
  - Provides feedback to stakeholders at VA facilities regarding key opioid parameters.
The VA Opioid Safety Initiative (OSI) Timeline

- **2007**: Launch of the Buprenorphine in VA (BIV) Initiative
- **2008**: VA National Pain Directive established
- **2009**: VA Pain Directive
- **2010**: OSI and AD - created standardized metrics for pain management therapies to pilot Opioid Safety Initiative (OSI) and select regions pilot Academic Detailing (AD)
- **2011**: OSI and AD
- **2012**: OSI and PDSI - Opioid Safety Initiative (OSI) expands nationally, Psychotropic Drug Safety Initiative (PDSI) launched nationally
- **2013**: OSI Launch - Opioid Safety Initiative (OSI) launched in 5 regions
- **2014**: Targeted intervention and OEND - Targeted interventions for opioid reduction in very high dose opioid patients, Overdose Education and Naloxone Distribution (OEND) campaign
- **2015**: Academy Detailing - Academic Detailing (AD) expands nationally to enhance Veteran outcomes by promoting evidence-based treatments
- **2016**: Teams, CPGs, and AD - Pain Management Teams at all VA facilities (consistent with CARA requirements), VA-DoD develop Clinical Practice Guidelines (CPGs) on Opioid Therapy for Chronic Pain as well as Low Back Pain, Academic Detailing Opioid Use Disorder (OUD) Campaign
- **2017**: SUD and CARA - VA-DoD develop clinical practice guideline (CPG) on Management of Substance Use Disorder (SUD), Comprehensive Addiction and Recovery Act (CARA) implementation in VHA

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**OHRM Initiative and PRIME Research**
- Opioid High Risk Medication Initiative
  - Policy requiring access to medication for OUD
- VA Pain Research, Informatics, Multimorbidities, and Education (PRIME) Center studies interaction between pain/associated chronic conditions and behavioral health factors

**VA-DoD FIRST**
- VA-DoD develop clinical practice guideline (CPG) on Opioid Therapy in Chronic Pain (FIRST)
The Opioid Crisis – National Initiatives

• Presidential Memorandum: Addressing Prescription Drug Abuse and Heroin Use (Oct. 2015)
  – Training of all federal prescribers; Access to addiction treatment incl. MAT for patients with OUD
• CDC Opioid Prescribing Guidelines (March 2016)
  – Guidance for primary care providers, to encourage dialogue with patients
• National Pain Strategy (April 2016)
• Comprehensive Addiction and Recovery Act (CARA) (July 2016)
  – Title IX: Jason Simcakoski Memorial Act with specific VHA mandates
  – Pain Management Best Practices Taskforce (HHS)
  – 56 recommendations
• President Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand (March 2018)
  – 1. Reduce drug demand through education, awareness, and preventing over-prescription; 2. Cut-off flow of illicit drugs; 3. Save lives by expanding proven addiction treatments
• Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) (June 2018)
  – Establishes Veterans Community Care Program, training, opioid safety, PDMP access for VA providers, expands telemedicine, peer support.
“We recommend against initiation of long-term opioid therapy. We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments. When pharmacologic therapies are used, we recommend non-opioids over opioids”.

– Recommendation against opioid therapy in patients < 30 years of age, in patients with active substance use disorder, and in combination with benzos.
– Recommendation for risk mitigation strategies, including UDT, PDMP, Naloxone distribution.
– If prescribing opioids: short duration and lowest dosage
– **No dosage is safe;** Strong rec against of opioids to > 90 MEDD.
– Opioid dosage **reduction should be individualized** to patient.
  *Avoid sudden reductions; taper slowly if opioid risk > benefit,*
– Acute pain: use alternatives to opioids; if opioids ≤ 3-5 days
– For OUD, offer medication assisted treatment.
– Assess for Suicide risk

https://www.healthquality.va.gov/guidelines/Pain/cot/
Non-Pharmacological Pain Treatments in VHA

VA State of the Art Conference Nov. 2016: Evidence-based non-pharmacological approaches for MSK pain management
- Evidence to support CIH and conventional therapies.
- Provision of multi-modal therapies accessible from Primary Care.

VHA Directive 1137: Advancing Complementary and Integrative Health (May 2017)
- List 1: Approaches with published evidence of promising or potential benefit.
  - Acupuncture
  - Massage Therapy
  - Tai Chi
  - Meditation
  - Yoga
  - Clinical Hypnosis
  - Biofeedback
  - Guided Imagery

- Chiropractic Care was approved as a covered benefit in VHA in 2004 and is part of VA whole health care.
- To be made available across the system, if recommended by the Veteran’s health care team.
The Whole Health approach is a reorientation of the Veteran’s relationship with VA. It combines conventional medicine with personalized health planning, CIH, and innovative, self-care approaches.
For chronic low back pain:
- Cognitive behavioral therapy (strong for)
- Mindfulness based stress reduction
- Clinician-directed exercises
- Exercise program, which may include Pilates, Yoga, and Tai Chi
- Acupuncture.

For acute/chronic low back pain: spinal mobilization/manipulation.
- For selected patients with chronic low back pain not satisfactorily responding to more limited approaches, we suggest offering a **multidisciplinary or interdisciplinary rehabilitation program**
- Include at least one physical component and at least one other component of the biopsychosocial model (psychological, social, occupational) used in an explicitly coordinated manner.

https://www.healthquality.va.gov/guidelines/Pain/lbp/
Updated Sept. 2017
Stepped Care Model for Pain Management (SCM-PM)

Foundational Step: Self-Care/Self-Management
- Broad approach.
- Primary Care (PACT) = Medical Home
  - Coordinated care and a long-term healing relationship, instead of episodic care based on illness
  - Primary Care Mental Health Integration (PCMHI) at all facilities

CARA Legislation:
- Full implementation of the SCM-PM
- Pain Management Teams at all facilities
The functions of the Pain Management Team (PMT) include:

- Evaluation of patients with complex pain conditions
- Resources to provide for *follow-up care as clinically indicated*
- *Medication management and actual prescribing* of pain meds, as needed
- Review of the clinical care of patients with high risk for overdose or suicide

At a minimum, the composition of the PMT must include:

- Medical Provider with Pain Expertise
- *Addiction Medicine expertise* to provide evaluation for Opioid Use Disorder (OUD) and access to Medication-Assisted Treatment (MAT)
- Behavioral Medicine with at least one evidence-based behavioral therapy.
- Rehabilitation Medicine discipline.

Optional team members: Interventional pain provider, Nursing, Case/Care manager, Pharmacist, etc.
Collaborative Pain Care

The Old Paradigm: Veteran needs specialist

Pain Specialty Team support individualized to the needs of the patient and providers.

Pain Specialty and the Expanded PACT Team

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

PACT Teamlet

Pain Specialty Team

PACT Teamlet

PACT Teamlet

Pact Teamlet

Pain Specialty Team

Veteran and PACT team with input from Pain Team, but not necessarily a visit (e.g. E-consultation)

Co-management with in-person evaluation and treatment by Pain Team (e.g. diagnostic evaluation; pain procedure)

Interdisciplinary pain specialty care with regular f/u by Pain team (e.g. CARF pain rehabilitation)

Pain Team support individualized to the needs of the patient and providers.
1. Veteran-centric biopsychosocial pain care systemwide in VHA.
2. Well-trained PACT teams supported by access to patient education/self-care programs and non-pharmacological pain treatment modalities.
3. Veterans with high impact chronic pain or at risk for chronification benefit from interdisciplinary Pain Team that works collaboratively with PACT.
4. Opioid risk review teams as example of bringing the Veteran’s providers together.
5. VA Telehealth, E-consultation, VA-ECHO are tools to maximize resources.
6. Team integration of MH providers and Case Management are essential.
7. The Stepped Care for Opioid Use Disorder brings OUD care to “where the Veterans are”.
8. System-wide care: Interfacility cooperation (hub and spoke), attention to care transitions.
9. Integration and collaboration with Community Care.
10. Metrics to monitor pain care and outcomes at the individual and population level.
The CARA Bill is a comprehensive effort to address the opioid addiction epidemic. **NINE TITLES** related to Pain Management, Opioid Prescribing and Opioid Safety including Opioid Use Disorder covering

- (I) prevention and education;
- (II) law enforcement and treatment;
- (III) treatment and recovery;
- (IV) addressing collateral consequences of opioid use;
- (V) addiction and treatment services for women, families, and Veterans;
- (VI) incentivizing State comprehensive initiatives to address prescription opioid abuse;
- (VII) miscellaneous provisions;
- (VIII) improvements to the Kingpin Designation Act; (narcotics trafficking; 2000)
- (IX) various measures affecting the Department of Veterans Affairs (VA)

= **“Jason Simcakoski Memorial and Promise Act”**

- **Deliverables:** 54 specific deliverables/milestones in CARA
Comprehensive Addiction Recovery Act (CARA)
PUBLIC LAW 114–198—JULY 22, 2016

- **Community interactions**: 90-day regular meetings.
- Expanded **VA Patient Advocacy program**.
- **VA/DoD Health Executive Committee Pain Management Workgroup**.
- System-wide implementation of the **Opioid Safety Initiative**.
  - Opioid risk mitigation strategies: PDMP, UDS, informed consent.
  - Opioid Overdose Education and Naloxone Distribution (OEND)
- **Dashboards** to assess risk and monitoring opioid/pain care
- **VA-DoD Clinical Practice Guideline** for Opioid Therapy of Chronic Pain.
- **Provider education** in evidence based pain care
- Reporting of providers/facilities in conflict with care standards
- Expanded **complementary and integrative health (CIH)** modalities, Whole Health flagship sites, CIH training and research.
- Full compliance with **Stepped Care Model of Pain Management**
- **Pain Management Teams** at all VA facilities.
- Full implementation of the **Stepped Care Model for Pain Management**
- Monetary limits on VA Awards and Bonuses.

- 39 milestones complete
- 7 milestones are in progress
- 8 additional milestones have no legislative date, or future dated
• Implementation of USH Notice 18-08, Utilizing STORM to Conduct High Risk Case Reviews and Risk Reviews prior to starting opioid therapy.
• Required community meetings at VAMC and CBOCs: 90-day and annual meetings.
• Full compliance with Pain Management Teams at all VA facilities.
• Full compliance with Stepped Care Model of Pain Management.
• Full compliance with the implementation of Academic Detailing at all sites.
• Expanding/enhancing VA Patient Advocacy program.
• Expanding availability of complementary and integrative health modalities.
• Continued system-wide implementation of the Opioid Safety Initiative.
  – Opioid risk mitigation strategies: PDMP, UDS, informed consent.
  – Opioid Overdose Education and Naloxone Distribution (OEND)
Additional mandates influencing and impacting CARA requirements, opioid prescribing, pain management, and Opioid Use Disorder/Substance Use Disorder treatments in VA:

- **President’s Commission on Combating Drug Addiction and the Opioid Crisis**
- **Presidential Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand**
  1. Reduce drug demand through education, awareness, and preventing over-prescription.
  2. Cut-off flow of illicit drugs across our borders and within communities.
  3. Save lives now by expanding opportunities for proven treatments for drug addictions.
- **VA Mission Act of 2018**
  - *Sec. 131. Ensure safe opioid prescribing practices by non-VA health care providers.*
    - Educating community care providers on VA Opioid Safety Initiative
    - Monitoring community care providers by VA with respect to adherence to VA Opioid safety guidelines
    - Enhance bi-directional prescribing data between community providers and VA providers
  - *Sec. 134. Department of Veterans Affairs participation in national network PDMPs.*
OSI Parameters/Opioid Risk Mitigation Strategies

OSI Dashboard

1. Opioid use overall, and Long-term opioid use
2. Opioid and Benzo co-prescribing
3. High dose >100 MEDD
4. Urine Drug Testing mandated within the last 12 months

   - **Informed Consent** policy issued 2014, for all pts on LTOT (90 d)
   - **PDMP** policy issued 2016, at least annually, for > 5 d supply
   - **OEND – Overdose Education and Naloxone Distribution**
     Naloxone for all pts at risk, broad inclusion, no cost to Veterans
   - **Opioid Risk Reviews (STORM data-based)** policy issued 2018
     - Systematic reviews of very high risk patients (centralized)
     - Point of care reviews prior to initiating opioid therapy (prescriber)
   - **Timely f/u** within 1-4 wks after dosage change; ≤ q3 months to review care

   LOT = Long-term opioid therapy

   >90% of LOT
   >90% of LOT
   >80% of LOT
   NEW!
Veterans with Opioid prescription: 48% ↓ (excludes tramadol). Veterans with opioid dispensed in reporting quarter as percentage of all Veterans with pharmacy activity

Source: Pharmacy Benefits Management (PBM) Services
Reduction in Opioid Prescribing in VHA

Decline in Prescription Opioids Attributable to Decreases in Long-Term Use: A Retrospective Study in the Veterans Health Administration 2010–2016

Hadlandsmyth et al, J Gen Intern Med 2018

- 83% of decline in opioid scripts due to decreases in long-term opioid therapy (LOT).
- 90% of reduction from fewer new LOT prescription fills.
- < 10% from increases in cessation of existing LOT users
**Provider Education: Academic Detailing**

- **In-person** educational outreach
- Evidence-based information and tools
- Pharmacists skilled in persuasive communication
- Trusted and useful *relationship* with providers
- Training/provider tools
- > 28,000 outreach visits (June 30, 2018)
- Multiple campaigns, examples: Pain Management, Opioid Safety Initiative, Opioid Use Disorder (OUD), Insomnia; Psychotropic Drug Safety Initiative (PDSI), incl. benzodiazepines.

**AD Exposure and Naloxone Prescribing**

- [Graph showing AD-exposed and AD-unexposed naloxone prescribing trends over time](image)
  - @12 months: IRR=3.2 (95% CI: 2.0, 5.3)
  - @24 months: IRR=7.4 (95% CI: 3.0, 17.9)
• Overdose Education (OE)  
  – How to *prevent, recognize, and respond* to an opioid overdose.

• Naloxone Distribution (ND)  
  – FDA approved as *naloxone auto injector and nasal spray.*  
  – *Dispense and train* patient and caregiver/family.

• Target patient populations: OUD and prescribed opioids.

• **Naloxone to be offered widely, low threshold for prescribing.**  
  – Factors that increase risk for opioid overdose include h/o overdose, h/o SUD, higher opioid dosages (≥50 MMED), or concurrent benzodiazepine use. Offer to patients with recent opioid discontinuations or during tapering of opioids

• **More than 174,000 kits dispensed, with 345 overdose reversals** (June 30, 2018)

• **No cost to patients** (elimination of copays for naloxone and training, as per CARA)

• **Rapid Naloxone Initiative**: disseminate to first responders/police and to AED cabinets at VA facilities.
Stratification Tool for Opioid Risk Mitigation – STORM

- Predicts individual risk of overdose or suicide-related health events or death in the next year
- For patients on opioids and when considering opioid therapy.
- Identifies patients at-risk for opioid overdose/suicide-related adverse events.
- Provides patient-centered opioid risk mitigation strategies, targeted at risk level.

https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx
Systematic review of the clinical care of patients at high risk for overdose or suicide

• 20-30% of patients with opioid overdoses are estimated to be intentional/suicidal.

• STORM dashboard identifies Veterans at very high risk.

• Other patients with high risk: dosage, opioid/benzo combination etc.

• OSI review teams include Primary Care, Pain specialty, MH, SUD programs.

• Care coordination across services.

• Care recommendations entered into the EMR to assist clinical providers.

Stratification Tool for Opioid Risk Mitigation (STORM)

• Model for interdisciplinary case review forums at facilities for patients with complex pain conditions.

• Routine screening for suicide risk in Primary Care, Mental Health, Pain, and Sleep Clinics.

Oliva et al. Psychol Serv. 2017;14:34-49
Approaching Opioid Tapering

• Integrated approach with patient buy-in and active participation
  – Goal is to improve function and long-term outcome while reducing risk.
  – Slower, more gradual tapers are often better tolerated, may take months to years.
  – Sudden interruption of opioid prescribing must be avoided with few safety exceptions.

• Provider approach: empathetic, personalized, building trust.

• Assess and address patient needs/concerns incl. psychological factors.
  Close collaboration with MH providers and integrated access to OUD treatment.
  – Patients are often scared about opioid dosage reduction
  – Expectations should be clear and reasonable/achievable
  – Assess patient preference regarding dosage changes (LA/IR opioid, timing)
  – Evidence of OUD may manifest during opioid dosage reduction

• Patients are often at high risk for overdose after tapering.
  – Protracted withdrawal and lowered tolerance increase risk of OD after opioid discontinuation.
  – Follow-up is recommended within 1 to 4 weeks after dosage adjustment.

• Caution: Involuntary tapers carry greater risk and interfere with provider/patient relationship.
Opioid Use Disorder (OUD) in Veterans

Prevalence of SUD in VHA
- 10% of Veterans (600,000 in FY15)
- AUD >> other SUD

“Diagnosed” OUD
- 1.1% of Veterans, 60,000+ (FY 2015)
- 23,000 Vets on MAT (2016)

What is the prevalence of OUD in Veterans on long-term opioids?

NOTE: Beginning in FY2016, VHA shifted from ICD-9 to ICD-10 diagnosis coding. Data from FY2016 onward should not be compared directly with those obtained in prior years using ICD-9 coding.
VHA Stepped Care for OUD

• Pain Management Teams must include providers with addiction expertise to allow for integrated access to OUD evaluation and treatment.

• Medication Assisted Treatment (MAT):
  • Buprenorphine/naloxone
  • Methadone
  • Naltrexone (incl. injection)

• Stepped Care for Opioid Use Disorder
  • Training began in August 2018
1. The Opioid Crisis in the US has **shifted from overdoses to prescription opioids to illicit drugs**, most recently synthetic opioids (i.e. fentanyl).

2. Risk of prescription opioids is correlated with **dosage and duration**.

3. Opioids in **combination with sedating drugs** are particularly dangerous.

4. **Mental health/substance use disorder** contribute greatly to risk.

5. The VA/DoD CPG for Opioid Therapy **recommends against initiation of long-term opioid therapy** for chronic pain.

6. Opioid risk mitigation strategies systemwide.

7. Overdose education and widespread **naloxone distribution** (OEND).

8. Opioid dosage reduction (opioid tapering) must be patient-centered and individualized with the goal to maximize function and safety.

9. Many (but not most) patients with long-term opioid therapy fulfill criteria for OUD and must be offered **access to evidence-based OUD therapy**.
Thank You

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THANKS TO:
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• PACT Pain Champions, Primary Care
• PBM/Pharmacy
• Academic Detailing
• Mental Health
• Suicide Prevention
• Addiction Medicine
• Nursing Service
• Rehabilitation Medicine
• Integrative Health, IHCC and OPCC
• EES, Ethics
• Connected Care/Telehealth
• DoD partners/colleagues
• The Veterans and their families

www.va.gov/painmanagement
Stepped Care Model for Pain Implementation
Disclaimer

The views expressed are those of the author and do not reflect the official policy of the Department of Defense (DoD), the U.S. Public Health Service, or the U.S. Government.

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Objectives

At the end of this presentation, participants will:

2. Understand how upcoming Stepped Care Model for Pain implementation pathway intends to operationalize the DHA-PI 6025.04.
Task: Implementation of DHA-PI 6025.04

Stepped Care Model for Pain pathway to implement DHA-PI 6025.04 Pain Management and Opioid Safety in the Military Health System (MHS) dated June 8, 2018 aims to:

- Enable Clinical Communities to provide evidence-based pain management guided by clinical practice guidelines.
- Effectively treat acute and chronic pain.
- Promote non-pharmacologic treatment of pain.
- Prevent acute pain from becoming chronic.
- Minimize use of opioids with appropriate prescribing and risk mitigation.
Providing Evidence-Based Management Guided by Guidelines

- Clinical guidelines can help improve providers’ professional practice and quality of care, and may empower patients to make more informed choices.

- Presence of guidelines does not necessarily mean recommendations are followed. In a Dutch observational study, for example, GPs followed guidelines in 61% of relevant decisions.

- Complexity matters. Guidelines have a greater chance of being used when easy to understand, can easily be tried out, do not require specific resources...

**Uh oh!**


SCM for Pain Implementation
Work Group Members

- Defense Health Agency and Tri-Service clinical subject matter experts
  - Primary care managers
  - Pain specialists
  - Health psychologists
  - Nurses
  - Pharmacists
- Analytics subject matter experts
- Enabling groups:
  - Defense and Veterans Center for Integrative Pain Management (DVCIPM)
  - Psychological Health Center of Excellence (PHCoE)
  - Uniformed Services University and external academia

“Medically Ready Force...Ready Medical Force”
Clinical pathway:
a documented sequence of clinical interventions, placed in an
appropriate timeframe, written and agreed to by a multidisciplinary
team. They help a patient with a
specific condition or diagnosis move progressively through a clinical
experience to a desired outcome.”

Hunter, B. & Sergott, S. (2008). Re-mapping client journeys and
professional identities: A review of the literature on clinical pathways.
Operationalizing the DHA-PI 6025.04 Pathway will enable patient-centered medical home staff to:

1. Understand the patient variables that perpetuate pain.
2. Screen patients for pain using the Defense and Veterans Pain Rating Scale.
3. Complete a biopsychosocial assessment.
4. Provide pain education and collaboratively set treatment goals.
5. Create an evidence-based, comprehensive treatment plan to effectively treat acute and chronic pain; promote non-pharmacologic treatment; and prevent acute pain from becoming chronic.
7. Minimize use of opioids; assess and minimize risk when used.
8. Determine level of the Stepped Care Model; connect with team members.

“Medically Ready Force...Ready Medical Force”
Pathway Implementation Components

- Algorithm/work flow
- Initial trainings
  - Champion training
  - PCMH training
  - IBHC training
  - Screener breakout training
  - Care coordinator breakout
- Follow-up support
  - Champion mentorship
  - Academic advising
  - Weekly training tid-bits
- Strategic messaging
- Job aids/tools for clinic staff
  - Tri-folds
  - Exit planning sheet
  - Talking points for providers
  - AHLTA TSWF updates
- Tools for champion
  - Mapping tool
  - Champion reporting tool
  - Implementation checklist
  - Data pulls
  - Feedback forms
  - Smart book
Learning Objectives

Job Aids and Tools

“Medically Ready Force...Ready Medical Force”
Exit Tool to Support Collaborating with Patient on a Treatment Plan

Your Pain Treatment Plan may include some of the following approaches

**Behavioral Health Modalities**
- Cognitive Behavioral Therapy
- Acceptance and Commitment Therapy
- Mindfulness, Meditation
- Problem-solving therapy

**Interdisciplinary Programs**

**Self Management**
- Education about pain
- Physical activity/movement
  - Stretching, walking
  - Strengthening
  - Pool/Aquatics
  - Yoga, tai chi
- Pacing
- Posture
- Performance, sleep, activity and nutrition tailored for added emphasis

**Physical Modalities**
- Physical therapy
- Occupational therapy
- Complementary and Integrative Health therapies
  - Chiropractic, Acupuncture, Yoga, Massage
  - Biofeedback

**Therapeutic injections**
- Trigger point injection
- Radiofrequency nerve ablation
- Epidural steroid injection
- Joint injection

**Medications**
- Your provider will determine if medications are recommended for you

Figure courtesy of Dr. Diane Flynn

“Medically Ready Force...Ready Medical Force”
Use of multifaceted implementation interventions are more likely to be effective than single interventions.¹

Stepped Care Model for Pain implementation incorporates a number of implementation strategies, including:

- Mapping of current clinic practices to desired practices.
- Use of local champions.
- Provider/team education.
- Audit and feedback.
- Assessment of/intervention for local barriers.
- Reminders (electronic health record, job aids and tools).

Connect with PHCoE

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“Medically Ready Force...Ready Medical Force”
Questions