Army Pain Management Task Force

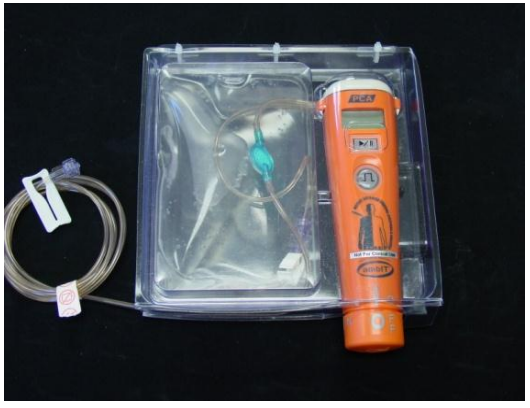
Findings-Recommendations-Way Ahead

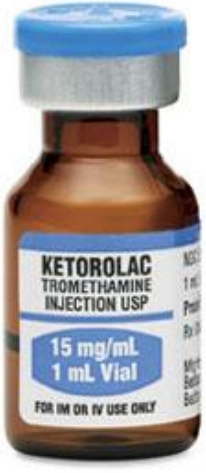
COL Chester "Trip" Buckenmaier, MC

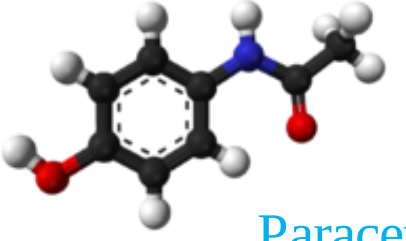
"What an infinite blessing."

21st Century Evacuation Realities

Novel pain control methods and equipment

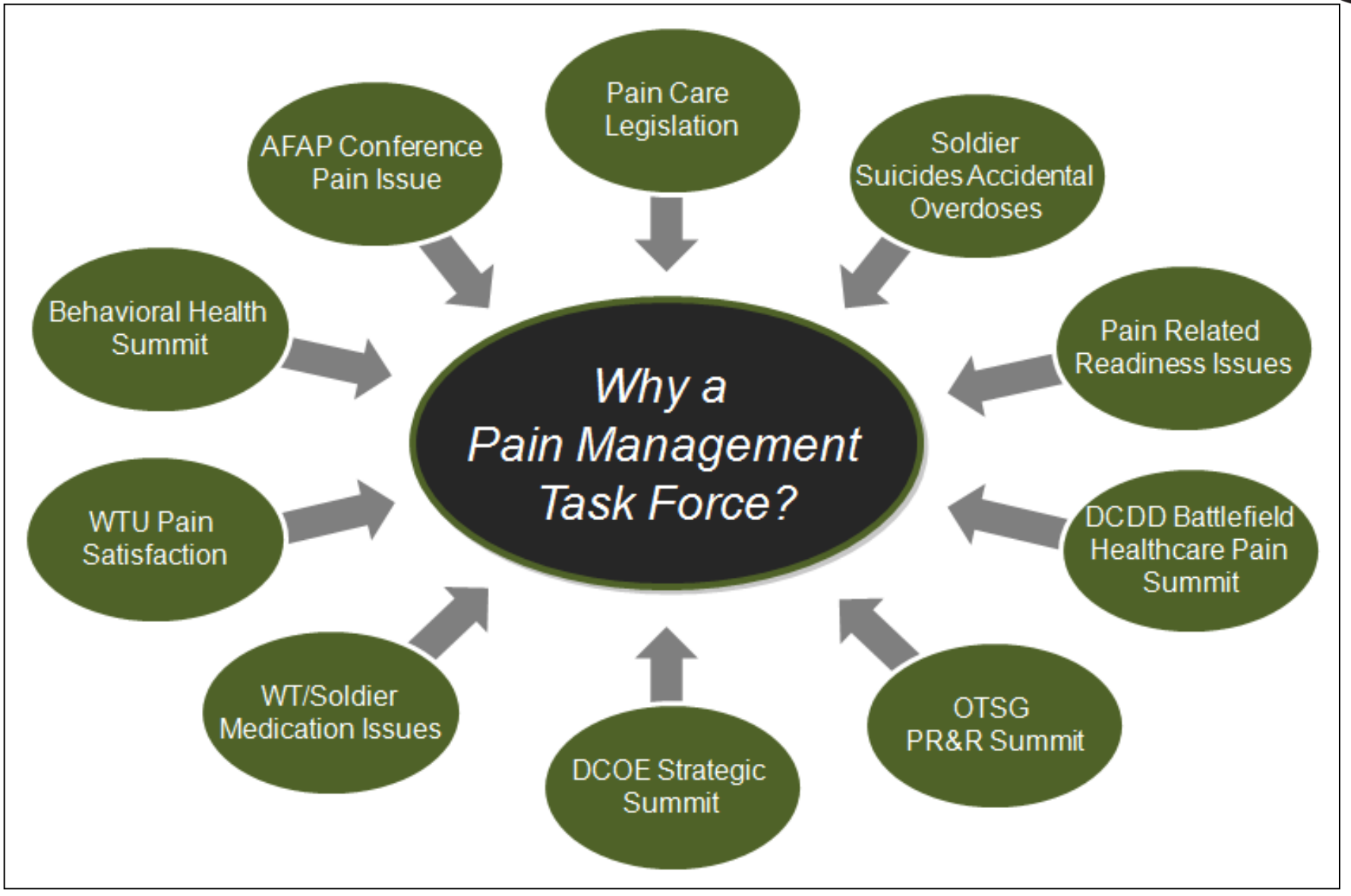






Paracetamol

Pain Management Task Force



Mission

To 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.

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

Vision Statement

Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families

"Standardize to Optimize"

Task Force Process

- TSG appointed BG Richard Thomas, Assistant Surgeon General for Force Projection, as the TF Chairperson
- Air Force, Navy, and Veterans Health Administration appointed TF representatives

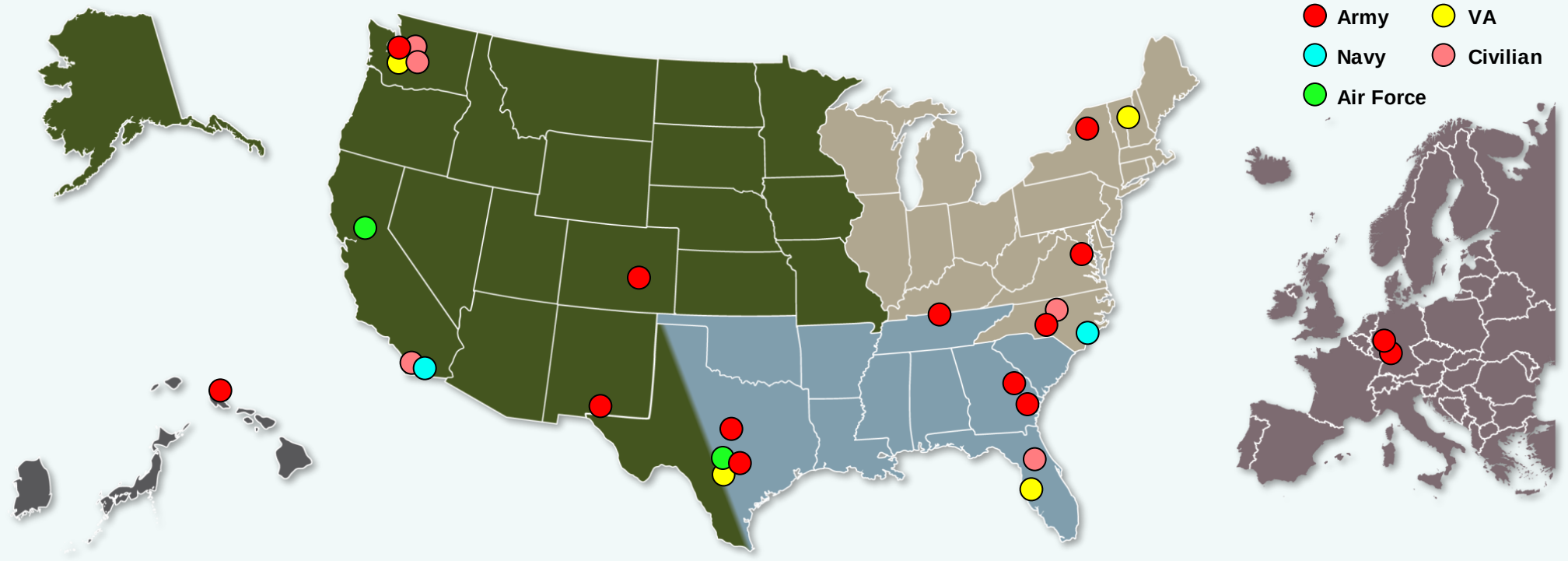
TASK FORCE

Army Reserve	National Guard	M&RA
TMA/Health Affairs	Warrior Transition Command	DCOE
Behavioral Health	Case Management	Integrated Medicine
Nursing	Occupational Therapy	Pain Management
Pharmacy	Physical Therapy	PM&R
Primary Care	Social Work	Family Medicine

Site Visit Map

WESTERN Region

NORTHERN Region



PACIFIC Region

1	Fort Lewis (MAMC) & Puget Sound VA & Univ of Washington & Swedish Hospital
2	Fort Drum (GAHC)
3	San Antonio VA,& Wilford Hall & Fort Sam Houston (BAMC)

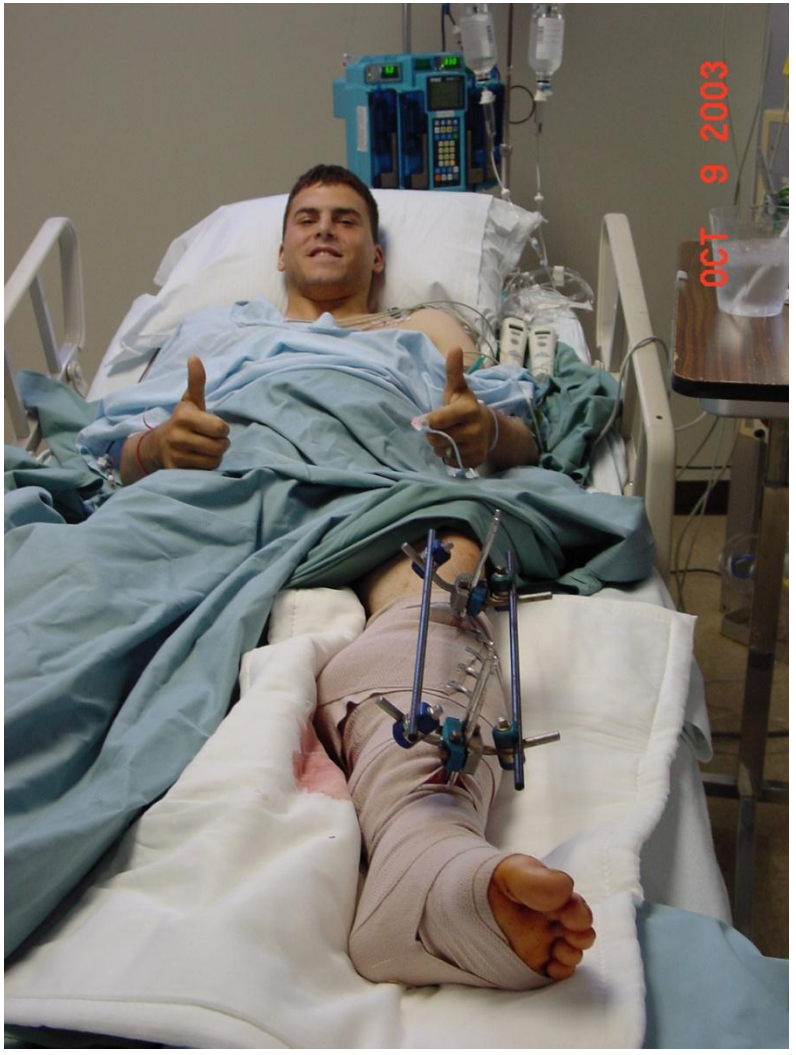
SOUTHERN Region

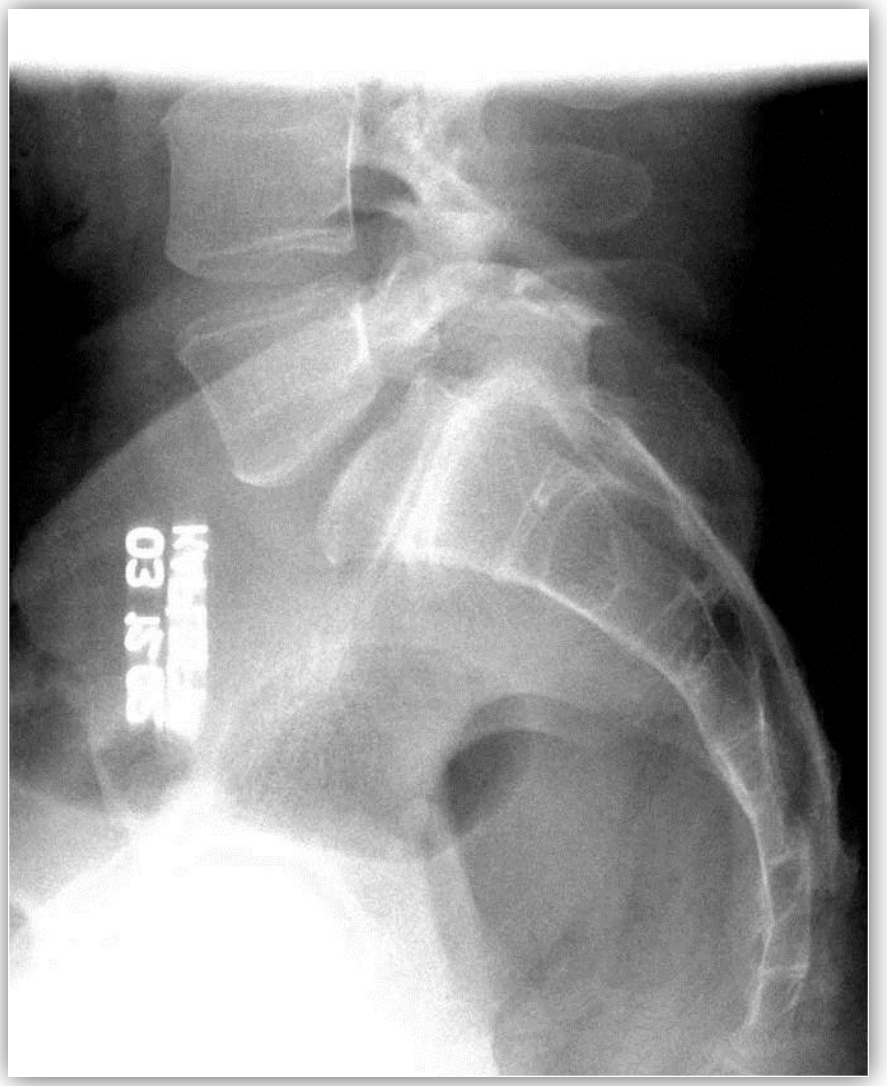
4	Fort Carson (EACH)
5	Fort Bliss (WBAMC) & Fort Hood (CRDAMC)
6	Tampa VA & Univ of Florida
7	Balboa Naval Hospital) & Travis AFB & Scripps Center
8	Landstuhl (LRMC) & Baumholder AHC
9	Duke Univ & Camp Lejeune & Fort Bragg (WAMC)
10	Fort Campbell (BACH)

EUROPEAN Region

11	Honolulu (TAMC)
12	Fort Gordon (DDEAMC) & Fort Stewart (WACH)
13	White River Junction VA
14	Walter Reed (WRAMC)

The Beginning of Pain for Veterans: Blast/Projectile Trauma and Axial Load Injuries





VHA National Pain Management Strategy

- Strategy initiated by the Undersecretary for Health in 1998
- Pain Management Directive 2009-053 recently published
- Three top priorities
  - Implement stepped pain care model
  - Integration into Medical Home
    - Expand Integrative Primary Care
  - Build partnership with DoD

Organization, VHA Pain Management Strategy

National Pain Management Office

Director (Robert Kerns PhD), Deputy Director (Rollin Gallagher MD, MPH)

National Coordinating Committee

Education

- Conferences (National)
- Websites materials

Research

Standing Subcommittee -

Journal Special issues *JRR&D, Pain Medicine*

- HSRD / RR&D Merit Awards, Training Awards
- PRIME Center

23 VISN Pain Points of Contact

Facility Pain Points of Contact

Facility Pain Coordinating Committees

Facility Pain Clinical Programs

Primary care<< >>Pain Medicine

<< >>Pain Rehabilitation

Frequency of Possible Diagnoses among OEF and OIF Veterans

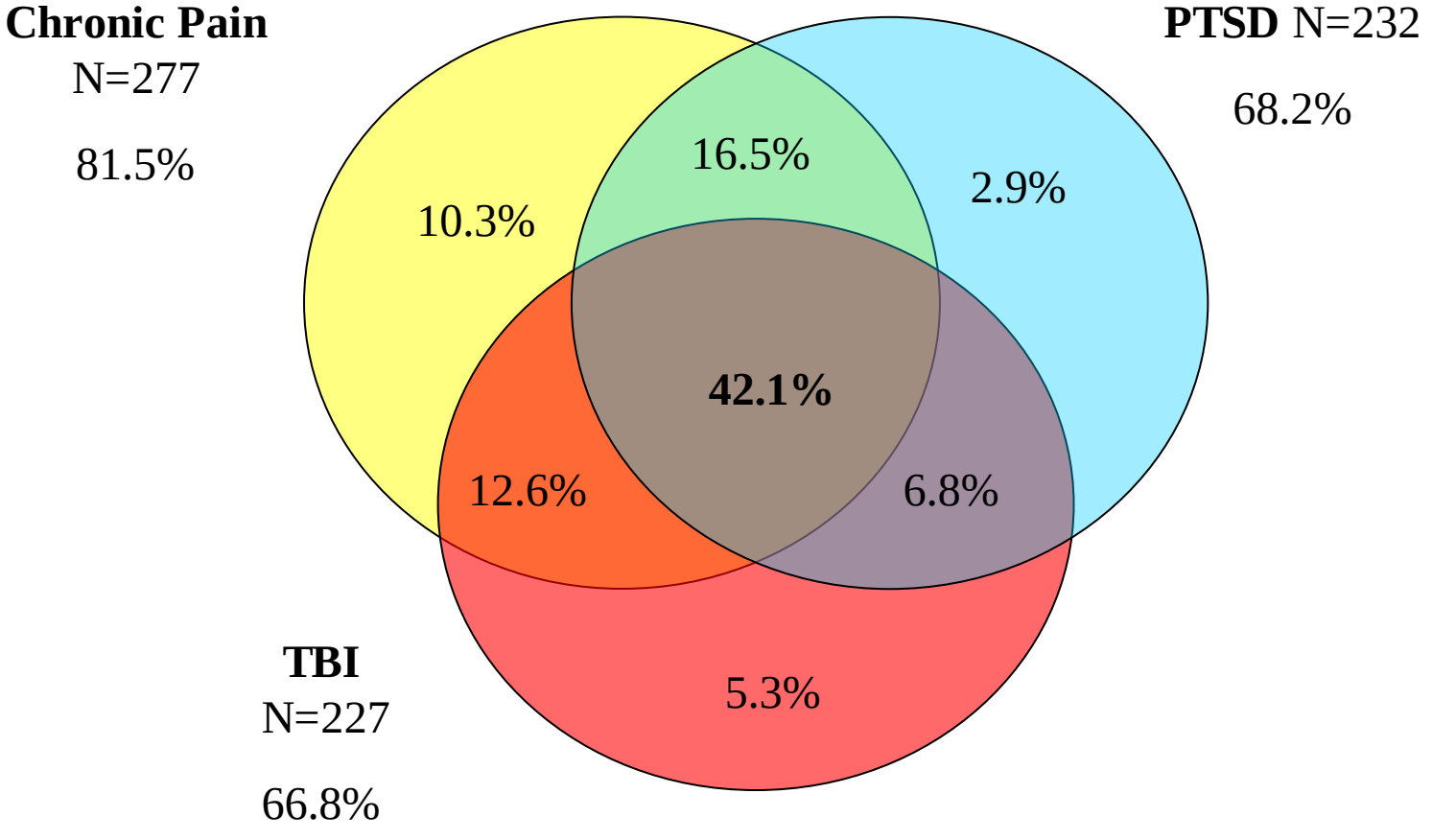
Diagnosis (Broad ICD-9 Categories)	Frequency	Percent
Infectious and Parasitic Diseases (001-139)	68,569	13.5
Malignant Neoplasms (140-208)	5,809	1.1
Benign Neoplasms (210-239)	25,491	5.0
Diseases of Endocrine/Nutritional/ Metabolic Systems (240-279)	135,250	26.6
Diseases of Blood and Blood Forming Organs (280-289)	14,342	2.8
Mental Disorders (290-319)	**243,685**	**48.0**
Diseases of Nervous System/ Sense Organs (320-389)	**202,298**	**39.8**
Diseases of Circulatory System (390-459)	94,671	18.6
Disease of Respiratory System (460-519)	116,308	22.9
Disease of Digestive System (520-579)	172,462	33.9
Diseases of Genitourinary System (580-629)	63,421	12.5
Diseases of Skin (680-709)	93,635	18.4
Diseases of Musculoskeletal System/Connective System (710-739)	**265,450**	**52.2**
Symptoms, Signs and Ill Defined Conditions (780-799)	**233,443**	**45.9**
Injury/Poisonings (800-999)	130,300	25.6

*These are cumulative data since FY 2002, with data on hospitalizations and outpatient visits as of September 30, 2009; Veterans can have multiple diagnoses with each health care encounter. A Veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 508,152; percentages add up to greater than 100 for the same reason.

Cumulative from 1st Quarter FY 2002 through 4th Quarter FY 2009

COL Kevin Galloway/DASG-HSZ/(703) 325-6913/kevin.galloway@us.army.mil

Prevalence of Chronic Pain, PTSD and TBI in a sample of 340 OEF/OIF veterans with polytrauma



Lew, Otis, Tun et al., (2009). Prevalence of Chronic Pain, Post-traumatic Stress Disorder and Post-concussive Symptoms in OEF/OIF Veterans: The Polytrauma Clinical Triad. *JRRD.*

Beginning to End: The Chronic Pain Cycle

Pathophysiology of Maintenance:
-Radiculopathy
-Neuroma traction
-Myofascial sensitization
-Brain, SC pathology (atrophy, reorganization)

Pathology:
-Muscle atrophy, weakness;
-Bone loss;
-Immunocompromise
-Depression
-Substance abuse

Psychopathology of maintenance:
-Encoded anxiety dysregulation
- PTSD
-Emotional allodynia
-Mood disorder

Acute injury and pain

Central Sensitization
-Neuroplastic changes

Peripheral Sensitization:
New Na+ channels cause lower threshold

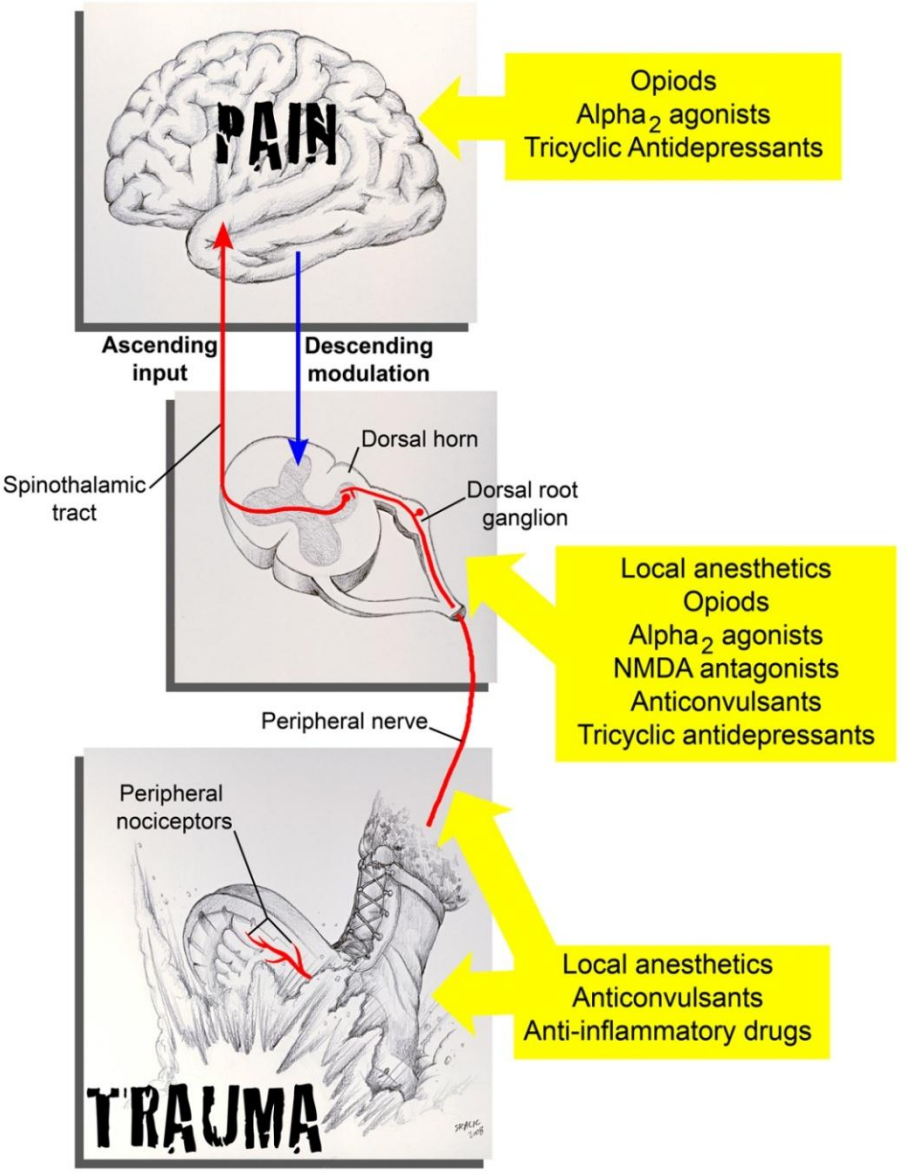
Neurogenic Inflammation:
Glial activation
- Pro-inflammatory cytokines
- blood-nerve barrier dysruption

Disability
Less active
Kinesophobia
Decreased motivation
Increased isolation
Role loss
Sleep disorder

The key elements in the continuum of pain care

- **Primary prevention**: avoiding injury, nociception, nerve damage
- **Secondary prevention**: after injury / start of disease,
  - minimizing pain's access to the CNS
  - minimizing concurrent augmenting factors (e.g. stress)
  - minimizing the pathophysiologic response of the CNS (e.g. neuroplastic pathophysiology)
- **Tertiary prevention**: Once "chronification" occurs, reducing its negative impact on quality of life by rehabilitation: social networks (love & support), motivation (goals) towards functional restoration, and reversal of neuroplastic damage

Multimodal Analgesia



VA Stepped Pain Care

RISK

Comorbidities

Treatment Refractory

Complexity

Tertiary, Interdisciplinary Pain Centers

- Advanced pain medicine diagnostics & interventions
- CARF accredited pain rehabilitation

STEP 3

Secondary Consultation

- Pain Medicine
- Rehabilitation Medicine
- Behavioral Pain Management
- Multidisciplinary Pain Clinics
- Mental Health & SUD Programs

STEP 2

Primary Care

- Routine screening for presence & intensity of pain
- Comprehensive pain assessment
- Management of common pain conditions
- Support from MH-PC Integration, OEF/OIF, &
- Post-Deployment Teams
- Expanded care management
- Opioid / Pharmacy Management Clinics

STEP 1

TF Site Visit Findings

BEST PRACTICES

- Integrated Pain Center (TAMC and BalboaNMC)
- Case Management of Pain Patients (Ft Drum)
- Strong Interventional Pain Capabilities at MEDCENs
- Integrated Pain Board (Travis AFB)
- WTU Medication Policies/Initiatives
  - Sole Provider
  - Medication Reconciliation (Ft Campbell, Baumholder, Ft Bragg)
  - WTU Pharmacist (Ft Bliss, Ft Hood, Ft Carson)
  - Embed Pain Mgt Resources in WTU (WRAMC, Ft Bragg)

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
  - Taxonomy
  - Practice
- Lack of common orientation to pain among Patients

EDUCATION

- 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)

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

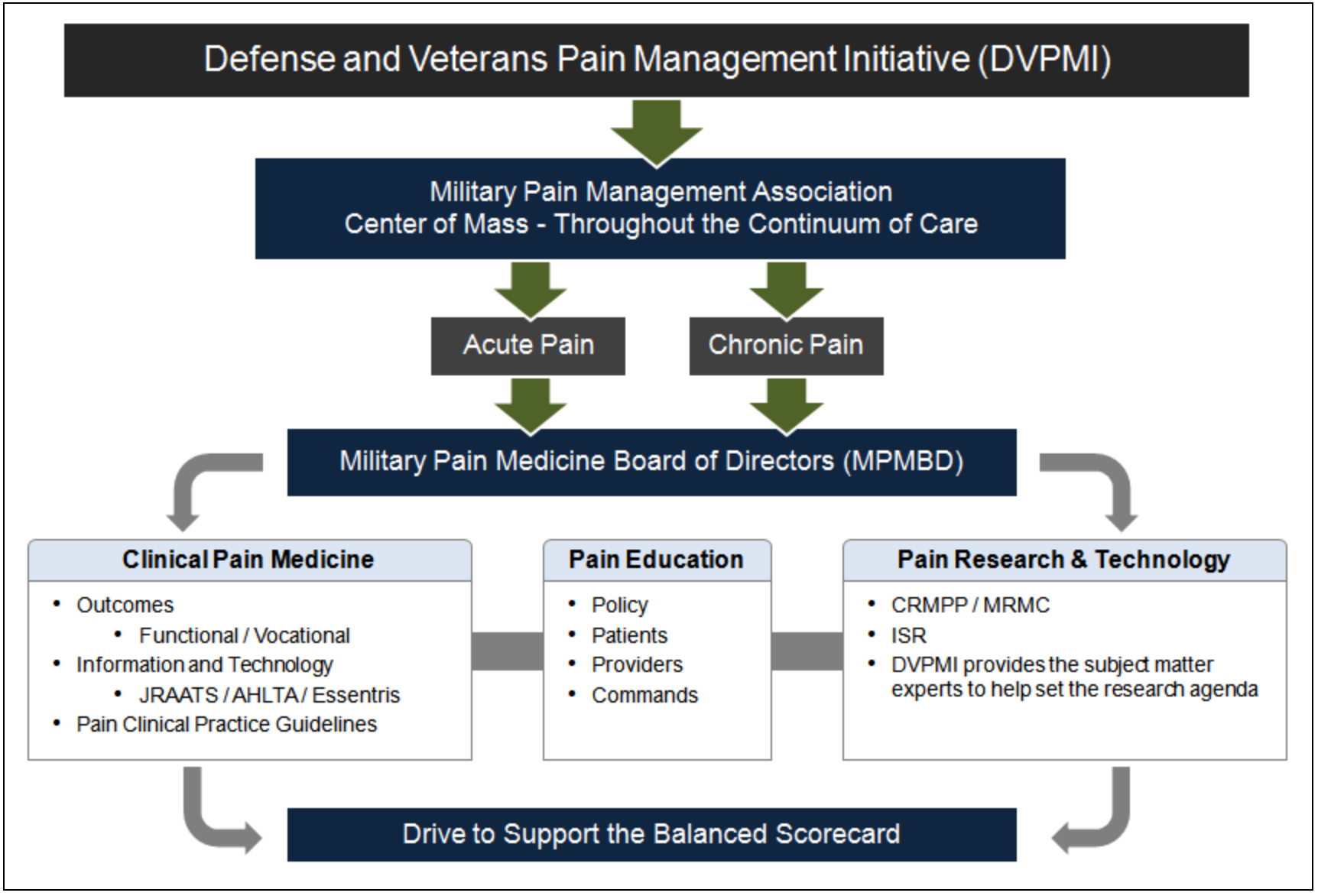
- **Lack of predictable pain management capabilities across our MTFs**
- **Lack of standardization not unique to MEDCOM or DoD**
- **Lack of non-medication modalities** for pain mgt
- Overwhelming majority of Providers not satisfied with pain management care received in network

Task Force Recommendations

Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families	
1	Focus on the Warrior and Family - Sustaining the Force
2	Synchronize a Culture of Pain Awareness, Education, and Proactive Intervention (Medical Staff, Patients and Leaders)
3	Provide Tools and Infrastructure that Support and Encourage Practice and Research Advancements in Pain Management
4	Build a Full Spectrum of Best Practices for the Continuum of Acute and Chronic Pain Care, Based on a Foundation of the Best Available Evidence

Pain Management Task Force

Army Pain Management Center of Excellence



Thank you