



Army Pain Management Task Force

Findings-Recommendations-Way Ahead

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Unclassified
(Information)



Pain Management Task Force



"What an infinite blessing."





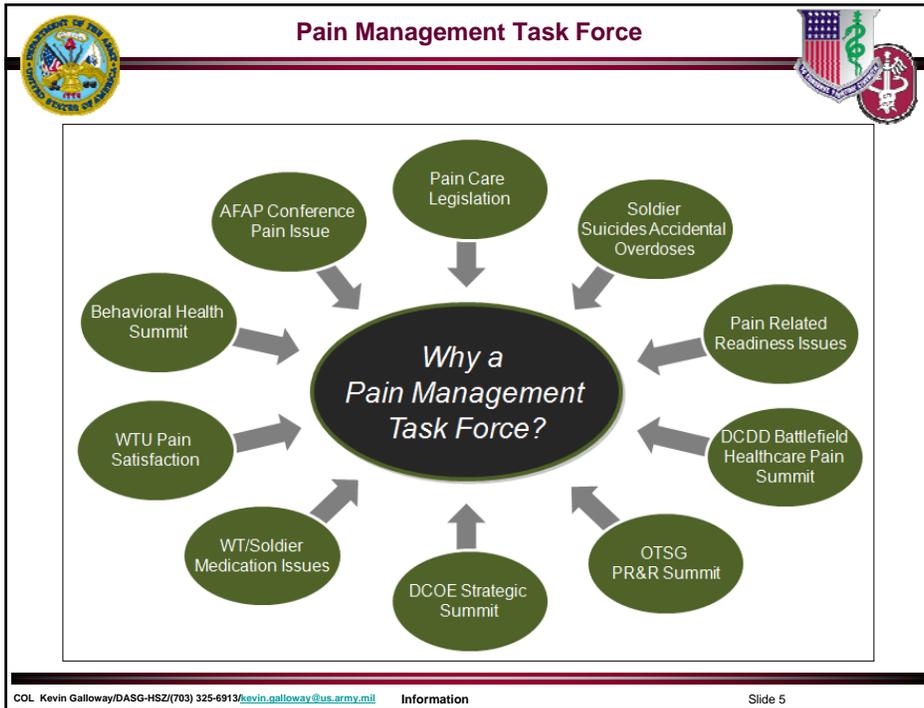
21st Century Evacuation Realities



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”

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Pain Management Task Force



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

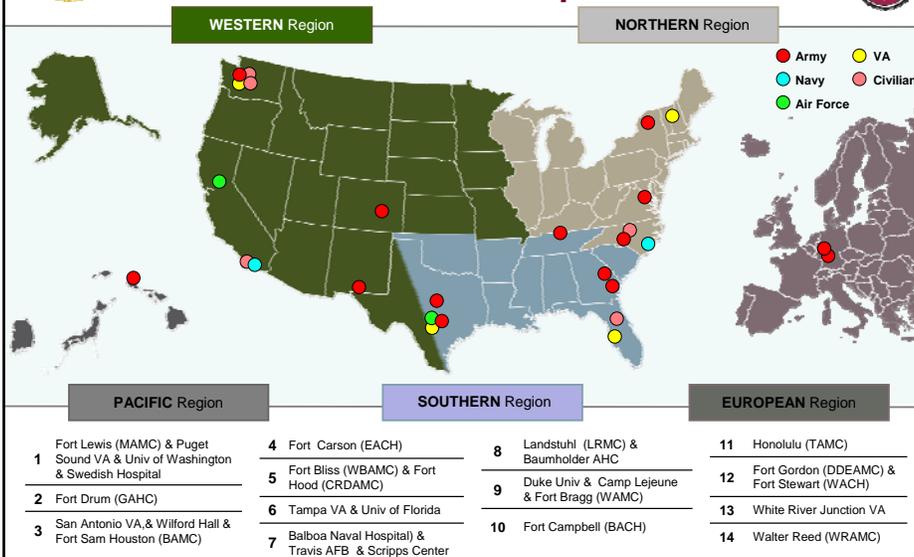
Army Reserve	National Guard	M&RA
TMA/Health Affairs	Warrior Transition Command	DCOE
Behavioral Health	Case Management	Integrated Medicine
Nursing	Occupational Therapy	Pain Management
Pharmacy	Physical Therapy	PM&R
Primary Care	Social Work	Family Medicine



Pain Management Task Force



Site Visit Map



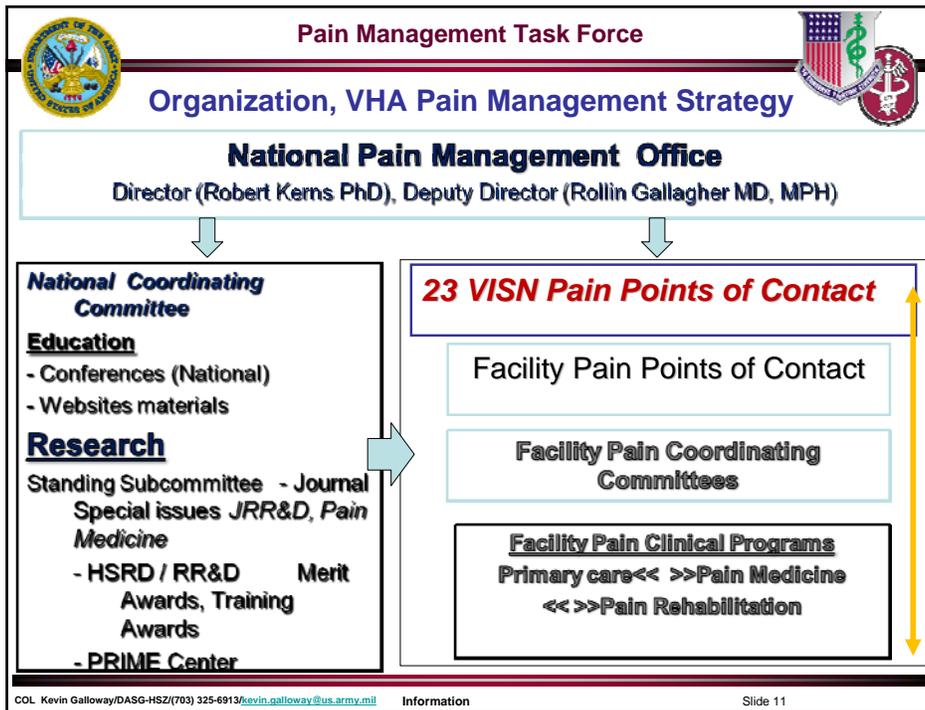


The Beginning of Pain for Veterans: Blast/Projectile Trauma and Axial Load Injuries



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



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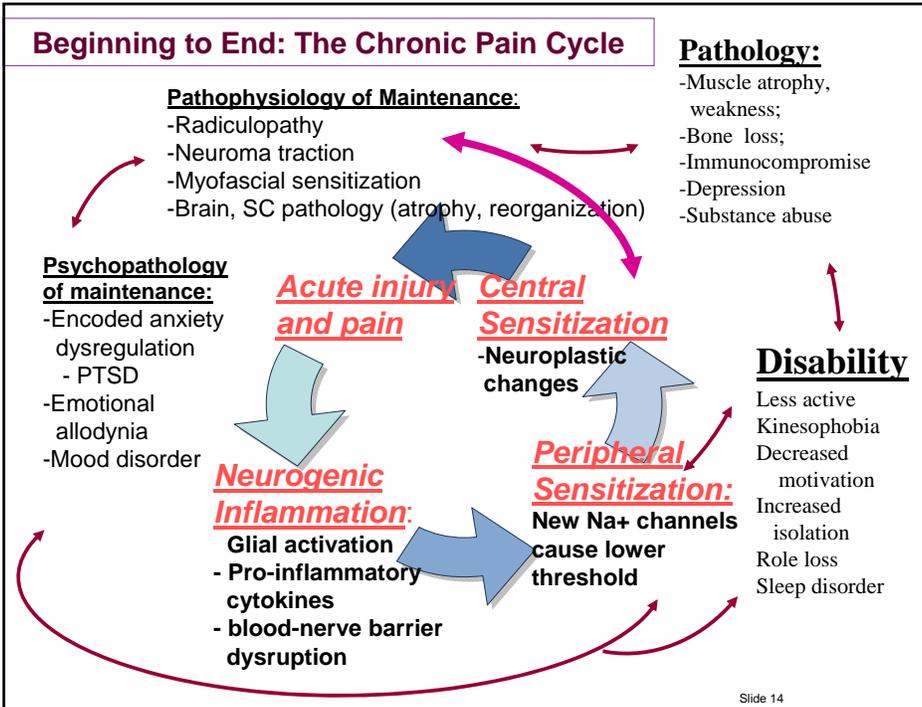
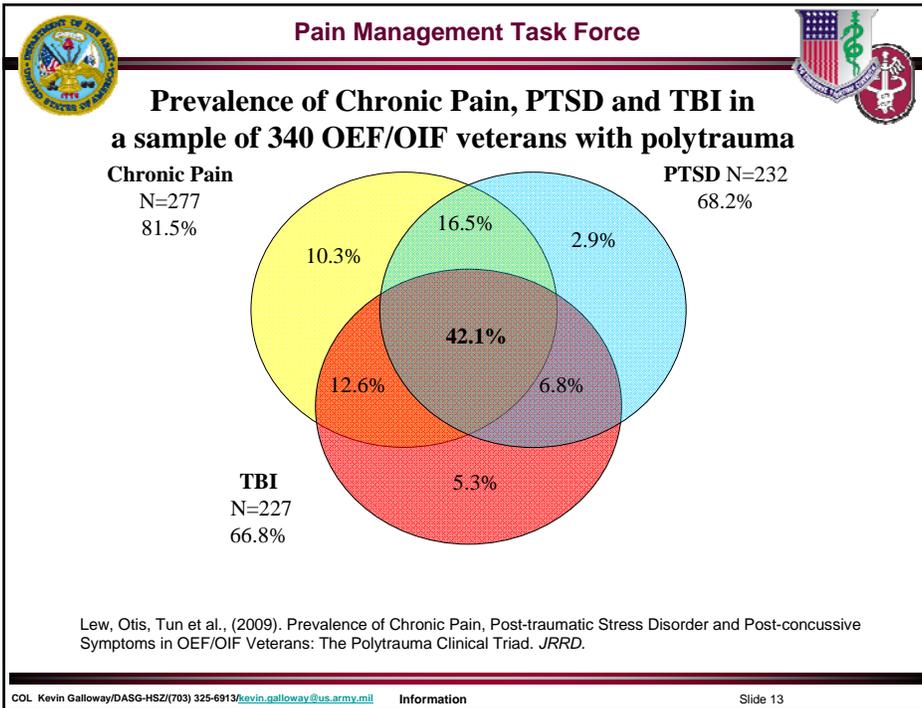
Frequency of Possible Diagnoses among OEF and OIF Veterans

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

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Established (by research) effects of chronic pain

- **Quality of life**
 - Physical functioning
 - Ability to perform activities of daily living (ADLs)
 - Work
- **Social consequences**
 - Marital/family relations
 - Intimacy/sexual activity
 - Social role and friendships
- **Psychological / CNS morbidity**
 - Fear, anger, suffering
 - Sleep disorders
 - Loss of self-esteem
- **Medical comorbidities & consequences**
 - Accidents
 - Medication effects
 - Immune function
 - Clinical depression
 - Neuroplasticity to pain disease

Societal consequences

- Health care costs
- Disability
- Lost workdays
- Business failures
- Higher taxes

Mismanaged chronic pain is often a personal, biopsychosocial catastrophe!and is a huge public health problem.

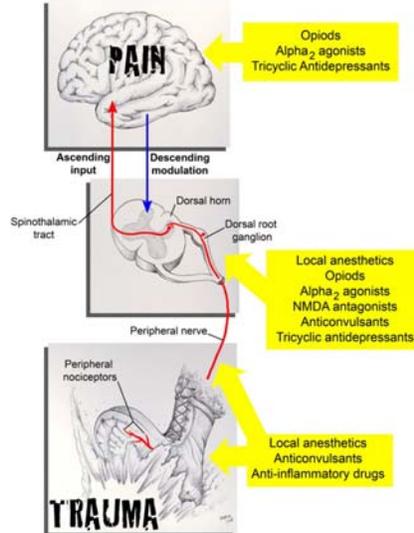


The key elements in the continuum of pain care

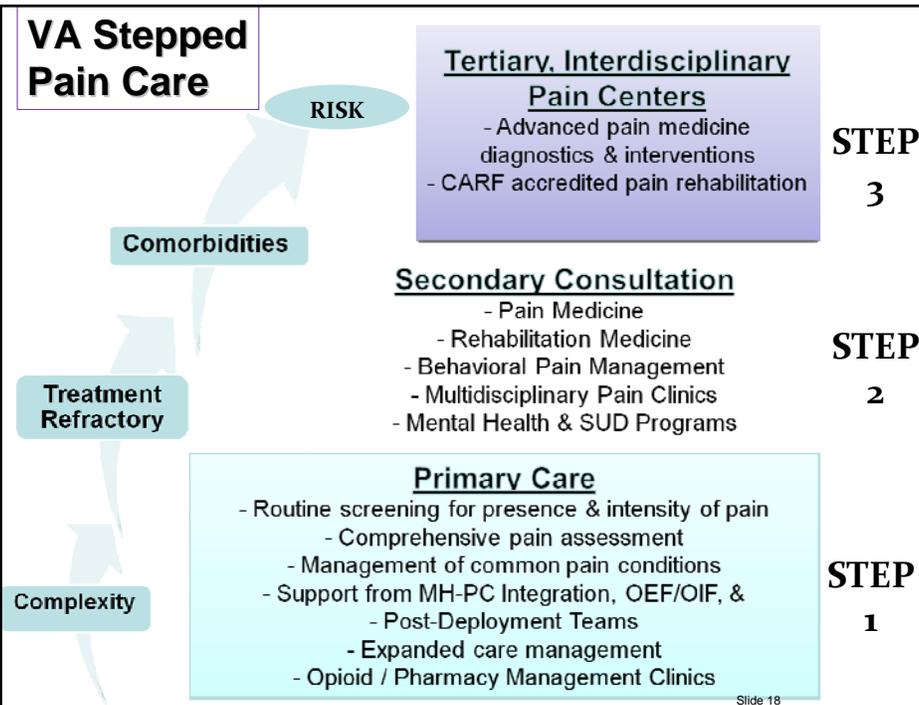
- **Primary prevention:** avoiding injury, nociception, nerve damage
- **Secondary prevention:** after injury / start of disease,
 - minimizing pain's access to the CNS
 - minimizing concurrent augmenting factors (e.g. stress)
 - minimizing the pathophysiologic response of the CNS (e.g. neuroplastic 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





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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



Pain Management Task Force



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

