



# Defense and Veterans Center for Integrative Pain Management (DVCIPM)



**Kevin Galloway**  
**COL, US Army (Retired)**  
**Deputy Director, Strategic Communications and Policy**



# Challenge vs Opportunity



# DoD and VHA Healthcare

## Military Health System:

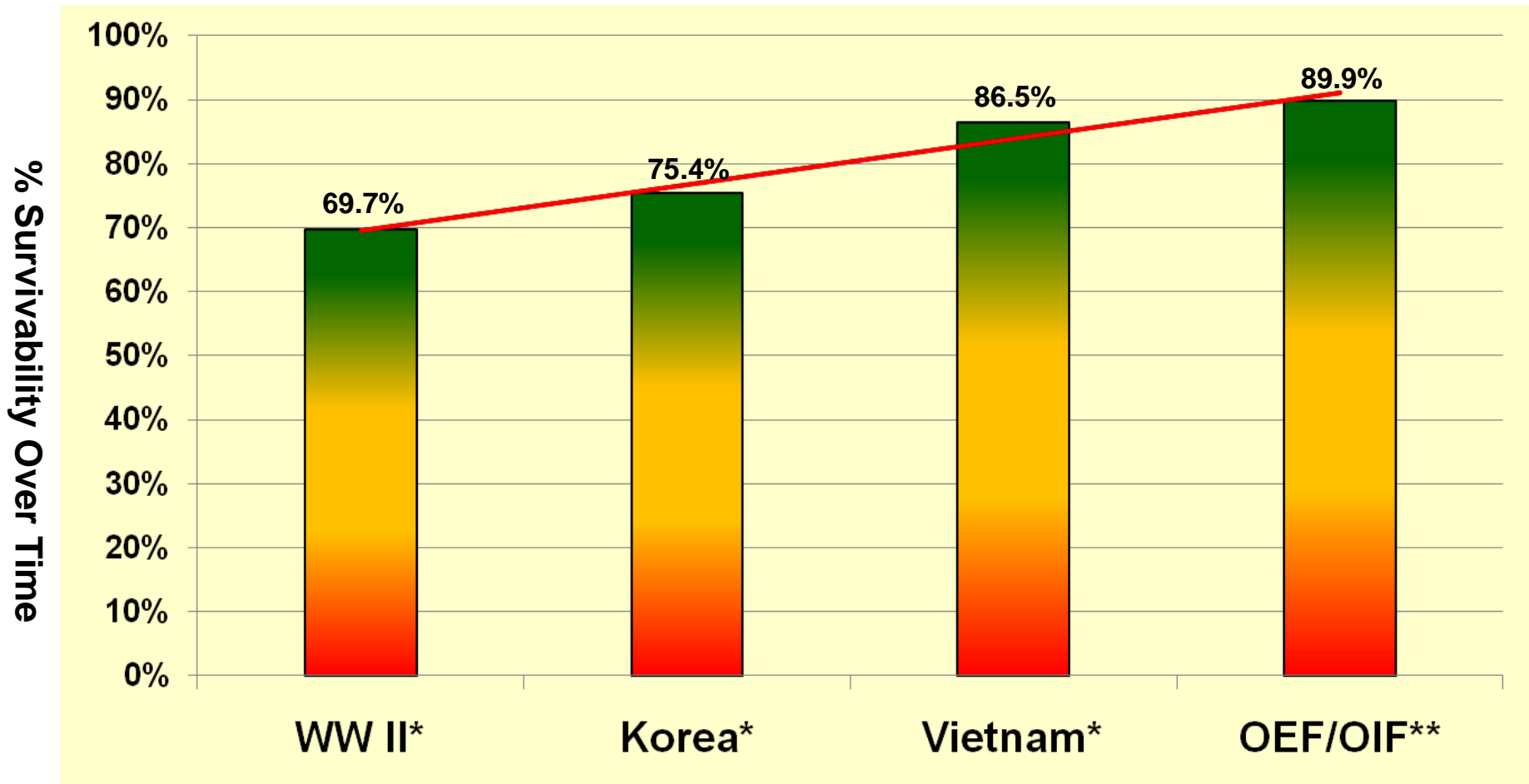
- *9.6 million Active Duty Service Members, Retirees, Family Members*
- *Annual budget of \$50 billion*
- *Worldwide network of 59 military hospitals, 360 health clinics, private-sector health business partners*
- *Includes the Uniformed Services University*

## Veterans Health Administration:

- *Care for 8.9 million Veterans each year*
- *Annual budget of \$68 billion*
- *168 VA Medical Centers*
- *1,053 outpatient sites of care*



# Remarkable survival rates achieved in battlefield medicine ...



\* May 2008 DoD Data

\*\*3 June 2010 DoD Data

[Wounds Not Mortal / (Battle Deaths + Wounds Not Mortal)] \* 100

-INFORMATION -

# ...These resulted from improvements in battlefield care...

## *Improvements on the battlefield*

*Better trained medics/corpsman*

*Improved equipment*

*Far forward emergency & surgical care*



## *Improvements in evacuation*

## *Improvements in recovery & rehabilitation*





But... the...

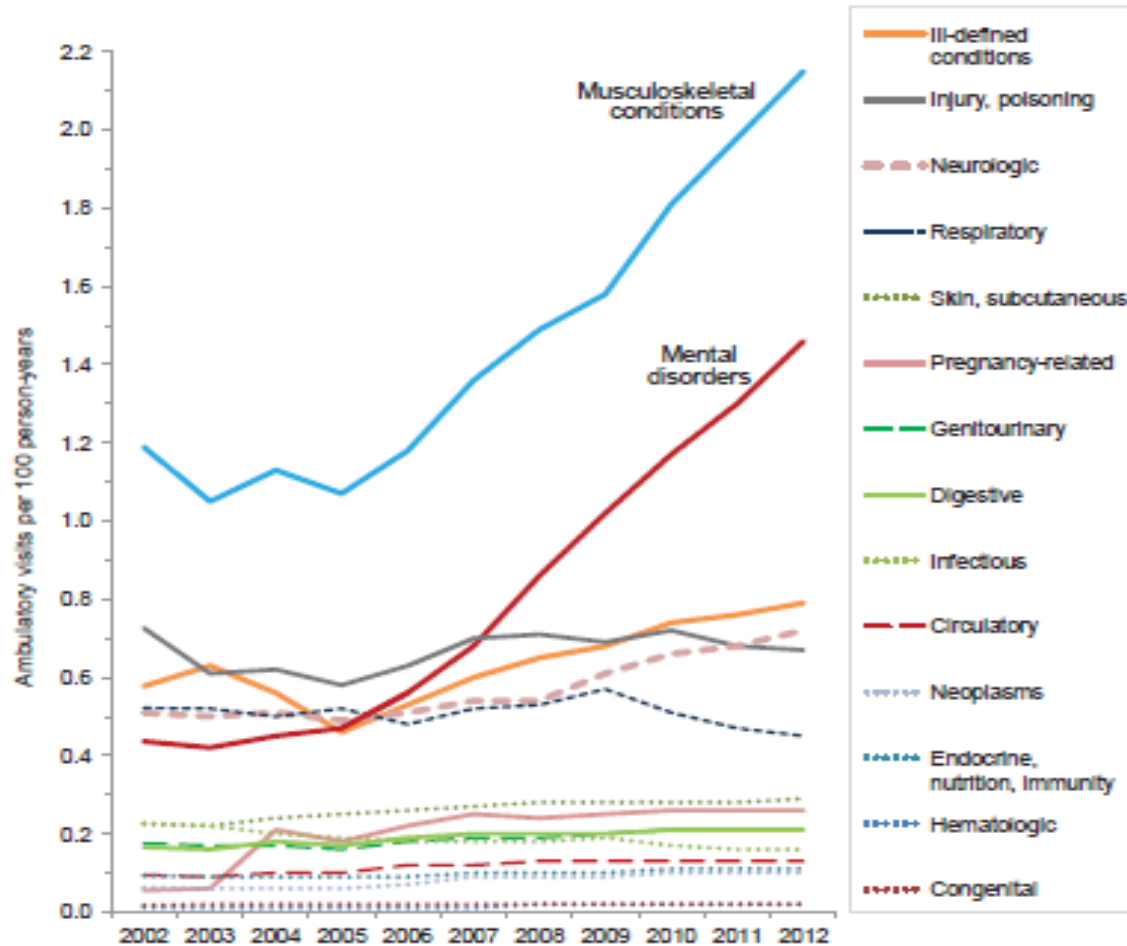




# Rising Musculoskeletal & Mental Health Disorders—Ambulatory Visits



**FIGURE 2.** Annual ambulatory visit rates (unadjusted) by major illness categories (per ICD-9-CM), active component, U.S. Armed Forces, 2002-2012 (data abstracted from April issues of the *MSMR*)





# Complexity/Severity of Wounds/Injuries





# Service Member Goals and Objectives



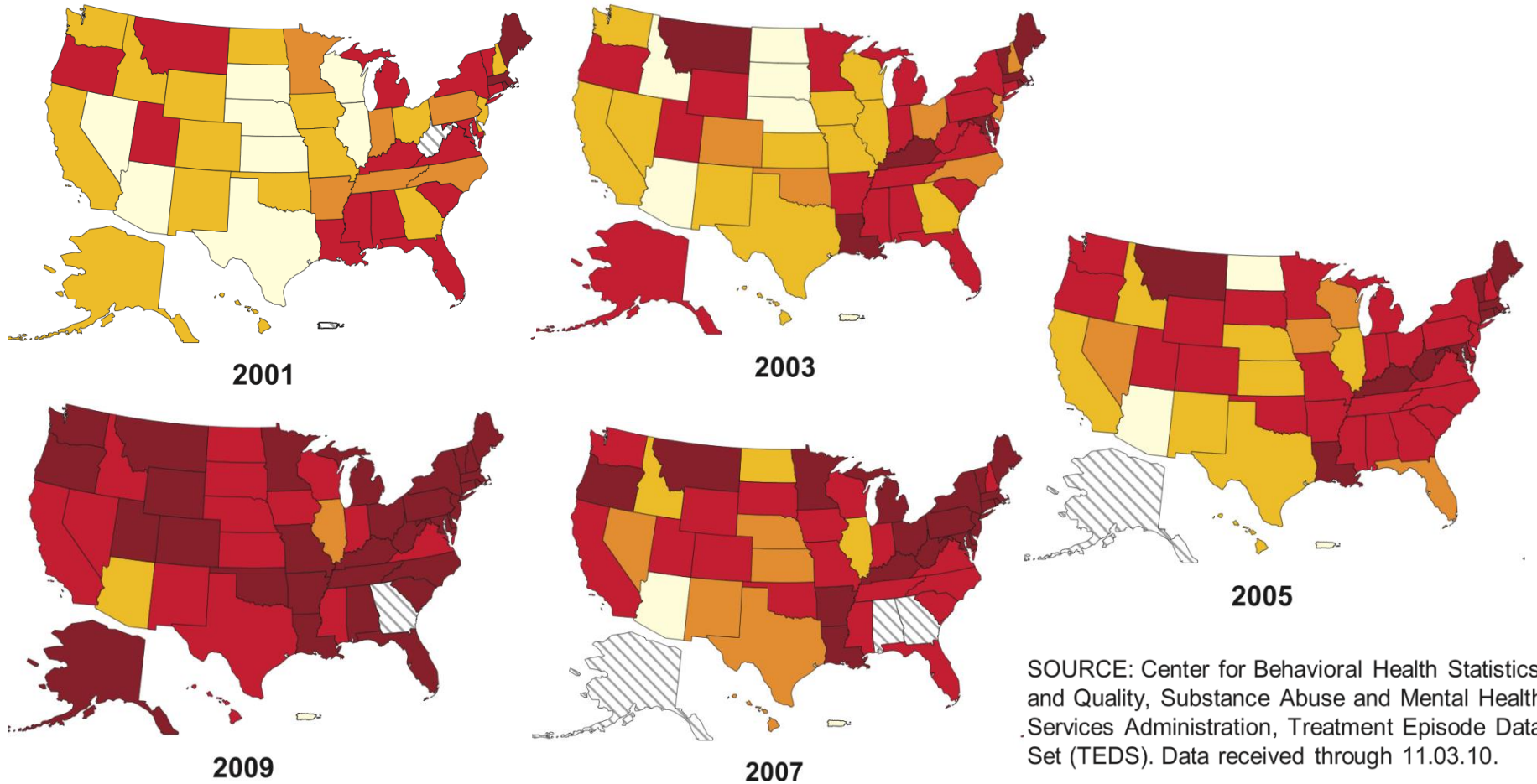


# .....Other Goals and Objectives

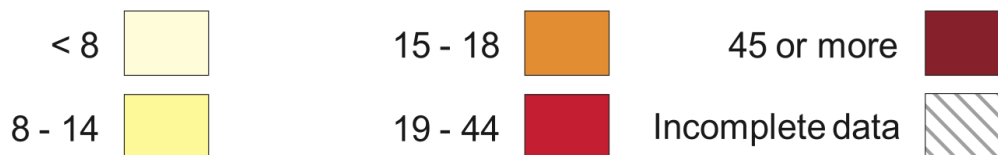


# An Epidemic of Opioid Problems in the US

Primary non-heroin opiates/synthetics admission rates, by State  
(per 100,000 population aged 12 and over)



SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.



— INFORMATION —

# Up to 35% of wounded soldiers addicted to drugs

Updated 1/26/2011 6:36 PM | Comments 46 | Recommend 3

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By Gregg Zoroya, USA TODAY

Medical officials estimate that 25% to 35% of about 10,000 ailing soldiers assigned to special wounded-care companies or battalions are or dependent on drugs — particularly prescription narcotic pain relievers, according to an Army inspector general's report made public Tue

The report also found that these formations known as Warrior Transition Units — created after reports detailed poorly managed care at W: Army Hospital— have become costly way stations where ill, injured or wounded soldiers can wait more than a year for a medical discharge

Some soldiers have become so irate about the delays in leaving the Army that doctors, nurses and other medical staff say they have been in their offices and threatened, or had their private cars damaged or tires flattened, the report says.

"I'm very concerned about folks and their personal safety," says Army Col. Darryl Williams, commander of Warrior Transition Units, of those allegations. "I'm going after that really, really hard."

Williams, however, called into question findings about high rates of drug addiction and dependency, saying these percentages were base estimates made by case managers and nurses working with troops, and are not statistically valid.

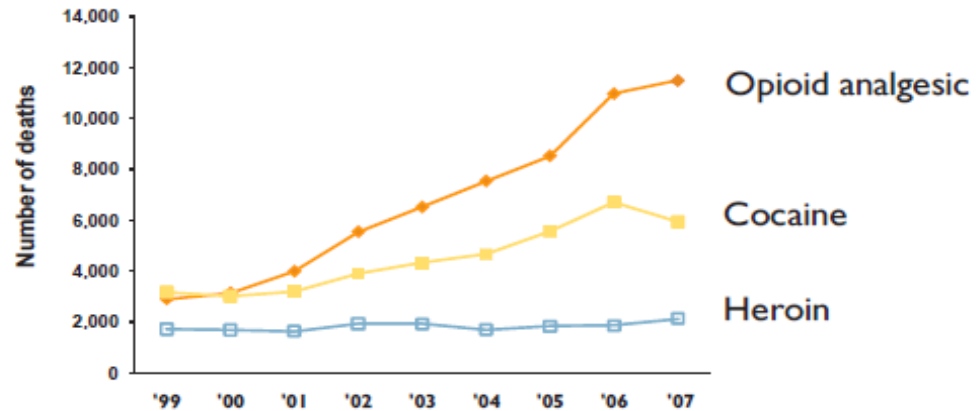
Most case managers and nurses interviewed by investigators said 25% to 35% of soldiers in warrior units "are over-medicated, abuse pre and have access to illegal drugs."

They said most soldiers arrive in the units with narcotics provided by battlefield doctors or military hospitals. They also said a few soldiers narcotics out of pocket and may be mixing legal and illegal drugs.

About three out of four soldiers in the warrior units either leave the Army or active duty, the report says.

In 2007, the number of deaths involving opioid analgesics was 1.93 times the number involving cocaine and 5.38 times the number involving heroin.

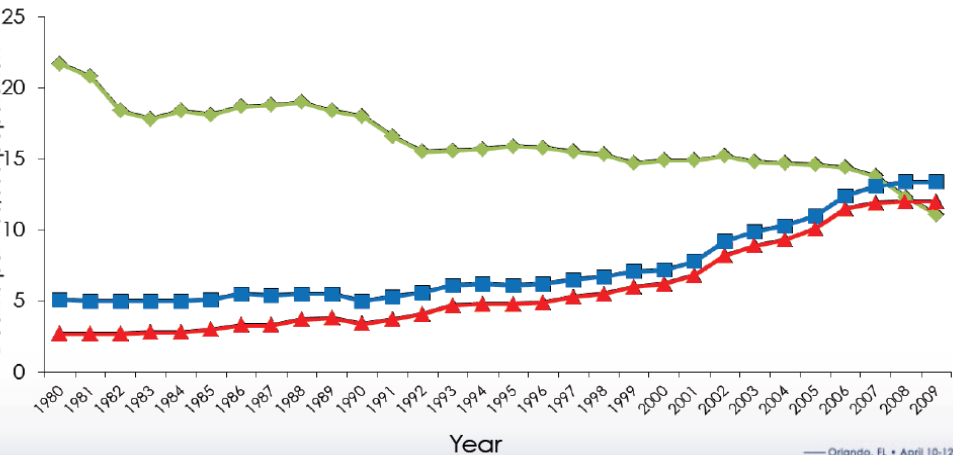
Figure 2: Unintentional drug overdose deaths by major type of drug, United States, 1999-2007



Source: National Vital Statistics System

# Motor Vehicle Traffic, Poisoning, and Drug Overdose Death Rates: United States, 1980-2009

Motor Vehicle Traffic Poisoning Drug Poisoning



# Troops reportedly popping more painkillers

Posted 5h 8m ago | Comments 20 | Recommend 2

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By Gregg Zoroya, USA TODAY

WASHINGTON — Narcotic pain-relief prescriptions for injured U.S. troops have jumped from 30,000 a month to 50,000 since the Iraq war began, raising concerns about the drugs' potential abuse and addiction, says a leading Army pain expert.

The sharp rise in outpatient prescriptions paid for by the government suggests doctors rely too heavily on narcotics, says Army Col. Chester "Trip" Buckenmaier III, of Walter Reed Army Medical Center in Washington.

By 2005, two years into the war, narcotic painkillers were the most abused drug in the military, according to a survey that year of 16,146 servicemembers.

**MORE:** Prescription drug abuse hits Mo. Army unit hard

Among Army soldiers, 4% surveyed in 2005 admitted abusing prescription narcotics in the previous 30 days, with 10% doing so in the last 12 months. Researchers said the results may have been skewed by respondents mistakenly referring to legal use of pain medication. A 2008 survey has not been released.

**FIND MORE STORIES IN:** Washington | Virginia | Iraq | Pentagon | Missouri | Marine Corps | Walter Reed Army Medical Center | Department of Veterans Affairs | Fort Leonard Wood | Afghanistan-era | Warrior Transition Units

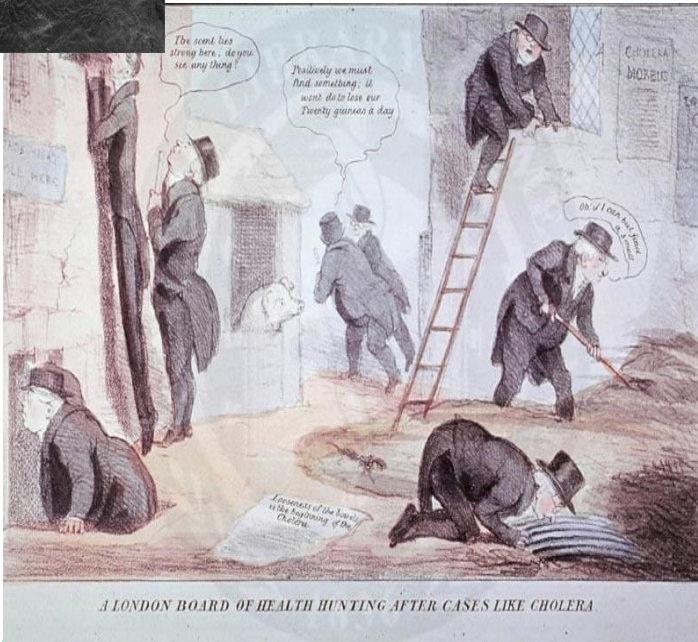
"You don't have to throw narcotics at people to start managing pain," says Buckenmaier, who pioneered technology that eases the pain of wounded soldiers.

Mixx it  
Other ways to share  
Yahoo! Buzz  
Digg  
Newsvine  
Reddit  
Facebook  
What's this?

# Another familiar epidemic: Cholera



# Follow the illness to the source: John Snow

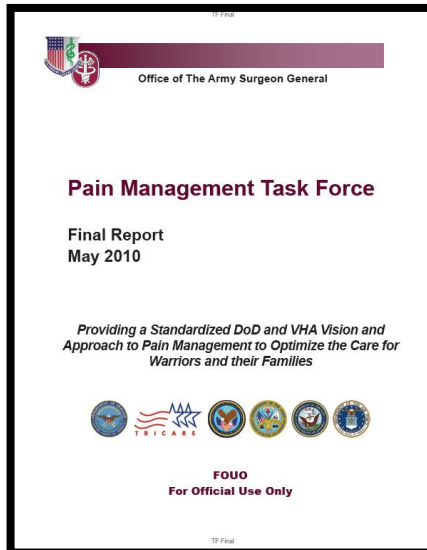




## DoD Pain Management Task Force

- Provide recommendations for a **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.

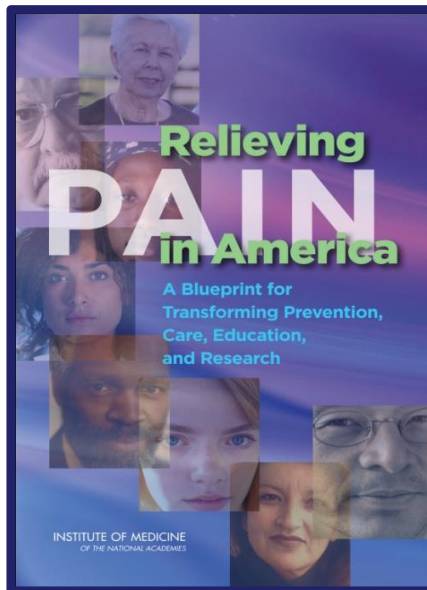
➤ ***2010 Pain Management Task Force Report***



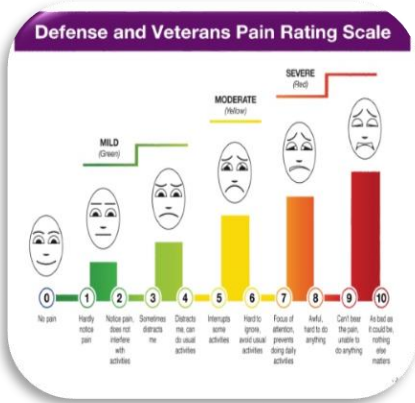
## IOM Report: Relieving Pain in America

- Validated PMTF Analysis, Findings, and Recommendations

➤ ***2011: Institutes of Medicine***



# VA and DoD Pain Collaboration:



DVPRS: New Pain Rating Scale



Pain and Opioid Prescribing Safety Videos



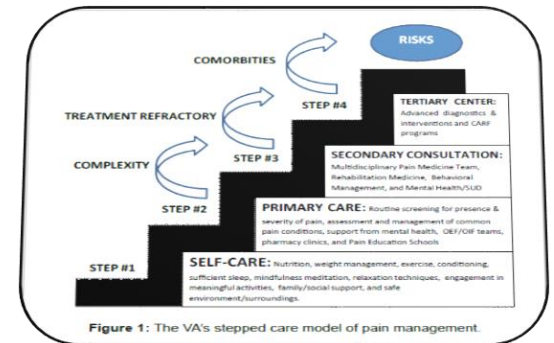
JPEP: Joint Pain Curriculum



Joint Acupuncture Training Project



Video Tele-Mentoring



Stepped Care Model



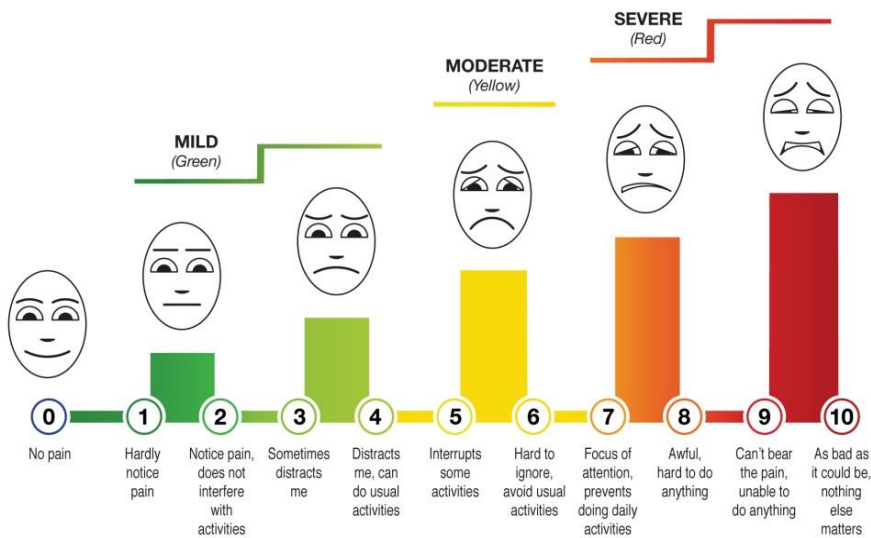


# Defense and Veterans Pain Rating Scale (DVPRS)

- Goal: Recalibrate Standardized Pain Assessment**

Move from a single focus on pain intensity to an assessment (and discussion) on function and bio-psychosocial impact of pain

## Defense and Veterans Pain Rating Scale



v 2.0

## 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 **ACTIVITY**:

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**:

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**:

0 1 2 3 4 5 6 7 8 9 10  
Does not affect Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**:

0 1 2 3 4 5 6 7 8 9 10  
Does not contribute Contributes a great deal

\*Reference for pain interference: Cleland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.

v 2.0

*1: Understanding Pain Introduction*

*2-1: Pain and Societal Impacts of Pain and Understanding Pain*

*2-2: Pain Terminology, Taxonomy, and Physiology*

*2-3: DoD/VA Pain Care Delivery Systems,*

*3-1: Assessment of Pain*

*3-2: Assessment Tools*

*4-1: Acetaminophen, NSAIDS and Opioid Basics*

*4-2: Anti-epileptics,*

*5-1: Chronic Opioid Therapy (COT) Risk Evaluation and Mitigation*

*5-2: Chronic Opioid Therapy Dose Reduction and Discontinuation*

*6-1: Behavioral Management of Chronic Pain – Treatment*

*7-1: Physical Based Therapeutic Approaches to Pain MGT*

*8-1: Integrative Pain Medicine*

*9-1: Pain Medicine Specialty Care*

*10-1: Neck Pain*

*10-3: Transitional and Chronic Low Back Pain*

*11-1: Shoulder Pain*

*11-2: Hip Pain*

*11-3: Knee Pain*

*12-1: Myofascial, Connective Tissue, and Fibromyalgia Pain*

*13-1: Central Neuropathic Pain*

*13-2: Peripheral Neuropathic Pain*

*14-1: Headache Pain*

*15-1: Visceral Pain*

*16:-1: Psychological and Psychiatric Conditions Related to Pain*

*16-2: Sleep and Pain*

*16-3: Substance Use Disorder*

*17-1: Geriatric Pain*

*17-2: Palliative and Oncologic Pain*

*18-1: Women Pain Related Issues*

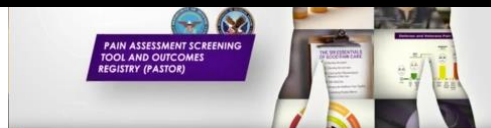
*18-2: Opioids and Preganancy*

*18-3: Pelvic Pain and Women*

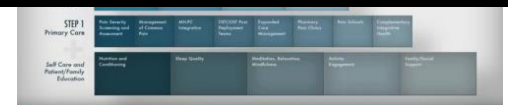
# Pain Education Videos



Safe Opioid Prescribing and Tapering



Pain Outcomes (PASTOR)<sup>19</sup>



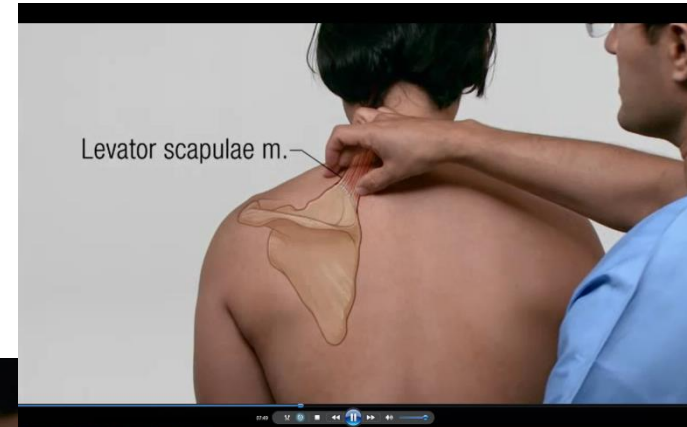
Stepped Pain Care Model

# Pain Exam Videos

## -included in JPEP curriculum download



**Exam: Back Pain**



**Exam: Shoulder Pain**



**Exam: Neck Pain**



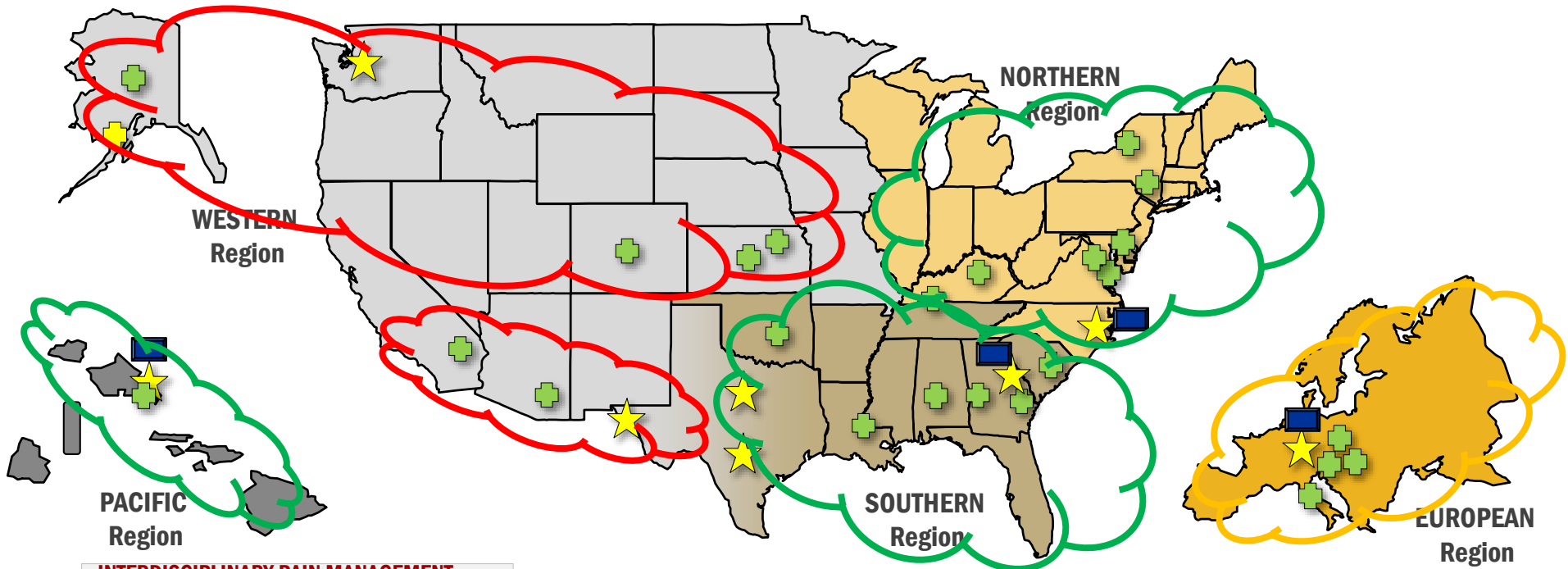
**Exam: Knee Pain**



**Exam: Hip Pain**



# ARMY | Pain Management ECHO Network



**INTERDISCIPLINARY PAIN MANAGEMENT CENTER (IPMC):** Serves as hub for pain management synchronization for designated MTFs within RMC. Provides pain management specialty referral /consultation services, patient and provider education, and coordination of research initiatives.

**Primary Care Pain Champion-** Designated member of PCMH team responsible to provide enhanced pain management in the medical home. Pain management education, training, and practice standards; linked to a designated IPMC for support.

**ECHO TELEMENTORING:** Weekly CME awarding educational activity hosted by IPMCs for PCPC and WTC primary care providers.



**IPMC**

- Ft Gordon
- Ft Hood
- Ft Bliss
- Ft Lewis
- Ft Sam Houston
- Landstuhl
- Tripler
- Ft Bragg



**PCPC in PCMH**

- Ft Benning
- Ft Campbell
- Ft Carson
- Ft Drum
- Ft Eustis
- Ft Huachuca
- Ft Irwin
- Ft Jackson
- Ft Lee
- Ft Knox
- Ft Leonard Wood
- Ft Meade
- Ft Polk
- Ft Riley
- Ft Richardson
- Ft Sill
- Ft Stewart
- Ft Wainwright
- Ft Leavenworth
- West Point



**ECHO**

- Schofield Barracks
- Grafenwoehr
- Katterbach
- Vicenza
- Vilceck
- Wiesbaden

- Ft Gordon
- Ft Bragg
- TAMC
- LRMC
- WRMC



# Stepped Care Model of Pain Management

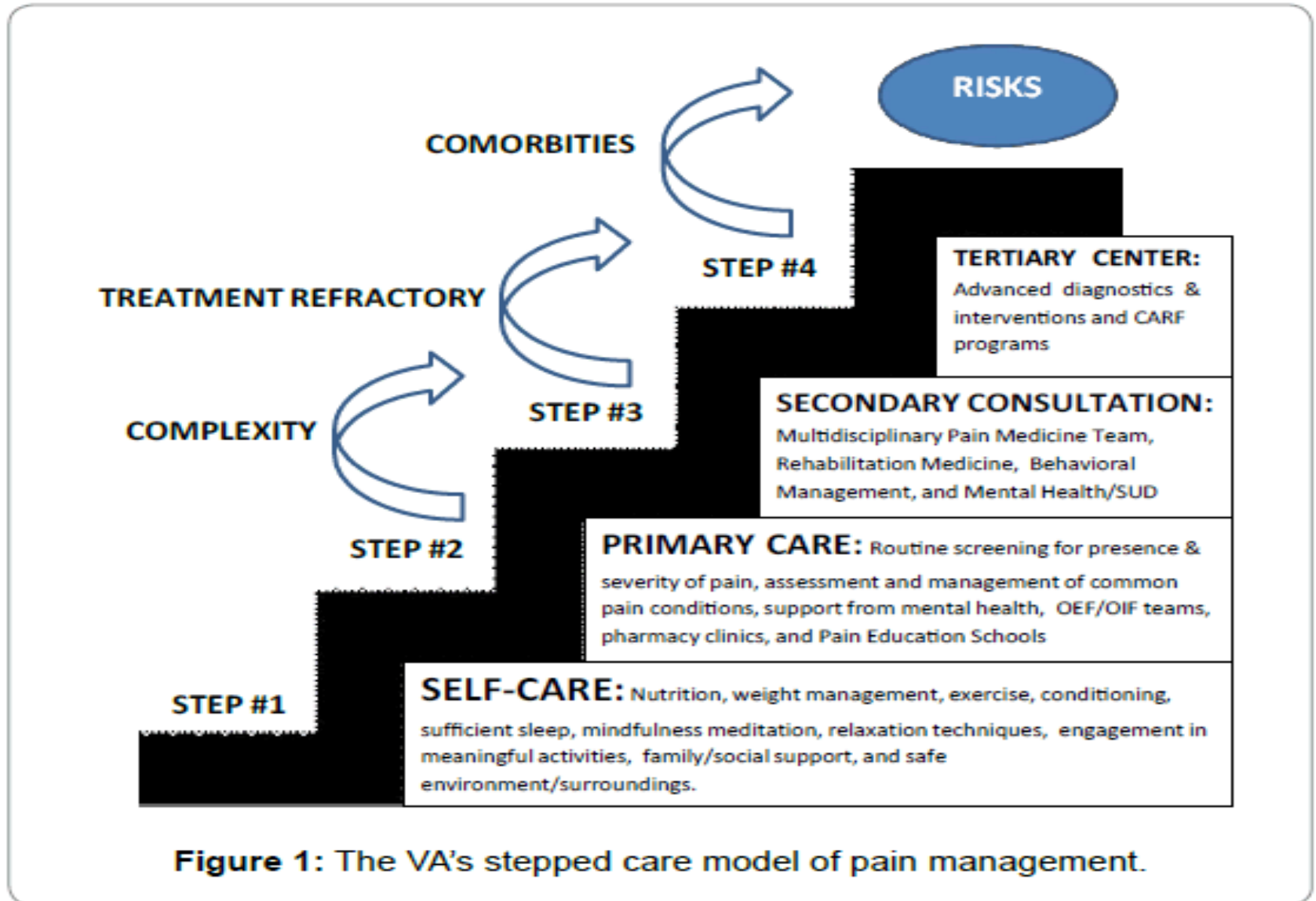


Figure 1: The VA's stepped care model of pain management.

# Comprehensive Pain Management

# Interdisciplinary

## ➤ Evidence-Based Complementary and Alternative Therapeutic Modes

- Acupuncture
- Biofeedback
- Yoga
- Meditation

## ➤ Standardizes Pain Management Services at echelons of care across our Medical Treatment Facilities: Team-Based

## ➤ Provides optimal quality of life for Soldiers and patients with acute and chronic pain

Holistic



Multimodal

# Teaching Our Own







# Advancing Evidence-Based Complementary & Integrative Practices and Consensus Guidelines



**ACP** American College of Physicians™  
Leading Internal Medicine. Improving Lives.

## Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians

CLINICAL GUIDELINE

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; and Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians\*

**Description:** The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations on noninvasive treatment of low back pain.

**Methods:** Using the ACP grading system, the committee based these recommendations on a systematic review of randomized, controlled trials and systematic reviews published through April 2015 on noninvasive pharmacologic and nonpharmacologic treatments for low back pain. Updated searches were performed through November 2016. Clinical outcomes evaluated included reduction or elimination of low back pain, improvement in back-specific and overall function, improvement in health-related quality of life, reduction in work disability and return to work, global improvement, number of back pain episodes or time between episodes, patient satisfaction, and adverse effects.

**Target Audience and Patient Population:** The target audience for this guideline includes all clinicians, and the target population includes adults with acute, subacute, or chronic low back pain.

**Recommendation 1:** Given that most patients with acute or subacute low back pain improve over time regardless of treatment, clinicians and patients should select nonpharmacologic treatment with superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). If pharmacologic treatment is desired, clinicians and patients should select nonsteroidal anti-inflammatory drugs or skeletal

muscle relaxants (moderate-quality evidence). (Grade: strong recommendation)

**Recommendation 2:** For patients with chronic low back pain, clinicians and patients should initially select nonpharmacologic treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence). (Grade: strong recommendation)

**Recommendation 3:** In patients with chronic low back pain who have had an inadequate response to nonpharmacologic treatment, clinicians and patients should consider pharmacologic treatment with nonsteroidal anti-inflammatory drugs as first-line therapy, or tramadol or duloxetine as second-line therapy. Clinicians should only consider opioids as an option in patients who have failed the aforementioned treatments and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients. (Grade: weak recommendation, moderate-quality evidence)

Ann Intern Med. doi:10.7326/M16-2367  
For author affiliations, see end of text.  
This article was published at Annals.org on 14 February 2017.

Annals.org

**L**ow back pain is one of the most common reasons for physician visits in the United States. Most Americans have experienced low back pain, and approximately one quarter of U.S. adults reported having low back pain lasting at least 1 day in the past 3 months (1). Low back pain is associated with high costs, including those related to health care and indirect costs from missed work or reduced productivity (2). The total costs attributable to low back pain in the United States were estimated at \$100 billion in 2006, two thirds of which were indirect costs of lost wages and productivity (3). Low back pain is frequently classified and treated on the basis of symptom duration, potential cause, presence or absence of radicular symptoms, and corre-

sponding anatomical or radiographic abnormalities. Acute back pain is defined as lasting less than 4 weeks, subacute back pain lasts 4 to 12 weeks, and chronic back pain lasts more than 12 weeks. Radicular low back pain results in lower extremity pain, paresthesia, and/or

**See also:**

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Web-Only CME quiz . . . . .	3

\* This paper, written by Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; and Mary Ann Forciea, MD, was developed for the Clinical Guidelines Committee of the American College of Physicians. Individuals who served on the Clinical Guidelines Committee from initiation of the project until its approval were Mary Ann Forciea, MD (Chair); Thomas D. Denberg, MD, PhD (Immediate Past Chair); Michael J. Barry, MD; Cynthia Boyd,

A photograph of a man with a beard and short hair, wearing a dark red turtleneck sweater, looking out of a window. The window frame is dark wood, and the background outside is slightly blurred, showing some greenery and a wooden structure.

Wall Street Journal  
December 29, 2016

## *The VA Hooked Veterans on Opioids, Then Failed Them Again*

The agency overprescribed painkillers to returning soldiers, fueling addiction; now rehab facilities are overwhelmed

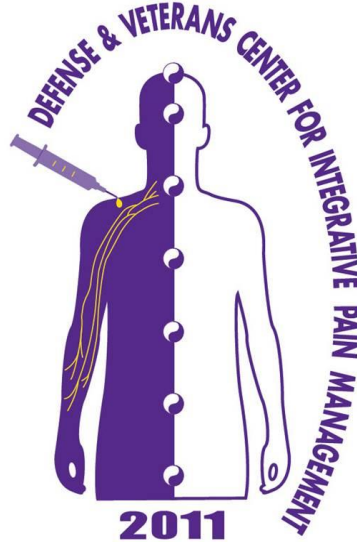
*By Valerie Bauerlein and Arian Campo-Flores | Photographs by Travis Dove for The Wall Street Journal*

**F**AYETTEVILLE, N.C.—Robert Deatherage, a 30-year-old Army veteran who has battled addiction to pain pills and heroin since suffering severe injuries in Afghanistan, says he reached rock bottom a year ago when he holed up in an empty church and tried to kill himself. Twice.

“I was just so sick of being as sick as I was,” he says. He put a gun in his mouth and pulled the trigger, but it didn’t fire. He says he then used two syringes to shoot all the drugs he had, but didn’t overdose.

Mr. Deatherage took the failure as a spiritual sign and walked to the

# DVCIPM.ORG



**Kevin Galloway**

**COL, US Army (Retired)**

**Deputy Director, Strategic Communications and Policy**

**Defense & Veterans Center for Integrative Pain Management**

**11300 Rockville Pike, Suite 709**

**Rockville, MD 20852**

**Office: [\(301\)816-4728](tel:3018164728)**

**[kgalloway@DVCIPM.org](mailto:kgalloway@DVCIPM.org)**