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Hahn School of Nursing and Health Science

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by

Erin Lind, BSN

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Final Manuscript

Supporting Self-Management in Veterans with Chronic Pain:

A Policy Perspective

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Abstract

The purpose of the project was to do an evidence-based review of the effectiveness of promoting self-care on pain levels and quality of life among veterans with chronic pain at a national level. A review of current chronic pain management policies for veterans in southern California was also conducted. Active self-management initiatives permit more diverse, patient-centered treatment, promote self-management, and are relatively safe and cost-effective. Our results have confirmed that chronic pain is on the forefront of priorities for the Veterans Health Administration (VHA) due to an increasing rate of both chronic pain and opioid overdoses.

Introduction of Problem

Increased combat exposure paired with improvements in protective gear and battlefield medicine have resulted in increased numbers of veterans of Iraq and Afghanistan surviving injuries that would have been deadly in prior wars. Veterans are returning home with comorbid psychological and physical health problems. Currently, pain is one of the most common reasons veterans make appointments with their primary care providers and is one of the most prevalent symptoms reported by returning veterans. Overwhelmed, primary care physicians have responded with increasing doses of prescription opioids. According to an analysis by the Center for Investigative Reporting there has been a 270% increase in Veterans Health Administration (VHA) prescriptions for opiates since 9/11. VHA patients are twice as likely to die from accidental drug overdoses as civilians, according to a VHA study published in the journal *Medical Care* in 2011.¹ A study conducted from 2007-2008 carefully reviewed three hundred and forty medical records of OIF/OEF veterans seen at a Department of Veterans Affairs Polytrauma Network Site. Analyses indicated a high prevalence of three conditions in this population: chronic pain (81.5%), post-traumatic stress disorder (PTSD) (68.2%), and persistent post-concussive symptoms (PPCS) (66.8%).

Chronic pain is not fully understood or well controlled for most patients living with pain. It is a debilitating condition that impacts a patient's quality of life (QOL), mobility, and strength, and can be associated with depression and other psychosocial problems. A study of 800 patients with chronic non-cancer pain conducted from 2009 to 2010 in a VHA primary care setting found that the rate of depression among chronic pain patients in the study was 48.4% and anxiety was 25%.² Pain is one of the most common

and debilitating patient complaints, affecting individual patients, their friends and families, the work force, and society in general.³ The National Institutes of Health⁴ defined chronic pain as any pain lasting longer than 12 weeks.

A survey among VHA primary care providers found that 77% of respondents identified pain control among the top three treatment priorities.⁵ Yet, many healthcare providers are not aware of policies, guidelines, and treatment options for chronic pain patients. Implementing and encouraging providers to use practice guidelines will help optimize chronic pain management, increase patient satisfaction and functioning, decrease total opioid use, and increase provider comfort/knowledge in the care of this patient population.

Pain is not the only issue. How pain is being controlled also needs to be addressed. According to a JAMA Internal Medicine Report, 26% of the general population and 44% of U.S. military combat veterans experience chronic pain.⁴ Fifteen percent of U.S. military combat veterans use opioids, compared to 4% of the general population. Drugs, such as opioids, are not consistently effective, have disabling side effects, may exacerbate pain conditions in some patients, and are often misused.⁴

According to the National Institute for Drug Abuse (NIDA), 52 million people have used prescription drugs for nonmedical reasons at least once in their lifetimes. These figures indicate a need to manage chronic pain among U.S. military personnel and veterans with nonpharmacologic approaches.⁴ Three related questions are addressed in this review.

1. What is the incidence of pain in the veteran population?
2. What are the current treatment modalities for chronic pain among veterans?
3. What policies related to chronic pain are addressed in the literature?

Background and Significance

The recent conflicts of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have put the issue of chronic pain front and center for the Department of Defense (DOD) and the U.S. Department of Veterans Affairs. Military members with chronic pain have higher rates of depression, posttraumatic stress disorder (PTSD), and somatic-like illness than the civilian population. With more than 50,000 military members wounded in action and nearly 80% of veterans returning from war with chronic pain, it is vital that we develop appropriate chronic pain treatment approaches.⁶

Military veterans with chronic pain are frequently more complex in their presentation than the general population due to challenges of returning to civilian life and the influence of their past military service on their pain.⁷ According to the Institute of Medicine (IOM), chronic pain treatment and lost productivity cost American society \$560 to \$635 billion annually.⁸ Conventional pain management methods have been largely dependent on the use of prescription and over-the-counter medications and opioids, which are often ineffective for the management of chronic pain and may actually contribute to the development of chronic pain.⁹ A multimodal and integrative approach that addresses the many dimensions of the biopsychosocial model may be better suited for individuals experiencing such pain.²

The biopsychosocial model takes into account the dynamic and complex interactions among biological, psychological and social factors that propagate and may worsen the clinical presentation. Each individual experiences pain uniquely, based upon these interactions. A study published in the Journal of Rehabilitation Research and Development found that poor biopsychosocial function predicts higher pain severity in

chronic lower back patients. Biological function reflects physical function and how health constrains physical activities.¹⁰

The evidence-based self-care model is a biopsychosocial model that has shown benefit for chronic pain patients. The model includes processes that develop patient's problem-solving skills, improve self-efficacy, and support application of knowledge in real-life situations that matter to patients. Active self-management initiatives permit more diverse, patient-centered treatment, promote self-management, and are relatively safe and cost-effective. Since chronic pain is complex and multidimensional, a multimodal and integrative approach that speaks to the many dimensions incorporated in the biopsychosocial model may be better suited for individual's facing such pain.¹¹

Buckenmaier and Schoomaker⁸ noted that these initiatives recognize the important role the patient plays in maintaining his or her own health, promote practices that have few side effects compared to pain medications, and are relatively easy to implement.

NIH⁴ and the VHA are partnering to conduct thirteen research projects totaling approximately \$21.7 million over 5 years that will explore nonpharmacologic approaches to managing pain and related conditions. "The need for nondrug treatment options is a significant and urgent public health imperative. We believe this research will provide much-needed information that will help our military and their family members," stated Josephine P. Briggs, M.D., Director of National Center for Complementary and Alternative Medicine (NCCAM).⁴

Current chronic pain treatments are primarily focused on treating the cause of pain, ignoring the other pain-related comorbidities that influence the pain cycle and can exacerbate symptoms. Many chronic pain patients become resistant to such treatments

and experience adverse effects from widely used prescription medications. These factors have caused many with chronic pain to seek integrative health care approaches that can provide efficient, safe, and comprehensive pain management options. The self-care approach requires management by a collaborative team with a shared vision of health care and permits both practitioner and patient to contribute equally to a shared plan of care.¹¹ This kind of therapy allows patients to practice a multitude of modalities; they have the opportunity to find the therapeutic modality or combination of modalities best suited for their particular needs, maximizing the potential for favorable outcomes and fostering patient empowerment.¹¹

Increasing evidence shows that self-management support reduces hospitalizations, emergency department use, and overall managed care costs. In 36 trials focused on adult asthma, self-management decreased nocturnal symptoms, hospitalizations, and emergency department use compared to usual care. Another community-based group program to increase self-efficacy among patients with diabetes, lead to improved self-efficacy and better HgA1C levels.

Despite this evidence, self-care is the least implemented and most challenging area of chronic disease management. An underlying tenet of self-care education is that the patient's belief in his or her own ability to achieve a reduction in symptoms leads to improved clinical outcomes. Physicians who want to provide increased self-care support to their chronic pain patients are advised to address three areas: structuring patient-physician interactions to include goal-setting and problem-solving strategies, making office protocol changes, and providing self-care education by linking patients to community self-care programs and resources.¹²

A self-care model tool that can easily be implemented in practice is shown in Figure 1. This tool allows providers to start conversations with their patients about various options for treating chronic pain.

Figure 1 Self-Care Model¹³

There are two assumptions underlying the Self-Care System Model. First, individuals are capable of developing the knowledge, attitudes and skills necessary to decide on and perform health-promoting behaviors. Second, due to the value of self-care in health promotion, nursing practice is directed toward fostering responsibility for the acquisition and maintenance of health-promoting behaviors. Self-care within the health promotion framework highlights personal commitment and responsibility for obtaining the knowledge, attitudes and skills necessary to enhance and preserve health.¹⁴

In a 2012 study, qualitative interviews were conducted with 26 veteran patients who underwent a self-management intervention for chronic musculoskeletal pain. Results showed patients were able to find what worked for their pain, felt they were held accountable for their pain management, and felt motivated by the emotional support provided through the self-care intervention¹⁵

A study was recently published in the Journal of the American Association of Nurse Practitioners that looked at the influence of self-management and self-management support on chronic low back patients in primary care. This study found that self-management support significantly influenced functional ability and pain intensity. Of the 120 participants, 54.2% believed that if they self-managed their chronic lower back pain, they would use less pain medication; 50.8% agreed that they would have fewer provider visits; and 60% felt that their physical activity level would increase.¹⁶

Literature Review

As discussed earlier, three questions will be addressed to provide a better understanding of the extent of chronic pain in the veteran population, what treatment modalities are currently being used to address this problem, and policies designed to address chronic pain in this population.

Pain Incidence among Veterans

Due to the recent Iraq and Afghanistan conflicts, pain is now the leading cause of short and long-term disability among veterans.¹⁷ This is partly due to greater combat exposure and improvements in battlefield medicine and protective gear. This has resulted in large numbers of veterans surviving injuries that would have been fatal in prior wars. The Department of Veterans Affairs has experienced a 270% increase in opioid prescriptions for pain since September 11, 2001. It's not surprising that there has also been a sharp increase in opioid overdoses. According to the VHA, opioid-related overdoses nearly doubled between 2001 and 2009 from 1,006,479 to 1,096,422.¹⁷

Figure 2. Demographics of Chronic Opioid Recipients in a National Sample of Veterans 2009-2011¹⁷

A June 2014 report in *JAMA Internal Medicine* of a study involving 2,597 participants found that 44% of troops experienced chronic pain after combat deployment and 15.1% regularly used opioids. Even accounting for the ready availability of military care, these rates are much higher than the estimates of 26.0% and 4.0%, respectively, in the general civilian population.¹⁸

Figure 3 Unintentional Overdose Deaths in the U.S.¹³

In a study of OIF/OEF/Operation New Dawn (OND) veterans, 613,391 (mean

age: 31.9 +/- 9.6 year) accessed VHA services at least once. More than 40% of these veterans were diagnosed with chronic pain.¹⁹

Another study that was conducted from 2007 to 2008, examined the prevalence with which returning OIF/OEF veterans reported symptoms consistent with chronic pain, posttraumatic stress disorder (PTSD), and persistent postconcussive symptoms (PPCS). Three hundred and forty medical records of OIF/OEF veterans seen at a Department of Veterans Affairs Polytrauma Network site were carefully reviewed. Analyses indicated a high prevalence of all three conditions in this population: chronic pain (81.5%), PTSD (68.2%), and PPCS (66.8%). Forty-two percent of participants were diagnosed with all three conditions simultaneously. The most frequent chronic pain locations were the back (58%) and head (55%).²⁰

The 2010 VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain indicated that more than 50% of male VHA patients in primary care reported chronic pain and that this figure may be even higher in female veterans. The VA and DOD reported that pain is the most frequent presenting complaint of returning OEF/OIF soldiers (>50% of OEF/OIF veterans signing into the VHA), and is particularly prevalent (>90%) in those with polytrauma. Some studies have shown that the combined prevalence of posttraumatic stress disorder (PTSD), traumatic brain injury, and pain exceed 40%.²¹ Refer to table 1 below for an analysis of each source on pain incidence.

Current Treatment Modalities for Chronic Pain

A study done in 2011 found that more than 80% of veterans reported previously trying complementary and alternative medicine (CAM), and almost all were willing to try one or more of the four CAM modalities addressed in the study (massage, acupuncture,

chiropractic care, herbal medicine). The Veterans who had already tried CAM treatments differed very little from veterans who had not tried CAM treatments. This suggested that many veterans experiencing chronic pain might be interested in CAM treatment options for chronic pain. The authors concluded that study results supported the increasing VHA movement toward offering CAM modalities as treatment options for pain management.²²

There have been major advances in how chronic pain is treated in the veteran population. In most cases, it is up to the primary care clinic to make a referral to any of four primary models of chronic pain service delivery, which are based on the results of the *International Association for the Study of Pain* (IASP) Task Force on Guidelines for Desirable Characteristics for Pain Treatment Facilities. These models include single service clinics, pain clinics, multidisciplinary pain clinics, and the multidisciplinary pain center. Single service clinics are outpatient clinics that provide a specific type of treatment for pain but do not provide comprehensive assessment or management. The next level of intervention occurs at a pain clinic, which specifically focuses on the diagnosis and management of individuals with chronic pain. As treatment intensity increases, patients are referred to the multidisciplinary pain clinic, which is suited for those with mild to moderate chronic pain who require more global and intensive treatment of their pain and related areas of dysfunction. Finally, there is a multidisciplinary pain center that offers treatment for both acute and chronic pain using a dedicated, interdisciplinary staff working in a team setting and is typically associated with a medical school or teaching hospital.²³

Currently, there are many options for treating chronic pain in the veteran population. With accidental overdoses from opioids on the rise, the VHA has initiated

many nonpharmacologic interventions for chronic pain management to be used independently or in conjunction with medication. Examples of popular pain treatment modalities in the VHA include:

- Pain medications (e.g., narcotic analgesics, NSAIDs, Tricyclic antidepressants, anticonvulsant medications, "muscle relaxants", etc.)
- Bed rest/braces for pain reduction
- Surgery
- Nerve blocks/steroid injections
- Trigger point injections
- Acupuncture
- Patient controlled analgesia pump
- Dorsal column stimulator implant
- Physical Therapy-passive modalities (e.g., ultrasound, infrared, massage)
- Electrical Stimulation Therapy
- Physical Therapy-active treatments (e.g., exercise, TENS, gait training)
- Manipulation
- Biofeedback
- Relaxation
- Group therapy
- Individual therapy
- Behavior therapy
- Cognitive-behavioral therapy
- Hypnosis
- Education
- Multidisciplinary pain management²³

For each of these interventions, it is up to the individual practitioner to determine whether a given treatment is effective for the condition and to determine if professional or state guidelines or standards of care governing the treatment of the particular pain condition exist.²³ Currently, there are no specific guidelines for the treatment modalities listed above, except opioid prescribing. The self-care model includes the above interventions in an organized chart that allows provider and patient to discuss all treatment options and decide on the best treatment plan.

The "Pain Management Opioid Safety Educational Guide"²⁴ stressed the importance

of reducing harm while helping the hurting veteran. The guide emphasized the importance of setting realistic expectations for pain management and noted that complete pain relief may not be a realistic goal. With thorough patient education, pain will be reduced, and the patient will have improved function and minimal side effects. Finally, the guide stressed the importance of addressing potential pain-management issues to increase the likelihood of adherence to treatment plans and self-care. With educational interventions comes improved self-management and reduced pain.

Current Policies on Chronic Pain

The Army Surgeon General's Pain Management Task Force (PMTF) was chartered in August 2009 to make recommendations for a U.S. Army Medical Command (MEDCOM) comprehensive, multidisciplinary, and multimodal pain management strategy for use in army treatment facilities. This strategy was to utilize state of the art science modalities and technology as well as provide optimal quality of life for soldiers. A focus of the plan was the complexity of chronic pain management, which is often considered beyond the expertise of a single practitioner. We see these complexities in patients whose pain problems are complicated by PTSD, combat injuries, and substance abuse. Pain medicine specialists and behavioral specialists, as well as interdisciplinary pain clinics, may be key players in effectively evaluating and managing these complex patients. The task force also recommended active self-care integrative therapies that require minimal training and can be practiced by patients on their own.²⁵

In Section 711 of the National Defense Authorization Act for fiscal year 2010, the Secretary of Defense was tasked with developing and implementing a comprehensive policy on pain management by the military health system (MHS). This was to be

completed no later than March 31, 2011.²⁵ Topics to be included in this policy were as follows:

1. The management of acute and chronic pain.
2. The standard of care for pain management to be used throughout the Department of Defense.
3. The consistent application of pain assessments throughout the Department of Defense.
4. The assurance of prompt and appropriate pain care treatment and management by the Department when medically necessary.
5. Programs of research related to acute and chronic pain, including pain attributable to central and peripheral nervous system damage characteristic of injuries incurred in modern warfare, brain injuries, and chronic migraine headache.
6. Programs of pain care education and training for health care personnel of the Department of Defense.
7. Programs of patient education for members suffering from acute or chronic pain and their families.

The Secretary of Defense must revise the policy on a periodic basis in accordance with experience and evolving best practice guidelines no later than 180 days after the policy has been implemented. On October 1st each year through 2018, the Secretary must submit to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representative a report on the current status of the policy.²⁵

In 2014, the VHA Directive established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain

care agreements (OPCA). VHA opioid prescribers must complete the patient education and informed consent process specified in the directive. Not only must patients be accountable for opioid use, but providers must also remain accountable as prescribers of opioids, maintaining compliance with this policy.²⁴

The Chiropractic Health Care and Alcohol, Tobacco, and Other Drugs sections of the American Public Health Association (APHA) have submitted an APHA policy proposal calling for an organized, multi-faceted expansion to integrate evidence-based, nonpharmacologic therapies as priority treatment options for pain. The policy supports further research on nonpharmacologic interventions for pain treatment across a variety of pain populations and healthcare settings, the endorsement of evidence-based nonpharmacologic therapies within best practice models for pain management, policies to expand access to providers of nonpharmacologic therapies, inter-professional education to supplement the training of pain management teams, and public health campaigns to increase awareness of drug-free treatment options for pain syndromes.²⁶ This policy will be among others considered by APHA leadership and membership at the organization's next general meeting in 2015.

Discussion

In this paper, we present the results of an examination of chronic pain in the veteran population from the perspectives of prevalence, current treatment approaches, and policy development. Our results have confirmed that chronic pain is on the forefront of priorities for the VHA due to increasing rates of both chronic pain and opioid overdoses. It is apparent that there are measures currently being implemented to move treatment away from controlled medications and toward greater use of nonpharmacologic

treatments, including CAM. Policies have been and are being established to minimize chronic pain in this population through research and clinical practice changes.

Gaps in Research

Despite practice and policy changes in the VHA there are still gaps in research. Standardizing treatment for those with chronic pain using a multitude of CAM modalities has not occurred. Standardized CAM tools need to be established for all providers in the VHA system to use whether in a pain clinic or a primary care clinic. The VHA has a multitude of resources available to their patients but without guidelines and protocols these modalities will be underutilized and chronic pain rates will increase.

Developing more effective and less risky pain relief remains a major challenge. In addition, there are many barriers to effectively translating research findings into practice. Adapting the regulatory process to enable more efficient evaluation and approval of effective therapies remains a challenge. This is especially true when trying to personalize medicine for pain management.

As discussed earlier, self-care modalities provide an open forum of communication for provider and patient. In particular, a self-care chart provides a visual aid for all treatment modalities for chronic pain. By including this in treatment protocols for chronic pain patients, all available resources will be considered. Further studies on self-care should be implemented in the veteran population.

Clinical Implications for the APRN

Chronic pain currently affects about 100 million adults; more than the total affected by heart disease, cancer, and diabetes combined.²⁷ These numbers should serve as a wake-up call to all those involved in the care of patients with chronic pain . Nurse

practitioners play a major role in leading this initiative. The 2011 IOM report stated, “Among steps to improving care, healthcare providers should increasingly aim at tailoring pain care to each person’s experience and self-management of pain should be promoted.”²⁷

Although the IOM report recommended self-management as a necessary approach in the care of chronic pain patients, there is currently no evidence-based protocol to guide providers in promoting self-management for chronic pain. The American Medical Association (AMA) has established a “Physician Resource Guide to Patient Self-management Support” for chronic diseases. This guide introduces patient self-management support concepts and presents selected resources and practice implementation tools. It encourages providers to implement cost-effective techniques in order to help patients achieve better health outcomes and increase their quality of life.²⁸ It is vital that we create self-care management programs that are specific to chronic pain patients’ needs. Healthcare providers who are effective in providing self-management can help enable patients to take responsibility for their health, decrease their pain, and improve their quality of life over time.

As APRNs, we should support healthy lifestyles and increased self-care guidance for our patients so that they may live longer happier lives. Nurse practitioners in primary care are in a significant position to lead self-management programs. Multidisciplinary and collaborative care are keys to self-management success.

Policy Implications/ Implementation

As APRNs it is imperative that not only do we comply with policies when practicing but that we actively support the development of policies that will allow for

better patient outcomes. APRNs bring a unique, broad perspective to patient care and are highly skilled collaborators in the delivery of team-based care. Continuing to promote evidence based care should be a priority among policy implementation in our healthcare systems today.

Currently, there are no pain policies that are geared specifically for CAM in the veteran population. As the nation considers ways to create a more effective healthcare delivery system that focuses on better patient outcomes, increased access, and decreased costs, it is up to APRNs to promote and support legislation that offers sound policy solutions. Establishing practice protocols for self-care of chronic pain patients in the VHA is a major step toward reducing rates of chronic pain and opioid abuse among the veteran population. Supporting and creating legislation that supports development of such protocols is imperative. Finally, there is a need for further evidence-based research on self-care in the population of veterans with chronic pain. By implementing such projects, we can provide evidence to support legislation and practice change.

Conclusions

Combat veterans are presenting to VHA primary care clinics in large numbers and are seeking relief from physical and psychological pain. Extra care should be taken when treating their pain. These patients may benefit from biopsychological models of pain care including non-opioid analgesics and evidence-based nonpharmacological therapies. Integrated treatments designed to improve both mental health disorders and pain are effective for both problems and may decrease harm resulting from opioid therapy.

The increasing prevalence of chronic pain in the veteran population in today's society points to the significance of this review. Despite remarkably high health care

costs for chronic pain management, current treatments have shown very little benefit for patients. Research shows that self-management is highly recommended in the management of patients with chronic pain. However, the current state of research merits an evaluation of these interventions in the veteran population. More funds and research need to be dedicated to this epidemic that is not only effecting veterans but the entire population.

References

1. Olsen, K. On the edge. *American Legion Magazine*. 2014. Retrieved from <http://www.legion.org/magazine/220428/edge>. Accessed on January 15, 2015.
2. Sekhon, R, Aminjavahery, N, Davis, C, Roswarski, M, Robinette, C. Compliance with opioid treatment guidelines for chronic non-cancer pain (CNCP) in primary care at a veteran's affairs medical center (VAMC). *Pain Medicine*. 2013; 14, 1548-1556. doi: 10.1111/pme.12164. Accessed October 15, 2014.
3. Rosenquist, E. Definition and pathogenesis of chronic pain. *UpToDate*. 2015. Retrieved from http://www.uptodate.com/contents/definition-and-pathogenesis-of-chronic-pain?source=search_result&search=definition+of+chronic+pain&selectedTitle=1%7E150. Accessed March 1, 2015.
4. National Institutes of Health (NIH). *NIH and VA address pain and related conditions in U.S. military personnel, veterans, and their families*. 2014. Retrieved from <http://www.nih.gov/news/health/sep2014/nccam-25.htm>. Accessed January 15, 2015.
5. Mitchinson, A., Kerr, E., & Krein, S. Management of chronic noncancer pain by VA primary care providers: When is pain control a priority? *The American Journal of Managed Care*. 2008; 14: 77–84. Retrieved from <http://www.ajmc.com/publications/issue/2008/2008-02-vol14-n2/Feb08-2833p077-084/> Accessed October 15, 2013.
6. Delgado, R, York, A, Lee, C, Crawford, C, Buckenmaier, C, Shoomaker, E.

- Assessing the quality, efficacy, and effectiveness of the current evidence base of active self-care complementary and integrative medicine therapies for the management of chronic pain: A rapid evidence assessment of the literature. *Pain Medicine*. 2014; 15, S9-S20. doi: 10.1111/pme.12412. Accessed January 15, 2015.
7. Cosio, D, Lin, E. Effects of a pain education program for veterans with chronic, noncancer pain: A pilot study. *Journal of Pain & Palliative Care Pharmacotherapy*. 2013; 27, 340-349. doi:10.3109/15360288.2013.846953. Accessed October 15, 2015.
  8. Buckenmaier, C, Schoomaker, E. Patients' use of active self-care complementary and integrative medicine in their management of chronic pain symptoms. *Pain Medicine*. 2014; 15, S7-S8. doi: 10.1111/pme.12384. Accessed October 15, 2013.
  9. Giron, SE. (in press). Chronic pain and decreased opioid efficacy: An inflammatory link. *Pain Management Nursing*,
  10. Koenig, A, Kupper, A, Skidmore, J, Murphy, K. Biopsychosocial functioning and pain self-efficacy in chronic low back pain patients. *Journal of Rehabilitation Research and Development*. 2014; 51, 1277–86. doi: 10.1682/JRRD.2014.02.0047. Accessed January 15, 2015.
  11. Lee, C, Crawford, C, Swann, S. Active self-care therapies for pain (PACT) working group, multimodal, integrative therapies for the self-management of chronic pain symptoms. *Pain Medicine*. 2014; 15, 76–S85. doi: 10.1111/pme.12408. Accessed January 15, 2015.
  12. Coleman, M, Newton, K. Supporting self-management in patients with

- chronic illnesses. *American Family Physician*. 2005; 72, 1503-10. Retrieved from <http://www.aafp.org/afp/2005/1015/p1503.html>. Accessed October 15, 2013.
13. U.S. Department of Veterans Affairs. *Pain management opioid safety educational guide*. 2014. Retrieved from <http://vaww.sandiego.portal.va.gov/sites/AD/SitePages/Home.aspx>. Accessed on January 15, 2015.
14. Simmons, S. The health-promoting self-care system model: Directions for nursing research and practice decision-making, performance and outcomes of health-promoting lifestyles. *Journal Of Advanced Nursing*. 1990; 15, 1162-1166. doi:10.1111/j.1365-2648.1990.tb01708.x. Accessed October 15, 2013.
15. Matthias, M, Miech, E, Myers, L, Sargent, C, Bair, Matthew J. An expanded view of self-management: Patients' perceptions of education and support in an intervention for chronic musculoskeletal pain. *Pain Medicine*. 2012; 13, 1018-1028. doi: 10.1111/j.1526-4637.2012.01433.x. Accessed October 15, 2013.
16. Kawi, J. Influence of self-management and self-management support on chronic low back pain patients in primary care. *Journal of the American Association of Nurse Practitioners*. 2013; 26, 664-673. doi: 10.1002/2327-6924.12117. Accessed October 15, 2014.
17. Kean, N. Profile of pain in the military. *Practical Pain Management*. 2014. Retrieved from <http://www.practicalpainmanagement.com/meeting-summary/profile-pain-military>. Accessed January 15, 2015.
18. Jonas, W, Schoomaker E. Pain and opioids in the military: We must do better.

- JAMA Internal Medicine. 2014; 174,1402-1403.
19. Cifu, D, Taylor, B, Carne, W, Bidelsbach, D, Sayer, N, Scholten, J, Campbell, E . Traumatic brain injury, posttraumatic stress disorder, and pain diagnoses in OIF/OEF/OND Veterans. *Journal of Rehabilitation Research and Development*. 2013; 50, 1169–76. doi: <http://dx.doi.org/10.1682/JRRD.2013.01.0006>. Accessed October 15, 2014.
20. Lew, H, Otis, J, Tun, C, Kerns, R, Clark, M, Cifu, D. Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: Polytrauma clinical triad. *Journal of Rehabilitation Research and Development*. 2009; 46, 697-702. doi: 10.1682/JRRD.2009.01.0006
21. Department of Veterans Affairs & Department of Defense. *Management of opioid therapy for chronic pain. VA/DoD clinical practice guideline*. 2010. Retrieved from http://www.healthquality.va.gov/guidelines/pain/cot/cot_312_full-er.pdf
22. Denneson, L, Corson, K, Dobscha, S. Complementary and alternative medicine use among veterans with chronic noncancer pain. *Journal of Rehabilitation Research and Development*. 2010; 48, 1119-28. doi:10.1682/JRRD.2010.12.0243. Accessed October 15, 2013.
23. U.S. Department of Veterans Affairs. *Chronic pain primer*. 2010. Retrieved from http://www.va.gov/PAINMANAGEMENT/Chronic_Pain_Primer.asp. Accessed October 15, 2013.
24. Office of the Army Surgeon General. *Pain management task force final report*:

- Providing a standardized DoD and VHA vision and approach to pain management to optimize the care for warriors and their families*. 2010. Retrieved from <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 15, 2013.
25. Department of Veterans Affairs. *Informed consent for long-term opioid therapy for pain*. 2014. Retrieved from http://www1.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=3005. Accessed January 15, 2015.
26. Maiers, M. Increased role for evidence-based non-pharmacologic management of pain to decrease the opioid abuse epidemic. Proposed policy statement for the American Public Health Association. 2015. Retrieved from http://www.apha.org/~media/files/pdf/policy/a4_nonpharmpxmgmt.ashx
27. Institute of Medicine. *Relieving pain in America: A blueprint for transforming prevention, care, education, and research. Report brief*. 2011. Retrieved from <http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research/Report-Brief.aspx?page=1> doi:10.1001/jamainternmed.2014.2114. Accessed January 15, 2015.
28. Bradley, M, Gaden, M, Irmiter, C, Meyer, M, Schwartzberg, J. *Physician resource guide to patient self-management support*. 2012. <http://selfmanagementalliance.org/wp-content/uploads/2013/09/phys-resource-guide.pdf>. Accessed April 10, 2015.

Figure 1 Self-Care Model¹³

Figure 2. Demographics of Chronic Opioid Recipients in a National Sample of Veterans 2009-2011¹⁷

Table 1. Demographics of Chronic Opioid Recipients in a National Sample of Veterans 2009-2011			
Year	2009	2010	2011
Number	1,006,479	1,060,731	1,096,422
Mean age, y	57.9	57.9	58.0
Male, %	92.5	92.3	92.2
Married, %	51.3	50.9	50.6
Race			
Caucasian	70.9	70.3	69.8
Non-Caucasian	20.6	21.0	21.4
Missing	8.5	8.7	8.8

Figure 3 Unintentional Overdose Deaths in the U.S.¹³

Table 1. Synopsis of Related Research

Author-Year-Journal	Level of Evidence	Purpose	Research Design	Sample: Size and Characteristics	Results	Relevance to Practice
Cifu, D., Taylor, B., Carne, W., Bidelspach, D., Sayer, N., Scholten, J., & Campbell, E. -2013 – Journal of Rehabilitation Research and Development	Level II B	To identify the prevalence of traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), and pain in Veterans from Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND), Veterans who received any inpatient or outpatient care from Veterans Health Administration (VHA) facilities from 2009 to 2011 were studied.	Retrospective Cohort Study	Patients seen between FY2009–11. There were 613,391 OIF/OEF/OND Veterans who accessed VHA inpatient or outpatient services at least once. Overall, the Veterans were 31.9 ± 9.6 yr old (mean ± standard deviation).	40.2% were diagnosed with chronic pain.	Chronic pain is a priority problem that needs to be addressed in the primary care setting. It is imperative that we come up with standardized protocols for treating chronic pain in the veteran population.

Jonas, W. & Schoomaker E. - 2014- JAMA Internal Medicine	Level IIB	To assess chronic pain prevalence and opioid use in a non-treatment-seeking, active duty infantry population following deployment.	Retrospective Cohort Study	2,597 study participants. Found that 44% of troops experienced chronic pain after combat deployment and 15.1% regularly used opioids.	A June 2014 report in <i>JAMA Internal Medicine</i> of 2,597 study participants found that 44% of troops experienced chronic pain after combat deployment and 15.1% regularly used opioids.	Chronic pain is a priority problem that needs to be addressed in the primary care setting. It is imperative that we come up with standardized protocols for treating chronic pain in the veteran population
Lew, H., Otis, J., Tun, C., Kerns, R., Clark, M., & Cifu, D. -2009- Journal of Rehabilitation Research and Development	Level II B	This study examines the prevalence and coprevalence with which returning Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans were reporting symptoms consistent with chronic pain, posttraumatic stress disorder (PTSD), and persistent postconcussive symptoms (PPCS)	Retrospective Cohort Study	340 OIF/OEF veterans seen at a PNS between January 1, 2007, and October 27, 2008 (22 months).	Analyses indicated a high prevalence of three conditions in this population, which included: chronic pain (81.5%), PTSD (68.2%), and PPCS (66.8%). Forty-two percent were diagnosed with all three conditions simultaneously. The most frequent chronic pain locations were the back (58%) and head (55%)	Chronic pain is a priority problem that needs to be addressed in the primary care setting. It is imperative that we come up with standardized protocols for treating chronic pain in the veteran population. It is important to recognize that the veteran population can be more complex than the general population when it comes to

Department of Veterans Affairs and Department of Defense-2010	Level V A	The Clinical Practice Guideline (CPG) for the Management of Opioid Therapy (OT) for Chronic Pain was developed under the auspices of the Veterans Health Administration (VHA) and the Department of Defense (DoD) pursuant to directives from the Department of Veterans Affairs (VA).	Expert Opinion	VA population as of 2010.	Pain is the most frequent presenting complaint of returning Operation / Enduring Freedom / Operation Iraqi Freedom (OEF/OIF) soldiers (> 50% of OEF/OIF veterans signing into the VHA), and is particularly prevalent (>90%) in those with polytrauma.	Pain. Utilizing interdisciplinary resources is imperative in treating this population. Chronic pain is a priority problem that needs to be addressed in the primary care setting. It is imperative that we come up with standardized protocols for treating chronic pain in the veteran population.
Office of the Army Surgeon General-2010	Level V A	Providing a standardized DoD and VHA vision and approach to pain management to optimize the care for warriors and their families.	Expert Opinion	DOD and VHA population as of 2010	Pain medicine specialists, behavioral specialists, as well as interdisciplinary pain clinics may be key players in effectively evaluating and managing these complex patients. The task force also recommends active-self	Nurse practitioners in primary care are in a significant position to lead self-management programs. Multidisciplinary and collaborative care in key in self-

U.S. Department of Veterans Affairs- 2010	Level V A	Defines chronic pain and discusses treatment modalities in the VHA	Expert Opinion	VA population as of 2010	care integrative therapies that require minimal training and can be practiced by patients on their own. Examples of popular pain treatment modalities in the VA include (U.S. Department of Veterans Affairs, 2010): -Pain medications -Bed rest/braces for pain reduction -Surgery -Nerve blocks/steroid injections -Trigger point injections -Etc.	management success. For providers working in the VHA it is important to be educated about all the VA resources available to manage chronic pain. This allows you to create a comprehensive treatment plan for your patients.
U.S. Department of Veterans Affairs- 2014	Level V A	An educational aid to improve care and safety with opioid therapy.	Expert Opinion	VA population as of 2014	The guide stresses the importance of potential pain-management issues to increase the likelihood of adherence to treatment plans and self-care. With educational interventions comes improved self-management and reduced pain.	Thorough educational interventions by providers are essential to a successful chronic pain self-management plan.
Department of Veterans Affairs- 2014	Level V A	This Veterans Health Administration (VHA) Directive establishes policy regarding patient education and informed consent	Expert Opinion	VA population as of 2014	VHA opioid prescribers must complete the patient education and informed consent process specified in the directive.	As a VHA provider it is important to be educated on current policies in regards to prescribing opioids.

SUPPORTING SELF-CARE IN VETERANS WITH CHRONIC PAIN: A POLICY PERSPECTIVE

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The purpose of the project was to do an evidence-based review of the effectiveness of promoting self-care on pain levels and quality of life among veterans with chronic pain at a national level. A review of current chronic pain management policies for veterans in southern California was also conducted. Active self-management initiatives permit more diverse, patient-centered treatment, promote self-management, and are relatively safe and cost-effective. Our results have confirmed that chronic pain is on the forefront of priorities for the Veterans Health Administration (VHA) due to an increasing rate of both chronic pain and opioid overdoses.

Supporting self-care in Veterans with chronic pain:

A policy perspective

Erin Lind, BSN, DNP Student, Joseph Burkard, DNSc, CRNA, David Bittleman, MD, FACP

GROUND

Chronic pain are frequently misdiagnosed or poorly managed. Veterans are more likely to return to civilian life than the general population. The Department of Veterans Affairs (VA) has a high rate of chronic pain, with an annual productivity cost of \$1.5 billion (Buckner et al., 2013).

Chronic pain is a leading cause of disability in the United States. It is a complex condition that can be difficult to manage. The VA has a high rate of chronic pain, with an annual productivity cost of \$1.5 billion (Buckner et al., 2013).

Initiatives permit more treatment, promote self-advocacy, and improve the management of chronic pain. The VA has a high rate of chronic pain, with an annual productivity cost of \$1.5 billion (Buckner et al., 2013).

PROPOSE

A review of the self-care on pain levels in veterans nationally with current chronic pain established in the VA system.

EVIDENCE

The performance of self-efficacy to allow patients to make decisions and move toward adequately managed chronic pain (Coleman and

initiatives allow for a more complex treatment of chronic pain. The VA has a high rate of chronic pain, with an annual productivity cost of \$1.5 billion (Buckner et al., 2013).

INCIDENCE OF PAIN

The 2010 VA/DoD Clinical Practice Guideline for Management of Pain states that more than 50% of VA patients in primary care report chronic pain, which may even be higher in female veterans.

CURRENT POLICIES ON CHRONIC PAIN

In Section 711 of the National Defense Authorization Act for fiscal year 2010 the Secretary of Defense was tasked to develop and implement a comprehensive policy on pain management by the Military Health System (MHS) (Office of the Army Surgeon General, 2010). In 2014, the VA, DOD, and DoD established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain care agreements (OPCA). The VA, DOD, and DoD established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain care agreements (OPCA). The VA, DOD, and DoD established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain care agreements (OPCA).

Author	Year	Findings	Notes
U.S. VA, DoD, and DoD	2010	The 2010 VA/DoD Clinical Practice Guideline for Management of Pain states that more than 50% of VA patients in primary care report chronic pain, which may even be higher in female veterans.	
U.S. VA, DoD, and DoD	2014	The 2014 VA, DOD, and DoD established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain care agreements (OPCA).	
U.S. VA, DoD, and DoD	2014	The 2014 VA, DOD, and DoD established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain care agreements (OPCA).	
U.S. VA, DoD, and DoD	2014	The 2014 VA, DOD, and DoD established a policy regarding patient education and informed consent for long-term opioid therapy for pain and policies regarding opioid pain care agreements (OPCA).	

SELF CARE CHART

GAPS IN RESEARCH

- Standardizing treatment for those with chronic pain using a multitude of CAM modalities has not been established. Standardized CAM modalities should be established for all providers in the VHA system to use whether in a pain clinic or a primary care clinic.
- The VHA has a multitude of resources available to their patients but without a guide and protocol these modalities will be underutilized and chronic pain rates will increase.
- There is a need to research to overcome translating effective research into practice. Adapting the regulatory process to enable more efficient evaluation and approval of effective therapies remains a challenge.
- Further studies on self-care should be implemented in the veteran population.

POLICY IMPLICATIONS

CONCLUSIONS/IMPLICATIONS FOR CLINICAL PRACTICE

- Although the OMI report recommended self-management as necessary interventions to help address the care of chronic pain, the report also recommended evidence-based protocols to guide providers in self-management. It is imperative that we create self-management programs that are specific to patients' needs. Healthcare providers who are effective in providing self-management can help enable patients to take responsibility for their health and improve quality of life and pain over time.
- Future practices in primary care are in a significant way to lead self-management programs for chronic pain patients we can improve their pain and QOL.
- By implementing self-care practices among chronic pain patients we can improve their pain and QOL.
- This will ultimately decrease healthcare costs, provide better quality care to patients, and increase patient satisfaction.

REFERENCES

- See handout provided.

SUPPORTING SELF-CARE IN VETERANS WITH CHRONIC PAIN: A POLICY PERSPECTIVE

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Purpose

- The purpose of the project was to do an evidence-based review of the effectiveness of promoting self-care on pain levels and quality of life among veterans with chronic pain at a national level.
- A review of current chronic pain management policies for veterans in southern California was also conducted.

Questions Addressed

- 1. What is the incidence of pain in the veteran population?
- 2. What are the current treatment modalities for chronic pain among veterans?
- 3. What policies related to chronic pain are addressed in the literature?