



**STATEMENT FOR THE RECORD
WOUNDED WARRIOR PROJECT**

**HEARING ON PAIN-MANAGEMENT PRACTICES
BEFORE THE
SUBCOMMITTEE ON HEALTH**

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

OCTOBER 10, 2013

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project to offer a perspective on VA treatment of veterans experiencing acute and chronic pain, and for convening a hearing on this very important subject.

Working with this generation of wounded, injured and ill veterans, we at Wounded Warrior Project (WWP) see daily the devastating impact of pain resulting from polytrauma and in-theater injury. In WWP’s surveying nearly 27 thousand wounded warriors this year, 63% of survey respondents had been hospitalized as a result of their wounds or injuries,¹ with some 68% having suffered blast injuries and 17% bullet or shrapnel wounds.² Most of these warriors live with pain. In fact, two-thirds of the nearly 14 thousand respondents said they had moderate, severe, or very severe bodily pain.³ Some 80% said their pain interferes with work; among them, 30% said pain interfered with work “extremely” or “quite a bit.”⁴

¹ Franklin, et al., 2013 Wounded Warrior Project Survey Report, 16 (July 23, 2013).

² Id., 22.

³ Id., 42.

⁴ Id., 42.

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Pain is the most frequent reason patients seek medical care in the United States.⁵ In general, studies of VA patients show that the pain veterans experience is significantly worse than that of the general public and is thought to be associated with greater exposure to trauma and psychological stress.⁶

Our troops' post-9/11 combat experience is adding new chapters to medicine's understanding of pain and pain-management. As is well understood, large numbers of combatants have survived polytraumatic injuries in Iraq and Afghanistan because of remarkable advances in modern military medicine and transport. But these warriors are at high risk of developing unremitting pain. Early study indicates that the prevalence of pain in soldiers with polytrauma is as high as 96%, and that high percentages of those suffering polytrauma experience pain-related impairment in physical and emotional function.⁷ (As we are learning, polytrauma pain is inherently complex, as multiple pathways may be affected, to include acute pain associated with surgery, centralized pain associated with spinal cord injury, headache due to traumatic brain injury, neuropathic pain due to nerve injury, and phantom pain associated with amputation.⁸ Post-traumatic stress disorder and traumatic brain injury, the largely invisible "signature wounds" of the war, not only have the effect of increasing warriors' pain but of complicating treatment. As we heard from one VA psychologist at a tertiary VA medical center in the Midwest, "[Pain issues are] a MAJOR problem that seriously and negatively impact mental health care, and make my job a lot harder."

While treating pain is one of medicine's oldest challenges, "pain medicine" is a relatively new and evolving medical specialty.⁹ The Veterans Health Administration has certainly played an important role in attempting to develop a systematized approach to managing pain, beginning in 1998 with the formulation of a national pain strategy. VHA promoted the concept of "Pain as the 5th Vital Sign" in order to provide consistency in pain-assessments throughout the health care system. The initiative recognized the complexity of chronic pain management, especially for patients whose pain was compounded by PTSD, combat injuries, and substance use, and recognized further that such management was often beyond the expertise of a single practitioner.

⁵ 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," E-1 (May 2010) . <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 1, 2013.

⁶ Id., 1.

⁷ War on Pain: New Strategies in Pain Management for Military Personnel and Veterans. (June 2011). Federal Practitioner. (28,2). Pg. 8.

⁸ Id, 8.

⁹ 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," E-1 (May 2010) , <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 1, 2013.

Taking account of an earlier Inspector General finding that the extent of VA's implementation of its national pain strategy had varied and that more work had been needed,¹⁰ Congress in 2008 directed VA to develop and implement a comprehensive policy on the management of pain experienced by VA patients.¹¹ In apparent response to the law, VHA in October 2009 published a directive on pain-management to provide policy and implementation procedures for improving pain management and to comply with generally accepted pain management standards of care. This directive reiterated that pain management is a "national priority," a priority first articulated in the initial 1998 national pain strategy. The 2009 directive not only established a "stepped care" continuum model – beginning with primary care and advancing to timely access to interdisciplinary specialty consultation and collaboration, and finally to tertiary, interdisciplinary care requiring advanced diagnostics and CARF-accredited pain rehabilitation programs. Among its objectives, the national strategy is to create system-wide care standards for pain-management; establish skills in pain management; ensure performance of timely, regular and consistent pain-assessments in all VHA settings; and provide for an interdisciplinary, multi-mode approach to pain management that emphasizes optimal pain control, improved function, and quality of life. VISN directors are responsible for ensuring that all facilities establish and implement pain management policies consistent with the directive, and facility directors are responsible for meeting the objectives of the strategy, for fully implementing the stepped model of care, and for meeting the strategy's standards of pain care.¹² (In addition to this framework, VHA and DoD counterparts developed clinical practice guidelines for management of opioid therapy for chronic pain. The guidelines, first published in 2003, were intended to improve pain management, quality of life and quality of care. The guidelines were updated in May 2010 to reflect evidence-based practice.¹³)

Viewed as a statement of policy and an implementation directive, the National Strategy directive is praiseworthy. But the measure of such an initiative is the reality on the ground – more specifically, what is the experience of veterans who live with often-chronic pain?

Over the past week, we have engaged key WWP field staff from around the country to understand the VA pain-management experience of warriors with whom they work on a daily basis. The accounts they provided us reflect their engagement with warriors at dozens of VA medical facilities across the country. We have also interviewed a number of warriors (among them WWP staff) who have struggled with chronic pain to understand their experience directly, following up on a pain-management roundtable we convened two years ago. Several themes emerged. Notwithstanding a strategic objective of systemwide standards of care, the picture is

¹⁰ Report on the Veterans' Health Care Policy Enhancements Act of 2008, H. Rep. 110-786 (July 29, 2008), accessed at <http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr786&dbname=110&>

¹¹ Section 501, Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387 (October 10, 2008)

¹² Department of Veterans Affairs, VHA Directive 2009-053 (October 28, 2009).

¹³ Department of Veterans Affairs and Department of Defense, Clinical Practice Guidelines: Management of Opioid Therapy for Chronic Pain (May 2010).

one of variability of experience – from medical center to medical center, and even from warrior to warrior. Despite a policy directive that addresses implementation-procedure and establishes levels of responsibility, VHA does not appear to be proactively working to enforce its pain-management policies. And while VHA does have valuable resources with which to support implementation of pain-management strategies, inadequate training of clinicians and staff play a role in their not being used.

A starting point in managing a patient’s pain is surely a full, competent pain assessment, and the national strategy directive identifies the performance of appropriate timely pain assessments consistently across the continuum as a core objective. Primary care is identified as a first step in that continuum, and when “a competent primary care provider workforce (including behavioral care)” cannot manage a pain condition, timely access to specialty consultation (step two) is required. The experience of our warriors suggests, however, that the fundamental objectives associated with these first steps are often not met. Specifically, our on-the-ground staff shared the following observations:

- Rather than being provided a full pain assessment, the common primary care experience is that a brief examination is provided and the remainder of the appointment is devoted to inputting (or updating) medication prescriptions. Staff report that “Medications are given with no treatment plan or direction other than ‘take the medications.’”
- A senior benefits specialist on our team told us that “when I review medical records for veterans and see that they are on extensive pain medication I always ask if they have been referred to pain management for an assessment. The answer is usually ‘no.’”
- A full pain assessment would include a review of a patient’s electronic medical records (to include records of earlier treatment at other VA facilities) to better understand their pain care needs. That information is also vital to ensure that medications and techniques will be efficacious for a given veteran and that previously-failed approaches will not be re-instituted, as well as to avoid prescribing medications that may exacerbate underlying psychological or neurological conditions. Notwithstanding the importance of such review, patients frequently find that clinicians do not use VISTA to pull remote data and/or other pertinent and often critical prior medical records. (It was observed, in that regard, that “VA has a ‘Cadillac e-record system,’ but many clinicians and staff “don’t know how to drive it,” reflecting deficiencies in training and adherence to standards.)
- Primary Care Managers routinely fail to present veterans with pain-relief options that are available and recommended for those presenting with chronic pain.
- The reality is that primary care is generally a hurried experience that does not allow time for questions, for development of a treatment plan, or for discussion of the appropriate

time-frame for any particular pain treatment before consideration of trying something new.

- The primary care provider will send out requests for additional treatment, but those requests are not necessarily followed up. Specifically, warriors experience a lack of follow-through within the VA Medical Centers for setting up requested medical appointments and/or routine care follow up appointments. Compounding this frustration, the patient has no way to reach the provider, doctor or nurse without physically having an appointment.

Reliance on and monitoring of the use of opiate medication is, of course, an area of particular concern, and requires delicate case-by-case consideration. Understanding how variable care can be from facility to facility, we do not suggest that our teammates' observations necessarily describe consistent systemwide practice. At the same time, the observations of WWP staff from around the country strongly suggest that the following scenarios they have described are not at all uncommon:

- Narcotic medications are provided regularly with no treatment plan. These medications are provided on six-month intervals without follow up, and can be filled using the online system or over the telephonic system. These are shipped directly to the warrior's home.
- Illustrative of that experience, a benefits-specialist on our staff described having gone to a VA medical center to have a prescription for Tylenol 3 filled. He stated that the medication had worked in managing pain associated with his collapsed discs in his upper back and herniated discs in his lower spine. He reported that "I went to the pharmacy and was waiting for an hour. When I asked what was the hold-up, I was told they had to get the prescription from the locked cabinet where they kept the opiates. I was told that Tylenol 3 is not on the formulary and they had substituted oxycontin. Bottom line: I asked for a 'hand grenade,' they gave me an 'A-Bomb.'"
- If, on the other hand, warriors ask for narcotic medications they are most often not given them.

Describing his own experiences as well as those of other warriors with whom he has worked at a number of VA medical facilities across the country, one of our staff offered the following perspective:

"From my own experiences and of those relayed to me by my fellow wounded warriors, VA facilities vary wildly in how they approach pain management. Overlooking potential complications with their referrals seems to be a common mistake and often the assessments are not comprehensive. VA pain-management practices for warriors with polytrauma have been incredibly inconsistent, generally unsuited for a full recovery, and have not taken into account the warrior's other issues (such as PTSD). The system seems to operate completely on 'easy fixes' by overprescribing. I know several warriors who

have become addicted to opiates as a result of mismanaged treatment plans and even turning to street drugs. One Marine I served with who was injured in 2005 has overdosed on prescribed medications, turned to heroin because of his addictions, and to this day relies on a VA referred methadone clinic. I have never heard of non-pharmaceutical options being offered directly, only of them being brought up by the warriors themselves to their physician. Despite resources for alternative treatments, I have not known the VA to directly point the warrior to them.”

VHA’s national pain management strategy reflects the important understanding that quality of life is a standard outcome measure of treatment effectiveness, including the treatment of pain. Consistent with that view, we applaud the emphasis the national strategy directive places on individualized plans of care – even as we convey our disappointment that the evidence we have compiled calls into question how much progress VA has made in instituting such individualized pain-care plans. As noted in the directive, however, one important element in such plans are non-pharmacologic interventions. In asking our field staff, however, how widely complementary therapies are available, we were advised, with two exceptions (one of whom had himself been prescribed acupuncture and massage therapy for severe back pain) that none was aware of any instance in which complementary therapies such as acupuncture or yoga had been offered.

While we see abundant evidence that there remain wide gaps in realizing the first two steps of the national strategy’s stepped-care model, its third step – providing tertiary, interdisciplinary care may be even more distant. To the best of our knowledge, the Chronic Pain Rehabilitation Program at James A. Haley Veterans Medical Center (Tampa, FL) is the only VA program that currently meets the pain center criteria and is CARF-accredited. With chronic pain so widespread a concern among veterans, and particularly among our wounded warriors, it is difficult to understand so limited a deployment of tertiary resources.

Accounts of the experiences of warriors with whom we work underscore that much more progress must be made:

Toby Snell, a Marine from Washington state, sustained severe injuries from a car bomb in Iraq in 2006 and shared his story with WWP:

Toby was originally prescribed Vicodin by the Navy, which did not work for pain. Upon leaving the Marines, the VA again prescribed Vicodin despite his objections. He was referred to the Pain Management Clinic in the late 2007-early 2008 timeframe. He was told many times the pain was "in his head" but was ultimately prescribed 120mg extended release morphine/day. Medication still did not address his pain.

He was not allowed to see Ortho Surgery per his Primary Care doctor and the Pain Management doctors because he was told there was nothing they could do. He was, however, sent to the University of Washington School of Medicine for a second opinion

in 2008, but the doctor there was not authorized to perform any diagnostic testing. As a result, she was unable to assist.

The VA then recommended a combination of morphine and fentanyl, but Toby refused because he was already very "out of it" due to the morphine and it wasn't working. He didn't want to add new meds.

In 2009, Toby self-reduced to 90mg/day with the help of Acupuncture. His Polytrauma doc had been trying to get fee-basis acupuncture for some time but had been denied until the VA hired their own provider.

In the Fall of 2011, the Wounded Warrior Regiment recommended Toby go to Operation Mend at UCLA. Toby finally made it to UCLA in March of 2013 after significant delays from the VA in providing Toby's medical records. Doctors there diagnosed him with significant damage in his sacroiliac joint and were able to conduct a 20 minute procedure to resolve the issue.

Ultimately, Toby wanted to get off of the morphine. A VA nurse told him that the only thing she could recommend was a "prison-like" detox facility intended for substance abusers.

Toby approached his VA Primary Care doctor who wanted to help, but clearly stated that he did not have experience in this field. The doctor recommended a slow/gradual approach but offered no additional specific guidance. As much as this doctor seemed to want to help, he was just not equipped to assist.

Over a 6 week period, Toby self-reduced from 90mg/day to 0mg/day. In the last few days/weeks, he was sick to his stomach and ultimately had to take other meds to control his nausea. At no point did the VA proactively assist in this process.

Ideally, Toby would have wanted them to treat the root cause of the pain rather than just trying to medicate. Additionally, at the time of the detox, he would have much preferred to be admitted to an "appropriate" in-patient facility that could have helped to monitor the weaning process as well as its effects on his other injuries (TBI, PTSD).

Each case is, of course, unique. But the profound frustration Toby described mirrors that of other veterans, for whom their battles with pain parallel their battles with seemingly rigid barriers encountered at some VA facilities.

A warrior in Houston, Brandon Price, for example, coping with back pain from an IED blast and knee pain from a gunshot wound, reported waiting over 3 years to get into a pain management program at the Houston VA. He was told he was ‘too young’ to be experiencing chronic pain and denied consults with the program until he worked with the Medical Center’s patient advocate. He finally got into the program in Spring of 2013, but was told because of his delay in getting appropriate pain management care, he would have to go back to primary care to treat the severe muscle tension that was impairing their ability to treat his back pain. He will not be seen again in the program until January of next year. In the meantime, his primary care team try to help all they can and he appreciates their work, however they do not have the resources and expertise to treat his severe pain. In addition, they are not allowed to prescribe any narcotic pain medication, so even if it would be appropriate for treating his pain, he would have to wait to be seen again by the pain management program for such a prescription.

Our warriors’ experiences and the observations of our teammates across the country do raise serious questions. What steps, for example, have been taken to address systems issues that may impede realization of pain-management policy goals?¹⁴ The gap between policy and practice, however, raises even broader questions. What, for example, does it mean for the Veterans Health Administration to describe pain management as a “national priority?” Given that declaration of “national priority,” the recognition that the practice of pain-management in this country has been widely variable,¹⁵ and VA’s important role in the education and training of a large percentage of our physician workforce, is there not a high burden on senior VHA leadership to ensure that the letter and spirit of its pain-management policy is actually implemented across the system? Does the term “priority” actually hold meaning, in an operational sense? Indeed, one might even ask whether the Veterans Health Administration has characterized so many subjects as “priorities” that it has become difficult to make any issue a real priority!

We pose these questions as an organization that works with and advocates for those whose sacrifices are immeasurable and to whom this country owes a profound debt that must include

¹⁴ The Report of (VA) Consensus Conference: Practice Recommendations for Treatment of Veterans with Comorbid TBI, Pain and PTSD (January 20, 2010) cited the need to support clinicians who provide interdisciplinary care, noting that “there is no consistent workload credit given to clinicians who take the time to manage or review cases with other providers” and the need for such credit to promote coordinated, collaborative care. The report also cited the importance of encouraging and offering incentives to providers to follow clinical practice guidelines regarding the use of non-formulary medications, noting the need for a “‘by-pass’ around the sometimes complex non-formulary approval process” and the lack of a standardized protocol for such review and approvals. See Report at http://www.ptsd.va.gov/professional/pages/handouts-pdf/TBI_PTSD_Pain_Practice_Recommend.pdf.

¹⁵ 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,” E-1 (May 2010) , <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 1, 2013.

provision of timely, effective care for and rehabilitation of service-incurred wounds, injuries and illnesses. We do not suggest that managing chronic pain in warriors who, for example, have suffered polytrauma is easy or necessarily susceptible of resolution in a primary care clinic. Nor – to cite another critical challenge VHA has identified as a priority -- is it necessarily easy to provide timely, effective mental health care to warriors who struggle with PTSD and often co-occurring behavioral health issues. But these surely must be real priorities – obligations that must be met ahead of others and met fully -- for a health care system dedicated to the care of veterans.

These concerns lead us to urge this committee to continue to press VHA to make much more progress in the area of pain-management, but also to re-establish what the term “priority” means for the Veterans Health Administration, and to exercise whatever tools are needed to realize those highest priorities. They begin, in our view, with wounded warriors and their optimal timely care and rehabilitation. To fail to meet that obligation is, in our view, to fail all veterans.