



**Statement of Jacqueline A. Maffucci, Ph.D.<sup>1</sup>**  
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*before the*  
**House Committee on Veterans Affairs**  
**Subcommittee on Health**

**October 10, 2013**

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

On behalf of Iraq and Afghanistan Veterans of America (IAVA), I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding pain management practices, an important issue that affects the lives of thousands of service members and veterans.

IAVA is the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is critically important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

In partnership with other military and veteran service organizations, IAVA has worked tirelessly to see that veterans' and service members' health concerns are comprehensively addressed by the Department of Veterans Affairs (VA) and the Department of Defense (DoD). IAVA understands the necessity of integrated, effective, world-class healthcare for service members and veterans, and we will continue to advocate for the development of increased awareness, recognition and treatment of service-connected health concerns, chronic pain and pain management included.

According to a 2011 Institute of Medicine report, chronic pain affects approximately 100 million American adults. Nationally, the number of individuals diagnosed with chronic pain and the number of powerful narcotics prescribed to treat pain have increased in the

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last decade. Concurrently, prescription drug abuse is on the rise<sup>2</sup>. The CDC has called prescription drug abuse an epidemic in the U.S, and the White House has developed a National Drug Control Strategy to address the issue<sup>3</sup>. This is a national issue, and one from which our service members and veterans are not immune.

A recent report from the Center for Investigative Reporting found that over the last 12 years, there has been a 270 percent increase in Veterans Health Administration (VHA) prescriptions for four powerful opiates<sup>4</sup>. Given the last 12 years of conflict and the intense physical demands on our troops, it is no surprise that over half of the OEF/OIF veterans seeking VA medical care report chronic pain, nor is it a surprise that the majority of veterans seeking primary care treatment from the VA report pain as a major concern<sup>5</sup>.

Reports presented by the VHA on pain management illustrate the scope of pain and pain management practices within the VA and the unique potential causes of pain among veterans<sup>5</sup>. For Iraq and Afghanistan veterans, improved body armor and medical advancements has allowed for higher survival rates, but increased amputations and other lifelong impacts of nerve and skeletal damage, coupled with musculoskeletal concerns from the weight of wearing heavy body armor, highlight a need for successful pain management strategies for veterans of these conflicts. In 2012, the second most common reason for outpatient clinical visits and the fourth most common reason for hospitalization among active duty service members was musculoskeletal concerns<sup>6</sup>. With time and age, these injuries will most likely worsen<sup>6</sup>. This highlights the importance of comprehensive, integrated pain management protocols in military and veteran medical care.

Pain management is challenging in that pain manifests itself differently from patient to patient. Further, assessing pain and devising a management strategy can be very difficult, particularly given that this is a relatively new area of focus in the clinical research field. Related to this, the primary care physicians who see the bulk of patients

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<sup>2</sup> Institute of Medicine. (2011, June). *Relieving pain in America a blueprint for transforming prevention, care, education, and research* [PDF]. Washington, D.C. Retrieved from <http://www.iom.edu/~media/Files/Report%20Files/2011/Relieving-Pain-in-America-ABlueprint-for-Transforming-Prevention-Care-Education-Research/Pain%20Research%202011%20Report%20Brief.pdf>

<sup>3</sup> Vital signs: overdoes of prescription opioid pain relievers-United States, 1999-2008. (2011, November 4). *Center for Disease Control and Prevention Morbidity and Mortality Weekly Report 60(43). 11-16*. Retrieved from [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s\\_cid=mm6043a4\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w)

<sup>4</sup> Glantz, A. (2013, September 28). VA's opiate overload feeds veterans' addictions, overdose death. *Center for investigative reporting*. Retrieved from <http://cironline.org/node/5261>

<sup>5</sup> Management of opioid therapy for chronic pain. (2010, May). *VA/DOD Clinical Practice Guideline*. Retrieved from [http://www.healthquality.va.gov/Chronic\\_Opioid\\_Therapy\\_COT.asp](http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp)

<sup>6</sup> Hospitalizations among members of the active component, U.S. armed forces, 2012. (2013, April). *Medical Surveillance Monthly Report 20(4), 11-23*. Retrieved from [http://www.afhsc.mil/viewMSMR?file=2013/v20\\_n04.pdf](http://www.afhsc.mil/viewMSMR?file=2013/v20_n04.pdf)

with chronic pain have repeatedly reported that they feel underprepared to treat these patients due to a lack of training. In a 2013 study specific to VHA, this trend was echoed by the VHA providers who were surveyed as well<sup>7</sup>.

These same providers reported that barriers within VHA kept them from feeling prepared to treat chronic pain. These included formulary barriers, inability to access state prescription monitoring programs (which would allow them to see if patients have previously been prescribed controlled medications like opioids), and barriers to consulting with experts outside of the VA.

Chronic pain is also particularly prevalent in polytrauma cases, which are among the most complex medical cases to address. Pain often presents in consort with other conditions, such as depression, anxiety, PTSD, or TBI. Providers can be challenged to treat pain that is comorbid with other conditions because of the difficulty of managing multiple conditions. Some of these conditions may also limit the drugs available to the patient, making treatment options limited.

These issues constitute major challenges to pain management. Certainly part of a treatment program for chronic pain may include strong anti-pain medication, including opioids; but a schedule of treatment should not be limited to pharmaceutical remedies and should integrate a host of other proven therapies. This is why a stepped case management system can be very helpful. In this type of system, a primary care physician has the support of an integrated, multi-disciplinary team of providers to design and implement a comprehensive pain management plan for the patient.

The VA and DoD have been relatively proactive in how they approach management of chronic pain. Since 2000, VHA has instructed its providers to treat pain as the fifth vital sign<sup>8</sup>. Much like heart rate and blood pressure, inquiring about and documenting complaints of pain has been integrated into the physical exam. VA has also put more resources into research to understand pain assessment and treatment. And they have partnered with DoD to publish clinical practice guidelines and to restructure pain management protocols, recognizing that the responsibility for care often falls on the primary care physician while specialty support in the form of multidisciplinary pain management clinics may be relied upon as well.

Given the challenging nature of understanding pain, how it manifests, and how to best treat it, these have all been laudable initiatives on the part of VA and DoD. But the challenge remains to uniformly and effectively translate all of these efforts into practice. Too often we hear the stories of veterans who are prescribed what seems like an assortment of anti-psychotic drugs and/or opioids with very little oversight or follow-up.

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<sup>7</sup> Kerns, R. (2013, February). "Psychological Treatment of Chronic Pain" [Webinar]. *VA Pain Management, Spotlight on Pain Management*. Retrieved from [www.va.gov](http://www.va.gov)

<sup>8</sup> Department of Veterans Affairs, Office of Public Affairs. (2011, February). *VA initiates pain management program* [Press Release]. Retrieved from <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=244>

On the flip side, there are also stories of veterans with enormous pain and doctors who won't consider their requests for stronger medication to manage the pain.

One IAVA family member has expressed tragic exasperation with respect to the VA's current opioid drug usage practices. Her husband, who was prescribed nine different medications to address a range of health issues related to pain, anxiety, and depression, tragically passed away from what was labeled an accidental overdose by the coroner. Since then, his widow has been fighting to include overmedication by the VA on his death certificate. The VA's response in this case has been to blame the widow, saying simply that she was trained to be a caregiver. But while she was indeed trained to provide care and assistance for her husband, that training did not include medication management.

In a similar case highlighted last month by CBS, a veteran with five tours of duty in Iraq and Afghanistan received a treatment plan from the VA with a total of eight prescriptions. When he was prescribed a ninth drug by the VA, he took the medicine as instructed. The next morning he was found by his wife; his death was classified as an accidental death due to overmedication.

It is not our job to second-guess the judgment of the doctors treating these patients, but it *is* our job to question the system that is providing overall care to our veterans and tracking this care. It is unacceptable to hear repeated stories like these, but they should drive us to look at the system as a whole and how it can be fundamentally improved.

In part, some of the challenges may be in the inherent differences between the VA and DoD systems of care, whether it be in their available formularies, uniformity of record keeping, use of medical terminology, or the interoperability, or lack thereof, of the medical record systems. Care for our service member and veteran population should involve one integrated approach and a successful pain management program requires a seamless transition between VA and DoD providers.

But beyond that, once a veteran is received into the VHA system, it's not just about putting out policies, clinical practice guidelines, and funding research. At the end of the day, the success will be seen in how those products are implemented into practice and how they are continually assessed for effectiveness. The key will be in education, integration, and assessment.

We can advance our knowledge of pain and pain management all we want, but it won't do our veterans any good if VA cannot efficiently and effectively integrate these findings into their management practices and have a plan in place to continually improve upon accepted practice with evidence-based findings.

Mr. Chairman, we again appreciate the opportunity to offer our views on this important topic and we look forward to continuing to work with each of you, your staff, and this subcommittee to improve the lives, health, and livelihoods of veterans and their families.

Thank you for your time and attention.