Department of Veterans Affairs **VHA DIRECTIVE 2009-053**
Veterans Health Administration
Washington, DC 20420 **October 28, 2009**

PAIN MANAGEMENT

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy and implementation procedures for the improvement of pain management consistent with the VHA National Pain Management Strategy and compliance with generally accepted pain management standards of care.

2. BACKGROUND

a. The VHA National Pain Management Strategy, initiated November 12, 1998, established Pain Management as a national priority. The overall objective of the national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness. VHA employs a stepped-care model of pain care that provides for management of most pain conditions in the primary care setting. This is supported by timely access to secondary consultation from pain medicine, behavioral health, physical medicine and rehabilitation, specialty consultation, and care by coordination with palliative care, tertiary care, advanced diagnostic and medical management, and rehabilitation services for complex cases involving co-morbidities such as mental health disorders and traumatic brain injury (TBI).

b. **Definitions**

(1) **Stepped Care.** Stepped care is instituted as a strategy to provide a continuum of effective treatment to a population of patients from acute pain caused by injuries or diseases to longitudinal management of chronic pain diseases and disorders that may be expected to persist for more than 90 days, and in some instances, the patient's lifetime.

(a) Step One, Primary Care. Requires the development of a competent primary care provider workforce (including behavioral health) to manage common pain conditions. To accomplish this, primary care requires the availability of system supports, family and patient education programs, collaboration with integrative mental health-primary care teams, and post-deployment programs.

(b) Step Two, Secondary Consultation. Requires timely access to specialty consultation in pain medicine, physical medicine and rehabilitation, Polytrauma programs and teams, and pain psychology; occasional short-term co-management; inpatient pain medicine consultation; and the collaboration of pain medicine and palliative care teams.

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(c) Step Three, Tertiary, Interdisciplinary Care. Requires advanced pain medicine diagnostics and pain rehabilitation programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

(2) **Quality of Life.** Quality of life is now accepted by the medical field as a standard outcome measure of effectiveness of treatment, including treatment of pain. The concept includes such factors as level of physical and psychosocial functioning (e.g., in roles at work and home) and treatment satisfaction.

(3) **The Biopsychosocial Model.** The Biopsychosocial Model takes the position that the causes and outcomes of many illnesses often involve the interaction of physical and pathophysiologic factors, psychological traits and states, and social-environmental factors. Effective treatment planning accounts for the salience of these factors in the precipitation and perpetuation of illness and illness-related disability.

(4) **VHA National Pain Management Strategy Coordinating Committee.** The VHA National Pain Management Strategy Coordinating Committee, a multidisciplinary Field Advisory Committee, was established to support the National Pain Management Program Office in meeting its responsibilities. The Committee is comprised of representatives from key clinical disciplines involved in provision of quality pain care as well as representatives from other VHA offices, including, but not limited to, the Employee Education System (EES), Office of Research and Development (ORD), Mental Health, Geriatrics and Extended Care, Primary Care, Nursing, Rehabilitation, and Pharmacy Benefits Management.

c. **Specific Objectives.** The updated VHA National Pain Management Strategy aims to:

(1) Establish expectations for attitudes, knowledge, and skills in pain management in primary, secondary, and tertiary care.

(2) Create system-wide VHA care standards for pain management, appropriate to setting and professional roles that reduces suffering and improves quality of life.

(3) Ensure that pain assessment is performed in an appropriately timely, regular, and consistent manner along the continuum of care from acute to chronic pain in all VHA settings.

(4) Ensure that pain treatment is prompt and strives to achieve pain management objectives along the continuum of care from acute to chronic pain in all VHA settings.

(5) Include patients and families as active participants in pain management.

(6) Provide for appropriate level and frequency of monitoring for improvement in outcomes of pain management including pain control, physical and psychosocial function, quality of life, and complications.

(7) Provide for an interdisciplinary, multi-modal approach to pain management that emphasizes optimal pain control, improved function, and quality of life.

(8) Promote standardized education and training to ensure that clinicians achieve standard competencies appropriate to their clinical setting (e.g., primary care, acute pain, pain medicine) and clinical role. ***NOTE:*** *Expectations specific to each professional role is determined by the relevant VHA office; more information can be found at each VHA office Web site and at: www.va.gov/painmanagement* .

(9) Encourage the development, testing, and implementation of clinical support systems needed to assess and manage pain effectively.

3. POLICY: It is VHA policy that VHA's National Pain Management Strategy and the on-going work of the VHA National Pain Management Program Office and Coordinating Committee is to be used to guide the development of local policies related to pain management.

4. ACTION

a. **VHA National Pain Management Program Office.** The VHA National Pain Management Program Office, in VA Central Office, has the responsibility for policy development, coordination, oversight, and monitoring of the VHA National Pain Management Strategy. Specifically, the National Pain Management Program office is charged with:

(1) Coordinating the system-wide implementation of the Strategy, including full implementation of a stepped care model of pain care at the facility and Veterans Integrated Service Network (VISN) levels.

(2) Coordinating a system-wide performance improvement plan. This plan evaluates the effectiveness of the VHA in meeting the objectives of the Strategy; it includes working with the appropriate VHA offices to establish target goals, mechanisms for accountability, and a timeline for implementation for a comprehensive, integrated VHA National Pain Management Strategy.

(3) Coordinating the development and dissemination of state-of-the-art treatment protocols for pain management that are appropriate for different facility types (e.g., neuropsychiatry facility, teaching facility, community-based outpatient clinic).

(4) Identifying VHA pain management expertise and resources at each facility and VISN.

(5) Facilitating a national and regional referral system to ensure that all eligible Veterans have timely and appropriate access to pain management services.

(6) Collaborating with the EES, Primary Care Program Office, and the several other relevant program offices, as appropriate, to develop, implement, and disseminate education and training tools to assist VHA clinicians in acquiring the skills necessary to provide high-quality pain assessment and treatment. This includes funding to:

(a) Establish performance expectations;

(b) Develop facility and VISN self-assessment tools;

(c) Develop effective educational programs and tools including distance learning;

(d) Evaluate the performance of these programs and tools in improving clinical care; and

(e) Establish feedback mechanisms for clinical improvement.

(7) Collaborating with ORD in identifying pain research opportunities and priorities and facilitating collaborative research efforts.

(8) Collaborating with the Office of Academic Affiliations in assessing the current state of pain management education in health professional training programs ("gap analysis") and in exploring the development of innovative educational interventions for enhancing pain management.

(9) Establishing a plan for both the internal and external communication of VHA's National Pain Management Strategy.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that:

(1) All facilities within the VISN establish and implement current pain management policies consistent with this Directive.

(2) A pain management Point of Contact (POC) is appointed and supported at the VISN level who is an appropriately trained and experienced clinician credentialed in pain medicine, pain management, or another credential appropriate to the clinical discipline.

(3) Tertiary interdisciplinary pain care services are available at the VISN level that include the capacity for advanced diagnostics and advanced integrated and interventional pain medicine, as well as functional rehabilitation for complex cases (e.g., chronic pain with co-morbidities, such as post-traumatic stress disorder (PTSD), TBI, and substance abuse). ***NOTE:*** *Each VISN is expected to have at least one CARF-accredited tertiary, interdisciplinary pain care program no later than September 30, 2014.*

(4) The implementation of the VHA Pain Management Strategy is evaluated according to performance measures established by the National Pain Management Program Office.

c. **VISN POC.** The VISN POC is responsible for:

(1) Reporting to the VISN Director annually to describe progress in implementing the Pain Management Strategy throughout the VISN;

(2) Establishing a VISN pain committee to develop timelines for achieving and maintaining pain management standards (see Att. A);

(3) Partnering with VISN primary care leadership to develop a shared implementation strategy;

(4) Collaborating with VISN leadership in preparing responses to formal inquiries from the National Pain Management Program Office;

(5) Maintaining a reliable contact list of facility Pain POCs; and

(6) Serving as a link in communication from the National Pain Management Program Office to the field and vice versa.

d. **Facility Director.** The Facility Director, in consultation with the Chief of Staff and Associate Director for Patient Care Nursing Services, is responsible for ensuring that:

(1) The objectives of the VHA National Pain Management Strategy are met, including establishing a multidisciplinary pain management committee.

(2) A stepped care model of pain care is fully implemented.

(3) Accepted standards of pain care are met (see Att. A). These standards are:

(a) Pain assessment and treatment;

(b) Evaluation of outcomes and quality of pain management; and

(c) Clinical competence and expertise in pain management (see Att. A).

5. REFERENCE: Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387 § 501.

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services (11), Medical-Surgical Services (111) is responsible for the contents of this Directive. Questions may be referred to the National Program Director for Pain Management at (203) 937-3841.

7. RESCISSIONS: VHA Directive 2003-021 dated May 3, 2003, is rescinded. This VHA Directive expires October 31, 2014.

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DISTRIBUTION: E-mailed to the VHA Publication Distribution List 10/28/09

ATTACHMENT A

STANDARDS OF PAIN MANAGEMENT

The accepted standards of pain management are:

1. PAIN ASSESSMENT AND TREATMENT

Procedures for early recognition of acute and persistent pain and the design of prompt, longitudinal, and effective treatment must be implemented at each medical facility.

a. VHA has implemented "Pain as the 5th Vital Sign" in all inpatient and outpatient clinical settings to ensure consistent recognition and assessment of pain intensity and pain's effects on function and quality of life. ***NOTE:*** *A toolkit for implementation of this standard is available at the VHA pain management Web site at: www.va.gov/painmanagement .*

b. Routine assessment for the presence of pain is required for non-communicative patients, as well as for patients who communicate well. Assessment in this circumstance requires an approach that involves a range of methods including: direct observation by clinical staff, input from family members, and close monitoring of the effects of pain management interventions. ***NOTE:*** *A consensus statement that provides additional guidance for pain screening in the non-communicative patient is available at the VHA pain management Web site at: www.va.gov/painmanagement .*

c. Once pain symptoms are recognized, a timely and appropriate comprehensive pain assessment is performed, a pain treatment plan is developed and implemented, and reassessment of the effectiveness of the plan is completed. Each of these parameters must be documented. ***NOTE:*** *To ensure consistency of documentation and to facilitate pain outcomes monitoring, all facilities are strongly encouraged to use the pain reminders and dialogs sponsored by the VHA National Pain Management Strategy Coordinating Committee. These reminders and dialogs can be downloaded from the Clinical Reminders Web page at: vista.med.va.gov/reminders.*

d. Patient and family education regarding pain and pain management is included in the treatment plan. ***NOTE:*** *Patients are encouraged to be active participants in pain management.*

e. Evidence-based, to the degree possible, pain management protocols are implemented in all clinical settings.

(1) Using guidelines. Published clinical practice guidelines and related resources providing information regarding these pain management protocols are available on the VHA pain management Web site at: *www.va.gov/painmanagement* and at: www.healthquality.va.gov.

(2) Patient participation in decision-making. Most uncomplicated pain conditions, for which the responsibility for assessment and management rests with the primary care provider or team (trained to implement a stepped care approach, as needed), respond best to one or more of several therapies readily available and coordinated in primary care settings. These therapies

emphasize continuing patient participation in decision-making and clinical planning, patient instruction in self-management, and appropriate levels of family participation (see Attachment B). ***NOTE:*** *Standards for training in the use of these therapies in a primary care and other settings is available on the VHA pain management Web site at:* www.va.gov/painmanagement .

(3) Implementing stepped, consultative care

(a) Integrating behavioral health in primary care of chronic pain is essential to optimize clinical outcomes and provide essential support to the medical care of patients. Chronic pain can be a complex, biopsychosocial condition involving cognitive, psychosocial, and substance abuse issues as well as medical and mental health co-morbidities. The complexity of chronic pain management is often beyond the expertise of a single practitioner, especially for patients whose pain problems are complicated by homelessness, PTSD, cognitive impairment from TBI and other conditions, including depression, combat injuries, Polytrauma, substance abuse, and other complex psychosocial issues. The experience of pain both impacts and is affected by social and family functioning. Veterans with complex chronic pain conditions are best served by a comprehensive, interdisciplinary approach within a continuum of care that is informed by a biopsychosocial model. ***NOTE:*** *The VHA Pain Management Program is presently developing models of pain care through inter-program collaboration with various VHA program offices, as listed below. Educational programs are being planned and executed through Employee Education System (EES) to present such collaborative clinical planning. New program models to achieve the objectives of this Directive will be found on the VHA pain management Web site at www.va.gov/painmanagement as they are implemented.*

(b) Primary care providers must have access to pain consultative and treatment sources to effectively evaluate and manage these complexities. Access must be timely to the needs of the Veteran. These sources include Pain Medicine specialists, interdisciplinary pain clinics and centers, Hospice and Palliative Care Services, Mental Health services, Social Work services, and Clinical Chaplaincy services, among others. If such consultative services are not readily available at a specific facility, the facility Director, or designee, is responsible for arranging with the VISN Director reasonable and timely access to these consultative services through inter-facility collaborations within the VISN or through community resources, as appropriate.

(c) At least one tertiary, interdisciplinary pain rehabilitation program must be available in each VISN to manage more complex cases.

(d) Acute pain management is expected in every environment, including provision for seamless pain management during transportation from primary care and secondary care facilities to tertiary care.

f. Effective pain management often requires consideration of the use of one or more of several different classes of medications and other treatment modalities prescribed simultaneously. Treatment may become particularly complex in the context of several causal or perpetuating mechanisms and co-morbidities. The potential for each modality for improving pain treatment outcomes is weighed against the potential for drug-drug and drug-disease interactions, side effects, and toxicities. Patients with cognitive deficits from disease or TBI are

particularly vulnerable when drug regimens increase in their complexity. Evidence-based stepped care treatment algorithms for managing different types and complexities of chronic pain and its co-morbidities is readily available to providers as is training appropriate to their practice setting.

g. The safe and effective use of opioid analgesics for the management of pain, particularly complex chronic pain conditions, requires special attention to personal and public health risks.

(1) Risks include adverse side effects of these medications, development of addiction, and risks to the public through diversion of prescribed medications.

(2) The potential for fatal overdose either by accident or in a suicidal attempt in patients suffering from multiple disorders or with polypharmacy must be considered in prescribing opioids and other medications, including prescribing for pain patients on opioid substitution programs. ***NOTE:*** *Published guidelines for chronic opioid therapy, pain polypharmacy, and management of pain in the post-operative setting are available to guide the use of these medications. These guidelines are available at www.healthquality.va.gov and on the VHA pain management Web site at www.va.gov/painmanagement . Completion of a written opioid pain care agreement is strongly encouraged to document provider-patient discussion of potential risks and benefits of opioids, provider and patient responsibilities related to their use, and the parameters for continued use. In this context, other methods such as random urine drug monitoring, frequent clinic visits and opioid renewal clinics may be useful to ensure adherence and safety. Further information about how to manage opioid treatment agreements can be found at www.healthquality.va.gov and on the VHA pain management Web site, www.va.gov/painmanagement .*

h. As pain management is an integral part of palliative and end-of-life care, the expertise of hospice and palliative care clinicians needs to be available to all patients with a serious, life-limiting illness.

i. Patient satisfaction with pain management is monitored on an on-going basis.

2. EVALUATION OF OUTCOMES AND QUALITY OF PAIN MANAGEMENT

a. A multidisciplinary pain management committee must be established at each VHA facility to provide oversight, coordination, and monitoring of pain management activities and processes to facilitate the implementation of the VHA Pain Management Strategy in compliance with evidence-based standards of pain care and adherence to requirements of external accrediting bodies. In some facilities, this function may be the responsibility of an overarching clinical practice committee. In each facility, processes will be developed and implemented to evaluate the success of meeting the goals of the VHA National Pain Management Strategy on a regular basis, at least yearly.

b. The quality of pain assessment and the effectiveness of pain management interventions must be monitored. Measures may include: adherence to published clinical practice guidelines, timeliness of pain treatment, adequacy of pain control, medication safety, appropriate use of

stepped care treatment including behavioral health and pain medicine consultation and treatment, and clinical outcomes such as improvements in pain control, patient satisfaction, physical and psychosocial functioning, and quality of life. ***NOTE:*** *A VHA Pain Outcomes Toolkit is available at www.va.gov/painmanagement .*

c. All elements of pain management must be documented in the patient record, often in the initial visit or in subsequent visits as clinically indicated over time. ***NOTE:*** *For clinical tips, clinicians may want to consult www.va.gov/painmanagement .* Elements of pain management include:

(1) **Medical History.** The patient's prior experience of pain and pain-related diseases, disorders, injuries and co-morbidities.

(2) **Routine Screening for Pain.** Routine screening for the presence and intensity of pain using "Pain as the 5th Vital Sign," or a validated alternative tool for special populations, must be documented. This must be accomplished in association with outpatient or home visits and in residential and inpatient settings at a frequency that is appropriate to the specific clinical setting and problem. Screening for pain in non-communicative patients must be documented by the use of the code "99," which indicates the pain assessment occurred in lieu of a verbal assessment. ***NOTE:*** *It is important to appreciate that the goals of this method include the timely monitoring of pain treatment effectiveness, and the identification of new or previously undetected pain concerns.*

(3) **Comprehensive Pain Assessment.** ***NOTE:*** *Use of pain reminders and dialogs is encouraged.*

(4) **Individualized Plan of Care.** An individualized goal-oriented, prioritized pain management plan of care that may include, but is not limited to:

(a) Pharmacologic interventions, including:

1. The use of mechanism-specific and condition-specific treatment algorithms,

2. Appropriate trials of individual medications to determine effectiveness (pain control and function), and

3. Cessation of medication without effectiveness.

(b) Prescribing opioid analgesics for regular use, documentation of:

1. An opioid pain care agreement, which is strongly encouraged, if not mandated (according to local facility policy),

2. Effectiveness, including pain control, function, and quality of life, and

3. Safe storage and management in the home.

(c) Non-pharmacologic interventions, to include:

1. Educational interventions to improve self-management;

2. Psychological interventions, including established psychotherapies for chronic pain and associated sequelae (e.g., Cognitive-Behavioral Therapy), in conjunction with other treatments as appropriate, particularly for patients with unremitting chronic pain that demonstrate limited response to other treatment approaches;

3. Family interventions and community supports;

4. Rehabilitation therapies;

5. Complementary therapies as available; and

6. Pain medicine specialty procedures, such as injections, nerve blocks, ablations, and neuromodulation.

(5) **Evaluation.** Periodic evaluation of adherence, response to interventions, and achievement of time-limited therapeutic goals in the pain management plan, should include:

(a) Moderation or alleviation of pain;

(b) Satisfaction with current treatment plan;

(c) Stabilization or improvement in physical and psychosocial function;

(d) Stabilization or improvement in salient co-morbidities and overall health status;

(e) Adherence to opioid pain care agreement, if used; and

(f) Adherence to pain management plan of care.

(6) **Education.** Pain education for family and patient that may include the availability of pain specific programs, such as: formal pain school; pain relevant Web sites; printed pain management patient education materials at or below the ninth grade literacy level; and hospital video networks. Veterans' learning needs, readiness, preferences and barriers should be considered to ensure that messages are presented in an understandable format which the Veteran finds helpful. This education needs to occur:

(a) During hospitalization, as soon as clinically appropriate and acceptable to the patient.

(b) At discharge from hospital or facility.

(c) In all outpatient treatment settings when pain is assessed or treated.

3. CLINICIAN COMPETENCE AND EXPERTISE IN PAIN MANAGEMENT

a. All clinical staff (e.g., physicians, psychologists, nurses, pharmacists, therapists, and chaplains), should have orientation related to the principles of pain assessment and management upon being hired, as well as ongoing education and training. While general principles of pain management apply to all VHA clinicians, each staffing group must clearly delineate its specific pain management responsibilities and abilities and ensure that all its members receive training adequate to meet these responsibilities and to maintain these abilities. Education and training must be relevant to the specific needs of the patient population and clinical setting that provider groups serve, and should include, as appropriate, pharmacologic (especially opiates and including education regarding physical dependency, pseudoaddiction, tolerance, and potential for addiction, overdose and/or suicide; appropriate titration; side effects and benefits) and non-pharmacologic (including psychological, physical, complementary, and spiritual) treatment modalities. ***NOTE:*** *Annual pain management education for clinical staff is highly recommended. Such education should include: for physicians, PAs, CRNPs, and nurses, 5 hours of continuing education in pain management, which can be obtained by attending continuing medical education (CME) and continuing education unit (CEU) offerings, completing online self-studies for CME and CEUs, or earning the credits in other ways and submitting evidence of the credits to the education staff at their facility. When feasible, facilities are encouraged to provide interactive "workshop" formats for learning specific cognitive and behavioral skills. Courses and educational tools for facilities can be found on the VHA pain management Web site at www.va.gov/painmanagement . It is highly recommended that Pain Medicine Physician specialists obtain and maintain one or more of the following certifications: Pain Medicine specialty board certification by the American Board of Pain Medicine; Pain Management subspecialty board certification by the American Board of Anesthesiology, the American Board of Physical Medicine and Rehabilitation, or the American Board of Psychiatry and Neurology; Hospice and Palliative Care Medicine subspecialty board certification by one of the various ABMS boards granting this certification. It is recommended that they should also obtain yearly pain-relevant continuing medical education. In addition, innovative training programs are being developed and evaluated to ensure the adequacy of the pain management workforce for providing quality pain management to all Veterans regardless of location.*

b. VHA standards for pain management will be communicated by training faculty to all medical students, allied health professional students, residents, and interns who provide patient care; appropriate education in pain assessment and management will also be provided to these students and trainees.

ATTACHMENT B

THERAPIES EMPHASIZING CONTINUING PATIENT PARTICIPATION

Most uncomplicated pain conditions, for which the responsibility for assessment and management rests with the primary care provider or team (trained to implement a stepped care approach, as needed), respond best to one or more of several therapies readily available and coordinated in primary care settings. These therapies emphasize continuing patient participation in decision-making and clinical planning, patient instruction in self-management, and appropriate levels of family participation. ***NOTE:*** *Standards for training in the use of these therapies in a primary care and other settings is available on the VHA pain management Web site at: www.va.gov/painmanagement* . Therapies may include, as medically appropriate and indicated:

1. Medication management through evidence-based algorithms;

2. Office-based procedures (e.g., myofascial injections);

3. Behavioral therapies (e.g., pain school, behavioral groups, support groups);

4. Physical therapy interventions (e.g., stretching, posture, exercise, ice, and electronic stimulation), occupational therapy interventions (e.g., splinting, positioning, and adaptive equipment for modified activity, and chiropractic interventions (e.g., spinal manipulation); and

5. Complementary and alternative therapies based on availability (e.g., acupuncture, massage, tai chi) may be considered.