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PRIMARY CARE & HEALTH SERVICES SECTION

Pain Care in the Department of Veterans Affairs: Understanding How a Cultural Shift in Pain Care Impacts Provider Decisions and Collaboration

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Abstract

Objective. Over the past decade, the Department of Veterans Affairs (VA) has experienced a sizeable shift in its approach to pain. The VA's 2009 Pain Management Directive introduced the Stepped Care Model, which emphasizes an interdisciplinary approach to pain management involving pain referrals and management from primary to specialty care providers. Additionally, the Opioid Safety Initiative and 2017 VA/Department of Defense (DoD) clinical guidelines on opioid prescribing set a new standard for reducing opioid use in the VA. These shifts in pain care have led to new pain management strategies that rely on multidisciplinary teams and nonpharmacologic pain treatments. The goal of this study was to examine how the cultural transformation of pain care has impacted providers, the degree to which VA providers are aware of pain care services at their facilities, and their perceptions of multidisciplinary care and collaboration across VA disciplines. **Methods**. We conducted semistructured phone interviews with 39 VA clinicians in primary care, mental health, pharmacy, and physical therapy/rehabilitation at eight Veterans Integrated Service Network medical centers in New England. **Results**. We identified four major themes concerning interdisciplinary pain management approaches: 1) the culture of VA pain care has changed dramatically, with a greater focus on nonpharmacologic approaches to pain, though many "old school" providers continue to prefer medication options; 2) most facilities in this sample have no clear roadmap about which pain treatment pathway to follow, with many providers unaware of what treatment to recommend when; 3) despite multiple options for pain treatment, VA multidisciplinary teams generally work together to ensure that veterans receive coordinated pain care; and 4) veteran preferences for care may not align with existing pain care pathways. **Conclusions**. The VA has shifted its practices regarding pain management, with a greater emphasis on nonpharmacologic pain options. The proliferation of nonpharmacologic pain management strategies requires stakeholders to know how to choose among alternative treatments.

Key Words: Veterans; Pain Management; Interdisciplinary Pain Care

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Introduction

Over the past decade, the Department of Veterans Affairs (VA) has undergone a major transformation in its approach to pain care. In response to the growing cohort of newly injured veterans returning from conflicts in Iraq and Afghanistan, Congress passed the VA Pain Care Act (2008), which required that the VA improve pain care and train clinicians appropriately [1]. The VA responded to Congress by implementing the VA Pain Management Directive in 2009 and, under the auspices of this Directive, implemented the Stepped Care Model. The Stepped Care Model features low-intensity interventions as the "first step," followed by the introduction of more intensive, multimodal, and multidisciplinary treatment options [2]. The Stepped Care approach involves primary care and patient-aligned care teams (PACTs), secondary consultation, and tertiary interdisciplinary pain centers [2]. Previous evaluations of the Stepped Care Model suggest reduced pain-related disability, interference, and severity compared with usual VA pain care [3]. Despite the implementation of the Stepped Care Model, however, by 2012 nearly 25% of veterans receiving outpatient care had received an opioid prescription [4]. For non-VA systems, the Stepped Care Model, with a foundation of self-management, was endorsed as a model by the National Pain Strategy (National Institutes of Health/Department of Health and Human Services [HHS]) and the recent HHS Report on Pain Management Best Practices [5].

Another major initiative to address pain and promote safer opioid prescribing in the VA to reduce pain was the Opioid Safety Initiative (OSI). The OSI aggregates electronic medical record (EMR) data to provide feedback using facility-, provider-, and patient-level opioid prescribing data and reduce the number of patients receiving higher daily opioid dosages and those receiving concurrent benzodiazepines. Overall, the OSI has led to a significant national decrease in veterans receiving risky opioid dosages as well as a reduction in veterans receiving concurrent benzodiazepine prescriptions [6]. Additionally, in 2017 the VA and DoD worked together to revise evidence-based clinical guidelines, which now recommend that opioids be used for no longer than 90 days, and create specific recommendations for risk mitigation, suicide prevention, and preventing opioid use disorder in younger veterans [7].

This cultural transformation of VA pain care over the past decade has resulted in important changes in prescribing and referral patterns among VA providers. Although providers previously relied heavily on opioids for pain management [8], the Stepped Care model has shifted the focus to nonpharmacologic pain treatments through a multimodal pain care approach [9], which may include self-management, complementary and integrative health, psychological, physical, or restorative therapy, and procedural treatments. Multimodal pain care has been extensively examined and implemented in the VA [2], and recent reports suggest that 93% of VA facilities offer complementary and integrative health (CIH) options [10] with demonstrated efficacy to treat pain, including acupuncture [11], chiropractic care [12–14], mindfulness meditation [15], and yoga [16]. Despite the availability of these services, especially at the larger VA medical centers, the number of veterans using these services remains small, and many of these services are not available at smaller VA facilities [2].

To date, no studies have examined how the cultural shift in pain management, coupled with the proliferation of nonpharmacologic options for pain care, has impacted providers' decisions about the treatment pathway for veterans with painful conditions. Most VA facilities do not have a "menu" of pain options available from which primary care providers can plan treatment with their patients, and many providers may be unaware of the full range of services available at their facilities. With the growing presence of Community Care in the VA, many treatment options may be available in the community, and veterans may be exercising their ability to utilize community providers to receive opioid prescriptions [17]. Therefore, the goal of this study was to examine how the transformation of pain care by the Stepped Care Model has impacted providers, the degree to which VA providers are aware of the range of pain care services at their facility, and their perceptions of multidisciplinary care and collaboration among VA colleagues across these disciplines.

Methods

Interviews were conducted as part of a formative evaluation for an eight-site clinical trial of counseling designed to engage veterans in nonpharmacological pain care. We conducted semistructured phone interviews with VA clinicians at the eight Veterans Integrated Service Network (VISN) 1 medical centers located in New England. Potential study participants were identified during initial site visits by study investigators, who identified staff who were involved in referrals and provision of nonpharmacological pain treatment.

Seventy-seven Veterans Health Administration (VHA) staff and providers from the departments of primary care, physical medicine and rehabilitation, mental health, pharmacy, and pain management were e-mailed to participate in an interview. Of these providers, 39 agreed to an interview. Using a standardized e-mail script to describe the study, VHA staff were invited to participate in an interview at their convenience. Before the interview, a brief reiteration of the study purpose was provided, and the interviewer confirmed consent to electronically record the interview for transcription and analysis purposes before proceeding. Each interview lasted approximately 30 minutes, and all interviews were conducted between June and August 2018. The VA Central Institutional Review Board approved the study.

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Data Collection and Analysis

A semistructured telephone interview guide was developed by the study's qualitative study team based on the principles of the Relational Coordination framework [18], which assesses teamwork that focuses on communication and relationships among health care professionals in a team. The interview guide, available as an Appendix, examined other key areas, such as current culture of pain care, nonpharmacologic treatment options, and barriers and facilitators to getting veterans connected to pain care. Audio-recordings of all interviews were transcribed and entered into Atlas.Ti qualitative analysis software for analysis. Additionally, a separate provider survey was used to identify onsite pain care options at each VA medical center in VISN 1. Authors representing each of the VISN 1 facilities verified the reported options and edited the list to include all available pain services at each VA facility.

Transcripts were analyzed qualitatively using procedures informed by grounded theory methodology, a systematic approach to deriving qualitative themes from textual data. We first conducted open coding in which two investigators identified key concepts emerging from the language used by participants and assigned codes (descriptive phrases) to segments of text. These codes were used to create a top-level codebook that was applied to all qualitative data. At all stages, coding was performed and discussed by two investigators, and the codebook was refined until agreement was reached. Themes that emerged in the interviews were examined for similarities and differences in perspectives in a process known as constant comparison analysis [19]. Subsequently, prominent themes and quotes exemplifying each were presented to the research team and refined. The current analysis focuses on emergent themes related to providers' experiences with coordination of pain care at eight New England VA medical facilities.

Results

Thirty-nine VA providers located at eight VISN 1 medical centers participated in the study (Table 2). A majority of study participants were female (57%), aged 49 or younger (72%), and/or had been employed in the VA for 10 years or less (76%); 44% were physicians. Themes related to an evolving culture of pain treatment strategies embedded in a multidisciplinary pain care approach emerged. Those themes, and associated quotes, are outlined in detail below.

The culture of VA pain care has changed dramatically, with a greater focus on nonpharmacologic approaches to pain, though many "old school" providers continue to prefer medication options. Most of the participants in the study pointed to the dramatic changes in the culture of pain care that had occurred in the VA over the past decade. Many participants noted that the new culture of pain care at the VA emphasized nonpharmacologic approaches over medication use. However, some participants noted a sharp divide in attitudes regarding pain care between "old school" clinicians and younger clinicians. One psychologist noted the following:

> Clinicians that I know here at the VA, some of them are wildly happy that the emphasis is no longer on narcotics for pain, and some of them feel like handing somebody a prescription for Vicodin or Percocet is a hell of a lot easier than getting them into a pain management program. They're going to have to do a lot more work now, so I mean it just depends on who it is.

One physician noted how the culture of pain care had changed substantially since he began working at the VA, as he inherited many patients who were on extremely high doses of opiates:

> Regarding pain management, I was dismayed, but not surprised, when I came here and had about 1,000 patients, and scores and scores and scores of them on opiates. And it's always hard for me to keep prescribing opiates when I didn't put the person on them and it may not have been what I would want to have done or the amount or the choice. Fortunately, at the same time I started, there was a big movement within our VA and also within the state to be very attentive to what's going on with these opiate prescriptions, so that helped me to get a handle on what's going on and didn't always give the patients the impression it was just my doing in trying to reign this in.

Another provider talked about the organizational shift at her facility regarding pain care, and how the process has evolved slowly.

> We were high prescribers of opioids and high doses and combinations of benzos. And since then we've started a pain mini-residency, which is a three-day course for providers. Basically, we go over changing the culture of pain management and how we're moving away from opioids and trying alternative therapy.

One provider who works in a pain clinic talked about how the organizational shift in pain management can have a negative impact on veterans:

> We're having this big shift in how we're treating pain with nonopioid, benzo; it's a hot topic. We don't order medications in our clinic, and that's a sore spot with other departments because they want to give us those patients. We had issues where patients don't want to see us. They don't want to do our treatments. They want pain medication, and the providers have even wrote on their pill bottles will not, "No refills until seen by pain clinic."

Most facilities in this sample have no clear roadmap as to which pain treatment pathway to follow, with many providers lacking awareness of the full range of treatment options. Though VA facilities have widely

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adopted numerous strategies regarding pain care, there was a general lack of consensus regarding what all the pain treatment options were at each facility, or which option should be tried first. Some participants noted that the first place to refer veterans with pain was physical therapy, but participants at other facilities noted that the first referral should always be to the pain clinic.

> Yeah, there is no clear clinical pathway for these types of decisions that people follow. It winds up being a combination of the referring provider and patient preference to some degree. But we don't have any clear pathways to guide clinicians in making these decisions and how to, let's say, stratify patients or sequence different types of treatments.

Another provider concurred and described the wide range of options available at his facility for pain care:

> I'm just trying to think if there's a standard map. There was actually discussion of an algorithm. One of our pain physicians had wanted to do an algorithm for back pain, but I think in general the rehab options are pretty widely used: PT, aqua therapy, and physiatry. I think mental health is often called a ton, and now our PCMH [Patient-Centered Medical Home] psychologists have also been trained in pain psychology. We have an interventional pain clinic. I think they're pretty commonly included in the care plan for complex chronic pain. And then the other things like yoga and Tai Chi and mindfulness and drumming and art workshops and different things that exist.

A physician at another VISN 1 facility thought that physical therapy was often the first option at his facility:

> I don't think everybody jumps to the interdisciplinary pain clinic as the first step. My sense is that other things are tried. I do think that physical therapy is heavily relied on, that that is one of the maybe go-to services initially. I think that depending on the individual situations and depending on the provider's comfort level with the available options and/or knowledge of the available options, I think the paths differ.

Other providers noted that the treatment options were based on veteran preference:

> I mean, I think it depends on the patient. So it depends on how willing they are to try alternative modalities. Are they interested in acupuncture? Are they interested in chiropractic? Are they really focused on getting injections? Do they, if they don't want any of that, it kind of just depends on the individual patient and what they want and what they're willing to do and what our discussion is.

A psychologist working in the pain clinic noted that frequent clinical staff turnover was a barrier to provider knowledge regarding the full range of pain care services at each facility. She noted that though they routinely visited primary care to talk about the pain clinic, there were always new providers arriving who weren't fully aware of the options:

> I think there's pockets of providers and teams that are very aware and using the pain clinic regularly. And then there's those that I could guarantee have no idea that we are here.

Despite multiple options for pain treatment, VA multidisciplinary teams generally work together to ensure that veterans receive coordinated pain care. Many providers spoke of the collaborative environment of VA pain care. Providers emphasized the multidisciplinary nature of pain care, with primary care, mental health, and physical therapy providers regularly working together to ensure that veterans are able to access the broad range of pain care services available at the facility. One provider spoke of the highly collaborative nature of pain care services at his facility:

> I think there's always been a strong partnership between behavioral health treatments and primary care, so the overarching vibe is that the mental health service line and the primary care service line feel that they're working on a shared mission to help patients cope better and move away from passive pain treatments like medications and move towards a more well-rounded, nonpharmacologic, multimodal pain care plan.

Another provider spoke specifically of the process to get the veteran to a pain clinic referral:

> I think there's a lot of collaboration. The pain clinic consultation process is very collaborative in that we have a team of providers that meets with the patient all together and we put together a fairly comprehensive assessment and recommendations. We include all of the providers involved with that patient's care on those notes and try to help coordinate care that's going to happen by those different providers. We have probably about eight to 10 different people from about eight different disciplines that come in to help teach the pain school program.

However, multidisciplinary coordination was seen as a struggle by some, who noted the difficulties of bringing providers together to address pain care:

> Operationally, I think, or administratively I think we still struggle with how to balance something like pain care that spans multiple service lines. And even though there's a lot of interest and collaboration and coordination, it's hard to have the time devoted for people in multiple departments to meet and plan and so on.

Another spoke specifically of the challenges working with the clinical pharmacy team:

> The clinical pharmacists have a new program that brings up high-risk patients, and now we're supposed to bring

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everybody in to discuss it. We're given the daunting task to start to work on getting that together, getting everyone to meet, which has been really hard because that includes primary care, mental health, all these providers to meet to discuss a patient, and we haven't really been able to do that yet.

Veteran preferences for care may complicate the pain care pathway. Veteran preferences for pain care and knowledge about available pain care options at their facility impact the treatment pathway for pain. Some veterans prefer to get their pain care from non-VA community providers, whereas others who stay in the VA are not compliant with pain treatment programs.

Community Care has become a big problem for us because the patients request Community Care, pain care in the community, chiropractic care, whatnot. And the patients get very angry, saying I'm in pain, I need to be seen, but they don't want to see us, they only want to see community providers.

Some providers spoke of the resistance that veterans may exhibit when asked to try nonpharmacologic treatment strategies:

Obviously there's a lot of resistance upfront, but since kind of the patients that go through the interdisciplinary pain clinic, we make the recommendations, and when they start really taking that active approach in their pain management, they're much happier on this end of it now where they're on less opioids, less medications, but doing more. But at first you're always going to meet that resistance.

Several providers talked about the inherent difficulty of working with service-connected veterans (e.g., those who have a condition coincidental with military service) who are afraid that nonpharmacological approaches could impact their overall service-connected disability rating:

I do think that most of the vets we're seeing are service connected for the area of pain, and they don't want it documented that they have less pain. And so that's why I think in some ways it's a big problem. I think probably the VA in general, with the disability connection, is that it makes it really hard for us to have them, feel like they can be honest with us and not lose their benefits, and so that's why we try to focus on the other areas. We've noticed that with our back boot camp program. They will be telling us they're doing so much more after they've worked with us for the eight weeks, but they'll give us almost the same outcome measure. We do an outcome measure before and after, and almost it won't change. But if you verbally talk to them, they're like, 'This is the best class. It's really changed my life. I'm doing so much more.' But the outcome measure doesn't pick it up. And our biggest hunch is that it's hard for them to actually, they don't want it on paper that these things have changed because they're usually 50% to 100% service connected for their back.

Pain Services Available at Each Facility

Regarding pain services available at each of the VISN 1 facilities, we found that facilities employ a wide range of multimodal pain treatment options (Table 1). Every VISN 1 facility has an interdisciplinary pain team, pain school, physical therapy, acupuncture, yoga, and cognitive behavioral therapy for chronic pain (CBT-CP). Many facilities also have art therapy, chiropractic care, nutrition consultations, occupational therapy, physiatry, rheumatology, and Tai Chi. Less common are services such as aqua therapy, reiki, and qi gong.

Discussion

This paper examines how VA providers have adapted to the cultural shift in pain treatment that emphasizes multimodal, multidisciplinary pain care. Our use of the Relational Coordination model to guide our interviews allowed us to understand how communication and coordination at each VA facility allow providers to work together to recommend the best nonpharmacological pain treatment options for veterans at that VA facility. Although participants in our study did not refer to the Opioid Safety Initiative and new treatment guidelines by name, they referred to the multiple initiatives underway in the VA to reduce the use of opioids for chronic pain. However, as many of the providers had been in the VA for <10 years, they may have been unaware of the culture of pain care before the initiatives began. Participants expressed satisfaction with the wide range of available nonpharmacologic pain care options and the collaborative, multidisciplinary nature of pain care within each facility. Challenges included understanding the array of services offered at each facility and prioritization among various pain care options for veterans.

VA facilities within VISN 1 employ a wide range of multimodal pain treatment options, which reflects the cultural transformation of VA pain care toward the promotion of nonpharmacologic pain treatments and a multimodal pain care approach. The early implementation of this broad array of innovative practices is somewhat unique to VISN 1, which has developed a strong, centralized interdisciplinary administrative team overseeing the implementation of Stepped Care and the OSI. This work has been strongly supported by the VISN Director, who identified pain management as a strategic initiative. The VISN leadership convened this oversight team to focus on both safety and quality metrics related to pain care. The quality metrics detailed a required list of clinical services that each medical center was responsible for offering within a timely manner, and facility compliance with these metrics was monitored on a monthly basis as part of the strategic initiative. Though many pain care

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Table 1. Onsite pain care services by VA VISN 1 facility

	Bedford VA	Boston VA	VA Central Western Massachusetts	VA Maine	Manchester VA	Providence VA	VA Connecticut	White River Junction VA
Acupuncture	X	X	X	X	X	X	X	X
Adaptive Sports	X	X						X
Art Therapy	X	X			X			X
Back Boot Camp		X	X					
Body Movement Class		X						
Chiropractic Care		X		X	X		X	X
CBT for Chronic Pain	X	X	X	X	X	X	X	X
Fitness Center or Pool	X	X	X	X	X		X	X
Interdisciplinary Pain Team	X	X	X	X	X		X	X
Massage						X		
Mindfulness					X	X		
Neurology		X	X	X		X	X	
Neurosurgery		X						
Neuromusculoskeletal/ Osteopathic Manipulation		X		X		X	X	X
Nutrition	X	X	X	X	X	X		X
Occupational Therapy	X	X	X	X	X	X	X	X
Opiate Treatment Program/ Reassessment Clinic	X		X		X	X	X	
Orthopedics		X		X		X		
Pain Clinic	X	X	X	X	X	X	X	
Pain School	X	X	X	X	X	X	X	X
Pharmacy Services	X	X	X	X	X	X		
Physiatry	X	X	X	X	X		X	
Physical Therapy	X	X	X	X	X	X	X	X
Podiatry		X	X	X		X		
Polytrauma/TBI Clinic	X	X			X			
Qi Gong			X		X	X		
Reiki						X		X
Rheumatology		X	X	X				
Self-Management Skills		X				X		X
Sleep Clinic/Study				X		X		X
Tai Chi		X	X		X	X		X
Vascular Surgery		X		X		X		
Whole Health		X			X	X		
Yoga	X	X	X	X	X	X	X	X

CBT = cognitive behavioral therapy; TBI = Traumatic Brain Injury; VA = Department of Veterans Affairs; VISN = Veterans Integrated Service Network.

services are offered at the VA, veterans may also receive pain-related treatment from community providers under the VA Community Care program, which allows veterans to receive services from community providers if certain distance, wait time, and service availability eligibility criteria are met. Providers in our study noted that they were generally unfamiliar with the wide range of options shown in Table 1, and other providers noted that awareness may also be strongly linked to the duration of time a provider has worked in the VA, with new providers being more unaware of the range of pain treatment options. To date, there are no formal standard operating procedures or facility-wide strategies for pain care pathways, though several of the participants in this study recommended that facilities adopt standardized pathways to treat pain.

Furthermore, providers noted that there is no widely accepted algorithm to determine the correct pathway for pain care for veterans, and it would be helpful if facilities created "maps" or "decision trees" of pain care for providers working with veterans on pain management. However, given that there is no evidence-backed consensus about an optimal sequence of pain treatments, the providers' description of a status quo in which the pathways to pain treatment vary by site is not surprising. It appears that pathways evolve at individual sites based on factors such as having gatekeepers to certain scarce resources and that these do not always align with patient preferences.

One important finding from this study was that at some VA facilities, despite the wide range of pain treatment options, providers expressed frustration that veterans preferred to forego VA pain care services to get care from community providers. The reasons why veterans may prefer to receive pain services from community providers remain somewhat unclear but may be related to beliefs about prescription opioid availability from community providers. A recent study found that

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Table 2. Demographics among SBIRT stakeholders

Demographic Variables	Frequency (%)
Sex	
Female	23 (59)
Male	16 (41)
Age, y	
≤29	1 (3.12)
30–39	8 (25)
40–49	14 (43.75)
50–59	4 (12.5)
60–69	3 (9.37)
≥70	2 (6.25)
No. years in VA	
2–5	12 (37.5)
6–10	12 (37.5)
11–15	6 (18.75)
16–20	2 (6.25)
Education	
MD	14 (43.75)
PhD	5 (15.62)
PsyD	2 (6.25)
RN/APRN	3 (9.37)
DPT/MPT	3 (9.37)
PA-C	2 (6.25)
PharmD	1 (3.12)
Other	2 (6.25)

SBIRT = Screening, Brief Intervention and Referral to Treatment for Pain Management; VA = Department of Veterans Affairs.

opioid prescriptions represented nearly 10% of all Community Care prescriptions [17]. Veterans may believe they can get prescription opioids from community providers concurrently with VA providers, but the presence of states' prescription drug monitoring programs [20] greatly reduces duplication in prescriptions from VA and community providers.

Another important finding from this study is that providers noticed a reticence among some veterans to utilize existing VA pain care services. Previous studies have described barriers that veterans experience related to nonpharmacologic pain options, including high cost, transportation problems, and low motivation [21], whereas other studies have reported on providers' perceptions of patient barriers, including geographical, financial, treatment delay, and technological barriers [22]. Providers noted that some veterans expressed uncertainty about the safety or efficacy of certain services (e.g., acupuncture), whereas other veterans worried that utilizing pain care services might eliminate their pain and thereby jeopardize their claims for financial compensation from the Veterans Benefits Administration. Providers in our study reported that veterans believed that any improvement in pain score might result in a lowered, or eliminated, disability rating for veterans. In fact, by statute, compensation is based on functional impairment and not on pain [23], and our group has shown that claims decisions are only impacted by pain severity to the extent that it mediates functional impairment [1]. Further education must be provided to veterans by VA providers to encourage veterans to participate in pain care services despite their fear of losing their benefits.

Our study has some limitations that may reduce the applicability of our findings. Our study focused exclusively on VISN 1 medical facilities and on providers who are routinely involved in pain care, and therefore may not represent the perceptions, experiences, or practices of providers in other VISNs or who are less involved in pain care treatment or referrals. Future research should focus on understanding how enhanced multidisciplinary collaboration may lead to favorable pain outcomes and developing a clinical decision tool to aid primary care providers in decisions regarding pain care treatment options at their facility.

In conclusion, our study sheds light on how providers are adapting to the cultural transformation of pain care in the VA. Further efforts should be taken across VA facilities to ensure that providers are aware of the full range of pain treatment options at their facility. Also, given the recent passage of the MISSION Act, which allows veterans to receive more care from community providers, VA providers should be aware that if a pain care service is not available within their VA (e.g., acupuncture), veterans may elect to receive this service from a community provider. As the VA continues in its commitment to providing nonpharmacologic treatments for pain, it will become increasingly important for each VA facility to have an easily accessible menu of available pain care services provided within that facility or from community-based providers, and this menu of options should be available to both VA clinicians and veterans.

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