A Pain Education School for Veterans: Putting Prevention Into VA Practice

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Veterans who live with chronic non-cancer pain can now go to a school to learn about pain management from the perspective of 20 different disciplines.

The VA is responsible for the health care of more than 5.5 million patients annually across the United States.[1] Pain has been cited as one of the most common reasons veterans consult with their primary care providers and is one of the most prevalent symptoms reported by returning veterans.[2] Pain can be classified as acute or chronic (persistent). Acute pain might be mild and last a moment or be severe and last for weeks or longer. Chronic, or persistent, pain continues although the injury has healed. In other words, pain signals remain active in the nervous system beyond normal healing time. Patients who have chronic pain tend to be unemployed, receive disability benefits, and are often diagnosed with mental illness and substance abuse.[3] Also, veterans with chronic pain are often more complex in their presentation due to difficulties returning to civilian life and the influence of their past military service on their pain.[4]

Believing that no veteran should experience unrecognized, preventable pain, the VA took a leadership role in the development of a national pain management strategy initiative, "Pain as the Fifth Vital Sign," to address the needs of veterans who live with pain.[5] Structures and processes have been put into place within the VA system since the beginning of this initiative, including the formation of multidisciplinary pain teams, the distribution of provider education and training, and the promotion of patient self-management of pain.[6,7] According to the International Association for the Study of Pain (IASP), a rehabilitative, multidisciplinary approach to pain management is the preferred method or gold standard.[8] For most patients who live with chronic pain, self-management of pain is a lifetime task. Thus, these patients must be self-efficacious, have access to information about pain and pain management, be receptive to adopting a self-management approach, and be willing to participate in education efforts.[9]

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BACKGROUND INFORMATION

Past research indicates that patients tend to lack education about pain and pain management.[10] Current research has also identified other barriers to self-management of chronic pain, including limited resources (ie, transportation, finances, etc) and difficult patient-provider interactions.[11] The literature pertaining to patient pain education is based mostly on individual, multi-method protocols with non-veteran patients who experience cancer pain and report findings that tend to be contradictory. A review of 33 studies on the effects of education for cancer pain concluded that patients' attitudes and knowledge improved afterward, but patients continued to witness only minimal changes in their pain level.[12] Another evaluation of the efficacy of patient educational self-management interventions for chronic diseases reviewed research from 1964 to 1999. Seventy-one trials with control groups were included in the analysis; 16 related to arthritic pain, and 12 related to disability due to arthritis. This meta-analysis revealed a trend toward a small benefit for pain and disability.[13]

More recently, research has demonstrated that elderly cancer patients and their family caregivers have benefited from a 3-part, structured pain education program that included a pain education booklet, audiotapes, and written instructions for 19 interventions.[14] Such education programs are usually separate from clinical patient care but are often the product of collaborating health care professionals. Research support for face-to-face, group pain education programs

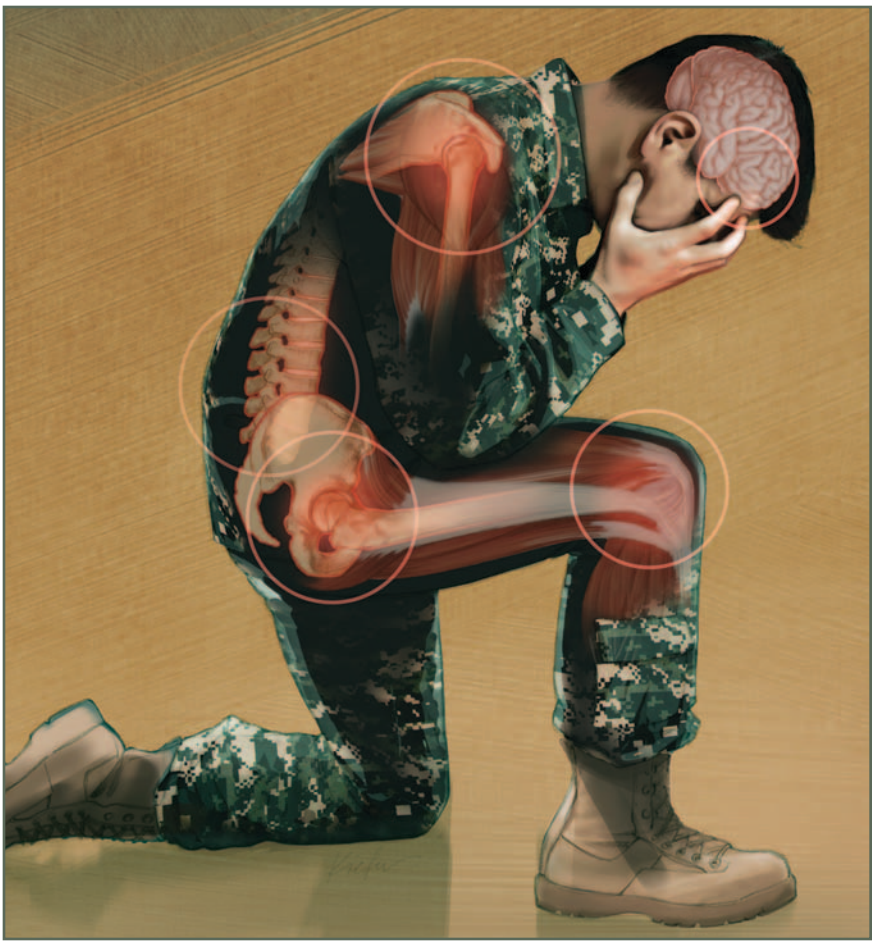
addressing chronic, non-cancer pain among veterans is lacking. In line with the VA's mission to provide empirically supported programs to its veteran population and keeping in mind facilitators to self-management as outlined in the research,[11] the authors developed and implemented a "Pain Education School" within VISN 12. The following delineates the process of development and implementation of such a program within the network.

METHOD

Using the principles researched and published by the Agency for Healthcare Research and Quality, the VA's National Center for Health Promotion and Disease Prevention developed a manual: "Put Prevention Into VA Practice: A Step-by-Step Guide to Successful Program Implementation."[15] Previous programs have focused on efforts such as increasing veteran physical activity, seat belt safety, smoking cessation, weight management, skin protection, and depression screening. These national guidelines have provided evidence-based recommendations for starting a program within the VA system by outlining 6 basic steps in developing a prevention program, including Plan, Do, Check, and Act (Figure 1).[15]

Plan—Initiate and Maintain a Prevention Team

A multidisciplinary pain team comprised of pain physicians (pain attendings, fellows, and residents), a physician assistant/clinic coordinator, a clinical pharmacist, an osteopath, a psychologist, a neurologist, nurses, and a nursing aide was created in September 2009 and is currently maintained at a Midwestern VA medical center. The pain team's psychologist and pharmacist were appointed as the pain education coordinators.



Plan—Assess Preventive Services

The pain team recognized the difference between health education and psychoeducation/psychotherapy and agreed that a need existed for a separate patient education program to complement the existing therapeutic psychological interventions (individual psychotherapy, cognitive behavioral therapy [CBT] groups, acceptance and commitment [ACT] therapy groups, hypnosis, and biofeedback). The pain team assessed current practices and outlined the following 3 necessary components for the proposed "Pain Education School":

a. Share basic principles of pain relief and prevention (diet and exercise, physical and occupational therapies, and sleep hygiene);

b. Provide education about pharmacologic interventions (opioids, nonopioids, and adjuvant medications); and

c. Introduce services offering non-pharmacologic interventions for relief of non-cancer pain (interventional pain procedures, spinal manipulation, biofeedback, hypnosis, and complementary alternative medicines).[14]

In addition, self-management strategies, such as (1) an opportunity for social comparison; (2) encouragement for being a proactive patient; (3) support from different treatment providers; and (4) the provision of a patient resource "menu" were considered in the development of the program.[11]

Team members assessed the availability of pain management services within their VA system and developed working relationships with more than 20 disciplines that provide different pain treatments. The result was a network including pain clinic services, mental health services, addiction services, physical medicine and rehabilitation, nutrition services, recreational therapy, sexual health, chaplain services, smoking cessation clinic, and sleep clinic, which patients can choose from to create a personal, comprehensive pain management treatment plan (Figure 2).

An important lesson learned during the planning process was that of also building close relationships with the support staff, such as room schedulers, public affairs officers, environmental management services, biomedical electronic services, and escort services, to ensure the success of the program. The team continues to identify gaps in the existing program and barriers to program attendance (ie, adding vocational rehabilitation to the program and considering how patient employment schedules, distance, and finances negatively affect attendance) and work toward making improvements (ie, using technology to reach rural patients). Participants are also asked to provide feedback after each session, which is later shared with presenters who can then incorporate the feedback to improve future sessions.

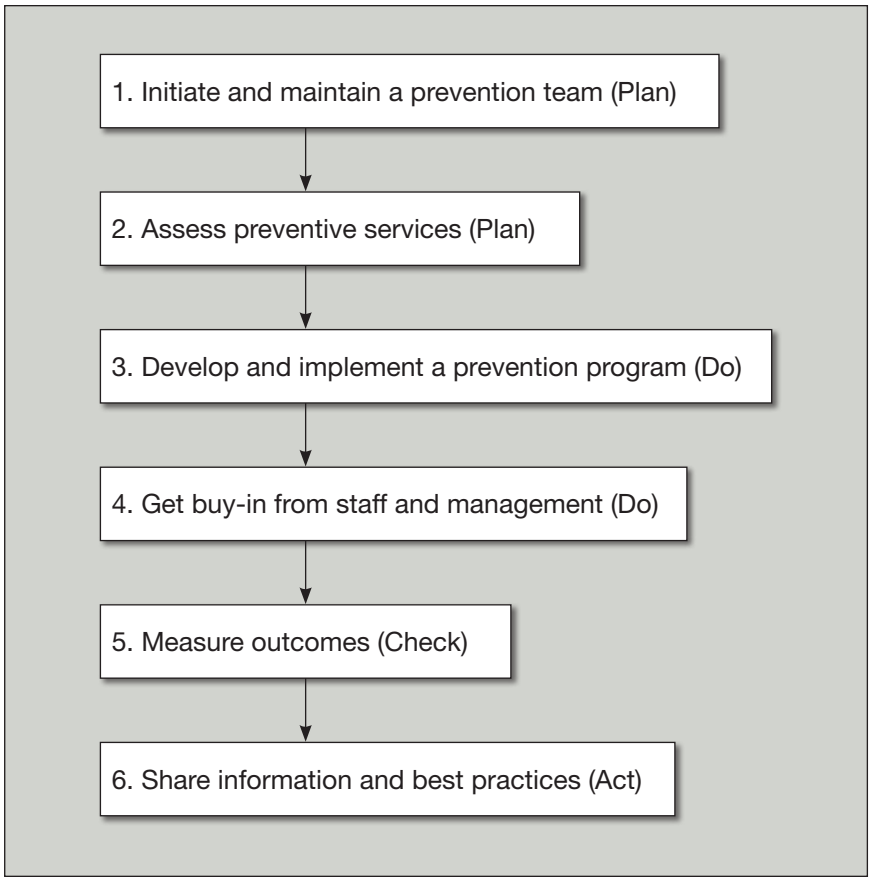


Figure 1. The 6 basic steps in starting a prevention program.

Do—Develop and Implement a Prevention Program

Team members outlined and planned the format and structure of the "Pain Education School." Patients are referred to the "Pain Education School" as an adjunct to current treatment by any provider within the VA system who may identify the veteran as (1) failing medical or surgical treatment; (2) exhibiting an overreliance on medications or therapies; (3) displaying pronounced inactivity; (4) experiencing significant depression or anxiety related to their pain; (5) demonstrating inadequate coping skills; and (6) appearing receptive to adopting a self-management approach to pain management.[16]

A consult is submitted in the Computerized Patient Record System and is then answered by the coordinators of the clinic. Referred patients are put on a waiting list until they can be scheduled for a mandatory introduction class that occurs on the first Friday of each month. The introduction class covers the ground rules, schedule of classes, and basic principles of pain management. Principles discussed include the IASP's definition of pain; the pain intensity numerical rating scale (0-10); how to use a pain diary; how to communicate pain effectively with providers; different pain theories (ie, gate control theory); the differentiation between acute, chronic, and breakthrough pain; and the effects of a Chronic Pain Syndrome on different life areas (ie, levels of physical activity, sleep, appetite, mood, interactions with others, finances, substance abuse, etc). The facilitators of the program also make sure to clarify that "Pain Education School" is not a requirement to be enrolled in the facility's Pain Clinic as this is a common misconception by both participants and providers.

Patients then attend their first edu-

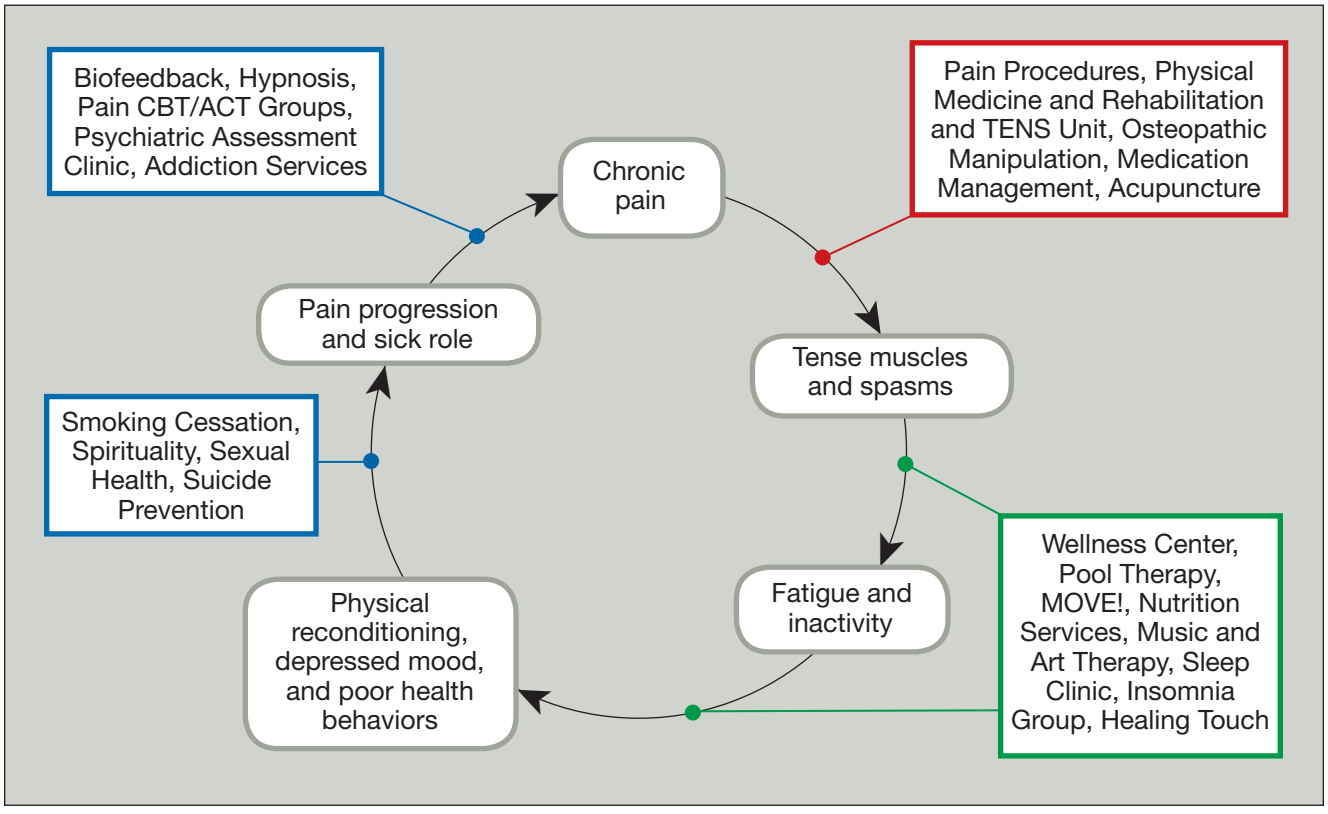


Figure 2. Comprehensive pain management model.

cation class on that same day. Patients who complete the introductory class are then scheduled for 11 consecutive education classes held on Fridays. Participation in subsequent classes is voluntary. Patients who are unable to attend the introductory class, but are still interested in participating in "Pain Education School," are put back on the waiting list for the next available introductory class. Classes are scheduled for 1 hour, and each guest speaker is allotted 30 minutes to share information about pain from his or her services' perspective, including available treatments for veterans and how to set up a clinic appointment. The 12 sessions rotate on a fixed schedule, with a new group of patients entering the rotation on the first Friday of every month. Despite starting "Pain Education School" with different classes, all patients rotate through all 12 classes (Table 1).

Another lesson learned when carrying out the program was how to bill for an education program. For billing and coding, providers set up the "Pain Education School" clinic using Primary Care stop codes instead of the standard 420 Pain Management code. This code was determined to be a more appropriate stop code for the clinic since the co-payment is $15 vs the $50 charged for a specialty clinic such as the Pain Clinic. In addition, patient encounters are coded with the health and behavior CPT code 99078, Educational Services Rendered to Patients in a Group Setting.

To broaden patient access, team members have considered other ways to deliver pain education programming, such as telehealth technology and a Web site. The current VA medical center is a parent facility to 3 community-based outpatient clinics (CBOC). The "Pain Education School" has been expanded to include 2 of these clinics via picture telephone technology (PICTEL). The inclusion of this technology allows rural patients who live far distances from the parent VA medical center access to the education program without having to face certain barriers, such as transportation and financial strain.

The HCPCS Code Q3014, Telehealth Originating Site Facility Fee, is used to claim the facility payment. The coordinators are also developing an online version of the "Pain Education School" for returning veterans who may be unable to attend face-to-face classes due to their employment or postsecondary education schedules. The online version will include Section 508 compliant PowerPoint presentations with metadata for each module.

Do—Get Buy-in From Staff and Management

As further incentive to participate in "Pain Education School," the presenters from more than 20 different disciplines have the opportunity to get workload credit for their time. Team members have also educated the VA medical center and CBOC staff about the program and its referral process. The clinic coordinators e-mailed the primary care chief of staff introducing the program and encouraged primary care physicians to refer their patients. "Pain Education School" flyers announcing the creation of the program were sent to all the guest speakers to be distributed to their service's staff and patients. In addition, team members have attended other departments' staff meetings to further outline the referral process and program. Furthermore, key personnel and staff in the director's office, such as the public affairs officer, have been introduced to the program and have become its advocates.

Check—Measure Outcomes

To measure the efficacy of the "Pain Education School," an Institutional Review Board proposal was submitted to the affiliated university and the Research and Development Office of the participating VA. The proposed study used a retrospective outcome design with 206 veterans aged 18 to 87 who participated in "Pain Education School" between November 6, 2009 and November 5, 2010. There were no exclusion criteria used for the study. As part of their introduction and conclusion to the program, all participants completed a pre- and post-education assessment. The assessments included a single item, the Readiness Questionnaire, which measured stages of change (Figure 3), a Patient Pain Questionnaire,[17] which measured knowledge and experience of pain, and the Patient Health Questionnaire,[18] which is a depression screen.

At the end of the program, patients completed a feedback form, which addressed patient satisfaction with the program (ie, I have learned new and useful information, the information was easy to understand, I will be able to use the information, and I would recommend this program). Veterans voluntarily participated in the "Pain Education School" program and were free to withdraw at any time.

Preliminary findings propose a significant difference in the pre-test and post-test measures of readiness to change, suggesting that the "Pain Education School" had a small-to-moderate effect in increasing readiness to change. On average, veterans moved from a contemplative to a preparatory stage of change during the 12-week program. In addition, there was a significant difference in the pre-test and post-test measures of patients' experience of pain, suggesting the program also had a moderate effect in decreasing the intensity of pain. Thus, on average, veterans' experience of pain improved by participating in this program. There was also a significant difference in the pre-test and post-test measures of depression, suggesting the program had a moderate-to-large effect in decreasing depressive symptoms.

Therefore, veterans who participated in this program, on average, witnessed an improvement in their mood. However, there was not a significant difference in the pre-test and post-test measures of patients' pain knowledge. It is unclear whether the difference between the existing program's passive approach vs a more active learning approach (ie, minute papers, audience-response technology, etc) has an impact on patients' knowledge. The current investigation also did not account for how each participant learns as an adult—whether by using audio, visual, or tactile methods. Furthermore, from previous patient education research, the idea exists positing that knowledge is necessary, but not sufficient, suggesting that an assessment of patient's beliefs independently of knowledge received may be necessary.

Table 1. Sample schedule of classes

1. Pain clinic (surgical procedures) and osteopath (osteopathic manipulation treatment)
2. Pharmacy (medication management)
3. Smoking cessation clinic and addiction services
4. Nutrition services and MOVE! program (weight management)
5. Physical and rehabilitation medicine (physical and occupational therapies)
6. Recreational therapy (pool, golf, and equine) and sexual health clinic
7. Mental health, suicide prevention, and vocational rehabilitation
8. Pain CBT and pain ACT groups
9. Hypnosis and biofeedback
10. Chaplain services (spirituality) and healing touch
11. Sleep clinic and psychology's insomnia group
12. Acupuncture and traditional Chinese medicine

Below are 5 statements that describe how different people think about their pain. Please read each statement carefully, and choose the one that best describes the way you think about your pain.

- ☐ There is nothing I can do to manage my pain without medication or other medical intervention.
- ☐ I'm not sure whether I should continue to look for a medical solution for my pain or realize that it is up to me to manage the pain.
- ☐ Managing my pain is up to me, and I am ready to begin to learn to deal with it.
- ☐ I have actively begun to learn ways to manage the pain, but I still have a long way to go.
- ☐ I am sure about my ability to manage the pain myself.

Figure 3. Readiness Questionnaire.

Act—Share Information and Best Practices

Information about the "Pain Education School" is shared with all 20 disciplines within the facility. In addition, best practices are shared with other VA facilities within VISN 12 during monthly pain committee teleconferences. The current feature article is an attempt to share information about implementing a pain self-management, education program within the VA system at the national level.

RESULTS

The "Pain Education School" started in November 2009. From November 6, 2009 until November 5, 2010, the clinic had a total of 542 unique referrals (not including patients who were rescheduled due to missing the introduction class). Referrals came from several different areas, including the multidisciplinary pain clinic, mental health clinics, general medicine clinics, and subspecialty clinics (such as orthopedics and neurology). Additionally, a few patients directly asked the coordinators to be put on the waiting list when they learned about the program through our flyers or through word of mouth. Of the 542 referred to the clinic, 206 (38%) were enrolled in "Pain Education School" (including those attending via PICTEL from the participating CBOCs). On average, 17.5 veterans joined the program each month, with a range from 9 (December 2009) to 28 patients (October 2010). The implementation of PICTEL technology in January 2010 allowed patients from far distances to participate in the program. On average, 8 veterans participated in the program via PICTEL each month, with a range from 4 (October 2010) to 12 patients (July 2010). From November 2009 to November 2010, the average participant attended 7 out of 12 classes, with patients most often attending 10 out of 12 classes.

DISCUSSION

The "Pain Education School" is a unique program developed and implemented in the VA system using the National Center for Health Promotion and Disease Prevention's step-by-step guidelines to successful program implementation. Unlike past research that has focused on cancer pain education programming, the current program specifically caters to veterans with chronic, non-cancer pain. The "Pain Education School" offers an opportunity for veterans to learn about pain management from the perspective of 20 different disciplines, be introduced to the various treatments available to veterans in the medical center, and understand how to access each service within the VA system. The creators of this program believe that a patient who experiences chronic pain can become a more active member of his or her interdisciplinary treatment, which research shows is predictive of better pain management outcomes.

The program delineated in this article may prove to be an avenue by which veterans can bypass identified barriers, such as difficult patient-physician interactions and limited resources (ie, transportation, finances, etc), and realize self-management goals by empowering veterans to self-tailor their own pain management plans. Additionally, the program provides encouragement from pain care providers across 20 disciplines within the VA system; access to mental health services to address mood disturbances due to pain; a safe, supportive environment to discuss pain disorders; and access to pain education and resources for family members of veterans living with chronic or persistent pain. ●

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

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