



Defense & Veterans Pain Management Initiative (DVPMI)

Spring 2009 Meeting

Minutes*

*DVPMI decisions and recommendations to service Anesthesiology Consultants to the Surgeons General can be found under the heading: **Service anesthesiology consultant recommendation.**

I. ATTENDANCE

Meeting Date: 4 June 2009 / 0900-1400

Meeting Location: Marriott North Bethesda Conference Center, North Bethesda, MD

Voting Members in Attendance:

Col Todd Carter, MD	Air Force	cartert4@UCMAIL.UC.EDU
MAJ Scott Griffith (Chronic Pain)	Army	scott.griffith@amedd.army.mil
LCDR Brent Bushey (CRNA)	Navy	Brent.Bushey@med.navy.mil

Voting Member on Conference Call:

COL Chester Buckenmaier, MD	Army	chester.buckenmaier@amedd.army.mil
CAPT Ivan Lesnik, MD	Navy	ilesnik@usuhs.mil
LCDR Erick Stedje-Larsen (Chronic Pain)	Navy	eric.stedje-larsen@med.navy.mil

Voting Members Absent:

Maj Greg Malone	Air Force	Gregory.malone@amedd.army.mil
Maj Brian Koonce (CRNA)	Air Force	brian.koonce-02travis.af.mil
Maj Jeff Barr (Chronic Pain)	Air Force	Jeffrey.Barr@Lackland.af.mil
LTC Scott Croll, MD	Army	scott.croll@amedd.army.mil
CPT Jimmie Foster (CRNA)	Army	jimmie.foster@amedd.army.mil
LCDR Justin Heil, MD	Navy	heiljw@yahoo.com

Other Attendees (listed as signed in):

BG Richard Thomas		Richard.william.thomas@us.army.mil
LTC Kevin Galloway		Kevin.galloway@us.army.mil
CDR Necia Williams	NNMC/WRAMC	Necia.williams@amedd.army.mil
Dr. Rollin Gallagher	Philadelphia VA	rollin.gallagher@va.gov
MAJ Gregory Applegate	WRAMC	Gregory.applegate@amedd.army.mil
CPT Anthony Plunkett	WRAMC	Anthony.plunkett@amedd.army.mil
MAJ Eric Holt	NNMC/WRAMC	ericholt@hotmail.com
CPT Peter DeSocio	USAISR	peter.desocio@amedd.army.mil
CPT Laura McGhee	USAISR	laura.mcgee@amedd.army.mil
Geselle McKnight, ARAPMI	WRAMC	geselle.mcknight@amedd.army.mil
Kelly Kiser, ARAPMI	WRAMC	Kelly.kiser@amedd.army.mil
Nancy Kwon, ARAPMI	WRAMC	kyung.kwon@amedd.army.mil

II. Introductions & New Business:

- A. COL Buckenmaier completed a short welcome via telephone and Col Carter served as the host for the meeting. Introductions were completed.
- B. Pain Task Force (PTF) Overview by LTC Galloway
 1. LTC Galloway provided an overview explaining that a Task Force would be established to evaluate the management of pain in the military. The PTF would examine multidisciplinary/interdisciplinary approaches to pain medicine and would be structured using Traumatic Brain Injury (TBI) as the model.

The Surgeon General's decision to charter the Army Pain Task Force has significant command visibility within DoD and will be briefed to the Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA M&RA). In addition to naming dedicated members to the PTF, there will be representatives from the M&RA staff, Air Force, Navy, and VA. The PTF will be commanded by BG Thomas, and LTC Kevin Galloway will serve as the Chief of Staff.

2. LTC Galloway noted pain issues, specifically related to the Army:
 - a. Suicides (medication related? Is there a link between pain, medications and suicide?)
 - b. Medication Misuse
3. Discussed actions leading up to Pain Task Force
 - a. Army Family Action Plan (Jan 09) – Teams looked at ways to help soldiers achieve improved pain management, higher functionality while managing pain, avoiding over-medication and would include alternative therapy and enhanced patient/provider education.
 - b. Establishment of Congressional Pain Care, National Pain Care, Veterans Pain Care, Defense Pain Care and Military Pain Care Acts.

- c. Proponency Office for Rehabilitation and Reintegration (PR&R) meeting in San Antonio. PR&R is the Army's lead organization for policy, direction, and oversight of rehabilitation and reintegration and was tasked with implementing a Pain Management Action Plan, to include Complementary and Alternative Medicine (CAM). LTC Galloway stated that this meeting did not include the right "pain folks."
- d. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) (Apr 09) meeting in San Diego to discuss substance abuse prevention and treatment in the military.
- e. Pain Care Legislation – meeting of the General Officers.
- f. MEDCOM Pain Management Working Group (PMWG) (Oct 08 & Dec 08). This meeting included a well-rounded group of representatives from the pain community.
 - Identified gaps
 - Identified stakeholders
 - Developed principles (G3)
 - Conclusions: no defined method or synchronization throughout.
 - Solution: develop Pain Task Force (PTF) lead by General Office (GO), linked to legislative requirements/recommendations from MEDCOM PMWG.

C. Introduction of BG Richard Thomas, Commander, PTF.

BG Thomas gave an overview of drug use and suicide in the military. He further discussed the objectives and challenges of the PTF

- Determine key stakeholders
- Leadership challenges
- Holes in formation/not enough personnel
- Army Substance Abuse Program (ASAP) "broke"
- Populations at risk

D. DVPMI – Tri-Service Model

1. COL Buckenmaier suggested the DVPMI (MARAA) be formalized as advisors to PTF to help develop a plan on how to proceed with ensuring that all soldiers receive standardized treatment at any military treatment facility (MTF). Imperative to identify the right providers in theater, Landstuhl and going forward.
2. Col Carter talked about pain through the continuum consisting of two parts:
 - Acute – treatment at point of injury is dependent upon who is deployed. Suggested aligning with Joint Theatre Trauma System and work with surgeons to improve the process.
 - Recovery

3. CAPT Lesnik commented that there needs to be more assets. The Navy is growing their pain management resources to address pain in combat, but gaps still exist in evidence-based care practices and research/data collection.
4. BG Thomas asked if the consensus was that DVPMI would function as consultant group to PTF.

COL Buckenmaier posed the following questions:

- How would DVPMI be structured and address issues?
 - Should the VA and other medical services (psych, PM&R, etc) be included?
 - Would DVPMI be given authority, which would allow quicker decision-making, policy changes and implementation?
5. CDR Williams provided a copy of the Comprehensive Pain Center of Excellence (CPCOE) briefing/plan to BG Thomas. She also suggested that all the sites and services could be more easily integrated through the DVPMI. She went on to talk about education and deploying pain physicians to clinics/units one day per week to “train” primary care physicians one-on-one or the through the use telemedicine.
 6. Vision for DVPMI as it relates to PTF
 - a. COL Buckenmaier: “The DVPMI should serve as the think tank, subject matter experts for all three services on pain issues. The DVPMI will provide recommendations that the individual services can then act on. I think each service should have a pain consultant who is a member of DVPMI. This would greatly enhance coordination of pain decisions among the services and the VA.”
 - b. Col Carter questioned the momentum of the DVPMI and whether DVPMI would lead the Task Force or serve as a component of the Task Force. He was concerned that the DVPMI would get absorbed into the PTF and lose its influence.
 - c. CAPT Lesnik asked if the DVPMI would be recognized for their input and would this lead to any funding to support the group?
 - d. LTC Galloway stated that he believed the DVPMI would complement the Task Force by providing discussion and recommendations that would influence the PTF. He said the PTF was not designed to take over the DVPMI, they would most probably become a sub-organization of the PTF, and that this involvement may help to empower the DVPMI. The PTF will come up with an execution plan to move forward when they assemble.
 - e. BG Thomas stated that this relationship is a work-in-progress and that he sees the DVPMI helping to identify over-arching issues and driving some decisions. He also believes that DVPMI can be used as a tool to leverage pain issues and help with implementation across the services (Army, Navy, and Air Force).

7. DVPMI sub-committee of MRMC

- a. There is the possibility that DVPMI would become a sub-committee under MRMC, similar to the USAISR. This may allow the DVPMI to obtain exclusive funding (outside the ARAPMI) and recognition.
- b. Can the DVPMI live with oversight and structure imposed by MRMC (what are pros/cons)?
- c. How will research be approved from theater to LRMC to U.S.? Centralized (Tri-Service) IRB? Identified need for a research registry to eliminate duplication of studies and encourage multi-site/service collaborations.
- d. What about the DCOE and meeting with General Sutton? Will the DVPMI become a part of DCOE?
- e. How will funding be managed? Will there a single director responsible for distributing funds and determining what should be funded or not?

Service anesthesiology consultant recommendation: ALL agreed that DVPMI would serve as consultants to PTF. Structure, objectives and deliverable to be determined.

E. Philadelphia VA – Dr. Rollin Gallagher

1. Dr. Gallagher talked about primary issues that the VA has been addressing:
 - Chronic opioid therapy guidelines. Also joint guidelines with DoD.
 - Continuity and continuum of care.
 - How to investigate severe trauma (stressed importance of translational research).
 - Train and integrate primary care physicians (step care).
2. Dr. Gallagher also talked about the model the National Program Office (VA) has been developing and the challenges of dispersing throughout all VAs. They are currently educating through the Veterans Integrated Service Networks (VISNs).
3. The strategy within the VA system includes:
 - Standardized treatment (to include opioid therapy guidelines)
 - Access to pain medication
 - Rehabilitation into the community
 - Additionally the VA would like to support provider education (test competency), and research.

III. Short-Term Goals

- F. Define pain as a disease process that has to be funded for medical, psychosocial and behavioral management, professional education, training, and research.
1. Treatment standards need to be created for each role of casualty care through rehabilitation and reintegration with initial emphasis on early and aggressive treatment at point of injury and primary care providers at Role IV facilities.
 2. Discuss inclusion or exclusion of end-of-life, obstetrical and pediatric pain management.

Service anesthesiology consultant recommendation: Table until next DVPMI meeting.

- G. Identify major capability gaps
1. Lack of trained personnel and equipment dedicated to the treatment of acute pain at Role II–III.
 - COL Buckenmaier: “We have suggested a special ‘P’ identifier for anesthesiologists who have the training and desire to be part of the special pain teams. All anesthesia providers should be receiving training in pain.” This has not happened and has not been discussed in the Army yet.
 - CAPT Lesnik states that the Navy is getting close and this is a complex issue that warrants more discussion at the next meeting.
 2. Lack of pain management clinical practice guidelines for MTF and Warrior Transition Clinic primary care providers and algorithms for referral of cases requiring specialty training is being addressed at WRAMC.
 3. Lack of education, training, tracking systems, risk identification, practice guidelines, and alternatives to prescription narcotics. The ARAPMI is taking the lead on most of these issues addressing education, outcomes, research, and technology.
 4. Lack of a DoD pain research infrastructure and funding to support it. There will be NO evidence-based practices without the research to support it.
 - Inability to coordinate (as opposed to duplicate) research efforts across the DoD and VA.
 - Lack of a pain data registry.
 - Need standardized IT enterprise system for data entry, storage, query and analysis from point of injury, through A/E, CONUS and the VA.
 - Use of JRAATS as possible solution.
 5. Lack of consensus on outcomes definitions, inability to consistently track outcomes and evaluate results across the DoD.

IV. Old Business

- H. MEDCOM has named MAJ Scott Griffith (Chief, Anesthesia & Operative Service and Chronic Pain Management, WRAMC) as specialty consultant to the OTSG for Pain.
- I. Decision to rename organization DVPMI approved at Fall 2008 meeting.
 - Ms. Kiser has made the appropriate changes to the Charter.
- J. Update on use of low-dose ketamine on A/E flights
 - COL Buckenmaier is using in Afghanistan. Unaware of any issues. Mixing it with morphine 1 to 1 in PCA. Has been quite effective. States ketamine is rapidly replacing morphine as the drug of choice on MEDEVAC.
- K. DVPMI representative at monthly TCC VTC
 - COL Buckenmaier: "That would be the DVPMI president or their representative."
- L. JRAATS update
 - The contract has been awarded. Discussion is on going about details of the interface. This will be funded by Tricare Management Activity (TMA) through theater Functional Working Group (TFWG), which is a Tri-Service organization that manages theater operations.
 - COL Buckenmaier: "This is needed. RATS is dead."

V. Fall 2009 DVPMI meeting.

The Fall 2009 DVPMI meeting will be held 16 Oct 09, in conjunction with the USSA in New Orleans, LA.

Meeting adjourned.