PAINWEEK®

Whole Lotta Health & Then Some

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Titles & Affiliations

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Disclosure

- No relevant financial disclosures
- The presentation is the personal opinion of the presenters and does not reflect the official views of the Department of Veterans Affairs or any other Federal Agency.

Learning Objectives

- Cite the role of whole health as related to pain care
- Apply evidence-based, non-pharmacological pain treatments to improve outcomes
- Describe treatment options within complementary and integrative health
- Summarize the stepped care model for pain management

Department of Veterans Affairs

FY 2018 – 2024 Strategic Plan

Refreshed May 31, 2019

Strategy 2.1.4:Emphasizing Veterans' And Their Families' Whole Health & Wellness

- VA will significantly improve Veteran health outcomes by shifting from a system primarily focused on disease management to one that is based on partnering with Veterans throughout their lives and focused on Whole Health.

- VA will provide *personalized, proactive, patient driven* health care to empower and equip Veterans to take charge of their health, well-being, and to adopt healthy living practices that deter or defer preventable health conditions.

- A Whole Health system focuses not only on treatment but also on self-empowerment, self-healing, self-care, and improvements in the social determinants of health.

Comprehensive Addiction and Recovery Act

- Complementary and Integrative Health (CIH)
  - Expansion of Research & Education on and delivery of CIH to veterans
  - Pilot program on integration of CIH and related issues for Veterans and family members of Veterans.
    - Minimum of *15 geographically diverse sites*; including at least 2 polytrauma rehab centers = 18 Flagship sites
  - By July 2020, a final report is due to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives.

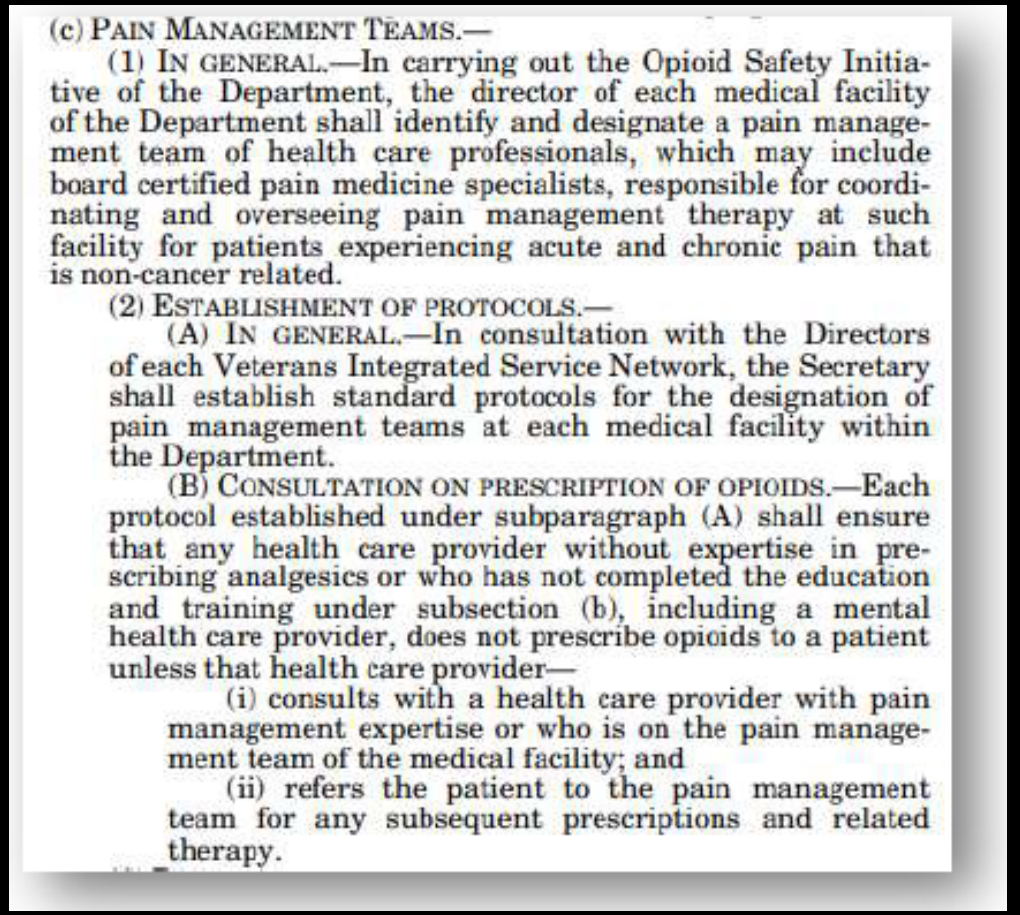
https://vaww.infoshare.va.gov/sites/OPCC/SiteAssets/SitePages/IHCC-home/2017%20CIH%20Plan_CARA%20932.pdf

CARA Pain Management Teams (PMTs) Section 911(c)

- July 2016: Comprehensive Addiction and Recovery Act (CARA)

- Section 911(c) of CARA mandates that each VAMC have a designated Pain Management Team of health care professionals responsible for coordinating and overseeing pain management at each facility for patients experiencing acute and chronic pain that is non-cancer related.

- May 2017: VHA PMT Memorandum was issued to VISN and VAMC Directors to communicate the PMT requirements.



(c) PAIN MANAGEMENT TEAMS.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the director of each medical facility of the Department shall identify and designate a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is non-cancer related.

(2) ESTABLISHMENT OF PROTOCOLS.—

(A) IN GENERAL.—In consultation with the Directors of each Veterans Integrated Service Network, the Secretary shall establish standard protocols for the designation of pain management teams at each medical facility within the Department.

(B) CONSULTATION ON PRESCRIPTION OF OPIOIDS.—Each protocol established under subparagraph (A) shall ensure that any health care provider without expertise in prescribing analgesics or who has not completed the education and training under subsection (b), including a mental health care provider, does not prescribe opioids to a patient unless that health care provider—

(i) consults with a health care provider with pain management expertise or who is on the pain management team of the medical facility; and

(ii) refers the patient to the pain management team for any subsequent prescriptions and related therapy.

Pain Management Teams (PMTs) Mandates

Functions of the interdisciplinary PMT include:

1. Evaluation and follow-up of patients with complex pain conditions
2. Pain consultation for medication management and actual prescribing of pain medication as needed
3. Review of patients with high risk opioid prescriptions with provision of recommendations to clinical providers

VHA PMT composition includes (at a minimum):

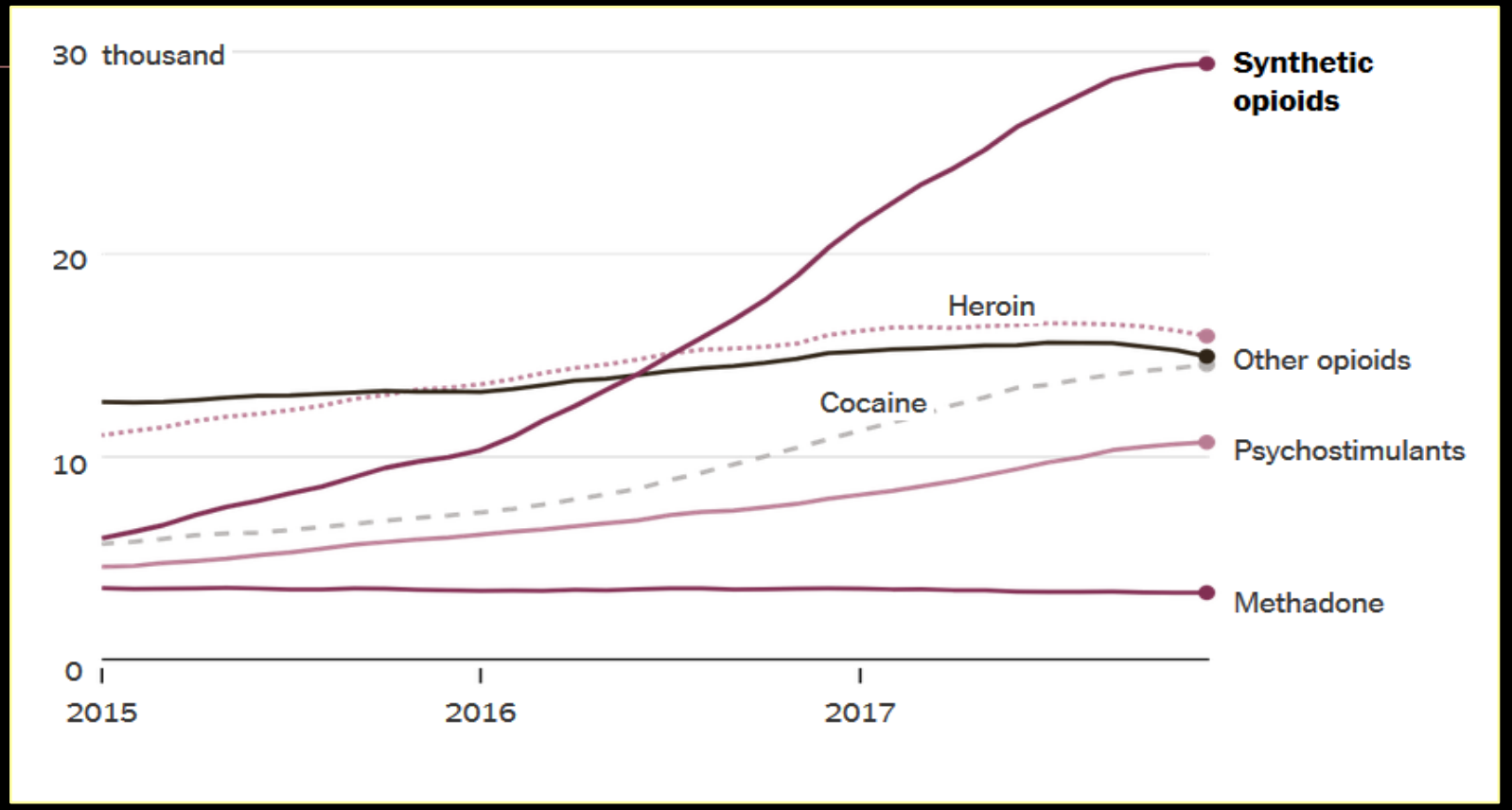
1. Medical Provider with Pain Expertise
2. Addiction Medicine expertise to provide evaluation for OUD and MAT
3. Behavioral Medicine
4. Rehabilitation Medicine discipline.

CDC Update Overdose Deaths United States 2018

CDC update in August 2019:

12-month period
Dec 2017 – Dec 2018:
5.1% decline dropping to
68,000 per year.

That is still
- 186 people every day
- 1 person every 8 minutes.



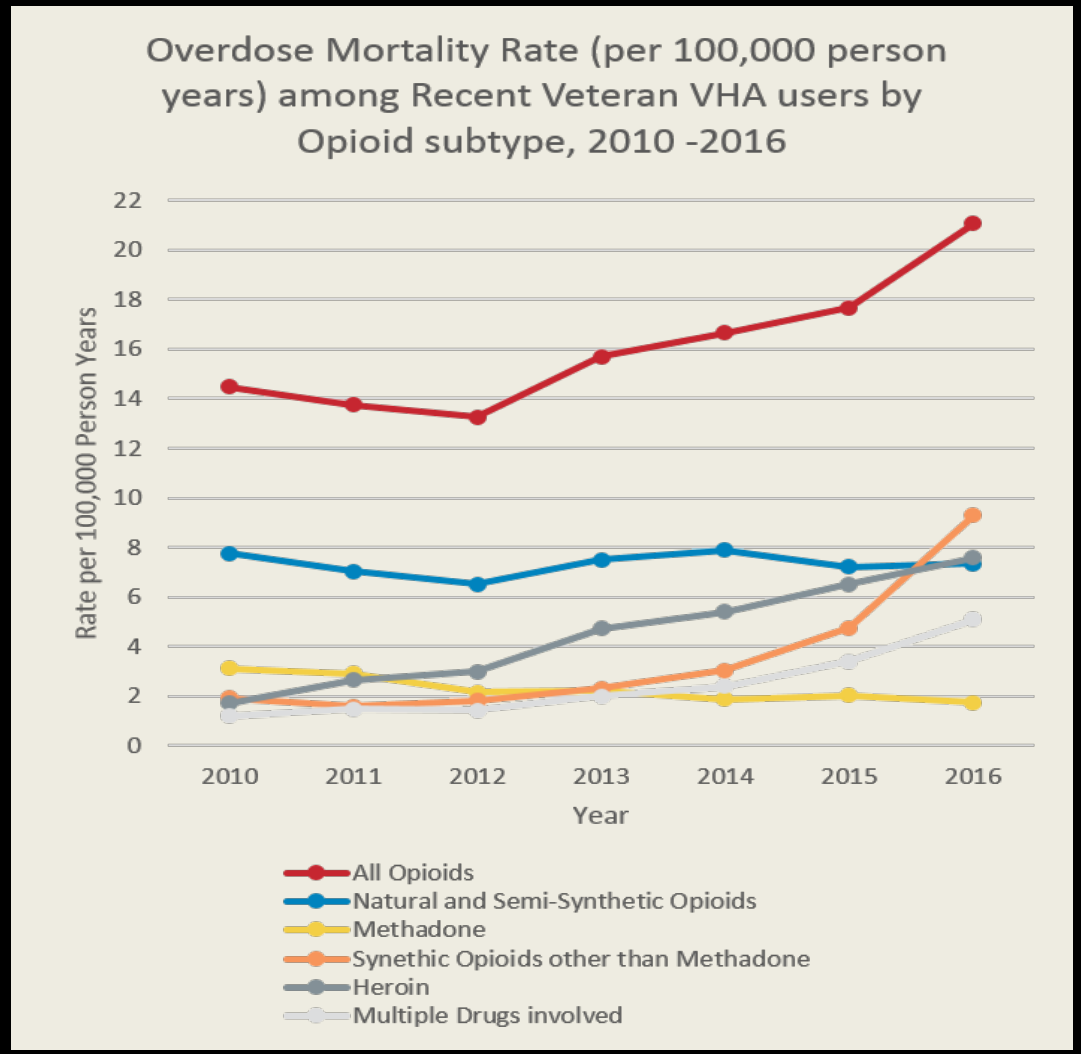
Overdose deaths in thousands in preceding 12 months

Note: These numbers are adjusted to account for some death investigations that are not completed. Some deaths involve more than one drug.

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

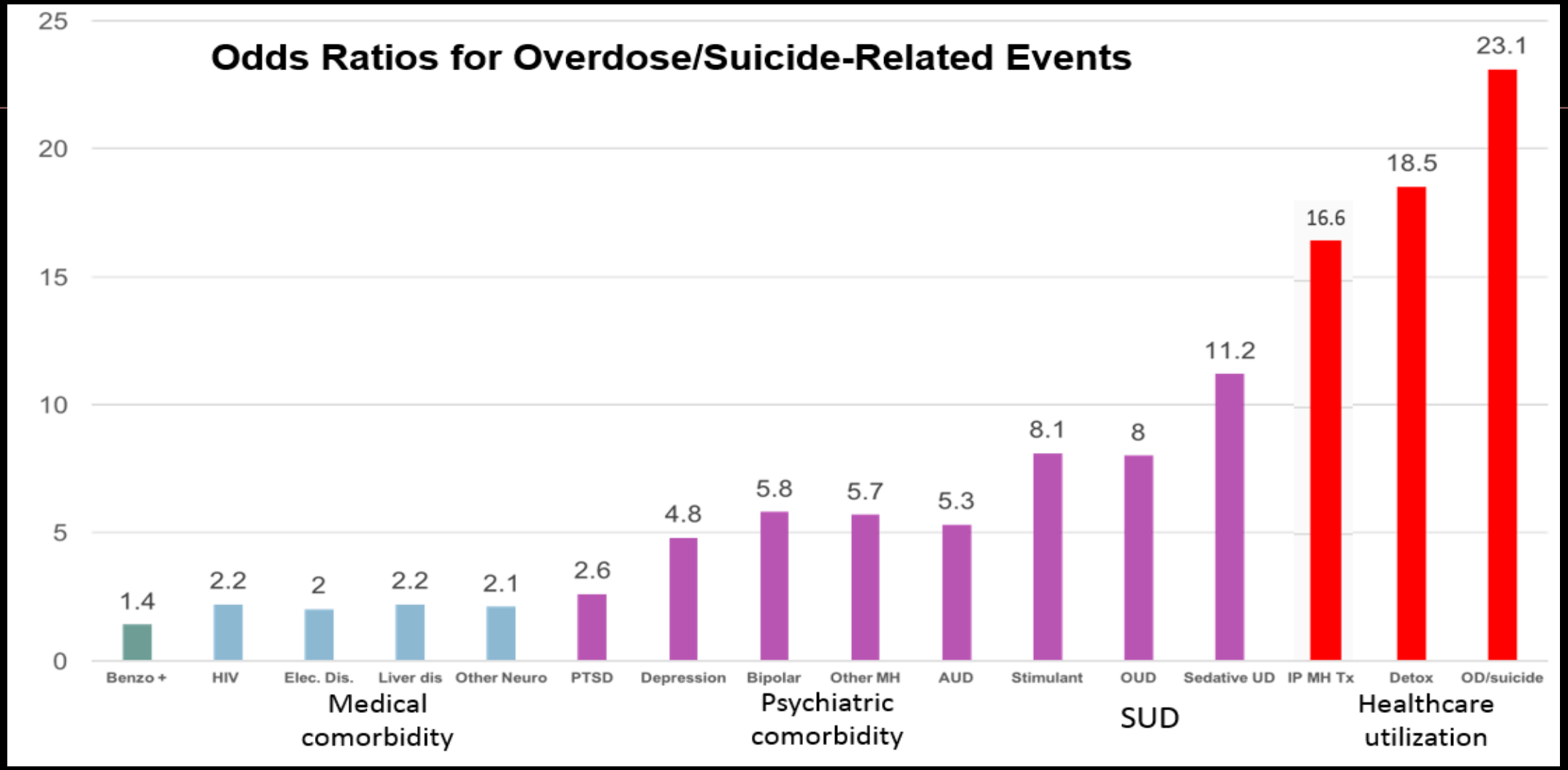
Changing Trends in Opioid Overdose Deaths and Prescription Opioid Receipt Among Veterans

- From 2010 to 2016, there were 6,485 VHA Veterans who died from any opioid overdose, with increasing trend over time.
- Opioid overdose rates in the VHA population increased from 14.47 in 2010 to 21.08 per 100,000 person-years in 2016 (adjusted rate ratio=1.65).
- Increase in opioid overdose is due to overdose on heroin (adjusted rate ratio=4.91) and synthetic opioids (adjusted rate ratio=5.46)



Peltzman T, McCarthy JF, Oliva EM, Trafton JA, Bohert AS. *Am J Prev Med. June 2019 In press*

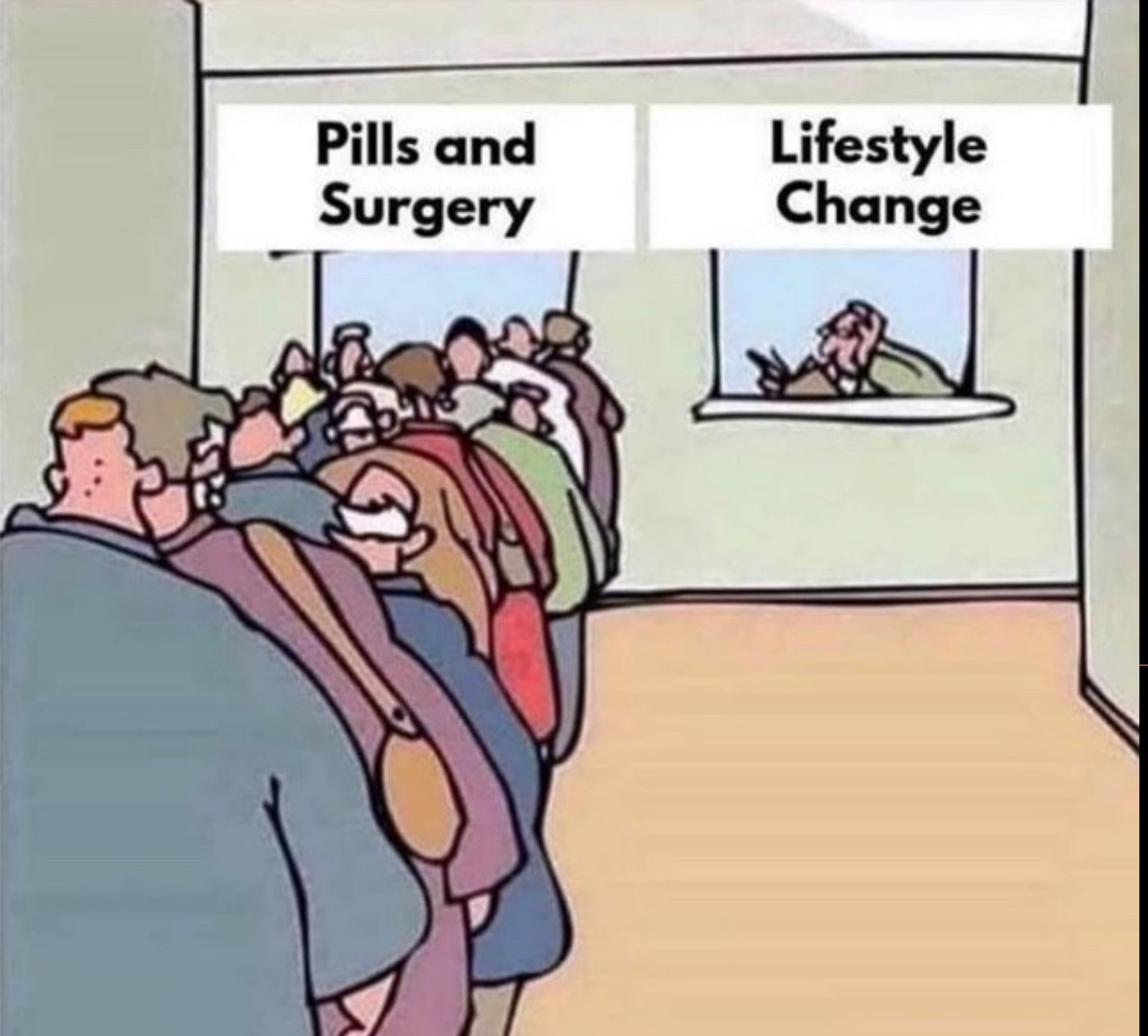
Veterans: Risk Factors for Overdose/Suicide



Oliva et. al. Psych. Services 2017

“Pain Care Transformation”

- ***Paradigm shift away from opioid therapy*** *for non-end-of-life pain management.*
  - There is no completely safe opioid dose threshold below which there are no risks for adverse outcomes.
  - Even a short-term use of low dose opioids may result in addiction.
  - Realization that any initial, short-term functional benefit will likely not be sustained in most patients.
  - Prolonged use of opioids, especially in higher doses, may lead to central sensitization and increase in pain over time (*Opioid Induced Hyperalgesia*)
  - Patients on opioids may experience a functional decline in the long term, measured by factors like returning to employment.
- ***Paradigm shift towards multimodal and integrated team-based pain care (biopsychosocial interdisciplinary care)***

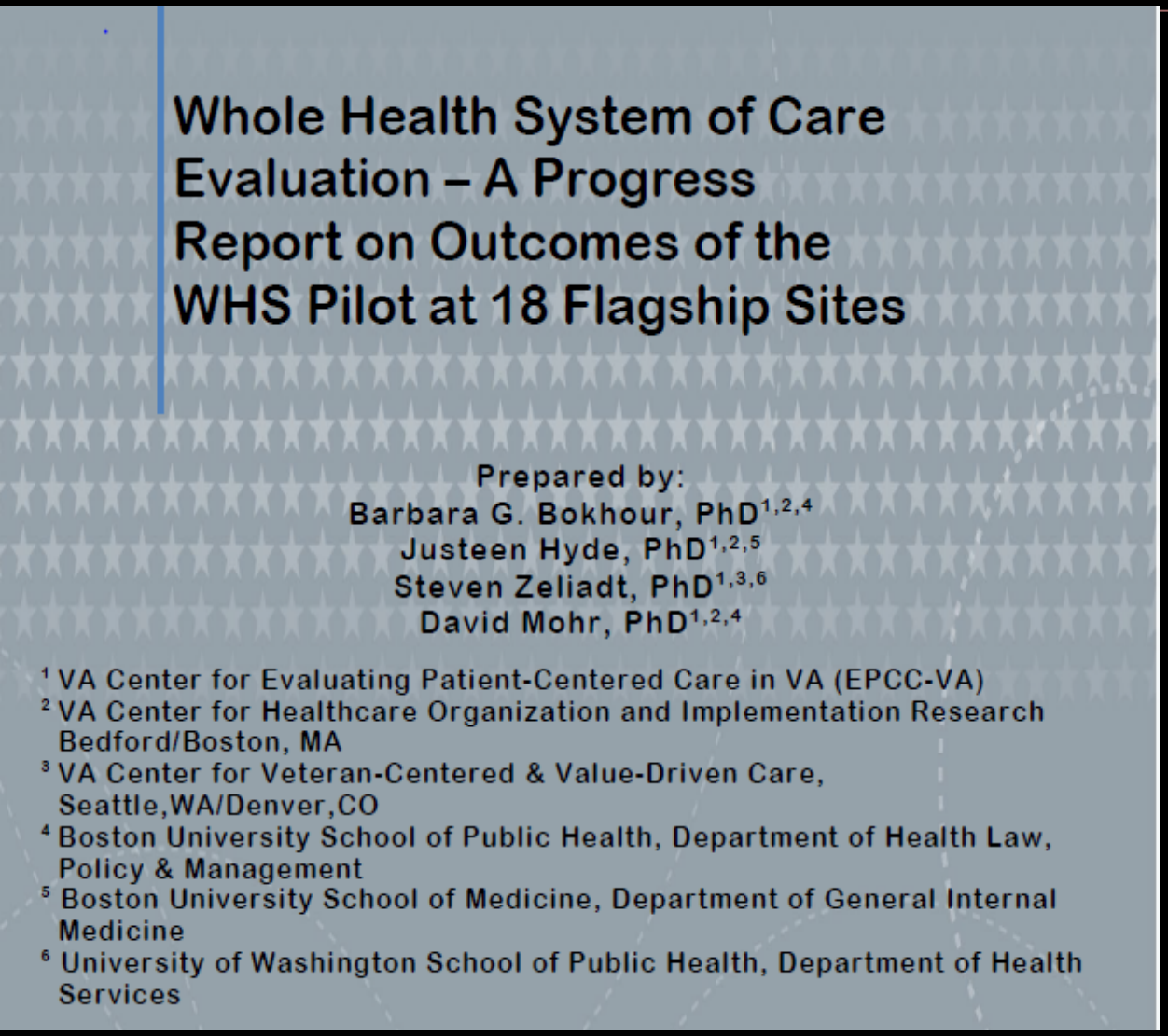


The biomedical approach in pain care

Whole Health System of Care Evaluation

Whole Health Encounters

National Cohort Size



Whole Health System of Care Evaluation – A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites

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Center for Evaluating Patient Centered Care in VA
QUERI Partnered Evaluation Initiative

Live Whole Health.

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

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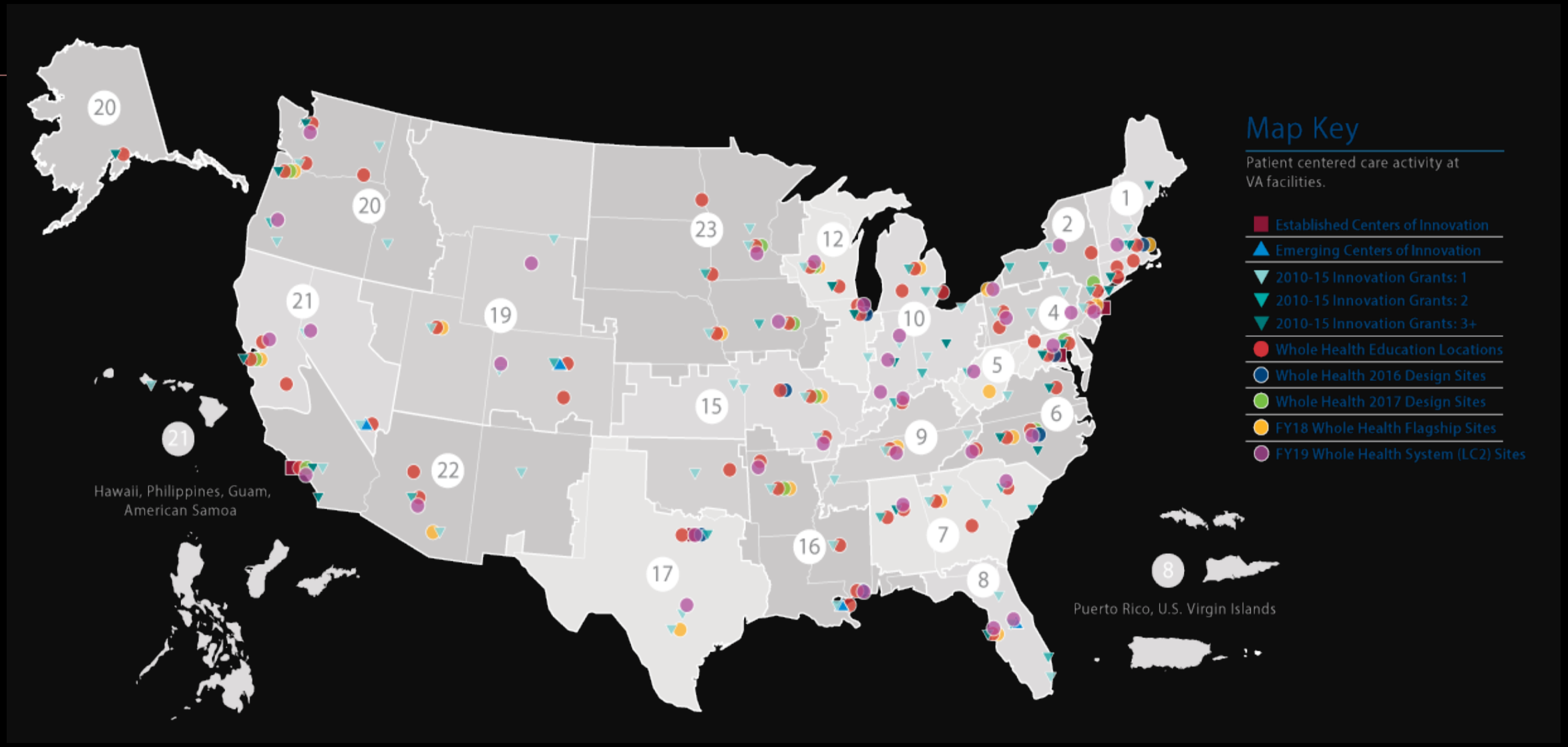
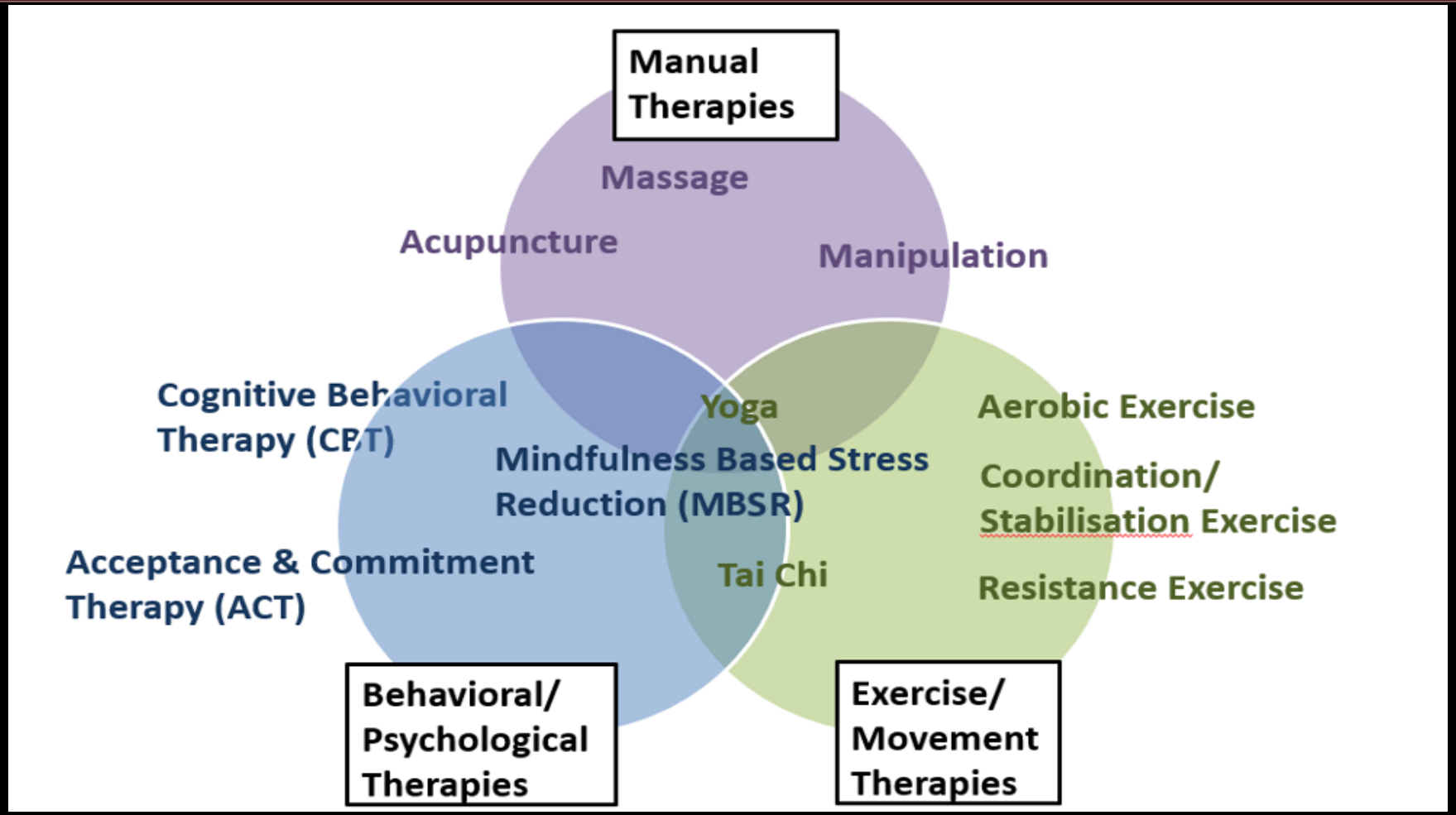
Whole Health Reach To Date



PAINWEEK

Non-Pharmacological Pain Treatments in VHA

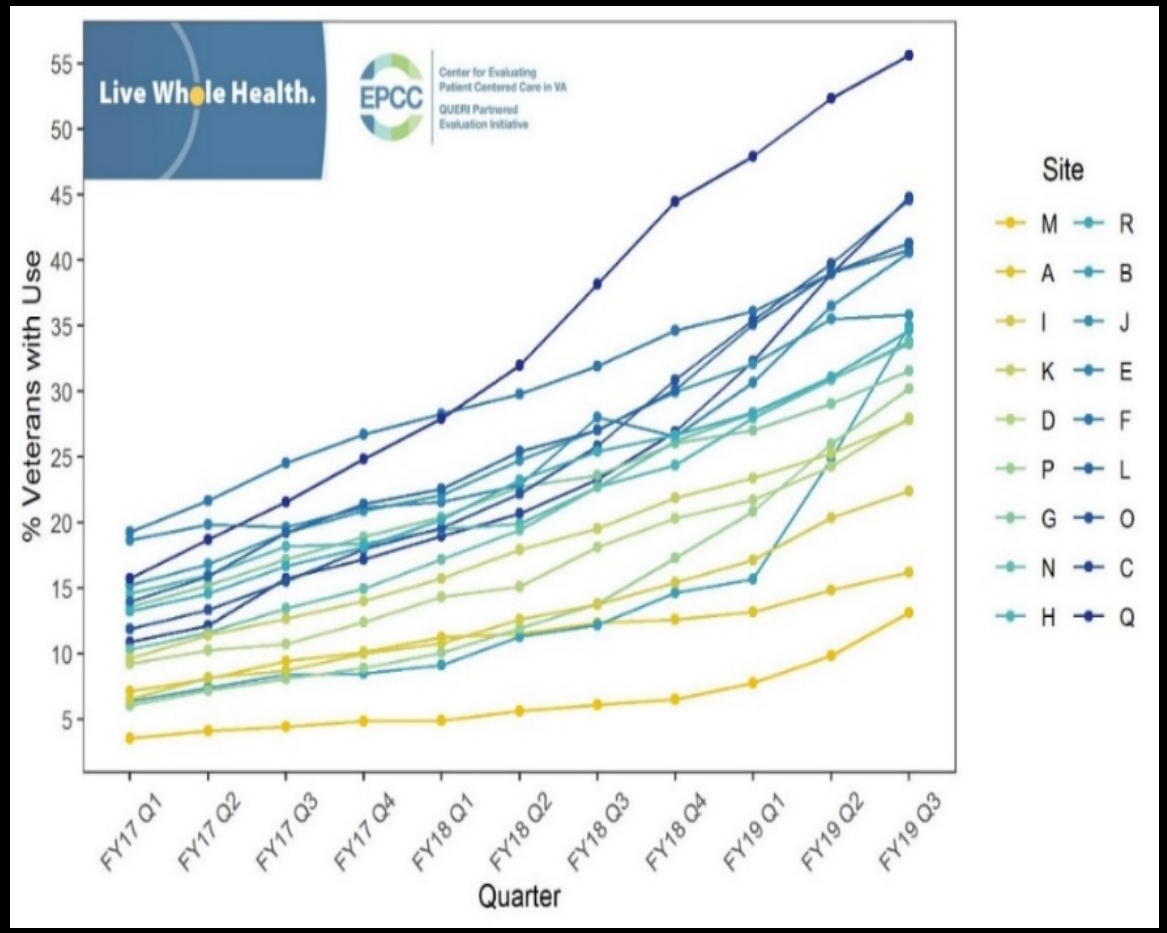


VA State of the Art Conference
Nov. 2016

Non-pharmacological approaches for musculoskeletal pain

Whole Health Service Category	Services included
Complementary and Integrative Health (List 1) **Chiropractic care**	Chiropractic care Massage Whole body acupuncture & Battlefield acupuncture Yoga Tai Chi Meditation Biofeedback Guided Imagery Hypnosis
Core Whole Health	Personal Health Planning Peer-led Whole Health Groups Whole Health Pathway services Whole Health Coaching Whole Health Educational Groups

Utilization: 31% of Veterans with chronic pain engaged in some WH services across the 18 sites (Q3FY19).



Changes in WHS Utilization Among Veterans with Chronic Pain

- At 1 flagship site, engagement = 55%
- Expectation: 44% Veterans with chronic pain will engage in WH services by the end of 2020.
- Increases in utilization since 2017:
  - Veterans with chronic pain: 193%
  - Veterans with MH diagnoses: 211%
  - Veterans with chronic conditions: 272%
- CIH utilization:
  - 26% of Veterans with chronic pain
  - Includes services delivered in the community
  - Increasingly being delivered within VA

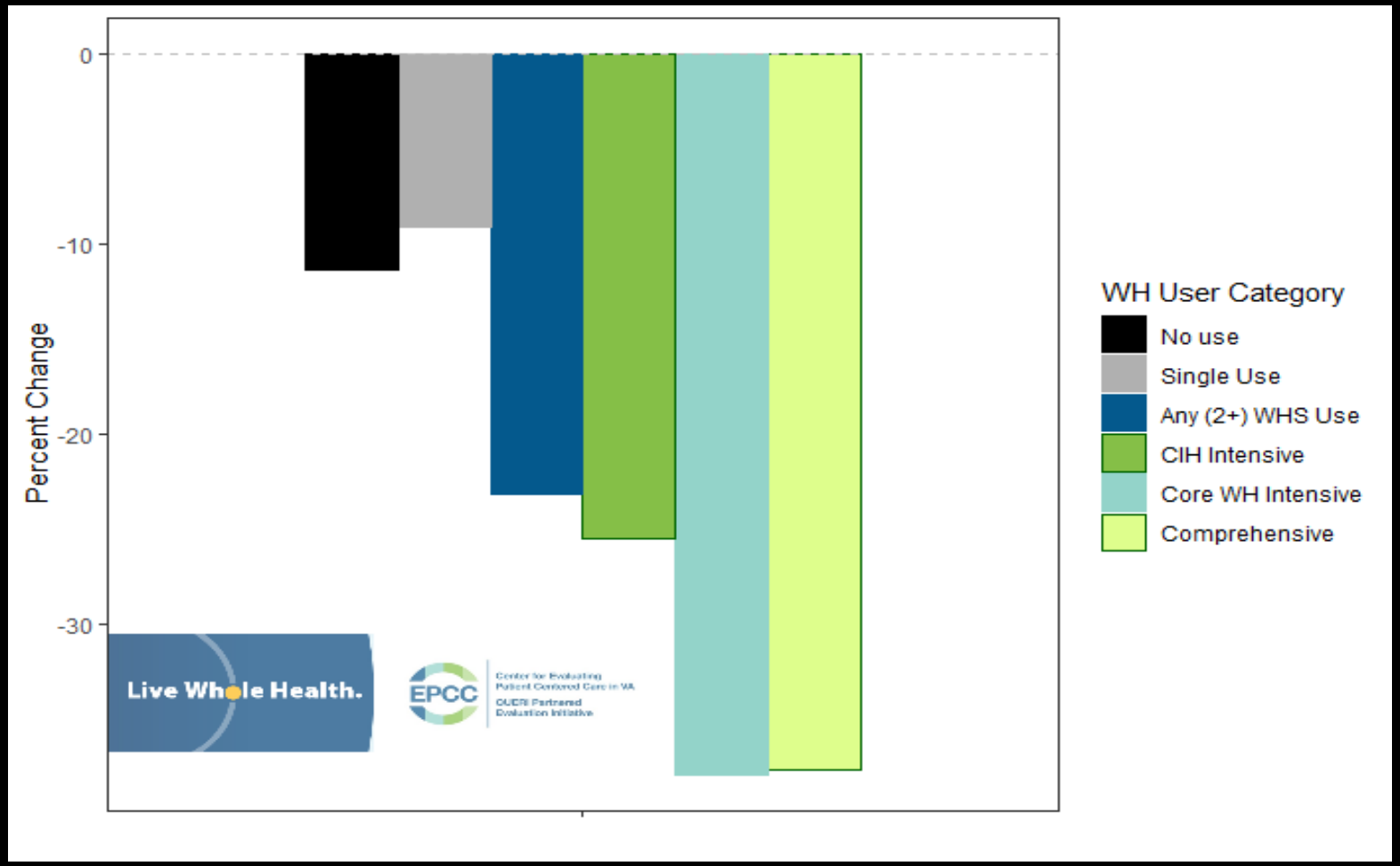
Preliminary Flagship Outcomes: Veteran Impact

- Impact on Veterans
  - Whole Health had a positive impact on reducing opioid use among Veterans.
    - There was a threefold reduction in opioid use among Veterans with chronic pain who used WHS services compared to those who did not.
    - Opioid use among comprehensive WH users decreased 38% compared with an 11% decrease among those with no WH use.

PRELIMINARY FLAGSHIP OUTCOMES: VETERAN IMPACT

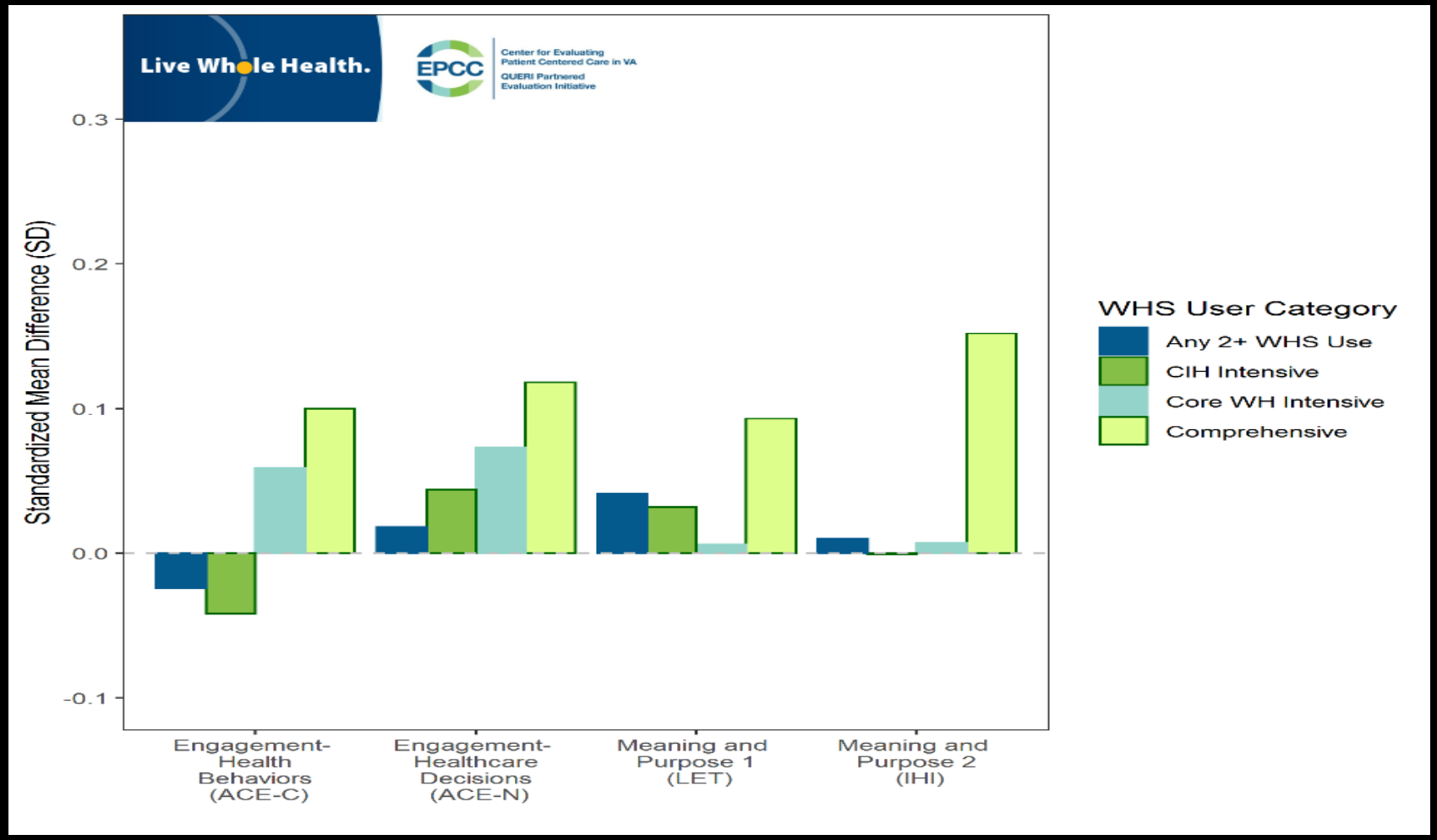
- Compared to Veterans who did not use WH services, Veterans who used WH services reported:
  - –Greater improvements in perceptions of the care received as being more patient-centered.
  - –Greater improvements in engagement in healthcare and self-care.
  - –Greater improvements in engagement in life indicating improvements in mission, aspiration and purpose.
  - –Greater improvements in perceived stress indicating improvements in overall well-being.

PRELIMINARY FLAGSHIP OUTCOMES: OPIOID UTILIZATION

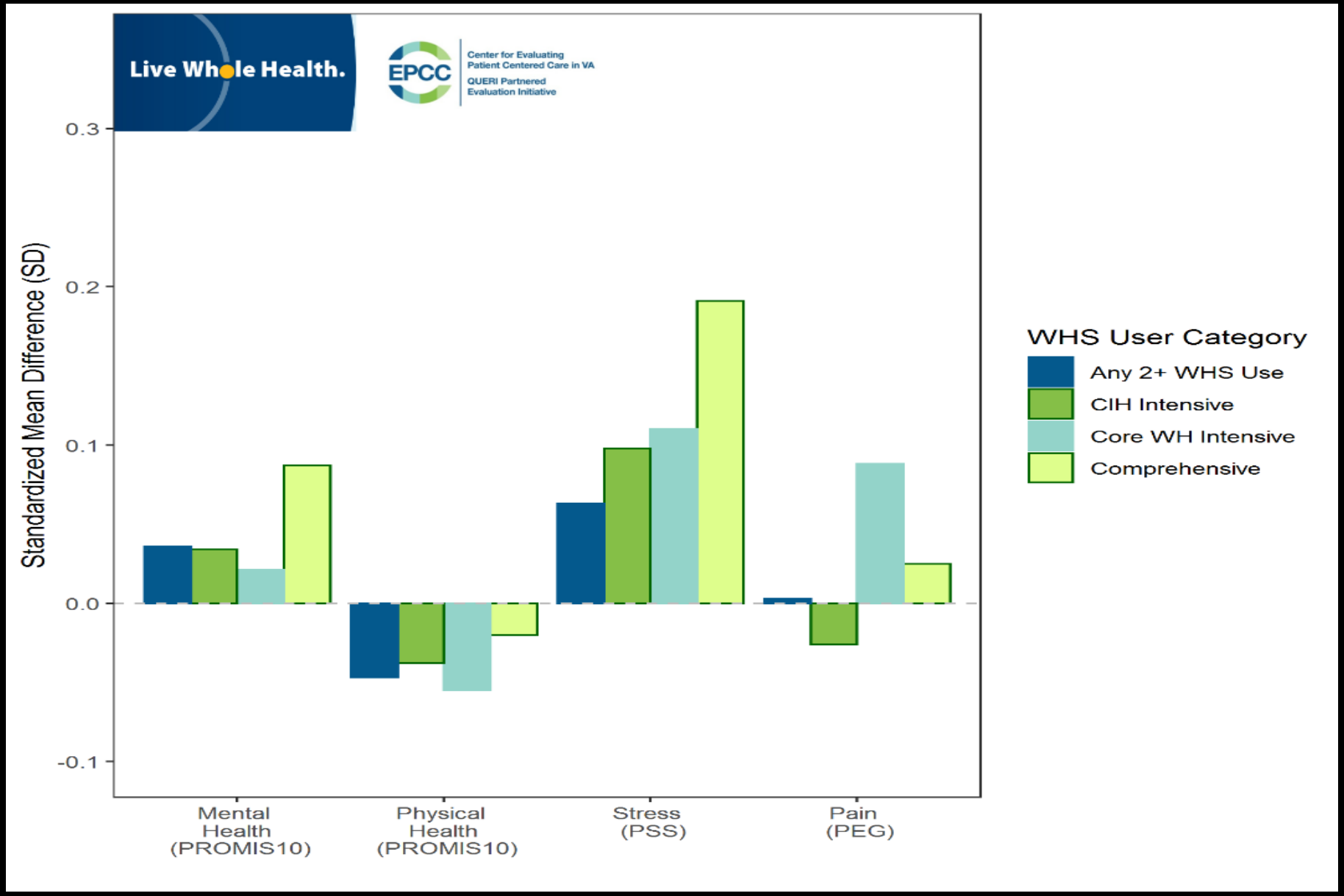


Change in opioid use by WH user category for Veterans with chronic pain (n=114357)

Preliminary Flagship Outcomes: Veteran Engagement



Association between changes in Veteran engagement and meaning and purpose and WHS service use compared to no use group (n=3266).



Association between changes in Veteran well-being and pain, and WHS service use compared to no use group (n=3266). *Note that any negative SD represents a relative change compared to the non-user group. All measures did improve across all groups.*

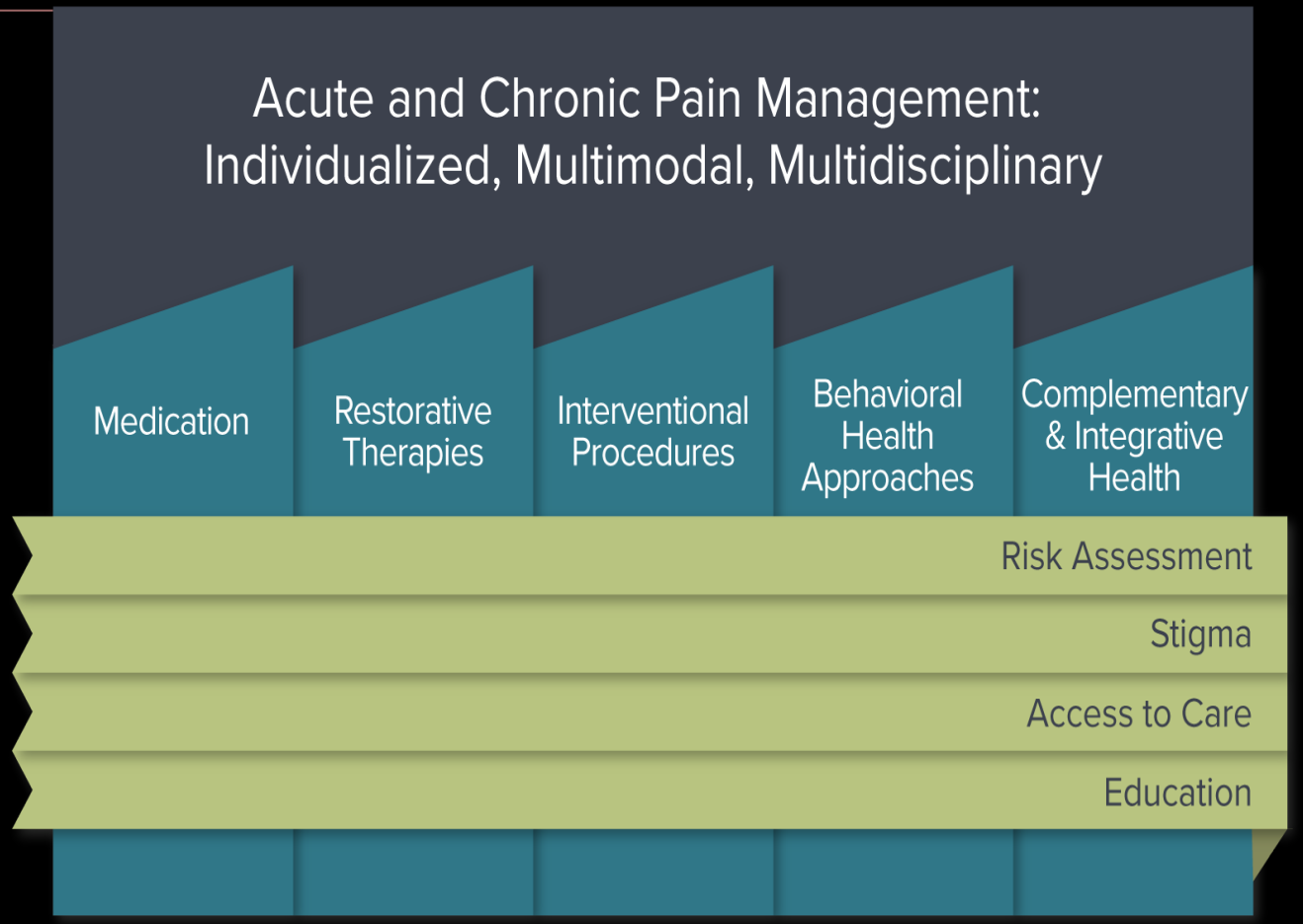
Task Force Report Calls for:
Individualized, multimodal, multidisciplinary approach to pain management

Five major treatment approaches:

- Medication
- Restorative therapies
- Interventional procedures
- Behavioral health
- Complementary and integrative health

Four cross cutting topics need to be addressed to ensure best practices:

- Risk Assessment
- Stigma
- Access to Care
- Education



Taskforce: https://www.hhs.gov/ash/advisory-committees/pain/index.html

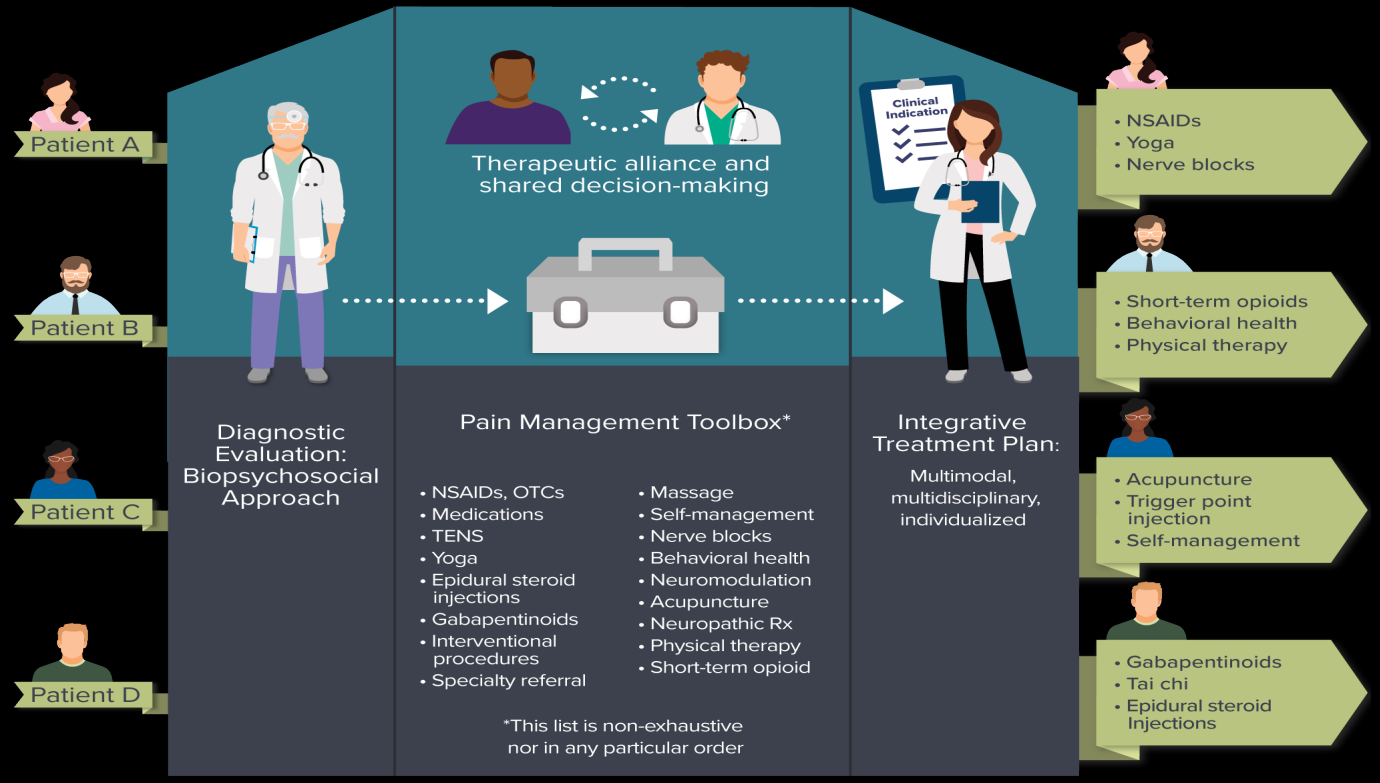
Individualized Patient Care for All Treatment Options

Individualized, patient-centered care best achieved:

- Diagnostic evaluation
- Biopsychosocial approach
- Access to needed treatment approaches

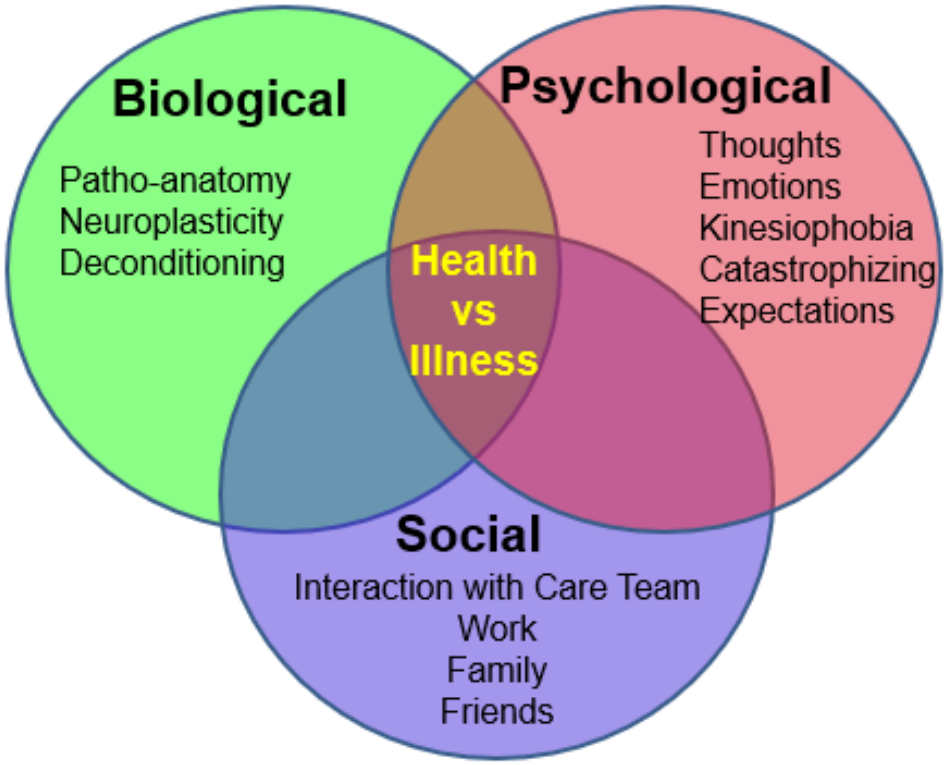
Resulting treatment plan, tailored to the specific needs of individuals requires a strong **patient-clinician relationship**:

- Mutual trust and respect
- Empathy
- Compassion
- Resulting in therapeutic alliance



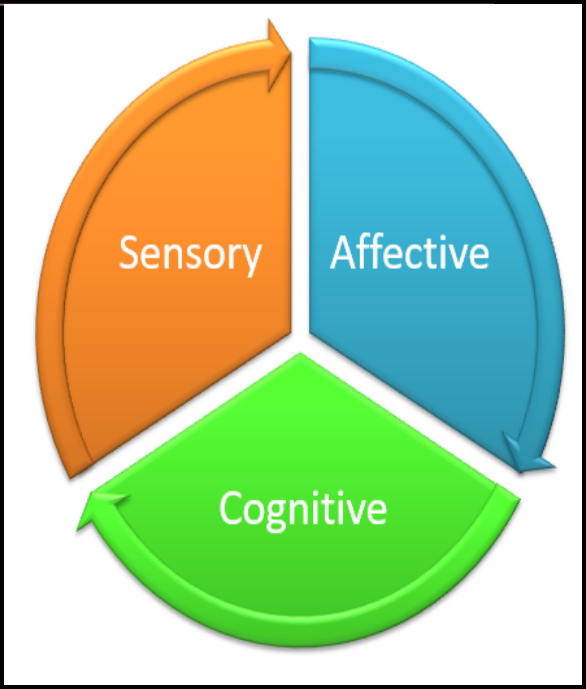
Taskforce: https://www.hhs.gov/ash/advisory-committees/pain/index.html

Bio-Psycho-Social Model of Pain: Multiple Components



As pain becomes persistent, the pain experiences shift:

- **Brain circuits involved in pain processing** become **sensitized**
- **Emotional and cognitive components become more prominent** than sensory/nociceptive circuits



- **Psychological and Social Elements:**
- **Take on a greater role**
  - **S**erving as a vicious cycle and contribute to the persistence of pain

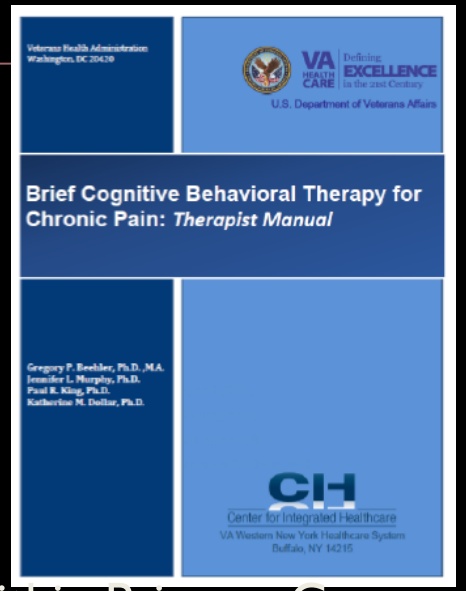
Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)

Full CBT-CP: 12 sessions

1. Interview & Assessment
2. CBT-CP Orientation
3. Assessment Feedback & Goal Planning
4. Exercise & Pacing
5. Relaxation Training
6. Pleasant Activities 1
7. Pleasant Activities 2
8. Cognitive Coping 1
9. Cognitive Coping 2
10. Sleep
11. Discharge Planning
12. Booster (optional).

Brief CBT-CP: 6 Modules

1. Education & Goal Identification
2. Activities & Pacing
3. Relaxation Training
4. Cognitive Coping 1
5. Cognitive Coping 2
6. Pain Action Plan



- Adapted for MH providers embedded within Primary Care
- Brief and time limited: 30 min each for 4-6 appts
- Early detection/prevention of chronification
- Promote self-management, improve self-efficacy
- Reduce functional limitations.

eline: Low Back Pain

- **Chronic low back pain**: Exercise, psychological therapies (primarily cognitive behavioral therapy [CBT]), spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation (MDR).
- **Chronic neck pain**: Exercise, low-level laser, Alexander Technique, acupuncture.
- **Knee osteoarthritis**: Exercise, ultrasound.
- **Hip osteoarthritis**: Exercise, manual therapies.
- **Fibromyalgia**: Exercise, CBT, myofascial release massage, ta chi, qigong, acupuncture, MDR.
- **Chronic tension headache**: Spinal manipulation.

Interventions that improved function and/or pain for at least 1 month.

- **Most effects were small.**
- **Long-term evidence was sparse.**
- There was no evidence suggesting serious harms from any of the interventions studied; data on harms were limited.

Comparative Effectiveness Review Number 209

Effective Health Care Program

Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review

Table 1: Low Back Pain

Interventions that improved function and/or pain for at least 1 month

- Short-Term: 1 to <6 months; Intermediate-Term: ≥6 to <12 months; Long-Term: ≥12 months
- Effect Size: none, slight/small, moderate, or large improvement
- SOE=Strength of Evidence: + = low, ++ = moderate, +++ = high

https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/nonpharma-chronic-pain-cer-209.pdf

Intervention	Function *Short-Term* Effect Size SOE	Function *Intermediate-Term* Effect Size SOE	Function *Long-Term* Effect Size SOE	Pain *Short-Term* Effect Size SOE	Pain *Intermediate-Term* Effect Size SOE	Pain *Long-Term* Effect Size SOE
Exercise	slight +	none +	none +	slight ++	moderate +	moderate +
Psychological Therapies: CBT primarily	slight ++	slight ++	slight ++	slight ++	slight ++	slight ++
Physical Modalities: Ultrasound	insufficient evidence	no evidence	no evidence	none +	no evidence	no evidence
Physical Modalities: Low-Level Laser Therapy	slight +	none +	no evidence	moderate +	none +	no evidence
Manual Therapies: Spinal Manipulation	slight +	slight +	no evidence	none +	slight ++	no evidence
Manual Therapies: Massage	slight ++	none +	no evidence	slight ++	none +	no evidence
Manual Therapies: Traction	none +	no evidence	no evidence	none +	no evidence	no evidence
Mindfulness Practices: MBSR	none +	none +	none +	slight ++	slight +	none +
Mind-Body Practices: Yoga	slight ++	slight +	no evidence	moderate +	moderate ++	no evidence
Acupuncture	slight +	none +	none +	slight ++	none +	slight +
Multidisciplinary Rehabilitation	slight +	slight +	none +	slight ++	slight ++	none +

Stepped Care Model for Pain Management

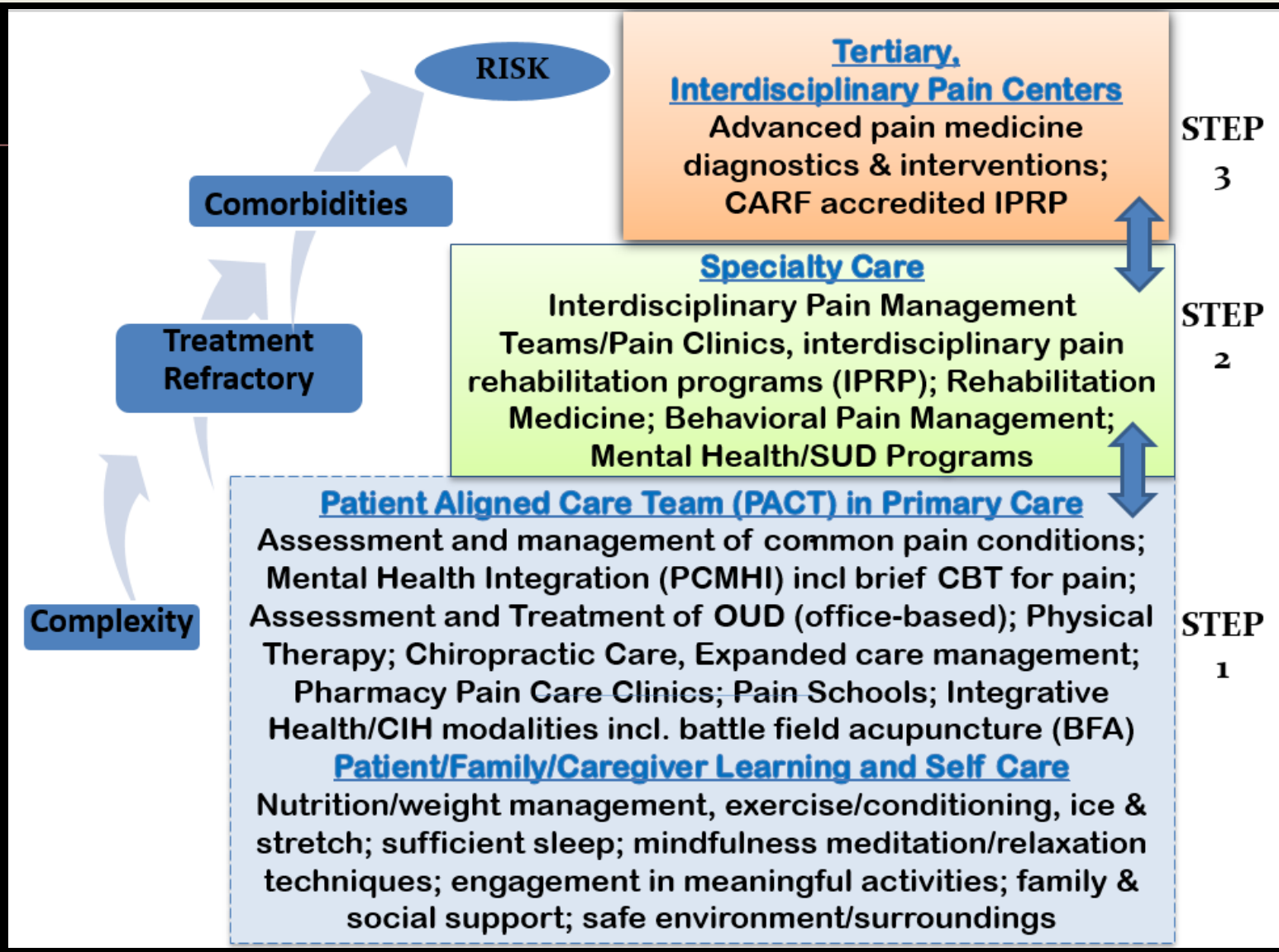
Stepped Care Model for Pain Management (SCM-PM)

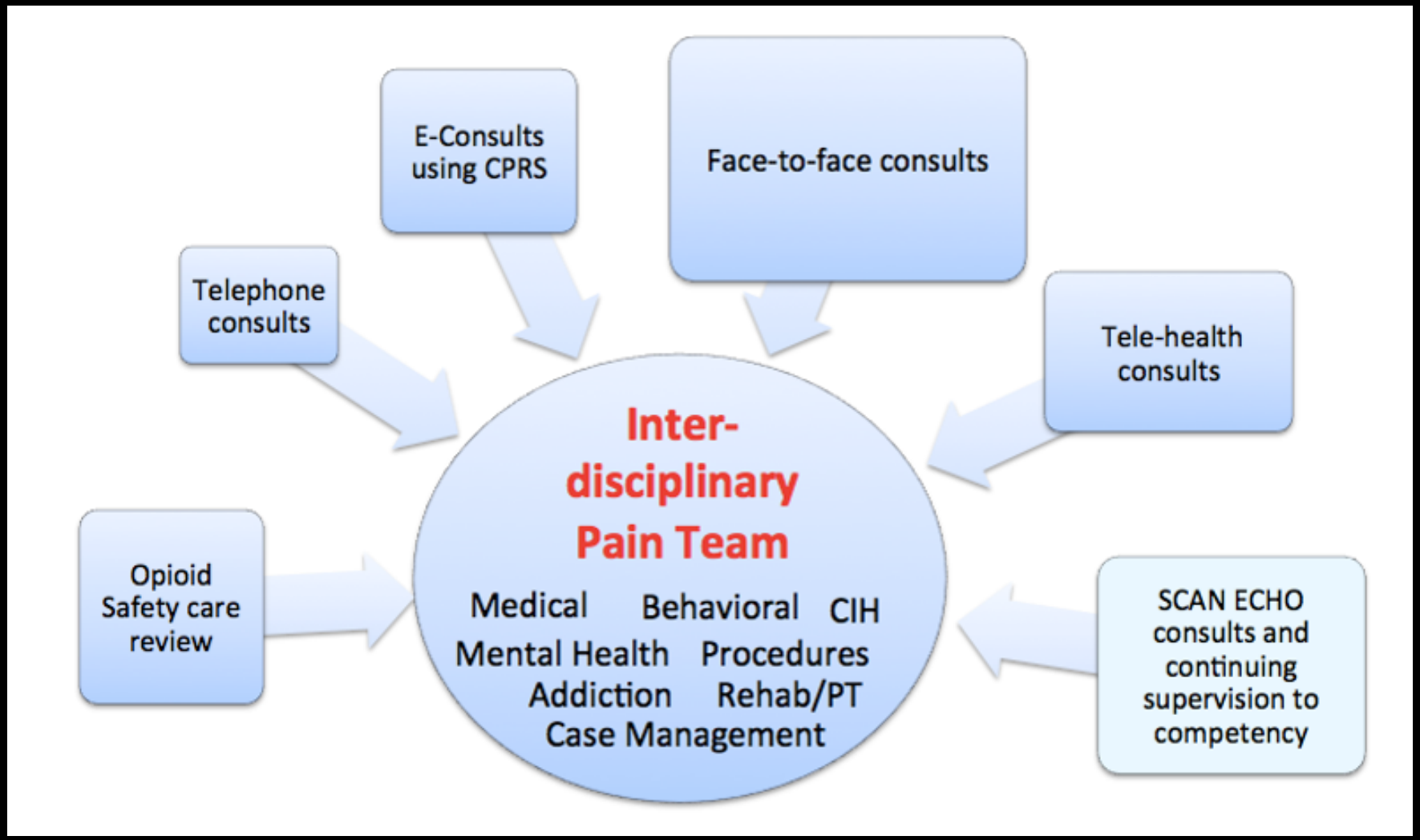
Foundational Step: Self-Care/Self-Management: broad approach.

Primary Care (PACT) = Medical Home

- **Coordinated care and a long-term healing relationship, instead of episodic care based on illness**
- **Primary Care Mental Health Integration (PCMHI) at all facilities**

Specialty Care: Interdisciplinary Pain Management Team/Pain Clinics mandated for all VA facilities

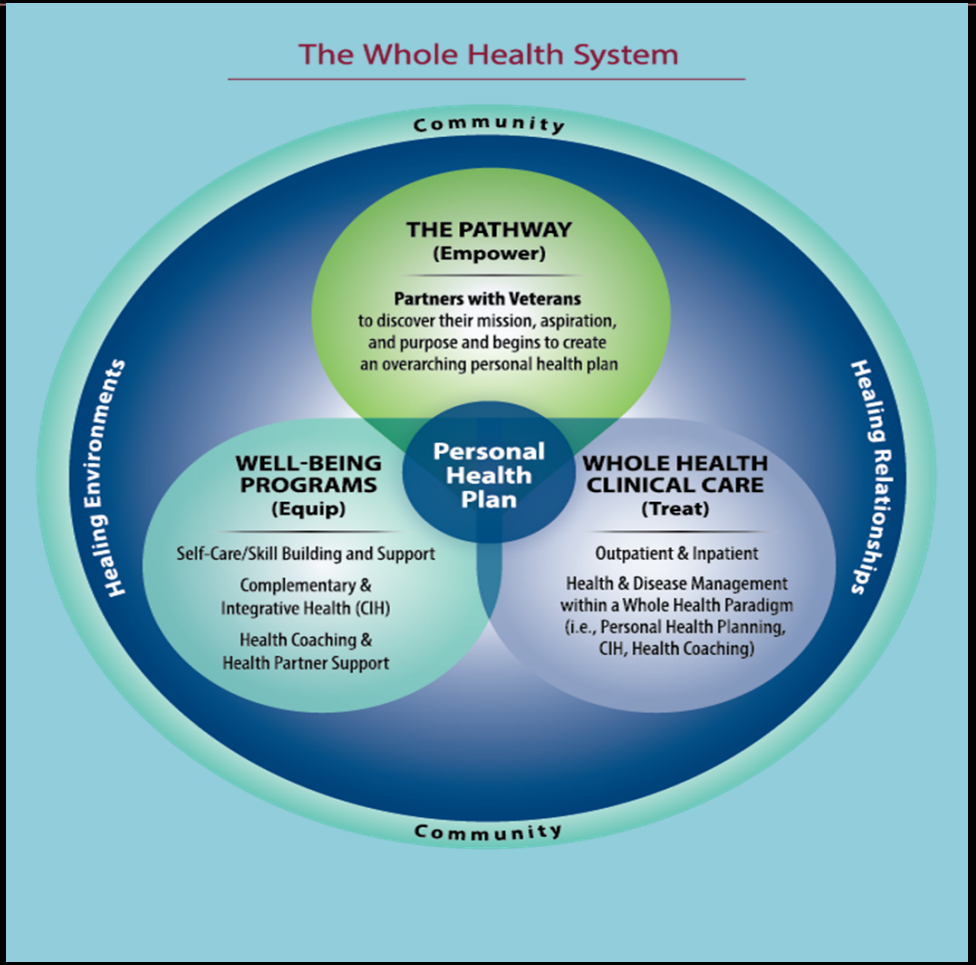



E-Consults using CPRS
Face-to-face consults
Telephone consults
Tele-health consults
Inter-disciplinary Pain Team
Medical
Behavioral
CIH
Mental Health
Procedures
Addiction
Rehab/PT
Case Management
Opioid Safety care review
SCAN ECHO consults and continuing supervision to competency

- Interdisciplinary Pain Rehabilitation Programs (IPRP) with CARF accreditation: 20 programs in VHA.
  - Pain Directive mandates at least one in each VISN
  - Variable structure to accommodate resource availability and Veteran preference
    - Outpatient
      - Least intensive programs: ½-1 day per week for 12-14 weeks
      - Most intensive program: 3 weeks intensive outpatient at Minneapolis with lodging option
    - Inpatient: 3 weeks with opioid tapering at Tampa
- Other IPRPs with variable structure/form
  - Interdisciplinary team, usually pain psychology and rehabilitation providers working together with others
  - Defined program with entry/exit date, often as groups
  - Empower Veterans Program (EVP) (Atlanta)
  - Pain University (Tomah)

VISN	Site
1	Togus, ME
2	Albany, NY; NY Harbor/NYC
4	Pittsburgh, PA
7	Columbia, SC
8	Tampa (inpt & outpt); San Juan, PR
10	Cleveland, OH
12	Chicago, IL
15	St. Louis, MO
16	New Orleans, LA
17	Dallas, TX
19	Denver, CO; Oklahoma City, OK
20	Puget Sound, WA
21	San Francisco, CA
22	Los Angeles, CA; Albuquerque, NM
23	Minneapolis, MN

Outcomes


The Whole Health System
Community
THE PATHWAY
(Empower)
Partners with Veterans
to discover their mission, aspiration,
and purpose and begins to create
an overarching personal health plan
Healing Environments
Healing Relationships
Personal
Health
Plan
WELL-BEING
PROGRAMS
(Equip)
Self-Care/Skill Building and Support
Complementary &
Integrative Health (CIH)
Health Coaching &
Health Partner Support
WHOLE HEALTH
CLINICAL CARE
(Treat)
Outpatient & Inpatient
Health & Disease Management
within a Whole Health Paradigm
(i.e., Personal Health Planning,
CIH, Health Coaching)
Community

Opioid Reduction and Risk Mitigation in VA Primary Care: Outcomes from the Integrated Pain Team Initiative

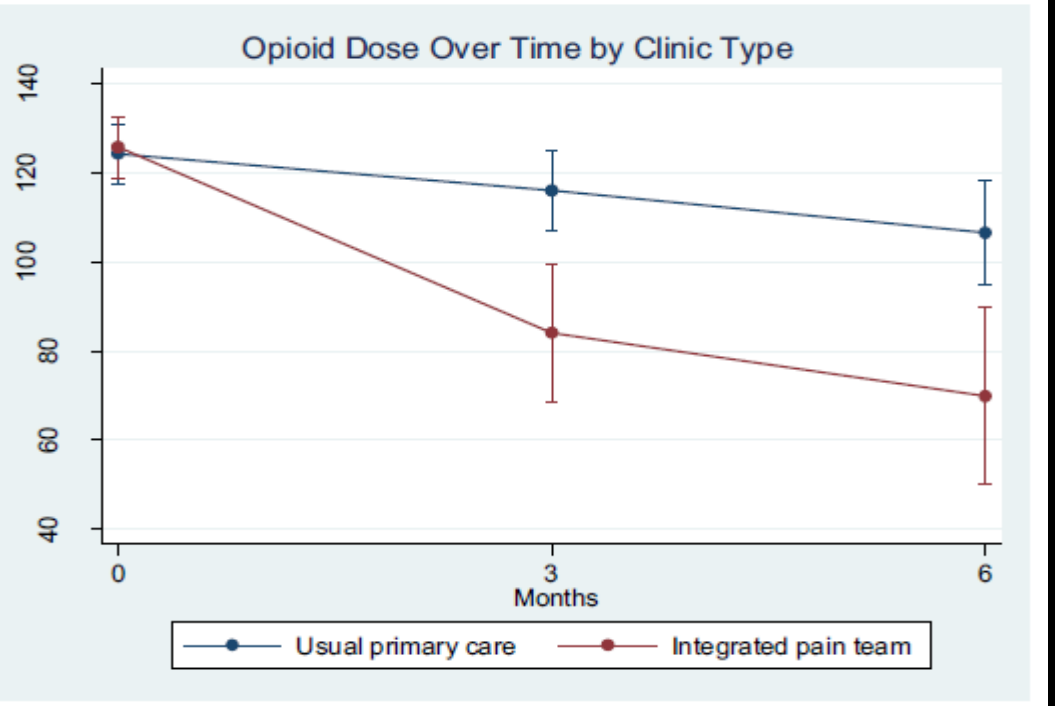
Karen H. Seal, MD, MPH[1,2], Tessa Rife, PharmD, BCGP[1,2], Yongmei Li, PhD[1], Carolyn Gibson, PhD[1,2], and Jennifer Tighe, MSPH[1]

[1]San Francisco Veterans Affairs Health Care System, University of California, San Francisco, San Francisco, CA, USA; [2]Departments of Medicine and Psychiatry, University of California, San Francisco, San Francisco, CA, USA.

Check for updates

Table 2 Unadjusted Change in Mean Opioid Dose in Morphine Equivalent Daily Dose (MEDD in milligrams) at 3 and 6 Months by Clinic Type

	Integrated pain team, *n* = 147	Usual primary care, *n* = 147	*p* value
Baseline dose, mean MEDD (SD)	124.1 (241.1)	124.5 (231.5)	0.37
3-month dose, mean MEDD (SD)	82.5 (157.7)	116.4 (230.0)	0.15
6-month dose, mean MEDD (SD)	68.4 (166.1)	107.1 (223.4)	0.03



AJPM American Journal of Preventive Medicine
A Journal of the American College of Preventive Medicine and Association for Prevention Teaching and Research

Yoga for Military Veterans with Chronic Low Back Pain: A Randomized Clinical Trial

Erik J. Groessl, PhD,[1,2] Lin Liu, PhD,[1,2] Douglas G. Chang, MD,[1,3] Julie L. Wetherell, PhD,[1,4] Jill E. Bormann, PhD, RN,[1,5,6] J. Hamp Atkinson, MD,[1,4] Sunita Baxi, MD,[1,7] Laura Schmalzl, PhD[2,8]

Results: Participant characteristics were mean age 53 years, 26% were female, 35% were unemployed or disabled, and mean back pain duration was 15 years. Improvements in Roland—Morris Disability Questionnaire scores did not differ between the two groups at 12 weeks, but yoga participants had greater reductions in Roland—Morris Disability Questionnaire scores than delayed treatment participants at 6 months −2.48 (95% CI= −4.08, −0.87). Yoga participants improved more on pain intensity at 12 weeks and at 6 months. Opioid medication use declined among all participants, but group differences were not found.

Conclusions: Yoga improved health outcomes among veterans despite evidence they had fewer resources, worse health, and more challenges attending yoga sessions than community samples studied previously. The magnitude of pain intensity decline was small, but occurred in the context of reduced opioid use. The findings support wider implementation of yoga programs for veterans.

JAMA Internal Medicine | Original Investigation

Interactive Voice Response–Based Self-management for Chronic Back Pain
The COPES Noninferiority Randomized Trial

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RESULTS Of the 125 patients (97 men, 28 women; mean [SD] age, 57.9 [11.6] years), the adjusted average reduction in NRS with IVR-CBT (−0.77) was similar to in-person CBT (−0.84), with the 95% CI for the difference between groups (−0.67 to 0.80) falling below the prespecified noninferiority margin of 1 indicating IVR-CBT is noninferior. Fifty-four patients randomized to IVR-CBT and 50 randomized to in-person CBT were included in the analysis of the primary outcome. Statistically significant improvements in physical functioning, sleep quality, and physical quality of life at 3 months relative to baseline occurred in both treatments, with no advantage for either treatment. Treatment dropout was lower in IVR-CBT with patients completing on average 2.3 (95% CI, 1.0-3.6) more sessions.

CONCLUSIONS AND RELEVANCE IVR-CBT is a low-burden alternative that can increase access to CBT for chronic pain and shows promise as a nonpharmacologic treatment option for chronic pain, with outcomes that are not inferior to in-person CBT.

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PAINWEEK®

Effects of 12 Weeks of Chiropractic Care on Central Integration of Dual Somatosensory Input in Chronic Pain Patients: A Preliminary Study

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Results: A significant decrease in the median and ulnar to median plus ulnar ratio and the median and ulnar amplitude for the cortical P22-N30 SEP component was observed after 12 weeks of chiropractic care, with no changes after the control period. There was a significant decrease in visual analog scale scores (both for current pain and for pain last week).

Conclusion: The dual SEP ratio technique appears to be sensitive enough to measure changes in cortical intrinsic inhibitory interactions in patients with chronic neck pain. The observations in 6 subjects revealed that 12 weeks of chiropractic care improved suppression of SEPs evoked by dual upper limb nerve stimulation at the level of the motor cortex, premotor areas, and/or subcortical areas such as basal ganglia and/or thalamus. It is possible that these findings explain one of the mechanisms by which chiropractic care improves function and reduces pain for chronic pain patients. (J Manipulative Physiol Ther 2017;40:127-138)

Evidence-based Treatments via Telehealth

- Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
  - Easily delivered via virtual platform
  - Self-managed skills even more important during COVID
    - Use of relaxation for muscle tension, stress, sleep, apps to assist
    - Pleasant activities, use of technology for access
    - Thoughts, uncertainty, anxiety management
    - Impacts on sleep, schedules
  - Positive feedback from patients

Challenges

- Discourage avoidance
- Boundaries remain important, must be explicitly set
- Use of measures

Evidence-based Treatments via Telehealth

- Interdisciplinary pain rehabilitation programs
  - Various programs across the country have shifted to virtual care
  - Continuum of care from less intensive to prehab to more comprehensive
  - Offering various modalities such as:
    - Psychology, PT, OT, Yoga, Tai Chi, Medical, Recreation therapy, and more
  - May actually increase access to this important treatment

Challenges

- Logistics can be difficult 2/2 numerous disciplines
- Use of Measures
- Boundaries remain important, must be explicitly set

Pain-Focused Self-Management Resources

SUGGESTED RESOURCES

WEBSITES

- **National VA Pain Management**
  - https://www.va.gov/painmanagement/
    Wealth of VA-specific information including pages devoted to information about cognitive behavioral therapy for chronic pain (CBT-CP)
- **Treatment Works for Vets**
  - https://www.treatmentworksforvets.org/proven-treatment-for-chronic-pain/
    User-friendly, patient-centered explanation about CBT-CP that includes videos, flip books, and other practical treatment information
- **American Chronic Pain Association (ACPA)**
  - http://theacpa.org
    Dedicated to peer support and education for individuals with chronic pain and their families; includes free tools and local support group info

FREE APPS

Breathe2Relax

- Breathing tool that monitors breath and assists with relaxation

iBreathe

- Simple guided breathing guide that is easy to use and understand

Virtual Hope Box

- Excellent all-in-one resource for relaxation, distraction, and quotes

Mindfulness Coach

- Assists with noticing and paying attention to present moment

ACT Coach

- Offers guide for using Acceptance and Commitment Therapy (ACT) to help

Why It Matters

Whole Health began my journey to joy, I am a changed person. I no longer need my cane. The Whole Health group has become my family. My neurologist says he doesn't need to see me anymore!"

., 52 year old Male

"I have lost 33 pounds. I go to FIT class, nutrition class, Battle-field acupuncture, and regular acupuncture. My wife says I have a positive attitude now! And my diabetes is under control, blood pressure down and lipids good. I see my primary care doctor much less"

., 71 year old Male

I used to drive over the Mississippi River Bridge, to Jefferson Barracks VA, and think about jumping every time. The whole health system has helped me explore my purpose, find ways to use nutrition to reduce my pain, and use iRest and Tai Chi to get moving again. Now I drive over that bridge and think about tomorrow…. I have hope"

K. H., 37 year old Female

Thank You

THANKS TO:

- VA, VISN and Facility leadership
- VISN POCs and all facility POCs for PAIN
- OSI POCs and the OSI review committees
- Pain research community
- Pain Medicine Specialty Teams
- Pain Psychologists
- PACT Pain Champions, Primary Care
- PBM/Pharmacy
- Academic Detailing
- Mental Health
- Suicide Prevention
- Addiction Medicine
- Nursing Service
- Rehabilitation Medicine
- Integrative Health, IHCC and OPCC
- EES, Ethics
- Connected Care/Telehealth
- Patient Advocacy
- DoD partners/colleagues
- Patient Advocacy
- Community Care Program and providers
- **The Veterans and their families**

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www.va.gov/painmanagement