Starting a Primary Care Pain Management Clinic in a Military Treatment Facility

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Pain is an ever-present challenge in military medicine. Our war-fighter is a high intensity professional. Through multiple trainings and deployments, they push their bodies, which can lead to injury, trauma, and chronic pain.[1,2] Opioid use for chronic non-malignant pain among U.S. patients is rising.[3,4] Recent estimates show that 3% of the population use opioids 30 days or more.[3,5] Among U.S. military soldiers, studies suggests an even higher prevalence, with 4.5% opioid prevalence in young veterans.[6,7] A recent Department of Defense survey showed that one-fourth of active duty soldiers reported abusing prescribed drugs over a 12-month period and an increase of 4 times the amount of prescription pain medications written by military physicians over the last 7 years.[8] These are alarming figures. Our soldiers are highly skilled professionals, but their skills can become dulled and their decision making compromised when using opioids.[9] A reliable pain-management physician is needed to help guide and educate these soldiers and their family members for their best care.

As the U.S. military is spread worldwide, we often do not have access to specialists who are utilized at large medical centers. As a result, primary care physicians often take on expanded roles at their military treatment facilities (MTF). To meet the increased need for the treatment of chronic pain, the Army has called for establishing a pain management clinic within primary care in the Pain Management Task Force report by the Office of the Army Surgeon General.[10]

I was tasked with starting our Primary Care Pain Management Clinic (PCPMC) at my MTF. My MTF provides primary care services to approximately 7,500 beneficiaries. I have a primary care patient panel of 950 patients and see about 300 to 325 patients per month. The PCPMC sees about 70 chronic pain patients per month, which includes approximately 25 to 30 continuous sole provider patients on chronic daily opioids. The vast majority of pain complaints are musculoskeletal, with back pain (44%) being the most predominate followed by knee pain (15%) and shoulder pain (11%).

The start of the PCPMC was hectic. Questions and patient encounters were coming from multiple angles, including calls, emails, front desk, and walk-ins. To assist me with the PCPMC and to manage my patients, we implemented a Team Care approach to include a strong dedicated pain clinic medic and a front desk clerk. The Team-based care allows me to maintain good therapeutic boundaries and to utilize my time efficiently.[11–13] My hardworking medic became proficient in the use of AHLTA (U.S. military electronic medical record) templates and software programs AsUType macros (Fanix Software, Brisbane, Australia) and Dragon Naturally Speaking dictation (Nuance Communications, Burlington, MA). I trained her on chronic pain history taking, pain medications, and some minimally invasive procedures which she could identify and set up quickly. The medic also coordinates with our front desk clerk for follow-up appointments and telephone consults. Team-based care has improved access to care and time efficiency, but access still remains an ongoing challenge.

For the active duty soldier, chronic pain often means multiple consults and visits to many different providers. To provide continuity and maintain communication between clinics, we have multidisciplinary team meetings that include Pharmacy, Psychiatry, Social work, Surgery Department, the Warrior Transition Battalion team, and Command representation, which meet monthly to discuss potential and current chronic pain patients. I also work closely with our Wellness Center and Medical Evaluation Board team. This parallels the new initiative in the Army, The Patient Centered Medical Home, which focuses on patient-centered care and biopsychosocial treatment of disease, utilizing an interdisciplinary team for health treatment.[14,15] A PCPMC could be an integral part of the Patient Centered Medical Home.

In general, a PCPMC provides an excellent opportunity for the patient to have outstanding continuity of care for their chronic pain and other medical needs. However, burnout for the provider may be an issue. Medication management of chronic pain is often a shared mission among many primary care providers, with each taking on a small number of sole provider patients or multiple providers in an interventional pain clinic. A PCPMC enlists 1 provider to manage all the patients in the MTF. Chronic pain can be difficult patient care. The Team Care approach with a strong medic, a multidisciplinary team, sole provider contracts, positive Command support, and practice guidelines helps make difficult patient care easier.[16–20]

Strengths of primary care such as continuity, strong patient–provider relationships, and holistic care can augment a pain management clinic. A primary care relationship can enhance patient education, understanding of treatment goals, and encourage compliance through a strong therapeutic relationship.[21] A PCPMC offers treatment of all family members, some of whom may also have chronic nonmalignant pain. Of my current 25 sole provider patients, 8 are couples

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who take daily opioids. My familiarity of all treatment plans within a family can help counsel and prevent against active diversion.

As a Family Medicine–trained physician, my training in pain management was general and brief. I was fortunate to get further training in pain management once tasked with the PCPMC. I spent 2 weeks in a Multidisciplinary Interventional Pain Clinic on temporary duty assignment seeing chronic pain patients and observing procedures. Although brief, the training gave me an overview of managing chronic pain. Because a primary care provider's training can be so varied, pointed training is essential once tasked with the job of being the primary care pain management provider. The training could include 1 to 2 weeks each in a Multidisciplinary Interventional Pain Clinic, Orthopedic clinic/Neurosurgery clinic, and Psychiatric pain clinic and training in specific procedures such as intra-articular steroid injections, acupuncture, and trigger point injections.

Future challenges in the PCPMC include how to measure success of treatment outcomes and pain relief and preventing and identifying abuse. As always in the military, maintaining new practice procedures such as a PCPMC, despite permanent change of station and deployments, will continue to be a challenge.

In summary, a strong PCPMC team utilizing the Team Care approach is invaluable to enable therapeutic boundaries and therapeutic goals and to prevent burn-out. The Patient Centered Medical Home has the potential to further strengthen treatment success for chronic pain patients. Further training for primary care pain management providers is essential to enhance their skills. It is vital that we manage our war-fighters and their dependents with chronic pain safely, effectively, and compassionately to sustain the mission and preserve strong moral at home. This can be accomplished through a PCPMC.

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