Defense Health Agency
PROCEDURAL INSTRUCTION

NUMBER 6025.04
June 8, 2018

DHA/Healthcare Operations

SUBJECT: Pain Management and Opioid Safety in the Military Health System (MHS)

References: See Enclosure 1.

1. BACKGROUND. Pain Management is a Clinical Support Service in the MHS Operating Model (Enclosure 4, Figures 1 and 2). The purpose of the MHS Operating Model is to enable front line clinicians to drive Enterprise-wide performance improvements in readiness and health; empower Enterprise-level Clinical Communities to create conditions for high reliability at the point of care (processes, standards, and metrics); and hold ourselves accountable to MHS standards and clinical outcomes. The Pain Management Clinical Support Service:

a. Is composed of the Service Pain Management Programs and Consultants, representation from Defense and Veterans Center for Integrative Pain Management, Center for Clinical Laboratory Medicine, Defense Health Agency (DHA) Pharmacy Operations Division (POD), DHA Healthcare Operations, TRICARE Health Plan, and others as invited.

b. Supports the Clinical Communities, as needed, in coordination with the Clinical Community Advisory Council.

Starting January 1, 2018, The Joint Commission (TJC) will enforce new pain assessment and management standards at accredited hospitals according to Reference (d). Requirements include the presence of leadership regarding pain management and safe opioid prescribing, provision of non-pharmacologic pain treatments, and monitoring of opioid use to maximize patient safety. The MHS Stepped Care Model has been affirmed by TJC leadership as a potential best practice for implementing these standards.

2. PURPOSE. The purpose of our MHS Pain Management Campaign is to enable Clinical Communities to provide evidence-based pain management guided by clinical practice guidelines (CPGs): effectively treat acute and chronic pain; promote non-pharmacologic treatment; prevent acute pain from becoming chronic; and minimize use of opioids with appropriate prescribing only when indicated.

The Pain Management Clinical Support Service achieves these ends through clinical improvements in pain care, clinician and patient education, and research. This Defense Health Agency-Procedural Instruction (DHA-PI) is a dual effort between the Pain Management Clinical Support Service and the Clinical Communities to achieve our stated purpose through implementation of the MHS Stepped Care Model.

This DHA-PI, based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (m), establishes the DHA procedures to:

a. Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for the MHS to provide consistent, quality, and safe care for patients with pain with an emphasis on non-pharmacologic treatments.

b. Educate patients in effective self-management of pain and injury rehabilitation.

c. Educate clinicians regarding effective pain management and optimal opioid safety consistent with Department of Veterans Affairs-Department of Defense (VA-DoD) and Centers for Disease Control and Prevention (CDC) CPGs.

d. Provide tools, including through MHS GENESIS and legacy Electronic Health Records (EHRs) to assist clinicians in evidence-based and patient-centered pain management.

e. Conduct pain research to continuously improve our approach to pain management.

3. APPLICABILITY. This DHA-PI applies to Defense Health Program-funded DoD Military Treatment Facilities (MTFs), and DoD health care practitioners who are involved in the delivery of health care services to eligible beneficiaries and all other organizational entities within the DoD (referred to collectively in this DHA-PI as the "DoD Components").

4. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (d) through (g), that the Services shall implement this DHA-PI to:

a. Standardize the MHS comprehensive approach to pain management required by Reference (e).

b. Comply with Reference (f) and the direction to use "all lawful means" to act against the opioid crisis by following VA-DoD and CDC clinical practice guidance regarding opioid safety (References (g) and (h)). More detailed instructions on implementation will be published in a subsequent DHA-Procedures Manual.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3.

7. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the DHA SharePoint site at: http://www.health.mil/dhapublications.

8. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with DHA-PI 5025.01 (Reference (c)).

FOR R. C. BONO
VADM, MC, USN
Director

Enclosures
1. References
2. Responsibilities
3. Procedures
4. Military Health System Operating Model (Figures 1 and 2)
5. Military Health System Stepped Care Model (Figure 3)
6. Primary Care Pain Champion Roles and Responsibilities

Glossary

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015
(d) R^3 Report (from The Joint Commission), "Pain assessment and management standards for hospitals," August 29, 2017
(e) Public Law 111-84, Section 711, National Defense Authorization Act for Fiscal Year 2010, October 28, 2009
(f) Presidential Memorandum, "Combatting the National Drug Demand and Opioid Crisis," October 26, 2017
(g) Department of Veterans Affairs-Department of Defense Clinical Practice Guidance for Opioid Therapy for Chronic Pain, February 2017
(h) Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, March 18, 2016
(i) Health Affairs Policy 11-003, "Policy for Comprehensive Pain Management," March 30, 2011
(j) Interagency Guideline on Prescribing Opioids for Pain, Washington State Medical Directors' Group (AMDG), June 2015
(k) Office of the Surgeon General Pain Management Task Force Final Report, May 2010
(l) Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use," October 21, 2015
(m) DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, will:

a. Monitor implementation of this DHA-PI to achieve the stated purpose.

b. Coordinate with the Surgeons General (SGs) of the Military Departments (MILDEPs) to implement guidance in this DHA-PI.

c. Ensure systems and tools (e.g., MHS Controlled Substance Prescriber Profile (CSPP) or Opioid Registry) are in place to collect data and measure compliance with this DHA-PI to achieve the stated purpose.

d. Ensure MHS GENESIS incorporates Defense and Veterans Pain Rating Scale (DVPRS) and Pain Assessment Screening Tool and Outcomes Registry (PASTOR) as pain measurement and outcomes tools. Ensure MHS GENESIS provides alerts and other clinical support tools to assist clinical personnel in evidence-based pain management and safe opioid prescribing.

e. Provide virtual Opioid Prescriber Safety Training (OPST) and other designated trainings regarding opioid prescribing and patient education on opioid risks.

f. Provide standardized informed consent form and educational materials for use by MTFs.

g. Provide training for designated health care providers in use of medication-assisted treatment (MAT) that complies with Federal, State, and Local laws.

h. Deliver laboratory support to assure urine drug testing for screening and confirmation of controlled or illicit substances for those on long-term opioid therapy (LOT) or other patients at risk for opioid use disorder to maximize patient safety.

2. SGs of the MILDEPs. The SGs of the MILDEPs will:

a. Ensure MTF Commanders and Directors implement the developed procedures for Clinical Operations (see Enclosure 3).

b. Provide pain management and pharmacy subject matter expertise to the Director, DHA.

3. REGIONAL COMMANDERS/DIRECTORS. The Regional Commanders/Directors will:

a. Provide oversight and accountability for MTFs regarding pain management and opioid safety metrics.

b. Provide information collected from MTFs to DHA as detailed in Enclosure 3.

4. ENTERPRISE SOLUTIONS BOARD (ESB). The ESB will:

a. Oversee and synchronize the Clinical Communities and Pain Management Clinical Support Service as they implement the developed procedures in Enclosure 3 for Clinical Operations (see Enclosure 4).

b. Recommend resource prioritization, and monitor clinical improvement efforts related to this DHA-PI.

5. CLINICAL COMMUNITIES. The Clinical Communities (Enclosure 4, Figure 2) will:

a. Drive clinical improvements in pain management through implementation of the MHS Stepped Care Model.

b. Eliminate preventable harm from opioid use in the MHS in partnership with the Pain Management Clinical Support Service and Pharmacy Operations Division.

c. Reduce unwarranted variation in pain management services in partnership with the Pain Management Clinical Support Service.

6. PAIN MANAGEMENT CLINICAL SUPPORT SERVICE. The Pain Management Clinical Support Service will:

a. Develop and improve MHS Stepped Care Model training (Enclosure 5) that promotes consistent, high quality, safe, and patient-centered care for patients with pain and minimizes opioid use.

b. Develop and/or promote patient education resources pertaining to effective self-management of pain and injury rehabilitation.

c. Support the Clinical Communities in implementation of the MHS Stepped Care Model.

d. Inform Service SGs regarding implementation of the MHS Stepped Care Model.

e. Recommend standardized pain management processes and metrics to support quality improvement.

f. Recommend standardized opioid prescribing tools and metrics using the MHS CSPP and Opioid Registry to support continuous quality improvement.

g. Provide subject matter expertise informing OPST, other designated opioid prescribing training, and patient education regarding opioids with best evidence.

h. Provide subject matter expertise in pain management and opioid safety to all relevant DHA work groups.

i. Promote telehealth modalities to assist in pain management and opioid safety, including the MHS Extension for Community Healthcare Outcomes (Project ECHO^{R}).

j. Assist Purchased Care Office with development of plans to improve opioid prescribing practices in purchased care.

7. PHARMACY OPERATIONS DIVISION (POD). POD will:

a. Enable MAT and opioid antagonist reversal capability (i.e., naloxone) at MTFs and in purchased care.

b. Inform Pain Management Clinical Support Service and ESB regarding opioid prescribing using the MHS Opioid Registry and CSPP in order to aid clinical improvement.

c. Inform MTF Commanders and Directors through Regional Commanders/Directors regarding prescribers who may fall outside VA-DoD and CDC opioid prescribing clinical practice guidance using the MHS CSPP.

d. Inform Service SGs regarding opioid safety initiatives implemented in Enclosure 3.

e. Notify Managed Care Support Contractors (MCSCs) (via TRICARE Health Plan) of adverse prescribing trends among purchased care providers.

f. Provide solutions allowing MTF providers and pharmacies to use Prescription Drug Monitoring Program (PDMP) websites to monitor patients' opioid therapy and improve patient safety.

g. Provide solutions allowing civilian providers and pharmacies to use PDMP websites to monitor TRICARE beneficiaries' opioid therapy and improve patient safety.

h. Support availability of drug take-back services at MTFs.

8. PURCHASED CARE OFFICE. Purchased Care Office will:

a. Work with Managed Care Support Contractors (MCSCs) and U.S. Family Health Plan/Designated Providers (USFHP/DPs) to develop strategies to reduce inappropriate opiate use and encourage use of alternate pain management strategies.

b. Develop value-based pilots, as appropriate, to incentivize both providers and beneficiaries to use alternate pain management strategies and minimize opiate use.

c. Identify, in conjunction with POD and MCSCs and USFHP/DPs, purchased care beneficiaries with potentially excessive opiate use and refer them to appropriate programs.

d. Refer purchased care providers with evidence of inappropriate opiate prescribing practices to MCSCs/USFHP/DPs.

9. MTF COMMANDERS AND DIRECTORS. MTF Commanders and Directors will:

a. Assure personnel are trained as described in Enclosure 3, and report compliance to their respective Regional Commanders/Directors.

b. Implement the MHS Stepped Care Model as described in Enclosure 3. Appoint a Primary Care Pain Champion (PCPC) as a liaison to Service Pain Management leadership and as a facilitator for this transformation.

c. Promote MTF providers' understanding of what non-pharmacologic pain treatment modalities are available locally.

d. Assure that MTF providers and pharmacies make MAT available as clinically appropriate and required in Enclosure 3. Assure that MTF providers and pharmacies make available opioid antagonists (i.e., naloxone), as clinically appropriate.

e. Provide feedback from the MHS CSPP, as deemed appropriate, to MTF providers whose opioid prescribing practices appear to be outside VA-DoD and CDC CPGs as a routine mechanism of peer review processes.

f. Report information regarding pain management and pharmacy practices to TJC during regular surveys or as otherwise required for accreditation.

g. Engage MTF staff in continuous quality improvement regarding pain management, reporting priorities, and progress on selected measures as required in Enclosure 3.

h. Engage MTF staff in continuous quality improvement regarding opioid safety, reporting priorities, and progress on selected measures observed in the MHS Opioid Registry as required in Enclosure 3.

i. Report information to DHA through Regional Commanders/Directors or Service representatives as appropriate regarding their responsibilities as required.

ENCLOSURE 3

PROCEDURES

1. OVERVIEW. The purpose of this DHA-PI is to guide the implementation of the MHS Stepped Care Model while optimizing opioid safety. The National Defense Authorization Act for Fiscal Year 2010 (Reference (e)) requires the MHS to develop and implement a comprehensive policy on pain management. Furthermore, according to Reference (f), it is United States policy to use "all lawful means" to act against the opioid crisis. This DHA-PI executes these policies by establishing the MHS Stepped Care Model as the comprehensive model for pain management for MHS while providing guidance, support, and accountability to assure the MHS utilizes VA-DoD and CDC clinical practice guidance regarding opioid safety.

2. CLINICAL OPERATIONS. MTF personnel shall follow guidance in this DHA-PI to execute the MHS Stepped Care Model. Within the model, they shall use VA-DoD and CDC clinical practice guidance (References (g) and (h)) to promote opioid safety for patients with pain.

a. MHS Stepped Care Model. MTF Commanders and Directors shall implement the MHS Stepped Care Model. The MHS Stepped Care Model seeks to enable Clinical Communities to provide evidence-based pain management guided by clinical practice guidelines (CPGs: effectively treat acute and chronic pain; promote non-pharmacologic treatment; prevent acute pain from becoming chronic; and minimize use of opioids with appropriate prescribing only when indicated. This model follows the guidance of Reference (i), and is further described in Enclosure 5. DHA will train PCPCs on the MHS Stepped Care Model. PCPC roles and responsibilities are described in Enclosure 6. Service Pain Management Programs may determine additional functions of the PCPC to further promote effective and safe pain management.

b. Non-pharmacologic treatments of pain. MTF clinicians shall use non-pharmacologic treatments (to include but not limited to acupuncture, chiropractic care, physical therapy, behavioral health treatments) of pain as clinically appropriate in accordance with References (g) and (h). Clinicians may provide or refer for non-pharmacologic treatments not listed here. They will understand what non-pharmacologic pain treatment modalities are available locally. Some non-pharmacologic treatments are not available at every MTF. Non-pharmacologic pain treatments are emphasized in OPST and are also emphasized in the MHS Stepped Care Model.

c. Purchased Care. DHA Purchased Care Office shall work with Managed Care Support Contractors (MCSCs) and US Family Health Plan/Designated Providers (USFHP/DPs) to develop strategies to minimize opioid use and promote the use of non-pharmacologic pain treatments.

d. Opioid Prescribing Guidance

(1) For uncomplicated, opioid-naïve patients, all prescribing providers should limit opioid prescriptions to no more than a 5-day supply of short-acting opioids for acute pain episodes, including postoperative pain from minor outpatient procedures. This is consistent with guidance

in References (g), (h), and (j). These patients should rarely require renewals of opioid medications; if renewals are given, they should be limited to a 3-day supply and occur only after clinical re-evaluation and documentation in the electronic health record (EHR).

(2) For uncomplicated, opioid-naïve patients who have had dental procedures, prescribing providers should limit opioid prescriptions to no more than a 1-day supply of short-acting opioids. Renewals should also be limited to 1 day. Dentists should first use nonsteroidal anti-inflammatory drugs for treatment of pain.

(3) Prescribing providers should use their best clinical judgment for patients who are not opioid-naïve or have other medical or surgical complications (e.g., cancer; terminal conditions).

(4) For patients with postoperative pain from major procedures, all prescribing providers should limit opioid prescriptions to no more than a 10-day supply of short-acting opioids. All patients requiring opioids after major procedures should receive an informed consent with information about the risks of opioids. This is consistent with the guidance in Reference (j). Renewals may be required depending on the situation. They should be given only if needed after surgical re-evaluation and should not exceed a 7-day supply. DHA may issue future guidance standardizing opioid prescriptions for specific procedures that will supersede this guidance.

(5) Patients who are unable to taper or are escalating their opioid use after surgery shall be fully evaluated to address any post-surgical issues. Providers should contact a patient's Primary Care Manager (PCM) or consult the Pain Management Clinic to receive comprehensive pain management through the MHS Stepped Care Model (see Figure 3), while continuing postsurgical care. These patients will require care from an integrated pain team found in the secondary or tertiary levels of the MHS Stepped Care Model depending on the complexity of their pain.

(6) All patients who are taking over 90 morphine milligram equivalents (MMEs) of opioids daily, are on long-term opioid therapy (LOT) (greater than 90 days of continuous use), or have had greater than 6 months of pain require care in the tertiary level of the model.

e. Training. All prescribing providers caring for TRICARE beneficiaries in MTFs (defined as at least 0.1 clinical full-time equivalent (FTE)) shall complete initial OPST upon starting work in the MTF and every 3 years (or as otherwise directed) afterwards. This training can be found online at https://opstp.cds.pesgce.com/hub.php. The training gives providers the knowledge, skills, and abilities to follow guidance in References (g) through (k). The Pain Management Clinical Support Service will evaluate and inform this training based on this DHA-PI and available evidence.

f. Patient Education and Informed Consent

(1) All patients who receive an opioid prescription will be educated on the risks associated with opioids. This education should be documented in the EHR by the prescribing provider.

(2) Patients on long-term opioid therapy are at risk for opioid use disorder or other opioid-related adverse events, or receiving renewals of opioid prescriptions for acute pain will be educated via informed consent by their provider. Informed consent forms will allow for assignment of a sole prescriber, give specific information about appropriate use of naloxone for overdose, and inform the patient that they are subject to random urine drug testing. MTF Commanders and Directors shall assure that both privileged and non-privileged providers are trained to educate patients in accordance with References (g) and (h).

(3) A standardized patient education process will be developed for both clinicians and non-clinicians. It will be updated periodically. The plan will address the knowledge, skills, and aptitudes required to educate patients receiving an opioid prescription. For prescribing providers, OPST will be updated to include this information. The training will include information on (1) proper use in taking opioid medications, including frequency, quantity, and duration; (2) potential side effects and risks associated with taking opioid medication to include risk of addiction and overdose; (3) proper safeguarding of opioid medications to include the risk of diversion; and (4) proper disposal of opioid medication.

(4) DHA will provide standardized informed consent forms and patient education products that will be distributed to patients receiving opioid prescriptions at MTFs and will be published in a subsequent DHA-Procedures Manual.

g. Accountability

(1) Provider accountability. POD uses the MHS CSPP to identify providers whose opioid prescribing practices may be inconsistent with VA-DoD and CDC CPGs. Through Regional Commanders/Directors, POD informs MTF Commanders and Directors so they may intervene with these providers to ensure appropriate opioid prescribing practice. MTF Commanders and Directors will determine whether any further training, review, or action regarding these providers is necessary.

(2) Joint Commission compliance. MTF Commanders and Directors provide information regarding compliance with pain management standards to TJC during regular surveys and as otherwise required for accreditation according to Reference (d). This DHA-PI enables meeting TJC requirements by outlining how MTFs will appoint leadership in pain management and safe opioid prescribing, provide non-pharmacologic pain treatments, and engage in quality improvement in pain management and opioid safety.

(3) Quality improvement. MTF Commanders and Directors shall engage in continuous quality improvement regarding both pain management and opioid safety, reporting selected measures to DHA through their respective Regional Commanders/Directors. MTF Commanders and Directors may use their discretion to choose which areas to improve except in cases otherwise noted in this DHA-PI. The Pain Management Clinical Support Service will review this information and share effective quality improvement efforts across the MHS.

h. Medications and Pharmacy

(1) Medication-assisted treatment (MAT). MAT (i.e., buprenorphine, methadone, and naltrexone) will be available either directly from the MTF, through direct care system referral, or through the purchased care network to all MTF patients with an opioid use disorder in accordance with References (g), (h), (l), and (m). MAT is one component of an overall opioid use disorder program. Prescribing providers who treat patients with opioid use disorder must be trained, possess the necessary Drug Enforcement Administration waiver, and privileged to prescribe these medications as required by law.

(2) Opioid antagonists. Naloxone or other Food and Drug Administration and enterprise-approved opioid antagonists will be available to outpatients considered at risk for opioid overdose in accordance with References (g), (h), (l), and (m). Opioid antagonists will be available at all MTFs for emergency use in case of opioid overdose.

(3) Drug take-back programs. Drug take-back programs and/or bins offer a convenient way for TRICARE beneficiaries to return unused medications, including controlled substances. DHA provides support to MTFs to make this service available.

i. Laboratory. Patients on long-term opioid therapy (LOT) and/or at risk for opioid use disorder must be monitored with urine drug testing in accordance with References (g) and (h). Safe monitoring requires the ability to screen for potential concomitant drug use or diversion while also allowing for confirmation of the screening test result. OPST trains prescribing providers in the use of urine drug testing. DHA will provide a test with screening and confirmatory capabilities to MTFs.

3. HEALTH INFORMATION SYSTEMS

a. EHR

(1) The DVPRS and Pain Assessment Screening Tool and Outcomes Registry (PASTOR) are pain measurement and outcome tools that will be incorporated into legacy and upcoming EHR systems. DHA will make these tools available to clinicians, provide training in their use, continuously improve them over time as appropriate, and incorporate their data into outcome measures.

(2) Both legacy and upcoming EHR systems will use alerts and other tools deemed appropriate to assist health care providers in following guidance in References (f) and (g). DHA will make these tools available to providers, provide training in their use, continuously improve them over time as deemed appropriate, and determine any reporting requirements from MTF Commanders and Directors.

b. Prescription Drug Monitoring Program (PDMP). PDMPs offer information on when, where, and how many controlled substances MTF patients obtained from a civilian pharmacy. MTF providers are licensed to a variety of states and may not have access to the PDMP website

where they currently practice. DHA will provide a seamless solution to facilitate MTF clinician compliance with clinical practice guidance in References (g) and (h).

4. MEASUREMENTS

a. Defense and Veterans Pain Rating Scale (DVPRS). DVPRS will be used as the standard pain scale in the MHS Stepped Care Model (Enclosure 7).

(1) Adolescent and adult patients should be screened for pain during each visit using the DVPRS. Re-screening for a visit on the same day may be deferred if agreed upon by patient and clinical staff.

(2) The supplemental questions of the DVPRS should be administered for any patient who presents with pain intensity greater than "4".

(3) All patients in the secondary or tertiary levels of care in the MHS Stepped Care Model should complete the entire DVPRS, including all supplemental questions, at every visit.

b. Pain Assessment Screening Tool and Outcomes Registry (PASTOR). PASTOR utilizes computer adaptive testing to administer a wide range of validated questions for pain-related biopsychosocial domains and provides a comprehensive report of a patient's chronic pain history and treatment. PASTOR will be implemented across MHS MTFs in coordination with Service Pain Program Offices. PASTOR will be the designated screening tool and outcomes registry for the tertiary level of the MHS Stepped Care Model and may be used for patients escalating to the secondary level.

5. MONITORING AND REPORTING

a. Process Measures for Pain Management. The ESB will monitor these initial process measures to determine the effectiveness of the MHS Stepped Care Model on a quarterly basis:

(1) Adoption of the MHS Stepped Care Model. DHA will develop a method with the Primary Care Clinical Community and Pain Management Clinical Support Service to determine whether the model is being implemented as instructed.

(2) PCPCs. ESB will monitor the percentage of MTFs that have named a PCPC. One hundred percent of MTFs should name their PCPC within 6 months of publication of this DHA-PI.

(3) Increase use of non-pharmacologic treatments. DHA will develop metrics to track use of non-pharmacologic pain treatments. ESB will monitor the utilization of non-pharmacologic treatments.

b. Process Measures for Opioid Safety. ESB will monitor these initial process measures quarterly to improve opioid safety:

(1) Providers completing OPST. ESB will monitor the percentage of providers completing OPST. Ninety percent of providers who are greater than 0.1 clinical FTE are expected to have completed the training within 6 months of publication of this DHA-PI.

(2) LOT patients with informed consent. LOT patients have had 90 days of continuous opioid therapy with no greater than a 30-day break in use. These patients are at higher risk for opioid-related complications. MTFs shall report to DHA the percentage of their LOT patients who have completed an informed consent and are assigned a sole prescriber.

(3) Availability of MAT. MAT is one component of an overall opioid use disorder treatment program. One hundred percent of MTFs shall make MAT available to patients either directly, through direct care referral, or through referral to the purchased care network within 1 year of publication of this DHA-PI.

(4) Availability of naloxone. Naloxone is an opioid antagonist used to reverse opioid overdose. All MTFs shall affirm to DHA that they make naloxone directly available to their patients.

(5) LOT patients receiving naloxone. LOT patients should receive naloxone because they are at risk for opioid overdose. ESB will monitor the percentage of LOT patients who have been prescribed naloxone.

(6) EHR alerts. DHA will develop tools in MHS GENESIS to assist providers in optimizing opioid safety and develop measures of effectiveness of these tools.

c. Outcome Measures for Pain Management. DHA will develop specific measures to monitor improvement in function for primary care patients seeking care for pain. ESB will monitor these measures on a quarterly basis.

d. Outcome Measures for Opioid Safety. ESB will monitor these initial outcome measures on a quarterly basis to improve opioid safety:

(1) Patients with greater than 90 morphine milligram equivalents (MME)/day. Patients taking greater than 90 MME/day are at increased risk for death from opioids. VA-DoD and CDC CPGs recommend against these doses. ESB will monitor the percentage of patients at MTFs who are prescribed greater than 90 MME/day.

(2) MME/day for LOT patients. LOT patients are at increased risk of opioid complications, but that risk can be mitigated through lower opioid doses. ESB will monitor the median MME/day for LOT patients at MTFs.

(3) Co-prescription of benzodiazepines and opioids. VA-DoD and CDC CPGs recommend against co-prescription of benzodiazepines and opioids due to increased risk of

respiratory depression and death. ESB will monitor the percentage of patients who are prescribed both benzodiazepines and opioids at MTFs and in purchased care.

ENCLOSURE 4

MILITARY HEALTH SYSTEM OPERATING MODEL

The purpose of the MHS Operating Model is to enable front line clinicians to drive Enterprise-wide performance improvements in readiness and health; empower Enterprise-level Clinical Communities to create conditions for high reliability at the point of care (processes, standards, metrics); and hold ourselves accountable to MHS standards and clinical outcomes.

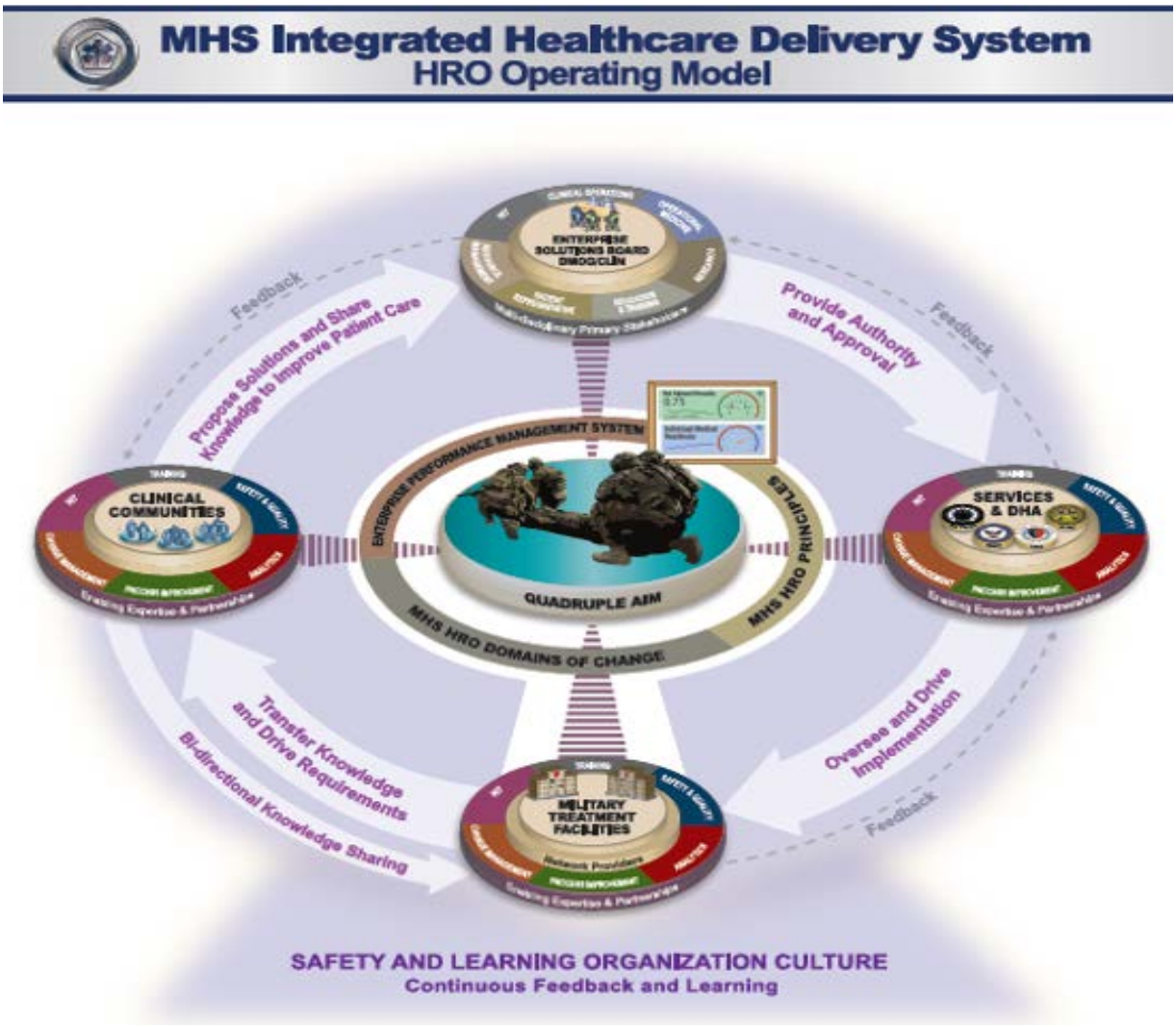

Figure 1: Military Health System Integrated Healthcare Delivery System: High Reliability Organization Operating Model

Pain Management is a Clinical Support Service in this model. The Pain Management Workgroup will serve as the coordinating body for this Clinical Support Service.

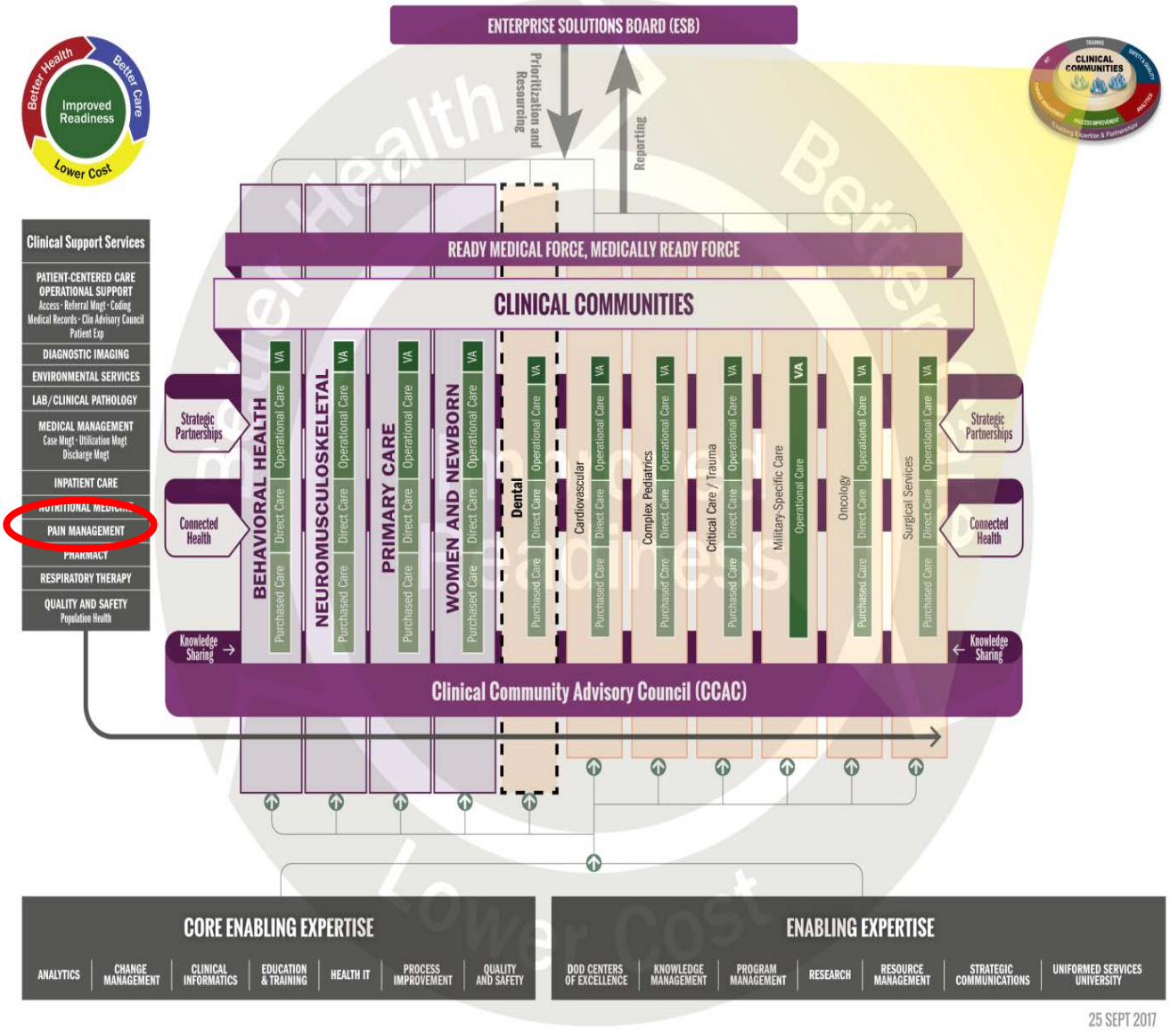

Figure 2: Military Health System Operating Model

ENCLOSURE 5

MILITARY HEALTH SYSTEM STEPPED CARE MODEL

The MHS Stepped Care Model seeks to enable Clinical Communities to provide evidence-based pain management guided by clinical practice guidelines (CPGs) to: effectively treat acute and chronic pain; promote non-pharmacologic treatment; prevent acute pain from becoming chronic; and minimize use of opioids with appropriate prescribing only when indicated. In order to facilitate dissemination and local implementation of the model, DHA will train PCPCs who are selected by their MTF Commanders or Directors.

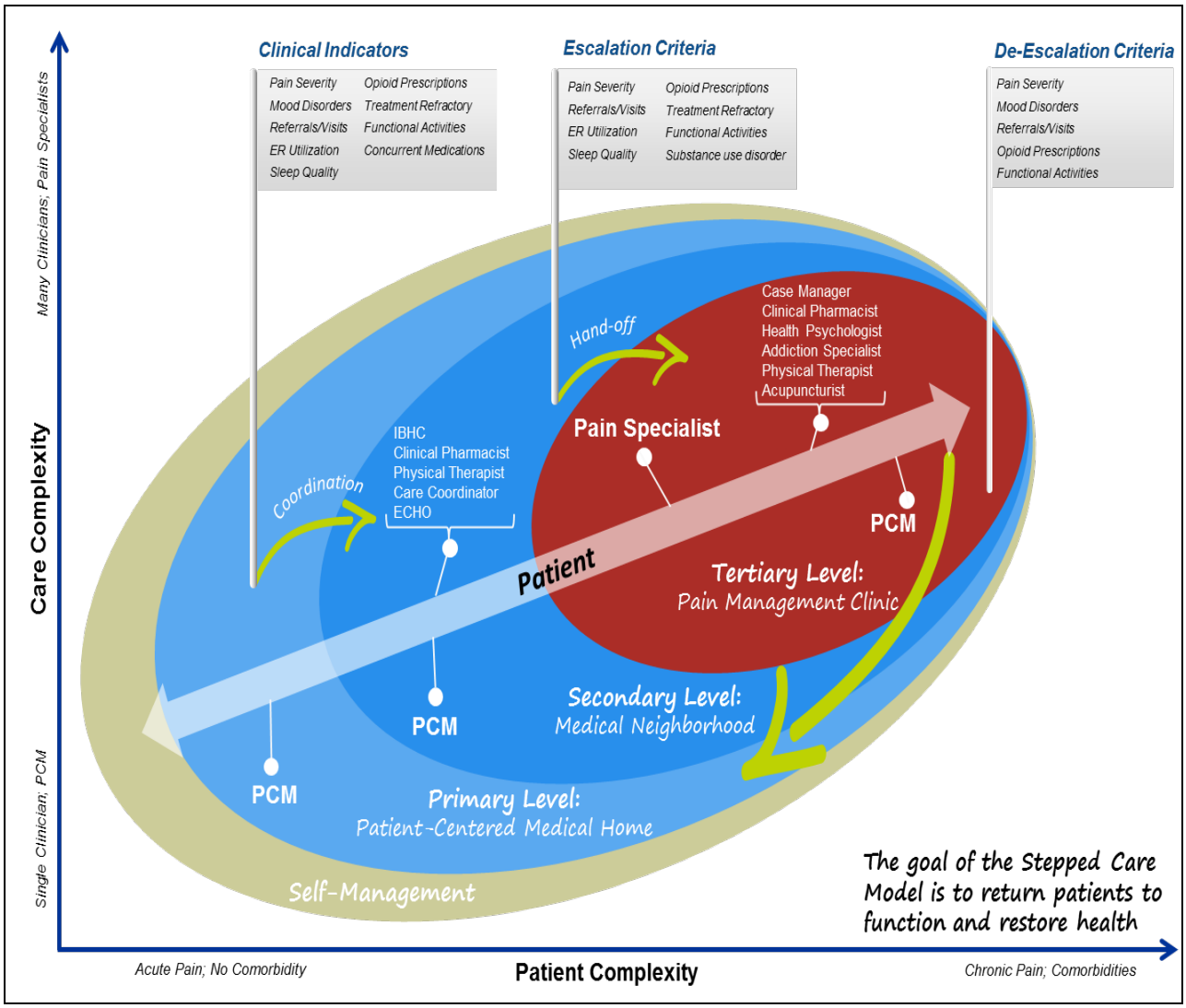

Figure 3: Military Health System Stepped Care Model

ENCLOSURE 6

PRIMARY CARE PAIN CHAMPION ROLES AND RESPONSIBILITIES

Roles and Responsibilities

Background

Comprehensive Pain Management Programs (CPMPs) improve the capability and capacity of MTFs to foster healing in our patients with simple acute, high-risk acute, and chronic pain in an interdisciplinary, multimodal, and coordinated fashion. The programs align with References (d) and (i) and the strategic goals and objectives of each Service.

The MHS Stepped Care Model is a team-based, interdisciplinary model for pain management that aligns across the Services. "Stepped care" delivers and monitors pain treatment utilizing the Patient-Centered Medical Home (PCMH) first, moving patients forward on the continuum of care only as clinically required. Patients with longer-lasting pain or higher medical complexity advance to the interdisciplinary Medical Neighborhood, where they benefit from additional services such as physical therapy, pharmacy review, care coordination, and behavioral health. Only the most chronic and/or complex patients who do not improve in the Medical Neighborhood will require referral to a Pain Management Clinic. The MHS Stepped Care Model seeks to enable Clinical Communities to provide evidence-based pain management guided by clinical practice guidelines (CPGs): effectively treat acute and chronic pain; promote non-pharmacologic treatment; prevent acute pain from becoming chronic; and minimize use of opioids with appropriate prescribing only when indicated. To effectively execute such a model, CPMPs must establish PCMH education initiatives to better equip primary care teams to manage care for patients with complex and chronic pain.

PCPCs ensure the successful deployment of primary care education initiatives. These individuals optimize pain services in the primary care structure at their local MTFs by ensuring all members of the treatment team understand their roles and responsibilities, answering clinical care questions from the team members, augmenting education and tele-mentoring initiatives (e.g., Project Extension for Community Healthcare Outcomes (ECHO®)), establishing local pain education initiatives (e.g., Joint Pain Education Program (JPEP)), and serving as the main point of contact for CPMP leadership regarding the program. PCPCs coordinate team efforts to enhance evidence-based pain management care, reduce adverse medication events and emergency room visits, improve clinical outcomes, and promote safe and effective use of multiple modalities for pain management.

Requirements and Time Allocation

PCPCs appointed by the MTFs should meet the following requirements:

- Currently, a board certified/board eligible physician, physician assistant, nurse practitioner, or other medical professional within primary care as designated by MTF Commander;
- Experienced and/or interested in providing pain management care and providing leadership, guidance, and feedback to members of the pain management team;
- Comfortable connecting and communicating with a wide variety of stakeholders; and
- Committed to advancing the goals and future success of the CPMPs.

A minimum of one PCPC is required per MTF, but MTFs have the flexibility to appoint additional PCPCs (i.e., one PCPC per Medical Home or per branch clinic), to fulfill all associated roles and responsibilities. It is recommended that each PCPC receive a minimum of 0.1 FTE deduction to perform the duties of the role; however, the appropriate deduction amount may vary based on the duties of the PCPC and should be determined based on the needs of the Service.

General Activities and Duties

The estimated time commitment for general activities and duties may vary based on the MTF. Key activities include:

- Maintaining awareness of CPMP services, assets, and capabilities.
- Communicating lessons learned, best practices, and CPMP policies to primary care clinics.
- Monitoring and promoting PCMH adherence to CPMP guidance and policies.
- Working with leadership to integrate new pain management team resources into the MTF.
- Providing Primary Care Managers (PCMs) and other team members with consultative and clinical support.
- Relaying feedback and relevant issues, questions, and concerns to CPMP leadership.
- Ensuring that site providers are leveraging training and resources to promote CPGs.
- Maintaining awareness of state and local governance affecting PCM practices and collaborating with MTF sections (i.e., legal, credentialing, quality management, etc.), to ensure MTF staff are fully informed.
- Leading regular team huddles with local pain management resources (i.e. integrated behavioral health consultant, physical therapist, acupuncturist, etc.).

Primary Care Provider Pain Education – Activities and Duties

Project ECHO® is an evidence-based model that provides high-quality medical education for common and complex diseases through tele-mentoring and co-management of patients with primary care clinicians. Project ECHO® creates virtual communities of practice between specialty care experts and Primary Care Providers. Project ECHO® leverages didactic content, case presentations and subject matter expert input with a goal of building expertise and capacity with primary care. Please note this is completely different and unrelated to the TRICARE ECHO Program.

JPEP is the designated VA-DoD pain management curriculum designed to improve patient and provider education and training. To expand accessibility to this curriculum, PCPCs will make JPEP training available locally by leveraging existing clinic training sessions. JPEP delivers trainings in brief sessions, each approximately 30 minutes long.

Roles and Responsibilities

Key PCPC training responsibilities include:

- Socializing Project ECHO® and JPEP training to promote primary care participation
- Presenting or facilitating at least one case per quarter at the weekly Project ECHO® sessions
- Briefing local leadership to maintain awareness and garner buy-in on Project ECHO® and JPEP training activities
- Establishing, identifying, and recruiting additional local personnel to deliver JPEP modules
- Supporting JPEP training efforts and coordinating quality oversight of instructors, ensuring smooth delivery and adherence to plan
- Connecting with remote or distant branch clinics via available technologies such as video teleconferencing where in-person visits are geographically prohibitive
- Tracking training attendance and distribution of training evaluations
- Serving as a liaison to the CPMP leadership, communicating on progress, success, and challenges of education initiatives
- Supporting knowledge sharing and collaboration efforts to continually improve Project ECHO® and JPEP delivery and identify best practices

Primary Care Provider Consultation

PCPCs may be utilized to consult with Primary Care Providers within the PCMH or MTF on pain patient cases. In this capacity, the PCPC minimizes face-to-face follow-up appointments with patients with chronic pain and guides the PCM with evidence-based recommendations and education to influence the care following initial consultation. PCPC consultations should be categorized appropriately to indicate whether a provider-to-provider discussion occurs about a particular patient or whether the PCPC sees the patient face-to-face.

Training

PCPCs will complete the following training, preferably before, but at a minimum within 6 months of PCPC duty assignment in order to be better prepared to assume the role and execute the responsibilities:

- Initial Train-the-Trainer course to learn JPEP content and techniques for delivering training effectively, as well as formulate MTF-specific strategies to ensure attendance and engagement
- Annual trainer refresher course to maintain awareness of training curriculum updates
- Regular attendance to available Project ECHO® trainings provided by the facility (this recommendation may be executed differently by service CPMPs)
- An orientation with Pain sub-specialty services to understand available assets and cultivate relationships between providers
- As available, supplementary trainings in addition to JPEP and Project ECHO® (e.g., Annual Pain Skills training), such as buprenorphine waiver training

Measures of Effectiveness

See Enclosure 3 for process and outcomes measures related to the MHS Stepped Care Model and opioid safety.

GLOSSARY

ABBREVIATIONS AND ACRONYMS

CDC	Centers for Disease Control and Prevention
CPG	clinical practice guideline
CPMP	Comprehensive Pain Management Program
CSPP	Controlled Substance Prescriber Profile
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DVPRS	Defense and Veterans Pain Rating Scale
ECHO^{R}	Extension for Community Healthcare Outcomes
EHR	Electronic Health Record
ESB	Enterprise Solutions Board
FTE	full-time equivalent
JPEP	Joint Pain Education Program
LOT	long-term opioid therapy
MAT	medication-assisted treatment
MCSC	Managed Care Support Contractor
MHS	Military Health System
MILDEP	Military Department
MME	morphine milligram equivalent
MTF	Military Treatment Facility
OPST	Opioid Prescriber Safety Training
PASTOR	Pain Assessment Screening Tool and Outcomes Registry
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PCPC	Primary Care Pain Champion
PDMP	Prescription Drug Monitoring Program
POD	Pharmacy Operations Division
SG	Surgeon General
TJC	The Joint Commission
USFHP/DP	U.S. Family Health Plan/Designated Provider

VA-DoD	Department of Veterans Affairs-Department of Defense