Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6025.08
February 8, 2023

DAD-MA

SUBJECT: Pain Management and Opioid Safety in Military Medical Treatment Facilities

References: See Enclosure 1

1. PURPOSE. The purpose of the Defense Health Agency's (DHA) Pain Management and Opioid Safety strategies 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 pain treatment, prevent acute pain from becoming chronic, and when appropriate, limit opioid prescribing to the minimal effective dose, for the shortest duration necessary, in conjunction with the designated risk mitigation actions by providers and leadership. The Pain Management Clinical Support Service achieves these ends through clinical improvements in pain care, clinician and patient education, and research. This DHA-AI, based on the authority of References (a) through (c), and in accordance with the guidance of References (d) through (aa), establishes DHA instructions to:

a. Establish the VA-DoD Stepped Care Model (SCM) for Pain Management as the comprehensive standardized pain management model for the DHA to provide consistent, quality, and safe care for patients with pain with an emphasis on multidisciplinary, multi-modal, and non-pharmacologic pain management.

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 all relevant DoD, VA-DoD, Centers for Disease Control and Prevention (CDC), and Food and Drug Administration (FDA) guidelines.

d. Provide tools, including those through the MHS GENESIS and legacy Electronic Health Record (EHR) systems, to assist clinicians in evidence-based and patient-centered pain management.

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

2. BACKGROUND

a. Pain Management is a Clinical Support Service in the MHS Operating Model (See 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 MHS Clinical Communities to create conditions for high reliability at the point of care (processes, standards, and metrics); and hold ourselves accountable to DHA standards and clinical outcomes. The Pain Management Clinical Support Service:

(1) Is composed of the Chair (appointed by DHA), designated representation from the DHA (Pain Management Program, MTF Clinicians, Center for Laboratory Medicine Services, Pharmacy Operations Division (POD), Medical Affairs (MA), and TRICARE Health Plan), Uniformed Services University for the Health Sciences (USUHS) and other Subject Matter Experts (SME) as required.

(2) Supports the Clinical Communities, as needed, in coordination with the Clinical Community Advisory Council.

b. The Joint Commission (TJC) updates to the pain assessment and management standards for accredited hospitals and ambulatory care settings are summarized in References (e) and (f). Requirements include the leadership accountability regarding pain management and safe opioid prescribing practices, provision of non-pharmacologic pain treatments, and monitoring of opioid use to maximize patient safety. TJC requirements also include the development of systems and processes for pain screening and assessment incorporating pain-related physical and functional impairment. The VA-DoD SCM is recognized by TJC as a best practice for implementing these standards.

3. APPLICABILITY. DHA Enterprise (components and activities under the authority, direction, and control of the DHA) to include: assigned, attached, allotted, or detailed personnel.

4. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (g), (h), (k) and (o) to:

a. Establish uniform processes, measures, and workflows that include documentation requirements and performance metrics to standardize the DHA's comprehensive approach to pain management and opioid prescribing safety required by References (g) and (h).

b. Comply with Reference (h) to monitor and provide oversight of opioid prescribing to ensure that the provider practices conform with: (1) the clinical practice guidelines of the DoD

and Department of Veterans Affairs, and (2) the prescribing guidelines published by the CDC and the FDA (References (n), (o), and (p)).

5. CANCELED DOCUMENTS. This DHA-AI cancels and replaces DHA-PI 6025.04, "Pain Management and Opioid Safety in the Military Health System (MHS)," June 8, 2018.

6. RESPONSIBILITIES. See Enclosure 2

7. PROCEDURES. See Enclosure 3

8. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), MA. When Activities are unable to comply with this publication the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

9. RELEASABILITY. **Cleared for public release**. This DHA-AI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx.

10. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

b. Will expire 5 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (d).

11. FORM. DHA Form 105, Consent for Long Term Opioid Therapy for Pain is available at: https://info.health.mil/cos/admin/DHA_Forms_Management/DHA_Forms1/DHA%20105.pdf

CROSLAND.TELITA.1017383040 Digitally signed by CROSLAND.TELITA.1017383040 Date: 2023.02.08 18:34:33 -05'00'

TELITA CROSLAND
LTG, USA
Director

Enclosures

1. References
2. Responsibilities
3. Procedures
4. Military Health System Operating Model (Figures 1 and 2)
5. VA-DoD Stepped Care Model for Pain Management (Figure 3)
6. Primary Care Pain Champion Roles, Responsibilities and Requirements
7. DHA Opioid Safety and Overdose Flyer
8. Defense and Veterans Pain Rating Scale (Figure 4)
9. DHA Clinical Decision Support Tools for Opioid Safety (Table 1)

Glossary

TABLE OF CONTENTS

ENCLOSURE 1: REFERENCES....7

ENCLOSURE 2: RESPONSIBILITIES....9

DIRECTOR, DEFENSE HEALTH AGENCY 9
DEPUTY ASSISTANT DIRECTOR, MEDICAL AFFAIRS 9
DEPUTY ASSISTANT DIRECTOR, HEALTH CARE OPERATIONS 10
DEFENSE HEALTH AGENCY, CHIEF HEALTH INFORMATICS OFFICER……..10
DIRECTORS, DIRECT REPORTING MARKETS....11
ENTERPRISE SOLUTIONS BOARD....11
PAIN MANAGEMENT CLINICAL SUPPORT SERVICE 11
PHARMACY OPERATIONS DIVISION 12
PRIVATE SECTOR CARE OFFICE....13
DIRECTORS, MILITARY TREATMENT FACILITY/DENTAL TREATMENT FACILITY 13

ENCLOSURE 3: PROCEDURES....15

OVERVIEW 15
CLINICAL OPERATIONS....15
HEALTH INFORMATION SYSTEMS 21
MEASUREMENTS....21
MONITORING AND REPORTING....22

ENCLOSURE 4: MILITARY HEALTH SYSTEM OPERATING MODEL....24

ENCLOSURE 5: DEPARTMENT OF VETERANS AFFAIRS - DEPARTMENT OF DEFENSE STEPPED CARE MODEL FOR PAIN MANAGEMENT 26

ENCLOSURE 6: PRIMARY CARE PAIN CHAMPION ROLES, RESPONSIBILITIES AND REQUIREMENTS....27

ENCLOSURE 7: DHA OPIOID SAFETY AND OVERDOSE FLYER....31

ENCLOSURE 8: DEFENSE AND VETERANS PAIN RATING SCALE....33

ENCLOSURE 9: DEFENSE HEALTH AGENCY CLINICAL DECISION SUPPORT TOOLS FOR PAIN MANAGEMENT AND OPIOID SAFETY 34

ENCLOSURE 10: PRESCRIPTION MONITORING PROGRAM ENROLLMENT FORM…35

GLOSSARY 36

ABBREVIATIONS AND ACRONYMS 36
DEFINITIONS.....37

TABLES

1. Defense Health Agency Clinical Decision Support Tools for Opioid Safety.....34

FIGURES

1. Military Health System Integrated Healthcare Delivery System: High Reliability Organization Operating Model.....24
2. Military Health System Operating Model.....25
3. VA-DoD Stepped Care Model for Pain Management 26
4. DHA Opioid Safety and Overdose Flyer 31
5. Defense and Veterans Pain Rating Scale 33

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) United States Code, Title 10, Section 1073c
(d) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
(e) R3 Report (from The Joint Commission), "Pain assessment and management standards for hospitals," August 29, 2017[1]
(f) R3 Report (from The Joint Commission), "Pain assessment and management standards for ambulatory care," June 25, 2018[2]
(g) Public Law 111-84, Section 711, National Defense Authorization Act for Fiscal Year 2010, October 28, 2009
(h) Public Law 116-283, Section 719, National Defense Authorization Act for Fiscal Year 2021, January 1, 2021
(i) TRICARE Operations Manual 6010.59-M, Chapter 28, "Prescription Monitoring Program (PMP)," Revision C-66, July 2, 2020
(j) DHA-Procedural Instruction 6025.25, "Military Health System (MHS) Drug Take Back (DTB) Program," February 20, 2018
(k) Presidential Memorandum, "Combatting the National Drug Demand and Opioid Crisis," October 26, 2017
(l) DHA-Procedural Instruction 6025.31, "Military Treatment Facility Pharmacy Operations," December 2019
(m) DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019
(n) Department of Veterans Affairs-Department of Defense Clinical Practice Guidance for Opioid Therapy for Chronic Pain, May 2022
(o) Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, March 18, 2016
(p) U.S. Food and Drug Administration, Drug Safety Communication: Naloxone, July 23, 2020
(q) Interagency Guideline on Prescribing Opioids for Pain, Washington State Medical Directors' Group (AMDG), June 2015[3]
(r) Office of the Surgeon General Pain Management Task Force Final Report, May 2010[4]
(s) Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use," October 21, 2015

[1] This reference can be found at: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_report_issue_11_2_11_19_rev.pdf/
[2] This reference can be found at: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_14_pain_assess_mgmt_ahc_6_20_18_final.pdf
[3] This reference can be found at: http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
[4] This reference can be found at: https://www.dvcipm.org/clinical-resources/pain-management-task-force/

(t) DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014, as amended
(u) DoD Instruction 1010.16 "Technical Procedures for the Military Personnel Drug Abuse Testing Program" June 15, 2020
(v) DHA-Procedural Instruction 6025.07, "Naloxone Prescribing and Dispensing by Pharmacists in Medical Treatment Facilities" June 19, 2018
(w) Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (2017) Patient Information Guide: Long-term Opioid Therapy for Chronic Pain[5]
(x) DHA Patient and Caregiver; Opioid Safety Flyer (2020)[6]
(y) DHA Procedures Manual 6025.13 "Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance," August 29, 2019
(z) DHA-Procedural Instruction 6025.27, "Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System (MHS)," October 18, 2019
(aa) Health Affairs Policy 11-003, "Policy for Comprehensive Pain Management," March 30, 2011
(bb) DHA-Procedural Instruction 6010.02, "Military Health System Prescription Drug Monitoring Program," October 2021

[5] This reference can be found at: https://www.qmo.amedd.army.mil/OT/OpioidTherapyPatientGuide_FINAL_508.pdf
[6] This reference can be found at: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/OEND-Program/For-Patients-and-Caregivers

ENCLOSURE 2

RESPONSIBILITIES

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

a. Support the DHA Direct Reporting Markets by identifying standard clinical, business, and administrative process changes or requirements, and assign resolution to the appropriate Directorate within DHA.

b. Provide leadership, guidance, and ensure DHA-AI implementation.

c. Coordinate with the Surgeons General (SGs) of the Military Departments to:

(1) Provide necessary pain management, pharmacy and clinical data subject matter expertise in support of MILDEPs' readiness activities.

2. DAD-MA. The DAD-MA will:

a. Collaborate with DAD, Health Care Operations (HCO), to exercise decision-making authority in support of this DHA-AI.

b. Advocate for alignment of sufficient resources and expertise to support implementation of this DHA-AI.

c. Oversee collaboration of Pain Management Clinical Support Service, DHA Clinical Support Division, and other DHA staff to identify, monitor, and track this DHA-AI.

d. Drive clinical improvements in multidisciplinary pain management through implementation of the VA-DoD SCM for Pain Management (Enclosure 5, Figure 3).

e. Mitigate potential harm from pain management and opioid use in the MHS in partnership with the Pain Management Clinical Support Service and Pharmacy Operations Division.

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

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

h. Implement established DHA forms and education materials that will be used by clinicians to document an informed consent and opioid safety education for patients receiving LOT and patients receiving renewal of an initial opioid prescription for acute pain.

i. Provide training for designated health care providers in use of medication-assisted treatment (MAT) complying with applicable federal, state, and local laws and regulations.

j. Deliver laboratory support to assure urine drug testing for screening and confirmation of controlled or illicit substances for those on LOT or other patients at risk for opioid use disorder to maximize patient safety.

k. Develop a sustainable implementation plan for tiered pain management and opioid safety capabilities across the DHA that includes alignment of the legacy Service pain management capabilities, personnel, and resources around the DHA model of pain management and opioid safety.

3. DAD-HCO. The DAD-HCO will:

a. Collaborate with DAD-MA to exercise decision-making authority in support of this DHA-AI.

b. Coordinate clinical business operations to support implementation of this DHA-AI.

c. Ensure Direct Reporting Markets can access and understand the standardized processes outlined in this DHA-AI.

4. DHA-CHIO. The DHA-CHIO will:

a. Ensure systems and tools (e.g., CarePoint Patient Lookup Tool, Care Point Opioid Management Clinical Registry, Prescription Drug Monitoring Program, and Opioid Prescriber Monthly Trend Report) are in place to collect data and measure compliance with this DHA-AI to achieve the stated purpose.

b. Ensure MHS GENESIS provides alerts and other clinical support tools that assist clinical personnel in the provision of evidence-based pain management and safe opioid prescribing practices detailed in this document. This includes integration and/or alignment of MHS GENESIS with established DHA:

(1) Pain measurement and outcomes tools (e.g., Defense and Veterans Pain Rating Scale (DVPRS) and Pain Assessment Screening Tool and Outcomes Registry (PASTOR)).

(2) Opioid prescribing high risk categories: Long-term Opioid Therapy (LOT), co-prescribed benzodiazepines, morphine equivalent daily dose $\geq$ 50 morphine milligram equivalents (MME)/day, history of overdose, Substance Use Disorder (SUD) or Opioid Disorder (OUD), or elevated suicide risk.

(3) Safe opioid prescribing documentation (e.g., Opioid Overdose Education and Naloxone Distribution, Consent for Long-term Opioid Therapy for Pain).

5. DIRECTORS, DIRECT REPORTING MARKETS. The Directors, Direct Reporting Markets must:

a. Ensure MTFs/DTFs under their authority, direction, and control develop guidance and procedures that conform to this DHA-AI and are tailored to meet the capabilities of their facility.

b. Ensure all Directors, MTF/DTF, administrative staff, and healthcare personnel are aware of and follow the guidance and procedures in this DHA-AI. Policies and procedures for clinical practice will be standardized at the MTF/DTF, as practicable.

c. Sponsor provider education regarding this DHA-AI based on the MTF/DTF individual capabilities.

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

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

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

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

a. With guidance and support from DHA Directorates, develop a sustainable DHA implementation plan for tiered pain management and opioid safety capabilities across the DHA MTFs that includes alignment of the legacy Service pain management capabilities, personnel, and resources around the DHA model of pain management and opioid safety.

b. Support continued development and improvement of the VA-DoD SCM for Pain Management training promoting consistent, high quality, safe, and patient-centered care for patients with pain and minimizes opioid use.

c. Develop and/or promote patient education resources pertaining to safe and effective pain management and opioid safety.

d. Support the Clinical Communities in implementation of the VA-DoD SCM for Pain Management and utilization of Primary Care Pain Champions (PCPC) as detailed in Enclosure 6.

e. Advise the MILDEPs regarding readiness components of pain management and opioid safety initiatives.

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

g. Recommend standardized opioid prescribing tools and metrics to support continuous quality improvement (Enclosure 3).

h. Provide subject matter expertise informing OPST, other designated opioid prescribing training, and patient education regarding pain management and opioids safety utilizing best available evidence.

i. Provide subject matter expertise in pain management and opioid safety to all relevant MHS Clinical Communities, Clinical Support Services, and other initiatives.

j. Support expanded utilization of pain management and opioid safety treatment and education provided by approved virtual health platforms, including the DHA Extension for Community Healthcare Outcomes telementoring initiative for providers.

k. Assist the TRICARE Private Sector Care Office with aligning pain management and opioid safety best practices across the direct care and private sector care systems.

8. POD. POD will:

a. Ensure MOUD and opioid antagonist reversal capability (i.e., naloxone) are available as part of the DoD Uniform Formulary.

b. Advise DHA Directorates and Directors, Direct Reporting Markets regarding DoD tools that assist with identifying prescribers who may fall outside recommended opioid prescribing practices contained in the VA-DoD and CDC opioid prescribing Clinical Practice Guidelines using the DHA Opioid Prescriber Monthly Trend Report.

c. Advise Service MILDEPs regarding readiness components of DoD pain management and opioid safety initiatives.

d. Coordinate provision of data to Managed Care Support Contractors (MCSC) related to beneficiary and provider prescribing monitoring programs.

e. Oversee the TRICARE Pharmacy contract requirements for TRICARE Pharmacy contractor's administrative responsibilities for the MHS Prescription Drug Monitoring Program (PDMP) to include, but not limited to, maintenance of the MHS PDMP data, validation of MHS PDMP users, and coordination with other state/territories.

f. Support availability of drug take-back services at MTFs/DTFs in accordance with Reference (j).

g. For additional information regarding pharmacy operations and opioid prescribing, see Reference (l).

9. PRIVATE SECTOR CARE OFFICE. Private Sector Care Office will:

a. Work with MCSCs and United States Family Health Plan/Designated Providers (USFHP/DPs) to develop strategies to improve pain management, promote safe opioid prescribing, and expand utilization of non-opioid and non-pharmacologic pain treatments.

b. Develop value-based pilots, as appropriate, to incentivize both providers and beneficiaries to use non-opioid and non-pharmacologic pain management strategies.

c. Identify, in conjunction with POD and MCSCs and USFHP/DPs, private sector care beneficiaries with potentially excessive opiate use and refer them to appropriate programs, as stated in Reference (i).

d. Refer private sector care providers with evidence of inappropriate opiate prescribing practices to MCSCs/USFHP/DPs, as stated in Reference (i).

10. DIRECTORS, MTFs/DTFs. The Directors, MTF/DTF must:

a. Assure personnel are trained as described in Enclosure 3, and report compliance to their respective Directors, Direct Reporting Markets.

b. Implement the VA-DoD SCM as described in Enclosure 3. Appoint a PCPC as a liaison to MILDEP Pain Management leadership and as a facilitator for this transformation.

c. Track availability and utilization of MTF/DTF non-pharmacologic pain treatment modalities.

d. Assure that MTF/DTF providers and pharmacies make MOUD available as clinically appropriate and required in Enclosure 3. Assure that MTF/DTF providers and pharmacies are utilizing opioid antagonists (e.g., naloxone), as clinically appropriate. Resources and tools regarding the DHA Opioid Overdose and Naloxone Distribution program are located on the MHS Health.mil website: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/OEND-Program.

e. Provide accountability and oversight of MTF/DTF provider opioid prescribing practices that may be outside routine standard of care, CPGs, and policies via established MHS monitoring tools and as a routine mechanism of the local credentialing process. Provider opioid prescribing practices will be reviewed as part of peer review or audit in accordance with DHA-PM 6025.13 (Reference (y)).

f. Assure that the credentialing process for MTF/DTF providers who are authorized to prescribe opioids includes a requirement to maintain current DoD Opioid Prescriber Safety Training. In accordance with Reference (s), current is defined as OPST training within the last 3 years. OPST training is integrated into Centralized Credentials Quality Assurance System.

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

h. Engage MTF/DTF staff in continuous quality improvement regarding multidisciplinary pain management and opioid safety, reporting priorities, and progress on selected measures as required in Enclosure 3.

i. Report information to DHA through Directors and Direct Reporting Markets regarding pain management and opioid safety responsibilities, as required.

j. Provide accountability and oversight of MTF/DTF provider opioid prescribing practices utilizing Prescription Monitoring Program (PMP) as required by DHA-PI 6010.02.

ENCLOSURE 3

PROCEDURES

1. OVERVIEW. The purpose of this DHA-AI is to guide implementation of the VA-DoD SCM for Pain Management while optimizing opioid safety and is a dual effort between the Pain Management Clinical Support Service and the Clinical Communities to achieve our stated purpose through implementation of the VA-DoD SCM for Pain Management. Section 711 of Reference (g) requires the DoD to develop and implement a comprehensive policy on pain management. The VA-DoD CPG for Opioid Therapy for Chronic Pain and the Pain Management Task Force Report (References (n) and (r)) identify the SCM for Pain Management as the evidenced-based best practice model for VA-DoD and health systems. This DHA-AI executes these recommendations by directives establishing the VA-DoD SCM for Pain Management as the comprehensive model for DHA pain management while providing guidance, support, and accountability to assure DHA utilizes VA-DoD, FDA, and CDC clinical practice guidance regarding pain management and opioid prescribing safety.

2. CLINICAL OPERATIONS. MTF/DTF personnel will follow guidance in this DHA-AI to execute the VA-DoD SCM for Pain Management. Within the model, they will use VA-DoD, CDC, and FDA guidance (References (n), (o), and (p)) to promote opioid safety for patients with pain.

a. VA-DoD SCM for Pain Management. Directors, MTF/DTF will implement the VA-DoD SCM for Pain Management. The SCM seeks to enable Clinical Communities to provide evidence-based pain management guided by CPG 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. This model follows the guidance of Reference (n) and is further described in Enclosure 5. DHA will train PCPCs on the SCM. PCPC roles and responsibilities are described in Enclosure 6. Directors, MTF/DTF may determine additional functions of the PCPC to further promote effective and safe pain management.

b. Non-pharmacologic treatments for pain. Non-pharmacologic pain treatments are emphasized in the SCM and DoD OPST. MTF/DTF clinicians will consider utilizing all available and approved non-pharmacologic treatments (to include, but not limited to, acupuncture, chiropractic care, physical therapy, behavioral health treatments) for pain management as clinically appropriate in accordance with References (n) and (o). Not all non-pharmacologic treatments are available at every MTF/DTF. Providers will understand what non-pharmacologic pain treatment modalities are available within their MTF/DTF or approved for TRICARE referrals.

c. Private Sector Care. The DHA Private Sector Care Office will work with Pain Management Clinical Support Services, MCSCs, and USFHP/DPs to develop strategies to minimize opioid use and promote the use of non-pharmacologic pain treatments.

d. Opioid Prescribing Guidance

(1) General prescribing guidance:

(a) When prescribing providers conclude that prescription opioids are necessary for effective outpatient pain management, they will prescribe the lowest effective dose and will prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

(b) Prescribing providers, clinical support staff, or pharmacists will provide all patients requiring outpatient opioid prescriptions with education regarding opioid safety and accidental overdose using the designated DHA patient education handout (Enclosure 7), available for download at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/OEND-Program/For-Patients-and-Caregivers. The patient education will be documented in the EHR.

(2) Prescribing guidance for acute pain treatment for opioid-naïve patients; defined as patients who have not taken opioids 90 days prior to the acute event or surgery:

(a) For those patients being treated for acute pain episodes related to musculoskeletal injuries, medical conditions, or minor surgical procedures, prescribing providers will limit opioid prescriptions to no more than a 5-day supply of short-acting opioids. This is consistent with guidance in References (n), (o), and (q). These patients should rarely require renewals of opioid medications; if renewals are given, they will be limited to a 3-day supply and occur only after clinical re-evaluation and documentation in the EHR.

(b) For those patients being treated for post-injury or postoperative pain from major surgical procedures, prescribing providers will limit opioid prescriptions to no more than a 10-day supply of short-acting opioids. Prescribers may consider renewals based on their clinical judgement. Renewals will be given only after re-evaluation and should not exceed a 7-day supply.

(c) Prescribing providers will document in the EHR the rational for any deviations from the prescribing guidance specified above (a) and (b).

(3) Additional guidance for other scenarios and conditions:

(a) For those patients who are prescribed LOT (90 days or more of opioid coverage in 180 day period), or for those who have experienced greater than 6 months of high impact chronic pain with unmet functional goals, the prescribing provider will consult with the tertiary level of the SCM through referral and/or Pain ECHO case presentation.

(b) For those patients who are unable to taper or are escalating their opioid use after surgery, will be fully evaluated to address any post-surgical issues. The prescribing provider will contact a patient's Primary Care Manager (PCM) or consult the Pain Management Clinic to escalate pain management through in accordance with the VA-DoD SCM (see Figure 3),

while continuing postsurgical care. These patients might require care from an integrated pain team found in the secondary or tertiary levels of the SCM depending on the complexity of their pain.

(c) For those patients being treated for pain related to cancer, palliative care, or end-of-life care, prescribing providers will use their clinical judgment, in consultation with pain management specialists as required, to determine how opioids will be utilized as a component of the patient's individualized pain management care plan.

(4) Special requirements for Service member (SM) and Coast Guardsman opioid prescriptions, as specified in Reference (u):

(a) An opioid prescription is valid for the period as written by the prescribing authority to the concerned SM or Coast Guardsman only.

(b) An opioid prescription is valid for the period as written by the prescribing authority, but no more than 6 months after the most recent date of filling on the prescription label.

(c) Prescribers will document in the EHR and inform the SM or Coast Guardsman of the following:

(1) The expiration date for legitimate use of the prescribed opioid medication.

(2) The need to follow-up with a provider prior to taking the prescribed opioid medication beyond the stated expiration date.

(3) As specified in Reference (m), the authority for the Provider to disclose medical information to the SM's or Coast Guardsman's chain of command, as it relates to suspected inappropriate or unauthorized use or diversion of prescription opioid medications.

(d) The prescribing provider will have primary responsibility, with pharmacy staff reinforcing at the time of dispensing, for education of SMs and Coast Guardsmen regarding expiration of the legitimate use of prescribed opioids and consequences (e.g., Uniform Code of Military Justice) for taking the opioid medication beyond the stated expiration date.

e. Training

(1) OPST. All providers who are authorized to prescribe opioids and caring for TRICARE beneficiaries in MTFs/DTFs (defined as at least 0.1 clinical full-time equivalent (FTE)) will complete OPST upon starting work in the MTF/DTF and every three years (or as otherwise directed) afterwards. This training can be found online at: https://www.dhaj7-cepo.com/content/dod-opioid-prescriber-safety-training-program. The training gives providers the knowledge, skills, and abilities to follow guidance in References (n), (o) and (p). The Pain Management Clinical Support Service will evaluate and revise this training based on this DHA-AI and available evidence.

(2) SCM for Pain Primary Care Training. Additional information regarding training requirements, training products, and webinar dates and times for trainings may be requested by emailing dha.ncr.j-9.mbx.phcoe-stepped-care-model-for-pain@mail.mil. Required trainings include:

(a) SCM for Pain PCPC Training Series. (See Enclosure 6 for additional information).

(b) SCM for Pain PCMH Team Training. All PCMH staff caring for adult patients 18 and older will complete the Stepped Care Model for Pain PCMH Team Training led by the PCPC (see Enclosure 6 for details). The SCM for Pain Team Training must be completed by all PCMH staff including, but not limited to, PCMs, RNs, intake staff, embedded clinical pharmacist, Behavioral Health Consultant (BHC), Behavioral Health Care Facilitator (BHCF), etc., and for all PCMH teams providing adult primary care services including but not limited to Family Medicine, Internal Medicine, Flight Medicine, active-duty clinics, etc. Training must be completed by all existing staff not yet trained, and then subsequently completed by all incoming PCMH staff within 90 days of arrival.

(c) Brief Cognitive Behavioral Therapy for Pain Training. All BHCs will complete the DHA training in Brief Cognitive Behavioral Therapy for Pain.

(d) Pain Care Coordinator (PCC) Training. Registered Nurses in primary care designated as PCCs will complete the SCM for Pain PCC breakout training.

f. Patient Education and Utilization of Informed Consent for LOT

(1) All patients who receive an opioid prescription will be educated on the risks associated with opioids and accidental overdose using the designated DHA patient education handout (Enclosure 7), available for download at https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/OEND-Program/For-Patients-and-Caregivers.
The prescribing provider will ensure this education is documented in the EHR.

(2) Patients who are prescribed long-term opioid therapy, at risk for opioid use disorder or other opioid-related adverse events, or receiving renewals of opioid prescriptions for acute pain will be educated by their provider using DHA Form 105, Consent for Long Term Opioid Therapy for Pain (Reference (w)). DHA Form 105 ensures patients receive essential information regarding the potential benefits, risks, and alternatives to long-term opioid therapy, use of naloxone for overdose, safe opioid storage and disposal, and information regarding use of risk mitigation strategies that might include more frequent appointments with their prescriber, no early refills, and random urine drug screening. If a prescriber desires to restrict opioid refills to designated prescriber(s), and/or pharmacy(ies), they will specify in DHA Form 105, Section 8, the restriction type, prescriber(s), and/or pharmacy(ies) and complete/submit Prescription Monitoring Program Enrollment Form (see Enclosure 10 and paragraph (g.) below.

g. Enrolling Patients in Prescription Monitoring Program

(1) In accordance with References (i) and (bb), MTF Providers and Pharmacists will utilize the Prescription Monitoring Program (PMP) as the sole mechanism to place prescription medication restrictions on beneficiaries suspected of unsafe behaviors or for those with complicated medication profiles or conditions for whom designated provider(s), pharmacy(ies), or both are necessary for safe care.

(2) Providers and Pharmacists will submit a Prescription Monitoring Program Enrollment Form (Enclosure 10) to Pharmacy Contractor (eg. Express Scripts) to enroll, modify existing enrollment, reinstate enrollment or discontinue enrollment in the Prescription Monitoring Program.

(3) The Prescription Monitoring Program (PMP), previously known as the TRICARE 1-1-1 Program, is designed to help Military Heath System providers protect the health and safety of TRICARE beneficiaries as well as reduce prescription drug misuse.

h. Accountability

(1) Provider accountability. The Directors, Direct Reporting Markets will identify prescribers whose prescribing practices may be inconsistent with VA-DoD, CDC, and FDA guidelines by utilizing available monitoring tools (e.g., Opioid Prescriber Monthly Trend Report and/or Provider PMP Reports as provided by TPharm contractor) and MTF/DTF governance (e.g., Pharmacy and Therapeutics committee, credentialing peer review, LOTS Committees under Medical Executive Committee Professional Staff, or similar MTF/DTF activity). Director, MTF/DTF will determine whether any further training, review, or action regarding these providers is necessary, per Reference (y).

(2) The Joint Commission compliance. Director, MTF/DTF provide information regarding compliance with pain management standards to TJC during regular surveys and as otherwise required for accreditation according to References (e) and (f). This DHA-AI enables meeting TJC requirements by outlining how MTFs/DTFs 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. Director, MTF/DTF will engage in continuous quality improvement regarding both pain management and opioid safety, reporting selected measures to DHA through their respective Directors, Direct Reporting Markets'. Director, MTF/DTF may use their discretion to choose which areas to improve except in cases otherwise noted in this DHA-AI. The Pain Management Clinical Support Service will review this information and share effective quality improvement efforts across the DHA.

i. Medications and Pharmacy

(1) MOUD. MOUD (i.e., buprenorphine, methadone, and naltrexone) will be available either directly from the MTF/DTF, through Direct Care system referral, or through Private Sector Care to all MTF/DTF patients with an opioid use disorder in accordance with References (n), (o), (s), and (t). MOUD is one component of an overall opioid use disorder program. Prescribing providers who treat patients with opioid use disorder must abide by all rules and regulations for MOUD treatment issued by Health and Human Services and Drug Enforcement Agency.

(2) Opioid antagonists. Naloxone (or other FDA and enterprise-approved opioid antagonists) will be available at all MTFs/DTFs for emergency use in case of opioid overdose, to dispense to patients who are assessed at increased risk of opioid overdose or for patients who self-request.

(a) Providers who are prescribing the opioid medication have the primary responsibility for conducting the opioid overdose risk assessment and evaluating the indications for naloxone prior to prescribing an opioid. Prescribing providers will assess opioid overdose risks by utilizing the Opioid Management Clinical Registry, and when indicated, prescribe naloxone and provide opioid safety/overdose education utilizing the designated DHA education materials (Reference (x)), and document in the EHR. MHS GENESIS sites will review and follow the guidance in the MHS GENESIS Opioid Alerts, to include prescribing naloxone.

(b) Naloxone will be prescribed to all outpatients who fall under any of the designated risk criteria as indicated in the Opioid Management Clinical Registry, CarePoint Patient Lookup tool, or, at MHS GENESIS sites, as indicated in MHS GENESIS Opioid Alert. Additionally, naloxone can be prescribed in accordance with the provider's clinical judgement or at the request of the patient.

(c) In accordance with Reference (v), MTF/DTF pharmacists will utilize the CarePoint Patient Lookup tool prior to dispensing prescribed opioid medications if the patient does not have an active prescription for Naloxone. When indicated in the Patient Lookup tool, pharmacists will prescribe naloxone and provide overdose education utilizing the designated DHA opioid overdose patient education materials (Enclosure 7), and document in the EHR. MHS GENESIS sites will review and follow the MHS GENESIS Opioid Alerts to prescribe naloxone, in addition to providing overdose education utilizing the designated DHA opioid overdose patient education materials (Enclosure 7), and documenting in the EHR.

(e) If a patient declines the prescriber's or pharmacist's recommendation for a naloxone prescription, the prescriber or pharmacist will document the patient's stated reason for declining the naloxone prescription in the EHR. In situations where naloxone is not clinically indicated (e.g., hospice care, naloxone already in the home), the prescriber or pharmacists will document this in the EHR.

(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/DTFs to make this service available (Reference (j)).

j. Laboratory. Patients on LOT and/or at risk for opioid use disorder must be monitored with urine drug testing in accordance with References (n) and (o). 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/DTFs.

3. HEALTH INFORMATION SYSTEMS

a. EHR

(1) The DVPRS and 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 (n) and (o). 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 Director, MTF/DTF.

b. MHS PDMP. The MHS PDMP offers MTF/DTF providers and pharmacies information on when, where, and how many controlled substances MTF/DTF patients obtained from a civilian pharmacy. The MHS PDMP is interconnected with other state/territory PDMPs; sharing information can be found at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/Prescription-Monitoring-Program/Prescription-Drug-Monitoring-Program-Procedures

4. MEASUREMENTS

a. DVPRS. DVPRS (Enclosure 8, Figure 5) will be used as the standard pain scale in the SCM.

(1) When indicated by their condition/complaint, adolescent and adult patients will be screened for pain during each encounter using the DVPRS. Re-screening for an encounter on the same day may be deferred if agreed upon by patient and clinical staff.

(2) The supplemental questions of the DVPRS will be administered for any outpatient who presents with pain intensity equal to or greater than "4".

(3) All patients in the secondary or tertiary levels of care in the SCM will complete the entire DVPRS, including all supplemental questions, at every visit.

b. 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 all MTFs in coordination with the Direct Reporting Markets. PASTOR will be utilized as the designated screening tool and outcomes registry for tertiary-level pain care and for all patients on LOT. PASTOR is also encouraged to be used for any patient escalating to the secondary level of pain care to facilitate collection of critical outcomes data as early as possible for those patients whose pain-related conditions do not resolve.

5. MONITORING AND REPORTING

a. Process Measures for Pain Management. The ESB will monitor these initial process measures to determine the effectiveness of the VA-DoD SCM on a quarterly basis:

(1) Adoption of the VA-DoD SCM for Pain Management. DHA will develop a methodology 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 number of PCPCs designated and trained at each MTF/DTF. Newly designated PCPCs will complete their training within 90 days.

(3) Increase use of non-pharmacologic treatments. DHA will develop and disseminate metrics to track utilization 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) Prescriber completion of OPST. ESB will ensure DHA implements a process ensuring prescribers complete OPST training in accordance with Reference (s).

(2) LOT patients with informed consent. Patients on LOT (90 days or more of opioid therapy within a 180-day period). These patients are at higher risk for opioid-related complications. DHA will develop capability for MTFs/DTFs to track enrolled LOT patients who have completed the LOT informed consent.

(3) Availability of MOUD. MOUD is one component of an overall opioid use disorder treatment program. Every MTF/DTF will make MAT available to patients directly, either through Direct Care referral, or through referral to Private Sector Care within 1 year of publication of this DHA-AI.

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

(5) Patients in designated risk categories receiving naloxone. Patients with LOT, ≥50 MME/day, or co-prescribed benzodiazepines will be prescribed naloxone because they are at risk for opioid overdose. ESB will monitor the percentage of these patients who have been prescribed naloxone.

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

c. Outcome Measures for Pain Management. DHA will develop and disseminate 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 or equal to 50 morphine MME/day. Patients taking ≥ 50 MME/day are at increased risk for death from opioids. VA-DoD and CDC Guidelines recommend against these doses. ESB will monitor the percentage of patients who are prescribed ≥ 50 MME/day.

(2) Co-prescription of benzodiazepines and opioids. VA-DoD and CDC Guidelines 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.

e. DHA Clinical Decision Support Tools: An overview of available DHA Clinical Decision Support Tools for pain management and opioid safety is provided in Enclosure 9, Table 1.

ENCLOSURE 4

MILITARY HEALTH SYSTEM OPERATING MODEL

1. 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

2. Pain Management is a Clinical Support Service in the MHS Operating Model. The Pain Management Clinical Support Service workgroup serves as the coordinating body for this Clinical Support Service.

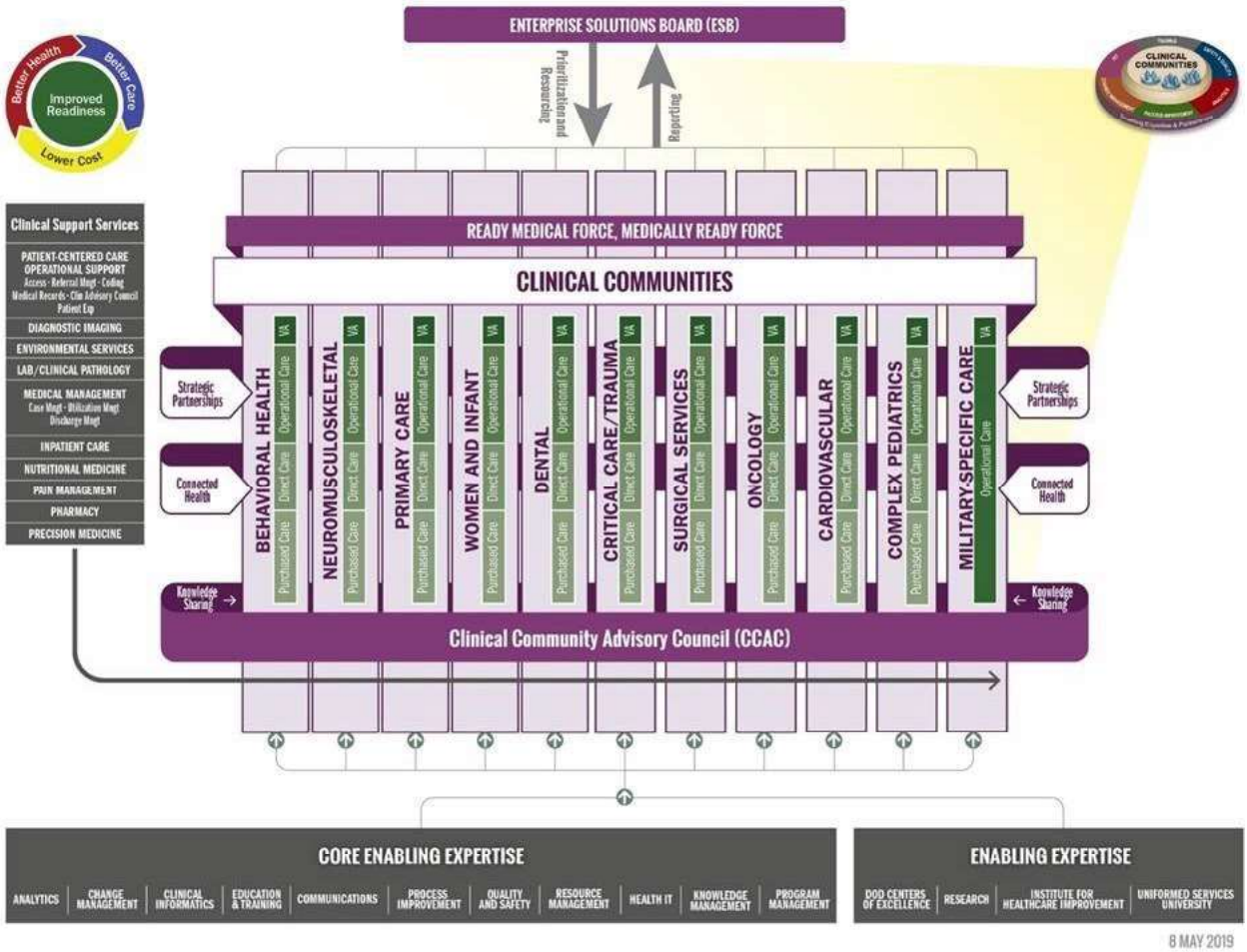


Figure 2: Military Health System Operating Model

ENCLOSURE 5

DEPARTMENT OF VETERANS AFFAIRS - DEPARTMENT OF DEFENSE
STEPPED CARE MODEL FOR PAIN MANAGEMENT

The VA-DoD SCM for Pain Management is being deployed in the DoD to enable Clinical Communities to provide evidence-based pain management guided by 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. To facilitate dissemination and local implementation of the model, DHA will train PCPCs who are selected by their Directors, MTF/DTF. NOTE: Non pharmacologic pain treatments should not be limited to Tertiary Care and are most effective when utilized as early as possible in the SCM.

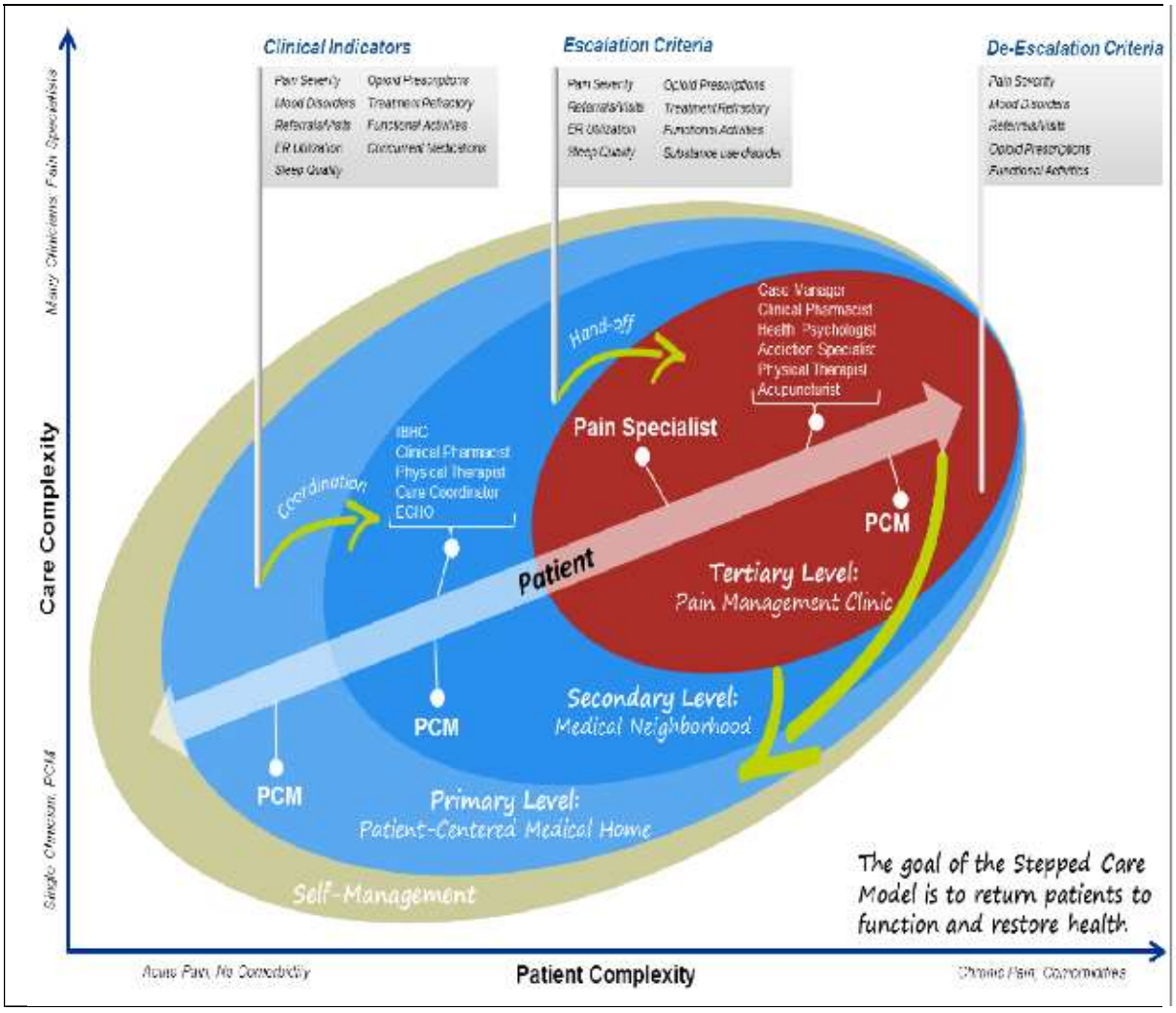


Figure 3: VA-DoD Stepped Care Model for Pain Management

ENCLOSURE 6

PRIMARY CARE PAIN CHAMPION ROLES, RESPONSIBILITIES, AND REQUIREMENTS

Background

Comprehensive Pain Management Programs (CPMPs) improve the capability and capacity of MTFs/DTFs 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) through (g), (n), (z), and (aa), and the strategic goals and objectives of each Service.

The VA-DoD Stepped Care Model (SCM) is a team-based, interdisciplinary model for pain management that aligns pain management across the enterprise. "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 SCM 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 and educate clinicians on appropriate referral to next appropriate level or tertiary multidisciplinary pain clinics.

PCPCs ensure the successful deployment of Primary Care education initiatives. These individuals optimize pain services in the Primary Care structure at their local MTFs/DTFs 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 ECHO®).

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/DTFs should meet the following requirements:

- Currently, a board certified/board eligible physician, physician assistant, nurse practitioner, or other medical professional in primary care as designated by Director, MTF/DTF;
- 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.

PCPC appointment minimum requirements by enrolled population:

- MTFs/DTFs with an enrolled population greater than 7,500;
- Each PCMH with an enrolled population of 7,500 or more enrollees will have an assigned PCPC to fulfill all associated roles and responsibilities;
- For PCMHs with enrolled population less than 7,500:

    - Two or more Patient Centered Medical Homes that combined have an enrolled population of 7,500 or more enrollees will together have an assigned PCPC to fulfill all associated roles and responsibilities.
    - When the combined smaller PCMHs do not have an enrolled population of 7,500 or more, each PCMH will receive PCPC coverage from the larger PCMH at that MTF/DTF.

- MTFs/DTFs with an enrolled population of less than 7,500 will generally receive PCPC coverage by the PCPC at the parent Defense Medical Information System (DMIS). MTFs/DTFs have the flexibility to appoint additional PCPCs (i.e., one PCPC per smaller MTF/DTF or branch clinic) where barriers exist to receiving coverage by the PCPC at the parent DMIS to successfully fulfill all associated roles and responsibilities (e.g., distance between locations).

Standard deduction for PCPCs:

- The standard deduction for PCPCs will be a 0.1 FTE deduction. This deduction can be taken at the clinic level or the MTF/DTF level depending on the structure and size of the facility. Parent DMIS PCPCs who are required to cover face-to-face visits with child clinics or PCPCs in clinics with greater than 15000 enrolled, are granted an additional standard deduction of 0.1 FTE (total 0.2 FTE deduction).

- Additional PCPCs who are appointed to cover smaller MTFs/DTFs or branch clinics (i.e., enrolled population of less than 7,500) will not receive the standard 0.1 FTE deduction but should be given 0.025 FTE deduction (equivalent to 2 hours every other week) to fulfill these PCPC responsibilities.

General Activities and Duties

The estimated time commitment for general activities and duties may vary based on the MTF/DTF. 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/DTF.
- Providing Primary Care Managers (PCMs) and other team members with training, consultative and clinical support.
- Relaying feedback and relevant issues, questions, and concerns to CPMP leadership.
- Ensuring site providers are leveraging training and resources to promote CPGs.
- Maintaining awareness of federal, state, and local laws and regulations affecting PCM practices and collaborating with MTF/DTF sections (e.g., legal, credentialing, quality management), to ensure MTF/DTF staff are fully informed.
- Leading regular team huddles with local pain management resources (e.g., integrated behavioral health consultant, physical therapist, acupuncturist).

Training

DHA SCM for Pain PCPC training series that must be completed within 90 days of being designated as a PCPC. This series enables the PCPC to train new PCMH staff in the SCM for pain:

- DHA SCM for Pain PCPC webinar series. Information on webinar dates and times is available by contacting dha.ncr.j-9.mbx.phcoe-stepped-care-model-for-pain@mail.mil. This webinar series must be completed before leading the SCM for Pain PCMH Team Training in PCMHs.
- Review the JPEP materials available at: https://www.dvcipm.org/.
- Initial Train-the-Trainer course to learn JPEP content and techniques for delivering training effectively, as well as formulate MTF/DTF-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 Annual Pain Skills training, buprenorphine waiver training and battlefield acupuncture.

Key PCPC training responsibilities include:

- Leading the SCM for Pain PCMH Team Training for all existing and new PCMH team members;
- 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®.

Primary Care Provider Consultation

PCPCs may be utilized to consult with Primary Care Providers within the PCMH or MTF/DTF 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.

Primary Care Behavioral Health Services Consultation and Collaboration

PCPCs collaborate with Primary Care Behavioral Health Services (PCBH) staff (e.g., Behavioral Health Consultants (BHC), Behavioral Health Care Facilitators (BHCF)) for patients who might benefit from behavioral health support.

In accordance with DHA-PI 6025.27, "Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System (MHS)," the DHA PCBH Committee develops and/or implements training that will be required DHA wide to ensure delivery of evidence-based assessment and treatment by BHCs, BHCFs, PCMH staff, as well as standards for referrals by PCMH staff for PCBH services.

Measures of Effectiveness

See Enclosure 3 for process and outcomes measures related to the VA-DoD SCM and opioid safety.

ENCLOSURE 7

DHA OPIOID SAFETY AND OVERDOSE FLYER

https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/OEND-Program/For-Patients-and-Caregivers

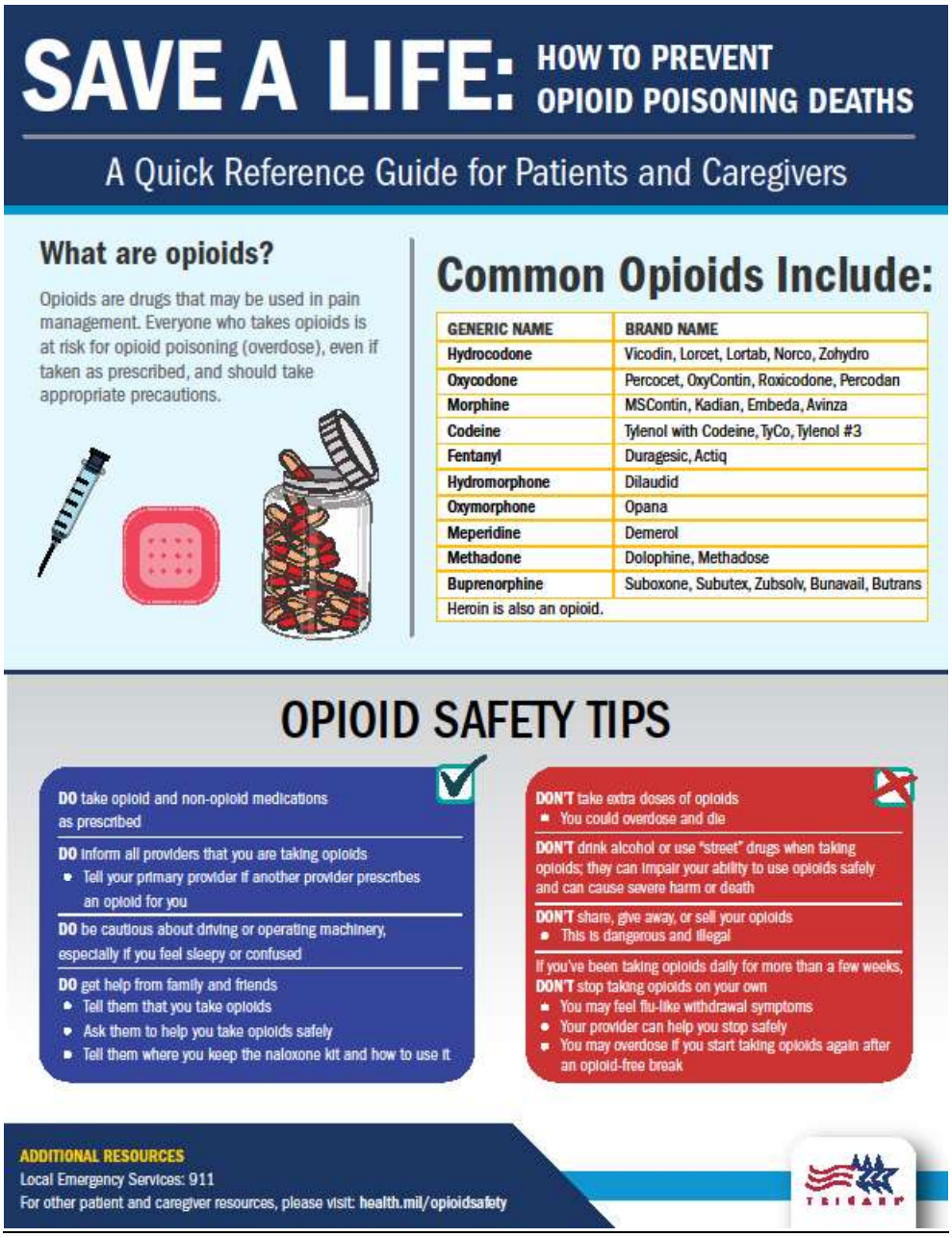


Figure 4: DHA Opioid Safety and Overdose Flyer (front)

IN CASE OF OPIOID POISONING (OVERDOSE)

What is naloxone?

Naloxone (brand name: Narcan) is a temporary antidote for an opioid overdose. Should an overdose occur, naloxone will temporarily restore your breathing. If you are prescribed opioids, your doctor or pharmacist may talk to you about or prescribe naloxone. If you or someone you know is taking opioids, you can request naloxone.

Someone else has to administer this medication to the person experiencing an overdose. Be sure to tell your family members and friends where you keep your naloxone, and teach them how to use it.

If you use naloxone, follow up with your provider.

1 Check responsiveness

Look for any of the following:

- No response even if you shake them, say their name, or do a sternal rub
- Breathing slows or stops
- Lips and fingernails turn blue or gray
- Skin gets pale or clammy

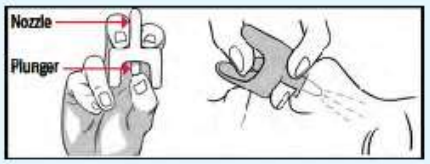
Sternal Rub

2 Call 911 and give naloxone

If no reaction in 2-3 minutes, give second naloxone dose in the other nostril. (medication comes in two packs)

This nasal spray needs no assembly and can be sprayed up one nostril by pushing the plunger.

Do not test device - each device can only be used once.



3 Follow 911 dispatcher instructions

Dispatcher may provide instructions for rescue breathing and/or CPR.

>> Stay with person until help arrives

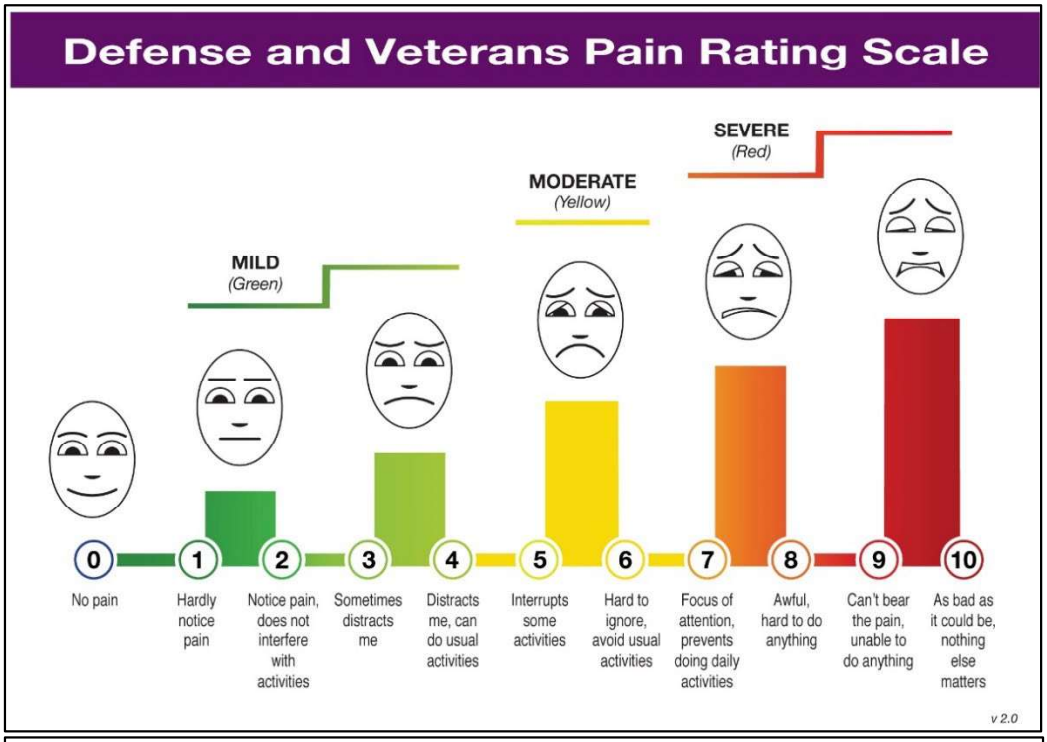
For video instructions, use your phone's camera to scan the QR code

For more information about accessing naloxone, talk to your pharmacist or provider.

Figure 4: DHA Opioid Safety and Overdose Flyer (back)

ENCLOSURE 8

DEFENSE AND VETERANS PAIN RATING SCALE



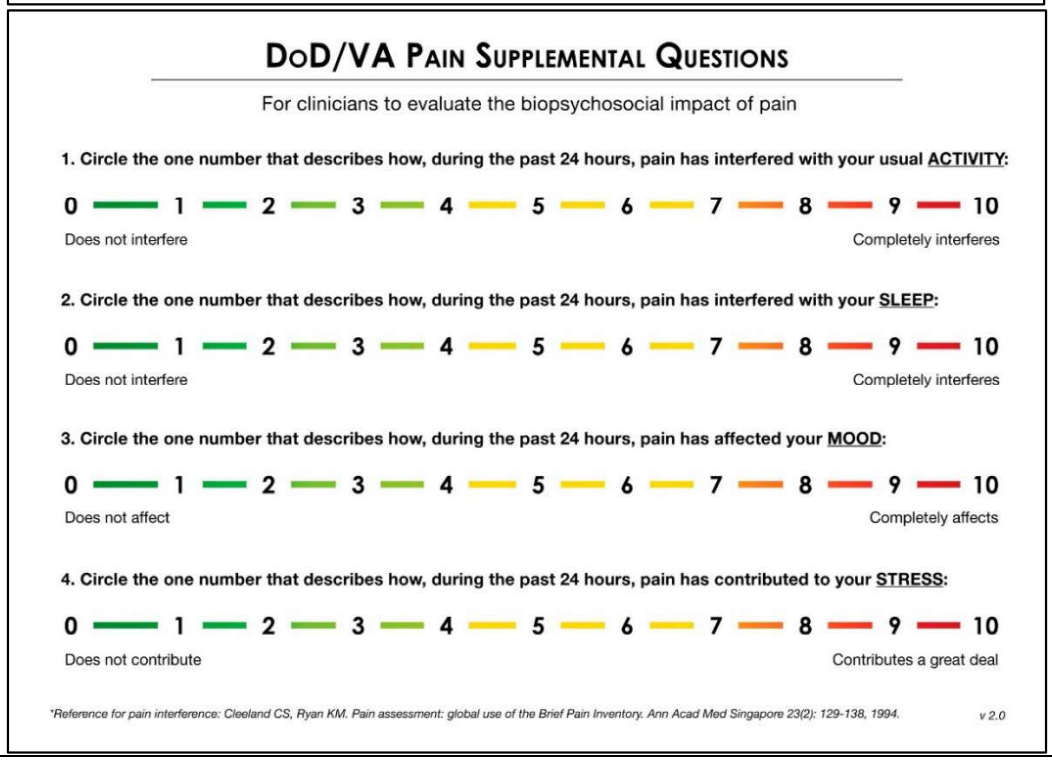


Figure 5: Defense and Veterans Pain Rating Scale

ENCLOSURE 9

DHA CLINICAL DECISION SUPPORT TOOLS FOR PAIN MANAGEMENT AND OPIOID SAFETY

DHA Pain Management and Opioid Safety Support Tools

DHA Tool	Users	Owner	Data Aggregation Level	Metrics Shown	Frequency of Updates	Design Features
Point of Care Information						
Opioid Registry	Providers, clinical pharmacists	PMCSS	Patient	LOT (currently, user must select to add this flag), RIOSORD, MEDD, Co-Rx Benzo, mental health flags, past-year naloxone	Nightly	Template customization, filtering capabilities, ORCA OTTR (reports) for step-wise CPG adherence support
Look-Up Tool	At-the-window pharmacists	EIDS	Patient	RIOSORD >32 flag and MEDD across time, co-Rx Benzo	Nightly	Barcode scanning on ID card for look-up ease
Pain Assessment Screening Tool and Outcomes Registry (PASTOR) *	Providers, Clinic Managers, Clinical Pharmacists, etc.	PMCSS	Patient (TBD – Dashboards in development for clinic and MTF aggregation)	Patient Reported Outcomes, appt data, etc.	(TBD)	Patient summary reports display patient data across time in an intuitive manner to aid decision-making. Automated HPI documentation is created for providers to copy/paste into medical record.
Prescription Drug Monitoring Program (PDMP)	Prescribers and Pharmacists	POD	Patient	Controlled substance prescriptions	Nightly	Data displayed can include multiple states

DHA Tool	Users	Owner	Data Aggregation Level	Metrics Shown	Frequency of Updates	Design Features
Practice Monitoring and Quality Improvement						
Look Up Tool Dashboard	MTF- and Market-Pharmacy leads, DHA Leadership	EIDS	Pharmacy, MTF, Enterprise (Can user-level metrics on Look Up Tool Usage)	Frequencies of opioid prescriptions, patients dispensed opioids, patients dispensed naloxone, including those who meet criteria for LOT, MEDD ≥50, Co-Rx Benzo, RIOSORD >32, or any risk category, as well as the number of patients with past-year naloxone who met criteria for these risk categories and Look-Up Tool utilization	Monthly	Can toggle by any combination of elevated risk categories and naloxone eligibility
Opioid Prescriber Trend Report	All	PMCSS	Provider, Clinic, MTF, Market, Enterprise	Opioid prescriptions, opioid prescriptions to patients at elevated risk, LOT, MEDD≥50, Co-Rx Benzo, RIOSORD>32, past-year naloxone to patients at elevated risk	Monthly	Simple data display; ability to visualize comparisons within clinics and between providers; Used to directly support Stepped Care Model Implementation, CPG adherence, and monitoring of out-of-norm prescribing practices; includes data download feature to support local QI efforts
Opioid Metric Dashboards	MTF and Market leads, Pain Champions	J5	MTF, Market, Enterprise	Patients at elevated risk receiving naloxone (plus naloxone coverage for each of the 4 risk categories)	Monthly/ Quarterly	Filterable to Market and MTF level data; clinic level data available on some dashboards
Prescription Monitoring Program (PMP)	MTF Leaders, Pharmacists, MCSCs	POD	Beneficiary (at MTF and in Managed Care Restriction Program)	Restrictions (e.g. Type I-II Lock; select-provider, hospital, DEA 2-5)	Monthly, Quarterly	Data provided to PMP Point of Contact; PMP lock data in Opioid Registry and Look-Up Tool (previously Sole Prescriber); for patients enrolled in direct care

Table 1: Defense Health Agency Clinical Decision Support Tools for Opioid Safety

ENCLOSURE 10

PRESCRIPTION MONITORING PROGRAM ENROLLMENT FORM

EXPRESS SCRIPTS®

Prescription Monitoring Program Enrollment Form

For Military Treatment Facility use only

Fax to 866.579.4662 or call 866.333.1348 for alternative CAC encryption submission option

**Contact information is required from authorized MTF personnel (RPh,MD,RN)

A check box must be selected when the request form is submitted**

New Request ☐ Modify Existing Request ☐ Reinstatement ☐ Date _____

Restricted Beneficiary's Information

Last Name: _____ First Name: _____ M.I.: ____

DOD ID Number: _____ Birth Date: _____

Step 1: Choose Lock Type (select ONE ONLY)

☐ **TYPE I LOCK**
Restrict all medications

☐ **TYPE II LOCK**
Restrict all controlled meds or a selected drug schedule
☐ II ☐ III ☐ IV ☐ V

☐ **TYPE III LOCK**
Restrict specific medications or medication class
Restricted Drug _____
☐ Short Acting Opioids ☐ Benzodiazepines/Barbiturates
☐ Long Acting Opioids ☐ Amphetamines
☐ Stimulants

Step 2: Set Authorized Provider and/or Pharmacy

Authorized Provider(s)

Add/Remove	Provider Name	DEA/NPI

Additional Comments

Authorized Pharmacy(ies) (select ONE ONLY)

☐ All MTF Pharmacies on Site
Site Name: _____

☐ Specific MTF Pharmacy (include all applicable NPIs)

☐ Retail Pharmacy Name and Address (NPI if known)

☐ Remove Pharmacy (include all applicable NPIs)

Requestor POC Information

*Required to complete restriction

Reason for Request _____

Restricting MTF Site _____ MTF Hospital _____

RN/RPh/MD	Email	Phone	Signature

☐ POC contact information can be provided to patient

☐ Patient has been notified of restriction

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GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

BHC	Behavioral Health Consultant
BHCF	Behavioral Health Care Facilitator
CDC	Centers for Disease Control and Prevention
CPG	clinical practice guideline
CPMP	Comprehensive Pain Management Program
DHA	Defense Health Agency
DHA-AI	Defense Health Agency-Administrative Instruction
DHA-PI	Defense Health Agency-Procedural Instruction
DMIS	Defense Medical Information System
DTF	Dental Treatment Facility
DVPRS	Defense and Veterans Pain Rating Scale
ECHO®	Extension for Community Healthcare Outcomes
EHR	Electronic Health Record
ESB	Enterprise Solutions Board
FDA	U.S. Food and Drug Administration
FTE	full-time equivalent
JPEP	Joint Pain Education Program
LOT	long-term opioid therapy
MCSC	Managed Care Support Contractor
MHS	Military Health System
MME	morphine milligram equivalent
MOUD	Medication for Opioid Use Disorder
MTF	Military Medical Treatment Facility
OPST	Opioid Prescriber Safety Training
PASTOR	Pain Assessment Screening Tool and Outcomes Registry
PCBH	Primary Care Behavioral Health
PCC	Pain Care Coordinator
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PCPC	Primary Care Pain Champion
PDMP	Prescription Drug Monitoring Program

POD	Pharmacy Operations Division
SCM	Stepped Care Model
SG	Surgeon General
SM	Service member
TJC	The Joint Commission
USFHP/DP	United States Family Health Plan/Designated Provider
USUHS	Uniformed Services University of the Health Sciences
VA-DoD	Department of Veterans Affairs - Department of Defense

PART II. DEFINITIONS

high impact chronic pain: Pain that has lasted 3 months or longer and is accompanied by at least one major activity restriction, such as being unable to work outside the home or perform routine activities of daily living.

minor procedure: Procedures in which short surgical techniques are applied on superficial tissues, usually with local anesthesia, and minimal complications, that usually do not require postoperative resuscitation and need minimal equipment, many of which are used on a daily basis, and can be easily and safely performed in a short amount of time during hospital or clinic visit.

major procedure: Procedures involving open body cavity, long-bone, joint replacement, or when normal anatomy is altered, utilizing local, regional or general anesthesia, usually requiring postoperative resuscitation and monitoring, and postoperative wound care.

non-privileged provider: An individual who possesses a license, certification, or registration by a state, commonwealth, territory, or possession of the United States, and is only permitted to engage in the delivery of healthcare as defined in their granted scope of practice. Examples include registered nurse (RN), licensed vocational nurse (LVN), registered dental hygienist (RDH), and medical technician.

privileged: An individual who possesses appropriate credentials and is granted authorized clinical privileges to diagnose, initiate, alter, or terminate regimens of healthcare with defined scope of practice.

Service member: A uniformed member of the Army, Navy, Air Force, Marine Corps, U.S. Coast Guard, or Space Force. Does not include members of U.S. Public Health Services or National Oceanic and Atmospheric Administration.