UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

DEC - 8 2021

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's report on Comprehensive Policy on Pain Management by the Military Health Care System for Fiscal Year (FY) 2021 is enclosed.

In FY 2021, the Military Health Service (MHS) continued the sustained improvement of pain-management policy, clinical care, education, and tri-Service coordination. Improved coordination and collaboration across the MHS contributed to advances in pain-management policy, clinical care, research, education/training products, and clinical tools that serve our beneficiaries and provide an example for the Nation.

Thank you for your continued strong support for our Service members. I am sending a similar letter to the Committee on Armed Services of the House of Representatives.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
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PERSONNEL AND
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DEC - 8 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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cc:
The Honorable Mike D. Rogers
Ranking Member

Report to Committees on Armed Services of the Senate and the House of Representatives

The Implementation of a Comprehensive Policy on Pain Management by the Military Health Care System for Fiscal Year 2021

Section 711 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84)

Office of the Secretary of Defense

The estimated cost of this report or study for the Department of Defense is approximately $17,000 in Fiscal Years 2020 - 2021. This includes $0 in expenses and $17,000 in DoD labor.
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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report provides an assessment of Military Health System (MHS) pain management at the MHS during Fiscal Year (FY) 2021. Key elements include: a description of the current pain management policy and revisions; a description of the performance measures used to determine the effectiveness of policy; and an assessment of the adequacy and effectiveness of pain management services, research completed or underway, training delivered to Department of Defense (DoD) health care personnel, education provided to beneficiaries, and dissemination of information on pain management to our beneficiaries.

During FY 2021, the MHS continued to mature the pain management capabilities and resources for our beneficiaries and health care workforce. Improved coordination and collaboration across the Military Departments (MILDEPs), the Defense Health Agency (DHA), and the Uniformed Services University of the Health Sciences (USUHS) resulted in several advances in pain management policy, clinical care, and fielding of innovative education, training products, and clinical tools.

The MHS pain strategy and initiatives align with the 2016 National Pain Strategy and the national interest in addressing overuse of prescription pain medications. The strategy and initiatives include:

- Focusing efforts for pain management improvements and initiatives on meeting clinical and educational needs of primary care providers and patients;
- MHS implementation of the Stepped Care Model of Pain Management to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain;
- Implementing pain-related Clinical Practice Guidelines (CPGs), as well as continued identification of requirements for new CPGs by using resources available through Department of Veterans Affairs (VA)/DoD Health Executive Committee (HEC) Work Groups and other work groups;
- Increasing pain telehealth integration in the MHS primary care by both direct care visits and provider webinar case-based education;
- Training in primary care pain skills offered annually by the National Capital Region (NCR) Pain Care Initiative;
- Training specialty care offered annually by the NCR Pain Care Initiative;
- Integrating specialty care pain services in Primary Care and increasing access to specialized pain care in the MILDEPs;
- Expanding pilot in-home telehealth visits to transitioning and rural Service members and beneficiaries;
- Developing and deployment of the Pain Assessment Screening Tool and Outcomes Registry (PASTOR) to integrate the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System (PROMIS) into a pain registry and clinical decision-making tool for providers;
- Assessing patient satisfaction on pain management;
- Executing the Joint Pain Education Program (JPEP) in disseminating a standardized DoD

and VA pain management curriculum and supplemental pain videos for widespread use in education and training programs to improve pain management competencies of the combined Federal clinical workforce;
- Participating in research efforts offered by DoD, VA, and NIH to examine non-pharmacological treatments to complex pain syndromes experienced by military populations; and
- Participating in the Department of Health and Human Services (HHS) Pain Management Best Practices Inter-Agency Task Force.

Exemplary management of pain in the MHS continues to align with drivers such as the October 2017, "Presidential Memorandum for the Heads of Executive Departments and Agencies," the October 2015 Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use," the National Pain Strategy, and the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain. The multiple MHS lines of effort in pain management research, clinical practice, education, and training of the MHS workforce will serve our beneficiaries well and provide an example for the nation.

INTRODUCTION

The MHS has been addressing the national challenges of pain management and prescription medications since the August 2009 Pain Management Task Force and ongoing implementation of a comprehensive pain management policy to improve pain management care and services within DoD. Efforts from the MHS Pain Management Clinical Support Service (PMCSS), comprised of representatives from the MILDEPs, DHA, and USUHS, in collaboration with the VA/DoD HEC Pain Management Working Group, which includes subject matter experts (SMEs) from the VA and the MHS, continue to progress and improve the MHS's pain strategy. Collaboration between DoD and other Executive Departments has been critical to many MHS accomplishments and advances in pain management, with activities to:

- Synchronize a culture of pain awareness, education, and proactive intervention among patients, medical staff, and leaders;
- Provide tools and infrastructure that support and encourage clinical practice and research advancements in pain management; and
- Build a full spectrum of best practices for the continuum of acute and chronic pain, based on a foundation of best available evidence.

Policies and Revisions

The policy for Comprehensive Pain Management (Health Affairs Policy 11-003), signed on March 30, 2011, was the original policy guiding the pain management activities across the MHS. It led to the creation of Operation Order (OPORD) 19-09, "Army Comprehensive Pain Management Program," published on November 16, 2018 and a subsequent Fragmentary Order 1 to OPORD 19-09, on July 2, 2019. Health Affairs Policy 11-003 also shaped the development of the Defense Health Agency-Procedural Instruction (DHA-PI) on Pain Management and Opioid Safety in the MHS.

The aligned DHA-PI 6025.04, "Pain Management and Opioid Safety in the MHS," published June 8, 2018, establishes DHA's procedures to:

- Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for MHS to provide consistent, quality, and safe care for patients experiencing pain, with an emphasis on non-pharmacological treatments;
- Educate patients in effective self-management of pain and injury rehabilitation;
- Educate clinicians regarding effective pain management and optimal opioid safety consistent with VA/DoD and CDC CPGs;
- Provide tools, including those through MHS GENESIS® and legacy electronic health records, to assist clinicians in evidence-based and patient-centered pain management; and
- Conduct pain research to improve the MHS approach to pain management.

As required by DoD and DHA policy, found in DoD Instruction 6025.13, "Medical Quality Assurance and Clinical Quality Management in the Military Health System," and DHA-Procedures Manual 6025.13, "Clinical Quality Management (CQM) in the Military Health System," for military medical treatment facilities (MTFs) to be accredited, all MTFs continue to demonstrate successful adherence to The Joint Commission's (DoD's accrediting agency) pain management standards. While meeting The Joint Commission's pain management standards is a significant accomplishment, the MHS has continued efforts to improve its pain assessment tools and capabilities to be the industry leader in pain management.

The Navy Comprehensive Pain Management Program (NCPMP) continued providing comprehensive Long-term Opioid Therapy (LOT) Patient Lists to the MTFs under Direct Support, as well as tracking LOT policy compliance through quarterly chart reviews. These chart reviews focused on measuring compliance with the VA/DoD 2017 CPGs for LOT Therapy that were included in Bureau of Medicine and Surgery Instruction 6320.101, "LOT Safety Program." Long-term Opioid Therapy Safety (LOTS) Committee Chairs from each MTF participated in quarterly Town Halls and Steering Committees to establish and drive standardized and consistent interpretations of the CPGs and share strategies for compliance. To better align with the transition of beneficiary care from the MILDEPs to DHA, the NCPMP focused its efforts on active duty Service member (ADSM) LOT patients and non-ADSM on a space available basis.

Due to the coronavirus disease 2019 (COVID-19) pandemic imposing limitations on hospitals and clinics, many providers were not able to comply with LOTS policies during the second through fourth quarters of FY 2020. Recognizing this, the NCPMP collaborated with pain providers across the Navy Enterprise to develop a formalized LOTS Contingency Guide. This guide provided comprehensive recommendations for how to maintain LOTS compliance via virtual encounters. LOTS compliance has been and will continue to be measured against these updated guidelines while COVID-19 restrictions remain in place.

Performance Measures Used to Determine Effectiveness

PASTOR

PASTOR is a 20-30 minute patient survey that produces a comprehensive 3-page clinician report of a patient's chronic pain. The MHS developed PASTOR in response to the National Defense Authorization Act for FY 2010's recommendation for "performance measures used to determine the effectiveness of the policy in improving pain care for beneficiaries enrolled in the military health care system."

In FY 2021, DHA enabled PASTOR at all MTFs with the priority of effort for PASTOR training and implementation centered on MTFs with designated pain management specialty clinics. DHA provided PASTOR training to 240 providers. As of August 1, 2021, staff at 20 MTF pain management specialty clinics use PASTOR. DHA will continue to train providers to use PASTOR and implement PASTOR at the 11 remaining MTFs pain management specialty clinics.

Military Orthopedics Tracking Injuries and Outcomes Network (MOTION)

Since its inception in 2016, MHS providers use MOTION, which is a musculoskeletal research initiative to prospectively gain consent to use patient survey data and link detailed surgical reporting with patient outcomes. MOTION has evolved into an enterprise patient outcomes and data collection solution for all MHS musculoskeletal communities. While the musculoskeletal communities focus on the restoration of patient functional movement and return to active and productive lives, pain management is a key component in the achievement of this goal.

MOTION and PASTOR clinics collect PROMIS (Patient-Reported Outcomes Measurement Information System) and Defense and Veterans Pain Rating Scale outcomes to enable longitudinal assessment of patients as they move among primary, secondary, and tertiary care (Appendix A). As of August 2021, patients completed over 194,000 MOTION surveys.

High-Risk Opioid Patient Metrics

The MHS continuously monitors high-risk opioid prescribing therapy through the PMCSS function. These high-risk categories include TRICARE® beneficiaries prescribed an average morphine equivalent daily dose (MEDD) equal or greater than 50mg, TRICARE® beneficiaries co-prescribed an opioid and a benzodiazepine prescription, TRICARE® beneficiaries on LOT, and those patients in any high-risk group who have also been prescribed the emergency overdose reversal agent naloxone. The monitoring includes TRICARE® beneficiaries for direct and private sector care.

Trends in all of the high-risk groups continue to show a decrease since 2017. The number of patients prescribed greater than 50mg MEDD declined 37.8 percent, from 145,847 patients in April 2017 to 90,751 patients in March 2021. [Figure 1] Also, the number of patients co-prescribed benzodiazepines and opioids declined 48.5 percent, from 79,164 patients in 2017 to 40,753 patients in 2021. Finally, the number of patients meeting LOT criteria decreased 17.2

percent, from 193,404 patients in 2017 to 160,149 patients in 2021. The use of naloxone subsequently climbed, from 1.5 percent of high-risk patients in 2017 to 15.1 percent in 2021.

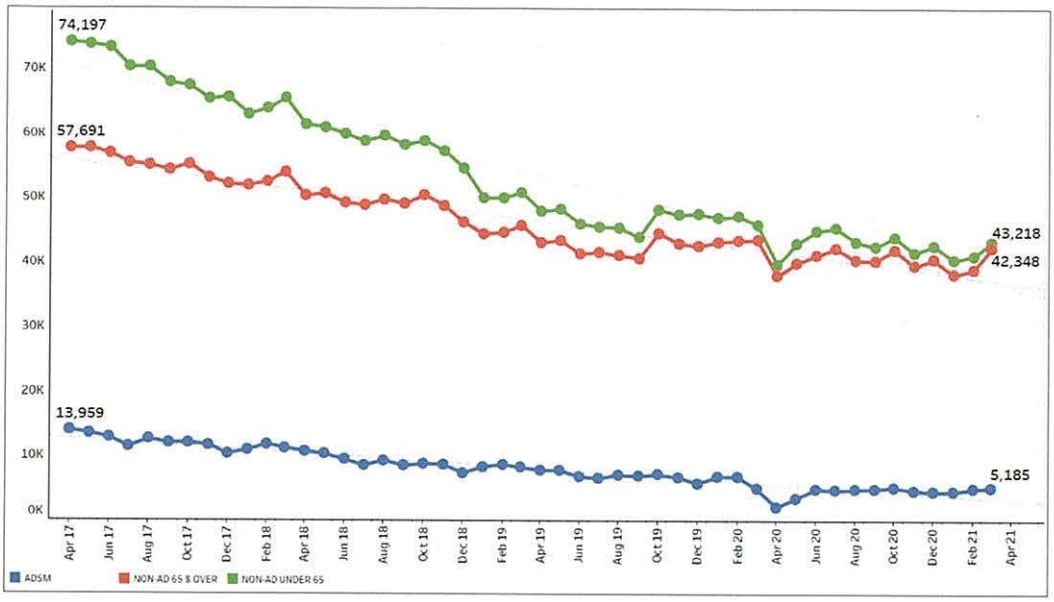


Figure 1. Frequency of Population Prescribed ≥ 50mg Morphine Equivalent Daily Dosage

Pain Management Services

Early identification and intervention occurs in Patient-Centered Medical Homes (PCMHs) with the support of full-time integrated behavioral health consultants and Primary Care Pain Champions (PCPCs). These consultants support patients and their primary care managers in implementing pain management care, particularly through education and encouraging non-pharmacological approaches to pain control and symptom management to limit opioid use.

Comprehensive Pain Management Programs

In conjunction with MHS expansion of the PCMH model, the Department's pain programs, along with the Defense and Veterans Center for Integrative Pain Management (DVCIPM), continue to focus significant effort on providing necessary clinical, education, and training support for pain management in primary care. PCMH and specialty care designated representatives participate in the PMCSS to facilitate synchronization across pain specialty and primary care lines of effort.

Department of the Army

Direct Support continues during FY 2021 for the 12 Army Interdisciplinary Pain Management Clinics located at: Fort Benning, Fort Bragg, Fort Bliss, Fort Campbell, Fort Carson, Fort Drum, Fort Gordon, Fort Hood, Joint Base Lewis McCord, Landstuhl-Germany, Joint Base San Antonio, and Scholfield Barracks. The Interdisciplinary Pain Management Centers (IPMCs) provided tertiary pain care to the beneficiaries at the MTFs. The IPMCs serve as SMEs to

primary care providers in the PCMHs via PCPCs. These IPMCs provide Complementary and Integrative Medicine (CIM) therapies, such as behavioral health treatments, physical therapy, yoga, and medical massage, in addition to pharmacological management by clinical pharmacists. Chiropractic care and acupuncture are limited to ADSM but, at some locations, CIM treatment modalities are available to non-active duty beneficiaries on a space available basis. During FY 2020, the IPMCs provided over 159,000 pain encounters. As of the third quarter of FY 2021, the IPMCs provided 127,543 pain encounters.

Several opioid safety tools have been developed and refined across the MHS for use by providers, pharmacists, and MTF and Market leads. These include metric dashboards that enable practitioners and administrators to monitor patients in high-risk categories: prescribed equal or greater than 50 morphine milliequivalents per day; on long-term opioid therapy; co-prescribed benzodiazepine(s); or a Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD) score greater than 32. Army Comprehensive Pain Management Program (CPMP) personnel, in collaboration with the DHA, developed the Opioid Prescriber Trend Report, the Prescription Drug Monitoring Program (PDMP), the Opioid Registry, and the Patient Look-Up Tool. The Opioid Education and Naloxone Distribution program provides education to providers and pharmacists to ensure that the MHS is dispensing naloxone to beneficiaries identified to be at high-risk for opioid-related complications. The development of clinical decision support tools is ongoing.

The Army CPMP continues supporting implementation of Execution Order 224.17, "Opioid Profiling Standardization," which directs medical providers to inform commanders of soldiers with opioid prescriptions via the e-profile system. This allows for transfer of vital duty-related information to improve medical care and readiness.

Department of the Air Force

The Air Force continues Direct Support to DHA during FY 2021 for six IPMCs located at: Joint Base Elmendorf-Richardson (JBER), Travis, Nellis, Wright Patterson, Eglin, and Lakenheath with supplementary Air Force pain staff at the Brooke Military Medical Center. Additionally, the Acupuncture and Integrative Medicine (AIM) Center at Joint Base Andrews is dedicated to non-pharmacologic pain management clinical care, training, and research. Air Force IPMCs have between one and three board-certified pain medicine physicians. In addition, VA and Air Force pain management physicians at JBER work in joint partnership, and Air Force physicians at Nellis work in coordination with the VA. The Air Force offers beneficiaries a wide array of multimodal pain care ranging from invasive therapies at Air Force IMPCs to an overall emphasis on non-opioid/non-pharmacologic modalities. The combination of these services maximizes patient beneficial outcomes and coordination of care with: 1) interventional therapies with epidural injections, radiofrequency ablation for treatment of spine-related and joint-related pain, spinal cord neuromodulation, vertebral augmentation, platelet rich plasma injections, trigger point injections, sympathetic ganglion nerve blocks, and advanced diagnostic procedures, as well as intravenous ketamine infusion for treatment of complex regional pain, central pain, depression, post-traumatic stress disorder (PTSD), and opioid-related disorders; and 2) integrative healthcare non-pharmacological services including full body acupuncture, Battlefield Acupuncture (BFA), osteopathic manipulation, bio-physics devices, dry needling, and behavioral health therapy. At some MTFs, pain management care in the Air Force IMPC is

focused to ADSM personnel due to staffing limitations. Non-active duty Service members are seen on a space available basis.

JBER integrated VA providers and support staff into its Air Force IPMC, thereby creating the first VA-Air Force joint-venture IPMC. Joint Base Andrews's AIM Center is a flagship asset leading acupuncture training, research, and clinical care. BFA is a rapid pain relief ear-only acupuncture technique. Studies in Iraq and Kuwait deployed settings have shown acupuncture and BFA reduce opioid use and quicken return to duty.

Department of the Navy

The Navy continues Direct Support to DHA during FY 2021 for seven IPMCs, located at: Camp Pendleton, Camp Lejeune, Navy Hospital (NH) Bremerton, NH Jacksonville, NH Pensacola, NH Okinawa, and Navy Medical Center San Diego. Since 2011, the NCPMP improves the capability and capacity of the Navy's pain management resources, as well as foster healing in those suffering from complex acute, high-risk acute, and chronic pain in a multimodal and coordinated fashion. The program was designed to align with statutory requirements, as well as Navy Medicine's strategic goals and objectives. A key component of the NCPMP's work is the engagement of SMEs on a variety of key topics, such as implementing LOTS guidance to prevent acute pain from becoming chronic and CIM. The NCPMP continued standardizing pain management through engagement and collaboration with the VA, DHA, Army, and Air Force.

NCR

The NCR continues to integrate pain services with telehealth modalities in primary care in Warrior Clinics at the Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, Naval Health Clinic Quantico, DiLorenzo TRICARE® Health Clinic, Naval Health Clinic Annapolis, Naval Medical Center Camp Lejeune, Naval Hospital Guantanamo Bay, and Malcolm Grow Medical Center. By embedding pain assets, TRICARE® beneficiaries have the advantage of receiving specialty care in PCMH, and Primary Care teams can co-manage and learn from pain specialists. The innovative programs of the NCR Pain Care Initiative continue to serve as a model for pain care to improve quality, efficiency, and access to pain care services with telehealth capabilities.

Furthermore, the NCR pain telehealth program continues to expand pain services, sites, and number of encounters in the MHS with a team including one pain physician, two pain Physician Assistants, two pain psychologists, one tele-pain Registered Nurse, one licensed social worker, one integrative medicine physician, as well as an integrative medicine nurse and support staff to the pain telehealth team. The NCR continues to expand an in-home tele-pain service to assist with transitioning Service Members.

Stepped Care Model for Pain

DHA-PI 6025.04, "Pain Management and Opioid Safety in the MHS", outlines the requirement for implementation of the MHS Stepped Care Model for pain (SCM-P). Over the course of 2019-2021, PCMHs continued to implement a SCM-P clinical pathway that aims to standardize workflow processes and incorporate evidence-based pain management strategies. Specific

clinical pathway objectives include the following:

- Begin the assessment of pain using the Defense and Veterans Pain Rating Scale.
- Complete a biopsychosocial assessment to identify factors contributing to the pain experience and understand patient values and circumstances.
- Provide pain education and collaboratively establish treatment goals.
- Create an evidence-based, comprehensive treatment plan to effectively treat acute and chronic pain; promote non-pharmacologic treatment; and prevent acute pain from becoming chronic.
- Support the patient's self-management and behavior changes.
- Minimize use of opioids; assess and minimize risk when used.

One way in which SCM-P supports the objectives above is that all behavioral health consultants in primary care clinics have been trained to provide brief cognitive behavioral therapy for acute and chronic pain. This ensures that evidence-based non-pharmacologic treatments for pain and support for patient's self-management and behavior changes are available in the PCMH.

Complementary and Integrative Medicine

DoD participates in NIH's National Center for Complementary and Integrative Health (NCCIH) National Advisory Council. Since December 2016, DoD and NCCIH have been partners in the NIH-DoD-VA Pain Management Collaboration to coordinate support for a portfolio of multi-year, multi-site complementary and integrative health research projects in DoD and VA to:

- Develop, adapt, and adopt technical and policy guidelines and best practices for the effective conduct of research in partnership with health care systems focused on military personnel, veterans, and their families;
- Work collaboratively with and provide technical, design, and other support to demonstration project teams to develop and implement a pragmatic trial protocol; and
- Disseminate widely collaboratory-endorsed policies, best practices, and Lessons Learned in the demonstration projects for implementing research within health care settings.

The NCPMP has continued its efforts to support the integration of auricular acupuncture - a highly effective, safe, and low-risk alternative to opioids - into the Navy's approach to pain medicine. This effort is supported and will continue under DHA. Major accomplishments in the further development and expansion of this program include:

- Integrating the Navy's Relias Health Auricular Acupuncture Course into the Cadre of Speakers Training program and developing course guides and materials which promote standardization and improvement of the course; and
- Uploading course materials to SharePoint, resulting in a more accessible and centralized repository for course facilitators and students to share best practices and Lessons Learned.

The NCPMP is also working to better identify the number of Navy providers who are trained and credentialed in auricular acupuncture. The dashboard is being updated to include automated

capabilities, which track the requests for trainings, the facilitation of trainings, credentialing of providers, and the overall utilization of trainings among Navy providers.

Prescription Drug Monitoring Program

The MHS PDMP is a web-based search tool that allows MTF controlled-substance prescription information to be shared with other state/territory PDMPs. Pursuant to a 2019 Memorandum of Understanding between the DoD and the National Association of Boards of Pharmacy (NABP), MHS providers have been allowed to use NABP's Prescription Monitoring Program Interconnect system, which then allows MHS PDMP data to be shared with other participating states and territories. As of early September 2021, the MHS PDMP was bi-directionally sharing information with 46 states/territories. Of the remaining PDMPs, one state is receiving MHS PDMP data, while 6 states are not receiving MHS PDMP data nor sharing their own data. The MHS will continue efforts to share information with those 6 States. The Pharmacy Benefit Manager functions as the administrator to implement data collection, submission, and storage; ensure data integrity; perform data analysis; and institute user registration.

Military Health System Opioid Registry

The CarePoint MHS Opioid Registry is a decision-support tool to support providers, staff, and decision makers in improving safety and quality of care of patients on prescribed opioids. The MHS Opioid Registry provides clinicians with the capability to monitor opioid activity from as early as a patient's first dispensing event; detect potential harm or misuse of opioid medications in non-cancer patients via flagging and validated risk scores; evaluate effectiveness of opioid safety programs using opioid measures and reports; and share relevant data such as medication history and opioid risk profiles for those patients transitioning from DoD to VA. Collaboration with subject matter experts has resulted in the development of additional decision support tools and enhancements within the MHS Opioid Registry:

- Risk Scores – Automatic calculation and incorporation of the RIOSORD to estimate a patient's risk of overdosing in the following 6 months.
- Patient Lookup Tool – Enhances the ability of clinical pharmacy professionals, physicians, and other authorized providers to proactively monitor and manage patients at point of care. Upon scanning of a patient's military ID card, a subset of the opioid registry (e.g., MEDD over time, RIOSORD score, probability of opioid induced respiratory depression, and whether the patient should be prescribed Naloxone based on known co-morbidities and other factors) is displayed.
- The Opioid Prescriber Trend Report – Provides insights regarding opioid prescriptions that can be aggregated at the Market, MTF, clinic, and provider level to facilitate early identification of outliers and trends through comparison to an average MTF clinic.

Opioid Use Disorder in ADSMs

The 2020 ADSM prevalence rate of opioid use disorder is 0.15 per 1000; thus far, based on available information, the 2021 ADSM prevalence rate of opioid use disorder is 0.08 per 1000. The rate in the U.S. population for the most recent year available, 2019, is over 30 times higher

than the ADSM 2020 rate and nearly 60 times greater than the ADSM 2021 rate (4.68 per 1000 in 2019, Substance Abuse and Mental Health Services Administration).

Patients' Perception of Adequacy of Pain Management Services: DoD continues to track patient satisfaction with pain management in Primary Care and several specialty care clinics utilizing the Joint Outpatient Experience Survey (JOES) program. JOES is a single survey for all MTFs across the DoD that combines and standardizes long-standing methods used by Army, Navy, Air Force, and NCR to learn about beneficiary healthcare. The most recent Pain Management Clinic survey data results, which are from May 2020 to April 2021, include:

- Access to Pain Care:
  - 75 percent of 2118 respondents stated that their care was received in-person.
  - 97.4 percent of 1928 respondents stated that their needs were addressed within 30 minutes of their appointment.
- Facility:
  - 93.1 percent of 2103 respondents stated they were satisfied with their healthcare facility.
  - 90.8 percent of 2097 respondents stated they were likely to recommend the facility.
- Patient:
  - 91.2 percent of 2058 respondents felt that they make healthy choices.
  - 91.4 percent of 2086 respondents state that they feel they have influence over their own health.
- Provider:
  - 93.3 percent of 2077 respondents stated they were satisfied with their provider.
  - 95.3 percent of 2088 respondents stated their provider was courteous and respectful.

Pain Management Research

In FY 2021, DVCIPM had over 30 ongoing research protocols and performance improvement projects and manuscripts. The areas of research broadly encompassed cellular mechanisms of pain chronification and treatments to big-data health services research in the MHS. DoD provides an overview of select studies below:

- Two studies, in collaboration with Brandeis University, are examining pain therapy, opioid, and polypharmacy treatment pathways of Service members after deployment.
- One big-data study, in collaboration with DHA partners and Johns Hopkins University Applied Physics Laboratory, received a Congressionally-Directed Medical Research Programs (CDMRP) grant and will examine pain management pathway disparities and areas of improvement, within a Health Equity Measurement Framework, levering a robust simulation analytic environment
- Several studies are examining pain management healthcare variation, including sources and effects of such variation, across different treatments (e.g., postsurgical opioid prescribing), populations (e.g., patients who report physical, sexual, or emotional abuse; patients undergoing total joint arthroplasty; etc.); and disciplines (e.g., gynecological, orthopedic, and neurosurgery).
- Two studies targeted implementation and evaluation of patient and provider pain

education. Results from the patient-focused study indicate pain education can be successfully delivered in primary care and pain clinic waiting rooms using a smartphone or tablet, which, in turn, increases patient interest in non-pharmacological pain management strategies. The results of the provider education study, a multi-site study in the NCR, indicated that online, self-guided pain management education was feasible and acceptable. Moreover, results indicated that providers across a variety of disciplines (e.g., surgery, emergency care, internal medicine, obstetrics and gynecology, etc.) and training (e.g., physicians, nurse practitioners, physician assistants, physical therapists, mental health workers, nurses, etc.) were interested in and completed a variety of pain management modules. Lastly, results indicated that the training was well received and helpful to learners.

- Two studies, one funded via a National Heart, Lung, and Blood Institute/DoD grant and the other through a CDMRP grant, are examining biomarkers of pain and sleep dysregulation, as well as biomarkers of chronic pain resolution.
- DVCIPM continues to conduct implementation and health services research for the Opioid Overdose Education and Naloxone Distribution Program, after successful completion of Phase 1 and 2 pilots. Results from the enterprise-wide study are completed and will be published shortly.
- Lastly, DVCIPM is conducting several studies to support operational readiness, provider workforce sustainability, and workforce equity.

Researchers at Madigan Army Medical Center (MAMC) recently completed the main outcome analysis for one clinical trial, and during FY 2021, they have been actively engaged in two other Institutional Review Board (IRB)-approved collaborative research protocols through a Cooperative Research and Development Agreement with the University of Washington and data-sharing agreements with DHA and Army.

- Analysis of main outcomes is complete for the "Integrative Modalities Plus Psychological, Physical, Occupational and Restoration Therapies" (IMPPPORT) clinical trial, a $1 million four-year clinical trial funded in 2015 by the Defense Medical Research and Development Program (DMRDP), designed to determine if an interdisciplinary program of complementary and integrative pain therapies improves outcomes, when added to a functional restoration program. The analysis showed that the strongest predictor of response to standard rehabilitative therapies with or without complementary therapies prior to a 3-week intensive functional restoration was baseline pain impact. ADSMs with the worst baseline pain impact (determined by a composite measure of pain intensity, pain interference, and physical function) showed the greatest improvement following treatment. DoD observed this relationship regardless of whether the ADSM was in the Medical Evaluation Board (MEB) system, dispelling concerns that ADSMs in the MEB process may have a disincentive to improve. Secondary analysis of IMPPPORT data showed strong psychometric properties of the "TLC-bat", a battery of functional performance measures used to measure physical function at the MAMC IPMC. The TLC-bat shows promise as a potential standard assessment of physical function for use across other military functional restoration programs. Analysis of correlations between PASTOR outcomes and TLC-bat measures showed that both self-reported and objective measures work together to provide a more complete understanding of treatment

response. DoD described the IMPPPORT study design in the Volume 19 of 2019 Contemporary Clinical Trials Communications. In 2021, researchers presented a poster presentation of the main results at the American Academy of Pain Medicine annual conference and submitted the results for publication in *Pain Medicine.*

- In continuous use at MAMC since 2014, more than 5,000 MAMC patients completed the PASTOR assessment. To support secondary analysis of this large data set, PASTOR data will be merged with data on clinical encounters, pharmacy, and military medical readiness to identify correlates between PASTOR outcomes and various pain therapies, demographic factors, and functional duty limitations that may lead to military retirement. To date, an analysis of treatment hours and PASTOR outcomes through October 2018 was completed and revealed that a minimum of 30 cumulative hours of interdisciplinary pain care was associated with meaningful improvement in pain impact and related PASTOR measures. In addition, ADSMs with a higher baseline pain impact, older than 40 years of age, and with minimal depressive symptoms experienced greater improvement than others did. In 2021, the publishers of *Military Medicine* accepted this analysis for publication. A separate analysis, accepted for publication in *Pain Medicine*, studied the correlation between PTSD screening (through PASTOR), PTSD diagnosis (documented in the medical record), and related PASTOR measures and demonstrated the importance of addressing PTSD symptoms (such as emotional numbness and avoidance) in pain care. Researchers obtained IRB approval to extend the observation period for the PASTOR secondary analysis through May 2021; this will permit additional analyses of PASTOR data collected at MAMC throughout 2021.

- The "Complementary, Integrative, and Standard Rehabilitative Pain Therapies" study, funded with a $2.5 million 4-year DMRDP grant with the objective of determining the optimal treatment duration and sequence of standard and complementary and integrative pain therapies, began enrollment of study subjects in March 2021. As of August 11, 2021, 69 study subjects (25 percent of target) consented to study participation. In addition, the study will include analysis of selected biologic specimens, in an effort to identify biological markers associated with positive response to various pain therapies. DoD projects that the study will be completed in 2023.

Navy Comprehensive Pain Management Program

Building on data gathered from the LOTS Proactive Patient Identification Analysis and Intervention Approach, in April 2021, the NCPMP initiated a study to identify all enrolled patients who meet LOT criteria, monitor adherence to CPGs, and propose intervention strategies to improve pain management of these patients. The performance aim is to promote greater return to duty rates among ADSMs on Limited-Duty.

At Nellis, a research project for acute and chronic pain began in December 2019 and is expected to be completed by the fourth quarter of FY 2022. The project uses non-opioid pain management protocols. Using a Food and Drug Administration-cleared device, microcurrent technology uses frequency pairs at microampere levels to focus on specific pathology (e.g., inflammation) in a specific tissue (e.g., spinal cord). For over 300 patients with severe chronic

pain, dramatic decreases in pain and increased functionality occurred within four to six treatments. Patients report that their quality of life and overall satisfaction is outstanding with this treatment protocol. Other clinicians gave high praise for the microcurrent training, and now clinicians at Travis, Scott, and Eglin MTFs use the treatment protocol.

Training and Education of Health Care Personnel

DoD Opioid Prescriber Safety Training (OPST)

The 2015 Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use," directed the DoD to develop and implement a mandatory training program for DoD opioid prescribers in order to reduce prescription pain medication deaths and promote the appropriate and effective prescribing of pain medications. In FY 2017, DHA fielded the 2-hour online DoD OPST program that all DoD opioid prescribers are required to complete every 3 years. DHA updated the original OPST content in FY 2021 to integrate new DoD prescribing policies and practices. As of June 2021, over 48,000 DoD prescribers completed this training, with over 5,000 prescribers to date in 2021 alone.

Primary Care Pain Champion and Behavioral Health Consultant Training

The PCPC is a clinician selected by their MTF leadership to receive specialized training on the SCM-P clinical pathway implementation. The training prepares the PCPC to lead implementation of SCM-P in their clinics and provide training to their PCMH team members. The most current data from March 11, 2021 reflects that 300 PCPCs completed the PCPC training series.

Behavioral Health Consultants (BHC) are psychologists and social workers in primary care who provide brief behavioral health interventions in the primary care setting. As part of the SCM-P clinical pathway implementation, DoD trained all BHCs to be able to provide manualized evidence-based brief cognitive behavioral therapy for pain, including protocols to use with patients who are experiencing acute pain and chronic pain. The most current data DoD has, which is from March 11, 2021, reflects that 326 BHCs completed brief cognitive behavioral therapy for pain training.

Project Extension for Community Healthcare Outcomes (ECHO®)

DoD continued increasing the reach of pain specialists beyond their clinics and expanding capacity for pain management services in primary care through use of the internationally recognized Project ECHO® telementoring model. Project ECHO® uses secure audio-visual networks to connect pain medicine specialists (hubs) with remote primary care providers (spokes) to increase providers' pain management competencies.

The Army began utilizing Project ECHO® telementoring to address pain management in 2013 and hosts Project ECHO® pain clinics with 5 regional hubs and 72 spokes to deliver the JPEP curriculum. The Army Project ECHO® hubs are located at Brooke, MAMC, Tripler, Womack Army Medical Centers, and Landstuhl Regional Medical Center, and staff at these sites provide

weekly didactic and clinical education to PCPCs and treatment teams.

In light of the COVID-19 restrictions on travel and in-person meetings, the NCPMP expanded its Cadre of Speakers trainings into a webinar format. Similarly, the NCPMP expanded the audience to include operational medicine providers, such as independent duty corpsmen and flight surgeons, as well as to providers representing DHA and the MILDEPs. The NCPMP's Cadre of Speakers program has now trained over 1,000 MHS providers. The webinars cover topics most relevant to operational medicine, which include: pain and biopsychosocial assessment, nutrition for pain, early intervention therapies, medication management, and stellate ganglion block.

The NCR serves as a hub of educational activity for undergraduate, graduate, and postgraduate medical education. By providing clinical experiences in the Walter Reed Pain Clinic, medical students, residents, and fellows are able to gain knowledge in state-of-the-art pain treatments. The Accreditation Council for Graduate Medical Education-accredited pain fellowship trains military physicians from all MILDEPs to be leaders for pain therapies in the field. The NCR typically trains three to four pain fellows per year. In addition, annual trainings for primary care teams provide them with tools to treat pain in the primary care settings.

Other areas of training and education

The Air Force provides training and education to improve patient outcomes, reduce opioid use, utilize non-pharmacological methodologies, and improve patient satisfaction. Air Force physicians have the opportunity to apply for a scholarship to attend a 300-hour certification course in medical acupuncture. For the past several years, the Air Force provided 16 to23 medical acupuncture scholarships per year to active duty physicians. Annually, 40 percent of the approximately 30 family medicine residents at Nellis complete the medical acupuncture course to become certified medical acupuncturists by graduation. The Travis pain program is a mandatory pain medicine rotation for all physician interns and family medicine residents. The Air Force family medicine residency programs at Travis, Offutt, Eglin, Nellis, and Scott have all incorporated BFA into their course curricula ensuring the majority of the residents graduate with this important non-pharmacologic skill, which can be used at their next duty station and while deployed.

The Air Force also participates in pain skills training, both for interventional pain physicians and primary care, provided by the National Capital Region Pain Initiative at Walter Reed National Military Medical Center; ECHO® telementoring led by the Army; DHA pain management training for PCPCs; Air Force acupuncture training for BFA; medical acupuncture for physicians; and an advanced acupuncture course provided by the Joint Base Andrews AIM Center.

At Eglin, IRB processes are underway for research involving a Functional Restoration Program, Endoscopic Spine Procedures, and Stellate Ganglion Blocks. AIM Center IRBs are moving forward with rapid acupuncture for PTSD and macular eye acupuncture to benefit pilots and crewmembers on Air Force missions, the Space Force program, and possibly NASA.

Patient Education and Dissemination of Information

DoD engages in several efforts to educate patients about pain management.

As a response to the COVID-19 pandemic, the NCPMP created the "Well-being for Pain Patients" brochure. This brochure highlights the danger of heightened emotions and their potentially negative impact on pain. The brochure also compiles tips and resources for patients to help manage their well-being. The NCPMP is expanding its training and education efforts by identifying innovative opportunities to enhance the patient experience through the dissemination of patient education materials and videos. By ensuring the fleet has the knowledge and tools to manage pain and overall well-being, the NCPMP supports a Ready Medical Force.

The Army CPMP continues to participate in the Annual Pain Awareness Campaign during Pain Awareness Month in September. Partnering with the U.S. Army Medical Command Public Affairs Office, the Army publishes tri-folds, postcards, a video, and social media graphics, which highlight MHS pain strategies. Materials are shipped to the 12 IPMCs and 16 additional Army Community Hospitals and Health Clinics to support local pain awareness month activities. Each Wednesday in September, the CPMP co-hosts a pain awareness information table at Defense Health Headquarters.

The Air Force continues to focus on education for patients through the Air Force IPMCs and other MTFs. Pain management education programs focus on medical and lifestyle information to encourage self-care strategies. The holistically-oriented course ranges from four to 10 sessions delivered one-on-one and in group sessions. The classes inform patients on the biological, behavioral, and social aspects of pain management. Topics include strategies for mindfulness, sleep, mental health, and social withdrawal; physical activity including yoga; and the impact of pain on quality of life. Some Air Force IPMCs offer patients one-on-one behavioral health coaching and group behavioral health pain classes. BFA is provided to participants during weekly classes at some Air Force IPMCs and other MTFs. The overall goal is to introduce participants proactively to the range of non-pharmacologic holistic modalities at the MTF, thereby educating patients in self-care strategies for chronic pain and managing their pain and reduce opioid use. Patient education for these programs utilize surveys to improve course development and pain management outcomes.

Summary

DoD pain management policies and initiatives focus on providing a patient-centered, holistic, multimodal, and inter-disciplinary pain care model that supports the balanced use of medications, primary care, specialty care, and self-care approaches for pain management. Improved coordination and collaboration across MHS resulted in several advances in pain management policy, clinical care, research, education and training products, and clinical tools that serve our beneficiaries and provide an example for the nation.

REFERENCES

ACGME Program Requirements for Graduate Medical Education in Pain Medicine (Anesthesiology, Neurology, or Physical Medicine and Rehabilitation) Retrieved from http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/530_pain_medicine_2016_1-YR.pdf?ver=2016-09-30-123813-903

Banks, D.E., Buckenmaier, C., & Mahoney, P.F. (2015). Combat anesthesia: The first 24 hours.
Falls Church, VA: Office of the Army Surgeon General. (2011). Retrieved from http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=123f6b20-e846-46a6-a2c0-5840a07944c4

Centers for Disease Control and Prevention (2016). Guideline for Prescribing Opioids for Chronic Pain. Retrieved from http://www.cdc.gov/drugoverdose/prescribing/guideline.html

Department of Defense (2011). Policy for Comprehensive Pain Management (Health Affairs Policy 11-003). Washington, DC: Assistant Secretary of Defense (Health Affairs). Retrieved from http://www.health.mil/Policies/2011/04/05/Policy-for-Comprehensive-Pain-Management

Department of Defense (2013). Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) (DoD Instruction 6025.13). Washington, DC: Office of the Secretary of Defense for Personnel and Readiness. Retrieved from http://www.dtic.mil/whs/directives/corres/pdf/602513p.pdf

Headquarters, Department of the Army, Execution Order 224-17 (Opioid Therapy Profiling Standardization). Office of the Surgeon General, US Army Medical Command.

National Defense Authorization Act for Fiscal Year 2010, Pub.L. No. 111-84, §711, 123 Stat. 4, (2009). https://www.gpo.gov/fdsys/pkg/PLAW-111publ84/pdf/PLAW-111publ84.pdf

National Institutes of Health (2016). National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain. Retrieved from https://iprcc.nih.gov/docs/HHSNational_Pain_Strategy.pdf

Office of The Army Surgeon General (2010). Pain Management Task Force Final Report. Retrieved from http://www.regenesisbio.com/pdfs/journal/pain_management_task_force_report.pdf

White House (2014). National Drug Control Strategy. Retrieved from https://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf

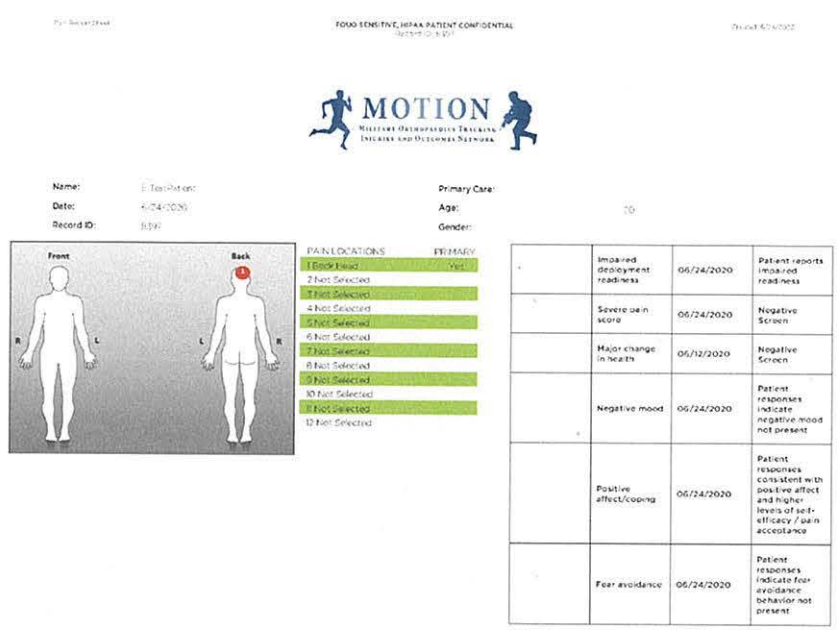
White House (2015). Presidential Memorandum—Addressing Prescription Drug Abuse and

Heroin Use. Retrieved from https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin

White House (2017). Presidential Memorandum for the Heads of Executive Departments and Agencies. Retrieved from https://www.whitehouse.gov/presidential-actions/presidential-memorandum-heads-executive-departments-agencies/

APPENDICES

Appendix A: MOTION Survey Sample



Appendix B: List of Abbreviations

ADSM	active duty Service member
AIM	Acupuncture and Integrative Medicine
BFA	Battlefield Acupuncture
BHC	Behavioral Health Consultant
CDC	Centers for Disease Control and Prevention
CDMRP	Congressionally-Directed Medical Research Program
CIM	Complementary and Integrative Medicine
COVID-19	coronavirus disease 2019
CPG	Clinical Practice Guideline
CPMP	Comprehensive Pain Management Program
DHA	Defense Health Agency
DHA-PI	Defense Health Agency – Procedural Instruction
DMRDP	Defense Medical Research and Development Program
DoD	Department of Defense
DVCIPM	Defense and Veterans Center for Integrative Pain Management
ECHO®	Extension for Community Healthcare Outcomes
FY	Fiscal Year
HEC	Health Executive Committee
HHS	Department of Health and Human Services
IMPPPORT	Integrative Modalities Plus Psychological, Physical, Occupational and Restoration Therapies
IPMC	Interdisciplinary Pain Management Center
IRB	Institutional Review Board
JBER	Joint Base Elmendorf-Richardson
JOES	Joint Outpatient Experience Survey
JPEP	Joint Pain Education Program
LOT	Long-term Opioid Therapy
LOTS	Long-term Opioid Therapy Safety
MAMC	Madigan Army Medical Center
MEB	Medical Evaluation Board
MEDD	morphine equivalent daily dose
MHS	Military Health System
MILDEP	Military Department
MOTION	Military Orthopedics Tracking Injuries and Outcomes Network
MTF	military medical treatment facility
NABP	National Association of Boards of Pharmacy
NCCIH	National Center for Complementary and Integrative Health
NCPMP	Navy Comprehensive Pain Management Program
NCR	National Capital Region
NH	Navy Hospital
NIH	National Institutes of Health
OPORD	Operation Order
OPST	Opioid Provider Safety Training
PASTOR	Pain Assessment Screening Tool and Outcome Registry

PCMH	Patient-Centered Medical Home
PCPC	Primary Care Pain Champion
PDMP	Prescription Drug Monitoring Program
PMCSS	Pain Management Clinical Support Service
PROMIS	Patient Reported Outcome Measurement Information System
PTSD	post-traumatic stress disorder
RIOSORD	Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression
SME	subject matter expert
USUHS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs