



OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

NOV 16 2016

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report covering fiscal year (FY) 2016 is submitted in response to section 711 of the National Defense Authorization Act for FY 2010 (Public Law 111-84), which requires the Department of Defense (DoD) to develop and implement a comprehensive policy on pain management by the Military Health System (MHS) and provide a report to the Armed Services Committees annually. Key elements include a description of the policy, performance measures, adequacy and effectiveness of pain management services, ongoing pain research, provider training, and patient education.

For FY 2016, the MHS has continued the sustained improvement of pain management policy, clinical care, education, and Tri-Service coordination. Improved coordination and collaboration across the MHS have resulted in several advances in pain management policy, clinical care, research, and education/training products and clinical tools that serve our beneficiaries and provide an example for the nation. As a result, the DoD is uniquely positioned to advance the objectives described in the October 2015 Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use," the National Pain Strategy, and the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the Chairman of the Committee on Armed Services of the House of Representatives.

Sincerely,

A handwritten signature in black ink, appearing to read "Peter Levine", with a long horizontal flourish extending to the right.

Peter Levine
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



OFFICE OF THE UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

NOV 16 2016

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Peter Levine
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to the Armed Services Committees 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 2016

**Required by: Section 711 of the National Defense Authorization Act
for Fiscal Year 2010 (Public Law 111-84)**

**Office of the Secretary of Defense
October 2016**

The estimated cost of this report or study for the Department of Defense is approximately \$25,200 for the 2016 Fiscal Year. This includes \$0 in expenses and \$25,200 in DoD labor.
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EXECUTIVE SUMMARY

This is the annual report required by section 711 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010 (Public Law 111-84). The NDAA requires the Secretary of Defense to submit an annual assessment of Military Health System (MHS) pain management to the Congressional Armed Services Committees. 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: Adequacy and effectiveness of pain management services; research completed or underway; training delivered to Department of Defense (DoD) healthcare personnel; education provided to beneficiaries; and dissemination of information on pain management to our beneficiaries.

During FY 2016, MHS continued to mature the pain management capabilities and resources for our beneficiaries and healthcare workforce. Improved coordination and collaboration across the Services, Defense Health Agency (DHA), and Uniformed Services University of the Health Sciences (USU) has resulted in several advances in pain management policy, clinical care, and fielding of innovative education and training products and clinical tools.

The MHS pain strategy and initiatives are aligned with the 2016 National Pain Strategy and the national interests in addressing overuse of prescription pain medications, which include:

- Focusing the efforts for pain management improvements and initiatives on meeting the clinical and educational needs of primary care providers and patients as MHS continues the roll-out of the Patient Centered Medical Home (PCMH) model;
- Service implementation of the stepped care model for pain management to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain;
- Continued improvement of the use and review of existing pain-related Clinical Practice Guidelines (CPG), as well as continued identification of requirements for new CPGs by using resources available through the Department of Veterans Affairs (VA)/DoD Health Executive Committee (HEC) Work Groups;
- Piloting the Defense and Veterans Pain Rating Scale (DVPRS), a pain assessment tool, at the DiLorenzo TRICARE Health Clinic in the Pentagon;
- Continued development and deployment of the Pain Assessment Screening Tool and Outcome 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;
- Ongoing assessment of patient satisfaction on pain management;

- Continued execution of the Joint Pain Education Project (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 the pain management competencies of the combined federal clinical workforce;
- Completion of the Acupuncture Training Across Clinical Settings (ATACS) VA/DoD Joint Incentive Fund (JIF) project that developed, piloted, evaluated, and provided the template for a uniform tiered acupuncture education and training program in order to expand its use across DoD and VA medical treatment facilities; and
- Addressing the education and training requirements contained in the Presidential Memorandum, “Addressing Prescription Drug Abuse and Heroin Use.”

As a result of the improved coordination and ongoing collaboration across MHS, DoD, and VA, MHS is uniquely positioned to respond to the recently released 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, and education & training of the MHS workforce will serve our beneficiaries and provide an example for the nation.

INTRODUCTION

In October of 2015, the President released the Presidential Memorandum, “Addressing Prescription Drug Abuse and Heroin Use.” In March of 2016, at the direction of the Secretary of the Department of Health and Human Services (HHS), NIH’s Interagency Pain Research Coordinating Committee released the National Pain Strategy, which outlined the federal government’s first coordinated plan to reduce the burden of chronic pain that affects over 116 million Americans with economic costs estimated at \$560 billion. The improvement of pain care, as outlined in the National Pain Strategy, was also an essential element in the HHS Secretary’s initiative to address the current epidemic of opioid overuse, abuse, and diversion in the United States.

The National Pain Strategy’s roadmap for reducing over-reliance on prescription opioid medications aligns with the MHS pain policy and strategy, including:

- Improving provider education on pain management practices and team-based care;
- Supporting use of multimodal pain treatments that include non-medication options;
- Improving patient self-management strategies;
- Encouraging the evaluation of risks and benefits of current pain treatment regimens;
- Providing patients and providers with educational tools to encourage safer use of prescription opioids; and
- Conducting research to identify how best to provide the appropriate pain treatments to individual patients based on their unique medical conditions and preferences.

Coupled with the March 2016 release of the CDC Guideline for Prescribing Opioids for Chronic Pain, the current Administration has provided a clear pathway to achieving the necessary cultural transformation of pain management, clinical care, and education and is beginning to address the national burden of overreliance and abuse of prescription pain medications.

BACKGROUND

MHS has been addressing the national challenges with pain management and prescription medications since the August 2009 Pain Management Task Force (PMTF) and subsequent development and ongoing implementation of a comprehensive pain management policy to improve pain management care and services within DoD. The continued progress and improvement of the MHS pain strategy has been supported by the efforts of the MHS Pain Management Work Group (PMWG), with membership from the Services, DHA, and USU, in collaboration with VA/DoD HEC PMWG, which includes subject matter experts (SMEs) from VA and MHS. Cross-Department collaboration has been critical to many MHS accomplishments and advances in pain management. The

VA/DoD HEC PMWG has also improved coordination across the 16 other VA/DoD Work Groups chartered by the HEC.

MHS continues to implement PMTF recommendations revolving around the following lines of effort:

- 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.

In February of 2016, the Assistant Secretary of Defense for Health Affairs designated the Defense and Veterans Center for Integrative Pain Management (DVCIPM) as an MHS Center of Excellence. Aligned under USU, DVCIPM serves as DoD's pain management advisory and coordinating organization as it continues to support advances in pain management clinical practice, research, and education. DVCIPM is active in both the MHS PMWG and VA/DoD HEC PMWG.

FY 2016 UPDATE

As presented in section 711 of the FY 2010 NDAA, this report is the FY 2016 update to the 2015 report on the implementation of DoD's comprehensive pain management policy. Per section 711 of NDAA 2010, each report shall include the following:

- A description of the policy implemented and any revisions made to the policy;
- A description of the performance measures used to determine the effectiveness of the policy in improving pain care for beneficiaries enrolled in MHS;
- An assessment of the adequacy of Department pain management services based on a current survey of patients managed in Department clinics;
- An assessment of the research projects of the Department relevant to the treatment of the types of acute and chronic pain suffered by members of the Armed Forces and their families;
- An assessment of the training provided to Department healthcare personnel with respect to the diagnosis, treatment, and management of acute and chronic pain;
- An assessment of the pain care education programs of the Department; and
- An assessment of the dissemination of information on pain management to beneficiaries enrolled in MHS.

Policies and Revisions

The Policy for Comprehensive Pain Management (Health Affairs Policy 11-003) signed on March 30, 2011, continues to guide pain management activities across MHS, and did not require updating during this reporting period. This policy outlines the requirements for pain research and appropriate assessment, treatment, and management of pain at every medical encounter in patients seeking care at medical treatment facilities (MTF). The following is a description of the policy and actions implemented during the reporting period across the key policy components of (1) pain assessment, (2) pain treatment and management, and (3) pain research. The policy strives to reinforce that pain is not only a symptom of disease, but is often, in fact, a disease process in itself. As is the case for all large population-based disease processes, the approach taken towards treatment needs to be evidence-based and utilize best practices.

DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System," addresses MTF accreditation, and the requirement that all MTFs be accredited by either The Joint Commission (TJC) or other accrediting body. By virtue of their accreditation, all MTFs have demonstrated successful adherence to TJC pain management standards. While meeting TJC pain

management standards is a significant accomplishment, MHS has continued efforts to improve its pain assessment tools and capabilities to be the industry leader in pain management.

Performance Measures Used to Determine Effectiveness

Defense and Veterans Pain Rating Scale

As presented in previous updates, the PMTF Report identified the need to develop and integrate a revised pain assessment tool that would provide additional insight into the impact of pain, beyond information provided with the standard 11 point, 0-10 Visual Analog Scale. The DVPRS was jointly developed by DoD and VA and has undergone multiple validation studies. The DVPRS has continued to be integrated into practice in multiple clinic settings across MHS, VA, and civilian medicine. Additional DVPRS validation studies have been published in 2016 and are annotated later in this report.

Following recommendation from the MHS PMWG, the Tri-Service Patient Care Integration Board approved piloting the DVPRS at three MTFs, in order to (1) develop products for patient and staff education and training, (2) ensure smooth DVPRS integration into clinic workflows, and (3) provide feedback from patients and staff regarding DVPRS implementation at the facility level. The initial DVPRS pilot is being conducted at the DiLorenzo TRICARE Health Clinic in the Pentagon.

Pain Assessment Screening Tool and Outcomes Registry

The PASTOR was developed in response to several recommendations in the PMTF report related to the need for improved pain outcomes measures. DoD adapted the initial PASTOR concept to integrate the NIH PROMIS, a 10-plus year initiative with a federal government investment of over \$100 million. The DoD intent was to leverage the PROMIS capabilities and methodologies in order to expedite the PASTOR implementation in MHS. DVCIPM coordinated the initial functional expertise for PASTOR development, starting in 2011. In 2016, MHS established the PASTOR Steering Committee to manage continued development and rollout of this clinical system capability.

The PASTOR development and implementation includes two areas: (1) a tool for pain research, PASTOR REDCap (Research Electronic Data Capture) Research; and (2) a clinical decision making tool integrated into the DoD electronic health record (PASTOR). The PASTOR REDCap Research tool greatly enhances utilization of the NIH PROMIS tools in a variety of clinical pain research scenarios. The REDCap database is open source software, developed and maintained by a consortium of over 1,450 research institutions, with 229,000 end users, and a strong track record among academic research institutions. The PASTOR REDCap Research database was created as a modular application to allow for fast and easy distribution of the software to existing REDCap institutions. The PASTOR REDCap Research is the main research database for pain-related research protocol submissions, creating an unparalleled and unique level of

standardization of validated research measurement tools. PASTOR REDcap is becoming the designated clinical outcomes tool for DoD pain related research projects.

Initial versions of PASTOR were rolled out at several locations for testing. For example, Navy began using PASTOR in the Functional Restoration Pain Program (FRPP), an intensive outpatient program at Naval Medical Center San Diego (NMCSA) in May 2014. FRPP is an intensive, interdisciplinary, medically supervised program, consisting of 160 hours of clinically structured healthcare over eight weeks. This integrative approach, based on the biopsychosocial model, provides optimized medication management, complementary alternative medicine strategies, and psychological interventions to address patients' pain.

FRPP uses PASTOR to measure the effectiveness of the program's techniques to address chronic pain and its multi-faceted effects on personal, social, spiritual, family, career, and financial well-being. Using the PASTOR tool, data is collected throughout clinical treatment, and periodic reports provide both cohort and individual feedback to patients and providers allowing for tailored treatment options as well as program improvement.

In September 2014, PASTOR was expanded to the NMCSA Pain Medicine Center. As of May 2016, 1,146 unique patients have used the tool to support pain clinicians' management of chronic pain. In the past two years, PASTOR has been utilized with nine cohorts of FRPP patients, resulting in 79 percent of patients who were enrolled and successfully completed the FRPP being found fit for full duty and meeting worldwide deployable standards.

MHS supports and plans to implement PASTOR across all Pain Clinics in FY 2017 and 2018. PASTOR received support from several Tri-Service governance bodies, to include the Medical Operations Group and Medical Business Operations Group. Each has endorsed funding for FY 2017 and 2018 to support sustainment and modernization. The capability is currently deployed at NMCSA and Madigan Army Medical Center (AMC) with plans for expansion to eight additional pain management clinics in FY 2017 to finalize the implementation across the MHS. The eight additional clinics include: Brooke AMC, Tripler AMC, Eisenhower AMC, Landstuhl Regional Medical Center, Womack AMC, Walter Reed National Military Medical Center, Joint Base Elmendorf-Richardson Medical Group, and Portsmouth Naval Medical Center. In the future, PASTOR will either interface or be replaced by the new MHS GENESIS capability or other modern enterprise reporting tool, as applicable. The functional community is also actively engaged in Program Objective Memorandum (POM) actions to address PASTOR in FY 2019-2024.

Pain Management Services

Patient Centered Medical Home

In conjunction with MHS expansion of the PCMH model, the Air Force, Army, and Navy pain programs, along with DVCIPM, also continue to focus significant effort on providing the necessary clinical, education, and training support for pain management in primary care. DVCIPM is coordinating two VA/DoD JIF projects, ATACS and JPEP, both discussed later in this report.

DoD is also 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 Extension for Community Healthcare Outcomes (ECHO) telementoring model. ECHO uses secure, audio-visual networks to connect pain medicine specialists (hubs) with remote primary care providers (spokes) to increase provider pain management competencies. Army began utilizing ECHO telementoring clinics to address pain management in 2013 and currently hosts four Pain ECHO clinics with six regional hubs and 48 spokes. Navy initiated ECHO telementoring clinics in 2014 and currently hosts two Pain ECHO clinics with two hubs and 22 spokes. Army and Navy plan to incorporate the standardized VA/DoD JPEP curriculum to improve clinical care and decrease variation in care. Air Force continues to maintain a variety of webinar-based provider training initiatives, including those for Chronic Pain and Addictions.

The National Capital Region Pain Initiative (NCRPI) innovative programs and initiatives continue to serve as a model for pain care in Federal healthcare systems. One of the primary initiatives involves imbedding pain assets in both the primary care medical home as well as specialty clinics to improve the quality, efficiency, and access to pain care services with telehealth services. Furthermore, the Tele-Pain program continued to expand services, sites, and number of encounters in the National Capital Region by adding a pain psychologist, integrative medicine physician as well as integrative medicine nurse and support staff to the Tele-Pain team. The team serves as the MHS pain expert to deployed providers via the Army e-consult program. The service now averages 70 patient encounters per month.

The Army Comprehensive Pain Management Program (CPMP) has also developed and is in the process of staffing a Primary Care Pain Champion (PCPC) Fragmentary Order (FRAGO) in support of the Army Medical Home Operation Order. This FRAGO was initiated to support the activities of the Primary Care Pain Champion within the Army Medical Home. The FRAGO provides specific instructions on the duties and requirements of the PCPC position along with required template changes.

Clinical Practice Guidelines

As indicated in the National Pain Strategy, the requirement for updated and additional evidence-based guidelines for pain management is a national priority. MHS is committed to the practice of evidence-based medicine and supports ongoing development and updates to CPGs through the VA/DoD HEC Evidence-Based Practice Work Group

(EBPWG). The VA/DoD CPGs and the supporting tool kits developed by the EBPWG provide clinicians with a standard to guide their clinical decisions as well as a tool for use in the peer review process.

In 2016, the EBPWG continued their systematic review and update on the VA/DoD CPG for the Management of Opioid Therapy for Chronic Pain, now referred to as the Long-term Opioid Therapy (LOT) CPG. The updated LOT CPG is due in early 2017, and the related CPG tool kits will integrate recent advances in medical evidence regarding quality pain care and the effective use of prescription medications, as well as compliance with the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain. The MHS PMWG and EBPWG are also collaborating to determine need for other CPG updates or new CPGs.

The Services also use CPGs to update their Service-level policies. For example, the Navy's Comprehensive Pain Management Program (NCPMP) assembled a team of SMEs in 2013, now called the Long-term Opioid Therapy Safety (LOTS) Working Group (WG) to review the 2010 VA/DoD CPG for the Management of Opioid Therapy for Chronic Pain. The LOTS WG, which included representatives from family medicine, pharmacy, anesthesiology, and other relevant specialties, was tasked with reviewing the CPG to identify and assess best practices for the safe prescription and use of opioid therapy for pain management. The outcome of this assessment was the selection of four key recommendations focused on:

- 1) Screening for past psychiatric history and substance use history for patients on LOT;
- 2) Screening for concurrent use of benzodiazepines;
- 3) Recommending the use and annual renewal of opioid care agreements; and
- 4) Recommending the administration of annual urine drug screening for every patient on LOT.

Following their review of the CPG, the LOTS WG stood up a CPG compliance monitoring initiative, developed a Chronic Opioid Therapy Safety (COTS) form for the Tri-Service Work Flow (TSWF), and developed a variety of education materials including modules for primary care providers in the JPEP curriculum on the safe prescription of opioids and management of patients on LOT.

In FY 2016, the LOTS WG completed a draft of a Long-term Opioid Therapy Safety Navy Bureau of Medicine (BUMED) Instruction codifying the recommendations from the 2010 VA/DoD CPG and lessons learned from the CPG Compliance initiative into official BUMED policy. The Instruction will require all Navy Medicine (NAVMED) facilities and prescribers to follow defined evidence-based procedures to improve clinical outcomes and patient safety for those receiving LOT. The policy includes requirements on screening patients for past psychiatric and substance use history including concurrent use of benzodiazepines; establishing and adhering to informed consent opioid care agreements; and continued surveillance through regular assessment of degree of

analgesia, opioid-related adverse effects, functional status /activities of daily living and aberrant behavior, as well as regular administration of urinary drug screens. Additionally, the BUMED Instruction will establish a standardized framework to measure compliance to the Instruction and LOT best practices. The requirements of the BUMED Instruction reflect the guidelines outlined in the 2010 VA/DoD CPG, the 2016 Guideline for Prescribing Opioids for Chronic Pain issued by CDC, and numerous evidence-based studies published on opioid prescription for chronic pain.

Included in the BUMED Instruction is a version of VA's Consent for LOT adapted for use by NAVMED as an informed consent opioid care agreement. The document standardizes the administration of informed consent and care agreements into a single form for use across the NAVMED enterprise. Likewise, the requirements of the Instruction will apply to all prescribers in the NAVMED enterprise in order to standardize key patient safety tenets and best practices across Navy.

As part of the NCPMP for FY 2015, Navy has implemented two CPG compliance initiative programs to monitor and improve provider adherence to the Low Back Pain and Opioid Therapy for Chronic Pain CPGs. These initiatives measure compliance in an effort to understand the impact of these CPGs on clinical care, identify issues that might prevent compliance with CPGs, and seek to promote the increased use of CPGs across the NAVMED enterprise.

Alternate Input Method Forms

The TSWF Section of the DHA Solutions Delivery Division has developed an Alternate Input Method (AIM) documentation tool, referred to as the COTS AIM form, which is based on the current VA/DoD CPG for Management of Opioid Therapy for Chronic Pain. The COTS AIM form works in conjunction with the Armed Forces Health Longitudinal Technology Application and provides clinicians a standardized format to document items critical to understanding and managing these patients appropriately. In addition, links to screeners, reference materials, and patient handouts are provided on the COTS AIM form.

By utilizing this standard form to treat patients on LOT, the Services are able to identify this population. The COTS AIM form facilitates peer review and other inquiries by local MTFs and oversight committees. This form also provides embedded and well delineated treatment algorithms for specialty care referrals for the initiation, follow up, and discontinuation of chronic opioid therapy.

MHS Opioid Registry

The MHS Opioid Registry is a collaborative, multi-disciplinary effort to support providers, staff, and decision-makers in improving the safety and quality of care of patients on opioid prescriptions. It was developed and tested in 2016 with a phased rollout planned in 2017.

The registry offers stakeholders access to near-real time demographic, clinical, and pharmaceutical data related to opioids such as morphine equivalent daily dosages. High risk opioids and other medications such as antidepressants, benzodiazepines, and sleep medications concurrently prescribed with opioids can be flagged to alert staff of potential fatal overdoses. Unlike other prescription drug monitoring programs where insight is limited to medication data only, a more comprehensive view can be provided by offering information related to patients' mental health co-morbidities, current and past urine drug testing, healthcare utilization practices, and other patient-associated behaviors enabling providers the ability to prioritize and stratify populations according to risk category. This effort reuses existing technology such as the Carepoint MHS Population Health Portal and leverages previously funded JIF innovations such as the DoD and VA Infrastructure for Clinical Intelligence (DaVINCI) project, which provides a common framework to combine, share, and analyze DoD and VA data, resulting in significant savings (development and hardware costs). This effort fosters collaboration within and across DoD and VA, and encourages a team-oriented approach in tackling a complex, multi-factorial epidemic. Partnerships continue to be made by DoD/VA experts representing the pharmacy, mental health, substance use, and pain communities. Potential standardization of common opioid management activities include implementation of clinical practice guidelines, morphine equivalence conversions, risk stratification and scoring, and adoption of opioid safety aggregate measures for reporting. The development of a comprehensive opioid registry brings multiple communities together in a common information platform to monitor opioid activity across the entire continuum 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 the DoD to the VA. This effort has the full support of the DHA leadership as one of the main core programs within the overall "Pain Campaign" as well as support from VA leaders already actively involved in opioid safety and risk mitigation programs.

Stepped Care Model of Pain Management

The MHS Pain strategy incorporates the Stepped Care Model of Pain Management (SCMPM) developed by VA. The SCMPM is instituted as a strategy to provide a continuum of effective treatment to patients with acute and chronic pain. In October 2015, the NCPMP initiated a formal briefing between BUMED, NAVMED East, and NAVMED West leadership focused on socializing the rollout of program-supported professional services and implementation of the SCMPM. Specialty care referral was identified as a challenge by Region leadership, and the recommendation was made that the program build closer connections with basic-level stakeholders to better understand local barriers. In response, in January 2016, the NCPMP successfully recruited specialty and primary care Pain Champions at the seven sites currently receiving program-funded specialty pain care service providers. The Pain Champions have since been instrumental in helping the program identify opportunities to improve pain care at the local and enterprise levels.

Effectiveness of Pain Management Services

The Air Force Medical Service (AFMS) is reviewing active duty and MTF TRICARE Prime member pain care in the network with the intent to recapture care and provide greater capacity within MTFs. AFMS plans to ensure network referrals are appropriate and necessary to reduce private sector care costs. Additionally, AFMS has upgraded its two current Continental United States Pain Centers, at Eglin Air Force Base (AFB) and Joint Base Elmendorf–Richardson, to Interdisciplinary Pain Management Centers (IPMCs).

In FY 2016, Navy initiated a value-based care pilot at Naval Hospital Jacksonville to organize and implement integrated practice units (IPUs) for four common conditions of Navy beneficiaries. Chronic low back pain was one of the four conditions selected and will be the first IPU stood up with a kick-off slated for October 2016. The unit is modeled after the Spine IPU stood up at NMCS D in 2014, which saw a 23 percent decrease in lumbar spine magnetic resonance imaging in its first year and increases across patient satisfaction scores as a result of the IPU.

In continuation from FY 2015, the NCPMP, working with the Navy Marine Corps Public Health Center (NMCPHC), has created five criteria, referred to as the Chronic Pain 5 (CP5), to identify and monitor changes in chronic pain patient populations across the NAVMED enterprise. Exhibit 1 provides an overview of the five criteria that make up the CP5 methodology.

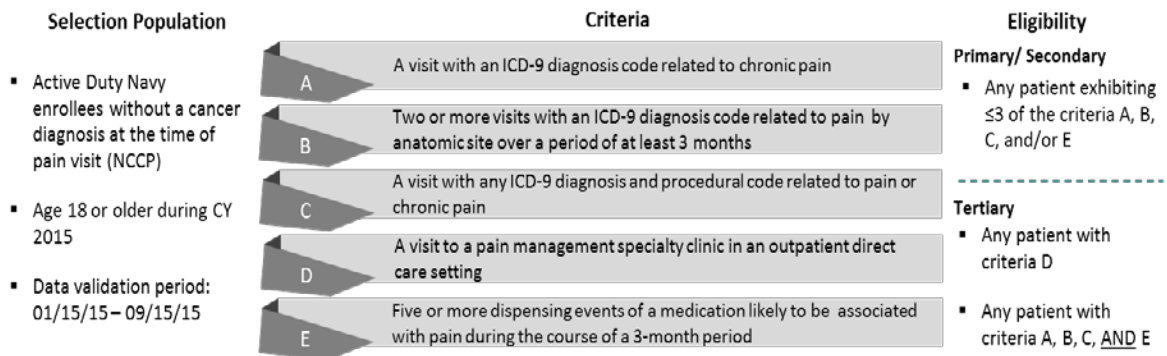


Figure 1: The Chronic Pain 5 criteria for chronic pain patient identification.

The implementation of the CP5 occurred in October 2015, and the first analysis found 104,952 patients suffering from primary, secondary, or tertiary pain conditions. After identifying the pain population, nine metrics to assess pain care processes within the NAVMED enterprise were purposed and developed. The metrics have been visualized in a Performance Management tool designed to support evidence-based decision making by BUMED and Command-level leadership. These nine metrics include:

- 1) Inpatient Visits
- 2) Inpatient Dollars Spent

- 3) Emergency Room Visits
- 4) Emergency Room Dollars Spent
- 5) Primary Care Visits
- 6) Primary Care Dollars Spent
- 7) Specialty Care Visits
- 8) Specialty Care Dollars Spent
- 9) Total Dollars Spent

Patients Perception of Adequacy of Pain Management Services

Congress has requested that an assessment of the adequacy of DoD's pain management services be included in this annual report. While there is no standardized tool for surveying patient satisfaction with pain management services in DoD outpatient settings, the Services measure patient satisfaction with pain management in primary care and several specialty care clinics.

DoD is also assessing beneficiary satisfaction with inpatient pain management as part of its annual Hospital Consumer Assessment of Healthcare Provider and Systems survey. Overall patient satisfaction with pain management is based upon patient self-report on two pain related questions:

- “During this hospital stay, how often was your pain well controlled?” (*Pain Controlled* Question); and,
- “During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?” (*Help Controlling Pain* Question).

Using a composite of these two questions, the chart below depicts inpatient satisfaction from Quarter 2, FY 2013 to Quarter 2, FY 2016. Data from Quarter 4, FY 2014 is not available. Overall pain management performance has remained above the national benchmark of 71 percent. The results for the *Pain Controlled* question have remained over 65 percent, while the responses for the *Help Controlling Pain* question have remained over 80 percent.

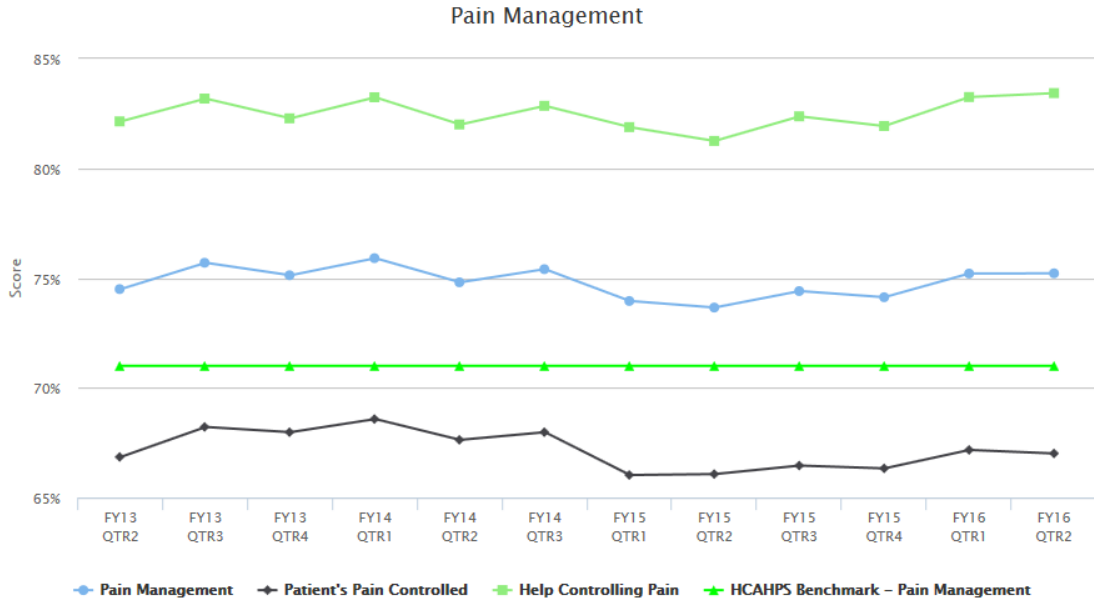


Figure 2: Pain Management Satisfaction – Direct Care

Pain Management Research

DoD continued to make advances in pain research across the Enterprise in FY 2016. The DoD Pain Management Portfolio has 84 ongoing projects in 10 major focus areas with a total funding of \$137.26 million. DoD personnel have published multiple articles on acute and chronic pain management in peer reviewed journals and, despite constraints on DoD attendance at conferences, numerous MHS clinicians and researchers have presented pain management projects at multiple military, national, and international medical conferences. In addition, DVCIPM continues to represent DoD on the NIH-Interagency Pain Research Coordinating Committee.

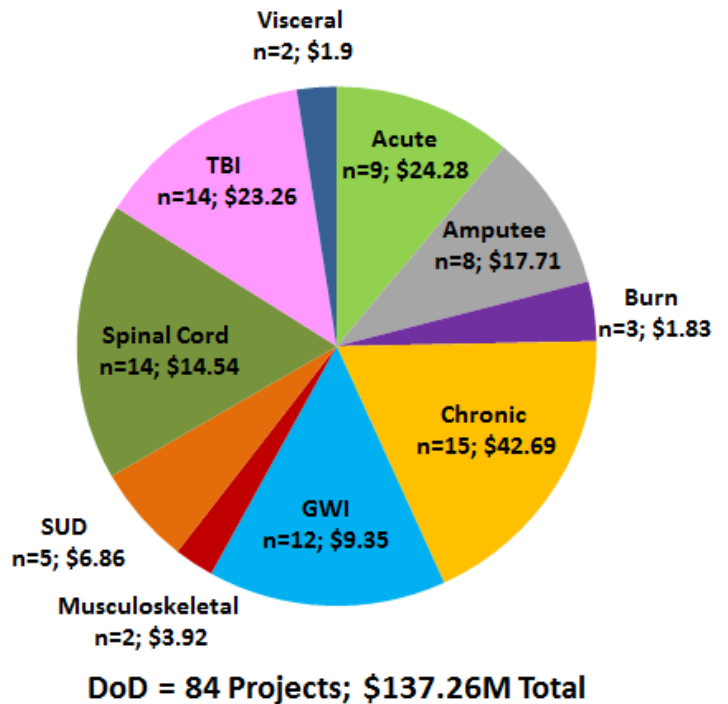


Figure 3: DoD Pain Management Portfolio

DoD entities engaged in pain management research include DVCIPM, U.S. Army Medical Research and Materiel Command, Clinical and Rehabilitative Medicine Research Program (CRM RP), Institute for Surgical Research, USU, and military MTFs. The CRM RP portfolio in particular

spans basic research through clinical development projects that address pain management from the point of injury to chronic pain management. CRMRP provides products and information solutions for the diagnosis and alleviation of battlefield acute and chronic pain and sequelae.

CRMRP objectives for FY 2017 through 2021 include the following:

Completion of Phase III Clinical Trial for Sufentanil Nanotab

Fielding of Sufentanil Nanotab

Completion of Phase II Clinical Trial for Oral Transmucosal Ketamine (Wafermine)

Investigate precision medicine and personalized pain management treatment strategies

Investigate treatment approaches for chronic pain in complex patients

Validation of Non-Pharmacological Approaches to Pain Management

Sufentanil Nanotab and Wafermine are rapidly acting products designed to relieve acute pain with minimal side-effects usually associated with the use of common analgesics currently in use. These products are developed primarily for use in the Tactical Field Care and Tactical Evacuation Care phases of Tactical Combat Casualty Care and at ROC-1 installations and activities.

DoD successfully completed a phase I/II clinical trial using Sufentanil Nanotab with patients following bunionectomy surgery. There was statistically significant ($p=0.003$) difference in pain for 30 mg sufentanil-treated patients and for placebo-treated patients. Phase III studies will be completed fall of 2016.

Ketamine is used as analgesic but with poor evidence. DoD recently issued a targeted Broad Agency Announcement to obtain evidence-based clinical data on the effectiveness and safety of intravenous and sublingual administration of ketamine IV in the treatment of acute pain to support the evidence-based recommendations for the use of ketamine in the treatment of acute pain. Pharmacokinetics and Pharmacodynamics studies in patient population with acute pain are needed to help determine therapeutic dose and bioavailability for ketamine using a US Food and Drug Administration acceptable clinical pain model.

Finally, the Services continue to develop and validate innovative practice models for pain management. For example, in FY 2016, NMCS D conducted outcome studies of FRPP, a program outlined above in Section 2 to promote Service members' ability to return to full military duty. FRPP has currently been piloted at NMCS D and has initiated stand up at NMC Portsmouth. As of March 2016, a total of 64 participants were enrolled and 54 had completed the FRPP program over the course of nine cohorts. Seventy-nine percent of patients achieved fit for full duty status upon successful graduation from the FRPP program.

Training and Education of Healthcare Personnel

Joint Pain Education Project

The JIF JPEP completed development of a standardized DoD and VA pain management curriculum for widespread use in education and training programs that will improve the pain management competencies of the combined federal clinical workforce. JPEP focuses on the needs of providers and patients in primary care, and provides a holistic, multi-modal, and multi-disciplinary pain care model that supports the balanced use of medications, procedures, specialty care, and self-care approaches for pain management.

The JPEP curriculum development process involved collaboration between DoD and VA inter-professional providers and coordinated SMEs to develop course content for 31 primary care focused pain management modules (Appendix B).

NCPMP established a strategic priority in FY 2016 to expand pain management education and training with a particular focus on patients and providers in primary care. Subsequently, NCPMP leadership selected the JPEP curriculum as the main vehicle for pursuing this priority. To facilitate the delivery of the curriculum, NCPMP hosted a four day ‘Train-the-Trainer’ course on the JPEP curriculum at USU at the end of June. Twenty-three Navy and Army clinicians participated in the training, which covered 26 of the JPEP training modules, as well as auxiliary presentations by SMEs from VA, NCPMP leadership, and USU instructors. The course equipped attendees with knowledge of the JPEP content as well as techniques for leading effective trainings and guidance for establishing delivery of the modules on a regular basis at their Commands. With the help of NCPMP, course attendees have begun to establish and execute JPEP training plans that meet the needs of their Commands.

Presidential Memorandum, “Addressing Prescription Drug Abuse and Heroin Use”

The October 2015 Presidential Memorandum, “Addressing Prescription Drug Abuse and Heroin Use,” directed the federal medicine Departments to develop and deliver training to prescribing providers that includes:

- 1) Best Practices for Appropriate and Effective Prescribing of Pain Medications
- 2) Principles of Pain Management
- 3) Misuse Potential of Controlled Substances
- 4) Identification of Potential Substance Use Disorders
- 5) Referral to Further Evaluation and Treatment
- 6) Proper Methods for Disposing of Controlled Substances

Overall prescription drug misuse is low in the military and on the decline. Data suggest the DoD’s strong focus in recent years on education and screening requirements for prescription drug abuse and addiction risk is having a positive impact. In addition, the

DoD is committed to provider training on evidence-based guidance for the prevention, screening, evaluation, and treatment of prescription drug abuse and substance use disorders.

DoD will leverage the content from the JPEP and the updated “Do No Harm” video to respond to the Presidential Memo directed training. Initially funded by BUMED and developed through a USU initiative, the “Do No Harm” training is a computer-based training on the identification and management of prescription drug misuse through a series of realistic clinical scenarios. The training has since been endorsed by the DoD Addictive Substance Misuse Advisory Committee. Training statistics have been reported to the Office of National Drug Control Policy quarterly with over 16,000 medical personnel completing training between FY 2012 and 2015. DHA is working to update the computer-based training and to develop a DHA Procedural Instruction in collaboration with representatives from all Services, to provide additional guidance and detailed procedures that will assist with tracking and compliance with the President’s mandate.

Complementary and Integrative Medicine

NMCS D’s Mind Body Medicine (MBM) Program received the 2015 MHS Innovation Award. The program integrates complementary and integrative medicine (CIM) approaches into the overall healthcare delivery system and targets beneficiaries with chronic health conditions to gain control over their stress, improve their resiliency to new adversities, and optimize their mind and body to best aid in their own recovery. As of 25 July 2016, 267 people have been trained in the MBM curriculum, and 18 patient-specific variants of the program have been applied in MTF and deployed care settings. Participants successfully created new meditation habits and demonstrated statistically significant improvement on measures of perceived disability, depression, anxiety, sleep, and quality of life.

Army CPMP coordinated Mayo Clinic ultrasound directed therapy and training at Army Medical Command (MEDCOM) facilities. The education program has been presented by the MTF IPMCs across two regional health Commands to increase skills of primary care managers to perform pain procedures in primary care. The program highlights the use of ultrasound to provide for a more precise application of medication to the areas causing pain or discomfort.

DVCIPM, in collaboration with Air Force Acupuncture and Integrative Medicine Center at Joint Base Andrews, completed execution of the JIF ATACS project. The ATACS project was initiated to develop, pilot, evaluate, and implement a uniform tiered acupuncture education and training program in order to expand its use across MHS and VA treatment facilities. The ATACS project also provides a much-needed alternative in cases where the initiation or continuation of opioid analgesics are deemed clinically risky; current medications and other therapies are not working; addiction and tolerance issues make medication therapies impractical; and there is existence of and potential for substance misuse.

The initial ATACS project goals were to train 1,200 providers in battlefield acupuncture (BFA), a rapid and effective auricular pain relief technique, and train DoD and VA physicians in an accredited 300 hour medical acupuncture course. At its completion, the ATACS project trained over 2,612 providers in BFA at over 100 training events, supported 124 BFA faculty to assist with continued training and sustainment, and sponsored the medical acupuncturist training of 80 medical providers.

The ATACS project team also developed a consensus document for recommended joint DoD/VA acupuncture utilization, credentialing, and education. The growing interest in expanding the number of trained medical acupuncturists in DoD and VA medical centers has led to an increased number of providers being trained by civilian acupuncture training organizations. The ATACS project team developed a recommended curriculum requirements document for medical acupuncture training to assist DoD and VA providers and leaders in selecting which medical acupuncture training programs address the needs of DoD and VA.

In addition to the ATACS project, NCPMP is working to increase access to evidence-based CIM modalities including acupuncture. Acupuncture has been shown to have particular benefit in the treatment of chronic pain, and NCPMP is seeking to increase the number of MTFs and providers able to offer this CIM modality through the provision of an Acupuncture Training Course (ATC) for active duty clinicians. In May 2015, the Navy CIM Tiger Team completed an ATC strategy, which will allow 30 NAVMED clinicians to fulfill the board eligibility requirements of the American Board of Medical Acupuncture (ABMA) within an eight month period, obtain acupuncture privileges at their local MTF, obtain 300 hours of American Medical Association Category I continuing medical education credit, and become eligible to apply for certification as an ABMA “Board Certified” medical acupuncturist. NCPMP has also supported the development of an innovative approach to provide auricular acupuncture training to NAVMED Clinicians and allied health providers through the online Swank HealthCare training platform.

Annual Pain Skills Training

As part of efforts to expand access to subspecialty pain management trainings, NCPMP has provided budgetary support to the 6th annual Pain Care Skills Training at NMCS D from 12-15 September 2016. This annual Pain Skills Training is the premier training activity in the federal system and continues to attract between 250-300 members of the healthcare teams for four days of interactive workshops designed to give attendees practical hands on experience. Tri-Service clinical SMEs will serve as instructors and lead discussions during the training’s plenary sessions as well as hosting full and half-day pain skills workshops.

The 2015 training included 321 attendees with Tri-Service participants from across the MHS. The agenda included a mix of didactic content on the latest pain topics and a combination of 32 different hands-on workshops that target all levels of healthcare providers involved in treating pain. The 2015 training was followed with monthly pain,

acupuncture, and addiction webinars which attract over 100 participants for case based discussions.

NCRPI continues to train up to forty providers quarterly in battlefield auricular acupuncture as well as sponsors a yearly Military Acupuncture Update for up to fifty acupuncturists. In addition, the NCRPI sponsors fifteen physicians yearly to attend a 300 hour physician acupuncture course. Finally, buprenorphine waiver training is offered quarterly in a webinar platform which allows prescribers in any location to attend. Forty physicians are trained quarterly.

Patient Education and Dissemination of Information

In 2016, the JPEP augmented the didactic pain management curriculum with a series of educational videos. These videos were developed in order to provide standardized and consistent explanations for some of the important and complex concepts introduced in the JPEP curriculum. The JPEP videos will be available on the DVCIPM website (DVCIPM.org) and the VHA's Pain Management website (<http://www.va.gov/painmanagement>).

The JPEP video topics include:

- 1) Pain Assessment
- 2) Opioid Prescribing/Tapering Overview
- 3) Stepped Care Model of Pain Management
- 4) Chronification of Pain
- 5) Essentials of Quality Pain Care
- 6) Safe Disposal/Opioid Take Back Program
- 7) Pain Assessment Screening Tool and Outcome Registry

Military Service Resource Allocation For Pain Management

The collaborations between NCPMP and NMCPHC continue to lay the foundation for an evidence-based approach to future allocation of pain care resources. Using the CP5 chronic pain patient identification criteria, NMCPHC was able to analyze the patient population by care site, as well as draw inferences regarding the adequacy of direct and purchased care services.

In 2016, NCPMP funded an additional 32 pain care professional services, bringing the total number of pain providers to 83 across 15 MTFs. In July 2016, a system was developed and implemented to track the hiring of new providers on a quarterly basis to facilitate program support for onboarding activities. As of September 2016, tracking data indicated that 42 of these providers have been on-boarded, trained, and were providing

specialty pain care to NAVMED beneficiaries, and an additional 12 hires were pending approval.

NCPMP has continued to support improved management of pain care pharmacotherapy through the inclusion of 23 clinical pharmacists within the programmed FY 2016 professional services budget. As of September 2016, 18 of these professional services had already been hired and were providing pharmacotherapy management at 12 MTFs, as well as participating in a monthly training and mentorship Polypharmacy Pain Initiative Community of Practice teleconference.

Air Force established a comprehensive pain management center at Travis AFB. The pain center officially opened in April 2016 and is open to all categories of beneficiaries with no deferments of any new TRICARE Prime beneficiary consults. This is allowing the local command to begin recapturing TRICARE Prime and active duty beneficiaries previously referred to the network for pain-related conditions. As of July 2016, greater than 75 percent of referrals have been recaptured from the network. The clinic is expected to yield an estimated cost avoidance of \$1.8 million. As capabilities continue to expand, the clinic is acquiring additional equipment and manpower with a planned end state of a multi-disciplinary comprehensive pain management clinic. Comprehensive care services include dietary counseling, physical conditioning advice, auricular acupuncture, transcutaneous electrical nerve stimulation treatments, pharmacotherapy, and interventional therapies. The clinic also has close coordination with on-base primary care, physical therapy, occupational therapy, behavioral health, orthopedic surgery, neurosurgery, chiropractic care, nutrition services, and anesthesiology.

Eglin AFB has been tentatively chosen as the site for an Invisible Wounds Clinic specializing in the treatment of traumatic brain injury, posttraumatic stress disorder, and complex pain syndromes. Additionally, the pain management clinic will be expanding services to merge with integrative medicine modalities for a comprehensive approach to pain management. This phased expansion will start with increasing access to acupuncture services in addition to the interventional therapies offered.

Wright-Patterson AFB is in the early stages of starting an interventional pain clinic to reduce expenditures for out-of-network referrals and is anticipated to be fully operational by FY 2017. Joint Base Elmendorf-Richardson is also expanding its clinic with the addition of a pain psychologist and physical therapist, organic to the clinic. These providers will work in conjunction with interventional pain specialists to provide comprehensive pain management care without dependence on opioid therapy. The end goal of this venture is to drastically reduce the amount of patients on chronic opioid therapy in line with the CDC guidelines and Presidential agenda of reduction of opioid abuse in the United States.

The Army's Comprehensive Pain Management team, the Army IPMC Chiefs, and representatives from a variety of complementary and integrative medicine modalities conducted a review of the current roles, responsibilities, and opportunities to synchronize pain care staff and resources across Army Medicine. Additionally, this team reviewed the various Functional Restoration Programs (FRPs) across the MEDCOM to define the variety of "high intensity" rehabilitation programs in the IPMCs, identify and disseminate

best practices, and develop a common operating picture for the Army FRPs in regards to staffing, therapies, and outcome measures.

Army developed an Opioid Electronic Profile (eProfile) Execution Order (EXORD) for staffing. Based on guidance from the Army's Vice Chief of Staff, the EXORD requires medical providers to document opioid prescriptions in the eProfile system in order to provide Commanders with visibility and insight on the number of Soldiers within their unit who are taking these types of medications.

Summary

DoD pain management policies and initiatives focus on providing a patient centered, holistic, multi-modal, and multi-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 the MHS has resulted in several advances in pain management policy, clinical care, research, and education/training products and clinical tools that serve our beneficiaries and provide an example for the nation. As a result, DoD is uniquely positioned to advance the October 2015 Presidential Memorandum and 2016 National Pain Strategy.

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APPENDICES

Appendix A: List of Acronyms

ABMA	American Board of Medical Acupuncture
AFB	Air Force Base
AFMS	Air Force Medical Service
AIM	Alternate Input Method
AMC	Army Medical Center
ATACS	Acupuncture Training Across Clinical Settings
ATC	Acupuncture Training Course
BFA	Battlefield Acupuncture
BUMED	Navy Bureau of Medicine
CDC	Centers for Disease Control and Prevention
CIM	Complementary and Integrative Medicine
COTS	Chronic Opioid Therapy Safety
CP5	Chronic Pain 5
CPG	Clinical Practice Guideline
CPMP	Comprehensive Pain Management Program
CRM RP	Clinical and Rehabilitative Medicine Research Program
DaVINCI	DoD And VA Infrastructure for Clinical Intelligence
DoD	Department of Defense
DHA	Defense Health Agency
DVCIPM	Defense and Veterans Center for Integrative Pain Management
DVPRS	Defense and Veterans Pain Rating Scale
EBPWG	Evidence-Based Practice Work Group
ECHO	Extension for Community Healthcare Outcomes
EXORD	Execution Order
FRAGO	Fragmentary Order
FRP	Functional Restoration Program
FRPP	Functional Restoration Pain Program
FY	Fiscal Year
HEC	Health Executive Committee
HHS	Department of Health and Human Services
IOM	Institutes of Medicine
IPMC	Interdisciplinary Pain Management Center
IPU	Integrated Practice Unit
JIF	VA/DoD Joint Incentive Fund
JPEP	Joint Pain Education Program
LOT	Long-term Opioid Therapy
LOTS	Long-term Opioid Therapy Safety
MBM	Mind Body Medicine
MEDCOM	Army Medical Command
MHS	Military Health System
MQA	Medical Quality Assurance

MTF	Medical Treatment Facility
NAVMED	Navy Medicine
NCRPI	National Capital Region Pain Initiative
NCPMP	Navy Comprehensive Pain Management Program
NDAA	National Defense Authorization Act
NIH	National Institutes of Health
NMCPHC	Navy Marine Corps Public Health Center
NMCSO	Naval Medical Center San Diego
PASTOR	Pain Assessment Screening Tool and Outcome Registry
PCMH	Patient Centered Medical Home
PCPC	Primary Care Pain Champion
PMTF	Pain Management Task Force
PMWG	Pain Management Work Group
PROMIS	NIH Patient Reported Outcomes Measurement Information System
REDCap	Research Electronic Data Capture
SME	Subject Matter Expert
SCMPM	Stepped Care Model of Pain Management
TJC	The Joint Commission
TSWF	Tri-Service Work Flow
USU	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs

Appendix B: JPEP Curriculum

- 1.1 Understanding Pain Video
- 2.1 Modern Understanding of Pain
- 2.2 Pain Taxonomy and Physiology
- 2.3 DoD/VHA Stepped Care Model for Pain Care Recovery
- 3.1 Assessment of Pain
- 3.2 Assessment Tools
- 4.1 Acetaminophen, NSAIDs and Opioids
- 4.2 Adjuvant Medications
- 5.1 Chronic Opioid Therapy Risk Evaluation and Mitigation
- 6.1 Behavioral Management of Chronic Pain
- 6.2 Provider Communication in Chronic Pain
- 7.1 Physical Based Therapeutic approaches to pain management
- 8.1 Integrative Pain Medicine
- 9.1 Pain Medicine Specialty Care
- 10.1 Neck Pain
- 10.2 Acute Low Back Pain
- 10.3 Chronic Low Back Pain
- 11.1 Shoulder Pain
- 11.2 Hip Pain
- 11.3 Knee Pain
- 12.1 Myofascial, Connective Tissue and Fibromyalgia Pain
- 13.1 Central Neuropathic Pain
- 13.2 Peripheral Neuropathic Pain
- 14.1 Headache Pain
- 15.1 Visceral Pain
- 16.1 Psychiatric Comorbidities and Pain
- 17.1 Geriatric Pain
- 17.2 Palliative and Oncologic Pain Care
- 18.1 Women's Pain Related Issues
- 18.2 Opioids and Pregnancy
- 18.3 Female Pelvic Pain