PRESERVING THE FORCE: A QUALITY IMPROVEMENT PROJECT TO REDUCE THE RISK OF OPIOID USE DISORDER IN THE MILITARY

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Abstract

Military service members incur combat and noncombat related injuries which may lead to acute or chronic pain. Treatment of these conditions with opioids may place them at risk for opioid use disorder (OUD). Opioid related overdoses among the military community increased by 50% from 2010 to 2019. The Sole Provider Program (SPP) is recommended to address the risks of OUD among Veterans receiving care at military installations. The goal of this evidence-based project was to ensure that all persons who receive opioid prescriptions at a military facility were evaluated for inclusion into a SPP and prescribed naloxone. Objectives included: (a) develop policy to outline the SPP program and staff/provider roles; (b) use the Analyze Prescription Monitoring Program Utilizer Report to identify patients who meet SPP criteria; (c) develop educational materials and educate clinic staff and providers on the SPP; and (d) educate patients on SPP, pain management and naloxone use. The Plan Do Study Act model was used to implement the evidence-based quality improvement project. Project outcomes were as follows: (a) SPP policy approved at all levels; (b) 43 patients alerted as high risk for OUD, 11 recommended for SPP, 19 required naloxone prescriptions; (c) patient educational materials developed and approved; and (d) 45% of providers trained, education adopted, and uploaded to virtual platform for mandatory completion. Advanced Practice Registered Nurses manage and prescribe opioids in the military setting and should play a key role in development and implementation of the SPP.

*Keywords***:** military; Sole Provider Program, opioid use disorder

Preserving the Force: A Quality Improvement Project to Reduce the Risk of Opioid Use Disorder in the Military

According to the Centers for Disease Control and Prevention (CDC, 2022) an estimated 27 million people in the United States age 12 years and older reported having an opioid use disorder in 2020, which includes members of the U.S. military community, veterans, and their family members. The daily rigorous activity military men and women are faced with puts them at great risk for battle and non-battle related injuries which may contribute to the development of acute and chronic pain (Dembek et al., 2020). Combat-wounded military personnel may be more susceptible to opioid use disorder (OUD) than their civilian counterparts due to their rigorous work life (Dembek et al., 2020). If this pain becomes chronic in nature, it may present a pathway for medication abuse and misuse among military personnel (Dembek et al., 2020).

Problem

Opioid related morbidity and mortality has steadily increased over the past several years within the ranks of the United States military (Becker et al., 2020; Bennett et al., 2022; CDC, 2022; Kelly et al., 2019). Between 2010 and 2019 overdose mortality among military veterans increased by more than 50% (Bennett et al., 2022). Potter et al. (2014) reported that the *2011 Army Posture Statement* brought to light the fallout of rigorous training and war on military service men and women. This report disclosed that pain is the leading cause of long and short-term disability, and within the military over 25% of soldiers suffered at least one pain related injury during time spent in basic training, while 29% of soldiers deployed during the same timeframe in the Iraq war sustained pain related injuries (Potter et al., 2014).

Opioid related overdoses among U.S. Veterans have increased by 23.7% from 2010 to 2015 and an additional 20.4% through 2016 (Peltzman, et al., 2020). For decades, military

service members have been faced with pain related injuries starting as early as basic training. Potter et al. (2014) reported that pain is the leading cause of long and short-term disability among military personnel, and during Operation Iraqi Freedom over 25% of soldiers suffered at least one pain related injury in basic training and 29% of deployed soldiers sustained pain related injuries.

Becker et al. (2020) highlighted associated increased risk for opioid use disorder contributory to various addictions, depression, sexual dysfunction, infectious disease transmission, and mental health conditions. In addition to increased mortality rates, Kelly et al. (2019) found that 46.2% of combat-wounded veterans reported "high rates of past-year prescription opioid misuse" (p. 168). Peltzman et al. (2020) brought to light an additional health concerns contributory to OUD in veterans. Between the years of 2010-2016 providers were decreasing opioid prescriptions yet veterans continued to present with OUD relating to a higher level of pain compared to the civilian population. Veterans also experienced a high risk for substance abuse and overdose deaths which correlated with post-traumatic stress disorder, traumatic brain injury, and mental health disorders (Peltzman et al., 2020). Between 2010 and 2015, overdose mortality among veterans increased by 23.7%, and for the 2015-2016 timeframe a 20.4% increase was noted (Peltzman et al., 2020). Additionally, the report noted that among female veterans, there was an 81.5% increase in mortality related to synthetic opioid use. A review of veteran OUD trends across the United States revealed a greater increase in OUD in the Northeast with mortality rates at an elevated rate of increase of 124% from the years of 2010-2015 and an additional increase of 42% the following year. The Midwest opioid mortality rate reflected an increase during the same time with a 51% increase from 2015-2016 (Peltzman et al., 2020).

Dembek et.al. (2020) found that among 2,567 deployed soldiers surveyed, 44% of those with opioid use experienced mild to no pain but continued to take the prescribed opioids, an action which increases risk of OUD. When reviewing OUD between civilians and veterans, combat wounded veterans demonstrated higher rates of prescription opioid misuse (46.2%) and sedative misuse (21.7%), which is much higher than that of the civilian population (Dembek et al., 2020). Sandbrink, et al. (2023) reported that synthetic opioids use had increased and that in 2019 as many as 50,000 people in the United States died from opioid overdoses. In April 2021 the CDC's National Center for Health Statistics estimated that overdose deaths from opioids increased to 75,673, an increase of 20,000 compared to 2020 (Sandbrink, et al., 2023).

Background and Significance

Multiple efforts have been brought about through legislative mandates and guidelines evolving from the Surgeon General guidelines, Comprehensive Addiction and Recovery Act (Office of National Drug Control Policy, 2022), the Veterans Affairs (VA) Opioid Safety Initiative (OSI) Requirements Memorandum (U.S. Department of Veterans Affairs, 2022) and the Centers for Disease Control and Prevention (CDC) Clinical Practice Guidelines for Prescribing Opioids for Pain (2022). The programs and policies that derived from these guidelines focus on providing a foundation for primary care providers (PCP) with an overall goal of improving opioid prescribing practices, deterring prescription misuse and abuse, providing opioid risk education, and improving public safety. The Surgeon General guidelines (Office of National Drug Control Policy, 2022) implemented various prevention strategies utilizing evidence-based practices and innovations which focused primarily on prevention efforts around prescription drugs, but also bringing awareness and training to the community on the risk of

opioids, harm-reduction, naloxone training, promoting a drug-free environment, increasing availability of local prescription drug take-back events, and promoting safe home storing.

The U. S. Department of Veteran Affairs (2017) established the OSI Directive and the Informed Consent Directive to help the PCP through challenging pain management and prescribing situations for Veterans with chronic pain. The OSI provides guidance on the safe and responsible use of opioids for both acute and chronic pain, transforming from opioids to other forms of pain management such as cognitive behavioral therapy and addressing psychological concerns (VA, 2017).

The CDC clinical practice guidelines (2022) approach to combating opioid abuse is geared towards managing outpatient prescribing for those suffering from acute and chronic pain. The guidelines help the PCP determine when to initiate opioids for pain, how to select the most appropriate opioid and dosing, strategies to decide the initial opioid prescription, recommendations for conducting follow-up appointments, and assessing risk and addressing potential harm of opioid use (Dowell et. al., 2022).

The Department of Defense (DoD) and VA collaborated on developing *VA/DoD Clinical Practice Guideline for the use of Opioids in the Management of Chronic Pain* (2022) based on evidence-based practice. This reference guides the PCP in care of Veterans by outlining safe opioid prescribing practices. and is similar to recommendations found in the CDC guidelines (2022). Various management algorithms are suggested based on the patient's pain characteristic, length of time of opioid use, and concurrent comorbidities (Sandbrink et al., 2023). This clinical practice guideline also focuses on the entire care team, including the patient and family members, to determine a plan of care and address non-pain related medical conditions such as psychological concerns and substance abuse issues, both of which increase the risk of OUD

(Sandbrink et al., 2023). Applying a patient-centered model gets the patient more involved in the shared decision-making process, which allows the patient to make decisions that they are held accountable for following the agreed upon resolution. Through effective communication and teamwork, the guideline created by the VA/DoD goal is to minimize preventable complications and morbidity from misuse and optimize the Veteran's health outcomes and quality of life (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2022). The VA guidelines are similar to recommendations found in the CDC guidelines (2022).

The United States Code Armed Forces, 10 U.S.C. §1074g. (2018) under the pharmacy benefit program calls for the Military Health System (MHS) to decrease the adverse effect opioids have caused throughout the military. Incorporating evidence-based practice information compiled from the program's prescription drug monitoring programs (PDMP) has been mandated throughout the MHS (MHS & Defense Health Agency [DHA], 2021). Prescription drug monitoring programs focus on management of opioid prescribing and identifying patients and beneficiaries who are potentially at risk for misuse of prescription drugs with an overall goal of preventing or decreasing abuse through enhanced management of controlled and high-risk medications. Efforts are currently in progress throughout MHS in the United States with each state having an individual operating program. The Institute for Intergovernmental Research (IIR) under guidance from the U.S. Department of Justice (2023) has developed the Prescription Drug Monitoring Program Training and Technical Assistance Center, a resource center to aid states in developing their PDMP. Along with this effort the DoD medical system has tailored a PDMP specific for its beneficiaries. The MHS and DHA (2021) released the Procedural Instruction (DHA-PI) 6010.02 Military Prescription Drug Monitoring Program which standardizes

recommended program requirements for use throughout the MHS PDMP. This guidance sets the precedence for independent military treatment facility (MTF) sole provider programs (SPP).

A SPP is a program that designates a primary and secondary provider to manage a patient's opioid prescriptions along with other high-risk medication prescriptions to decrease misuse and OUD. As part of the program, a binding safety contract is created between the patient and provider. The patient must follow a set of standard guidelines to maintain compliance with the program including safe use, management, and storage of the opioid or high-risk prescription (Sole Provider Program Function, 2022). The patient is limited to specific locations for prescription pick-up as designated by the sole provider. In special circumstances such as surgery and emergency management, the managing care team can prescribe opioids for short-term use (Sessions, 2022).

Currently, a military market region in Texas is establishing its PDMP and SPP which provides the student with an opportunity to advance evidence-based practice within the region. The implementation of these programs should enhance the military's ability to promptly identify and intervene on behalf of persons at risk for OUD. The number of deaths in the military related to OUD has posed a great concern for the military, and similar scenarios are still relevant in today's services members. If not controlled OUD could greatly impact the military's mission both in the United States and abroad. Therefore, the project will focus on the development of a SPP in a specific military market.

Assessment

The Military Health System is composed of many echelons of care. At the top of the MHS is the DHA. The system is further divided into multiple regions across the United States. The next level of health care facilities are the large market regions which are referred to as the

Direct Reporting Market. The large market region for this project is in a large city in the southwestern United States. The markets provide shared administrative services to the hospitals and clinic within its footprint and are responsible for generating medical readiness of veterans, active-duty members, their families, and medical personnel in the region (MHS & DHA, 2022). The market region for this project consists of two medical facilities and nine clinics.

The Military Surgical Center serves as one of the two medical facilities and has three clinics. The market is responsible for the care of more than 250,000 military beneficiaries (Sanchez, 2021). The medical director oversees all departments within the MTF. This facility comprises 24 primary and specialty care departments. Each department is usually staffed with three senior leaders, a chief medical officer, a chief nurse, and a chief technician, all who work together to ensure proper functioning within the department. Most departments are comprised of the primary care provider (physicians, nurse practitioners and physician assistants), registered nurses, licensed vocational nurses, medical technicians or certified nursing assistants, and administrative assistants.

There are multiple pathways that may result in a patient being recommended for the SPP. The first path for SPP recommendation may be triggered during the patient – provider encounter. The patient initiates contact with the provider through the Tricare telecommunication operators who are responsible for booking in-person and telehealth appointments. For in-person appointments. the patient will check in with the administrative assistants upon arrival and then be seen by the medical technician to obtain an initial intake on past and present medical history including medications and vital signs and may alert a nurse or provider of potential issues or concerns. At this point, the patient is seen by the provider (nurse practitioner, physician's assistant, or physician) to address and manage the patient's reason for visit. It is during the

provider patient encounter that assessment of pain needs, and current pain medication use is evaluated and the recommendation for SPP may occur at this level, if indicated.

The pharmacy team may initiate the second pathway for the SPP recommendation based on opiate prescription request alerts. For example, if a patient makes frequent requests for early refill of an opiate prescription or obtains opioids from more than one pharmacy, the pharmacist may alert the provider and verify the need for the prescription. Additionally, the pharmacy team may review Express Script records to identify beneficiary use of prescribed opioids. In this realm, the pharmacy team can pinpoint a person who is filling opiate prescriptions from more than one provider and at more than one pharmacy.

A third pathway that may indicate a person could benefit from the SPP is through staff concern. Clinic staff will be educated and provided tools on warning signs to look for in patients receiving opioids and other high-risk prescriptions. Staff will be able to report their concerns to an appointed department pain champion or a message explaining the concern can be submitted to the SPPF through the appropriate portal for review. See Figure 1 for sole provider program pathway for SPP inclusion or monitoring.

Figure 1

Sole Provider Program Pathway

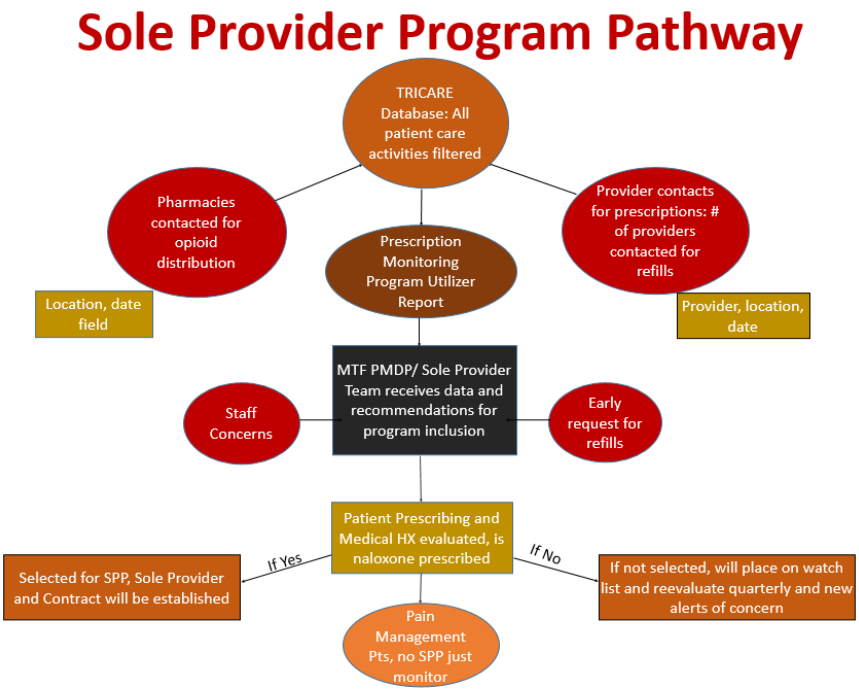


Figure 1 shows the prescribing activity of the patient which then feeds into the Tricare database. The various provider contacts for prescription(s) and the pharmacies accessed for prescriptions are captured. Express Scripts retrieves the data from all facilities which is then retrievable within the Tricare database. A prescription monitoring program utilizer report is compiled monthly and available for pharmacy retrieval at the MTF level. The reports get reviewed by the MTF PDMP/SPPF for criteria inclusion into the SPP. Patients who meet certain criteria are identified as possible participants in the SPP so that they can collaborate with the Primary Care Provider (PCP) on management of their high-risk prescriptions. Alternatively, some patients will be placed on the watch list and reviewed quarterly for inclusion or continued monitoring.

Readiness for Change

When it comes to the implementation of new quality improvement innovations, a facility would assess staff readiness for change. The assessment starts with the facility senior leaders and filters down through all staff that may have the ability to affect the patient's health. Facilities under the MHS are required to implement certain changes including the rollout of the PDMP throughout the DoD medical facilities. Facilities under the MHS must establish PDMP programs within fiscal year 2023 including the military ambulatory surgical center in south Texas. Although this was a mandated policy project, the medical director and senior leaders were on board with PDMP implementation and received support from the various multidisciplinary teams under their wing. As part of their commitment to readiness, the Pain and Well Being Working Group (PAWWG) was tasked with creating a Sole Provider Program Function which utilized the PDMP platform to create the Sole Provider Program at the immediate medical treatment facility level. Ensuring that the PCP and nursing staff have a clear understanding of the fundamental goals of the PDMP may increase patient and public safety, and in turn, lead it to be a more acceptable change (MHS & DHA, 2021).

Project Identification

Project Purpose

The purpose of the SPP was to prevent the misuse and diversion of opioid medications and other designated controlled substances within the MHS. For this program to be successful, the interim military treatment facilities needed to establish a Sole Provider Program Function to create and oversee the policy and procedures needed to establish and govern the SPP.

In accordance with the United States Code (2023) pharmacy benefit program, the MHS PDMP is meant to enhance the management of prescribing opioids and offer support for

providers using guidance from Joint Commission and Institute for Health Care Improvement (Martin et al., 2016). This SPP is focused on achieving the following aims: enhance legitimate medical use of prescribed controlled medications, identify, deter, or prevent drug abuse and diversion, and recognize patients who may be addicted to prescribed medications and offer intervention and treatment (USC, 2023). The intent of the SPP is to promote providers to closely monitor and manage their patient's-controlled substances.

Project Objectives and Outcomes

Objectives, interventions, evaluation, and measurement criteria for this project are highlighted in Table 1. This project was multifaceted and required a series of interventions to achieve the outcome of establishing the SPP within the market region.

Summary and Strength of Evidence

The U.S. Department of Veterans Affairs and Department of Defense (2022) updates the management of chronic pain clinical practice guideline every five years. To ensure that the guidelines reflect the highest level of evidence-based recommendation, the Grading of Recommendations, Assessments, Development and Evaluations (GRADE) approach is used to drive guideline development. These VA/DoD guidelines (2022) served as the primary foundation for recommendations and rules concerning the SPP. The guidelines include four domains: confidence in the quality of the evidence, balance of desirable and undesirable outcomes, patient values and preferences, and other considerations, such as resource use, equity acceptability, and feasibility. The guidelines on the components of pain and biopsychosocial assessment incorporate the following: methods to manage chronic pain using non-opioid treatments, opioid risk assessment, consideration checklist for prescribing opioids for chronic pain, risk mitigation strategies, considerations for tapering, dosage reduction, and discontinuation.

Table 1

SPP Objectives and Interventions

Objectives	Interventions	Evaluation	Measurement
Policy to outline the SPP program and staff/provider roles will be developed and approved by the medical director	Meet with multidisciplinary team including pharmacy, nursing, medicine, and staff in the development of SPP medication management contract	SPP medication management	Policy approval
Develop patient education materials addressing the PDMP and naloxone use	Create educational material	Approval from MHS to provide educational materials to persons selected for SPP	Authorization from medical director
Educate staff and providers on the SPP, and how to report patients at risk for OUD	Inservice for providers and clinic staff prior to project implementation.	Attendance record	90% of staff attending in-service, unit staff roster will be used to annotate presence for training.
Educate patients on PDMP and naloxone.	Naloxone patient education information will be presented at patient pain management classes, video in pharmacy waiting area, Flyers for patients available.	Record of attendance, and or verification of participation.	40% of patients will sign up for and attend patient education on indication for Naloxone administration.
Analyze prescription monitoring utilizer report at least quarterly to identify patients who meet inclusion criteria for SPP and Naloxone prescriptions	Review all patients receiving opioid prescriptions for inclusion in the SPP	Quarterly Express Script review of patients meeting inclusion criteria, and patient electronic medical record review	Documentation that quarterly review of all high-risk patients by the SPP Committee has been conducted.

Additionally, these guidelines cover relevant items such as the need for patient follow-up, factors requiring immediate attention, instructions on possible discontinuation of opioids,

recommendations to switch to safer pain regimen, and considerations for reassessment and tapering treatment. If needed, talking points are available to provider so that they can assess patients currently on opioids (Sandbrink et al., 2023).

A study by Chen et al. (2016) revealed that unintentional death related to opioid overdose is now the leading national cause of accidental death, surpassing street drugs such as cocaine and heroin. This study provided insights to non-opioid treatments, screening for depression and substance abuse, defining functional treatment goals, plan for opioid discontinuation, performance of ongoing risk versus benefit assessments, and avoiding concurrent benzodiazepine use (Chen et al., 2016). Through the review of national guidelines Chen et al. provides a list of tools to aid in the management of a patient's pain including three-month follow-up for chronic non-cancer related pain, referral to pain clinic to manage complex opioid consumption behavior, referral to physical therapy, consultation with a psychiatrist for patients with chronic pain and comorbid psychiatric illness, and routine urine toxicology screening. Additionally, it is highly recommended that patients receive their opioid prescription from a single provider and that providers should consider gradual attempts to reduce and eventually discontinue opioid use.

A classic study by Potter et al. (2014) provides preliminary insight regarding the origin of pain amongst military personnel. The study documented that soldiers were encountering pain related injuries during basic entry training at a rate of 25% annually, and at that time 29% of deployed soldiers had incurred lifelong pain related injuries that increased as training intensity was augmented to prepare soldiers for war (Potter, 2014). The study highlighted that service members affected by pain related injuries had the potential to develop chronic pain that would require long term pain management. Use of opioids for long term pain management is considered

a risk factor that may lead to opioid dependency. In response to the burden of OUD in the military, the MHS health care program developed the health system program operations manual which provides guidelines and support for developing a Prescription Monitoring Program. This tool would aid military treatment facilities (MTF) providers in methods to more closely manage the pain of an individual with one individual (USC, 2023).

An identified gap by Bachhuber et al. (2016) is that metropolitan areas should take a closer look at benzodiazepine misuse, along with opioids. Treatment goals are aimed at continuing to identify interventions to improve prescribing safety. Additional gaps that need to be addressed concern local area medical treatment facilities that are not enrolled in PDMPs or systems that lack the ability to communicate with electronic health records from other facilities. This lapse in technology could allow those individuals with OUD easy access to opioids without control (Bachhuber et al., 2016). Rural area MTF would also fall into this category as many places may not have the funding to access the necessary technology for PDMP. This could lead to an increase in divergence and increased abuse within these areas. Medical facilities should be aware of capabilities in neighboring counties' medical facilities.

Methods

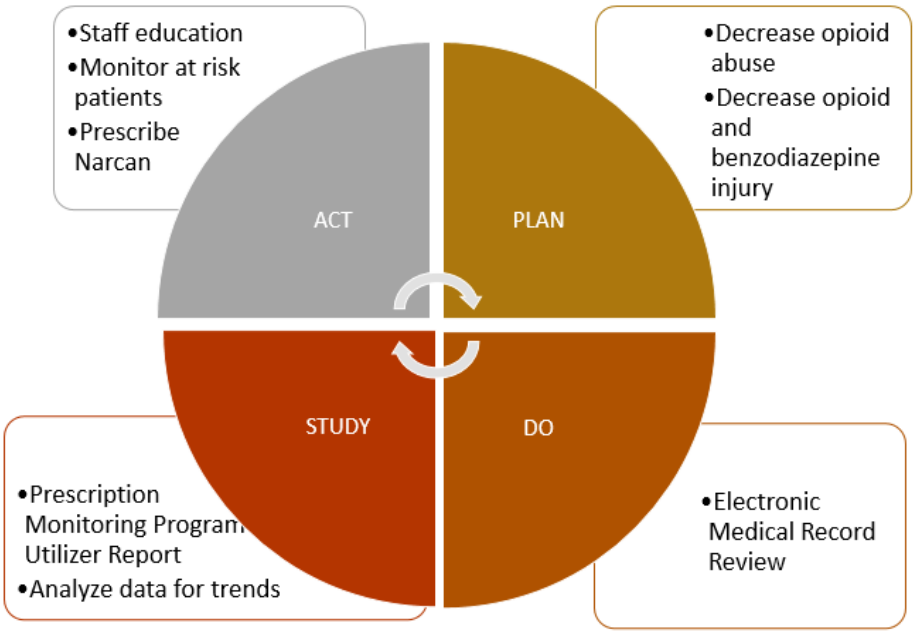
Project Intervention

The PDMP is a mandated MHS quality improvement program, and it is up to each facility to thoroughly engage their staff on all angles to ensure that all staff understand the aim of the SPP, apply the most appropriate pain management with or without the use of opioids, and ensure the safe use of opioids by their patients. At the South Texas MHS the PDMP SPP was established to set the standard of operation for program management applying guidelines in the DHA-PI 6010.02 Military Prescription Drug Monitoring Program. A local SPP policy was also

used from a military medical facility within the region. Because this local military facility was smaller in operational size by patient load and staffing, appropriate adjustments were made to address the facility operational environment. This medical facility had a functioning PAWWG which incurred the responsibility of developing the SPP since their initiatives were similar in improving the management and outcome of patients with chronic pain. The established policy made note that chronic pain management required a multidisciplinary care team, data collection, for determining inclusion into the SPP, along with staff and patient education of the SPP and opioid risk assessment for a successful sustain program. The model for improvement for this project was the Plan-Do-Study-Act model.

Figure 2

Model for Improvement: Plan-Do-Study-Act



The multidisciplinary care team includes Physicians, Advanced Practice Registered Nurses (APRN), Physician Assistant (PA), pharmacy providers, and nursing support staff. The SPP policy and SPP Charter outlined below details each medical asset responsibility within this MHS. These responsibilities serve as the intervention to achieve the project objectives.

a. The Pharmacy and Therapeutics Committee (PTC):
    i. Provide oversight and guidance for all activities of the Sole Provider Function (SPF).
    ii. Review recommendations of the SPF at the PTC meeting every quarter at minimum (SPP, 2022).
b. The Sole Provider Function:
    i. Maintain a record of patients who are designated as Sole Provider patients, along with the current Sole Provider and Alternate Sole Provider.
    ii. Perform routine screening of provider prescribing practices, patient medication profiles, chronic opioid use, Prescription Drug Monitoring Programs (PDMP) and patient access to pharmacy services to identify possible inappropriate prescribing, potential high-risk behavior, or potential prescription misuse involving controlled substances.
    iii. Evaluate Sole Provider Program Referrals. Patients recommended for enrollment in the Sole Provider Program will be offered participation in the Interdisciplinary Pain Class.
    iv. Monitor and report on patient's compliance with designated Sole Provider and alternate as required by the PTC.

v. Approve disenrollment from the Sole Provider Program for a patient if the designated Sole/Alternate Provider and the Sole Provider Function deem that the patient no longer exhibits high-risk behavior or that the patient's complex pharmaceutical care issue has resolved.

vi. Recommend disenrollment from the Sole Provider Program if the patient is compliant with the contract with no high-risk behaviors exhibited for six months. If this recommendation is rejected, the Sole Provider will be asked to provide justification for continued enrollment.

vii. Monitor prescribing patterns of providers to ensure that they meet accepted standards of care and the recommended prescribing and documentation policies. If not, notify the provider's department or service chief regarding the prescribing provider's activity (SPP, 2022).

viii. The department will be obligated to conduct provider review, and report actions and recommendation to the Chief of Medical staff (SGH).

c. Sole Provider Function Coordinator (SPFC):

i. Review the quarterly CDRL Q240 Prescription Monitoring Program Utilizer Report review potentially concerning patients for recommendation.

1. Documentation may be accessed through Carepoint, PDMP and MHS Genesis.

ii. Ensure that patient's SPP Agreement is signed and scanned into MHS Genesis (to be done by provider)

iii. Confirm that if a Restriction Form is submitted to Express Scripts for any lock that the patient profile warnings are active in MHS Genesis (To be done by provider).

iv. Ensure that a Controlled Substance Use Agreement alert is entered into MHS Genesis

1. Initiate a pharmacy intervention in Medication Manger Retail
2. Select DoD – Controlled Substance Use Agreement
3. Document all appropriate fields.
4. In the comment field document, all drug classes or pharmacy restrictions needed.
5. This will trigger a warning in Medication Manger Retail and Powerchart when the patient's chart is opened (SPP, 2022).

v. Ensure the provider enrolls the patient into the Military Treatment Facility Prescription Restriction Program by completing an Express Scripts "MTF Rx Restriction Request Form" and "locking in" the patient into one of three restriction types available:

1. Type I Lock: Restrict ALL MEDS for a beneficiary to a specific pharmacy or list of pharmacies and/or providers or list of providers.
2. Type II Lock: Restrict CONTROLLED MEDS for a beneficiary to a specific pharmacy or list of pharmacies and/or provider or list of providers.
3. Type III Lock: Exclude controlled substances and/or specific non-controlled substance(s) from a beneficiary at the mail order or retail pharmacies.

vi. Run drug utilization reports (DURs) of "Sole Provider Program" beneficiaries and beneficiaries enrolled in the MTF Prescription Restriction Program.

1. Run the PDMP report on patients enrolled in the SPP.
2. SPF Coordinator (SPFC) will reconcile and compare these reports. Results are reported to the SPC for awareness and action.

vii. Maintain a database of enrolled Sole Provider patients along with the current Sole Provider and Alternate Sole Provider to be used by the SPF. (SPP, 2022).

d. The Sole Provider/Alternate Sole Provider:

i. Conduct an initial visit with the patient where the Express Scripts MTF Rx Restriction Request Form, and Sole Provider Agreement are filled out and submitted.

1. Providers may use the Sole Provider Agreement without enrolling the patient in the SPP if the patient does not meet the high-risk behavior criteria for enrollment.
2. If the provider chooses to use the Sole Provider Agreement without enrollment in the SPP, it is the provider's responsibility to recommend enrollment to the SPP at a later date if the patient is considered high-risk or has behaviors that warrant monitoring by the SPP in the future.

ii. At the initial visit use a therapeutic approach to express concerns about the patient's safety, on-going health problems, provide the patient with an assessment of the concern and present a management plan. Ensure the patient knows the mechanism for access to care while in the SPP.

iii. Emphasize the concern for patient safety and present the SPP as being in the patient's best long-term interest.

iv. Prescribe any necessary controlled substance prescriptions for the patient.

v. Present the patient with opportunities for additional care, including but not limited to, the Department of Behavior Health, or the Interdisciplinary Pain Class, Battlefield acupuncture, and physical therapy. Active-Duty service members with high-risk behavior require referral to the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program for evaluation.

vi. Monitor the patient's progress in the appropriate use of controlled substances as well as the patient's other medication needs.

vii. Report disengagement, whether through problem resolution, noncompliance, PCS, or ETS, to the following individuals via email:

1. Sole Provider Function's Chair.
2. Sole Provider Function Coordinator
3. Medical Director
4. Coordination must be made to provide patient with a new Sole Provider or disenroll the patient from the program. (SPP, 2022).

e. Medical Director:

i. Ensure completed Sole Provider Agreements are scanned into the electronic health record.

ii. Evaluate providers identified by the SPF as having potentially aberrant prescribing practices and take action as needed. Actions may include Focused Professional Practice Evaluations (FPPEs), Peer Reviews.

iii. Ensure staff are familiar with this policy (SPP, 2022).

f. The Pharmacy Representative:

i. Assume the role as proponent of the SPP Policy.

ii. Ensure that the controlled substance prescriptions for patients enrolled in the SPP are screened at least quarterly in order to identify abnormal prescription patterns.

iii. Ensure, for designated patients, the pharmacy staff confirms that prescriptions for controlled substances are either issued by or specifically approved by the patient's Sole Provider/Alternate Sole Provider (SPP, 2022).

g. All Providers:

i. Report patients with potential problems to their Medical Director, SGH, Department of Pharmacy or the Sole Provider Function as needed.

ii. Prescribe only the minimum quantity of controlled substance medications sufficient to treat acute conditions (e.g., dental work, acute injury) not to exceed a seven-day supply when the provider is not the patient's Sole Provider or Alternate Sole Provider. Notify the Sole Provider or Alternate Sole Provider if a patient enrolled in the SPP is attempting to obtain controlled substances other than as indicated (SPP, 2022).

Data gathering and intervention started when a patient encounter occurred outside of the MHS footprint and was prescribed a high alert medication such as an opioid. This information was available to the pharmacy team who receives reports for all opioid prescriptions filled for beneficiaries, regardless of where the prescription is filled (on base or at a community pharmacy). The patient preferred pharmacy will receive an electronic medical record alert for filling a high-risk medication. If the facility shares data with the MHS or the pharmacy as part of

the National Association of Boards of Pharmacy PDMP the system will alert the prescribing pharmacy that the patient is part of the SPP (National Association of Boards of Pharmacy, 2020). The provider will be notified if a high alert risk status has been designated under the SPP (SPP, 2022). If there is no SPP alert the data will continue to the MHS Tricare database Express Scripts program and create an alarm code for the Prescription Monitoring Program Utilizer Report (PDMPUR). The medication alert is retrieved by the regional PDMP SPPF where it gets separated by Market Region. This information then becomes available for the local military medical facility pharmacist to retrieve for their facility's SPPF committee review. Part of the intervention tasks the local SPPF to review all high-risk patient data before an appointed panel of medical providers for decision on inclusion or monitoring in the SPP. Patients may be recommended for SPP or, if there is question about meeting inclusion criteria, they may be placed on a watch list and monitored for inclusion in 30 days.

The PAWWG SPP convened monthly for patient review, and for program policy updates as needed. As part of the project implementation, the team reviews the electronic medical record to identify opioid and benzodiazepine use, the patient's diagnosis, relevant past and current medical history to include previous medication or substance abuse of any type, frequency of refills, number of providers prescribing, refill dates, and the number of pharmacies frequented to fill medications (SPP, 2022). Although demographics were available and used when making contact with a patient PCP for an OUD risk, this information did not prove beneficial for use when deciding inclusion into the SPP. The PAWWG SPP convened monthly for patient review, and for program policy updates as needed.

Guidelines set forth by the CDC (2022), and VA/DoD (2022) were used in the creation of staff and patient education. Staff was provided a brief history of OUD amongst the military

community, and rationale for the DoD mandate on the establishment and purpose of PDMP and SPP. Staff also received a detailed breakdown of each staff member function by specialty in the SPP, bringing about awareness of everyone's responsibility. Additional information covered was communication tips for interacting with patients. Talking about opioid risk can be a sensitive topic for many patients and the staff must be sure to not make the patient feel comfortable while getting across the importance of the ideals of the SPP. Staff education also included safe medication management and naloxone training to review with patients; these two topics served as the foundation for creating patient education materials.

Inclusion and exclusion criteria were established for the SPP along with an overview of provider/patient contracts and documentation to ensure the EMR gets updated with the new patient SPP information. Table 2 lists the inclusion criteria suggestive of high-risk behavior and recommendations for enrollment in the Sole Provide Program as well as exclusion criteria. Based on best-practice guidelines the project mandated that all patients who receive prescription opioids must receive a naloxone prescription and instructions on indications for use (SPP, 2022).

Setting and Population

The population for this project comprised adults of all races and ethnicities from age 18 years and older who were Tricare DoD medical beneficiaries. Specifically, the intended population was all Tricare beneficiaries that received care from the South Texas military health system which serves over 150,000 military personnel. This number comprises all components of service and includes family members, civilian employees, and contract workers. This MTF encompassed one large medical outpatient surgical center, an intermediate care outpatient clinic, and multiple outlying primary clinics that provide over ten specialty care services.

Table 2

Inclusion and Exclusion Criteria for SPP

Inclusion Criteria	Exclusion Criteria
Changing or forging opioid prescriptions.	Limited quantity of prescribed opioids.
Procuring opioids from more than one provider in a defined time period.	Medical diagnosis such as cancer that requires ongoing opioid management.
Providing false information when requesting opioid prescriptions.	Patient pain needs overseen by Pain Management Clinic
Multiple unscheduled appointments to ask for early refill of opioid.	
Non-compliance with instructions on frequency of opioid treatment. Multiple claims that opioids were lost, stolen or damaged.	
Displaying aggressive behavior towards staff/provider when prescription is not refilled or changed	

Note: Adapted from Sole Provider Program Function (2022).

Organizational Facilitators

A major facilitator for this project was given by the facility Chief of Medical Staff, as the SPP is part of an initiative mandated by the MHS for fiscal year 2023. Additionally, the military has a built-in process of facilitating changes and it is an expectation that teams will work together to achieve objectives such as the one for this project. Many educational materials needed to be developed for this project. The Chief of Medical Staff and Hospital Education Deputy readily reviewed DOD project resources and provided prompt feedback to the student so that project development and implementation could proceed in a timely manner.

Ethical Considerations

This project was deemed non-research by the Chief of Medical Staff. The project focused on inclusion of all patients at risk for opioid use disorder based on their current comorbidities, prescriptions, and medical management. Electronic medical record (EMR) review was based on the Tricare prescription alerts in the PDMPUR. Care was taken to maintain patient confidentiality through limiting personal identifiable information and only relevant data was assessed in relation to the PDMP. Due to the project location caution was needed when it entailed the format and audience for certain policies. Some of the materials are intended exclusively for the MHS and not the general public.

Results

Support for the SPP project was received by the facility leaders, the medical director for the Primary Health Clinic, pharmacy, and various PCPs through the PAWWG. This team of providers collaborated on getting an approved SPP policy charter which governed all staff roles and expectations. The hospital executive staff approved the development of the SPPF as part of the PAWWG in October 2022. Based on previous PDMP policies, the working group was able to review, edit and create a PDMP SPP to better accommodate the smaller medical treatment facility. The Medication Management Contract was created for patients requiring monitoring through the SPP. Standard contract and system alert documentation were implemented to maintain documentation consistency amongst the providers.

The second objective, to develop patient education materials addressing the PDMP, was achieved. The patient naloxone education flyer was developed and adopted as the primary education document to be utilized by the PCP and pharmacy staff when providing patient education on opioid management and naloxone training. The training is currently

being reviewed for useability across the South Texas MHS Market Region. Both staff and patient education will be uploaded to the Relias education platform for staff access and mandatory completion by all within the facility umbrella.

The third objective of this project was to educate at least 90% of the providers and staff by the end of 3 months using face-to-face training. The training provided general knowledge of the current problem affecting the military, the PDMP, the referral system, and PDMP patient contract (SPP, 2022). The student conducted in-person training including detailed descriptions of all staff functions within the SPP, required contract documents, and explanations for proper documentation and reporting. Staff received communication techniques for improving patient/ staff repour while education opioid risk, safe use of opioids and naloxone training.

All training was approved by the PAWWG members with the committee chair signing off as final approving authority for both the patient and staff education prior to implementation. To help facilitate staff training the Family Health Clinic Department Chief allocated time to conduct training during the staff scheduled education stand down which allowed time for all present providers to be trained which consisted of 45% of the clinic providers. The provider list included physicians, APRNs and PAs. Training revealed only one provider was knowledgeable and executed SPP actions at a previous facility, so the education proved to be beneficial for the staff at this medical facility. With this new insight the Medical Director deemed the new education materials to be established as mandatory staff training for all medical providers throughout the remaining specialty clinics and outlying medical clinics. Ultimately, 45% of staff and providers participated in the educational training. When it came to hurdles to training implementation, I implemented

training during the summer months which occurred during time of staff vacation, which may account for not meeting the targeted percentage.

The fourth objective of the project entailed educating patients on the PDMP and indications for naloxone. Achievement of this objective remains in progress as multiple levels from the MHS are reviewing the delivery options for this education.

The final project objective concerned use of the PDMPUR to identify patients who met inclusion criteria for the SPP. Data analysis revealed 51 high-risk patients initially meeting review criteria. After careful review of the EMR only 11 patients were recommended for SPP, 19 required naloxone prescriptions and 40 patients were placed on the watch list which is reviewed quarterly or as needed. A report of all patients requiring naloxone over a 4-month period revealed that an average of 50% of patients who had current prescriptions for opioids were prescribed naloxone. To increase this percentage to 100% staff and providers may need further education.

Discussion

Summary

Multiple factors aided in the successful creation and implementation of this facility's SPP. The PDMP SPP is a mandatory implementation project set forth by the medical hierarchy of the MHS and DHA. This factor aided in the local military medical center leadership and staff buy-in. Being able to join the established PAWWG which also served as the SPPF for the medical facility, further contributed to the successful establishment of the PDMP SPP. The PAWWG consisted of a multidisciplinary provider team which collaborated on the creation and implementation of the SPP. The team dynamics allowed for great insights and support, all executed in a timely manner. The facility has preset training days which do not interrupt patient

care. The scheduled staff training days increased the potential for staff and providers to complete training.

Staff and patient knowledge of the SPP, opioid risk factors and naloxone was delinquent for this facility. Educating clinic leadership and staff on the effects of opioids within the military community helped them to understand the need for this project training and establish education to improve patient management for patients receiving opioids. I consider this a tremendous strength. Being aware of shortcomings and being open to improve upon them is one of the greatest strengths a medical facility can have.

Development of this project is consistent with recommendations from other research studies and guidelines and may improve patient adherence to pain management regimens. For example, Marszalek et al., (2020) found that those enrolled in a SPP were more likely to follow VA/DoD recommendations. Due to the timeframe in which the project was developed and implemented, long-term outcomes have not been identified for this facility. However, Aker (2021) found that opioid prescriptions decreased up to 69% amongst the active-duty military and 47% for non-active-duty beneficiaries between 2017-2021. Also, there was an overall decline in long-term opioid use throughout the MHS. Aker (2021) contributes the decline of opioid prescription to decreased opioid prescribing, emphasis on non-pharmacological pain management, provider training, and educating patients on injury rehabilitation and self-management of pain. These preventative measures are addressed in SPP.

Limitations

One major limitation revealed during this quality improvement project was the loss of oversite for those patients who receive physician care and medications outside of the MHS network. Patients are diverted to local treatment facilities to increase their access to care, but this

decreases the ability of the MHS to have true oversight of overall patient care and some patients with OUD risk have the potential to get overlooked. Express Scripts and the PDMPUR will eventually create an alert in the system of high-risk opioid prescribing, but this could take up to 90 days or more depending on when the processing pharmacy uploads information to the Tricare database. An additional concern relates to sending patients who exhibit high-risk related behaviors while using opioids to facilities outside of the MHS. It may prove more difficult to enforce SPP standards on a civilian facility. Increasing interfacility partnerships and utilizing pharmacies within the National Association of Boards of Pharmacy could increase the ability for the systems to transmit information in a more expedient manner and all for the medical facilities to support the SPP.

Recommendations

The SPP is recommended to address the risks of OUD among veterans receiving care at military installations. The PDMP Sole Provider Program at this facility will bring much needed education to the providers, nursing, and administration staff on their role and responsibility in the recognition of patients at risk for prescription medication misuse and abuse. It may also serve to prevent opioid abuse related injuries amongst the patient population. The national guidelines highlighted in this project and the PDMP promotes looking at different avenues of approach to pain management instead of just prescribing opioids and other abused prescription drugs. The provider working with services such as physical therapy, pain management and behavioral health, could bring greater insight of their patient's injury or illness, in turn improving processes for patient management and overall outcome.

Sustainability

The long-term goals of the SPP focus are to ensure that all at-risk patients are evaluated for inclusion into the SPP, and that all patients and staff are educated on the risk of using opioids, medication management, and the use of naloxone. This program is feasible for MTFs of all sizes but may require editing to fit each facility depending on their operational capacity, location, and information technology system. Sustaining this program calls for improved electronic medical record keeping and sharing as well as increasing provider communication between military and civilian health systems (Chen et al, 2020). Improvement of these systems is a way to arm military providers with knowledge that can be used to recognize and intervene in the abuse and misuse of prescription medication that may lead to OUD. The use of virtual training platforms allows patients and staff access to much-needed training at the right time and location for the individual. Virtual access should increase staff compliance and the ability of providers to share educational information with patients more readily.

Implications for Practice

The DNP-prepared Advanced Practice Registered Nurse who works in the military setting is charged with managing and prescribing opioids more frequently than APRNs in the civilian setting. Because the APRN plays an integral role in pain management within MTFs, they should play a key role in development and implementation of the SPP. The SPP is recommended to address the risks of OUD among veterans receiving care at military installations and the DNP prepared APRN is well positioned to collaborate with other disciplines and execute this mandate.

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Appendix A

Pharmacy Naloxone Evaluation and Prescription Form

59 MDW OUTPATIENT PHARMACY NALOXONE EVALUATION AND PRESCRIPTION FORM

Opioid	>50 MEDD	Conversion Factor
Morphine	50mg/day	1
Oxycodone	33.3mg/day	1.5
Hydrocodone	50mg/day	1
Hydromorphone	12.5mg/day	4
Fentanyl Patch	25mcg/hr=60 MEDD	2.4
Tramadol	200mg/day	0.25
Methadone	12.5mg/day	3-4 (not linear)
Oxymorphone	16.7mg/day	3
Tapentadol	125mg/day	0.4
Codeine	333mg/day	0.15

Appendix B

Opioid and Non-Opioid Management Patient Education

Who should carry Naloxone?

- Morphine Equivalent Daily Dose 50mg.
- Individuals taking opioids and benzodiazepines together.
- People who use illicit drugs (ex. heroin)
- If you or someone you know is at increased risk for opioid overdose, especially those with opioid use disorder or history of abuse.

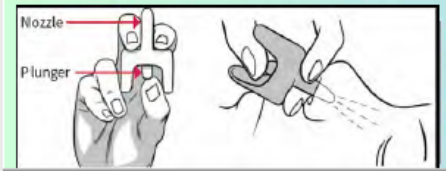
Naloxone Nasal Spray

How do you know if Naloxone should be used?

CHECK FOR RESPONSIVENESS

- No response even when you shake the person, say their name or do a sternal rub.
- The person breathing has slowed or stopped.
- The person lips and fingernails has turn blue or grey.
- The skin gets pale and clammy.

If the above are noted spray one nostril with Naloxone and CALL 911. Stay with the person and make sure their breathing has returned or until emergency help arrive.



COMMON OPIOIDS

Hydrocodone: Vicodon, Lorcet, Lortab, Norco, Zloydro
Oxycodone: Percocet, Oxycontin, Roxicodone, Percodan
Morphine:MSContin, Kadian, Embeda, Avinza
Codeine:Tylenol with Codeine, TyCo
Fentanyl: Duragesic, Actiq
Hydromorphone: Dilaudid
Oxymorphone: Opana
Meperidine: Demerol
Methadone: Dolophine, Methadone
Buprenorphone:Suboxone, Subutex, Zubsolv, Bunavail, Butrans
Heroin

- Contact your primary care clinic or pharmacist for more information on Naloxone, if you have any questions or concerns.
- It is safe to use Naloxone if you are unsure what the person overdosed on.
- Naloxone is available upon request over the counter at the pharmacy window without a prescription .

Naloxone Education/ Informational Videos:

- http://www.cdc.gov/stopoverdose/naloxone/index.htm
- Introduction to Naloxone for People Taking Prescribed Opioids - YouTube
- How to Use the VA Naloxone Nasal Spray - YouTube

OPIOID AND NON-OPIOID MANAGEMENT: HOME MANAGEMENT

PATIENT EDUCATION

DO YOU UNDERSTAND HOW TO TAKE YOUR PAIN MEDICATION?

HAVE YOU HEARD ABOUT NALOXONE?

59TH MDG PAIN AND WELLBEING WORKING GROUP
SEPT 2023

Opioid and Non-Opioid Management Patient Education (continued)

What should you know?

How to take you opioid or non-opioid pain medications as prescribed:

- Inform all providers that you are taking opioids.
- Take the right dose at the right time.
- Do not avoid taking pain medication to save it for later.
- Do not take someone else prescriptions.

What should you not do?

DON'T TAKE EXTRA DOSES

- You could become sick or die from an overdose.
- You may run out of your opioids or prescriptions before it can be refilled, which may lead to withdrawal symptoms.
- Early opioid refills are usually denied, to protect the patient from harm due to opioid abuse and addiction.
- If pain increases or new pain symptoms develops, notify your PCM or go to ER

Do not drink or take "street drugs."

- This could change the effect of medication on your body and cause severe harm or death.

Do not stop taking opioids abruptly on your own.

- This may lead to withdrawal.

What should you do?

If another provider has prescribed you opioids or non-opioids:

- Notify your PCM within 24 hours or the next weekday if another provider prescribes an opioid.
- Notify if there was an unexpected ER visit, or for acute pain after surgery.

Make an effort to remain in the care of one primary provider.

- Inform PCM if you have additional providers (e.g., behavioral health, interdisciplinary team)
- This will help to ensure the right amount and type of medication is prescribed so you can have an optimal pain management and continued care.

What are Opioid side effects and risk?

- Drowsiness, impaired driving & ability to operate heavy machinery.
- Mental confusion, bad dreams and hallucinations
- Increased infections, immunity changes, immune related illnesses and Birth Defects
- Decreased hormones.
- Sleep Apnea
- Worsening of pain
- Increased risk of death
- Withdrawal, physical dependence
- Addiction/ Tolerance

What will the health care provider do?

- Review patient medications and medical history to determine most appropriate medication to manage pain.
- Schedule follow-up appointments to assess the effectiveness of medication management.
- Prescribe preventative medications as needed::
  -Naloxone in case of overdose
  -Antiemetic for nausea
  -Stool softener for constipation

What is Naloxone aka Narcan and how does it work?

- A Life-saving medication that can reverse an overdose from opioids including heroin, fentanyl and prescription opioid medications-WHEN GIVEN in TIME
- Reverses an overdose by blocking the effect of opioids.
- Breathing can be restored within 2-3 minutes, a second dose may be needed

Appendix C

Key to Abbreviations

ADAPT	Alcohol and Drug Abuse Prevention and Treatment
APMPUR	Analyze Prescription Monitoring Program Utilizer Report
APRN	Advanced Practice Registered Nurses
CARA	Comprehensive Addiction and Recovery Act
CDC	Centers for Disease Control and Prevention
CDRL	Contract Data Requirements List
CPG	Clinical Practice Guideline
DHA	Defense Health Agency
DoD	Department of Defense
EMR	Electronic Medical Record
GRADE	Grading of Recommendations, Assessments, Development and Evaluations
IIR	Institute for Intergovernmental Research
MHS	Military Health System
MTF	Military Treatment Facility
NMPP	Non-Menstrual Pelvic Pain
OUD	Opioid Use Disorder
OSI	Opioid Safety Initiative
PA	Physician Assistant
PAWWG	Pain and Wellbeing Working Group
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Program
PDSA	Plan Do Act Study
PTC	Pharmacy and Therapeutics Committee
SPFC	Sole Provider Function Committee
SPPF	Sole Provider Program Function
SPP	Sole Provider Program
USC	United States Code
VA	Veteran Affairs
VHA	Veteran Health Administration