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MILITARY HEALTH SYSTEM REFORM: PAIN MANAGEMENT, OPIOIDS PRESCRIPTION MANAGEMENT AND REPORTING TRANSPARENCY

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

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MILITARY HEALTH SYSTEM REFORM: PAIN MANAGEMENT, OPIOIDS PRESCRIPTION MANAGEMENT AND REPORTING TRANSPARENCY

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Wednesday, June 20, 2018.

The subcommittee met, pursuant to call, at 3:30 p.m., in room 2212, Rayburn House Office Building, Hon. Mike Coffman (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. MIKE COFFMAN, A REPRESENTATIVE FROM COLORADO, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Mr. COFFMAN. I want to welcome everyone to the Military Personnel Subcommittee's hearing on "Military Health System Reform: Pain Management, Opioids Prescription Management and Reporting Transparency." Our panel includes the Director of the Defense Health Agency and the Director of Mental Health Policy and Oversight for the Assistant Secretary of Defense for Health Affairs.

They are here to address opioid abuse, an important problem that has affected every congressional district in the United States. The opioid epidemic in the United States claims roughly 116 people from drug overdoses every day; 42,249 people died from overdosing on opioids in 2016 with an estimated cost of over $504 billion. With the military being a vital subset of the overall population that may encounter stresses related to deployment, training, and family separations, understanding the magnitude of opioid abuse and the challenges related to overall pain management is a critical part of the Military Personnel Subcommittee's congressional oversight efforts. We are here today to understand the scope of the opioid abuses, abuse issues in the military and with non-Active Duty TRICARE beneficiaries. Our panel will also address policy reform on opioids from a strategic enterprise perspective and the Department of Defense model for pain management.

The subcommittee is also concerned with the Department of Defense's efforts to ensure reporting transparency with State prescription drug monitoring programs. We understand there have been some challenges with developing a State prescription drug monitoring programs, PDMPs, model that balances military related cybersecurity and operational concerns with the need for data transparency with nonmilitary treatment facility clinicians and pharmacists that are serving TRICARE beneficiaries accessing multiple points of healthcare services.

I ask unanimous consent that nonsubcommittee members be allowed to participate in today's briefing after all subcommittee members have had an opportunity to ask questions. Is there objection?

Without objection, [nonsubcommittee] members will be recognized at the appropriate time for 5 minutes.

Before I introduce our panel, let me offer Congresswoman Speier an opportunity to make any opening remarks.

[The prepared statement of Mr. Coffman can be found in the Appendix on page 19.]

STATEMENT OF HON. JACKIE SPEIER, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Ms. SPEIER. Mr. Chairman, thank you, and I am delighted that after a couple of opportunities to have this hearing that had to be postponed, we welcome our individuals who are testifying today, and I want to thank the chairman for having this hearing because, indeed, it is a crisis in our country. When we have over 2 million people over the age of 12 who are either dependent on opioids or are abusing them, it is time for us to take very seriously the impacts on everyone, none the least our service members, their dependents, and retirees. I think the military has the opportunity to lead the Nation to reduce opioid abuse and develop alternative pain management therapies, and today I am eager to hear about your efforts to exercise such leadership.

Several years ago, the military realized it had an opioid problem when it became clear that the predominant pain treatment for our wounded warriors was prescription medication. Changing prescribing practices and increasing the use of alternative pain management methods has enabled the military to reduce the prescription opioid abuse among Active Duty service members to 1 percent.

However, opioid abuse remains a challenge, especially for retirees and dependents. I am interested in hearing how the Department's new opioid prescription guidance will be implemented to limit the amount of days for each prescription, as well as how the DHA [Defense Health Agency] will implement it if it becomes law, the NDAA [National Defense Authorization Act] requirement to create a Prescription Drug Monitoring Program to increase transparency with States as well as reduce prescription monitoring.

I am also interested in hearing about how DHA will lead research on and increase the availability of alternative pain methods like acupuncture, chiropractic care, and other services that are now being utilized by healthcare providers around the country.

So with that, Mr. Chairman, I yield back.

Mr. COFFMAN. Thank you Ranking Member Speier. We will give each witness the opportunity to present his or her testimony and each member an opportunity to question the witnesses for 5 minutes.

We would also respectfully remind the witnesses to summarize to the greatest extent possible the high points of your written testimony in 5 minutes or less. Your written comments and statements will be made part of the hearing record.

Let me welcome our panel: Vice Admiral Raquel C. Bono, Medical Corps, United States Navy, Director, Defense Health Agency;

and Captain Mike Colston, Medical Corps, United States Navy, Director of Mental Health Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs.

Vice Admiral Bono, you are now recognized for 5 minutes.

STATEMENTS OF VADM RAQUEL C. BONO, M.D., USN, DIRECTOR, DEFENSE HEALTH AGENCY; AND CAPT MIKE COLSTON, M.D., USN, DIRECTOR, MENTAL HEALTH POLICY AND OVERSIGHT, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Admiral BONO. Thank you, sir. Chairman Coffman, Ranking Member Speier, and members of the subcommittee, I am honored here to be alongside with Captain Colston, who serves as our senior clinical policy expert for DOD [Department of Defense] on issues related to pain management and opioid abuse issues.

I want to thank the committee for your continued support and investments in pain management research and opioid addiction.

The Military Health System's mission is to ensure the medical readiness of our Nation's Armed Forces and to provide world-class healthcare for all of our 9.4 million beneficiaries.

The Military Health System is also part of the larger U.S. health system, and we have a shared responsibility to take action and help address the Nation's public health crisis regarding opioid abuse and addiction.

Today, what I would like to do is outline what we know about the current state of opioid issues and addiction among DOD beneficiaries, highlight the steps the Department is taking to address this crisis, describe the partnerships we have built across the public and private sectors, and, finally, to describe our efforts to enhance our ability to share our data on our beneficiaries with State prescription drug monitoring programs.

The Department has made strides in managing opioid abuse within our system and is continuously looking to further enhance our programs. Fewer than 1 percent of our Active Duty forces either abuse or are addicted to opioids, and our overdose death rate among Active Duty is one-quarter the national average.

Chronic opioid use is more common among our patients who are 45 years or older, and they are more likely to be retirees or family members of retirees, and they receive the majority of their care outside of our military hospitals and clinics.

Just last week, the Department published the Defense Health Agency Procedural Instruction for Pain Management and Opioid Safety, which establishes the MHS [Military Health System] stepped-care model as the comprehensive standardized pain management framework for providing consistent, quality, and safe care for patients with pain with an emphasis on nonpharmacologic therapies.

With the help of this model, we have reduced opioid prescriptions by 15 percent. We plan to further reduce this rate through a focus on nonpharmacologic therapies within the military treatment facilities and through direct care policy changes.

Working closely with our pharmacy contractor, Express Scripts, Incorporated, ESI, we are closely monitoring the distribution of opioids across all venues, military pharmacies, civilian retail phar-

macies, and our mail-order system. We are identifying high users of opioids and sharing that information with our providers within the military treatment facilities. We have also taken measures to minimize complications for patients requiring opioids. We are able to monitor the daily morphine intake of those patients requiring opioid therapy and easily identify those at increased risk for death from opioids. We have a patient lookup tool that calculates the risk of overdose or serious opioid-induced respiratory depression to assist providers in safe opioid prescribing. Naloxone is readily available through the pharmacy and the military treatment facilities to be dispensed to eligible beneficiaries upon beneficiary request or when the pharmacist determines elevated risk for life-threatening opiate overdose using the patient lookup tool.

In addition, the new TRICARE managed care contracts require our contract partners to act on information provided by DOD on a quarterly basis regarding patients with unusually high or lengthy opioid use, as well as providers who prescribe high amounts of opioids.

And we have been working with ESI to establish a prescription drug monitoring program, PDMP, that will connect with the States. This provides a key tool in the opioid fight as it will allow DOD providers to access State PDMPs, as well as allow civilian providers to access the DOD PDMP.

Although prescriptions filled for DOD beneficiaries through mail or retail venues are readily reported to the States, the establishment of the DOD PDMP will provide a full controlled substance profile for all providers and pharmacists. Our DOD PDMP solution will operate through a commercially available portal and hub technology that not only allows us to bidirectionally share DOD controlled substance information with a State but addresses operational security concerns. I expect this new capability to be available by December 2018.

Mr. Chairman, Madam Ranking Member, this crisis is touching the lives of so many of our fellow citizens, and the Department is committed to playing its part to help combat the epidemic and ensure our patients receive the finest care we can provide. DOD is making headway, but there is more to be done educating our patients and providers on threats from opioid addiction and strategies to reduce abuse.

Thank you for asking us to be here today. Between myself and Captain Colston, who is deeply involved in this issue day to day, I look forward to addressing all of your questions. Thank you.

[The joint prepared statement of Admiral Bono and Captain Colston can be found in the Appendix on page 20.]

Mr. COFFMAN. Thank you, Admiral Bono.

How is the Department of Defense planning to ensure compliance and transparency reporting with the State prescription drug monitoring programs, and how do we know this is the right model?

Admiral BONO. Sir, this is a model that has been in use by many of the States, and so with what we are doing with making our data available to the State PDMPs is by adhering to their practices and their requirements for participation. It is bidirectional, and so, we have found a way to make sure that our data is completely visible to them.

Mr. COFFMAN. Okay. Admiral Bono, or Captain Colston, what steps or processes are we putting in place to wean service members off of opioids, and is this tracked across the Military Health System?

Captain COLSTON. Yes, sir, it is. So, in fact, opiate use is down even over the last year in Active Duty service members from 3.2 percent to 2.7 percent. We have introduced a stepped-care model with regard to the way that we treat pain that puts an emphasis on nonpharmacologic therapy and wants to take people off of opiates. We want acute pain not to become chronic pain, and we want to be able to treat both acute and chronic pain without opiates.

There are several methods to detox someone from opiates that we approach clinically, and, of course, for folks who struggle with both pain disorders and opiate use disorders, we have a full suite of medication-assisted therapy available both in network and in MTFs [military treatment facilities].

Mr. COFFMAN. Okay. Admiral Bono, anything to add to that?

Admiral BONO. No, sir, this is very comprehensive, and Captain Colston described it well.

Mr. COFFMAN. Very well.

Admiral Bono, are we considering healthcare industry best practices when it comes to management of opioids? Please provide some examples.

Admiral BONO. Yes, sir. Yes. As a matter of fact, the stepped-care model that we are using was done in partnership with the VA [Department of Veterans Affairs] and was validated with them. We are also working with NIH [National Institutes of Health], and we are also working with West Virginia. And part of the research that we have been able to do is not only collaborate across these institutions but also validate that the tools that we are using are effective. The pain scale that we use, the Defense Veterans Pain Scale, is something that we have done in partnership with the VA. So many of the tools that you see in use here have not only been done with best practices in civilian and academic centers, but it has been validated by them, as well.

Mr. COFFMAN. Thank you Admiral Bono.

Ranking Member Speier.

Ms. SPEIER. Thank you, Mr. Chairman.

Thank you, Admiral and Captain. I would like to spend a little time on the CDC [Centers for Disease Control and Prevention] guidelines. The CDC guidelines recommend immediate release of opioids, not extended. They recommend less than 3 days' supply and suggest that 7 days will rarely be needed and not to allow the use of benzodiazepines at the same time. So that is the recommendations by the CDC, and I am wondering why your recommendations, your guidelines are, frankly, much more liberal than that? In fact, I believe you have 7 days as your floor, which to me is more than twice what is being recommended by CDC.

Admiral BONO. So, for minor procedures and acute pain, we actually recommend 5, and we also are looking at the morphine milligram equivalent to keep that below 90 per day. In that case, too, for acute and minor procedures, there can only be refill on that prescription for 3 days only if evaluated by a provider. For major procedures, we do—we recommend 7 days, but, again, refill can only

be done after evaluation by a provider and with maintaining a morphine milligram equivalent below 90.

Ms. SPEIER. You are not quite answering my question. Let me just read to you one of the other recommendations. It says that when considering increasing dosage to more than 50 morphine milligram equivalents per day and should avoid increasing dosage to 90 milligrams per day or carefully justify a decision to titrate dosage to 98 milligrams per day. I guess my point is, is that you are exceeding the guidelines in some ways significantly from what the CDC is recommending, and I want to know why.

Admiral BONO. While I am familiar with the CDC guidelines, I think what I was trying to share is how we stratified it between minor procedures and major procedures, and so I would probably need to understand it a little bit more, and perhaps I might be missing something in the question, if I could——

Ms. SPEIER. Ask the Captain?

Admiral BONO. Yes. One of my lifelines.

Captain COLSTON. Ma'am, so most folks get much, much less than 50 morphine milligram equivalents per day. For dental procedures, it is 1 day with 1-day refill. For short-term pain or acute procedures or small procedures, it is 5 days with a 3-day refill, and again, most people don't get opiates at all for these types of procedures. For major procedures, 10 days with 7 days.

I can tell you from personal experience, most of the time, you don't get opiates. I just broke my foot in four places, and I didn't get a shred of opiates. Recovered faster, felt much better.

The overwhelming—there is a consensus both between CDC and the VA–DOD guidelines that we don't want to use opiates. We would much rather use other modalities for pain, and if we are going to use a pharmacological approach, we want to use non-opiates. When you look at the amount of opiates that we are prescribing in the system, that number is down precipitously, and I have seen this evolve over the last 5 years.

Ms. SPEIER. Okay. I am running out of time. So I think you have gotten my point. You might want to go back and look at whether you need to reduce it a little bit more. I have a subsequent question on—is it gabarbardine or—do you know what, Doctor? Gabapentin. And are you using that in lieu of opioids, or is that considered an opioid?

Captain COLSTON. Yes, ma'am.

Ms. SPEIER. All right. Can I just make a point there because I was just talking to a doctor because I am about to have surgery, and he was saying now the abuse is shifting from opioids to this particular drug, so I think we should just be on the lookout that if we are just substituting one drug for another and it still has addictive qualities, that that is a problem as well.

But I would like to just shift gears for the little time that I have left to asking about these alternative pain management methods, the use of acupuncture, relaxation therapy, chiropractic care. Are there plans to expand these treatments to all MTFs, and if they are not currently available in MTFs can beneficiary receive treatments in the civilian network?

Admiral BONO. Yes, ma'am. So 83 percent of our MTFs currently offer some kind of complementary modality. I am actively looking

to see how we can make sure that all beneficiaries have availability or access to these complementary treatments and have started studying how commercial and private plans are including this and what we can do to make sure that we have this in our health plan for all beneficiaries.

Ms. SPEIER. So you are saying, at 80 percent you have at least one of these, but you may not have all of them. Is that what you are saying?

Admiral BONO. Yes, ma'am. At least one. There may be a combination depending with acupuncture, meditation, and alternate pain treatment modalities.

Ms. SPEIER. And do you have that chilling system that many hospitals are now using in lieu of opioids?

Admiral BONO. I am sorry?

Ms. SPEIER. There is some system where you can put a chilling—I am way above my pay grade. I think I will just—I will yield back.

Admiral BONO. I will Google it, if I may.

Mr. COFFMAN. Dr. Abraham.

Dr. ABRAHAM. Thank you, Mr. Chairman.

If you guys are only got a 1 percent rate, you guys are phenomenally doing a great job, I can tell you, because we know, compared to the civilian population, that is way below. So kudos to what you are doing.

A couple questions. Admiral, you said there was a 15 percent reduction. Is that in the young Active troop, or is that in the troop that maybe has retired that has comorbid conditions, such as arthritis, degenerative disk disease, or something like that?

Admiral BONO. These are primarily with the patients that are being treated in our MTFs.

Dr. ABRAHAM. So that is a young troop. Good deal. You mentioned naloxone, what we call Narcan.

Admiral BONO. Yes, sir.

Dr. ABRAHAM. And we know that that can be immediately lifesaving, and it seemed like the caregiver is able to access that if it is deemed necessary for that particular individual. Is that a correct statement?

Admiral BONO. Yes, sir.

Dr. ABRAHAM. Do you guys track the amount of Narcan that is used?

Admiral BONO. We have just—I just signed off on the policy that allows us to dispense the Narcan from our pharmacies, making that available to prescribers as well as pharmacists who—so we are just now going to be able to start tracking that in real time.

Dr. ABRAHAM. And you said by April of 2019 or December of 2018, you will be linking up with some of the States. Have you guys got a pilot program already in place?

Admiral BONO. December of 2018.

Dr. ABRAHAM. So this year?

Admiral BONO. Yes, sir. We will be able to communicate with all State PDMPs.

Dr. ABRAHAM. I am from Louisiana, and we have a pretty good reporting system there, and it does make a difference as far as—I mean, if I can punch up a patient and see that they are seeking

from another physician, then, you know, we go in and we have a little discussion with them, so.

Admiral BONO. Yes, sir. Our patient lookup tool allows providers like Captain Colston to look up day or night into the patient's profile, so that has been very helpful.

Dr. ABRAHAM. Okay. And, you know, again, we understand the necessity of getting this right. We certainly understand the severity of the problem, not only in the military but across the spectrum.

Kudos to you, Captain, if you had four breaks and did not take an opioid.

Admiral BONO. That is because he did not have many days off.

Dr. ABRAHAM. And we probably rightly and maybe wrongly do vilify the opioid drug, but like any particular drug, used in the proper setting at the proper dose for the proper amount of time, it can be certainly—you don't want your patient to suffer. So I think we need to find that little niche, and I know it is hard. Individual patients take individual therapy, but, you know, we don't need to throw the baby out with the bathwater completely. We want to make sure that that troop, that retiree does not suffer because we were scared to write a prescription. We have got to do the right thing in a lot of areas, and so hopefully we will get this right.

So thanks for what you guys are doing. Maybe we can use this as a model for our civilian population.

So I yield back, Mr. Chairman.

Admiral BONO. Thank you, sir.

Mr. COFFMAN. Thank you, Dr. Abraham.

Ms. Rosen.

Ms. ROSEN. Thank you, Mr. Chairman.

And thank you for being here today. I have a couple of questions. One of my questions is about your prescribing, and so I know—I am from a physician family. My husband is a physician. Actually, he just had back surgery, and he has had a little bit of experience in some of these prescription issues, but are your models separating out inpatient drug use versus outpatient drug use because there is major and minor procedures. My husband had back surgery; major procedure, requires different types of treatment than someone coming in. So that is my first part of the question.

And then also, in regards with that inpatient to outpatient, how are you working with emergency rooms, not in our VA hospitals or in our treatment facilities but in the general population, to be sure that people aren't drug shopping by going to some other outpatient center?

Admiral BONO. Yes, ma'am. I will take the ED [emergency department] one, and then I will let Captain Colston talk about the difference of inpatient with outpatient because you are right, there is a difference there. Part of our participation with the PDMP allows us now to have full visibility of people going to the ED for prescriptions and even pharmacy being able to see these pharmacies that—the pharmacies that they attend or go to to get their prescriptions filled. So we have a lot of visibility now on what we are doing.

Our partnership with Express Scripts, since 63 percent of our patients receive their care from—or receive their opioids from civilian pharmacies or get the prescriptions from our civilian partners, they

have provided us complete visibility of that, as well, and they report to us when we—when one of our patients reaches a certain threshold of opioid prescriptions or—and how much they are taking.

Ms. ROSEN. And they do that across all types of prescriptions because people can get multiple drugs——

Admiral BONO. Yes, ma'am.

Ms. ROSEN [continuing]. That do the same effects.

Admiral BONO. Yes, ma'am. And as a matter of fact, part of our training has raised the awareness of some of those other multiple drugs, particularly benzodiazepines, and that is what we have actually seen a slight decrease in our providers avoiding prescribing benzodiazepines at the same time. So, yes, exactly, we are tracking that very closely, and we have much better visibility of that now.

As far as inpatient and outpatient, since Captain Colston is actively taking care of both inpatient and outpatient, I will let him—I think you were in outpatient, weren't you?

Captain COLSTON. Yes.

Ms. ROSEN. Inpatient monitoring is different, and then you have to worry about when they become an outpatient as they transition, right?

Captain COLSTON. Yes, ma'am. So a few things about inpatient care and major procedures. Of course we use opiates. We use opiates surgically. We use them with other drugs. We use them with ketamine drips. We use them with nerve blocks. We use other pharmacological modalities to reduce the amount of opiate exposure that someone needs. Now, after a major procedure, say, a coronary artery bypass graft or something along those lines, you get 10 days of opiates when you leave. That is an extremely painful procedure, and you have got your sternum cracked in two. And if you need another one, 7 days, but that is really at the point where we really need to watch you closely. Because the thing that creates addiction is, it is almost always iatrogenic. Three-quarters of people who become addicted get it from medical intervention. So it is very important for us to watch you in those of situations.

And the two variables that matter most are the dose, the amount of opiates that we gave you, and how long we gave them to you. And an opiate use disorder is an extremely lethal thing to have. The 20-year mortality for that is 40 to 60 percent. So you give—you turn an 18-year-old into an opiate addict, that person may not reach 40. So we always need to weigh the risks and benefits when we start medicine, but opiates are part—definitely part of the medical care suite and something that, of course, we want to deliver humane care, and we want to get to pain.

One of the big things that we struggled with as physicians in the early 2000s is we just tried to get rid of pain no matter what the price, and we really created a number of folks who struggled and died.

Ms. ROSEN. Right. Well, thank you.

I yield back my time. I appreciate your work.

Mr. COFFMAN. Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you, and thank you for being here. I wanted to show you a picture of Daniel Keegan. Daniel Keegan was from my district, and he died from substance use disorder. And I

wanted to tell you the story and ask you a couple of questions about him in honor of him and his mother, who is working very hard to let the country know that we have a problem and we have to do something about it.

Daniel Keegan enlisted out of high school at the Dover Recruiting Office in my district. All he wanted to do was to serve his country. He was the type of recruit that we need many more of. Incredibly smart. He scored an 800 on the verbal and 760 on math. He was well trained by our military. He was an impressive soldier. He attended the University of New Hampshire to further his military career. We have an All-Volunteer Force. We need people like Dan to stand up and answer that call to serve, as you well know.

While serving, Dan developed a substance use disorder. DOD diagnosed him, was aware of his problem, but when he separated, he did not receive any help getting into the VA system to continue treating his substance use disorder. In the time period after he separated, he struggled to get his comp and pen [compensation and pension] exam, relapsed, and then he died waiting for his appointment, which was not scheduled until nearly 16 months after he separated.

His mother Stephanie shared his story with us. When he separated, Dan was struggling with this and was not equipped to navigate the VA system. Nobody offered him help. The DOD did not offer any help at all, even though they knew he had this problem. In Dan's words, he was a disposable soldier. We spent a fortune training him, but when he got sick, DOD dropped him. The VA bears some responsibility here, but it is clear from listening to Stephanie that Dan felt that DOD failed him. Dan loved the VA and wanted to help other veterans with their illness so they could access treatment. He would have been an incredible member of our community after separating from the DOD, but he wasn't given the chance because DOD dropped the ball. He was not connected to DOD or VA service in a way that might have saved his life.

In your testimony, you talk about all of the data that DOD has to identify at-risk patients. You have medical records that should show when a service member is being treated for substance use disorder. You also talk about coordinating care with VA, but you do not mention anything about what you will do to ensure separating service members get the health care that they need. I strongly believe that there has to be a system in place that ensures separating service members who are eligible for VA care and need VA care have an appointment scheduled before they separate from DOD. The command responsible for a soldier when he or she is separating should also be held responsible for making sure that soldiers are receiving the health care that they need when separating. As I said, they knew what his problem was.

Many separating service members are simply left in a position to navigate that whole system themselves, and clearly, he couldn't. So I would like to ask you to respond to the following questions. What is DOD doing to ensure that there is no delay in getting care for separating service members? Is there any way that they talk to the VA or in some way make sure that there is a handoff, that we don't just leave them outside the door of the military? Can DOD employ case managers or coordinate care and ensure that his appointment

is waiting for separating service members that are diagnosed either or are at risk for substance use disorder? And can we continue offering mental health care to separated service members when the handoff of the VA does not go smoothly and the service member is encountering significant delays in accessing VA care? I thank you for listening and would like to hear your response.

Admiral BONO. Thank you very much for sharing that, and it is very sobering to hear something like that when we have missed the ball on that, or we have let somebody fall through the cracks. We do have quite a few programs, and we recognize that we needed to be able to help transitioning service members from the DOD to the VA, and actually, we have fairly numerous programs. I would like to be able to give you a more complete answer, if I could, to give you the list of some of those programs because I don't have them readily at my fingertips. So I would like to take that for the record if I could.

But if I may speak from a very broad perspective, DOD and VA have done some considerable partnering in recent years because we recognize that many of our patients are of the same continuum, and part of their care needs to transition from DOD to VA. We have recently agreed with the VA to share the same electronic health record so that we would be able to retrieve that information, the clinical information that is so necessary to understand how to make these handoffs happen more smoothly so we don't create unnecessary gaps in their care.

We have also been working at very high levels between the DEPSECDEF, Deputy Secretary of Defense, and the Secretary of the VA to make sure that we are working on those strategic objectives, those strategic imperatives that allow us to be more seamless in their delivery of care. And then we also have several working groups and subcommittees of the DOD and VA to address several transition issues, whether it is health, behavioral health, or even in some cases the ability to transition from working in the DOD to working in the VA health system.

So, if I could, I would like to take that for the record so I can give you a much more comprehensive answer, but at a general level, we are working much more closely with the VA.

[The information referred to was not available at the time of printing.]

Ms. SHEA-PORTER. I appreciate that. So, if Dan was discharged tomorrow, would that system work, the one you just described?

Admiral BONO. Yes, ma'am. I think that what you have described and how his process went, I would like to think that what we have put in place would not have let that happen.

Ms. SHEA-PORTER. Okay. Thank you very much. I yield back.

Admiral BONO. Thank you, ma'am.

Mr. COFFMAN. Thanks. So we are going to do a second round. My question is to Active Duty personnel who sustain some type of injury or requires surgery where they are given opioids for a limited period of time, and let's say that that Active Duty individual is then returned—they are returned to their duty station, whatever it is, so they are not medically discharged, but severe enough to be given—to undergo a regimen of opioid medications or treatment. So let's say that, because of that, they have a problem and that they

are seeking out opioids or drugs to—that they became addicted at some degree. Through—so what tracking programs does the military have now? Do we still have—we have periodic urinalysis program, would that pick up these—is that programmed to pick up the opioids? And at what level does it pick it up at? I mean, if somebody is not—maybe tell me what the threshold is, if somebody has done it within so many hours, what is the threshold requirement that that test could pick it up?

Admiral BONO. Yes, sir. I think in general terms, and I will let Dr. Colston refer to the actual milliequivalents that we have set the threshold, not only do we—not only do Active Duty undergo routine screening and for those patients that we have identified that are long-term opioid users, they are actually put on a regular regimen of urine screening so that we can monitor that.

Mr. COFFMAN. Okay.

Admiral BONO. The other thing is we have also expanded our urine screening, urine drug screening, to include many more substances recognizing that that is a risk.

Mr. COFFMAN. Okay.

Admiral BONO. But in terms of what the actual level, I don't know if Captain Colston might be more familiar with that.

Captain COLSTON. Yes, sir. So there is the readiness testing that we do is totally separate from medical testing that we do.

Mr. COFFMAN. Okay.

Captain COLSTON. The readiness testing does have thresholds between positive and negative tests. It is extremely accurate. We have confirmatory testing, which uses very expensive linear chromatography gas mass spectrometry equipment. That is something that has nothing to do with health. And what we want to do is we want to treat these folks. We want to get these folks medication-assisted therapy. We want—if they still have a pain disorder, we want to use for medication-assisted therapy a drug that also addresses their addiction, like methadone or buprenorphine, and we have any number of providers who are qualified to give those drugs. In fact, we have a surfeit of providers capable of giving those drugs.

We have a policy on the medical side that we do not want to stigmatize any kind of addiction. We want folks to get treated, and, in fact, at the partial hospitalization program where I work, command is kind of kept away for a little while as we focus on these folks because, in fact, relapse is part of recovery for addiction, and it is such a dangerous addiction, opiates, that we really need folks to almost live in a vacuum away from command, and we have been doing that for 7 years there, I think, with great success.

Mr. COFFMAN. So I think my point is, so if somebody undergoes this regimen of treatment due to surgery or due to some injury that they have sustained, they then—you have a monitoring system for them postelection—postprescription or whatever you want to call it, and so nobody is going to fly under the radar from your perspective in terms of——

Captain COLSTON. Well, the point I was trying to make, sir, is the readiness testing is not a way that we find people who are addicted. If we identify that you have an opiate use disorder, you are going to get regular urinalysis. You are going to get pill counts. We

are going to check you for diversion. We are going to do any number of actions that help you get sober.

Mr. COFFMAN. But the readiness test would indicate——

Admiral BONO. Yes, oh, yes.

Captain COLSTON. Yes, sir. I just want to add that readiness testing, the number of positive opiate screens is down 76 percent in the last 5 years. So we know that we are headed in the right direction on that problem, sir.

Mr. COFFMAN. Okay. And then how long have we been screening for opioids and the testing?

Captain COLSTON. Since the Nixon administration.

Mr. COFFMAN. A long time. Okay.

Ranking Member Speier.

Ms. SPEIER. Thank you.

Admiral Bono, you are embarking on an $81 million, 6-year research collaboration. Can you describe your plans for the research, what population you are going to conduct the research on, and the extent to which you are going to implement your conclusions if they prove—therapies that they prove effective before the actual research is completed, or are you going to wait the 6 years?

Admiral BONO. Yes, ma'am. So we have several ongoing research collaboratives. One of the most robust ones is with West Virginia and also with NIH. So what we do with both of these collaboratives is we make sure that, as we see results and they get validated—and this is the important part of the research, is being able to address certain types of aspects of opioid addiction and treatment. And once we get validation and we know that it is effective, we try to put those into place right away.

As a matter of fact, Captain Colston and I were just remarking that, in the last several years since 2015, because we have started seeing the results of some of this research, we have been able to put in many of those practices and those treatments that we have understood better because of the research, and that has been happening in the last few years. So I anticipate that as we continue this level of effort, that we will be able to implement things much more quickly.

Ms. SPEIER. Yield back.

Mr. COFFMAN. Dr. Abraham, nothing? Ms. Shea-Porter.

Ms. SHEA-PORTER. I am good.

Ms. SPEIER. One more question, Mr. Chairman.

Mr. COFFMAN. Go ahead.

Ms. SPEIER. I read an article that suggests that the use of marijuana reduces the amount of opioid usage in those areas that have legalized marijuana. I realize the Federal Government is not one of them, but I am curious if you have done any research on that. It was "Medicare Patients Use Fewer Opioids with Medical Marijuana Laws," was the headline on this particular article.

Admiral BONO. Yes, ma'am. We are always monitoring other aspects of care and seeing if there is scientific evidence-based data that would help support that. So we are monitoring that. We don't necessarily do that research, but we monitor everybody else's research.

Ms. SPEIER. And if, in the end, it is found to be helpful, what do we do about it?

Admiral BONO. Well, I think that would be something——

Ms. SPEIER. I guess that is our job.

I yield back.

Admiral BONO. I was going to ask for help on that one.

Mr. COFFMAN. I think you would need it.

I wish to thank the witnesses for their enlightening testimony this afternoon. There being no further business, the subcommittee stands adjourned.

[Whereupon, at 5:32 p.m., the subcommittee was adjourned.]

A P P E N D I X

JUNE 20, 2018

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

JUNE 20, 2018

Opening Remarks – Chairman Coffman
Military Personnel Subcommittee Hearing

Military Health System Reform: Pain Management, Opioids Prescription Management and Reporting Transparency

June 20, 2018

I want to welcome everyone to the Military Personnel Subcommittee's hearing on Military Health System reform for pain management, opioids prescription management and reporting transparency. Our panel, includes the Director of the Defense Health Agency and the Director of Mental Health Policy and Oversight for the Assistant Secretary of Defense for Health Affairs.

They are here to address opioid abuse an important problem that has affected every Congressional District in the United States. The opioid epidemic in the United States claims roughly 116 people from drug overdoses every day; 42,249 people died from overdosing on opioids in 2016; with an estimated cost of over $504 billion.

With the military being a vital subset of the overall population that may encounter stresses related to deployment, training and family separations, understanding the magnitude of opioid abuse and the challenges related to overall pain management is a critical part of the Military Personnel Subcommittee's congressional oversight efforts.

We are here today to understand the scope of the opioid abuse issue in the military and with non-active duty TRICARE beneficiaries. Our panel will also address policy reform on opioids from a strategic enterprise perspective and the Department of Defense model for pain management.

The subcommittee is also concerned with the Department of Defense's efforts to ensure reporting transparency with State Prescription Drug Monitoring Programs (PDMPs). We understand there have been some challenges with developing a PDMP model that balances military related cybersecurity and operational concerns with the need for data transparency with non-military treatment facility clinicians and pharmacists that are serving TRICARE beneficiaries accessing multiple points of health care services.

I ask unanimous consent that non-subcommittee Members be allowed to participate in today's briefing after all subcommittee Members have had an opportunity to ask questions.

Before I introduce our panel, let me offer Congresswoman Speier an opportunity to make any opening remarks.

Prepared Statement

of

Vice Admiral Raquel Bono, M.D.

Director, Defense Health Agency

and

Captain Mike Colston, M.D.

Director for Mental Health Programs
Office of the Assistant Secretary of Defense-Health Affairs

REGARDING

THE CURRENT STATE AND FUTURE AIMS IN OPIOID USE, AND ABUSE - RESEARCH, DIAGNOSTIC TESTING AND EVALUATION, AND TREATMENT

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

20 JUNE 2018

Not for publication until released by the Committee

Chairman Coffman, Ranking Member Speier and members of the Subcommittee – thank you for the opportunity to discuss the Department of Defense's (DoD) efforts regarding opioid use, misuse and overdose. We are honored to testify on this important issue. We would also like to thank you for your sustained leadership and support of our nation's Service members, veterans and their families, and especially those dealing with complex issues related to opioid use. Your investments in pain research and opioid addiction treatment have led to important advances in care and a greater understanding of where future efforts should be targeted.

The Military Health System's (MHS) overriding mission is to ensure a medically ready force. For those ill or injured in service to our nation, we have an ongoing obligation to provide the full range of services to assist with their recovery and rehabilitation. This includes the management of pain and addiction. We have taken a comprehensive set of actions to include: instituting comprehensive provider education (leading to a reduction in opioid prescribing); expanding partnerships with federal, state, private sector and contracted partners; developing alternatives to opioids for both our direct and purchased care settings; and now further expanding our Prescription Drug Monitoring Program (PDMP) to include state monitoring programs.

Acute pain afflicts much of the active force every year. By all major measures, DoD personnel and the MHS are carefully managing individuals with pain. Abuse of opioids by active duty Service members (as measured by random drug testing) is less than 1%, addiction to opioids (as measured through our MHS Clinical Data Repository) is less than 1%, and overdose deaths are 2.7/100,000, half of the national rate when adjusted for demographics. For DoD, the majority (83%) of long-term opioid patients

are: greater than 45 years old; most likely to be retirees or retiree family members; and obtain most of their care outside of military hospitals and clinics.

We are also cognizant of the broader public health crisis facing this nation, and focused on ensuring our medical workforce, our patients, and our families are familiar with the most current science regarding the responsible treatment and management of pain. Our data analytics have identified the number of TRICARE enrollees that reside in areas with high opioid prescribing rates, enabling us to apply a risk rating to each county to better target those individuals who may be at risk and military installations that may be most influenced by prescribing practices in the civilian community. Exhibit 1 shows one portrayal of the data we analyzed to assist with our outreach and education effort.

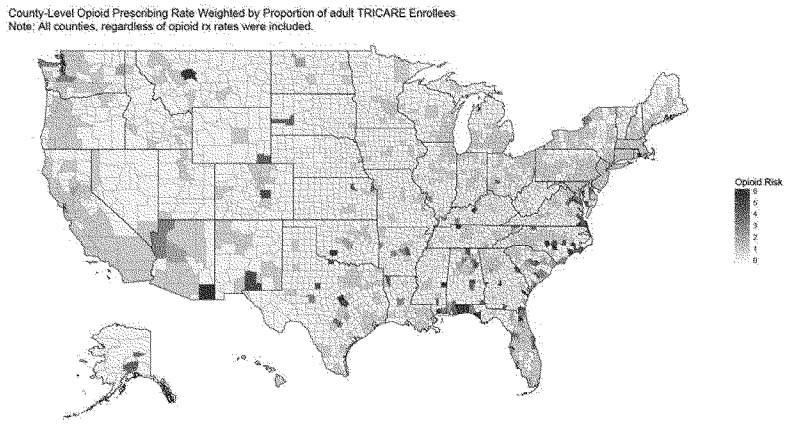


Exhibit 1: County-Level Prescribing Rate Weighted by Adult TRICARE Enrollees

The Department continues to emphasize advances in pain and addiction treatment, pharmacy interventions, and research into pain and addiction syndromes. And, we are working closely with our colleagues at the Department of Veterans Affairs (VA) to coordinate treatment for our shared population of beneficiaries.

While it is difficult to quantify chronic pain in any population, it is safe to say rates are especially high in our active duty and veteran populations. At least one national health survey reported over 65% of veterans report ongoing pain; another study found that 44% of active duty service members (ADSM), who recently deployed, experienced pain. Given the physically demanding nature of military service, the incidence of pain must be anticipated and addressed. DoD's approach to the opioid crisis has a dual focus: (1) to implement a comprehensive model of pain management that focuses on non-pharmacologic pain treatments, and (2) when opioid use is necessary to optimize safe usage for our patients.

Opioid Safety Pharmacy Initiatives

The MHS has introduced a number of initiatives to lower the risk of adverse outcomes from the use of opioids. Since 2016, DoD has partnered with Express Scripts, Inc. (ESI), our pharmacy benefits manager, to develop and utilize the TRICARE prescription monitoring program (PMP). This program identifies patients at all of our points of service who are at risk for an opioid overdose or other negative outcomes due to controlled substance prescriptions, particularly patients using multiple classes of controlled substances. DoD also rolled out a MHS Opioid Registry, identifying patients receiving care in military treatment facilities (MTFs) who are taking opioids. Data in this

registry includes the number of opioid prescriptions filled, the cumulative dosage of opioids, as well as supplemental medical information that allows medical providers in the MTFs to understand a specific patient's risk for addiction, overdose death or opioid-related complications.

On a quarterly basis, ESI provides the top 300 utilizers to each TRICARE contractor or the MTF when the MTF is the primary care manager. Upon contractor or MTF review, ESI can restrict beneficiaries from obtaining their opioid prescription to one doctor or from one pharmacy. ESI manages the Lock-In Restriction Program for beneficiaries that obtain medical care and prescriptions from both the MTF and the TRICARE managed care support contractor (MCSC) network. Restricted beneficiaries who obtain opioids from a doctor or pharmacy they are not locked in to are responsible for 100% of the cost. In the first six months of this program, through January 2018, ESI has added restrictions for 697 beneficiaries.

While the MHS Opioid Registry focuses on opioid prescribing from the patient perspective, DoD also uses a database that examines provider prescribing practices. The Controlled Substance Prescriber Profile identifies providers with the highest volume of opioids prescribed by total dosage and number of prescriptions over a period of time. This report is used by MTF leaders to identify and address those prescribers whose prescribing practices may indicate an overreliance on opioids for pain control.

The Department is also working on adopting and implementing the MHS Stepped Care Model, a comprehensive model of pain management. The MHS Stepped Care Model will provide our patients with evidence-based pain management guided by clinical practice guidelines (CPGs): effectively treat acute and chronic pain; promote

non-pharmacologic treatment; prevent acute pain from becoming chronic; and minimize use of opioids with appropriate prescribing only when indicated.

Furthermore, DoD was one of the first federal agencies to establish a drug "Take Back Program" that provides its beneficiaries with a mechanism to properly and safely dispose of unused or expired controlled medications. By December 2017, 100% of DoD MTFs had established local "Take Back" programs and had collected over 166,000 pounds of drugs through collection receptacles, mail-back envelopes, and participation in U.S. Drug Enforcement Administration drug take back events.

Provider Training and Education

DoD has established a comprehensive, mandatory Opioid Prescriber Safety Training (OPST) program, an online interactive education module that guides and reinforces safe opioid prescribing, and is also accepted by many states as meeting their opioid safety training requirements. This training instructs providers in evidence-based and effective pain management without opioids. In addition, DoD hosts monthly web-based training and annual seminars to assist health care teams in treating pain and substance use disorders.

DoD conducted a study to evaluate the impact of the OPST, specifically to compare (a) if providers are prescribing opioids more safely since receiving the training, and (b) if changes in provider prescribing behavior differs substantially between "trained" and "untrained" providers. The study evaluated 8,884 prescribers trained by April 2017. Preliminary data suggest that the training led to improved outcomes related to enhanced compliance with the Department's CPGs. There was a reduction in the

mean morphine milligram equivalent daily dose per prescription (32.4 mg pre-training; 32 mg post-training) and a reduction in the mean percentage of prescriptions with benzodiazepine overlap (7.4% pre-training; 7.1% post-training). These reductions are a small, but an important indication that our prescribing practices are trending in the right direction.

DoD plans to extend the impact study to cover all prescribers who completed the training for whom we have data for a full year pre- and post-training to look at patterns of behavioral change over time. Data collection will be completed by September 30, 2018 and analysis completed by December 31, 2018.

DoD's Graduate Medical Education (GME) programs train clinicians in non-pharmacologic pain treatments across the spectrum of care, ranging from battlefield acupuncture training for primary care residents to radiofrequency ablations and implantable pain systems in specialty care.

In 2017, the VA and DoD published the VA-DoD CPGs for Management of Opioid Therapy for Chronic Pain. These CPGs provide comprehensive evidence-based recommendations regarding opioid prescribing. The guidelines encourages providers to focus on non-pharmacologic pain treatments and to avoid long-term opioid therapy. The guidelines encourage clinicians to use a patient-centered care approach that is tailored to the patient's capabilities, needs, goals, prior treatment experience, and preferences. Regardless of setting, all patients in the healthcare system are offered access to evidence-based interventions appropriate to that patient. When properly executed, patient-centered care decreases patient anxiety, increases trust in clinicians, and improves treatment adherence.

Complementary and Integrative Medicine Therapies

DoD makes extensive use of complementary and integrative medicine (CIM) therapies that assist in de-escalating or preventing opioid use. A 2017 RAND study surveyed MTFs and found that 83% offered some form of CIM modalities. Three-quarters offered stress management or relaxation therapy and two-thirds offered acupuncture. The study estimated that there are 76,000 CIM encounters per month in MTFs. DoD is committed to expanding evidence-based non-pharmacologic pain treatments.

Prescription Drug Monitoring Programs (PDMP)

One important tool for opioid safety is a PDMP – programs used in every state that allow both providers and pharmacists to review patient's opioid prescription histories to ensure there are no overlapping opioid prescriptions to worsen an opioid use disorder or cause an overdose.

DoD currently shares controlled substance prescription data with state PDMPs for prescriptions issued through our mail order or retail pharmacy networks. 63% of our DoD beneficiaries exclusively use these two outlets when filling controlled substance prescriptions. In addition, our Pharmacy Data Transaction Service (PDTS) allows military providers to view opioid prescriptions obtained at a civilian pharmacy or through the mail order program and billed through TRICARE.

There are some existing limitations of this data sharing. Principal among these limitations is that due to operational security concerns, MTF pharmacies cannot

currently share opioid prescribing information from MTFs with state PDMPs. Additionally, a military provider has no visibility of an opioid prescription obtained through a cash transaction at a civilian pharmacy – those transactions are captured by state PDMPs but not the PDTS.

The Department is working diligently to establish a PDMP that will be accessible by both military and civilian providers who treat our beneficiaries. The enhanced DoD PDMP will interface with state PDMPs through a portal that will be single-use and allow for anonymous access. This new capability is expected to available by December 2018.

Federal, State and Private Sector Partnerships

DoD partners with a number of government and non-government organizations as it seeks to adopt best practices in opioid safety. In addition to the VA-DoD CPGs for Management of Opioid Therapy for Chronic Pain that were mentioned earlier. The VA and DoD also published CPGs for the treatment of low back pain and comorbid psychiatric conditions which are conditions where opioids may also be prescribed. Moreover, VA and DoD have partnered on the Joint Pain Education Project (JPEP). JPEP is a project that creates a common pain management curriculum between the two Departments, allowing for standardization of pain care and optimization of healthcare services.

DoD has partnered with National Institutes of Health (NIH) and its National Center for Complementary and Integrative Health (NCCIH), to collaborate on chronic pain and non-pharmacologic treatment approaches to pain. Jointly supported by the NIH, DoD, and VA, twelve research projects totaling approximately $81 million over six

years will focus on developing, implementing, and testing cost-effective, large-scale, real-world research on non-pharmacologic approaches for pain management and related conditions in military and veteran healthcare delivery organizations. . The NIH-DoD-VA Pain Management Collaboratory Program, will also:

- Provide leadership and technical expertise in all aspects of research supporting the design and execution of high impact demonstration projects on non-pharmacological approaches for pain management and other comorbid conditions;
- Provide important information about the feasibility, acceptability, safety, and effectiveness of nondrug approaches in treating pain. Types of approaches being studied include mindfulness/meditative interventions, movement interventions (e.g., structured exercise, tai chi, yoga), manual therapies (e.g., spinal manipulation, massage, acupuncture), psychological and behavioral interventions (e.g., cognitive behavioral therapy), integrative approaches that involve more than one intervention, and integrated models of multi-modal care.
- Disseminates data, tools, best practices, and resources from these and other projects to facilitate a research partnership with other health care delivery systems that provide care to military personnel, veterans and their families.

Projects under this initiative will be conducted within healthcare systems that serve military, veterans and their families.

DoD also collaborates with state governments and academic institutions in tackling the opioid crisis. The Defense and Veterans Center for Integrative Pain Management (DVCIPM) has established a cooperative research and development

agreement with West Virginia University to share pain management education, tools, and expertise. One example of work being performed is the Defense and Veterans Pain Rating Scale (DVPRS) -- an innovative and validated pain scale developed by the DoD, in collaboration with the VA, building on the familiar 0-10 numeric pain rating scale (NRS) widely used in medicine. The DVPRS was developed in to improve on the utility and clarity of the NRS.

The DVPRS has been extraordinarily popular with patients and providers. Following multiple validation studies conducted by DVCIPM and a MHS systematic review of other pain scales, the Defense Health Agency (DHA) selected the DVPRS as the designated pain scale for adolescents and adults, and we will incorporate this work into future DoD-wide policies as well as part of the DHA Procedural Instruction (DHA PI) for Pain Management and Opioid Safety.

The DVPRS has also been adopted for use in multiple civilian hospitals and other healthcare settings and organizations. West Virginia University Health System is rolling out the DVPRS across its eight hospitals as part of their pain management and opioid safety strategies.

DoD participates in the North Carolina Payer's Council, a group of healthcare payers convened by the North Carolina Department of Health and Human Services. The recently established Payers' Council is working to identify, align and implement policies to improve health outcomes by:

- Supporting providers in judicious prescribing of opioids;
- Promoting safer and more comprehensive alternatives to pain management;

- Improving access to naloxone, substance use disorder treatment and recovery supports; and
- Engaging and empowering patients in the management of their health.

Finally, DoD is partnering with other departments and agencies on a fast track action committee to identify gaps in current knowledge and create a research roadmap for opioids focusing on pain, addiction and overdose. The committee is being convened by the White House Office of Science and Technology Policy, and co-chaired by NIH and the National Science Foundation.

DHA is working closely with DoD's MCSC partners on the issues of opioid safety and effective pain management. The new TRICARE contracts require MCSCs to act on information provided by DoD regarding patients with unusually high doses or lengthy opioid use as well as providers who prescribe high amounts of opioids.

Consistent with its use of CIM in MTFs, DHA is crafting policy to expand TRICARE coverage for non-pharmacologic pain treatment modalities.

Conclusion and Way Ahead

DoD is strongly committed to optimizing opioid safety for our Service members and our beneficiaries. DoD's focus and response is strongly connected to readiness and our commitment to deliver safe, effective healthcare to all of our patients. The Department believes that improving opioid safety must be paired with exceptional pain management. We closely monitor opioid use across our system of care serving our 9.4 million beneficiaries, in both the direct and purchased care sectors.

Although our performance shows rates of opioid addiction that are significantly lower than that found in the private sector, we are constantly looking at ways to improve. With Congress' support for our research agenda, we have a number of well-designed research projects underway that will soon be adding to our evidence-based practices. We must continue to synchronize our policies that support alternatives to opioids in both the direct and purchased care systems and ensure that our entire workforce and beneficiary population knows how to access these alternatives. Importantly, we are strengthening our PDMP to further expand the sharing of data with state PDMPs.

Using the best evidence in opioid safety, a Stepped Care Model for pain management, and your continued support, our beneficiaries will realize improved readiness and health. We appreciate the opportunity to discuss our programs and future plans, and we look forward to answering your questions.

Vice Admiral Raquel C. Bono
Director, Defense Health Agency
Medical Corps, United States Navy

Commissioned in June 1979, Vice Adm. Raquel Bono obtained her baccalaureate degree from the University of Texas at Austin and attended medical school at Texas Tech University. She completed a surgical internship and a General Surgery residency at Naval Medical Center Portsmouth, and a Trauma and Critical Care fellowship at the Eastern Virginia Graduate School of Medicine in Norfolk.

Shortly after training, Bono saw duty in Operations Desert Shield and Desert Storm as head, Casualty Receiving, Fleet Hospital 5 in Saudi Arabia from August 1990 to March 1991. Upon returning, she was stationed at Naval Medical Center Portsmouth as a surgeon in the General Surgery department; surgical intensivist in the Medical/Surgical Intensive Care Unit and attending surgeon at the Burn Trauma Unit at Sentara Norfolk General Hospital. Her various appointed duties included division head of Trauma; head of the Ambulatory Procedures Department (APD); chair of the Laboratory Animal Care and Use Committee; assistant head of the Clinical Investigations and Research department; chair of the Medical Records Committee and command intern coordinator. She has also served as the specialty leader for Intern Matters to the surgeon general of the Navy.

In September 1999, she was assigned as the director of Restorative Care at the National Naval Medical Center in Bethesda, Maryland, followed by assignment to the Bureau of Medicine and Surgery from September 2001 to December 2002 as the Medical Corps career planning officer for the chief of the Medical Corps. She returned to the National Naval Medical Center in January 2003 as director for Medical–Surgical Services.

From August 2004 through August 2005, she served as the executive assistant to the 35th Navy Surgeon General and chief, Bureau of Medicine and Surgery. Following that, she reported to Naval Hospital Jacksonville, Florida, as the commanding officer from August 2005 to August 2008. She then served as the chief of staff, deputy director Tricare Management Activity (TMA) of the Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)) from September 2008 to June 2010. She later served as deputy director, Medical Resources, Plans and Policy (N093), chief of Naval Operations. From November 2011 to June 2013, she served as the command surgeon, U.S. Pacific Command, Camp H.M. Smith, Hawaii. From July 2013 to September 2013, she served as acting commander Joint Task Force National Capital Region Medical. From September 2013 to October 2015, she served as director, National Capital Region Medical Directorate of the Defense Health Agency, and as the 11th Chief, Navy Medical Corps. She currently serves as director, Defense Health Agency.

Bono is a diplomat of the American Board of Surgery and has an Executive MBA from the Carson College of Business at Washington State University. Her personal decorations include Defense Superior Service Medal (three), Legion of Merit Medal (four), Meritorious Service Medal (two) and the Navy and Marine Corps Commendation medal (two).

Updated: 4 November 2015

Captain Mike Colston, M.D.

Captain Mike Colston, M.D., is the Director for Mental Health Programs in DoD's Health Services Policy and Oversight office. This office, under the Assistant Secretary of Defense for Health Affairs, seeks to improve the lives of our nation's service members and families through oversight, strategy management, program evaluation and policy regarding DoD's care of psychological health and substance use disorders, traumatic brain injury and the clinical management of suicidality. Captain Colston is stationed at The Pentagon.

In previous medical corps assignments, Captain Colston served as the Director of the Defense Centers of Excellence for Psychological Health (PH) and Traumatic Brain Injury (TBI), a 600-employee national laboratory focused on implementation science for PH, TBI, suicide and addiction. As Director of the Mental Health Program in the Office of the Assistant Secretary of Defense for Health Affairs, Captain Colston oversaw a mental health board project that reviewed over 200,000 cases involving PTSD and depression diagnoses, led a mental health team in the independent investigation of the Washington Navy Yard tragedy, and co-chaired DoD's Addictive Substances Misuse Advisory Committee, helping address the nationwide scourge of opiate addiction on several fronts. As Chair of the Mental Health Department at Naval Hospital Great Lakes, he oversaw a large-scale clinical integration of VA and DoD services at the Lovell Federal Health Care Center in the Chicago metro area. During deployment in support of Operation Enduring Freedom, he led a combat and operational stress team that supported a catchment of 10,000 service members.

Captain Colston has represented DoD in testimony to both chambers of Congress and at Executive Offices of the President including the Office of National Drug Control Policy, the Domestic Policy Council, and the National Security Council. He has served in study sections for federal research portfolios and on research advisory boards for the Congressionally Directed Medical Research Program and the NIH National Advisory Council on Neurological Disorders and Stroke. He currently serves on panels for the Military Suicide Research Consortium, the Consortium to Alleviate PTSD, and the National Academies of Medicine. He authored a chapter on the forensic aspects of PTSD in the Textbook of Military Medicine series, and has been published in peer-reviewed journals on uncertainties in diagnosis and treatment of mental illnesses and bioethical considerations related to PH, TBI and suicide research.

Captain Colston joined the Navy as a line officer, serving as a nuclear engineer and surface warfare officer aboard USS Carl Vinson (CVN-70), deploying twice to the Arabian Sea and completing a Pacific Rim Exercise. He then commanded a littoral patrol boat as an afloat officer-in-charge. Transitioning to Medical Corps service, he earned an MD from the Uniformed Services University of the Health Sciences, trained as a resident in psychiatry at Walter Reed Army Medical Center and completed a fellowship in child and adolescent psychiatry at Northwestern University. Captain Colston holds a BS in Industrial and Management Engineering from Rensselaer Polytechnic Institute and a master's degree in Marine Affairs from the University of Rhode Island. He is a fellow of the American Psychiatric Association and is board certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology.

Captain Colston is credentialed at Fort Belvoir Community Hospital, practicing inpatient adolescent psychiatry and step- down addictions medicine. His military decorations include the Defense Superior Service Medal and Defense Meritorious Service Medal, Surface Warfare and Officer-in-Charge Afloat devices, and campaign ribbons stemming from four overseas movements.

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

JUNE 20, 2018

QUESTIONS SUBMITTED BY MS. TSONGAS

Ms. TSONGAS. I was pleased to read in your written testimony about the Department's work to establish a Prescription Drug Monitoring program. How does the DOD plan on requiring military medical treatment facilities across the country to utilize and share information through this new PDMP—particularly in emergency situations?

Admiral BONO. The Department has issued a Prescription Drug Monitoring Program (PDMP) Contract Modification to Express Scripts Inc. to provide visibility to Schedule II–V controlled substances dispensed within the Military Health System (MHS) to registered PDMP prescribers, pharmacists and law enforcement in all other states. Scheduled completion date is 31 Dec 2018. The DOD PDMP program is an adjunct to the existing monitoring capabilities that now exist for providers at our Military Treatment Facilities (MTF). Prescriptions filled at any of the three points of service (mail, retail and MTFs) through TRICARE which have been cost shared by TRICARE are collated and available for query by MTF providers in real time. The DOD PDMP program will also capture controlled substances that were dispensed when the beneficiary paid cash. This will ensure a complete history is available to any provider, both military and civilian, who is registered to use the PDMP program. Once available, DOD will work towards incorporating appropriate PDMP review as part of the MHS patient care work flow.

Ms. TSONGAS. Admiral Bono, have you seen any issues or trends involving service members seeking opioid pain relievers due to chronic musculoskeletal pain caused, in part or in whole, by heavy personal protective equipment? If so, how is the Department seeking to manage this causal factor?

Admiral BONO. Musculoskeletal injuries are the number one medical threat to readiness. However, the rates of opioid abuse and dependence are below 1% among TRICARE beneficiaries, with a 56% decrease since 2016. Currently, there is no direct evidence of opioid seeking behavior related to heavy personal protective equipment. DOD has taken action to address pain management and opioid safety through a comprehensive, holistic approach by providing intensive training, utilizing external partnerships, and implementing policies to discourage opioid overuse. The MHS is synchronizing pain care under a stepped care model, which equips primary care providers to encourage self-care and provide pain management to patients with a focus on non-pharmacologic therapies. Our goal is to help patients manage their pain at the lowest care level necessary and to teach them the skills necessary to move back down the continuum of care with the stepped care model. The MHS has optimized opioid safety through specific opioid prescribing guidance for acute pain episodes and minor procedures as well as major procedures in the uncomplicated patient. The MHS has increased the opioid safety patient information availability at the point of care. The Opioid Risk and Recommended Clinical Actions (ORRCA) report is a clinical decision support tool that providers will use to promote recommendations based on clinical practice guidelines into each patient's individualized care plan.

Ms. TSONGAS. How does the DOD plan on offering and tracking the effectiveness of opioid alternative treatments for chronic pain?

Admiral BONO. We use a tool called Pain Assessment Screening Tool and Outcomes Registry (PASTOR) in specialty clinics to assess the efficacy of our complementary and integrative therapies for chronic pain. PASTOR is based on the National Institutes of Health investment in Patient-Reported Outcomes Measurement Information System (PROMIS) and provides advanced analytics for assessing patient reported outcomes. PASTOR utilizes evidence-based patient reported outcomes to assess effectiveness of clinical and programmatic pain management interventions at both the individual and population health levels.

Ms. TSONGAS. Admiral Bono, does the DOD have a plan to address how retired service members can obtain alternate forms of pain management through TRICARE without these retirees having to pay out of pocket?

Admiral BONO. We agree that complementary and integrative pain therapies, such as mindfulness, massage, yoga, chiropractic care, and acupuncture are essential to managing pain in our healthcare system. We are actively considering addition

of complementary and integrative therapies to the TRICARE benefit for provisional coverage. Acupuncture and chiropractic care are currently under review. Acupuncturists currently are not TRICARE-authorized providers. DHA is proceeding with a rule-making to remove the regulatory exclusion of acupuncture and add acupuncturists as authorized providers.

Ms. TSONGAS. How is the DOD training its medical professionals on the treatment of newborns suffering from opiate exposure? If that training is already in place, what does it look like?

Admiral BONO. There is no formal DOD training in place at this time. However, providers caring for neonates should be following and delivering care in accordance with the American Academy of Pediatrics (AAP) Policy on Neonatal Drug Withdrawal, which utilizes a clinical scoring system to determine abstinence and potential need for drug therapy. Also, the General Pediatric Content Specifications published by the American Board of Pediatrics and utilized in the curricula of all the DOD Pediatric Residencies lists neonatal abstinence syndromes (i.e., how neonates respond to withdrawal of any substance) among the required knowledge for preparation for the certifying examination and practice in the care of neonates.

Ms. TSONGAS. What lessons has DOD learned from the Department of Veterans Affairs on opioid prescribing practices?

Admiral BONO. has adopted the MHS Stepped Care Model for Pain, modeled on the Department of Veterans Affairs (VA) patient experience, as the comprehensive model of pain management focusing on non-pharmacologic pain treatments. DOD and VA also developed the Defense and Veterans Pain Rating Scale as the standard for pain scale. DOD continues to execute the Joint Pain Education Project in disseminating a standardized DOD and VA pain management curriculum used in education and training programs improving pain management competencies in the combined federal clinical workforce. DOD is committed to continued coordination and collaboration with VA regarding comprehensive pain management and opioid safety.

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