



Delivering Exceptional Pain Care to Service Members



Pain is the leading cause of disability among active-duty service members. Given the widespread potential impact of pain on military readiness and ability to deploy, providing high-quality treatment to service members with pain conditions is a strategic priority for the Military Health System (MHS).

EXCEPTIONAL CARE

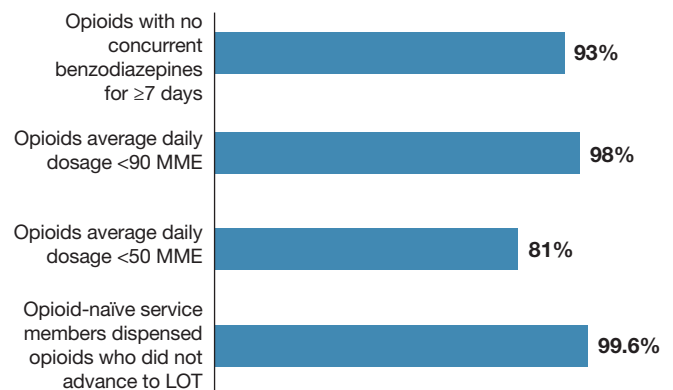
Providers Prescribe Opioids in a Manner Largely Consistent with Recommended Guidance

MHS administrative records from fiscal years 2018 and 2019 show that, in the vast majority of cases in which opioids were used to treat pain, providers followed prescribing practices that mitigated the risk of opioid misuse or dependence.

- Concurrent use of opioids and benzodiazepines has been associated with an increased risk of overdose and death, and less than 10 percent of service members were co-prescribed opioids and benzodiazepines concurrently for seven or more days.
- Higher dosages of opioids are associated with an increased risk of harm, including both nonfatal and fatal overdose. Also, higher doses do not necessarily improve pain symptoms. Nearly all service members (98 percent) who were dispensed opioids had an average daily dosage below levels of highest risk. Updated U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense (DoD) clinical practice guidelines emphasize using effective nonopioid treatments before opioids, and if opioids are prescribed, there is a need for continued patient reassessment and monitoring of patient risks.
- Less than 1 percent of opioid-naïve service members who were dispensed opioids progressed to long-term opioid therapy (LOT) within 12 months. LOT has multiple risks, including substance use disorder, overdose, suicide behaviors, and increased all-cause mortality.

These findings suggest that the MHS performs well on multiple metrics assessing the safety and quality of opioid prescribing. The Centers for Disease Control and Prevention (CDC) emphasizes the need for careful assessment and management of each patient with pain—specifically, the risks and benefits of nonopioid therapies as first-line treatment before initiating opioids. This effort is known as the *stepped-care model*. When opioids are used, they should be prescribed at the lowest effective dosage, with regular patient monitoring.

Percentage of Service Members Receiving Recommended Care Among Those Dispensed Opioids



NOTES: MME = morphine milligram equivalent. Previous VA/DoD and CDC clinical practice guidelines strongly recommended against daily opioid dosages above 90 MME and acknowledged the increased risk and need for monitoring at daily dosages of 50 MME. Updated guidelines do not focus on specific dosages but emphasize the importance of considering alternative treatments to opioids and individualized patient assessment and monitoring when opioids are used.

OPPORTUNITY TO IMPROVE

Providers Need Training in Appropriate Opioid Prescribing

In interviews, most MHS prescribers expressed a reluctance to treat chronic pain with opioids, preferring nonopioid medication (e.g., oral NSAIDs) or nonpharmacologic treatment (NPT) as initial treatments, consistent with the stepped-care model. One prescriber admitted, “If I get a new patient that is on opioids, I will do my damndest to find another provider in the clinic that prescribes opioids to have them see [the patient].” Providers would benefit from additional training and support, including in safely tapering off LOT for patients when appropriate.





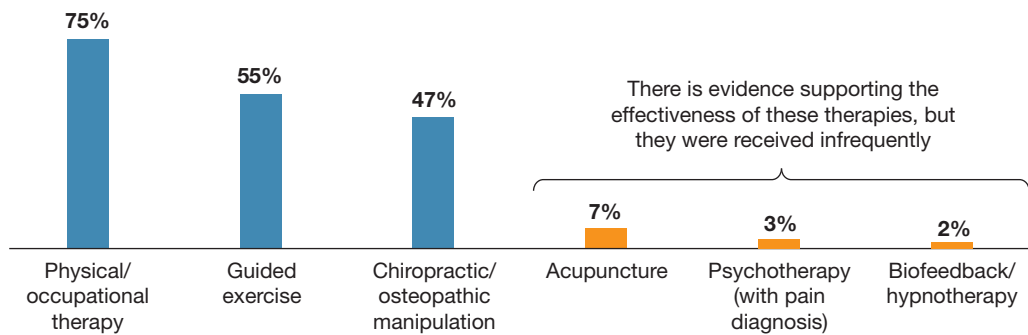
EXCEPTIONAL CARE

More Than 80 Percent of Service Members with Chronic Pain Receive Some Nonpharmacologic Treatment

The use of NPT is consistent with the stepped-care model, which promotes evidence-based pain care and minimization of opioid use. Patients whose pain is not responsive to primary or secondary treatment, including NPT, can be referred to specialty pain management clinics. Among service members with *chronic pain* (defined as pain lasting three or more months), 81 percent received at least one visit for a recommended NPT.

- Among those with acute low back pain, 79 percent received treatment consistent with stepped care. Specifically, in the three months following patients’ initial back pain visits, they received NPT or nonopioid medication prior to receiving opioids.
- Physical and occupational therapy was the most common type of NPT that service members received, followed by guided exercise and chiropractic care. However, other types of recommended NPT were underutilized in the MHS, including acupuncture, psychotherapy for pain (i.e., cognitive behavioral therapy), and biofeedback.

Percentage of Service Members with at Least One NPT Visit



NOTE: An individual service member could have received more than one type of NPT.

OPPORTUNITY TO IMPROVE

Service Members Need Better Access to Nonpharmacologic Treatment

More than **three-quarters** of administrative leadership and providers who provide pain care cited the limited availability of NPT as a barrier to broader use, and **more than one-half** described it as the *biggest* barrier to integrating these treatments into pain care. One provider explained, “Everybody’s fighting for that physical therapy.” Many providers made few referrals to chiropractic care and acupuncture because of limited availability at military treatment facilities and a lack of TRICARE reimbursement in the private sector. Other common barriers included inadequate staffing and long wait times for NPT appointments. The MHS should assess the availability and wait times for NPT appointments and routinely monitor timely access to NPT.



Study Approach

RAND researchers analyzed MHS administrative treatment data to assess the quality of outpatient noncancer pain care and opioid prescribing by military and private-sector providers who treat service members, identifying areas of strength and opportunities for improvement. This rigorous process involved developing and applying 14 pain care quality measures, as well as interviewing 68 military treatment facility administrators and pain care providers and 54 service members who were receiving care for chronic pain, to understand the real-world implications of MHS practices and policies for delivering pain care.

Did You Know?

The Defense and Veterans Pain Rating Scale—or DVPRS—is the standard pain scale used by all providers in military treatment facilities to screen and assess their patients during each visit. Starting with the patient’s rating of the pain’s intensity, the DVPRS guides providers in assessing the impact on functioning. This structured approach to pain assessment helps ensure that decisions about treatment adjustments are based on data that are collected consistently over time. In interviews, only about **one-half of providers** who treat service members’ pain said they used a structured method to assess pain severity and impact on patient functioning. This finding suggests that DVPRS could improve pain care if more providers used it.



This brief describes work done in the RAND National Defense Research Institute and documented in *Assessing the Quality of Outpatient Pain Care and Opioid Prescribing in the Military Health System*, by Kimberly A. Hepner, Carol P. Roth, Tisamarie B. Sherry, Ryan K. McBain, Teague Ruder, and Charles C. Engel, RR-A1193-1, 2022 (available at www.rand.org/t/RR-A1193-1), and *Improving Pain Care for Service Members: Administrator, Provider, and Patient Perspectives on Treatment, Policies, and Opportunities for Change*, by Kimberly A. Hepner, Jessica L. Sousa, Carol P. Roth, Shreya S. Huilgol, Chester Jean, Lucy B. Schulson, Priya Gandhi, Nipher Malika, and Charles C. Engel, RR-A1193-2, 2023 (available at www.rand.org/t/RR-A1193-2).



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