The VA Opioid Safety Initiative – how did we get here and what is ahead?

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No relevant financial relationships or conflicts of interest.
No discussion of off label use of drugs or devices.
The presentation is the personal opinion of the presenters and does not reflect the official views of the Department of Veterans Affairs or any other Federal Agency.
Objectives/Overview

- Introduction
- Risk factors for Overdose/Suicide and OUD
- Opioid Safety Initiative in VHA
- Federal Initiatives and the Comprehensive Addiction and Recovery Act (2016)

OSI components:
- Opioid Safety Initiative/Opioid Risk Mitigation
- Dashboards
- VA-DoD Clinical Practice Guideline
- Provider Education
- Complementary and integrative health (CIH)
- Stepped Care Model and Pain Management Teams

OSI patient care reviews

Pain, MH and SUD cooperation
Chronic pain is more common in Veterans than in the non-veteran US population, more often severe and in the context of comorbidities.

Pain severity and co-occurrence with mental health comorbidities result in high impact pain (i.e. associated with substantial restriction of participation in work, social, and self-care activities).

Behavioral Health Autopsy report (2015) “The most frequently identified risk factor among Veterans who died by suicide was pain”.

Pain, medical and/or mental comorbidities are often related to military service and/or require Veteran-specific expertise.

Veterans are at high risk for harms from opioid medication.

Integrated care: systematic coordination of medical, psychological and social aspects of health care is required for high quality pain care.

VHA: Pain Management and Opioid Safety is included in the list of “Foundational Services”
Patient Robert B.*

32 y/o OEF/OIF Veteran recently transitioned to care in VHA
CC of low back pain

- Pain condition: low back pain with axial and radicular features, with significant degenerative disk disease on his spine by MRI; not surgical candidate.
- Comorbidities: PTSD (severe), TBI (mild)
- No illicit drug use
- Longstanding high dose opioid therapy that was already initiated during active military service, with Morphine SR 45 mg TID.
- At VA: Morphine dosage was gradually reduced over several months to 30 mg TID and then kept stable per patient request.
- Patient is on time with refills, not early. UDS as expected.
- The day after one of his opioid medication renewals, he was found by his father unresponsive in his bed at home.
- Review of chart: about 2 weeks prior to his last opioid renewal, he was seen by his Mental Health provider where he complained about poor sleep and also reported worsened anxiety. He had received a new diazepam prescription at that time.
- Accidental or suicidal overdose of multiple CNS depressant medications/substances.
The Opioid Overdose Challenge in VHA

Accidental Poisoning Mortality Among Patients in the Department of Veterans Affairs Health System. Bohnert, Ilgen, Galea et al. Med Care 2011

- Study of all 5,567,621 Veterans in VHA in FY 2004/05 alive at start of FY 2005
- 1,013 died of accidental poisoning in FY 2005.

<table>
<thead>
<tr>
<th>Gender/Age Group</th>
<th>U.S. 2005 Accidental Poisonings</th>
<th>Crude Rate per 100,000 person-years</th>
<th>V.H.A. FY2005 Accidental Poisonings</th>
<th>Crude Rate per 100,000 person-years</th>
<th>Standardized Mortality Ratio</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>15,679</td>
<td>14.51</td>
<td>960</td>
<td>20.62</td>
<td>1.98</td>
<td>1.85, 2.10</td>
</tr>
<tr>
<td>18-29 yrs</td>
<td>3,390</td>
<td>13.45</td>
<td>28</td>
<td>21.86</td>
<td>1.62</td>
<td>1.02, 2.23</td>
</tr>
<tr>
<td>30-64 yrs</td>
<td>11,826</td>
<td>17.53</td>
<td>841</td>
<td>36.81</td>
<td>2.10</td>
<td>1.96, 2.24</td>
</tr>
<tr>
<td>65+ yrs</td>
<td>463</td>
<td>3.01</td>
<td>91</td>
<td>4.06</td>
<td>1.35</td>
<td>1.07, 1.63</td>
</tr>
<tr>
<td>Females</td>
<td>7,647</td>
<td>6.68</td>
<td>53</td>
<td>11.82</td>
<td>1.61</td>
<td>1.18, 2.04</td>
</tr>
<tr>
<td>18-29 yrs</td>
<td>1,024</td>
<td>4.28</td>
<td>1</td>
<td>1.70</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>30-64 yrs</td>
<td>6,155</td>
<td>8.91</td>
<td>50</td>
<td>15.34</td>
<td>1.72</td>
<td>1.24, 2.20</td>
</tr>
<tr>
<td>65+ yrs</td>
<td>468</td>
<td>2.19</td>
<td>2</td>
<td>3.14</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td>23,326</td>
<td>10.49</td>
<td>1,013</td>
<td>19.85</td>
<td>1.96</td>
<td>1.83, 2.08</td>
</tr>
</tbody>
</table>

- Opioid medication 32.3% (incl. methadone 13.8%), cocaine 23.3%, other/unspecified narcotics 8.5%, antidepressants 8.1%, benzos 7.55, synthetic heroin 6.3%, psychostimulants 4.4%, synthetic narcotics 4.3%

- “VHA patients had nearly twice the rate of fatal accidental poisoning compared with adults in the general US population.”
64,070 Americans died from drug overdoses in 2016, including illicit drugs and prescription opioids – nearly double in a decade. For comparison: cocaine: 10,619; methamphetamine 7,663

Opioid Use Disorder (OUD) Epidemic

• Anyone who takes prescription opioids can become addicted to them.
• In 2014, nearly two million Americans either abused or were dependent on prescription opioid pain relievers.
• 25-41% of patients on prescription opioids meet criteria for OUD (DSM-5).
• Heroin-related deaths more than tripled between 2010 and 2014.
• Among new heroin users entering treatment programs, ¾ report initiating misuse with prescription opioids.

Why America Can’t Kick Its Painkiller Problem, TIME Magazine June 4, 2015
Risk factors for Overdose and OUD

Risk factors are related to:
- Opioid prescribing
- Interaction with other medication/drugs
- Medical comorbidities
- Mental health comorbidities

“Opioid dosage was the factor most consistently analyzed and also associated with increased risk of overdose. Other risk factors include concurrent use of sedative hypnotics, use of extended-release/long-acting opioids, and the presence of substance use and other mental health disorder comorbidities.”

Review of 15 articles published between 2007 and 2015 that examined risk factors for fatal and nonfatal overdose in patients receiving opioid analgesics.
Higher Dosage Increases Risks from Opioids

Hazard Ratios (HR):

**Mortality (all causes):**
- HR 1.64 for LA opioids

**Overdose deaths (unintentional):**
- HR 7.18-8.9 for MME > 100 mg/d

**Opioid use disorder**
on long-term opioids (> 90 d)
- HR 15 for 1-36 mg/d MME
- HR 29 for 36-120 mg/d MME
- HR 122 for > 120 mg/d MME

Edlund et al 2014
"Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths"

**Bohnert et al, JAMA 2011**

- Case-cohort study
- All FY2004/05 VHA pts who died of opioid overdose by FY2008
- Random sample for comparison

<table>
<thead>
<tr>
<th>Maximum prescribed daily opioid dose, mg/d</th>
<th>Risk of Opioid Overdose Death, HR (95% CI)</th>
<th>Chronic Pain (n = 111,759)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-&lt;20</td>
<td>1.88 (1.33-2.67)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>20-&lt;50</td>
<td>4.63 (3.18-6.74)</td>
<td></td>
</tr>
<tr>
<td>50-&lt;100</td>
<td>7.18 (4.85-10.65)</td>
<td></td>
</tr>
<tr>
<td>≥100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain-related diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>0.99 (0.72-1.36)</td>
<td></td>
</tr>
<tr>
<td>Chronic bodily pains</td>
<td>0.69 (0.35-1.33)</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>1.02 (0.74-1.41)</td>
<td></td>
</tr>
<tr>
<td>Neuropathy</td>
<td>0.64 (0.38-1.08)</td>
<td></td>
</tr>
<tr>
<td>Injuries and acute pain</td>
<td>1.37 (1.08-1.74)</td>
<td></td>
</tr>
<tr>
<td>Other diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>2.53 (1.99-3.22)</td>
<td></td>
</tr>
<tr>
<td>Other psychiatric disorders</td>
<td>1.87 (1.48-2.38)</td>
<td></td>
</tr>
<tr>
<td>COPD, CVD, and sleep apnea</td>
<td>0.63 (0.50-0.80)</td>
<td></td>
</tr>
</tbody>
</table>

**Opioid OD deaths:**

Total 750 cases
- 296 cases
- 498 cases
**Dosage and Risk of Overdose from Opioids**

"Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths"  
Bohnert et al, JAMA 2011

<table>
<thead>
<tr>
<th>Maximum prescribed daily opioid dose, mg/d</th>
<th>Overdose Deaths, No.</th>
<th>Person-Months</th>
<th>Overdose Death Rate per 1000 Person-Months (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>243</td>
<td>2,729,022.7</td>
<td>0.09 (0.08-0.10)</td>
</tr>
<tr>
<td>1-&lt;20</td>
<td>44</td>
<td>395,205.0</td>
<td>0.11 (0.08-0.15)</td>
</tr>
<tr>
<td>20-&lt;50</td>
<td>108</td>
<td>458,296.2</td>
<td>0.24 (0.19-0.28)</td>
</tr>
<tr>
<td>50-&lt;100</td>
<td>86</td>
<td>129,491.6</td>
<td>0.66 (0.53-0.82)</td>
</tr>
<tr>
<td>≥100</td>
<td>125</td>
<td>100,479.3</td>
<td>1.24 (1.04-1.48)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fill types</th>
<th>Overdose Deaths, No.</th>
<th>Person-Months</th>
<th>Overdose Death Rate per 1000 Person-Months (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly scheduled only</td>
<td>115</td>
<td>323,304.7</td>
<td>0.36 (0.29-0.43)</td>
</tr>
<tr>
<td>As needed only</td>
<td>152</td>
<td>672,276.0</td>
<td>0.23 (0.19-0.27)</td>
</tr>
<tr>
<td>Simultaneous as needed and regularly scheduled</td>
<td>96</td>
<td>87,891.5</td>
<td>1.09 (0.88-1.33)</td>
</tr>
</tbody>
</table>

- Chronic non-cancer pain were 606 of the 750 total cases
- The vast majority of overdoses happened in pts with no or lower dose opioids
“A Detailed Exploration Into the Association of Prescribed Opioid Dosage and Overdose Deaths Among Patients With Chronic Pain”  Bohnert et al, Med Care 2016

2004-2009 study
- Nested case control design
- New starts of opioids for pts with chronic pain (excluding tramadol and buprenorphine)

Average opioid dosages
Cases (overdose deaths):
98.1 MEDD (SD 112.7)
Controls:
47.7 MEDD (SD 65.2)

- No clear cut-point in opioid dosage to distinguish between OD cases and controls.
- Median dosage for pts with OD was 60 mg; i.e. vast majority below 100 mg MEDD.
Patient Risk Factors for Harm from Opioids

- **Psychiatric disorders**, including anxiety or depression.
- Personal or family history of **substance use disorder**.
- History of aberrant behavior/non-compliance.
- Age 65 or older.
- Young age (below 30).
- COPD or other underlying respiratory conditions.
- Renal or hepatic insufficiency.
- Pregnancy.

Every patient is at risk

http://www.cdc.gov/drugoverdose/opioids/prescribed.html
The VA Opioid Safety Initiative (OSI)

- **Opioid Safety Initiative (OSI)** expanded nationally in FY 2013
- The OSI aims to **reduce over-reliance on opioid analgesics for pain management** and to promote **safe and effective use of opioid therapy** when clinically indicated.
- Comprehensive OSI strategy that includes **education of providers** and **expanded access to non-pharmacological treatment options**, in particular behavioral and complementary integrative health modalities.
- **OSI Dashboard** makes the totality of opioid use visible within VA and provides feedback to stakeholders at VA facilities regarding key parameters of opioid prescribing.
The VA Opioid Safety Initiative (OSI) Timeline

- **BIV Initiative**: Launch of the Buprenorphine in VA (BIV) Initiative
- **VA Pain Directive**: VA National Pain Directive established
- **OSI and AD**: Created standardized metrics for pain management therapies to pilot Opioid Safety Initiative (OSI) and Select regions pilot Academic Detailing (AD)
- **OSI and PDSI**: Opioid Safety Initiative (OSI) expands nationally, Psychotropic Drug Safety Initiative (PDSI) launched nationally
- **Academic Detailing**: Academic Detailing (AD) expands nationally to enhance Veteran outcomes by promoting evidence-based treatments
- **Teams, CPGs, and AD**: Pain Management Teams at all VHA facilities (consistent with CARA requirements), VA-DoD develop Clinical Practice Guidelines (CPGs) on Opioid Therapy for Chronic Pain as well as Low Back Pain, Academic Detailing Opioid Use Disorder (OUD) Campaign

- **OHRM Initiative and PRIME Research**: Opioid High Risk Medication initiative, Policy requiring access to medication for OUD, VA Pain Research, Informatics, Multi-morbidities, and Education (PRIME) Center studies interaction between pain/associated chronic conditions and behavioral health factors
- **VA-DoD FIRST**: VA-DoD develop clinical practice guideline (CPG) on Opioid Therapy in Chronic Pain (FIRST)
- **OSI Launch**: Opioid Safety Initiative (OSI) launched in 5 regions
- **Targeted intervention and OEND**: Targeted interventions for opioid reduction in very high dose opioid patients, Overdose Education and Naloxone Distribution (OEND) campaign
- **SUD and CARA**: VA-DoD develop clinical practice guideline (CPG) on Management of Substance Use Disorder (SUD), Comprehensive Addiction and Recovery Act (CARA) implementation in VHA

Timeline:
- 2007
- 2008
- 2009
- 2010
- 2011
- 2012
- 2013
- 2014
- 2015
- 2016
- 2017
The Opioid Crisis - Nationally

• Presidential Memorandum: Addressing Prescription Drug Abuse and Heroin Use (Oct. 2015)
  – Training of all federal prescribers
  – Patients with OUD require access to addiction treatment incl. MAT

• CDC Opioid Prescribing Guidelines (March 2016)
  – Guidance for primary care providers
  – Recommendations includes non-opioid therapy as first line therapy for pain, limit opioid therapy to short duration/low dosage if possible, and specific dosage limits (50/90 mg MEDD)

• Comprehensive Addiction and Recovery Act (CARA) (July 2016)
  – Title IX: Jason Simcakoski Memorial Act with specific VHA mandates

• Presidential Opioid Commission Report (November 2017)
  – 56 recommendations
Comprehensive Addiction and Recovery Act (CARA)

PUBLIC LAW 114–198—JULY 22, 2016

• **Community interactions**: 90-day regular meetings.
• Expanded **VA Patient Advocacy program**.
• **VA/DoD Health Executive Committee Pain Management Workgroup**.
• System-wide implementation of the **Opioid Safety Initiative**.
  – Opioid risk mitigation strategies: PDMP, UDS, informed consent.
  – Opioid Overdose Education and Naloxone Distribution (OEND)
• **Dashboards** to assess risk and monitoring opioid/pain care
• **VA-DoD Clinical Practice Guideline** for Opioid Therapy of Chronic Pain.
• **Provider education** in VA-DoD CPG and evidence based pain care
• Reporting of providers/facilities in conflict with care standards
• Expanded **complementary and integrative health** modalities.
• Full compliance with **Stepped Care Model of Pain Management**
• **Pain Management Teams** at all VA facilities.
Addressing the Opioid Epidemic in the United States
Lessons From the Department of Veterans Affairs

Over the past 15 years, more than 165,000 people in the United States have died from overdoses related to prescription opioids, and millions more have suffered adverse consequences. The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.

Patients treated in the health care system of the Department of Veterans Affairs (VA) are part of this epidemic. Of the nearly 1 million veterans using the VA, more than half of veterans using the VA, compared with the national average, received 30 or more opioid prescriptions per year, and nearly two-thirds of those veterans had additional medical or psychosocial burdens.

The VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment (eTable in the Supplement).

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Gellad, Good CB, and Shulkin. JAMA Intern Med. 2017 May 1;177(5):611-612
In keeping with the Department of Veterans Affairs’ effort to be the most transparent agency in government, VA will begin posting information publicly on opioids dispensed from VA pharmacies, along with VA’s strategies to prescribe these pain medications appropriately and safely.

The interactive map shows data over a five-year period (2012-2017) and does not include Veterans’ personal information. The posted information shows opioid-dispensing rates for each facility and how much those rates have decreased over time. It is important to note that because the needs and conditions of Veterans may be different at each facility, the rates of the use of opioids may also be different for that reason, and cannot be compared directly.

The prescribing rate information will be updated semi-annually, on January 15 and July 15 of each year.

If you are having issues viewing the map please click here.
The Opioid Safety Initiative (OSI) is the coordinating center for all of VA's efforts to promote safe prescribing practices and to address the broader opioid epidemic in the United States.

Prescribing Rates
Opioid prescribing rates are calculated by dividing the number of Veterans who received any opioid prescription by the total number of Veterans who received a prescription from that pharmacy within the specified time period.

Percent Change
The percent change represents the relative decrease (or increase) in opioid prescribing rates between 2012 and 2017. Overall, 99% of VA facilities have decreased prescribing rates since 2012.

Regional Non-VA Prescribing Rate
It is well-established that opioid prescribing rates and abuse vary across different parts of the country. Regional comparison categories were generated using publicly available data from the Centers for Medicare & Medicaid Services (CMS). CMS reports opioid prescribing rates by state, which are calculated by dividing the number of Medicare Part D claims for opioid medications by the total number of prescription claims.

Data for states are aggregated in to 5 groups by CMS. The "Low" Regional Non-VA comparison category represents the 40% of states with the lowest prescribing rates for Medicare beneficiaries. The "High" Regional Non-VA comparison category represents the 40% of states with the highest prescribing rates. The "Average" Regional Non-VA comparison category represents the 20% of states in the middle. The most current available comparison data is from 2015.

<table>
<thead>
<tr>
<th>Facility</th>
<th>State</th>
<th>Rate in 2012</th>
<th>Rate in 2017</th>
<th>Percent Change</th>
<th>Non-VA Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louis Stokes Cleveland VA Medical Center</td>
<td>Ohio</td>
<td>5%</td>
<td>3%</td>
<td>-41%</td>
<td>Low</td>
</tr>
<tr>
<td>San Juan VA Medical Center</td>
<td>Puerto Rico</td>
<td>5%</td>
<td>3%</td>
<td>-34%</td>
<td>n/a</td>
</tr>
<tr>
<td>Edith Nourse Rogers Memorial Veterans' Hospital</td>
<td>Massachusetts</td>
<td>6%</td>
<td>4%</td>
<td>-34%</td>
<td>Low</td>
</tr>
<tr>
<td>East Orange VA Medical Center</td>
<td>New Jersey</td>
<td>6%</td>
<td>4%</td>
<td>-27%</td>
<td>Low</td>
</tr>
<tr>
<td>Manhattan VA Medical Center</td>
<td>New York</td>
<td>8%</td>
<td>4%</td>
<td>-49%</td>
<td>Low</td>
</tr>
</tbody>
</table>

OSI Parameters

OSI Dashboard (PBM) – quarterly updated

1. Opioid use overall, and Long-term opioid use
2. Opioid and Benzo co-prescribing
3. High dose >100 MEDD
4. UDS in Veterans on long-term opioid therapy within the last 12 months
   • Report for provider specialty
   • Report of all providers with high opioid prescribing / Outliers

• Informed consent policy issued 2014, for all pts on LTOT (90 d)
• PDMP checks policy issued 10/2016, at least annually, for > 5 d supply
• OEND – Overdose Education and Naloxone Distribution
  Naloxone prescribed for all pts at risk, broad inclusion, no cost to Veteran
• Timely f/u with prescriber at least q3 months
Veterans with Dispensed Opioid Medication
Q4 FY2012 to Q1 FY2018

- 17.2% of pts with pharmacy activity
- 9.7% Opioid patients (excludes tramadol)

Patients with opioid dispensed as percentage of all patients with pharmacy activity (excludes tramadol)
Veterans with Opioid and Benzodiazepine
Q4 FY2012 to Q1 FY2018

13.9% of opioid patients

Opioid data include patients on tramadol
Patients on opioid therapy (excluding tramadol) dispensed in the selected quarter and ≥90 days total cumulative supply of opioid medications in the last two quarters.
Veterans Dispensed Greater Than Or Equal to 100 MEDD*

<table>
<thead>
<tr>
<th>Veterans (n)</th>
<th>Q4 FY12</th>
<th>Q4 FY13</th>
<th>Q4FY14</th>
<th>Q4FY15</th>
<th>Q4FY16</th>
<th>Q4FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>59,499</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>60% Reduction</td>
<td>35,531 fewer Veterans</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Source: Pharmacy Benefits Management (PBM) Services

*MEDD = Morphine Equivalent Daily Dose
All Opioid and High Dose Opioid Therapy
Q1 FY2003 to Q4 FY2017

Veterans with opioid (incl. tramadol)

Veterans with high dose >100 mg

869,956 Veterans in Q4 FY2013
543,782 in Q1 FY2018
60,299 Veterans in Q3 FY2011
23,968 in Q1 FY2018

Veterans

Q1 FY2003
FY03 Q1
FY03 Q3
FY04 Q1
FY04 Q3
FY05 Q1
FY05 Q3
FY06 Q1
FY06 Q3
FY07 Q1
FY07 Q3
FY08 Q1
FY08 Q3
FY09 Q1
FY09 Q3
FY10 Q1
FY10 Q3
FY11 Q1
FY11 Q3
FY12 Q1
FY12 Q3
FY13 Q1
FY13 Q3
FY14 Q1
FY14 Q3
FY15 Q1
FY15 Q3
FY16 Q1
FY16 Q3
FY17 Q1
FY17 Q3
FY18 Q1

Q1 FY2018
High Dose Opioid Therapy
Q1 FY2003 to Q1 FY2018

Veterans

60,299 Veterans in Q3 FY2011
23,968 Veterans in Q1 FY2018
Q1FY18: Top 10 Prescriber Specialties*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Count (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician**</td>
<td>10,562</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>4,145</td>
</tr>
<tr>
<td>Nurse Practitioner**</td>
<td>3,528</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2,428</td>
</tr>
<tr>
<td>Physician Assistant**</td>
<td>2,049</td>
</tr>
<tr>
<td>Surgery</td>
<td>1,922</td>
</tr>
<tr>
<td>Dentist</td>
<td>1,509</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1,330</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>678</td>
</tr>
</tbody>
</table>

*Prescribers must have prescribed at least one opioid to be included in the count.

**Specialty was not defined in administrative data.
Average Daily Morphine Milligram Equivalent (MME)

<table>
<thead>
<tr>
<th>Daily Morphine Equivalent Dose</th>
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<tbody>
<tr>
<td>65.0</td>
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<tr>
<td>60.0</td>
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<tr>
<td>55.0</td>
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<tr>
<td>50.0</td>
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<tr>
<td>45.0</td>
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<tr>
<td>40.0</td>
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<tr>
<td>35.0</td>
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<tr>
<td>30.0</td>
</tr>
<tr>
<td>25.0</td>
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<tr>
<td>20.0</td>
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</tbody>
</table>

**VA MME per Rx**

**CDC MME per Rx**

[https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm#T1_down](https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm#T1_down)

VA: Pharmacy Benefits Management (PBM) Services

*NOTE: VA data is Fiscal Year (October to September) and CDC is Calendar Year*
Opioid Utilization Rates, 2013-2016*

![Graph showing opioid utilization rates from 2013 to 2016 for the United States (All Ages) and Centers for Medicare and Medicaid Services (CMS) Part D.]

- **United States (All Ages)**
- **Centers for Medicare and Medicaid Services (CMS) Part D**

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**VA**: Pharmacy Benefits Management (PBM) Services.

*NOTE: VA data is Fiscal Year (October to September) and CDC and CMS is Calendar Year*
Community Care/Choice: Veterans Dispensed an Opioid

Opioid Patients # (Choice)

- Q1FY15
- Q2FY15
- Q3FY15
- Q4FY15
- Q1FY16
- Q2FY16
- Q3FY16
- Q4FY16
- Q1FY17
- Q2FY17
- Q3FY17
- Q4FY17
- Q1FY18
VA Office of Inspector General report on opioid prescribing, dated Aug 1, 2017
“Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care”

- Veterans receiving opioid prescriptions from VA-referred clinical settings may be at greater risk for overdose and other harm because medication information is not being consistently shared.

- “Healthcare providers serving veterans should be following consistent guidelines for prescribing opioids and sharing information that ensures quality care for high-risk veterans.”

- OIG recommendations:
  - Non-VA providers to review the evidence-based guidelines for prescribing opioids in the OSI.
  - Include in care consults an updated list of the patient’s medications and medical history.
  - Require non-VA providers to submit opioid prescriptions directly to VA pharmacies
  - If opioid prescribing in conflict with OSI guidelines: facility must take action to ensure safety.

- Letter was sent out by facilities to all Non-VA providers by January 8, 2018.

Patients receiving long-term opioid therapy should be monitored and reassessed at least every 3 months, with greater frequency based on risk.

Always maintain vigilance for sedation, declining function, evidence of opioid use disorder or other opioid related harms.

Each follow-up interaction with the patient is an opportunity to provide education about self-management strategies and the risks associated with opioid therapy while optimizing whole person approaches to pain care and treatment of comorbid health conditions.

**Essential components of Opioid Safety include:**

1. An informed consent for long-term opioid therapy.
2. Prescription drug monitoring programs (PDMPs).
3. Random urine drug testing.
4. Overdose education, and naloxone distribution as appropriate (OEND).
Informed consent (via I-Med) is required for all patients on Long Term Opioid Therapy (LTOT), defined as > 90 days (excluding patients enrolled in hospice, on opioids for cancer pain, when oral consent is sufficient).

- Opportunity to discuss risks of and alternatives to long-term opioid therapy with the veteran.
- Provides some protection to provider and facility in case of harm to the patient related to opioid therapy.
- Brochure “Taking Opioids Responsibly” should given to the patient.
- Currently being updated.

January 05, 2018 report:
- National Score: 89.7%

As of January 2018, 48 states and the District of Columbia are activated for PDMP data transmission.

States share data through PMP InterConnect

- Veterans in VHA: 23.9% received controlled substance, and 12% opioids
- From Q3 FY 2013 to Q4 FY 2017, VA providers documented > 2.3 million queries
- Long-Term Opioid Therapy Patients with a PDMP within the last 365 days: 70.2% (Jan. 2017)

MO just recently established a statewide PDMP by executive order. NE’s program has transitioned to Appriss AWARxE and work is underway to initiate transmissions; state working to implement FIPS 140-2 cryptography required for federal data sharing. VA-NSOC requires specific security documentation in order to open the firewall for outbound transmissions.
National: State Prescription Drug Monitoring Program (PDMP) Queries and the Number of Veterans Dispensed a Controlled Substance Prescription*

*Queries are underestimated because documentation was not standardized system-wide prior to publication of VHA Directive 1306

Source: Pharmacy Benefits Management (PBM) Services
• **Overdose Education (OE)**
  – Education on how to prevent, recognize, and respond to an opioid overdose.

• **Naloxone Distribution (ND)**
  – FDA approved as naloxone autoinjector and nasal spray.
  – Dispense and train patient and caregiver/family.

• Target patient populations: OUD, and prescribed opioids.
• Highly successful: > 100,000 kits dispensed to > 70,000 Veterans
• From May 2014 to Jan 2016, 172 overdose reversals documented
• **Offer naloxone when factors that increase risk for opioid overdose are present:** h/o overdose, h/o SUD, higher opioid dosages (≥50 MMED), or concurrent benzodiazepine use.
• No cost to patients (elimination of copays for naloxone and training, as per CARA)
**Academic Detailing**

- **In-person** educational outreach
  - Information is provided *interactively* so the academic detailer can:
    - **Understand** where the provider is coming from in terms of knowledge, attitudes, and *personal motivations* for practice
    - **Modify** the interaction to meet the needs of the provider
    - **Engage** the provider by acknowledging their expertise and learning together rather than teaching

- Uses balanced evidence-based information and tools
- Delivered by a healthcare professional specially skilled in empathic persuasive communication
- Over time, the educator and provider develop a trusted and useful *relationship*
- Multiple campaigns incl. Pain Management, Opioid Safety Initiative, Opioid Use Disorder (OUD), Insomnia; Psychotrophic Drug Safety Initiative (PDSI), incl. benzodiazepines.

Academic Detailing: Impact on Naloxone Prescribing

Chart 4. Academic Detailing’s impact on naloxone distribution at the provider level.

@12 months
IRR=3.2
(95% CI: 2.0, 5.3)

@24 months
IRR=7.4
(95% CI: 3.0, 17.9)

Average number of naloxone prescribed per month per provider

Time (month)

AD-exposed
AD-unexposed
Chart 1: Reduction in Veterans on High Dose Opioids (>100 MEDD).

- 58% reduction in high dose opioids patients with providers who received AD intervention
- 34% reduction for providers unexposed to AD
Self Care/Active non-Pharmacologic Therapies
SOTA 2016

- Cognitive Behavioral Therapy (CBT)
- Acceptance & Commitment Therapy (ACT)
- Mindfulness Based Stress Reduction (MSBR)
- Yoga
- Tai Chi
- Aerobic Exercise
- Coordination/ Stabilisation Exercise
- Resistance Exercise
- Exercise/ Movement Therapies
- Behavioral/ Psychological Therapies
- Massage
- Acupuncture
- Manipulation

Alliance for Balanced Pain Management
The Whole Health approach is a reorientation of the Veteran's relationship with VA. It combines state-of-the-art conventional medicine with personalized health planning, complementary and integrative health approaches, and innovative self-care approaches.

### Whole Health System Flagship Sites

**Key**
- FY16 Original Design Sites
- FY17 Additional Design Sites

[Map of Whole Health System Flagship Sites]
• Predicts individual risk of overdose or suicide-related health events or death in the next year.
• For patients on opioids and when considering opioid therapy.
• Identifies patients at-risk for opioid overdose-/suicide-related adverse events.
• Provides patient-centered opioid risk mitigation strategies.
• Risk score is designed to support treatment planning. The goal should be to design a treatment plan that addresses risk factors and is appropriate for the patients risk level.
• [https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx](https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx)
• Tool optimized for PACT: review their panel for all patients on long-term opioids
• Included in CPRS under Tools → Primary Care Almanac.
• Veteran lookup by SSN
• Multitude of factors that potentially increase risk incl. MH diagnoses

• Opioid risk mitigation parameters including last PDMP check
• Updated nightly
• Individual report includes Visual display
  • Opioid dosage
  • Pain score (severity)
• LTOT definition: opioid dispensed in the last 90 days and total days supply ≥ 90 days in the past 180 days
The guideline describes the critical decision points in the Management of Opioid Therapy (OT) for Chronic Pain and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. The workgroup consensus statements are provided to minimize harm and increase patient safety in patients requiring opioid therapy.

Disclaimer: This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment.

Guideline Links
- OT Full Guideline (2017)
- OT Provider Summary (2017)
- OT Pocket Card (2017)

Patient-Provider Tools
- OT Patient Summary (2017)
- Managing Side Effects Fact Sheet (2017)

Related Guidelines
- Substance Use Disorder (SUD)

http://www.healthquality.va.gov/guidelines/Pain/cot/
“**We recommend against initiation of long-term opioid therapy**”. **We recommend alternatives to opioid therapy** such as self-management strategies and other non-pharmacological treatments. When pharmacologic therapies are used, we recommend non-opioids over opioids”.

- Recommendation against opioid therapy in patients < 30 years of age, in patients with active substance use disorder, and in combination with benzos.
- Recommendation for risk mitigation strategies, including urine drug testing, PDMP, overdose education, naloxone distribution.
- If prescribing opioids: short duration and lowest dosage.
- **No dosage is safe**; Strong rec against of opioids to > 90 MEDD.
- **Opioid dosage reduction should be individualized to patient**. Avoid sudden reductions; taper slowly if opioid risk>benefit.
- Suicide prevention in pain patients.
- Use multimodal pain care.
- Acute pain: use alternatives to opioids; if opioids ≤ 3-5 days.
- For OUD, offer medication assisted treatment.

https://www.healthquality.va.gov/guidelines/Pain/cot/
Impact of the Opioid Safety Initiative on opioid related prescribing in veterans

Lin et al, Pain 2018

- Interrupted time series analyses
- October 2012 to September 2014

- High-dosage opioid >100 MME: 331 per month reduction due to OSI
- High dosage opioid > 200 MME: 164 per month reduction due to OSI
- Benzodiazepine coprescribing: 781 per month reduction due to OSI
Reduction in Opioid Prescribing in VHA

Decline in Prescription Opioids Attributable to Decreases in Long-Term Use: A Retrospective Study in the Veterans Health Administration 2010–2016

Hadlandsmyth et al, J Gen Intern Med 2018

- 83% of decline in opioid scripts due to decreases in LOT.
- 90% of reduction from fewer new LOT prescription fills.
- < 10% from increases in cessation of existing LOT users
Reduction in Opioid Prescribing in VHA

Decline in Prescription Opioids Attributable to Decreases in Long-Term Use: A Retrospective Study in the Veterans Health Administration 2010–2016

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- 90% of reduction from fewer new LOT prescription fills.
- <10% of reduction from increases in cessation of existing LOT users.
Opioid Tapering Considerations

• Several factors go into the speed of taper selected:
  – **Slower, more gradual tapers are often the most tolerable and can be completed over a several months to years based on the opioid dose**
  – The longer the duration of the opioid therapy, the longer the taper
  – CDC: “… patients tapering opioids after taking them for years might require very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages.”

• **Most commonly, tapering will involve dose reduction of 5-20% every 4 weeks.**

• More rapid tapers may be required in situations where the risks of continuing the opioid outweigh the risks of a rapid taper.

• **SUDDEN interruption of opioid prescribing must be avoided** for opioid dependent patients with few exceptions (safety issues, diversion, etc.)

• F/u is recommended within 1 to 4 weeks after dosage adjustment.
Approaching Opioid Tapering.

- Integrated approach with patient buy-in and active participation leads to improved pain control and enhanced quality of life.
- Goal is to improve function and long-term outcome while reducing risk.
- Provider approach: empathetic, personalized, building trust.
- Patients are often scared about opioid dosage reduction, and some are desperate, especially if they have features of opioid use disorder.
- Expectations should be clear and reasonable/achievable. The patient needs a clear plan that appears manageable and helps avoid or minimize fear or anxiety.
- Close collaboration with mental health providers including addiction medicine is recommended for many patients - evaluation for OUD and, if present, referral to Medication-Assisted Treatment is usually indicated.
- Caution: Involuntary tapers may carry significantly greater risk than voluntary tapers, and interfere with collaborative provider/patient relationship and shared decision making.
SUD and OUD in VHA

• Prevalence of SUD in VHA –
  – 10% of Veterans (600,000 in FY 2015)
  – AUD >> other SUD

• “Diagnosed” OUD
  – 1.1% of Veterans (FY 2015)
  – About 60,000 Veterans total
  – 23,000 Veterans on MAT (2016)

• What is the Prevalence of OUD in Veterans on long-term opioids?
  – Estimate of 25 to 40% of LOT patients?
  – How many truly have OUD? 10,000 to 100,000 Veterans?
  – How many need addiction medicine? MAT?
Stepped Care Model for Pain Management

**VA-DoD Stepped Pain Care**

**Speckled model**

- **Step 1**
  - **Patient Aligned Care Team (PACT) in Primary Care**
    - Routine screening for presence & severity of pain; Assessment and management of common pain conditions; Support from MH-PC Integration; OEF/OIF, & Post-Deployment Teams; Expanded care management; Pharmacy Pain Care Clinics; Pain Schools; CAM integration
  - **Patient/Family Education and Self Care**
    - Understand BPS model; Nutrition/weight mgmt, exercise/conditioning, & sufficient sleep; mindfulness meditation/relaxation techniques; engagement in meaningful activities; family & social support; safe environment/surroundings

- **Step 2**
  - **Secondary Consultation**
    - Multidisciplinary Pain Medicine Specialty Teams; Rehabilitation Medicine; Behavioral Pain Management; Mental Health/SUD Programs

- **Step 3**
  - **Tertiary, Interdisciplinary Pain Centers**
    - Advanced pain medicine diagnostics & interventions; CARF accredited pain rehabilitation

**Comorbidities**

**TREATMENT**

**Refractory**

**VA-DoD Stepped Pain Care**

**Complexity**
CARA mandates designated Pain Management Teams at all VA facilities

Developed the Pain Management Team standards and provided the information to directors regarding reporting requirements.

Veterans must have timely access to specific components of pain care that are available system-wide

Coordination between the different clinical areas is essential to promote efficient use of resources and smooth transition of the Veteran between the care areas.

Facility with higher complexity may be tasked to provide services to lower resourced facilities via tele-health/VA-ECHO, as VISN-supported hubs.

Field Data call for the collection of the Facility Director Reports on Pain Management Teams is ongoing.
The functions of the Pain Management Team (PMT) include:

• Evaluation and follow-up of pts with complex pain conditions
• Medication management and actual prescribing of pain meds, as needed.
• OSI Reviews: Review of patients with high risk opioid prescriptions with provision of recommendations to clinical providers

• At a minimum, the composition of the PMT must include:
  • Medical Provider with Pain Expertise
  • Addiction Medicine expertise to provide evaluation for Opioid Use Disorder (OUD) and access to Medication-Assisted Treatment (MAT)
  • Behavioral Medicine with availability of at least one evidence-based behavioral therapy.
  • Rehabilitation Medicine discipline.
The PCP and the OSI.... ?

Caution: Perceived Burden on the PCP
Integrated Pain Care in VHA

Collaborative Care that centers around the patient and supports the PCP/PACT team
“Development and Applications of the Veterans Health Administration’s Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide” Oliva et al, Psych Serv 2016

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds Ratio</th>
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<tr>
<td>Age (years)</td>
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<td>&lt;=30</td>
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<tr>
<td>31–50</td>
<td>3.5</td>
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<tr>
<td>&gt;=66 (reference)</td>
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<th>Previous treatment risk indicators</th>
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<td>Previous overdose/suicide</td>
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<tr>
<td>Detoxification</td>
<td>18.5</td>
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<tr>
<td>Inpatient MH treatment</td>
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<tr>
<td>ER visit</td>
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<table>
<thead>
<tr>
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<tr>
<td>Opioid type, tramadol=reference</td>
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<td>Tier 1 (long acting)</td>
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<td>Tier 2 (chronic, short acting)</td>
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<tr>
<td>Tier 3 (acute, short acting)</td>
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<td>Coprescription with sedatives</td>
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<tr>
<td># of classes other sedating</td>
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<tr>
<td>1</td>
<td>2.1</td>
</tr>
<tr>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>3</td>
<td>6.1</td>
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### STORM Risk Factors for Overdose/Suicide

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<th>Variable</th>
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<tr>
<td><strong>Substance use disorders</strong></td>
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<td>Opioid use disorder</td>
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<td>Alcohol use disorder</td>
<td>5.3</td>
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<td>Tobacco use disorder</td>
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<td>Sedative use disorder</td>
<td>11.2</td>
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<tr>
<td>Stimulant use disorder</td>
<td>8.1</td>
</tr>
<tr>
<td>Cannabis/hallucinogen use disorder</td>
<td>5.9</td>
</tr>
<tr>
<td>Other substance use disorders</td>
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<tr>
<td><strong>Mental Health disorders</strong></td>
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<td>Posttraumatic stress disorder</td>
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<td>Major depressive disorder</td>
<td>4.8</td>
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<tr>
<td>Bipolar disorder</td>
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<tr>
<td>Other mental health disorder</td>
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<td><strong>Medical comorbidities</strong></td>
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<td>AIDS</td>
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<td>Liver disease</td>
<td>2.2</td>
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<tr>
<td>Other neurological disorder</td>
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<tr>
<td>Electrolyte disorders</td>
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<tr>
<td>Weight loss</td>
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<tr>
<td>Coagulopathy</td>
<td>1.4</td>
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<tr>
<td>Paralysis</td>
<td>1.4</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary</td>
<td>1.3</td>
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<tr>
<td>Metastatic cancer</td>
<td>1.3</td>
</tr>
<tr>
<td>Pulmonary circulation disorder</td>
<td>1.3</td>
</tr>
<tr>
<td>Sleep apnea</td>
<td>1.2</td>
</tr>
<tr>
<td>Deficiency anemia</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Oliva et al, Psych Serv 2016
### Opioids and Suicide

**Opioid dose and risk of suicide**

Mark A. Ilgen, Amy S. Bohnert, Dara Ganoczy, Matthew J. Bair, John F. McCarthy, Frederic C. Blow

- VA patients with chronic pain receiving opioids in FY 2004-2005 (N=123,946).
- 2,601 patients died by suicide before the end of 2009.
- Controlling for demographic and clinical characteristics, higher prescribed opioid doses were associated with elevated suicide risk.
  - Compared with those receiving ≤20 mg/d
  - 20 to <50 mg/d HR 1.48 (95% CI, 1.25-1.75)
  - 50 to <100 mg/d HR 1.69 (95% CI, 1.33-2.14)
  - 100+ mg/d HR 2.15 (95% CI, 1.64-2.81)
- **Veterans receiving the highest doses of opioid painkillers were more than twice as likely to die by suicide.**
- The researchers could not tell, however, whether there was a direct causal link between the pain medications and suicide risk.
- **→ High doses may be a marker for other factors that drive suicide,** including unresolved severe chronic pain.
What is the Impact of Opioid Safety Policies?

**Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates**

Dowell et al, Health Affairs 2016

- IMS Health’s National Prescription Audit and government mortality data to examine the effect of these policies on opioid prescribing and on prescription opioid and heroin overdose death rates in the United States during 2006 – 13.
- Combined implementation of mandated provider review of state-run prescription drug monitoring program data and pain clinic laws reduced opioid amounts prescribed by 8 percent and prescription opioid overdose death rates by 12 percent.
- We observed relatively large but statistically insignificant reductions in heroin overdose death rates after implementation of these policies.
Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review

Frank et al, Ann Intern Med 2017

• 67 studies (11 randomized trials and 56 observational studies) examining 8 intervention categories, including interdisciplinary pain programs, buprenorphine-assisted dose reduction, and behavioral interventions, were found.

• Study quality good for 3 studies, fair for 13 studies, poor for 51 studies.

• Among 40 studies examining patient outcomes after dose reduction (very low overall quality of evidence), improvement was reported in pain severity (8 of 8 fair-quality studies), function (5 of 5 fair-quality studies), and quality of life (3 of 3 fair-quality studies).

• Conclusion: Very low quality evidence suggests that several types of interventions may be effective to reduce or discontinue LTOT and that pain, function, and quality of life may improve with opioid reduction.
The Opioid Crisis is Continuing in the US

- Opioid overdose deaths continue to climb
- Large number of the population that has been exposed to opioids
- Availability of illicit opioids
- Lethality of illicit substances
- High rate of OUD/complex dependence
- OUD/Addiction continues to be stigmatized
- Lack of resources for OUD care and challenges to enter treatment program
- High relapse/failure rate in patients with OUD, esp. if not on MAT
- Fragmented, poorly integrated care
Veterans on opioid medication in FY 2010 who had their opioid therapy discontinued by FY 2011 were compared with Veterans who stayed on opioids.

Groups did not differ in opioid overdose rates.

Evidence that Veterans with opioid discontinuations had elevated suicide rates compared to Veterans who remained on opioid therapy.

Patients with MH, and in particular SUD comorbidities, are highly vulnerable, especially if they were on high dose opioid medication.

Veterans with opioid discontinuation may have greater behavioral or medical risks for OD/Suicide than patients remaining on opioid therapy.

High risk on the STORM dashboard suggests the need for active risk management, such as close f/u and case management/care coordination.

Interdisciplinary OSI Reviews using STORM data can identify patients at very high risk for OD/Suicide. These care reviews may allow the interdisciplinary OSI review team to focus resources on such patients including case management.

MH and Addiction medicine providers must be part of the OSI review teams to maximize benefit and allow for care coordination.
The missing ‘P’ in pain management: how the current opioid epidemic highlights the need for psychiatric services in chronic pain care.

Howe CQ, Sullivan MD

“The opioid epidemic thus reflects a serious unmet need for better recognition and treatment of common mental health problems in patients with chronic pain. Psychiatry is the missing P in chronic pain care.”

Rates and Correlates of Pain Specialty Clinic Use Nationally in the Veterans Health Administration.

Arout CA, Sofuoglu M, Rosenheck RA

“Patients attending pain specialty clinics have more difficult-to-treat pain conditions and comorbid, psychiatric disorders (...), use more outpatient services, and receive a greater number of opioid prescriptions. These data support the inclusion of mental health care in the specialized treatment of chronic pain.”
S.T.O.P. P.A.I.N. Toolbox

Toolbox available to the public on our website:
https://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp

- Stepped care model
- Treatment alternatives/complementary and integrative care
- Ongoing monitoring of usage
- Practice guidelines
- Prescription monitoring
- Academic detailing
- Informed consent for patients
- Naloxone distribution
Summary – VHA OSI and Pain Teams

1. In accordance with CARA, VHA is reducing reliance on opioid medication for chronic pain management, providing safer prescribing and monitoring practices, and Veteran-centric, biopsychosocial pain care.

2. The majority of Veterans with chronic pain conditions receive their care from Primary Care. **Well-trained PACT teams** must be supported with access to patient education/self-care programs and non-pharmacological pain treatment modalities. The PACT Pain Roadmap is a valuable tool.

3. Veterans with high impact/severe chronic pain benefit from biopsychosocial pain care by an **interdisciplinary Pain Team that works collaboratively** with Primary Care. Pain Management teams at all facilities to support PACT are legislatively mandated by CARA.

4. **Telehealth, E-consultation, VA-ECHO** are tools to maximize resources.

5. MH comorbidities are common in patients with chronic pain. **Integration of MH providers and access to OUD treatment** within Pain teams and Primary care are essential for success.

6. **Centralized pain care reviews** by interdisciplinary pain teams allow targeted interventions to minimize risk and optimize outcomes.
Thank You

Contact information:  
**friedhelm.sandbrink@va.gov**  
Phone 202-745-8145

- VACO, VISN and Facility leadership  
- VISN POCs and all facility POCs for PAIN  
- OSI POCs and the OSI review committees  
- Pain research community  
- Pain Medicine Specialty Teams  
- Pain Psychologists  
- PACT Pain Champions, Primary Care  
- PBM/Pharmacy  
- Academic Detailing  
- Mental Health  
- Suicide Prevention  
- Addiction Medicine  
- Nursing Service  
- Rehabilitation Medicine  
- Integrative Health, IHCC and OPCC  
- EES, Ethics  
- Connected Care/Telehealth  
- The Veterans and their families

www.va.gov/painmanagement