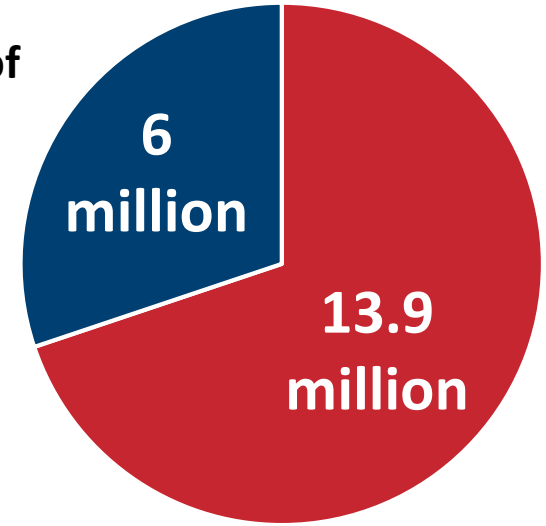
The Opioid Crisis: Treating Our Nations Veterans

6 million Veterans use VA healthcare (about 30% of all Veterans)



Veterans who do not use VA healthcare

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Associate Chief of Staff for Education

VA Maryland Health Care System

No relevant financial relationships or conflicts of interest. No discussion of off-label use of drugs or devices.

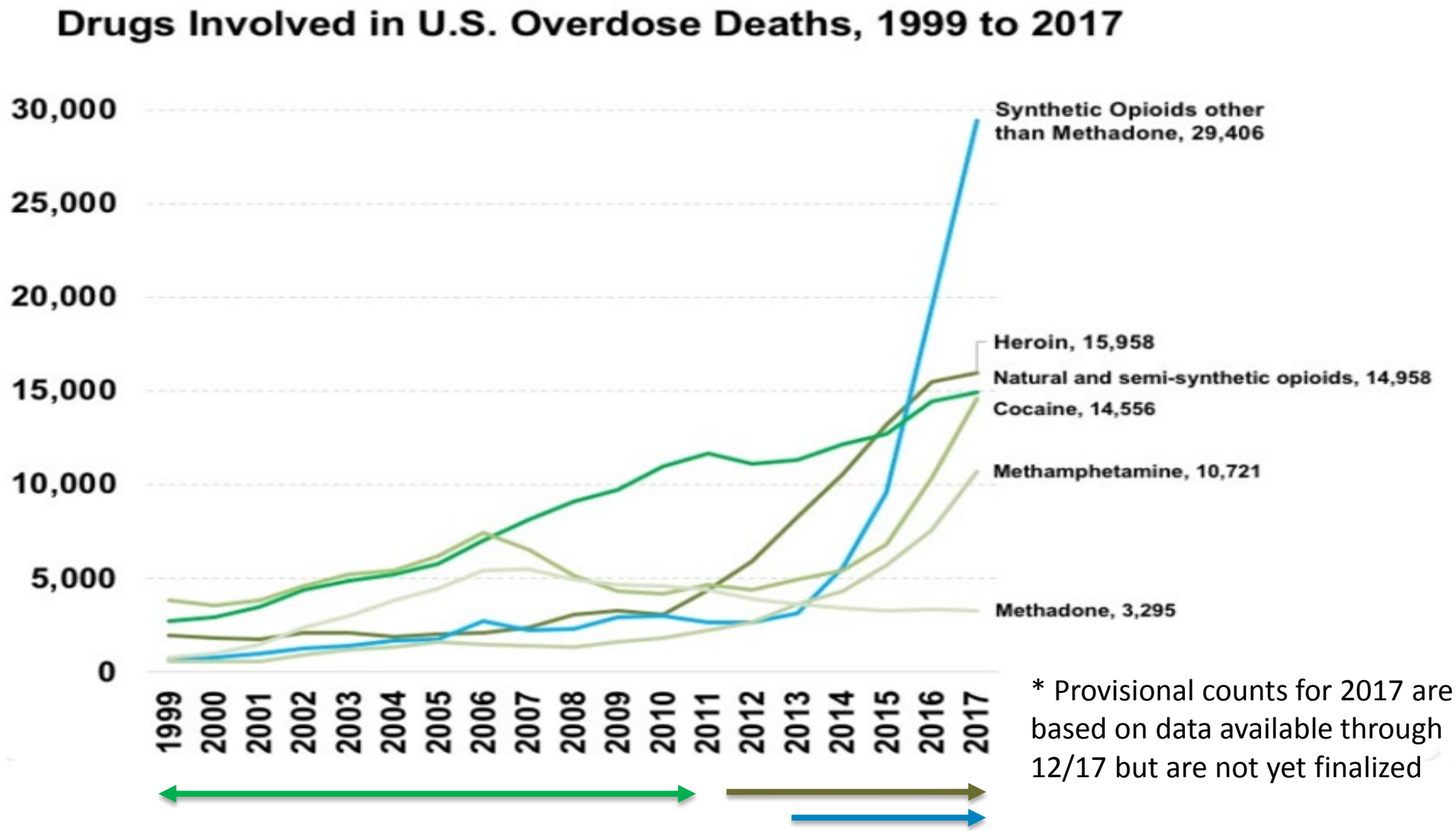
The presentation is the personal opinion of the presenter and does not reflect the official views of the Department of Veterans Affairs or any other Federal Agency.

OUTLINE

- **Epidemiology of Opioid Overdose, SUD and Chronic Pain**
- Pharmacology of Opioids and Treatment of Opioid Use Disorders/ Overdose
- Assessing Veterans
- VHA Initiatives to Address the Opioid Epidemic

Overdose Deaths Involving Opioids: 3 Waves

1) **Natural and semi-synthetic opioid deaths increased 4-fold from 1999 to 2011;** Methadone rate increased 6-fold from 1999 to 2007
2) **Heroin death rate increased over 5-fold since 2011**
3) **Synthetic opioid (excluding methadone) death rate increased more than 6-fold from 2013 to 2016**



* Provisional counts for 2017 are based on data available through 12/17 but are not yet finalized

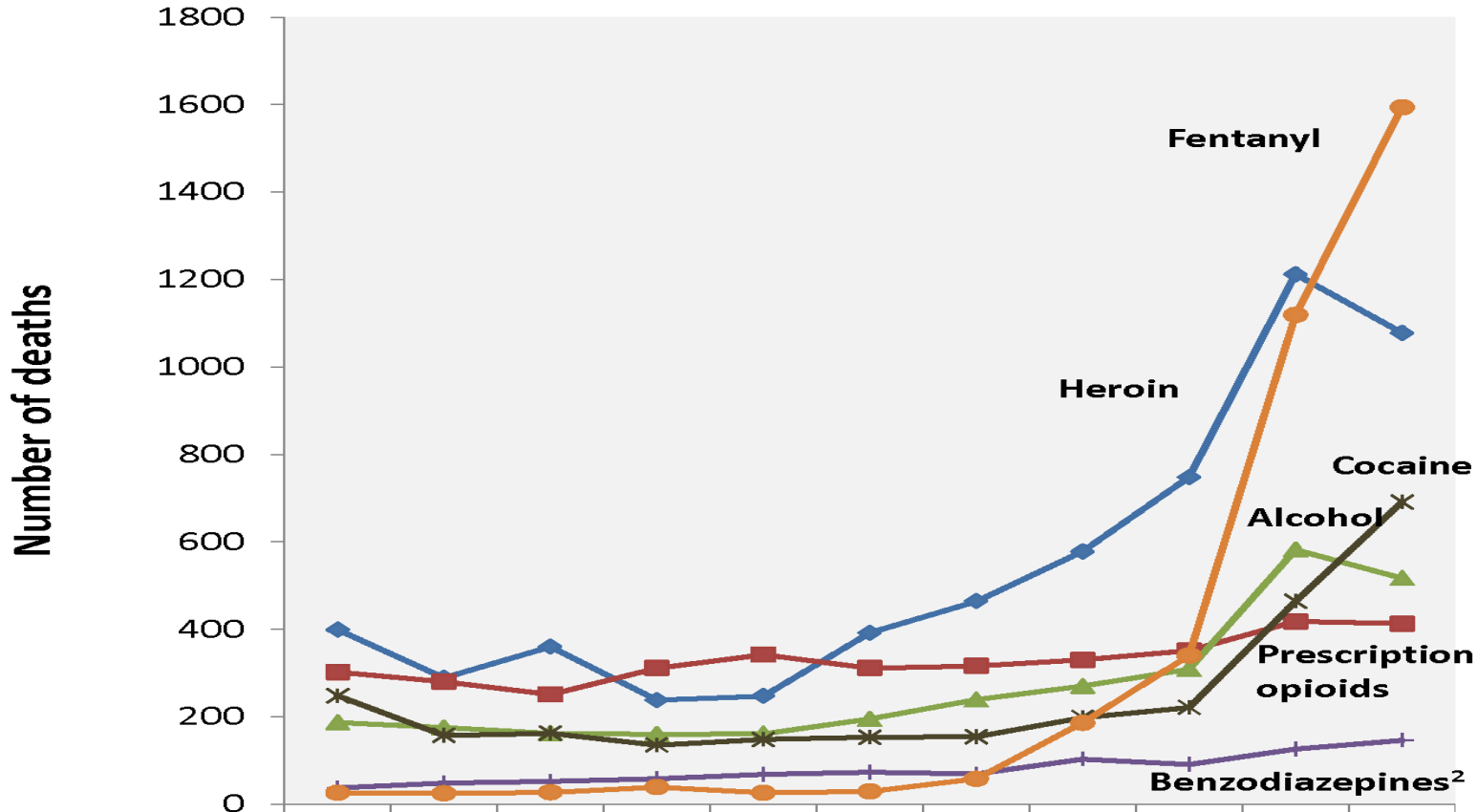
https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

United States (2017)

- More than 47,000 Americans Died of an Opioid Overdose (~ 130 per day)
- Approximately 1.7 Million have an Opioid Use Disorder related to Opioid Pain Relievers
- Approximately 650,000 have a Opioid Use Disorder related to heroin

National Institute on Drug Abuse

Total Number of Drug- and Alcohol-Related Intoxication Deaths by Selected Substances1, Maryland, 2007-2017.

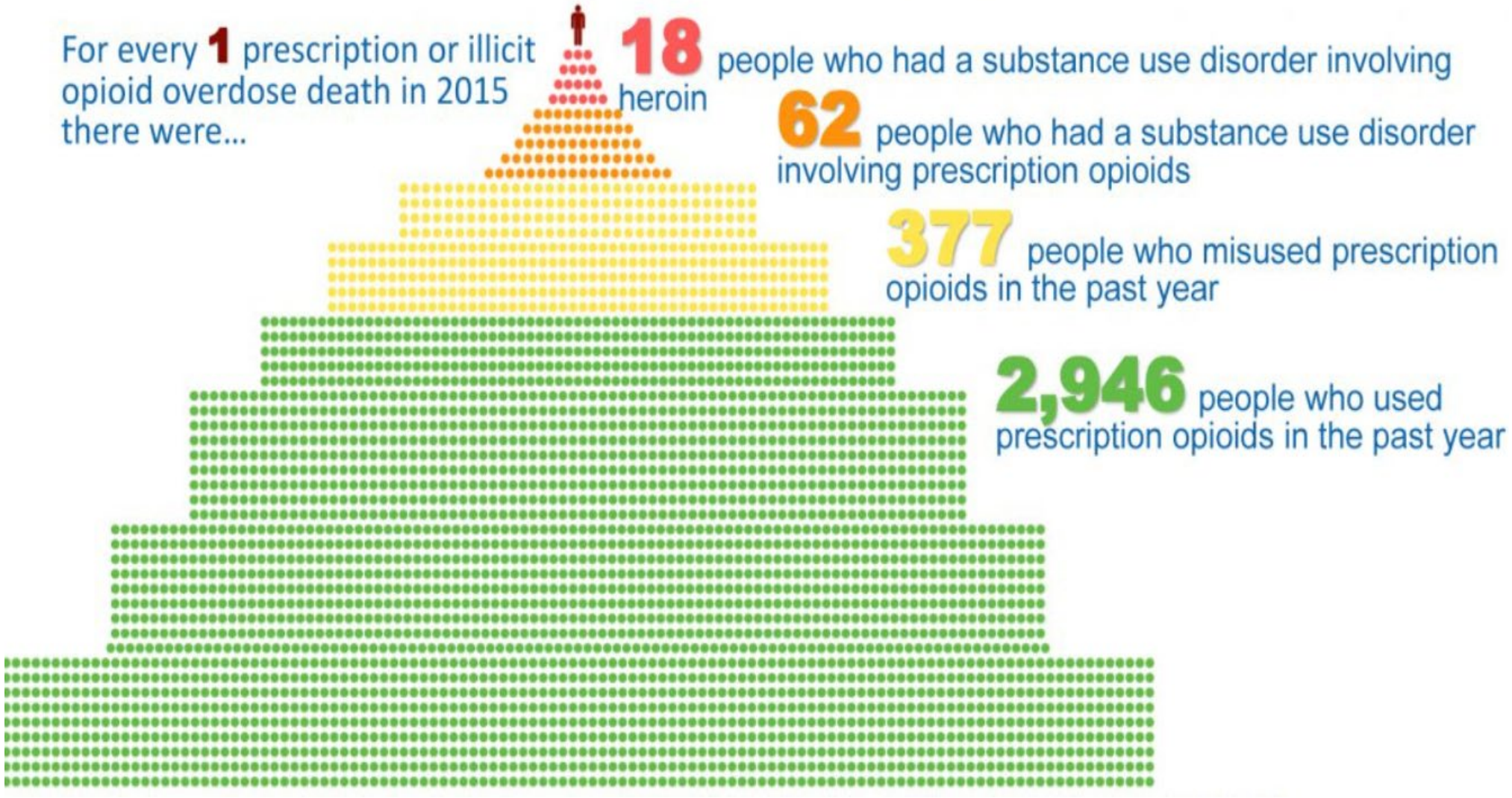


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Heroin	399	289	360	238	247	392	464	578	748	1212	1078
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413
Alcohol	187	175	162	160	161	195	239	270	309	582	517
Benzodiazepines	37	48	52	58	68	73	69	103	91	126	146
Cocaine	248	157	162	135	148	153	154	198	221	464	691
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594

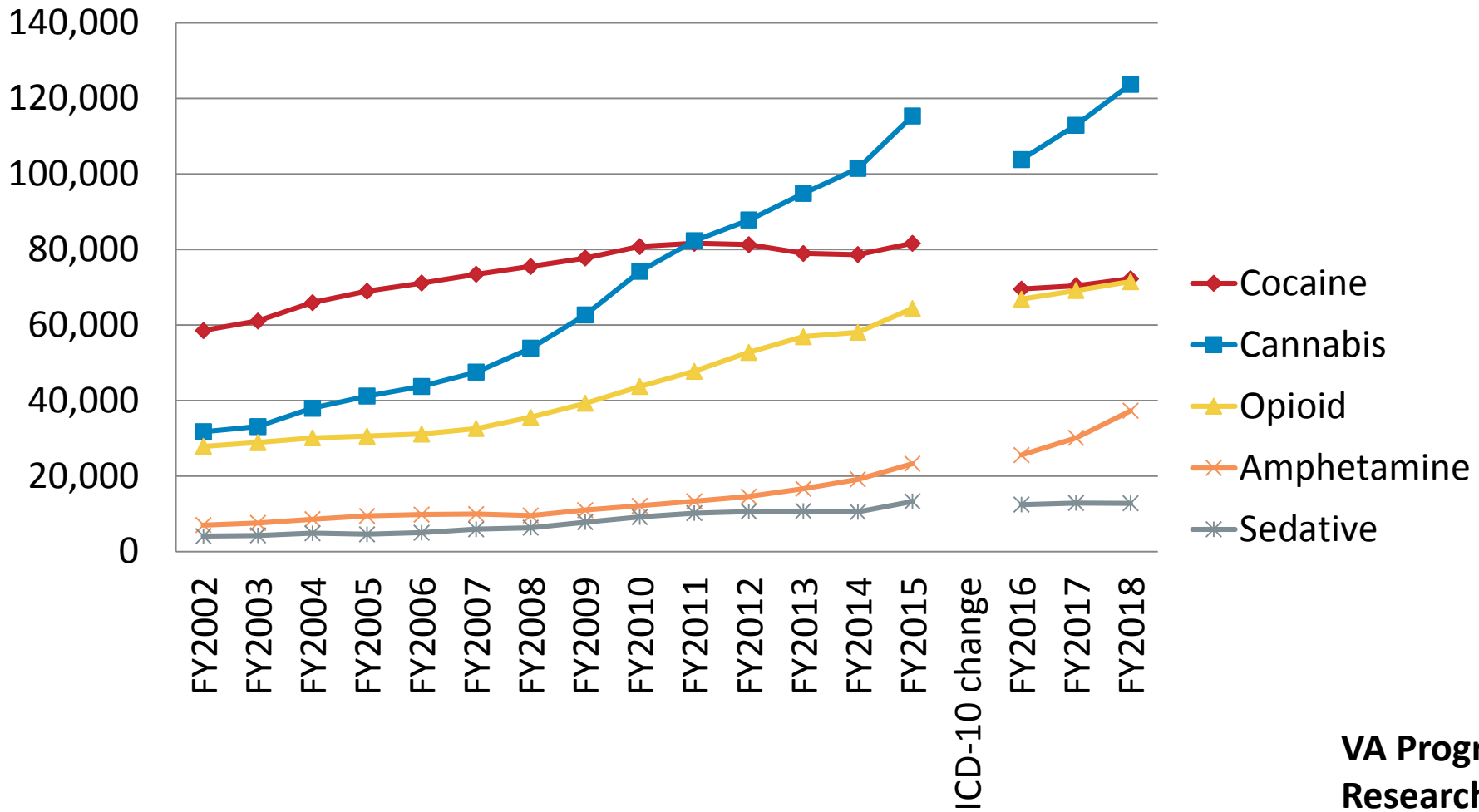
[1]Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.
[2]Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

MARYLAND
Department of Health

Opioid Overdoses as the Tip of the Iceberg



Results from the 2015 National Survey of Drug Use and Health, as reported by
https://www.cdc.gov/media/releases/2017/a1203-hargan-fitzgerald-infographic-508.html



VA Program Evaluation Research Center

Women's Past Year Prevalence (%) of Substance Use Among US Veterans in the General Population National Surveys on Drug Use and Health 2002-2012 (Hoggart et al. 2016)					
	Alcohol Use Disorder	Daily Cigarette Use	Prescription Drug Misuse	Drug Use Disorder	Substance Use Disorder
18-25 Veterans	11.5	**26.3**	14.1	5.4	14.7
18-25 Civilians	12.6	**15.7**	13.3	5.9	15.8
26-34 Veterans	6.7	23.2	6.9	1.2	7.6
26-34 Civilians	6.9	17	7.9	2.4	8.4
35-49-Veterans	5.3	**23.5**	6.1	2.1	6.1
35-49 Civilians	4.6	**17.5**	5.5	1.4	5.6
50+ Veterans	2.8	17.6	2.2	0.9	3.6
50+ Civilians	1.5	11.1	1.9	0.3	1.8
Age Adjusted Veterans	4.8	**21.0**	5.0	1.6	5.7
Age Adjusted Civilians	4.1	**14.5**	4.8	1.4	5.0

Men's Past Year Prevalence (%) of Substance Use Among US Veterans in the General Population National Surveys on Drug Use and Health 2002-2012 (Hoggart et al. 2017)					
	Alcohol Use Disorder	Daily Cigarette Use	Prescription Drug Misuse	Drug Use Disorder	Substance Use Disorder
18-25 Veterans	**24.7**	**33.4**	18.3	10.2	**30.1**
18-25 Civilians	**20.5**	**18.0**	15.7	10.1	**25.4**
26-34 Veterans	15.3	**27.3**	9.7	4.9	17.8
26-34 Civilians	15.5	**20.8**	10.1	5.3	18.3
35-49-Veterans	10.8	**25.7**	6.0	3.3	12.6
35-49 Civilians	9.9	**18.4**	5.9	2.7	11.5
50 – 65 Veterans	6.7	**20.7**	2.7	1.3	7.5
50 – 65 Civilians	6.2	**15.8**	3.2	1.2	6.9
65+ Veterans	2.8	7.2	0.6	0.1	2.9
65+ Civilians	2.4	8.3	1.2	0.2	2.6
Age Adjusted Veterans	6.6	**16.5**	3.0	1.5	7.4
Age Adjusted Civilians	6.0	**13.5**	3.4	1.4	6.8

Risk Factors for Overdose and OUD

Risk factors are related to:

- Opioid prescribing
- Interaction with other medication/drugs

Prescribing

- Medical comorbidities
- Mental health comorbidities

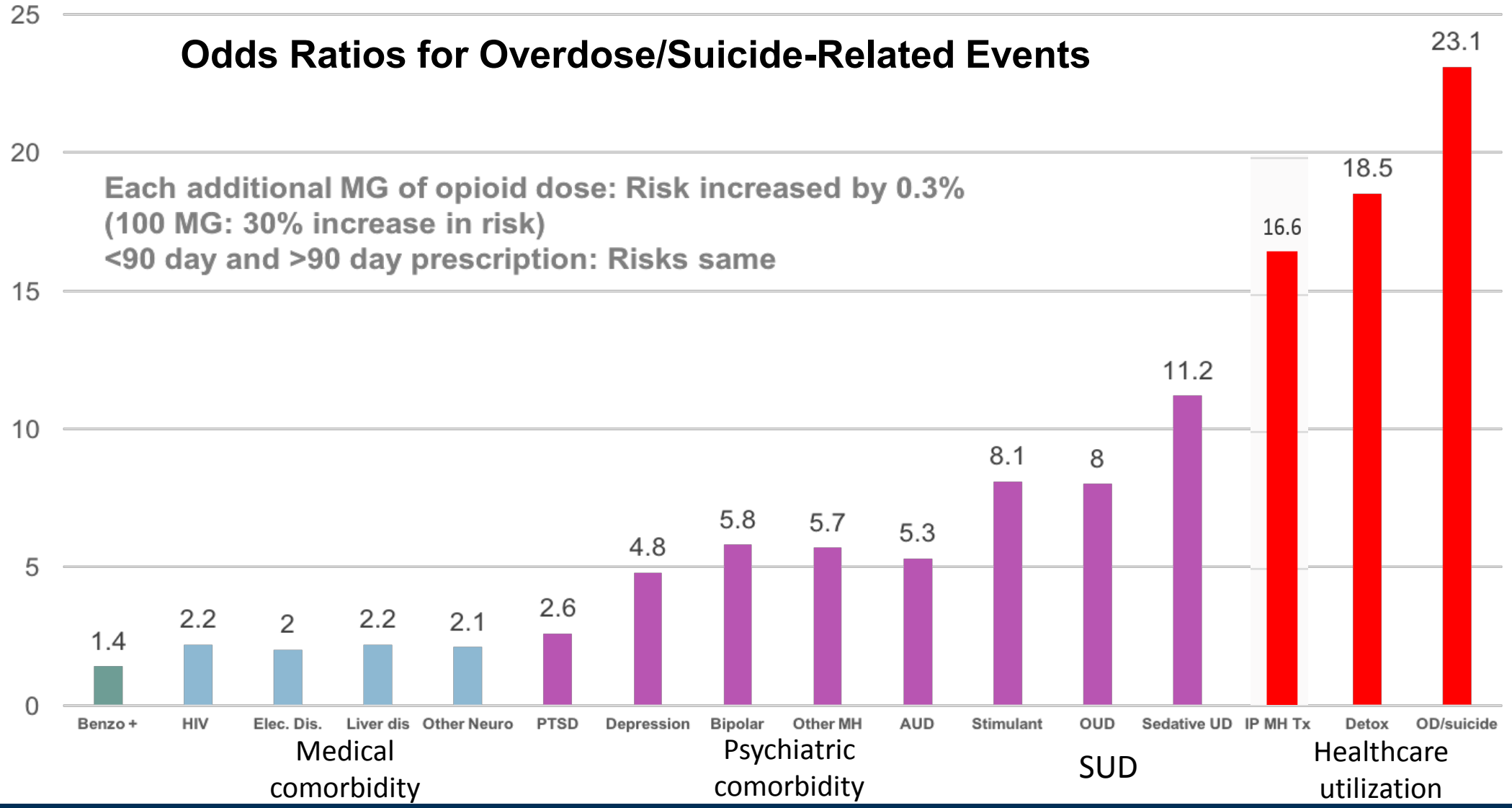
Patient factors

"**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**."

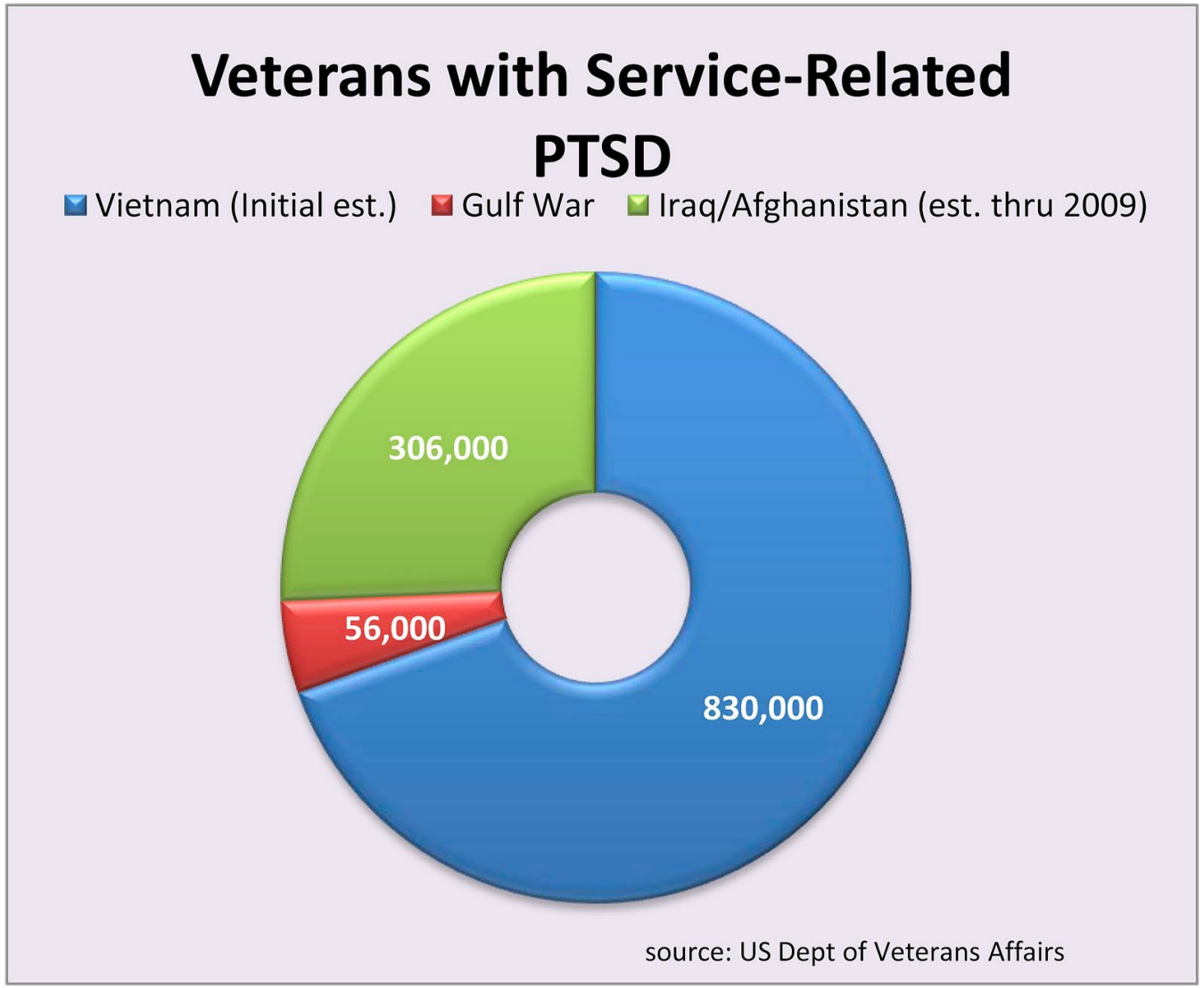
Park et al. J Addict Med 2016

Review of 15 articles published between 2007 and 2015 that examined risk factors for fatal and nonfatal overdose in patients receiving opioid analgesics.

Veterans: Risk Factors for Overdose/Suicide



STORM Analysis: Oliva et. al. Psych. Services 2017



Current prevalence

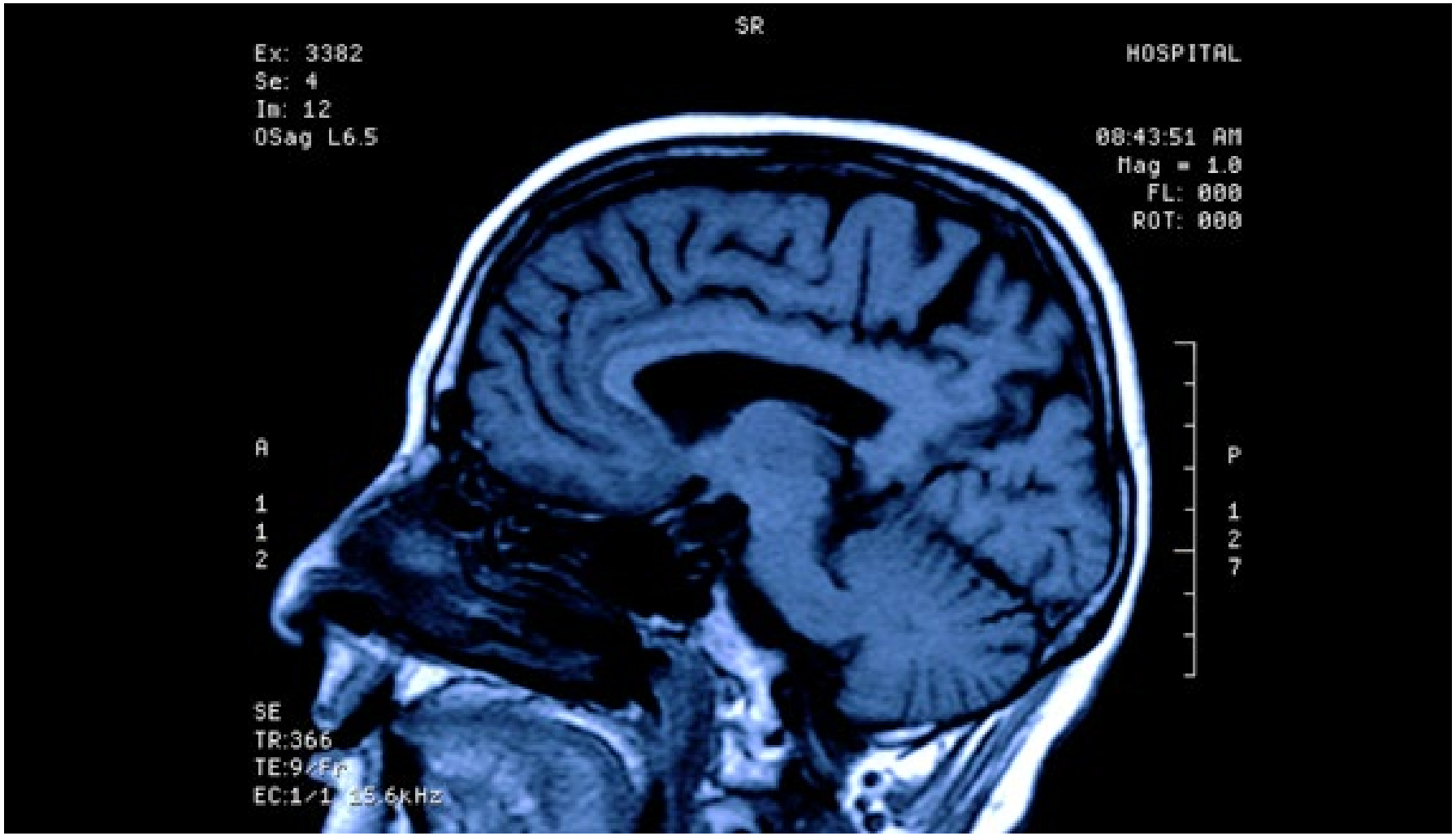
General Adults in US – 1.8% m, 5.2% w

Vietnam - 15.2%m 8.1% w

Gulf War – 12.1%

OEF/ OIF – 13.8%

Traumatic Brain Injury



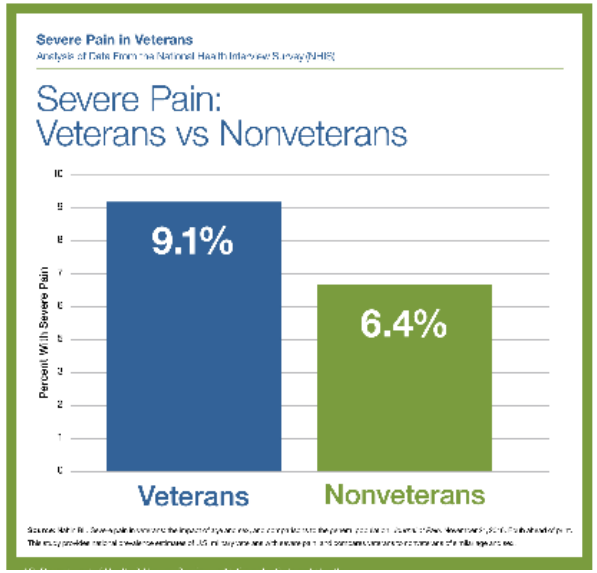
Medical Comorbidity - Prevalence of Pain in Veterans (US population)

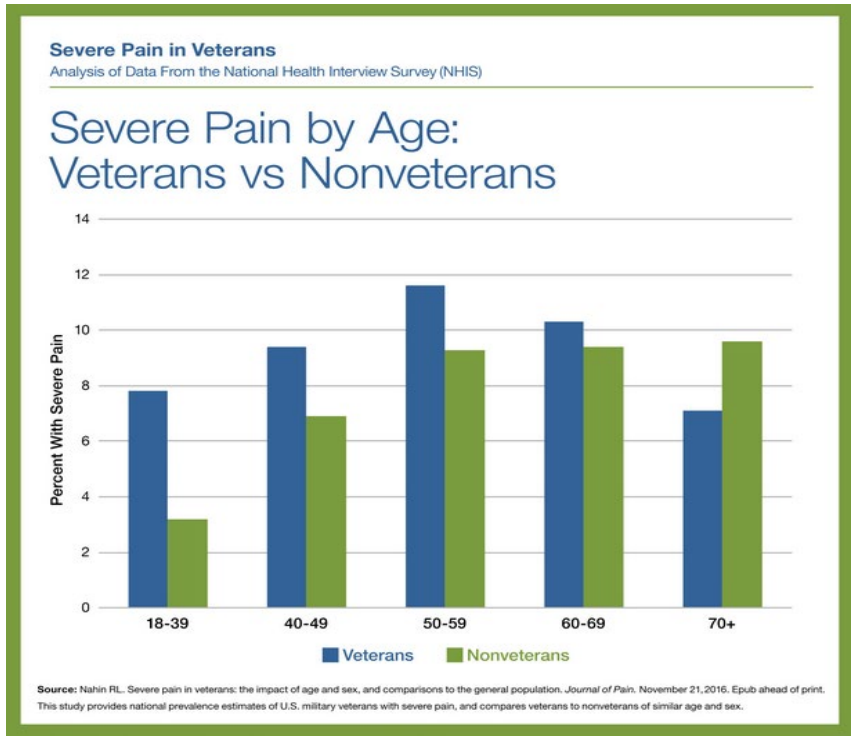
Chronic pain is more common in Veterans than in non-veterans and more often severe.

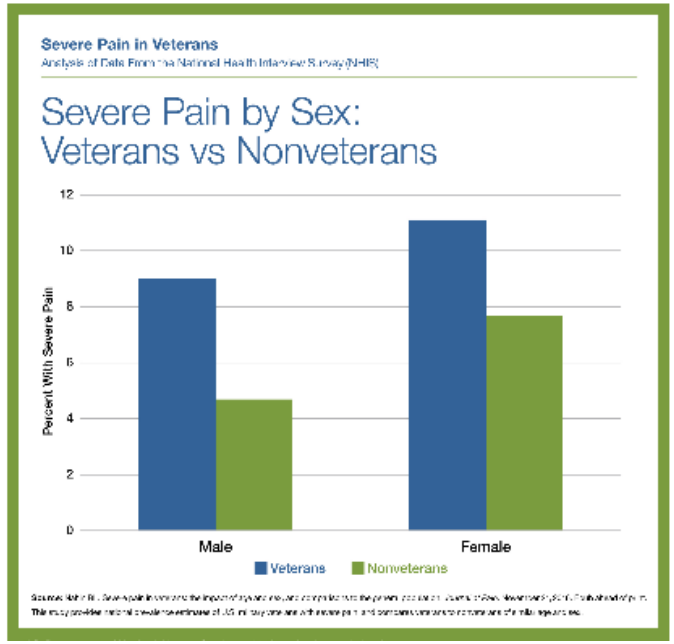
- 66% of Veterans vs. 56% of non-veterans with pain in prior 3 month
- Severe pain in Veterans is 40% more common than in non-Veterans
- Most common pain conditions: musculoskeletal pain (joint 44%, back 33%, neck 1%)

Severe Pain

Pain which occurs "most days" or "every day" and bothers the individual "a lot,"





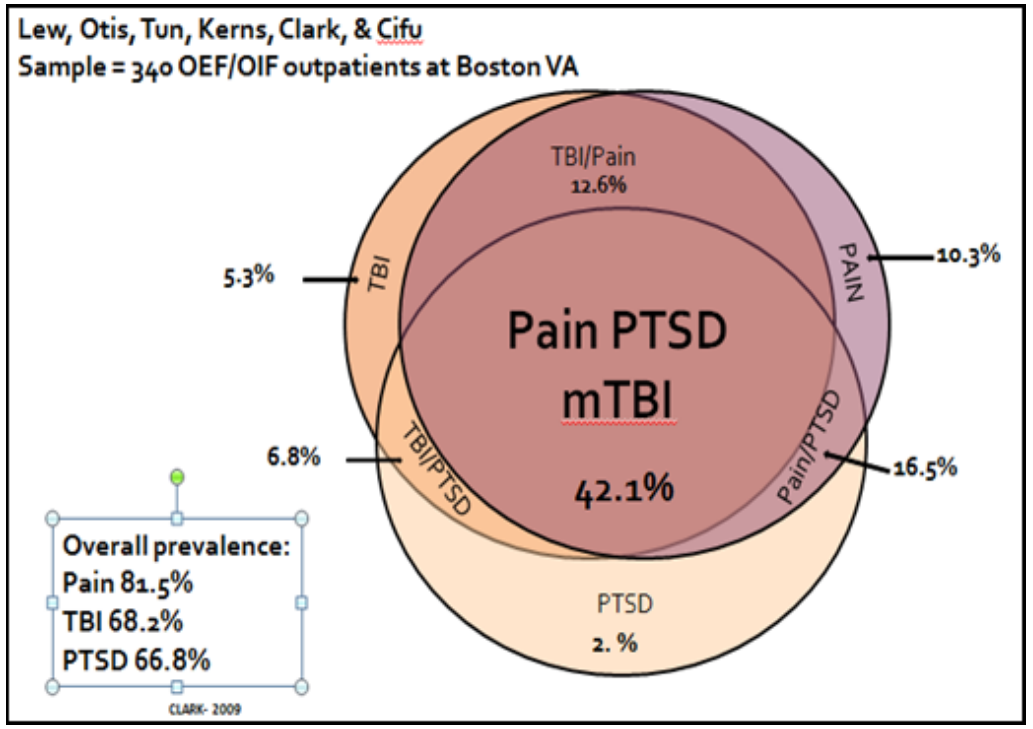


National Health Interview Survey
Nahin RL, Journal of Pain 2017;
nccih.nih.gov/veterans pain

The Pain Challenge in VHA

Chronic pain in Veterans receiving care in VHA is often severe and in the context of mental health comorbidities.

- 60% of Veterans from Middle East conflicts with chronic pain, up to 75% in women Veterans.
- More than 2 Mil Veterans with chronic pain diagnosis (In 2012, 1/3 on opioids).



- **MH and Pain conditions increased in prevalence from 2008 to 2015.**
- Increase in pain scores/pain severity.

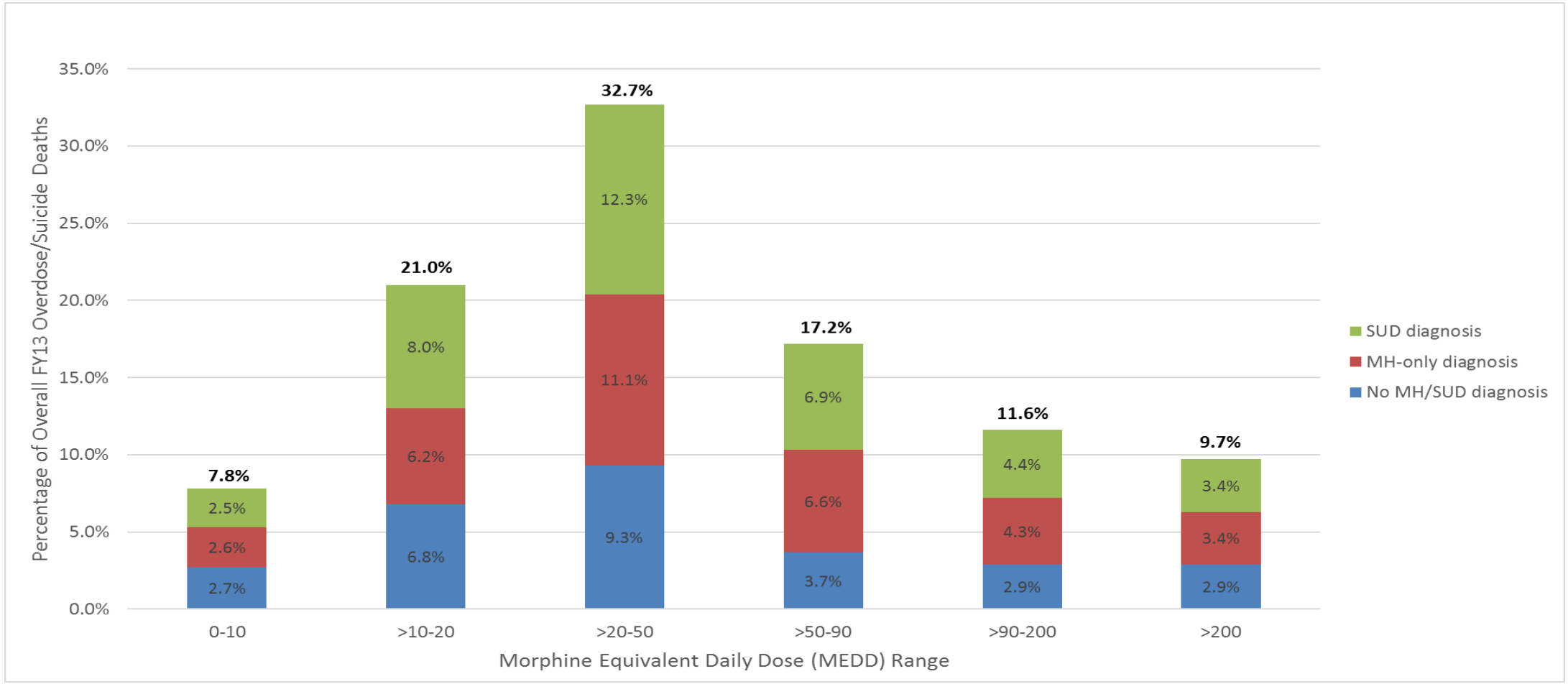
Pain in Veterans (in VHA):
1 in 3 with chronic pain diagnosis
1 in 5 with persistent pain
1 in 10 with severe persistent pain

United States (2017)

- ~ 25% of patients prescribed opioids for chronic pain misuse them
- ~ 10% of those that misuse prescribed opioids develop an Opioid Use Disorder
- ~ 5% who misuse prescribed opioids transition to heroin

National Institute on Drug Abuse

FY2013 Overdose/Suicide Mortality - VHA



- Almost 4 out of every 5 patients who died from overdose/suicide were prescribed doses < 90 MEDD
- Almost 3 out of every 4 overdose/suicide deaths were among patients with MH/SUD diagnoses
- More than 1 out of every 2 deaths were among patients with MH/SUD diagnoses prescribed < 90 MEDD

OUTLINE

- Epidemiology of Opioid Overdose, SUD and Chronic Pain
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Common Opioids

Schedule II

Oxycodone	**Percodan®, Tylox®, Roxicet®, OxyContin®**
Hydrocodone	**Norco®Vicodin®,Lortab®,Lorcet®**
Fentanyl	**Duragesic®, Actiq®**
Carfentanyl	**Wildnil®**
Meperidine	**Demerol®**
Morphine	**MS Contin® , Oramorph®**
Methadone	**Dolophine®**

Schedule III

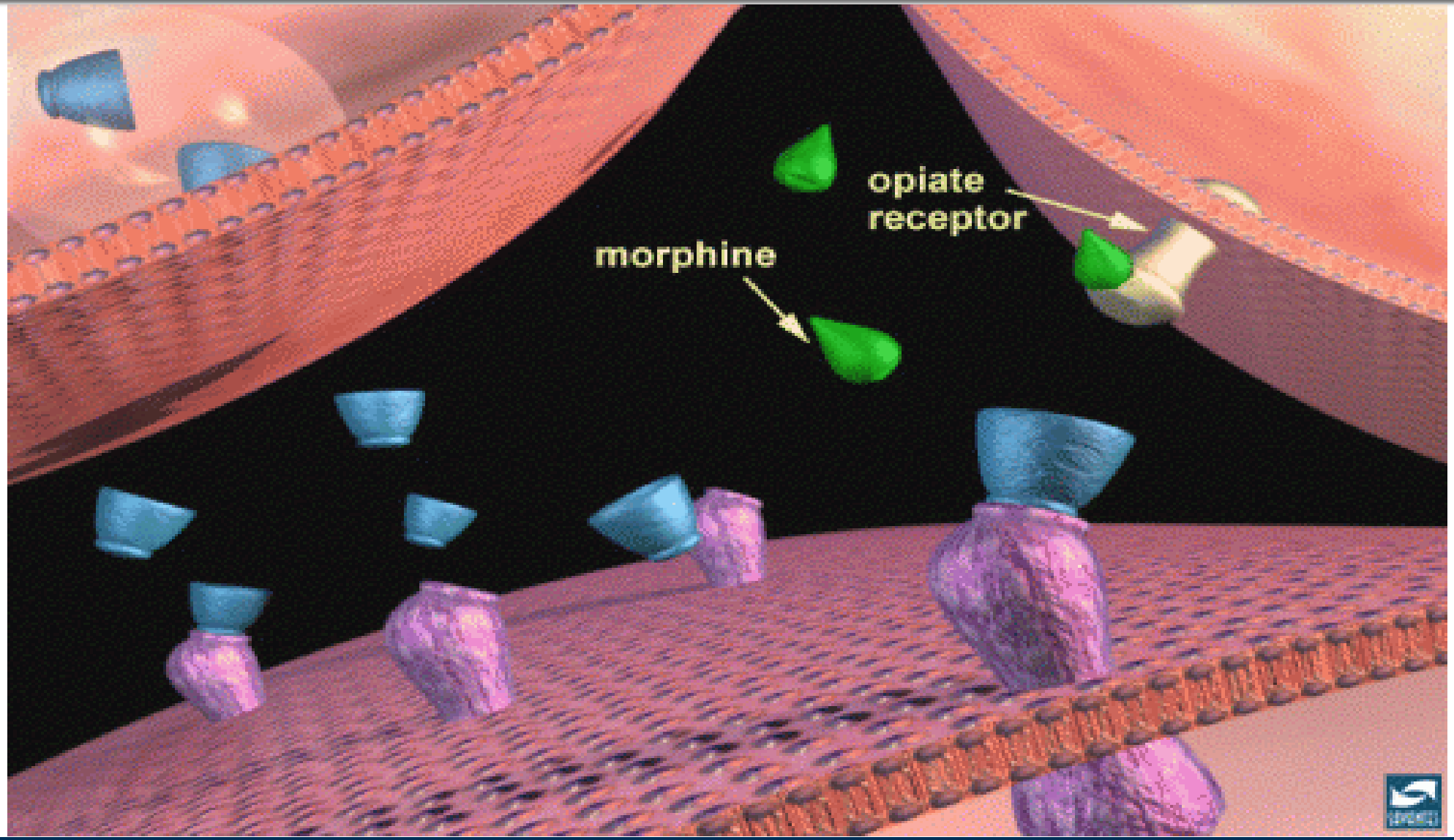
Codeine	**Tylenol® #3, #4** **APAP/Codeine #2,#3,#4**
Buprenorphine	**Suboxone®, Zubsolv®, Butrans®, Bunavail®, Suboxone®, Sublocade®, Cizdol®**

HEROIN, FENTYNYL, CARFENTANYL (Schedule I)

Kensington
Police Service

Opioid Receptor Types

- Delta (DOP)
- Kappa (KOP)
- **Mu (MOP)**
- Nociceptin (NOP)


opiate
receptor
morphine

Opioid Drug Effects

Acute Use Effects:			
Euphoria	Vomiting	Constricted Pupils	Depressed Respiration
Drowsiness	Decreased Pain Sensation	Decreased Awareness	Decreased Consciousness
Chronic Use Effects:			
Physical dependence	Psychological dependence	Lethargy	Constipation
Large Dose Effects:			
Non-Responsive	Pinpoint Pupils	If Severe Anoxia Pupils May Dilate	Bradycardia & Hypotension
Skin Cyanotic	Skeletal Muscle Flaccid	Pulmonary edema in ~50%	Slow or Absent Respiration

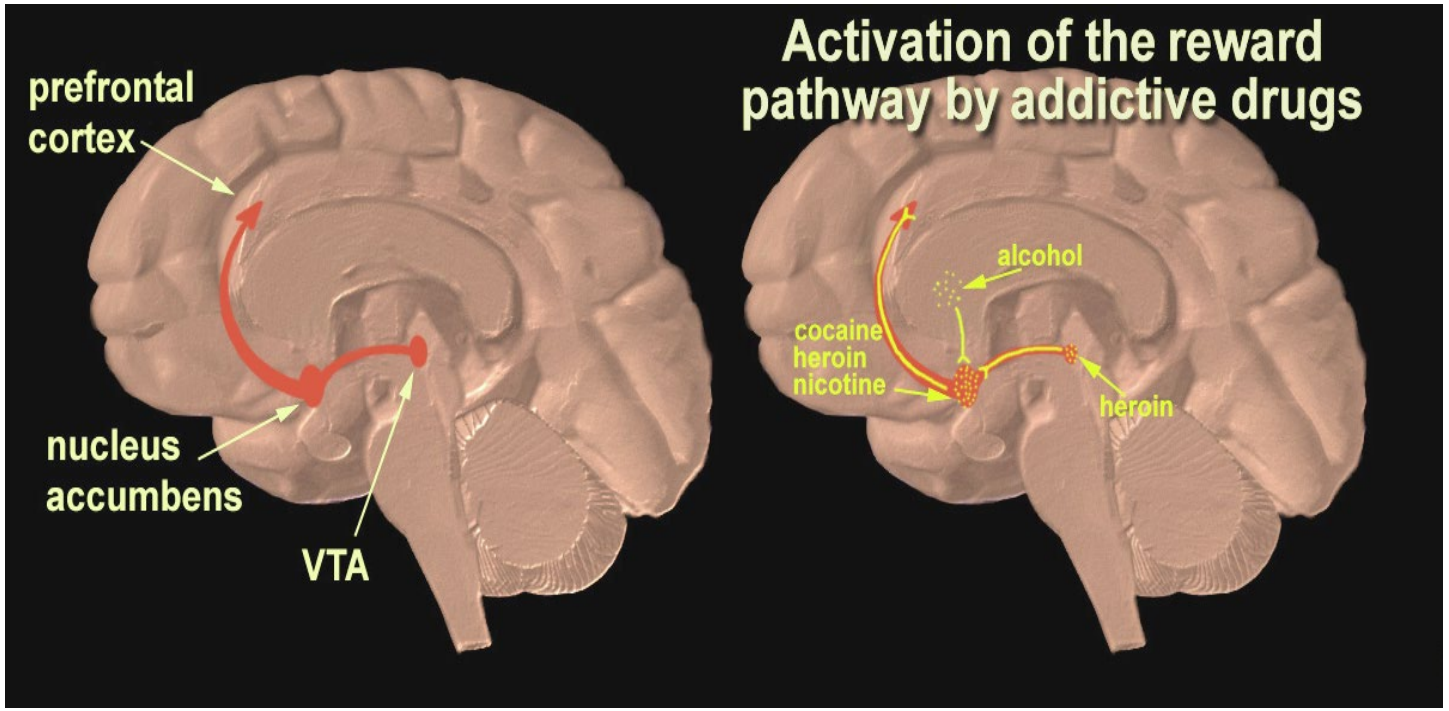
CSAT

WHY PEOPLE USE DRUGS & ALCOHOL

- It feels good
- To fit in
- To feel different
- To experiment
- To relieve boredom
- As a “social lubricant”
- To enhance performance
- To relieve pain
- To “self medicate”

Welsh

Reward/Reinforcement



- Reward/Reinforcement is in part controlled by mu receptors in the:
  - Ventral Tegmental Area (VTA) and
  - Nucleus Accumbens with projections to
  - Prefrontal Cortex

NIDA

ADDICTION

IS

TREATABLE!!!

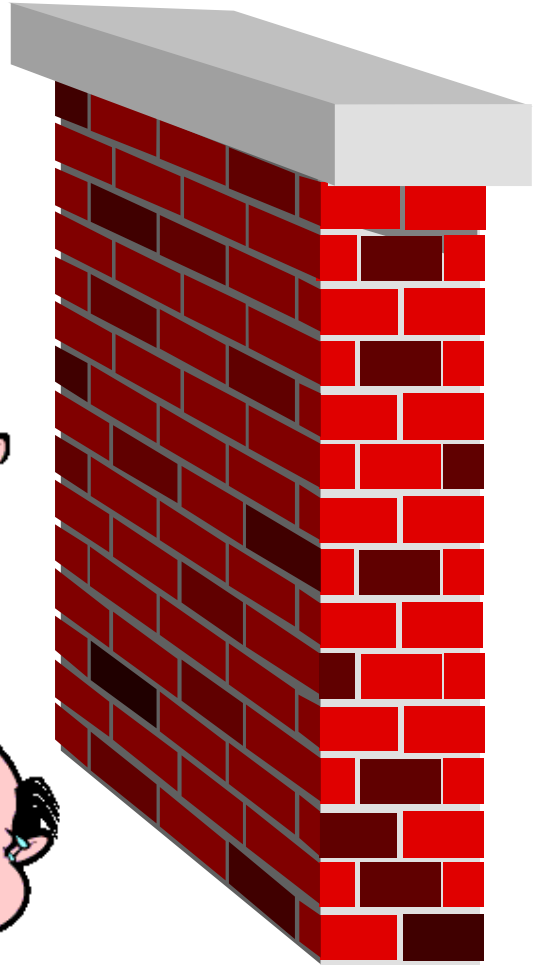
TRADITIONAL VIEW OF TREATMENT OUTCOMES

“Before”

Using

“Dirty”

Criminal

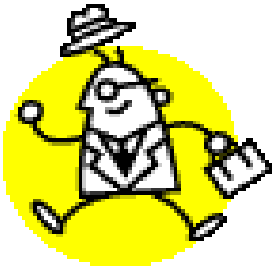


“After”

Not Using

“Clean”

Recovered



Welsh

MORE REASONABLE VIEW OF TREATMENT

Excess Negative Consequences With No Improvement In Function

No Negative Consequences With Great Improvement In Function

Absolute **use** may or may not correlate with this

Welsh

GOALS OF TREATMENT

- **Individual**
  - Total abstinence
  - Reduction in alcohol or drug consumption that will allow the person to better function in all facets of life.
  - Reduction in harm from substance use

- **Societal**
  - Reduction in crime, violence, family discord, accidents, spread of HIV and other infectious diseases associated with the use of needles, and other health complications.

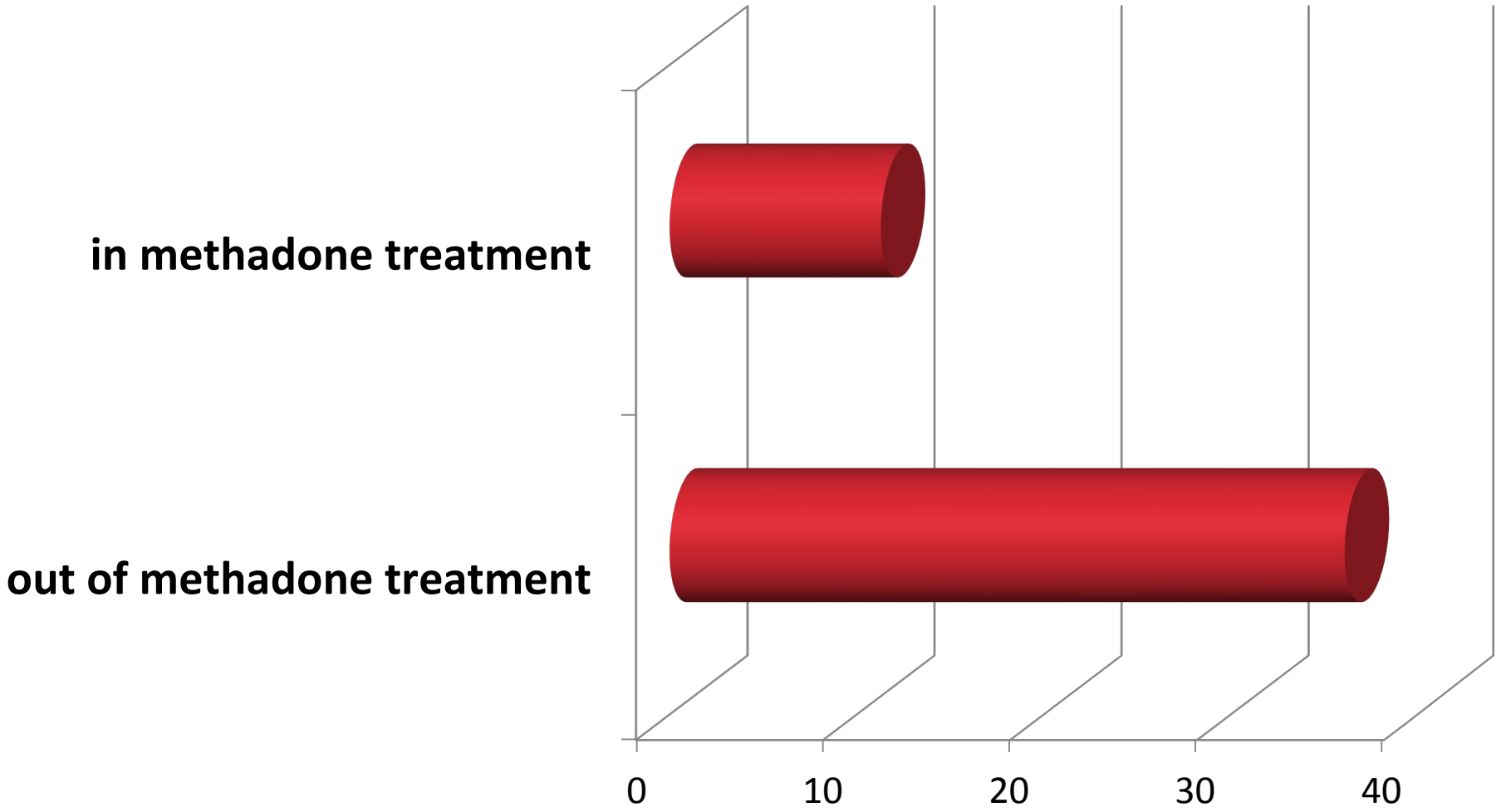
Psychotherapy

- 12 Step Facilitation
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)

Opioid Agonist TreatmentOutcomes

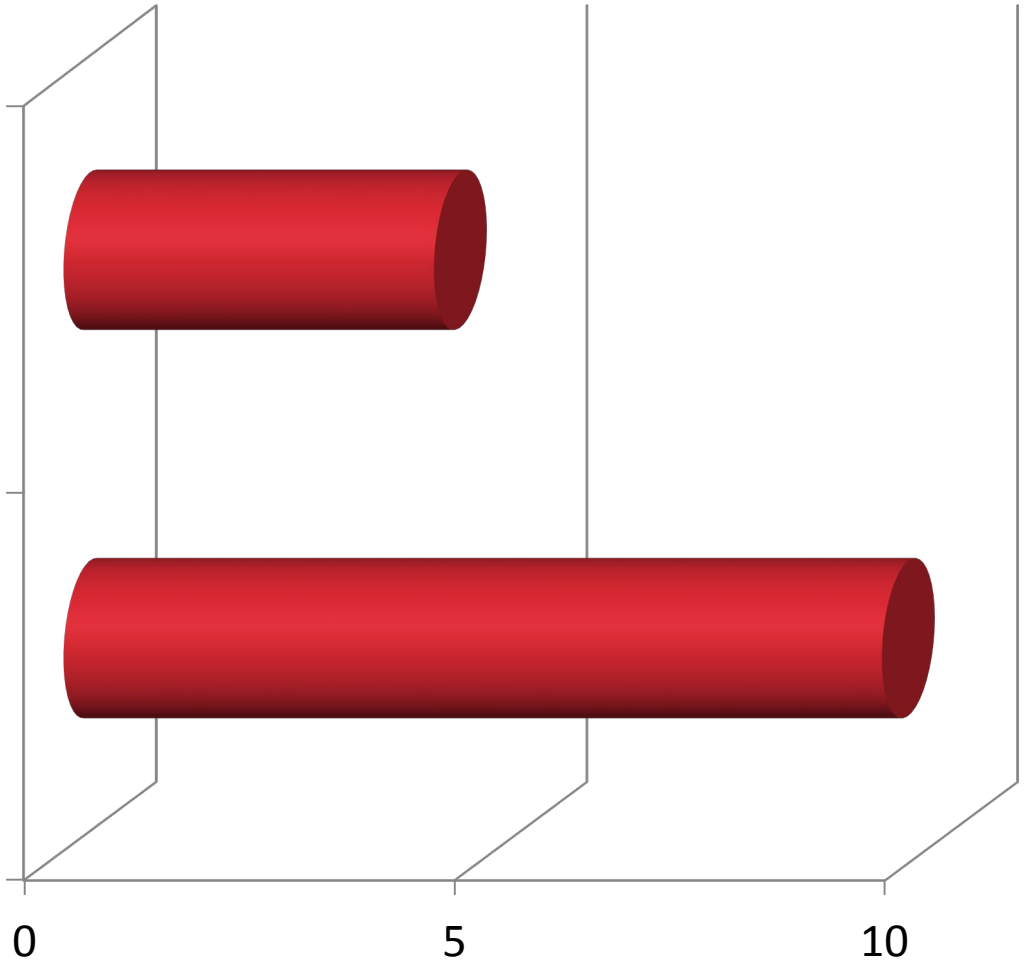
- 67% of patients on methadone who entered a detoxification protocol were using heroin 6-12 months later (Milby)
- Of 105 patients who discontinued methadone treatment, 82% resumed intravenous drug use by 12 months (Ball)
- 88% used opiates 3 months after buprenorphine detoxification (Gandhi)

Mortality Per 1000 People



Sordo, etal 2017

Mortality Per 1000 People



Sordo, etal 2017

Opioid Agonist TreatmentOutcomes

- Decrease mortality
- Decrease acquisition of HIV infection and hepatitis
- Decrease crime
- Decrease illicit-substance use
- Improve social functioning
- Increase the rate of retention in treatment
- Increase compliance with HIV medication regiment

MEDICATIONS TO TREAT OPIOID ADDICTION

- **FDA Approved**
  - **Methadone (Methadose; Dolophine)**
  - **Buprenorphine(Suboxone; Suboxone Film; Subutex; Bunavail; Zubsolv; Sublocade)**
  - **Naltrexone (Trexan; Vivitrol)**
  - **levo-alpha-acetylmethadol (ORLAAM)**

Function at Receptors: Full Opioid Agonists

Mu receptor

Full agonist binding …

❶ fully activates the mu receptor

❷ is highly reinforcing

❸ is the most abused opioid receptor type

❹ substances include heroin, oxycodone,codeine, etc

Center for Substance Abuse Treatment

Opioid Drug Effects

Acute Use Effects:			
Euphoria	Vomiting	Constricted Pupils	Depressed Respiration
Drowsiness	Decreased Pain Sensation	Decreased Awareness	Decreased Consciousness
Chronic Use Effects:			
Physical dependence	Psychological dependence	Lethargy	Constipation
Large Dose Effects:			
Non-Responsive	Pinpoint Pupils	If Severe Anoxia Pupils May Dilate	Bradycardia & Hypotension
Skin Cyanotic	Skeletal Muscle Flaccid	Pulmonary edema in ~50%	Slow or Absent Respiration

Center for Substance Abuse Treatment

Function at Receptors: Partial Agonists

Mu receptor

Partial agonist binding ...

❶ less activation at the receptor site

❷ is relatively less reinforcing

❸ is a less abused opioid type

❹ includes buprenorphine

Center for Substance Abuse Treatment

Function at Receptors: Opioid Antagonists

Mu receptor

Antagonist binding …

❶ occupies without activating

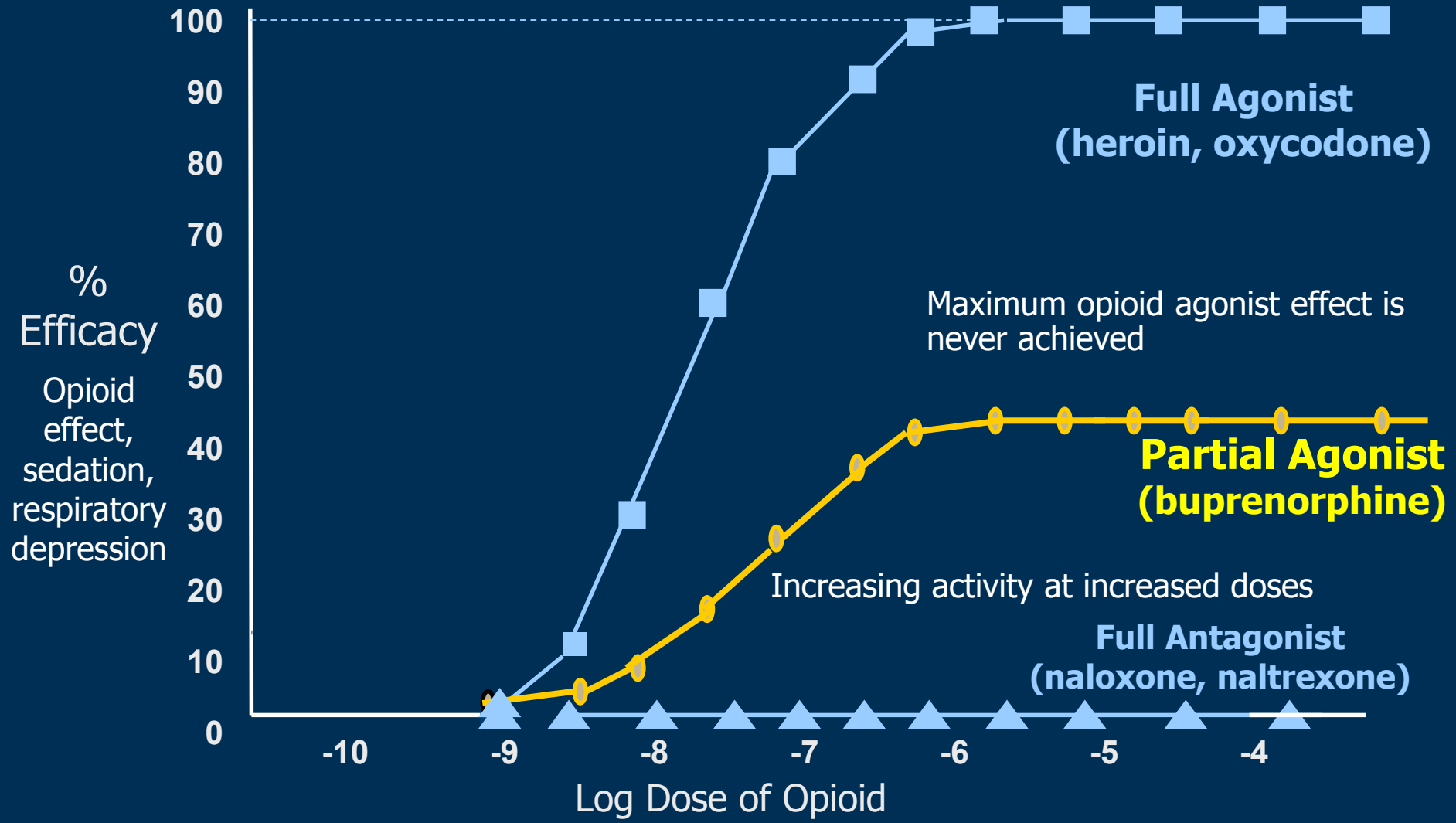
❷ is not reinforcing

❸ blocks agonist opioid receptors

❹ includes naloxone (IV, SC, IM) and naltrexone (PO)

Center for Substance Abuse Treatment

Partial Agonist: Ceiling Effect



Center for Substance Abuse Treatment

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History taking

- Family and Social history
  - What was it like growing up, abuse, parental occupations, sibling distribution, education, employment, relationships, off-spring, legal history.
- Substance History
  - Ask about each substance, manor of use, length of use, current use, highest use, longest time without using, date last used, medical complications of use, History of DTs, Seizures, past treatments
- Military History
  - ??

Reading

Military History: General Questions

- Military History
  - Would it be ok if I talked with you about your military experience?
    - When and Where did you serve and in what branch?
    - What type of work did you do while in the service?
    - Did you have any illnesses or injuries while in the service?
    - If yes, “Can you tell me more about that”

VA Office of Academic Affiliations

World War II Era (1939-1945)

16 million served: ~ 500,000 surviving Veterans

Noise Exposure

Ionizing Radiation

Occupational (job-related) Hazards

Extreme Cold Injury

Mustard Gas

Veterans Benefits Administration

Korean War Era (1950-1953)

5.7 million served: ~ 2.25 million surviving Veterans

Extreme Cold Injury

Occupational (job-related) Hazards

Noise

Veterans Benefits Administration

Vietnam War (1961-1975)

8.7 million served: ~ 7.25 million surviving Veterans

Diseases related to Agent Orange

Hearing Problems Caused by Noise

Occupational (job-related) Hazards

Hepatitis C (Substance Abuse)

Veterans Benefits Administration

Gulf War and Iraq War Era (1990-)

~ 5.4 million surviving Veterans

First Gulf War
Second Gulf War
Global War on Terrorism
Operation Active Endeavour
Operation Iraqi Freedom
Operation Enduring Freedom
Operation New Dawn

Sand, Dust and Particulate
Depleted Uranium
Oil Well Fires
Sulfur Fire
Burn Pit Smoke
Chemical and Biological Weapons
Chemical Agent Resistant Coating Paint
Chromium
Pesticides
Extreme Heat Related Injuries
Explosions
Toxic Embedded Fragments
Noise
Infectious Diseases
Occupational (job-related) Hazards
Traumatic amputations
Blast Injury
Traumatic Brain Injury
(PTSD/MST)

Veterans
Benefits
Administration

Combat Stressors

- Losing Friends
- Not Seeing Successes
- Using Deadly Force
- Being Injured
- Seeing, Smelling, Tasting Death and Destruction
- Collateral Damage
- IED Threat
- Green on Blue Violence (Friend vs. Enemy)

Buser

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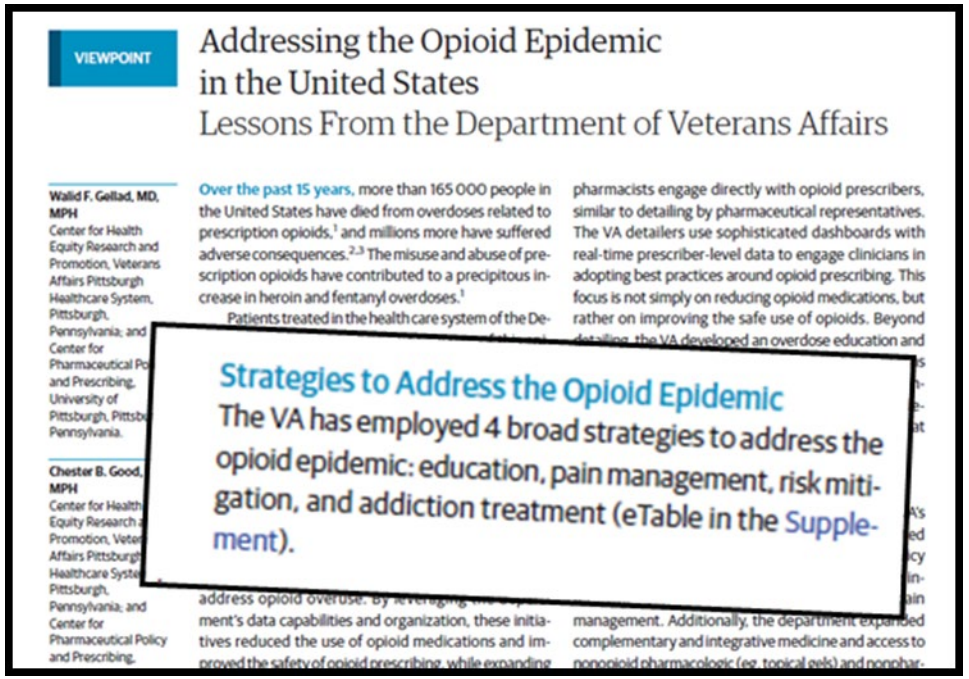
- **VHA Initiatives to Address the Opioid Epidemic**

The VA Opioid Safety Initiatives (OSI)

- **Opioid Safety Initiatives (OSI) Aims**
  - Reduce over-reliance on opioid analgesics for pain management.
  - Safe and effective use of opioid therapy when clinically indicated.
  - Improve access to lifesaving medication assisted treatment for opioid use disorder
- **Comprehensive OSI strategy includes**
  - Provider education; Academic Detailing.
  - Access to non-pharmacological modalities, incl. behavioral and CIH modalities.
- **OSI Dashboard**
  - Totality of opioid use visible within VA.
  - Provides feedback to stakeholders at VA facilities regarding key opioid parameters.



VIEWPOINT

Addressing the Opioid Epidemic in the United States
Lessons From the Department of Veterans Affairs

Walid F. Gellad, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

Chester B. Good, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing.

Over the past 15 years, more than 165 000 people in the United States have died from overdoses related to prescription opioids,[1] and millions more have suffered adverse consequences.[2,3] The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.[1]

Patients treated in the health care system of the De-

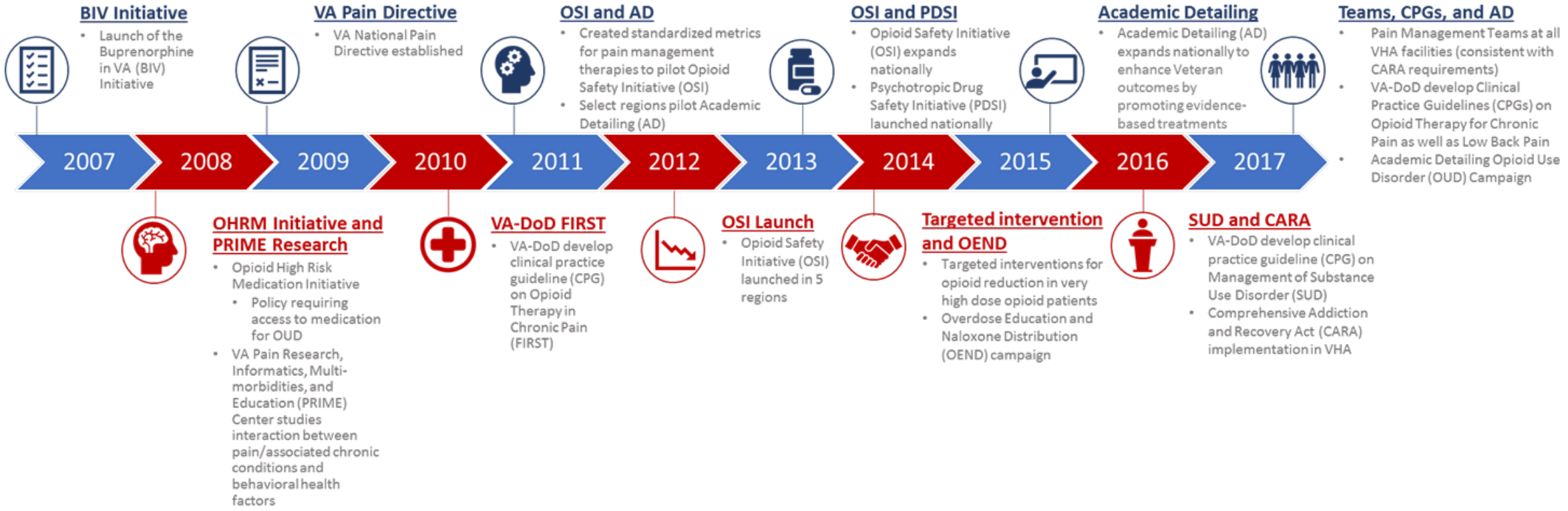
pharmacists engage directly with opioid prescribers, similar to detailing by pharmaceutical representatives. The VA detailers use sophisticated dashboards with real-time prescriber-level data to engage clinicians in adopting best practices around opioid prescribing. This focus is not simply on reducing opioid medications, but rather on improving the safe use of opioids. Beyond

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

address opioid overuse. By leveraging the department's data capabilities and organization, these initiatives reduced the use of opioid medications and improved the safety of opioid prescribing, while expanding

management. Additionally, the department expanded complementary and integrative medicine and access to

Gellad, Good CB, and Shulkin.
JAMA Intern Med. 2017 May 1;177:611-2



The VA Opioid Safety Initiatives

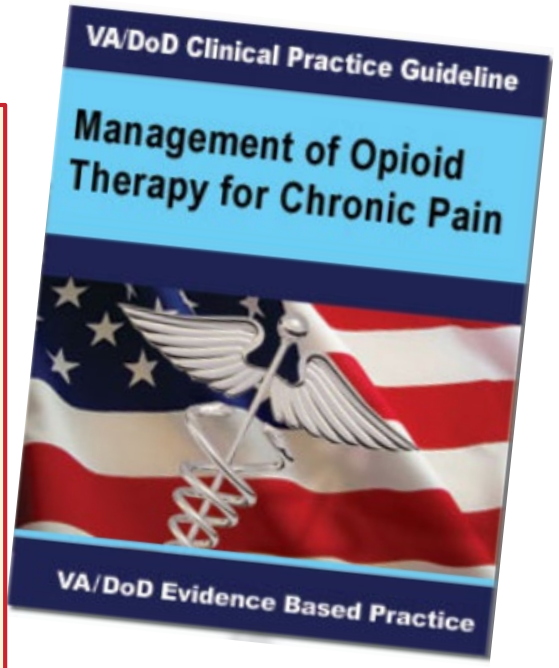
Paradigm Shift in Pain Care

- ***Paradigm shift away from opioid therapy*** *for non-end-of-life pain management.*
  - There is no completely safe opioid dose threshold below which there are no risks for adverse outcomes.
  - Even a short-term use of low dose opioids may result in addiction.
  - Realization that any initial, short-term functional benefit will likely not be sustained in most patients.
  - Prolonged use of opioids, especially in higher doses, may lead to central sensitization and increase in pain over time (*Opioid Induced Hyperalgesia*)
  - Patients on opioids may actually experience a functional decline in the long term, measured by factors like returning to employment.
- ***Paradigm shift towards multimodal and integrated team-based pain care (biopsychosocial interdisciplinary care)***

VA/DoD Clinical Practice Guideline: Opioid Therapy (2017)

– VA/DoD CPG includes 18 recommendations, organized in 4 topic areas

- Initiation and Continuation of Opioids



Recommendation 1:

"We recommend against initiation of long-term opioid therapy.

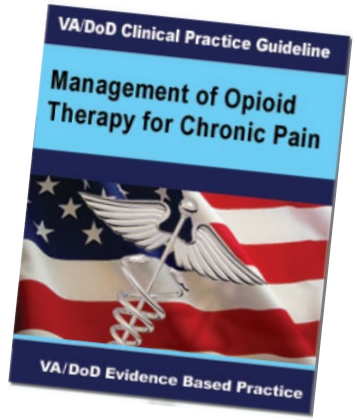
We recommend **alternatives to opioid therapy** such as self-management strategies and other non-pharmacological treatments.

When pharmacologic therapies are used, we **recommend non-opioids over opioids**".

https://www.healthquality.va.gov/guidelines/Pain/cot/

VA/DoD Clinical Practice Guideline: Opioid Therapy (2017)

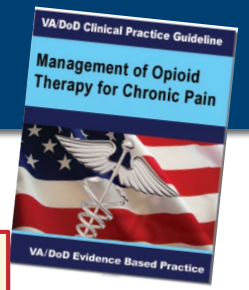
- Initiation and Continuation of Opioids (cont'd)
  - Recommendation against opioid therapy in patients **< 30 years of age**, in patients with active substance use disorder, and in combination with benzos.



- Risk Mitigation
  - Recommendation for risk mitigation strategies, including **Informed Consent, UDT, PDMP, Overdose education and Naloxone prescribing**.
  - Assess for **Suicide risk**
  - Evaluate benefits and risks **at least every 3 months.**

https://www.healthquality.va.gov/guidelines/Pain/cot/

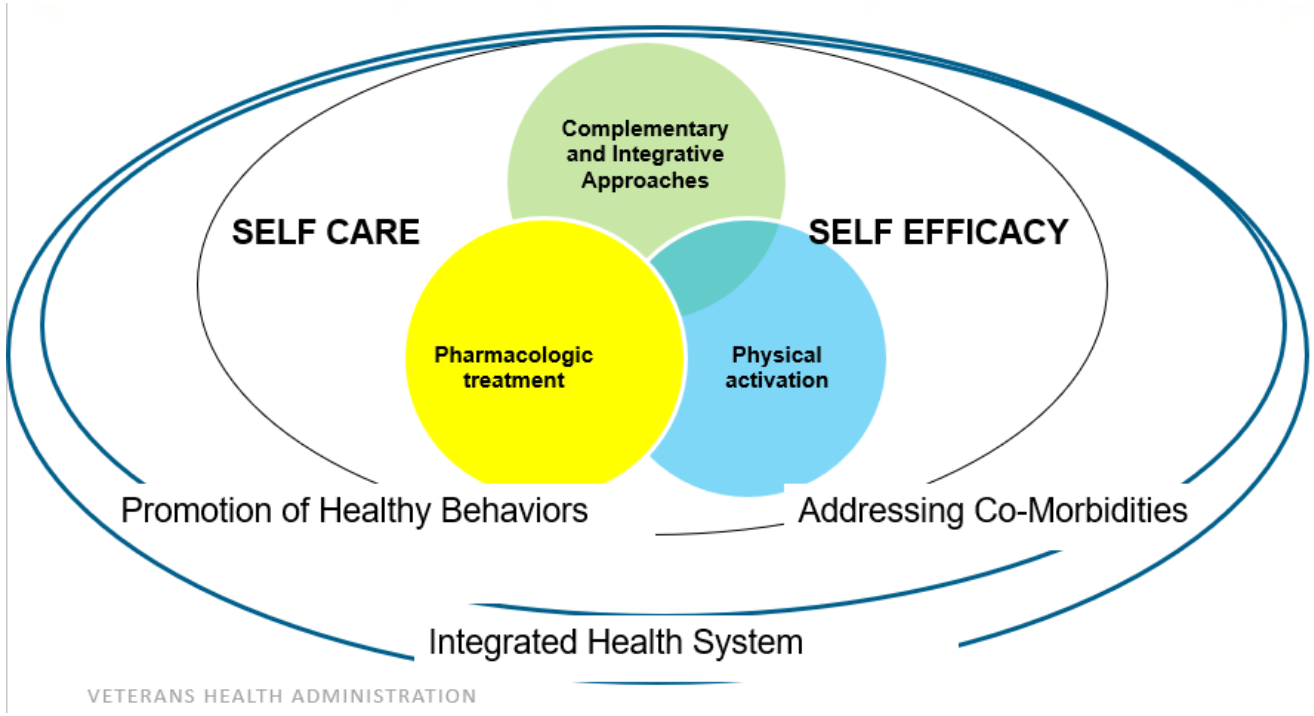
VA/DoD Clinical Practice Guideline: Opioid Therapy (2017)



- Type, Dose, Follow-up, and Taper of Opioids
  - If prescribing opioids: **short duration and lowest dosage.**
  - **No dosage is safe**; Strong rec against of opioids to > 90 MEDD.
  - **Avoid long-acting opioids for acute pain, as prn, or upon initiation** of opioid therapy.
  - Opioid dosage **reduction should be individualized** to patient.

    Avoid sudden reductions; taper slowly if opioid risk > benefit,
  - For **OUD**, offer medication assisted treatment (MAT).
- Opioid Therapy for Acute Pain
  - **Acute pain:** use alternatives to opioids; use multimodal pain care, **if opioids prescribe for ≤ 3-5 days.**

https://www.healthquality.va.gov/guidelines/Pain/cot/

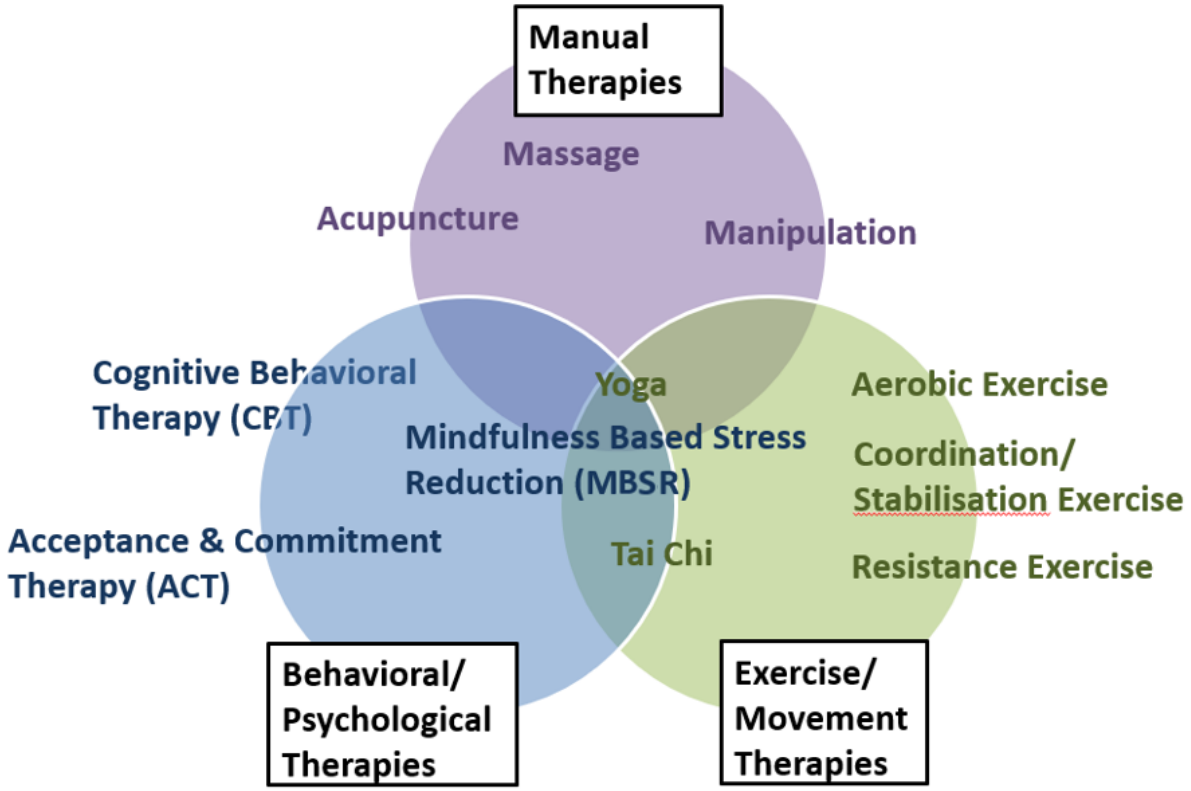


Pain Management - Beyond Opioids …

Non-Pharmacological Pain Treatments in VHA

VA State of the Art Conference Nov. 2016: Evidence-based non-pharmacological approaches for MSK pain management

- Evidence to support CIH and conventional therapies.
- Provision of multi-modal therapies accessible from Primary Care.



VHA Directive 1137: Advancing Complementary and Integrative Health (May 2017)

- List 1: Approaches with published evidence of promising or potential benefit.
  - **Acupuncture**
  - **Massage Therapy**
  - **Tai Chi**
  - **Meditation**
  - **Yoga**
  - **Clinical Hypnosis**
  - **Biofeedback**
  - **Guided Imagery**
- **Chiropractic Care** approved as a covered benefit in VHA in 2004 and is part of VA whole health care.
- To be made available across the system, if recommended by the Veteran's health care team.

Stepped Care Model for Pain Management

Stepped Care Model for Pain Management (SCM-PM)

Foundational Step: Self-Care/Self-Management

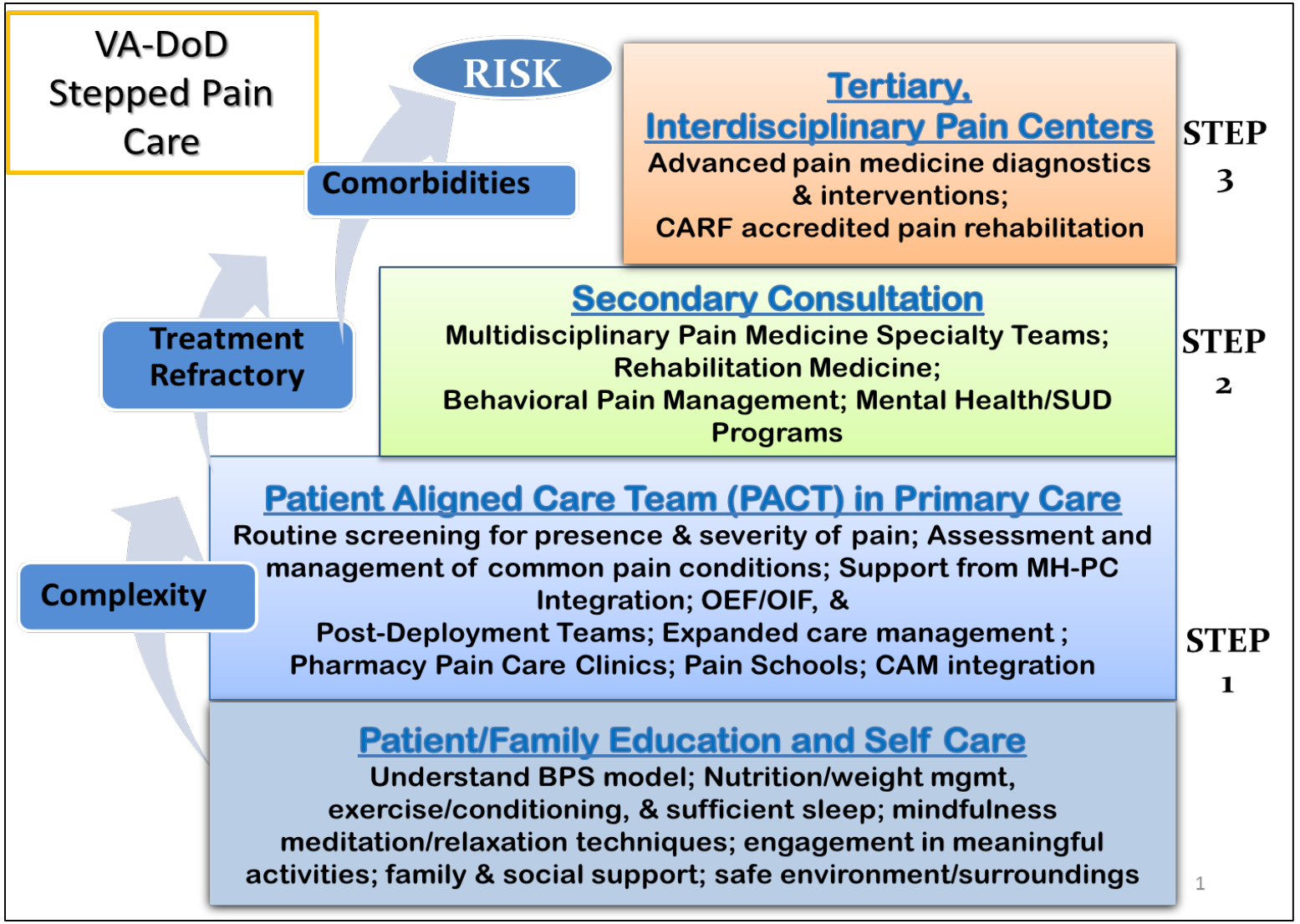
- Broad approach.

Primary Care (PACT) = Medical Home

- Coordinated care and a long-term healing relationship, instead of episodic care based on illness
- Primary Care Mental Health Integration (PCMHI) at all facilities

CARA Legislation:

- Full implementation of the SCM-PM
- Pain Management Teams at all facilities

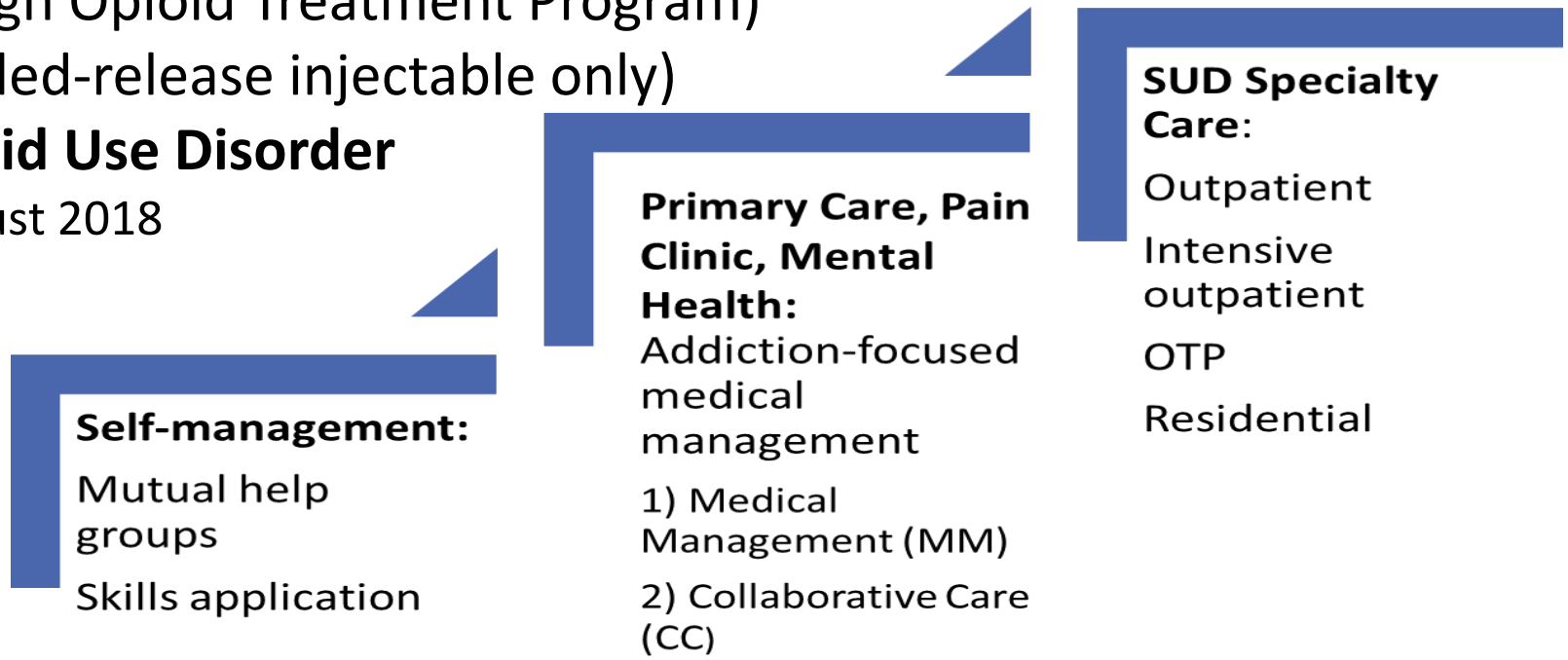


Stepped Care for Opioid Use Train the Trainer (SCOUTT)

- Aims to improve access to lifesaving medication assisted treatment for opioid use disorder by bringing appropriate evidence-based medication, monitoring, and brief counseling to the points of care where patients with opioid use disorder are most likely to be seen.
- These settings include Pain Management clinics, Primary Care, and Mental Health Clinics.
- In a stepped care model, care for stabilized and less complex patients can be provided in these primary clinics.

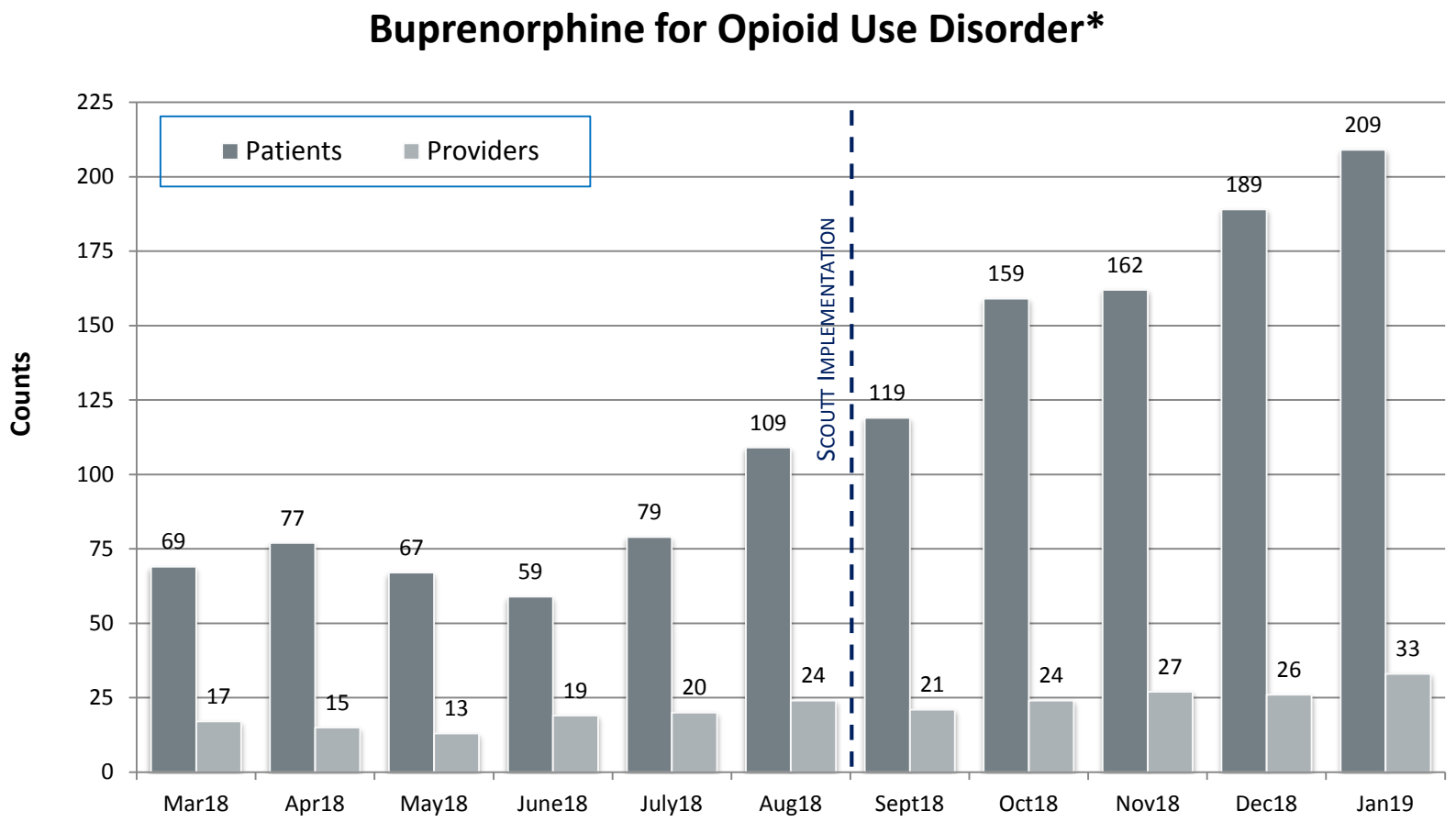
VHA Stepped Care

- Pain Management Teams must include providers with addiction expertise to allow for integrated access to OUD evaluation and treatment.
- **Medication Assisted Treatment (MAT):**
  - Buprenorphine/naloxone
  - Methadone (through Opioid Treatment Program)
  - Naltrexone (Extended-release injectable only)
- **Stepped Care for Opioid Use Disorder**
  - Training began in August 2018



VA/DoD CPG: Management of Substance Use Disorder (SUD) (2015) : https://www.healthquality.va.gov/guidelines/MH/sud/

Buprenorphine in SCOUTT level one clinics



**Includes patients with a diagnosis of OUD seen in the implementation clinic. Excludes patients seen in Clinic Stop 523 and/or prescribed buprenorphine in non-implementation clinics.*

Overdose Education and Naloxone Distribution - OEND

- **Overdose Education (OE)**
  - How to *prevent, recognize, and respond* to an opioid overdose.
- **Naloxone Distribution (ND)**
  - FDA approved as **naloxone auto injector and nasal spray.**
  - *Dispense and train* patient and caregiver/family.
- **Target patient populations: OUD and prescribed opioids.**
- **Naloxone to be offered widely, low threshold for prescribing.**
  - Factors that increase risk for opioid overdose include h/o overdose, h/o SUD, higher opioid dosages (≥50 MMED), or concurrent benzodiazepine use. Offer to patients with recent opioid discontinuations or during tapering of opioids
- **No cost to Veterans**.
- Rapid Naloxone Initiative: first responders, AED (defibrillator) cabinets. .

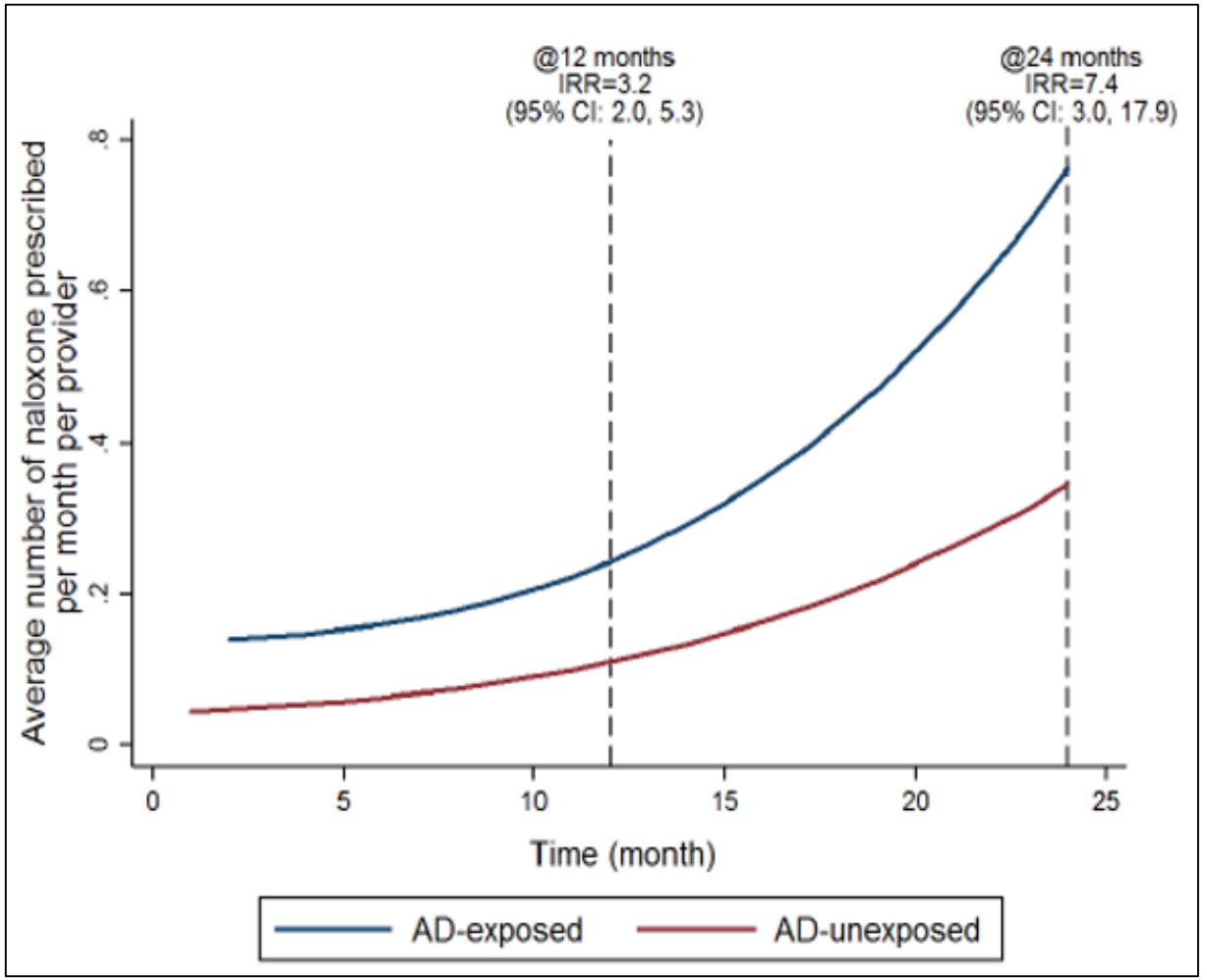
https://www.youtube.com/watch?v=0w-us7fQE3s

Provider Education: Academic Detailing

VA Academic Detailing Service

- ***In-person*** educational outreach
- Evidence-based information and tools
- Pharmacists skilled in persuasive communication
- Trusted and useful ***relationship*** with providers
- Training/provider tools
- > 28,000 outreach visits (June 30, 2018)
- Multiple campaigns, examples:
  Pain Management, Opioid Safety Initiative, Opioid Use Disorder (OUD), Insomnia; Psychotropic Drug Safety Initiative (PDSI), incl. benzodiazepines.

AD Exposure and Naloxone Prescribing



VA Academic Detailing Educational Materials

Pain/Opioid Safety Initiative

Marijuana: Natural = Safe, Right?

Classification: Patient Factsheet
File Name: Marijuana Use: Patient Discussion Tool
IB&P Number: IB 10-927; P96809

Slowly Stopping Opioid Medications
Helpful Tips to Getting Off Your Opioid Successfully

Classification: Patient Factsheet
File Name: Pain – Patient – Slowly Stopping Opioids
IB&P Number: IB 10-1016; P96884

Pain
New Ways to Treat a Common Problem

Classification: Patient Factsheet
File Name: Pain – Patient – Pain Information Guide
IB&P Number: IB 10-1017; P96885

Opioid Use Disorder

Provider Materials

Opioid Use Disorder
A VA Clinician's Guide to Identification and Management of Opioid Use Disorder (2016)

Classification: Provider Educational Guide
File Name: OUD – Provider AD – Educational Guide
IB&P Number: IB 10-933; P96813

Opioid Use Disorder
Identification and Management of Opioid Use Disorder

Classification: Provider Quick Reference Guide
File Name: OUD – Provider AD – Quick Reference Guide
IB&P Number: IB 10-932; P96812

Patient Materials

Opioids: Do You Know the Truth About Opioid Use Disorder?

Classification: Patient Brochure
File Name: OUD – Patient AD – Direct to Consumer Brochure
IB&P Number: IB 10-937; P96829

Opioid Overdose Education and Naloxone Distribution

Provider Materials

VA OEND Program Quick Reference Guide

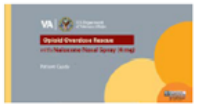
Classification: Provider Quick Reference Guide
File Name: OEND – Provider – Quick Reference Guide_V2
IB&P Number: IB 10-788; P96790

Provider DVD: VA Overdose Rescue with Naloxone

Classification: DVD
File Name: OEND – Patient – Provider DVD: VA Overdose Rescue with Naloxone
IB&P Number: IB 10-770; P96764

Patient Materials

Naloxone Instructions



Naloxone Nasal Spray 4 mg Instructions – Pocket Card

Classification: Patient Brochure
File Name: OEND – Patient – OEND Patient Brochure – Pocket Card
IB&P Number: IB 10-926; P96808

Opioid Overdose Rescue with Naloxone: Auto-Injector Kit Instructions_v2

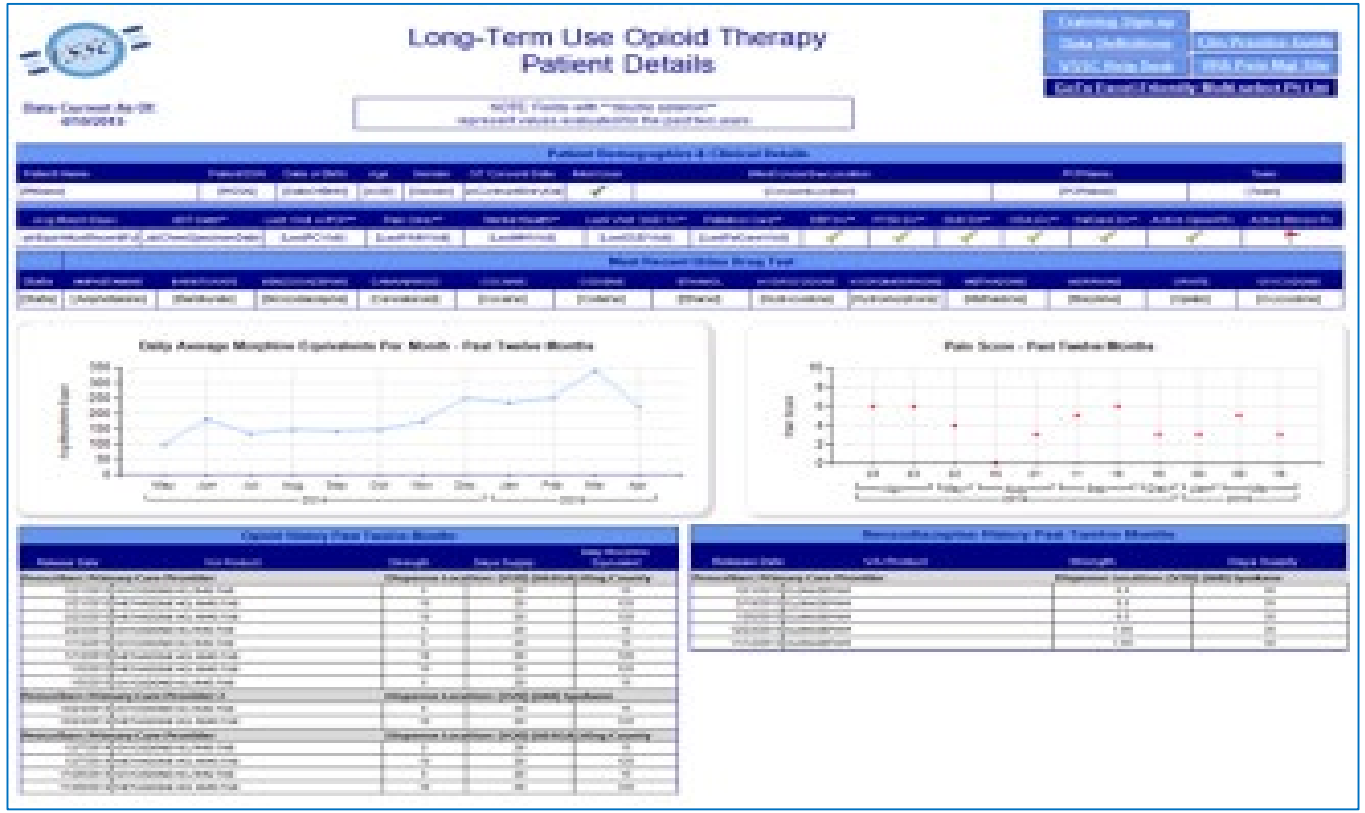
Classification: Patient Brochure
File Name: OEND – Patient – Naloxone Kit Instructions – Auto-Injector_V2
IB&P Number: IB 10-780; P96782

Internet: VA PBM Academic Detailing Public Internet Site LINK

Opioid Therapy Risk Report – OTRR

- Tool optimized for Primary Care Aligned teams: review their panel for all patients on long-term opioids
- Multitude of factors that potentially increase risk incl. MH diagnoses

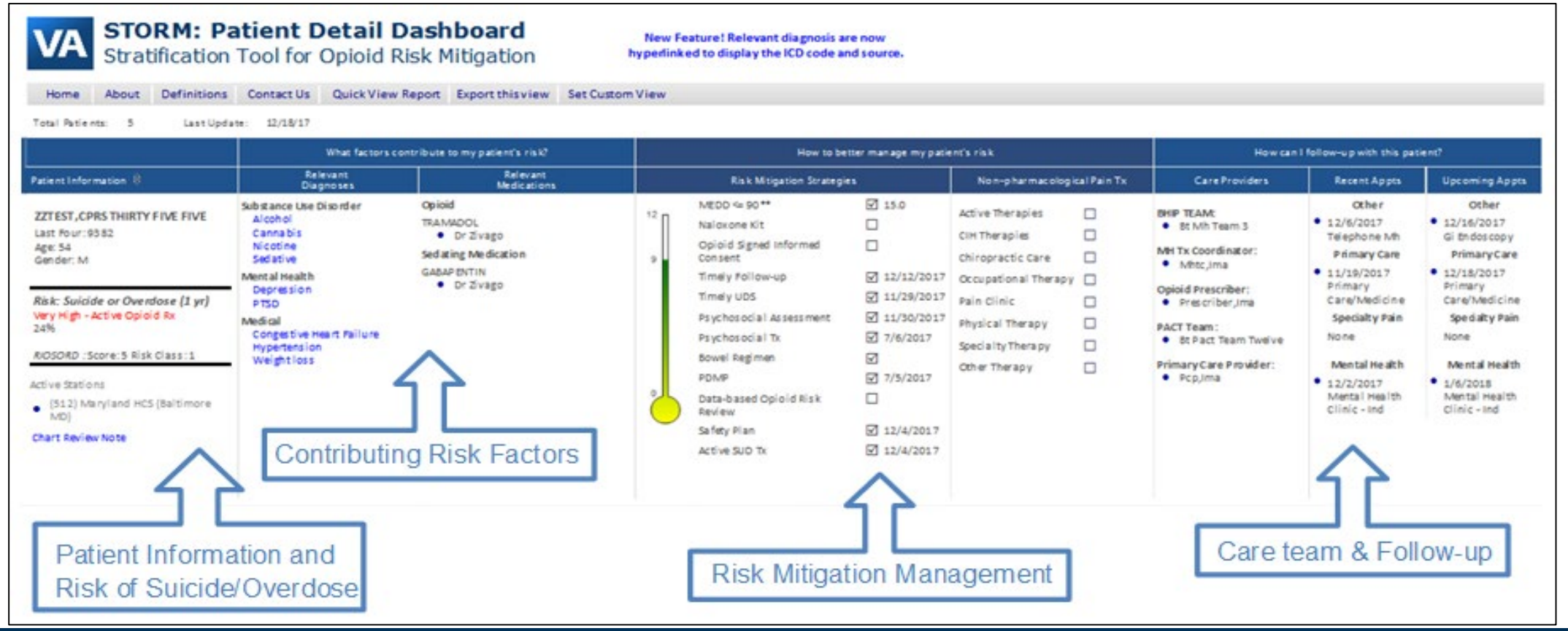
  - Opioid risk mitigation parameters including last PDMP check
  - Updated nightly
  - Individual report includes Visual display
    - Opioid dosage
    - Pain score (severity)
  - LTOT definition: opioid dispensed in the last 90 days *and* total days supply ≥ 90 days in the past 180 days



Patient Name	Patient SSN	Date Of Birth	Age	Gender	Last 30 Days Avg Morph Equiv	RIOSORD Score	RIOSORD Class	RIOSORD Prob	Last PDMP Check Date	Days Since Check	Urine Drug Test**	Entry Date National OT Consent	Signed by IMED USER	Long-Term Opioid Therapy	Active Opioid Rx	Active Benzo Rx	Last Naloxone Dispensed	Last Visit w/PCP**	Last Visit Pain Clinic**	Last Visit Mental Health**	Last Visit SUD Tx**	DEP Dx***	SMI Dx**	OMD Dx**	PTSD Dx**	SUD Dx**
DOE, JOHN	1	1/1/1910	55	M	46	31	2	14%	2/26/2019	63	12/7/2018	12/11/2015	✓	✓	✓		6/21/2018	3/8/2019	3/14/2019	4/24/2019		✓	✓	✓		
DOE, JANE	2	1/1/1920	66	F	45	22	1	3%	2/26/2019	63	3/1/2019	5/17/2016	✓	✓			3/1/2019	3/15/2019								
DEF, ABC	3	1/1/1930	58	M	41	38	4	34%	1/28/2019	92	4/4/2019	8/4/2017	✓	✓	✓		11/29/2016	1/18/2019		8/8/2018	4/4/2019					✓
JKL, GHI	4	1/1/1940	81	M	15	29	2	14%	2/26/2019	63	3/11/2019	4/22/2016	✓	✓	✓		7/6/2018	3/15/2019	8/6/2018							✓
PQR, MNO	5	1/1/1950	69	M	12	24	1	3%	2/8/2019	81	2/28/2019	9/25/2015	✓	✓	✓		10/22/2018	2/8/2019	4/8/2019	1/14/2019						

Stratification Tool for Opioid Risk Mitigation – STORM

- 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, targeted at risk level.**

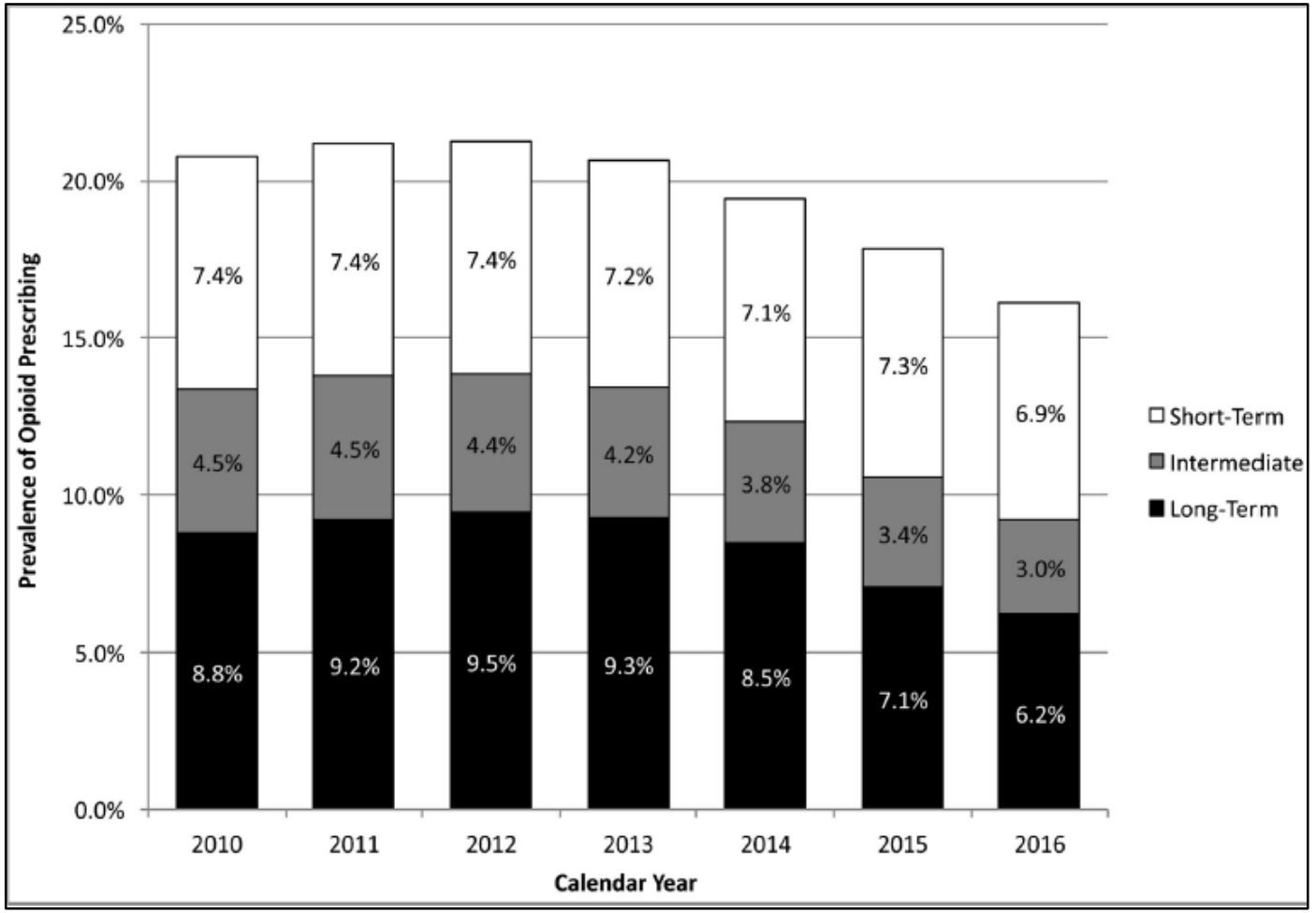


Patient Information	What factors contribute to my patient's risk?		How to better manage my patient's risk		How can I follow-up with this patient?		
	Relevant Diagnoses	Relevant Medications	Risk Mitigation Strategies	Non-pharmacological Pain Tx	Care Providers	Recent Appts	Upcoming Appts
Risk: Suicide or Overdose (1 yr)* High - Active Opioid Rx 6% *PRF - High Risk for Suicide: No* *RIOSORD:* Score: 11 Risk Class: 1 Active Station(s) • (653) Roseburg HCS Chart Review Note	PTSD **Medical** Lymphoma Obesity Renal Failure	PREGABALIN • Dr Zivago **Sedating Medication (Consider Tapering)** ZOLPIDEM • Dr Zivago CLONAZEPAM • Dr Zivago Opioid Prescription History	PDMP ☑ 3/3/2019 Psychosocial Assessment ☑ 1/28/2019 Psychosocial Tx ☐ Suicide Safety Plan ☑ 12/23/2009 Taper/Minimize Sedative Rx ☐ Timely Follow-up (90 Days) ☑ 4/25/2019 Timely UDS (1 Year) ☑ 12/13/2018	Occupational Therapy ☐ Pain Clinic ☑ 1/28/15 Physical Therapy ☐ Specialty Therapy ☐ Other Therapy ☐		• 1/16/2017 Primary Care/Medicine **OtherRecent** • 4/9/2017 Chemotherapy Proc. Unit-Med. **MH Appointment** • 4/25/2017 Mental Health Clinic - Ind	None **OtherRecent** • 8/12/2016 Laboratory **MH Appointment** • 8/1/2016 Mental Health Clinic - Ind
ZZTESTPATIENT,THE HULK Last Four: 2751 Age: 68 Gender: M ***Risk: Suicide or Overdose (1 yr)**** Medium - Active Opioid Rx 2% *PRF - High Risk for Suicide: No* *RIOSORD:* Score: Unknown Active Station(s) • (508) Atlanta, GA Chart Review Note	**Mental Health** Major Depressive Disorder Other MH Disorder PTSD **Medical** Hypertension	**Opioid** TRAMADOL • Dr Zivago **Pain Medications (Sedating)** GABAPENTIN • Dr Zivago Opioid Prescription History	Data-based Opioid Risk Review ☐ MEDD <= 90** ☑ 15 Naloxone Kit ☐ PDMP ☑ 3/20/2019 Psychosocial Assessment ☐ Psychosocial Tx ☑ 4/11/2019 Suicide Safety Plan ☑ 3/3/2010 Timely Follow-up (90 Days) ☑ 4/11/2019 Timely UDS (1 Year) ☐	Active Therapies ☐ CIH Therapies ☐ Chiropractic Care ☐ Occupational Therapy ☑ 2/5/16 Pain Clinic ☐ Physical Therapy ☑ 3/8/18 Specialty Therapy ☐ Other Therapy ☐		**OtherRecent** • 3/8/2017 Pm&Rs Physician **Primary Care Appointment** • 3/20/2017 Primary Care/Medicine **Specialty Pain** None **MH Appointment** • 4/11/2017 Mental Health Clinic - Ind	**OtherRecent** • 5/9/2016 Ophthalmology **Primary Care Appointment** • 5/8/2016 Primary Care/Medicine **Specialty Pain** None **MH Appointment** • 5/1/2016 Mental Health Clinic - Ind
ZZTESTPATIENT,SUPER MAN Last Four: 0001 Age: 82 Gender: M ***Risk: Suicide or Overdose (1 yr)**** Low - Active Opioid Rx 0% *PRF - High Risk for Suicide: No* *RIOSORD:* Score: Unknown Active Station(s) • (534) Charleston, SC Chart Review Note	**Medical** Sleep Apnea	**Opioid** TRAMADOL • Dr Zivago Opioid Prescription History	Data-based Opioid Risk Review ☑ 4/15/2019 MEDD <= 90** ☑ 15 Naloxone Kit ☐ PDMP ☑ 4/15/2019 Psychosocial Assessment ☐ Psychosocial Tx ☑ 10/30/2018 Suicide Safety Plan ☐ Timely Follow-up (90 Days) ☑ 4/15/2019 Timely UDS (1 Year) ☐	Active Therapies ☐ CIH Therapies ☐ Chiropractic Care ☐ Occupational Therapy ☐ Pain Clinic ☐ Physical Therapy ☑ 9/7/17 Specialty Therapy ☐ Other Therapy ☐		**MH Appointment** None **Specialty Pain** None **OtherRecent** • 3/22/2017 Ophthalmology	**MH Appointment** None **Specialty Pain** None **OtherRecent** • 3/16/2017 Ophthalmology

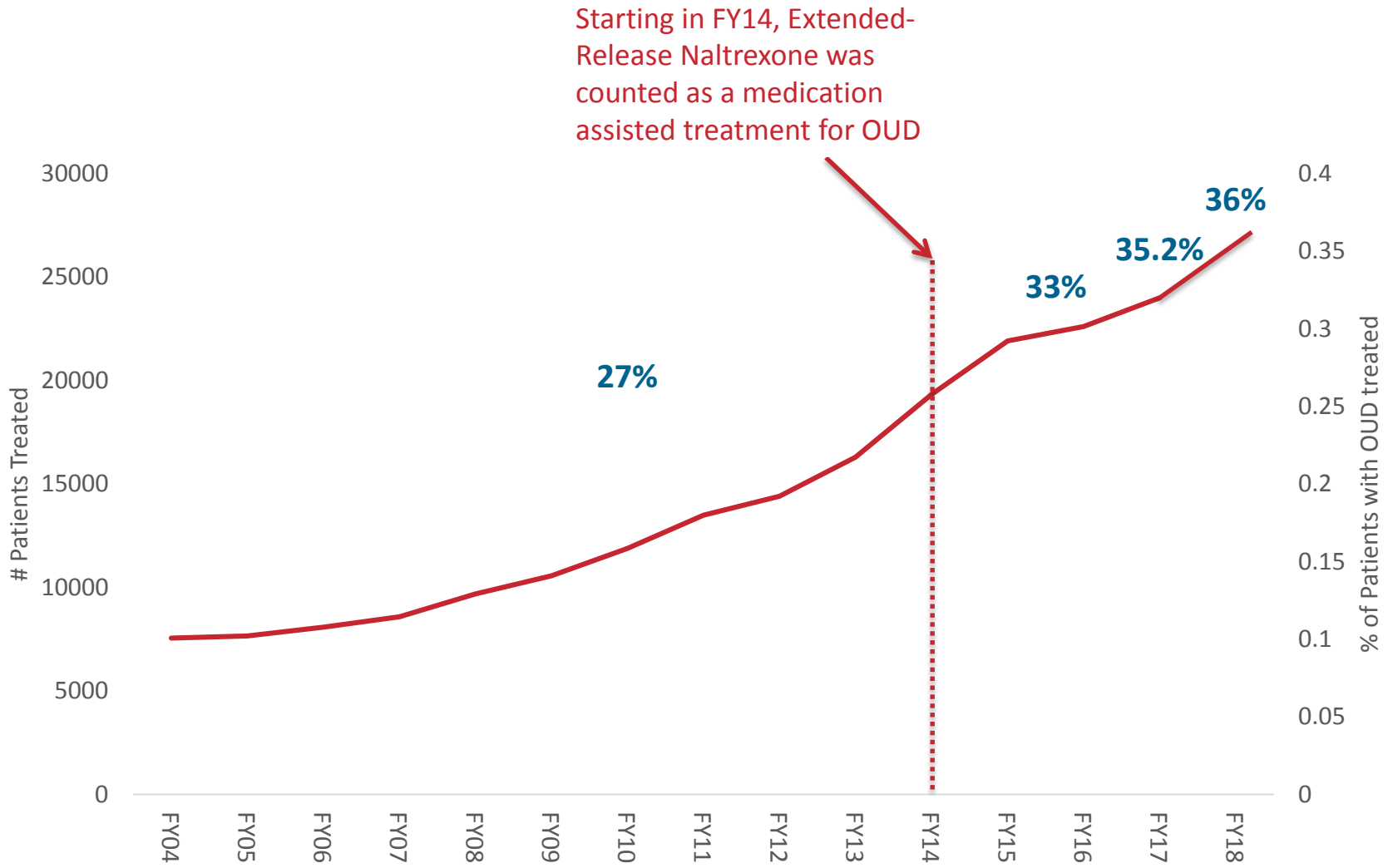
Reduction in Opioid Prescribing in VHA

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



Opioid Use Disorder (OUD) Medication for VHA Treated Veterans with OUD



Suicide Risk, Pain, and Opioids

- Co-occurring mental illness is associated with increased risk of suicidal thoughts and behaviors in opioid-dependent individuals. (Demidenko-2017, Gen Hosp Psychiatry)
- Internal VHA data show that Veterans were at increased risk of unintentional overdose or suicide death (all manner of suicide, not just overdose) within the first six months of starting or stopping prescription opioid pain medicine. (Sordo et al-2017, BMJ)

Suicide Risk, Pain, and Opioids

- Patients with chronic pain are twice as likely as those without chronic pain to die of suicide (Tang & Crane- 2006, Psychol Med)
  - Risk increases with the intensity of pain (Ilgen et al-2010, Suicide & Life)
  - Risk increases with opioid analgesic dose (ilgen-2016, Pain)
- Patients with opioid use disorder are 13 times more likely to die of suicide than the general population (Wilcox et al-2004, Drug Alc Dep)
  - VHA-treated Veterans are ~7 times more likely to be diagnosed with OUD than the commercially insured population (Baser et al-2014, Pain Practice)

Ways You Can Help Prevent Suicide in Veterans with Pain, Opioid Use, or Opioid Use Disorder (OUD)

- Assess for suicide risk among all Veterans with opioid use
- Assess for opioid use among Veterans at risk for suicide
- Access the Opioid Safety Initiative Toolkit (https://www.va.gov/painmanagement/opioid_safety_initiative_osi.asp)
- Direct Veterans to the VHA's online opioid safety information:
  - https://www.va.gov/painmanagement/opioid_safety/index.asp
- Provide additional support, treatment, and wrap around services during transition periods on and off opioid therapy for pain and medication for OUD

Ways You Can Help (continued)

- Ensure that Veterans considered for or receiving opioid pain medication are screened for illicit substances and other prescriptions per treatment guidelines.
- Address and treat co-occurring psychiatric conditions in Veterans who have attempted suicide or are at risk for suicide.
- Encourage medication treatment for opioid use disorder which reduces the risk of suicide.
  - Treatment with buprenorphine may benefits those with depression and OUD
- Provide opioid overdose education and naloxone for overdose reversal to Veterans and their family members

Special THANKS

- Chris Buser, LCSW-C, BCD
- Karen Drexler, MD
- Sarah Reading, MD
- Friedhelm Sandbrink, MD
- Christopher Welsh, MD
- VA Center for Medication Safety
- VA National Mental Health Program -Substance Use Disorders
- VA Pharmacy Benefits Management Services
- VA Program Evaluation Research Center
- VA Program for Pain Management
- VA Office of Academic Affiliations

QUESTIONS ?

National Suicide Prevention Hotline
(1-800-273-TALK)

Treatment Referral HELPLINE
(1-800-662-HELP)

Contact Information

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