Conflict of Interest Statement
Caveats for this Presentation

• I have no financial conflicts of interest with any pharmaceutical company
• Chair of the Medical Advisory Panel for Pharmacy Benefits Management for the Department of Veterans Affairs
• Co-Director of the VA Center for Medication Safety
• Member, FDA Drug Safety Board
American Pain Society was the first to promote pain as the 5th vital sign.

James Campbell, President's Address to the American Pain Society 1996: “Vital signs are taken seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly.”

VA - Early Adopter of the 5th vital sign (1998 started a national pain strategy)

2000: VA Mandates Pain as the 5th Vital Sign
- Routine screening and documentation of pain (0-10 scale)
- Documentation of a plan for improved pain management
VA Opioid Prescribing- FY 2016

- 1.2M VA patients received at least one opioid Rx
  - 15.4% of all VA patients who got any Rx in FY
- > 7 M total opioid Rxes
- ~30,000 VA prescribers of at least 1 opioid Rx in VA
  - > 35K patients remain on > 100 Morphine Eq/day
    - Down from ~60K in FY 2012
- Pain especially prevalent in VA, as well as non-VA population
  - 50-60% of Veterans have chronic pain (11 % get opioids chronically)
  - 30 % of general US population with chronic pain
  - 30% of Medicare Part D get opioids
  - Many patients entering VA system (from DoD, and community) are already getting opioids, some inappropriately
VA and the Opioid Crisis

VA Timeline

- 2007  Buprenorphine in the VA (BIV) Initiative
- 2009  National office to coordinate and improve pain practices
- 2011  Standardized metrics for opioid use across system
- 2013  Opioid Safety Initiative (OSI)
- 2013  Legislation allows reporting of VA data to State PDMPs
- 2013  Overdose Education and Naloxone Distribution Program
- 2013  Opioid Agonist Therapy (OAT) part of national QI initiative
- 2013  Opioid Therapy Risk Reduction (OTTR) to assist providers with opioid safety risk assessment
- 2014  Academic Detailing (focus on opioid prescribing initially)
VA and the Opioid Crisis

VA Timeline

- 2014  Mandatory documentation in EMR for Informed Consent chronic Opioids
- 2014  Medication Take-Back Program
- 2015  Stratification Tool for Opioid Risk Mitigation (STORM)
- 2016  Joint VA/DoD Pain Guidelines issued
- 2016  Mandatory opioid training for all VA opioid prescribers
- 2016  Complementary and Integrative Health Center established
Opioid Safety Initiative (OSI)

• Comprehensive program to provide:
  – Individualized prescriber, facility, and regional reports
  – Provider tools to identify high-risk patients
• Comprehensive naloxone distribution program
• Academic detailing
• Prescriber education
  – Pain guidelines
  – Mandatory training
Opioid Safety Initiative (OSI)

- Provides patient, prescriber, facility, region, and national-level opioid prescribing information
- Dashboards available to prescribers, and site managers for review
- Tracks metrics of interest; aggregate data routinely provided to facilities for benchmarking
- Metrics include:
  - Patients prescribed opioids
  - Presence of urine drug screens
  - Concurrent opioids plus benzodiazepines
  - Patients on high-dose opioids (> 100 morphine-equivalent daily dose)
Opioid Education and Naloxone Distribution Program

• 2013- Provides patient and provider education regarding overdose prevention
  – Web-based, accredited provider education modules
  – Patient and provider handouts and YouTube videos

• Provides free naloxone rescue kits to patients (with instruction for use)

• Provides reports back to facilities to track distribution

• As of March 2017, 5,280 VA prescribers had distributed 72,000 naloxone kits across VA

• 172 documented opioid reversals using these kits
Academic Detailing

- 2014 VA funded Academic Detailing Program
- Outreach education for VA healthcare professionals
- One on one communication approach, by clinical pharmacists, using pharmaceutic industry detailing models
  - Initial focus- opioids and psychiatric drugs
  - Utilizers individual on-line dashboard metrics
- 285 academic detailers in VA
- As of August 2016, 10,436 clinical staff detailed regarding pain and opioid safety
  - Among those detailed, a 58% reduction in high dose opioids compared to 34% in those without AD
Academic Detailing
Number of OSI/OEND Visits
VA Clinical Practice Guidelines

• VA/ Department of Defense Clinical Practice Guidelines for the Management of Opioid Therapy for Chronic Pain: Feb 2017
  – Recommends against initiation of long-term opioids for chronic pain
  – Recommends setting limits- e.g. short duration only
  – Recommends risk mitigation strategies for those already on chronic opioids, and tapering when feasible

• VA/ Department of Defense Clinical Practice Guidelines for the Management of Low Back Pain: 2017
  – Recommends against the use of opioids for LBP
October 2015 White House memorandum directed all Federal employees who prescribe opioids be trained in safe and effective opioid prescribing practices

VA developed several mandatory training programs to meet this directive

Centralized tracking metrics for training, with site level feedback

As of April 2017, 96% of VA opioid prescribers had documented meeting training requirements
VA Opioid Safety Initiative: What are the Results?

- VA has seen dramatic improvement in every metric involving opioids
  - Fewer patients getting opioids
  - Fewer patients on concomitant benzodiazepines
  - Fewer patients on high dose opioids
  - More patients with informed consent, and drug screens
  - Near universal PDMP, and opioid training of prescribers
VA Unique Patients Dispensed an Opioid* Over Time (by Quarter)

*Opioid = VA Drug Class CN101-Opioid Analgesics. Tramadol containing VA product names were excluded.

VA Opioid Safety Initiative Charter

Fully Implemented Aug 2013
Veterans Dispensed an Opioid and Concomitant Benzodiazepine Over Time

60% Reduction
73,468 fewer Veterans
Veterans On Opioid Therapy
Long-Term Over Time

39% Reduction
169,298 fewer Veterans
Veterans Dispensed Greater Than or Equal to 100 MEDD

48% Reduction
28,725 Veterans
What about Unintended Consequences of the VA Opioid Safety Initiative?

• Isolated reports of physicians implementing rapid tapers or setting arbitrary opioid dose limits for patients who were stable on chronic opioids

• Might prescribers be denying patients appropriate pain management, when an opioid might be indicated?

• Reports outside VA that some physicians are no longer prescribing opioids

• Is prescribing of opioids being delegated to a diminishing number of prescribers?
Are Fewer Primary Care Physicians Writing for Opioids in VA? No

- Evaluated numbers of VA Physicians identified as primary care specialty, before and after the VA Opioid Safety Initiative
- Evaluated the % of primary care physicians who prescribe opioids over time
- Evaluated the top 25% of opioid prescribers, to see if they were now caring for an increased number of patients requiring opioids
- Results- remarkably unchanged, in all areas, over time
- At least in VA, it does not appear that physicians are abdicating responsibility to write for opioids- although the trend for all physicians is to decrease the overall % of patients getting opioids
Conclusions

• Many lessons learned
• Continue to look at ways to assess our program, and improve success
• Continue to seek ways to educate opioid prescribers, as well as our patients
  – Balance between creating work for providers/facilities, maintaining the trust of our patients, and improving the safety of opioids in VA
• Outcomes like overdose, and transitioning of Veterans to illicit drug use difficult to measure