Opioid Prescribing and the Opioid Safety Initiative in the Veterans Health Administration

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Disclosures

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None to Report  
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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.
Background:

Pain Management and Opioid Safety in VHA Veterans

The Opioid Safety Initiative:

Opioid Prescribing and Opioid Risk Mitigation

Medication Use Evaluation (MUE):

Deprescribing/ tapering among Veterans Who Discontinued Opioids
Background:

Pain Management and Opioid Safety in VHA Veterans
Prevalence of Pain Among Veterans in the US

National Health Interview Survey 2016

• **Severe pain was reported by 9.1% of Veterans**, and thus was 40% more common than in non-veterans
  • pain that occurs “most days” or “every day” and bothers the individual “a lot”
  • Musculoskeletal pain is the most common type reported (joint 44%, back 33%).
Pain Management and Opioid Safety in VHA Veterans

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

- 6 Mil Veterans in Primary Care
- 2 Mil with at least one pain diagnosis
- About 120,000 Veterans had at least one visit in a pain specialty clinic
  - 5.8% of Veterans with pain condition attended a pain clinic in VHA (2012 data)
  - Pain clinic users had higher rates of muscle spasms, neuralgia, neuritis, radiculitis, and fibromyalgia, as well as major depression and personality disorders
  - Patients attending pain specialty clinics have more difficult-to-treat pain conditions and comorbid psychiatric disorders, use more outpatient services, and receive more opioids.
  - Inclusion of mental health care in the specialized treatment of chronic pain

Arout et al. 2017 Rates and Correlates of Pain Specialty Clinic Use Nationally in the Veterans Health Administration - PubMed (nih.gov)
Increased Nonopioid Chronic Pain Treatment in VHA

2,095,938 Veterans incident chronic pain

Pain diagnoses
- Back pain 27%
- Neck or other joint pain 34%
- Migraine 5%
- Neuropathy 3%
- Fibromyalgia 1%

MH and SUD diagnoses
- Depression 19%
- Anxiety 10%
- PTSD 14%
- Bipolar disorder 2%
- Alcohol use disorder 8%
- Opioid use disorder 1%
- Other SUD 5%

Pain Management and Opioid Safety in VHA Veterans

• Pain and mental health conditions occur often together.
• Pain, medical and/or mental health comorbidities are often related to military service and require Veteran-specific expertise.
• **Mortality rate for opioid overdose** is 1.5 x greater in VHA Veterans than in the general US adult population.
  → *In 2016, there were 1,271 deaths of VHA Veterans from opioid overdose, or 3.5 per day.*
• **Suicide** rate is about 1.5 x greater in VHA Veterans than in the general US adult population.
  → *Pain is the most common factor among Veterans who die by suicide; there is a close correlation between pain intensity, suicide risk and death rates.*

Pain care requires a systematic coordination of medical, psychological and social aspects of health care (integrated care).

Dosage and Risk of Overdose and Suicide from Opioids

Opioid Dose and Risk of Death (Patients with Chronic Pain)

- **Unintentional Overdose**
  - Patients with prescribed opioids in FY 2004 or 2005
  - Followed until end of 2008 (unintentional OD) or 2009 (suicide).
  - Nested case control design

- **Suicide**

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.
The Opioid Safety Initiative:
Opioid Prescribing and Opioid Risk Mitigation
OSI was piloted in 2012 and expanded nationally in FY 2013

**OSI Aims**
- Reduce over-reliance on opioid analgesics for pain management
- Safe and effective use of opioid therapy when clinically indicated

- Comprehensive OSI strategy including
  - **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

Gellad, Good CB, and Shulkin. 
*JAMA Intern Med. 2017 May 1;177:611-2*
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/
• Type, Dose, Follow-up, and Taper of Opioids

– If prescribing opioids: **short duration and lowest dosage.**
– **No dosage is safe**; Strong rec against increasing 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**: non-opioid treatment, multimodal pain care as first-line
– if opioids are prescribed, use short term ≤ 3–5 days (short-acting)
OSI Dashboard

1. Opioid use overall, and long-term opioid use
2. Opioid and Benzo co-prescribing
3. High dose $\geq 90$ MEDD
4. New starts for Long-Term Opioid Therapy (LTOT, i.e. $\geq 90$ days)
5. Urine Drug Testing (for LTOT)

Other OSI parameters/risk mitigation strategies (implementation/guidance year):

- Informed consent (2014) for pts on LTOT (90 d)
- PDMP checks (2016) annually or more often per state, for all controlled medications if $> 5$ d supply
- Overdose Education and Naloxone Distribution (2014) broad inclusion, no cost to Veterans
- Timely f/u within 1-4 weeks after dosage change, and at least q3 months to review care (2017)
- OSI Risk Reviews based on STORM (2018) optimize care of pts with very high risk for OD/suicide, and assess risk prior to initiation of opioid therapy
Opioid Safety Initiative (OSI): Opioid Prescribing

PBM OSI Dashboard
Update implemented with FY 2021
Quarterly report

- **Outpatient pharmacy users:**
  - Dispensed an opioid
  - Dispensed an opioid and benzodiazepine
  - Long-term opioid therapy (LTOT) patients (>/= 90 days) with a urine drug screen within the past 365 days
  - New Long-term opioid therapy (New LTOT) patients (LTOT for current quarter, LTOT or not in prior quarter (3-6 months), but no prior LTOT in last 7-12 months)
  - Morphine Equivalent Daily Dosing (MEDD) stratification

Veterans Dispensed Opioids Over Time

All opioids, including Tramadol

Starting with Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention Annual Surveillance Report of Drug-Related Risk and Outcomes definitions. For this metric, tramadol has been added.
Opioid Safety Initiative (OSI): High Risk Opioid Prescribing

Veterans Dispensed Opioid and Benzodiazepine

Number of Veterans Dispensed Opioids & Benzodiazepines

- Line graph showing the number of veterans dispensed opioids and benzodiazepines over time.
- Fiscal Quarter: Q4FY12
- Total: 162,444
- Percent: 4.10%

Percent Change: 88% (Decrease)

Veterans on High Dose Opioid Therapy

Number of Veterans With Morphine Equivalent Daily Dose $\geq$ 90

- Line graph showing the number of veterans on high dose opioid therapy over time.
- Fiscal Quarter: Q4FY12
- Total: 76,466
- Percent: 1.93%

Percent Change: 78% (Decrease)

Dispensed Opioids $\geq$ 90mg MEDD

- Initial notes mention financial data impacts, dosage metrics, and reporting period.
- Data source includes VA medical facilities, VA disability compensation, and other relevant metrics.

For metrics data changes, please refer to the Opioid Safety Initiative (OSI) guidelines.
Veterans on Opioid Therapy Long-Term

**Number of Veterans With Long Term Opioid**

- **Change**: 367,229 (Decrease)
- **Percent Change**: 65% (Decrease)

**Percent of Veterans With Long Term Opioid**

- Fiscal Quarter Q4FY12: 569,027 (14.37%)
- Fiscal Quarter Q2FY21: 201,798 (4.85%)

**Veterans on Opioid Therapy Long-Term with Urine Drug Screen in the last 365 days**

**Percent Change**: 45% (Increase)

**Percent Change**

- Fiscal Quarter Q4FY12: 32.46%
- Fiscal Quarter Q2FY21: 77.45%

Comparisons are not available for community care providers as only the prescriptions are filled by VA medical facilities' pharmacies. The Urine Drug Screen (UDS) ordered and completed at non-VA laboratories are not available.

Starting with the Quarter 4, Fiscal Year 2023 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention Annual Surveillance Report of Drug-Related Risks and Outcomes Indicators. For this metric, tramadol has been added.

Starting with Quarter 1, Fiscal Year 2021, data for VA medical facilities utilizing CARE are incomplete. At this time, National VA, Veterans Integrated Service Network (VISN) 20 and the Spokane VA medical facility CSS dashboard metrics are impacted.

ChooseVA

U.S. Department of Veterans Affairs
New Long-term opioid therapy (New LTOT) patients
• LTOT for current quarter, LTOT or not in prior quarter (3-6 months), but no prior LTOT in last 7-12 months
• New measure since FY 2021
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

- > 500,000 naloxone prescriptions issued, > 1,800 overdose reversals (March 31, 2021)
- No cost to patients (elimination of copays for naloxone and training, as per CARA)
- **Rapid Naloxone initiative**: VA first responders and VA staff including deployment in automated external defibrillator (AED) cabinets and to VA police

https://www.youtube.com/watch?v=0w-us7fQE3s
More than 254,000 Veterans dispensed naloxone by over 28,000 prescribers with over 1,500 reported overdose reversals (Sept. 28, 2020)
Prescription Drug Monitoring Program (PDMP)

  - PDMP check for all **controlled substances** on annual basis at a minimum
  - PDMP check prior to initiating therapy with a controlled substance
  - PDMP check more frequently, at the discretion of the prescriber according to clinical indication and patient safety concerns.
  * Controlled substances prescriptions with ≤ 5-day supply without refill and for patients in hospice care are exempt.

- **Compliance with the Directive is monitored and reported** using data from the Academic Detailing dashboard
  - Current compliance targets: **95% for “Annual” PDMP queries, 75% for newly initiated “New Start” prescriptions**

- **VHA launched a national IT solution in November 2020** for querying PDMPs that integrates within VHA’s electronic health record (CPRS).

Currently 4 states are not participating with the national integrated solution. We are actively working with the states to resolve issues.
- California
- Nebraska
- New Hampshire
- New York
Guidance since 2017: Approaching Opioid Tapering

There is no VHACO policy that mandates opioid reductions. All care must be individualized with the goal to improve the Veteran’s life.

• 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.
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.”

AD Opioid Taper Decision Tool: 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.
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.

Oliva et al. Psychol Serv. 2017;14:34-49
Opioid Safety Risk Review Teams

Systematic review of the clinical care of patients at high risk for overdose or suicide

- Data-based risk reviews of opioid-exposed Veterans
- Interdisciplinary membership
  - Include Primary Care, Pain specialty, MH, SUD programs
  - 20-30% of patients with opioid overdoses are estimated to be intentional/suicidal
  - STORM dashboard identifies Veterans at very high risk
  - Other high risk: dosage, opioid/benzo combination, etc.
- Care coordination across services
- Care recommendations entered into the EHR

- Model for interdisciplinary case review forums for patients with complex pain conditions

Stratification Tool for Opioid Risk Mitigation (STORM)
Safety of Opioids, Tapering/Discontinuations in Veterans

WHAT THIS STUDY ADDS
In patients prescribed opioids in the VHA, stopping treatment with opioids at any time had an increased risk of death from overdose or suicide, with the risk increasing the longer patients were treated. Efforts to mitigate the risk should be intensified for at least 3 months after starting or stopping opioids.

Observational study. Circumstances that triggered the decision to stop prescribing an opioid might drive the increased risk.

Probability of death from overdose or suicide in patients treated with opioids in FY 2013 after stopping opioid treatment (n=799 668)
• **Medication for Opioid Use Disorder (MOUD)**
  - Buprenorphine/naloxone
  - Methadone
  - Naltrexone (including injection)

• **Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative**

**LEVEL 0:**
- **Self-management:**
  - Mutual help groups
  - Skills application

**LEVEL 1:**
- **Addiction-focused medical management:** in
  - Primary Care in Pain Clinics in Mental Health

**LEVEL 2:**
- **SUD Specialty Care:**
  - Outpatient
  - Intensive outpatient
  - Opioid program
  - Residential

VHA Notice 2020-30: Buprenorphine Prescribing for Opioid Use Disorder
Medication Use Evaluation (MUE):
Deprescribing/ tapering among Veterans Who Discontinued Opioids
• VHA initiated the Opioid Safety Initiative (OSI) in fiscal year (FY) 2013 to enhance the safe and appropriate use of opioids in the VA

• VA Conducted a Medication Use Evaluation (MUE) to assess patient characteristics and patterns of deprescribing /tapering of chronic high-dose opioids among OSI Veterans who discontinued opioids in either FY13 or FY17 to assess changes in management and outcomes over time
Describe documented plans for tapering/de-prescribing of high dose chronic opioid therapy in the cohort.

a. Documented tapering plan
b. Reasons for discontinuation
c. VA services responsible for recommendation and implementation – primary care, pain specialty, pharmacy, other
d. Target MEDD prior to discontinuation
e. Tapering vs no tapering
f. Gradual vs quick taper
g. Length of tapering period
### Baseline Demographics and Other Characteristics of Chronic HD Opioid Discontinuers (N = 637)

<table>
<thead>
<tr>
<th></th>
<th>FY13, (N = 315)</th>
<th>FY17, (N = 322)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age in yrs., median (IQR)</strong></td>
<td>57 (49, 63)</td>
<td>61 (55, 67)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td><strong>Male, N (%)</strong></td>
<td>300 (95.24%)</td>
<td>302 (93.79%)</td>
<td>0.42</td>
</tr>
<tr>
<td><strong>MEDD, median (IQR)</strong></td>
<td>160 (120, 230)</td>
<td>135 (120, 180)</td>
<td>&lt;0.05</td>
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<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
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<tr>
<td>Non-Hispanic White</td>
<td>256 (81.27%)</td>
<td>238 (73.91%)</td>
<td>0.03</td>
</tr>
<tr>
<td>Black or African American</td>
<td>33 (10.48%)</td>
<td>38 (11.80%)</td>
<td>0.60</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12 (3.81%)</td>
<td>15 (4.66%)</td>
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<tr>
<td>Other</td>
<td>7 (2.22%)</td>
<td>16 (4.97%)</td>
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<tr>
<td><strong>Level of completed education</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Less than high school diploma</td>
<td>17 (5.40%)</td>
<td>11 (3.42%)</td>
<td></td>
</tr>
<tr>
<td>High school degree or equivalent</td>
<td>57 (18.10%)</td>
<td>59 (18.32%)</td>
<td></td>
</tr>
<tr>
<td>Some college, no degree</td>
<td>58 (18.41%)</td>
<td>48 (14.91%)</td>
<td></td>
</tr>
<tr>
<td>College degree</td>
<td>34 (10.79%)</td>
<td>35 (10.87%)</td>
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<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed or Student</td>
<td>42 (13.33%)</td>
<td>34 (10.56%)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>124 (39.37%)</td>
<td>123 (38.20%)</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>74 (23.49%)</td>
<td>98 (30.43%)</td>
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</table>
## Discontinuation: Clinician Involvement and Rationale by Fiscal Year (N = 637)

<table>
<thead>
<tr>
<th>Clinician Involvement (recommended/ initiated/ involved) in Discontinuation</th>
<th>FY13, (N= 315)</th>
<th>FY17, (N= 322)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical pharmacist Involved in Tapering Process</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Non-adherence to opioid risk mitigation strategies as outlined in the Informed consent for LOT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinuation rationale</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Clinician Involvement (recommended/ initiated/ involved) in Discontinuation

- **Primary care provider**
  - FY13: 266 (84.44%)
  - FY17: 218 (67.70%)
  - *p-value* <0.05

- **Pain management**
  - FY13: 18 (5.71%)
  - FY17: 57 (17.70%)
  - *p-value* <0.05

- **Pharmacy**
  - FY13: 11 (3.49%)
  - FY17: 24 (7.45%)
  - *p-value* 0.03

- **Clinical pharmacist Involved in Tapering Process**
  - FY13: 51 (16.19%)
  - FY17: 115 (35.71%)
  - *p-value* <0.05

- **Non-adherence to opioid risk mitigation strategies as outlined in the Informed consent for LOT**
  - FY13: 136 (43.17%)
  - FY17: 73 (22.67%)
  - *p-value* <0.05

### Discontinuation rationale

- **Strong concern for diversion, unsafe behaviors, or other misuse**
  - FY13: 88 (27.94%)
  - FY17: 61 (18.94%)
  - *p-value* 0.01

- **Risks of LOT outweigh benefits**
  - FY13: 41 (13.02%)
  - FY17: 77 (23.91%)
  - *p-value* <0.05

- **Lack of clinically meaningful improvement in function**
  - FY13: 33 (10.48%)
  - FY17: 59 (18.32%)
  - *p-value* <0.05

- **Concomitant use of medications that increase risk of OD**
  - FY13: 23 (7.30%)
  - FY17: 38 (11.80%)
  - *p-value* 0.05

- **Provider determined prescribed dose is higher than max recommended dose**
  - FY13: 23 (7.30%)
  - FY17: 66 (20.50%)
  - *p-value* <0.05

- **OSI dashboard (i.e. more visibility in conjunction comprehensive assessment)**
  - FY13: 3 (0.95%)
  - FY17: 19 (5.90%)
  - *p-value* <0.05
DESCRIPTION OF TAPER SPEED PLANS BY FISCAL YEAR

<table>
<thead>
<tr>
<th>Taper Length in days, median (IQR)</th>
<th>FY13</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUICK (&lt;1 MONTH)</td>
<td>59 (29, 199)</td>
<td></td>
</tr>
<tr>
<td>MODERATE (1–3 MONTHS)</td>
<td></td>
<td>162.5 (64.5, 335)</td>
</tr>
<tr>
<td>STEADY (3–12 MONTHS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRADUAL (&gt;12 MONTHS)</td>
<td>0%</td>
<td>6.50%</td>
</tr>
<tr>
<td>TRIAL OF STEP-DOWN THERAPY</td>
<td>5.61%</td>
<td>21.95%</td>
</tr>
</tbody>
</table>

p-value <0.05

FY13 Tapers, (N = 177)
FY17 Tapers, (N = 227)
Monitoring Activities and Events During Discontinuation Process by Fiscal Year

<table>
<thead>
<tr>
<th>Service Description</th>
<th>FY13, (N=315)</th>
<th>FY17, (N=322)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk vs. benefit assessment</td>
<td>150 (47.62%)</td>
<td>190 (59.01%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>VA Services during tapering period or before discontinuation</td>
<td>312 (99.05%)</td>
<td>315 (97.83%)</td>
<td>0.22</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>163 (52.24%)</td>
<td>123 (39.05%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Pain Management/Pain Clinic</td>
<td>70 (22.44%)</td>
<td>99 (31.43%)</td>
<td>0.01</td>
</tr>
<tr>
<td>Primary Care Involved in Opioid Therapy or Pain Management</td>
<td>188 (60.26%)</td>
<td>169 (53.65%)</td>
<td>0.09</td>
</tr>
<tr>
<td>Utilized Complementary and Alternative Medicine</td>
<td>19 (6.09%)</td>
<td>41 (13.02%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Other Specialty Services (e.g., Neurology, Rheumatology, Orthopedics)</td>
<td>70 (22.44%)</td>
<td>68 (21.59%)</td>
<td>0.80</td>
</tr>
<tr>
<td>Pharmacy Services/Consults</td>
<td>47 (15.06%)</td>
<td>82 (26.03%)</td>
<td>&lt;0.05</td>
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</table>
MODES OF THERAPY AND PAIN MANAGEMENT AFTER OPIOID DISCONTINUATION

<table>
<thead>
<tr>
<th>Mode of Therapy</th>
<th>FY13, (N = 315)</th>
<th>FY17, (N = 322)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-opioid Pharmacological Treatment</td>
<td>59.68%</td>
<td>69.88%</td>
</tr>
<tr>
<td>Non-pharmacological Treatment</td>
<td>28.57%</td>
<td>36.65%</td>
</tr>
<tr>
<td>No Treatment</td>
<td>19.68%</td>
<td>16.15%</td>
</tr>
<tr>
<td>Pain improvement with therapy transition</td>
<td>85.40%</td>
<td>92.55%</td>
</tr>
</tbody>
</table>
The overall assessment and comparison of opioid discontinuation and tapering methods between Fiscal Year 13 and 17 proved that VA is a true “Learning Healthcare System”

High Dose Opioid Discontinuation was more optimal in FY 17
  • High dose opioid tapering plans were significantly longer compared to FY 13 and were dynamically customized to the patient response.
  • The final median opioid MEDD was significantly lower compared to FY 13
  • Pain management and improvement were significantly better in FY 17

While primary care was the main discipline responsible for opioid de-prescribing overall and in FY 13, following implementation of the OSI, there was a significant increase in other provider involvement specifically pain management and pharmacy in the high dose opioid de-prescribing effort.

The MUE comparing FY 17 to FY 13 showed that dashboard utilization, pain management education, and other risk mitigation strategies for OSI have appeared to optimally influence the tapering and discontinuation of high-dose opioid therapy.
Key Sources

• Main VA sites
  – VHA Pain Management
    • https://www.va.gov/PAINMANAGEMENT/index.asp
  – VA Substance Use Disorder Treatment
    • https://www.mentalhealth.va.gov/substance-abuse/index.asp
  – VA OEND
    • https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp

• VA Academic Detailing Service

• Veterans Health Library
  – www.veteranshealthlibrary.va.gov

• Make The Connection
  – www.MakeTheConnection.net

• DoD/VA Joint Pain Education Program (JPEP)
  – https://www.dvcipm.org/clinical-resources/joint-pain-education-project-jep
Thank You

www.va.gov/painmanagement