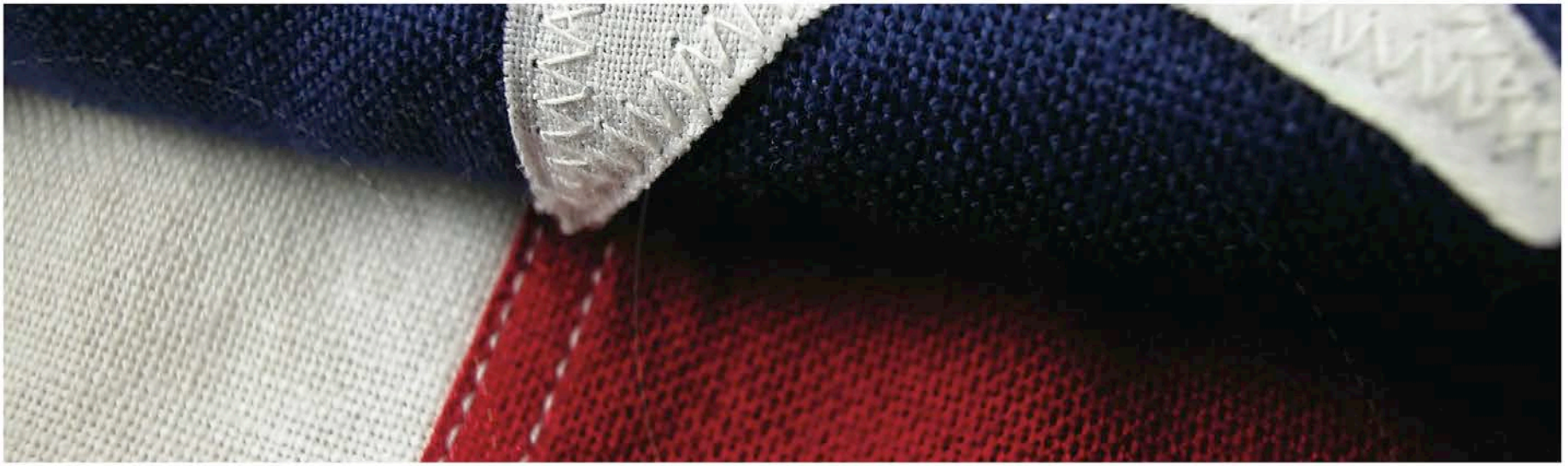

Federal Healthcare System Experience: VA Implementation, Maintenance, and Evaluation

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Veterans Affairs Pharmacy Benefits Management
May, 2017

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

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

Pain: The Fifth Vital Sign

- American Pain Society was the first to promote pain as the 5th vital sign
- James Campbell, Presidents Address 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

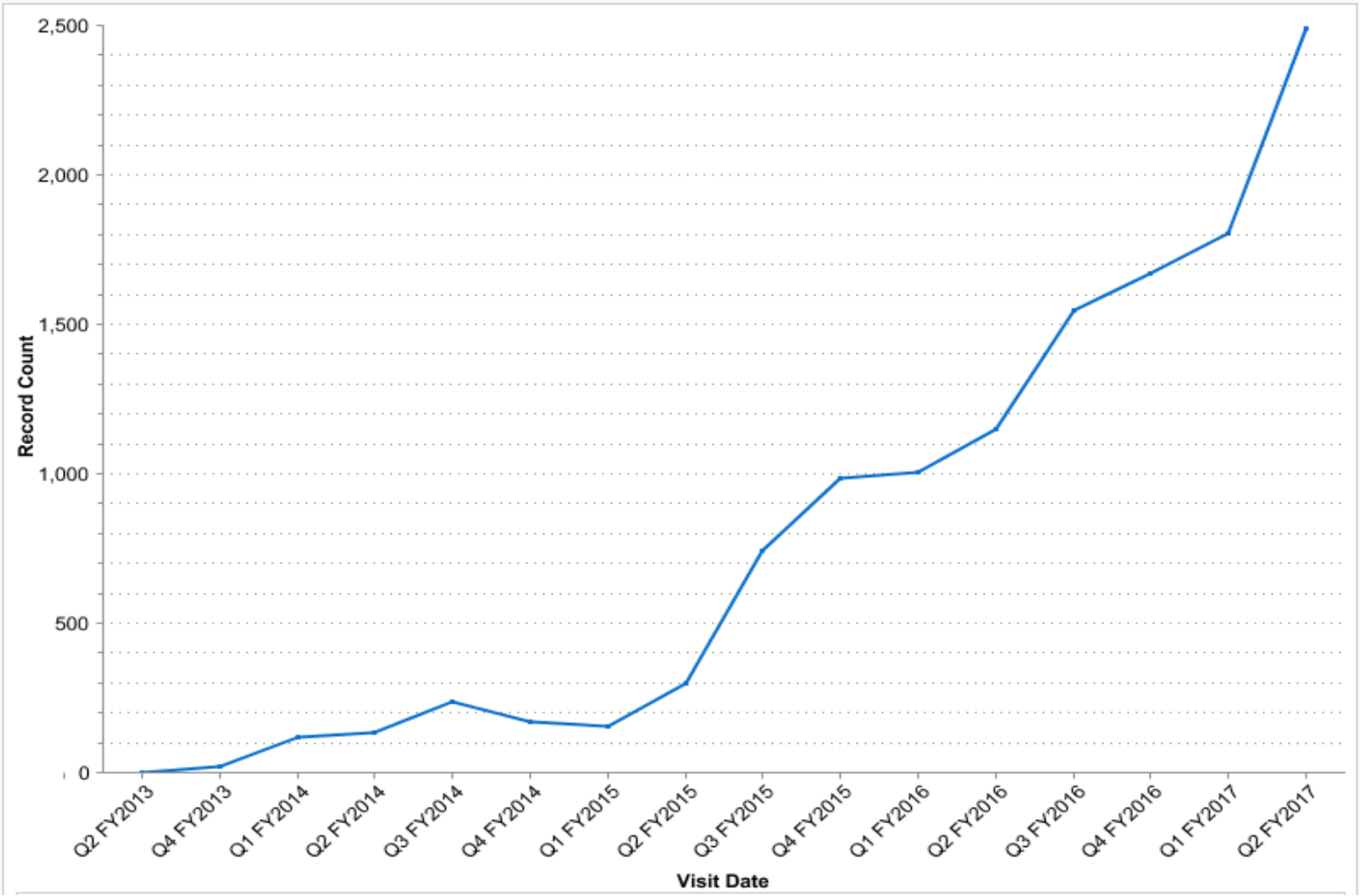
- 2013- Provides patient and provider education regarding overdose prevention
  - Web-based, accredited provider education modules
  - Patient and provider handouts and YouTube videos
- Provides free naloxone rescue kits to patients (with instruction for use)
- Provides reports back to facilities to 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

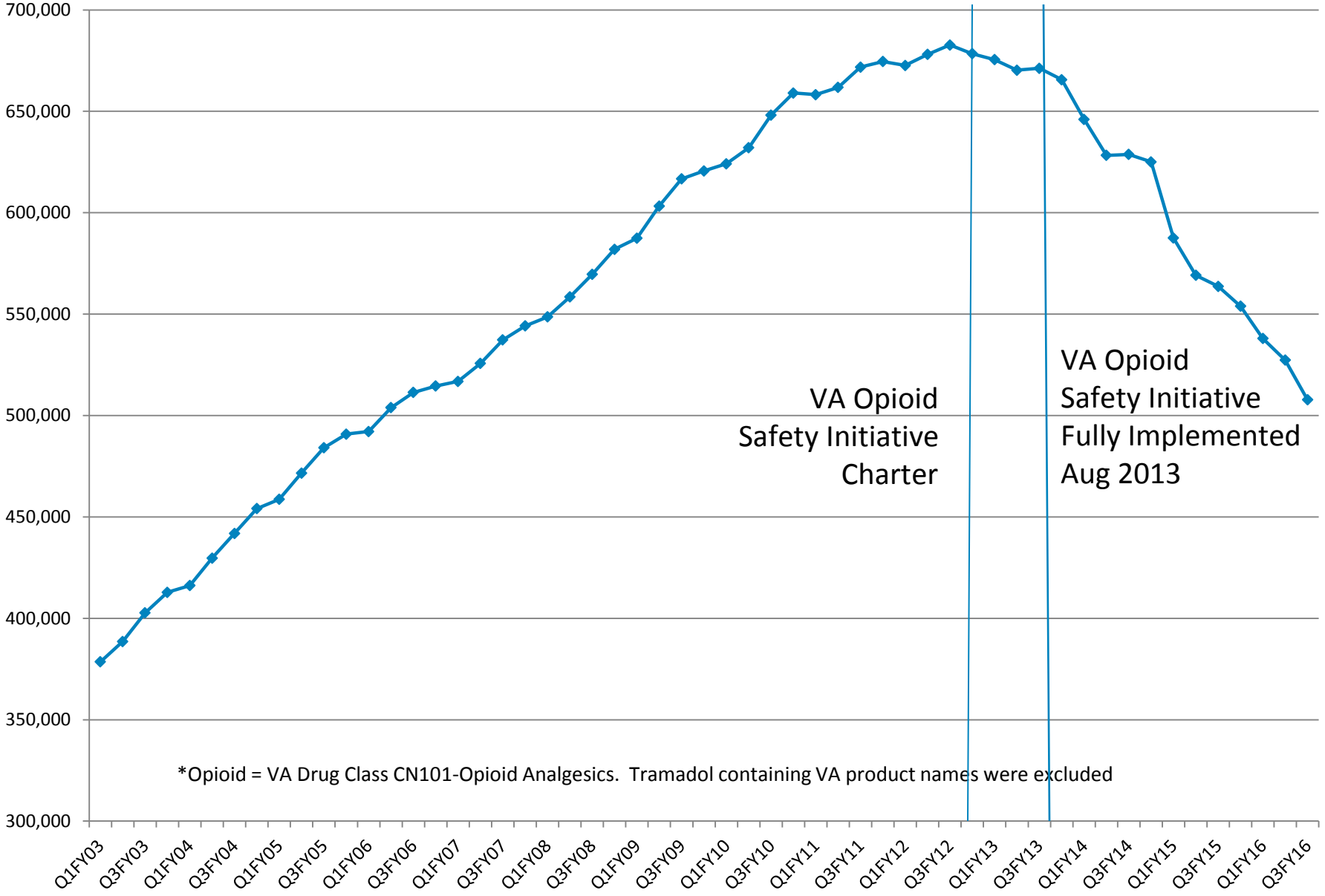
VA Provider Opioid Education

- 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

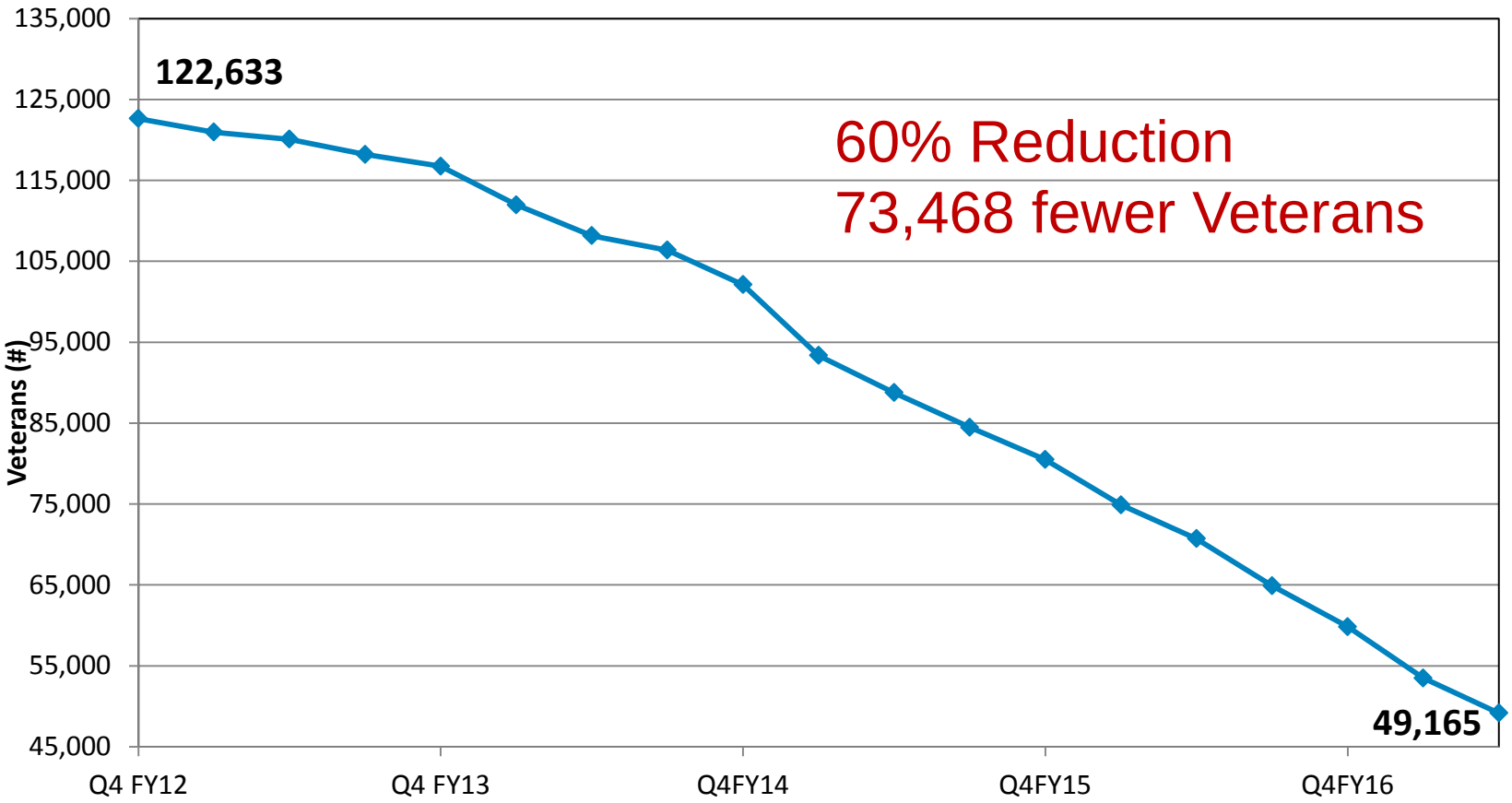
VA Opioid Safety Initiative: What are the Results?

- 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

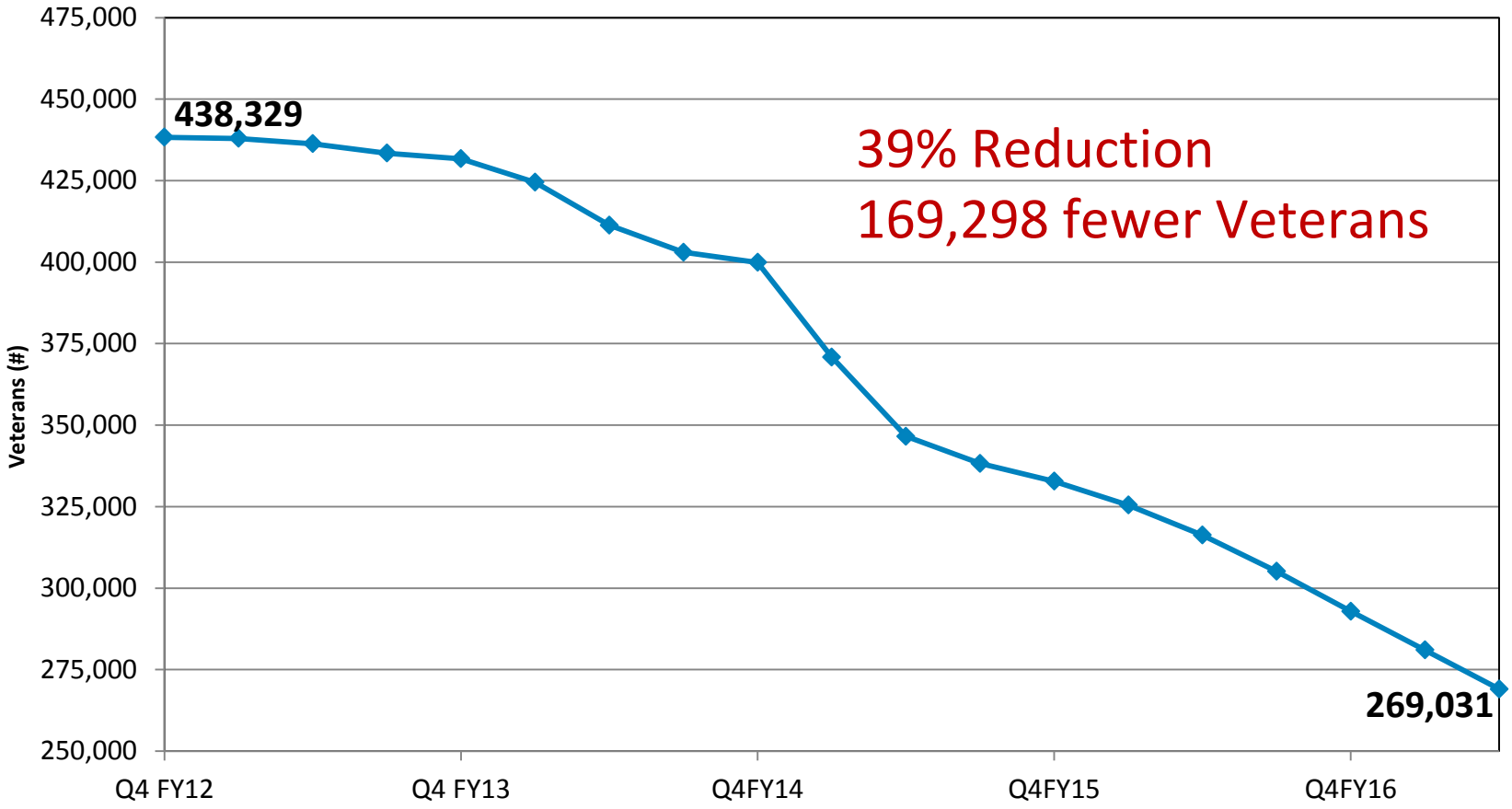
VA Unique Patients Dispensed an Opioid* Over Time (by Quarter)



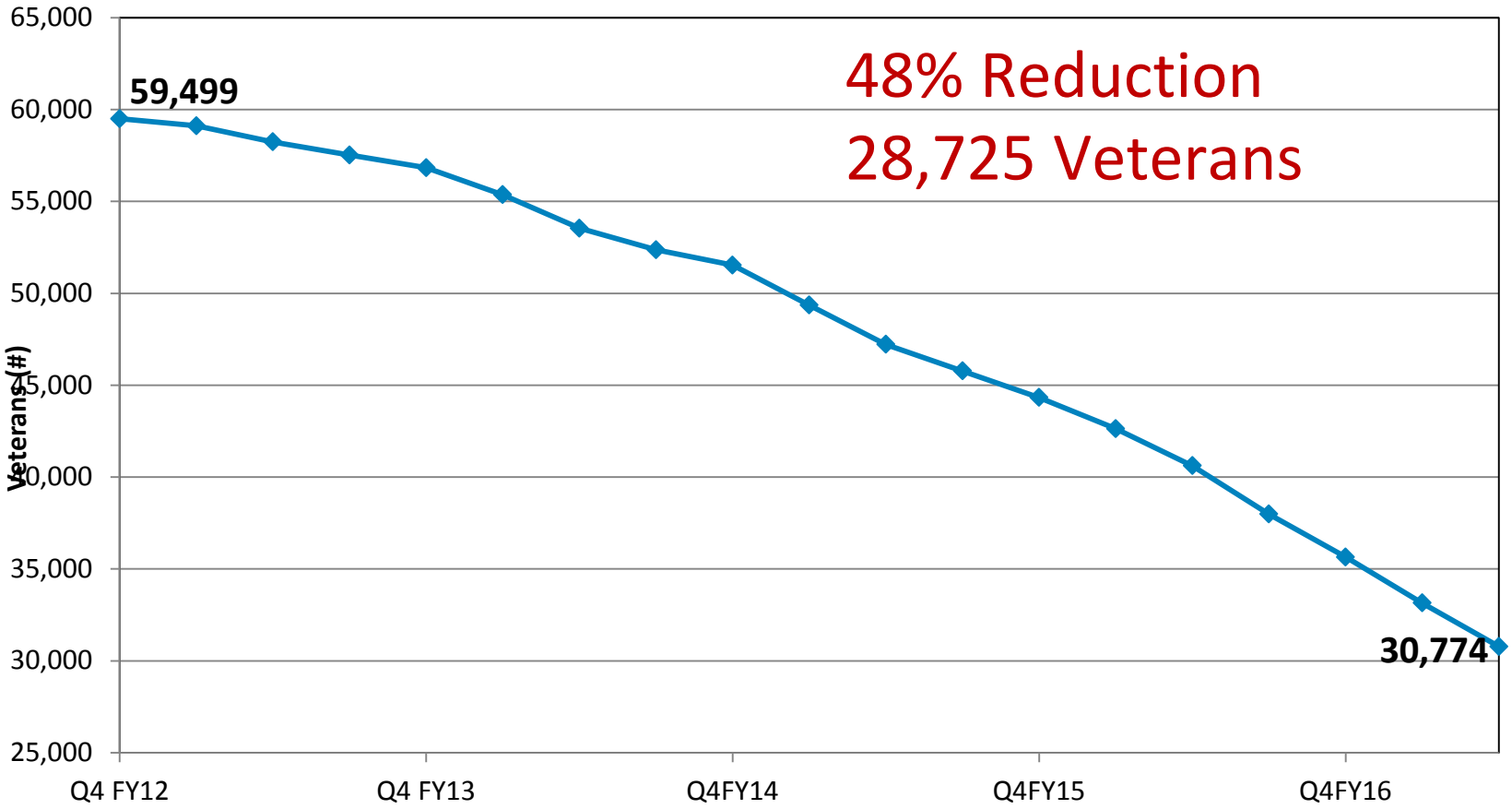
Veterans Dispensed an Opioid and Concomitant Benzodiazepine Over Time



Veterans On Opioid Therapy Long-Term Over Time



Veterans Dispensed Greater Than or Equal to 100 MEDD



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