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

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Disclosures

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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.

Overview

Background:

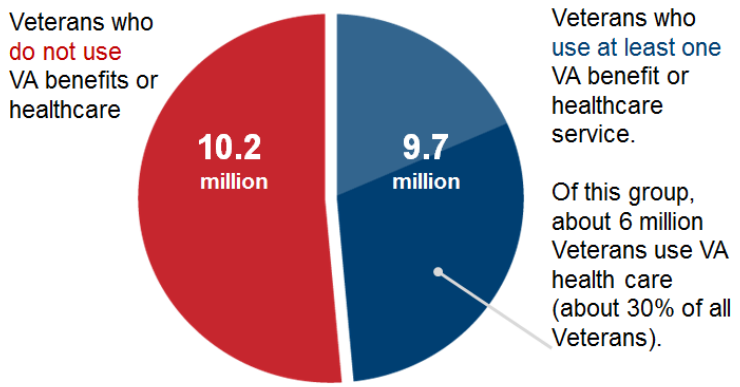
Pain Management and Opioid Safety in VHA Veterans

The Opioid Safety Initiative:

Opioid Prescribing and Opioid Risk Mitigation

Medication Use Evaluation (MUE):

Deprescribing/ tapering among Veterans Who Discontinued Opioids



Background:

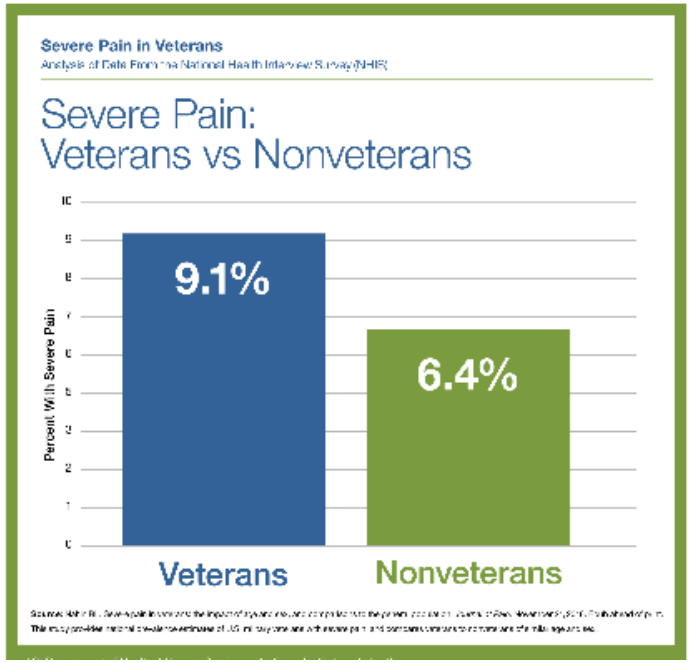
Pain Management and Opioid Safety in VHA Veterans

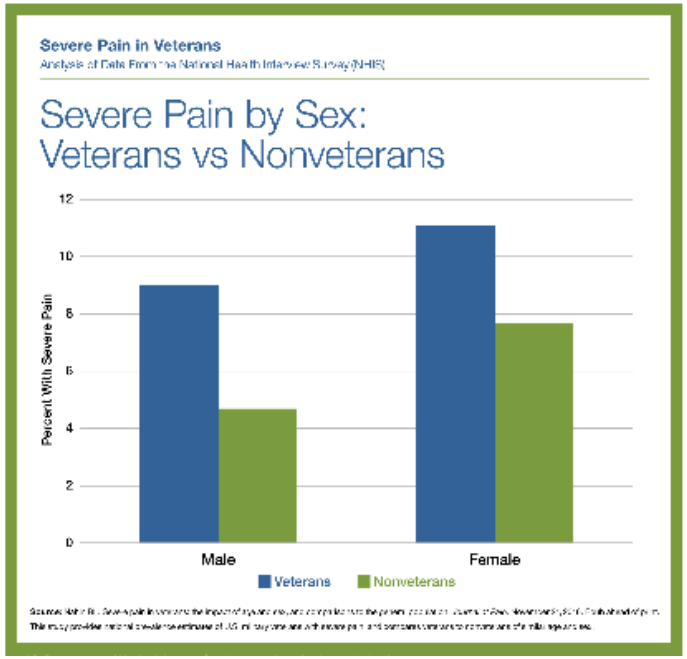
Prevalence of Pain Among Veterans in the US

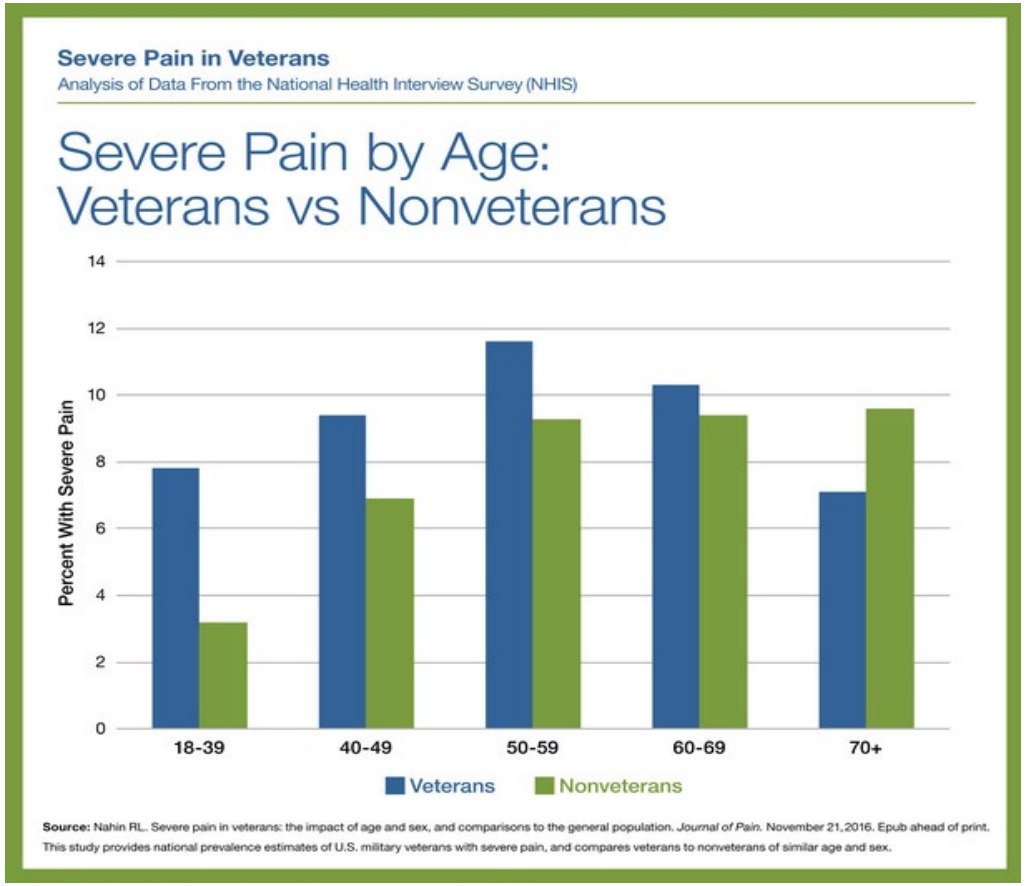
National Health Interview Survey 2016

- **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%).

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



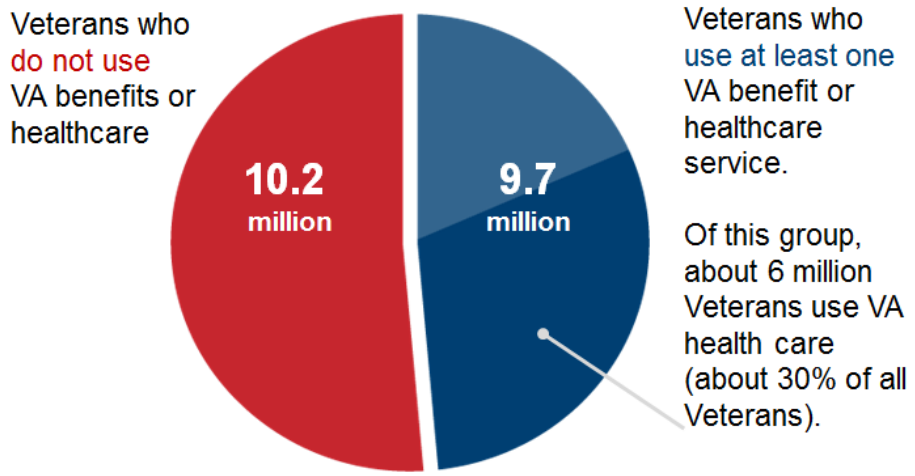




National Health Interview Survey Nahin RL, Journal of Pain 2017; https://www.nccih.nih.gov/health/pain/veterans

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 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

Increased Nonopioid Chronic Pain Treatment in VHA

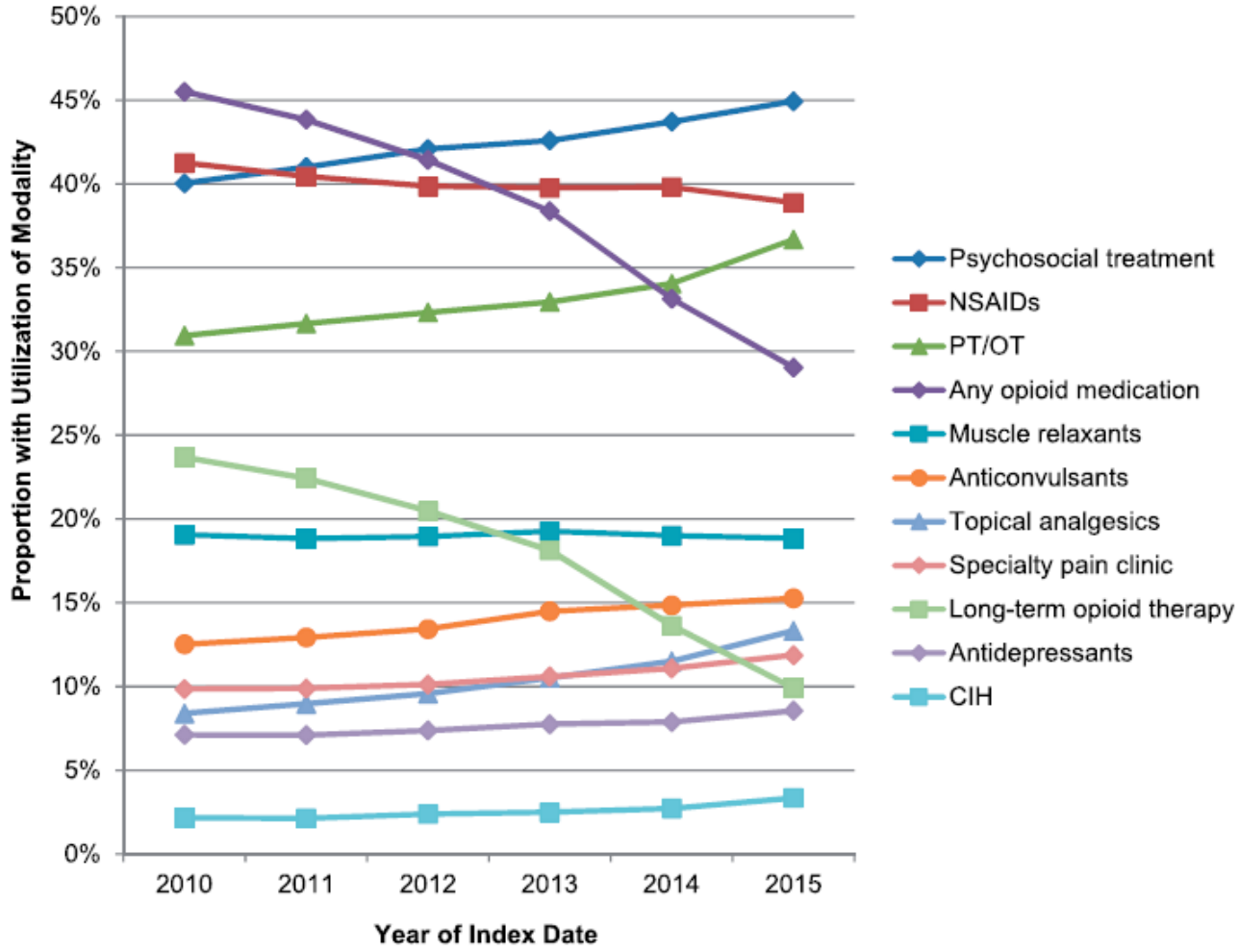
2,095,938 Veterans incident chronic pain

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%



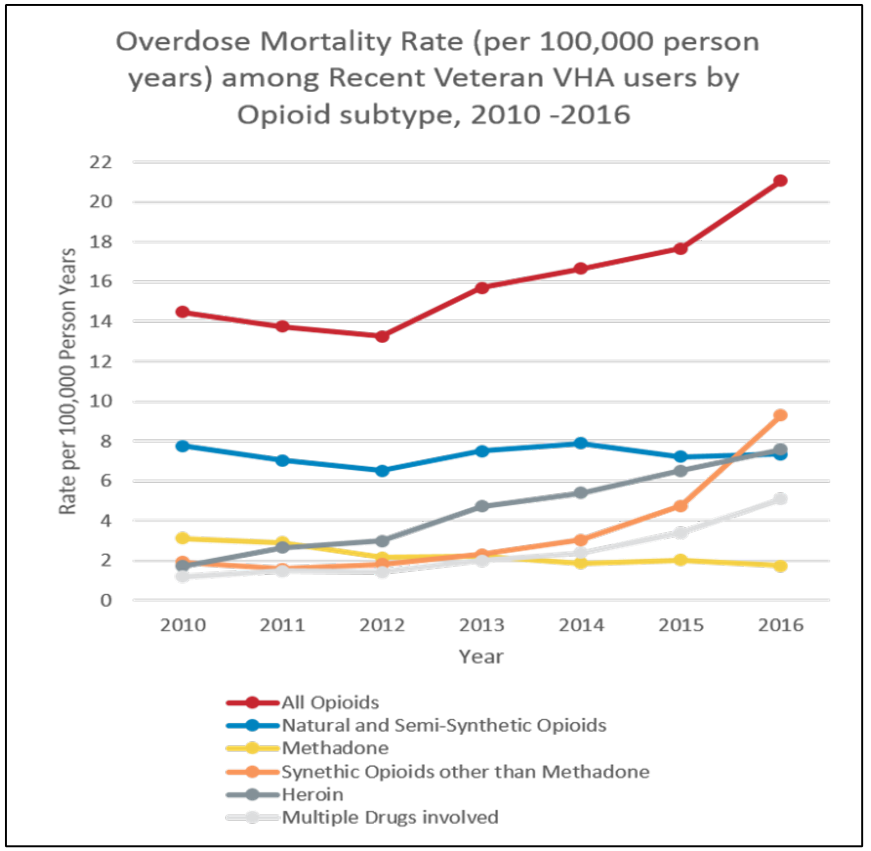
Frank et al. Pain Med. 2019 May 1;20(5):869-877

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.***

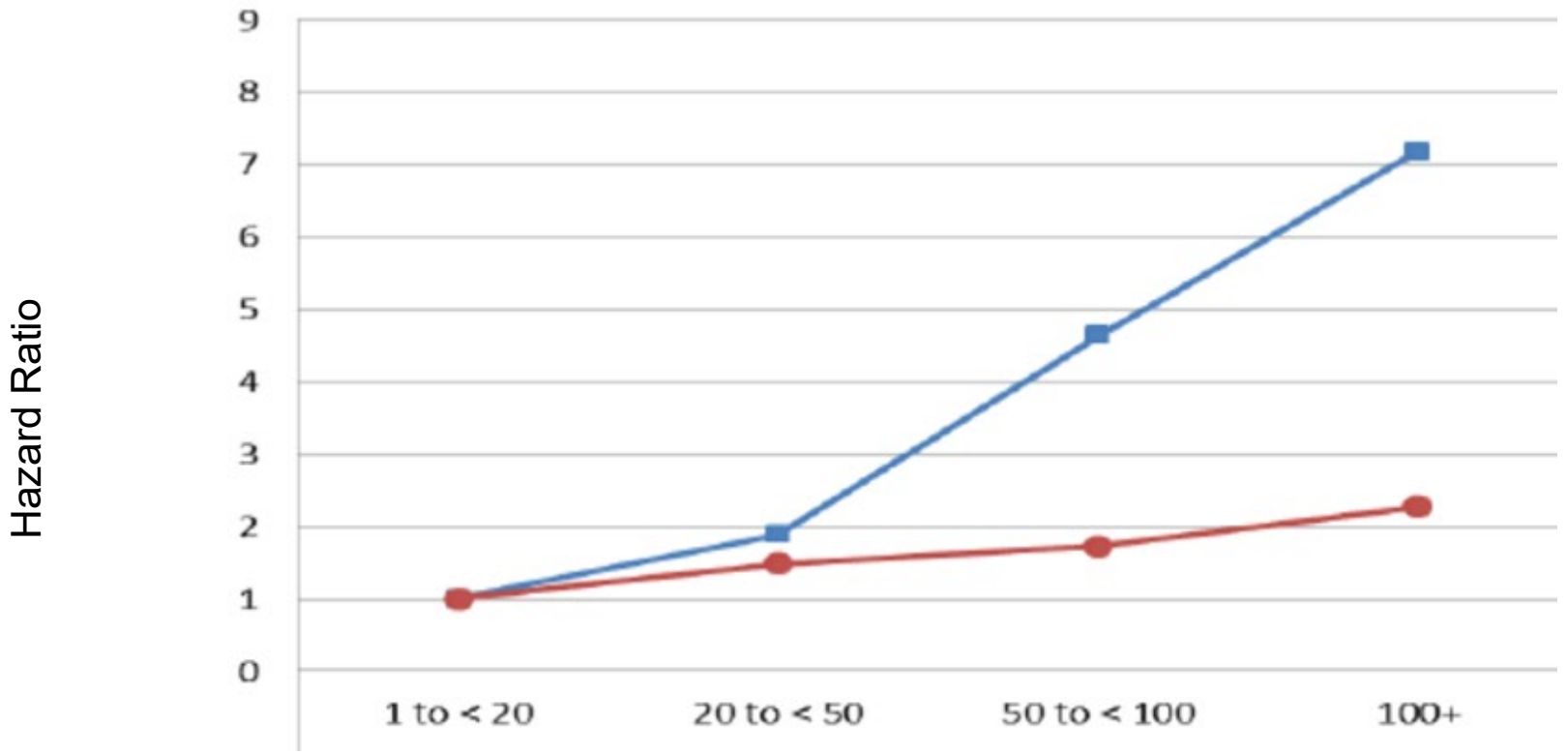


Pain care requires a systematic coordination of medical, psychological and social aspects of health care (integrated care).

Ashrafioun et al., J Pain. 2019 Jul;20(7):852-859 https://pubmed.ncbi.nlm.nih.gov/30690167/

Dosage and Risk of Overdose and Suicide from Opioids

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



Unintentional Overdose

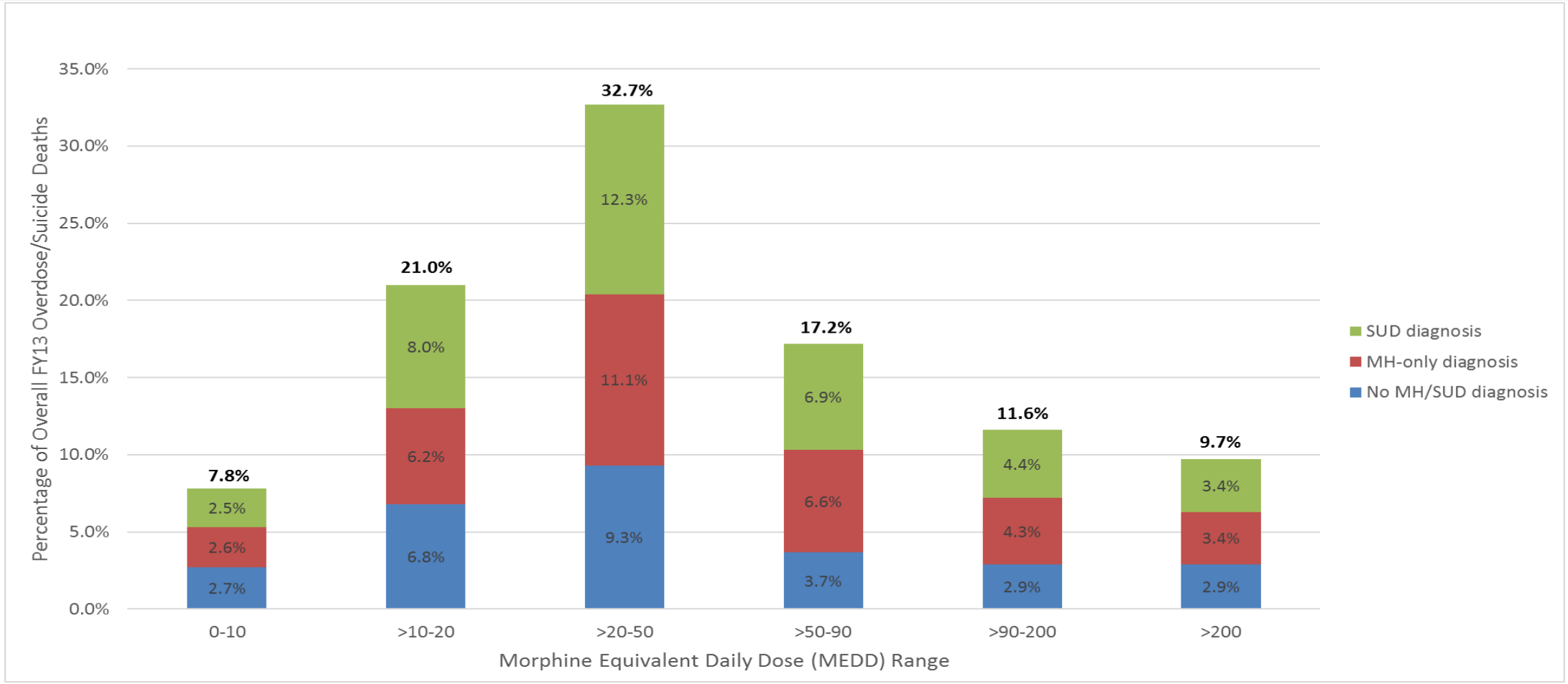
Suicide

Patients with prescribed opioids in FY 2004 or 2005

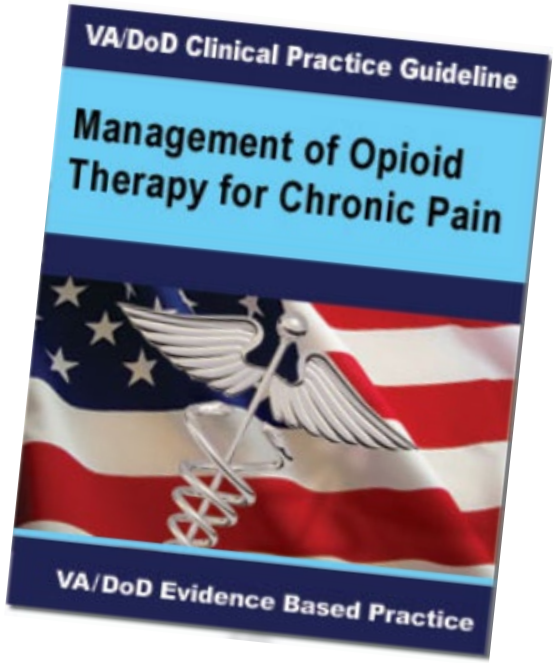
Followed until end of 2008 (unintentional OD) or 2009 (suicide).
Nested case control design

Bohnert AS et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA*. 2011.
Ilgen MA et al. Opioid Dose and Risk of Suicide. Pain. 2016;157(5):1079-1084

FY2013/14 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



The Opioid Safety Initiative:

Opioid Prescribing and Opioid Risk Mitigation

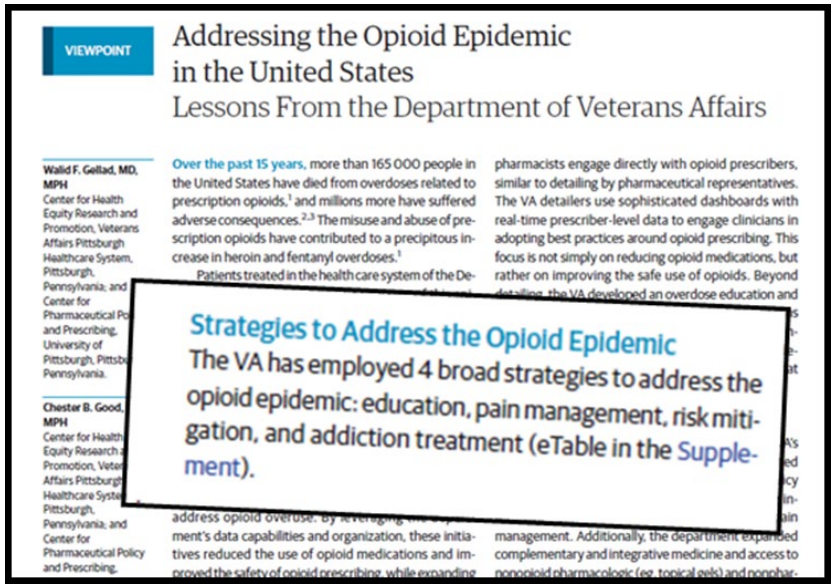
The VA Opioid Safety Initiative (OSI)

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


VIEWPOINT

Addressing the Opioid Epidemic in the United States

Lessons From the Department of Veterans Affairs

Walid F. Gellad, MD, MPH

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]

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).

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

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

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

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

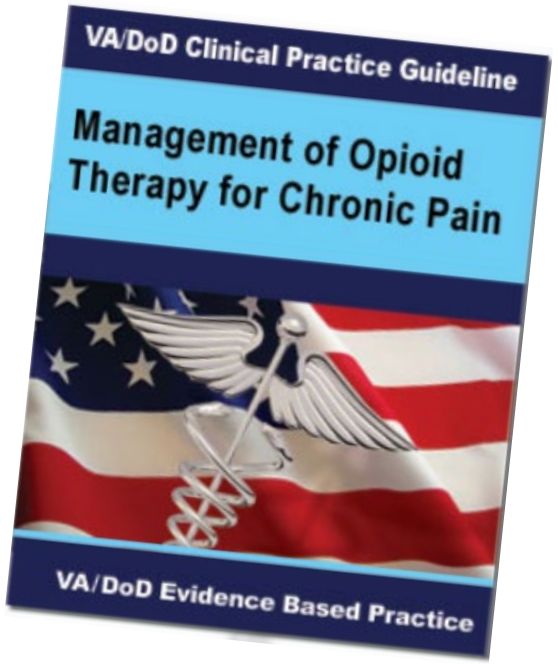
- Initiation and Continuation of Opioids

Recommendation 1:

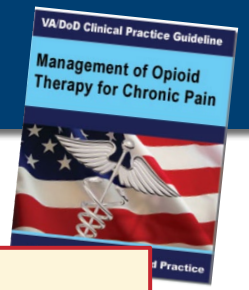
"We recommend against initiation of long-term opioid therapy.

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**".



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 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)

VHA Opioid Safety Initiative: OSI Parameters and Policies (selected)

OSI Dashboard

1. **Opioid use overall**, and long-term opioid use
2. **Opioid and Benzo co-prescribing**
3. **High dose ≥ 90 MEDD**
4. **New starts for Long-Term Opioid Therapy (LTOT, i.e. ≥ 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

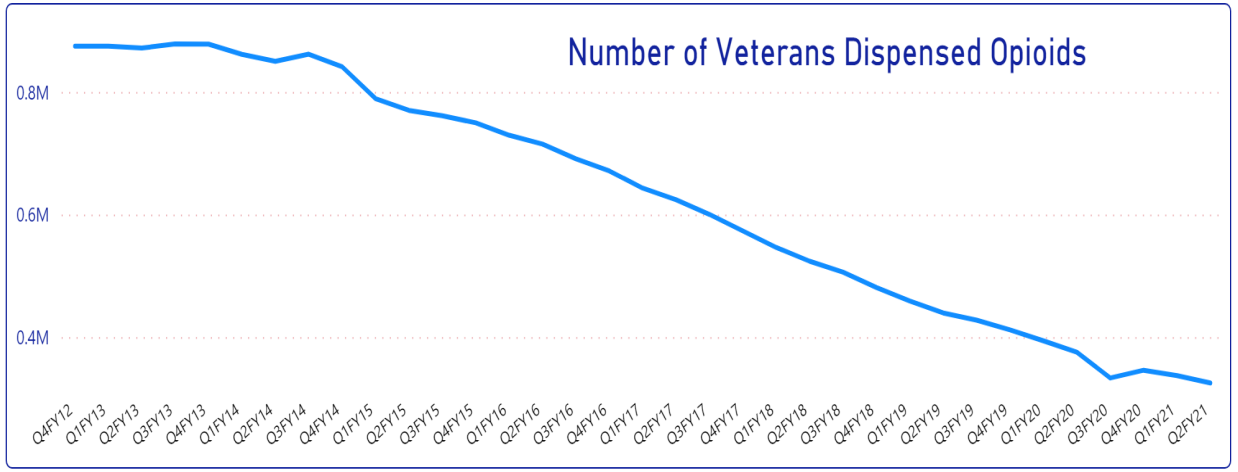
PBM OSI Dashboard

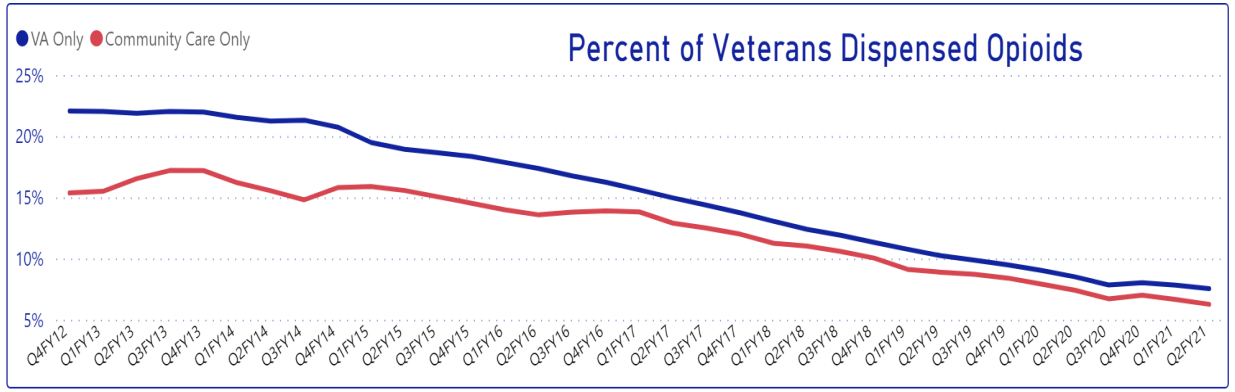
Update implemented with FY 2021

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





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

Change
549,749
(Decrease)

Percent Change
63 %
(Decrease)

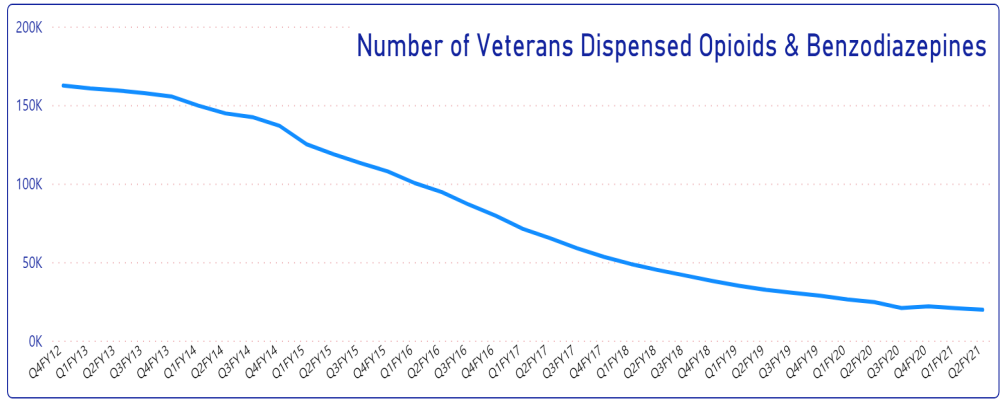
Fiscal Quarter	Total	Percent
Q4FY12	874,897	22.10%
Q2FY21	325,148	7.81%

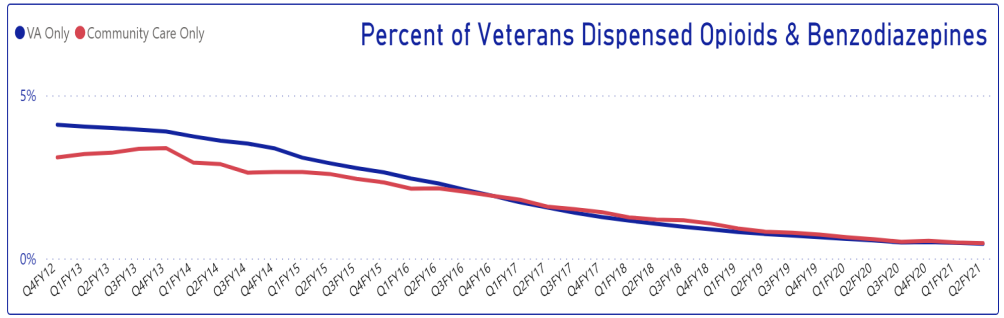
Starting with the Quarter 4, Fiscal Year 2020 reporting period, all metrics were recalculated from Quarter 4, Fiscal Year 2012 to present to harmonize the OSI metrics with the U.S. Department of Health and Human Services (HHS) Center for Disease Control (CDC) and Prevention *Annual Surveillance Report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

All opioids, including Tramadol

Opioid Safety Initiative (OSI): High Risk Opioid Prescribing

Veterans Dispensed Opioid and Benzodiazepine





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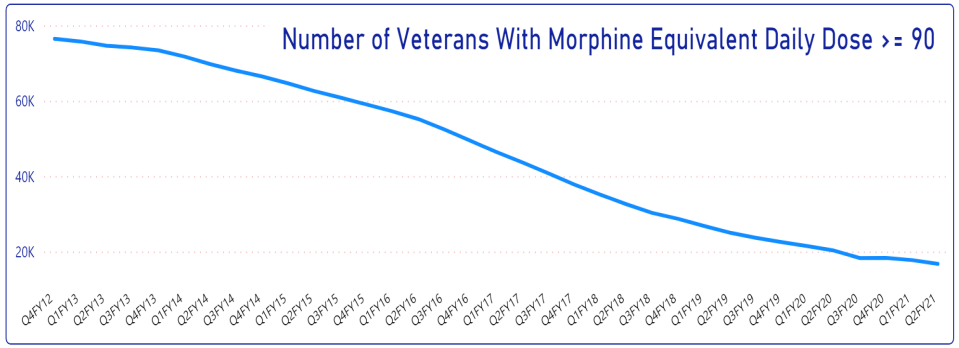
Change
142,753
(Decrease)

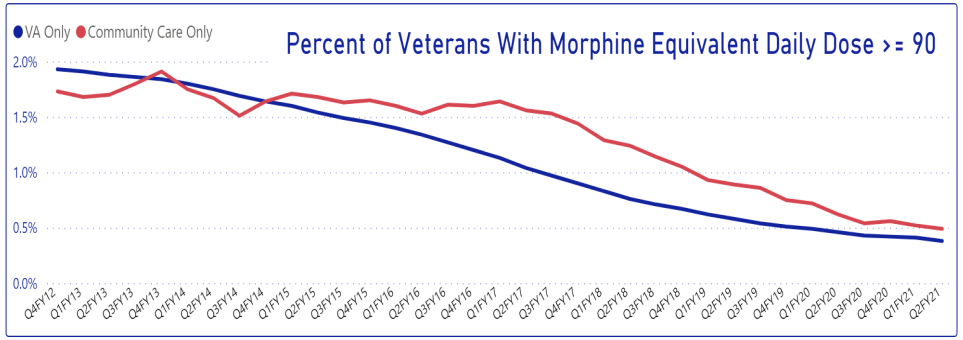
Percent Change
88 %
(Decrease)

Fiscal Quarter	Total	Percent
Q4FY12	162,444	4.10%
Q2FY21	19,691	0.47%

Starting with the 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, clonazepam has been added.

Veterans on High Dose Opioid Therapy





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Change
59,708
(Decrease)

Percent Change
78 %
(Decrease)

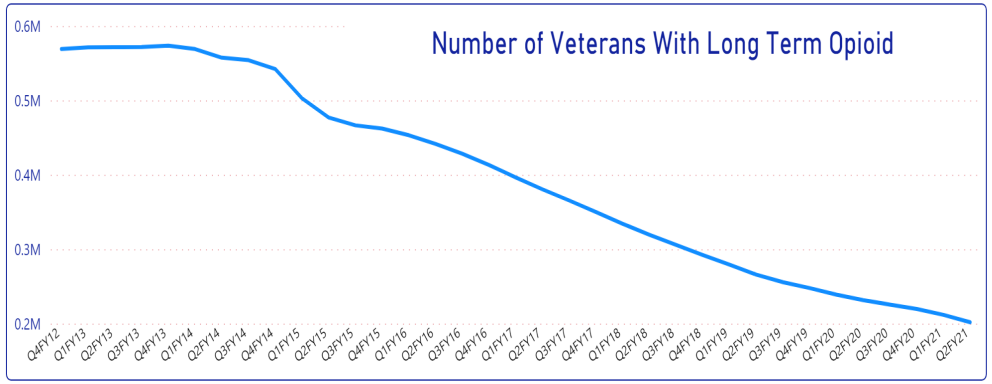
Fiscal Quarter	Total	Percent
Q4FY12	76,466	1.93%
Q2FY21	16,758	0.40%

Starting with the 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, the reporting has been changed from greater than or equal to 100 MEDD to 90.
***MEDD = Morphine Equivalent Daily Dose**

Dispensed Opioids ≥ 90mg MEDD

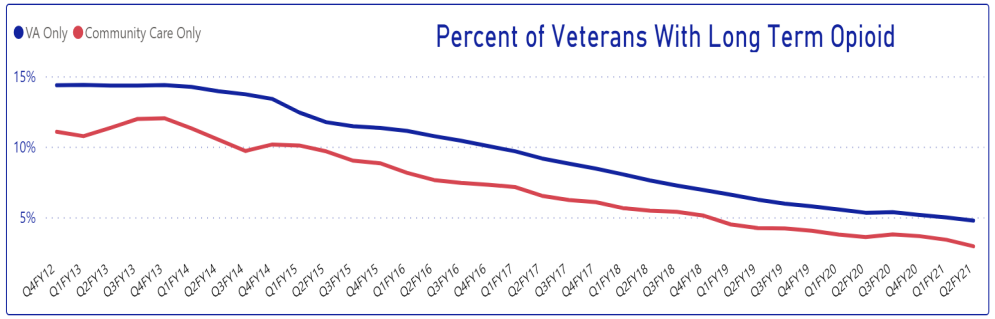
Opioid Safety Initiative (OSI): Long-Term Opioid Therapy

Veterans on Opioid Therapy Long-Term



Change
367,229
(Decrease)

Percent Change
65 %
(Decrease)



Fiscal Quarter	Total	Percent
Q4FY12	569,027	14.37%
Q2FY21	201,798	4.85%

Starting with the 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.

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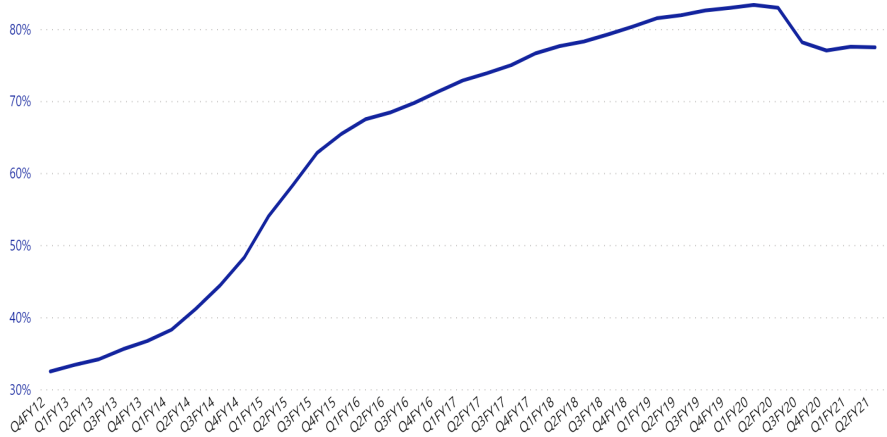
Veterans on Opioid Therapy Long-Term with Urine Drug Screen in the last 365 days



Percent Change
45 %
(Increase)

Fiscal Quarter	Percent
Q4FY12	32.46%
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 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.

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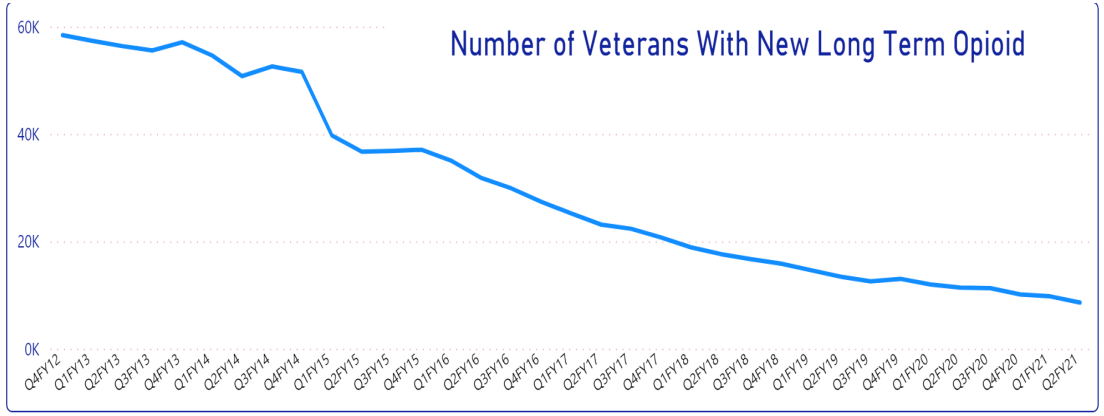
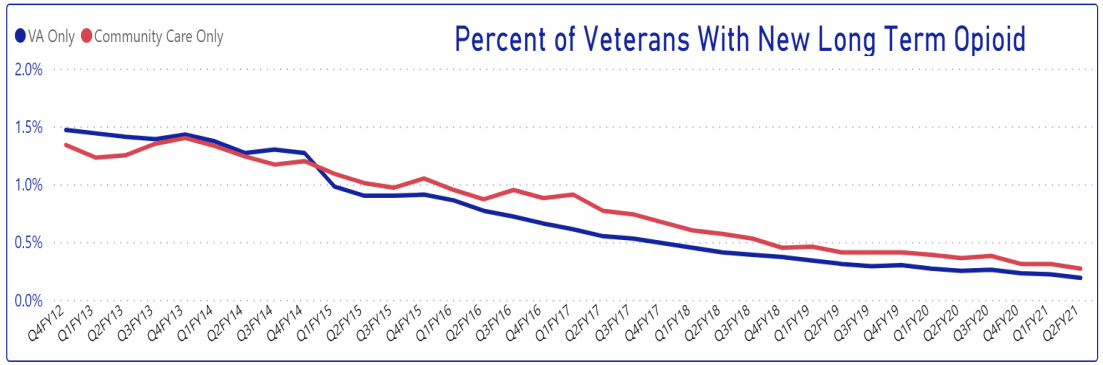
Opioid Safety Initiative (OSI): New Long-Term Opioid Therapy

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

Veterans with NEW Long-Term Opioid Therapy





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Change
49,820
(Decrease)

Percent Change
85 %
(Decrease)

Fiscal Quarter	Total	Percent
Q4FY12	58,417	1.48%
Q2FY21	8,597	0.21%

Starting with the 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.

Overdose Education and Naloxone Distribution - OEND

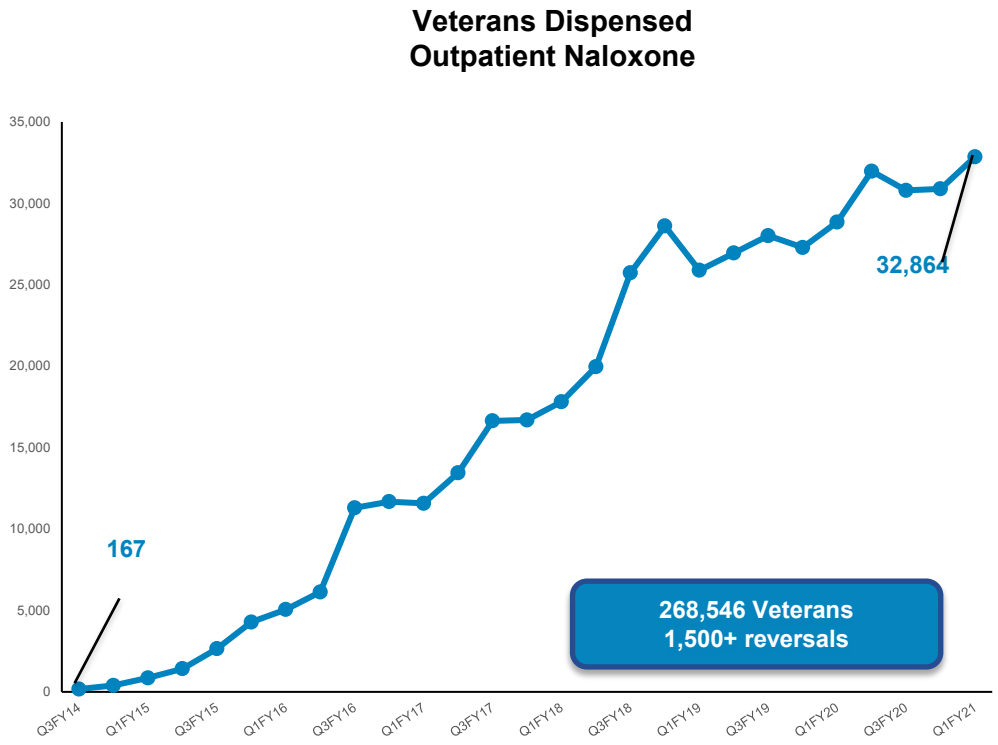
- **Overdose Education (OE)**
  - How to *prevent, recognize, and respond* to an opioid overdose
- **Naloxone Distribution (ND)**
  - FDA approved as **naloxone auto injector and nasal spray**
  - *Dispense and train* patient and caregiver/family
- Target patient populations: OUD and prescribed opioids

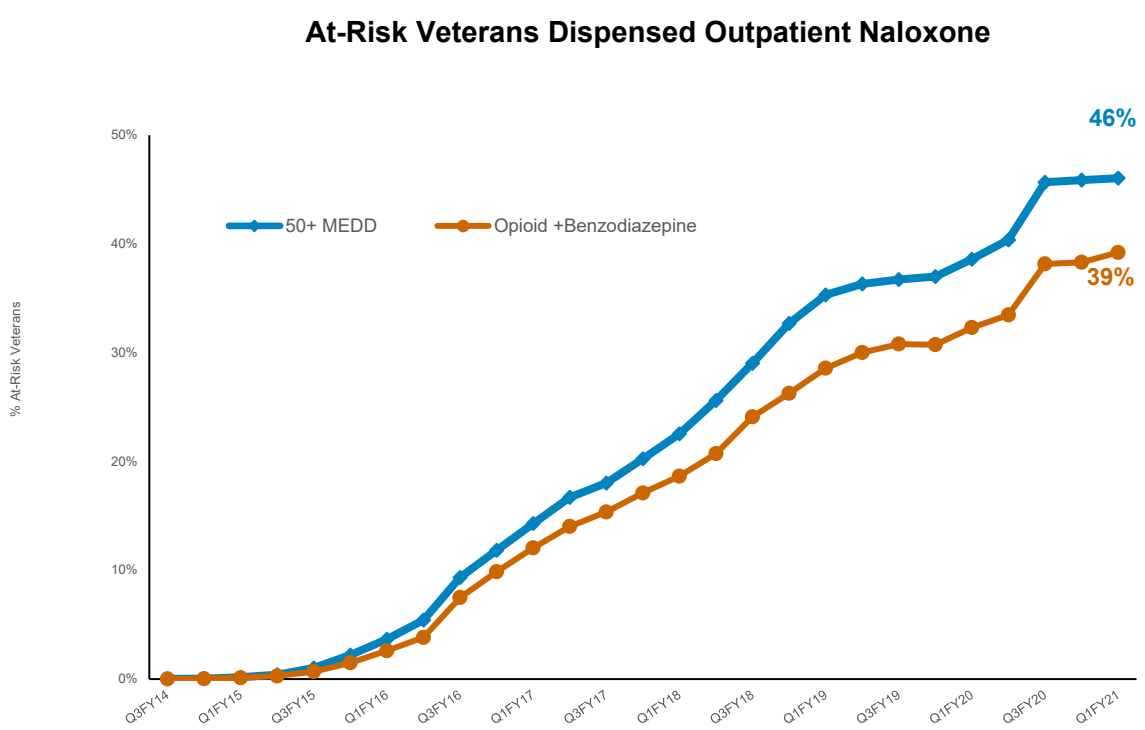
https://www.youtube.com/watch?v=0w-us7fQE3s

- **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

Opioid Safety Initiative (OSI): Naloxone

Veterans Dispensed Outpatient Naloxone





More than 254,000 Veterans dispensed naloxone by over 28,000 prescribers with over 1,500 reported overdose reversals (Sept. 28, 2020)

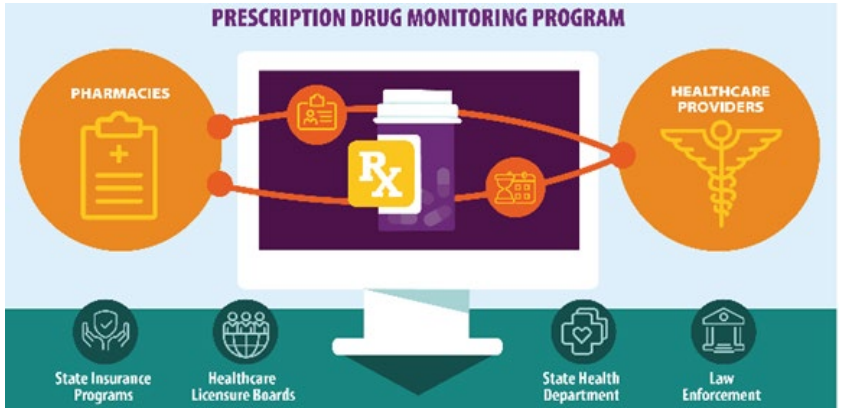
Prescription Drug Monitoring Program (PDMP)

- **VHA Directive 1306**, Querying State Prescription Drug Monitoring Programs

  (PDMP) issued Oct. 2016 and updated 2019 requires:
  - 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**

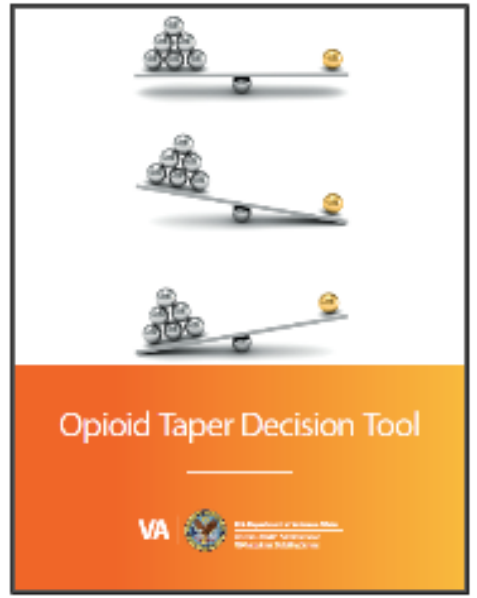
Guidance since 2017: Approaching Opioid Tapering

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.

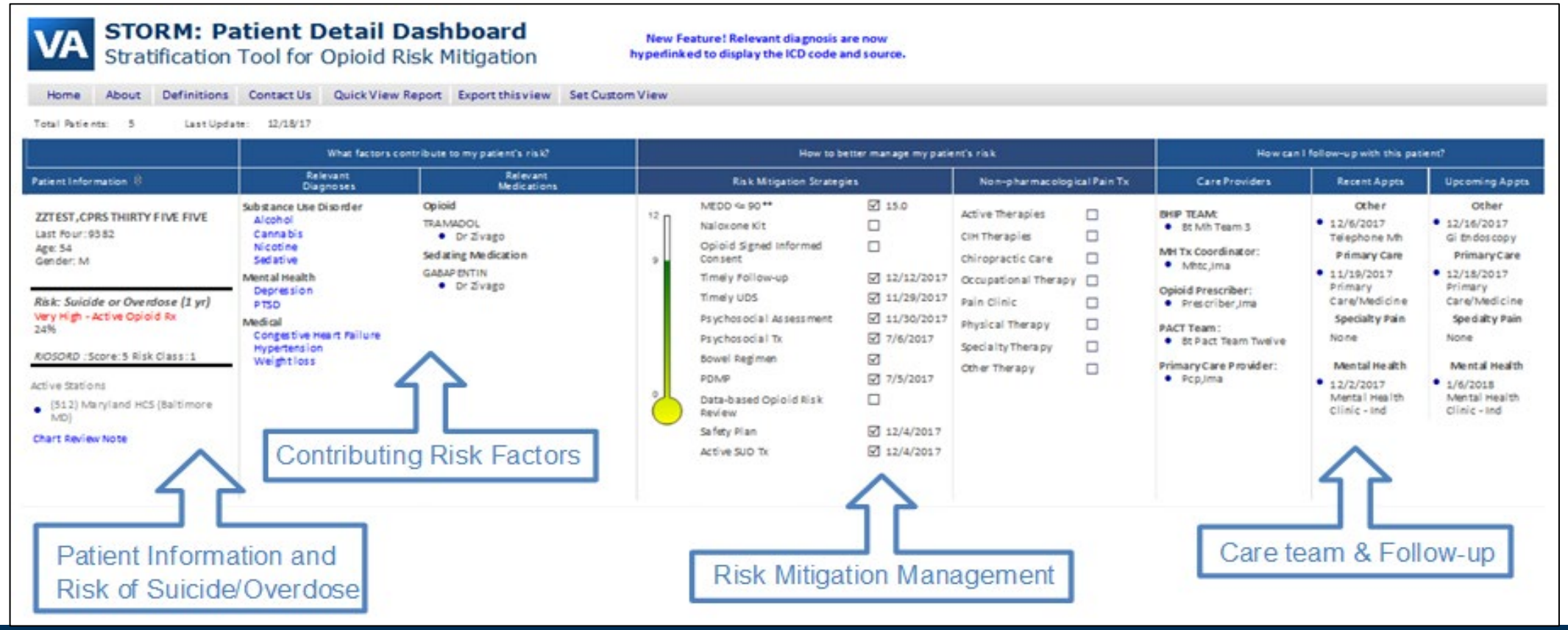
Opioid Tapering Considerations

- 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."
- **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.**

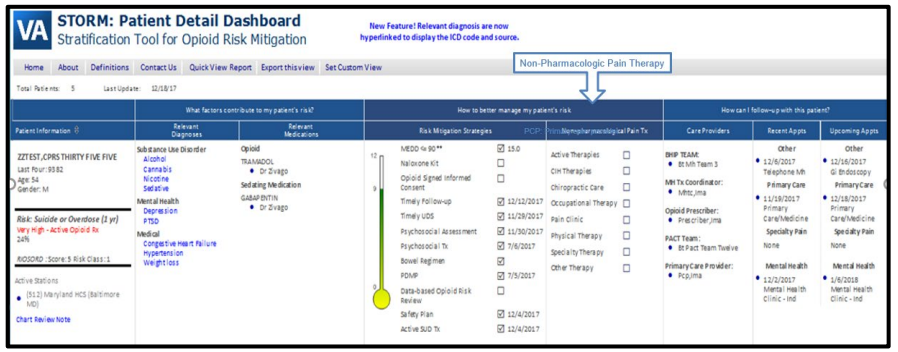


Opioid Safety Risk Review Teams

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

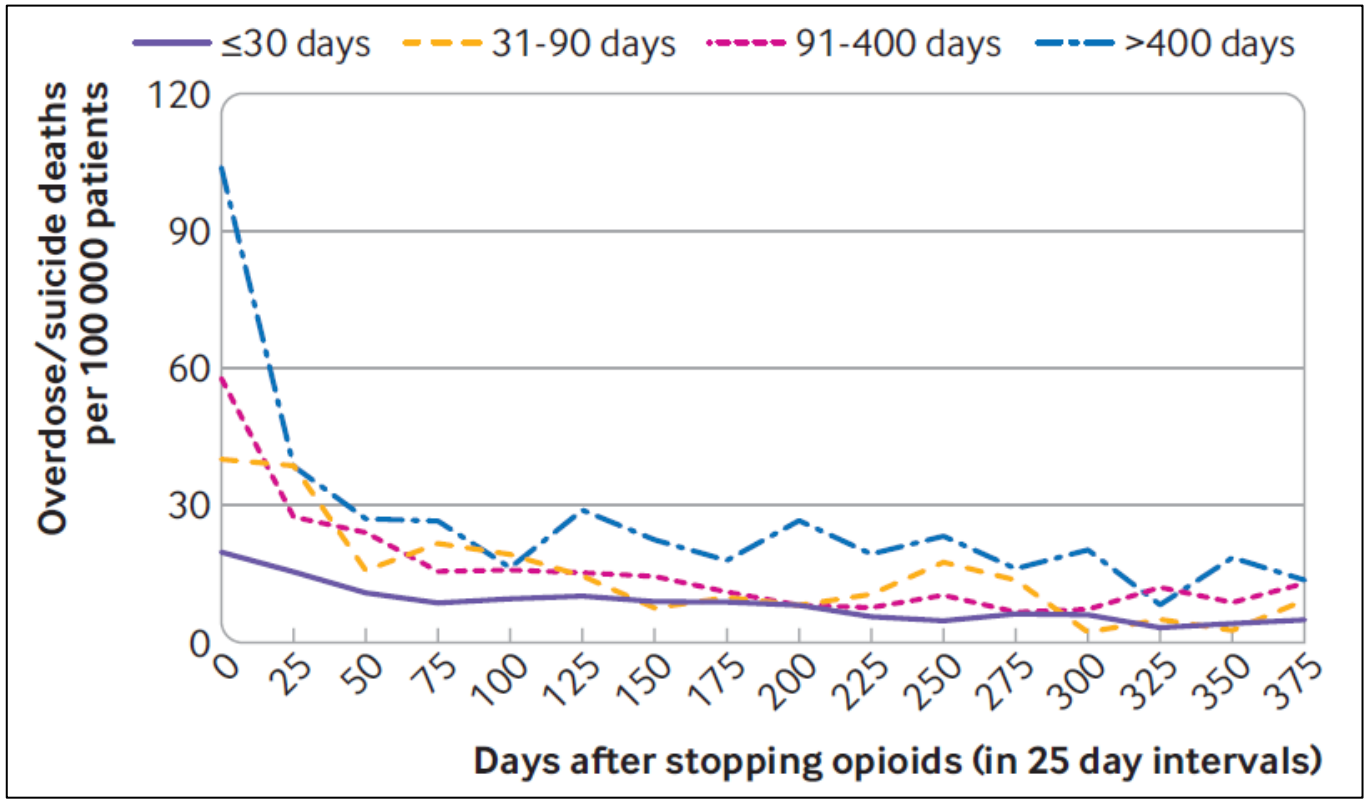
Stratification Tool for Opioid Risk Mitigation (STORM)



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

Oliva et al. J Gen Intern Med. 2017;14:34-49

Safety of Opioids, Tapering/Discontinuations in Veterans



Probability of death from overdose or suicide in patients treated with opioids in FY 2013 after stopping opioid treatment (n=799 668)

OPEN ACCESS
Check for updates

Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation

Elizabeth M Oliva,[1,2] Thomas Bowe[1,2] Ajay Manhapra,[3,4,5,6] Stefan Kertesz,[7,8] Jennifer M Hah,[9] Patricia Henderson,[1] Amy Robinson,[10] Meenah Paik,[1] Friedhelm Sandbrink[11,12,13] Adam J Gordon,[14,15,16] Jodie A Trafton[1,2,17]

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.

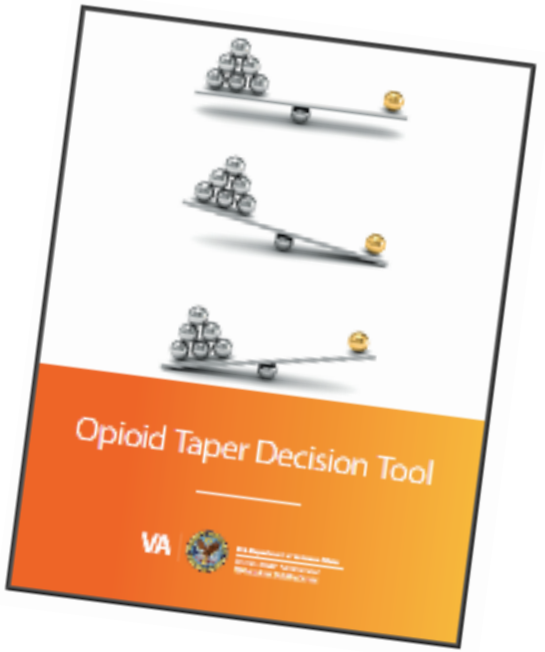
Efforts to mitigate the risk should be intensified for at least 3 months after starting or stopping opioids.

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

Stepped Care for OUD Train the Trainer

- **Medication for Opioid Use Disorder (MOUD)**
  - Buprenorphine/naloxone
  - Methadone
  - Naltrexone (including injection)
- **Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative**

VHA Notice 2020-30: Buprenorphine Prescribing for Opioid Use Disorder



Medication Use Evaluation (MUE):

Deprescribing/ tapering among Veterans Who Discontinued Opioids

VA – A Learning Healthcare System: High-Dose Opioid Tapering and Discontinuation Medication Use Evaluation Comparing Early vs Later OSI Management

- 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

Sample of Pertinent Measures

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

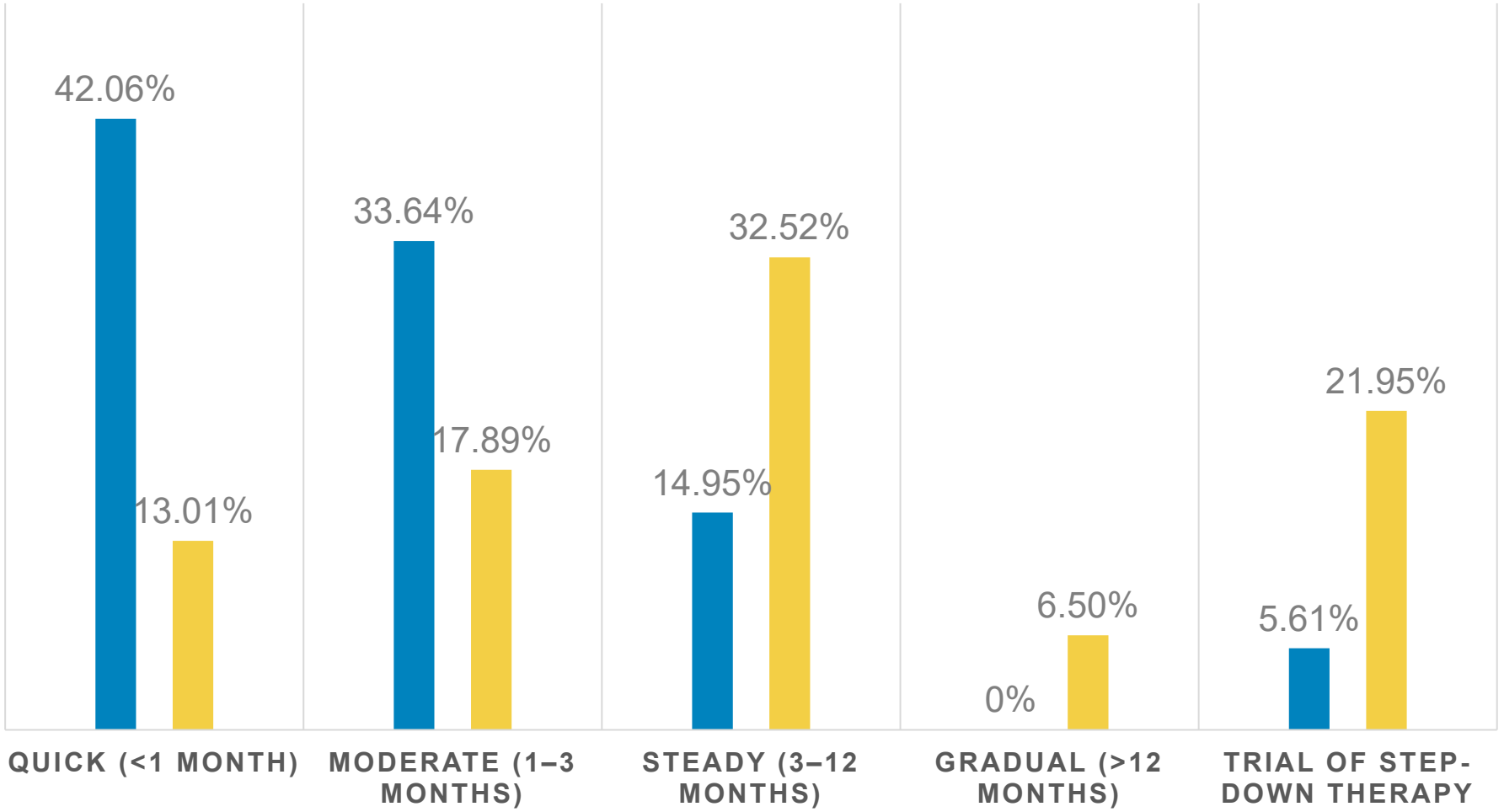
Baseline Demographics and Other Characteristics of Chronic HD Opioid Discontinuers (N = 637)

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

Discontinuation: Clinician Involvement and Rationale by Fiscal Year (N = 637)

	FY13, (N= 315)	FY17, (N= 322)	p-value
Clinician Involvement (recommended/ initiated/ involved) in Discontinuation			
Primary care provider	266 (84.44%)	218 (67.70%)	<0.05
Pain management	18 (5.71%)	57 (17.70%)	<0.05
Pharmacy	11 (3.49%)	24 (7.45%)	0.03
Clinical pharmacist Involved in Tapering Process	51 (16.19%)	115 (35.71%)	<0.05
Non-adherence to opioid risk mitigation strategies as outlined in the Informed consent for LOT	136 (43.17%)	73 (22.67%)	<0.05
Discontinuation rationale			
Strong concern for diversion, unsafe behaviors, or other misuse	88 (27.94%)	61 (18.94%)	0.01
Risks of LOT outweigh benefits	41 (13.02%)	77 (23.91%)	<0.05
Lack of clinically meaningful improvement in function	33 (10.48%)	59 (18.32%)	<0.05
Concomitant use of medications that increase risk of OD	23 (7.30%)	38 (11.80%)	0.05
Provider determined prescribed dose is higher than max recommended dose	23 (7.30%)	66 (20.50%)	<0.05
OSI dashboard (i.e. more visibility in conjunction comprehensive assessment)	3 (0.95%)	19 (5.90%)	<0.05

DESCRIPTION OF TAPER SPEED PLANS BY FISCAL YEAR

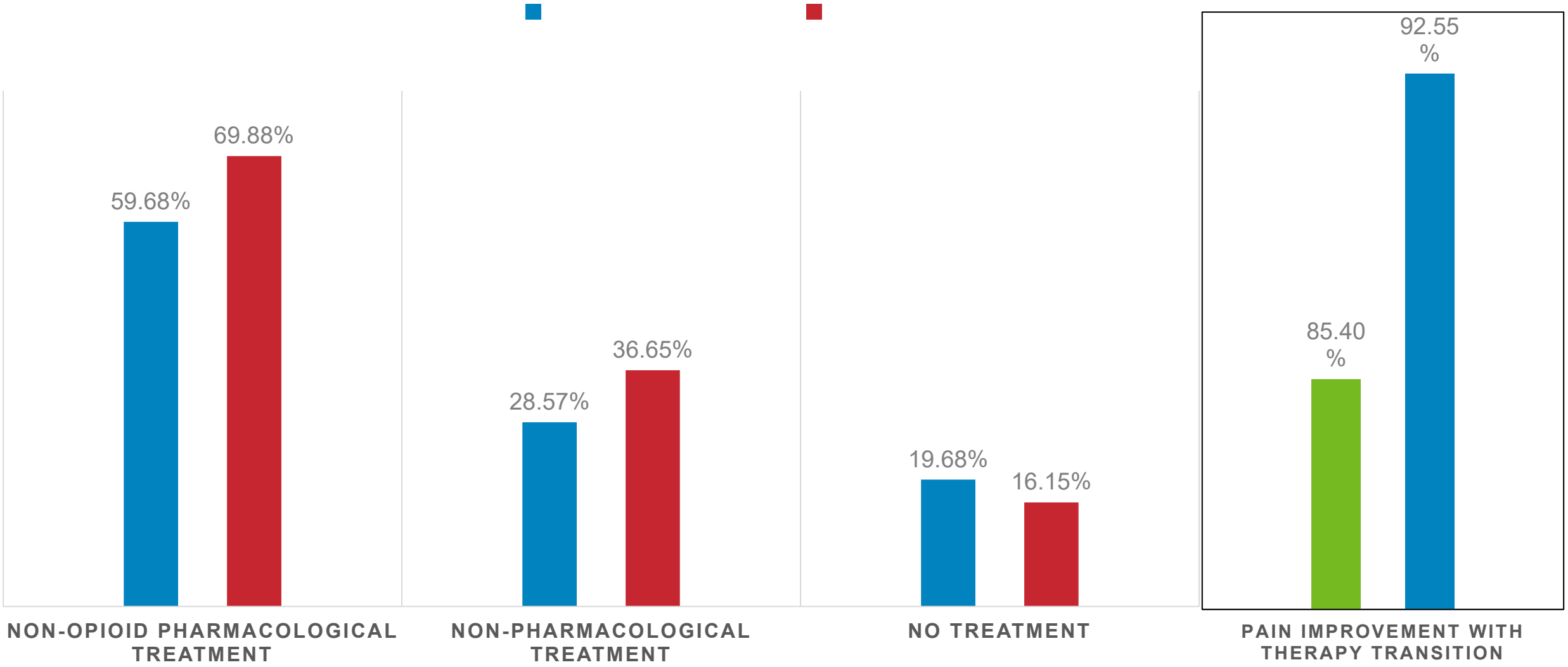


Taper Length in days, median (IQR)	
FY13	59 (29, 199)
FY17	162.5 (64.5, 335)
p-value	**<0.05**

Monitoring Activities and Events During Discontinuation Process by Fiscal Year

N=637	FY13, (N=315)	FY17, (N=322)	p-value
Risk vs. benefit assessment	**150 (47.62%)**	**190 (59.01%)**	**<0.05**
VA Services during tapering period or before discontinuation	312 (99.05%)	315 (97.83%)	0.22
Behavioral Health Services	**163 (52.24%)**	**123 (39.05%)**	**<0.05**
Pain Management/Pain Clinic	**70 (22.44%)**	**99 (31.43%)**	**0.01**
Primary Care Involved in Opioid Therapy or Pain Management	188 (60.26%)	169 (53.65%)	0.09
Utilized Complementary and Alternative Medicine	**19 (6.09%)**	**41 (13.02%)**	**<0.05**
Other Specialty Services (e.g.., Neurology, Rheumatology, Orthopedics)	70 (22.44%)	68 (21.59%)	0.80
Pharmacy Services/Consults	**47 (15.06%)**	**82 (26.03%)**	**<0.05**

MODES OF THERAPY AND PAIN MANAGEMENT AFTER OPIOID DISCONTINUATION



Summary

- 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**
  - https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp
- **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-jpep/

Thank You

www.va.gov/painmanagement