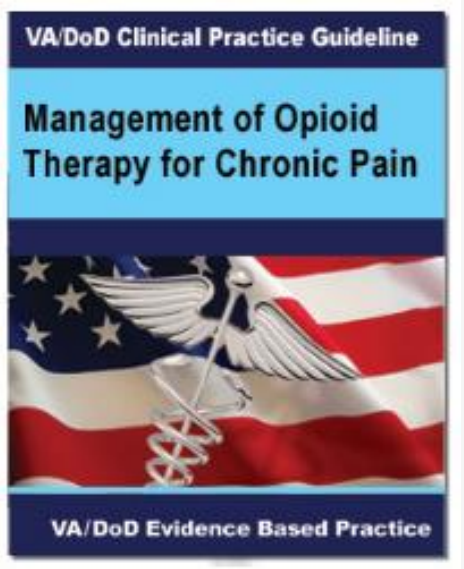
Pain Management and Opioid Safety

For VHA Prescribers

Background

This updated training is informed by recent updates to Clinical Practice Guidelines, in particular the VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, Version 3.0.



This training is provided by the Pain Management, Opioid Safety, and PDMP (PMOP) office in accordance with the requirements set forth by the Comprehensive Addiction and Recovery Act (CARA) and the Presidential Memorandum, "Addressing Prescription Drug Abuse and Heroin Use."

Overview and Objectives

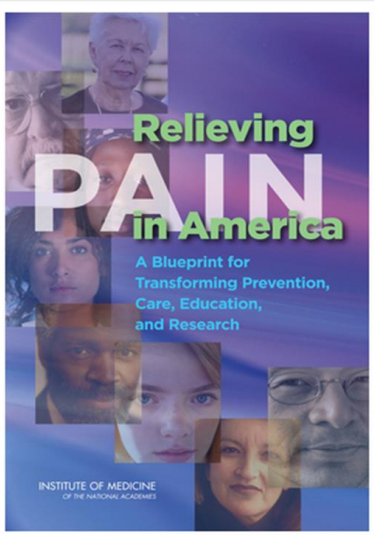
This Training Consists of Seven Sections:

1. Pain and Opioid Overdose Epidemiology
2. New Principles of Pain Care
3. Clinical Practice Guidelines for Opioid Therapy
4. The Opioid Safety Initiative (OSI) and Best Practices
5. Recommended Treatments for Pain
6. Opioid Use Disorder (OUD) Treatment
7. Opioid Dose Reduction and Tapering

Each section is concluded by a knowledge check and summary slide which will help prepare you for the post-training quiz. You must achieve a score of 8/10 (80%) to pass the quiz.

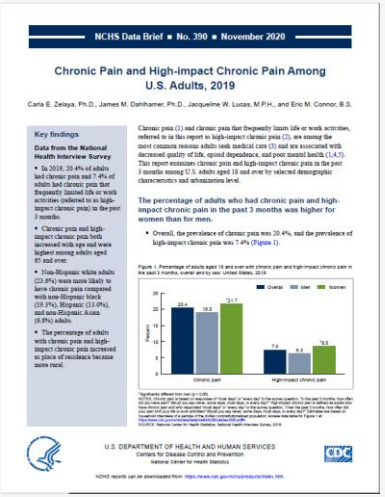
1. Pain and Opioid Overdose Epidemiology

Chronic Pain as a Major Public Health Problem



Institute of Medicine (IOM) Report (2011)

- The financial burden of chronic pain exceeds those of cancer and heart disease combined.



2019 National Health Interview Survey (NHIS) (2020)

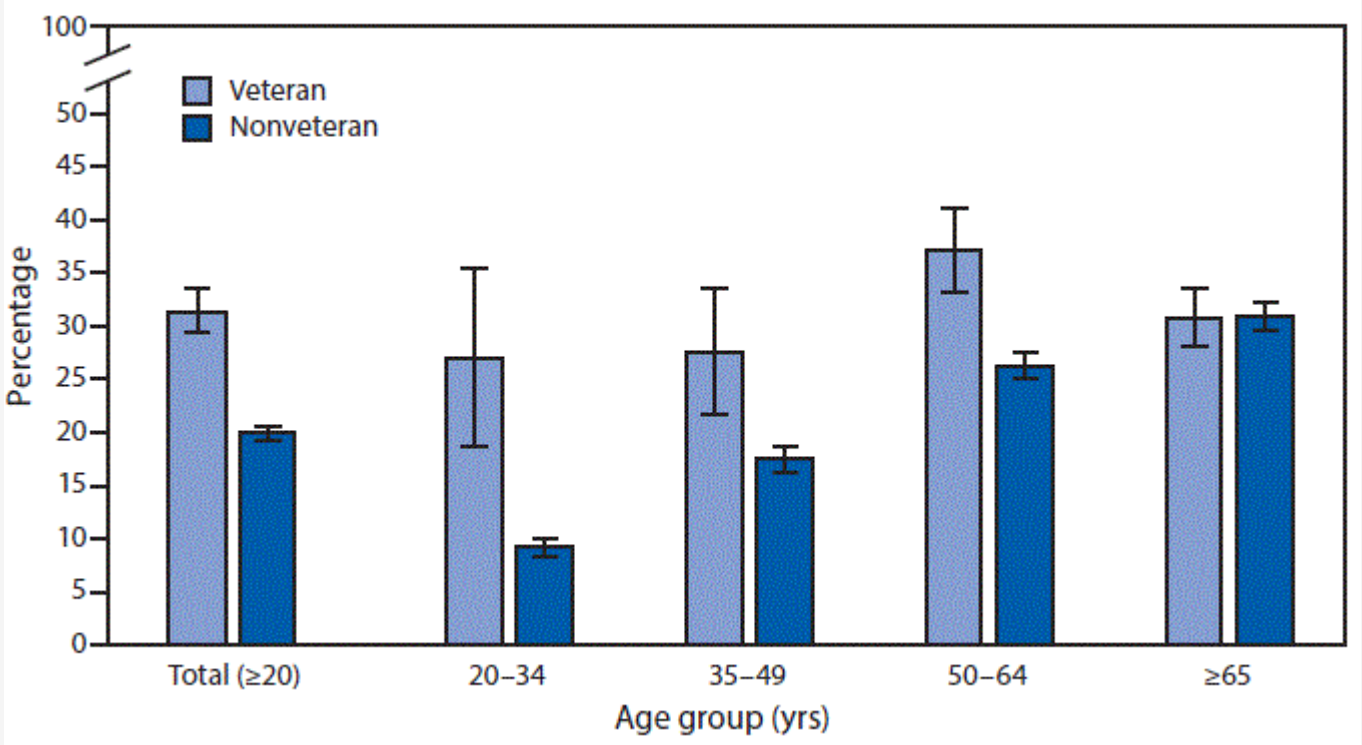
- 20.4% of adults in the US had **chronic pain** in 2019, and
- 7.4% had **high impact chronic pain,** defined as chronic pain that frequently limited life or work activities.
- Groups with higher rates of high-impact chronic pain include women, those over 65, Non-Hispanic white adults, and those in rural locations.

National Academies Press http://www.ncbi.nlm.nih.gov/books/NBK91497/; Zelaya CE et al. NCHS 2020 Nov https://www.cdc.gov/nchs/data/databriefs/db390-H.pdf

Prevalence of Pain Among Veterans

Chronic pain is more common in Veterans than non-Veterans.

- In a national survey, **31.5% of Veterans vs. 20.1% of non-Veterans reported experiencing chronic pain in the past three months.**
- Chronic pain was defined as pain on most days or every day in the past three months.
- Veterans of all age groups except those ≥65 years of age were significantly more likely than non-Veterans of the same age group to experience chronic pain.



QuickStats: Percentage of Adults Aged ≥20 Years Who Had Chronic Pain, by Veteran Status and Age Group — National Health Interview Survey, United States, 2019 (cdc.gov)

Pain Management and Opioid Safety

The VA 2018-2024 Strategic Plan included Pain Management and Opioid Safety in the list of Focus Areas.

- The co-occurrence of pain and mental health conditions often result in high impact pain.
- Pain, medical and/or mental health comorbidities are often related to military service and require Veteran-specific expertise.
- Veterans are at higher risk for harm from opioid use and accidental poisoning than non-Veterans.
- Pain is the most common factor among Veterans who die by suicide, and 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).**


VA

Department of Veterans Affairs

FY 2018 – 2024 Strategic Plan

Refreshed May 31, 2019

Section 508 Compliance Statement:

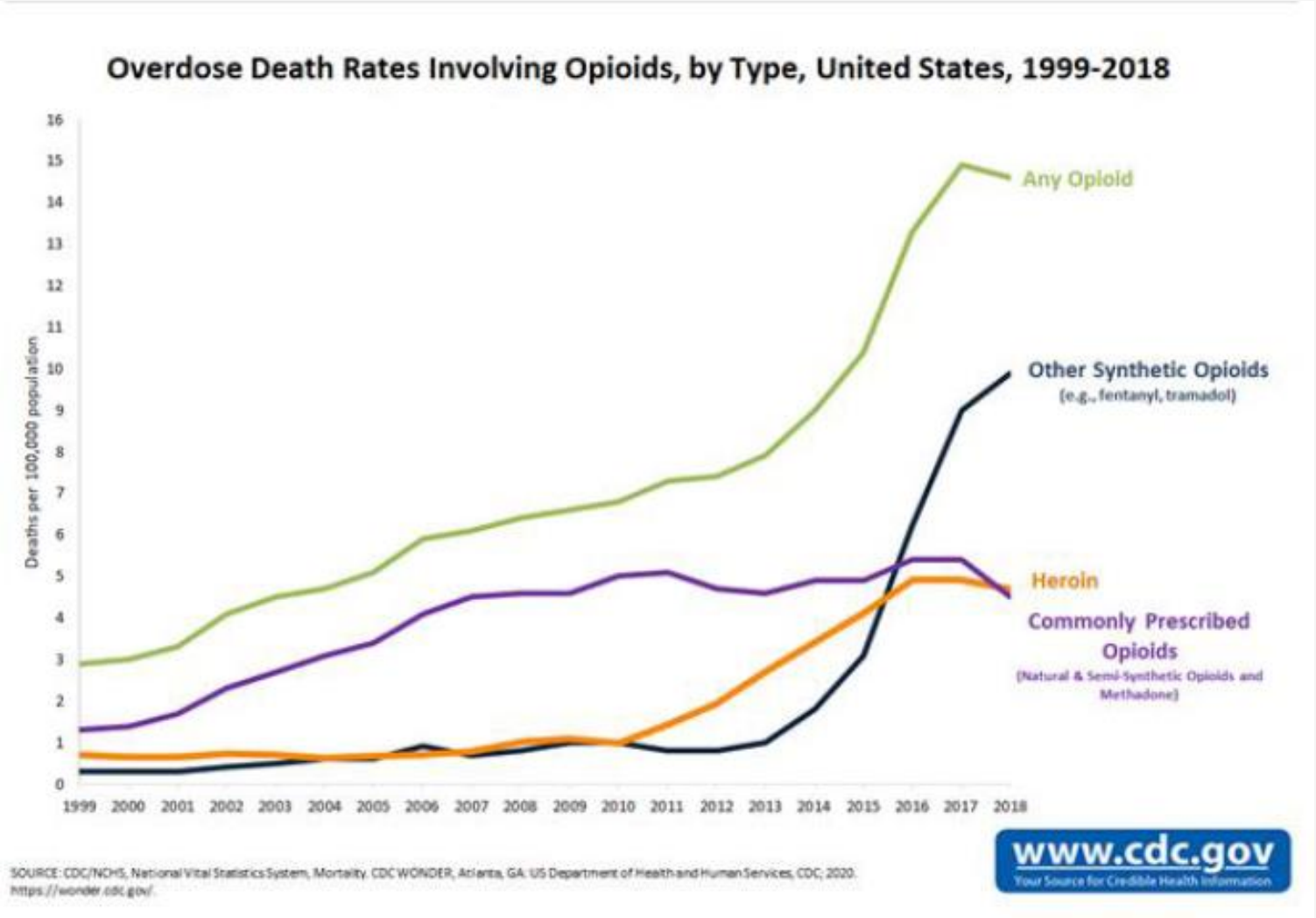
The U.S. Department of Veterans Affairs is committed to making its electronic and information technologies accessible to individuals with disabilities in accordance with Section 508 of the Rehabilitation Act (Title 29 U.S.C. § 794d), as amended in 1999. For further information, questions or comments related to this document accessibility, contact VA 508 Office at section508@va.gov.

VA 2018 – 2024 Strategic Plan (508 Compliance) – Refreshed May 31, 2019 1

https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf; Ashrafioun et al., J Pain. 2019 Jul;20(7):852-859 https://pubmed.ncbi.nlm.nih.gov/30690167/

Overdose Death Rates by Opioid Type

Overdose Deaths due to Synthetic Opioids on the Rise



In the past several years, the relative contribution of drug type to overdose deaths has changed: initially primarily **prescription opioids**, then also **heroin** and more recently **synthetic opioids** (such as carfentanil).

Now, **polysubstance** use is common, such as the combination of opioids with sedatives and/or stimulants.

https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf

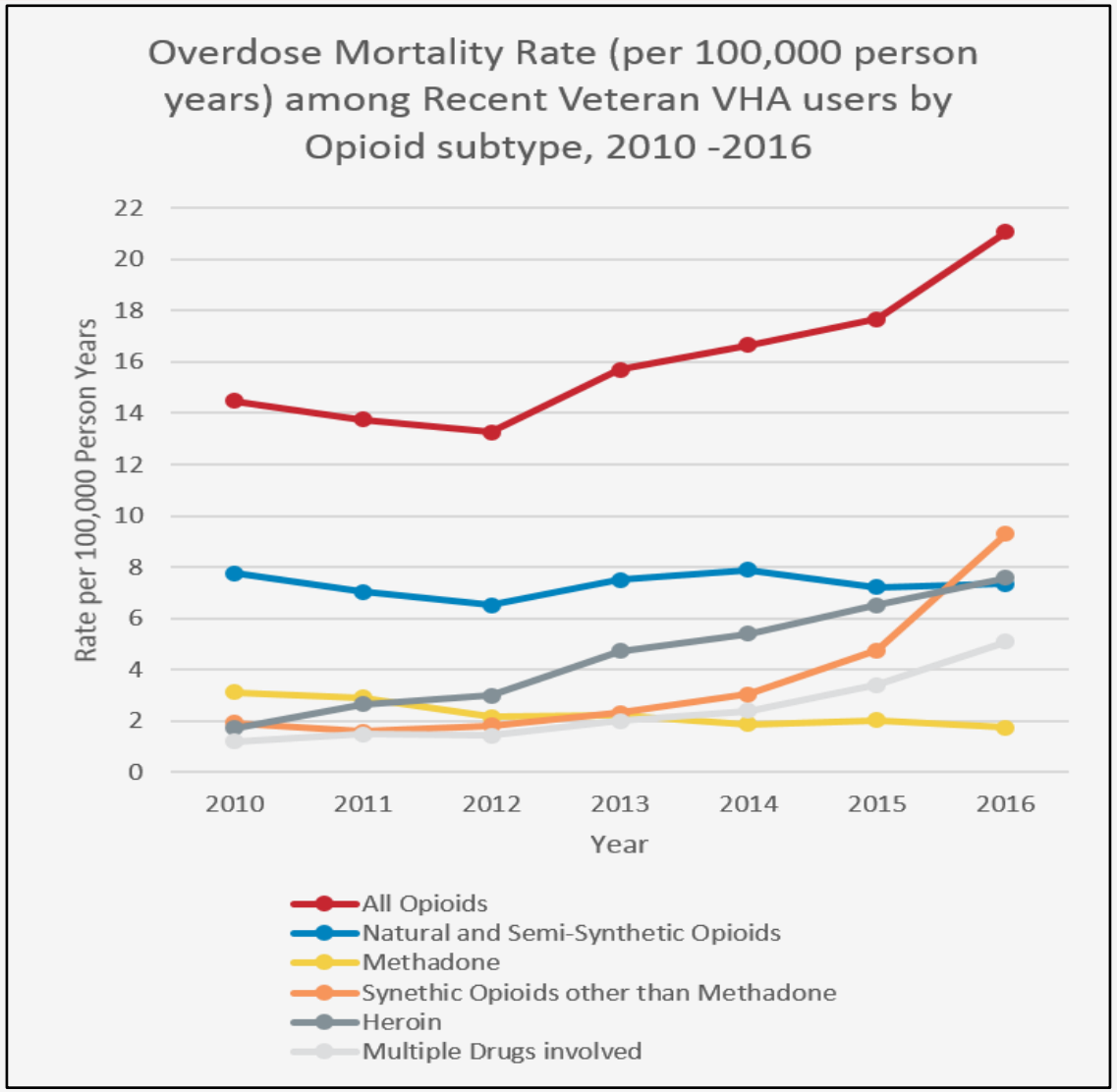
Opioid Overdoses Among Veterans in VHA

Veterans are at Elevated Risk for Death due to Overdose

- 6,485 Veterans receiving care in VHA died from an opioid overdose between 2010 and 2016, with increasing rate over that time period.

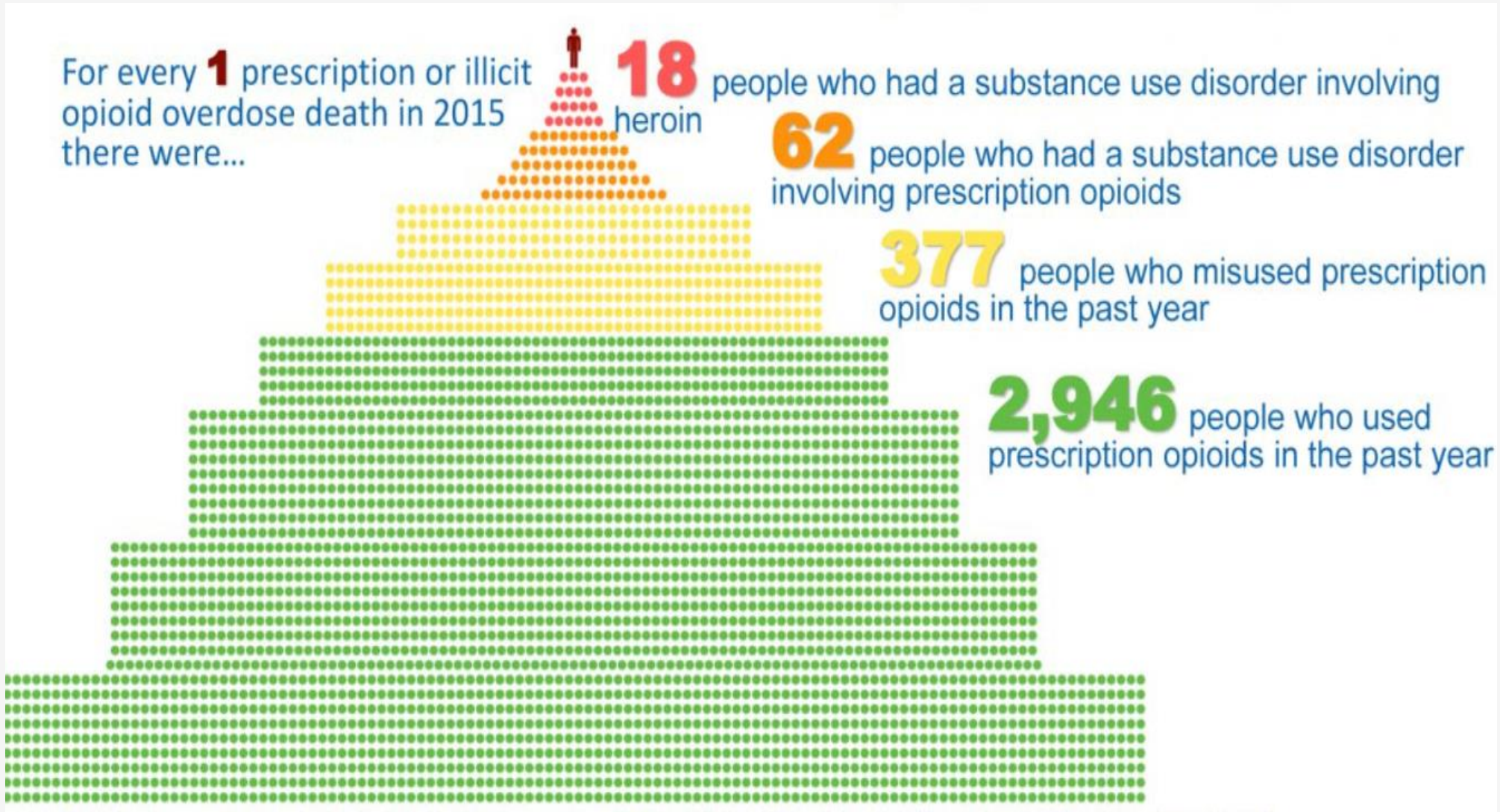
- **In 2016 alone there were 1,271 deaths of Veterans in VHA, or 3.5 per day.**
  - This is 1.5x greater than the general population opioid overdose mortality rate.*
  - 62% of VHA Veteran overdoses involved opioids.

**This equates to a mortality rate of 21.1/100,000 among VHA Veterans and 13.3/100,000 in the general population.*



Data from Lin LA et al. *Am J Prev Med. June 2019;* https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#page=1

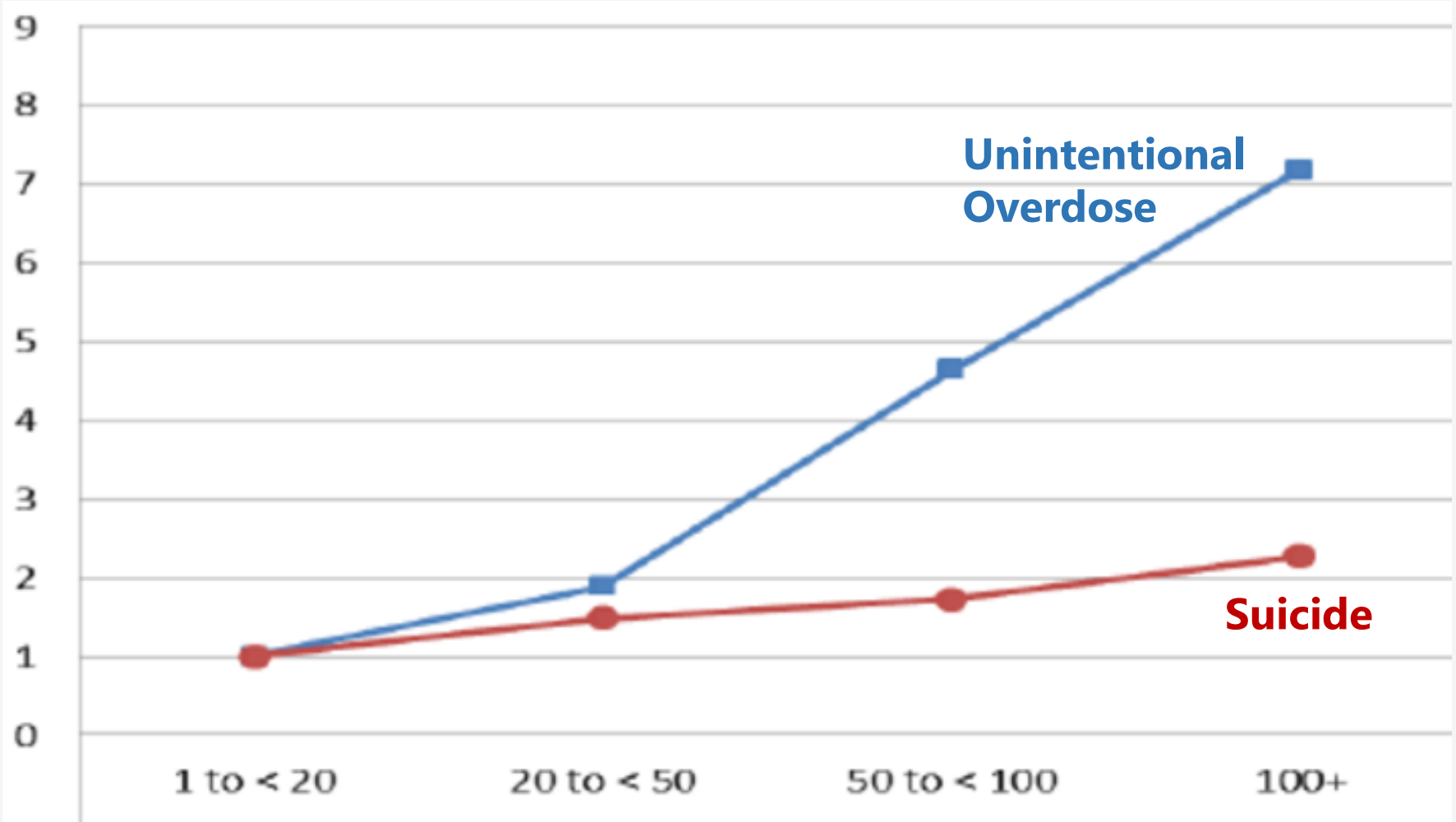
Opioid Overdoses Are Just the Tip of the Iceberg



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

Dosage and Risk of Overdose

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

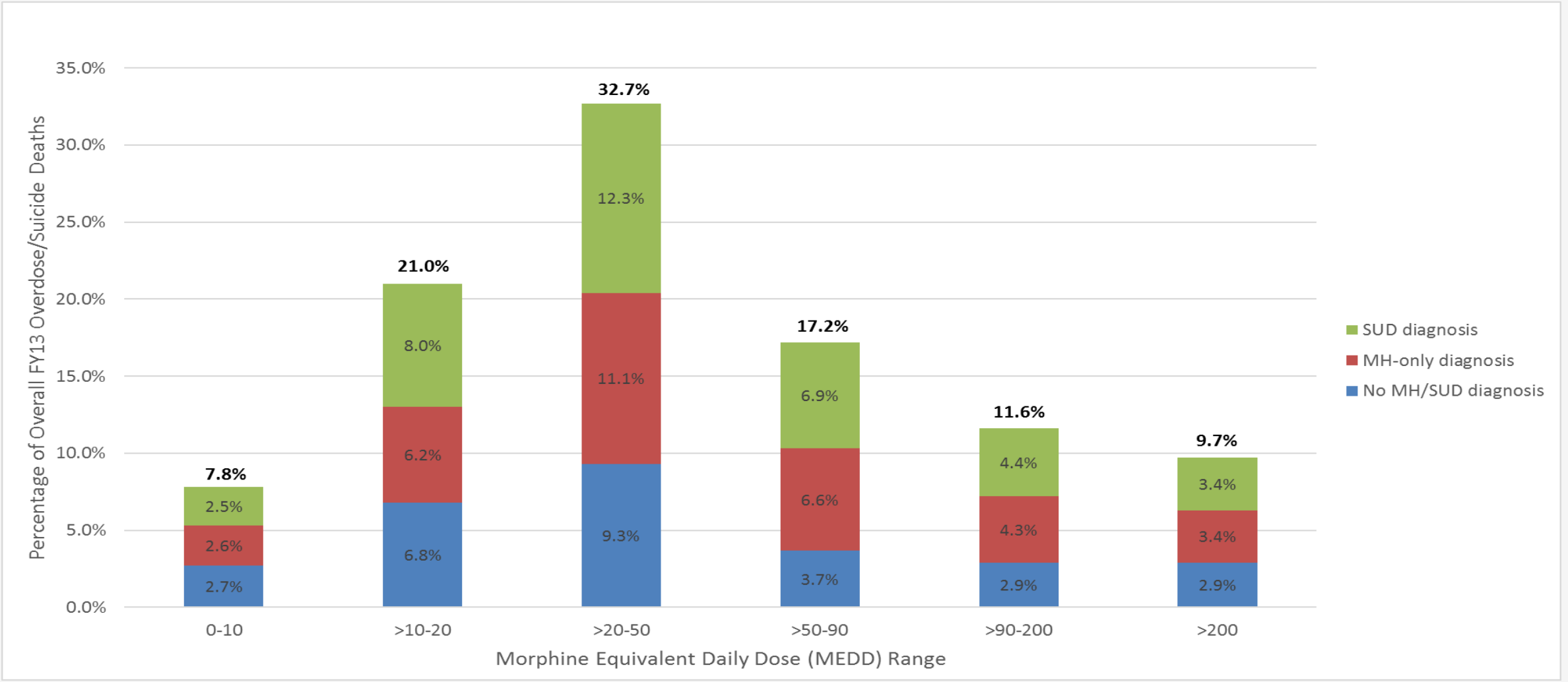


Multiple studies demonstrate **higher doses carry higher risk of opioid-related death**.

- This may in part reflect the **prevalence of mental health comorbidities** in patients with chronic pain.

Bohnert AS et al. JAMA 2011 Apr 6 https://pubmed.ncbi.nlm.nih.gov/21467284/; Igen MA et al. Opioid Dose and Risk of Suicide. Pain. 2016 May https://pubmed.ncbi.nlm.nih.gov/26761386/

Overdose/Suicide Mortality Data Among VHA Veterans Demonstrate: No Safe Opioid Dosage



Analysis of FY2013-2014 VHA data.

Of the Veterans who died from overdose/suicide:

- Almost **4/5** were **prescribed < 90 Morphine Equivalent Daily Dose** (MEDD).
- Almost **3/4** had **Mental Health diagnosis (including Substance Use Disorder)**
- More than 1/2 had MH/SUD diagnoses and were prescribed < 90 MEDD.

Unpublished Data from the Patient and Family Education Resource Center (PERC).

Risk Factors for Overdose and Opioid Use Disorder (OUD)

Risk Factors Include:

- Opioid prescription, including:
  - Dose and Duration
  - Type (Extended-Release/Long-Acting forms)
- Interaction with other medication/drugs, such as sedative hypnotics

Prescribing factors

- Medical comorbidities (e.g., chronic pulmonary disease, sleep apnea)
- Mental health comorbidities (e.g., depression, bipolar disorder)
- Substance Use

Patient factors

Park et al. J Addict Med 2016 https://pubmed.ncbi.nlm.nih.gov/27525471/

Summary: Pain and Opioid Overdose Epidemiology

- **Chronic pain in Veterans is more common, and more often severe** than in the general US adult population.
- **Mental health comorbidities often result in high impact**, or severe **pain**.
- Pain is the most common factor among Veterans who die by suicide.
- Veterans are 1.5x as likely as the general population to die from an opioid overdose.
- **Higher dosages carry higher risk of opioid-related death**; however, **no dose is completely safe**.
- **Risk factors for Opioid Use Disorder (OUD) and overdose** include:
  - Higher dosages
  - Extended-release/longer-acting forms
  - Drug-drug interactions, such as with sedative-hypnotics (e.g., Benzodiazepines)
  - Medical comorbidities such as sleep apnea
  - Mental health comorbidities
  - Substance use

Knowledge Check: Pain and Opioid Overdose Epidemiology

Question: Which of the following is NOT a risk factor for Opioid Use Disorder (OUD) or overdose?

A) Extended-Release forms of opioid medications.
B) Sleep Apnea.
C) Bipolar Disorder.
D) Use of NSAIDs.

Knowledge Check: Pain and Opioid Overdose Epidemiology

Question: Which of the following is NOT a risk factor for Opioid Use Disorder (OUD) or overdose?

A) Extended-Release forms of opioid medications.
B) Sleep Apnea.
C) Bipolar Disorder.
D) Use of NSAIDs.

The correct answer is D) NSAIDs. Use of most over-the-counter pain relievers do not elevate risk for OUD or overdose.

2. Addressing the Problem: The New Principles of Good Pain Care

What is Pain?

First, a Definition

In 2020, the International Association for the Study of Pain (IASP) Task Force Reconvened for the first time since 1979 to develop an updated definition of pain:

OLD Definition:

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage **or described** in terms of such damage."

NEW Definition:

"An unpleasant sensory and emotional experience associated with, **or resembling** that associated with, actual or potential tissue damage."

IASP
International Association for the Study of Pain

Pain is Now Recognized as:

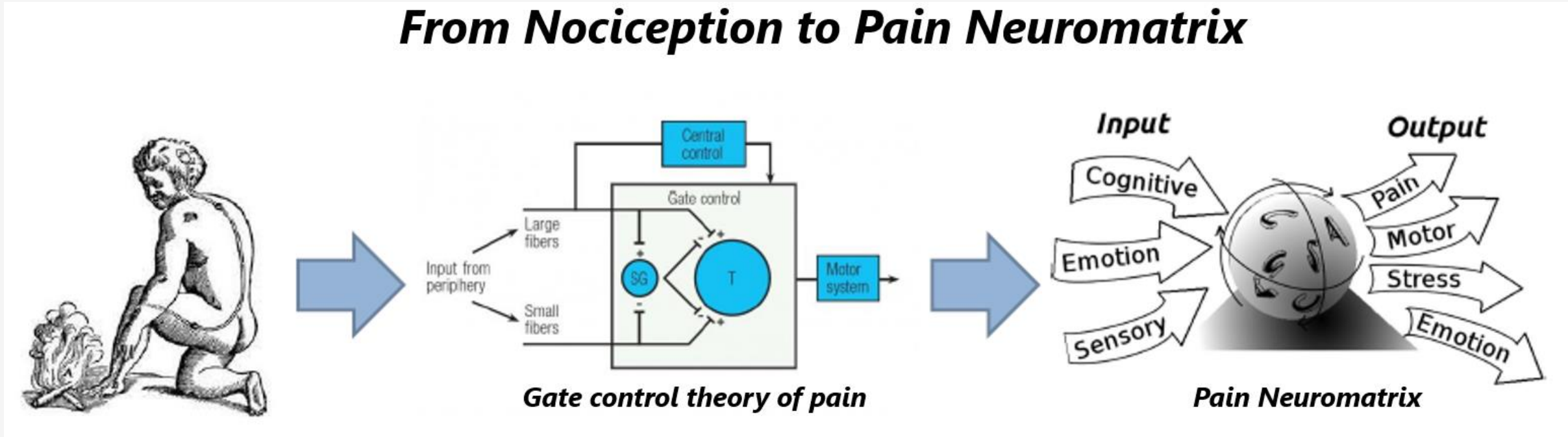
- A different phenomenon from nociception.
- Influenced by biological, psychological and social factors.
- An experience that is learned throughout the life course.
- **A personal experience to be respected regardless of objective evidence of tissue damage.**

https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ItemNumber=10475

What is Pain? (continued)

Visualizing the Mechanisms of Pain

Our framework for the underlying mechanisms of pain has evolved from basic nociception in the 17th century to Gate Control Theory (1965) to the Neuromatrix model involving the input and output of interacting domains (2012).

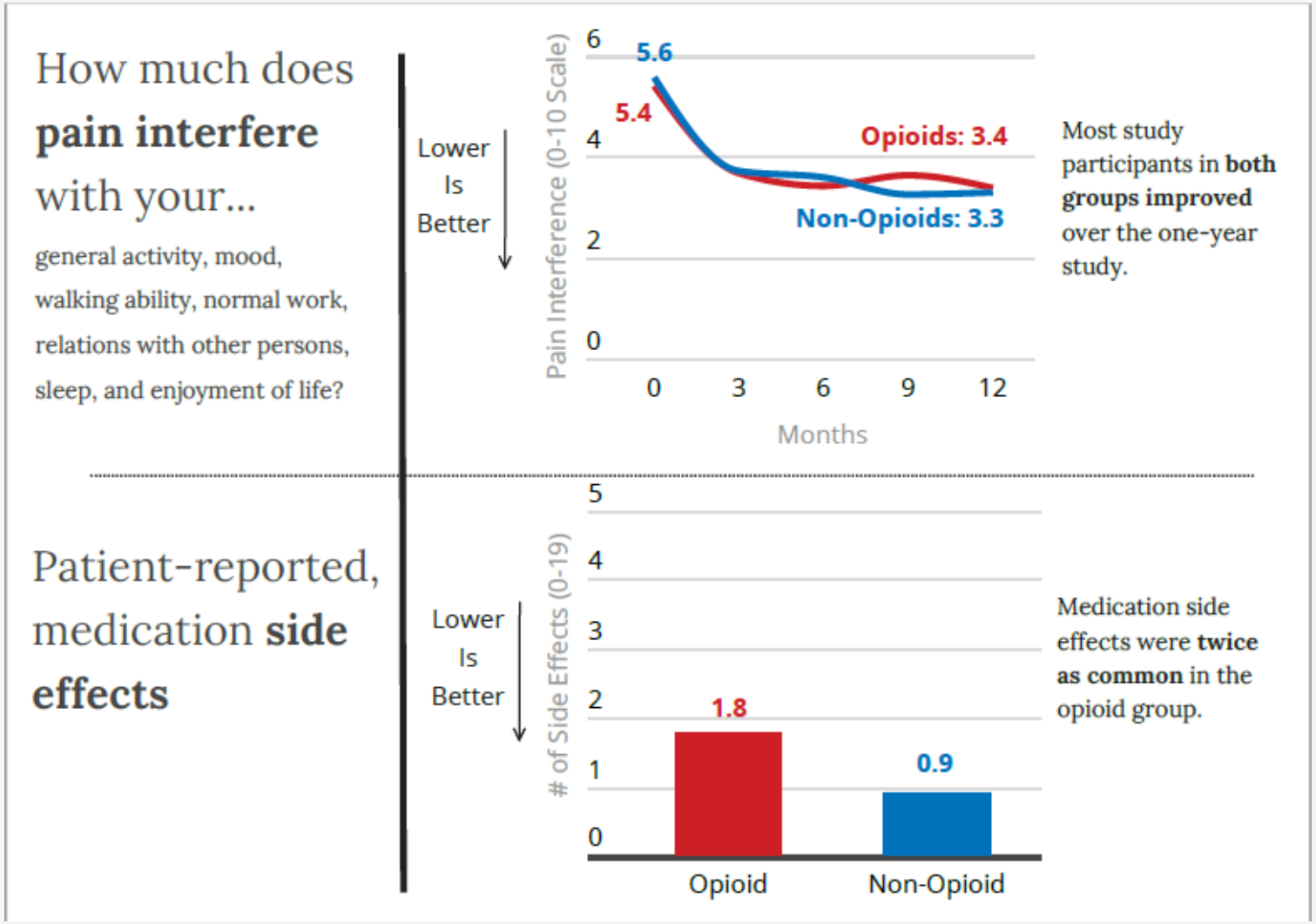


Descartes 1664; Melzack and Wall, Science 1965;150(3699):971-9 https://pubmed.ncbi.nlm.nih.gov/5320816/;
Leung J Prim Health Care 2012; 4(3):254-8 https://pubmed.ncbi.nlm.nih.gov/22946077/

No Benefit from Opioid Therapy for Pain Control After 12 Months

The SPACE Randomized Controlled Trial (2018)

Among 240 VA patients with long-term back, hip, or knee pain treated for 12 months, **opioids did not work better than non-opioids for chronic pain and resulted in twice as many side effects**.



Krebs et al. JAMA 2018 https://pubmed.ncbi.nlm.nih.gov/29509867/

The Paradigm Shift in Pain Care: Re-thinking Opioids

Shift **TOWARDS multimodal and integrated team-based pain care** (biopsychosocial interdisciplinary care) and **AWAY FROM opioid therapy** for non-end-of-life pain management

- There is **no completely safe opioid dose threshold** for which there are no risks for adverse outcomes.
    - Even short-term use of low-dose opioids may result in addiction.
- Any initial, **short-term functional benefit will likely not be sustained** in most patients.
- There is a concern that 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 experience a functional decline in the long-term**, measured by factors such as return to employment.

https://www.healthquality.va.gov/guidelines/Pain/cot/; https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf; Lee et al. Pain Physician 2011 https://pubmed.ncbi.nlm.nih.gov/21412369/; Hoffman et al. JAMA Neurol 2017 https://pubmed.ncbi.nlm.nih.gov/28531306/

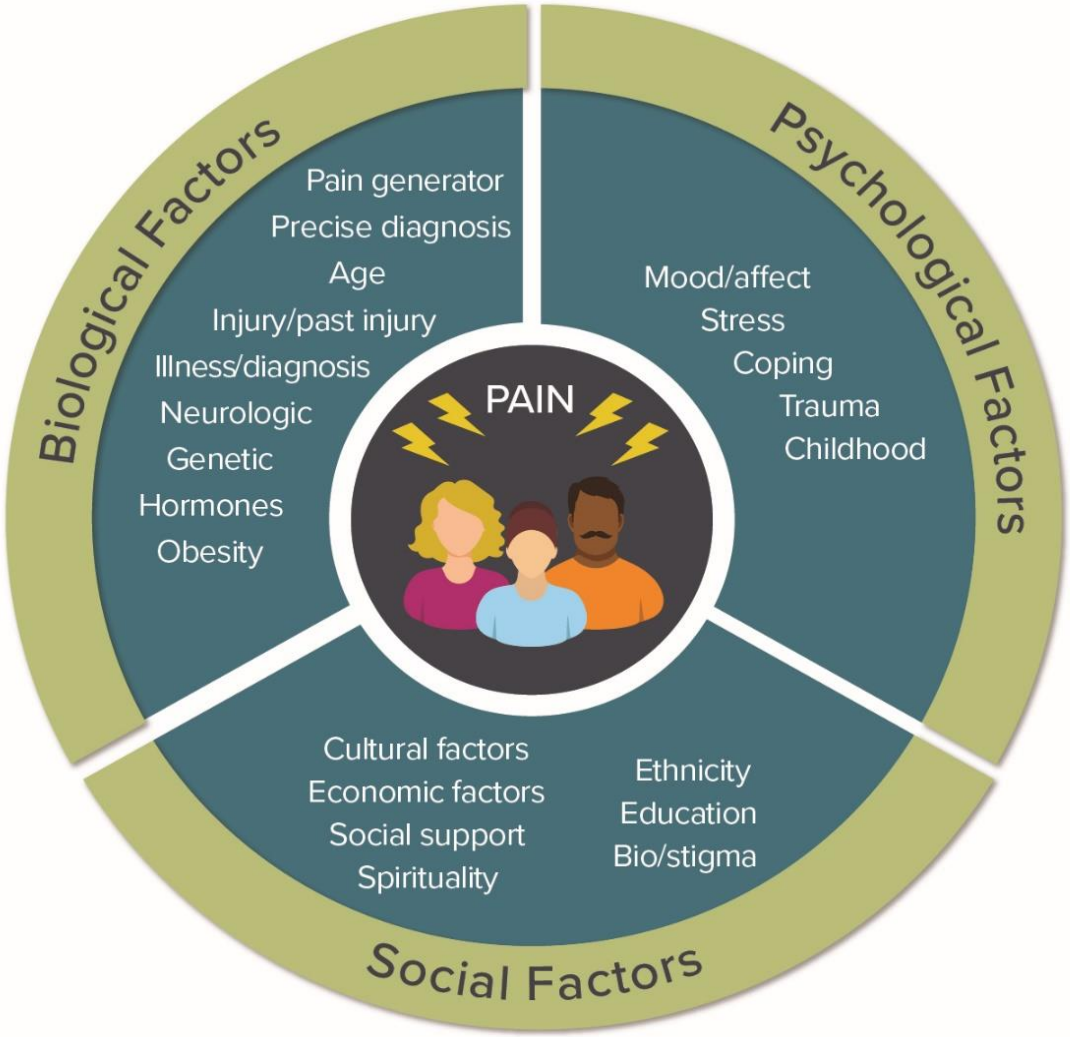
The Biopsychosocial Model Approach to Pain Management

Key Components:

- Biological Factors (e.g., diagnosis, age)
- Psychological factors (e.g., mood, stress)
- Social factors (e.g., social support, spirituality)

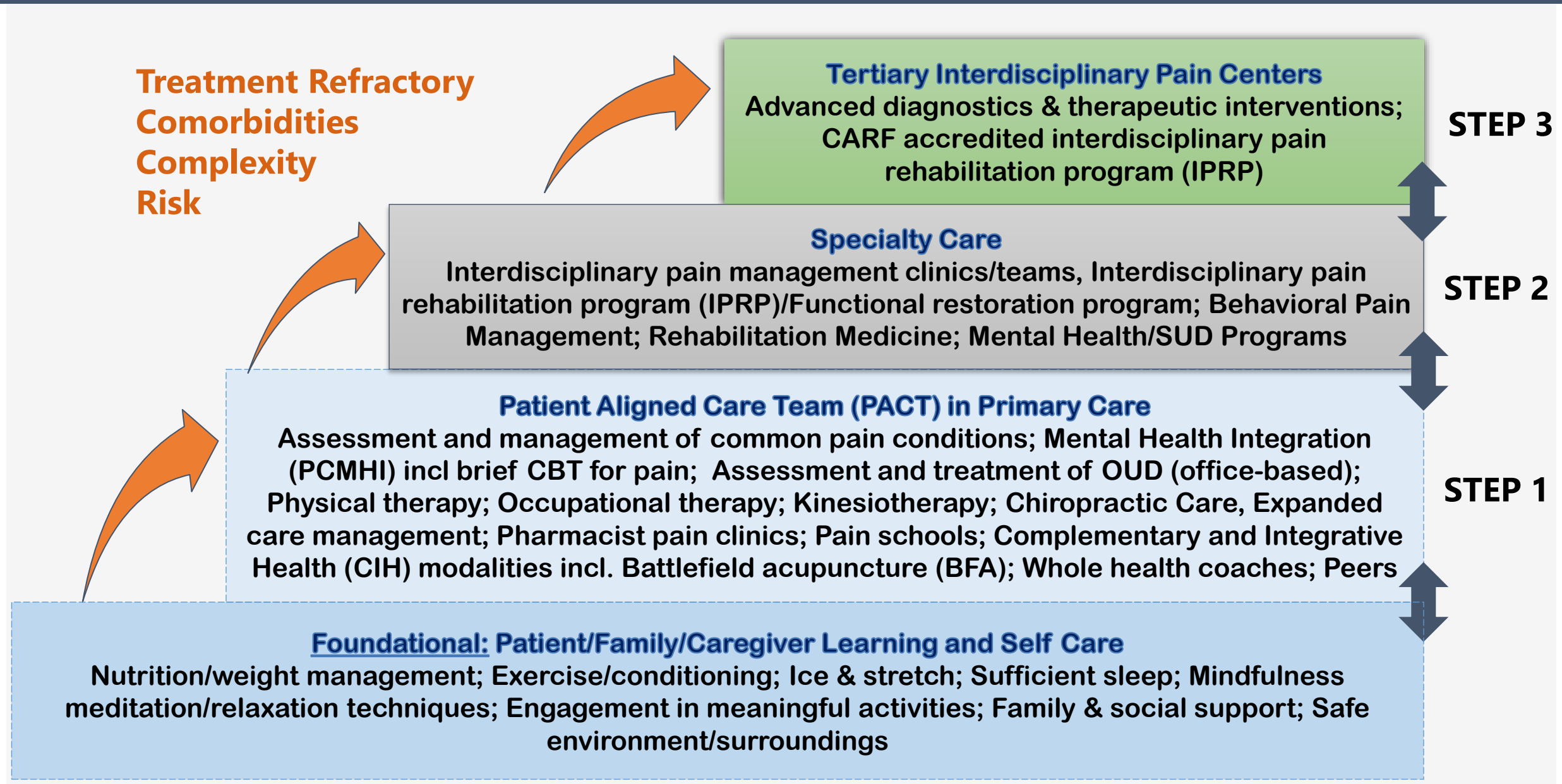
Goals:

- Improve the experience of pain
- Enhance physical functioning
- Promote activities of daily living
- Increase quality of life (QoL)



https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

The Stepped Care Model for Pain Management



The Stepped Care Model for Pain Management

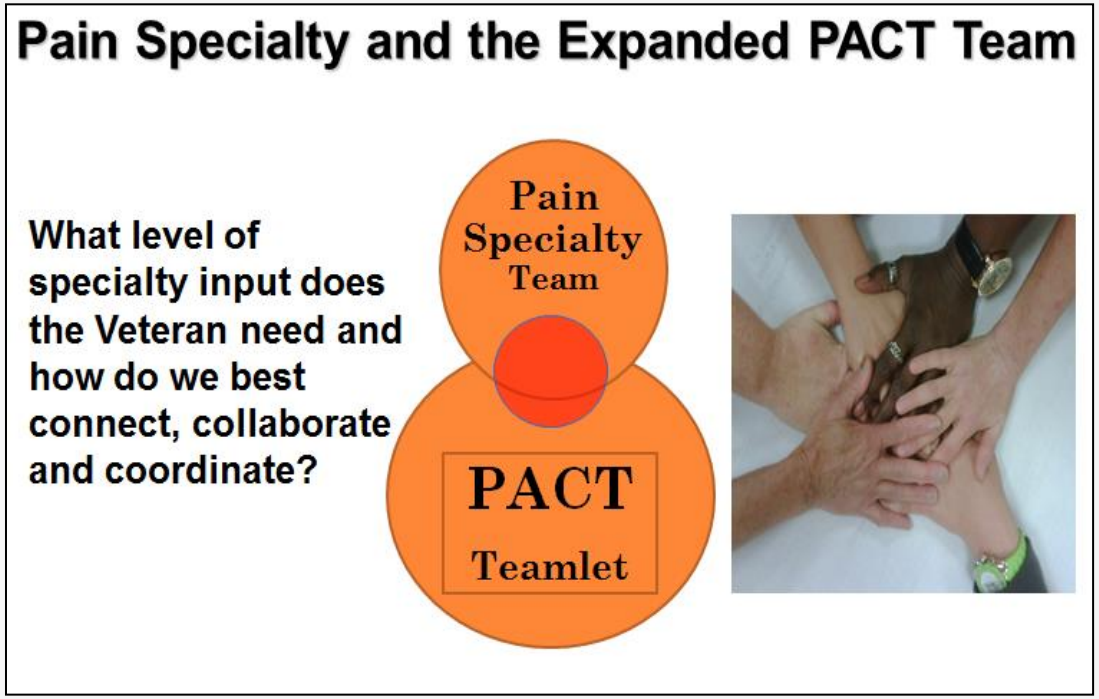
Person-centered pain care: Whole Health

Foundational to the **Stepped Care Model for Pain Management** is **self-care/self-management** that takes a broad approach consistent with "Whole Health" care.

The **Patient Aligned Care Team (PACT) in Primary Care** is the **Medical Home** with integrated Mental Health services and direct access to pain care modalities.

A **Pain Management Specialty Care Team** is available at all facilities to support Veterans and their Primary Care teams.

Providers from **PACT and Specialty Care work collaboratively** and coordinate pain care across service lines.



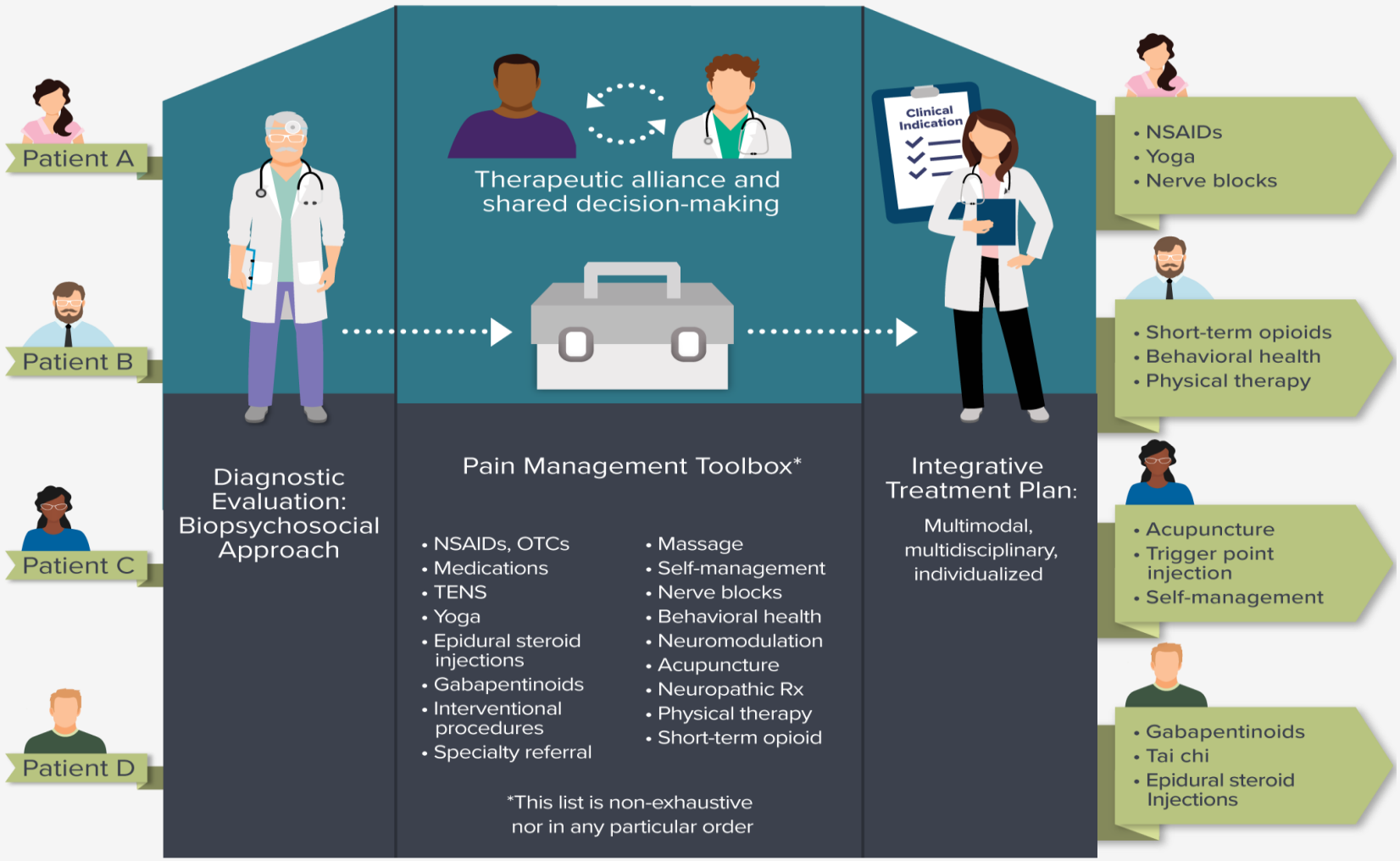
Individualized Patient Care for All Treatment Options

Individualized, patient-centered care is best achieved through:

- Diagnostic evaluation
- A biopsychosocial approach
- Access to needed treatment approaches

Producing an individualized, patient-centered treatment plan requires a strong patient-clinician relationship:

- Mutual trust and respect
- Empathy
- Compassion



https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

Summary: New Principles of Good Pain Care

Integrated Collaborative Pain Care that is Patient-Centered

- **Pain** has been **redefined as being a complex personal experience** and is influenced by biological, psychological, and social factors (**biopsychosocial model**).
- Pain care in VHA is **moving away from the use of opioids** and **towards multimodal, interdisciplinary pain care** that takes a "**Whole Health**" approach in order to provide individualized care.
- **Foundational** is **self-care/self-management.**
- The **Patient Aligned Care Team (PACT) in Primary Care** is the **Medical Home** with integrated Mental Health services and direct access to pain care modalities.
- The **PACT team and Pain Management Teams/Specialty Care work collaboratively** and coordinate pain care across service lines.

Knowledge Check: New Principles of Good Pain Care

Question: Which one of the following pain treatment approaches is NOT available within Primary Care (Step 1 of the Stepped Care Model for Pain Management)?

A) Assessment and management of common pain conditions.
B) Physical therapy.
C) Evaluation for neuromodulation (spinal cord stimulator placement)
D) Battlefield acupuncture (BFA)

Knowledge Check: New Principles of Good Pain Care

Question: Which one of the following pain treatment approaches is NOT available within Primary Care, i.e., Step 1 of the Stepped Care Model for Pain Management (SCM-PM)?

A) Assessment and management of common pain conditions.

B) Physical therapy.

C) Evaluation for neuromodulation (spinal cord stimulator placement)

D) Battlefield acupuncture (BFA)

The correct answer is C) Spinal cord stimulation is an advanced pain care intervention that requires evaluation in a Pain Management Specialty Clinic (Step 2/3 of the SCM-PM).

Knowledge Check: New Principles of Good Pain Care

Question: Which level of the Stepped Care Model does an implantable spinal cord stimulator fall under?

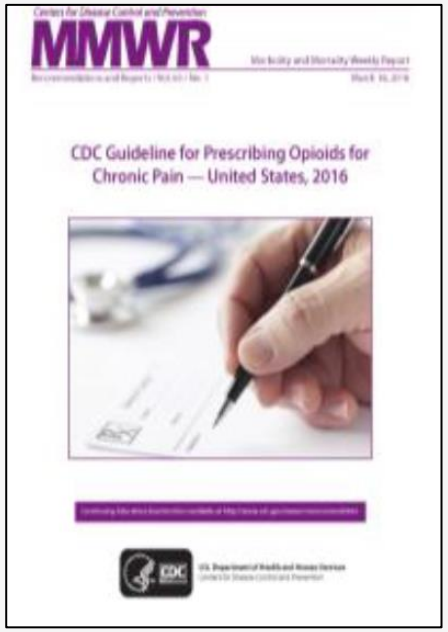
A) Step 2 (Specialty Care Services).
B) Step 1 (Primary Care).
C) Step 3 (Tertiary Care).
D) None of these; it is part of the foundation.

The correct answer is C) Step 3 or Tertiary Care. Self-care makes up the foundation of the Stepped Care Model. Spinal cord stimulation is an advanced pain care intervention which should be used when necessary, to build upon the other levels of care.

3. Clinical Practice Guidelines (CPGs) for Opioid Therapy

Evidence: The CDC Opioid Prescribing Guideline (2016)

"Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with **insufficient evidence to determine long-term benefits** versus no opioid therapy, though evidence suggests risk for **serious harms that appear to be dose-dependent**."

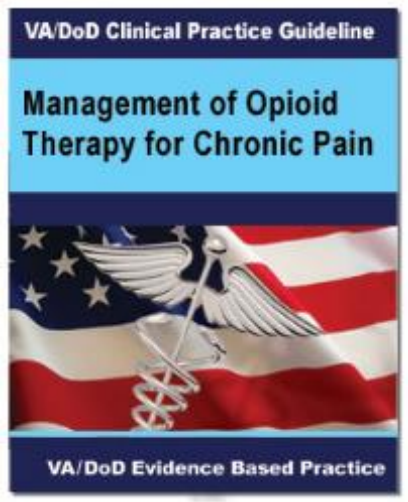


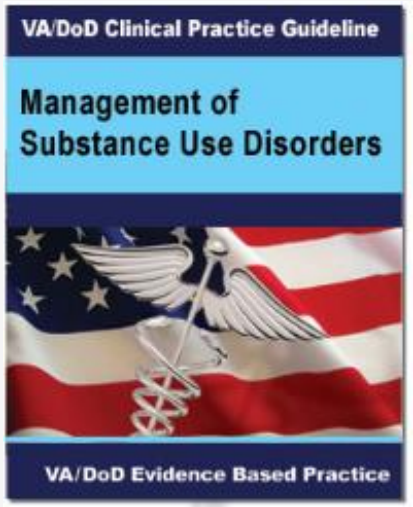
"Clinical decision-making should be based on a relationship between the clinician and patient, and an understanding of the patient's **clinical situation, functioning, and life context**."

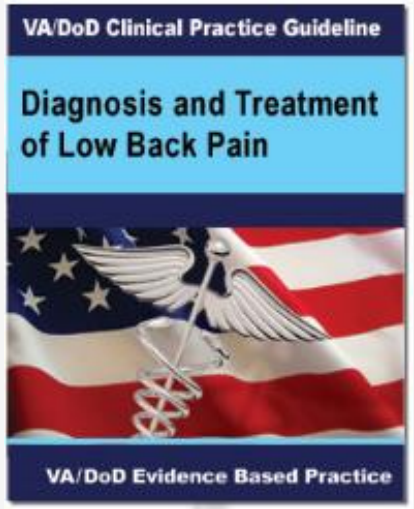
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

VA/DoD Clinical Practice Guidelines (CPGs)

The VA Office of Health Integrity collaborates with the Department of Defense (DoD), VA and DoD clinicians and clinical researchers, and content experts to create evidence-based guidance for common medical problems.







Click on the above images for corresponding patient and provider resources.

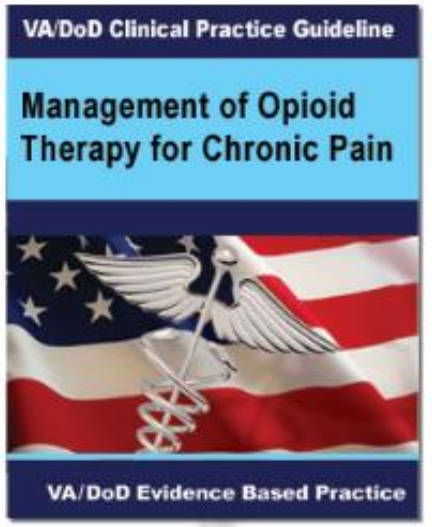
https://www.healthquality.va.gov/guidelines/Pain/cot/

VA/DoD 2017 Clinical Practice Guideline: Opioid Therapy

VA/DoD CPG Includes 18 Recommendations, Organized In Four Topic Areas:

1) Initiation and Continuation of Opioids

- "**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**."
- **Recommendation against opioid therapy** in patients <30 years of age, in patients with active substance use disorder, or **in combination with benzodiazepines**.

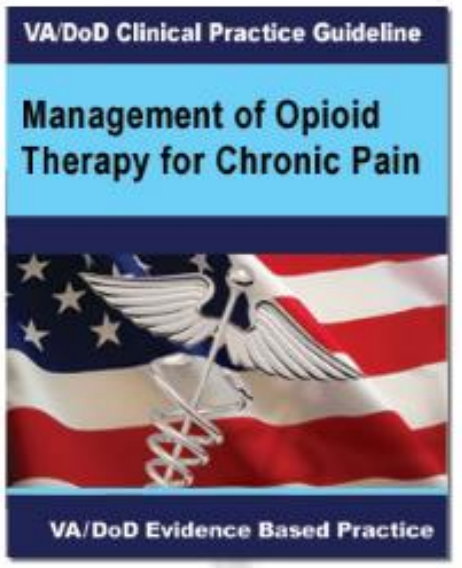


https://www.healthquality.va.gov/guidelines/Pain/cot/

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

2) Risk Mitigation

- Recommendation to use risk mitigation strategies, including **Informed Consent, Urine drug testing, Prescription Drug Monitoring Program (PDMP), Overdose education and Naloxone prescribing.**
- Assess for **Suicide risk.**
- Evaluate benefits and risks **at least every 3 months.**

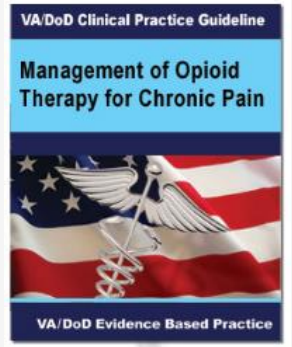


https://www.healthquality.va.gov/guidelines/Pain/cot/

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

3) Type, Dose, Follow-up, and Tapering of Opioids

- If prescribing opioids: **use the shortest duration and lowest dosage.**
- **No dosage is absolutely safe**; strong recommendation against increasing opioid dosage >90 MEDD.
- **Avoid long-acting opioids for acute pain, as PRN, or upon initiation** of opioid therapy.
- Opioid dose **reduction should be individualized** to the patient.
- For **OUD**, offer **medication treatment (m-OUD)**.

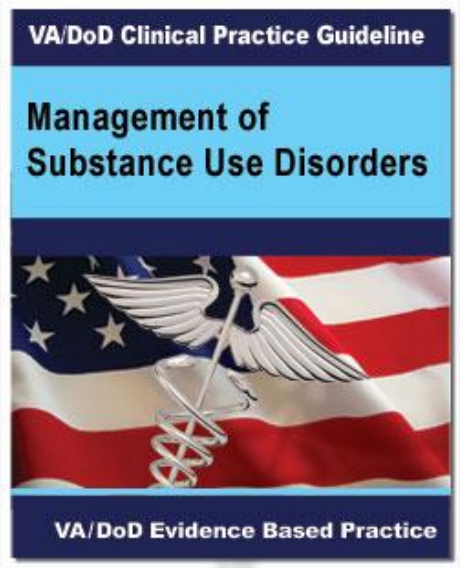


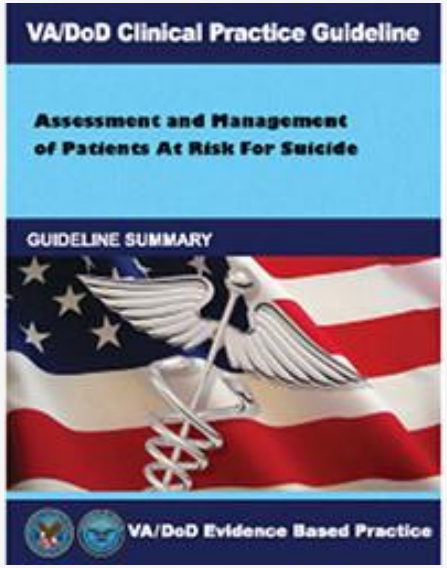
4) Opioid Therapy for Acute Pain

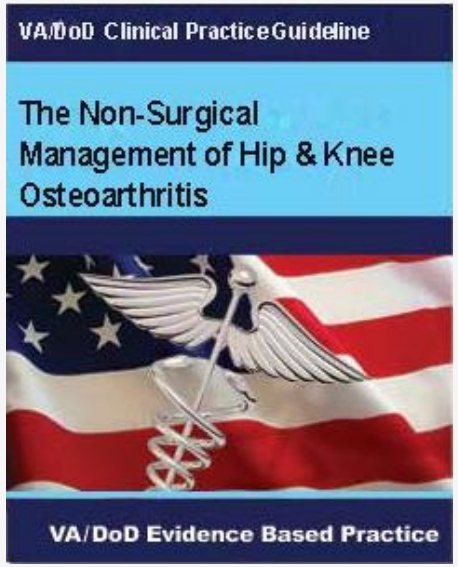
- **Acute pain:** use alternatives to opioids; use multimodal pain care, **if using opioids prescribe for ≤3-5 days.**

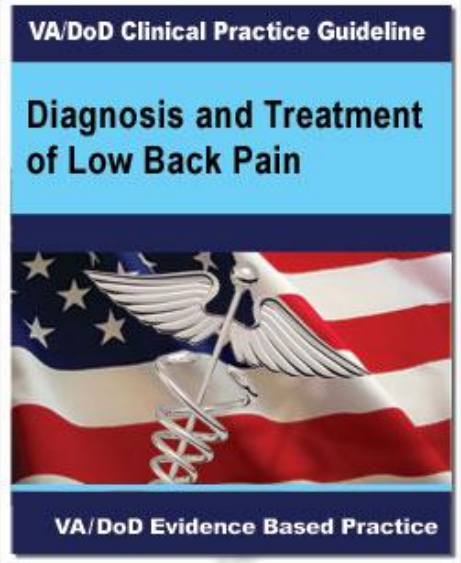
https://www.healthquality.va.gov/guidelines/Pain/cot/

Additional VA/DoD CPGs Involving Opioid Therapy









https://www.healthquality.va.gov/

Summary: Clinical Practice Guidelines (CPGs) for Opioid Therapy

- **The VA/DoD CPG recommends against *initiation* of long-term opioid therapy**, i.e., new starts should be avoided.
- Alternatives to opioid therapy, such as non-pharmacological treatments, are preferred for pain management. Non-opioids are preferred over opioid medications.
- **Risk mitigation strategies** include **Informed Consent, Prescription Drug Monitoring Program (PDMP) queries, Urine Drug Testing (UDT), and Overdose Education and Naloxone Distribution (OEND)**.
- **Avoid combination with benzodiazepines**, if possible.
- Risks and benefits should be **reevaluated at least every three months**.
- If prescribing opioid medications, the dose and duration should be minimized as no dose is free of risk.
- For Opioid Use Disorder (OUD), provide **access to Medication for OUD (m-OUD).**
- **For acute pain**, use alternatives to opioids, if feasible. **If using opioids prescribe for ≤3-5 days.**

Knowledge Check: Clinical Practice Guidelines (CPGs) for Opioid Therapy

Question: When considering continuing opioid therapy, how often should you re-evaluate the risks and benefits?

A) At least once a week.
B) At least once every three months.
C) Once a year.
D) There is no recommended frequency; as long as the patient doesn't mention any concerns, re-evaluation is not necessary.

Knowledge Check: Clinical Practice Guidelines (CPGs) for Opioid Therapy

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B) At least once every three months.
C) Once a year.
D) There is no recommended frequency; as long as the patient doesn't mention any concerns, re-evaluation is not necessary.

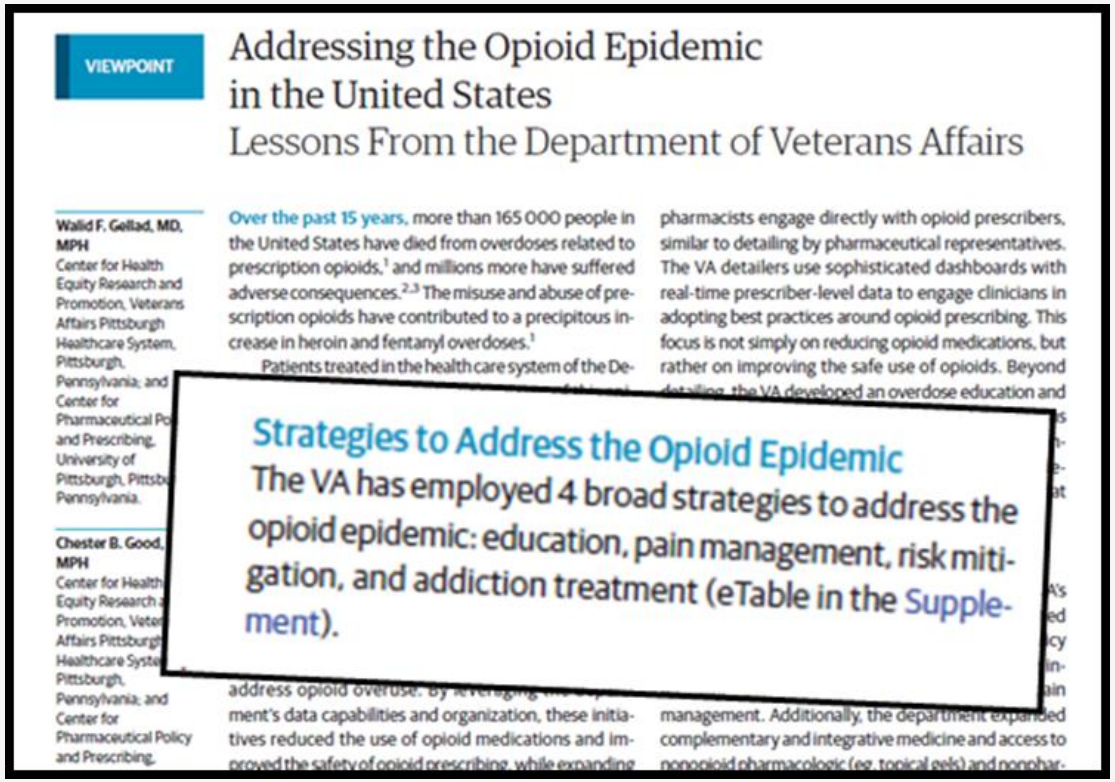
Per the Clinical Practice Guidelines for Opioid Therapy, the correct answer is B) At least once every three months and more frequently if deemed clinically appropriate.

4. The Opioid Safety Initiative (OSI) and Best Practices

The VA Opioid Safety Initiative (OSI)

The Opioid Safety Initiative (OSI) Expanded Nationally in 2013

- **Aims**
  - Reduce over-reliance on opioid analgesics for pain management.
  - Safely and effectively use opioid therapy when clinically indicated.
- **Comprehensive strategy**
  - Provider education, Academic Detailing.
  - Expanded access to non-pharmacological modalities, including behavioral and complementary and integrative health (CIH) modalities.
- **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 Po... and Prescribing, University of Pittsburgh, Pittsb... Pennsylvania.

Chester B. Good, MPH
Center for Health... Equity Research ... Promotion, Vete... Affairs Pittsburgh Healthcare Syste... 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...

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).

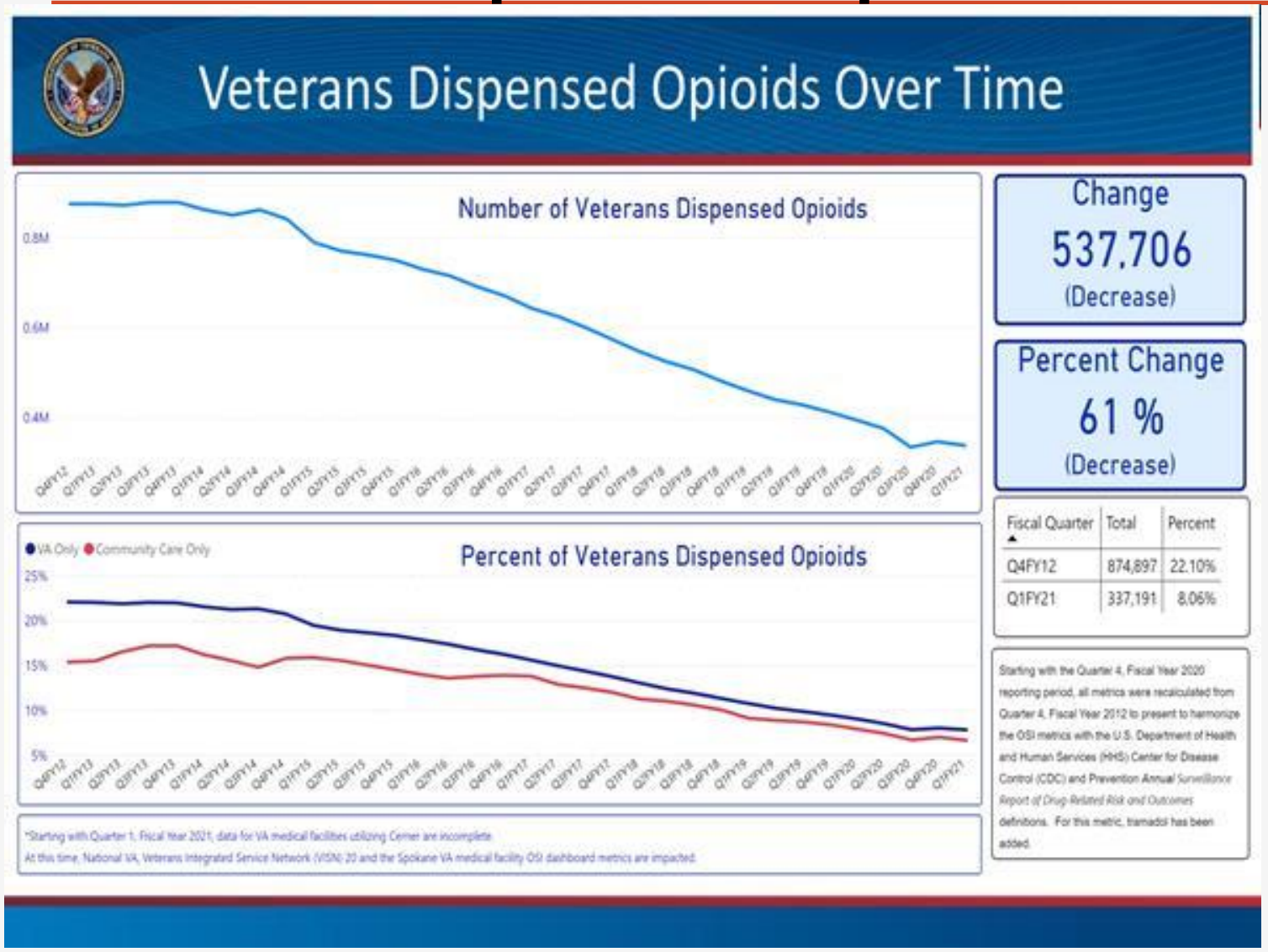
address opioid overuse. By ... ment's data capabilities and organization, these initiatives reduced the use of opioid medications and improved the safety of opioid prescribing, while expanding

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 ... the VA developed an overdose education and ... management. Additionally, the department expanded complementary and integrative medicine and access to nonopioid pharmacologic (eg, topical gels) and nonphar-

Gellad, Good CB, and Shulkin. JAMA Intern Med. 2017 May 1;177:611-2 https://pubmed.ncbi.nlm.nih.gov/28288245/

Opioid Safety – Veterans Dispensed Opioids Over Time

Veterans with Opioid Prescription*



From **FY2012 to FY2021**, there was **a 61% reduction in opioid prescriptions** within VHA.

*Veterans with opioid dispensed in reporting quarter as percentage of all Veterans with pharmacy activity.

Overview of OSI 2.0 Dashboard Parameters

1. Opioid utilization (total opioid prescribing).
2. Opioid and Benzodiazepine co-prescribing.
3. High-dose prescribing (defined now as ≥90 MEDD).
4. Long-Term Opioid Therapy (LTOT) (use of opioids for ≥ 90 days).
5. Urine Drug Screen (UDS) in LTOT.
6. Newly started LTOT.

OSI 2.0 Parameters and Policies *(Select Items)*

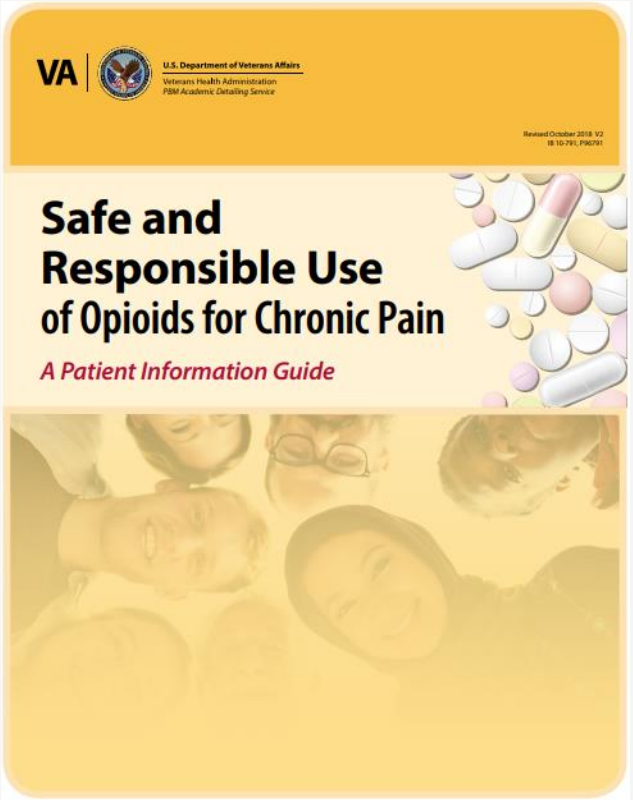
Other Parameters and Risk Mitigation Strategies:

- **Informed consent** (2014) required for patients on LTOT.
- **PDMP checks** (2016) required at least annually and prior to new starts for all controlled medications (unless ≤5-day supply and without refills).
- **Overdose Education and Naloxone Distribution (OEND)** with broad inclusion, no cost to Veterans.
- **Timely follow-up** within 1-4 weeks after change in dosage, and at least every 3 months to review care.
- **Data-based OSI Risk Reviews (STORM dashboard)** (2018) to assess risk prior to initiation of opioid therapy and interdisciplinary care coordination of patients at very high risk for overdose or suicide.

Informed Consent for Long-Term Opioid Therapy (LTOT)

VHA Policy: Informed Consent (Via I-Med) Required for all Patients on LTOT

- **LTOT is use of opioids for ≥ 90 days.**
  - Patients enrolled in hospice or on opioids for cancer pain can be orally consented.
- Opportunity to **discuss risks of and alternatives to opioid therapy** with the Veteran.
- Provides some **protection to the provider and facility** in case of harm to the patient related to opioid therapy.
- The **brochure "Safe and Responsible Use of Opioids for Chronic Pain"** is part of the Informed Consent.
- Informed consent **can be obtained remotely** during telehealth visits (by video or phone).



VHA Directive 1005, Informed Consent for Long-Term Opioid Therapy for Pain. May 13, 2020 https://www.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=8822

Overdose Education and Naloxone Distribution (OEND)

What is OEND?

Overdose Education (OE)

- How to *prevent, recognize, and respond* to an opioid overdose.

Naloxone Distribution (ND)

- Most common use is as **nasal spray or injection.**
- *Dispense and train* patient and caregiver/family.

Providers should have a low threshold for prescribing Naloxone.

- Use of naloxone has saved lives with over 1500 VHA reported overdose reversals (as of Sept. 2020).
- **No cost to patients.**

Rapid Naloxone Initiative provides for VA Police to carry naloxone and placing naloxone into select Automated External Defibrillator (AED) cabinets.

https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5349; Unpublished VHA data.

Identifying Patients at Risk for Overdose

- **Target patient populations**:
  - Veterans with OUD
  - Veterans on opioid prescriptions.
  - Veterans who are being tapered or recently discontinued opioids.
- **Factors that increase risk** for opioid overdose include:
  - Higher opioid dosages (≥50 MMED)
  - Concurrent benzodiazepine use
  - History of overdose
  - History of SUD and/or mental health disorders

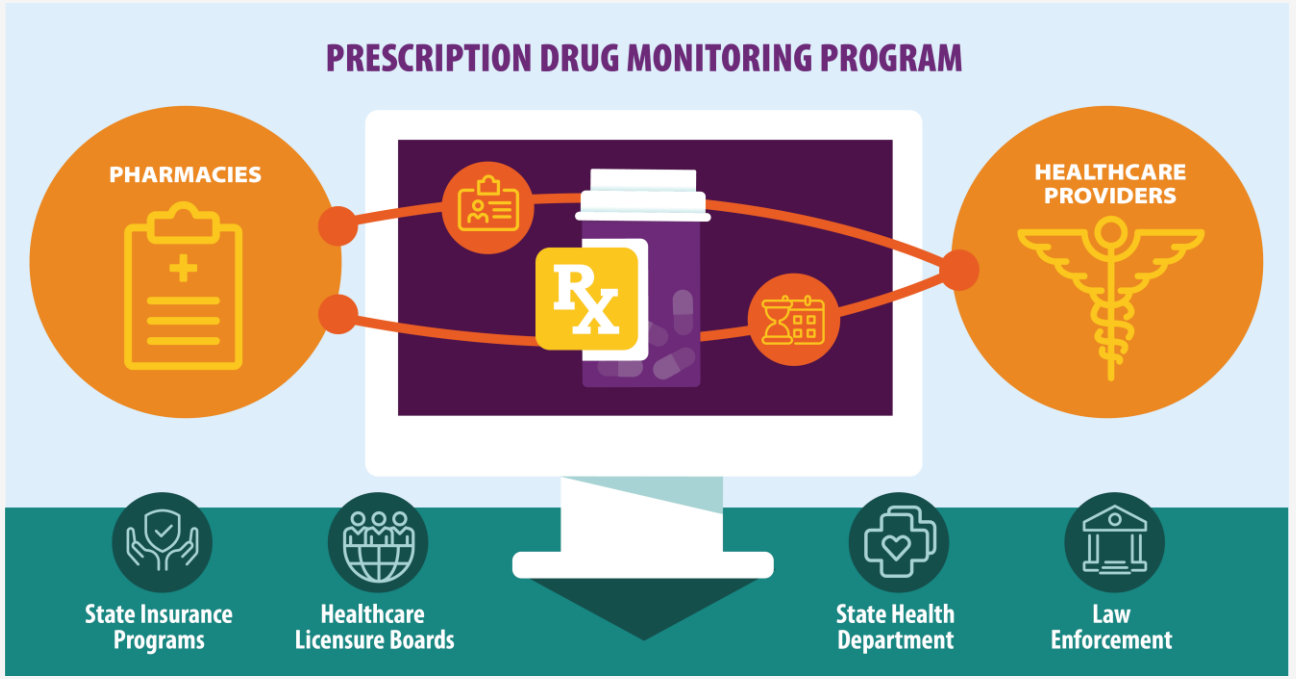
What is a Prescription Drug Monitoring Program (PDMP)?

A PDMP is an **electronic database that tracks controlled substance prescriptions, usually at a state level**.

The CDC and the VA/DoD clinical practice guidelines for opioid therapy recommend regular PDMP queries, **at initiation and usually at least every 3 months.**

CDC: Clinicians should review PDMP data when starting opioid therapy for pain and periodically during opioid therapy ranging from every prescription to every 3 months.

VA/DoD: Opioid risk mitigation strategies at initiation of long-term opioid therapy; evaluating benefits of continued opioid therapy and risk at least every 3 months.



Querying the PDMP is an important component of risk mitigation when prescribing controlled substance(s).

https://www.cdc.gov/drugoverdose/pdmp/states.html; https://www.healthquality.va.gov/guidelines/pain/cot/

Prescription Drug Monitoring Programs (PDMPs)

VHA Policy

- **Prescribers must adhere to VHA Directive 1306 and be aware of the VA/DoD Clinical Practice Guidelines on Opioid Therapy for Chronic Pain.**
  - The PDMP Directive applies to **all controlled substances.**
  - Frequency of PDMP queries:
    - **Prior to initiating therapy** with a controlled substance.
    - **On an annual basis at a minimum.**
    - When clinical indications and patient safety concerns warrant it, **more frequent checks at the discretion of the prescriber.**
  - Exclusions from the policy mandate:
    - Controlled substance prescription for ≤5-day supply without refills.
    - Any patient enrolled in Hospice care.

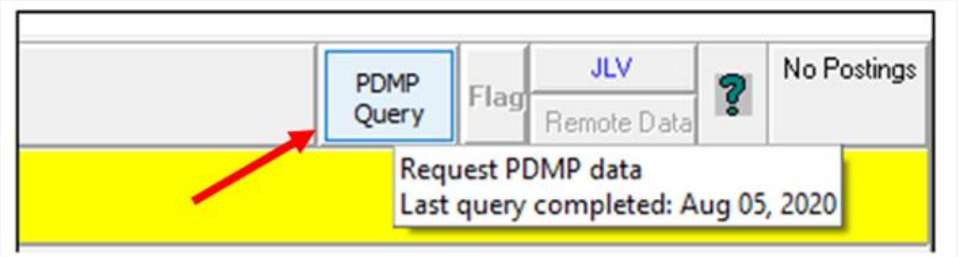
- **If there is variation between VA policy and participating state laws for PDMPs** (such as PDMP querying frequency)**, providers and prescribers must conform to the more stringent requirement** whether that of VA Policy or state/location of practice (prescribing) or licensure.

- **PDMP queries must be documented in CPRS by standard note title**.

VHA Directive 1306, Querying State Prescription Drug Monitoring Programs (PMDP). Oct. 19, 2016 http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3283

Integrated PDMP Solution for CPRS

- VHA has a **national IT solution for querying the network of PDMPs within CPRS.** The process links CPRS with PDMPs from states/regions and the Military Health System.
- Most states participate in the new process; not all participating states have approved PDMP queries by delegates yet. Map of state PDMP participation.



- The CPRS integrated PDMP solution is accessed through a button on the CPRS ribbon.
- VHA **PDMP users must be registered with the state PDMP portal**, i.e., the state where their facility is located and maintain an active registration (such as for password changes).
  - **Providers** with their **individual DEA number**
  - **Pharmacist** with their **individual NPI number**
  - **Delegates** with their **"va.gov" email** and clinical supervisor information.
- Further information is available on the CPRS Integrated PDMP Solution SharePoint.
- **PDMP queries may also be performed outside CPRS** by accessing the state and regional **PDMP portals** on their websites.

Urine Drug Testing (UDT)

VHA Guidance

- **Urine Drug Testing (UDT)** should be completed prior to and routinely throughout duration of long-term opioid therapy.*
- A **verbal consent** should be obtained and documented in the patient's medical record by the provider (may be done in advance, at least every 12 months).
- Frequency of UDT needs to be based on risk:
  - **at a minimum, every 12 months for low risk**
  - every 3 months or **more frequently for higher risk patients.**
- Correct interpretation of the result is imperative.
- **Unexpected/abnormal results** on urine drug screen **should be confirmed by confirmatory testing when clinically appropriate**.

If a patient shows an unexpected result on a UDT, work with the patient to clarify and address the issue. If indicated provide treatment for opioid use disorder or other SUD. Do not abruptly discontinue opioids due to unexpected results.

VA Academic Detailing Educational Materials

VHA Pharmacy Benefits Management: National Academic Detailing Service (ADS)

- **ADS** was rolled out in 2016 and utilizes innovative strategies to **eliminate the gap between clinical practice and evidence-based care**.
- The **ADS SharePoint** contains **many patient and provider resources,** including those related to:
  - Pain Management
  - PDMP
  - OEND
  - OUD
  - Emergency Department (ED) OSI
  - Suicide Prevention

- Visit the ADS Intranet (for VHA providers) and Internet (Public website) to learn more about how ADS can help you and your patients!

Stratification Tool for Opioid Risk Mitigation (STORM)

The STORM dashboard is a clinical decision support tool for VA providers

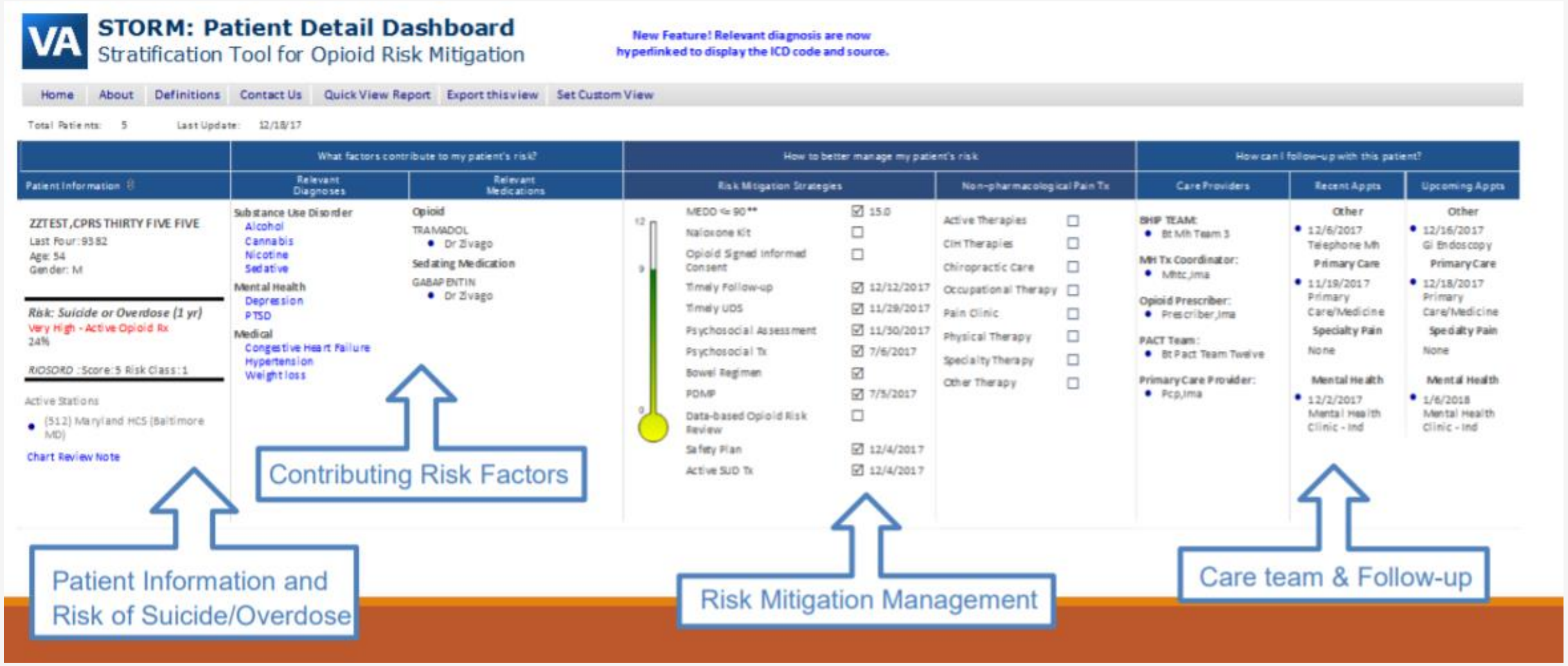
- **Predicts the Veteran's individual risk** of overdose or suicide-related health events or death **in the next one year and within three years**.
- **Identifies patients at-risk for opioid overdose/suicide-related adverse events**.
- Reports individual implementation of **opioid risk mitigation strategies**.
- Use for **data-based risk assessments** by providers (point-of-care) and OSI review teams.
- **Point-of-care reviews** by providers:
  - **Risk review prior to initiation of opioid therapy** (required in VHA).
  - **Review of care and treatment planning in Veterans on opioid therapy**.

STORM is accessed in CPRS through a weblink (under Tools); in Cerner; at the STORM Home Page.

3 reports types: STORM Summary Report: facility OSI report; drills down to actionable patients
STORM Detailed Patient Report: list of patients reported by risk with their details
STORM SSN Lookup Report: Individual patient data (enter SSN).

Oliva et al. Psychol Serv. 2017;14:34-49 https://pubmed.ncbi.nlm.nih.gov/28134555/

Stratification Tool for Opioid Risk Mitigation (STORM)



OSI Risk Review (Data-Based) of Opioid-Exposed Veterans

Systematic Review of the Clinical Care of Patients at High Risk for Overdose/Suicide

- **All VHA facilities have an interdisciplinary team of providers that reviews the care of Veterans with opioid therapy** (chart reviews).
- Team members include **Primary Care, Pain Management, MH including PCMHI, Suicide Prevention, and SUD, and Pharmacy** and others.
- The team reviews **Veterans identified by STORM as very high risk (required),** based on prescribing or other criteria (such as dosage, opioid/benzo co-prescribing), or provider referral.
- **Care recommendations are entered into the electronic medical record (EMR)** to assist clinical providers.
- Recent data shows that OSI risk reviews have saved many lives of Veterans!

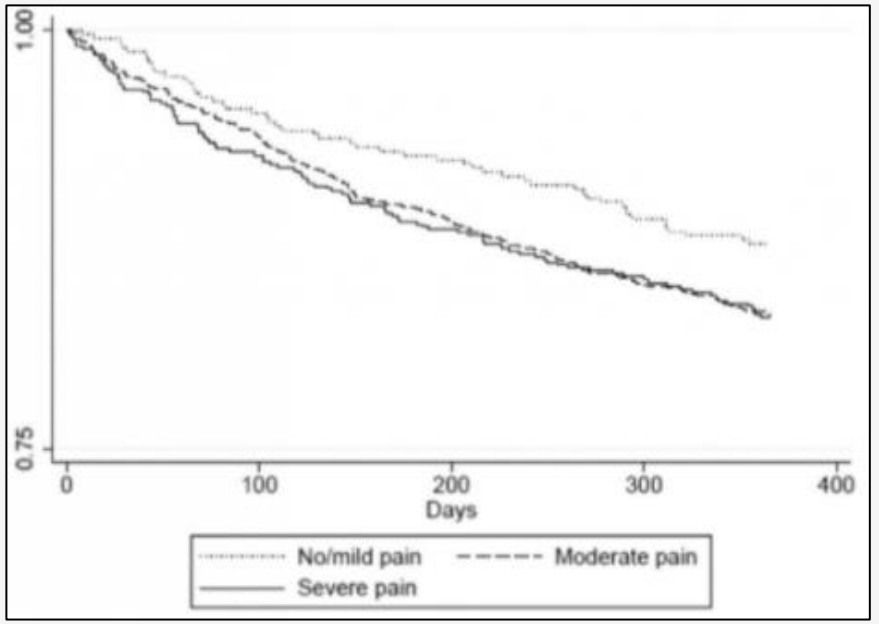
Oliva et al. Psychol Serv. 2017;14:34-49 https://pubmed.ncbi.nlm.nih.gov/28134555/

Veterans with Chronic Pain are at High Risk for Suicide

Severity of Pain Predicts Suicide Risk

- **Suicidality in patients with chronic pain is common:** 1/3 contemplate or attempt suicide, with an almost 3-fold increased risk for suicide attempts compared to the general public.
- **Correlation between pain intensity, suicide risk and death rates**.
- VA's Behavioral Autopsy Program reports **pain as the most common risk factor among Veterans** who die by suicide,
- Risk factors include pain severity, opioid therapy, OUD/SUD, depression, and possibly recent discontinuation of opioids, among others.

Survival Estimates for Suicide Attempts After the Index Visit, by Pain Intensity



Veterans with higher pain intensity had lower survival rates than those who had mild pain or no pain.

https://blogs.va.gov/VAntage/67708/va-study-uncovers-link-pain-intensity-suicide-attempts/;
Ashrafioun et al. J Pain 2019 Jul;20(7):852-859 https://pubmed.ncbi.nlm.nih.gov/30690167/

Suicide Risk Screening

Primary Measure: C SSRS → **Secondary Measure: CSRE**

- **Suicide screening is required for ALL patients newly evaluated in VHA Pain Clinics** and at least annually upon follow-up
- **Primary Measure**: Columbia- Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent Screener
- **Secondary Measure (only needed if positive results on C-SSRS)**: VA Comprehensive Suicide Risk Evaluation (CSRE)

If you are a Veteran in crisis — or you're concerned about one — free, confidential support is available 24/7. Call the Veterans Crisis Line at 1-800-273-8255 and Press 1, send a text message to 838255, or chat online or at www.veteranscrisisline.net

https://www.mentalhealth.va.gov/suicide_prevention/

Summary: Opioid Safety Initiative (OSI) and Best Practices

1. The Opioid Crisis in the US has **shifted from overdoses to prescription opioids to illicit drugs**, most recently synthetic opioids (e.g., fentanyl).
2. Risk of prescription opioids is correlated with **dose and duration**.
3. **Opioids in combination with sedating drugs are particularly dangerous**.
4. **Mental health/substance use disorders contribute greatly** to increased risk.
5. The VA/DoD CPG for Opioid Therapy **recommends against *initiation* of Long-Term Opioid Therapy (LTOT)** for chronic pain.
6. **Opioid risk mitigation strategies are available systemwide.**
   - Overdose Education and widespread **Naloxone Distribution** (OEND).
   - Stratification Tool for Opioid Risk Mitigation (STORM).
   - Prescription Drug Monitoring Programs (PDMP).
   - Urine Drug Testing (UDT).
7. **Opioid dose reduction (opioid tapering) must be patient-centered** and individualized with the goal of maximizing function and safety.
8. Patients on long-term opioid therapy (LTOT) who fulfill the criteria for OUD must be offered **access to evidence-based therapy, i.e., medication for Opioid Use Disorder (m-OUD).**

Knowledge Check: Opioid Safety Initiative (OSI) and Best Practices

Question: Where can providers find out how often they need to conduct Prescription Drug Monitoring Program (PDMP) checks and Urine Drug Testing (UDT) for patients on opioid therapy?

A) The VA/DoD Clinical Practice Guidelines for Opioid Therapy.
B) VHA Directive 1306.
C) This is determined on a case-by-case basis depending on the clinical indications and patient safety concerns.
D) The is dictated by the provider's state or jurisdiction of practice/licensure.
E) All of the above.

Knowledge Check: Opioid Safety Initiative (OSI) and Best Practices

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D) The is dictated by the provider's state or jurisdiction of practice/licensure.
E) All of the above.

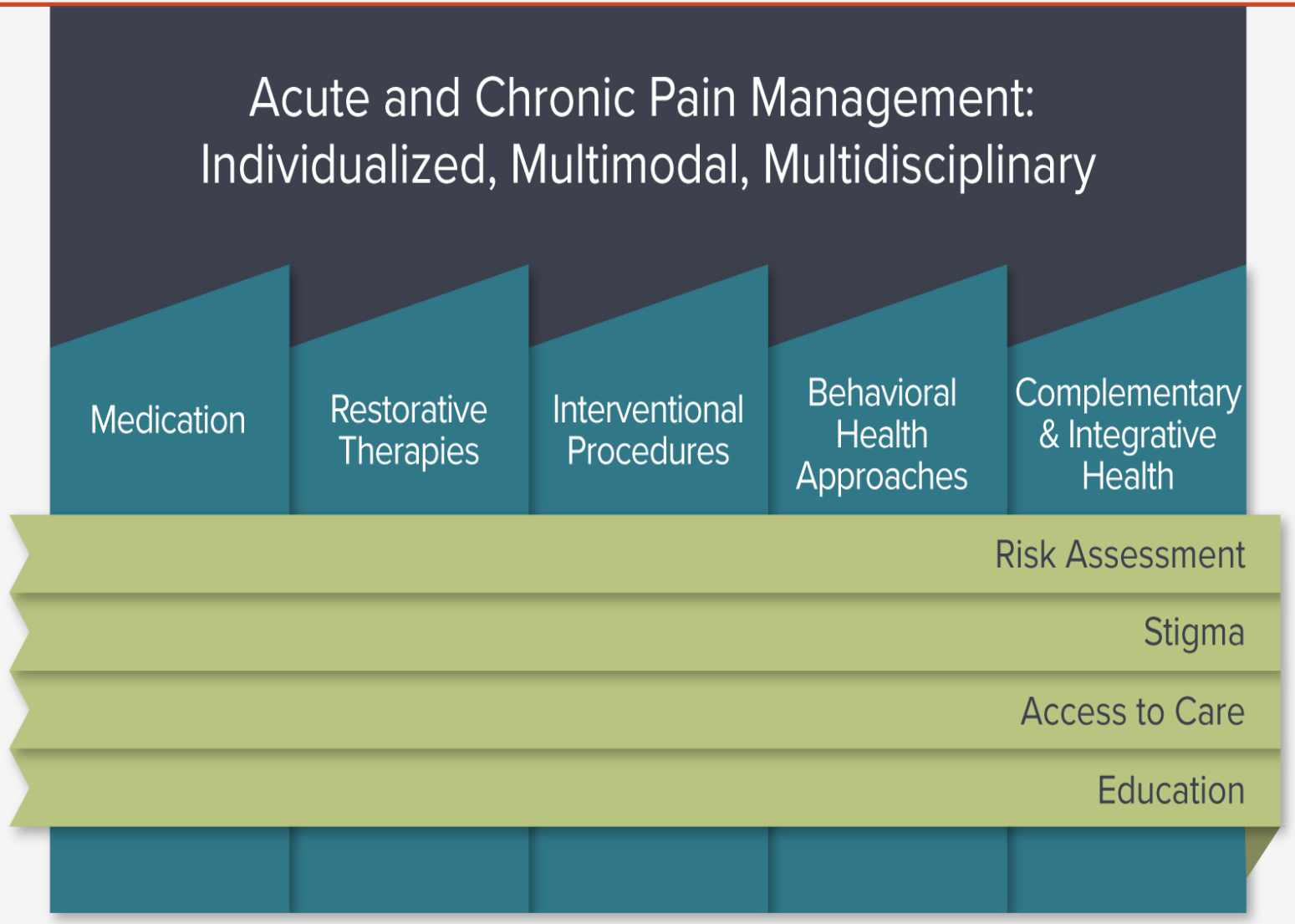
The correct answer is E) frequency of PDMP queries and UDT needs to be determined by a combination of all of these factors, with the most stringent of these being the ultimate determinant for what should be adhered to in order to ensure total compliance.

5. Recommended Treatments for Pain

Multimodal Pain Care

Pain Management Best Practices Task Force report 2019

5 categories of pain treatment modalities.



pmtf-final-report-2019-05-23.pdf (hhs.gov)

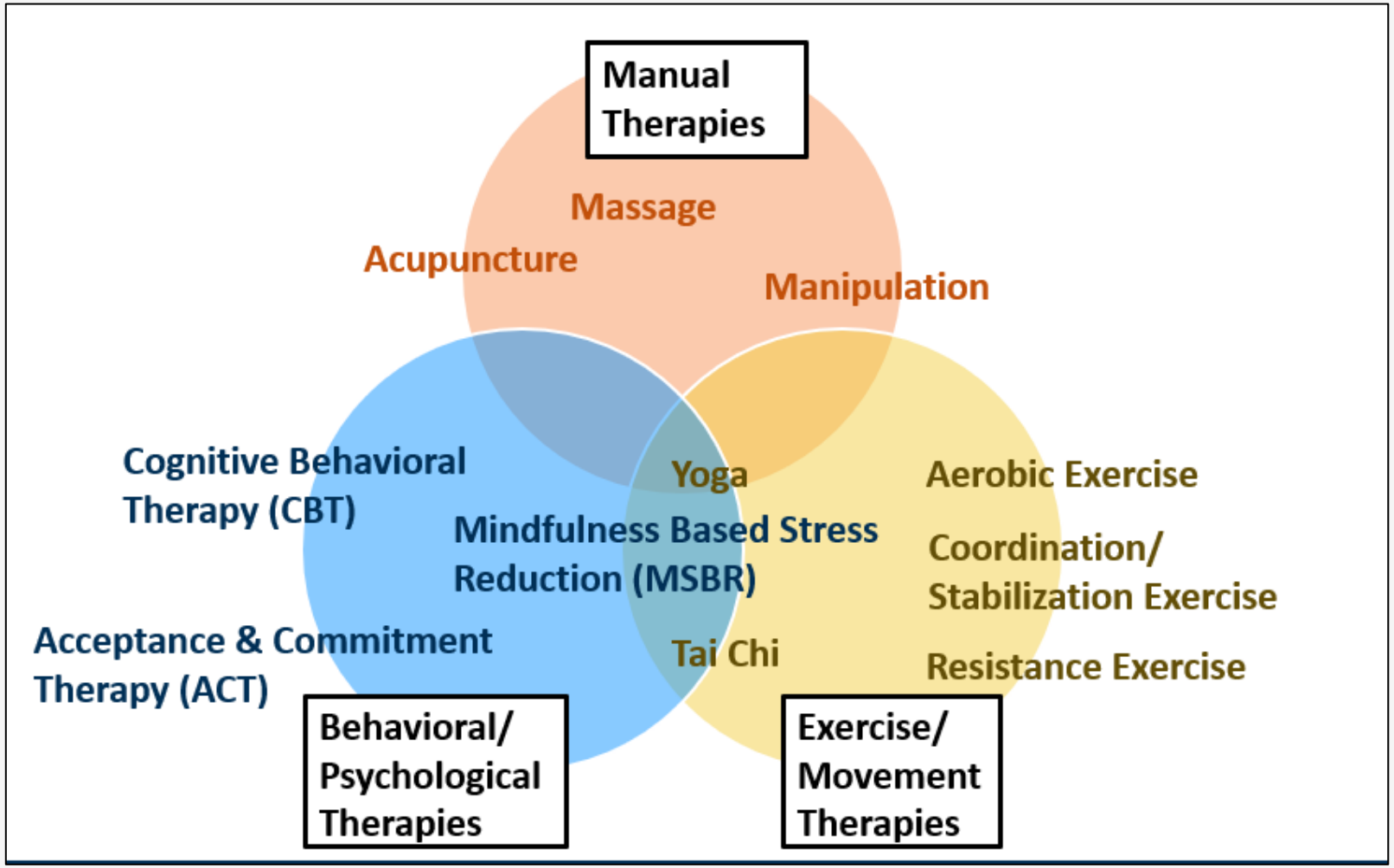
Non-Pharmacological Pain Treatments in VHA

VHA Conference on Non-Pharmacological Approaches to Chronic Musculoskeletal Pain 2016

Restorative Therapies include Physical Therapy and exercise approaches.

Yoga/Tai Chi are CIH approaches to movement therapies.

In addition to CBT for chronic pain, other evidence-based behavioral therapies are ACT and Mindfulness.

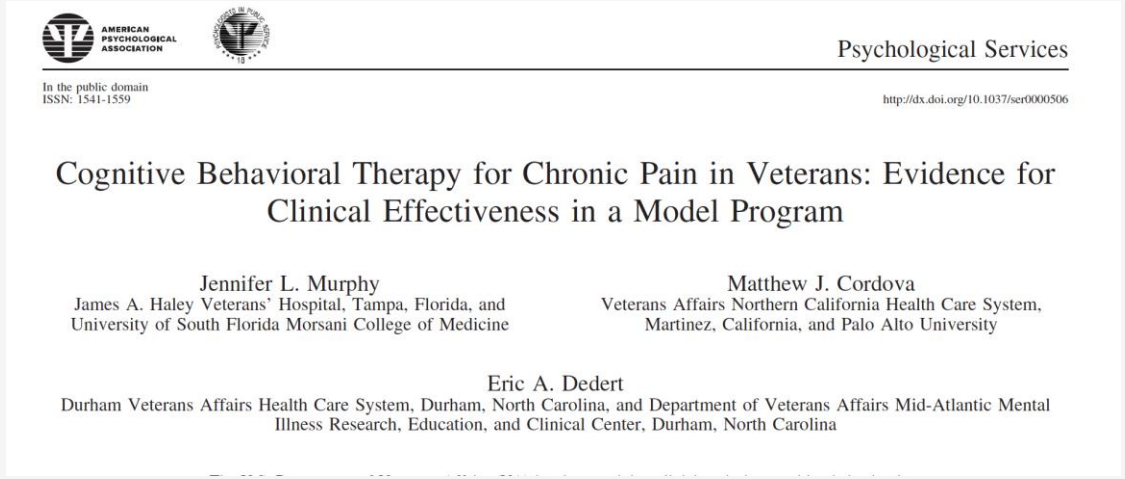


Kligler et al. J Gen Intern Med. 2018 May;33(Suppl 1):16-23

Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)

CBT-CP as First Line Treatment for Chronic Pain

- CBT-CP is recommended as first line treatment for chronic pain across guidelines:
  - VA/DoD Clinical Practice Guidelines for Low Back Pain
  - NIH Pain Consortium
  - CDC Guidelines



AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychological Services

In the public domain
ISSN: 1541-1559

http://dx.doi.org/10.1037/ser0000506

Cognitive Behavioral Therapy for Chronic Pain in Veterans: Evidence for Clinical Effectiveness in a Model Program

Jennifer L. Murphy
James A. Haley Veterans' Hospital, Tampa, Florida, and University of South Florida Morsani College of Medicine

Matthew J. Cordova
Veterans Affairs Northern California Health Care System, Martinez, California, and Palo Alto University

Eric A. Dedert
Durham Veterans Affairs Health Care System, Durham, North Carolina, and Department of Veterans Affairs Mid-Atlantic Mental Illness Research, Education, and Clinical Center, Durham, North Carolina

- CBT-CP is the **most empirically supported behavioral treatment** for pain
- CBT-CP empowers individuals to take control of their pain experience and includes:
  - **Relaxation techniques** to regulate physiology and calm the nervous system
  - **Behavioral activation and pacing** to safely move and engage in meaningful activities
  - **Cognitive tools** to manage pain-related expectations and thoughts
- A **brief CBT-CP protocol** is available for use within Primary Care and other settings.
- VA has trained over 900 clinicians in CBT-CP and offers it across the system

Murphy et al., Psychol Serv 2020;10:1037 https://pubmed.ncbi.nlm.nih.gov/32986454/; https://www.healthquality.va.gov/guidelines/Pain/lbp/; Dowell et al., MMWR Recomm Rep 2016;65 http://dx.doi.org/10.15585/mmwr.rr6501e1

Physical Therapy for Chronic Pain

- Physical Therapy may be indicated for some patients with chronic pain across guidelines:
  - VA/DoD Clinical Practice Guidelines for Low Back Pain
  - VA/DoD Clinical Practice Guidelines for the Non-Surgical Treatment of Osteoarthritis
  - CDC Guidelines

Childs *et al. BMC Health Services Research* (2015) 15:150
DOI 10.1186/s12913-015-0830-3

BMC Health Services Research

RESEARCH ARTICLE Open Access

Implications of early and guideline adherent physical therapy for low back pain on utilization and costs

John D Childs[1*], Julie M Fritz[2], Samuel S Wu[3], Timothy W Flynn[4], Robert S Wainner[4], Eric K Robertson[5], Forest S Kim[6] and Steven Z George[7]

- Physical Therapy encompasses several modalities including:
  - Exercise Therapy, which aims to restore muscular and skeletal function
  - Manual Physical Therapy, which includes soft tissue mobilization, joint manipulation, and joint mobilization
  - Education related to pain, lifestyle, and activity modifications

Childs et al., BMC Health Serv Res 2015;15:150 https://pubmed.ncbi.nlm.nih.gov/25880898/; https://www.healthquality.va.gov/guidelines/Pain/lbp/; https://www.healthquality.va.gov/guidelines/CD/OA/; Dowell et al., MMWR Recomm Rep 2016;65 http://dx.doi.org/10.15585/mmwr.rr6501e1

Complementary and Integrative Health (CIH) Pain Treatments in VHA

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

- Complementary and Integrative Health (CIH) includes "a group of diverse medical and health care approaches and practices that are not considered to be part of conventional or allopathic medicine."

- VHA Directive 1137: VA practitioners proactively offer and include, as appropriate (based on the individual clinical facts of each patient), any of the…approved CIH approaches." (see table)

- The Integrative Health Coordinating Center (IHCC) serves as an up-to-date resource for approved CIH services.

- **Chiropractic Care**
  - Approved as a covered benefit in VHA in 2004 and is part of VA whole health care.
- **Acupuncture**
- **Massage Therapy**
- **Meditation**
- **Yoga**
- **Clinical Hypnosis**
- **Biofeedback**
- **Guided Imagery**

https://vaww.infoshare.va.gov/sites/OPCC/SiteAssets/SitePages/IHCC-home/2017%20CIH%20Plan_CARA%20932.pdf

Whole Health and CIH in VHA

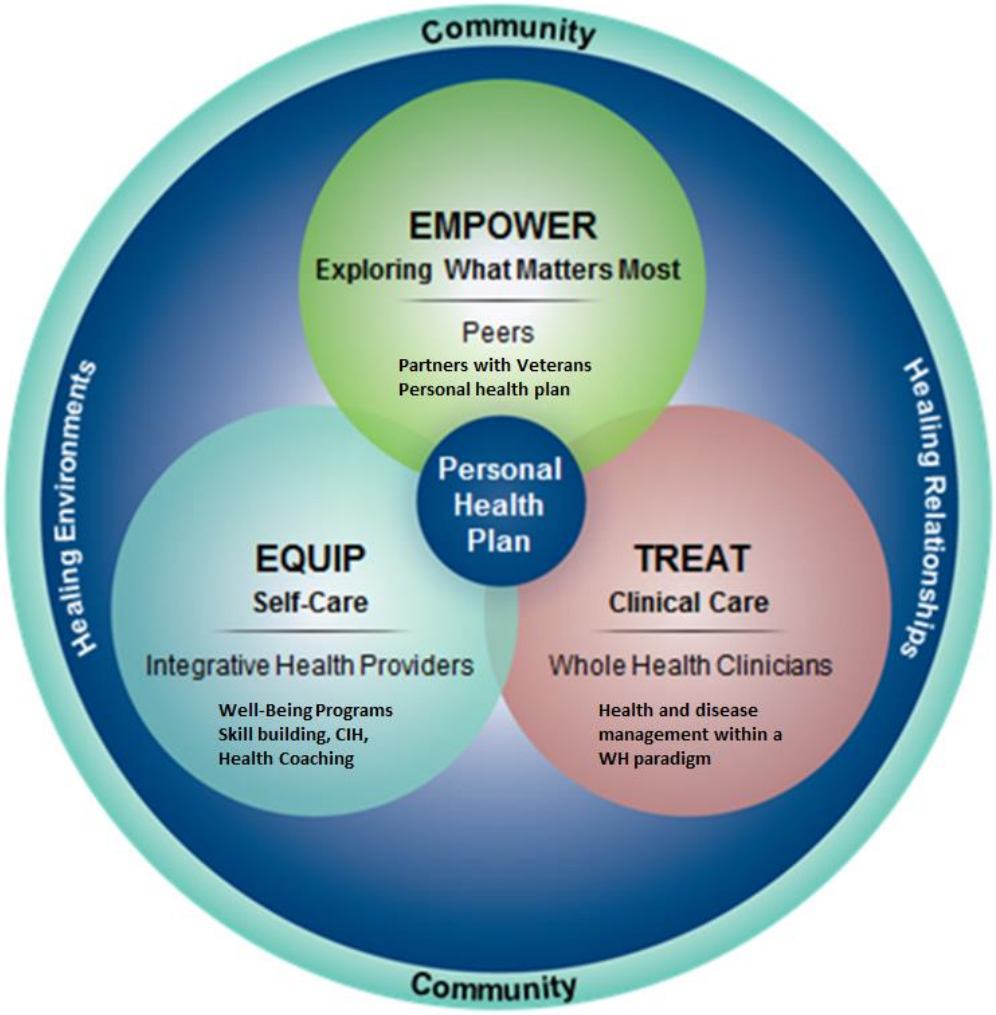
"Whole Health centers around what matters to you, not what is the matter with you."

Whole Health

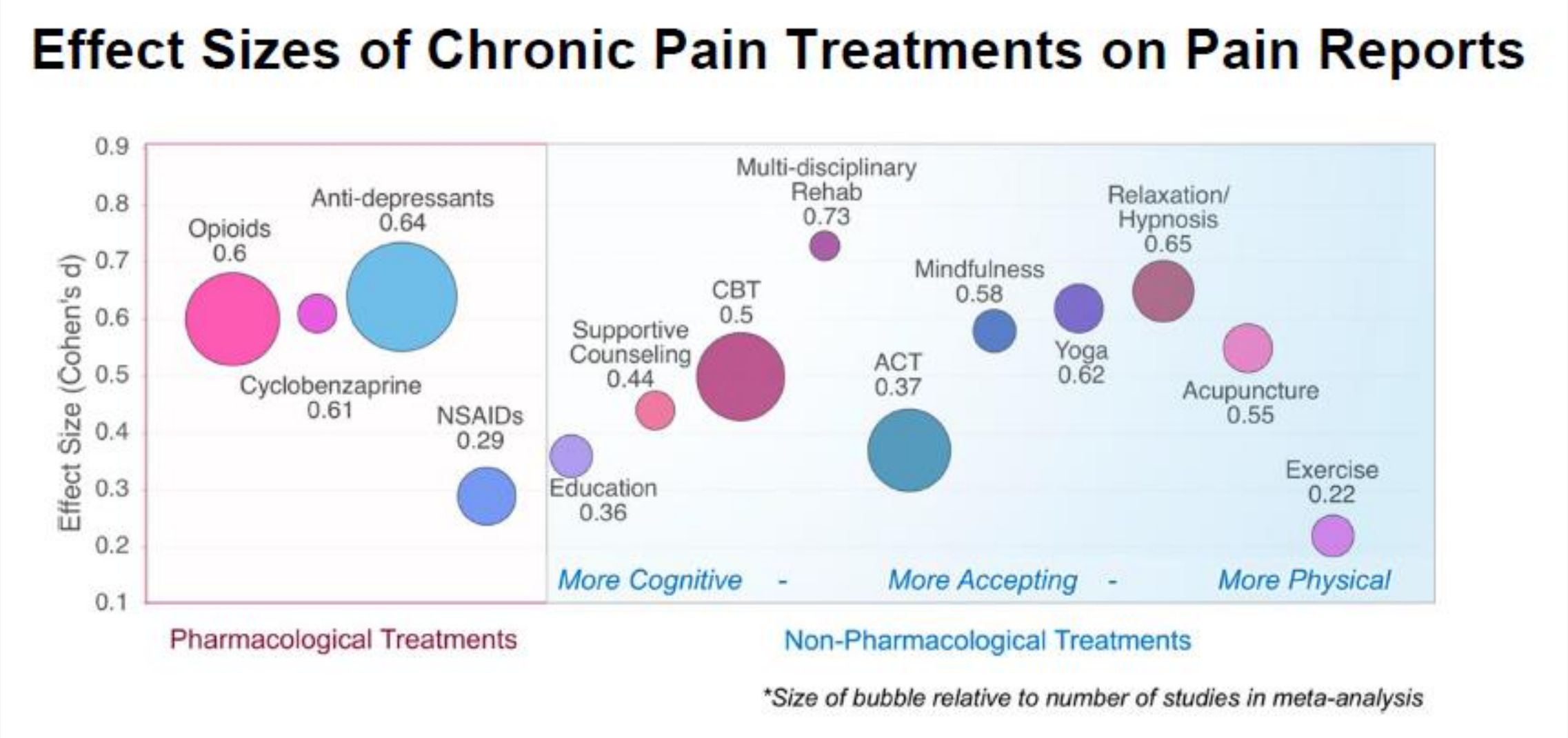
is an approach to health care
that empowers and equips people
to take charge of their health and well-being,
and live their life to the fullest.

The Whole Health approach is a reorientation of the Veteran's relationship with VA.

It combines conventional medicine with personalized health planning, CIH, and innovative self-care approaches.



Evidence: Relative Effectiveness of Chronic Pain Treatments



Reddan and Wager Neurosci Lett. 2018; 702:24-33 https://pubmed.ncbi.nlm.nih.gov/30503923/

Summary: Recommended Treatments for Pain

- **Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)** is the most empirically supported behavioral treatment and **recommended as a first line treatment for chronic pain**.
- **Physical Therapy may also be beneficial** for some Veterans with chronic pain.
- **Complementary and Integrative Health (CIH) treatments** are practices that are **not considered to be part of conventional or allopathic medicine**, some of which are currently recommended for chronic pain.
  - More up-to-date information can be found on the Integrative Health Coordinating Center (IHCC) website.
  - The Comprehensive Addiction and Recovery Act (CARA) of 2016 mandates the evaluation and appropriate expansion of CIH treatment modalities within VHA.
- The **Whole Health approach** combines conventional medicine with personalized health planning, CIH, and innovative, self-care approaches.

Knowledge Check: Recommended Treatments for Pain

Question: Where can VHA providers find the currently approved list of Complementary and Integrative Health (CIH) treatment modalities?

A) The Comprehensive Addiction and Recovery Act (CARA).
B) The VA/DoD Clinical Practice Guidelines (CPGs) for Opioid Therapy.
C) There is none, CIH treatment modalities are not currently approved for use within VHA.
D) The Integrative Health Coordinating Center (IHCC).

Knowledge Check: Recommended Treatments for Pain

Question: Where can VHA providers find the currently approved list of Complementary and Integrative Health (CIH) treatment modalities?

A) The Comprehensive Addiction and Recovery Act (CARA).
B) The VA/DoD Clinical Practice Guidelines (CPGs) for Opioid Therapy.
C) There is none, CIH treatment modalities are not currently approved for use within VHA.
D) The Integrative Health Coordinating Center (IHCC).

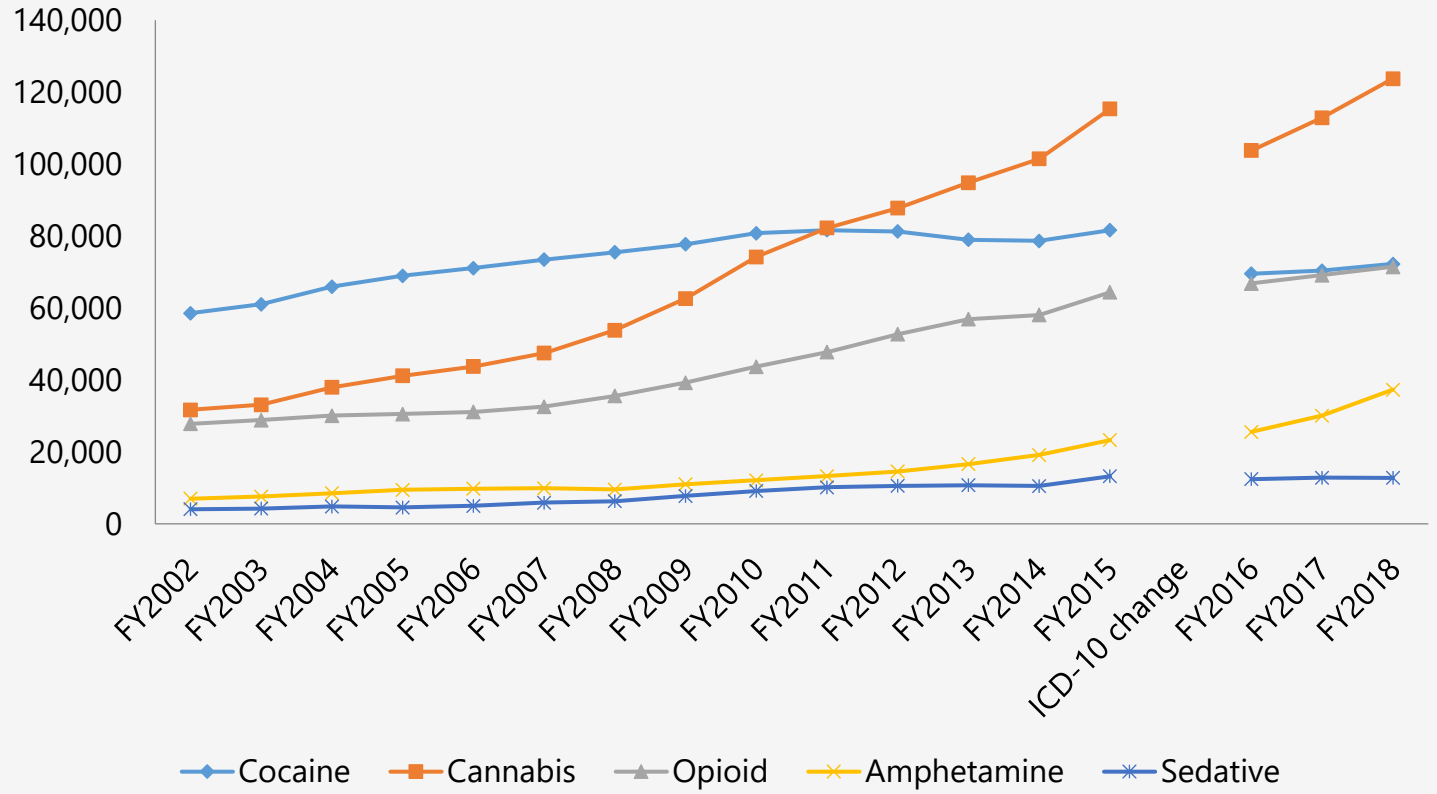
The correct answer is D) The Integrative Health Coordinating Center (IHCC).

6. Opioid Use Disorder (OUD) Treatment

Substance Use Disorder (SUD) in Veterans

	Veterans	Non-Veterans
Alcohol use disorder	6.3%	6.8%
Illicit drug use disorders	1.5%	1.7%
Illicit drug use	8.4%*	10.5%*
Non-medical use of pain relievers	2.4%*	3.0%*

- **Prevalence of SUD in VHA**
  - 10% of Veterans (600,000 in FY2015)
  - AUD >> other SUD
- **"Diagnosed" OUD**
  - 1.1% of Veterans, (71,000 in FY2018)
  - 24,696 Vets with OUD on (FY2018) m-OUD



NOTE: Beginning in FY2016, VHA shifted from ICD-9 to ICD-10 diagnosis coding. Data from FY2016 onward should *not be compared* directly with those obtained in prior years using ICD-9 coding.

Lipari and Hughes SAMHSA. Jan. 12, 2017 https://www.samhsa.gov/data/sites/default/files/report_2686/ShortReport-2686.html Volkow and McLellan, NEJM 2016;374:1253-62 https://pubmed.ncbi.nlm.nih.gov/27028915/

Opioid Use Disorder (OUD), Addiction, Misuse, and Dependence

Definitions

- **Dependence:** Occurs due to physiological adaptations to chronic exposure to a drug, manifesting in withdrawal symptoms when use of the medicine is suddenly reduced or stopped or when an antagonist to the drug is administered. Symptoms can be minor or severe and can usually be managed medically or avoided by using a slow drug taper.
- **Misuse:** Taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a medical complaint such as pain; misuse also includes non-medical use, such as taking a medication to feel euphoria (i.e., to get high), also termed **prescription drug abuse**,
- **Addiction:** A primary, chronic disease of brain reward, motivation, memory and related circuitry. Characterized by pathological pursuit of reward and/or relief by substance use and other behaviors. There is also an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.
- **Opioid Use Disorder (OUD) in DSM-5** indicates a problematic pattern of opioid use leading to clinically significant impairment or distress. It is very similar to **Opioid Dependence in ICD-10** for the same condition characterized by a cluster of cognitive, behavioral, and physiological features.

Lipari and Hughes SAMHSA. Jan. 12, 2017 https://www.samhsa.gov/data/sites/default/files/report_2686/ShortReport-2686.html Volkow and McLellan, NEJM 2016;374:1253-62 https://pubmed.ncbi.nlm.nih.gov/27028915/

DSM-5 Opioid Use Disorder (OUD) 2-3 symptoms = mild; 4-5 = moderate; ≥6 = severe	ICD-10 Opioid Dependence 3 or more criteria	Example signs and symptoms
1. Craving or strong desire to use opioids	**A.** A strong desire to take the drug	Constantly thinking about the next dose
2. Using larger amounts of opioid over a longer period than initially intended	**B.** Difficulties in Controlling Opioid Use	Repeatedly driving when impaired Requests for early refills, multiple providers Unable to cut down use
3. Persisting desire or unable to cut down on or control use		
4. Recurrent use in situations that are physically hazardous		
5. Continued use despite physical or psychological problems related to opioids	**C.** Persisting in opioid use despite harmful consequences	Driving to different doctor's offices to obtain opioids Requesting opioids after overdose, bowel obstruction
6. Continued use despite persistent social or interpersonal problems related to opioids		
7. Spending a lot of time to obtain, use, or recover from opioids	**D.** Higher priority given to opioid use than to other activities and obligations	Spending a lot of time frequenting EDs or clinics with a goal of obtaining opioids Continued use despite poor work performance or family requests to quit Neglecting tasks- cleaning, gardening No longer playing softball, bridge
8. Failure to fulfill obligations at work, school or home due to use		
9. Activities are given up or reduced because of use		
10. Withdrawal – upon reduction or cessation of opioids**	**E.** A physiologic withdrawal state	*excluded by DSM-5 when opioids are taken under medical supervision
11. Tolerance – requiring 50% more to achieve effect**	**F.** Tolerance	*excluded by DSM-5 when opioids are taken under medical supervision

ED = emergency department. *The criteria in the Table should be present at the same time within the prior 12 months in order to make a diagnosis. ** Tolerance and withdrawal do not count for the DSM-5 diagnosis if taken as prescribed under medical supervision. Example: Veterans who have been taking opioids to manage pain will develop tolerance and withdrawal but may not meet DSM-5 criteria for OUD.

Opioid Use Disorder (OUD)

- In 2019, **about 1.6 million adults in the US had an opioid use disorder (OUD)** *(SAMHSA, 2019)*.
- Iatrogenic **prevalence estimates for OUD in patients on prescription opioids** vary greatly – **anywhere from less than 1% to 26%** although rates of carefully diagnosed iatrogenic addiction have averaged less than 8% *(Volkow and McLellan, 2016)*.


REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies

Nora D. Volkow, M.D., and A. Thomas McLellan, Ph.D.

  - In a recent study from the Journal of Pain Research 26.5% of patients on opioid medication for non-cancer pain met DSM-5 criteria for OUD while 9% met criteria for moderate or severe OUD *(Boscarino et al., 2020)*. This is consistent with other studies that have reported the range of opioid addiction to be about 10 to 12% in this population *(Vowles et al., 2015)*.

SAMHSA, 2019 https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases; Volkow and McLellan, NEJM 2016;374:1253-62 https://pubmed.ncbi.nlm.nih.gov/27028915/; Boscarino et al., J Pain Res 2020;13:2697-2705 https://pubmed.ncbi.nlm.nih.gov/33122939/; Vowles et al., Pain 2015; 156(4):569–576 https://pubmed.ncbi.nlm.nih.gov/25785523/

VHA Stepped Care for OUD

Pain Management Teams must include providers with addiction expertise to allow for integrated access to OUD evaluation and treatment.

- **Medication for Opioid Use Disorder (m-OUD)**
  - Buprenorphine/naloxone
  - Methadone
  - Naltrexone (including injection)

- **Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative**
  - Created to facilitate access to m-OUD in VHA

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

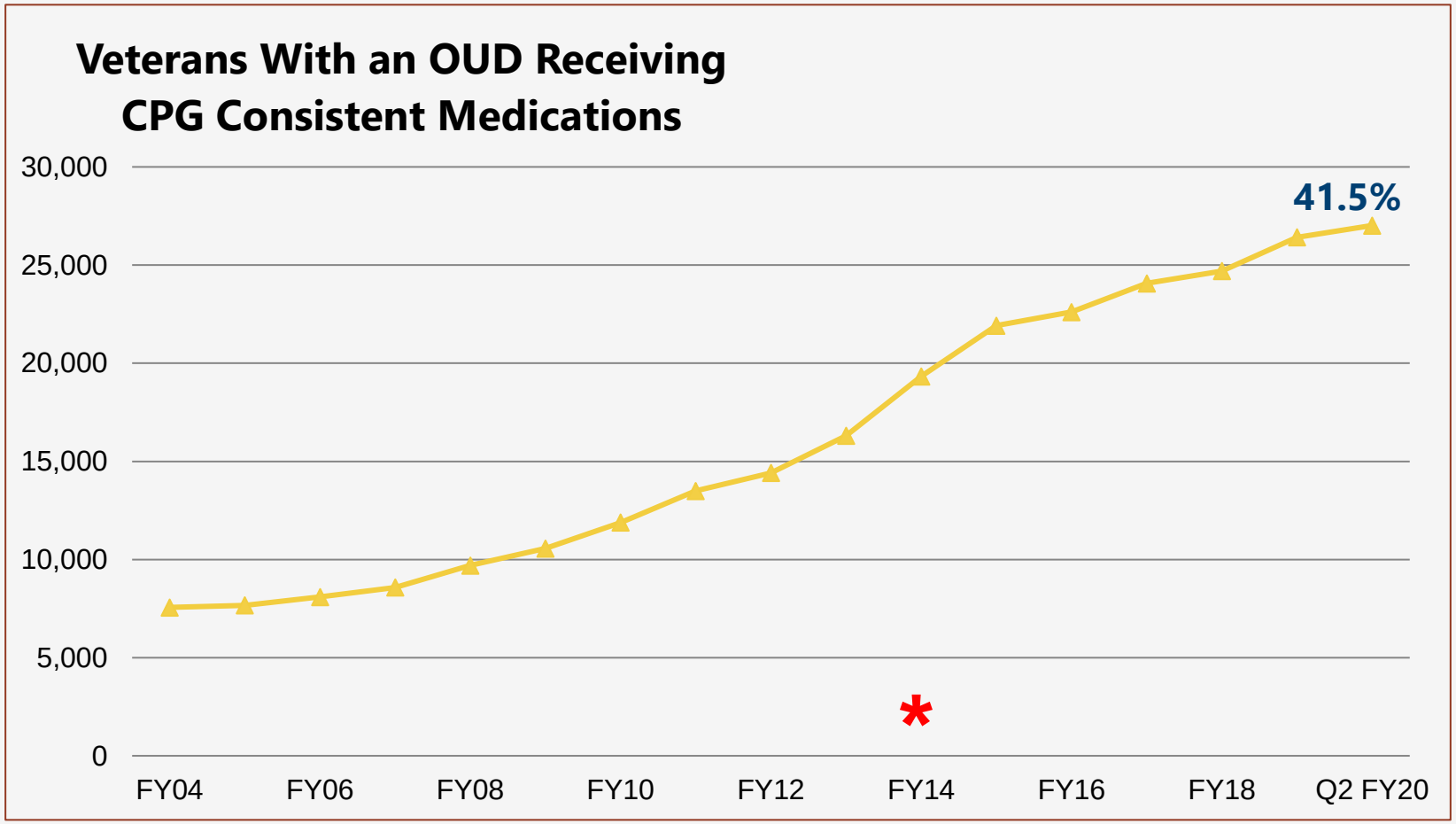
Goals and Outcomes

- **Improve** patient survival.
- **Increase** retention in treatment.
- **Increase** patients' ability to gain and maintain employment.
- **Improve** birth outcomes among women who have substance use disorders and are pregnant.
- **Decrease** illicit opiate use and other criminal activity among people with substance use disorders.
- **Contribute to lowering** a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse.

SAMHSA 2020, https://www.samhsa.gov/medication-assisted-treatment

Medication for Opioid Use Disorder (m-OUD) For Veterans Treated in VHA with an OUD

- M-OUD included methadone, buprenorphine, or injectable naltrexone.
- During FY 2019, among Veterans with an OUD diagnosis 87% were seen in outpatient mental health clinics and 55% were seen in SUD Specialty Care.
- Most of this medication was provided in SUD specialty care settings.



***Starting in FY14, Extended-Release (injectable) Naltrexone was counted as a medication for OUD.**

https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3806-notes.pdf

Patients with OUD and Pain

AVOID:

Medications with Addiction Potential:

- Opioid analgesics.
- Sedative-hypnotics.
- Muscle relaxants.

RECOMMENDED:

Nonpharmacological Therapies for Pain Care:

- As described in the previous section.

Non-Opioid Medications:

- Serotonin and Norepinephrine Reuptake Inhibitor (SNRI) or low dose Tricyclic Antidepressant (TCA)
- Gabapentin/Pregabalin
- Acetaminophen, NSAIDs
- Topicals (e.g., Lidocaine, Capsaicin)

Assessment for and treatment of co-morbid psychiatric conditions (e.g., PTSD, insomnia, anxiety).

Medications for Opioid Use Disorder (m-OUD):

- Buprenorphine/naloxone
- Methadone
- Naltrexone (including injection)

Lipari and Hughes SAMHSA. Jan. 12, 2017 https://www.samhsa.gov/data/sites/default/files/report_2686/ShortReport-2686.html Volkow and McLellan, NEJM 2016;374:1253-62 https://pubmed.ncbi.nlm.nih.gov/27028915/

Summary: Opioid Use Disorder (OUD) Treatment

- **Opioid Use Disorder (OUD)** is defined by the Diagnostic and Statistical Manual-V (DSM-5) as a problematic pattern of opioid use leading to clinically significant impairment or distress, **characterized by two or more symptoms**.
- **Pain Management Teams must include providers with addiction expertise** to allow for integrated access to OUD evaluation and treatment.
- **Medication for Opioid Use Disorder (m-OUD)** includes Buprenorphine/Naloxone, Methadone, and Naltrexone (including injection).
- **Medications with addiction potential** (including opioid analgesics, sedative-hypnotics, and muscle relaxants) **are contra-indicated for individuals with OUD.**
- **Non-pharmacological therapies** such as CBT, rehabilitation therapies, CIH and **non-addictive medications** (e.g., Acetaminophen) **are recommended for OUD**.

Knowledge Check: Opioid Use Disorder (OUD) Treatment

Question: Which of the following is NOT a recommended pain treatment in patients with Opioid Use Disorder (OUD)?

A) Muscle Relaxants.
B) Serotonin and Norepinephrine Reuptake Inhibitors (SNRI).
C) Cognitive Behavioral Therapy (CBT).
D) Acupuncture.

Knowledge Check: Opioid Use Disorder (OUD) Treatment

Question: Which of the following is NOT a recommended pain treatment in patients with Opioid Use Disorder (OUD)?

A) Muscle Relaxants.

B) Serotonin and Norepinephrine Reuptake Inhibitors (SNRI).

C) Cognitive Behavioral Therapy (CBT).

D) Acupuncture.

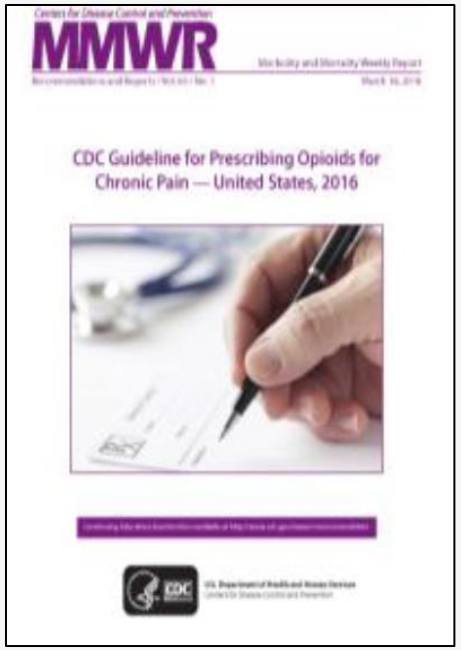
The correct answer is A) Muscle Relaxants. Muscle Relaxants have addiction potential and therefore are contra-indicated for individuals with OUD.

7. Opioid Dose Reduction and Tapering

CDC Guideline – Follow-up 2019

No Shortcuts to Safer Opioid Prescribing

"Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations… inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in **sudden opioid discontinuation or dismissal of patients** from a physician's practice…Such actions are **likely to result in harm to patients**."

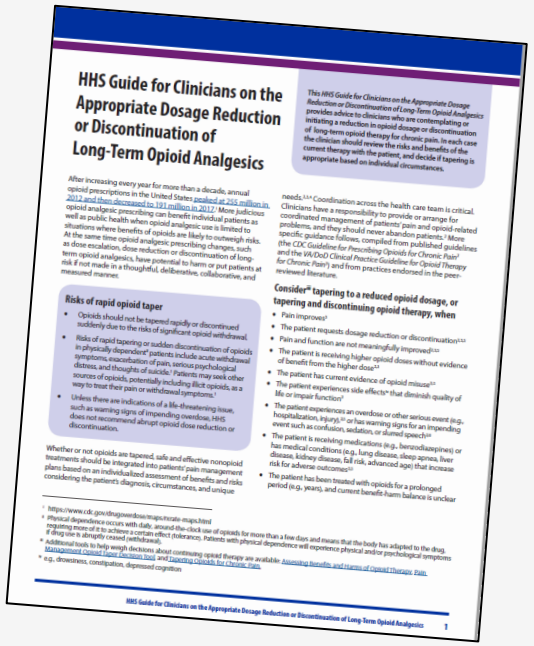


Dowell D, Haegerich T and Chou R., NEJM April 24, 2019 https://www.nejm.org/doi/full/10.1056/NEJMp1904190

Approaching Opioid Tapering

Integrated Approach With Patient Buy-In and Active Participation

- When tapering is clinically indicated due to risks outweighing benefits, providers should **seek patients' active buy-in** by providing **education** and by **using motivational interviewing**.
- **Assess and address patient needs/concerns incl. psychological factors**.
- Goal is to **improve function** and long-term outcomes while reducing risk.
- Slower, **more gradual tapers** (e.g., ≤ 10% per month) are often better tolerated than more rapid tapers, with pauses as clinically required.
- **Sudden interruption** of opioid prescribing (rapid tapers or discontinuations) **should be avoided,** with few safety exceptions.


HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

HHS Tapering Guide (2019)

"Care must be a patient-centered experience. We need to treat people with compassion, and emphasize personalized care tailored to the specific circumstances and unique needs of each patient" *Adm. Brett P. Giroir, M.D., Assistant Secretary for Health*

https://www.hhs.gov/about/news/2019/10/10/hhs-announces-guide-appropriate-tapering-or-discontinuation-long-term-opioid-use.html

Approaching Opioid Tapering (continued)

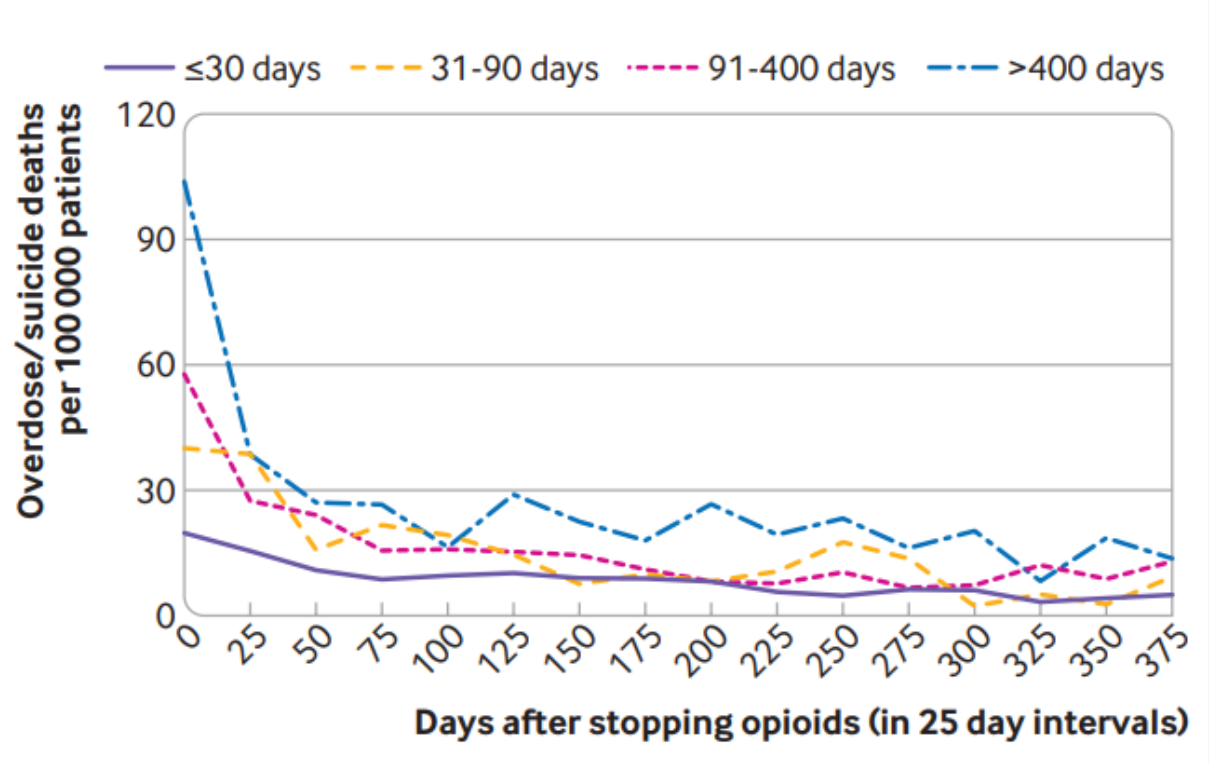
Provider Approach

- **Complete a biopsychosocial evaluation of the patient prior to initiating a taper**, weighing the risks and benefits of opioid dose reduction**.**
- **Utilize a slower taper** with the aim of improving function and minimizing risk. Sudden tapers should be avoided unless necessary. Allow for pauses if clinically indicated.
- Discuss options and **collaborate with the patient about their preferences** (e.g., reduction of short vs long-acting medication, timing of reductions).
- Be cognizant of patient concerns regarding opioid dose reduction.
- **Set** clear and reasonable/**achievable expectations**.
- **Collaborate** closely **with MH providers** and integrated access to OUD treatment.
- **Watch for signs of OUD** during opioid dosage reduction.

Opioid Discontinuation and Overdose/Suicide Deaths in Veterans

VHA Study: Opioid Discontinuation Linked to Overdose/Suicide Risk for Several Months

- Patients were at greater risk of death from overdose or suicide after opioid treatment stopped.
- **Risk was greatest in the first 25 days after opioid treatment ended, with elevated risk for about 3 months.**
- **Initiating opioid therapy** also increased risk.
- **Close follow-up with the patient during these time periods** is recommended.
- The associations observed cannot be assumed to be causal; the context in which opioid prescriptions were started and stopped might contribute to risk.
- Of opioid-related overdoses, 20-30% are estimated to be intentional/suicidal.



Risk was correlated with duration of opioid therapy prior to discontinuation: the longer patients had been treated before stopping, the greater the risk.

Oliva et al., BMJ 2020 Mar;368:m283 https://pubmed.ncbi.nlm.nih.gov/32131996/; Oliva et al. Psychol Serv. 2017;14:34-49 https://pubmed.ncbi.nlm.nih.gov/28134555/

Approaching Opioid Tapering (continued)

Patients are often at high risk for overdose after tapering.

- Protracted withdrawal and lowered tolerance increase risk of OD after opioid discontinuation.
- **Follow up within one to four weeks** after dosage adjustments and continue follow-up after discontinuation.
- The VHA PBM Academic Detailing Service provides a helpful Opioid Taper Decision Tool to aid in this process.

Exercise Caution: Involuntary tapers carry greater risk and interfere with the provider/patient relationship.

Example Tapers for Opioids[5-9]

Slowest Taper (over years)	Slower Taper (over months or years)	Faster Taper (over weeks)****	Rapid Taper (over days)****
Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed *Consider for patients taking high doses of long-acting opioids for many years*	Reduce by 5 to 20% every 4 weeks with pauses in taper as needed **MOST COMMON TAPER**	Reduce by 10 to 20% every week	Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction]* **Month 2:** 75 mg SR qam, 75 mg noon, 90 mg qpm **Month 3:** 75 mg SR (60 mg+15 mg) Q8h **Month 4:** 75 mg SR qam, 60 mg noon, 75 mg qpm **Month 5:** 60 mg SR qam, 60 mg noon, 75 mg qpm **Month 6:** 60 mg SR Q8h **Month 7:** 60 mg SR qam, 45 mg noon, 60 mg qpm **Month 8:** 45 mg SR qam, 45 mg noon, 60 mg qpm **Month 9:** 45 mg SR Q8h**	Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 75 mg (60 mg+15 mg)SR Q8h [16% reduction] **Month 2:** 60 mg SR Q8h **Month 3:** 45 mg SR Q8h **Month 4:** 30 mg SR Q8h **Month 5:** 15 mg SR Q8h **Month 6:** 15 mg SR Q12h **Month 7:** 15mg SR QHS, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Week 1:** 75 mg SR Q8h [16% reduction] **Week 2:** 60 mg SR (15 mg x 4) Q8h **Week 3:** 45 mg SR (15 mg x 3) Q8h **Week 4:** 30 mg SR (15 mg x 2) Q8h **Week 5:** 15 mg SR Q8h **Week 6:** 15 mg SR Q12h **Week 7:** 15 mg SR QHS x 7 days, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Day 1:** 60 mg SR (15 mg x 4) Q8h [33% reduction] **Day 2:** 45 mg SR (15 mg x 3) Q8h **Day 3:** 30 mg SR (15 mg x 2) Q8h **Day 4:** 15 mg SR Q8h **Days 5-7:** 15 mg SR Q12h **Days 8-11:** 15 mg SR QHS, then stop***

Medication Disposal

- **Medication Disposal Envelopes**
  - Mailable free of charge.
  - Can also be dropped off in receptacles present in more than 100 VA facilities or community sites.
- **Medication Take-Back Events**
  - See takebackday.dea.gov for more information.

Figure 9. Common options to safely dispose of medications

If none of these options are available, the FDA recommends flushing opioid medications down the toilet.[49]

*Controlled and non-controlled medications may be co-mingled in the envelope; however, illicit drugs may not be placed in the envelope. The filled envelopes are sent to a facility where they are destroyed in an environmentally responsible manner.

Summary: Opioid Dose Reduction and Tapering

- When tapering is clinically indicated due to risks outweighing benefits, providers should **seek patients' active buy-in** by providing **education** and by **using motivational interviewing**.
- Providers should complete a **biopsychosocial evaluation** of patients **prior to initiating a taper**.
- **Utilize a slower taper** with the aim of improving function and minimizing risk. Sudden tapers should be avoided.
- Providers should **watch for signs of OUD** while tapering and have access to m-OUD.
- Providers should **follow up with patients one to four weeks after adjustments and discontinuation due to elevated risk of overdose.**
- The Opioid Taper Decision Tool can aid in decision-making.
- Free **Medication Disposal Envelopes** and Take-Back events can help in reducing risk of misuse and overdose.

Knowledge Check: Opioid Dose Reduction and Tapering

Question: True or False?

It is typically best to taper patients off opioids without a discussion in order to prevent any unwanted confrontation.

Knowledge Check: Opioid Dose Reduction and Tapering

Question: True or False?

It is typically best to taper patients off opioids without a discussion in order to prevent any unwanted confrontation.

False. *Providers should encourage patients' active buy-in by providing education and using motivational interview skills, when tapering is clinically indicated due to risks outweighing benefit. Sudden discontinuations or rapid tapers carry greater risk and may interfere with the patient-provider relationship and should be avoided unless necessary. When involuntary tapers are necessary, any dose-reduction decisions should be discussed with the patient in order to increase patient awareness. If there is concern for OUD, provide access to evidence-baed treatment with M-OUD.*

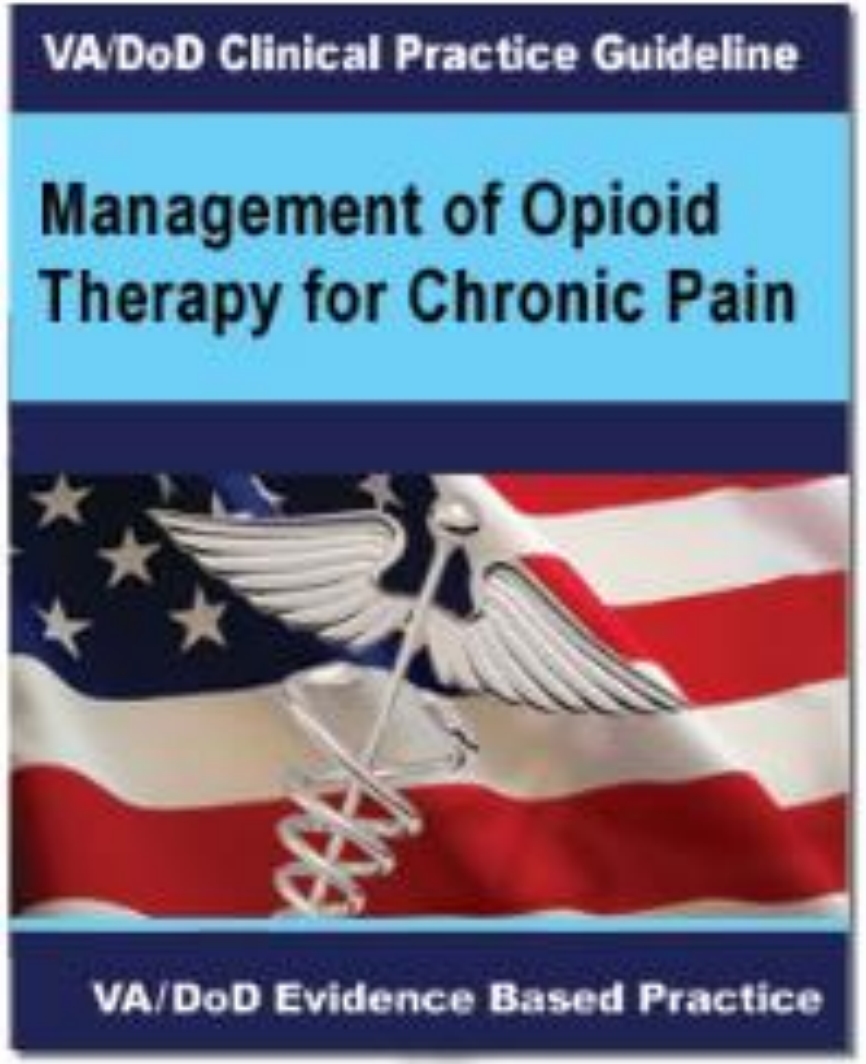
Additional Resources

VA Pain Management and Clinical Resources

- **VA Pain Management:** http://www.va.gov/painmanagement
- **VA/DoD Joint Pain Education Program:** https://www.dvcipm.org/clinical-resources/joint-pain-education-project-jpep/
- **VA Whole Health:** https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Index.aspx
- **Integrative Health Coordinating Center:** https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC
- **Telehealth Resources:** https://vaww.telehealth.va.gov/
- **VA Mobile Applications:** https://www.mobile.va.gov/appstore

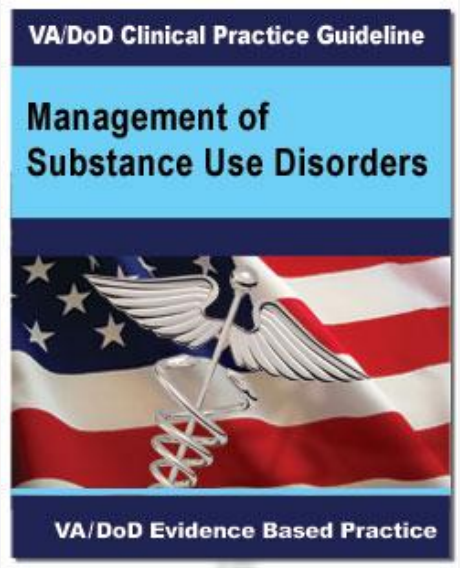
VA/DoD Opioid Therapy CPG

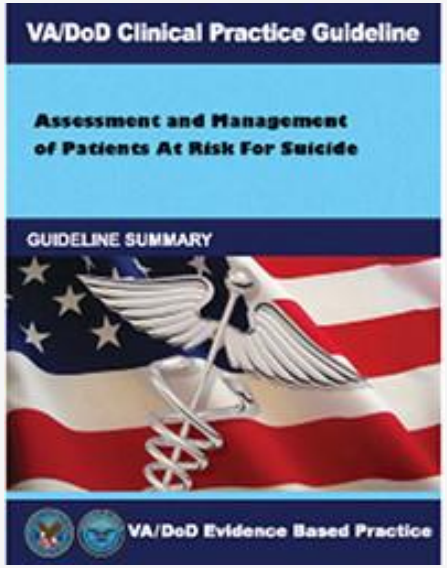
The VA/DoD Clinical Practice Guidelines for the Management of Opioid Therapy for Chronic Pain should be adhered to when treating chronic pain along with any relevant state and federal requirements and the practice of appropriate clinical judgment.

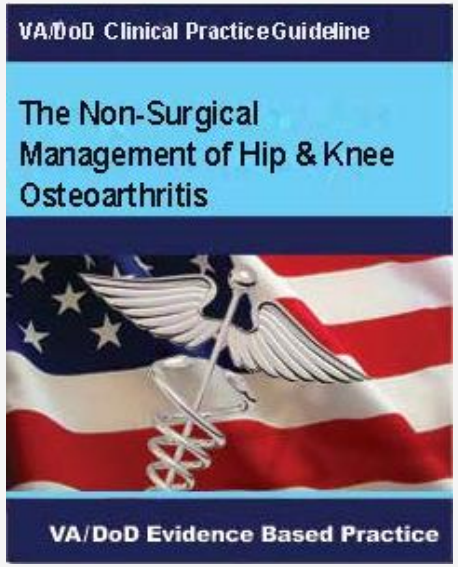


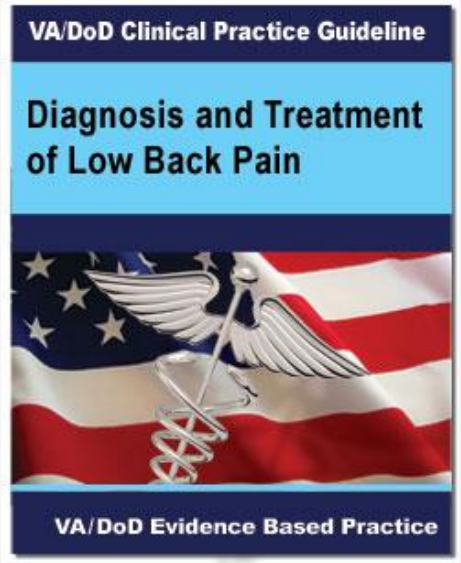
https://www.healthquality.va.gov/guidelines/Pain/cot/

Additional VA/DoD CPGs Involving Opioid Therapy









https://www.healthquality.va.gov/

Consultation and Support Resources

National SUD Program in collaboration with the National TeleMental Health Center has augmented the existing SUD TeleMental Health “Ask the Expert” program with additional subject matter experts to answer questions from the field.

Questions can be submitted to:
AskTheExpert-SubstanceUseDisorder@va.gov

Please do not include patient specific Protected Health Information (PHI)

VA SUD/OUD Resources

- **VA-DoD Clinical Practice Guidelines for the Management of SUD:** https://www.healthquality.va.gov/guidelines/MH/sud/
- **SUD SharePoint:** https://vaww.portal.va.gov/sites/OMHS/SUD/default.aspx
- **Telehealth m-OUD Toolkit:** https://vaww.portal.va.gov/sites/OMHS/SUD/SUDfiles/Telehealth/TeleMOUD Toolkit_with Covid19 Updates.pdf
- **Academic Detailing Resources for OUD:** https://vaww.portal2.va.gov/sites/ad/SitePages/OUD.aspx
- **Academic Detailing Resources for OEND:** https://vaww.portal2.va.gov/sites/ad/SitePages/OEND.aspx
- **Academic Detailing Resources for Alcohol Use Disorder:** https://vaww.portal2.va.gov/sites/ad/SitePages/AUD.aspx
- **Buprenorphine Home Initiation:** https://vaww.portal.va.gov/sites/OMHS/SUD/SCOUTT/_layouts/15/start.aspx#/Resources/Forms/AllItems.aspx?RootFolder=%2fSsites%2fOMHS%2fSUD%2fSCOUTT%2fResources%2fHome%20Induction&Folder

Non-VA Resources

- **National Institute on Drug Abuse:** https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis
- **SAMHSA: Guidance for Opioid Treatment Programs:** https://www.samhsa.gov/medication-assisted-treatment
- **Harm Reduction Related Guidance:** https://harmreduction.org/issues/
- **American Society of Addiction Medicine Clinical Practice Guideline on Alcohol Withdrawal Management:** https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management

National Initiatives: Legislation/Federal Guidance

- **Presidential Memorandum: Addressing Prescription Drug Abuse and Heroin Use (Oct. 2015)**
  - Training of all federal prescribers; access to addiction treatment including m-OUD for patients with OUD.
- **Comprehensive Addiction and Recovery Act (CARA) (July 2016)**
  - Title IX: Jason Simcakoski Memorial Act with specific VHA mandates, including Pain Teams, CIH.
  - Pain Management Best Practices Taskforce (HHS).
- **Nationwide Public Health Emergency to Address Opioid Crisis (Oct. 2017)**
- **Presidential Opioid Commission Report (November 2017)**
- **Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) (June 2018)**
  - Community Care Program. CC provider training on VA Opioid Safety Initiative, provider monitoring, data exchange, PDMP integration.
- **Presidential Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand (Oct 2018)**
  1. Reduce demand through education, awareness, and prevent over-prescription.
  2. Cut-off flow of illicit drugs.
  3. Save lives by expanding proven addiction treatments.
- **Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Oct. 2018), H.R.6.**
  - Provisions for Medicare/Medicaid, HHS, FDA, DEA (telemedicine).
  - VA: Veterans Treatment Court Improvement Act, peer counseling.

National Initiatives: Clinical Initiatives

- **CDC Opioid Prescribing Guidelines (March 2016)**
- **National Pain Strategy (April 2016)**
  - Created by the Interagency Pain Research Coordinating Committee (IPRCC) based on the findings and recommendations of a study conducted by the Institute of Medicine regarding pain as a public health problem in the United States.
- **Pain Management Best Practices Inter-Agency Task Force Report (May 2019)**
  - Joint report by HHS, DoD, and VA.
- **HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (Oct. 2019)**
- **AHRQ Systematic Review Update: Noninvasive Nonpharmacological Treatment for Chronic Pain (Apr. 2020)**
- **NAM Best Practices, Research Gaps, and Future Priorities to Support Tapering Patients on Long-Term Opioid Therapy for Chronic Non-Cancer Pain in Outpatient Settings (Aug. 2020)**

VA OEND Technical Assistance

VA Academic Detailing Service OEND SharePoint (Key resources, including reports to identify at-risk patients and patient and provider materials that can be ordered from VA National Repository)

- Patient education brochures, DVDs for providers and patients—order through depot

VA National OEND SharePoint (resources to support new OEND programs; monthly call links)

VA OEND Videos

- Intro for People with Opioid Use Disorders https://youtu.be/-qYXZDzo3cA
- Intro for People Taking Prescribed Opioids https://youtu.be/NFzhz-PCzPc
- How to Use the VA Naloxone Nasal Spray https://youtu.be/0w-us7fQE3s
- How to Use the VA Intramuscular Naloxone Kit: https://www.youtube.com/watch?v=Ig1LEw-PeTE

Opioid Safety Initiative (OSI) & **Psychotropic Drug Safety Initiative (PDSI)**

Panel Management Tools

- OEND Patient Risk Dashboard; Stratification Tool for Opioid Risk Mitigation; Opioid Therapy Risk Reduction Report

TMS trainings:

- Accredited, hour-long OEND training: 27440 and 27441
- Short, "How to Use Naloxone Nasal Spray (Narcan®)" training to support VHA Rapid Naloxone Initiative: 37795

End of Teaching Material

Thank you for taking the time to learn more about pain management and opioid safety!

For questions, please contact the Pain Management, Opioid Safety, and PDMP (PMOP) program office at VHA11SPEC20Action@va.gov.