Veteran’s Health Administration
OPIOID SAFETY INITIATIVE

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History of Treating Chronic Pain

March 1967

April 9, 2001

March 7, 2011

Pain as 5th Vital Sign

• 1992—American Pain Society
• 1996—VA named pain the 5th Vital Sign
• 1998—VHA Pain Management Strategy—Ken Kiser
  • Elements of Pain Management Strategy
    • Pain Assessment and Treatment
    • Evaluation of Outcomes and Quality of Pain Management
    • Clinician Competence and Expertise in Pain Management
    • Research
    • Coordination of National VHA Pain Management Strategy
• 2000—Institute on Healthcare Improvement
• 2000—Joint Commission on Accreditation of Healthcare Organizations (JCAHO) pain management standards
What we were taught?

- Pain was not being assessed often enough or well enough
- Opioids should be given more often at higher doses
- Opioids worked for all pain
- Opioids were safe to be routinely used
- There were no long-term side effects from opioids
- There was no dosage ceiling
- If you didn’t want to use high doses you were an opioidphobe and a bad clinician

Opioids in the News

- “Over the last decade, the number of prescriptions for the strongest opiates has increased nearly fourfold, with only limited evidence of their long-term effectiveness or risks, federal data shows.” (Meier, B. Tightening the Lid on Pain prescriptions; 04/08/2012. New York Times)
- The USA represents 4% of the world population. Yet prescribes 80% of the world’s opioids.

- Unintentional overdose deaths parallel per capita sales of opioid analgesics and are now the leading cause of injury deaths among 25-65 years old in the United States.

Drug Overdose in the United States, 2013
Seal, 2013
More than one hundred people die from drug overdoses every day in the United States. Most deaths are caused by prescription medications.

Unintentional Overdose Deaths in the U.S.1,2

Risk of Death by Prescription Opioid Overdose for Chronic Non-Cancer Pain3

Data shows an unintentional opioid overdose death (n = 750) in a national sample of Veterans Health Administration patients (n = 156,680) from 2004-2006. The risk of opioid overdose increased when opioid dose was equivalent to 50 mg/day of morphine. Mortality risk related to opioid doses at or above 100 mg/day morphine base equivalent increased seven-fold.

For every 1 death there are:
10 treatment admissions for abuse6
32 emergency dept visits for misuse or abuse2
130 people who abuse or are dependent1
825 nonmedical users5
2 million new nonmedical users in 2011

Policy Impact - Prescription Painkiller Overdoses - CDC 2011
The Concern/ Patient Safety……. Why?

* In 2010, there were 38,329 drug overdose deaths in the United States
* Of those 22,134 or 57.7% of the total involved pharmaceuticals
* 16,451 or 74.3% of these were unintentional deaths
* Top 3 common pharmaceutical deaths alone or in combination w/other drugs included
  * 16,651 (75.2%) were opioid related overdose deaths
  * 6497 (29.4%) benzodiazepines related deaths
  * 3889 (17.6%) antidepressants related deaths


U.S Veterans returning from Iraq and Afghanistan who have chronic non-cancer pain and PTSD are at a high risk of adverse outcomes with opioid therapy.

Although taking opioids significantly increased risk for adverse outcomes in any veteran, those with PTSD had more:

> Opioid related accidents and overdoses,
> Alcohol and non-opioid drug related accidents and overdoses,
> Self-inflicted injuries (i.e gunshot wounds),
> Violence-related injuries.

No Change in Chronic Low Back Pain
73 mg Morphine versus Placebo

<table>
<thead>
<tr>
<th>Study, Year (Reference)</th>
<th>(95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kurtz and Brossel, 1996 (40)</td>
<td>-0.04 (-0.96 to 0.87)</td>
</tr>
<tr>
<td>Richards et al., 2002 (21)</td>
<td>-0.31 (-0.68 to 0.08)</td>
</tr>
<tr>
<td>Jamison et al., 1998 (44)</td>
<td>-0.02 (-0.82 to 0.78)</td>
</tr>
<tr>
<td>Hale et al., 2005 (41)</td>
<td>-0.4 (-0.74 to -0.07)</td>
</tr>
<tr>
<td>Pooled</td>
<td>-0.19 (-0.49 to 0.11)</td>
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</tbody>
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Martell... Kerns...; Ann Int Med; 2007

Disability Associated with More Opioids

Presented by Michael Von Korff; Summit for Opioid Safety, 2012

VA and the Opioid Safety Initiative
Institute of Medicine

- Create a comprehensive population-level strategy for pain prevention, treatment, management, and research.

IOM, 2011

Review of Pain Assessment, Documentation, Therapy

- Documentation lacking
- Patient follow-up sometimes inadequate
- Many patients prescribed opioids as first line therapy, no other therapy offered
- Large variation in prescribing
- Many patients on high-dose opioids without gaining benefit
- Need for education in chronic pain management identified by primary care

Opioid Safety Initiative
Patient-Centric Goals

- Provide high quality patient care using evidence based knowledge.
- Document safety assessment for patients on concomitant use of opioids and benzodiazepines.
- Reduce volume of prescribed opioids and concomitant use to a safer level based on individual assessments.
- Reduce the percent of patients on opioids and concomitant benzodiazepines and opioids.
- Provide patient and provider education about the VHA OSI.
Goals of the OSI

1. Educate Providers about effective use of urine drug screens
2. Increase the use of urine drug screening
3. Facilitate use of states prescription drug monitoring databases
4. Establish safe and effective VISN tapering programs for patients using combination benzos and opioids

Goals of OSI (cont)

5. Develop tools to identify higher risk patients
6. Improve prescribing practices around long-acting opioids formulations
7. Review treatment plans for patients on high doses of opioids
8. Offer CAM modalities at all facilities
9. Develop new models of mental health and primary care collaboration to manage prescribing of opioid and benzos

Develop System-Wide Approach to Pain Management

• Clinical Practice Guideline for Chronic Opioid Therapy
• Pocket guide
• Computer App
• Wide dissemination
• National movement to engage every facility
• Computer available pain management information for patients
• Staff Education—national, regional, local
• Developed dashboard to identify prescribing practices
• Informed consent for chronic opioid therapy
Dashboard

- Data from computerized record
- Pain assessment done
- Level of prescribing
- Side effect management—bowel regime, adverse outcomes
- Dangerous drug interactions—overlapping opioids, benzos, barbiturates, carisprodol, methadone interactions
- Appropriate acetaminophen prescribing
- Misuse risk—psychiatric or substance use disorders
- Appropriate follow up
- Appropriate lab testing
- Use of appropriate pain therapies
- Accessing state prescription monitoring program

Informed Consent for Chronic Opioid Therapy

- Consistent nation-wide
- Opioid treated like other therapy with known significant risks
- Pain Care Plan
- Do’s and don’t of opioid use
- Short term and Long-term side effects
- How to refill prescriptions
- Protect opioids from damage, loss, theft
- Work with provider on pain care
- Accessing prescription drug monitoring programs

Patient Education Handout

- Based on best evidence
- Vetted by all national VA services impacting chronic pain
- Primary Care
- Pain
- Nursing
- Pharmacy
- Addiction
- Ethics

TAKING OPIOIDS RESPONSIBLY for Your Safety and the Safety of Others

Patient Information Guide on Long-term Opioid Therapy for Pain
What do we now know?

- Opioids work well for some pain problems.
- Opioids reduce persistent pain an average of 30%.
- Opioids are not always safe to use.
- There are significant long-term side effects from opioid use.
- Higher doses don't necessarily results in better pain control.
- The higher the opioid dose, the higher the incidence of unintentional overdose.
- Higher incidence of birth defects in women who use opioids.

What do clinicians now “hear”?

- “You're a bad clinician because you prescribe opioids.”
- “You have to take all of your patients with persistent pain off opioids.”

What do we want clinicians to “hear”?

- “Opioids are a useful tool for many pain problems when thoughtfully prescribed in appropriate patients.”
- “However, opioids do not always provide sufficient pain relief in light of the risks in some patients.”
- “We need to balance benefits and risks.”
- “We need to thoughtfully evaluate each pain problem and the patient with the pain problem before embarking on long-term opioid therapy.”
- “We go into opioid therapy as a trial and need to reevaluate that trial prior to long-term prescribing.”
The Message to Providers

1. Based on compelling evidence over the last 10 years that has shown poor outcomes with high dose long-term opioids in chronic pain, we are recommending change in the way opioids are prescribed in this population.

2. Opioid Safety Initiative IS NOT about stopping or not starting opioids. The goal of the initiative is to provide the best possible pain care with opioids if indicated utilizing standardized evidence-based prescribing practices that safeguard against harm and abuse.

Outcomes

- Some patients aren’t happy with us, others are.
- Not seeing a difference in pain scores
- Too early yet to determine opioid overdose rates
- More appropriate opioid prescribing
- Increased safe prescribing
- Less combination benzos and opioids
- Therapeutic amsalantewen levels
- Lower opioid doses
- More availability of non-opioid and CAM therapies
- Increased use of appropriate lab tests
- Increased use of state prescription monitoring programs
- Increased use of informed consent

References

- Van Ryn M, Kassebaum NJ, Dahan P, and Walrath JS. (2013) JAMA Internal Medicine, 173(16), 1556-1565
Thank you!

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Questions??

PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (InNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

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