VA | U.S. Department of Veterans Affairs

GOVERNOR BRIAN SANDOVAL'S PRESCRIPTION DRUG ABUSE PREVENTION SUMMIT

AUGUST 31, 2016

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

PRESENTATION OUTLINE

- DEPARTMENT OF VETERANS AFFAIRS
- OPIOID SAFETY INITIATIVE
- MEDICATION DASHBOARD
- OPIOID RISK MITIGATION

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF VETERANS AFFAIRS TIMELINE

- 1789 FIRST FEDERAL VETERAN PENSION ESTABLISHED
- 1833 VETERAN PROGRAMS CONSOLIDATED UNDER THE ***BUREAU OF PENSIONS***
- 1833 NAVAL HOME, PHILADELPHIA ESTABLISHED
- 1853 SOLDIERS' HOME, WASHINGTON D.C. ESTABLISHED
  ST. ELIZABETH'S HOSPITAL, WASHINGTON D.C. ESTABLISHED
- 1865 LAW PASSED TO DIRECT THE ESTABLISHMENT OF NATIONAL SOLDIERS AND SAILORS ASYLUMS
- 1919 RESPONSIBILITY FOR MEDICAL CARE OF VETERANS MOVED FROM THE MILITARY TO THE ***PUBLIC HEALTH SERVICE*** ALONG WITH TRANSFERRING OF SEVERAL MILITARY HOSPITALS
- 1921 VETERANS' BUREAU CREATED TO CONSOLIDATE 3 FEDERAL VETERAN PROGRAMS

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DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF VETERANS AFFAIRS TIMELINE

- 1924 — VETERANS BENEFITS EXTENDED TO COVER DISABILITIES THAT ARE NOT SERVICE-RELATED
- 1930 — ***VETERANS ADMINISTRATION*** CREATED TO "CONSOLIDATE AND COORDINATE GOVERNMENT ACTIVITIES AFFECTING WAR VETERANS".
  54 MEDICAL FACILITIES UNDER THE NEW FEDERAL AGENCY
- 1946 — POLICY ESTABLISHED TO AFFILIATE ALL NEW VA HOSPITALS WITH MEDICAL SCHOOLS. HINES HOSPITAL IN CHICAGO WAS THE FIRST (AFFILIATED WITH NORTHWESTERN AND UNIVERSITY OF ILLINOIS.)
  97 MEDICAL FACILITIES UNDER THE VETERANS ADMINISTRATION
- 1952 — 151 MEDICAL FACILITIES UNDER THE VETERANS ADMINISTRATION

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DEPARTMENT OF VETERANS AFFAIRS TIMELINE

- 1989 VETERANS ADMINISTRATION RAISED TO CABINET-LEVEL STATUS; CREATION OF ***DEPARTMENT OF VETERANS AFFAIRS***

THE DEPARTMENT OF VETERANS AFFAIRS COMPOSED OF THREE MAIN DIVISIONS:

VETERANS HEALTH ADMINISTRATION [VHA]

VETERANS BENEFITS ADMINISTRATION [VBA]

NATIONAL CEMETERY SYSTEM [NCS]

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

VA NATIONAL AND NEVADA STATISTICS

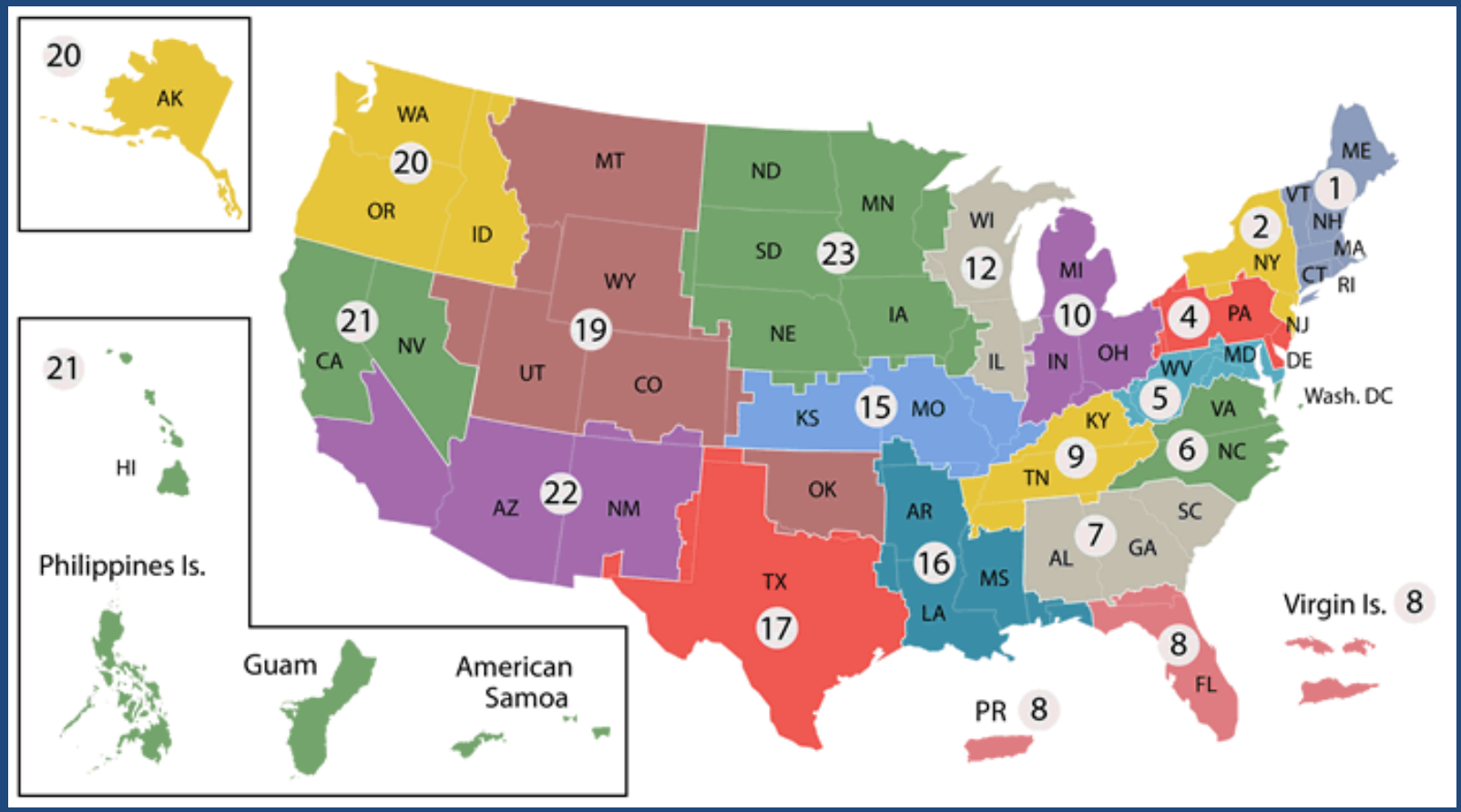
- VETERANS HEALTH ADMINISTRATION
  - 144 MEDICAL CENTERS NATIONALLY
  - 2 MEDICAL CENTERS IN NEVADA

FY2014	NEVADA	NATIONAL
TOTAL VETERANS	228, 027	21,619,731
ENROLLED VETERANS	105,904	9,111,955

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF VETERANS TERRITORY BOUNDARIES

VETERANS INTEGRATED SERVICE NETWORKS



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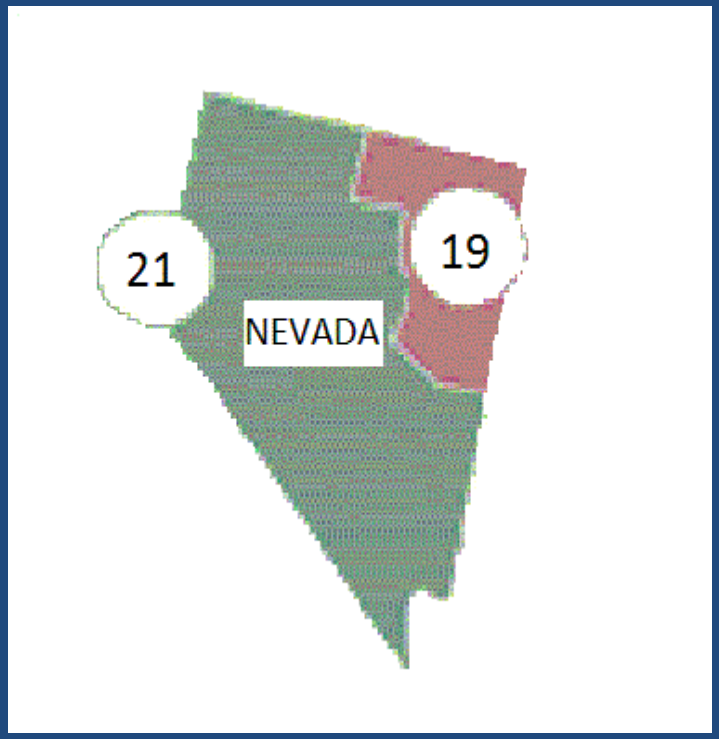
DEPARTMENT OF VETERANS
NEVADA VISN DESIGNATION

VA Sierra Pacific Network
VISN 21

MARE ISLAND,
CALIFORNIA



VISN 19
HEADQUARTERS

GLENDALE,
COLORADO

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

- DEPARTMENT OF VETERANS AFFAIRS FACILITIES LOCATED IN A PARTICULAR STATE DO NOT FOLLOW THOSE STATE LAWS
- HEALTHCARE PROVIDERS PRACTICING WITHIN A VETERANS AFFAIRS FACILITY ARE NOT OBLIGATED TO OBTAIN LICENSURE WITHIN THE HOST STATE.

EXAMPLE

Field:	Surgery
Board Certifications:	General Surgery Vascular Surgery
Education:	MD, UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
Licensed In:	Vermont ← **STATE MEDICAL LICENSE**
Provider Type:	Physician
Gender:	Female
Language:	English
Location:	VA Southern Nevada Healthcare System (VASNHS) ← **MEDICAL FACILITY** 6900 North Pecos Road North Las Vegas, NV 89086 702 791 9000

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2008 - 11% ACTIVE DUTY PERSONNEL WITH PRESCRIPTION DRUG ABUSE [PRIMARILY OPIOIDS]

2009 - MILITARY PHYSICIANS HAD QUADRUPLED OPIOID PRESCRIBING FROM 2001-2009

- 1 IN 3 SUICIDES INVOLVED ALCOHOL OR MEDICATIONS

2008 - DEATH RATES FROM OPIOID OVERDOSES AMONG VETERANS WERE DOUBLE THE NATIONAL AVERAGE

- 30% OF VETERANS WITH MENTAL HEALTH DISORDERS WERE PRESCRIBED

2009 - VHA DIRECTIVE 2009-053 INSTRUCTED VA FACILITIES TO BEGIN COORDINATION OF PAIN TREATMENT THROUGHOUT THE VHA

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- VHA DIRECTIVE 2009-053
  - DEVELOP A STEPPED APPROACH TO CARE WITH PRIMARY CARE AS THE FOUNDATION
  - DEVELOP STANDARDIZED EDUCATION ON PAIN MANAGEMENT FOR ALL VHA PROVIDERS
  - ADOPT VHA SYSTEM-WIDE STANDARDS FOR PAIN MANAGEMENT
  - DESIGNATE A VISN “POINT OF CONTACT” FOR PAIN MANAGEMENT AND APPOINT A FACILITY “POINT OF CONTACT” FOR EACH MEDICAL CENTER
  - SUPPORT THE CREATION OF INTERDISCIPLINARY, MULTI-MODAL APPROACHES TO PAIN MANAGEMENT

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OPIOID SAFETY INITIATIVE

- A PILOT PROGRAM WAS INITIATED IN 2011 AT THE MINNEAPOLIS VA MEDICAL CENTER.
- DEVELOPMENT OF SYSTEMS USED TO IDENTIFY PATIENTS ON HIGH RISK OPIOIDS AND TO PROVIDE A TEAM-BASED SUPPORT FROM PHARMACY, PRIMARY CARE, AND MENTAL HEALTH.
- THE MINNEAPOLIS VAMC SAW NEARLY A 70 PERCENT DECREASE IN HIGH-DOSE OPIOID PRESCRIBING FOR NON-CANCER PAIN PATIENTS.

- OPIOID SAFETY INITIATIVE
  - 2012 CHARTERED BY THE VA UNDER SECRETARY OF HEALTH WITH PILOT PROGRAMS EXTENDED TO SEVERAL VISN TERRITORIES
  - 2013 IMPLEMENTED NATIONWIDE TO ALL VISN
  - 2014 REQUIRED OSI INFRASTRUCTURE FOR PROGRAMS WITHIN EACH FACILITY

- 9 GOALS OF THE OPIOID SAFETY INITIATIVE

Goal One:	Educate prescribers of opioid medication regarding effective use of urine drug screening
Goal Two:	Increase the use of urine drug screening
Goal Three:	Facilitate use of state prescription databases
Goal Four:	Establish safe and effective tapering programs for the combination of benzodiazepines and opioids
Goal Five:	Develop tools to identify higher risk patients

- 9 GOALS OF THE OPIOID SAFETY INITIATIVE

Goal Six:	Improve prescribing practices around long-acting opioid formulations
Goal Seven:	Review treatment plans for patients on high doses of opioids
Goal Eight:	Offer Complementary and Alternative Medicine (CAM) modalities for chronic pain at all facilities
Goal Nine:	Develop new models of mental health and primary care collaboration to manage opioid and benzodiazepine prescribing in patients

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OPIOID SAFETY INITIATIVE

- CLINICAL METRICS FOR VHA MEASURED BY THE OSI FROM QUARTER 4, FISCAL YEAR 2012 (JULY 2012) TO QUARTER 1, FISCAL YEAR 2015 (DECEMBER 2014)
  - 91,614 (13%) fewer patients receiving opioids (679,376 => 587,762);
  - 29,281 (24%) fewer patients receiving opioids and benzodiazepines together (122,633 => 93,352);
  - 71,255 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 => 231,856);
  - 67,466 (15%) fewer patients on long-term opioid therapy (438,329 => 370,863);
  - The overall dosage of opioids is decreasing in the VA system as 10,143 (17%) fewer patients are receiving greater than or equal to 100 MEDD (59,499 => 49,356); and
  - The desired results of OSI have been achieved during a time that VA has seen an overall growth of 75,843 (2%) patients who have utilized VA outpatient pharmacy services (3,959,852 => 4,035,695).

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HOW IS THE DEPARTMENT OF VETERANS AFFAIRS CURRENTLY ADDRESSING PRESCRIPTION MEDICATION ABUSE?

Stepped Care Model for Pain Management

Tertiary Interdisciplinary Pain Centers
Advanced diagnostics & interventions
Commission on Accreditation of Rehabilitation Facilities accredited pain rehabilitation
Integrated chronic pain and Substance Use Disorder treatment

STEP 3

Secondary Consultation
Pain Medicine
Rehabilitation Medicine
Behavioral Pain Management
Interdisciplinary Pain Clinics
Substance Use Disorders Programs
Mental Health Programs

STEP 2

Primary Care/Patient Aligned Care Teams (PACTs)
Routine screening for presence & intensity of pain
Comprehensive pain assessment
Management of common acute and chronic pain conditions
Primary Care-Mental Health Integration, Health Behavior Coordinators, OEF/OIF/OND & Post-Deployment Teams
Expanded nurse care management
Clinical Pharmacy Pain Medication Management
Opioid Pain Care and Renewal Clinics

STEP 1

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FOCUS OF THE MAJORITY OF PRESCRIBING REFORM IS WITH PRIMARY CARE

- -- OPIOID SAFETY INITIATIVE GUIDELINES
  - -- INFORMED CONSENT FOR OPIOID TREATMENT
  - -- ROUTINE URINE DRUG SCREENS
  - -- STATE PRESCRIPTION MONITORING
  - -- MEDICATION RISK ASSESSMENT
- -- PHARMACY ACADEMIC DETAILING
  - -- MONITORING OF CLINICAL PRACTICES
  - -- REGULAR FEEDBACK TO PROVIDERS ON PERFORMANCE
  - -- UTILIZATION OF MEDICATION DASHBOARDS TO TRACK PATIENT PRESCRIPTIONS
- -- SPECIALTY CARE ACCESS NETWORK EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES [SCAN-ECHO]
- -- PAIN MANAGEMENT MINI-RESIDENCY

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OPIOID SAFETY INITIATIVE TOOLKIT

OPIOID SAFETY TOOLKIT [BLUEPRINT]

- KEY DOCUMENTS FOR REVIEW TO ASSIST WITH:
  - STARTING OPIOID MEDICATIONS
  - CONTINUATION OF OPIOID MEDICATIONS
  - TAPERING OPIOID THERAPY

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OPIOID SAFETY INITIATIVE TOOLKIT

OPIOID SAFETY INITIATIVE TOOLKIT TABLE OF CONTENTS

1. Pain Management Opioid Safety– Education Guide (Academic Detailing)
    a. Introduction – Chronic Pain Management: Reducing Harm While Helping the Hurting Veteran. pp.1-2
    b. Chronic Pain Treatment Strategies pp.3-6
    c. Universal Precautions in Opioid Therapy pp. 4-11
    d. Discussing Pain Management p. 12
    e. High Dose Opioid Therapy pp. 12-14
    f. High risk Medication Combinations p. 15
    g. Opioid Reduction and Discontinuation pp. 16-17
2. Pain Management Opioid Safety – Quick Reference Guide (Academic Detailing)
    a. Tools for Opioid Risk Classification pp 1-2
    b. Urine Drug Screening pp. 3-9
    c. Opioid dosing p. 10
    d. Methadone p. 11
    e. Opioid Rotation pp. 12-14
    f. Opioid Adverse Effects pp 15-17
    g. Opioid Dose Reduction or Discontinuation p. 18
    h. Benzodiazepine Dose Reduction or Discontinuation p. 19
    i. Non Opioid Agents for Acute and Chronic pain p. 20 – 21.

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OPIOID SAFETY INITIATIVE TOOLKIT

3. Clinical Considerations when caring for patients on Opioids and Benzodiazepines
4. Effective Treatment for PTSD – Clinician Handout
5. Effective Treatment for PTSD – Patient Handout
6. Helping Patients Taper Benzodiazepines – Clinician Handout
7. Helping Patient Taper Benzodiazepines – Patient Handout
8. Opioid Dose Reduction. Fact Sheet
9. Final, IMed Consent Opioid Directive-1005. Rationale
10. Frequently asked questions (FAQ): Informed Consent for Long Term Opioid Therapy Directive (VHA 2014-1005)
11. Shared Medical Appointment. Taking Opioids Responsibly. Education Visit Template - Power Point
12. Written and Informed Consent for Long Term Opioid Therapy- Shared Medical Appointment - Power Point
13. Pain management opioid safety guide 91314 - Power Point
14. Patient Information Guide on Long- term Opioid Therapy for Chronic Pain – Power Point
15. Transcript and link to podcast on opioid analgesia and Signature Informed Consent for patients.

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STRATIFICATION TOOL FOR OPIOID RISK MITIGATION [STORM]

DISPLAYS:

(A) Risk score for suicide or overdose event for patients with active opioid prescriptions

(B) Risk factors and customized **risk mitigation strategies** for patients with active opioid prescriptions or opioid use disorder diagnosis in the last year

The predictor variables were drawn from available VA administrative data and addressed the following domains:

(A) Demographics
(B) Previous Overdose/Suicide and Treatment Risk Indicators
(C) Prescriptions
(D) Substance Use and Mental Health Disorder diagnoses
(E) Medical Co-morbidities.

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OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION [OEND] PROGRAM

The OEND campaign was initiated in 2014 and attempts to target Veterans at risk for an overdose. It provides these individuals and those close to them with education on preventing, recognizing, and responding to an overdose, along with a naloxone kit with instructions for safe administration.

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OEND PROGRAM

VA Patient Education Brochure: Patients with Opioid Use Disorder

Choose Before You Use

If at all possible, do not use. There is no safe dose of opioids. Help is available, contact your local VA. But if you do use—Choose!

1. Go Slow - Not taking drugs for even a few days can drop your tolerance, making your "usual dose" an "overdose," which can result in death. If you choose to use, cut your dose at least in half.
2. Wait - If you choose to use, wait long enough after you use to feel the effects before you even consider dosing again (regardless if IV, snorting, smoking).
3. Let Someone Know - Always let someone know you're using opioids so that they can check on you. Many who overdose do so when dosing alone.

Buddies take care of Buddies.
Share this card with a friend or family member.

www.mentalhealth.va.gov/substanceabuse.asp

(Adapted from the Harm Reduction Coalition, Oakland, CA)

Date Created: 12/14

You are at higher risk for opioid overdose or death when

- You've not used for even a few days, such as when you are in the hospital, residential treatment, detoxification, domiciliary, or jail/prison.
  Lost tolerance = higher risk for overdose (OD).
- You use multiple drugs or multiple opioids, especially: downers/ benzodiazepines/ barbiturates, alcohol, other opioids, cocaine (cocaine wears off faster than the opioid).
- You have medical problems (liver, heart, lung, advanced AIDS).
- You use long-acting opioids (such as methadone) or powerful opioids (such as fentanyl).
- You use alone, and don't let someone know you are using opioids.

Ask a VA clinician if a naloxone kit is right for you

Important considerations:

- During an overdose the user cannot react, so someone else needs to give naloxone.
- Encourage family and significant others to learn how to use naloxone (see "Overdose Resources" section).
- If you have a naloxone kit, tell family and significant others where you keep it.
- Store naloxone kit at room temperature, out of the heat, cold, and light (e.g., do not store in your car), otherwise naloxone will lose its effectiveness.

CHOOSE BEFORE YOU USE

OPIOID OVERDOSE PREVENTION

Overdose Resources

SAMHSA Opioid Overdose Prevention Toolkit
- Contains safety advice for patients and resources for family members
  http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742

Community-Based Overdose Prevention and Naloxone Distribution Program Locator
- Identifies programs outside of the VA that distribute naloxone
  http://hopeandrecovery.org/locations/

Prescribe to Prevent
- Patient resources and videos demonstrating overdose recognition and response, including naloxone administration
  http://prescribetoprevent.org/video/

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Employee Education System

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OEND PROGRAM

Signs of Overdose

Signs of an Overdose*

Check: Appears sleepy, heavy nodding, deep sleep, hard to arouse, or vomiting
Listen: Slow or shallow breathing (less than 1 breath every 6-8 seconds); snoring; raspy, gurgling, or choking sounds
Look: Bluish or grayish lips, fingernails, or skin
Touch: Clammy, sweaty skin

- If the person shows signs of an overdose, see next section "Responding to an Overdose"

* *Even if the person responds to an initial safety check, bystanders should continue to monitor any person with these signs constantly to make sure the person does not stop breathing and die.*

Resources

Consider seeking long-term help at your local VA substance use disorder treatment program

Help on the Web

» VA Substance Use Disorder Program Locator: *www2.va.gov/directory/guide/SUD.asp*
» Substance Use Disorder Treatment Locator for non-Veterans: *http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx*
» VA PTSD Programs: *www.va.gov/directory/guide/PTSD.asp*

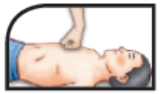
Help is Available Anytime

» **Local Emergency Services: 911**
» **National Poison Hotline: 1-800-222-1222**
» **Veteran Crisis Line: 1-800-273-TALK (8255), or text – 838255**

Responding to an Overdose

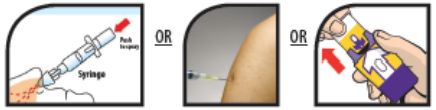
1. Check For A Response

- Lightly shake person, yell person's name, firmly rub person's sternum *(bone in center of chest where ribs connect)* with knuckles, hand in a fist
- If person does not respond—**Give Naloxone, Call 911**


Rub Sternum

2. Give Naloxone, Call 911

- If you have intranasal naloxone, spray one half of the naloxone cartridge into each nostril
- If you have intramuscular naloxone, inject 1 mL into muscle of upper arm, upper thigh, or outer buttocks
- If you have the naloxone auto-injector, pull device from case and follow voice instructions
- When calling 911, give address and say the person is not breathing



Intranasal | Intramuscular | Auto-injector

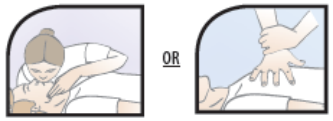
3. Airway Open

Rescue Breathing
(if overdose is witnessed)

- Place face shield *(optional)*
- Tilt head back, lift chin, pinch nose
- Give 1 breath every 5 seconds
- Chest should rise

Chest Compressions
(if collapse is unwitnessed)

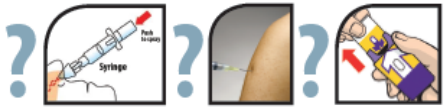
- Place heel of one hand over center of person's chest *(between nipples)*
- Place other hand on top of first hand, keep elbows straight, shoulders directly above hands
- Use body weight to push straight down, at least 2 inches, at rate of 100 compressions per minute
- Place face shield *(optional)*
- Give 2 breaths for every 30 compressions



Rescue Breathing *(if overdose is witnessed)* | Chest Compressions *(if collapse is unwitnessed)*

4. Consider Naloxone Again

- If person doesn't start breathing in 2-3 minutes, or responds to the first dose of naloxone and then stops breathing again, give second dose of naloxone
- Because naloxone wears off in 30 to 90 minutes be sure to stay with the person until emergency medical staff take over or for at least 90 minutes in case the person stops breathing again



5. Recovery Position

- If the person is breathing but unresponsive, put the person on his/her side to prevent choking if person vomits

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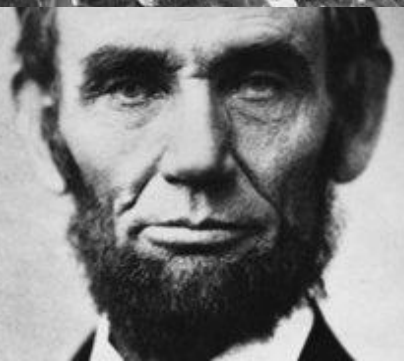
DEPARTMENT OF VETERANS AFFAIRS STATISTICS

VA HEALTHCARE SYSTEM INCLUDES:

144	**MAJOR MEDICAL CENTERS**
1221	OUTPATIENT MEDICAL SITES
300	VETERANS CENTERS
135	NURSING HOMES
108	COMPREHENSIVE HOME CARE PROGRAMS
47	RESIDENTIAL REHABILITATION TREATMENT PROGRAMS
107	MEDICAL SCHOOL AFFILIATIONS
55	DENTAL SCHOOL AFFILIATIONS
1200	ALLIED HEALTH CARE AFFILIATIONS
118,000	HEALTH CARE PROFESSIONALS TRAINED ANNUALLY
21,619,731	TOTAL VETERAN POPULATION
9,111,955	ENROLLED VETERAN POPULATION
305,000	EMPLOYEES
76,000	ACTIVE VOLUNTEERS

TO CARE FOR HIM WHO SHALL HAVE BORNE THE BATTLE AND FOR HIS WIDOW, AND HIS ORPHAN A. LINCOLN



PRESIDENT LINCOLN'S SECOND INAUGURAL ADDRESS
-- MARCH 4, 1865