Mitigating Risks of Long-Term Opioid Therapy in Veterans

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Disclosures

• Employed by the Department of Veterans Affairs (VA)
Learning objectives

• The participant will be able to:
  – Describe the scope of the problem of pain among Veterans
  – Describe VA- Department of Defense (DoD) Stepped Model of Pain Care.
  – Gain skills to mitigate the risks of long-term opioid therapy (LTOT) among Veterans.
  – Assist veteran patients to access VA healthcare resources.
Overview

- Scope of the problem
- VA-DoD guidance and resources for management of chronic pain
- VA strategies for mitigating risks of long-term opioid therapy (LTOT)
- Treatment of Opioid Use Disorders (OUD)
- Resources for veterans
Pain is a public health problem

- Affects at least 100 million American adults
- Costs society $560–$635 billion annually

56% incoming veterans from present conflicts have musculoskeletal pain
- 49% with mental health dx.
- 41% with neurological dx.
Chronic Pain in Veterans of Recent Operations

• Wear and tear of military during war
  – Prolonged repeated deployments
  – Osteoarthritis and spinal/limb injuries
  – Posttraumatic stress disorder

• 90% survival of battlefield injuries
  – Musculoskeletal and multiple organ wounds
  – Blast injuries and TBI
  – Psychological wounds
Do the Risks of Long-term Opioid Therapy Outweigh the Benefits?

- What is the data supporting the efficacy of long-term opioid therapy (LTOT) for chronic non-cancer pain (CNCP)?
Long-term Opioid Therapy No Better than NSAIDS for Back Pain

NSAIDs: First Line Medication for Chronic Non-specific Low Back Pain

### Change in pain intensity from baseline (outcome measure: VAS, 0 – 100; Follow-up: 4 – 12 weeks)

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>COX-2 NSAIDs Mean</th>
<th>COX-2 NSAIDs SD</th>
<th>COX-2 NSAIDs Total</th>
<th>Placebo Mean</th>
<th>Placebo SD</th>
<th>Placebo Total</th>
<th>Mean Difference IV, Fixed, 95% CI</th>
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</thead>
<tbody>
<tr>
<td>Coats 2004</td>
<td>-42</td>
<td>27.7</td>
<td>148</td>
<td>-30.2</td>
<td>27.7</td>
<td>143</td>
<td>-11.80 [-18.17, -5.43]</td>
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<tr>
<td>Katz 2003</td>
<td>-37.9</td>
<td>24.9</td>
<td>233</td>
<td>-27.5</td>
<td>24.9</td>
<td>228</td>
<td>-10.40 [-14.95, -5.85]</td>
</tr>
<tr>
<td>Pallay 2004</td>
<td>-34.9</td>
<td>31.75</td>
<td>233</td>
<td>-19.24</td>
<td>31.17</td>
<td>106</td>
<td>-15.66 [-24.05, -7.27]</td>
</tr>
</tbody>
</table>

Total (95% CI): 594 Favor COX-2 NSAIDs

Heterogeneity: Chi² = 1.38, df = 3 (P = 0.71); I² = 0%

Test for overall effect: Z = 7.94 (P < 0.00001)
Opioids No Different than Antidepressants for LBP Relief

**Analysis 6.1. Comparison 6 Opioids (all types) compared to antidepressants, Outcome 1 Pain (higher score means worse pain level).**

Review: Opioids compared to placebo or other treatments for chronic low-back pain

Comparison: 6 Opioids (all types) compared to antidepressants

Outcome: 1 Pain (higher score means worse pain level)

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Opioids</th>
<th>Other analgesic</th>
<th>Mean (SD)</th>
<th>Mean (SD)</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khoromi 2007</td>
<td>28</td>
<td>28</td>
<td>3.4 (2.5)</td>
<td>2.9 (2.4)</td>
<td></td>
<td>20.6 %</td>
<td>0.20 [-0.32, 0.73]</td>
</tr>
<tr>
<td>Uberall 2012</td>
<td>107</td>
<td>109</td>
<td>3.9 (2)</td>
<td>3.5 (1.8)</td>
<td></td>
<td>79.4 %</td>
<td>0.21 [-0.06, 0.48]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>135</strong></td>
<td><strong>137</strong></td>
<td><strong>3.65</strong></td>
<td><strong>3.42</strong></td>
<td></td>
<td><strong>100.0 %</strong></td>
<td><strong>0.21 [-0.03, 0.45]</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Chi² = 0.00, df = 1 (P = 0.98); I² = 0.0%

Test for overall effect: Z = 1.71 (P = 0.087)

Test for subgroup differences: Not applicable

Opioids compared to placebo or other treatments for chronic low-back pain (Review)

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Do the Risks of Long-term Opioid Therapy Outweigh the Benefits?

• Lack of data supporting the efficacy of long-term opioid therapy (LTOT) for chronic non-cancer pain (CNCP).

• What are the risks of LTOT?
U.S. Rate of Overdose Rose with Increased Opioid Analgesic Prescribing

Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

- **Opioids**
- **Heroin**
- **Cocaine**
- **Benzodiazepines**

Overdose Risk in Veterans

• Similar to US civilian populations, opioid overdose deaths increased significantly among veterans from 2001 to 2009.
• Increase in overdose deaths correlates with increases in opioid prescribing.
• Variations in state level opioid prescribing correlate modestly and significantly with variations in opioid overdose deaths ($r = 0.29$).

Bohnert A et al: JAMA 2011;305(13):1315-21
Opioid Analgesics and Adverse Events in Veterans

• Improvements in protective gear and battlefield medicine resulted in Iraq and Afghanistan veterans surviving injuries.
• Returning veterans have high rates of co-occurring pain and PTSD.
• Observational studies show an association between opioid analgesics, mental illness, PTSD and opioid-related adverse events.
High Risk Opioid Use Patterns Associated with Mental Health Diagnosis in Veterans

Seal KH et al: Association of Mental Health Disorders with prescription opioids and high-risk opioid use. JAMA 2012;307(9):940-947
Risk of Adverse Events Increases with Opioid Therapy and MH Diagnosis

Proportion of Veterans with Adverse Events by Opioid Use and Mental Health Diagnosis

2012 Past Year Drug Use Disorders in Persons $\geq 12$ Years

- Marijuana: 4,304
- Pain Relievers: 2,056
- Cocaine: 1,119
- Tranquilizers: 629
- Stimulants: 535
- Heroin: 467
- Hallucinogens: 331
- Inhalants: 164
- Sedatives: 135

Numbers in Thousands
Do the Risks of Long-term Opioid Therapy Outweigh the Benefits?

• Lack of data supporting the efficacy of long-term opioid therapy (LTOT) for chronic non-cancer pain (CNCP).

• Increased risk of adverse events including:
  – Opioid-related accidents/overdose
  – Alcohol- & other drug-related accidents/overdose
  – Self-inflicted and other violence related injuries
  – Addiction to opioids
Overview

• Scope of the problem
• VA-DoD guidance and resources for management of chronic pain
• VA strategies for mitigating risks of long-term opioid therapy (LTOT) and Opioid Use Disorders (OUD)
• Resources for veterans
VA and DoD are shifting current health care delivery which is **problem-based disease care**, to one that provides **patient-centered health care**.

### Key Components

1. **Personalized Health Planning**
2. **Whole Person, Integrative Strategies**
3. **Behavior Change & Skill Building That Works**
Routine screening for presence & severity of pain; Assessment and management of common pain conditions; Support from MH-PC Integration; OEF/OIF, & Post-Deployment Teams; Expanded care management; Pharmacy Pain Care Clinics; Pain Schools

Nutrition/weight management; ice & stretch and exercise/conditioning; sleep management; mindfulness meditation/relaxation techniques; engagement in meaningful activities; family & social support; safe environment/surroundings

Tertiary, Interdisciplinary Pain Centers
Advanced pain medicine diagnostics & interventions; CARF accredited pain rehabilitation

Secondary Consultation
Multidisciplinary Pain Medicine Specialty Teams; Rehabilitation Medicine; Behavioral Pain Management; Mental Health/SUD Programs

Patient Aligned Care Team (PACT) in Primary Care
Routine screening for presence & severity of pain; Assessment and management of common pain conditions; Support from MH-PC Integration; OEF/OIF, & Post-Deployment Teams; Expanded care management; Pharmacy Pain Care Clinics; Pain Schools

Self Management
Nutrition/weight management; ice & stretch and exercise/conditioning; sleep management; mindfulness meditation/relaxation techniques; engagement in meaningful activities; family & social support; safe environment/surroundings
VA Guidance on Management of Chronic Pain

• 2007- VA-DoD Clinical Practice Guideline (CPG) for Management of Low Back Pain (LBP)
• 2010- VA-DoD CPG for Management of Opioid Therapy for Chronic Pain
• 2014- Opioid Safety Initiative and VHA Directive 1005 Informed Consent for Long-term Opioid Therapy for Pain
Follow ACP and APS CPG (2007- Chou et al)

1. Hx & PE to place LBP in one of 3 categories:
   a) Non-specific
   b) Potential radiculopathy or spinal stenosis
   c) Potential other specific spinal cause

2. Do not routinely obtain diagnostic imaging in patients with non-specific LBP.

3. Perform diagnostic imaging when severe or progressive neurologic deficits or other evidence of serious underlying condition from Hx and PE.
4. Evaluate persistent LBP and radiculopathy with MRI (preferred) or CT only if patient is a candidate for surgery or spinal injection.

5. Provide evidence-based LBP information about course & self-care; advise activity.

6. Use medications with proven efficacy for LBP. For most patients, acetaminophen and NSAIDs.

7. For patients who do not improve with self-care, consider evidence-based non-pharmacologic therapies.
   - For acute LBP, spinal manipulation.
   - For chronic LBP, intensive interdisciplinary rehab, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation.

Trial of OT is indicated for a patient with chronic pain meeting all of the following criteria:

- Moderate to severe pain that has failed to respond to non-opioid and non-drug interventions.
- Potential benefits outweigh risks (i.e. no absolute contraindications).
- The patient is fully informed and consents to OT.
- Clear and measurable treatment goals are established.
Other CPG Recommendations

• Shared-decision making of an individualized, multimodal treatment plan
  – Written opioid pain care agreement/informed consent

• Monitoring for:
  – Efficacy in meeting treatment goals
  – Adherence (including random urine drug testing)
  – Side effects- weigh costs versus benefits

• Consider discontinuation for lack of efficacy, lack of adherence, or adverse events.
Contraindications to OT

• Absolute
  – Severe respiratory instability
  – Acute psychiatric instability
  – Active SUD not in treatment
  – Allergy to opioids
  – Drug-drug interaction
  – QTc > 500 msec (methadone)
  – Active diversion
  – Previous unsuccessful OT

• Relative (May proceed with caution & risk mitigation)
  – Patient receiving SUD tx
  – Medical condition in which OT may cause harm:
    • Sleep apnea without CPAP
    • Central sleep apnea
    • COPD, moderate asthma
    • QTc 400 – 500 msec
    • Paralytic ileus
    • Respiratory depression
  – Risk for suicide
  – Complicated pain
  – Conditions that impact adherence
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Minneapolis VAMC developed a multimodal initiative to reduce over-utilization of opioid pain medications

- Highest level leadership support
- Patients on high-risk opioid medications identified
- Team-based support provided from Pharmacy, Primary Care and Mental Health to develop individualized care plans to decrease high risk opioid use and improve patient safety
- Interdisciplinary pain management services utilized
- Initiative has achieved a nearly 70% decrease in high-dose opioid prescribing for non-cancer pain.
Minneapolis VA - Opioid Safety Initiative
Changes in Opioid Prescribing April 2011 - February 2014

- -19%
- -45%
- -51%
- -68%
- -100%
-0%
-10%
-20%
-30%
-40%
-50%
-60%
-70%
-80%
-90%
-100%

- Patients Receiving at least 1 Opioid rx
- MEQ/PC Patient
- 120+ MED
- 200+ MED
- Oxycodone SA
VA Opioid Safety Initiative 9 Goals

• Educate prescribers in safe and effective urine drug testing (UDT)
• Increase use of UDT
• Educate prescribers on access to prescription drug monitoring programs (PDMP)
• Establish safe and effective tapering programs for patients using the combination of opioids and benzodiazepines.
Opioid Safety Initiative Goals

• Develop tools to identify patients at high risk.
• Improve prescribing practices around long-acting opioid formulations.
• Review treatment plans for patients on high doses of opioids.
• Offer Complimentary and Alternative Medicine modalities for treatment of chronic pain at all facilities.
• Develop new models of mental health and primary care collaboration to manage opioid and benzodiazepine prescribing in patients with chronic pain.
Several aspects of the Opioid Safety Initiative have begun to bear positive results*:

- Decrease in the number of Veterans (by 50,896) who received an opioid prescription (including short and long-term use) from VA, despite an increase in the number of Veterans who were dispensed any medication from a VA pharmacy.
- Increase in the number of Veterans (by 37,824) on long term opioid therapy who have had at least one urine drug screen - performing urine drug screens is a useful tool to assist in the clinical management of Veterans receiving long-term opioid therapy.
- Decrease in the total number of Veterans (by 26,979) on long-term opioids.
- Decrease in the number of Veterans (by 14,475) who received opioid and benzodiazepine medications. Whenever clinically feasible, the concomitant use of opioid and benzodiazepine medications should be avoided.
- The average dose of selected opioids has begun to decline slightly in VA, demonstrating that prescribing and consumption behaviors are changing.

*Note: All results are between the quarter beginning in July 2012 compared to the quarter ending in March 2014.
Veterans Dispensed Opioids Over Time

- Q4 FY12: 679,376
- Q1 FY13: 675,939
- Q2 FY13: 671,156
- Q3 FY13: 671,216
- Q4 FY13: 665,786
- Q1 FY14: 646,234
- Q2 FY14: 628,480

50,896 fewer Veterans
Opioids/Opioid Safety Initiative (OSI)

- 5 Things we are doing in the VA Pain Management Program:
  - Every Medical Center has a pain management clinic
  - Every Medical Center has a pain consultation service
  - VHA uses alternative medicine
  - VHA uses a stepped care model for pain management
  - Opioid dashboard provides information to every medical center about prescribers and users so that clinicians can address outliers’ circumstances.
Integrative Health - Clinical

Complementary health practices catalyze synergies across the dimensions of health and well-being to activate the Veteran’s innate healing capacities.
Collaborative Pain Management

• Patient Information- Taking Opioids Responsibly
  – [http://www.va.gov/PAINMANAGEMENT/Taking_Opioids_Responsibly201108_FINAL.pdf](http://www.va.gov/PAINMANAGEMENT/Taking_Opioids_Responsibly201108_FINAL.pdf)

• Consent for Long-Term Opioid Therapy for Pain
  – VHA Directive 1005
Opioid Overdose Education and Naloxone Distribution (OEND)

- Recommendations for use from VA Pharmacy Benefits Management (PBM).
- Intranasal and intramuscular naloxone kits available through VA National Formulary.
- Educational information for patients and providers available through OEND SharePoint.
- Education to VA providers to consider OEND for veterans at risk for opioid overdose.
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• Resources for veterans
VHA Handbook 1160.01

• Appropriate SUD treatment services must be available to veterans who need them.
  – During new patient encounters (& annually) in primary and mental health care, screening for tobacco and alcohol use
  – Assessment, brief intervention, and, if indicated, medication and counseling for + screens

• Sensitivity to needs of special populations including women, HIV, PTSD, TBI, etc.
VHA Handbook 1160.01

- Ongoing monitoring and encouragement of those who decline SUD treatment
- Residential &/or intensive outpatient treatment
- Medically supervised withdrawal management
- Motivational counseling and incentives
- Pharmacotherapy for EtOH, tobacco and opioids
- Co-occurring mental illness + SUD management
VHA 1160.04- SUD Tx Principles

• Access- timely access to the continuum of SUD care
• Informed consent- shared decision making
• SUD continuum of care- outpatient through residential
• Collaborative care- across programs to meet individual veteran needs
• Special populations- women, older veterans, etc.
• Specialty SUD care must address co-occurring psychiatric and medical conditions
• Residential treatment when needed- on-site or through agreements
VHA Trends in Diagnoses by Drug for Veterans with PTSD and SUD
Trends in Opioid Agonist Therapy

• ~25% of US residents with opioid use disorder (OUD) receive opioid agonist therapy (OAT).

• In the VHA from 2003 to 2010,
  – Veterans with an OUD increased 45% from 30,000 in 2003 to 44,000 in 2010.
  – 25% to 27% of veterans with OUD received OAT.

• Increased buprenorphine prescribing enabled facilities to keep pace with increasing demand for OAT.
Opioid Agonist Pharmacotherapy for Opioid Dependence (ICD 304.0)

<table>
<thead>
<tr>
<th>Year</th>
<th>Treated*</th>
<th>Diagnosed</th>
<th>National</th>
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<tbody>
<tr>
<td>FY09</td>
<td>9,265</td>
<td>33,122</td>
<td>28.0%</td>
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<tr>
<td>FY10</td>
<td>10,668</td>
<td>36,970</td>
<td>28.9%</td>
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<tr>
<td>FY11</td>
<td>11,383</td>
<td>40,502</td>
<td>28.1%</td>
</tr>
<tr>
<td>FY12</td>
<td>12,444</td>
<td>45,077</td>
<td>27.6%</td>
</tr>
<tr>
<td>FY13</td>
<td>14,212</td>
<td>48,926</td>
<td>29.0%</td>
</tr>
</tbody>
</table>

Change FY09-13: +53.4%  +47.7%

Includes office-based care (buprenorphine/naloxone) Opioid Treatment Program (methadone or buprenorphine/naloxone), or fee basis care.
Buprenorphine/Naloxone Treatment for Opioid Use Disorders (OUD) in Calendar 2013

- Pharmacy data indicate there were 10,647 unique Veterans who received at least some buprenorphine/naloxone
  - (up ~75% since FY2010)
- 956 total unique VHA providers
  - (up 39% since FY2010).
- Of 151 major medical centers, 94% (all but 9) provided buprenorphine/naloxone.
- At least 10 unique Veterans received some buprenorphine/naloxone care at 170 distinct VHA sites of care (including medical centers and CBOCs)
- An additional 128 VHA sites had between 1 and 9 unique Veterans treated with buprenorphine/naloxone.
- Relatively little treatment for OUD is contracted in the community
  - a few sites do so for methadone and even fewer for buprenorphine.
Resources Available to Veterans

• Returning veterans who served after November 11, 1998 and who were discharged on or after January 29, 2003 are eligible to enroll in VA Healthcare for 5 years from the date of discharge or release.
  – Cost-free health care for condition related to service in theater
  – Access to VA’s full Medical Benefits Package.

• For veterans benefits details see: http://www.benefits.va.gov/benefits/

• For healthcare benefits application see: http://www.va.gov/healthbenefits/online/
Summary

• Chronic pain is a common condition among veterans.
• LTOT for chronic pain carries significant risks.
• VA providers are partnering with veterans to improve comprehensive pain management.
• There are early indications that high-risk opioid prescribing is being reduced.
• A menu of evidence-based treatment for pain and for opioid use disorders is available for veterans.
Please Click the Link Below to Access the Post Test for the Online Module

• Upon completion of the Post Test:
  
  • You will receive an email detailing correct answers, explanations, and references for each question.

• You will be directed to a module evaluation, upon completion of which you will be emailed your module Certificate of Completion.

http://www.cvent.com/d/trq1sy