Systems Changes to Improve Opioid Prescribing

Rosemary Mehl MD
Physician, Primary Care
VA Boston Healthcare System

VA Boston HealthCare System

- Primary care to 30,000+ veterans Boston-Lowell-Worcester-Brockton(Plymouth). Academic practice (4 MA residency programs, 3 Medical Schools).
- Procedure-based pain clinic, Integrated Mental Health, Pain Psychology, Substance abuse services, Abundant Rehabilitation resources including 2 Pools.

- Part of New England Regional and National Veterans Health Administration
    - National Electronic Medical Record
    - VA Pharmacy Benefits – restricted formulary (Oxycodone CR 3rd-line)
    - Abundant on-line resources. Share ideas on national level
- 2009 VHA Pain Management Strategy: "Stepped Care Model"
    - COMPETENT PRIMARY CARE PROVIDER WORKFORCE
    - SPECIALTY CONSULTATION, INPATIENT PAIN REHAB

The Problem

- Persistent pain complaints: 50% male/75% female veterans. Leading diagnosis in Persian Gulf and OIF/OEF veterans.

Kerns, Clark VA National Pain Management Conference 2009

The Service-Connected Veteran: *How do I say NO to the Veteran with Military or VA care-related injuries when he demands pain medications?*

Veterans Pain Care Act 2007 (Senate bill 2160)

Military Pain Care Act 2008 (HR bill 5465)

Pain – the 5th Vital Sign

Veterans are allowed to request another PCP – and Pain management is a frequent reason to transfer PCPs.

Medical Center Directors, Local/State Rep, Congress/White House

The Problem

- VA Primary Care Providers – not unlike Non-VA PCPs:
  - Not Enough Time (Older patients with co-morbid illness)
  - Not Enough Training, Unfamiliar with Guidelines
  - Unaware of Specialty Help. Specialists may not be Local
  - Don’t Want to Manage Chronic Pain
  - Veterans may also be getting care outside VA HCS. (Shared Care). Federal mandates bar us from accessing non-VA information, including PMPs.

The Problem

- March 2009 ~1000 patients on COT for CNCP every month

  90% from Primary Care

  10% : SCI, Sleep, Oncology for CNCP.

  NO Neurology, Rheumatology, Pain clinic

Adequate documentation of pain assessment <50%

Pain Agreement ~10%

Significant Psych/Substance Abuse history *~50%*

PATIENT CARE MEMORANDUM-119-003-LM December 2007
LONG-TERM USE OF CONTROLLED SUBSTANCES

The Problem

Substance Abuse among Veterans

- SUD in up to 75% of Vietnam veterans with Pain and PTSD. AmJPsych 2001

-OIF/OEF “frequently” use alcohol and drugs to treat deployment-related stress.

Prescription drug abuse = 5x illegal drug use among military personnel. Prescription drugs caused a third of military suicides 2009, and 100 accidental OD deaths among military personnel 2006-2009. Boston Globe 2-13-11

Tackling the Problem: Primary Care Survey May 2009 (N=24/~60)

- **< 20pts per month** **54%**
  - **did not specify number** **37%**
- ***Difficult* cohort to treat** **83%**
- **Need *more education*** **79%**
- ***More time* needed for visit** **83%**
- **Inadequate pain management specialist *support*** **54%**
  - **Mental Health specialist support *inadequate*** **71%**
  - **Addiction Medicine support *inadequate*** **71%**

- 2008 VHA Primary Care Survey, a majority of Primary Care *Leaders* said
  - Management of Chronic noncancer pain in Veterans is “moderately” or “extremely” challenging.
  - ***Successfully treating chronic pain is an unachievable goal.***
  - Veterans with chronic pain are difficult and require a great deal of time.

Tackling the Problem: Primary Care 2009-2010

- Updating the Boston VA Policy on COT
- VA/DoD Guidelines on COT for CNCP

Tackling the Problem

- Templates for the EMR
  - Opioid Pain Care Agreement
  - Progress notes for initial and follow-up assessments of patients on COT

Tackling the Problem: EMR Template

- Follow-up Chronic Opioid Use
-
- Indication for chronic narcotic use:
- Average Pain level during the past week:Best pain level during the past week:
- Has there been any difference in your life while taking pain meds?Do your current pain meds provide a real difference in your life?
- Better Same Worse
- Physical functioning [ ] [ ] [ ]
- Relationships [ ] [ ] [ ]
- Employment [ ] [ ] [ ]
- Mood [ ] [ ] [ ]
- Sleep [ ] [ ] [ ]
- Adverse effect assessment: Constipation [ ] ON Bowel regimen [ ] Yes [ ] No Drowsiness [ ] Imbalance/Falls [ ]
- Aberrant behavior: Illicit drugs or problem drinking [ ] Ran out/used more than prescribed [ ] Requested from other provider [ ]
- Medications:
- LAST UDS PHYSICAL EXAM LAB
- ASSESSMENT Patient is/is not stable on current regimen. PLAN: Continue present regimen____Adjust/Rotate__Taper off opioid and treat pain with non-opioid therapies_____
- Consult:___Mental Health ___Substance ___Physical therapy/Rehab Medicine ___MOVE! ___Social Work ___Neurology
- ___Rheumatology ___ Other
- Patient was counseled and warned against the following: - Drowsiness and dizziness - Caution against driving or operating heavy machinery while taking medication - Avoid alcoholic beverages as they enhance the risk of side effects
- (Patient Name auto insert) verbalized understanding of these instructions.

Tackling the Problem: EMR Template

- Initial Assessment for Chronic Opioid use
- Pain Hx/Onset/Location: Radiation: Quality: Improves by: Exacerbated by: Interference with daily activities:
- Impact on sleep:
- What would you do if pain was better? SET GOALS FOR THERAPY
- Best Pain Intensity (0-10):
- Usual Pain Intensity (0-10):
- Previous and/or Concurrent therapies:
- Active Problems: (pull in list) SOCIAL HISTORY: Marital Status:Work: ..Physical activity:Abuse: Alcohol: Tobacco:
- Illicit Drugs(past, current):Legal history (arrests, DUI):
- PSYCHIATRIC HISTORY:
- **Opioid Risk Tool**
- **Pex, Labs**
- **UDS**
- **I have discussed the Pain Agreement ___**

Tackling the Problem: EMR Pain Agreement

"Partnership for the Safe and Effective Use of Opioids for Pain Control: An Agreement to Participate"

This agreement is between you and the VA Boston Healthcare System or its Community-Based Outpatient Clinics. ***This form is used throughout VA***. The VA wants to provide you with the best possible care when you take opioids to help your pain.

Signed, part of electronic record

Tackling the Problem

- Educational Series (VANTS-conference call) *for Prescribers* 2009-2010 (VA Boston, then New England VISN)
  - *Using templates* to document Pain and Assessing Opioid Benefit/Risk
  - *Opioid basics, Non-Opioid Therapies*
  - *The Dual-Diagnosis Patient*
  - Interpreting *UDS*
  - The Pain Care Agreement
  - *VHA website and resources*

Tackling the Problem

Opioid Review Committee

- Mandated by VA Boston Policy.
- Pharmacy-generated chart reviews and *help for prescribers*

Volunteer “Primary Care Pain Champions” in all PCCs

Results

Charts Reviewed 16 months later (77):

	3/2009	7/2010
Adequate documentation	<50%	>80%
Pain Agreement	~10%	>60%
UDS	1%	>40%

1 non-opioid related death

12 (15%) were OFF opioids – patient requested, admitted to abuse/diversion. Those 12 continue to be followed in Primary Care.

Results

- Providers are starting to ask for help.
- Patients are being referred for substance abuse and nonopioid therapies.
- Coordinated Primary Care and Mental Health care for dual diagnosis patients (Pain and SA)

Results

Continued variability among individual prescribers

- "One strike – you're out"
  - » Patient complains to chief of staff and legislators, may be allowed to switch providers
- Ignore unsafe and aberrant behaviors
  - » Difficult patients, Hospitalizations
- Appropriate monitoring, Referral for substance abuse disorders
- New staff and trainees may be unaware of guidelines and available resources

Lessons Learned

- Changing behaviors takes time
  - Patients: “I’ve gotten these drugs for years. Why the new rules?”
  - Providers: Templates rarely used. “I don’t have time”. Prescribe the drugs first, think about the UDS and Agreement later.
- Policies and Guidelines protect prescribers

Lessons Learned

- Enforcement is difficult
  - Pharmacy gets “pushback” from prescribers
  - Prescribers “opt out” of educational efforts
  - Enforcing safe opioid use and stopping opioids is difficult.

Lessons Learned

- Educational efforts *limited to prescribers exclude our most valuable allies* in Nursing, Mental Health, Pharmacy, Social Work are not enough

- When nursing staff created “Pain Self-Management and Pain Resources” brochure, result was increased referrals to Rehab, Pool, Mental Health services.

Next Steps

- Patient-Affiliated Care Teams 2010
  - Prescribers, Nursing, Mental Health, Pharmacy, Social Work working together
  - *Educate and empower the entire Primary Care staff* to promote safe opioid use by ensuring that VA Policy requirements are being met. Prescribers are no longer alone in dealing with patients.

Next Steps

- Pain Champions - Continue to Educate Prescribers
  - No longer Opioids “Yes or No”, *but as part of a Pain Management Program (Physical therapy, mental health/addiction)*
  - *OPIOIDS ARE DANGEROUS*
  - Use Primary Care skills to manage pain, negotiate opioid use, and address misuse.
    - VA provides model care for DM, HTN, SCI.
- VA Pharmacy restrictions
  - National policy. Non-Formulary drugs