

Pain Management and Opioid Safety

Addressing the Opioid Crisis:
Adverse Events, Opioid Overdose and
Opioid Use Disorder

For VHA Prescribers



The White House

2016.09.16

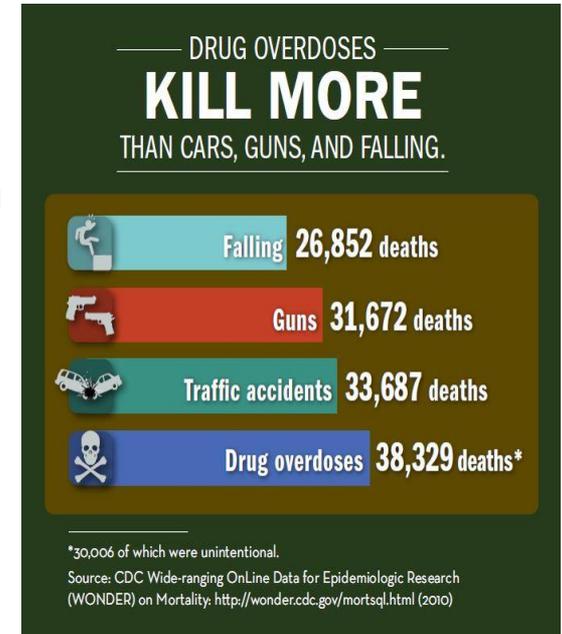
“Each year, more Americans die from drug overdoses than in traffic accidents, and more than three out of five of these deaths involve an opioid.

Since 1999, the number of overdose deaths involving opioids, including prescription opioid pain relievers, heroin, and fentanyl, has nearly quadrupled. “

Presidential Proclamation -- Prescription Opioid and Heroin Epidemic Awareness Week, 2016

<https://www.whitehouse.gov/the-press-office/2016/09/16/presidential-proclamation-prescription-opioid-and-heroin-epidemic>

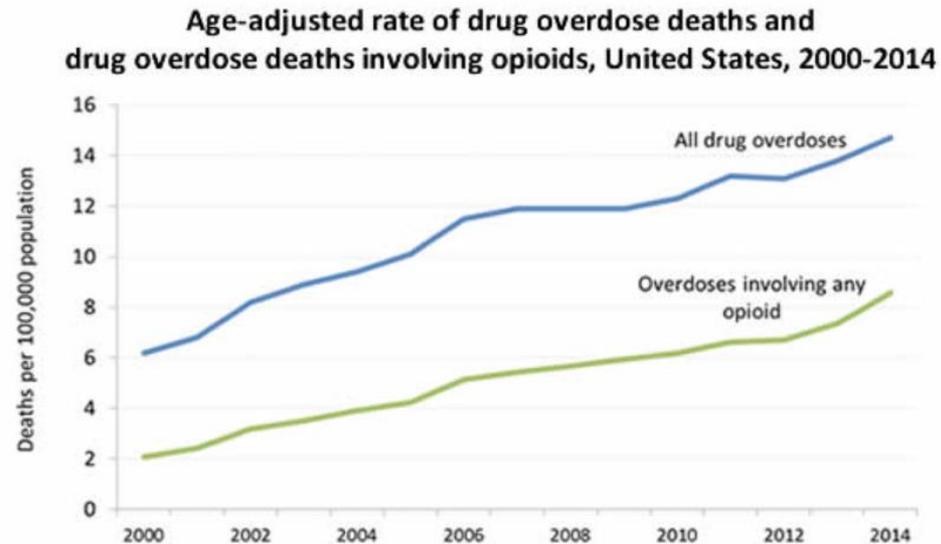
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Opioid Overdose Epidemic

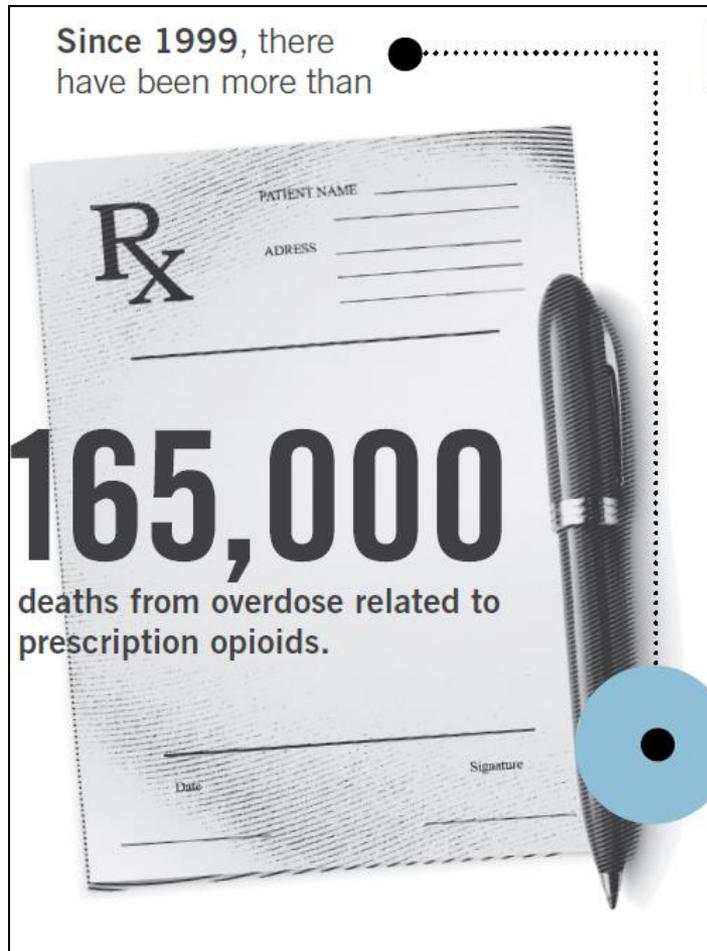
- From 2000 to 2014 nearly half a million people died from drug overdoses.
- In 2014 alone, 47,055 persons died from drug overdoses – more than in any year on record before.
- The majority of drug overdose deaths (more than 6 out of 10) involve an opioid.
- 78 Americans die every day from an opioid overdose. (source: CDC)

- In 2012, 80% of drug overdose deaths in the United States were unintentional. (Drug Overdose in the US: Fact Sheet, 2014)



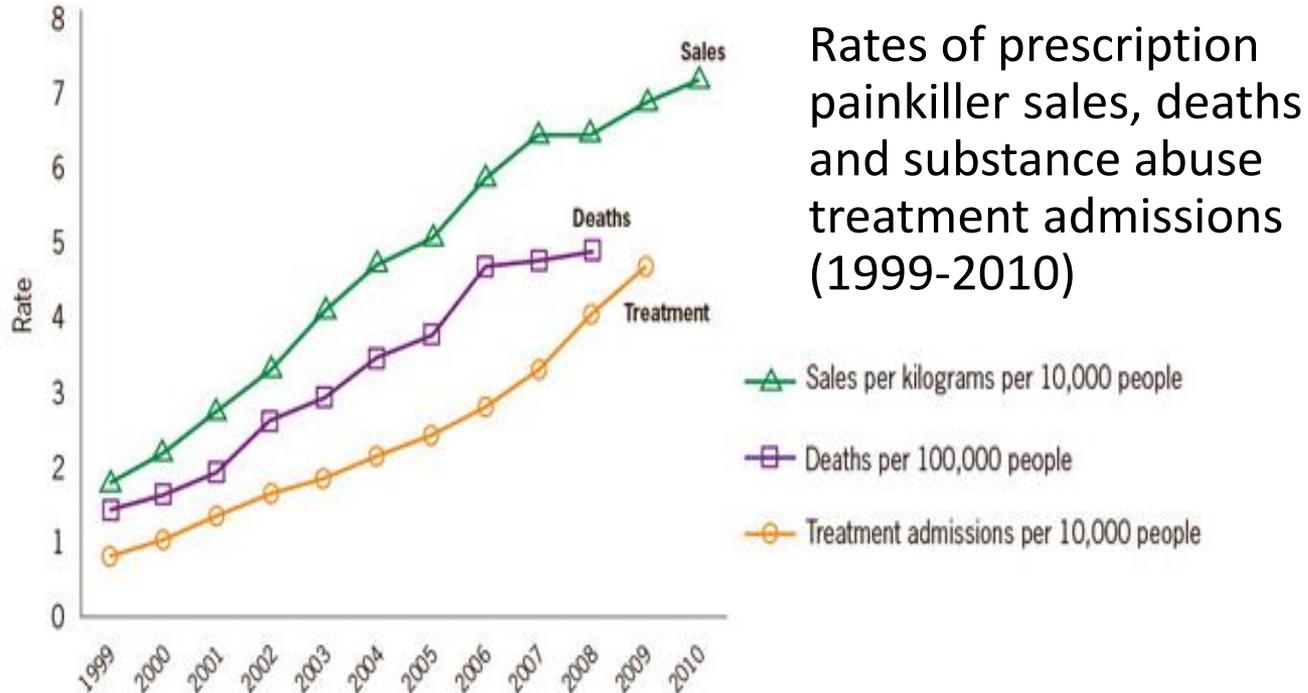
Source: National Vital Statistics System, Mortality file; CDC

Overdose Deaths related to Prescription Opioid Medication



- 72% of deaths related to prescription medications involve an opioids.
- At least half of all opioid overdose deaths involve a prescription opioid.

Correlation of Opioid Sales with Overdose Deaths and Treatment for Opioid Use Disorder



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009; <http://www.cdc.gov/vitalsigns/painkilleroverdoses/infographic.html>

Veterans are twice as likely to die from accidental overdose compared to non-Veterans.

(Bohnert et al., 2011)

Open Letter To America's Physicians

AMA President 05/11/2016



“For the past 20 years, public policies — well-intended but now known to be flawed — compelled doctors to treat pain more aggressively for the comfort of our patients. But today’s crisis plainly tells us we must be much more cautious with how we prescribe opioids.”

“We must accept and embrace our professional responsibility to treat our patients' pain without worsening the current crisis.”

TOGETHER WE CAN MAKE A DIFFERENCE

Stephen J. Stack, Emergency physician and the 170th president of the American Medical Association



Surgeon General campaign “Turn the Tide”

- Open letter to all Medical Providers:

“Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way.”

- TurnTheTideRx.org website launched Aug. 8, 2016 as a platform with resources for physicians and their patients.

- <http://turnthetiderx.org/>

OUR PLEDGE

AS HEALTH CARE PROFESSIONALS, WE BELIEVE WE HAVE THE UNIQUE POWER TO END THE OPIOID CRISIS. WE PLEDGE TO:

- 1 Educate ourselves to treat pain safely and effectively.
- 2 Screen our patients for opioid use disorder and provide or connect them with evidence-based treatment.
- 3 Talk about and treat addiction as a chronic illness, not a moral failing.

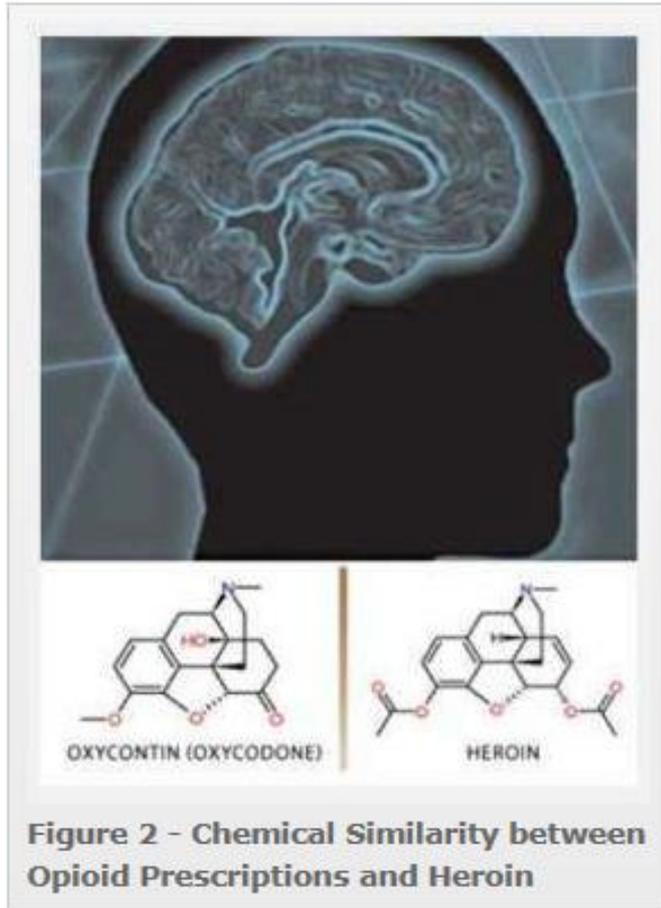
FIRST	LAST
Choose a Profession	Choose a Specialty
PROFESSION	SPECIALTY (optional)
ZIP CODE	EMAIL

By signing the pledge, you'll also be joining our contact list to stay connected as we #TurnTheTide.

count me in

The Misuse Potential of Controlled Substances

Prescription Opioids and Heroin



Prescription opioids and heroin are chemically similar and work through the same mechanism of action.

- Both Heroin and prescriptions work at the Mu-opioid receptor.
- Reward regions of the brain have high concentration of Mu-opioid receptors.
- Because **prescription opioids are similar to and act on the same brain systems affected by heroin** they present an intrinsic abuse and addiction liability.

Opioid Use Disorder (OUD) Epidemic

- **Anyone who takes prescription opioids can become addicted to them.**
- In 2014, nearly two million Americans either abused or were dependent on prescription opioid pain relievers.
- 25-41% of patients on prescription opioids meet criteria for opioid use disorder (DSM-5 criteria).
- **The risk of developing OUD increases with the duration and with the prescribed dosage of opioid therapy.**

Opioid Use Disorder Epidemic

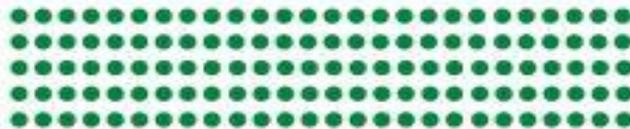
For every **1** death there are...



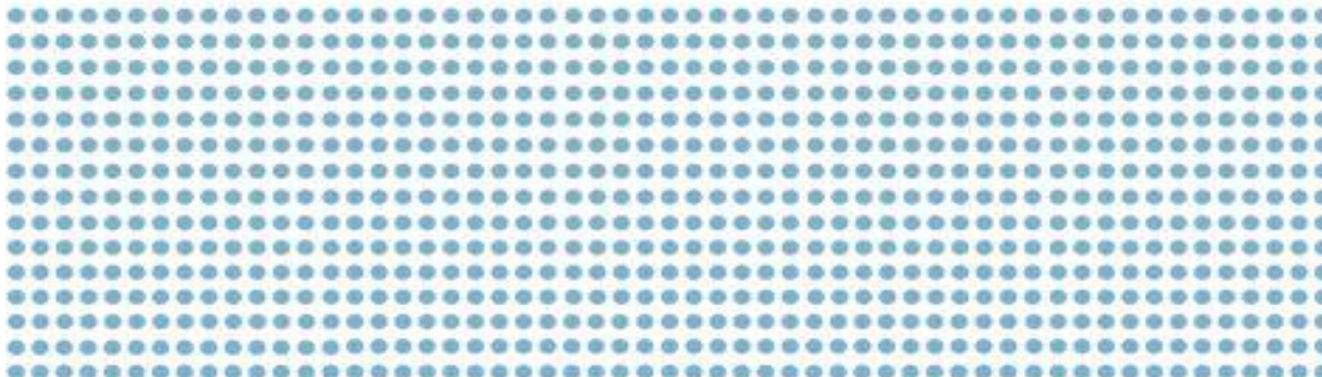
10 treatment admissions for abuse⁹



32 emergency dept visits for misuse or abuse⁶



130 people who abuse or are dependent⁷

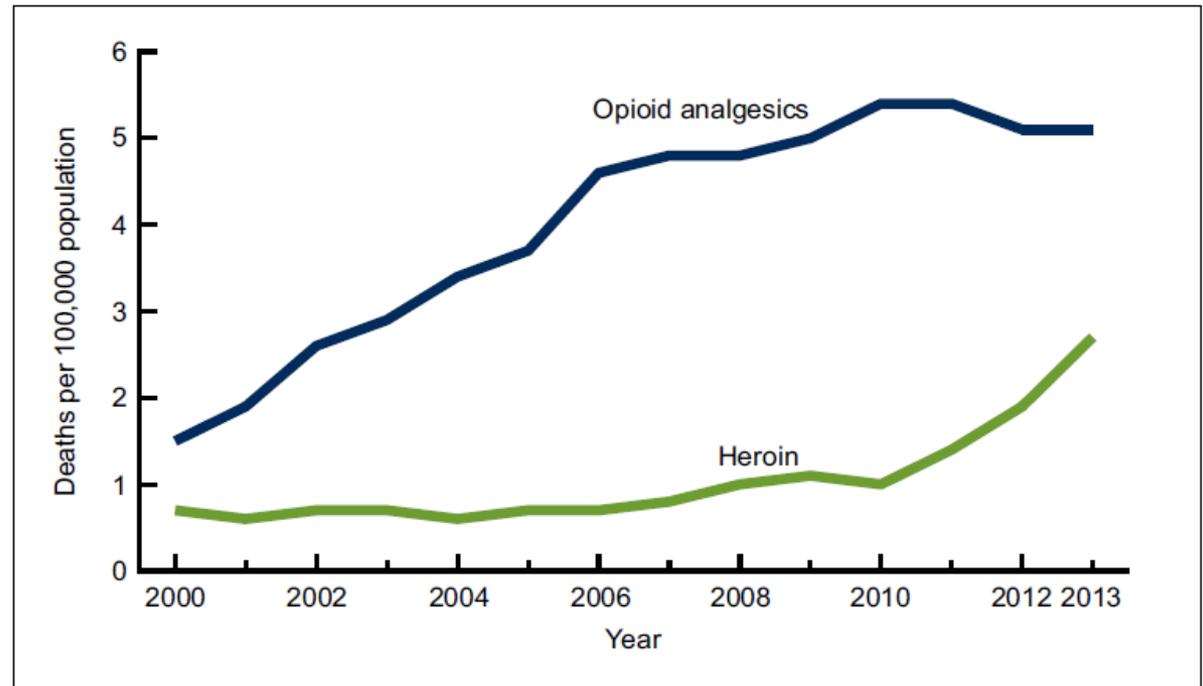


825
nonmedical
users⁷

Opioid Use Disorder Epidemic

- Among new heroin users, approximately three out of four report abusing prescription opioids prior to using heroin.

Figure 1. Age-adjusted rates for drug-poisoning deaths, by type of drug: United States, 2000–2013



- Heroin-related deaths more than tripled between 2010 and 2014.
- 10,574 heroin deaths in 2014.

Risks of Opioid Therapy

- Mortality (of all-causes)
 - **Hazard ratio (HR) 1.64** for long acting opioids for non-cancer pain
- Overdose deaths (unintentional)
 - **HR 7.18-8.9** for MED > 100 mg/d
- Opioid use disorder

For patients on long-term opioids (> 90 days)

 - **HR 15** for 1-36 mg/d MED
 - **HR 29** for 36-120 mg/d MED
 - **HR 122** for > 120 mg/d MED

MED=Morphine Equivalent Daily Dose (in mg/d)

Other Medical and Psychological Adverse Effects from Long-Term Opioid Therapy:

- **Endocrine deficiencies** in men and women, including sexual dysfunction from low testosterone levels in men, and osteoporosis.
- **Cognitive impairment**, sedation, and impaired judgment (including driving)
- Worsening of **depression, anxiety**, and symptoms of PTSD.
- **Falls** and related injuries
- **Immunosuppression** and **cardiovascular** side effects.
- **Disrupted and impaired sleep** including with possibility of developing worsening of sleep-disordered breathing, like sleep apnea.
- **Opioid induced hyperalgesia**: opioids contribute to central sensitization and may actually worsen pain control in some patients
 - When this occurs, the threshold to experience pain decreases, and incident pain may be more difficult to tolerate.

Paradigm Shift in Pain Care

- There is no completely safe opioid dose threshold below which there are no risks for adverse outcomes.
- Even a short-term use of low dose opioids may result in addiction.
- Realization that any initial, short-term functional benefit will likely not be sustained in most patients.
- Patients on opioids may actually experience a functional decline in the long term, measured by factors like returning to employment.
- ***Paradigm shift away from long-term opioid therapy for chronic, non-end-of-life pain management.***

Principles of Pain Management

Pain - Overview

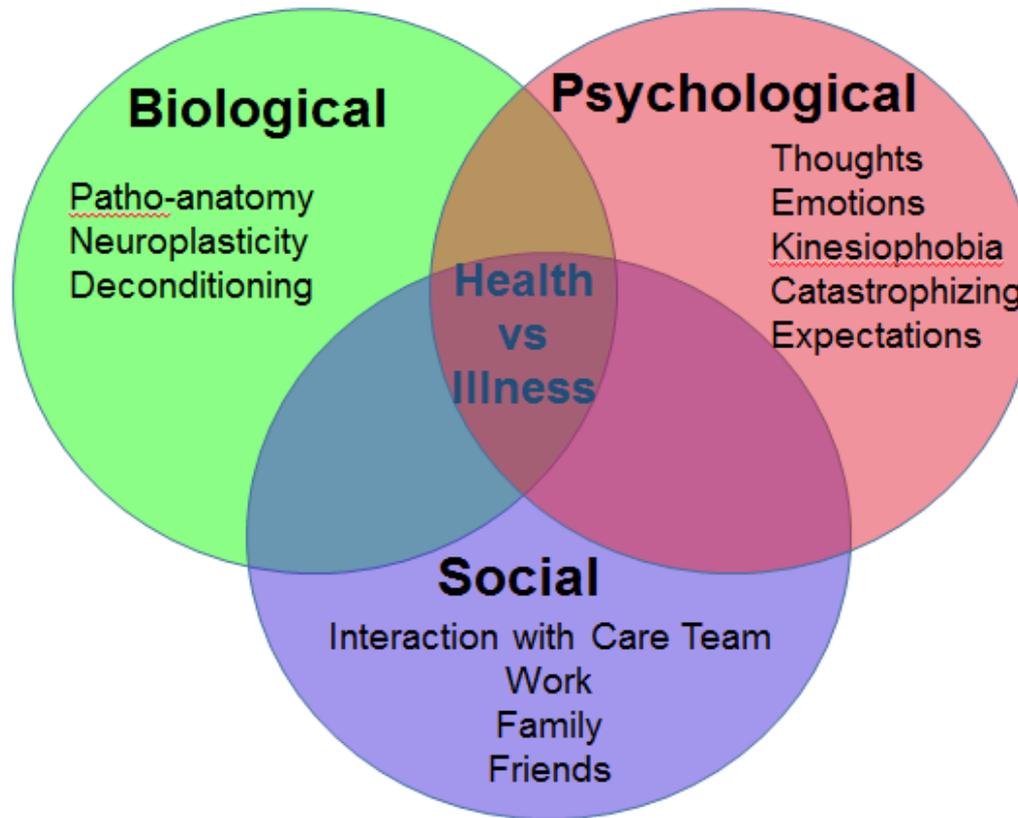
- The IASP definition describes pain as “**an unpleasant sensory and emotional experience**” (International Association for the Study of Pain, 1974)
- Pain is a **complex multidimensional experience** that involves biological, psychological, social, and spiritual domains and is made up of cognitive, emotional, and sensory components.
- When pain becomes persistent, biopsychosocial and behavioral influences change the brain and central nervous system, such that circuits involved in pain processing are sensitized and circuits involved in goal-directed behavior, emotional modulation, and the embodied sense of self appear to be disrupted.
- As pain becomes persistent, the processing of pain in the brain **shifts from nociceptive brain circuits** – where pain perception arises from stimulation of pain sensors – **to brain circuits involved with emotional and cognitive processing.**

Biopsychosocial Model

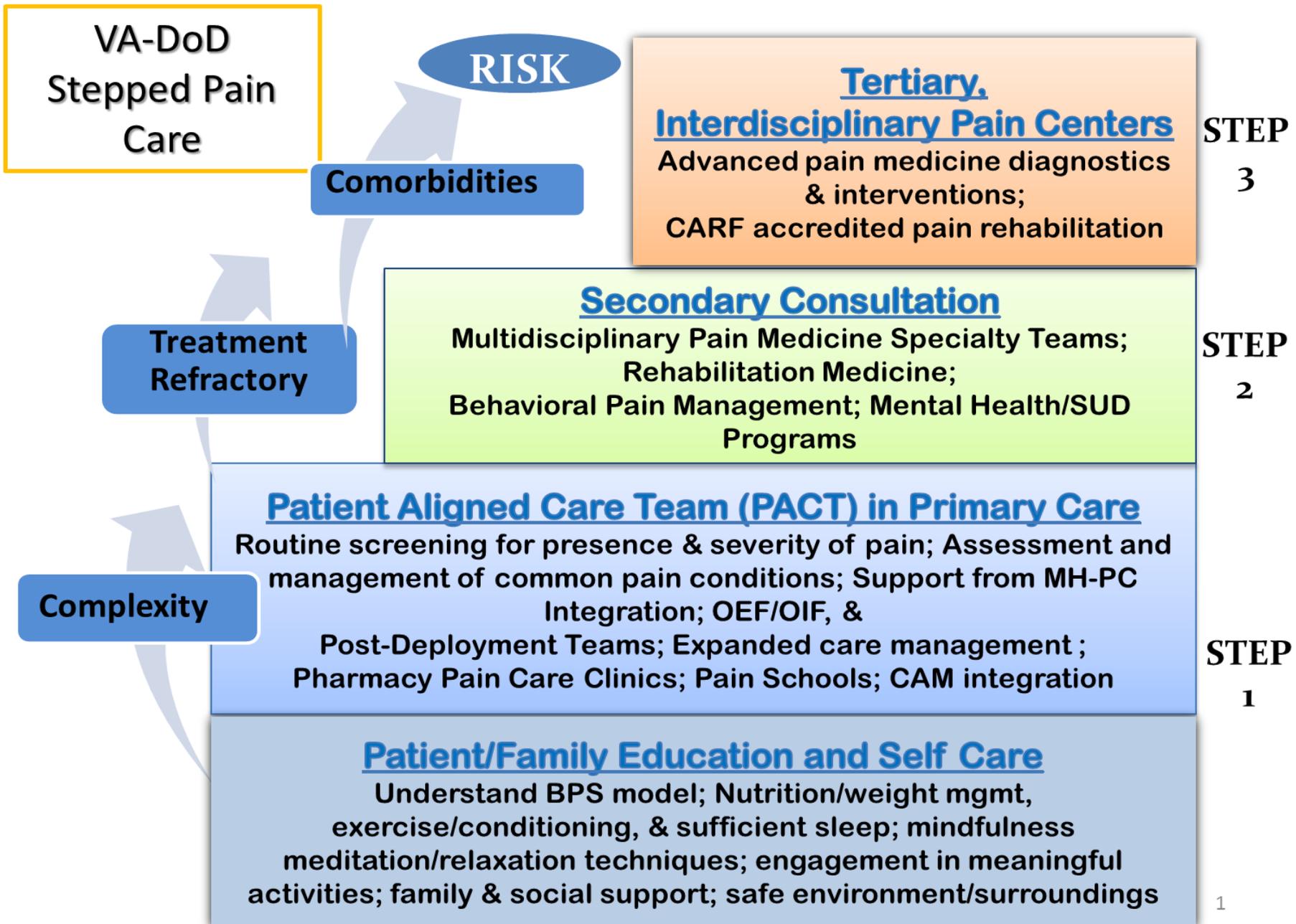
Start with a whole person biopsychosocial assessment.

Assess: sleep, psychiatric co-morbidities, psychosocial-spiritual situation, patient's goals, substances, suicidal ideation, UDT, PDMP, prior records.

Biopsychosocial Model: “Whole Person”



Assess daily function, sleep, psychosocial-spiritual situation, social support, patient’s goals; medical and psychiatric comorbidities, substance use/abuse, suicidal ideation, etc. Include data from urine drug testing, prescription drug monitoring programs, prior records, etc.



Assessing Pain and Function

- Talk to the patient about the pain care plan
- Set realistic goals for pain and function
- Several tools are available
- **PEG**
 - Pain
 - Enjoyment of Life
 - General activity

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*

0 = “no pain”, 10 = “worst you can imagine”

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*

0 = “not at all”, 10 = “complete interference”

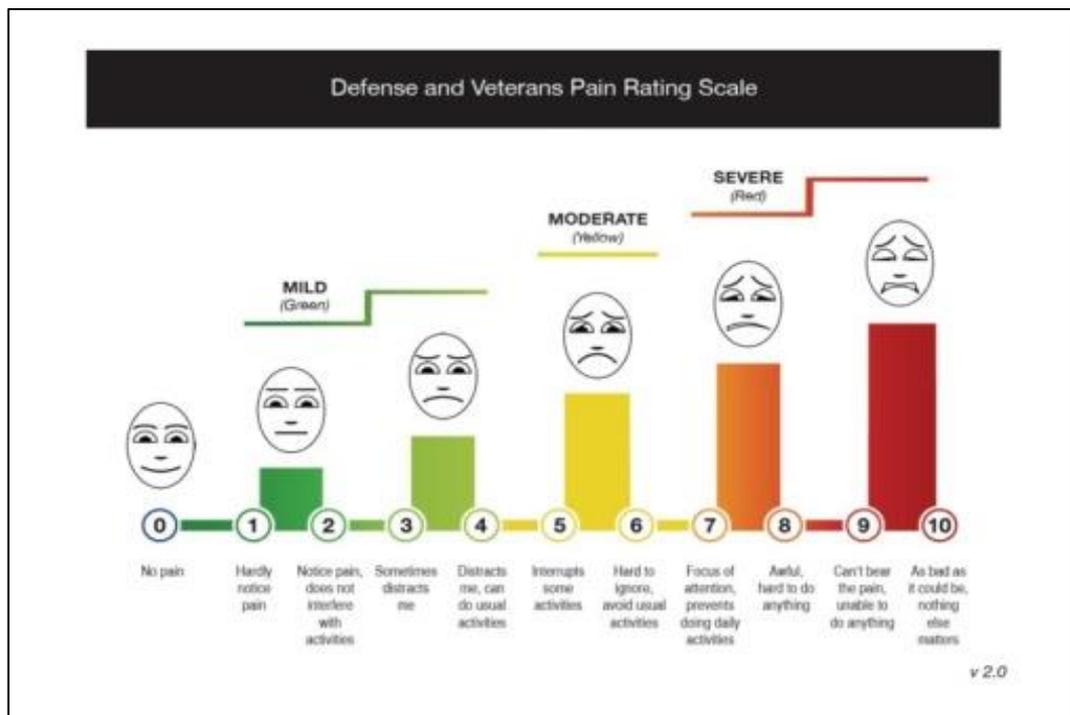
Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0 = “not at all”, 10 = “complete interference”

Assessing Pain and Function

- DVPRS Pain Scale:

- Pain Severity
- Interference: Function, Sleep, Mood, Stress



- NIH Promis

- subset for pain related function

Quality Of Life Scale

A Measure Of Function For People With Pain

0 Non-functioning	Stay in bed all day Feel hopeless and helpless about life
1	Stay in bed at least half the day Have no contact with outside world
2	Get out of bed but don't get dressed Stay at home all day
3	Get dressed in the morning Minimal activities at home Contact with friends via phone, email
4	Struggle but fulfill daily home responsibilities Minimal activities outside of home Not able to work/volunteer
5	Do simple chores around the house Minimal activities outside of home two days a week
6	Work/volunteer limited hours Take part in limited social activities on weekends
7	Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends
8	Work/volunteer for at least six hours daily Have energy to make plans for one evening social activity during the week Active on weekends
9	Work/volunteer/be active eight hours daily Take part in family life Outside social activities limited
10 Normal Quality of Life	Go to work/volunteer each day Normal daily activities each day Have a social life outside of work Take an active part in family life

- American Chronic Pain Association Quality of Life Scale

- 0-worst to 10-best

https://www.theacpa.org/uploads/documents/Quality_of_Life_Scale.pdf

Setting SMART Goals

<u>S</u>pecific	Identifies a specific action or event that will take place
<u>M</u>easurable	Should be quantifiable so progress can be tracked
<u>A</u>chievable	Should be attainable and realistic given resources
<u>R</u>elevant	Should be personally meaningful
<u>T</u>ime-bound	State the time period for accomplishing the goal

Preferred Treatments for Pain

Self-Care and Active Non-Pharmacologic Therapies

- Enhance whole health **self-care** and **lifestyle modification**.
- Provide behavioral, mindfulness, and cognitive therapies.
- Offer **movement therapies**.
- Use **coordinated, team-based** approach.
- Optimize **treatment of co-morbidities**.

Bridging Therapies

- Safe, short-term therapies that are implemented to help patients transition to more active strategies from less safe, passive strategies.
 - Acupuncture
 - Spinal manipulation (e.g., chiropractic)
 - Physical modalities (e.g., self-applied electrical stimulation, etc.)
- Invasive therapies that may be implemented when the benefits of facilitating active treatment strategies outweigh the potential risks of therapy.
 - Trigger point injections
 - Joint injections
 - Nerve blocks
 - Spinal injections

Pharmacological Therapies: Non-Opioids Medications are Preferred

- Non-steroidal anti-inflammatory drugs (NSAIDs) and Acetaminophen.
 - For musculoskeletal/nociceptive pain, not for neuropathic pain.
- Antidepressants* : tricyclic antidepressants (TCAs), serotonin/norepinephrine reuptake inhibitors (SNRIs).
 - For musculoskeletal and neuropathic pain conditions.
- Anticonvulsants*: gabapentin/pregabalin.
 - For neuropathic pain conditions.
- Topical therapies: lidocaine, capsaicin, NSAIDs.
- Muscle relaxants.
 - Usually only short term use.

*Includes off-label use, outside of FDA-approved conditions

CDC

Nonopioid Treatments for Chronic Pain

PRINCIPLES OF CHRONIC PAIN TREATMENT

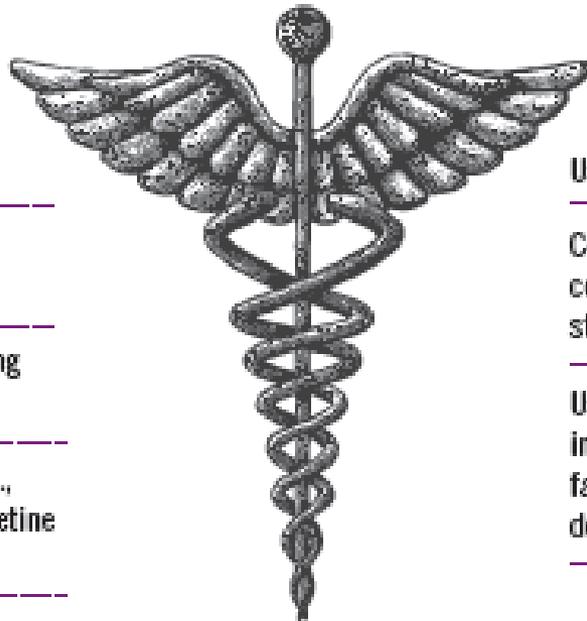
Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

Use nonopioid therapies to the extent possible

Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)

Focus on functional goals and improvement, engaging patients actively in their pain management

Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)



Use first-line medication options preferentially

Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies

Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

Best Practices for Appropriate and Effective Prescribing of Opioid Pain Medications

If Initiation of Opioid Therapy is Considered

The Core Challenge: Finding the Appropriate Place for Opioids
in the Context of Safe and Effective Pain Care

Use Caution When Opioid Therapy is Considered for Acute Pain

- Start with a whole person biopsychosocial assessment.
- **Use caution with all opioid prescribing, including for acute pain**
 - Even a single opioid prescription may increase risk for developing OUD.
 - Often, opioid therapy for an acute pain condition unintentionally becomes long-term opioid therapy.
- ➔ Avoid opioids for minor injuries (e.g. acute low back pains, sprains).
- ➔ When opioids are required for acute pain, prescribe the lowest effective dose of immediate-release opioids for the shortest therapeutic duration.
- ➔ 3 days or less is often sufficient; more than seven days will rarely be needed.
- ➔ Combine opioids with other pharmacological and non-pharmacological modalities – do NOT use opioids in isolation.
- ➔ Do not use long-acting opioid medication for acute pain, as-need pain or postoperatively.
- ➔ Discuss with the patient benefits, side effects and risks (e.g., sedation, addiction, overdose).
- ➔ Check patient understanding of treatment plan.
- ➔ Counsel patients about safe storage and disposal of unused opioids.

Use Caution When Continuation of Opioid Therapy is Considered

For persistent pain:

- In general, opioid therapy should be used only short-term (< 90 days).
- Prescribe lowest effective dose.
- Combine opioids with other pharmacological and non-pharmacological modalities, i.e. “whole person” care.
- Ensure that risks do not outweigh potential modest short-term benefits by utilizing opioid risk assessment tools and risk mitigation strategies.
- **Educate** regarding realistic effects, risks, responsibilities, and goals of therapy.
- Determine realistic goals for pain and **function**.
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Identify **exit strategy**.
- **Reassess benefits/risks within 1 – 4 weeks** after initial assessment.

Risk Factors for Harm from Opioids

- Personal or family history of substance use disorder.
- Psychiatric disorders, including anxiety or depression.
- History of aberrant behavior/non-compliance.
- Age 65 or older.
- Young age (below 30).
- COPD or other underlying respiratory conditions.
- Renal or hepatic insufficiency.
- Pregnancy .



Risk Assessment

- Stratification Tool for Opioid Risk Mitigation (STORM) risk score
 - For all providers.
- Opioid Therapy Risk Report (OTRR) dashboard
 - For Primary Care panel management, accessible from CPRS.
- Comprehensive clinical assessment
 - Biopsychosocial assessment.
- Opioid Risk Tool (ORT)
 - Caution: even patients labeled “low risk” may be at significant risk.

Opioid Risk Assessment and Mitigation: STORM

Stratification Tool for Opioid Risk Monitoring - STORM

- **Leverages VA national data and predictive modeling.**
- States the probability of adverse event within next year (suicide and overdose) and 3 years (suicide and overdose +/- falls and accidents).
- **When considering opioid therapy and for patients on opioids.**
- Key features:
 1. **Identifies patients** at-risk for drug overdose or suicide.
 2. **Lists risk factors** that place patients at-risk.
e.g., co-Rx benzodiazepines, previous adverse events, mental health and medical diagnoses, MEDD.
 3. **Displays risk mitigation strategies, including non-pharmacological treatment options**, that have been employed and/or could be considered.
 4. **Displays upcoming appointments and current treatment providers** to facilitate care coordination.
 5. **Updated nightly.**
- https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx

Continuation of Opioids

Use Caution If Opioid Therapy is Continued

- Combine opioids with other pharmacological and non-pharmacological modalities, i.e. “whole person” care.
- Keep opioid therapy at the lowest effective dosage for the shortest therapeutic duration, in general only short-term (< 90 days).
- **Educate** regarding realistic effects, risks, responsibilities, and goals of therapy.
- Determine/Reassess realistic goals for pain and **function**.
- Prioritize **assessment of function, quality of life, sleep, and mood** over pain intensity.
- **Reassess benefits/risks within 1 – 4 weeks** after initial assessment.
- Follow-up on previously established criteria for regular progress assessment and opioid therapy.
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- Utilize opioid risk assessment and mitigation strategies/tools.

Risk Mitigation

- Patients receiving long-term opioid therapy should be monitored and reassessed at least every 3 months, with the frequency based on risk.
- Innovative strategies for monitoring patients include use of shared medical appointments and utilizing the expanded patient care team.
- Always maintain vigilance for sedation, declining function, evidence of opioid use disorder or other opioid related harms.
- Each follow-up interaction with the patient is an opportunity to provide education about self-management strategies and the risks associated with opioid therapy while optimizing whole person approaches to pain care and treatment of comorbid health conditions.
- Essential components of Opioid Safety include:
 - (1) An informed consent for long-term opioid therapy.
 - (2) Prescription drug monitoring programs (PDMPs).
 - (3) Random urine drug testing.
 - (4) Overdose education, and naloxone distribution as appropriate (OEND).

Informed Consent for Long-Term Opioid Therapy

- **Informed consent (via I-Med) is required for all patients on Long Term Opioid Therapy (LTOT), defined as > 90 days (excluding end-of-life care).**
- Opportunity to discuss risks of and alternatives to long-term opioid therapy with the veteran.
- Provides some protection to provider and facility in case of harm to the patient related to opioid therapy.
- After obtaining the signature informed consent, a copy of the signed document including the brochure “Taking Opioids Responsibly” should given to the patient.

Prescription Drug Monitoring Programs (PDMP)

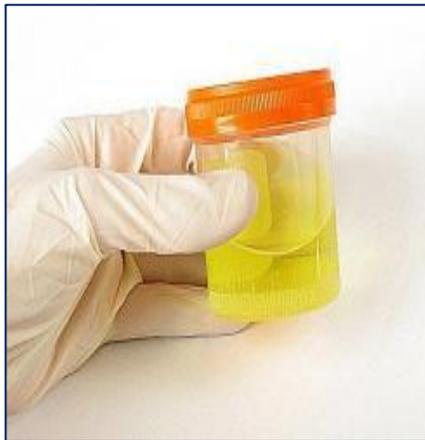
- PDMP is a statewide electronic database that tracks all controlled substance prescriptions.
- Includes prescription data such as dispensed medications and doses.



- All prescribing providers should **register and use** the PDMPs regularly.
- PDMPs improve patient safety by allowing clinicians to:
 - Identify patients who are obtaining opioids from multiple providers.
 - Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.
- Check PDMP prior to initiation of opioids and at least once every 3 months, consider check prior to every opioid prescription (CDC recommendations).
- State requirements vary.

Urine Drug Testing

- Random urine drug testing (UDT) needs to be performed prior to and routinely during opioid prescribing
- Frequency of UDT needs to be based on risk, but at a minimum once every 6 to 12 months for low risk and every 3 months or more frequently for high risk patients



- Determine compliance with prescribed medications
 - Reveal diversion of prescribed substances
 - Identify use of undisclosed substances
 - Enhance patient motivation to adhere to treatment plan
- 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).
 - **Before requesting urine, always ask***:
 - When did you take your last dose? How much?
 - Have you taken any other pain medicine? Any drugs?

*Documentation of this is crucial for interpreting UDT results

Urine Drug Testing

Urine Drug Screening (UDS)

- Enzyme-Multiplied Immunoassay (EMIT)
- Qualitative
- Rapid, inexpensive, widely available
- High sensitivity, with exceptions
- Limited specificity: false positives

• Urine Drug Confirmation Testing*

- Gas Chromatography-Mass Spectrometry (GC-MS)
- Quantitative
- Time consuming, expensive, usually send out
- Very high sensitivity
- Very high specificity

- Interpretation of urine drug testing should be made within the full clinical context of the patient's medical situation.
- **Confirmatory testing is usually necessary to accurately assess an unexpected positive or negative result on UDS.**
- ***Urine Drug Confirmation Testing may also be done by Liquid Chromatography. When available, this is less expensive, has faster turn around times and allows detecting of multiple substance.**

Urine Drug Testing

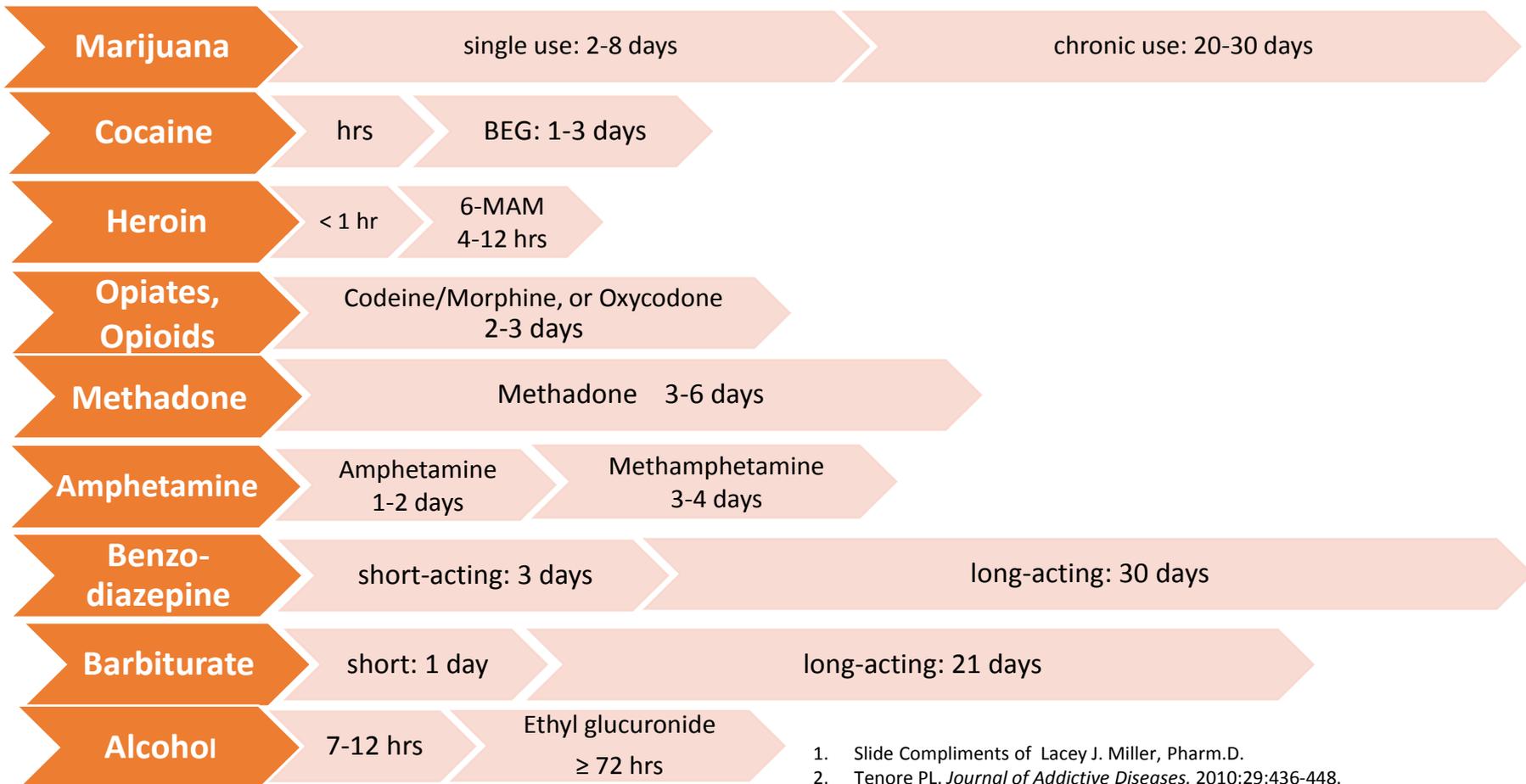
Urine Drug Screening (UDS) for OPIOIDS

Source of Opioid Analgesics		
Natural (from opium)	Semisynthetic (derived from opium)	Synthetic* (man-made)
<ul style="list-style-type: none">• Codeine• Morphine	<ul style="list-style-type: none">• Hydrocodone• Hydromorphone• Oxycodone• Oxymorphone• Buprenorphine	<ul style="list-style-type: none">• Fentanyl• Methadone• Meperidine• Tapentadol• Tramadol
Immunoassay for opiates (UDS) <ul style="list-style-type: none">• High sensitivity• Usually positive	Immunoassay for opiates (UDS) <ul style="list-style-type: none">• Low sensitivity• Positive only if taken in high dosage and recently	Immunoassay for opiates (UDS) <ul style="list-style-type: none">• Inability to detect• Always negative

(*) Specific immunoassay tests and GC-MS are necessary

Urine Drug Testing

Detection Period After Last Dose



1. Slide Compliments of Lacey J. Miller, Pharm.D.
2. Tenore PL. *Journal of Addictive Diseases*. 2010;29:436-448.
3. Standbridge JB, et al. *Am Fam Physician*. 2010;81(5):635-640.
4. Moeller KE, et al. *Mayo Clin Proc*. 2008;83(1):66-76.
5. Gourlay DL, et al. *Connecticut: PharmaCom Group, Inc*;2012.
6. Drug Testing: A White Paper of the American Society of Addiction Medicine. 2013.

Overdose Education and Naloxone Distribution

OEND

- **Overdose Education (OE)**

- Provide patient education on how to *prevent, recognize, and respond* to an opioid overdose.

- **Naloxone Distribution (ND)**

- FDA approved as **naloxone autoinjector and nasal spray**.
- *Dispense and train* patient and caregiver/family.
- Target patient populations: OUD, and prescribed opioids.
- Offer naloxone when factors that increase risk for opioid overdose are present: h/o overdose, h/o SUD, higher opioid dosages (≥ 50 MMED), or concurrent benzodiazepine use.
- OEND provides opportunity to discuss risk; however, naloxone does not eliminate risk or make opioids more effective.

Opioid Risk Assessment and Mitigation: OTRR

Opioid Therapy Risk Report – OTRR

Tool optimized for Primary Care.

- For PACT providers to review their panel for all patients on LTOT.
- Included in CPRS under Tools → Primary Care Almanac.
- Veteran lookup by SSN <http://go.usa.gov/3DH9g>
- Multitude of factors that potentially increase risk incl. MH diagnoses
- Opioid risk mitigation parameters
- Individual report includes Visual display
 - Opioid dosage
 - Pain score (severity)
- Updated nightly
- LTOT definition: opioid dispensed in the last 90 days *and* total days supply \geq 90 days in the past 180 days



Opioid Risk Assessment and Mitigation: STORM

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VHA – Opioid Monitoring/Risk Mitigation Tools

Stratification Tool for Opioid Risk Monitoring – STORM Example



STORM SSN Look-up Report

Stratification Tool for Opioid Risk Mitigation

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ATTENTION: Patient information may only be accessed for the purpose of treatment, payment or health care operations Last Update: 09/14/16

Patient Information	What is my patient's risk-level? (Click + for details)			What factors contribute to my patient's risk?		How can I reduce my patient's risk?				How can I follow-up with this patient?		
	Suicide-related event, overdose, falls or accident 3 yr	Suicide-related event or overdose 1 yr	Overdose or opioid-induced respiratory depression	Relevant Diagnoses	Relevant Medications	Risk Mitigation Strategies		Non-pharmacological Pain Treatment		Recent Appointments	Upcoming Appointments	Care Providers
John Smith Last Four: 5555 Age: 55 Gender: M Station: 100 Chart Review Note <i>Palliative Patient</i>	Very High 71% risk of suicide-related event, overdose, falls or accidents in the next three years	Very High 16% risk of suicide-related event or overdose in the next year	Risk Class: 9 RIOSORD Score: 64	SUD Dx: Other SUD Mental Health Dx: PTSD Bipolar Other MH Medical Dx: Chronic Pulm Dis. Electrolyte Disorder Hypertension Liver Disease Non-metast. Tumor Coagulopathy Deficiency Anemia	Active Opioids: Morphine - Chronic Hydrocodone - Chronic	MEDD <= 100** <input type="checkbox"/> MEDD: 220 Naloxone Kit <input type="checkbox"/> Opioid Signed Informed Consent <input checked="" type="checkbox"/> 10/10/10 Timely Follow-up <input checked="" type="checkbox"/> 10/10/10 Primary Care Timely UDS <input checked="" type="checkbox"/> 10/10/10 Psychosocial Assessment <input checked="" type="checkbox"/> 10/10/10 Psychosocial Tx <input checked="" type="checkbox"/> 10/10/10 Active SUD Tx <input type="checkbox"/> Bowel Regimen <input checked="" type="checkbox"/> 10/10/10 Med. Reconciliation <input checked="" type="checkbox"/> 10/10/10	Active Therapies <input type="checkbox"/> CIH Therapies <input type="checkbox"/> Chiropractic Care <input type="checkbox"/> Occupational Therapy <input checked="" type="checkbox"/> Pain Clinic <input checked="" type="checkbox"/> Physical Therapy <input checked="" type="checkbox"/> Specialty Therapy <input type="checkbox"/> Other Therapy <input checked="" type="checkbox"/>	Primary Care: 10/10/10 Primary Care/Medicine Mental Health: 10/10/10 Mental Health Clinic - Ind Pain Clinic: None Other: 10/10/10 Telephone Primary Care	Primary Care: None Mental Health: 10:00 AM Mental Health Clinic - Ind Pain Clinic: None Other: 10/10/10 10:00 AM Hepatology Clinic	Recent Opioid Prescriber: Primary Care Provider: MH Tx Coordinator: BHIP Team:		

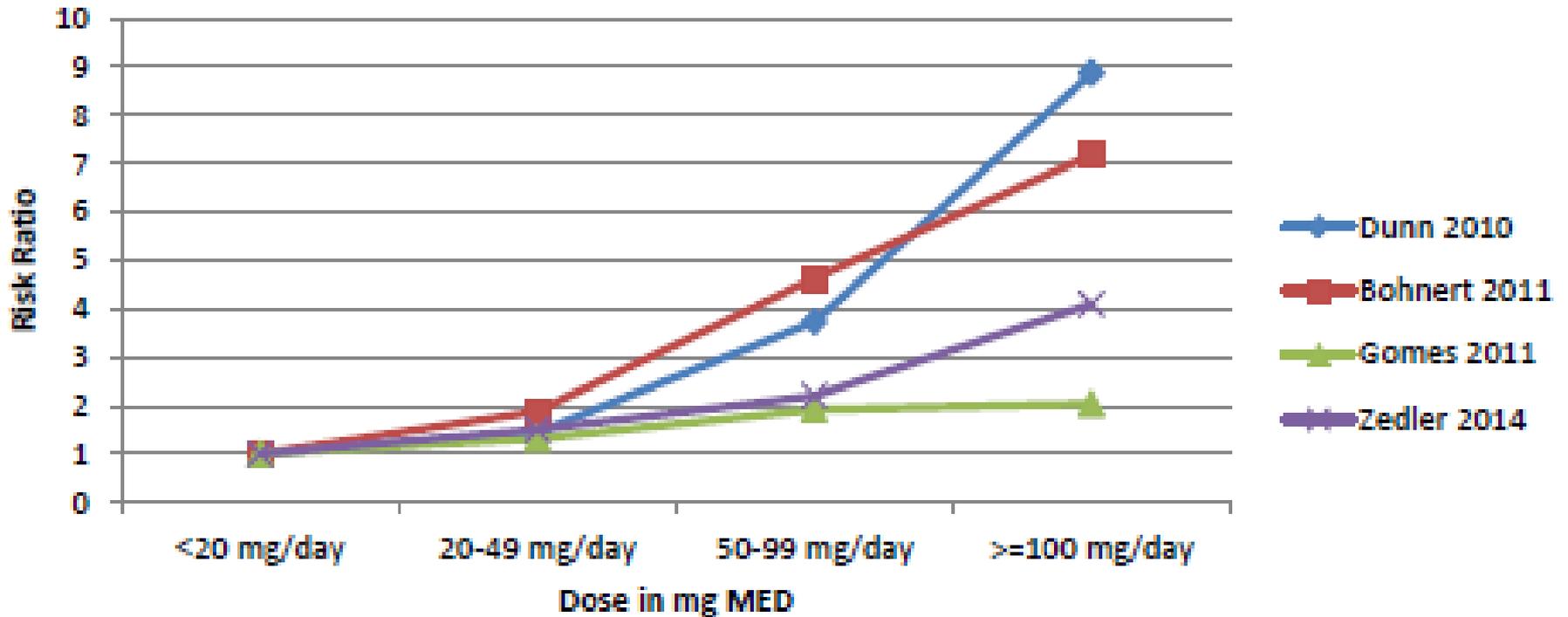
Opioid Risk Increases with Dosage

Prescription risk factors:

- **No completely safe opioid dose.**
- **Risk increases with dose** and begins to significantly increase at 20-50 mg/d MED.
- **Generally avoid increasing above 50 mg/d MED** and if > 50 mg/d MED then **MUST** add additional precautions including more frequent monitoring; Avoid increasing above 90 mg/d MED.
- Avoid combining with **benzodiazepines.**

Opioid Risk Increases with Dosage

Risk of Overdose Event



Washington State - Interagency Guidelines on Prescribing Opioids for Pain

Dose Related Risk of Death from Opioids

“We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.”

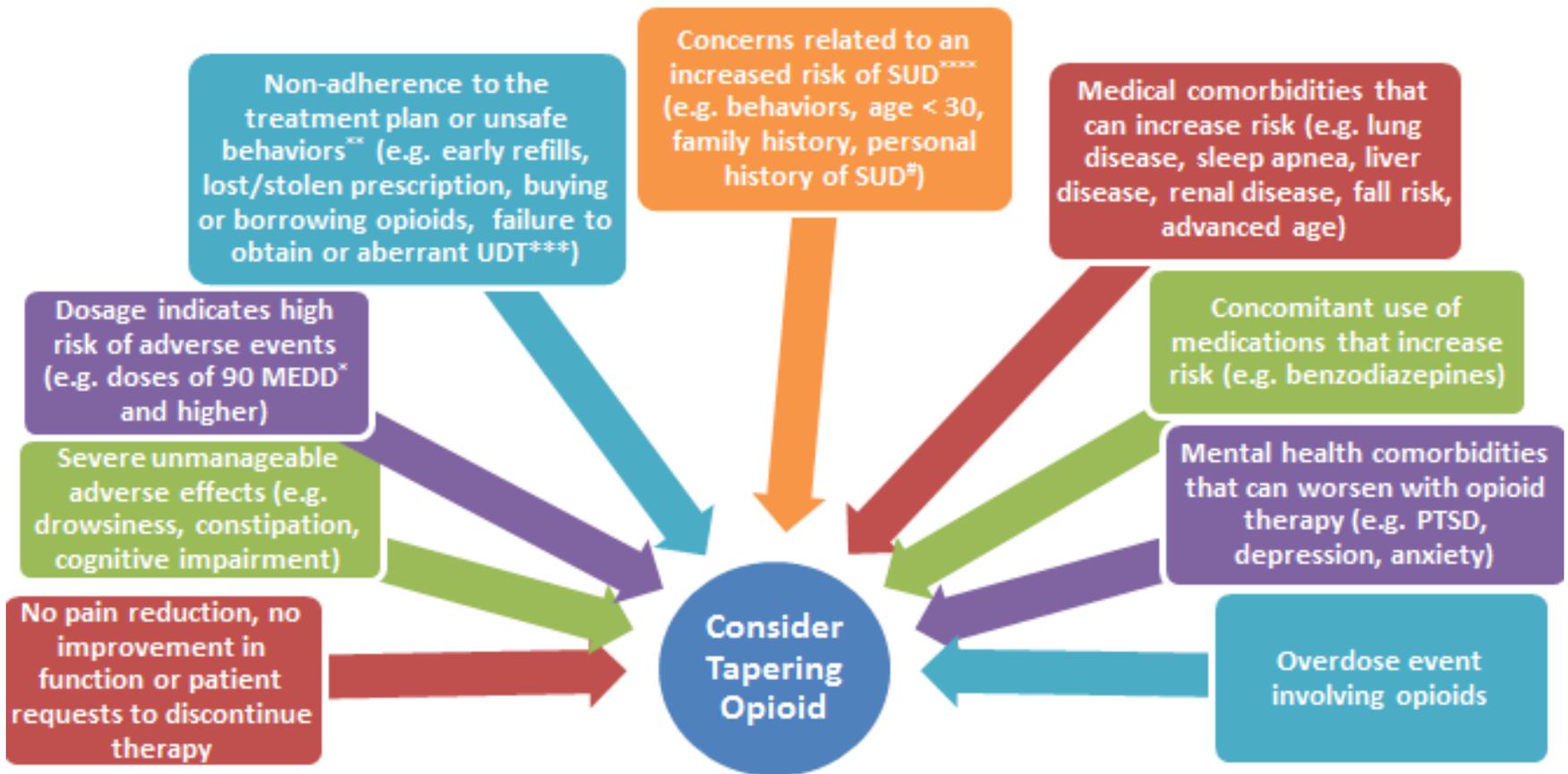
- **“1 in every 550 patients** started on opioid therapy died... a median of 2.6 years after the first opioid prescription”
- **“as high as 1 in 32** among patients receiving doses of 200 MME”

Frieden and Houry, NEJM, 2016

MME = Morphine Milligram Equivalent dosage per day

Tapering and Discontinuing Opioids

Indications for Opioid Tapering



Tapering/Discontinuation of Opioids

Indications

- Risks outweigh benefits.
- Treatment goals not met.
- Opioid use disorder suspected.
- Unsafe or illegal behaviors.
- Non-adherence to treatment plan.
- Severe side effects.
- Patient preference.

Process

- Individualize care plan.
- Optimize whole person care.
 - Psychological, physical, social, spiritual support
- Gradual taper preferred if safety allows.
 - Can reduce by 5-20% per month.
- Frequent monitoring by team.
- Vigilance for unmasked opioid use disorder.
- Seek specialty consultation for moderate and high risk patients.

Opioid Tapering Considerations

- Determine if the initial goal is a dose reduction or complete discontinuation. If initial goal is determined to be a dose reduction, subsequent regular reassessment may indicate that complete discontinuation is more suitable.
- Several factors go into the speed of taper selected:
 - **Slower, more gradual tapers are often the most tolerable and can be completed over a several months to years based on the opioid dose**
 - The longer the duration of previous opioid therapy, the longer the taper
- **Most commonly, tapering will involve dose reduction of 5-20% every 4 weeks**
- More rapid tapers may be required in certain instances like drug diversion, illegal activities, or situations where the risks of continuing the opioid outweigh the risks of a rapid taper.
- Document the rationale for the opioid taper and the opioid taper schedule in the Veteran's medical record.
- Strongly caution patients that it takes as little as a week to lose their tolerance and that they are at risk of an overdose if they resume their original dose.

Academic Detailing

Examples for Opioid Tapering

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

Academic Detailing:

During the taper: Follow up with the Veteran

Follow-up with the Veteran during the taper:

Follow-Up	Slowest Taper (over years)	Slower Taper (over months)	Faster Taper (over weeks)	Rapid Taper (over days)
When	1 to 4 weeks after starting taper then monthly before each reduction	1 to 4 weeks after starting taper then monthly before each reduction	Weekly before each dose reduction	Daily before each dose reduction or if available offer inpatient admission
Who	PACT Team*			
How	Clinic and/or telephone**	Clinic and/or telephone**	Clinic and/or telephone**	Hospital, clinic or telephone**
What	Patient function,*** pain Intensity, sleep, physical activity, personal goals, and stress level			
*Follow-up for tapering is recommended to be a team function with various team members taking on roles in which they have demonstrated specific competencies. Mental Health practitioners may need to be included in the follow-up plan.				
**Providers will need to determine whether a telephone or in clinic appointment is appropriate based on the risk category of the Veteran. A Veteran with high risk due to a medical condition may have decompensation during the taper and may require a clinic visit over telephone follow-up. If there are issues with the Veteran obtaining outside prescriptions or they are displaying other aberrant behaviors during the taper, providing follow-up in a clinic visit may be more optimal than a telephone visit.				
***Quality of Life Scale for patients with pain: https://www.theacpa.org/uploads/documents/Quality_of_Life_Scale.pdf				

Potential Substance Use Disorders

Identification, Referral, and Treatment

Key Points: Opioid Use Disorder and Long Term Opioid Therapy

- Anyone can develop opioid use disorder (OUD).
- Even without other known risk factors for OUD, patients receiving opioids for pain are all at risk for developing OUD.
- OUD Risk increases with duration of therapy and with dosage.
- OUD is a chronic disease, not a “moral weakness” or willful choice.
- OUD, like other diseases (e.g. hypertension), often requires chronic treatment.
- Patients with OUD can achieve full remission.
- Using medication-assisted treatment (MAT) for OUD saves lives.
- MAT is always assisting core therapies for psycho-social-spiritual wholeness and well-being.

DSM-5 Criteria for OUD (prescription opioids)

(2 or more of the following criteria)

DSM-5 Criteria	Example behaviors
Craving or strong desire to use opioids	Describes constantly thinking about opioids
Recurrent use in hazardous situations	Repeatedly driving under the influence
Using more opioids than intended	Repeated requests for early refills
Persistent desire/unable to cut down or control opioid use	Unable to taper opioids despite safety concern or family's concern
Great deal of time spent obtaining, using or recovering from the effects	Spending time going to different doctor's offices and pharmacies to obtain opioids
Continued opioid use despite persistent opioid-related social problems	Marital/family problems or divorce due to concern about opioid use
Continued opioid use despite opioid-related medical/psychological problem	Insistence on continuing opioids despite significant sedation
Failure to fulfill role obligations	Poor job/school performance; declining home/social function
Important activities given up	No longer active in sports/leisure activities

Opioid Use Disorder

Principles

- Vigilance for signs and symptoms of OUD, particularly when tapering LTOT.
- MAT and behavioral treatment when OUD is identified.
- Pain and OUD can and often does co-exist along with psychiatric comorbidities.

Toolbox

- Integrated SUD, pain, mental health, and primary care teams.
- VA/DoD 2015 SUD CPG.
- DSM-5 criteria for OUD.
- Buprenorphine waiver training.
- Clinical Opioid Withdrawal Scale.

Urine Drug Testing

- Urine drug testing can serve as a helpful diagnostic and educational tool.
- Interpretation of urine drug testing should be made within the full clinical context of the patient's medical situation.
- Confirmatory testing is usually necessary to accurately assess an unexpected positive or negative result.
 - Possible **Red Flags** that require further evaluation can include:
 - Negative for opioid(s) prescribed.
 - Positive for prescription medications not prescribed. (benzodiazepines, opioids, stimulants, etc.)
 - Positive for illicit substances.
 - Positive for alcohol or alcohol metabolites.

Approach to Unexpected UDT Result

- Obtain confirmatory drug test to follow up on the “**Red Flag**”.
- If testing confirms the red flag result (e.g. positive for amphetamines), further action is necessary (and must be documented).
- Patient takes the prescribed drug (UDT is **positive for prescribed opioids**): have a discussion with the patient, come up with a plan (consider a controlled taper &/or MAT, and consultation with/referral to an addiction treatment program)
- Patient does not take prescribed opioid (**UDT is negative**): have a discussion with the patient, come up with a plan (discontinue opioids, consider consultation with/referral to an addiction treatment program).

Principles of Engaging Patient

Treatment works	Treatment is more effective than no treatment; medication-assisted treatment (MAT) has been shown to be more effective than treatments without MAT for moderate to severe OUD
Respect patient preference	Consider the patient's prior treatment experience and respect patient preference for the initial intervention
Use motivational interviewing (MI) techniques	Emphasize common elements of effective interventions (e.g. improving self-efficacy for change, promote therapeutic relationship, strengthen coping skills, etc.)
Emphasize predictors of successful outcomes	<ul style="list-style-type: none">• Retention in formal behavioral and well-being treatment• Adherence to medications for OUD• Active involvement with community support for recovery
Promote mutual help programs*	Narcotics Anonymous (NA)

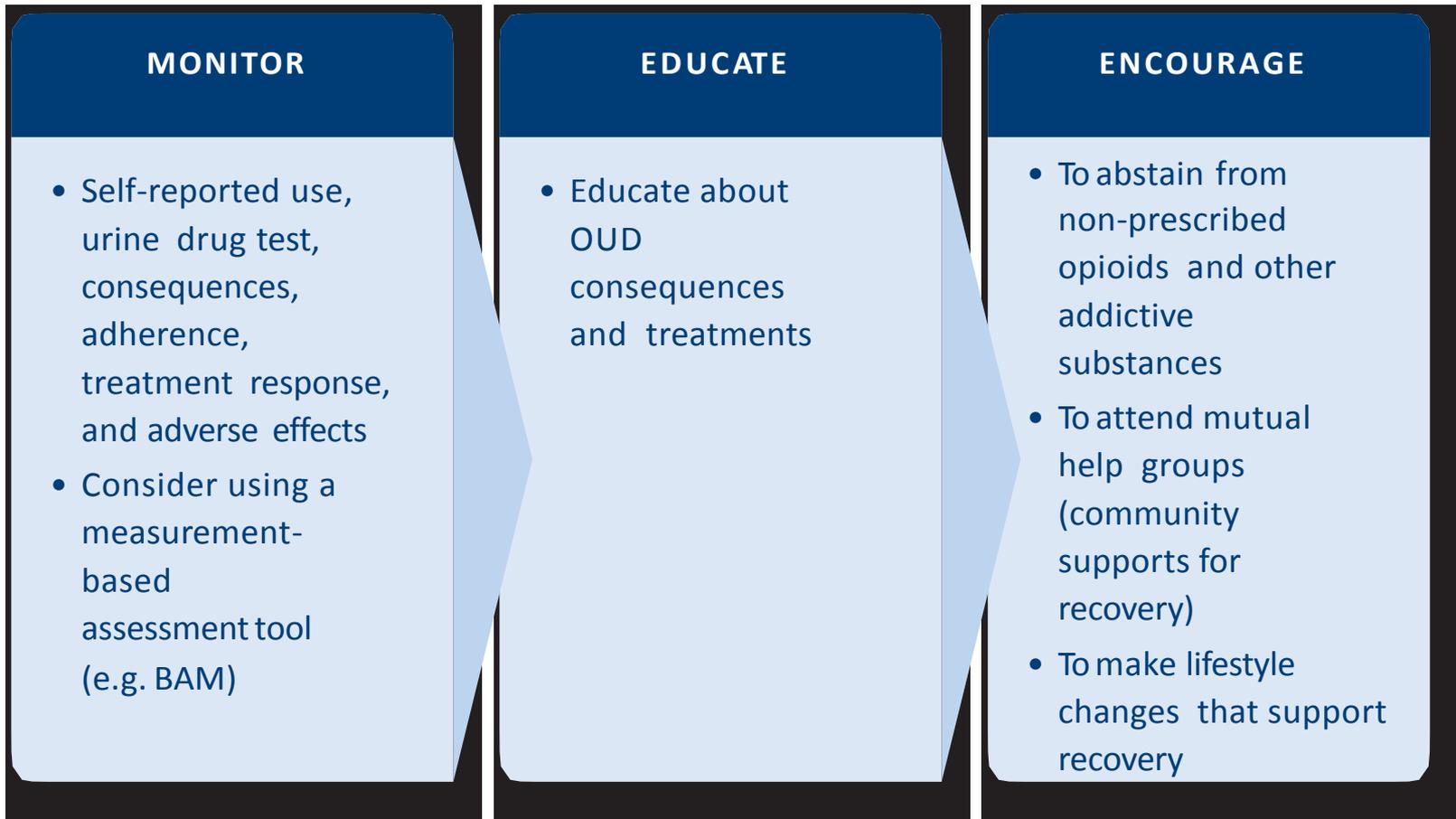
Principles of Engaging Veterans about OUD

Address concurrent problems and pursue Whole Health and Well-Being (not just disease management)	Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems and with effective well-being strategies
Promote least restrictive setting	Provide intervention in the least restrictive setting necessary to promote access to care, safety, and effectiveness
Emphasize that options will remain available	If unwillingness remains, maintain MI style, emphasize that options remain, determine where medical/psychiatric problems managed,** look for opportunities to engage

Medication Assisted Treatment (MAT) along with Addiction Focused Medical Management and/or Addiction Treatment

- Is considered 1st line treatment for OUD.
- Allows the patient to **focus more readily on recovery activities by preventing withdrawal and reducing cravings.**
- Helps achieve long-term goal of reducing opioid use and the associated negative medical, legal, and social consequences, including death from overdose.
- **In patients with an active OUD, opioid withdrawal management should be followed by treatment with OUD pharmacotherapy (MAT). Do NOT provide withdrawal management alone due to high risk of relapse and overdose.**
- **Do not provide MAT as sole therapy; MAT is assisting therapies for psycho-social-spiritual wholeness and Well-being.**

Addiction-focused medical management management*



*Session structure varies according to the patient's substance use status and treatment compliance.

BAM = Brief Addiction Monitor

Comparison of Methadone and Buprenorphine/Naloxone

	Buprenorphine/Naloxone**	Methadone
Treatment setting	Office-based	Specially licensed OTP
Mechanism of action	Partial opioid agonist*	Opioid agonist
FDA approved for OUD	Yes	Yes
Reduces cravings	Yes	Yes
Best for mild, moderate, or severe OUD?	Mild—Moderate	Mild, Moderate, and Severe
Candidates and history of failed treatment attempts	None/few failed attempts	Many failed attempts
Recommended for OUD candidates with pain conditions requiring ongoing short-acting opioids?	No	Yes
Psychosocial intervention recommendations	Addiction-focused MM	Individual counseling and/or contingency management

Extended-Release Injectable Naltrexone

- FDA-approved for the prevention of relapse in adult patients with OUD following complete detoxification from opioids.
- Recommended for patients unable/unwilling to take OAT (Opioid Agonist Therapy) and have not used an opioid in the past 7-14 days).
- Consider Naltrexone IM in patients with comorbid OUD and Alcohol Use Disorder.

Patients with OUD and Pain - **Avoid**

- Opioid analgesics.
- Sedative-hypnotics.
- Muscle relaxants.
- Other medications with potential for addiction.

Patients with OUD and Pain – Recommend

- **Nonpharmacological therapies**
 - Cognitive behavioral therapy (CBT) and /or Acceptance and Commitment Therapy (ACT) for pain, as well as other effective trainings for empowering Whole Health and Well-being.
 - Pain school or behavioral groups.
 - Support groups/Community support.
 - Rehabilitation therapies (e.g. physical therapy and occupational therapy).
 - Specialty procedures (e.g. injections, nerve blocks).
 - Complementary and alternative therapies (e.g. acupuncture, massage, Tai Chi).
- **Non-opioid medications**
 - SNRI or low dose TCA.
 - Gabapentin/pregabalin
 - Acetaminophen, NSAIDs
 - Topicals (e.g. lidocaine, capsaicin)
- **Assessment for and treatment of co-morbid psychiatric conditions* (e.g. PTSD, insomnia, anxiety)**

Proper Methods for Disposing of Controlled Substances

Medication Safety Steps You Should Take

- Consider **writing prescriptions in smaller amounts when appropriate** to prevent the accumulation of unneeded medication in the home.
- **Educate patients about safely storing their medication.**
 - Tell patients to secure their medications in an area where others do not have ready access to them or a locked box.
 - Studies show the majority of people misusing controlled substances get them from family and friends, often out of a medicine cabinet.
- **Educate patients about safe disposal options.**
 - All VHA facilities should have mail back envelopes.
 - Some facilities also have on-site receptacles.
- Ask patients not to advertise to others that they are taking these types of medications and to keep their medications secure.

Medication Mail-Back Programs

- VHA has partnered with a DEA registered reverse distributor to provide mail back envelopes to Veterans.
 - All VA facilities should have envelopes. Check with Pharmacy if in need.
 - Pharmacy can also mail envelopes to patients if the need is identified (e.g., by a Home Based Primary Care visit, or patient phone call).
 - There are flyers posted on the PBM intranet that can be used to education patients.
 - Only legally obtained, patient owned medications may be placed in mail-back envelopes and receptacles.
 - Controlled and non-controlled medications may be co-mingled in mail-back envelopes and receptacles.

It is illegal for pharmacist, technicians, nurses, physicians or any health care worker to take controlled substances directly back from patients.

- Exception in long term care – staff may assist patient or dispose of medications if patient leaves or expires.

Disposal Instructions for Patients

Disposal Instructions for unused medications:

Mix with coffee grounds or cat litter and dispose in trash, outside the reach of any children.

- Drug disposal information (DEA):

http://www.dea.gov/diversion/usdoj.gov/drug_disposal/index.html

- VHA Information for patients:

<http://www.pbm.va.gov/vacenterformedicationsafety/vacenterformedicationsafetyprescriptionsafety.asp>

- PBM Intranet, marketing materials, staff education and other resources:

[https://vaww.cmopnational.va.gov/cmop/PBM/Medication Disposal for Patients](https://vaww.cmopnational.va.gov/cmop/PBM/Medication%20Disposal%20for%20Patients)

Opioid Prescribing Recommendations: Summary of 2016 CDC Guidelines

Determining when to initiate or continue opioids for chronic pain

- Opioids are not first-line or routine therapy
- Establish treatment goals before starting opioid therapy and a plan if therapy is discontinued
- Only continue opioid if there is clinically meaningful improvement in pain and function
- Discuss risks, benefits and responsibilities for managing therapy before starting and during treatment

Opioid selection, dosage, duration, follow-up and discontinuation

- Use immediate-release (IR) opioids when starting therapy
- Prescribe the lowest effective dose
- When using opioids for acute pain, provide no more than needed for the condition
- Follow up and review benefits and risks before starting *and* during therapy
- If benefits do not outweigh harms, consider tapering opioids to lower doses or taper and discontinue

Assessing risk and addressing harms of opioid use

- Offer risk mitigation strategies, including naloxone for patients at risk for overdose
- Review PDMP* data at least every 3 months and perform UDT** at least annually***
- Avoid prescribing opioid and benzodiazepines concurrently when possible
- Clinicians should offer or arrange MAT**** for patients with OUD†

*Prescription drug monitoring program

**Urine drug testing

***Some VA facilities may require more frequent testing

****Medication-assisted treatment

†Opioid use disorder

Website

Website – www.va.gov/painmanagement



Intranet - vaww.va.gov/painmanagement

CDC and Turn The Tide: Resources

ASSESSING BENEFITS AND HARMS OF OPIOID THERAPY

THE OPIOID CRISIS

The United States is the only nation in the world to experience an epidemic of opioid overdose deaths, which killed more than 16,000 people in 2014 alone.

Since 2010, rates of prescription opioid use and related overdose deaths have quadrupled.

ASSESS BENEFITS OF OPIOID THERAPY

How do we get the best of both worlds? In 2015, the CDC published a new report on the benefits and harms of opioid therapy. The report is based on a review of the scientific literature and includes a checklist for clinicians to use when prescribing opioids for chronic pain.

1. **What is the patient's pain and how long has it lasted?**
2. **What is the patient's current pain management plan?**
3. **What are the risks and benefits of opioid therapy for this patient?**
4. **What are the risks and benefits of non-opioid therapy for this patient?**

FOR MORE INFO:

U.S. Department of Health and Human Services
 2015-2016 | www.cdc.gov/drugoverdose/pdf/assessing_benefits_harms_of_opioid_therapy-a.pdf

Checklist for prescribing opioids for chronic pain

FOR CLINICIANS WHO WRITE 15- or 30-day OPICOID PRESCRIPTIONS FOR CHRONIC PAIN

WHEN TO CONSIDER OPIOID THERAPY

- The patient has long-term (chronic) pain that is not controlled by non-opioid therapy.
- The patient has a clear goal for pain management.
- The patient has a clear understanding of the risks and benefits of opioid therapy.
- The patient has a clear understanding of the risks and benefits of non-opioid therapy.
- The patient has a clear understanding of the risks and benefits of opioid therapy.

WHEN TO AVOID OPIOID THERAPY

- The patient has a history of substance use disorder.
- The patient has a history of respiratory depression.
- The patient has a history of respiratory depression.
- The patient has a history of respiratory depression.
- The patient has a history of respiratory depression.

WHEN YOU PRESCRIBE

- Prescribe the lowest effective dose.
- Prescribe the shortest duration of therapy.
- Prescribe the most appropriate formulation.
- Prescribe the most appropriate formulation.
- Prescribe the most appropriate formulation.

FOR MORE INFO:

U.S. Department of Health and Human Services
 2015-2016 | www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDANCE

BEFORE PRESCRIBING

1. **ASSESS THE PATIENT'S PAIN**
2. **ASSESS THE PATIENT'S CURRENT PAIN MANAGEMENT**
3. **ASSESS THE PATIENT'S RISK OF HARM**
4. **ASSESS THE PATIENT'S NEED FOR OPIOID THERAPY**

WHEN YOU PRESCRIBE

- Prescribe the lowest effective dose.
- Prescribe the shortest duration of therapy.
- Prescribe the most appropriate formulation.
- Prescribe the most appropriate formulation.

FOR MORE INFO:

U.S. Department of Health and Human Services
 2015-2016 | www.turnthetiderx.org/wp-content/uploads/2016/08/PocketGuide_FINAL6.pdf

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Chronic pain is a complex condition that requires a comprehensive approach to treatment. The goal of treatment is to reduce pain, improve function, and enhance quality of life. This approach includes a combination of non-opioid medications, behavioral therapies, and physical therapies.

NONOPIOID MEDICATIONS

Medication	Typical Dose	Notes	Comments
Acetaminophen	325-650 mg q4-6h	Do not exceed 4g/day	Effective for mild to moderate pain
NSAIDs (e.g., ibuprofen, naproxen)	200-400 mg q6-8h	Use with caution in patients with kidney, stomach, or heart disease	Effective for moderate to severe pain
Antidepressants (e.g., duloxetine, nortriptyline)	As directed	May take several weeks to become effective	Effective for chronic pain, especially neuropathic pain
Anticonvulsants (e.g., gabapentin, pregabalin)	As directed	May take several weeks to become effective	Effective for chronic pain, especially neuropathic pain

FOR MORE INFO:

U.S. Department of Health and Human Services
 2015-2016 | www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf

http://www.cdc.gov/drugoverdose/pdf/assessing_benefits_harms_of_opioid_therapy-a.pdf

http://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

http://turnthetiderx.org/wp-content/uploads/2016/08/PocketGuide_FINAL6.pdf

http://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf

The Six Essential Elements of Good Pain Care

-  1. Educate Veterans / families and promote self-efficacy
-  2. Educate / train all team members
-  3. Develop non-pharmacological modalities
-  4. Institute safe medication prescribing, including safe opioid use
-  5. Develop approaches to bringing the Veteran's expanded team together (virtual pain consulting and education as well as ongoing communication between team members)
-  6. Establish metrics to monitor pain care

End of Teaching Material

VA Technical Assistance

- [**VA National OEND SharePoint**](#) (Step-by-step implementation instructions; implementation models)
- [**VA OEND Videos**](#) (links to all 5 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 Auto-Injector Naloxone Kit <https://youtu.be/-DQBCnrAPBY>
 - How to Use the VA Intranasal Naloxone Kit <https://youtu.be/WoSfEf2B-Ds>
- [**VA OEND Naloxone Kit Distribution Report**](#)
- [**VA Academic Detailing**](#)
 - Patient education brochures, “Kit” brochures, DVDs for providers and patients—order through [depot](#)
- [**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](#)
- **Accredited TMS training:** TMS trainings 27440 and 27441