CDC and VA/DoD on the Offense: How Are We Addressing the National Opioid Epidemic?

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CPE Information

- Target Audience: Pharmacists & Technicians
- ACPE#: 0202-0000-16-158-L04-P/T
- Activity Type: Knowledge-based

CPE Information and Disclosures

Mitchell Nazario, Pharm.D.: declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Learning Objectives

At the completion of this activity, participants will be able to:
1. Describe the epidemiology of opioid use and abuse in the United States.
2. Recognize the three areas of consideration with the corresponding recommendations outlined in the CDC Guideline for Prescribing Opioids for Chronic Pain.
3. Explain the VA Opioid Safety Initiative and the metrics that are being monitored for safe opioid use within the veteran population.
4. Describe the opioid risk assessment and stratification tools and their utility in guiding opioid therapy.

Self-Assessment Questions

1. The CDC Guidelines for prescribing opioids for chronic pain establish prescriptive standards for chronic opioid use. T or F
2. Both the CDC and the VA/DOD guidelines recommend urine drug testing, PDMP monitoring and distribution of the naloxone kit as risk mitigation strategies. T or F
3. A 9-fold increase in opioid OD has been reported in patients receiving high dose opioids (> 100mg MEDD) compared to low dose (< 20mg MEDD). T or F

Chronic Disease Prevalence

Atkinson T, Guldem Ah, Forkum WG. The future of pain pharmacy: driven by need. Integrated Pharmacy Research and Practice 2016: 5 33–42
Drug overdose deaths in the United States hit record numbers in 2014

- More people died from drug overdoses in 2014 than in any year on record.
- The majority of drug overdose deaths (more than six out of ten) involve an opioid.
- Since 1999, the number of overdose deaths involving opioids (including prescription opioid pain relievers and heroin) nearly quadrupled.
- From 2000 to 2014, nearly half a million people died from drug overdoses.

https://www.cdc.gov/drugoverdose/epidemic/

Opioid Overdose Data

- In 2012, 259 million prescriptions for opioid pain medication were written. That is equivalent to every adult having their own bottle of pills (such as oxycodone, hydrocodone or methadone).
- Since 1999, the number of sales and the number of deaths related to prescription opioids quadrupled.
- One in 4 people receiving prescription opioids for long term, non-cancer pain struggles with addiction.
- The 2013 and 2014 National Survey on Drug Use and Health (NSDUH), reported that 50.5% of people who misused prescription painkillers got them from a friend or relative for free, and 22.1% got them from a doctor.

http://www.samhsa.gov/disorders/substance-use
https://www.cdc.gov/drugoverdose/epidemic/

Opioid Overdose Data

- More than 1,000 people are treated every day in emergency departments for the misuse of prescription opioids.
- About 78 people die each day from opioid overdose.
- The average age for first-time use of a prescription painkiller is 21.2 years.
- The overdose rate of an opioid is highest among adults aged 25-54 years.
- People addicted to prescription opioids are 40 times more likely to be addicted to heroin.

http://www.samhsa.gov/disorders/substance-use
https://www.cdc.gov/drugoverdose/epidemic/

High-Dose Opioid Analgesics

- A 9-fold increase in opioid OD has been reported in patients receiving high dose opioids (> 100mg MEDD) compared to low dose (< 20mg MEDD)
- Patients on > 120mg MEDD were more likely to have alcohol or drug related encounters (intoxication, withdrawal, OD)
- A reduction in the proportion of patients receiving > 120mg MEDD resulted in a 50% reduction in opioid related deaths.


Deaths from OD and Opioids Prescribing Patterns

JAMA 2011; 305: 1315-1321

- Veterans are twice as likely to die from accidental OD compared to non-Veteran population
- Veterans with PTSD are more likely to:
  - Be prescribed opioids at higher doses
  - Receive opioids and sedative hypnotics (including benzodiazepines) concurrently
- Opioid use in Mental Health populations is associated with:
  - Opioid-related, alcohol, and non-opioid drug related accidents and overdoses
  - Self-inflicted injuries and violence related injuries
  - Higher incidence of wounds or injuries

https://www.cdc.gov/drugoverdose/epidemic/
Opioid Epidemic: How to Address?

- Washington State Interagency Guideline for Prescribing Opioids for Pain
- National Pain Strategy
- CDC Guidelines
- VA/DOD Guidelines
- APS/AAPM Guidelines
- VA Pain Initiatives/Directives
  - Opioid Safety Initiative
  - Opioid Education and Naloxone Distribution
  - AI for the review of appropriateness of opioid therapy at > 100mg MEDD

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016

Introduction

This guideline provides recommendations for the prescribing of opioid pain medication by primary care providers for chronic pain (i.e., pain conditions that typically last longer than 3 months or past the time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care.

The guideline offers recommendations rather than prescriptive standards; providers should consider the circumstances and unique needs of each patient.

Three Areas of Consideration

The Guideline addresses:
1. When to Initiate or Continue Opioids for Chronic Pain
2. Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation
3. Assessing Risk and Addressing Harms of Opioid Use

1. Determining When to Initiate or Continue Opioids for Chronic Pain

1. OPIOIDS ARE NOT FIRST-LINE THERAPY
   - Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

2. ESTABLISH GOALS FOR PAIN AND FUNCTION
   - Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function.

3. DISCUSS RISKS AND BENEFITS
   - Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.
2. Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING
   - When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. USE THE LOWEST EFFECTIVE DOSE
   - Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to ≥90 MME/day.

6. PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN
   - Providers should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days usually will be sufficient for most non-traumatic pain not related to major surgery.

7. EVALUATE BENEFITS AND HARMS FREQUENTLY
   - Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
   - Providers should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
   - If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids.

8. USE STRATEGIES TO MITIGATE RISK
   - Providers should incorporate strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, or higher opioid dosages (≥50 MME), are present.

9. REVIEW PDMP DATA
   - Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. USE URINE DRUG TESTING
    - Providers should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING
    - Whenever possible.

12. OFFER TREATMENT FOR OPIOID USE DISORDER
    - Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Case

- BC is a 43y/o morbidly obese male with CLBP, and bilateral knee pain, PTSD, HTN, DM with bilateral LE neuropathy who transfers his care to the VA because his private provider at Main Street Pain Clinic moved out of town.
- Pertinent meds:
  - OxyContin 80mg q 8 hrs
  - OxyIR 30mg qid prn for pain
  - Alprazolam 0.5mg tid prn for anxiety
  - Sertraline 50mg daily
  - Gabapentin 300mg tid
  - Metformin 1000mg once daily
What interventions would you recommend based on the CDC Guidelines?

- Oxycodone dose reduction to < 90MEDD?
- DC the Opioid
- DC Alprazolam
- Offer/adjust non-opioid analgesics
- Offer Physical Therapy and other non-pharmacologic interventions
- Offer CBT
- Obtain UDS
- Offer Naloxone Kit
- Query the PDMP

OPIOID SAFETY INITIATIVE DATA & COMPOSITE SCORE

VISN 8
3rd QTR 2016

3rd QTR 2016 OSI Composite Score

<table>
<thead>
<tr>
<th>Facility</th>
<th>Opioids</th>
<th>Opioid + BZD</th>
<th>UDS</th>
<th>&gt;=100 MEDD</th>
<th>Composite Score</th>
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Mean + 1SD = 96.35

Composite Score: Top 10 VISNs

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<th>Opioids</th>
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Percent Patients Prescribed Opioids
3rd QTR 2016 Station Level Report

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<tr>
<th>Station Main:</th>
<th>VA Patients Count:</th>
<th>VA Patient Population Count:</th>
<th>Station %</th>
<th>National %</th>
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<td>2,607</td>
<td>31,075</td>
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<td>548 West Palm Beach, FL</td>
<td>3,023</td>
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<td>573 Gainesville, FL</td>
<td>7,927</td>
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<td>672 San Juan, PR</td>
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<td>673 Tampa, FL</td>
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<td>7,070</td>
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</table>

VISN 8 Average: 8.8%
Veterans Dispensed Opioids Over Time - National

- 679,376 in Q4FY12
- 507,847 in Q4FY16
- 171,529 fewer veterans (a 25% reduction)

Opioids/Tramadol in Combination with Benzos 3rd QTR 2016 Station Level Report

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<tr>
<th>Station Main:</th>
<th>Opioid or Tramadol Count:</th>
<th>Opioid or Tramadol Percentage:</th>
<th>Station Main:</th>
<th>Opioid or Tramadol Count:</th>
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<td>7,594</td>
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<td>1,180</td>
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Visn 8 Avg: 9.7%

Veterans Dispensed An Opioid And A Benzodiazepine Over Time - National

- 122,633 in Q4FY12
- 78,717 in Q4FY16
- 57,734 fewer veterans (a 47% reduction)

Patients On Long-Term Opioids With Urine Drug Screen 3rd QTR 2016 Station Level Data

<table>
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<tr>
<th>Medical Facility:</th>
<th>Patients On Long-Term Opioids With UDS:</th>
<th>Patients On Long-Term Opioids:</th>
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<td>675 Orlando, FL</td>
<td>3,572</td>
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Visn 8 Avg: 87.1%

% Veterans on Long Term Opioids with an Urine Drug Screen - National

- An increase of 45.7% (82.3% vs. 36.60%)

Percent Patients Dispensed MEDD (Includes Tramadol) 3rd QTR 2016 Station Level Data

<table>
<thead>
<tr>
<th>Medical Facility:</th>
<th>&lt; 100mg MEDD</th>
<th>100-200mg MEDD</th>
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<th>300- &lt;400mg MEDD</th>
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Visn 8 Avg: 82.3%
Veterans Dispensed Greater Than Or Equal to 100 MEDD - National

21,515 fewer veterans (a 36% reduction)

OPIOID OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION
As of 9/15/16

OEND Distribution Report
9/15/16

<table>
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<tr>
<th>Location</th>
<th># Kits Released</th>
<th>Location</th>
<th># Kits Released</th>
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<td>2134</td>
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Naloxone Kit Distribution by VISN
9/15/16

OEND Distribution Report

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RIOSORD: RISK INDEX FOR OVERDOSE OR SERIOUS OPIOID-INDUCED RESPIRATORY DEPRESSION
STORM: STRATIFICATION TOOL FOR OPIOID RISK MITIGATION
riosord design

- Case control analysis
- 8,987 veteran patients included
- 10 Controls assigned to each veteran included
- Variables were selected for the risk index model
  - Based on logistics regression modeling
- Each variable was assigned a value point
- Point values added up to scores
  - Scores were then defined by predicted probability


results

does the patient consume:
- An extended-release or long-acting (ERLA) formulation of any prescription opioid? (e.g., OxyContin, Oxycontin-SR, methadone, fortextend) 9
- Methadone? (Methadone is a long-acting opioid so also check “ERLA formulation” [9 points]) 9
- Oxycodone? (If it has an ERLA formulation, e.g., OxyContin) also check “ERLA formulation” [9 points]) 3
- A prescription antidepressant (e.g., fluoxetine, citalopram, venlafaxine, amitriptyline) 7
- A prescription benzodiazepine (e.g., diazepam, alprazolam) 4

is the patient’s current maximum prescribed opioid dose:
- >100 mg morphine equivalents per day? 16
- 50–100 mg morphine equivalents per day? 9
- 20–50 mg morphine equivalents per day? 5

results

in the past 6 months, has the patient:
- Had one or more emergency department (ED) visits? 11
- Been hospitalized for one or more days? 8

Total point score (maximum 115) 4

overdose or serious opioid-induced respiratory depression (all patients, n=18,007)

<table>
<thead>
<tr>
<th>Risk Class</th>
<th>Risk Index Score (Points)</th>
<th>All Patients (n=18,007)</th>
<th>Average Predicted Probability (95% CI)</th>
<th>Observed Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0–24</td>
<td>7,153 (79.4)</td>
<td>0.83 (0.82, 0.84)</td>
<td>0.93</td>
</tr>
<tr>
<td>2</td>
<td>25–34</td>
<td>7,153 (79.4)</td>
<td>0.81 (0.80, 0.82)</td>
<td>0.92</td>
</tr>
<tr>
<td>3</td>
<td>35–45</td>
<td>7,153 (79.4)</td>
<td>0.80 (0.79, 0.81)</td>
<td>0.91</td>
</tr>
<tr>
<td>4</td>
<td>46–55</td>
<td>7,153 (79.4)</td>
<td>0.79 (0.78, 0.80)</td>
<td>0.91</td>
</tr>
<tr>
<td>5</td>
<td>56–65</td>
<td>7,153 (79.4)</td>
<td>0.78 (0.77, 0.79)</td>
<td>0.90</td>
</tr>
<tr>
<td>6</td>
<td>66–75</td>
<td>7,153 (79.4)</td>
<td>0.77 (0.76, 0.78)</td>
<td>0.89</td>
</tr>
<tr>
<td>7</td>
<td>76–85</td>
<td>7,153 (79.4)</td>
<td>0.76 (0.75, 0.77)</td>
<td>0.88</td>
</tr>
<tr>
<td>8</td>
<td>86–95</td>
<td>7,153 (79.4)</td>
<td>0.75 (0.74, 0.76)</td>
<td>0.87</td>
</tr>
<tr>
<td>9</td>
<td>96–100</td>
<td>7,153 (79.4)</td>
<td>0.74 (0.73, 0.75)</td>
<td>0.86</td>
</tr>
<tr>
<td>10</td>
<td>&gt;100</td>
<td>7,153 (79.4)</td>
<td>0.73 (0.72, 0.74)</td>
<td>0.85</td>
</tr>
</tbody>
</table>

Model performance:
- C-statistic = 0.88
- Hosmer-Lemeshow goodness-of-fit statistic = 10.6 (P = 0.06)

welcome to the STORM home page!

STORM summary tools:
- Facility/Network Summary Dashboard
- Provider Team Summary Dashboard AS/RS/RA
- ONS Patient Report
- ONS Patient Risk Dashboard
- Opioid Therapy Guideline Adherence Report

STORM patient level tools:
- Patient Demographics Dashboard
- Patient Demographic Summary - Admin/Provider
- Patient Quick View Dashboard - Admin/Provider
- Patient Look-Up Dashboard - see for patients by IDN

related tools:
- ONS Data Hub Dashboard
- ONS Patient Report
- ONS Patient Risk Dashboard
- Opioid Therapy Guideline Adherence Report

*API permission required: check data or report permission.

Supporting material:
- Questions/Feedback Contact our Help Desk
- OpioidSTORM Publications Dashboard
- OpioidSTORM Usage Summary - National
- OpioidSTORM Usage Summary - By State/County
- Local STORM
- FAQs
- Opioid Implementation SharePoint
We:
– Described the epidemiology of opioid use and abuse in the United States.
– Discussed the three areas of consideration with the corresponding recommendations outlined in the CDC Guideline for Prescribing Opioids for Chronic Pain.
– Described the VA Opioid Safety Initiative and the metrics that are being monitored for safe opioid use within the veteran population.
– Described the opioid risk assessment and stratification tools and their utility in guiding opioid therapy.

Self-Assessment Questions

1. The CDC Guidelines for prescribing opioids for chronic pain establish prescriptive standards for chronic opioid use. **False**
2. Both the CDC and the VA/DOD guidelines recommend urine drug testing, PDMP monitoring and distribution of the naloxone kit as risk mitigation strategies. **True**
3. A 9-fold increase in opioid OD has been reported in patients receiving high dose opioids (> 100mg MEDD) compared to low dose (≤ 20mg MEDD) **True**