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Session: Data-Based Case Reviews of Patients with Opioid Related Risk Factors as a Tool to Prevent Overdose and Suicide

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Molly: At this time I would like to introduce our speaker. Joining us today we have Dr. Eleanor Lewis. She is the deputy director for the Program Evaluation and Resource Center in the Office of Mental Health and Suicide Prevention and an investigator at the HSR&D Center for Innovation to Implementation located at VA Palo Alto Healthcare System. So with that, I'd like to thank you for joining us, Dr. Lewis, and I will turn the screen over to you now.

Dr. Eleanor Lewis: Thanks Molly. I’ll show my screen. So the title of the talk today is Data-Based Case Reviews of Patients with Opioid-Related Risk Factors as a Tool to Prevent Overdose and Suicide, since this audience is coming at this from a research perspective, I assume, interested in suicide prevention. And I want to point out that I prepared this talk with Jodie Trafton, the director of PERC, or the Program Evaluation and Resource Center, and my colleague Elizabeth Oliva, but both of them are on travel today. So Molly, do you want bring up the first poll question?

Molly: Yes. So for our attendees, as you can see on your screen, you do have the first poll question up. So we, whoops, pardon me. We would like to get an idea, give me just one second. My computer is running a little bit slow. There we go. We would like to get an idea of what brought you to today’s presentation. So are you primarily attending because you’re interested in suicide prevention, pain management and opioid therapy, implementation of new clinical initiatives, or other? And if you are selecting other, feel free to write in your interest in the chat section or inside the question section and I can read those aloud.

All right, looks like we’ve got a very responsive audience. Over 75% reply rate, so I'm going to go ahead and close this out and share those results. And as you can see on your screen, and remember this was a select all that apply, 51% of our respondents selected suicide prevention, 59% pain management and opioid therapy, 36% implementation of new clinical initiatives, and 10% selected other. And with regards to someone that selected other, they said research on suicide and opioid poisoning, so thank you. Do you have any comments on that before we move on?

Dr. Eleanor Lewis: I’m glad that people have a mix of interest because I think this talk is going to hit on all three, but if people had fallen primarily into one of those buckets, I would have tried to focus a little more, but I’ll proceed. And now the second poll question?

Molly: Perfect. So for attendees, we do have the second poll question up on your screen now, and do you want to explain the acronym STORM real quick before we move on?

Dr. Eleanor Lewis: Sure. That is the Stratification Tool for Opioid Risk Mitigation, and it’s the tool that, excuse me, is going to be discussed a lot in this talk as the resource to be used for data-based case reviews.

Molly: Excellent. Thank you. So for our attendees, go ahead and select how much experience you have with STORM. None, a little, some, or quite a bit. And it looks like most of our respondents have selected their answers, so at this point I'm going to close that poll out and share those results. Looks like 66% of our respondents selected none, 23% a little, 7% some, and 4% quite a bit. So thank you again to those respondents, and I will give you the screen share one more time.

Dr. Eleanor Lewis: Great. Yeah, so I'm glad that this will be something new for a lot of people. So the talk is going to have, there are three components. In the first section, I'm going to talk about opioid prescribing and overdose, or suicide-related events, and I want to provide some data that’s going to kind of back up the initiative that I'm going to talk about and provide a little context about opioid prescribing in the VA.

So first of all, it’s important to point out that of course VA is committed to enhancing safe and efficacious care of Veterans exposed to opioids. About a year ago, this article came out in internal medicine, which included Dr. Shulkin as a co-author, and it described four strategies that the VA has used to address the opioid epidemic, education, pain management, risk mitigation, and addiction treatment.

At about the same time, the VA released what they call the STOP PAIN, which was VA best practices around opioid prescribing, and those are listed there. Stepped care for opioid use disorder and pain, treatment alternatives and complementary care, ongoing monitoring of usage, practice guidelines, clinical practice guidelines, prescription monitoring which is through prescription drug monitoring programs at the state level, academic detailing, informed consent for long-term opioid therapy, and naloxone distribution. And one of the things that’s interesting to note about this STOP PAIN kind of list here is that different VAs under office, program office or unit was responsible for almost every single one of these. So we’ve got a lot of different parts of VA who are really involved and engaged in opioid prescribing and in trying to encourage safe opioid prescribing. And all this is also happening at the same time as the VA Opioid Safety Initiative.

I threw in a timeline here, which I know is pretty small, but just to give you sense that really starting with the OSI launch in 2012, VA has really been focusing on safe and efficacious opioid prescribing, and they’ve done that through a variety of different things including, as you can see along the top there, the Psychotropic Drug Safety Initiative, academic detailing, and then in 2016 in response to the Comprehensive Addiction and Recovery Act. And there has also been an update of the VA DoD clinical practice guidelines on prescribing of opioid therapy.

So the Opioid Safety Initiative has been, most people, I think, in the VA would consider it a success because it targeted some specific practices, and it had a real impact on improving those prescribing practices. But the VA continues to receive external reviews that argue VA is struggling with reducing risk and improving opioid safety. Literally last week the GAO put out this report that progress has been made, but further efforts to reduce risk are needed. And 20 minutes ago I was not preparing for this talk because I was reviewing a response to a GAO report that’s going to come out about pain management practices. So it’s critical that VA efforts are on safe opioid prescribing.

This is all just to provide context. So what should VA do next? What’s the next step? And program offices wanted kind of a different approach that builds on the success of the Opioid Safety Initiative but maybe moved in a slightly different direction.

So the initial Opioid Safety Initiative efforts focused on improving opioid prescribing practices, and it did have, like I said, huge improvements. So fewer opioids are being prescribed, there’s less high-dose prescribing, less co-prescribing with benzodiazepine, and more use of universal precautions, which I know is informed consent, urine drug screening, and checking in prescription drug monitoring programs. So all those things are happening, and those are all part of improving safe and effective opioid prescribing.

But patients are still dying of overdose and suicide, so overall, overdose and suicide rates among VA patients are still high. Even if rates are declining among patients receiving a VA opioid prescription, most of the patients who die of overdose or suicide are receiving low to moderate-dose opioid prescriptions, and I’ll show you some data from that on the next slide. And this all indicates, again, VA needs to kind of think about what’s the next step. We need to go beyond the prescriptions to address biopsychosocial factors that contribute to suicide and overdose mortality, addiction, and other adverse events. And the visual on this slide just kind of shows where opioids fit in to these complex arrays of conditions that our patients are facing. And the patients who are at high risk of overdose and suicide rates, those are vulnerable patients. And so we really need to take care of those patients the best that we can, which means going beyond what we’ve been able to accomplish with the Opioid Safety Initiative so far, which has been very important, and address these complex comorbidities that our patients are facing.

This table just shows you a little data to kind of emphasize that the tallest column there, which is the percentage of overall FY13 overdoses and suicide deaths are among patients receiving what would be considered a low to moderate morphine-equivalent daily dose. We tend to think of those patients on the far column here as being at highest risk, but if you go by number of patients, it’s here. And I also want to emphasize as I was saying about comorbidities, patients with substance use disorder diagnoses, mental health only diagnoses, those are big bars. Those are big components of these bars. These are complex patients. So while some clinical practice guidelines really encourage focusing just on high-dose patients, we really think we have to move beyond looking at those if you’re going to affect the majority of the patients that die from suicide or overdose-related mortality.

So what tools do we have if we’re going to go beyond those? Well, VA has had some experience with using predictive model to drive clinical review and reduce mortality, and these results are preliminary from the REACH VET project initiative, but I did want to share them with you. So REACH VET is a program that estimates the risk of a suicide death in the next month. The top point one percent of those patients based on each facility are sent to each facility each month, and they receive case review and an outreach phone call. So that top point one percent of patients at risk of a suicide death in the next month receive a clinical intervention.

Now the initial evaluation of this project, which has been going on for more than a year, found reductions in all-cause mortality in the first three to six months. And that’s pretty surprising and dramatic because it’s not an intensive intervention, but it is an intervention that’s targeted. So what you see there is the reduction in all-cause mortality. But there also were fewer inpatient admissions and emergency department visits and more outpatient mental health visits, fewer missed appointments, more safety plans. So this suggests that targeting extra clinical attention to those with modeled risk have substantial clinical and healthcare system benefits.

So what should VA do next? So hopefully I've set the stage that you’ll be interested to hear about the STORM model and the STORM dashboard because that is really the initiative that I’ll be talking about in the rest of this call that is going to be moving the Opioid Safety Initiative forward and moving VA’s efforts toward safe and effective opioid prescribing forward.

So the STORM model primarily looks back one year. It uses demographic, diagnostic, pharmacy, and healthcare use data from the Corporate Data Warehouse to predict risk of overdose or suicide-related healthcare events or death in the next year, and it generates a patient-specific risk score. Parameters from the model are then applied to Veteran healthcare data. It’s updated nightly to create an individual estimate of risk, and then the risk factors all sort of feed into this model. There’s a lot of detailed background and data on this in a paper that was published by my colleague, Elizabeth Oliva, and as you can see, many other people on our team in PERC. And the STORM risk model does go beyond those, and it does go beyond co-prescribing, but it also includes a number of risk factors that aren’t changeable, which I think is important to emphasize. And it has implications for how we approach people clinically.

So that individual risk score that I described, it’s designed to help understand the Veteran’s risk level to support treatment planning. Risk factors are often not changeable. They may be things like age or existing health condition the person has. So the goal of any kind of clinical intervention with these patients who are at higher risk can’t be to change that estimated risk; it can just be to make the patient safer and to give them a more appropriate treatment plan. And that means higher risk patients may need more monitoring, they may need more intervention, and they very well may need care coordination between services and higher intensity of care. And as you saw on the slide that I showed earlier, many of these patients who do have an overdose or suicide are taking low to moderate doses of opioids, but they do have mental health and substance use disorders, so that’s one indication that care coordination is going to be important.

I'm not going to go over these slides in detail. These are from the paper that I cited earlier. This particular table only includes diagnoses with odds ratios that are greater than two, but you can see again prior overdose or suicide-related event, detoxification, inpatient mental health treatment, sedative use disorder, stimulant. Many of these things on this list are things that are going to require care coordination.

And this slide just shows a pictorial version of this. And some prescription factors are here, but they’re weaker factors in the model. So again, I'm not going to go into too much detail. This is from the paper that Elizabeth published, but this is just to emphasize that there’s multiple clusters of things that are feeding into the patient's risk. So it’s much more than morphine-equivalent daily dose. It’s also all these other things that are going on in patients that STORM is modeling as having a high risk of an overdose or suicide-related event.

So also there’s high odds ratios for other evidence-based sedating pain medications. So you can see that having tricyclic, SNRIs, anticonvulsants is associated with increased risk, and it could be related to unmanaged pain, cumulative sedation, depression symptoms. There’s a lot going on for these patients. And so it’s just important that any kind of tool that we provide to people to help them manage patients that STORM says are very high risk is going to have to present a complex portrait of those patients. And the patient's treatment regimen and the complexity of that treatment is going to be important for their entire care team to understand.

There’s also a way that the STORM model can create risk scores for patients who don’t have an active opioid prescription. So if a patient doesn’t have an active opioid prescription, we can generate what we call a hypothetical risk score based on three different levels of hypothetical opioid prescription, MEDD of an opioid prescription, which is morphine-equivalent daily dose. And if a patient has no active opioid prescription but has an opioid use disorder diagnosis in their record, report, the report will calculate also a hypothetical STORM risk score. But these patients are their own category in STORM because having an opioid use disorder diagnosis really has a substantial impact on how those patients should be cared for and managed.

So now that we’ve, so once we developed this model and were able to test it on cohorts of patients to try to understand how well it targeted patients who would benefit from additional intervention, we wanted to create a tool that could be used by providers to help those patients and again sort of present a complex clinical portrait of these people. So the clinical decision support tool, which is we call the STORM dashboard, is updated nightly. And it identifies patients at risk for overdose or suicide-related adverse events based on the statistical model, and it provides patient-centered opioid risk mitigation strategies. So I’ll be walking you through a little bit detail about what’s presented on that dashboard. And access to STORM is based on whatever your particular access permissions are at your local facility. So it’s been available for people to use for a few years, but now we’re systematically rolling it out at a national level to encourage use to review very high-risk patients.

So key features of STORM. It estimates an individual patient’s risk for an overdose or suicide-related adverse event or death based on the predictive model. So it encompasses patients with active opioid prescriptions, patients with an opioid use disorder diagnosis in the past year, and a hypothetical risk for patients who are considering initiating opioid therapy. And it provides patient-centered opioid risk mitigation strategy by displaying risk factors that place those patients at risk, which include some of those things that the Opioid Safety Initiative targeted so effectively, risk mitigation strategies including non-pharmacological treatment options that could be employed or considered, and also information about patients’ upcoming appointments and current providers to help facilitate care coordination.

Now we always remind people who would be using the STORM dashboard to help manage patients that changes made to the patient’s medical record will not display until the next day. So people need to use STORM in conjunction with CPRS, the electronic medical record, for the most up-to-date clinical information. And of course things go wrong. I mean just this morning again there was a problem with people accessing our dashboard. It was not due to any internal problem in PERC but was widespread across VA, and people are working to resolve that even as I am talking now. So things like that are going to happen. So STORM can’t be the only tool that you use, but it can be a very helpful tool, we think, to help manage these complex patients who are at very high risk.

You can access STORM from a hyperlink in the CPRS tools menu or at the hyperlink that I provided there on the slide.

When you go to that hyperlink, you’ll see a home page with a variety of buttons. There is a STORM summary report, a STORM patient detail report, a STORM SSN Look-Up Report. I’ll be describing these each briefly. And then of course supporting materials and a variety of helpful links here on the side as well.

This is a small snapshot of the STORM patient detail report, main page. So in this first column here you have patient information and the risk score. So you can see this person is in a very high category of risk with an active opioid prescription, and there is the percentage. It also shows where they’re actively being seen. This set of columns has contributing risk factors. What factors contribute to my patient’s risk? Relevant diagnoses and relevant medications. And then this set of columns is one that we emphasize a lot. It’s how to better manage my patient’s risk. So we have a set of risk mitigation strategies and non-pharmacological pain treatment. And we try to keep these as up-to-date as possible with current clinical practice guidelines, but there’s never a complete match. And sometimes subject matter experts disagree on what should be included here, what should be include there, or things happen such as Integrative Health Coordinating Committee comes out with a variety of different things that they want included in a metric that captures complementary and integrative health. So we’re constantly trying to update this, and we’re constantly trying to improve. And we get tons of great suggestions from the field, and it’s just an ongoing effort to make this as useful and usable as possible.

And in this final set of columns, we have how can I follow up with this patient? We have their care providers, recent appointments, and upcoming appointments that are relevant to their care. And sometimes people may have been assigned to a provider at one panel at one facility but be primarily receiving care at another facility, and those patients will show up in both places. And that’s, again, an emphasis on how important it is to coordinate care.

And risk mitigation strategies are overly inclusive, so not all risk mitigation strategies are actually recommended or relevant for all patients. So we tell people your goal isn’t to click each box; the goal is to provide the best possible treatment plan for your patient.

So that’s an overview of what the STORM dashboard looks like and tries to incorporate components that we think are important for care for these patients. So the STORM risk mitigation strategies support implementation of policy initiatives to reduce opioid risks and policy initiatives that are already out there, and you’ll recognize some of these from that STOP PAIN slide. Informed consent for chronic opioid therapy; prescription drug monitoring program checks; urine drug screening during opioid therapy, which is one of the targets of OSI; safety planning, which is relevant for patients at high risk of suicide in particular; medication-assisted therapy for opioid use disorders; and opioid overdose education and naloxone distribution. So all of these are supported by the STORM dashboard display in terms of things showing up here under risk mitigation strategies. And again, just to emphasize the breadth of these things, I mean so many of these come from different program offices such as informed consent coming from the Ethics Office and urine drug screening being supported by laboratory and pharmacy, safety planning being supported by suicide prevention coordinators and the Office of Mental Health and Suicide Prevention. So it’s really VA’s effort to take a comprehensive approach to helping to manage these complex patients.

So now we’ve got this great tool, and we know that we need to do more than we’ve been able to do before with our existing initiatives, and it seems like there’s some evidence emerging in predicative modeling to drive clinical interventions is an effective way to help reduce mortality. So how do we put this all together? We worked with multiple program offices and particularly closely with pain management obviously, to develop this notice, the VHA Notice 2018-08, which is Conduct of Data-Based Case Reviews of Patients with Opioid-Related Risk Factors. So I’m going to be spending a while talking a little bit about this, which was hot off the press just a couple months ago. And it is part of an effort to bring the focus back from the prescription to the Veteran and to coordinating their care and providing them with the optimal treatment plan. It’s designed to encourage a Veteran-centered approach to risk mitigation.

So here’s a link to that notice, and this notice extends the efforts of the Opioid Safety Initiative. And it also meets the mandates in the Comprehensive Addiction and Recovery Act of 2016, which I mentioned a while ago and may have slipped past you because it was part of a long list of things that are providing a context for this initiative. And patient information may be reviewed in the medical record or any clinical decision support tool. For example, the Opioid Therapy Risk Report, or OTRR. And data-based case reviews do not replace universal precautions or clinical discretion. It’s very important to emphasize that because sometimes clinical practice guidelines in particular tend to get interpreted as absolute hard rules. This was a real problem when the CDC guidelines were issued. And so we emphasize you know the patient, and if you don’t know the patient, then you need to find someone who knows the patient in order to provide them with the best treatment plan.

So what is in this notice? The notice requires data-based risk review. These data-based risk review efforts are designed to focus attention on the whole patient needs and encourage collaborative treatment planning, particularly across primary care, mental health, and pain management providers. The data-based risk reviews address two populations of patients, and I'll be talking about these a little bit more as well. So the first is the patients who are estimated by the STORM model to be at very high risk of overdose or suicide based on predictive modeling. And the second group of patients that this data-based risk review applies to are patients considering new initiation of opioid therapy. So those are two very different groups and two very different clinical contexts. It’s going to continue to encourage safe prescribing practices but extend efforts to ensure engagement with mental health, substance use disorder treatment, suicide prevention, specialty pain, and rehabilitation services. So we want to increase awareness of all those options for providing the most safe and efficacious care for Veterans. But given those two different populations that the notice targets, there is going to be slightly different approaches to using STORM to help care for those patients.

So first we’re going to talk about the centralized review of patients on opioid therapy who are modeled as being at very high risk for an adverse event. Again, these reviews don’t replace universal precautions or clinical discretion, but they are a tool.

This is just sort of a flowchart that walks you through how facilities and providers are going to be engaged in doing these reviews of patients at very high risk. So the Comprehensive Addiction and Recovery Act required VA to stand up interdisciplinary pain management teams at every facility. And these interdisciplinary teams are going to review the very high-risk patients. And the list of people who are included on that interdisciplinary team are listed there. When they complete that individual patient review, they’ll decide do you want to taper or discontinue or continue? If they are going to continue the opioid, then they want to coordinate recommendations with the patient care team and document those review and any actions. But if they do decide to taper, it’s absolutely essential to plan for additional ongoing care and absolutely essential to maintain treatment engagement. We know that involuntary opioid tapers are not good for patients unless they’re well managed and unless every effort is made to maintain those patients in care.

So that’s a broad outline of the centralized review process. And as long as the interdisciplinary care teams are checking the STORM dashboard weekly, they should pick up on new patients who are entering that very high-risk cohort. And those interdisciplinary pain management teams are described in the memo that I have a link to there, and they are required by the Comprehensive Addiction and Recovery Act. These reviews could actually also be carried out by the Opioid Safety Initiative review teams. But regardless, the facility leadership needs to ensure that staff on these teams have training, adequate dedicated time, and appropriate representation from diverse disciplines because, again, to emphasize these patients who are at very high risk are among the most vulnerable patients in the VA. These are patients who have a lot of complex comorbidities. They’re going to require management from variety of different people.

Veterans suffer more commonly from chronic pain than non-Veterans, and their pain, again, is more often severe and complex, often associated with psychiatric and medical comorbidities. And suicide and overdose prevention includes timely access to pain management with integrated behavioral therapies and mental health and addiction expertise as appropriate. So coordination between these different clinical areas is really essential to promote efficient use of resources and smooth transitions for the Veteran between care areas. They’re going to need care coordination and overlapping treatment. And this is the message from Friedhelm Sandbrink, who is the director of Pain Management Services in the VA. Interdisciplinary review is really important.

And commonly observed challenges that we see for managing these complex patients who are at very high risk is siloed pain management and siloed mental health care. That’s one of the primary things we got immediate feedback on when this notice came out was people contacting us and saying, hey, mental health doesn’t want to work with us with these patients. Or hey, primary care doesn’t want to work with us with these patients. And that’s not a message that we want to hear because we know that effective non-opioid treatments for chronic pain and mental health conditions include a variety of things that may come from different types of providers, psychotropic prescribing, psychosocial treatment, integrated health. And the functional goal and the recovery focus is key to effective treatment planning and patient management. Biopsychosocial factors, sleep problems, all these complicate treatment of both pain and mental health. So there are gaps in perceptions and responsibilities for care coordination because traditionally these things have fallen to different providers and different services in the VA. So interdisciplinary care and care that communicates, providers who are communicating across those silos is, we think, really important. And taking collaborative care of these patients is important. Treatment planning can really optimize their care and help people avoid falling through the gaps.

Another commonly observed challenge is we have patients who are receiving care at multiple locations. So an example, again, of a lot of comments that we get are that we haven’t seen this patient in years because the patient is showing up as very high risk at a facility where they may not be receiving active care. But there is incomplete awareness of care being received elsewhere and confusion around ongoing management plans, assignments, and providers. Some patients have multiple PACT or BHIP team assignments, so they show up in multiple facilities very high risk in STORM. And gaps in management during patient moves, duplicative prescriptions, these things can happen when patients are being seen in multiple locations. And so to the extent that STORM can help highlight where those patients are receiving care at multiple locations, even if ultimately one facility is going to be responsible for completing interdisciplinary review of this high-risk patient, it’s important for all the providers who might be touching that patient to understand what the complete picture of that patient’s care is.

A couple other commonly observed challenges for these patients are a lack of patient engagement and treatment for known substance use disorder and mental health conditions, and a lack of focus on suicide risk in pain-focused settings and a lack of focus on overdose risk in mental health-focused settings. And again, we sometimes hear from facilities where they say kind of primary care says they don’t do X or mental health care says they don’t do X, pain management says they won’t do X. And we want to encourage more care coordination and more willingness to be involved and engaged in treatment of the whole patient. So if patients are getting opioids and they’re at very high risk for an overdose or suicide-related event, not engaged in mental health or SUD treatment, we hope we can bring those risk assessments together and really encourage better coordination.

And to illustrate why this is important, we thought it was helpful to provide a couple profiles of very high-risk patients. And this is just to suggest the value of interdisciplinary review and care coordination. So an example of a very high-risk patient like being older white man, extensive medical comorbidities, substance use disorder including opioid use disorder and depression, recent history of suicidal ideation, sedative overdose and fall, multiple active opioid prescriptions from different providers within a facility, multiple active prescriptions for the same psychotropic medication across facilities, and no mental health care in the last 10 months. So interdisciplinary teams reviewing this patient could resolve duplicative prescribing across providers and facilities, converge on a single medication plan, try to reengage that patient in mental health and substance use disorder care, consider medication-assisted therapy, and provide overdose education and naloxone to help reduce any potential opioid overdose, and provide suicide prevention because suicide prevention and opioid safety really are not necessarily separate services for patients who are receiving opioids. And this is an example of one type of very high-risk patient.

But of course another example would be somebody diagnosed with polysubstance use disorders, although it may or may not include opioid use disorders. They may have mental health comorbidities, and they may have a low opioid dose but no informed consent, no naloxone, no prescription drug monitoring program checks, no urine drug screening. So even though they might have a low opioid dose, all these other things going on are going to contribute to the patient being at very high risk. And what can that interdisciplinary team do? They can encourage engagement in mental health and substance use disorder treatment. They could review the psychotropic prescribing, minimize overdose risk, provide overdose education, and try to ensure ongoing monitoring of substance use and proactive coordinated care management. So the low dose was initiated because of the patient's risk with all these other things going on. And to reemphasize, we don’t want to treat the dose, we don’t want to treat the prescription, we want to treat the patient. So reducing this dose doesn’t reduce their risk. It just means that their pain is not going to be well managed, at least within the VA. And we certainly know that many Veterans get pain medication prescriptions outside the VA.

So STORM and patients with opioid use disorders. I want to emphasize this point too. STORM is designed to facilitate care for patients with opioid use disorders. Patients with opioid use disorders have an elevated risk of overdose or suicide. These patients have a 12% annual rate of overdose or suicide-related events. Patients with an OUD diagnosis in the last year without an active opioid prescription are broken out into an OUD patient risk category separately in STORM because of this. And there’s an emphasis through other initiatives in the VA, both in the mental health domain of SAIL and the Psychotropic Drug Safety Initiative, to provide extra care and attention to these patients, but they are easily identifiable in STORM.

Now I mentioned that there are three reports in STORM, or three dashboards. There’s the patient detail report, and there’s the summary report and the SSN Look-Up Report. So the summary report presents data at the national, facility, and provider level; identifies patients who might benefit from specific risk mitigation strategies; and allows tracking of implementation of these data-based case reviews.

And just to give you a snapshot of this summary report, you can see here a facility, you’d have a breakdown of those very high patients. And you could click there to generate a list of patients to review.

Or you could go down to this risk mitigation strategy, data-based opioid risk review, and click there to see the patients who do not have that review in their chart within the last year.

Now required data-based case reviews are the second main component of this Notice 2018-08, and these are designed to support implementation of the Comprehensive Addiction and Recovery Act, which I've mentioned a couple times.

And I'm not going to read this, which is the actual legal language. My screen just froze. There we go. So I'm not going to read this, but this is the actual language in the CARA. So each healthcare provider, before initiating opioid therapy, is supposed to do a comprehensive assessment and review. There’s no population exemptions in the law, but the way we’re tracking it provides some modest exemptions. And as I pointed out at the very beginning of the talk, VA’s prescribing and VA pain management practices continue to be constantly scrutinized by GAO, by the Inspector General, by Freedom of Information Act requests, by Congress. There’s just a lot of scrutiny. And so while this seems like a very onerous mandate, this is in fact the law.

So here’s a brief flowchart of the point of care review process, and again view STORM, the provider can review patient risk and benefits of an opioid therapy trial. And at the end of this try to ensure that the Veteran’s need for pain management is met. This can also work through consult as well.

Now the third dashboard that I mentioned is the SSN Look-Up Report. And the SSN Look-Up Report is really designed to facilitate these risk reviews mandated by CARA. They’re mandated prior to initiating an opioid. And so for patients with no active opioid prescriptions, it’s going to display that hypothetical risk that I described at the beginning of the talk, and it’s also going to support risk-benefit discussions, patient-centered pain management, and safety planning before opioid therapy is started.

So there’s that third link on the STORM home page.

And that takes you to this page where you’re going to enter the Social Security number, and then it brings up the main display here.

I won’t go into the components of the display in detail. But again, much like the main dashboard, it provides a risk assessment section, factors contributing to the patient's risk, risk medication strategies, and relevant providers for follow-up care and coordination.

And in addition, as a way to try to help reduce provider burden, STORM has a chart review note feature that creates a summary of the patient's data in the document the clinician can copy and paste and annotate in a CPRS note. And the note is a starting point for documentation, but many facilities are working on developing something of their own. And you can see that chart review note. There’s a link right there on the patient detail report and a link right there on the SSN Look-Up Report.

And then, again, you can track successfully documented reviews right on the main display for the patient because it’s one of the risk mitigation strategies or here on that summary report.

So as part of trying to implement this notice, we want to make it as straightforward as possible for facilities to understand what they’re doing and how well they’re succeeding. So there’s a variety of links for implementation support on the main STORM page and also an implementation SharePoint, there’s a help desk, and there’s a Listserv.

There’s also implementation support from academic detailing, which is the A in STOP PAIN, and implementation support in development including a monthly collaborative call.

And then this just provides some information on how those centralized reviews are going to be monitored, which is patients who have a note title in their, a note with a specific note title in their medical record. And then this is going to be true for both patients who are eligible or going to be required to have that centralized interdisciplinary review completed and also for patients who are receiving that point of care risk review prior to opioid prescribing. And like I said, while the legislation itself doesn’t provide any exclusions from that risk review, we will not be monitoring patients if their prescription is for five days or less or if the patient is enrolled in hospice care. And that’s consistent with another VA directive for the implementation of prescription drug monitoring programs.

So some key takeaways as I wrap up, the goal of the data-based opioid risk reviews is to review the patient, not the prescription. So going beyond a check of the risk of the prescription itself, beyond just is the patient receiving a high dose of an opioid or are they receiving it in combination with another medication, it’s moving beyond focusing on changing a patient’s modeled risk score. Because as I said, a lot of factors that contribute to a patient being modeled as being at very high risk are things that you can’t necessarily change. And we do want to emphasize that providers who are engaged in caring for these patients should focus on optimizing the patient's treatment plan using available risk mitigation interventions, considering alternative or other options such as complementary or integrative healthcare. And really providers should be empowered to do their part to ensure patients receive the safest, most appropriate care. And that includes responsibilities across multiple service lines because most very high-risk patients have complex mental health or substance use disorder issues. And collaborating with each other because collaborative treatment planning across provider services and facilities is a key goal for comprehensively addressing risk of suicide and overdose among these patients.

So to summarize, VA needs to continue to work toward ensuring patients’ pain care is as safe and effective as possible. Predictive modeling may be an effective way to target patients for clinical intervention. The STORM model and dashboards facilitate prioritizing patients for clinical review, so the pre-initiation reviews that should facilitate risk-benefit discussions and design of a treatment plan and an opioid trial if appropriate to optimize patient safety and effectiveness, and prioritizing patients modeled as being at very high risk. And we expect at most facilities implementation of Notice 2018-08 is going to require engaging new types of providers in opioid safety efforts and clarifying protocols for care coordination across services, which we think ultimately will be of great benefit to patients, and not just patients necessarily modeled as being at very high risk but also patients with opioid use disorders or other complex conditions where care coordination is a legitimate and very real challenge because patients are very complex.

So that’s the end of my prepared talk. I think I came in right about where Molly asked me to target, but we do have one final poll question, which is your feedback to me on the talk.

Molly: Thank you. So for our attendees, I am putting up the third poll. Pardon me one second. I am putting up the third poll question at this time, so please take just a moment and fill that out. So after this talk, how convinced are you that data-based risk reviews are an important component of suicide prevention? The answer options are very convinced, somewhat convinced, a little convinced, or not convinced. These are anonymous replies, and it looks like they’re streaming in, just over half so far.

Dr. Eleanor Lewis: And it is anonymous, so you can tell me if it’s true or not.

Molly: Okay, it looks like we’ve had about two-thirds of our audience reply. We’ll give people just a few more seconds. Okay, I'm going to go ahead and close this out and share the results. Looks like 54% are very convinced, 36% somewhat convinced, 5% a little convinced, and 5% not convinced. Thank you to those respondents. Eleanor, I'm going to give you the screen share one more time so we can put the last slide up during the Q&A.

Dr. Eleanor Lewis: Okay.

Molly: And we do have lots of questions pending, so are you ready to start taking those now?

Dr. Eleanor Lewis: Yeah, and I do want to mention again that Jodie Trafton and Elizabeth Oliva and actually the primary technical programmer for STORM are all traveling today, so I'm kind of the B team, but if I can’t answer your question, I will certainly, I hope, receive them so that I can respond in writing.

Molly: Excellent. Thank you. Thanks for making yourself available after the talk. So for our attendants that joined us after the top of the hour, if you’re looking to submit a question or a comment, you can do so using the GoToWebinar control panel located on the right-hand side of your screen. Just click the arrow next to the word question. That will expand the dialogue box, and you can submit your question or comment there.

The first one we received: Does the opioid use disorder diagnosis have to be in the last year or updated in CPRS within the last year?

Dr. Eleanor Lewis: That’s a good question. You mean for, I guess my clarification question would be in order for it to be included in the patient’s modeled risk score, or I mean I assume that that’s the question, and the model primarily looks back one year. So yeah, primarily, but I wouldn’t say that that’s necessarily a hundred percent exactly how opioid use disorder feeds into the patient's modeled risk, but primarily . . .

Molly: Thank you.

Dr. Eleanor Lewis: . . . it looks back one year.

Molly: Yeah, they did specify in order to include it in the hypothetical risk, and they fear it might miss a lot of patients that way.

Dr. Eleanor Lewis: Yeah, yeah.

Molly: Thank you for that question. The next one: Where is the STORM link in CPRS? I'm not seeing it.

Dr. Eleanor Lewis: Yeah, and I'm not a provider myself, so I, unfortunately, am not a good person to answer that question. But I do know on every talk where this question comes up, usually somebody else will pipe up and be able to help you find the link. So I apologize that I can’t pull it up right now and show you.

Molly: No problem. If anybody is in the audience that wants to submit a response to that, they’re welcome to.

The next question: Is STORM available for non-VA primary care providers to use in the private sector?

Dr. Eleanor Lewis: So it is not. It is a VA-specific tool. That said, of course, we do send more and more patients out into the community for care. And there’s no reason that as part of the care coordination for patients who are receiving care in the community that a provider couldn’t share STORM with, a VA provider couldn’t share STORM information with a non-VA provider as far as I know. I had one person, I think, on one of the informational calls that we did say that she thought there were some legal restrictions on that, but not as far as I know.

Molly: Thank you. The next question: Somebody did send in the link, but the easy answer for finding STORM in CPRS is to go to Tools, More, Medical Libraries, and then Reach Vet STORM, so thank you for all of those that wrote in. And there’s a lot of, everybody wrote the same thing, so I have good faith in those answers.

Dr. Eleanor Lewis: Yeah, crowdsourcing is great.

Molly: The next question: How often is the risk model updated with new data? Is the schedule of updating the model limited by scheduled release of mortality data? And what additional data is needed to improve the model?

Dr. Eleanor Lewis: Yes. So we are in the process of updating the model. That is as we have received additional mortality data. So it is contingent on receiving updated mortality data. And yes, we expect those updates to be rolled out within the next couple of months. But our preliminary analysis of mortality data indicates that it’s going to be pretty consistent in terms of the patients who are going to be modeled as being at very high risk. And for people on the call who don’t know, there is a pretty long lag in terms of when we get access to cause of death data as opposed to just mortality, so we are eagerly awaiting the 2016 cause of death data.

Molly: Thank you. The next question: Can you clarify the outcome of quote suicide-related event used in the predictive model? Does this include suicide due to any cause or suicide just related to opioid use?

Dr. Eleanor Lewis: It includes the suicides that could be sort of plausibly related to opioids but also other suicide events, so not just overdoses.

Molly: Thank you. This is a fantastic, I’m sorry, this is a fascinating tool. Can you talk about how this is being used clinically? Is it just being used by pain specialists or are primary care providers using it?

Dr. Eleanor Lewis: We’re learning more every day about who is using it. So we know patients in mental health and substance use disorder programs are using it. We know that academic detailers are using it when they’re talking with providers in primary care. And we know pain management specialists are using it. But we don’t know a lot of details about how people are integrating it into their clinical practice. One of the things we’re going to be doing on the monthly collaborative calls is having people from different facilities present about exactly that topic.

Molly: Thank you. We do have a few more people writing in saying thank you for the excellent presentation. That was final question we have at this time. If any of our attendees have any last-minute questions or comments, feel free to write them in now. And while we wait for those, Dr. Lewis, I'd like to give you the opportunity to make any concluding comments that you’d like to.

Dr. Eleanor Lewis: Sure, and I mean this is a great audience with a diverse set of interests in the topics that we talked about today. And I hope I gave you not only sort of a taste of the specific initiative but gave you a sense of how challenging it is in a complex environment that the VA exists in for us to provide the best care for patients. I mean there’s a lot of external pressure on opioid prescribing practices, but there’s also a lot of patient need for improved prescribing practices and improved pain management. So we all have a responsibility to do the best that we possibly can to take care of these patients. And to some extent that may sometimes mean resisting external pressures, but it also means being responsive to our obligations to be accountable for the care that we provide.

Molly: Thank you. And for our attendees, we do have a couple more opioid-related sessions coming up, so feel free to check out our registration titles online.

Well, Dr. Lewis, I want to thank you so much for coming on and lending your expertise to the field on this very important topic, and of course thank you to our attendees for joining us today. I am going to close out the session in just a moment. For our attendees, please wait while the feedback survey populates on your screen. It’s just a few questions, but we do take the time to look at your answers closely, so please take a moment and respond to those. And with that, this does conclude today’s HSR&D Cyberseminar presentation. Have a great rest of the day.

[ END OF AUDIO ]