Erin Krebs: I think we’ll start with maybe each of the panelists introduce yourselves and then we’ll talk a little bit more about what we’re hoping to do today.

Alicia Heapy: I can start. I’m Alicia Heapy. I’m a Clinical Health Psychologist and a Health Services Researcher at VA Connecticut and I’m also the Associate Director of the PRIME COIN there and Associate Professor at Yale School of Medicine. My interests are really in psychological and behavioral treatments for chronic pain, especially using technology to enhance access.

Friedhelm Sandbrink: Good afternoon. So I’m Friedhelm Sandbrink. I’m a Neurologist and Pain Physician at the Washington, DC VA Medical Center. So I actually could just come by Metro here today. And I really appreciate you all being here actually. And I am also the Acting National Program Director for Pain Management in the VA.

Will Becker: Good afternoon everybody. I’m the stand-in for Joe Frank. I’m Will Becker. I’m a General Internist by training, Health Services Researcher, Core Investigator at the Prime Center with Alicia and primary interests are improving the quality of chronic pain care in primary care, looking at novel systems of care and particularly now focused on de-implementing long-term opioid therapy.

Erin Krebs: Great. Thank you. So the overall agenda here is to really talk about some partnered research about implementing multimodal pain care. So discuss we’re going to have several separate but related query-funded projects focused on pain. And then we’ll talk about the policy environment and partnership with that side of things.

 So just to start, I know many of you in the room but not all. So I’m going to ask you to just kind of raise your hand here to indicate your level of experience, expertise around chronic pain in VA. So I’ll say, you know, Expert, Medium, and Novice. So, let’s see, who in the room would say that they are in the Novice, really new to this whole pain research in VA thing? Oh, we have an experienced crowd, okay. Who would put themselves in sort of the Medium category? Alright. And who has been doing this for a long time, this is your thing, Expert people? Excellent.

 Alright, so we won’t have to go back to the basics or anything here, everyone’s moderately at least familiar with the issues. I will assume maybe some of the people online would put themselves in the Novice category.

 So nuts and bolts, what we’re going to do, we’re going to have a couple of brief presentations. We’re going to try to have mostly conversation here today. We’re going to use mikes for conversations so that people who are not present physically with us can here. And also to facilitate that, I handed out some notecards. There should be some notecards sort of on all of the middle ends of the rows. So if you’re having a question but don’t want to raise your hand right now, if you want to put those questions on notecards, I will come back around to those in the second half of discussion. So we will hopefully have a full representation of extrovert discussion and introvert discussion.

 And with that, I think I will turn this over to Alicia. Is there anything else I ought to say first?

Alicia Heapy: I don’t think so.

Erin Krebs: Okay, excellent. Alright.

Alicia Heapy: I think we’re going to bring it a little—have an adventure together. Okay. So instead of starting out with a slide that talks about the opioid epidemic, as I’m sure all of you have seen many, many times, we thought we would bring it back to the patient level and give and illustrated case presentation of a patient who has chronic pain and whose pain is not being managed well either by him or by the healthcare system. So this patient, Mr. M is a 64-year-old white man with chronic low back pain who was see in Will Becker’s opioid reassessment clinic at West Haven. His chief complaint was “I’m in a rut.” So his prior medical history is notable for lumbar spondylosis and PTSD. He is on a number of medications, including morphine, on oxycodone. And looking at his notes, it was noted that he started opioid therapy in 2004 at a dosage of 30 mg MEDD a day. And over time, I think probably through the good intentions of the people who were treating him in both pain clinic and primary care and kind of in the spirit of the knowledge of the day, his dose was escalated. And when he was seen in Will’s clinic, he was at a dosage of 240 mg MEDD. He was also taking Lorazepam TID for his PTSD. He reported he was sedentary but had intermittent high-intensity activity. So he might need to shovel snow. And that would leave him bed-bound for at least a day when that happened. The review of systems was notable for daily moderate to severe pain interfering with his activities and daily living, nightmares, and snoring.

 So from this assessment, there were noticed several problems. First of all, this gentleman has poorly controlled chronic pain, has opioid tolerance, has poorly controlled PTSD and likely also has sleep disordered breathing. But we noticed other things. He also has several quality of care problems. So he has sub-optimal treatment of his chronic pain in the setting of elevated risk for overdose death because of his high opioid use and Lorazepam. He also has suboptimal treatment of his PTSD. And all of this really speaks to a mismatch of this patient’s needs versus the resources that he’s able to access in the healthcare system. So that’s an example of the poor quality care that we want to get away from. So what is our goal?

 The National Pain Strategy notes that chronic pain is a bio-psychosocial condition that often requires integrated multimodal interdisciplinary care. And multimodal paint treatment really addresses the wide range of biopsychosocial problems that may go along with chronic pain and may include multiple different types of therapies—medical, surgical, behavioral, psychological, and integrative.

 So the biopsychosocial model is really the predominant model for understanding chronic pain and also conceptualizing what is optimal pain care. So we know that pain doesn’t just cause unpleasant sensations. We know that pain can have adverse effects on a patient’s physical, emotional, and social functioning. And those domains in turn can feed back into the pain aggravating it. So for example, patients who are afraid that they’ll encounter more harm with movement can become deconditioned, they can have further functional problems, and their mood can be negatively affected.

 So the biopsychosocial model shows us that pain affects all of these different domains. So it’s kind of intuitive to think that a multimodal problem like chronic pain is probably not going to be well controlled by a monotherapy, and in particular just pharmacotherapy. So really what the guidelines promote is interventions that touch on all of these areas, that include behavioral, pharmacotherapy, and physical modalities. And that’s given in the setting of self-management, so promoting the patient’s self-management and self-advocacy of the patient in the context of an integrated health system. So we’re trying to reduce multiple workups and provide an integrated care package for patients.

 So what are our aspirations for multimodal care? There are several in addition to including all of these different components. It would say that because we’re asking the patient to take an active role in their treatment, the treatment plan has to be consistent with the patient’s goals and values and what’s important to them. We incorporate information from prior trials, engage the patient and the system resources, be coordinated in our care with the patient’s comorbid conditions. And then, in recognition that pain is a chronic condition often and that there will likely be changes not only in the patient’s condition but in the patient’s circumstances, we want to have regular assessment and revision of the treatment plan in light of those changes.

 So here’s the big question. How do we go from this to this? So the good news is that there are a number of evidence-based modalities for the treatment of chronic pain. So we kind of grouped these loosely into physical, behavioral, and other techniques. So everything that’s on this slide has randomized control trial evidence for it. The underlying treatments really have multiple large meta analyses that indicate at least moderate effects, durable benefit, and low risk.

 I think one thing to note is that there’s really very little evidence for superiority either between the modalities so that we don’t have clear evidence that exercise is better than behavioral interventions of vice versa. And also within treatments, there’s also little evidence of superiority. So CBT or Cognitive Behavioral Therapy has a strong evidence base, but in head-to-head comparisons with say ACT or Acceptance and Commitment Therapy, you won’t necessarily see superiority. And I think the good news about that is we don’t need to spend a lot of time with wondering what to recommend to the patient. It’s not so much what we recommend, it’s that we recommend something. And that really among the list, the menu of options for the patient, the most important factor are patient preferences and local availability. Those will probably control what the patient is willing or able to engage in.

 So I know there may be skeptics in the audience that raise concerns about patient acceptance of these modalities, access, and cost, and I would agree with you and we’re going to talk a little bit about some studies that we have to try to address those barriers. But I guess I would also point out that I think we all understand that what we’re doing right now is not working. And so we need to move to new treatments and new ways of thinking about treatment. So I’m going to go ahead and leave it there and hand off to Will Becker.

Will Becker: Thanks, Alicia. So I’m going to segue into some of the studies that are ongoing in VA that try to address the issues that Alicia laid out for us. Addressing the gaps in knowledge, how do we implement this multimodal pain care, the gold standard for biopsychosocially informed pain care that focuses more on probably non-pharmacologic treatment than pharmacologic treatment? What are the best methods to increase uptake of evidence-based multimodal pain care, the implementation strategies, alternate modalities, education? What strategies and factors are present and high performing facilities? And how do we support the efforts of the provider and the patient?

 Before I talk about these studies—and I’m really just going to touch on them fairly briefly. Any questions to this point that I could address? Well, let’s keep going then.

 So again, it’s a small snapshot of the studies that we have in the VA landscape. I know there’s others in the room who are doing a lot of great pain work—Maryann Matthias, Kelly Allen. I hope as we move through the next 70 minutes or so, we hear about those studies as well. But I’ll touch on the improving pain related outcomes for Veterans Improve QUERI on which Alicia and I and Amanda Midbow or PI’s. I’ll talk about Primary Care Integrated Pain Support which is my study. Alicia and John Pate [ph.] studied COPES. Amanda Midbow’s Academic Detailing Quality Improvement Study. Joe Frank, who again is at his family reunion today, I’ll touch on his Target of Pain ECHO study. And then from the Measurement Science QUERI, Karen Seal’s [ph.] Integrated Science Pain Team Study. Again, just to give you a flavor of the work that we’re doing to bring evidence-based treatments to the fore.

 So here’s one slide on PIPS, a Hybrid III implementation effectiveness trial of a pharmacist-primary care provider collaborative care program to support voluntary reduction of high-risk opioid regimens and engagement with non-pharmacologic treatment. So this study just rolled out in May and June at three sites: Denver, Little Rock, and Tennessee Valley. Basically, the structure of the intervention is we have a dashboard that identifies eligible patients for the intervention and those would be folks who are on greater than 100 mg morphine equivalent daily dose or combination opioids and benzodiazepines at any dose. The dashboard identifies those folks. We send them a letter. This is a patient-centered letter that’s meant to be non-judgmental, non-threatening, saying in essence, “We know the VA got you to this place of this potentially risky therapy and we’d like to help you with the program to get you to safer doses and to integrate non-pharmacologic pain treatment.”

 So the letter arrives. Ideally, that’s a cue for the patient and the primary care provider to discuss the program at the upcoming primary care visit. The primary care provider places the consult and then the pharmacist engages with the patient and works towards a tapering goal and to identify what non-pharmacologic treatments they would prefer to engage with.

 So again, we’re really early on in the process. Tennessee Valley just got their RB approved. As you can see, we’ve mailed out a lot of letters at Denver and Little Rock and a small fraction of consults initiated at this point. And I think it’s been a little slow going in the beginning and I think that’s largely to do with the fact that at the initial stage, we’re identifying a large group of patients who have already been approached by their primary care provider. So we’re sort of cycling through to get to the people who this may be new information for them. We are doing a mixed methods evaluation and I just wanted to share some of the things we’ve heard early on from a Denver primary care provider who said, “I can’t imagine trying to do this without PIPS support.” Lowering opioid doses is fairly labor intensive work. It requires frequent touches with the patient and to have a pharmacist who’s engaged and who’s expert in this, we think is going to facilitate this process.

 Little Rock Pharmaco Chief reviewed this as team-based care and action. And then one Denver patient actually did start a taper and is on about 25% lower dose, said, “I feel clearer. I feel overall better.” So some early results from that study.

 Next is Alicia’s study, Cooperative Pain Education and Self-Management or COPES. This is another three-site Hybrid III implementation effectiveness trial of an evidence-based technology delivered form of CBT, which involves interactive voice response. Alicia had a non-inferiority trial of this intervention published in Journal of Internal Medicine just earlier this spring.

Erin Krebs: Dr. Becker?

Will Becker: Yeah?

Erin Krebs: I’m so sorry. I’m going to interrupt and just ask, could you remind those of us who are not expert implementation researchers what Hybrid III means?

Will Becker: Oh, thank you. Thank you, Dr. Krebs. So Hybrid, we’re talking about—in a Hybrid study, we’re studying the effectiveness of both the clinical intervention itself and the implementation strategy. And in a Hybrid study it could be a I, II, or a III. In the end of things, you’re studying more the clinical effectiveness and at the III end of things, you’re studying more the implementation strategy. So really the weight here, the emphasis here is on the implementation strategy.

 So, you know, when we talk about this high-quality pain care, one of the major questions that comes up is “How are we going to reach patients who aren’t at major medical center, who aren’t at Level I facilities?” And thus was born the IVR technology that brings CBT to folks who might have restricted access to CBT, which is strong evidence-based treatment for chronic pain. So it allows Veterans to engage in the treatment from their home and it’s primarily focused on CBSC’s. It also involves automated case finding and direct outreach to patients. Again, this study is also just rolling out in the pre-implementation phase at this point. Rollout will be in August 2017. So pre-implementation interviews have yielded important information about crafting communications to providers. So what was elicited is that providers don’t often know how to pitch CBT to patients, so structuring conversations, helping providers learn how to pitch this to patients is a critical aspect of it.

 And then also the ease of referral. Providers have a perception that it takes a lot of steps to get someone enrolled in a pain treatment. Well, with COPES, it’s really not much more than a click of a button. So I think that’s one of the strong components of a facilitation strategy.

 Quick slide on Amanda Midbow’s Academic Detailing Quality Improvement Project. So Academic Detailing for those who don’t know the lingo is basically information transfer from an expert, in this case a pharmacist, to primary care providers to help them feel more comfortable and confident in pain management. Amanda’s project evaluated Vision 21’s [sic] Academic Detailing Intervention to improve safe opiate prescribing. They did qualitative interviews with both high and low-performing academic detailers and providers. Basic take home points: strategies for effective detailing were spending extra time motivating providers, gaining their buy-in and assessing their needs in resolving barriers. To engage providers, they found one-on-one meetings were by far the most successful, that they give tailored feedback. Providers were often reticent or hesitant to talk about their weaknesses in a large group, so the one-on-one really did a lot better. And then if the detailers offered persistence of flexibility, especially with scheduling meetings, that was particularly effective.

 Not surprisingly, facility leadership were important to help engage providers and, probably from a pragmatic standpoint, allowing staff time to participate with some lead time was a critical element of success.

 Joe Frank’s study from the Triple AIM QUERI, they’re doing targeted pain ECHO, which is tele-mentoring of primary care physicians by a multidisciplinary pain team. And I can say, as a generalist, we did not get good pain training in medical school or residency and then you hit practice and you realize a third to half of your patients have chronic pain. So in some ways, we’re needing to retrain the workforce and ECHO is an evidence-based method for doing that, which is done via tele-video.

 So Joe’s got that project as part of the Triple AIM QUERI. He also set out to identify trends and variation of the delivery of multimodal pain care in VHA nationally and he developed this lovely slide, which shows the proportion of facilities that utilize each of the treatment modalities listed on the right-hand side. And, as you can see, everything is increasing, except long-term opioid therapy there in the light blue, which has decreased fairly markedly from 2000 to 2015, as have the use of muscle relaxants, which I’m sure Dr. Sandbrink would agree is not good long-term treatment for chronic pain anyway. And in complimentary and integrative health, there shown in the orange on the bottom, about 2% of facilities offered CIH therapies and it doesn’t look like a great increase, but up to 3.5. So nearly doubling.

 And then finally, a mention of Karen Seal’s mixed methods evaluation of her San Francisco VA Integrated Pain Team. So it’s pretty well described in several RCT’s from Kurt Kronke, Matt Bair, Erin Krebs, and others that a team-based approach to complex chronic pain management is most effective. And so this is Karen and her colleagues in San Francisco have built an interdisciplinary team that’s embedded in primary care, MD, nurse practitioner, pharmacist, psychologist. They refer out to physical therapy and nutrition. They do face-to-face visits in San Francisco. They do VTELS [sic] at rural VA clinics. And they treat patients who are the highest utilizers and probably the most complex chronic pain, problematic, opioid use, mental health comorbidities. PCPS refer patients to the clinic.

 The goal of the clinic is to emphasize non-pharmacologic and high-quality pain management to target improved functioning and quality of life, which is really what we want to see in our patients. And among patients who have opioid misuse and perhaps opioid use disorder, the use of buprenorphine in that population.

 So quickly, with their mixed methods evaluation, in a sample of 56 patients who came through their clinic compared to administrative controls who did not, after three IPT visits the current opioid misuse measure, the brief pain inventory, the pain catastrophizing measures were all significantly improved. However, the pain treatment satisfaction scale, they observed no significant improvement.

 And then in a cohort control study—sorry, this was the one where they had 81 patients who went through IPT, 81 in usual care. They did observe significantly greater reductions in daily opioid dose in the IPT intervention versus usual care. And this successful IPT model is really the basis of one of the arms of Erin Krebs’ recently funded PER QUERI study.

 So, again, it was mixed methods, the qualitative evaluation of IPT clinic stakeholders revealed that there was satisfaction with IPT’s clinics management, that overall mental health and addiction issues were better managed when they were done together. And PCPS actually felt low self-efficacy with long-term pain management and, again, felt very supported by having this integrated interdisciplinary pain team that they could call on for their complex patients.

 So that was a bit of a whirlwind, but I want to plant some ideas for question and discussion topics. How do we partner with clinical operations to evaluate pain initiatives, of which there are many? How do we improve coordination of effort and information? There was a state of the art HSRND conference back in November looking at complimentary integrative health. Many of you were in attendance. How do we enact the recommendations out of that conference, examining combined treatments or sequencing of treatments, improving assessment of patients at the point of care? How do we promote this notion of universal messaging of what is true north when it comes to high-quality pain management? Getting everyone on the same page throughout the healthcare system and then examining patient and provider beliefs about care.

 So with that, I think we’re going to—

Erin Krebs: So we could chat for 10 minutes before our operational partner gives a talk and then we’ll have time for a bigger chunk of discussion afterwards. That was a lot so—

Will Becker: That was a lot. Questions about specific studies? Anything else on your mind? Sure.

Unidentified Female: Does this study talk about \_\_\_\_\_ [00:28:20] huge providers? Because they can talk about maybe voluntary reduction of \_\_\_\_\_ [00:28:25]. Are there studies out there that study the best type of physicians, healthcares, or can you teach goals for providers’ teams?

Will Becker: Sure.

Unidentified Female: Especially if you have a patient with \_\_\_\_\_ [00:28:40] symptoms or a little bit \_\_\_\_\_ [00:28:44].

Will Becker: Okay. And I’ll just repeat the question for the viewing audience at home. So we talked about sort of academic detailing of providers to help them with their messaging to patients. I think for COPES particularly, it’s how to pitch cognitive behavioral therapy. Your question in particular might be related to getting patients on board with opioid tapers. So actually, I’ll turn it over to Alicia to talk about helping providers pitch CDT. And then I think we could also talk about opioid reductions as well.

Alicia Heapy: Okay. So there’s not a lot that’s known about this and I feel like we’re really learning a lot about how to pitch this message. And there are a number of different things that we’re trying to target. What we’ve learned from some initial interviews with providers is they have a lot of different ideas about who might be appropriate for CBT, who might engage in CBT, and who might benefit? And those beliefs are often different from our beliefs about who those patients might be. And they’re different from each other. And so one of the things that that told us was that we needed to craft a universal message that really told providers: a) We just want to remind you this is a first line treatment, so increasing first line is a first line treatment. Not everyone needs a formal program. But many providers would say, “Well, I’ll wait until the patient fails first line treatment before I introduce this,” right. Which is kind of at odds with our idea of promoting the biopsychosocial model. Right, it’s really kind of emphasizing this biomedical acute pain care model. So that’s one thing.

 The other thing is we want to tell them, since they’re not quite sure and we haven’t been doing a good job in psychology messaging around these interventions, who might be good for this? So it’s just about anyone. It’s not risky. If they’ll do it, you should suggest it. And then I think one of the things that comes up on both the patient and the provider side for patients especially is they don’t understand right off. It’s not intuitive. How does this psychological intervention act on what I believe is purely a physical complaint that I have? Right? We don’t do a good job of helping them understand what is the mechanism for that. And so they are often skeptical about whether this will work and rightly so. So I think we need to lay that out for them.

 And on the provider side, I think the limitation there is we need to provide more supports. Providers know that CBT is an evidence-based intervention. There are many other evidence-based interventions. But they may not know enough about it to really feel comfortable. If a patient starts to really ask too many detailed questions, I might not be able to answer. So if my patients asks—if I were a primary care provider—about blood pressure medication and has concerns, I know what to say for that. But if they ask me about CBT, I don’t. And so I may hesitate unless I think the patient is going to be very accepting.

 So we understand that we need to help providers learn like three bullet points. This is what you say to the patient about CBT or other self-management. You emphasize function. You emphasize with them what would they like to get back to doing that they haven’t been doing? And it may not take the first time, and that’s okay. Because we’re playing the long game on this. So it’s about changing the message that the health system gives in that it’s oftentimes, we talk about biopsychosocial, but when patients initially come in, we often revert to biomedical and acute because most of the time, luckily, patients pain will remit and they won’t have chronic pain. But I think that transition from, you probably have chronic pain. You have acute pain so you have chronic pain is not often explicated to the patient. And so they don’t feel comfortable. All of a sudden, they think, “Okay, the game has changed now and I’m not sure why. Maybe you’re not a good provider. Maybe you think I’m not a good patient.”

 So I think we have to think about not formal education, but the learning that patients do just by interacting with the system. Like the messages that we’re giving them in subtle ways about what we think is good and what we think works and what we think doesn’t work. So that’s a lot about that. Yes?

Friedhelm Sandbrink: Just in regard to what you had asked about opioid tapering, I think there are really two different processes in place. On one hand, you need to motivate the patient clinically to want to come and reduce the opiate medication. And the other part is that to engage the patient in the different other modalities that are available. I think in regard to motivating somebody from a clinical standpoint and in regard to reducing opiate medication, it’s really the same as we outline for academic detailing just a few slides ago. As academic detailers need to motivate providers to actually change behavior, meaning change the prescribing, that’s how we do and motivate our patients. So you need to understand where the patient is coming from. I think in many ways the close provider-patient relationship is really what is most important. If you have a trusted provider, if your patient trusts you, they are much more willing to listen to your suggestions and go with you. You have to understand where the patient is coming from. You maybe have to give a story of somebody who did well in your clinic.

 So it’s the same technique that we’re using over and over again to motivate people to change their behavior. And you have to give it time. You have to speak in the same language system-wide, which is part of our multimodal care—the pain specialty provider, the primary care provider, the integrative health provider who does chiropractic manipulation. If we all speak with the same language, if we collaborate and coordinate our efforts, then we will be much more likely to be successful.

Erin Krebs: So I’ll give you so either a short question that I repeat or you can go to the back mike. Just so our online audience can hear.

Unidentified Male: I think I can pare it down.

Erin Krebs: Okay.

Unidentified Male: So when we want patients to talk about sexual risk taking with condoms and \_\_\_\_\_ [00:35:52] and posters, is there something equivalent that you do to make a clinic feel like a place that this is the modality? Is there a poster or something about the layout that you would \_\_\_\_\_ [00:36:09].

Erin Krebs: So the question is just using an analogy to another area where conversations can be difficult. If we want to talk about sexual risk behavior, we put condoms out. We give visual cues in addition to saying things. Are there cues like that, posters, other information we can have readily available and physical for people to get this message across?

Friedhelm Sandbrink: And you’re talking about opioid reduction in particular? I mean, in that regard it actually has become much easier nowadays because patients know about other famous people who have been helped. I think, you know, if we had been trying to do this five or ten years ago, it was a much, much harder new situation. Because really our healthcare system now is more or less speaking with the same language.

 I think as we address opiate reduction, one of the biggest steps we can do clinically is actually to reduce the anticipation of worsening. Patients have experience often with voids. They’ve run out of their meds out of whatever reason. Not because they necessarily took it wrong. Maybe somebody didn’t make out the meds in time. So they anticipate getting worse when the medication gets initially reduced. And whatever you can do to reduce that, maybe by taking a tiny initial step rather than a big step, by telling them about other people who have done well on it. Anticipate and validate their concerns in that regard and you can get the patient to buy in. Now asking about special process, we don’t really have any. Maybe it’s actually a good consideration. I’m wondering if women’s health has something possibly in that regard. But we haven’t already put something up.

Erin Krebs: I’ll offer as an example, I think the Melaxone [ph.] distribution has worked a little bit this way or people have been thinking about it this way as sort of a condom-ish. But an opportunity to give someone something and provide education that is delivering a message basically that is overdose could happen to you. You know, since I’m the Moderator and I get to offer opinions, I’m a little concerned about the language we use when we talk about these things. We so often talk about things that patients don’t see as their behavior. We talk about misuse, diversion, and overdose. And those all sounds like the kinds of things that people who purposely abuse drugs would have a problem with. But when we say misuse and when the National Survey on Drug Use defines misuse, they include the kind of normal behaviors that—well, I’ll say these are culturally normal behaviors. Things like saving meds after a procedure. I won’t ask for hands who might have any hydrocodone or oxycodone in their medicine cabinet, but this is culturally normative behavior, so let’s recognize that that’s what it is. And we all think that that’s problematic when we talk about preventing opioid use disorder and overdose. But when we just talk about misuse and diversion, our patients do not think we’re talking about them. They are not thinking this is non-medical use. They’re thinking this is the normal thing that anyone would do because it’s hard to get these drugs. So, you know, “I’m going to hang onto them and there’s not going to be a problem in my house or associated with this.”

 So I think we need to somehow change the language and probably have more patient friendly information about things like saving medicines, the risks of savings medicines, not the risk of misuse or diversion. And, you know, the risks of opioid poisoning, not the risk of opioid overdose, which sounds like purposefully taking too many pills.

 So I actually think we have some work to do and I like the idea of looking at women’s health because women’s health has had this great culture change campaign about—not about this topic, but about just kind of trying to reframe the messaging and be in a positive manner. So maybe there’s some interesting opportunities there.

 Other questions now and if you’re not sure, we do have additional time later. I’m going to ask Dr. Sandbrink to give us his brief talk too. If not, I’ll let you have the mike here.