Conflict of Interest Disclosure

• None of the presenters in this panel have conflicts of interest.
  • Susan Hagan
  • Nancy Wiedemer
  • Eve Broughton
  • Janette Elliott

A conflict of interest is a particular financial or non-financial circumstance that might compromise, or appear to compromise, professional judgment. Anything that fits this should be included. Examples are owning stock in a company whose product is being evaluated, being a consultant or employee of a company whose product is being evaluated, etc.

• Taken in part from “On Being a Scientist: Responsible Conduct in Research”. National Academies Press. 1995.

Any views or opinions in this presentation are solely those of the author/presenter and do not necessarily represent the views or opinions of the American Society for Pain Management Nursing®.

Pain Resource Nurses Improve Quality of Care

Susan Hagan, MS, ARNP-C, BC-Pain
Coordinator: Pain Programs
Chair, VHA ONS Pain Field Advisory Committee
James A Haley Veterans Affairs Medical Center

Objectives

• Participants of this panel discussion will
  • be able to identify how variation in Pain Resource Nurse programs can impact systems of care.
  • recognize the importance of a structured opioid renewal program for high risk patients on chronic opioid therapy
  • gain an understanding of the patient/RN interactive program GetWell Network and how it helps RN staff to respond to patient self report of pain in the inpatient setting
  • gain an understanding of what the Opioid Safety Initiative is within the Department of Veterans Affairs
History of PRN Programs

- Pain Resource Nurse program started at City of Hope in 1993 in the inpatient Oncology setting
- In 2000, the program at the Tampa VAMC was started in the inpatient units
- 2002 expanded to include the entire continuum of care, inpatient, outpatient primary care and specialty clinics

Research Related to PRNs

- Several studies have been completed related to the role
- Studies including those done at the Tampa VAMC show that the PRN programs improve nursing knowledge in pain management, improve documentation, and reassessment of patients with pain

Research and Expanding Roles

- Research shows that Pain Resource Nurses function as champions of hospital pain initiatives, educators, communicators, coaches and mentors, troubleshooters and evaluators
Quality Outcome

• Quality outcome study done at Tampa showed that one of the outcomes from the Pain Resource Nurse program was that nurses began to not only “Believe in themselves, but also believe their patients when they described their pain”
• Since we know that knowledge alone does not change behavior, it is possible this change in belief enables a change in behavior.

Expansion of the Pain Resource Nurse Program

• In 2008, the VA Tampa changed to the shortened curriculum that was developed by the University of Wisconsin.
• We also initiated a pilot program of including staff beyond Tampa in a Train the Trainer, to help other facilities begin their own PRN program

Further Movement

• In 2011 we began working with June Dahl to modify the curriculum to include material specific for our Veterans to include information on headaches, mild TBI, PTSD and psychiatric co-morbidities, complex pain syndromes, and other dual diagnosis that we manage within our continuum of care.
• In 2013, we sent out a DVD with this curriculum to each VA facility.
Expansion of Presentations

• In 2014, we have begun presenting the PRN program via a webinar format so that nurses throughout the VA system could obtain this education.
• Continuation of Train the Trainer programs.
• These Leaders are now presenting the PRN programs at both their local facilities and some at the VISN level which is a regional collection of VAs

Outcomes in Practice Changes

• Our nurses as a result of this education have developed a number of programs:
  • developed nurse run opioid renewal clinics for patients who are on stable doses of opioids
  • participate in the pain school, teaching classes in pain management, relaxation and other pain management programs
  • teaching classes on opioid safety and opioid consents

Outcomes in Practice

In the Inpatient settings, nurses have:
• developed classes for patients on psychiatric units to help with their pain management
• improved outcomes on documentation
• improved pain outcomes related to staff ability to advocate more effectively for patients
• participated in facility committees for opioid safety, quality improvement
Ultimate Goal

- To help every nurse within the VA system to believe in themselves as pain management nurses and their ability to impact their patients' pain, and to enable them to feel competent in advocating for their patients as they work together on the journey to health.

References


Opioid Renewal Program for High Risk Patients on Chronic Opioid Therapy

Nancy Wiedemer, RN, MSN, CRNP
Pain Management Coordinator
Philadelphia VA Medical Center
**Objectives/Agenda**

- Present the "Opioid Renewal Clinic (ORC)" – an innovative solution implemented in 2001 to assist Primary Care in the management of chronic opioids
- Report on lessons learned: how the ORC is functioning NOW in the midst of the prescription drug addiction epidemic and inadvertent overdose/death

**Primary Care Management of Pain at the Philadelphia VA**

- Group of Primary Care providers concerned about incorporating chronic opioids in practice established policy in 1999
  - Treatment Agreement (we called it a narcotic contract!)
  - Urine Drug Screens
  - Changed the patients to the "new long-acting opioid" oxycodone SA (Oxycontin) because it was better than keeping patients on short-acting opioids
  - Oxycodone SA use soared
  - Wide variation in practice without following the established policy

**Primary Care Management of Pain at the Philadelphia VA**

- Dangers of oxycodone SA (and the $$$) hit the papers (2000-01)
  MANDATE: get your oxycodone SA use down from 42% of all opioids prescribed to 3% !!!

- **Development of Opioid Renewal Clinic 2001**
  Clinical Pharmacist run program in Primary Care to manage
  high risk patients on chronic opioid therapy
Goal: To support PCPs in managing patients with chronic pain requiring opioids

- Assist with management of *challenging* patients requiring structured prescribing and monitoring of long-term opioid therapy
  - Patients with aberrant drug related behaviors to r/o substance misuse vs. pseudoaddiction vs. addiction
  - Patients with h/o addiction, recent addiction, active addiction
  - Patients with complexity (e.g., psych co-morbidity)


**Pharmacy Pain Management Clinic**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 FTE Clinical Pharmacist</td>
<td>Individualized Opioid Treatment Agreement</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Frequent Visits</td>
</tr>
<tr>
<td>- Work-up &amp; Pain Diagnosis</td>
<td>- Prescribing opioids on short term basis</td>
</tr>
<tr>
<td>- Opioid Treatment Agreement</td>
<td>- i.e. weekly or bi-weekly</td>
</tr>
<tr>
<td>- Baseline Urine Drug Test</td>
<td>- Random UDT</td>
</tr>
<tr>
<td>- PCP CONTINUES TO BE RESPONSIBLE TO PRESCRIBE OPIOID</td>
<td>- Pill Counts</td>
</tr>
<tr>
<td></td>
<td>- Co-management with addiction services</td>
</tr>
</tbody>
</table>


**Examples of patients referred**

- Difficult opioid rotation
- **ABERRANT URINE DRUG SCREENS**
  - cocaine, marijuana, un-prescribed medication
  - negative urines
- History of addiction past or current (and in addiction treatment) but compelling reason for treatment with opioids
- High dose opioid monitoring and tapering
Differential Diagnosis of opioid misuse

• Inadequate analgesia
• Disease progression
• Opioid resistant pain
• Opioid induced hyperalgesia
• Self-medication of psychiatric disorders
  • Organic mental disorder
  • Personality disorder
  • Depression/anxiety/situational stressors
• Substance Abuse Disorder
• Criminal intent - diversion

Impact of Mental Health Conditions at the Philadelphia VA
Breakdown of Psychiatric Diagnoses in Chronic Opioid Users (n=1453)

<table>
<thead>
<tr>
<th>Condition</th>
<th>2002-2006</th>
<th>2009</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Disorders</td>
<td>29%</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>PTSD</td>
<td>16%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>17%</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Depression</td>
<td>16%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>No Psych Dx</td>
<td>2%</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Outcomes

<table>
<thead>
<tr>
<th>2002-2006 DATA</th>
<th>2009 DATA</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberrant</td>
<td>67%</td>
<td>50%</td>
</tr>
<tr>
<td>Non-Aberrant</td>
<td>33%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes in the Aberrant Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-2006</td>
</tr>
<tr>
<td>Resolved</td>
</tr>
<tr>
<td>Self Discharged</td>
</tr>
<tr>
<td>Clinic Discharged</td>
</tr>
<tr>
<td>Accepted referral for addiction treatment</td>
</tr>
</tbody>
</table>
Opioid tapering

- As part of the VHA Opioid Safety Initiative, we are reviewing all patients on high dose opioids
- We discuss with patients the RISKS of long-term high dose opioids and suggest a taper
  - If there are no immediate safety concerns, we institute a slow taper
- Retrospective review of 50 patients
  - Average of 46% reduction in opioids in 12 month period
  - When compared to baseline: 70% reported less or no change in pain

VA Stepped Pain Care
VHA Directive, 2009

Primary Care
- Routine screening for presence & intensity of pain
- Comprehensive pain assessment
- Management of common pain conditions
- Support from MH-PC Integration, OEF/OIF, & Post-Deployment Teams
- Expanded care management
- Opioid Renewal Pain Care Clinics

STEP 1

STEP 2

STEP 3
Interactive Patient Care
Pain Assessment at the Bedside

Eve L. Broughton, MS, ACNS-BC, CNRN, Pain -C

Getwell®network and VHA working Together for Improved Patient Care at the Bedside -- and into Outpatient Areas

Objectives

• Introduce VHA partnership with GetWell Network
• Discuss the Barriers and Improvements to patient care secondary to the Partnership
• Discuss the process from the bedside that occurs for the patient, the nurse and the Technology
• Where is this technology taking the VHA next.

What is GWN?

• An interactive IT process that provides education at the bedside, allows self assessment (in this case of pain), alerts the nurse via a paging system when the pain score is greater than 4, places a note in the chart. The nurse can then respond to the call, treat the patient and chart the care.

• A set of orderable educational videos ordered by the nurse, which when viewed by the patient will place a note into the patient chart. The education has a set of cognition questions for the patient to answer to assess understanding and another note is placed in the chart.
A Little History

- 2007: VHA and GetWellNetwork (GNW) established contact
- 2008: the Birmingham VA contract was signed
- 2009: VACO/OPFCC worked w/ GWN to align with VHA Veteran Centered Care Priorities
- 2011: VACO/ Region 4 Chief Information Officer and DSS on GWN to interface with VistA (Veterans Health Information Systems and Technology Architecture) (developed an implemented in 1965+/
- 2014: 22 VA have installed GWN for a total of 7400 beds. And 10 more VAs are anticipated to go live w/ GWN by the end of 2014.

Benefits of IPC in VA

- Veterans and Families
  - Engages veterans proactively, anywhere, anytime
  - Aligns to veteran's preferences, needs and goals
  - Sustains patient activation
- Clinicians and Staff
  - Increases care access, coordination and continuity
  - Insights into experience, satisfaction, quality and transparency
- Veterans Health Administration
  - Improves operational and cost efficiency
  - Enhances veteran and public perception

Plus and Minuses

<table>
<thead>
<tr>
<th>Noted improvements</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real time feedback for the</td>
<td>Culture change for the staff</td>
</tr>
<tr>
<td>patients</td>
<td>Older VA's have building</td>
</tr>
<tr>
<td>SHEP Scores are improving</td>
<td>limitations</td>
</tr>
<tr>
<td>(patient experiences reports)</td>
<td>VistA/CPRS/BCMA interface</td>
</tr>
<tr>
<td>Standardization of education</td>
<td>Budget Restrictions</td>
</tr>
<tr>
<td>Standardization of Clinical</td>
<td>Education GWN is providing</td>
</tr>
<tr>
<td>process</td>
<td>is from an outsourced venue and outdated.</td>
</tr>
<tr>
<td>Standardization of nursing</td>
<td>Education needs updated</td>
</tr>
<tr>
<td>process</td>
<td>and expanded.</td>
</tr>
</tbody>
</table>
OPFCC & Interactive Patient Care

• Goal: By 2017 to be the leader in population health
• #1 Strategic Priority: To provide personalized, proactive, patient-driven health care
• Requirements: Redesign care delivery model, implement scalable platform
• Partner: GetWellNetwork – proven patient-facing platform and change management expertise

GetWellNetwork Solution

• GetWellNetwork: Cross-continuum patient engagement with a consistent veteran experience for inpatient, outpatient, or at home.
• Proprietary library of evidence-based Patient Pathways (workflows)
• IT system integration for ‘whole view’ decision supports resource for veteran care management

VAMC’s implementing IPC

<table>
<thead>
<tr>
<th>#</th>
<th>Medical Center</th>
<th>VA Shared Initiatives</th>
<th>VA Corporate Initiatives</th>
<th>Total Network Impact</th>
<th>Stage I Patient Pathway Impact</th>
<th>Stage II Patient Pathway Impact</th>
<th>Stage III Patient Pathway Impact</th>
<th>GettingITRight Evaluation</th>
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<tr>
<td>1</td>
<td>St. Louis VAMC</td>
<td>✔️</td>
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<tr>
<td>2</td>
<td>NWA VAMC</td>
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<tr>
<td>3</td>
<td>Baltimore VAMC</td>
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<td>✔️</td>
<td>✔️</td>
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<tr>
<td>4</td>
<td>NACE</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>5</td>
<td>NCAVA</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>6</td>
<td>NCAVA</td>
<td>✔️</td>
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<tr>
<td>7</td>
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<tr>
<td>8</td>
<td>NCAVA</td>
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<tr>
<td>9</td>
<td>NCAVA</td>
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<td>✔️</td>
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<tr>
<td>10</td>
<td>TAComa VAMC</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>11</td>
<td>Las Vegas VAMC</td>
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<tr>
<td>12</td>
<td>San Francisco</td>
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</tr>
<tr>
<td>13</td>
<td>SFVAMC</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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</tbody>
</table>
Veteran Experience Impact – Utilization*

- 77% of all veterans complete one or more patient care interventions (e.g., education, satisfaction, feedback, etc.) through GetWellNetwork
- Following is the average percent of all veterans discharged that have completed an intervention:
  - 53% completed prescribed education
  - 79% completed safety education
  - 43% provided feedback with satisfaction of their stay
  - 61% utilized the entertainment features

* Data sources included the following VAMCs: Birmingham, Erie, Gainesville and Lake City.
The Future: In to the Ambulatory Care setting – and into the Home Setting

Process:

- When patient signs into ambulatory facility/doctor’s office a caregiver hands them an iPad
- Caregiver explains what iPad is for; helps log them in (via an interface to VistA)
- Patient is presented with items that the facility wants them to be engaged in (education via videos on Pain for example; smoking cessation questions; enrollment into My HealtheVet; what issues the patient wants to discuss with the doctor; patient satisfaction questions)
- There are also optional items that the patient can be engaged with (PTSD support groups; PTSD apps available; medication teaching; VA Pharmacy hours, etc.)
- Patients watches videos; answers questions and provides input; gives iPad back to caregiver
- All data flows to a Management Console for review in real-time and reviewed by caregivers
- Provider treats patient and addresses patient issues

Looking ahead:
Innovation and Integration Opportunities

- Connected Health
  - My HealtheVet
  - Go patient
  - Telehealth
- Integration with other VA priorities/initiatives
  - Mental Health
  - VA – eBenefits
  - Veterans Canteen Service (retail)
  - VA National Center for Patient Safety – Daily Flex automation through GetWellNetwork Whiteboard
- IPC Governance Structure
  - Personal Health Inventory / Personal Health Plan
  - Pain Management
  - Discharge Education
- Biomedical Engineering Project
  - Assistive Device Integration for SCI patients

References
- Get Well next work staff
- Interaction from participating
- on workgroups with GWN
- VHA data sources

OPIOID SAFETY INITIATIVE

Janette Elliott, RN-BC, MSN, AOCN
Pain Management Clinical Coordinator
Palo Alto VA Medical Center
Opioid Safety Initiative

• Implemented a nation-wide effort to promote appropriate opioid prescribing
• Large variation in opioid prescribing
• Need for education in chronic pain management identified by primary care
• Many patients prescribed opioids as first line therapy, no other therapy offered
• Many patients on high-dose opioids without benefit
• Incidence of opioid overdose deaths rising

Risk VA Overdose Death by Dose

Public Health and Opioids

For every 1 death there are...

Treatment admissions for abuse
32 emergency dept visits for misuse or abuse
130 people who abuse or are dependent
825 nonmedical users
2 million new nonmedical users in 2010

Policy Impact – Prescription Painkiller Overdoses – CDC 2011
No Change in Chronic Low Back Pain 73mg Morphine versus Placebo

<table>
<thead>
<tr>
<th>Study, Year (Reference)</th>
<th>Standardized Mean Difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kurtz and Brosel, 1996 (40)</td>
<td>-0.04 (-0.96 to 0.87)</td>
</tr>
<tr>
<td>Richards et al., 2002 (21)</td>
<td>-0.3 (-0.68 to 0.08)</td>
</tr>
<tr>
<td>Jumpson et al., 1998 (44)</td>
<td>-0.02 (-0.32 to 0.78)</td>
</tr>
<tr>
<td>Hole et al., 2005 (41)</td>
<td>-0.4 (-0.74 to -0.07)</td>
</tr>
<tr>
<td>Pooled</td>
<td>-0.19 (-0.49 to 0.11)</td>
</tr>
</tbody>
</table>

Disability Associated with More Opioids

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Lower dose (≤50 mg. MED)</th>
<th>Medium Dose (50 to ≤150 mg. MED)</th>
<th>Higher dose ≥150 mg. MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working</td>
<td>56%</td>
<td>39%</td>
<td>36%</td>
</tr>
<tr>
<td>Retired</td>
<td>26%</td>
<td>32%</td>
<td>18%</td>
</tr>
<tr>
<td>Not working</td>
<td>18%</td>
<td>30%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Source: CONSORT Survey (N=2119) Group Health, Seattle WA and Kaiser Permanente N CA
Presented by Michael Von Korff, Summit for Opioid Safety, 2012

Develop System-Wide Approach to Pain Management

- Clinical practice guideline for chronic opioid therapy
- Pocket guide
- Computer App
- Wide dissemination
- National movement to engage every facility
- Computer available pain management information for patients
- Staff Education—national, regional, local
- Developed dashboard to identify prescribing practices
- Informed consent for chronic opioid therapy
Dashboard
• Data from computerized record
• Pain assessment done
• Level of prescribing
• Side effect management—bowel regime, adverse outcomes
• Dangerous drug interactions—overlapping opioids, benzos, barbiturates, carisprodol, methadone interactions
• Appropriate acetaminophen prescribing
• Misuse risk—psychiatric or substance use disorders
• Appropriate follow up
• Appropriate lab testing
• Use of appropriate pain therapies
• Accessing state prescription monitoring program

Informed Consent for Chronic Opioid Therapy
• Consistent nation-wide
• Opioid treated like other therapy with known significant risks
• Pain Care Plan
• Do’s and don’t of opioid use
• Short term and Long-term side effects
• How to refill prescriptions
• Protect opioids from damage, loss, theft
• Work with provider on pain care
• Accessing prescription drug monitoring programs

Patient Education Handout
• Based on best evidence
• Vetted by all national VA services impacting chronic pain
• Primary Care
• Pain
• Nursing
• Pharmacy
• Addiction
• Ethics
The Message to Providers

1. Based on compelling evidence over the last 10 years that has shown poor outcomes with high dose long-term opioids in chronic pain, we are recommending change in the way opioids are prescribed in this population.

2. Opioid Safety Initiative IS NOT about stopping or not starting opioids. The goal of the initiative is to provide the best possible pain care with opioids if indicated utilizing standardized evidence-based prescribing practices that safeguard against harm and abuse.

Outcomes

- Too early yet to determine opioid overdose rates
- More appropriate opioid prescribing
- Increased safe prescribing
  - Less combination benzos and opioids
  - Therapeutic acetaminophen levels
  - Lower opioid doses
- More availability of non-opioid and CAM therapies
- Increased use of appropriate lab tests
- Increased use of state prescription monitoring programs
- Increased use of informed consent

References

- Centers for Disease Control and Prevention, CDC 25/7: Saving Lives, Protecting People, downloaded 7/19/2014 from http://cdc.gov/injury/about/focus-rx.html