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

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Poll question #1

I am primarily attending because I’m interested in:

- Suicide prevention
- Pain management and opioid therapy
- Implementation of new clinical initiatives
- Other

Please check all that apply
Poll question #2

How much experience do you have with STORM

- None
- A little
- Some
- Quite a bit
Opioid prescribing and overdose or suicide-related events
VHA is committed to enhancing the safe and efficacious care of Veterans exposed to opioids

Gellad WF, Good CB, and Shulkin DJ. JAMA Intern Med. 2017 May 1;177(5):611-612
S.T.O.P. P.A.I.N. — 8 VA Best Practices

S – Stepped Care Model for Opioid Use Disorder & Pain
T – Treatment alternatives/Complementary care
O – Ongoing monitoring of usage
P – Practice Guidelines
P – Prescription monitoring
A – Academic Detailing
I – Informed Consent
N – Naloxone distribution

https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2934
Pain Directive

VA National Pain Directive established

OHRM Initiative and PRIME Research

Opioid High Risk Medication Initiative
Policy requiring access to medication for OUD
VA Pain Research, Informatics, Multimorbidities, and Education (PRIME) Center studies interaction between pain/associated chronic conditions and behavioral health factors

OSI and AD

Created standardized metrics for pain management therapies to pilot Opioid Safety Initiative (OSI)
Select regions pilot Academic Detailing (AD)

OSI and PDSI

Opioid Safety Initiative (OSI) expands nationally
Psychotropic Drug Safety Initiative (PDSI) launched nationally

VA Pain Research, Informatics, Multimorbidities, and Education (PRIME) Center studies interaction between pain/associated chronic conditions and behavioral health factors

OSI LAUNCH

Opioid Safety Initiative (OSI) launched in 5 regions

Targeted interventions for opioid reduction in very high dose opioid patients
Overdose Education and Naloxone Distribution (OEND) campaigns

SUD and CARA

VA-DoD develop clinical practice guideline (CPG) on Management of Substance Use Disorder (SUD)
Comprehensive Addiction and Recovery Act (CARA) implementation in VHA

OSI LAUNCH

VA-DoD FIRST

VA-DoD FIRST develop clinical practice guideline (CPG) on Opioid Therapy in Chronic Pain (FIRST)

2007
BIU Initiative
Launch of the Buprenorphine in VA (BIU) Initiative

2008

VA Pain Directive
VA National Pain Directive established

2009

OSI and AD
Created standardized metrics for pain management therapies to pilot Opioid Safety Initiative (OSI)
Select regions pilot Academic Detailing (AD)

2010

OSI and PDSI
Opioid Safety Initiative (OSI) expands nationally
Psychotropic Drug Safety Initiative (PDSI) launched nationally

2011

OSI Launch
Opioid Safety Initiative (OSI) launched in 5 regions

Targeted interventions for opioid reduction in very high dose opioid patients
Overdose Education and Naloxone Distribution (OEND) campaigns

2012

Academic Detailing
Academic Detailing (AD) expands nationally to enhance Veteran outcomes by promoting evidence-based treatments

2013

OSI and PDSI
Opioid Safety Initiative (OSI) expands nationally
Psychotropic Drug Safety Initiative (PDSI) launched nationally

2014

Academic Detailing
Academic Detailing (AD) expands nationally to enhance Veteran outcomes by promoting evidence-based treatments

2015

Teams, CPGs, and AD

Opioid Safety Initiative (OSI) expands nationally to enhance Veteran outcomes by promoting evidence-based treatments

2016

SUD and CARA
VA-DoD develop clinical practice guideline (CPG) on Management of Substance Use Disorder (SUD)
Comprehensive Addiction and Recovery Act (CARA) implementation in VHA

2017

VA Opioid Safety Initiative (OSI) Timeline
But…

External reviews continue to argue that VA struggles with reducing risk and improving opioid safety.
Extending the Opioid Safety Initiative

• Initial Opioid Safety Initiative efforts focused on improving opioid prescribing practices, making the prescription safer

• Huge improvements in opioid prescribing practice have been made through efforts across the system:
  ◦ Fewer opioid prescriptions
  ◦ Less high dose prescribing
  ◦ Less co-prescribing with benzodiazepines
  ◦ More universal precautions
    ◦ Informed consent
    ◦ Urine Drug Screening
    ◦ Prescription Drug Monitoring Program checks
Extending the Opioid Safety Initiative

• But patients are still dying of overdose and suicide
  ◦ Overall overdose and suicide rates among VA patients are still high, even if rates are declining among patients receiving VA opioid prescriptions
  ◦ Most of the patients who die of overdose or suicide are receiving low to moderate dose opioid prescriptions

• Need to go beyond the prescriptions to address the biopsychosocial factors that contribute to suicide and overdose mortality, addiction and other adverse events
FY2013 Overdose/Suicide Mortality

![Chart showing percentage of FY13 overdose/suicide deaths by morphine equivalent daily dose (MEDD) range and diagnoses.](chart-image-url)
Experience with predictive model-driven clinical review for reducing mortality

• REACH VET Model estimates risk of a suicide death in the next month

• Top 0.1% of patients based at each facility each month receive:
  ◦ Case review
  ◦ Out-reach phone call

• Initial evaluation found reductions in all-cause mortality in first 3-6 months:
  ◦ 1.1% versus 1.6% in comparison to pre-time frame
  ◦ 1.1% versus 2.2% in comparison to patients from top 0.1%-0.5%
  ◦ Fewer inpatient admissions and ED visits, more outpatient mental health visits
  ◦ Fewer missed appointments and more safety plans

• Suggests that targeting extra clinical attention to those with modeled risk has substantial clinical and health care system benefits
What should VA do next?
The STORM model and Dashboard
What is the STORM risk model?

- Uses demographic, diagnostic, pharmacy, and health care utilization data from the Corporate Data Warehouse.

- Predicts risk of overdose or suicide-related health care events or death in the next year and generates patient-specific risk score.

- Parameters from model are applied to Veteran health care data and updated nightly to create individual estimates of risk in STORM.

- Detailed background and data on the STORM risk model:
Interpreting the STORM Risk Score

• The risk score is designed to help understand Veteran risk level to support treatment planning

• Risk factors are often not changeable, so the goal should not be to change estimated risk

• The goal should be to design a treatment plan that addresses risk factors and is appropriate for the patient’s risk level
  o For example, higher risk patients may need more monitoring, more risk mitigation intervention, care coordination between services, and higher intensity of care
### Strong diagnostic and health care event risk factors for overdose or suicide-related events

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Odds Ratio</th>
<th>Model Parameter</th>
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<tbody>
<tr>
<td>Prior overdose or suicide-related event</td>
<td>23.1</td>
<td>2.62</td>
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<tr>
<td>Detoxification treatment</td>
<td>18.5</td>
<td>.06</td>
</tr>
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<td>Inpatient mental health treatment</td>
<td>16.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Sedative use disorder diagnosis</td>
<td>11.2</td>
<td>.23</td>
</tr>
<tr>
<td>Stimulant use disorder diagnosis</td>
<td>8.1</td>
<td>.73</td>
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<tr>
<td>Opioid use disorder diagnosis</td>
<td>8.0</td>
<td>.31</td>
</tr>
<tr>
<td>Mixed substance use disorder</td>
<td>8.0</td>
<td>.33</td>
</tr>
<tr>
<td>Cannabis use disorder</td>
<td>5.9</td>
<td>.27</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>5.8</td>
<td>.82</td>
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<tr>
<td>Alcohol use disorder</td>
<td>5.3</td>
<td>.36</td>
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<tr>
<td>Other mental health disorder</td>
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<td>.73</td>
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<tr>
<td>Major Depression</td>
<td>4.8</td>
<td>.61</td>
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<tr>
<td>Emergency Department visit</td>
<td>3.4</td>
<td>.72</td>
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<tr>
<td>Fall or accident</td>
<td>2.9</td>
<td>.44</td>
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<tr>
<td>PTSD</td>
<td>2.6</td>
<td>.34</td>
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<tr>
<td>Tobacco use disorder</td>
<td>2.2</td>
<td>.18</td>
</tr>
<tr>
<td>AIDS</td>
<td>2.2</td>
<td>.20</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>2.2</td>
<td>.15</td>
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<tr>
<td>Other neurological disorder</td>
<td>2.1</td>
<td>.18</td>
</tr>
<tr>
<td>Electrolyte disorders</td>
<td>2.0</td>
<td>.19</td>
</tr>
</tbody>
</table>
MH/SUD and Non-Opioid Related Factors Have Higher Odds Ratios than Opioid-Related Factors in VHA Predictive Model

Odds Ratios for Overdose/Suicide-Related Events

- Risk increased slightly with increasing MEDD
- e.g., 120 MEDD would increase modeled risk by about as much as a PTSD or AUD diagnosis

STORM Analysis: Oliva et. al. Psych. Services 2017
High Odds Ratios for Other Evidence-Based Sedating Pain Medications

Odds Ratios for Overdose/Suicide-Related Events

- Having TCAs, SNRIs and Anti-convulsants is associated with increased risk
- Association could be related to unmanaged pain, cumulative sedation, depressive symptoms, etc.

Oliva et al., Psychol Serv 2017
Risk scores for patients with no opioid prescription

- If a patient has **no active opioid prescription** the report will calculate 3 “hypothetical” STORM risk scores
  - On the STORM look-up report a patient’s risk factor information is combined with hypothetical prescription information assuming prescription of a low (20 MEDD), medium (50 MEDD), or high (90 MEDD) dose of a short-acting opioid analgesic.

- If a patient has no active opioid prescription and an **opioid use disorder**, the report will calculate a “hypothetical” STORM risk score. These patients are their own category in STORM.
  - The STORM model includes information on opioid dose and prescription type in the model. We do not have any information on the dose of opioids consumed by patients taking them illicitly.
  - To calculate the hypothetical score, STORM assumes that a patient with an opioid use disorder is consuming a high dose of short-acting opioids daily, estimated as 90 MEDD in the model.
What is the STORM dashboard?

Clinical decision support tool updated nightly that:

- Identifies patients at-risk for overdose-/suicide-related adverse events
- Provides patient-centered opioid risk mitigation strategies
Key features of STORM

Estimates an individual patient’s risk for an overdose-/suicide-related adverse event or death based on predictive models
  ◦ Patients with active opioid prescriptions
  ◦ Patients with an opioid use disorder diagnosis in the past year
  ◦ Hypothetical risk for patients considering initiating opioid therapy

Provides patient-centered opioid risk mitigation strategies by displaying:
  ◦ Risk factors that place patients at-risk (e.g., co-Rx benzodiazepines, previous adverse events, mental health and medical diagnoses, opioid dose)
  ◦ Risk mitigation strategies, including non-pharmacological treatment options, employed and/or to be considered
  ◦ Patients’ upcoming appointments and current providers to facilitate care coordination

Note: changes made to the patient medical record/CPRS will not display until the next day. Use STORM in conjunction with CPRS for most up to date clinical information.
Accessing STORM

- Hyperlink in the CPRS Tools Menu
- STORM Dashboard Hyperlink:
  - [https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx](https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx)
Welcome to the Stratification Tool for Opioid Risk Mitigation (STORM) Home Page!

Reports:

- STORM Summary Report
- STORM Patient Detail Report
  
  Click here for de-identified version
  Click here for quick view patient report
- STORM SSN Look-Up Report

Supporting Materials

Other Resources

- Opioid Overdose Education & Naloxone Distribution (OEND)
- Opioid Metrics Report
STORM Risk Mitigation Strategies support implementation of policy initiatives to reduce opioid risks

• Informed Consent for Chronic Opioid Therapy
• Prescription Drug Monitoring Program Checks
• Urine drug screening during opioid therapy
• Safety planning
• Medication assisted therapy for opioid use disorders
• Opioid Overdose Education and Naloxone Distribution
VHA Notice 2018-08: Conduct of Data-Based Case Reviews of Patients with Opioid-Related Risk Factors
Key Points of Notice 2018-08

• Link: https://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=6366

• This notice extends the efforts of the Opioid Safety Initiative
  o Data-based case reviews can be conducted in lieu of OSI reviews at facility discretion

• This notice meets the mandates in the Comprehensive Addiction and Recovery Act of 2016, Title IX, Subtitle A, Section 911(a)(2)

• Patient information may be reviewed in the medical record and any clinical decision support tool

• Data-based case reviews do not replace universal precautions or clinical discretion
Data-based Risk Review

These data-based risk review efforts are designed to focus attention on whole patient needs and encourage collaborative treatment planning, particularly across primary care, mental health, and pain management providers.

- Two populations addressed:
  - Patients estimated to be at very high risk of overdose or suicide based on predictive models
  - Patients considering new initiation of opioid therapy

Continue to encourage safe prescribing practices, but extend efforts to ensure engagement with mental health, substance use disorder treatment, suicide prevention, specialty pain, and rehabilitative services (e.g., PT, OT, homeless) as needed.

  - Additionally increase awareness of cross-facility care and clarify care responsibilities
Required Data-Based Case Reviews

Centralized Review of Patients on opioid therapy at Very High Risk for an Adverse Event

Point of Care review of patients with new opioid prescribing prior to initiation
Centralized Review Process

Facility Leadership directs case Reviews of very high risk opioid prescribed patients

Team Reviews Very High Risk Patients; Team should include pain specialist, addiction psychiatrist, behavioral medicine psychologist, and a primary care physician; Recommend completion by Pain Management Team

Complete Individual Patient Review

Do recommendations include opioid taper or discontinuation?

Y

Essential to plan for additional on-going care and maintain treatment engagement

N

Coordinate recommendations with Patient Care Team and document review and any actions using appropriate note titles per national guidance

Case reviews completed; Weekly monitoring by team of the STORM Dashboard for new patients
Who conducts interdisciplinary reviews?

• **Interdisciplinary Pain Management Teams:**
  ◦ [Mandated in 10N Memorandum](#)
  ◦ Comprehensive Addiction and Recovery Act (CARA) Requirements from Section 911(c) Pain Management Team Facility Report, dated May 22, 2017

OR

• Opioid Safety Initiative review teams with interdisciplinary representation

• Facility leadership should ensure that staff on teams have training, adequate dedicated time, and appropriate representation
Why is interdisciplinary review so important?

- Veterans suffer more commonly from chronic pain than Non-Veterans, and their pain is more often severe and complex, and often associated with psychiatric and medical comorbidities.
- Suicide and overdose prevention includes timely access to pain management with integrated behavioral therapies and mental health and addiction expertise as appropriate.
- Coordination between the different clinical areas is essential to promote efficient use of resources and smooth transition of the Veteran between the care areas.
Commonly observed challenges

Siloed pain management and mental health care

- Effective non-opioid treatments for chronic pain and mental health conditions include psychotropic prescribing, psychosocial treatment, and integrated health approaches
- Functional goal/recovery focus is key to effective treatment planning and patient management
- Biopsychosocial factors and sleep problems complicate treatment of both pain and mental health/SUD
- Provider collaboration on treatment planning is key to optimizing psychotropic prescribing, avoiding conflicting plans, and preventing patients from falling through gaps in perceived clinical responsibility
Commonly observed challenges

Transient patients receiving care at multiple locations
  • Incomplete awareness of care being received elsewhere
  • Confusion around on-going management plans/assigned providers
    o Multiple PACT/BHIP team assignments
  • Gaps in management during patient moves
  • Duplicative prescriptions

Common complaint: “We haven’t seen this patient (on my panel) in years!”
Commonly observed challenges

• Lack of patient engagement in treatment for known substance use disorder and mental health conditions

• Lack of focus on suicide risk in pain-focused settings and lack of focus on overdose risk in mental health-focused settings
### Example Very High Risk patient profile

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older white male</td>
<td>What can you do?</td>
</tr>
<tr>
<td>Extensive medical comorbidity</td>
<td>Resolve duplicative prescribing across</td>
</tr>
<tr>
<td>SUD including opioid use disorder and depression</td>
<td>providers and facilities and converge on a</td>
</tr>
<tr>
<td>Recent history of suicidal ideation, sedative</td>
<td>single medication plan</td>
</tr>
<tr>
<td>overdose and falls</td>
<td>Reengage patient in MH and SUD care and</td>
</tr>
<tr>
<td>Multiple active opioid prescriptions from different</td>
<td>consider medication assisted therapy</td>
</tr>
<tr>
<td>providers within a facility</td>
<td>Provide overdose education and naloxone and</td>
</tr>
<tr>
<td>Multiple active prescriptions for same psychotropic</td>
<td>review safety plan with patient</td>
</tr>
<tr>
<td>across facilities</td>
<td></td>
</tr>
<tr>
<td>No MH/SUD care in last 10 months and none</td>
<td>Suicide prevention and opioid safety are not</td>
</tr>
<tr>
<td>scheduled</td>
<td>separate</td>
</tr>
</tbody>
</table>
Example Very High Risk patient profile

Diagnosed polysubstance use disorder, including opioid use disorders
- No active engagement in SUD treatment or MAT

Mental health comorbidities
- Bipolar and PTSD
- No upcoming MH appts

Low opioid dose
- Tramadol 5 mg
- But no informed consent, OEND, PDMP checks, or UDS

Sedative overdose in the last year

Medical Comorbidities
- Liver disease

What can you do?
Encourage engagement in mental health and SUD treatment

Review psychotropics prescribing to minimize overdose risk, provide overdose education

Ensure on-going monitoring of substance use and proactive coordinated care management

The low dose was initiated because of the patient’s risks
STORM & Patients with Opioid Use Disorders

- STORM is also designed to facilitate care for patients with opioid use disorders (OUD)
- Patients with OUD have 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 a “OUD patients (Elevated Risk)” category
- Implementation of medication assisted treatment for these patients is monitored by the SUD16 measure on the Mental Health Domain of SAIL and by the Psychotropic Drug Safety Initiative (Phase III)
STORM Summary Report

- Presents data at the national, facility, and provider level
- Identifies patients who might benefit from specific risk mitigation strategies
- Allows tracking of implementation of data-based case reviews
## STORM Summary Report

**STORM Summary Report BETA**

Stratification Tool for Opioid Risk Mitigation

Data displayed has a 1-2 day lag from CPRS entry. This report is to be used in conjunction with the electronic medical record and direct discussion with the patient to help facilitate decision-making.

[Home] [Definitions] [Contact Us] [Save/Share Current View]

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To access STORM SSN-level Reports you will need to ensure you have PHI/PII access: [Request SSN Access]

---

### Facility X — All Providers/Teams

<table>
<thead>
<tr>
<th>STORM Cohort Summary</th>
<th>Risk Category**</th>
<th>Patients</th>
<th>Active Opioid</th>
<th>OUD Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility X</td>
<td>OUD Patients (Elevated Risk)</td>
<td>532</td>
<td>0</td>
<td>532</td>
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<tr>
<td>Active Patients: 60,274</td>
<td>Very High</td>
<td>20</td>
<td>20</td>
<td>8</td>
</tr>
</tbody>
</table>

**Risk Mitigation Strategies**

<table>
<thead>
<tr>
<th>Minimize MEDD (&lt;80)</th>
<th>Risk Category**</th>
<th>National Score (%)</th>
<th>Score (%)</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Actionable (# Nbt Met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility X</td>
<td>Very High</td>
<td>93.2</td>
<td>80.0</td>
<td>16</td>
<td>20</td>
<td>4</td>
</tr>
</tbody>
</table>

| Naloxone Kit        | OUD Patients (Elevated Risk) | 30.5               | 20.9      | 111       | 532         | 421                   |
|                     | Very High        | 18.9               | 10.0      | 2         | 20          | 18                    |

| Opioid Informed Consent | Very High | 56.3 | 85.7 | 6 | 7 | 1 |

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[Click here to generate a list of patients for review]
**Short-Cut to List of Very High Risk Patients That Need Review**

<table>
<thead>
<tr>
<th>Risk Mitigation Strategies</th>
<th>Risk Group**</th>
<th>National Score (%)</th>
<th>Score (%)</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Actionable (# Not Met)</th>
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<tbody>
<tr>
<td>Minimize MEDD (&lt;=90)</td>
<td>Very High</td>
<td>93.0</td>
<td>77.8</td>
<td>14</td>
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<td>4</td>
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<tr>
<td>Naloxone Kit</td>
<td>OUD Patients (Elevated Risk)</td>
<td>33.2</td>
<td>23.7</td>
<td>122</td>
<td>515</td>
<td>393</td>
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<tr>
<td></td>
<td>Very High</td>
<td>22.1</td>
<td>22.2</td>
<td>4</td>
<td>18</td>
<td>14</td>
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<tr>
<td>Opioid Informed Consent</td>
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<td>75.2</td>
<td>100.0</td>
<td>8</td>
<td>8</td>
<td>0</td>
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<tr>
<td>Timely Follow-Up</td>
<td>Very High</td>
<td>82.7</td>
<td>72.2</td>
<td>13</td>
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<td>5</td>
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<td>Timely Drug Screen</td>
<td>OUD Patients (Elevated Risk)</td>
<td>47.3</td>
<td>48.2</td>
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<td>515</td>
<td>267</td>
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<tr>
<td></td>
<td>Very High</td>
<td>54.0</td>
<td>72.2</td>
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<td>5</td>
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<td>Psychosocial Assessment</td>
<td>OUD Patients (Elevated Risk)</td>
<td>56.8</td>
<td>66.6</td>
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<td>172</td>
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<tr>
<td></td>
<td>Very High</td>
<td>55.9</td>
<td>94.4</td>
<td>17</td>
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<td>Psychosocial Tx</td>
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<td>515</td>
<td>110</td>
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<td></td>
<td>Very High</td>
<td>76.7</td>
<td>94.4</td>
<td>17</td>
<td>18</td>
<td>1</td>
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<tr>
<td>Bowel Regimen</td>
<td>Very High</td>
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<td>50.0</td>
<td>9</td>
<td>18</td>
<td>9</td>
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<td>PDMP</td>
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<td>94.4</td>
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<td>Data-based Opioid Risk Review</td>
<td>OUD Patients (Elevated Risk)</td>
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<td>0.0</td>
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<td>515</td>
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<tr>
<td></td>
<td>Very High</td>
<td>1.0</td>
<td>5.6</td>
<td>1</td>
<td>18</td>
<td>17</td>
</tr>
</tbody>
</table>

Very high risk “actionable patients” links directly to the patient view of just those very high risk patients who do not have a review documented in the last 12 months.
Required Data-Based Case Reviews

- Centralized Review of Patients on opioid therapy at Very High Risk for an Adverse Event
- Point of Care review of patients with new opioid prescribing prior to initiation
CARA Mandate for Point of Care Reviews

Title IX, Subtitle A, Section 911(a)(2) of the Comprehensive Addiction and Recovery Act (CARA):

The Secretary shall establish guidance that each health care provider of the Department of Veterans Affairs, before initiating opioid therapy to treat a patient as part of the comprehensive assessment conducted by the health care provider, use the Opioid Therapy Risk Report tool of the Department of Veterans Affairs (or any subsequent tool), which shall include information from the prescription drug monitoring program of each participating State as applicable, that includes the most recent information to date relating to the patient that accessed such program to assess the risk for adverse outcomes of opioid therapy for the patient, including the concurrent use of controlled substances such as benzodiazepines, as part of the comprehensive assessment conducted by the health care provider.
Veteran presents to clinic

Provider considers initiating opioid therapy

Using STORM, provider reviews patient risk and benefits of opioid therapy trial

Provider discusses risk, benefits, mitigation strategies, functional goals, and discontinuation plans with the patient

Routine patient care

Additional care needs addressed

Veteran need is met

Service receives consult

Provider uses STORM as part of consult triage and review

Provider takes appropriate action and documents STORM review
SSN Look-up Report

• This report can be used to complete the data-based case reviews *prior to initiation*, meeting the mandate in CARA

• For patients with no active opioid prescription, it displays hypothetical overdose/suicide risk score estimates based on low, medium, or high opioid doses

• Supports risk-benefit discussions, patient-centered pain management, and safety planning before opioid therapy is started
Point of Care Review Using the STORM SSN Look-up Report
Patient SSN Look-up Report

Enter SSN to view patient’s:
• Current Suicide Risk
• Predicted opioid-related suicide/overdose risk
• Opioid-related risk mitigation strategies
• Potential non-pharmacological treatments
• Recent or upcoming appointments
• Current providers

Are you considering co-prescribing an opioid and a benzodiazepine? Assess your patient’s risk and information about co-prescribing.

Can’t see patient data? Click here to troubleshoot.
STORM SSN Look-up Report 2.0
Stratification Tool for Opioid Risk Mitigation

Data displayed has a 1-2 day lag from CPRS entry. This report is to be used along with the electronic medical record and direct discussion with the patient to help facilitate decision-making.

PATIENT NAME
SSN
No Known Active Opioid Exposure

Suicide Risk and Current High Risk Flags

STORM Model: Risk Estimate (hypothetical)

- Suicide-related event or overdose in the next year
  - High (9.3%)
  - High (9.7%)
- Suicide-related event, overdose, fall or accident in the next 3 years
  - If MEDO = 90
    - Medium (17.7%)
  - If MEDO = 10
    - Medium (18.5%)
  - If MEDO = 50
    - Medium (19.3%)

What factors contribute to my patient's STORM risk score?

- Diagnosis: included
  - Bipolar
  - Depression
  - Other Mental Disorders
  - Personality disorder
  - Severe Mental Illness
  - Suicide Attempt or Ideation
  - Substance Use Disorder
    - Alcohol
    - Cannabis
    - Substance Use Disorder

- Medications

Risk mitigation strategies that help manage patient's risk

- Non-pharmacological Pain Tx
  - Active Therapies
  - CM Therapies
  - Occupational Care
  - Physical Therapy
  - Specialty Therapy
- Active GUID Tx
- Medication Assisted Therapy

Additional supplemental information is displayed below the main display

Risk Assessment section: Patient's predicted and clinical suicide risk information, including high risk flags

Factors contributing to patient's risk

Relevant providers for follow-up and care coordination

Last VA Contact: (544) Columbia, SC

Future Appointments: (544) Columbia, SC

Assigned Providers: Columbia, SC HCS

XXXXXXX
Documenting Data-Based Case Reviews

- STORM has a ‘chart review note’ feature that will create a summary of the patient’s data in a document that the clinician can copy, paste, and annotate in a CPRS note.
- Use a note title that complies with the guidance in the STORM Notice and Supplementary Materials and meets facility needs.
Documenting Data-Based Case Reviews

Patient Detail Report

- ZZTEST, CPRS THIRTY FIVE FIVE
  - Last Four: 9382
  - Age: 54
  - Gender: M

  **Risk: Suicide or Overdose (1 yr)**
  - Very High - Active Opioid Rx
  - 24%

  **ROISORD Score: 5 Risk Class: 1**

- Active Stations
  - (512) Maryland HCS (Baltimore, MD)

SSN Look-Up Report

- Chart Review Note
- Active Opioid Rx + Current OUD Dx
- Suicide Risk and Current High Risk Flags
  - STORM Model Risk Estimates
  - Suicide-related event or overdose in the next year
  - currently identified in REACH VET: No
  - Suicide-related event, overdose, or fall in the next 3 years
  - High Risk Flags
Track Successfully Documented Reviews

Patient Detail Report and SSN Look-Up

Summary Report

When a patient has a note in CPRS with a qualifying note title, the box will be checked on the Patient Detail Report and SSN Look-Up Report. The patient will also be in the numerator of the risk mitigation strategy on the Summary Report.
Implementation Support

- Links on the main STORM page:
  
  https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx

- STORM Implementation SharePoint:
  https://vaww.portal2.va.gov/sites/PERC/STORM/SitePages/Start.aspx

- STORM Help Desk:
  V21PALSTORMteam@va.gov

- VHA STORM Listserv:
  ◦ Contact Amy.O'Donnell@va.gov to be added to the listserv
Implementation Support: Academic Detailing

- Provider materials
- Patient materials
- PDMP map
- Data resources from AD and others
- Additional resources: research studies, presentations, links

https://vaww.portal2.va.gov/sites/ad/SitePages/Campaigns.aspx
Implementation Support in Development

- Monthly collaborative call
  - Schedule posted on the STORM Implementation SharePoint site
- Additional FAQs and training and briefing materials
- Implementation toolkit
- Collaborative listserv
How will implementation of centralized review be monitored?

**Numerator:** Patients in the denominator who have a note including “Data-based” and “Opioid Risk Review” in the title in their medical records within the last 4 quarters.

**Denominator:** Patients with an opioid prescription who are in the “Very High – Opioid Patients” risk category in STORM for at least 7 days in the last quarter. The 7-day criterion insures that a process of consistent reviews on at least a weekly basis will identify all patients in the metric denominator.
How will implementation of point of care reviews be monitored?

Numerator: Patients in the denominator who have a note including “Data-based” and “Opioid Risk Review” in the title in their medical records since January 1, 2018

Denominator: Patients receiving an outpatient opioid analgesic prescription in the index quarter who have received no prior outpatient opioid analgesic prescriptions since January 1, 2017

As in VHA Directive 1306, patients will be excluded from the denominator if:

- Their only opioid prescription is for a 5-day supply or less without refills
- The patient is enrolled in Hospice Care
The goal of data-based opioid risk reviews is to **review the patient** not the prescription.

Need to go beyond a check of the risk of the prescription itself.

**Do not** focus on changing the patient’s modeled risk score. You **cannot** change many of the factors that contribute to the risk score.

**Do** focus on optimizing the patient’s treatment plan, using risk mitigation interventions and considering alternative or augmentative options.

You **can** do your part to ensure the patient receives the safest, most appropriate care.

Most very high risk patients have complex mental health issues. Collaborative treatment planning across providers, services and facilities should be a key goal for comprehensively addressing risk.
Summary

• VA’s 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 interventions

• The STORM model and dashboards facilitate prioritizing patients for clinical review:
  o Pre-initiation reviews should facilitate risk-benefit discussions and design of a treatment plan, and, opioid trial (if appropriate) that optimizes safety and effectiveness

• We expect that at most facilities implementation will require engaging new types of providers in Opioid Safety efforts and clarifying protocols for care coordination across services
Poll question #3

After this talk, how convinced are you that data-based risk reviews are an important component of suicide prevention?

- Very convinced
- Somewhat convinced
- A little convinced
- Not convinced
Questions/Comments?

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