VA Pain Management Program

Painkiller Epidemic

Dr. Robert Kerns spoke recently with North Carolina's Fayetteville Observer's staff writer John Ramsey about the painkiller epidemic and the Department of Veterans Affairs' position on prescription drugs and their use. Dr. Kerns is the Department of Veterans Affairs national program director for pain management. A professor of psychiatry, neurology and psychology at Yale University, Kerns also serves on the Institute of Medicine's Committee on Advancing Pain Research, Care, and Education. Following is the full conversation:

Q: *The number of hydrocodone prescriptions at the Fayetteville VA went from about 1,100 in 2001 to more than 47,000 last year. That's a 4,100 percent increase when hydrocodone prescriptions have gone up nationally by about 56 percent. Do those number raise any red flags?*

A: I think there are many reasons to be concerned about those numbers. At the same time there are probably many possible contributors to understand some of those concerns. In 2001, this was early on in the stages in which the Joint Commission of Health Care Organizations, as well as the VA, were leading advocates for persons with pain, particularly persons with chronic pain. And (they) were encouraging health care organizations, including the VA, to draw attention to the needs of people - in our case veterans - with pain and chronic pain. And (toward) data that were being published in the prior decade about the undertreatment of pain and an unnecessary burden of pain. Although we continue to have concerns about care of people with pain, there was much that the VA did to try to draw attention to those concerns. VA launched its national pain management strategy in late 1998, 1999, and really in 2000 launched the "Pain as the Fifth Vital Sign" initiative that required screening for the presence and intensity of pain at all clinical encounters. It may well be that, for example at Fayetteville, that initiative prompted a much greater attention to pain and potentially some weaknesses or deficits at that time in terms of how pain was being managed.

In 2001, my hunch is that the number was extraordinarily low. So the attention to pain at that time at that facility may have been an important effort in fact in addressing the concerns of veterans with pain and their needs. Moving full speed ahead, we now have reason to be greatly concerned about both the continued needs to care for veterans with pain, but also, of course, the now understood harms of prescription medications, including opioids. We're seeing the pitting of two of what some people have called, including the Centers for Disease Control and Prevention, two public health crises: The crisis of chronic pain and the crisis of prescription drug abuse. We've learned a lot in the last decade that causes us to be greatly concerned about both of those issues. VA, like other health care systems, and really it's a

national issue in the United States about how do we both try to promote better management of pain and help people, in this case veterans with pain, while we also work diligently to reduce exposure to harms associated with prescription drugs like opioids.

Q: *Specifically regarding these prescription numbers, what causes concern? We talked about how we got here, But what is the concern behind these numbers?*

A: I think we now understand what we didn't understand 10 years ago, which is that for some proportion of people who use opioids on a sustained basis, addiction and substance abuse disorders emerge. We know that pain itself is associated with, for example, heightened distress including multiple mental health co-morbidities, including depression and even suicide risk. And these medications are associated with both unintentional and potentially intentional overdose, in this case, suicide. So that raises concern as well. We know more about some of these medications, too, in terms of there's growing information about some other unintended harms related to these medications, side effects and so forth. So there's a great national effort now that I'm involved in, both within and outside the VA, to draw attention to the concerns that we have about prescription opioid medications. We want to continue to promote access to these medications, but in a way that is safe or at least mitigates risk. We're trying diligently in VA, and I would say VA is frankly a leader and is recognized by other federal agencies in the country as a leader in its efforts to mitigate risk related to opioids, as well as to provide alternative therapies to managing chronic pain and meeting the pain care needs of veterans.

Q: *I filed a Freedom of Information request with the Fayetteville VA in January to see how many of their veterans have died of prescription painkiller overdoses. The VA here says they have no way of figuring that out. Does that hold true across the VA? Why wouldn't the VA be able to track those outcomes?*

A: There are mostly, I would say, VA Health Services Research and Development investigators who are funded through VA and some through non-VA sources who are utilizing VA data and matching it with other available databases, such as the national death index data. These are data, for example, on cause of death. There are many many challenges related to connecting those data and making the connection between, for example, an individual veteran and the access and availability of opioids and cause of death. But there are investigators working on those challenges. The bottom line is that we can see correlations between prescription opioids and things like suicide rates and also unintentional overdose related deaths.

Even distinguishing those two categories is a very hard distinction to make and there's a great deal of unreliability that's recognized in the National Death Index data and long delays in actually even having access to those data. It's at least a couple of year lag in being able to do that work. But the associations are there and are pointing in the direction of an important association. I think it's very important to acknowledge however, the obvious when you think it through. Which is that providers of care for veterans with chronic pain, sometimes disabling chronic pain conditions, medical conditions associated with medical co-morbidities like trauma-related injuries in the younger veterans in particular but also medical co-morbidities in older veterans, for example arthritis and degenerative disorders, as well as mental health co-morbidities. There's a large literature that I and others have contributed to about the high

co-prevalence of depression, for example, among people with chronic pain including veterans with chronic pain.

So we have providers who are trying to provide care for veterans, and opioids are an important tool. We all are happy to know that there are these medications that are powerful methods for trying to manage or control pain in both the acute care and chronic care setting. It's in that context that we need to understand that some of these negative outcomes, these really distressing data about suicide and unintentional overdose, are in the context of persons with chronic pain and providers who are trying their best to try to address those pain care needs. It's a very complicated and difficult challenge, as I hope you can understand. It's important that we know that we have to show respect to the veterans for their service and for their experiences of pain and also have, to a certain extent, some level of compassion and understanding for providers who are trying to provide that care in the safest way possible.

Q: *We have this high number of prescriptions coming out of the VA, and, like you said, there's a growing body of research showing that the more that's prescribed the more likely some of these other issues, such as substance abuse and addiction and overdose death, are going to come up. We've got people in the city who see the Fayetteville VA as "the biggest dope dealer on the block." Have you heard similar concerns in other communities with VA hospitals, and is that a fair assessment?*

A: I think we absolutely understand that there are issues about diversion of medications that are being prescribed for legitimate reasons and then are being diverted into the public. The VA is not unique, of course, in that regard. And your example of the Fayetteville VA and anecdotes that come your way seems entirely consistent with what we've understood to be a national problem. I would say that VA now is really working hard to try to reduce this likelihood in a couple of important ways. First of all, VA now has written and published the regulations that allow VA to query state prescription drug monitoring program databases to be able to know whether a veteran is receiving medications from more than one prescriber. There are reasons that may occur for legitimate reasons, but it also may be at least a red flag for further inquiry or investigation about the possibility of diversion.

The other thing VA is doing, which is a growing standard in the field, is the use of toxicology screening, urine drug monitoring that historically has been used in forensic settings and substance use disorder settings but now has found its way as a routine or growing standard of care for prescribing long-term opiod therapy. This is an opportunity to test a veteran's urine to know whether they are in fact taking the drugs that have been prescribed.

These two tools in particular are among other evidence-based guidelines that encourage more frequent visits. Other strategies, such as pill counts, having people bring in their unused medications to be able to count and make sure that they have the medication they should have at a follow-up visit. And more generally encouraging the use of what are called opioid pain-care agreements or agreements with a veteran that set out the rules of behavior, the roles and responsibilities of both the prescriber but importantly the patient. These are all tools that are now in the hands of our prescribers and increasingly being employed and understood as accepted standards of practice.

Q: *You mentioned state prescription monitoring systems. The VA officials I spoke to here said they have the ability to look into the N.C. Controlled Substances Reporting System. They say they also have the OK*

to put their prescriptions into the system, but because of incompatible computer systems there's no timeline for that to occur. Is there a timeframe for when the VA will put its prescription data into these monitoring systems?

A: The short answer is no, I can't. As you can intuit, there's a great deal of complexity related to this. It starts with issues related to patient privacy and a need to protect these important data connected to what you would understand as HIPAA regulations. It's also important to understand what's also obvious, which is VA is a federal system made up of a very large number of points of access: 150 core or main facilities and then several, literally thousands of points of contacts beyond that that cut across multiple states. These state prescription monitoring program databases are all regulated at the state level. And, for example, in facilities that are close to a border there are challenges about being able to provide the data in multiple state databases because of veterans who potentially live or access facilities across state boundaries. VA is working very diligently about this. I don't think that the issue is so much about the incompatibility of the databases. It's the complexity of a federal system trying to talk with 50 states, or close to that.

Not every state has these databases. We're working on it. It's the highest priority. I think if the secretary (of the VA, Eric Shinseki) was speaking, he would acknowledge that this is an extremely high priority. The fact that VA providers now can query these databases was a huge step. Legislation had to be written specifically to allow this. VA wrote regulations related to it in a very quick timeframe and I think that's important, it really shows great determination on the part of the VA to use these databases and to be a full partner.

Q: *One concern people have spoken to me about in this community is mailing the prescriptions of painkillers to veterans' front doors. I know it's a convenience, but I've heard from a woman whose husband kept getting painkillers in the mail while not going to appointments. He used them in a suicide and she didn't know he was still getting them. Directors of homeless shelters say they get these giant bags in the mail and they don't want to give them to homeless veterans who are clearly hooked on their painkillers, but they have to. The concern is that mailing these prescriptions makes it easier for people to slip through the cracks or avoid monitoring. Do you have any reservations about mailing painkiller prescriptions?*

A: It's not unique to the VA. I get my prescriptions through the mail and I would get my controlled substance prescriptions through the mail as well, so it's not a unique issue related to the VA. I think there are always anecdotes so you'd be likely to find people that would raise that concern. The one that you gave was the concern of a wife who was not aware of her husband's health and how he was managing his health. That's entirely consistent with what we all understand to be good practice, frankly, in terms of protecting privacy, so that's a relationship issue probably. Of course there are reasons to be concerned about how medications are handled, but I think the VA is handling them in an extremely appropriate manner and consistent with appropriate medical practices.

Q: *While we're talking about the wife and patient privacy issues, is it not better to include family members in care for patients who have things like depression and are also on painkillers. When patients*

are taking drugs that may alter their mood or other related consequences, isn't it a good idea to try to get the family members involved when possible?

A: Absolutely. A hallmark of good pain management is involving family members or significant others so there's a great push to do that even around pain management specifically but in health care more generally. There are major initiatives in VA specifically to address this. Acknowledge, for example, the major VA caregivers' initiatives around veterans with trauma-related injuries and VA's efforts to reach out to include significant others or family members. Having said that, of course, it's really up to the veteran to control his or her health care and to make decisions about including others and who to include. There's nothing surprising about that. So yes, of course, there are efforts to include family members. Come to any VA, you'll see many veterans who are there with their spouses or parents or significant others and VA embraces that kind of model of care.

Q: *How do we solve this in the future? If we're going to be moving away from throwing huge numbers of opiates out there, what else can we do?*

A: I was privileged to serve as a national leader in the area of pain and pain management on an Institute of Medicine committee that developed recommendations and promulgated a report on transforming pain care in America. I am delighted now to be serving on a committee that is taking up the recommendations of that Institute of Medicine report and working with the secretary for Health and Human Services and others in our community to develop and enact a strategy that starts with public education about pain and pain management and the broad array of evidence-based approaches to pain care other than opioids. For example, my area as a psychologist is evidence-based psychological treatments but also complementary and alternative approaches to medicine. Essentially, self-management approaches are important.

It includes promoting better education in our medical schools, nursing schools and other professional schools to build competencies in the next generation of providers. It includes education of providers who are already out and practicing to continuing education efforts. And it includes a great investment in science to build alternative pharmacologic and, importantly, non-pharmacologic approaches that can meet the challenges of the epidemic of chronic pain. I'm privileged to be in a position as a national leader, independent of my VA role, in promoting those transformational efforts and adjustments. I'm also very privileged to be in a role in VA where VA is providing leadership on this front as well through our patient education, provider education and research efforts in particular. It's a huge challenge. I'm glad you're acknowledging that, but I think we're up to the task as a nation and I look forward to continuing to work on it.

Q: *Let's talk about what you can do for the patients who are already hooked, either dependent on or addicted to painkillers. There's a consensus here that substance abuse services are severely lacking. What should be the VA's role in helping this community and communities in which it is involved?*

A: I think it's important to distinguish that the minority of veterans with chronic pain who are prescribed opioid medications who have developed a substance use disorder or addiction and provide services that meet their needs. It starts with educating providers and patients to recognize when that has occurred and then provide them access to those services. I can't speak to the capacity at the Fayetteville

VA in particular, but I can tell you that our leadership in mental health services and the leader of substance abuse services in VA is a very strong partner with me in our program office in trying to build the capacity for treatment of people with co-morbid chronic pain and substance use disorder.

We also need to build the capacity for providers to learn how to taper these medications when they're no longer effective or when they're causing problems, so VA is working very diligently to provide continuing education to providers at the Fayetteville VA and any other VA facility to be able to taper medication and reduce exposure to harm. Then we need to work to build capacity for non-pharmacologic approaches. And VA's evidence-based psychological treatment program for chronic pain, building capacity for complementary or alternative medicine approaches, such as chiropractic care, acupuncture, these are all growing and increasingly available at VA facilities, maybe already available at Fayetteville VA. I think we're working really hard. We want to make these kinds of services available to veterans who are in harm's way because of their substance use disorder.

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