MEMORANDUM FOR ST
ATTN: SANDRA VALTIER

FROM: 59 MDW/SGVU

SUBJECT: Professional Presentation Approval

1. Your paper, entitled **Feasibility of Implementing an Opioid Risk Mitigation System** presented at/published to the 2016 SURF Meeting, TX 20 May 2016 with MDWI 41-108, and has been assigned local file #16213.

2. Pertinent biographic information (name of author(s), title, etc.) has been entered into our computer file. Please advise us (by phone or mail) that your presentation was given. At that time, we will need the date (month, day and year) along with the location of your presentation. It is important to update this information so that we can provide quality support for you, your department, and the Medical Center commander. This information is used to document the scholarly activities of our professional staff and students, which is an essential component of Wilford Hall Ambulatory Surgical Center (WHASC) internship and residency programs.

3. Please know that if you are a Graduate Health Sciences Education student and your department has told you they cannot fund your publication, the 59th Clinical Research Division may pay for your basic journal publishing charges (to include costs for tables and black and white photos). We cannot pay for reprints. If you are 59 MDW staff member, we can forward your request for funds to the designated wing POC.

4. Congratulations, and thank you for your efforts and time. Your contributions are vital to the medical mission. We look forward to assisting you in your future publication/presentation efforts.

LINDA STEEL-GOODWIN, Col, USAF, BSC
Director, Clinical Investigations & Research Support
INSTRUCTIONS

USE ONLY THE MOST CURRENT 59 MDW FORM 3039 LOCATED ON AF E-PUBLISHING

1. The author must complete page two of this form:
   a. In Section 2, add the funding source for your study [e.g., 59 MDW CRD Graduate Health Sciences Education (GHSE) (SG5 O&M); SG5 R&D; Tri-Service Nursing Research Program (TSNRP); Defense Medical Research & Development Program (DMRDP); NIH; Congressionally Directed Medical Research Program (CDMRP); Grants, etc.]
   b. In Section 2, there may be funding available for figures, tables or photographs for your publication. Please state “YES” or “NO” in Section 2 of the form if you need publication funding support.

2. Print your name, rank/grade, sign and date the form in the author's signature block or use an electronic signature.

3. Attach a copy of the 59 MDW IRB or IACUC approval letter for the research related study. If this is a technical publication/presentation, state the type (e.g. case report, OA/OI study, program evaluation study, informational report/briefing, etc.) in the “Protocol Title” box.

4. Attach a copy of your abstract, paper, poster and other supporting documentation.

5. Save and forward, via email, the processing form and all supporting documentation to your unit commander, program director or immediate supervisor for review/approval.

6. On page 2, have either your unit commander, program director or immediate supervisor:
   a. Print their name, rank/grade, title; sign and date the form in the approving authority's signature block or use an electronic signature.

7. Submit your completed form and all supporting documentation to the CRD for processing (59crdpubsres@us.af.mil). If you have any questions or concerns, please contact the 59 CRD Publications and Presentations Section at 292-7141 for assistance.

8. The 59 CRD/Publications and Presentations Section will route the request form to clinical investigations, 502 ISGJ/JAC (Ethics Review) and Public Affairs (59 MDW/PA) for review and then forward you a final letter of approval or disapproval.

9. Once your manuscript, poster or presentation has been approved for a one-time public release, you may proceed with your publication or presentation submission activities, as stated on this form. Note: For each new release of medical research or technical information as a publication/presentation, a new 59 MDW Form 3039 must be submitted for review and approval.

10. If your manuscript is accepted for scientific publication, please contact the 59 CRD/Publications and Presentations Section at 292-7141. This information is reported to the 59 MDW/CC. All medical research or technical information publications/presentations must be reported to the Defense Technical Information Center (DTIC). See 59 MDW 41-108, Presentation and Publication of Medical and Technical Papers, for additional information.

NOTE: All abstracts, papers, posters, etc., should contain the following disclaimer statement:

"The views expressed are those of the [author(s)] [presenter(s)] and do not reflect the official views or policy of the Department of Defense or its Components"

NOTE: All abstracts, papers, posters, etc., should contain the following disclaimer statement for research involving humans:

"The voluntary, fully informed consent of the subjects used in this research was obtained as required by 32 CFR 219 and DODI 3216.02_AFI 40-402."

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"The experiments reported herein were conducted according to the principles set forth in the National Institute of Health Publication No. 80-23, Guide for the Care and Use of Laboratory Animals and the Animal Welfare Act of 1966, as amended."
Processing of Professional Medical Research/Technical Publications/Presentations

1. TO: CLINICAL RESEARCH
   FROM: (Author's Name, Rank, Grade, Office Symbol)
   Sandra Valtier/GS13/ST

2. GME/GHSE STUDENT: YES NO

3. PROTOCOL NUMBER:
   FWA0001750

4. PROTOCOL TITLE: (NOTE: For each new release of medical research or technical information as a publication/presentation, a new 59 MDW Form 3039 must be submitted for review and approval.)
   Identification Of Risk Factors That Predict Long-Term Opioid Use And Subsequent Adverse Events

5. TITLE OF MATERIAL TO BE PUBLISHED OR PRESENTED:
   Feasibility of Implementing an Opioid Risk Mitigation System

6. FUNDING RECEIVED FOR THIS STUDY? YES NO
   FUNDING SOURCE: JPC-5 Substance Abuse Working Group

7. DO YOU NEED FUNDING SUPPORT FOR PUBLICATION PURPOSES? YES NO

8. IS THIS MATERIAL CLASSIFIED? YES NO

9. IS THIS MATERIAL SUBJECT TO ANY LEGAL RESTRICTIONS FOR PUBLICATION OR PRESENTATION THROUGH A COLLABORATIVE RESEARCH AND DEVELOPMENT AGREEMENT (CRADA), MATERIAL TRANSFER AGREEMENT (MTA), INTELLECTUAL PROPERTY RIGHTS AGREEMENT ETC.? YES NO
   NOTE: If the answer is YES then attach a copy of the Agreement to the Publications/Presentations Request Form.

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11a. PUBLICATION/JOURNAL (List intended publication/journal)

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11c. POSTER (To be demonstrated at meeting: name of meeting, city, state, and date of meeting)

11d. PLATFORM PRESENTATION (At civilian institutions: name of meeting, state, and date of meeting)
   2016 SURF Meeting, Tx 20 May 2016

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12. EXPECTED DATE WHEN YOU WILL NEED THE CRD TO SUBMIT YOUR CLEARED PRESENTATION/PUBLICATION TO DTIC
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13. 59 MDW PRIMARY POINT OF CONTACT (Last Name, First Name, M.I., email)
    Valtier, Sandra sandra.valtier@us.army.mil

14. DUTY PHONE/PAGER NUMBER
    292-0504

15. AUTHORSHIP AND CO-AUTHOR(S) List in the order they will appear in the manuscript.

   LAST NAME, FIRST NAME AND M.I. GRADE/RANK SQUADRON/GROUP/OFFICE SYMBOL INSTITUTION (If not 59 MDW)
   a. Primary/Corresponding Author
      Erin Finley
      UTHSCSA/South Texas VA

   b. Jennifer S. Potter
      UTHSCSA

16. AUTHOR'S PRINTED NAME, RANK, GRADE
    Sandra Valtier, GS13

17. AUTHOR'S SIGNATURE
    VALTIER, SANDRA 1230990403

18. DATE
    May 10, 2016

19. APPROVING AUTHORITY'S PRINTED NAME, RANK, TITLE
    Brenda J. Morgan, Col, Director 59 MDW Nursing Research Division

20. APPROVING AUTHORITY'S SIGNATURE
    MORGAN, BRENDA J, 1120100030

21. DATE
    May 11, 2016
The presentation is approved.

- **28. PRINTED NAME, RANK/GRADE, TITLE OF REVIEWER**
  Rocky Calcote, PhD, Clinical Research Administrator

- **29. REVIEWER SIGNATURE**
  CALCOTE ROCKY D 117526554

- **30. DATE**
  2016

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  - **APPROVED**
  (In compliance with security and policy review directives.)

- **34. PRINTED NAME, RANK/GRADE, TITLE OF REVIEWER**
  Christopher Carwile, TSgt/E-6, NCOIC, PA

- **35. REVIEWER SIGNATURE**
  CARWILE CHRISTOPHER STEW 1280477229

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  Christopher Carwile, TSgt/E-6, NCOIC, PA

- **41. REVIEWER SIGNATURE**
  CARWILE CHRISTOPHER STEW 1280477229

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- **44. SENIOR AUTHOR NOTIFIED BY PHONE OF APPROVAL OR DISAPPROVAL**
  - YES
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  - **APPROVED**
  - **DISAPPROVED**

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- **46. PRINTED NAME, RANK/GRADE, TITLE OF REVIEWER**
  Christopher Carwile, TSgt/E-6, NCOIC, PA

- **47. REVIEWER SIGNATURE**
  CARWILE CHRISTOPHER STEW 1280477229

- **48. DATE**
  2016
Feasibility of Implementing an Opioid Risk Mitigation System

Qualitative Lead: Erin P. Finley, Ph.D., M.P.H.
Principal Investigator Jennifer Sharpe Potter, Ph.D., M.P.H.
May 20, 2016
Disclaimer

The views expressed are those of the presenters and do not reflect the official views or policy of the DoD or its components.

The voluntary, fully informed consent of the subjects used in this research was obtained as required by 32 CFR 219 and DODI 3216.02_AFI 40-402.
Overview

- Qualitative Goals
- Data collection methods
- Preliminary findings
- Next steps and problem-solving
Goals

Wave 1
- To identify providers’ knowledge, attitudes, and behaviors regarding opioid prescription management and monitoring
- To learn from providers about what would be necessary to make expected reports useful and functional in their setting/context

Wave 2
- Return to providers with plan for PDMP and/or generated reports to assess feedback, barriers and facilitators, and training/facilitation needs for successful implementation
Recruitment and Methods

- Referrals, calling and follow-up
- BAMC visit
- Brief telephone interviews (15-20 minutes)
- No audiorecording -> corroborated note-taking
Interviews

25 formal (6 informal), with diversity in:

- **Specialty:** emergency medicine physicians (13), psychologist, orthopedic surgeon, internists (4), geriatrics/palliative care, nurse manager (MSN, RN), RN, PharmD, PA, Pain specialists (2, 1 scheduled), family/community medicine

- **Roles:**
  - 5 identifiers
  - 19 prescribers (1 more scheduled)
  - 1 responder

- **Services:**
  - 12 Air Force (including retired and active duty)
  - 13 Army
  - 5 Civilian
Interview Content

- PARIHS (Promoting Action on Implementation Research in Health Services)

- Literature review focusing on:
  - Barriers and facilitators/implementation/uptake
PARIHS

Perceived Evidence
- Research/practice guidelines
- Clinical experiences and perceptions
- Patient experiences, needs, and preferences (perceived)
- Local practice information
- Characteristics of the targeted evidence-based practice

Context
- Leadership support
- Culture
- Evaluation capabilities
- Receptivity to the targeted innovation/change
Literature search

• Facilitators
  ◦ PDMP users believe in their utility

• Barriers
  ◦ Lack of awareness
  ◦ Lack of training
  ◦ User interface complexity
  ◦ Time burden
  ◦ Delay in data

• Little available literature on contextual readiness and facilitation
Analysis

- Dedoose
  - Online software for mixed-method studies
- Revision(s) of initial coding scheme
- Initial coding and training (2 coders, 3\textsuperscript{rd} for 50%)
- 16 interviews coded
- Focus on “big bucket” coding $\rightarrow$ themes identified using PARIHS and prior literature search
- Attentive to emergent concerns
Results

- Complex clinical decision-making

Baseline behaviors for opioid prescribing and monitoring

Crux of the decision depends on whether it's acute or chronic pain. For acute, I am likely to give opiates. For fracture or traumatic injuries, I will certainly give opioids. Hydrocodone rather than oxy because oxy causes more nausea. Chronic pain I'm very less likely to give opioids unless it is one of the situations where 'oh the dog ate my prescription,' then I will give 10 pills to hold them over until they talk to or get back to their pain management specialist. I only give enough to bridge them over until they can see their primary. I very much disapprove of pain meds for chronic pain.
Clinical Experiences and Perceptions

- Provider role/setting
- Education/training
  - Formal training in pain or substance abuse relatively rare
- Prior PDMP experience
  - Few mention use of Texas PDMP
  - More common mention of PDMP use (self/observed) during residency elsewhere

I really liked it. For residents it was very helpful. However, all you can do is judge based on info on the screen. There’s not really a way to assess if there were holes in the information. For us, we were at the state border, so the patient information wouldn’t always carry over into the system. Sometimes we wouldn’t see if they got a medication across the border.
Clinical Experiences and Perceptions

- Tensions and balancing act
  - Appropriate/ethical practice
  - Patient satisfaction

There are the ones [providers] that give out all the meds that patients ask for. There's also clinical reasons for less concerned providers. It depends on the setting. Also depends on recent ratings in emergency medicine. Patient satisfaction is usually based on if they get what they want. You're aware that your [patient satisfaction] score increases or decreases depending on that. We typically take criticism from our supervisor or whoever reviews the complaints, but there are competing interests in the way the system works.
Patient Needs and Preferences

- Active duty, retirees, dependents, injured, polytrauma
- Opioid abuse/misuse/diversion
- Patient needs and vulnerabilities

Let me make a comment on the civilian side. Oxy and hydrocodone were made Schedule II last year. You have to have a triplicate to get it. Most guys don’t have that and they’re just giving them Tylenol 3, but it doesn’t work for 20% of the patients who have the enzyme to break it down in the body. What’s going on is that people can’t get the oxy anymore because people don’t prescribe them anymore, so now we have this huge surge in heroin. Any kind of attempt to limit opiate access... these people are sick and they have an addiction, they are going to get heroin instead.
Perceived Characteristics of PDMPs

- Relative advantage
  - [The current system] would only come back positive on CHCS if they used Tricare. If they went to see someone paying in cash, You wouldn’t see that. The Louisiana [PDMP] would tell you that no matter what method they use to pay. The DoD is limited in that you can only see what Tricare was being billed for. Louisiana is contracted by several other states that would ping other nearby states. Ideally [the military PDMP] it would be integrated with state systems and neighboring states.
Perceived Characteristics of PDMPs, II

• Compatibility, complexity, and design
  ◦ Ease of use
  ◦ Ease of access (e.g., available to residents, mid-levels, medical licenses in other states)

• Acceptability
  ◦ Any tool that makes me a better provider for my patient would be good. My colleagues would say the same thing.
  ◦ Concerns/perceived problems with PDMP
    ◦ It’s hard for us to see too many downsides. The only thing is that it may avoid people from getting medication that they need. Other than that can’t see anything else
There's already a system [in the military] called CHCS, which is an EHR system. It is not user friendly. Ideally, [a new PDMP] would be something that needs to be integrated into the current system or workflow. If there's some way to monitor what meds are getting to some people. The only ones we can see is from military providers. If you want to see what non-military providers are prescribing, you have to really dig for it. It's not an intuitive method to find it. You have to really know how to do it. There's so many steps to go through... It needs to be robust in the sense that it needs to be comprehensive and can access easily. It needs to be integrated.
PDMP Reports

• Information to include
  ◦ Diagnosis
  ◦ Prescriptions, prescriber, setting received, dose, number pills
  ◦ Varying time periods
  ◦ Prior history of substance abuse or other risk factors

• User interface
• Location
• EHR Integration
Conclusions

- Military providers at times struggle to access necessary information to inform safe and high-quality pain care.
- Providers report that a military-based PDMP would offer valuable tool for clinical decision-making.
- PDMP would need to be well-integrated into current/future EHR systems and clinic workflows to be of highest utility.
- Ease of access across clinical teams should be considered.
- Initial and ongoing training on PDMP is likely to be important in ensuring optimal use and continuous learning.
Thank you!

Contact: Erin P. Finley, PhD MPH
finleye@uthscsa.edu