Overriding
Chronic Pain

Through Virtual, Interdisciplinary Care

Override

Who We Are

Jennie Shulkin, J.D.

- Harvard Law School graduate
- Former law clerk to federal judge, Manhattan Assistant District Attorney, big law criminal defense

David Shulkin, M.D.

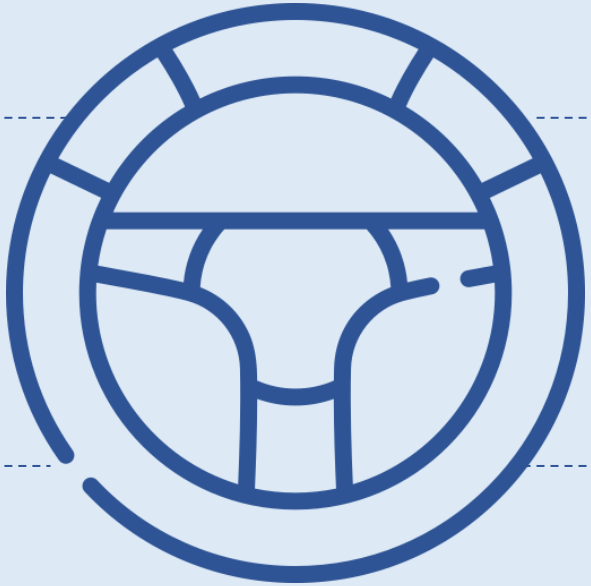
- 9th Secretary, US Department of Veterans Affairs
- Former President & CEO, Beth Israel Medical Center
- Serial Entrepreneur & industry thought leader

Override

Pain-Trained, Interdisciplinary Care Team

1. Pain Physicians

3. Pain Psychologists



2. Pain-Trained Physical Therapists

4. Pain Coaches

Evaluations → Collaboration→ Creation of personalized pain plan

Scope of Chronic Pain

>20%

of Americans are living with chronic pain

>45%

have associated anxiety or other behavioral health disorders

Most common reason Americans **misuse opioids:** trying to reduce pain

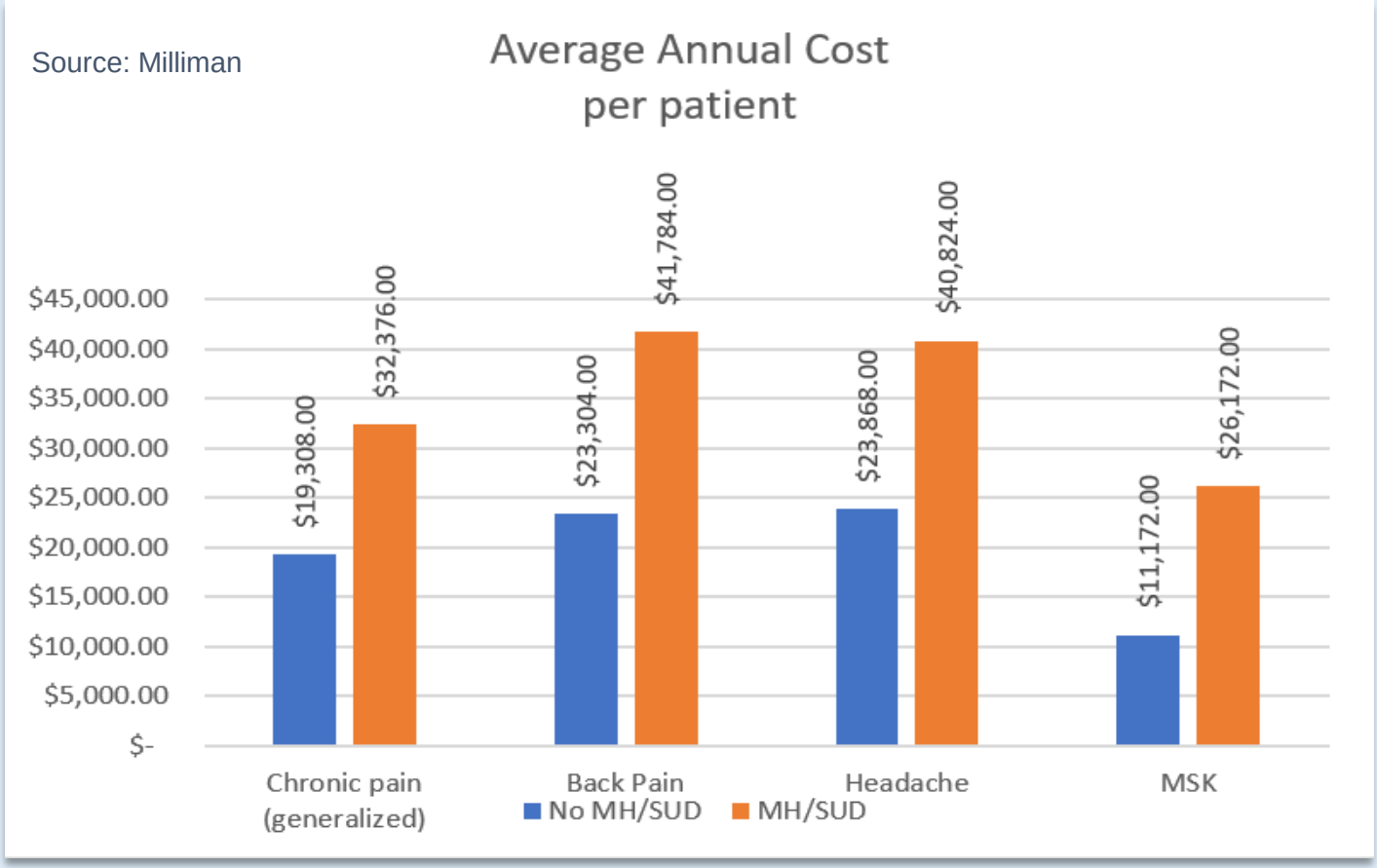
25M

chronic pain patients lack effective non-opioid treatments

Source: NIH, CDC, Institute of Medicine; Practical Pain management

Cost of Chronic Pain

Source: Milliman



Range of $19,000 to $42,000 per patient each year

2x more ED visits and outpatient visits

My Story: Before Chronic Pain

My Story: Living with Pain

8.5
Years Battling Chronic Pain

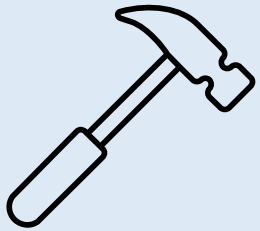
9
States Traveled to for Care

200+
Medical Providers Consulted

50+
Medications Failed

Why Traditional Pain Care Failed Me

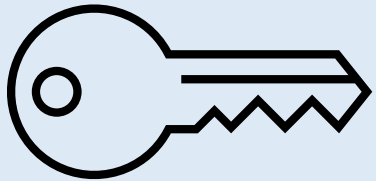
- “When all you have is a hammer, everything looks like a nail”
    - One-size-fits-all
    - Fragmented, not integrated care (siloes)



- Access problem to chronic pain specialists
- Scarcity of interdisciplinary, pain rehab programs
- Lack of pain neuroscience education

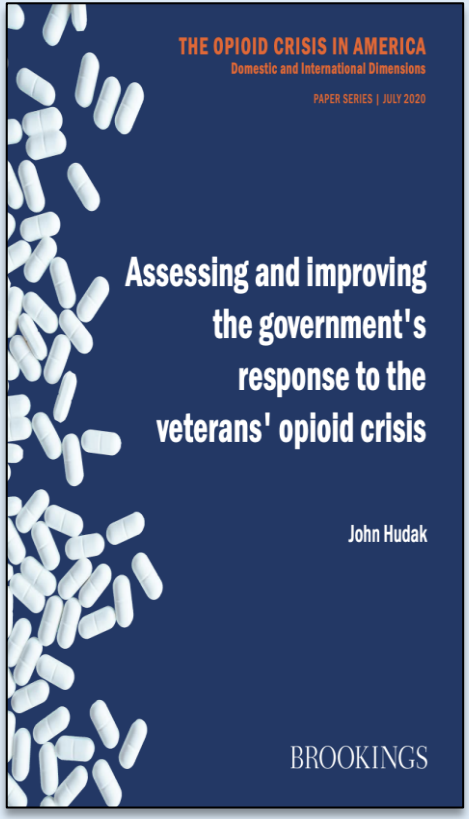
Key Elements for Chronic Pain Recovery

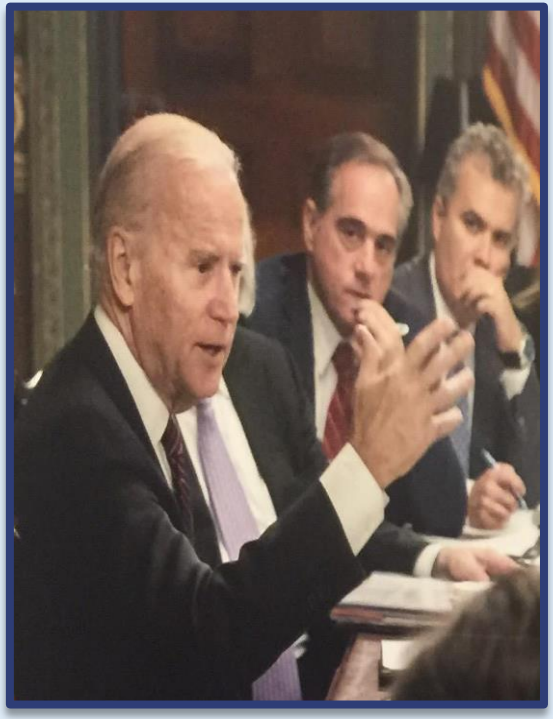
1. **Care Teams that Work Together**
2. Access to Chronic Pain Specialists
3. Pain Neuroscience-Informed Approach



Professional Experience with Chronic Pain

The White House Opioid Comission






COAST GUARD

VA Opioid Rate Posting

Facility	State	Rate in 2012	Rate in 2017
Roseburg VA Medical Center	Oregon	28%	20%
Mann-Grandstaff VA Medical Center	Washington	26%	18%
Martinez VA Medical Center	California	25%	16%
Boise VA Medical Center	Idaho	23%	16%
Las Vegas VA Medical Center	Nevada	24%	16%
Thomas E. Creek VA Medical Center	Texas	25%	16%
Tuscaloosa VA Medical Center	Alabama	18%	15%
Fresno VA Medical Center	California	24%	15%
Charlie Norwood VA Medical Center	Georgia	24%	15%
John D. Dingell VA Medical Center	Michigan	26%	15%

VIEWPOINT

Addressing the Opioid Epidemic in the United States

Lessons From the Department of Veterans Affairs

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Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

Chester B. Good, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

David J. Shulkin, MD
Office of the Under Secretary for Health, US Department of Veterans Affairs, Washington, DC.

Over the past 15 years, more than 165 000 people in the United States have died from overdoses related to prescription opioids,[1] and millions more have suffered adverse consequences.[2,3] The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.[1]

Patients treated in the health care system of the Department of Veterans Affairs (VA) are part of this epidemic. C… half of veterans using the VA, com… morbidities such… stress … office … tices, opio… near… VA … address op… ment's data capabilities and … tives reduced the use of opioid medications… proved the safety of opioid prescribing, while expanding alternative pain therapies (**Figure**). By mid-2016 compared with mid-2012, the number of veterans dispensed an opioid each quarter had decreased by 172 000, or about 25%. Moreover, there were 57 000 (47%) fewer patients receiving concomitant opioids and benzodiazepines and 22 000 (36%) fewer patients receiving daily opioid dosages of more than 100 morphine-milligram equivalents, both measures of potentially unsafe opioid use. Between 2010 and 2015, the rate of

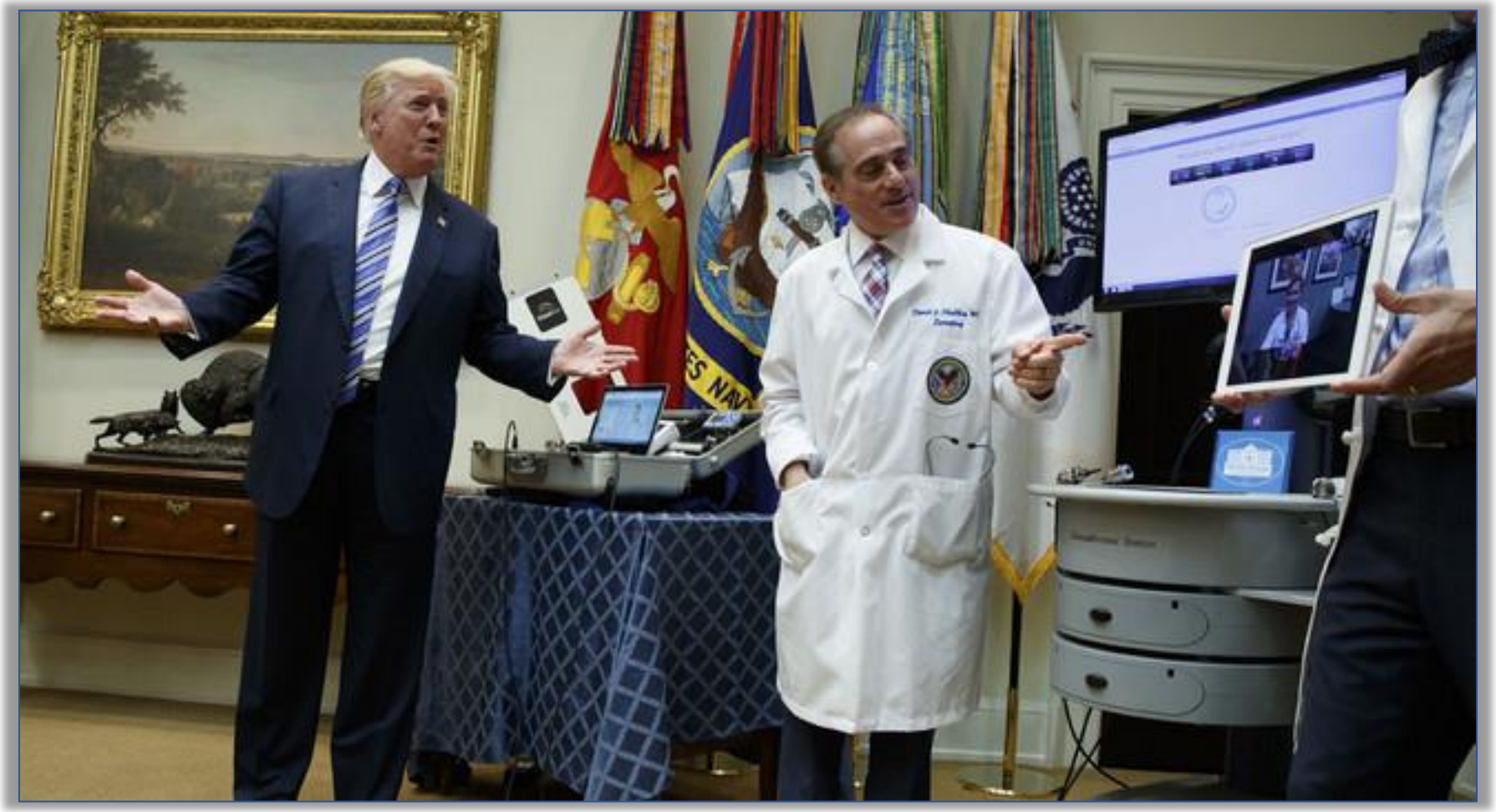
Strategies to Address the Opioid Epidemic
The VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment (eTable in the Supplement).

pharmacists engage directly with opioid prescribers, similar to detailing by pharmaceutical representatives. The VA detailers use sophisticated dashboards with real-time prescriber-level data to engage clinicians in adopting best practices around opioid prescribing. This focus is not simply on reducing opioid medications, but rather on improving the safe use of opioids. Beyond detailing, the VA developed an overdose education and naloxone distribution system that has distributed tens of thousands of naloxone doses and developed stan… …lized patient and provider education to comple… …tional efforts outside of the VA that … macologic (eg, acu… expanded mini-residency program… consult capabilities for primary care clinicians to … prove their management of pain.

Risk Mitigation

The VA implemented several strategies to support and track risk mitigation activities for opioid therapy (eTable in the Supplement). A key component of the Opioid

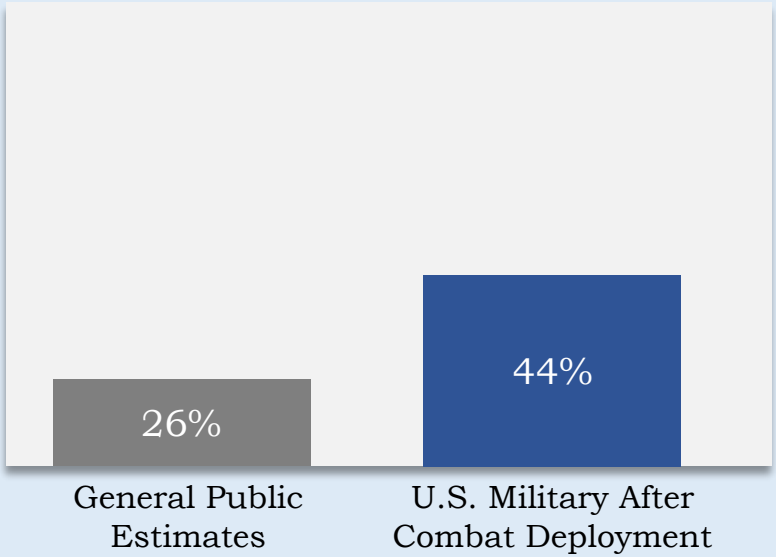

DEPARTMENT OF VETERANS AFFAIRS
UNITED STATES OF AMERICA
HARVARD
DAD



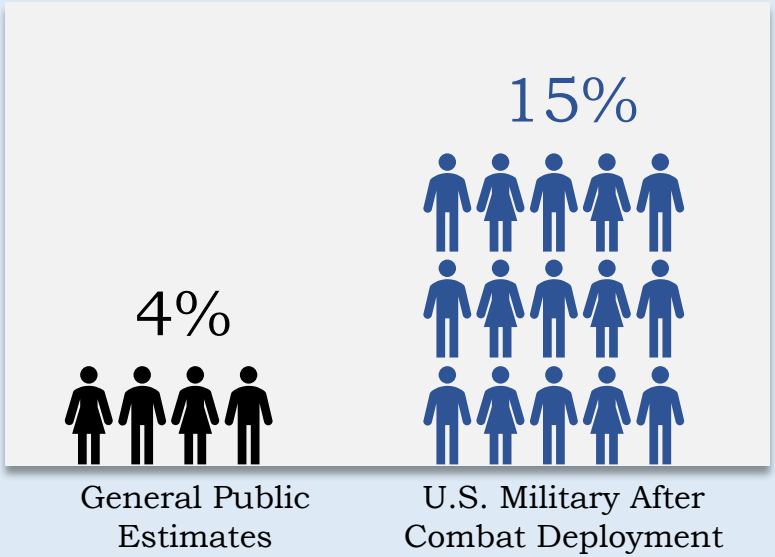

David J. Shulkin
Secretary

Chronic Pain & Opioid Use among US Military

Chronic Pain (past 3+ months)

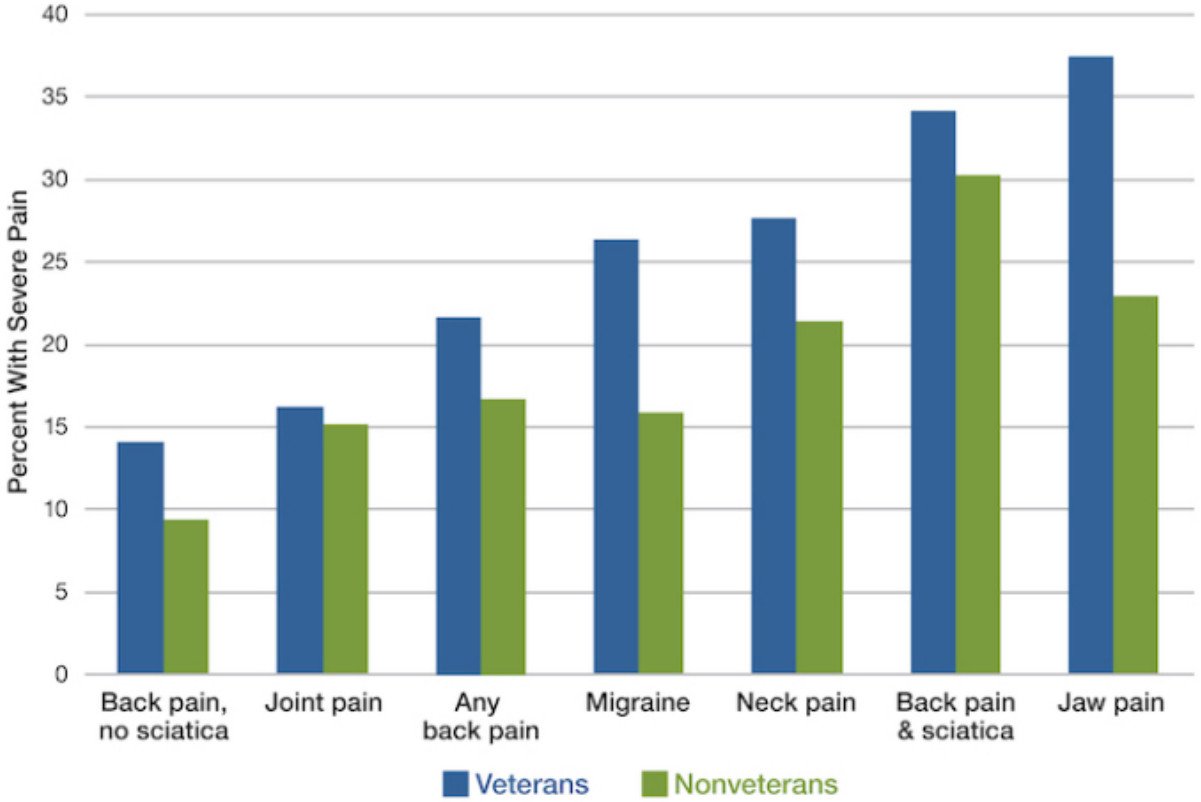


Opioid Use (past month)

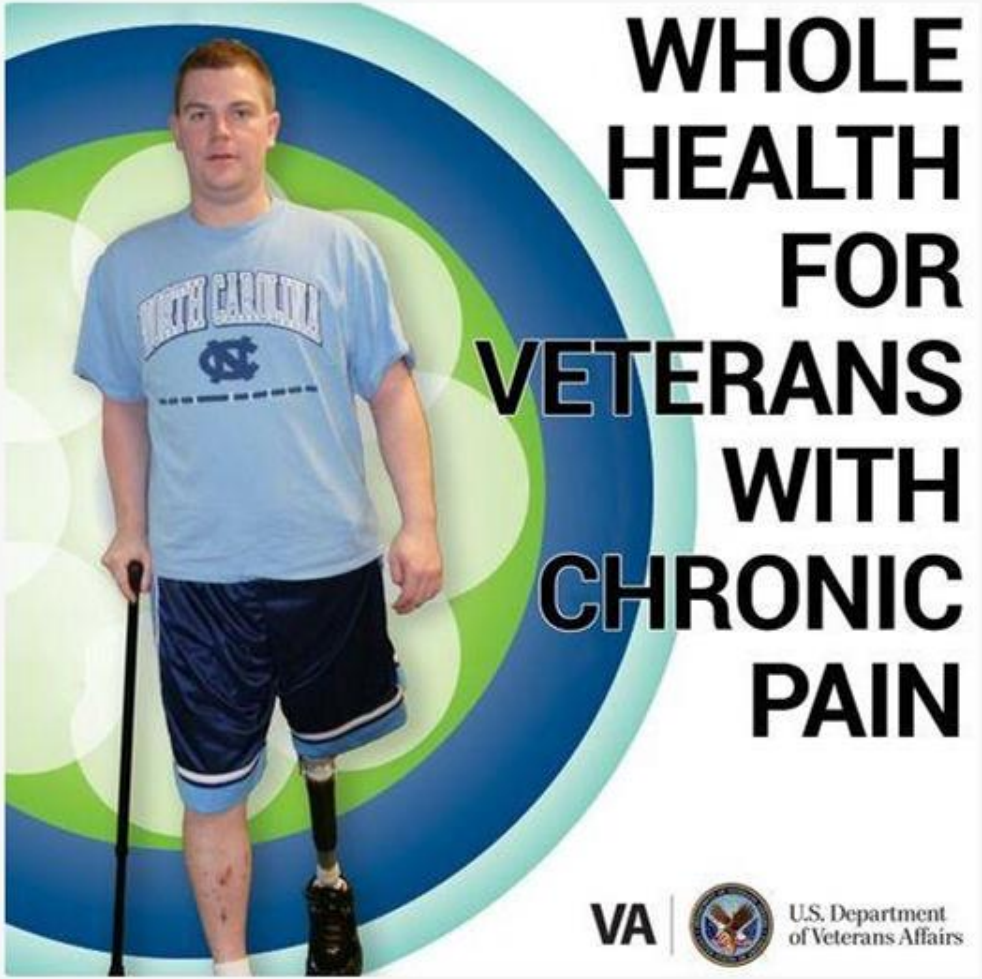


Source: NIH

Severe Pain by Condition: Veterans vs Nonveterans



Source: NIH


WHOLE
HEALTH
FOR
VETERANS
WITH
CHRONIC
PAIN
VA
U.S. Department
of Veterans Affairs

VA Whole Health Protocol

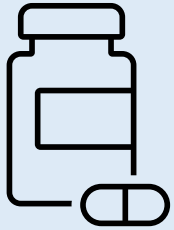
Interdisciplinary Pain Care in the Private Sector

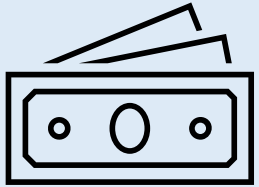
CARF-accredited interdisciplinary pain programs in the US

- 210 in 1988 → 48 in 2022
- 42% are veterans' hospitals

Why so few?

- Opioids
- Current reimbursement system





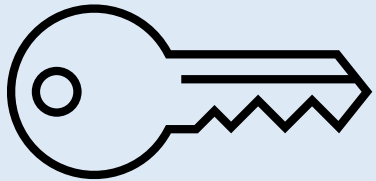
Yet interdisciplinary care improves **pain relief**, **return to work**, **activity levels**

↳ Leading to **reduced medical spend**

Source: Journal of Pain; J Pain Res

Key Elements for Chronic Pain Recovery

1. Care Teams that Work Together
2. **Access to Chronic Pain Specialists**
3. Pain Neuroscience-Informed Approach



Access to Chronic Pain Specialists

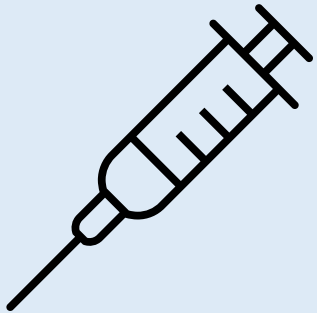
1 physician certified in pain care for every **27,000 Americans** with chronic pain

- Most patients **never see a specialist**
  - Yet most primary care providers are **not comfortable managing chronic pain**

Source: NIH

Access to Chronic Pain Specialists

Pain specialists are most often ACUTE *not* CHRONIC pain specialists



Once interventions & meds fail

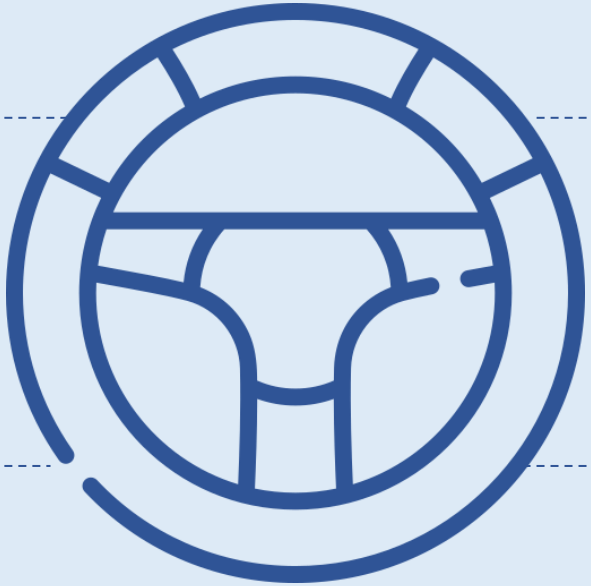
→ “You’re out of options”

Override

Pain-Trained, Interdisciplinary Care Team

1. Pain Physicians

2. Pain-Trained Physical Therapists



3. Pain Psychologists

4. Pain Coaches

Creating Networks of Providers

Override Chronic Pain Management Coaching

Coach Qualifications:

- Nationally certified health & wellness coaches
- Advanced training & certification in chronic pain management

Protocol:

- Individual sessions
- Group sessions w/ pain neuroscience education

Coaching instills: “You are no longer a passive patient, but an active manager of your own health.”

Key Elements for Chronic Pain Recovery

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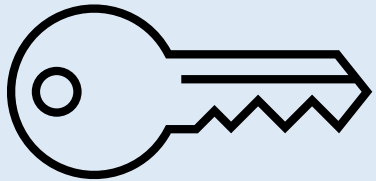


Pain Neuroscience

Normal Brain

Chronic Pain Brain

Covered in major publications, including, for example, the *New York Times* (example 1, example 2, example 3) & the *Washington Post* (example 1, example 2).

Just as the brain can learn pain, **the brain can also UNLEARN pain – virtually!**

Retraining the Brain Out of Pain

- CU Boulder study on Pain Reprocessing Therapy
  - 4-week brain-first, psychological treatment for chronic back pain
  - 66% were pain-free or nearly pain-free

- Pain education as an intervention to reduce pain-related fear, catastrophizing, and disability scores

- Virtual Reality

Override Program Summary

Override Health System Partnerships

Overrides acts an extension of your team

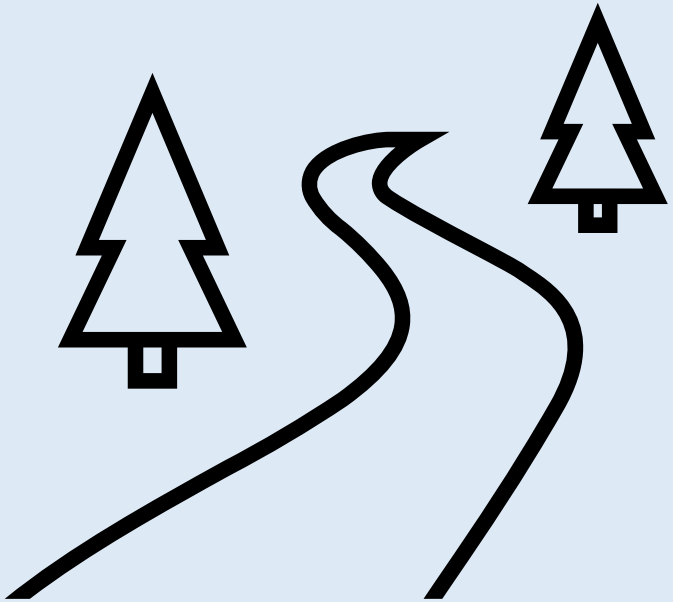
Without disrupting existing provider-patient relationships

To provide biopsychosocial support b/w provider visits

To take the burden off existing providers

Within primary care OR pain management

Long Road Ahead



Thank you!

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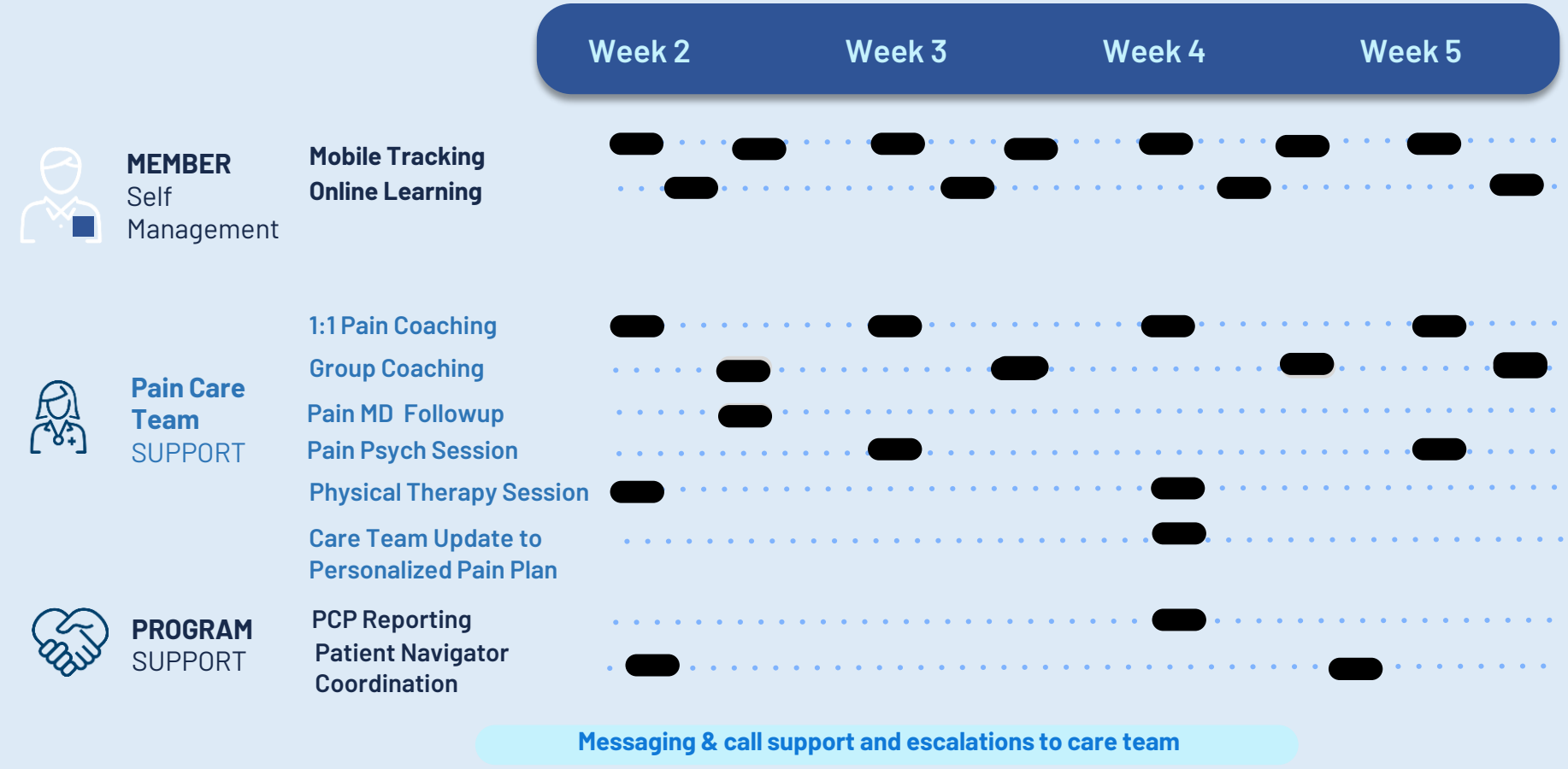
- david@override.health

www.override.health

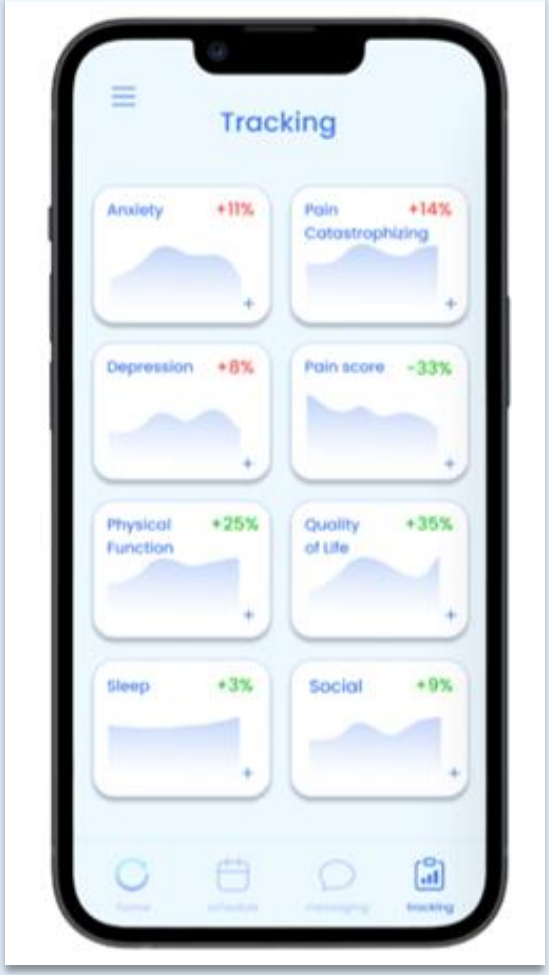
Appendix

Sample 4 Weeks



Override Outcomes Reporting

- Functional status
- Pain levels
- Anxiety, depression, and pain catastrophizing
- Sleep
- Quality of Life



Patient Identification by Medical Condition

- Fibromyalgia
- Low back pain & sciatica
- Failed back surgery syndrome
- Post-surgical pain
- Spinal cord injury
- Arthritis
- Abdominal pain
- Irritable Bowel Syndrome (IBS)
- Inflammatory arthritis
- Sickle cell disease
- Complex regional pain syndromes
- Ehlers Danlos Syndrome
- Centralized pain or chronic pain syndrome
- Migraines, cluster headache, etc.
- Endometriosis & pelvic pain
- Lupus, rheumatoid arthritis, Multiple Sclerosis, other autoimmune diseases
- MSK pain unresponsive to physical therapy & interventions
- Osteoarthritis
- Lyme disease
- Phantom limb pain
- Trigeminal neuralgia
- TMJ
- Burning Mouth Syndrome
- Cancer pain

Patient Identification by Rx

Anti-Epileptic/neuropathic pain medications:
- Gabapentin
- Pregabalin
- Topiramate
- Phenytoin
- Oxcarbazepine

Antidepressant/neuropathic pain medications:
- Tricyclics (Amitriptyline, Nortriptyline)
- SNRIs – Cymbalta, Savella, Effexor

Opioids
- Tramadol
- Methadone
- Oxycodone
- Etc.

Muscle relaxants:
- Flexeril
- Skelaxin
- Zanaflex

Migraine Medications
- Triptans
- DHE
- Anti-CGRP meds

Other Non-Opioid Analgesics
- Medical Cannabinoids
- Topical treatment
- Lidocaine creams & patches
- Capsaicin
- NSAIDs
- Acetaminophen
- Low-dose Naltrexone

Override Collaboration with Groups & Systems