Opioid Stewardship Across the Continuum of Care

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Disclosures

Drs. Mendoza and McPherson have no financial conflicts of interest to disclose.

Dr. Uritsky was on an Advisory Board for AcelRx.

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Learning Objectives

1. Describe ways to measure success in opioid stewardship across four practice arenas – outpatient, inpatient, palliative care, and hospice.

2. Discuss examples of best practices as part of opioid stewardship.

3. Recognize barriers to implementing opioid stewardship.

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Historical Background

- Opioid prescribing rate in the United States has been declining since 2012

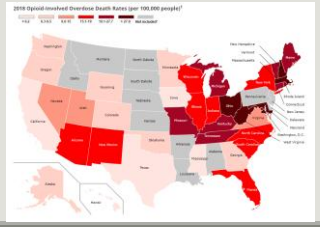
HOWEVER

- Amount of opioids in morphine milligram equivalents (MME) prescribed per person is still **~3x higher** than 1999

- CDC reports overdose deaths involving prescription opioids were **4x higher** in 2018 than 1999

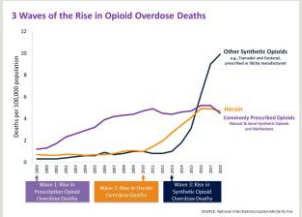
https://www.cdc.gov/mmwr/volumes/67/wr/mm6731a3.htm 4

Historical Background



https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state. Revised April 2020. Accessed October 12, 2020 5

Historical Background



https://www.cdc.gov/drugoverdose/epidemic/index.html. Revised March 2020. Accessed October 12, 2020 6

Opioid Stewardship

- "Coordinated interventions designed to improve, monitor, and evaluate the use of opioids in order to support and protect human health" - Institute of Safe Medication Practices (ISMP) Canada

- Appropriate and safe use of analgesics with effective monitoring and surveillance

Tanya J. Uritsky, Michelle E. Busch, Sul Gi Chae & Cheryl Gerord (2020) Opioid Stewardship: Building on Antibiotic Stewardship Principles, Journal of Pain & Palliative Care Pharmacotherapy, DOI: 10.1080/15360288.2020.1765066 7

Outpatient Chronic Pain

Opioid Stewardship and Chronic Pain

San Francisco Department of Public Health. Opioid Stewardship and Chronic Pain: A Guide for Primary Care Providers. San Francisco, CA. March 2017. 9

Opioid Stewardship and Chronic Pain

- If opioid medications are part of the treatment plan, following steps are recommended:
  - Informed Consent or **Pain Agreement** at least annually
  - **Prescription Drug Monitoring Program (PDMP)** checks: CA requires checking upon new-start opioids and once every 4 months
  - **Assessments** of risk, function, and pain at least annually
    - SBIRT – AUDIT (alcohol abuse), DAST (drug use)
    - PHQ9 (Depression)
    - COMM (Current Opioid Misuse Measure)
    - ORT (Opioid Risk Tool)
    - STOP-BANG (Obstructive Sleep Apnea)
  - **Urine Drug Screen/Confirmatory tests** at least annually
  - **Pill counts** each visit
  - **Naloxone** prescribing

San Francisco Department of Public Health. Opioid Stewardship and Chronic Pain: A Guide for Primary Care Providers. San Francisco, CA. March 2017.

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PRIME Project 2.6 (State of CA)

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

- PRIME 2.6 Objectives: To improve primary care providers' and care teams' ability to identify and manage chronic non-malignant pain using a **function-based, multimodal approach**, and to improve outcomes by distinguishing between, and implementing appropriate care plans, for patients who will benefit from opioids and patients who are likely to be harmed by them.

- Establishment of a referral-based pharmacist-run chronic pain management clinic

https://www.dhcs.ca.gov/provgovpart/Documents/MCQ2020_AttachmentQ_PRIMEProjectsMetrics.pdf. Ammended March 2016. Accessed October 12, 2020.

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Improving Performance for PRIME Metrics

- SBIRT (2.6.1)
  - Pain assessment in Electronic Health Record (EHR) includes SBIRT screening
  - Check in process at ambulatory care clinics ensured SBIRT collection
- Opioid Agreement/Urine Tox (2.6.2)
  - Quality management (QM) report sent to pain management pharmacists detailing fall-outs by provider and clinic location
    - Reach out to clinical staff to inform of issue and how to close gap
  - Creation of DocType in EHR where outside records (opioid agreement and UDS) can be scanned
  - Creation of yearly patient advisory for opioid agreement and urine/blood toxicology
- PDMP Checks (2.6.3)
  - Global alert created where provider must select if they checked PDMP or not, and if not give a reason why
  - Direct PDMP within EHR

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Improving Performance for PRIME Metrics

- PHQ9 (2.6.4)
  - Development and implementation of EHR PowerForms to carry out screening in outpatient setting
  - Screening implemented into ambulatory check-in workflow
  - QM report detailing fallouts by provider and clinic location to notate gaps in screening
- Use of Multi-modal therapy (2.6.5)
  - Identification of patients who needed additional support with referral to pain pharmacist
  - Efforts to improve documentation of referrals for multi-modal treatment
  - Education to Rural Health Clinic (RHC) providers about improving documentation to include multi-modal therapies

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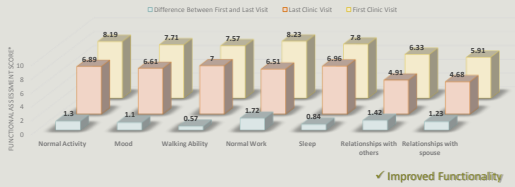
Chronic Pain managed by Pharmacists

- In 2019: 44% overall reduction in OME (29 patients)

✓ Decrease in Opioid Burden



✓ Improved Functionality

*lower score is better

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Success Story #1

Patient was referred on extraordinarily high dose of opioids (630 OME per day) for osteoarthritis/rheumatoid arthritis

- Referred back to PCP on 86 mg OME achieved by careful dose reductions **(86%)** over a period of 19 months
- Initiation and optimization of non-opioid adjunct analgesics
- 70% improved functionality and QOL with 80% reduction in pain (patient reported)
- Equal to **eliminating 19,847 10-mg Vicodin tabs per year**

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Success Story #2

Patient was referred on high dose of opioids (335 OME per day) for peripheral neuropathy with high level of anxiety/depression

- Currently on 45 mg OME achieved by careful dose reductions **(87%)** over a period of 17 months
- Initiation and optimization of non-opioid adjunct analgesics
- Improved functionality (60%) and QOL without increased pain
- Equal to **eliminating 10,585 10-mg Vicodin tabs per year**

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Barriers

Lack of Coverage for Psych Services (Medi-Cal)	• Issues: Medi-Cal does not cover psychology services to assist with non-pharmacologic pain management techniques (CBP). Extended wait time to see licensed clinical social worker (LCSW) due to lack of available services. • Solution: Implementation of psychology services within outpatient clinics. Increase availability of psychology services including LCSW.
Economic Prospects	• Issue: Limited billing opportunities since pharmacists are not federally recognized as providers. • Solution: Continued involvement in inpatient and outpatient pain directives, including stewardship services. Potential expansion into other service lines (MAT, Palliative Care).
Patient Volume	• Issue: Large fluctuations in # of patient referrals from providers. • Solution: Continue with activities assisting providers with pain management at RHCs. Discuss about more direct involvement with FM residents managing chronic pain patients.

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General Inpatient Acute Care

Pain in Hospitalized Patients

- 52-71% of patients
- More than 50% of nonsurgical patients in hospital in the U.S. receive at least one dose of opioid while hospitalized
- Of opioid-naïve hospitalized patients, 15%-25% fill an opioid Rx within one week of discharge
  - 43% get a second fill within 90 days post-discharge
  - 15% meet criteria for long-term use within one year
- Specific guidelines exist in certain settings

Herzig SJ, et al. J Hospital Med. 2018;13:256-262.

The Joint Commission (TJC) Pain Standards

The Hospital:

- Has a **Leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities**.
- **Provides staff and…practitioners with educational resources and programs**
- **Actively involves medical staff** through participating in the **establishment of protocols and quality metrics**
- **Treats** the patient's pain or **refers** the patient for treatment
- **Develops a pain treatment plan** …

TJC Pain Standards

- **Involves patients in the planning process**:
  - **Developing realistic expectations and measurable goals**
  - **Discussing the objectives used to evaluate** treatment progress
  - **Providing education** on pain management, treatment options, and safe use
- **Monitors patients identified as being high risk** for adverse outcomes related to opioids
- **Reassesses and responds to the patient's pain**:
  - Evaluation and documentation, progress toward pain management goals including functional ability; side effects of treatment; risk factors for adverse events
- **Educates the patient and family on discharge plans** related to pain management
- **Collects and analyzes data** to identify areas **to improve safety and quality**
- **Monitors the use of opioids** to determine if they are being used safely

Inpatient Quality Indicators - Top 10!

- Proportion of hospitalized patients who have:
  - Received naloxone
  - Multiple PRN opioid orders with duplicate indication
  - Long-acting or extended release opioid orders and are opioid naïve
  - A POSS ≥3 and are on opioids
  - Concurrent administration of high doses of opioids and one other CNS sedative medication
  - Opioid doses > 90 MEDD
  - Documented patient-defined pain goals
- Average dose of MME administered per day
- Proportion of opioid discharge prescriptions that exceed 7 days of treatment
- Proportion of discharged patients with opioid Rx ≥ 50 MEDD

Rizk E, et al. Am J Health-Syst Pharm. 2019; 76:225-35.

Gap Analysis Survey

THEMES – PATIENTS

- Expectation setting on prescribing
- Education - Patients at discharge
- Uncontrolled pain in the hospital and after discharge
- Non-opioids and non-pharmacologic interventions
- Multimodal analgesia

THEMES- CLINICAL STAFF

- Expectation setting on prescribing
- Education - Provider
- Uncontrolled pain
- Identification of opioid-tolerant patients
- Guidelines on tapering
- Prior Authorization processes
- Changes in regimen on day of discharge

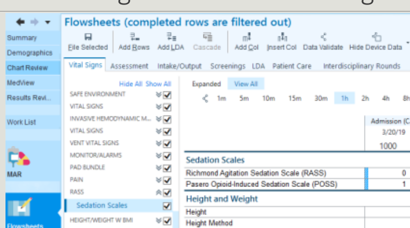
Working Hard To Promote CHANGE

- PDMP in EMAR
- Penn Medicine Pain Agreement
- 5-Day Prescribing Best Practice Advisory (outpatient)
- Enhanced Recovery After Surgery protocols
- PCA Documentation improvements and guidelines
- Nonpharmacologic Survey
- Inpatient Pain Committee
- Drug Disposal Education
- Sedation Monitoring
- Naloxone Co-Prescribing
- Opioid Prescribing Dashboard and reports
- E-Prescribe

Still to Come

- Nursing assessment and reassessment documentation changes
- Identifying high risk patients
- MEDD identification in EMAR
- PDMP utilization and documentation assessment
  → Leap Frog metrics?
- Academic Detailing for opioid discharge prescribing
- Inpatient-focused opioid safety training

Documenting Sedation Monitoring



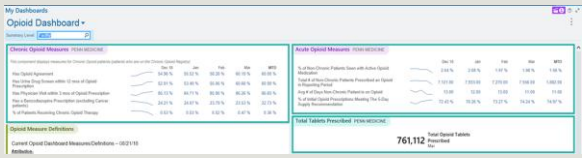
Discharge Prescribing

- MME threshold
- Day-supply considerations
- Prescribe based on post-op opioid consumption in the hospital 24 hours prior to discharge
  - Discharged POD1 = 15 pills
  - Discharged POD2 or later
    - Patients taking 1-3 pills = 15 pills
    - Patients taking ≥ 4 pills = 30 pills

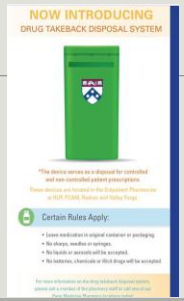
Procedure	Oxycodone 5 mg tablets
Dental extraction	0
Thyroidectomy	0-5
Laproscopic Anti-reflux	0-10
Appendectomy – Lap or Open	0-10

Hill MV, et al.J Am Coll Surg. 2018; 226; 996-1003; Shah A, et al. MMWR 2017;66:265-9.
http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Pages/Prescribing-Guidelines.aspx#.WucdeC7waUk;
https://michigan-open.org/prescribing-recommendations/, accessed February 10, 2020

Prescribing DashBoard

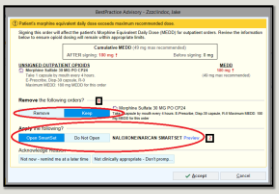


Drug Disposal at Penn



Naloxone

- Best Practice Advisory
- Standing order or prescription
- Intranasal, Auto-injector
- For patients on > 50 MEDD and/or co-prescribed a benzodiazepine
- Education to reduce stigma and encourage prescribing



www.getnaloxonenow.org or https://www.pavtn.net/act-139-training

Barriers to Inpatient Pain Stewardship

- Resources
- Time
- Complexity of health systems
- Many other competing needs
- Electronic Medical Record
- Training

Inpatient Palliative Care

NCCN Guidelines

- Use caution with co-prescribing other sedating medications
- Assessments of risk
- Educate, support, counsel
- Possible interventions:
  - Pain medication diaries
  - Pill counts
  - Urine Drug Screens
  - More frequent outpatient visits/smaller quantity prescribing
  - Early referral to interventional pain specialists
  - Education on appropriate disposal

Stewardship in Oncology

- Self-management of opioids
  - Cutting pills
  - Self-tapering
  - Long-acting medications used PRN
  - OTC combinations
  - Illicit medications
  - Access barriers to nonopioids and nonpharmacologic interventions
- Interventions
  - Communication
  - Patient education
  - Safety
  - Improve access to effective nonopioid alternatives

Moghani, S. et al. J Pain Symp Manage 2019; doi10.1010/j.jpainsymman.2019.10.029

Universal Precautions

- Oncology Patients
  - Rx for >5 days will require prior authorization (PA) in most cases
    - Majority of chronic pain criteria not needed for initial prior authorization
  - While prior authorization is pending, patients can receive:
    - Max 6 tablets per day up to 5 days every 30 days for immediate release formulations
  - Patient contract is preferred for new starts & renewals
  - Urine drug screen required for prior authorization renewals
  - Max 6 tablets per day for immediate release formulations or else 2nd prior authorization needed for exceeding quantity limit

Opioid Risk Screening

Barriers to Stewardship in Inpatient Palliative Care

- Time!
- Clinical Staff Resources
- Consultative Model
- Stigma
- Evidence
- Training

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Hospice

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