Establishment of an Opioid Stewardship Program

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Disclosure

• I have no relevant financial relationships to disclose.
Learning Objectives

• Describe contributors to current opioid epidemic

• Discuss regulatory oversight efforts related to opioids

• List 3 goals of an opioid stewardship program

• Discuss key stakeholders in an opioid stewardship program
Do you have a formal opioid stewardship effort in your organization?

A. Yes
B. No
C. Not sure
Since 1999, sales of prescription opioids in the U.S. have quadrupled.

An estimated 1 out of 5 patients with non-cancer pain or pain-related diagnoses are prescribed opioids.

From 1999 to 2014, more than 165,000 people died from overdose related to prescription opioids.

Nearly 2 million Americans abused or were dependent on prescription opioids in 2014.
Why Opioid Stewardship?

- Opioid pain medication use presents serious risk, including overdose and opioid use disorder.
- In 2011, estimated that >420K ED visits related to the misuse of abuse of narcotic pain relievers.
- In 2013, 16,235 Americans died from prescription opioid misuse — four times more than in the entire previous decade and greater than the number of deaths that year from heroin, cocaine, and benzodiazepines combined.
- Opioids — both prescription painkillers and heroin — are the primary drug associated with drug overdoses;
  - in 2014, opioids were involved in 61 percent of all drug overdose deaths.
  - From 2013 to 2014, there was a 9 percent increase in deaths attributed to overdose of commonly prescribed opioid pain relievers.

Why Opioid Stewardship?

- From 2000 to 2009, the number of opioid prescriptions increased by 68 percent, reaching 202 million prescriptions
- In 2010, hydrocodone/acetaminophen was the most commonly prescribed drug in the United States, with 131.2 million prescriptions; the US uses 99 percent of the world’s supply
- In 2012, health care providers wrote 259 million prescriptions for opioid pain medications, enough for every adult in the US to have a bottle of pills

Virginia Statistics

• In 2013, fatal drug overdoses became the # cause of unnatural death
• 2014: first time that more people died from opioid overdoses than from car accidents
• In 2016, 77% increase in fatal overdose deaths as compared to 2011
  • In first half of 2016, # of fatal overdoses increased by 35% over same period prior year
• ED visits for heroin overdoses increased by 89% from Jan-Sept 2015 to same period in 2016

Why Opioid Stewardship?

- Use, misuse and abuse of prescription opioids have rapidly escalated and become a major health problem.
- Opioid sales, opioid deaths and opioid abuse have increased in parallel.
Why Opioid Stewardship?

• Pain is major public health problem
  • Impacts more American adults than heart disease, cancer and diabetes combined
  • More than 116M adults in US suffer chronic pain
  • Management of pain costs up to $635B annually
• Gaps remain in quality and safety of pain management
External Oversight

• CDC Guideline for Prescribing Opioids for Chronic Pain (2016)

• The Joint Commission
  • Sentinel Event Alert (Aug 2012)
  • Proposed Standards Related to Pain Assessment and Management (Dec 2016)

• State/Federal legislation
  • Surgeon General
  • CMS
  • Virginia

• Payers
CDC Guideline For Prescribing Opioids in Chronic Pain

• Published March 2016

• Focused on treatment of chronic pain (>3 months or past time of normal tissue healing) in patients ≥ 18yo
  • Excludes cancer, palliative and end-of-life care

• Focused on family practice/general practice/internal medicine
  • Between 2007 and 2012, opioid prescribing rates increased more compared with other specialties

• Guideline intended to:
  • Clinicians and patients consider safer and more effective treatment
  • Improve patient outcomes
    • Reduced pain, increased function
  • Reduce number who develop opioid use disorder, overdose or other adverse events related to opioids

• Voluntary, evidence based

US Dept HHS/CDC, MMWR/March 18, 2016, Vol 65 No 1
• Recommendations grouped into three areas for consideration (12 total recommendations)

1. Determining when to initiate or continue opioids for chronic pain

2. Opioid selection, dosage, duration, follow-up and discontinuation

3. Assessing risk and addressing harms of opioid use
The Joint Commission

• Sentinel Event Alert: Safe use of opioids in hospitals
  • Published August 8 2012
  • Focused only on inpatient use
  • Focused on over-sedation, respiratory depression
  • Includes recommended use of multi-modal pain management

https://www.jointcommission.org/assets/1/18/SEA_49_opioids_8_2_12_final.pdf accessed March 26, 2017
The Joint Commission

• Proposed Standards Revisions Related to Pain Assessment and Management

  • Released 12/27/16 for public comment

  • Proposed implementation 7/1/17
The Joint Commission

• LD.04.05.17. Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital
  • EP1. The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, develops and monitors performance improvement activities
  • EP2. The hospital promotes access to nonpharmacologic pain management treatment modalities
  • EP3. The hospital provides staff and LIPs with educational resources and programs to improve pain assessment, pain management and the safe use of opioid medications based on the identified needs of its patient population
  • EP4. The hospital establishes a plan to monitor pain assessment and pain management for potential disparities in care within patient subgroups (age, race, ethnicity, language)
The Joint Commission

• LD.04.05.17. Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital (cont)
  • EP5. The hospital provides information to staff and LIP on available services for consultation and referral of patients with complex pain management needs
  • EP6. The hospital identifies opioid treatment programs that can be used by clinicians for patient referrals
  • EP7. The hospital facilitates practitioner and pharmacist access to the PDMP databases
  • EP8. The hospital provides equipment for clinicians to monitor patients considered high risk for adverse outcomes from opioid treatment during hospitalization
The Joint Commission

• MS.05.01.01. EP18. The medical staff is actively involved in pain assessment, pain management and safe opioid prescribing through the following
  • Participating in the establishment of protocols and quality metrics
  • Reviewing performance improvement data

• PC.01.02.07. The hospital assesses and manages the patient’s pain based on clinical practice guidelines and evidence-based practices that minimizes the risks associated with treatment
  • Provides patient education on pain management treatment options, including the safe use of opioids.
  • Provides patient education on the safe use, storage and disposal of opioids
The Joint Commission

• PI.02.01.01. EP19. The hospital establishes and monitors indicators of safe use of opioids
  • Adverse events
  • Use of naloxone
  • Use of high doses
  • Duration of opioid prescriptions
Surgeon General

Turnthetiderx.org accessed March 26, 2017
Surgeon General

- Turnthetiderx.org
- Letter to providers
- Comprehensive toolkit
- Take the pledge
  - As HEALTH CARE PROFESSIONALS, we believe we have the unique power to end the opioid crisis. We pledge to:
    - Educate ourselves to treat pain safely and effectively.
    - Screen our patients for opioid use disorder and provide or connect them with evidence-based treatment.
    - Talk about and treat addiction as a chronic illness, not a moral failing.
CMS has made attacking this devastating epidemic a top priority and is providing help and resources to clinicians, beneficiaries, and families. This is an ongoing CMS strategy, as part of the HHS Opioid Initiative launched in March 2015, to combat misuse and promote programs that support treatment and recovery support services. The CMS effort includes four priority areas:

1. **Implement more effective person-centered and population-based strategies to reduce the risk of opioid use disorders, overdoses, inappropriate prescribing, and drug diversion;**

2. **Expand naloxone use, distribution, and access, when clinically appropriate;**

3. **Expand screening, diagnosis, and treatment of opioid use disorders, with an emphasis on increasing access to medication-assisted treatment; and**

4. **Increase the use of evidence-based practices for acute and chronic pain management.**

Virginia Legislative Oversight

• Requirement for focused education
  • Board of Medicine: 2 hr CAT 1
    • Pain management
    • Proper prescribing
    • Diagnosis and management of addiction

• Board of Pharmacy
  • Pharmacists only
  • 1 hr CE
    • Proper opioid use, opioid overdose prevention, naloxone administration

• Regulations
  • Board of Medicine Emergency Regulations
  • Governors declaration
  • 2017 legislative session
Virginia Legislative Oversight

• Board of Medicine Emergency Regulations
  • Does not apply to
    • treatment of acute or chronic paint related to cancer, hospice care or palliative care
    • Treatment of acute or chronic pain during an inpatient hospital admission, in a nursing home or assisted living facility that uses a sole source pharmacy
    • Patient in clinical trail
  • Treatment of acute pain with opioids
    • Short-acting opioids
    • No more than 7-day supply (max of 14 consecutive days for surgical procedure in immediate post-op period)
    • Documentation in medical record for reason to exceed 50 MME/day
    • Reasonable justification for use exceeding 120 MME/day OR refer/consult with pain management specialist
    • Naloxone prescribed for any patients with risk factors of prior overdose, substance abuse, doses in excess of 120 MME/day or concomitant benzodiazepines
    • Co-prescribing of opioids with benzo, sedative hypnotics, carisoprodol and tramadol only when extenuating circumstances with documentation in the medical record, including a tapering plan
    • Buprenorphine not indicated for acute pain in the OP setting unless SAMHSA waiver and treating disease of addiction
    • Medical record shall include a description of the pain, presumptive diagnosis, examination appropriate to the complaint, a treatment plan and medication prescribed to include date, type, dosage and quantity prescribed or administered
Virginia Legislative Oversight

• Board of Medicine Emergency Regulations
  • Treatment of chronic pain with opioids
    • Non-pharmacologic and non-opioid treatment for pain given consideration prior to treatment with opioids
    • Consideration and documentation in record the reason to exceed 50 MME/day
    • Prior to exceeding 120 MME/day, document in the medication record the reasonable justification for such dose OR refer/consult with pain management
    • Document rationale to continue opioid therapy every 3 months
    • Buprenorphine may be prescribed for chronic pain in formulations and doses that are FDA approved for purpose
    • Co-prescribing of opioids with benzo, sedative hypnotics, carisoprodol and tramadol only when extenuating circumstances with documentation in the medical record including a tapering plan
    • The practitioner shall regularly evaluate for opioid use disorder and initiate specific treatment for opioid disorder, consult with appropriate healthcare provider or refer for evaluation and treatment
    • Documentation of treatment plan
    • Informed consent and agreement for treatment
  • Prescribing of Buprenorphine for Addiction Treatment
Challenges

It’s Complex.....

Necessary part of pain management therapy

Risk of harm from addiction, misuse, overdose and death
Challenges

- Lack of coordination of approaches and resources
- Failure to engage across multiple stakeholders and with local communities
- Lack of effective implementation of promising practices
- Failure to spread promising practices
- Direct and indirect counter-forces by the pharmaceutical industry
- Lack of awareness among patients and consumers of the danger of prescription opioids

Gaps in Opioid Efforts

- Absence of key players in community efforts
  - Health Systems
  - Law enforcement
  - Corrections
  - social services
  - Schools
- Shortage of detox beds, addiction facilities and outpatient treatment options
- Poor bridging between detox and addiction treatment

Interventions

• Interventions need to account for multiple populations at different points in the system:
  • Naïve patient: Avoid starting, thus preventing, opportunities for opioid use, misuse, and abuse
  • High-dose chronic use: Compassionately taper opioids and move to alternative pain management
  • Opioid-dependent, seeking within health care: Address opioid-seeking behavior without moving patients to illegal means of obtaining opioids
  • Opioid-dependent, seeking outside of health care: Address addiction behaviors and outcomes

4 drivers to reduce opioid use

- Limit supply of opioids
- Raise awareness of risk of opioid addiction
- Identify and manage opioid-dependent population
- Treat opioid-addicted individuals
  - Collaborative community-wide approach

Opioid Stewardship Goals

- Robust and coordinated pain care system that optimizes both opioid stewardship and patient outcomes
  - Multi-pronged, context sensitive
  - Built on foundation of rational prescribing
  - Improve quality of overall pain management
  - Improve safety, outcomes and cost
  - Partnership between organization, patient and community
Role of the Hospital in Opioid Stewardship

- Ensuring clinician education about appropriate prescribing practices
- Oversight of appropriate prescribing practices
- Patient education
- Offering treatment/referrals for patients with substance abuse disorder
- Ensuring that patients treated for substance use disorder are properly discharged
- Handling individuals with drug-seeking behavior in the ED appropriately
  - Including use of PMP
- Reviewing treatment alternatives for pain management
- Safeguarding prescription opioids against diversion
Operating principles for healthcare system

- Opioid prescribing crosses many different types of providers with varying degrees of training on pain management and opioid use, so provider education must take these differences into account.
- Patients need to be better informed about the effectiveness and risks of opioids.
- Use of prescription opioids is linked to heroin use and needs to be recognized as such.
- Any intervention effort needs to take into account possible unintended consequences for other parts of the system.
Key implementation components

• Retrain provider/clinicians
• Identify alternative treatment options
• Development of prescribing/treatment algorithms
• Transition of patients across care continuum
  • Access to addiction treatment
• Create a role for pharmacists and retail pharmacy
• Engage in public messaging
• Recognize that geography is important
• Include community partners
Practice Examples
Dartmouth Hitchcock

- Reduced opioid prescriptions in minor procedures by 53%
  - Targeted 5 specific procedures
  - Developed specific prescribing guidelines with maximum # of opioids surgeon can prescribe
  - Patients educated to use opioids as secondary treatment to OTC agents

- Results:
  - 53% reduction in opioid prescriptions
  - Patients only utilized 34% of opioids prescribed

Intermountain Healthcare Acute Pain Management

• **Stop**
  • Avoid prescribing long-acting or extended-release opioids for acute conditions
  • Opioids in doses ≥ 50mg morphine equivalents/day (MME)

• **Caution**
  • For elderly patients and those at risk for opioid induced respiratory distress, reduce dose and frequency when opioid unavoidable

• **Go**
  • Prescribe the lowest effective dose, immediate-release, short acting. No more than the number needed for usual pain duration associated with condition
  • Integrate non-opioid therapies (multimodal)
  • Re-evaluate severe acute pain that continues beyond the anticipated duration
  • Follow-up with primary care within 3-5 days of discharge
  • Educate patient and caregiver
  • Consider prescribing naloxone for all patients at risk for opioid-induced respiratory depression if discharged on opioids

https://intermountainphysician.org/Documents/AcutePainOpioidPrescribing_FINAL.pdf
accessed March 27, 2017
In order to reduce opioid deaths, the Commonwealth must use all the tools in the toolkit.

**Prevention**
- School-based prevention education
- Parent education about signs of addiction
- Community coalition initiatives
- Local drug-free school initiatives
- Prescriber and patient education
- Drug take-back programs
- Public awareness

**Intervention**
- Evidence-based screening for risk behaviors and appropriate intervention methods
- Prescription monitoring program
- Civil commitment
- Utilization of data to identify hot spots
- Access to naloxone
- Recovery coaches in Emergency Departments

**Treatment**
- Continuum of treatment from acute inpatient services to outpatient services
- Civil commitment: court-ordered SUD treatment
- Medication assisted treatment
- Outpatient counseling
- Emergency services
- Central database of treatment resources

**Recovery Support**
- Residential rehabilitation programs
- Alcohol and drug free housing
- Family and peer support
- Recovery high schools
- Resource navigators and case management
VHHA Emergency Department Opioid Prescribing Guidelines

• Dedicated provider outside of the ED should provide all opioids to treat chronic pain
• Administration of IV/IM in the ED for acute exacerbation of chronic pain is discouraged
• Prescriptions for opioids from the ED should be written for the shortest duration appropriate (no more than 3 days)
• Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse
• When patients present with acute exacerbations of chronic pain, summary of ED care communicated to PCP/primary opioid provider
• ED providers should not dispense prescriptions for CS that were lost, destroyed, stolen or finished prematurely

accessed March 27, 2017
VHHA Emergency Department Opioid Prescribing Guidelines

• ED providers should use caution when prescribing CS to patients without proper photo ID
• ED providers are encouraged to consult PMP before writing opioids for acutely painful conditions
• ED providers, should not provide replacement doses of methadone or buprenorphine for patients in opioid treatment programs
• ED providers should not prescribe long-acting or controlled release opioids
• ED providers are strongly discouraged from prescribing or dispensing buprenorphine
• Hospitals are encouraged to support provider decisions
• EDs are encouraged to coordinate the care of patients who frequently visit the ED for evaluation of acute exacerbation of chronic pain

accessed March 27, 2017
Do you think you may have a problem with substance abuse?

1. Have you ever felt you ought to cut down on your drug use?
2. Have people annoyed you by criticizing your drug use?
3. Have you ever felt bad or guilty about your drug use?
4. Have you ever used drugs first thing in the morning to steady your nerves or get ready for the day?

If you answered “Yes” to 2 or more questions above, you may have an issue with drug use.

Let us help by calling:

- Hampton/Newport News CSB
  300 Medical Drive, Hampton, VA 23666
  757-788-0300
- Colonial CSB (Williamsburg Region)
  3804 George Washington Memorial Hwy
  Yorktown, VA 23690
  757-898-7926
- Middle Peninsula/Northern Neck CSB
  414 Main St, Warsaw, VA 22572
  804-333-3671
- Eastern Shore CSB
  10129 Rogers Dr, Nassawadox, VA 23413
  757-442-3636

Adopted ??????? 1, 2016

Safe Opioid Prescribing Guidelines
A collaborative of Bon Secours Virginia Health System, Riverside Health System, and Sentara Healthcare
The health systems of the Coastal Virginia area are committed to the health and safety of our patients and our community.

For safety, one medical professional outside of the emergency department should provide all opioids to treat a patient’s condition.

WE WILL:

- Evaluate your pain and determine what is the best treatment option for your condition.
- Use the Virginia Prescription Monitoring Program.
- Contact your Primary Care Physician who manages your pain condition to discuss your care.
- Share Emergency Department visit history with other Emergency Departments.
- Upon request, provide you:
  - A list of primary care providers who will see patients regardless of insurance.
  - A list of intervention and treatment referrals for opioid abuse.

WE WILL NOT:

- Administer intravenous or intramuscular opioids in the emergency department for relief of chronic pain conditions.
- Provide replacement prescriptions for prescription opioids that were lost, stolen, or destroyed. Refills are the responsibility of your Primary or Specialty prescribing physician.
- Prescribe any long acting opioid such as oxycodone, extended release morphine, methadone, buprenorphine, hydromorphone or fentanyl patches.
- Prescribe controlled substances to any patient without a government-issued photo ID. (If a government-issued photo ID is not available, we will take a photo of the patient and post it.

REMEMBER:

- The Emergency Department (ED) is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of narcotics.
- Obtaining prescription opioids by fraud, deceit, misrepresentation, concealment of material fact, use false names, use of false addresses or forgery is a Class 6 felony and can be reported to the Pharmaceutical Drug Diversion Program.
Learning Activity

• Share opportunity or best practice from your organization/community
Key Takeaways

• Balancing opioid access with effective patient management is complex
• To be successful, organizations must partner with community agencies
• Best practices are emerging
• Regulations/legislation will continue to be introduced to combat opioid epidemic
• Pharmacy can play a key role in opioid stewardship efforts within their organizations and community
Resources

1. CDC Guidelines for Prescribing Opioids for Chronic Pain
   https://www.cdc.gov/drugoverdose/prescribing/guideline.html

2. SHM Improving Pain Management for Hospitalized Medical Patients Guide
   http://tools.hospitalmedicine.org/resource_rooms/imp-Guides/Pain_Management/PainMgmt_Final3.4.15.pdf

3. University of Washington School of Medicine provider education tools
   http://www.coperems.org/

4. IHI Innovation Report: Addressing the opioid crisis in the US
   http://www.ihi.org/resources/Pages/Publications/Addressing-Opioid-Crisis-US.aspx
Resources

5. Johns Hopkins The Prescription Opioid Epidemic: An Evidenced Based Approach  

6. ISMP Canada Opioid toolkit  
   https://www.ismp-canada.org/opioid_stewardship/

7. AHA Opioid Epidemic toolkit  
   http://www.aha.org/advocacy-issues/initiatives/behavioral/opioid.shtml

8. VHHA Opioid Prescribing Guidelines  
   http://www.vhha.com/communications/the-opioid-epidemic/

9. Massachusetts Hospital Association  
   https://www.mhalink.org/Content/NavigationMenu/Newsroom/SubstanceAbuse/default.htm  

10. ASHP Guidelines on Preventing Diversion of Controlled Substances  