New Strategies in Opioid Stewardship
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1:30PM – 2:20PM

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INTRO

Christina Wiekamp
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CONFLICT OF INTEREST DISCLOSURE

Author’s Conflicts of interest:
• Christina, no conflict of interest
• Lana, no conflict of interest

LEARNING OBJECTIVES

• Explain how the opioid epidemic has impacted and burdened our healthcare system
• Express how the opioid epidemic led to the demand for pain management services and stewardship programs
• Evaluate the importance of an opioid stewardship program
• Specify the goals of an opioid stewardship program
• List the components of an opioid stewardship program
• Build an institutional specific opioid stewardship program (OSP)

Audience Response Question #1

Do you feel comfortable in initiating or adjusting pain management pharmacotherapy in patients with medical and psychological comorbidities?

• A. Yes
• B. No
Audience Response Question #2

Are you expected to initiate or adjust pain management pharmacotherapy in patients with medical and psychological comorbidities at your workplace?

- A. Yes
- B. No

THE OPIOID EPIDEMIC

“Opioid abuse is a serious public health issue, but PREVENTATIVE ACTIONS, treatment for addiction, and proper response to overdoses can help.” – U.S. Dept of HHS

Some states have more painkiller prescriptions per person than others.
THE PARADOX OF PAIN MANAGEMENT

Pain continues to be a prevalent problem for medical and surgical patients\(^2,3\)

- 2003 landmark study of the impact of acute pain management in the hospitalized patient over a 10 yr period\(^1\)
  - Improvement in pain management has not kept up with other advances in healthcare
  - Reports of “any pain” and “extreme pain” are reported as higher

- 2013 surgical pain congress report\(^4\)
  - Inadequate pain control was the most common reason for readmission after same-day surgery
  - Surgical pain was the leading driver of surgery patient dissatisfaction


THE DEMAND FOR PAIN MANAGEMENT SERVICES

1 → 2 → 3 → ✓
“Consult a pharmacist or pain management expert (when available) when converting from one opioid to another, or changing the route of administration (from oral to IV or transdermal).”

“Create and implement policies and procedures that allow for a second level review by a pain management specialist or pharmacist of pain management plans that include high-risk opioids, such as methadone, fentanyl, IV hydromorphone and meperidine.”

Effective January 1, 2018 new and revised pain assessment and management standards will be applicable to all Joint Commission-accredited hospitals.

Opioid Stewardship is a HealthEast organization tactic for 4 out of the 6 JC standards for pain management.

If patients do not experience improvement in pain and function at >/= 90 MME/day, or if there are escalating dosage requirements, clinicians should...consider consulting a pain specialist.

For patients agreeing to taper to lower opioid doses as well as for those remaining on high opioid dosages, clinicians should...consider consulting a pain specialist.

Because pain management in patients with substance abuse disorder can be complex, clinicians should consider consulting...pain specialists.

Experts noted that naloxone co-prescribing can be facilitated...by collaborative practice models with pharmacists.

Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians and should consider involving pharmacists and pain specialists.

In patients with opioid use disorder clinicians should...consider consulting a pain specialist.”
MAKING THE CASE

Audience Response Question #3

Do you have an opioid stewardship program at your institution?

• A. Yes
• B. No

HEALTHEAST CARE SYSTEM

St. Paul, MN
• 7,500 employees
• 850 physicians
• 100+ primary care providers
• 4 hospitals
  – Bethesda: 254 beds
  – St. Joseph’s: 491 beds
  – St. John’s: 184 beds
  – Woodwinds: 86 beds

“To deliver optimal health and well-being for our patients, our communities and ourselves.”
Pain is common among medical patients
- 43% of medical patients experienced pain
- 12% reported unbearable pain

Published Opioid Stewardship Programs

Outpatient Palliative Care Practice – University of California

Objective
- Evaluate pharmacist interventions and patient outcomes of a pharmacist-led outpatient palliative care practice

Results (March 2011 – March 2012)
- New consults were referred by an oncologist or hematologist
- 84 new and 135 follow-up visits
- A change in pain medication dose and initiation of a new medication for constipation and N/V were the most common interventions
- Statistically significant change in pain score was observed at the 3rd visit

Published Opioid Stewardship Programs

Academic Medical Center – University of Minnesota

Objective
- Described their experience with development of a opioid stewardship pharmacy service implemented in June 2010

Pharmacist responsibilities
- Admission medication reconciliation (PMP), review of pharmacy-generated reports (oral long-acting opioids, fentanyl formulations, and medications), monitor high-risk opioid therapy (high-dose IV opioids, multiple pain medications, PCA, continuous infusions), providing pain management consultations for complex patient cases

Results (June 2010 – June 2011)
- 2469 patients reviewed (16% of all admissions)
- 1266 (44%) required an intervention related to medication reconciliation, most commonly clarifying the most recent opioid use history (n=945, 80%)
- 156 consultations requested by physicians or pharmacists
Published Opioid Stewardship Programs

Community Hospital – Kaweah Delta Medical Center, California

- Pharmacist responsibilities
  - Opioid stewardship: review of pharmacy-generated reports (patients at high-risk for oversedation, inadequate analgesia, continuous infusions, PCAs, fentanyl patches, and methadone), and medication recommendations
  - Pain Management Consultations placed by providers
  - Post-discharge phone calls to patients

- Results (October 2013 – June 2014)
  - 1,355 interventions (81% consultations, 19% stewardship)
  - $1.6 million in estimated indirect cost avoidance ($400k from stewardship interventions)
  - 59% reduction in opioid related RRT calls and Code Blues
  - > 50% reduction in use of 2-4 mg IV hydromorphone dose vials
  - 19% reduction in fentanyl patches
  - Increase in patient satisfaction scores related to pain management

Published Opioid Stewardship Programs
Community Hospital – Kaweah Delta Medical Center, California

OPIOID STEWARDSHIP GOALS

- Optimize pain management pharmacotherapy
  - Pharmacy generated report that identifies patients are using > 6 prn opioid doses in 24 hours

- Minimize opioid associated adverse events and cost
  - Pharmacy generated report that identifies patients that are receiving high-risk opioid therapy
  - Epic generated patient list that ranks hospitalized patients who have received an opioid in the last 24 hours at risk for opioid induced respiratory depression

- Quality and safety improvement
  - Ongoing review of naloxone events/IV opioid usage/ prescribing patterns/documentation compliance
  - Findings have warranted order set reviews, practice improvements, epic prescribing thresholds, and directed education

- Enhance patient experience

METRICS

- % of recommendations accepted
- # interventions
- Decrease hospital induced naloxone events
- Decrease in IV opioid utilization
- Decrease # of opioids prescribed
- Improve RN documentation compliance with PCA policy
SUMMARY OF OPIOID STEWARDSHIP IMPROVEMENT WORK

- Retrospective review/activities
  - Naloxone use
  - Evaluate provider prescriber patterns with goal to reduce prescribing
  - Decrease IV opioid utilization, optimize use of orals when appropriate

- Prospective review/activities
  - Medication profile review by decentral pharmacists
  - Computer generated report of pain scores > 6 in the last 16 hours for opportunity to optimize use of PRN medications (opioid and/or opioid-sparing) for uncontrolled pain
  - Determine if there is a need for a Pain Team Consult
  - Pilot by clinical pharmacy pain specialists on Pain Team for daily review of all patients meeting select criteria to reduce risk

Conclusions
- Similar use in 2016 and 2017; however 3 interventions were implemented from 2016 review by 2017
  - Documentation for indication of naloxone use in MAR
  - Opioid Stewardship Pilot Program implemented 8/1/2017
  - Provider, RN, and Pharmacist education completed

Goals for 2018
- Assess compliance rate with MAR documentation re: indication of naloxone use
- Assess order sets that contain both opioids and benzodiazepines and consider adjustment
- Ongoing opioid stewardship pilot
Prospective Review: Recipe for Success

- Determined by the meds or patients you choose to review
- Screen patients for opioid therapy problems
- Obtain computer generated reports
- Comprehensive medication review
- Communicate recommendations
- Modify orders
- Document interventions
- Monitor
- Report outcomes


Case Studies

- "When I completed the specific opioids report for OS on 5/11, I noticed he was on same long acting and high dose short acting opioids at home, even though he came in with respiratory failure. I left sticky note to decrease long acting and short acting, but pt was discharged the next am. He came right back in for severe SOB, and the same provider who discharged him consulted our team the day after. The pain team did end up decreasing the opioids and patient improved.

- The win here is that the Hospitalist may order a consult more readily when they see our opioid stewardship notes for more complex cases, and maybe realize this patient would have been better served with a consult from the beginning of his first hospital visit. The hospitalized ordered a consult when he came back in, and another new consult from the day after, for a chronic opioid tolerant patient."

Case Studies

- ML 78 yo female, admitted 01/12/18 for community-acquired pneumonia with symptoms of dyspnea on O2 as well as AKI
- PMH includes chronic back pain, DM2, GERD, HTN and pancreatitis.
- Med Rec recorded pt taking morphine sulfate controlled-release (MS Contin)15 mg tid, and MS Contin 60 mg bid. RPh noted that the pt ran out of her morphine day prior to admission and that her last refill was 3 months ago for a 30 day supply.
- Both medications were ordered however provider ended up d/c'ing MSER 15 mg TID and continued MSER 60 mg BID with oxy IR 5-10 mg q4h prn d/t AKI
- Pt unable to wean off O2, drowsy
- Days later pt seen giving MSER to husband
- O/S pharmacist reviews case and left recommendations to resident that patient has not filled this in 3 months and diversion witnessed
- Opioids d/c’d and APAP scheduled, patient able to wean off O2
Strengths of an OSP

- Simplicity and adaptability
  - Use of existing infrastructure (i.e., decentralized pharmacists)

- Impact on quality patient care
  - Individualized treatment of patients

- Medication safety
  - Close review of patients deemed high risk for respiratory depression or receiving high-risk opioid therapy

- Enhanced patient satisfaction

- Indirect cost avoidance data supporting pharmacist interventions

Challenges and barriers

- Not all patients in pain or experiencing adverse events are on high risk opioid therapy or deemed high risk for respiratory depression

- Pain services are usually only available during business hours leaving evening and overnight requests to be addressed the following day

- Indirect cost savings makes it difficult to proactively budget for additional positions to manage increased referrals and requests for policy revision and education

- Estimating the time required for services

Challenges and barriers

- Identification of patients at risk for poorly managed pain and timely communication with anticipated members of team

- Early patient education reviewing goals and setting expectations

- Timely follow-up with PCP or pain management provider
Summary

- Overreliance on opioid-based therapies has led to significant adverse events and nationwide epidemic of opioid misuse and diversion
- Societal and economic costs of pain are substantial
- Opioid stewardship programs can help adjust and monitor analgesic pharmacotherapy
- Opioid stewardship and pain management programs have demonstrated the ability to improve opioid prescribing, social services associated with opioid addiction (e.g., improve patient education and enhance patient satisfaction)
- Opioid stewardship programs help ensure the safe use of opioids and improve patient care through proactively mitigating opioid-associated adverse events
- Patient experience, MD/RN satisfaction, education, intervention documentation, and cost avoidance tracking are important to the sustainability of opioid stewardship programs

Questions?