Principles of Opioid Stewardship

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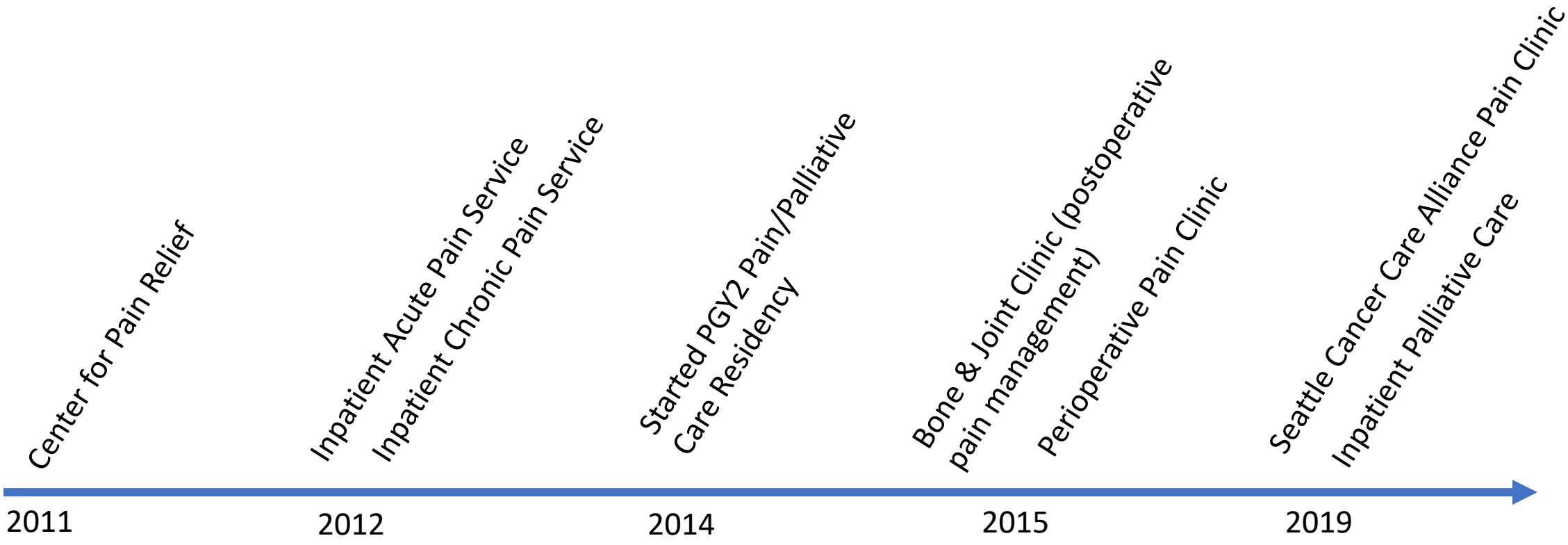
Introduction: Current Role

- VA Portland Health Care System
  - Palliative Care Pharmacist
    - Opioid management of cancer, COPD/CHF patients
  - Ambulatory Care Specialty Supervisor
    - Pain, SUD, Geriatrics, Hepatology, Cardiology
  - PGY2 RPD for Pain Management and Palliative Care
- Perioperative Pain Clinic: started April 2023

Introduction: Previous Role

- University of Washington Medical Center

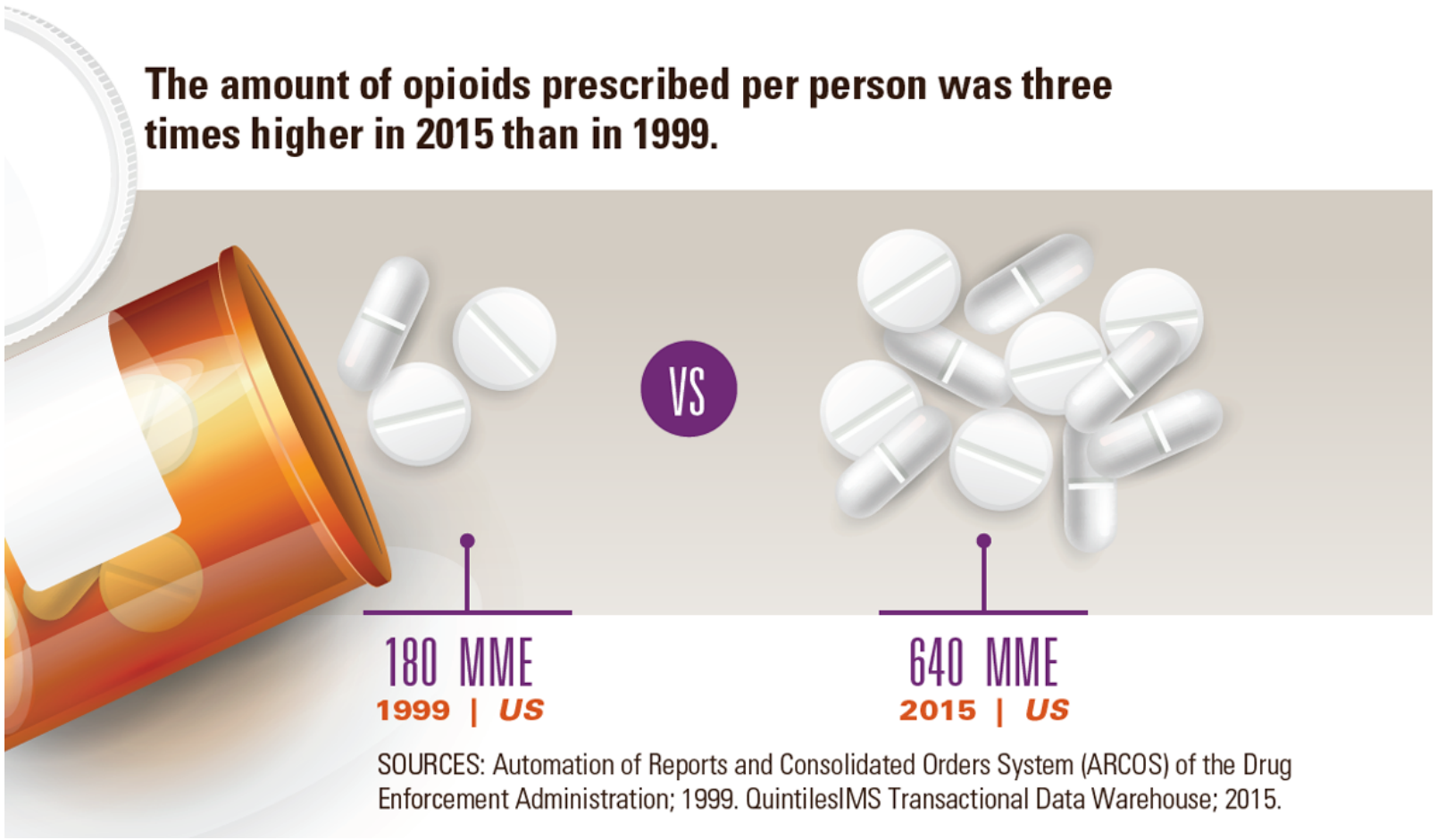


Opioid Prescribing Practices[1]

- Starting with an increase in 2006, the total number of prescriptions dispensed peaked in 2012
  - 81.3 prescriptions per 100 persons
  - >255 million opioid prescriptions

- Started to decrease and by 2020, data showed:
  - 43.3 prescriptions per 100 persons
  - >142 million opioid prescriptions
  - Certain counties had rates 9 times higher than the national average

Opioid Crisis[2]



Morphine Milligram Equivalence = MME

Opioid Crisis

- Patients who took opioids for >90 days, were 15x more likely to developing an opioid use disorder (OUD) compared to those who were not prescribed opioids[2]

- Despite reductions in opioid prescribing, opioid-involved overdose death rates continue to increase (increase in illicit opioids, such as heroin and illicitly manufactured fentanyl)[3]

- Average duration of opioid prescriptions increased from 13.3 days (2006) to 17.7 days (2015). Taking opioids for longer periods increases the risk of OUD, overdose, and death.[3]

Factors Contributing to Opioid Crisis

- Pain as the 5th vital sign
- Drug industry
- Stigma of addiction and lack of access to opioid use disorder (OUD) treatment
- COVID-19
- Socioeconomic factors
- Comorbid disease states

Pain Statistics[4]

- Pain is one of the most common reasons adults seek medical care in the United States
- 1 of 5 U.S. adults had chronic pain in 2019 and 1 of 14 adults experienced “high-impact” chronic pain
- Pain leads to impaired physical functioning, poor mental health, and reduced quality of life
- In 2020, prescription opioids was the most commonly misused prescription drug in the United States
  - However, reasons for misuse included: 64.6% - relieve physical pain
    13.6% - other (including euphoria, addiction)

Opioid Stewardship Programs

- To optimize pain management while preventing opioid-related harm
- Helps provide a framework for hospital or health systems to identify areas of quality improvement and implement changes in culture/practice to improve opioid prescribing practices
- Opioid Stewardship is highly encouraged to be implemented in small and large institutions in varying scales
- Identify needs/gaps in the institution
- Set goals and determine how progress will be measured through metrics

Joint Commission Updated 2018 Standards[6]

- January 1, 2018, Joint Commission released new and revised pain assessment and management standards
- Some new requirements include:
  - Identifying a leader or leadership team that is responsible for pain management and safe opioid prescribing
  - Involving patients in developing their treatment plans and setting realistic expectations and goals
  - Promoting safe opioid use by identifying high-risk patients
  - Monitoring high-risk patients
  - Facilitating clinician access to prescription drug monitoring program (PDMP) databases
  - Conducting performance improvement activities focusing on pain assessment and management to increase safety and quality for patients

CDC Guidelines for Prescribing Chronic Opioids

- Published 2016
  - Decreases in opioid prescribing and high-risk prescribing practices
  - Increase in non-opioid pain medications prescribing
  - Led to implementation of new laws, regulation and policies based on CDC guidelines

- Updated 2022
  - Acknowledgement that misapplication of guidelines led to rapid opioid tapers or discontinuations without patient buy-in, rigid application of opioid dosage thresholds, duration limits by insurers and pharmacies
  - Softer language instituted to emphasize avoid increasing dosage that exceed benefit vs. risk ratio, specific recommendations around dosage have been moved to considerations and more nuanced information offered to help with clinical decision-making and individualized patient care.

Recommendation 1[4]

Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy

- Regarding non-traumatic, non-surgical acute pain (i.e., strains, sprains, tendonitis, dental pain, headaches), opioids non-superior to NSAIDs
- Patient education before starting acute or chronic opioid therapy:
  - Importance of tapering as soon as possible
  - Serious adverse effect, including respiratory depression, opioid use disorder with longer use
  - Common side effects
  - Risks to household members

Recommendation 2[4]

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1. Modify or develop pain order sets to include commonly used non-opioid therapies (NSAIDs, APAP, topicals, muscle relaxants, antidepressants, referrals/consults available to pain specialists, acupuncture, chiropractor, physical therapy). Discuss how opioids should be or should not be included in order sets.
2. Patient handouts for education with opioid Rxs

- Confirm diagnosis - evaluate for pote
opioid prescribing does not unintentiona
- Before starting opioid therapy, establish meas
discussion of benefits vs. risks
- Patient education on expected benefits, common and serious adverse effects/risks

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e treatment and function goals,

Recommendation 3[4]

When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting

- ER/LA opioids should not be used intermittently and should be reserved for severe, continuous pain
- Not indicated for acute pain or as part of initial treatment in subacute or chronic pain
- Pre-cautions when using methadone of transdermal fentanyl

Recommendation 4[4]

When opioids are initiated for opioid-naïve patients with acute pain, clinicians should **prescribe the lowest effective dose**. When prescribing opioids for acute, subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above 90 MME/day unless benefits relative to risks are expected.

Implement MME calculators into opioid orders

- Patients often don't have benefit in pain or function from increases to ≥50 MME/day, but are instead at higher risk of adverse effects including opioid overdose
  - In chronic pain management, opioid overdose factor compared to 1-20 MME/day:
    - 50-99 MME: 1.9-4.6
    - ≥100 MME/day: 2.0-8.9
  - Veterans Health Administration: patients who died from opioid overdose had a mean MME of 98, compared with mean MME of 48 for those not experiencing fatal overdose (*204*)
- Caution that there is not a single dosage threshold below which overdose risk is eliminated

Recommendation 5[4]

For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. **If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids.** Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.

- Shared decision making is important when discussing decision to taper and creating plan
- Recommend taper ≤10% per month for patients on opioids ≥1 year, tapers can take months to years, take pauses when indicated and management of opioid withdrawals may be needed
- Consider transition to buprenorphine for overall long-term opioid safety if patients unable to taper

Recommendation 6[4]

When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the ain severe enou

- Establish or use procedur
  recommendations for amo
  operative pain. Look at 24
  to help guide prescription o
- Evaluate patients at least every 2 w

Instituting policy/guidance for opioids Rx

1. Acute (non-traumatic/non surgical) to not exceed 3-7 days
2. Quantity for common surgeries and build into order sets
3. 24 hour MME prior to discharge and influence on discharge opioid Rxs

Recommendation 7[4]

Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients.

- Re-evaluate closer to 1 week for patients ≥50MME, starting methadone or other ER/LA opioids
- Reevaluate patients on chronic opioid therapy at least every 3 months or more frequently for most patients at higher risk for opioid use disorder or overdose
- At follow-up, clinicians should continue to evaluate if opioids continue to meet treatment and functional goals and assess for any signs of common or serious adverse effects, including signs of OUD

Recommendation 8[4]

Before starting and periodic… **clinicians should evaluate** …**k with patients.** Clinicians sh… …ne management plan strategi Nal… …**one.**

1. Pharmacist protocols for prescribing
2. Sticker with information on naloxone on all Opioid Rxs
3. Include naloxone order on discharge ordersets (particularly post-surgical)

- Naloxone prescription and edu…
  - Recommended for all but particularly … (i.e. SUD or overdose history, concurrent opioid use with CNS dep… …g benzodiazepines, taking higher doses of opioids ≥50MME)
- Careful decisions in following patient po…ulations
  - Pregnancy
  - SUD, previous opioid overdose, alcohol use
  - Renal/hepatic insufficiency, ≥ 65 years of age, sleep apnea

Recommendation 9[4]

When prescribing initial opioid
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1. Incorporation of PDMP into the EHR
2. Incorporate PDMP check in pre-anesthesia clinic workflow
3. Electronic reminders for PDMP checks

- Ideally check PDMP prior to every opioi res or unexpected controlled substances (i.e. opioids, ben azepines, sleep agents, etc)
- In long-term opioid therapy:
  - Initial check and then every 3 months
  - Only one prescriber for opioids
- Never dismiss patients from management based on PDMP results

Recommendation 10[4]

When prescribing opioids for subacute or chronic pain, **clinicians should consider the benefits and risks of toxicology testing** to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

- Urine drug screens should be performed prior to opioid start and periodically (at least annually, but more often based on risk)
- Always confirm with patient expected presence of drugs and about the potential for unexpected results
- Always discuss unexpected results with patients and send immunoassays off for confirmatory testing before making decisions to alter patient management, discuss with toxicologist if needed
- Never dismiss patients from management based on urine drug screens

Urine Drug Screens

Immunoassay	Chromatography / Spectrometry
Tests for classes of drugs (opioids, amphetamines, cocaine, oxycodone, methadone, benzodiazepines)	Test for specific drugs, including metabolites. Amount of drug found in urine has no indication to drug dose.
Rapid (<1 day), cost-effective	High cost, slow turnaround time (3-7 days) – often have to be sent out
Higher detection limits	Low detection limits
Less specificity which may result in false negatives and false positives	

Recommendation 11[4]

Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.

- Increased risk of overdose deaths in patients on both opioids and benzodiazepines vs. opioids alone
- Take precaution when co-prescribing other CNS depressants with opioids such as muscle relaxants, sedative hypnotics, gabapentin/pregabalin
- If indicated, taper benzodiazepines slowly and offer other medications for anxiety, including psychotherapies

Recommendation 12[4]

Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for OUD because of increased risks for resuming drug use, overdose, and overdose death.

- In adults receiving long-term opioid therapy for pain:
  - 23.9%–26.5% for any prescription OUD
  - 5.2%–9.0% for moderate to severe OUD (DSM-V Criteria for OUD)
- Buprenorphine treatment combined with standard medical management as effective as buprenorphine combined with more intensive opioid dependence counseling
- Standard medical management (recommendation of abstinence, self-help group participation) or opioid dependence counseling, without buprenorphine, was NOT found to be effective in preventing return to drug use

Removal of X-Waiver for Buprenorphine Prescribing[5]

- Consolidations Appropriations Act of 2023 passed in January 2023, removed need for X-waiver for prescribing of b[illegible]pre[illegible]in[illegible]OUD

- Those applying for a new or re[illegible] 2023, must have one of the[illegible]
  - A total of eight hours of train[illegible] substance use disorders
  - Board certification in addictio[illegible] American Board of Medical Specialties, Amer[illegible] the American Osteopathic Association
  - Graduation within five years and status in g[illegible]standing from medical, advanced practice nursing, or physician assistant sch[illegible]in the United States that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours

1. Treatment / Referral Pathway for providers
2. Implement drug disposal programs
3. Invest in OUD/SUD programs

Questions

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