Impacting Opioid Misuse

Randall Stewart, MD

Taking Ownership

EXCUSE #1: *"It's not our problem"*

EVIDENCE CITED:

- Non-prescription opioids

EXCUSE #2: *"It's not our fault"*

EVIDENCE CITED

- **APS** (1995) – "pain = 5th vital sign"
- **JCAHO** (2000) – "…a bold attempt to address widespread under-assessment and under-treatment of pain."
- **President's Commission** (2017) – this fostered "a growing compulsion to detect and treat pain, especially to prescribe opiates beyond traditional boundaries…"

Taking Ownership

*"It **IS** our problem"*

EVIDENCE:

- 80% of heroin users misuse Rx opioids first
- 40% of opioid deaths in 2016 were connected to a prescription (>40 deaths/day)
- 249,000,000 opioid prescriptions written by healthcare providers in 2013

Taking Ownership

It may not be completely our fault that we are in this crisis…

*…but we **ARE** at fault, completely, if we don't become a proactive in its solution.*

Taking Ownership

GUIDELINES/RECOMMENDATIONS

AMA	Michigan Commission
BCBS	Alberta Commission
CDC	Oklahoma Commission
CMS	President's Commission
JCAHO	Purdue Pharmacy

Treating with Opioids

THE TASK IS HARDER FOR SOME

Emergency Departments (*difficult)*

Hospitals (*more difficult)*

Outpatient Clinics (*complex)*

Opioid Prescriptions

	Dr. A	Dr. B	Dr. C
# Rx/Month	30	10	30
MME 0-50/day	99%	95%	99%
Duration ≤ 7 Days	99%	90%	7%
Duration 30 Days	< 1%	< 1%	54%
	ED	**Hospital**	**Clinic**

Opioids and ACUTE PAIN

WHAT **EVERYONE** CAN DO:

- Use alternatives first (NSAIDs, acetaminophen, PT, etc.)
- Use immediate-release opioids
- Limit duration to ≤ 7 days
- Limit dose to ≤ 50 MME/day
- Check the PDMP
- Check a Urine Drug Screen
- Consider co-morbidities (COPD, CHF, OSA, age, etc.)
- Consider potentiating medications (benzodiazepines, muscle relaxants, hypnotics, phenothiazines, etc.)

Opioids and CHRONIC PAIN

WHAT **EVERYONE** FACES

- Deferment of chronic pain to "someone else"
- Subjectivity of pain
- Socioeconomic factors → greater tendency toward psychological dependence
- Paucity of referral options (pain clinics)
- Fear of morbidity and mortality ("Do no harm!")
- Fear of reprimand/exposure (insurances, CMS, licensing boards, JACHO, pharmacies, etc.)

Opioids and CHRONIC PAIN

WHAT THE **ED** CAN DO:

- Develop an ED team → a consensus plan of action
- Don't treat chronic pain (ED Rx = acute pain Rx)
- Check the PDMP
- Check a UDS
- Don't automatically default to parenteral opioids: "reflect before you inject"
- Collect data/follow trends → commend and correct
- Staff/patient communication and education

Opioids and CHRONIC PAIN

WHAT THE **HOSPITAL** CAN DO

- Develop an inter-disciplinary team → develop plan/protocol
- Physician, staff, and patient education
- Include non-opioid alternatives
- Check the PDMP
- Check a UDS
- Order opiates prn rather than scheduled, if appropriate
- Use lowest feasible dose and frequency
- Don't automatically default to parenteral opioids: "*reflect before you inject*"
- Monitor patients (O2sat, assessment of alertness, etc.)
- Don't treat chronic pain at discharge (≤ 7 days)
- Make naloxone available at discharge in high-risk patients
- Collect data/follow trends → commend and correct

Opioids and CHRONIC PAIN

WHAT THE **CLINIC** CAN DO

- Develop a plan; follow the plan
- Include protocols for dealing with non-compliance
- Educate patients and staff
- Consider non-opioid options first-line
- Keep a “Chronic Controlled Medication Patients” list
- Initiate a patient-provider agreement
- Conduct an annual chronic pain reassessment
- Monitor compliance: PDMP, UDS, pill counts
- Consider decreasing the dose and frequency (e.g. BID)
- Refer high-risk or refractory patients to a pain clinic
- Co-prescribe naloxone, especially in patients at risk

IMPACTING OPIOID MISUSE

TAKING OWNERSHIP

- ✔ ED
- ✔ Hospitals
- ✔ Clinics

What can **pharmacies** do?

Elise Dasinger, PharmD
Birmingham VA Medical Center & UAB