Opioid Stewardship and Overdose Prevention

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Disclosures

The authors of this presentation have no financial or other relationships to disclose.
Objectives

• Develop workflow best practices for opioid use in inpatient and outpatient settings
• Identify ways in which technology can be incorporated for safer practices
• Formulate strategies to engage patients and providers in opioid stewardship
• Review naloxone for community use, including administration and counseling points
Opioid Deaths are an epidemic

• According to the CDC, opioids killed more than 47,600 people in 2017
• 91 people die EVERY DAY in the United States from opioid overdose (prescription + illegal)
  • This is more than the number of people that die from motor vehicle collisions
• Heroin overdoses have been on the rise since 2011
Not just a national problem

- In 2017, 354 people died in the state of Mississippi from drug overdoses

- 723,508 Mississippians filled an opioid prescription in 2018
  - Down from 932,578 in 2014

https://www.cdc.gov/drugoverdose/data/statedeaths.html
The number of prescriptions is down, but the potency of the prescriptions written is increasing.
Implementation Considerations

Goals

Interventions

Resources

Data monitoring
Goals

• Improve patient safety
• Understand the current prescribing patterns
• Establish best practices for your company/institution
• Optimize pain management
Audience Poll: Who would be appropriate personnel to include as stakeholders?

A. Information Technology
B. Quality Improvement
C. Administrative Officers
D. Healthcare Professionals
E. C & D
F. All of the above
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Data Monitoring
Monitoring of Data

Monitor all available resources for data related to opioid use and overdose prevention

- CDC
- Emergency departments
- Medical Examiners
- Prescription Monitoring Programs
- Your pharmacy/EHR reports
Increased Use of Prescription Monitoring Program
Mississippi Prescription Monitoring Program

- Mississippi Prescription Monitoring Program (MS PMP) is a statewide electronic database that monitors Scheduled II-V controlled drugs being dispensed

- This program is designed to track any information speculated against drug diversion or abuse

- Provides physicians and pharmacists detailed information regarding patients controlled substance prescription history

Reporting Requirements

• December 31, 2013
  • Board of Medical Licensure required any physician licensed to practice in Mississippi who prescribes, administers, or dispenses any controlled substance to register with the MS PMP

• December 31, 2015
  • All pharmacists licensed in MS are required to register to use the MS PMP

• Anyone misusing the PMP can result in a $50,000 penalty

http://www.mbp.state.ms.us/mbop/pharmacy.nsf
http://www.namsdl.org/library/C605033C-EABE-8725-6763D1AD1F7159CB/
Verification Regulations

- MS Pharmacy Practice Regulations Article XLIII (7/30/2018)
- “It is the intent of the Board that pharmacists utilize the PMP on a regular basis based on their professional judgment.”

- A pharmacist shall review the PMP if:
  - The patient is a new customer
  - The patient has not had an opioid at that pharmacy within 6 months
  - Review PMP at least once every 6 months for any patient receiving controlled substances

https://www.mbp.ms.gov/Regulations/ARTICLE%20XLIII%20PRESCRIPTION%20MONITORING%20PROGRAM.pdf
Challenges

• Incorporating into the work flow
• Registration and reporting requirements varies among states
• Locating patient information
• Inadequate training
• Errors with pharmacy data entry
• Errors with PMP software
Best Practices

• According to the MS PMP Guidelines, a pharmacist can elect a “delegate” user, such as a pharmacy technician

• Document on hard copy prescriptions

• Use reports in your dispensing system or EHR
Audience Poll: Which of the following is an appropriate use of the database?

A. Your teenage daughter has a new boyfriend and you want to know if he takes any concerning medications
B. A patient comes in and asks to pay cash for a prescription of generic Norco 5/325mg because her insurance is “messed up right now”
C. Your friend has been acting strange lately, showing up late to events and dressing sloppier than usual
D. You want to make sure that no one has been filling controlled substances under your name
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Develop “Report Cards”

Provider Dashboard: Acute Opiate Prescribing

Provider Dashboard: Acute Opiate Prescribing

Opioid Orders MEDD

- <=90
- 91-120

What % of ordered opioids for acute patients have an MEDD > 90?

Total Rx for Acute Pts: 34
Median Rx MEDD: 40
Median Day Supply: 8

97% (n=33)

3% (n=1)

Image courtesy of Anil Goud, MD, Elizabeth Kiefer, Lyyna Truong
Provider Dashboard: Acute Opiate Prescribing

Medications Ordered *(sorted by highest Median MEDD)*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>MECF</th>
<th>Distinct count of Order ID</th>
<th>Median Rx MEDD</th>
<th>Median Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>BUTORPHANOL TARTRATE 10 MG/ML NA SPRY</td>
<td>7</td>
<td>1</td>
<td>77</td>
<td>7</td>
</tr>
<tr>
<td>HYDROCODONE-ACETAMINOPHEN 10-325 MG PO TABS</td>
<td>1</td>
<td>3</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>HYDROCODONE-ACETAMINOPHEN 5-325 MG PO TABS</td>
<td>1</td>
<td>11</td>
<td>40</td>
<td>8</td>
</tr>
<tr>
<td>HYDROCODONE-ACETAMINOPHEN 7.5-325 MG PO TABS</td>
<td>1</td>
<td>2</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>ACETAMINOPHEN-CODEINE 300-30 MG PO TABS</td>
<td>0.15</td>
<td>2</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>HYDROCODONE-IBUPROFEN 7.5-200 MG PO TABS</td>
<td>1</td>
<td>1</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>OXYPHЕНONE 10 MG PO TABS</td>
<td>1.5</td>
<td>1</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>OXYPHЕНONE-ACETAMINOPHEN 5-325 MG PO TABS</td>
<td>1.5</td>
<td>3</td>
<td>30</td>
<td>19</td>
</tr>
<tr>
<td>TRAMADOL 50 MG PO TABS</td>
<td>0.1</td>
<td>10</td>
<td>20</td>
<td>8</td>
</tr>
</tbody>
</table>

What meds are you ordering for acute pts? How often? Median MEDD and DS?

Image courtesy of Anil Goud, MD, Elizabeth Kiefer, Lyn Truong

Interventions
Leverage EHR

- Prescriber Education
- Identify High Risk Patients
- Order Sets/Policies
- E-Prescribing
- Patient Education
Prescriber Education

• The “Problem”
• Impact of initial prescribing
• Use of pain care plans
• Safety and best practices
• Requirements

https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html
Opioid Prescribing Guidelines

- Opioids are not first-line for chronic pain
- Use non-opioids whenever possible
- Start low and go slow
- Use immediate release whenever possible
- Establish goals for treatment early and re-evaluate every 3 months
- Avoid concurrent prescribing of opioids and benzodiazepines

DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1
Identify High Risk Patients

- Chronic vs. Acute
- Cancer vs. Non-Cancer
- Palliative or Hospice Care
Order Sets/Policies

- Opioids should **not** be first-line therapy unless severe pain unlikely to respond to alternatives

- **IF** Opioids are prescribed for Acute Pain, providers should use only immediate-release forms and avoid extended-release or long-acting forms of opioids
  - The **lowest** possible effective dosage of a short-acting agent should be prescribed – **3 days** usually sufficient; **rarely more than 7 days** required

- Check CURES every 4 months – **IT’S THE LAW**

- Check urine toxicology prior to providing any prescription >5 days duration
Order Sets/Policies

- Avoid prescribing opioids at a dose that is ≥ 90 MME or at a dose that exceeds 50 MME if the patient is taking concomitant benzodiazepines

- If provider is prescribing opioid(s) at a dose that exceeds recommendations, provider should initiate efforts to reduce to safer doses starting with patients at the highest risk of adverse events

- Provider options:
  - Pain Specialist
  - Formal Programs (Chronic Pain Management, Tapering, Pain Psychology)
  - Alternative Programs (acupuncture, exercise, mindfulness, physical therapy)
  - Chemical Dependency Programs

- Adhere to Guidelines:
  - Ensure visits with patients every **3-6 months**
  - Have patient sign Pain Agreement **annually**
  - Conduct urine drug toxicology screen **annually**
  - Check CURES every 4 months – **IT’S THE LAW**
  - Limit prescriptions to a **30-day supply**
E-Prescribing

• Documentation
  • Pain Care Plan
  • E-PDMP attestation

• E-prescribe controlled substances
  • Except CIIIs (with some exceptions)
  • Automatic day supply 3-7 days for acute needs
Patient Education

• After Visit Summary
• Opioid information
• Safety plan
• Resources

https://www.cdc.gov/drugoverdose/patients/materials.html
Pharmacy Controlled Substance Policy

• What information should you require from the patient?
• Will you only fill prescriptions within a certain mile radius?
• When should you check the PMP?
• Will you require diagnosis codes to document medical necessity?
• What do you do for an early refill? What about habitual early refills?
Substance Abuse Treatment Services

• There are a number of treatment facilities in Mississippi
• Medication-assisted treatment
  • Methadone
  • Buprenorphine
  • Naltrexone
Other Preventative Efforts

- Community Groups
- School-based programs
- Pain Management Support Groups
- Special use of drug diversion law enforcement
- Tool kits from other institutions
  - [http://www.safemedia.org/](http://www.safemedia.org/)
- Stakeholder involvement
Medication Disposal

- Partner with your local law enforcement for National Drug Take Back Day – April 27, 2019 from 10AM-2PM
- Register as a DEA authorized collector
  - Registrations Tab
  - “Registration for Disposal of Controlled Substances”
    - DEA Number
    - Business Name
    - SSN
    - Tax ID
    - Zip Code
    - Current DEA Expiration Date
Medication Disposal

• Collection Receptacle Options
  • MedSafe
  • WasteManagement
  • Stericycle
  • CleanHarbors

• Requirements of a receptacle
  • Securely placed and maintained
  • Securely locked
  • Permanent outer container and removable inner liner
  • Removable inner liner must have a unique ID number that can be tracked

Drug Enforcement Agency – http://www.deadiversion.usdoj.gov/
Audience Poll: Which of the following medications is recommended to flush down the toilet if other disposal options are not available?

A. lorazepam
B. carisoprodol
C. oxycodone
D. A, B, and C
E. none of the above
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https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm#Medicines_recommended
Medication Safety at Home

• Medication Disposal
  • Mix medications in an undesirable substance (coffee grounds, kitty litter) in a plastic bag in the trash
  • Narcotics should be flushed down the toilet as they are especially harmful and the benefits of getting rid of them outweighs the potential risk to the water supply

• Be sure patients keep medications in a cool, dry place
  • Out of reach of children
  • In a lockbox
  • In the original, labeled container
Increased access to Naloxone

• Proactive approach to the failure to prevent opioid overdoses
• CDC recommended guidelines for use
• Utilization of a standing order
• Encourage local law enforcement/first responders to possess
Naloxone

• Naloxone is a pure opioid antagonist
• Available as IV, IM, nasal spray, auto-injector
• Indicated for the “complete or partial reversal of opioid depression (including respiratory depression) induced by natural and synthetic opioids.”
CDC Guidelines for Naloxone use

- History of overdose
- History of substance use disorder
- Taking benzodiazepines with opioids
- At risk for returning to high dose to which they are no longer tolerant (recently released from incarceration)
- Taking higher than 50 morphine mg equivalents per day
Signs of an Opioid Overdose

• Softened breathing or breathing that has stopped altogether; also shallow breathing
• Blue or purple lips or fingernails
• Unresponsive to outside stimuli
• Inability to respond
• Pinpoint pupils
What to do in an overdose situation

• Attempt to wake the individual
• If the person isn’t breathing, do rescue breathing for 3-4 breaths first
• Prepare the naloxone for use and administer
• Call 911
• If the person isn’t breathing, continue to perform rescue breaths or CPR (if trained) while waiting for the naloxone to take effect
• After 3 minutes, if no change, administer a second dose of naloxone as above and continue rescue breathing until help arrives
• If you must leave the person for any reason, place them in the recovery position
Rescue Breathing

• Make sure nothing is in the person’s mouth
• Tilt the head back, lift the chin, and pinch nose shut
• Give one slow breath every 5 seconds
Recovery Position

• Position the person’s arm farthest from you across the person’s body and the arm closest to you above the head
• Grasp the person at the shoulder and hips and roll them towards you
• Bend both legs so the person is stabilized with the top knee out in front a few inches
• Tilt the head back to make sure their airway is open
Narcan® (naloxone) Nasal Spray

- Narcan is a nasal spray
- Available as 4mg
- To use:
  - Remove Narcan from the foil packaging
  - Place fingers on either side of the nozzle
  - Place the nozzle in one nostril only
  - Depress the plunger to administer the full dose
- Use a new device to give additional dose if necessarily in the other nostril

Narcan Nasal Spray - https://www.narcan.com/pharmacists/pharmacist-role
naloxone for nasal use

How to Give Nasal Spray Naloxone

1. Pull or pry off yellow caps.
2. Pry off red cap.
3. Grip clear plastic wings.
4. Gently screw capsule of naloxone into barrel of syringe.
5. Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose; one half of the capsule into each nostril.
6. If no reaction in 2-5 minutes, give the second dose.

Evzio® (naloxone) for auto-injection

- Evzio® is a naloxone auto-injector with voice guidance
- Available as 2mg
- To use:
  - Pull Evzio® from the outer case
  - Pull off the red safety guard
  - Place the black end against the middle of the victim’s outer thigh (does not require removal of clothing)
  - Press firmly for 5 seconds after you hear the click and hiss sound
- Each Evzio® kit comes with a trainer for practice

Evzio auto-injector http://www.evzio.com/hcp/
Naloxone

- Potential Side Effects/Symptoms of opioid withdrawal:
  - Anxiousness/nervousness
  - Body aches
  - Fever
  - Runny nose
  - N/V/D
  - Increased blood pressure
Mississippi House Bill 996

“Emergency Response and Overdose Prevention Act”

“A practitioner acting in good faith and in compliance with the standard of care applicable to that practitioner may issue a standing order to one or more individual pharmacies that authorizes the practitioner to dispense an opioid antagonist to a person at risk of experiencing an opioid-related overdose or to a family member, friend or other person in a position to assist such person at risk of experiencing an opioid-related overdose, without the person to whom the opioid antagonist is dispensed needing to have an individual prescription.”
Statewide Standing Order

- A standing order is a written agreement between a medical practitioner and a pharmacy or pharmacist that authorizes the non-prescribing provider to dispense and/or administer naloxone to a patient without an individual prescription
- Should have the following (at a minimum):
  - Criteria for dispensing
  - Product to be dispensed
  - Signatures of participating physician(s) and pharmacist(s)
  - Method of tracking product dispensed
Good Samaritan Law

"No duly licensed, practicing physician, physician assistant, dentist, registered nurse, licensed practical nurse, certified registered emergency medical technician, or any other person who, in good faith and in the exercise of reasonable care, renders emergency care to any injured person at the scene of an emergency, or in transporting the injured person to a point where medical assistance can be reasonably expected, shall be liable for any civil damages to the injured person as a result of any acts committed in good faith and in the exercise of reasonable care or omissions in good faith and in the exercise of reasonable care by such persons in rendering the emergency care to the injured person."
Good Samaritan Law

• Anyone who administers naloxone to a person in good faith is immune from civil or criminal charges
• Physicians are authorized to prescribe naloxone to those in a position to assist a person at risk for an opiate-related overdose

• The Bottom Line: Do not fear any retribution in helping someone who is in dire need of medical attention, you are not liable for anything that may go wrong in the attempt to take care of this individual.
Communicating with Patients
Communicating with Patients

• Be empathetic
• Be non-threatening and non-accusatory
• Use objective facts
  • Pain scores over time
  • Functional change over time
  • Presence of adverse effects
  • Risk of overdose or addiction
Communicating with Patients

• Explain your reasoning in a neutral tone
• Keep the patient in perspective

“I want to provide the best care for you”

“I can only dispense medications when it can be done safely”

“It looks like opioids are not working well for you” or “I have noticed that you are on a high dose of opioids and having side effects, although your pain is not being well managed”
Communicating with Patients

• Ask open-ended questions
• Use active listening
• Include written information
• Summarize for clarification
  • “It sounds like you are saying the pain makes you feel edgy”
Conclusion

• Implementing an opioid stewardship program will require a multidisciplinary approach

• Make your technology work for you!

• Active and engaging communications with both patients and providers is essential

• Naloxone administration for emergent situations can save a life!
Guidelines

- CDC Guideline for Prescribing for Chronic Pain
- VA/DoD Guidelines for Opioid Therapy for Chronic Pain
- National Quality Partners Opioid Stewardship Playbook
- National Institutes of Health National Pain Strategy
- Joint Commission 2018 Pain Assessment and Management Standards
Questions?
Opioid Stewardship and Overdose Prevention

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