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The Opioid Epidemic

Implications for Healthcare Organizations

Presentation to Nebraska Hospital Association Convention October 24, 2018
Christine Hoskin Christine.Hoskin@medpro.com 402-292-0887

Objectives

At the conclusion of this program, participants should be able to:

- Identify organizational strategies to address opioid management within a facility.
- Identify prescribing considerations when initiating opioid therapy.
- Discuss strategies for effectively adjusting opioid therapy treatment plans.
- Identify nonopioid treatment options for pain management.
- Discuss the role all healthcare workers have in battling the opioid epidemic.

Opioid crisis — no boundaries

News > Neurology

93-Year-Old 'Pill Mill' Physician Gets 10 Years in Prison

Robert Lowes
August 14, 2017

Almost half of all opioid misuse starts with a friend or family member's prescription

Health Jul 31, 2017 5:00 PM EDT

An Illinois doctor traded drugs for sex and cash. He just pleaded guilty.

One family loses two sons to opioid epidemic: It's 'overwhelming'

Donna Freydkin
TODAY

Oct. 17, 2017 at 9:29 AM

CMAJ Open. 2017 Jan-Mar; 5(1): E184–E189. PMCID: PMC5378545
Published online 2017 Mar 2. doi: 10.9778/cmajo.20160013

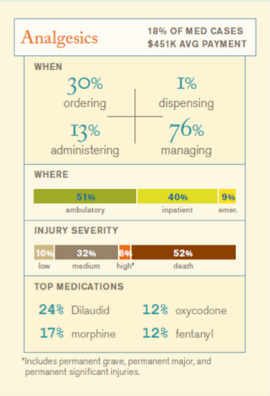
Fatal overdoses involving hydromorphone and morphine among inpatients: a case series

Amanda Lowe, BScFS, (Hons), MSc, Michael Hamilton, MD, MPH, Julie Greenall BScPhm MHSc, Jessica Ma, BScPhm, Irfan Dhalla, MD, MSc, and Nav Persaud, MD, MSc

Opioid epidemic is a public health emergency

Malpractice claims data

1 in 9 malpractice cases involves a medication-related problem.

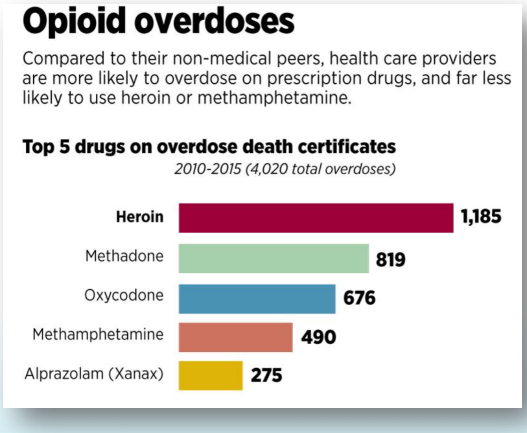


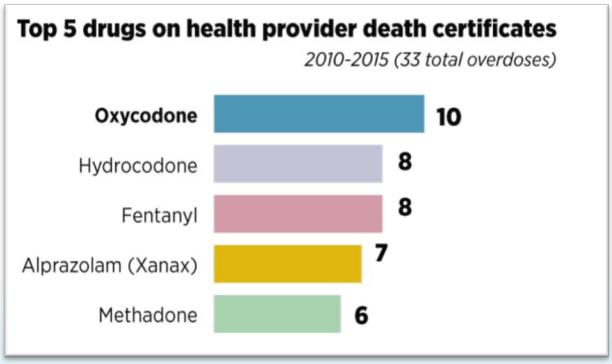
Analgesics were associated with 18 percent of those cases.

Source: CRICO. (2016). *Medication-related malpractice risks* (2016 CRICO Strategies National CBS Report). Retrieved from www.rmf.Harvard.edu/Malpractice-Daa/Annual-Benchmark-Reports/Risks-in-Medication

Healthcare worker overdose and death

Washington

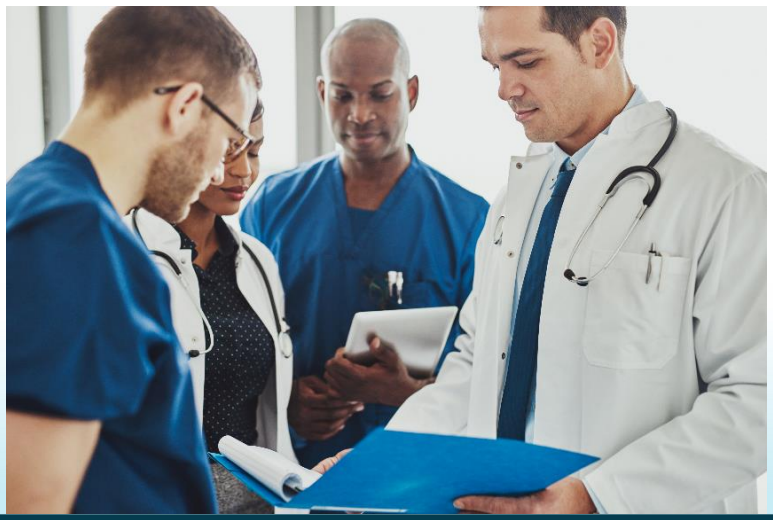




Source: Washington Department of Health records

A starting point

Everyone is responsible for helping to address this epidemic through identification and response.



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Organizational Strategies

Pain Management Stewardship Team

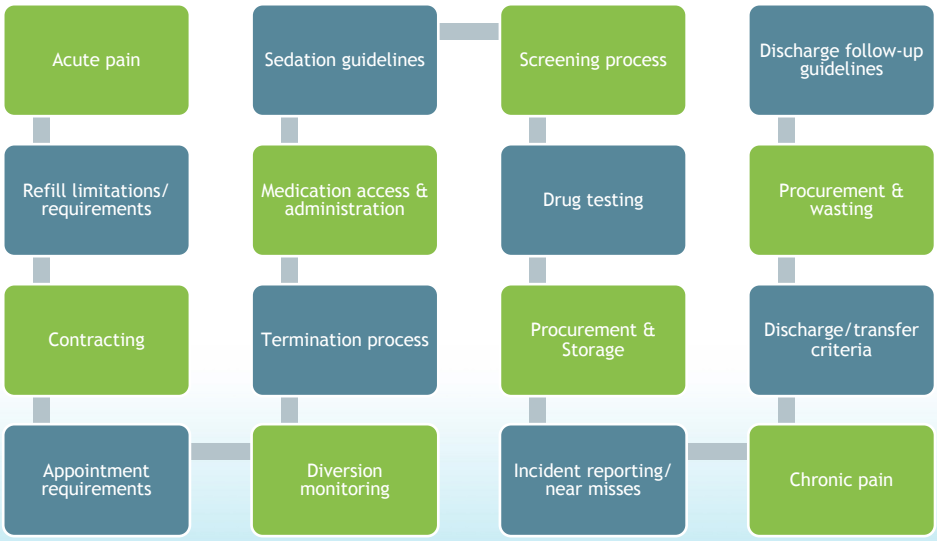
Multidisciplinary

- Leadership support
- Provider support

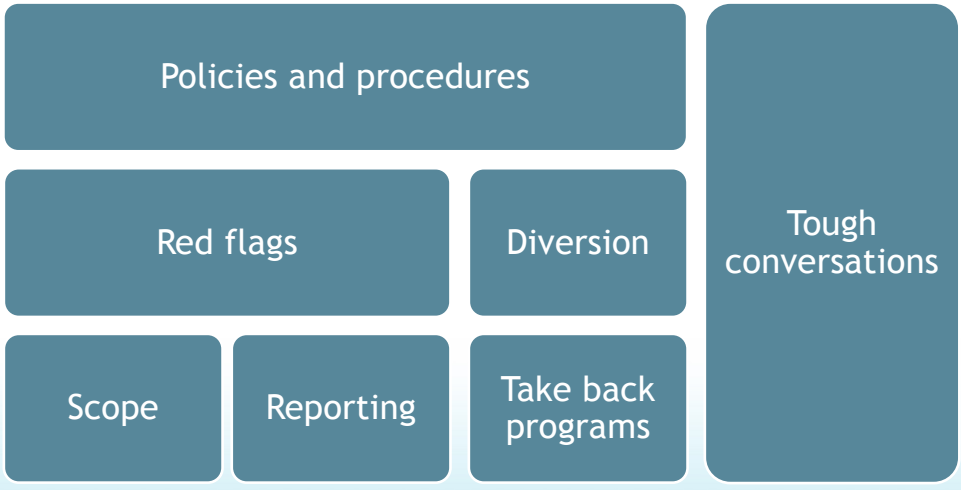
Role

- Evaluate organizational pain management culture
- Goals
- Determine quality measures
- Plan for improvement- Stewardship program
- Educate
- Implement
- Evaluate

Suggested opioid management guidelines



Provider/Staff training



Storage

- Pharmacy/Med room
- Procurement and delivery
- Quantity control
- Integrity of product/package
- After hours access and overrides

Diversion monitoring and response

General considerations

*Awareness
*Policies and procedures
*Red flags
*Community resources

Employee/Provider

*Human resources involvement
*Credentialing involvement
*Mechanism for reporting internally
*State reporting requirements
*Audit process/monitoring

Patient/Caregiver

*PDMP
*Communication between healthcare team
*Documentation

Red flags

Employee/Provider

- Higher opioid usage rate
- Signs out larger amount than needed and wastes the rest
- Shared access codes
- Sign out times do not correspond with schedule
- Increased errors
- Forged documentation
- Unauthorized access
- Patients reporting higher than normal pain levels
- Medication signed out but not documented on patient chart
- Financial issues
- Tardy/sick frequently
- Increased drowsiness
- History that includes drug usage or diversion
- Unaccounted for (frequently disappears for short periods)
- Isolates self
- Increasing difficulty doing routine tasks
- Sloppy or illogical charting

Patient/Caregiver

- Urine screens are not consistent with prescriptions/doses ordered
- Missed appointments
- PDMP (multiple scripts, prescribing concerns)
- Doctor shopping
- Financial problems
- Social withdrawal
- Needing script refilled early (lost, stolen, etc.)
- Noticeable elation/euphoria
- Marked sedation/drowsiness
- High blood pressure
- Confusion
- Constricted pupils
- Slowed breathing
- Intermittent nodding off or loss of consciousness
- Constipation
- Flu-like symptoms may indicate withdrawal (headache, nausea/vomiting, diarrhea, sweating, fatigue, anxiety, inability to sleep

*Not intended to be an all inclusive list

More considerations

ACLS	Reversal agents	Drill
Discharge instructions	Obstructive sleep apnea	Script writing safety nets
Prescribing habits	Patient complaints	Credentialing
	Special populations	

How do you measure up

CHECKLIST
Pain Management

MedPro Group

Pain management is a complex and evolving issue for healthcare organizations and providers. Sometimes described as the "fifth vital sign," pain affects millions of Americans. Yet, unlike other vital signs, pain cannot be quantitatively measured, and it is often undertreated or not treated at all.

Proper pain management largely depends on consistent, accurate pain assessments; qualified, competent, and properly credentialed staff; medication safety measures; and patient education about pain management and the risks of pain. Use the following checklist to evaluate your organization's risk in relation to pain management.

	Yes	No
Has your organization conducted a facility-wide assessment of its approach to pain management?	☐	☐
Does your organization have a pain management committee?	☐	☐
Does your organization take a multidisciplinary, team-based approach to pain management?	☐	☐
Does your organization have written policies and procedures regarding pain management?	☐	☐
Do pain management policies and procedures adhere to federal and state drug monitoring regulations specific to pain management and controlled substances?	☐	☐
Does your organization have written protocols for acute and chronic pain management?	☐	☐
Are physicians and multidisciplinary staff members who specialize in pain management credentialed for specific pain management techniques and treatments?	☐	☐
Are physicians and multidisciplinary staff members who are involved in procedural sedation given in conjunction with interventional pain management certified in advanced cardiovascular life support?	☐	☐
Are patient complaints about pain management monitored, trended, and reviewed for improvement opportunities?	☐	☐

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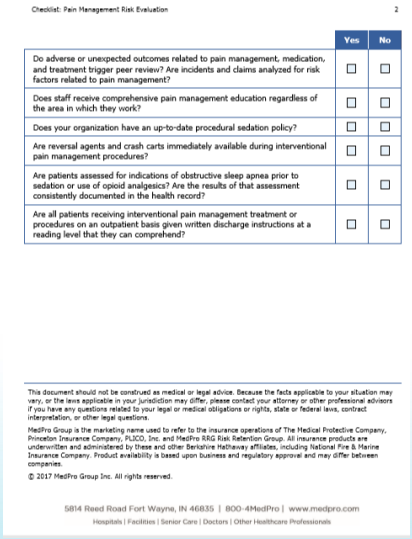

Checklist: Pain Management Risk Evaluation 2

	Yes	No
Do adverse or unexpected outcomes related to pain management, medication, and treatment trigger peer review? Are incidents and claims analyzed for risk factors related to pain management?	☐	☐
Does staff receive comprehensive pain management education regardless of the area in which they work?	☐	☐
Does your organization have an up-to-date procedural sedation policy?	☐	☐
Are reversal agents and crash carts immediately available during interventional pain management procedures?	☐	☐
Are patients assessed for indications of obstructive sleep apnea prior to sedation or use of opioid analgesics? Are the results of that assessment consistently documented in the health record?	☐	☐
Are all patients receiving interventional pain management treatment or procedures on an outpatient basis given written discharge instructions at a reading level that they can comprehend?	☐	☐

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https://www.medpro.com/documents/10502/2899801/Checklist_Pain+Management.pdf

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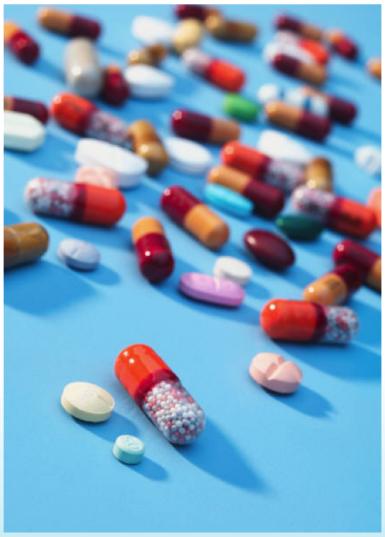
Patient Care Strategies

Considerations for acute and chronic pain patients

- Nonpharmacologic
- Goals
- Risk and benefits
- Lowest effective dosage (start low and go slow)
- Immediate release vs. extended release
- Minimal supply
- Drug combinations (eg. Avoid benzos and opioid combos)
- Follow-up requirements
- Tapering

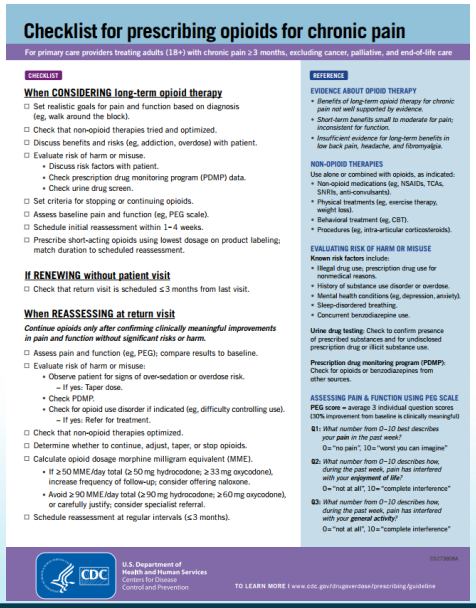


Nonpharmacologic and nonopioid interventions including complementary medicine

Behavioral	Cognitive	Energy based	Environmental
Interventional	Physical/ exercise	Spiritual	Psychological
	Alternative medicine	Nonopioid medication	

Source: Centers for Disease Control and Prevention. Nonopioid treatments for chronic pain. Retrieved from www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

Checklist for prescribing opioids for chronic pain



Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your pain in the past week?*
0 = "no pain", 10 = "worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?*
0 = "not at all", 10 = "complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your general activity?*
0 = "not at all", 10 = "complete interference"

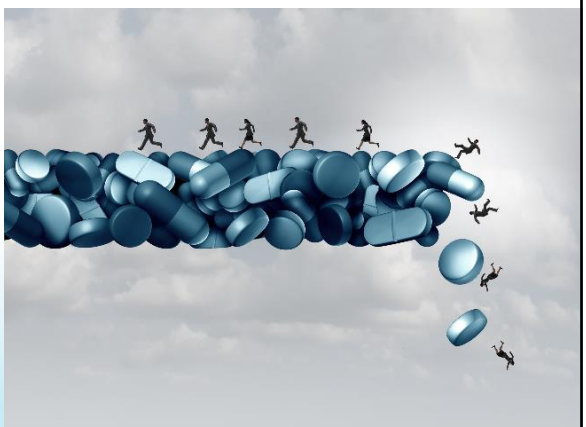
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

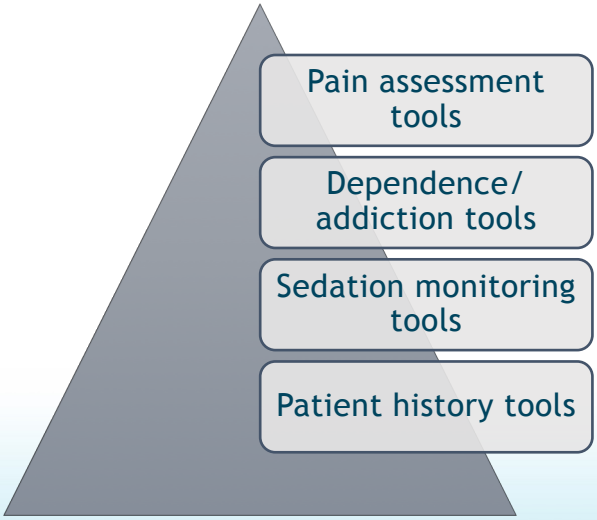
Source: Centers for Disease Control and Prevention. Checklist for prescribing opioids for chronic pain. Retrieved from www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

Risk mitigation strategies

- Evaluation tools
- Contracting
- PDMP
- Documentation

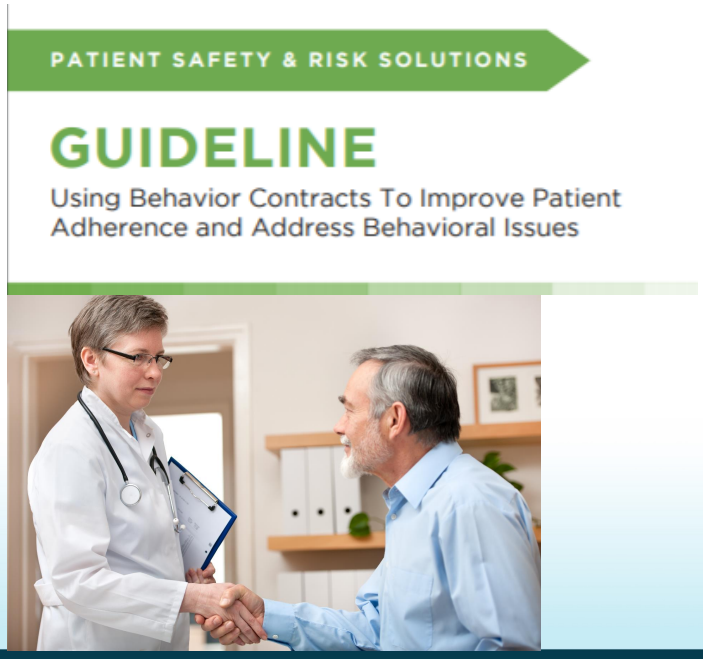


Evaluation tools



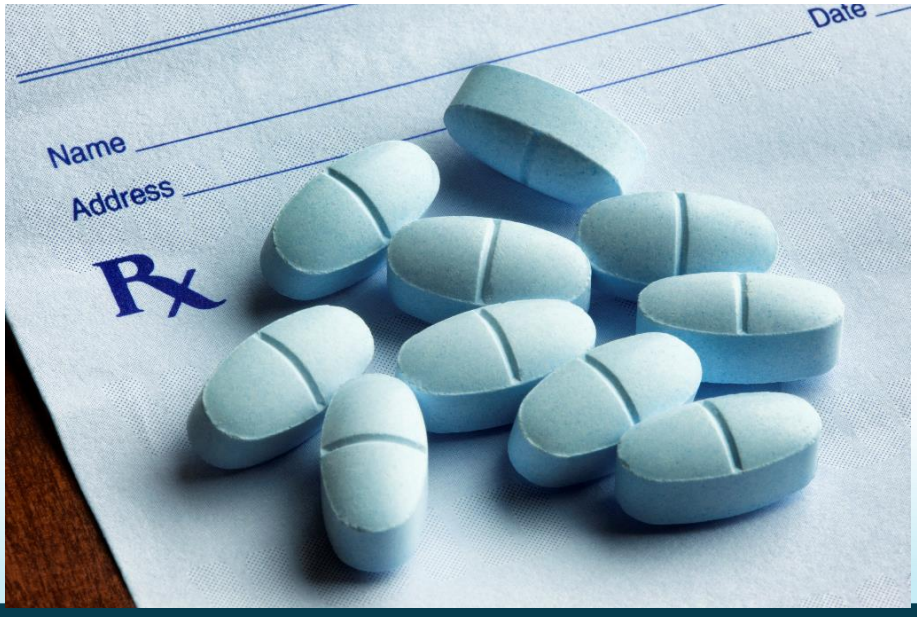
Source: Janssen Pharmaceuticals. (2016). Pain assessment resources. Retrieved from www.prescriberesposibly.com/pain-assessment-resources | 20

Contracting

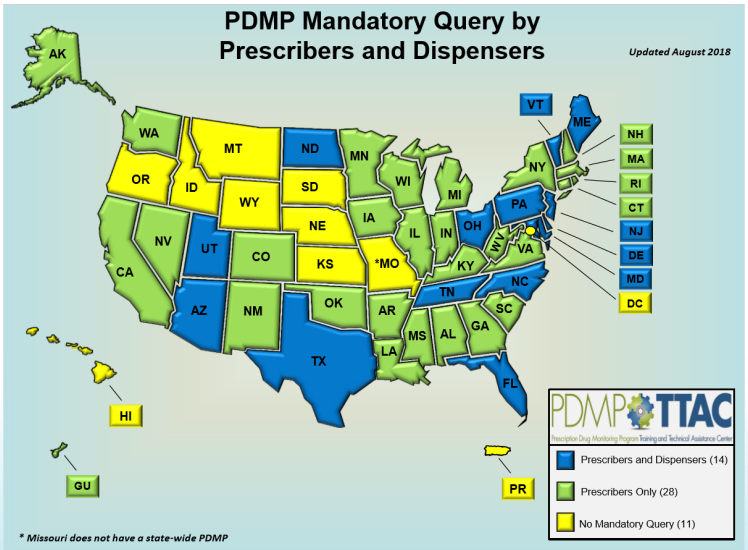


Source: MedPro Group. (2017). *Guideline: Using behavior contracts to improve patient adherence and address behavioral issues.* Retrieved from www.medpro.com/documents/10502/2837997/Behavior+Contracts.pdf | 21

Prescription Drug Monitoring Program

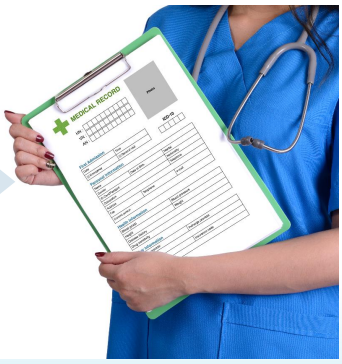


PDMP mandatory query by prescribers and dispensers



Documentation

- Data tool for performance improvement activities
- Secures and ensures reimbursement
- Communication tool
- Health record is the single source to memorialize all care provided to the patient



Legislation 2018

LB 788 would require continuing education for certain health-care professionals to include information on prescribing opiates.

LB 923 would provide immunity for administering naloxone to law enforcement employees and contract employees who regularly handle evidence or property that may include or contain opioids.

LB 931 would set a seven-day limit on new prescriptions of opioids for patients who are younger than age 19 diagnosed with an acute (or temporary) condition.

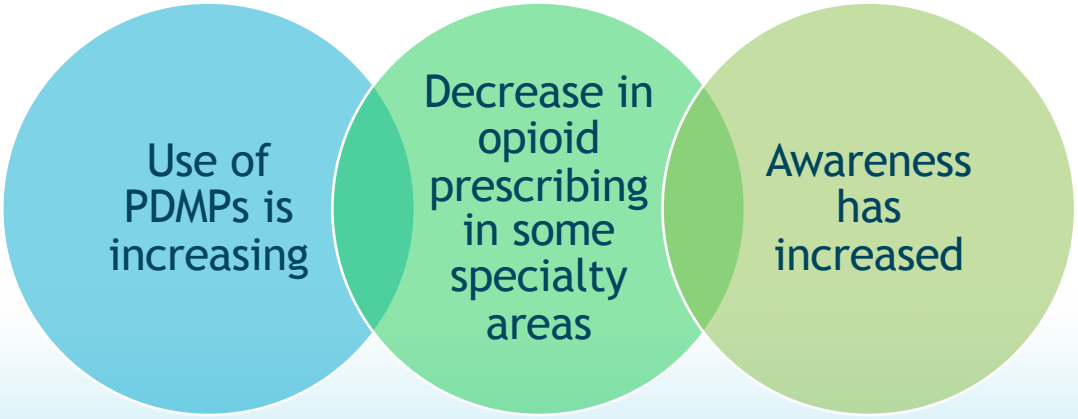
LB 932 would require discharge planning for state inmates to include whether an inmate should receive medication-assisted treatment for opioid addiction.

LB 933 would require medical practitioners to discuss with their patients the dangers of addiction and overdose before prescribing opioids

LB 934 would require individuals to present identification before picking up an opioid prescription.

Conclusion

Progress is being made . . .



. . . but we have a long way to go.

Resources

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- National Institute on Drug Abuse. (2012). Resource guide: Screening for drug use in general medical settings. Retrieved from www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen

Questions

What questions do you have?

Thank You!

Disclaimer

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