Opioid Safety: Prescribing Guidelines, Quality Measures and Care Coordination Best-Practices

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Disclosure

Michael Crooks does not have (nor does any immediate family member have) actual or potential conflict of interest, within the last twelve months, a vested interest in or affiliation with any corporate organization offering financial support or grant monies for this continuing education activity, or any affiliation with an organization whose philosophy could potentially bias this presentation.
Learning Objectives

► Describe the current climate of opioid use, misuse, and social impact
► Summarize the recommendations of the CDC Guideline for Prescribing Opioids for Chronic Pain;
► Recognize factors that increase the risk for opioid harm and care coordination practices to improve the safe use of opioids;
► Identify emerging quality measures related to opioid prescribing
The Opioid Problem and Guidelines for Providers
GA: 3rd Biggest Increase in Opioid-Related ED Visits
GA: Biggest Increase in Opioid-Related Hospitalizations

<table>
<thead>
<tr>
<th>State</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>99.8</td>
</tr>
<tr>
<td>North Carolina</td>
<td>70.9</td>
</tr>
<tr>
<td>Oregon</td>
<td>60.2</td>
</tr>
<tr>
<td>Washington</td>
<td>60.1</td>
</tr>
<tr>
<td>South Dakota</td>
<td>59.6</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>58.9</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>54.6</td>
</tr>
<tr>
<td>Texas</td>
<td>15.0</td>
</tr>
<tr>
<td>New Jersey</td>
<td>14.2</td>
</tr>
<tr>
<td>Iowa</td>
<td>11.5</td>
</tr>
<tr>
<td>Nebraska</td>
<td>8.0</td>
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<tr>
<td>New York</td>
<td>2.9</td>
</tr>
<tr>
<td>Maine</td>
<td>2.7</td>
</tr>
<tr>
<td>Louisiana</td>
<td>-4.8</td>
</tr>
<tr>
<td>Illinois</td>
<td>-5.5</td>
</tr>
<tr>
<td>Maryland</td>
<td>-9.7</td>
</tr>
<tr>
<td>Kansas</td>
<td>-18.0</td>
</tr>
</tbody>
</table>

Percent Change in the Rate of Opioid-Related Inpatient Stays (per 100,000 Population)

Vertical line is the national value: 23.8
Policy Levers: Reducing Opioid Harm

- Law Enforcement - Distribution
- Law Enforcement - Use
- Regulatory Enforcement
- Professional Guidance
- Medical Support/Assistance
- Social Support/Assistance
Vectors for Disease Transmission

Image Credit. 1) Mosquito. CDC Public Health Image Library #5814; 2) Tick. Photo by Scott Bauer
Vectors in the Opioid Epidemic?

Image Credit. 1) Captain Planet, Cartoon Network screenshot, 2017 ; 2) Memecenter.com, 2017
Vectors in the Opioid Epidemic

The CDC Guideline for Prescribing Opioids for Chronic Pain

► Chronic Pain: >3 months, or beyond healing
  - Not acute pain, or therapy related to cancer, palliative, or end-of-life care

► Primary Care Clinicians
  - Not specialists, acute care, emergency clinicians, dentists, and surgeons

► Voluntary
  - Not mandatory or enforced

► Addresses Public Health Crisis (Abuse/Overdose)
  - Not safe and effective management of pain
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

**CLINICAL REMINDERS**

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)
Avoid Opioids: Use non-pharmacological and/or non-opioid medicines. Don’t use opioids alone.

Talk to Your Patients: Agree on realistic expectations; use of opioids only if benefits outweigh risks, clinician and patient responsibilities. Reassess and discuss frequently.
**CLINICAL REMINDERS**

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

1. **Use immediate-release opioids when starting**
2. **Start low and go slow**
3. **When opioids are needed for acute pain, prescribe no more than needed**
4. **Do not prescribe ER/LA opioids for acute pain**
5. **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

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**4** When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

**5** When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

**6** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

**7** Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

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[LEARN MORE](www.cdc.gov/drugoverdose/prescribing/guideline.html)
Avoid ER/LA Opioids: When starting chronic pain therapy, for any acute pain.

Limit Dose and Quantity: Acute pain rarely requires >7 days, usually 3 is enough.
Reassess risk/benefit for doses above 50 MME/day.
Avoid (or be very cautious) above 90 MME/day.

Talk to Your Patients: Reassess and discuss risk/benefit within 1-4 weeks, at dose changes, and at least every 3 months.
**HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?**

1. **Determine** the total daily amount of each opioid the patient takes.
2. **Convert** each to MMEs—multiply the dose for each opioid by the conversion factor. (see table)
3. **Add** them together.

### Calculating morphine milligram equivalents (MME)

<table>
<thead>
<tr>
<th>OPIOID (doses in mg/day except where noted)</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
</tr>
<tr>
<td>41-60 mg/day</td>
<td>10</td>
</tr>
<tr>
<td>≥ 61-80 mg/day</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
</tr>
</tbody>
</table>

*These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.*

**CAUTION:**

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

**USE EXTRA CAUTION:**

- **Methadone**: the conversion factor increases at higher doses.
- **Fentanyl**: dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors.
Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

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**Clinical Reminders**

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed
Opioid Management Best Practices are Medication Management Best Practices

- **Know** the Medications
- **Discuss** the Medications
- **Assess** the Medications
Know the Medications

- Conduct a complete medication history review at every healthcare encounter:
  - Gather medication use information from multiple sources:
    - Patient/Caregiver Interview
    - Medication Review
    - Prescription Drug Monitoring Program
    - Pharmacy and Health Provider Records

Free My Meds bags and medication safety resources at www.AlliantQuality.org/content/orders
Discuss the Medications

► Review the name, dose, directions, and indication for every medicine.
  – Record the indication on prescription orders
► Ask about patient side-effects and patient concerns.
► Counsel patients on what to expect from medications and what to do if the unexpected or undesirable happens.
Assess the Medications

► Reconcile medications following hospitalizations, changes in conditions, or addition of new medications.

► Review medication therapy goals and patient treatment goals.

► Discuss patient preferences and adherence influencers, including cost, dose schedule, side-effects, and actual/perceived efficacy.
Opioid Quality Measures
PQA Endorsed Opioid Quality Measures

- Use of Opioids at High Dosage in Persons Without Cancer (>120 MME for 90+ consecutive days)
- Use Opioids from Multiple Prescribers and Pharmacies (4+ each)
- Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer
- Concurrent Use of Opioids and Benzodiazepines (2+ Opioid Rx with 30 concurrent days benzo use)

PQA Concept
Opioid Quality Measures

► Health care utilization related to opioid use
  - Hospital, ED or Urgent Care for opioid related treatment

► Triple Threat/Holy Trinity: Concurrent use of opioids, sedative/hypnotic, and muscle relaxer
  - 30 days concurrent use of all three. Sedatives/hypnotics may be benzodiazepine or non-benzodiazepine

Opioid Quality Measures
GA’s Prescription Drug Monitoring Program

- Changes to existing law effective July 1, 2017
- All GA prescribers with DEA # must register with PDMP by Jan 1, 2018
- Prescribers required to check PDMP beginning July 1, 2018 for first-time C-II and BZD prescriptions
- Dispensers must report controlled substance transactions within 24 hours
- Dispensers not required to check PDMP
GA’s Prescription Drug Monitoring Program

- Permits delegation of PDMP access to support staff (with several caveats)
  - Max of 2 delegates per shift
  - Must be a licensed/registered health care provider
  - Maintain confidentiality of PDMP data
  - More flexibility allowed for delegates in hospitals and health care facilities with Medical Director oversight

- Transfer to Dept. of Public Health may expand use of data for epidemiologic studies
Naloxone Standing Orders

- Naloxone may be dispensed by individual prescription or under the authority of a state health official.
  - Current Standing order authorized by Patrick O’Neal, MD Interim Commissioner of the GA Department of Public Health.
  - “Every pharmacy in this state shall retain a copy of the standing order issued under Code Section 31-1-10.”
Naloxone Standing Orders

- Exempts certain formulations/packaging of naloxone products
  - Nasal Adapter Kit – minimum 2 prefilled luer-lock 1mg/mL syringes with mucosal atomizer device
  - Prepackaged nasal spray – minimum 1 unit with 0.4mg/0.1mL naloxone (available as Narcan Nasal Spray)
  - Muscle rescue kit – 1 multidose 10mL vial of 0.4mg/1mL naloxone with minimum 2 IM syringes
  - Prepackaged IM autoinjector – 2 devices each with minimum 0.4m/mL naloxone (available as Evzio)
Grissenger M. Results of the Opioid Knowledge Self-Assessment from the PA Hospital Engagement Network Adverse Drug Event Collaboration. PA Patient Saf Advis 2013 Mar;10(1)


For more Opioid Safety and Care Coordination Resources

► CDC Opioid Resources
  www.cdc.gov/drugoverdose/index.html

► Alliant Quality – Med Safety and Care Coordination
  www.alliantquality.org/content/orders

► Georgia Pharmacy Association – Free Opioid CPE for Pharmacists
  www.gpha.org/cpeasy
Making Health Care Better

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-C361-17-01