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Solutions to Implementing Holistic Opioid Stewardship Programs

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Disclosures

Tamara Mattox has no relevant financial relationships with any Accrediting Council of Continuing Medical Education defined commercial interest* to disclose.

Candace Fong, PharmD, has the following relevant financial relationships with ACCME-defined commercial interests and will not be discussing any off-label or investigational use of products. *Ownership Interest*: Novo Nordisk

*A commercial interest is any entity producing, marketing, re-selling, or distributed health care goods or services consumed by, or used on, patients.

Agenda

Upon completion of this webinar, participants should be able to:

- Describe regulators' latest moves in addressing the opioid endemic
- Design a comprehensive opioid stewardship program that includes prescription analytics, optimizing pain management, prevention, and detection diversion controls
- Formulate population health management programs to assist patients with opioid addictions such as Medication-Assisted Treatment programs

Health System Risks?

Medication Errors

Employee Diversions

DEA Investigations

Provider Under the Influence

Negative Publicity

Patient Harm

INFECT PATIENTS

DEA Investigations

University of Michigan Health to pay $4.3-million penalty in opioids case

Georgia health system paying $4.1M to settle opioid diversion claims

DEA raids some West Coast Kaiser Permanente pharmacies

Alia Paavola - Wednesday, September 18th, 2019 Print | Email

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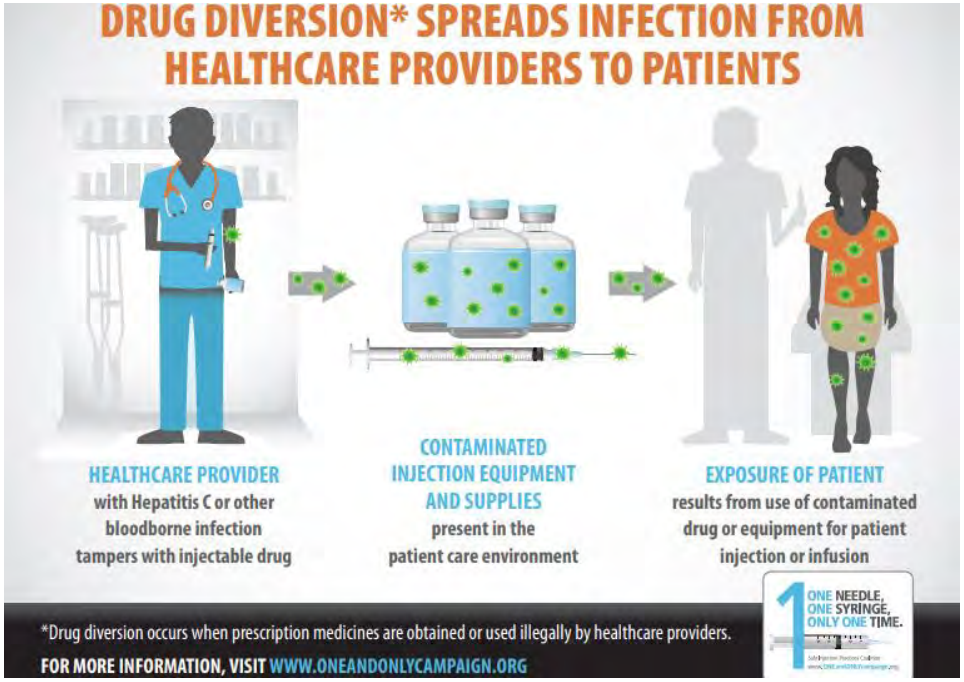
Nurse Diversions – Patient Safety

Former Utah nurse indicted for allegedly diverting narcotics, infecting patients with Hepatitis C

News > Medscape Medical News

Drug-Diverting Nurse Blamed for Washington HCV Outbreak

Diana Swift
April 25, 2019



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Pharmacy Employee Diversions

UPMC pharmacy tech accused of stealing $52K worth of painkillers

Ex-pharmacy head gets 5 years for stealing $5.6M in painkillers

The former chief pharmacist at Beth Israel Hospital, accused of stealing $5.6 million in painkillers, took a plea deal in a Manhattan court Wednesday that will send him to prison for five years.

Provider Arrested

'Drug dealers with stethoscopes:' Feds warn of more doctor arrests in opioid crackdown

Brett Kelman, Nashville Tennessean Published 9:57 a.m. CT April 19, 2019

U.S. AUGUST 27, 2019 / 2:02 PM / 24 DAYS AGO

Ohio hospital where doctor accused of opioid murders worked settles lawsuits

SPECIAL REPORT

While addiction crisis raged, many surgeons overprescribed opioids, analysis shows

By JULIE APPLEBY AND ELIZABETH LUCAS — KAISER HEALTH NEWS / JUNE 21, 2019

Ultimate Risk: New Addicts / Overdoses

6%	• Per JAMA 6% of patients prescribed opioids after surgery (minor and major) are still taking them 3-6 months later, having become dependent = *1 million new addicts annually*
80%	• With 22 million Americans undergoing hospital surgeries in 2014 * and at least 80% received opioids after surgery (18 million) ** =
200	• Each hospital creates around 200 new opioid addicts per year!
130	• 130 people die each day from Opioids! ***

*Agency for Healthcare Research and Quality
**Per US National Library of Medicine National Institute of Heath
***National Institute of Drug Abuse

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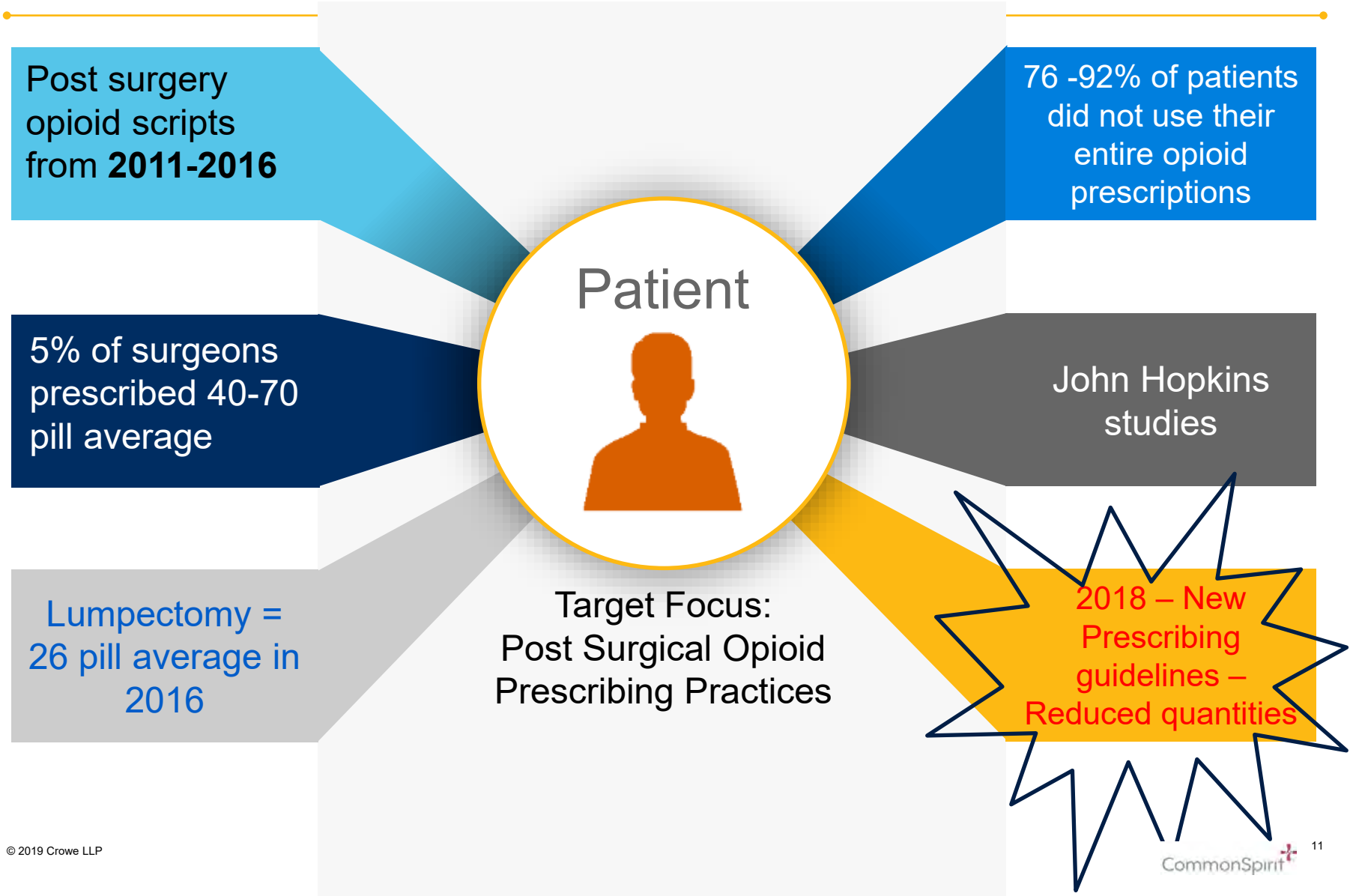
Focus: New Youth Addicts

States	Age (0-24 years)	Age (25-34 years)	Total Deaths (all ages)
California	208	536	2,199
Virginia	103	366	1,241
Pennsylvania	272	819	2,548
Ohio	336	1,263	4,293

Hospitals Creating New Opioid Use Disorder Patients



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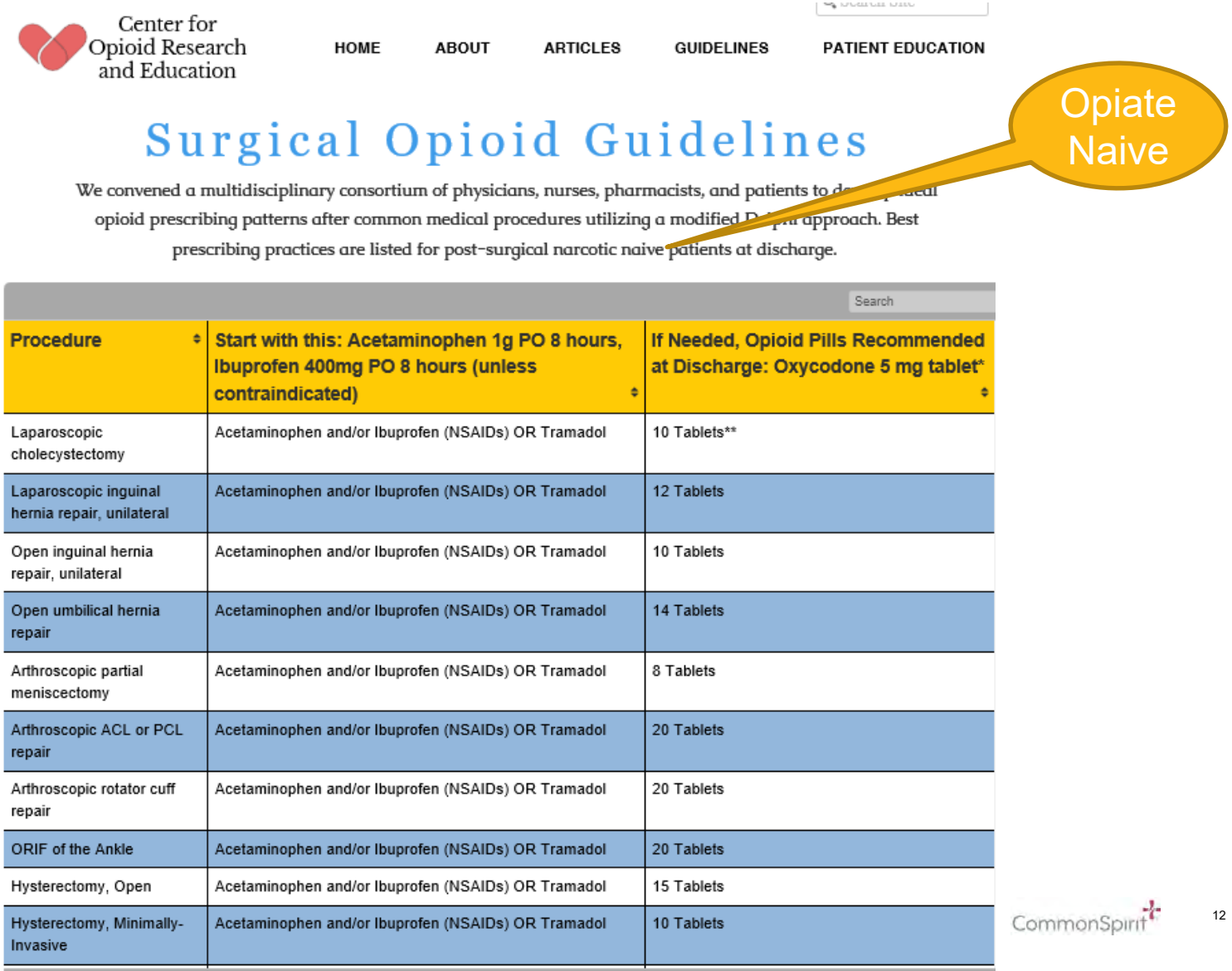
Opioid Use Disorders Leads to New Standards



Center for Opioid Research and Education

HOME ABOUT ARTICLES GUIDELINES PATIENT EDUCATION

Opiate Naive

Surgical Opioid Guidelines

We convened a multidisciplinary consortium of physicians, nurses, pharmacists, and patients to d[illegible] opioid prescribing patterns after common medical procedures utilizing a modified D[illegible] approach. Best prescribing practices are listed for post-surgical narcotic naive patients at discharge.

Search

Procedure	Start with this: Acetaminophen 1g PO 8 hours, Ibuprofen 400mg PO 8 hours (unless contraindicated)	If Needed, Opioid Pills Recommended at Discharge: Oxycodone 5 mg tablet*
Laparoscopic cholecystectomy	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets**
Laparoscopic inguinal hernia repair, unilateral	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	12 Tablets
Open inguinal hernia repair, unilateral	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets
Open umbilical hernia repair	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	14 Tablets
Arthroscopic partial meniscectomy	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	8 Tablets
Arthroscopic ACL or PCL repair	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	20 Tablets
Arthroscopic rotator cuff repair	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	20 Tablets
ORIF of the Ankle	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	20 Tablets
Hysterectomy, Open	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	15 Tablets
Hysterectomy, Minimally-Invasive	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets

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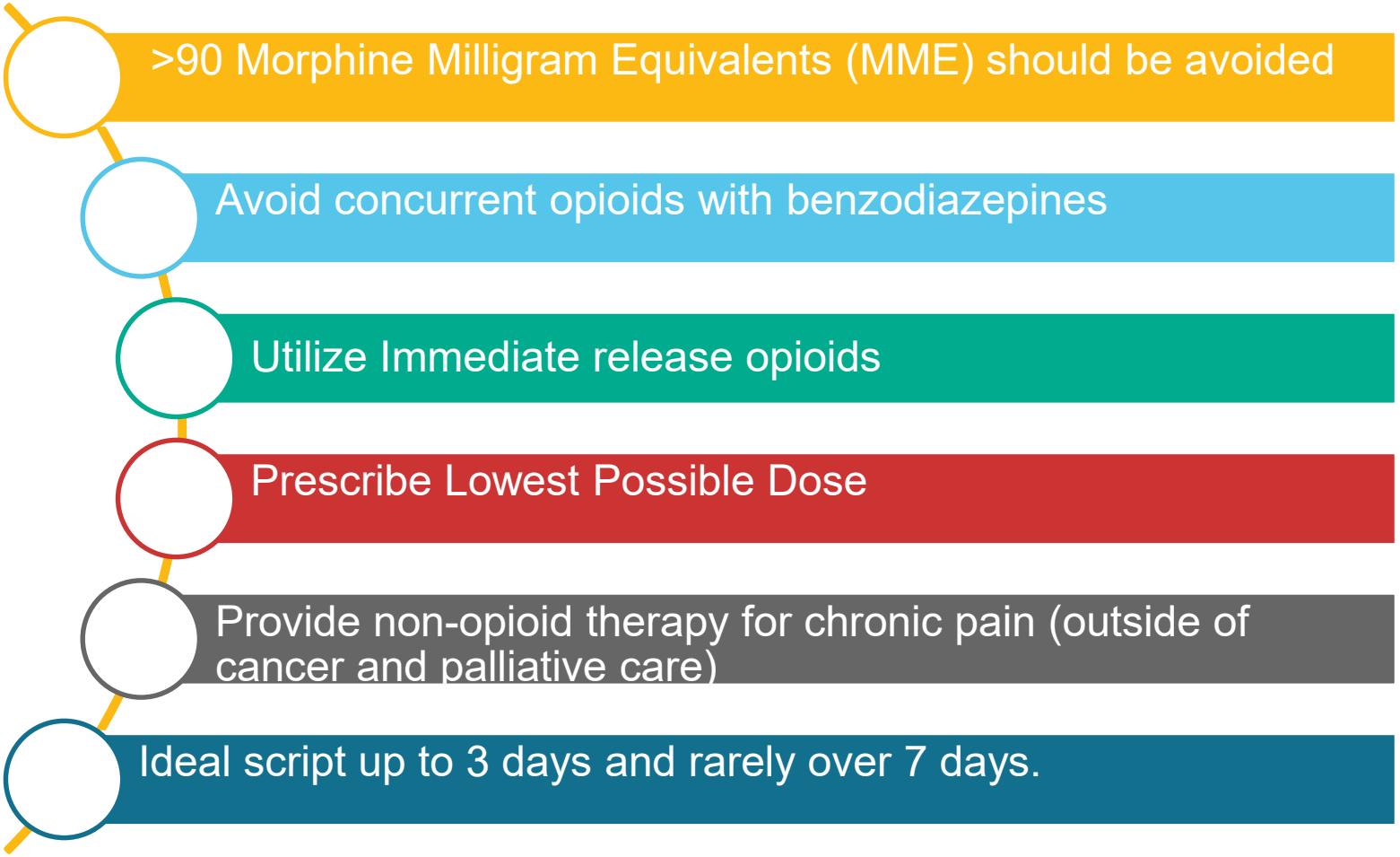
CDC Guidelines



Today's Risks Addressed Through Opioid Stewardship

- DEA Investigation / Fines
- Pharmacy Diversion
- Provider Diversion
- Nurse Diversion
  - Patient care
    - – Errors due to altered state
    - - Patients in pain – nurse diverted patient med
    - - Infect patients

1 Diversion Monitoring

- Over sedation of patients from opioids
- Administering high levels of opioids not necessary

2 Pain Management

- Non compliance with BOP scripts writing
- Non-alignment with CDC guidelines

3 Opioid Prescribing

- Addressing the patient with opioid use disorder (OUD)

4 Medication Assisted Treatment (MAT)

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Beyond The Risk – Opioid Stewardship

- Educate patient on destroying controlled substance
- Educate patient on opioid use / Narcan (naloxone)
- MAT program
- Educate OUD patients

- Move to candace

A Large Health System's Journey Through a DEA Settlement Agreement

DEA Findings

Published

Department of Justice

U.S. Attorney's Office

Eastern District of California

SHARE

FOR IMMEDIATE RELEASE

Wednesday, July 16, 2014

Dignity Health Agrees To Pay $1.55 Million In Civil Penalties To Resolve Controlled Substances Act Claims

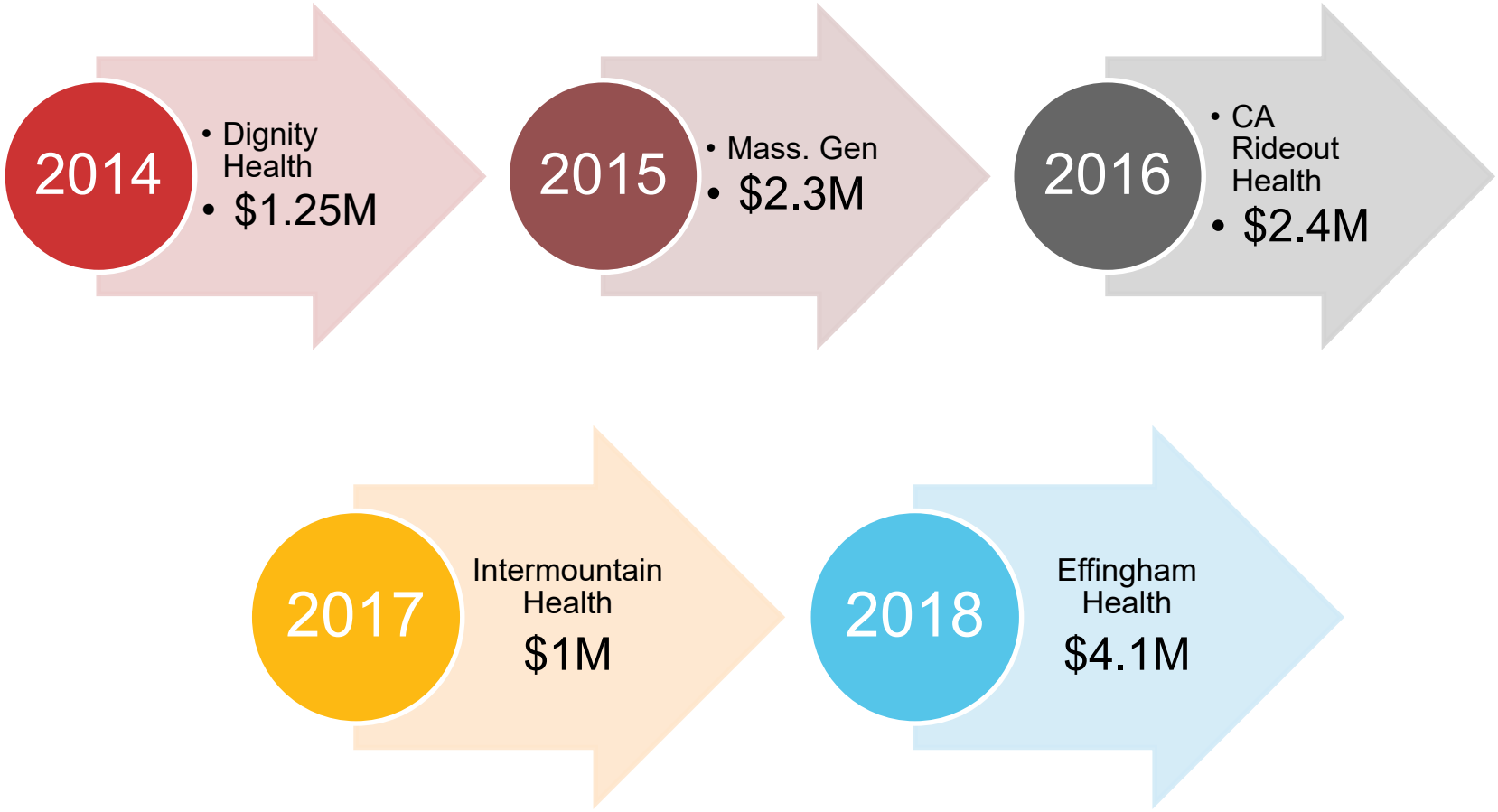
Poor Recordkeeping

Failure to maintain accurate records of receipt

Failure to maintain required inventory

The DEA audit identified numerous infractions in recordkeeping requirements with each infraction fined at $10,000 / infraction.

"The DEA is committed to investigating hospitals that are not in compliance with the Controlled Substances Act (CSA)" Special Agent in Charge Michael J. Ferguson – 2015



DEA Settlement

Culture Prior to DEA Agreement

Pharmacy System Leadership was "Advisory"

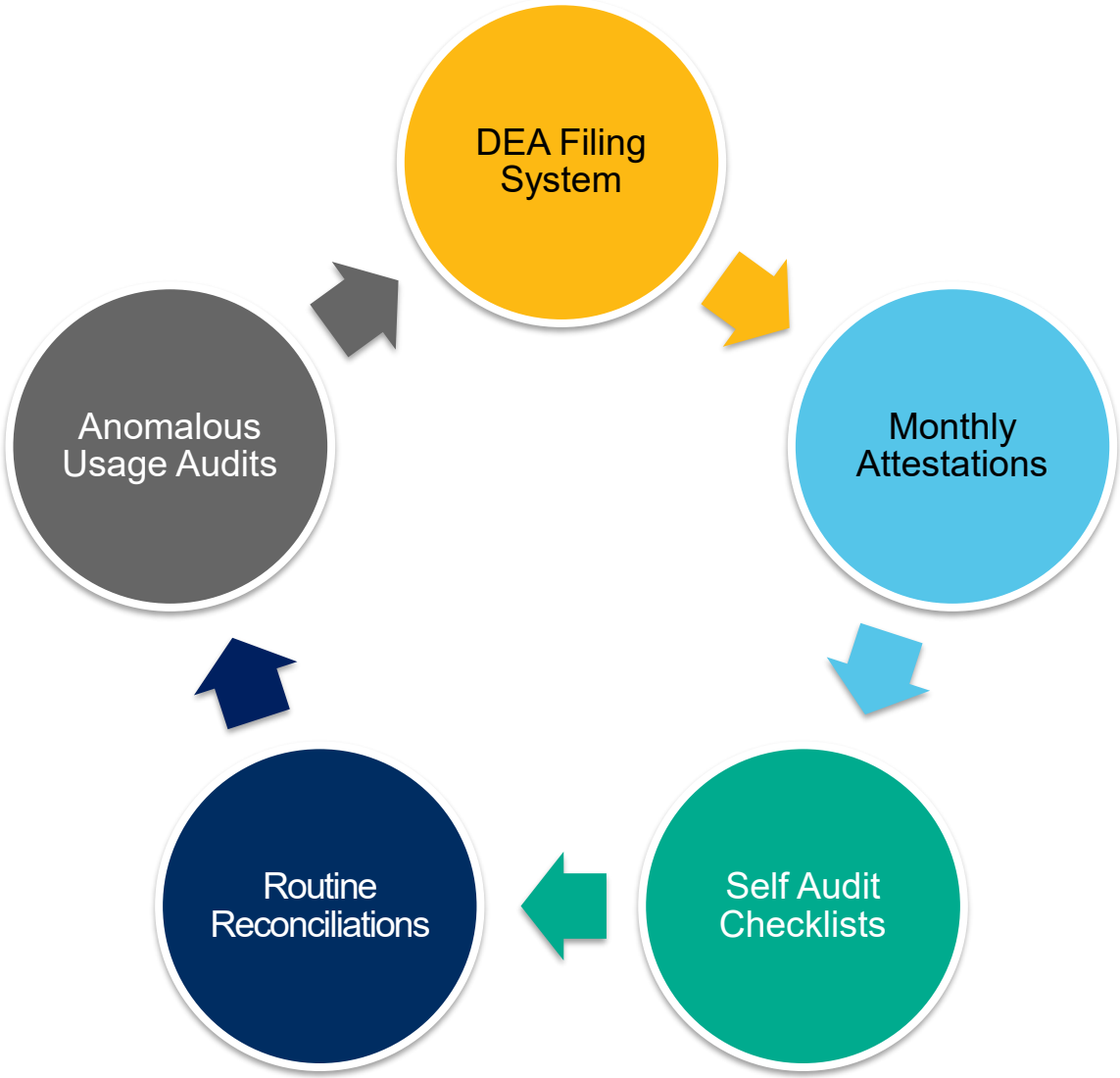
- No System Requirements

Regulation compliance focus (vs. prevention and detection controls)

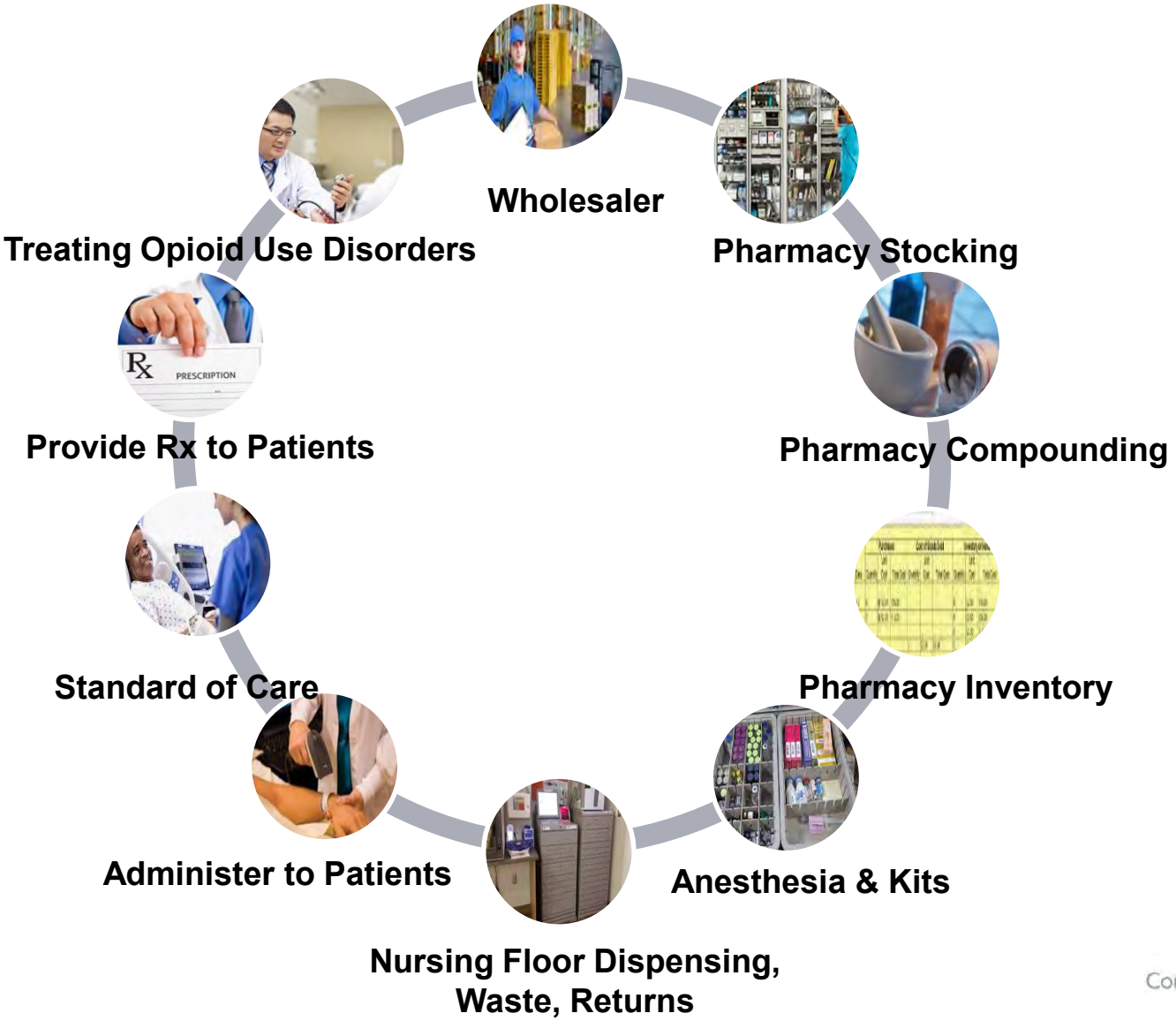
Relied on PIC license for effective controls

Impact Throughout System

DEA Agreement Required Control Highlights



Opioid Stewardship – Holistic Program



Pharmacy Diversion Controls

Fundamentals

- Reconcile orders to stockings
- Oversight of compounding waste
- Oversight of kit replenishment
- Reconcile transfers

Leading Practice

- Pharmacy CII-CV counted monthly
- Discrepancy in Pharmacy part of hospital wide discrepancy report
- Compounding recipe and waste in ADM
- All pharmacy ADM transactions are separated so all transactions reviewed

Future State

- Continuous reconciliations so any variance is immediately identified
- Using technology to match vendor purchases and reconcile all transactions through block chain technology

Opioid Continuous Accountability Audits / Reconciliation

- Quarterly Reconciliation of hospital opioid inventory accounting of drugs from wholesaler through distribution to identify variances

Opioid Continuous Accountability - Example

- Lead sheet example:

FACILITY A
CYCLE COUNT RECONCILIATION SUMMARY
BEGINNING CYCLE COUNT DATE: 20190101
ENDING CYCLE COUNT DATE: 201900101

Pharmacist-In-Charge: _____ Pharmacist-In-Charge Signature: _____ Date: _____

FACILITY	BEGINNING CYCLE COUNT DATE TIME	BEGINNING CYCLE COUNT QUANTITY	ADDITION		SUBTRACTION				ENDING CYCLE COUNT QUANTITY	ENDING CYCLE COUNT DATE TIME	ENDING CYCLE COUNT VARIANCE	TRANSACTION DETAILS PDF
			RESTOCK (S)	RETURN (U)	PICK (G)	EXPIRED (X)	WASTE (W-FI)	DISCREPANCY (D)				
Facility A	1/1/2019 07:00:01	12,905	7,880	293	11,379	239	1	6	9,453	2/1/2019 07:00:01	0	

Purchase and Stock Reconciliation

FACILITY	INVENTORY TRANSACTION RESTOCK (S)	PURCHASE PER MCKESSON REPORT	PURCHASE PER VENDOR B REPORT	PURCHASE PER VENDOR C REPORT	PCA / DRIP / EIPIDERAL ADJUSTMENT	PURCHASE AND STOCKING VARIANCE
Facility A	7,884	-7,740			-144	0

VARIANCE EXPLANATION (ENDING INVENTORY VARIANCE, PURCHASE AND STOCKING VARIANCE AND DISCRPENCY (D) TRANSACTIONS):

Item ID _____ Description _____

Reason

Nursing Diversion Controls

Fundamentals

- High user audits
- Discrepancy review (resolved and unresolved)

Leading Practices

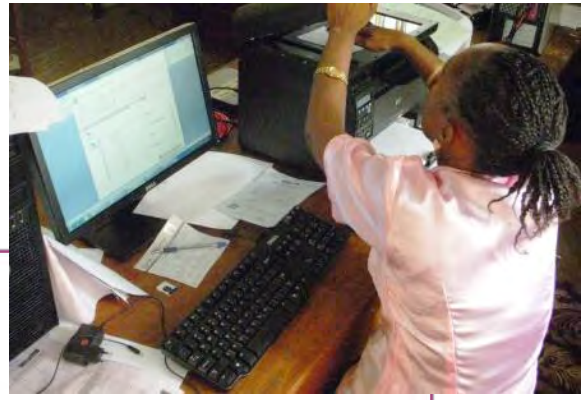
- Waste patterns by nurse
- Pain score analysis
- Track and trend documentation or discrepancy issues (honest error or not)

Future State

- Machine learning to identify diverters using nurse patterns, pain scores, etc.

Fundamentals

- Manual Anomalous Usage Audits / Chart Reviews
- Diversion Task Force



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Controlled Substance Anomalous Usage Audit
Time Period_____

Name of Employee_____ Name of Auditor:_____
Has employee been on report previously for same controlled substance? Y/N Date Completed:_____
Investigatory Meeting Required? Y/N
The auditor shall review a minimum of 10 controlled substance dispenses from the identified high user unless there is <10, then 100% of dispenses shall be reviewed.

Location of Controlled substance removal (nursing unit)	Name of Controlled Substance	Does admin follow parameters of order? (correct dose, frequency)	Is dose selected from Omnicel approp. for dose required	Date/ Time of narcotic removal from omnicell	Date/ Time narcotic docu-mented as given on MAR	Time nurse charted	Pre/Post Pain Score docu-mented	If waste, document waste dosage, date and time	Name of waste witness	Are there any other narcs taken or admin at the same time?	Comments

Standard of Care, Prescriptions & Opioid Use Disorders

Standard of Care

- Pain Committee
- Recovery Controlled Substance Protocols
- Checks for opioid naïve
- Clinical pharmacist involvement
- Sedation scales
- Multimodal Therapy

Prescriptions

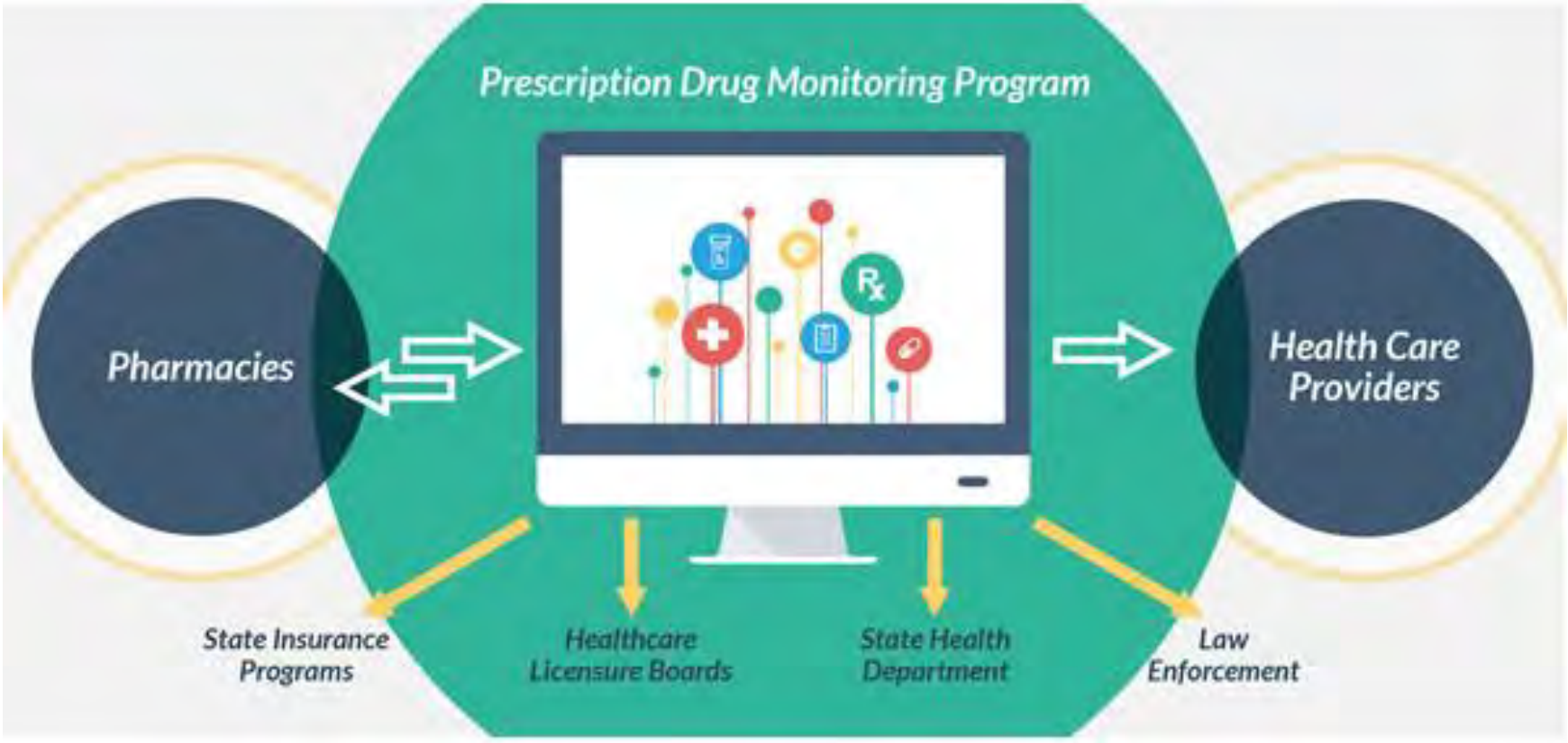
- Analyze Opioid Scripts
- Educate on destruction of controlled substances
- Educate on overdose risks especially if benzo/opioid comb
- Comply with BOP (review PDMP)

Opioid Use Disorders

- Medicated-Assisted Treatment
- Educate Patients on Opioid Use Disorders, destroying medications and Naloxone

Prescription Regulatory Environment

- 29 states have Prescription Drug Monitoring Programs



Prescription Regulatory Environment

23 states and D.C. require or recommend transactions, obtain continuing education related to prescribing CS, pain management, or substance abuse/misuse.

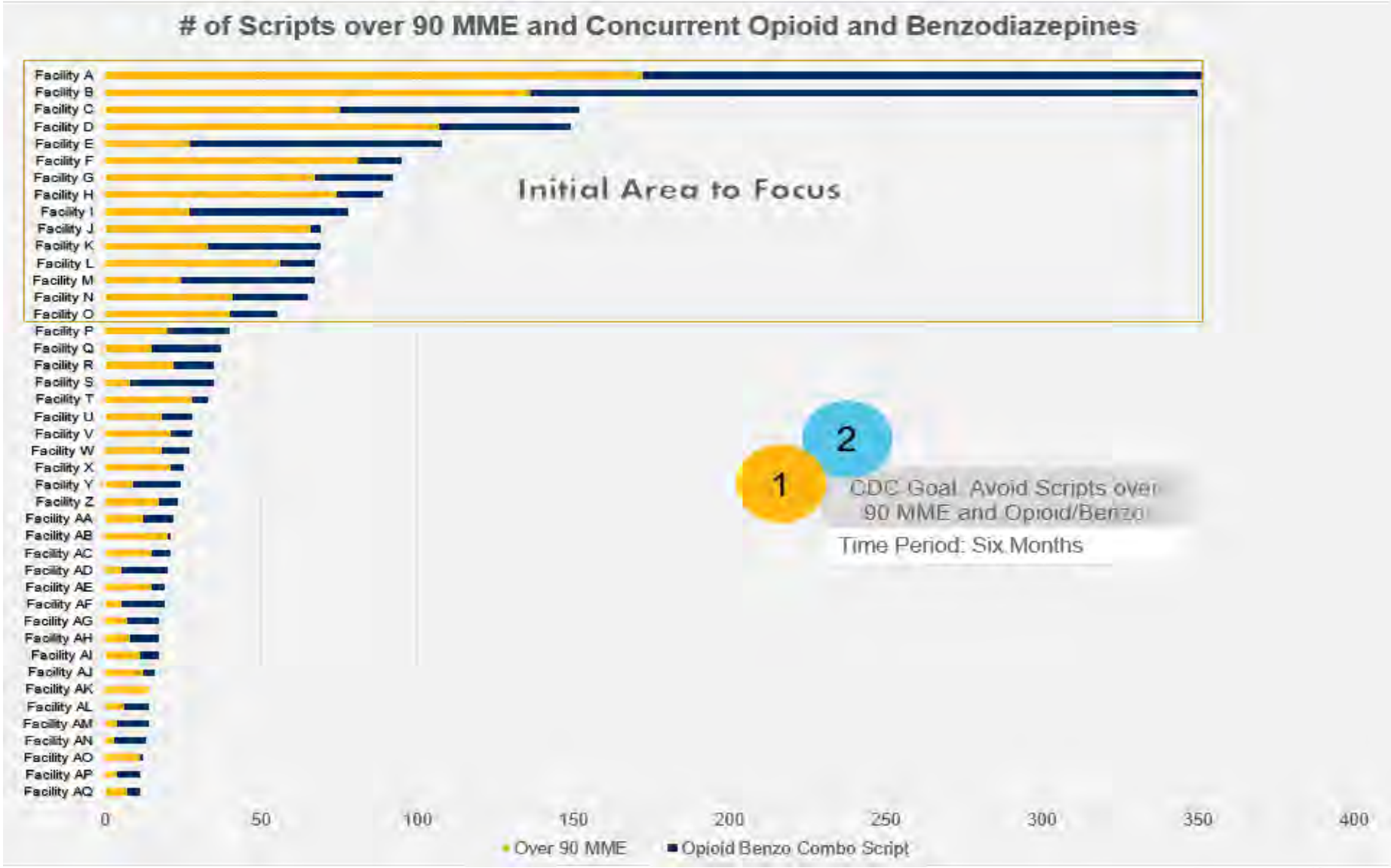
36 states require or command practitioners to have a treatment agreement.

32 require or recommend an informed consent or agreement for treatment document

10 states that limit days supply of Schedule II prescriptions

States obtaining access to DEA 80 million prescriptions

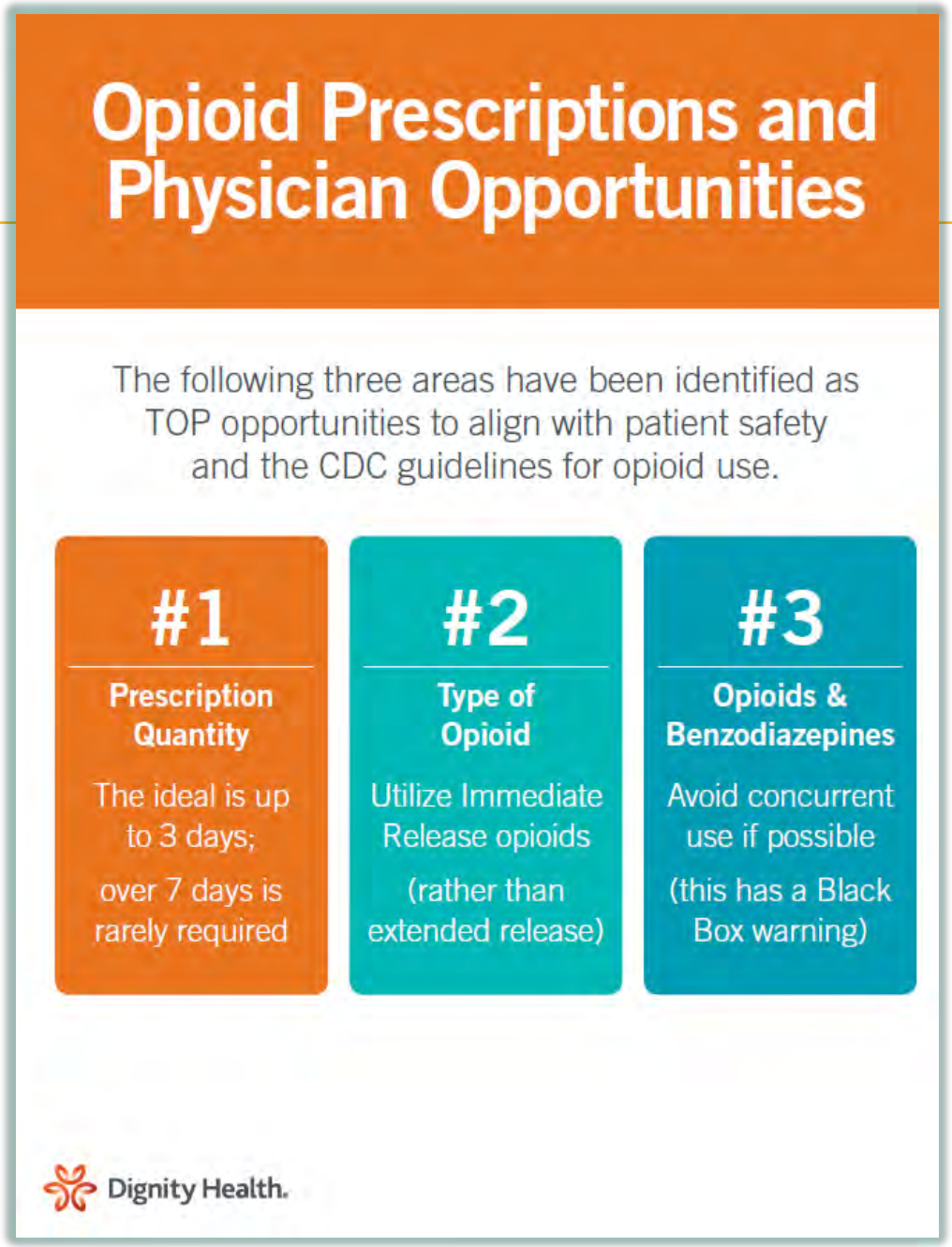
Future State – Data Analytics



- Move to candace

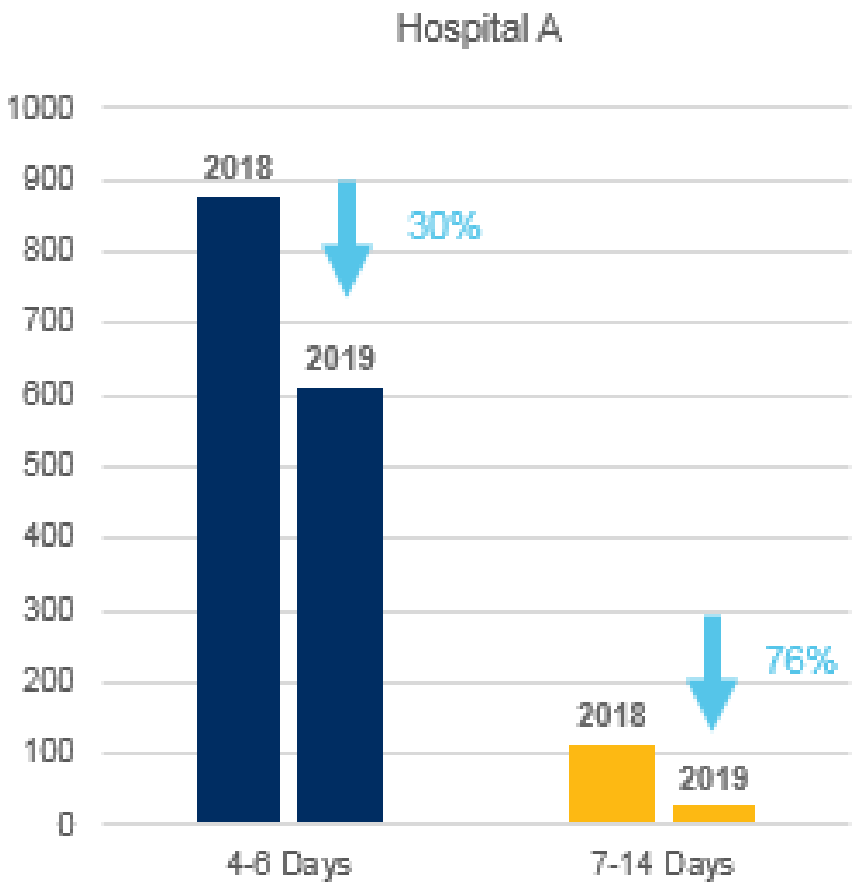
CDC Guidelines

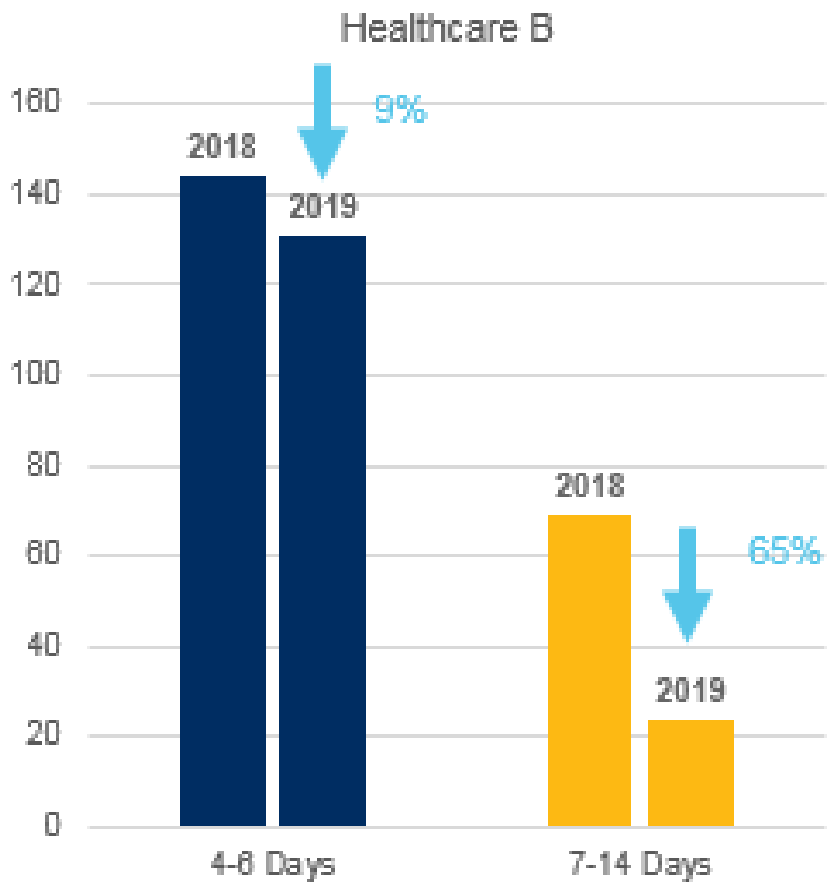
- ✓Prescribing practices reviewed with clinicians
- ✓CDC Guidelines reviewed
- ✓Re-assessment of results



Improvements Seen Through Data Analytics

February – July 2019





Beyond Prescriptions – Helping Opioid Use Disorder Patients

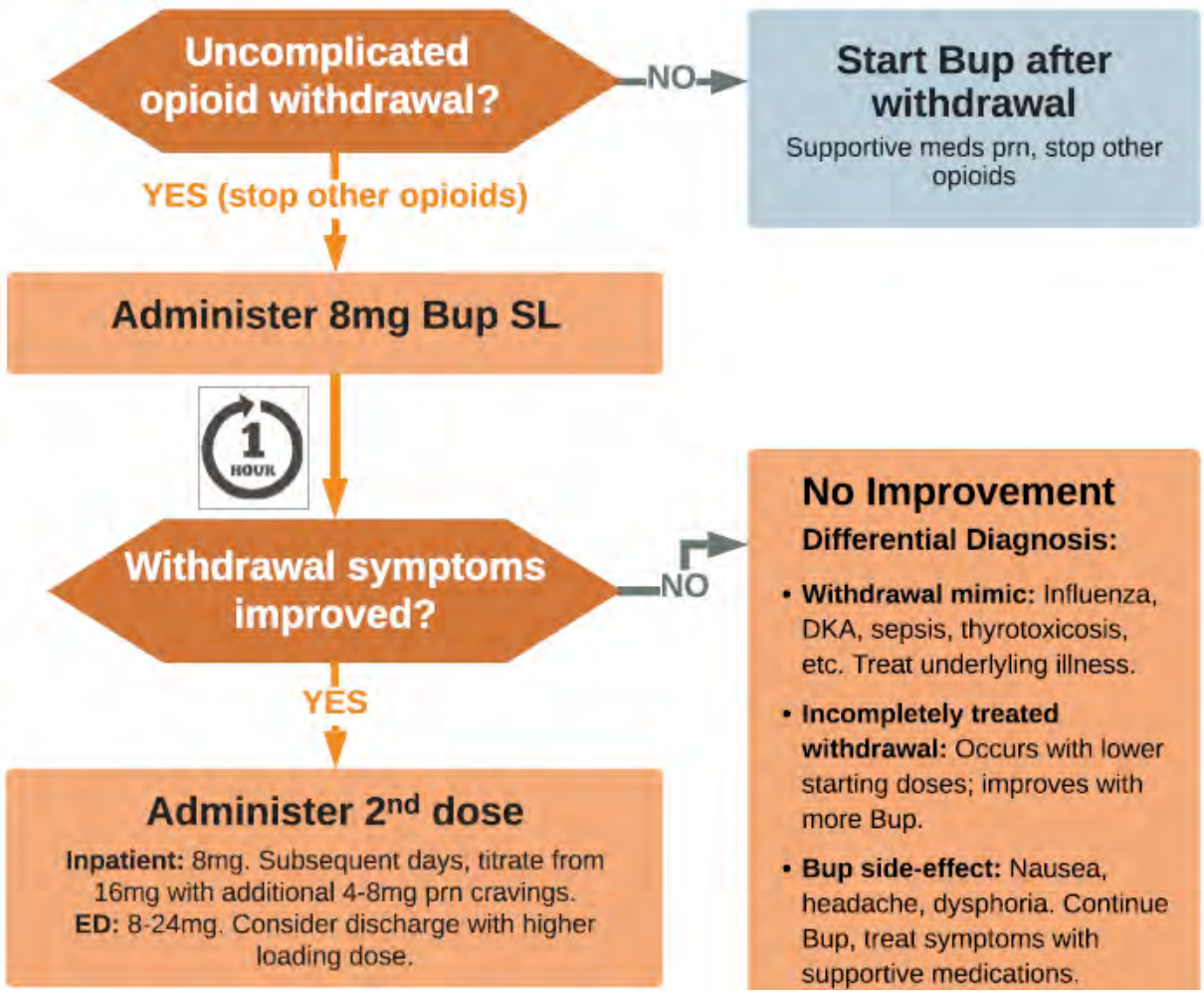
MAT

Medication-Assisted Treatment (MAT) includes counseling and behavior therapies to provide a "whole patient" approach

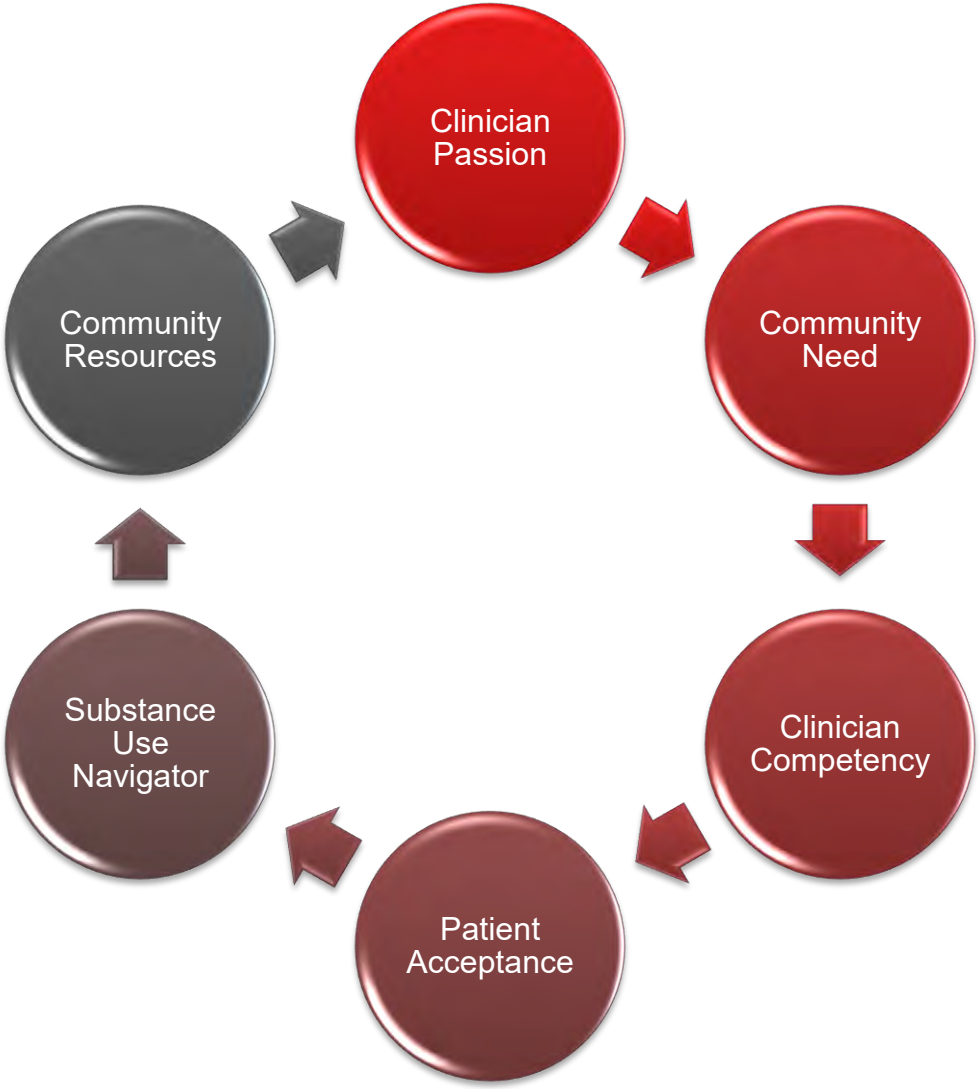
50% of MAT patients are drug free 18 months after treatment

(National Institute for Drug Abuse)

Treatment Algorithm (through Buprenorphine)



A Community Hospital Program– The Journey



Challenges, Successes, and Next Steps

Challenges

- Homeless Patients
- Saturation of Treatment Centers
- Free Naloxone Distribution in ED

Successes

- Over 50% referral
- Hope for Recovery
- X-Waiver = 7 ED physicians

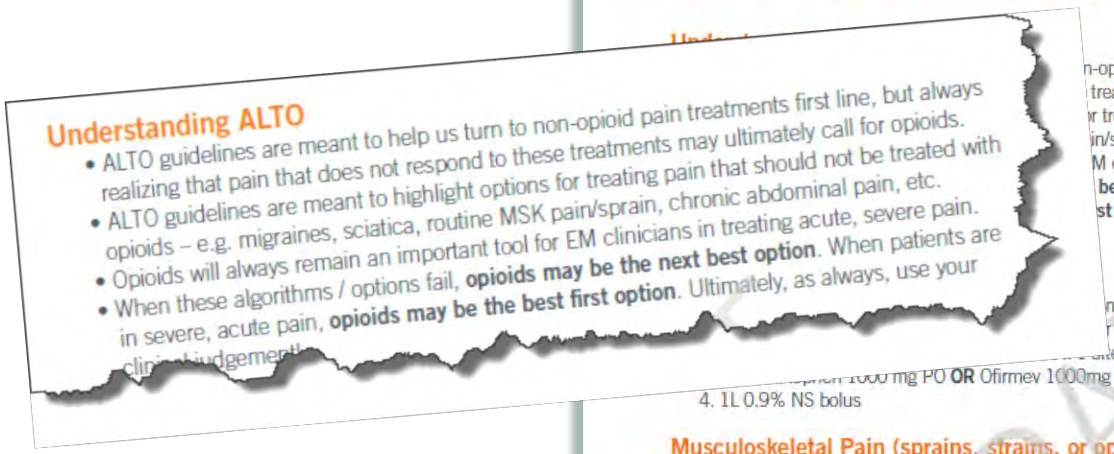
Next Steps

- Add Other Substance Abuse Treatment (alcohol, methamphetamine)
- Add Labor & Delivery
- Align with Other Grants for HIV, Hep C and Syphilis Treatment

Referral Success

May	June	July	August
Total SUN Encounters: 10	Total SUN Encounters: 34	Total SUN Encounters: 35	Total SUN Encounters: 24
Referrals: 4	Referrals: 17	Referrals: 18	Referrals: 13

Alternatives to Opioids



Understanding ALTO

- ALTO guidelines are meant to help us turn to non-opioid pain treatments first line, but always realizing that pain that does not respond to these treatments may ultimately call for opioids.
- ALTO guidelines are meant to highlight options for treating pain that should not be treated with opioids – e.g. migraines, sciatica, routine MSK pain/sprain, chronic abdominal pain, etc.
- Opioids will always remain an important tool for EM clinicians in treating acute, severe pain.
- When these algorithms / options fail, **opioids may be the next best option**. When patients are in severe, acute pain, **opioids may be the best first option**. Ultimately, as always, use your clinical judgement

Alternatives To Opioids (ALTO) Program

n-opioid pain treatments first line, but always
treatments may ultimately call for opioids.
r treating pain that should not be treated with
in/sprain, chronic abdominal pain, etc.
M clinicians in treating acute, severe pain.
be the next best option. When patients are
st option. Ultimately, as always, use your

mg IV
r 10 minutes (MAX 200 mg). Not for cardiac,liver,
ter 90 minutes.
4. 1L 0.9% NS bolus

Musculoskeletal Pain (sprains, strains, or opioid naïve LBP

1. Acetaminophen 1g PO **AND** Motrin 400-600 mg PO (analgesic ceiling) **OR** Ketorolac 30mg IM/15mg IV
2. +/- Single does Muscle Relaxant – choose one of the following:
   a. Flexeril 5 mg PO (patients >65 years old OR <70 kg OR concerns for somnolence)
   b. Flexeril 10 mg PO (patients >70 kg)
   c. Valium 5 mg PO
3. Lidocaine ointment TID **OR** Lidoderm 4% patch to most painful area, MAX 3 patches. Instruct patient to remove after 12 hours.
4. If neuropathic sounding pain: Gabapentin (neuropathic component of pain) 300-600mg PO x 1 in ED
5. If palpable muscle knot: Trigger Point Injection with 1-2 mL Marcaine 0.5% or Lidocaine 1% to anesthetize skin + dry needling using 25-27 gauge 1.5" needle at site of "trigger point."

Acute on Chronic Radicular low back pain (LBP) – *Opioid tolerant pt*

Start with above MSK algorithm. Then other options include:

1. Dexamethasone 10mg IV x 1
2. Ketamine 0.1-0.3 mg/kg in 50cc NS over 10 mins, or 0.3mg/kg IM, or 0.5mg/kg IN. Max dose 30mg, can repeat after one hour. Can do Ketamine 0.1 mg/kg/hr until pain is tolerable.

Modified for MSJ by Alicia Kurtz, MD – from guidelines by Alexis LaPietra, DO –nMedical Director of Emergency Medicine Pain Management @ St. Joseph's Regional Medical Center in Paterson, NJ

Dignity Health.

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Emergency Department Opioid Prescribing Guidelines

Dignity Health is committed to delivering compassionate, high-quality, and affordable health services to all individuals seeking care in our emergency departments. Recognizing the impact of the opioid epidemic, and in accordance with recommendations made by the Center for Disease Control (CDC) and the American College of Emergency Physicians (ACEP), we recommend the following guidelines to decrease the risk of addiction and overdose in the patients we serve.

These guidelines do not establish a standard of care, and each patient requires a unique treatment plan. They are intended to serve as a resource for emergency clinicians to standardize the use of opioids in the emergency department and to empower clinicians in the challenging encounters that involve the use and misuse of opioids.

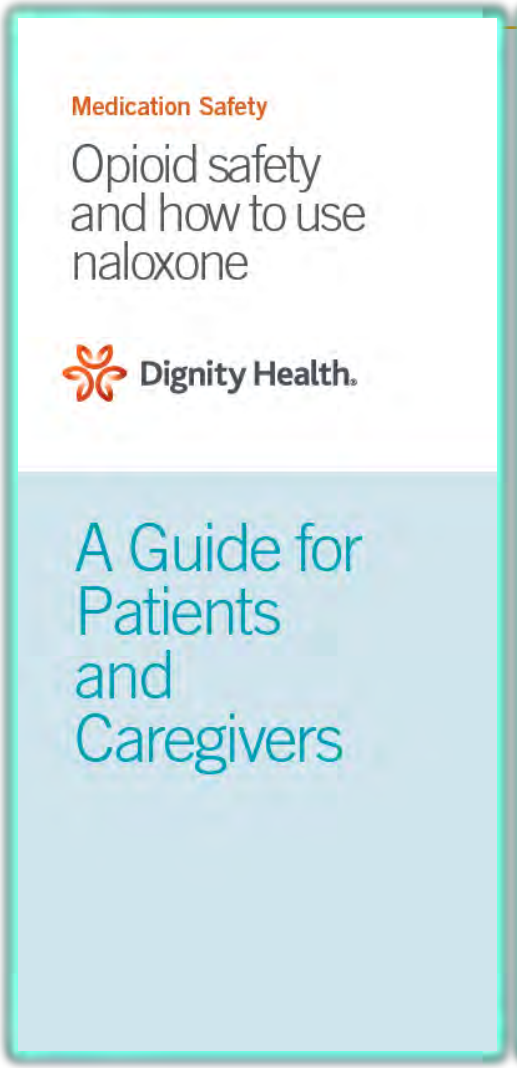
1. **One Provider:** Ideally, one medical provider should provide all opioids to treat a patient's chronic pain.
2. **Discouraged Practices:**
   - Administration of IV and IM opioids in the ED for the relief of acute exacerbations of chronic pain.
   - Replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
   - Replacement doses of methadone for patients in a methadone treatment program.
   - Prescribing long-acting or controlled-release opioids (eg., OxyContin, fentanyl patches, methadone).
   - Administration of Demerol (meperidine).
3. **PDMP:** ED providers should use the state's prescription drug monitoring program (PDMP) when appropriate.
4. **Coordination of Care:** EDs and ED providers should strive for coordination of care as follows:
   - Work together with pain clinic or clinician regarding pain agreements in place.
   - Coordinate the care of patients who frequently visit the ED using an ED care coordination program.
   - Maintain a list of clinics that provide primary care for patients of all payer types.
   - Perform screening, brief interventions, and treatment referrals for patients with suspected prescription opioid abuse problems.
   - For exacerbations of chronic pain, contact the patient's primary opioid prescriber or pharmacy, and only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.
5. **Substance Abuse Screening:** ED patients should be screened for risk factors for substance abuse prior to prescribing opioid medication for acute pain.
6. **Prescription Duration:** Prescriptions for opioid pain medication from the ED for breakthrough pain in acute injuries, such as fractured bones, in most cases should not exceed three days. Providers should counsel patients regarding the use of non-opioid medications (e.g., NSAIDs) as their first line pain medication.
7. **No Legal Requirement to Treat with Opioids:** The law does not require ED providers to use opioids to treat pain. ED providers should use their clinical judgment when treating pain. The provider should have an open conversation with the patient regarding the indication, or lack thereof, for using opioids for pain.

Dignity Health.

Content authors: Alicia Kurtz, MD; Gregg Miller, MD; Neil Parikh, MD; Rob Wyman, MD; Katie Hesse, RN; Candace Fong, PharmD

- www.acep.org/patient-care/clinical-policies/opioids/
- www.cdc.gov/mmwr/volumes/65/rr/rr6501e1er.htm

Patient Infographics



Thank You

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