Opioid Stewardship Series, Season 1, Episode 2:
Opioid Stewardship 101

Speaker 1 (00:02):

We're going to be going down a journey that comes from a very personal experience on my part. Um, if you are one of the two thirds of hospitals or organizations in the United States that don't have currently an opioid stewardship program, um, you are currently in the majority as, uh, I just, um, gave you the figures. It's challenging to start and it's an absolute essential. We're going to be talking about some very helpful tools and tricks that we've learned along the way at Mayo Clinic to help establish that program, make it functional, um, and individualize it to our patients. Um, I want to go over how does opioid stewardship impact overdose deaths? I want to go over what the concept of stewardship is anyway, and who needs to be engaged as you start forming your stewardship committee, your leadership council, and ultimately, is there a right way to execute opioid stewardship?

Speaker 1 (00:51):

I want to just jump in a bit to how we did it at Mayo Clinic, um, back in 2016. For those of you that are in Arizona, um, we were starting to see upward trends in deaths that were, uh, uh, overtaking the state to the point that the state mounted a very aggressive response between 2016 and 2018, including emergency orders and legislation. We did not have an opioid stewardship program, and we thought we were doing a good job internally, but study after study was showing that we were way over over-prescribing opioids, especially in our surgical populations. We began by assembling a group, um, that we thought represented the key stakeholders in this discussion. Some of the key ones I would highlight is administrative support, um, government relations, or legal if they're in that position. And of course, any of the physicians that will be prescribing these, um, from divisions, departments such as surgery, internal medicine, hospital medicine, um, and nursing staff.

Speaker 1 (01:51):

Um, all of which were, were key to helping really understand what was coming down from state and what are best practices. Um, we knew that we needed to disseminate all of the workflows, protocols, and information that we were going to be developing down to the practice. And so, our opioid team essentially was structured with this administrative and physician partnership, along with, um, other fields into this opioid response team where we created department liaisons in each and every division and department across Mayo Clinic in Arizona. These are individuals that have stepped up to the plate and decided that they would speak on behalf of their areas to disseminate information. They work directly with division or department chairs, and, um, they help monitor prescribing. They create the individualized requirements for the divisions. We give them a number of roles at the beginning. And, uh, like I mentioned, um, there's an initial training course that they go through.

Speaker 1 (02:46):

Ours was about three hours where we talk about the epidemic, the basic prescribing requirements as expected, uh, within Mayo Clinic, which we'll go over, and how we'll be in communication with them as a leadership team when state law changes or other information comes out that we want to pass on. Um, so at the beginning, everyone should be reviewing the opioid stewardship website, and this is where we've housed all of our educational material. Um, it's got patient workflows, for when we do prescribe, when we don't prescribe acute and chronic settings. It's got most of our refill recommendations and Narcan prescribing. It's got physician education, um, and it's got many other resources that might be useful. Um, we host a division and department meeting to go over Mayo Clinic policies as they were being rolled out to make sure that everyone knew across our, uh, campus that things were about to change.

Speaker 1 (03:39):

And then we reviewed current, uh, division department prescribing metrics, um, just to make sure that every area knew what was coming down and where areas for targetable improvements could be made. We also made recommendations for reduction goals for some of these areas. What we really needed to develop was the material, and this was a process of evolution for Mayo. I can assure you much of it was developed at an enterprise level. We had to take into account other state laws to do that. And then of course, we built on the CDC guidelines that were released, uh, 2016 for chronic prescribing. When we're looking for opioid misuse, um, a lot of our policies revolve around the ability to identify it and treat it appropriately. And I want to make it clear of what isn't misuse. Tolerance and withdrawal are expected side effects of the drug.

Speaker 1 (04:26):

So tolerance, meaning you need higher and higher doses to maintain the same degree of pain relief or honestly, to get the same high as previously experienced and withdrawal when you stop the drug. How bad do symptoms of resurgence start? And, new symptoms occur as well. These are signs of dependence in the setting of appropriate opioid use. You will see these signs over time. If you're seeing it in someone using these drugs illicitly or inappropriately, they can be counted towards DSM-5 criteria as opioid use disorder. Things you're going to want to work, uh, watch for in your practice. If someone's changing the dose, the route or the treatment interval warning signs, you know, if it's, I took an extra pill early because it really, really hurt day two after surgery, that's very different than someone taking your, uh, Oxycontin and turning it from an oral route to IV.

Speaker 1 (05:16):

So of course, individualize all of these, um, personal use for indications other than prescribed big warning sign. They should be taking it as per the bottle for the indication. If they are providing the medication to other parties. This is diversion. This is illegal. This is a reason to automatically discontinue prescribing. If you believe that's opioid use disorder, please refer them. But this is not something you wanna get dragged into from a legal standpoint. Accessing similar controlled substances from multiple sources, you'll probably pick this up on a PDMP search warning sign, um, doctor shopping. Um, if you have a patient provider contract where you've limited what they can get and from whom they can get it, it, and now they're using different sources to acquire their opioids or other controlled substances that might be a reason to really have a hard conversation about where to go with this hostile or aggressive behavior.

Speaker 1 (06:08):

This really has no rule in the provider-patient relationship, and oftentimes it's, uh, seen in the setting of uncontrolled opioid use disorder. So, keep that as a red flag and requesting specific drugs, especially if they're more powerful than what you're offering. Red flag, um, risk factors. Many of you have probably heard these, but younger ages, 18 to 45, the higher the dose, the more likely they were of likely to have built this up over time in terms of tolerance. And the longer you're on these, the more likely you are to become addicted. Um, the biggest two risk factors, mental health disorders, and this includes depression and anxiety, as well as prior substance use disorders, including alcoholism and even tobacco. If they've got chronic pain, their lifestyle circumstances aren't great. They've got family history of substance use disorders. If they're not willing to participate in other forms of therapy, meaning you've got 'em on opioids, you want to engage in stewardship.

Speaker 1 (07:02):

You say, you know what, we're going to tack on physical therapy and Tylenols for line therapy, and they say no, um, red flags. And then any lack of normal lifestyle functioning if they're under a bridge or sleeping in their car. Um, you, you've got to set up for disaster here. Misuse may represent addiction, and as we mentioned. This is

being replaced by opioid use disorder. You're going to see opioid use disorder manifested in almost every aspect of that individual's life. Biological, psychological, social, and spiritual manifestations are a part of the disorder, and they become much more prominent over time as the disorder proceeds. So, this is why we look at this from a biopsychosocial standpoint when it comes to treatment. So how do you prescribe for patients with opioid use disorder once you've diagnosed it? Um, we had to develop protocols for this, and it's a bit of a challenge.

Speaker 1 (07:50):

We know that the laws for buprenorphine prescribing, or MAT (medication assisted treatment), have changed even this year to allow for anyone with a prescriber, DEA prescriber's license, to be able to do so once they get waivered. There's no formal training required. We diagnose opioid use disorder using DSM-5. If it's suspected, please feel free to refer your patient to treatment programs or an addiction medicine or addiction psychiatry area. The goal is to establish all patients that you have diagnosed with opioid use disorder on MAT. In our, uh, provider world, it's typically buprenorphine, suboxone, which is a combination drug with Naltrexone. We recommend that, you, you take a patient that you suspect, and make sure that they get quick referrals and or some type of bridging therapy to get them to treatment.

Speaker 1 (08:43):

Quick referrals can include making sure that they have enough of their own opioid supply to get them to treatment. If you don't have that DEA X-waiver license, or alternatively, prescribing buprenorphine for a couple of days, if you have that, um, uh, we are recommending everybody consider getting that DEA X-waiver certification and that can be found on the SAMHSA website. Again, if you're seeing obvious diversion, please do not prescribe. Get them straight into rehab. I want to go over some acute prescribing recommendations. And this is something that's been built off state laws in the state of Arizona, CDC guidelines, and best practices based on other articles. For every patient that's being prescribed opioids, even for acute pain, you're want to, you're going to want to complete a history and physical examination, make sure you know what therapies they've already trialed, because lower indices therapies, meaning non-opioids, may work just as well in many cases.

Speaker 1 (09:35):

As to those in the opioid class, we recommend using some type of a screening tool. The opioid risk tool has many helpful, I should say, uh, elements to it. Keep in mind, it has not been validated in the acute prescribing setting. So, when you come up with a number for that, you're not going to know what to do with it <laugh>. But the elements, the high-risk components are going to be there. So, consider integrating that into the screening process. We recommend having a risk benefit discussion or at least providing the patient a handout on opioids, when they're being prescribed. Please always, always review that PDMP. Make sure there's not doctor shopping or they're not on concomitant medications that put them at high risk for overdose. We put a three-day limit for most medical illnesses, and our internal data does support that.

Speaker 1 (10:24):

That's, um, really the, the most, um, that people use these for. Acute illnesses, we've got a seven-day limit for more severe things like surgery or very high pain expectations. We want to limit the entire prescription to 200 morphine milligram equivalents. Always, always reassess your patient before refilling. Use your EMR to do this if you can. And we've put these prescribing limitations as hard stops without better explanations into the EMR. It also gives recommended doses and lengths for the prescription. Patient counseling--Every patient should be counseled on these, uh, uh, basics. What we've learned out of the opioid crisis, especially moving from the early two thousands where pain is the first vital sign and the goal is to eradicate it, um, that is not necessarily a realistic goal, especially in the setting of chronic pain. What you want your patients to understand is that they should be functional with pain.

Speaker 1 (11:17):

Can they get to the restroom? Can they cook dinner? Can they perform basic activities and can they have some degree of quality of life while on pain medications? So, this requires patient and staff education to really nail in as they change in mindset. Build it into institutional expectations. Other counseling elements that we've included: Make sure patients are not changing the dose throughout or the frequency. All of these can lead to fatal overdoses. Give instructions on how to handle a missed dose if it's not taken PRN. Early on, there's a lot of recommendations coming out from surgical societies to say, take it around the clock. We've really moved away from that, although some surgeons still do it. Opioids in general should put, should be PRN unless they're the twice daily long-acting versions. And then recommend stop taking the opioids.

Speaker 1 (12:09):

When symptoms are controlled, they do not need to finish the bottle. Diverting medications is illegal. This can lead to death. Please, pass that on. Get the drugs out of the house when done, when the bottle's completed, dispose of it. And there's some recommendations on this screen. All the patients really need to know what's illegal diversion, what'll kill 'em, changing it, um, how to dispose the leftovers. And then of course, the side effects. Naloxone, so this is gonna be offered to your higher-risk patients. Those are individuals within baseline cardiopulmonary conditions. So COPD, congestive heart failure, or if they process the medications inappropriately. So, chronic liver disease or kidney dysfunction, anyone with a history of an overdose should automatically be prescribed naloxone before you even give them the prescription for the opioid. We use 50 morphine milligram equivalents a day as our cutoff for when someone should also be given a naloxone prescription.

Speaker 1 (13:07):

Educate everyone that's in that room. And if you can access those that aren't, that's wonderful. This is friends and family because the patient's not the one who's going to be self-administering most of the time. In many states, including Arizona, you do not need a prescription. You can go to a pharmacy and it can be dispensed by that pharmacist. Keep in mind that it only lasts about 30 to 90 minutes, and that's for your prescribed medications. If they've switched over to fentanyl or illicit substances off the street, it's gonna last shorter and you're going to need higher doses to get it in. So, be sure you educate that into them. The safe administration opioids, uh, we're, we're gonna talk about these very briefly. Many of you work in hospital settings and there's been a lot of talk here about how we administer opioids appropriately.

Speaker 1 (13:55):

You're going to want to screen all of these patients when they come in PDMP. Those that are receiving opioids should be individuals with moderate to severe pain, not low, indices pain, make it multimodal. We're always going to want other medications on the charts such as Tylenol, um, non-pharmacologic treatments, um, uh, NSAIDs, if they can take them. If you can't find a cause for their pain and they've been appropriately worked up, no opioids, um, you're going to want to treat resourcefully. So, use the lowest dose possible for short duration. Think very short courses and only use oral opioids if they're capable of taking opioids. Unless there's specific indications such as being NPO or malabsorption problems. Get them back to baseline if they're on chronic opioids to the whatever dose they were on before they came to the hospital. Don't leave them on higher doses when they leave.

Speaker 1 (14:48):

If you can, um, make sure that you're always keeping side effects in the back of your mind, such as having bowel regimens ready to go, and having the naloxone on the chart for emergency reversal if needed. Use subspecialists if

necessary. So, if you don't know how to treat appropriately, if they have high oral morphine equivalents, or if they came in on MAT, make sure that you've got the right subspecialists engaged to help you with this. Make sure that you're limiting co-administration of other drugs that could lead to overdosing, such as benzodiazepines or other central nervous system depressants. Try not to refill if you're a hospitalist or an internal provider within the inpatient setting. And then just briefly here on metrics, some of the big ones that we will be incorporating for sure is increasing the PDMP utilization prior to opioid prescribing, making sure that naloxone prescription is on the chart for patients on high morphine milligram equivalents, and then reducing benzodiazepine in opioid co-prescribing. I have created a series of podcasts. They will be featured soon on the American Hospital Association website. This is starting an opioid stewardship program 101, and it has a tremendous amount of detail that really talks you through how stem the tide through AHA, can be a great resource if you're starting from scratch.

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