PRISMA HEALTH SM

Opioid Symposium: Guidelines, Weaning, and Stewardship

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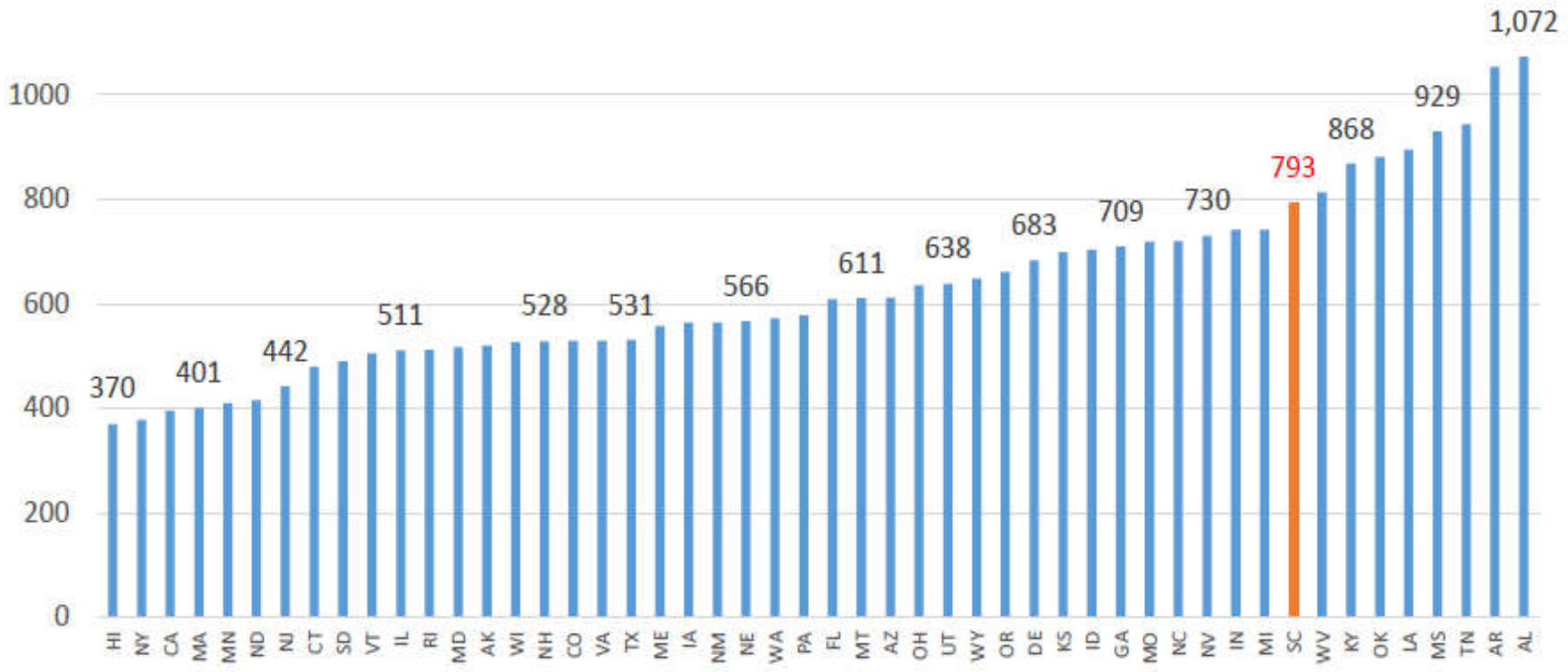
Disclosure

- Advisory board-Heron Therapeutics

Objectives

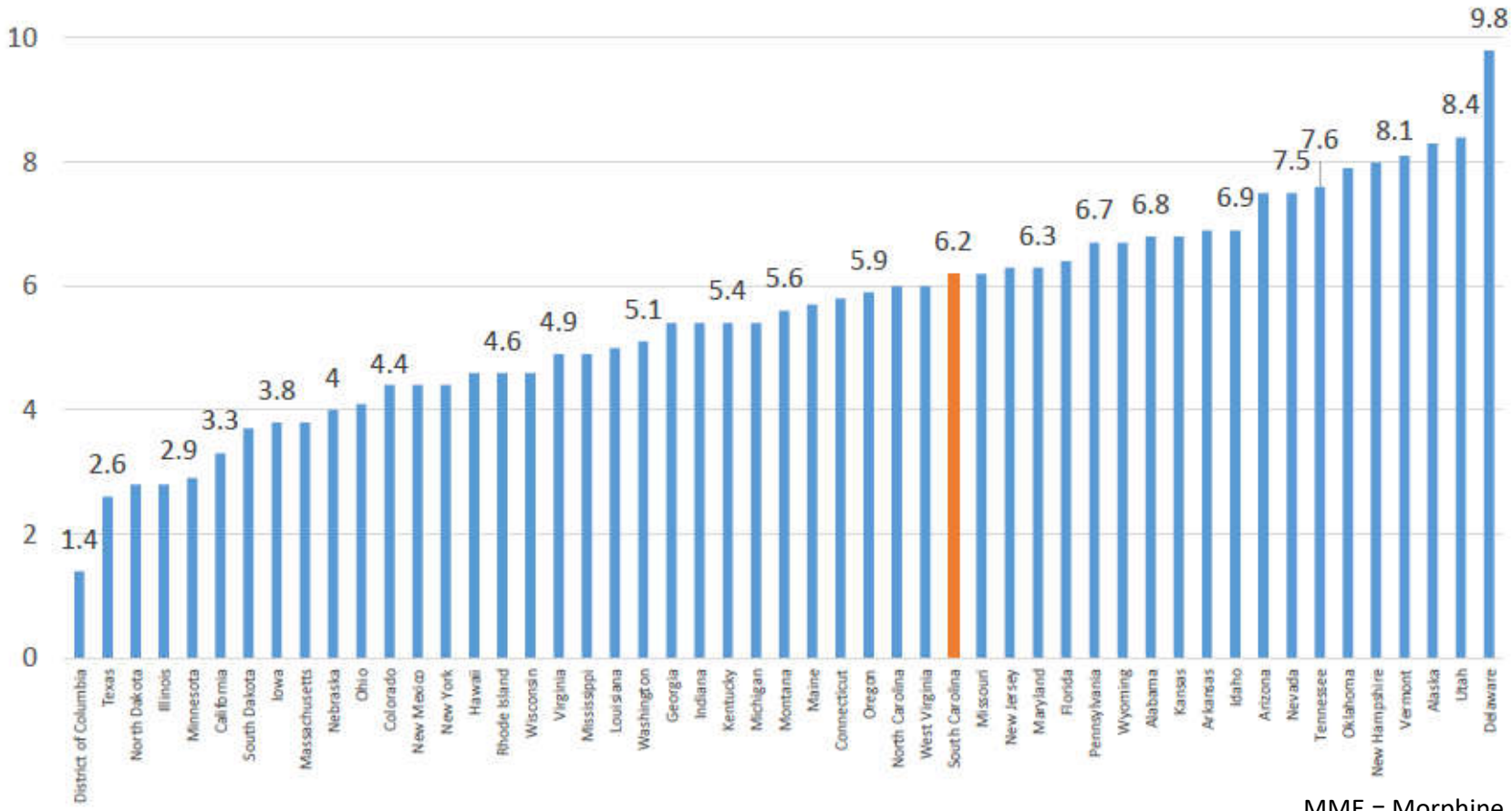
- Review CDC guidelines. Understand the why?
- Legacy patients.
- Opioid weaning: who, when and why?
- Opioid Stewardship

Why are we talking about this?



South Carolina Rank: 9th

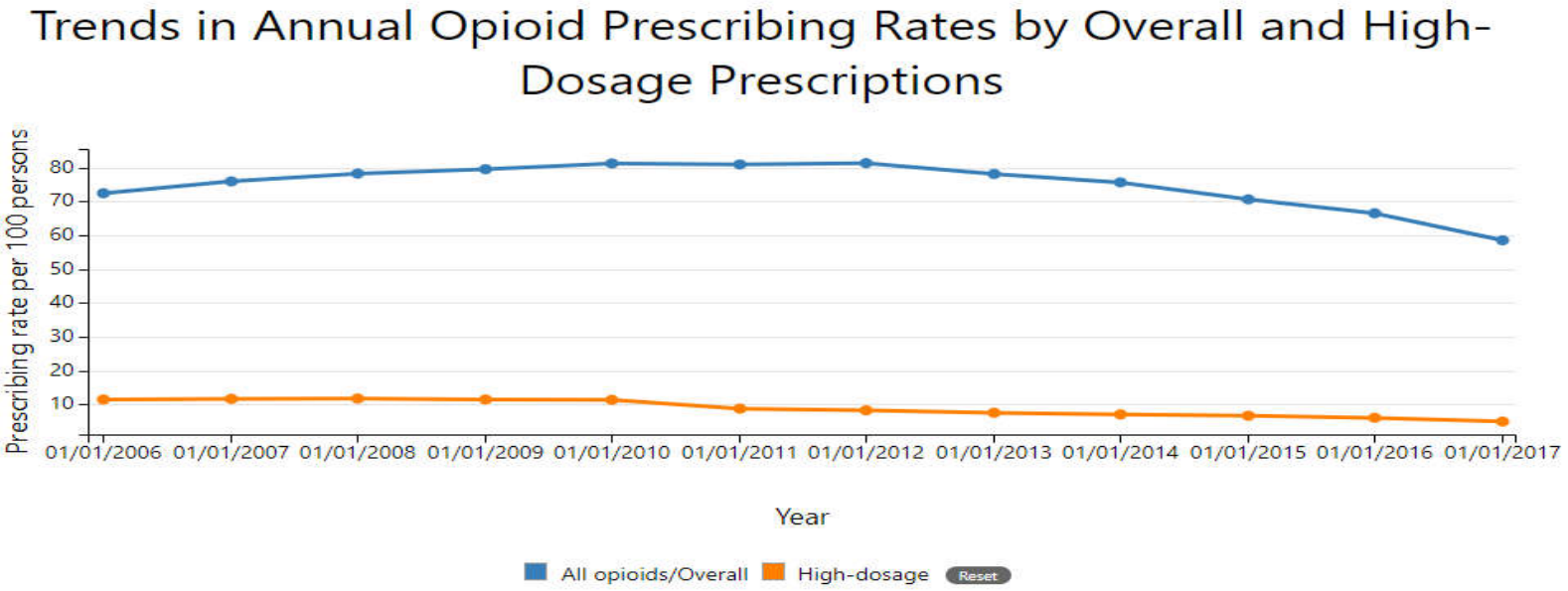
Opioid RXs (≥ 90 MME) Dispensed per 100 Persons



South Carolina
Rank: 20th

MME = Morphine Milligram Equivalents

Decrease in prescribing



Source: IQVIA® Transactional Data Warehouse

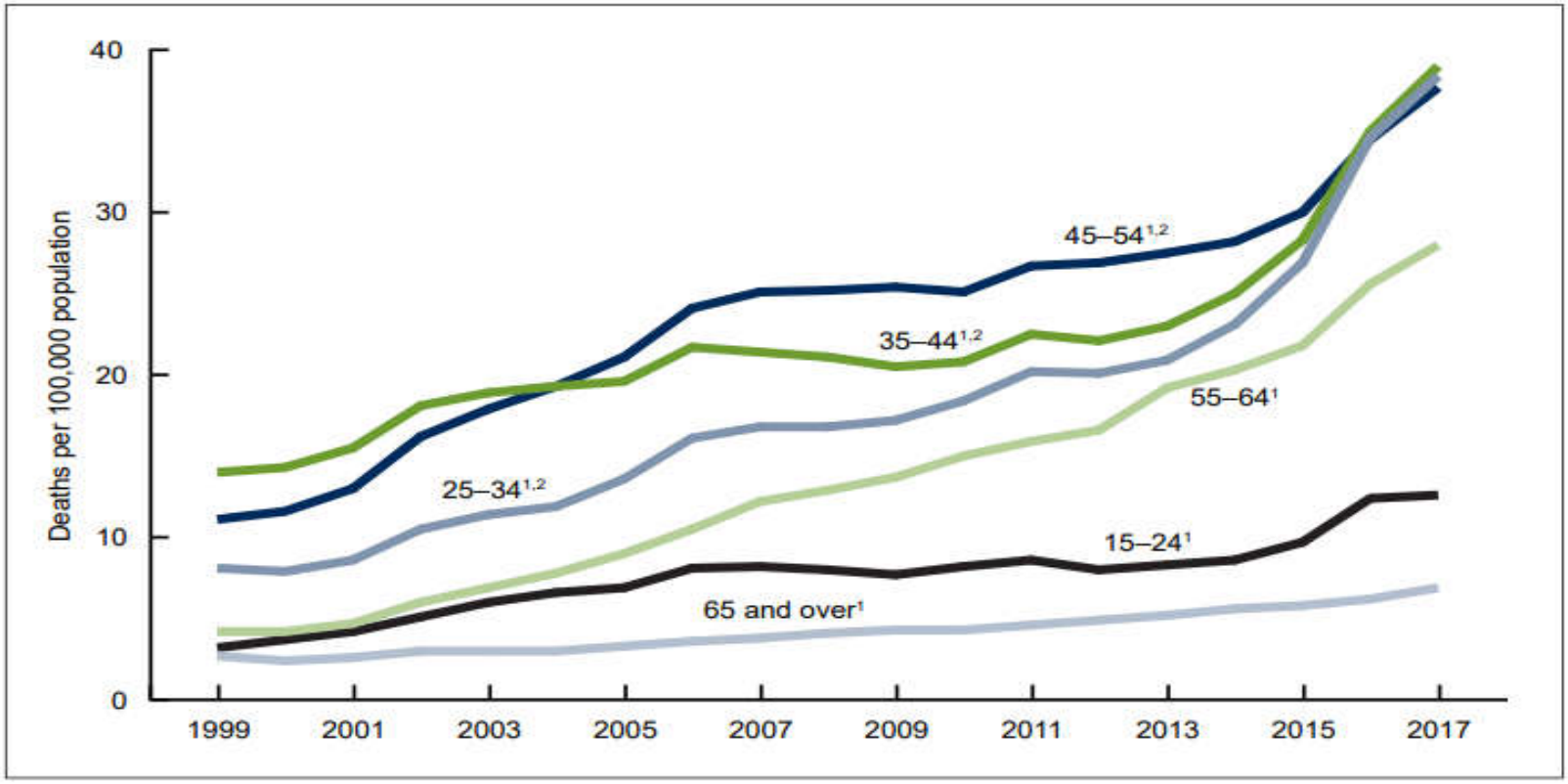
Data Table

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
All opioids/Overall	72.4	75.9	78.2	79.5	81.2	80.9	81.3	78.1	75.6	70.6	66.5	58.5
High-dosage	11.5	11.7	11.8	11.5	11.4	8.8	8.3	7.6	7.1	6.7	6.1	5

https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html

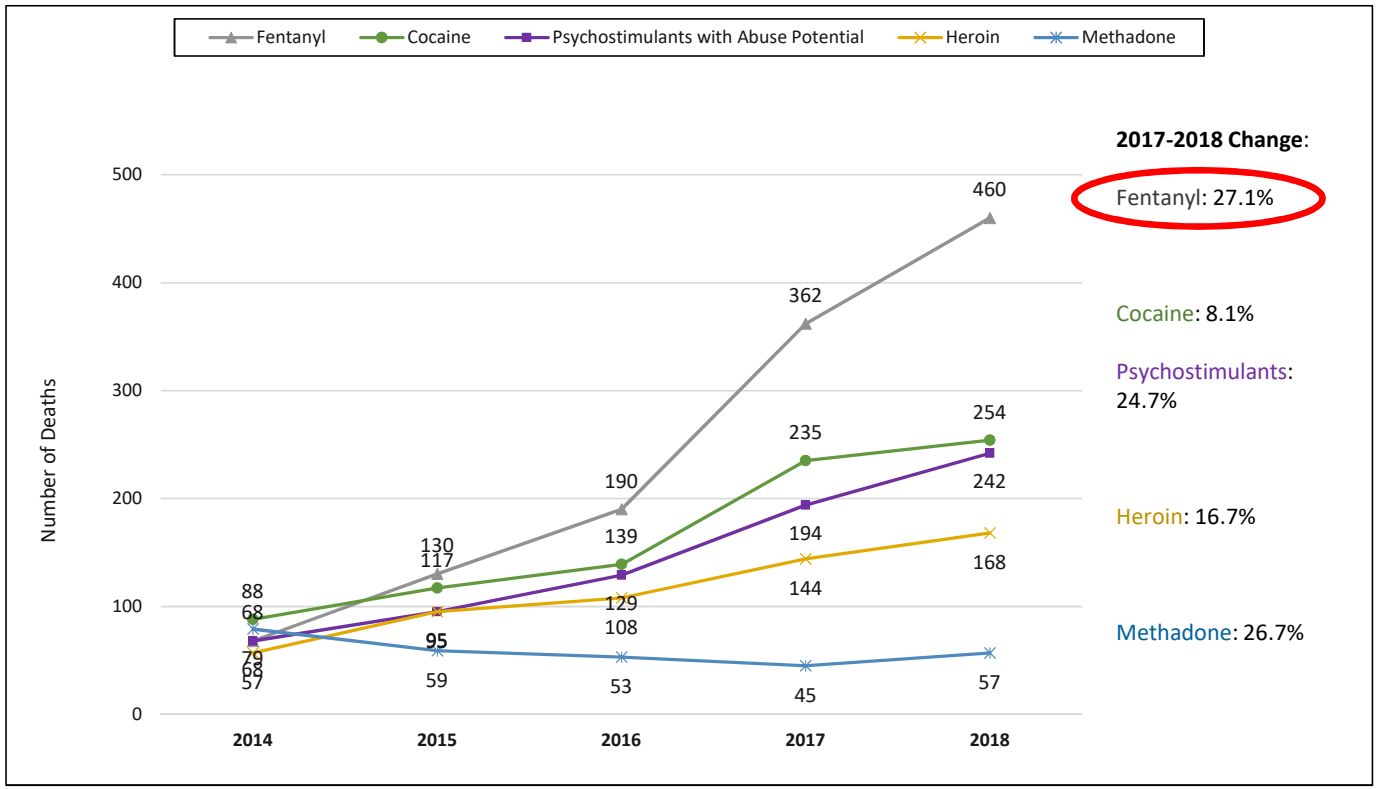
Overdoses rise

Figure 2. Drug overdose death rates, by selected age group: United States, 1999–2017

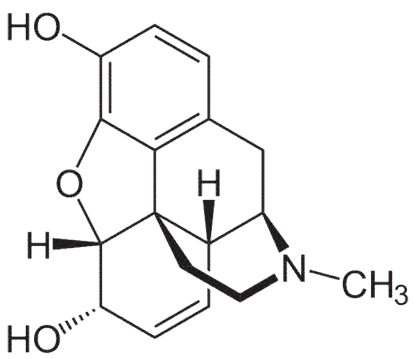


https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf

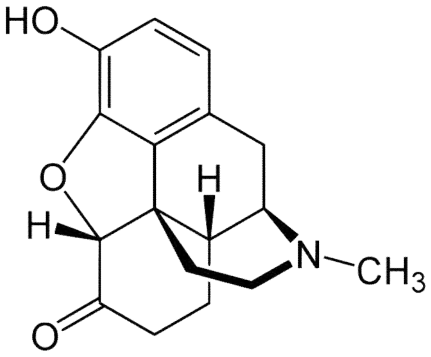
Drug Overdose Deaths by Selected Drug Category, 2014-2018



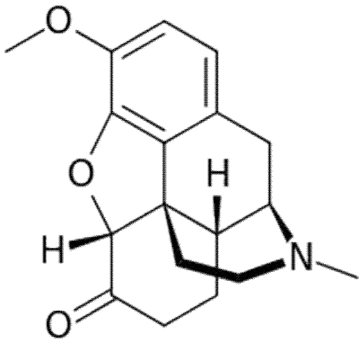
Opioids



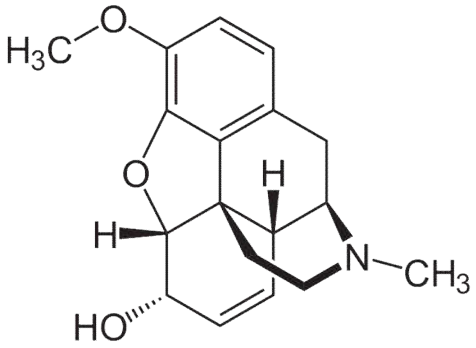
morphine



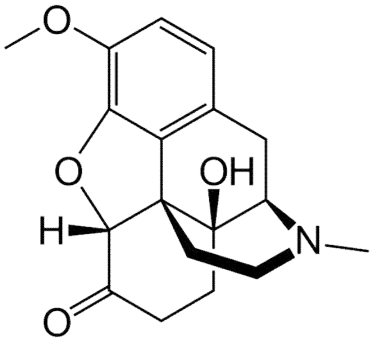
hydrocodone



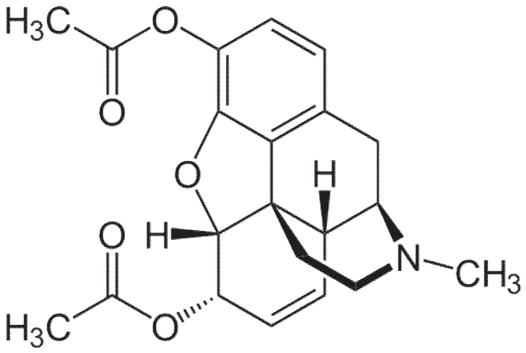
hydromorphone



codeine



oxycodone



heroin

CDC gu

- Prescrib
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BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic 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 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.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

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 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.

Assessing Risk and Addressing Harms of Opioid Use

8. 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.
9. 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.
10. 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.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. 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.

*All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

Dowell D, Haegerich

;315(15):1624–1645.

CDC Recommendation

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA. 2016;315(15):1624–1645.

- **Determining When to Initiate or Continue Opioids for Chronic pain**
  1. Nonpharmacologic/Nonopioid therapies
     - PT, weight loss, ψ therapy, interventional therapy
  2. Establish Treatment goals
     - "Quality of Life", functional goals
     - "Realistic"
  3. Discuss known risk of opioid therapy
     - No good evidence opioids improve function, focus on function, respiratory depression, physical/chemical dependence

CDC Recommendation

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- Opioid Selection, Dosage, Duration, Follow-up and Discontinuation
  4. Use immediate release opioids
     - Increased risk of overdose
     - ER/LA not more effective
  5. Lowest effective dosage
     - Self explanatory
  6. No greater quantity then needed*
     - S 918
     - Diversion (3-7 days)

Dangerous Trends

CDC Recommendation

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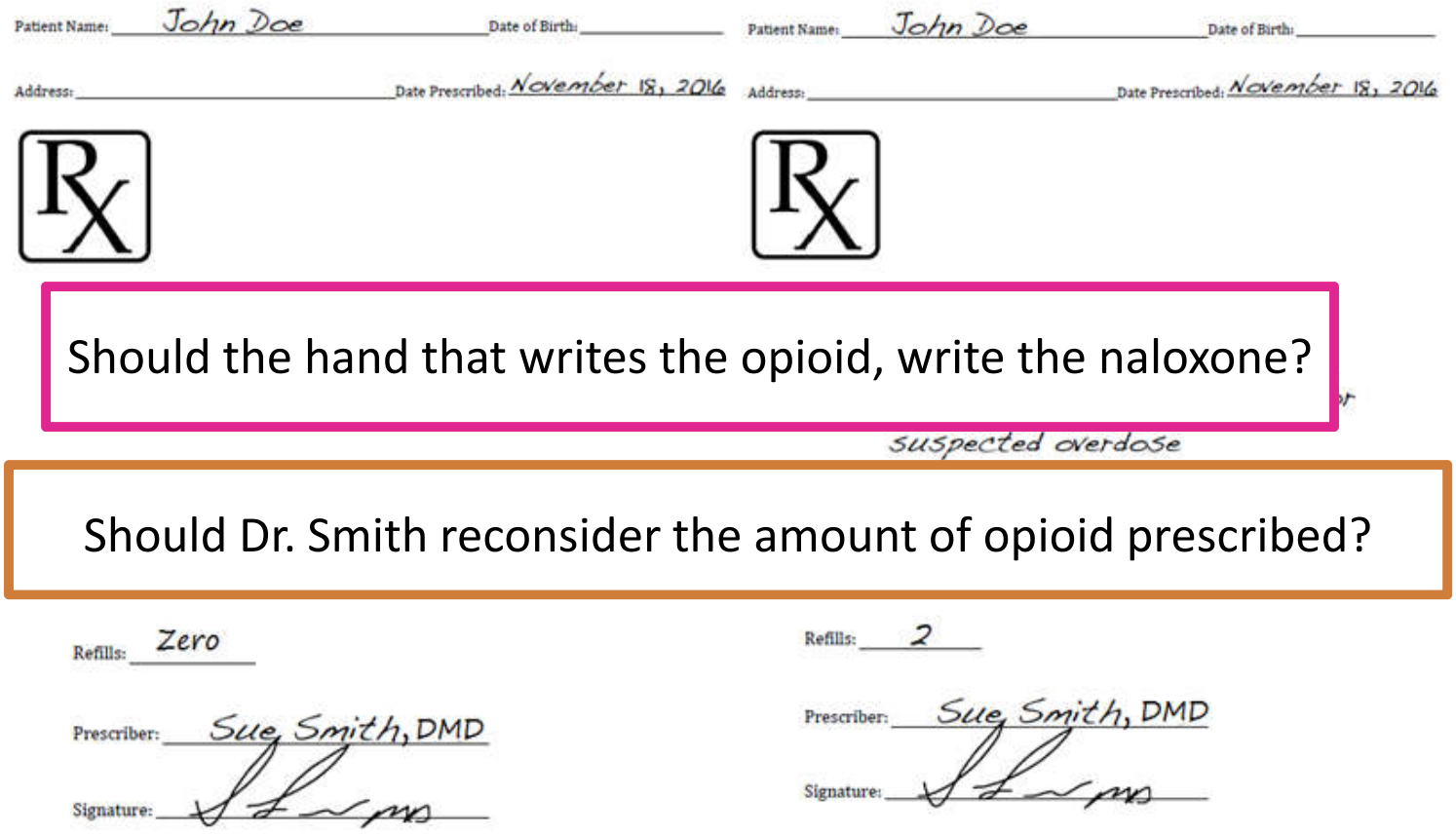
- Opioid Selection, Dosage, Duration, Follow-up and Discontinuation
  4. Use immediate release opioids
     4. Increased risk of overdose
     5. ER/LA not more effective
  5. Lowest effective dosage
     - Self explanatory
  6. No greater quantity then needed*
     - S 918
     - Diversion (3-7 days)
     - *= discharge plan not quantity
  7. Re-evaluation (benefits versus harm)
     - >3 months of opioid therapy increased risk of OUD
     - Tapering/weaning will talk later…

CDC Recommendation

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA. 2016;315(15):1624–1645.

- Assessing Risk and Addressing harms of Opioid Use
  8. Risk Stratification
     - Medical comorbidities (OSA, CRI)
     - Pregnancy
     - Monitor for other substances, ETOH, benzos
     - Ψ and SUD

Thoughts on this Picture?



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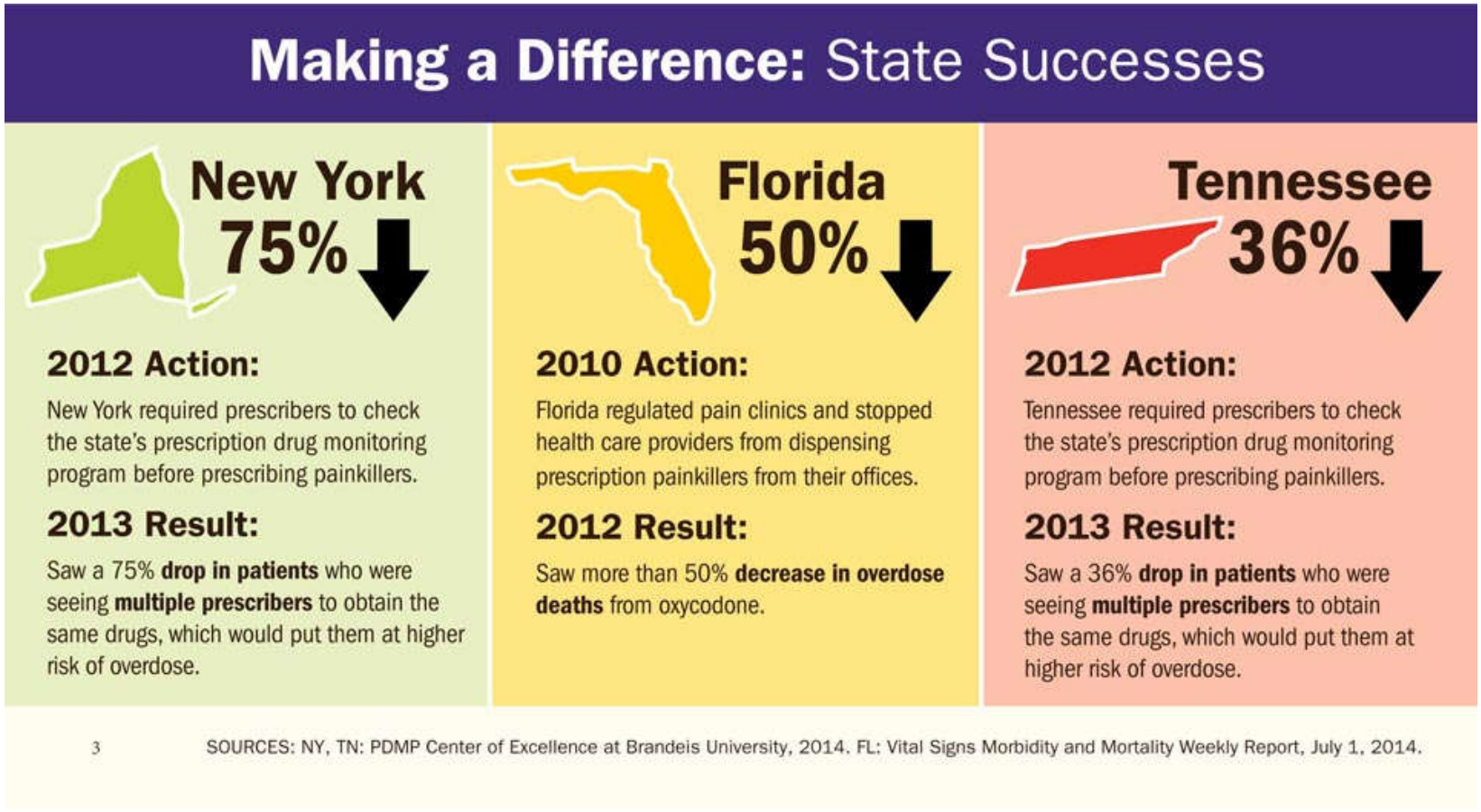
- Assessing Risk and Addressing harms of Opioid Use
  8. Risk Stratification
  9. Review PDMP
     - SCRIPTS
     - CII-CV drugs

Prescription Drug Monitoring Program

- Prescription data available to prescribers and pharmacists
- Early studies showed lower Schedule II prescribing rates in PDMP states
- Recent studies found no significant difference in opioid prescribing and no reduction of overdose mortality in PDMP states
- **Key question: How do practitioners use PDMP and integrate the information into their prescribing ?**

JAMA. 2015;313:891-892.

PDMP Successes



Summary

Summary		Narcotics* (excluding buprenorphine)		Sedatives*		Buprenorphine*	
Total Prescriptions:	24	Current Qty:	100	Current Qty:	0	Current Qty:	0
Total Prescribers:	1	Current MME/day:	40.00	Current LME/day:	0.00	Current mg/day:	0.00
Total Pharmacies:	1	30 Day Avg MME/day:	40.00	30 Day Avg LME/day:	0.00	30 Day Avg mg/day:	0.00

Rx Data

PRESCRIPTIONS

Total Prescriptions: 24
Total Private Pay: 0

Fill Date	ID	Written	Drug	Qty	Days	Prescriber	Rx #	Pharmacy	Refill	Daily Dose *	Pymt Type	PMP
01/08/2020	2	01/06/2020	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
12/09/2019	2	11/12/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
11/09/2019	2	09/24/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
10/08/2019	2	09/24/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
09/08/2019	1	07/30/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
08/09/2019	1	07/30/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
07/09/2019	1	06/04/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
06/09/2019	1	06/04/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
05/10/2019	1	03/26/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
04/10/2019	1	03/26/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
03/11/2019	1	01/29/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
02/09/2019	1	01/29/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
01/10/2019	1	11/20/2018	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC
12/10/2018	1	11/20/2018	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Comm Ins	SC

Fill Date	ID	Written	Drug	Qty	Days	Prescriber	Rx #	Pharmacy	Refill	Daily Dose *	Pymt Type	PMP
01/10/2020	2	01/10/2020	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	0	12.00 LME	Medicaid	SC
12/16/2019	2	12/16/2019	Lorcet Hd 10-325 MG Tablet	120.00	30			Pow (5749)	0	40.00 MME	Private Pay	SC
12/11/2019	2	10/10/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	2	12.00 LME	Medicaid	SC
11/09/2019	2	08/29/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (3015)	0	40.00 MME	Private Pay	SC
11/09/2019	2	10/10/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	1	12.00 LME	Medicaid	SC
10/10/2019	2	10/10/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (2772)	0	40.00 MME	Medicaid	SC
10/10/2019	2	10/10/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	0	12.00 LME	Medicaid	SC
10/03/2019	2	10/03/2019	Hydrocodone-Acetamin 7.5-325	28.00	7			Sou (2772)	0	30.00 MME	Private Pay	SC
10/03/2019	2	10/03/2019	Alprazolam 2 MG Tablet	21.00	7			Sou (2772)	0	12.00 LME	Private Pay	SC
08/30/2019	2	08/30/2019	Hydrocodone-Acetamin 10-325 MG	120.00	30			Sou (2772)	0	40.00 MME	Medicaid	SC
08/29/2019	2	08/29/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	0	12.00 LME	Medicaid	SC
08/10/2019	2	04/24/2019	Clonazepam 1 MG Tablet	60.00	30			Sou (2772)	2	4.00 LME	Private Pay	SC
07/24/2019	2	04/24/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	2	12.00 LME	Medicaid	SC
07/10/2019	2	04/24/2019	Clonazepam 1 MG Tablet	60.00	30			Sou (2772)	1	4.00 LME	Private Pay	SC
06/30/2019	2	04/24/2019	Oxycodone Hcl 5 MG Tablet	60.00	30			Wal (5092)	0	15.00 MME	Comm Ins	SC
06/30/2019	2	04/24/2019	Dextroamp-Amphetamin 20 MG Tab	60.00	30			Wal (5092)	0		Comm Ins	SC
06/27/2019	2	04/24/2019	Hydrocodone-Acetamin 10-325 MG	110.00	28			Sou (2772)	0	39.29 MME	Medicaid	SC
06/23/2019	2	04/24/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	1	12.00 LME	Medicaid	SC
06/11/2019	2	04/24/2019	Clonazepam 1 MG Tablet	60.00	30			Sou (2772)	0	4.00 LME	Private Pay	SC
05/31/2019	2	03/21/2019	Oxycodone Hcl 5 MG Tablet	60.00	30			Sou (2772)	0	15.00 MME	Medicaid	SC
05/31/2019	2	03/21/2019	Hydrocodone-Acetamin 10-325 MG	110.00	30			Sou (2772)	0	36.67 MME	Medicaid	SC
05/24/2019	2	03/21/2019	Dextroamp-Amphetamin 30 MG Tab	40.00	20			Sou (2772)	0		Medicaid	SC
05/24/2019	2	04/24/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	0	12.00 LME	Medicaid	SC
04/29/2019	2	03/21/2019	Hydrocodone-Acetamin 10-325 MG	110.00	30			Sou (2772)	0	36.67 MME	Medicaid	SC
04/29/2019	2	03/21/2019	Oxycodone Hcl 5 MG Tablet	60.00	30			Sou (2772)	0	15.00 MME	Private Pay	SC
04/24/2019	2	04/24/2019	Dextroamp-Amphetamin 20 MG Tab	60.00	30			Sou (2772)	0		Medicaid	SC
04/23/2019	2	01/28/2019	Clonazepam 1 MG Tablet	60.00	30			Sou (2772)	2	4.00 LME	Private Pay	SC
04/23/2019	2	01/28/2019	Alprazolam 2 MG Tablet	90.00	30			Sou (2772)	2	12.00 LME	Medicaid	SC

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- Assessing Risk and Addressing harms of Opioid Use
  8. Risk Stratification
  9. Review PDMP
  10. Urine Drug Screening
      - Monitoring

CDC Rec

Dowell D, Haegerich TM, Cho

5(15):1624–1645.

- Assessing

Use

8. Risk S
9. Revie
10. Urine
11. Avoic

oids

CDC Recommendation

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- Assessing Risk and Addressing harms of Opioid Use
  8. Risk Stratification
  9. Review PDMP
  10. Urine Drug Screening
  11. Avoid concurrent Benzodiazepines and Opioids
  12. Medication Assisted Treatment
      - Good data to show improved life expectancy.
      - Real deal!

Need for Opioids

"Opiophobia"

"No pain left behind"

Responsible Opioid Pharmacotherapy

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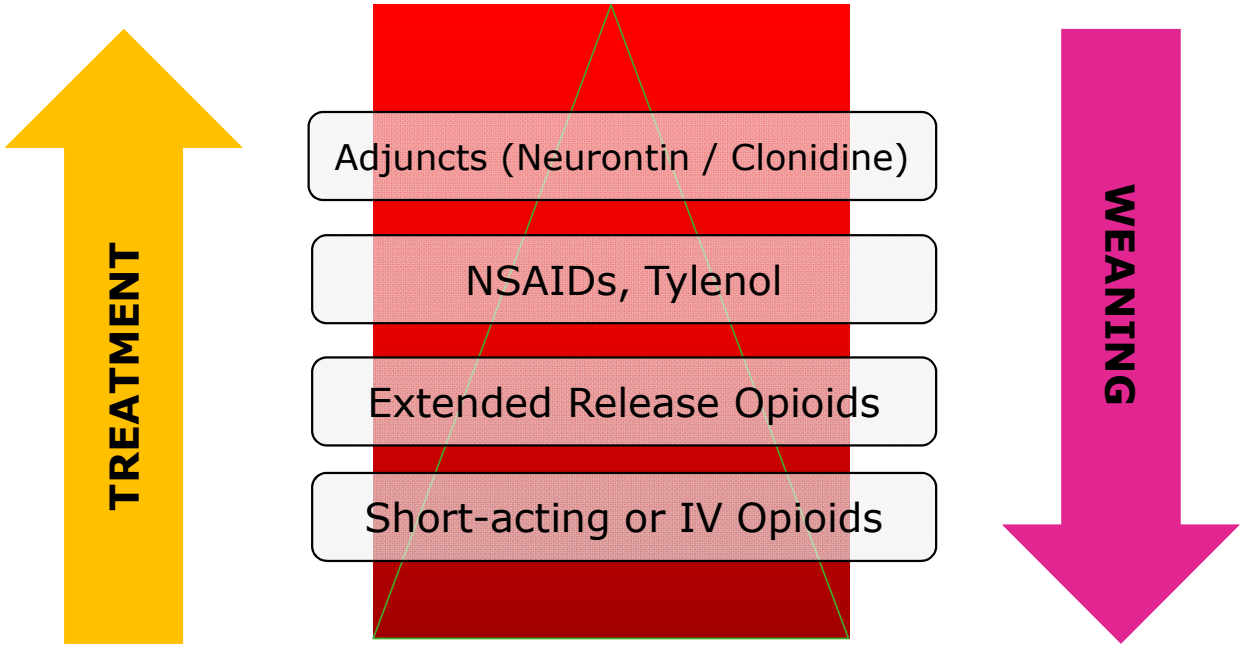
Legacy Patients

Legacy Patient

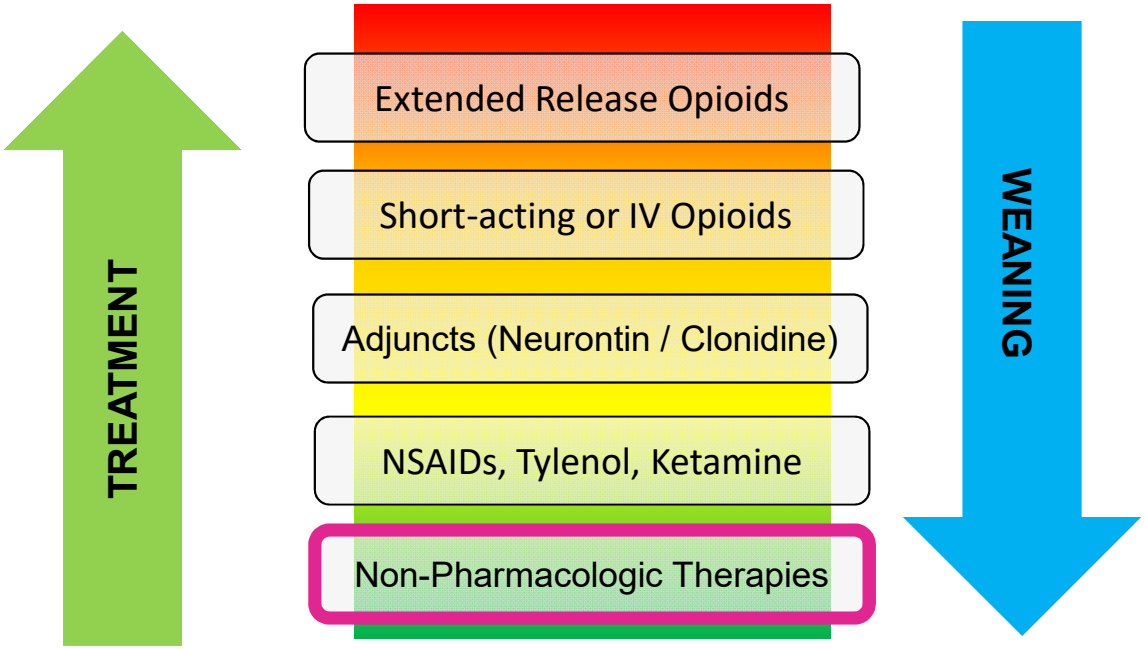
Legacy Patient

- Outpatients
- Inpatients

Culture Change – Old Practice



Culture Change – Future Practice



Patient Education

- Get an accurate medication history
- Set realistic pain expectations for patient
- Focus on ADLs with acceptable pain levels
- Educating patients and families
  - Why certain medications may be more beneficial for the type of pain experienced (NSAIDs)
  - Utilize non-pharmacological therapies first-line
  - Explain risks and safe use of opioids
  - Safe storage and disposal of opioids

Legacy Patient

- Outpatient

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 65

March 15, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

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

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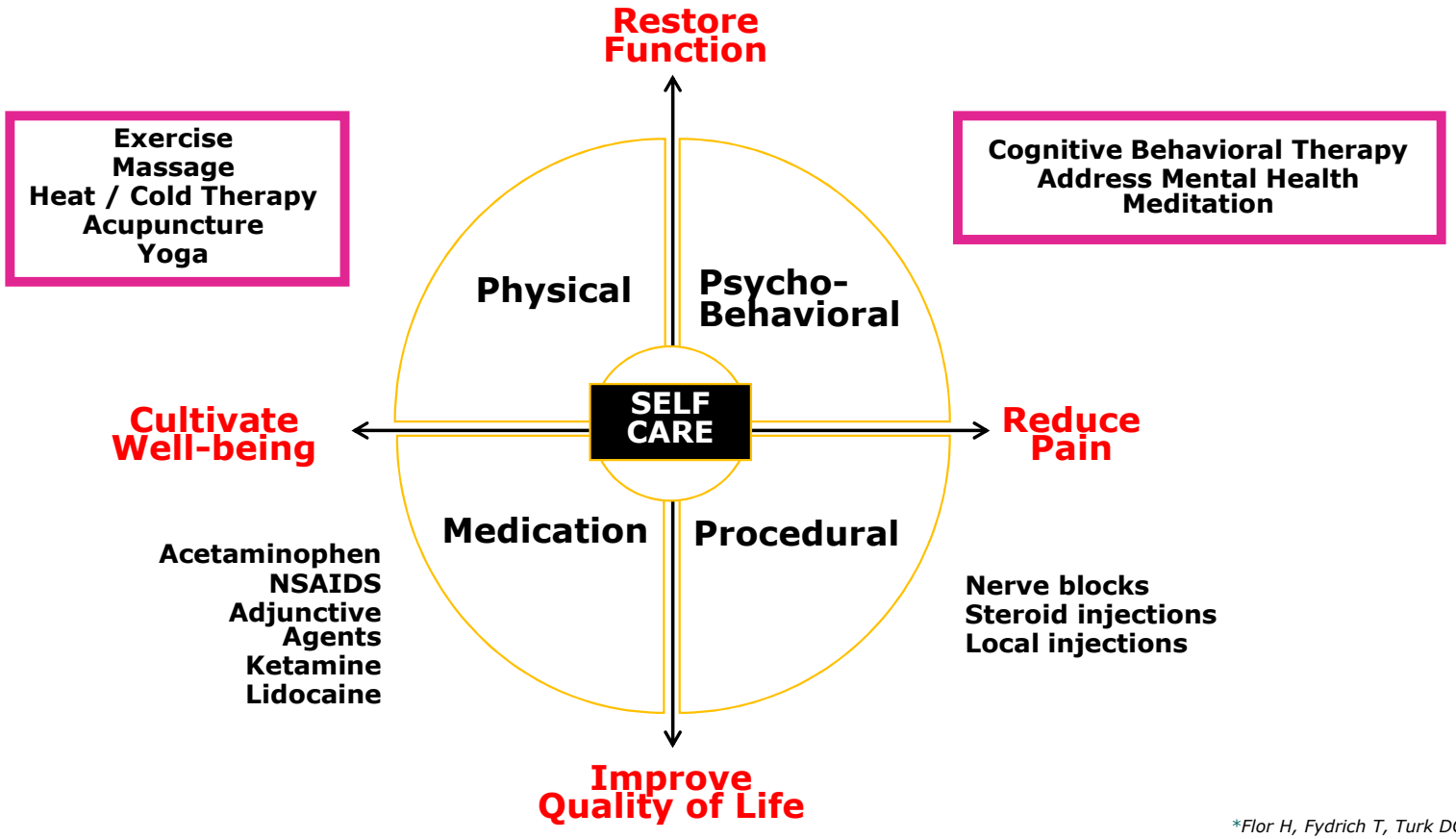
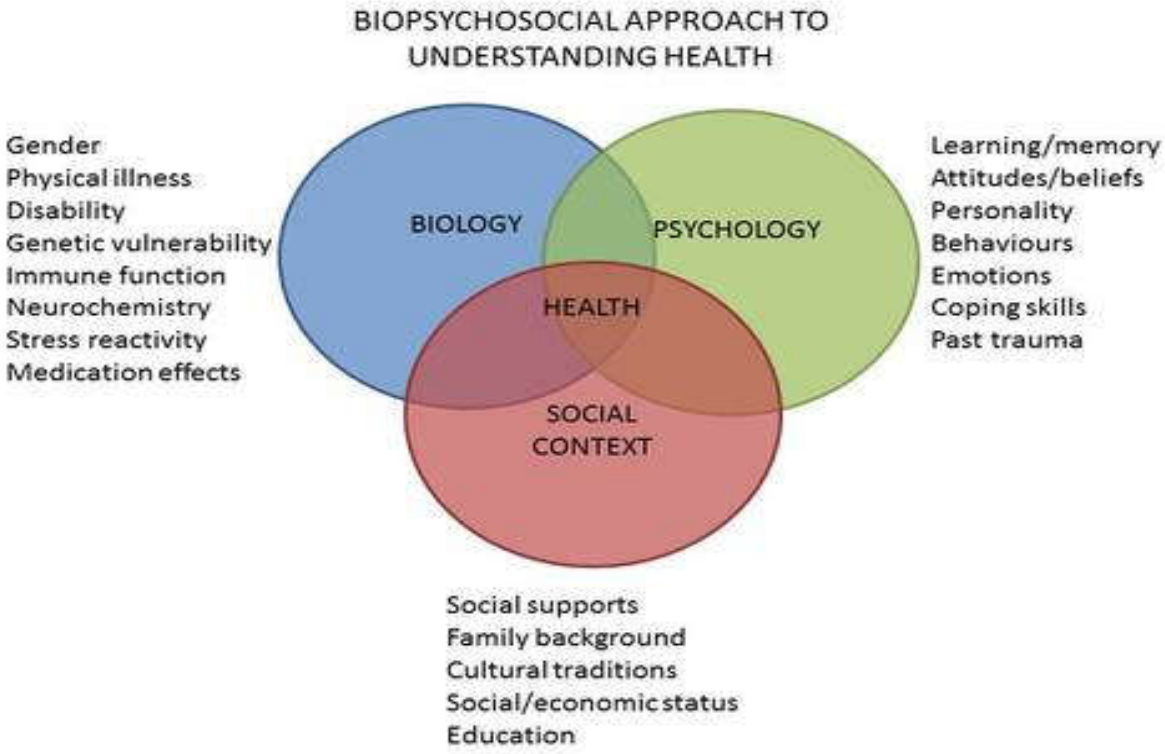
Multi-Dimensional Care



*Flor H, Fydrich T, Turk DC. Pain. 1992;49:221-230.
*Gatchel RJ, Okifuji A.J Pain. 2006;7:779-793.
Kamper SJ et al. Cochrane Database Syst Rev. 2014:CD000963.

Biopsychosocial Model



Legacy Patient

- Inpatient
  - Not a lot of guidance in the literature
  - Home doses= everyday
    SCRIPTS
  - Recommendations:
    Set expectations (realistic!)
    Add what you would normally

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Weaning!

Definitions

- Opiates-
  - A drug containing or derived from opium and tending to induce sleep or alleviate pain
- Narcotics-
  - A drug that in moderate doses dulls the senses, relieves pain, and induces profound sleep but in excessive doses causes stupor, coma, or convulsions
- Opioid-
  - A synthetic drug possessing narcotic properties similar to opiates but not derived from opium

Merriam-Webster dictionary

Who to Wean?

- 1. Inability to achieve or maintain "relief" or functional improvement
- 2. Intolerance to side effects
- 3. Persistent nonadherence
- 4. Deterioration
- 5. Resolution and healing of the painful condition

Tapering Long-term Opioid Therapy in Chronic Noncancer Pain Berna, Chantal et al. Mayo Clinic Proceedings , Volume 90 , Issue 6 , 828 - 842

Who to Wean?

- Does the diagnosis meet an indication for long term opioids?
- 50 MME/90 MME?
- Tolerance?

Why to wean?

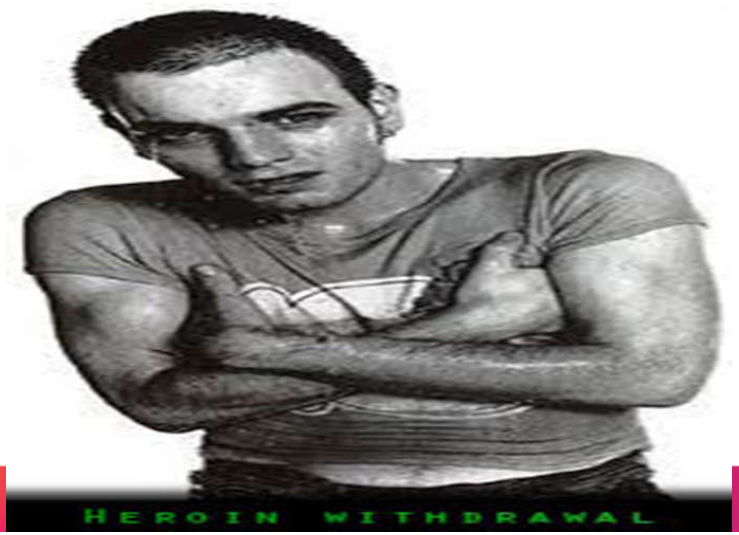
- What's the goal?

How to Wean?

- Pitfalls:
  - It is not an easy discussion
  - “Angry” patients
  - TIME consuming
  - Refusal

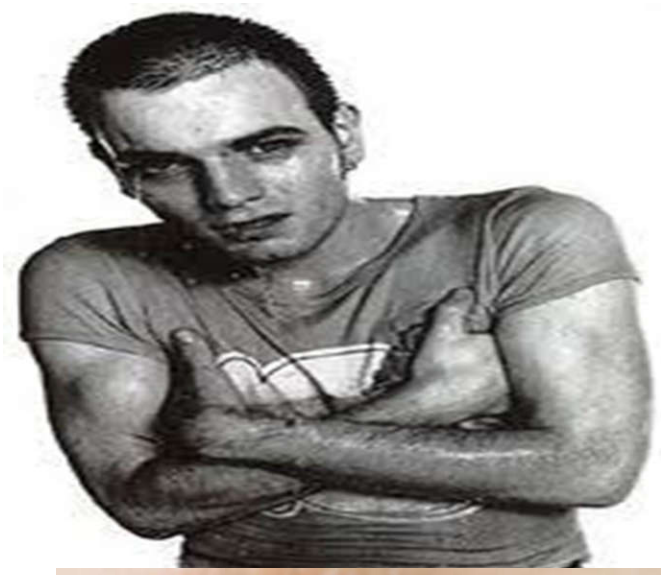
Weaning?

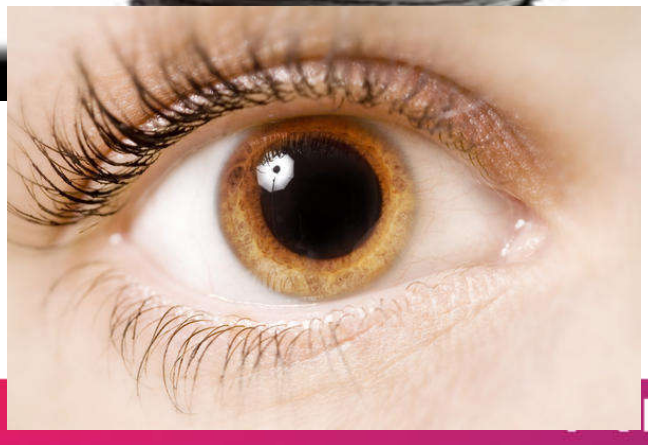
- Tolerance- using larger and larger amounts to have the "same" effect
- Withdrawal- considered the "opposite" of effects of the medications. Examples…



Opoid Withdrawal

- Opioid withdrawal:
- GI- nausea, vomiting, abdominal cramping, diarrhea
- Flu-like- runny nose, diaphoresis, piloerection, shivering
- Sympathetic- insomnia, irritability, anxiety, mild hypertension, tachycardia, restlessness, mydriasis
- Other- “pain”, myalgias, arthralgia





Is Withdrawal Dangerous?

I. Opioids	I. No-just worst flu*
II. Benzodiazepine	II. Yes
III. Alcohol	III. Yes
IV. THC	IV. No
V. Cocaine	V. No

Weaning

- Start with “long-acting” formulations of opioids
- Short acting opioids
- Short, intermediate and slow methods
- Benzodiazepines use slow only!

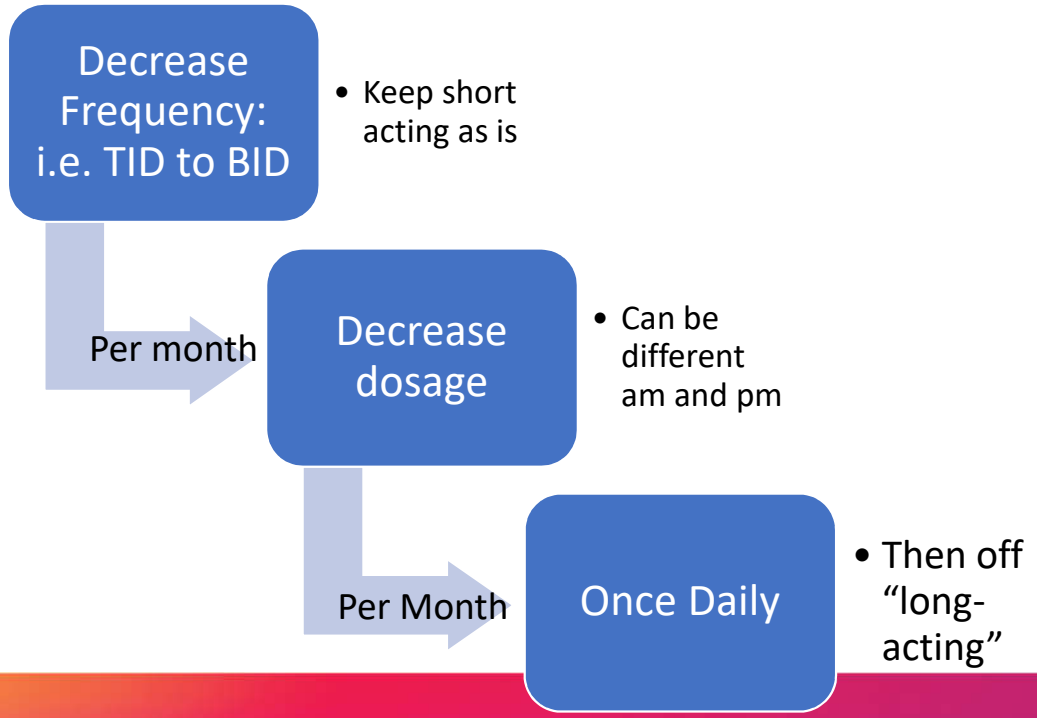
- Minimal guidance/Literature on this topic!

Helpful website

- PAIN-Outlet Clinical Guide
  - www.pain-outlet.info
  - VA and DoD

Long Acting

- Long acting wean will be “slow”



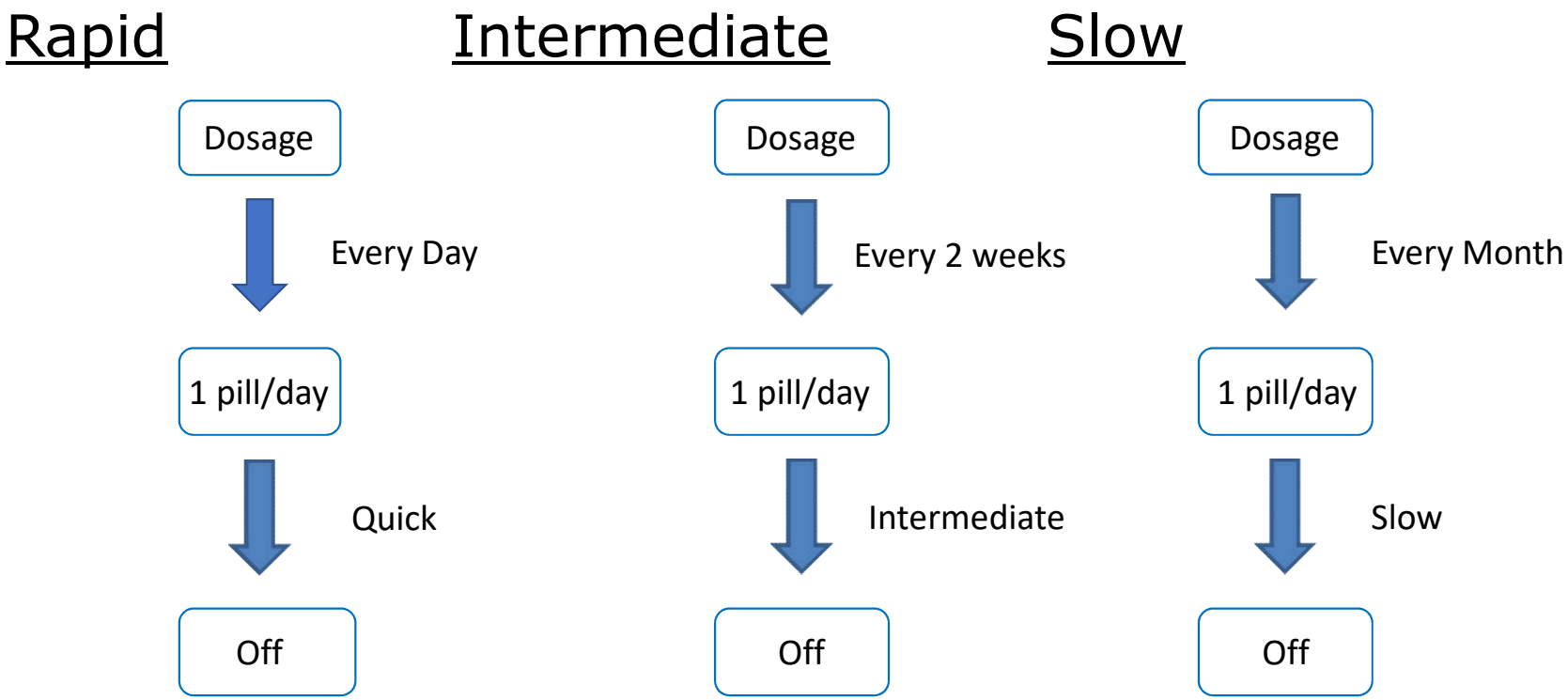
Example: MS contin 90mg TID

- Decrease to 90mg BID
- 90mg/60mg …60mg/60mg…60mg/45mg…
- Once to 30mg/30mg convert to 30mg daily.
- Then OFF long acting.

Methadone

- Is a unique medication
- Must use a “slow” taper, i.e. 5mg decrease per month
- Long half life

Immediate release



Now "BENZO's"

- Xanax?
- Others

Benzo's rec's

- If on Xanax recommend converting to a long acting formulation.
- Example of Xanax 2mg BID:

Benzodiazepine Equivalent Doses and Suggested Taper

	Approximate Dosage Equivalents	Elimination Half-life
Chlordiazepoxide	25 mg	>100hr
Diazepam	10 mg	>100hr
Clonazepam	1 mg	20-50 hr
Lorazpam	2 mg	10-20 hr
Alprazolam	1 mg	12-15 hr
Temazepam	30 mg	10-20 hr

Benzodiazepine Taper:

- Switch to a longer acting benzodiazepine
- Reduce dose by 50% the first 2-4 weeks then maintain on that dose for 1-2 months then reduce dose by 25% every two weeks

Milestone Suggestions		Example: Alprazolam 2 mg bid Convert to 40 mg diazepam daily
Week 1		35 mg/day
Week 2	Total dose decrease by 25%	30 mg/day (25%)
Week 3		25 mg/day
Week 4	Total dose decrease by 50%	20 mg/day (50%)
Week 5-8	Hold dose	Continue at 20 mg/day for 1 month
Week 9-10	Current dose reduction of 25% every two weeks	15 mg/day
Week 11-12		10 mg/day
Week 13-14		5 mg/day
Week 15		discontinue

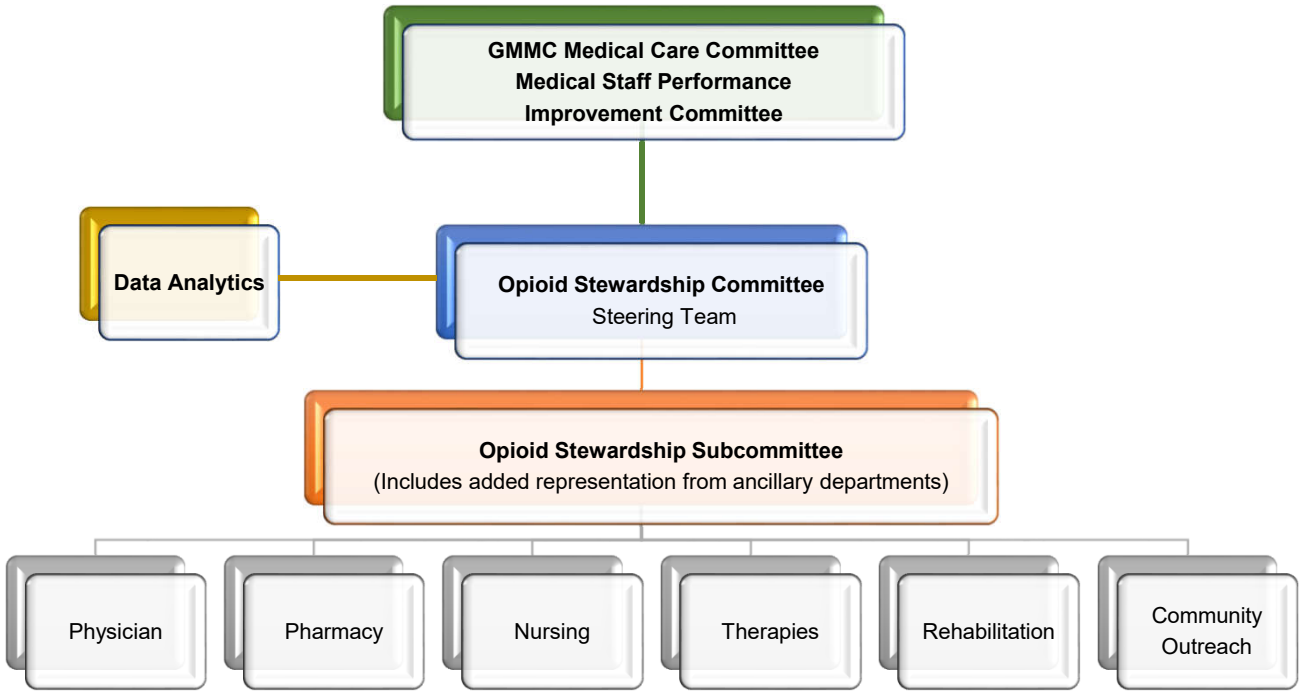
Perry PJ et al. Psychotropic Drug Handbook Philadelphia PA. 2007

Lader M et al. CNS Drugs 2009 ; 23:19-31.

PRISMA HEALTH SM

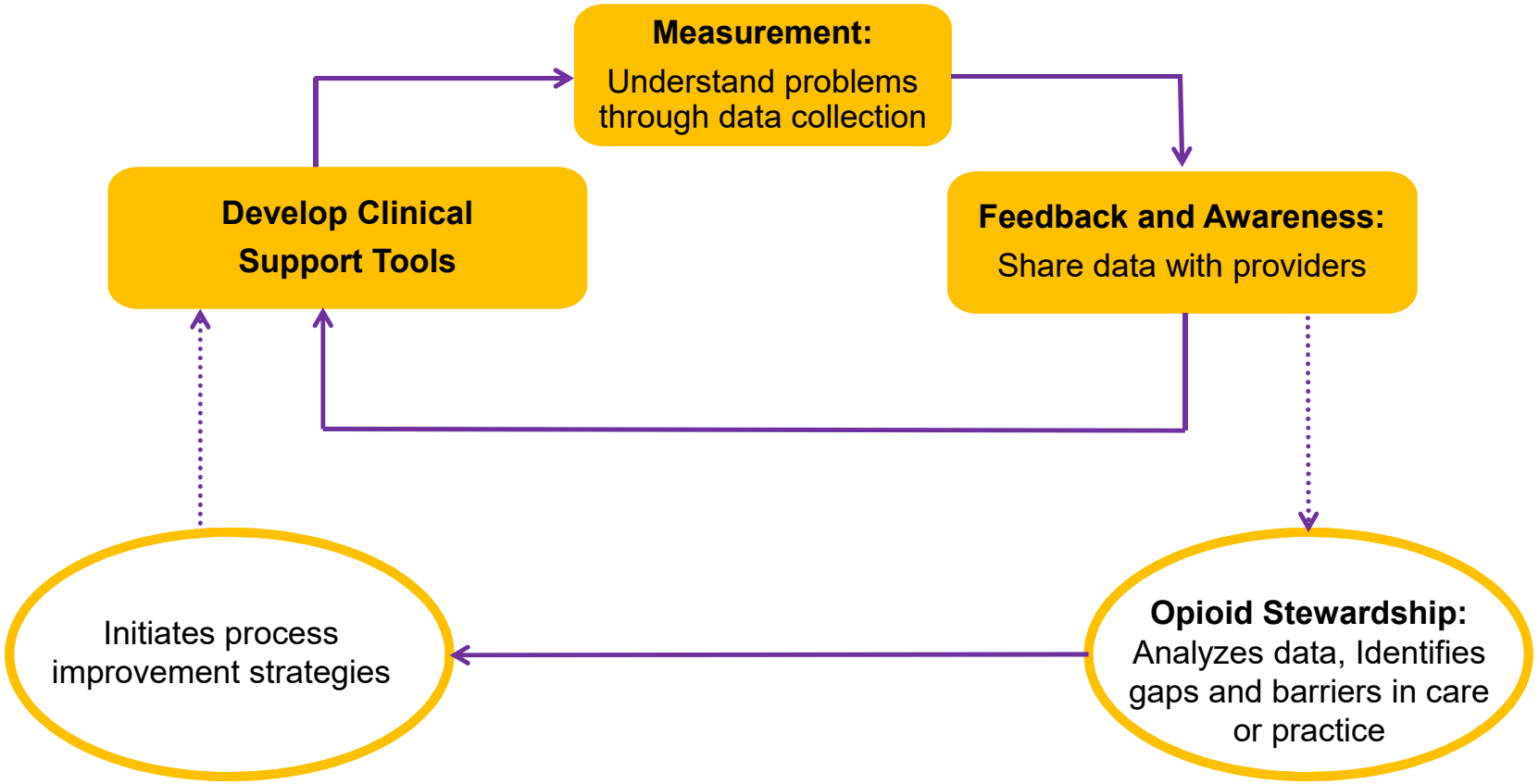
Opioid Stewardship

Prisma Health-Upstate Organizational Structure



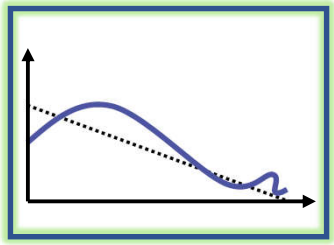
Workgroup Streams – Charged with Rolling out Initiatives

Opioid Stewardship
Philosophy for Process Improvement



Data-Driven Approach to Change

- How do we know what we don't know?
  - Targeted initiatives
  - Focused education
  - Needed resources or endorsement

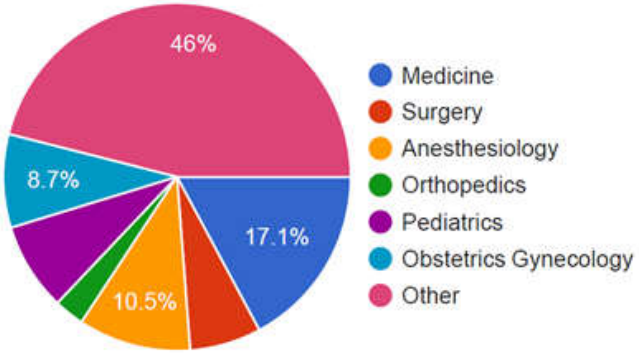


- Do we have data to support our theories?
  - What data metrics do we need to implement change?
  - What data elements can be pulled out of our EMR?
  - What is the most impactful manner to present the data?

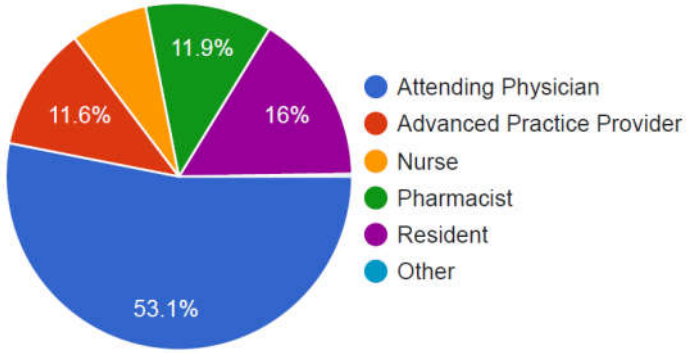
- Identify barriers and strategies to overcome them
  - Improve patient care without "policing"

Practitioner Pulse Check on Opioids

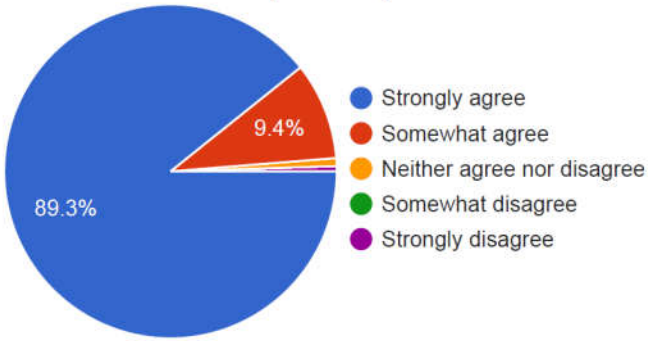
What is your specialty?



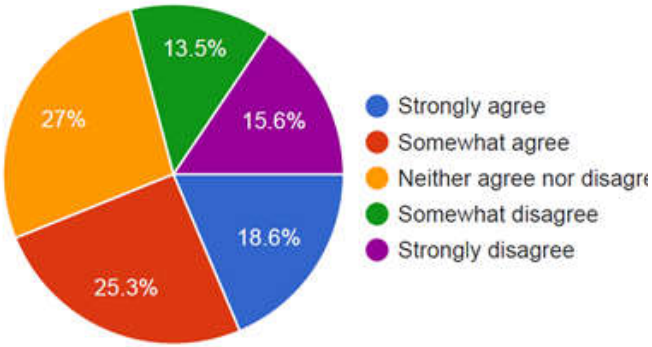
What is your job title?



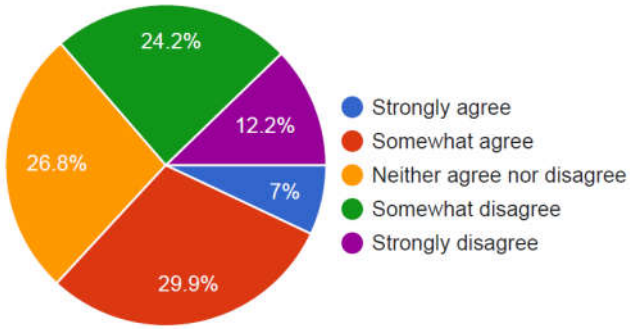
There is a national opioid epidemic.



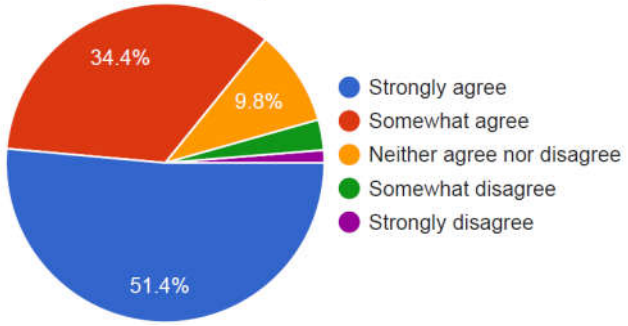
I feel pressured to prescribe opioids.



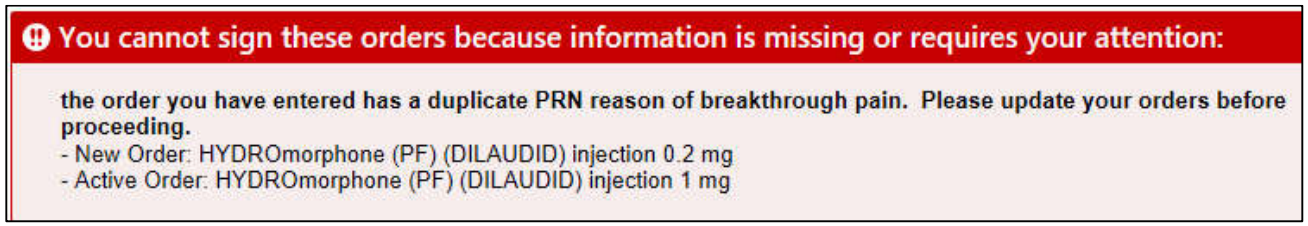
Most patients would be receptive to using non-opioids.



Patients have unrealistic expectations about pain control.



EMR – Standardized Pain Panels & Duplicate Alerts



EMR – Messaging and 24 hour stops

You selected:

HYDROmorphone (PF) (DILAUDID) injection: Intravenous, starting today at 0709, For 1 day

Details

Opioid Stewardship Recommendation

GHS is committed to instituting processes that ensure the safe and appropriate prescribing of IV opioid medications. Therefore, IV opioids will continue to be restricted for use in Severe Pain (7-10 / BPS 9-12) or Breakthrough Pain only.

Clinicians are encouraged to use an oral alternative offered below if possible.

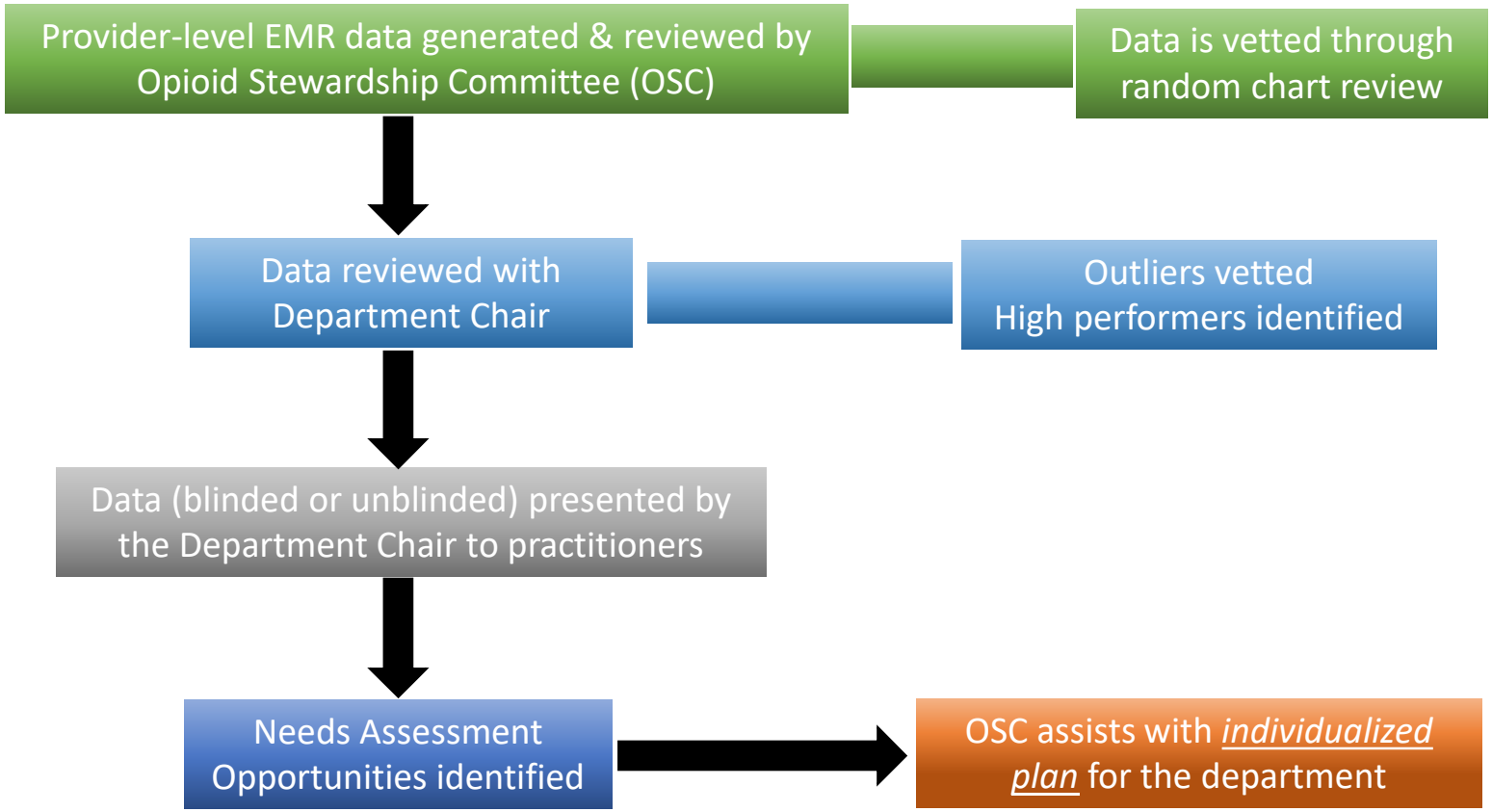
morphine 5 mg IV = HYDROmorphone 0.5 mg IV

Other therapy options for pain not offered below include but are not limited to:
- Scheduled PO alternating acetaminophen and ibuprofen
- Post-op pain Adults ONLY: pregabalin (LYRICA) PO twice daily

Continue with:

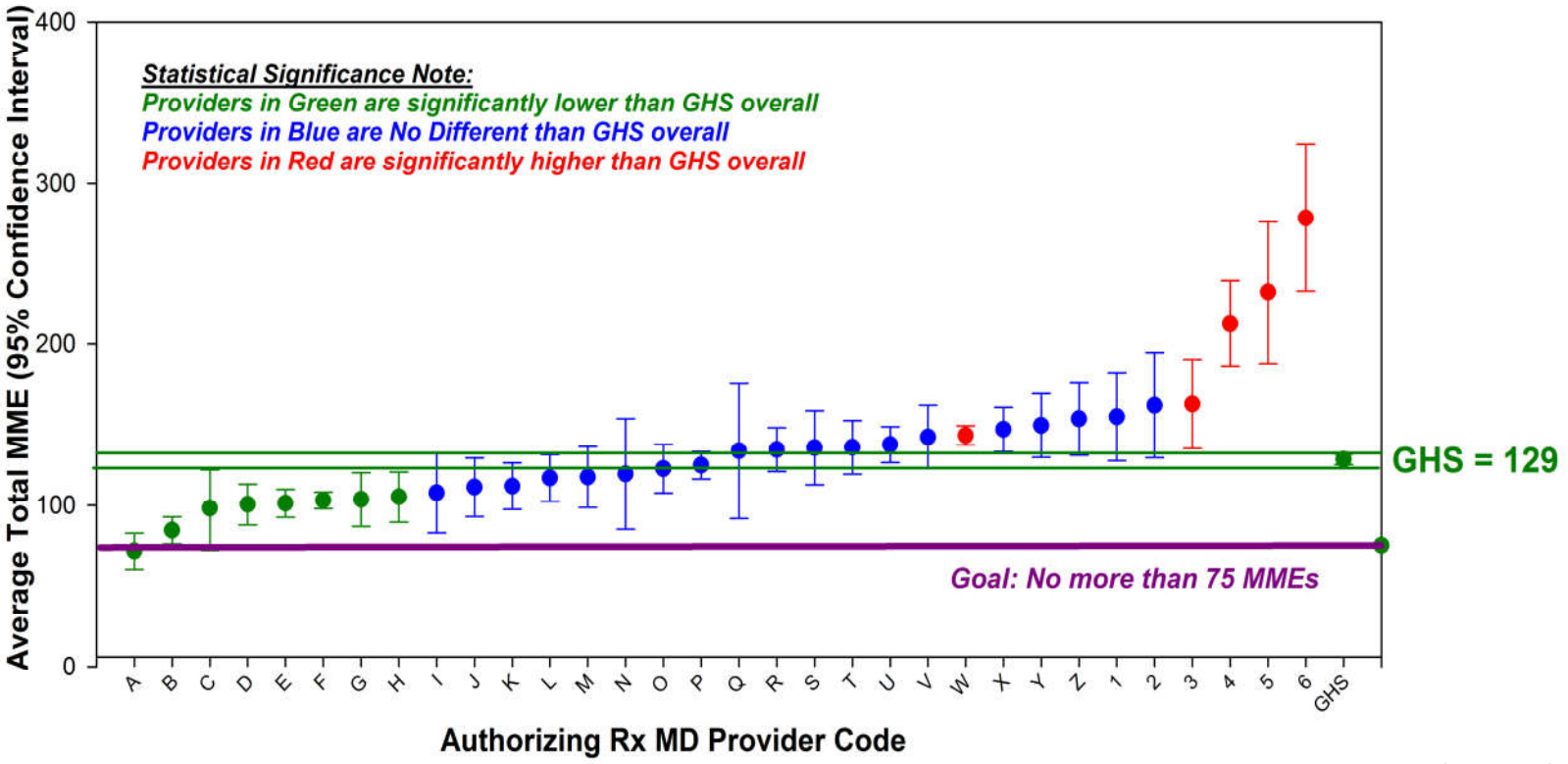
○ HYDROmorphone (PF) (DILAUDID) injection: Intravenous, starting today at 0709, For 1 day

Data-Driven Approach to Change



Prisma Health-Upstate Vaginal Deliveries:

Average Total Discharge MME by Provider (95% Confidence Interval)

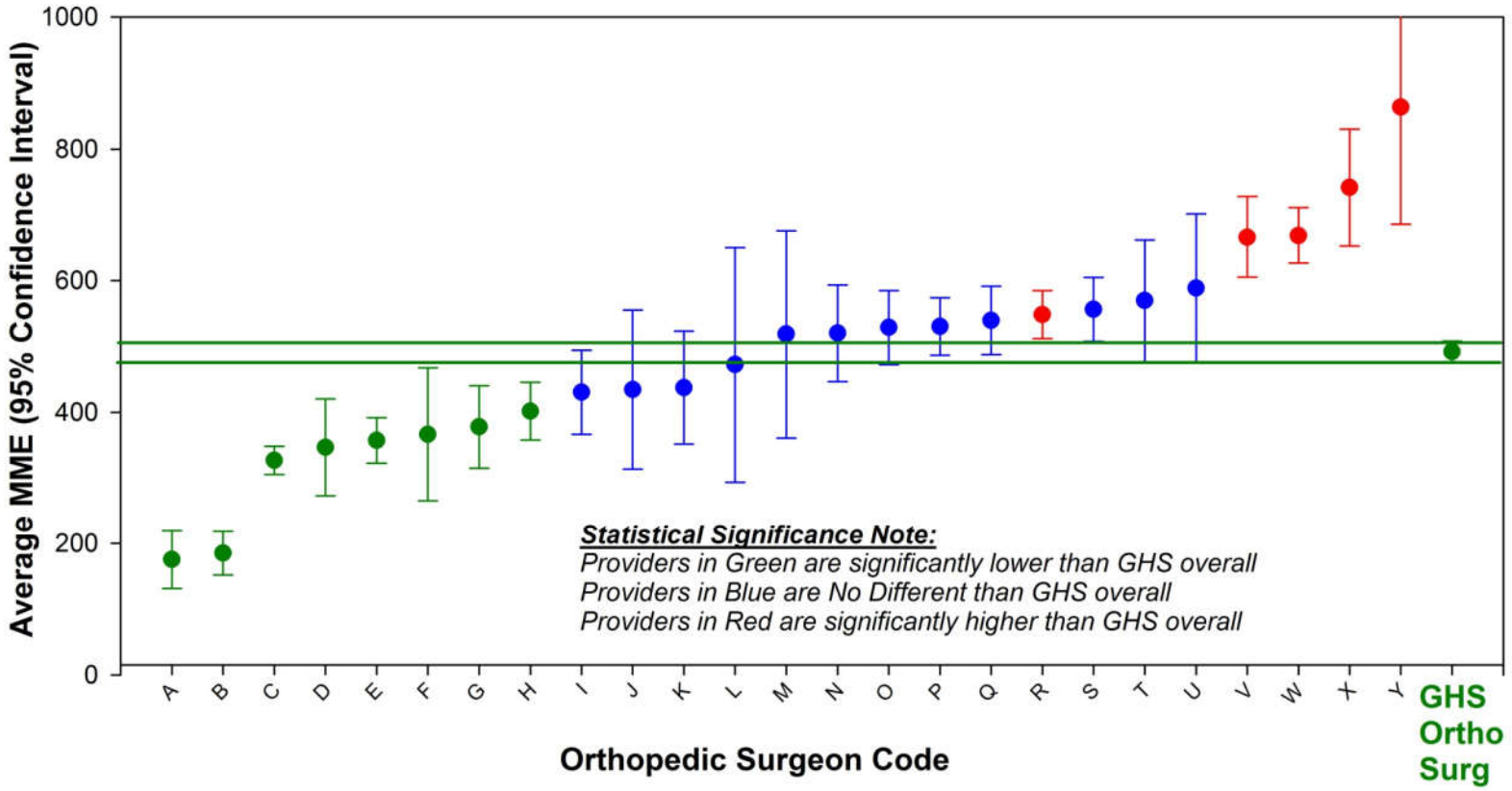


Data Source: Oct '17 – Dec '18

Note: Graph excludes MDs with < 20 Vaginal Delivery encounters with an opioid prescription at discharge

Prisma Health-Upstate Ordering MD: Orthopedics

Average Total Discharge MME (95% Confidence Interval)

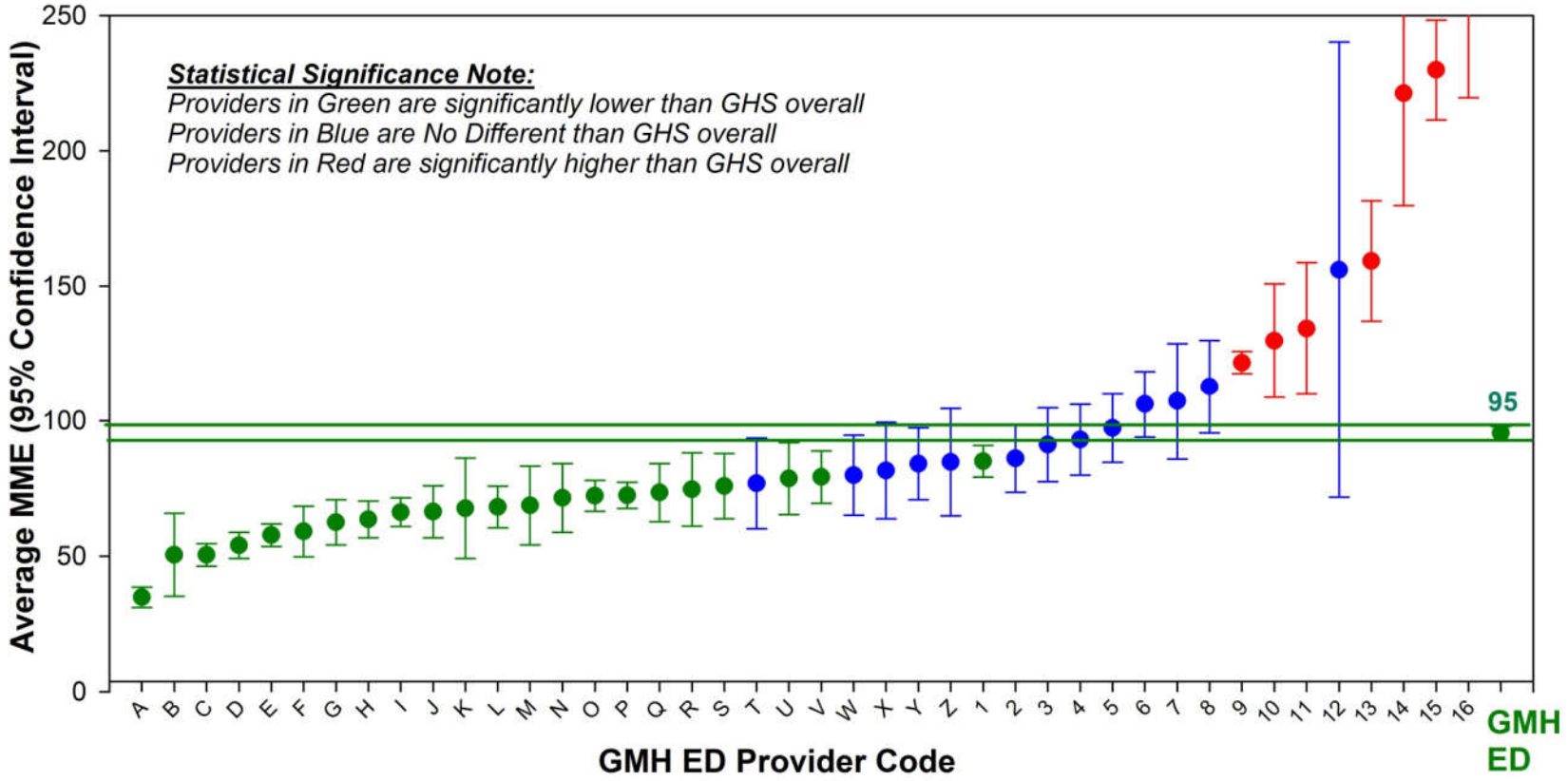


Data Source: Jan '17 – Jul '18

Note: Graph excludes surgeons with < 30 discharges with an opioid prescription

Prisma Health-Upstate Emergency Departments:

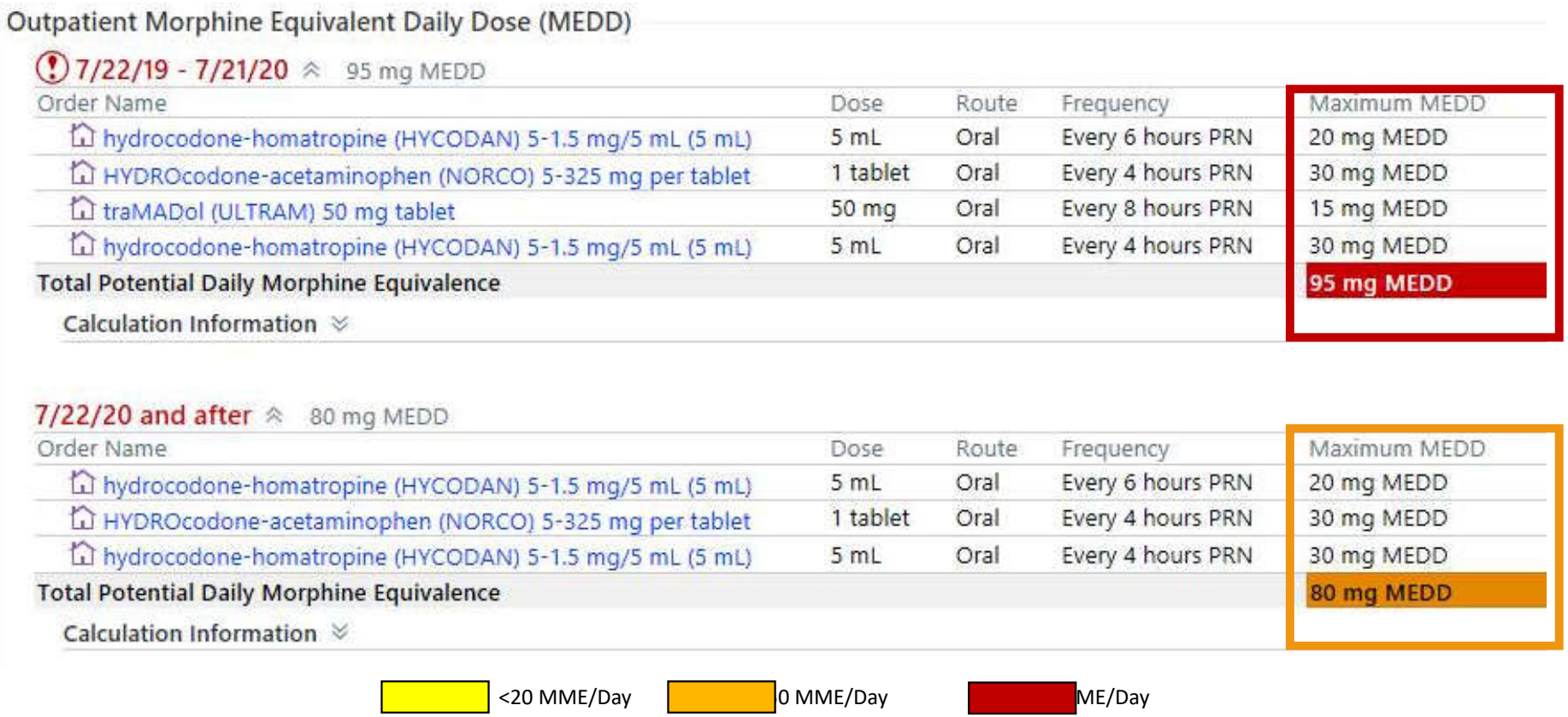
Average Discharge MME (95% Confidence Interval)



Data Source: Jul '17 – Jun '18

Note: Graph excludes MDs with < 50 ED discharges with an opioid prescription

EMR – Display of Total MME



Outpatient Morphine Equivalent Daily Dose (MEDD)

7/22/19 - 7/21/20 95 mg MEDD

Order Name	Dose	Route	Frequency	Maximum MEDD
hydrocodone-homatropine (HYCODAN) 5-1.5 mg/5 mL (5 mL)	5 mL	Oral	Every 6 hours PRN	20 mg MEDD
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	1 tablet	Oral	Every 4 hours PRN	30 mg MEDD
traMADol (ULTRAM) 50 mg tablet	50 mg	Oral	Every 8 hours PRN	15 mg MEDD
hydrocodone-homatropine (HYCODAN) 5-1.5 mg/5 mL (5 mL)	5 mL	Oral	Every 4 hours PRN	30 mg MEDD
Total Potential Daily Morphine Equivalence				95 mg MEDD
Calculation Information				

7/22/20 and after 80 mg MEDD

Order Name	Dose	Route	Frequency	Maximum MEDD
hydrocodone-homatropine (HYCODAN) 5-1.5 mg/5 mL (5 mL)	5 mL	Oral	Every 6 hours PRN	20 mg MEDD
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	1 tablet	Oral	Every 4 hours PRN	30 mg MEDD
hydrocodone-homatropine (HYCODAN) 5-1.5 mg/5 mL (5 mL)	5 mL	Oral	Every 4 hours PRN	30 mg MEDD
Total Potential Daily Morphine Equivalence				80 mg MEDD
Calculation Information				

<20 MME/Day

0 MME/Day

ME/Day

Patient Education

- Get an accurate medication history
  - Identify naive vs. tolerant pain patients
- Set realistic pain expectations for patients
  - Begins with education in anesthesia pre-assessment
  - Nurse liaisons communicating pain plan of care to patients
- Focus on function, not pain score
- Alternative therapies
  - Non-pharmacological therapies (ice, heat, positioning, quiet time)
  - Multimodal therapy
  - Explain risks of opioids including side effects
- Use whiteboards as a communication tool

2-Day Pain Liaison Nurse Course

Target Audience: Nurses identified for the Pain Liaison Role

Speakers include: Kevin Walker, MD; Teny Gomez, MD; Geralyn McDonough, MA,BSN,RN;
Meredith Purgason, APRN, NP-C; Ineke Tolbert, APRN, NP-C;
Douglas Furmanek, PharmD BCPS, Theresa Varughese, BSN, RN

Learning Outcomes:

1. Identify the role of a Pain Liaison Nurse
2. Discuss classifications of pain as they relate to assessment and management of pain
3. Interpret valid and reliable pain intensity assessment tools to assess pain
4. Identify principles of pain management related to acute pain, chronic non-cancer pain, and cancer pain
5. Explore setting goals for pain management as it related to the patient experience.

6.75 Contact Hours will be awarded for this activity

Registration details: Pre-register in Health stream

In order to receive credit for this session, the participant must attend entire program and complete a pre survey; post survey - complete an evaluation form in HealthStream within 10 days of the completion of the activity.

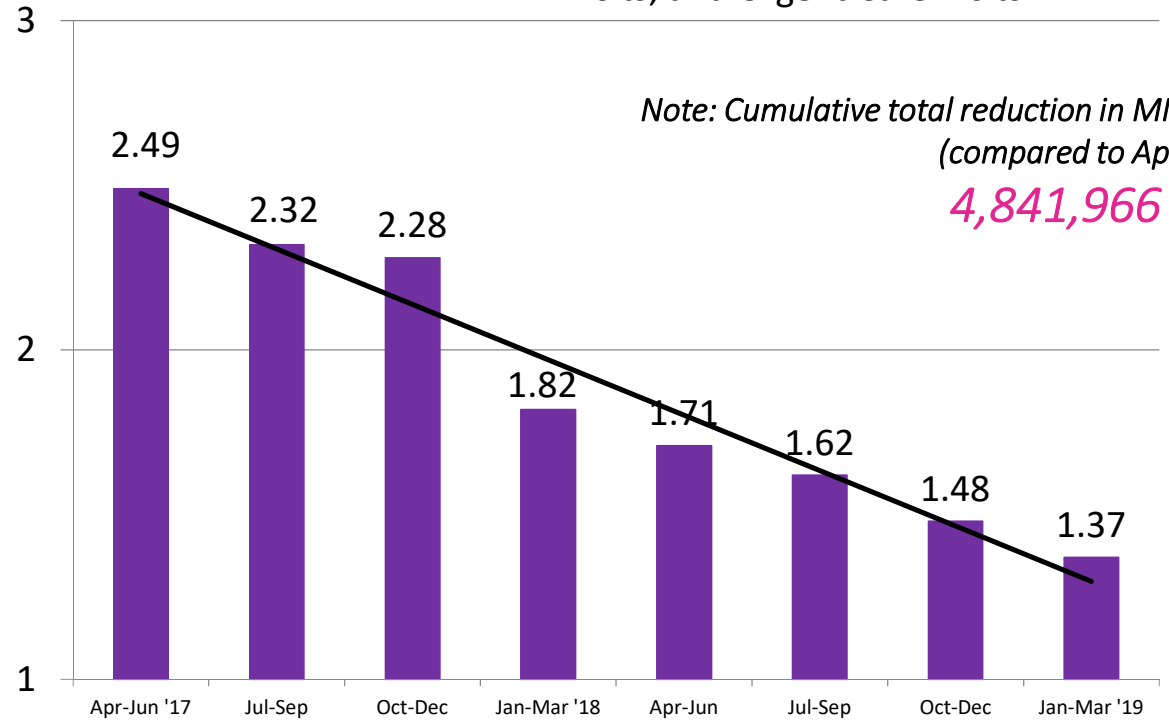
There has been no commercial support for this presentation. Speaker(s) and planners report no conflict of interest.

The Greenville Health System is an approved provider of continuing nursing education by the South Carolina Nurse Association, an accredited approver with distinction, by the American Nurses Credentialing Center's Commission on Accreditation.

Prisma Health-Upstate Hospital Encounters:

Total Discharge MME Burden by Quarter

Hospital Encounters include Hospitalizations, Outpatient Surgery Visits, ED Visits, and Urgent Care Visits

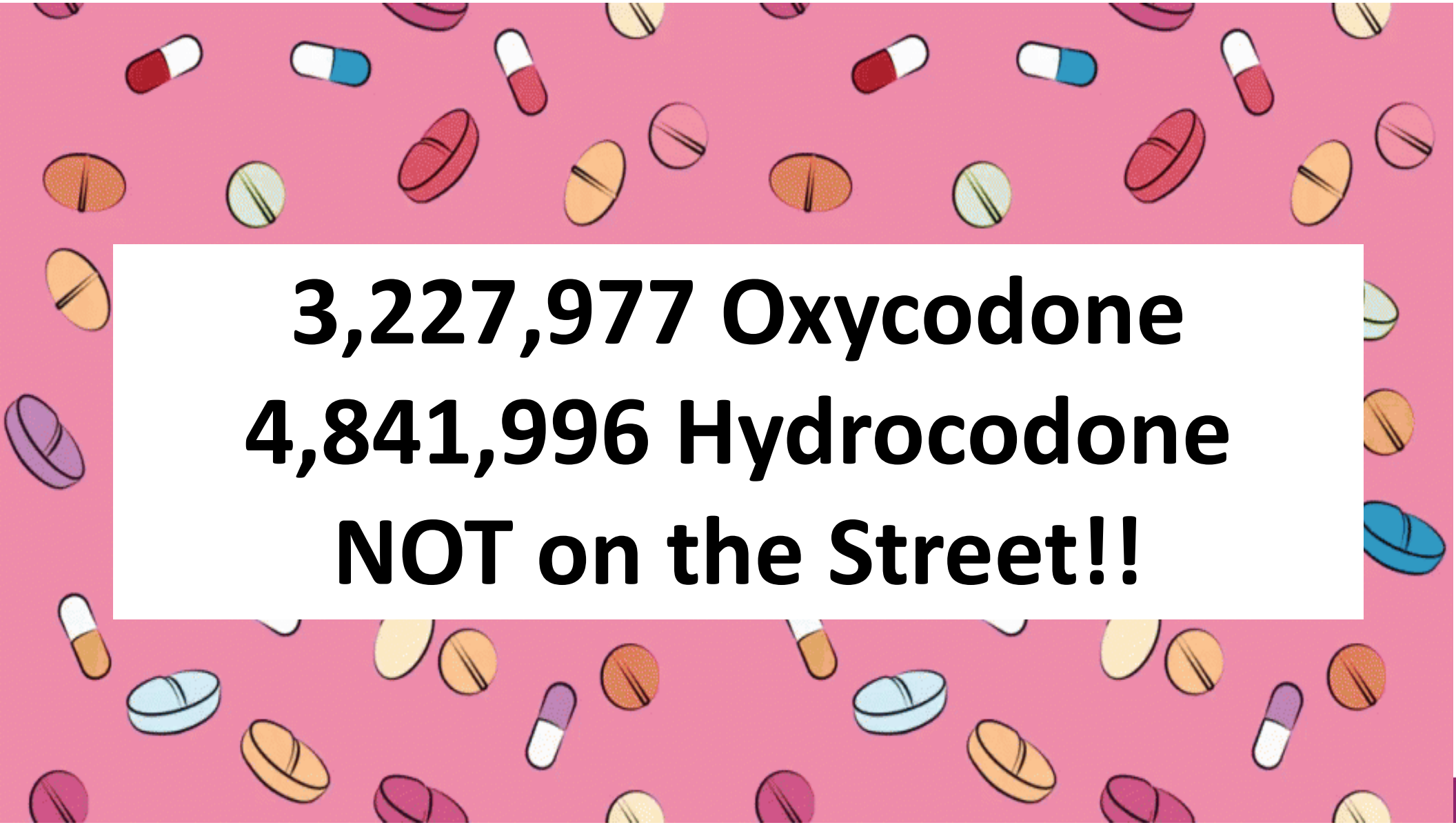


Note: Cumulative total reduction in MME burden over past 7 quarters (compared to Apr-Jun '17)

4,841,966 MME

**** Statistically significant 45% reduction***

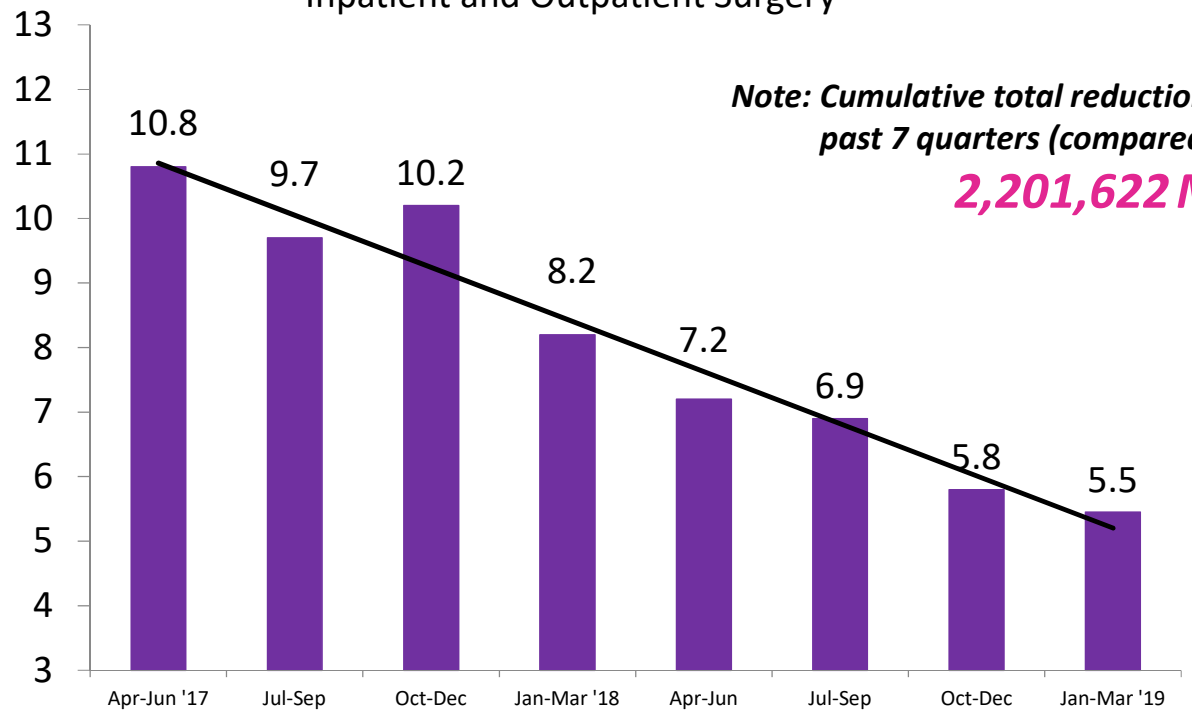
Data Source: Apr '17 – Mar '19


3,227,977 Oxycodone
4,841,996 Hydrocodone
NOT on the Street!!

Prisma Health-Upstate Hospital Surgical Encounters

Total Discharge MME Burden by Quarter

Hospital Surgical Encounters include Hospital-Based Inpatient and Outpatient Surgery



Note: Cumulative total reduction in MME burden over past 7 quarters (compared to Apr-Jun '17)

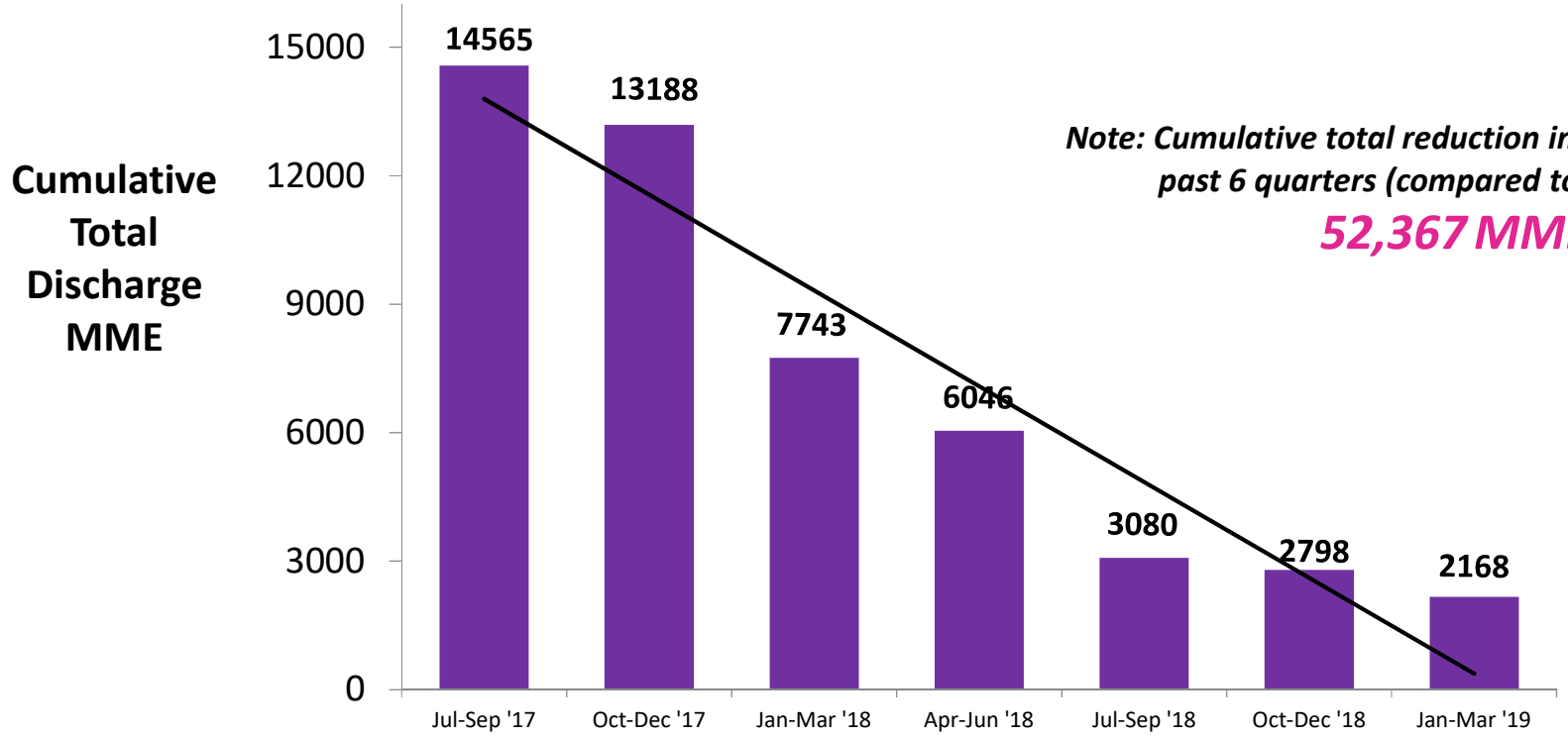
2,201,622 MME

**** Statistically significant 49% reduction***

Data Source: Apr '17 – Mar '19

Prisma Health-Upstate Incisional Hernia Procedures

Total Discharge MME Burden of Opioid Prescriptions by Quarter



Note: Cumulative total reduction in MME burden over past 6 quarters (compared to Jul-Sep '17)

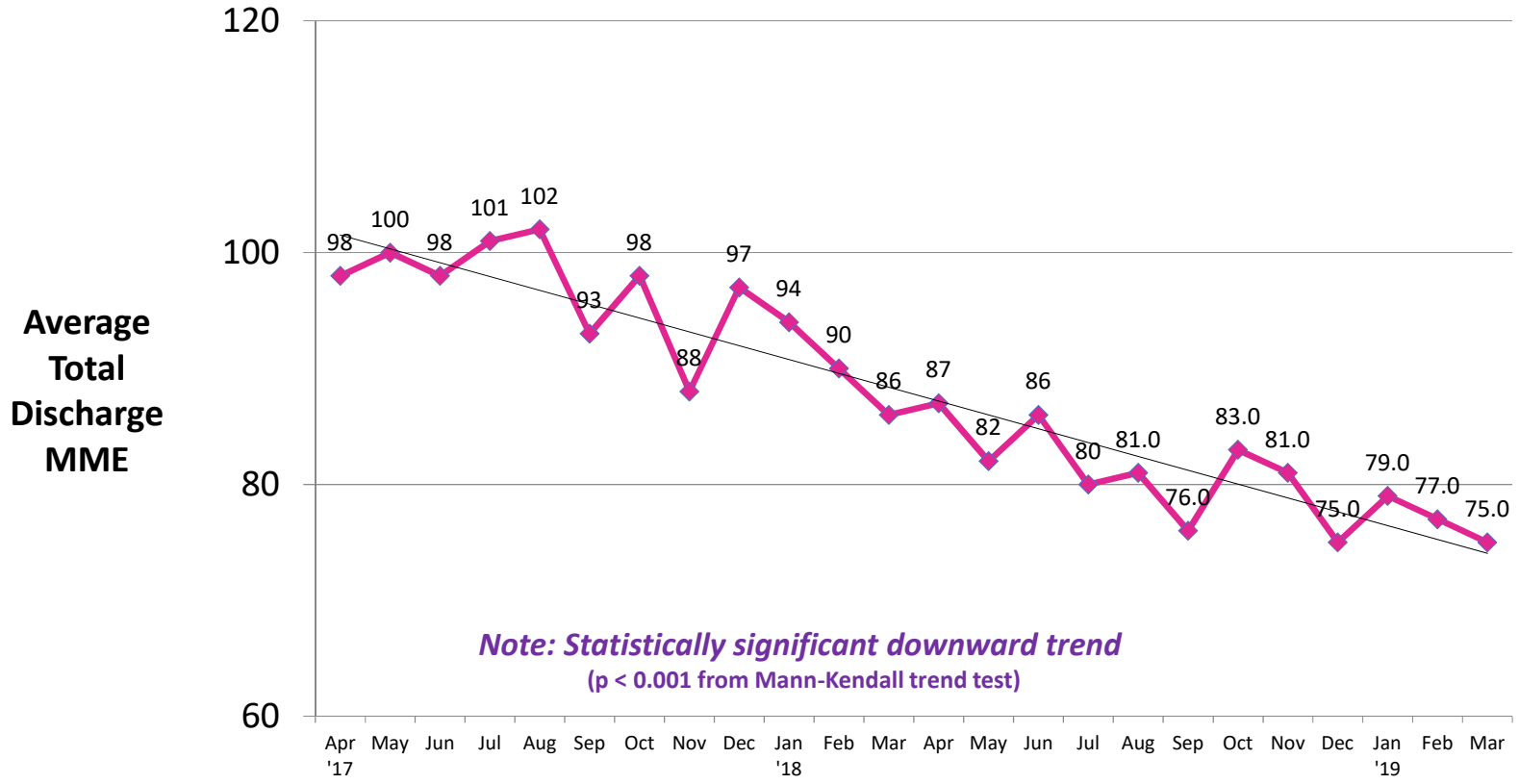
52,367 MME

**** Statistically significant 85% reduction***

Data Source: Jul '17 – Mar '19

Prisma Health-Upstate Emergency Departments:

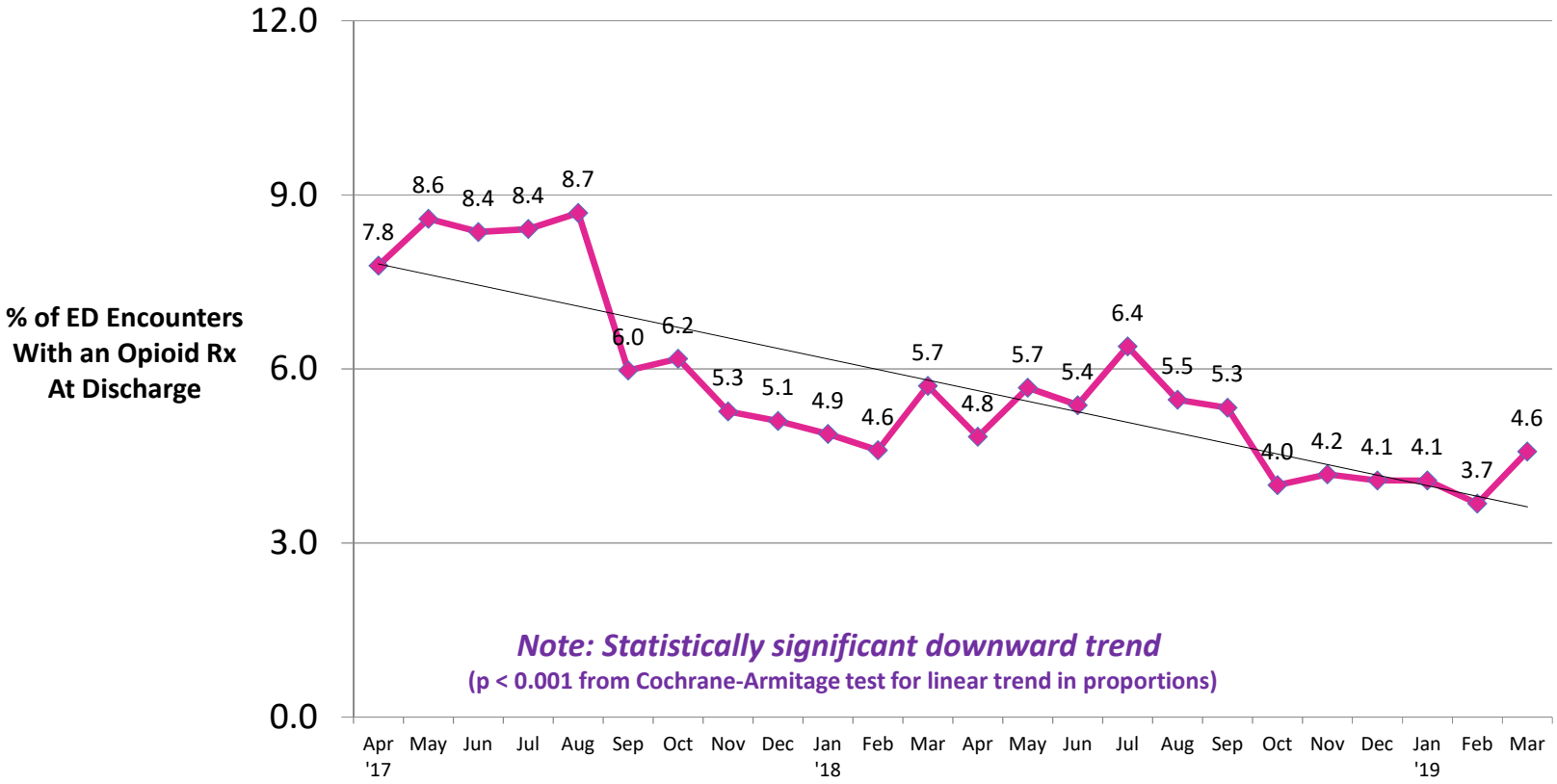
Average Total Discharge MME (Morphine Milligram Equivalent)



Data Source: Apr '17 – Mar '19

Prisma Health-Upstate Emergency Departments:

% Encounters with an Opioid RX at Discharge



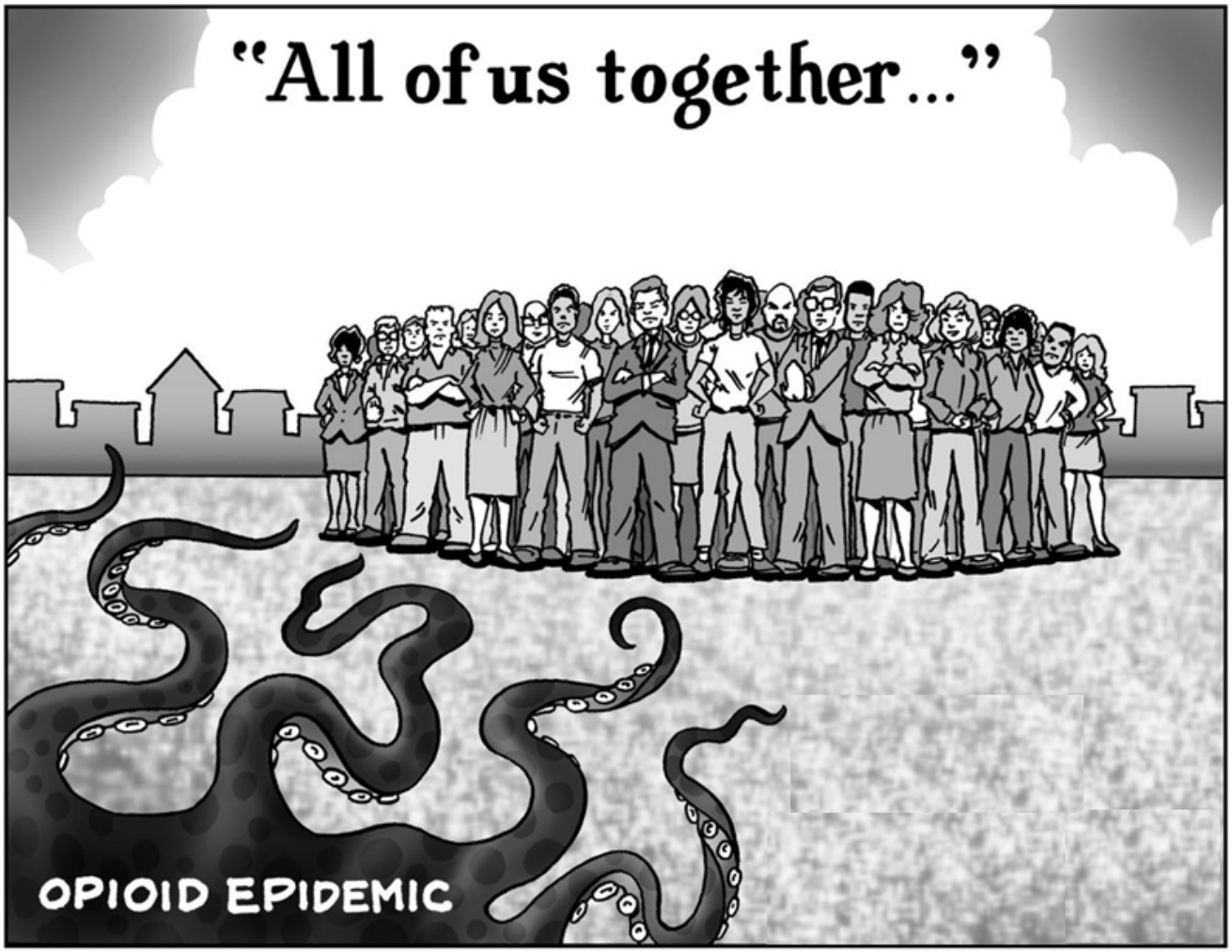
Data Source: Apr '17 – Mar '19

Local, State, and Federal Outreach

- E.C.H.O. Empowering Communities for Health Outcomes
- Speaking Opportunities
  - Prisma Health Grand Rounds
  - SC Birth Outcomes Initiative
  - SC Medical Association
  - American Dental Association
  - Governor's Opioid Summit
- Aligning with state political partners
  - Research grants establishing best practices for SC from government agencies
- National efforts:
  - Prisma Health Upstate efforts incorporated into Senator Graham’s Congressional Testimony on Combating the US Opioid Crisis to the Department of Homeland Security

Summary

- CDC guideline are useful but are guidelines
- Acute pain can lead to chronic lets set our patient up for success
- Legacy patient are difficult
- Weaning should be considered
- You do play a role in Opioid Stewardship


"All of us together..."
OPIOID EPIDEMIC


Thank You!

PRISMA HEALTH℠

PrismaHealth.org

Kevin B. Walker, MD FASA

Medical Director, Prisma Health Upstate Affiliate Division of Pain Management

Douglas L Furmanek, PharmD BCPS

Clinical Director, Prisma Health Upstate Affiliate Pharmacy Services