The Opioid Crisis: Effective Strategies to Turn the Tide

Adam Bursua, Pharm.D., BCPS
Laura Meyer-Junco, Pharm.D., BCPS, CPE
Mary Lynn Moody, BSPharm
Annette Hays, Pharm.D., BCPS
Kevin O. Rynn, Pharm.D., FCCP, DBAT
Christopher Shriever, MS, Pharm.D.

The speakers have no conflicts of interest to disclose

Responsible Opioid Prescribing

Laura Meyer-Junco, PharmD, BCPS, CPE
Clinical Assistant Professor, UIC College of Pharmacy at Rockford
Clinical Pharmacist, MercyHealth and Hospice Care of America

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Learning Objectives – Pharmacists and Technicians

1. Develop an approach to responsible opioid prescribing, reducing the risk of misuse, abuse, and diversion of opioids.
2. Evaluate the role prescription drug monitoring programs play in decreasing opioid misuse and abuse.
3. Order the effectiveness of various types of interventions to ensure the safe use of opioid therapy.
4. Formulate effective strategies to influence positive changes in the opioid medication use process in a health care organization.
Definitions

01 Aberrant Drug Behavior
Any drug-related deviation from the medical plan

02 Abuse
Use of an opioid for a non-therapeutic intent

03 Misuse
Inappropriate use of a drug, whether deliberate or unintentional (therapeutic intent)

04 Pseudoaddiction
Drug-seeking behavior from undertreatment of pain

05 Chemical Coping
Reliance on a drug for psychological stability

06 Diversion
Transfer of a prescription from a lawful to unlawful method of distribution

07 Addiction
("Substance Use Disorder") Out-of-control, compulsive drug use despite harm to health, relationships, finances

“All addicted people are abusers, but not all abusers are addicted”

What is driving the abuse or misuse?
• Chemical coping
• Uncontrolled pain
• Misunderstanding of treatment plan

Recognize Components of Total Pain. Explore the "Hurt"

Physical Pain
Psychological Pain
Spiritual Pain
Existential Pain

Total Pain


Total Pain Population
Aberrant Behavior (40%)
Abuse 20%
Addiction 2-5%


These guidelines do not apply to cancer pain or end-of-life care.

Guideline Consensus: Non-Opioids First

**CDC #1**
- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.

**VA #1**
- “We recommend against initiation of long-term opioid therapy for chronic pain.
- We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments.
- When pharmacologic therapies are used, we recommend non-opioids over opioids.”

- Literature review conducted found no studies evaluating opioid therapy >16 weeks.

**APS**
- “Clinicians may consider a trial of chronic opioid therapy (COT) as an option if chronic non-cancer pain (CNCP) is moderate or severe, pain is having an adverse impact on function or quality of life, and potential therapeutic benefits outweigh or are likely to outweigh potential harms (strong recommendation, low-quality evidence)”
Guidelines Consensus: Risk Assessment before Opioid Initiation

- *CDC #3 & #10*
- *VA #7 & #8*
- *APS #1 & #2*

Discuss known risks and realistic benefits of opioid therapy AND patient/clinician responsibilities (Recommendation #3)

Conduct an assessment of risk of substance abuse, misuse, or addiction (Recommendation 1.1)

Evaluate risk factors for opioid-related harms (Recommendation 2)

Conduct an assessment of risk of substance abuse, misuse, or addiction (Recommendation 1.1)

Evaluate benefits and harms of opioid therapy (Recommendation 2.1)

Review state prescription drug monitoring program (PDMP) data (Recommendation 9)

Informed consent should be obtained and contain goals, expectations, risks, and responsibilities of patient and clinician (Recommendation 2.1)

The Ideal First Visit

- Obtain a Good History
- Perform Risk Assessments
- Collect Additional Data
- Individualize Treatment Plan

Opioid Risk Tool (ORT)

<table>
<thead>
<tr>
<th>Family History of Substance Abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>1 point</td>
<td>3 points</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>2 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal History of Substance Abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>3 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>5 points</td>
<td>5 points</td>
</tr>
<tr>
<td>Age (16 to 45 years old)</td>
<td>1 point</td>
<td>1 point</td>
</tr>
<tr>
<td>Preadolescent sexual abuse</td>
<td>3 points</td>
<td>0 points</td>
</tr>
<tr>
<td>Depression</td>
<td>1 point</td>
<td>1 point</td>
</tr>
<tr>
<td>ADD, OCD, Bipolar or Schizophrenia</td>
<td>2 points</td>
<td>2 points</td>
</tr>
</tbody>
</table>

Low Risk: 0-3 points
Moderate Risk: 4-7 points
High Risk: ≥ 8 points
Sample Informed Consent

Available at:
http://americanpainsociety.org/education/guidelines/overview

Opioid Agreement (or Contract)

Key features may include:

- Goals of opioid treatment
- Clear explanation that opioid treatment is a trial and will be continued or discontinued based on progress toward goals, benefits, and harms/risks
- Specification of 1 physician and 1 pharmacy
- Random urine drug tests
- Office visits at a minimum interval
- Use of pill counts
- Limited prescriptions (i.e. biweekly, monthly)
- Safe storage requirements and disposal
- If medication stolen, must file police report
- Behaviors that constitute non-adherence
- Consequences of non-adherence

What are our treatment goals?

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.
What are realistic goals?

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

30% - 50%

Reduction in pain demonstrated in well controlled randomized trials

Guideline Recommendations for Initiating Opioid Therapy for Chronic Pain

... prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (Recommendation 4)

Prescribe the lowest effective dose (Recommendation 1)

“Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine chronic opioid therapy is appropriate.” (Recommendation 3.1)

Prescribe the lowest effective dose (Recommendation 10)

“Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine chronic opioid therapy is appropriate.” (Recommendation 3.1)

Consider Impact of Opioid Pharmacokinetics on the Addiction Cycle

The “size of the reward” is based on two factors:
- The speed at which dopamine is released
- The amount of dopamine released, which depends on:
  - Potency of the opioid
  - Difference in opioid concentration at the receptor before and after drug administration

The rate of decline of opioid blood levels is associated with potential for abuse
- The sharper the decline, the stronger the motivation for another dose.

Craving after a period of abstinence (could be hours for some).
Guideline Recommendations for Monitoring Opioid Therapy for Chronic Pain

**CDC #9-10, VA #7, APS #5**

- **Check PDMP at least every 3 months**
- **Consider annual urine drug screen** (Recommendation 9 and 10)
- **Frequency based on risk:**
  - Ongoing, random urine drug testing (including appropriate confirmatory testing)
  - Checking PDMP
  - Monitoring for overdose potential and suicidality
  - Providing overdose education
  - Prescribing of naloxone (Recommendation 7)
- **Monitor urine drug screens periodically in patients at high risk of abuse** (Recommendation 5.2)

Match Monitoring to the Level of Risk of Aberrant Opioid Behaviors

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Low Risk (ORT 0-3)</th>
<th>Moderate Risk (ORT 4-7)</th>
<th>High Risk (ORT ≥ 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Visits</strong></td>
<td>Every 3 months</td>
<td>Every 2 to 4 weeks</td>
<td>Every 1-2 weeks</td>
</tr>
<tr>
<td><strong>Informed Consent or Opioid Agreement</strong></td>
<td>Informed Consent</td>
<td>Opioid Agreement</td>
<td>Opioid Agreement</td>
</tr>
<tr>
<td><strong>Random Urine Drug Screen</strong></td>
<td>Initial and Annual</td>
<td>Initial and every 3-6 months</td>
<td>Initial and monthly</td>
</tr>
<tr>
<td><strong>Prescription Database Check</strong></td>
<td>Initial and Annual</td>
<td>Initial and every 1-3 months</td>
<td>Initial and every month</td>
</tr>
<tr>
<td><strong>Pill Counts</strong></td>
<td>Annually</td>
<td>Every 6 months</td>
<td>Every 1-3 months</td>
</tr>
<tr>
<td><strong>Medication Choice</strong></td>
<td>Adequate analgesia, no restrictions</td>
<td>Limit Rapid-Onset Opioids</td>
<td>Limit Rapid-Onset and Short-Acting Opioids</td>
</tr>
<tr>
<td><strong>Family/Third Party Involvement</strong></td>
<td>Not necessary</td>
<td>Verify patient’s adherence and assess for environmental influences</td>
<td>Enlist family member/caregiver to manage medication</td>
</tr>
<tr>
<td><strong>Progress Toward Therapeutic Goals</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Risk vs. Benefit</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
</tbody>
</table>

Guideline Recommendations for 'Maximum' Opioid Dosage in Chronic Pain

**CDC #5, cont.**

- **...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) or more per day, and should avoid increasing to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day. (Recommendation 5)**

**VA #11-12**

- **...“Risks for overdose and death significantly increase at a range of 20-50 mg morphine equivalent daily dose.” (Recommendation 11)**

**APS #7**

- **“There is no standardized definition for what constitutes a ‘high’ dose. By panel consensus, a reasonable definition for high dose opioid therapy is >200 mg daily of oral morphine (or equivalent), based on maximum opioid doses studied in randomized trials and average opioid doses observed in observational studies.” (Discussion following recommendation 7)**
Nonfatal Opioid Overdose (and Overdose Death)

Increases with Dose

- 1.5x risk (1-19 MME/day)
- 6x risk (20-49 MME/day)
- 6.6x risk (50-99 MME/day)
- 10x risk (≥ 100 MME/day)
- ≥ 200 MME/day

↑Risk Across Doses:
- Concurrent Depression
- History or Active SUD
- Concurrent Sedative-Hypnotics and Benzodiazepines

Increases with Dose:

<table>
<thead>
<tr>
<th>Dose Range</th>
<th>Risk Factor</th>
<th>Relative to 1-19 MME/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-19 MME/day</td>
<td>1.5x risk</td>
<td></td>
</tr>
<tr>
<td>20-49 MME/day</td>
<td>6x risk</td>
<td></td>
</tr>
<tr>
<td>50-99 MME/day</td>
<td>6.6x risk</td>
<td></td>
</tr>
<tr>
<td>≥ 100 MME/day</td>
<td>10x risk</td>
<td></td>
</tr>
<tr>
<td>≥ 200 MME/day</td>
<td>~15x risk</td>
<td></td>
</tr>
</tbody>
</table>

Opioid Guidelines Against Concurrent Benzodiazepines (and CNS depressants)

| CDC #1 | VA #5 | APS
|--------|-------|-----|
| "Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently." (Recommendation 21) | "We recommend against the concurrent use of benzodiazepines and opioids" (Recommendation 5) | No Recommendation

Also advises:
- "In addition, the central nervous system depressants (e.g. muscle relaxants, hypnotics) can potentiate central nervous system depression associated with opioids"
- "We suggest not prescribing Z-drugs to patients who are on chronic opioids..."
- "Respiratory depression may occur when... opioids are combined with other drugs that are associated with respiratory depression or potentiate opioid-induced respiratory depression (such as benzodiazepines)"

Guideline Recommendations for Opioid Therapy for Acute Pain

| CDC #6 | VA #18 | APS
|--------|--------|-----|
| "Three days or less will often be sufficient; more than seven days will rarely be needed." (Recommendation 6) | If opioids are prescribed, use immediate release opioids and reassess "no later than 3-5 days to determine if adjustments or continuing opioid therapy is indicated." (Recommendation 28) | No recommendation

Reduce Opioid Left-overs!
Summary

- Limited evidence for efficacy of long term opioid therapy. However, considerable evidence for harm.
- Current guidelines agree that non-opioids/non-pharmacological therapy should be first and foremost in non cancer pain and non end of life pain.
- Before considering opioids, evaluate benefits/harms for individual patient and assess risk for opioid related misuse, abuse, and addiction.
- Set realistic expectations for opioid therapy, and monitor function (as a measure of opioid efficacy but also as a measure of opioid misuse, abuse, or addiction).
- Perform ongoing opioid stewardship activities/monitoring (UDT, PDMP, opioid agreements, pill counts, etc).
- Evaluate “total pain” before opioid initiation, when chemical coping is suspected, with vague descriptions of pain, and when pain increases despite increased analgesic use.
- Take back the opioids and the benzodiazepines (limit prescribing and dispose of leftovers!)

We can palliate pain while avoiding abuse

Additional Slides

For your reference

Look for Aberrant Drug-Related Behavior

- Definition: behaviors during treatment with a controlled substance that raise concern about addiction, abuse, or diversion

<table>
<thead>
<tr>
<th>More Serious</th>
<th>Less Serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selling prescription drugs</td>
<td>Aggressive complaining about need for higher doses</td>
</tr>
<tr>
<td>Forging prescriptions</td>
<td>Drug hoarding</td>
</tr>
<tr>
<td>Stealing or borrowing another person’s medications</td>
<td>Requesting specific drugs</td>
</tr>
<tr>
<td>Injecting oral formulation</td>
<td>Acquiring similar medications from other medical sources</td>
</tr>
<tr>
<td>Obtaining prescription drugs from nonmedical sources</td>
<td>Unapproved dose escalation 1-2 times</td>
</tr>
<tr>
<td>Concurrent use of illicit drugs</td>
<td>Unapproved use of medication to treat another symptom (i.e. insomnia, anxiety)</td>
</tr>
<tr>
<td>Multiple unapproved dose escalations</td>
<td>Reporting effects (i.e. euphoria) not intended by the clinician</td>
</tr>
<tr>
<td>Recurrent loss of prescription</td>
<td>Occasional impairment</td>
</tr>
</tbody>
</table>

Risk Factors for Opioid Abuse

- A Personal History of Substance Abuse
- A Family History of Substance Abuse
- Young Age
- A History of Pre-Adolescent Sexual Abuse
- Mental or Psychologic Disorder
- Poor Social Support
- Social Patterns of Drug Use
- Psychologic Stress

Avoiding opioid abuse will managing pain.

Risk Assessment Tools (perform at initial visit)

<table>
<thead>
<tr>
<th>Tool*</th>
<th># of items</th>
<th>Administered by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Risk Tool (ORT)</td>
<td>5</td>
<td>Patient</td>
</tr>
<tr>
<td>Screener &amp; Opioid Assessment for Patients with Pain (SOAPP)</td>
<td>24, 14, and 5 (3 versions)</td>
<td>Patient</td>
</tr>
<tr>
<td>Diagnosis, Intractability, Risk, &amp; Efficacy Score (DIRE)</td>
<td>7</td>
<td>Clinician</td>
</tr>
</tbody>
</table>

* Predicts risk of developing opioid-related aberrant behavior, but does NOT diagnosis addiction or opioid use disorder.

Urine Drug Tests (UDT): Know Your Metabolites

<table>
<thead>
<tr>
<th>Opioid Prescribed (or using non-medically)</th>
<th>Screening: Opioid Immunoassay</th>
<th>Confirmatory Test with GC/MS (*Metabolites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Positive</td>
<td>Hydromorphone*</td>
</tr>
<tr>
<td>Heroin</td>
<td>Positive</td>
<td>Metyrapone*</td>
</tr>
<tr>
<td>Codeine</td>
<td>Positive</td>
<td>Codeine</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Positive/negative (varies among assays)</td>
<td>Hydrocodone</td>
</tr>
<tr>
<td>Hydroxymorphone</td>
<td>Positive/negative (varies among assays)</td>
<td>Hydroxymorphone*</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Positive/negative (varies among assays)</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>Negative</td>
<td>Oxymorphone</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Negative</td>
<td>Fentanyl</td>
</tr>
<tr>
<td>Methadone</td>
<td>Negative</td>
<td>Methadone</td>
</tr>
</tbody>
</table>
FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use.

For Immediate Release
August 6, 2018

https://www.fda.gov/Drugs/ResourcesForYou/Consumer/PrescriptionDrugApproval/ucm565247.htm

Opioid Tapers courtesy of the VA/DoD

Speed of Taper

Determine speed of taper based on opioid dose, duration of therapy, type of opioid formulation, and risk factors such as co-occurring psychiatric, medical, and substance use conditions.

1. Higher opioid dose
2. Longer therapy duration
3. Higher risk of opioid dependence
4. Higher risk of withdrawal symptoms

Higher opioid dose: Non-adherence to treatment plan
Longer therapy duration: Higher risk of withdrawal symptoms
Higher risk of opioid dependence: Higher risk of withdrawal symptoms
Higher risk of withdrawal symptoms: Higher risk of opioid dependence

Opioid Left-overs: Take Back the Opioids

- Medication Take Back Programs
- DEA National Take Back Day: April 28, 2018 - 10AM to 2PM
  - Cub Foods Parking Lot 1512 S. West Ave Freeport, IL 61032
- DEA Authorized Collector:
  - https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1x1
    - OSF Healthcare System 5666 E. State Street, Rockford, IL
    - CVS 110 S. Alpine Rd, Rockford, IL
    - Walgreens 5065 Hononegah Rd, Roscoe, IL
- Dispose in Household Trash
  - Mix in unpalatable substance, place in sealable bag, and put in trash
- Flush in Toilet
- Walmart Dispose Rx

Opioid Disposal: FDA recommendations for flushing?

Opioids recommended for disposal by flushing by the FDA:
• All fentanyl products—transmucosal and transdermal
• All buprenorphine products—buccal/sublingual, transdermal (includes combination naloxone products)

Basically all opioid products are on the flush list except:
• Hydrocodone/acetaminophen
• Tramadol
• Codeine products


Opioid Disposal: the Walmart method

https://www.usatoday.com/story/money/2018/01/17/walmart‐takes‐opioid‐crisis‐offering‐free‐solution‐safely‐dispose‐unused‐meds/1039548001/

Opioid Safe Storage

• Remind patients that medications should be stored out of reach of children
• In a safe place—preferably locked

Per the CDC, prescribers should “discuss risks to household members and other individuals if opioids are intentionally or unintentionally shared with others for whom they are not prescribed, including the possibility that others might experience overdose at the same or at lower dosage than prescribed for the patient.”

https://www.end‐opioid‐epidemic.org/storage‐and‐disposal/
Supplemental Resources (referenced during talk also)

Guidelines (freely Available):

- 2009 American Pain Society/American Academy of Pain Medicine Chronic Pain Guideline
  (samples of informed consent, opioid agreement, OMT in appendix)
- VA/DoD Clinical Practice Guidelines
  [https://www.healthquality.va.gov/](https://www.healthquality.va.gov/)
- VA/DoD Clinical Practice Guidelines on Pain (includes tapering resource)
  [https://www.healthquality.va.gov/guidelines/Pain/cot/](https://www.healthquality.va.gov/guidelines/Pain/cot/)
- CDC Guideline for Prescribing Opioids for Chronic Pain
  [https://www.cdc.gov/drugoverdose/prescribing/guideline.html](https://www.cdc.gov/drugoverdose/prescribing/guideline.html)

Books:

  [http://americanpainsociety.org/education/principles‐of‐analgesic‐use](http://americanpainsociety.org/education/principles‐of‐analgesic‐use)
- Webster LR. Avoiding Opioid Abuse While Managing Pain, 2007 ($16)
  [https://www.amazon.com](https://www.amazon.com)

Webinars:

- Treating Pain and Avoiding Opioid Use Disorders:
- ER/LA Opioid REMS program from the American Society of Addiction Medicine
  [https://www.asam.org/education/resources/Opioid-Prescribing](https://www.asam.org/education/resources/Opioid-Prescribing)

Websites:

- Opioid Information from the FDA (news, approved abuse deterrent formulations, opioid REMS, disposal information)
  [https://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm337066.htm](https://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm337066.htm)
- Everything Pain Management! (and sign up for free monthly journal mailing)
  [https://www.practicalpainmanagement.com/](https://www.practicalpainmanagement.com/)

Illinois Prescription Drug Monitoring Program- 2018 Requirements

Mary Lynn Moody BSPharm
Assistant Dean, Business Development
Clinical Associate Professor
Department of Pharmacy Practice
University of Illinois at Chicago College of Pharmacy
Illinois Prescription Monitoring Program Overview

• The ILPMP receives Controlled Substance prescription data from retail pharmacies daily
• Allows Prescribers and Dispensers to view the historical data for current and prospective patients.

What is Public Act 100-0564?¹

• Amends the current Controlled Substance Act to address concerns of doctor shopping
• Effective January 1, 2018
• Prescribers must register with the Illinois Prescription Monitoring Program
• Should review ILPMP with initial prescription of Schedule II narcotic

PMP Registrations

• 64,638 PMP Users (as of March 30th, 2018)
  • 53,548 Prescribers
  • 11,090 Dispensers
• 27,696 registrations since December, 2017
Public Act 100-0564

• Each Prescriber (or their designee) shall document an attempt to access the PMP
• Assess the patient on initial prescription of a Schedule II narcotic (opioid)
• Documentation shall be in the patient’s medical record;
  • Exceptions:
    • Oncology Treatment
    • Palliative Care
    • 7-Day or less supply provided by an Emergency Department (treating an acute, traumatic medical condition)
Public Act 100-0564

• Dispensing pharmacies will receive a copy of the 3:3:1 reports sent to a prescriber
• 3 (or more) pharmacies, and/or 3 (or more) prescribers in a 1 month timeframe
• 786 cases in March 2018

Who can access the data contained in the ILPMP?

• Licensed prescribers and dispensers (pharmacists) of controlled substances AND THEIR DESIGNEES can view the ILPMP data for current and prospective patients only
• Law enforcement officers are allowed indirect access to prescription data during an active investigation

How many designees can I have and who can they be?

• Prescribers or dispensers may have up to 3 designees
• Only those listed below can serve as an authorized designee
  • registered nurse
  • licensed practical nurse
  • pharmacy technician
  • student pharmacist
  • certified medical assistant
• You must register your designees and agree to the terms and conditions
**Desigenees**

- Each designee shall have an individual account that must be linked to the prescriber or dispenser.
- PMP staff shall verify the following information about each designee:
  - license/certification number
  - employer’s phone number and address
  - work email address
  - If no work email is available, PMP staff shall contact the prescriber or dispenser to verify the designee.
- PMP shall send out a notice for the prescriber or dispenser to ensure continued employment of their designee.
- If the designee is no longer employed with the prescriber or dispenser, the prescriber or dispenser shall terminate the designee’s access to the PMP by locking the designee’s account or by notifying the PMP that the designee’s account should be locked.

**Can I consult with prescribers and other dispensers listed on the ILPMP without patient authorization?**

- According to HIPAA, this type of consultation is permitted because consultation is within the HIPAA definition of “treatment.”

**Why can’t I find prescriptions that I know were filled?**

- There could be several reasons for this:
  - Dispensing pharmacy is not properly reporting their prescription data
  - Search strategy-Names are ambiguous
Example of ambiguous name

• A prescription written by a prescriber for a patient with the first name of “Jennifer” but the pharmacy filled it as “Jenifer”
• Enter the first few defining letters of the name up to the point where ambiguity may begin. For example, enter “Jen” as the patient’s first name

PMPnow

• Allows seamless integration of PMP Data into the Electronic Health Record System
• No need to logon to PMP website
• 31 Connections-671 sites in Illinois, Missouri and Iowa
  • hospitals
  • clinics
  • pain clinics
  • FQHC

References

Improving Opioid Safety with Behavioral Economic Theory

Adam J. Bursua, PharmD, BCPS
Medication Safety and Quality Coordinator - UI Health Clinical Assistant Professor – UIC College of Pharmacy

Solutions to the Opioid Crisis

- Awareness campaigns
- Clinical care guidelines
- Prescribers education
- Utilizing PMPs
- Screening for and treating opioid use disorders

All of these interventions rely on traditional theories of decision making behavior:
- Rationale operators making rational choices

The “Nudge” Theory of Decision Making

- Traditional economic theory:
  - Rational beings making rational decisions

- “Nudge theory”:
  - People often choose what is easiest over what is wisest
What is a “Nudge”?

• A strategy to alter “people’s behavior in a predictable way without forbidding any options or significantly changing their economic incentives.”

• “Nudges are not mandates. Nudges do not impose material costs but instead alter the underlying choice architecture”

- Thaler & Sunstein

A Different Crisis

• Fueled by switch to defined contribution plans from defined benefit

• Workers don’t enroll in 401k programs at high enough rates

• Even when they do enroll, they don’t save enough

Nudge Theory - Applied
Nudge Theory - Applied

• Free flu shots are being offered
  • Email 1:
    • Your appointment for influenza vaccination has been scheduled for 10/01/2018 at 2pm
    • To change or modify your appointment, click here
  • Email 2:
    • To schedule an appointment for your vaccine click here

36% higher vaccination rates for E-mail 1 group

What About Opioid Prescribing?

“Rational beings making rational decisions.”

“People often choose what is easiest over what is wisest.”

Traditional solutions
Develop guidelines
Educate prescribers
Awareness campaign
Academic detailing

Nudge solution
Modify choice architecture to nudge prescribers toward the desired behavior
Opioid Prescribing Choice Architecture

- 1 tab, po, q4H, prn for pain
- 1 tab, po, q4H, prn for pain
- 2 tab, po, q6H, prn for pain
- 2 tab, po, q6H, prn for pain

Nudging Theory - Applied

- 1 tab, po, q6H, prn for pain
- 2 tab, po, q6H, prn for pain
- 2 tab, po, q6H, prn for pain

Before
Q4 hour orders = 33.1%
2 tab orders = 3.85%
3 day supply = 5.79%

Total tablets written/month = 88380

After
Q4 hour orders = 11.7%
2 tab orders = 2.46%
3 day supply = 11.6%

Total tablets written/month = 67323

On average ~ 21,000 thousand fewer tablets prescribed each month
Medication Event Case Report

A patient who was receiving an opioid for pain was found unable to be aroused. Naloxone was given, and the patient was successfully rescued.

Progress notes:
"Pain: Morphine 2mg Q2 as needed"

Order:
Morphine, IV Push, 2mg, Q2 hours
Nudged...the wrong way

- During the RCA, it was noted that one of the order sentence defaults was:
  
  Morphine, IV Push, 2mg, Q2 hours

Use Default Selections to Your Advantage

- People tend to exhibit inertia
- Expectation that defaults are screened by experts
- Defaults can then serve as reference points
- Defaults normalize behavior

Target the System
Target the System

Learning From Failure
Using Naloxone Utilization Data to Identify Improvement Opportunities

Naloxone Case Review
• Each case of naloxone administration is analyzed
  • Patient information
    • Opioid risk factors
    • Encounter characteristics (e.g., surgery vs. medical)
  • Medication information
    • Opioid(s) used
    • Concomitant sedatives
Common Themes

- Morphine use in renal dysfunction
- Opioid use for mild pain indications
- Substandard sedation assessment documentation

Modifying Choice Architecture

Opioid Use for Mild Pain
Questions?

Contact:
Adam Bursua, abursu1@uic.edu
Panel Discussion

Any ideas??? What’s our plan?

• Numerous local members convened to determine ideal location to initiate strategies to combat current opioid epidemic.

• Participants identified a number of clinic-wide approaches to address the issue.

• Region-wide tactics were developed attempting to tackle problem from a community standpoint.

• End result is to provide multiple, adaptable approaches to control current epidemic.

UI Health L.P. Johnson Family Health Center

• Family Medicine Clinic
  • 21 resident physicians
  • 10 attending physicians
  • 4 registered nurses
  • 1 pharmacist

• Controlled Substance Policy
  • Five key components
  • Personnel accountability
  • Pre and post assessments

1. Risk Assessment
2. Controlled Substance Agreement
3. Prescribing
4. Documentation
5. Monitoring
Regional Strategies

- Single-day, interprofessional Opioid Summit held at the Rockford Campus
- UIC drug take-back partnership with Keep Northern Illinois Beautiful
- Improved relationship with Winnebago County Health Department and alignment of initiatives
- Development of student-driven opioid crisis advertising and education
- Continuing education programs
The Opioid Crisis: Effective Strategies to Turn the Tide

Post Test Questions pertain to the following case:

Jane is a 42 year old female with chronic back pain from a motor vehicle accident 5 years ago and painful diabetic neuropathy. You are seeing her for the first time as her PCP retired.

- Comorbid conditions include anxiety, depression, diabetes, insomnia, current smoker of 1 pack/day, and a remote history of alcohol use disorder
- Denies history of sexual or domestic abuse
- Family history of alcoholism
- Currently going through divorce from husband of 15 years
- Pertinent prescriptions include:
  - Oxycodone/acetaminophen 5 mg/325 mg 1 tablet q 4 hours as needed for pain
  - Gabapentin 300 mg TID
  - Lorazepam 1 mg TID
  - Cyclobenzaprine 5 mg BiD
  - Zolpidem 5mg nightly
- Review of the prescription drug monitoring program reveals several early refills over the last three months.
- Today, she reports increasing diffuse pain that does not appear consistent with physical examination
- She reports that taking 2 tablets 5 times daily has really helped her pain, and she is wondering if her prescription could be increased

1. Which term best describes Jane’s recent oxycodone/acetaminophen use?
   A. Tolerance
   B. Addiction
   C. Pseudoaddiction
   D. Chemical Coping
   E. Diversion

2. How would you stratify Jane’s risk of aberrant opioid taking behavior (using the Opioid Risk Tool)?
   A. Very Low
   B. Low
   C. Moderate
   D. High
   E. Very High
3. Which of the following can increase Jane’s risk of respiratory depression from opioids?

A. Lorazepam
B. Cyclobenzaprine
C. Zolpidem
D. Gabapentin
E. All of the above