COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Exploring Strategies to Prevent Opioid Morbidity and Mortality

Compass, Telligen, IPRO and Alliant

Joint Hospital Quality Improvement Contract (HQIC) Learning and Action Network

March 8, 2022

We will get started shortly!

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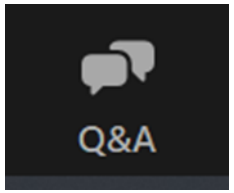

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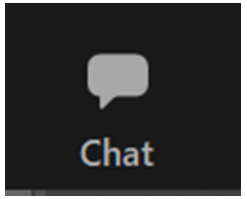

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Continuing Medical Education (CME)

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Agenda

- Welcome and Introductions
- Exploring Strategies to Prevent Opioid Morbidity and Mortality
- The Rural Perspective: Compass Care at Coteau des Prairies
- Q&A
- Tools and Resources
- Leaving in Action
- Upcoming Events

Presenter

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Stader Opioid Consultants

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Opioid Stewardship Best Practices

Exploring Strategies to Prevent Opioid Morbidity and Mortality

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STADER OPIOID CONSULTING

Conflict of Interest Disclosure

Rachael Duncan has no conflicts of interest, financial or otherwise, to disclose.

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Abbreviation Glossary

- ORADEs: Opioid-related adverse drug events
- ALTO: Alternatives to opioids
- DHHS: Department of Health and Human Services
- CERTA: Channels, enzymes, and receptors for targeted analgesia
- COX: Cyclooxygenase
- MOP: Mu-opioid receptor
- DOP: Delta-opioid receptor
- KOP: Kappa-opioid receptor
- GABA: Gamma-aminobutyric acid
- DDI: Drug-drug interactions
- OTC: Over the counter
- MME: Morphine milligram equivalents
- IV: Intravenous
- LA: Long-acting
- ER: Extended-release
- IR: Immediate-release
- ICD: International classification of diseases
- OUD: Opioid use disorder
- SUD: Substance use disorder
- ACEs: Adverse childhood experiences
- CV: Cardiovascular
- DM: Diabetes mellitus
- NJEM: New England Journal of Medicine
- JAMA: Journal of American Medical Association
- Rx: Prescription
- APAP: Acetaminophen
- NSAID: Nonsteroidal anti-inflammatory drugs

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Learning Objectives

- Discuss measures to reduce, recognize and manage opioid-related adverse drug events
- Identify strategies to prevent opioid mortality at hospital discharge and beyond
- Describe the role of health equity in the opioid epidemic and how to decrease health disparities

Four Pillars of Care

How can we address the opioid epidemic in your hospital?

Limit Opioids and ORADEs

ALTO Approach to Pain Control

Harm Reduction + Naloxone

Treatment of Addicted Patients and Referral

Question:

What percentage of admitted patients receive an opioid at some point during their hospital stay?

A. 5%

B. 20%

C. 35%

D. 50%

Hospital-Based Opioid Usage

> 50% of all inpatients are exposed to opioids at some point during their hospitalization

- > 95% of surgical patients receive opioids

ORADE = opioid-related adverse drug event

- Correlate to morbidity, mortality, increased length of stay and costs

J Hosp Med. 2014;9:73-81.
Pharmacotherapy. 2013;33:383-391.
Am J Health Syst Pharm. 2014;71:1556-1565.

ORADEs: Common vs Serious

Common Side Effects	Serious Side Effects of Chronic Opioid Use
Nausea / vomiting Constipation Pruritus Euphoria Respiratory depression Light-headedness Dry mouth	Cardiac abnormalities, including prolonged QTc and torsades de pointes Sudden cardiac death with the concomitant use of benzodiazepines and methadone Hormonal disruptions, including ↓ testosterone in males ↓ luteinizing hormone, follicle-stimulating hormone and fertility in women Musculoskeletal compromise, including ↑ risk of osteoporosis Immunosuppression Inhibition of cellular immunity via delta and kappa receptors Hyperalgesia (upregulation of receptors and increased tolerance) Sleep disturbances (shortened deep sleep cycle) Delayed / inhibited gastric emptying, ↑ sphincter tone, blockade or peristalsis

Martin PR et al. New York: McGraw Hill; 2000: 233-259.

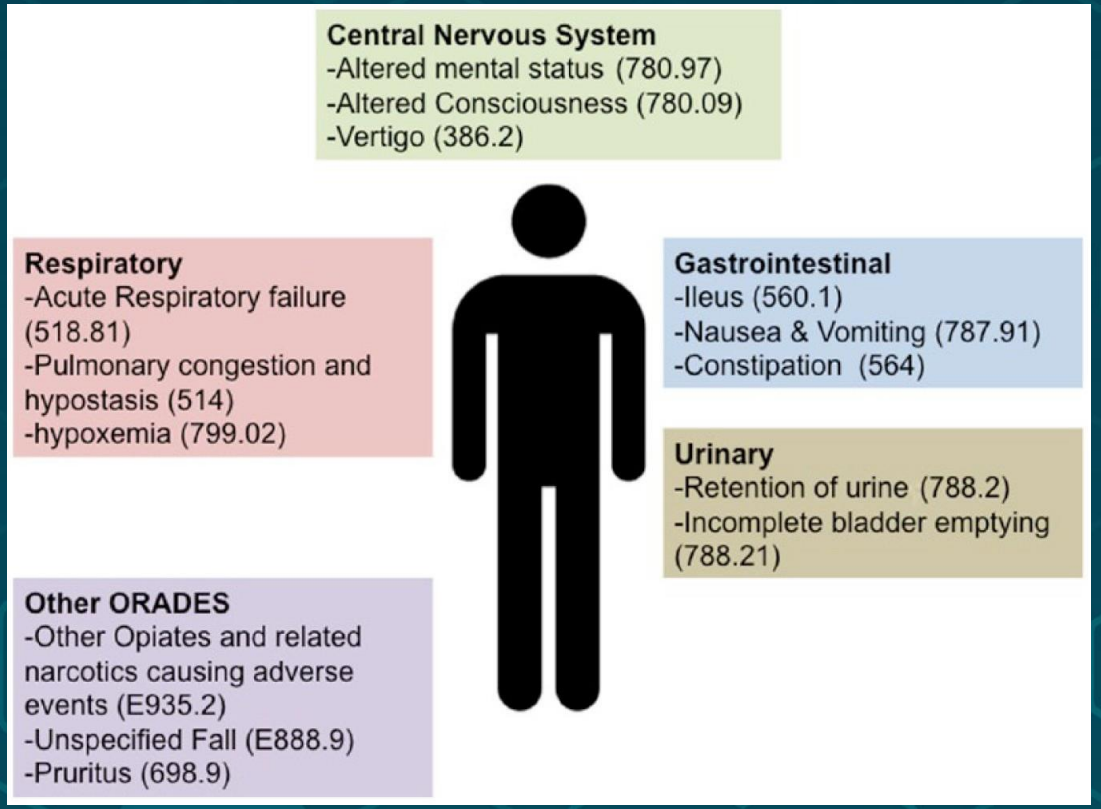
ORADEs

Heterogeneous group of complications that affect numerous organ systems, making them difficult to quantify in a reliable manner

- Querying naloxone administration as a surrogate marker provides data on only the most severe ORADEs

Opioids as a class are among the most commonly associated with inpatient medication errors

In 2014, DHHS called for better systems to monitor ORADEs to improve health care quality and reduce complications



Opioid Morbidity

and ORADEs

Reducing Opioid Morbidity

Reduce, recognize and manage ORADEs in the hospital

1) Limit inpatient opioid usage

- Rely on multimodal and nonopioid analgesics (the "ALTO" approach)

2) Screen patients

- Risk of developing an ORADE

3) Know your opioids

4) Monitor for and manage ORADEs when they occur

1) Limiting Opioids in the Hospital

- Reserve opioids for severe pain, rescue therapy, or if nonopioid therapies are contraindicated
- Screen for abuse potential and medical comorbidities; use judiciously
- Have a "no" list that everyone agrees on and supports = uncomplicated back pain, dental pain, cyclic vomiting, HA/migraine
- When prescribing opioids on discharge, have a pill/day limit = 3-7 days, depending on indication
- Don't replace lost or stolen opioid prescriptions once patient discharged

Myth: Opioids are just more effective

Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial.

Table 2. Numerical Rating Scale (NRS) Pain Scores and Decline in Pain Scores by Treatment Group

	NRS Pain Score, Mean (95% CI)[a]				
	Ibuprofen and Acetaminophen[b]	Oxycodone and Acetaminophen[c]	Hydrocodone and Acetaminophen[d]	Codeine and Acetaminophen[e]	*P* Value[f]
No. of patients[g]	101	104	103	103	
Primary end point: decline in score to 2 h	4.3 (3.6 to 4.9)	4.4 (3.7 to 5.0)	3.5 (2.9 to 4.2)	3.9 (3.2 to 4.5)	.053
Baseline score	8.9 (8.5 to 9.2)	8.7 (8.3 to 9.0)	8.6 (8.3 to 9.0)	8.6 (8.2 to 8.9)	.47
Score at 1 h	5.9 (5.3 to 6.6)	5.5 (4.9 to 6.2)	6.2 (5.6 to 6.9)	5.9 (5.2 to 6.5)	.25
Score at 2 h	4.6 (3.9 to 5.3)	4.3 (3.6 to 5.0)	5.1 (4.5 to 5.8)	4.7 (4.0 to 5.4)	.13
Decline in score to 1 h	2.9 (2.4 to 3.5)	3.1 (2.6 to 3.7)	2.4 (1.8 to 3.0)	2.7 (2.1 to 3.3)	.13

CONCLUSION: no statistically significant or clinically important differences in pain reduction at 2 hours among single-dose treatment with ibuprofen and acetaminophen or with 3 different opioid and acetaminophen combination analgesics.

Source: JAMA. 2017 Nov 7;318(17):1661-1667. doi: 10.1001/jama.2017.16190.

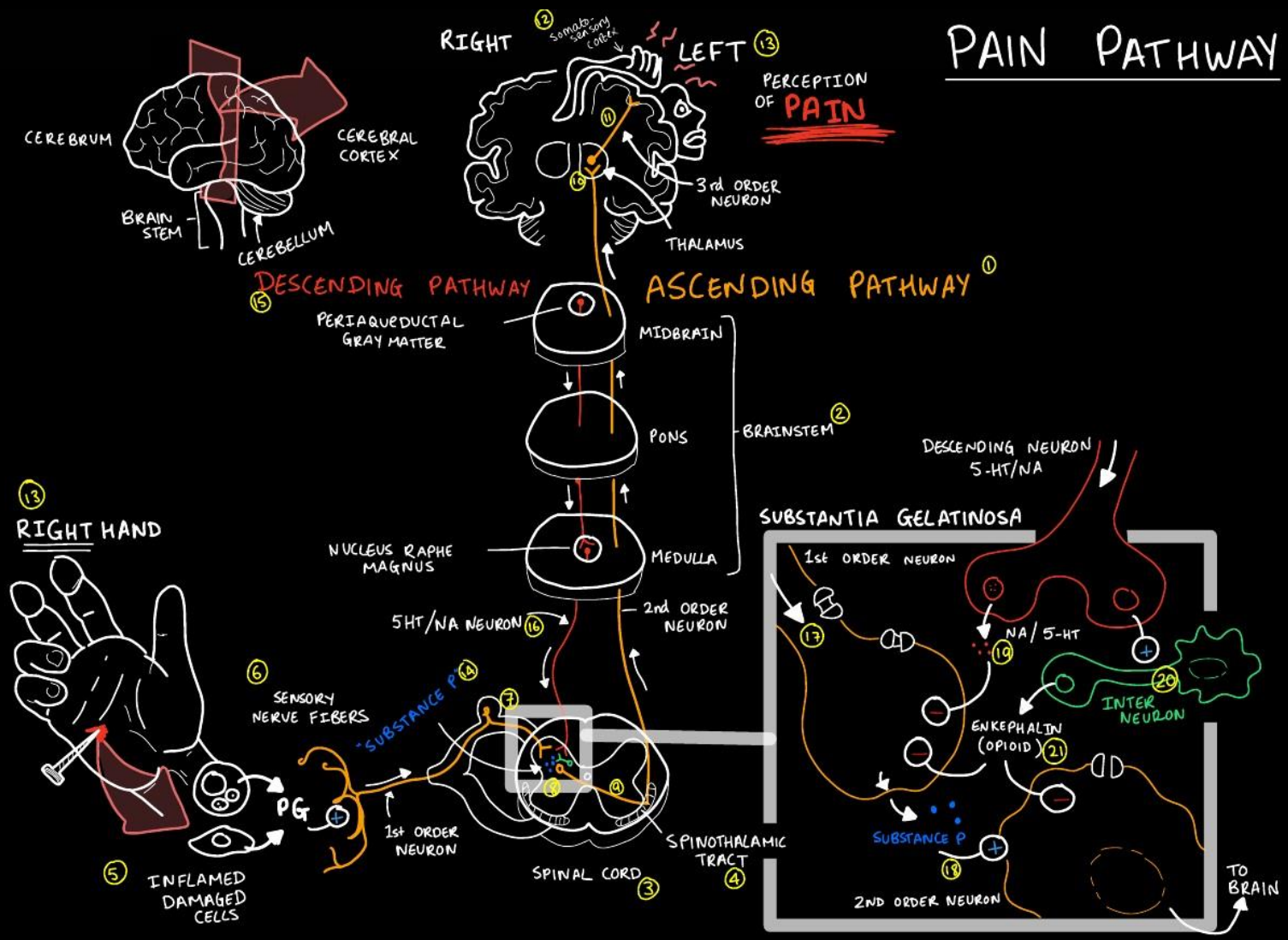
ALTO Approach

ALTO = alternatives to opioids

1. Consider nonopioid medications first
2. Consider several agents for multimodal pain control > monotherapies
3. Use opioids as rescue therapy
4. Discuss realistic, functional pain management goals

CERTA

Channels, Enzymes and Receptors for Targeted Analgesia



Examples

Channels

- Sodium (lidocaine)
- Calcium (gabapentin)

Enzymes

- COX 1,2,3 (NSAIDs)
- Amine reuptake inhibitors (duloxetine, venlafaxine, amitriptyline)

Receptors

- MOP/DOP/KOP (opioids)
- NMDA (ketamine/magnesium)
- GABA (gabapentin/pregabalin/ sodium valproate)
- 5HT1-4 (haloperidol/ondansetron/ metoclopramide)
- D1-2 (haloperidol/droperidol/ prochlorperazine)

Pain Pathways

First-Line Agents

- Centered around evidence-based nonopioid options
- What has patient already tried?
- Worked/not worked in past?
- Contraindications?
- DDIs?

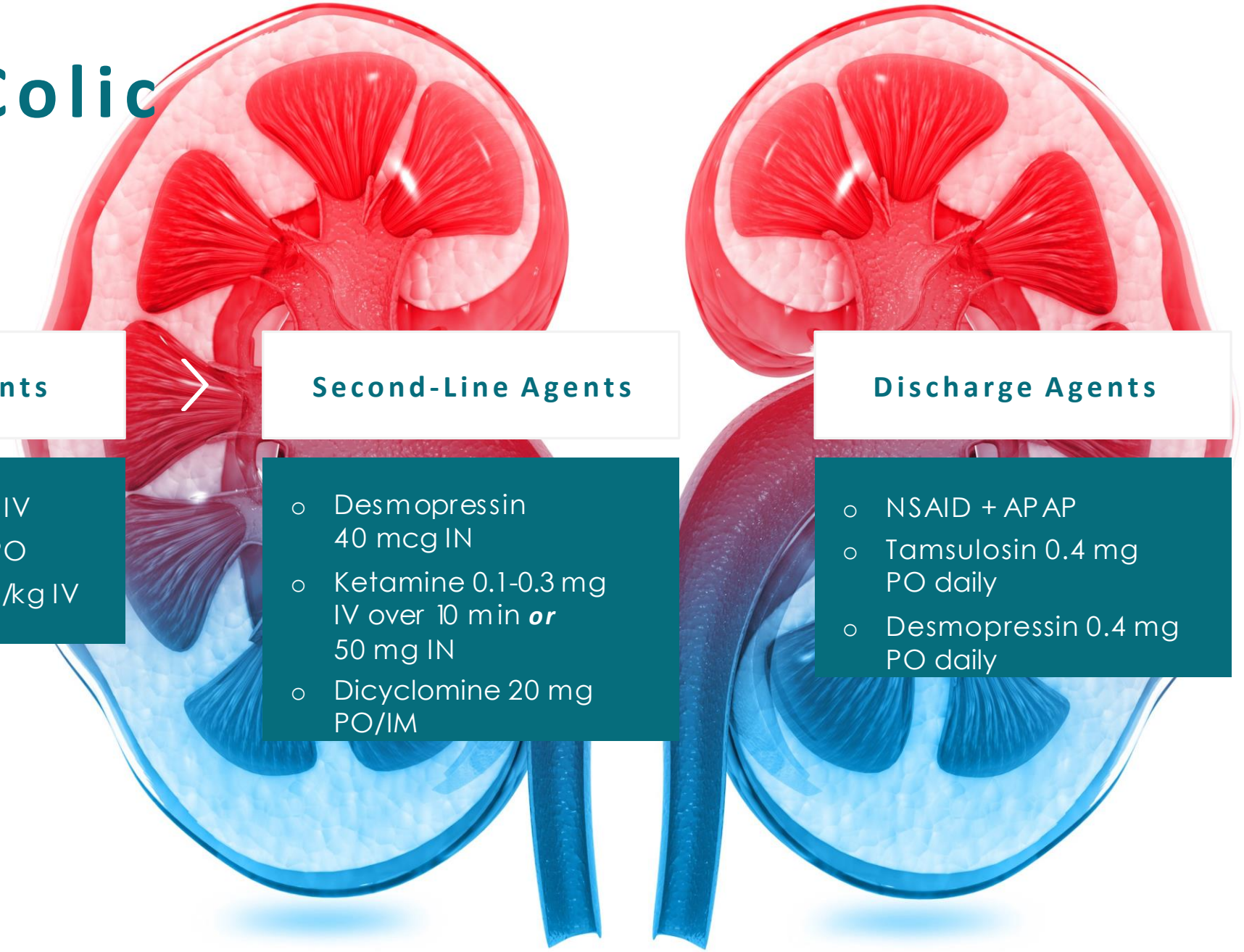
Second-Line Agents

Discharge

- What nonopioid therapy options can be transitioned to outpatient care?
- Prescription and OTC options
- Nonpharmacologic options
- Patient counseling

Prevention

Renal Colic



First-Line Agents

- Ketorolac 10 mg IV
- APAP 1000 mg PO
- Lidocaine 1.5 mg/kg IV over 10 min

Second-Line Agents

- Desmopressin 40 mcg IN
- Ketamine 0.1-0.3 mg IV over 10 min ***or*** 50 mg IN
- Dicyclomine 20 mg PO/IM

Discharge Agents

- NSAID + APAP
- Tamsulosin 0.4 mg PO daily
- Desmopressin 0.4 mg PO daily

2) Screening Patients: ORADE Risk

Opioid-Related Factors:

Dosage (MME > 50, 90)

Route (IV vs enteral)

Frequency

Half-life (LA/ER vs IR)

Duration

Patient-Related Factors:

Pulmonary disease

Cardiac disease

Renal or hepatic disease

Elderly

Concomitant medications

Prior opioid exposure

Source: Pharmacotherapy. 2022 Feb 1. doi: 10.1002/phar.2666.

Question:

Which opioids are most likely to contribute to serotonin syndrome?

A. Hydrocodone/oxycodone

B. Morphine/codeine

C. Tramadol/tapentadol

D. Fentanyl

3) Opioid Selection

Constipation Worse: Better:	Methadone Buprenorphine TD	Morphine Fentanyl TD	
Renal Disease Avoid: Safer:	Morphine Buprenorphine	Codeine Methadone	(also avoid NSAIDs) Fentanyl
Hepatic Disease Avoid: Safer:	Methadone Fentanyl	Codeine	(also avoid NSAIDs, APAP)
Serotonin syndrome risk more likely:	Tramadol	Tapentadol	
Depression less likely:	Buprenorphine		
Respiratory depression less significant:	Buprenorphine	Tapentadol	
Addiction liability lower:	Buprenorphine Methadone	Tapentadol Methadone	Tramadol Abuse deterrent forms
Hypogonadism less likely:	Buprenorphine	Tapentadol	

Pain Pract. 2008; 8(4): 287-313.
Anaesth Intensive Care. 2005; 33(3): 311-22.

4) Recognizing ORADEs

- Education to staff
- Hospital-wide reporting systems
- Surveillance systems
- Surrogate markers
    - -Naloxone administration
    - -ICD-9/10 codes that correlate

4) ORADE Management

Change the opioid therapy:

- Transition to nonopioid therapy
- Transition to a different opioid therapy
- Reduce or taper opioid therapy to a safer MME/day

*Prescribe/dispense naloxone at discharge

Opioid Mortality

at hospital discharge and beyond

Reducing Opioid Mortality

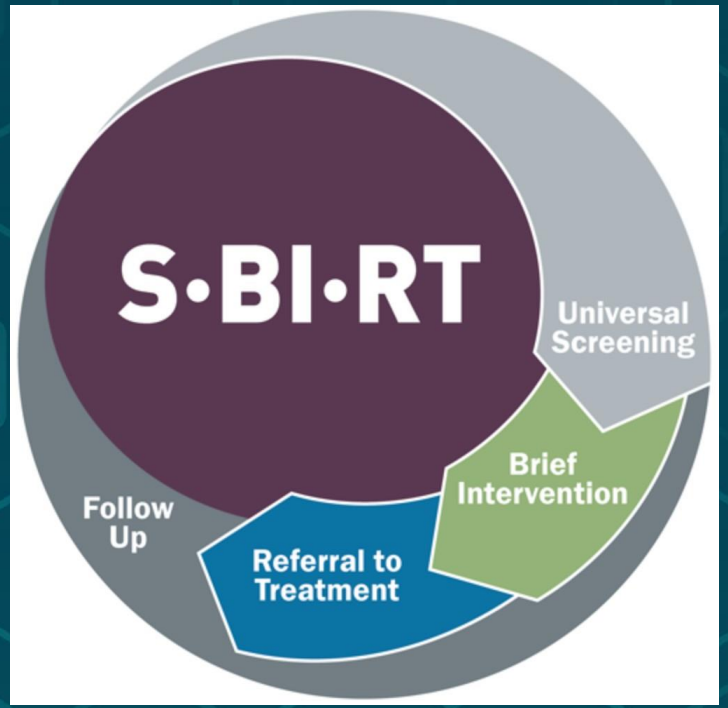
Preventing and reducing opioid mortality at hospital discharge and beyond

1. Screen patients for risk of OUD and overdose
2. Reduce MMEs at discharge
3. Stop dangerous coprescribing
4. Take-home naloxone program + overdose education
5. Buprenorphine induction while in ED or inpatient
6. Transition to outpatient OUD treatment
7. Educate patients and caregivers on risks of unsecured opioids and provide instructions on proper storage and disposal

1) Screen Patient for OUD

Patient-related factors associated with opioid nonmedical use and development of OUD

- Personal/family hx of SUD (esp OUD)
- Personal hx of psychiatric or mood problems
- Personal hx of trauma (ACEs)
- Male gender
- Younger age



Solution = systematically screen for OUD-related factors when considering discharge opioid rx (example: screening portion of the SBIRT)

Source: Subst Abuse Rehabil. 2015;6:83-91.

1) Screen Patients for Overdose

JAMA Network Open

Original Investigation | Substance Use and Addiction

Factors Associated With Opioid Overdose After an Initial Opioid Prescription

Scott G. Weiner, MD, MPH; Sanae El Ibrahimi, PhD; Michelle A. Hendricks, PhD; Sara E. Hallvik, MPH; Christi Hildebran, LMSW; Michael A. Fischer, MD; Roger D. Weiss, MD; Edward W. Boyer, MD, PhD; Peter W. Kreiner, PhD; Dagan A. Wright, PhD, MSPH; Diana P. Flores, BS; Grant A. Ritter, PhD

Solution = systematically screen for overdose-related factors when considering discharge opioid rx

- Patient-level factors: age >/= 75 or </= 24; gender = male
- Race and ethnicity: Caucasian, African American
- Insurance type: Medicaid, Medicare, dual eligibility
- Medical and psychiatric comorbidities: 3+ comorbidities (CV disease, DM, cancer); dx of depression or previous SUD
- Prescription-level characteristics: initial prescriptions for oxycodone or tramadol

Source: JAMA Netw Open. 2022; 5(1): e21345691.

2) Reduce MMEs at Discharge

Dose-Dependent Risk of Overdose:

- 2x Risk: MME = 50/day ➔ MME = 99/day
- 9x Risk: MME >/= 100/day vs MME </= 20/day

Duration-Dependent Risk:

- Each additional week of opioid use has been associated with a 20% increased risk for the development of an OUD or occurrence of an overdose

Solution = reduce MMEs prescribed at hospital discharge

Source:
JAMA Netw Open. 2019; 2(3): e190665.
Clin J Pain. 2014; 30(7): 557-64.
BMJ 2018; 360: j5790.

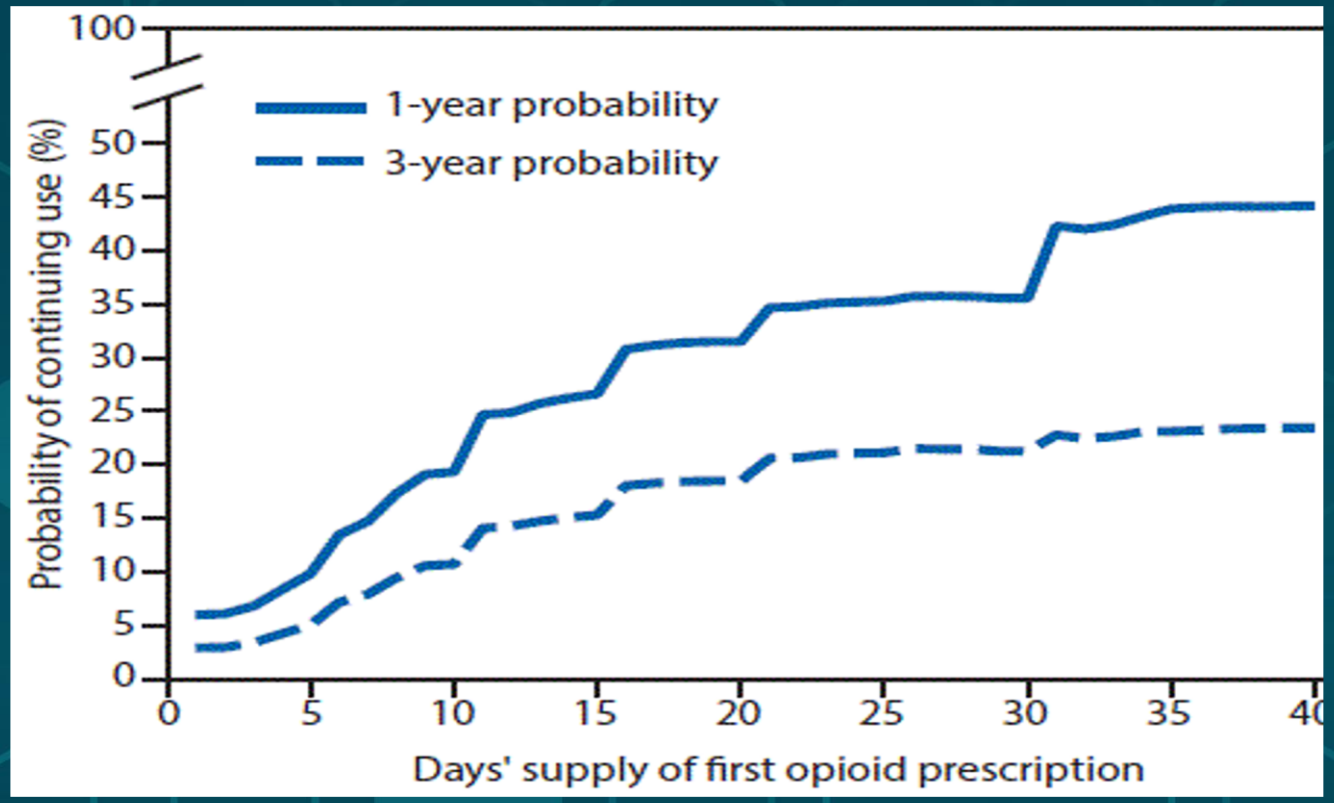
2) Reduce MMEs at Discharge

Duration and Continued Use

- 1- and 3- year probability of continued use increases with each additional day of medication supplied, **starting with the 3rd day**
- Sharpest increases in chronic opioid use after the 5th and 31st day of therapy

Solution = reduce opioid rx duration at hospital discharge

Myth: Short term opioids = no risk



https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

Source: CDC Weekly 2017; 66(10): 265-9.

Question:

Compared to opioid users who do not use a concurrent benzodiazepine, concurrent use of both drugs is associated with what % increased risk of ED visit or inpatient admission?

A. 10%

B. 25%

C. 50%

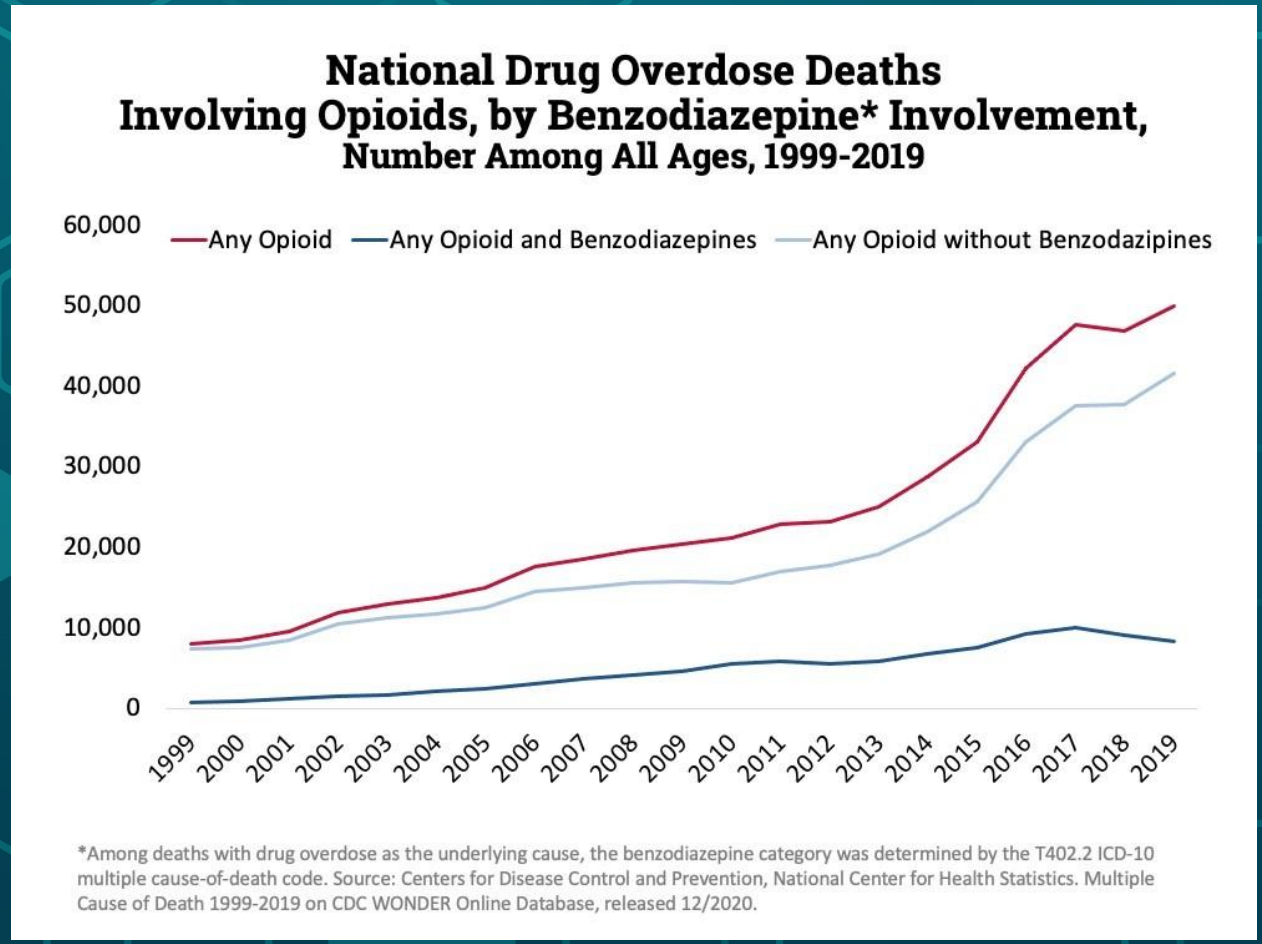
D. 100%

3) Stop Dangerous Coprescribing

Evidence:

- Compared with opioid users who did *not* use benzos, concurrent use of both drugs increased risk of ED visit or inpatient admission for opioid overdose (OR 2.14)
- 16% of overdose deaths in 2019 involving opioids also involved a benzo

Solution = limit coprescription of opioids and benzodiazepines at discharge



Source: BMJ 2017; 356:j760.

4) Safe Storage and Disposal

Evidence:

- 95% of medication-related ED visits among children </=5 are due to a child getting into unsecured medicine
- 3.6% of children age 12-17 report misusing opioids over the past year; vast majority of misuse is due to rx opioids
- 53% of prescription opioid users report getting pills from friends and family

Solution = use patient-facing safe storage education material at discharge; become a safe disposal site

Source:
U.S. Dept HHS Off Adol Health: Opioids and Adolescents.
Safe Kids Worldwide. 2016.
SAMHSA.

Question:

What % of at-risk patients will fill a prescription for naloxone?

A. 1.6%

B. 5%

C. 24.3%

D. 33%

5) Take-Home Naloxone Programs

Take-home naloxone program (THNP):
Why not just write a discharge rx?

Evidence:

- Data shows that < 2% of patients at risk of an opioid overdose actually fill their naloxone prescription
- Patients who receive naloxone have 63% fewer opioid-related ED visits at 1year

Solution = implement a THNP in your ED and hospital; until then, coprescribe naloxone.

Source:
Ann Emerg Med 2017; 70(4): S101.
Ann Intern Med 2016. 165(4): 245-52.

6) Buprenorphine for OUD

Evidence:

- Studies show that 37-91% of individuals initiating treatment with medication for OUD are retained in treatment at the 12-month f/u
- Swedish 2003 study compared patients maintained on buprenorphine 16 mg daily vs control group; all patients received psychosocial support

  -Treatment failure rate for placebo 100% vs 25% for buprenorphine

  -Of patients not retained in treatment, mortality rate = 20%

Solution = implement a buprenorphine induction program in your ED and hospital

Source: Lancet Lond Engl 2003; 361(9358): 662-8.

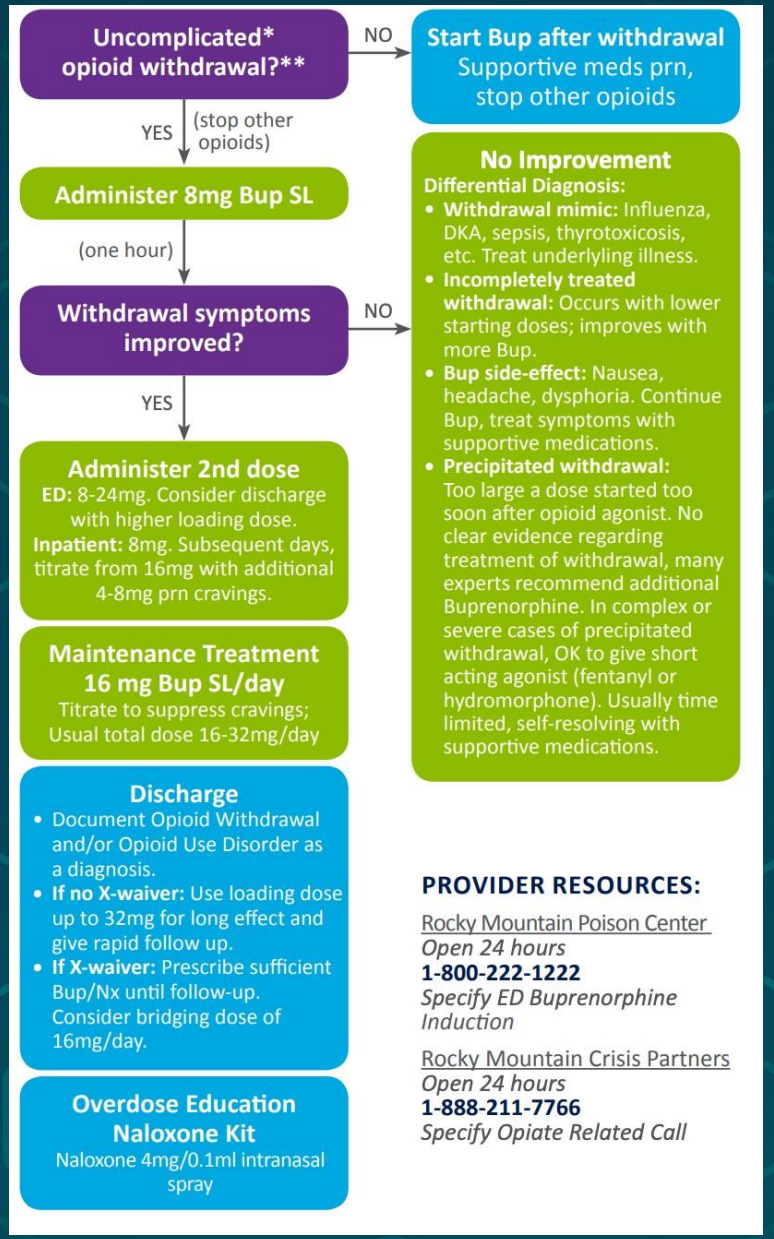
6) Buprenorphine Induction

Evidence:

Buprenorphine induction in the ED:

- 30-day treatment retention 2x higher in group that received buprenorphine induction in addition to SBIRT vs SBIRT alone
- Cost analysis found significantly lower patient time costs in buprenorphine group ($97 vs $322, $p < 0.001$)

Solution = implement a buprenorphine induction program in your ED and hospital



Source: JAMA. 2015; 313(16): 1636-44.

Question:

Of patients seen in the ED for an opioid overdose, what % will access OUD medications or treatment within 3 months of their ED visit?

A. 16%

B. 25%

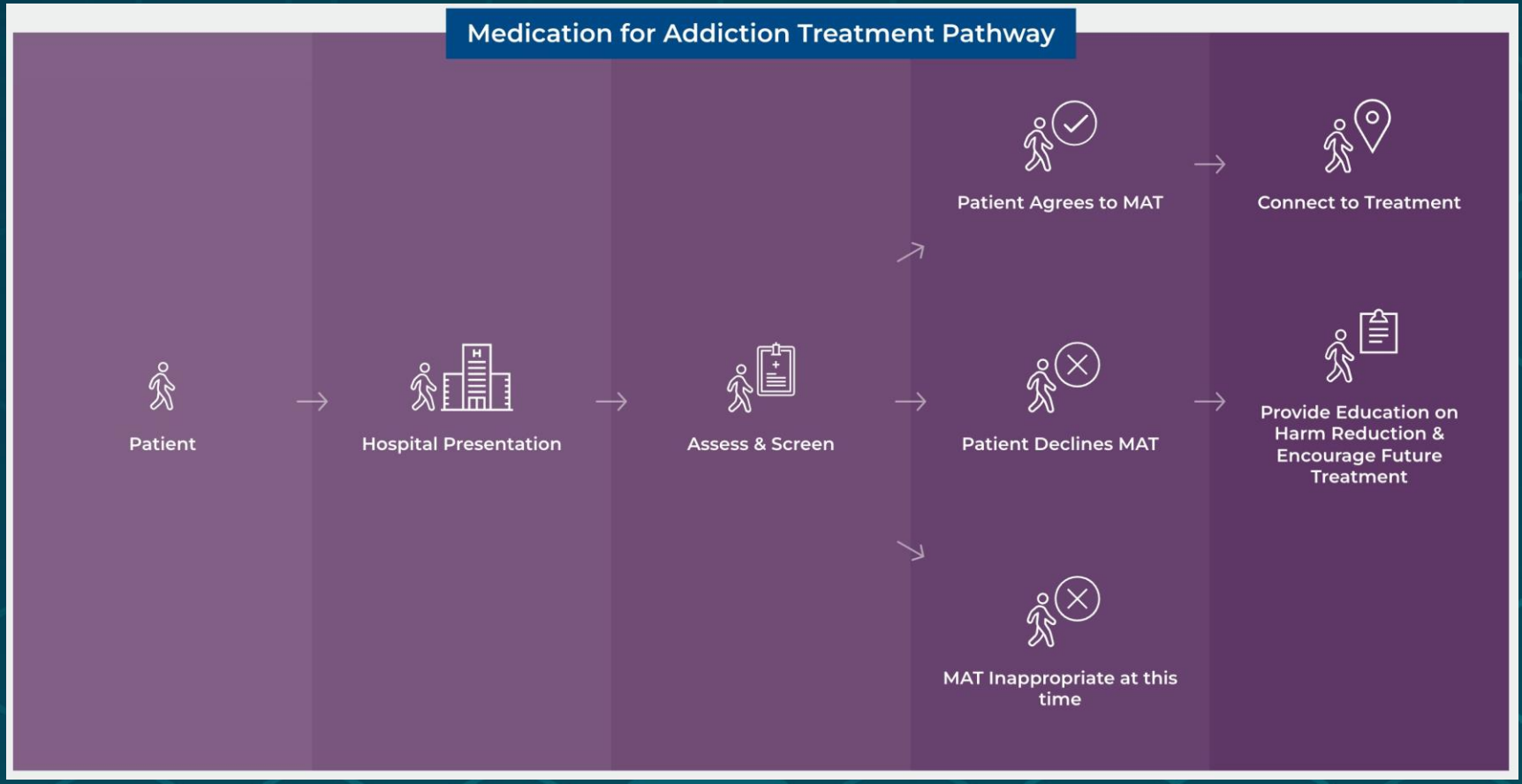
C. 36%

D. 50%

7) Connecting to Treatment

Evidence:

- Of 6,500 commercially insured patients who visited the ED for an opioid overdose, only 16% accessed OUD medications or another form of treatment within 3 months of ED visit



Solution = implement a discharge referral program for OUD treatment.

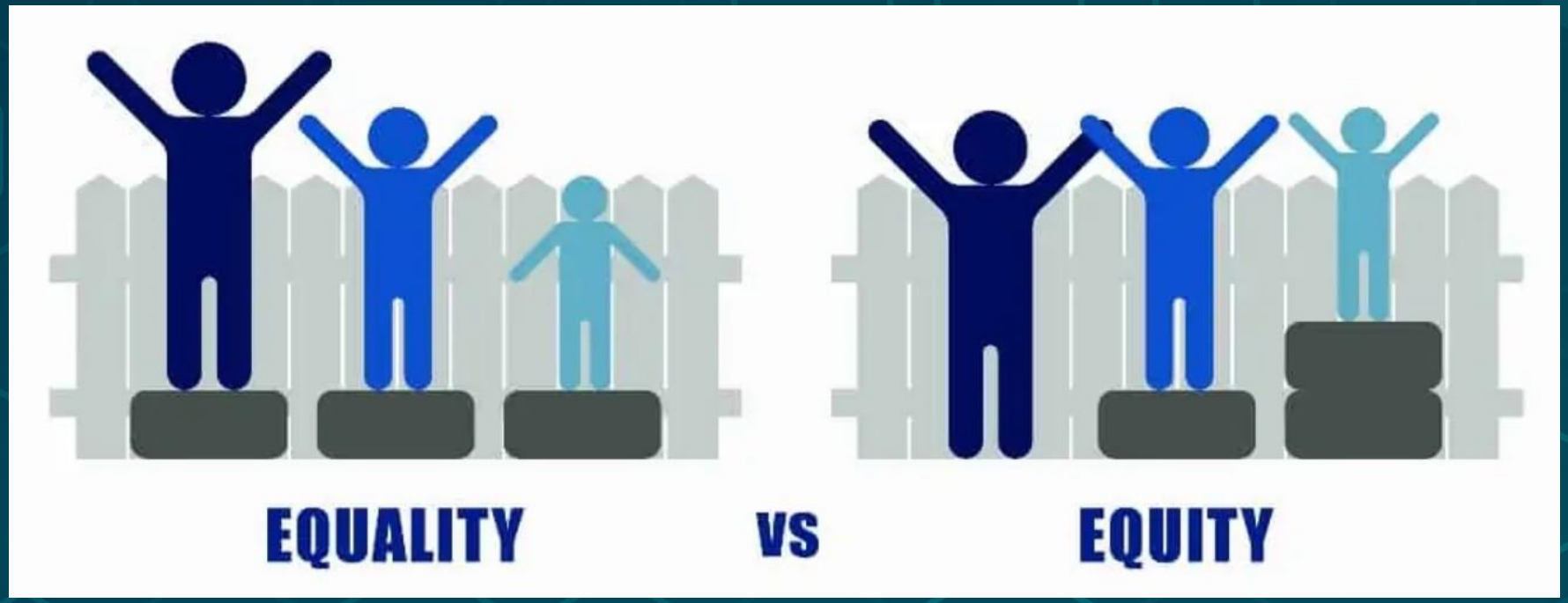
JAMA 2020; 3(5): e205852.

Health Equity

and the Opioid Epidemic

Health Equity

- Is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."



Health Inequities

Reflected in differences in:

- Length of life
- Quality of life
- Rates of disease, disability, and death
- Severity of disease
- Access to treatment

Social determinants:

- Race/ethnicity
- Gender/sexual orientation
- Location/community
- Economic stability
- Education
- Healthcare system

Goal = achieve health equity by eliminating health disparities and achieving optimal health for all patients.

Health Inequality in Opioid Prescribing

Evidence: NJEM 2021 Publication

- Among 310 racially diverse health systems
- The annual prevalence of opioid receipt differed little between race
- The mean annual opioid dose was **36% lower** among Black patients than among White patients

Solution = further research and exploration of the causes and consequences of these differences, along with provider education

Disparities in Opioid Overdose Deaths

Evidence: HEALing Communities Study (HCS)

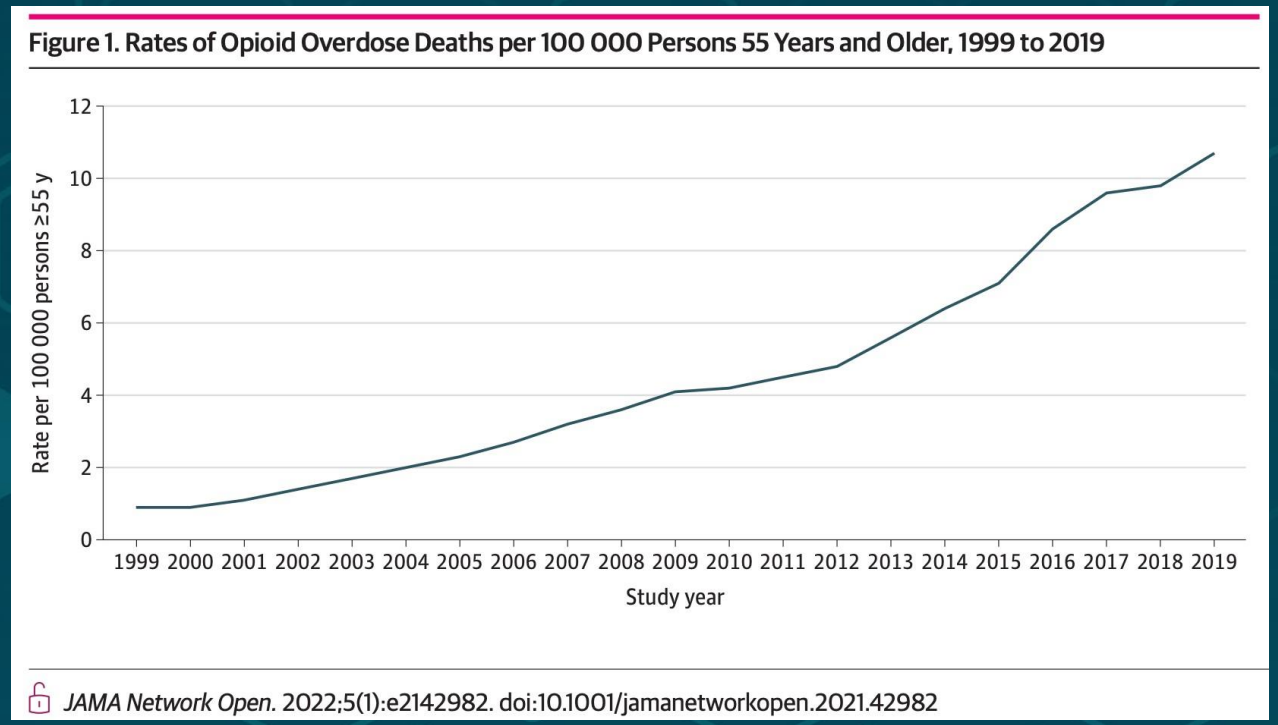
- Disparities in opioid overdose death trends by **race/ethnicity**
- 76 HCS communities in Kentucky, New York, Massachusetts and Ohio for 2018-2019
- Overall opioid overdose death rates did not significantly change between 2018 and 2019
- A **40% increase in opioid overdose death rate** for non-Hispanic Black individuals relative to non-Hispanic White individuals

Solution = use an antiracist public health approach to address the crisis of opioid-related harms

Disparities in Opioid Overdose Deaths

Evidence: JAMA 2022 Publication

- Disparities by sex, race and ethnicity in death rates due to opioid overdose among adults 55 years or older, 1999 to 2019
- Annual numbers of deaths increased over time from 518 in 1999 to 10,292 in 2019 (**> 10x increase**)

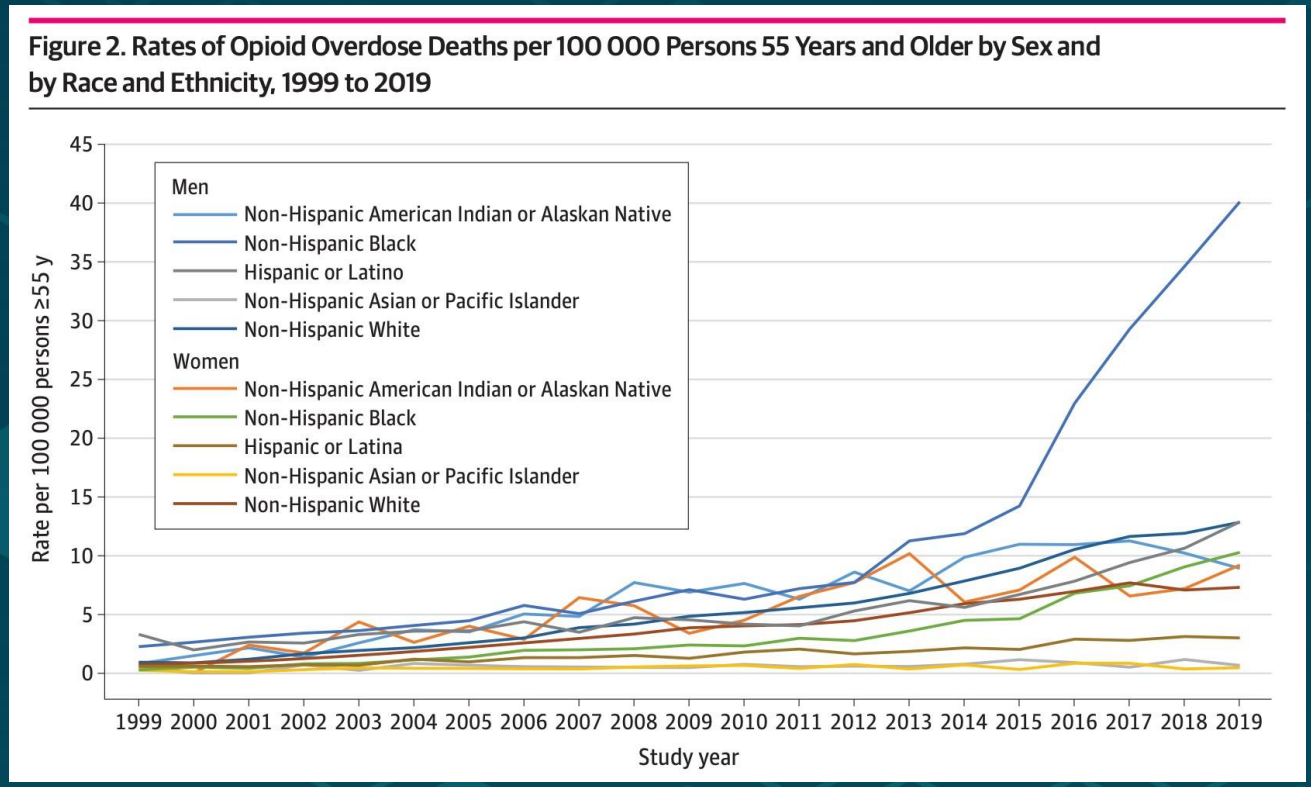


Solution = increase screening for SUD among older adults along with outreach and treatment models adapted to their unique circumstances

Disparities in Opioid Overdose Deaths

Evidence: JAMA 2022 Publication

- Of those US residents 55 years or older died due to an opioid overdose: 80% were aged 55-65 years; 60% were men
- By 2019, the opioid overdose fatality rate among non-Hispanic Black men 55 years or older was **4x greater** than the overall opioid overdose fatality rate for persons the same age

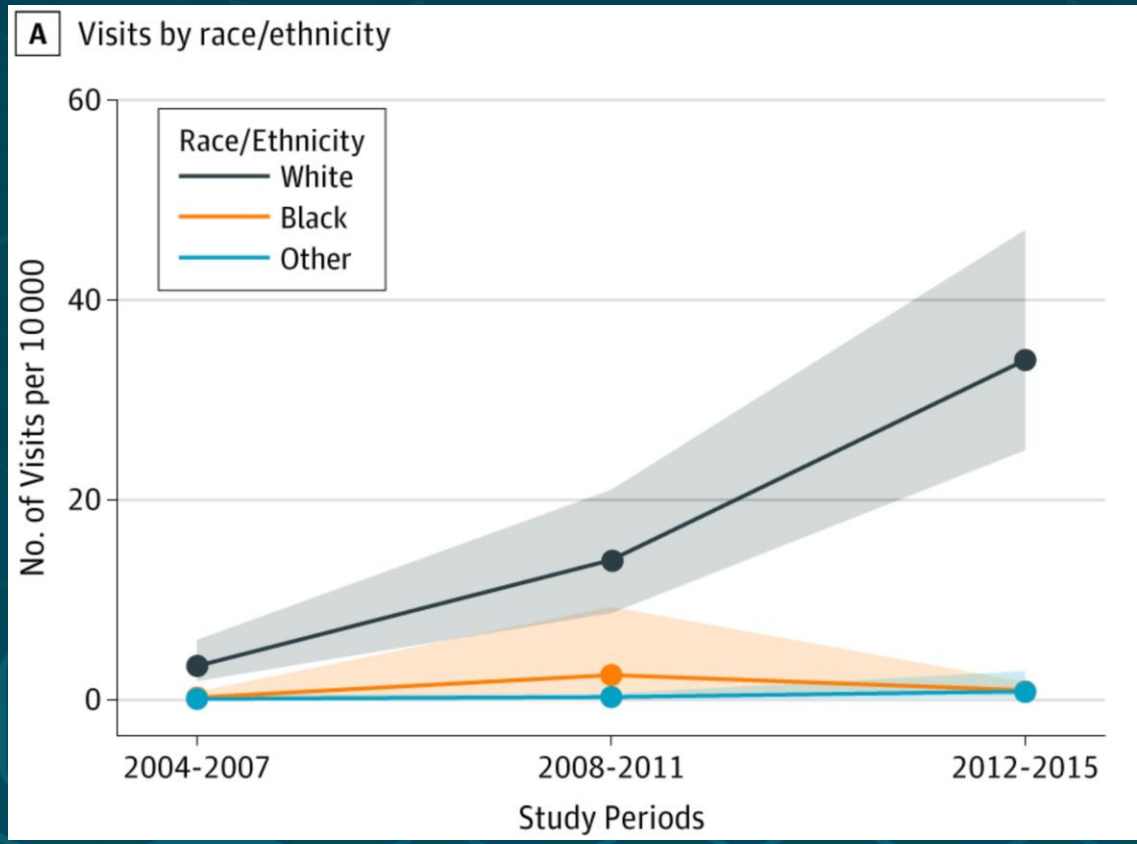


Solution = increase screening for SUD among older black men along with increase referral to OUD treatment

Disparities in OUD Treatment

Evidence: JAMA Psychiatry 2019 Publication

- From 2004 to 2015, the number of buprenorphine-related visits rose by 9x
- White patients were **35x more likely** to have abuprenorphine-related visit when compared to persons of color
- Black patients had significantly lower odds of receiving buprenorphine rx (OR 0.23, 95% CI, 0.13-0.44)

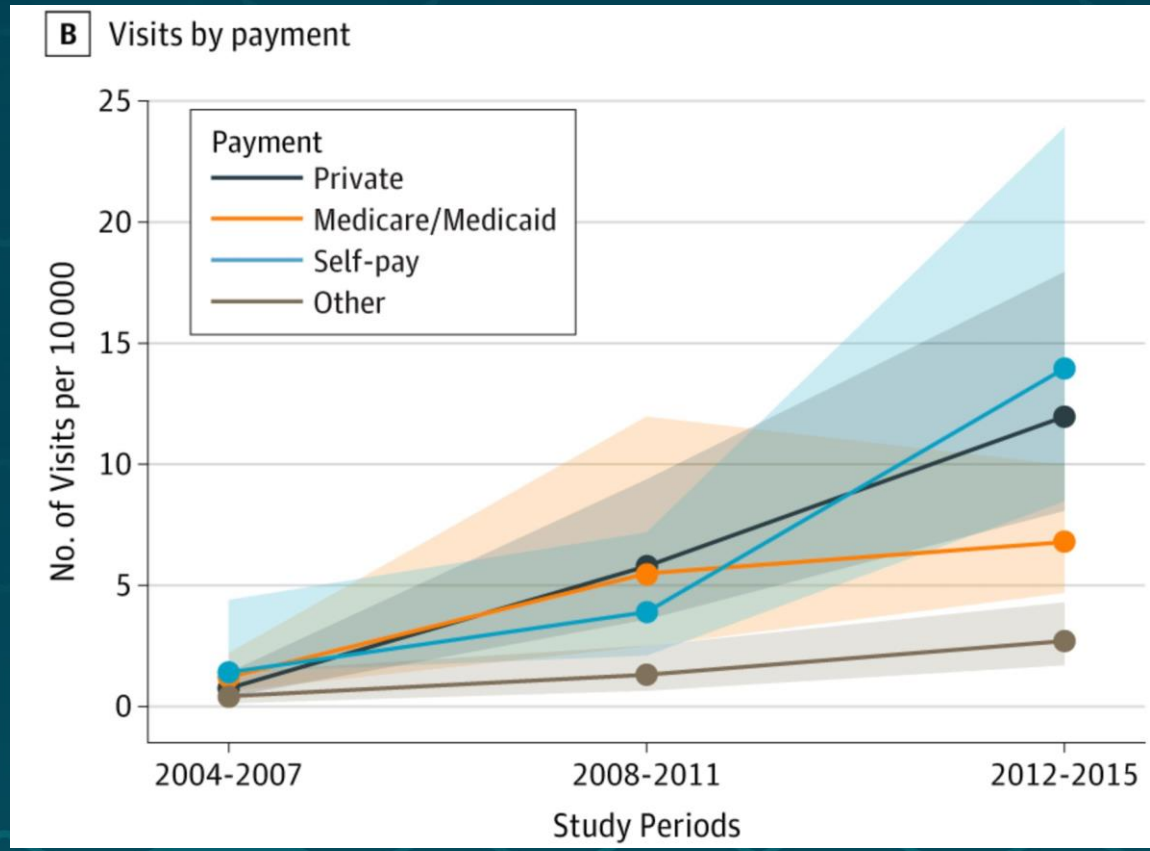


Solution = increase access to treatment for black populations; develop policy and research efforts specifically addressing racial/ethnic differences in treatment and engagement

Disparities in OUD Treatment

Evidence: JAMA Psychiatry 2019 Publication

- **¾ of prescriptions** go to those who pay cash or have private insurance
- Private insurance picked up the cost of 34% of visits, an increase from 20% a decade earlier
- Medicaid and Medicare account for 19% of visits



Solution = increase access to low income populations; Medicaid expansion; mental health parity legislation; increase MOUD providers that accept Medicaid

Reducing Health Disparities

Improve data collection

- Timelier access to data on opioid-related overdose fatalities and treatment
- Include important demographic information, including race and ethnicity

Policy and implementation

- Ensure data to shape public health response, inform intervention planning, including discussions ensuring evidenced-based practices are equitably available to all racial and ethnic groups
- Example: HCS data informed partnerships with Black community organizations to improve access to overdose education and naloxone distribution

Resources and Toolkits

Toolkits

- Inpatient/ED/Surgery/OB/Dental/Occ Med/Pharmacy
  - The CO's CURE Initiative: https://cha.com/opioid-safety/cos-cure/ (Link)
- Outpatient/Clinic
  - Compass Opioid Prescribing andTreatment Guidance Toolkit: https://www.ihconline.org/opioid-prescribing-and-treatment-guidance-toolkit (Link)
- MAT and Buprenorphine Induction
  - https://cha.com/opioid-safety/coloradomat/ (Link)
- Take-Home Naloxone Program
  - http://naloxoneproject.com/ (Link)

Questions?

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Presenter

Michaela Johnson Pharm.D.

Coteau des Prairies Health Care System

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Conflicts of Interest and Disclosure

- Michaela Johnson has no conflicts of interest, financial or otherwise, to disclose.

Our Journey…

- Identifying the need
- Finding a solution
- Our “secret” for success
- Reflection and ongoing progression

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Identifying the **NEED**

- Statistical Data
- Anecdotal Information

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Finding a **SOLUTION**

- Medication Assisted Treatment
- Support Services

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Medication Assisted Treatment

- Low barrier access
- Phased treatment approach
- Contingency management

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Support Services

- Counseling
- Peer Support
- Primary Care
- Naloxone Training
- Food/Housing
- Health Insurance
- Pregnancy-focused support
- Recovery-focused support

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Our "Secret" for **SUCCESS**

COLLABORATION

Reflection and Progression

- 48 patients engaged in treatment
- 75% retention rate
- Diverse patient population
- Primarily OUD and polysubstance use disorders

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Margaret’s Journey

- My Journey
- My Experience with Compass Care

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Interactive Discussion: Speakers, Panelists and Attendees

Questions submitted at registration:

- Alternative medications to help with postoperative pain for patients with history of opioid abuse?
- How does one influence emergency rooms to start a take home Naloxone program?
- How to develop an Opioid Team (for a team approach)
- Recent CDC guidance changes, chronic opioid attempted taper success vs MAT, buprenorphine, etc.

Register for the Next HQIC Collaborative Event!

WALK with the WOC and Step into

a Brighter Future of Pressure Injury Prevention

Tuesday, April 26, 2022, from 1:00 - 1:30 PM (CST)

Event Brochure (Link)

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Thank you for joining us today!

We value your input!

Please complete the brief evaluation after exiting the event

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