Breaking the Opioid Prescribing Cycle through Stewardship

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Jim Lichauer, PharmD, BCPS, FASHP

Project Manager, PI Collaboratives and Advisory - Pharmacy

In 2015, 90 people died each day from an opioid overdose. If you subtract deaths attributed to heroin and synthetic opioids, such as illicitly manufactured fentanyl, the number drops to 42 deaths per day. That is still 42 deaths daily from drugs that were prescribed by a licensed health care professional. How did we get here?

It’s complex, with many factors contributing to the changes in prescribing. But what we can all agree on is that many opioids being prescribed are not necessary. Sometimes they are abused and misused by the patients for whom they are prescribed, but often they end up in the hands of others. Data from 2012 showed that nearly 50 percent of those using opioids for non-medical purposes for more than 200 days received those medications from a friend or relative.

Health care providers need to work on reducing this oversupply of prescription opioids available in the community by improving our prescribing habits. The good news is we are already seeing a downward trend in opioid prescribing rates. The bad news is we are still prescribing far more than we have in the past, and more than any other developed country in the world. This is where the development of opioid stewardship programs comes into play.

For some patients, such as those living with cancer, opioids are needed for pain management, but I’d like to focus on prescribing for chronic non-cancer pain (CNCP). The CDC guidelines provide three focus areas: determining when to initiate or continue opiates for chronic pain; opioid selection dosage, duration, follow-up and discontinuation; and assessing risk and addressing harms of opioids. These focus areas include 12 recommendations, which can be overwhelming.

As a pharmacist who regularly discusses this topic with members, I am often asked where to start. I have broken those recommendations down to the following key strategies you can use to build an opioid stewardship program.

**Prepare a patient provider agreement.** In my opinion the patient provider agreement (PPA) is one of the most essential components of a good opioid stewardship program. This is the basis for consistent communication between the provider and the patient. The PPA – or whatever you choose to call it – should focus on the patient and provider, not the opioids. This agreement is a commitment between the provider and the patient on how pain will be managed. Using patient-centered, non-punitive language, the PPA should include required treatment goals, components of the monitoring program, risk and benefits of the prescribed therapy, and exit plans based on patient actions and efficacy. I recommend including key health care team members, patients (including patient-family councils), hospital leadership, and risk management in the development of your PPA.

**Obtain the right data.** You need data to identify your population and to monitor your progress. Having data to monitor population- and provider-level outcomes such as the percent of patients on opioids, the percent of patients on high doses and patients receiving an opioid and benzodiazepine combination will be very important.

Once you establish prescribing guidelines and appropriate criteria for opioid use (see next), you should review your population-level data and conduct a systematic review of patients currently receiving opioids. The goal should be to improve prescribing going forward, but don’t ignore the patients currently receiving chronic opioid therapy. It is important to conduct a risk-benefit analysis on current patients and determine if there are non-pharmacologic or non-opioid therapies that were not considered or available when those patients started receiving opioids. In order to tackle a big problem, I recommend starting with patients on the highest morphine milligram equivalents and those on opioids and benzodiazepines.

**Develop an organizational policy for prescribing opioids.** I recommend that opioid prescribing guidelines be a part of your organization’s larger pain management plan, and include not only guidelines and criteria for opioid use, but also non-pharmacologic and non-opioid treatment options. I know this will be challenging as pain management is complex and we need more research on the treatment of CNCP. So, understand there may be some exceptions to your established criteria, but your focus should be on developing guidelines that are appropriate for the majority of patients in your care. The CDC guidelines provide recommendations regarding considerations for non-pharmacologic and non-opioid therapy, use of immediate use versus extended release products, and initial dosing strategies.

**Establish a risk assessment process.** I get many questions about risk assessment tools and the specificity, validity and outcomes associated with using them. From a practical standpoint, these tools allow you to establish a consistent process for assessing your patients prior to initiating therapy. The risk factors evaluated in most tools are factors that should be a part of a good assessment when prescribing opioids anyway. For best results, choose an established tool or tools that your organization’s team members can agree on and fits into their workflow. It is critical to ensure everyone is using the tool(s) consistently.

These are just a few critical components to start the process of developing a comprehensive opioid stewardship program. The opioid epidemic has taken a huge toll on the communities we serve. Although there is still much work to be done, and change is never easy, by working together the health care industry can make a significant impact in reducing the number of
opioids available and save thousands of lives.

About the author. As project manager for performance improvement collaboratives and advisory in the pharmacy area at Vizient, Lichauer is primarily responsible for developing and leading performance improvement collaborative programs focusing on medication safety and adverse drug events. He has more than 20 years of experience as a clinical pharmacy specialist and clinical pharmacy administrator in both private sector health systems and the Veterans Health Administration. His professional experience includes medication utilization, formulary management, regulatory compliance, medication safety, quality management, clinical program development and leadership. He is a board certified pharmacotherapy specialist and a fellow of the American Society of Health-System Pharmacists.

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