Policies, Procedures, & Protocols

Putting safe opioid prescribing evidence-based guidelines into practice is supported with the adoption of specific policies, procedures, and protocols by physician groups, care systems, and/or health plans.

(The Tool Kit section on Clinical Decision Support "hardwires" these policies/procedures/protocols through tools embedded in the EMR or other work flow protocols.)

a. <u>CURES Use</u>

Establish a routine practice for when it is appropriate for clinicians (and pharmacists) to check the CURES database when considering prescribing an opioid medication. SB482 was signed into law by the Governor on September 27, 2016 and provides a guide for designing that policy/protocol.
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB482

> *A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.*
>
> *If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption …, to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.*

b. <u>Formulary/Medication Use</u>:

1) **Restricted prescribing of opioids to specialists**, e.g. long acting, high risk opioids restricted to pain management, oncology, and hospice/palliative care clinicians only.
2) **Quantity Limits:** Establish maximum quantity limits for specific opioid medications, e.g., 3 days, 5 days, 7 days, or maximum 30 days without refills.
3) **Daily Dosing Limits**: Clinical guidelines describe various thresholds for MME/day (Mg Morphine Equivalents) to assure safe opioid prescribing – 50 MME/day, 90 MME/day, 100 MME/day, 120 MME/day. Such thresholds may trigger pharmacy review, peer review, pre-authorization, or escalation.
4) **Combination Medication Prescribing:** Avoid prescribing of opioid + benzodiazepine or opioid + carisoprodol prescribing.
5) **Naloxone Use and Co-Prescribing:** Co-prescribing of Naloxone (Narcan) in specific clinical situations can be supported, e.g., for high risk chronic opioid using patients on > 200 MME/day, past history of OD, etc.

6) **Tapering Protocols:** A consistent protocol can aid clinicians in physician groups/care systems with an acceptable and safe guide to tapering chronic opioid using patients on high MME/day doses to lower safer daily doses or discontinuation of the opioid medication.
7) **Follow-up rules for Chronic Opioid Patients:** The Medical Board of California (MBC) advises that patients on chronic opioids should be seen "monthly, quarterly, or semiannually, as required by the standard of care." (http://www.mbc.ca.gov/About_Us/Laws/laws_guide.pdf) With such a policy, a tickler/reminder file can assure such patients are brought back in for re-visits with the prescribing clinician, as guided by the policy or protocol set up by the physician practice, care system, or health plan..

c. <u>Pre-authorization</u>

To assure safe and appropriate opioid prescribing, specific indicators (red flags) may trigger more intense (just-in-time) review, including pre-authorization (or Pre-Peer review) before a prescription may proceed to fulfillment. Some of these indicators may follow from the Formulary/Medication Use policies above.

d. **<u>Inter-Specialty Cooperation and Relationships:</u>**

Managing difficult pain patients requires the help of colleagues and other team members. Establishing working rules/agreements for when informal and formal consultation, advice, or referral is appropriate can assure safe and appropriate pain management, prescribing, and substance use management.

1) **Inter-specialty Working Agreements:** SCPMG established such an agreement
2) **When should patients be referred to Pain Management or Substance Use Management?**
3) **Multi-specialty Pain Management Task Force/Huddle/Review Team/Committee:** Formation of a multi-specialty team can be useful in collaborative case review/consultation for difficult patients, as well as pro-active review of identified high risk patients (high MME/day, frequent fliers, etc.) and high prescribing clinicians.

e. **<u>Education:</u>**

With the emergence of new scientific evidence and new clinical guidelines, ongoing (re-) education of clinicians is critical to assuring up-to-date safe opioid prescribing and pain management. Some physician groups and professional organizations are advocating and sponsoring "required" CME on safe and appropriate opioid prescribing and pain management for their medical staff and members.

- **Example:** SCPMG currently requires all new physicians, residents, and fellows to complete a minimum 3-hour online CME on safe opioid prescribing, from Boston University's SCOPE of Pain program (https://www.scopeofpain.com/online-training/). BU tracks and reports to SCPMG on which clinicians have completed the program. For more information, contact Steve Steinberg, MD (steven.g.steinberg@kp.org)

f. <u>Medication Assisted Treatment (MAT)</u>

Some chronic opioid using patients have substance use disorder and will benefit from substance abuse treatment, including MAT with buprenorphine, which can be prescribed by clinicians (addiction medicine and primary care) who have a DEA waiver to prescribe for addiction management. Physician groups, care systems can establish and design programs to assure the availability of trained physicians with the waiver in each practice/facility, who can provide access to such life-saving treatments.

- **Medication-Assisted Treatment of Opioid Use Disorder- Pocket Guide**
  http://store.samhsa.gov/shin/content//SMA16-4892PG/SMA16-4892PG.pdf
- **Buprenorphine Training for Physicians**
  http://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
- **Apply for a Waiver**
  http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/apply-for-physician-waiver

g. Pharmacy Collaboration

Professional collaboration between clinicians and pharmacists can help support safe opioid prescribing practice. Pharmacies can/should adopt protocols with red flags for when further consultation and review with the prescribing clinicians is indicated. Joint development and review of these protocols is recommended to assure a collaborative clinical relationship.

- **Example:** SCPMG jointly developed Policies and Procedures with the Kaiser Pharmacy Operations, where certain red flags (high doses, high quantity, drug combinations) trigger pharmacist review with calls to the prescribing clinician and occasional escalation to Chief of Service for questionable prescribing.