


Disclosures

- I have no actual or potential conflict of interest in relation to this program/presentation
- The planners, speakers, moderators, and/or panelists of this CME activity have no relevant financial relationships with commercial interests to disclose
- There is no commercial support for this session

The logo of the University of Illinois at Springfield, featuring the letters "UIS" in a stylized blue font, followed by the text "THE UNIVERSITY OF ILLINOIS AT SPRINGFIELD" in a smaller, blue, sans-serif font.

Current U.S. OPIOID CRISIS

An over-sized appetite for painkillers

4.5%

80%

Americans make up about 4.5% of the world's population...
...but consume 80% of the world's opioid painkillers.

Source: IMS Health survey

Alabama Opioid Prescribing

Opioid Overdose

U.S. State Prescribing Rates, 2017

f t +

U.S. State Prescribing Rates, 2016

Alabama has the highest opioid prescribing rate in the nation

U.S. Department of Health & Human Services

2017 Rate per 100 persons
= 44.1
64.1 - 62.3
62.3 - 107.9
89.9
Insert maps


Regional variation in use of prescription opioids cannot be explained by the underlying health status of the population.²

https://www.cdc.gov/opioids/about-the-epidemic/CDC_2018_Surveillance

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Birmingham, AL 35294-0001


Opioid Stewardship

1. Own it - *Take responsibility*



Own It Do Right Always Care Win Together

NEW YORKER



A REPORTER AT LARGE OCTOBER 30, 2007 \$5.00

THE FAMILY THAT BUILT AN EMPIRE OF PAIN

The Sackler dynasty's ruthless marketing of painkillers has generated billions of dollars—and millions of addicts.

By Patrick Radden Keefe

33. Sackler family - \$14 billion

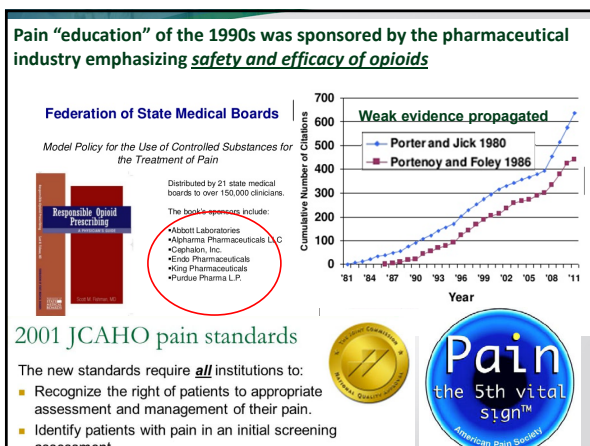


16. Sackler family

\$14 Billion

Patricia Sackler	\$100 million
David Sackler	\$100 million
Matthew Sackler	\$100 million
James Sackler	\$100 million
Robert Sackler	\$100 million
Thomas Sackler	\$100 million
William Sackler	\$100 million
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William Sackler	

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7

Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences

JAMA. 2012 Apr 4; 307(13): 1377–13780

Aleksandra Zgierska, MD, PhD, Michael Miller, MD, FASAM, FAPA, and David Rabago, MD

1. Pressure on clinicians to maximize “throughput” to meet patient volume benchmarks has intensified.
2. Patient expectations shape the health encounter and many **patients expect to receive a prescription** for a medication
3. Increased pressure to produce positive results as the “quality” of services provided is often based on **patient satisfaction targets**

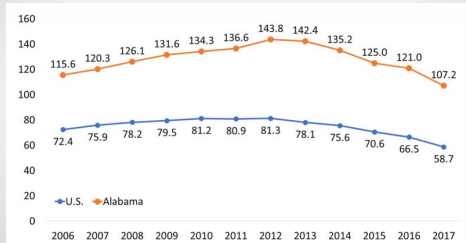
It takes 30 seconds to write a prescription for Norco, But it takes 30 minutes to NOT prescribe Norco.

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Alabama Opioid Prescribing

Despite decreasing opioid prescribing by 25% since 2013...



We prescribe opioids at nearly twice the national average

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Prescription opioid use is a risk factor for heroin use

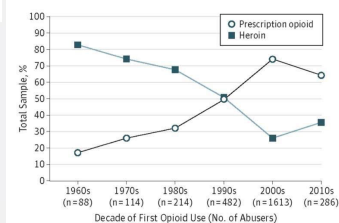
National Institute on Drug Abuse (NIDA)
Prescription Opioids and Heroin

Last Updated January 2018

86% of young, urban heroin users started off misusing prescription opioids

Initiation into nonmedical use was from 3 main sources of opioids:

family, friends, or personal prescriptions.



JAMA Psychiatry. 2014 Jul 1;71(7):821-6. doi: 10.1001/jamapsychiatry.2014.366

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10

Dynamic Model of Nonmedical Opioid Use Trajectories and Potential Policy Interventions

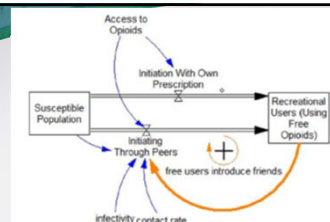
Wayne Wakeland, Alexandra Nielsen, and Peter Geissert
Portland State University, Portland, OR

Am J Drug Alcohol Abuse. 2015 November ; 41(6): 508–518. doi:10.3109/00952990.2015.1043435.

- ▶ Using national surveys and published studies, a system model was constructed to represent nonmedical prescription opioid use as an infectious disease
- ▶ The “susceptible, infected, recovered” (SIR) epidemic framework follows a trajectory in which people may:
 1. initiate nonmedical use
 2. transition to paying for opioids
 3. tamper with opioids
 4. eventually transition to heroin
- ▶ Model was able to replicate the patterns seen in the historical data for different user populations, and assoc. overdose deaths

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Prescription opioid use may start with exposure via legitimate prescription, peer influence, or social exposure.

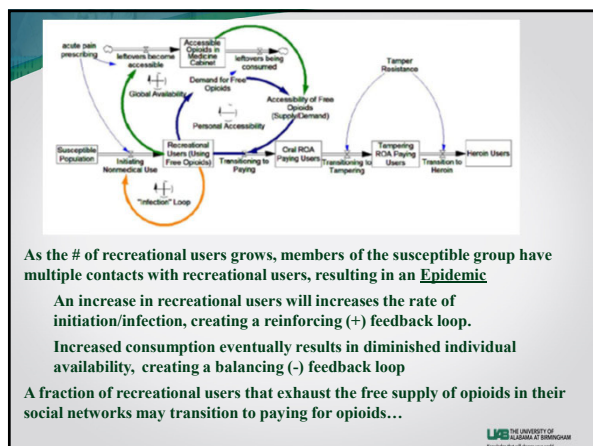
Susceptible individuals are those who have never used opioids nonmedically.

Infectivity is the likelihood that contact results in infection

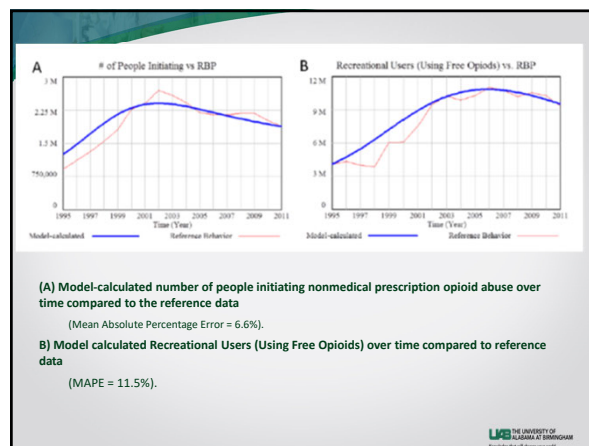
Susceptible person may initiate recreational opioid use depending on the how compelling the idea is — its “infectivity.”

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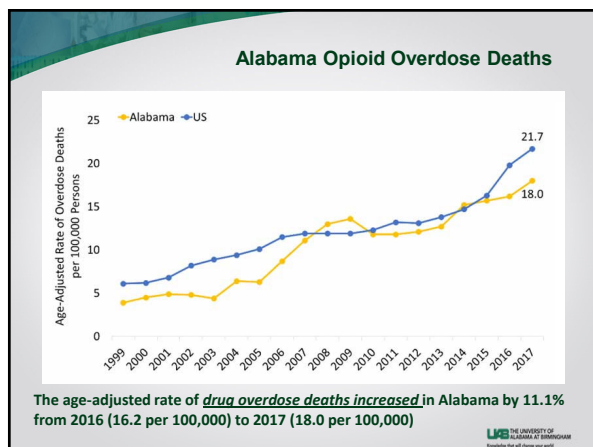
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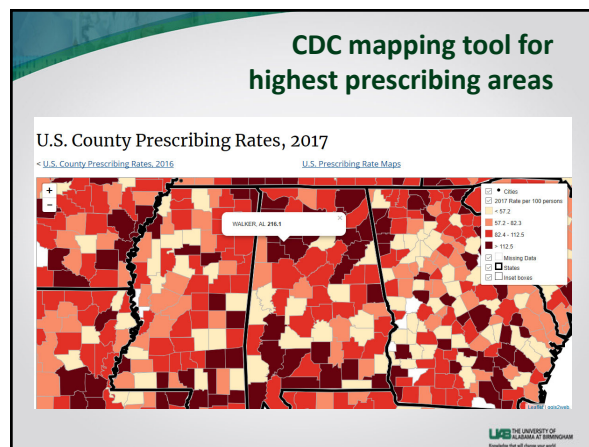
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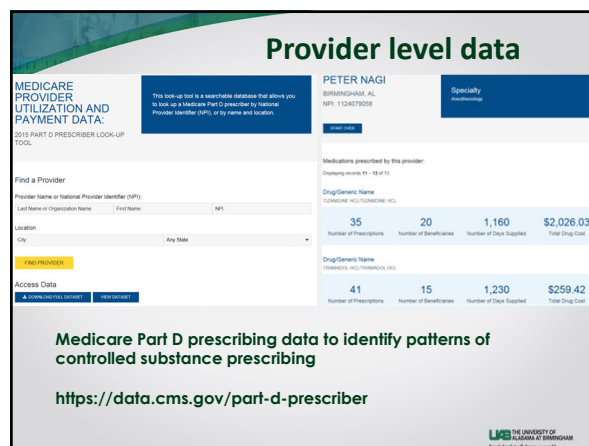
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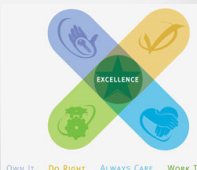
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18

Opioid Stewardship

1. Own it - Take responsibility
2. Do right - *Practice good, evidence-based medicine*



OWN IT · DO RIGHT · ALWAYS CARE · WORK TOGETHER

25

Follow CDC Guidelines for all opioid prescribing

PRESCRIBE WITH CONFIDENCE.
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
www.cdc.gov


2016 CDC guidelines note:

"The recommendations in the guideline are voluntary, rather than prescriptive standards."

- However, with some important exceptions, CDC guidelines have become representative of the **standard of care related to the use of opioids**
- Legally, medical expert witnesses, medical licensing boards, judges, or courts of law can interpret the guidelines as the standard for what a reasonably prudent practitioner might do in the same or similar circumstances.

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 The NEW ENGLAND JOURNAL of MEDICINE
April 24, 2019

CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain

- **Not intended for populations outside of Guideline's scope:** active cancer treatment, acute sickle cell crises, or post-surgical pain
- **Does not support hard limits or "cutting off" opioids.** "Clinicians should... avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day."
- **Does not support abrupt tapering or sudden discontinuation of opioids.** Which can result in severe opioid withdrawal symptoms including pain and psychological distress
- **Does not apply to dosage recommendations for patients receiving or starting MAT for opioid use disorder**

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Follow CDC Guidelines for opioid prescribing

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www.cdc.gov

12 recommendations are organized into 3 areas:

- A. When to initiate or continue opioids
- B. Opioid selection, dosage, duration, follow-up, and discontinuation
- C. Assessing risk/harms of opioid use

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Part A: WHEN TO INITIATE OR CONTINUE OPIOIDS

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www.cdc.gov

1. Opioids are not first-line therapy (recommendation category: A, evidence type: 3)
Nonopioid pharmacologic therapy (NSAIDs, Acetaminophen) and nonpharmacologic therapy (counseling, PT, blocks) and are preferred.

If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy

NONOPIOID MEDICATIONS			
MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia; TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/burning; irritation of mucous membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized arthralgias, topical capsaicin for musculoskeletal and neuropathic pain

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Part A: WHEN TO INITIATE OR CONTINUE OPIOIDS

PRESCRIBE WITH CONFIDENCE.
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
www.cdc.gov

1. Opioids are not first-line therapy (recommendation category: A, evidence type: 3)
Nonopioid pharmacologic therapy (NSAIDs, Acetaminophen) and nonpharmacologic therapy (counseling, PT, blocks) and are preferred.

If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy

2. Establish goals for pain and function (recommendation category: A, evidence type: 4)
Establish treatment goals with all patients, including realistic goals for pain and function, including how opioid therapy will be discontinued if benefits do not outweigh risks.

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PROVIDING PAIN MANAGEMENT
www.cdc.gov

Part A: WHEN TO INITIATE OR CONTINUE OPIOIDS

PEG: Scale to Assess Pain Intensity and Interference
The PEG is a three-item scale to assess pain intensity and interference.

1. What number best describes your **pain on average** in the past week?

0 1 2 3 4 5 6 7 8 9 10
No pain Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your **enjoyment of life**?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

3. What number best describes how, during the past week, pain has interfered with your **general activity**?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

Source: Krohn KE, Lomax BA, Bae M, et al. Development and initial validation of the PEG, a three-item Scale Assessing Pain Intensity and Interference. J Gen Intern Med. 2009;24(6):753-758.

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PROVIDING PAIN MANAGEMENT
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Part A: WHEN TO INITIATE OR CONTINUE OPIOIDS

- Opioids are not first-line therapy (recommendation category: A, evidence type: 3)**
Nonopioid pharmacologic therapy (NSAIDs, Acetaminophen) and nonpharmacologic therapy (counseling, PT, blocks) and are preferred.
If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy
- Establish goals for pain and function (recommendation category: A, evidence type: 4)**
Establish treatment goals with all patients, including realistic goals for pain and function, including how opioid therapy will be discontinued if benefits do not outweigh risks.
- Discuss risks and benefits (recommendation category: A, evidence type: 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. *Use patient-provider treatment agreements*

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UAB Pain Treatment Clinic
UAB Highlands
1201 11th Avenue South
Birmingham, AL 35205

Agreement for Controlled Substance Prescriptions

Controlled substance medications (i.e., Opioids, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are therefore controlled by the federal, state and local government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. Because my physician is prescribing such a medication for me to help manage my pain, I agree to the following conditions:

- I am responsible for my controlled substance medication.** If the prescription of medication is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
- I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from my physician while under his/her care.** Besides being illegal to do so, it may endanger my health. The only exception is when it is prescribed while I am admitted to the hospital.
- Refill of controlled substances medication:**
 - Will be made only during regular business hours** Monday through Friday, in person, during a scheduled office visit. Refills will not be made at night, on holidays, or weekends.
 - Will not be made** if I "run out early" or "lose a prescription" or "spill or misplace my medication". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
 - Will not be made** as an "emergency" such as a Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least twenty-four (24) hours ahead if I need assistance with a controlled substance medication prescription.

I have been fully informed by Dr. _____ and his/her staff regarding psychological dependence (addiction) of a controlled substance medication, which I understand is rare. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms. I have read this agreement and the same has been explained to me by Dr. _____ and/or his/her staff. In addition, I fully understand the consequences of violating this agreement.

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The Role of Opioid Prescription in Incident Opioid Abuse and Dependence Among Individuals With Chronic Noncancer Pain

The Role of Opioid Prescription

Mark J. Edlund, MD, PhD,* Bradley C. Martin, PharmD,† Joan E. Russo, PhD,‡
Andrea DeVries, PhD,§ Jennifer B. Braken, PhD,‡ and Mark D. Sullivan, MD*
Clin J Pain • Volume 30, Number 7, July 2014

Background: Many providers were taught that there was almost no chance of addiction if you are treating someone for legitimate pain.

Methods: This study utilized claims data (n=568,640) for individuals aged 18 and over with a new CNCP episode (no diagnosis in the prior 6 months), and no opioid use or OUD in the prior 6 months

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TABLE 3. Variables Associated With Incident OUDs

Variables†	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Opioid dose and days		
No opioid use (reference)	1.00	1.00
Low dose, acute	3.31 (2.54-4.31)***	3.63 (2.32-5.69)***
Low dose, chronic	17.63 (12.33-25.20)***	14.92 (10.38-21.46)***
Med dose, acute	3.04 (2.30-4.01)***	2.80 (2.12-3.71)***
Med dose, chronic	35.19 (24.75-50.02)***	28.69 (20.05-41.13)***
High dose, acute	2.68 (1.45-4.90)**	3.10 (1.67-5.77)***
High dose, chronic	171.95 (105.97-279.08)***	122.45 (72.78-205.09)***
Age, N (%) (y)		
18-30	14.12 (7.43-26.86)***	10.51 (5.47-20.20)***
31-40	6.45 (3.37-12.33)***	4.62 (2.38-8.91)***
41-50	4.60 (2.40-8.80)***	3.27 (1.70-6.30)***
51-64	2.08 (1.44-5.46)**	2.18 (1.12-4.26)*
≥ 65 (reference group)	1.00	1.00
Sex		
Female (reference group)	1.00	1.00
Male	2.38 (1.96-2.91)***	2.27 (1.85-2.78)***
Chlorzoxazone (refer)	1.01 (0.85-1.23)	1.11 (0.93-1.34)

Results:

- a single prescription for an opioid increased the patients risk for Opioid Use Disorder by 3x
- Low-dose chronic opioid therapy increases risk by 15x
- Patients on high-dose chronic opioid therapy have 122x greater risk of OUD than those not on opioids.

Conclusion: Opioid exposure was a strong risk factor for OUDs; Duration of opioid therapy was more important than daily dose

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Part B: OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

- Prescribe short durations for acute pain (category: A, evidence type: 4)**
 - Long-term opioid use often begins with treatment of acute pain.
 - 3 days or less will often be sufficient; >7 days will rarely be needed.

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015

Probability of continued opioid use (>1 yr) among opioid-naïve patients increases based on:

- days supplied
- cumulative dose

* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest day's supply was considered the first prescription.

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ORIGINAL INVESTIGATION

Long-term Analgesic Use After Low-Risk Surgery

A Retrospective Cohort Study *Arch Intern Med.* 2012;172(5):425-430

Asim Mann, MD, Tara Gomes, MSc, Hong Zheng, MSc, Muhammad M. Mamdani, PharmD, MA, MPH, David N. Juurlink, MD, PhD, Chaim M. Bell, MD, PhD

Table 2. Risk of Long-term Analgesic Use After Low-Risk, Short-Stay Surgery

Primary Outcome	Opioid Cohort			NSAID Cohort		
	No. of Events in Non-Early Users	No. of Events in Early Users	Adjusted Odds Ratio (95% CI)	No. of Events in Non-Early Users	No. of Events in Early Users	Adjusted Odds Ratio (95% CI)
All operations	27 288	2857	1.44 (1.39-1.50)	29 795	285	3.74 (3.27-4.28)
All operations except surgery	28 284	2102	1.82 (1.54-1.67)	28 082	247	4.61 (3.88-5.50)
Laparoscopic cholecystectomy	222	549	1.23 (1.13-1.35)	1088	15	1.14 (0.87-1.50)
Transurethral resection of the prostate	425	123	1.33 (1.07-1.64)	440	17	4.10 (2.36-7.14)
Varicose vein stripping	57	85	1.41 (0.99-2.02)	173	6	0.82 (0.35-1.95)

Results: 7.7% of opioid naïve pts prescribed opioids after surgery were taking opioids at 1 year postop

44% higher than matched cohort that did not receive post-op opioids

Conclusion:
Rx for opioids after low risk surgery is associated with long-term use

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JAMA Surgery | Original Investigation JAMA Surgery June 2017 Volume 152, Number 6

New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults

Chad M. Brummett, MD, Jennifer F. Waljee, MD, MPH, MS, Jenna Goesling, PhD, Stephanie Moser, PhD, Paul Lin, MS, Michael J. Englesbe, MD, Amy S. B. Bohnert, PhD, MHS, Sachin Kheterpal, MD, MBA, Brahmajee K. Nallamothu, MD, MPH

STUDY DESIGN:

- US nationwide insurance claims data from 2013-2014
- Adults 18-64 yrs without opioid use in the year prior to surgery
- For pts filling a perioperative opioid Rx, incidence of persistent opioid use >90 days after both:
 - minor surgical procedures
 - varicose vein removal, lap chole, lap appy, hemorrhoidectomy, thyroidectomy, TURP, parathyroidectomy, and carpal tunnel
 - major surgical procedures
 - ventral incisional hernia repair, colectomy, reflux surgery, bariatric surgery, and TAH
- Assessed data for patient-level predictors of persistent opioid use.

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JAMA Surgery | Original Investigation

New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults

Chad M. Brummett, MD, Jennifer F. Waljee, MD, MPH, MS, Jenna Goesling, PhD, Stephanie Moser, PhD, Paul Lin, MS, Michael J. Englesbe, MD, Amy S. B. Bohnert, PhD, MHS, Sachin Kheterpal, MD, MBA, Brahmajee K. Nallamothu, MD, MPH

MAIN OUTCOMES AND MEASURES

- 36,177 patients met the inclusion criteria
- 29,068 (80.3%) underwent minor surgery
- 7,109 (19.7%) had major surgery

Rate of new persistent opioid use were similar between the 2 groups: **5.9% to 6.5%**

- incidence of persistent opioid use in nonoperative control was 0.4%

Figure 2. Flow Diagram

```

graph TD
    A[66543 Opioid-naïve patients] --> B[33184 Patients <65 y excluded]
    A --> C[55398 Opioid-naïve patients aged 18-64 y]
    C --> D[19182 Excluded: 12586 did not fill an opioid prescription within 10 d before procedure to 4 d after discharge; 6467 had sequential anesthesia; 35 Whose length of stay was >30 d]
    C --> E[36177 Patients included in analysis]
  
```

Figure 3. Incidence of New Persistent Opioid Use by Surgical Condition

Surgical Condition	Minor surgery group (%)	Major surgery group (%)	Control group (%)
Varicose Vein Removal	~5.5	~6.0	~0.4
Laparoscopic Cholecystectomy	~5.5	~6.0	~0.4
Laparoscopic Appendectomy	~5.5	~6.0	~0.4
Hemorrhoidectomy	~5.5	~6.0	~0.4
Thyroidectomy	~5.5	~6.0	~0.4
Transurethral Prostate Surgery	~5.5	~6.0	~0.4
Parathyroidectomy	~5.5	~6.0	~0.4
Carpal Tunnel	~5.5	~6.0	~0.4
Ventral Incisional Hernia Repair	~5.5	~6.0	~0.4
Colectomy	~5.5	~6.0	~0.4
Reflex Surgery	~5.5	~6.0	~0.4
Bariatric Surgery	~5.5	~6.0	~0.4
Hysterectomy	~5.5	~6.0	~0.4
Nonoperative Comparisons	~0.4	~0.4	~0.4

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JAMA Surgery | Original Investigation

New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults

Chad M. Brummett, MD, Jennifer F. Waljee, MD, MPH, MS, Jenna Goesling, PhD, Stephanie Moser, PhD, Paul Lin, MS, Michael J. Englesbe, MD, Amy S. B. Bohnert, PhD, MHS, Sachin Kheterpal, MD, MBA, Brahmajee K. Nallamothu, MD, MPH

MAIN OUTCOMES AND MEASURES

Risk factors independently associated with new persistent opioid use included:

- preoperative tobacco use
- alcohol & substance abuse disorders
- mood disorders
- anxiety
- preoperative pain disorders

CONCLUSIONS

New and persistent opioid use after surgery is a common occurrence

- not significantly different between minor and major surgical procedures
- assoc with behavioral and pain disorders suggests occurrence is not solely due to surgical pain, but other patient-level predictors may be involved

Table 1. Multivariable Logistic Regression Model of New Persistent Opioid Use

Characteristic	Adjusted Odds Ratio (95% CI)	SE	P Value
Age (10-y higher) (22 surgery cohort)	1.09 (0.96-1.23)	0.07	.18
Sex			
18-29	1.00 (reference)	NA	NA
30-39	0.76 (0.64-0.90)	0.07	.002
40-49	0.72 (0.61-0.84)	0.06	<.001
50-59	0.68 (0.57-0.80)	0.07	.01
60-64	0.66 (0.54-0.80)	0.08	.001
Education			
College degree or more	1.00 (reference)	NA	NA
Some college	1.24 (0.93-1.58)	0.09	.02
High school	1.22 (1.04-1.43)	0.10	.01
Less than high school	1.58 (1.27-1.94)	0.19	.001
History of tobacco use	1.51 (1.31-1.74)	0.07	<.001
Substance Comorbidity Index	1.19 (1.06-1.33)	0.01	<.001
Insurance			
Adjustment	0.86 (0.68-1.07)	0.10	.18
Anxiety	1.28 (1.10-1.47)	0.08	<.001
Mood	1.15 (1.01-1.30)	0.07	.04
Chronic pain	1.01 (0.78-1.34)	0.14	.98
Other psychiatric	0.88 (0.61-1.26)	0.19	.17
Alcohol or substance abuse	1.34 (1.05-1.72)	0.17	.02
Other pain	1.29 (1.16-1.54)	0.07	<.001
Sex			
Male	1.57 (1.42-1.73)	0.09	<.001
Race	1.22 (1.02-1.39)	0.08	.002
Hispanic	1.56 (1.40-1.73)	0.08	<.001
White	1.00 (reference)	NA	NA
Black	1.41 (1.01-1.97)	0.06	.02

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JAMA Surgery | Original Investigation

Correlation Between 24-Hour PredischARGE Opioid Use and Amount of Opioids Prescribed at Hospital Discharge

Eric Y. Chen, MD, PhD, Andrew Marcantonio, DO, MBA, Paul Torretta III, MD

Figure 1. Amount of Opioids Used 24 Hours Before Hospital Discharge vs Quantity Prescribed at Discharge

DESIGN: Retrospective review of 18,343 postop pts

OUTCOME MEASURES: Patient's 24-hr pre-discharge opioid use vs. total opioids prescribed at discharge.

RESULTS:

- Opioids prescribed at discharge were highly variable and
- Did not correlate with pt's 24-hour pre-discharge opioid use.

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PRESCRIBE WITH CONFIDENCE. Part B: OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4. Prescribe short durations for acute pain (category: A, evidence type: 4)

- Long-term opioid use often begins with treatment of acute pain.
- 3 days or less will often be sufficient; >7 days will rarely be needed.

5. Use immediate-release opioids when starting (category: A, evidence type: 4)

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

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TABLE 1. Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain

Outcome	Studies	Limitations	Inconsistency	Imprecision	Type of evidence	Other factors	Estimates of effect/ findings
Pain and function	3 randomized trials (n = 18,958)	Serious limitations	No inconsistency	No imprecision	3	None identified	No differences
All-cause mortality	1 cohort study (n = 106,402) New for update 1 cohort study (n = 38,758)	Serious limitations	Serious inconsistency	No imprecision	4	None identified	One cohort study found methadone to be associated with lower all-cause mortality risk than sustained-release morphine in a propensity-adjusted analysis (adjusted HR 0.56, 95% CI = 0.51–0.62) and one cohort study among Tennessee Medicaid patients found methadone to be associated with higher risk of all-cause mortality than sustained-release morphine (adjusted HR 1.46, 95% CI = 1.17–1.73).
Abuse and related outcomes	1 cohort study (n = 1,684)	Serious limitations	Unknown (1 study)	Serious imprecision	4	None identified	One cohort study found some differences between ER/LA opioids in rates of adverse outcomes related to abuse, but outcomes were nonspecific for opioid-related adverse events, precluding reliable conclusions.
ER/LA versus immediate-release opioids	New for update 1 cross-sectional study (n = 1,385)	Serious limitations	Unknown (1 study)	No imprecision	4	None identified	One cross-sectional study found ER/LA opioids associated with increased risk of androgen deficiency versus immediate-release opioids (adjusted OR 3.39, 95% CI = 2.39–4.77).

No evidence that ER/LA opioids are more effective or safer than intermittent use of short-acting opioids

No evidence that scheduled use of ER/LA opioids reduces risks for opioid misuse or addiction (KQ3)

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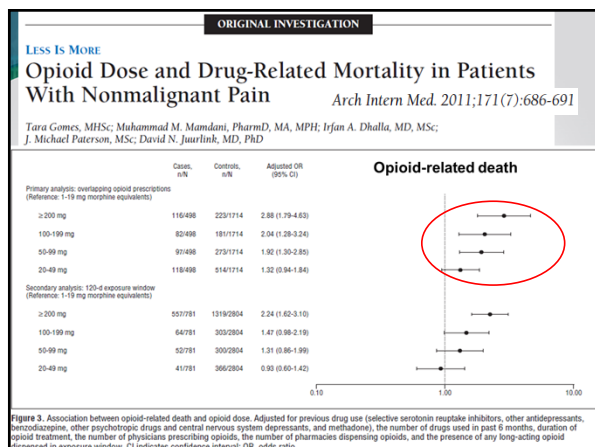
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GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
www.cdc.gov

Part B: OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

- Prescribe short durations for acute pain (category: A, evidence type: 4)
 - Long-term opioid use often begins with treatment of acute pain.
 - 3 days or less will often be sufficient; >7 days will rarely be needed.
- Use immediate-release opioids when starting (category: A, evidence type: 4)
 - When starting opioids prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- Use the lowest effective dose (category: A, evidence type: 3)
 - Develop a policy on dosages thresholds.
 - Use caution with dosage ≥ 50 morphine mg equivalents (MME) per day
 - Avoid increasing dosage ≥ 90 MME per day for non-cancer pain

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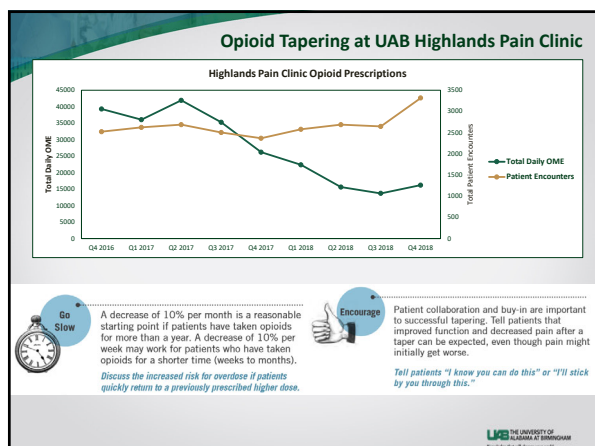
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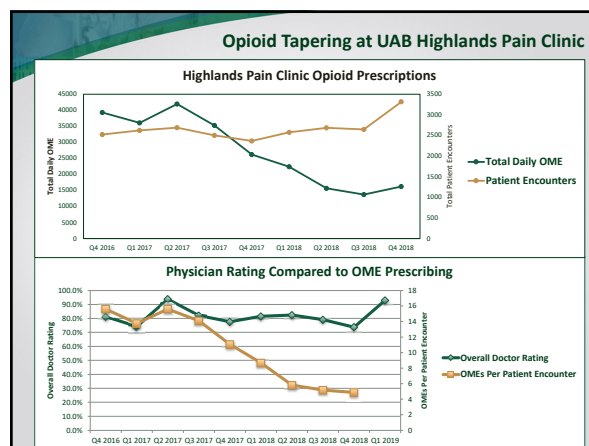
- Evaluate benefits and harms frequently (category: A, evidence type: 4)
 - Clinicians should re-evaluate patients within 1–4 weeks of starting opioid therapy
 - Schedule follow-up with patient to assess benefits and harms of continued opioid therapy **at least every 3 months**
 - If benefits do not outweigh harms, taper opioids to lower dosages or to taper and discontinue opioids

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Part B: OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

- Evaluate benefits and harms frequently (category: A, evidence type: 4)
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 - Schedule follow-up with patient to assess benefits and harms of continued opioid therapy **at least every 3 months**
 - If benefits do not outweigh harms, taper opioids to lower dosages or to taper and discontinue opioids
- Use strategies to mitigate risk (category: A, evidence type: 4)
 - Evaluate risk factors for opioid-related harms and incorporate into mgmt plan
 - Provide **naloxone** for high-risk patients
 - higher opioid dosages (≥ 50 MME/day)
 - obstructive sleep apnea
 - renal or hepatic insufficiency
 - mental health conditions
 - history of substance use disorder
 - concurrent benzodiazepine use
 - pregnancy
 - age ≥ 65 years
 - history of overdose



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Part B: OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn B. Waldman, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE	ADMINISTRATION
FAMILY HISTORY OF SUBSTANCE ABUSE			
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3	SCORING (RISK) 0-3: low 4-7: moderate ≥8: high
Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
Rx drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4	
PERSONAL HISTORY OF SUBSTANCE ABUSE			
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3	
Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4	
Rx drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5	
AGE BETWEEN 16-45 YEARS			
	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
HISTORY OF PREADOLESCENT SEXUAL ABUSE			
	<input type="checkbox"/> 3	<input type="checkbox"/> 0	
PSYCHOLOGICAL DISEASE			
AD/OD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2	
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
SCORING TOTALS			




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Part C: ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Review prescription drug monitoring program (PDMP) data (recommendation category: A, evidence type: 4)
 - Review PDMP data when starting opioid therapy and periodically ranging from every prescription to every 3 months.
- Use urine drug testing (recommendation category: B, evidence type: 4)
 - for chronic pain, use UDS before starting opioid therapy and at least annually




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
Part C: ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Avoid concurrent opioid and benzodiazepine prescribing (recommendation category: A, evidence type: 3)
 - Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible

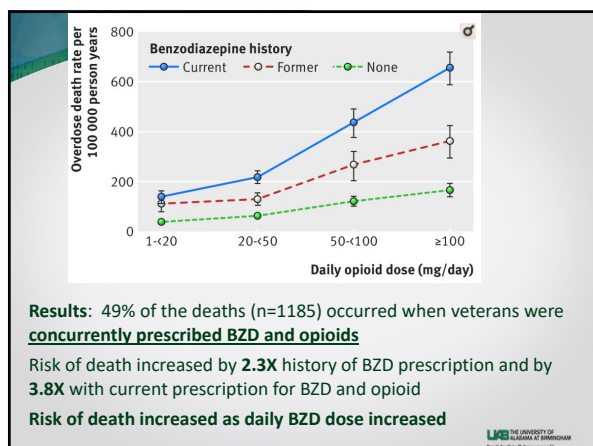
Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study
BMJ 2015 Jun 10;350:h2698. doi: 10.1136/bmj.h2698

Tae Woo Park,¹ Richard Saitz,² Dara Ganoczy,³ Mark A Ilgen,^{3,4} Amy S B Bohnert^{3,4}

Participants: US veterans receiving opioid analgesics **who died from a drug overdose** (n=2400), compared to random sample of veterans (n=420 386) that received opioids analgesics from VHA medical services



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


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GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
www.cdc.gov

Part C: ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Offer treatment for Opioid Use Disorder
 - Offer or arrange referral to behavioral therapy or addiction specialist for consideration of medication assisted treatment (MAT) with buprenorphine, methadone, or vivotril

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Opioid Addiction and Coronavirus

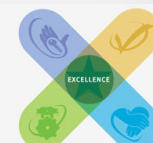
- Emotional distress and economic volatility of a public health crisis could lead vulnerable people to abuse opioids.
- Lawmakers suspended a federal law that *“required patients to have an in-person visit with a physician before they could be prescribed drugs that help quell withdrawal symptoms”*



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Opioid Stewardship

- Own it - Take responsibility
- Do right - Practice good, *evidence-based* medicine
- Work together – toward a common goal**

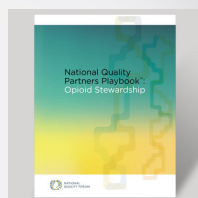


OWN IT - DO RIGHT - ALWAYS CARE - WORK TOGETHER

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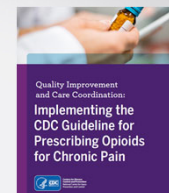
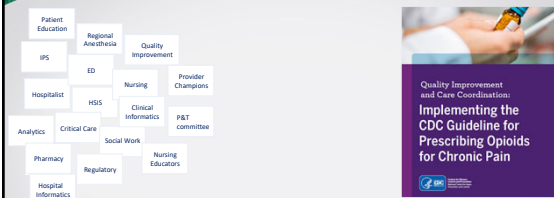
Hospital Based Opioid Stewardship

“Opioid Stewardship” is the idea that **health care systems, clinicians, pharmacists and patients must take a shared approach** to the use of opioids that recognizes their potential for harm and looks to nonopioid options whenever possible.



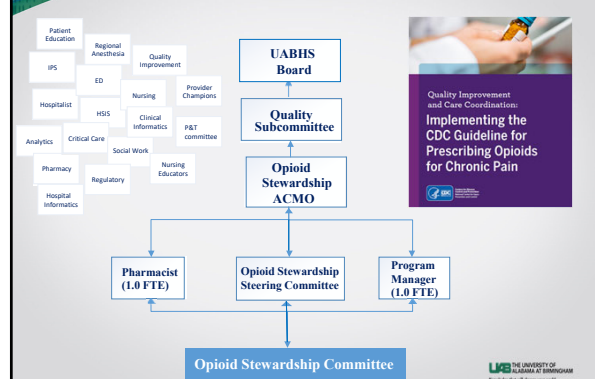
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Opioid Stewardship Program at UAB



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Opioid Stewardship Program at UAB



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Patient Education

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Opioid Stewardship EMR tools

e-Prescribing of Controlled Substances

Click on the e-prescription link in the patient's IMPACT record to go to the e-prescribing tool.

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Opioid Stewardship EMR tools

Revised IMPACT order sets

- Lower default settings for opioid prescriptions
- Easier access to non-opioid and integrative medicine options
 - Physical and Occupational therapy
 - TENS, Ultrasound, Exercise
 - EMMI videos on patient portal
- Decision support tools

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Opioid Stewardship EMR tools

PDMP IMPACT Integration

- Clicking link in patient's IMPACT record will automatically:
 - Log the prescriber into the state PDMP
 - Perform the search and display the patient's PDMP report

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Opioid Stewardship EMR tools

PDMP IMPACT Integration

Narx Score

prescribers
pharmacies
MME / LME
overlapping Rx

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Opioid Stewardship EMR tools

Opioid Dashboard / Provider Scorecard

Five dashboards developed in Tableau which are in process of being validated:

- Opioid administrations for mild pain - last documented pain score < 4 (within 4hr of administration)
- Breakdown of opioid orders for mild pain, pain categories, power plans, providers
- Opioid discharge prescriptions for > 7 days
- Combination of Benzodiazepines and Opioid prescriptions
- Daily Oral Morphine Equivalents for hospitalized patients

DISCLAIMER: Dashboard data is not meant to be punitive, nor does it indicate poor practices. These dashboards simply show current state practices and can help guide Opioid Stewardship to use data to determine best practices and opportunities for improvement.

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BCBS of Alabama Prescriber Dashboard

Opioid Pain Management Tool

- analytics regarding Rx patterns and opioid prescription history
- Risk Identification Mitigation (RIM) tool utilizes 14 prescribing quality metrics affecting patient safety
 - histogram demonstrates where prescribers fall within their specialty peer group

Opioid patient panel
Opioid dose
Polydrug rx
Multiple prescribers
Multiple pharmacies
Early opioid refill
Behavioral Health dx

SUD diagnosis
Medical diagnosis
ER visit for Opioid OD
ER visits while on opioids
Routine EKG on methadone
Opioid tapering
Drug testing

"BCBS will eventually determine qualification for incentive programs based on Opioid Risk Identification Mitigation (RIM) scores"

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Not just good practice...it's mandatory!

ALBME 540-X-4-08 Jan 1, 2014
Requirements for the Use of Controlled Substances for the Treatment of Pain

ALABAMA
State Board of Medical Examiners
Medical Licensure Commission
Newsletter and Report
www.albme.org June – October 2019 Volume 28, Number 2

Inside:
H&P Prescribing update
Solid not courses your additional efforts of prescribing course
Annual Report
The ALBME report on 2017 activity
New Board Members
Welcome three new members to the Board
Hyperbaric Oxygen Therapy
Know the appropriate use of hyperbaric oxygen

Pain Medicine Legislation: An overview
In the 2013 session, the Legislature passed Act 2013-277, pain medicine legislation dealing with the practice of pain medicine and the question of pain clinics. The legislation is extremely specific and covers everything relative to pain medicine, clinics and practices from monitoring and operation of a clinic to the training requirements for the medical director, supervision and investigations, and even includes disciplinary actions and sanctions. The Legislature is concerned with the source of opioid being prescribed in Alabama and has reacted accordingly.
For one, the preceding legislation, it is apparent to be aware of the parameters of this new legislation. If you are a licensed physician practicing in Alabama and fall into any of the following categories you MUST register under the new Alabama Pain Management Act. This Act becomes effective Jan. 1, 2014.
1. A physician who prescribes or generates based (based) in a provider of pain management services;
2. A physician who dispenses opioids;
3. A physician who prescribes more than 50 percent of his/her patients with pain management services;
4. A physician who is on the top 10 percent of controlled substance prescriptions within the state.

"The Board is obligated under the laws of the State of Alabama to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances may lead to drug diversion and abuse..."

Additional registration required for pain physicians:

1. physicians who advertise pain management services
2. Practices that dispense controlled substances
3. top 3% prescribers of controlled substances in AL by PDMP

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ALABAMA
State Board of Medical Examiners
Medical Licensure Commission
ALBME 540-X-19-09
Requirements for the Use of Controlled Substances for the Treatment of Pain

Evaluation of the Patient:

- H&P must document the presence of one or more recognized medical indications for the use of controlled substance

Treatment Plan

- The plan should state objectives that will be used to determine treatment success,
 - goal is to reduce pain and/or improve patients' function
- Alternative non-opioid treatment modalities should be considered

Informed Consent and Agreement for Treatment should include:

1. Drug screening with appropriate confirmation
2. A prescription refill policy; and
3. Reasons for which drug therapy may be discontinued (e.g., violation of agreement)
4. The patient should receive prescriptions from one physician and one pharmacy

Periodic Review.

- The physician shall monitor patient compliance in medication usage and related treatment plans

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ALABAMA
State Board of Medical Examiners
Medical Licensure Commission
ALBME rule 540-X-4-.09
Risk and Abuse Strategies by Prescribing Physicians
Effective March 9, 2017

1. Mandated Risk and Abuse Mitigation Strategies (RMS)
Examples:

(a) Pill counts;	(f) Providing a patient with opiate risk education prior to prescribing controlled substances;
(b) Urine drug screening;	(g) Using validated risk-assessment tools;
(c) PDMP checks;	(h) Physicians should consider co-prescribing naloxone in patients deemed to be appropriate
(d) Consideration of abuse-deterrent medications;	
(e) Monitoring the patient for aberrant behavior;	

2. Querying Prescription Drug Monitoring Databank (PDMP) based on Morphine Milligram Equivalents (MMEs)

- >30 MMEs – query at least 2 times per year
- >90 MMEs – query on same date of prescribing

3. Opioid-Specific Continuing Medical Education (CME)

- 2 hrs CMEs in controlled prescribing every 2 years

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ALABAMA
Board of Medical Examiners
Medical Licensure Commission
ALBME rule 540-X-4-.09
Risk and Abuse Strategies by Prescribing Physicians
Amended: effective September 2, 2018

2019 license and registration renewals

Benzodiazepine use, misuse, and abuse
by J. Luke Engstrom, MD, Deputy Chief Medical Director, AltaPainCare Health, Mobile

There has been a great deal of attention the past several years on the potential dangers of abuse of prescribed opioid medications; and although this attention is certainly warranted due to our nation's current opioid epidemic and increase in opioid-related overdose deaths, other prescribed medications such as stimulants, benzodiazepines, and certain muscle relaxants also carry a risk of misuse and abuse.

Physicians should **reconsider co-prescribing benzodiazepines and opioids**, or decline to add a benzodiazepine when prescribing an opioid

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Industry Opioid Stewardship efforts

CVS Caremark®
CVS Caremark® Opioid Quantity Limits Pharmacy Reference Guide

In 2018, CVS Caremark® introduced guidelines which are aligned with the 2017 CDC Guidelines for Prescribing Opioids for Chronic Pain.

1. 7-Day Acute Limit: A new

Walmart's Opioid Stewardship Initiative

Walmart made a commitment to move to electronic prescribing (e-prescribing) for controlled substances by 2020. We recognize not all provider networks and prescribers will have the technology and systems in place to accommodate this requirement. We will work collaboratively with prescribers to encourage their use of e-prescribing for controlled substances by 2020, so that patients are not unintentionally negatively affected by this process. E-prescribing has the potential to reduce errors, misuse, abuse and diversion of prescription medications.

ALABAMA MEDICAID
EFFICIENCY INNOVATION QUALITY

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Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act

In Rare Bipartisan Accord, House and Senate Reach Compromise on Opioid Bill
The New York Times

Combating the Opioid Crisis: Legislation
SIGNED INTO LAW
HR 6
SUPPORT FOR PATIENTS AND COMMUNITIES ACT
OCTOBER 24, 2018

CMS updated the HCAHPS patient experience of care survey measure by **removing the three recently revised pain communication questions.**

- removal of these pain questions was effective Oct 2019

In addition, the President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended that **CMS review its payment policies for certain non-opioid pain management treatments.**

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Knowledge that all things are possible

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Combating the Opioid Crisis Legislation
SIGNED INTO LAW

**HR 6
SUPPORT FOR PATIENTS
AND COMMUNITIES ACT**

OCTOBER 24, 2018

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act

Establish a Technical Expert Panel (TEP) to review quality measures related to opioids and opioid use disorders to:

- (1) review existing measures related to opioids
- (2) make recommendations regarding existing measures, new measures, and recommendations for inclusion in **value-based payment programs**
 - i. **best practices for pain management in surgical settings**
 - ii. Within 1 year, make recommendations for broad implementation of **pain management protocols that limit the use of opioids in the perioperative setting**

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HEALTH AFFAIRS BLOG

The Case For Confronting Long-Term Opioid Use As A Hospital-Acquired Condition

Michael Schlosser, Ravi Chari, Jonathan Perlman

SEPTEMBER 8, 2017 10.1377/hlthlog.20170908.061857

In a perioperative pain management summit, Healthcare leaders were alarmed by frequency of **post-operative opioid dependence** relative to other surgical complications

- surgical site infection rates are now as low as 1.9%
- persistent post-operative opioid use ranges from 6-8%

Persistent opioid use following surgery could be considered a *patient safety concern* that meets CMS criteria for **hospital acquired condition**:

- It arises during a hospitalization,
- It is a high-cost and high-volume condition
- It could reasonably have been prevented through the application of evidence-based guidelines.

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Opioid Stewardship

1. Own it - Take responsibility
2. Do right - Practice good, *evidence-based* medicine
3. Work together – *toward a common goal*
4. Always care –
Be a leader of change

UAB MEDICINE
ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

Do Right Always Care Work Together

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Preoperative Assessment, Consultation, & Treatment Clinic

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Guidelines Algorithms, PROMPTS, PATIENT EDUCATION, LEADERSHIP TEAM, CONTACT US

✓ Assessment
✓ Education
✓ Optimization

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Rationale for and approach to preoperative opioid weaning: a preoperative optimization protocol

McAnally Perioperative Medicine (2017) 6:19
DOI 10.1186/s13741-017-0079-y

Literature increasingly supports an association between **preop opioid use** and worsened postop pain, surgical outcomes, length of stay, and financial costs.

Conversely, there is evidence that *preop opioid reduction* may result in substantial improvements in outcomes.

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DOI:10.1186/s13741-017-0079-y
2019 May 22. Effect of Preoperative Opioid Use on Adverse Outcomes, Medical Spending, and Prolonged Opioid Use Following Elective Total Joint Arthroplasty: A Large Retrospective Cohort Study of Administrative Claims Data.

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WHAT YOU SHOULD KNOW ABOUT OPIOID (PAIN) MEDICATIONS

Opioids (pain medications) are very effective in treating short-term severe pain. However, we now know that long-term use of these medications may actually be harmful.

Long-term Use of Opioids Can Cause:

1. Tolerance – Your body can get used to the opioids and it may be difficult to control any new pain you experience.
2. Opioid Induced Hyperalgesia (OIH) – Long-term use of these medications may actually cause you to be more sensitive to and feel more pain!
3. Surgical Complications – Individuals taking long-term opioids are at higher risk for infection, for longer recovery time, and for poorer outcomes.

Weaning Off Of Your Pain Medication

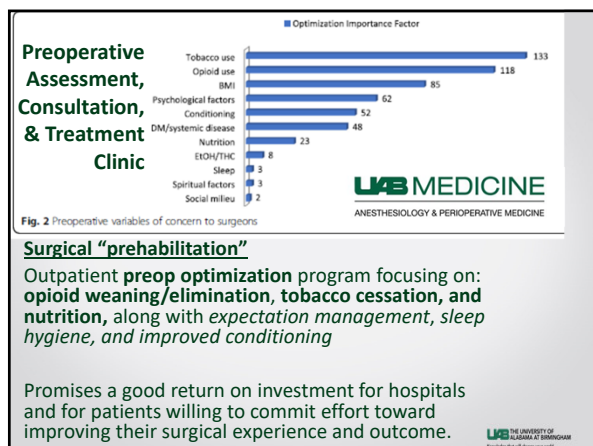
If you have been on opioids for a long time, your doctor may want to slowly decrease your dosage as tolerated. You may discover that your pain is as well controlled or possibly better controlled at lower doses. Your doctor will work with you to develop a plan that is right for you.

PATIENTS PREPARING FOR NON-EMERGENCY (ELECTIVE) SURGERY:

If you have been on opioids for a long time, it is in your best interest to work with your doctor to slowly decrease your dosage as much as you can tolerate prior to surgery. By doing so, it will give you the best opportunity to have the most successful surgery.

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Sandra L. Frazier, MD, FASAM

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WEIGHT LOSS MEDICINE

SeamlessMD
Integrate with your EHR using any standard integration interfaces including HL7, FHIR, SMART on FHIR and OpenID.

LIFESTYLE
January - March

UAB helping Full Customization of Content And Workflows
Written by Bob Shepard
Your patients, your care. Modify or replace any content or workflows to fit the needs of your organization and patient population.

The University of Alabama at Birmingham is available to hospital patient habit.

Template Care Pathways
Promote behavioral change. Access our library of evidence-based care pathways that follow best practices for accessibility and health literacy.

The service provides an assessment patient's need for medication tobacco counselors and tele service by calling the UAB LL 934-0411.

Alerts & Notifications
Deliver proactive care. Customize your workflow to receive alerts when a patient falls off track or shows signs of complication.

February 5 February 6 February 7 February 8

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A Review of Opioid-Sparing Modalities in Perioperative Pain Management: Methods to Decrease Opioid Use Postoperatively
ANESTHESIA & ANALGESIA

Kanupriya Kumar, MD,* Meghan A. Kirksey, MD, PhD,* Silvia Duong, BScPharm, PharmD,† and Christopher L. Wu, MD†
November 2017 • Volume 125 • Number 5

Article reviews relevant literature describing the use of

1. adjunct medications,
2. regional anesthesia and analgesic techniques, and
3. regional block additives

Nonopioid Adjunct Medications

- Combining nonopioid adjuvants to modulate pain pathways at central and peripheral sites to:
 1. enhance analgesia
 2. decrease opioid requirements
 3. reduce ORADEs

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Table 1. Nonopioid Adjuvants

Adjuvant	Purported Mechanism of Action	Duration/Magnitude of Opioid-Reduction Effect
Dexmedetomidine, clonidine	Stimulation of α_2 adrenoreceptors located in the dorsal horns of the spinal cord and locus coeruleus	Up to 24 h, with a greater effect with dexmedetomidine
Ketamine, amantadine, dextromethorphan	Decreased nociceptive and inflammatory pain transmission due to N-methyl-D-aspartate receptor blockade	Up to 40% opioid sparing with ketamine, unclear data on benefit with amantadine, up to 24 h with dextromethorphan
Gabapentinoids	Decreased release of excitatory neurotransmitters (eg, glutamate, substance P and calcitonin gene-related peptide) due to interaction with $\alpha_2\delta$ -subunits of voltage-gated calcium channels	Reduction of opioid use postoperatively after gabapentin likely overestimated previously but still some effect Up to 24 h with pregabalin for some surgical procedures
Duloxetine	Modulating effect on descending inhibitory pain pathways in the brain and spinal cord	Up to 48 h
Tricyclic antidepressants	Suppression of central pain sensitization through the inhibition of reuptake of norepinephrine and serotonin as well as antagonism of peripheral sodium channels and spinal N-methyl-D-aspartate receptors	No clear benefit of use
Lidocaine	Decreased release of proinflammatory cytokines (eg, IL6, IL8), NF- κ B-mediated downregulation at the mRNA level, and inhibition of N-methyl-D-aspartate receptors	Intraoperative and immediately postoperative (PACU), with possible greatest effect in open and laparoscopic abdominal procedures
Esmolol	Blockade of the excitatory effects of pain signaling in the central and peripheral nervous system and modulation of the central adrenergic (pronociceptive) activity	Significant but clinically small effect on postoperative opioid consumption in meta-analysis of small trials; more studies needed
Caffeine	Improved analgesic drug absorption (due to increased gastric blood flow), reduced drug clearance (due to decreased hepatic blood flow), blockade of peripheral pronociceptive adenosine signaling, and activation of the central noradenosine pathway	Addition to commonly used analgesics significantly increased the number of patients experiencing good pain relief (50% over 4–6 h)

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REGIONAL ANESTHESIA AND ACUTE PAIN July 2018
SPECIAL ARTICLE

Consensus Guidelines on the Use of Intravenous Ketamine Infusions for Acute Pain Management From the American Society of Regional Anesthesia and Pain Medicine, the American Academy of Pain Medicine, and the American Society of Anesthesiologists

UAB Inpatient Pain Service is using low-dose IV ketamine infusions to supplement postop analgesia and reduce opioid utilization

Postop IV ketamine is reserved for pts who have a **high likelihood of requiring large amounts of postop opioid**, such as:

1. Patients taking >50 mg OME/day preop
2. Multilevel spine surgery
3. Open thoracotomy or laparotomy

References:

1. Adam F, Chauvin M, DuManoir B, et al. Small-dose ketamine infusion improves postoperative analgesia and rehabilitation after total knee arthroplasty. *Anesth Analg*. 2005;100:475–480.
2. Remerand F, Le Tendre C, Baud A, et al. The early and delayed analgesic effects of ketamine after total hip arthroplasty: A prospective, randomized, controlled, double-blind study. *Anesth Analg*. 2009;109:1963–1971.
3. Loftus RW, Yeager MP, Clark JA, et al. Intraoperative ketamine reduces perioperative opioid consumption in opiate-dependent patients with chronic back pain undergoing back surgery. *Anesthesiology*. 2010;113:639–646.
4. Pacreu S, Fernandez CJ, Molto L, et al. The perioperative combination of methadone and ketamine reduces postoperative opioid usage compared with methadone alone. *Acta Anaesthesiol Scand*. 2012;56:1250–1256.
5. Mueller MF, Golembiewski J. The changing landscape of perioperative pain management. *J Perioper Nurs*. 2011;26:290–293.
6. Clifford T. Ketamine for pain management. *J Perioper Nurs*. 2012;6:423–424.

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Regional Anesthesia:

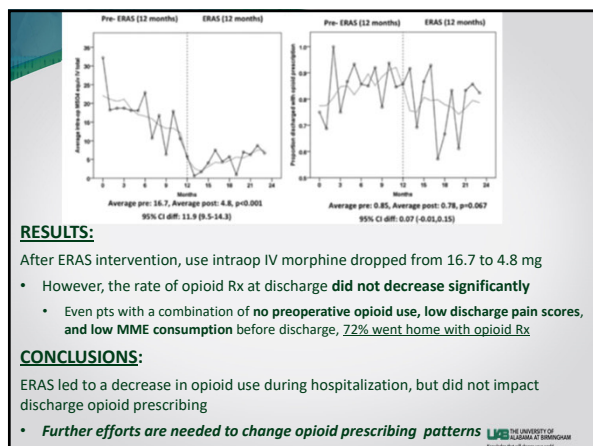
- Upper extremity blocks
- Lower extremity blocks
- Truncal blocks
- Epidural Anesthesia
- Spinal Analgesics

Regional Post-op Blocks

The ultimate goal is to tailor individual analgesic plans, based on particular patient's risk for a given surgery, in a way that **optimizes pain relief, recovery, and function.**

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Gynecologic Oncology Post-op Prescribing Project UAB Care Redesign

UAB care team leadership
Physician Project Leads: Drs. Haller Smith and Michael Straughn
Administrative Project Lead: Allison Todd
Nursing Project Leads: Erika Lumpkin and Carissa Purvis
UAB Care Team Lead: Laura Leal

UAB GYNECOLOGIC ONCOLOGY PAIN MEDICATIONS (OPIOIDS) AFTER SURGERY

WHAT YOU SHOULD KNOW

An opioid is a strong prescription pain medication. Possible side effects of opioids include nausea, vomiting, sleepiness, dizziness, and constipation.

Common opioids include:

- Hydrocodone (Vicodin)
- Oxycodone (Percocod)
- Codeine (Tylenol #3)
- Hydrocodone/Buprenorphine (Buprenex)
- Tramadol (Ultram)
- Morphine
- Fentanyl

Only use your opioids for the reason they were prescribed. As your pain gets better, use less opioids.

Our goal is to control your pain enough to help you heal faster and get back to normal sooner.

Project Goals:

- To create guidelines for opioid prescriptions for common gyn-onc surgical procedures
- To educate patients on safe and effective use of opioids and the role of non-opioid medications in controlling postoperative pain
- To encourage safe disposal of unused pain medications to prevent misuse or diversion
- To maintain excellent pain control and patient satisfaction postop

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Gynecologic Oncology Post-op Prescribing Project UAB Care Redesign

Discharge Prescription Tiers

Tier I – Minor procedure: EUA, Hysteroscopy, D&C, Cold Knife Cone/LEEP

- No opioid pain medication prescribed
- 650 mg Acetaminophen q6 hrs and 400-800 mg Ibuprofen q 6-8 hrs prn

Tier II – Laparoscopic/Robotic procedure: Hysterectomy, TAH/BSO

- Oxycodone 5mg x 5 tabs, take one tab by mouth every 6-8 hours prn pain
- 650 mg Acetaminophen q6 hrs and 400-800 mg Ibuprofen q 6-8 hrs prn

Tier III – Major procedure: Exploratory Laparotomy, Open TAH, Vulvectomy

- Oxycodone 5mg x 15 tabs, take one tab by mouth every 6-8 hours prn pain
- 650 mg Acetaminophen q6 hrs and 400-800 mg Ibuprofen q 6-8 hrs prn

Tier IV – Chronic opioid use/Excessive postoperative pain

- Oxycodone 5-10 mg individualized: 3X amount used in 24 hours prior to D/C
- Patients treated for chronic pain will continue pain meds from primary MD
- 650 mg Acetaminophen q6 hrs and 400-800 mg Ibuprofen q 6-8 hrs prn

* Patients with allergy to oxycodone prescribed Tramadol 50 mg q6hr

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Average pills per prescription: Goal < 50%

	FY17 Average Pill Count	FY18 Average Pill Count	FY19 to date (Oct'18-June'19) Average Pill Count
acetaminophen-HYDROcodone	27.05	19.80	0
acetaminophen-oxycodone	30.04	23.28	0
HYDROMorphone	136.67	35.25	60.00
morphine	90.00	42.00	90.00
oxycodone	31.57	20.10	11.06
tramadol	28.80	18.77	9.92
Yearly Pill Summary:	30.45	20.73	11.29

Source: Cancer Timeline: Oct'18 - June'19

Refills by Index Discharge Month	FY17 Summary	FY18 Summary	FY19 to date (Oct'18-June'19)
% of Patients with a Refill	13.00%	10.69%	11.37%

Refills: Goal ≤ 13%

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Gynecologic Oncology Post-op Prescribing Project UAB Care Redesign

Patient Survey

Place Patient Sticker Here

Thank you very much for doing your part in addressing the opioid crisis. Your participation is crucial in this effort and you are making a difference. Our goal is for your pain to be well controlled while ensuring any unused pills are being disposed of appropriately. Thank you again for helping us with this important part of our care.

Today's date: _____

What was your surgery date? _____

What day did you return home? _____

Did you understand your pain medication plan prior to surgery? YES or NO

Did you receive education about pain prior to surgery? YES or NO

Did you receive education about pain medication disposal prior to surgery? YES or NO

Was your pain tolerable after surgery at home? YES or NO

Overall, how satisfied were you with your pain management after surgery?

VERY SATISFIED SOMEWHAT SATISFIED NOT SATISFIED

Do you have any suggestions on how we could have improved your postoperative experience?

Did you receive an opioid pain medication prescription when you left the hospital? YES or NO

If YES, did you have to call in and request a prescription? YES or NO

If you received an opioid prescription when you left the hospital, please answer the following questions.

Did you have left over opioid pain medications (e.g. morphine, tramadol)? YES or NO

If so, how many pills? _____

Did you discard your leftover pain medications? YES or NO

If so, how did you discard the pills? 1. Flushed down toilet 2. Disposed in trash 3. Taken to Disposal Center

If so, when did you dispose of them? _____

Did you require additional opioid pain medication prescriptions? YES or NO

Survey Results	Total
% surveys completed	59% (406/694)
Pts Very or somewhat Satisfied	96%
% Patients that did not fill Opioid Rx	16%
% Patients that disposed pills	35%
% Flushed down toilet	71%
% Patients requiring additional Opioid RX	11%

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Gynecologic Oncology Post-op Prescribing Project UAB Care Redesign

UED Visits within 30 days of DC: Goal ≤ 5%

UED/ED Admissions by Index Discharge	FY17 Summary	FY18 Summary	FY19 to date (Oct'18-June'19)
% of UED/ED Visits	4.45%	3.43%	2.42%

No increase in UED Visits

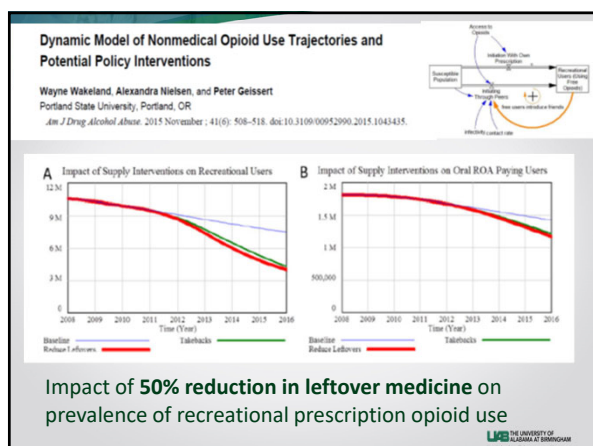
Source: Cancer Timeline: Oct'18 - June'19

	FY17 Total Pill Count	FY18 Total Pill Count	FY19 to date (Oct'18-June'19) Average Pill Count
acetaminophen-HYDROcodone	4,924	891	0
acetaminophen-oxycodone	16,282	4,330	0
HYDROMorphone	410	282	120
morphine	180	42	180
oxycodone	11,902	16,223	8,098
tramadol	432	657	635
Yearly Pill Summary:	34,130	22,425	9,033

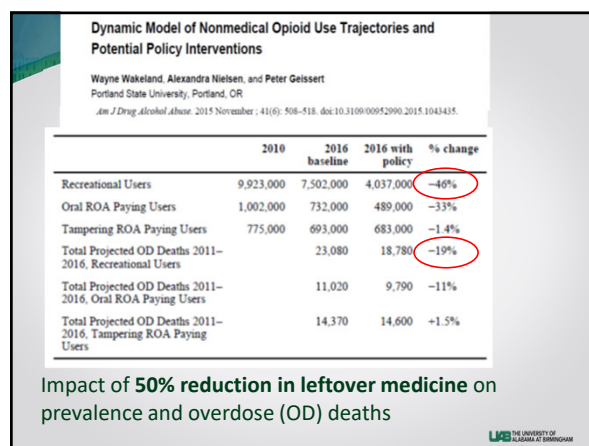
Total Pills Extrapolated 12 months = **12,044**

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ALABAMA State Board of Medical Examiners Medical Licensure Commission

CDC Centers for Disease Control and Prevention National Center for Injury Prevention and Control

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Questions?

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