ASHPOfficial - Implementation of an Opioid Stewardship Program at an Academic Medical Center

Transcript

Speaker 1:
Welcome to the *ASHPOfficial Podcast*. Your guide to issues related to medication use, public health and the profession of pharmacy.

James Blackmer:

Thank you for joining us for the *Pharmacy Leadership Podcast*. Our discussion for this podcast series focuses on leadership topics within pharmacy practice, including the business of pharmacy development of leadership skills, career transitions, and more. My name is James Blackmer from Johns Hopkins Hospital, and I will be your host for today's podcast. With me today are Doug Oyler Director at the Office of Opioid Safety at University of Kentucky healthcare and assistant professor of pharmacy practice in science at University of Kentucky, senior Director of medication safety, outcomes and values at University of Kentucky healthcare and Stephanie Abel opioid stewardship program coordinator at the University of Kentucky healthcare. Thanks for joining us today, doctors Oyler, Hite and Abel let's get started by talking about today's topic, implementation of an opioid stewardship program. Opioids have negatively impacted millions of Americans leading to a public health crisis. Your team at University of Kentucky Healthcare has been able to implement a multidisciplinary group tasked with reducing harm from opioid use in your area, the Commonwealth of Kentucky, Dr.Hite, can you start by telling us a little bit about the challenges you face to establish this group and how the pharmacy leadership was what's tasked with taking on this effort?

Kimberley B.:

Well actually it wasn't really that hard to get started. We've been fortunate in that we were already working on opioid management in the trauma service and specifically Doug Oyler and Dr.Chang, who is our CMO, who is a trauma surgeon, already had a long history of work developing the order sets and protocols that were being used in the trauma service. And so as the standards were being drafted and joint commission had come out with their Sentinel Event Alert and as the joint commissions leadership standard that addressed opioid stewardship was coming out. This was naturally occurring in the trauma service with their work together. And so as the Senior Director of our medication safety outcomes and value, I also have a dotted line to the CMO. And so we regularly meet. And so as the standards were being drafted and there was more and more discussion about it, it was kind of natural for him to identify that we need to develop a working committee specifically to address opioid stewardship.

Kimberley B. Hite:

And of course he had just the person in mind that he wanted to serve as the lead for this working committee. And that was Doug Oyler. The other really good thing about it is he resourced us with

providers that were passionate about it as well. And so he resourced the working group with Dr. Christie Diep, who is an internal medicine physician, but also had a background in palliative care. We have others in the institution that were already very much engaged and so forming the working committee was very easy. And we had a lot of engagement from the very beginning. In the beginning, the working committee was done on a shoestring. So it was in addition to the roles they already had. So Doug was our clinical pharmacist for the trauma service as is Dr. Diep had her service commitments as well. And so as the working committee continued, this was just in addition to, you know, the standard work.

Kimberley B. Hite:

And then as the opioid stewardship program became more robust that's when the position was evolving and the opioid stewardship program coordinator position was developed. And that one specifically reported to the CMO and the thought there was that this was the appropriate reporting relationship since this was part of the joint commissions leadership chapter, and his role has continued to evolve as he's expanded. And the role now has more supervision. We've been able to add other positions, et cetera, to the team, to, to make this happen. It evolved from the working committee to the subcommittee. After we attended a number of webinars together, we sat and listened to a number of the webinars and other webinars that were coming out, trying to get our hands around, you know, exactly what was the scope of this working committee and what did we want to start with and how to go about that. And so, as we develop the goals that we were going to first tackle, once we had that scope and that those goals that's when we transitioned it to the opioid stewardship subcommittee of the PNT. And so that has been an ongoing subcommittee of the PNT ever since

James Blackmer:

Sounds like the relationships your pharmacy team had with physicians and hospital leadership really laid the groundwork for putting those groups together. That's excellent.

Kimberley B. Hite:

We've been really fortunate here at UK to have a long history of very good working relationships between our providers and our nursing colleagues and really working together. So that, I mean, many times pharmacists have had to really carry them the load to develop these things and to really do a lot of the work, but we also collaborate very well and can make sure that we're listening and addressing all the concerns that the providers and the nurses may have in the work that we're preparing.

James Blackmer:

Thank you very much for that response. As with most things in healthcare, I imagine data plays a major role in the work that the opioid stewardship group does. Dr. Oyler, what are the key metrics your group is using to track the success?

Doug Oyler:

Yeah, thanks. And thanks for again for having us and everything else. So, yeah, as we look at the metrics that we have, we've got a number of different metrics that we currently track. Now we're currently using Allscripts as our electronic medical record. So a number of you guys probably use Epic or Cerner, and they may have things that are already built in and we're in the process of transitioning. So I'm getting more and more familiar personally with the kind of stuff that that is already built in there. And we can touch on that a little bit if we'd need to, but I guess a couple of things that I want to touch on. So first is it's important to align whatever metrics you're tracking with, whatever the goals of your institution are, or the goals of your program. So we've done that some here, if you look at the kind of overarching goals in general of a program, keep opioid naive patients, opioid naive, as best you can.

Doug Oyler:

If you're using opioids, make sure you're doing it safely. And then you want to provide and passionate, comprehensive care too, or facilitate at least compassionate, comprehensive care to patients with an opioid use disorder. So we look at all of those kinds of pieces and try to put it into, into our metrics. So looking at the goals of your program and build metrics based on that, it was a really good paper published actually in *AJHP.* I think it was February of last year, looking at metrics associated with an opioid stewardship program. They prioritized somewhere around 18, 19 different metrics or so that they can kind of help guide you. If you're looking for a place to start, we have ours largely lumped into kind of four big categories. If you will. Some of this has limitations of our medical record and what we can and can't track.

Doug Oyler:

So if we look at these four categories, it's basically opiate use. So these would be things like daily morphine equivalents on a per patient basis. Most of our stewardship program right now is focused on the inpatient side. So if you have an ambulatory program, these might change for you as well. But things like the number of patients that get opioids on a given day, what is their morphine equivalents look like? How many times are we starting patients on opioids? How many times are we continuing them on discharge? That sort of thing. So that's one area. The next area is high risk opioid use. And so that may be opioids at high doses, whether that's 50 or 90 morphine equivalents as some kind of threshold that you want to set their opioids and benzodiazepines and opioids and muscle relaxes, your gabapentinoids, you know, combinations of different sedating drugs.

Doug Oyler:

So how often are you starting these? How often are you continuing at the same time, some safety measures? So you can look at if your institution tracks Pesaro scores or past scores for sedation, that's something that you may consider tracking, certainly Naloxone reversals, pursuant to an opioid administration. So you've given a patient, an opioid. How often are you reversing the over sedating respiratory depressant effects of that opioid with Naloxone? So that's a metric that's been talked about by CMS and others. So that's a high priority metric at our institution is looking at Naloxone reversals for patients that are admitted to the hospital, not necessarily patients in the emergency department. And then at the same time you want a balancing measure. So we also track pain scores over time. So we look at the percent of patients that have severe pain on any given day.

Doug Oyler:

The percent that have their highest score is something that would be reflective of moderate pain or mild pain or no pain. And we trend those over time. So, you know, kind of what we've seen as a whole, as are our morphine equivalents have gone down we're starting fewer and fewer patients on opioids each year, but at the same time, our pain scores actually have gone down a little bit as well. But I think the important point here is you're looking at what's available already in your medical record, what you can pull from it certainly Epic has a lot of stuff and Cerner and others have things that are, that are already out there. So you can tailor some of those and then setting whatever kind of reasonable benchmark you think is, is aligns with your goals for your program. And, and working on one or two specific things as you get started,

James Blackmer:

Just a quick follow up question. Are there any metrics that you aren't able to capture now, but would like to in the future?

Doug Oyler:

We have some limitations around paper prescriptions, for example, now there's initiatives in Kentucky and there's some initiatives nationally with part D there may be initiatives in a number of other States, mandating electronic prescriptions for controlled substances that will really help facilitate getting descriptive variables about those prescriptions. So right now, you know, we can look at your discharge medication list and say, yes, no, you left with an opioid. You weren't on one before that kind of thing. But what we'd really like to be able to do is, is trend this kind of stuff over time, get more, how often are we sending people out with high doses, that sort of thing. That's capturable with electronic prescribing, certainly those kinds of things are metrics that already built into other medical records. So that's stuff that institutions can look at and then know, as you look at chronic opioid use, you know, how often are

you putting various safety benchmarks often? Are you doing risk screens? If you have some kind of informed consent pain treatment agreements, those kinds of things, how often does that come into play as well? So as we expand our program into the ambulatory setting, we're going to start looking at those kinds of metrics. And at the same time, as we adopt more and more electronic prescribing, we'll be able to capture a lot more of what happens out in the community.

James Blackmer:

Great. I appreciate you sharing your insight on those key metrics at some point, all initiative, space challenges, Dr. Abel, what are the biggest barriers that you found in trying to influence the prescribing and use of opioids?

Stephanie Abel:

Hi James, thanks for having us. That's a really great question. I'm going to kind of tackle this issue from a couple of different time points. So I think at the beginning of the program, some of the initial barriers had to do with the time to receive the data that we were looking for to implement some of these inpatient metrics to kind of guide we needed it to start targeting our interventions. And once again, this is just due to constraints based on the electronic health record that we currently have. The other piece, I think that's interesting in talking to folks who run opioid stewardship programs across the country is that I think opioids in and of themselves kind of touch a lot of different moving parts in an organization. So for example, opioid management from a kind of a pain perspective, there's the substance use disorder aspect of it for specifically opioid use disorder and medication for opioid use disorder with methadone and buprenorphine.

Stephanie Abel:

And then there's also kind of the diversion aspect and making sure that the supply chain piece is working appropriately. And so I think for our specific program, based on what was in place and what the needs were, we already had a very strong presence in the realm of substance use disorder and opioid use disorder, and then also a fairly strong presence within kind of the diversion tracking and management as well. So our program was primarily targeted at opioid use as it pertains to pain management and prescribing in that aspect. So I think just kind of targeting that piece took some time, but helped us to, to narrow our scope a bit more. And then that also helped getting the buy-in. So I think Dr. Hite and Dr. Oyler have also mentioned some of the pieces that were helpful in that front, in terms of ongoing barriers that I have seen.

Stephanie Abel:

I think expanding the use of non-opioid modalities has been kind of an interesting one because we're looking at utilizing things like intravenous lidocaine and ketamine, for example, as opioid sparing therapies. And I think there's just a lot of discomfort from some folks who haven't used those before. So there's kind of that aspect. The other piece would be supporting your ongoing improvement beyond the initial startup. So I think that you've had some great buy-in from folks all over the organization and made some good strides. And I think initially when you're starting a program like this targeting the low hanging fruit makes the most sense, but getting people to have kind of that continued engagement and buy in to see that, you know, we've made intervention a we've absolutely made some good strides with that, but we really need to continue to move forward and continue making progress and just helping people to understand that one intervention isn't enough to kind of carry them forward definitively, but this is truly an ongoing process and will likely continue to be.

James Blackmer:

Yeah. And I can imagine that drug shortages play a major role, especially for some of the alternative products that we use. You mentioned lidocaine, and I know that's been an issue. What do you do in those cases when it may be difficult to come by some of those alternative products?

Stephanie Abel:

Great question. So I feel this far in my career, a lot of the shortage related issues have mostly been related to opioids themselves, so that sometimes can be a leveraging factor to get some of these alternative therapies moving forward. But there also have been instances where for example, ketamine has been on shortage and that can be problematic at times for various reasons. So I think having a solid drug shortage task force or whatever that might be called in your organization is exceptionally helpful and yeah, tapping into the resources that are available within your organization to help navigate that because there's a lot of moving parts when you're talking about shortages of these medications. So just the opioid example, I mean, that kind of touches everyone, but ketamine would also be one where, you know, you have to consider the ICU implications of that potentially procedural implications of that, as well as the patients who may be utilizing those for opioid sparing modalities or severe acute and refractory pain. So I think that really having a strong group with various backgrounds at the table to help navigate those issues is imperative.

James Blackmer:

That's a great response. Thank you. I want to quickly pivot back to a few data points that show the success of your program. I believe that the data showed that you were able to decrease inpatient opioid use by 25% and decrease high risk opioid use overall by 50%. Dr. Oyler, can you share what has contributed the most to the success of your program?

Doug Oyler:

Sure. Yeah. I think a couple of things, certainly having dedicated people that this is their full time responsibility to work on. This has been really helpful. Right. Cause everybody's stretched thin, so that is just one more thing to somebody's plate and then it's organized against all the other priorities, but you bring in dedicated people and you say, this is a specific thing that you're working on. Not necessarily hitting a benchmark, but you're working on various opioid initiatives. And so we've had specific people. That's one point that I think is really helpful. I think as Kimberly mentioned earlier, moving this into, into the chief medical office has been really helpful as well. So we've got, we've got direct lines of communication with hospital leadership and that can really help facilitate direct lines of communication with whether it's high risk prescribing groups, whether it's specific areas for intervention, whether it's new populations, where pharmacy hasn't had a strong presence historically at our institution or wherever it happens to be, right.

Doug Oyler:

We've gotten more people at the table now that can help make those different kinds of connections. I think the other thing that's been really helpful is having a fairly diverse team. So we've touched on this a few points throughout, but one of the most successful things that we did was actually, we didn't do it soon enough, but bringing nursing colleagues on board and really getting nursing leadership engaged because they spend more time with, with the patients than just about anybody else. Right? And a lot of this comes back to changing patient expectations and having realistic discussions with patients about what those expectations are and ensuring that that same messages convey from everyone. So that's how we've been able to these kinds of things without at the same time, adversely impacting pain control and improving pain control in some degree. So I think there's that piece.

Doug Oyler:

And then the last thing that I think is helpful is the way that we've tried to approach opioid stewardship as a whole. I mean, there's a number of, or there's a few, at least guidance documents out there, but this is what you should do, or this is how you should consider operating your program. And certainly there's a number of things, microbial stewardship programs that are like that, but we've really tried to take the approach here of help us, help you. We're going to try and make it easiest to do the right thing. We're not going to add more work to your day as a prescriber. We understand that these can be emotional conversations with patients. It's different than some other types of medications at times. So what we're really here to do is to support you, not just come in and restrict and say, you can't do this unless you've done X, Y, or Z. So I think, approaching people in that supportive manner, having engaged colleagues from the same professions, whether that's physicians, pharmacists, nurse colleagues as well and others, and having dedicated personnel is really good. Helpful too.

James Blackmer:

Thank you for those thoughts. It's great to hear how you utilize caregivers from across the hospital to help make this program successful. And that transitions really well into our next question, Dr. Abel, can you tell the listeners how having a pharmacist in a leadership role has helped facilitate the success and what does a pharmacist bring to the table that others may not?

Stephanie Abel:

Absolutely. So I think the first thing that comes to mind for me with this question would be that the integration of pharmacy throughout the various aspects of the healthcare system and the navigation of the health system as a whole, and not just in terms of medication use process in clinical care, but I feel like we are kind of interwoven in all aspects of patient care. So I think that we are a trusted and recognized profession to engage in something like this, where it really does span into multidisciplinary groups, also the policy aspect of things, the patient aspect of things, as well as engaging with key stakeholders from the community. I think also our content expertise definitely plays a role here. I think pharmacists in general tend to be kind of very type A and have good project management skills as well as starting with the end in mind.

Stephanie Abel:

So we kind of have an overarching framework of where we want to go with this and then the steps specifically that we need to take within the healthcare system to make that happen. I also think that, there are many pharmacists that are in these roles in the United States today that have training, whether that's kind of formal or self-taught training in kind of pain management and palliative care. And I think a lot of that training also involves some aspect of treatment of substance use disorders. And so I feel that as a collective, that group of people specifically can be very helpful in kind of bridging all of those gaps because physicians, for example, only have fellowship training in palliative and hospice or interventional pain management or addiction. It doesn't necessarily span all of those. And so I think that we can be a helpful bridge to speak the language between all of them and help to have some very facilitative discussions.

Stephanie Abel:

And then lastly, I think that we do end up doing a fair amount of just at baseline in terms of driving change within an organization in general, I think between the pharmacy and therapeutics committee medication use and safety, and a lot of these other various committees that exist within most organizations, pharmacists are kind of at the core of that and are used to working through the system, using their skills time and training within the constraints of what they have to make things happen. And

so I think for those reasons, a pharmacist in, in a position like this is very well suited to successfully drive a program forward.

James Blackmer:

You make some really great points. And I think this program really brings out the high level skills that a pharmacist can bring to the healthcare team across the board. I'd like to change gears for a second and talk about something that has greatly impacted everybody across the planet the past few months. And that is the COVID-19 pandemic. Dr. Abel, how has the pandemic changed the approach to opioid stewardship?

Stephanie Abel:

COVID-19 has definitely turned the world upside down a little bit for all of us in various ways. I think specifically for our program, one of the biggest things is just kind of balancing business as usual and keeping things moving with the immediate needs and knowing that a lot of our staff at various points were pulled away for not only the preparation, but also as patients started coming in. So being able to also be flexible during these times. So lots of discussions about the drug shortages with opioids and otherwise, and kind of preemptive planning that occurred with some of those things across the nation. Quite honestly, I think affected a lot of people from a longer standing perspective. Some things that we're thinking about that are evolving, we don't necessarily have a full idea of the impact and scope would include things like are these patients who are survivors of COVID-19 who have lung damage when to have an increased respiratory risk factors due to that.

Stephanie Abel:

And is that going to potentially increase their risk for an opioid related event in the future? Additionally, there have been some concerns from the opioid use disorder community about increased risks of overdose related to heightened stressors during this time. So those stressors being everything from, you know, financial to health concerns and otherwise, I mean, everything's okay in kind of a different state of affairs right now. So not necessarily having the support that they're normally having available to them, maybe they don't have the in person meetings with their provider. Maybe they're not being able to present to their methadone clinics for example. And so is that going to kind of present and increased risk of overdoses within that community? So I think that's something to keep in mind and then also, you know, prescribing via tele health and what does that entail? So generally speaking, there are some kind of best practices in regards to chronic opioid management and being able to perform periodic urine drug tests and pill counts when those are appropriate. And, you know, the monitoring of a lot of those pieces has kind of been put on hold for a lot of folks because of the risks of COVID-19. And so I think that there

will be potentially some downstream repercussions that we aren't fully aware of yet, but being flexible in being able to assess these things as they show themselves will be imperative.

James Blackmer:

Yeah. Thank you for that response. And I completely agree that we're still just beginning to wrap our heads around all the different impacts that the pandemic is having on us as healthcare providers, patients and people. Finally, I'd like to open this question up to the entire group. Do you as opioid stewardship program experts from the University of Kentucky healthcare, have any tips for others who may want to implement a program like this?

Doug Oyler:

Sure. A couple. So the things I would think about first of all, it's got to be a collaborative effort between a ton of people. When I talk about the opioid crisis, that it took a lot of people, a long time and a lot of money to create this problem over a few decades and it's reasonable to expect it's going to take the same kind of a response. So stewardship programs are one part of that. It's not the whole thing, but even to be successful in an institution, if even if you're just looking at a small scope of prevention efforts, you still have to get a lot of different stakeholders engaged. You need to work with prescribers and physician colleagues, nursing colleagues, and things as well. So building a big collaborative team, I think is really helpful. The second piece is, is tailoring your response to your site.

Doug Oyler:

So what we did here at an academic health system, just outside of Appalachia may not work if you're a community hospital somewhere else, or if you're in a much more urban center or in some different kinds of environments. So you do have to tailor this a little bit to your site. Do you have motivated providers in your emergency department, for example? Well then maybe that's a really good place to start. So think about what this looks like at your site. And don't necessarily try to just replicate what somebody else did because, because it may not work there. And the last piece, that's maybe a little unconventional, but it's setting reasonable goals, right? Because, what you want to do here? So I read a book, not too long ago, talking about goal setting and achieving goals. It's really just take goal and cut it in half, whatever you said you are going to do, just cut it in half.

Doug Oyler:

Do you say you want to reduce opioid use by blah, blah, blah, blah, blah. We'll cut that in half and say that I want to do it by half as much because the end point isn't necessarily what's as important. It's more of you making progress towards something and you changing the culture over time. So I think that's, what's helped us be successful. It's really aiming, not so much at hitting a benchmark of whatever,

because they're not benchmarks out there, but trying to change the culture. So making progress towards something, getting some quick wins and going from there.

Stephanie Abel:

I'll go next. So I think that from my standpoint, the biggest thing that I think is helpful is to be aware of helpful resources that are free and available to use. So for example not reinventing the wheel, utilizing things like the Michigan open, which has great information about prescribing after various surgeries also prescribed to prevent has great tools for providers, pharmacists and patients regarding Naloxone. Co-Prescribing, they're all open access and free to use project support for hospital use treatment or project shout via the California health care foundation has some great resources for inpatient initiation of MOU D and perioperative management of acute pain for patients coming on buprenorphine for MOU. So I think these are just a couple of examples where there's already some great tools available and really leveraging those good resources with, or without your kind of personal touch and modification on them allows more time for you to actually spend on project execution and engaging key stakeholders to get things done more effectively.

Kimberley B. Hite:

And then finally, I think part of our success has been that we have leveraged our PNT committee structure because it is such a longitudinal effort that it allows a forum for us to continue to report back and to show the progress that we're making. Like Doug was saying, we need to continue to come back to the metrics, to come back to the progress that we're making so that we really can bring it to fruition. And certainly the metrics have helped, but having a forum to be able to bring those back and to get in front of people that has been really, really helpful. Sometimes we also need to go to and get in front of the various service lines so that we can provide that data and that feedback back to them so that we can assure them that the changes that we're making, aren't making any negative impact on pain control or satisfaction or those types of things so that we can assure them that the trends are in a positive way and not negatively impacting our patient care. So those are two other areas

James Blackmer:

And I think those are all great points, really utilizing internal and external resources to create a culture of change in order to better manage opioid prescriptions. That's all the time we have for today. Thank you so much for your time. It has been a pleasure learning more about your opioid stewardship program. And I hope our listeners are able to take a lot of weight from this. Join us here on Tuesdays, where we will be talking with ASHP members about leadership topics within pharmacy practice.

Speaker 1:

Transcript

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