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Pain Management: More is Not Better, Better is Better

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TENNESSEE Center for Patient Safety

Cynosure HEALTH

Disclosure of Conflicts of Interest

The speaker reports no real or apparent conflicts of interest.

Today's Objectives

- Describe the benefits of completely avoiding opioids where possible.
- List medications which have been successfully used to manage pain in the Emergency Department and the surgical and post-surgical arena.
- List non-medication modalities which have been successfully used to manage pain in the Emergency Department and the surgical and post-surgical arena.
- Describe the benefits of therapies such as pet therapy and music therapy.

Why This Matters

- Stand up if you know someone, including yourself, who has been harmed by opioids
- Stay standing if the person harmed was a loved one

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This is NEW…AND SO IMPORTANT

- Everything regarding opioid safety we have worked on in the HIIN is at least in part assumes that opioids were necessary

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Topics to Discuss

1. Is it really that bad?
2. Four strategies to reduce opioid deaths
   - Focusing on the optimal places to address in the hospital
3. Examining some bright spots across the country
4. How do you make it happen?
   - A focus on implementation

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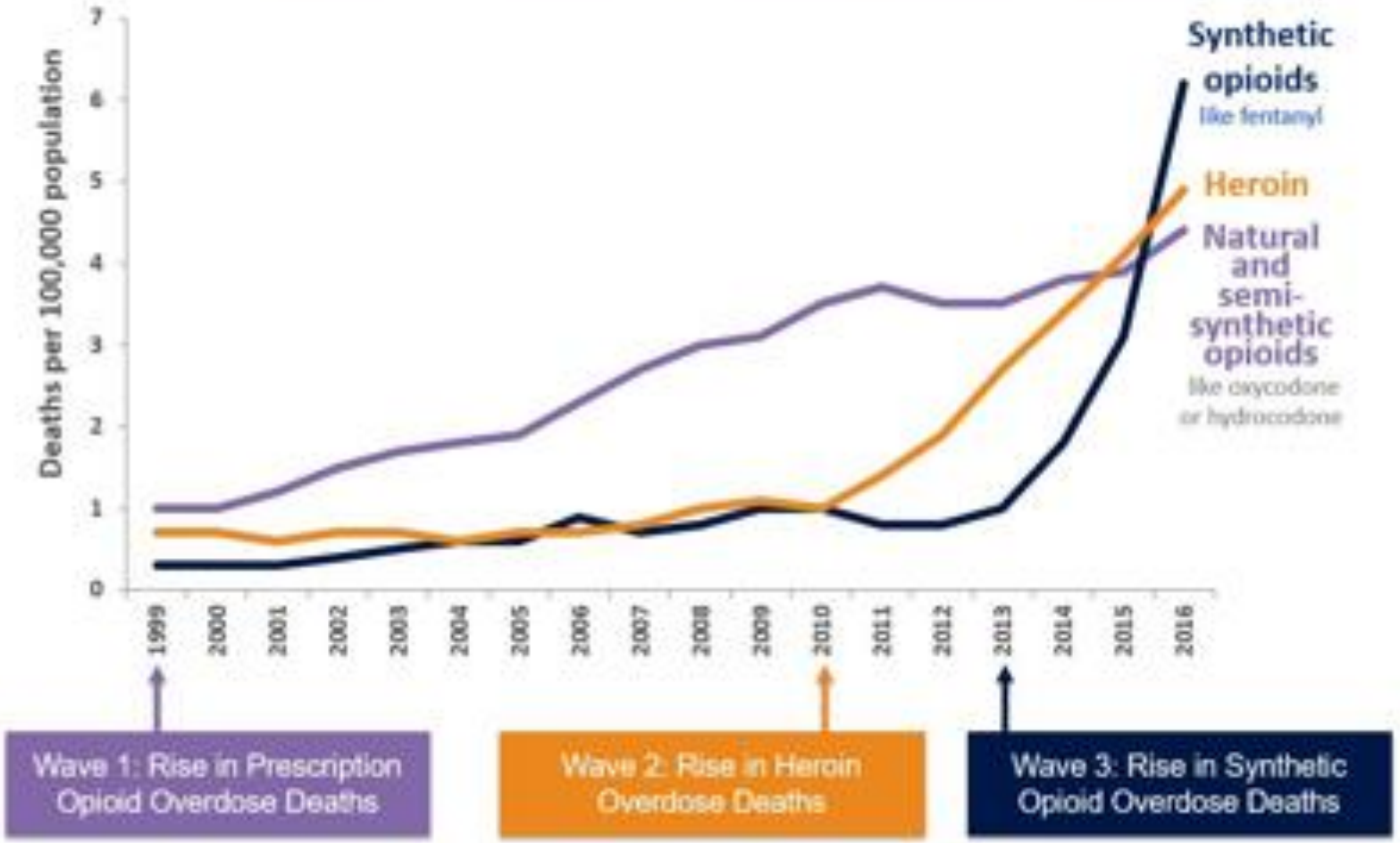
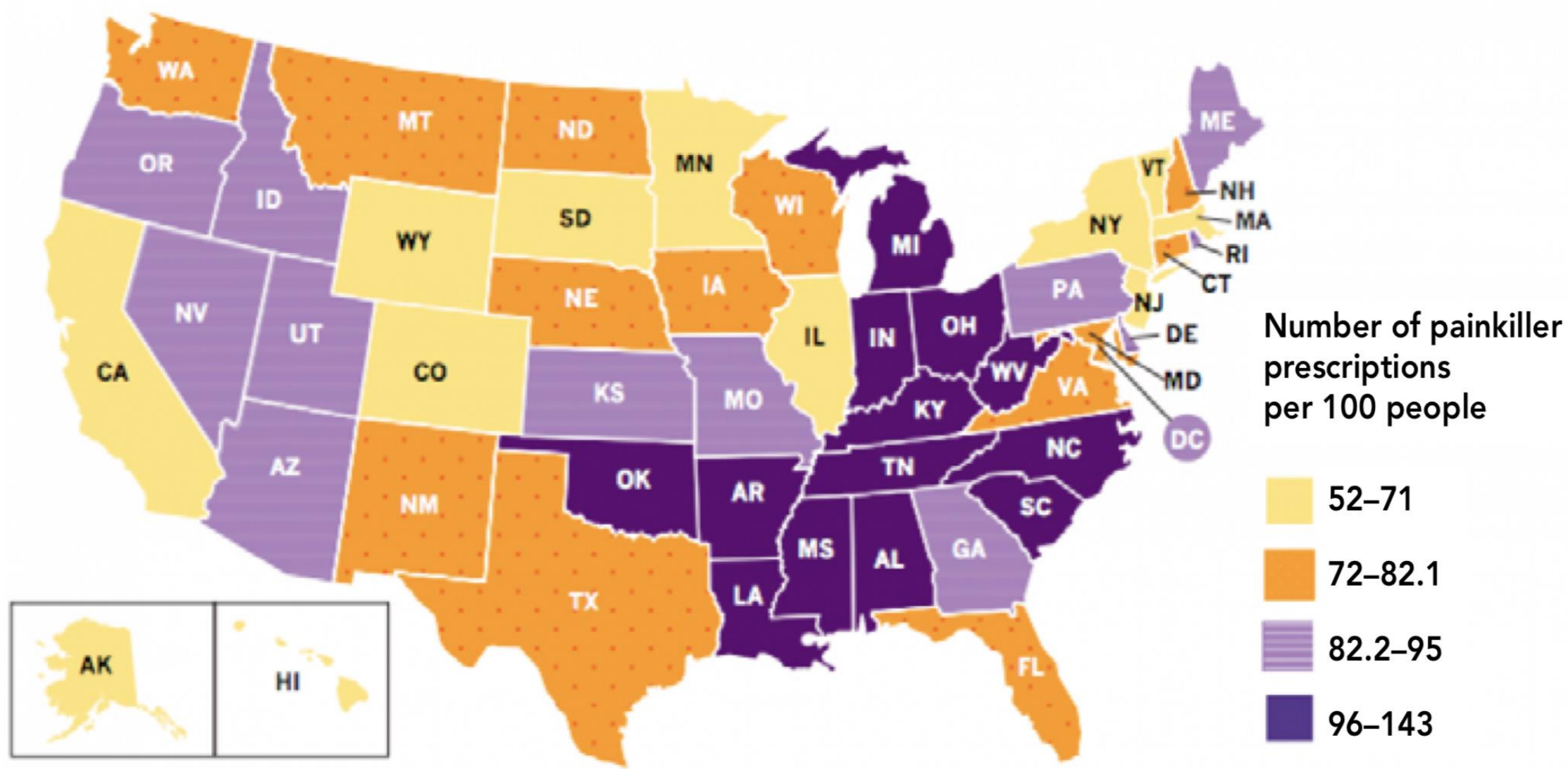
3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

FIGURE 1. PAINKILLERS IN AMERICA



Source: IMS, National Prescription Audit (NPA), 2012.

Four Strategies to Reduce Opioid Deaths

- Prevent – new starts on long-term opioid use
- Manage – chronic pain safely; focus on highest risk
- Treat – addiction effectively; MAT
- Stop – deaths with naloxone

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Prevent New Starts – Hospital Based Methods

1. Elective patients – set expectations
2. Select surgical patients – Enhanced Recovery After Surgery (ERAS)
3. Use Alternative to Opioids – ALTOs
   - Medication alternatives
   - Non-medication alternatives
4. If necessary, short-term use
5. Don’t discharge patients on both opioids and benzodiazepines
6. Eliminate carisoprodol (Soma) from formulary
7. NOT opioid free

ERAS

Enhanced Recovery After Surgery

Fast-track patients on the road to recovery

Enter ERAS

The Enhanced Recovery After Surgery Protocol is

Patient Centered & Evidence Based
Built to decrease stress & optimize recovery
Designed to decrease complications & length of stay

Pre-Op

- Targeted patient education
- Carbohydrate loading
- Less fasting time
- Warming
- Selective bowel prep

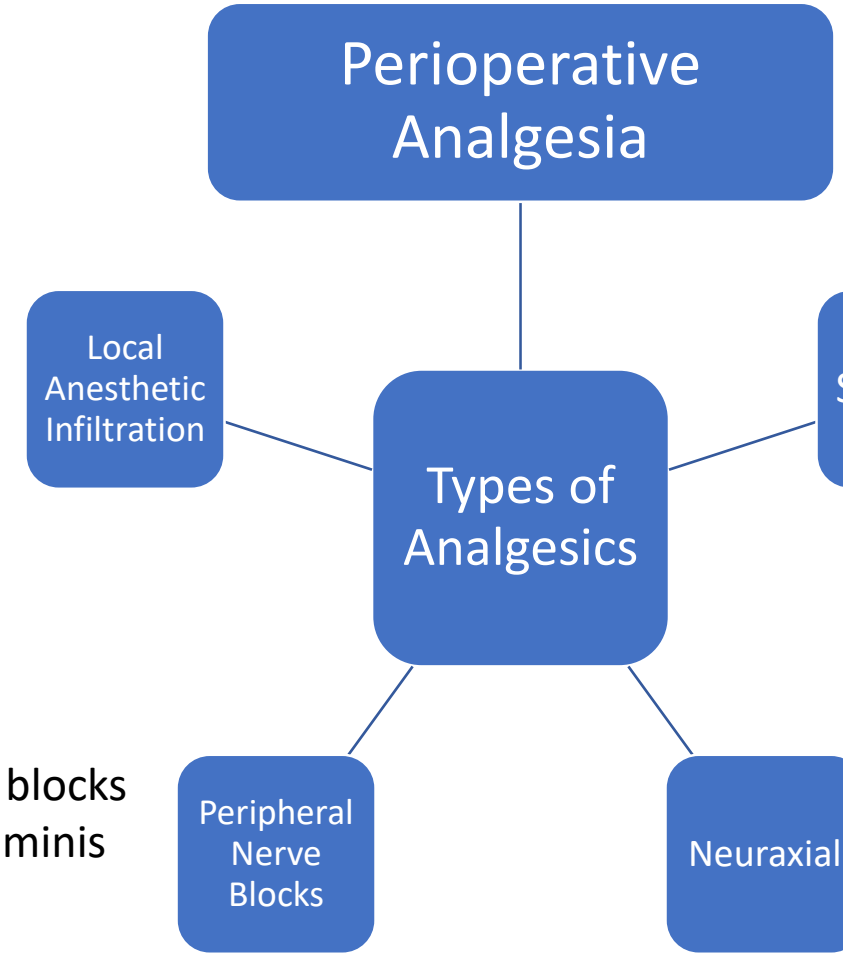
Intra-Op

- Epidural
- Warming
- No NG tubes or drains
- MIS surgery
- Short-acting anaesthetics

Post-Op

- Regular analgesia + Tylenol & NSAIDs
- Pre-emptive pain & nausea management
- Early feeding
- Nutrition supplements
- Early mobilization
- Discharge criteria
- Audits

Perioperative Pain Management



Incisional
Or Continuous infusion (on Q Pump)

Acetaminophen
NSAID's
Ketorolac
Cox-2 Selective
Lidocaine
Ketamine
Alpha 2 agonists
Gabapentin
Opioids

peripheral nerve blocks
transversus abdominis plane block

Epidural
Spinal (Intrathecal)

ALTOs - Medications

- Lidocaine (IV, topical)
- IV Ketamine
- Ketorolac
- Other NSAIDs
- Acetaminophen (IV, PO)
- Metoclopramide
- Haloperidol
- Nitrous Oxide
- Trigger Point Injections (local anesthesia)
- Cyclobenzaprine
- Others
  - Sumatriptan
  - Valproate
  - Propofol

Surgeons play an important role in the opioid epidemic

Surgeons commonly prescribe opioids after surgery

Prescribing opioids for our patients has risks for them:

- 5-10% of opioid naïve patients become chronic users after prescribed opioids for surgery.

The pills our patients don't use can be used by others:

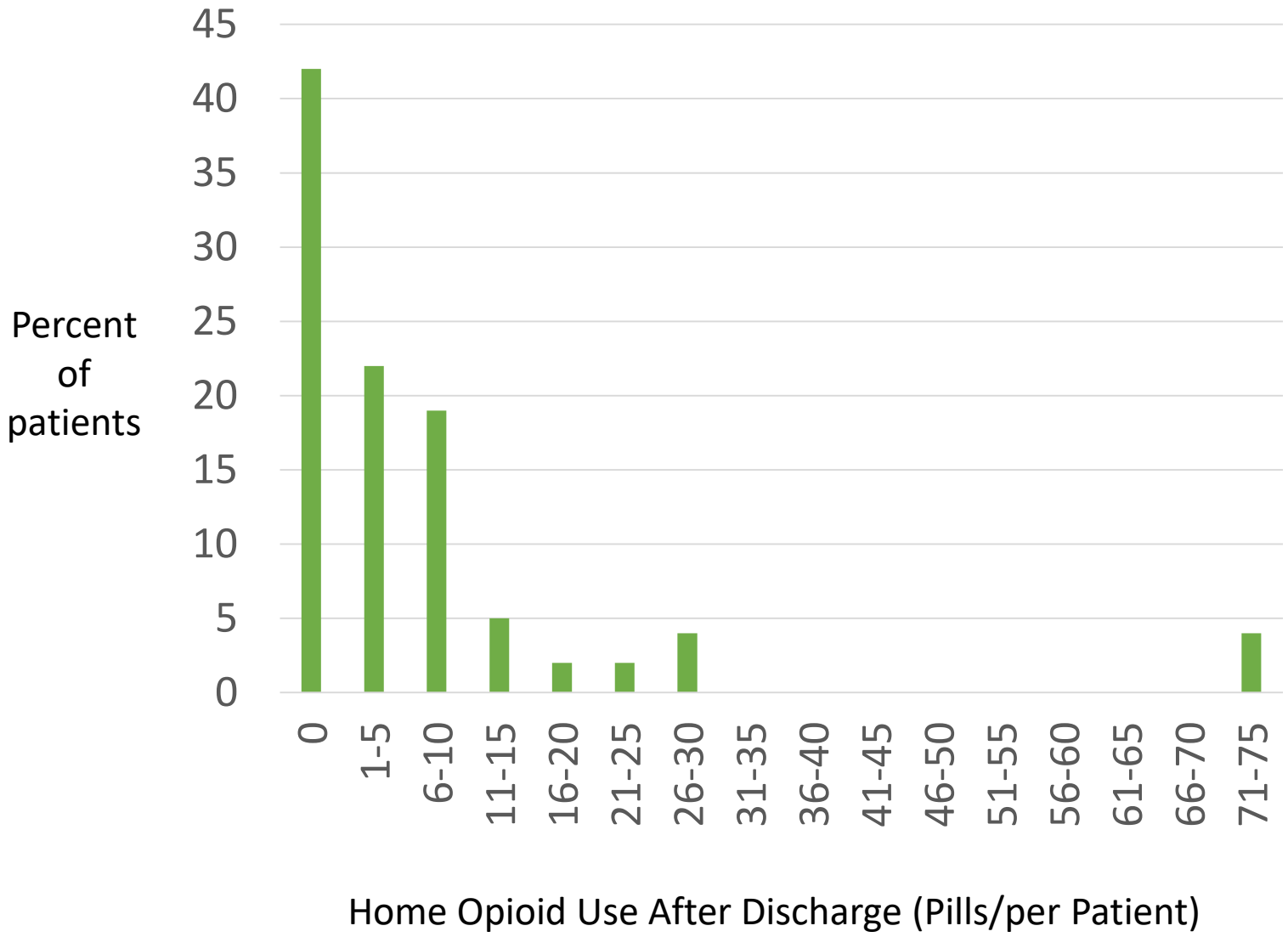
- Diversion: 71% of users get drugs by diversion.

Home Opioid Use Summary:

Only ¼ of pills were taken!

Dartmouth and others

Home opioid use for patients discharged on POD 1

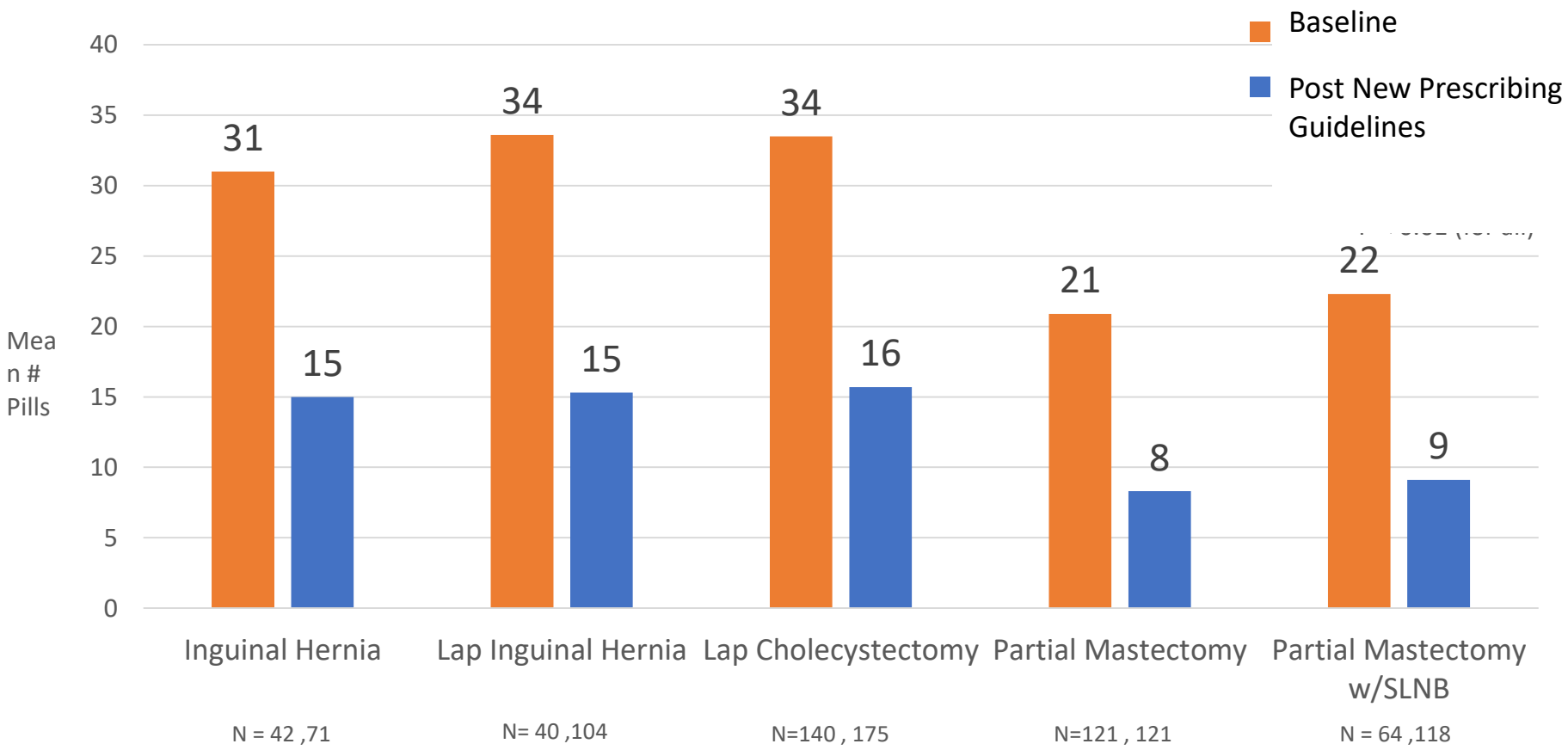


Dartmouth Study

1) The number of pills taken the day prior to discharge was the best predictor of how many opioids were used at home

2) Opioid use at home after inpatient admission was independent of the operation performed

Fewer Opioids Prescribed For Each Index Procedure



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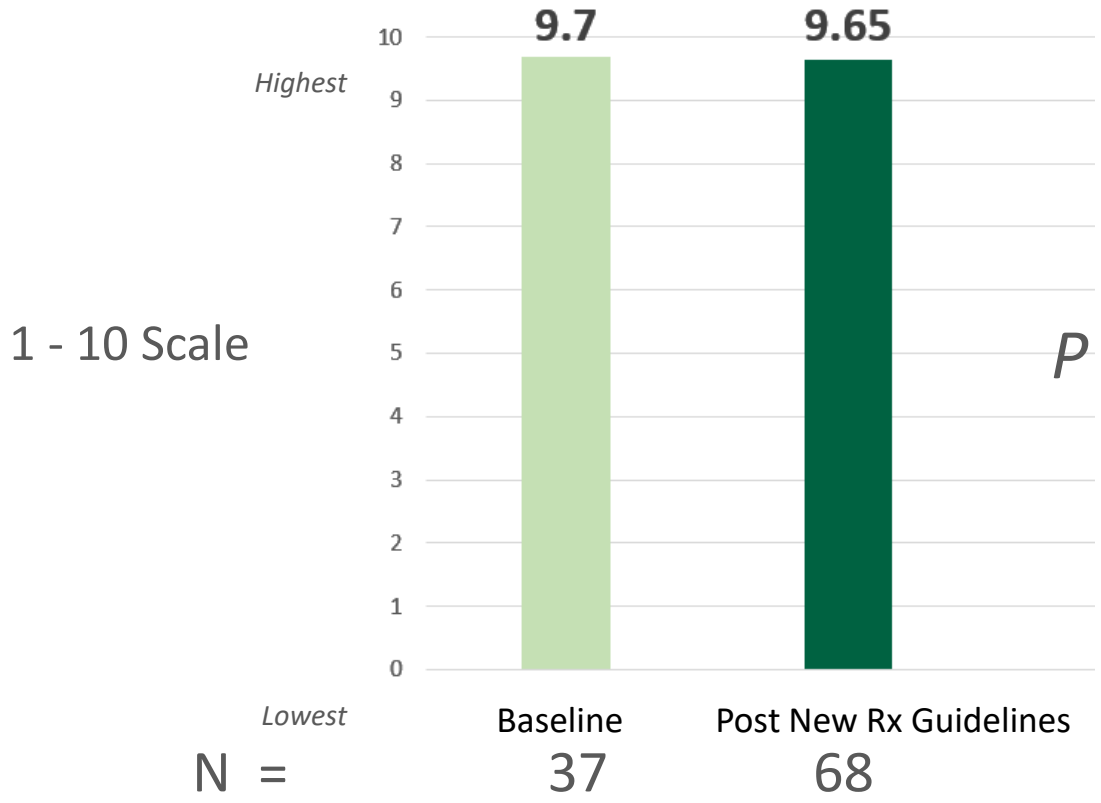
Overall Provider Satisfaction Scores From Index Cases, N = 105



P = 0.69

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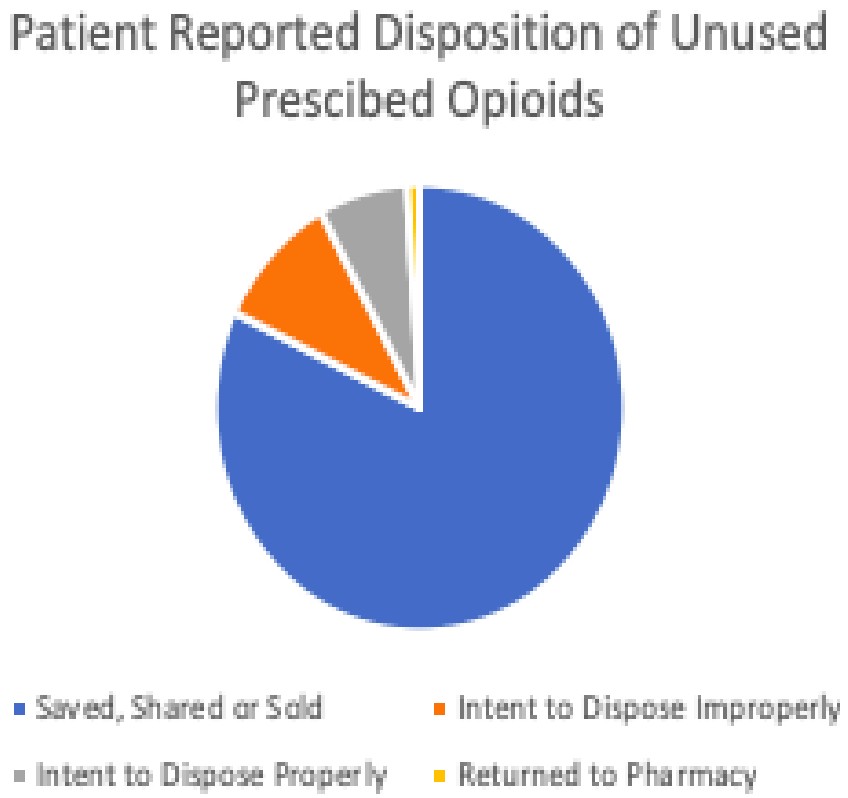
What happens to the excess pills?

- Saved
- Shared
- Sold
- disposed properly/improperly
- returned to the pharmacy



JAMA Nov 2017

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The Colorado ALTO Project

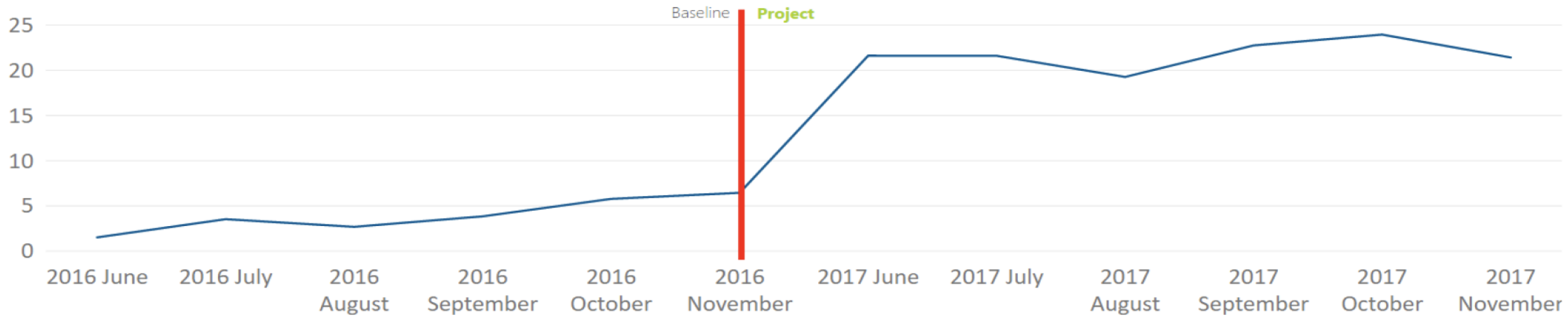
Produced in collaboration by the Colorado Hospital Association and the Colorado Chapter of the American College of Emergency Physicians

Using Alternatives to Opioids (ALTOs) in Hospital Emergency Departments

PRE-LAUNCH CHECKLIST

Based on the Colorado Chapter of the American College of Emergency Physicians
2017 Opioid Prescribing & Treatment Guidelines

Total Lidocaine Administrations per 1,000 ED Visits



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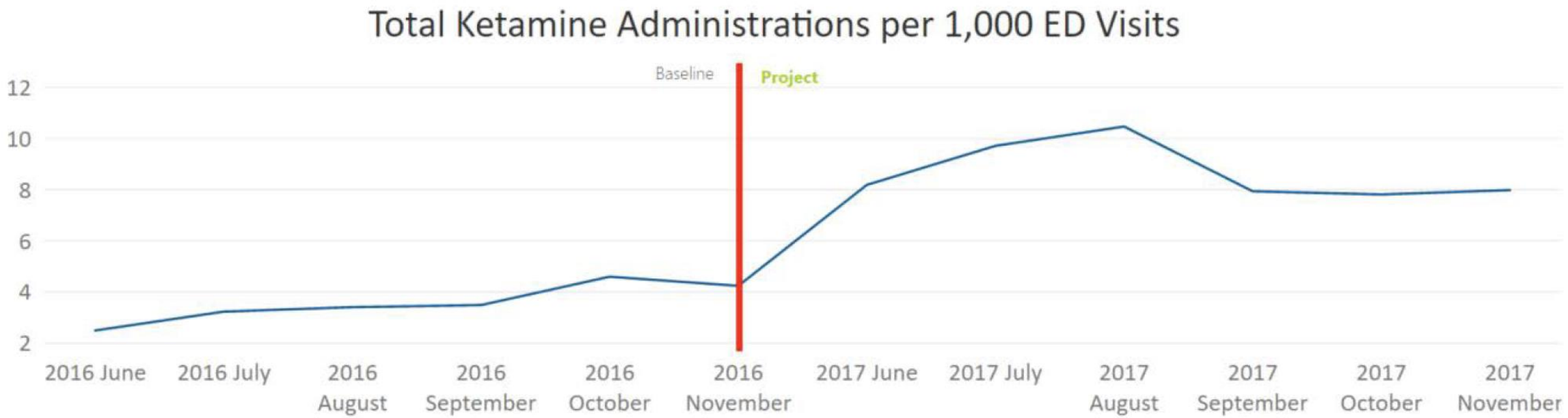

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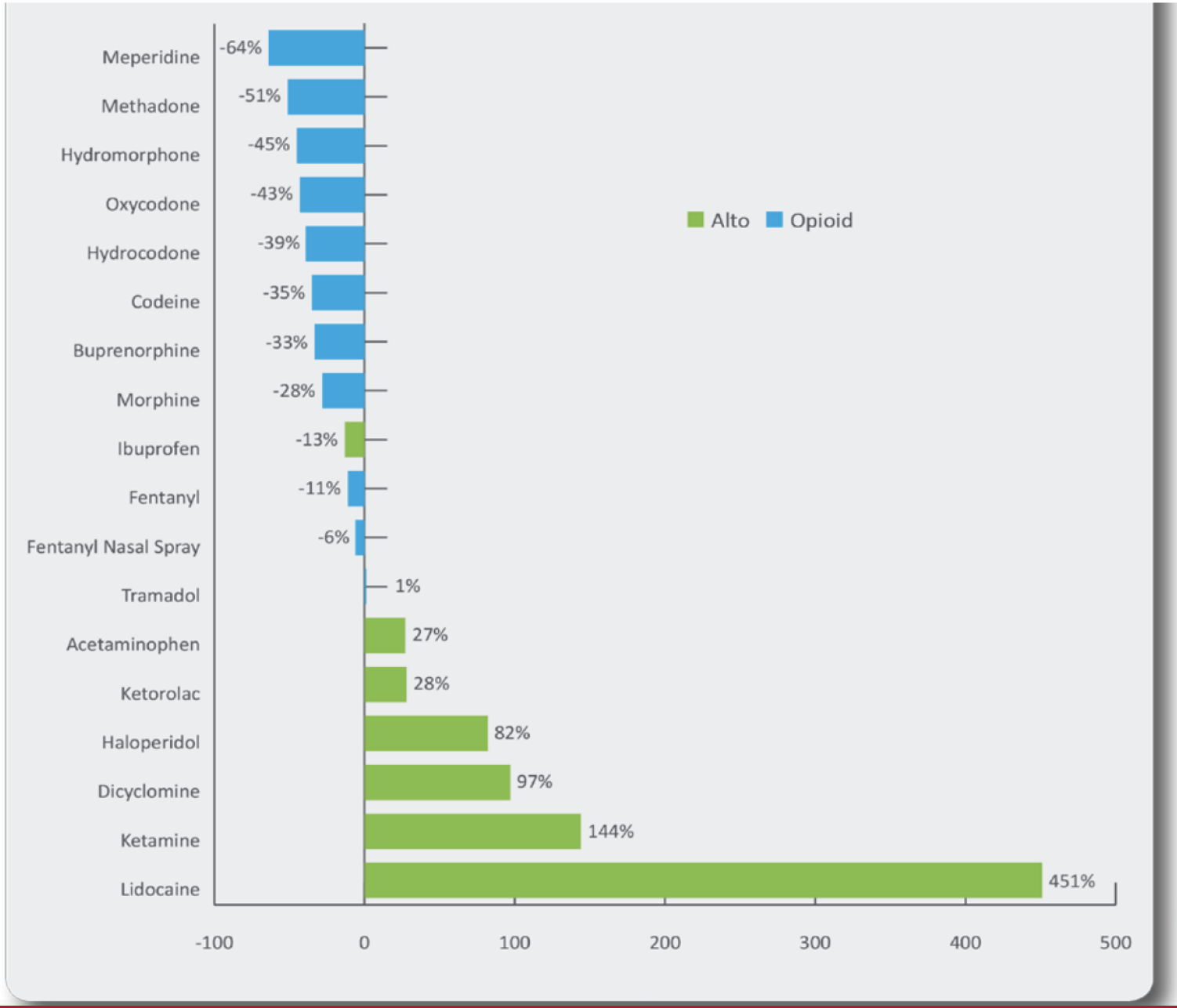
Percent Change in Administrations per 1,000 ED Visits from Baseline by Medication



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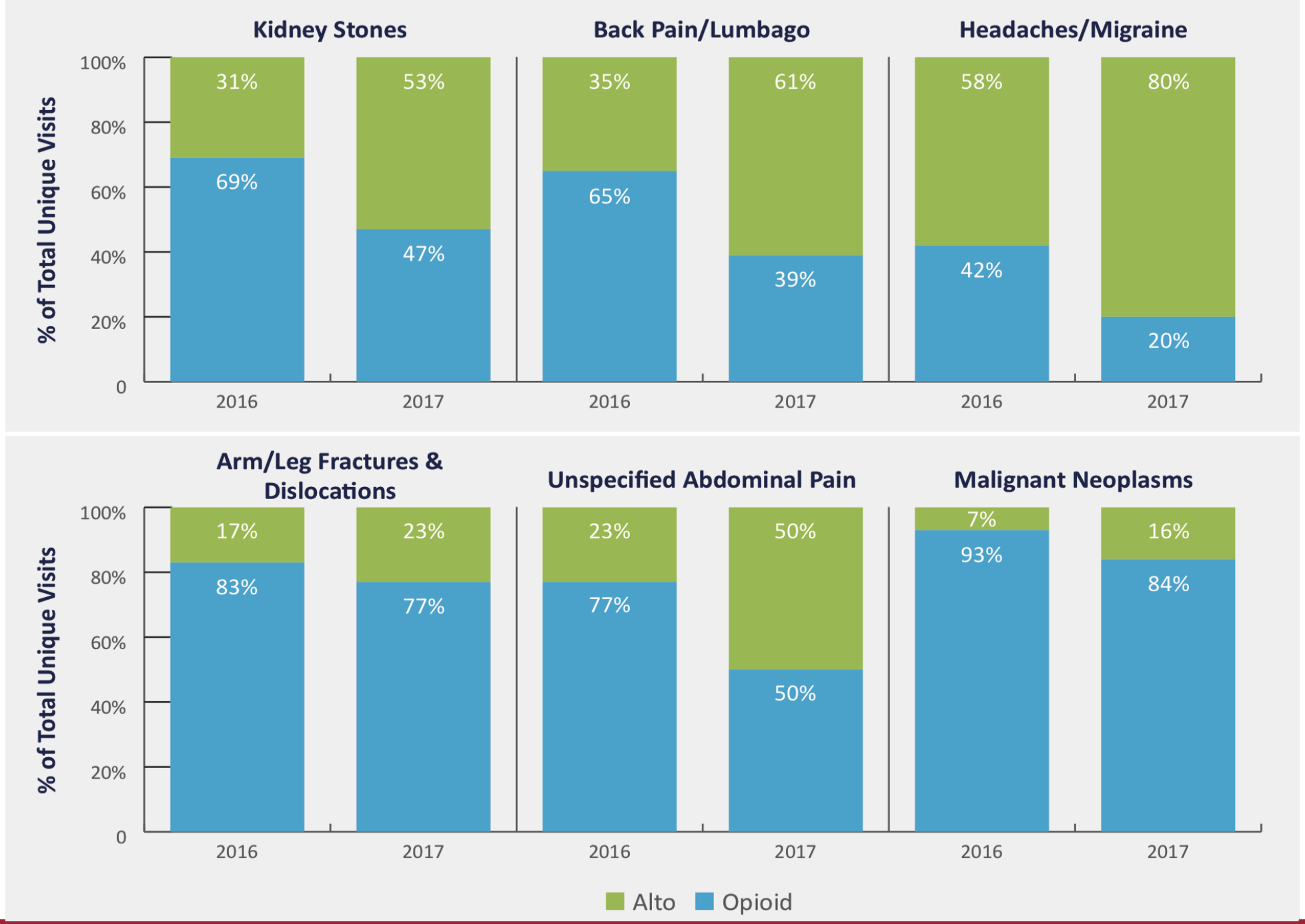

Kidney Stones
Back Pain/Lumbago
Headaches/Migraine
Arm/Leg Fractures & Dislocations
Unspecified Abdominal Pain
Malignant Neoplasms
% of Total Unique Visits
100%
80%
60%
40%
20%
0
31%
69%
53%
47%
35%
65%
61%
39%
58%
42%
80%
20%
17%
83%
23%
77%
23%
77%
50%
50%
7%
93%
16%
84%
2016
2017
Alto
Opioid

Non-medication ALTOs

- Ice/heat
- Massage
- Acupuncture – in the ED????
- Osteopathic manipulation
- Yoga
- Cognitive Behavioral Therapy
- Pet therapy
- Music therapy
- Herbals (lavender oil)

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 66 / No. 10
March 17, 2017

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

Anuj Shah[1]; Corey J. Hayes, PharmD[1,2]; Bradley C. Martin, PharmD, PhD[1]

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

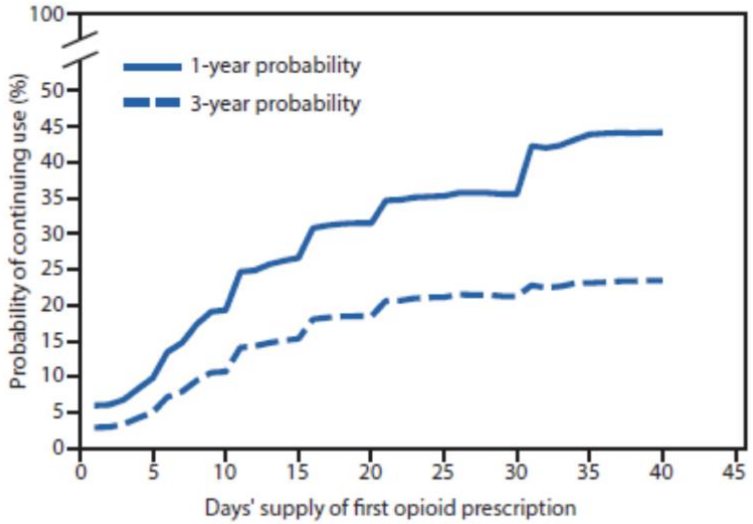
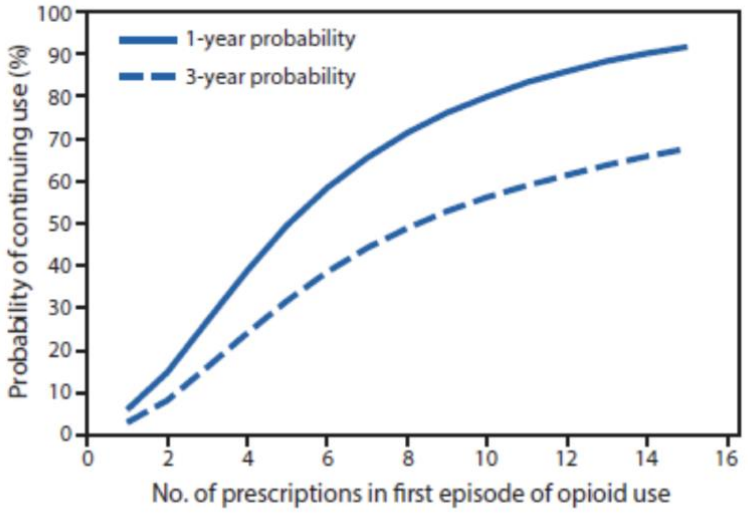


FIGURE 2. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of prescriptions* in the first episode of opioid use — United States, 2006–2015



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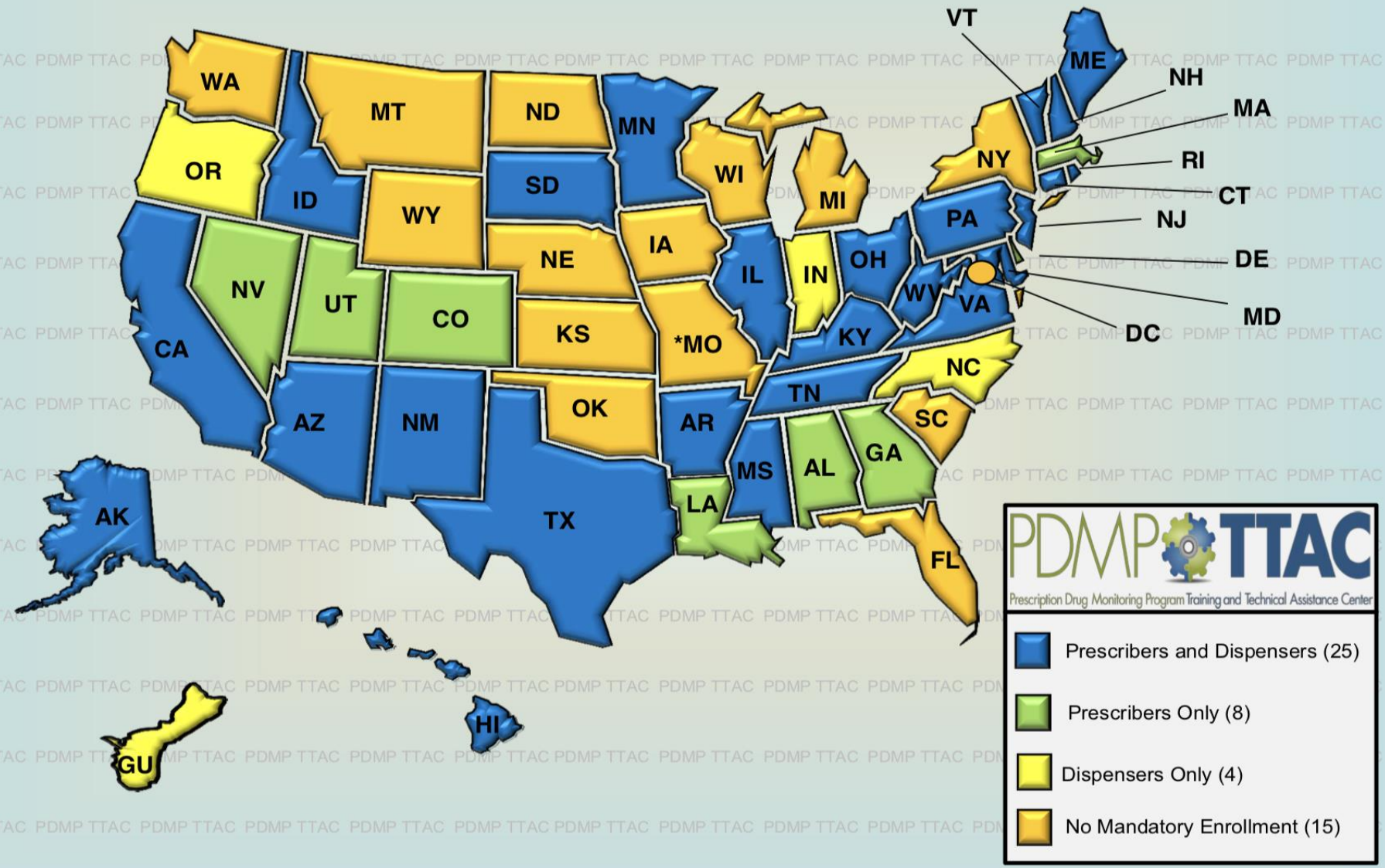
Manage Chronic Pain Safely

1. Focus tapering on highest risk patients
   - High dose (>100 MME/d)
   - Dual opioid + benzodiazepine
2. Consider standard approach to lost, stolen prescriptions in the ED
   - Consult PDMP (Prescription Drug Monitoring Program)
   - Consider drug screen
   - Opioid use agreements
3. Goal is not zero
4. Address Stigma

PDMP Mandatory Enrollment of Prescribers and Dispensers

(Listing of the specific conditions for mandatory enrollment)



Research is current as of November 9, 2017 *Missouri does not have a state-wide PDMP

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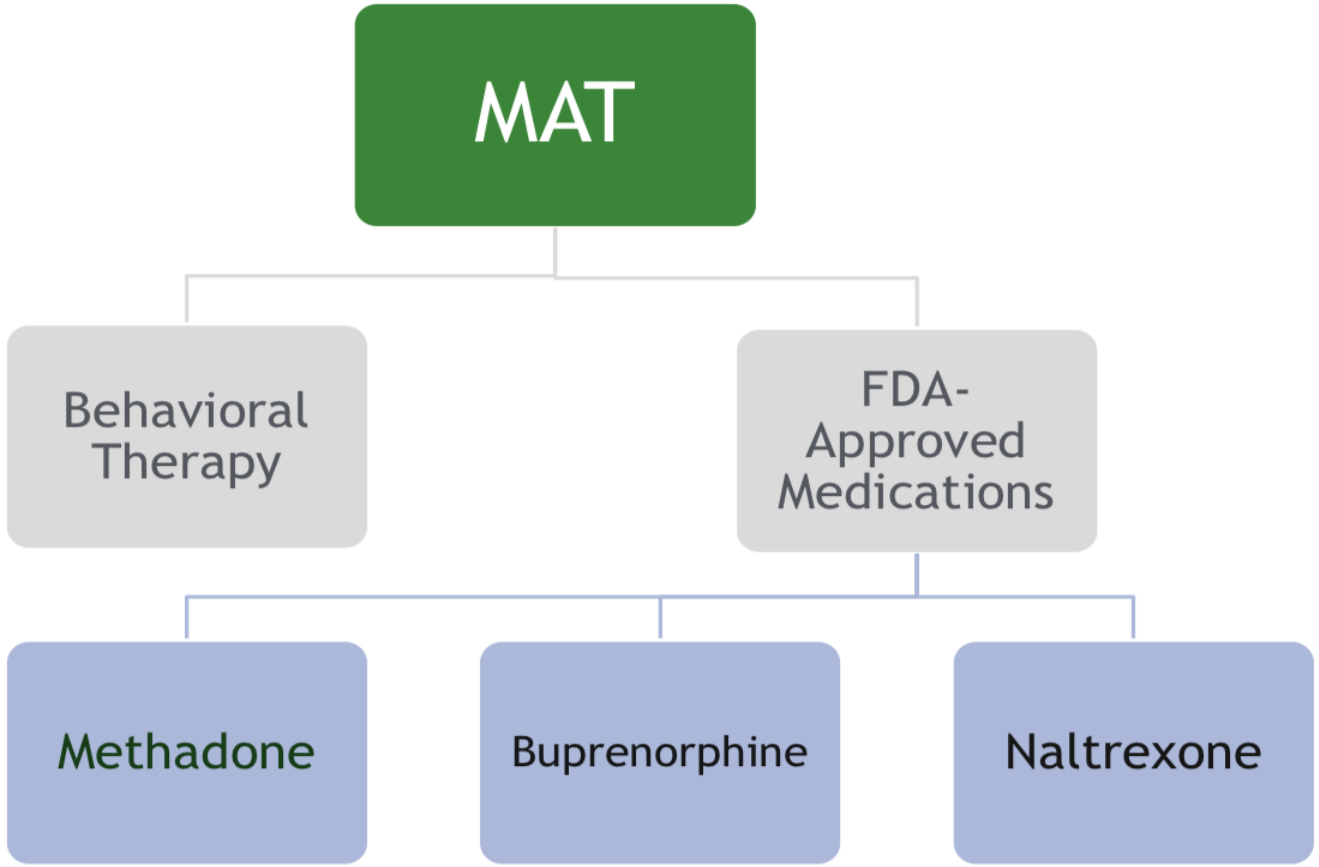
We Know How to Treat OUD

Medication-Assisted Treatment is an evidence-based effective regiment to treat OUD

Two components: Behavioral and chemical

Three effective medications



MAT in the hospital requires impeccable hand-off

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Consider for every patient >50 MME

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Measures

Morphine milligram equivalents (MME)/1000 patient days
MME/dose
Total opioid prescriptions/1000 patient days (or/ED visit)
Patients discharged with opioid + benzo/Patients discharged with opioid alone
Use of ALTOs
Balancing – HCAHPS scores (overall and pain)
Employee surveys

Questions?

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