SAFE OPIOID PRESCRIBING - METHODS FOR OPIOID MISUSE RISK STRATIFICATION AND REDUCTION OF A PUBLIC HEALTH CRISIS

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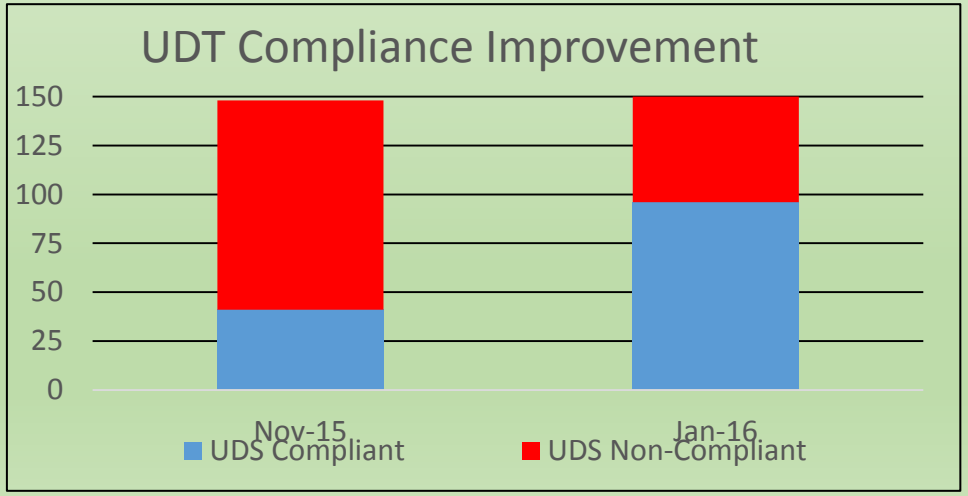
PROBLEM

- In 2003, more overdose deaths involved prescription opioids than heroin and cocaine combined.
- In 2010, 700,000 people received treatment for the misuse of prescription opioids and more than 16,000 overdose deaths occurred.
- Annually, the economic cost of non-medical use of prescription opioids is in excess of $70 billion.
- The Centers for Disease Control recently published the '2016 Guidelines for Prescribing Opioids for Chronic Pain', which promotes the safe prescribing of opioid therapy through the use of various assessment/monitoring methods.
- No 'gold standard' for risk assessment and monitoring in patients on opioid therapy.
- **Our intention with this quality initiative (QI) is to ensure safe opioid prescribing through the continued assessment for prescription opioid diversion, abuse, addiction, and overdose by complying with regulatory agency recommended strategies.**



STUDY

- TOOLS: After a through evaluation of literature and regulatory agency recommendations, we determined that we would risk stratify our patients using the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R). The SOAPP-R is a self-report screening instrument for assessing risk of opioid medication misuse in chronic pain patients and it assists the physician in differentiating those patients who require more or less clinician monitoring while on long-term opioid therapy. A protocol, as follows, was created based on the numeric SOAPP-R score and corresponding risk category in order to define a frequency interval for random UDT monitoring.

SOAPP-R Risk (numerical score)	Low (1-9)	Moderate (10-21)	High (>21)
UDT (recommended interval)	Annually	Q6 months	Q3 months

- METHODS: Based on a chart review in November 2015, we found that instead of high-risk category patients undergoing four UDTs yearly as our protocol stipulates, the majority had only undergone one UDT since completing their SOAPP-R form one year prior. We, therefore, wanted our QI study to focus on increasing our high-risk group compliance with random UDTs. Our definition of compliance is that a high-risk group patient has received a random UDT within the previous three months.
- DESIGN: Starting in November 2015, we preformed a daily review of our high-risk category patients' current UDT compliance. Each day, the number of total high-risk patients, UDT compliant high-risk patients, and UDT non-compliant high-risk patients was recorded. The UDT non-compliant high-risk patient charts were then flagged with a sticker by the fellow to promote increased awareness of need for UDT. It was then up to the discretion of the attending physician to prescribe a UDT to be completed.
- **GOAL: A 50% increase in UDT compliance in our high-risk group patients by January 2016.**

CONCLUSION

We met our goal of increasing the random UDT compliance in high-risk group patients by 50% at the completion of our QI in January 2016. On initial chart review in November 2015, only 41/148 or 27.7% of our high-risk group patients had received a random UDT within the previous three months. However, by increasing our awareness of this fact and instituting this QI, by the end of January 2016, 96/150 or 64% our our high-risk group patients had undergone a random UDT within the previous three months. **Overall, we had more than a 50% increase in compliance.** Increasing compliance with risk stratification measures and monitored testing ensures oversight of the potential for opioid diversion, abuse, and overdose. The use of opioid treatment will continue and is our duty as physicians to follow our Hippocratic oath and it's 'first do no harm' principle. By establishing this supervision, we are able to provide the safest environment for opioid prescribing.

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