CMS 2024 Quality Conference

Resilient and Ready Together

Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Optimizing Opioid Stewardship in 2024: How the Compass Program is changing clinical care for patients on chronic opioid therapy

April 2024

COMMUNITIES

FAMILIES

INDIVIDUALS

RESILIENT

READY

This material was prepared by the Iowa Healthcare Collaborative, the Opioid Prescriber Safety and Support contractor, in collaboration with Stader Opioid Consultants, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS.

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Objectives

- Explore the implementation of Opioid Stewardship principles, focusing on:
  - Reduction of opioid usage for acute pain and the incorporation of Alternatives to Opioids (ALTOs) in healthcare practices.
  - Risk management strategies for patients on Chronic Opioid Therapy (COT)
  - Use of safer agents such as buprenorphine.
  - Implementing effective tapering strategies.
- Discuss the knowledge and skills necessary for the treatment of Opioid Use Disorder (OUD), specifically focusing on the use of buprenorphine as part of an effective treatment plan.
- Describe lessons learned from a front-line clinician, who is part of the program.
- Share results of the program, and its effect on opioid stewardship practices in our cohort.

Compass Program Overview

SUPPORT Act

- 2018 Federal legislation to address opioid addiction
  - The SUPPORT Act: Section 6052 of Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
- Supporting improvement of prescribing practices to advance opioid stewardship alongside eligible clinicians across the nation

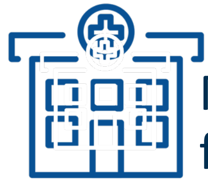
Program Goals

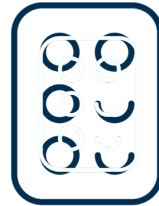
Educate and provide outreach to outlier prescribers of opioids about **best practices for prescribing opioids**

Educate and provide outreach to outlier prescribers of opioids about **non-opioid pain management therapies**

Reduce the number of opioid prescriptions prescribed by outlier prescribers of opioids.

8 Pillars of Opioid Stewardship


Multimodal analgesia for pain control


Opioid risks + side effects

Risk management for COT patients

Naloxone + overdose prevention

Opioid use disorder + buprenorphine

Opioid + benzodiazepine tapering

Patient communication skills

Documentation + charting best practices

Roadmap to Success

Building Knowledge

- 8 Core lectures – self paced
- Core reading list
- Multiple on-demand podcast series

Current Practice and Coaching

- Chart review
- Peer mentorship and coaching

Quality Improvement

- Selected based on clinician need
- Based on 8 pillars of opioid stewardship
- Pain control, screening & monitoring, Documentation, naloxone & harm reduction, OUD, etc.

Data and analytics functions

- Burden reduction
- Quarterly provider dashboard dissemination
- Customer service - feedback collection

Community of Practice

- iCompass communications
- Attendance of live case-based Community of Practice events
- Submit case or questions

Coaching and Education

- Individualized coaching based on provider needs
- Chart review
- Monthly live Grand Round events (Community of Practice)
- Compass On-Call (weekly office hours)
- Toolkit development –
  - Compass Opioid Prescribing and Treatment Guidance Toolkit
  - https://www.ihconline.org/opioid-prescribing-and-treatment-guidance-toolkit
  - Patient Facing Toolkit
  - Perinatal Substance Use Toolkit

- Multiple podcast series:
  - Program Podcast
  - Clinical Case Series (includes mini-series on motivational interviewing)
  - Mini-series on Health Equity and Health Disparities
  - Stigma Mini-series
  - Expert Spotlight
  - Coaches Top 5 Weekly Article Review
- ihconline.org/initiatives/ambulatory/opioid-stewardship-program/podcasts (Link)

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Opioid Stewardship Principles

Pain Management

Alternatives to Opioids = ALTO

Treatment Algorithm

<table>
<tr><th>Treatment</th><th>Nociceptive Pain</th><th>Neuropathic Pain</th><th>Mixed Pain</th></tr>
<tr><td rowspan="6">1st Line</td><td colspan="3">Nonpharmacological</td></tr>
<tr><td colspan="3">Acute trial of nonsteroidal anti-inflammatory drug/acetaminophen</td></tr>
<tr><td colspan="3">Add topical agent (nonsteroidal anti-inflammatory drug, lidocaine, capsaicin, menthol)</td></tr>
<tr><td></td><td>Gabapentinoids</td><td></td></tr>
<tr><td></td><td>Serotonin-norepinephrine reuptake inhibitor</td><td></td></tr>
<tr><td></td><td>Tricyclic antidepressant</td><td></td></tr>
<tr><td rowspan="5">2nd Line
Intended to be added to 1st-line therapy, when appropriate</td><td>Serotonin-norepinephrine reuptake inhibitor</td><td>Antiepileptics</td><td>Gabapentinoids</td></tr>
<tr><td>Tricyclic antidepressant</td><td></td><td>Serotonin-norepinephrine reuptake inhibitor</td></tr>
<tr><td></td><td></td><td>Tricyclic antidepressant</td></tr>
<tr><td colspan="3">Condition-specific pharmacologic agents</td></tr>
<tr><td colspan="3">Consider referral to specialist</td></tr>
<tr><td rowspan="4">3rd Line
Intended to be added to 1st and 2nd – line therapy, when appropriate</td><td colspan="3">Acute add-on muscle relaxer</td></tr>
<tr><td colspan="3">Interventional therapy</td></tr>
<tr><td colspan="3">Consider short (<7 days) trial of opioid agent* for breakthrough pain</td></tr>
<tr><td colspan="3">Referral to specialist</td></tr>
</table>

*Monoproduct opioid agents are preferred (rather than combination agents) so that acetaminophen can continue to be scheduled around the clock. Monoproducts include morphine sulfate IR, oxycodone IR, and tramadol.

Adopted from the West Virginia Safe & Effective Management of Pain (SEMP) Guidelines. www.sempguidelines.org.

Table 1 | Summary of Multimodal Analgesic Agents

Type	Example
Nonopioid analgesics	APAP, NSAIDs (Cox-1, 2, 3 inhibitors)
Amine reuptake inhibitors	Duloxetine, venlafaxine, amitriptyline, nortriptyline
Antipsychotics	Haloperidol, olanzapine
Gabapentinoids/antiepileptics	Gabapentin, pregabalin, carbamazepine, topiramate
Glucocorticoids	Dexamethasone, prednisone
Local anesthetics/sodium channel blockers	Lidocaine, bupivacaine
Muscle relaxants/antispasmodics	Cyclobenzaprine, tizanidine, methocarbamol, metaxalone, baclofen, dicyclomine
Other topicals	Capsaicin, diclofenac, lidocaine, menthol

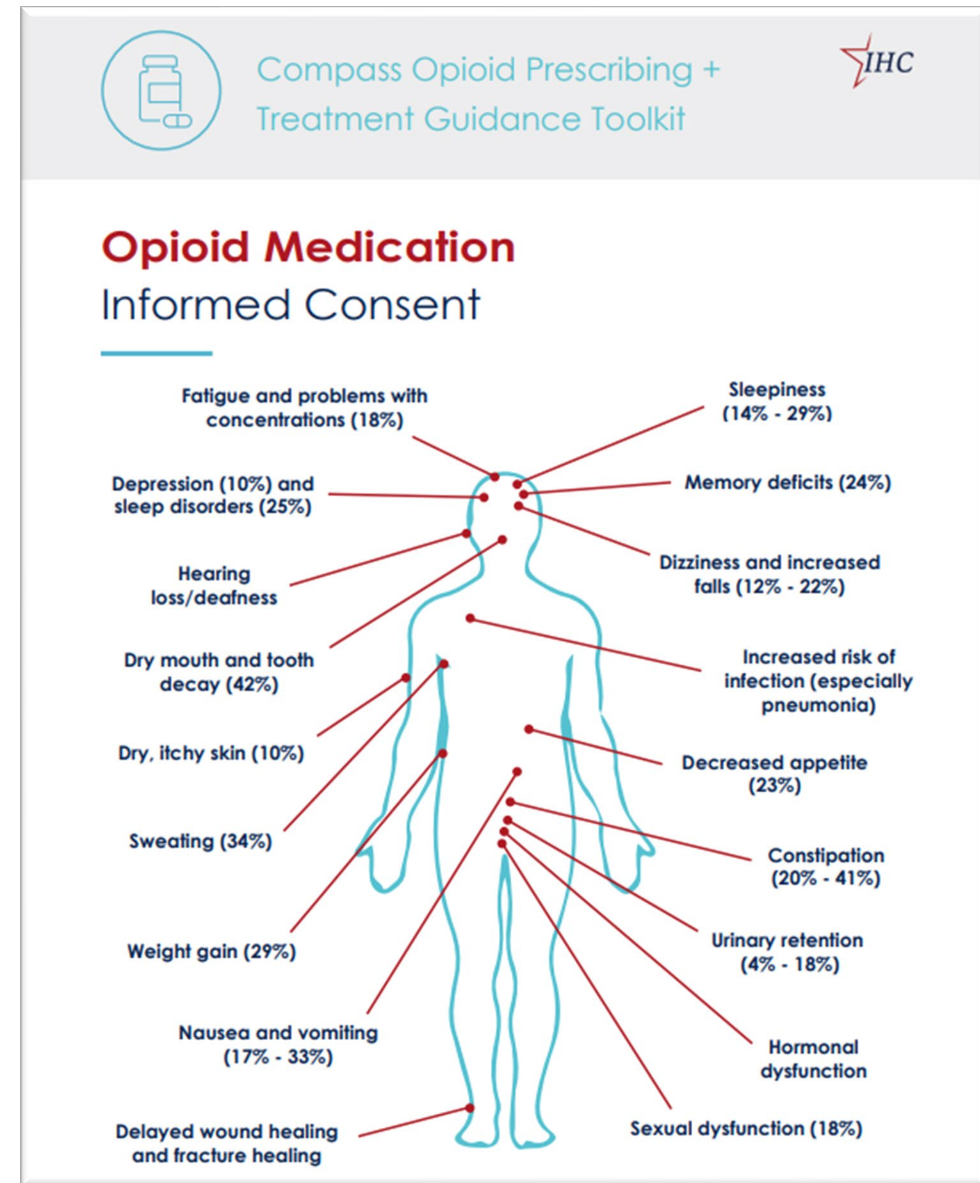
Pain Management – Patient Handbook

- **Controlled Substance Agreement:** a mutual agreement between you and your healthcare provider that outlines the responsible use of prescription medications, ensuring your safety and the effectiveness of treatment while minimizing the risk of misuse or addiction.
- **PEG Scale:** a three-question scale will be utilized during your clinic visits to help your provider better understand your pain level and the impact on your life.
- **COMM: The Current Opioid Misuse Measure:** a measure to help patients and healthcare providers understand the level of risk or concern regarding opioid misuse, allowing for more informed discussions and personalized strategies for safer and more effective pain management when opioids are prescribed.
- **Introduction to Pain:** an overview of pain to help patients understand the difference between nociception, pain, suffering and acute versus chronic pain.
- **Non-Pharmacologic Treatment Options:** alternative treatment options such as physical therapy, acupuncture, relaxation techniques, and exercises, which can help reduce pain and improve your overall well-being.
- **Buprenorphine:** an opioid that is frequently used for pain management because of its effectiveness in relieving moderate to severe pain, particularly in cases where other opioids may pose a higher risk of addiction or misuse.
- **Pain Journal:** a place to keep a detailed record of your pain symptoms, triggers, and treatments, which can help both you and your healthcare provider better understand and manage your pain over time.

Risk Management

Patient-Facing Resources:

- Providing informed consent
- Supporting shared decision making
- Opportunities Identified:
  - Promoting health literacy
  - Translation to Spanish



Buprenorphine for Pain

<table>
<tr><th rowspan="2">CURRENT MME</th><th colspan="3">INITIAL DOSING</th><th rowspan="2">TITRATION</th></tr>
<tr><th>BELBUCA
PATIENT MUST BE TAPERED TO <30 MME BEFORE STARTING</th><th>BUTRANS
PATIENT MUST BE TAPERED TO <30 MME BEFORE STARTING</th><th>SUBOXONE/ SUBUTEX
SEE STANDARD & MICRO-ROTATION GUIDES</th></tr>
<tr><td>Opioid Naive</td><td rowspan="2">75 mcg BID</td><td rowspan="2">5 mcg/hr patch</td><td rowspan="4">May Consider
(based on patient specific factors like insurance costs, previous product failure, etc.)</td><td rowspan="6"><u>Belbuca:</u> every 4 days (minimum) as needed
75mcg
150 mcg
300 mcg
450 mcg
600 mcg
750 mcg
900 mcg
<u>Butrans:</u> every 72 hours (minimum) as needed
5 mcg/hr
7.5 mcg/hr
10 mcg/hr
15 mcg/hr
20 mcg/hr
If max dosing insufficient, consider Suboxone/ Subutex</td></tr>
<tr><td>Opioid Experienced: MME<30</td></tr>
<tr><td>Opioid Experienced: MME 30-80</td><td rowspan="2">150 mcg BID</td><td>10 mcg/hr patch</td></tr>
<tr><td>Opioid Experienced: MME 81-89</td><td rowspan="3">Not Indicated</td></tr>
<tr><td>Opioid Experienced: MME 90-160</td><td>300 mcg BID</td><td rowspan="2">Standard/Micro-Rotation to uboxone/ Subute (see next table for target doses based on MME)</td></tr>
<tr><td>Opioid Experienced: MME>160</td><td>Not Indicated</td></tr>
</table>

Safe Tapering Strategies

Example Taper Using Oxycodone IR

Week	Dose 1	Dose 2	Dose 3	Total Daily Dose	Total MME
0	40mg	40mg	40mg	120mg	180mg
1-2	40mg	35mg	40mg	115mg	172.5mg
3-4	40mg	35mg	35mg	110mg	165mg
5-6	35mg	35mg	35mg	105mg	157.5mg
7-8	35mg	30mg	35mg	100mg	150mg
9-10	35mg	30mg	30mg	95mg	142.5mg
11-12	30mg	30mg	30mg	90mg	135mg

Withdrawal Symptoms and Management

Symptom	Management
Autonomic symptoms (sweating, myoclonus, tachycardia)	Clonidine* 0.1mg PO QID Gabapentin 100-300mg PO BID-TID Tizanidine 4mg PO TID Lofexidine 0.1mg 2 tabs PO TID
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine 25-50mg PO TID prn Diphenhydramine 25mg PO q6hr prn
Myalgias	Naproxen* 220mg PO BID QID prn APAP 650mg PO q6h prn Topicals (menthol/methylsalicylate cream, lidocaine cream/ointment)
Sleep disturbance	Trazodone 25-300mg PO qhs
Nausea/Vomiting	Prochlorperazine 5-10mg PO q6hr prn Promethazine 25mg PO or PR q6h prn Ondansetron* 4mg PO q6h prn Haloperidol 0.5-1mg PO q12hr prn Metoclopramide 10mg PO q4-6hr prn
Abdominal Cramping	Dicyclomine 20mg PO q6-8hr Hyoscyamine 0.125mg PO QID prn
Diarrhea	Loperamide* 4mg PO x 1, then 2mg with each loose stool (Max 16mg/day)

*Consider providing initial prescription when initiating opioid taper

Treatment of Opioid Use Disorder (OUD)

Buprenorphine Induction for Opioid Use Disorder
Quickstart Guide

Note: See separate guide for buprenorphine for pain.
Diagnose Moderate or Severe Opioid Use Disorder: DSM-5 Criteria (Link).

Choose Agent/Level of Care

Buprenorphine from PCP:
Moderate tolerance < 360 MME
Irregular or intermittent fentanyl use
Stable home life, highly motivated
No/limited access to OTP

Order Labs: CBC, CMP, HIV, Hep C, HepB SAb & SAg, syphilis, Upreg, GC/ Chlamydia, Urine Drug Screen

(ensure fentanyl, benzo confirmatory, opioid confirmatory, buprenorphine if indicated, EtG/EtS are included)

Home Induction: Most people.

Standard Induction:
Short acting opioids
Most XR/ER opioids
Handout (PDF)

Methadone or Specialty Clinic:
High tolerance > 360 MME
Regular fentanyl use
Unhoused, no support
Concomitant SUD(s):
Alcohol, benzos, stimulants

Refer, Rx naloxone 4 mg/mL IN

Clinic Induction:
Unsafe to do at home (cognitive impairment, unhoused, etc)

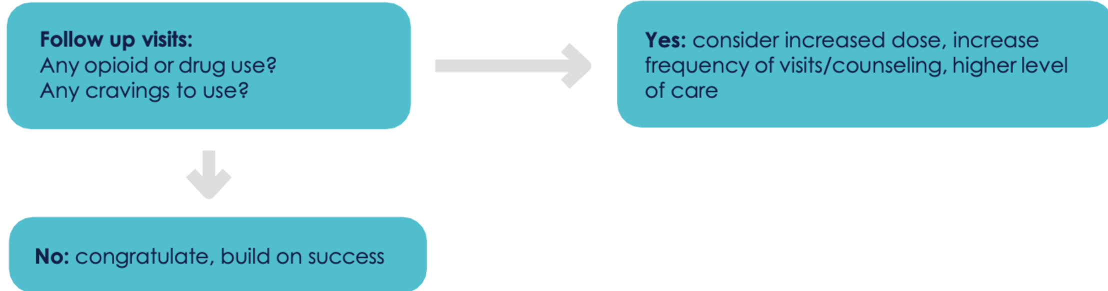
Low-Dose (Micro) Induction:
To decrease the risk of precipitated withdrawal in people using methadone or illicit fentanyl
Handout (PDF)

Visit 1

Order labs if not done already (see above)
Review patient handout for standard or micro-induction (linked above)
Prescribe enough buprenorphine for up to 1 week
Prescribe non-opioid meds to treat withdrawal (see below):

Medication	Dose
Clonidine	0.1-0.2 mg tab q4h prn hyperactivity
Hydroxyzine	25-50 mg q6h prn anxiety
Loperamide	2 mg q2h prn diarrhea
Ondansetron	4 mg q6h prn N/V
Ibuprofen	600 mg q6h prn pain
Trazodone	50 mg QHS prn insomnia

Follow up in 1 week or less; consider daily check-ins during low-dose (micro) induction. Rx naloxone 4 mg/mL IN.



Monitoring:
- Collect Urine for Monitoring
- Check PDMP
- Ensure they have Naloxone and know how to use it
- Plan relapse prevention

Schedule follow up:
- 1-2 weeks for new/struggling
- 2-4 weeks for dose adjustments
- 4-12 weeks for stable

Patient Resources

- Destigmatize OUD
- Normalize treatment of OUD
- Facilitate conversation with patient and family/support
- Reinforce messaging from provider

Opioid Use Disorder

Patient Education Resource

Facts

- People can develop opioid use disorder with any opioid, even those prescribed for pain.
- You are at risk of opioid use disorder if you take prescription opioid medications, such as hydrocodone, oxycodone, morphine, fentanyl, codeine, tramadol, or hydromorphone, or if you use heroin.
- Opioids are not usually a safe or effective therapy for the long-term management of pain.
- Opioid use disorder develops over time and is not a choice or weakness; it's a brain **disease that needs treatment**, just like other diseases like diabetes and high blood pressure.
- Signs of opioid use disorder include:
  - Cravings
  - Difficulty with work, relationships, and activities
  - Trouble controlling drug use, **even when it causes harm**
- People with opioid use disorder can **recover and live meaningful, productive lives**.
- There are multiple **medication choices that can treat opioid use disorder**, including buprenorphine, methadone, and naltrexone.

Talking to Your Clinician

- Ask if there are safer ways to manage your pain.
- Your clinician should **regularly screen you for opioid use disorder**; this is a normal and expected part of your health care plan that keeps you safe and healthy.
- If you think you might be dependent on your opioid medication or have an opioid use disorder, ask your clinician about **treatment options**.
- Opioid use disorder is a disease — don't feel guilty or ashamed to ask for help!

Guest Speaker

- Dr. Laurie Fisher, MD
- Board-certified family medicine physician in Kansas
- Enrolled in Compass Program June 2022
- Graduated program October 2023

Data and Outcomes

October 2020 – December 2023

Data and Analytics

- Self reported data collected from providers quarterly
- Customer service satisfaction data collected to inform efforts
- CMS Part D data used to monitor prescribing habits
- Provider dashboards to display demographics for patient population
- Use of population level data into to drive mitigation strategies

Outcomes to Date

Reduction in Opioid Prescribing

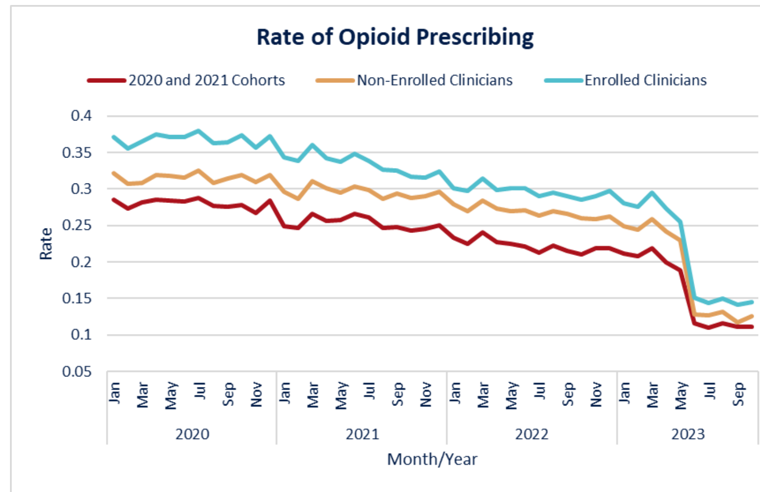
- 74,211 fewer opioid claims
- 18.11% reduction in opioid claims
- 3,394 fewer beneficiaries receiving opioids.

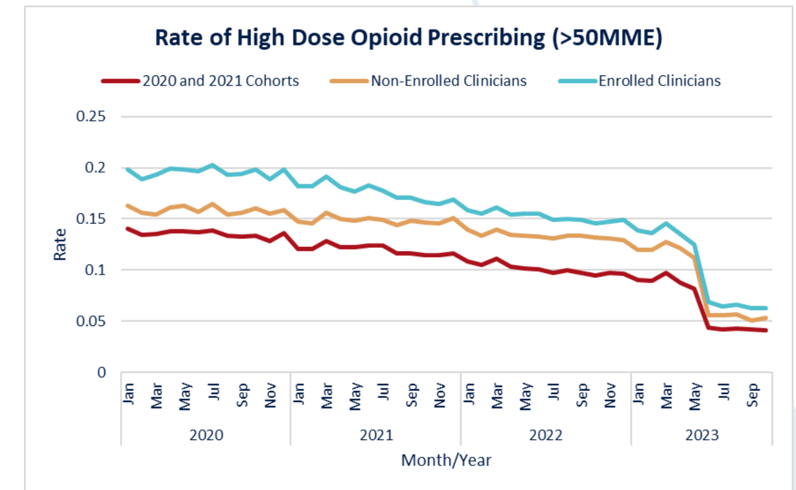
Reduction in High Dose Opioid Prescribing - >50 Morphine milligram equivalents (MME)

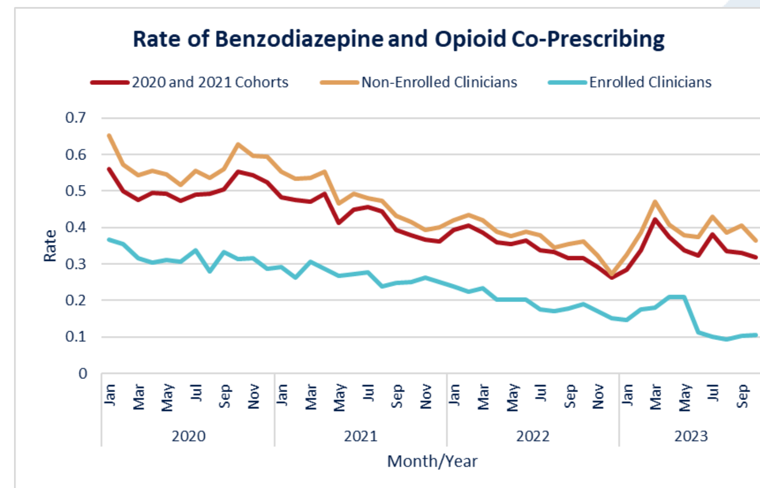
- 6,303 fewer claims >50 MME
- 20.76% reduction in opioid claims >50 MME
- 486 fewer beneficiaries receiving opioids prescriptions >50MME.

Reduction in Opioid and Benzodiazepine Co-prescribing

- 2,137 fewer co-prescription claims
- -2.29% reduction in co-prescription claims
- 119 fewer beneficiaries receiving opioid and benzodiazepine co-prescriptions.







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Cost Savings

OPIOID DRUG COSTS	Cost Estimate Per Event	Event Risk Per Prescription	Estimated Cost Per Claim	Reduction in Opioid Claims	Cost Savings
Reduction in Opioid Prescriptions	NA	NA	$70.00	83,195	$5,823,650
Reduction in Opioid/Benzo co-prescribing prescriptions	NA	NA	$80.00	2,213	$177,040
Reduction in dosage from >50 MME prescriptions	NA	NA	$70.00	6,768	$473,760

MEDICAL COSTS	Cost Estimate Per Event	Event Risk Per Beneficiary	Estimated Cost Saving Per Beneficiary	Reduction in Beneficiaries	Cost Savings
OUD	$16,365	4.5%	$736	3,575	$2,631,200
Fatal overdose	$6,303	0.09%	$5	3,575	$17,875
Non-Fatal overdose	$4,512	11%	$496	3,575	$1,773,200

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Compass Changes Practices & Changes Lives

“Alone, we can do so little; together, we can do so much”

– Helen Keller

"There is no power for change greater than a community discovering what it cares about."

– Margaret Wheatley

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Questions?

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Thank you

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