

Dr. Lynn McPherson:

Hello. This is Dr. Lynn McPherson. Welcome to Palliative Care Chat, the podcast brought to you by the Online Master of Science and Graduate Certificate Program at the University of Maryland. I am super-duper excited about our two guests today. Both of these ladies were my resident, former life. Both are just smart as a whip. I'm very excited.

Dr. Lynn McPherson:

First is Dr. Kelly Mendoza who is a Clinical Pharmacist in Pain Management at Kaweah Delta Health Care District in Visalia, California. The second is Dr. Tanya Uritsky who's the Opioid Steward Pharmacist at Hospital of the University of Pennsylvania. Welcome, ladies! How are we today?

Dr. Tanya Uritsky:

Great.

Dr. Kelly Mendoza:

Great. I'm doing well. Thank you.

Dr. Lynn McPherson:

Very good. So, who would like to start us off and tell me... We're going to be talking about Opioid Stewardship and particularly as an uprising to hospice and palliative care. What the heck is Opioid Stewardship? Who wants to take a crack at that first?

Dr. Tanya Uritsky:

I can kick it off and then, Kelly, if you want to supplement, feel free to chime in.

Dr. Tanya Uritsky:

Typically, I think of stewardship as the appropriate use of pain medications. I know it basically says opioid, which makes you think it's just opioid. But when we're stewarding opioid, we have to also steward all of the other medications that we're using instead, or trying to use to optimize our pain medication while also using opioid. What I like to think about it is more like right sizing and appropriate use and safe use of pain medications. All pain medications, in that regard. Kelly, if you want to add anything to that?

Dr. Kelly Mendoza:

No. I totally agree. We think of it as just the appropriate use, making sure we're using medications safely and effectively. Making sure that we are consistently monitoring our patients for side effects. Making sure that their pain is well-managed and that they're not having any issues with these medications.

Dr. Lynn McPherson:

Steward is just being the opioid police, right?

Dr. Tanya Uritsky:

I think-

Dr. Kelly Mendoza:

Yeah. Absolutely. Unfortunately, I don't like to be a policeman when it comes to these things, but I think it becomes more widely accepted as a practice. I think that, unfortunately, where our role fits right now as well as doing other things. But a lot of my job is policing them and the prescribers as well. [crosstalk 00:02:32]

Dr. Tanya Uritsky:

I think it's a lot about... Sorry.

Dr. Lynn McPherson:

No. Go ahead.

Dr. Tanya Uritsky:

I think it's a lot about education and steering people. Helping people get to where they need to be because if they don't know what the right thing is to do, they can't do it. We talk a lot about that in the work I'm doing in stewardship in the hospital. If we want to go and give someone a report card and say you're not doing a good job, but how can you do that? How can you say you need to do better when they don't actually know what better is. So, starting to lay the groundwork for better and then trying to help people get there.

Dr. Lynn McPherson:

Yeah.

Dr. Kelly Mendoza:

Right. Exactly. With a lot of the new laws that have come out in California, mandatory use of the prescription drug monitoring program, the Naloxone offering and things like that, it's about providing education and say, "Hey! These are the things that we have to do now as practice." You need to start integrating these in your everyday practice.

Dr. Lynn McPherson:

I think a nice analogy is when you think of antimicrobial stewardship. When I think of that, it's not saying yes or no to antimicrobials. It's saying use them when they're appropriate in the appropriate fashion. I think people sometimes forget that not all pain is opioid-responsive pain. When you see people on 80 googabillion milligrams of Morphine, can anybody stop to think is this even opioid-responsive pain? I think, as Tanya was saying, some of the basic good principles of pain management is certainly the foundation for opioid stewardship or analgesic stewardship, I would say. [crosstalk 00:04:02]

Dr. Kelly Mendoza:

Opioid stewardship came out of antimicrobial stewardship. That was the first stewardship for the pharmacist-led in this world and that's where opioid stewardship came out of. You're right. We had a patient prescribed, which is on 360 something or working equivalence for fibromyalgia and osteoarthritis. I was like, "What are we doing? What are we doing for this patient?" I hardly ever see those numbers in cancer. We got her down and used adjuvants and stuff. It's a world that I think a lot of prescribers are being opened up and needing to re-adjust their approach to these patients.

Dr. Tanya Uritsky:

I think when you speak of antibiotic stewardship just to shameless plug for the pharmacist here, not that we have any kind of reason to want to put a shameless plug in for pharmacist. But they do require as part of antibiotic stewardship, the pharmacist is part of that team. An aspirational goal as an opioid steward is that would a requirement for opioid stewardship as well. While we believe we're integral and we're demonstrating that on various levels, to aspire to have it be like antimicrobial stewardship in that regard as well.

Dr. Kelly Mendoza:

Yeah. I agree.

Dr. Lynn McPherson:

Pharmacists are the drug expert. Who else can push aside the knots on a [Calciol Nut 00:05:24] and then draw the chemical structure of Methadone beside us, am I right? [crosstalk 00:05:28] We really need to get out is all I can say.

Dr. Kelly Mendoza:

[inaudible 00:05:33]

Dr. Lynn McPherson:

Oh yes. I taught you well, young Jedi.

Dr. Lynn McPherson:

Talk to me about... Is opioid stewardship applicable to hospice and palliative care. Should we care about this?

Dr. Kelly Mendoza:

I absolutely think so especially in the palliative care world, right? Because palliative care doesn't mean that patient's dying in the year or in the next couple of weeks or even in the next couple of months. [inaudible 00:05:58] there's a use for safe and efficacious medication management which relates to symptom management and pain. I think that the principles of offering Naloxone... Because a lot of these patients are on medications that increase the risk for respiratory depression and making sure that they're safely storing their medications and away from family members and pets. Making sure that you're getting a urine drug screen and making sure they're not taking other things that they're not supposed to be taking that could make their risk higher. I think that there definitely is a need for opioid stewardship in this population. Hospice, they get a little bit... Reason to be more lenient in hospice, right, especially with imminent death because it really is a focus on comfort. But I do think of these principles, in general, so apply.

Dr. Tanya Uritsky:

I agree. I think when we boil it down to the definition of safe, effective and appropriate, that seems to apply no matter where you go. If I were still at end-of-life, I'd still want someone to make sure everything is working well for me, that it's safe and appropriate. Maybe the definition of safe and appropriate changes. Am I worried about long-term effects of steroids here? Am I worried about long-

term effects of opioid? No. But I am worried about short-term effects and making sure that that's safe and appropriate and effective.

Dr. Tanya Uritsky:

I do think you have to tease out what specific elements or data points or whatever you want to call it in stewardship you're talking about. So maybe we're not so worried about 90 MME. We can go a little further than that. But maybe we are still worried about making sure that there's a Naloxone in the home for the young child or whatever. This is thinking through the individual and how it might apply there.

Dr. Lynn McPherson:

Let me play devil's advocate. Is there anything about opioid stewardship that would fly in the chronic pain world, but really wouldn't be applicable in hospice and palliative care?

Dr. Tanya Uritsky:

I think it's along to what I was saying. If you think about the CDC guidelines, let's say, and how that has been broadly applied and not meant to be to a lot of different population namely patients with cancer or facing palliative care issues. I don't think a 7-day prescription is indicated for that patient. No, probably not. Might you be some of those types of rules, the 90 MME. Yes, I agree. Maybe if you go above that, you might be willing to go a little further above that and see how that goes. Weigh your risks and benefits along the way.

Dr. Tanya Uritsky:

I think some of our stewardship principle, we do have loosen in those regards. In elder ones, like I mentioned there are certain things that would make sense to me, to make sure that we're giving the lowest effective dose, right? But maybe not for the duration required because that might not become an issue, but definitely best prescribing habits. Looking at all patients factors and making sure we are doing it safely. Kelly, if you want to expand...

Dr. Kelly Mendoza:

No. I absolutely agree. I think there's bit and pieces that don't apply to hospice namely... Obviously, we use a lot of long-acting in hospice and palliative care which could lead you to not to. I agree and that make me think about not 90 as a cap, but... Obviously, we're getting up into the 90 MME. Start thinking that we might start to need to look at these things. But even probably buy a little bit more because these patients tend to need higher requirements and stuff. I think it's definitely a gray area that's why we're having this podcast, but I think it's a learning opportunity. We are learning to see where these principles fit in the hospice population.

Dr. Tanya Uritsky:

I think an interesting point that intensive product we talk about is the risk of opioid use disorder in hospice and the individual patient. As you think, at times we're not as concerned because they're not going to have long to live. But it is an issue a lot of times because we've have it where people have voiced concern about oh-well-they're-going-to-die-anyway kind of thing. You don't really want them to die from an overdose. Just trying to make sure we're thinking about holistically how we manage opioid use disorder and the risk for that overall and trying to keep patient safe in that regard, too. Yes, we don't want to withhold. We want to make sure we are treating their pain and giving them adequate

care. But we also do not want them having some types of issue around opioid being prescribed that we did not anticipate or planned for.

Dr. Kelly Mendoza:

Right. I think that's right. You can still have the practice of pill counting like we do in chronic pain management, making that sure their numbers add up to what they're prescribed. If not, that is conversation to be had. Is it inadequately treated pain? Or are they diverting or using more than prescribed? That would need to be determined. But I think it's still an adequate or an appropriate practice to maintain, making sure that these medications are still being safely used safely.

Dr. Lynn McPherson:

Being a practitioner of a certain age, it used to be in hospice we were walled off from the rest of the world. We didn't have to worry about this nonsense. But, boy, is reality coming to hospice. We absolutely have to worry about abuse and diversion. I think all hospice and palliative care practitioners should really up their game in terms of trying to differentiate physical discomfort from existential angst can people use in controlled substances to chemically coat with their total pain picture which could be physical, psychological, spiritual, social. As you both very well know because you did an awesome residency.

Dr. Lynn McPherson:

When you talk about MEDE, which we'll talk about in a moment. I know my personal line in the sand is when somebody gets up to about 90, a hundred milligrams a day, even though the CDC is not standing there with a hammer, I think you have to take a step back and say, "Am I doing the best job that I can do because people's pain generally respond by the time you get to a hundred milligrams a day." It's worth a second look to do another fresh, total assessment of the patient's pain. Maybe there is an existential component that all the Morphine in the world is not going to fix that or somebody is afraid they're going to go to hell and roast in hell for the rest of eternity, morphine is not going to fix it. Even [Migron 00:12:20] Methadone probably won't fix that, right?

Dr. Kelly Mendoza:

Yeah.

Dr. Tanya Uritsky:

That's right. Not methadone?

Dr. Lynn McPherson:

I love [Migron 00:12:26] Methadone. Now, riddle me this. So much of the palliative care literature comes from the oncology population. What are the guidelines in palliative care say about the role of opioid stewardship and cancer pain management? Also, a step further, cancer survivors.

Dr. Tanya Uritsky:

Yeah. Great question. The NCCN guidelines do touch on this. They do say that we should be looking at risks and benefits. It's really important that we are screening patients as far as risk for misuse. I also feel a risk for accidental overdose and what risk factors patients have that we can make sure we're thinking through as we're prescribing. They say things like doing the risk assessment prescribing Narcan when the

patient is high-risk. They also actually recommend to refer to palliative care and palliative care experts if you're dealing with a patient who you feel you need some help managing their pain or who may have some risk concerns.

Dr. Tanya Uritsky:

They do address it and they talk about universal precautions really and using universal precautions. Non-pharmacologic, non-opioid medications, using interventions when appropriate or if indicated. They definitely go there and encourage everyone to think about safe and appropriate use of opioids in cancer patients. And the same thing, actually, in survivorship as you don't get folks off of opioids when they have no longer have an indication for acute or chronic pain due to cancer and get the lowest effective dose, shortest duration possible. Kelly, you do a lot of chronic pain. You may be able to speak to that more if you see patients who come in as survivors.

Dr. Kelly Mendoza:

Yeah. We obviously do a lot of chronic pain. We have a few malignancy patients. Primarily our practice is for non-malignant pain, but I think the same principles apply, right? We need an indication to see the patient, in general, to be referred to us. I need imaging to say what's going on with the patient. I needed diagnoses, obviously, as pharmacist. Diagnosing is beyond our scope of practice. That's what I need to have a patient referred to me.

Dr. Kelly Mendoza:

Then, if I sense that their pain is incongruent with the imaging that I do have available, I do not hesitate to refer to another specialist. Order more imaging, have for them go to interventional and do that concurrently with the pharmacological treatment that I'm doing. Recommending massage, recommending acupuncture, all these kinds of things. Just making sure that we're really limiting the medications. We realize in our practice that not all patients can get off of opioids. Some people just do need some to maintain quality of life and perform their activities of daily living. But it's about finding, like you said, that lowest effective dose and trying to put them down as much as possible within the grounds of utilizing the non-opioid additives.

Dr. Tanya Uritsky:

I also think sometimes you get into trouble with the other sedating medications because we have patients who are, like you we're saying Lynn, hoping and we're giving them Ativan, too, and we're helping with anxiety. We're essentially trying to avoid giving opioids, so we're giving a lot of Gabapentin, lots of other sedatives on board. That's where you could really get into trouble. Also, if opioids are the right drug, let's try and get them some of those other guys out of there to keep that risk down.

Dr. Kelly Mendoza:

Right. Yeah. It is about risk assessment. Before a patient comes to see us, if we're going to start opioids, we do an Opioid Risk Tool to see about their potential for misuse. We always do Current Opioid Misuse Measure every visit, if they're on opioids, to determine their ongoing risk for diversion and misuse. We have them do a STOP-BANG for sleep apnea screening before we even start opioids on them. We make sure that we get all of those information to make sure that we are being safe in our prescribing.

Dr. Kelly Mendoza:

Annual PHQ-9 to assess if there is some depression and alcohol and other drug misuse [inaudible 00:16:33]. Making sure that we're keeping open line with me, patient with the other providers that we sense that there's issues or untreated, other agonies, depression, anxiety. Those are not treated, we all know that the pain meds would not going to be effective, right? Making sure that they're referred to therapy or seeing someone for their depression and getting appropriate treatment, management better.

Dr. Lynn McPherson:

I don't know if you guys remember, but a couple years ago, the news blew up with the data that oh my gosh cancer survivors are using 10%, 20% more opioids than the rest of the chronic pain population. I think just listening to both of you, this all boils down to using common sense. Use the lowest dose possible, that still helps you accomplish therapeutic goal. I read that women who have or breast cancer survivors can have post-mastectomy pain or even post-lymph node dissection pain the rest of their life which may or may not be opioid-responsive. But it just seems like common sense is the order of the day. [crosstalk 00:17:34] And there's so many social construct issues that influences this whole conversation, I think.

Dr. Tanya Uritsky:

Yeah.

Dr. Kelly Mendoza:

I think there's a big issue because we had such media around opioid crisis, all those prescriptions, da da da da. That a lot of providers has a tense to prescribe opioids. They don't want to be scrutinized by the DEA and all that kind of stuff. Unfortunately, I feel like a lot of these pain patients are getting tossed aside, saying, "I don't want to manage you anymore." There's a lot of pain management clinician available to adequately manage. Goes back to education. Part of our job is providing education to the primary care provider on how to do pain management so that all our patients can be adequately treated and they can feel like they're not just being thrown out to the walls eventually.

Dr. Tanya Uritsky:

I think you also have the patient becoming very hesitant, too. A lot of fear around taking opioid, around pain management themselves. One of my colleagues at UPenn, she did a study, [Selena Magani 00:18:49], on and looked at patients with cancer and how their relationship is with their opioids in the interviews of the patients. What she found is actually stewardship is needed, not for the reasons we think. It's because these patients are afraid they stock pile a lot of the times. They're afraid when they're going to get another prescription, if they're going to have access to Morphine medication. But also, they take it PRN. They take everything PRN. They take their Oxycotin a lot of the times PRN and that's extremely dangerous if they are not opioid-tolerant. Having Naloxone is important in a home. Not just because we think we're giving them or too much, but because actually they are not taking it as much as you think they are. When they go to take it the right way, they can get into trouble.

Dr. Tanya Uritsky:

Just thinking about it a little bit differently and educating the patient regarding those fears so that we can hopefully steward the medication in that respect as well. Because everybody is afraid of this [inaudible 00:19:40]

Dr. Lynn McPherson:

Let's talk about Naloxone. Sorry, Kelly. Are you going to say something else?

Dr. Kelly Mendoza:

Yeah. I'm just going to say I do have quite a few patients who want to introduce the concept of opioids because it makes sense for what's going on with them. They're like, "I don't want to become addicted. I don't want any of that. I don't want to become addicted." That's where you provide education. The difference between tolerance and dependence. Physical dependence versus addiction and how it's different. After that, they're like, "Oh! Okay. I understand that now." They're willing to try it. But I think that there's a lot of fears going on because they've seen everything in the media about everybody's addicted and withdrawing and things like that. That's a huge fear that has to be vexed in the patient population.

Dr. Lynn McPherson:

I think what makes me crazy in hospice in particular, which is my primary practice setting, is they don't shoulder and say, "Oh. No, no, no, no, no. I don't want mom to get addicted. We don't want mom saying, 'Go get the Morphine! Yes, I didn't want the pain!'" [crosstalk 00:20:37]

Dr. Tanya Uritsky:

People don't realize untreated pain can also be... It's a very bad sequelae. There is definitely a balance there and we need to be treating pain.

Dr. Lynn McPherson:

I don't think this is black or white. We've got evidence-based medicine that there are at least 50 shades of gray, right? Common sense.

Dr. Lynn McPherson:

Let's talk about Naloxone. Kelly, let's start with you because I think you and I were chatting earlier that there was a bill. I think it did pass in California saying patients who got an opioid prescription had to be offered Naloxone. Those of us in the hospice community turned inside out because we did not want automatically deliver Naloxone to the dying person's home for fear that somebody would throw a grandma into withdrawal. [crosstalk 00:21:14] What's all this?

Dr. Kelly Mendoza:

California passed Assembly Bill 2760 which requires that Naloxone be offered to any patient prescribed 90 or more milligram equivalents per day or a patient who is on both an opioid plus the Benzo. Or patient who has an increased risk for overdose or a history of overdose in the past. Yeah. You're right. Originally, hospice was not carved out of this. The fear was hope we don't want someone to administer Naloxone for a hospice patient who seems to be a little bit [inaudible 00:21:52] and then send them into withdrawal and a pain crisis, right? Because that's not the point of hospice.

Dr. Kelly Mendoza:

They got hospice carved out, but I think in general the law is a good step in the right direction, right? We take it one step further and if you're just prescribing opioid or just offer Naloxone, anyways. The pharmacists here can do it off of a state protocol as well. You can just walk in and say, "Hey. I want some

Naloxone." They can do it. We just also started an EE program, too. Be our worse patients come in. People just from the community go often to ED and they can be given to them safe from the ED.

Dr. Kelly Mendoza:

I think, in general, it's a step in the right direction. I do think that there are populations of people where they do not apply like hospice and nearly dying and things like that. But I think, in general, it is a move in the right direction, to have the Naloxone protocol in the law.

Dr. Lynn McPherson:

Okay. We touched on MEDD a little bit in this conversation already, but what are your thoughts on that? It strikes me like when people turn 65. You go to bed 64. Your birthday is in the middle of the night. You wake up 65. Boom! You're old! What's with that? You're on 89 MEDD, then you have rolled over to 90. Now, all goes to heck in a hand basket. What are your thoughts on the application of MEDD both in chronic pain and in hospice and palliative care?

Dr. Tanya Uritsky:

I agree with what you were saying before, Lynn. It's really a point to stop and check yourself and say, "Am I doing the right thing? What's the risk here? What's the benefit? What other medication does this person own? What are we treating? How else can we tease this out?" It's not a solid stop. I think there are patients who need more than 90 MEDD. There are pharmacogenomic things we don't understand. There are all kinds of metabolic things we don't necessarily know before we start the medication. I think that patients may need more than that, but it's about assessing function and assessing risk. The patient is more functional and doing better with a little bit more Morphine and tolerating it fine. We have the conversations and we're re-assessing frequently. Probably okay, but if we're going up and up and up and we're seeing patients become less functional or it's not helping them anymore, it doesn't make sense. What else should we be doing? I think it's not a firm cut-off, but more chance to stop and think and re-assess what you're doing. Then go from there.

Dr. Kelly Mendoza:

Yeah. I agree. Obviously, 90 is a lot in the literature and for this to [inaudible 00:24:19] I've seen other documentation that talks about 50 MME or MEDD. There's not really a consensus where is it dangerous at that point. It's dangerous at any point, right? An opioid is a dangerous medication. With every dose, you can have an issue. It's about risk-benefit with other chronic medications they're on. Do they have renal disease and therefore have clearance issues? Do they have liver disease and therefore metabolic issues? Look at the whole person and assess their individual risk, right?

Dr. Kelly Mendoza:

Obviously, yes, as you get higher. Like most chronic pain patients don't need to be on anything higher than... I think my max is probably 80-ish and 90-ish, but she had some surgery in there. I'm getting her down. I feel like most chronic non-malignant pain, I should say, is probably not ever be that high. It's just a checkpoint, right? Stop, re-assess. What are we doing? What else is going on? Did I miss something? Are their pain complaint still coincide with the injury that they have?

Dr. Tanya Uritsky:

It's interesting because I look at our Naloxone administration data in the hospital. We have a very long patient population. It's basically a tertiary, quaternary referral center. We get pretty young, pretty sick people. But our Naloxone administration, actually, the bulk of it is given to patients who are on than 50 MEDD. It's really just the opioid in those very sick patients that it's tricky more than the amount of opioid itself. I do agree with Kelly. It's about the whole patient and what's going on with that patient. I'm starting to think I don't care that much about inpatient MEDD. I care more about all the other complexities and the fact that they're on any opioids at all. I think the risk picture depends a lot on everything else than the opioid.

Dr. Kelly Mendoza:

Riddle me this. Calculating an MEDD. I'm very interested in this question. You got a patient in Oxycontin 30 Q12 and Oxy IR 15 Q4 PRN. Do you just count the long-acting? Do you count all of the IR that they could potentially take in that calculation or do you say, "Man. They probably take two or three a day."

Dr. Tanya Uritsky:

All of it. [crosstalk 00:26:41] Possibly all of it. That's what we have to do. That's how [crosstalk 00:26:44] do it.

Dr. Kelly Mendoza:

I calculate the potential, their maximum that they can take it in a day as prescribed. But then I always ask them how are they actually taking it to get an idea. But if I'm just doing my chart review before I go in to see a patient, I say, "Well, their maximum only is this." And then I check as to how many... What's their code count? Do they have extra remaining that I'm not expecting? [inaudible 00:27:10] means they're not taking all of it, so what are they actually taking?

Dr. Lynn McPherson:

That can be problematic, though. For example, if it's a community pharmacist she's trying to follow that same rule. If somebody with an advanced illness and they've got that Oxycontin 30 Q12, or even 10 Q12, let's say. But then, you've got the Oxycodone immediately. So, maybe Q2 PRN and you multiply by 12 and just like, "Sorry. You crossed the line. Back in the corner with you."

Dr. Tanya Uritsky:

You have to get prior authorization usually.

Dr. Kelly Mendoza:

Yeah.

Dr. Tanya Uritsky:

That is also a huge barrier, unfortunately, for these patients. It's probably the biggest barrier is making sure they get access with their medications. Because the insurance requires Q4, they're going to stop you at that because that's their quantity limit. Yeah. It's definitely a huge barrier.

Dr. Lynn McPherson:

So arbitrary, it seems to me. You really need to look at the whole situation. But talking about backing people up, how do you taper? Do you fast taper? Do you slow taper? And here for the bonus round of

my question, as you know I used to have a primary care practice, that means you both stepped in that clinic. Let's say somebody comes back and they have another urine where something is in it that shouldn't have been in it. The physician says, "That's it." They cut off. Do we have a moral, legal, ethical obligation to taper them down? Do we give them another one month supply, a kiss on the forehead and a cookie and say, "Don't come back." How do you handle that?

Dr. Tanya Uritsky:

All right. Kelly, I'm going to give it to you because I do the tapering clean. So, go for it.

Dr. Kelly Mendoza:

Yeah. Obviously, in our practice we do have our patients sign a controlled substances agreement with us. In that, it states you will take your medication as prescribed. You will refrain from alcohol and a list of recreational substances. Cannabis is... We go here for recreational in California, but because we are federal facility we maintain that Cannabis is not a controlled substance or scheduled ones. Therefore, they tend to get it.

Dr. Kelly Mendoza:

If we have a patient come back with a dirty urine, we always get confirmatory because things can be false-positive, false-negative on screens. We do get a confirmatory to make sure that they're actually taking something that [inaudible 00:29:13] with it. And then I do have the conversation and say, "Hey! This is not in your urine. What's going on?" Right? I generally do a repeat and see if it's still in their urine. If it is, then I start the tapering process because that's why they come back. They're going to refrain from all those things. I give them a choice and say, "If you want to take Cannabis, that's fine. I'm just going to get you off the opioids. I'll maintain treating you with the non-opioid things, but I will not be giving you the opioids anymore."

Dr. Kelly Mendoza:

In that case, I generally do a fairly consistent taper. Probably, 20 to 30% per visit which I usually see them on a monthly visit until I get them off. If I'm tapering just to get them down because they just don't need as much like they're post-surgery and now I'm getting them down, I generally go with a patient-led experience. I say, "Here are your choices." I give them a couple of choices for tapering and I let them choose their own adventure, so to speak.

Dr. Kelly Mendoza:

The only time I will rapidly taper someone down or cut them off is if they've had an adverse event. They're obviously over sedated during the day or they were hasslers for an overdose or in acute situation. Then clearly the stuff they have at home is too much, I'll definitely taper them down. But you need to have patient buy in, right? Especially because they've been on opioids for so long. This is what they know and they're terrified of getting off of them. You need to have buy in for the process. If you don't have buy in for the process, they're going to just say "Okay. I'm not going to back to you. I'll just go back to my PCP and get what they prescribe me everyday."

Dr. Kelly Mendoza:

I had that lady who came in on 360 or whatever opioid for osteoarthritis and some sort of arthritis, things like that. We got her down to around 80 or something when I send her to her PCP. It took almost

two years to get her down because she just, "By my holidays, I have Ben coming over. I'm super stressed. I just want to hold for the holidays and resume in January." And I said, "Fine. That's a totally an acceptable approach." Yeah. That's generally how I go.

Dr. Tanya Uritsky:

It depends on the risk, right? I think that's what I hear you saying. We want the patient to be obviously very involved and they have to be. There's [inaudible 00:31:38] to do it. But I think the risk is what drives the pace. I recently watched a really interesting TED talk about rapid tapering and the harms that can have when we do it way too quickly and have patients who really can feel like they're going to die and might go the street and get medication because it feels pretty terrible. Weighing that risk... I think we forget that, too. Like after surgery, if you have someone on opioids for a month, you need to taper that. You can't just stop that. Even though it's acute pain, that's a month worth of exposure to higher dose of medication.

Dr. Kelly Mendoza:

I do have quite a few patients that... I did have one patient come to me on Methadone and I said, "Okay. We're going to flip you to something else. We needed that you taper down." She was like, "Just do it. Do it quickly." And I said, "You know, you're going to feel like crap. Just FYI, you're going to feel like crap. The good thing is opioid withdrawal doesn't kill you like the Benzo withdrawal could potentially, right? You just feel really, really crappy for a while." She came back and said, "You know what? I did. I felt super, super crappy. I can't tolerate how fast we're going. You need to slow it down." And I said, "Okay. That's fair." We need to get the patient an education that yes they're going to feel crappy but they're not going to die. But they're going to feel really, really crappy for a couple of days.

Dr. Lynn McPherson:

I've heard doctors say that. It won't kill you to do just feel like you're dying.

Dr. Kelly Mendoza:

Yeah.

Dr. Lynn McPherson:

Does all this tapering, fast, slow, whatever, matter whether it's a chronic non-cancer pain patient or a cancer patient?

Dr. Tanya Uritsky:

It's all about the duration they're on opioid for. I say if you're on a prolonged time and you didn't get there overnight, you're not going to get off it overnight. If you're on it for just a few days, you can get off of it pretty quickly.

Dr. Lynn McPherson:

Yeah.

Dr. Kelly Mendoza:

I think it's about telling the patient. "You are going to have increase pain every time we do a taper and that's completely expected. You need to have your body re-adjust to this new normal to then be able to

continue. Find other coping mechanisms for your pain." Adjusting other adjuvants and things like that to account for that increase pain to be able to get off opioid.

Dr. Tanya Uritsky:

I think that brings it back to your first question about what applies in these patients and what doesn't. I think another thing that applies is what Kelly saying is setting expectations whether tapering, starting, stopping, doing something else. What do we expect to happen when we do that so the patient's that up for success and if something goes different than what we expect, they know then that it's time to reach out. They will not go and, "Hey. You told me this was going to go." And then that's an opportunity to make an adjustment or do something different regardless of what element of prescribing we're on in the process.

Dr. Lynn McPherson:

Right. Are there any barriers that you see in implementing opioid stewardship in palliative care? What role might the pharmacist play in all these?

Dr. Tanya Uritsky:

Yeah. I think I said one of my big barriers before is like, "Well, the patient's dying. So, let's just give them whatever they need." That's not necessarily the right idea all the time. I think sometimes it's about personal values that come in the way sometimes, seeing objectively there. I think that's one of the barriers is just this patient is dying and it doesn't usually apply, but not being able to see what does and doesn't apply. Taking the full picture into account is really important.

Dr. Tanya Uritsky:

The other big barrier to doing it is the insurance, I think. That's probably more on being able to get access to medication like the [inaudible 00:35:17] and making sure patients can access medication. That's a barrier that has been very hard to overcome for a lot of people. Then also, the stigma are on opioid that has made it hard to treat pain in palliative care. Making patients maybe possibly misuse medications in atypical way, like I mentioned, taking them differently than prescribed. Taking them less. Taking them sporadically. Stuff like that. That really has created a safety barrier and how we understand how patient use their medication.

Dr. Kelly Mendoza:

Yeah. We focus a lot of our stewardship efforts in healthcare system on getting the other providers to meet the metrics, right? Patients see they have a contract here at [inaudible 00:36:00]. We have a UDS that we [inaudible 00:36:02]. We got a lot of fall-outs from providers who aren't meeting those metrics. It's providing the education to the providers about why this is important and why we do this. That's make us start getting UDS which is great because that's metric met. Check. But now, you're not interpreting the UDS's. You're not making any changes if those UDS's come back inappropriate. Then it's providing the education about why we do what we do. Why are we even getting UDS if they're not going to take any action if it's inappropriate. That's a lot of our barriers in getting the other providers to recognize the principles of opioid stewardship and why we do what we do.

Dr. Lynn McPherson:

Okay.

Dr. Tanya Uritsky:

Resources is another big barrier. Who's going to do it? Who's going to pay for it? Kind of thing. Very busy doing a lot of other things. So set aside time just to focus on some metrics or some data that you don't have time for. I'm lucky to have a dedicated physician, but that's not always the case as far as stewardship goes in. If you're running around in hospice, seeing patients at end-of-life, you have a lot of other priorities. How are you fitting that in as well, where and who. That's where I think the pharmacist really does fit in, actually, and helped to provide some of that higher system level, system-driven type of change and looking at the data, looking at the metrics, presenting how to educate patients. Giving more of the real structural type of support that's needed for a program.

Dr. Kelly Mendoza:

Yeah. Because California [inaudible 00:37:45] with the law that said you have to check the prescription drug monitoring program every four months if someone's on a chronic opioid. We actually implement that into our EMR where you prescribe something in, I test each and watch you pop up and see did you check here [inaudible 00:38:00]. We made some system changes based on these laws. But it is to pharmacists to go through weekly and provide the prescribers their "fall-out" reports, right? Which patients are not meeting this metrics. It is a lot of work for changes within the individual clinics. We have five rural health clinics where a lot of our patients are being treated by primary care for pain management. It's a maze who are chart scrubbing and checking to make sure all these things are being done and then proposing orders to the provider for urine drug screens and things like that. Getting the contracts ready. It's definitely a process, but it's still in place. We haven't employed that yet.

Dr. Lynn McPherson:

As we wrap up, I'd like to ask one more question. I remember years ago, Dr. Lynn Webster made a comment that if every community pharmacist in the country would refuse to fill a prescription for Methadone greater than 10 milligrams a day in an opioid-naïve patient, they would save so many lives. It is difficult in community pharmacy. As you know, my sister is a community pharmacist. She'll call me once in a while. Obviously, there they agree this case somebody who presents with the holy grail of Morphine, the Ativan and Soma, for example. They come from 200 miles away. It's Friday night and they're paying cash. A blind man in Peoria could see that one coming. You know what I mean?

Dr. Lynn McPherson:

What are three tips you would give given any pharmacist to say, "Something ain't right here. I need to take a closer look"? Anything come to mind?

Dr. Kelly Mendoza:

I think our many pharmacists, at least when I prescribe, they're really good about calling us and asking questions and clarification, making sure that they have a diagnosis code and all that kind of stuff. I'm very happy to get on the phone with them. I can fax them progress notes. I can do whatever they need to their documentation to make them feel like this is appropriate.

Dr. Kelly Mendoza:

Obviously, still at the end of the day, comes at to their license and their willingness to do things. I get there's company policies and things like that that are a little bit tough to get around sometimes. But they're very good about calling our office. I know that they try a lot to communicate with the providers.

Not every provider is as open and willing to discuss as I am, as we are in our clinic, which is unfortunately probably a barrier for a lot of [inaudible 00:40:23] pharmacist. But just trying to maintain that open communication with the patient and the provider, right? Don't just not fill and not tell the patient why you're not filling and say, "Oh. I need to check with [Miss Fiber 00:40:34] about X, Y and Z." So that they are on the same page and not expecting something and then not getting it.

Dr. Lynn McPherson:

Tanya, do you want to add to that?

Dr. Tanya Uritsky:

Yeah. I think reaching out with something that doesn't look right is really important because the prescriber, the provider may not know. They might not have that glimpse into that patient. You set that time that you have. Kelly said there's push back and a lot of times, it's difficult. Recently, we are doing a little bit of Buprenorphine microdosing and I've been doing it for pain as well in some of my patients with Sickle Cell Disease. When the patient showed up to the pharmacy with well, very extremely smart and well-intended pharmacist should have educated the patient about the risk for withdrawal scared the patient. We have to dig back out and say, "It's going to be okay. We know this is how this works and [inaudible 00:41:22] on." And get the patient buy in again.

Dr. Tanya Uritsky:

When something looks funny, reaching out to say, "Is this what you really intended to do?" Before putting your stuff out there and maybe scaring the patient away from it because maybe we do intend to prescribe a hundred MME or 200 MEE. If that's what you want and you think it's right, call the provider first, make sure that's right and then say, "Hey! Mrs. So-and-so, I talked to your provider, they say this makes sense and we're going to do it" versus "Oh! It scares me!" Then you call you doctor because that has a different intent, a different outcome potentially. I think that the intentions are good in it and should be there and I want as much scrutiny as possible. But we're on the team scrutinizing together. I think that's really important.

Dr. Tanya Uritsky:

I think the other important thing is Naloxone and Naloxone carrying it, distributing it. How we talk about it, remembering that it's not a risky patient. It's a risky drug. When something does look funny, if we're not comfortable, talk to the patient about having Naloxone in the home and making sure that they're aware of the benefits of that.

Dr. Lynn McPherson:

Great. Any last comments from either of you, as we wrap up?

Dr. Kelly Mendoza:

I don't think so.

Dr. Tanya Uritsky:

Thank you so much for having us.

Dr. Lynn McPherson:

This transcript was exported on Mar 02, 2021 - view latest version [here](#).

Sure. We covered the waterfront. Thank you both very, very much. Very interesting conversation.
[crosstalk 00:42:36]

Dr. Lynn McPherson:

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