SçO.S.  
Academic Detailing for Safer Prescribing 

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SCORxE Clinical Pharmacy Consultant  
MUSC College of Pharmacy
Objectives

1. Appreciate the value of academic detailing (AD) to change or validate clinical practice behavior
2. Learn about AD in SC to promote safer opioid use
3. Consider future AD efforts to address the opioid epidemic
Disclosures

• Nothing to disclose personally with regards to financial support

• Grant funding to acknowledge
  – SC Department of Health and Environmental Control Bureau of Drug Control – *current visits*
  – Centers for Disease Control and Prevention Prescription Drug Overdose: Prevention for States Program – *current visits*
  – National Institute on Drug Abuse – *past visits*

• Contributors to Academic Detailing to acknowledge
  – DATIS (Drug and Therapeutics Information Service)
  – NaRCAD (National Resource Center for Academic Detailing)
Academic Detailing: Social marketing for better clinical practice
What is Academic Detailing

• Personalized support for good clinical decision-making through:
  — Periodic face-to-face encounters
    • Trained health professionals visit clinicians in their practice settings, often one-to-one
    • Discuss topics of interest
    • Deliver key evidence-based messages to facilitate better patient care
    • Unbiased by commercial or other extraneous interests
  — Useful support services between visits

• Goal – to optimize practice patterns
Structure of an AD Visit

1. Introduction
2. Build trust and establish credibility
3. Identify the provider's needs
4. Present key messages, features and benefits
5. Overcome objections/handle challenging responses
6. Close the communication loop
7. Follow-up and maintain relationship
Why Academic Detailing

*Trousting Relationships* formed between academic detailers, physicians and other healthcare practitioners can become the spearhead for many clinical practice improvement strategies
Why Academic Detailing

• Initial study on AD (randomized controlled trial) demonstrated effectiveness
  • 14% reduction in inappropriate drug use of targeted drugs
  • $2 saved for every $1 spent (subsequent analysis)
• Review of 69 randomized trials confirmed efficacy
  – Effectiveness varying with quality or delivery
• Review of strategies to implement guidelines showed effectiveness of AD

Avorn J, Soumerai SB. NEJM. 1983
Avorn J, Soumerai SB. Medical Care. 1986
NEJM. 1983 Cochrane O’Bien et al. Cochrane Database of Systematic Reviews 2007, Issue 4
Academic Detailing in SC

- Development of scientifically sound, user-friendly provider packets
  - Physicians ‘love the materials’
- Individualized, interactive office visits (first visits in 2007)
- Continuing Medical Education
  - Reinforces key messages and discussions
- Reinforcement through subsequent visits
  - “Follow-up on topic is good. It helps keep me motivated.”

**Topics**

- Schizophrenia
- Major Depressive Disorder
- Bipolar Disorder
- Promotion of Smoking Cessation
- ADHD
- Asthma
- Antipsychotics
Academic Detailing in SC

- Development of scientifically sound, user-friendly provider packets
  - Physicians ‘love the materials’
- Individualized, interactive office visits (first visits in 2007)
- Continuing Medical Education
  - Reinforces key messages and discussions
- Reinforcement through subsequent visits
  - “Follow-up on topic is good. It helps keep me motivated.”

**Topics**

<table>
<thead>
<tr>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
</tr>
</tbody>
</table>

**Monitoring Practices to Promote Safe Opioid Use**

<table>
<thead>
<tr>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Antipsychotics</td>
</tr>
</tbody>
</table>
• Reports to help confirm a patient’s controlled drug history
  • Schedule II, III and IV

• A check for
  • Adherence
  • Potential drug misuse/abuse/diversion

• Sometimes called DHEC or PMP reports
## Blending Two Unique and Useful Strategies for Safe Opioid Prescribing

<table>
<thead>
<tr>
<th>Academic Detailing</th>
<th>SCRIPTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective interactive technique to deliver physician education on optimal pain management and safe opioid prescribing</td>
<td>Does not offer latest scientific knowledge on medication use and patient care decisions</td>
</tr>
<tr>
<td>Rarely has access to real-time data</td>
<td>Provides real-time data to monitor for aberrant behaviors and opioid risks</td>
</tr>
<tr>
<td>Increase physicians’ awareness of SCRIPTS and assist with access/effective use of SCRIPTS data report requests</td>
<td>An untapped resource that is underutilized</td>
</tr>
<tr>
<td>Address barriers to change in practice and prescribing</td>
<td>Data resource to track changes in practice patterns</td>
</tr>
</tbody>
</table>
• SC Opioid Safety Initiative – Military

• 87 AD visits to physicians who serve military members and veterans
  – Mean visit length: 62.3 minutes

• 59 follow-up surveys
  – AD visit itself felt to be most helpful component of the intervention

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### SCOSI-M

#### Post-Visit Survey Results

<table>
<thead>
<tr>
<th>How helpful was this intervention addressing the following points:</th>
<th>Not helpful at all</th>
<th>Somewhat helpful</th>
<th>Helpful</th>
<th>Very Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved safety of your patients when prescribing opioids</td>
<td>0%</td>
<td>8.5%</td>
<td>44.1%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Recognizing patient doctor-shopping</td>
<td>0%</td>
<td>13.6%</td>
<td>32.2%</td>
<td>54.2%</td>
</tr>
<tr>
<td>Recognizing when to consider opioid alternative for specific patient</td>
<td>1.7%</td>
<td>15.3%</td>
<td>40.7%</td>
<td>42.4%</td>
</tr>
<tr>
<td>Confidence in communicating about expectations when prescribing opioids</td>
<td>0%</td>
<td>13.6%</td>
<td>40.7%</td>
<td>45.8%</td>
</tr>
</tbody>
</table>

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# SCOSI-M

**Post-Visit Survey Results**

<table>
<thead>
<tr>
<th>How much do you agree disagree with the following</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AD visit provided me with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information I intend to use for my patients with chronic, non-cancer pain</td>
<td>45.6%</td>
<td>45.6%</td>
<td>7%</td>
<td>0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Written tools I intend to use in my practice</td>
<td>36.8%</td>
<td>43.9%</td>
<td>10.5%</td>
<td>8.8%</td>
<td>0%</td>
</tr>
<tr>
<td>On-line or local resources I intend to refer to in my practice</td>
<td>29.8%</td>
<td>45.6%</td>
<td>17.5%</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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The Current S.c.O.S.

MONITORING PRACTICES TO PROMOTE SAFE OPIOID USE IN THE TREATMENT OF CHRONIC NON-CANCER PAIN AND TO REDUCE RISK OF MISUSE AND ABUSE IN SC
Key Messages

Share a patient provider agreement prior to initiating a trial of opioids

Optimize patient treatment (drug/non-drug) using a multi-dimensional pain measure

Screen for appropriate opioid use and continued need for opioid therapy
Share a patient provider agreement (PPA) with clearly established boundaries and patient expectations prior to initiating a trial of opioids for chronic non-cancer pain.

- A PPA signed by both patient and prescriber and given to the patient is an important, convenient communication tool that can also document patient counseling and education.

- Offering a PPA to all patients regardless of a patient’s identified risk of opioid misuse and abuse reduces stigma and provides a minimal level of precaution/protection to prescriber and patient.

- There is no standard, validated or legally binding form of a PPA; consider inclusion of informed consent (e.g., potential risks and benefits of an opioid trial, continuation and discontinuation) and plan of care (e.g., goals of care and expectations, rights and responsibilities of prescriber and patient).
Optimize patient treatment (Drug/non-drug) using a multi-dimensional rating scale to access chronic pain, quality of life and progress towards functional goals

- The PEG is a brief multi-dimensional measure of Pain, Enjoyment of life and General activity useful at baseline and at regular intervals to assess and document patient response to treatment.

- Set realistic expectations that full pain relief is unlikely and set individualized goals that are Achievable, Recovery-related, and Measurable (A.R.M.); e.g., 15 minute daily walk.

- Continue or modify opioid treatment with demonstrated benefit and discontinue when the risks of side effects, misuse, addiction, and/or overdose outweigh the benefit.

- Engage family and other key individuals when possible to support patient-obtained information.
# PEG Scale Assessment

1. What number best describes your pain on average in the past week:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Pain as bad as you can imagine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. What number best describes how, during the past week, pain has interfered with your general activity?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
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<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Opioid Fast Facts

Things you need to know...Opioid Fast Facts

If prescribed, Opioid pain medications (Opioids) are just one part of a total pain management plan. Expected benefits and goals include IMPROVED: (1) ability to engage in work, social, recreational and/or physical activities; (2) quality of life; and (3) pain.

Opioids often have side effects, which may include but are not limited to:

- Itching
- Rash
- Nausea
- Constipation, sometimes severe
- Trouble urine or passing stool/poop
- Drowsiness
- Slow or depressed breathing (especially if obese)
- Problems thinking clearly
- Mood changes
- Depression getting worse
- Increased risk of bone fractures or brittle bones
- May worsen sleep apnea (periods of not breathing while sleeping)
- Sexual difficulties, such as lack of menstrual periods in women and low male hormone in men
- Life-threatening irregular heartbeat (methadone)

Taking too much Opioids OR using them with alcohol, illegal drugs, or some prescriptions (especially sedatives or anxiety medicines, such as Xanax® AND especially without supervision or your provider knowing) can cause:

- Overdose
- Harm to myself of others (i.e., car wreck)
- Trouble breathing, may stop breathing
- Brain damage, Coma, Death

Some Opioids also contain acetaminophen, a medication found in many OTC products (also called APAP, Tylenol®). Ask your doctor or pharmacist before taking OTC products because too much acetaminophen may damage your liver.

If an Opioid is stopped suddenly without medical supervision, it often makes you feel sick from physical withdrawal symptoms such as:

- Anxiety
- Irritability
- Aching, Pain
- Sweating
- Abdominal/stomach cramping
- Diarrhea

While on Opioids, you may develop an increased sensitivity to pain.

You could become addicted to Opioids and have a higher chance if you or a family member has ever had drug or alcohol problems. Addiction is associated with drug craving, loss of control, and poor response to treatment.

Secure and dispose of Opioids properly to lessen the risk: (1) of hurting children or others who accidentally take it; and (2) of theft, deceit, assault or abuse by persons seeking Opioids for purposes of misuse.

Funding provided by the Centers for Disease Control and Prevention (CDC) Prevention for States Program

March 2017
Screen for appropriate opioid use and the continued need for opioid therapy, including prescription drug monitoring reports (i.e., SCRIPTS reports)

- Assess and document risk of opioid misuse with subjective and objective measures PRIOR to prescribing, and individualize level of monitoring and possible co-management to match the identified risk.

- Review SCRIPTS reports at baseline and periodically to help identify potential opioid misuse/abuse and support safe prescribing and dispensing.

- Continue to assess, monitor and document risk of opioid misuse/abuse (including input from family members and key contacts) since risk level can change for any patient at any point.

- Adjust ongoing monitoring plan (e.g., SCRIPTS report review, frequency of visits, urine drug tests, pill counts) to match risk level, and co-manage or refer for addiction treatment as needed.
Generate a SCRIPTS Patient Report

1. Go to https://southcarolina.pmpaware.net/login
   Enter email and password, click <LOG IN>

2. Select <Rx SEARCH> then <PATIENT REQUEST>
   Input required fields: FIRST NAME, LAST NAME, DOB (mm/dd/yyyy)
   Check 'I agree to the terms of the acknowledgement' then click <SEARCH>

3. View the Patient Request Report

<table>
<thead>
<tr>
<th>WHAT IF...</th>
<th>CONSIDERATIONS...</th>
</tr>
</thead>
</table>
| 'NO MATCHING PATIENT IDENTIFIED' | Check required fields for errors. If there are no errors, try modifying the search criteria:  
  - To broaden search, enter the zip code OR city and state OR use partial name option  
  - Consider using the partial name option when a name is hyphenated or contains a suffix (e.g., Jr., Sr.)  
  - If more than one last name, request multiple reports (e.g., one for Smith-Doe and one for Doe-Smith) |
| 'PATIENTS FOUND BUT NO PRESCRIPTIONS FOUND' | The default prescription fill dates search one year prior to the current date; consider expanding the prescription fill dates and/or modifying your search criteria |
| 'MULTIPLE PATIENTS FOUND' | Multiple patient records found that match the search criteria:  
  - Be sure to move/scroll sidebar, if present, to view all patient groups  
  - To complete patient request, check the boxes next to the patient group(s) that may represent your patient, then click <Run Report>  
  - To modify search criteria before completing patient request, click <Refine Search Criteria> |

VIEWING TIPS
Linked Records Section
- View the details of each patient record included in the patient request report
Summary Section
- View summary of prescription data
- Use the Active Daily Morphine Milligram Equivalent (MME) to assess the cumulative sum MME/day of all the active opioid prescriptions in the prescription table
Prescription Table
- Sort the table by clicking any of the column headers; by default, the table is sorted by fill date
- Use the ID column to identify the linked patient record that corresponds to each prescription. If you are not confident that all the linked records belong to your patient, consider sorting the table by ID
- Use the MME/D column to assess the calculated MME per day for each individual prescription
- Hover over the individual prescriber, pharmacy, or payment type within each row to display more detailed information
## Review SCRIPTS Report

### What’s going on with the patient?

<table>
<thead>
<tr>
<th>WHAT IF...</th>
<th>CONSIDERATIONS...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Apparently good results</strong>&lt;br&gt;(1 pharmacy, 1 opioid prescriber)</td>
<td>• Does it match clinical evaluations (e.g., urine drug test) and patient interview?&lt;br&gt;• Consider non-adherence behaviors not captured in results (e.g., binging, running out early).</td>
</tr>
<tr>
<td><strong>Potential aberrant behavior</strong>&lt;br&gt;(2 or more pharmacies, 2 or more opioid prescribers, prescriptions filled that were not verbally reported)</td>
<td>• Does it match clinical evaluations (e.g., urine drug test) and patient interview?&lt;br&gt;• Consider differential diagnosis, including: addiction (drug seeking), Pseudo-addiction (relief seeking), other psychiatric illnesses, or diversion (criminal intent).</td>
</tr>
</tbody>
</table>
## Review SCRIPTS Report

**What’s going on with the patient?**

<table>
<thead>
<tr>
<th>WHAT IF...</th>
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</tr>
</thead>
</table>
| Combination of opioid and other controlled substance(s), especially benzodiazepines (consider all) | • Is the combination clearly indicated?  
• What’s the patient’s level of functioning?  
• Pain guidelines concur benzodiazepines and opioids are high risk combinations, especially in the elderly; many recommend against combination unless clearly indicated. |

**Opioid-acetaminophen (Opioid/APAP) combination product**

• Consider likelihood that patient is taking other prescription medications or over-the-counter products containing APAP
A SCRIPTS REPORT REQUEST WILL NOW DISPLAY

- **ACTIVE DAILY MME** – MMEs of ALL current opioid prescriptions added together
- **MME/D** – MMEs per day for each individual opioid prescription filled (current and past)

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test</td>
<td>Patient</td>
<td>01/01/1900</td>
</tr>
</tbody>
</table>

### Summary

<table>
<thead>
<tr>
<th>Prescriptions 6</th>
<th>Prescribers 3</th>
<th>Pharmacies 3</th>
<th>Private Pay 0</th>
<th>Active Daily MME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75</td>
</tr>
</tbody>
</table>

### Prescriptions

Per CDC guidance, the conversion factors and associated daily morphine milligram equivalents for drugs prescribed as part of medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain.

<table>
<thead>
<tr>
<th>Filled</th>
<th>ID</th>
<th>Written</th>
<th>Drug</th>
<th>QTY</th>
<th>Days</th>
<th>Prescriber</th>
<th>Rx #</th>
<th>Pharmacy *</th>
<th>Refills</th>
<th>MME/D</th>
<th>Pymt Typo</th>
<th>PMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/02/2017</td>
<td>1</td>
<td>02/01/2017</td>
<td>OXYCODONE-ACETAMINOPHEN 5-325</td>
<td>60.0</td>
<td>30</td>
<td>DA TES</td>
<td>4455</td>
<td>Dave (0000)</td>
<td>0</td>
<td>15.0</td>
<td>Comm Ins</td>
<td>SC</td>
</tr>
<tr>
<td>01/28/2017</td>
<td>1</td>
<td>01/26/2017</td>
<td>OXYCODONE HCL 20 MG TABLET</td>
<td>60.0</td>
<td>30</td>
<td>AL TES</td>
<td>3344</td>
<td>Carol (8506)</td>
<td>0</td>
<td>60.0</td>
<td>Comm Ins</td>
<td>SC</td>
</tr>
<tr>
<td>12/26/2016</td>
<td>1</td>
<td>12/26/2016</td>
<td>OXYCODONE HCL 20 MG TABLET</td>
<td>60.0</td>
<td>30</td>
<td>AL TES</td>
<td>2233</td>
<td>Carol (8506)</td>
<td>0</td>
<td>60.0</td>
<td>Comm Ins</td>
<td>SC</td>
</tr>
</tbody>
</table>
A SCRIPTS REPORT REQUEST WILL NOW DISPLAY

- **ACTIVE DAILY MME** – MMEs of ALL current opioid prescriptions added together
- **MME/D** – MMEs per day for each individual opioid prescription filled (current and past)

MME/day is the MME per day for each individual prescription (current and past)
The Active Daily MME in the summary is the cumulative sum total of ALL current/active opioid prescriptions – medications theoretically on hand for a virtual pill count.
<table>
<thead>
<tr>
<th>WHAT IF...</th>
<th>CONSIDERATIONS...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Morphine Milligram Equivalents per day (MME/day) suggests concern for adverse events or overdose</td>
<td>More recent guidelines recommend additional precautions when prescribing above dosing thresholds ranging from $\geq 50$ total MME/day to $\geq 120$ MME/day</td>
</tr>
<tr>
<td></td>
<td>SC Board of medical examiners, SC board of dentistry, and SC board of nursing recommend scrutiny when prescribing doses $&gt;80$ MME/day for more than three continuous months</td>
</tr>
<tr>
<td></td>
<td>The CDC recommends to avoid, to carefully justify, or to consider specialist referral when prescribing doses $\geq 90$ MME/day.</td>
</tr>
</tbody>
</table>
### Selected Resources

**Key Contact Information**

<table>
<thead>
<tr>
<th>SCFS-specific Resources (SCFS)</th>
<th>Selected Guidelines</th>
<th>Provider tools</th>
<th>Where to refer</th>
<th>Drug Information</th>
<th>Safe Drug Disposal</th>
<th>Opioid Tapering</th>
<th>Tele-Education</th>
<th>Overdose Prevention</th>
</tr>
</thead>
</table>

- SC-specific Resources
- Selected Guidelines
- Provider tools
- Where to refer
- Drug Information
- Safe Drug Disposal
- Opioid Tapering
- Tele-Education
- Overdose Prevention
# Calculating MME

## Use Opioid Products: Characteristics and Conversion Factors Chart

<table>
<thead>
<tr>
<th>Brand/Generic Name</th>
<th>Strengths</th>
<th>Morphine Milligram Equivalent Conversion Factor&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Dosage Form&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Dose Interval</th>
<th>Alcohol Dose Dumping Effect&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Abuse-Deterrent Formulation&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Scored</th>
<th>Amount of Medication Equal to 50 Morphine Milligram Equivalents (MME)&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OXYCODONE, C-II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone HCl</td>
<td>5 mg</td>
<td></td>
<td>IR capsule</td>
<td>4-6 hours</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Oxycodone HCl</td>
<td>5 mg, 10 mg, 15 mg, 20 mg, 30 mg</td>
<td></td>
<td>IR tablet</td>
<td>4-6 hours</td>
<td>-</td>
<td>-</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Roxicodone&lt;sup&gt;8&lt;/sup&gt;</td>
<td>5 mg, 15 mg, 30 mg</td>
<td></td>
<td>ER tablet</td>
<td>12 hours</td>
<td>-</td>
<td>√</td>
<td>-</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxyday&lt;sup&gt;8&lt;/sup&gt;</td>
<td>5 mg, 7.5 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone HCl CR</td>
<td>10 mg, 15 mg, 20 mg</td>
<td></td>
<td>ER capsule</td>
<td>12 hours</td>
<td>-</td>
<td>√</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>OxyContin&lt;sup&gt;8&lt;/sup&gt;</td>
<td>30 mg, 40 mg, 60 mg, 80 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xtampa&lt;sup&gt;8&lt;/sup&gt; ER</td>
<td>9 mg, 13.5 mg, 18 mg, 27 mg, 36 mg [Equivalent to 10, 15, 20, 30, and 40 mg Oxycodone HCl, respectively]&lt;sup&gt;8&lt;/sup&gt;</td>
<td>1.5</td>
<td>ER capsule</td>
<td>12 hours</td>
<td>-</td>
<td>√</td>
<td>-</td>
<td>33 mg PO oxycodone = 50 MME</td>
</tr>
</tbody>
</table>

Developed in part through funding provided by SCDHHS
Calculating MME

Use **Opioid Products: Characteristics and Conversion Factors Chart**:

<table>
<thead>
<tr>
<th>Brand/Generic Name</th>
<th>Strengths</th>
<th>Morphine Milligram Equivalent Conversion Factor</th>
<th>Dosage Form</th>
<th>Dose Interval</th>
<th>Alcohol Dose Dumping Effect</th>
<th>Abuse-Deterrent Formulation</th>
<th>Scored</th>
<th>Amount of Medication Equal to 50 Morphine Milligram Equivalents (MME)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OXYCODONE, C-II</strong></td>
<td></td>
<td></td>
<td>IR capsule</td>
<td>4-6 hours</td>
<td>-</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone HCl</td>
<td>5 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone HCl</td>
<td>5 mg, 10 mg, 15 mg, 20 mg, 30 mg</td>
<td></td>
<td>IR capsule</td>
<td>4-6 hours</td>
<td>-</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roxicodone</td>
<td>5 mg, 15 mg, 30 mg</td>
<td></td>
<td>IR tablet</td>
<td></td>
<td>-</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These values help to quickly eyeball commonly know risk thresholds. Example: 33 mg oxycodone = 50 MME. Multiply both by 2 to get dosage = 100 MME; e.g., 66 oxycodone (33mg x 2) = 100 MME (50 MME x 2)
ScO.S. Closure and Follow-up

If opioid initiation or continuation is a consideration for appropriate pain management

- Buy-in to key messages
- CME credit
- Connecting Prevention to Treatment
  - DHEC/CDC to DAODAS/SAMHSA
- Provider Packets as a useful resource
  - Trifold
  - Useful tools
  - Additional reinforcing print materials
- Plan for brief follow-up visit and post-visit survey to inform future AD visits

◊ Implement strategies to assess if benefits outweigh the risks
  ◊ At baseline and follow-up
  ◊ Document, document, document
**S.c.O.S. as a ‘Catalyst’**

Expansion of intervention and additional topics

- Expand current AD intervention to additional ‘hot spots’
- Follow-up Intervention(s) for current providers visited
- Additional topics on pain management
- AD to specialists, in particular surgeons
- Naloxone Co-Prescribing
- Shift from Prevention to Treatment
Medication Safety Matters Grant

- Educational Outreach on SCRIPTS and safe prescribing practices
  - Mass mailings
  - Newsletters
  - Presentations
  - **Academic detailing**

- Marketing/Social Media

- Disposal Sites for unwanted medications

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Questions?

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