

Naloxone Prescription Upon Hospital Discharge

An Interdisciplinary Approach

Kriti Thapa, MD, MPH & Nilbhi Patel, MD

*Internal Medicine Residents
Strong Memorial Hospital*

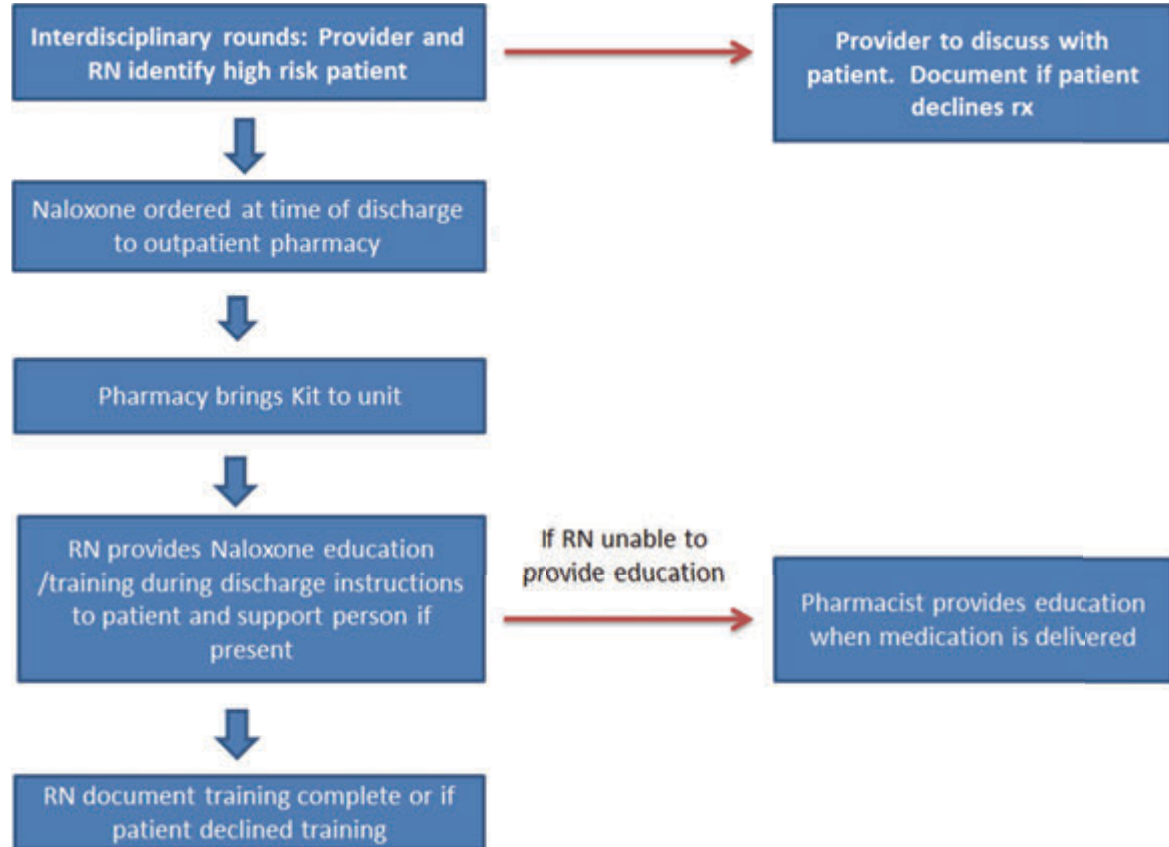
Project Background

- Center for Disease Control & Prevention and the Surgeon General have issued guidelines recommending co-prescription of naloxone with opiates for a subset of patients
 - Those on opiate pain medications
 - Those with risk factors for opiate overdose
- Naloxone prescribing for high-risk patients is a risk mitigation strategy.
- Multidisciplinary quality improvement pilot project
 - Aim: to **increase access to naloxone** in the community by **identifying patients at risk of an OAE (opioid adverse event) upon hospital discharge**, targeting **staff and patient education**, and **increasing the number of naloxone prescriptions**.

Program Description: At risk patient identification

Category A recommendation from the CDC Guideline for Prescribing Opioids for Chronic Pain:

- history of substance abuse
- co-administration of opioids and benzodiazepines
- prescription of ≥ 50 morphine milligram equivalents (MME)/day
- previous history of an overdose
- risk for returning to doses of opiates after a period of abstinence
- patients with a significant reduction in opiate dose upon discharge

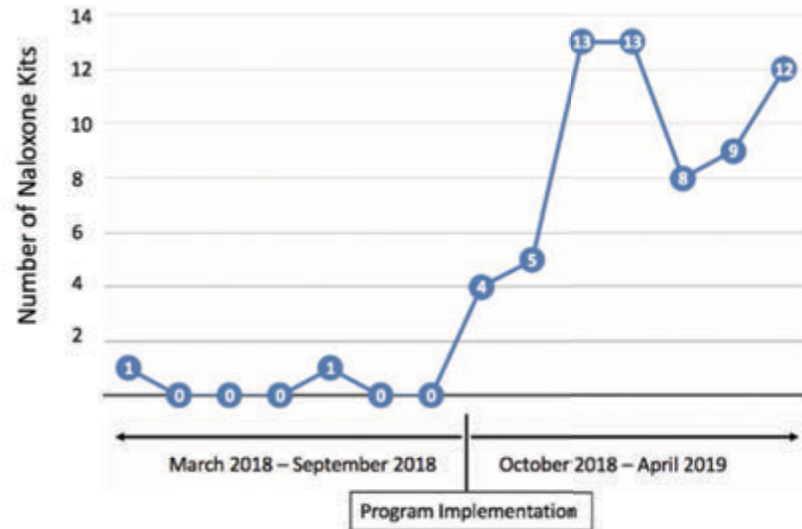


Program Evaluation

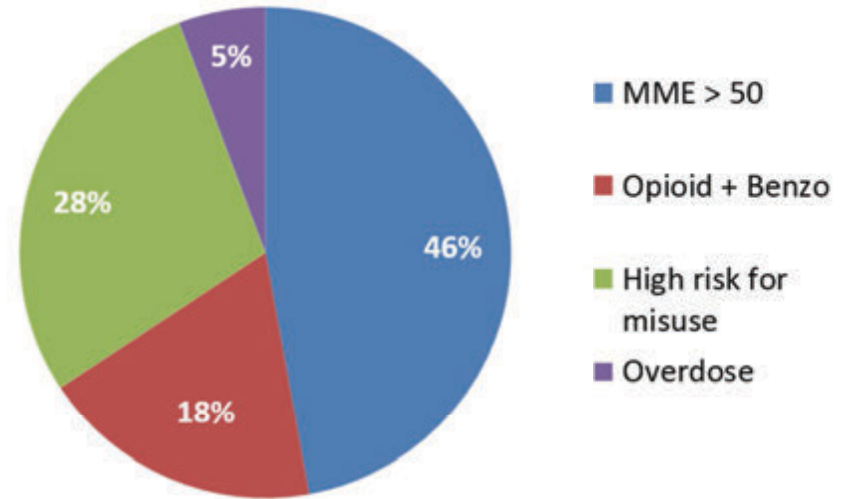
- Data was obtained from the hospital outpatient pharmacy records of naloxone nasal spray prescriptions at the time of discharge
- Patients who received naloxone after program implementation:
 - mostly male (56%, n=36)
 - mean age 51 ± 15 years
 - median hospital length of stay was 6 days
 - 59% were on chronic opioids prior to admission
- Co-payments
 - 85.9% of patients had a co-pay ranging from zero to one dollar
 - Seven patients (10.9%) had a co-pay ranging from two to thirty-five dollars and two patients
 - 3% had a co-pay of higher than thirty-five dollars

Program Evaluation

Naloxone Prescriptions



HIGH-RISK CATEGORIES



Limitations

- At-risk patients who were not included:
 - decreased opioid clearance and metabolism (ie: liver cirrhosis or chronic kidney disease)
 - discharged to skilled nursing facilities and thus already have access to naloxone
 - preferred to use an external pharmacy
 - receiving opioids for cancer-related pain
- Inability to measure how often naloxone is being used after discharge, partly due to limited access to external databases
- Ability to study how our intervention of increasing naloxone in the community is impacting the number of ED visits and deaths related to OAE

Future Projects

- Expanding the intervention to visiting nursing services, local nursing homes and long-term care facilities
- Automating the identification of high-risk patients in the computerized physician order entry system and electronic medical record
- Evaluation of the efficacy of these educational interventions

Acknowledgments

- Meghan Train, DO
- Nicole M. Acquisto, Pharm.D., FCCP, BCCCP
- Marissa Pasho, NP

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