#FSHP2018

When Less is More: How to start and run a pharmacist driven opioid stewardship program

Sandra DiScala, PharmD, BCPS
Clinical Pharmacy Specialist for Pain, Palliative Care, and Geriatrics
Director, PGY2 Pain Management and Palliative Care Pharmacy Residency
West Palm Beach VAMC

Nhi Tran, PharmD, BCPS
Clinical Pharmacist Specialist, Palliative Care and Pain Management
Oncology Pharmacy Division
Florida Hospital Orlando

Disclosure

We do not have (nor does any immediate family member have) a vested interest in or affiliation with any corporate organization offering financial support or grant monies **for this continuing education activity**, or any affiliation with an organization whose philosophy could potentially bias my presentation.

Objectives

- **Describe** current pain management guidelines and recommendations
- **Discuss** challenges of pain management in the hospital setting
- **Summarize** elements needed to develop an opioid stewardship program at your site
- **Explain** different strategies to assess the results of the program

Describe current pain management guidelines and recommendations

Pain Management Guidelines

- The Joint Commission (TJC): Hospital Standards (revised)
- American Pain Society (APS) Postoperative Pain
- National Comprehensive Cancer Network (NCCN) Adult Cancer Pain
- American Society for Pain Management Nursing (ASPMN) Position Statement & Opioid Monitoring
- Florida Controlled Substances Bill

TJC: Hospital Standards[1,2]

Effective January 2018

- Identify a team that is responsible for pain management and safe opioid prescribing
- Involve patients in developing their treatment plans and setting realistic expectations and measurable goals
- Promote safe opioid use by identifying & monitoring high-risk patients
- Conduct performance improvement activities focusing on pain assessment/management to increase safety & quality

TJC: Leadership (LD)[1,2]

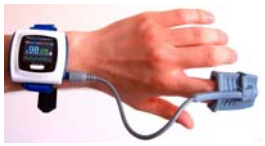
- Pain assessment, pain management, & safe opioid prescribing is identified as an organizational priority for the hospital

- (Standard LD.04.03.13)

- **Hospital Responsibilities**
- Provide nonpharmacologic pain treatments
- Offer educational resources and programs on pain and safe prescribing
- Give information on consultation/referral for complex pain needs

TJC: Hospital Leadership, cont'd[1,2]

- Facilitate clinician access to prescription drug monitoring databases (PDMP) access and use
- Identify opioid treatment programs for referrals
- Acquire equipment needed to monitor patients at high risk for adverse outcomes from opioid treatment



TJC: Medical Staff[1,2]

The medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety (Standard MS.05.01.01)

Element of Performance #18

- The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through:
  - Participating in establishment of protocols/quality metrics
  - Reviewing performance improvement data

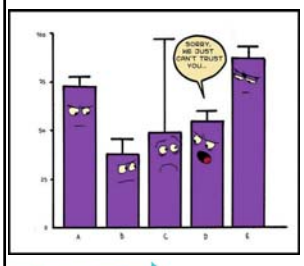
TJC: Provision of Care[1,2]

The hospital assesses and manages the patient's pain and minimizes risks associated with treatment (Standard PC.01.02.07)

Elements of Performance #5-8

- Numerical pain scales alone are inadequate – assess patient's function and ability to reach treatment goals
- Involve patients in developing their treatment plans and setting realistic expectations and measurable goals
- Monitor high-risk patients for opioid adverse outcomes
- Educate patients and family on pain management plans, including side effects and safe use/storage/disposal of opioids

TJC: Performance Improvement[1,2]



- Collects data on pain management (Standard PI.01.01.01)
  - Types of interventions & effectiveness
- The hospital compiles and analyzes data (Standard PI.02.01.01)
- Identify areas needing change to increase safety and quality
- Monitor the use of opioids
  - Track adverse events, naloxone use, and duration/dose of opioid prescriptions

American Pain Society (APS)[3]

2016 Guidelines on Postoperative Pain

Preoperative Education and Perioperative Pain Management Planning

- Recommendation 1: Provide patient and family-centered, individually tailored education, including information on treatment options for postoperative pain, and document the plan and treatment goals.

APS, cont'd[3]

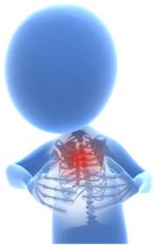
- Recommendation 2: Provide parents or caregivers of children who undergo surgery with proper instruction for assessing pain & counseling on administration of analgesics.
- Recommendation 3: Conduct preoperative evaluation that includes assessment of medical/psychiatric comorbidities, concomitant medications, history of chronic pain, substance abuse, and previous postop treatment/responses.

APS, cont'd[3]

- Recommendation 4: Adjust pain management plan based on adequacy of pain relief and presence of adverse events.

Methods of Assessment

- Recommendation 5: Use a validated pain assessment tool to track responses to postoperative pain treatments and adjust treatment accordingly.



Validated Pain Scales (APS)[3]

Name of Scale	Rating System
Numeric Rating Scales (NRS)	• Six-point NRS (0-5) • Eleven-point NRS (0-10) • Twenty-one point NRS (0-20)
Verbal Rating Scale (VRS)	• Four-point NRS • Seven-point Graphic Rating Scale • Six-point Present Pain Inventory
Visual Analogue Scales	• Commonly rated 0-10 cm or 0-100 mm
Pain Thermometer	• Combines visual thermometer with verbal descriptions of pain
Faces Rating Scales	• Faces Pain Scale (revised) • Wong-Baker FACES pain rating scale • Oucher scale

Multimodal Therapy (APS)[3]

- Recommendation 6: Offer multimodal analgesia, or a variety of analgesic medications and techniques with nonpharmacological interventions, for postoperative pain.

- Recommendation 7: Consider transcutaneous electrical nerve stimulation (TENS) as adjunct to other postoperative pain treatments.

Multimodal (APS), cont'd[3]

- Recommendation 8: Neither recommend nor discourage acupuncture, massage, or cold therapy as adjuncts to other postoperative pain treatment.
- Recommendation 9: Consider cognitive-behavioral modalities as a multimodal approach.

Pharmacological Therapy (APS)[3]

- Recommendation 10: Use PO over IV opioids for postoperative analgesia in patients who can use oral.
- Recommendation 11: Avoid IM administration of analgesics for management of postoperative pain.
- Recommendation 12: Use IV patient-controlled analgesia (PCA) be used for postoperative analgesia when parenteral route is needed.
- Recommendation 13: Discourage routine basal infusion of opioids with IV PCA in opioid-naïve adults.

Pharmacological (APS), cont'd[3]

- Recommendation 14: Monitor sedation, respiratory status, and other adverse events in patients who receive systemic opioids for postoperative analgesia.
- Recommendation 15: Provide APAP and/or NSAIDs as part of multimodal analgesia for postoperative pain if no contraindications.

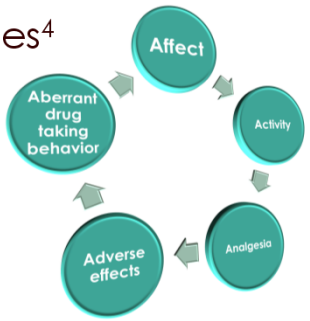
Pharmacological (APS), cont'd[3]

- Recommendations 16-19: Clinicians should consider…
  - Preoperative dose of celecoxib if no contraindications
  - Gabapentin or pregabalin for multimodal analgesia
  - IV ketamine as part of multimodal analgesia
  - IV lidocaine infusions for open and laparoscopic abdominal surgery if no contraindications

NCCN Guidelines[4]

2018 Adult Cancer Pain

Goals of pain management are highlighted by monitoring the **"5 A's"**



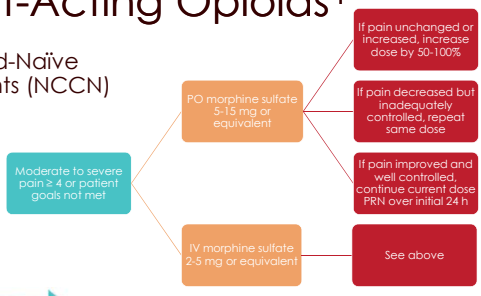
NCCN, cont'd[4]

Management of Pain in Opioid-Naïve Patients

- Moderate to Severe Pain ≥ 4
  - Consider inpatient admission to achieve patient-specific goals for comfort and function
  - Start and rapidly taper short-acting opioid

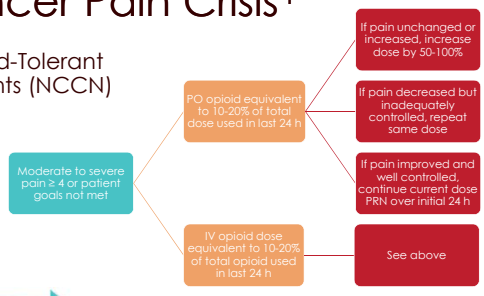
Short-Acting Opioids[4]

Opioid-Naïve Patients (NCCN)



Cancer Pain Crisis[4]

Opioid-Tolerant Patients (NCCN)



NCCN, cont'd[4]

Management Strategies for Specific Cancer Pain Syndromes

- Bone pain without oncologic emergency:
  - NSAIDs, APAP, or steroids
  - Consider bone-modifying agents (e.g., bisphosphonates or denosumab)
  - Consider hormonal therapy or chemotherapy, steroids, and/or radioisotopes for diffuse bone pain
  - Consider local RT, nerve block, vertebral augmentation, or radiofrequency ablation for local bone pain

NCCN, cont'd[4]

- Bowel obstruction
  - For medical management, consider corticosteroids and/or metoclopramide
  - Palliative management can include bowel rest, nasogastric suction, corticosteroids, H2 blockers, anticholinergics, and/or octreotide
- Nerve pain
  - Trial corticosteroids for nerve compression or inflammation
  - Trial antidepressants, anticonvulsants, and/or topical agents for neuropathic pain

ASPMN Position Statement[5]

Prescribing and Administering Opioid Doses Based Solely on Pain Intensity Should be Prohibited

Other Factors that Influence Opioid Dose Requirement

- Age, comorbidities, quality of pain, sedation level, tolerance reaction/response to prior opioid treatment
- Cardiovascular/respiratory status, functional status, genitourinary status
- Drug-drug interactions

ASPMN Guidelines[6]

2011 Monitoring Opioid-Induced Sedation and Respiratory Depression

Risk Factors for Sleep-Disordered Breathing

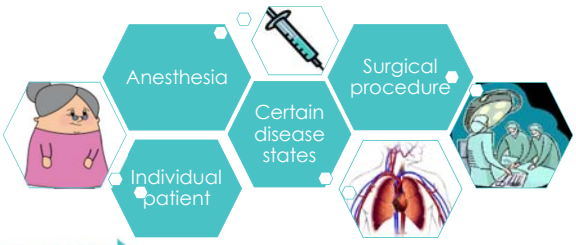
- Obesity, male gender, age >55 years, BMI >30
- Snoring, apnea, daytime sleepiness, hypertension

Risk Factors for Central Sleep Apnea

- Medical conditions affecting cardiac and respiratory systems and medications that depress the CNS
- Age >65 years

ASPMN, cont'd[6]

Risk Factors for Postoperative Pulmonary Complications



ASPMN, cont'd[6]

Recommendation Statements

- Perform comprehensive preadmission, admission, and preoperative therapy assessments to identify/document patient risk factors for unintended sedation and respiratory sedation with opioids
- Nurses should communicate all pertinent information regarding patients' risk during shift report and across all transitions in care from pre-hospitalization to discharge

ASPMN, cont'd[6]

Recommendation Statements

- Organizations should develop and implement policies/procedures that define:
  - Scope of patient risk assessment practices
  - Requirements for documentation
  - Standards of care
  - Accountability of health care providers
- Mechanisms for oversight and surveillance of practice outcomes with patient risk assessment can be effective to ensure safe and optimal care

Controlled Substances (CS) Bill[7]

CS/CS/HB 21

- Signed by FL Governor Rick Scott on March 19, 2018
- Effective date of July 1, 2018
- Addresses opioid abuse by:
  - Establishing CS prescribing limits
  - Requiring CE on CS prescribing
  - Expanding required use of E-FORCSE

Acute Pain Exception[7]

For the treatment of acute pain, a prescription for a CII may not exceed a 3-day supply, except that up to a 7-day supply may be prescribed if the prescriber:

- Believes, in his or her professional judgment, that more than a 3-day supply of such an opioid is medically necessary to treat the patient's pain as an acute medical condition;
- Indicates "ACUTE PAIN EXCEPTION" on the prescription;
- Adequately documents in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply limit.

Emergency Opioid Antagonist[7]

For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II CS listed in s. 893.03 or 21 U.S.C. s. 812 **must** concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1).

Discuss challenges of pain management in the hospital setting

Knowledge Limitations[8]

- Inadequate training/knowledge about pain management pharmacotherapy
  - Large employee pool
  - Wide range of disciplines and levels of training
- Misconceptions about assessment, side effects of analgesics, and addiction
  - Variabilities in therapeutic practice
  - Opioiphobia
- Lack of understanding about appropriate use and limitations of pain assessment tools

Institutional Concerns[8]

- Lack of pain management experts who could:
  - Provide guidance in the development of safe, effective policy and practice
  - Respond effectively to practice recommendations that risk optimal pain control or patient safety
- Clinical leadership's lack of familiarity with pain management principles and advances in technology
  - Underfunding
  - Under-resourced
- Institutional pain assessment policies that erroneously promote pain intensity as the most important part of pain assessment

Intensity of Pain: The Wrong Metric?[9]

- The 1986 World Health Organization (WHO) ladder for managing cancer pain led to the use of pain intensity reduction as the goal for drug treatment
- TJC term "fifth vital sign" led to the use of numerical pain rating scales in hospital vital sign packages
- Extent/severity of tissue damage cannot reliably predict the intensity of chronic pain
  - Chronic pain is not determined by nociception
  - Chronic pain intensity linked more with emotional and psychosocial factors and reward

He Said – She Said? Who's Right?

- True addiction vs. under-treatment of pain?
- Substance Use Disorder (SUD) is a behavioral, social, and psychological disorder
- Per DSM-5, diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria

Summarize elements needed to develop an opioid stewardship program at your site

National Quality Forum (NQF)[10]

National Quality Partners Playbook™: Opioid Stewardship identifies seven fundamental actions to support opioid stewardship programs:

1. Promoting leadership commitment and culture change that includes allocation of resources
2. Implementing organizational policies that support evidence-based multimodal approaches
3. Advancing the clinical knowledge, expertise, and practice of clinicians
4. Enhancing patient and family caregiver education and engagement

7 Fundamental Actions, cont'd[10]

5. Tracking, monitoring, and reporting performance data on:
   A. Opioid prescribing
   B. Patient-reported outcomes
   C. Adverse events
   D. Use of PDMPs
6. Establishing accountability to convey clear expectations for a culture of opioid stewardship
7. Supporting collaboration with community leaders and stakeholders

1. Leadership & Resources[10,11]

- Leadership committed to achieving zero patient harm
- Elevate quality and patient safety to the organization's highest strategic goal
- High reliability has three central attributes: trust, report, and improve
- Adopt Robust Process Improvement (RPI)
  - Lean (remove wasted efforts)
  - Six Sigma (reducing frequency of defective product outcomes)
  - Change Management (prepares organization to accept, implement, and sustain improved processes)

Create Your Leadership Team[10,11]

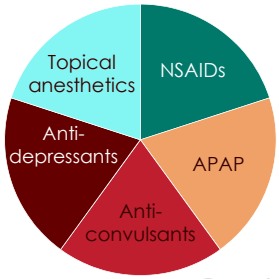
Incorporate various disciplines responsible for pain management oversight

- Anesthesia
- Surgery
- Pharmacy
- Nursing
- Physical Medicine & Rehab
- Mental Health

2. Multimodal Approaches[10]

Pharmacists are a key resource for facilities

- Develop protocols for use facility-wide
- Contribute clinically through providing pain consult service to identify non-opioid options when needed



3. Clinical Knowledge[10]

Florida HB21 requires everyone enrolled with the DEA complete 2 hours of CE on the controlled substance prescribing

Have readily available resources for your healthcare team:

- "SAFE Opioid Prescribing: Strategies. Assessment. Fundamentals. Education."
  - Educational resource freely available for completion by several professional organizations
  - CO*RE REMS online training
- Opioid-Induced Ventilatory Impairment video by the Anesthesia Patient Safety Foundation (APSF)
- E-FORCSE®, Florida Prescription Drug Monitoring Program

4. Patient & Family Education[10]

Pharmacists review safe analgesic use upon discharge

- When and how much medication to take
- Opioid disposal education can reduce diversion and decrease the risk of accidental exposure to someone other than the person for whom the opioid was prescribed
  - DEA Take Back Program
  - List of medications that can be flushed
- How to Use the Naloxone Nasal Spray and signs of overdose at harm reduction coalition.org
- U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has a directory of opioid treatment programs

5. Performance Data[10]

Opioid prescribing

- How much is your facility prescribing and when?

Patient-reported outcomes

- Improvement in analgesia and function
- Post-op discharge day's supply of analgesics
- Quantity and duration of analgesic use

Adverse events

- Monitor naloxone reversals

Use of prescription drug monitoring programs (PDMPs)

6. Culture of Accountability[10]

- Clear message hospital-wide
- Provide facility education to enhance awareness of opioid stewardship and the leadership team
- Create, promote, and maintain a culture of opioid stewardship

7. Community Collaboration[10]

- Collaboration with local law enforcement to enhance availability of naloxone use

Motorcycle Ambulance Service of Melbourne Victoria. By John Torcasio - Own work, CC BY-SA 4.0, https://commons.wikimedia.org/w/index.php?curid=46182725

What is Being Prescribed?[12]

- Retrospective review of ER opioid prescribing (Sutter, et al)
- Increase in intravenous (IV) hydromorphone use with decrease in IV morphine use from 2011-13
- Opioids not prescribed in an equipotent manner
- Naloxone infrequently needed after opioid administration

N=35,00	2011	2013
Total opioid doses	79,879	86,800
Total opioid doses per patient	2.28	2.48
Fentanyl	2,855 (3.6%)	3,728 (4.3%)
Hydromorphone	21,950 (27.5%)	37,269 (42.9%)
Morphine	55,074 (68.9%)	45,803 (52.8%)

Pediatric Pain Stewardship[8]

- 200-bed tertiary pediatric mid-Atlantic hospital
- Staffed by two advanced practice nurses and one anesthesia rotating attending physician
- Electronic database highlighted all patients with a pain score of ≥ 7/10 in the last 12 hours
  - Patients grouped into several categories: no action (78%), phone call to attending (1%), one-time consult (2.5%), consult with management (3.4%), or already on pain service (15.1%)
- 22% required pain service action, and sickle cell disease and abdominal pain (32.5%) required more frequent attention

Pilot Inpatient Pain PharmD Consult Service (IPPCS)[13]

Pharmacist-led services can complement the existing layer of pain management to provide an additional level of review

- Enhance prescribing practices at a facility level
- Improve outcomes by optimizing medication therapy
- Increase adherence and avoid adverse drug events

Tran N, et al: Pilot IPPCS at West Palm Beach VA Medical Center (WPB VAMC)[13]

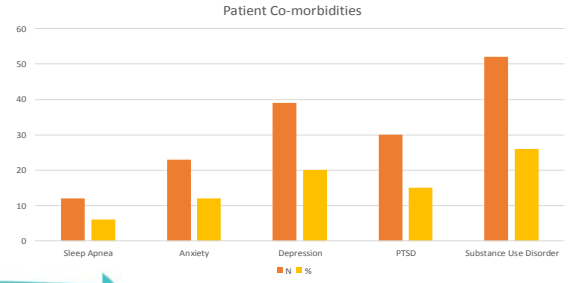
- WPB VAMC: 301-bed teaching facility
  - 130 acute/intensive care beds
  - 120 nursing home beds, including 12 for inpatient hospice
- Evaluated all 100 consults during the pilot period from November 2, 2015 through May 6, 2016
- Objectives for program feasibility
  - Volume/type of pain consults
  - Types of pharmacist interventions
  - Provider satisfaction
  - Response to recommendations

Tran, et al: Pilot IPPCS – Results[13]

- Mean age of 59.4 years, 91% male
- Type of pain
  - 69% acute on chronic
  - 16% malignant/end-of-life
  - 15% postoperative/trauma
- High risk for opioid misuse as per mean Opioid Risk Tool score of 8.3

Reported Average Pain Severity	N	%
No Pain	1	1
Mild Pain	4	6
Moderate Pain	29	39
Severe Pain	40	54

Tran, et al: Pilot IPPCS – Results, cont'd[13]



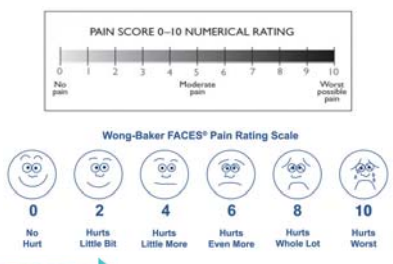
Tran, et al: Pilot IPPCS – Interventions[13]

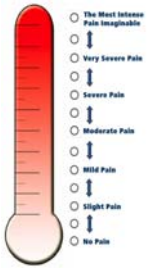
- Providers accepted 76% (179/234) of pharmacist medication recommendations
- Most common interventions included initiation/optimization of adjuvant therapy at 46% (83/179), followed by opioid discontinuation at 22% (40/179)
- Declined pharmacologic recommendations mostly included topical analgesics at 35% (19/55)
- Providers implemented 100% of recommendations in whole for 58% (47/81) of consults and reported high level of satisfaction with consult service

Recommendations for Clinicians

- Participate in educational endeavors to improve knowledge of pain assessment and management, which is now mandatory in Florida per HB:21
- Conduct comprehensive pain assessments that include patient-specific factors to guide sound clinical decision-making
- Implement an individualized, multimodal pain treatment that includes not just opioids
- Use pain assessment tools that are valid, reliable, and tailored to the patient's needs/characteristics

Pain Scales[3]





Clinically Aligned Pain Assessment Tool (CAPA)[14]

- Multidimensional scale
- Social transaction based on complex interplay between patient/clinician
- No script

- Conversation that addresses five domains:
  - Comfort
  - Change in pain
  - Pain control
  - Functioning
  - Sleep

CAPA Sample Questions[14]

Are you experiencing any pain?
How comfortable are you?
Is your discomfort improving or worsening?
Has the medication/heating pad/ice helped manage your pain?
Are you able to do what the staff is asking you to do (e.g., walking, coughing, physical therapy)?
Have you been able to sleep? Is the pain waking you up?

Recommendations for Institutions[15,16]

- Provide mandatory, ongoing pain education
- Use on-site pain experts or outside consultants to help develop safe, effective pain policies
- Ensure that policies/procedures and documentation systems include information to guide sound decisions on opioid dosing
- Implement a written/electronic template and quick order sets for safe analgesic prescribing

Conclusion

- Develop your interprofessional pain management team
  - Oversight of TJC pain management guideline adherence
  - Implement monitoring, tracking and trending of opioid data
  - Disseminate opioid stewardship polices
  - Provide clinical staff with on-demand educational activities
- Pharmacists are uniquely qualified to be key players as opioid stewardship pharmacists

Helpful Website Resources

- "SAFE Opioid Prescribing: Strategies by the American College of Physicians (ACP) https://www.acponline.org/meetings-courses/focused-topics/safe-opioid-prescribing-strategies-assessment-fundamentals-education
- CO*RE REMS opioid educational resources. http://core-rems.org/opioid-education/online-courses/
- Opioid-Induced Ventilatory Impairment video by the Anesthesia Patient Safety Foundation (APSF) https://www.youtube.com/watch?v=j4brtlBmGzc
- E-FORCSE®, Florida Prescription Drug Monitoring Program https://florida.pmpaware.net/login
- List of medications that can be flushed https://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/UCM588196.pdf
- Harm reduction coalition.org http://harmreduction.org/issues/overdose-prevention/tools-best-practices/overdose-videos/
- U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has a directory of opioid treatment programs http://dpt2.samhsa.gov/treatment/directory.aspx

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Clinical Pharmacy Specialist for Pain, Palliative Care, and Geriatrics
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West Palm Beach VAMC
Nhi Tran, PharmD, BCPS
Clinical Pharmacist Specialist, Palliative Care and Pain Management
Oncology Pharmacy Division
Florida Hospital Orlando
Break Through
August 4, 2018
Branch Out