Implementing Opioid Stewardship at the Health System Level: Strategies, Results, and What We’ve Learned from Antimicrobial Stewardship

HIIN Leadership, Improvement Advisors, and Hospitals Pacing Event

May 23, 2019
Welcome!

Who’s in the Room?

Bruce Spurlock, MD
Executive Director
Cynosure Health
National Content Developer
Overview

• Blessing Health’s Stewardship Journey
  • Mary Barthel, MD, FACP, SFHM (Blessing Health / Vizient HIIN)

• Virginia Mason’s Pain Management: Taking On Opioids
  An Organizational Approach
  • Angie McDaniel, MSN, RN, CNL, CPHQ (Virginia Mason Medical Center / WSHA HIIN)

• Questions and Answers

• CMS Comments
Questions to Run On

• What can your organization apply and/or adapt from its antimicrobial stewardship efforts to address opioid stewardship?

• How can patients and their family members be integrated into your opioid stewardship work?

• What processes and outcomes can be impacted by implementing an opioid stewardship program?
Implementing an Opioid Stewardship Program

Mary Frances Barthel, MD, FACP, SFHM
Chief Quality and Safety Officer
Infection Control Officer
Medical Director Utilization Management
Blessing Health System
The Stewardship Journey

• Describe the history behind Antimicrobial Stewardship Programs (ASP)

• Introduce our initial efforts for opioid stewardship in the rural clinic setting

• Present our application of ASP principals to Opioid Stewardship in the acute setting during the recent IV opioid shortage
Blessing Health System

- Outpatient services in West central Illinois and Eastern Missouri
- Blessing Hospital is the largest and most advanced medical center in a 100-mile radius, with 317 licensed beds, level II trauma center
What is Antimicrobial Stewardship?

• Optimal selection, dosage and duration of antimicrobials that results in:
  – Improved patient outcomes
  – Prevention of unnecessary exposure to antibiotics
  – Reduction in the emergence of bacterial resistance

• Applied discipline
  – Not just antibiotic guidelines
  – Antibiotics are a shared resource
  – Exposure affects future infections beyond the currently treated illness
CDC Core Elements of Antimicrobial Stewardship

• Leadership Support

• Accountability

• Drug Expertise

• Actions to Support Optimal Antimicrobial Use

• Tracking: Monitoring Antibiotic Prescribing, Use, and Resistance

• Reporting

• Education
Leadership Commitment

• Dedicate necessary human, financial, and information technology resources
  – Antimicrobial Stewardship Committee
    • Recruited Key Committee Members
    • Revised the mission and purpose
  – Investment in clinical decision support tool for clinical pharmacists
    • Real-time surveillance with direct feedback to physicians
    • Intervention and cost tracking
• Antimicrobial Stewardship Certification—all pharmacists
• Contractual addition of Infectious Disease consultant
• Medical Staff Commitment
  – Engagement across all disciplines
  – Exceptional intervention acceptance rate
  – Adherence to appropriate use criteria
Staphylococcus aureus MIC Distribution 2009-2017

Active Surveillance began

Number of isolates

Year


Isolates MIC = 2
Drug Susceptibility 2009-2017
*Pseudomonas aeruginosa* non-urine

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Fundamental Actions of Opioid Stewardship

• Leadership commitment and culture
• Organizational policies
• Clinical knowledge, expertise, and practice
• Patient and family education and engagement
• Tracking, monitoring, and reporting
• Accountability
• Community collaboration

• http://www.qualityforum.org/nqf_store.aspx
Blessing’s First Steps to Opioid Stewardship

• Multidisciplinary team formed in 2016 to address opioid prescribing health system wide.

• We created a gap analysis from the National Quality Partners Playbook
  – Offer non-opioid treatments. If opioids are used, treat with lowest dose possible for the shortest duration necessary
  – we started with the opportunities that had the largest potential impact

• We participated in Vizient Collaborative on OSP
Vizient Collaborative
Blessing Health System

• Project: Reduction of Opioid Use Across Rural Clinics
  - Historically, the percent of patients being treated with opioids in rural health clinics has been high which can lead to dependence. A reduction in opioid dependence would reduce overall morbidity and mortality. Project focus: implementation of a consistent treatment guideline across multiple clinics.

- Planned Strategies/Interventions:
  - establish a consistent process for intake, screening, assessment, treatment, and follow up of patients with pain that is in line with current guidelines.

- Performance Measures:
  - Reduce outpatient prescriptions for opioids in rural clinics by 20%.

- Milestones:
  - Rural clinic education complete
  - MME calculations by provider to target patients eligible for naloxone
  - Rollout of program system wide to all primary care and urgent care clinics
Inpatient Opioid Prescribing

• Following successful implementation of the stewardship program in regional clinics, in 2018 we began evaluating prescribing practices of our emergency department and with inpatient discharges.

• Just as we were beginning that work, a shortage of IV opioids became an urgent issue.
The “new” opioid crisis: from stewardship to shortage

• In 2018, production of injectable opioids nearly came to a halt due to manufacturing problems
• The shortage affected hospitals and hospice providers across the country
• We had an immediate need for information on inpatient IV opioid utilization
• We formed a multidisciplinary task force
Change Acceleration

- Immediately removed IV opioids from all order sets
- Provided widespread education on non-opioid analgesia and built new order set
  - Increased utilization of IV acetaminophen and toradol
  - Increased availability of non-pharmaceutical relief, including massage, aromatherapy, pain resource nurse
- Limited the duration to 24 hours when IV opioids ordered
- Evaluated use by location, by procedure, by provider
  - Restrictions initiated to preserve supply to OR, PACU, ICU, and hospice
- Monitored use in daily stewardship rounds, using decision support tool, with feedback to providers on IV to PO, alternate agents
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Community Education

• News channels featured our conservation efforts and reassured the community that we would still control pain that patients may experience.

• Informational sessions for the community were posted on social media.

• Fragility fracture program had previously had success with non-opioid medications, so we were able to share experiences with patients and providers.
Supplies Reached Critical Levels

- Utilization during all surgical procedures was reviewed and tracked weekly, with projected “run out” date, and distributed to all medical staff. A “red line” level was established, after which decisions would be made to postpone elective procedures.

- Surgical departments were encouraged to work with anesthesia on alternative pain modalities.
New strategies for pain control emerged…

- Oral medications administered pre-op and PACU
- Exparel and Ropivacaine used in ortho procedures, use expanded to hernia repair, etc.
- Procedures historically using fentanyl performed with reduced or no opioids, e.g., cataracts, cardiac cath, bronch

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Alternative Analgesics
Oral Opiate Use

Opiate Alternate Milligrams by Patient Day

Sample Count Per Unit

Month

Tests are performed with unequal sample sizes.
Metabolic Encephalopathy

Rate of Medical Encephalopathy not POA over IP Surgical Procedures

Tests are performed with unequal sample sizes.
Hospital Narcan Utilization by Month

Sample Count

Month


C=3.79  UCL=9.62  LCL=0
Monthly Pain Scores for Blessing Hospital

Pain Communication

Rate of Opioid Prescriptions Written Upon Discharge (our next stewardship opportunity)

Tests are performed with unequal sample sizes.
Blessing Health System Today

• Patients have adapted

• Physicians have adapted

• All restrictions remain in place today, our stewardship program having been propelled forward by the shortage

• Use of Alternative agents has continued

• “Never let a good crisis go to waste”
Suggestions for Getting Started

• Assess your scope: inpatient vs outpatient, medical vs surgical, ER, etc.

• Begin by auditing your prescribing practices, if possible, by tracking prescriptions leaving your organization to look for trends by location or prescriber

• Provide education and feedback

• Review the NQF playbook and create a gap analysis

• Leadership commitment is essential

• Find an early win/look for low-hanging fruit
Pain Management: Taking On Opioids
An Organizational Approach

Angie McDaniel MSN, RN, CNL, CPHQ
Virginia Mason Medical Center

- Integrated health care system
- 501(c)3 not-for-profit
- 336-bed hospital
- Ten locations
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute
Disclosures

• Virginia Mason was one of 10 healthcare organizations across the country chosen to receive a grant from Cardinal Health Foundation with the goal of creating measurable action plans designed to modify opioid prescribing, increase patient engagement and improve outcomes for patients suffering from chronic, non-cancer pain.

• Angie McDaniel today has no other relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
The number of people who die each year from...

- **Drug overdoses**: 52,404
- **Car accidents**: 37,757
- **Guns**: 35,763
- **H.I.V.**: 6,465

US prescription opioid use increased dramatically since the late 1990s and decreased slightly since 2011.
“If there is a place where blame for silos and politics belong, it is at the top of an organization.”

- *Silos, Politics and Turf Wars* (p.177) by Patrick Lencioni

“The ‘horizontal weave’ must be stronger than the ‘vertical weave’”

- Kaoru Ishikawa

Draft Guiding Principles

• Virginia Mason support the use of evidence based guidelines and best practice standards for caring for people with pain.
• We will support our providers and our teams with training, tools and resources to support the patients in our care.
• Optimizing functional status will guide our decision making rather than complete relief of pain.
• We know that opioids are not generally effective for long term treatment. Chronic opioid treatment is not generally indicated for frequent headache, non-specific low back pain and fibromyalgia.
• Long term chronic opioid use leads to severe side effects including: hyperalgesia, hypogonadism, dependence, addiction, osteoporosis, fatigue, somnolence and cognitive dysfunction.
• We endorse the limit of 50 MED (daily morphine dose equivalents) for patients where opioids are indicated.
• For people we care for with substance use disorder we will partner with community to provide care.
• The prescriber adherence to opioid best practice is critical to quality of care, quality of health and community health.
“Pain is a dynamic and personal experience. We will seek to listen and understand yours. Guided by your goals and best evidence, we will empower you to become your best self.”
Virginia Mason: An Integrated Response

- ED
- Surgery
- Behavioral Health
- Nursing
- Patient Safety
- Clinical Quality
- Data Analytics
- IT
- Hospital
- Outpatient Specialty
- Primary Care

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### Acute Pain
- Acute prescribing standards
- Educate teams and increase awareness
- Use safe alternatives
- Provide non-pharmacological therapy
- Shortest course possible
- ≤ 7 days opioids
  - Dispose of “extra”

### Chronic Pain/Chronic Opioids
- Standards for prescribing chronic opioids safety
  - Narcan
  - Wean opioids slowly
  - Partner with Pharmacist and Behavioral Health
- Provide needed support to patient & family
- Consult with experts
- If unable to wean: consider medication assisted treatment with buprenorphine (Suboxone), and support

### Opioid Use Disorder
- Wean opioids slowly
- Narcan
- Provide needed support for patient and family
- Consult with specialist
- Partner with Pharmacists, Behavioral Health and Community Resources

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Communication Training “Compassionate Limit Setting”
EHR tools, Data, Patient Education
Our Journey

SUPERFLOW
1. Surgical Optimization of Opioid Familiar
2. Surgical Optimization of Opioid Naive

RPIW
COT Management in Neurology

DPC Policy Approved
Standardized Assessment Tools

VISIONING SESSION
Acute Prescribing Standards

RPIW
Standardized risk stratification of patients on COT

VISIONING SESSION
RN Pain Management Call to Action

Hospital Medicine Standards

VISIONING SESSION
Identification & Treatment of OUD

Kaizen
Mistake-proofing Naloxone Prescribing

Kaizen
Pain Education Bundle

RPIW
Identification & Treatment of OUD

2016
VISIONING SESSION
Guiding Team Formation

2017
RPIW
COT Management in Neurology

2018
VISIONING SESSION
Hospital Medicine Standards

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Chronic Opioid Therapy
# Reference Tool Utilized in Neurology

## Persistent Pain and Opioid Therapy Reference Sheet

### EXPLAIN

*Pain is a dynamic and personal experience. In the Virginia Mason Health System, we will seek to listen & understand our patients’ pain. Guided by the patients’ goals and the best evidence, we will empower patients to become their best.*

**Assess PMP at each visit for Potential High Risk Scenarios:**

- >3 providers in 12 months
- >4 CII in 12 months
- >2 CII in last 40 days
- Overlapping opioid/benzo Rx in last 6 months
- Any Rx for: methadone, suboxone, fentanyl, LA morphine or oxycodone
- > 90 MED/day in last 40 days

### New Patient & Annual Assessment

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<td>CSR: If Opiate on Med List, give Pain Packet</td>
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<tr>
<td>MA Ask: Is persistent pain part of your visit today?</td>
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<tr>
<td>MA Review/Assess PMP</td>
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</tbody>
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### Visit

- Review Risk Assessment, Persistent Pain, Prescription Monitoring Program (PMP) Forms
- Add ‘Chronic Pain’ and/or ‘Chronic Narcotics’ to Problem List
- Discuss:
  - Consider non-pharmacological options
  - Social Work consult, if comorbid mental health issues
  - Set functional treatment goals
  - Patient education
  - Compact review
  - Consider naloxone Rx when MED >=50 mg/day and/or when ↑ risk for opioid-related harms are present
  - Create Follow Up & Urine Tox Screen Plan

### Interim Review

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- If comorbid mental health issues, Social Work Consult

#### High Intensity Risk:

- Clinic Visit with MD or PharmD Q1 month, Utox Q3 months
- Provide ≤ 1 month supply

#### Moderate Intensity Risk:

- Clinic Visit with MD or PharmD Q3 months, Utox Q6 months
- Provide ≤ 3 month supply

#### Low Intensity Risk:

- Clinic Visit with MD or PharmD Q3 months, Utox Q12 months
- Provide ≤ 3 month supply

### Patient Risk Intensity Plan

#### High Intensity Risk

- >90 mg/day MED
- Age ≤25 years
- ≥ 8 on Opioid Risk Tool
- Repeated problems e.g. frequent refills, escalating doses, multiple ER presentations
- Visit Q1 month/ Utox Q3 months
- Provide ≤ 1 month supply

#### Moderate Intensity Risk

- Taking 50-90 mg/day MED
- 4–7 on Opioid Risk Tool
- Visit Q3 months/ Utox Q6 months
- Provide ≤ 3 month supply

#### Low Intensity Risk

- <50 mg/day MED
- 0–3 on Opioid Risk Tool
- Visit Q3 months/ Utox Q12 months
- Provide ≤ 3 month supply

#### Negligible/No risk

- Not on Opioids
Persistent Pain Organizational Standards

- Based on a shared vision & determined guiding principles
- Alignment with CDC, Washington Agency Medical Directors Group, & Department of Health best practice recommendations
- Provide foundation for department specific policies

Persistent Pain and Opioid Management Best Practice Standards

**Type:** Practice Standards

**Status:** Active

**Last Revised:** 08/23/2017

**Regulatory Source(s):** WAC

**Regulatory Citation Number(s):** WAC 246-018-800 through 246-019-803

**Purpose:** Guidelines for pain management are based on recommendations from the Centers for Disease Control (CDC), Agency of Medical Director's Group (AMDG), and the Washington State Pain Management Rule (WAC 246-019-800 through 246-019-803).

Pain is a dynamic and personal experience. In the Virginia Mason Health System, we will seek to listen and understand our patients' pain. Guided by the patients' goals and the pain assistance, we will empower patients to become their best.

**Scope:** Licensed Staff across the Virginia Mason Health System

Applying to the management of patients with post-surgical or persistent, non-malignant pain and chronic use of opioid medications for non-painful conditions. The terms persistent and chronic for this policy are defined as conditions or use of medication lasting ≥ 12 weeks.

This policy supports and should be followed in conjunction with the Virginia Mason Medical Center/Agenda Department Narcotic Therapy Guidelines.

**Practice Standards:**

- Washington state law requires consultation from a pain specialist if doses ≥120 MED/day are used. Exceptions to this requirement are included in WAC 246-018-800 and 246-019-801.
- Non-pharmacologic therapy and nonopioid pharmacologic therapy are preferred treatments for persistent pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
- If opioids are used, they should be combined with non-pharmacologic therapy and nonopioid pharmacologic therapy, if appropriate.
- Before starting opioid therapy, clinicians must establish treatment goals with all patients, including realistic goals for pain and function, and consider how therapy will be discontinued if benefits do not outweigh risks.
- Clinicians should consider opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
Risk & Opioid Use Disorder
Comorbid conditions increase risk of any opioid therapy (e.g. COPD, obesity, sleep apnea, heart failure)

### Risk Stratification

#### Opioid Use Disorder
- Any MED plus meeting DSM-V diagnostic criteria
- VM Opioid Medication Safety Assessment Tool

#### Unsafe Opioid Use
- MED >90mg/day
- Age <25 on COT
- ORT >8 (for initial visits)
- Undertreated/Symptomatic behavior health dx
- Benzos/sedatives Rx
- >2 Falls since last visit
- ACE >4
- Unsafe Medication Use/VM Opioid Medication Safety Assessment Tool

### Treatment Pathways

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>CONSIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient education on Opioid Use Disorder</td>
<td>Pain Consult for patients with acute uncontrolled pain</td>
</tr>
<tr>
<td>Community Medication Assisted Therapy Resources</td>
<td>Detoxification Options</td>
</tr>
<tr>
<td>Naloxone Prescription</td>
<td>Palliative Care Referral</td>
</tr>
<tr>
<td>Patient Buprenorphine Therapy Agreement</td>
<td>Behavioral Health Referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>CONSIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult to Pain Specialist if MED &gt;90 mg/day</td>
<td>Collaborative care conference</td>
</tr>
<tr>
<td>Pharmacist consult for polypharmacy</td>
<td>Behavioral Health Referral</td>
</tr>
<tr>
<td>Naloxone Prescription</td>
<td>Caregiver &amp; Patient Engagement Education Pathway</td>
</tr>
</tbody>
</table>

### Rising Risk
- MED 50-90mg/day
- ORT 4-7 (for initial visits)
- PHQ 9/GAD 7
- No Unsafe Medication Use Issues
- No Falls

### Moderate Risk
- MED 30-50 mg/day
- ORT 4-7 (for initial visits)
- PHQ 9/GAD 7
- No Unsafe Medication Use Issues
- No Falls

### Low Risk
- MED <30mg/day
- ORT 0-3 (for initial visits)
- No Unsafe Medication Use Issues
- No Falls

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Are you Safe?

Chronic pain is complicated. We are here to partner with you.
1 in 10 people using chronic opioid therapy develop opioid use disorder. Unsafe opioid use increases the risk of harm which may include:

- Increased Pain
- Relationship conflicts
- Fear
- Loneliness
- Despair
- Loss of life

<table>
<thead>
<tr>
<th>Safe</th>
<th>Unsafe Opioid Use</th>
<th>Opioid Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>o  No early refills</td>
<td>o  Falls</td>
<td>o  Self-identified unsafe use</td>
</tr>
<tr>
<td>o  Engaged with activities &amp; loved ones</td>
<td>o  Work or school difficulties related to opioids</td>
<td>o  Any overdose on opioids</td>
</tr>
<tr>
<td>o  Engaged in non-opioid treatment for pain</td>
<td>o  Emergency department visits to request opioids</td>
<td>o  Driving under the influence</td>
</tr>
<tr>
<td>o  Consistent urine screen results</td>
<td>o  Concerns raised by family or friends</td>
<td>o  Taking other people's prescriptions or outdated</td>
</tr>
<tr>
<td></td>
<td>o  Opioid are becoming more important to me than my pain</td>
<td>prescriptions</td>
</tr>
</tbody>
</table>
<pre><code>                                                                  |                                                             | o  Buying, selling or trading opioids                     |
</code></pre>

If you, your family, or your healthcare team have concerns, we will work together to identify safe options.

- Medically assisted therapies work and can be managed by your primary care provider. These medications include:
  - buprenorphine/naloxone, naltrexone, and methadone
- Tapering off your opioids in consultation with your healthcare providers.
- Consultation with specialists to offer other options to treat pain.
Opioid Use Disorder Management Pathways

**OUD, Moderate to severe**

**Initial Visit**
- Triggering event
- OUD mod-sev dx’d
- 4+ DSM criteria
- Review “unsafe opioid use” tool with patient
- Give packet + MAT info

**RN Phone Call**
- Check In
- Withdrawal meds?
- Scheduling + follow-up

**MAT Provider Initial Visit or Follow-up**
- Check In
- Motivational Interviewing
- Review referrals and resources
- Answer questions
- Tx options: pharm non-opioid vs non-pharm

**Outcomes**
- Document OUD mod-sev in note
- Rx MAT +/- withdrawal meds, OR
- Appointment for MAT in 1 week with plan to initiate then
- Patient is more informed
- Care team with better understanding of patient’s problem and circumstances
- Document selected options and status
- Patient feels more supported

**WEEK 1**

**WEEK 2**

**WEEK 3**

**WEEK 4**

**Outcomes**
- Relapse prevention
- Documented increasing functioning
- Improved relationship with care team

**RN/ISW Phone Call**
- Check In
- Motivational Interviewing / Cognitive Behavioral Therapy
- Establish plan for harm reduction
- Answer questions
- Review referrals and available resources

**Provider Follow-up**
- Initiate pathway
- Clear plan
- Necessary referrals
- OUD reassessment

**Outcomes**
- Document assessment and plan
- Utilizes template
- Expectations are clear
- Document patient level of acceptance of plans
- Necessary referrals made

**OUD, Mild**

**Initial Visit**
- Triggering event
- OUD mild dx’d
- 2-3 DSM criteria
- Review “unsafe opioid use” tool with patient
- Give packet
- Phone call prep
- Warm handoff

**Patient Reviews Packet**

**WEEK 1**

**WEEK 2**

**WEEK 3**

**WEEK 4**

**Outcomes**
- Appointment for follow-up in 4 weeks
- Document OUD mild in note
- Patient is more informed
- Care team with better understanding of patient’s problem and circumstances
- Document selected options and status
- Pt feels increased support

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Acute & Acute on Chronic Opioid Therapy
New Persistent Opioid Use

Risk of continued use increases at **4-5 days**

- **6%**

![Bar graph showing incidence of new opioid use](image1)

- Varicose Vein Removal
- Laparoscopic Cholecystectomy
- Laparoscopic Appendectomy
- Hemorrhoidectomy
- Thyroidectomy
- Transurethral Prostate Surgery
- Parathyroidectomy
- Carpal Tunnel Surgery
- Ventral Incisional Hernia Repair
- Colectomy
- Reflux Surgery
- Bariatric Surgery
- Hysterectomy
- Nonoperative Comparisons

**Likeliness of dependency spikes here**

Organizational Acute Prescribing Standard

Enacting 7 day limit (~42 tabs) on new opioid prescriptions for acute pain

- Decrease supply of opioids for initial prescription
- Improve care coordination
- Increase availability of non-opioid treatment therapies
- Consistent & accurate patient education & instructions
### Focus & Results

**Problem:** Variability in post-op prescribing, increased unused pills

**What we did:**
PDSA to standardize post-op prescribing on opioid naïve patients undergoing outpatient spine procedures

- Acetaminophen/hydrocodone 5/325mg, 24 tablets

### Barriers

- Out of town/state patients
- Extrapolating to other procedures

### Next Steps

- Increased use of multi-modals
- Decreased rate of “2nd prescription”
Process at a Glance

Opioid Familiar Surgical Optimization

Visit with Surgeon
- Pt identified as COT/familiar
- Pt Education initiated
- Operators: Surgeon & Scheduler

PAAC Chart Review
- PMP review
- Determine Visit vs. Phone
- Develop Plan of Care
- Operators: PAAC resident and APS attending

Pain Consultation
- Patient Goal Setting
- Baseline documentation
- 2nd layer Patient education/expectation setting
- Operators: APS Team

Pain Mgt Plan of Care
- Visibility in Cerner to all of Care Team
- Form given to patient for reference
- Operators: All Care Team
• Need for clear referring provider reference identified through PDSA cycles in Orthopedics

• Goal for consistent reference document across all surgical sections
Acute Opioid Taper Calculator

A step-wise approach to treating acute pain, starting with multimodal non-opioid medications is recommended. NOTE: This calculator is intended for tapering a patient off opioids that were started for acute pain only. It should not be used for methadone, buprenorphine, extended release medications, or chronic opioids tapers. Tips and Tricks

STEP 1: Enter current opioid regimen

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Tablet Size*</th>
<th>Dose</th>
<th>Frequency</th>
<th>Current</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>oxycodone</td>
<td>5 mg/tab</td>
<td>15 mg/dose</td>
<td>3 hours</td>
<td>120 mg per day</td>
<td>180 MED/day</td>
</tr>
</tbody>
</table>

*Lowest mg tab recommended to avoid sudden withdrawal
Consider naloxone prescription for >50 MED/day.

STEP 2: Enter start date and duration of taper (Acute opioids for < 3 days do not need a taper)

Start Date: 12/11/2018
Duration: 7 days

STEP 3: Review suggested taper schedule

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Opioid</th>
<th>mg/dose</th>
<th>doses/day</th>
<th>mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>12/11/18</td>
<td>oxycodone</td>
<td>15</td>
<td>6</td>
<td>90</td>
</tr>
<tr>
<td>Day 2</td>
<td>12/12/18</td>
<td>oxycodone</td>
<td>15</td>
<td>6</td>
<td>90</td>
</tr>
<tr>
<td>Day 3</td>
<td>12/13/18</td>
<td>oxycodone</td>
<td>15</td>
<td>6</td>
<td>90</td>
</tr>
<tr>
<td>Day 4</td>
<td>12/14/18</td>
<td>oxycodone</td>
<td>10</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Day 5</td>
<td>12/15/18</td>
<td>oxycodone</td>
<td>10</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Day 6</td>
<td>12/16/18</td>
<td>oxycodone</td>
<td>5</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Day 7</td>
<td>12/17/18</td>
<td>oxycodone</td>
<td>5</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>

STEP 4: Write the prescription
Copy and paste the instructions below into the prescription order comments.
Take only as needed. Day 1: Take 3 tabs q6h. Day 2: Take 3 tabs q6h. Day 3: Take 2 tabs q6h. Day 4: Take 2 tabs q4h. Day 5: Take 2 tabs q6h. Day 6: Take 1 tab q6h. Day 7: Take 1 tab q8h.

STEP 5: Review total pill count
Total number of 5mg tablets to prescribe: 75
Compassionate Limit Setting
What is the human experience?

- Improved Clinician Experience
- Improved Patient Experience
- Better Outcomes
- Lower Costs

Adapted from graphic by Cardiac Interventions Today
How did we get here?

1900: Bayer Co. begins commercial sale of heroin

1900s: Nerve block clinics emerge to help treat nerve related injuries from WWI & WWII

Harrison Anti-Narcotic Act

1910: Heroin is made illegal

1920: "Gate Control" model published

1930: "Gate Control" model published

1940: Nerve block clinics emerge to help treat nerve related injuries from WWI & WWII

1950: Vicodin & Percocet introduced into the market

1960: "Gate Control" model published

1970: OxyContin introduced as an extended-release reformulation

1980: The VA Adopts Pain as the 5th Vital Sign

1990: New Recommendations from CDC & AMDG re: safe opioid management

2000: TJC updates standards on pain management

2010: Providers beginning their practice would now be:

- 55-65 yoa
- 45-55 yoa
- 35-45 yoa
- 25-35 yoa

2020: The FDA issued a warning re: misleading advertising re OxyContin's addictive nature

The VA Adopts Pain as the 5th Vital Sign

OxyContin introduced as an extended-release reformulation

TJC establishes standards on pain management

New Recommendations from CDC & AMDG re: safe opioid management

TJC updates standards on pain management

Publishing in the NEJM that addiction is a rare event

55-65 yoa

45-55 yoa

35-45 yoa

25-35 yoa
The 3 Criteria for Principled Prescribing

- **Efficacy**: Will this continue to be effective?
- **Sustainability**: Safe trajectory?
- **Safety**: More harm than good?
Implementation
Implementation Strategies

Guiding Team

Organizational Standards
Care Team Education
Metrics
Patient Pathways
EHR Optimization

Strategic Planning & Development

Implementation

Department of Medicine
Department of Surgery
Department of Primary Care
Hospital & Emergency Services

Clinical Leader
Operations Leader
Clinical Leader
Operations Leader
Clinical Leader
Operations Leader
Clinical Leader
Operations Leader
Clinical Leader
Operations Leader

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Implementation Strategies

1. Sharing of current and future work
2. Venue for open dialogue with stakeholders
3. Opportunity to identify champions
4. Provides feedback to guiding team
Integration of Tools with EHR

- Available at point of use
- Creates transparency in the EHR
- Promotes resiliency of interventions
- Allows for data mining and trending
Pain Management

Announcements

- Use this new tool to help develop a plan taper for opioids prescribed for acute pain: Acute Opioid Taper Calculator.
  - Note: This calculator is intended for tapering a patient off opioids that were started for acute pain only. It should not be used for methadone, buprenorphine, extended release medications, or chronic opioid therapy tapers.
- Access it quickly by going to Clinical Resources on V-Net. (See below.)
Organizational Metrics

July 2017- Opioid Prescribing Metrics

1. Patients prescribed any opioid
2. Patients prescribed chronic opioids
3. Patients prescribed high-dose chronic opioid therapy
4. Patients prescribed chronic concurrent opioids and sedatives
5. New Opioid patients days supply of first opioid prescription
6. New Opioid patient subsequently prescribed chronic opioids
7. Opioid overdose deaths
8. Non-fatal overdose involving prescription opioids
9. Patients prescribed chronic opioids who receive a diagnosis of opioid use disorder
Slide left intentionally blank. Data omitted from distribution.
"Without standards, there can be no improvement"

- Taiichi Ohno

Founder of the Toyota Production System
Virginia Mason

Each Person.
Every Moment.
Better Never Stops.
Questions to Run On

• What can your organization apply and/or adapt from its antimicrobial stewardship efforts to address opioid stewardship?

• How can patients and their family members be integrated into your opioid stewardship work?

• What processes and outcomes can be impacted by implementing an opioid stewardship program?
Questions and Answers

Please share your questions for our presenters!

To share a question, you may enter it into the chat box or press 7# on your telephone keypad to have your line unmuted.
Key Takeaways

• The CDC’s Core Elements of Antibiotic Stewardship Programs offer a framework that can be adapted and applied to the implementation of opioid stewardship programs.
  – For example, the principles and actions associated with leadership commitment, appropriate use and surveillance, reporting, and education are fundamental to the implementation of opioid stewardship as well.

• Understanding the prescribing practices within your system or facility will help identify gaps that may need to be addressed, as well as help assess the culture change that may be needed.
  – Staff education and leadership support will facilitate culture change!

• Use data (such as those around prescribing practices and types of opiates prescribed) as a source of ongoing feedback.

• Educate patients about the risks of opioids, and engage patients and their family members in the work to understand and modify prescribing practices. For example, seek their feedback about what medications they were prescribed versus what they used.
Participant Polling

Please share your feedback!
Upcoming Events

NCD Weekly Pacing Event
Thursday, May 30, 1:00 – 2:00 PM ET
Topic: New Jersey’s HAI Reduction Collaboration: A CDC TAP Strategy Pilot

HIIN-Only Office Hours
Thursday, June 6, 1:00 PM – 2:00 PM ET