OHIO HOSPITAL ASSOCIATION

A COMPREHENSIVE APPROACH TO OPIOID STEWARDSHIP

January 20, 2022

CONTINUING EDUCATION

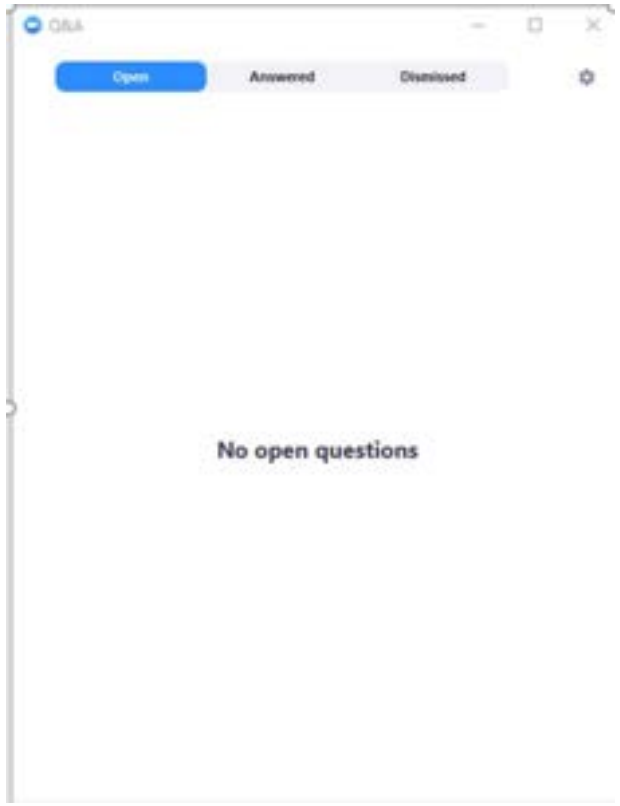
- The link for the evaluation of today's program is: https://www.surveymonkey.com/r/OpioidStewardship-1-20-22

- Please be sure to access the link, complete the evaluation form, and request your certificate. The evaluation process will remain open **two weeks** following the webcast. Your certificate will be emailed to you when the evaluation process closes after the 2-week process.

- If you have any questions, please contact Dorothy Aldridge (Dorothy.Aldridge@ohiohospitals.org)

The Ohio Pharmacists Foundation, Inc. is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

SUBMITTING QUESTIONS



ACKNOWLEDGEMENT

The Ohio Hospital Association received a grant from Covery's Community Healthcare Foundation to support this opioid stewardship effort.

Making Opioid Stewardship Actually Happen

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Emergency Physician & Opioid Stewardship Champion, Dignity Health

CA BRIDGE

CA Bridge is a program of the Public Health Institute. The Public Health Institute promotes health, well-being and quality of life for people throughout California, across the nation, and around the world.

No financial disclosures.

(Any brand names are said from habit only!)

Problem Defined.

Opioid OD > Car Crash Deaths
Spike in synthetic drug use
Rising opioid deaths
After 5 days, 6% [illegible] long term use

Solutions Explained.

Prevention: ALTO, Rx Guidelines
tment: MAT
uction: Naloxone,
eedle exchange
n counseling, etc.

Vision seen...

Comprehensive Opioid Stewardship
at every site!

Where you've been…

But how do we
make it happen?!

CA Bridge Model

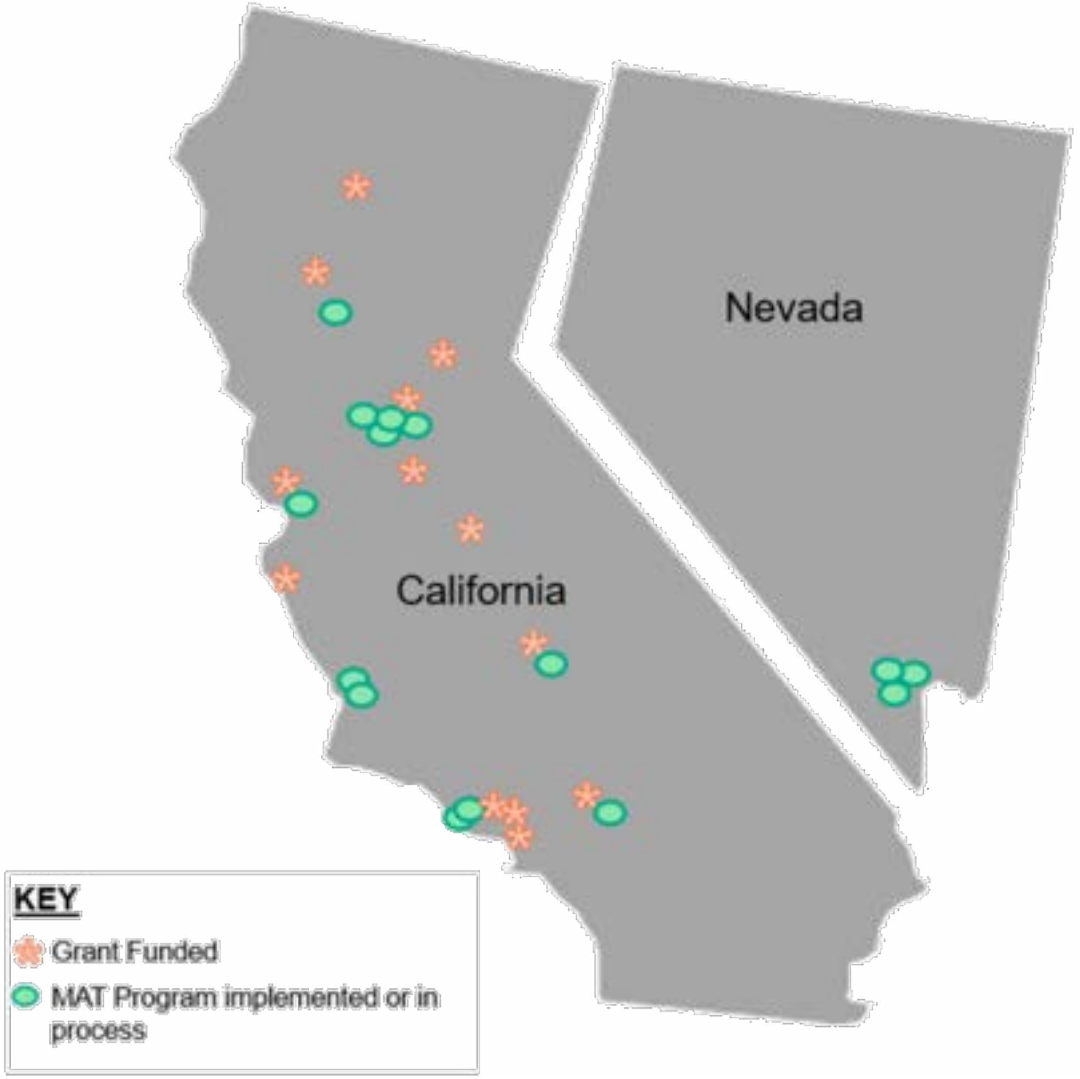
Revolutionizing The System Of Care

Low-Barrier Treatment

Connection to Care
and Community

Culture
of Harm Reduction

Starting out 2019: 28 sites



Dignity Health.

Dignity Health.


Nevada
California
Grant Funded
MAT Program im
process
Dignity Health.

Pro Tip #1:

Establish Leaders.

Calendar logistics & reminders
Set the agenda
Support questions

Pro Tip #2:

Build a support network.

Site, hospital system, association…
Schedule regular touch bases
Gain & give accountability
Troubleshooting support

Opioid Stewardship Team Members

LOCAL TEAMS

- ED RN & Clinician
- Pharmacist
- Care Coordination
- Outpatient provider/contact
- Inpatient RN & Hospitalist
- Executive Sponsor

LARGER TEAMS

- Subject matter expert(s): Clinician, RN, Pharmacy
- Admin/Technical Support
- Executive Sponsor/Support

+ Support from OHA, CA Bridge, ACEP, etc.

We've got a team.
Now what?!

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CA BRIDGE

SEPTEMBER 2020

Blueprint for Hospital Opioid Use Disorder Treatment

A patient-centered approach to 24/7 access to medication for addiction treatment

Implementation Checklist

Start Treatment

- ❑ Ensure buprenorphine is on formulary and available in the hospital.
- ❑ Share treatment protocols with nursing teams, pharmacy teams, and coordination teams (social work, case management, patient navigation) and post in visible locations.
- ❑ Ensure there are no barriers (e.g., unnecessary diagnostic testing) that delay the start of treatment.
- ❑ Provide medications on discharge.

Connect Patients to Ongoing Care

- ❑ Hire a substance use navigator (SUN) or dedicate other staff to link patients to care.
- ❑ Provide training and support to prepare navigators to function effectively.
- ❑ Establish informal or formal relationships with at least one clinic or outpatient setting that provides MAT.
- ❑ Develop patient materials including list of MAT follow-up options, discharge instructions, home start guidance, and harm reduction.
- ❑ Establish a patient-centered referral process including workflows for night and weekend follow-up.

Change Hospital Culture

- ❑ Learn about harm reduction and trauma-informed care and integrate them into your clinical practice.
- ❑ Educate providers and staff about the use of non-stigmatizing language through flyers or presentations.
- ❑ Print and hang patient-facing signs in ED lobby and patient care areas.

Initial Action Items

1. Identify important stakeholders & reach out! (ED, Pharmacy, Hospitalist, Outpatient)
2. Set up for *prevention & treatment:*
    1. Prepare site-branded **Opioid Prescribing Guidelines** & patient education
    2. Get **ALTO meds** on formulary
    3. Get **Buprenorphine** on formulary
    4. EHR ALTO/MAT **orders/order sets**
    5. **X-waiver** clinicians

Initial Action Items

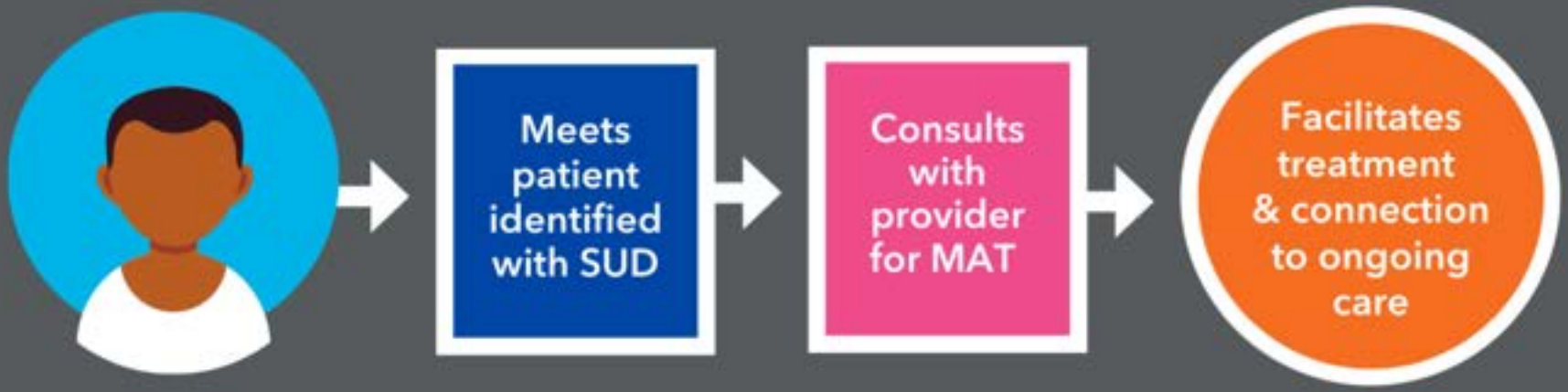
3. Establish a **referral process with** at least one MAT clinic, & one Telehealth provider.

4. Designate a person responsible for the ***"warm handoff" / linkage to care*** – Substance Use Navigator, Social Worker, charge RN, etc.

Substance Use Navigators

The Substance Use Navigator

guides patients with acute substance use disorder (SUD) through the emergency department and beyond.



SUN Alternatives

- Social Worker
- PA / NP
- Unit Clerk
- Case Manager
- Scribes
- RN

Take home: Have staff equipped to facilitate the *bridge* to care – from the ED to the outpatient setting.

Warm Handoff Must Haves

- **In-person option** (https://findtreatment.samhsa.gov/) ***and***
- **Telehealth options:**

  Bicycle Health
  BrightHeart Health
  Kaden Health
  Workit Health (Ohio)

- **Smooth Referral Process –** *phone v. voicemail v. fax*
- **Patient support –** including clear instructions (in patient's language!) & who to call with questions
- **X-waivered ED team** to write Bup Rx

Pro Tip #3:

Create a smooth referral process for ongoing care.

Who, Where, & How

Initial Action Items

5. ****Education plan for *<u>everyone</u>*****

   re: ALTO, Rx guidelines, & MAT basics

   1. Pharmacy
   2. RNs
   3. Clinicians
   4. Care Coordination

Initial Action Items

5. ****Education plan for *<u>everyone</u>*****

   re: ALTO, Rx guidelines, & MAT basics

   1. Pharmacy
   2. RNs
   3. Clinicians
   4. Care Coordination

Good news: This education *already exists*!

- CA Bridge YouTube Channel – Browse away!

  Includes below and more re: substance use navigation, full spectrum opioid stewardship, alcohol use treatment, etc.

- Alternatives to Opioids (ALTO) in pain treatment
- FAQ on MAT – 12min basic intro for anybody!
- Treating Acute Opioid Withdrawal in the ED – 20min basics
- RN Call to Action in MAT – 7min
- ASAM Buprenorphine Mini-Course – 1hr, for clinicians

Good news: This education *already exists*!

Pro Tip #4:

Map timeline for initial & subsequent Action Items.

Include education plan!
Use CA Bridge & OHA resources to help you

We've got a plan.
Time to get 'em involved!


Sounds great! We're in!
I'm in… but let's be real. You're going to have to remind me!
Cool… No thanks.

Let Green Lights Shine!

Sounds great! We're in!

1. Let them *lead*!
   - Resource development
   - Present at meetings
   - Case examples
   - Pilot projects
2. Pair with weaker sites

Engage Yellow Lights

You're going to have to remind me!

1. Make remembering *easy*
   - Calendar invites & reminders
   - Accountability for absence
2. Make it *worth it*
   - Use their time *well*!
   - Share successes

Motivate Red Lights!

1. Do this… but later.
   - Iron the kinks out
   - Set the "standard"
   - Positive peer pressure!
2. Use an Executive Sponsor

Cool… No thanks.

Pro Tip #5:

Have a strategy for inclusion.

How will you engage your green, yellow, and red lights?
When? On what timeline?

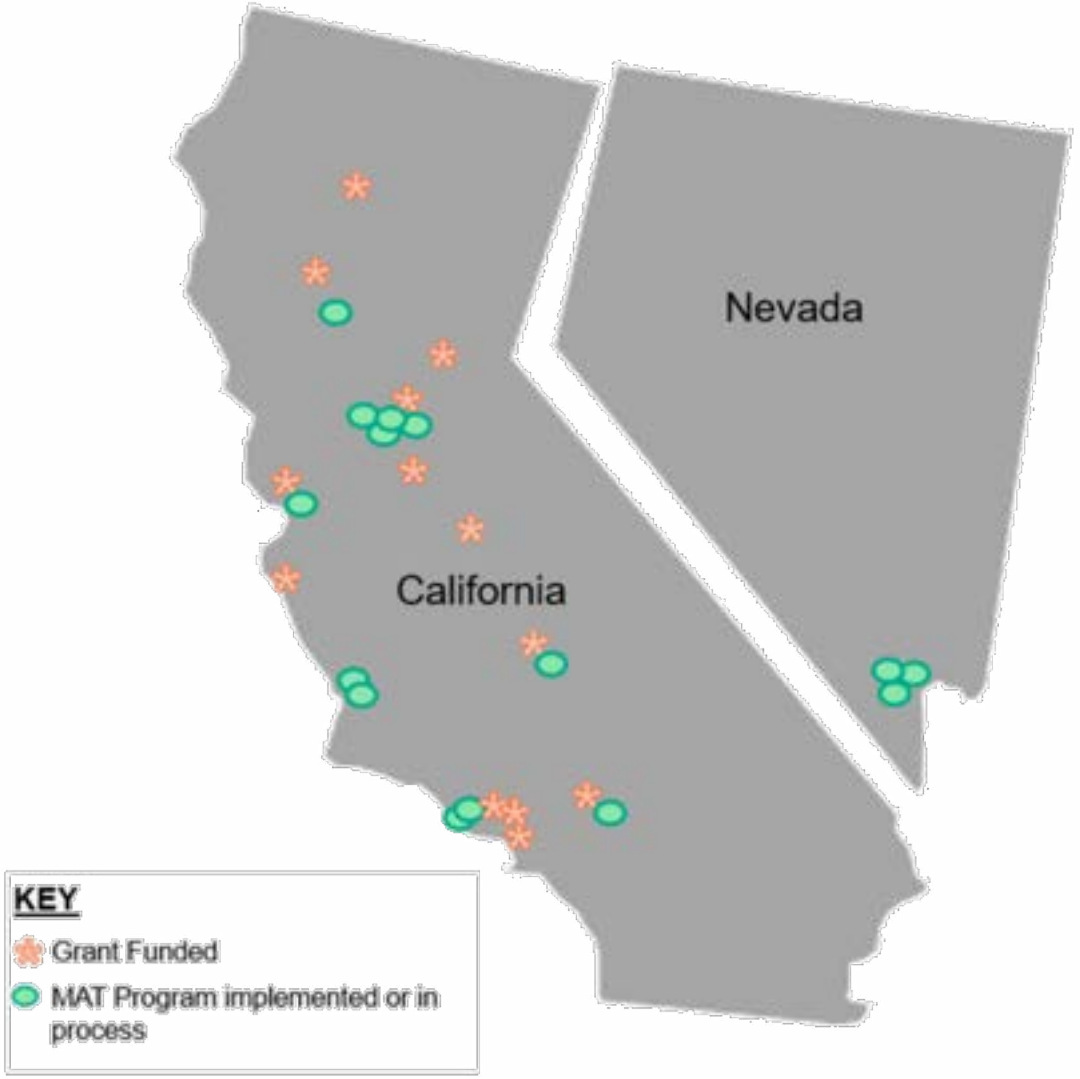
Pro Tip #6:

Secure Executive support.

**Chief Medical Officer*
**Chief Nursing Executive/Officer*
**Quality Department*
Pharmacy / RN & Dept Medical Directors

We did all of this in CA
and it's working…

Starting out 2019: 28 sites



Dignity Health.

Starting out 2019: 28 sites

Current Status: 50+ hospitals

in CA currently access points

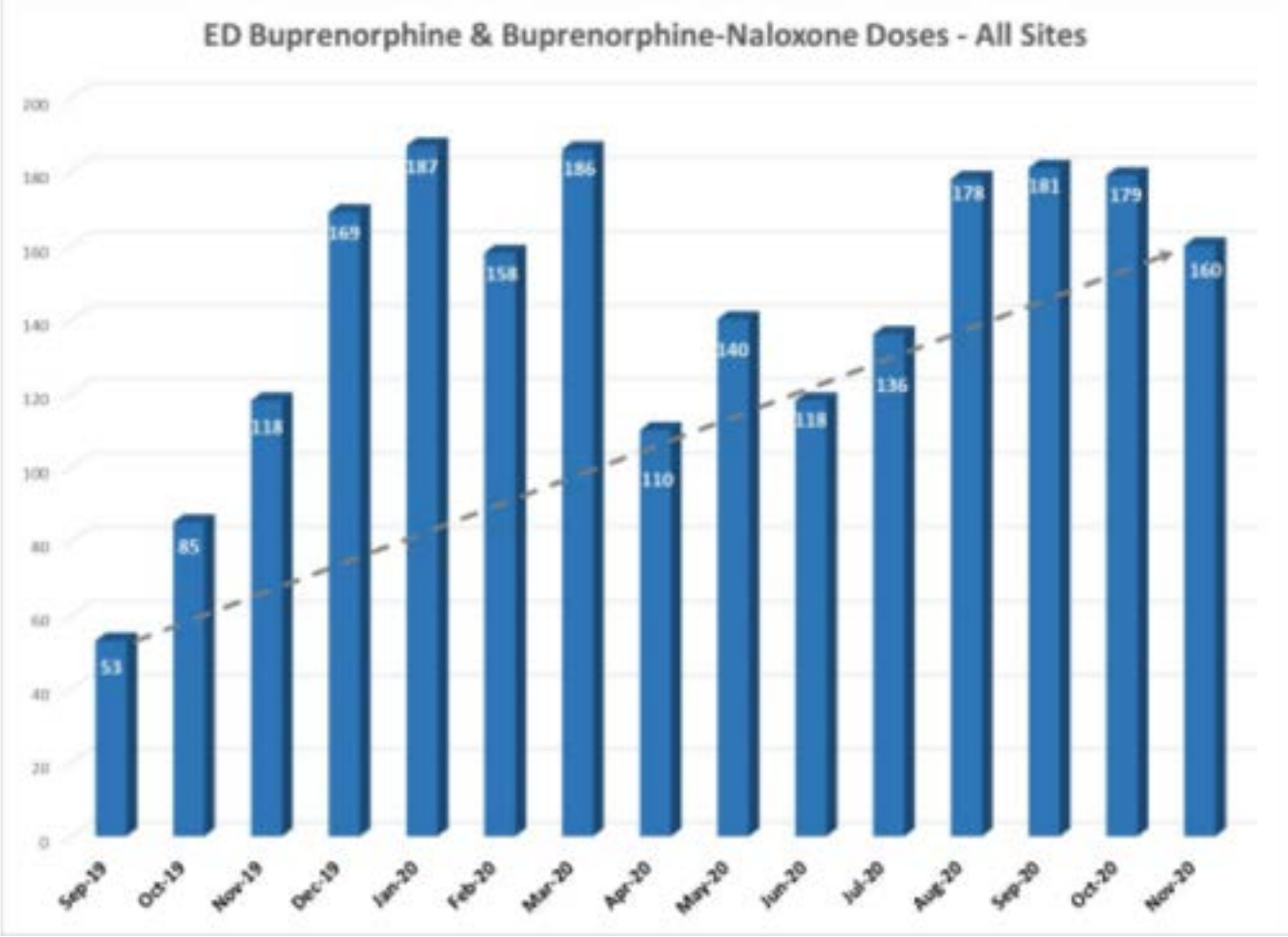
for patients with SUD.

And many others nation wide…

Dignity Health.

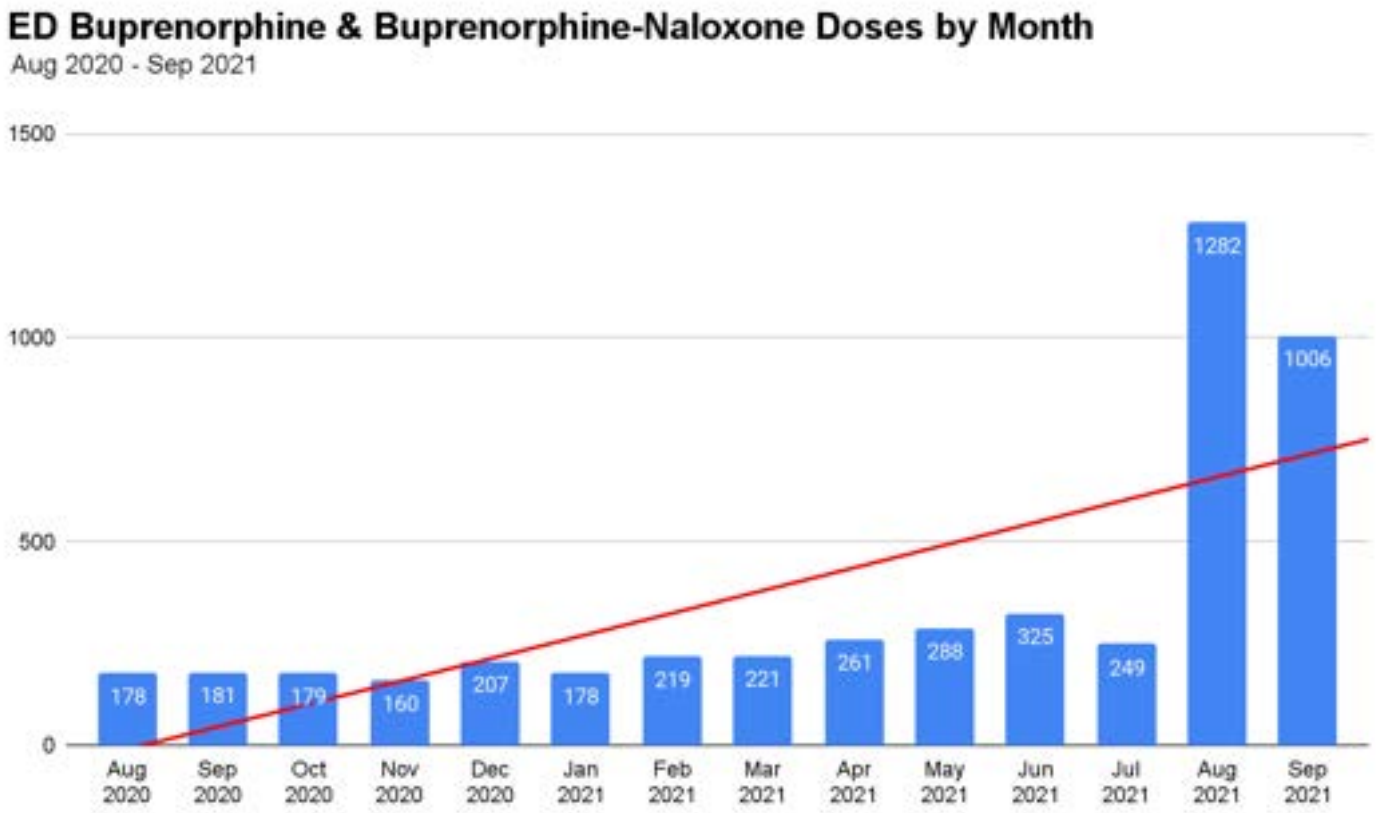
MAT:

Our First Year



MAT:

Year #2!


ED Buprenorphine & Buprenorphine-Naloxone Doses by Month
Aug 2020 - Sep 2021
1500
1000
500
0
178
181
179
160
207
178
219
221
261
288
325
249
1282
1006
Aug 2020
Sep 2020
Oct 2020
Nov 2020
Dec 2020
Jan 2021
Feb 2021
Mar 2021
Apr 2021
May 2021
Jun 2021
Jul 2021
Aug 2021
Sep 2021

MAT Mentorship:

Using our experience as a strength

Opioid Prescriptions and Physician Opportunities

The following three areas have been identified as TOP opportunities to align with patient safety and the CDC guidelines for opioid use.

#1

Prescription Quantity

The ideal is up to 3 days;

over 7 days is rarely required

#2

Type of Opioid

Utilize Immediate Release opioids

(rather than extended release)

#3

Opioids & Benzodiazepines

Avoid concurrent use if possible

(this has a Black Box warning)

Dignity Health.

Emergency Department Opioid Prescribing Guidelines

Dignity Health is committed to delivering compassionate, high-quality, and affordable health services to all individuals seeking care in our emergency departments. Recognizing the impact of the opioid epidemic, and in accordance with recommendations made by the Center for Disease Control (CDC) and the American College of Emergency Physicians (ACEP), we recommend the following guidelines to decrease the risk of addiction and overdose in the patients we serve.

These guidelines do not establish a standard of care, and each patient requires a unique treatment plan. They are intended to serve as a resource for emergency clinicians to standardize the use of opioids in the emergency department and to empower clinicians in the challenging encounters that involve the use and misuse of opioids.

1. **One Provider:** Ideally, one medical provider should provide all opioids to treat a patient's chronic pain.
2. **Discouraged Practices:**
   - Administration of IV and IM opioids in the ED for the relief of acute exacerbations of chronic pain.
   - Replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
   - Replacement doses of methadone for patients in a methadone treatment program.
   - Prescribing long-acting or controlled-release opioids (eg., OxyContin, fentanyl patches, methadone).
   - Administration of Demerol (meperidine).
3. **PDMP:** ED providers should use the state's prescription drug monitoring program (PDMP) when appropriate.
4. **Coordination of Care:** EDs and ED providers should strive for coordination of care as follows.
   - Work together with pain clinic or clinician regarding pain agreements in place.
   - Coordinate the care of patients who frequently visit the ED using an ED care coordination program.
   - Maintain a list of clinics that provide primary care for patients of all payer types.
   - Perform screening, brief interventions, and treatment referrals for patients with suspected prescription opioid abuse problems.
   - For exacerbations of chronic pain, contact the patient's primary opioid prescriber or pharmacy, and only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.
5. **Substance Abuse Screening:** ED patients should be screened for risk factors for substance abuse prior to prescribing opioid medication for acute pain.
6. **Prescription Duration:** Prescriptions for opioid pain medication from the ED for breakthrough pain in acute injuries, such as fractured bones, in most cases should not exceed three days. Providers should counsel patients regarding the use of non-opioid medications (e.g., NSAIDs) as their first line pain medication.
7. **No Legal Requirement to Treat with Opioids:** The law does not require ED providers to use opioids to treat pain. ED providers should use their clinical judgment when treating pain. The provider should have an open conversation with the patient regarding the indication, or lack thereof, for using opioids for pain.

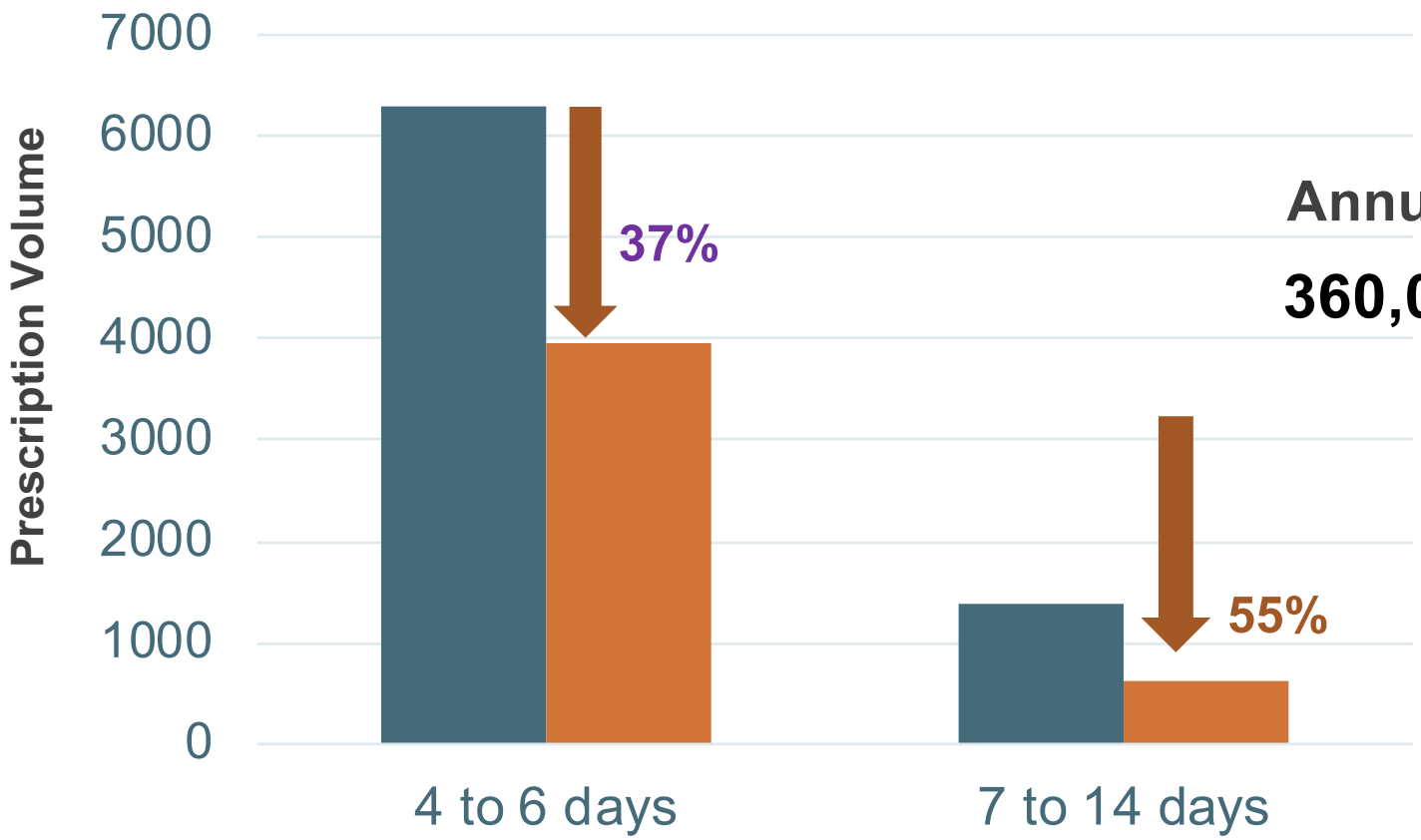
Dignity Health.

Content authors: Alicia Kurtz, MD; Gregg Miller, MD; Neil Parikh, MD; Rob Wynsen, MD; Katie Hesse, RN; Candace Fong, PharmD

- www.acep.org/patient-care/clinical-policies/opioids/
- www.cdc.gov/mmwr/pdf/rr/rr6501e1.pdf

Opioid Prescribing Practices

Comparison of 2018 and 2019 Practices (comparative 3 month snapshots)

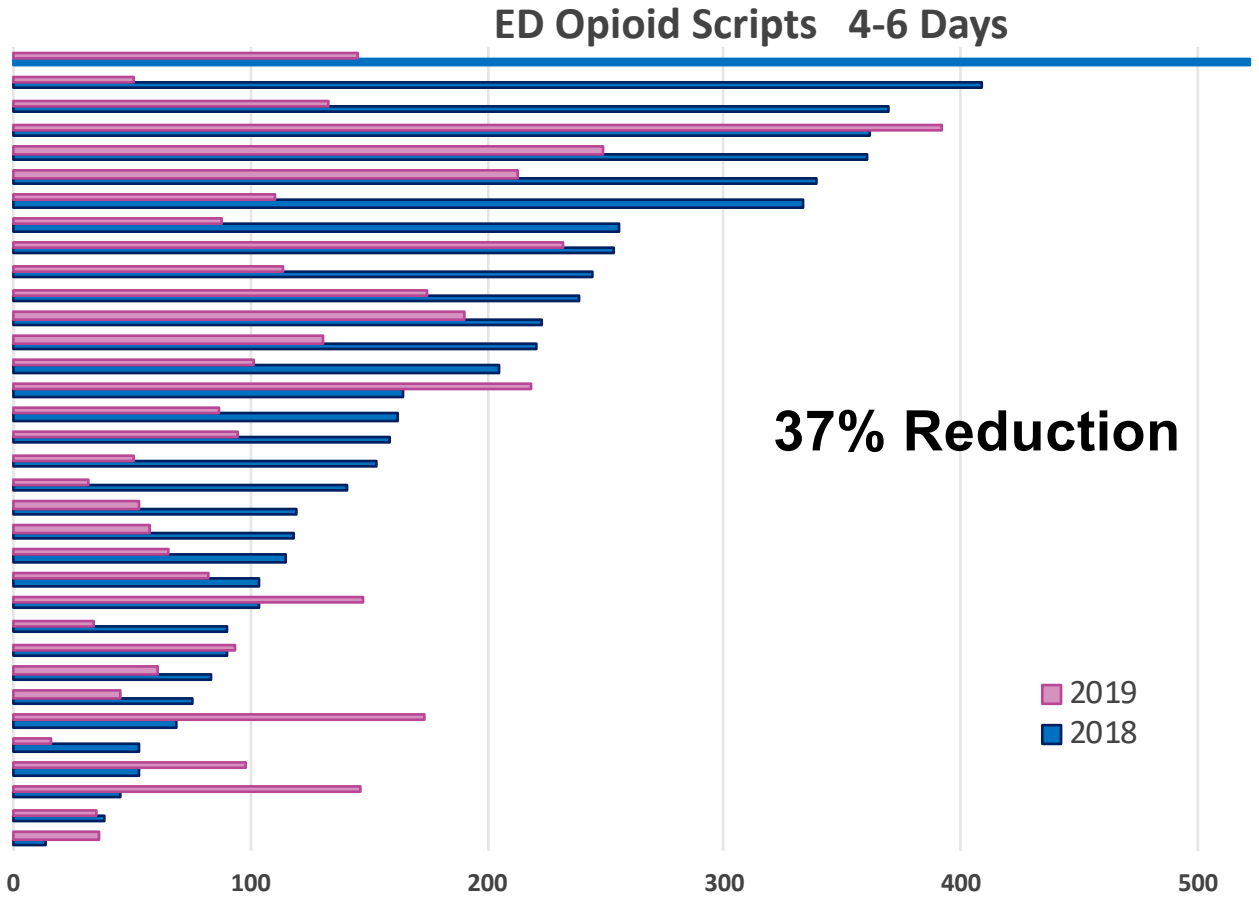


Annualized Reduction:

360,000 pill reduction

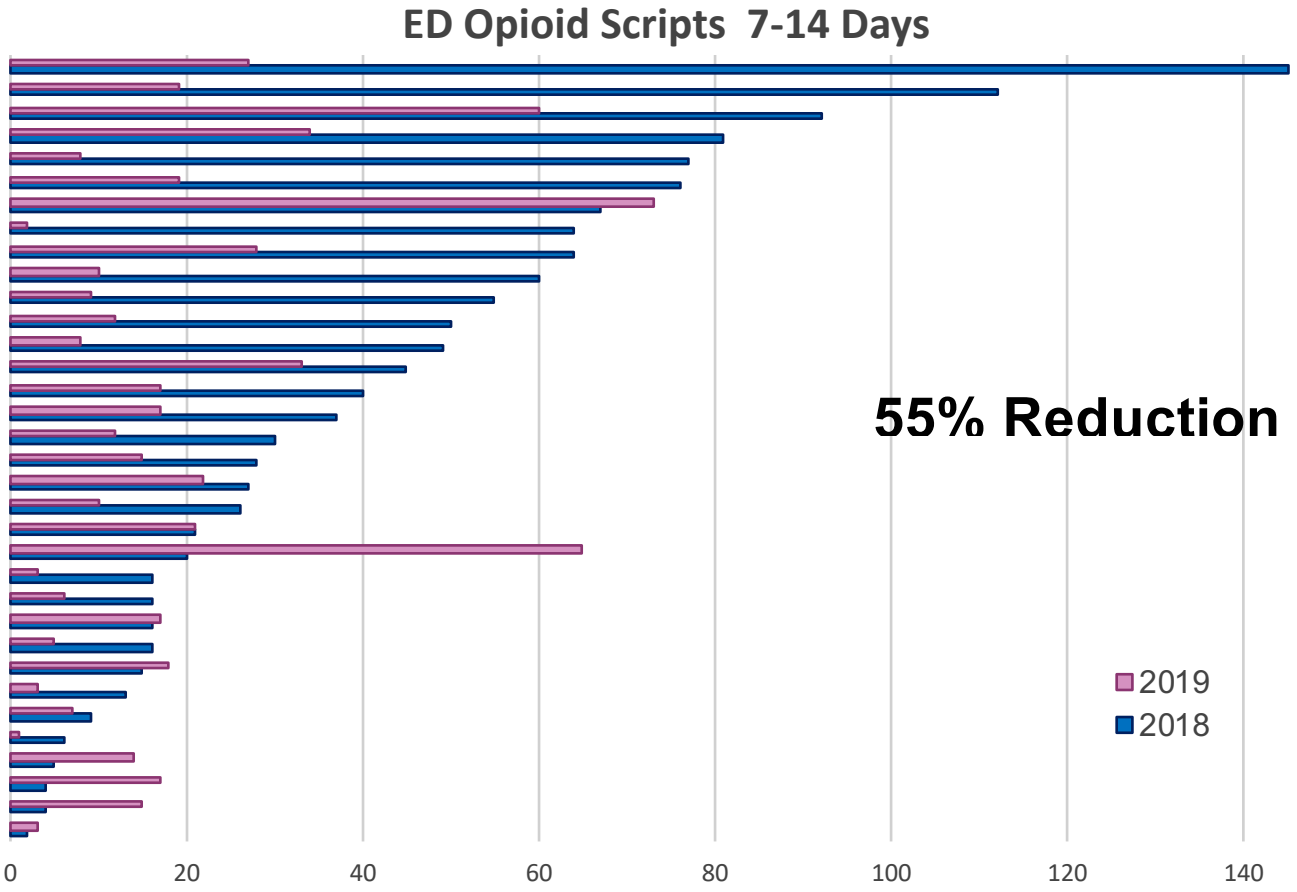
Opioid Prescribing Practices

Prescription Volume Reductions by Facility



Opioid Prescribing Practices

Prescription Volume Reductions by Facility



Pro Tip #7:

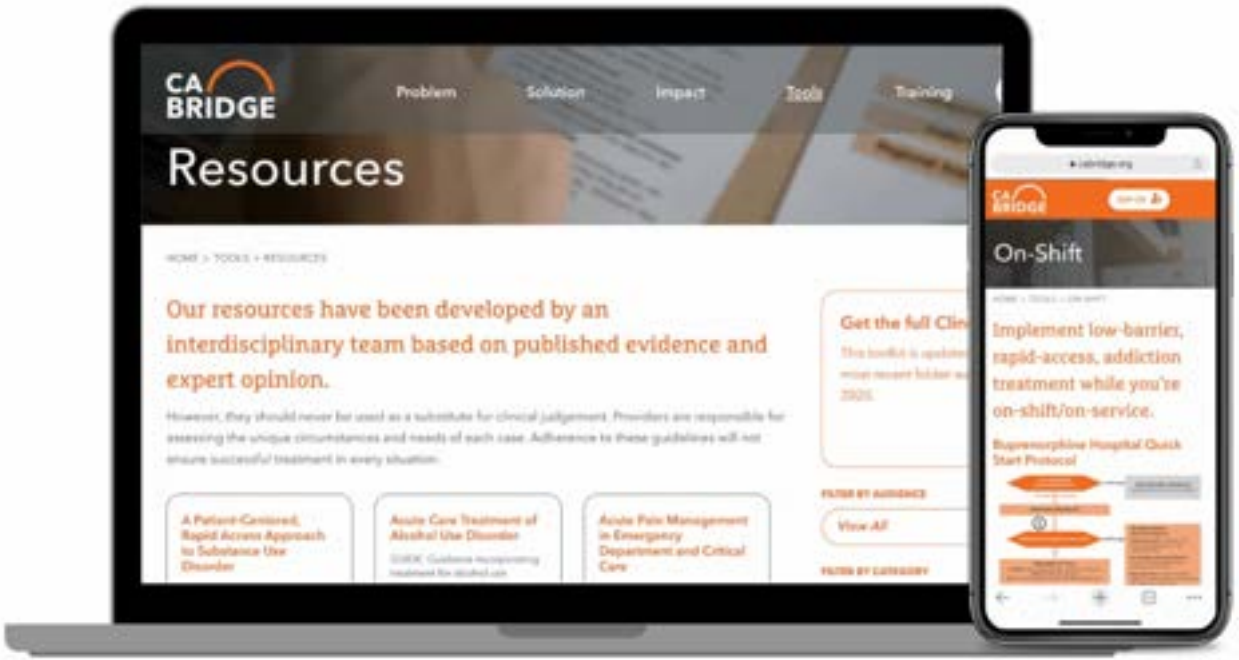
Measure & report back.

Identify priorities
Establish baseline
Track progress
Find gaps or refresher needs

Pro Tips to Make it Happen:

1. Establish **Leaders**.
2. Build a support **network**
3. Create a smooth **patient referral process**
4. Map **Action Items** & **Timeline** ***(including education plan for everyone!)***
5. Have a strategy for inclusion *(red/yellow/green)*
6. Secure **Executive Support**
7. **Measure & report back**

CABridge.org Resources



CABridge.org Resources

CA BRIDGE

SEPTEMBER 202

Blueprint for Hospital
Opioid Use Disorder Treatm

A patient-centered approach to 24/7 access to medication for addiction treatment

CA BRIDGE

CA Bridge
MAT Toolkit for Nurses

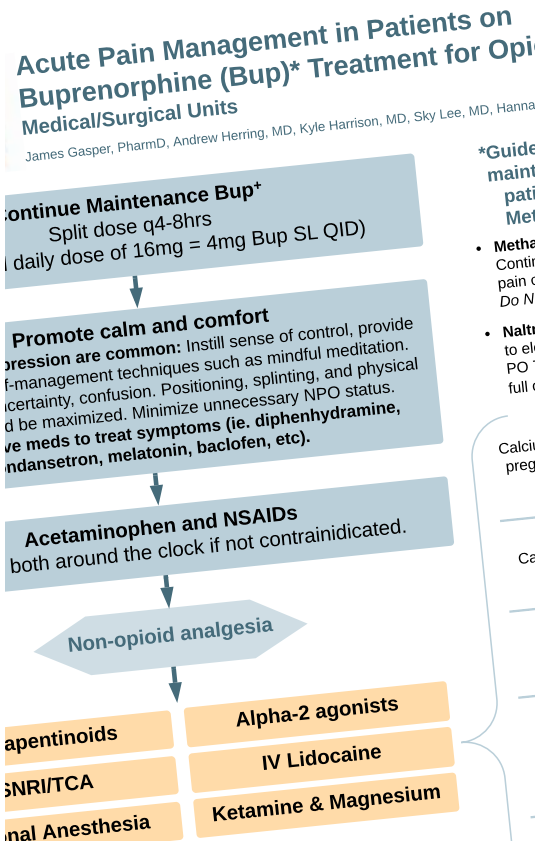
A patient-centered approach to 24/7 access to medication for addiction treatment

CA BRIDGE

JANUARY 2021

Substance Use Navigation Toolkit

CABridge.org Resources



Acute Pain Management in Patients on Buprenorphine (Bup)* Treatment for Opi

Medical/Surgical Units

James Gasper, PharmD, Andrew Herring, MD, Kyle Harrison, MD, Sky Lee, MD, Hanna

ontinue Maintenance Bup+
Split dose q4-8hrs
daily dose of 16mg = 4mg Bup SL QID)

Promote calm and comfort
pression are common: Instill sense of control, provide
f-management techniques such as mindful meditation.
certainty, confusion. Positioning, splinting, and physical
d be maximized. Minimize unnecessary NPO status.
ve meds to treat symptoms (ie. diphenhydramine,
ndansetron, melatonin, baclofen, etc).

Acetaminophen and NSAIDs
both around the clock if not contrainidicated.

Non-opioid analgesia

apentinoids
SNRI/TCA
nal Anesthesia
Alpha-2 agonists
IV Lidocaine
Ketamine & Magnesium

*Guide
maint
pati
Met

- **Metha**
  Contir
  pain
  Do N
- **Naltr**
  to el
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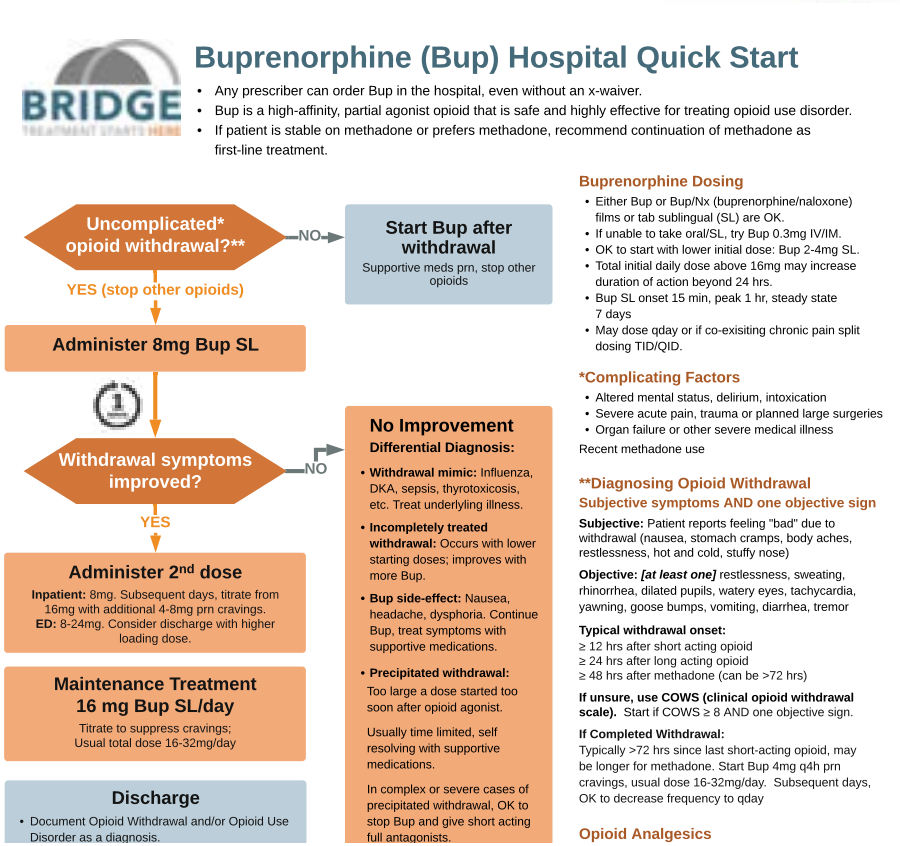

BRIDGE
TREATMENT STARTS HERE

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

Uncomplicated* opioid withdrawal?**
NO → **Start Bup after withdrawal**
Supportive meds prn, stop other opioids

YES (stop other opioids)

Administer 8mg Bup SL

Withdrawal symptoms improved?
NO → **No Improvement**
Differential Diagnosis:
- **Withdrawal mimic:** Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlyling illness.
- **Incompletely treated withdrawal:** Occurs with lower starting doses; improves with more Bup.
- **Bup side-effect:** Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
- **Precipitated withdrawal:**
  Too large a dose started too soon after opioid agonist.
  Usually time limited, self resolving with supportive medications.
  In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short acting full antagonists.

YES

Administer 2nd dose
Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment
16 mg Bup SL/day
Titrate to suppress cravings;
Usual total dose 16-32mg/day

Discharge
- Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

Buprenorphine Dosing
- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days
- May dose qday or if co-exisiting chronic pain split dosing TID/QID.

*Complicating Factors
- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness

Recent methadone use

**Diagnosing Opioid Withdrawal
Subjective symptoms AND one objective sign

Subjective: Patient reports feeling "bad" due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)

Objective: ***[at least one]*** restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor

Typical withdrawal onset:
≥ 12 hrs after short acting opioid
≥ 24 hrs after long acting opioid
≥ 48 hrs after methadone (can be >72 hrs)

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.

If Completed Withdrawal:
Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

Opioid Analgesics

Starting Buprenorphine Outside of Hospitals/Clinics

Wait, Withdraw, Dose
r medical issues or with lower opioid tolerance
in pills like Norco or Percocet)

ed Bup before:
great! Just do that again.
with your care team to find ways to make it better.

Place dose under your tongue (sublingual).

time on Bup:
team and if possible take a "day off."

alcohol or pills makes starting Bup harder. Be safe.
e you still feel withdrawal.
ke you feel sick or sleepy.

DAY 1
nd have a place to rest.
you feel **very sick** from withdrawals (at least 12 hours is best).
let or strip (4mg) under your tongue & let it dissolve.
se after the first dose,
Navigator or go to the ER.
4mg) in an hour to feel well.
another 4mg every 6 hours, up to 24 mg.

Split 8mg film or tablet in half.

Join us.

cabridge.org

Visit our website for tools and resources

cabridge.org/join-us

Join our email list for new announcements

@BridgeToTx

CA BRIDGE

CA Bridge Resources:

www.cabridge.org

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OPIOID GAP ANALYSIS

Opioid Stewardship Program Leadership Assessment

1. Contact Information

Name

Title

Email Address

Hospital Name

Health System Name

* 2. State in which your hospital is located:

- New Jersey
- Ohio
- Pennsylvania

3. Has your facility's leadership identified opioid stewardship as a facility/system priority supported by strategic and operational planning?

- Yes
- No

https://www.surveymonkey.com/r/OPIOID2021

OHA collaborates with member hospitals and health systems to ensure a healthy Ohio

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HelpingOhioHospitals

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www.youtube.com/user/OHA1915