OHIO HOSPITAL ASSOCIATION

OPIOID STEWARDSHIP: TRACKING/REPORTING

November 18, 2021

CONTINUING EDUCATION

- The link for nursing credits is: https://www.surveymonkey.com/r/Opioid-OLN-11-18

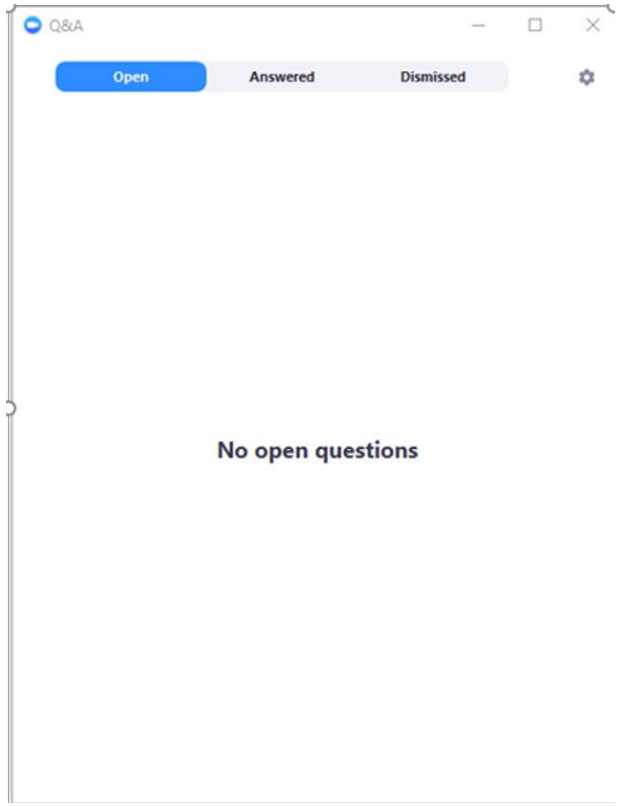
- The link for pharmacy credits is: https://www.surveymonkey.com/r/Opioid-Pharm-11-18

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.

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Pain Stewardship Committee

PRESENTER:

Marisa Brizzi, PharmD, BCPS, AAHIVP

2018 New and Revised Standards to Pain Assessment and Management

- Identify pain assessment and pain management, including safe opioid prescribing, as an organizational priority (LD.04.03.13)
- Actively involve the organized medical staff in leadership roles in organization performance improvement activities to improve quality of care, treatment, and services and patient safety (MS.05.01.01)
- Assess and manage the patient's pain and minimize the risks associated with treatment (PC.01.02.07)
- Collect data to monitor its performance (PI.01.01.01)
- Compile and analyze data (PI.02.01.01)

Requirement, Rationale, Reference Report. Pain Assessment and Management Standards for Hospitals. *The Joint Commission,* 2017.

UC Health Opioid Stewardship Program

Project Charter

Project Aim

To optimize prescribing of both opioid and non-opioid analgesics, while reducing opioid-related adverse events and diversion of opioids into the community

Project Scope

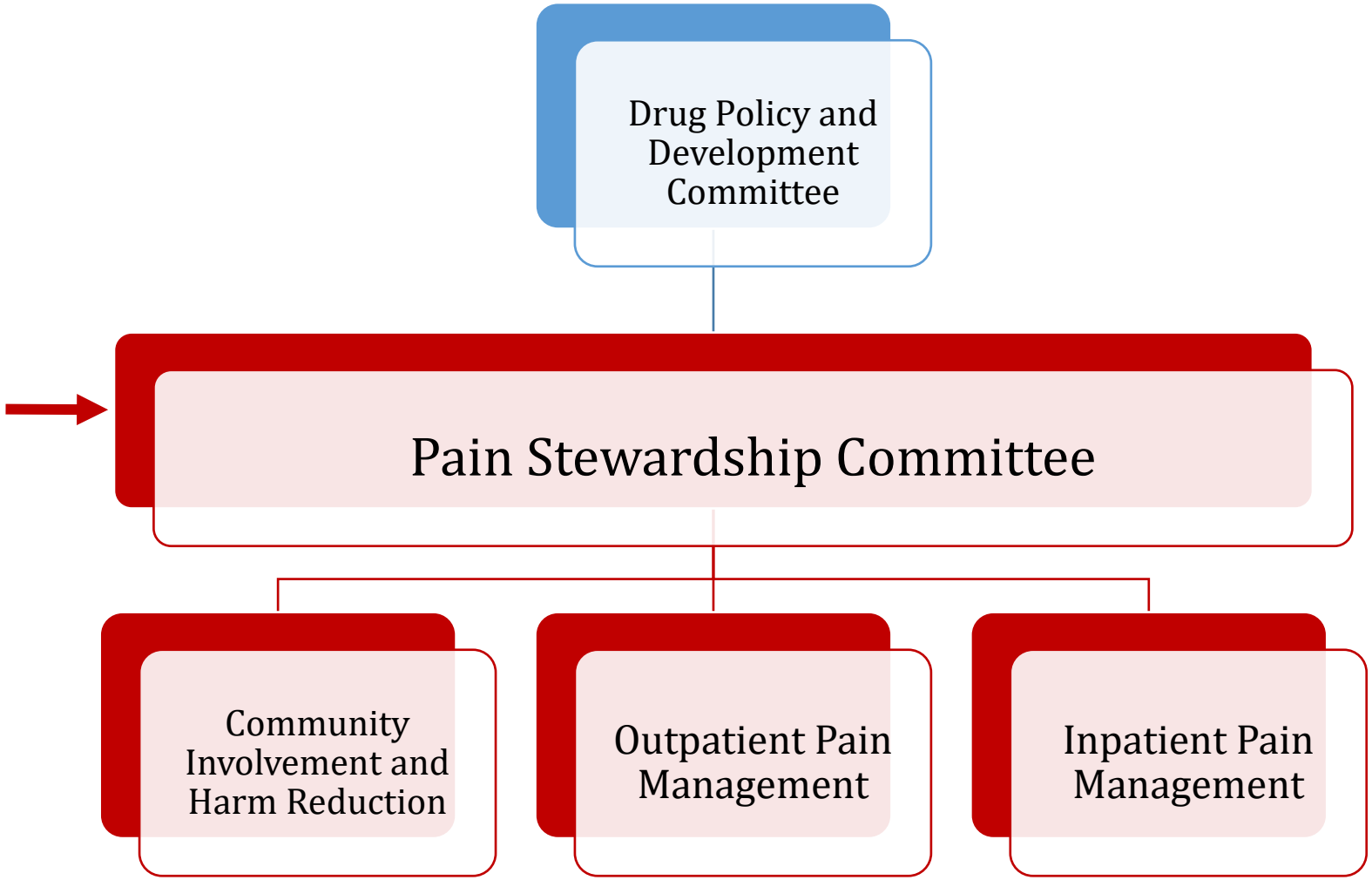
1. Develop evidence based clinical practice guidelines and provide education to appropriate staff on pain management
2. Incorporate computerized clinical decision support to assist in appropriate prescribing of opioid and non-opioid analgesics
3. Create resources for staff to involve patients in the pain management treatment planning process through development of realistic expectations and education on safe use of opioids and non-opioids, when prescribed
4. Improve outcomes in patients with acute pain through optimization of pain management using a multimodal approach
5. Perform comprehensive pain assessments and provide safe and effective treatments for chronic pain
6. Utilize technology to assist in the identification of patients at increased risk of adverse effects from opioids and patients suffering from opioid use disorder
7. Streamline consultation and referral of patients with complex pain management needs and for treatment of OUD
8. Provide supportive medications, such as naloxone, for patients at high risk for opioid adverse effects

UC Health Opioid Stewardship Committee Members

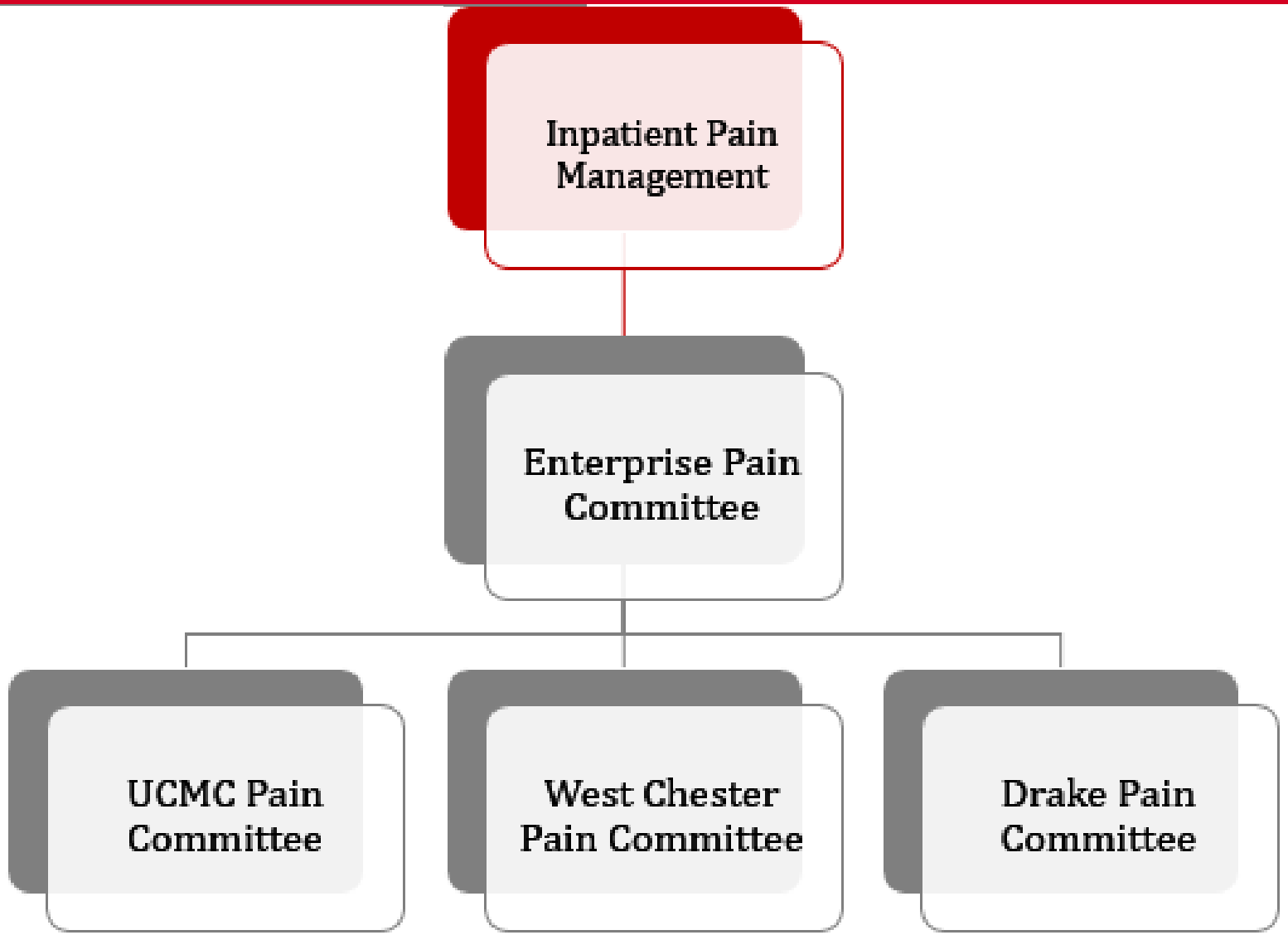
Pain Stewardship Committee Structure

GLOBAL AIM

To optimize pain management and reduce opioid-related adverse events within not only our health system, but the greater Cincinnati community



Key Focus Areas


Inpatient Pain Management
Enterprise Pain Committee
UCMC Pain Committee
West Chester Pain Committee
Drake Pain Committee

PROJECT AIM

Acute Pain

Global Aim:
To optimize inpatient pain management, and reduce opioid related adverse effects

SMART Aim:
Reduce quantity of opioids prescribed for acute pain and increase multimodal therapy by 12.5% by December 31, 2022

Chronic Pain

Global Aim:
To optimize outpatient pain management, and reduce opioid related adverse effects

SMART Aim:
Reduce opioids prescribed with high doses (>80 MEDD) by 12.5% and increase multimodal therapy by 12.5% by December 31, 2022

Harm Reduction

Global Aim:
To reduce opioid-related adverse events within the greater Cincinnati community

SMART Aim:
Increase naloxone prescribing and Medication for Opioid Use Disorder (MOUD) prescribing in indicated populations by 25% by December 31, 2022

Compliance

Global Aim:
To optimize monitoring of patients receiving opioids and reduce opioid related adverse effects

SMART Aim:
Increase overall compliance to the Ohio Board of Pharmacy prescribing requirements for opioids by 12.5% by December 31, 2022

Acute Pain | **Chronic Pain** | **Harm Reduction** | **Compliance**

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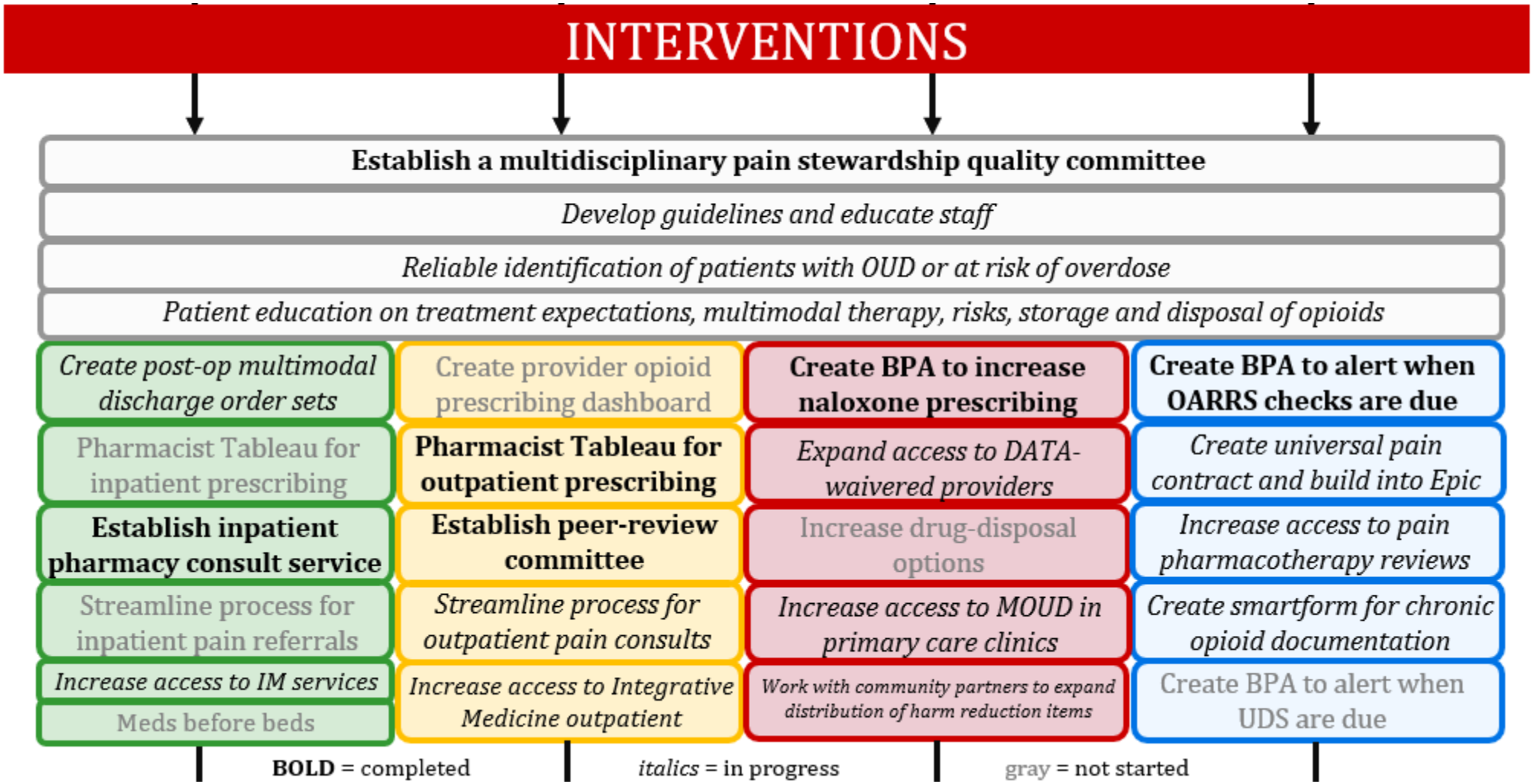

Acute Pain

Chronic Pain

Harm Reduction

Compliance

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PROCESS METRICS

Acute Pain	Chronic Pain	Harm Reduction	Compliance
Average quantity of opioids for post-op Rx	Average quantity of opioids prescribed	Percentage of patients with OUD on MOUD	Percentage of patients on opioids for ≥90 days with OARRS reviews every 3 months
Average MEDD of opioids for post-op Rx	Average MEDD of opioids prescribed	Percentage of patients with naloxone Rx	Percentage of patients on opioids for ≥90 days with yearly UDS
Average days on IV opioid therapy	Percentage of patients on ≥80 MEDD	Number of providers prescribing MOUD	Percentage of patients on opioids for ≥90 days with pain contracts
Percentage of patients receiving multimodal therapy for pain		Percentage of patients screened for OUD	Percentage of patients on opioids for ≥90 days pain documentation
Percentage of patients with referrals for non-pharm treatments (ex. PT, integrative med)		Percentage of patients screened for HIV and HCV	Percentage of patients on MEDD ≥80 with pharmacotherapy review
Percentage of acute pain patients with >7 day supply opioids	Percentage of patients on opioids + benzos	Opioid-related overdose Rates from HC	Percentage of patients on MEDD ≥50 with visits every 3 months

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Pain Stewardship Interventions

LeapFrog Opioid Metrics

LEAPFROG HOSPITAL SURVEY

Opioid Prescribing Requirements

Does your hospital require that all licensed prescribers who are authorized to prescribe scheduled drugs adhere to national, evidence-based Surgical Opioid Guidelines?

Does your hospital conduct regular retrospective reviews of licensed prescribers to identify the extent to which they adhere to the Surgical Opioid Guidelines?

Does your hospital have a process in place for communicating with licensed prescribers, as well as leadership, when a licensed prescriber's trend or prescribing pattern suggests challenges to adhering to the Surgical Opioid Guidelines to understand barriers and improve adherence?

Center for Opioid Research and Education

Surgical Opioid Guidelines

Created by a multidisciplinary consortium of physicians, nurses, pharmacists, and patients to develop ideal opioid prescribing patterns after common medical procedures utilizing a modified Delphi approach. Best prescribing practices are listed for post-surgical narcotic naive patients at discharge

Published in final edited form as:

J Am Coll Surg. 2018 October ; 227(4): 411–418. doi:10.1016/j.jamcollsurg.2018.07.659.

Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus

The Center for Opioid Research and Education Surgical Opioid Guidelines are based on the Johns Hopkins opioid prescribing guidelines for select surgical procedures

LeapFrog Opioid Metrics

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Orders

ENT Multimodal Pain Post-Op Discharge

Minimal Pain	
HN	Lymph node excision, direct laryngoscopy, esophagoscopy and dilation
Otology	Tympanostomy tube, BAHA, tympanoplasty, cochlear implant
Laryngology	Direct laryngoscopy with intervention, endoscopic zenkers
Facial Plastics	Upper blepharoplasty, tarsal strip canthopexy, eyelid weight placement, minor soft tissue procedures
Rhinology	Balloon dilation, functional endoscopic sinus surgery

Mild Pain	
HN	Thyroidectomy, parathyroidectomy, neck dissection, parotidectomy, temporal bone dissection, WLE, sentinel node
Otology	Tympanomastoidectomy, endolymphatic sac decompression
Laryngology	Thyroplasty, external laryngocele
Facial Plastics	Adjacent tissue transfer, SRP, septoplasty, melolabial/paramedian forehead flaps, auricular cartilage graft, nerve transfers, browlift, lower blepharoplasty, midface/chin implant placement
Rhinology	FESS with septoplasty

Moderate-Severe Pain	
HN	Glossectomy, tonsillectomy, tracheal reconstruction, partial laryngectomy, open or endoscopic, radical tonsillectomy, base of tongue resection
Otology	n/a
Laryngology	n/a
Facial Plastics	Facial fracture repair, neck/facelift, SRP with autologous rib graft
Rhinology	n/a

Pain Medications

Select Procedure Type:

- ○ Minimal Pain Procedures
- ○ Mild Pain Procedures
- ○ Moderate to Severe Pain Procedures

LeapFrog Opioid Metrics

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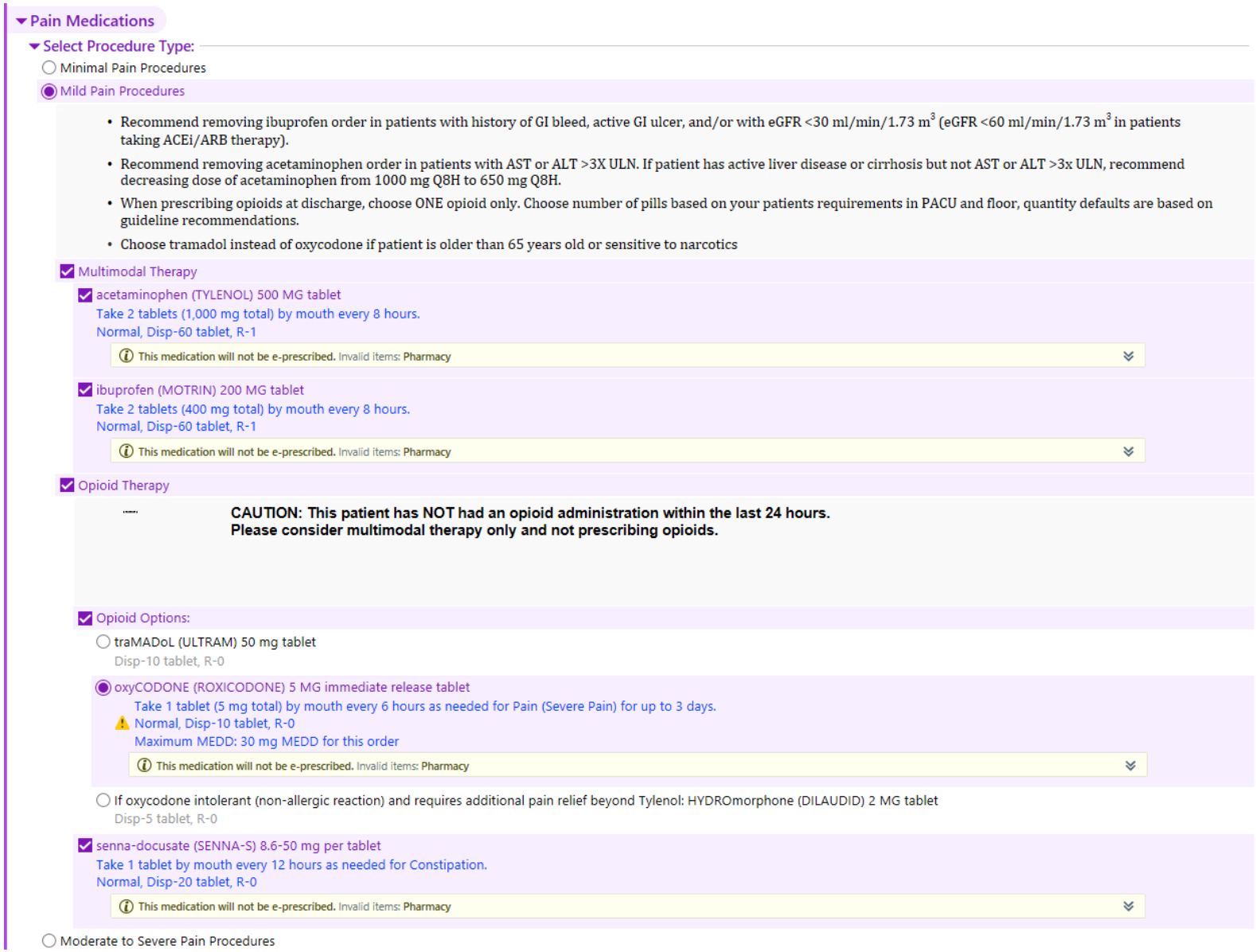

LeapFrog Opioid Metrics

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PATIENT'S GUIDE TO MANAGING ACUTE PAIN

How to Take My Pain Medications

Taking your pain medications around the clock is very effective to control pain after surgeries or injuries. This means that you should take your medication on schedule, rather than as needed. This can help keep the pain under control all day and night.

You will alternate between two different medications:

- **Acetaminophen** (Tylenol®)
- **Ibuprofen** (Advil® or Motrin®)

PAIN MEDICATION SCHEDULE:

You will be taking a dose of pain medication -every four hours:

8:00 a.m.	Take 1000 mg (two pills of 500 mg) of acetaminophen.
12:00 p.m.	Take 400 mg (two pills of 200 mg) of ibuprofen.
4:00 p.m.	Take 1000 mg (two pills of 500 mg) of acetaminophen.
8:00 p.m.	Take 400 mg (two pills of 200 mg) of ibuprofen.
Bedtime	Take 1000 mg (two pills of 500 mg) of acetaminophen.
If you wake up in the middle of the night:	Take 400 mg (two pills of 200 mg) of ibuprofen.

*If your prescriber decides either ibuprofen or acetaminophen are not right for you, then you may only be prescribed one of the above medications. If so, take prescribed medication every six hours rather than every eight hours.

Your doctor may also prescribe an opioid:

Example: Oxycodone or Tramadol

Opioids should only be used for breakthrough pain.

NON-MEDICATION THERAPIES

- Ice.
- Rest.
- Meditation.
- Mindfulness.
- Art Therapy.
- Music Therapy.

Recommended Apps:

- Headspace.
- Calm.
- BioZen.
- The Mindfulness Training App.
- Color by Number.

STILL IN PAIN?

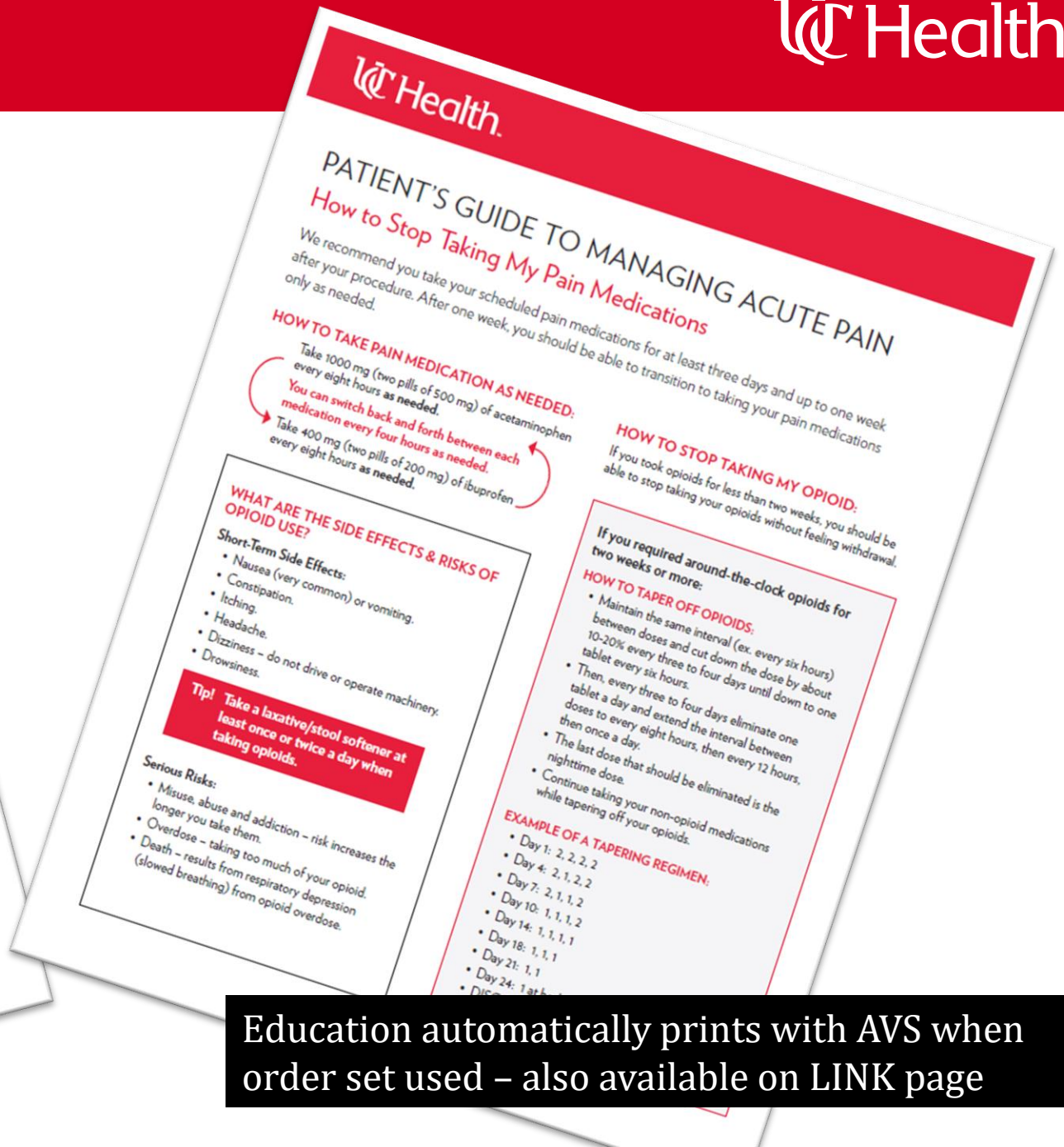
- If your pain is manageable, **avoid taking opioid medication.**
- If your pain is intolerable, keeping you awake and you cannot do any activities:

Take one pill of your opioid.

Every six hours as needed.

WHAT IS THE GOAL OF PAIN CONTROL?

- ✓ **Minimize pain.**
- ✓ **Keep you moving.**
- ✓ **Help you heal.**



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PATIENT'S GUIDE TO MANAGING ACUTE PAIN

How to Stop Taking My Pain Medications

We recommend you take your scheduled pain medications for at least three days and up to one week after your procedure. After one week, you should be able to transition to taking your pain medications only as needed.

HOW TO TAKE PAIN MEDICATION AS NEEDED:

Take 1000 mg (two pills of 500 mg) of acetaminophen every eight hours **as needed.**

You can switch back and forth between each medication every four hours as needed.

Take 400 mg (two pills of 200 mg) of ibuprofen every eight hours **as needed.**

WHAT ARE THE SIDE EFFECTS & RISKS OF OPIOID USE?

Short-Term Side Effects:

- Nausea (very common) or vomiting.
- Constipation.
- Itching.
- Headache.
- Dizziness – do not drive or operate machinery.
- Drowsiness.

Tip! Take a laxative/stool softener at least once or twice a day when taking opioids.

Serious Risks:

- Misuse, abuse and addiction – risk increases the longer you take them.
- Overdose – taking too much of your opioid.
- Death – results from respiratory depression (slowed breathing) from opioid overdose.

HOW TO STOP TAKING MY OPIOID:

If you took opioids for less than two weeks, you should be able to stop taking your opioids without feeling withdrawal.

If you required around-the-clock opioids for two weeks or more:

HOW TO TAPER OFF OPIOIDS:

- Maintain the same interval (ex. every six hours) between doses and cut down the dose by about 10-20% every three to four days until down to one tablet every six hours.
- Then, every three to four days eliminate one doses to every eight hours, then every 12 hours, then once a day.
- The last dose that should be eliminated is the nighttime dose.
- Continue taking your non-opioid medications while tapering off your opioids.

EXAMPLE OF A TAPERING REGIMEN:

- Day 1: 2, 2, 2, 2
- Day 4: 2, 1, 2, 2
- Day 7: 2, 1, 1, 2
- Day 10: 1, 1, 1, 2
- Day 14: 1, 1, 1, 1
- Day 18: 1, 1, 1
- Day 21: 1, 1
- Day 24: 1 at b...

Education automatically prints with AVS when order set used – also available on LINK page

Summary of Data

Total Number of Tablets Prescribed:

	Pre-Intervention (2/1/20 to 5/11/20) (n=281)	Post-Intervention (2/1/21 to 5/11/21) (n=460)	P-Value
Average Number of Tablets Per Prescription	20 (±17.6)	14.8 (±8.1)	**<0.0001**
Average MEDD Prescribed Per Patient	32.7 (±19.5)	25.9 (±11.0)	**<0.0001**

Data presented as Mean (SD) or n (%)

Summary of Data (continued)

Utilization of order set – Post-intervention data

	Used ENT Discharge Order Set (n=131)	Did Not Use ENT Discharge Order Set (n=329)	P-Value
Average Number of Tablets Per Prescription	10.9 (±3.97)	15.7 (±8.1)	**<0.0001**
Average MEDD Prescribed Per Patient	22.1 (±5.8)	27.1 (±11.1)	**<0.0001**
Discharged with Multimodal Therapy	131 (100%)	202 (61.3%)	**<0.0001**
ED Visit for Opioids During Study Period	1 (0.07%)	4 (1.21%)	0.5594

Data presented as Mean (SD) or n (%)

LeapFrog Order Sets

Specialties with Order Sets Implemented

- **OB/GYN**
- **ENT**
- **Ortho/Trauma**

Specialties with Order Sets In Progress

- **Breast Oncology**
- **Hepatobilary**
- **Ortho/Sports Medicine**

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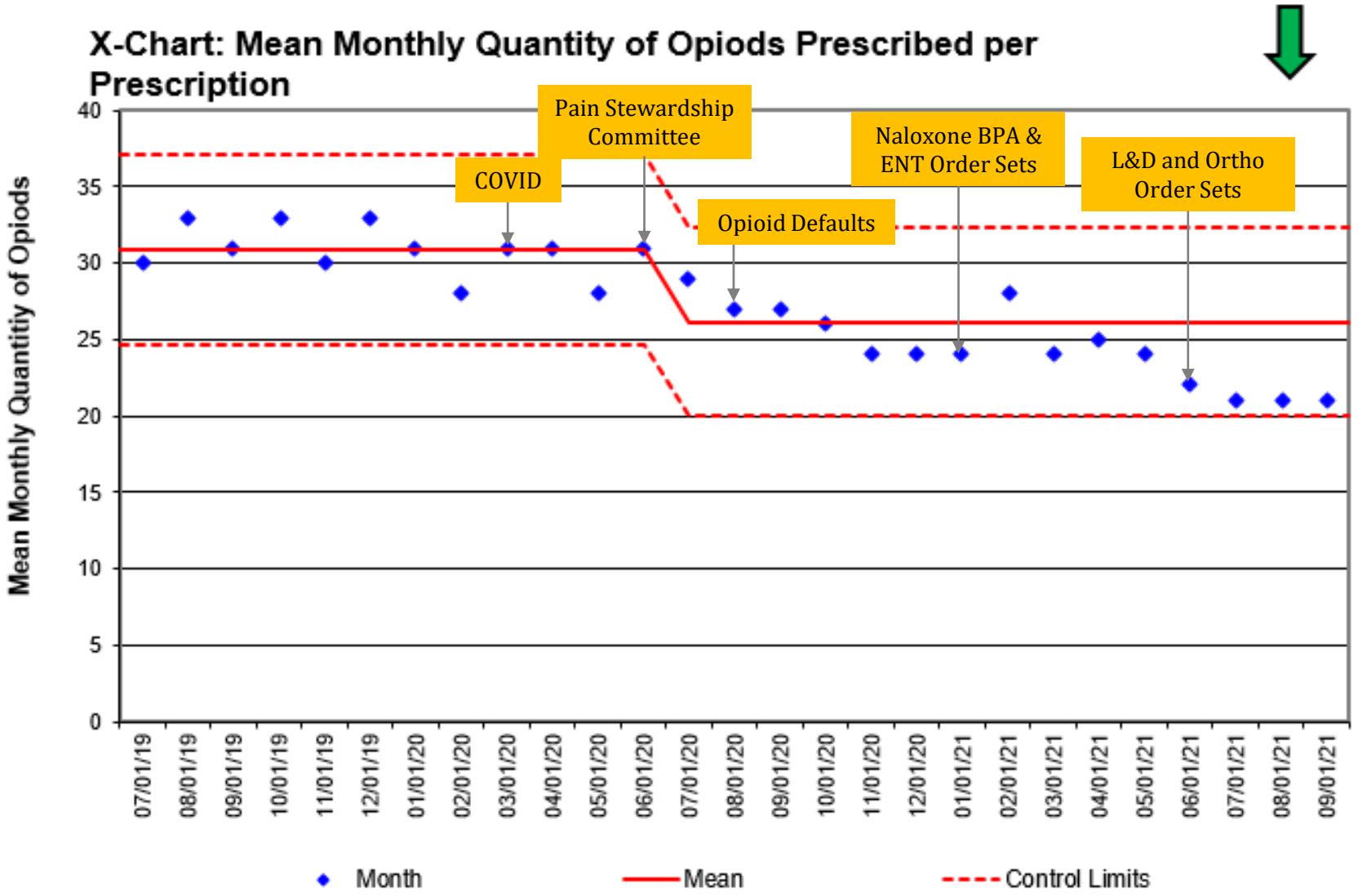

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Improving Access to Naloxone

Naloxone Prescribing Pre and Post Best Practice Advisory

1/5/20 to 5/31/20 **VS.** **1/5/21 to 5/31/21**

Prescriber Intervention

Order entry: hard stop BPA, naloxone prescription generated

BPA to fire	Any of the following are present: • MED ≥ 80 • Diagnosis of substance use disorder • History of previous opioid overdose • Opioid prescription with the addition of benzodiazepine, tramadol, carisoprodol, sedative hypnotic, or gabapentin
Suppress BPA	Any of the following are present: • Naloxone prescription already exists • Palliative care, end of life treatment • Refill encounters
Frequency	Once every 90 days

BPA = Best Practice Advisory

Epic BPA for Naloxone Prescribing

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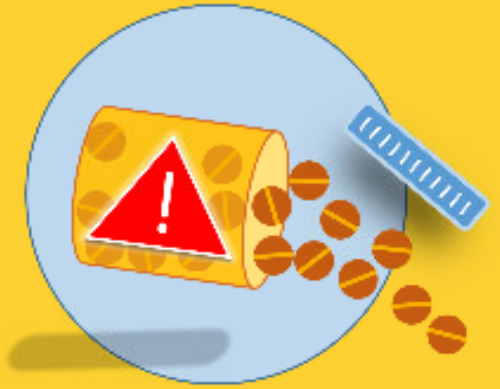
High Priority (1)



- Opioid Overdose Risk -

This patient is at risk for an unintentional opioid overdose due to various risk factors. A naloxone prescription is recommended.

For more information, please click HERE

Note: MED calculations may not be calculated accurately for prescriptions with free text sig

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OAC 4731-11-14 does not apply if the patient has terminal cancer or another terminal condition

If the patient refused naloxone, please document in a progress note using the ".naloxonenote" smart phrase

Order | Do Not Order | naloxone (NARCAN) nasal spray

Acknowledge Reason

Refused naloxone, please document | Already received or has naloxone at home | Palliative care / End of life | Other (see comment)

✔ Accept

Epic BPA for Naloxone Prescribing

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Patient Education

→Patient education available on the Link
  → Also prints with AVS whenever an outpatient prescription for naloxone is ordered
→Received feedback requesting information for patients on how to access naloxone without insurance coverage
  →Asked marketing to add QR code and information for free naloxone via an Ohio grant to patient education


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OVERDOSE RECOGNITION AND RESPONSE

Patient Education

RISK FACTORS FOR OVERDOSE

- Mixing drugs together – for example: opioids + benzos (ex. Valium, Xanax) and/or alcohol.
- Using opioids again after a period of abstinence.
- Poor physical health, especially breathing problems, liver or kidney problems and HIV.
- Previous overdose.

STRATEGIES TO PREVENT OVERDOSE

- Avoid mixing opioids with other drugs, including alcohol and/or benzodiazepines (ex. Valium, Xanax), because these substances, like opioids, impact your ability to breathe.
- If you are using opioids after a period of abstinence, use at a lower dose.
- To prevent an overdose, teach your family and friends how to recognize and respond to an overdose.

HOW DO I KNOW IF SOMEONE IS OVERDOSING?

- Slow breathing (less than one breath every five seconds) or no breathing.
- Vomiting.
- Face is pale and clammy.
- Blue lips, fingernails or toenails.
- Slow, erratic or no pulse.
- Snoring or gurgling noises while asleep or nodding out.
- No response when you yell the person's name or rub the middle of their chest with your knuckles.

WHAT IS NALOXONE?

Naloxone (Narcan®) is a prescription medication that can reverse an overdose that is caused by an opioid drug. When administered during an overdose it blocks the effects of opioids on the brain and restores breathing. Naloxone has no potential for abuse. If administered to a person who is not experiencing an opioid overdose, it is harmless. If administered to a person who is experiencing an opioid overdose, it will produce withdrawal symptoms. Naloxone does not reverse overdoses from non-opioid drugs.

HOW TO RESPOND TO AN OVERDOSE

1. Try to wake person by yelling their name and rubbing the middle of their chest with your knuckles (sternum rub).
2. Call 9-1-1. Indicate the person has stopped breathing or is struggling to breath.
3. Make sure nothing is in the person's mouth that could be blocking their breathing. If breathing has stopped or is very slow, perform rescue breathing by tilting their head back, lifting their chin and pinching their nose shut, then giving one slow breath every five seconds, blowing enough air for their chest to rise.
4. Use naloxone and continue rescue breathing.
5. If the person begins to breathe on their own, put them on their side so they do not choke on their vomit. Continue to monitor their breathing and perform rescue breathing if respirations are below 10 breaths per minute.
6. Stay with the person until EMS arrives.

HOW TO ADMINISTER NALOXONE NASAL SPRAY

Peel back packaging to remove device.

Place nozzle in the nostril until your fingers touch the bottom of the person's nose.

Press the plunger firmly.

If no response after two to three minutes, repeat in other nostril with the second spray device.

State of Ohio Board of Pharmacy. Naloxone Resources: Patient Counseling Brochure. Available at: https://www.pharmacyohio.gov/Documents/Pubs/Naloxone/Pharmacist/Patient%20Counseling%20Brochure.pdf

BPA = Best Practice Advisory

Summary of Data

Total Number of Naloxone Kits Prescribed:

487 → 3924

	Pre-Intervention (1/5/20 to 5/31/20) (n=11,137)	Post-Intervention (1/5/21 to 5/31/21) (n=10,627)	P-Value
Patients with naloxone Rx who met criteria for prescribing	487 (4.4%)	3924 (36.9%)	**<0.0001**
Median MEDD Prescribed Per Patient	30 (20, 40)	30 (20, 33)	0.808
Quantity of Opioid Solid Doses Prescribed Per Prescription	30 (20, 75)	28 (12, 60)	**<0.0001**

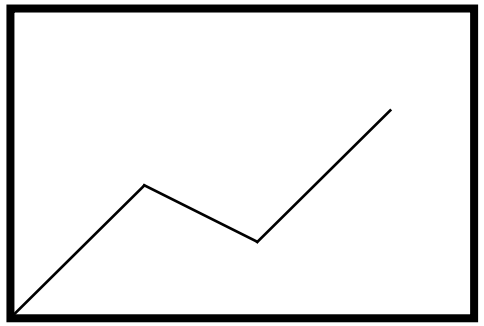
Data presented as Median (IQR),or n (%)

Provider Peer Review

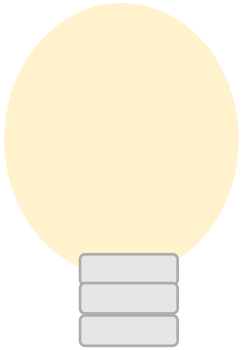
PEACH Committee

Practice Enhancement and Collaborative Healing

PEACH Committee

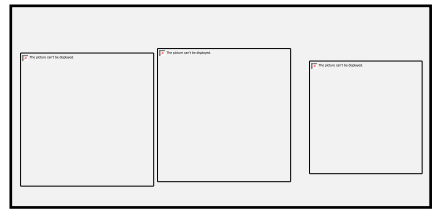


Review Data



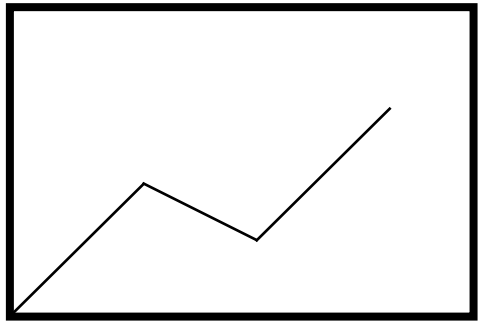
Identify Areas for Improvement

This step will offer an open discussion with Dan and Marisa about how we can support the prescriber



Provider Communication & Support

Implement Changes (Education, order sets, etc.)



Review Data Again

Provide Feedback

If no improvement, will involve pain physician leader and physician from prescriber department

Prescriber Review Example

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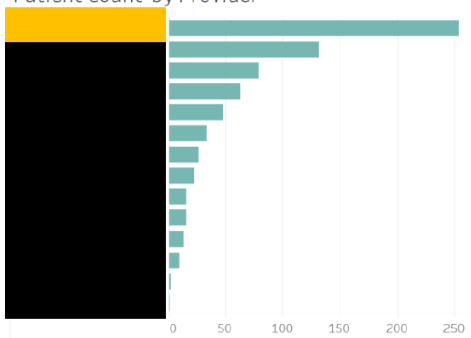
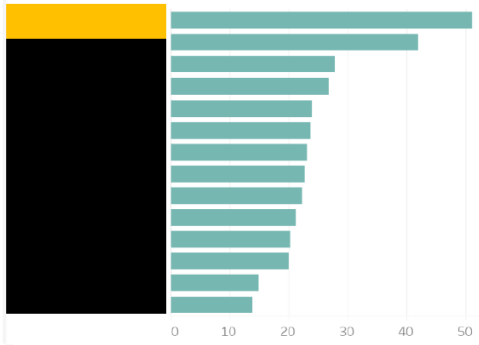
Practice Enhancement and Collaborative Healing Committee Review

Peer-to-Peer Comparison

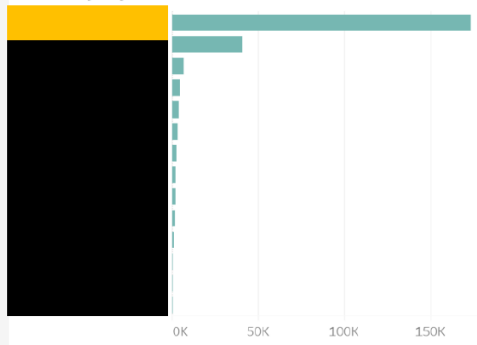
Patient Count by Provider



Avg M.E.D by Provider

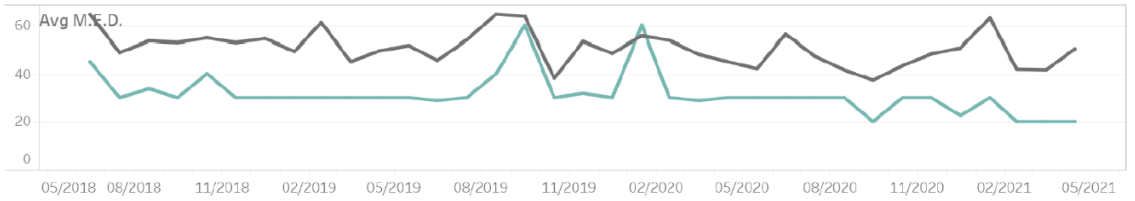


Quantity by Provider



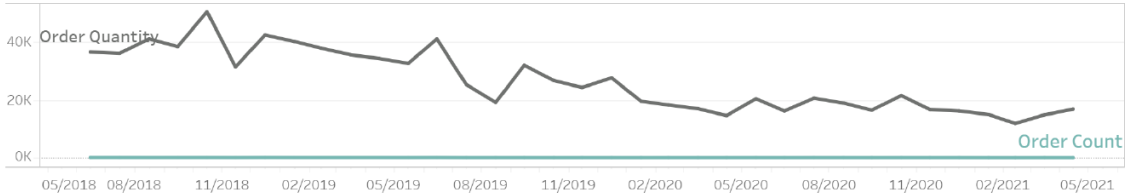
Average MEDD for Opioid Prescriptions over Time

Avg M.E.D and Median M.E.D. -07/2018 to 05/2021



Average Quantity for Opioid Prescriptions over Time

Order Count and Order Quantity -07/2018 to 05/2021



Percentage of Patients Receiving Multimodal Therapy with Opioids

66%

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88%

Percentage of Patients with Naloxone Prescribed when Indicated

35%

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37%

Percentage of Patients on Opioids and Benzos

15%

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2.4%

Compliance with State Medical Board of Ohio Prescribing Requirements

- ✗ Opioid Documentation Requirements
- ✗ PDMP Checks every 3 months
- ✗ Urine Screen every year <u>at minimum</u>
- ✓ Pain contracts

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IN SCIENCE LIVES HOPE.

Pain Stewardship Committee

PRESENTER:

Marisa Brizzi, PharmD, BCPS, AAHIVP

Mercy Health and the opioid epidemic: A system strategy focus on Prevention, Identification, and Treatment

Brian Latham, Pharm.D., MBA, Executive Director Pharmacy for Bon Secours Mercy Health
Jacob Stabler, MSW, LSW, Program Manager Behavioral Health Services for Bon Secours Mercy Health
Robert Wheeler, MD, Mercy Health St. Rita's Internal Medicine

BON SECOURS MERCY HEALTH

Objectives

1

Demonstrate how focused electronic health record alerts and data evaluation can help to reduce the opioid burden being prescribed into our communities as a preventative tactic for opioid dependency.

2

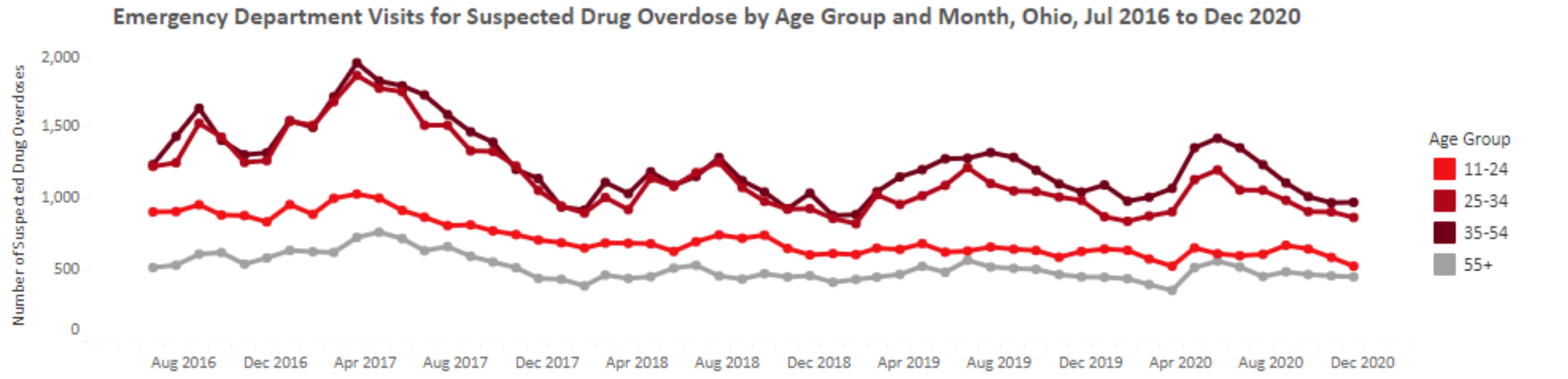
Demonstrate how the screening and linkage processes in the ED support the recovery processes.

3

Demonstrate how expedited access to ambulatory medication for opioid use disorder services and a holistic treatment approach positively impacts patient care and recovery.

Opioid Related Overdoses in Ohio : Where are we in 2021?

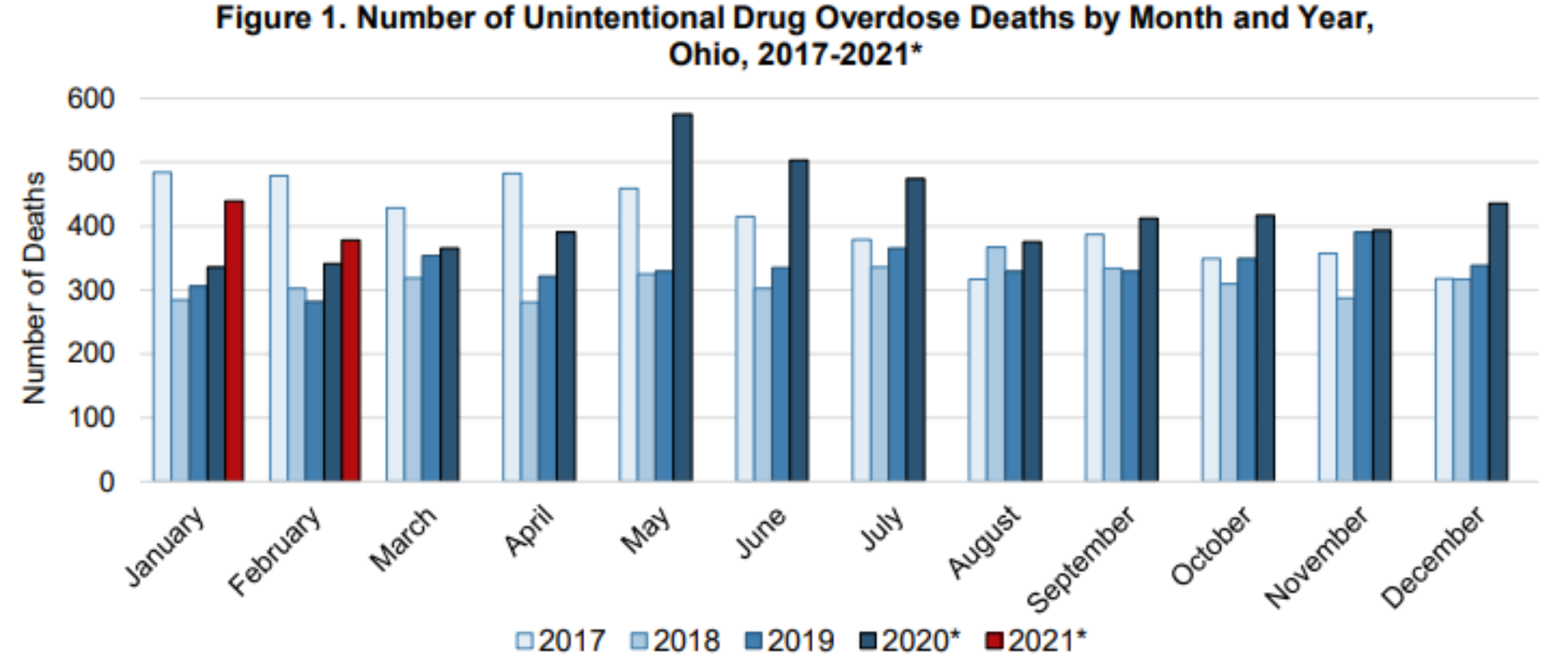
- Tragically, opioid overdose deaths nationwide rose last year to a record 93,000, nearly a 30 percent increase over the previous year.
- During the second quarter of 2020 in Ohio, 11 of every 100,000 people died of an opioid overdose, the state's highest mortality rate at any point during the epidemic



Data source: EpiCenter- Syndromic Surveillance System. Analysis: ODH Violence and Injury Prevention Section

ODH Preliminary* Data Summary for Unintentional Drug Overdose Deaths

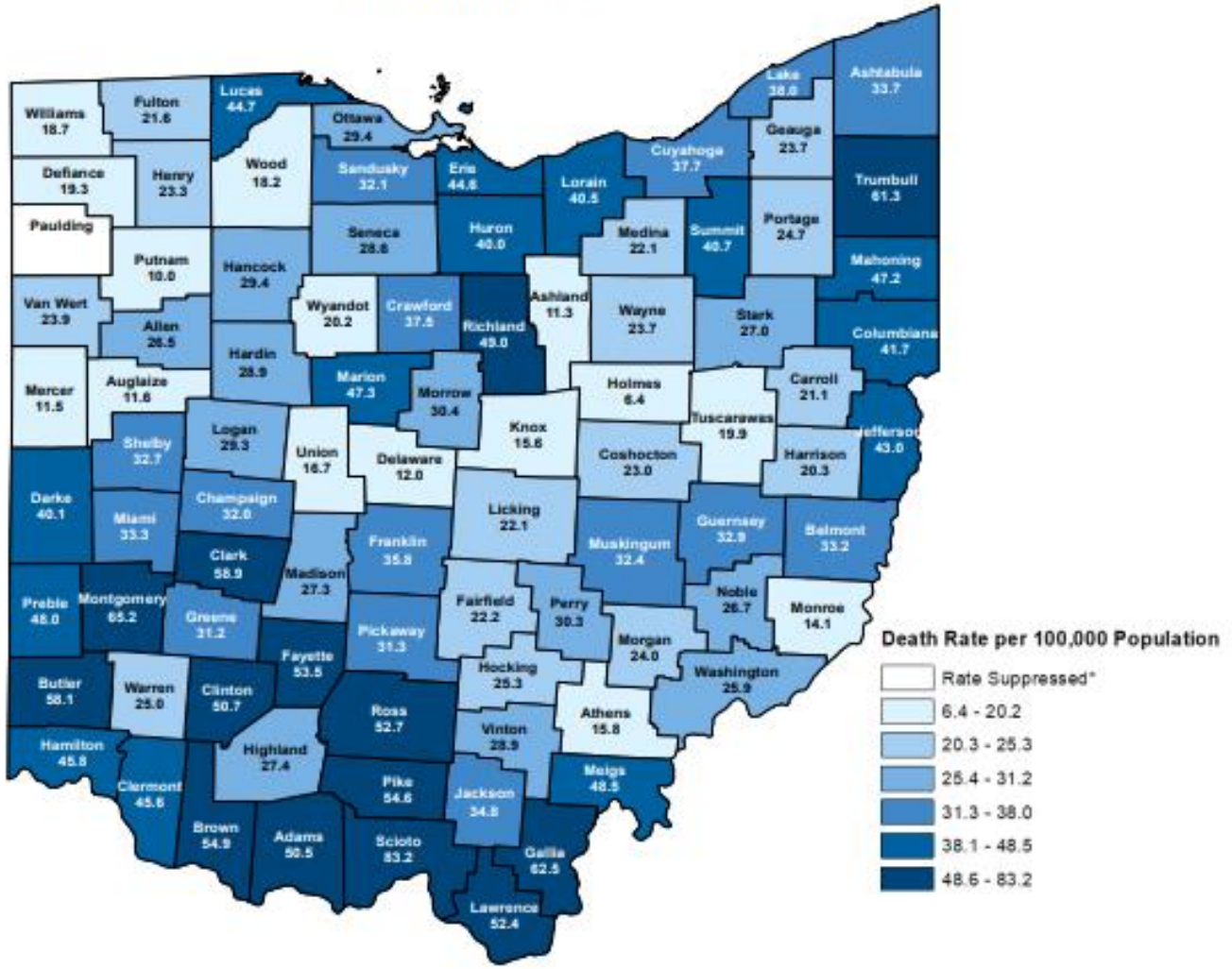
*2020 and 2021 data is incomplete



- ODH Link to Injury Surveillance Data

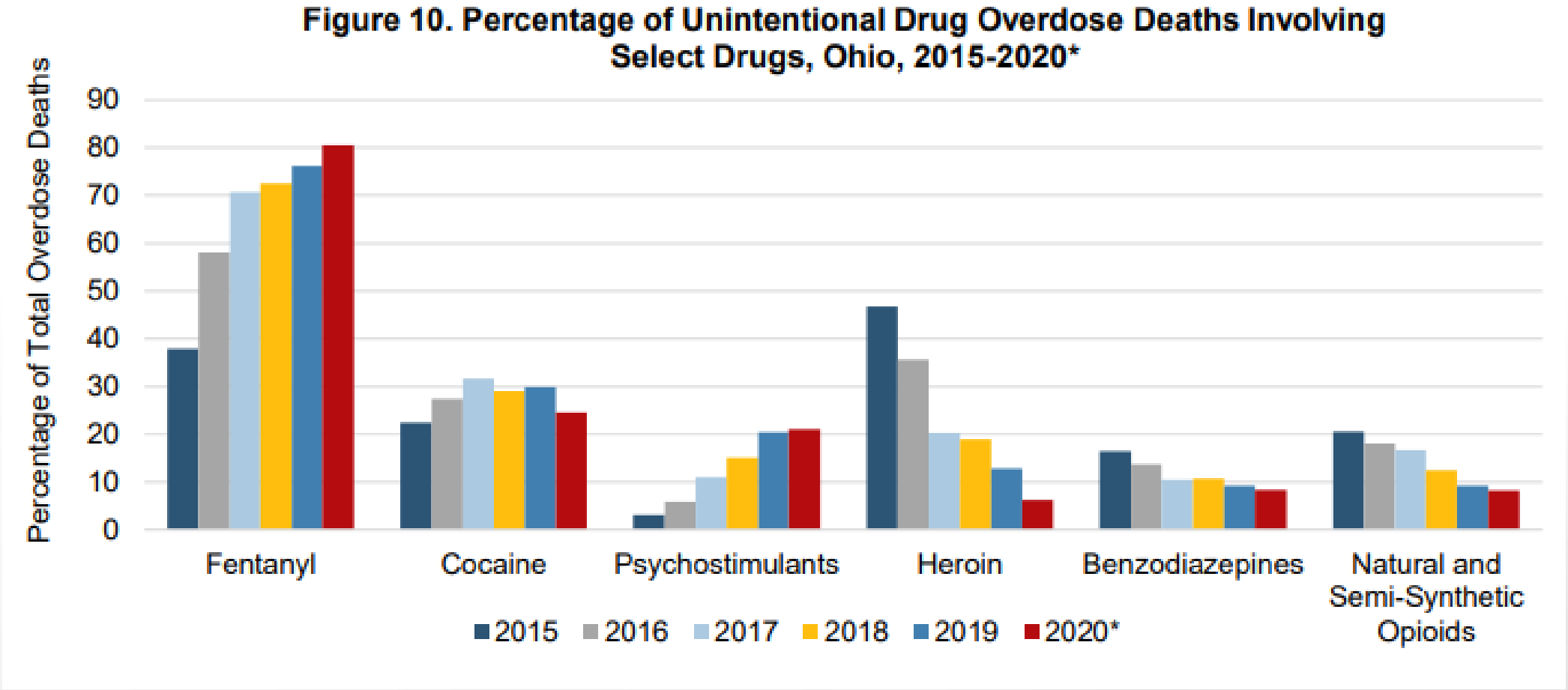
Where in Ohio are drug overdoses most prevalent?

Figure 8. Average Age-Adjusted Rate of Unintentional Drug Overdose Deaths by County, Ohio, 2015-2020*



BON SECOURS MERCY HEALTH

Select Drug Classes contributing to Overdose Deaths



$808 million settlement by Ohio AG Yost with drug distributors- Sept. 2021

OneOhio has been incorporated into the settlement, with 85 percent of the settlement money targeted for local distribution:

- 55% goes to a foundation created to disburse the money and fund programs that benefit Ohioans affected by opioids and/or prevent addiction.
- 30% is earmarked for community recovery programs at the local level.
- 15% goes to the state of Ohio.

- Cardinal, McKesson, and AmerisourceBergen must make internal changes to help prevent a similar crisis:
  - Improved aggregated data and analytics about where drugs are going and how often, eliminating blind spots in the current systems used by distributors and improving detection of suspicious opioid orders.
  - Use data-driven systems to detect suspicious opioid orders from customer pharmacies.

U.S. Department of Health & Human Services: Overdose Prevention Strategy

- Primary Prevention
- Harm Reduction
- Evidence-Based Treatment
- Recovery Support

Mercy Health- Part of Bon Secours Mercy Health

Bon Secours Mercy Health by the numbers

ONE OF THE 5 LARGEST
Catholic health care systems in the US;
the LARGEST not-for-profit private provider in Ireland

MORE THAN **1,200** SITES OF CARE IN THE US AND IRELAND

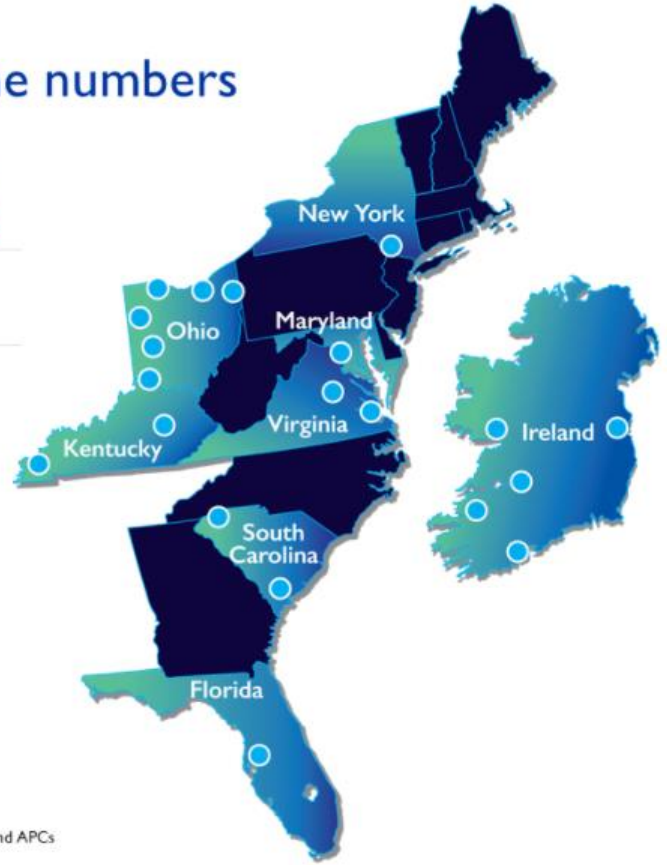
Approximately **$10 BILLION**
in pro forma net operating revenue

MORE THAN **$2 MILLION** A DAY IN COMMUNITY BENEFITS

50 HOSPITALS

3,000* PROVIDERS IN THE US
450 CONSULTANTS IN IRELAND
60,000 TOTAL ASSOCIATES

*BSMH Medical Group physicians and APCs



Mercy Health- 20 hospitals in Ohio providing care in five market areas

Primary Prevention of Opioid Addiction

Modify Opioid Prescribing Practices

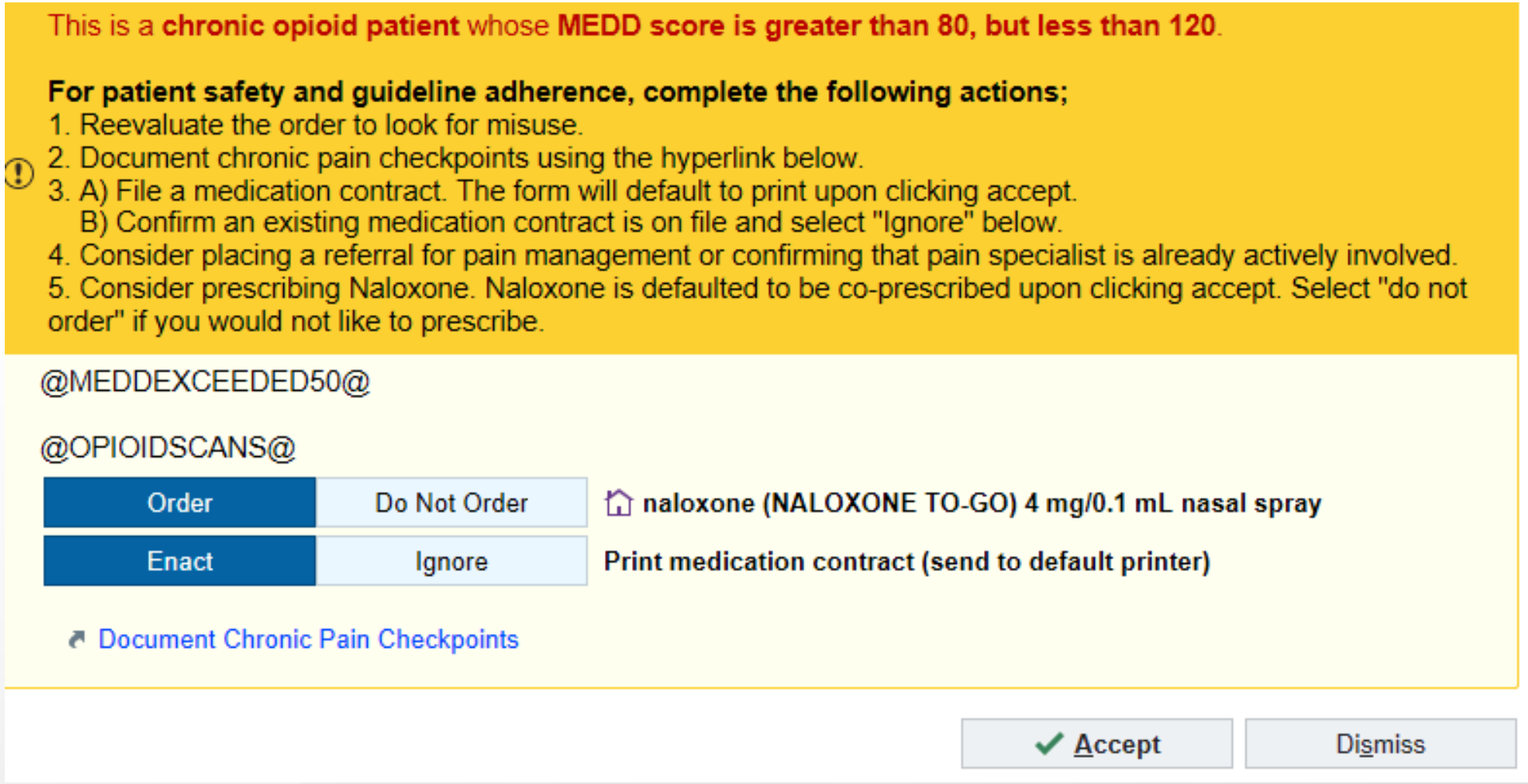
- Inpatient
  - Opioid Stewardship Program with prescribing task force
  - ERAS-Enhanced Recovery after Surgery to reduce opioid needs
    - Regional Anesthesia, Nerve blocks, non-pharmacologic or approach
  - Multimodal non-opioid and non-pharmacologic treatments

- Hospital discharges, including ED
  - Discharge order suggestions – dose/duration
  - Best Practice Advisories incorporating patient data and PDMP information for review
  - Access to Opioid Risk Score in electronic health record
  - Comparison to Peers/ Provider education

Modify Opioid Prescribing Practices contd.

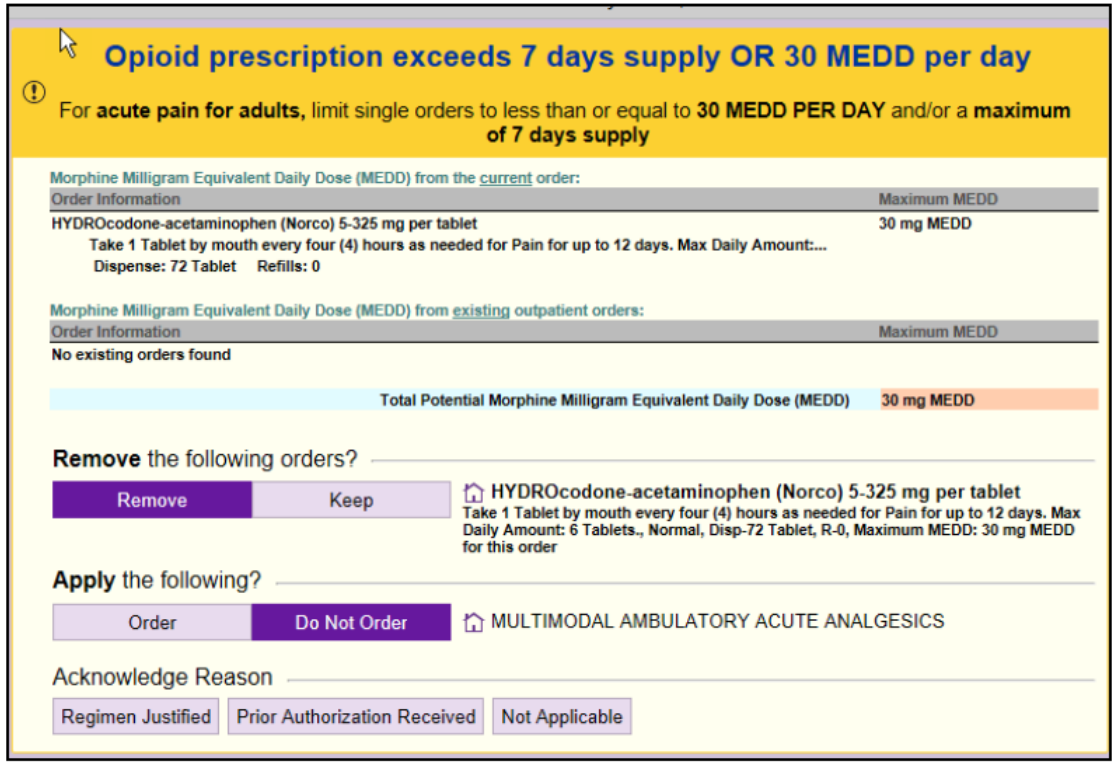
- Community providers
  - Best Practice Advisories
  - Patient contracts/agreements
  - Opioid tapering
  - Comparison to peer groups
  - Provider Education

Example of Best Practice Advisory (BPA) for patient discharge prescription

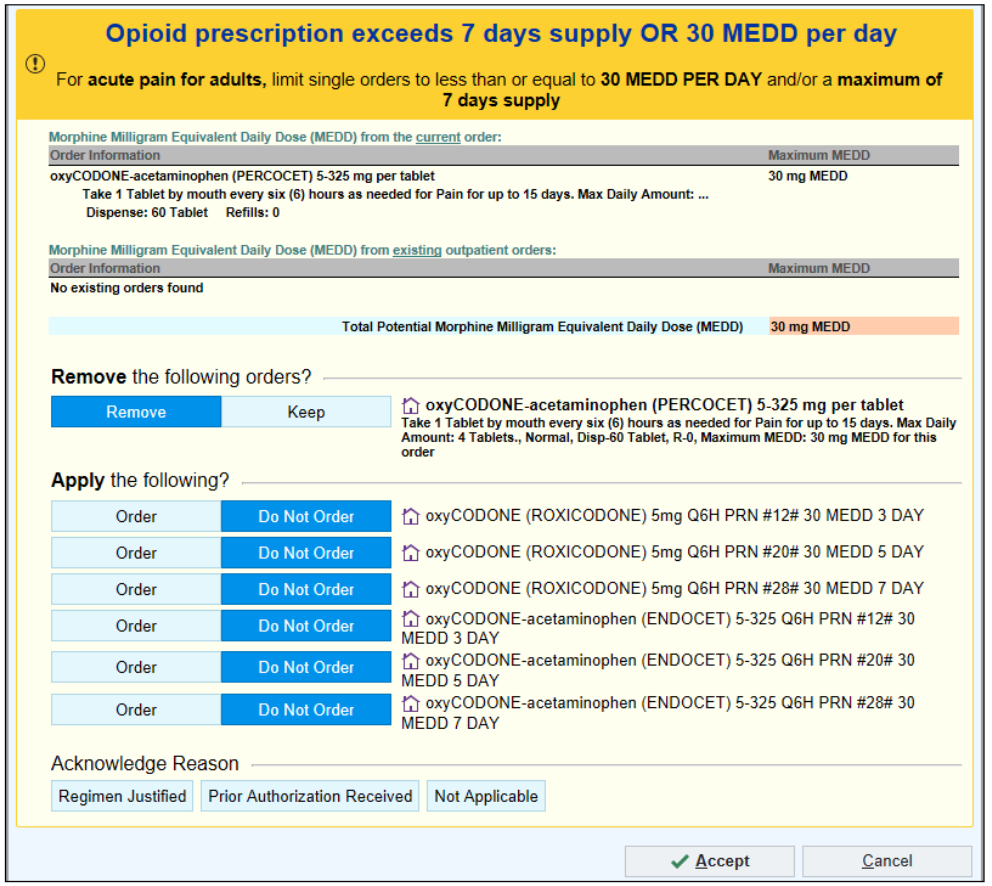


Best Practice Advisories for hospital discharge or community prescription

- **For inpatient encounters:** Users can remove the triggering order and switch to a multimodal analgesic medication panel

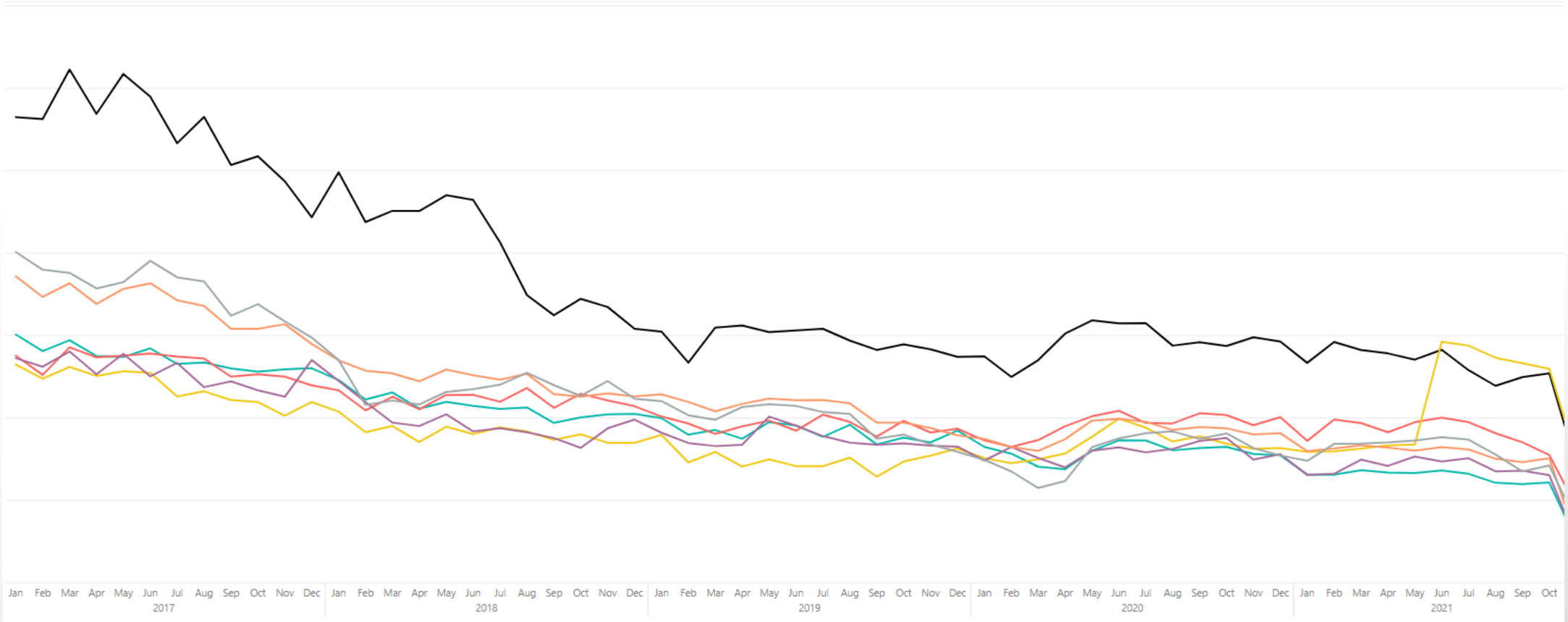


- **For outpatient encounters:** Users can remove the triggering order and switch to common opioid orders with no greater than a 7-day duration



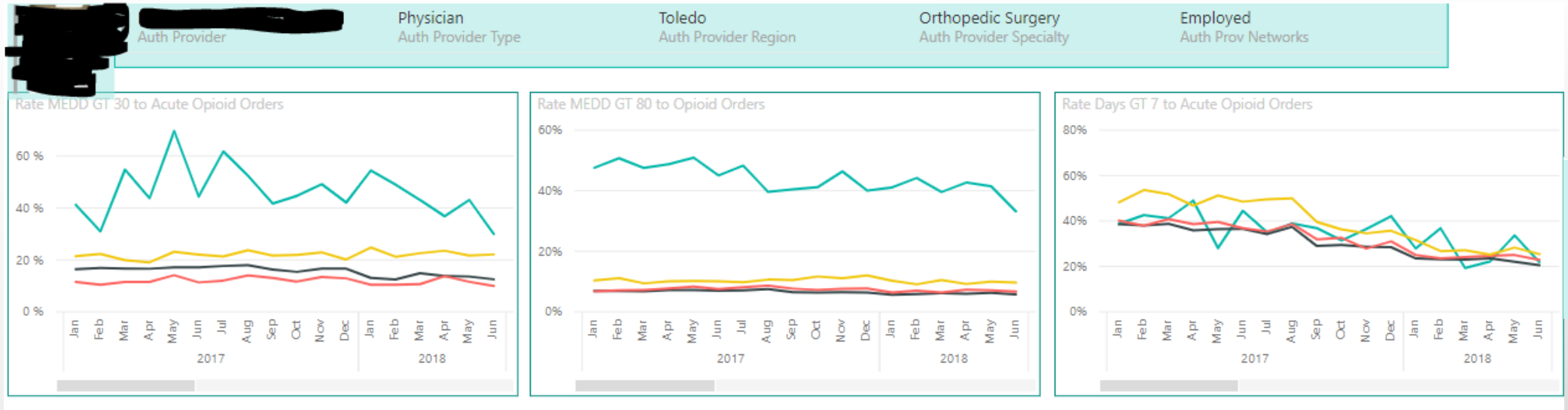
Improvements in Outpatient Opioid Prescribing

- Opioid Burden- Total of opioid morphine equivalents / number of unique patients



Database to help with provider evaluation

- Data can be viewed at hospital level, all the way down to provider level
- Various statistics can be shown such as:
  - Benzo-opioid concurrent prescribing;
  - Rate of acute prescriptions >30 MME/day or >7 days
  - Average MME/day, rate of orders greater then 30, 50, 80 MME/day
- Comparison of specialties with like provider prescribing across the system

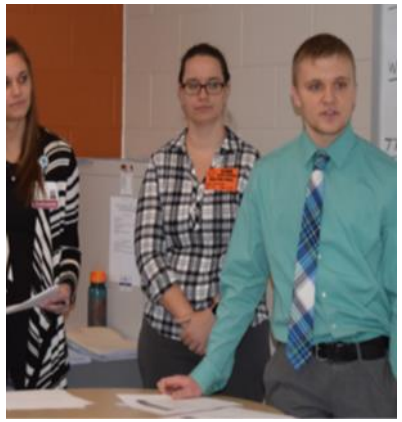


Education

- Peer Education with Chief Medical Officer
- Formalized Education Modules:
    1. Intro to Opioid Reduction
    2. CarePath tools Part 1
    3. CarePath tools Part 2
    4. Alternatives to Opioids
    5. Emergency medicine principles
    6. Treatment of Patients with Opioid Addiction
- Opioid Toolkit—External links to helpful tools for tapering and appropriate prescribing post operatively
- ERAS (Enhanced Recovery After Surgery) protocols

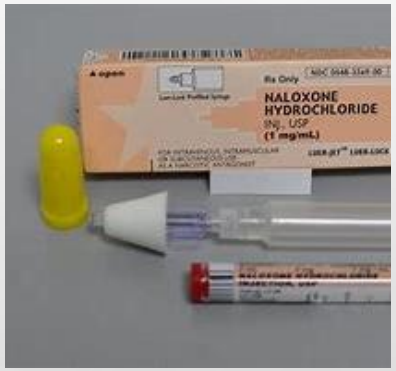
Other Preventative and Harm Reduction Strategies that Health Systems can implement

- Education Initiatives
  - Mandatory Prescriber training
  - Community Education
  - Youth Education- GenerationRx through OSU/Cardinal Health



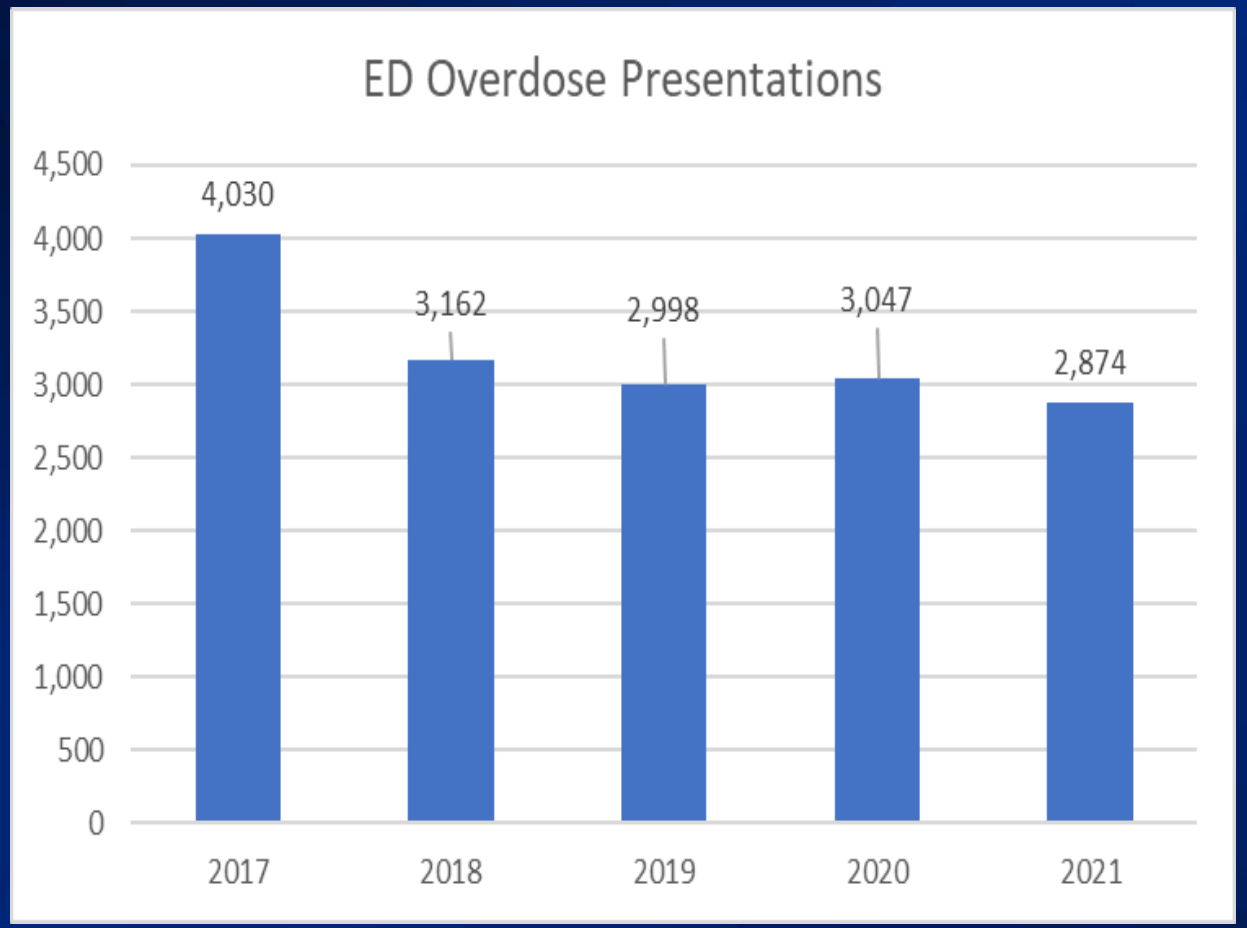
- Opioid Disposal
  - Prescription Take-back days
  - Drug disposal bins
  - Mail-back envelopes

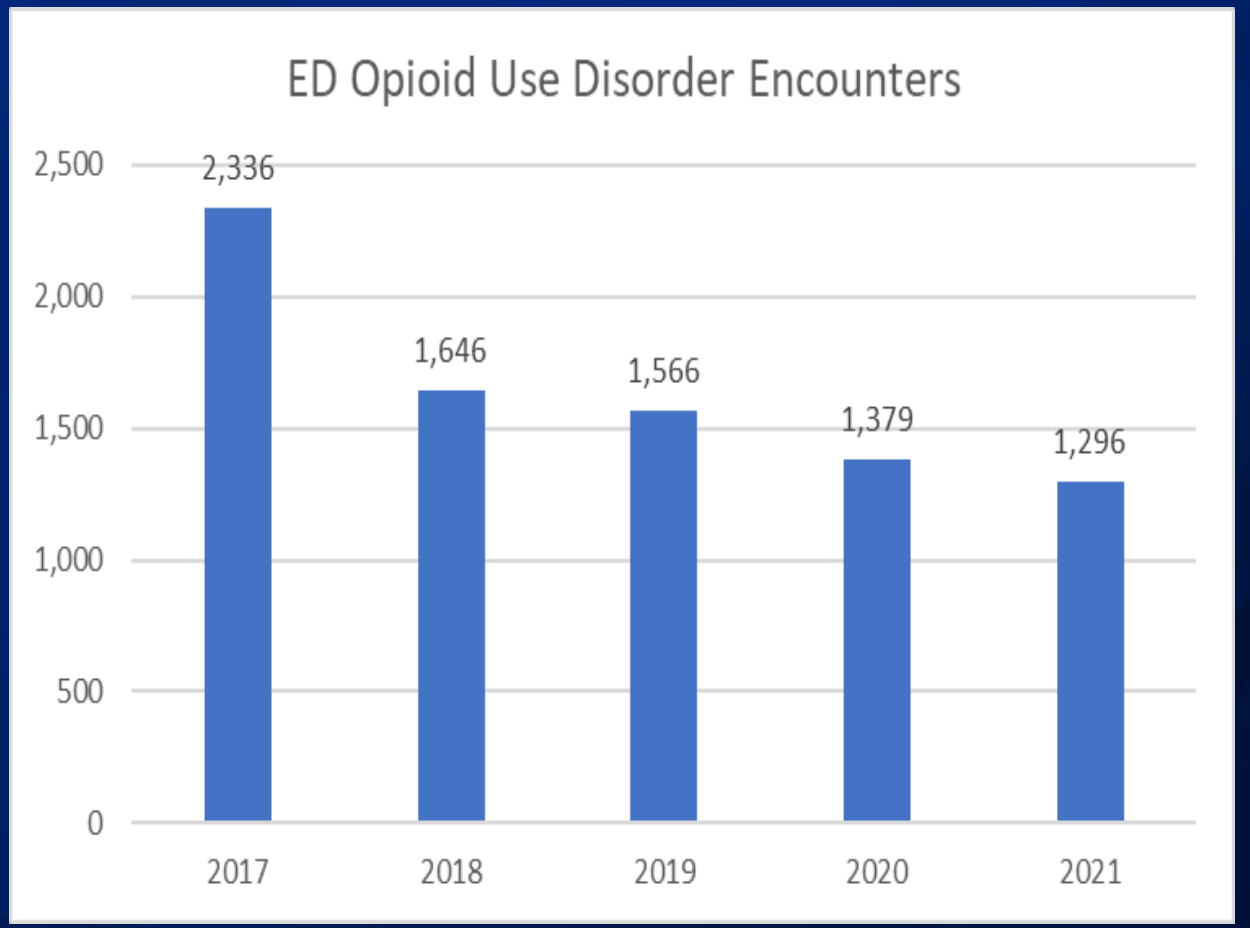
- Naloxone Kit dispensing / Fentanyl test kits
  - Retail Pharmacy
  - ED to-go protocol



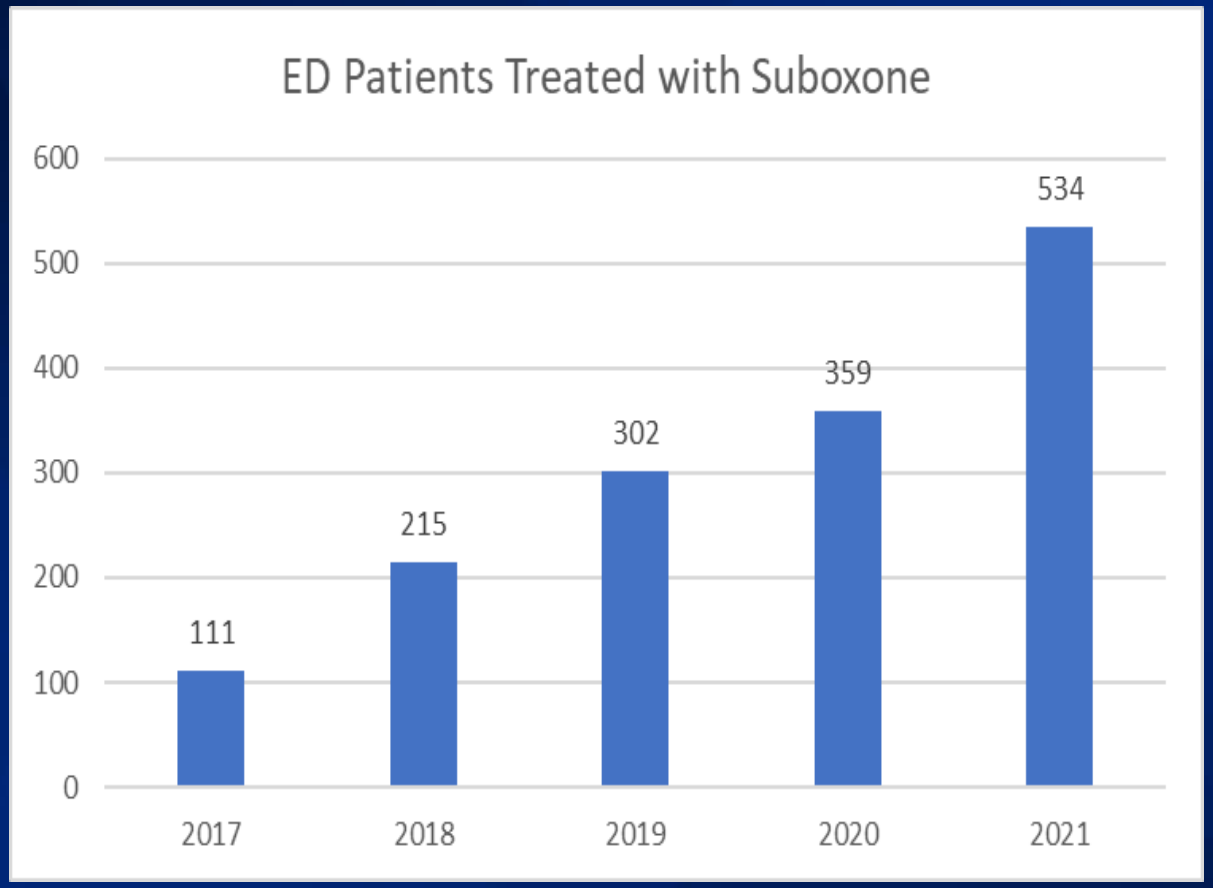
Evidence-Based Treatment- Screening and Linkage to therapy

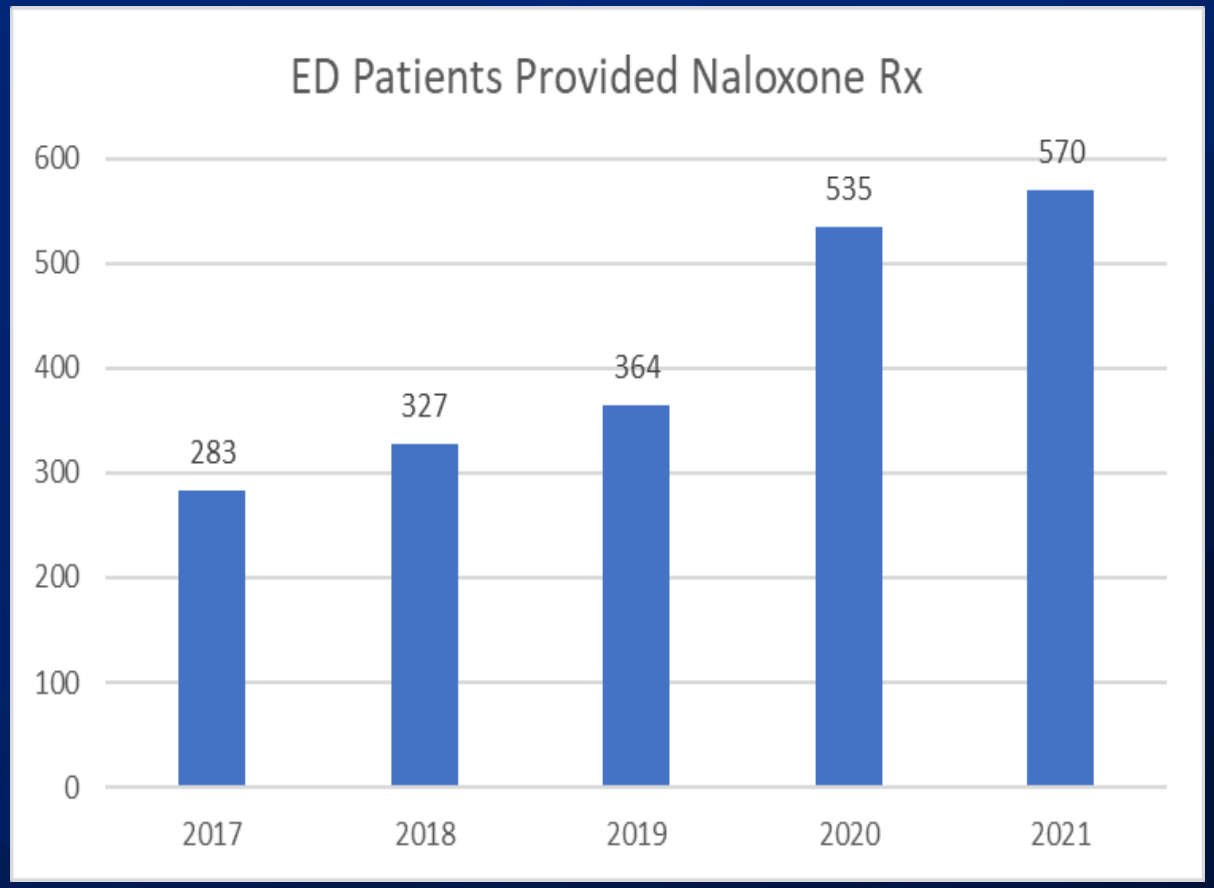
BSMH ED Overdose & Opioid Use Disorder Encounter Data



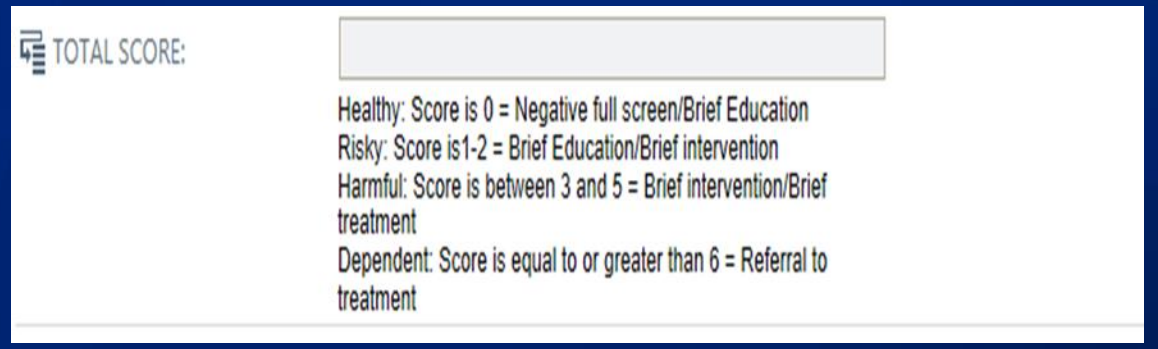


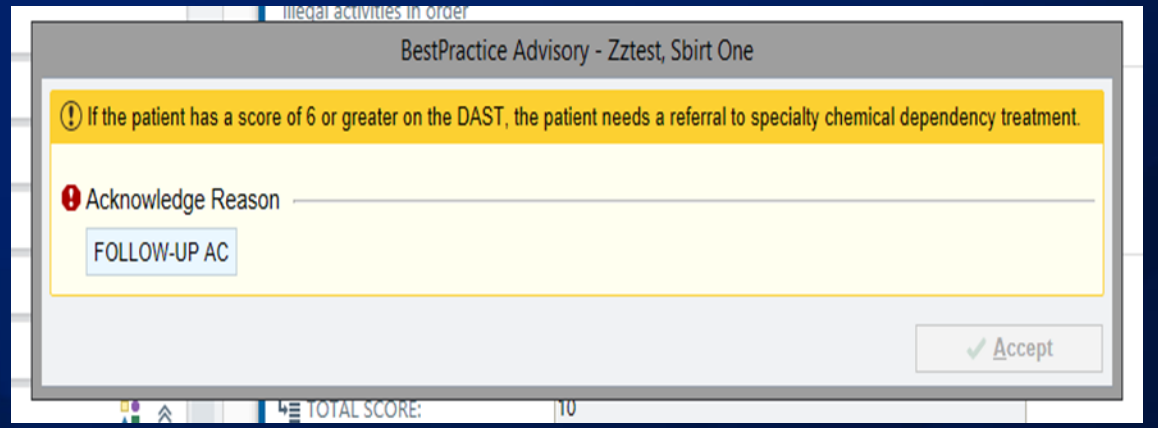
BSMH ED Medication for Opioid Use Disorder Data



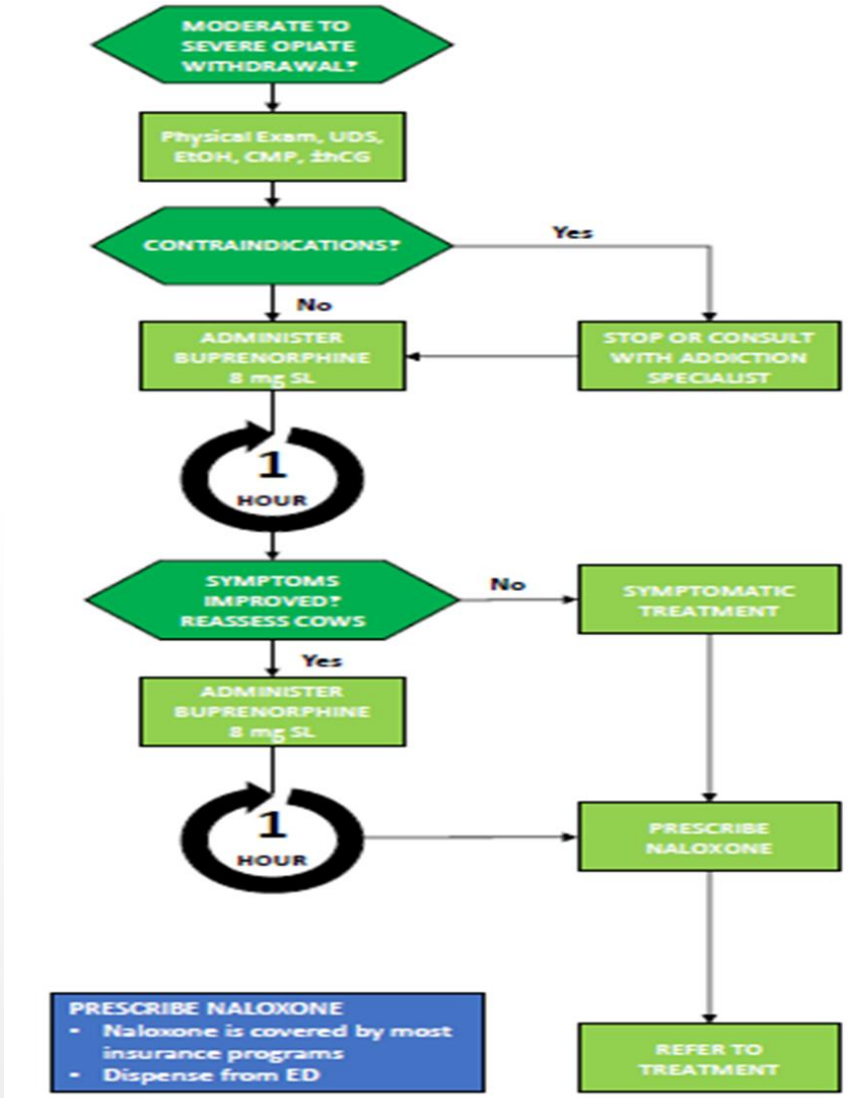


Screening, Brief Intervention, Referral to Treatment





ED MOUD Workflow



OPIATE WITHDRAWAL
- Calculate the Clinical Opiate Withdrawal Scale (COWS)
- COWS score should be ≥ 8 to consider starting buprenorphine
- Document patient's opiate use: dose, frequency, route, time of last use

NALOXONE
- If the patient was given naloxone and is interested in MAT with buprenorphine, wait 2 hours before calculating COWS

CONTRAINDICATIONS
- Acute liver failure
- Altered mental status, intoxication
- Borderline opiate withdrawal (COWS 6-8) or opiate use within 12 hours
- Pregnancy
- Methadone, long-acting opiate, benzodiazepine, or other polysubstance use

BUPRENORPHINE PRECIPITATED WITHDRAWAL
- Buprenorphine can cause precipitated withdrawal if given too soon before last opiate use or too large a dose is given
- The longer since the last opioid use (> 24 hours) and the more severe the withdrawal symptoms (COWS > 12), the better response to initial dosing
- Only patients with objective improvement in withdrawal after the first dose should receive subsequent dosing. Worsening of symptoms likely indicates precipitated withdrawal

SYMPTOMATIC TREATMENT
- Clonidine, metoclopramide, ondansetron, acetaminophen, NSAIDS, loperamide, etc.

REFER TO TREATMENT
- Utilize 1-click to schedule outpatient appointment for MAT follow up
- Consult with BAC to provide resources for MAT and OUD treatment
- Arrange same day follow up if possible, otherwise within 3 days maximum
- findlocaltreatment.com

Clinical Opioid Withdrawal Scale

- Staff are assessing the patient for:
  - Resting Pulse Rate
  - Sweating
  - Restlessness
  - Bone or Joint Aches
  - Runny Nose or Tearing
  - GI Upset
  - Tremors
  - Yawning
  - Anxiety/Irritability
  - Gooseflesh Skin

Patient Referral & Linkage

FindLocalTreatment.com (FLT)

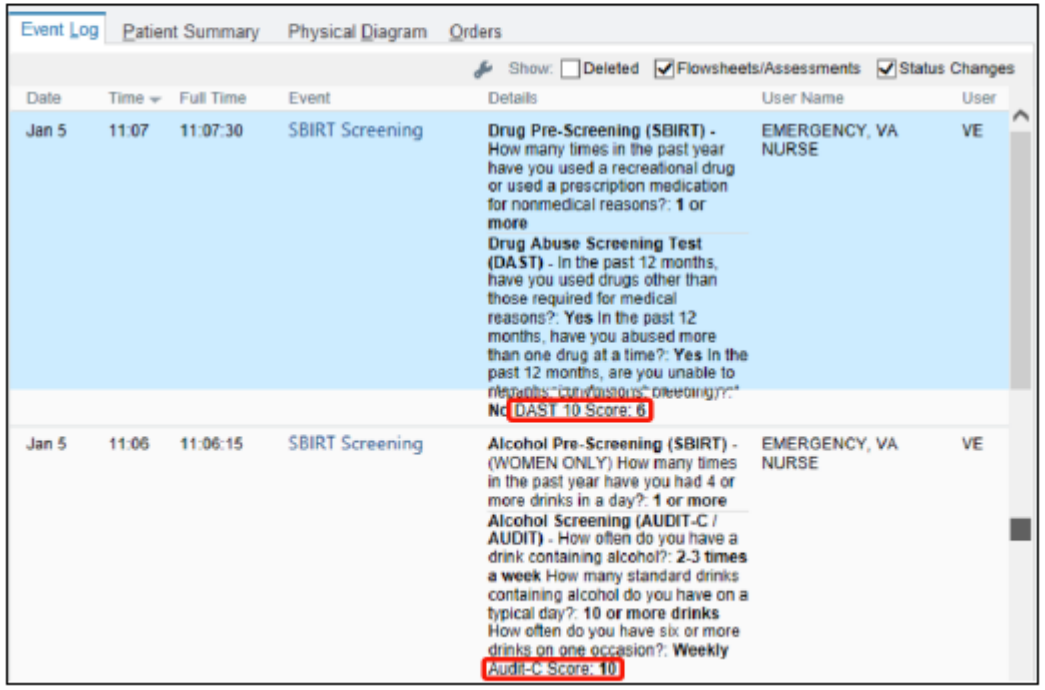
- BSMH has partnered with FLT to ensure that patients with substance use disorders (SUDs) are able to be linked to appropriate treatment easily and efficiently (piloting linkage to mental health services in Greenville, SC as well)
- The FLT hyperlink is embedded into CarePath and ConnectCare so that it is easily accessed by clinicians
- The link allows clinicians to filter by location, substance of choice, and type of treatment. The search will populate available treatment programs meeting the criteria within the identified service area
- Currently available in the ED and inpatient units and will soon be expanded to ambulatory settings

BON SECOURS MERCY HEALTH

Find Local Treatment (FLT) QR code will populate in the ED After Visit Summary (AVS) on patients who have either an elevated Audit-C score (10 or greater) or DASH score (6 or greater) with SBIRT screening.

Patients can scan the FLT QR code in the AVS to access findlocaltreatment.com to find quality addiction treatment centers.

- SBIRT documentation with elevated DAST and elevated Audit-C scores.



Recovery Support

Understanding Addiction

Addiction is a complex but treatable **disease** that affects brain function and behavior.

- No single treatment is right for everyone.
- People need to have quick access to treatment.
- Effective treatment addresses all of the patient's needs, not just his or her drug use.
- Staying in treatment long enough is critical.

Treatment Perspective

- Personal calling to support those in recovery
- Eliminating barriers to treatment and improving access
  - Appointments within 24hrs of patient reaching out
- Treating each individual with empathy, dignity and respect while walking alongside them through their recovery
- Seeing each individual and their needs as unique

Treatment Options

- Medications that are individualized to patients needs and condition.
- Counseling and other behavioral therapies are the most commonly used forms of treatment
- Peer specialist support are recommended to provide round the clock support to those in recovery.

Medication Assisted Treatment (MOUD) Outpatient

- Implemented 8/6/18 Physician's Inc. 830 West High, Suite 207
- Easy Access Call: **419-996-5037** Same day or next business day.
- M-Thursday 8a-5pm. Friday: 8a-12p.
- # Served to date: 1,101 patients
- Retained OP: 518 patients currently active
- Patient Testimony is Compelling—"Life Changing"
- Combination of:
  - Substance abuse screening
  - Mental health and lethality screening
  - Psychosocial screening
  - Medication management
  - Routine drug screens and monitoring
  - Linking to other community agencies to meet each person's unique needs in order to enhance their recovery

New Patient Visit

- Nurse Visit
  - Vitals
  - Drug Screen
  - Medication contract

- Social Work Screening
  - PHQ-9, GAD-7, Mood D/O screening, CSSR-S DAST, AUDIT
  - Social Determinants of Health Identified
  - Review program expectations for counseling
  - Review treatment menu for local community for linkage

New Patient Visit

Physician Intake

- H&P
- Patient Interview
- Review of MOUD options
- Development of treatment plan
- COWS
- Induction

Community Linkage

- Linking individuals to appropriate counseling, psychiatry, case management, peer recovery support, supportive housing, and community resources based on their needs and treatment preferences.
- Patients linked to services with 36 different treatment providers
  - Providers include: SRMC Psychiatry Associates, SRMC IOP, Coleman Health Services, UMADAOP, Full Circle, Pathways, Westwood, Foundations, Lighthouse Behavioral Health, TCN, Century Health, Practice of Clinical Psychiatry, A Renewed Mind, Family Resource Center, and multiple private therapist offices.
- Patients linked to providers in 23 different counties
  - Allen, Auglaize, Hardin, Van Wert, Mercer, Putnam, Logan, Shelby, Miami, Darke, Seneca, Wood, Champaign and many more

Engagement

Engagement is a significant component to treatment success.

Patients need:

- To feel cared for
- To feel safe and unjudged
- To feel understood
- To feel like they matter

Treatment Approach for those in Recovery

- Address the individual healthcare needs of each patient, we are not just treating addiction; their physical, emotional, and spiritual health along with their psychosocial needs are equal parts of their overall recovery.
- Patient Centered Care-Listen to patient, Encourage their participation, understand what their health needs are, Care plan accordingly.
- Multidisciplinary approach: MOUD, Primary care, counseling, psychiatry, peer recovery support, case management, community supports.

How can you help?

- Know your clients and the individuals you are serving
- Provide education on prescription drug abuse
- Encourage them to put prescription medications in safe locations to prevent theft
- Know your local resources and treatment providers

How can you help?

- Show empathy and show that you care about their well-being
- Make yourself available to have difficult conversations with them when they are ready
- You can’t force treatment, but you can plant the seed and make yourself a resource for their recovery when they are ready to accept it.

Our Treatment Center Believes

1. Treatment over punishment
2. Compassion over condemnation
3. Empathy over placing blame

Questions?

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

2021 OPIOID STEWARDSHIP WEBCAST SERIES

Opioid Stewardship: Education

December 16, 2021

11:30 a.m. – 12:30 p.m.

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

James Guliano, MSN, RN, NPD-BC, NEA-BC, FACHE
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HelpingOhioHospitals

@OhioHospitals

www.youtube.com/user/OHA1915