CEPOP SALUTES

Hospital Networks Lead Efforts to Reduce Opioid-Related Adverse Events

Monday, August 15, 2016
1:00pm – 2:30pm ET
Today’s Agenda

- Who is CEPOP?
- Framing the Issue – The Opioid Epidemic: Rich Hamburg, Trust for Americas Health, CEPOP Co-Founder & Hon. Mary Bono, FaegreBD Consulting, CEPOP Co-Founder
- Opening Remarks: Dr. Kate Goodrich, Director, CMS Center for Clinical Standards and Quality
- CEPOP SALUTES: Highlighting Hospital Engagement Networks
  - Michigan Health & Hospital Association Keystone Center
  - Hospital & Healthcare Association of Pennsylvania
  - Dr. Anita Gupta, DO, PharmD, Drexel University College of Medicine
- Q&A Session
- Next Steps & Follow-Up
The Collaborative for Effective Prescription Opioid Policies

- Launched in January 2015
- Three Co-Conveners
  - Community Anti-Drug Coalitions of America (CADCA)
  - The Honorable Mary Bono
  - Trust for America’s Health (TFAH)
- 70 participating organizations – including patient and family advocates, providers, public health, dispensing, distribution, and manufacturing organizations.
- [www.CEPOPonline.org](http://www.CEPOPonline.org)
Since 1999, U.S. sales of prescription opioids have quadrupled.

47,055 overdose deaths in the US in 2014 alone, a 6.5% increase from 2013.

- 61% of drug overdose deaths were due to an opioid, heroin included.
- Significant increases in drug overdose deaths for the following cohorts:
  - Men and women;
  - Persons aged 25-34 years, 35-44 years, 55-64 years, and ≥ 65 years;
  - Non-Hispanic whites and non-Hispanic blacks; and
  - Residents in the Northeast, Midwest and South census regions.

While prescriptions for opioid medications now remain steady, deaths due to opioid overdose continue to climb.
Recently, there have been a variety of actions taken by U.S. Government agencies and lawmakers in response to the opioid epidemic.

- CDC Guideline for Prescribing Opioids for Chronic Pain
- The Comprehensive Addiction and Recovery Act of 2016
- Increases in medication-assisted treatment (MAT) provider caps to 275 patients; finalized on August 8, 2016, per [SAMHSA](https://www.samhsa.gov).
- HCAHPS Pain Scores and CMS recalibration for reimbursement.
- Increased federal funding.
Beyond U.S. Government interventions, a wide array of key stakeholders have put forth considerable effort to maintain appropriate pain management while addressing the epidemic.

- Joint Commission Sentinel Alert #49: Safe Use of Opioids in Hospitals
- Multimodal analgesia and other opioid-sparing pain management protocols have been recommended by various professional organizations, including, but not limited to:
  - American Society of Anesthesiologists
  - American Academy of Orthopedic Surgeons
  - Society of Hospital Medicine
  - Enhanced Recovery After Surgery Society
  - American College of Surgeons and American Geriatrics Society
- Studies released citing the usefulness of non-opioid foundations in reducing length of stay and readmissions, lowering incidences of opioid-related adverse events, and improving pain scores.
Dr. Kate Goodrich
Director, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
Today’s webinar is the first iteration of the **CEPOP Salutes** awards initiative.

Clear need to highlight and exemplify key partners in the fight against the opioid epidemic.

Nominations are ongoing and covers the entire spectrum of patient care from inpatient pain management to treatment and recovery programs.
Improving Pain Control and Reducing Opioid Related Adverse Events

Michelle Norcross, Director Performance Improvement
Opioid Crisis - Background

Some states have more painkiller prescriptions per person than others.

Methods/Timeline of Activities

• CMS PfP Hospital Engagement Network (HEN)
  • Opioids called out as high risk medication needing to be addressed
  • Coupled with MHA Keystone: Surgery efforts around Enhanced Recovery After Surgery (ERAS)
• Advisory Committee
  • Convened an advisory committee comprised of an anesthesiologist, director of surgical services, independent nurse consultant, Michigan Surgical Quality Collaborative (MSQC) abstractor, pain nurse resource specialists, surgeon and surgical nurses
• Gap Analysis
  • Completed Gap Analysis
• Roll Out
  • Project launch meeting was held
  • Educational materials were distributed including the Michigan Opioid Safety Score (MOSS) tool, sample order sets, data dictionaries, and schedule of monthly content webinars and coaching calls
Opioid Adverse Drug Event Prevention Gap Analysis
Intervention 1: CUSP

- The Comprehensive Unit-based Safety Project (CUSP) follows a six step iterative program to improve patient safety and the culture that drives safety attitudes and practices.

Intervention 2: Educational program including in-person and multi-media sessions

- Monthly content webinars, monthly coaching calls (in collaboration with the Armstrong Institute for Patient Safety & Quality, Johns Hopkins University), and an annual conference (in person meeting) with national speakers.

Intervention 3: Implementation of a perioperative pain management toolkit

- Gap Analysis tool, Michigan Opioid Safety Score (MOSS tool), patient and family education templates, pre-op checklist modification recommendations, and a multimodal analgesia tool (with specific recommendations for order sets).
Goals

- Incorporate patient/procedural risk factors
- Incorporate respiratory rate
- Incorporate sedation
- Reinforce need for multimodal analgesia
- Improve nursing documentation of patient assessment

MOSS = Health Risk (max 2 points) + RR Score +/- STOP modifier

Possible score 0 – 4 with possible STOP modifier

A) Health Risk: 1 point per group with maximum of 2 points possible

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSA</td>
<td>Abd/Thor surgery</td>
<td>Concomitant sedatives received</td>
<td>Age &gt; 75</td>
</tr>
<tr>
<td>Snoring</td>
<td>Anesth time &gt;3hr</td>
<td>within 2 hr</td>
<td>Smoker</td>
</tr>
<tr>
<td>BMI &gt; 40</td>
<td>(within 24hr of assessment)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B) Respiratory Rate Score:

| RR ≥ 10     | 0 points |
| RR < 10     | 2 points |

C) Modified Pasero Opioid-Induced Sedation Scale (mPoss): STOP Modifier

<table>
<thead>
<tr>
<th>MOSS Points</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>STOP</td>
<td>Excessively sedated, drifts off to sleep, difficult to arouse or unarousable</td>
</tr>
</tbody>
</table>
**MOSS Interpretation**

<table>
<thead>
<tr>
<th>MOSS Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>STOP</td>
</tr>
<tr>
<td></td>
<td>Stop all opioids</td>
</tr>
<tr>
<td></td>
<td>Notify primary physician</td>
</tr>
<tr>
<td></td>
<td>Institute increased levels of monitoring</td>
</tr>
<tr>
<td></td>
<td>Consider anesthesia/pain consultation</td>
</tr>
<tr>
<td></td>
<td>Ensure multimodal analgesia delivered</td>
</tr>
<tr>
<td></td>
<td>Consider reversal agents (naloxone or flumazenil as appropriate)</td>
</tr>
<tr>
<td>3</td>
<td>CAUTION</td>
</tr>
<tr>
<td></td>
<td>Decrease opioid dose</td>
</tr>
<tr>
<td></td>
<td>Increase levels of monitoring</td>
</tr>
<tr>
<td></td>
<td>Ensure multimodal analgesia delivered</td>
</tr>
<tr>
<td>2</td>
<td>CONCERN</td>
</tr>
<tr>
<td></td>
<td>Increase opioids as needed with special attention</td>
</tr>
<tr>
<td></td>
<td>Consider increased levels of monitoring</td>
</tr>
<tr>
<td></td>
<td>Ensure multimodal analgesia delivered</td>
</tr>
<tr>
<td>1</td>
<td>SAFE</td>
</tr>
<tr>
<td></td>
<td>Safe to proceed with further opioid dosing</td>
</tr>
<tr>
<td></td>
<td>Ensure multimodal analgesia delivered</td>
</tr>
<tr>
<td>0</td>
<td>SAFE</td>
</tr>
</tbody>
</table>
YOUR GUIDE TO CONTROLLING & MANAGING PAIN AFTER SURGERY
WHAT YOU SHOULD DO

BEFORE Surgery, ask your surgeon:
- How much pain should I expect after surgery?
- What type of pain will I experience?
- When will the pain be at its worst?
- How long will the pain last?

AFTER Surgery, tell your surgeon or nurse:
- If your pain is above 4/10 and isn’t getting better with medication (see next page)
- If you are experiencing a new type of pain
- If you are experiencing side effects of the pain medication you are taking

Before you leave the hospital
Make sure you understand your surgeon’s instructions regarding pain medication.
- What pain medicine am I taking?
- Why am I taking it?
- How should I take it?
- What are the side effects I should watch out for?
- When should I stop taking it?

Once home, call your surgeon
- If your pain is not getting better with medication
- If you are experiencing unpleasant side effects of pain medication

WHY IS IT IMPORTANT?

You can dramatically influence the outcomes you experience following your surgery by actively participating in your own recovery. The actions you take can influence how soon you recover and how satisfied you are with your surgical experience.

You have the right to have your pain assessed and treated and we will work with you to develop a customized pain management plan.

Unrelieved pain can lead to prolonged recovery, increased length of hospital stay, depression and sleeplessness.
## TOOLS TO HELP MANAGE YOUR PAIN

**Keeping a Pain Diary will help your medical care team best control your pain**

<table>
<thead>
<tr>
<th>Date</th>
<th>Pain Level (From 1-10 with 10 being the highest)</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Surgery</td>
<td>Morning: At Rest /10, With Movement /10</td>
<td>Constipation</td>
</tr>
<tr>
<td></td>
<td>Noon: At Rest /10, With Movement /10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evening: At Rest /10, With Movement /10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Night: At Rest /10, With Movement /10</td>
<td></td>
</tr>
<tr>
<td>1 Day After Surgery</td>
<td>Morning: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Noon: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evening: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Night: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td>2 Days After Surgery</td>
<td>Morning: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Noon: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evening: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Night: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td>3 Days After Surgery</td>
<td>Morning: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Noon: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evening: Location of pain, Location of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Night: Location of pain, Location of pain</td>
<td></td>
</tr>
</tbody>
</table>

Use the chart above to help keep track of your pain and any side effects you may be experiencing. It is important to note the different types of pain (dull, sharp, cramping) you are experiencing and when you feel that pain. Pain while at rest and pain during movement can often be different. Remember, our goal is to keep your pain at or below a 4/10.

![Pain Scale from 0 to 10]
Talk to your doctor about developing a pain goal or a targeted goal you wish your pain level to be, both at rest and with movement. Work with your doctor to develop a pain management plan that will work to achieve your pain goal and write it here:

Once you leave the hospital, please keep track of the pain medication you are taking

<table>
<thead>
<tr>
<th>What is this medicine called?</th>
<th>How much do I take?</th>
<th>How often do I take it?</th>
<th>What is the medicine for?</th>
<th>Do I take it with food or water?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICATION NAME</td>
<td>DOSE</td>
<td>FREQUENCY</td>
<td>REASON I'M TAKING</td>
<td>TAKE MEDICINE WITH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is important that you understand all the pain medications you are taking. Use the chart above to help keep track of your pain medications.
Common Medications, Ingredients and Side Effects

Here is a list of common medications used to treat pain. These may not be available at all hospitals. If you are given any of these, watch for any of the possible side effects, and make a note to tell your medical care team if you do.

<table>
<thead>
<tr>
<th>Name</th>
<th>Active Ingredient</th>
<th>Side Effects</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tylenol</td>
<td>Acetaminophen</td>
<td>None</td>
<td>Pills, liquid or IV</td>
</tr>
<tr>
<td>Motrin</td>
<td>Ibuprofen</td>
<td>Some stomach discomfort</td>
<td>Pills, liquid or IV</td>
</tr>
<tr>
<td>Aleve</td>
<td>Naproxen</td>
<td>Some stomach discomfort</td>
<td>Pills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Active Ingredient</th>
<th>Side Effects</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toradol</td>
<td>Ketorolac</td>
<td>Mild bleeding risk</td>
<td>Pills or IV</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
<td>Sedation</td>
<td>Pills</td>
</tr>
<tr>
<td>Lyrica</td>
<td>Pregabalin</td>
<td>Sedation</td>
<td>Pills</td>
</tr>
<tr>
<td>Local Anesthetics</td>
<td>Lidoceine, bupivacaine, ropivacaine</td>
<td>Numbness</td>
<td>Injection or patch</td>
</tr>
<tr>
<td>Steroids</td>
<td>Dexamethasone, hydrocortisone</td>
<td>Can increase glucose levels in diabetics</td>
<td>Pills or IV</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Acetylsalicylic acid</td>
<td>Some stomach discomfort, easy bruising or bleeding</td>
<td>Pills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Active Ingredient</th>
<th>Side Effects</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Morphine</td>
<td>Constipation, dizziness, sleepiness, nervousness, nauseaus</td>
<td>Pills, liquid, IV or IV patient controlled</td>
</tr>
<tr>
<td>Dilaudid</td>
<td>Hydromorphone</td>
<td>Constipation, dizziness, sleepiness, nervousness, nauseaus</td>
<td>Pills, liquid, IV or IV patient controlled</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Fentanyl</td>
<td>Constipation, dizziness, sleepiness, nervousness, nauseaus, problems breathing</td>
<td>IV or patch</td>
</tr>
<tr>
<td>Vicodin/Lortab/Norco</td>
<td>Hydrocodone/acetaminophen</td>
<td>Constipation, dizziness, sleepiness, nervousness, nauseaus</td>
<td>Pills</td>
</tr>
<tr>
<td>Percocet</td>
<td>Oxycodone/acetaminophen</td>
<td>Constipation, dizziness, sleepiness, nervousness, nauseaus</td>
<td>Pills</td>
</tr>
</tbody>
</table>

MHA Keystone Center
www.mhakeystonecenter.org

Follow us on social media www.mhakeystonecenter.org

©2016 MHA Keystone Center. All rights reserved.
Results

Percent of patients who received naloxone during surgical related care

Percent of surgical patients receiving MOSS assessments
1. All patients will be screened to determine if they are opioid naïve or opioid tolerant prior to receiving any opioids.

2. All patients needing pain control will have multimodal analgesia. Providers will follow the World Health Organization (WHO) analgesic pain ladder when prescribing.

3. All patients receiving opioids will be formally assessed via the Michigan Opioid Safety Score (MOSS) or Pasero Opioid-induced Sedation Scale (POSS) on a regular basis to prevent unintended sedation and respiratory depression.

4. Patients receiving opioids will not receive more than one concomitant sedative.

5. All patients receiving pain medications will be counseled on the medication they are receiving, any potential side effects and expectations of realistic pain management.

6. Policies and procedures will be established for patients who are no longer responding to treatment, directing that those patients receive increased monitoring, level of care, and appropriate pain consultation.

7. Patients requiring a PCA will be monitored via pulse oximetry and/or capnography.
10 Things Every Patient in Pain Should Know

1. BE PART OF YOUR CARE
   It is hard to know what another person's pain feels like. You need to be involved and be able to describe your pain. You can bring family or friends to advocate for you.

2. TELL YOUR DOCTOR IF
   You have any risk factors such as, using opioids (like morphine or codeine) daily or regularly. If you have a history of sleep apnea, you are taking blood thinners. Ask if you have any additional risk factors.

3. ASK YOUR DOCTOR
   Why are you experiencing pain? How long should you expect the pain to last? How will your pain be treated if there are alternative treatments or if you should change your dose to match your pain level?

4. MAKE A PAIN MANAGEMENT PLAN
   It is important that you work with your physician to make a personal pain management and treatment plan. Your care team will work with you to balance pain control with as few side effects as possible. It is important to know that you may receive non-opioid medication to treat pain and your breathing may also be monitored.

5. LET YOUR DOCTOR KNOW OF ANY SIDE EFFECTS
   It is likely your doctor will prescribe a combination of medicines to control your pain. Unfortunately, opioids have unpleasant side effects including nausea, vomiting, itching, diarrhea, loss of balance, falls, severe constipation, confusion or difficulty waking up and staying awake. Overdoses can occur from requesting pain medication when you are too sleepy or applying a pain patch after forgetting that one has already been applied.

6. TRACK YOUR PAIN
   Report any side effects you may feel. It is important to write down the different types of pain you are experiencing and when you feel that pain. Pain while at rest and pain during movement can often feel different. Your care team will ask you about your pain: it is important to share what you have tracked.

7. SPEAK UP
   If your pain is above 4 out of 10 and isn’t getting better with medication. Also, if you feel a new type of pain or side effect from pain medication you are taking, tell your nurse or doctor.

8. BE AWARE
   Of signs of an overdose or being overly medicated which may include skin that is clammy or pale, low heart rate and blood pressure, small pupils, limpness, slow breathing, restlessness, slurred speech, confusion and extreme sleepiness. Seek help immediately if you notice any of the above symptoms.

9. CONSULT A PAIN SPECIALIST
   If you have risk factors or a history of problems with managing pain or if your pain is not consistently controlled. Ask if a pain specialist or anesthesiologist can be part of your care team.

10. TALK TO YOUR PHARMACIST
    When going home with opioids, you should know the dose, how often and when it is taken and how long you will take it. If you miss a dose, do not take a double dose. Ask your pharmacist about using opioids safely at home.
Matthew Grissinger, RPh, FISMP, FASCP
Director, Error Reporting Systems
HAP PA-HEN

Achieving More Together

Preventing Harmful Adverse Events with Opioids
Preventing Harmful Adverse Events with Anticoagulants, Insulin, and Opioids Collaboration

- HAP PA HEN
  - Hospital Association of Pennsylvania (HAP)
  - PA Patient Safety Authority (PSA)
  - Institute for Safe Medication Practices (ISMP)
    - Matthew Grissinger, RPH, FISMP, FASCP
      - Manager, Medication Safety Analysis (PSA)
      - Director, Error Reporting Programs (ISMP)
    - Michelle M Bell, RN, BSN, FISMP, CPPS
      - Patient Safety Liaison, Southeast, Delaware Valley North
      - michbell@pa.gov
Tools and Measures

• Tools: patientsafetyauthority.org
  • HAP PA-HEN Opioid knowledge assessment
  • HAP PA-HEN Opioid organization assessment

• Outcome measures
  • Naloxone use
  • Rapid response team (RRT) calls due to opioids
Opioid Knowledge Assessment

• Assess practitioners knowledge of opioids
• 11 multiple choice questions
• Intended for ALL practitioners involved with opioid use
  • Prescribers
  • Pharmacists
  • Nurses
• Reviewed and endorsed by Pennsylvania Medical Society
• Types of questions
  • Opioid-naïve vs. opioid-tolerant patients
  • Long-acting opioids
  • Equianalgesic dosing
    • HYDROMorphone dosing
  • Patient-specific conditions requiring a lower starting dose of opioids
  • Concomitant medications
  • Monitoring the effects of opioids
3) Patients who are considered opioid-tolerant are those who have been:

a) Taking acetaminophen 300 mg with codeine 30 mg, up to 5 doses a week
b) Taking oxyCODONE 10 mg with acetaminophen 325 mg 4 times daily for 5 days
c) Taking oxyCODONE 10 mg with acetaminophen 325 mg 4 times daily for 14 days
d) Taking extended-release morphine 15 mg twice daily for 1 week
e) All of the above
Opioid Tolerant Answer
Opioid Organization Assessment

• Assess medication use system/processes with the use of opioids
• 45 questions
• Addresses all phases of the medication use process
  • Prescribing
  • Dispensing
  • Administration
  • Monitoring
Purpose

• To help HAP PA-HEN participating hospitals:
  • Assess the safety of current opioid practices
  • Identify opportunities for improvement
  • Compare experiences with the aggregate of other hospitals
Instructions for Completion

1. Establish an interdisciplinary team
   - Chief medical officer
   - Nurse executive
   - Director of pharmacy
   - Clinical information technology specialist
   - Medication safety officer/manager
   - Risk management and quality improvement
   - At least 2 staff nurses (different specialty areas)
   - At least 2 staff pharmacists (1 clinical/1 distribution)
   - At least 1 active staff physician who orders opioids
<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>% None</th>
<th>% Partial</th>
<th>% Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Parenteral opioid orders include the mg/kg or mcg/kg dose for pediatric patients along with the total calculated patient-specific dose (e.g., morphine 0.1 mg/kg x 15 kg = 1.5 mg IV every 4 hours prn severe pain).</td>
<td>59%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>13</td>
<td>Pharmacists have easy access to the patient’s opioid status (opioid-naïve / opioid-tolerant) and take it into consideration when profiling or reviewing orders for opioids.</td>
<td>59%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>6</td>
<td>Standardized preprinted order forms/CPOE order sets are used to prescribe oral and parenteral opioids.</td>
<td>53%</td>
<td>0%</td>
<td>47%</td>
</tr>
<tr>
<td>10</td>
<td>Long-acting opioids (e.g., fentaNYL patches, MS Contin 100 and 200 mg tablets, OxyCONTIN doses greater than 40 mg) are restricted for use in opioid-tolerant patients and are NOT used for acute pain management.</td>
<td>53%</td>
<td>29%</td>
<td>18%</td>
</tr>
</tbody>
</table>
## Low Scoring Items

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>% None</th>
<th>% Partial</th>
<th>% Full</th>
<th>% N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Pain management protocols define opioid-naïve and opioid-tolerant patients, and outline the differences in the management of these patients.</td>
<td>53%</td>
<td>18%</td>
<td>6%</td>
<td>24%</td>
</tr>
<tr>
<td>40</td>
<td>Smart infusion pumps with computer software that is capable of alerting the user to unsafe opioid doses (i.e., soft and hard stops) are utilized when PCA is delivered.</td>
<td>50%</td>
<td>6%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Equianalgesic dosing charts for oral, parenteral, and transdermal opioids (e.g., fentaNYL patches) have been established and are easily accessible to all practitioners when prescribing, dispensing, and administering opioids.</td>
<td>47%</td>
<td>24%</td>
<td>29%</td>
<td></td>
</tr>
</tbody>
</table>
## Low Scoring Items

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Asthma/ COPD</th>
<th>Sleep Apnea</th>
<th>Opioid Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Patients are screened for the following elements which might affect the dose, monitoring parameters, or appropriateness of opioid use.</td>
<td>35%</td>
<td>29%</td>
<td>47%</td>
</tr>
<tr>
<td>36</td>
<td>Patients are screened for the following elements which might affect the dose, monitoring parameters, or appropriateness of PCA use.</td>
<td>25%</td>
<td>25%</td>
<td>31%</td>
</tr>
</tbody>
</table>
Assessments Performed by Nurses Prior to and Following Administration of Parenteral Opioids
1) Naloxone use in patients on opioids/the number of patients prescribed opioids
   a. Inclusion criteria:
      i. Patients prescribed opioids within your organization
   b. Exclusion criteria:
      i. Diagnostic use (e.g., patients coming into the ED unconscious/obtunded and were administered naloxone to determine if an opioid was a causative factor)
      ii. Prevention or treatment of pruritus or nausea
   c. Measuring harm from opioid use
      a. Intent is not to have zero naloxone use
   d. If patient gets 2 doses = 1 “use”
2) Rapid response team (RRT) calls for patients on opioids/Total number of RRT calls?
   a) Inclusion criteria:
      i. RRT calls to rescue patients being treated with opioids (RRT call due primarily to the opioid)
Dr. Anita Gupta, DO, PharmD
Vice Chair, Pain Medicine & Regional Anesthesia
Drexel University College of Medicine
What We Will Review…..

- The Burden of the Opioid Epidemic
- Opioid Sparing Techniques and Multimodal Treatment
- What Hospitals Can Do
- Michigan HEN Best Practices
- Pennsylvania HEN Best Practices
- Facilitating Change
- Key Tools of the Trade
The Burden of the Opioid Epidemic

- Approximately 23 million people undergo surgery each year in the United States.
- Despite pharmacologic interventions, at least 40-50% of postoperative patients report inadequate pain relief.
- In last 10 years, pain patients are being treated more intensively and incurring greater costs, but without improvements in health status.
- And now 78 people die everyday from opioid overdoses.

Centers for Disease Control [www.cdc.gov](http://www.cdc.gov) and Institute of Medicine - Report on Pain
Striking a Balance of Pain Relief, Risk of Abuse and Multimodal Care Cost

- Patients using opioids are perceived to be especially difficult to manage, costly and complicated
- Large multidisciplinary groups are a particularly challenging arena as they must work within a capitated environment while endeavoring to improve the quality of care but at time of lowered reimbursements and insurance coverage
Understanding Multimodal Treatment
Characteristic of Postoperative Pain

- Somatic Pain
  - muscle, fascia, ligament
- Visceral Pain
- Nociceptor sensitisation
- Referred pain
- Reflex response
  - muscle spasm
- Cortical Responses
- Cutaneous Somatic pain
Multimodal (opioid-sparing) analgesia

Non-opioids
- Acetaminophen/Paracetamol
- NSAIDs

Opioids
- Tramadol? (‘weak’)
- Morphine (‘strong’)

Invasive approaches
- Regional anesthesia
  - Epidural or intrathecal
  - Nerve blocks
  - Neurolytic blocks
- [Intraventricular opioids?]
- [Percutaneous cervical cordotomy?]

Adjuvants
- Alpha-agonist
- Anticonvulsants
- Tricyclic antidepressants
- NMDA-receptor-channel blockers
- Na-receptor-channel blockers
- Antispasmodics
- Benzodiazepines
- Corticosteroids
- Muscle relaxants
- Radiopharmaceuticals
- Bisphosphonates

WHO principles
- ‘By the clock’
- ‘By the child’
- ‘By the appropriate route’
- ‘By the WHO ladder’

Integrative therapies
- Massage
- Heat/cold
- Deep breathing
- Biofeedback
- Hypnosis
THE MULTIMODAL APPROACH TO PAIN MANAGEMENT

- **Pharmacological treatment**: e.g. NSAIDs, opioids, adjuvants
- **Physical Therapies**: e.g. physiotherapy, exercises/stretches, TENS
- **Interventional Therapy**: e.g. procedures, surgery
- **Psychological Therapies**: e.g. counselling, treatment of depression
- **Patient Education**: e.g. knowledge about pain, realistic goals
Be proactive and take steps before opioid prescribed
Consider opioid discontinuation plan and discuss the real risks of using opioids.
What Hospitals Can Do and Why?
Why Do Hospitals Need Better Pain Services?

- Better Multimodal Treatment Options
- Growing Public Health Crisis
- CDC Opioid Guidelines
- JCAHO Standard
- Patient Bill of Rights
- Patient Satisfaction
- Decrease Length of Stay
- Less Opioid Related Complications
What Hospitals *Can* Do?

- Organize committees to address the epidemic, include patients, primary care, pain management, pharmacy, emergency room, and information technology and define clear responsibilities
- Develop benchmark data, standardize pain care using ERAS protocols or SOPs
- Emphasis on multimodal, multidisciplinary and biopsychosocial treatment models
- Frequent self-assessment tools for safe and responsible opioid use via integration of technology to engage and educate
- Increase safeguards when on opioid therapy such as naloxone, safe drug storage and disposal, and PDMPs checks
- Connecting services such as -- addiction consult services, social work, follow up appointments, detox programs and shelter
Michigan HEN Initiatives

Why it Works

CUSP Initiative
- Comprehensive and specific to population, changes culture, improves patient safety

Webinars/Annual Meetings Coaching Calls
- Demonstrates investment in education and multimodal therapies and raises the bar in education for community

Preoperative Checklist Gap Analysis MOSS Tools
- Establishes consensus and best practices, tangible tool to be used quickly and effectively, and provides documentation and provides clear action plan
Pennsylvania HEN Initiatives  Why it Works

- **Opioid Knowledge Self-Assessment**
  
  Identification of gaps in knowledge, raises the level of expectations, and eye opening self assessment tool

- **Organization Assessment of Safe Opioid Practices**
  
  Benchmarking data and creation of population based protocols that will improve process

- **Outcome Measures**
  - Naloxone Use
  - Rapid Response Team
  
  Establishes breadth and scope of educational need, provides documentation of effectiveness of collaborative actions plans
Facilitating Change & Anticipating Challenges

- Selecting A Champion
- Creating Structure and Accountability
- Adopting Staff-Driven Strategies
- Realistically Appraising the Need for Resources
- Anticipating and Addressing Staff Resistance and Culture Change Through Education
- Engaging in Robust Data Collection
Tools of the Trade....

- Multimodal and Multidisciplinary Therapy
- Organizing Committees
- Education
- Benchmark Data
- Best Practices
- ERAS Protocols
- Change Culture and Practice

TeamWork
“If we want more evidence-based practice, we need more practice-based evidence…..

Practitioners and their organizations represent the structural links (and barriers) to addressing the important health issues. Engage them.”

Open Q&A

Open session to all webinar participants.
Please virtually raise your hand if you would like to speak.
Next Steps: Where do we go?

- To learn more about CEPOP or to become an active participant, please visit www.CEPOPonline.org.

- To recognize other leaders in the fight against the opioid epidemic, nominate HERE!
To follow up on today’s webinar...

Rich Hamburg, Trust for America’s Health, rhamburg@tfah.org
The Honorable Mary Bono, FaegreBD Consulting, Mary.Bono@FaegreBD.com
Dr. Kate Goodrich, CMS Center for Clinical Standards and Quality, Kate.Goodrich@cms.hhs.gov
Michelle Norcross, Michigan Health & Hospital Association Keystone Center, MNorcross@mha.org
Matthew Grissinger, Hospital & Healthcare Association of Pennsylvania, MGrissinger@ismp.org
Dr. Anita Gupta, Drexel University College of Medicine, Anita.Gupta@drexelmed.edu
Matthew Rubin, FaegreBD Consulting, Matthew.Rubin@FaegreBD.com
Michael Adelberg, FaegreBD Consulting, Michael.Adelberg@FaegreBD.com