EQIC *ROADE Work* Office hour

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This meeting is for you!

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Data review

Let’s dig into the data

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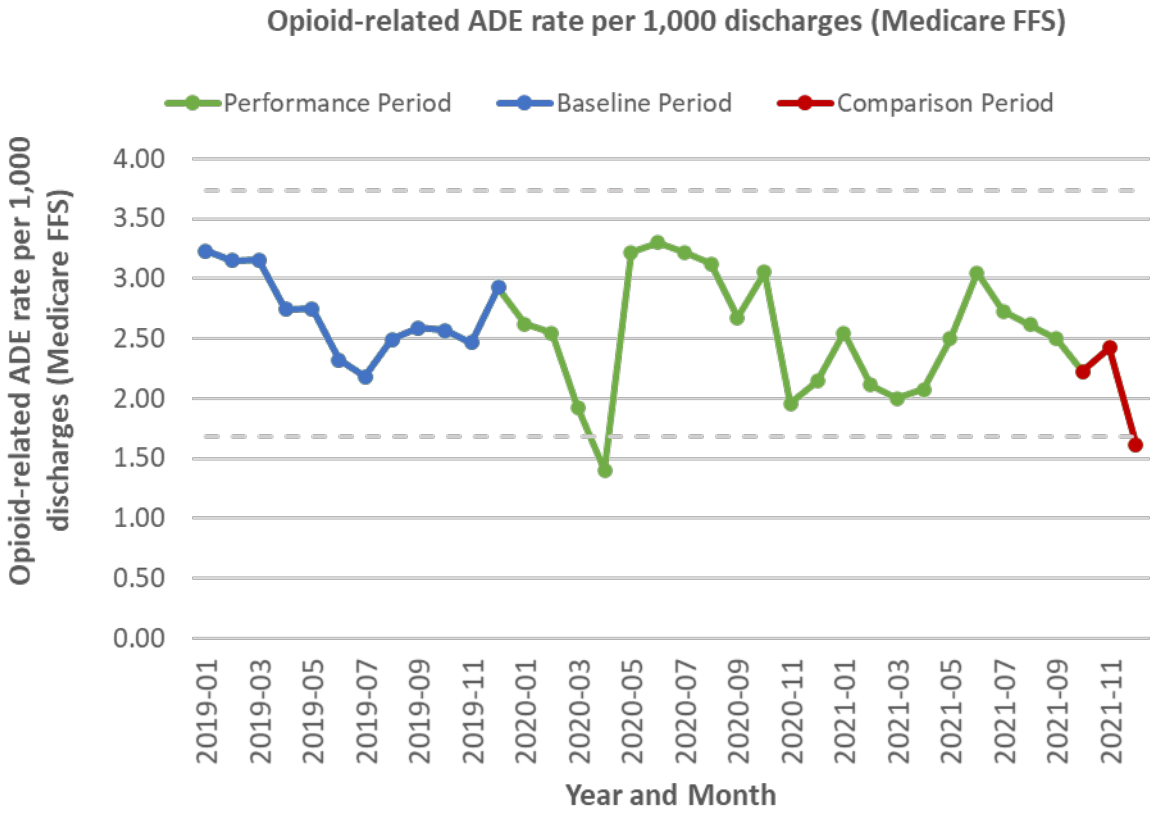
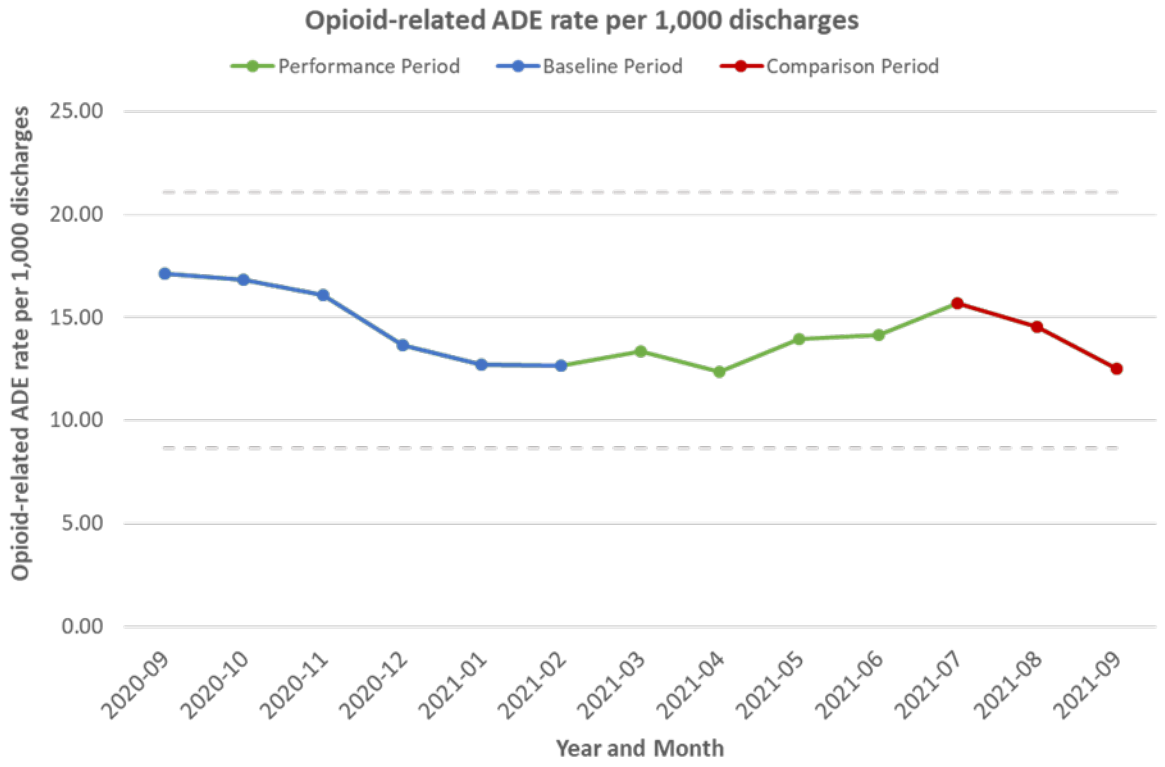
Data review - EQIC performance

CMS Goal: Reduce by 7%





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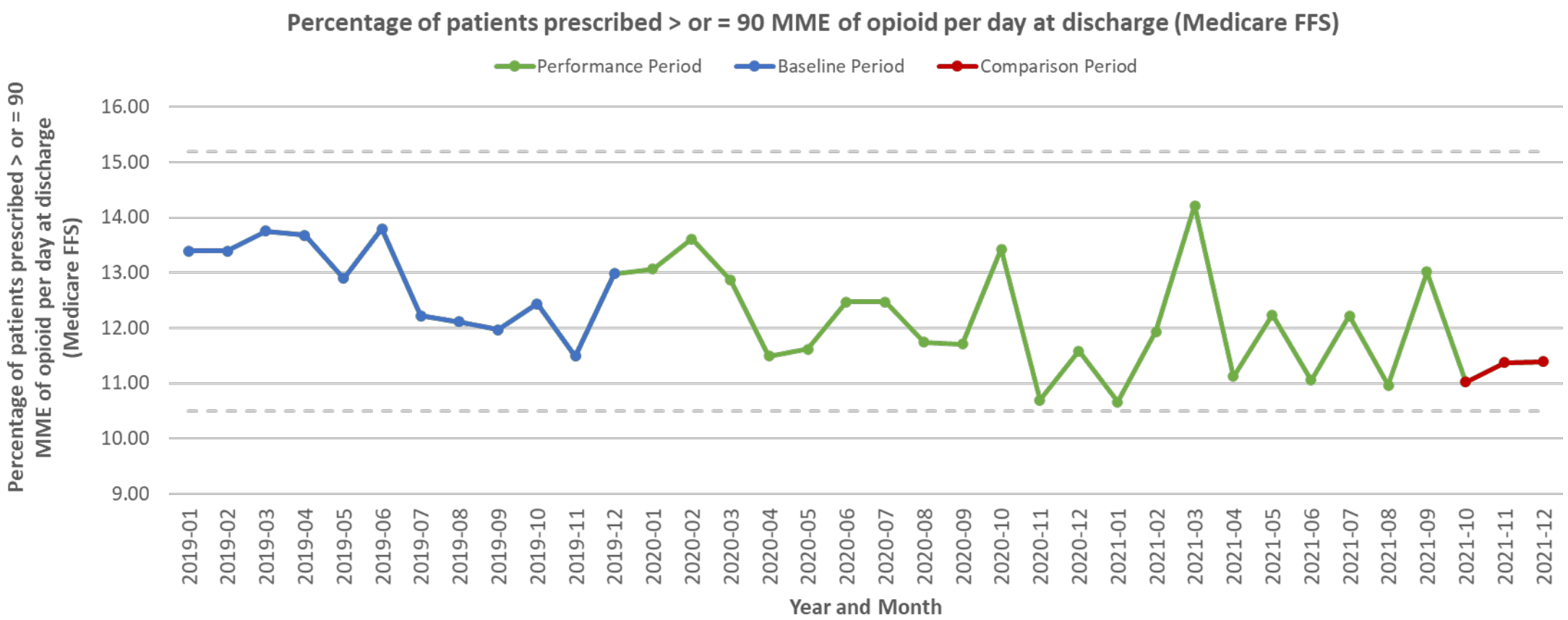
Data review - EQIC performance

CMS Goal: Reduce by 12%



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Take a trip down memory lane…

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July: Kickoff

- Gap analysis
- Develop multidisciplinary teams
- Report development

Adverse Drug Event Gap Analysis for Opioids

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The following checklist assesses a hospital's compliance with best practice strategies to reduce opioid-related adverse drug events.

EVIDENCE BASED BEST PRACTICE FOR OPIOIDS	IMPLEMENTATION STATUS			ACTION PLAN/NEXT STEPS
	FULLY	PARTIALLY	NONE	List specific activities your team will seek to accomplish to fully implement each practice recommendation.
HOSPITAL LEADERSHIP AND OVERSIGHT				
Hospital has a leader or leadership team that is responsible for safe opioid prescribing and development and monitoring of performance improvement activities related to opioids.	○	○	○	
Hospital routinely tracks and trends opioid usage and ADE data and information.	○	○	○	
Hospital routinely provides departments and physicians with opioid usage data and information such as: • referrals to medication-assisted treatment; • percent of patients discharged on opioids with Narcan prescriptions; • percent of patients with 90 MME or greater dosing; • percent of patients on co-occurring benzodiazepines; and • percent of patients on two or more opioids simultaneously.	○	○	○	
PATIENT RISK ASSESSMENT				
Standardized assessments are utilized throughout the hospital to assess the patient's: • opioid status (naïve v. tolerant); • respiratory risk factors; • sedation levels; and • risk of sleep apnea.	○	○	○	

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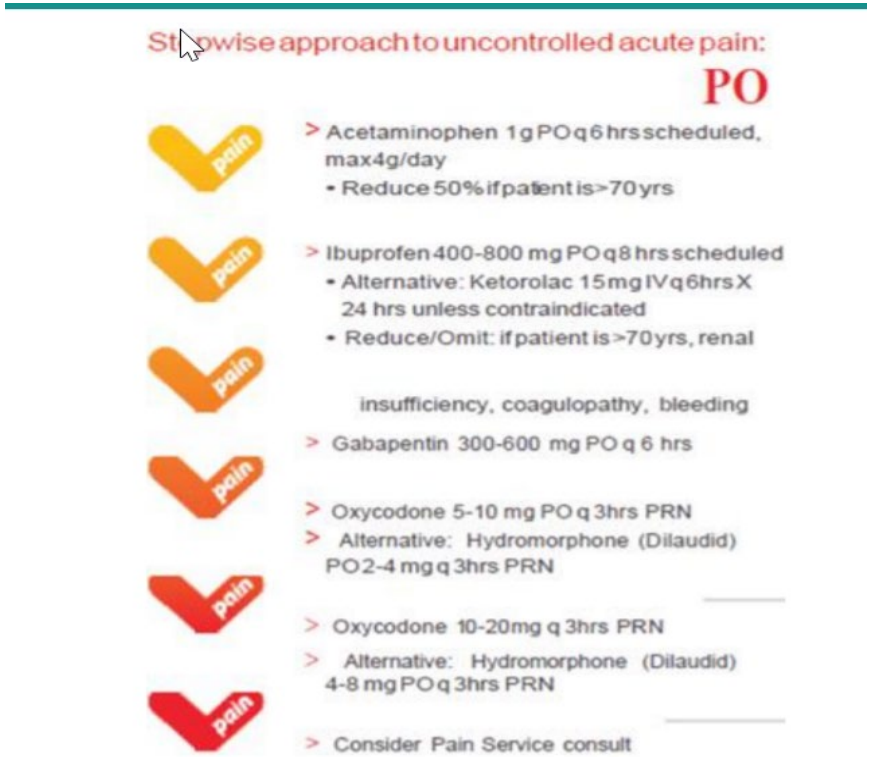
September: Prescribing best practices

- All patients should be screened and assessed for prior opioid history and sensitivity
- Consider multi-modal and stepwise approach to pain management
- Opioid should NOT be the first option for pain control
- Consider pharmacological alternatives such as anti-inflammatory drugs/acetaminophen
- Consider non-pharmacological alternatives such as physical therapy, dry needling, aromatherapy, acupuncture
- Pain management should be built on functional goals, not only pain management scales



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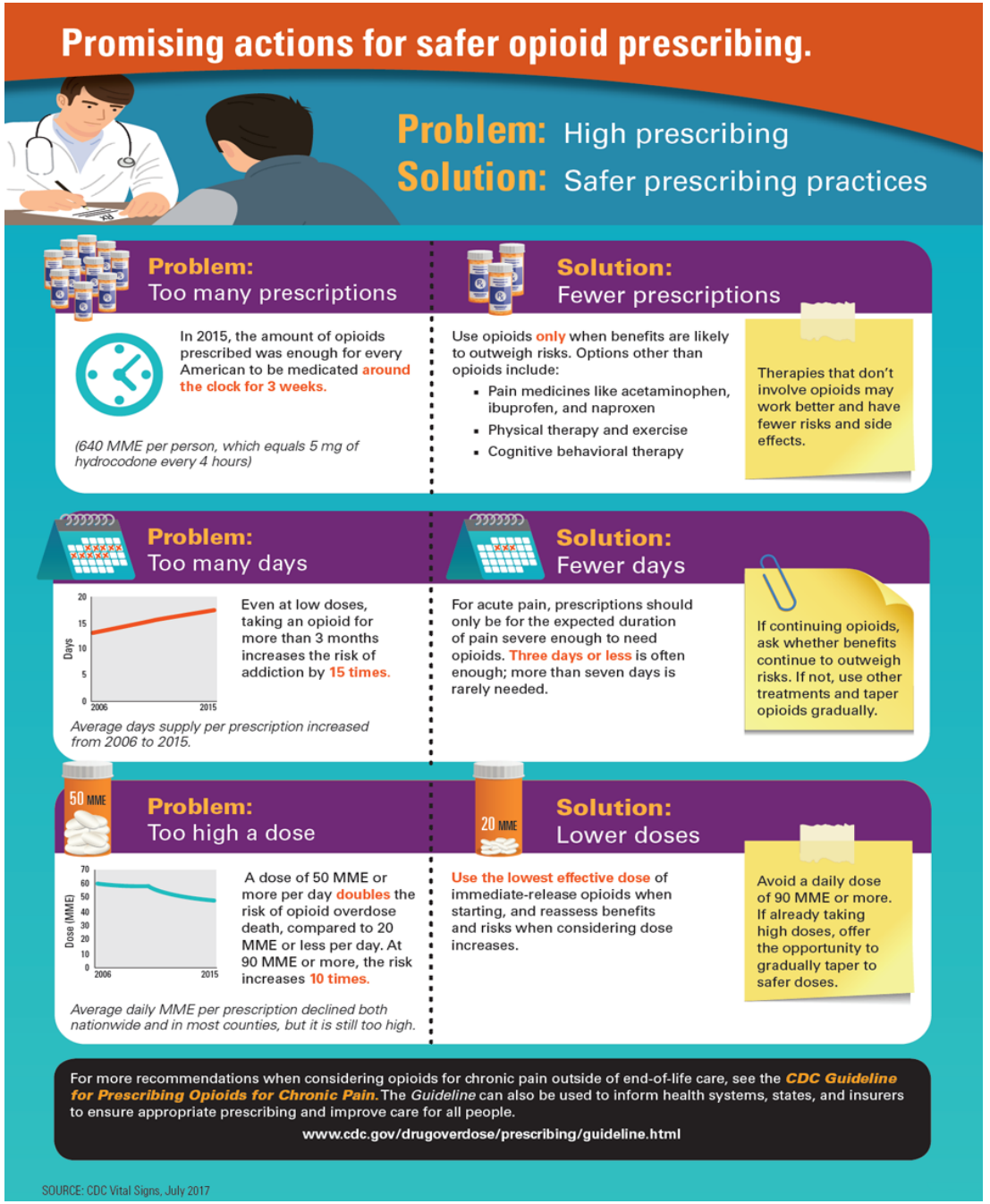
Prescribing best practices

- Assess patient's Opioid Naïve vs Tolerant status
- Co-prescribe Naloxone with Opioids
- Avoid co-prescribing opioids and benzodiazepines
- Avoid prescribing more than one opioid at a time
- Include pharmacology of opioids in decision-making process
- If still requiring opioids at discharge, limit amount of pills prescribed at discharge
- Avoid the exclusive use of opioids for pain management
- Utilize EHR decision-support where possible



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Prescribing best practices

- Always start with the lowest effective dose
- Reassess patient's opioid tolerance and adjust doses accordingly (opioid tolerant patients may require increased doses)
- Review daily MME targets; daily maximum is 90 MME, 50-90 is the recommended target
- Include PCA safety considerations
- Consider multimodal therapy to enhance pain management
- Use breakthrough or one-time dose for special indications

†Tapentadol is a mu receptor agonist and norepinephrine reuptake inhibitor. MMEs are based on degree of mu-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely mu receptor agonists.

Opioid	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone: 1-20 mg/day	4
Methadone: 21-40 mg/day	8
Methadone: 41-60 mg/day	10
Methadone: ≥61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol†	0.4

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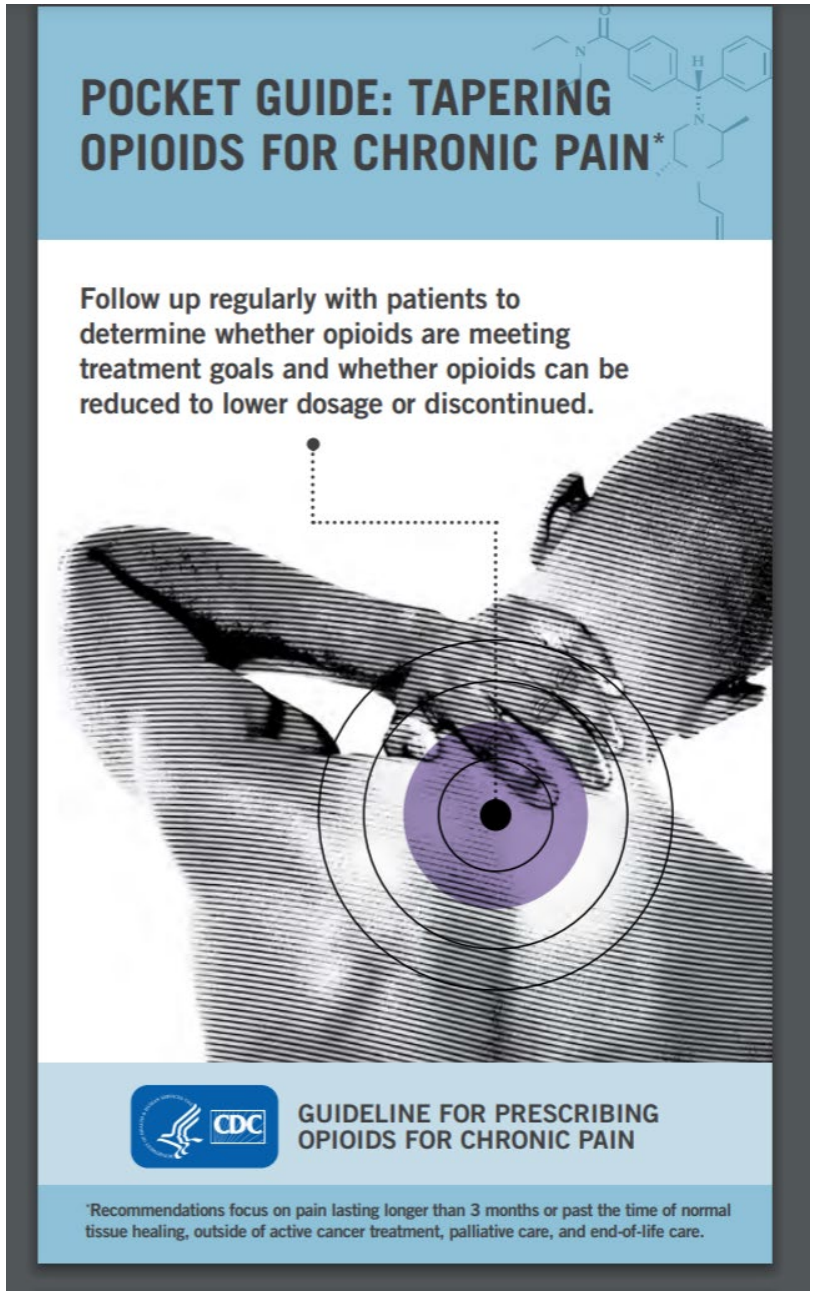
Prescribing best practices

- Consider opioid tapering if:
  - No clinically meaningful response to opioid treatment
  - Patient requests to cut back
  - Using doses greater than 50-90 MME daily
  - Showing signs of opioid use disorder
  - DSM V criteria
  - Demonstrates Pasero-Opioid Sedation Scale level 3 or 4
  - Experiences overdose or adverse events
- Opioid weaning considerations:
  - Rate of taper: Rates >10% associated with relapse/abuse (see CDC guidance)
  - Avoid arbitrary goals or treatment doses
  - Ensure primary care provider available to monitor tapering
  - Referral to Medication Assisted Treatment (MAT) as needed



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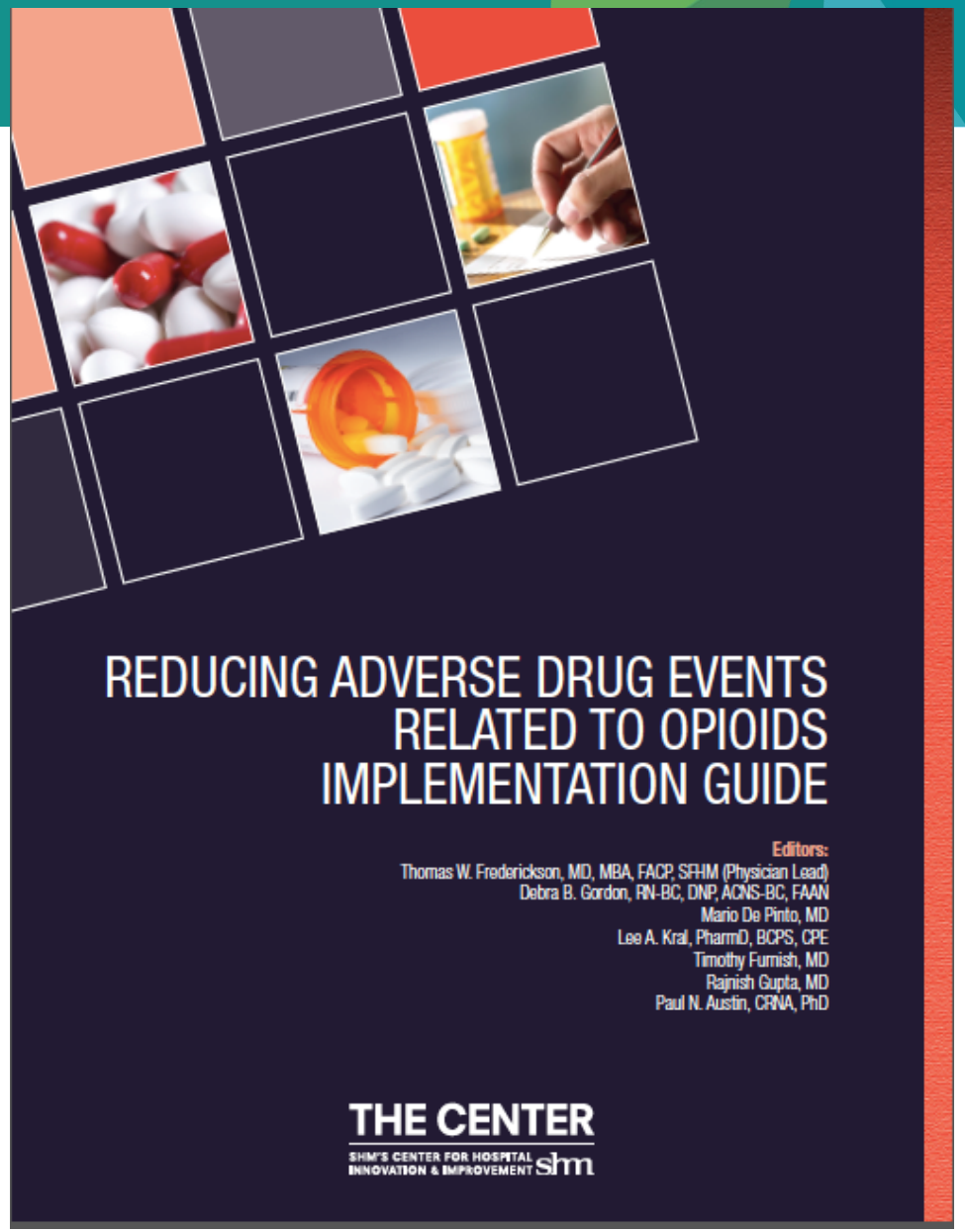
October: Reducing opioid-related ADE

- Vital signs
  - Evaluate with continuous pulse ox, if high-risk patient
- Assess pain and sedation pre- and post-medication administration
  - Pain score: CPOT screener for delirious patients, functional pain scale for alert patients
  - Sedation: PASERO for awake, alert patients; Richmond Agitation Sedation Score for intubated and sedate patients; Ramsay for patients wakening from sedation
- Evaluate underlying conditions or clinical problems that may increase or cause pain
- Supplemental oxygen: Opioids and supplemental oxygen can be a very dangerous combination—measuring more than oxygen saturations is important



Reducing opioid-related ADE

Mitigating opioid-related ADE

- Naloxone: should be available in all clinical areas, as well as co-prescribed for patients on opioids
- Weaning: titration should be carefully monitored
- Opioid alternatives: pharmacologic and non-pharmacologic
- Medication Assisted Treatment (MAT)
- Consider mental health support in treatment plans
- Avoid starting opioids when not necessary

November: Targeted areas

Emergency department

- Ensure patient has a primary care provider to follow up on medication management
- Prescriptions should be written for the shortest duration appropriate (no more than 3 days)
- Patients suspected of substance use disorder should be screened
- Emergency department should not dispense prescriptions for controlled substances that were lost, destroyed, stolen or finished prematurely
- Emergency department and urgent care providers, or other designees, should reference prescription drug monitoring program resources
- Consider Medication-assisted treatment (MAT) with buprenorphine as a strategy to reduce OUD

Targeted areas

- *Perioperative Counseling*
  - Discuss the expectations regarding recovery and pain management goals with the patient
  - Educate the patient regarding safe opioid use, storage and disposal
  - Determine the patient's current medications (e.g., sleep aids, benzodiazepines) and any high-risk behaviors or diagnosis (e.g., substance use disorder, depression or anxiety)
  - Do NOT provide opioid prescription, for postoperative use, prior to surgery date
- *Intraoperative*
  - Consider nerve block, local anesthetic catheter or an epidural when appropriate.
  - Consider non-opioid medications when appropriate (e.g., ketorolac)
- *Postoperative*
  - Ensure written discharge instructions communicate consistent messaging regarding functional pain management goals

January: Stigma

- Consider language carefully
- Engage patient/family/caregiver
- Recognize implicit bias

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Next steps

- PDSA Cycles, ongoing improvement
- EQIC will revisit opioid work towards Q4 2022
- Capstone webinar
- Other questions can be discussed in listserv

Thank you.

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