

# EQIC *ROADE Work* Office hour

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February 22, 2022



## EQIC

EASTERN US QUALITY  
IMPROVEMENT COLLABORATIVE

# This meeting is for you!



# Data review



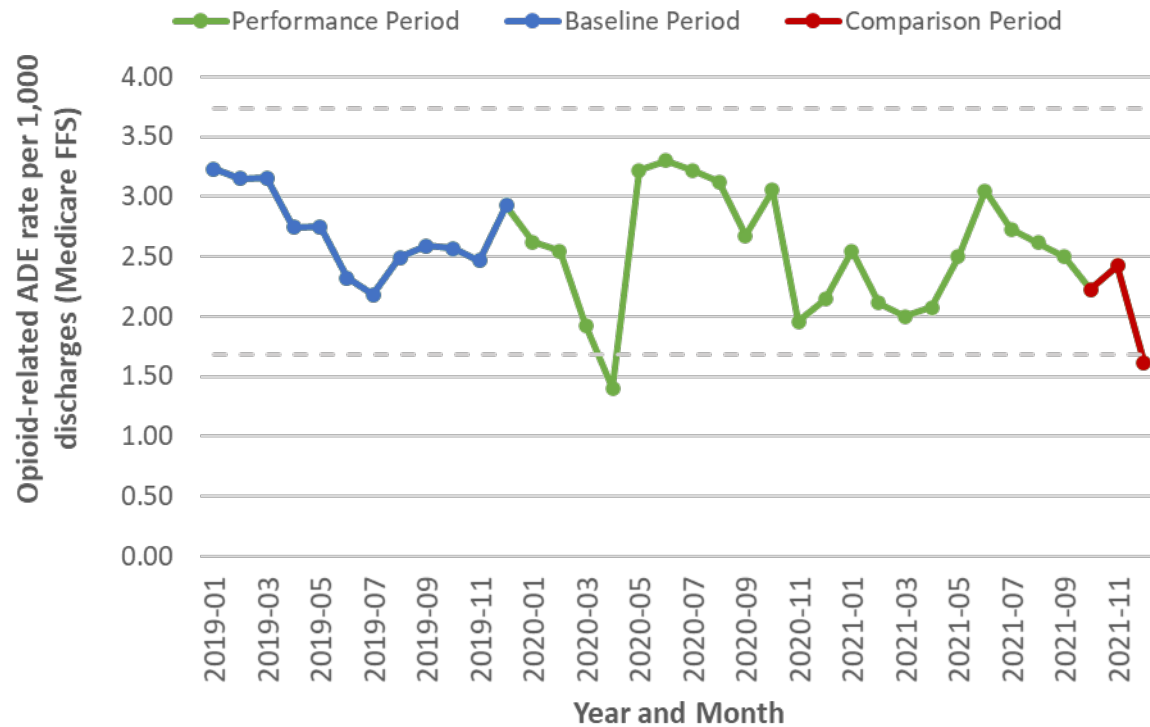
Let's dig into the data



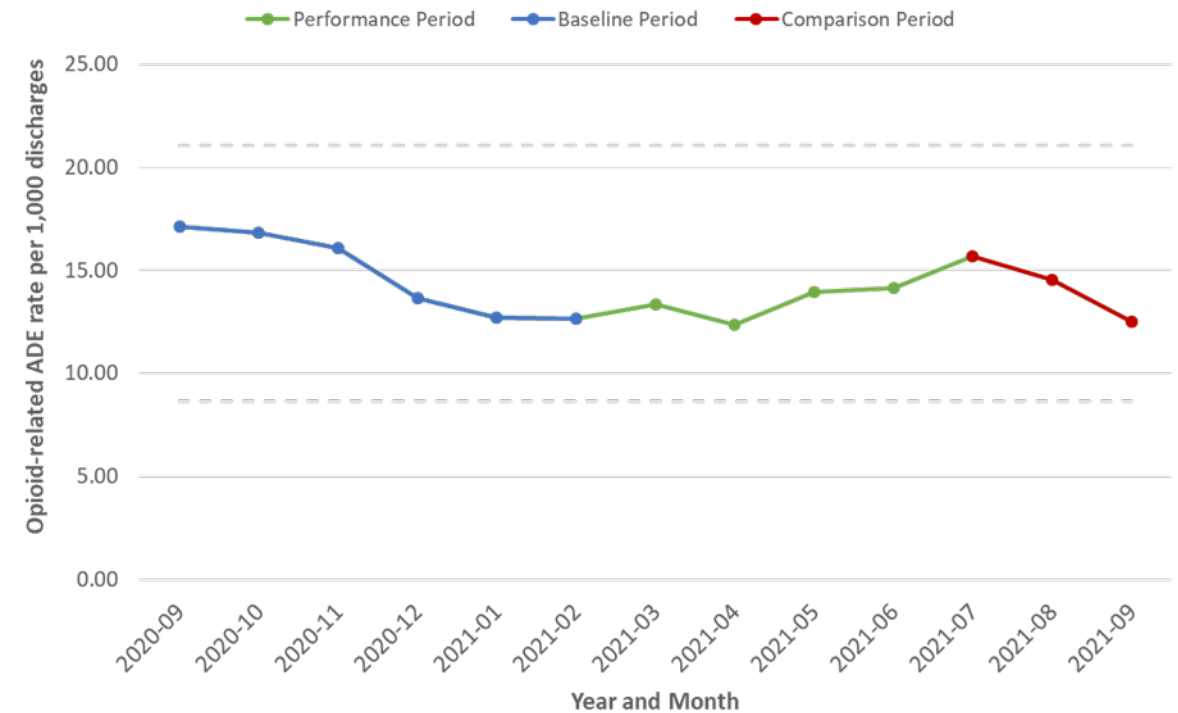
# Data review - EQIC performance

CMS Goal: Reduce by 7%

Opioid-related ADE rate per 1,000 discharges (Medicare FFS)



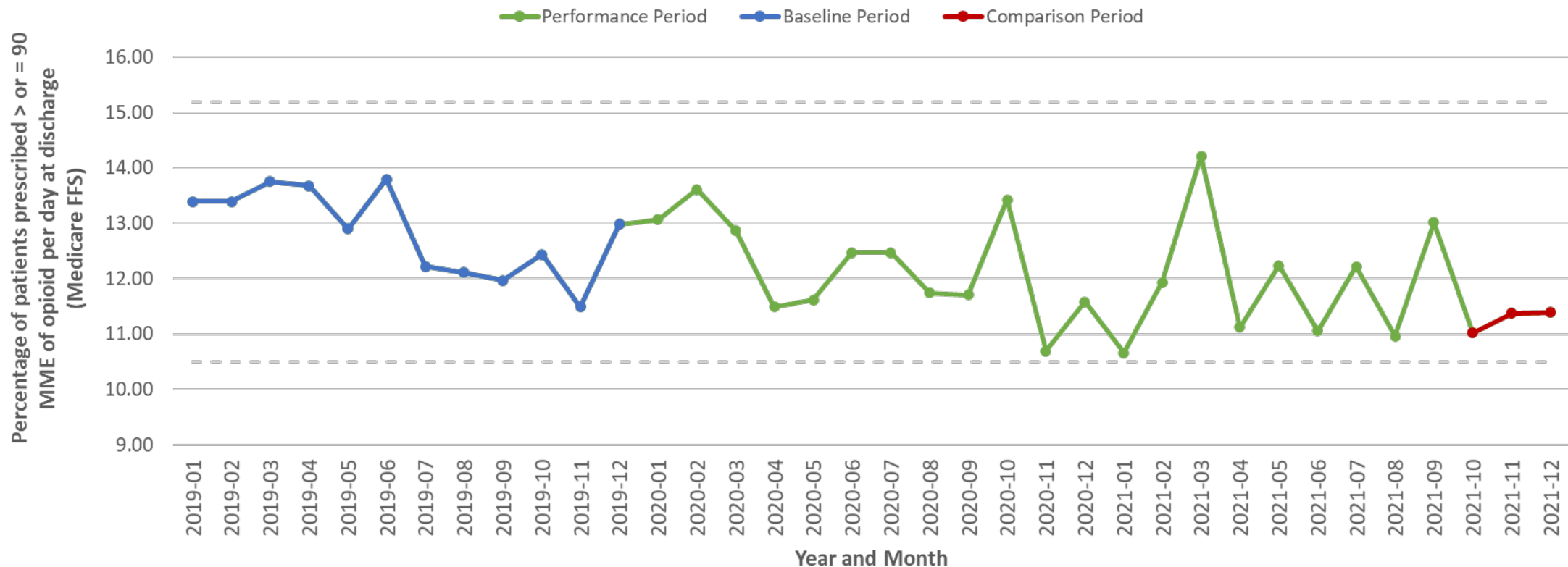
Opioid-related ADE rate per 1,000 discharges



# Data review - EQIC performance

CMS Goal: Reduce by 12%

Percentage of patients prescribed > or = 90 MME of opioid per day at discharge (Medicare FFS)





# Take a trip down memory lane...



# July: Kickoff

- Gap analysis
- Develop multidisciplinary teams
- Report development

## Adverse Drug Event Gap Analysis for Opioids



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  List specific activities your team will seek to accomplish to fully implement each practice recommendation.
	FULLY	PARTIALLY	NONE	
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hospital routinely tracks and trends opioid usage and ADE data and information.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hospital routinely provides departments and physicians with opioid usage data and information such as: <ul style="list-style-type: none"><li>• referrals to medication-assisted treatment;</li><li>• percent of patients discharged on opioids with Narcan prescriptions;</li><li>• percent of patients with 90 MME or greater dosing;</li><li>• percent of patients on co-occurring benzodiazepines; and</li><li>• percent of patients on two or more opioids simultaneously.</li></ul>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
PATIENT RISK ASSESSMENT				
Standardized assessments are utilized throughout the hospital to assess the patient's: <ul style="list-style-type: none"><li>• opioid status (naïve v. tolerant);</li><li>• respiratory risk factors;</li><li>• sedation levels; and</li><li>• risk of sleep apnea.</li></ul>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

# 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

## Stepwise approach to uncontrolled acute pain:

**PO**


- 
- > Acetaminophen 1g PO q 6 hrs scheduled, max 4g/day
    - Reduce 50% if patient is > 70 yrs
  - > Ibuprofen 400-800 mg PO q 8 hrs scheduled
    - Alternative: Ketorolac 15 mg IV q 6 hrs X 24 hrs unless contraindicated
    - Reduce/Omit: if patient is > 70 yrs, renal insufficiency, coagulopathy, bleeding
  - > Gabapentin 300-600 mg PO q 6 hrs
  - > Oxycodone 5-10 mg PO q 3 hrs PRN
    - Alternative: Hydromorphone (Dilaudid) PO 2-4 mg q 3 hrs PRN
  - > Oxycodone 10-20 mg q 3 hrs PRN
    - Alternative: Hydromorphone (Dilaudid) 4-8 mg PO q 3 hrs PRN
  - > Consider Pain Service consult



# 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

## Promising actions for safer opioid prescribing.



**Problem:** High prescribing

**Solution:** Safer prescribing practices

 <p><b>Problem:</b> Too many prescriptions</p> <p>In 2015, the amount of opioids prescribed was enough for every American to be medicated <b>around the clock for 3 weeks.</b></p> <p>(640 MME per person, which equals 5 mg of hydrocodone every 4 hours)</p>	 <p><b>Solution:</b> Fewer prescriptions</p> <p>Use opioids <b>only</b> when benefits are likely to outweigh risks. Options other than opioids include:</p> <ul style="list-style-type: none"> <li>• Pain medicines like acetaminophen, ibuprofen, and naproxen</li> <li>• Physical therapy and exercise</li> <li>• Cognitive behavioral therapy</li> </ul> <p>Therapies that don't involve opioids may work better and have fewer risks and side effects.</p>
 <p><b>Problem:</b> Too many days</p> <p>Even at low doses, taking an opioid for more than 3 months increases the risk of addiction by <b>15 times.</b></p> <p>Average days supply per prescription increased from 2006 to 2015.</p>	 <p><b>Solution:</b> Fewer days</p> <p>For acute pain, prescriptions should only be for the expected duration of pain severe enough to need opioids. <b>Three days or less</b> is often enough; more than seven days is rarely needed.</p> <p>If continuing opioids, ask whether benefits continue to outweigh risks. If not, use other treatments and taper opioids gradually.</p>
 <p><b>Problem:</b> Too high a dose</p> <p>A dose of 50 MME or more per day <b>doubles</b> the risk of opioid overdose death, compared to 20 MME or less per day. At 90 MME or more, the risk increases <b>10 times.</b></p> <p>Average daily MME per prescription declined both nationwide and in most counties, but it is still too high.</p>	 <p><b>Solution:</b> Lower doses</p> <p>Use the <b>lowest effective dose</b> of immediate-release opioids when starting, and reassess benefits and risks when considering dose increases.</p> <p>Avoid a daily dose of 90 MME or more. If already taking high doses, offer the opportunity to gradually taper to safer doses.</p>

For more recommendations when considering opioids for chronic pain outside of end-of-life care, see the **CDC Guideline for Prescribing Opioids for Chronic Pain.** The *Guideline* can also be used to inform health systems, states, and insurers to ensure appropriate prescribing and improve care for all people.

[www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

SOURCE: CDC Vital Signs, July 2017

# Prescribing best practices

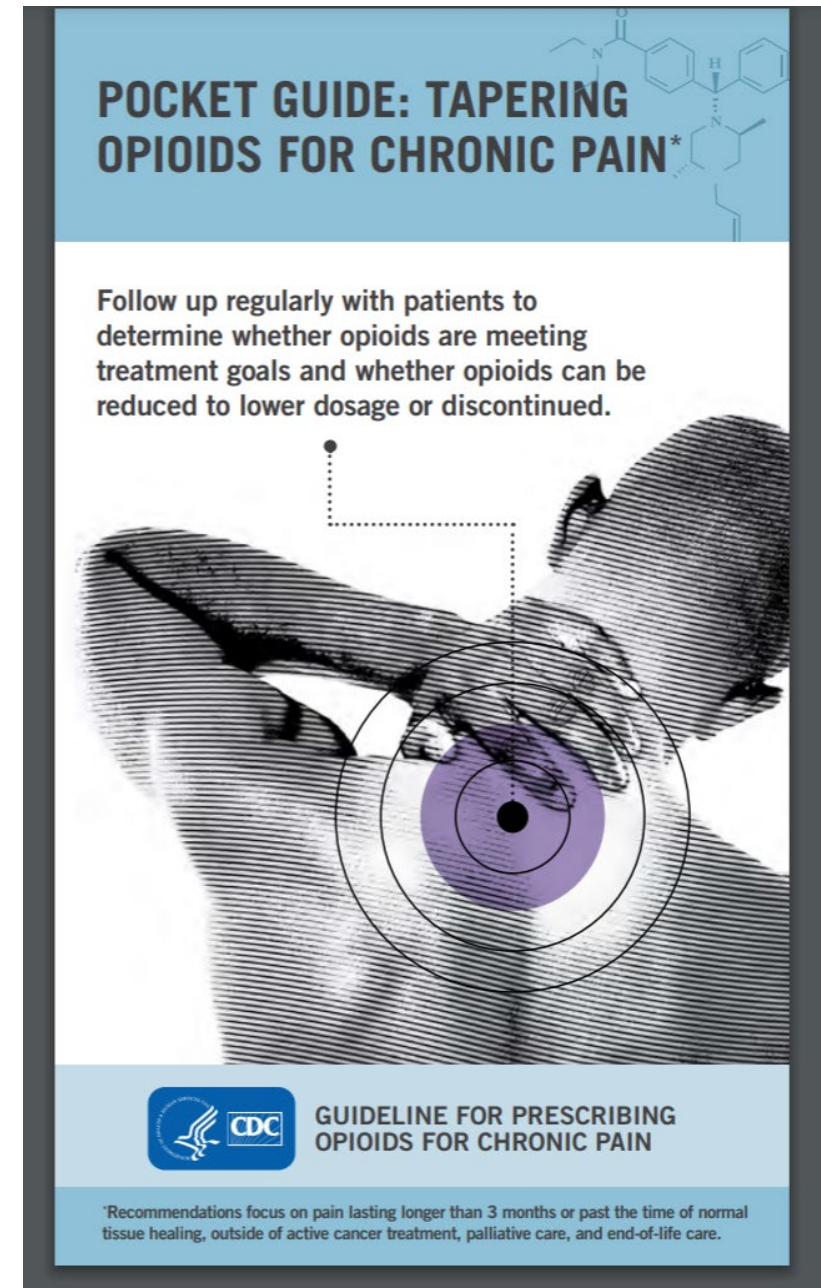
- Always start with the lowest effective dose
- Reassess patient's opioid tolerance and adjust doses accordingly (opioid tolerant patients may require increased doses)
- Review daily MME targets; daily maximum is 90 MME, 50-90 is the recommended target
- Include PCA safety considerations
- Consider multimodal 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 <sup>†</sup>	0.4

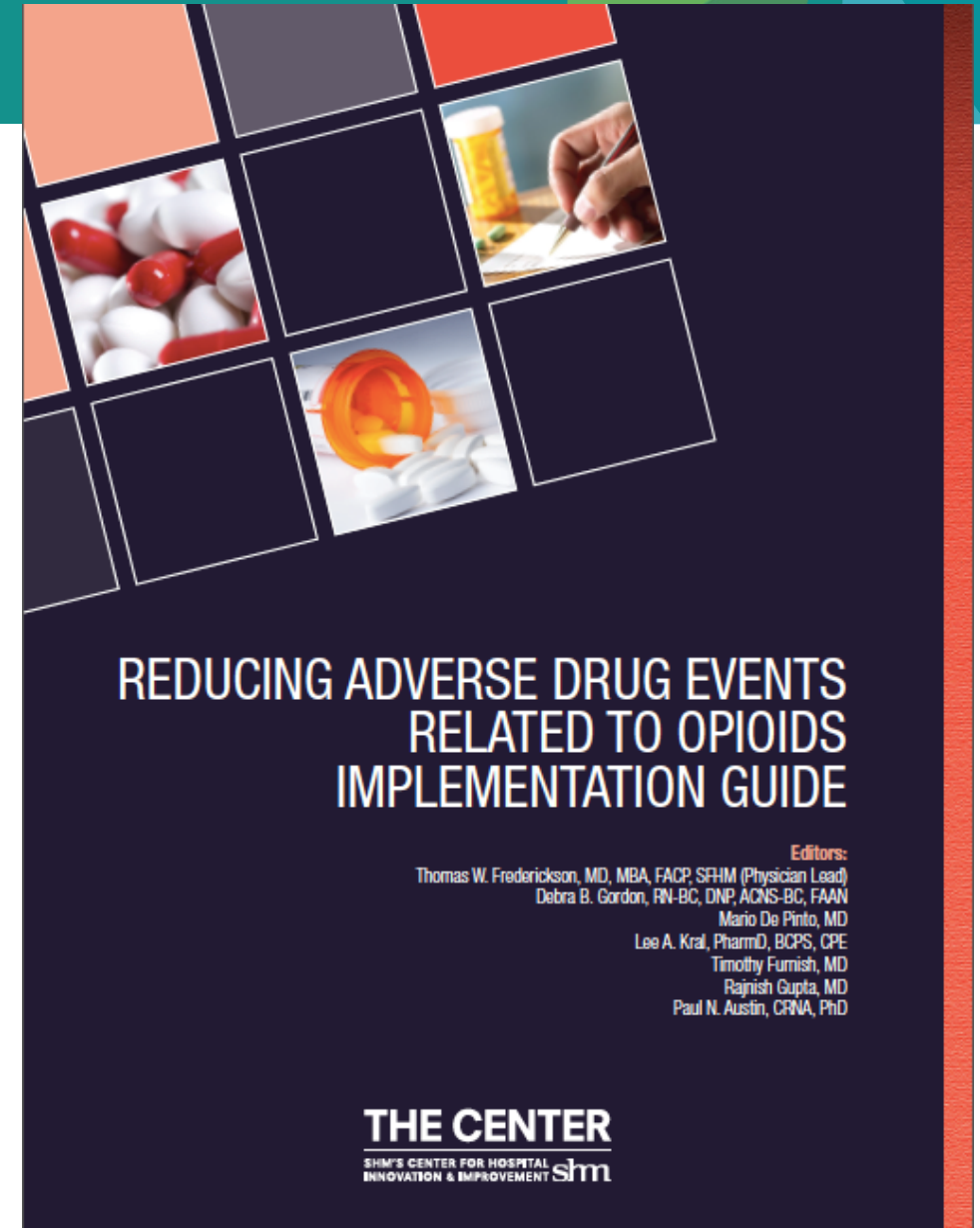
# Prescribing best practices

- 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



# 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 waking 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



# 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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