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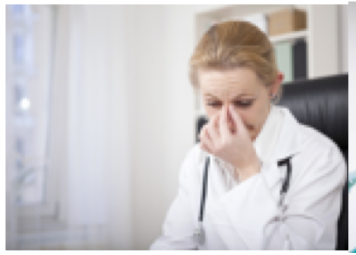
Opioid Stewardship: It Takes a Village
Why? What? How?

Governance Advisory Council
October 31, 2018

Why Do We Care? The Purpose



- Devasting effects of opioid crisis; role of providers in prescribing behaviors and contributing to harm
- Provider burnout and personal impact of opioid prescribing on well-being
- Stress on patient/provider relationships
- Caring for increasingly complex patients with more “acute on chronic” pain
- Adverse impact on our surgical and other quality outcomes
- Extensive public attention on addressing opioid crisis with increasing mandates on horizon

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Where did we start?

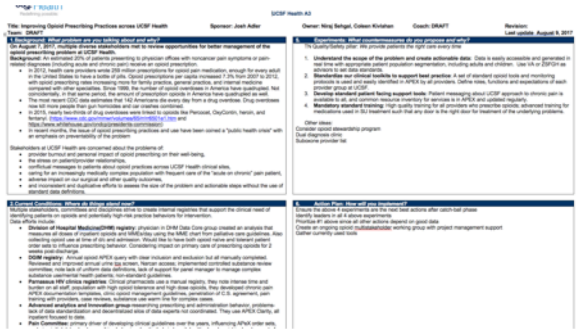
Identified large multidisciplinary taskforce

Fall 2017

Key Questions:
* Why does this problem exist?
* What are the key gaps and barriers we need to address?
* Where should we focus our priorities to make the greatest impact over the next 12-18 mos?

Current State Assessment:
* Many stakeholder meetings
* Learn from areas already doing opioid improvement work
* Learn from other organizations
* SWOT analysis (next slide)

Development of Strategic A3



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What did we learn about our current state?

Strengths

- Established UCSFMC Opioid Equivalence Table
- Patient Provider Agreement Templates Developed
- CURES Best Practice Alert Being Developed
- Many Local Opioid Improvement Initiatives
- Engagement for Opioid Improvement VERY High

Weaknesses

- Lack of Morphine Equivalent Calculator in APeX
- Lack of Opioid Clinical Decision Support
- Lack of Best Practice Guidelines for Prescribing
- Lack of Meaningful Metrics to Drive Improvement
- No Opioid Data Definitions, Standards or Governance

Opportunities

- Align, Govern & Leverage Current Opioid Efforts
- CURES Report Mandate Effective October 2018
- Epic 2018 Updates: Ambulatory-Based Opioid Registry in Healthy Planet Being Offered
- Multiple Services and Residency Programs Choosing to Focus on Opioid Stewardship Initiatives in FY19

Threats

- No Consistent Messaging to Patients
- Lack of Resources for Pain Management Services/Support
- Lack of Visibility for Opioid Stewardship as a Priority

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What did we identify as our Key Priorities?

A Roadmap for Opioid Stewardship

1. Create actionable data to understand the scope of the problem & drive improvement
2. Standardize clinical tools & guidelines to support best practices across our care settings
3. Develop patient-facing tools to support patient engagement, education and relationships
4. Provide training to our clinical workforce that reinforces the above priorities

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Principle: Let's Not Recreate What Others Have Done

- Formed an *Opioid Data Strategy Workgroup* that reviewed: current opioid reports within UCSF Health, data consistency and inconsistency across settings, current data definitions/standards (to align to CDC guidelines), and best practices for data governance from other organizations (including our colleagues at SFVA)

Goals:

- ✓ Create an opioid data strategy that allows us to assess, monitor, and improve opioid prescribing practices (and related quality metrics) across all care settings
- ✓ Learn from what current groups are doing (e.g., local examples of opioid improvement work in both ambulatory and inpatient settings) that could inform and align a common set of data solutions and tools
- ✓ Learn from other organizations and their approaches to opioid stewardship

Fast Forward: August 2018 Opioid Summit

Goals: community-building for opioid stewardship, engagement into improvement work, and crowdsourcing for input into 4 Key Priority Areas

- *Learn from representative Case Studies across UCSF Health*
- *Define centralized solutions for decentralized implementation/innovation*

~65 participants across disciplines, departments and clinical settings

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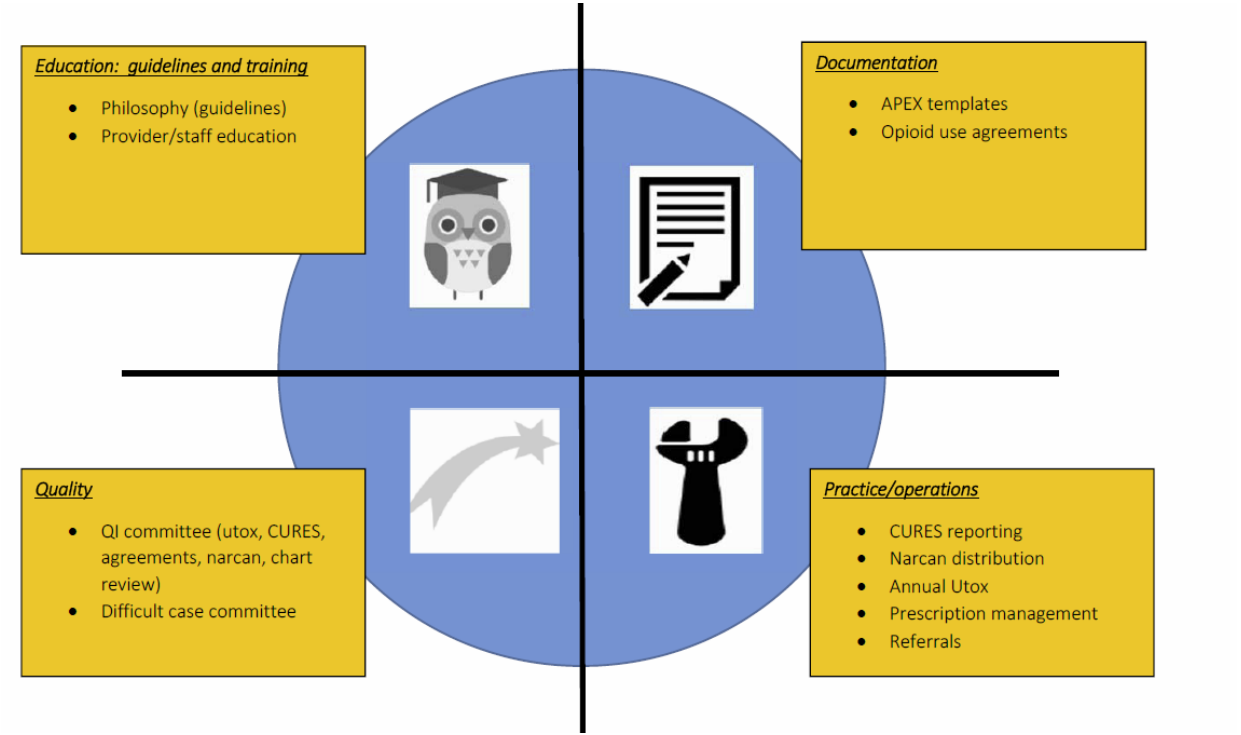
CASE STUDY #1: OPIOID STEWARDSHIP IN POSITIVE HEALTH

Jennifer Cocohoba, PharmD & Cristina Gruta, PharmD



- *Opioid stewardship = coordinated interventions designed to improve and measure the appropriate use of opioids by promoting the selection of the optimal regimen, dose, duration of therapy, and route of administration. Stewards seek to achieve optimal clinical outcomes related to use, minimize toxicity and other adverse events including addiction, and reduce overall costs of health care, and minimize impact of release of opioids into the community setting.*

As adapted from IDSA's definition of antimicrobial stewardship

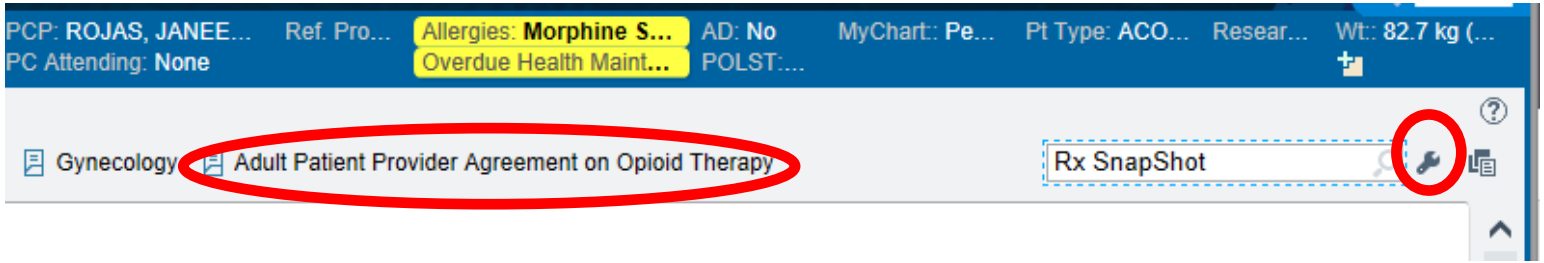
CASE STUDY #1 DOCUMENTATION: OPIOID USE AGREEMENTS

Opioid use agreements

- Philosophy/approach – informed consent
- Focus on chronic opioid therapy patients; eventually ANY opioid prescription
- Providers shown how to "wrench" in agreement template in APEX

Proposed process

- Problem based charting
- Add "Opioid use agreement exists" Code = Z02.89 to problem list
  - Write in date you started/renewed it
- Filed/scanned into scanned clinical documents



GOAL: 90% of patients prescribed chronic opioids will have an opioid use agreement problem in problem list by March 2018 & 90% will have current agreement by 12/2018. Baseline ~20%.

Case Study #2: Evaluating the Ability to Influence Opioid Prescribing Patterns and Use Among Older Adults following Discharge from an Inpatient Setting

Andy Auerbach MD (PI), Stephanie Rogers MD, Daphne Stannard RN, Ashley Thompson Pharm D, Sarah Brynelson RN

- Creation of first-in-nation Epic-native Oral Morphine Equivalent calculator for use in inpatients
  - Key step in identifying patients at high risk for adverse events related to opioids
- Physician, nursing, and pharmacist decision support for patients on opioids
  - Instructions on tapering, use of non-opioid medications, discontinuation of problematic medications
  - Placing patient into a 'work queue' for potential 'human touch' interventions (e.g. pharmacy consult, post-acute phone calls)
- Improved discharge guidance
  - Enhanced After Visit Instructions for patients
  - Instructions to referring and primary care physicians about how to reduce risk and taper off opioids after discharge.

intellix solutions

CDC Centers for Disease Control and Prevention

UCSF University of California San Francisco

Case Study #2 Learning Health System Approach

- Outcomes:
  - Readmissions, ED visits, and clinic visits to UCSF (all, as well as those related to falls and injuries related to falls), and readmissions with possible opioid-related side adverse events
  - Patient reports of pain, mobility, and use of opioids at 14, 30, and 90 days.
  - Patient reports of unexpected returns to hospital, ED, and clinic due to falls.
  - Patient reports of referrals to specialists and physical therapy (PT), educational recommendations, and use of community resources.

❖ Primary care providers awareness and understanding of opioid prescribing practices (In development)

❖ UCSF provider (MD, RN, Pharmacist) awareness of how to taper off opioids, prescriptions at discharge.

Case Study #3: Reducing Opioids at Discharge in Surgery

Opiate Naïve Patients

Guidelines

	Total Patients	No Opioid Rx	# Norco Pills
Thyroid Parathyroid	774 (90%)	28 (4%)	26 25 0
Lap Ventral Hernia	86 (76%)	2 (2%)	67 47
Inguinal Hernia	264 (87%)	10 (4%)	41 35 15
Lap Chole	300 (81%)	20 (7%)	37 35 15
Lap Appy	195 (90%)	14 (7%)	29 29 15
Anorectal	378 (62%)	91 (24%)	33 21

Elizabeth Lancaster (Surg Resident) & Liza Wick (Faculty)

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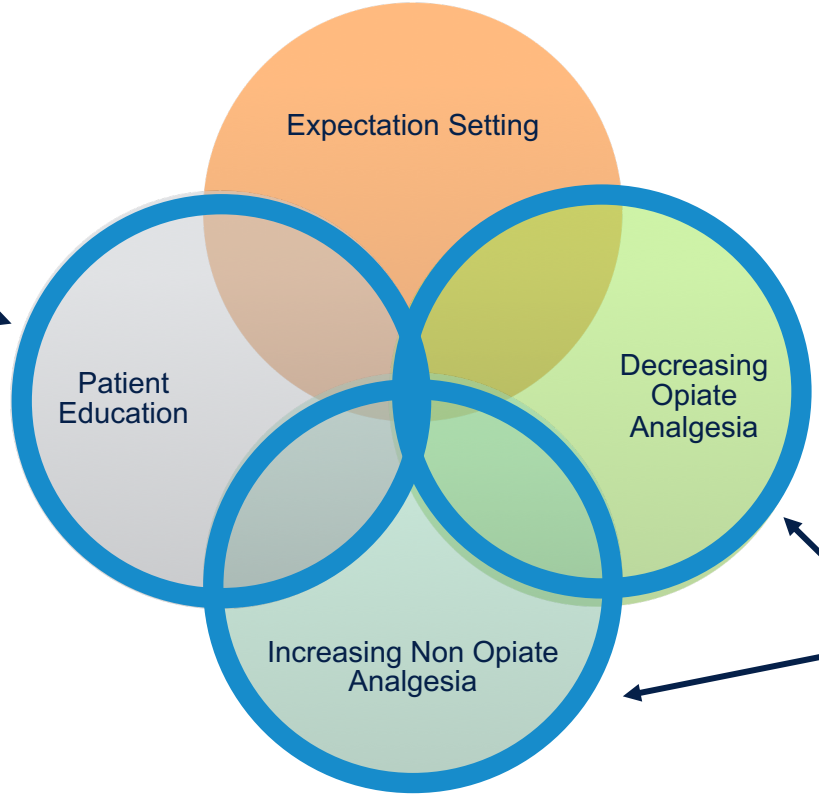
Case Study #3: Reducing Opioids at Discharge in Surgery

Standardized Discharge Instructions



Discharge Recommendations
Discharge Order Set
Provider Education
Provider Feedback

Elizabeth Lancaster (Surg Resident) & Liza Wick (Faculty)

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Case Study #3: 2018-2019 Surgery GME QI Project

Goals:

1. Use non opioid analgesia as the first line approach for pain management on discharge (>90%)
2. Use standardized discharge instructions on postoperative pain management in the discharge instructions (>90%)

Procedures:
Laparoscopic cholecystectomy, laparoscopic appendectomy, laparoscopic ventral hernia repair, laparoscopic and open inguinal hernia repair, thyroid and parathyroid resections, anorectal procedures

Elizabeth Lancaster (Surg Resident) & Liza Wick (Faculty)

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Crowdsourcing: August 2018 Opioid Summit

Priorities	Categories	Post-Its	Votes
Priority 1: Create actionable data to understand the scope of the problem and drive improvement	Define Data Standards	Ability to request meaningful data and receive the same thing no matter who I ask	5
		Data fields within APeX that allows providers to state how they addressed patients pain (if pt. in pain)	
		Data on/ tools to measure engagement in care (as a measure of opioid impact)	
		Include patient reported measures to understand problem deeper	
	Define Performance Metrics (structure, process and outcome)	Datasets that include inpatient and outpatient clinical and financial data	4
		Mechanisms for real time provider/prescriber feedback about their prescribing patterns	14
		Data around appropriate prescribing of long acting opioids	
		Longitudinal datasets to better understand risk factors, predictors of opioids misuse and impact on patient level outcomes	4
		Data that is as close to real time as possible	
		OME patient level data	
		Brainstorm and track possible unintended consequences of opiate Rx during implementation (i.e. other high risk med use or ↑ pain)	3
		How many patients with new Rx are in opioids and 2 months post discharge	
		To include variation in practices	
		A way to track patients pain score over time (with corresponding opioid prescription or timeline)	
Priority 2: Standardize clinical tools and guidelines to support best practices across care settings	OME Calculator (Define "at risk" patients)	Standardized, universal (UCSF and external benchmark, if possible) OME algorithm with standard handling of data e.g. median vs. mean	20
		One definition of an OME	
		OMEs visible at time of discharge (or time of prescribing) to guide best practices	
		Pain tab in APeX that makes OMEs visible	
Priority 3: Develop patient-facing tools to support patient education, engagement, and relationships	Categories: Promoting AVS Standards, Opioid Stewardship Campaign, Patient Education Materials	with motivational interviewing and teach back	
		Patient-facing educational campaign (opioid stewardship)	4
		Multilingual patient education materials	
		After-visit summary standard opioid language	
		Educate patients more on goals of pain treatment and less on just numeric rating scales	
		Patient-facing materials should also be posted online, so providers can send them to patients before a visit, surgery, etc.	
		Patient education re: different treatment modalities offered at UCSF and how to navigate	3
		Widely available education material on pain management, particularly in the periop setting	5
		EMMI model for opioids for patient education	

Priorities	Categories	Post-Its	Votes
Priority 4: Provide training to our clinical workforce that reinforces priorities #1-3	Pain Management & Opioid Stewardship 101	Education - appropriate use of pain scales	8
		More education of providers on how to manage patients on high OMEs	
		Clinical guidelines around opioid use, training	
		Guidelines on non-opiate pain treatments and brief evidence	
		Increase complimentary med Rx options for chronic pain	
		Non-pharm: Integrative Medicine access, massage, acupuncture	
		Standardized provider education to all nurses about opioids and opioid safety either on orientation and/or other mandatory class	
		Educate on how to manage patient behavior exhibited related to addiction issues (avoid abandonment but manage)	
		Nursing - functional pain scale	
	Treatment-Specific Training (MAT, Narcan, Bupro)	Protocol or specific service for buprenorphine induction in hospital	6
		Improve system for giving naloxone to all high risk patients across the health system	5
		Identifying outlier prescribers and targeting provider education to their individualized needs	
		More widely available DEA waiver training	
		Training on CAM, acupuncture, other non-pharm pain treatments	
Other: What did we miss within our 4 priorities		$, resources, people. This will be critical	9
		Actual addiction-trained specialists hired by the health system to assist with complex patients	8
		We need partnerships with addiction management clinics in the community	
		Expand substance use programs at UCSF	
		Referrals system to refer to addiction treatment with in UCSF	
		Development of Addiction Medicine resources for providers and patients at UCSF	
		We should study this as we do it	

Crowdsourcing Activity: >215 post-it notes & voting with stickers

Key takeaway: providers wants tools in APeX (dominant bucket)

5th Priority "Other bucket"—what else was identified as a key need?

What's the Status of Priority #1?

Create actionable data to understand the scope of the problem & drive improvement

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HOW STANDARDS PROLIFERATE:
(SEE: A/C CHARGERS, CHARACTER ENCODINGS, INSTANT MESSAGING, ETC)
SITUATION: THERE ARE 14 COMPETING STANDARDS.
14?! RIDICULOUS! WE NEED TO DEVELOP ONE UNIVERSAL STANDARD THAT COVERS EVERYONE'S USE CASES.
YEAH!
SOON:
SITUATION: THERE ARE 15 COMPETING STANDARDS.

What is our current status update? Next Steps?

Ambulatory Approach

- Upcoming APeX upgrade will provide a comprehensive Opioid Registry solution as part of Healthy Planet in early 2019
- Registry already running in background to understand functionality, data standards that require defining, and related tools to drive patient care improvement (e.g., panel management)
- Registry will provide population health management style data and prescribing practices at provider and practice-level (with need to identify cancer, palliative care/hospice patients)

Inpatient Approach

- Ambulatory solution in APeX won't address the inpatient needs (or at least not entirely)
- Leveraging Pain Committee, APeX Informatics Team, Opioid Data Strategy Workgroup and other stakeholder groups to create greater consistency and standards for inpatient-oriented opioid data reports
- Create partnerships among inpatient services already invested in opioid stewardship (e.g., periop pathways, OB) to assure data consistency moving forward

What's the Status of Priority #2?

Standardize clinical tools & guidelines to support best practices across our care settings

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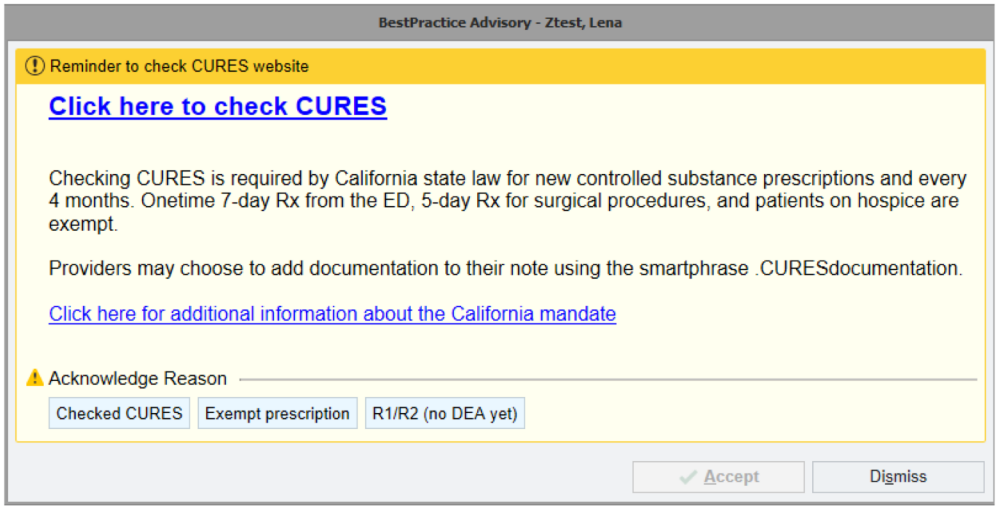
What is our current status update? Next Steps?

Goals	
CURES Best Practice Alert	• Implemented October 2018 aligned with CA Mandate; evaluating impact and user behaviors • Credentialing application revised to include CURES attestation page approved by Credentials/EMB • Hopeful that DoJ and CA Medical Board will foster direct access to CURES within APeX (could come in 2019), similar to what's occurred in other states



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What is our current status update? Next Steps?

Goals	
CURES Best Practice Alert [Done]	• Implemented October 2018 aligned with CA Mandate; evaluating impact and user behaviors • Credentialing application revised to include CURES attestation page approved by Credentials/EMB • Hopeful that DoJ and CA Medical Board will foster direct access to CURES within APeX (could come in 2019), similar to what's occurred in other states
OME Calculator Identifying "at risk" patients [Inpatient pilot soon; Ambulatory in early 2019]	• Development of a "morphine milligram equivalent" (MME) calculator is the backbone of CDC guidelines in identifying "high-risk" prescriptions across care settings • Ambulatory OME definition standards now set (will become part of Opioid Registry) • Inpatient OME definition standards just set via Pain Committee and stakeholder discussions
OME at time of Rx [by June 2019]	• Providers will see OMEs for their patient at time of prescribing opioids
Narcan Rx [by June 2019]	• Based on OMEs, a trigger will result in recommendation for prescribing Narcan (aligned with future regulatory requirement reportedly coming in 2019)
Benzos/Opioids [by June 2019]	• An APeX Best Practice Alert (BPA) will get implemented to reduce the known risks of co-prescribing opioids and benzos

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What is our current status update? Next Steps?

Goals	
Clinical Guidelines	• Need centralized data and tools to allow for decentralized improvement work in ambulatory practices and inpatient services; the decentralized improvement work is already happening • Defining and disseminating “best practices” for managing opioid prescriptions at discharge from hospital, ED and/or after procedures (e.g., # of days or pills written), particularly for opioid-naive patients; same best practice approach required in partnership with primary care and across continuum of care • Creating greater consistency and standards for how individual services approach their opioid stewardship improvement work in coordinated fashion (need better structure to convene, learn, share and disseminate) • Reduce variation across services/practices and providers in prescribing practices
Order Sets & Pathways	• Better marry above guidelines by forcing practice changes via new (and semi-standard) order sets

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What's the Status of Priority #3?

Develop patient-facing tools to support patient engagement, education and relationships

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What is our current status update? Next Steps?

Goals	
Patient-Provider Agreements [by June 2019]	• Standard agreement developed by Pain Committee (in partnership with Primary Care) and already available for patients on chronic opioids in any setting • Workgroup convened to define standards and best practices, including workflows, recommendations for where/when to document, etc.
After-Visit Summary Enhancements [by June 2019]	• Developed patient-centered language to include in AVS for patients being prescribed opioids • Adult inpatient pilot that auto-populates AVS language into discharge summary will start in next month; information also translated in multiple languages • Ambulatory and BCHSF inpatient to follow as getting adapted and translated
Educational Campaign [TBD]	• Desire for broader educational/marketing efforts that provide a consistent and visible message across settings that reinforce key principles of pain management and safety around opioid use • Need to balance with our patient populations for whom opioids are a critical part of their treatment plans (e.g., Cancer Center, Palliative Care, etc.). • Campaign will follow other work that was prioritized more highly

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What's the Status of Priority #4?

Provide training to our clinical workforce that reinforces the above priorities

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What is our current status update? Next Steps?

In-Person Training?

Offer in-person seminar or modules focused on safe opioid use and pain management at the department/division level

Online Training?

Develop e-learning modules that fulfill the same goals but in an easily scaled fashion

Toolkits/ Checklists?

Create and disseminate toolkits that are embedded within APeX for “real-time” training/support at point of clinical decision-making

TBD: still early in this discussion

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What's in the "Other" Priority Bucket?

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What were other needs identified?

Goals	
New Care Models & Substance Use Disorder Resources	• Group visits, telehealth, etc. • Addiction specialists • Inpatient Addiction Consult Service • Increased capacity for pain clinic, palliative care, and other ambulatory resources to assist in caring for patients with pain (particularly chronic pain) • Community Resources to bridge gaps in our system (e.g., addiction, telehealth, Osher, etc.) • Mental/Behavioral Health options in this patient population
Specific Treatment Options	• Medication-Assisted Treatment (Buprenorphine induction in hospital) • DEA Waiver Training • Non-pharm treatment options and training (acupuncture, etc.)

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The Village: How are we coordinating and bringing it all together?

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Integrate

Communicate

Align

Opioid Stewardship
Coleen Kivlahan (co-lead)
Niraj Sehgal (co-lead; sponsor)
Jermaine Blakeley

SFHP Grant: Addiction Services
Sujatha Sankaran (Med Dtr)
Matt Tierney (SON/Pop Health)
[*Formal Needs Assessment Underway]

APeX/Informatics/AC3
Andy Auerbach
Maria Byron
Rhiannon Croci
Russ Cucina (sponsor)
Sara Murray
Joanne Yim

Pain Committee
Matthias Behrends (chair)
Sarah Brynelson (RN/CNS Pain)
Mark Schumacher
Jenifer Twiford (Quality)

Decentralized Groups
Ambulatory Practices
Inpatient Services
Periop Pathways

Revamped Pain Committee & Centralized Governance

- ✓ Membership expanded and diversified (ambulatory, palliative care, etc.)
- ✓ Workgroups formed (e.g., APeX data, patient-provider agreements, non-pharm options, pain assessment, order sets, substance use disorders, etc.)
- ✓ Goal to bring previously disparate and parallel work organized into single structure

- ➢ Future Goal: local improvement work brought to committee to get input, disseminate strategies, and align standards across clinical settings

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Opioid Stewardship: It Takes a Village

- Burning platform and engagement for work is incredibly strong
- Need to marry content expertise with APeX data/tools and improvement work expertise for success
- “If we build it, we will need more…”—better identification of patients with pain (or at-risk for opioid dependence/adverse effects) will require new resources to care for them