Colorado Opioid Safety Summit

8-Minute Champions of Change

c|h|a Colorado Hospital Association

COLORADO Office of Behavioral Health Department of Human Services

Centura Health

Opioid Safety

Castle Rock Adventist Hospital

- **Dr Andrew French, MD**—Chief Medical Officer
- **Chris Lowe, PharmD**—Director of Pharmacy Services
- **Jane Braaten, RN PhD**—Director of Quality and Patient Safety
- **Kathryn Podorsek, RN, MSN**—Director of Women's Services
- **Elisabeth Wiethorn RN, BSN, MBA, CPHQ**—Regulatory Program Manager
- **Larissa Nattrass, BS, CPHQ**—Clinical Outcomes Coordinator

01/15/2018

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Reason for Action

- ALTO program to reduce opioid usage
- 10% of the general population is at risk for opioid addiction
- Monthly diversion monitoring showed opportunity for improvement
- Started with LDRP population based on similarities of the group
- Opioids cross over into breastmilk
- Studies are suggesting that alternating ibuprofen and acetaminophen on a schedule provides equal or superior pain relief than narcotics

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Method

- Joint project between pharmacy, quality and LDRP
- Data collected regarding the appropriateness of the administration of pain meds
  - All patients were included, charts individually abstracted.
  - Education done with patients pre-admission regarding decreasing opioid usage
  - Education done with staff regarding setting pain expectations, using non-narcotic options (giving Motrin q6 and Tylenol q6 on an alternate schedule), and non-pharmacologic options
  - Discussion at service line meeting with providers about this project
  - Data could be skewed based on delivery type (i.e. c-section vs vaginal birth)
- Data was then collected regarding each type of medication: Acetaminophen, Ibuprofen, Norco, and Percocet
  - Pyxis data pulled for each patient
  - Vaginal Births separated from C-Sections
  - Rates - overall and for vaginal births
  - Rates – narcotics and non-narcotics
- Follow up education with staff and providers regarding results and reinforcing previous education

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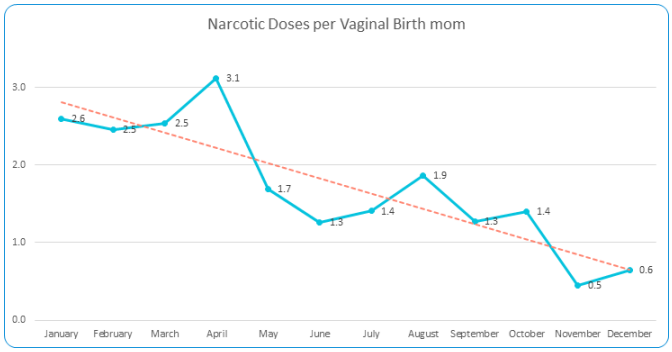
RESULTS



Ongoing Initiatives

- Goal is to maintain and/or continue to decrease narcotic usage
- Continue to present data at staff meetings/huddles and address concerns brought forward
- Continue to present at service line meetings to discuss issues with providers
- Centura wide vaginal delivery order set reviewed in October—suggestions made to schedule Tylenol and ibuprofen and change Norco/Percocet to oxycodone 5 mg for moderate pain and 10 mg for severe pain
- Original discharge prescriptions defaulted to 30 tablets for opioids, default was changed to 21. Requesting Epic report to follow trend and see if we can decrease further

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Improving the Care of Substance Exposed Newborns

Colorado Hospitals Substance Exposed Newborns Collaborative (CHoSEN)

Danielle Smith, MD

BACKGROUND:
significant variation in clinical and social interventions exits among hospitals caring for substance exposed newborns

CHoSEN was developed to:
- Decrease variability in practice
- Implement a bundle of care practices
- Collect clinical outcomes data on interventions

KEY PRACTICE IMPROVEMENT DRIVERS:
- Increase and improve participation of hospitals
- Reduce post-natal exposure to opiates
- Increase family involvement in care
- Improve discharge process for infants

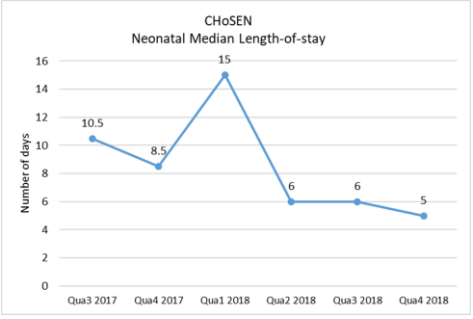
EAT, SLEEP, CONSOLE

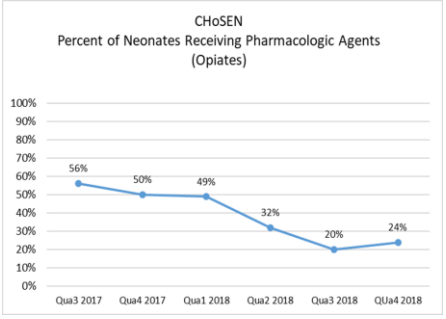
- A function-based assessment tool that evaluates how well the infant is eating, sleeping, and how easily the infant is to console
- Emphasizes non-pharmacologic interventions for management of withdrawal symptoms

KEY CHANGES IN CULTURE

- Partnering with family
- Focus on continuum of care
- Caregiver huddles
- Non-pharmacologic care as primary intervention

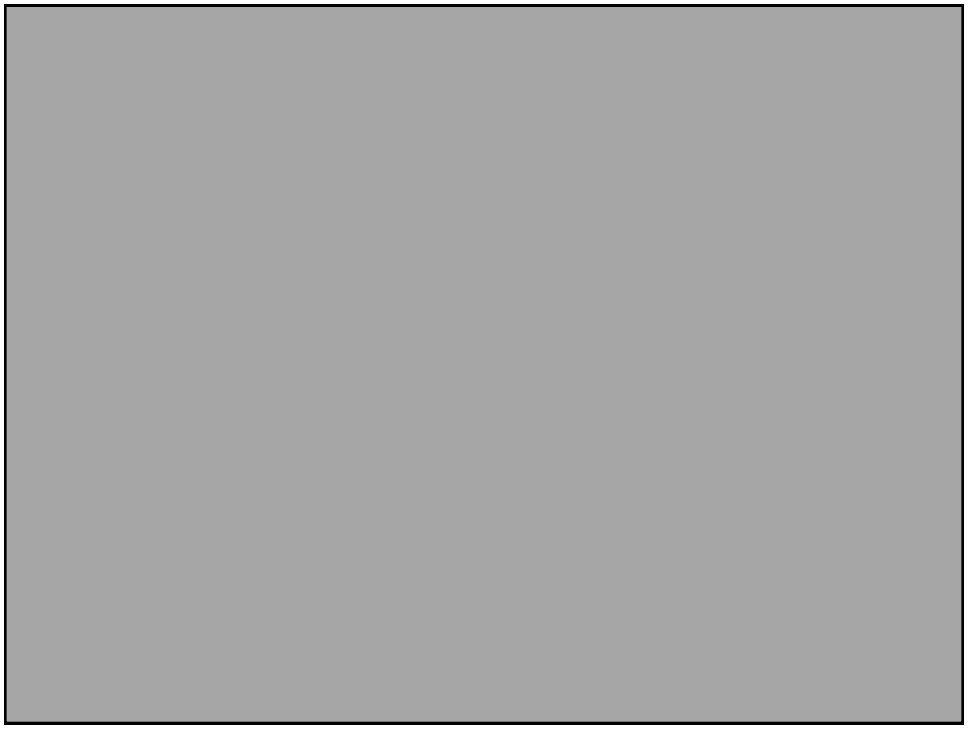
OUTCOME MEASURES:





CONTINUED OPPORTUNITIES FOR IMPROVEMENT:

Consistent Prenatal Counseling and Education
Safe Discharge and Transition to Primary Care Provider



Changing the Culture on Opioids in a Rural Setting

Trampas Hutches, MHA, BSRT (R)(CT)(MR)
Melissa Memorial Hospital

Spring of 2018

- **The number of patients on dangerous levels of opioids at Melissa Memorial Hospital (MMH) and The Family Practice of Holyoke (FPH) was astounding.**
  - 4% of patients served at MMH were on over 90 of morphine milligram equivalents (MME).
  - These patients were mostly in the primary care settings but were also consistently seen in the ER for problems consistent with chronic pain and opioid use.
  - Consistent pain agreements were not followed, nor were drug screening being performed to ensure compliance with these patients.
- **Understanding the severity of the problem, an initiative was undertaken**.
  - Goal #1: reduce the number of opioids used and prescribed while introducing alternatives to opioids in both the primary care and hospital settings.
  - Goal #2: A cultural change for use of strict pain agreements, drug screening and acceptance of telemedicine for pain management and opioid reduction was sought.

Plan of Attack

- **A new pain management program was started at MMH led by Dr. Kajsa Harris**
  - Dr. Harris specializes in family practice, emergency medicine, acupuncture, trigger point injections, manipulations, nutrition therapy, and suboxone
  - New pain agreements and processes were created and mandatory drug screening along with send-outs for confirmation were implemented
  - Training for primary care providers in acupuncture and other alternatives to opioids was done
  - Telemedicine processes were established for visits when Dr. Harris was not on site
  - CHA ALTO program was implemented in the ER
  - PR/marketing campaign was done to educate the community about the changes

Prescription drug monitoring program (PDMP) was requested to be embedded into MMH's EHR (Athena)

Results

- **MMH's efforts were validated on day one of go-live when every patient failed their drug screening.**
  - Some patients had the wrong drug, some had recreational drugs, but most concerning was those that had no drugs in their system.
  - Since these processes have been put into place it is now rare to get a positive result. After initial patient dissatisfaction (and some on-going dissatisfaction) with this new program, the results are encouraging.
  - With the use of the alternatives, telemedicine and a culture change **MMH has seen a near 100% reduction of all patients to below 90 MME.**
  - 72% of the patients in this program have been completely tapered off of opioids in six months.
  - The last quarter of this year patient satisfaction scores have been the highest year-to-date.

Strategies to Promote Safe Use of Opioids in Hospice and Palliative Care

Shannon Ryan-Cebula, MD
Sabryna Silva, RN

SCL Health LUTHERAN

- **Culture:** Liberal use, minimal oversight, "they're dying, just give them what they want."
- **Need for change**: Unrecognized misuse and unrecognized red flags for diversion potential.
- **Barriers to change**:
  - Staff lack of awareness of risks
  - No guidelines appropriate to our population
  - Fear of profiling pts and jeopardizing symptom control
- **How did we make the culture change happen?**
  - We shifted thinking, practice, belief and understanding by educating, developing a novel tool and operationalizing practice change in the field

Risk Evaluation and Mitigation (REM): Strategies to Promote the Safe Use of Opioids

ALL PATIENTS RECEIVING OPIOIDS

1. Conduct opioid risk assessment
2. Identify who will control medications
3. Opioid safety education
4. Sign opioid agreement form

Combines safety, responsibility and relevant legal issues in one short form.

*Personal or family history of substance abuse?
*Personal history of depression or anxiety?
*Overuse of alcohol or other substances by member of the household?
*Children or teens in household?
*Multiple visitors to home who do not live there?
*Any concern about safety of opioid medications in the home?
*Any known risk of theft or diversion?

*Side effects handout
*Secure storage
*One prescriber only
*Driving limitations
*Take only as prescribed
*Safe disposal handout

AT EVERY VISIT FOR EVERY PATIENT CURRENTLY TAKING OPIOIDS

1. Reconcile opioids
2. Must see all bottles/boxes
3. Encourage use of admin log
4. 2 week maximum supply
5. Destroy discontinued opioids
6. Identify & document WHAT pain, WHERE, and response to medications
7. Ask about side effects, bowels

ABERRANT BEHAVIORS-HOME SETTING

-Missing bottles, "lost" medications
-Running out early, without explanation or change in symptoms
-Evidence of recurrent narcotization or use beyond that needed for symptoms
-Refusing long acting meds in favor of large qty of short acting
-Inadequate symptom relief reported by caregiver despite evidence to contrary with patient
-Caregivers visibly narcotized
-Use of other prescribers / pharmacies to obtain opioids
-Evidence of tampering with lock box

ANY RISK FACTORS OR OBSERVED ABERRANCIES MUST BE PROMPTLY ADDRESSED BY TEAM WITH HIGH RISK PLAN

INTERDISCIPLINARY TEAM REVIEW

-Do other team members have similar concerns or observations?
-Could there be an alternative explanation or info that would help team better understand the patient / situation / caregiver?

Pseudo-addiction? Opioid failure? Concern for exploitation?
Untreated depression or anxiety?
Unaddressed spiritual distress? Unaddressed emotional distress?

TEAM INTERVENTION

-Bring concerns to patient and caregivers (two person visit)
-Clearly describe the specific behaviors or issues that the team find worrisome.
-Clearly and firmly explain what it is about behaviors that is unacceptable.
-Gauge response and offer a resolution strategy

ACTION PLAN

-**Flag** Electronic medical record and pharmacies, file an incident report
-**Required:** Lock box, logs, small supply orders, identify and document who is responsible for medications storage and administration, explain violation of federal law and our moral duty to inform authorities of theft or exploitation.
-**Consider:** Adjuvants, rotation, tapering, IPU admission, treat depression/anxiety, increase SW and/or chaplain visits, referrals to community specialists
-**Repeat offender:** Dispense 1 day supply, consider discharge for cause, APS referral

The Lockbox Tracking System

- Population: 30+ nurses, >160 patients coming/going: admissions, deaths, relocations, revocations, discharges.
- Lockboxes serve to pinpoint where high risk situations have been identified and allows a concrete method of tracking.

Program Achievements

→Established a structure needed to build a culture of change.
→Provided a consistent means to identify at risk situations, which improves staff confidence and compliance.
→Enhanced opioid safety for our patients, their families, our staff and ultimately the community at large.

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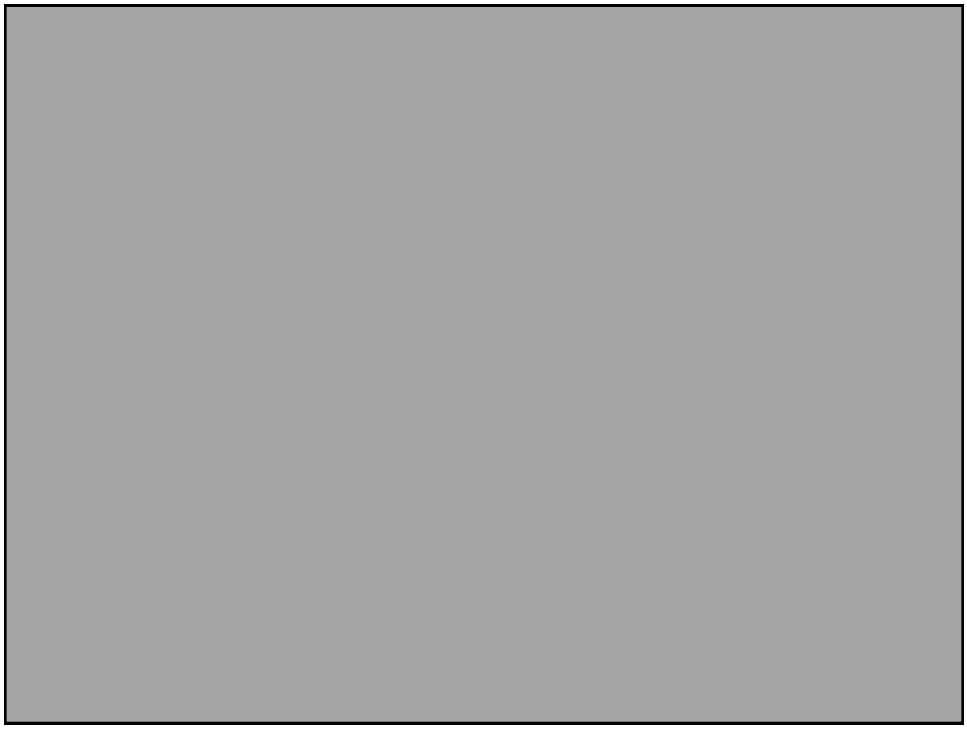


IT ATTTRs
Colorado
Expanding Access to
Medication Assisted Treatment
Implementing Technology,
Medication Assisted Treatment,
Team Training, and Resources
Linda Zittleman, MSPH
Kyle Knierim, MD
University of Colorado Department of Family Medicine
Thanks to Kristen Curcija, MPH and Daniel Pacheco, MBA
University of Colorado Dept of Family Medicine

1. Provider MAT Training

IT MATTTRs Colorado

Components

- FREE access to the *Treatment of Opioid Use Disorder Course*
- Compensation for training time
  - $760 for MDs & DOs (8 hour training)
  - $1800 for NPs & PAs (24 hour training)
  - $240 to apply for DEA waiver to prescribe buprenorphine

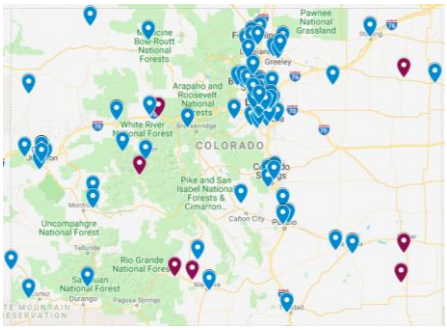

Figure 1 Zip codes with newly waiver trained providers

Progress

- 556 completed waiver training; 428 applied for DEA waiver (73%)
- 35 reported prescribing buprenorphine within 3 months of being trained (30%)

Translates to

- Prescribing MAT to >1,000 more patients
- Capacity to serve 12,800 more patients

2. Practice Team Training

IT MATTTRs Colorado

- Primary Care Practice
  - 5-Module training
  - Covers epidemiology, neurophysiology of opioids and addiction, medication (bup) safety & effectiveness, preparing patient, induction steps, stabilization, maintenance, special populations
  - IT MATTTRs MATerials Resource Toolkit
  - Follow-up implementation support
- Behavioral Health Team Training
  - 6-module training
  - Creates a common language between primary care and behavioral health and supports integrated care and MAT
  - Additional resources and content relevant to BH setting

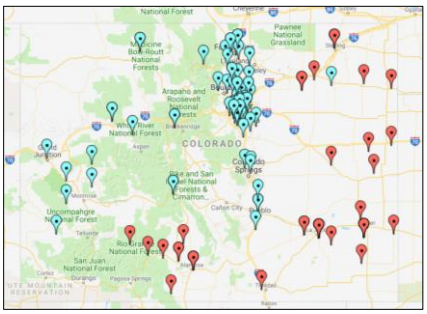

Figure 2 Zip codes of practices receiving team training

Progress

- 124 primary care practices engaged
- 65 primary care practices have completed training
- Mental health centers: Centennial, Salud, Southeast Health Group

Engage with IT MATTTRs

- Sign up for a free **DEA waiver training**
- Bring **IT MATTTRs Team Training** to your local primary care practice or behavioral health center
- Drop in on our new **MAT Learning Forums** – held on 4th Thursdays @ 12:30 pm starting **February 28th**
- **Talk with us** about how we can better support interested community members, providers, clinics and health systems

www.itmatttrscolorado.org

http://www.practiceinnovationco.org/itmatttrs2/

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Safe opioid prescribing, harm reduction and addiction treatment initiatives in a vertically-integrated health system

Lisa Gawenus, MNM, CAC III
FACHE
Judith Shlay, MD, MSPH

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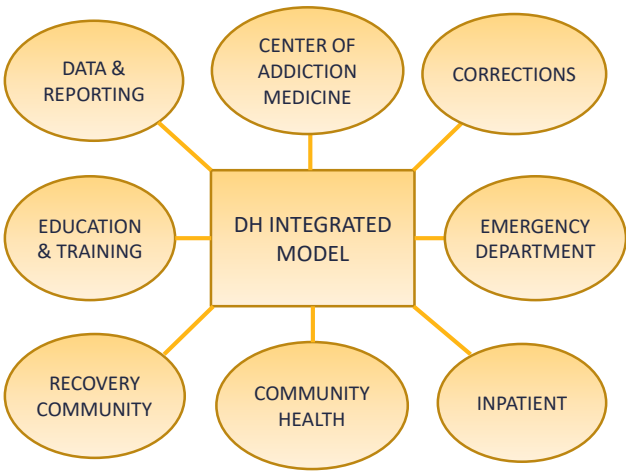
FOR LIFE'S JOURNEY

Denver Health Addiction Treatment



- Organizational priority
- Center of Addiction Medicine
- Hub-and-Spoke model
- "No wrong door"
- Infrastructure **"substance agnostic"**
- System-wide Stakeholder involvement

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Thank you

Thank you, 8-Minute Champions of Change Presenters!

Visit www.cha.com for all presentations and additional Colorado Opioid Safety Summit materials.

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