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Opioid Stewardship: Where the Rubber Meets the Road

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Learning Objectives

- Discuss three benefits of opioid stewardship programs and service line partnerships.
- Explain how data is instrumental in driving quality improvement of pain practices.

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University of Alabama Birmingham Hospital

- Academic Medical Center with 1,207 beds
  - ~ 364,000 inpatient days
  - ~ 119,000 ED visits
  - ~ 37,000 surgical cases
- Largest comprehensive transplantation program in the southeastern United States
- Only ACS-designated Level 1 Trauma Center in Alabama
- Only Magnet Designated Hospital in Alabama

UAB's Opioid Stewardship Program Overview

Established in 2019

Mission:

Provide safe, effective, and patient-centered pain management at UAB Medicine

Dedicated Leadership

Program Manager
Pharmacist
Anesthesia/Pain Provider

OSP Initiative Foundation:

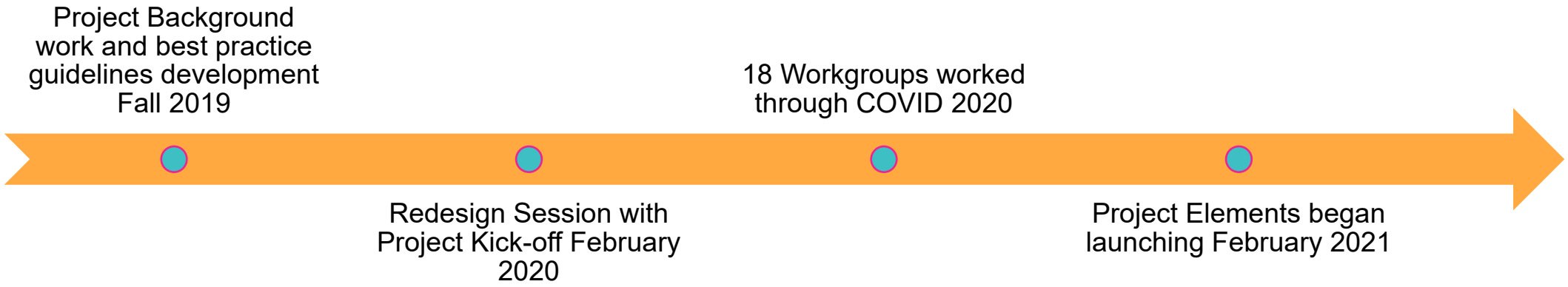
National Quality Forum Opioid Stewardship Playbook

OSP Formal Reporting Structure

- UAB Health System Board
- Patient Care and Quality Assurance Committee (PCQAC)
- Clinical Effectiveness Team
- Opioid Stewardship Executive Committee
- Opioid Stewardship Initiative Teams

Prioritized Inpatient Acute Pain Management

- Worked with over 100 frontline staff through COVID to develop general best practices for acute pain management at the institutional level.



- Inpatient Acute Pain Management Project Key Elements

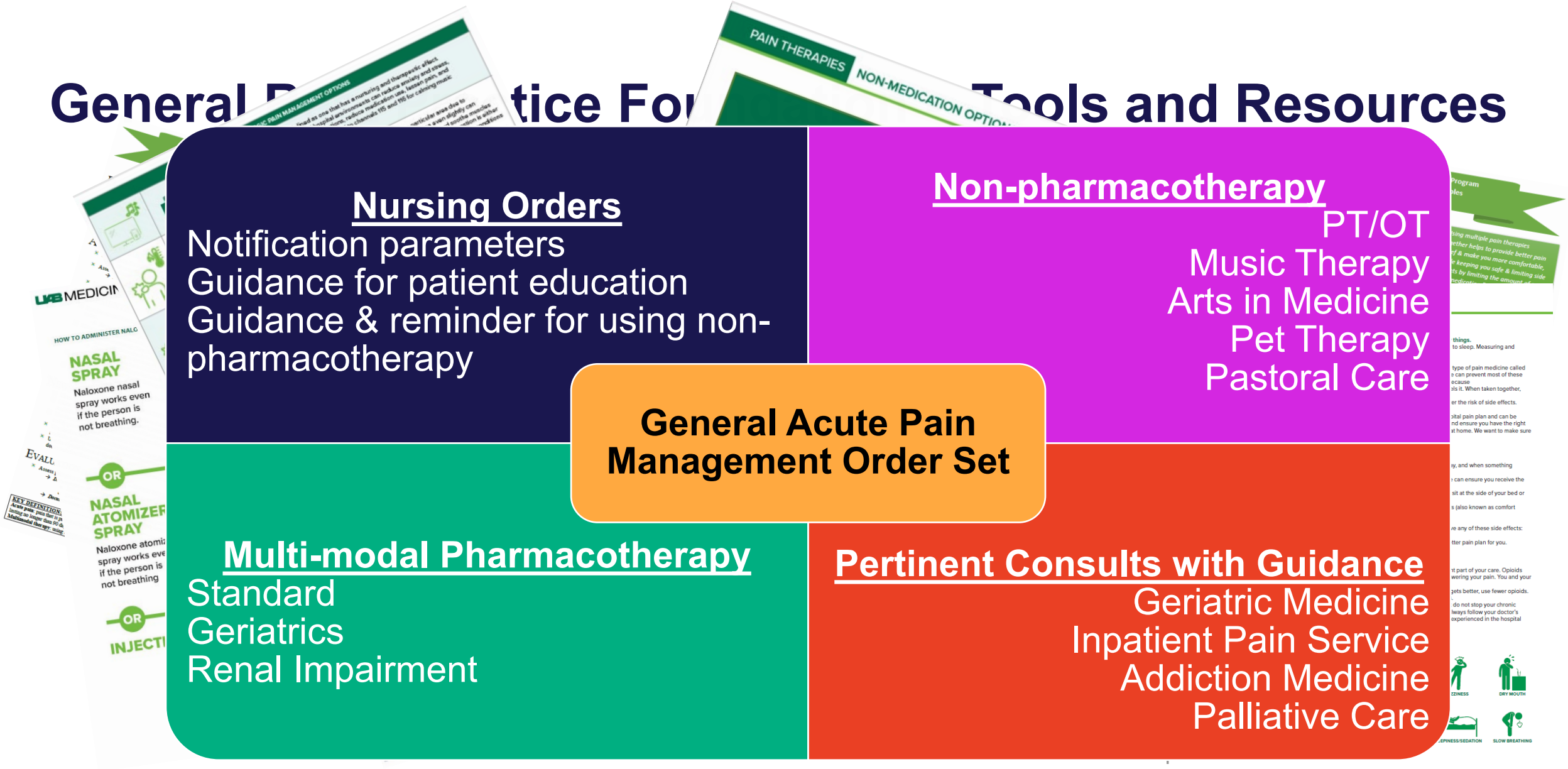
Best practice guidelines	**Data – Measurement of Success**
Form to collect pre-hospital home opioid pain management information	Standardized daily rounding checklist
Standardized multi-medication order sets	**Opioid Stewardship mPage – 1 place to review and evaluate acute pain management plan 'real-time'**
Non-medication pain relief optimization	
Patient safety EMR alerts	**Staff and Patient Education**

General Best Practice Foundation – EMR Resources

All inclusive

OSP EMR Real-time Pain Management Platform

General P tice Fo Tools and Resources



Nursing Orders

Notification parameters
Guidance for patient education
Guidance & reminder for using non-pharmacotherapy

Non-pharmacotherapy

PT/OT
Music Therapy
Arts in Medicine
Pet Therapy
Pastoral Care

General Acute Pain Management Order Set

Multi-modal Pharmacotherapy

Standard
Geriatrics
Renal Impairment

Pertinent Consults with Guidance

Geriatric Medicine
Inpatient Pain Service
Addiction Medicine
Palliative Care

Roadblocks to Institutional Implementation

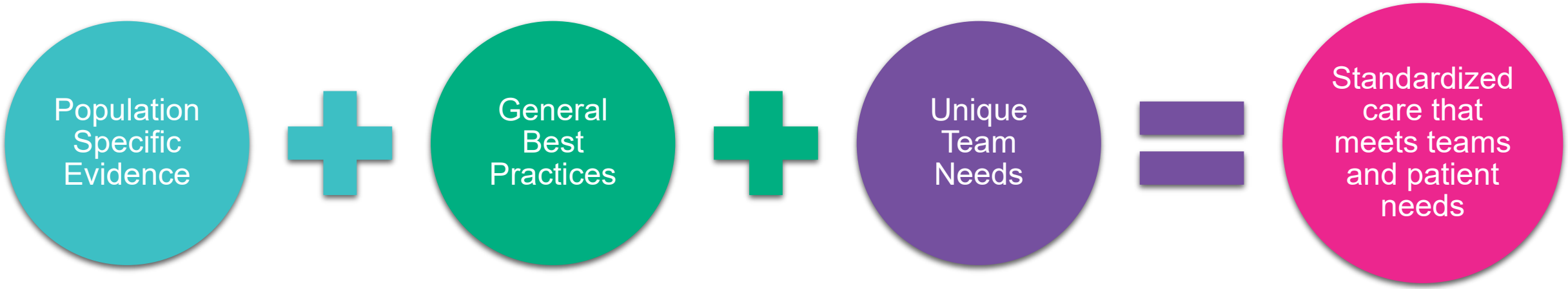
- Adoption was slow
- General tools and resources were not enough
- To change a culture, change has to be meaningful and applicable
  - Academic Medical Center
  - Countless subspecialties

From Macro to Micro

"Taking the show on the road" partnering with individual teams to further expand acute pain best practices.

OSP + Service Partnership Foundation

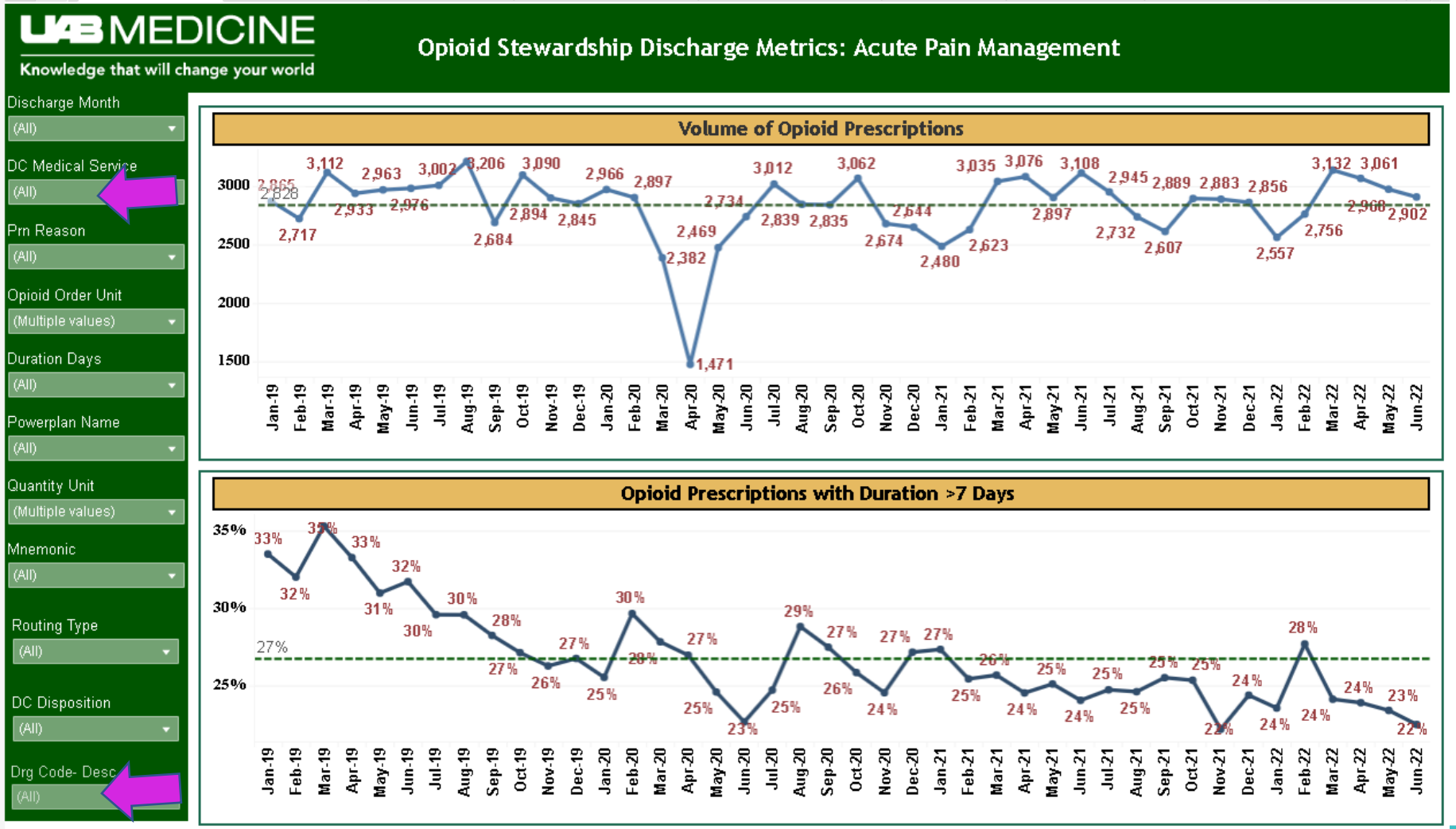
- Provide data, tools, and resources applicable to their practice



Obtaining and Sharing Data - Dashboards

Data Development

- Internal data
- Iterative process
  - Inpatient metrics
  - Discharge metrics
  - Granular level



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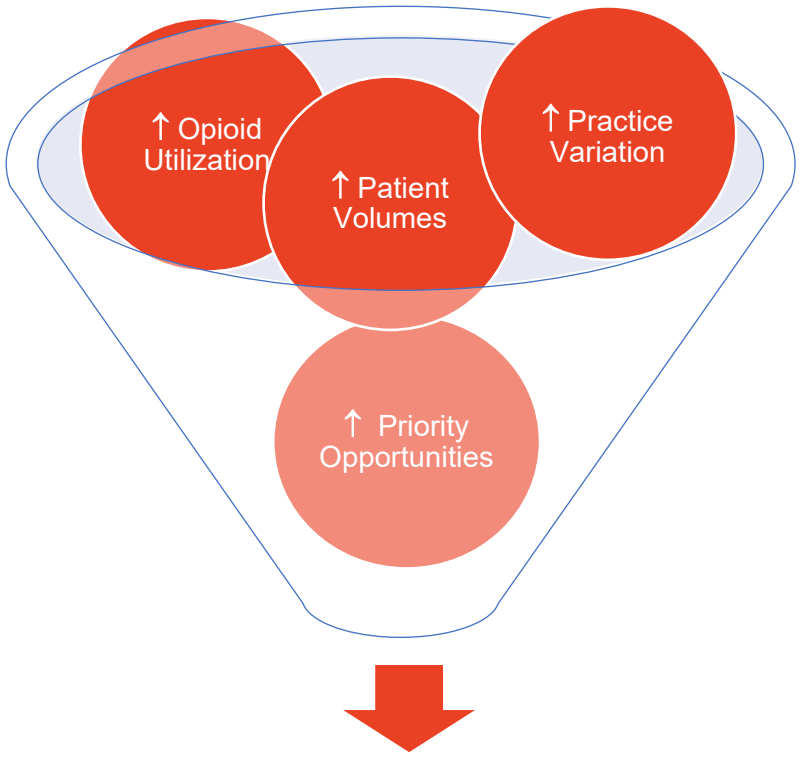
Identifying and Creating Partnerships

Identifying Partnerships:

- Data
- Frontline requests
- Leadership priorities
- Patient safety events

Creating Partnerships:

- Connections via C-suite & service leadership
- Gaining buy-in with frontline stakeholders → temporary integration of OSP PharmD



OSP Data Priorities

Team Collaboration

Standardized template for forming a strong communication network and platform for partnership.

Initial meeting with key stakeholders:

- Share data
- Review "Academic Detailing Outline"
- Principles of partnership
- Important points
- OSP resources

Academic Detailing Outline

Team Leaders:

- Who to include in email communications?
- Who needs to review/approve changes?

Literature Search:

- Specific guidelines to know about?

Current State:

- What order sets are currently used? New sets needed?
- Pre-op Clinic Opportunities?
- Patient Education??
- Escalation (Provider Notification) Pathway??
- Pain Management Evaluation (daily, PRN)??
- Discharge Planning?? Prescribing?? Follow-up??

Data & Measures:

- Measures collected by OSP:
  - Inpatient: Total Opioid Administrations
  - Inpatient: Total Administrations PRN Mild Pain
  - Discharge: Opioid Rx > 7 Day Duration
  - Discharge: Number of Opioid Pills per Rx
  - Discharge: E-Prescribing Opioids
- Manual Audits:
  - Who will monitor new processes & escalate real-time?
  - Who collects the information during sustainment?

Staff Education:

- Who?? What?? Venues??

Timeline:

- Goal 'Go-Live' Date vs Element Implementation and Rollout?
- Goal for first data report out at department meeting?

Principles:

- Do NOT want patients to be in pain
- Do NOT want clinicians to be paged repeatedly about pain
- Have an open mind… it has been shown to work ☺
- Goal – make it work for your workflow
- Standardized Best Practices that can be individualized (titrated up or tapered down) to meet patient needs

Important Points:

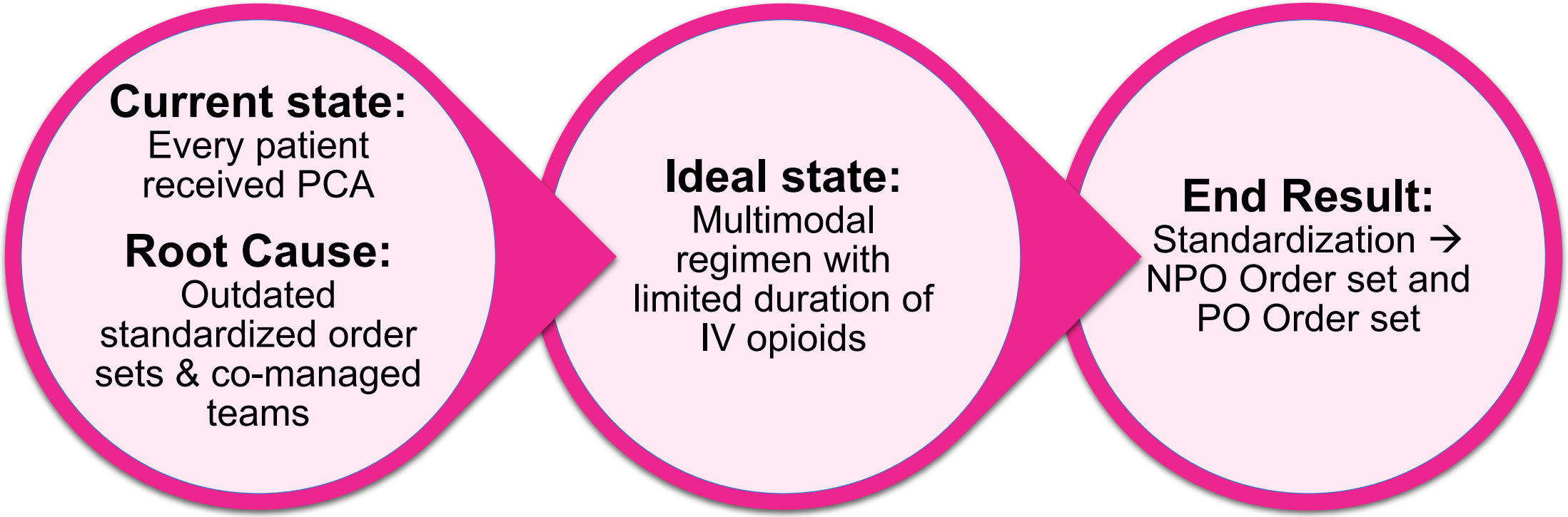
- E-Prescribe Controlled Substances
- Do not order opioids for mild pain
- Foundation of non-pharm therapy use with scheduled non-opioids and PRN opioids for unresolved pain → *Shift from different orders for 'mild, moderate, severe'*
- Re-evaluate pain & treatment daily
- Use PO formulations when possible
- Register for PDMP use it frequently
- Prescribe based on need (as close to discharge as possible)
- Lowest dose for shortest duration
- Use the Opioid Stewardship mPage
- Use standardized checklist
- Use standardized patient education materials to educate: early, frequently, & consistently

Where the Rubber …

… Meets the Road

Renal Transplant – Initial OSP Partnership

- Population – DRG 650, 651, 652 (post-operative kidney transplant recipients)
- Key Focus: Minimize the need for PCA use

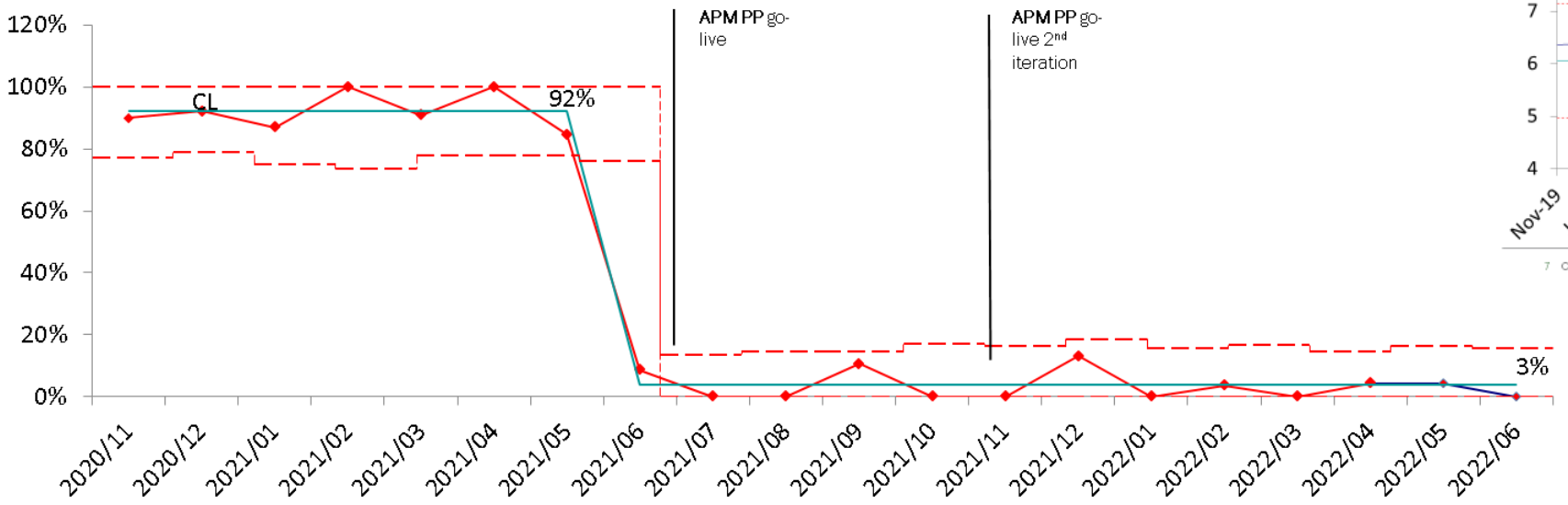


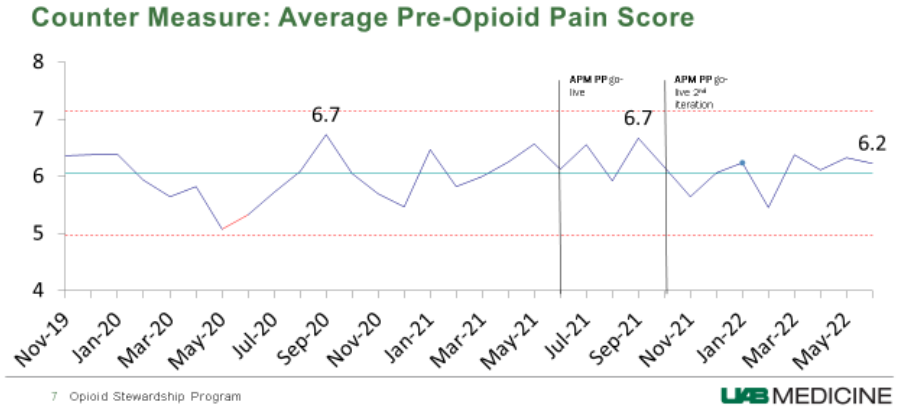
Renal Transplant Partnership Outcomes

PCA Utilization

Goal: Decrease to < 5% - reserve for extenuating circumstances

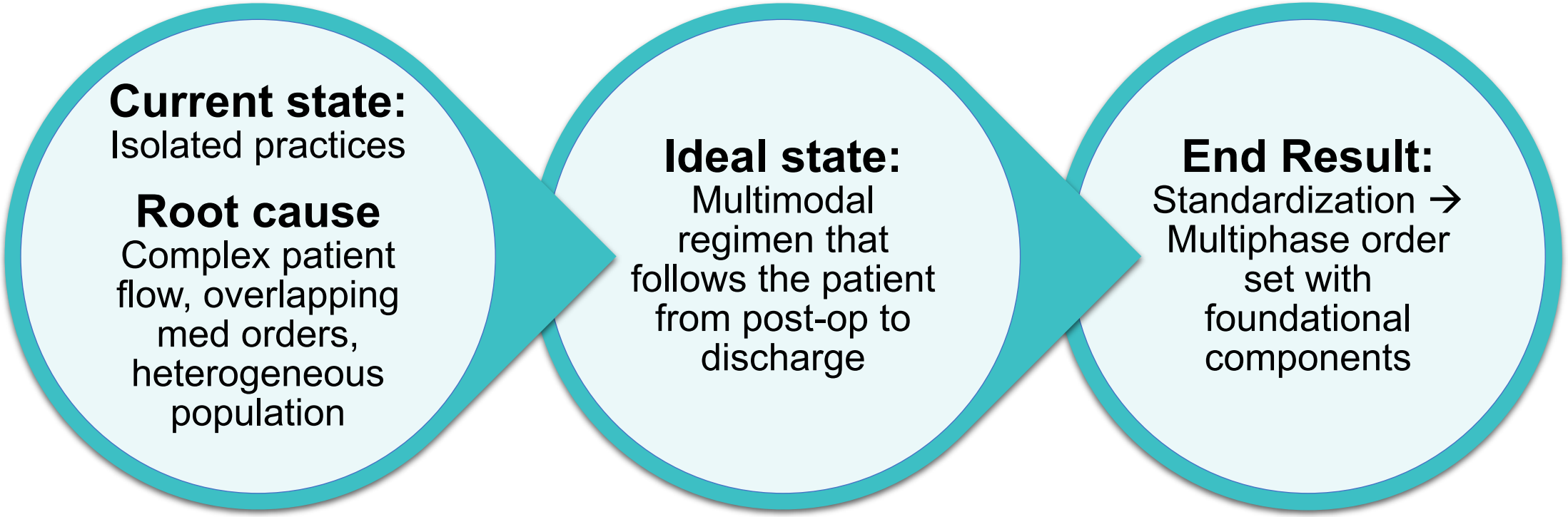
Rationale: Use multi-modal order sets to provide holistic pain management, reduce opioid use, and reduce need for PCAs to help patients minimize lines and accelerate post-op milestones feats



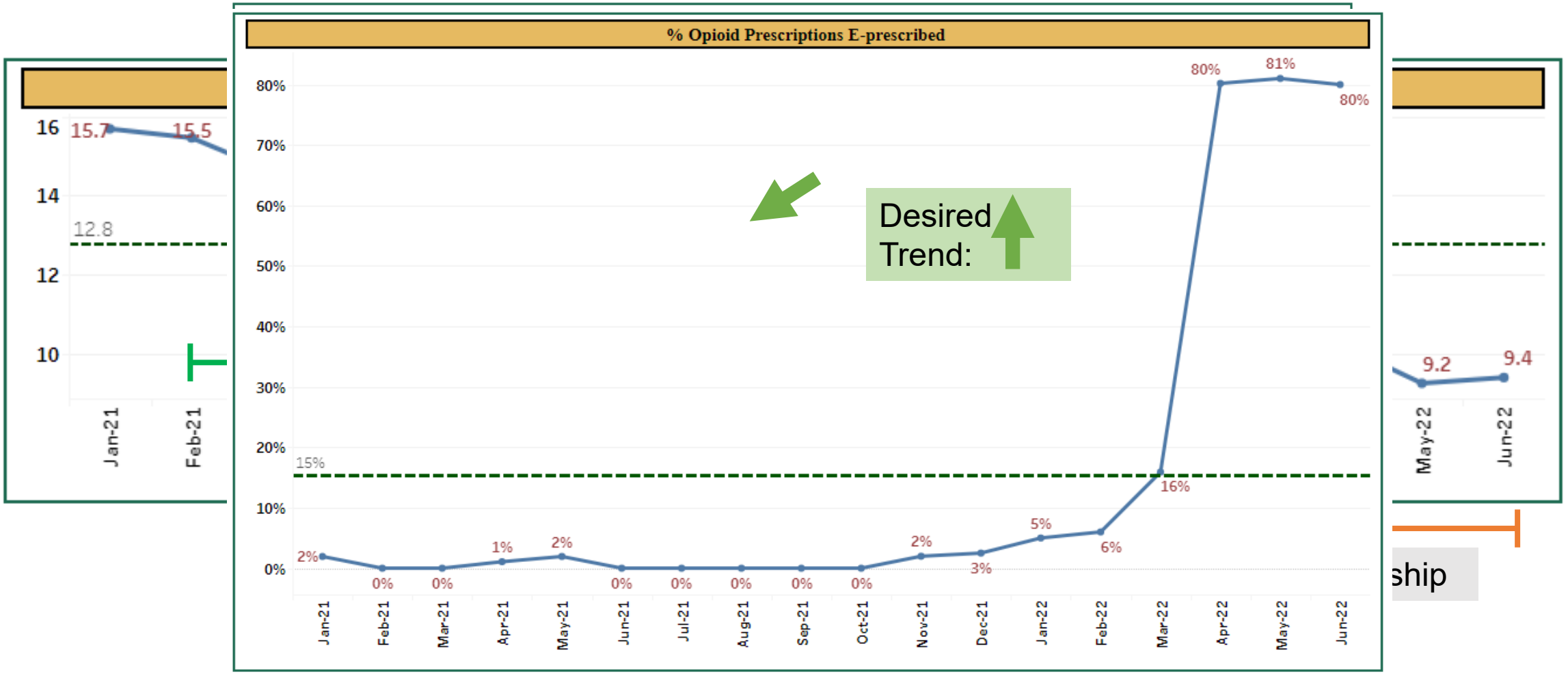


Cardiovascular Surgery Partnership

- Population: Patients admitted to CV-surgery medical service
- Key Focus: Acute pain management across continuum of care



Cardiovascular Surgery Partnership Outcomes



Qualitative Data

Renal Transplant Team Feedback:

"Going well"

"definitely seeing improvements with pain management"

"(data) slides representative of what we are seeing on the floor"

"patients not using PCA pumps"

"seeing patients get up and move more"

"on occasion some require a little more pain meds when (opportunities identified)"

"rarely filling pain meds in clinic anymore"

CV-Surgery Team Feedback:

"One of the things that stands out … how fast we have been able to implement changes and make adjustments."

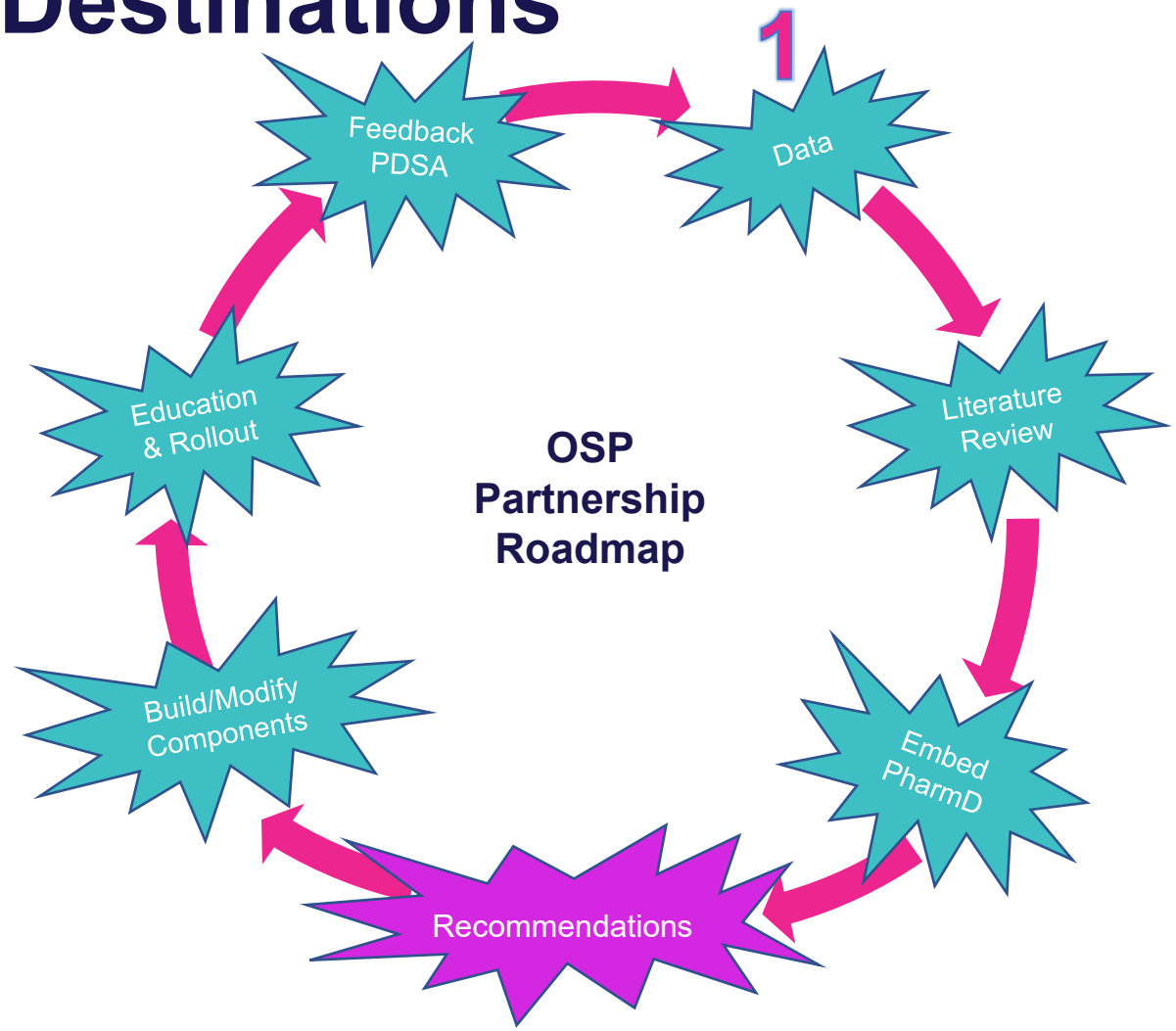
"The OSP team has been extremely responsive in answering questions and working with us to create a custom plan to improve care in a way that fits with the needs of CV surgery patients (not just copy and pasting from other areas of the hospital)."

"… not hearing concerns about the plan or an increase in complaints of pain from patients"

"We really appreciate all the help, time, and hard work that has gone into improving patient experience and safety within CV surgery!"

OSP Current and Future Destinations

- Orthopedic Surgery – current partnership
- Hospital Medicine – current partnership
- Trauma – Goal is to partner by the end of CY 2023



Lessons Learned

- Voluntold change gets some results… voluntary change gets infinite results
- No such thing as “one and done”
- 3rd party approach is not as effective
- Data drives change
- Unanticipated benefits come from OSP and service line partnerships

Key Takeaways

- Build a strong general best practice foundation
- Develop a reliable data platform
- Develop meaningful partnerships
- Become a part of the microsystem team

Questions?

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Contact us: opioidstewardship@uabmc.edu

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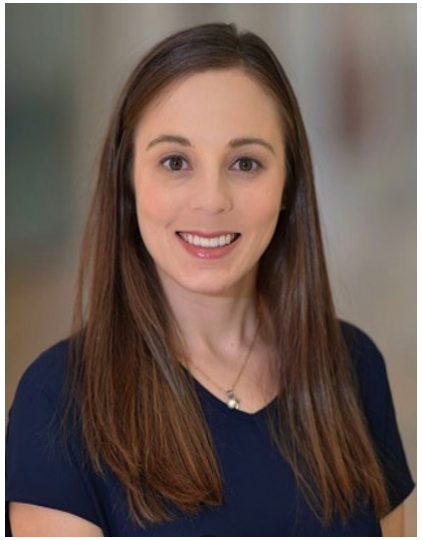

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