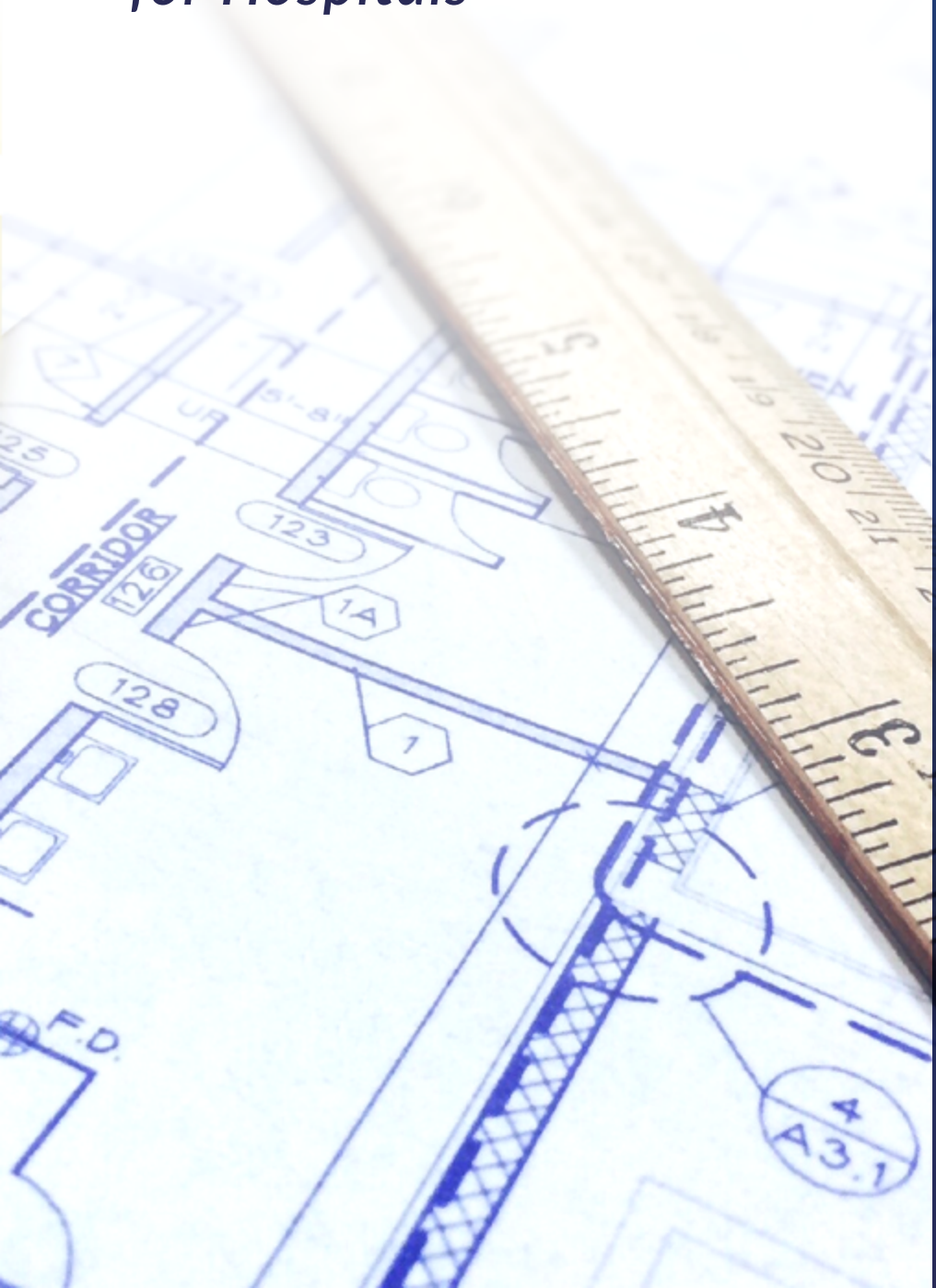
YOUR BLUEPRINT TO FIGHT THE OPIOID EPIDEMIC

Proven Strategies for Hospitals



Cynosure HEALTH

CASE FOR CHANGE

BLUEPRINT FOR SUCCESS

KEY MILESTONES TO GUIDE YOUR CHANGE PLANNING

PRACTICAL STEPS TO DRIVE IMPROVEMENTS IN OPIOID CARE

1. PREVENT NEW OPIOID STARTS
2. MANAGE CHRONIC PAIN-RELATED OPIOID USE
3. EFFECTIVELY TREAT ADDICTION
4. PREVENT OVERDOSE DEATHS
5. CREATE SUSTAINABLE INFRASTRUCTURE FOR IMPROVEMENT

CONCLUSION

ABOUT CYNOSURE

Cynosure Health is a nonprofit organization that works with diverse stakeholders to accelerate spread, implementation, and sustainable improvement in healthcare quality. Although our work spans multiple sectors in topics such as collaborative learning and care management, we specialize in working with hospitals, clinicians, health systems, and community-based coalitions on federal and statewide initiatives, regional collaboratives, and local partnerships.

For two decades, the Cynosure team has done pioneering work to improve outcomes, and we're committed to fostering innovative solutions to healthcare's toughest challenges. Nationally, opioid misuse and addiction have become a serious crisis, resulting in thousands of overdose deaths each year. Providers and communities have struggled to stem the tide.

Our team of experts has played a key role in developing and spreading proven strategies to reduce opioid-related deaths in the acute-care setting through: 1) Identifying how to assess opioid care practices, 2) Developing a framework to improve outcomes, and 3) Convening a workgroup of organizations engaged in this work to highlight bright spots and support the rapid spread of evidence-based practices among hospitals.

We have developed this blueprint for improving opioid care with support from the California Health Care Foundation, Cal Hospital Compare and California Bridge Program. We thank the many California hospitals, health plans, providers and patients who contributed their feedback and direction along the way.

The Blueprint for Fighting the Opioid Epidemic is intended for use by hospitals, healthcare organizations, and clinicians to identify strategies to positively impact outcomes for patients with opioid use disorder (OUD) and reduce deaths from opioid overdose.

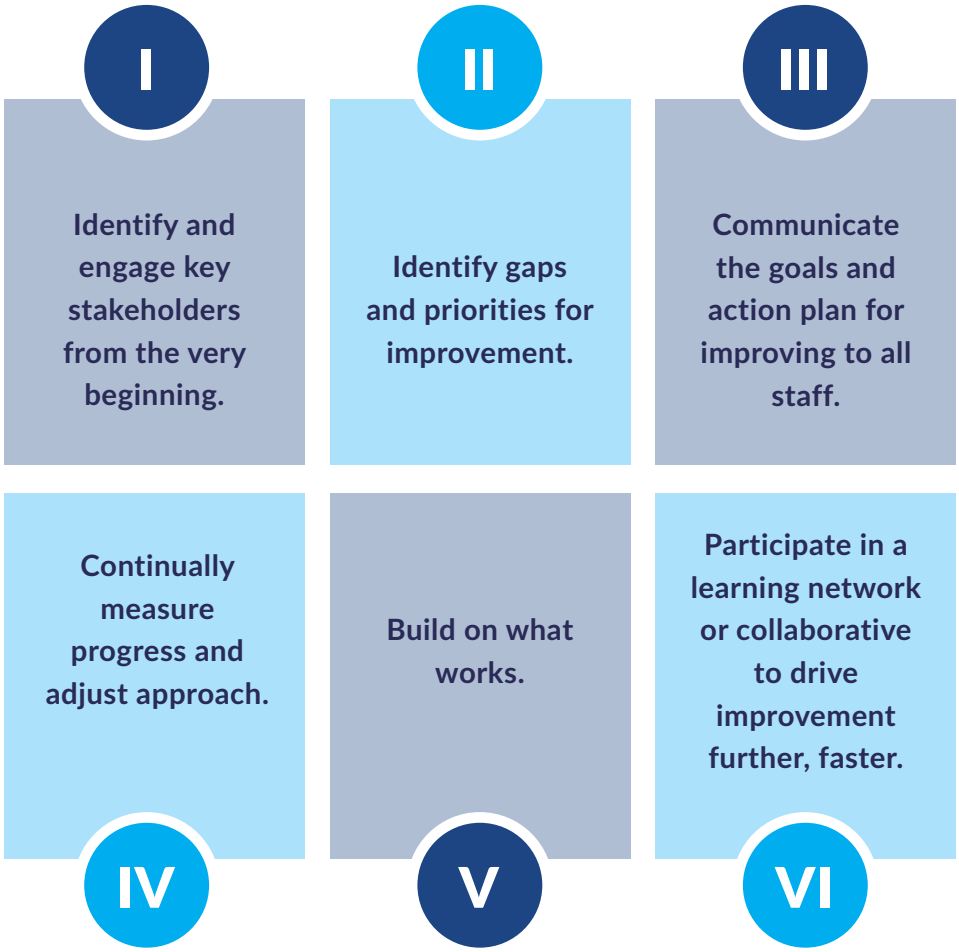
THE CASE FOR CHANGE

More than 750,000 people have died since 1999 from a drug overdose. More than 67,000 people died from drug overdoses in 2018 alone, making it a leading cause of injury-related death in the United States. Of those deaths, almost 70% involved a prescription or illicit opioid. Every day, more than 130 people die after overdosing on opioids—including prescription pain relievers, heroin and synthetic opioids such as fentanyl. In 2017, the U.S. Department of Health and Human Services declared the opioid crisis a public health emergency, underscoring the urgent need for better strategies to halt the epidemic. Since this declaration, national and local efforts to address OUD have been implemented and there has been a decline in overdose deaths, with 2018 data indicating opioid-related overdoses have started to decrease. But there is still more work to be done to reduce mortality rates.[1]

A "reachable moment" for many people with OUD is at a hospital, either as a patient in an emergency department (ED), maternal child health unit, outpatient surgery or as a hospital inpatient. This touchpoint with a healthcare organization is an opportunity to make a meaningful difference in reducing deaths from overdose in the future, either by preventing new opioid starts with prescribing standards, or by preventing opioid-related deaths by providing access to addiction treatment.

[1] *Centers for Disease Control & Prevention: Opioid Overdose/index.html*

A BLUEPRINT FOR SUCCESS



Hospitals can address several critical factors to improve outcomes for patients. The above blueprint outlines foundational building blocks that hospitals can use to design and implement initiatives to improve outcomes and reduce opioid-related deaths in a way that fits the needs of the particular hospital and the community they serve.

FOUNDATIONAL RESOURCES

Stem the Tide: Addressing the Opioid Epidemic (AHA)

Advancing the Safety of Acute Pain Management (IHI)

Effective Strategies for Hospitals Responding to the Opioid Crisis (IHI)

A Health System–Wide Initiative to Decrease Opioid-Related Morbidity and Mortality (TJC)

I

Identify key stakeholders and a team to champion this effort, including but not limited to, staff from the following areas:

- Executive sponsor
- Pharmacy
- Department providers and staff: ED, medical inpatient, surgery, obstetrics
- IT
- Registration
- Quality Improvement

II

Perform a self-assessment to identify gaps and priorities for improvement. Early wins matter; start with the most accessible change initiatives.

- Identify opportunities at the state level and/ or county level (OUD deaths, ED visits, hospitalizations, prescriptions, etc.)
  - Annual Surveillance Report of Drug Related Risks and Outcomes (CDC)
  - State Public Health Department (e.g., CA Opioid Overdose Surveillance Dashboard, Minnesota Department of Health Opioid Dashboard)
- Identify opportunities at the hospital level: Opioid Safe Hospital Self-Assessment

III

Once the team identifies priorities, develop a communication plan including the purpose, goal and steps in the change process for all staff.

- Develop goals around reducing OUD-related deaths and increasing access to addiction treatment for all patients.
- Explain the what, why, how and "What's in it for me?"

IV

Make a small change; complete Plan Do Study Act (PDSA) cycles; "adapt, abandon or adopt" new practices; and continue moving forward.

- Fail fast.
- Track what works and what doesn't.
- How do you know that change is an improvement? Measure progress!
  - Use measurement tips included throughout this blueprint.
  - Use existing measures whenever possible.
  - Select three to five meaningful measures to track over time.

V

Use lessons learned from the small tests of change to continue to drive improvement.

- Build on what works.
- Continue to tweak the process as needed.

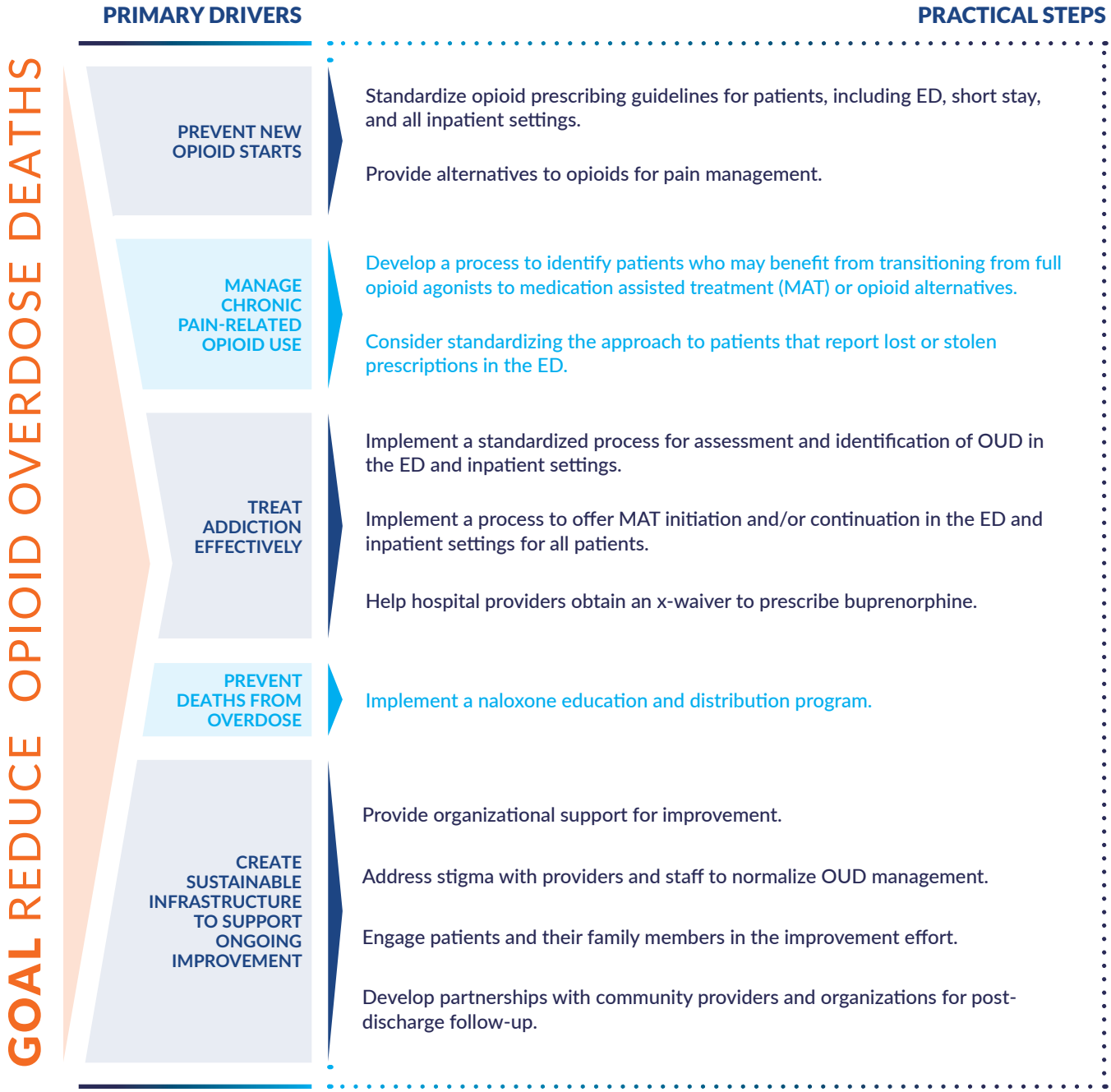
VI

Participate in a learning network or collaborative to help drive improvement further, faster.

- Peers are a great resource. If a learning collaborative is available in your area, join it.
- Don't have time to participate in a collaborative? Do site visits, shadowing, call peers and review literature (see some resources on the previous page).

DRIVERS FOR IMPROVEMENT
IN REDUCING OPIOID-RELATED DEATHS

The below drivers for improvement are critical to improve opioid care and reduce opioid deaths. The activities below are rooted in evidence-based guidelines and practices, the Joint Commission's pain-management standards and the real-life expertise of our work group members. The driver diagram shows the causal relationship between the overall aim of reducing opioid overdose deaths, the critical elements that will drive change, and practical steps hospitals can implement to address those drivers. Use this driver diagram to help you and your care team design and implement an approach for your facility.



Driver 1 PREVENT NEW OPIOID STARTS

Reducing the number of new opioid prescriptions is the first step hospitals can take to address the opioid epidemic. Prescribing practices that include pain-management alternatives to opioids, especially in response to chronic pain, may be effective for many patients.

PRACTICAL STEPS

Standardize opioid-prescribing guidelines for patients in ED, short stay, and all inpatient settings.

Develop and implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new starts on long-term opioid treatment (with exceptions for cancer care and end-of-life care). Service lines should include ED, medical inpatient, general surgery and obstetrics. Start small with one department or service line before spreading to other areas. In the last year alone, over 9,000 patients with OUD presented to California EDs, highlighting the opportunity for improvement in this area.[2] Collaborate with other local hospitals to share best practices when developing and implementing guidelines. In California, examples of local and statewide collaboration include Cal Hospital Compare's Opioid Care Webinars, the CA BRIDGE grant and the California Opioid Safety Network. There are many established collaborative learning communities working to address the opioid epidemic across the country for hospital organizations to join in their local area.

[2] *California Opioid Overdose Surveillance Dashboard*

HELPFUL RESOURCES

Ensuring Emergency Department Patient Access to Appropriate Pain Treatment (ACEP)

Optimizing the Treatment of Acute Pain, the Emergency Department (ACEP)

Safe and Effective Pain Control After Surgery (ACS)

Pain Management & Comfort Options for Patients (John Muir Health)

Postpartum Pain Management (ACOG)

Opioid Prescribing Guidelines (MN DHS)

Non-Opioid Treatment (American Society of Anesthesiologist)

Alternatives to Opioids Program (St. Joseph's Regional Medical Center)

Pain Pathways by Indication (Colorado ALTO Project)

ED guidelines

- Use alternatives to opioids for pain when possible, which includes both medication and non-medication alternatives.
- If opioids are necessary, prescribe limited dosages (e.g., XX Morphine Milligram Equivalent (MME)) and durations (e.g., <7 days) to patients on discharge.
- As a general rule, do not prescribe both opioids and benzodiazepines to patients at discharge.
- Prescribing guidelines should include assessment and related dosing recommendations for either opiate-naïve or opiate-tolerant patients.

- Limit or eliminate carisoprodol (Soma) from the formulary, as it increases the risk for respiratory depression.
- When developing prescribing guidelines, identify exceptions such as cancer or end-of-life patient populations.

Inpatient or short-stay department guidelines

- Set expectations in advance for patients and families about pain management during pre-operative visits.
- Offer alternatives to opioids to patients after surgery for pain management.
- When opioids are necessary, limit prescribing to short-term use.
- When developing prescribing guidelines, identify exceptions such as cancer or end-of-life patient populations.
- Consider developing post-discharge prescribing guidelines for common procedures.
- Prescribing guidelines should include assessment and related dosing recommendations for either opiate-naïve or opiate-tolerant patients.
- For patients on benzodiazepines on admission, continue or taper dosage as needed if also administering opioids for pain management.
- As a general rule, do not prescribe both opioids and benzodiazepines to patients at discharge.
- Implement Enhanced Recovery After Surgery (ERAS) protocols for select procedures to both reduce the use of opioids post-operatively and improve recovery.

Provide alternatives to opioids for pain management.

A multi-modal pain-management program should include:

- Guidelines for pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic and fracture/dislocation (ALTO Program).
- Non-opioid approaches as first-line therapy for pain, while recognizing it's not the solution to all pain.
- Patient engagement that includes discussion about realistic pain management goals and addiction potential.
- Aligned standard order sets with the non-opioid analgesic, multi-modal pain-management program.
- Pharmacologic alternatives to opioids (e.g., NSAIDs, acetaminophen, non-opioid patches, medications for neuropathic pain, nerve blocks, etc.) on hospital pharmacy formulary and available for use.
- Non-pharmacologic alternatives to opioids (e.g., virtual-reality pain management, acupuncture, chiropractic medicine, guided relaxation, music therapy, etc.) along with supportive pathways for care teams to incorporate them into patient care (e.g., integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, etc.).

OPTIONS FOR MEASURING PROGRESS

Potential Outcome Measures (doesn't apply to patients with cancer diagnoses or end-of-life care):

- *Measure name*: Opioid prescribing rate in the ED
  - *Numerator*: Number of patients presenting to the ED with complaint of pain given opioid prescription
  - *Denominator*: Number of patients presenting to the ED with complaints of pain
- *Measure name*: Opioid prescribing rate for Short Stay or Inpatient Discharges
  - *Numerator*: Number of patients discharged from Short Stay or Inpatient areas with opioid prescription for greater than 3-day supply
  - *Denominator*: Number of patients discharged from Short Stay or Inpatient areas

Potential Process Measures (doesn't apply to patients with cancer diagnoses or end-of-life care):

- *Measure name*: Opioid prescribing appropriateness
  - *Numerator*: Number of opioid prescriptions written in either ED, short stay or inpatient areas at discharge that comply with the organizational standard guidelines
  - *Denominator*: Number of opioid prescriptions written in either ED, short stay or inpatient areas at discharge
- *Measure name*: Rate of use of alternatives to opioids
  - *Numerator*: Number of patients presenting with complaints of pain with documented offering of alternative pain management
  - *Denominator*: Number of patients presenting with complaints of pain
- *Measure name*: Rate of proper use of opioids—concurrent prescribing (CMS eCQM starting 2022)
  - *Numerator*: Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge
  - *Denominator*: Inpatient hospitalizations prescribed a new or continuing opioid or benzodiazepine at discharge

UNDERSTANDING AND OVERCOMING BARRIERS

- Changing prescribing patterns requires physician and staff buy-in using a multi-pronged approach. Successful strategies include:
  - Focused feedback to providers on MME/patient
  - Developing, implementing and educating on opioid discharge prescribing protocol
  - Training on the medical model of addiction
  - Human-centered design (e.g., reduce default pill count in the EMR to five pills)
  - Celebrating successes
- Challenges to offering alternatives to opioids for pain management may include:
  - Comfort-care items may be expensive and not billable, so choose an approach that works for your hospital and patients.
  - Takes additional provider and nursing time to explain alternatives and set realistic expectations on pain management. Consider engaging spiritual care services or other staff members who can connect with and support patients.

HOW HAVE OTHERS DONE THIS?

Scripps Health Reduced the average number of opioid pills prescribed per patient by 25% in just 12 months through the development and implementation of system-wide prescribing guidelines for opioid-naïve patients experiencing acute pain. Guidelines were integrated into the electronic medical record (e.g., default pill count for certain opioids in the ED were lowered to five or ten and the prescriber would need to actively change the quantity to prescribe higher amounts). Procedure-specific guidelines were also developed to help educate providers on appropriate discharge prescribing practices. Key factors that have contributed to the success of this effort are: 1) prescriber education and engagement, and 2) the opioid stewardship committee's support and oversight.

UCLA Health Developed and implemented a set of recommendations for post-surgical opioid prescriptions for opioid-naïve patients for common procedures. While these guidelines are being integrated into the electronic medical record, the health system is generating awareness by distributing the physician pocket guide with this information during the credentialing and re-appointment process and to residents engaged in their residency program. To further improve opioid prescribing habits, UCLA Health tracks opioid prescriptions via their e-prescribing program and has aimed to maximize their electronic prescribing to help improve guidelines as well as finding areas that may need more education.

John Muir Health Supported their multi-modal pain management program by giving patients a brochure on pain management and comfort options. The brochure helps staff manage patient expectations while also providing patients with ideas for collaboratively managing their own pain in partnership with their care team.

Missouri Hospital Association Developed hospital discharge prescribing guidelines based on hospitals adopting a medication-first model, incorporating both naloxone as a rescue medicine and buprenorphine to treat OUD, leveraging existing community resources to ensure patient access to treatments through transitions of care, and improving opioid prescribing practices to reduce OUD and overdose.

St. Joseph's Regional Medical Center Implemented an Alternatives to Opioids (ALTO) Pain Management program across their EDs for renal colic, musculoskeletal extremity and back pain, acute or chronic abdominal pain, headache, and procedural pain control. Critical to success is formulary management and provider engagement.

Colorado Hospital Association In 2017, CHA and its partners developed the Colorado Opioid Safety Pilot, a study that was conducted in 10 hospital EDs over a six-month span with a goal of reducing the administration of opioids in those EDs by 15%. The cohort of 10 participating sites achieved an average 36% reduction in the administration of opioids during those six months, as well as a 31.4% increase in the administration of alternatives to opioids (ALTOs).

Driver 2 MANAGE CHRONIC PAIN-RELATED OPIOID USE

Management of chronic pain without opioids is possible in certain cases. For patients currently treating chronic pain with opioids, it's important to discuss tapering strategies and replacement with alternatives to opioids where appropriate. It's also important to develop processes to maintain opioid prescribing care with patients who present to the ED. When opioids are tapered too rapidly, patients often turn to more dangerous sources of opioids that are harder to manage and have worse outcomes, such as illicit fentanyl. In general, chronic pain is best treated and managed by a pain specialist or primary care physician in the outpatient setting. Only one provider and one pharmacy should help patients with chronic prescription medications.

PRACTICAL STEPS

Develop a process to identify patients who may benefit from transitioning from full opioid agonists to MAT or opioid alternatives.

Opioids shouldn't be abruptly discontinued for patients with chronic use. The Centers for Disease Control and Prevention (CDC) has issued guidance on the misapplication of the *Guideline for Prescribing Opioids for Chronic Pain* that can risk patient health and safety. Consider prioritizing patients at highest risk for overdose to discuss tapering. This includes:

- Patients who receive greater than 100 MME per day
- Patients who receive medications from another healthcare provider (As a general rule, don't prescribe chronic pain medications to these patients.)
- Patients who are dually prescribed opioids and benzodiazepines
- Patients with an anxiety component to their pain perception (Consider psychiatric consultation.)

HELPFUL RESOURCES

Guidelines for Prescribing Opioids for Chronic Pain (CDC)

Emergency Department Pain Medication Prescribing Guidelines (Safe Prescribe Monterey County)

Opioid Patient Prescriber Agreement (UC Davis Health System)

Consider standardizing the approach to patients who report lost or stolen prescriptions in the ED.

- Consider consulting your state's Prescription Drug Monitoring Program (PDMP) database.
- Implement medication-management agreements with patients.
- Standardize discharge prescription instructions to include information that a prescription will not be refilled or replaced.
- Consider drug screening.

OPTIONS FOR MEASURING PROGRESS

Potential Outcome Measure:

- *Measure name*: MAT Initiation Rate
  - *Numerator*: Number of patients identified with OUD that initiate MAT while in the hospital setting
  - *Denominator*: Number of patients identified with OUD

Potential Process Measure:

- *Measure name*: Rate of referrals for patients who may benefit from MAT
  - *Numerator*: Number of patients identified with OUD that were offered MAT while in the hospital setting
  - *Denominator*: Number of patients identified with OUD
- *Measure name*: Rate of referrals to community providers
  - *Numerator*:Number of patient identified with OUD that receive a referral to a community provider for follow-up care
  - *Denominator*: Number of patients identified with OUD

UNDERSTANDING AND OVERCOMING BARRIERS

Patient-satisfaction scores are a priority for hospitals and providers alike. It's challenging for care teams to strike the balance between proper care and patient satisfaction for patients with chronic pain on opioids. Most will agree that chronic pain is best treated and managed by a pain specialist or primary care physician in the outpatient setting. Setting realistic pain expectations, involving a behavioral health provider, offering alternatives to opioids, initiating MAT, and/or providing a single PO dose of pain medication are all effective strategies.

HOW HAVE OTHERS DONE THIS?

Implementing Countywide Prescribing Guidelines: Emergency Department Pain Medication Prescribing Guidelines—Safe Prescribe Monterey County

Engaging Patients in Improving Opioid Safety: Opioid Patient and Prescriber Agreement—UC Davis Health System

Driver 3 TREAT ADDICTION EFFECTIVELY

Identification and treatment of OUD is a key driver for reducing deaths from opioid overdose. Patients should have access to start MAT when they present to the ED or other hospital departments. The ability to successfully implement a program to treat addiction effectively is contingent on the ability to identify OUD. Identification is both an art and a science. There are no evidence-based OUD screening tools. However, hospitals have had great success developing and implementing screening tools that best fit their patient population, such as this Opioid Risk Tool created by the Community Hospital of the Monterey Peninsula.

PRACTICAL STEPS

Implement a standardized process for assessment and identification of opioid use disorder in the ED, short stay settings and all inpatient settings.

- Standardize assessment of opioid use history to include the following while also taking into consideration your hospital's unique patient population:
  - Opioid use history (e.g., naïve versus tolerant)
  - Co-morbid behavioral health conditions
  - Pain history
  - Current medications
  - Daily dosage/morphine milligram equivalent (MME)
  - Use of extended-release or long-acting opioids
  - Use of benzodiazepine medications
- Consider offering addiction treatment to all patients as an alternative to screening, given the lack of evidence-based OUD screening tools.

HELPFUL RESOURCES

Clinical Opioid Withdrawal Score (J Psychoactive Drugs)

Buprenorphine Hospital Quick Start Algorithm (CA BRIDGE)

Complete Guide: Inpatient Management of Opioid Use Disorder: Buprenorphine (Project SHOUT)

Complete Guide: Inpatient Management of Opioid Use Disorder: Methadone (Project SHOUT)

Quick Guide: Acute Pain and Perioperative Management in Opioid Use Disorder (Project SHOUT)

Buprenorphine Waiver Management (SAMHSA)

How to Pay for It: MAT in the ED (CHCF)

How to Pay for It: MAT for Hospitalized Patients (CHCF)

Implement a process to offer MAT initiation and/or continuation in the ED, short stay settings, and inpatient settings for patients identified with opioid use disorder.

A MAT program should include:

- A standardized method for identifying patients eligible for MAT or already on MAT
- A system for initiating MAT in the ED and inpatient or short stay areas of the hospital that includes follow-up guidelines such as the CA BRIDGE Buprenorphine Hospital Quick Start Algorithm. For inpatients, MAT may be used to manage withdrawal while a patient's comorbid medical issues are being addressed, regardless of whether a patient is committed to long-term outpatient MAT.
    - Symptom management guidelines
    - Standardized re-evaluation time intervals for patients
    - Discharge guidelines
        - *If no X-waiver*: Use loading dose up to 32mg for long effect, provide follow-up care in the ED that is in alignment with the DEA Three Day Rule, or connect patient to X-waivered community provider for immediate follow-up care.
        - *If X-waiver*: Prescribe sufficient buprenorphine and connect patient to X-waivered community provider for follow-up care within 24 to 72 hours.
- Almost all patients receiving buprenorphine or methadone as part of a chronic treatment program need to be maintained on these agents during hospitalization and mechanisms in place to detect opioid withdrawal if the medication history is not readily available.
- One or more hospital staff with the time and skills to engage with patients on a human level, motivating them to engage in treatment, e.g., Substance Use Navigators (SUNs).
- Hospital has an arrangement with at least one community provider to accept referrals within 72 hours. Staff provides assistance and follow-up to help patients successfully access outpatient treatment.

Help hospital providers obtain a practitioner waiver (aka X-waiver) to prescribe buprenorphine at discharge.

Under the Drug Addiction Treatment Act of 2000, all providers can initiate MAT with buprenorphine in the hospital setting. This is particularly important for patients withdrawing from opioids, but also valuable if patients request it or see it as an appropriate alternative when providing pain-management options. However, only waivered providers can discharge a patient with a buprenorphine prescription so that the patient can seek appropriate follow-up with a community provider. The X-waiver streamlines follow-up care for patients initiating MAT in the hospital setting by connecting them to outpatient services, and reduces the burden on hospitals to provide continued follow-up care.

To receive a waiver to practice opioid dependency treatment with approved buprenorphine medications, a practitioner must notify the SAMHSA Center for Substance Abuse Treatment (CSAT).

Get started building your numbers of waivered providers:

- Identify three to five physicians to encourage and support obtaining the practitioner waiver using both financial and non-financial incentives such as:
  - Paying for the training
  - Bringing the training to them
  - Facilitating the application process
  - Providing protected time to complete the application
  - Contract alignment
  - Bonus structure
- Consider supporting physician assistants, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and clinical nurse specialists (prescribing authority varies by state) in obtaining the practitioner waiver in addition to physicians. Under the SUPPORT Act, these practitioners can prescribe buprenorphine until October 1, 2023.

OPTIONS FOR MEASURING PROGRESS

Potential Outcome Measures:

- *Measure name*: Medication Assisted Treatment (MAT) rate
  - *Numerator*: Number of patients identified with OUD and provided MAT resources
  - *Denominator*: Number of patients identified with OUD
- *Measure name*: Rate of Appropriate Opioid Prescribing
  - *Numerator*: Number of opioid prescriptions given at discharge that meet organizational prescribing guidelines
  - *Denominator*: Number of opioid prescriptions given at discharge

Potential Process Measures:

- *Measure name*: Rate of availability of clinicians to prescribe buprenorphine
  - *Numerator*: Number of ED and/or IP shifts in 30 days with a provider on shift that is x-waivered
  - *Denominator*: Number of ED and/or IP shifts in 30 days
- *Measure name*: X-waivered provider rate
  - *Numerator*: Number of ED and/or IP providers that have obtained the x-waiver
  - *Denominator*: Number of ED and/or IP shifts in 30 days

UNDERSTANDING AND OVERCOMING BARRIERS

- Identifying and/or screening patients with OUD can be a challenge as there are no standardized, evidence-based screening tools available, the process itself may be time-consuming, and much of the information gathered is self-reported information therefore reliability is low. Rather than screening all or some patients for OUD, consider offering all patients MAT and overdose prevention.
- Most providers in the hospital setting have only a general understanding of addiction medicine and may be unprepared to initiate MAT using buprenorphine. This can be a barrier for many hospitals in developing a MAT program. Engaging and educating providers on the risk and evidence-based benefits of using buprenorphine to treat addiction is a must.
- The process for practitioners to obtain an X-waiver is a known barrier to most MAT programs. Rather than asking all practitioners to complete an 8-hour course and lengthy application process consider supporting/encouraging three to five practitioners across the hospitals so there is at least one waivered provider within the hospital at all times.

HOW HAVE OTHERS DONE THIS?

Marshall Medical Center Started Medication Assisted Treatment (MAT) with buprenorphine in their ED August, 2017 using the CA BRIDGE program model. In 2019, with the help of a Substance Use Navigator (SUN), 118 ED patients with OUD received MAT and were referred to treatment. More than 90 percent of referrals presented to an outpatient clinic for follow-up treatment. More than 60 percent of patients were still in treatment as of February 2020. Patient satisfaction scores have increased with the growth of the MAT program. The ED's *Left Without Being Seen* rate is at an all-time low. Key factors that have contributed to the success of this effort are: 1) A hospital culture focused on providing treatment options for patients with OUD and 2) Strong relationships with outpatient clinics that can offer standing appointment times for ED referrals.

Zuckerberg San Francisco General Hospital Providers in medical/surgical, obstetric, and intensive care units routinely treat patients with OUD who are admitted for acute medical or surgical issues. Patients who are on methadone or buprenorphine prior to admission are continued on their outpatient medication, and patients who have not yet engaged in treatment are offered these evidence-based medications. The hospital offers X-waiver trainings twice a year for 50-100 participants, and providers are waived in departments across the hospital. Order sets for starting and continuing these medications are integrated into the EHR, and multiple departments focus on naloxone distribution as a cross-cutting quality improvement strategy. Approximately 100 patients per month receive buprenorphine or methadone, of whom about one-third are newly initiating treatment and connecting to outpatient care.

Oregon Health Sciences University Their Improving Addiction Care Team (IMPACT) intervention includes a team-based inpatient consult service that engages patients identified with substance use disorder in developing an appropriate treatment plan including MAT, and the use of "in-reach" liaisons to create rapid-access pathways to outpatient care.

Driver 4 PREVENT DEATHS FROM OVERDOSE

Naloxone is a life-saving medication that reverses an opioid overdose while having little to no effect on an individual if opioids are not present in their system. Naloxone works by blocking the opioid receptor sites, reversing the toxic effects of the overdose. Naloxone requires a prescription but is not a controlled substance. It has few known adverse effects, and no potential for abuse.

Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin) or by intravenous injection.[3] An important tool in the prevention of opioid overdose deaths is distribution of intranasal naloxone to patients with opioid use disorder.

PRACTICAL STEPS

Implement a process for a naloxone education and distribution program.

- Implement standing orders and/or standard work for MDs and physician extenders to prescribe naloxone at discharge for patients with a long-term opioid prescription and/or at risk of overdose.
    - Discharge prescriptions sent to patient's pharmacy of choice
- Consider a standardized process to provide naloxone in hand to all patients, caregivers and visitors at low or no cost while in the hospital setting.
    - Any staff member (examples include MD, PA, NP, pharmacist, RN, LVN, health coach, substance use navigator, clinical social worker, research staff, ED technician, clerk, medical assistant, security guard) can identify a patient, visitor or caregiver who would benefit from access to naloxone.
    - Any staff member may act as an overdose prevention educator, provided they complete standardized training.
    - The Overdose Kit is directly dispensed, and dispensing is documented.
    - The overdose prevention educator provides education while reviewing instructional brochure with patient.

HELPFUL RESOURCES

Overdose Prevention and Take-Home Naloxone Projects (Harm Reduction Coalition)

Naloxone Kit Materials (Harm Reduction Coalition)

How to Develop a Naloxone Distribution Program (Highland Hospital):

- Program Summary
- Brief Staff Instructions
- Detailed Staff Instructions
- Project Dispense Log
- Opioid Overdose Response Instructions for Patients & Families
- Hospital Standing Order Template
- Hospital Standard Operating Procedure Template

[3] *CA DHCS Naloxone Distribution Project Fact Sheet*

OPTIONS FOR MEASURING PROGRESS

Potential Outcome Measures:

- *Measure name*: Naloxone prescription at discharge after opioid poisoning, overdose and/or prescribed opioids at discharge
  - *Numerator*: Number of patients identified with opioid poisoning, overdose and/or prescribed opioids at discharge receiving naloxone prescription at discharge
  - *Denominator*: Number of patients identified with opioid poisoning, overdose and/or prescribed opioids at discharge
- *Measure name*: Naloxone dispensing rate
  - *Numerator*: Number of patients identified with OUD or at risk for overdose from opioids who receive a naloxone kit
  - *Denominator*: Number of patients identified with OUD or at risk for overdose from opioids

Potential Process Measure:

- *Measure name*: Rate of staff training to distribute naloxone kits
  - *Numerator*: Number of staff identified as able to distribute naloxone kits to applicable patients who have received education
  - Denominator: Number of staff *identified* as able to distribute naloxone kits to applicable patients

UNDERSTANDING AND OVERCOMING BARRIERS

The continued challenge for hospitals is providing patients with naloxone in hand at the time of discharge. Asking patients to fill their prescription at an outpatient pharmacy is an added step and fill rates are quite low. Specific barriers may include the following:

- Pharmacist concern for dispensing in the ED
- Lack of a hospital outpatient pharmacy for dispensing naloxone
- Limited experience prescribing/distributing to family and friends and not the patient
- HIPAA concerns or other privacy considerations with Substance Use Navigators (SUNs) and educators
- Stigma surrounding naloxone use, like that of needle exchange programs

HOW HAVE OTHERS DONE THIS?

Highland Hospital Provides no-cost naloxone in the hands of patients at-risk, their caregivers and any other visitors who might benefit from having access to this life saving medication. Under a hospital-wide standing order, a team of providers and staff, including lay people, are engaged in identifying eligible recipients, distribution and educating recipients on how to properly use naloxone. This program operates outside of the pharmacy department and allows for anonymous dispensing to overcome the stigma associated with OUD. The hospital acquires naloxone at no cost via the California Department of Health Care Service's Naloxone Distribution Project.

Sevier Valley Hospital Offers free opioid overdose prevention training for all community members on how to recognize an overdose and information about opioid misuse. Participants receive free naloxone kits. Individuals can visit any Intermountain community pharmacy in Utah and purchase naloxone without a prescription from their doctor.

Driver 5 CREATE SUSTAINABLE INFRASTRUCTURE TO SUPPORT ONGOING IMPROVEMENT

Prevention of deaths related to opioid use is a strategic priority that requires multi-stakeholder buy-in and programmatic support to drive continued/sustained improvements in opioid use (e.g., executive leadership, pharmacy, ED, IP units, etc.) An effective program to combat the opioid epidemic and reduce deaths from overdose requires an organizational infrastructure that supports a multi-pronged approach to improvement. This includes quality improvement expertise, leadership buy-in and support, clinical champions, and the ability to collaborate with other organizations and experts.

PRACTICAL STEPS

Address stigma with providers and staff to normalize OUD management.

- Provide education and promotion of the medical model of addiction across all departments to facilitate disease recognition and stigma reduction.
- Find and share stories of patients and families dealing with OUD or recent overdose cases with hospital personnel.
- Provide general education on hospital opioid prescribing guidelines, identification, and treatment and overdose prevention to all providers and staff (e.g., M&M, lunch and learns, push resources, CME requirements, RN competencies, etc.)
- Provide targeted follow-up and support to providers and staff based on performance.
- Provide education on evidence-based prescribing practices to reduce harm from opioids and share performance towards utilizing guidelines.
- Address the WIIFM (What's In It For Me) for providers and staff with the use of patient and provider stories.
- Begin tracking measures on hospital or department-wide opioid use, use of alternatives, doses of buprenorphine prescribed, pain-management effectiveness or other easy to capture data for evidence of success.

HELPFUL RESOURCES

FOR PROVIDERS/STAFF

Selection of relevant web-based trainings (Harm Reduction Coalition)

End the Stigma Flyer (Sacramento County)

FOR PATIENTS

Comfort option brochure for patients (John Muir Health)

Buprenorphine-Naloxone: What You Need to Know – Flyer (Project SHOUT)

Know your options for successful treatment – Flyer (Project SHOUT)

Opioid Fact Sheet for Patients (El Camino Hospital)

DISCHARGE TO THE COMMUNITY

Substance Use Navigator Overview (CA BRIDGE)

Drug Screening Treatment Referral Form (Southeast Health Group)

Engage patients and their families in the improvement effort.

- Provide education to patients using the hospital website, newsletters and written communication at the hospital.
- Include a former OUD/SUD patient or family member on the improvement team or include a member of the hospital's Patient and Family Advisory Committee.
- Convene a group of former OUD/SUD patients for a focus group on their experiences to better understand how the hospital may improve efforts to address the risk of harm from opioids.

Develop partnerships with community providers and organizations for post-discharge follow-up.

- Develop formal relationships with the community organizations with which you share the care of your patients.
- Develop an inventory of community partners and resources.

OPTIONS FOR MEASURING PROGRESS

Potential Outcome Measure:

- *Measure name*: Rate of new chronic opioid starts
  - *Numerator*: Number of patients who received a new opioid prescription still in use after 30 days as identified through the applicable state PDMP
  - *Denominator*: Number of patients that received a new opioid prescription

Potential Process Measures:

- *Measure name*: Patient and family engagement to implement a process for including former patients or family members in the review and development of prescribing guidelines
- *Measure name*: Development of formal educational programs to address stigma and medical model of addiction for staff.
- *Measure name*: Development of a team designated to oversee opioid efforts
- *Measure name*: E-prescribing rate by department

HOW HAVE OTHERS DONE THIS?

Mission Hospital, Mission Viejo Deployed a Behavioral Evaluation and Addiction Management (BEAM) Team of registered nurses to proactively identify and manage patients at risk for behavioral issues and disorders in the acute inpatient setting, respond to any care provider's concern about patient or staff, and conduct in-time staff education on managing behavioral issues regarding appropriate initial medications, triggers for titration of medications, withdrawal symptom management, reassurance about proper benzodiazepine dosing, or upgrade to higher level of care.

UC Davis Health This Substance Use Navigator (SUN) program has become a model for other CA hospitals. The SUN works alongside the ED care team to increase access to treatment for patients with OUD. SUNs communicate with patients, consult with providers to start treatment, guide patients through the next steps of ongoing care, and establish relationships with community-based resources and treatment facilities.

Prescribe Safe Monterey County Prescribe Safe is meant to guide, educate, and provide resources for local physicians and patients in the use of prescription medications and promote effective pain management in Monterey County. The Prescribe Safe initiative was created by Monterey County law enforcement, administration of the four Monterey County hospitals, and local physicians in response to concerns about prescription medication misuse in the county.

Boston Medical Center In an effort to reduce stigma towards persons with OUD, BMC instituted a hospital-wide language pledge around addiction. The pledge provides information for all staff about the importance of word choice when interacting with patients and their families (e.g., words like "addiction" or "person in recovery" versus "drug habit" or "clean.")

CONCLUSION

Please use this blueprint as one tool to strengthen opioid care provided to patients in your hospitals and communities. Mold these guidelines and tactics to fit your unique hospital, providers and patients. There will be times when prescribing opioids for pain relief is the most appropriate treatment option. However, hospitals have many more opportunities to prevent addiction and support those with OUD in getting the help they need to thrive. By working together, we can improve healthcare, faster.

Cynosure Health is a nonprofit organization dedicated to improving healthcare by fostering innovative solutions to address healthcare's toughest challenges. For over two decades, the Cynosure team has delivered far-reaching results with a steady focus on driving sustained, high-impact change. Contact us at **Cynosure@CynosureHealth.org** or 916-772-6090, or go to **CynosureHealth.org** to learn more.