**HealthTrust Members Take On the Opioid Epidemic:**

**Awareness and Education Initiatives Underway**

Health systems participating in the inaugural HealthTrust Perioperative Pain Management Collaboration Summit last April have made significant progress in raising awareness of the risks posed by prescription opioid drugs—notably, unpleasant side effects that include chronic use and dependency. Understanding current prescribing patterns, and why some physicians rely on opioids more than non-narcotic alternatives, are among the investigative tasks currently underway.

As originally envisioned, the objective of the summit was for participants to use clinical evidence and best practices to develop organization-specific strategies for implementing multimodal approaches to managing surgical pain. But, as described by one of the co-authors of a recent *Health Affairs* blog post—**Michael Schlosser**, M.D., MBA, FAANS, chief medical officer (CMO), HCA National Group and vice president, Clinical Excellence and Surgical Services at HCA—the conversation quickly shifted to “ways to change the pervasive and damaging culture of reflexive prescribing for pain management.”

HCA Healthcare is one of two health systems at the event that have launched a major education initiative in hopes of reversing the disturbing trend of opioid addiction that often begins with a surgery. The other is San Diego-based Scripps Health, whose opioid stewardship initiative was awarded the 2017 HealthTrust Innovation Grant (*see article on page xx*). With the same end in mind, Franklin, Tennessee-based Community Health Systems (CHS) is fast-tracking development of enhanced recovery after surgery (ERAS) programs, which in 2018 will be the top priority of CMOs systemwide.

“Before I attended the summit, I was unaware of the solid connection that had been made between people having surgery and developing an opioid addiction,” says CHS Vice President of Clinical Services **F.J. Campbell**, M.D., MBA. “I couldn’t shake it. These patients are literally between a rock and a hard place, and we’re putting them there. Knowing was enough to make us intolerant of complacency.”

**FOCUS ON JOINT REPLACEMENTS**

 Leaders at HCA’s TriStar Centennial Medical Center, including CEO **Scott Cihak** and CMO **Divya Shroff**, M.D., have enthusiastically embraced the idea of wholesale culture change around the way pain is viewed, assessed and treated, according to summit attendee **Jeffrey Hodrick**, M.D., an orthopedic surgeon with Nashville, Tennessee-based Southern Joint Replacement Institute (SJRI).

The group is working to identify the most effective pain management regimen for its patient population, which is expected to involve fewer narcotics. SJRI surgeons have created a database that allows them to make changes to prescriptions on the fly based on how well patients’ pain is being managed, he explains. Currently under investigation is a perioperative cocktail of the pain medicines bupivacaine, ketamine and ketorolac, which gets injected around the knee or hip being replaced and appears to decrease the need for narcotics in the perioperative period. The doctors are also researching the benefit of using the older intravenous anesthetic ketamine, especially for patients known to be chronic narcotic users.

Aromatherapy has already been embraced as a pain-reducing strategy by surgeons at SJRI, says Hodrick. Other alternative pain management practices commonplace in obstetrics and oncology, including massage and acupuncture, are also being explored for use in the surgery setting.

According to data pulled from the state’s Controlled Substance Monitoring Database, orthopedic surgeons at SJRI aren’t currently overprescribing narcotic pain medicines at discharge, says Hodrick. But that’s the baseline for measuring the impact of ongoing initiatives. The biggest opportunity overall will be in preventing diversion of opioids from the individual for whom they were prescribed to another person—often a loved one at home—for illicit use. That highlights the need for patient education about how to securely store and safely dispose of unused narcotics, as covered during the U.S. Drug Enforcement Administration’s annual Prescription Drug Take Back Day.

 In the near future, Hodrick says, he hopes to see greater adoption of a functional pain scale for joint replacement patients that would limit the prescribing of pain medicines to instances where they’re truly needed—e.g., those who have trouble getting out of bed or engaging in physical therapy. “There’s a big difference between being uncomfortable and being totally incapacitated by pain, which I don’t think describes a lot of our patients.”

With the support of a pharmacist from a psychiatric hospital, TriStar Centennial Parthenon Pavillion, a large in-service event was recently held to educate nurses on how to identify, diagnose and treat opioid withdrawal symptoms, says Hodrick. Eventually, much of what is being piloted with joint replacement patients is expected to be rolled out more broadly across Centennial Medical Center. Some of the key principles—e.g., as much as possible use medicines that are non-narcotic, non-systemic and have no addictive properties—would apply, irrespective of the surgical population.

On the patient education front, Hodrick has been exploring the idea of having Centennial Medical Center host a communitywide event drawing attention to the diversion issue. A brochure designed to raise awareness of the opioid epidemic, and the potential for misuse and addiction of narcotic pain relievers, is expected to be ready for distribution across the hospital and its associated clinics by the end of this year.

Hodrick notes that he is keeping Centennial’s Joint Replacement Council apprised of progress. It’s a large, diverse group that includes hospital administrators, surgeons, nurse managers, operating room managers, case managers and environmental services, each of whom provides support as needed for the various pain management initiatives.

Additionally, Hodrick is serving as a subject matter expert at some of the upcoming regional pain summits HCA Healthcare has planned around the country. The objective is for HCA hospitals and divisions to develop specific action plans for balancing patient comfort and safety, and a process for continued collaboration well into the future.

**Emergency Department Is a Good Place to Start**

First steps taken by Brentwood, Tennessee-based LifePoint Health included presenting enterprisewide data on prescriptions per 100 patient ED encounters—looking at all controlled substances, not just opioids—at its biennial Executive Patient Safety Conference in June, which also featured a breakout session on the opioid crisis, says National Medical Director **John Young**, M.D., MBA, FACHE. The conference had approximately 600 attendees, including CEOs, COOs, CMOs and CNOs from most of its 72 hospitals.

The aggregated data revealed what has been reported in related literature—notably high variability across prescribers and states, says Young. This includes a proportionately higher level of opioid prescribing in rural, less socioeconomically advantaged states where LifePoint has a market presence, including West Virginia, Utah and Kentucky.

Facility-specific data on the same metric was shared by one LifePoint hospital, pointing to a quantitative reduction in its opioid prescribing rate after issuing a guidance document on how to do so responsibly. LifePoint’s newly authored national guidance statement for EDs was revealed at the conference and disseminated across the enterprise in July. Tracking of its implementation and adoption is now underway, says **Carly Feldott**, PharmD, MS, CPPS, director of medication management informatics.

“We realize there’s much more to do beyond the ED space,” says Feldott. “It was just a really good starting point because we had the interest and buy-in from our ED Physician Guidance Council.” The group, national in scope and representation, had already begun working on a number of quality improvement initiatives that include standardizing the approach to managing painkillers and opiates.

At the corporate level, a new multidisciplinary Opioid Stewardship Committee is meeting monthly to guide efforts moving forward, Young explains. In addition to himself, it includes Feldott and other representatives from the IT clinical team, as well as subject matters experts from the quality department, pharmacy operations, surgical services and the ED. Upcoming initiatives include developing a multimodal pain management order set, reviewing the latest Joint Commission guidelines for pain management and assessment guidelines, and identifying appropriate “milestones and metrics” around opioids for the ED and surgical service lines. The director of surgical services, he adds, is also very interested in developing enterprisewide guidelines or strategy for ERAS programs. Currently, just a few LifePoint hospitals have a program of this type.

Efforts will “slowly but surely extend into the realm of primary care,” Young notes. “We’ll need to take inventory of who within that space is licensed to treat opioid withdrawal. Right now, we don’t know who across LifePoint is and is not doing that.”

The national guidance statement offers some suggestions for speaking with patients about pain, limitations on the dispensing of opioids and non-narcotic alternatives. LifePoint has many local-level “community coalitions” involving both hospitals leaders and regional resources, such as public health departments, which could be used as a forum for more broadly disseminating educational materials to patients, Young says.

**No-Cost ERAS**

CHS will most immediately be leveraging its 20-plus CMOs to lower the risk of post-surgery opioid addiction, says Campbell. One of its newest ERAS programs, funded and guided by the Agency for Healthcare Research and Quality, is being piloted at Tennova Healthcare – Lebanon under the leadership of CMO **James Morris**, M.D., another summit attendee. The initiative launched earlier this year by the American College of Surgeons (ACS) in collaboration with the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality in Baltimore, and will initially focus on colorectal surgery. Hundreds of hospitals nationwide will be similarly supported in implementing perioperative evidence-based protocols as a means to improve clinical outcomes, reduce healthcare utilization and improve the patient experience.

As many as seven CHS facilities could be enrolled in the ACS/Johns Hopkins program by the end of 2017, Campbell says, and the goal is to have 20 ERAS programs established systemwide in 2018. ERAS is expected to be central to the operational strategy of 12 accountable care organizations under development at CHS.