APPLICATION FORM

Title of Entry: Our Commitment to Community: Combating the Opioid Epidemic

Division: Small Organizations

Award: Excellence in Care

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Our Commitment to Community: Combating the Opioid Epidemic

The opioid epidemic has touched all corners of our state. In 2015, the Drug Enforcement Agency reported over 3300 deaths in Pennsylvania; an alarming 23.4 percent increase from the previous year (Golberg, 2016). This perilous situation has impacted our family, our friends, and our patients. We, as a healthcare organization, were troubled not only by the numerous statistics being distributed amongst our professional societies, but also the daily headlines from our local news outlets. From a healthcare organization perspective, perhaps the most startling statistic was that nearly 70 percent of new or occasional abusers of prescription medications obtained drugs from a friend or relative without asking (Hardesty, 2012). We recognized our opportunity, and our obligation, to do more for our community. Our entire health system committed themselves to reducing the number of pills prescribed and the number of opioid prescriptions initiated to parallel the duration of the acute, severely painful phase only. As our target audience included all patients within our system, we also committed to a strategic, consistent focus on robust opioid related patient education.

We embarked on this journey in early 2016 and started by examining our baseline data from the last quarter of 2015. This included not only the numbers related to the number of pills and prescriptions, but also our quality data as our organization strives to exceed the expectations of our patients in both clinical care and compassionate care. In 2015, our organization wrote for 16,976 opioid prescriptions totaling 666,952 pills. During this time frame, our organization was recognized by Press Ganey for our high patient satisfaction scores.

Our interventions included education for both our entire clinical staff and our patients. We also standardized the discharge prescriptions for our most common diagnoses and procedures. Our organizational standardized prescriptions were the result of assessing historic discharge prescription habits, combined with robust physician and provider engagement. Our providers and clinical team members relied on our patients for their feedback as to the number of opioid pills that were actually used from a particular prescription. Our initial protocols were simply starting points; as we constantly pushed providers to whittle down those numbers based on patient feedback and clinical outcomes.

The results of this program have been astounding. When comparing data from 2015 to 2016, we saw a 15 percent decrease in total prescriptions (14,372), and a 33 percent decrease in the overall prescribed volume of opioid tablets (447,968). These overall prescription reductions occurred during a time frame when our organization experienced a significant increase in patient visits. Careful to keep our patient's overall needs in mind, we also continued to maintain our high patient satisfaction scores.

Assessment

Focusing our efforts around the statistic that almost 70 percent of new or occasional prescription medication abusers procured the drugs from a friend or relative without asking (Hardesty, 2012), our target opportunities that were identified by an interdisciplinary team were prescriptions exceeding necessary quantities and superfluous "refills". (Please note, "refills" of opioid prescriptions are not allowed in Pennsylvania. In this article, we use the term refill as it is used in context as another prescription prolonging the duration of a treatment without a change in diagnosis, medication dose, or medication frequency. Per Pennsylvania requirements, continuation of opioid therapy beyond its originally prescribed duration would require a new prescription.) Understanding that some patients will keep any left-over prescription medication in their home, we wanted as little medication as possible to remain after a painful episode. That meant writing for prescriptions that did not exceed the expected duration of a severely painful episode. Historically, our prescription habits were primarily based around the duration of time between a patient's initial procedure or diagnosis and her follow-up appointment. Patients who are unable to move easily, or drive after certain procedures, could face hardships if another opioid pain medication prescription was warranted between appointments; as this meant returning to the physician for a hand-signed prescription followed by a visit to the pharmacy. Our priorities were to standardize opioid prescriptions amounts for our most common procedures and surgeries while slowly decreasing the overall amount prescribed in both quantity and duration. We aimed to better mimic the true medication needs of our patients, paralleling that acute, severely painful period only while using other medication modalities for mild pain. In addition, we prioritized creating education that was purposefully redundant for both our patients and our organization's clinical team members that was specific to the opioid treatment duration. This initiative's success was founded on the basis of a patient's involvement and understanding of their treatment care plan from their first encounter with any team member within the system. Our priorities meant that our measurable indicators included the quantity of opioids prescribed and the quantity of opioid prescriptions dispensed; all data that could be acquired though our electronic medical record system.

Intervention

Once priorities were initiated, a core group of team members representing various areas of the organization began tackling this initiative. First, we focused on data collection. We collected baseline numbers from the end of 2015 to serve as a comparison for our indicators. Per coding reports, we identified our most frequent procedures and diagnoses within the organization. After the list of procedures was collected, we researched each credentialed physician's discharge prescriptions per care event. Last, but certainly not least, we were sure to quantify our patient satisfaction scores as depicted in our Press Ganey scores.

The first item to address was standardizing the opioid prescription and duration. The information we collected from each physician was sorted so that we could clearly distinguish any differences in prescription patterns related to choice of medication, prescribed dose, frequency and duration. We were very respectful of this diversity, as each physician has incorporated his or her years of professional education, anecdotal lessons, and patient feedback into their care plan development. We were very clear in outlining there was no "right" or "wrong" prescribing habits; just differences. The next critical step after collecting this information was an open dialogue discussion with the

chair of the department or a high-volume producer within a particular service line, and a physician champion within the department. With clear evidence as to the issues facing our community, evidence of unique prescribing habits per physician, and a clear outline of goals towards this initiative, our physician leaders within the organization recognized the importance of a successful result. We looked for a consensus within the prescribing patterns, and asked our physicians to have discussions with their patients about the amount of medication used after discharge. With that information in hand, initial prescriptions outlining specific medications, quantities and duration were established. As we disseminated these initial prescription guidelines, we simultaneously challenged our clinical care providers to continue those patient conversations to determine if we could use less or decrease the length of treatment from those original targets.

Our organization's physicians guided our multidisciplinary team's efforts related to education. Once an expected duration of treatment had been established, we created an Opioid Safety Handout. This informative brochure discussed the importance of accurate past medical histories, common side effects of opioids, disposal options for unused medication, alternatives to typical pain medications, and outlined the duration of therapy and our organization's policy regarding refills. Before we introduced this handout to our patients, we placed emphasis on our own clinical staff members' education. We wanted each team member to deliver the same message to patients, with the confidence that their message would be reinforced by physicians and senior leadership also. Our organization also made certain to emphasize open communication from all team members. We frequently talked with front line team members to gain their feedback as it pertained to patient complaints, requests for refills, and other patient concerns.

Once the Opioid Safety Handout education was completed for clinical staff members, we rolled out our plan. Patients, from their first clinical encounter, could anticipate end points for certain therapies and independently plan for eventually weaning off these opioid medications. Physicians were able to answer more appropriate patient questions related to the risks of opioid therapy before it was initiated. Posters were displayed reminding teams of the standardized therapies approved by the physicians. As patients were treated, and complaints were few, we again asked our physicians to decrease the quantity prescribed. We did this until the number of patients requiring or requesting refills greatly increased; our own internal alert that the quantity prescribed was not meeting the majority of patients' needs.

Results

Overall, we achieved very positive results from this initiative. Comparing data from 2015 to 2016, we saw a 15 percent decrease in total prescriptions (from 16,976 annually to 14,372), and a 33 percent decrease in the overall prescribed volume of opioid tablets (from 666,952 annually to 447,968). These overall prescription reductions occurred during a time frame when our organization experienced a significant increase in patient visits. Careful to keep our patient's overall needs in mind, we were honored to again accept an award from Press Ganey related to our patient satisfaction scores in 2016.

We understand that this initiative must be a continuous program within our facility. As technology and procedural techniques continue to improve, we aim to continue our push to decrease the overall use of opioids while utilizing opioid-sparing medications and alternative pain relief methods during an acute, painful episode. We are committed to consistent patient education related to other pain relieving choices.

Adaptability

The ability to replicate this project amongst other organizations is very possible. Start this process focusing on the rewards of a successful project: less opioids within the community and better informed patients. Compelling information related to the opioid epidemic can unfortunately be found all around us. However, we have all been taught the old adage, "if it's not broke, don't fix it." This initiative defies that broken connotation, as organizations will be asking providers who do very well with patient satisfaction scores and who have very few complaints to change what is proven to work within their care plan.

Regardless of service line, or population type, data related to prescription habits can be extracted and discussed. If the organization has many providers caring for the same patient population, compile prescription information. Look for variation. Invite key stakeholders to review the information to better determine if opportunity for a change is both warranted and possible. In those organizations with very few providers within a single service line, we advocate to start with the patients. Ask patients how many tablets they used from their prescription. The answers may surprise providers and overcome any barrier to provider resistance. Alternatively, the organization may find that the prescribing quantity very closely aligns with the patient's need. This information can be extracted from patients during follow-up phone calls, prior to clinic visits, or with paper surveys distributed to patients upon dispensing a written prescription.

Data collection and assessment is paramount to the ongoing success of this initiative. We support continued oversight related to prescribing habits and patient feedback. As we experienced, had we not been monitoring our refill requests, we would not have realized that we had been too zealous in our efforts to reduce quantities for certain diagnoses. We also monitored for outliers, finding that education for our rotating residents who provided care at our organization several months after our initial system-wide education had been inadvertently overlooked.

Maintaining our initiative has also involved reaching out to other providers within our community to share our project's highs and lows. Ultimately, this project is aimed at improving the overall health of our community which means that we want all local providers, including facilities outside of our organization, to implement this type of project into their facility's population health goals. Our organization has invited local legislators to our facility to learn about our initiatives, the issues we see during clinical care, and to answer their clinical questions. In turn, we have been educated about their non-medical perspectives related to the opioid problem and their current strategies to combat this issue. Additionally, in sharing their own data collection information with us, we were better able to tailor our education and safe prescribing strategies. We have invited area drug abuse educators into our organization to better inform our clinical team members and administrators of the current trends as seen in our adolescent population. We recognize that we must continue to expand on our own education of this population health issue so that we do not become stagnate in our efforts. As relationships develop with civic leaders, they too will hold our organization accountable for continued success in their initiatives.

By extending our care beyond our walls, we live out a desire to make people's lives better not just through healthcare, but through concrete demonstrations of commitment to our community. Knowing that we are helping to make a difference enhances the meaning of our organization and translates our daily care into something even more far-reaching and worthwhile. We hope that all practitioners find key takeaways from our program so that they too can work towards a safer, healthier community.

Supporting Appendices and References:

Golberg, M. (2016, July 15). *DEA: Drug overdose deaths up sharply in Pennsylvania*. Retrieved April 28, 2017, from The Reporter: http://www.thereporteronline.com/article/RO/20160715/NEWS/160719879

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