

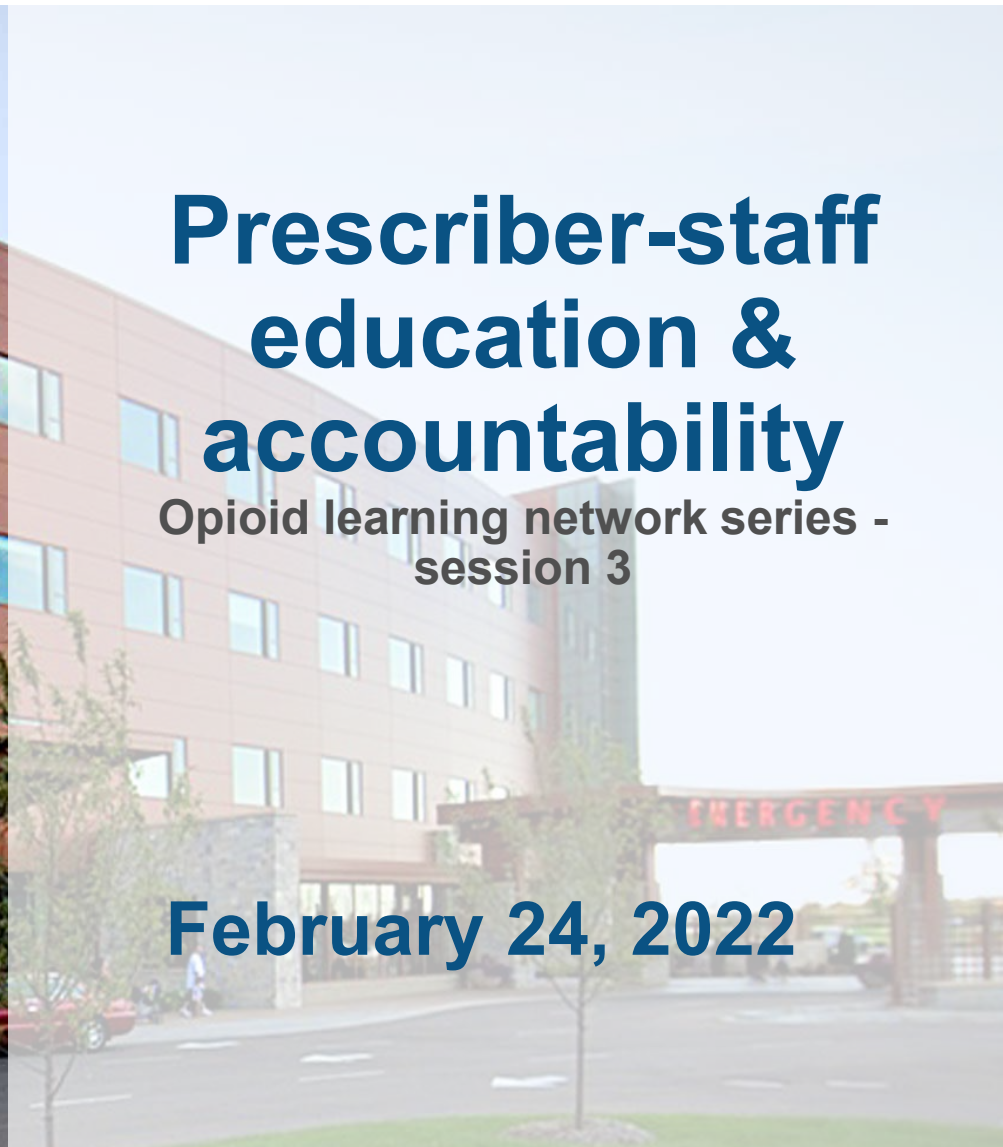


*Minnesota Hospital Association*

# **Prescriber-staff education & accountability**

**Opioid learning network series -  
session 3**

**February 24, 2022**



# MHA Opioid Stewardship Road Map



Minnesota Hospital Association

## Opioid Stewardship Road Map

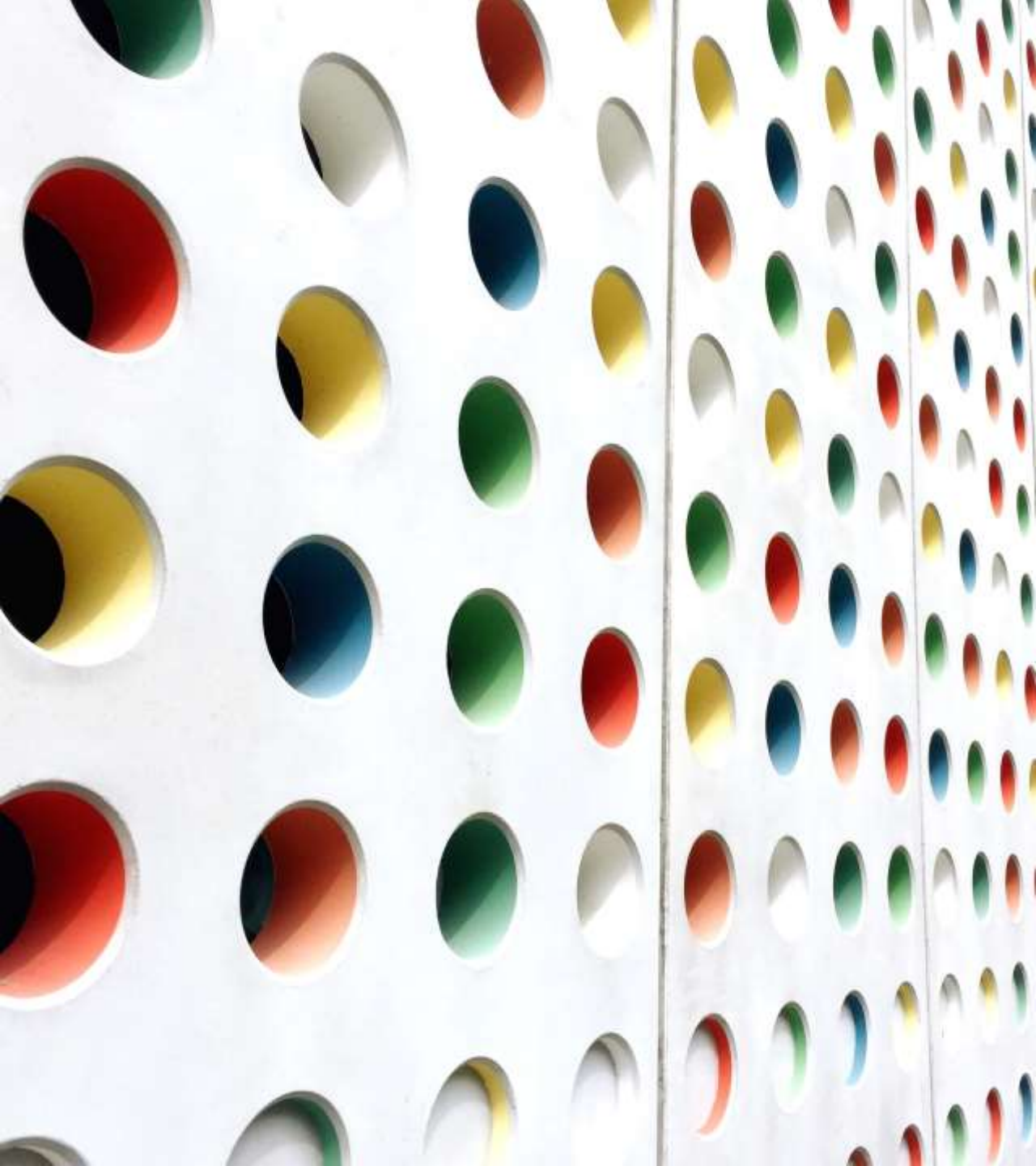
MHA's road maps provide clinics, hospitals and health systems with evidence-based recommendations and standards for the development of topic-specific prevention and quality improvement programs and are intended to align process improvements with outcome data. Road maps reflect published literature and guidance from relevant professional organizations and regulatory agencies, as well as identified proven practices. MHA quality and patient safety committees provide expert guidance and oversight to the various road maps.

**Operational definitions** are included to assist organization teams with roadmap auditing and identifying whether current work meets the intention behind each roadmap element.

**Resources** linked within the roadmap include journal articles, expert recommendations, electronic order sets and other pertinent tools which organizations need to assist in implementation of best practices.

**This road map is not intended for treating patients who are in active cancer treatment, palliative care, or end-of-life care.**

Track, Monitor, Report and Respond to Data	<ul style="list-style-type: none"> <li>□ Opioid prescribing is monitored, comparing like specialties and service lines for outliers.</li> <li>□ The organization has a means to gather prescribing practices that may include reports or dashboards with information. E.g., MME daily dose, number of scripts/refills, concurrent opioids, and benzodiazepines.</li> <li>□ Use data from external sources to identify patients at risk for overdose. i.e., pharmacy, emergency department and PMP.</li> <li>□ Data are collected and widely available for quality improvement purposes. E.g., number of new opioid prescriptions that exceed 3 days for acute pain, # or percentage of patients taking a long-acting opioid, # or percentage of patients taking &gt; 50 or 90 MME per day, # or percentage of patients on both opioids and a benzodiazepine, etc.</li> </ul>	<p><a href="#">Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain</a> includes 16 measures related to opioid analgesia.</p> <p><a href="#">SHM RADEO Toolkit</a> (Reducing Adverse Drug Events Related to Opioids Implementation Guide)</p>
Tapering	<ul style="list-style-type: none"> <li>□ Best-practice standards are followed for tapering patients off long-term opioid analgesics. Example: HHS Guide for Clinicians</li> <li>□ Unless there are life threatening or usage concerns, opioids are not tapered abruptly</li> <li>□ Taper rates are individualized to minimize opioid withdrawal symptoms with regular input sought from the patient</li> <li>□ Taper COAT patients receiving additional opioid therapy for acute pain to the pre-surgical or pre-injury dose as tissue healing progresses.</li> <li>□ Clinicians follow the HHS guidelines when tapering patients safely off of long-term opioid use</li> </ul>	<p><a href="#">Tapering and discontinuing opioid use</a> (mn.gov), 2021</p> <p><a href="#">HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics</a> (2019)</p> <p><a href="#">Tapering: How to Safely Transition Off Opioid Pain Medications</a></p>
OUD & MAT	<ul style="list-style-type: none"> <li>□ The organization supports early identification and treatment of patients with OUD utilizing evidence based best practices</li> <li>□ The organization encourages and supports clinicians in achieving the DATA 2000 waiver to provide medication assisted therapy (MAT) for opioid use disorder (OUD).</li> <li>□ Options of MAT, addiction screening and treatment within your organization or referral pathways that are clear and easy to use</li> <li>□ Clinicians offer or arrange evidence-based treatment for patients with OUD if not an option within the organization</li> </ul>	<p><a href="#">After Opioid Addiction: What It's Like to Go Through Medication-Assisted Treatment</a></p> <p><a href="#">Opioid Use Disorder on the Rise in Pregnant Women</a></p> <p><a href="#">Hennepin Healthcare Project ECHO</a></p>
Community Collaboration	<ul style="list-style-type: none"> <li>□ Community based coalitions, law enforcement, public nursing, mental health specialists, county personnel, and other social service agencies etc. to review data and work on community-based interventions. E.g., drug take-back days.</li> <li>□ Work with appropriate community champions to review data and work on community-based o.</li> <li>□ The health care organization has a process in place to provide information sharing with law enforcement, and have direct communication to troubleshoot emergency situations, which complies with HIPAA and Minnesota Health Records Act.</li> </ul>	<p>MHA's <a href="#">Health Care &amp; Law Enforcement Road Map</a></p> <p><a href="#">The Role of Community Coordinated Efforts in Combating the Opioid Overdose Crisis</a>, The Pennsylvania Opioid Overdose Reduction Technical Assistance Center</p> <p><a href="#">Collaborating with Communities   AHA</a></p> <p><a href="#">Community in Crisis- A Collaborative Approach to Responding to the Opioid Epidemic ASPMN</a></p> <p><a href="#">Community Forums to Address the Opioid Crisis: An Effective Grassroots Approach to Rural Community Engagement - PubMed Central (PMC)</a></p>



# Opioid Learning Network: Provider & Staff Education & Accountability

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# Disclosures

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Research funding from the National Institutes of Health and the Foundation for Opioid Response Efforts

Medicolegal expert work



# Disclosures

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# Objectives

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Understand why provider and staff education and accountability are foundational to the success of an opioid stewardship program.

Recognize implementation strategies related to education and accountability for your facility to advance opioid stewardship.

Discuss the role of the board of directors, chief executives, and department and team leaders in a culture of opioid stewardship.

# Objectives

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Understand why provider and staff education and accountability are foundational to the success of an opioid stewardship program. (WHY)

Recognize implementation strategies related to education and accountability for your facility to advance opioid stewardship. (HOW)

Discuss the role of the board of directors, chief executives, and department and team leaders in a culture of opioid stewardship. (WHO)

# Resources

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[bcore.brighamandwomens.org](https://bcore.brighamandwomens.org)



## Advancing the Safety of Acute Pain Management

Report of an Expert Panel Convened by the  
Institute for Healthcare Improvement

The Joint Commission Journal on Quality and Patient Safety 2019; 45:3–13

### A Health System–Wide Initiative to Decrease Opioid-Related Morbidity and Mortality

*Scott G. Weiner, MD, MPH; Christin N. Price, MD; Alev J. Atalay, MD; Elizabeth M. Harry, MD; Erika A. Pabo, MD, MBA; Rajesh Patel, MD, MPH; Joji Suzuki, MD; Shelly Anderson, MPM; Stanley W. Ashley, MD; Allen Kachalia, MD, JD*

**Background:** The opioid overdose crisis now claims more than 40,000 lives in the United States every year, and many hospitals and health systems are responding with opioid-related initiatives, but how best to coordinate hospital or health system–wide strategy and approach remains a challenge.

**Methods:** An organizational opioid stewardship program (OSP) was created to reduce opioid-related morbidity and mortality in order to provide an efficient, comprehensive, multidisciplinary approach to address the epidemic in one health system. An executive committee of hospital leaders was convened to empower and launch the program. To measure progress, metrics related to care of patients on opioids and those with opioid use disorder (OUD) were evaluated.

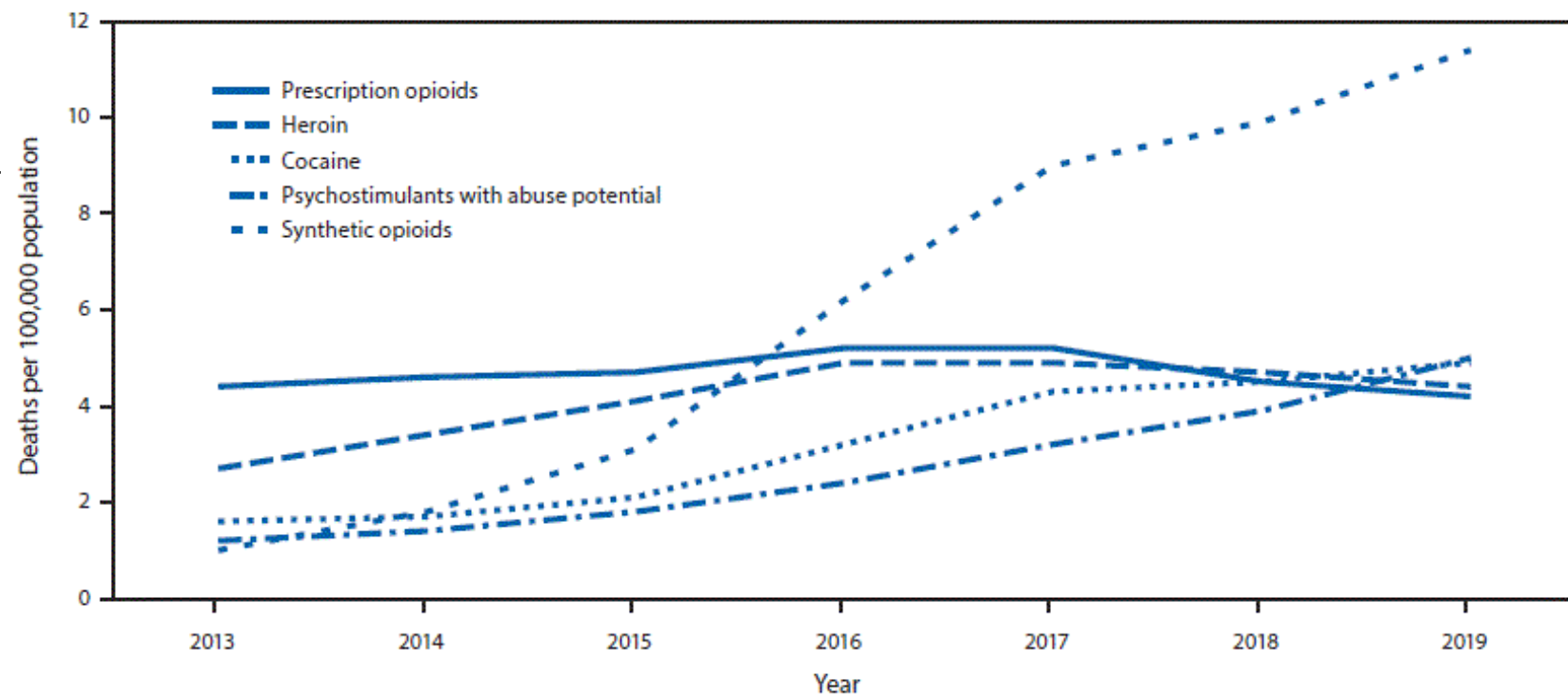
**Results:** The OSP created a holistic, health system–wide program that addressed opioid prescribing, treatment of OUD, education, and information technology tools. After implementation, the number of opioid prescriptions decreased (−73.5/month;  $p < 0.001$ ), mean morphine milligram equivalents (MME) per prescription decreased (−0.4/month;  $p < 0.001$ ), the number of unique patients receiving an opioid decreased (−52.6/month;  $p < 0.001$ ), and the number of prescriptions  $\geq 90$  MME decreased (−48.1/month;  $p < 0.001$ ). Prescriptions and providers for buprenorphine increased (+6.0 prescriptions/month and +0.4 providers/month; both  $p < 0.001$ ). Visits for opioid overdose did not change (−0.2 overdoses/month;  $p = 0.29$ ).

**Conclusion:** This paper describes a framework for a new health system–wide OSP. Successful implementation required strong executive sponsorship, ensuring that the program is not housed in any one clinical department in the health system, creating an environment that empowers cross-disciplinary collaboration and inclusion, as well as the development of measures to guide efforts.



# Background

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## Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019

*Weekly* / February 12, 2021 / 70(6);202–207

Christine L. Mattson, PhD<sup>1</sup>; Lauren J. Tanz, ScD<sup>1</sup>; Kelly Quinn, PhD<sup>1</sup>; Mbabazi Kariisa, PhD<sup>1</sup>; Priyam Patel, MSPH<sup>1,2</sup>; Nicole L. Davis, PhD<sup>1</sup> ([View author affiliations](#))

# Background

**NBC NEWS**

'A staggering increase': Yearly overdose deaths top 100,000 for first time

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HEALTH NEWS

## 'A staggering increase': Yearly overdose deaths top 100,000 for first time

The largest increases were seen in Vermont, West Virginia and Kentucky.



Overdose deaths due to opioids, including fentanyl, accounted for more than 75 percent of the deaths. Chelsea Stahl / NBC News

# 12 Month-Ending Provisional Number of Drug Overdose Deaths

Based on data available for analysis on:

12/5/2021

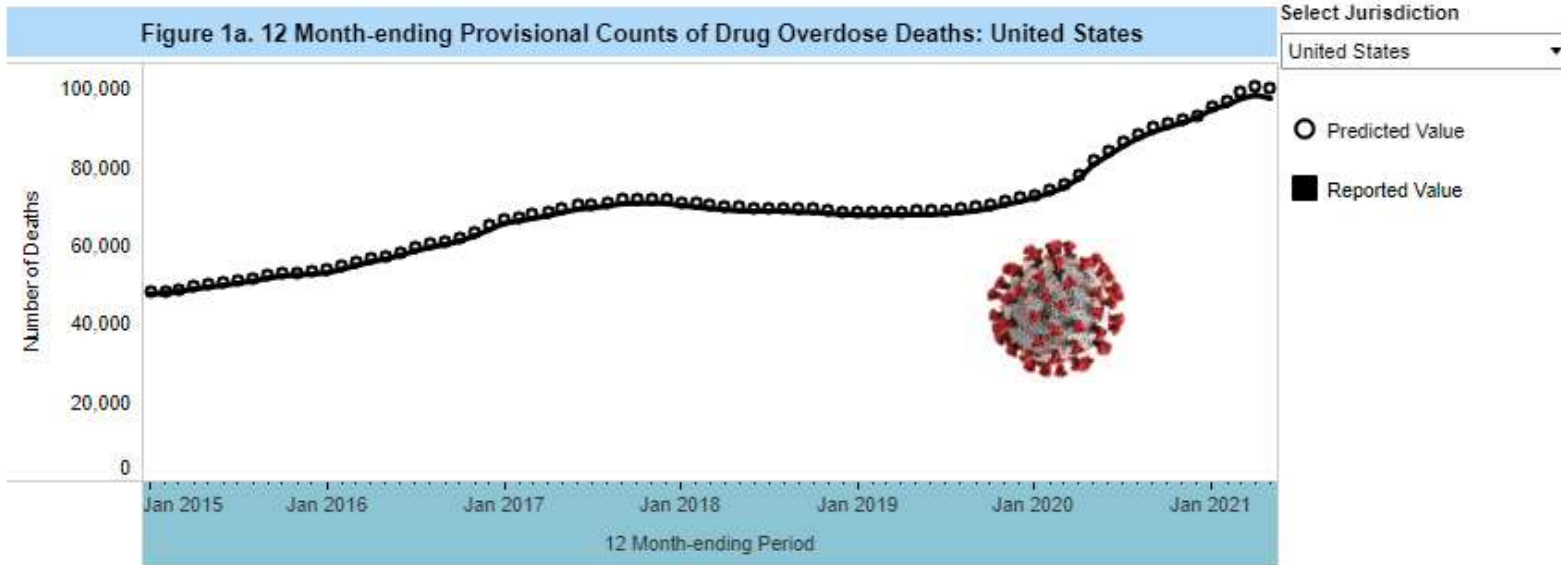
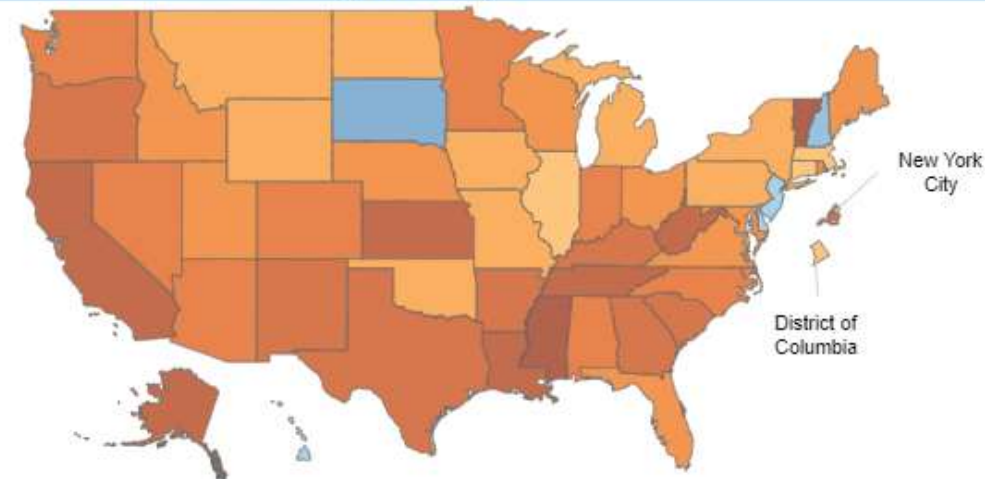


Figure 1b. Percent Change in Predicted 12 Month-Ending Count of Drug Overdose Deaths, by Jurisdiction: May 2020 to May 2021



Select predicted or reported number of deaths

- Predicted  
○ Reported

Percent Change for United States

22.7



Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

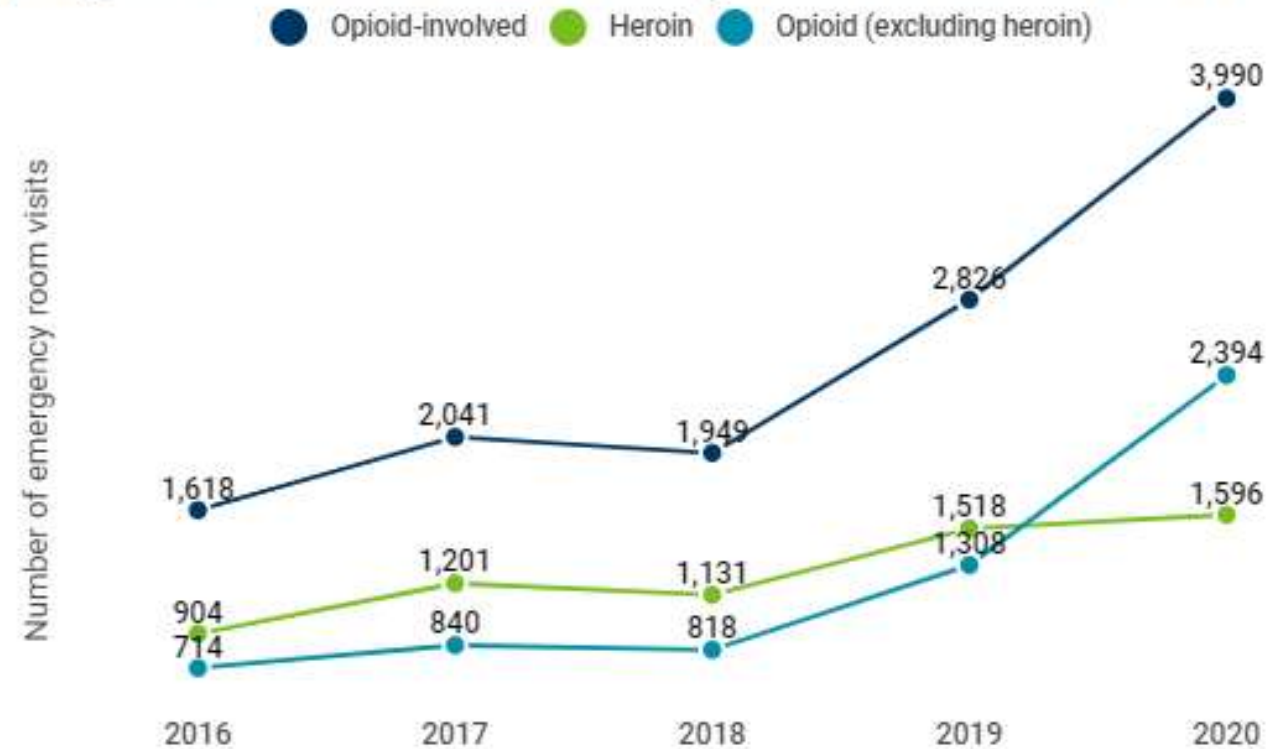
-23.3 54.4

# Minnesota

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## Nonfatal Overdose

Emergency room visits for opioid-involved overdose substantially increased for all drug categories from 2019 to 2020, excluding heroin which remained stable.



[Download data](#) [Drug Overdose Data Sources](#)

Source: Minnesota hospital discharge data

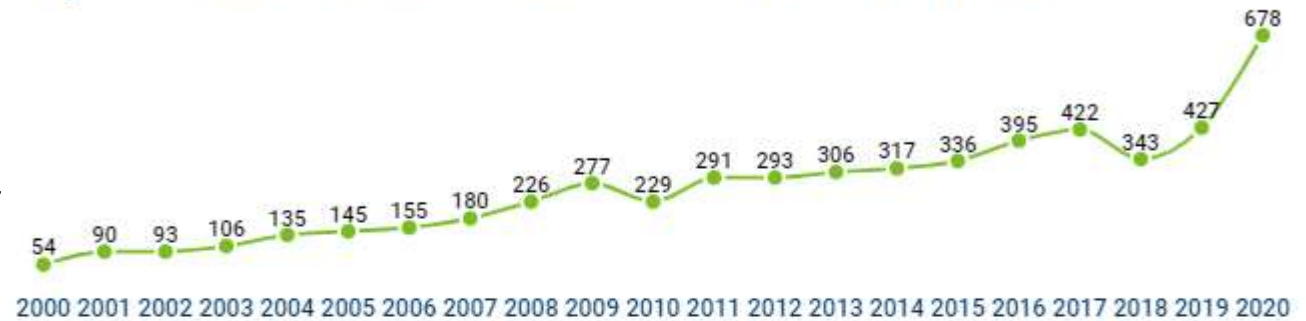
Minnesota Department of Public Health: <https://www.health.state.mn.us/opioiddashboard>



# Minnesota

## Opioid Overdose Deaths

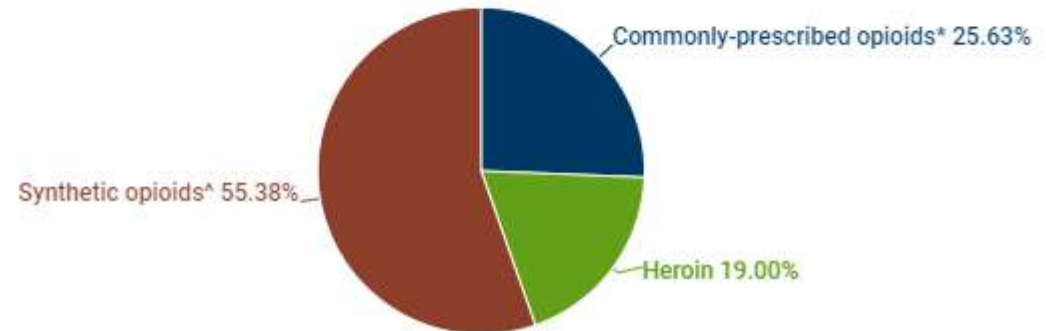
Opioid-involved overdose deaths have increased in Minnesota since 2000.



[Download data](#) [Drug Overdose Data Sources](#)

Source: Minnesota death certificates

In 2019, synthetic opioids were involved in the greatest proportion of opioid overdose deaths.



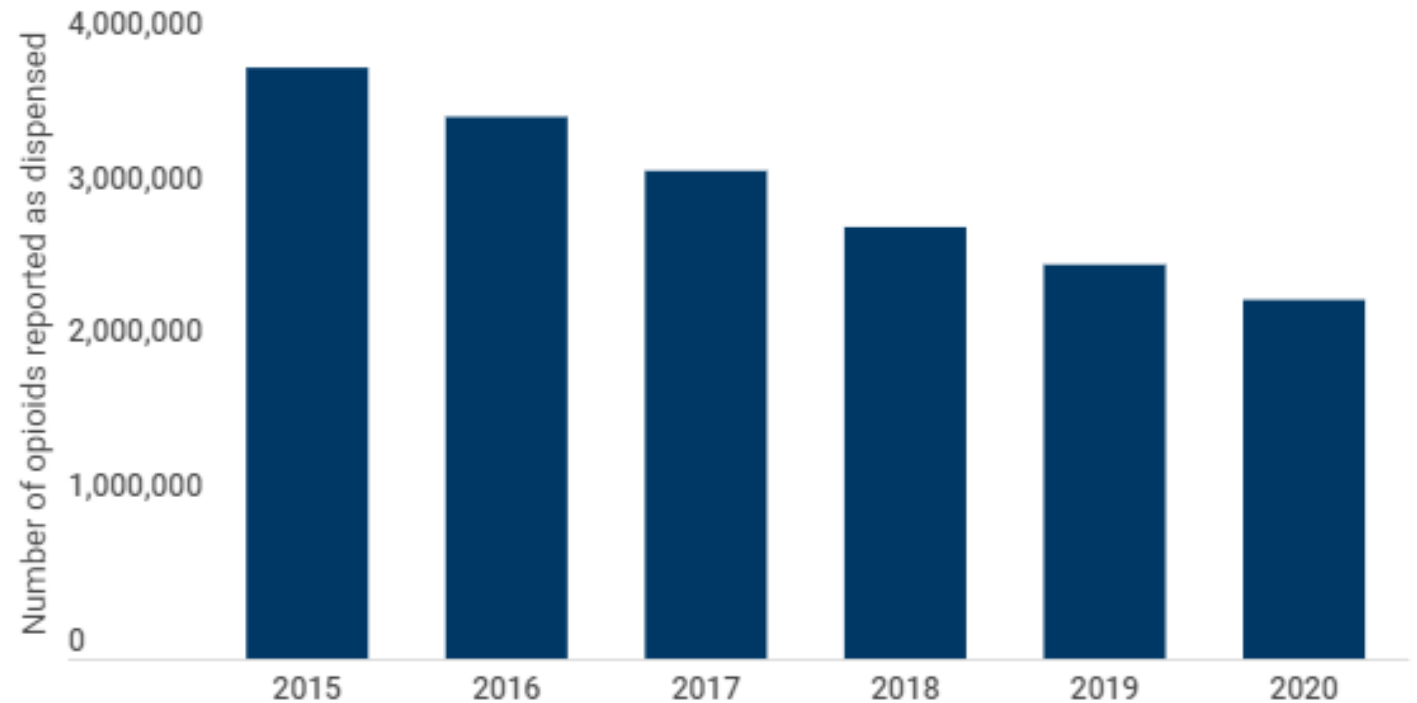
Minnesota Department of Public Health: <https://www.health.state.mn.us/opioiddashboard>

# Minnesota

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## Opioid Prescriptions Dispensed

The number of opioids reported as dispensed in Minnesota has steadily decreased since 2015.

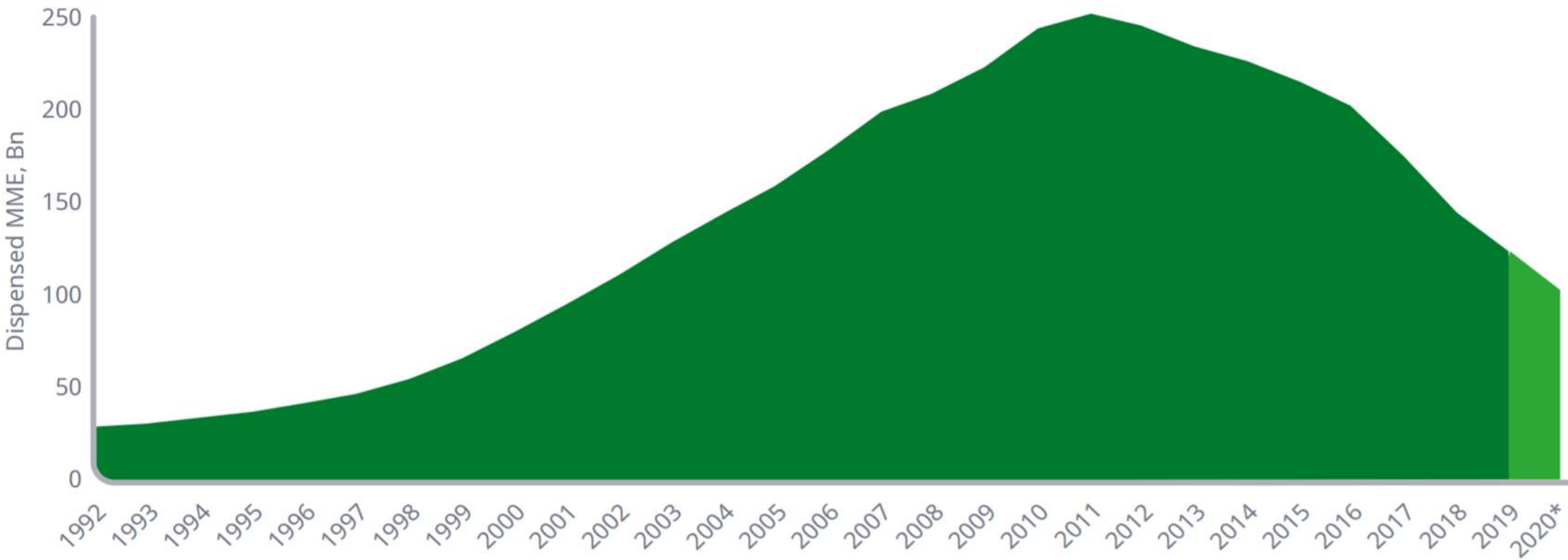


[Download data](#) [Drug Overdose Data Sources](#)

For county-level prescribing rates, visit the [Minnesota PMP 2020 Annual Report \(PDF\)](#). Rates start on page 15.  
Source: Minnesota Board of Pharmacy Prescription Monitoring Program

Minnesota Department of Public Health: <https://www.health.state.mn.us/opioiddashboard>

**Exhibit 1: Prescription Opioid Use in Morphine Milligram Equivalents (MME) Bn, 1992–2020\***



Source: IQVIA Xponent, Mar 2020; IQVIA National Prescription Audit; IQVIA Institute, Nov 2020

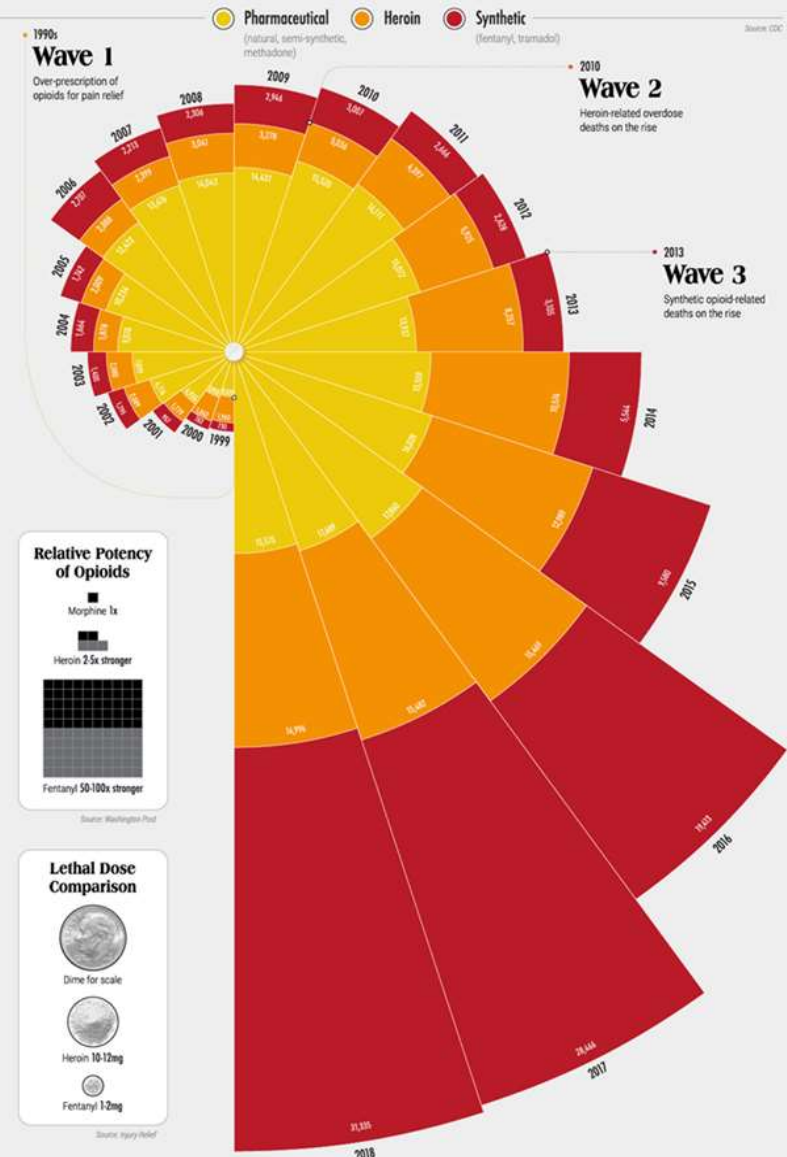
# Don't forget Rx opioids



## The Spiraling Opioid Epidemic IN AMERICA

Over the last 20 years, the U.S. opioid crisis has escalated dramatically—  
leaving a trail of harm in its wake.

### U.S. Opioid Overdose Deaths





# Why provider and staff education and accountability are foundational to the success of an opioid stewardship program.

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Can't Just Preach to the Choir

Gaps in Knowledge

- About safe prescribing guidelines
- About opioid-related best practices
- About opioid use disorder and how to treat it (buprenorphine waiver)
- About how to safely taper opioids
- About how to treat pain when someone is treated with MOUD

Protection of the Hospital

Stigma

# Why provider and staff education and accountability are foundational to the success of an opioid stewardship program.

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## **R<sup>3</sup> Report** | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 11, August 29, 2017

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Published for Joint Commission-accredited organizations and interested health care professionals, *R<sup>3</sup> Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R<sup>3</sup> Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R<sup>3</sup> Report* may be reproduced if credited to The Joint Commission. Sign up for [email](#) delivery.

### **Pain assessment and management standards for hospitals**

Effective Jan. 1, 2018, new and revised pain assessment and management standards will be applicable to all Joint Commission-accredited hospitals. These standards — in the Leadership (LD); Medical Staff (MS); Provision of Care, Treatment, and Services (PC); and Performance Improvement (PI) chapters of the hospital accreditation manual — are designed to improve the quality and safety of care provided by Joint Commission-accredited hospitals. The new and revised standards accomplish this by requiring hospitals to:

- Identify pain assessment and pain management, including safe opioid prescribing, as an organizational priority (LD.04.03.13).
- Actively involve the organized medical staff in leadership roles in organization performance improvement activities to improve quality of care, treatment, and services and patient safety (MS.05.01.01).
- Assess and manage the patient's pain and minimize the risks associated with treatment (PC.01.02.07).
- Collect data to monitor its performance (PI.01.01.01).
- Compile and analyze data (PI.02.01.01).

# Implementation strategies related to education and accountability for your facility to advance opioid stewardship.

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## Education

- Guidelines
- Best practice advisories
- Didactics
- Recovery Month

## Accountability

- Metrics
- Mandatory education
- Buprenorphine waivers

# Guidelines



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## QUALITY & PATIENT SAFETY

You are here: [Patient safety in Minnesota hospitals](#) > [Quality & Patient Safety Improvement Topics](#) > [Medication Safety](#) > [Opioids](#)

### Quality & Patient Safety

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## OPIOIDS

Opioid use disorder related to prescription pain relievers affected an estimated 1.9 million people in 2014. From 2000 to 2015, more than a half million people died from drug overdoses. Every day, 91 Americans die from an opioid overdose.

Prescription opioids are a driving factor in the rising rates of opioid overdose deaths. Deaths from prescription opioids have quadrupled since 1999. This trend can only be reversed with collaboration from health care systems and their patients. Hospitals and health systems are partnering with patients, families and communities to prevent misuse by improving opioid prescribing practices, to reduce exposure to opioids by using alternative therapies and to treat opioid use disorder with evidence-based therapy.

The resources below will help hospitals, health systems, health care providers and patients meet the goal of safe pain management.

### Download the opioid stewardship road map:





# Guidelines

## DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 1** Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Non-opioids first

- 2** Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

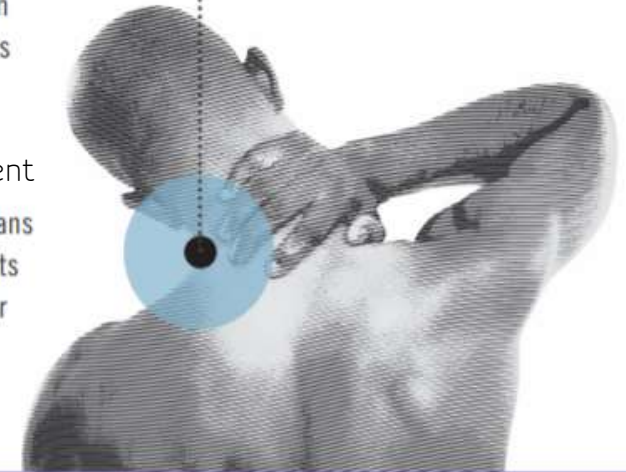
Pain Treatment Agreement

- 3** Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Embedded Education

### CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



# Guidelines

## OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

### CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed



4

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

BPA to avoid ER/LA

5

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/day.

BPA for  $>50$  or  $>90$  MME

6

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Metrics + Standardized Guidance

7

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Clinic Visit Every 3 Months



# Guidelines

## ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

**8** Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ( $\geq 50$  MME/day), or concurrent benzodiazepine use, are present.

Screening/Naloxone

**9** Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

PDMP Integration

**10** When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Random Toxicology Testing

**11** Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Alert for Opioids/Benzos

**12** Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Metrics

### CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

# Determining whether or not to initiate opioids for pain



(DRAFT VERSION!)

1. Nonopioid therapies are effective for many common types of acute pain. Clinicians should **only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.**
2. Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should **only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient.** Before starting opioid therapy for subacute or chronic pain, clinicians should **discuss with patients the known risks and realistic benefits** of opioid therapy, should work with patients to **establish treatment goals for pain and function**, and should **consider how opioid therapy will be discontinued** if benefits do not outweigh risks





(DRAFT VERSION!)

# Opioid selection and dosage

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3. When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids
4. When opioids are started for opioid-naïve patients with acute, subacute, or chronic pain, **clinicians should prescribe the lowest dosage to achieve expected effects**. If opioids are continued for subacute or chronic pain, clinicians should **use caution when prescribing opioids at any dosage**, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients
5. For patients already receiving higher opioid dosages, clinicians should **carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage**.



(DRAFT VERSION!)

# Opioid duration and follow-up

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6. When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
7. Clinicians should **evaluate benefits and risks with patients within 1 to 4 weeks** of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and risks of continued therapy with patients **every 3 months** or more frequently.



(DRAFT VERSION!)

# Assessing risk and addressing harms of opioid use

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8. Before starting and periodically during continuation of opioid therapy, clinicians should **evaluate risk for opioid-related harms and discuss with patients**. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering **naloxone** when factors that increase risk for opioid overdose are present.

9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state **prescription drug monitoring program (PDMP)** data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.



(DRAFT VERSION!)

# Assessing risk and addressing harms of opioid use

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10. When prescribing opioids for subacute or chronic pain, **clinicians should consider toxicology testing** to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances.
11. Clinicians should **use extreme caution when prescribing opioid pain medication and benzodiazepines concurrently** and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.
12. Clinicians should offer or **arrange treatment with medication for patients with opioid use disorder**.

# Disclaimers!

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(DRAFT VERSION!)

This clinical practice guideline is not:

- A replacement for clinical judgment or individualized, person-centered care
- Intended to be applied as inflexible standards of care across patients, and/or patient populations by healthcare professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or discontinuation of opioids for patients
- A law, regulation, and/or policy that dictates clinical practice or a substitute for FDA-approved labeling
- Applicable to the following types of pain treatment: o sickle cell disease-related pain; o cancer pain; o palliative care; or o end-of-life care



# Use of Opioid Therapy for Acute, Non-Malignant Pain

## Executive Summary

**Purpose/Definition:** The purpose of this document is to support MGB providers to administer compassionate, evidence-based, responsible care while improving the quality and safety of care that is delivered to our patients experiencing acute pain. 'Acute pain' is defined as pain provoked by a specific disease or injury, or subsequent to surgery, and is self-limited, lasting no longer than 90 days.

**Pain Assessment and Indications:** In acute situations, consider opioid prescriptions based on the **degree of tissue disruption, a strong consideration of alternatives, specialty specific published guidelines, the impact of pain upon function, and the risk/benefit ratio given the provider's knowledge of the individual patient.**

- Opioids may only be prescribed after a clinical examination, diagnosis, review of medication and medical/psychiatric history, consideration of alternatives as well as the risk to the individual patient of opioids, and review of data from the Prescription Drug Monitoring Program (PDMP)

**Non-Opioid Alternatives to Pain Management:** Opioids should be the last consideration for acute pain management. Do not prescribe without first considering non-opioid and non-pharmacological measures.

**Risk Assessment:** All patients should be screened for opioid misuse. Consider using a validated screening tool to determine whether it is appropriate to prescribe opioids based on diagnosis and risk.

- You may use validated screening tools such as [Opioid Risk Tool](#) (ORT), which is in eCare, or the Screener and Opioid Assessment for Patients with Pain-Revised ([SOAPP-R](#)).
- Screen for family/personal history of substance use disorders (SUDs) and mental health problems before prescribing opioids.
- If a patient is at high risk for opioid misuse, then consider very close follow up and evaluation. For [surgical patients](#), develop a pain management plan before elective surgery and as soon as feasible for urgent surgery.

**Prescribing:** For acute pain, opioids should be prescribed only when alternative pain treatment modalities are not expected to be sufficient.

- Opioids should never be prescribed for treatment of mild pain where non-opioid over the counter pain relievers or alternative therapies can be used effectively to treat mild pain.
- If opioids are necessary, they should be prescribed at the **lowest effective dose** and for a **limited period**. For acute pain unrelated to surgery/major trauma, providers should **prescribe no more than a 7-day supply**.

# Use of Opioid Therapy for Chronic, Non-malignant Pain

## Executive Summary

**Purpose/Definition:** The purpose of this document is to support MGB healthcare providers in delivering compassionate, evidence-based, responsible care for the patients we serve, while improving the quality and safety of care for patients treated for chronic pain. 'Chronic opioid therapy' is the continuous use of an opioid medication as prescribed for greater than 90 days.

### Diagnosis, Screening, and Documentation:

- **History, physical exam, diagnosis, and plan must be documented before any opioid is prescribed.**
- **All patients should be screened for risk of opioid misuse** using a validated screening tool to determine whether it is appropriate to prescribe opioids based on diagnosis and risk.
- **All patients on chronic opioid medications should receive, review, and sign one of the approved [Opioid Medicine Management Agreements](#)**
- **All patients receiving chronic opioid medications for pain should have 'Chronic Pain' or 'Pain Management' documented as a problem in the problem list in the EMR, including indication, prescribing physician, and medication type.**

### Prescribing Opioids:

- Prescribing opioids for chronic pain should only be pursued once all other options have been exhausted.
- Non-pharmacologic and non-opioid pharmacologic options should be used as a first line for chronic pain unless otherwise contraindicated.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid newly increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/day.
- Providers should review side effects and **discuss the risks of addiction and overdose with all patients on chronic opioid therapy. Providers should also counsel regarding [safe storage and disposal](#) of medications.**
- The stigma of pain is not limited to opioids. Patients reporting pain have sometimes been disbelieved, dismissed, or labeled as "drug-seeking" for wanting relief. Discrimination, stigma and dismissal of pain

# Guidelines

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## Guideline for Perioperative Management of Opioid Tolerant Patients and Patients Treated with Medications for Opioid Use Disorder (MOUD)

Perioperative pain management in patients treated with opioid therapy (including patients treated with MOUD) requires close collaboration among surgeons, anesthesiologists, pain management specialists, addiction specialists, pharmacists and primary care physicians. To coordinate the optimal perioperative care of these patients, this guideline was developed for the perioperative management of opioid medications based on best current evidence and clinical experience. Each institution should follow their site's pre-procedure screening process, as well as pain management and addiction eConsults/referrals, as available.

### Types of patients receiving opioid medications

- a. Patients with complex chronic pain history currently taking high enough doses of opioid pain medications daily to be considered opioid-tolerant (e.g., greater than 60 mg morphine equivalent per day).
- b. Patients with a history of opioid use disorder (OUD) currently being treated with methadone or buprenorphine.
- c. Patients currently taking naltrexone for treatment of alcohol or OUD, or for weight loss.

### Recommendations for the perioperative management of home opioid medications

For the patients listed above, providers should follow the recommendations below for perioperative management of home pain medications, and instruct patients on the steps that need to be taken, where appropriate:

**\*\*Note:** due to the different formulations of buprenorphine, brand names for the buprenorphine products are listed in Table 1, 2, and 3; see Appendix for corresponding generic name.



# Guidelines

---

## Background

Although not supported by level 1 and 2 data, long-term (i.e., greater than 2 months) use of opioids has been associated with harm or no clear evidence of improved function or health related quality of life; thus, it is prudent to continuously reassess the need for opioid therapy. Reasons for reduction in dose or discontinuation may include resolution of pain, no significant functional improvements, intolerable side effects, medication diversion, or development of an opioid use disorder. Tapering opioids should ideally be a shared decision between patient and provider(s). Whereas voluntary opioid tapers have been associated with improved function, there is no evidence to support involuntary tapers of chronic opioid therapy for patients who are not otherwise diverting their medications. In the absence of an opioid use disorder, opioid misuse, diversion or confirmed non-medical use, social, emotional (e.g., patient fears of abandonment), and health factors must be considered. When the decision is made to taper down or off of opioids, an individualized tapering plan should be used. In general, tapering should occur gradually, though there may be cases in which a rapid taper or no taper is warranted.

## Purpose/Scope

To assist prescribers in tapering chronic opioid therapy

## Eligibility

Discontinuation of long-term opioid therapy should be considered in any of the following situations  
Concurrent referral to pain specialist is recommended:

- Resolution of the painful condition
- Patient desire to discontinue opioid therapy
- Inability to achieve or maintain significant pain relief or functional improvement despite reasonable dose escalation; this depends upon the clinical situation but would generally reflect dose escalations no greater than the range of 50 to 90 MME/day per CDC guidelines.
- Intolerable adverse effects at the minimum dose that produces effective analgesia despite adequate attempts to treat where possible
- Objective non-adherence with a Partners opioid patient agreement ([Link to Partners Opioid Medication Management Agreements](#))
- Deterioration in physical, emotional or social functioning attributed to opioid therapy
- Development of an opioid use disorder (Appendix I)
  - Note: discontinuation of opioids without proper treatment of opioid use disorder can exacerbate symptoms
- Evidence of non-medical use of prescription opioids

## Tapering plan

- General tenets
  - Speed of taper should be inversely correlated to duration of opioid treatment. Also consider dose, type of pain being treated and the physical and psychological attributes of the patient.

# Guidelines

## BWH Surgery Opioid Prescribing Guidelines

Recommended number of *Oxycodone 5mg* tablets to prescribe on discharge

DAY SURGERY		INPATIENT	
Breast (ambulatory)	5	Breast (inpatient)	10
Umbilical Hernia	10	Para/Thyroidectomy	10
Lap Appendectomy	10	Sleeve/RYGB	10
Lap Cholecystectomy	10	Lap Colectomy/LAR	20
Open/Lap Inguinal Hernia	10	Open Colectomy/LAR	20
Hemorrhoidectomy	15-25		



## Opioid Prescribing Recommendations

### NAVIGATION

Non-Opioid Pain Management  
Patient Counseling  
Pain Control Optimization Pathway  
Best Practices  
Provider Education & Resources

Colon and Rectal Surgery	Oxycodone 5mg tablets*
▼ <a href="#">Colectomy - Laparoscopic</a>	0 - 10
▼ <a href="#">Colectomy - Open</a>	0 - 15
▼ <a href="#">Ileostomy/Colostomy Creation, Re-siting, or Closure</a>	0 - 15
▼ <a href="#">Small Bowel Resection or Enterolysis - Open</a>	0 - 15

# Best Practice Advisories

Order Validation

!

You can proceed and sign these orders, but the following information is missing or might require your attention:

Signing these orders will cause the patient's morphine equivalent daily dose to be 270 mg MEDD, which exceeds the threshold of 90 mg MEDD.

Please verify patient's complete opioid medication history for clinical appropriateness before proceeding.

Maximum morphine equivalent daily dose before signing: 90 mg MEDD  
Maximum morphine equivalent daily dose after signing: 270 mg MEDD

✓ Accept

✗ Cancel

Opioid Disposal Needed

[provide feedback](#)

Your patient was prescribed opioids for pain management at hospital discharge following a recent delivery. Please follow up with patient regarding appropriate medication disposal and remove the opioids from the medication list, if appropriate.

[Patient Information Regarding Opioid Disposal](#)

! Acknowledge Reason

Completed Therapy / Already Disposed

On Chronic Opioids

Not Applicable

✓ Apply Selected

Opioid medication management agreement not identified in eCare system. If the opioid you are prescribing is for chronic use, please complete and file an Opioid Agreement.

[Opioid Medication Management Agreement \(Blank Form\)](#)

! Acknowledge Reason

Will complete file agreement

Agreement previously completed/filed

Not indicated at this time









# Best Practice Advisories

## Requested Medications

**R** **morphine (KADIAN) 10 mg 24 hr capsule**  
Take 1 capsule (10 mg total) by mouth daily. For palliative care related dyspnea. Partial fill permissible at request of patient

Disp: 30 capsule      Refills: 0  
Class: Print      Start: 10/18/2017  
Originally ordered: 1 year ago by


**Opioids Protocol Failed** 10/18 1:31 PM 

-  Opioid Agreement identified on file in Media Management
-  Urine, Saliva or Serum Toxicology performed within the last 12 months
-  REMINDER ANNOUNCEMENT: Clinician needs to check MassPat before refilling opioid medications
-  Active Medication List does not include Benzodiazepines
-  Patient has had appointment in the past 4 months or appointment in the next 30 days

[Protocol Details](#)

 High narcotic dose, consider naloxone


 Accept (1)  

provide feedback:   

Your patient is on  $\geq 90$  morphine milligram equivalents (MME) and could benefit from naloxone prescription. Please consider ordering.

[Order](#)

[Do Not Order](#)

 **naloxone (NARCAN) intranasal spray 4 mg/actuation**

Acknowledge Reason

[Already on naloxone](#)

[Patient declined](#)

[Not appropriate](#)

 Accept (1)

# Didactics

---



# Recovery Month





# Metrics

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	
1	MRN	PatientDepartment	PatientA	PatientG	PatientP	PatientF	PrimaryI	CSN	Ordering	Ordering	TheraCI	PharmaI	DEACla	Medicati	Medicati	Medicati	Dose	DoseUn	DoseFo	Frequen	Route	Quantity	ED_AllDxI	CD
2		BWH EMERGENC	23 Male	English	White	BLUE C	#####			Physicia	ANALGI	OPIOID	C-II	3760	HYDRO	HYDRO	2	mg	Tab	Every 6	Oral	8.00	A04.72	
3		BWH EMERGENC	23 Male	English	White	BLUE C	#####			Physicia	ANALGI	OPIOID	C-II	3760	HYDRO	HYDRO	2	mg	Tab	Every 6	Oral	8.00	A04.72	
4		BWH EMERGENC	74 Female	English	White	MEDIC/	#####			Physicia	ANALGI	OPIOID	C-II	3760	HYDRO	HYDRO	2	mg	Tab	Every 4	Oral	7.00	B02.29	
5		BWH EMERGENC	41 Female	English	White	MASSH	#####			Physicia	ANALGI	OPIOID	C-III	19474	ACETA	ACETA	1	tablet	Tab	Every 6	Oral	24.00	B34.9	
6		BWH EMERGENC	52 Male	English	White		#####			Residen	ANALGI	OPIOID	C-II	27873	MORPH	MORPH	60	mg	Cap	2 times	Oral	15.00	C18.9	
7		BWH EMERGENC	31 Male	English	Unavail	MASSH	#####			Residen	ANALGI	OPIOID	C-II	5178	MORPH	MORPH	7.5-15	mg	Tab	Every 3	Oral	24.00	C18.9	
8		BWH EMERGENC	27 Female	English	White	MEDIC/	#####			Physicia	ANALGI	OPIOID	C-II	87795	OXYCO	OXYCO	20	mg	Tab	Every 4	Oral	20.00	C41.9	
9		BWH EMERGENC	27 Female	English	White	MEDIC/	#####			Physicia	ANALGI	OPIOID	C-II	87795	OXYCO	OXYCO	20	mg	Tab	Every 4	Oral	20.00	C41.9	
10		BWH EMERGENC	27 Female	English	White	MEDIC/	#####			Physicia	ANALGI	OPIOID	C-II	87795	OXYCO	OXYCO	20	mg	Tab	Every 4	Oral	20.00	C41.9	
11		BWH EMERGENC	63 Female	English	White	HARVA	#####			Physicia	ANALGI	OPIOID	C-II	28899	OXYCO	OXYCO	15	mg	Tab	Every 4	Oral	42.00	C50.919	
12		BWH EMERGENC	36 Female	English	White	UNITEC	#####			Residen	ANALGI	OPIOID	C-II	5178	MORPH	MORPH	15	mg	Tab	Every 6	Oral	5.00	D21.9	
13		BWH EMERGENC	25 Male	English	Black or	TUFTS	#####			Physicia	ANALGI	OPIOID	C-II	10814	OXYCO	OXYCO	5	mg	Tab	Every 4	Oral	10.00	D57.00	
14		BWH EMERGENC	25 Male	English	Black or	TUFTS	#####			Physicia	ANALGI	OPIOID	C-II	10814	OXYCO	OXYCO	5	mg	Tab	Every 8	Oral	9.00	D57.00	
15		BWH EMERGENC	33 Male	English	Black or	AETNA	#####			Residen	ANALGI	OPIOID	C-II	20921	MORPH	MORPH	60	mg	Tab	Every 8	Oral	8.00	D57.00	
16		BWH EMERGENC	33 Male	English	Black or	AETNA	#####			Residen	ANALGI	OPIOID	C-II	10226	HYDRO	HYDRO	8	mg	Tab	Every 4	Oral	12.00	D57.00	
17		BWH EMERGENC	27 Male	English	Black or	ALLWA	#####			Physicia	ANALGI	OPIOID	C-II	87795	OXYCO	OXYCO	10	mg	Tab	Every 6	Oral	15.00	D57.00	
18		BWH EMERGENC	27 Female	English	Black or	CIGNA	#####			Residen	ANALGI	OPIOID	C-II	10814	OXYCO	OXYCO	5	mg	Tab	Every 4	Oral	12.00	D57.00	
19		BWH EMERGENC	18 Male	English	Black or	UNITEC	#####			Physicia	ANALGI	OPIOID	C-II	3760	HYDRO	HYDRO	2	mg	Tab	Every 8	Oral	9.00	D57.00	

# Metrics

---

## 1) Ambulatory care

Opioid rx/1,000 patients

Mean MME/prescription

## 2) Emergency department

Percent of discharged patients with opioid rx

Number of pills/prescription

## 3) Surgical

Number of pills/prescription

Number of long-acting/extended release rx



# Metrics

## Ambulatory Report: Percentage of patients prescribed opioid - All Patients

Measurement Period: 7/1/2019 - 6/30/2020

### PHS Rate

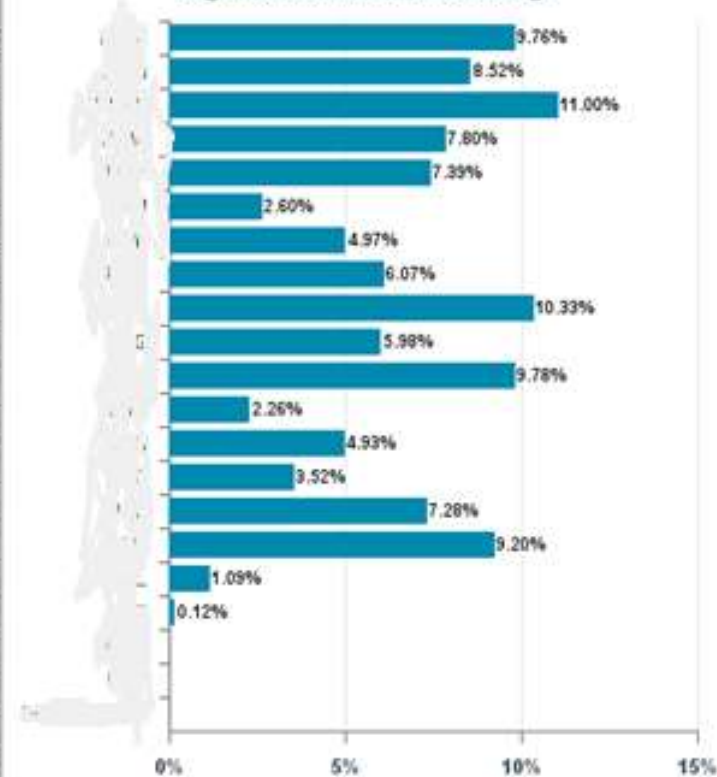
Naive Patients with Rx	Naive Patients with Visit	Naive Percentage	All Patients with Rx	All Patients with Visit	All Percentage
29,278	413,905	7.07%	58,472	535,738	10.91%

### Reporting Level Selected: Organization

#### Organizations Rate - All

Organization	All Patients with Rx ▼	All Patients with Visit	All Percentage
...	19,137	196,032	9.76%
...	13,467	157,977	8.52%
...	9,865	89,698	11.00%
...	8,293	106,292	7.80%
...	2,696	36,472	7.39%
...	1,215	46,771	2.60%
...	960	19,329	4.97%
...	894	14,733	6.07%
...	625	6,049	10.33%
...	605	10,114	5.98%
...	385	3,936	9.78%
...	128	5,674	2.26%
...	99	2,007	4.93%
...	82	2,329	3.52%
...	22	302	7.28%
...	8	87	9.20%
...	7	641	1.09%
...	4	3,252	0.12%
...	0	8	0.00%
...	0	1	0.00%
...	0	25	0.00%

#### Organizations Rate - All Percentage



# Metrics

## Emergency Department Report: Percentage of patients prescribed C-II or C-III Opioids during ED discharge – All discharged patients

Measurement Period: 7/1/2019 - 6/30/2020

### PHS Rate

Naïve patients with Rx	Naïve patients with Visits	Naïve Percentage	All patients with Rx	All patients with Visits	All Percentage
5,956	144,567	4.12%	8,010	176,638	4.53%

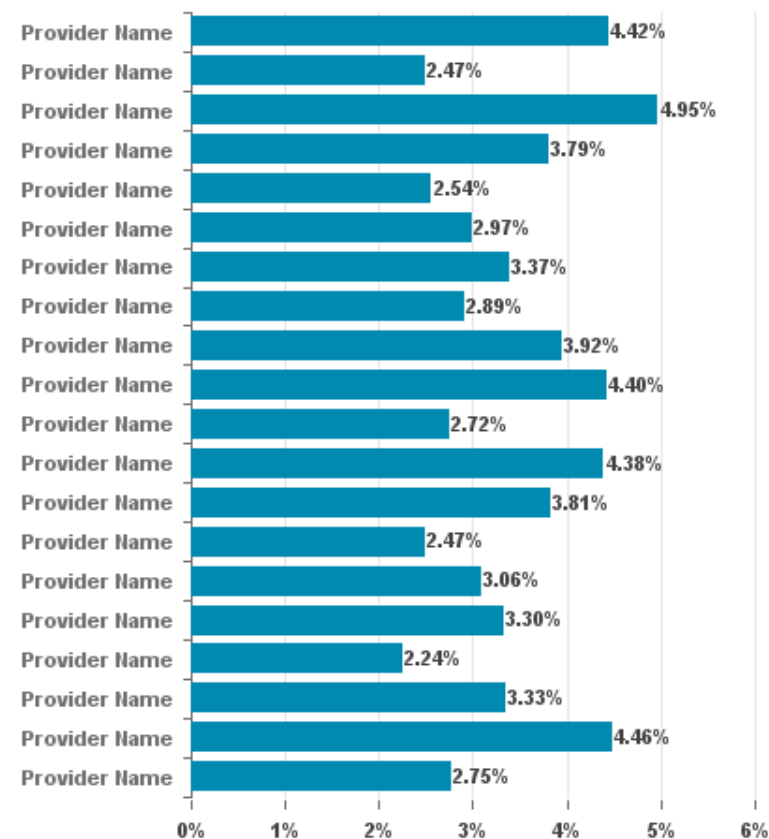
Reporting Level Selected: Provider

### BWH Top 20 Provider Rate - All

Organization	Provider	All patients with Rx ▼	All patients with Visits	All Percentage
BWH	Provider Name	49	1,108	4.42%
BWH	Provider Name	31	1,257	2.47%
BWH	Provider Name	31	626	4.95%
BWH	Provider Name	29	765	3.79%
BWH	Provider Name	28	1,102	2.54%
BWH	Provider Name	28	943	2.97%
BWH	Provider Name	28	832	3.37%
BWH	Provider Name	25	865	2.89%
BWH	Provider Name	24	612	3.92%
BWH	Provider Name	23	523	4.40%
BWH	Provider Name	23	845	2.72%
BWH	Provider Name	21	480	4.38%
BWH	Provider Name	20	525	3.81%
BWH	Provider Name	19	770	2.47%
BWH	Provider Name	19	620	3.06%
BWH	Provider Name	18	545	3.30%
BWH	Provider Name	17	760	2.24%
BWH	Provider Name	17	511	3.33%
BWH	Provider Name	17	381	4.46%
BWH	Provider Name	17	618	2.75%

[Select to see all provider detail](#)

### BWH Top 20 Provider Rate - All Percentage



# Metrics

Reporting Level

☐ 1. Organization

☒ 2. Provider

Population (All Values is All Patients)

All values  
Chronic  
Naive

Surgery Type

Anorectal  
Bariatric  
Colorectal  
Delivery C-Section  
Delivery Vaginal  
Hip  
Inguinal Hernia Repair  
Knee  
Laparoscopic Cholecystectomy  
Lumbar Fusion  
Thoracotomy  
Ventral Hernia Repair

Surgery Type selected – Inguinal Hernia Repair

## PHS Rate - Naive Patients

Pill Count	Discharge with Opioid (Tablet)	Average Pills
11,766	1,026	11.47

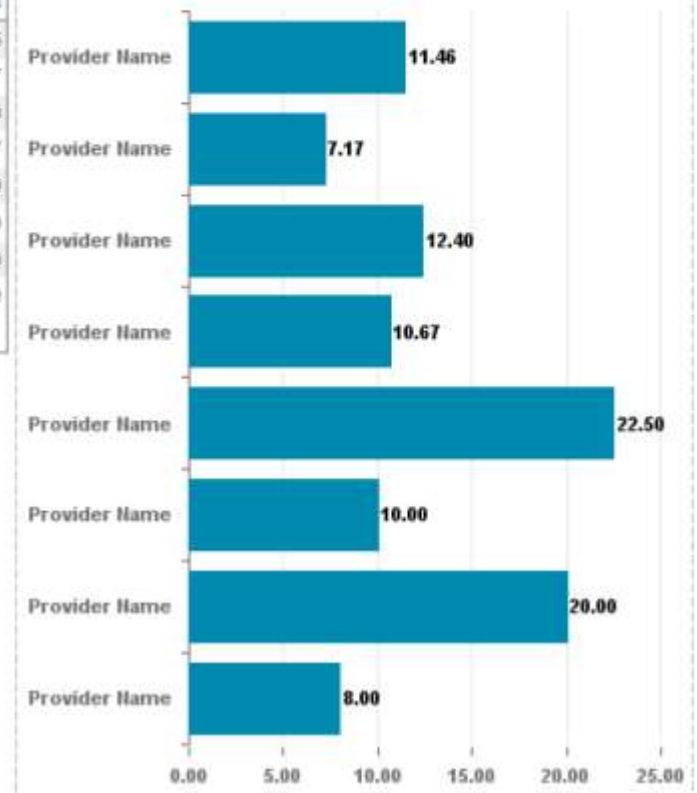
Reporting Level Selected – Provider

## Top 20 Provider Rate - Naive Patients

Organization	Provider	Pill Count	Discharge with Opioid (Tablet)	Average Pills
	Provider Name	321	28	11.46
	Provider Name	43	6	7.17
	Provider Name	62	5	12.40
	Provider Name	32	3	10.67
	Provider Name	45	2	22.50
	Provider Name	20	2	10.00
	Provider Name	20	1	20.00
	Provider Name	8	1	8.00

[Select to see all Provider Detail](#)

## Top 20 Provider Rate - Naive Patients (Average Pills)



# Metrics

---

# of Days Covered	Opioid Agreement	Dt of Opioid Ag	Tox Screen With	ORT Score	Active Methadone	Active Buprenorphine	History of SUD	History of Overdose	Active SUD?	Dt of Last Medication	Current MEDD	Enc in Primary	Next Enc in Primary	GFR	↑
134	Yes		✓		No	No	No	No	No					95.0	
7					No	No	No	No	No		45			83.0	
180	Yes		✓		No	No	No	No	No		75			69.1	
160	Yes		✓		Yes	No	No	No	No					65.0	
136	Yes		✓		No	No	No	No	No		90			116.0	
46	Yes		✓		No	No	No	No	No		45			44.1	
180	Yes		✓		No	No	No	No	No		67.5			90.1	
178	Yes		✓		No	No	No	No	No		75			102.0	
14	Yes		✓		No	No	No	No	No		22.5			102.1	
179	Yes		✓		No	No	No	No	No		75			69.0	
167	Yes				No	No	No	No	No		75			Patient's most recent lab	



# Mandatory Training

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## **Boston and Cambridge Hospitals Announce Commitment to Enhanced Provider Training and Employee Support for Substance Use Disorders**

1. Commit to mandatory training for all hospital-based physicians and residents in key departments. With this commitment, addiction care will be further mainstreamed into all primary care encounters and residents will be further prepared to treat addiction, including with medication, as a foundational part of their practice.
2. Commit to at least three support initiatives for employees and their families.

## All undersigned hospitals in Boston and Cambridge have agreed to:

### 1. Care Provider Training

Hospitals see many people in need of substance use disorder care at critical times. Unfortunately, there are often too few addiction medicine experts available and many internal medicine providers and other specialists have limited knowledge of how to treat addiction. Most have not taken the training required to prescribe buprenorphine, a key medication, or any continuing education courses on treating addiction. These courses offer a key entry point for broader knowledge and understanding of the disease of addiction. To address this issue, we propose that all hospitals:

- a. 1. Commit to mandatory training for all hospital-based emergency physicians, hospitalists, obstetricians, psychiatrists, adolescent pediatricians, infectious disease specialists, primary care providers, and internal medicine residents who are not waiver trained. These trainings should last at least 1 hour and emphasize a) fundamentals of addiction; b) effective treatment of opioid use disorder, including utilization of medications, and c) addressing stigma. In order to facilitate participation, the trainings can take place as part of regularly scheduled Grand Rounds or other educational series or departmental meetings. Enduring web-based recordings will also be an option for training.
- b. 1. Strongly encourage training for all non-hospital-based primary care providers, psychiatrists, as well as hospital and non-hospital-based OBs, pediatricians and infectious disease specialists, as well as NPs and PAs working in these areas.
- c. 1. Commit to increase the number of the above listed providers who obtain their buprenorphine waiver by a) demonstrating strong institutional support through a communications campaign, hospital statement, or other method; and b) providing in-person waiver trainings sessions.

<https://www.bmc.org/addiction/hospital-consortium-opioids-one-hour-training>

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PowerPoint

Videos

Discussion points

Pre- and post-test

Tracking Guidance



## **Understanding problems related to substance use**

A presentation of the Boston and Cambridge Hospital Consortium  
on Opioids

Developed by Miriam Komaromy, MD; Medical Director, Grayken Center for Addiction at Boston Medical Center, with the support of Scott Weiner, MD; Lorraine Magner, NP; Claudia Rodriguez, MD; and Maia Gottlieb, MPH

Attestation for another program  
X-waiver



## BWHC Understanding Problems Related to Substance Abuse

[Certificate >](#)

STATUS: Completed EST. TIME: 1h 5m

[Learning Activities](#) [Overview](#)

### Learning Activities *in this Course*

#### Prior Learning Survey

EVALUATION STATUS: Passed



#### Attestation for Credit

TEST STATUS: Passed SCORE: 100 %



#### Course

ONLINE STATUS: Not Yet Started

[Start](#)

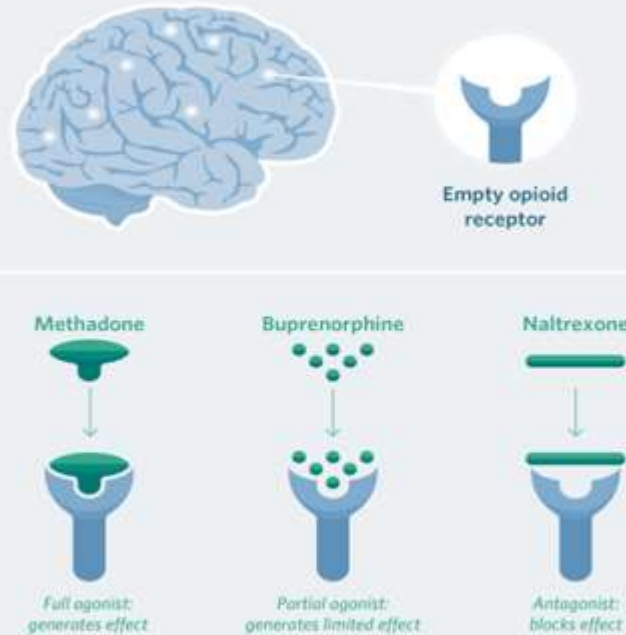
#### Attestation

TEST STATUS: Not Yet Started

[Locked](#)

# Buprenorphine

Figure 1  
How OUD Medications Work in the Brain



© 2016 The Pew Charitable Trusts

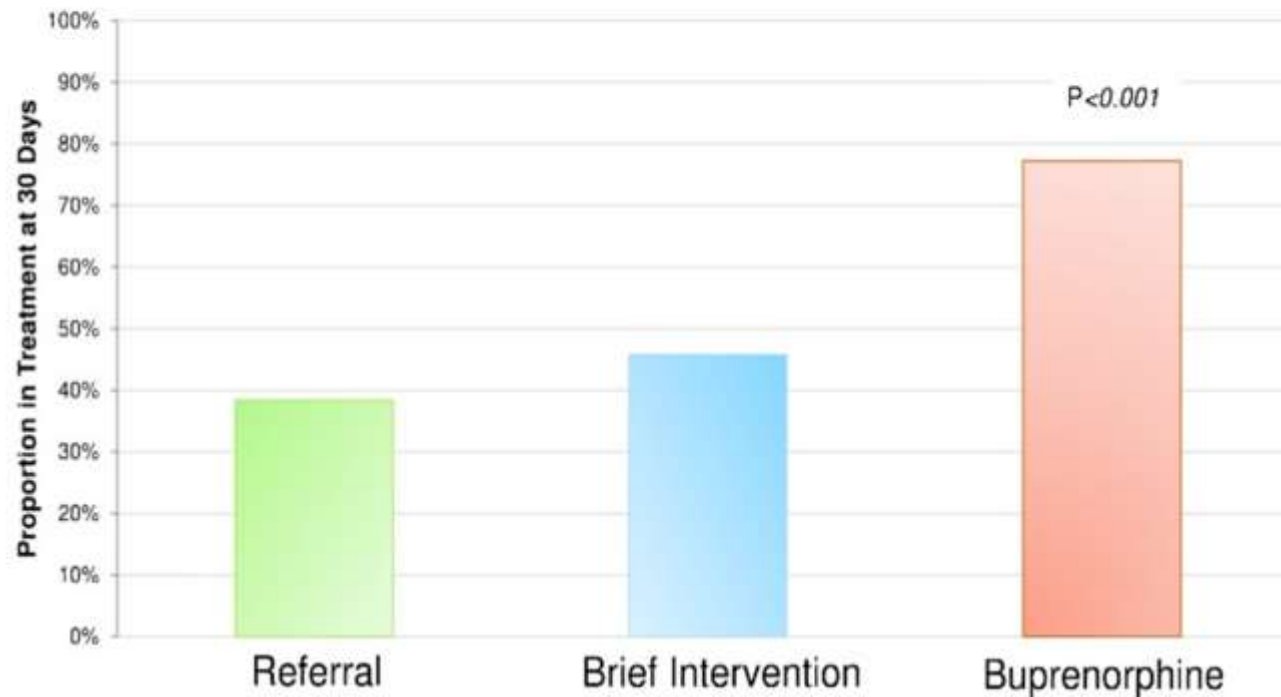
**MAT:**  
Methadone  
Buprenorphine  
Naltrexone



# Buprenorphine

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## Engaged in Treatment at 30-Days



D'Onofrio G, O'Connor PG, Pantalon MV, et al, *JAMA*. 2015 Apr 28;313(16):1636-44

# Buprenorphine

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## Brigham Health Bridge Clinic

### Roles and Services:

- **Addiction Psychiatry and Medicine physicians**
  - Perform intake, prescribe medications, monitor comorbid medical and mental health complications
- **Recovery Coach**
  - Provide peer support services; connect pts with long-term SUDs programs in community
  - Co-leads group sessions
- **Care Transition Specialist**
  - Screen for social determinants of health and connect pts with community resources (e.g., housing, food, transportation)



### Available Medications:

- Buprenorphine (OUD)
- Oral Naltrexone (OUD, AUD)
- Intramuscular Vivitrol (OUD, AUD)





# All About the X Waiver

## What is an X Waiver?

An "X waiver" refers to the Drug Addiction Treatment Act (DATA 2000) "waiver" legislation that authorized the outpatient use of buprenorphine for the treatment of opioid use disorder.

## What has changed? NEW Updated April 28, 2021

Any clinician can administer buprenorphine to a patient with opioid withdrawal symptoms in the hospital. However, in order to write prescriptions for buprenorphine, clinicians must have an X Waiver. The X waiver previously required an 8 hour (physician) or 24 hour (APP) training prior to applying for the waiver. This has changed and the training certificate is no longer required. However, clinicians still need to apply for their waiver. See below for instructions.

# Buprenorphine

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Discuss the role of the board of directors, chief executives, and department and team leaders in a culture of opioid stewardship

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## **Executive Committee for BCORE Program**

### **Scott Weiner, Director**

Shelly Anderson, BH VP  
Craig Bunnell, DFCI CMO  
John Co, Partners GME  
Jessica Dudley, BWPO CMO  
Peggy Duggan, BWFH CMO  
Sunny Eappen, BWH CMO  
John Fanikos, BWH Pharmacy

Chris Gilligan, BWH Pain Medicine  
Richard Gitomer, Director, BWH Primary Care  
Mike Healey, BWPO eCare Ambulatory CMIO  
Allen Kachalia, BWHC CQO  
Jessica Logsdon, BWHC PA Director  
Wanda McClain BWHC VP Community Health  
Maddy Pearson, BWH CNO  
Jim Rathmell, Chair BWH Anesthesia  
David Silbersweig, Chair BWH Psychiatry  
Joji Suzuki, BH Addiction Psychiatrist

**Clinical  
Consultant/Project  
Manager:**  
Christin Price

### **Other Key Stakeholders to keep Informed/Involved:**

Matt Fishman  
James Tulsy/Doug Brandoff  
Mike Hession  
Liz Harry/Raj Patel  
Jennifer Kales  
BWH Psych Resource Nurse  
Service/Christine Murphy

**Task Force Coordinating Committee:** Shelly Anderson, Alev Atalay, Mike Healey, Christin Price, Joji Suzuki, Scott Weiner

### **Prescribing Task Force**

Chairs Alev Atalay, Ed Ross

#### **Representation from:**

Addiction, Oncology, Pain, Nursing,  
Pharmacy, Rheumatology, Hospitalists  
Surgery, Ortho, Primary Care, EM, Pharmacy

### **Addiction Task Force**

Chair: Joji Suzuki

#### **Representation from:**

Addiction, Oncology, Pain, Pharmacy,  
Rheum, Hospitalists, Surgery, Ortho,  
Primary Care, EM, Pharmacy

### **Education Task Force**

Chair: Darin Correll

#### **Representation from:**

Addiction, Palliative Care, Orthopedics,  
ENT, Primary Care, Emergency Medicine,  
Nursing, Physician Assistants, Hospitalists

### **Implementation Responsibilities:**

- Data Capture Training
- Benchmarks, Reporting & Performance Improvement
- Technology Development Outreach Activities
- Model Development (capacity, roles, responsibilities)

### **Advisory Groups:**

- PFAC Social Work (Martha Burke)
- Information technology
- Partners Health System Opioid Task Force
- Employee engagement – EAP
- RADEO Project (Hospitalists) Nursing

# Role of Leadership

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Funding – opioid stewardship director, bridge clinic, incentives for training, at the elbow support for addiction treatment/tapering

IT Prioritization – BPAs, metrics, PDMP integration

Define the practice and support the clinicians (and sometimes be the hard line)

Model behavior

# Hospital without Stigma

**The words we use matter.  
Together we can reduce stigma through language.**

As a member of the Brigham community, we believe the words we use in regards to ALL patients are of paramount importance. The language we use when referring to people, whether in the presence of patients and family members or privately among colleagues, speaks volumes. When we use the right language, we decrease the stigma that prevents individuals from receiving quality medical care. We pledge to recognize the power of words and raise awareness around language used. This is especially important for patients suffering from substance use disorders.

We pledge to treat all people with a substance use disorder with respect and integrity. We pledge to recognize a substance use disorder as a chronic medical condition, not as a weakness or moral failing. We pledge to be an advocate for treatment and recovery from this disease.

Instead of using this stigmatizing language ...	Say this ...
✗ Drug abuse or drug habit	✓ Substance use disorder
✗ Addict or junkie or user	✓ Person with a substance use disorder
✗ Alcoholic or drunk	✓ Person with an alcohol use disorder
✗ Dirty urine	✓ Abnormal, positive or unexpected urine test result
✗ Clean urine	✓ Normal or negative urine test result
✗ Clean (referring to a person)	✓ Abstinent, in remission, in recovery
✗ Replacement therapy or medication-assisted treatment	✓ Medication for opioid/alcohol use disorder treatment or medication for addiction
✗ Shooting up	✓ Injecting
✗ Shooter or IV drug user	✓ Person who injects drugs
✗ Problem	✓ Risky, unhealthy or heavy use
✗ Abuse	✓ Use, misuse





# Questions/ Discussion

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