Minnesota Hospital Association

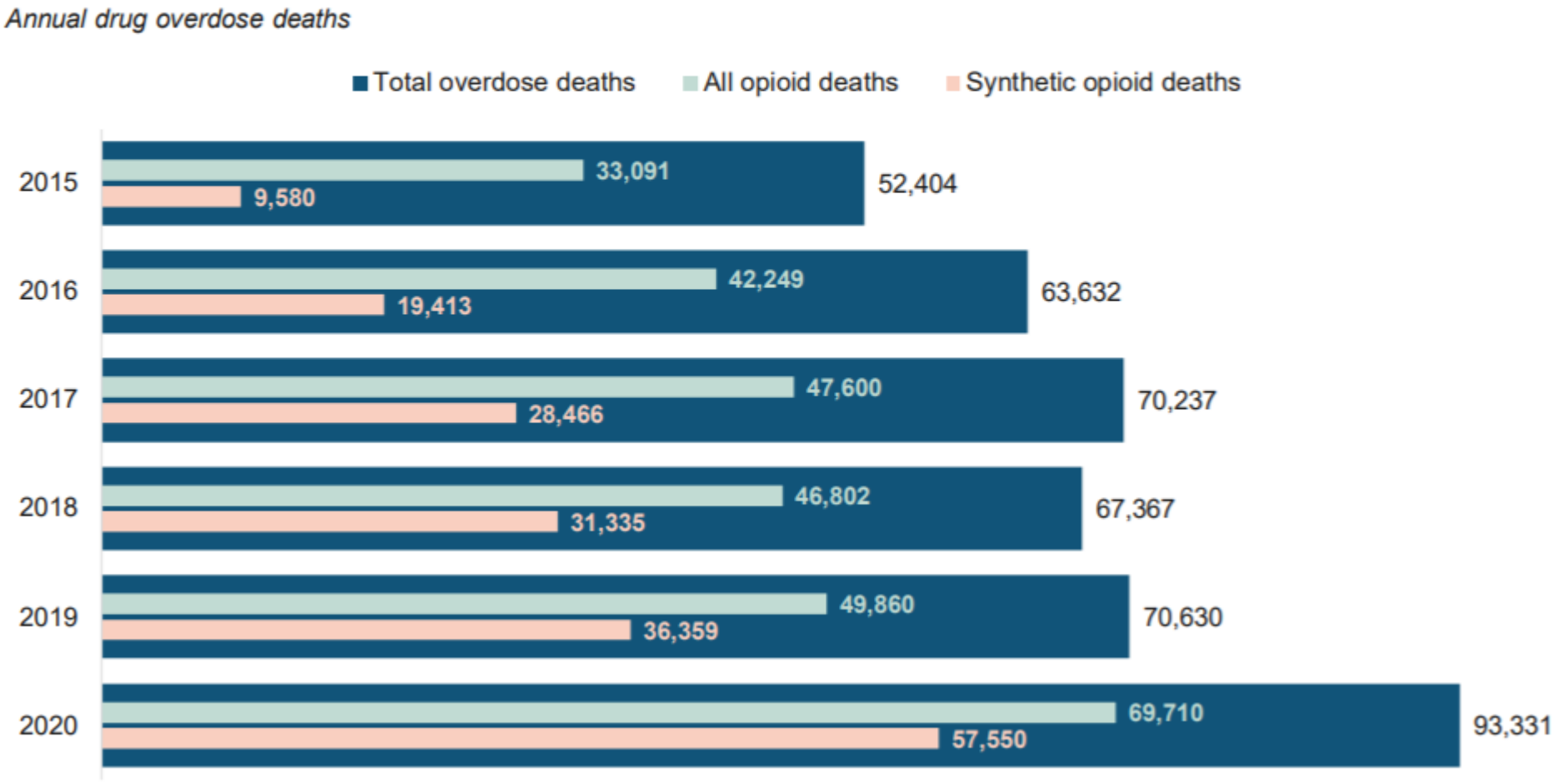
MHA Opioid Stewardship Road Map & Toolkit Rollout

September 9, 2021

Agenda

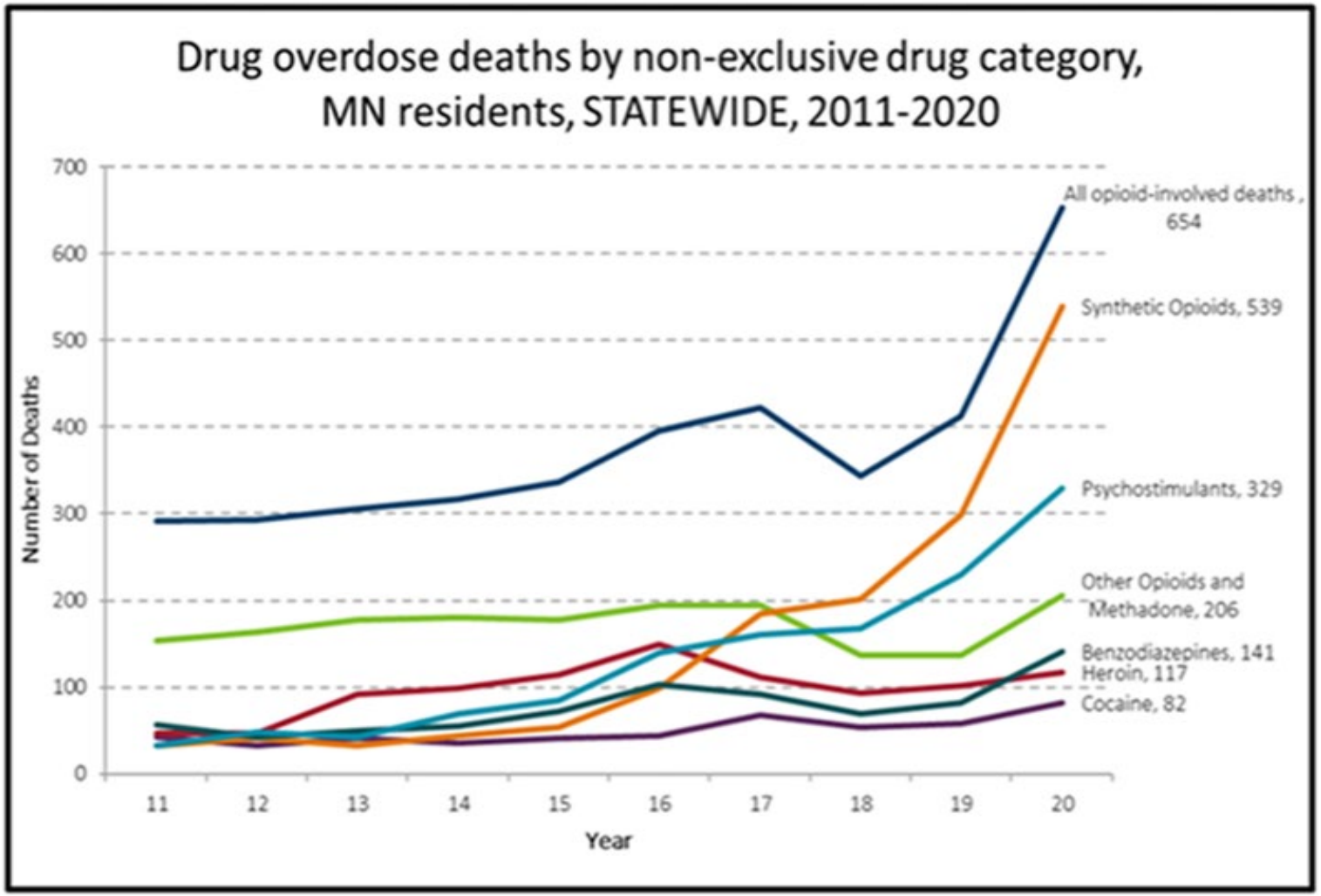
- Journey to creating the road map and toolkit
- Contributors
- Speaker introductions
- Objectives
- Road map review
- Speaker panel Q & A
- Resources and upcoming learning opportunities

Overdose deaths exploded to more than 90,000 in 2020, and synthetic opioids were involved in more than 60 percent of all overdose deaths.



https://www.commonwealthfund.org/blog/2021/drug-overdose-toll-2020-and-near-term-actions-addressing-it

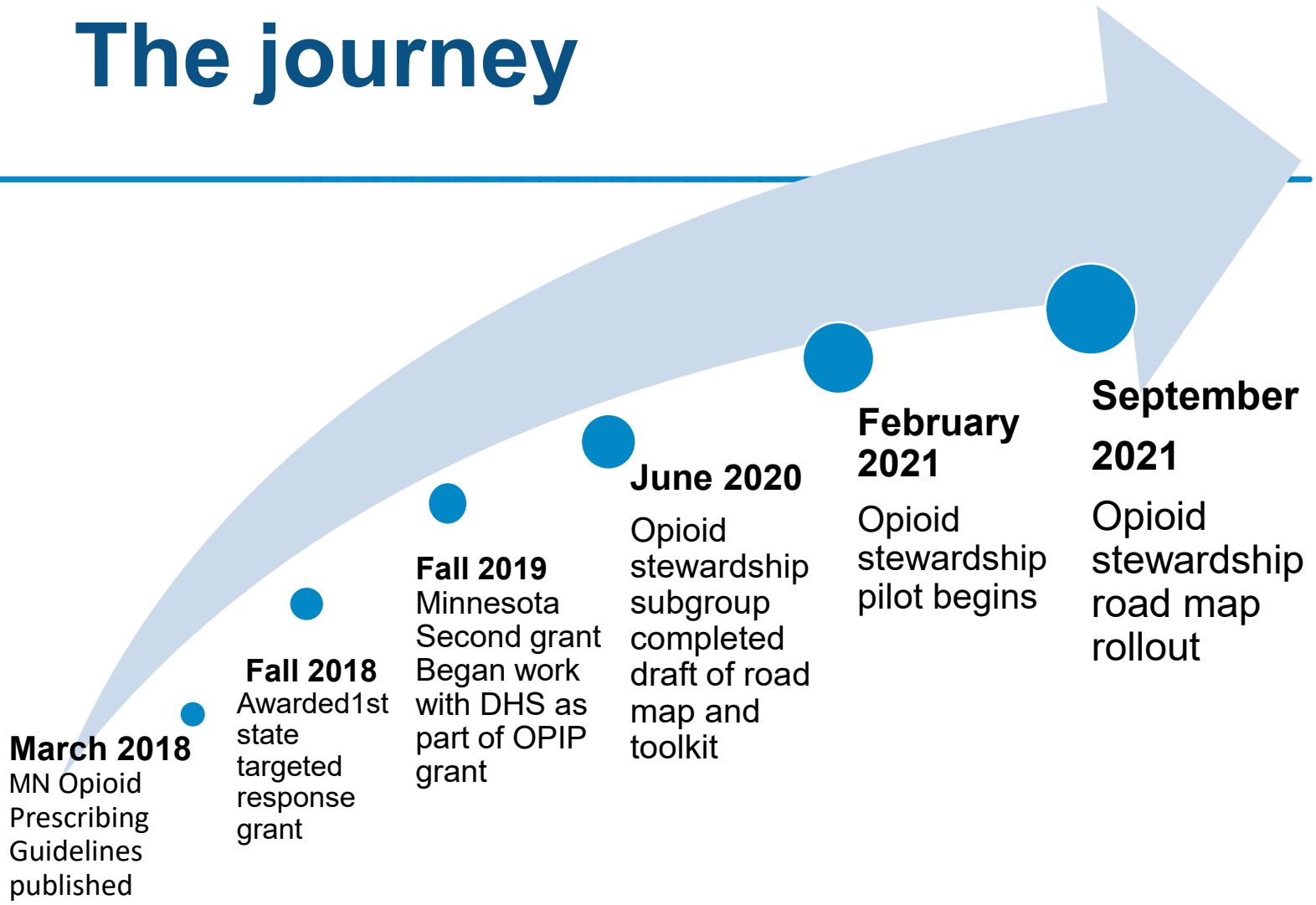
Opioid overdose jump in 2020



DHS Opioid Prescribing Improvement Program (OPIP) Grant

- Opioid prescribing guidelines
- Sentinel prescribing measures
- Provider education
- Reports and quality improvement program
- mn.gov/dhs/opip (OPIP in general)
- mn.gov/dhs/opwg (work group)

The journey


March 2018
MN Opioid Prescribing Guidelines published
Fall 2018
Awarded1st state targeted response grant
Fall 2019
Minnesota Second grant Began work with DHS as part of OPIP grant
June 2020
Opioid stewardship subgroup completed draft of road map and toolkit
February 2021
Opioid stewardship pilot begins
September 2021
Opioid stewardship road map rollout

Contributors

- **Bret Haake**, M.D., Regions Hospital
- **Jennifer Watson**, PharmD, CMSO, CentraCare
- **Joseph Bianco**, M.D., Essentia Health
- **Karen A. Brill**, MHA, RN, Gillette Children's Specialty Healthcare
- **Katie Nixdorf**, M.D., M Health Fairview Clinic
- **Kelly Black**, MA, BS, Essentia Health
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- **Kristen Beyer**, PharmD, Gillette Children's Specialty Healthcare
- **Kristie Bryan**, RN, Welia Health
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- **Melissa McGinty-Thompson**, MA, ACNS-BC, Swift County- Benson Health Services
- **Minnesota Department of Human Services**, Alcohol and Drug Division
- **Nick Van Deelen**, M.D., St. Luke's Hospital
- **Rachel Uzlik**, CPHQ, Revo Health
- **Randy Hemann**, M.D., Olmsted Medical Center
- **Sarah Young**, Carris Health
- **Steve Meister**, M.D., Avera Marshall Regional Medical Center

Speakers

- **Bret Haake, M.D., MBA,** chief medical officer and vice president of medical affairs, Regions Hospital; neurologist; member of the Minnesota DHS Opioid Prescribing Work Group
- **Ken Flowe, M.D., MBA, FACHE,** physician director - Carris Health Acute Care; emergency physician
- **Alicia M. Gonzalez, MD, FACEP,** emergency medicine medical director, Marian Regional Medical Center; regional director, CA Bridge Program
- **Joseph Bianco, M.D., FAAFP,** ambulatory quality leader, Essentia Health; primary care physician

Objectives

- Describe the tenets and purpose for an opioid stewardship program.
- Explain the key foundational pillars used in the development of the opioid stewardship road map.
- Use the toolkit to assist in implementing a more robust opioid stewardship program.

MHA Opioid Stewardship Road Map

The road map, toolkit and prescriber quick reference guide are now available on the [MHA Quality & Safety website]

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.

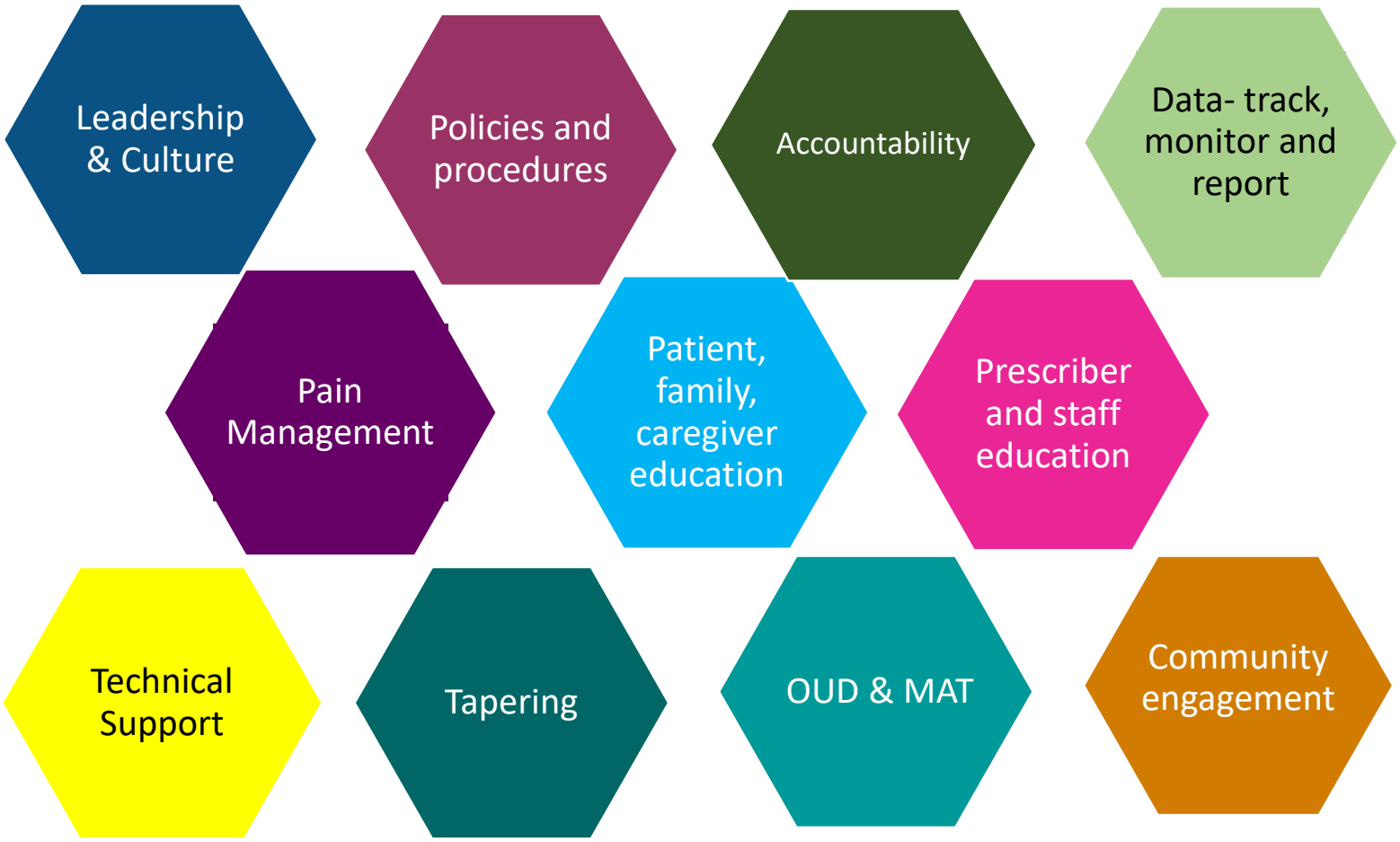
Operational definitions are included to assist organization teams with roadmap auditing and identifying whether current work meets the intention behind each roadmap element.

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	☐ Opioid prescribing is monitored, comparing like specialties and service lines for outliers. ☐ 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. ☐ Use data from external sources to identify patients at risk for overdose. i.e., pharmacy, emergency department and PMP. ☐ 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 > 50 or 90 MME per day, # or percentage of patients on both opioids and a benzodiazepine, etc.	Quality Improvement and Care Coordination: **Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain** includes 16 measures related to opioid analgesia. SHM RADEO Toolkit (Reducing Adverse Drug Events Related to Opioids Implementation Guide)
Tapering	☐ Best-practice standards are followed for tapering patients off long-term opioid analgesics. Example: HHS Guide for Clinicians ☐ Unless there are life threatening or usage concerns, opioids are not tapered abruptly ☐ Taper rates are individualized to minimize opioid withdrawal symptoms with regular input sought from the patient ☐ Taper COAT patients receiving additional opioid therapy for acute pain to the pre-surgical or pre-injury dose as tissue healing progresses. ☐ Clinicians follow the HHS guidelines when tapering patients safely off of long-term opioid use	Tapering and discontinuing opioid use (mn.gov), 2021 HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (2019) Tapering: How to Safely Transition Off Opioid Pain Medications
OUD & MAT	☐ The organization supports early identification and treatment of patients with OUD utilizing evidence based best practices ☐ The organization encourages and supports clinicians in achieving the DATA 2000 waiver to provide medication assisted therapy (MAT) for opioid use disorder (OUD). ☐ Options of MAT, addiction screening and treatment within your organization or referral pathways that are clear and easy to use ☐ Clinicians offer or arrange evidence-based treatment for patients with OUD if not an option within the organization	After Opioid Addiction: What It's Like to Go Through Medication-Assisted Treatment Opioid Use Disorder on the Rise in Pregnant Women Hennepin Healthcare Project ECHO
Community Collaboration	☐ 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. ☐ Work with appropriate community champions to review data and work on community-based o. ☐ 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.	MHA's Health Care & Law Enforcement Road Map The Role of Community Coordinated Efforts in Combating the Opioid Overdose Crisis, The Pennsylvania Opioid Overdose Reduction Technical Assistance Center Collaborating with Communities | AHA Community in Crisis- A Collaborative Approach to Responding to the Opioid Epidemic ASPMN Community Forums to Address the Opioid Crisis: An Effective Grassroots Approach to Rural Community Engagement - PubMed Central (PMC)

Key themes/sections



Leadership Commitment & Culture

Policies and procedures

Bret Haake, M.D., MBA, chief medical officer and vice president of medical affairs, Regions Hospital; neurologist; member of the Minnesota DHS Opioid Prescribing Work Group

Leadership Commitment & Culture

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Leadership & Culture	☐ The organization, including leadership and staff, identifies safe opioid prescribing (dose based on best-practice) as a priority for the clinic/hospital and supports a culture of opioid reduction. **Op Def.: Put information for patients in waiting room that came from leadership-attend safe opioid prescribing task group** ☐ The organization surveys and adopts the latest information on opioid use. ☐ Pain/functional assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the clinic and hospital. Staff champion- similar to ABS. Survey patients-reduced waste-opened up conversations Surveying patients post surgery ☐ The organization has a multidisciplinary committee/subgroup that reviews opioid related events and make recommendations to improve patient safety to reduce morbidity and mortality-, i.e., Opioid Stewardship Program (OSP). ☐ Members of the OSP are responsible for staying current with relevant evidence-based best practices and are competent in pain management and opioid stewardship.

Policies and procedures

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Policies & Procedures	☐ The organization's policies and protocols meet national best practice guidelines for opioid prescribing, patient monitoring , safe dosing and tapering that meet best practice standards ☐ Policies and procedures are used to prevent opioid diversion ☐ Function and pain assessments are fully and accurately documented. ☐ Facility policies support evidence-based guidelines and system requirements. - Utilization of the Minnesota Prescription Monitoring Program (PMP) - Minnesota Opioid Prescribing Guidelines - CDC Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain. ☐ Policies and pain order sets are standardized for procedural areas and specialties. e.g. family practice, labor and delivery, endoscopy, orthopedics, surgery. ☐ Policies are used to establish processes for training, monitoring and adhering to best practices for pain management and opioid prescribing

Prescriber and staff education

Accountability

Patient, family and caregiver education

Ken Flowe, M.D., MBA, FACHE, physician director - Carris Health Acute Care; emergency physician

Prescriber and staff knowledge

Prescriber and staff education

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Prescriber and Staff Education and Competency	☐ The organization has developed core competencies for best practice in pain management-for clinical staff. Training and proficiency testing are required for all multidisciplinary team members. ☐ Clinical and support staff receive ongoing education on evidence-based protocols and guidelines ☐ Interdisciplinary team (IDT) onboarding includes training on opioid policies, procedures and protocols, including the risks and symptoms of opioid addiction and diversion ☐ The organization encourages continued learning by pharmacists, prescribers and support staff ☐ The multidisciplinary team receives training on the Minnesota Hospital Association Opioid Adverse Drug Event Prevention Road Map. ☐ Staff receive education to understand how mental health can impact the patients dealing with pain

Accountability

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Accountability	☐ Leadership at all levels of the organization set measurable goals and support the work to improve pain management and opioid prescribing practices. ☐ Individual opioid prescribing patterns are included in Ongoing Professional Practice Evaluation. ☐ The multidisciplinary pain and opioid team have a mechanism to keep up with the current literature and guidelines on opioid use and pain management. ☐ The organization has a process in place to address providers whose opioid prescribing practices are not meeting established measurement goals and are outliers amongst their peers.

Patient, family and caregiver education

Patient, family, caregiver education

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Patient and Family/Caregiver Education	☐ Patient and Family Advisory Council members provide feedback related to patient education material and opioid related therapies ☐ Patient education includes the following: - Appropriate use of opioids - Risks of opioid therapy - Safe and secure storage of opioids - Safe disposal of opioid analgesics in the home - Pain management rather than the elimination of pain as the goal of treatment. - The organization provides an appeal process for individual patients to have physician/APP decisions reviewed at patient request. - Safe tapering instructions ☐ Patient and families are educated on how to activate the rapid response team.

Pain Management

Opioid Use Disorder (OUD) & Medication Assisted Treatment (MAT)

Alicia M. Gonzalez, MD, FACEP ,emergency medicine medical director, Marian Regional Medical Center; regional director, CA Bridge Program

Pain Management

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Pain Management	☐ The organization uses best-practice guidelines in pain management, i.e., The Joint Commission Opioid Prescribing Guidelines and ICIS recommendations. ☐ Multi-modal and other non-opioid pain management is the most appropriate, first line treatment for most acute and chronic pain conditions. (Opioids are not indicated for fibromyalgia, headache/migraine, self-limited illness, uncomplicated neck and back pain, dental pain, and uncomplicated musculoskeletal pain). ☐ An interdisciplinary team approach is used when managing complex chronic pain. ☐ Pain treatment plans are based on the patient's clinical condition, past medical history and pain management goals. ☐ Pain order sets are standardized for procedural areas and specialties e.g. endoscopy, orthopedics, surgery, labor and delivery, etc. ☐ The Prescription Monitoring Program is checked whenever prescribing opioid therapy ☐ Prescribing opioids and benzodiazepines or other sedatives concurrently is to be avoided whenever possible. ☐ Discuss and document the risks and benefits whenever prescribing opioids. ☐ A patient provider agreement or understanding is initiated prior to beginning chronic analgesic therapy. ☐ Monitor patients receiving chronic opioid analgesia therapy (COAT) for the presence of Opioid Use Disorder (OUD). Note: Clinicians who are unable to diagnose OUD using the DSM-5 criteria can use a brief, standardized screening tool and make a referral as appropriate.

Alternatives To Opioids (ALTO) Program

Our nation faces an opioid epidemic that is, in part, a direct result of overuse and over-prescribing of opioid medication by medical providers. Part of the solution is moving away from opioids as first-line treatment in situations where many safer, effective alternatives are available. *This document illustrates the non-opioid treatment options. Please refer to the EHR order set for the most current dosing guidelines.*

Renal Colic

1. **Ibuprofen** 400mg PO OR **Ketorolac** 15-30mg IM / 10-15mg IV
2. Preservative-free **Lidocaine** 1.5 mg/kg IV over 10 mins (MAX 200 mg). Cardiac monitor x 30min. Not for cardiac, liver, and renal disease patients. Can repeat dose x 1 after 90 minutes
3. May add **Acetaminophen** 1g PO
4. If volume depleted/hypovolemic: 1L 0.9% **NS bolus** (no evidence to support routine use)
5. **Ondansetron** (Zofran) 4mg po/IV X 1

Musculoskeletal Pain (sprains, strains, or opioid naïve Low Back Pain)

1. Anti-Inflammatory: **Ibuprofen** 400mg PO (analgesic ceiling) OR **Ketorolac** 15-30mg IM/10-15mg IV AND **Acetaminophen** 1g PO
2. +/- Single dose Muscle Relaxant to help pt sleep (does not improve pain) – choose one:
   a. **Cyclobenzaprine** (e.g. Flexeril) 5mg PO (caution: somnolence age > 65yrs or <70 kg)
   b. **Cyclobenzaprine** 10mg PO (patients >70 kg)
   c. **Diazepam** (e.g. Valium) 5mg PO (less preferred due to addiction risk)
   d. **Methocarbamol** (Robaxin) 1000mg IV
3. Add Topical Tx: **Diclofenac gel** Q6-8hrs (NSAID) OR **Lidocaine ointment** TID OR **Lidocaine patch** to most painful area, MAX 3 patches, instruct patient to remove after 12 hours
4. Neuropathic sounding pain: **Gabapentin** 300mg PO x 1 in ED. For gabapentin naïve patients. Advise to discuss Rx for home with PCP

Acute on Chronic Radicular Low Back Pain (LBP) – *Opioid tolerant patient*

Avoid opioids – the mu receptors are already occupied! Start with MSK algorithm above. Then consider:

1. **Dexamethasone** 8-10mg IV or PO x 1
2. **Ketamine** 0.1-0.3 mg/kg in 50cc NS IV over 10 mins, or 0.3mg/kg IM, or 0.5mg/kg IN. Max single dose 30mg, can repeat after 1 hour. Can do Ketamine 0.1 mg/kg/hr until pain is tolerable

Acute on Chronic Pain (e.g. Abdominal Pain)

Opioids not recommended — builds tolerance, requires higher doses over time leading to worse opioid side effects, and ultimately no relief. Set expectations upfront with compassion, but honesty; goal is to "break crisis," get to "functional level" – walk, eat/hydrate, get to the bathroom. **Goal is not pain free.**

1. **Acetaminophen** 1g PO AND **Ibuprofen** 400mg PO OR **Ketorolac** 15-30mg IM/10-15mg IV
2. Neuropathic sounding pain: **Gabapentin** 300mg PO x 1 in ED. For gabapentin naïve patients. Advise to discuss Rx for home with PCP
3. Opioid tolerant: **Ketamine** 0.1-0.3 mg/kg in 50cc NS over 10 mins
4. Non-nociceptive pain (e.g. psychosomatic, stress/anxiety, cannabis): **Haloperidol** 5mg IM
   a. Stress/Anxiety component: **Prochlorperazine** (e.g. Compazine) 10mg PO/IV
5. Pro-kinetic agent (e.g. DM, gastroparesis): **Metoclopramide** (e.g. Reglan) 10mg PO/IV
6. Anti-kinetic agent (e.g. IBS, cramping): **Dicyclomine** (e.g. Bentyl) 20mg PO/IM
7. Cannabinoid Hyperemesis Syndrome: **Capsaicin** cream 0.025% applied 1x to abdomen

Tension or Migraine Style Headache

Opioids not recommended, known to cause rebound headaches.

1. **Start with "Headache Cocktail"**
   a. Anti-inflammatory: **Ibuprofen** 400mg PO OR **Ketorolac** 15mg IM/10-15mg IV AND **Acetaminophen** 1g PO
   b. Anti-emetic: e.g. **Metoclopramide** 5-10mg PO/IV
   c. Anti-histamine: e.g. **Diphenhydramine** 25mg PO/IV or **Prochlorperazine** 10mg PO/IV
   d. PO fluids vs. 1L 0.9% NS IV bolus
2. Consider **Sumatriptan** 6mg Subcutaneously if headache <6 hours
3. If neck muscle pain: Cervical or Trapezius **Trigger Point Injection** as per MSK section above
4. If frontal: Consider **Sphenopalatine Ganglion Block** with 1/2cc 4% or 1cc 2% Lidocaine IN, split dose between b/l nares, administer with atomizer or hollow cotton-tipped applicator
5. If occipital: Consider **Greater Occipital Nerve Block** with 2cc 1-2% Lidocaine with or without Epi

If <50% pain relief then try:

6. **Magnesium** 1-2 g IV over 60 minutes (smooth muscle relaxation)
7. **Dexamethasone** 4-10mg IV (decreases bounce-backs at 72 hours)

If still <50% pain relief then try:

8. **Haldol** 5 mg IM
9. **Valproic Acid** 500mg in 50mL IV NS over 20 min (used by neurologists to prevent migraines)

If still <50% pain relief then may need opioids, and likely admit for intractable pain and Neuro consult.

Modified by Alicia Kurtz, MD – from guidelines by Alexis LaPietra, DO – Medical Director of Emergency Medicine Pain Management @ St. Joseph's Regional Medical Center in Paterson, NJ

Distributed by: Candace Fong, PharmD, CommonSpirit Health System VP Medication Safety, Candace.Fong@Dignityhealth.org, on behalf of the Dignity Health System P & T Committee
April 2020

ILLUSTRATION BY CHRISTOPHER DAVID RYAN

We are not going to get your pain to Zero today.

Goal is to move from **INTOLERABLE** pain to **TOLERABLE** pain.

The body needs **time to heal.**
You may have *some* pain for a **long time**…
And *some pain is ok*.

It's my job to **keep you safe**. While opioids may make you feel better now, in the long run **they aren't safe or effective** at controlling pain. I'm not willing to do something I know isn't safe for you.

Opioid Use Disorder (OUD) & Medication Assisted Treatment (MAT)

OUD & MAT

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
OUD & MAT	☐ The organization supports early identification and treatment of patients with OUD utilizing evidence based best practices ☐ The organization encourages and supports clinicians in achieving the DATA 2000 waiver to provide medication assisted therapy (MAT) for opioid use disorder (OUD). ☐ Options of MAT, addiction screening and treatment within your organization or referral pathways that are clear and easy to use ☐ Clinicians offer or arrange evidence-based treatment for patients with OUD if not an option within the organization

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

Uncomplicated* opioid withdrawal?**

NO → **Start Bup after withdrawal**
Supportive meds prn, stop other opioids

YES (stop other opioids)

Administer 8mg Bup SL

1 HOUR

Withdrawal symptoms improved?

NO → **No Improvement**

Differential Diagnosis:

- **Withdrawal mimic:** Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlying illness.
- **Incompletely treated withdrawal:** Occurs with lower starting doses; improves with more Bup.
- **Bup side-effect:** Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
- **Precipitated withdrawal:** Too large a dose started too soon after opioid agonist.

  Usually time limited, self resolving with supportive medications.

  In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short acting full agonists.

YES

Administer 2nd dose

Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment
16 mg Bup SL/day

Titrate to suppress cravings;
Usual total dose 16-32mg/day

Discharge

- Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
- **If no X-waiver:** Use loading dose up to 32mg for long effect and give rapid follow up.
- **If X-waiver:** Check CURES (not required in Emergency Department if ≤7 day prescription), prescribe sufficient Bup/Nx until follow-up.

Overdose Education Naloxone Kit

Buprenorphine Dosing

- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days
- May dose qday or if co-exisiting chronic pain split dosing TID/QID.

*Complicating Factors

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness
- Recent methadone use

**Diagnosing Opioid Withdrawal

Subjective symptoms AND one objective sign

Subjective: Patient reports feeling "bad" due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)

Objective: ***[at least one]*** restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor

Typical withdrawal onset:
≥ 12 hrs after short acting opioid
≥ 24 hrs after long acting opioid
≥ 48 hrs after methadone (can be >72 hrs)

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.

If Completed Withdrawal:
Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

Opioid Analgesics

- Pause opioid pain relievers when starting Bup.
- OK to introduce opioid pain relievers after Bup is started for breakthrough pain. Do not use methadone with Bup.

Supportive Medications

- Can be used as needed while waiting for withdrawal or during induction process.

Pregnancy

- Bup monoproduct or Bup/Nx OK in pregnancy.
- Consider referencing buprenorphine in pregnancy guide.

CA BRIDGE GUIDE

DEA X-Waiver Notification

CA BRIDGE

SEPTEMBER 2020

Blueprint for Hospital Opioid Use Disorder Treatment

A patient-centered approach to 24/7 access to medication for addiction treatment

https://cabridge.org/tools/resources/

Technical Support

DATA-track, report, monitor and respond

Tapering

Community engagement

Joseph Bianco, M.D., FAAFP, ambulatory quality leader, Essentia Health; primary care physician

Technical Support

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Technical Support	☐ The electronic health record (EHR) pain management templates and order sets support alternative treatments to opioid therapy i.e. nonopioid multi-modal ☐ When clinicians are prescribing opioids, they have quick, easy access to the PMP from the ordering template. **Op Def: repetitive sign on not required** ☐ MME conversion calculator and guidance in MME dose based on type of pain ☐ Medication order alerts are used to prevent adverse events related to opioid prescribing. I.e., contraindications, allergies, unsafe dose, etc. ☐ The EHR includes best practice screening/assessment tool templates to be used when considering prescribing opioids for acute, post-acute and chronic pain. E.g., GAD7, PHQ-2/9, CAGE ☐ EHR has functionality to calculate cumulative and daily MME and provide guidance on MME dose based on type of pain

DATA-track, report, monitor and respond

Data- track, monitor and report

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Track, Monitor, Report and Respond to Data	☐ Opioid prescribing is monitored, comparing like specialties and service lines for outliers. ☐ 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. ☐ Use data from external sources to identify patients at risk for overdose. i.e., pharmacy, emergency department and PMP. ☐ 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 > 50 or 90 MME per day, # or percentage of patients on both opioids and a benzodiazepine, etc. ☐ The organization appoints a senior executive to oversee analyze and respond to data reporting activities to the multidisciplinary committee. i.e., peer review)

Tapering

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Tapering	☐ Best-practice standards are followed for tapering patients off long-term opioid analgesics. Example: HHS Guide for Clinicians ☐ Unless there are life threatening or usage concerns, opioids are not tapered abruptly ☐ Taper rates are individualized to minimize opioid withdrawal symptoms with regular input sought from the patient ☐ Taper COAT patients receiving additional opioid therapy for acute pain to the pre-surgical or pre-injury dose as tissue healing progresses. ☐ Clinicians follow the HHS guidelines when tapering patients safely off of long-term opioid use

Minnesota Department of Health and Human Services recently released their **Tapering and discontinuing opioid use** guidance

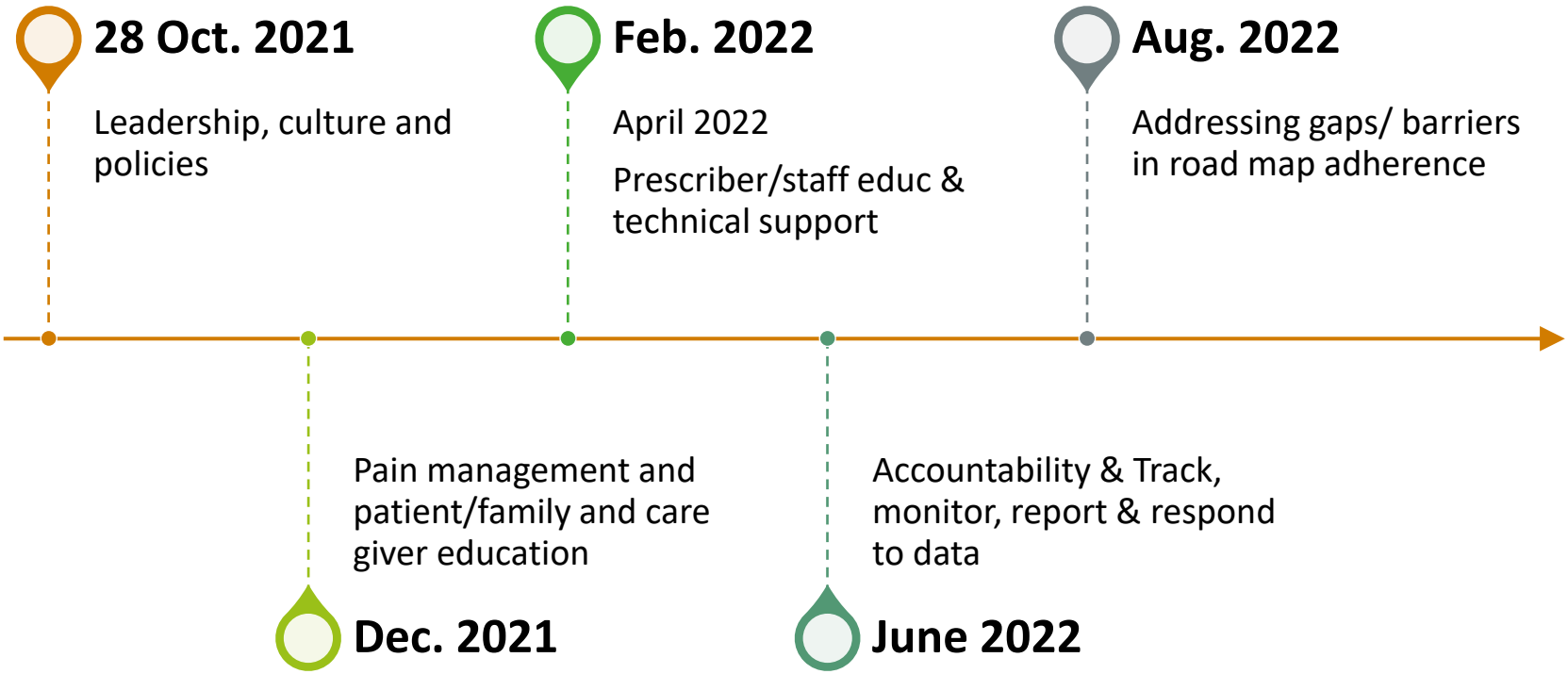
Community engagement

Road map sections	Road Map questions (if not present at your clinic/hospital or answering no, please see next column for suggested resources)
Community Collaboration	☐ 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. ☐ Work with appropriate community champions to review data and work on community-based o. ☐ 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.

Opioid Stewardship Toolkit

- **Tools to implement guidelines**
- **Strategies and tactics for implementation**
- **Best practices for pain management**

Implementing the opioid stewardship road map webinar series



Closing Q & A

Link to documents

- MHA Opioid Stewardship Road Map

Other resources

- Opioid Stewardship Toolkit
- Prescriber quick reference guide