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Health Quality Innovation Network

HQIC Office Hours

July 13, 2023

Logistics – Zoom Meeting

To ask questions, click on the **Chat** icon. At the end of the presentation, you will also be able to unmute to ask a question verbally.

You may adjust your audio by clicking the caret next to the **Mute** icon.

Resources from today's session will be shared after the call.

Health Quality Innovation Network

Today's Presenter

David Klein, MD, FACEP

National Director of Quality
US Acute Care Solutions

First Do No Harm: Our Patient Safety Initiative to Change Clinician Opioid Prescribing

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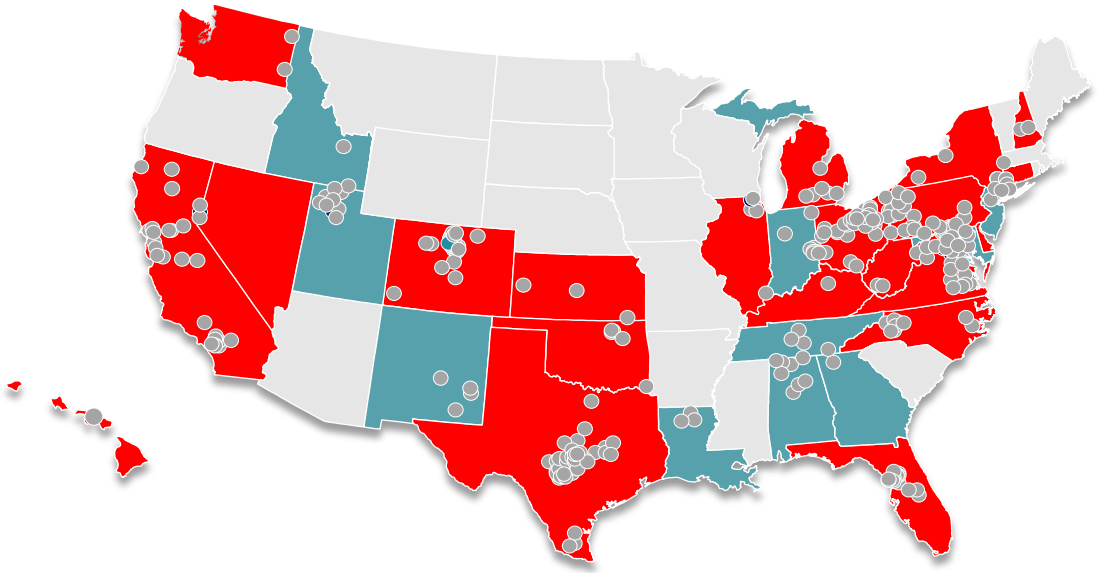
Agenda- What I'm NOT covering…

1. **Why opioid are bad**
2. **Tons of stats to support why opioids are bad**
3. **Pathophysiology of opioids**
4. **How the ED in not actually the primary problem**

Agenda- What I will talk about

1. How to change Clinician practice behavior at scale through opioid prescribing

Who we are (and why that matters)



9,300,000
Patient encounters

5,300
Clinicians

514
Programs

EM	283
Inpatient (HM, CC, Obs)	127
PAC/other (SNF, LTACH, tele, etc.)	104

INOVA · VHC HEALTH · SENTARA · Allegheny Health Network · AdventHealth · BON SECOURS MERCY HEALTH · CommonSpirit · LIFEBRIDGE HEALTH · Providence · Ascension · Sutter Health · Trinity Health · Atrium Health · Adventist HealthCare · Centura Health · Martin Luther King, Jr. Community Hospital

What are the options for changing Clinician practice behavior at scale?

Push the site data to the Medical Directors

House the data, Clinicians can pull

Push data to all Clinicians

- Blinded or unblinded
- Individual, Site-level and/or national-level

Pushing data to outlier Clinicians only

Create a national target for Opioid Prescribing and have everyone try to meet it

Contact Clinicians to discuss

- All Clinicians
- Outlier Clinicians only

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4 “easy” steps to change Clinician behavior

4 “easy” steps to change Clinician behavior in opioid prescribing

Start with the Patient

- Reducing opioids improves patient care and population health

Don’t use blunt instruments to solve fine problems

- Opioid Rx per clinician ➔ opioid Rx per hour ➔ opioid Rx per patient seen ➔ **opioid Rx per 100 patients discharged**
- Focused on opioid Rx NOT opioids in the ED or hospital

Make your data better than good but worse than perfect

- Obtain clinician-level data (but site-level data works)
- Kept metric easy to gather (didn’t go to MMEs or by Dx)
- **Mean: 10.36 opioid prescriptions per 100 patients discharged**
- Defined Outlier Clinicians as 2x mean

Keep your actions as simple as possible

- Optimize signal-to-noise ratio
- **We did NOT tell clinicians to reduce prescribing**
- We provided their data, asked about challenges, ALTO awareness, opioid guideline

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What happened after we pushed the site data to Medical Directors?

a. Significant improvement was seen
b. Mild improvement was seen
c. No change
d. Mild deterioration was seen
e. Significant deterioration was seen

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Outlier Clinicians: Data push and conversation

Email #1 → Email #2 → Medical Director contact

Our national quality team set up conversations with Outlier Clinicians via phone or zoom

Goal of conversation: Inform, listen, solutions

What happened after we started emailing Outlier Clinicians?

- Surprise and willingness to change
- Lack of surprise and willingness to change
- Kubler Ross stages of grief
- Ignoring (this didn't work—we contacted 100%)

Common reasons cited by Outlier Clinicians for overprescribing opioids

"I don't overprescribe."

- "I see sicker patients than everyone else."
- "Your data is wrong."
- "I have a huge family issue with opioid abuse, I would never overprescribe."

"I don't know how to say no when Patients ask me to prescribe."

"I feel like I have to prescribe them."

"Patients have already tried everything else, and they came to me for help."

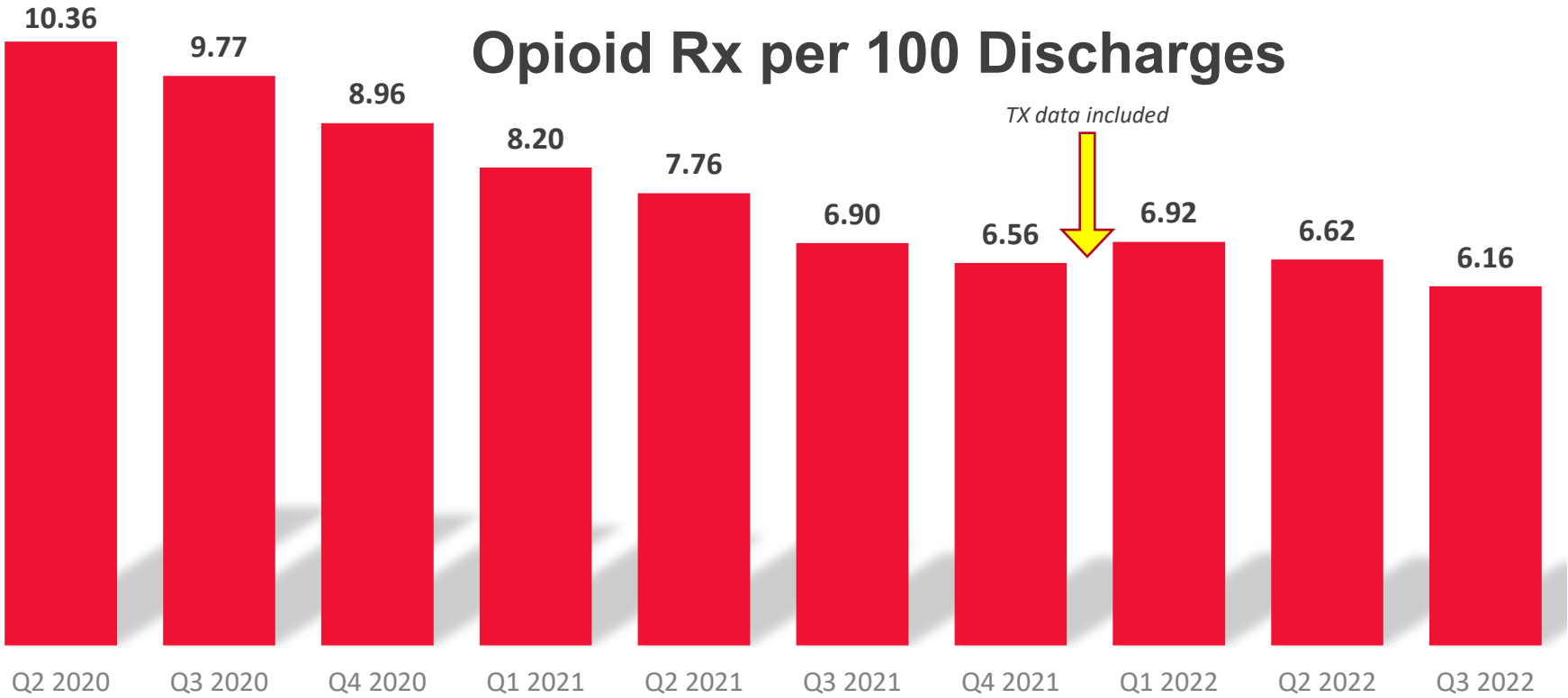
"I feel like my patient satisfaction will decrease if I don't prescribe them."

"I feel like my patient will sue me if I don't prescribe them."

"Nothing else works for pain."

"The Joint Commission told me I have to prescribe them."

Our Results: We have reduced opioid prescribing 36% in 2 years with 100,000 *fewer* opioid prescriptions annually



US Acute Care Solutions

Oskvarek J, Aldeen A, Shawbell J, et al. Opioid prescription reduction after implementation of a feedback program in a national emergency department group, Ann Emerg Med. 2022;79:420-432.

4 “easy” steps to change Clinician behavior

Questions?

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Dialog
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Communication
PARTNERSHIP
Forum
EXPLORATION
Community
Group
TALK
Debate

Resources

- Opioid Prescription Reduction After Implementation of a Feedback Program in a National Emergency Department Group - Annals of Emergency Medicine (annemergmed.com)
- Relationship Between Pain Management Modality and Return Rates for Lower Back Pain in the Emergency Department.
- Opioid-prescribing patterns of Emergency Physicians and Risk of Long-Term Use
- 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain
- Training Modules | Opioids | CDC
- HQIN Opioid Resources for Clinicians

DATE Office Hours

Topic: Hear from your Peers: What Works to Reduce Readmissions

Date: August 10, 2023
Time: 12:00 PM EST

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