MEDITECH Nurse Advisory Committee

Strategies and Challenges: Managing the Opioid Crisis

SPECIAL REPORT

MEDITECH's Nurse Advisory Committee (NAC) *is an important component of MEDITECH's Nurse Informatics Program. Their mission is to advance information technology for nurses, as well as to enhance the practice of nursing and the delivery of patient care. The committee reflects MEDITECH's diverse customer base, with 16 members representing a range of healthcare organizations — from large teaching hospitals, to community hospitals, to Critical Access Hospitals.*

Executive Summary

NAC members joined forces at MEDITECH's 2016 Nurse and Home Care Forum to share information about the current opioid epidemic: what they see in their communities, the organizational initiatives and strategies they use to manage the crisis, and the challenges that persist.

This special report summarizes key discussion topics, including:

- Identifying drug-seeking behavior in the emergency department
- Preventing fraud and abuse
- Monitoring narcotic ordering patterns
- Managing inpatient pain
- Examining the role that patient satisfaction scores play in incentivizing providers to order narcotics.

NAC members kicked off the discussion with strategies their hospitals use in the ED — the front line of the opioid crisis.

Identifying Drug-Seeking Behavior in the ED

E-Prescribing in the ED

Several NAC members shared how ED physicians use e-Prescribing to check patient histories for narcotic prescriptions the patient may have filled. The software program, which maintains a record of all prescriptions purchased under the patient's insurance plan, is particularly useful for identifying drug seekers, who frequently change hospitals, providers, and health systems to avoid detection. They will even cross state lines to avoid state databases. Easy access to electronic prescription information has helped ED physicians to identify patients who are "doctor shopping." E-Prescribing has replaced the paper script pad, which may be stolen to forge prescriptions.

E-Prescribing, however, relies on pharmacies to electronically input the drug information and, sometimes, the payment method. For example, if the patient uses cash to pay for the medication, the drug information is not always captured. To make e-Prescribing foolproof, all scheduled medications must be captured electronically.

Several NAC members stated that their organizations have staffed EDs with medication reconciliation technicians to collect detailed information on the patient's home medications. This process — combined with the patient's e-prescription history and Continuity of Care Document — provides physicians with a more complete picture of the patient's prescriptions.

ED Care Coordination

Beth Israel Deaconess Hospital - Plymouth, located 40 miles from Boston, realized that discharging ED patients with referrals for substance abuse treatment wasn't effective. Barbara Kilroy, MBA, RN-BC, director of clinical informatics, stated that the hospital responded by embedding social workers and mental health professionals in the ED, to include them at the outset of the patient's treatment plan. The social workers are able to fast-track care coordination with physician practices that provide counseling and get immediate help for patients suffering from psychiatric and addiction issues. This approach is becoming a model for community hospitals across the commonwealth; Beth Israel Deaconess Hospital - Plymouth was recently awarded a $3.7 million grant from the Massachusetts Health Policy Commission to continue their work.

Nationwide, approximately 6% of controlled substances are prescribed electronically, 5.7% of prescribers are able to electronically submit prescriptions for controlled substances, and 80.6% of pharmacies can receive such prescriptions, according to Surescripts ' 2015 National Progress Report.[1] These numbers are increasing dramatically as more and more states mandate ePrescribing for all schedules of controlled drugs.[1]

Tonya Ellingson, RN, CEN, SANE-A, nurse navigator at Avera McKennan Hospital & University Health Center in Sioux Falls, SD shared how the hospital's ED Nurse Navigator Program manages at-risk patients who frequently use the ED as a clinic or a substitute primary healthcare provider rather than for emergent situations. The program provides care coordination for these "super-utilizers." Patients who exhibit drug-seeking behavior often fall into this category. The nurse navigator assesses these patients and creates a care plan with them, so the patients are aware of the actions that will be taken to address their problems.

If a patient arrives at the ED looking for controlled medications and is enrolled in the ED Nurse Navigator program, the tracker indicates the patient has an ED care plan for clinicians to reference. This care plan is shared with the Avera Health system, allowing ambulatory coordinators to simultaneously view patient problems and discuss potential interventions with the nurse navigator. (For program details, see the case study, *Avera McKennan's ED Nurse Navigator Program Uses MEDITECH's EHR to Steer ED to $475,000 Annual Cost Savings*.)

ED Narcotic Policy for Chronic Pain

To manage drug-seeking behavior, Avera McKennan's ED instituted a "no narcotic prescriptions for chronic pain" policy. The idea for this bold move came from the ED physicians themselves, who wanted to help stem the opioid crisis. As providers on the front line, they recognized that prescribing narcotics for chronic pain contributes to the problem and is not always in the best interest of the patient.

Avera McKennan's policy includes the following:

- Prescriptions for controlled substances that have been lost, destroyed, stolen, or expired will not be refilled. The patient must maintain active prescriptions with his or her PCP.
- Controlled substances prescribed by another provider for a chronic condition will *not* be refilled in the ED; the patient will be asked to follow up with his or her prescriber.

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[1] Surescripts® 2015 National Progress Report. Surescripts website. Accessed November 3, 2016.

- Patients who present with acute exacerbations of chronic pain conditions are treated with non-opioid analgesics, non-pharmacological therapies, or are referred to pain specialists for follow up.
- Under special circumstances, a small amount of Ultram may be prescribed for severe dental issues.

Avera McKennan's policy is rooted in the fact that treating chronic pain is complicated and requires a thorough assessment and determination of appropriate long-term therapy. A patient with chronic pain issues should have his or her plan of care and narcotic prescriptions monitored by one provider who is familiar with the patient's condition. Patients are considered to have chronic pain syndrome if they visit the ED multiple times for relief from painful conditions. These patients are routed to the ED nurse navigator for an assessment to rule out other issues; identify their needs; and determine necessary services, including non-narcotic alternatives such as ice therapy, positioning, and distraction.

Managing patients with chronic conditions who experience acute episodes of breakthrough pain can be challenging. When a patient who responsibly manages chronic pain presents to the ED with breakthrough pain, the ED physician will treat him or her with non-narcotic therapies. For example, a patient with severe migraine may receive a "headache cocktail," which does not contain narcotics.

For the "no narcotics for chronic pain" policy to succeed, the entire ED team *must* enforce it consistently. If the ED physician determines it is necessary to order a narcotic related to chronic pain, he or she is able to proceed with the order in the EHR — Avera has not implemented any "hard stops" to prevent narcotics from being ordered. However, ED physicians do realize that deviating from the policy will be noted and may have repercussions from their colleagues, who all agreed to the policy.

While the policy has meant significant change for both patients and providers, the hospital reports that patients are not bouncing back to the ED seeking narcotics for chronic pain.

Other NAC members shared that they are also seeing more stringent narcotic ordering practices; the rigid approach presents an additional challenge for nurses handling the discharge of patients with a history of drug abuse. Physicians are often reluctant to prescribe narcotics for these patients upon discharge, even if they report a pain level as high as 7 or 8.

Preventing Fraud Abuse

Patient Photos in the EHR

Several NAC members stated that staff take photographs of patients and upload the images to the EHR, to confirm patient identification and prevent patients from using aliases. One NAC member shared that a patient presented multiple times to the ED — with no identification; the hospital later learned that the patient had been to 16 hospitals around the state. Displaying the patient's photograph in the header of his or her chart allows for easy identification.

Drop Boxes and Lock Boxes

One other successful intervention discussed is placing drop boxes in the hospital lobby for leftover prescription medications. Drop boxes are an easy and effective method for getting unused narcotics out of the patient's home, away from teenagers and others. Beth Israel Deaconess Hospital - Plymouth reported that their drop box proved more successful when it was moved from the police station to the hospital lobby. A security process, which includes pharmacy staff, is in place to manage the box.

Union Hospital of Cecil County, in Elkton, Maryland, distributes lock boxes to the community at local health fairs, so people can securely store their medications away from family members and others.

Monitoring Narcotic Ordering Patterns

State Regulations

NAC members agreed that their respective states have taken steps to regulate the ordering of controlled substances, but that the regulations sometimes don't go far enough.

- Connecticut regulations mandate that an initial prescription cannot exceed 7 days. A significant loophole allows physicians to use their clinical judgment when overriding the restriction.

- New York regulations vary on how much the physician may prescribe. The state requires that physicians consult the I-STOP/Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients.

  NAC members from New York reported that their ED physicians check the registry regularly, particularly for patients complaining of back or dental pain; these complaints are traditionally used by patients with drug-seeking behavior.

- In March 2016, Massachusetts became the first state in the nation to limit first-time opioid prescriptions to a 7-day supply for adults and most opiate prescriptions for minors, with certain exceptions. The commonwealth also requires physicians to check the PMP database before writing a prescription for Schedule II or Schedule III narcotics, and to earn CME credits in topics ranging from effective pain management to the risks of abuse and addiction associated with opioids.

Sharing Ordering Reports with Physicians to Identify Patterns

NAC members agreed that reviewing ordering reports with physicians is an effective tool for identifying narcotic ordering patterns. Quantifying controlled substance prescribing helps physicians to recognize their common ordering practices and assess if changes need to be made. While states do monitor physician ordering of controlled substances, NAC members have found that reviewing these in-house reports directly with physicians has proven to be effective.

It's Not Just About the ED

Although EDs are on the front line of the opioid crisis, inpatient and surgical settings also require attention.

Patient Education

Katie Boston-Leary, RN, MBA, MHA, NEA-BC, CNO and senior VP of patient care services at Union Hospital of Cecil County, shared an anecdote about a patient who was placed on a pain pump after bowel surgery. When discharged home, the patient actually went through withdrawal but was unaware of the symptoms. This example points to a need for increased patient education in settings where controlled substances are used for pain management, to enable patients to identify and manage symptoms of withdrawal.

Use of Pain Management Order Sets

Several NAC member hospitals use pain management order sets that include multimodal treatments, and recommend narcotic dosages based on the patient's pain scale. Some order sets are built specifically for pain management, while others include pain medications and interventions as part of a broader order set. Embedding this information in the order set helps organizations to standardize ordering and ensure optimal dosing. The group also discussed the potential need for more specific pain management order sets — those for patients acclimated to pain medication, and those for patients who are "narcotic naive."

Managing PCAs

Clinical Informatics Coordinator Karen Parker, RN from Meadville Medical Center in Meadville, PA shared their policy to renew patient-controlled analgesia (PCA) pumps every 72 hours. Beth Israel Deaconess Hospital - Plymouth is attempting to decrease the use of PCA pumps by administering acetaminophen, for example, to help manage patient pain at the midpoint between narcotic doses. This method may control the pain so that the patient's next narcotic dose can be lower or not needed at all.

Embedding Pharmacogenomics into Clinical Decision Support for Personalized Medicine

Pharmacogenomics — the study of how genes affect an individual's response to medication — is revolutionizing how providers order pain medications for post-op surgical inpatients. Avera Institute for Human Genetics (AIHG), in collaboration with Avera McKennan Hospital & University Health Center, uses discrete genetics lab results to drive clinical decision support that guides clinicians to the most appropriate drug options for the patient. The provider is alerted at the point of ordering if he or she selects a pain medication that will not be effective based on the patient's DNA profile. Instead of taking a trial and error approach to pain management, the provider selects the most effective medication at the outset. The patient's pain relief is optimized, hastening recovery without the prolonged use of multiple narcotics.

Role of Patient Satisfaction Scores

As $1.5 billion in Medicare payments are allocated to hospitals based, in part, on patient satisfaction surveys, NAC members pointed out that tying these scores to reimbursement creates an incentive for providers to prescribe narcotics. Many patients have the unrealistic expectation that medications can completely alleviate their pain, resulting in poor patient satisfaction scores when this is not the case. NAC hospitals themselves experienced a corresponding drop in patient satisfaction scores as their providers cut back on narcotic prescriptions.

> *"In the past, a provider may have prescribed antibiotics to appease a sick patient, even though the provider was not necessarily convinced the patient had an infection. This has contributed to resistant strains. A similar dynamic is at work with the over-prescribing of narcotics, as physicians succumb to subtle — and not so subtle — pressure from their patients."*
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Opportunities Identified

Pain Assessments

NAC members discussed the importance of stronger, more individualized pain assessments that include questions about the patient's worst pain ever and how it was managed. By digging a little deeper, clinicians get a better sense of

the patient's tolerance for pain and effective measures he or she used in the past, as well as an opportunity to educate the patient on managing pain with non-narcotic analgesics.

Pain Management for Patients with a History of Substance Abuse

Several NAC members identified opportunities to advance pain management for recovering addicts admitted to the hospital for a serious illness, injury, or surgery. Improvements could include building specific order sets designed with an eye on dosing, tapering, and alternatives to narcotics. Clinicians can also work closely with patients to develop an appropriate pain management plan that minimizes the risk of relapse.

Problem List Underutilized

The Problem List can be underutilized as a tool to track substance abuse issues. There are instances where hospital-based physicians have expressed hesitation to add these types of problems to the patient's record since the information is included in the discharge packet that is reviewed with and given to the patient at discharge. This situation could trigger a difficult conversation at discharge if it has not been addressed by the physician during the patient's stay or visit to the ED.

Use of Case Managers

Union Hospital of Cecil County has deployed case managers into the ambulatory setting, i.e. hospital owned primary practices, to better coordinate care and resources to patients struggling with substance abuse. Union believes the case managers have made a difference by being available to address concerns and provide additional support and coverage.

Discharge Instructions

Patient discharge instructions are automatically generated, and contain canned responses such as "Take the prescribed medication to keep your pain level under control." NAC members suggested removing these canned responses so that physicians can educate patients more extensively on the prescribed narcotic and warn them about overusing the medication. When appropriate, physicians could advise patients that Tylenol® may be adequate to control their pain.

The NAC members also noted that discharge instructions create an opportunity to educate patients and their families on the signs and symptoms of withdrawal.

Scratching the Surface

NAC members covered a range of challenges that hospitals and healthcare providers face as they confront the opioid crisis. Although their discussion just scratched the surface in terms of the epidemic's scope, the NAC members in attendance valued the opportunity to share strategies and interventions that are proving to be successful.

Join the Conversation

What is your healthcare organization doing to manage the opioid epidemic? What strategies or initiatives have you successfully deployed? Please click here to share your experience with us.

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MEDITECH Case Study

Avera McKennan's Nurse Navigator Program Uses MEDITECH's EHR to Steer ED to $475,000 Annual Cost Savings

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