GLPP and MN Sustainability Webinar Series Opioid Stewardship

May 21, 2020

Agenda

- Minnesota Hospital Association
  -road maps, consortium, boot camps, ECHO and MNDOSA
- Illinois Health and Hospital Association
  -ALTO, ECHO, prescribing guidelines, COVID-19
- Wrap-up, Q & A

Minnesota Hospital Association

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Minnesota Opioid Initiatives

Opioid Prescribing Road Maps

85 hospitals

MAT Boot Camps

300 participants

MNDOSA Pilot

41 hospitals

North Star Opioid Consortium

MHA Opioid Work

- MN Opioid Prescribing Guidelines Road Maps
- Neonatal Abstinence Syndrome (NAS) Road Map
- Creating an Opioid Stewardship Road Map
- North Star Opioid Consortium
- Buprenorphine Boot Camps
- ECHO
- MNDOSA

Opioid Road Maps (RM)

- Neonatal Abstinence Syndrome (NAS)- 87 hospitals
- 3 Minnesota Opioid Prescribing Guidelines RM's- 85 hospitals

  Acute Pain Post-acute Pain Chronic Pain

- Opioid Stewardship DRAFT

Others

- Opioid ADE Prevention
- Controlled Substance Diversion Prevention

Minnesota Hospital Association

Opioid Adverse Drug Event (ADE) Prevention Road Map

MHA's road maps provide 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.

Each road map is tiered into fundamental and advanced strategies:

- **Fundamental strategies** should be prioritized for implementation, and generally have a strong evidence base in published literature in addition to being supported by multiple professional bodies and regulatory agencies.
- **Advanced strategies** should be considered in addition to fundamental strategies when there is evidence the fundamental strategies are being implemented and adhered to consistently and there is evidence that rates are not decreasing and/or the pathogenesis (morbidity/mortality among patients) has changed.

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

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

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
nd management	**FUNDAMENTAL** *(check each box if "yes")* ☐ The hospital has a leader or leadership team that is responsible for pain management, safe opioid prescribing, development and monitoring of performance improvement activities. ☐ Standardized pain assessments are used throughout the facility. - Facility has defined its pain assessment and nursing applies it consistently, e.g. pain scales or assessment of function.	• SHM RADEO Toolkit (Reducing Adverse Drug Events Related to Opioids Implementation Guide) • TJC R3 Report (Issue 11, Aug. 29, 2017) • TJC Hospitals are required to have defined criteria that they will use to screen, assess and reassess pain that are consistent with the patient's age, condition and ability to understand

Road map design

Fundamental or advanced strategies to help with prioritization

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
NAS treatment, continued	☐ The facility has developed and implemented a standardized NAS assessment and treatment protocol for infants with prenatal substance exposure (Hudak & Tan, 2012; Kocherlakota, 2014) - The process utilizes a formal assessment or scoring system, and staff are trained in correct use of the selected assessment/tool. Development of scoring guidelines may support improved inter-rater reliability. - The protocol addresses the care model for newborns who are identified as at-risk for NAS but do not score/assess at a level that necessitates treatment of NAS. - The protocol describes both non-pharmacologic and pharmacologic treatment approaches (e.g., through development of a treatment algorithm) and indicators for initiation, monitoring, and discontinuation of treatment. - The protocol includes a clear handoff procedure for neonates requiring transfer to another facility for pharmacologic treatment. Caregiver needs, such as transportation, are addressed in collaboration with care coordination/social work ☐ The facility has a process to engage caregivers (e.g., mothers, fathers, foster parents) in educational opportunities focused on newborn care and parenting strategies.	• Additional resources to support NAS treatment standardization: - MHA NAS Toolkit (includes a comparison of neonate assessment tools, treatment options, example algorithm, and sample policy) - Fairview Health Services NAS policy & algorithms for care of couplet with suspected or known risk factors for NAS - Specimen Collection: Meconium for Detection of Fetal Drug Exposure: Mayo Clinic – Rochester - Mayo Clinic – NAS Pharmacologic Management Algorithm & Maternal Breast Milk and Illicit or Illegal Drug Use Guideline - St. Cloud Hospital - NAS Policy - St. Cloud Hospital – NAS Treatment Algorithm - Ohio Perinatal Quality Collaborative Finnegan Neonatal Abstinence Scoring Tool and Inter-Rater Reliability Scoring Sheet - Northern New England Perinatal Quality Improvement Network Caring for Opioid-Exposed Newborns Using the Eating, Sleeping, Consoling (ESC) Care Tool

Organized by section to address specific aspects of care

Audit-style format for key elements

Operational definitions (what yes means)

Mapped resources with live links

Minnesota Hospital Association

Neonatal Abstinence Syndrome (NAS) road map

MHA's roadmaps provide 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.

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

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
& partnership	**FUNDAMENTAL** *(check each box if "yes")* ☐ The facility has convened an internal multidisciplinary workgroup to address maternal and neonatal concerns related to substance use disorder and prenatal substance exposure. - The multidisciplinary team meets at least quarterly. - Multidisciplinary team members may include but are not limited to: representatives from labor and delivery, postpartum, and	• A coordinated, multi-system approach and advanced planning for service implementation are critical to optimizing care of pregnant women with substance use disorders and their infants. The Substance Abuse and Mental Health Services Administration (SAMHSA)'s publication, A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating

NAS Sections

- Collaboration & partnership
- Antepartum care
- Intrapartum care
- Postpartum care
- Neonatal care & NAS treatment
- Discharge planning
- Performance Improvement Monitoring
- Education of the health care team

NAS Cont.

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)
Collaboration & partnership, continued	☐ The facility has a process in place for the transfer of a pregnant woman and/or newborn affected by substance use disorder or prenatal substance exposure in the event the case requires a higher level of care beyond what is available at the current location.
	ADVANCED *(check each box if "yes")* ☐ The facility proactively collaborates with local law enforcement, child welfare services, and social work regarding the child protective hold placement protocol.

MN Opioid Prescribing Guidelines

- Created by Minnesota Opioid Prescribing Work Group in response to a trend in opioid overdose deaths in MN.
- Based on these guidelines 3 road maps were created, one for each pain stage: acute, post-acute and chronic

MN Opioid Prescribing Guidelines

Guidelines based on stage of pain:

- Acute Pain (0 – 4 days following acute event)
- Post Acute-pain (5 – 45 days following acute event)
- Chronic pain

Five sections:

- Patient Safety
- Biopsychosocial and Risk Assessment
- Opioid Prescribing
- Women of Childbearing Age
- Non-opioid and Non-pharmacologic Pain Management

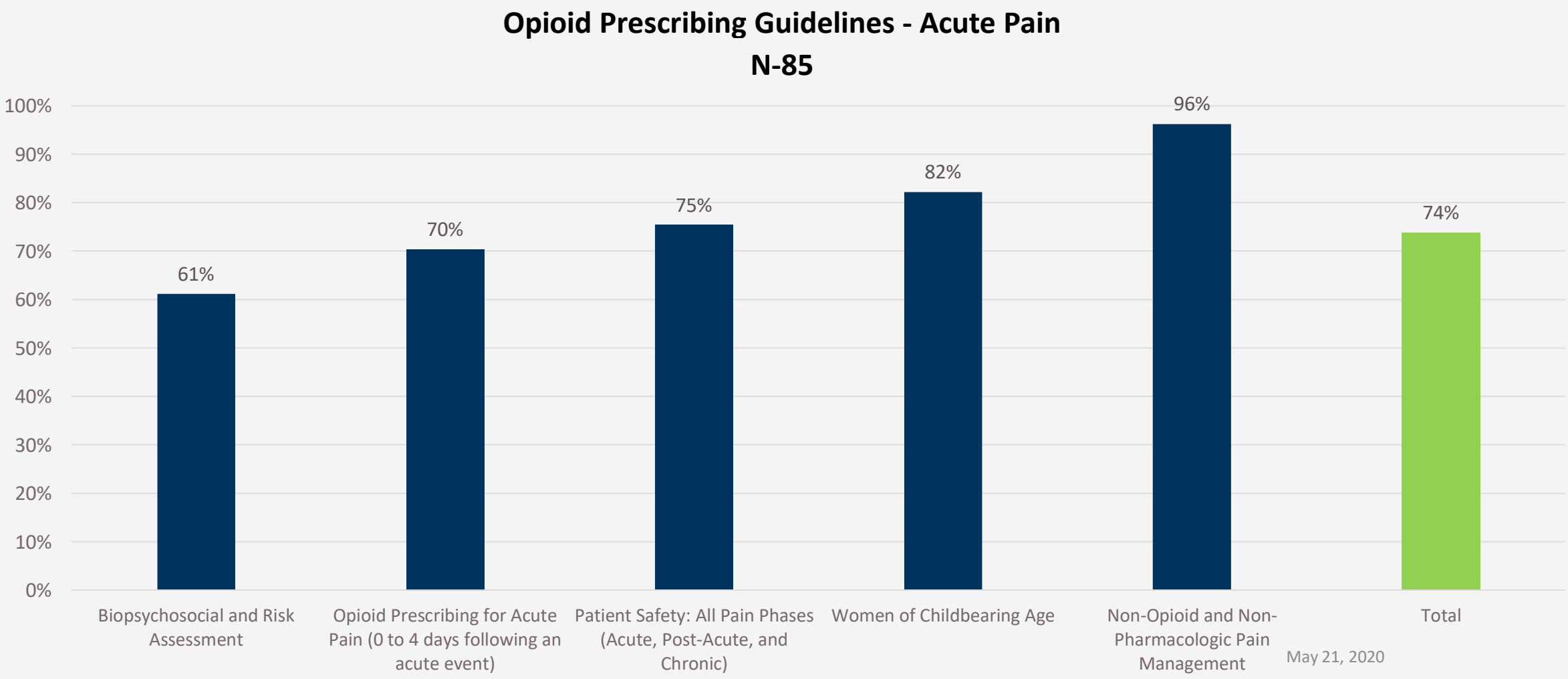
MN Opioid Prescribing Guidelines RM's

Road map sections	Road Map questions (if not present at your hospital or answering no, please see next column for suggested resources)
Patient Safety	**FUNDAMENTAL** (check each box if "yes") ☐ The Prescription Monitoring Program is checked whenever prescribing opioid therapy for pain. ☐ Prescribing opioid therapy and benzodiazepines or other sedative hypnotics concurrently is avoided whenever possible. o Patients are advised to stop use while taking opioids for acute pain. ☐ Avoid prescribing opioids for 1) Fibromyalgia, 2) headache, including migraine, 3) self-limited illness, e.g. sore throat, 4) uncomplicated, acute neck and back pain and 5) uncomplicated acute musculoskeletal pain. - Provide appropriate non-opioid alternative pain management for acute conditions not indicated for opioid analgesic therapy. ☐ Use extreme caution when prescribing opioids to patients with comorbid conditions that may increase the risk of adverse health outcomes. ☐ Provide patient education on an ongoing basis that addresses risks and benefits associated with opioid use, self-management of painful conditions, and safe use, safe storage and disposal. ☐ Considering co-prescribing naloxone to patients at elevated risk for overdose who receive opioids for pain management

Opioid Prescribing Guidelines- Acute Pain

Opioid Prescribing for Acute Pain (0 to 4 days following an acute event)	**FUNDAMENTAL** (check each box if "yes") ☐ Use multi-modal, non-opioid analgesia as the first line of drug therapy for acute pain management. e.g., NSAIDS and acetaminophen ☐ Avoid prescribing more than 100 MME of low-dose short acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (not 100 MME per day). ☐ Limit the initial prescription for acute pain following an extensive surgical procedure or major traumatic injury to no more than 200 MME, unless circumstances clearly warrant additional opioid therapy. ☐ Dental Pain a) Avoid prescribing more than the recommended dose following a dental procedure - 100 MME of low-dose, short acting opioids	Institute for Clinical Systems Improvement (ICSI). Pain Assessment, Non-Opioid Treatment Approaches and Opioid Management. Eighth Edition. August 2017 [7] Minnesota Dental Association. MDA Protocol for Assessment and Treatment of Oral/Facial Pain. 2015. [8] MOPG, Appendix C: Morphine Milligram Equivalence MOPG, Appendix B: Acute and Post-acute Pain Prescribing and Assessment Guide

Road Map Participation



Opioid Stewardship Road Map- DRAFT

Road map sections	Road Map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Opioid Stewardship Program (OSP)	**FUNDAMENTAL** ☐ 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). ☐ There are OSP champions within various operating divisions- ED, clinics, hospital ☐ The OSP is empowered by leadership support and stakeholder engagement, i.e.- Senior executive buy-in- CEO, CMO, CNO, Board level executive sponsor. ☐ The organization has policies and procedures on opioid prescribing, monitoring and tapering - strong policies and procedures that are well socialized and easy to access. **ADVANCED** (check each box if "yes") The opioid stewardship program provides pain management consultative services and works to identify patients at risk for adverse events as well as potentially risky opioid ordering practices	Sample opioid prescribing policy National Quality Partners Playbook: Opioid Stewardship The Time for Opioid Stewardship is Now (TJC) National Institute on Drug Abuse. *Benzodiazepines and Opioids*. March 2018. [1] Available at: https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

Buprenorphine Boot Camps

Partnered with two MN ECHO teams- to host two MAT boot camps with close to 300 participants.

- Session content met DATA 2000 waiver educational requirements.
- Presentation tracks by experts in their field

Partnering with MN DHS to host 3 more boot camps this year and 2021

North Star Opioid Consortium

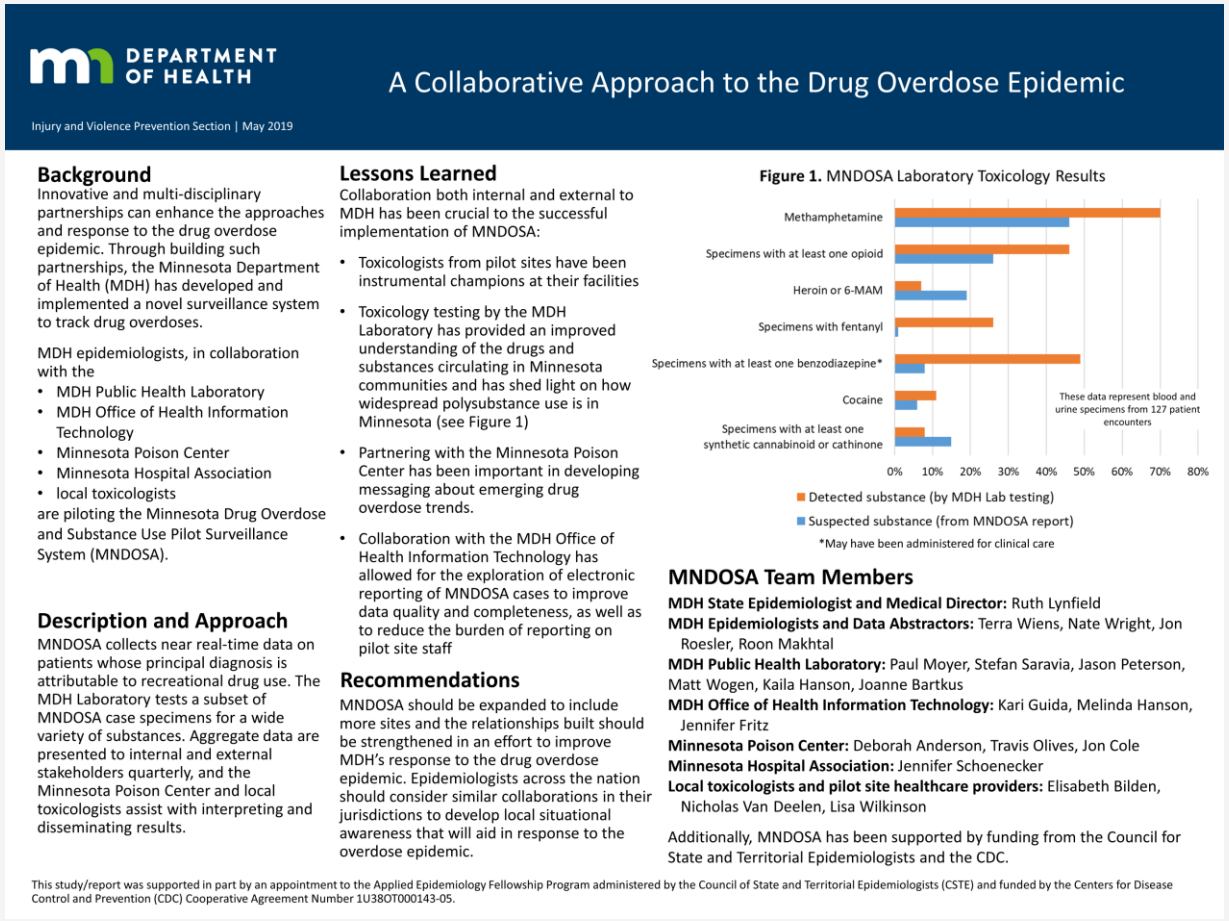
MHA partnering with Certified Community Behavioral Health Clinics (CCBHC's) to:

- Build opioid and addiction care pathways for clinics and hospital partners
- Increase peer recovery support programming by increasing access to training and certification of peer recovery staff
- Ensure patients' care transition from inpatient to community services with smooth, warm handoffs, reduce unnecessary inpatient admissions
- Engage community stakeholders in public education and awareness in rural MN communities

Minnesota Drug Overdose and Substance Use Pilot Surveillance Activity (MNDOSA)

41 hospitals participating

- Determine impact to hospitals
- Raise awareness of overdose clusters
- Identify new substances



DEPARTMENT OF HEALTH

Injury and Violence Prevention Section | May 2019

A Collaborative Approach to the Drug Overdose Epidemic

Background

Innovative and multi-disciplinary partnerships can enhance the approaches and response to the drug overdose epidemic. Through building such partnerships, the Minnesota Department of Health (MDH) has developed and implemented a novel surveillance system to track drug overdoses.

MDH epidemiologists, in collaboration with the

- MDH Public Health Laboratory
- MDH Office of Health Information Technology
- Minnesota Poison Center
- Minnesota Hospital Association
- local toxicologists

are piloting the Minnesota Drug Overdose and Substance Use Pilot Surveillance System (MNDOSA).

Description and Approach

MNDOSA collects near real-time data on patients whose principal diagnosis is attributable to recreational drug use. The MDH Laboratory tests a subset of MNDOSA case specimens for a wide variety of substances. Aggregate data are presented to internal and external stakeholders quarterly, and the Minnesota Poison Center and local toxicologists assist with interpreting and disseminating results.

Lessons Learned

Collaboration both internal and external to MDH has been crucial to the successful implementation of MNDOSA:

- Toxicologists from pilot sites have been instrumental champions at their facilities
- Toxicology testing by the MDH Laboratory has provided an improved understanding of the drugs and substances circulating in Minnesota communities and has shed light on how widespread polysubstance use is in Minnesota (see Figure 1)
- Partnering with the Minnesota Poison Center has been important in developing messaging about emerging drug overdose trends.
- Collaboration with the MDH Office of Health Information Technology has allowed for the exploration of electronic reporting of MNDOSA cases to improve data quality and completeness, as well as to reduce the burden of reporting on pilot site staff

Recommendations

MNDOSA should be expanded to include more sites and the relationships built should be strengthened in an effort to improve MDH's response to the drug overdose epidemic. Epidemiologists across the nation should consider similar collaborations in their jurisdictions to develop local situational awareness that will aid in response to the overdose epidemic.

Figure 1. MNDOSA Laboratory Toxicology Results

MNDOSA Team Members

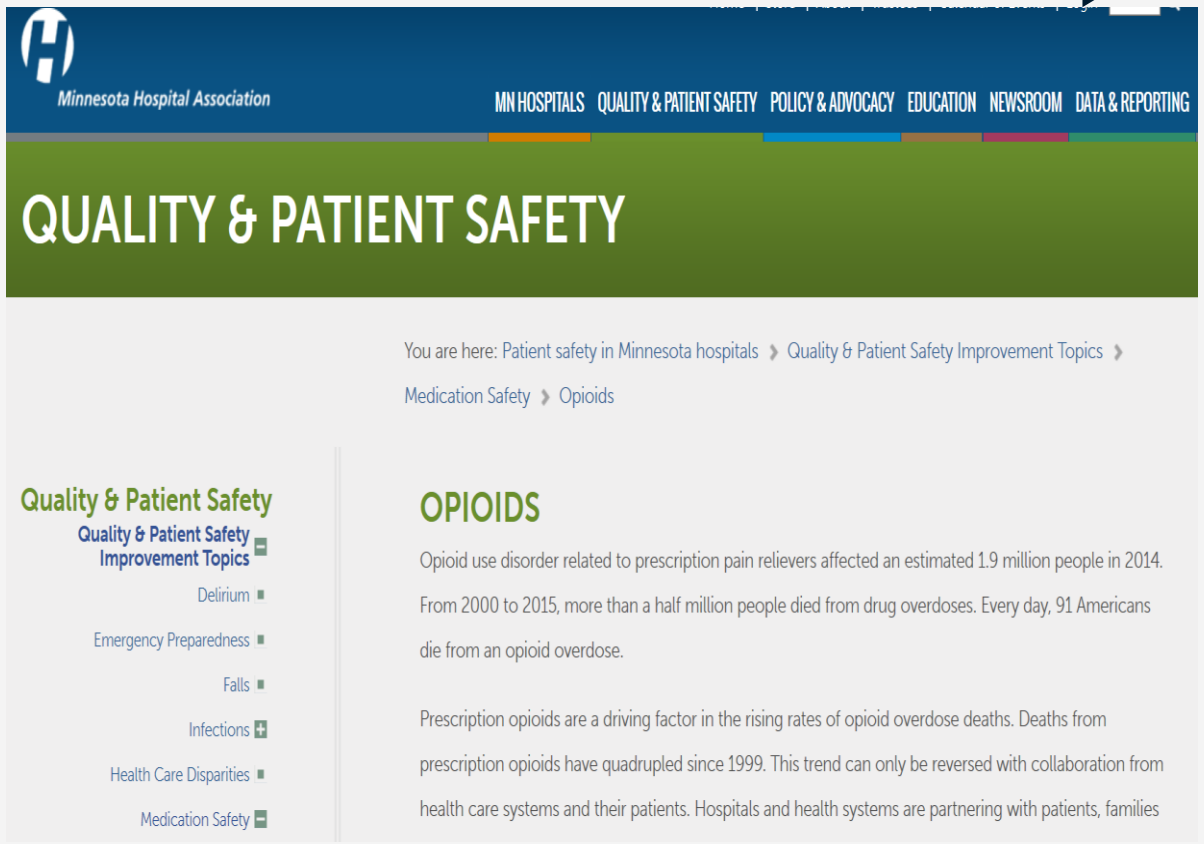
MDH State Epidemiologist and Medical Director: Ruth Lynfield
MDH Epidemiologists and Data Abstractors: Terra Wiens, Nate Wright, Jon Roesler, Roon Makhtal
MDH Public Health Laboratory: Paul Moyer, Stefan Saravia, Jason Peterson, Matt Wogen, Kaila Hanson, Joanne Bartkus
MDH Office of Health Information Technology: Kari Guida, Melinda Hanson, Jennifer Fritz
Minnesota Poison Center: Deborah Anderson, Travis Olives, Jon Cole
Minnesota Hospital Association: Jennifer Schoenecker
Local toxicologists and pilot site healthcare providers: Elisabeth Bilden, Nicholas Van Deelen, Lisa Wilkinson

Additionally, MNDOSA has been supported by funding from the Council for State and Territorial Epidemiologists and the CDC.

This study/report was supported in part by an appointment to the Applied Epidemiology Fellowship Program administered by the Council of State and Territorial Epidemiologists (CSTE) and funded by the Centers for Disease Control and Prevention (CDC) Cooperative Agreement Number 1U38OT000143-05.

Resource Links

- MHA road maps, toolkits and resources
- Minnesota Opioid Prescribing Guidelines
- Opioid Prescribing Road Maps



Questions?

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Illinois Health and Hospital Association

May 21, 2020

Illinois Opioid Resources

The Midwest ALTO Project

- 21.6% reduction in the amount of opioids prescribed
- 13.7% increase in ALTOs administered

Project ECHO Opioid Hub

- Medication Assisted Treatment: Trained 147 physicians from 28 organizations across IL

ED Prescribing Guidelines

- Provide safer, more effective care for patients with acute and chronic pain
- Help reduce opioid use disorder and overdose

Opioids in the times of COVID-19

- A look at OUD care
- A Look at Pain Management

The Midwest ALTO Project

Opioids are the last resort…

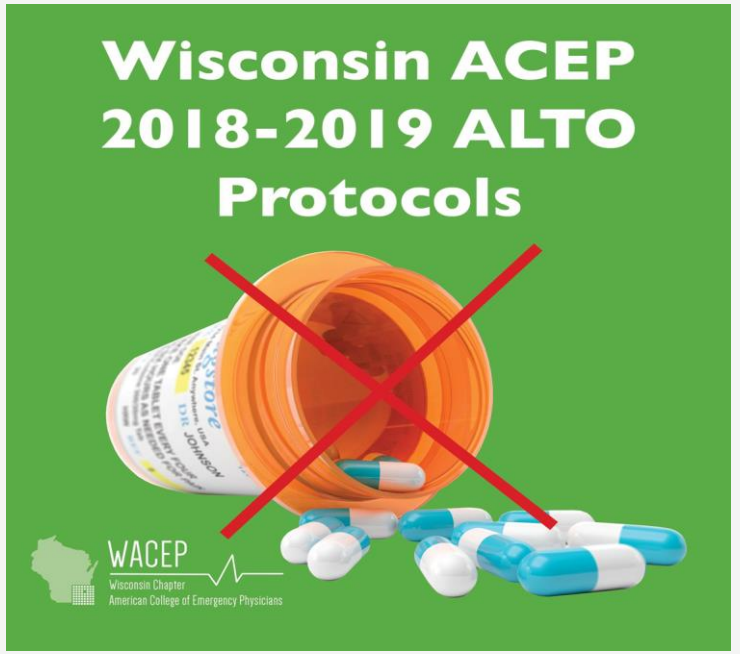
not the first option.

ALTO Approach

- Multi-modal non-opioid approach to analgesia for specific conditions
- **Goals:** To utilize non-opioid approaches as first-line therapy and educate our patients:
  - Opioids will be second-line treatment
  - Opioids can be given as rescue medication
  - Discuss realistic pain management goals
  - Discuss addiction potential and side effects of opioids

ALTO Principles

1. Non-opioid medications first
2. Opioids as rescue therapy and sparingly
3. Multimodal and holistic pain management
4. Specific pathways exist
   - Renal Colic
   - Opioid-naive musculoskeletal pain
   - Opioid tolerant low back pain
   - Fractures or joint dislocations
   - Headache/Migraine
   - Chronic abdominal pain or gastroparesis
5. Requires more patient engagement:
   - Discuss realistic pain management goals w/ patients
   - Discuss addiction potential and side effects of opioids



http://wisconsinacep.wildapricot.org

The Midwest ALTO Project

Objectives

The GLPP ALTO Project will expand on the success of the Colorado Hospital Association's Opioid Safety Pilot, which achieved a 36 percent average reduction in the administration of opioids in 10 hospital emergency departments by utilizing alternatives to opioids (ALTOs) when appropriate. Based off of outcomes from the Colorado ALTO Pilot, it is evident that changing pain management strategies results in the reduction of opioid use and an increase of ALTO use, without a reduction in patent satisfaction scores.

The GLPP ALTO Project established the following specific goal and aim:

Goal:

Reduce administration of opioid medications by ED clinicians through implementation of the ALTO approach.

Aim:

Reduce administration of opioids by 15 percent, measured in morphine equivalent units (MEUs) in 2019, as compared with the baseline period in 2018.

Project Design

- This project was run collaboratively between the Illinois, Michigan and Wisconsin Hospital Associations, collectively working as Great Lakes Partners for Patients (GLPP), representing a unique opportunity to impact ED prescribing across the region.

- Subject Matter Experts (SMEs) were hired which assisted the associations in facilitation of the project and that provided content expertise.

- GLPP provided a variety of training options, including in-person regional train-the-trainer sessions, webinars, podcasts and train-the trainer videos. Training was specifically designed for clinicians, nurses, pharmacists, quality improvement specialists, data specialists and communication and marketing champions.

- Weekly implementation calls were facilitated by the GLPP SMEs in order to assist participating EDs as they implemented the ALTO Project.

- Train-the-trainer toolkits were provided to hospitals. After the four months of training, EDs engaged in the project started prescribing more ALTOs and began reporting data so we can track outcomes of the project across the region.

GLPP ALTO Project – Phases and Timeline – Cohort 1

Step One: Pre-Launch Phase	Step Two: Training and Development Phase	Step Three: Project Launch Phase
July-September 2018	September-December 2018	January-February 2019
1.1 Executive Readiness Checklist and Commitment Form– Download here	2.1 Project Champions attend Train-the-Trainer Session – Registration coming soon, event will be held in each state September 11, 2018	3.1 ALTO Project launch in the ED – January 2019
	2.2 Train and prepare facility staff: Pre-Launch Champion Role Checklist	3.2 Submit data to IHA – February 2019-July 2019
	2.3 Develop data collection system	

Population of Interest and Timeframe

Population of Interest

- Emergency Department patients receiving an opioid or an ALTO administration
- Adults age 18 years old to 100 years old

Timeframe

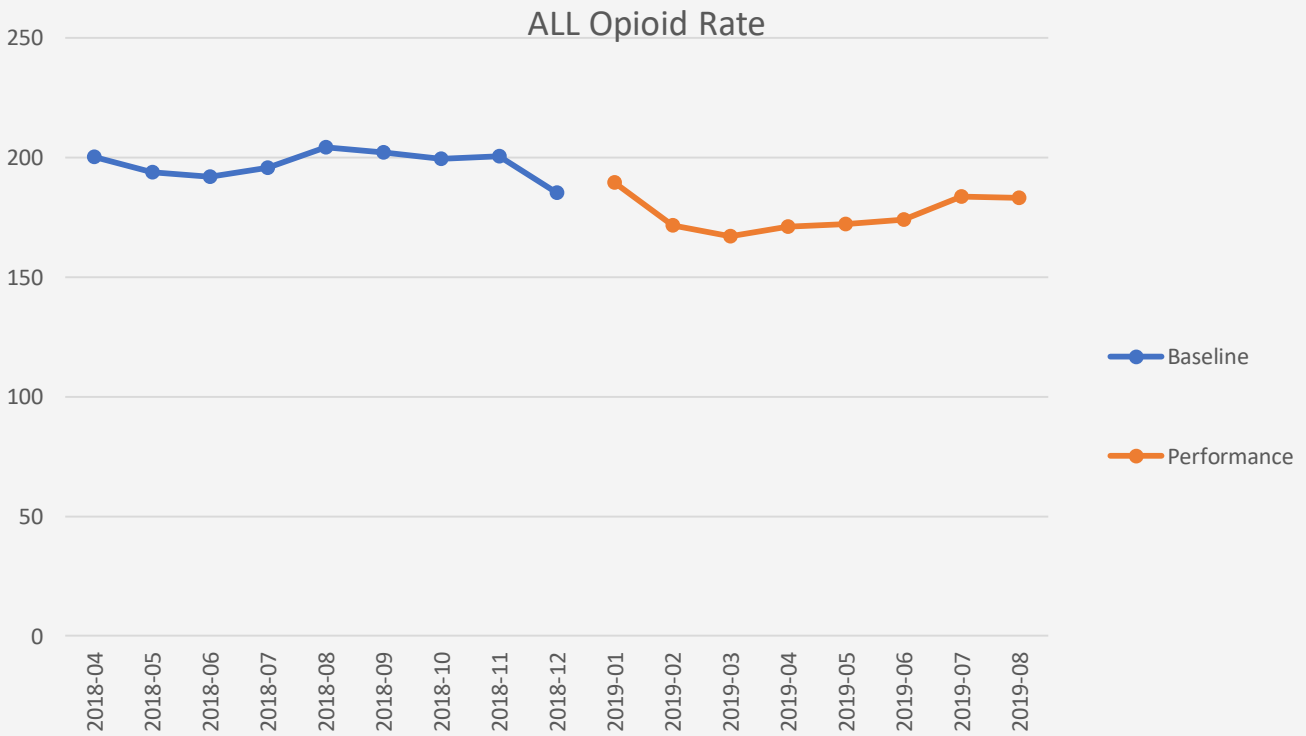
- Baseline data: three/six months of data collection prior to launch
  - Project launch: January 2019
  - Baseline: October 2018 – December 2018 (3) *OR* June 2018 – December 2018 (6)
- Project data: nine months of data collection
  - January 2019 – September 2019 (9)
  - Data submissions must start on the first of selected month
  - Must contain full month of data

Measures

- **Opioids Administered per 1,000 Emergency Department Visits**
  - Numerator: Opioids Administered for month
  - Denominator: # ED Visits for month
- **ALTOs Administered per 1,000 Emergency Department Visits**
  - Numerator: ALTOs Administered for month
  - Denominator: # ED Visits for month

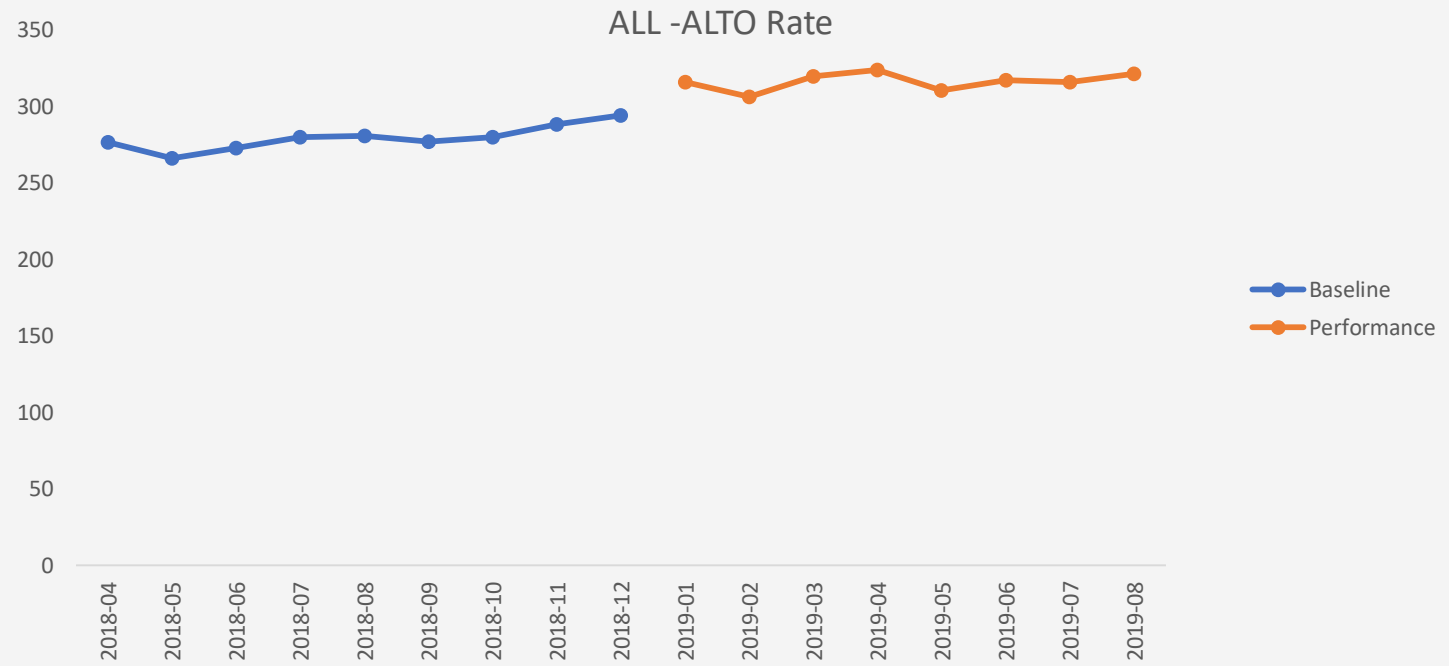
Outcomes-Opioid Rates

Row Labels	Opioids Administered	Emergency Department Visits	Opioid Rate	Improvement
Baseline	153,794	780778	196.98	
Performance	123,441	699412	176.49	
Grand Total	277,235	1,480,190	187.30	10.4%



Outcomes-ALTO Rates

GLPP HIIN ALTO Data Cohort 1				
Row Labels	Alternatives to Opioids Administered	Emergency Department Visits	ALTO Rate	Improvement
Baseline	218,182	780,778	279.44	
Performance	221,341	699,412	316.47	
Grand Total	439,523	1,480,190	296.94	13.2%



GLPP ALTO Resources

- Midwest ALTO Project Pre-launch Checklist
- Midwest ALTO Project Clinical Pathways
- Midwest ALTO Project Action-Planning Document
- Communications Toolkit

Midwest ALTO Project Pre-launch Checklist

GREAT LAKES PARTNERS FOR PATIENTS

The Midwest ALTO Project

Midwest ALTO Project Champion

Role:
Sets the direction for implementation of the Midwest ALTO Project by effectively developing an Opioid Safety Team, establishing goals, timelines, project tracking, an implementation schedule, a communication plan, performance improvement plan and an effective use of resources. Responsible for translating the Executive Team's opioid safety goals and expectations into an action plan.

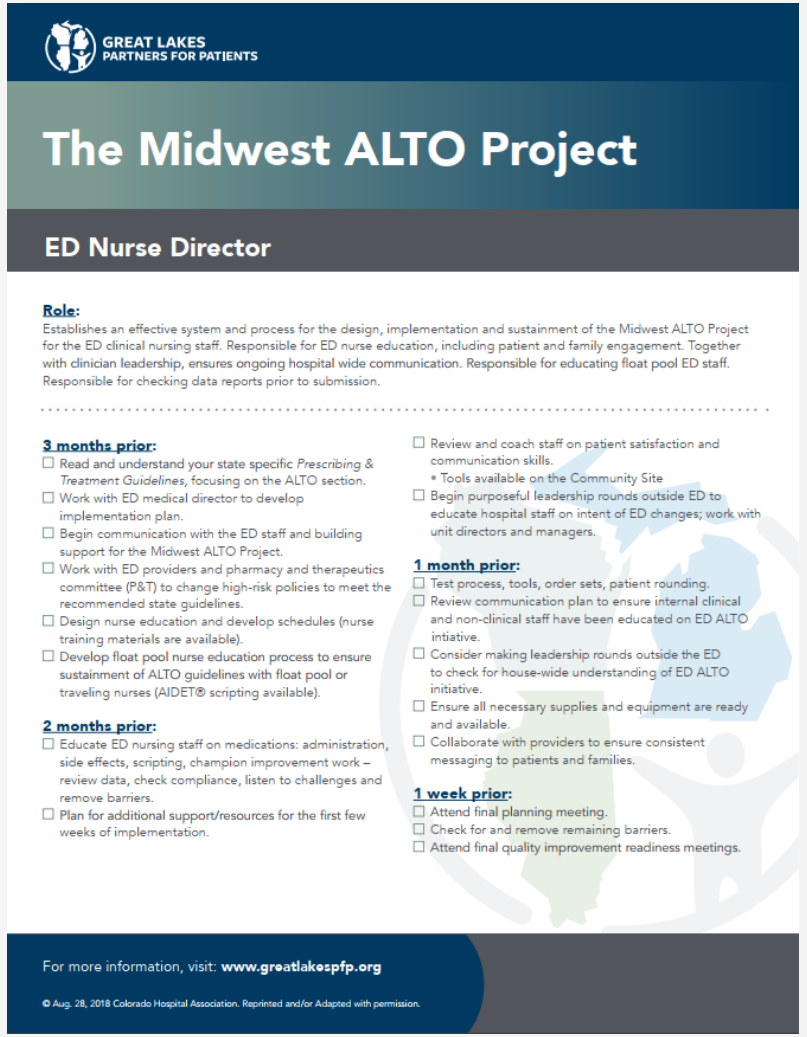
3 months prior:
- ☐ Read and understand your state specific *Prescribing & Treatment Guidelines*, focusing on the ALTO section.
- ☐ Work with executive team to clearly identify goals and expectations.
- ☐ Present to hospital Board of Directors as requested.
- ☐ Identify champions. Recommended team members include:
  - ED medical director
  - ED nurse director
  - Pharmacy director
  - Quality champion
  - Communications and marketing champion
  - IT champion
  - Data support
- ☐ Review electronic medical records for data pulling capabilities.
- ☐ Work with communications and marketing to develop internal and external communication plan.
- ☐ Follow up with team action items as outlined below:
  - Ensure internal communication plan is launched.
  - Progress toward goal report to executive team.

2 months prior:
- ☐ Ongoing performance improvement readiness.
- ☐ Ensure all team members are trained, ready for launch and there have been no key turnover issues for the team.

1 month prior:
- ☐ Ensure all necessary supplies and equipment are ready and available.
- ☐ Work with organization and/or system IT champion and data champion to beta test reports.
- ☐ Ensure all training is complete.
- ☐ Beta test launch including all reports.

1 week prior:
- ☐ Hold final planning meeting.
- ☐ Check for and remove remaining barriers.
- ☐ Attend final quality improvement readiness meetings.

For more information, visit: **www.greatlakespfp.org**



GREAT LAKES PARTNERS FOR PATIENTS

The Midwest ALTO Project

ED Nurse Director

Role:
Establishes an effective system and process for the design, implementation and sustainment of the Midwest ALTO Project for the ED clinical nursing staff. Responsible for ED nurse education, including patient and family engagement. Together with clinician leadership, ensures ongoing hospital wide communication. Responsible for educating float pool ED staff. Responsible for checking data reports prior to submission.

3 months prior:
- ☐ Read and understand your state specific *Prescribing & Treatment Guidelines*, focusing on the ALTO section.
- ☐ Work with ED medical director to develop implementation plan.
- ☐ Begin communication with the ED staff and building support for the Midwest ALTO Project.
- ☐ Work with ED providers and pharmacy and therapeutics committee (P&T) to change high-risk policies to meet the recommended state guidelines.
- ☐ Design nurse education and develop schedules (nurse training materials are available).
- ☐ Develop float pool nurse education process to ensure sustainment of ALTO guidelines with float pool or traveling nurses (AIDET® scripting available).

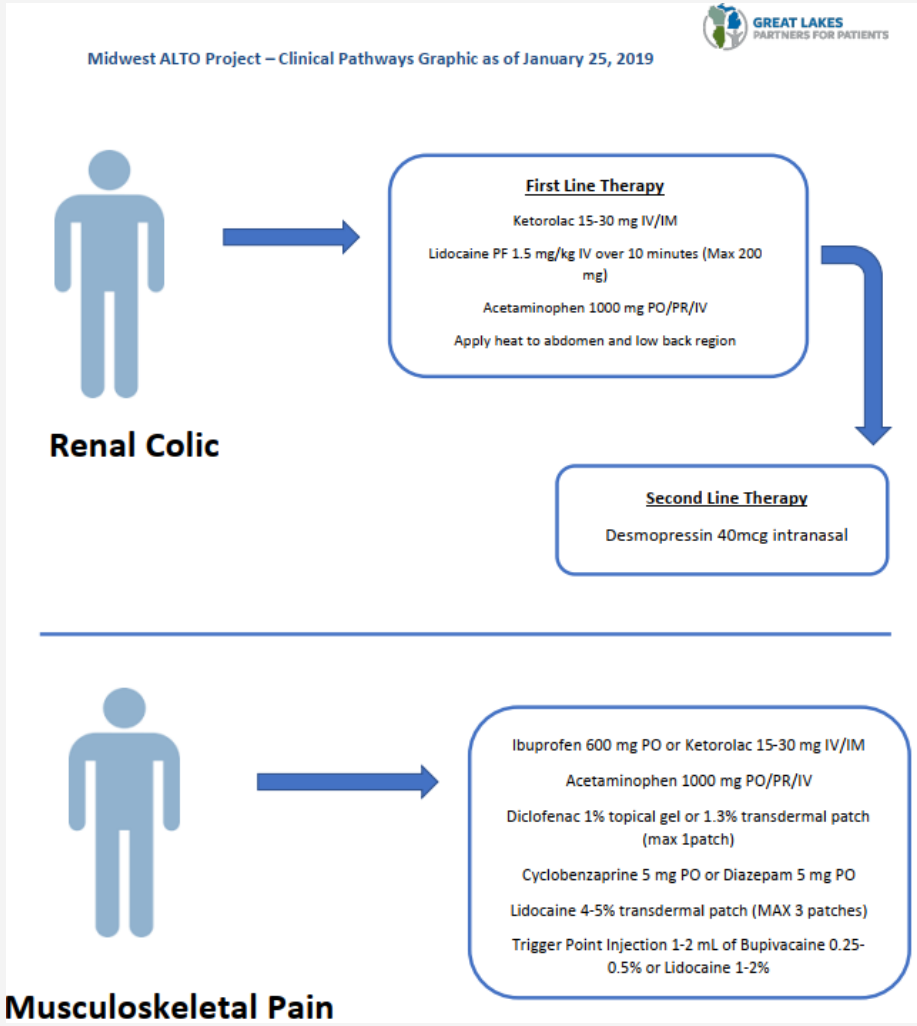
2 months prior:
- ☐ Educate ED nursing staff on medications: administration, side effects, scripting, champion improvement work – review data, check compliance, listen to challenges and remove barriers.
- ☐ Plan for additional support/resources for the first few weeks of implementation.
- ☐ Review and coach staff on patient satisfaction and communication skills.
  - Tools available on the Community Site
- ☐ Begin purposeful leadership rounds outside ED to educate hospital staff on intent of ED changes; work with unit directors and managers.

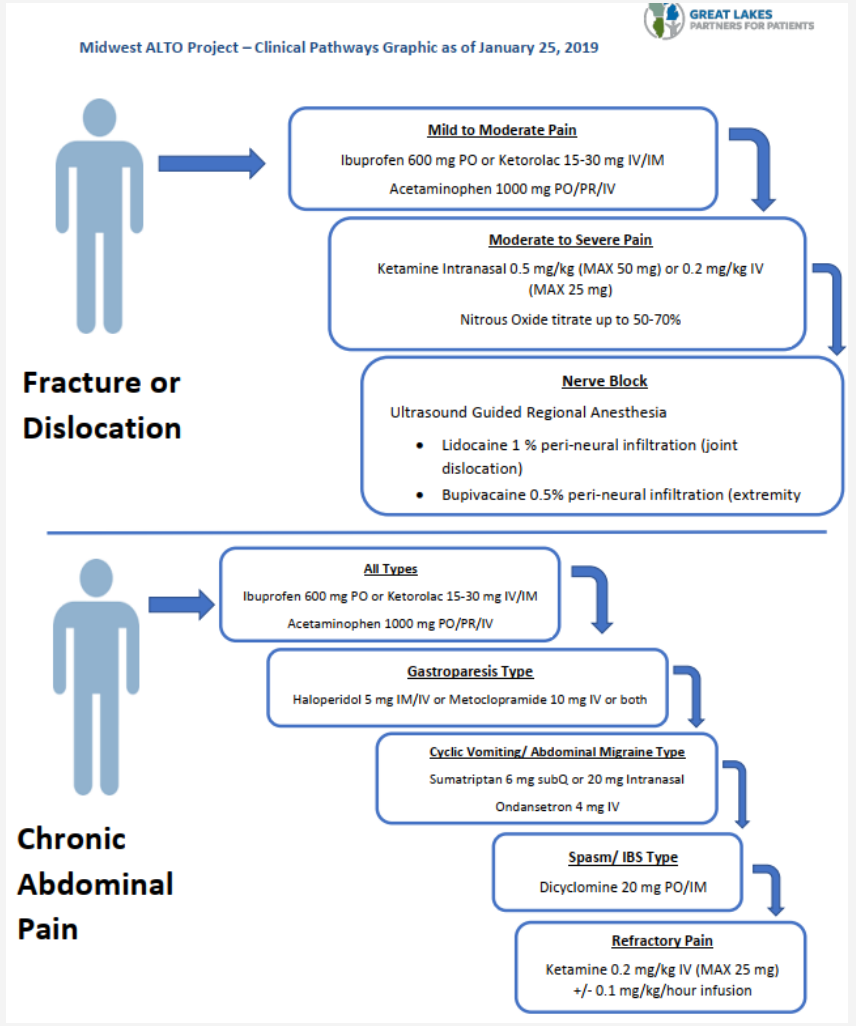
1 month prior:
- ☐ Test process, tools, order sets, patient rounding.
- ☐ Review communication plan to ensure internal clinical and non-clinical staff have been educated on ED ALTO intiative.
- ☐ Consider making leadership rounds outside the ED to check for house-wide understanding of ED ALTO initiative.
- ☐ Ensure all necessary supplies and equipment are ready and available.
- ☐ Collaborate with providers to ensure consistent messaging to patients and families.

1 week prior:
- ☐ Attend final planning meeting.
- ☐ Check for and remove remaining barriers.
- ☐ Attend final quality improvement readiness meetings.

For more information, visit: **www.greatlakespfp.org**

Midwest ALTO Project Clinical Pathways





Midwest ALTO Project Action-Planning Document

GREAT LAKES PARTNERS FOR PATIENTS

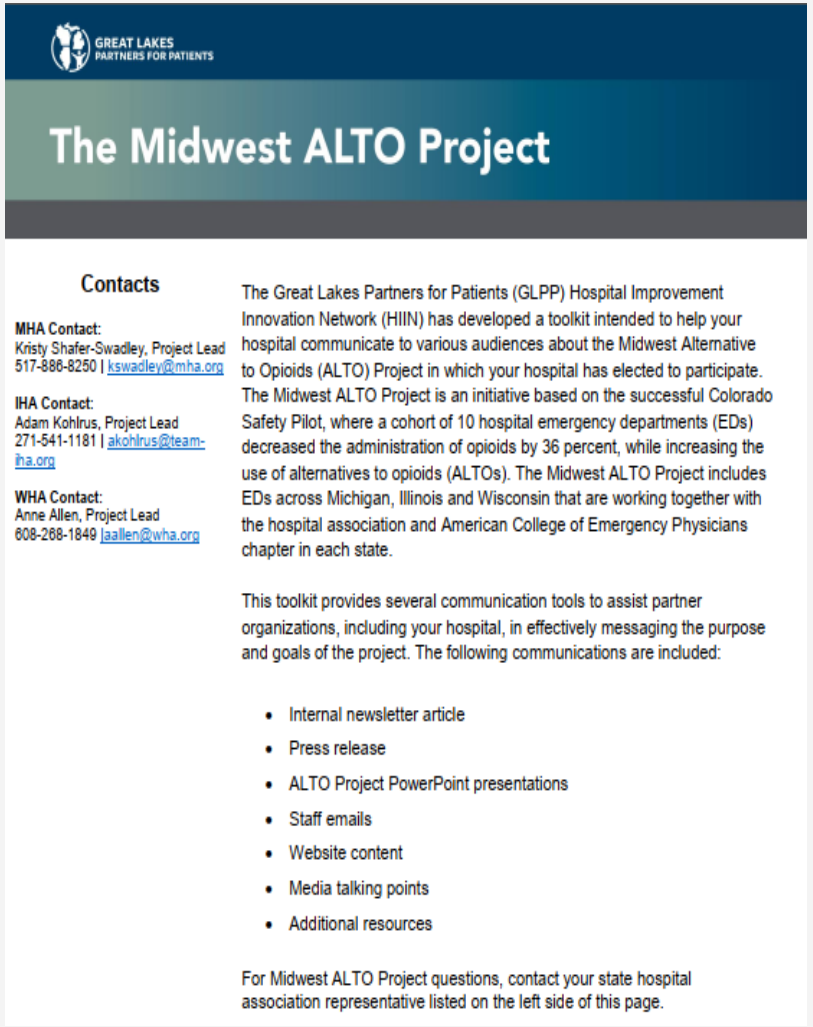
Illinois | Michigan | Wisconsin
Powered by the MHA Keystone Center

Great Lakes Partners for Patients HIIN
30-60-90 Day Action Plan
Midwest ALTO Project

Please complete the worksheet below, identifying action items for the Midwest ALTO Project Champions:

Task Description – ED Medical Director and ED Provider	Who?	By When?	Done
3 Months Prior			
Develop ED Clinician implementation plan.			☐
Present Midwest ALTO Project to Medical Executive Committee and build support for the Project with ED Clinicians.			☐
Review high-risk policies to ensure medications such as Ketamine and IV drip lidocaine can be given for pain in the ED; have policies approved one month prior to launch. Assist in developing communication plan.			☐
Cover specific education on trigger point injections/IV nerve blocks.			☐
Work with the medical staff office to develop a strategy for house-wide and clinic provider education.			☐
2 Months Prior			
Continue ALTO education, communication and support.			☐
Review baseline data.			☐

Communications Toolkit



GREAT LAKES PARTNERS FOR PATIENTS

The Midwest ALTO Project

Contacts

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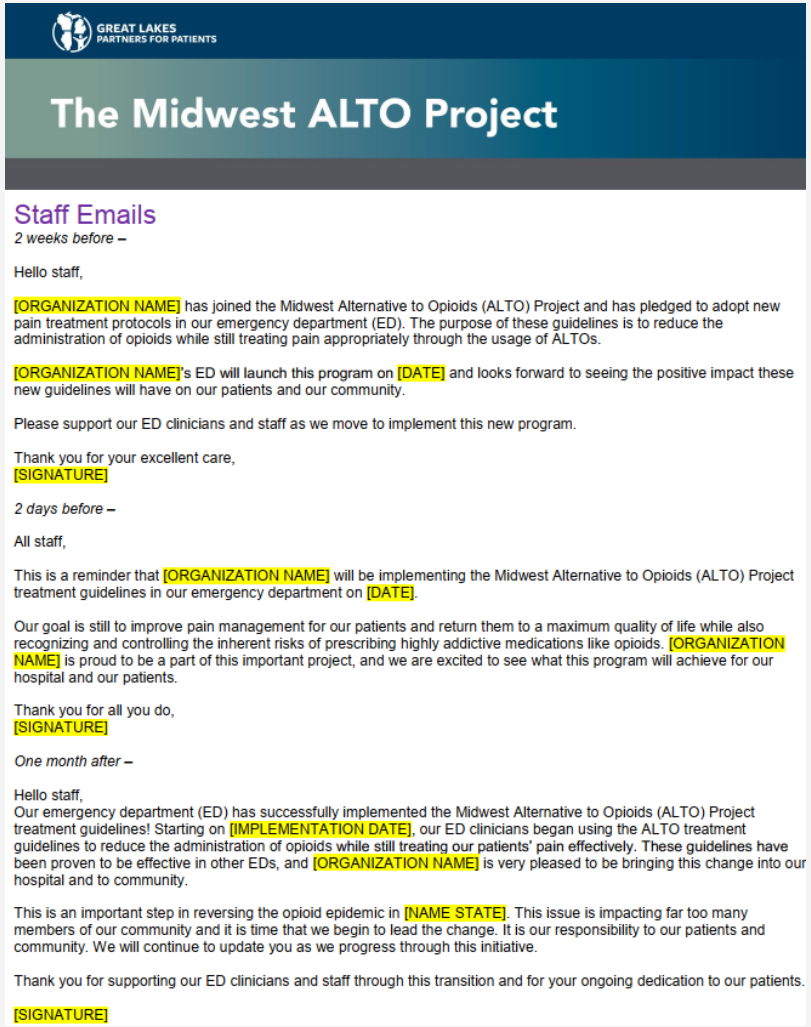
The Great Lakes Partners for Patients (GLPP) Hospital Improvement Innovation Network (HIIN) has developed a toolkit intended to help your hospital communicate to various audiences about the Midwest Alternative to Opioids (ALTO) Project in which your hospital has elected to participate. The Midwest ALTO Project is an initiative based on the successful Colorado Safety Pilot, where a cohort of 10 hospital emergency departments (EDs) decreased the administration of opioids by 36 percent, while increasing the use of alternatives to opioids (ALTOs). The Midwest ALTO Project includes EDs across Michigan, Illinois and Wisconsin that are working together with the hospital association and American College of Emergency Physicians chapter in each state.

This toolkit provides several communication tools to assist partner organizations, including your hospital, in effectively messaging the purpose and goals of the project. The following communications are included:

- Internal newsletter article
- Press release
- ALTO Project PowerPoint presentations
- Staff emails
- Website content
- Media talking points
- Additional resources

For Midwest ALTO Project questions, contact your state hospital association representative listed on the left side of this page.



GREAT LAKES PARTNERS FOR PATIENTS

The Midwest ALTO Project

Staff Emails

2 weeks before –

Hello staff,

[ORGANIZATION NAME] has joined the Midwest Alternative to Opioids (ALTO) Project and has pledged to adopt new pain treatment protocols in our emergency department (ED). The purpose of these guidelines is to reduce the administration of opioids while still treating pain appropriately through the usage of ALTOs.

[ORGANIZATION NAME]'s ED will launch this program on [DATE] and looks forward to seeing the positive impact these new guidelines will have on our patients and our community.

Please support our ED clinicians and staff as we move to implement this new program.

Thank you for your excellent care,
[SIGNATURE]

2 days before –

All staff,

This is a reminder that [ORGANIZATION NAME] will be implementing the Midwest Alternative to Opioids (ALTO) Project treatment guidelines in our emergency department on [DATE].

Our goal is still to improve pain management for our patients and return them to a maximum quality of life while also recognizing and controlling the inherent risks of prescribing highly addictive medications like opioids. [ORGANIZATION NAME] is proud to be a part of this important project, and we are excited to see what this program will achieve for our hospital and our patients.

Thank you for all you do,
[SIGNATURE]

One month after –

Hello staff,
Our emergency department (ED) has successfully implemented the Midwest Alternative to Opioids (ALTO) Project treatment guidelines! Starting on [IMPLEMENTATION DATE], our ED clinicians began using the ALTO treatment guidelines to reduce the administration of opioids while still treating our patients' pain effectively. These guidelines have been proven to be effective in other EDs, and [ORGANIZATION NAME] is very pleased to be bringing this change into our hospital and to community.

This is an important step in reversing the opioid epidemic in [NAME STATE]. This issue is impacting far too many members of our community and it is time that we begin to lead the change. It is our responsibility to our patients and community. We will continue to update you as we progress through this initiative.

Thank you for supporting our ED clinicians and staff through this transition and for your ongoing dedication to our patients.

[SIGNATURE]

Project ECHO Opioid Hub

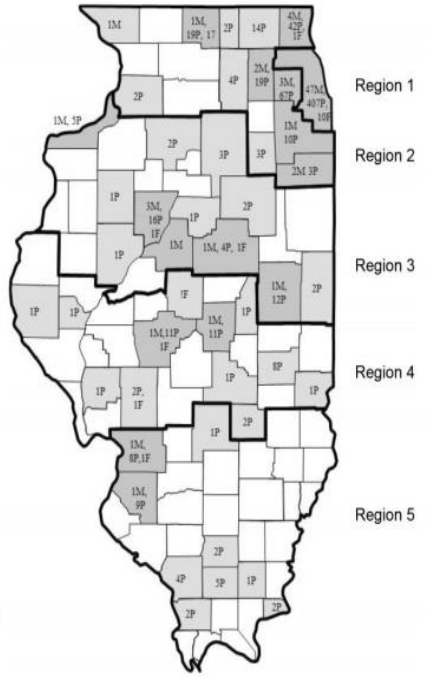
Project ECHO Opioid Hub

- Medication Assisted Treatment: Trained 147 physicians from 28 organizations across IL

SIU-IHA Opioid ECHO

Increasing access to MAT, behavioral therapy, and recovery services across the state will reduce opioid misuse, overdoses, and deaths, as well as give people with OUD the evidence-based treatment they need to regain their quality of life.

Current MAT Availability in Illinois



Service Availability

- No MAT
- Physician or FQHC MAT
- Methadone/Buprenorphine Program and Physician and/or FQHC MAT

- The map above shows the availability of MAT services in Illinois. The text in counties shows the number OMT programs (M), physician prescribers of buprenorphine (P), and federally qualified health centers (FQHCs) (F) that provide MAT. Areas in white are counties that have no MAT. As the map illustrates, there are large areas of Illinois where residents have little or no access to MAT.
  - The majority of OMT sites are in Cook County. There are only three OMT sites in IDHS Region 3 and only two in each of Regions 4 and 5.

Data-2000 Waiver Training

Objective 1: Increasing MAT Access in Illinois

- Increase the number of providers with a Data-2000 waiver in Illinois counties which have little or no medication-assisted treatment (MAT) services by providing training. **IHA hosts 8 hours of training** which allows any MD, DO, NP, or PA to obtain their DATA-2000 waiver.

- Upon completion of the IHA in-person training, physicians can apply for the DATA-2000 waiver to prescribe buprenorphine (NPs and PAs will have to complete the remaining 16 hours of required training, which is also online and free for NPs and PAs).

- These providers will then be invited to engage in the SIU-IHA Project ECHO Opioid Hub. We believe it is critical to have a multidisciplinary team approach in combating the Opioid epidemic. We are encouraging participants to **add a behavioral health partner to their ECHO Hub teams**.

Project ECHO Opioid Hub

Objective 2: Activating providers to administer MAT

- Include clinicians who meet Objective 1 and activate clinicians who have received their Data-2000 waiver but are not utilizing it to treat patients by mitigating perceived barriers through the SIU-IHA ECHO Opioid Hub.

- Teams are encouraged to identify local behavioral health (BH) partner(s) to participate in the SIU-IHA ECHO Opioid Hub. Consultation from SIU-ECHO team available to identify prospective BH partners.

SIU-IHA Project ECHO Opioid Curriculum

The Opioid SIU-IHA ECHO Hub covers 12 didactic topic areas:

- Anxiety Disorders and Role in Substance Abuse
- Addressing Trauma/PTSD in Patients with Substance Abuse
- The Role of Substance Abuse in Psychosis
- Bipolar Disorder-Accurate Diagnosis and Evidence Based Treatments
- Managing Depression in People with Substance Abuse
- Managing Personality Disorders
- Opioid Treatment Medication Essentials – describe opioid disease etiology and psychopharmacology issues related to buprenorphine/subozone, vivatrol, methadone and other medication interactions/implications

SIU-IHA Project ECHO Opioid Curriculum

- Continuum of Care Needed to Effectively Treat Opioid Users- review co-morbid social, psychological and behavioral conditions often correlated with Opioid addiction/use. Identify psychosocial and behavioral resources needed to provide effective MAT services and options available to provide in the primary care practice and/or partner with local behavioral health professionals; define range of services needed to effectively run a MAT service and options for partnering or accessing different services

- Psychosocial and Behavioral Considerations Relevant to Opioid Addiction and Treatment- Describe components of psychosocial care that must accompany MAT; review evidence-based practices related to effective, comprehensive MAT 2-Data-2000 Activation Training

- Complications of Opioid Medications – hypokalemia and hypomagnesemia, lethargy/fatigue upon initiation/intensification of drug therapy, rising creatinine (acute kidney injury), calcium-antagonist lower extremity edema, angioedema/cough with ACE inhibitors

- Management Strategies for the Relapsing or Aggressive Patient – establishing treatment contracts, reviewing de-escalation techniques, developing protocols to removing agitated patient from waiting/exam room, establishing safety protocols.

- Setting Up and Sustaining a PCP based MAT Service – present the business model and programmatic components required to meet patient needs while maintaining PCP clinic flow and operational sustainability.

SIU-IHA Project ECHO Expectations

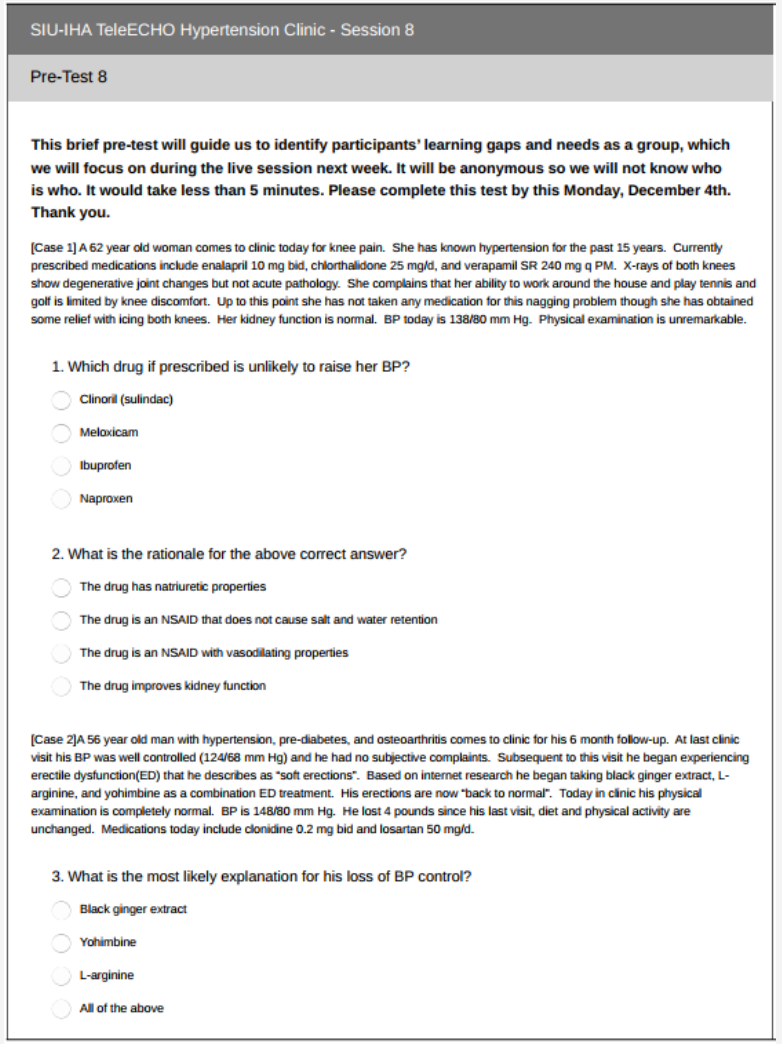
- Pre-Test and Post-Tests
- Submission of 2 Case Presentation Forms over the course of the cohort
- All-Teach, All-Learn

Pre-Tests and Post-Tests

- Before each Project ECHO session your team will be sent a pre-test pertaining to the content which will be covered in the upcoming ECHO session

- After each Project ECHO session your team will then be sent a post-test which will help us evaluate the effectiveness in enhancing competencies through our Project ECHO sessions

- The pre/post tests are short in nature (7-10 questions) and should only take your team members a minute or two to complete



SIU-IHA TeleECHO Hypertension Clinic - Session 8

Pre-Test 8

This brief pre-test will guide us to identify participants' learning gaps and needs as a group, which we will focus on during the live session next week. It will be anonymous so we will not know who is who. It would take less than 5 minutes. Please complete this test by this Monday, December 4th. Thank you.

[Case 1] A 62 year old woman comes to clinic today for knee pain. She has known hypertension for the past 15 years. Currently prescribed medications include enalapril 10 mg bid, chlorthalidone 25 mg/d, and verapamil SR 240 mg q PM. X-rays of both knees show degenerative joint changes but not acute pathology. She complains that her ability to work around the house and play tennis and golf is limited by knee discomfort. Up to this point she has not taken any medication for this nagging problem though she has obtained some relief with icing both knees. Her kidney function is normal. BP today is 138/80 mm Hg. Physical examination is unremarkable.

1. Which drug if prescribed is unlikely to raise her BP?

- Clinoril (sulindac)
- Meloxicam
- Ibuprofen
- Naproxen

2. What is the rationale for the above correct answer?

- The drug has natriuretic properties
- The drug is an NSAID that does not cause salt and water retention
- The drug is an NSAID with vasodilating properties
- The drug improves kidney function

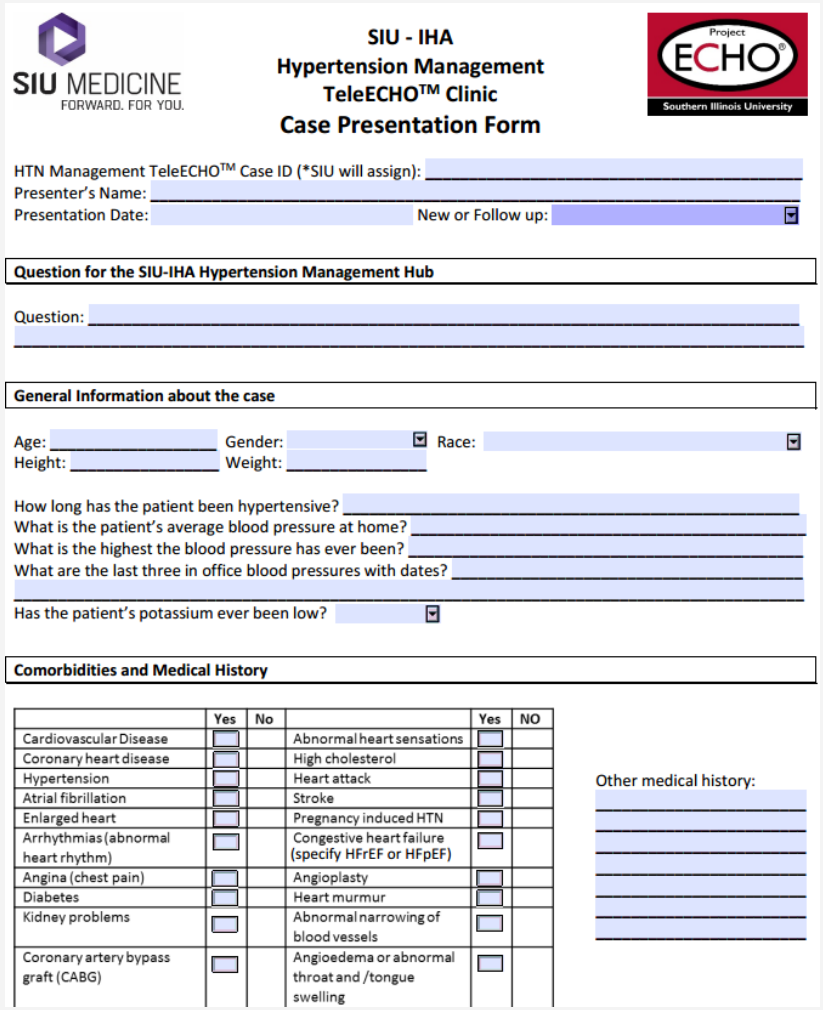
[Case 2]A 56 year old man with hypertension, pre-diabetes, and osteoarthritis comes to clinic for his 6 month follow-up. At last clinic visit his BP was well controlled (124/68 mm Hg) and he had no subjective complaints. Subsequent to this visit he began experiencing erectile dysfunction(ED) that he describes as "soft erections". Based on internet research he began taking black ginger extract, L-arginine, and yohimbine as a combination ED treatment. His erections are now "back to normal". Today in clinic his physical examination is completely normal. BP is 148/80 mm Hg. He lost 4 pounds since his last visit, diet and physical activity are unchanged. Medications today include clonidine 0.2 mg bid and losartan 50 mg/d.

3. What is the most likely explanation for his loss of BP control?

- Black ginger extract
- Yohimbine
- L-arginine
- All of the above

Case Presentation Forms

- Submission of 2 Case Presentation Forms over the course of the cohort
- These forms capture the pertinent information we need to know about the patient you would like to case manage in the ECHO hub
- Your 2 Case Presentation Forms may be of the same patient or two different patients



SIU MEDICINE
FORWARD. FOR YOU.

SIU - IHA
Hypertension Management
TeleECHO™ Clinic
Case Presentation Form

Project ECHO
Southern Illinois University

HTN Management TeleECHO™ Case ID (*SIU will assign): _____
Presenter's Name: _____
Presentation Date: _____ New or Follow up: _____

Question for the SIU-IHA Hypertension Management Hub

Question: _____

General Information about the case

Age: _____ Gender: _____ Race: _____
Height: _____ Weight: _____

How long has the patient been hypertensive? _____
What is the patient's average blood pressure at home? _____
What is the highest the blood pressure has ever been? _____
What are the last three in office blood pressures with dates? _____
Has the patient's potassium ever been low? _____

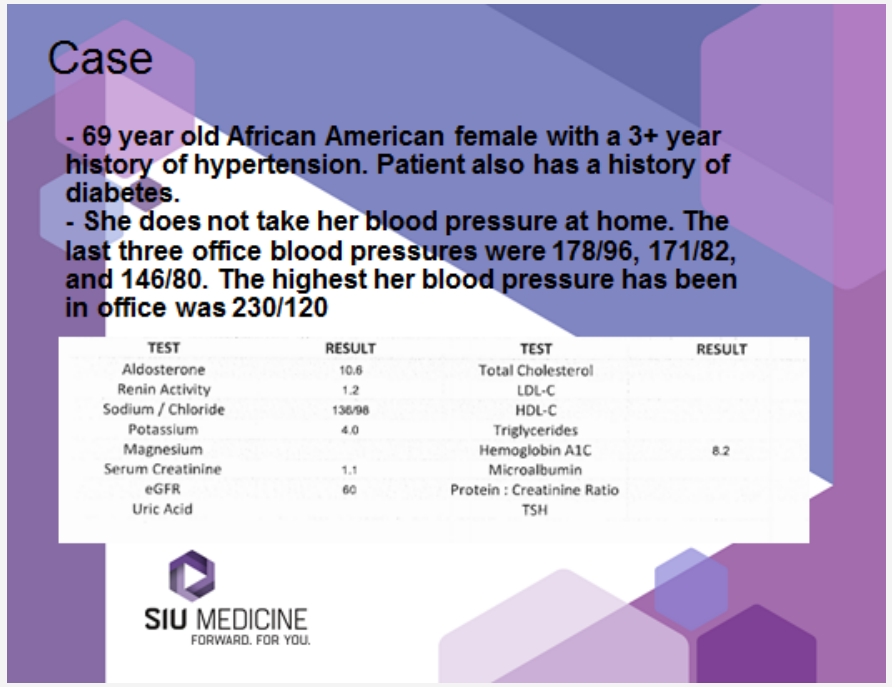
Comorbidities and Medical History

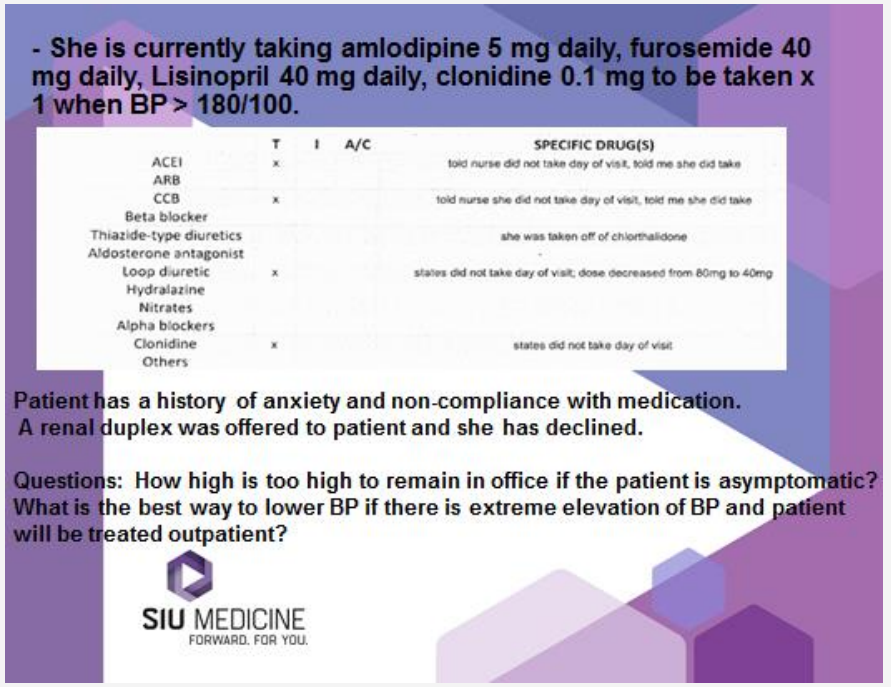
	Yes	No		Yes	NO
Cardiovascular Disease	☐		Abnormal heart sensations	☐	
Coronary heart disease	☐		High cholesterol	☐	
Hypertension	☐		Heart attack	☐	
Atrial fibrillation	☐		Stroke	☐	
Enlarged heart	☐		Pregnancy induced HTN	☐	
Arrhythmias (abnormal heart rhythm)	☐		Congestive heart failure (specify HFrEF or HFpEF)	☐	
Angina (chest pain)	☐		Angioplasty	☐	
Diabetes	☐		Heart murmur	☐	
Kidney problems	☐		Abnormal narrowing of blood vessels	☐	
Coronary artery bypass graft (CABG)	☐		Angioedema or abnormal throat and /tongue swelling	☐	

Other medical history:
_____
_____
_____
_____
_____
_____

Case Presentation Forms

Once submitted, The SIU Team will take your Case Presentation Form and translate it into a couple of PP slides which you will present to the cohort- then the case management of that patient begins!





All Teach, All Learn

- What makes Project ECHO unique, and what sets it apart from grand rounds type forums, is the engagement between all participants throughout the session

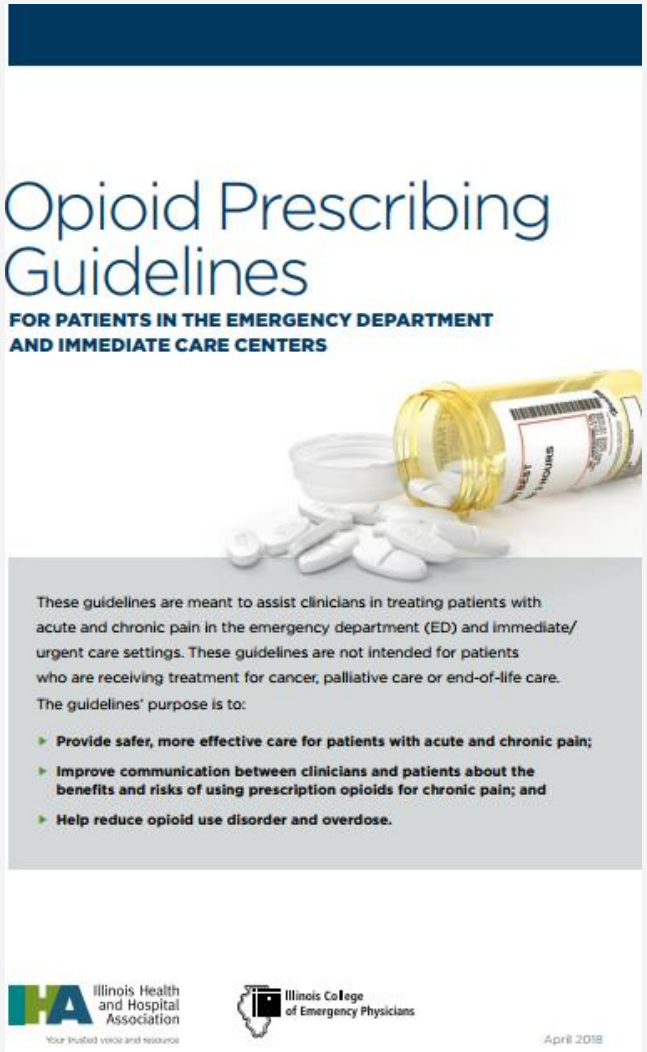
- We want your clinicians to come to Project ECHO ready to engage-by presenting a case, providing feedback on a colleague's case or tapping the SIU multidisciplinary team for their expertise on any questions you may have

ED Prescribing Guidelines

ED Prescribing Guidelines

- Provide safer, more effective care for patients with acute and chronic pain;
- Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain; and
- Help reduce opioid use disorder and overdose.

https://www.team-iha.org/files/non-gated/quality/opioid-guidelines-longversion.aspx



The Epidemic in the middle of the Pandemic

Opioids in the times of COVID-19

- A Look at OUD care
- A Look at Pain Management

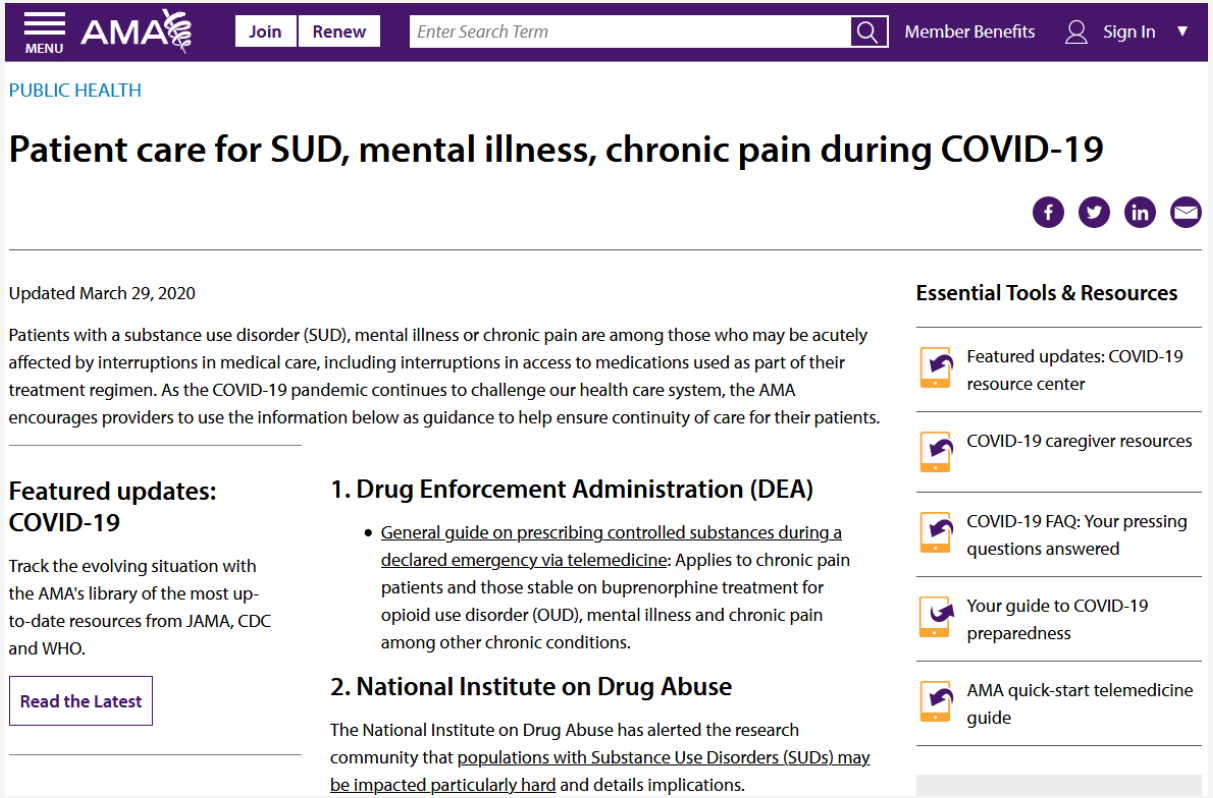
The Epidemic in the middle of the Pandemic
OUD Care

For OUD care, there are waivers for Buprenorphine and Methadone.

Buprenorphine visits can be done by telemedicine. This may limit things like drug screens, package counts and other monitoring, but there is a touch point between a new prescription.

Methadone which is highly regulated, has a waiver to allow for a few weeks supply as an outpatient. Social distancing in the daily morning line not possible and not safe for staff or people with OUD.

The outcomes of these changes are not known. Will there be more diversion? Will there be abuse? Or will outcomes be the same or better?



https://www.ama-assn.org/delivering-care/public-health/patient-care-sud-mental-illness-chronic-pain-during-covid-19

The Epidemic in the middle of the Pandemic Pain Management

(1) The public health consequences of COVID-19 for patients with pain

(2) The consequences of not treating these patients for the unknown duration of this pandemic

(3) Options for remote assessment and management

(4) Clinical evidence supporting remote therapies

Guidance for those attempting to rapidly transition to remote care with technology and discuss the lessons for the future of the pain treatment center

Topical Review

PAIN

Managing patients with chronic pain during the COVID-19 outbreak: considerations for the rapid introduction of remotely supported (eHealth) pain management services

Christopher Eccleston[a,b,*], Fiona M. Blyth[c], Blake F. Dear[d], Emma A. Fisher[a,b], Francis J. Keefe[e], Mary E. Lynch[f], Tonya M. Palermo[g,h], M. Carrington Reid[i], Amanda C de C Williams[j]

1. Introduction

Across the world, pain treatment centres have closed their doors. Because of the COVID-19 pandemic, healthcare providers are abruptly changing their care delivery to protect patients and staff from infection and to reallocate resource towards the greatest acute needs. Elective, routine, and nonemergency casework has stopped in secondary and tertiary centres, while in primary care, patients are requested to stay away or "socially distance," and in residential care facilities and hospices, strict isolation and separation protocols have been introduced.

Before the COVID-19 pandemic, telemedicine and eHealth approaches were being developed and tested in a gradual fashion with many studies focusing on lessons learned and barriers to using digital solutions.[3,37,39,51] Overnight, however, treating or supporting people with non-urgent and long-term conditions at a distance from healthcare providers has become imperative. These immediate changes are happening across healthcare systems. Telemedicine is being used to demand-manage the flow of patients with respiratory distress accessing emergency departments[25]; video consultation is being introduced in multiple settings[23]; and using social media is being discussed positively for its potential to direct people to trusted resources, to counteract misinformation, and to provide psychological first aid.[36]

Pain management providers face the challenge of delivering face-to-face service through different modes. Fortunately, there is a rich stream of research and clinical experience in the use of different technological solutions. **Table 1** provides a summary of the definitions and terminology in use.

We consider 4 related factors to help guide healthcare professionals caring for patients with chronic pain: (1) the public health consequences of COVID-19 for patients with pain; (2) the consequences of not treating these patients for the unknown duration of this pandemic; (3) options for remote assessment and management; and (4) clinical evidence supporting remote therapies. Finally, we provide guidance for those attempting to rapidly transition to remote care with technology and discuss the lessons for the future of the pain treatment centre.

2. Public health considerations

Pain prevention and control—particularly for chronic pain—will inevitably be disrupted by the COVID-19 pandemic. Diversion of resources will be planned (eg, cancelling elective surgery and outpatient procedures for chronic disease management) and unplanned (eg, medication shortages due to panic buying and inaccessibility of remaining healthcare options during movement restrictions). Longer-term, healthcare workers are likely to be at higher risk of lasting psychological morbidity based on evidence from the 2002 to 2003 SARS epidemic.[33]

The effect of the pandemic on pain burden will be differentially distributed across and within populations, depending on population characteristics emerging as determinants of the pandemic, including older age, population density, socioeconomic gradient, smoking prevalence, levels of chronic disease morbidity, availability of diagnostic testing, and access to health care. Some of these characteristics are also associated with higher levels of chronic pain

Sponsorships or competing interests that may be relevant to content are disclosed at the end of this article.

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7172975/pdf/jop-161-889.pdf

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Illinois Health and Hospital Association

Questions and Wrap Up

Questions about ALTO, ECHO or any of the other GLPP or MN Opioid offerings?

Our next webinar in this series will be June 18th focused on Sepsis

- **June 18:** Sepsis
- **July 16**: Hospital-acquired Infections
- **Aug. 20:** Readmissions
- **Sept. 17:** Pressure Ulcers