Collaborating to Prevent Opioid Abuse: What Does That Mean?

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Chief Medical Officer
Tennessee Department of Health
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Patients and Pain: Part of Primary and Specialty Practice

- Pain one of the most common presentations
- We all treat acute and/or chronic pain
- Multidisciplinary effort
- Too much, too long is clearly dangerous
- Prevention, treatment, law enforcement
Pain Management Is A Patient Safety Issue

• First, do no harm
• We have strayed
• We can and must do better
• But *HOW* can we do better?
We Can Stand On the Shoulders of Giants

• Don Berwick, MD
  – 100,000 Lives Campaign

• Peter Pronovost, MD PhD
  – Keystone ICU Project
IHI 100,000 Lives Campaign

• The IOM estimated that as many as 98,000 die annually in US hospitals due to medical injuries.
• The CDC estimated two million patients suffer hospital acquired infections each year.
• “These circumstances are not acceptable. It is time to change; and you can help.”
• Six quality improvement initiatives were launched
Institute for Healthcare Improvement
100,000 Lives Campaign

“Some Is Not a Number, Soon Is Not a Time. The number is 100,000. The time is NOW. The goal is achievable, but we need your help.”

[Portrait]
The Number:
100,000 Lives
The Time:
June 14, 2006 – 9 a.m. ET
“The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.”

Donald M. Berwick, MD
100,000 Lives Campaign In 60 days
1,000 hospitals joined

- 3,200 Hospitals ultimately joined
- 18 months > 122,000 fewer deaths reported
What did IHI control?

- Not the hospitals
- Not the physicians
- Not the money / reimbursement
- Not the regulators
- Not the legislatures
Why do we need to improve quality?

Sorrel and Josie King

On February 22, 2001, eighteen-month old Josie King died from medical errors at Johns Hopkins University Hospital.

A young ICU intensivist was profoundly impacted.
The Keystone ICU Project
October 2003

• **Goal:** “Improve care... [by] creating a culture of safety, CLABSI and VAP, and improving compliance with evidence-based practices”

• **Who:** Dr. Pronovost’s group, the Michigan Health and Hospital Association, and 108 intensive care units (ICUs) from 77 hospitals across MI began collaborative improvement
The Keystone ICU Project

• **What happened?**
  – 50 percent improvement in safety culture
  – Median CLABSI rate of zero
  – 99% compliance with evidence-based ventilator care practices

• **How long did it take?**
  – Total of two years (September 2005)
The Keystone Improvement Model

- **Pick a dot**
  - Goals, measures, current performance

- **Move the dot**
  - Select intervention, PDSA

- **Share the dot**
  - Spread the change state-wide
Selecting a Dot

• Evidence to guide practice
• Impact on morbidity and mortality
• Variation in practice
• Ability to change practice
Selected Dots

• Patient Education
• Prescriber Education
• Perioperative pain management
• ED pain management
What Does Medicine Do Best?

- Recognize a problem
- Analyze a problem
- Design interventions for a problem
- Gather evidence interventions work
- Validate effective interventions
- Spread interventions statewide
What About Tennessee?

PAST 72 HOURS: Massive increase in overdose cases in Murfreesboro.

Police: Mom, daughter both overdose at same time.

Six overdose deaths reported in Rutherford Co. in 10 hours.

Coroner investigates 145 suspected Fentanyl deaths in a month.

Fentanyl shares experience of daughter's overdose death.

Tennessee sees rise in Fentanyl overdoses.
Collaboration In Healthcare

• **Provide a place** to collaborate across professional and competitive lines to identify the most significant healthcare interventions to decrease opioid abuse
• **Provide a framework** for collaboration and intervention
• **Provide focus areas** for ongoing innovation in key areas
• **Facilitate group selection of projects** and next steps so that activities can begin quickly
• **Provide a blueprint** to move forward, change the culture, improve quality and safety for pain management
What Model Can We Follow?

- IHI → TIPQC (Tennessee Initiative for Perinatal Quality Care)

Invested Community Willing to Collaborate

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*Maternal Arm *Statewide* Kick-off at March 1&2 Meeting

As of March, 2012
Consider...

• Drug overdose deaths ↑ annually for >5 y
• 1631 overdose deaths in TN in 2016
• 72.7% involved opioids (1186)
• 47% CS dispensed w/in 60d of death (557)
Tennessee Healthcare Collaborative To Reduce Opioid Abuse

“Some Is Not a Number, Soon Is Not a Time. The number is 365 LIVES SAVED. The time is NOW. The ONE YEAR goal is achievable, and we need your help.”
How Will We Know When We Succeed?

![Graph showing data from 2011 to 2018 with values for each year: 1062, 1094, 1166, 1263, 1451, 1631, 1635, 2000.]

- 2011: 1062
- 2012: 1094
- 2013: 1166
- 2014: 1263
- 2015: 1451
- 2016: 1631
- 2018: 1635
What’s Different?

• We have not yet identified the key projects and launched them
  – The breakout groups will begin the process
• We have not yet established the supporting organization
  – The Steering Committee has begun the process

And one thing is the same...
“The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.”

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