Tennessee Opioid Abuse Summit – Day 1
Emergency Department SWOT Analysis

Focus:
ED pain management, collaborating to prevent opioid abuse

FINAL SWOT

Strengths:

1. CSMD
2. Commitment to quality of care
3. National recognition of the problem
4. Universally endorsed pain guidelines
5. Clinical diagnostic capabilities

Weaknesses:

1. Patient satisfaction scores
2. Lack of time with accessing database, educating patient
3. No felony law for violence against healthcare providers
4. Expand formulary

Opportunities:

1. Set patient expectations and educate
2. Educate all patient and providers and students on alternative pain treatment
3. Revisit ACEP guidelines
4. Consider Narcan prescription with opioid prescription
5. Engage other partners in a statewide initiative
6. Alternative treatments like physical therapy

Threats:

1. Legal action/complaints for not prescribing
2. Regulatory bodies regarding pain assessment
3. Workplace violence and safety
4. Economic threats to hospitals/pharmacies/insurance to comply versus hospitals who don't

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SWOT Analysis initial draft work:

Strengths:

1. State sharing CSMD in real time in all states – 7 days
2. Willingness and devoted mindset of ED staff to provide good care and educate / comm
3. Staff who will teach and energize about opioid opportunities- internally and in community
4. C-suite willing and motivated to bring about change, opioid crisis is a pain point for them
5. ED state guidelines on pain medicine
6. Recognizing clinical syndromes and drug seeking behavior
7. Limited relationship with patient/clean slate for therapy
8. Protocol driven
9. Captive audience for education
10. Pharmacy in the ED including education on narcotics
11. Diagnostic accuracy-evaluating acute situations – phys discern
12. Drug testing
13. Peer recovery specialists
14. Pharmacist authority to not fill prescription
15. USDA funding in rural areas
16. Discernment of physician – pain S&S

Weaknesses:

1. Data-being able to obtain and share interagency (DOH, highway patrol, getting whole picture)
2. Time constraints to fully assess patient
3. Lack of standard criteria on drug screens and when to do one
4. Drug screens don't cover all drugs (don't show carphentanyl and other drugs measured in micrograms)
5. External pharmacies- Walgreens, CVS vs small independent (price discrepancies)
6. Not good at chronic care/pain
7. Don't know the patients yet
8. Inability to know Dr. shoppers ahead of time
9. Patient satisfaction scores make us vulnerable
10. Not enough time
11. IV APAP is expensive
12. Lack of security response
13. TN- no felony law for violence against heath care providers
14. Rapid culture change
15. Some drugs like Ketamine not approved for RN to administer
16. CSMD data base needs data from all states
17. CSMD not integrated into HER
18. Some providers don't follow protocols
19. Patient expectations
20. Lack of access to follow up care including behavioral health
21. No opioid detox beds
22. Inability to refuse care; healthcare provider abuse/intimidation

Opportunities:

1. Orders based on age/diagnosis
2. Revisit ACEP guidelines for opioid prescribing *set as a standard of care
3. Consumer facing messaging/education (posters) in patient room
4. Immediate patient education upon entry to ED (marketing platform w/symbol that is recognized universally)
5. THA/administrator buy-in
6. Eliminate pain scores from patient satisfaction
7. Make patient health and pharmacy data available in a timely fashion 24/7/365
8. Educate ED providers (and other providers) in other treatment modalities, ex: nerve blocks in ED
9. Utilize state and national physician groups to spread information about laws/problems
10. A state app for health info exchange
11. Prescribing guidelines for acute vs. chronic
12. Set patient expectations and educate on addiction potential
13. Education for medical/nursing students on the epidemic/treatment/how to be nice
14. Develop support for admin and risk managers to address patient complaints
15. Improved communication on the transitions of care and establish protocols
16. Harm reduction/anti-drug coalitions
17. Narcan prescribed with all opioids
18. Engage partners/stakeholders

Threats:

1. Lack community resources for referral (especially in rural settings)
2. Behavioral health patients-physical violence from pt to staff, injury to self, lack of behavior support so patients have no place to go, stay in ER
3. Workplace safety (challenge for implementing guidelines)/ violence
4. Low availability of Narcan (needs to be more readily available)
5. Legal action against prescribers
6. Economic penalties
7. Increase in outpatient surgical care may lead to more patients presenting for pain
8. Easy access and good reputation
9. Regulatory bodies require that pain must be assessed
10. Judging attitudes toward addiction
11. Cost/reimbursement for behavioral health
12. Repeat visitors to healthcare facilities
13. Pregnant patient who cannot take anti-inflammatory pain meds
14. Infrastructure – limited space, more behavioral health beds
15. Safety threat leading to hospital lock downs
16. Patient satisfaction scores
17. Clinician culture – community based providers
18. Unintended exposure to narcotics during emergency response

Tennessee Opioid Abuse Summit – Day 2
Emergency Department Goals and Action Plans

Goal:
Decrease opioid use and prescriptions by 25% in the Emergency Department.

Use will be defined by morphine milligram equivalents per 100 patient visits to the Emergency Department. To reach this goal, each facility will have to be able to provide baseline data regarding patient utilization in Emergency Department treatment status by month from point of pilot start to one year after. A method will have to be established for facilities without electronic health records.

Action Steps for opioid stewardship:

1. Model Swedish Medical Center's (located in Denver) best practice of opioid light order sets.
2. Revisit current guidelines to consider a maximum 3 day default for opioid prescriptions. (EBP)
3. Utilize best practice approach once those guidelines are in place.
4. Recognize and celebrate accomplishments/small successes.
5. Educate providers/clinicians and set patient expectations regarding pain.
6. Be able to have future comparisons for like facilities in state and nationally.
7. Share the comparisons but make them non-punitive.
8. Establish this team as a task force.
9. Expand coverage of non-opioid pain medicines and non-medication therapies.
10. ALTO order sets
11. Share what works through the State Board.
12. Have a state-wide roll out of education through smaller groups such as regional outreach.
13. Tennessee Hospital Association will take the 3 day limit guidelines to CMOs.
14. Form a task force within 90 days to determine the details of the goals and action steps.
15. Tennessee Hospital Association hosts training – probably by WebEx.

Barriers/Opportunities:

1. Facilities without Electronic Health Records
2. The ability to capture data on prescriptions written versus prescriptions dispensed.
3. Data base.
4. Expand coverage of non-opioid treatments.
5. Alternate medications are not always available.
6. Becomes punitive.

Volunteers:

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Background Goal Setting Work:
What does our future look like? How do we get there?

Draft Group Goals and [vote count]:

1. Decrease opioid use and prescriptions by 25% **[25]**
2. Increase CSMD Usage (value increased to prescribers and patients) [0]
3. Increase awareness and education to patient and providers [4}
4. Establish data sharing network similar to TIPQC [18]
5. Establish discharge prescribing guidelines (to improve baseline prescribing habits) [14]
6. Keep opioid naïve people opioid naïve – EVER [3}
7. Increase availability of non-opioid therapies (medication, physical therapy, pain management services, blocks) [18}
8. Increase dissemination of opioid best practices using recertification process to all levels of clinicians [2}

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Pam Browning, facilitator
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