2018 Hospital Quality Symposium

July 31, 2018 – Santa Rosa
HOUSEKEEPING

- Restroom Locations
- Electronic Devices
- Wi-Fi Code
- Evaluation
- CE/CME – must sign in
- Materials
All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.
GROUND RULES

- Begin and end on time
- Be open-minded – respect all ideas and opinions
- Use technology sparingly and place on silent
  - If you must take a call, please step out of the room
- Be engaged – participate
- Share & Learn!!
Dr. Robert Moore, MD, MPH, MBA
Chief Medical Officer
Partnership HealthPlan of California
Mission:
To help our members, and the communities we serve, be healthy.

Vision:
To be the most highly regarded managed care plan in California.
How We Are Organized

PHC is a County Organized Health Systems (COHS) Plan

Non-Profit Public Plan
Low administrative Rate (less than 4 percent) allows for PHC to have a higher provider reimbursement rate and support community initiatives

Local Control and Autonomy
A local governance that is sensitive and responsive to the area’s healthcare needs

Community Involvement
Advisory boards that participate in collective decision making regarding the direction of the plan
Major PHC Updates

- Palliative Care Benefit starting January 2018
- Partnership Wellness and Recovery Program
- Whole Child Model (California Children’s Services Carve In), January 1, 2019
- NCQA Accreditation anticipated 2019
Ways PHC supports hospital quality

- Incentivize hospital performance on a set of meaningful measures (Hospital QIP)
- Find ways to support small + rural hospitals in PHC network
- Develop platforms for hospital-hospital collaboration
- Seek + disseminate new and current information
Hospital Quality Improvement Program

• Pay-for-performance program started to **support hospitals** serving PHC members to **improve quality and health outcomes**.

• Substantial Financial Incentives; approximately $14 million awarded among 26 hospitals in 2016-17

• Five domains: Readmissions, Advance Care Planning, Clinical Quality: OB/Newborn/Pediatrics, Patient Safety, and Operations and Efficiency
1. Where possible, pay for outcomes instead of processes
2. Actionable measures
3. Feasible data collection
4. Collaboration with providers in measure development
5. Simplicity in the number of measures
6. Representation of different domains of care
7. Align measures that are meaningful
8. Stable measures
2018-19 Hospital QIP

• For 2018-19, we have outreached to 27 hospitals (increased from 26 in 2017-18)

• Hospitals located in: Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Tehama, and Trinity counties
For More Information about HQIP…

- Visit our website: www.partnershipphp.org

- Email us: HQIP@partnershipphp.org

- See handout to learn more!
Ready for Palliative Care: Growing and Strengthening Palliative Care Teams for Improved Patient Experience

Dr. Steve Pantilat, MD, MHM, FAAHPM
Kates-Burnard and Hellman Distinguished Professor in Palliative Care
Chief, Division of Palliative Medicine
Director, Palliative Care Quality Network
University of California, San Francisco
Ready for Palliative Care

Steven Pantilat, MD
Kates-Burnard and Hellman Distinguished Professor in Palliative Care
Chief, Division of Palliative Medicine
Director, Palliative Care Quality Network
University of California, San Francisco

Twitter: @stevepantilat
Life Expectancy: Good News, Bad News

Life expectancy (years)

Death Rate: 100%
Palliative Care is medical care focused on improving quality of life for people with serious illness.
Extra Layer of Support

“Live as well as possible for as long as possible”

- **Palliative care**
- **Curative care**
- **Hospice**
- **Bereavement**
- **Death**
Live Well and Live Long with Palliative Care

Better quality of life
Better mood
Less pain and shortness of breath
Less likely to get invasive care at end of life
Better health for loved ones
Greater satisfaction with care
Live just as long, and maybe longer

If it was a drug, everyone would get it

Temel et al. NEJM 2010;363:733-42
Pantilat Arch Int Med 2012;172:1172-3
Kavalieratos et al. JAMA 2016;316:2104-14
El-Jawahri et al. JAMA 2016;316:2094-2103
Patients Appropriate for Palliative Care

• Serious illness
• Metastatic cancer
• Heart failure, COPD, ESRD, Cirrhosis and two admissions or ED visits in a year
• Stroke
• Dementia w/aspiration pna
• Parkinson’s disease, ALS
• Anyone on a transplant list

• Utilization
• "Would I be surprised if this patient died in the next year?"
Challenge of Care for the Seriously Ill: What We Say

- “She’s not ready yet”
- “She will lose hope”
Most Important Issues at End of Life

Making sure family not burdened financially by my care: 67%

Being comfortable and without pain: 66%

Being at peace spiritually: 61%

Making sure my family is not burdened by tough decisions about my care: 60%

Living as long as possible: 36%
Talking About Values and Goals

• “When you think about the future, what do you hope for?”

• “When you think about what lies ahead, what worries you the most?”
Palliative Care Teams

• Interdisciplinary
  – Nurse, doctor, social worker, chaplain
  – Access to pharmacist

• 24/7 access

• Sustainable jobs
  – Burnout among highest in healthcare
  – Self care and resiliency

National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 3rd ed. [link]

Dying in America. 2014 The National Academies Press

Kamal et al. JPSM 2016;51:690-6
## Inpatient PC team staffing: PCQN

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<th>Discipline</th>
<th>Number of staff</th>
<th>FTE</th>
<th>Credentialed</th>
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<td>0.8</td>
<td>0.4</td>
<td>0.3</td>
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<tr>
<td>Social Worker</td>
<td>1.2</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1.2</td>
<td>1.0</td>
<td>0.8</td>
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<tr>
<td>Nurse Practitioner</td>
<td>1.3</td>
<td>1.1</td>
<td>0.9</td>
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<tr>
<td>Physician</td>
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<td><strong>3+ Disciplines</strong></td>
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<td><strong>84%</strong></td>
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<td>Chaplain, SW, RN, NP, MD</td>
<td>4.2</td>
<td>3.4</td>
<td>0.5 – 17.6</td>
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<tr>
<td>Nurse, MD</td>
<td>3.0</td>
<td>2.3</td>
<td>0.3 – 11.9</td>
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<th>Mean</th>
<th>Median</th>
<th>Range:</th>
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<tr>
<td>Staff/100 beds*</td>
<td>2.3</td>
<td>1.8</td>
<td>0.7 – 10.4</td>
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Challenge of Care for the Seriously Ill: What We Say

- “She’s not ready yet”
- “She will lose hope”
- “There is nothing more we can do”
  - Simply not true
  - Feels like abandonment
Better Words to Say

• “There is nothing more we can do”
  “I wish there was something we could do to make your heart get stronger.”

• “Would you like us to do everything possible?”
  “How were you hoping we could help?”

Pantilat *JAMA* 2009;301:1279-81
Evolution of US Healthcare in the 21st Century

Palliative Care
Increases quality and lowers costs for the most seriously ill people
Meeting the Needs of Patients and Families
Division of Palliative Medicine

Hospital
Acute Illness
Palliative Care teams

Outpatient/Telehealth

Home/Telehealth

SNF/LTC/Telehealth

End of Life Hospice

Palliative Care
System of Care for People with Serious Illness

- Advance care planning
- Primary Palliative Care
- Consultative Palliative Care
- PC as primary focus of care

Intensity of PC needs

Advance care planning

Time
System of Care for Seriously Ill Patients and Families

- Hospice
- Social support services
- SNF/LTC
- Home PC
- Hospital
- ER
- Telehealth
- ER
- Specialty Clinics
- Case Management
- Palliative Care
- Primary care

UCSF Division of Palliative Medicine
Conclusions/Recommendations

- Palliative Care improves care for people with serious illness in every way that matters
- All clinicians should provide primary palliative care
- Be ready to care for people with serious illness by developing a system of care
Share & Learn Sessions

Session 1 – Dry Creek Ballroom
Claire Manneh, MPH
CHPSO Patient Safety Organization

Bringing Patient Safety Event Reports to Life: Sharing data with CHPSO

Session 2 – Sonoma Mountain
Leigh Burns, RD, CDE
Marin General Hospital

Community Partnerships for Better Health: An interactive discussion drawing from PRIME complex/palliative care program development

Session 3 – Chalk Hill
Cathie Markow, RN, MBA
California Maternal Quality Care Collaborative (CMQCC)

CMQCC’s Strategy for Helping you Meet NTSV Goals: Improving Maternal Health Outcomes
Lunch Discussion
12:00 – 12:30
What operational or performance areas are missing from the current Hospital QIP measurement set, and should be prioritized for inclusion in the 2019-20 measurement year?
What are some meaningful measures your hospital is reporting on? What improvement activities have resulted from reporting on these measures?
One area we have tried to address is infections and/or sepsis. CMS and The Joint Commission have a Severe Sepsis and Septic Shock Early Management Bundle (SEP-1), as part of the **National Hospital Inpatient Quality Measures**, which monitors whether key interventions have occurred within 3 hours of presentation of severe sepsis or within 6 hours of presentation of septic shock.

What are your thoughts on this measure? What other methods may be used to measure performance in this area?
Are there any emerging or existing challenges you have related to quality, that you are not finding resources (education, peer groups, etc.) to address?
What platforms does your hospital have to measure and address patient satisfaction?
TeamSTEPPS for Patient Safety and Staff Satisfaction

Julia Slininger, RN, BS, CPHQ
Vice President, Regional Quality Network
Hospital Quality Institute
TeamSTEPPS for Patient Safety and Staff Satisfaction

Julia Slininger RN, BS, CPHQ, VP Regional Quality Network, HQI

Partnership HealthPlan of California
Hospital Quality Symposium
7/31/18 & 8/2/18
Advancing Quality and Patient Safety in California

A collaboration of

- California Hospital Association
- Hospital Council of Northern and Central California
- Hospital Association of Southern California
- Hospital of San Diego and Imperial Counties
TeamSTEPPS® 2.0

It’s a Jungle in there!
The Iceberg Model

- Known Adverse Events
- Reported Near Misses

System Design

Human Behaviors
To Err is Human

- The IOM Report published in 2000 recommended interdisciplinary team training to increase patient safety and quality healthcare delivery.

- The greatest factor in the occurrence of errors, near misses, and other incidents is “communication”
  - Poor
  - Hesitant
  - Absent
  - Unwelcome
Patient Safety: the Final Frontier

- Team Strategies and Tools to Enhance Performance and Patient Safety
- This program goes where no program has gone before.
  - Beyond evaluation and improvement of systems
  - Beyond quality improvement models
  - Beyond human factors and crew resource management
Destination: Patient Safety

TeamSTEPPS takes us

- To a new environment
- Using a new language
- That builds teams
- Brings more joy and meaning to the workplace
- and Saves Lives
Team Training? Really?

- The vehicle for all these helpful interventions is usually a multidisciplinary team of healthcare workers at various professional levels.

- So, like, Nike? *Just Do It?*
- Physicians don’t learn teamwork in Med School.
- Nursing education lacks assertiveness training.
- Executives are most attentive to the “big picture.”
- Patients/families are sometimes not listened to.
Communication

- Assumptions
- Fatigue
- Distractions
- HIPAA

Message

Source

Assumptions
Fatigue
Distractions
HIPAA

Feedback

Receiver
What Do You See?
Communication is...

- The process by which information is **exchanged** between individuals, departments, or organizations
- The lifeline of the Core Team
- Effective when it permeates every aspect of an organization

Assumptions, Fatigue, Distractions, HIPAA
# TeamSTEPPS Toolkit

## BARRIERS
- Inconsistency in Team Membership
- Lack of Time
- Lack of Information Sharing
- Hierarchy
- Defensiveness
- Conventional Thinking
- Complacency
- Varying Communication Styles
- Conflict
- Lack of Coordination and Follow-Up with Co-Workers
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity

## TOOLS and STRATEGIES
- Brief
- Huddle
- Debrief
- STEP
- Cross Monitoring
- Task Assistance
- Feedback
- Advocacy and Assertion
- Two-Challenge Rule
- CUS
- DESC Script
- Collaboration
- SBAR
- Call-Out
- Check-Back
- Handoff

## OUTCOMES
- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- *Patient Safety!!*
Multi-Team System (MTS) for Patient Care
TeamSTEPPS™ Program

Key Attribute…

SIMULATION TRAINING!

A picture paints...

Practice makes…
Team Structure Video
Mutual Support
Mutual Support

Mutual support involves members:

1. Assisting each other
2. Providing and receiving feedback
3. Exerting assertive and advocacy behaviors when patient safety is threatened
4. Practicing Situation Monitoring
Situation Monitoring

SVT...180 bpm...
...pressure...98...50

mmm...might need the crash cart???
Components of Situation Monitoring:

- **S**tatus of the Patient
- **T**eam Members
- **E**nvironment
- **P**rogress Toward Goal
**Leadership**

- Holds a teamwork system together
- Ensures a plan is conveyed, reviewed, and updated
- Facilitated through communication, continuous monitoring of the situation, and fostering of an environment of mutual support
Building Blocks for a Patient Safety Culture

- Leadership
- Teamwork
- Standardization
- Accountability
- A Just Culture
A “Just” Culture

- Justice
  - Understanding
    - Safety
    - Trust

“Julia Slininger”
Justice

- Doing the Right Thing
  - For the right reason

- Involving the Right People
  - Including support systems

- Accountability
  - To the patient, to the team, to oneself
  - “Sorry” works
Understanding

■ Human Factors
  ■ “I’m Safe” checklist
■ Mutual Support
  ■ I’ve Got Your Back
■ Care for the Caregiver
  ■ NQF Safe Practice #8
“Following serious unintentional harm due to systems failures and/or errors that resulted from human performance failures, the involved caregivers (clinical providers, staff, and administrators) should receive timely and systematic care to include: treatment that is just, respectful, compassionate, supportive medical care, and the opportunity to fully participate in event investigation and risk identification and mitigation activities that will prevent future events.”

[Frankel, 2006; MCPME, 2006a; MCPME, 2006b; IHI, 2009; MITSS, 2009]
I’M SAFE Checklist

I = Illness
M = Medication
S = Stress
A = Alcohol and Drugs
F = Fatigue
E = Eating and Elimination
Safety- *first and foremost!*

- Communication
  - Brief and Debrief
  - Safety Walk Rounds
  - Reward error and near miss reporting, AND
- Standardization
  - *It’s about systems, not individuals*
Trust

- Leadership walks the talk
  - For all the preceding points
  - Available (“office hours”?)

- Rewarding Teamwork
  - Call it out publically (at meetings?)

- Protection from the bus
  - “I know I will not be thrown under”

*Staff satisfaction = Staff retention*
A Shared Mental Model is…

The perception of, understanding of, or knowledge about a situation or process that is shared among team members through communication
Shared Mental Model?
Transforming concepts in patient safety: a progress report
Tejal K Gandhi, Gary S Kaplan, Lucian Leape, Donald M Berwick, Susan Edgman-Levitan, Amy Edmondson, Gregg S Meyer, David Michaels, Julianne M Morath, Charles Vincent, Robert Wachter

(1) Medical education must be redesigned to prepare new physicians and other health professionals to function in these new cultures;
(2) care must be delivered by multidisciplinary teams working in integrated care platforms;
(3) healthcare workers need to work in safe environments and find joy and meaning in their work;
(4) patients must become full partners in all aspects of designing and delivering healthcare and
(5) transparency must be a practiced value in everything we do.
So, enough with the talk. Let’s do something.
Coaching Workshop
You are assigned to coach day shift staff in the Emergency Department (ED) on teamwork skills. When you arrive at 0900, the department is very busy and there is no evidence that teams have been formed. You locate the coordinating team nurse in the department for an update, and she tells you, “We’re not doing teamwork today, the ED is just too busy. I have made the assignments, and we are going to manage things “the good old fashioned way today.”
A staff member comes to you complaining of being put on a team in the Surgery Clinic with a “slacker.” She says, “Joan makes herself scarce and almost never offers to help her teammates, even when she has down time. I’ve had it!”
You observe a confrontation at the desk area, where a physician has just reprimanded an Intensive Care Unit nurse for moving his patient to the ward without notifying him. The nurse is upset and embarrassed but later states that she has experienced this side of Dr. Pool before. She decides it is not worth discussing with him because he never listens anyway.
Coaching Tips

Do…

- Actively monitor and assess team performance
- Establish performance goals and expectations
- Acknowledge desired teamwork behaviors and skills through feedback
- Coach by example; be a good mentor

Do not…

- Coach from a distance
- Coach only to problem solve
- Lecture instead of coach
Strengthening our Patient Safety Culture Together!

Communication

Create a new culture
Don’t let up—Be relentless
Short-term wins
Empower others
Understanding & buy-in
Develop a change vision & strategy
Build the guiding team
Create sense of urgency

John Kotter
Opioid Use Disorder Treatment in the Hospital: Moving from Stigma to Science

Dr. Diana Coffa, MD
Director
UCSF Family and Community Medicine Program at San Francisco General Hospital
Hannah Snyder, MD  
Clinical Instructor, UCSF at ZSFG  
Project Director, SHOUT

Diana Coffa, MD  
Associate Professor, UCSF at ZSFG  
Project Mentor, SHOUT
A Brief Intro

• The opioid epidemic affects hospital and ED patients
• Buprenorphine and methadone maintenance saves lives
• Treatment should be available in every hospital and ED
• SHOUT and ED-Bridge resources can help get you begin
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016

- Any Opioid
- Other Synthetic Opioids (e.g., fentanyl, tramadol)
- Heroin
- Natural & Semi-Synthetic Opioids (e.g., oxycodone, hydrocodone)
- Methadone

Sonoma County:
• 22 overdose deaths in 2016
• 5.7/100 misuse opioids
• 1.0/100 have OUD
OUD Impacts Your County

Humboldt County:
- 26 overdose deaths in 2016
- 6.2/100 misuse opioids
- 1.1/100 have OUD

OUD Impacts Hospitals

https://hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.jsp
Chief Complaints

- Overdose, withdrawal
- Cellulitis/abscess, endocarditis/osteomyelitis
- Unrelated

- Often not engaged in care elsewhere
OUD Complicates Treatment

- 25-30% of admitted patients leave AMA
  - Craving
  - Fear of mistreatment
  - Financial and social pressures
  - **Withdrawal**
    - Reduced adherence
    - Increased readmission
Drug Related Death Rate per 1000 Post Discharge

- No hospital admission: 2
- 28 days after discharge: 31.7
- 1-3 months: 14.9
- 3 months-1 year: 10.6

Withdrawal Management

• Adjunctive medications
Withdrawal Management

- Adjunctive medications
- Methadone 20-30mg
Withdrawal Management

- Adjunctive medications
- Methadone 20-30mg
- Buprenorphine taper
A Chronic Disease Requires Chronic Meds

A thought experiment
Withdrawal Management

- Adjunctive medications
- Methadone 20-30mg
- Buprenorphine taper
- Maintenance Opioid Agonist Therapy
Log Dose

Opioid Effect

100%

Ceiling Effect

Log Dose

Agonist (methadone, heroin)

Partial Agonist (buprenorphine)

Antagonist (naloxone, naltrexone)
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<th>Methadone</th>
<th>Buprenorphine</th>
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<td></td>
<td>Partial agonist, often paired with naloxone</td>
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<tr>
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<td>Buprenorphine</td>
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<tr>
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<tr>
<td>Full opioid agonist</td>
<td>OTP (aka methadone clinic)</td>
<td>Clinic w/ X waived provider (primary care, prenatal, psychiatry, or addiction)</td>
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<tr>
<td></td>
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<td>Buprenorphine</td>
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<tr>
<td><strong>Mechanism</strong></td>
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<td><strong>Location of care</strong></td>
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<td>Clinic</td>
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<td><strong>Retention</strong></td>
<td>Higher</td>
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<td>Clinic</td>
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<tr>
<td><strong>Retention</strong></td>
<td>Equivalent</td>
<td>Equivalent at doses ≥16 mg</td>
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<tr>
<td><strong>Opioid negative urine</strong></td>
<td>Equivalent</td>
<td>Equivalent at doses ≥16 mg</td>
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Prevents Morbidity, Promotes Recovery

• Reduce injection and illicit drug use
• Increased abstinence
• Promotes return to work and family obligations
• Reduce HIV and HCV transmission
• Reduce bacterial infections
• Reduce criminal behavior
Decreased Mortality

All cause mortality per 1000 person years

Barriers to Treatment

• Stigma regarding OUD patients
• Stigma regarding OUD medications
• Insufficient providers
• Long wait times, psychosocial requirements
Why Start in the Hospital?

• Patients are ready for change
  • Fear of bad outcomes
  • Forced abstinence allows time for thinking
  • Desire to reconnect with family, old life
  • Respect and kindness from providers

• 67% of hospitalized people who use drugs state that they would like to cut back or quit

Hospital Initiation of Buprenorphine

% Patients

Received MAT in 6 mo after discharge
- Linkage: 72
- Detox: 12

In MAT at 6 months
- Linkage: 16
- Detox: 3

Days in MAT over 6 months
- Linkage: 65
- Detox: 7

ZSFG Experience

- 53 methadone starts referred over 8 months
  - 37% had intake at on site methadone clinic
- 14 buprenorphine starts over 3 months
  - 79% had at least one MAT visit in 90 days
- 4 through a facility (SNF, jail)
Why Start in the ED?

- Frequent site of care for patients with OUD
- Often otherwise not engaged in care
- Clinical monitoring for rapid induction
ED Initiation of Buprenorphine

Highland Experience

- 2/2017-2/2018
  - 209 patients contacted by linkage coordinator
  - 110 patients received buprenorphine
  - 90 patients attended first appointment at on site clinic
  - 82% follow up
Is it Legal?

• Methadone
  • If used to treat addiction, must be in a federally licensed opioid treatment program

• Buprenorphine
  • If used to treat addiction, prescriber must have a DEA waiver
    • 8 hours of training for MD, 24 hours of training for NP or PA
DEA Makes Exceptions

• If patient is admitted for any other reason than addiction
  • Methadone and buprenorphine can be dispensed for addiction in the hospital
  • Including new starts
• If the patient presents to ED or urgent care in withdrawal
  • Legal to provide 72 hours of methadone or buprenorphine to treat withdrawal
• On discharge, regular rules apply

Drug Enforcement Administration/Department of Justice, 2017, §1306.0
Worst Case Scenario

Return to use

• Death rate is likely reduced because tolerance has not been lost
• Prior quit attempts predict future success
Patients on Home OAT

• Continue home dose
  • Even if NPO
  • Even if pain management required
  • Even if surgery planned
• Confirm last dose
Harm Reduction

• Universal **naloxone** prescribing
  • OUD
  • Chronic opioids
  • Stimulants

• Safe injection practices
  • Clean needles and works
  • Avoid injecting alone
  • Use test doses
Models of care
Preparing Your Hospital

• Develop a team
  • Hospital leadership
  • Clinician champion
  • Pharmacy
  • Nursing
  • Linkage navigator
• Train prescribers, nurses, pharmacy
• Guideline, order set
• Just prescribe it!
Providing discharge medications

• If a team member has an x-license
  • Prescribe sufficient medication until next appointment

• If no team member has an x-license
  • Next day outpatient follow up
  • Next day ED follow up
  • Have an in-house buprenorphine team that provides discharge rx
Discharge to Outside Provider

- PCPs or addiction specialists with x-licenses
- Hubs/Opioid Treatment Programs

Finding a Primary Care Provider with an x-license:
https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
Develop a bridge clinic

- Without x-license
  - Bridge clinic must see patients daily
  - Medication can be *dispensed*, not prescribed
  - No more than 72 hours
  - Utilizes the 72 hour emergency exception in DEA regulations

- With x-license
  - Bridge clinic can see patients the day after discharge
  - Then daily to weekly until maintenance care is established

- [https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm](https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm)
Use Telemedicine

SHOUT - Support for Hospital Opioid Use Treatment
Myths and Realities

- To solve the opioid epidemic we just need to decrease prescribing
- Medication is substituting one addiction for another
- Medication is unsafe
- It's an outpatient issue
- Need an X waiver or special training
- Need a perfect discharge plan
Key Points

• Medications save lives

• Buprenorphine and methadone both work

• Inpatient initiation is straightforward and within scope

• Preventing mortality is the primary goal
Support from SHOUT and ED-Bridge

Webinars
Evidence based guidelines
Clinical Support—Poison Control and UCSF Warmline
Toolkit with resources for implementation
Coaching calls, site visits
Training templates to modify for your organization
Closing Remarks

Partnership HealthPlan of California