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Guidance on Opioid Utilization

By Linda Paternie, RN, BS, MHA, CJCP

CMS is attempting to improve the quality of care for patients requiring pain management while also addressing the public health crisis of overuse and/or misuse of opioids. The goal is to adopt policies and practices that monitor and control opioid use while still making appropriate medications available. As stated in an article entitled "Fighting the Opioid Crisis" published by CMS 12/2019, the CMS strategy focuses on three key areas:

Prevention: preventing and reducing opioid use disorder (OUD) by promoting safe opioid prescribing and encouraging non-opioid pain treatment options that rely less on prescription opioids. The goals of prevention are to stop improper prescribing, to enhance diagnosis of OUD, and encourage non-opioid utilization.

Treatment: increasing access to evidence-based treatment for OUD. The goals are to make sure people can access treatment, and that people have treatment options presented to them.

Data: leveraging data to target prevention and treatment efforts and to support the detection of fraud, waste and abuse. By knowing and understanding opioid use patterns and promoting data sharing, trends can be identified and watched over time to see if whether solutions are working.

As of September 2019, CMS had approved 27 state Medicaid 1115 demonstration projects, including new flexibility to cover inpatient and residential treatment.

Beginning January 2020, CMS expanded Medicare coverage to opioid treatment programs that deliver medication-assisted treatment to people suffering from OUD. These treatment programs provide a range of services including medication-assisted treatment and counseling to people with OUD.

Both prevention and treatment efforts address misuse, overuse and over-prescribing with the intention of reducing emergency department visits, hospitalization, and family crises.

The Joint Commission (TJC) hospital accreditation standards were designed to assist in preventing the overprescribing of opioids and to effect improvement of opioid use when prescribed. Applicable standards related to pain management are addressed in the Leadership (LD), Provision of Care, Treatment and Services (PC), Human Resources (HR) and Performance Improvement (PI) chapters of the Accreditation Standards for Hospitals manual.

LD.04.03.13 EP1 requires that the organization identify a leader or leadership team who will be responsible for pain management, safe opioid prescribing and for the monitoring of performance improvement activities. It is recommended that the organization identify this team in writing.

LD.04.03.13 EP2 requires that the organization provide non-pharmacologic pain treatment that is designed for the specific patient population served and to the assessed needs of those patients. Non-pharmacologic treatment modalities may include transcutaneous electrical nerve stimulation (TENS), acupuncture therapy, chiropractic therapy, osteopathic manipulative treatments, massage therapy, physical therapy, cognitive behavioral therapy, relaxation therapy, music therapy and behavioral therapy.

Per TJC, there is not an expectation that the organization will be prepared to provide all types of non-pharmacologic therapies that may be requested by patients when hospitalized.

LD.04.03.13 EP3 requires the organization to provide to staff educational programs and resources related to pain management and to the safe use of opioids. Such offerings may include on-line

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resources, clinical guidelines addressing safe opioid prescribing, treatment options, multi-modal pain management, as well as assessment/reassessment criteria.

In addition to education, the organization is to provide staff orientation on specific job duties related to assessing and managing pain, per HR.01.04.01 EP3. All education and orientation is to be documented.

LD.04.03.13 EP4 states that the organization is to provide information to staff and providers on what sources for consultation and referral are available for patients with complex pain management needs.

LD.04.03.13 EP5 calls for the organization to furnish current information on opioid treatment programs and other services available in the community. The U.S. Substance Abuse and Mental Health Services Administration has a directory of opioid treatment programs, for example.

LD.04.03.13 EP6 requires the organization to facilitate access for practitioners and pharmacists to the Prescription Drug Monitoring Program (PDMP). Facilitation may be providing Information Technology (IT) support for: shortcuts on designated computers to the PDMP, links from the organization's intranet or electronic medical record, education on when the PDMP is to be queried and perhaps creating prompts in the electronic medical record. It is recommended that the organization periodically monitor compliance. During TJC surveys, compliance with access to the PDMP may be evaluated during tracers and in interviews with practitioners and pharmacists. (Check to see if your state has a PDMP database and whether your state has specific mandates for use.)

LD.04.03.13 EP7 calls for leadership collaboration with staff to assure all the equipment required to monitor patients at high risk for adverse outcomes from opioid treatment is available.

PC.01.02.07 EP1 requires the hospital to have defined criteria for pain screening, assessment and reassessment. Policies should be developed to define the criteria.

PC.01.02.07 EP2 requires patients to be screened for pain in the emergency department and when admitted to the hospital.

PC.01.02.07 EP3 calls for pain to be treated. The treatment may be pharmacologic and/or non-pharmacologic. At least one non-pharmacologic modality should be provided when clinicians determine the need for pain treatment.

PC.01.02.07 EP4 requires documentation of a pain management treatment plan.

PC.01.02.07 EP5 defines the expectation for patient involvement in formulating the pain management treatment plan.

PC.01.02.07 EP6 calls for appropriate monitoring of high risk patients receiving opioid treatment. Note, that during survey, clinicians may be asked to describe how they identify a patient is high risk and how that patient would be monitored and managed. Examples of high risk patients may be people with sleep apnea, patients receiving continuous intravenous opioids, patients on supplemental oxygen, etc.

PC.01.02.07 EP7 calls for documentation of responses, side effects, and progress related to pain interventions.

PC.01.02.07 EP8 requires documentation of patient and family education on aspects of discharge planning related to pain management, such as the pain management plan, side effects that may be experienced, activities that may impact the plan and safe use, storage and disposal of opioids when prescribed.

PC.02.03.01 EP10 refers again to patient education and training specific to pain management based on patient need and ability to understand and to carry out the activities necessary to assist in achieving improved pain management.

PI.01.01.01 EP40 requires the organization to collect data on pain assessment and management, interventions and effectiveness as part of its ongoing performance improvement activities.

PI.02.01.01 EP18 calls for the analysis of the pain management data collected and the subsequent identification of any changes needed to increase safety and quality of care for the patients. Note, the use of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) alone is not sufficient to meet this element of performance. The hospital and medical staff are to determine what quality metrics are collected in the patient population served by the hospital. As patient populations change and as services provided are modified, the organization may need to modify its quality metrics.

PI.02.01.01 EP19 requires the hospital to monitor opioid utilization in order to make sure they are being used safely. Monitoring may include tracking of adverse events, the use of naloxone or other reversal agents, the dose and duration of opioid prescriptions, trends of opioid induced respiratory depression, practitioner prescribing patterns, etc.

As a Note: As quoted in The Journal of Family Practice, October 2019, David. W. Baker, executive vice president of The Joint Commission stated "The Joint Commission did not dub pain assessment the 'fifth vital sign'."

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Principles of Adult Education for Infection Control Professionals

By Kimberly Tomas, MPH(c)

In accordance with CMS SS 482.42(c)(2)(iv), infection preventionists are responsible for competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of infection prevention and control guidelines, policies, and procedures. In the age of COVID-19, CMS has placed particular focus on educating and updating hospital staff on dynamic guidelines regarding a novel pathogen. Because education and training are so intertwined in our day-to-day activities as healthcare leaders, it is important to have a better understanding of the principles of adult education.

The first consideration to make when creating an effective education program is conducting a needs assessment. What areas are deficient amongst your staff or peers? Perhaps a recent Performance Improvement Committee meeting discussed a decrease in hand hygiene compliance last quarter, revealing an opportunity to revise current tools and re-educate staff on proper hand hygiene techniques and observation methods. A needs assessment will help determine the focus of your education, and the goals and objectives. Once a topic is in mind, assess the learning needs of your audience. Who will be attending your educational session? Residents? Nurses? EVS staff? Hospital Leadership? Each group will have varying learning needs and communication styles. Assess their learning needs by way of self-assessments, group discussions, questionnaires, knowledge assessment tests, observational studies, or a review of data/reports. Common concerns that may arise are the fear of embarrassment, fear of the unknown, fear of failure, and fear of stating an opinion. For these reasons, creating a safe environment is paramount to encourage active participation, which is discussed further down.

The next step in creating an education program is writing the goals and learning outcomes or objectives. The program goals are the overarching principles—this can be broad and more generalized (e.g. Increase Hand Hygiene Compliance). The program learning objectives must be S.M.A.R.T., that is specific, measurable, attainable, relevant, and time-bound (e.g. at the end of the training, attendees will be able to document hand hygiene observations accurately using the new hand hygiene observation form). Learning objectives can be in concordance with known competency standards, as well.

Once the goals and learning objectives are in place, consider the learning environment and begin preparing the content. An effective education program will refer to social behavioral models to facilitate an environment of experiential learning and thoughtful processing. One such model is Bloom's Taxonomy, a hierarchical order of cognitive skills (Bloom, Engelhart, Furst, Hill, Krathwhohl, 1956); which include cognitive (knowledge-based), affective (emotive-based), and psychomotor (action-based) elements. The six levels are remembering, understanding, applying, analyzing, evaluating, and creating. Each level has associated planning verbs that address the level of skill; examples of the verbs can be found at: https://www.teachthought.com/learning/what-is-blooms-taxonomy-a-definition-for-teachers/. A variety of methods such as questions posed in group discussions, knowledge checks, and interactive activities can fulfill each level.

The learning and environment can help or hinder your program. The learning environment should be an atmosphere of mutual respect, and comfortable and conducive to learning. Special considerations should be made for seating arrangement and eye-contact, audio/visual set-up, eliminating distractions, and providing an agenda that includes breaks. The seating arrangement should encourage discussion and interactions, and ensure visibility of the speaker/facilitator.

A variety of Instructional methods can make up an education program. Traditionally, hospitals have deployed symposiums, panels, and lectures. Yet, according to the National Training Laboratories, the average learning retention rates for lectures are only 5%; lecture, reading, and audio-visual combined make up 35%. The most effective instructional methods are group discussions (50%), practice by doing (75%), and teaching others (90%). Another important consideration is that on average, individuals can pay attention for only 15-20 minutes at a time, any longer and their attention spans wane. Methods that may be effective are: computer-based training (CBT) or webinars, interactive games, educational carts, videos, train the trainer, role playing, mentoring, and simulations. Each strategy has their advantages and disadvantages, so it is important to choose what will work best for the most people. A combination of methods can address a spectrum of learning styles. One consideration that is often overlooked is universal design. Not everyone has the same capabilities, so it is important to make your program as accessible as possible. Presentations should have easy-to-read font with high contrasting colors (dark on light or light on dark). The room chosen for the session should be accessible. When the education program is announced, contact information should be provided for those that have varying requirements. A tool that can assist in creating accessible programs can be found at: https://lincs.ed.gov/state-resources/federal-initiatives/teal/guide/udl

The last section of an effective education program is evaluation. Not only is it pertinent to investigate the effectiveness of your program through measurable change, but it is required to document who attended your educational session, what the take-aways were (learning objectives), and the feedback they can provide to improve the education program for the future. Elements should include: thoughts on program design, feedback on adequacy of teaching, and understanding of learning objectives (knowledge, skills, attitudes). Some evaluation approaches can include: pre- and post-test, direct observation of practice, exit questionnaires, or one-on-one, or group interviews.

In conclusion, education programs have the potential to be effective and fun. The facilitator must be flexible and creative and the content should be interesting, useful, and relevant for various levels of knowledge and learning styles. Thinking creatively and combining various elements/methods will provide the best programs.

References:

Bloom, B.S., Engelhart, M.D., Furst, E.J., Hill, W.H., Krathwohl, D.R. (1956). Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain. New York: David McKay Company.

Information adapted from two lectures by David Woodard, M.Sc., MT(AMT), CLS, CIC, CPHQ, FSHEA, and Michelle Epps, MSN, MPH, RN

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Guidance on Opioid Utilization

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There are numerous resources available from a variety of professional organizations, including:

American Society of Anesthesiology

Anesthesia Patient Safety Foundation

American Pain Society

The American Society for Pain Management Nursing

Responsible, Safe, and Effective prescription of Opioids for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines (2017)

References:

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"CMS Roadmap: Fighting the Opioid Crisis", Centers for Medicare and Medicaid, November 2019.

"The Journal of Family Practice", Vol.68, No.8, October 2019.

The Joint Commission R3 Report, Issue 11, August 29, 2017.

Nurse Practitioner - Orthopedic Specialty

By Margo Smith, RHIT (Retired), CPMSM, CPHQ

The need for certified nurse practitioners in orthopedics is growing, as the scope of the Allied Health Professional (AHP) is extending beyond the basic training for a nurse practitioner. As hospitals are beginning to see the increase of the orthopedic specialist, requesting that they be allowed to have their nurse practitioner join the AHP staff to assist them in orthopedic surgery being performed in a hospital setting.

The medical staff office will usually have a delineation of privilege form for a nurse practitioner, but the education and training required will be that of a nurse practitioner with no special training or certification in orthopedics. Many nurses have had "on the job" training, but may have a gap in training of the musculoskeletal system.

The medical staff leadership should begin to look at criteria that extends beyond the basic training of the nurse practitioner. In addition to having a valid nursing practitioner license, the criteria should include a certificate of training in orthopedics and board certification by the Orthopedic Nurses Certification Board.

The eligibility requirements for taking the exam include being a licensed registered nurse with two full years of nursing experience, as well as a minimum of 1,000 hours of experience in an orthopedic nursing practice within three years of taking the exam.

As hospitals want to ensure that they are providing the best treatment and care to their patients, they should also look to the medical staff leadership for guidance on experience training and certification of AHP specialties. Certification provides value to the nurses, the organization, the patients and the community.

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