The Opioid Crisis
A Shared Responsibility

By Laura Ramos Hegwer

Healthcare executives can take a leadership role in confronting the epidemic

Overdoses involving opioids, including prescription pain medications and heroin, killed more than 47,000 people in the United States in 2017, and more than one-third of those deaths involved a prescription opioid, according to the Centers for Disease Control and Prevention. And although the rate of prescription opioid-related deaths stabilized in most states from 2016 to 2017, the fact that one person dies from an opioid-related overdose every 12 minutes is a statistic that can't be ignored.

So what can healthcare executives actually do? They can—and should—play an important leadership role by bringing greater awareness to the problem and reducing the stigma surrounding addiction, says Jay Bhatt, DO, FACP, senior vice president and CMO, American Hospital Association.

Bhatt believes healthcare executives can be especially effective when they work alongside clinical leaders as stewards of their communities. "This is a shared responsibility," he says. Together, these leaders can engage their boards in building bridges with community organizations and develop philanthropic partnerships to address the issue.

Following are examples of organizations that have developed innovative strategies—from implementing IT-driven solutions to adding peer counselors in the ED—to confront opioid overprescribing, misuse and addiction.

Leveraging the EHR

Leading organizations are making the most of their investments in EHRs and other IT tools to help change opioid prescribing patterns.

Case Study: Anne Arundel Medical Center, Annapolis, Md.

According to a Kaiser Family Foundation analysis of CDC data, Maryland ranks among the top 10 states for opioid-related overdose deaths, and Anne Arundel County has one of the highest opioid death rates in the state. "We realize we need to be part of the solution,"

says Victoria "Tori" Bayless, president and CEO, and an ACHE Member. "This problem has evolved over the past 22 years, and it is not going to be solved in 22 months."

In January 2017, leaders at the not-for-profit regional health system set out to reduce opioid prescribing within their health system by 50 percent by 2019. It was an ambitious goal, considering that their prescribing levels were in line with their peers nationwide. Two years later, the health system exceeded its goal, cutting opioid prescribing by 67 percent, compared with its baseline quarter in February 2017.

Leaders are cautious not to set arbitrary goals that could compromise pain control for patients. "Our approach is to give patients all of the opioids they need but none that they don't," says Barry Meisenberg, MD, chair of the department of medicine and an oncologist. Meisenberg recently published results from a quality improvement study in *JAMA Network Open*, demonstrating that the reduction in opioid prescribing had no impact on patient satisfaction.

A key initiative was to accurately measure physicians' prescribing patterns and provide feedback that compared them with their peers. To complement this effort, CIO Dave

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Lehr developed a dashboard to help prescribers visualize how much they prescribed and help drive accountability. The initiative was led by a task force that included medical directors from key service lines who set new opioid prescribing protocols and provided input on which metrics mattered most to them. His team also worked with clinical leaders to adjust order sets in the EHR to make it easier for clinicians to prescribe less.

Additionally, Lehr's team built a tool in the patient portal to help prescribers track the amount of opioids that patients actually took—which was often less than prescribed. In many cases, patients only used opioids on their clinician's recommendation, not because they were in pain. "When doctors saw that feedback from their own patients, it was powerful and helped to change their prescribing patterns," Lehr says.

Forging Community Partnerships

Experts stress the need for healthcare executives to partner with law enforcement, government agencies, mental health groups, schools, local media and other organizations. By working together, organizations can avoid duplicating efforts and use their resources more effectively.

Case Study: Intermountain Healthcare, Salt Lake City

In 2015, the not-for-profit system of 22 hospitals launched a consortium of public and private organizations called the Opioid Community Collaborative. A. Marc Harrison, MD, president and CEO, believes community partnerships like the collaborative are essential for battling the opioid epidemic in states like Utah, which had one of the highest opioid-involved death rates in 2017, according to CDC data.

"At Intermountain Healthcare, we understand that to address the opioid epidemic, we needed the help of our communities and our caregivers," says Harrison, who is also an ACHE Member. "Providers have been able to achieve prescribing reductions by adopting prescribing guidelines for acute conditions and seeking feedback from patients about the number of tablets used to guide future prescribing. We also engaged community partners and empowered our patients to have a conversation with their doctors about the risks of opioids."

Additionally, Intermountain distributes naloxone (used to reverse opioid overdose) at low cost and without prescription at its community pharmacies, says Lisa Nichols, associate vice president of community health. From January 2018 through November 2018, the pharmacies had dispensed more than 850 naloxone kits. Intermountain also distributed, free of charge, more than 1,700 kits through its traveling speakers bureau, which includes pharmacists who educate rural and underserved communities on opioid use.

Provider education is another priority. Until 18 months ago, most clinicians did not understand the magnitude of the opioid problem, says David Hasleton, MD, CMO. Since then, service-line leaders have been developing prescribing targets by specialty and procedure. For example, orthopedic service-line leaders convened spine surgeons to discuss variations in opioid prescribing

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following a multilevel laminectomy procedure. After reviewing the blinded data—which showed no difference in outcomes among patients whose surgeons prescribed 30 pills versus 120 pills—leaders set a new prescribing standard.

As a result of these efforts, the organization reduced the average number of opioid tablets prescribed by nearly 1.8 million. "The reduction was difficult to achieve, and we have found that each incremental percentage change now is exponentially more difficult," Hasleton says. "It takes more and different tactics to accomplish an even higher goal."

Looking ahead, Harrison says Intermountain will continue to push forward on its opioid-reduction goals. Some tactics for the coming year will build on the health system's IT capabilities. To help providers comply with a new state law that requires clinicians to check the state's controlled substance database before an acute opioid prescription is perscribed to a patient for the first time, Intermountain will integrate its EHR with the database, sometimes referred to as a prescription drug monitoring program, by the end of the first quarter of 2019.

Leaders also are focusing on how to reduce opioid-related safety events among inpatients (See web extra, "Preventing Harm From Opioids in Hospital Settings" on **healthcareexecutive.org**). For example, they are using EHR tools to assign morphine milligram equivalent values to drugs that patients already take to avoid potential overdoses if they receive opioids in the hospital.

Providing Peer Counselors in the ED

Innovative organizations recognize that addressing the opioid epidemic in their communities means targeting addicted patients where they are most likely to interface with the health system: in the ED.

Keeping an Eye on Legislation

Many healthcare executives are encouraged by the 2018 passage of the bipartisan Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, which has been applauded by the AHA. Lisa Nichols, assistant vice president of community health at Intermountain Healthcare, says the act normalizes addiction treatment as an integral part of clinical care and thus reduces the stigma of addiction.

Among its many provisions, the act improves access to treatment for Medicaid patients and requires state Medicaid programs to cover medication-assisted treatment. It also authorizes grants to improve prescription drug monitoring programs and eases requirements for sharing PDMP data across states. Additionally, the act mandates electronic prescribing for controlled substances covered by Medicare by January 2021.

Yet policymakers' work is far from done. "It's really important for healthcare executives to be active in supporting legislation and policies that help us combat the opioid crisis," says Marilu Bintz, MD, FACS, senior vice president of population health and strategy at Gundersen Health System, La Crosse, Wis., and an ACHE Member. This includes policy changes that support reimbursement for and financing of providers' efforts. Ultimately, Bintz believes that "solving the opioid crisis has huge implications for lowering the cost of care."

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Case Study: Gundersen Health System, La Crosse, Wis.
To help prevent more opioid-related deaths, the not-for-profit system with seven hospitals in Wisconsin and Iowa has launched a pilot program in its main campus' ED that provides peer support counselors to talk with individuals who survive an overdose and try to get them the immediate help they need.

"If you can catch someone after a near-death experience from these overdoses, you can have more influence with getting them into treatment," says Chris Eberlein, MD, an emergency medicine specialist.

Eighteen months ago, Gundersen also integrated the state's enhanced prescription drug monitoring program database with its EHR so providers can easily check patients' medication usage to determine if they may be obtaining opioids from several sources or potentially diverting medication. Gundersen also maintains a pain registry that alerts clinicians to patients' opioid usage via the EHR.

Giving clinicians and IT staff time to work on such strategies should be a priority for healthcare executives, says Marilu Bintz, MD, FACS, senior vice president of population health and strategy, and an ACHE Member.

Like Anne Arundel Medical Center and Intermountain, Gundersen has entered into community partnerships to address the opioid epidemic. In August 2018, the health system joined with Mayo Clinic, the La Crosse Community Foundation and the La Crosse County Health Department to form the Alliance to HEAL (Halting the Effects of Addiction Locally). The alliance is working with the Institute for Healthcare Improvement to improve patient access to addiction treatment while decreasing the utilization of opioids. Gundersen and its alliance partners also are exploring building residential treatment facilities in the community.

Bintz believes healthcare executives should approach community partnerships as aggregators, or conveners, to avoid dictating a particular strategy. "To be good partners in the community, we need to be good listeners to understand what the community needs," she says.

Learning From the Leaders

The previous case studies demonstrate the importance of taking a multipronged approach to address the opioid

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epidemic. The following are tactics to confront the crisis. (Additional tactics can be found in the online version of this article.)

Create a taskforce. Bhatt of AHA recommends that C-suite executives appoint a multidisciplinary team in their organizations to develop a system-level response to the opioid crisis.

Establish bold goals. At Anne Arundel Medical Center, leaders list reducing opioid prescribing as a goal on their annual operating plan to enhance its visibility.

Adjust the default settings in your EHR order sets. Anne Arundel Medical Center adjusted order sets to include smaller opioid doses and fewer pills per prescription.

Use prescribing data to spur behavior change among clinicians. Bhatt urges organizations to expand their provider education, a strategy he covered in a recent article for *NEJM Catalyst*.

At Intermountain, leaders gained the most traction when they combined in-person opioid education with dashboards showing clinicians' own prescribing data.

Don't focus solely on specialists. Hasleton of Intermountain advises other organizations to be inclusive and engage advanced practice clinicians and primary care physicians in their opioid-reduction initiatives early on.

Provide public education on opioids. Comprehensive public awareness campaigns can help quell demand and promote more meaningful conversations between providers and patients, Gundersen's Eberlein says.

At Anne Arundel Medical Center, the marketing department developed a public education campaign via print and social media that covered the risks of opioids and suggested opioid alternatives.

Improve access to medication-assisted treatment for those struggling with addiction. During the past three years, Intermountain has worked with two counties in Utah to expand access to MAT, which incorporates methadone, naltrexone and buprenorphine to treat opioid addition. Later in 2019, Intermountain will offer MAT through its 24-hour behavioral health access centers.

Tap into existing resources. The AHA has released a toolkit, "*Stem the Tide: Addressing the Opioid Epidemic*," that provides strategies for hospitals.

Leaders also can review the Electronic Health Record Association's "*CDC Opioid Guideline: Implementation Guide for Electronic Health Records*," which offers suggestions on using EHR-based tools to follow CDC recommendations on opioids.

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