Collaborating to Prevent Opioid Abuse: What Does That Mean?

David Reagan, MD PhD
Chief Medical Officer
Tennessee Department of Health
November 13, 2017

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

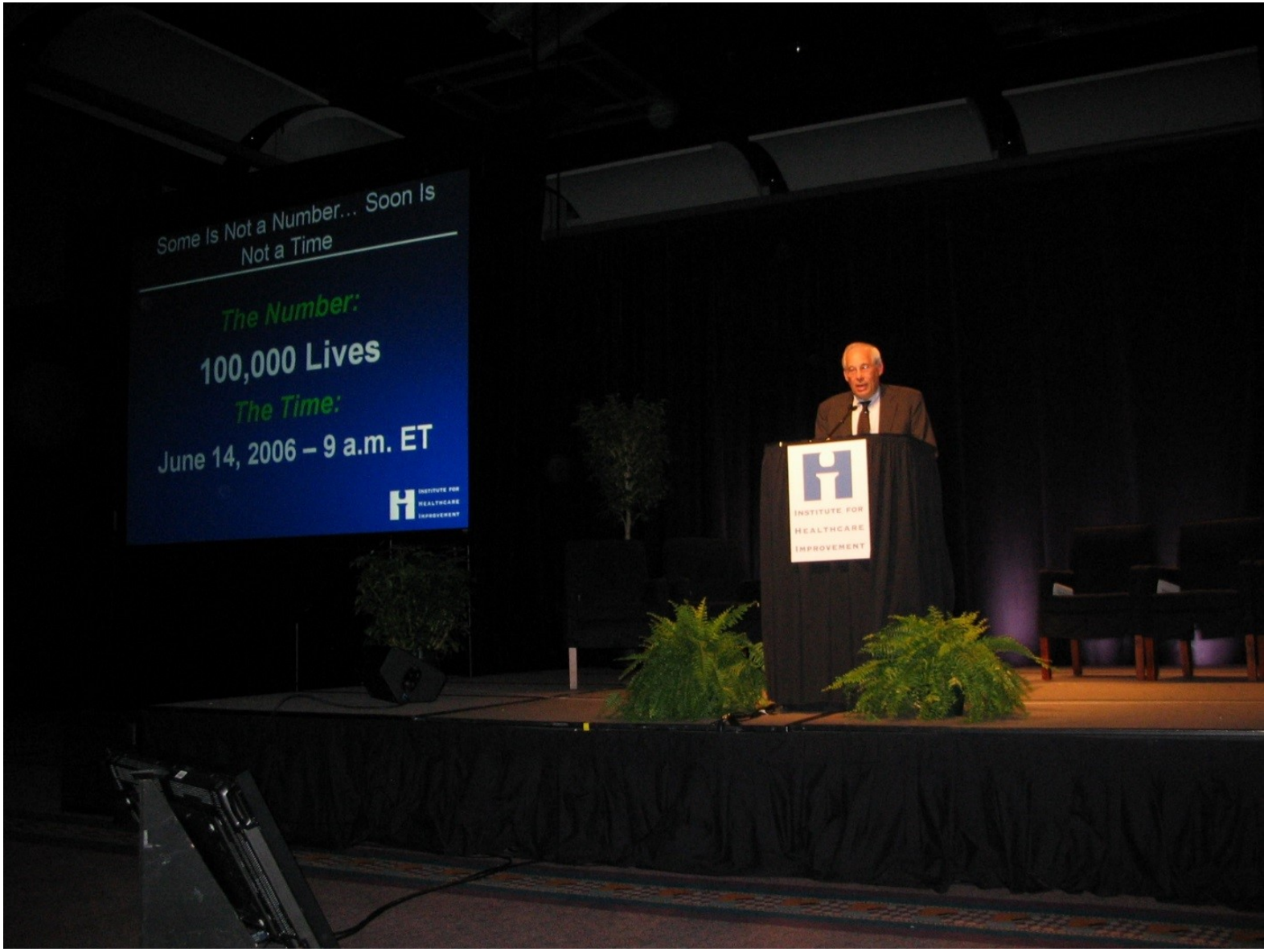
IHI 100,000 Lives Campaign

- 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."

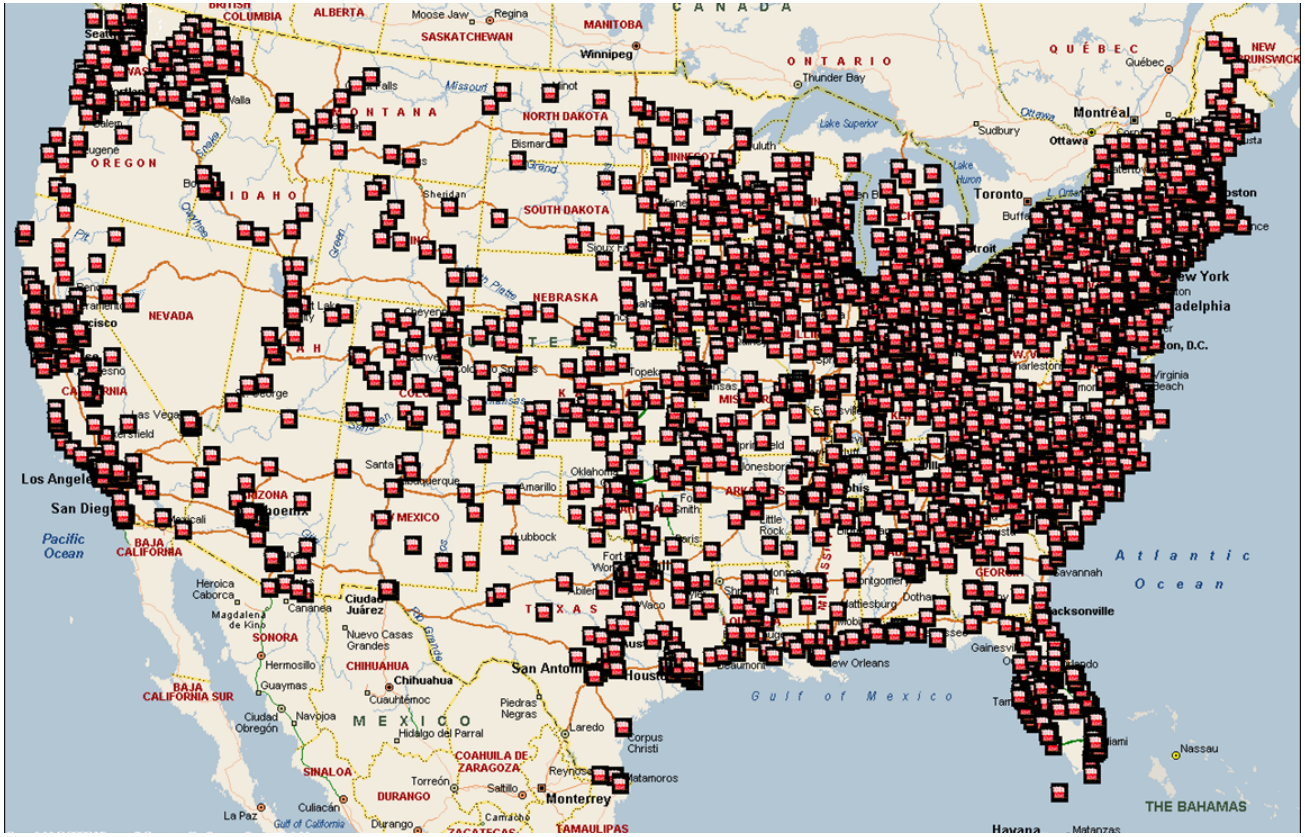

Some Is Not a Number… Soon Is Not a Time
The Number:
100,000 Lives
The Time:
June 14, 2006 – 9 a.m. ET
INSTITUTE FOR HEALTHCARE IMPROVEMENT

IHI 100,000 Lives Kickoff
December 2004, Orlando, FL

"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

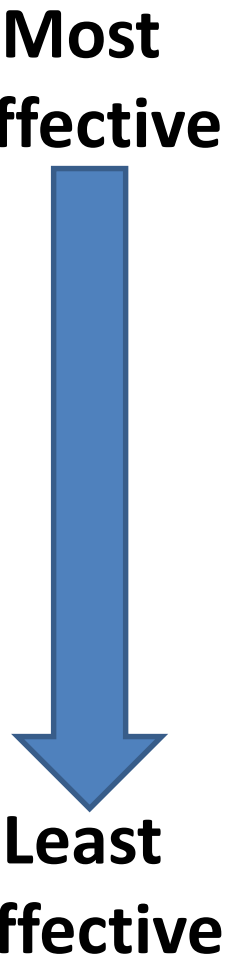
- **Evidence to guide practice**
- **Impact on morbidity and mortality**
- **Variation in practice**
- **Ability to change practice**

Selected Dots

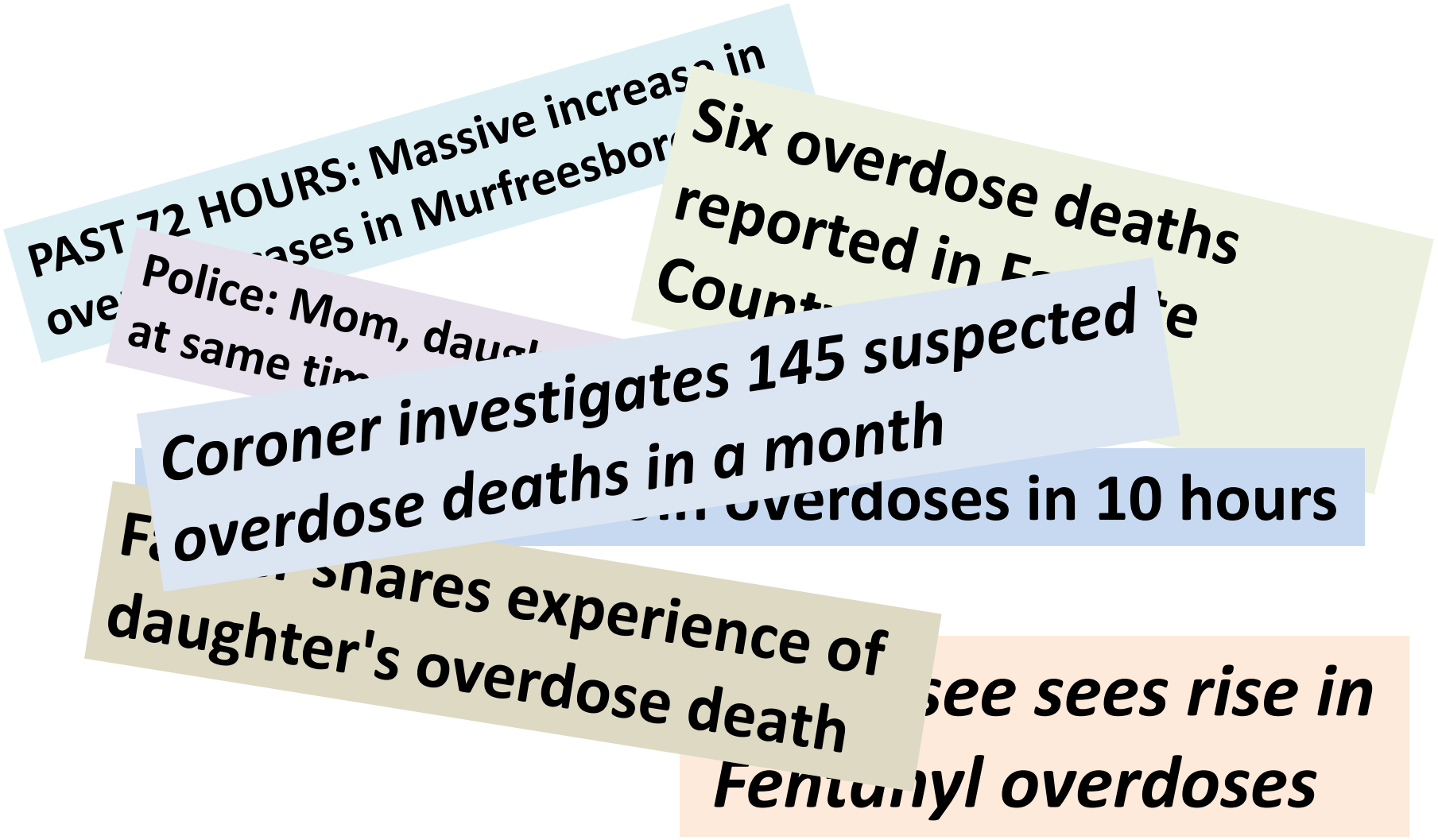
- **Patient Education**
- **Prescriber Education**
- **Perioperative pain management**
- **ED pain management**

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?

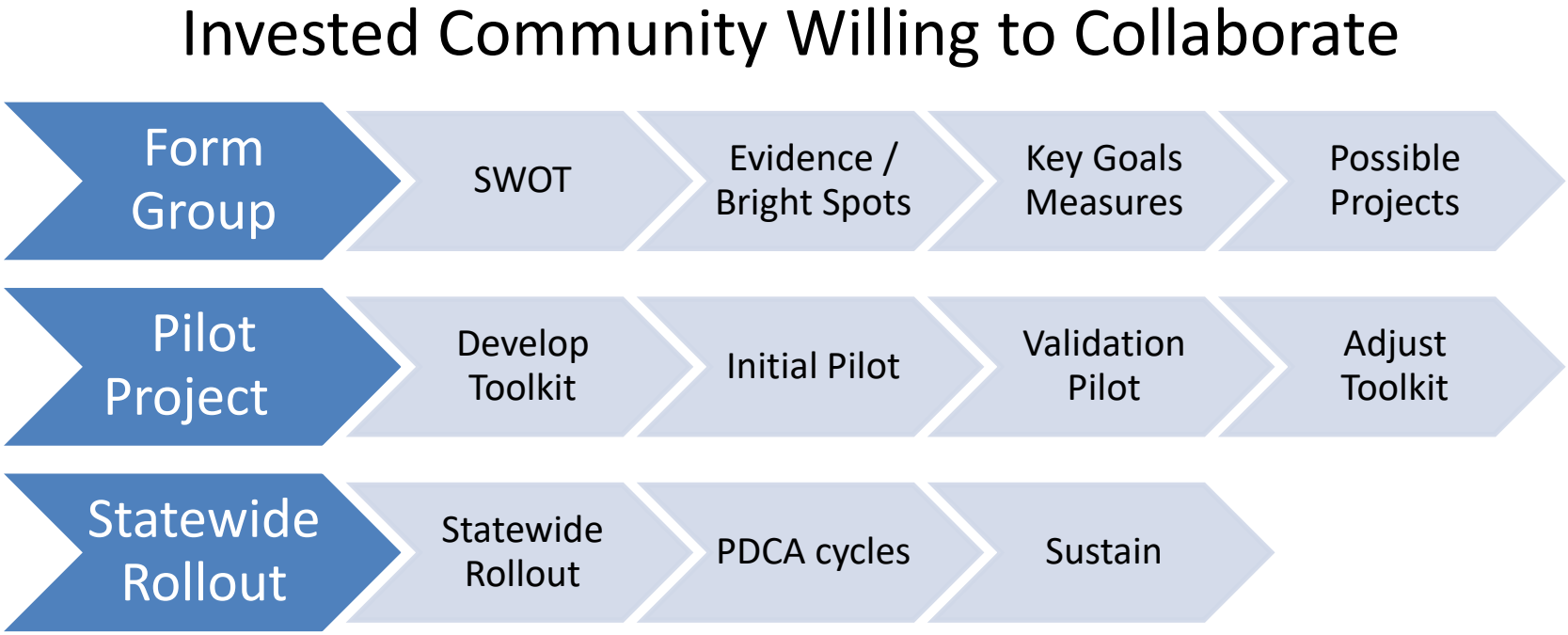


Collaboration In Healthcare

- **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)



Projects Matrix

Project	Team Meeting	Aim & Charter	Measures	Compiling Toolkit	IRB reviews	Data Agreement	Pilot	State Kickoff	Huddle #	Sustainment
Temperature									11	
CLABSI									16	
HM4NICU									12	
39 weeks								*	6	
Antenatal BFP								*	6	
UCCHD									3	

*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.

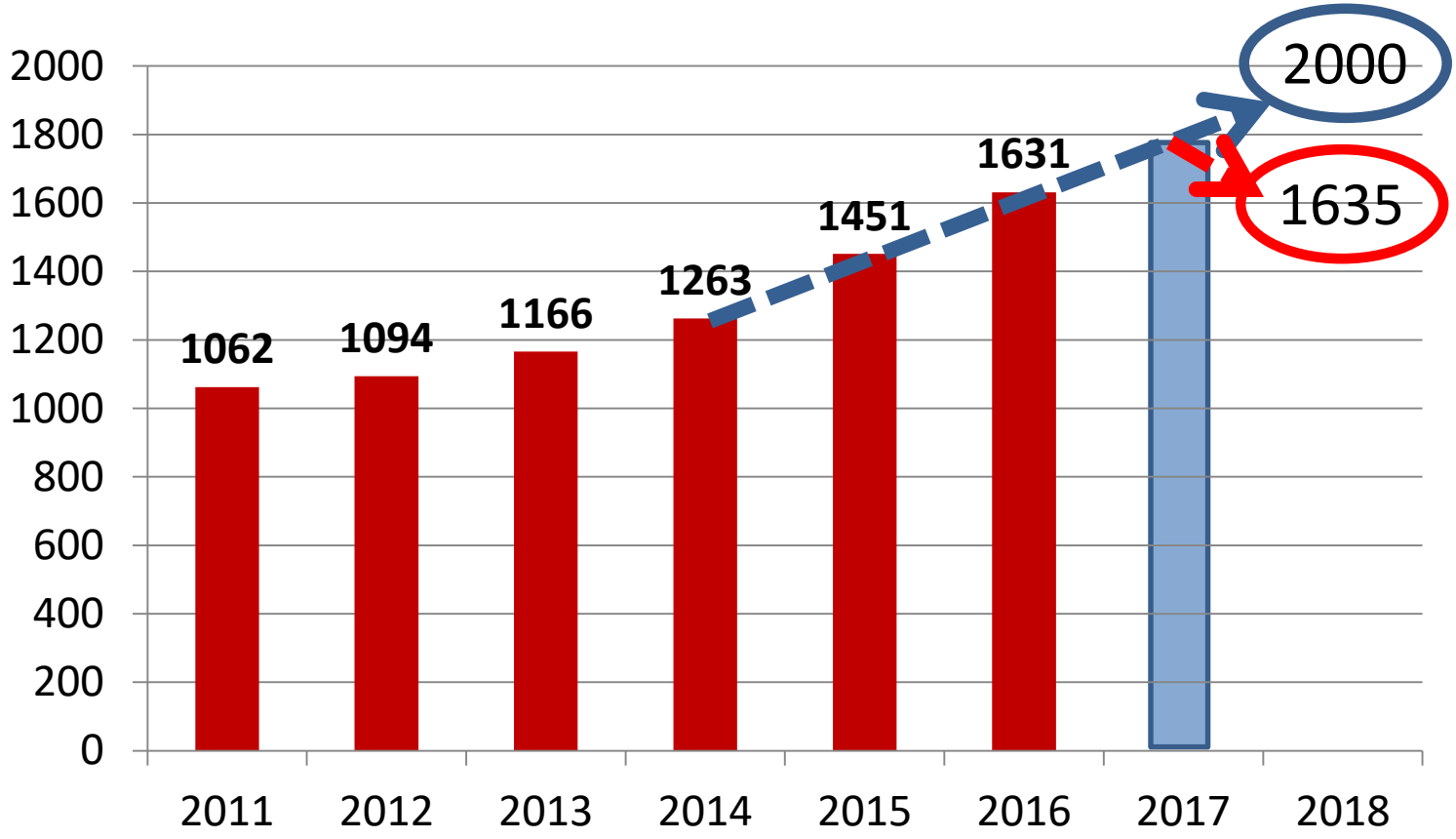
The number is 365 LIVES SAVED.

The time is NOW.

The ONE YEAR goal is achievable,

and we need your help."

How Will We Know When We Succeed?



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.”

Donald M. Berwick, MD