Educational Webinar

January 10, 2019

Noon - 1 p.m.

Developing and Enhancing Your Opioid Stewardship Program

For Audio, please call the following:

U.S. and Canada Toll Free: (800) 239-9838
Required Participant Passcode: 6919935

In Partnership

This webinar, the first in a series of upcoming offerings, is part of an opioid safety provider education initiative developed in partnership with the Kansas Hospital Association/Kansas Medical Society Joint Committee on Opioid Use.

Funding Acknowledgment

Funding for this webinar was provided by the Prescription Drug Overdose: Data-Driven Prevention Initiative (Federal Grant Award Number 6 NU17CE924868-03-01), a cooperative agreement between the Kansas Department of Health and Environment and the Centers for Disease Control and Prevention.

Opioid Stewardship in the Health System

January 10, 2018

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Stormont Vail Health

Disclosures

- Nothing to disclose

Learning Objectives

- Brief discussion of Opioid Epidemic in US
- Development and implementation of Opioid Stewardship Program
  - Identification of stakeholders, resource development, assessment of progress, target relevant patient populations and areas of practice
- Implementation of system wide strategies to improve opioid stewardship
  - KTRACS integration, documentation, duration of therapy, dose reduction strategies, scheduled drug agreements
- Education of prescribing providers and staff regarding best practices

Background

- An estimated 100 million Americans report chronic pain.
- The estimated economic cost of chronic pain is over $600 billion annually
  - Combined for cost of treatment (up to $300m) and lost productivity (up to $335m)
- Chronic pain may be a symptom of another chronic disease (diabetic neuropathy, cancer pain, arthritis, etc.) or may be a disease on its own (fibromyalgia, vulvodynia, migraine, etc.)

Background

The Opioid Epidemic in the U.S.

In 2015...

12.5 million People misused prescription opioids[1]

2.1 million People misused prescription opioids for the first time[1]

33,091 People died from overdosing on opioids[2]

2 million People had prescription opioid use disorder[1]

15,281 Deaths attributed to overdosing on commonly prescribed opioids[2,3]

828,000 People used heroin[1]

9,580 Deaths attributed to overdosing on synthetic opioids[2,5]

135,000 People used heroin for the first time[1]

12,989 Deaths attributed to overdosing on heroin[2,4]

$78.5 billion In economic costs (2013 data)[6]

Sources: [1] 2015 National Survey on Drug Use and Health (SAMHSA). [2] MMWR. 2016; 65(50-51):1445–1452 (CDC). [3] Prescription Overdose Data (CDC). [4] Heroin Overdose Data (CDC). [5] Synthetic Opioid Data (CDC). [6] The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. Florence CS, Zhou C, Luo F, Xu L. Med Care. 2016 Oct;54(10):901-6

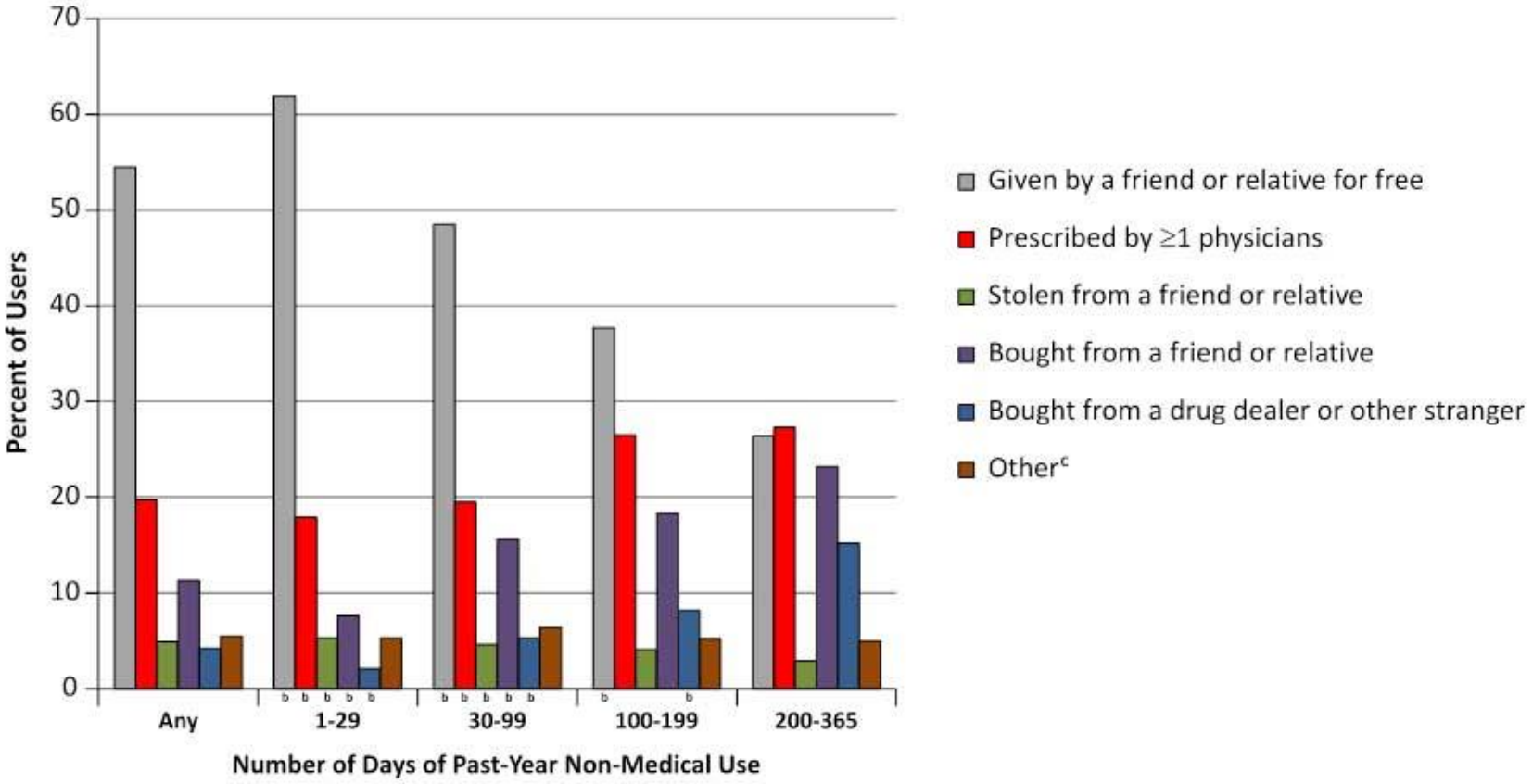
Background- Opioid Epidemic

- 214,881,622

(number of opioid Rx written in 2016)

- 2006 Opioid Rx rate: 72.6 prescriptions per 100 persons
  - Opioid Rx rate peaked in 2012
  - Current Rate (2016) 66.5 Rx/100 persons
- Estimated that ~47 million Americans misuse prescription drugs
- Average Milligram Morphine Equivalent (MME) prescribed per person/year
  - 1999: 180
  - 2015: 640

Sources of Prescription Opioids Among Past-Year Non-Medical Users[a]



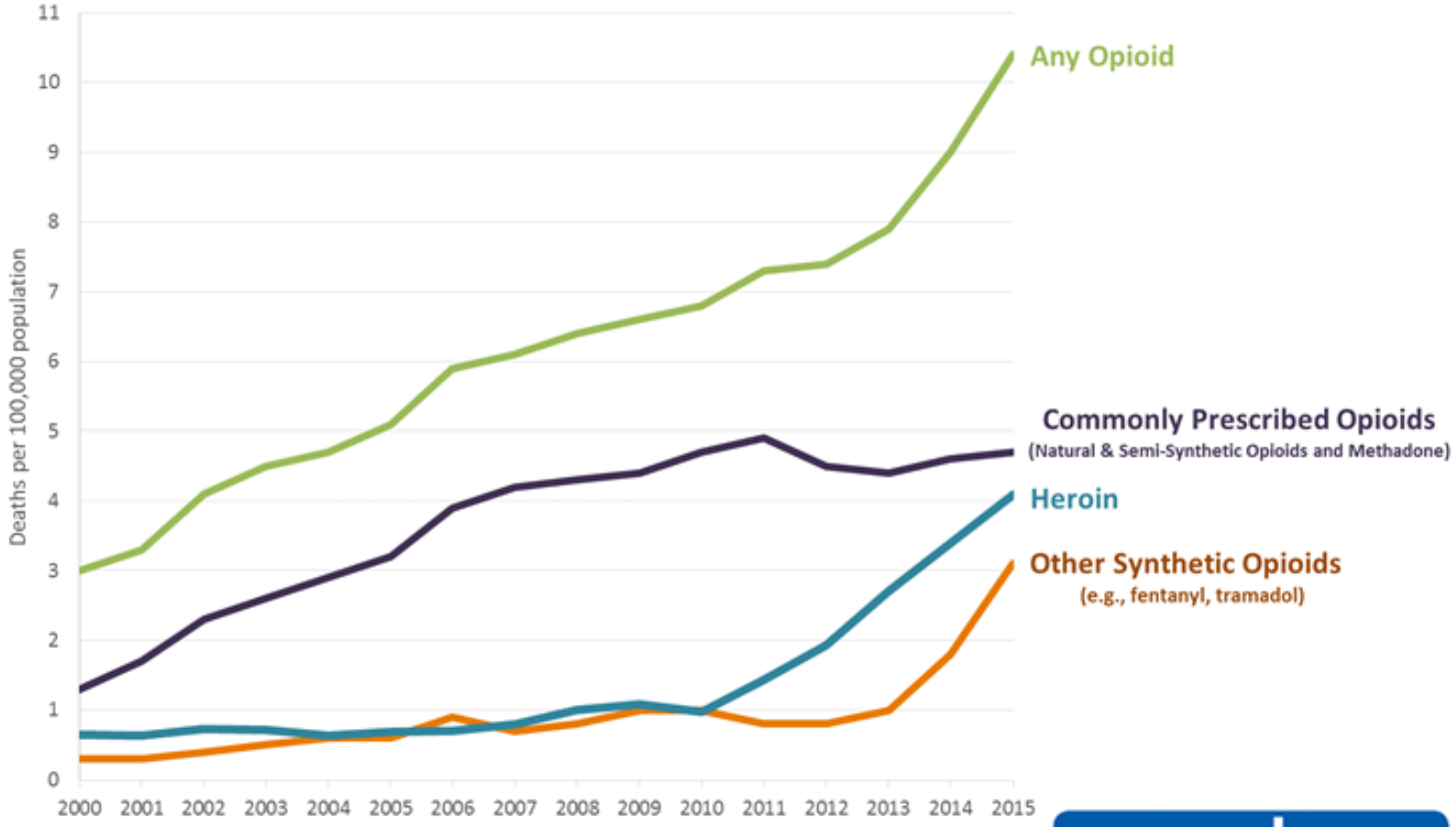
[a] Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.[5]
[b] Estimate is statistically significantly different from that for highest-frequency users (200-365 days) ($P < .05$).
[c] Includes written fake prescriptions and those opioids stolen from a physician's office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.

SOURCE: Jones C, Paulozzi L, Mack K. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use: United States, 2008–2011. JAMA Int Med 2014; 174(5):802-803.

Opioid Overdose Deaths

- 2015: 52,404 drug related overdose
  - Opioids involved in 33,067 (63.1%)
  - Most common co-ingestant: benzodiazepines
- Heroin was implicated in 12,989 OD deaths
- Rx opioids implicated in 12,727 OD deaths
- 2014: 418,313 estimated ED visits for nonfatal unintentional drug poisoning
  - Opioids accounted for 92,262 (22.1%) of visits
  - Cocaine and methamphetamine accounted for 17,436 (4.17%) combined

Overdose Deaths Involving Opioids, United States, 2000-2015



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.

www.cdc.gov
Your Source for Credible Health Information

CDC Guideline, 2016

- Goal: Provide primary care providers with guidance for using opioids for chronic non-cancer pain.
- NOT for the provision of pain management for patients at end of life.
- Evidence based, built on Agency for Healthcare Research and Quality 2014 report on risks and benefits of opioid therapies for pain.
  - Evaluated 5 Key Questions (KQ)
  - Risk of harm (ADE, OD, misuse) v benefit (pain control, increase in functioning, quality of life)

CDC guideline, 2016

- KQ 1- Effectiveness and comparative effectiveness
- KQ2- Harms and Adverse Drug Events
- KQ4- Risk Assessment and Mitigation Strategies
- KQ5- Effect of Opioid Therapy for Acute Pain on Long Term Use

- KQ3- Dosing strategies
  - comparative effectiveness of different methods for initiating and titrating opioids
  - Comparative effectiveness of immediate release opioids v ER/LA
  - Scheduled dosing vs PRN only
  - Dosing thresholds and dose escalation
  - Effect of tapering, and tapering strategies

Guideline Overview

- “Avoid increasing doses to > 90MME/day, or carefully justify a decision to titrate to doses > 90MME/day”
- CDC discourages opioid prescriptions > 3 days in length for acute pain
- Long acting opioids are not used for acute pain
- Before starting, and periodically during continuation of opioid therapy, clinicians should *evaluate risk factors for opioid-related harms*.
- *Monitoring PDMP (KTRACS) data during treatment* is advised, at a frequency of at least quarterly

The Joint Commission (TJC) Requirements

- Published June 2017, Effective 1/1/2018
- LD.04.03.13 Pain management and safe opioid practices are institutional priorities
  - *Access to PDMP*
  - *Providing non-pharmacologic therapy*
  - *Assessment of high risk patients*

- PI.01.01.01
  - Data collection on pain therapies and their efficacy

- PI.02.01.01
  - Data analysis for quality and safety improvement
  - Monitoring opioid ordering for safe use

Developing and Implementing Health System Strategies for

OPIOID STEWARDSHIP

Development

- Identify relevant stakeholders
  - Administration
  - Pharmacy
  - Information Technology
  - Nursing
  - Prescribing providers!

Stormont Vail Team

- VP level Administrators
- Director of Pharmacy
- Pharmacy Clinical Director
- Clinical Informatics Pharmacist
- Clinical Pharmacist
- Clinical Informatics Manager
- Clinical Informatacists
- Director Accreditation and regulatory affairs
- Medication Safety Coordinator
- Administrative Director of Med/Surg
- Physician advisor of Clinical Informatics
- Physician representatives from Primary Care, Emergency Medicine, Surgery, Palliative Medicine
- Nurse Managers post surgical and medical floors
- Education and Talent Development representative

Development

- Once relevant stakeholders are identified:
  - Form dedicated Opioid Stewardship Team
    - Meet on regular intervals
  - Obtain support
  - Engage relevant staff
  - Assess organizational practices

Development

- Obtain buy-in and support
  - Assess barriers to change
  - Assess current practices
    - Leverage EMR for data collection
    - Identification of areas for improvement
      - KTRACS
      - Days supply on acute Rx
      - Tablet Quantities
      - Non-opioid therapies
      - Work flow/documentation
      - Scheduled drug agreements

Development

- Assessments:
  - CDC Organizational Self Assessment. https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf
  - ISMP Medication Safety Self Assessment for High-Alert Medications. Opioids. 2018. https://www.ismp.org/assessments/high-alert-medications

CDC Organization Self Assessment

- Two part questionnaire
  - Part One
    - Baseline assessment of current culture/practices
    - Encompasses many of the ideas already touched upon, and individualizes it to your organization
  - Part 2
    - Evaluation of prescribing practices as they relate to providers in your organization and how they relate to the CDC guideline

Development

- Resource development
  - Evidence based guidelines (CDC, CMS, VA etc.)
    - Tailor to organizational needs
      - Focused on identified areas for practice improvement
      - Develop organizational policies and procedure using this framework
  - Integrate new practices/workflows into EMR
    - KTRACS integration
    - New order sets
    - Documentation work flows
      - Drug Agreements
      - Screening tools
      - Quantity defaults

Development- Resources

- AHRQ and CDC 6 Building Blocks. https://www.improvingopioidcare.org/

- Department of Veterans Administration Opioid Therapy Clinical Practice Guidelines, 2017. https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf

- Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain. 2018. https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

Development- Evaluation

- Developing tools to evaluate progress
  - Develop measureable and useful endpoints
  - Leverage discreet data from EMR
    - Use to evaluate progress in previously identified areas
  - Chart Reviews

Practice and Patient Selection

- Inpatient areas
  - Emergency Department
  - Post Surgical
  - Other Acute Care functions
- Outpatient Areas
  - Primary Care
  - Outpatient Acute Care
  - Chronic pain patients (exclusionary diagnoses)

Implementation

- Goal setting
  - Realistic and measurable
    - % of prescriptions within certain days supply
    - % of KTRACS monitoring prior to new Rx
    - UDS monitoring
    - Drug Agreements
  - Selection of appropriate time periods

Practice and Patient Selection

- Select which guideline recommendations to implement
  - Prioritization
    - Based on identified gaps/areas for improvement
  - Implementation
  - Data Collection
  - Analysis
    - Determine frequency, reporting, who will review, what will be done with the data

Stormont Vail New Opioid Rx Measures

- Percentage of patients with a new opioid prescription for an immediate-release opioid.
- Percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing.
- Percentage of patients with a new opioid prescription for acute pain for a 3 days' supply or less.
- Percentage of patients with a follow-up visit within four weeks of starting an opioid for chronic pain
- Percentage of patients with a new opioid prescription for chronic pain with documentation that a urine drug screen was performed prior to prescribing

Long Term Opioid Measures (SV)

- The percentage of patients on long-term opioid therapy:
- who are taking 50 MMEs or more per day.
- who are taking 90 MMEs or more per day.
- who received a prescription for a benzodiazepine.
- who had a follow-up visit at least quarterly.
- who had at least quarterly pain and functional assessments.
- who had documentation that a PDMP was checked at least quarterly.
- who the clinician counseled on the risks and benefits of opioids at least annually.
- with documentation that a urine drug test was performed at least annually.

Long Term Opioid Measures contd.

- The percentage of patients on long-term opioid therapy who were counseled on the purpose and use of naloxone, and either prescribed or referred to obtain naloxone.
- The percentage of patients with chronic pain who had at least one referral or visit for non-pharmacologic therapy as a treatment for pain.
- The percentage of patients with an opioid use disorder (OUD) who were referred to or prescribed medication assisted treatment (MAT).

Implementation

- Which guideline(s)?
- Which recommendations?
  - Prioritize based on Self Assessment
- Which Practice areas?
- What analysis will be done?

Implementation- Facilitation

- USE THE EMR
  - Data outputs
  - KTRACS integration
    - Tracking?
  - Quantity defaults
  - Opioid Toolkit

Tool kits/Order Sets

- Develop opioid order sets
  - Standardized defaults
    - Quantity limits
    - Opioid tolerant vs naïve
      - While still providing options for flexibility based on patient variability

Opioid tools

- Standard use pathway (Stormont Vail)
  - Includes option for standard opioid agreement
  - Includes documentation of a risk assessment
  - Populates recommended labs (UDS)
  - Encourages non-pharmacologic/non-opioid therapy first
  - Has KTRACS integration (and data capture)
  - Documentation of risk/benefit
  - Documentation of clinician reasons for Exceeding maximum Morphine Milligram Equivalents (MME)

Opioid Smart Pathway

Pain Management [65]

Pain Management Principles

1) Prioritize Non-Pharmacologic Measures.
2) Consider Non-Opioid Pharmacologics prior to Opioid.
3) Continue Non-Pharmacologic and Non-Opioid treatments after Opioids are started.

Review/Reassess PEG scores — **URL:** EpicACT:custom_pain_management

Opiate Use Pathway — **URL:** \\stormontvail.org\epic\EpicFileShare\Ambulatory\Opiate Use Pathway.pdf

K-TRACS — **URL:** https://kansas.pmpaware.net/login

Urine Drug Screening Elements — **URL:** http://svppm/dotNet/documents/?docid=35554&mode=view

Diagnoses

Diagnoses

☐ Neck pain	Cervicalgia
☐ Thoracic pain	Pain in thoracic spine
☐ Lumbar pain	Lumbago
☐ Fibromyalgia	Mylagia and myositis, unspecified
☐ Neuropathic pain	Neuralgia, neuritis, and radiculitis, unspecified
☐ Radiculopathy	Neuralgia, neuritis, and radiculitis, unspecified

Labs

Labs

Lab info coming soon — **URL:** http://svppm/dotNet/documents/?docid=33493&LinkedFromInsertedLink=true

☐ ToxASSURE Select	■ Routine, ONCE Copies to non-Cotton providers(limit 3):
☐ Opiates Confirmation MedWatch	■ Routine, ONCE Copies to non-Cotton providers(limit 3):
☐ Drug Screen (8) Medical	■ Routine, ONCE Copies to non-Cotton providers(limit 3):
☐ Urinalysis, reflex culture if indicated	■ Routine, ONCE Copies to non-Cotton providers(limit 3):
☐ Basic metabolic panel	■ Routine, ONCE Should the patient be fasting for this test?
☐ CBC and differential	■ Routine, ONCE
☐ Comprehensive metabolic panel	■ Routine, ONCE Should the patient be fasting for this test?
☐ C-reactive protein	■ Routine, ONCE

Imaging

Imaging

☐ XR Spine Cervical (4 or 5 views)	■ Routine, 1 TIME IMAGING Reason for exam: Is the patient pregnant?

☐ XR Thoracic Spine (3 views)	■ Routine, 1 TIME IMAGING Reason for exam: Is the patient pregnant? Interpreting?
☐ XR Lumbar Spine (4+ views)	■ Routine, 1 TIME IMAGING Reason for exam: Is the patient pregnant? Interpreting?
☐ MRI Cervical Spine (without contrast)	■ Routine, 1 TIME IMAGING Is the patient pregnant? Sedation requirement?
☐ MRI Cervical Spine (with and without contrast)	■ Routine, 1 TIME IMAGING Is the patient pregnant? Sedation requirement?
☐ MRI Thoracic Spine (without contrast)	■ Routine, 1 TIME IMAGING Is the patient pregnant? Sedation requirement?
☐ MRI Thoracic Spine (with and without contrast)	■ Routine, 1 TIME IMAGING Is the patient pregnant? Sedation requirement?
☐ MRI Lumbar Spine (without contrast)	■ Routine, 1 TIME IMAGING Is the patient pregnant? Sedation requirement?
☐ MRI Lumbar Spine (with and without contrast)	■ Routine, 1 TIME IMAGING Is the patient pregnant? Sedation requirement?

Medications & Treatments

Non-Pharmacologic

Non-Pharmacologic

☐ CERVICAL SPRAIN EASY-TO-READ (ENGLISH)	CERVICAL SPRAIN EASY-TO-READ (ENGLISH)
☐ CHRONIC BACK PAIN (ENGLISH)	CHRONIC BACK PAIN (ENGLISH)
☐ LOW BACK SPRAIN REHAB-SPORTSMED (ENGLISH) (aka low back pain)	LOW BACK SPRAIN REHAB-SPORTSMED (ENGLISH)
☐ CRYOTHERAPY EASY-TO-READ (ENGLISH) (aka ice for injuries)	CRYOTHERAPY EASY-TO-READ (ENGLISH)
☐ HEAT THERAPY EASY-TO-READ (ENGLISH)	HEAT THERAPY EASY-TO-READ (ENGLISH)
☐ HOW TO INCREASE YOUR LEVEL OF PHYSICAL ACTIVITY (ENGLISH) (aka exercise)	HOW TO INCREASE YOUR LEVEL OF PHYSICAL ACTIVITY (ENGLISH)

Non-Opioid

Non-Opioid

☐ acetaminophen (TYLENOL) 500 MG tablet	500 mg, Oral, EVERY 6 HOURS PRN, Routine
☐ ibuprofen (ADVIL,MOTRIN) 200 MG tablet	200 mg, Oral, EVERY 6 HOURS PRN, Routine
☐ naproxen (NAPROSYN) 500 MG tablet	500 mg, Oral, 2 TIMES DAILY WITH MEALS, Routine
☐ celecoxib (CELEBREX) 200 MG capsule	200 mg, Oral, 2 TIMES DAILY, Routine
☐ lidocaine (LIDODERM) 5 %	1 patch, Transdermal, EVERY 12 HOURS, Routine
☐ Gabapentin, Once-Daily, 300 & 600 MG MISC	Oral, Routine
☐ diclofenac (VOLTAREN) 1 % gel	Topical, 4 TIMES DAILY, Routine Apply topically to:

Short Acting Opioid (Opiate Naive)

Short-Acting Opioid

- [ ] I have determined that the use of a short acting opiate is the most appropriate medication intervention at this time based on this patient's history and pain presentation

Short-Acting Opioid

[ ] traMADol (ULTRAM) 50 MG tablet	50 mg, Oral, EVERY 6 HOURS PRN, Starting today, Routine
[ ] HYDROcodone-acetaminophen (NORCO) 5-325 MG tablet	1 tablet, Oral, EVERY 6 HOURS PRN, Routine
[ ] HYDROcodone-acetaminophen (NORCO) 7.5-325 MG tablet	1 tablet, Oral, EVERY 6 HOURS PRN, Routine
[ ] oxyCODONE (ROXICODONE) 5 MG immediate release tablet	5 mg, Oral, EVERY 6 HOURS PRN, Routine
[ ] oxycodone-acetaminophen (PERCOCET) 5-325 MG	1 tablet, Oral, EVERY 6 HOURS PRN, Routine

Long Acting Opioid

Long-Acting Opioid

- [ ] I acknowledge that consideration for a non-pharmacological, non-opioid and short-acting opiod treatment took place prior to moving to a long-acting opioid.

[ ] HYDROcodone ER (HYSINGLA ER) 20 MG 24 hr tablet	20 mg, Oral, DAILY, Routine
[ ] HYDROcodone ER (HYSINGLA ER) 30 MG 24 hr tablet	30 mg, Oral, DAILY, Routine
[ ] HYDROcodone ER (HYSINGLA ER) 40 MG 24 hr tablet	40 mg, Oral, DAILY, Routine
[ ] HYDROcodone ER (HYSINGLA ER) 60 MG 24 hr tablet	60 mg, Oral, DAILY, Routine
[ ] HYDROcodone ER (HYSINGLA ER) 80 MG 24 hr tablet	80 mg, Oral, DAILY, Routine
[ ] morphine CR (MS CONTIN) 15 MG 12 hr tablet	15 mg, Oral, 2 TIMES DAILY, Routine
[ ] morphine CR (MS CONTIN) 30 MG 12 hr tablet	30 mg, Oral, 2 TIMES DAILY, Routine
[ ] oxyCODONE (OXYCONTIN) 10 MG 12 hr tablet	10 mg, Oral, EVERY 12 HOURS, Routine
[ ] oxyCODONE (OXYCONTIN) 20 MG 12 hr tablet	20 mg, Oral, EVERY 12 HOURS, Routine
[ ] oxyCODONE (OXYCONTIN) 30 MG 12 hr tablet	30 mg, Oral, EVERY 12 HOURS, Routine
[ ] fentaNYL (DURAGESIC) 12 MCG/HR 72 hr patch	1 patch, Transdermal, EVERY 72 HOURS, Routine
[ ] fentaNYL (DURAGESIC) 25 MCG/HR 72 hr patch	1 patch, Transdermal, EVERY 72 HOURS, Routine

Opiate overdose treatment

[ ] naloxone (NARCAN) 4 MG/0.1ML nasal spray	1 spray, Nasal, PRN, Routine

Referrals

Referrals

[ ] Ambulatory referral to Physical Therapy	Routine This service to be performed by?

☐ Ambulatory referral to Anesthesia Pain Management Consult/Follow up	Routine Which Anesthesiologist should the patient be scheduled with? If patient has seen an Anesthesiolgist in the past they should be scheduled with that provider.
☐ Ambulatory referral to Physical and Rehabilitative Medicine	Routine
☐ Ambulatory referral to Occupational Therapy	Routine This service to be performed by?
☐ Ambulatory referral to Orthopedic Surgery	Routine
☐ Ambulatory referral to Neurosurgery	Routine
☐ EMG	■ Routine, ONCE Extremity to be tested?

Documentation

Documentation

☐ Visit Note	SV AMB CHRONIC PAIN MANAGEMENT INITIAL VISIT NOTE

Level of Service

Level of Service

☐ PR OFFICE VISIT ESTABLISHED PATIENT 15 MINUTES	LOS Code
☐ PR OFFICE VISIT ESTABLISHED PATIENT 25 MINUTES	LOS Code
☐ PR OFFICE VISIT ESTABLISHED PATIENT 40 MINUTES	LOS Code
☐ PR OFFICE VISIT NEW PATIENT 20 MINUTES	LOS Code
☐ PR OFFICE VISIT NEW PATIENT 45 MINUTES	LOS Code

Follow-up

Follow-Up

☐ 2 Weeks	Follow-up
☐ 1 Month	Follow-up
☐ 3 Months	Follow-up

Ordering Provider [redacted] Date Time_____

Implementation- KTRACS

- Integration with APPRISS system
  - Ease of use for providers
  - Data collection and sharing
  - Individualized to health system based on EMR
    - (Why you need IT on your team!)

Implementation- Assessment

- Develop reporting
  - Use EMR data (IT)
    - Validation of data!
  - Who will review reports
    - Stewardship team
    - Administration
    - Prescribers
  - What will be done with the data

Implementation-Assessment

- Measure progress vs baseline and vs goal
- Measure at reasonable intervals
- Re-assess goals
  - After initial goals met: Reassess and determine if can do more/better
  - Goals not met: Are goals reasonable
    - Providing the appropriate resources and education?

Pearls for Existing Programs

- Revisit goals and assess progress
  - Narrow or expand scope of program if goals are/are not being met
- Implement changes in EMR if not already done
- Expand scope and patient populations
- Expand disciplines on your team!
- Review data and determine if more or less data is desired

Education

- EDUCATE AT ALL STAGES
  - Solicitation of feedback
    - Development
      - Whose workflows will be impacted
      - Prescribers
        - » Use data to show why change is needed
        - » Legal/Regulatory issues
    - Implementation
      - After roll out, seek constructive comments from end users
    - Analysis

Education

- Education of Staff
  - New workflows
  - Any EMR changes that affect usual workflow
  - Credentialing for KTRACS access?
  - Best practices and reasons behind practice changes

Education

- Prescribers
  - How changes may affect practice
  - What practice areas are of concern
  - Show/Share the data that are driving the changes

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Questions?