Opioid Prescribing PDSA

(Plan, Do Study, Act) Sample Worksheet

**This sample is designed to provide facilities with a framework and ideas for developing facility- specific content and action steps. This form can be modified or utilize a blank template (**[**Alliant**](https://www.alliantquality.org/wp-content/uploads/2021/09/QII_PDSA_12SOW-AHSQIN-QIO-TO1QII-20-242_508-1.pdf)[**Health Solutions Blank PDSA Worksheet**](https://www.alliantquality.org/wp-content/uploads/2021/09/QII_PDSA_12SOW-AHSQIN-QIO-TO1QII-20-242_508-1.pdf)**) to create the facility-specific PDSA plan.**

**Facility Name: CCN#: Date:**

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| **Goal Setting: Describe the problem to be solved** |
| **State the problem.**Who, what when, where, and how long? | Opioids can effectively alleviate pain and maintain function for residents receiving end-of-life care or who have severe acute or chronic pain that has not responded to non-opioid analgesics or non- pharmacologic measures. The use of opioid analgesics outside of current CDC (Centers for Disease Control and Prevention) opioid prescribing guidelines increases the risk of adverse events, dependency, and diversion. Fifteen patients/residents *(change to reflect your facility patient/ resident number)* who arenot receiving end-of-life care currently have active orders for an opioid analgesic. Current orders for 10 of the 15 patients/residents *(change to reflect your facility patient/ resident numbers)* exceed the current CDC opioid prescribing recommendation of no more than 90 morphine milligram equivalents (MME) daily. |
| **What do you want to accomplish/what idea do you want to test?**Identify the goal and estimated time frame for resolution. | Goal: Reduce the number of patients/residents with opioid analgesic orders exceeding the CDC recommendation of no more than 90 MME daily or duration of greater than X days *(insert facility-specific goal for number of days).*Idea(s) to test:1. Implementing a comfort menu, providing education on CDC guidelines, and establishing a process for ongoing surveillance by a QAPI (Quality Assurance and Performance Improvement) team will increase awareness.
2. Initiation of a dose reduction plan within 90 days of identification of a patient/resident on opioids exceeding 90 MME daily, will result in a decrease in orders exceeding the recommended limit of 90 MME daily.
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| **What changes will result in improvement?**e.g., safety, effectiveness, patient-centered care, timely, efficiency, equitability, etc. | *What are you going to change based on your RCA (root cause analysis) that you feel will result in improvement?*Changes will be made to the admission process, staff education process, care plan process and surveillance process. |
| **Who will be affected by accomplishing the goal?** | Staff, Prescribers, Patients and Residents |

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| **Plan: Describe the change (intervention) to be implemented** |
| **What exactly will be done?**e.g., initial intervention(s), expected outcome for each intervention, goal(s), and expected overall outcome goal rate in a percentage format | *List interventions you will provide and your expectations for improvement rates.*1. Establish a QAPI team (recommended composition includes pharmacist, Medical Director or designated prescriber, nurse leader, front line staff, patient/resident and/or family representative) by (insert date) to:
	1. Conduct a review of current patients and residents with active opioid analgesic orders (Note: the review should include:
		1. Indication, dose, directions, start and stop date, MME
		2. Whether patient/resident is also prescribed a benzodiazepine
		3. Evidence of previous opioid use
		4. Prescribing physician (note: recommendation to have only 1 prescriber managing the patient/resident’s opioid and benzodiazepine prescriptions)
		5. Diagnosis that would exclude patient/resident from opioid reduction, such as sickle cell anemia, cancer, or end-of-life care
	2. Establish a baseline to measure improvement.
	3. Identify any trends in prescribing above the recommended limit of 90 MME daily or stop dates of greater than X days (insert date established in collaboration with the Medical Director).
	4. Conduct ongoing surveillance of opioid analgesic orders and care plans for comfort menu interventions and non-opioid pain medications (ongoing surveillance could include an interdisciplinary review of patient X days prior to renewal).
	5. Establish a process for flagging, reviewing and actions for any new opioid medication orders above 90 MME.
	6. Establish criteria for recommendation of referral to pain management specialist *(if available in the provider service area*)
2. Implement a comfort menu (e.g., Alliant Health Solutions Comfort Menu) of non-pharmacologic pain management interventions and utilize it on all units by (insert date).
3. Collaborate with facility Medical Director to educate prescribing staff by (insert date) on CDC guidelines, AMDA (The Society for Post- Acute and Long-Term Care Medicine) recommendations and facility goals to implement a comfort menu and minimize the use of opioid analgesics when appropriate.
4. Provide training for all clinical staff by (insert date) and incorporate training on opioid prescribing guidelines, black box warnings, use of the comfort menu, signs of opioid overdose, dose tapering and the use of Naloxone into:
	1. New hire orientation
	2. Annual competency reviews
5. Review Emergency boxes inventory to ensure Naloxone is available in Emergency boxes on all units by (insert date).
6. Establish a process for quarterly review of Emergency boxes to ensure Naloxone is not expired
7. Collaborate with the Medical Director to establish a process for the prior approval or review of new opioid analgesics of over 90 MME daily or stop dates of longer than X days (insert number of days). Process to include discharge orders to next level of care.
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|  | 1. Revise admission process by (insert date) to include identification of:
	1. Indication, dose, start and stop date and MME
	2. Whether patient/resident is also prescribed a benzodiazepine
	3. Evidence of previous opioid use
	4. Prescribing physician (note: recommendation is to have only 1 prescriber managing the patient/resident’s opioid and benzodiazepine prescriptions)
	5. Diagnosis that would exclude patient/resident from opioid reduction such as sickle cell anemia, cancer, or end-of-life care.
	6. Interdisciplinary team members to notify (nurse leader, Medical Director or QAPI team member) of any new admission with an opioid analgesic order.
2. Develop and implement a plan to communicate initiative goals to referring hospitals by (insert date). (Note: Consider transfer process that includes Physician- to-Physician communication for care management/discharge planning).
3. Develop and implement a plan to communicate initiative goals to patients, residents, families, health care agents and care partners by (insert date).
4. Establish a schedule for review of opioid prescribing data by the QAPI committee.
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| **Who will be responsible for implementing the change?** | *Usually, leadership for QAPI methodology. This person will support and supervise the process the team is working on.* |
| **Where will it take place?** | *Where and when will you provide the interventions listed?* |
| **What will be measured? Describe the measure(s) to determine if prediction succeeds.** | *What data or outcome will you measure?*Number of patients with orders exceeding 90 MME daily.Number of patients/residents with orders for greater than X number of days. |
| **Who will be responsible for measuring the data?** | *This can be a group or an individual.* |
| **How will the data be collected/computed/ analyzed?** | *Identify process owner(s) for data collection and schedule for review and analysis* |
| **What is the current data figure for that measure?** e.g., count, percent, rate, etc. | *Baseline* |
| **What should the number increase/decrease to in order to meet the goal?** | *Goal rate should show improvement from baseline.* |
| **Did you base the measure or figure you want to attain****on a particular best practice/ average score/ benchmark?** | *Based on CDC guidelines for opioid prescribing.*[***CDC Guidelines for Opioid Prescribing***](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm)[***CDC Opioid Prescribing Fact Sheet***](https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf) |

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| **Do: Implement Change** |
| Enrollment in upcoming learning collaborative. The learning collaboratives will provide group technical assistance using a data-driven, action-oriented approach. Unlike individual learning, people engaged in learning collaboratives capitalize on one another’s resources and skills. |
| **Was the plan executed?** | *Yes, on (what date did you do the first audits)* |
| **How long was the plan executed?** | *You will answer this at the conclusion of your project.* |
| **Document any events or problems.** | *Put employee comments, change in staff and any other events that affected the outcomes here.* |
| **Describe what happened when you ran the test?**e.g., the indicators measured, the adoption of the change by staff, process change, etc. | *Did you see improvement in reducing opioids? What feedback did the team observe/receive around the use of the comfort menu?* |

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| **Study: Review and Reflect on Results of the Change** |
| Scheduled monthly check-in with Alliant Health Solutions will include data analysis and building sustainability. |
| **Describe the measured results and how they compared to the predictions.**State at least 1 or more interventions that contributed to the improvement of the problem. | *Did you see the outcome you expected? What interventions made the improvement possible?* |
| **Graphically illustrate data improvement comparison****from baseline to current data in percentages.** | Baseline= %Weekly or monthly audits = % |
| **Is this change likely to continue?**Identify at least one or more of the continued sustainable interventions that addresses the problem. | *Answer here if your intervention(s) led to an improvement in opioid prescribing practices and reduction efforts.* |

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| **Act: Determine the Action Needed Based on Results of the Change** |
| Monitor data and adjust interventions/tactics. |
| **What will you take forward from this PDSA?** | *Answer here (later) if you will Adopt, Adapt, or Abandon this Plan.* |
| **Describe what modifications to the plan will be made from what you learned.** | *If you make changes or additions to this process, add changes here as an adaptation* |

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| **Intervention/Improvement Details:** *(sample action steps)* |
| Action Step | Start Date | Target Completion Date | Person Responsible | Monitoring Strategy | Findings and Lessons Learned | Outcome, Recommendations and Next Steps |
| Conduct review of all current orders for opioids | 11/15/21 | 11/22/21 | Nurse Managers | QAPI to review | 15 orders currently written outside of guidelines, of those 11 percent were ordered by one mid-level practitioner | Review findings with Medical Director |
| Develop strategy to establishframework for opioid reduction initiative (e.g. all clinical managers will view[**https://www.youtube.com/**](https://www.youtube.com/watch?app=desktop&v=m_KfyKcDKD0)[**watch?app=desktop&v=m\_KfyKc-**](https://www.youtube.com/watch?app=desktop&v=m_KfyKcDKD0)[**DKD0**](https://www.youtube.com/watch?app=desktop&v=m_KfyKcDKD0)**)** | 11/08/21 | 11/11/21 | ED/DNS | QAPI to review in-service records | One non-clinical department head had heard that facility was going to be taking all patients/residents off all opioids andwas concerned patients/residents would be suffering. | Add non-clinical managers to training schedule |
| Randomly select 10% of staff (include staff from all shifts, staff, agency…) and interview to determine how staff find, select nonpharmacological interventions to increase patient/resident comfort/alleviate stress. Identify 5-6 interdisciplinary team members to conduct the interviews. | 11/15/21 | 11/29/21 | Director, Social Services | Scheduler to audit selection to ensure inclusive of weekend staff, all shifts, PRN and contract agency staff. | 8% of 3rd shift staff interviewed were not aware of any facility resources12% of contract agency staff were not aware of any facility resources | Develop a training schedule on the Alliant Health Solutions comfort menu.Incorporate comfort menu into orientation materials for staff and contract agency personnel. |

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| **Findings from the Root Cause Analysis:** |
| **Category** | **Barriers Identified** |
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Communication/Notes:

Additional Resources:

1. **The Society for Post-Acute and Long-Term Care Medicine™ (AMDA) Opioids in LTC resources:** [**https://paltc.org/opioids-ltc-resources**](https://paltc.org/opioids-ltc-resources)
2. **CMS State Operations Manual:** [**https://www.cms.gov/Regulations-andGuidance/**](https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.p)[**Guidance/Manuals/downloads/som107ap\_pp\_guidelines\_ltcf.pdf**](https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.p)
3. **Alliant Health Solutions tools and resources:** [**https://www.alliantquality.org/**](https://www.alliantquality.org/)
4. **Alliant Health Solutions YouTube channel:** [**https://www.youtube.com/channel/UC9mITtil3m-**](https://www.youtube.com/channel/UC9mITtil3mHpVNd87vaxD6w)[**HpVNd87vaxD6w**](https://www.youtube.com/channel/UC9mITtil3mHpVNd87vaxD6w)
5. **Alliant Health Solutions webinar: Neuroscience of Addiction: Disease or Decision?** [**https://bit.ly/DiseaseorDecision**](https://bit.ly/DiseaseorDecision)

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