HRET HIIN Physician Virtual Event

Opioid Safety and Introduction of Human Diagnosis Project
# Agenda for Today

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00-3:05 p.m.</td>
<td>Welcome and Framing</td>
<td>Elisa Arespacochaga</td>
</tr>
<tr>
<td>3:05-3:25 p.m.</td>
<td>Northwestern’s Efforts on Opioid Safety</td>
<td>Dr. Jonah Stulberg</td>
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<tr>
<td>3:25-3:55 p.m.</td>
<td>Human Diagnosis Project Overview</td>
<td>Seiji Hayashi</td>
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<tr>
<td>3:55-4:00 p.m.</td>
<td>Wrap Up</td>
<td>Elisa Arespacochaga</td>
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Defining the Issue

Overdose Death Rates

1999

2015
Defining the Issue

**Doctors Continue to Prescribe Opioids for Ninety-one Percent of Overdose Patients**

In a study of 2848 patients who had a nonfatal opioid overdose during long-term opioid pain treatment:

- **63%** of high-dose opioid patients were still on a high dose 31-90 days after overdosing.
- **10%** were still on a moderate dose.
- **13%** were still on a low dose.
- **17%** were still on none.

Addressing the Opioid Epidemic

- Awareness and Education
- Access to Treatment
- Opioid Stewardship
Addressing the Opioid Epidemic

Topics
- Ensuring Clinician Education About and Oversight of Appropriate Prescribing Practices
- Nonopioid Pain Management
- Addressing Stigma
- Options to Identify and Treat Opioid Use Disorders
- Ensuring Patient, Family and Caregiver Education about the Risks of Opioids
- Ensuring Safe and Effective Transitions of Care
- Safeguarding Prescription Opioids Against Diversion
- Collaborating with Communities

http://www.aha.org/opioidtoolkit
#StemTheTide

Webinars

Resources
Our Speakers

Jonah Stulberg, MD, PhD, MPH, FACS
Assistant Professor of Surgery, Division of Gastrointestinal & Oncologic Surgery
Surgical Outcomes & Quality Improvement Center (SOQIC)
Department of Surgery
Northwestern University Feinberg School of Medicine

Seiji Hayashi, MD, MPH
Director of Medicine
The Human Diagnosis Project
NM System Opioid Project-
Reducing Opioid Prescribing at Hospital Discharge in General Surgery

Jonah Stulberg, MD, PhD, MPH, FACS
Northwestern University Feinberg School of Medicine
Over Prescribing Can Lead to Diversion
Excess pills are a readily available source for non-medical use

Surgeons Tend to Overprescribe
• >50% of pts use ≤5 pills
• Average Prescription = 30 pills

Diversion is Common
• Diversion = >70% of Non-Medical Use
• Diversion is non-medical use of legally prescribed prescription medication
Heroin Addiction Starts with Prescription Addiction

We need more responsible prescribing practices

Three out of four heroin addicts began by using prescription drugs.
Minimizing Opioid Prescribing in Surgery (MOPiS)
A Comprehensive, Multi-Component Intervention

- Expectation Setting
- Risk Screen
- Optimize Function
- Monitor and Improve

Prescriber
Opioid
Patient

Northwestern Medicine
MOPiS: A Comprehensive Solution
Minimizing Opioid Prescribing in Surgery

Preoperative

Screen and Prepare
1 – Assess Risk
2 – Educate
   - Risks/Benefits
   - Storage
   - Disposal
3 – Set Expectations

Perioperative

Select Inpatients
(ERAS¥)

Prescribe Responsibly
1 – Prescribing Opioid Alternatives
2 – Lower Default Quantities
3 – Avoid Multiple Prescribers (PMPµ)
4 – Use e-Prescribing

Postoperative

Monitor Use
1. Retrieve
2. Educate

¥ - ERAS (Enhanced Recovery After Surgery)
£ - MOPiS (Minimizing Opioid Prescribing in Surgery)
µ - PMP (Prescription Monitoring Program)
### NM System-wide Performance Improvement Project

#### Project Overview

**Problem Statement**
- Over-prescribing of opioids has contributed to the current US opioid epidemic.
- Research indicates surgical providers write nearly 10% of all opioid prescriptions filled each year, with approximately 80% of pills remaining unused and available for diversion.
- At NM, General Surgery opioid prescribing practices at hospital discharge indicate **82% of opioid prescriptions are in variance of established guidelines**, potentially leading to misuse, diversion, addiction and death by overdose.

**Project Goal / Objective**
- Support the reduction of opioid misuse and diversion by increase compliance of guideline supported opioid prescribing at hospital discharge by General Surgery at NM by 50% by end of FY18.

**Scope**
- General surgery at NMH, CDH, Delnor, NLFH, Kish (pre-hospital, inpatient and post discharge)

**Metrics**
- % of opioid prescriptions at hospital discharge aligned with prescribing guidelines

#### Timeline

<table>
<thead>
<tr>
<th>Stage</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
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<td>Measure/Analyze</td>
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Project Work Streams

Patient, Provider and System-level Strategies

- **Safe Disposal**
  - Support the operationalizing of safe medication disposal
    - Kiosks
    - DEA supported “Take Back Day” April 28th and Oct 2018

- **Patient/ Provider Education**
  - Engage NM Academy/ Patient Education/ Marketing
  - Educational video and scenario based modules-July 2018
  - NMI Opioid Team resource page

- **EMR Optimizations**
  - Optimize clinical decision support- appropriate opioid dosing
  - Automated opioid education (safe use and disposal) in DC instructions

- **Measure and Reporting**
  - Develop automated reporting to provide clinician level data on % compliance with opioid prescribing guidelines

Goal:
- Support NM patients/ communities
- Educate and provide resources to providers and patients
- Reduce opioid prescribing
- Increase use of alternative pain medications
- Provide feedback, support and accountability to the provider level
Safe Disposal

Progress To-Date/ Next Steps

• Medication disposal kiosks across NM
  – Active at NMH Digestive Health Center Since May 2017
  – Delnor/CDH/NMH interested or actively working towards placement in public space
  – Operational tools developed (procedures, wayfinding, education)
  – Next Steps
    ➢ Obtain leadership approvals
    ➢ Confirm locations and kiosk wrap
    ➢ Installation

• Successful participation in National Drug Take Back Day event April 2018
  – Participate in the October event and continue partnerships with DEA/ CPD and Lurie Children's
Safe Disposal

Drug Take Back

Impact

• NMH campus collected **79 lbs** of prescription drugs!

• West Region-Delnor ICC collected **82 lbs** of prescription drugs!

• West Region-Valley West collected **160 lbs** of prescription drugs!

The next National Prescription Drug Take Back Day will be in **October 2018**!
Safe Disposal
Implementation Guides

Clinic or hospital-based opioid retrieval: Implementing a retrieval kiosk

Pre-implementation steps:

- Identify institutional champions & engage stakeholders
  - Pharmacy lead: Name:
  - Security/facilities lead: Name:
  - Legal lead: Name:
  - Risk lead: Name:
  - Physician champion: Name:
  - Nurse leadership champion: Name:
  - Other: Name:
- Meet with key institutional stakeholders and leaders to make the case and gain support

Select physical location that fits the following criteria:

- Is there an on-site pharmacy? Yes No
- Is the pharmacy hospital-based (rather than commercial)? Yes No
- Is the proposed location open to the public? Yes No
- Is the proposed location regularly monitored by employees? Yes No
- Is the proposed location in a setting that is NOT emergency or urgent care? Yes No
- Is there a permanent structure to which the kiosk can be fastened? Yes No

Potential locations:

Implementation steps:

1. Modify DEA authorized collector registration through the DEA website
   - Is the site eligible to handle Schedule II controlled substances? Yes No Not sure
   - One site becomes an authorized collector, it will show on the DEA’s online list of public disposal sites, even if the kiosk is not yet installed.
   - Who will manage responding to questions from patients or the public and redirect them accordingly? Name(s):
   - Next steps:

2. Select kiosk vendor
   - The kiosk must meet all of the following requirements:
     - Security locked
     - Has a permanent outer container and a removable inner liner that meets DEA requirements (per Title 21-1317.62)
     - Outer container prominently displays sign indicating that Schedule II drugs only are permitted.
   - Kiosk vendors that meet these requirements:

Next steps:

https://www.isqic.org/opioid-reduction-initiatives
Patient and Provider Education

Aligning Provider and Patient

- **Expectation Setting**
- **Risk Screen**

- **Optimize Function**
- **Monitor and Improve**

**Prescriber**

**Opioid**

**Patient**

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Screening for High Risk
Brief intervention prior to OR Scheduling

• Provider Script for Risk Screening

ISQIC Shortscreen

Providers should ask patients the following question:

“How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?”

If the patient responds with 1 or more times, they should be referred for formal screening using the 10-item Drug Abuse Screening Test (DAST). Formal screening may be conducted by providers such as social workers, psychologists, addiction counselors, and other providers identified by your institution.

• Patient completed Risk Survey
Setting Expectations
Provider training and materials on good communication

Setting Appropriate Expectations for Postoperative Pain: Best Practices

1. Surgery is painful, but current pain management techniques are very good and the pain is temporary. It is normal for patients to be very worried about pain after surgery. It is important to focus on the knowledge that the pain will improve in a few days and that we can usually manage post-operative pain very well.

2. The goal of controlling pain is to restore function. It is important for patients not to focus on getting their pain score down to zero. Instead, the goal of pain control is to allow for restoration of function. Providers must work with patients to achieve safe pain relief that allows patients to actively participate in their recovery (e.g., physical therapy).

3. Two-way communication between patients and providers is essential. Pain control expectations, patient participation, and surgical outcome are linked together. Poor communication and treatment of pain can impair physiologic function, psychological well-being, and quality of life. It is important to stress that patients take an active role in their recovery and work through expected pain to achieve the best possible outcome.

4. Patients should be open to adjusting. The perioperative team may suggest medications (e.g., gabapentin) or procedures (e.g., nerve blocks) the patient may not be familiar with. The surgical team can reinforce that keeping an open mind about adjunct treatments could improve pain.

5. Pain management expectations do not end at hospital discharge. Recovery can take weeks or even months, and the patient’s baseline pain may be altered during that time period. Surgery is not a quick fix; it takes dedication and work on the patient and provider sides.

6. Limiting preoperative opioids is in the best interest of the patient. By limiting opioids preoperatively, there is greater ability to safely increase dosage to address acute postoperative pain. If your patient is on chronic opioids, consider working with their primary care doctor or pain management doctor to limit their current regimen prior to surgery.

Provider Training
Optimizing Perioperative Practices: Non-Opioid Alternatives

IV opioids

Oral opioids

Gabapentin, nerve blocks, acetaminophen, NSAIDs, Cox-2 inhibitors, and alternative modalities such as: cognitive behavior therapy, physical therapy, massage, pet therapy, etc.
# Standardized Protocols

## Optimizing Perioperative Practices: Non-Opioid Alternatives

| Preoperative  | • Acetaminophen (Tylenol) 1,000mg  
|              | • Ibuprofen (Motrin) 600 mg  
|              | • Gabapentin 300mg (optional)  
| Perioperative | • Infiltration of local anesthetic recommended prior to incision  
|              | • Coordination with anesthesia recommended to minimize intra-operative opioid use  
| Post-operative (Days 1-3) | • Use cold pack on surgical site 20 minutes on, 20 minutes off  
|              | • Acetaminophen (Tylenol) 1,000mg every 6 hours  
|              | • Ibuprofen (Motrin) 600 mg every 6 hours  
|              | • Gabapentin 300mg every 8 hours  
|              | • Tramadol 50 mg every 6 hours, as needed  
|              | • Oxycodeone 5mg every 4 hours, as needed for breakthrough pain  
| Post-operative (Days 4-7) | • Use cold pack on surgical site 20 minutes on, 20 minutes off, as needed  
|              | • Acetaminophen (Tylenol) 1,000mg every 6 hours, as needed  
|              | • Ibuprofen (Motrin) 600 mg every 6 hours, as needed  
|              | • Gabapentin 300mg every 8 hours  
|              | • Tramadol 50 mg every 6 hours, as needed  
| Post-operative (Days 8-14) | • Gabapentin 300mg every 8 hours  
|              | • Acetaminophen (Tylenol) 1,000mg every 6 hours, as needed  
|              | • Ibuprofen (Motrin) 600 mg every 6 hours, as needed  

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# Lowering Default Quantities

Realign pill quantities with patient need

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<thead>
<tr>
<th>PROCEDURE</th>
<th>Recommended quantity of opioid pills to prescribe</th>
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<tbody>
<tr>
<td>Laparoscopic cholecystectomy</td>
<td>15</td>
</tr>
<tr>
<td>Laparoscopic appendectomy</td>
<td>15</td>
</tr>
<tr>
<td>Laparoscopic inguinal hernia repair</td>
<td>15</td>
</tr>
<tr>
<td>Open inguinal hernia repair</td>
<td>20</td>
</tr>
<tr>
<td>Colectomy</td>
<td>25</td>
</tr>
<tr>
<td>Umbilical hernia repair</td>
<td>15</td>
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<tr>
<td>Laparoscopic ventral hernia repair</td>
<td>15</td>
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<tr>
<td>Laparoscopic hiatal hernia repair</td>
<td>15</td>
</tr>
<tr>
<td>Open whipple</td>
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<tr>
<td>Open liver resection</td>
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<td>Melanoma and skin excision procedures</td>
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<td>Laparoscopic hysterectomy</td>
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<tr>
<td>Open hysterectomy</td>
<td>25</td>
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<tr>
<td>Breast biopsy</td>
<td>5</td>
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<td>Carotid endarterectomy</td>
<td>15</td>
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<tr>
<td>Cesarean section</td>
<td>15</td>
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<tr>
<td>Cataract surgery</td>
<td>0</td>
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<td>Coronary artery bypass</td>
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<tr>
<td>Debridement of wound</td>
<td>Variable</td>
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<tr>
<td>Dilatation and curettage</td>
<td>5</td>
</tr>
<tr>
<td>Free skin graft</td>
<td>25</td>
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<tr>
<td>Hemorrhoidectomy</td>
<td>20 (use sparingly, causes constipation)</td>
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<tr>
<td>Hysteroscopy</td>
<td>5</td>
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<tr>
<td>Total mastectomy, simple or radical</td>
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<tr>
<td>Partial mastectomy (lumpectomy)</td>
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<td>Open proctectomy</td>
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<tr>
<td>Robotic proctectomy</td>
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<tr>
<td>Tonsillectomy</td>
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<tr>
<td>Thyroidectomy</td>
<td>10</td>
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<tr>
<td>Parathyroidectomy</td>
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<tr>
<td>Video-assisted thoracoscopic lobectomy</td>
<td>15</td>
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<tr>
<td>Open lobectomy</td>
<td>25</td>
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<tr>
<td>Chemical or mechanical pleurodesis</td>
<td>25</td>
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<tr>
<td>Total hip replacement</td>
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<tr>
<td>Total knee replacement</td>
<td>25</td>
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Patient and Provider Education

Progress To-Date/ Next Steps

- Development of educational content /Video
  - Leveraged subject matter experts across NM
    - Pain
    - Nursing
    - Pharmacy
    - Physicians

- Partnered with NM Academy-Engaged and external vendor
  - Developing scenario based, multidisciplinary, electronic modular-based training
  - End user cognitive interviews planned to access usability/ knowledge capture

- Launch in NM E-Learning platform-July/August
  - Computer/Tablet and phone compatible
  - Monitor completion compliance and knowledge capture
EMR Enhancements

Progress To-Date/ Next Steps

• Engaging NM Gen Surg ISQIC Surgeon Champions
  – Shared hospital level data on prescribing
  – Discussed possible EMR enhancements to support prescribers
  – Requested socializing data and proposed EMR enhancements with peers/ Chairs to solicit feedback

• Working with IT/ Epic Architects
  – Determine how best to leverage EMR
  – Develop timeline

• Presentation to System Clinical Collaborative Workgroup
  – For consensus building and approvals to move forward with build and implementation
EMR Enhancements-Proposed
Opportunity to leverage the EMR to support prescribing practices

Provider initiates discharge process/ Med rec

Patient ready for discharge post gen surgery procedure

(TBD) Epic logic will look to see what procedure type has been completed

Opioid RX will default to # of pills based on guidelines established

Provider can modify RX based on patient specific clinical considerations

Goal achieved! Appropriate # of pills prescribed to reduce risk of misuse or diversion

Opioid RX will default to # of pills based on guidelines established

Provider can modify RX based on patient specific clinical considerations

Goal achieved! Appropriate # of pills prescribed to reduce risk of misuse or diversion

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Measure and Reporting

Progress To-Date/ Next Steps

• Data Pull/Analysis Completed
  – To understand baseline NM data

• Developed mock-up of proposed EDW-based report
  – To hospital/ provider level
    • % compliance with recommended opioid prescribing practices at hospital discharge

• Working with Analytics on report build
  – End user feedback
  – Delivery late summer

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total Opioid Scripts</th>
<th>Avg of Opioid Pills Per Script</th>
<th>% Compliant Scripts</th>
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<td>27</td>
<td>24.9%</td>
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<td>NMH 2</td>
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<td>NMH 6</td>
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<td>28.6%</td>
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<td>NMH 9</td>
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<tr>
<td>NMH 32</td>
<td>60</td>
<td>28</td>
<td>30.0%</td>
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</table>
% of NM RX's On Target with ISQIC Opioid Prescribing Guidelines
By Hospital/ Region for General Surgery Procedures

Date Range 1/1/2017 to 4/17/2018
% of NM RX's On Target with ISQIC Opioid Prescribing Guidelines

Based on Procedure Type*

Date Range=1/1/2017 to 4/17/2018
Per procedure count = of 200 or more
Project Next Steps

• Complete educational video/modules
  – SME review
  – Usability testing
  – Identify providers who receive education
    • Physicians/APP’s
    • Nursing
    • Pharmacy

• System-wide feedback opportunities-July/August
  – Department meetings
  – Quality Meetings
  – Goals
    • share project work and obtain input on EMR enhancements and report build
    • Generate interest for spread to other clinical specialties

• October 2018 Drug Take Back Day
Thank you!

It takes an Army

Special Thanks to:
Karl Bilimoria, MD MS FACS
Barb Buckley, RN, MS
Meagan Shallcross, MPH
Shelby Parilla, MPH
Julie K. Johnson, PhD
Willemijn Shaeffer, PhD
Reiping Huang, PhD
Questions?

Contact information:
ISQIC Website: [www.isqic.org/Opioid-Reduction-Initiatives](http://www.isqic.org/Opioid-Reduction-Initiatives)

Jonah Stulberg MD [Jonah.Stulberg@nm.org](mailto:Jonah.Stulberg@nm.org)
Appendix
## Proposed Default Quantities

From literature and M-OPEN

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</tr>
<tr>
<td>Open inguinal hernia repair</td>
<td>20</td>
</tr>
<tr>
<td>Open liver resection</td>
<td>30</td>
</tr>
<tr>
<td>Open lobectomy</td>
<td>25</td>
</tr>
<tr>
<td>Open whipple</td>
<td>30</td>
</tr>
<tr>
<td>Parathyroidectomy</td>
<td>10</td>
</tr>
<tr>
<td>Partial mastectomy (lumpectomy)</td>
<td>15</td>
</tr>
<tr>
<td>Thyroidectomy</td>
<td>10</td>
</tr>
<tr>
<td>Total mastectomy, simple or radical</td>
<td>25</td>
</tr>
<tr>
<td>Umbilical hernia repair</td>
<td>15</td>
</tr>
</tbody>
</table>
Rapidly training physicians on the opiate guidelines through fun, interactive cases

Seiji Hayashi, MD, MPH
Director of Medicine, The Human Diagnosis Project Nonprofit

@human_dx
Who we are: the Human Dx Alliance for the Underserved
Opioid assessment tool via fun, quick case simulations

- **Aim:** Improve physicians’ understanding of opiate and pain management guidelines as well as their relevant diagnostic and management skills.
- **Solution:** A tool to assess physician competency though 15 peer-reviewed cases.
- **Pilot Goal:** Share data on case solves. Assess participation and dissemination.
Cases are fast, engaging, & fun to solve

Solve Dr. Marc Rabner's case of a 43 yo M with episodic abdominal pain

Provide your best differential diagnosis as you reveal each finding to have the most impact on the Project.

Solve
Score reports show variation in CDC guideline adherence

**CDC guideline domains**

- **Initiation**: Determining when to initiate or continue opioids for chronic pain
- **Dosage**: Opioid selection, dosage, duration, follow-up, and discontinuation
- **Risks and harms**: Assessing risk and addressing harms

Source(s): 1,400 case solve simulations by > 250 unique learners (66% residents or fellows, 16% attendings, 5% medical students, 13% other).
Guideline adherence by clinical experience

Percentage of guideline adherent solves by clinical tenure

- Attending: 45.9%
- Fellow: 46.7%
- Resident: 42.7%
- Intern: 45.3%
- Medical student: 37.7%
- Other: 33.7%
“Increased my knowledge of opiate management.”
www.humandx.org/opioid

- Background
- How to get started
- Video
- Cases
Next Steps

Step 1) Indicate your interest by 6pm EST on July 20th.

Step 2) Decide whether to
   a) send us physicians’ email addresses so we can send cases directly or
   b) email your physicians through internal channels.

Step 3) After physicians solve the cases, receive aggregated reports across several useful measures.
Questions?

Human Dx contact: Seiji Hayashi
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Sign up by emailing me by 6pm ET on Friday, July 20
WRAP UP

Elisa Arespacochaga, VP Physician Alliance,
American Hospital Association
Thank You!

Find more information on our website:

www.hret-hiin.org