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INSIDE

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Case Managers in Transitional Pain Service Programs Can Help Stem Opioid Epidemic

High-risk patients are identified early

Healthcare professionals across all disciplines, including case managers, are doing their part to end the opioid epidemic. Opioid abuse and misuse have contributed to more than half a million overdoses nationwide in the past two decades, and problems have continued. Federal data show that more than 56 million Americans filled at least one opioid prescription in 2017. *(For more information, visit: http://bit.ly/2GzCtkL.)*

Recognition that some surgical patients could benefit from case management services to help with pain has led one organization to develop a transitional pain service for surgery patients.

"OUR GOALS ARE TO REDUCE PAIN SUFFERING, IMPROVE FUNCTIONAL OUTCOMES, STOP NEW CHRONIC OPIOID USE, AND HELP CHRONIC OPIOID USERS TO REDUCE OR ELIMINATE USE OF OPIOIDS."

"This is a strategy that is fairly new," says **Benjamin Brooke**, MD, PhD, FACS, associate professor of surgery and an adjunct professor of bioinformatics and population health sciences at the University of Utah in Salt Lake City. Brooke also is the chief of the division of vascular surgery and director of the Utah Intervention Quality and Implementation Research group.

Before the opioid epidemic,

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physicians were taught to think of patient pain as a fifth vital sign. They were supposed to ask about it and help reduce it as much as possible. Doctors would prescribe opioids for patients who reported pain at a level two or three, Brooke explains.

"So patients expected to get medication if they had any pain at all," he adds. "What we've realized now is that patients don't need opioids unless they have severe breakthrough pain, and we can give them a lot of nonopioids and nonmedical interventions, like acupuncture."

This evolution away from opioid prescriptions for all pain has led to the need for a more holistic program that includes case management.

"Every institution's environment is different," Brooke says. "You have to do an assessment of barriers and facilitators to make sure it will fit within your own institution and the providers executing the model."

When patients with complex medical needs are given opioids at the time of surgery, there is a need for better care coordination, Brooke says.

"We've taken a couple of different models for the concept of integrative case management and tried to put these in this program," he adds. "We've also looked at a lot of evidence for what causes people to continue opioids and tried to develop a program that uses the evolving evidence."

Research shows that post-surgery opioid treatment has served as a significant gateway to continued opioid use and misuse. One recent study found that 8.3% of opioid-naïve patients given opioids after shoulder surgery had developed new, prolonged opioid use.

Another study found that 14% of opioid-naïve patients that received opioids for pain after lung resection continued to fill their opioid prescriptions three to six months post-surgery.[1,2]

In the traditional surgery model, patients would be sent home with opioid prescriptions and would be seen in one or a few follow-up visits. After that, community providers would take over the opioid prescriptions, so surgeons rarely knew whether patients developed persistent opioid use.

But the new model of transitional pain service addresses this care gap, says **Kimberlee Bayless**, DNP, APRN, FNP-BC, director of The Transitional Pain Service and an

EXECUTIVE SUMMARY

Case managers in surgical practices can help fight the opioid epidemic by working with patients to reduce any current opioid use and prevent persistent opioid misuse.

- A Veterans Administration medical center started a transitional pain service for surgery patients to help them find alternative strategies to reducing surgical pain.
- The old model of giving patients more pills if they experience any pain post-surgery is giving way to a new model, allowing that some pain is acceptable.
- Care coordination is important to ensure patients do not fall through the cracks.

acute pain service nurse practitioner, anesthesia department, at George E. Wahlen Department of Veterans Affairs (VA) Medical Center in Salt Lake City.

"We thought we should formulate a transitional pain service and start taking care of veterans in a more well-grounded, holistic approach," Bayless says. *(See story on how pain program works, below.)*

"Our goals are to reduce pain suffering, improve functional outcomes, stop new chronic opioid use, and help chronic opioid users to reduce or eliminate use of opioids," she says.

Patients are stratified based on risk factors, such as surgery type, current chronic opioid use, substance abuse, mental health concerns, and medical history. They are placed in groups of low, moderate, and high risk for the development of new, persistent, chronic post-surgical pain.

"Involve nurse care managers in the process of identifying these patients," she says. "Nurses can do detailed chart reviews and also meet with the veterans to get a detailed history from them about their chronic pain, social history, and family history."

The transitional pain service is a team, including an anesthesiologist, psychologist, and nursing case manager, Brooke says.

"The team is very integrated in terms of following patients [and] meeting on a daily basis to ensure all patients are being followed, and there's a clear plan to prevent patients from being dropped or falling through the cracks," Brooke adds.

"We started this program with orthopedic patients and now are expanding it to all surgical specialties," he says. "When we started the program, we had a very intensive follow-up after surgery of at least weekly and then once a month. Now, we're trying to taper back and say, 'What is the right amount of follow-up that patients need?'"

The follow-up provides patients with reassurance that they can handle their post-surgery pain even if they do not use opioids. And they try to reduce the trend of patients going to other providers to renew their opioid prescriptions, he says.

"We reinforce that there are other options than taking medications," Brooke says. "We have clinics set up for people who are chronic opioid users, and after a three- to six-month window, if the team feels patients are still at risk of having opioid misuse or abuse patterns, then we can refer patients to these other specialty clinics." ■

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Transitional Pain Service Begins With Screening Process

As providers in all disciplines, including surgical settings, look for strategies to be part of the solution when it comes to opioid prescriptions, one Veterans Administration model provides a blueprint.

The team educates patients about nonopioid methods of post-surgical pain reduction, including taking Tylenol, using ice machines, and following their physical therapists' instructions, says **Kimberlee Bayless**, DNP, APRN, FNP-BC, director of the Transitional Pain Service and an acute pain service nurse practitioner, anesthesia department at George E. Wahlen Department of Veterans Affairs (VA) Medical Center in Salt Lake City.

"We follow up with patients, calling them within two days to answer any questions or concerns," she says.

The following is how the program works:

• **Screening process.** For surgery patients at the Salt Lake City VA, there is a screening algorithm that asks these questions:

- Is the patient at high risk for opioid misuse?

- Does the patient have a history of substance abuse?

- Has the patient been on opioids previously or currently?

- Does the patient have a mental health history of anxiety, depression, or post-traumatic stress disorder (PTSD)?

- Does the patient lack social support?

"All of those are risk factors we've identified and that are evidence-based," says **Benjamin Brooke**, MD, PhD, FACS, associate professor of surgery and an adjunct professor of bioinformatics and population health

sciences at the University of Utah in Salt Lake City.

Patients who are at risk of prolonged opioid use are contacted and offered enrollment in the program.

The program uses PROMIS (Patient-Reported Outcomes Measurement Information System) scores. *(For more information, visit: http://bit.ly/2VzMAj4.)*

PROMIS is a program developed with funding from the National Institutes of Health and is available for public use. It includes a subset of instruments that can be used to assess pain. Its other instruments assess alcohol use, social roles, anger, anxiety, asthma, depression, emotional support, psychological stress, smoking, substance use, and many others categories.

Case managers also might assess a patient's pain catastrophizing scale. The catastrophizing scale is used to predict which patients might experience worse or prolonged pain, leading to greater opioid use. If patients catastrophize their pain, then they might use more medication or develop chronic pain post-surgery, Bayless explains.

"We're trying to see if that score can predict outcomes postoperatively," she adds. "If they say, 'I don't think my pain will be any better' or 'the pain always will be bad,' then that's a valid pain measure."

• Preoperative education. Sometimes, patients do not know what to expect with post-surgery pain and treatment, Brooke notes.

"A pre-op education course can give patients information on what their expectations would be and set the stage for saying, 'You're not going to need as much opioids as was previously expected for a lot of patients,'" he says.

Nurse case managers can start a conversation with patients. Patients also can view a one-hour surgical expectations course.

"One thing we focus on is patient-reported outcomes and patient-reported assessments of their pain intensity, pain interference, and pain catastrophizing," Brooke says. "Nurse case managers interview patients to assess baseline scores, and then after the operation, the nurses will reach out to patients at regular intervals about whether their pain scores have improved the way they should."

THE COURSE "CAN GIVE PATIENTS INFORMATION ON WHAT THEIR EXPECTATIONS WOULD BE AND SET THE STAGE FOR SAYING, 'YOU'RE NOT GOING TO NEED AS MUCH OPIOIDS AS WAS PREVIOUSLY EXPECTED FOR A LOT OF PATIENTS.'"

A pre-surgery expectation class run by psychologists can help patients change their attitude about surgical pain.

"The psychological component includes talking about opioids and medications that can be used with surgery," Bayless says. "Psychologists introduce mindfulness in that class."

• Pre-op case management. "A lot of the role of the case manager is being a liaison between veteran and surgical services, the go-to person for veterans for anything related to their surgical questions," Bayless says. "Developing a relationship with the veteran is one of the most important roles."

Case managers spend an hour with patients at the initial intake and are available afterward to answer any questions.

"They build a real relationship with veterans preoperatively," Bayless says. "Veterans find that case managers are quick to respond and answer their questions."

Case managers also explain the program's policy that patients who are currently using opioids for pain management must taper off their opioid medications by 50% prior to scheduling the surgery. *(See stories on pain control and opioid tapering, pages 65 and 66.)*

"Nurse case managers do care coordination with veterans with our recommendations for how to taper pain medications, monitor withdrawal symptoms, and get medications to 50% before the surgery is scheduled," Bayless explains. "Our case managers coordinate with primary care providers, doing follow-up with prescription renewals, and follow-up weekly to see how the taper is going and whether they have any side effects."

The program and case management approach has had a very positive impact on individual patients, Bayless notes.

"Just today, I was stopped in the canteen by one of our veterans that we served," she says. "She told me that she just finished with yoga and she is one year out from her total knee replacement." The former

patient told Bayless that she often thinks about the transitional pain service team and gives the team credit for how she was able to regain her functional life. "I enjoy hearing about the struggles and successes of our veterans," Bayless says. "I feel blessed and honored to serve those that have so valiantly served our country." ■

Pain Service Balances Opioid Reduction With Pain Control

Team includes case managers

Some surgery practices have begun to require preoperative patients who take opioids for chronic pain to reduce their opioid prescriptions before surgery. Evidence-based outcomes suggest this helps them better deal with post-surgery pain and reduces their risk of opioid-related problems.

"We started a transitional pain service in January 2018," says **Kimberlee Bayless**, DNP, APRN, FNP-BC, director of the Transitional Pain Service and an acute pain service nurse practitioner, anesthesia department at George E. Wahlen Department of Veterans Affairs (VA) Medical Center in Salt Lake City.

"Our number-one goal is to take the best care of veterans that we can," she says.

"We don't want to see veterans suffer," she adds. "And, in reducing the opioid epidemic, our biggest fear is [opioid-sparing strategies] might increase suffering, and we don't want to see the suicide rate increase among our veteran population."

Fortunately, the new strategy to taper off opioids preoperatively and to reduce overall reliance on opioids for post-surgical pain management has worked very well, Bayless notes.

"Our patients' function scores are not worse — they're actually improving, and our patients' perceptions of pain have improved," she explains. "Their pain intensity is what you'd expect after surgery, and we can prevent chronic or persistent opioid use after surgery among opioid-naïve patients."

Before the transitional pain service, the institution's results were similar to the national average of 5-15% of people developing persistent opioid use, she says. "Now that's zero percent."

The program collects data, including patients' self-reported pain levels, and it shows that the tapering program does not increase their suffering. Instead, they are improving their functioning post-surgery and are stopping all opioids within 90 days, Bayless says.

"That's a true testament to our nurse case managers, who do the majority of our follow-up phone calls," she adds. "The service would not run without nurse case managers."

They call patients, post-surgery, at two days, seven days, 14 days, 21 days, 30 days, 60 days, and 90 days. They also perform a chart review.

"If the patient is not off opioids or back to baseline within 21 days, then they'll call them until they're off opioids," Bayless adds.

In one case, a man who was on opioids for chronic neck pain needed to reduce his medication before back surgery, says **David Merrill**, RN, transitional pain service coordinator at George E. Wahlen VA Medical Center.

The patient tapered down his opioid intake and underwent the surgery. Afterward, the team helped him wean off of opioids for a number of months.

"We worked with him through phone calls and helped him with withdrawal symptoms as he was winding down," Merrill says.

The patient wanted to reduce his opioid intake because it caused him to be so lethargic that he could not

EXECUTIVE SUMMARY

When surgery patients already are taking opioids for chronic pain issues, the new goal is to get them to reduce their daily opioid intake — and prevent their suffering.

- It is important to prevent veteran patients from experiencing pain and emotional distress that could lead to suicidal behavior.
- Follow-up calls from case managers can help monitor their pain levels, symptoms, and emotional states.
- Hospital patients have been happier and better able to move around post-surgery when they are less reliant on opioids.

spend time with his granddaughter. Once he was off opioids, he enjoyed babysitting his grandchild, Merrill explains.

But the patient returned to his community provider due to ongoing neck pain. The patient was prescribed opioids again, although at a lower dose than what he had been taking before surgery, Merrill says.

"He's not back to his baseline and probably is taking half of what he was when we met him," he adds. "This coincides with where we have great success, winding people down, and then they go back on pain medications — but with reduction."

In other cases, patients might report they have stopped taking opioids when they are continuing with a prescription. The transitional pain service team will compare patients' self-reported opioid use with prescription drug monitoring program data.

The focus on reducing opioids pre- and post-surgery includes changing hospital staff perceptions of pain management, as well. For instance, the VA hospital holds monthly inservices on the surgical floor about pain medication, Bayless says.

"This has empowered nurses on the floor," she says. "This helps nurses better take care of post-surgical pain, and nurses have seen better outcomes: The patients are happier and getting out of bed more."

From the nurses' perspective, the reduction in opioid use has been very positive, she adds. ■

Opioid Tapering Can Work With the Right Strategies

First step is obtaining patient buy-in

A transitional pain service at George E. Wahlen Department of Veterans Affairs Medical Center in Salt Lake City helps patients reduce their opioid use before surgery, and it helps patients taper off post-surgery opioids for pain management.

This approach is a big change in culture, says **Kimberlee Bayless**, DNP, APRN, FNP-BC, director of the Transitional Pain Service and an acute pain service nurse practitioner, anesthesia department at the VA Medical Center.

"We're changing the culture of nursing and of our surgeons and staff at the VA," Bayless explains.

The program uses different approaches for patients who already are taking opioids vs. those who would receive their first opioids after surgery.

"We look at patients that come in opioid-naïve and those that are on opioids differently because they have different risk factors," says **Benjamin Brooke**, MD, PhD, FACS, associate professor of surgery and an adjunct professor of bioinformatics and population health sciences at the University of Utah in Salt Lake City. Brooke also is the chief of the division of vascular surgery and director of the Utah Intervention Quality and Implementation Research group.

"One-third of our patient population has been on opioids. When you've been on opioids chronically, it's hard to get off the medication," Brooke says. "We have been able to wean off 45% of our people who were chronic opioid users."

One big opportunity has been to help patients wean off opioids after surgery.

"Sometimes, the surgery relieves what was causing their chronic pain," Brooke adds. "For the opioid-naïve patients, we have been able to achieve nearly perfect success in not having them need opioids three months after surgery."

The program's strategy is to reduce opioid use at each stage.

"We want to give patients an adequate supply of narcotics if they need them, but also teach them how to taper," Brooke says.

"Instructions say to take one tablet every four to six hours for pain, but do not distinguish between a pain level of 10 vs. a one or two," he explains. "We say, 'You don't need to take opioid medication unless your pain is at a higher level; for the lower level, take Tylenol, ibuprofen, and nonopioid analgesics, which can be used just as effectively."

For instance, knee surgery patients used to be discharged with 180 tablets, 5 mg, of oxycodone. Now they might receive 30 to 60 tablets, 5 mg, Bayless says.

The pain service uses a standardized multimodal pain treatment that includes Tylenol and anti-inflammatory medication.

"Things are becoming more standardized, and surgeons are becoming more thoughtful on how they're prescribing," she says.

And the results have been positive.

"The nursing staff has commented that pain is better controlled and patients are happier," Bayless says. "The nurses' satisfaction also is improved, overall."

Part of the reason the program is successful is because case managers work closely with patients, helping them cope with the pre-surgery opioid reduction and with their pain management after surgery.

Nurse case managers and a care team can assist with opioid-tapering strategies, employing this process:

• Have a conversation with patients about opioid tapering.

At intake, surgeons and staff let patients know that their elective surgery will not be scheduled until they have reduced their current opioid prescriptions, Bayless says.

"If they have decreased their opioids, there is less risk of having respiratory depression," she says.

When case managers meet with patients to discuss their current opioid use and how this needs to be reduced by 50%, they help patients set up a plan, says **David Merrill**, RN, transitional pain service coordinator at the VA Medical Center.

"Through coordination with other services, the nurse practitioner, the nurse, and physician, we all work to set up a plan to help motivate the patient," Merrill says. "We make monthly calls and follow up on a taper plan for the patient, checking in and giving encouragement."

Occasionally, patients are overzealous in their desire to reduce opioid use — and this can cause problems.

For instance, one patient had been on a high dose of opioids before he met with the case manager to discuss tapering off his prescription, Merrill says.

"He wanted his surgery so badly that he went against our advice and basically did a 50% reduction overnight," he recalls. "That never works because withdrawal symptoms kick in."

The team helped the patient return to his baseline opioid prescription level and then slowly tapered off the amount until he reached 50% of the baseline dosage.

> "FOR THE OPIOID-NAÏVE PATIENTS, WE HAVE BEEN ABLE TO ACHIEVE NEARLY PERFECT SUCCESS IN NOT HAVING THEM NEED OPIOIDS THREE MONTHS AFTER SURGERY."

"We'd call him each day to make sure he was doing OK," Merrill says. "We got him back on a normal program we set up for him."

The patient underwent surgery and was able to sustain using only half the dose of opioids he needed before he entered the program.

• Case managers call the prescriber.

The nurse case manager discusses with the opioid prescriber how the patient has agreed to a 50% taper of opioid medication, starting with the next prescription renewal. The case manager suggests the prescriber can refer to case notes on the patient or call the surgery center physician for any additional information, Bayless says.

"We can write out the opioid taper prescription for patients," she says. "We go over withdrawal medication and any other nonopioid medications that we would recommend they take."

The goal is a warm handoff to the prescriber, and that usually works well, Bayless says.

• Check back with the patient.

"One of the novel things about our program is we have a dashboard, a health information technology tool that was developed by our medical informatics pharmacist," Bayless says. "Our smart template has unique health factors imported into a dashboard, and it is able to track all of our patients."

Case managers will see patients' names with a list of their next appointments and alerts about which patients to call and check on.

"Every day, they can print out a unique list for that day," Bayless says. "The dashboard shows which patients are in pre-op and post-op and helps case managers prioritize their day."

Based on the dashboard data, a case manager can call the patient to talk about opioid tapering and to see how he or she is doing.

"The patients usually say, 'Things are going OK, but I'm having withdrawal symptoms like you said, and I'm not sleeping as well, and the medications you gave us are either helping or not helping,'" Bayless says. "We ask how we can address this and see if they are taking their medications as prescribed. Then the nurse case manager puts a note in the electronic medical record about what's happening."

Case managers might check back with patients weekly, asking, "Is a week follow-up okay? Or do you need me to call you sooner?" Bayless says.

Some patients might want a call the next day, so they drive the pace of the case manager calls.

This level of connection between case manager and patient continues

throughout the tapering period, which lasts four to eight weeks in most patients, she adds.

"When they're done, the nurse case manager will alert the surgical team and say the patient has done the 50% taper and they can schedule surgery," Bayless says. "They call the patient and say, 'You've done a great job, and we'll schedule you for surgery.'"

• Meet patients at pre-op appointments.

"They will see the patient again at the pre-op appointment to make sure everything stays OK," Bayless explains. "We ask if they have any more questions or concerns, and we go to the surgery appointment with them, touching base with the surgery team and answering any questions the team has for us."

The goal is another warm handoff. Case managers might discuss the patient's expectations once his or her surgery date is set.

• Set patients up with a psychologist, as needed.

"Our team works closely together, and the psychologist sees patients, initially," Bayless says. "If patients are at high risk for chronic opioid use, then the psychologist will do an individual session with them and a two-hour class, and see them as needed as they go through the opioid taper."

Psychologists lead a surgical expectation class and work with patients on cognitive-behavioral interventions before surgery, Brooke says.

"We found that having the class before surgery is the most effective way to do it, and those interventions can be reinforced while the patient is in the hospital," he says.

Psychologists have tried models that are validated for patients with addiction issues, including mindfulness and acceptance therapy, he adds.

The team encourages patients to use relaxation strategies, such as mindfulness, meditation, or hypnosis, to help them cope with the opioid medication reduction.

For example, one opioid-naïve patient who underwent shoulder surgery was still taking his post-surgery opioids a month after the procedure, Merrill says.

"We brought him back in, educated him, and had him work with our clinical psychologist," Merrill says. "Through the course of multiple visits, we found that his underlying problem was anxiety, and he'd never been treated for it."

With help from his case manager and the psychologist, the patient discovered that he was attracted to opioids because they numbed his anxiety. The team provided him with antianxiety medication and helped him taper off opioids, he adds.

Case managers build trusting relationships with patients, Merrill notes.

"We build a sense of trust with them," he says. "They're able to be open with us."

Once the patient trusted his case manager, he was able to answer questions honestly about why he still needed his pain medications and how he was feeling. Those answers led to a referral to the clinical psychologist and the anxiety diagnosis, Merrill adds. ■

Overmonitoring Addressed With EHR Order Set, Adherence to Best Practices

A Minnesota hospital is addressing the problem of overmonitoring patients with an order set in the electronic health record (EHR) that prompts clinicians to limit monitoring and unit assignments to only what is needed. However, introducing the system was not without challenges.

Excessive and unnecessary ECG monitoring of patients is a common problem in hospitals, says **Sue Sendelbach**, PhD, APRN, CNS, who retired recently from her position as director of nursing research at Abbott Northwestern Hospital in Minneapolis. She worked at that time with Allina Health colleagues at nearby United Hospital/Allina Health Leaders in St. Paul, MN, to reduce unnecessary monitoring so that care could be improved for patients and resources could be used more appropriately for those needing more monitoring, she says.

"A lot of times, patients would be monitored for days without an assessment to determine if they really needed to have that monitoring continued. Hospitalists would put patients on our telemetry units for progressive care and say the patient doesn't need to be monitored, but then the nurses thought they needed to be monitored because it was a telemetry unit," she says. "There was a lot of confusion around who needed to be monitored. It was not without risks, either, because the literature has shown that patients who are monitored will have a higher risk of adverse outcomes."

Excessive and unnecessary ECG monitoring can contribute to alarm fatigue and has even been tied to fatalities, Sendelbach notes. The best practice for ECG monitoring calls for it to be used in the ICU only with a program that includes continuing assessment of its value, with the option to discontinue it while the patient remains in the ICU, she says.

Guidelines Available for Monitoring

The goal was to use ECG monitoring in the ICU only for those patients who truly needed it, Sendelbach says. To accomplish that, she worked with **Kristin Sandau**, PhD, RN, staff nurse at United Hospital/Allina Health and professor of nursing at Bethel University in St. Paul. Sandau chaired the 2017 American Heart Association (AHA) team that updated the ECG monitoring practice standards. *(The standards are available online at: https://bit.ly/2V9lv2V.)*

Sandau says the overuse of ECG monitoring is a side effect of the rapid proliferation of technology in healthcare over recent years.

"We have come to a point where we have more technology than needs to be used sometimes with our patients. We need to pause and take time to review the evidence and determine what really needs to be used for patients in a way that will help them," Sandau says. "A lot of this monitoring has been grandfathered into patient care without any studies. Some of it makes sense, because if someone is having a heart attack, we don't need a randomized, controlled trial to tell us that monitoring is appropriate. But there are quite a few populations for which we don't have the evidence indicating they need to be monitored."

Way Too Much Monitoring

To address the problem, the team at Allina Health began by getting a baseline assessment of how many ICU patients were being monitored. An assessment of charts suggested that, according to the AHA guidelines, the system might have been overmonitoring by as much as 50%, Sandau says.

"That first informal assessment was to determine if we had an actual problem that justified investing resources in this, and we found out that indeed we seemed to have an incredible amount of overmonitoring of patients who were receiving remote monitoring on a noncritical care, nonprogressive care telemetry unit," Sandau says. "They might be in with a foot ulcer or a GI bleed. But you can have a GI bleed and be very stable or you can be in an ICU, so we can't just use diagnoses."

Instead, clinical judgment and guidelines are necessary to dictate when ECG monitoring is necessary, she says. The team at the hospital determined that an order set would be the most effective way to guide decision-making on ECG monitoring, but implementing an order set often is no easy task, says **Steven Hanovich**, MD, MS, an intensivist at United Hospital/Allina Health in St. Paul.

When introducing any new order set or other clinical guidance, resistance from physicians is to be expected, Hanovich says. They respond by saying they already know how to take care of patients, so why are you telling them what to do and what monitoring to order?

Physicians responded to the call for better monitoring decisions more positively than expected.

"The challenge is always to get them to listen to you, to educate them on why this is good for patient care. In this particular case, we had the advantage of saying there are some very specific practice guidelines on when to use cardiac monitoring," Hanovich explains. "They were excited to learn these existed, and there was a thirst for the knowledge because they all realized we were using cardiac monitoring as a babysitter. A lot of doctors thought we were overdoing it. I knew we were."

Monitoring Does Not Mean More Care

Sandau says physicians who overprescribe ECG monitoring often are under the impression that the monitoring means their patients receive more care from nurses, that they are checked more often, and that any type of problem will be discovered sooner.

That's not the case, she says. Physicians may think their patients will receive more attention with monitoring because those units have more staff, but even that is not true across all shifts, Sandau explains.

"They see the cardiac monitoring as a proxy for higher staffing levels, and we need to be helping physicians understand it just does not work that way. Putting your patient on a cardiac monitor does not mean they receive the more attentive care that you think they should have and would have if we had more staff available," Sandau says.

"But not monitoring does not mean that your patient receives inadequate care, either. We do need the right staffing levels, but it also is

important that the patients be on the unit where they need to be."

Hanovich confirms that it can be common wisdom among physicians that ordering cardiac monitoring, whether the patient truly needs it or not, is an effective way to get better care for your patient. "It's a line you hear over and over throughout your training and residencies — just admit them to a telemetry unit, and they'll get closer care up there," Hanovich says. "That's just accepted as a real-world strategy, so you have to start by explaining to them that's not true."

EHR Integration Was Challenging

The hospital team developed the order set using the AHA guidelines and gained approval to introduce it throughout the Allina health system, but integrating it into the care process was not easy. The EHR was the biggest challenge, Hanovich says. He had recently been trained by the vendor in programming the hospital's EHR, so he was able to build a dashboard for ECG monitoring into the existing system.

A primary concern was to make it user-friendly, which for clinicians means not having to click through too many options and enter too much information to get to what you want, he explains. In his training on the EHR platform, he had seen how a few other hospitals were implementing cardiac monitoring protocols.

"Some hospitals had decided their criteria for cardiac monitoring and placed the onus on the nurses to decide when to stop monitoring because the indications were gone. But we had decided early on that it would be the doctor making that decision; the doctors were going to own this," Hanovich says. "So I had to come up with a way to achieve that and the best way still to decrease the amount of clicks."

He determined that the best approach when the physician entered an indication for cardiac monitoring was for the EHR to present a menu of orders appropriate for that indication.

"We built the order such that they only saw a few things on the screen at a time, and based on what they ordered, they would see another few things to click on," Hanovich says. "The doctor had to give the indication for the order, which made the doctor think about why telemetry was being ordered."

That still added a few more clicks to an EHR process that many clinicians already found bothersome, so the order set team had to sell physicians on the reasons behind the change.

"I told them yes, we have a couple more clicks on here, but if you think about what we're doing and how the end result is better patient care, you'll feel better about what you're thinking of as unnecessary, extra clicks," Hanovich says.

"We implemented this with a road show. Sue and I went to every hospital in our system and met with the hospitalists, the primary ordering teams for cardiac monitoring, for a half hour to an hour at a time. It was the interpersonal relationships that got all of this going with a surprisingly small amount of guff from the physicians."

Sell the Reason for Changing

Sandau also points out that clinicians are more likely to bristle at being told by upper-level administrators or even top physician leaders how to care for their patients. The new order set was presented more as the result of a collaboration among many clinicians looking for the best solution that would provide better care, she says.

"You have to be wise in understanding that people don't like receiving a top-down mandate for change, at least not without having some personal involvement in the decisions leading to that change," Sandau says. "At the same time, you also have to gauge how much people at different hospitals or in different areas want to be involved and respond accordingly. We had some hospitals where people wanted to be involved in the process and provide input, so you have to take some time and exchange emails with them. But we also had some other smaller sites that more often just wanted it handed to them, ready to plug in."

Sendelbach points out that the team also trained all the nurses and cardiac technicians responsible for cardiac monitoring. At Abbott Northwestern, she visited them often during the implementation of the new order set to see whether they had any questions.

"We made a very concerted effort to involve stakeholders and keep communication lines open so that people could call you up and ask, 'What about this patient or what about this situation?'" Sendelbach says. "It also was important to have clinical champions who could make this work by supporting it among their peers. We had champions who were cardiologists, intensivists, hospitalists, [and] nurses, and they made a big difference in moving this forward."

It also was important to have a team member from the EHR department to help with introducing the order set and tweaking the EHR

component after implementation, as well as a project manager to help coordinate the contributions of all the members, Sendelbach says.

Gradual Introduction to Health System

Allina Health introduced the order set at just a few hospitals at first, giving the team time to fine-tune it before rolling it out across the system's 13 hospitals and 90-plus clinics in Minnesota and western Wisconsin.

"You can build what you think works great, but you don't know until you actually go live with it what works and what doesn't. Our order was very successfully implemented without any major difficulties at the first hospitals, but there are always a few little things you find when you first roll out something like this," Sandau says. "Be sensitive, listen to your end users, and respond to what they're saying."

Sendelbach, Sandau, Hanovich, and their colleagues recently reported on their use of the order set, saying the proportion of appropriately monitored patients increased from 48% before implementation to 61.2% after.

"Hospitalists, none of whom completed the formal education, had no statistically significant improvement in adherence to the practice standards (51.6% appropriate monitoring before intervention vs. 56.6% after intervention; *P = .51*), whereas medical residents, who received mandatory education, had a statistically significant improvement in ordering compliance, from 30.8% appropriate monitoring before intervention to 76.5% after the intervention," they reported.

"Most striking was the difference between hospitalists and medical residents in their participation in education and correct use of the electronic order set. Although education alone does not change practice, our results indicate that education may provide a key element to understanding the rationale for a practice change and may increase adherence to the practice change." *(The report is available online at: https://bit.ly/2UXoHhQ.)*

Some Patients Still Hard to Classify

Sandau notes that they found no increase in adverse outcomes for the patients who were not monitored under the new protocol, although she suggests that is an area that could use further study. Other remaining questions involve patients who may not seem to fit easily into one category for ECG monitoring.

For example, what do you do with a patient who has an indication for monitoring when the potassium level is very low, but then that level comes up the next day, and then goes down the following day?

The team at United Hospital/Allina Health includes those patients in the protocol for ECG monitoring, but Sandau says fine-tuning the guidelines and order sets for difficult cases like that will be an ongoing effort.

"If it's an orthopedic issue but they're in a rapid atrial fibrillation, is the solution to be on a cardiac step-down so the nurse can manage the AFib after surgery [even if the nurse is] perhaps less familiar with the orthopedic care?" Sandau says. "Or is it better to have them on an orthopedic unit and remotely monitored by nurses who are not at that station? Those are questions that we still need to answer, and we'd like sites that are building remote monitoring to look at the evidence for that and share with each other."

Nurses on some units may be made uncomfortable by caring for patients on their unit with remote monitoring overseen by nurses elsewhere, Hanovich says.

He and Sandau say that is an issue that hospitals must address if they use remote monitoring, particularly if they are trying to place patients on more appropriate units to reduce overmonitoring.

"We have a lot of stakeholders who truly want the best for their patients, so if they don't feel qualified or ready, they will balk at these patients being admitted to their units. It's not that they don't want to do the work, but rather that they don't want to take on a patient for whom they cannot provide proper care," Sandau says.

"A lot of conversations have to take place to get patients in the right units with the right monitoring, but also to make the nurses and other caregivers comfortable with what you're doing." ■

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CE QUESTIONS

1. **According to federal data, how many people in the United States filled at least one opioid prescription in 2017?**

   a. 11 million
   b. 28 million
   c. 42 million
   d. 56 million

2. **When a psychologist is working with a surgical patient experiencing difficulty coping with pain and tapering off opioids, what is a potential strategy the psychologist can employ?**

   a. Shock therapy
   b. Mindfulness
   c. Yoga
   d. Past regression therapy

3. **Which of the following is the first step in tapering patients off of opioids before surgery?**

   a. Call the prescriber
   b. Talk with the patient about opioid tapering
   c. Refer the patient to pain management services
   d. Have case managers call and check in with the patient

4. **Some patients at risk of developing persistent opioid use have experienced substance use problems, anxiety, and past illicit drug use. They also might engage in what kind of behavior?**

   a. Frequent pain complaints
   b. Quietness and inability to express their feelings
   c. Catastrophizing their pain
   d. Anger outbursts

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.