2022 ACHQC Quality Improvement Summit
Data Driven Collaboration to Improve Core Health

Improving Pain Management
Using Individual Data to Change Practice

March 19, 2022

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Disclosures

- None
Thank You

- Micki Reinhorn
- The entire Opioid Reduction Task Force
Overview

- Current ACHQC recommendations
- Open and MIS Inguinal Hernia Repair
  - Individual Data, ≤10 tablet prescribing, Zero Prescribing, Best Performers
- Umbilical Hernia Repair
  - Individual Data, ≤10 tablet prescribing, Zero Prescribing, Best Performers
- Incisional Hernia Repair
  - Individual Data, Zero Prescribing, Abdominal Binder Use
- Getting to Zero opioids – is it necessary?
Opioid Task Force

- Started in 2019
- Led by Dr. Micki Reinhorn
- Multidisciplinary group with 16 members
  - Surgery
  - Anesthesia
  - Primary Care
Current ACHQC Recommendations

Perioperative

- Discuss pain expectations and discuss medications in preop holding
- Provide ACHQC opioid education handout with discharge instructions
- Educate, prescribe or recommend to patients: Acetaminophen, Ibuprofen, Gabapentin, ice
- Provide opioid Rx for no more than 10 pills
Individual data

Opioid usage after hernia procedures - Surgeon ID 138
Data Analysis Report for 2020-08-01 through 2021-10-04

Sharon Phillips
October 21, 2021
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<th>Patient reported opioid use - ventral</th>
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<td>0% (0)</td>
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N is the number of non-missing values. Numbers after proportions are frequencies.
Open and MIS Inguinal Hernia Repair
Did you change your prescribing practice for inguinal hernia repairs due to Opioid Task Force recommendations and/or your individual data?

10 responses

100%
Describe your pain medication prescribing changes for inguinal hernia repair

- Given me the comfort to **reduce prescribing**
- Further **reduced prescribing**. Added Robaxin to standard prescriptions
- **Prescribing less opioids.** Have started to prescribe ribaxin
- Decreased opioid tablets prescribed to 10, increased patient education pre-op with opioid education handout, increased usage of non-opioid medications post-operatively
- **Drastically reduced opioid Rx** and Rx number of pills; increased use of Rx strength acetaminophen and ibuprofen
- Continued to decrease narcotic scripts to the point now where I **no longer prescribe opioids** for inguinal hernias. Also have changed the way I deliver expectations for pain in the office preop as well as in the pre-surgery area before surgery
- **decreased down to 7 tabs** based on data
- From 30 pills to 5 pills over the past 4 years
- 15 tabs for inguinal -> then 10 tabs and more recently -> 7 tabs
- **Went to essentially no opioid prescriptions**
Open Inguinal
Do you administer a nerve block for your inguinal hernia repairs?
Open Inguinal

≤10 tablets

39

101
Open Inguinal Zero Prescribers

Surgeon 27 n=27

Surgeon 128 n=18

Surgeon 128 n=11

Surgeon 24 n=30

Surgeon 39 n=395

Surgeon 57 n=13

39

101
Top Performers

27:
- **Open-ilioinguinal nerve block** with lidocaine/bupivacaine/HCO3 and field block. Postop opioid sparing regimen (alt tylenol/ibuprofen with backup oxy)
- Regularly Prescribe Tylenol, Prescribe Ibuprophen
- Clinic instructions and QC app

49:
- Intraop Local prior to every step with Bupivacaine/Lido combo. **Block** with lido only. Lido only in preperitoneal space to avoid femoral nerve block. Tylenol and Mortrin together q6 hours 2-5 days and ice second line. Selective prescribing based on postop pain or patient request
- Regularly Recommend tylenol, Recommend Ibuprophen, Ice to the surgical site

57:
- tylenol and gabapentin pre-op, bupivacaine at the end of the operation - **ilioinguinal block** plus sub-q, post-op told to alternate ibuprofen and tylenol OTC and only take oxycodone if needed
- Regularly Recommend tylenol, Recommend Ibuprophen, Ice to the surgical site

In clinic and day of surgery I describe the roll of opioids as a third line if tylenol and ibuprofen aren’t working; I also like to mention that many patients don’t take any opioids so that they know it’s possible.
MIS Inguinal

Graphs showing the comparison between % prescribed and % used for different procedures.
Do you administer a nerve block for your inguinal hernia repairs?
MIS Inguinal

<10 tablets

Lap

Robo

Lap

Robo

Lap

Robo

Lap

Robo

Lap

Robo

Lap

Robo

Lap

Robo

Lap

Robo

Lap

49
MIS Inguinal Top Performer

Lap

Robo

Lap

Robo

Lap

Robo

Lap
Top Performer

- 89:
  - Tylenol Preop, bupivacaine mixed with dexamethasone for tapp block intraop lap guided for all robotic inguinals
  - Regularly Prescribes Tylenol, Prescribe Ibuprophen, Ice to the surgical site
  - Patients get expectations discussed with them in the pre-op area as well as in my office before surgery and also get a sheet that they can carry with them home that contains the directions for the Motrin and Tylenol and ice
Umbilical and Incisional Hernia Repair
Did you change your prescribing practice for ventral hernia repairs due to Opioid Task Force recommendations and/or your individual data?

10 responses

100% Yes

No
Describe your pain medication prescribing changes for ventral hernia repair

Selective prescribing based on my own data

Decreased prescription changes for ventral hernia repair

Decrease from everyone getting 50 tabs on DC to graded based on what they take and can be from 0-28 tabs

Decreased opioid tablets prescribed to 10, increased patient education pre-op with opioid education handout, increased usage of non-opioid medications post-operatively

Further reduction in prescribing, addition of robaxin

Less opioids prescribed

Continued education about expected pain postop and use of q6 hour Motrin and Tylenol

15 tabs for umbilicals -> then 10 tabs and more recently -> 7 tabs; inpatient ventral hernias - discharge opioids dependent on how many tabs they took in the last 48 hours

No opioid usage
Umbilical Hernias
Umbilical Hernias  Zero Prescribers

Surgeon 27 n=40

Surgeon 136 n=100

Surgeon 109 n=15

Surgeon 39 n=18

Surgeon 24 n=34

Surgeon 49 n=16

Surgeon 57 n=15
Top Performer

89:

- Patients will get Tylenol in the preoperative area, for most of my robotic ventral hernia repair patients they will get an intraoperative lap TAP block, for open ventral local only unless able to do incision large enough for direct TAP block such as an open TAR.
- No abdominal binder used
- Regularly Prescribes Tylenol, Prescribe Ibuprophen, Ice to the surgical site
- Patients get expectations discussed with them in the pre-op area as well as in my office before surgery and also get a sheet that they can carry with them home that contains the directions for the Motrin and Tylenol and ice
Intraop Local prior to every step with Bupivicaine/Lido combo. Block with lido only. Lido only in preperitoneal pain to avoid femoral nerve block. Tylenol and Mortrin together q6 hours 2-5 days and ice second line. Selective prescribing based on postop pain or patient request - slightly more prescribing for bigger hernias.

- No abdominal binder used
- Regularly recommends Tylenol and Ibuprophen, Ice to the surgical site
- I briefly tell them in the office that 90% of patients do well with tylenol, motrin and ice. In preop I tell them the same thing, plus mention the side effects of opioids and that we selectively prescribe or they can call for a script if they want - We get 1/100 patients calling.
Do you use TAP blocks for ventral, umbilical, epigastric hernia repairs?

10 responses

- Yes: 70%
- No: 30%
How do you perform you TAP block if you use them?

- Pre op - US guided, full dose per body weight diluted with saline and injected in TAP
- Anesthesia performs it pre-op with ultrasound using exparel
- Intra-op by me with 0.5% bupivicaine - 25cc on each side (I stopped diluting with saline)
- Intraop will usually give some sort of block with exparel mixed with 0.25% plain marcaine. For small umbilicals, I do a lido/bupivicaine mix
- For tars intraop surgeon performed and bupivicaine
- Bupivivaone plus dexamethasone lap guided by me tap block
- most often by myself under direct visualization near end of procedure.
How do you perform you TAP block if you use them?

- **Pre op - US guided**, full dose per body weight diluted with saline and injected in TAP
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- For tars intraop **surgeon performed** and bupivicaine
- Bupivivaone plus dexamethasone lap guided **by me** tap block
- most often **by myself** under direct visualization near end of procedure.
How do you perform you TAP block if you use them?

- Pre op - US guided, full dose per body weight diluted with saline and injected in TAP.
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- Intra-op by me with 0.5% bupivicaine - 25cc on each side (I stopped diluting with saline).
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- For tars intraop surgeon performed and bupivicaine.
- Bupivivaone plus dexamethasone lap guided by me tap block.
- Most often by myself under direct visualization near end of procedure.
Incisional Hernias Zero Prescribers

24

49
Do you make your patient wear and abdominal binder after ventral hernia repair

10 responses

40% Yes
60% No
How do you recommend abdominal binder use?

- Binder to be worn continuously for 2 weeks, then with activity only for an additional 2-4 weeks depending on patient comfort.
- I tell to wear when not sitting or sleeping the first two weeks then at 2wk f/u I tell them it's up to them; I'm a little more strict if they have a huge sub-q space.
- Binder on during day for 4 weeks, may remove at night.
- per ACHQC recs mostly - 2 weeks 24/7 and then 4 weeks just during the day.
- I do but I have no idea why. They seem to like it.
- Binder to be worn continuously for 2 weeks, then with activity only for an additional 2-4 weeks depending on patient comfort.
- Wear it for 6 weeks.
- Variable use of binders.
Incisional Hernias  Abdominal Binder

24

49
Getting to Zero
Is zero prescribing an important goal? SHOULD zero prescribing be an important goal? Are MD's who write zero doing a 'better job' than those writing 5, or maybe even 10?
Are you hesitant to stop regularly prescribing opioids?

10 responses

70% Yes
30% No
Why won’t you stop prescribing opioids?

- while a lot of patients don’t require opioids, many still do; I think giving them a limited number gives them some peace of mind just in case they need it
- Patient satisfaction and having to field more calls to my office staff and myself after hours/weekends for an Rx.
- Residents are first line to receive pages and they are often very delayed in responding
**24:**

- "Patient satisfaction, and having to field more calls to my office staff and myself after hours/weekends for an Rx"
- Provide patients w detailed 2 page 'Pain Management Protocol' at the time of scheduling, prescribe 5 opioids, use lido/marcaine injection into incisions before incisions are made, and at the end of case before closing for both open and lap cases.

**138:**

- "Residents are first line to receive pages and they are often very delayed"
- Provide written info during clinic visit. Discuss a little bit, but not too much. Discuss in preop. Have written post-op instructions.
MIS Inguinal

Graphs showing data for different surgeons and procedures, with labels for Lap and Robo.
24:

- “Patient satisfaction, and having to field more calls to my office staff and myself after hours/weekends for an Rx”
- Provide patients w detailed 2 page 'Pain Management Protocol' at the time of scheduling, prescribe 5 opioids, use lido/marcaine injection into incisions before incisions are made, and at the end of case before closing for both open and lap cases.

57:

- “while a lot of patients don’t require opioids, many still do; I think giving them a limited number gives them some peace of mind just in case they need it”
- in clinic and day of surgery I describe the roll of opioids as a third line if tylenol and ibuprofen aren’t working; I also like to mention that many patients don’t take any opioids so that they know it’s possible.
Umbilical Hernias
Clinic instructions and QC app

Residents are first line to receive pages and they are often very delayed

Provide written info during clinic visit. Discuss a little bit, but not too much. Discuss in preop. Have written post-op instructions.

"Patient satisfaction, and having to field more calls to my office staff and myself after hours/weekends for an Rx"

Provide patients w detailed 2 page 'Pain Management Protocol' at the time of scheduling, prescribe 5 opioids, use lido/marcaine injection into incisions before incisions are made, and at the end of case before closing for both open and lap cases.

"while a lot of patients don't require opioids, many still do; I think giving them a limited number gives them some peace of mind just in case they need it"

in clinic and day of surgery I describe the roll of opioids as a third line if tylenol and ibuprofen aren't working; I also like to mention that many patients don't take any opioids so that they know it's possible.
Incisional Hernias  Zero Prescribers

24

49
Conclusions
The majority of patients for inguinal and umbilical hernia repairs do not require postoperative opioids.

Surgeon prescribing continues to be more than what patients use.

Collaboration as well as knowledge of individual data can change prescribing habits.

There is power in education and setting pain expectations is beneficial.
Describe your pain medication prescribing changes for inguinal hernia repair

- Having my own data has given me the comfort to reduce prescribing.
- Decreased opioid tablets prescribed to 10, increased patient education pre-op with opioid education handout, increased usage of non-opioid medications post-operatively.
- 15 tabs for inguinal -> then 10 tabs and more recently -> 7 tabs.
- From 30 pills to 5 pills over the past 4 years.
- Went to essentially no opioid prescriptions.
- Prescribing less opioids. Have started to prescribe ribaxin.
- I decreased down to 7 tabs based on data.
- Continue to decrease narcotic scripts to the point now where I no longer prescribe opioids for inguinal hernias and rarely give more than five oxycodone’s for most Outpatient VentralHernias, Also have changed the way I deliver expectations for pain in the office preop as well as in the pre-surgery area before surgery.
- Drastically reduced opioid Rx and Rx number of pills; increased use of Rx strength acetaminophen and ibuprofen.
- Further reduced prescribing. Added Robaxin to standard prescriptions.
Do you administer a nerve block for your inguinal hernia repairs?
Please describe your current typical perioperative pain regimen for inguinal hernia repairs (anything preop, local, postop, etc)

- Intraop Local prior to every step with Bupivicaine/Lido combo. Block with lido only. Lido only in preperitoneal pain to avoid femoral nerve block. Tylenol and Motrin together q6 hours 2-5 days and ice second line. Selective prescribing based on postop pain or patient request

- Pre-op tylenol, gabapentin and diamox. Intraop, 0.25% marcaine injected at trocar sites. Post-op robaxin x 10 tablets, tylenol, ibuprofen and only 10 tablets of oxycodone if absolutely needed tylenol and gabapentin pre-op, bupivicaine at the end of the operation - ilioinguinal block plus sub-q, post-op told to alternate ibuprofen and tylenol OTC and only take oxycodone if needed

- Provide patients w detailed 2 page 'Pain Management Protocol' at the time of scheduling, prescribe 5 opioids, use lido/marcaine injection into incisions before incisions are made, and at the end of case before closing for both open and lap cases.

- Pre op - Tylenol 975mg, Celebrex 200mg, Gabapentin 300 mg (<70) 100 mg > 70, Intraop op Lidocaine /Bupivacaaine incisional - full dose based on body wt, Post op Tylenol 650 mg every 6 hours for 5 days , Ketorolac 10 mg every 6 hrs prn for 5 days (20 pills) unless renal or GI contraindication
Please describe your current typical perioperative pain regimen for inguinal hernia repairs (anything preop, local, postop, etc)

- **Prep** - per anesthesia, usually give Tylenol and Lyrica. Intraop - give local most commonly with lido/bupivacaine mix, both local and as block. Postop - recommend Tylenol and ibuprofen scheduled, ice pack, and then give 5-6 tab Rx of oxycodone.
- **Local** as above, encourage Advil/Tylenol and ice
- **Tylenol**
  - Preop, bupivacaine mixed with dexamethasone for tapp block
  - Intraop lap guided for all robotic inguinals. For open inguinal's new routine by Pippa Kane local for incision and local used underneath the External oblique that's all
  - Open-ilioinguinal nerve block with lidocaine/bupivacaine/HCO3 and field block. Lap-no block. Postop opioid sparing regimen (alt tylenol/ibuprofen with backup oxy)
- **Preop**:
  - celebrex, tylenol. Intraop: local at incision sites, minimize IV opioid by using ketamine bolus. Postop: prescribed tylenol, ibuprofen, robaxin +/- small rx of opioid (5 or fewer pills)
Describe your pain medication prescribing changes for ventral hernia repair

- Selective prescribing based on my own data
- Decreased opioid tablets prescribed to 10, increased patient education pre-op with opioid education handout, increased usage of non-opioid medications post-operatively
- 15 tabs for umbilicals -> then 10 tabs and more recently -> 7 tabs; inpatient ventral hernias - discharge opioids dependent on how many tabs they took in the last 48 hours.
- from 30 pills to 5 pills over the past 4 years
- No opioid usage
- Less opioids prescribed
- I decreased from everyone getting 50 tabs on DC to graded based on what they take and can be from 0-28 tabs
- Continued education about expected pain Postop and use of q6 hour Motrin and Tylenol
- Further reduction in prescribing, addition of robaxin
Do you use TAP blocks for ventral, umbilical, epigastric hernia repairs?

10 responses

- Yes: 70%
- No: 30%
How do you perform you TAP block if you use them?

- Pre op - US guided, full dose per body weight diluted with saline and injected in TAP
- Anesthesia performs it pre-op with ultrasound using exparel
- intra-op by me with 0.5% bupivicaine - 25cc on each side (I stopped diluting with saline)
- Intraop will usually give some sort of block with exparel mixed with 0.25% plain marcaine. For small umbilicals, I do a lido/bupivicaine mix
- For tars intraop surgeon performed and bupivicaine
- Bupivivaone plus dexamethasone lap guided by me tap block
- most often by myself under direct visualization near end of procedure.
Current typical perioperative pain regimen for ventral hernia repairs:

- Intraop Local prior to every step with Bupivicaine/Lido combo. Block with lido only. Lido only in preperitoneal pain to avoid femoral nerve block. Tylenol and Motrin together q6 hours 2-5 days and ice second line. Selective prescribing based on postop pain or patient request - slightly more prescribing for bigger hernias.

- Pre-op tylenol, gabapentin and diamox. Intraop, 0.25% marcaine injected at trocar sites. Post-op robaxin x 10 tablets, tylenol, ibuprofen and only 10 tablets of oxycodone if absolutely needed

- post-op tylenol and gabapentin, PCA with dilauded until tolerating pills on POD#2 or 3

- Provide patients w detailed 2 page 'Pain Management Protocol' at the time of scheduling, prescribe 5 opioids, use lido/marcaine injection into incisions before incisions are made, and at the end of case before closing for both open and lap cases.
Current typical perioperative pain regimen for ventral hernia repairs:

- **Pre op** - Tylenol 975mg, Celebrex 200mg, Gabapentin 300 mg (<70) 100 mg > 70; Post op - Tylenol 650 mg every 6 hours for 5 days, Ketoralac 10 mg every 6 hours prn (20 pills) unless contraindicated due to GO or Renal issues.

- **Prep** - per anesthesia, usually give Tylenol and Lyrica. Intraop - give local +/- block with exparel. Postop - Tylenol and ribaxin scheduled, ice pack, oxycodone PRN.

- **Postop** - patients will get Tylenol in the preoperative area, for most of my robotic ventral hernia repair patients they will get an intraoperative lap TAP block, for open ventral local only unless able to do incision large enough for direct TAP block such as an open TAR.

- **Smaller ventrals** - nothing; AWR-intrathecal morphine.

- **Preop** - celebrex, tylenol. Intraop: local at incision sites, minimize IV opioid by using ketamine bolus or drip. Postop: prescribed tylenol, ibuprofen, robaxin +/- small rx of opioid (10 or fewer pills).
Do you make your patient wear and abdominal binder after ventral hernia repair

10 responses

- Yes: 60%
- No: 40%
How do you recommend abdominal binder use?

- Binder to be worn continuously for 2 weeks, then with activity only for an additional 2-4 weeks depending on patient comfort.
- I tell to wear when not sitting or sleeping the first two weeks then at 2wk f/u I tell them it’s up to them; I’m a little more strict if they have a huge sub-q space.
- Binder on during day for 4 weeks, may remove at night.
- per ACHQC recs mostly - 2 weeks 24/7 and then 4 weeks just during the day.
- I do but I have no idea why. They seem to like it.
- Binder to be worn continuously for 2 weeks, then with activity only for an additional 2-4 weeks depending on patient comfort.
- Wear it for 6 weeks.
- Variable use of binders.
Do you REGULARLY recommend/prescribe any of the following after hernia repair?

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<th>Responses</th>
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<td>70%</td>
</tr>
<tr>
<td>Recommend Ibuprofen</td>
<td>6</td>
<td>60%</td>
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<td>Prescribe Tylenol</td>
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<tr>
<td>Prescribe Ibuprofen</td>
<td>4</td>
<td>40%</td>
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<td>Prescribe Gabapentin</td>
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<td>0%</td>
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<tr>
<td>Prescribe Robaxin</td>
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<td>20%</td>
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<td>Ice to the surgical site</td>
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<td>ACHQC Core rehab</td>
<td>1</td>
<td>10%</td>
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How do you educate patients about pain management expectations?

- I briefly tell them in the office that 90% of patients do well with tylenol, motrin and ice. In preop I tell them the same thing, plus mention the side effects of opioids and that we selectively prescribe or they can call for a script if they want - We get 1/100 patients calling.

- Provide pre-op ACHQC handout on post-op pain control, in discharge instructions this is reiterated

- In clinic and day of surgery I describe the roll of opioids as a third line if tylenol and ibuprofen aren’t working; I also like to mention that many patients don’t take any opioids so that they know it’s possible.

- Provide patients w detailed 2 page 'Pain Management Protocol' at the time of scheduling. No open discussions otherwise.

- Expectations set in office and in the pre op holding area with significant other present
How do you educate patients about pain management expectations?

- Provide written info during clinic visit. Discuss a little bit, but not too much. Discuss in preop. Have written post-op instructions.
- Not much on that front is done
- All of the above, Patients get expectations discussed with them in the pre-op area as well as in my office before surgery and also get a sheet that they can carry with them home that contains the directions for the Motrin and Tylenol and ice
- Clinic instructions and QC app
- I have a discussion in preop holding to specify their pain regimen (first line, second line, breakthrough) and what they can expect their pain to be. Set more strict criteria for when narcotics should be used (after exhausting other options and when pain is severe enough to limit mobility). Specify any prior adverse reactions to ensure no scripts given that have to be changed.
Who typically handles patient phone calls and requests for opioid refill prescriptions?

- I do: 30%
- My nurse: 10%
- A resident: 10%
- Admin Asst tell my NP or Fellow: 10%
- My nurse practitioner: 10%
- Nurse or resident: 10%
- Either me, my PA or covering MD / PA: 10%
- MA takes the calls, then passed to myself: 10%
Who typically completes the ACHQC data entry?
Other things to keep in mind

- Feedback on our own patient consumption data
- Is zero prescribing an important goal? SHOULD zero prescribing be an important goal? Are MD's who write zero doing a 'better job' than those writing 5, or maybe even 10?
- Consider checking OARRS report prior to a procedure for someone that may have a history and discuss that with them