Opioid Use and Pain Treatment in the United States

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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Historical Perspective of the Opioid Crisis</td>
<td>6</td>
</tr>
<tr>
<td>Demographics of Opioid Use</td>
<td>8</td>
</tr>
<tr>
<td>Financial Impact of the Opioid Crisis</td>
<td>10</td>
</tr>
<tr>
<td>Bay County, Michigan and the Opioid Epidemic</td>
<td>15</td>
</tr>
<tr>
<td>The Joint Commission Response to the Opioid Epidemic</td>
<td>16</td>
</tr>
<tr>
<td>McLaren Bay Region Pain Stewardship Committee</td>
<td>17</td>
</tr>
<tr>
<td>Formation of the Pain Stewardship Committee</td>
<td>20</td>
</tr>
<tr>
<td>Strategic Goals of the Pain Stewardship Committee</td>
<td>22</td>
</tr>
<tr>
<td>Conclusion</td>
<td>25</td>
</tr>
<tr>
<td>References</td>
<td>26</td>
</tr>
</tbody>
</table>
Executive Summary

The United States is in the midst of one of the greatest public health emergencies in history. Opioid use has skyrocketed since the late 1990s, causing dramatic increases in opioid related addictions, overdoses, and deaths. Treatment of pain in the 90s was thought to be inadequate and opioids were believed to be the nonaddictive solution. Since then, opioids have been found to be highly addictive, and significant increases in opioid prescribing for over a decade has precipitated an unprecedented opioid epidemic in the United States. Since 1999, opioid sales in the United States have more than quadrupled, while drug overdoses have become the leading cause of death of Americans under the age of 50.

To combat the opioid problem, The Joint Commission issued new pain standards in 2018. One the standards required all healthcare organizations to create a pain stewardship committee. McLaren Bay region, a 400-bed hospital in Bay County, Michigan, is in the process of implementing that required pain stewardship committee. The hospital’s pain stewardship committee must create an effective and sustainable pain management program.

Formation of the McLaren Bay Region Pain Stewardship Committee included an initial SWOT analysis. The analysis was a detailed evaluation of all internal strengths and weaknesses and all external opportunities and threats that could impact the committee. The team assembled must be highly effective and must maintain a high level of engagement in an effort to effectively achieve all strategic goals. A strong pain stewardship committee at McLaren Bay Region can dramatically reduce opioid use in its patient population and begin to reverse the opioid crisis in Bay County, Michigan.
Opioid Use and Pain Treatment in the United States

The use of opioids in pain treatment has grown significantly since the 1990s. This reliance on opioids to treat both acute and chronic pain has had devasting effects on an entire generation of pain patients in the United States. Opioid use disorder, overdoses, and deaths have rapidly risen since opioids have become the drug of choice when treating pain. Much of the growth in opioid use can be attributed to The Joint Commission pain standards released in 2001. These standards mandated closer attention to pain diagnosis and increased pain treatments. In addition, and happening concurrently, opioid use was also driven by aggressive marketing from opioid manufactures to capitalize on the pain treatment focus prevalent at that time. These two factors greatly increased the use of opioids in the country.

A decade of sustained over-prescribing created an unprecedented opioid epidemic. From 1999 to 2010, opioid sales in the United States quadrupled. In that same time period, overdose death rates increased four-fold while treatment admissions increased six-fold (Paulozzi, Jones, Mack & Rudd, 2011). Overdose deaths in the United States now exceed the peak levels of fatalities associated with both HIV infection and automobile accidents (Katz, 2017).

The opioid crisis has also had huge economic impacts on local, state, and federal institutions in the United States. Some estimates calculate the country’s total financial burden attributable to the opioid epidemic at over $500 billion. The types of costs associated with opioid abuse, such as healthcare costs, criminal justice costs, and lost workforce productivity, are easier to quantify from a national level. However, as the epidemic has greatly impacted some regions of the country while sparing others, it is difficult to estimate the more detailed financial impact at state and local levels.
In January of 2018, The Joint Commission released updated pain standards in an effort to curb the opioid crisis. The standards mandated that all healthcare organizations create a protocol driven standardized pain management program. The intent of the new standards was to create a change in prescribing habits when treating pain in the acute setting. The goal was to reduce the reliance on the opioid class of drugs and to dramatically reduce the quantities used on a national level. The first standard was a requirement that all healthcare organizations form a pain stewardship committee. The committee’s charge is to create a pain management program within the particular organization. The committee would be responsible for the institution meeting all of the other pain standards.

McLaren Bay Region Hospital, a 404-bed acute care hospital located in Bay City, Michigan is currently developing its pain stewardship committee. A SWOT analysis was completed that provided strengths, weaknesses, opportunities, and threats related to the pain stewardship committee. The information gathered in the analysis will be used to steer the strategic directives of the committee. The committee members assembled should be cross-functional in nature and should represent different but relevant areas of the hospital.

The three primary strategic goals of the McLaren Bay Region Pain Stewardship Committee are to create an effective pain management program that meets all Joint Commission pain standards, to reduce opioid use at the hospital in the inpatient and outpatient setting, and to eliminate the stereotype, stigma and prejudice within the organization towards those that suffer from opioid use disorder. With successful execution, these strategic initiatives should be accomplished and will have a significant impact in mitigating the opioid crisis in the Great Lakes Bay Region of Michigan. With all healthcare organizations in the United States following the Joint Commission pain standards, the country as a whole should see a reversal in opioid use.
With proper pain treatment, proper treatment of substance use disorder, and an all-out effort to substantially reduce opioid use, the opioid epidemic in the United States can be stopped.

**Historical Perspective of the Opioid Crisis**

Opioids are chemical compounds that control pain by acting on the central nervous system. Originally derived from the opium poppy, this pharmaceutical class of drugs has been around for thousands of years. Today opioid compounds are often used to treat moderate and severe pain associated with cancer, injuries and surgery. They are still used illicitly for their euphoric effects as well. The most commonly used opioids are hydrocodone (Norco®), oxycodone (OxyContin®), morphine and fentanyl. Heroin is also an opioid but has no legitimate medical use. Up until the late 1990s, opioids were restricted to the treatment of cancer pain. At that time, many state medical boards removed the restriction and opened the use of opioids to other conditions. This relaxation of restrictions coincided with a prevailing consensus that chronic pain was underdiagnosed and undertreated.

In 2001, as part of a national effort to address the widespread problem of underassessment and undertreatment of pain, the Joint Commission on the Accreditation of Healthcare Organizations (now known as The Joint Commission) introduced standards for organizations to improve their care for patients with pain (Philips, 2000). The Joint Commission is a nonprofit organization that accredits more than 21,000 healthcare organizations in the United States. The mission of The Joint Commission is to continuously improve the safety and quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in healthcare organizations (The Joint Commission, 2018). Healthcare organizations that achieve accreditation are determined to meet or exceed Medicare and Medicaid requirements. Most state governments recognize The Joint
Commission accreditation as a condition of licensure for receipt of Medicare and Medicaid reimbursements (The Joint Commission, 2018). Hospitals must comply with all Joint Commission standards. Noncompliance would mean a vast majority of the healthcare consumers in the country, those with Medicaid or Medicare, would be ineligible to use the hospital’s service.

In addition to The Joint Commission’s pain standards, The Centers for Medicare and Medicaid Services (CMS) linked a portion of a hospital’s payment on performance to a set of quality metrics. One of these metrics included patients’ satisfaction regarding pain management on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. With the regulatory focus on pain treatment and patient satisfaction, healthcare organizations were forced to treat pain aggressively. While the treatment of pain in the United States could certainly have been improved in the late ‘90s, the regulatory bodies that mandated specific pain treatment certainly laid the foundation for the country’s opioid epidemic. The pendulum swung from possible undertreatment to mass overprescribing of highly addictive drugs. Many critics claimed the 2001 standards fostered and encouraged dangerous prescribing habits by physicians. Most of the negative fallout from the revised standards was precipitated by the dramatic increase of opioid use for the treatment of any type of pain.

The pharmaceutical industry, and in particular pharmaceutical companies that manufactured opioid drugs, saw the huge financial potential that the lifting of restrictions to treat non-malignant pain could provide. Makers of opioid pain medications saw a golden opportunity in The Joint Commission standards and CMS HCAHPS pain metric. The companies believed these new regulatory oversights were an excellent opportunity to increase markets share. Many of these companies dramatically increased the promotion and marketing of these controlled
substances to physicians and patients. Purdue Pharma was at the forefront of this marketing campaign. Purdue started an aggressive push to promote the use of their drug Oxycontin® for chronic pain. Sales of OxyContin® grew from $48 million in 1998 to almost $1.1 billion in 2000 (OxyContin® Marketing Plan, 2002). All of these factors greatly contributed to a nationwide movement to treat pain more aggressively.

Conventional wisdom within the medical communities in the ‘90s held that opioid drugs had little addiction potential. In addition, Purdue touted their formulation of OxyContin® as even less addictive, due to its timed-release formulation. Physicians prescribing these medications felt they had an excellent treatment option for pain sufferers with little side effect potential. These factors greatly contributed to a full-scale push to treat pain more aggressively as well as a significant increase in prescribing of opioid analgesics.

For close to a decade, physicians across the country treated all types of pain with high doses of opioids. As exposure to these drugs increased, so did the incidence of illicit use and opioid addiction. Reports of opioid related addiction, overdoses, and death started to dramatically increase around the country. Healthcare professionals began to realize that opioids were not as safe as once thought. The United States was starting to see the beginning stages of one of the largest public health emergencies in the country’s history.

**Demographics of Opioid Use**

Opioid use grew substantially since the late 1990s. An estimated 20% of patients presenting to physician offices with noncancer pain symptoms or pain-related diagnoses (including acute and chronic pain) received an opioid prescription (Daubresse et al., 2013). In 2012, prescribers wrote 82.5 opioid prescriptions for every 100 people in the United States, amounting to an estimated 258.9 million opioid prescriptions written nationwide. This is enough
for every adult in the United States to have a bottle of opioid pills (Paulozzi, Mack, & Hockenberry, 2014). Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties (Levy, Paulozzi, Mack, & Jones, 2015). Americans, constituting only 4.6% of the world’s population, have been consuming 80% of the global opioid supply, and 99% of the global hydrocodone supply (Manchikanti & Singh, 2008).

The increases in opioid prescribing for family practice, general practice, and internal medicine exposed a much broader patient population base to opioids. The drugs were no longer exclusive to cancer patients or long-term chronic pain sufferers. High school athletes, soccer moms, businessmen were all prescribed these highly addictive medications. Those with a predisposition to substance use disorder quickly fell victim to the addictive effects of opioids. Physicians, not understanding the dangers, continued to prescribe for these individuals, and the patients developed an opioid use disorder. Addiction moved into the mainstream.

With the significant increase in opioid use came a proportional increase in the misuse and abuse of this class of pharmaceutical drugs. According to Paulozzi, a medical epidemiologist with the CDC’s Division of Unintentional Injury Prevention, increases in opioid prescribing and sales during the 1990s brought “abuseable” drugs into rural areas where no distribution network had existed for illicit drugs, such as heroin and cocaine. “Everybody’s within a few miles of a pharmacy” Paulozzi said, though he admits that increased availability is not the only relevant factor (as cited in Okie, 2010). While opioid drugs are some of the most effective medications for treating pain, the medical establishment now understands they also carry significant risk in the form of abuse potential, addiction and death from overdose.
Volkow and McLellan (2011) showed there has been a 5-fold increase in drug treatment admissions for pharmaceutical opioids between 1998 and 2008. In addition, emergency department visits related to pharmaceutical opioids have increased from 144,644 to 305,885 between 2004 and 2008 (Rudd, Seth, David, & Scholl, 2016). The U.S. opioid epidemic is continuing, and drug overdose deaths nearly tripled during 1999-2014 (Rudd, Seth, David, & Scholl, 2016). During 2015, drug overdoses accounted for 52,404 U.S. deaths, 63.1% of which were due to opioids (Rudd, Seth, David, & Scholl, 2016). The Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (2017) data, in 2016, estimated over 11 million Americans misused opioids and 2.1 million had an opioid use disorder due to prescription opioids or heroin and preliminary data for 2016 indicate at least 64,000 drug overdose deaths, the highest ever recorded in United States history.

The rapid growth in opioid prescriptions used to treat chronic and acute pain has led to significant quantities of unused surplus opioids. These unused drugs may be diverted for nonmedical use and certainly contribute to the nationwide opioid crisis. In 2015, a survey by the U.S. Centers for Disease Control and Prevention showed that 17% of youth took prescriptions drugs without a doctor’s order (Kann et al., 2015). The opioid epidemic in the United States has become a national healthcare crisis.

**Financial Impact of the Opioid Crisis**

The reliance on opioids to treat both acute and chronic pain has caused significant increases in substance use disorder and overdose cases across the country. In addition, the high abuse potential of opioids has made patients susceptible to abuse of more lethal opiates like heroin and illicitly produced fentanyl. While the health implications of this crisis are tragic and are having a devastating impact on families and communities everywhere, the economic and
financial toll on the country is staggering. The opioid epidemic is costing the economy of the United States tens of billions, if not hundreds of billions, of dollars annually. The types of costs attributable to opioid abuse, such as healthcare costs, criminal justice costs, and lost workforce productivity, are fairly well understood as is the impact of the crisis at a national level. However, the economic burden of the epidemic is unevenly distributed across the United States, with many communities especially hard hit (Brill & Ganz, 2018). This makes it difficult to quantify on a state and local level.

It has been difficult to establish detailed data sets regarding the financial impact of the opioid crisis on the United States economy with any degree of reliability. Previous financial studies have looked at particular aspects of the problem, but the limitations in data have prevented an all-encompassing study. Florence, Luo, Xu, and Zhou (2016) estimated the total economic burden of the opioid crisis on the United States in 2013 to be $78.5 billion. This study found that 73% of the cost was attributable to nonfatal consequences, including healthcare spending, lost productivity due to addiction and incarceration, and criminal justice costs. The remaining 27% was due to fatality costs consisting of lost potential earnings (Florence et al., 2016). Another analysis released the following year by the Altarum Institute, a health policy think tank, also included lost productivity from overdose deaths and estimated the cost in 2016 to be $95.3 billion (Rhyan, 2017). The crisis has escalated substantially since 2016, with an increase in heroin abuse, and evidence suggests that fatality statistics understate the number of opioid related deaths actually occurring in the United States.

Economists have been examining the national opioid crisis from a number of different macroeconomic perspectives as well. Princeton economist Alan Kruegar (2017) studied the relationship between opioid prescription rates per county and the decline in labor force
participation. Kruegar (2017) estimated that the opioid epidemic could be responsible for 20 percent of the decline in men’s labor force participation.

On October 26, 2017, President Trump declared the opioid crisis a national public health emergency under federal law (Davis, 2017). In November of 2017, the Executive Office of the President of the United States Council of Economic Advisors (CEA) released a report titled The Underestimated Cost of the Opioid Crisis. The CEA determined that previous estimates of the economic costs of the opioid epidemic where vastly understated due to the undervaluation of the fatalities associated with the overdose (CEA, 2017). The CEA incorporated an estimate of the cost to society of the lives lost to opioids. To quantify the loss of life, CEA used a metric known as the value of statistical life, which goes beyond just lost productivity (CEA, 2017). Using data gathered by the Florence study, the CEA estimates that in 2015, the total economic cost associated with opioids was $504.0 billion, or 2.8% of the Gross Domestic Product that year. This estimate was over 6 times larger than the most recent estimated economic cost of the crisis (CEA, 2017).

Understanding the costs associated with the opioid crisis is critical as local, state, and federal agencies attempt to establish fiscal and regulatory policies to address the problem. Decision makers in the government and the healthcare sector face financial constraints that require balancing effective cost-efficient strategies while addressing the growing opioid public health crisis. Unfortunately, limitations exist that make adequate data collection and reporting unreliable. Standardized surveillance systems are not in place to adequately measure the incidence of the condition in the population. Most healthcare cost estimates use the International Classification of Diseases definitions of opioid abuse and dependence. These definitions do not differentiate between prescription opioids and heroin. The costs attributable to specific drugs if
multiple types of drugs are abused are not collected. If the healthcare cost impact of abuse and dependence is different between prescription opioids and heroin, the data will be biased (Florence et al., 2016). According to the Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (2017), abuse and dependence of prescription opioids is far more common than for heroin. Moreover, drug diversion is difficult to quantify and plays an important part in the equation as well (Florence et al., 2016). A firm estimation of the real impact in the United States is difficult to determine.

A number of studies have attempted to narrow the national estimates of the opioid financial impact down to the state and county level. This information is important as there is a huge regional variation in the epidemic across the United States. In addition, the factors underlying estimates of cost, such as healthcare, criminal justice services, and worker productivity, also vary locally. Brill and Ganz (2018), from the American Enterprise Institute, looked at the opioid problem from a state and county level in their study The Geographic Variation in the Cost of the Opioid Crisis. The study utilized the CEA’s estimated opioid economic burden data. They estimated per-capita state-level and county-level non-mortality economic burdens of the opioid crisis in 2015 by distributing national estimates based on variations in local wages, healthcare costs, and criminal justice costs along with variation in opioid-related death and addiction rates, and average age-adjusted value of statistical lives lost (Brill & Ganz, 2018). Their model also utilized key state and local indicators of opioid use and opioid-related costs in order to allocate the national cost estimates to each state (Brill & Ganz, 2018).

Brill and Ganz (2018) found that the non-mortality per-capita economic burden of the opioid crisis was highest in the District of Columbia ($493 per resident) and lowest in Iowa
($118 per resident). When the mortality costs were added West Virginia had by far the highest per-capita economic burden ($4,378 per resident) and Nebraska the lowest ($394 per resident). Michigan ranked 27th ($201 per resident) for non-mortality cost per capita and ranked 13th ($2,012 per resident) when total costs were factored (Brill & Ganz, 2018).

While state level data are more informative than national estimates, there is also a wide variation within each state as it relates to opioid abuse, opioid overdose, and opioid associated death rates. Counties with the highest non-mortality costs are not always those with the highest total costs. The non-mortality results are driven by a combination of abuse rates and healthcare costs, and the total costs are driven primarily by estimated deaths per capita (Brill & Ganz, 2018).

Data regarding the actual deaths attributable to opioids is often slow in being reported. There is often a time delay in death certificates getting reviewed and the data getting assimilated. Emergency department data reviewed and published by the Centers for Disease Control (CDC), however, can point to alarming spikes in opioid overdoses. Unfortunately, not all states report emergency department data to the CDC. Of 16 states that did report to the CDC from July 2016 through September 2017, emergency department visits for opioid overdoses increased 35%. Significant increases occurred in all states in the Midwest that report including Wisconsin (109 percent), Illinois (66 percent), Indiana (35 percent), Ohio (28 percent), and Missouri (21 percent) (CDC, 2018). It is interesting to note that a state like Ohio has a relatively low percentage increase of opioid related emergency department visits compared to that of Wisconsin despite Ohio being considered one of the epicenters of the opioid crisis. This is likely attributable to the fact that the opioid crisis in Ohio started much sooner than for other states. The dramatic spike in Ohio probably occurred prior to 2016 and out of the window of the CDC study. This CDC
data shows that the epidemic is moving out from Ohio and Kentucky and into other Midwest states. Michigan does not report but it could be assumed that it would have a similar rate to these other states.

Local governments and hospitals can be caught by surprise when opioid related deaths begin to occur. With no history of opioid issues and no warning of a spike in opioid use and adverse events, local institutions often have not budgeted for the significant economic toll. In addition, most have not started the often long and arduous task of securing additional funding. It will take local governments and healthcare institutions time to develop a plan, mitigate the issue, and get spending back in line with what is considered normal.

**Bay County, Michigan and the Opioid Epidemic**

McLaren Bay Region Hospital is the largest hospital in the Great Lakes Bay Region of Michigan and the only hospital in Bay County, Michigan. It is also the largest employer in Bay County. Bay County ranks fourth out of 83 counties in Michigan with regard to rate of opioid related discharges. Wayne County (Detroit) had 410 opioid related discharges per 100,000 people, followed by Jackson County and Marquette County. Bay County had 341 opioid related discharges per 100,000 people (Agency for Healthcare Research and Quality, 2018).

While Bay County’s top four ranking in opioid related discharges is significant, data from the Michigan Department of Health and Human Services (2018) shows an even more disturbing statistic. Bay County is the number one county in Michigan with regard to opioid prescribing. In 2015, pharmacies in Bay County filled 19,365 prescriptions per 10,000 people. This is equivalent to 1.9 prescriptions for every county resident. It also represents a 50% increase from the number of opioid prescriptions filled in 2009 (Michigan Health and Human Services, 2018). Given the substantial number of opioid prescriptions filled in Bay County on an annual basis, the
potential exists for opioid related discharges to continue to climb at McLaren Bay Region. Deaths attributable to opioids in the region are quickly closing in on the number of deaths attributable to firearms and traffic accidents.

While there are many physicians in Bay County that have no affiliation with McLaren Bay Region, most do. The hospital must assume the majority of responsibility, even if only through association, with the number of opioid prescriptions generated in its operating market. The McLaren Bay Region Pain Stewardship Committee must make opioid use reduction at the hospital and within the region a major priority. The public perceives community health and wellness as the sole responsibility of the hospitals serving that community. McLaren Bay Region Hospital is responsible for health and wellness of the citizens of Bay County, Michigan.

The Joint Commission Response to the Opioid Epidemic

In 2016, as the nationwide opioid crisis continued to develop, The Joint Commission began a project to revise its pain management standards. The intent was to develop new standards that supported safe and judicious prescribing of opioids (Baker, 2017). The initial focus of the new standard revision was on treating acute pain in the hospital setting, while limiting the medical profession’s reliance on opioids as a treatment modality in acute settings. In August of 2017, the revised pain standards were released with a desired implementation deadline of January 1, 2018. The revised standards are a significant departure from the original standards and are intended to improve the quality and safety of care by significantly changing pain management concepts.

The primary Joint Commission pain standard, as it relates to hospital responsibility, is LD.04.03.13, which requires the formation of a Pain Stewardship Committee. The standard states pain assessment and pain management, including safe opioid prescribing, is identified as
an organizational priority for the hospital (The Joint Commission, 2017). The standard stipulates that the hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities (The Joint Commission, 2017). Leadership engagement in the oversight of pain management must support safe and effective practice and sustainable improvements across the various disciplines and departments involved in pain assessment, pain management, and safe opioid prescribing. The pain stewardship committee must assure monitoring of hospital data and performance in opioid prescribing practices and is responsible for pain management improvements (The Joint Commission, 2018).

**McLaren Bay Region Pain Stewardship Committee**

In an effort to maintain compliance with all Joint Commission mandates, McLaren Bay Region began development of its pain stewardship committee early in 2018. It was determined that the committee should complete a SWOT analysis as part of the strategy building and organizational planning process. A SWOT analysis is a tool used to assess the competitive position of an organization. The central purpose is to identify the strategies to exploit external opportunities, counter threats, build on and maintain company strengths, and diminish weaknesses (Hill, Schilling, & Jones, 2015). The McLaren Bay Region Pain Stewardship Committee SWOT analysis identified many key factors impacting the committee as it relates to internal strengths and weaknesses, and external opportunities and threats.

The McLaren Bay Region Pain Stewardship Committee has several strengths that will be advantageous in achieving its objective of creating a sustainable pain management program. These strengths include Joint Commission requirements, physician and hospital support, potential for reduction in length of stay and readmission rates, reduction in regional opioid use,
and state opioid prescribing law changes. Key to the success of the committee’s pain management goals will be to leverage these internal strengths.

The key strength in the committee’s favor is that the new Joint Commission pain standards mandated that all accredited hospitals follow a standardized care plan as it relates to pain management. Medicine is often subjective and many physicians traditionally practice with a high level of autonomy. Standardized care is a significant paradigm shift for the medical community, and potentially removes a level of autonomy and decision-making physicians once enjoyed (Goitein & James, 2016). This is especially true when considering the subjective nature of pain and pain treatment. It would be anticipated that McLaren Bay Region would face greater resistance in trying to standardize pain treatment within the institution had The Joint Commission not created the new mandated standards. The pain stewardship committee can leverage the mandate to more easily implement pain treatment best practice protocols at the hospital.

The McLaren Bay Region SWOT analysis identified two key weaknesses that could negatively impact the pain stewardship committee. Those challenges include limited resources at the hospital in an environment of competing strategic priorities and physician support. While limited resources are a large hurdle, it is not unique to the pain stewardship committee. All departments in every hospital face fiscal constraint. The primary weakness of the organization is largely a lack of physician support. Physicians that are not employed by a hospital may have the potential to disregard some standard operating procedures or protocols they may not agree with. While an evidence-based pain management program may be shown to effectively treat pain patients while reducing opioid use, some physicians may still choose to operate independently.
Regional and state collaboration in combating the opioid epidemic and the 2016 Centers for Disease Control Pain Guidelines were identified as the two significant external opportunities for the pain stewardship committee to leverage. Of particular importance will be the regional focus on opioid reduction. Collaboration among all healthcare organizations in the Great Lakes Bay Region will set an expectation of substantial opioid reduction and make being a physician outlier difficult. The movement in healthcare is towards population health and the opioid epidemic will require partnership across many organizations. McLaren Bay Region participates in the Michigan Health Improvement Alliance and the Michigan Opioid Prescribing Engagement Network. Both organizations have a goal of regional opioid use reduction. McLaren’s participation with these groups will provide resources, knowledge, and leverage from organizations and people outside of the hospital in an effort to promote the pain stewardship committee’s goals.

The McLaren Bay Region Pain Stewardship Committee SWOT analysis identified government haste towards regulation and rapid changing state and federal opioid laws as the primary external threats. Government and regulatory agencies are all moving quickly in an attempt to mitigate the opioid crisis. Unfortunately, many of the initiatives are ill conceived with little thought of downstream impact. The McLaren Bay Region Pain Stewardship Committee must serve as subject matter expert, and will need to assure regulatory compliance within the hospital as the regulatory changes and laws evolve.

The McLaren Bay Region Pain Stewardship Committee clearly has strong strengths and opportunities that it should exploit. Leveraging these factors to the greatest extent possible will be imperative to the success of the committee in their attempt to create a hospital wide pain management strategy. The weaknesses and threats identified will need to be addressed with
plans to minimize their potential impact. The SWOT analysis showed strengths and opportunities clearly outweighed weaknesses and threats setting the pain stewardship committee up for success.

**Formation of the Pain Stewardship Committee**

The McLaren Bay Region Pain Stewardship Committee must be a high-performance cross-functional team to achieve its strategic goals within the hospital and the Great Lakes Bay Region. The committee will utilize the Team Effectiveness Model as a tool to ensure top performance of the group. The key components of the Team Effectiveness Model are organized into three general categories. First are resources, leadership, and other contextual influences that make teams effective. The second relates to the actual team composition. The third category contains process variables that influence team effectiveness (Robbins & Judge, 2016).

There are a number of variables that determine how a team functions and to what level it performs. The four contextual factors that impact team performance most significantly are adequate resources, effective leadership, a climate of trust, and a performance evaluation and reward system that reflects team contributions. The McLaren Bay Region Pain Stewardship Committee must ensure these factors are adequately addressed.

The most critical of these contextual issues is adequate resources. A lack of resources, funds, or support can certainly hamper the group. Hyatt and Ruddy (1997) concluded that one of the most important characteristics of an effective team is the support the group receives from the organization. Support can mean any number of things, including equipment, funds, people, and time. Cross-functional teams must compete for their members’ time with a variety of competing obligations. With most healthcare organizations looking to reduce expenses, there may be pressure to reduce time devoted to the team (Alexander et al., 2005). Members of the McLaren
Bay Region Pain Stewardship Team should be provided with ample resources given the level of importance with this project. The Joint Commission pain standards must be achieved and the hospital leadership must be willing to invest in the associated projects and programs.

The team composition elements of the Team Effectiveness Model include abilities of members, personality, allocating roles, diversity, size of the teams, member flexibility, and member preferences. In health care, and hospitals in particular, employee relationships and behavior are often influenced by the highly professional nature of the workforce. Often times with physicians, nurses, and pharmacists, there is a stronger alliance to the profession than to the organization (Leggat, 2007). Factoring this tendency in the selection of the team will be important.

The ability of members is the key composition element of the Team Effectiveness Model as it relates to the McLaren Bay Region Pain Stewardship Committee. Research reveals insight into team composition and performance. High-ability teams with intelligent people are more adaptive to changing situations, can more effectively apply existing knowledge to new problems, and function at an overall higher level than lower-ability teams (Robbins & Judge, 2016). Given the professional nature of the potential pain stewardship team composition at McLaren, which will include doctors, nurses, pharmacists, and chief administrators, the team will have high-ability members. The ability of the pain stewardship committee members will be a huge asset as the team moves forward with its initiatives.

The process variables of the Team Effectiveness Model include common purpose, specific goal, team efficacy, team identity, team cohesion, mental models, conflict levels, and social loafing. A common plan and purpose are the most important process variables that need to be firmly established and communicated. The McLaren Bay Region Pain Stewardship Team’s
three primary strategic goals are to create an effective pain management program that meets all Joint Commission pain standards, to reduce opioid use at the hospital in the inpatient and outpatient setting, and to eliminate the stereotype, stigma and prejudice within the organization towards those that suffer from opioid use disorder. All members of the committee must collectively embrace these strategic goals for the program to be successful.

**Strategic Goals of the Pain Stewardship Committee**

The McLaren Bay Region Pain Stewardship Committee has laid a solid foundation with which to build an excellent pain management program and potentially reverse the impact of the opioid crisis in the Great Lakes Bay Region. The SWOT analysis provided insight to strengths and opportunities to leverage as well as weaknesses and threats to mitigate. The Team Effectiveness Model will provide a workable plan with regard to continuous development of a highly functioning team. The work completed thus far has given the committee three primary goals which, when achieved, will have long lasting effects positive effects with regard to the opioid crisis.

The committee’s top strategic goal is assuring McLaren Bay Region is compliant with all 2018 Joint Commission Pain Standards. These standards are an accreditation requirement and non-compliance could negatively impact the financial performance of the organization. The mere facilitation of the pain stewardship committee satisfies the first pain standard. Achieving compliance with the remaining standards will move the hospital towards achieving the second and third goal. All three goals will be worked on simultaneously, but consideration needs to be given towards always assuring continued momentum towards compliance with the other joint commission pain standards.
The second primary goal of the pain stewardship committee is the reduction of opioid use and prescribing. Reduction in the use of opioids at McLaren Bay Region Hospital from an inpatient and outpatient perspective will have a tremendous impact in reducing the development of new opioid addiction cases. The pain stewardship committee can have the greatest impact by focusing on creating standardized protocols and order sets for surgical services. These order sets should use opioids only when absolutely necessary and only in very limited amounts. A reduction in the use and quantity of opioids will not only protect the surgical patient from potential addiction, but will also reduce the availability of unused opioid doses used for unintended uses.

Unused opioid medication prescribed following a surgery is a major source of opioids that are used illicitly. Once people have unused doses of opioids, most are not aware of the proper disposal methods of prescription drugs. The diversion of legitimate prescription opioids can occur when only a portion of the discharge post-surgical prescription is used and the remainder is not properly destroyed. The unused doses are often shared or discovered and used by people without a legitimate medical need and not under the supervision of a physician. A recent group of studies from 2017 reviewed by researchers at Johns Hopkins University School of Medicine and led by Dr. Mark Bicket, MD (2017), showed results where 67% to 92% of patients reported unused opioids. Of all opioid tablets obtained by surgical patients, 42% to 71% went unused. Patients reported a 73% to 77% incidence of prescription opioids not stored in locked containers (Bicket, Long, Pronovost, Alexander & Wu, 2017).

The McLaren Bay Region Pain Stewardship Committee should work to create order sets that more closely match the quantity of opioids actually needed by patients for a particular surgery. With a collaborative effort among physicians and other healthcare professionals, best
practices can be developed with regard to post-surgical supply reduction and proper education regarding disposal. Changing prescribing habits of all McLaren Bay physicians is clearly needed to reduce the supply of opioids in circulation in the Great Lakes Bay Region. Surgeons must play an important role in reducing the availability of opioids for nonmedical use. These practitioners should analyze prescribing patterns and work to reduce the quantity of prescription opioids doses dispensed.

Many professional, state and federal agencies have developed guidelines and policies in an attempt to develop standardization and responsible opioid prescribing practices. In 2016, the CDC released guidelines that specifically address appropriate dosing of opioids for chronic pain and duration of opioid therapy for acute pain including post-surgical treatment. Physicians should use these best practice guidelines in an effort to properly treat their patient’s while utilizing available strategies to prevent and deter prescription opioid abuse. If 42% to 71% of post-surgical opioid doses go unused, then surgeons at McLaren Bay Region should be reducing the quantity of opioids prescribed by at least those same percentages.

The third key strategic initiative for the McLaren Bay Region Pain Stewardship Committee is to implement training programs, policies, and procedures in an attempt to eliminate negative stereotypes, prejudice, and discrimination towards those suffering from substance use disorder. Negative attitudes by healthcare professionals towards individuals with substance use disorder can contribute to a lower quality of care and negative outcomes. Moreover, health professionals lack sufficient education, training, and infrastructure to work with this patient population. The overall attitude of health care professionals can influence the diagnosis and treatment of substance use disorders.
Stigma associated with drug addiction and use is strong and often reinforced by government and healthcare policies that contribute to its widespread acceptability. Studies show health professionals generally have a negative attitude towards patients with substance addiction issues. They perceive violence, manipulation, and poor motivation as impeding factors in the healthcare delivery for those patients (VanBoekel, Brouwers, VanWeeghel, & Garretsen, 2013). Healthcare providers may hold negative beliefs about people with substance use disorders, including they overuse the healthcare system, are not vested in their own health outcomes, abuse the system through drug seeking behavior and diversion, and fail to adhere to recommended care (El Rasheed, et al., 2016). Physicians, nurses and other healthcare professionals at McLaren Bay Region can counter the stigma associated with opioid use disorder by increasing their knowledge regarding pain treatment, addiction, and addiction treatment. It will be the responsibility of the pain stewardship committee to foster this paradigm shift.

**Conclusion**

The opioid epidemic is a horrific consequence of misguided judgement by The Joint Commission, pharmaceutical manufacturers of opioids, and healthcare practitioners across the country. Every community in the United States is currently feeling the devastating effects of addiction disorders caused by inappropriate opioid use. The resource and financial strain on the healthcare system and government institutions at a local, state, and federal level will continue to get worse if collaborative efforts are not made quickly to reverse the crisis. While healthcare regulatory agencies and healthcare systems and practitioners are a primary cause of the emergency, they also hold the key to the solution. A concerted effort across all aspects of healthcare and government agencies can stop the opioid epidemic from growing. This is a problem that can be solved.
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