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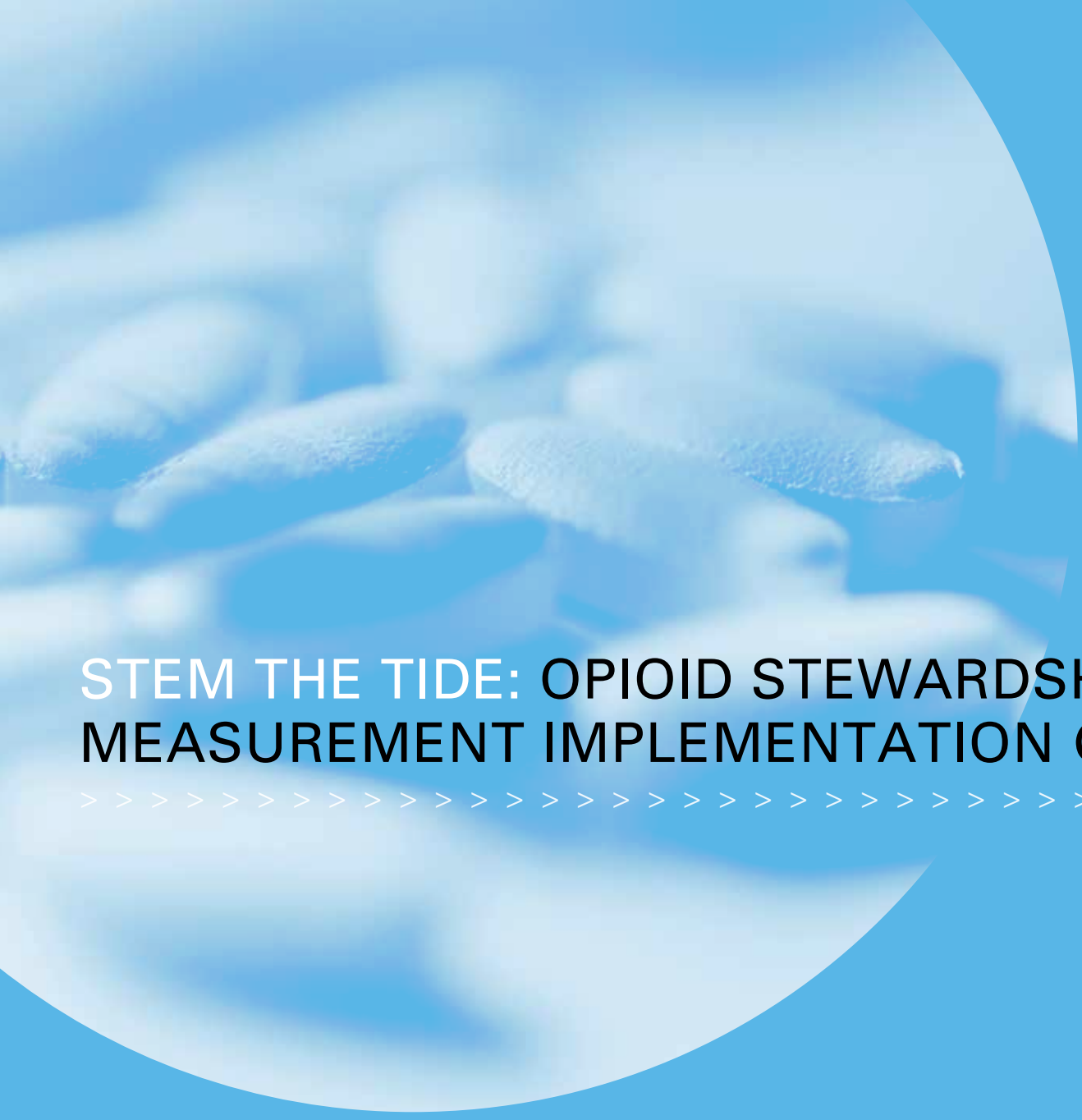
STEM THE TIDE:

OPIOID STEWARDSHIP MEASUREMENT IMPLEMENTATION GUIDE > > > > > >

American Hospital Association (AHA)



STEM THE TIDE: OPIOID STEWARDSHIP MEASUREMENT IMPLEMENTATION GUIDE

A Project of:
American Hospital Association (AHA)
Opioid Stewardship Measures Advisory Group
Centers for Medicare & Medicaid Services (CMS)

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**The American Hospital Association does not endorse or recommend any of the measures included herein for use outside of their intended purpose of internal quality improvement.*

EXECUTIVE SUMMARY

Stem the Tide **initially was published by the American Hospital Association (AHA) in 2017 to provide guidance and information to hospitals and health systems on how they can partner with patients, clinicians and communities to address the opioid epidemic. Since that time, a multitude of best practices, guidelines and literature related to opioid stewardship efforts have emerged. AHA is pleased to continue efforts to stem the tide with this Opioid Stewardship Measurement Implementation Guide and Menu of Measures.**

The direction for this work was directed by three factors. First, we recognized the complexity of the opioid epidemic. No two communities have the same priorities or resources available when it comes to addressing the various faces of the epidemic. Differences include varying levels of data availability, opioid use, mortality rates, and opioid use disorder prevalence. This complexity is compounded by a rise in chronic pain conditions, underemphasized education for health care providers in pain management, and a limited number of specialists in pain management and addiction medicine. Second, we realize that many hospitals and health systems face a challenge in navigating the latest available literature, federal and state guidelines; best practices; and other available tools and resources—to really understand their organization's and community's greatest opportunities for improvement. Analysis paralysis could hamper progress in just knowing where to get started on opioid stewardship. Last, while hospital and health systems across the U.S. have dedicated tremendous efforts and resources to opioid stewardship, it has been more difficult for these organizations and their communities to identify and implement methods to measure and track progress and results.

To respond swiftly to these concerns, AHA formed an Opioid Stewardship Measures Advisory Group to oversee developing this implementation guide and menu of measures. The advisory group was designed to represent diverse hospital sizes and diverse geographies across the U.S., and members represent multiple specialties and professional disciplines, including patient advocates and patient education specialists.

The Guide addresses six critical elements that can support users through a process of implementing a data-driven approach to an opioid stewardship program: 1) developing a leadership strategy; 2) conducting an environmental scan of available resources, existing efforts and available data; 3) selecting measures; 4) setting goals and developing an improvement plan to drive progress on those measures; 5) creating policies and education for care teams; and 6) providing patient education and engaging patients in shared decision-making. We believe that these elements lay the foundation for driving and measuring progress in opioid stewardship.

As part of the Guide, a Menu of Measures has been curated, which presents 30 ranked quality improvement measures categorized into the primary focus areas of acute pain management, harm reduction, and identification and treatment of opioid use disorder. The measures have been ranked based on both impact of use and level of effort for implementation. The measures included in this Guide are not intended or recommended for use beyond internal quality improvement purposes. While not all of the measures have extensive or sophisticated definitions available to date, the measure concepts can still be useful guideposts in identifying opportunities for tracking progress.

Given the continued negative impact the opioid epidemic is having on our nation, as well as the flood of opioid-related best practices and guidelines being proposed, developed and used, we hope that this Implementation Guide and compiled Menu of Measures will be used by hospitals and health systems to accelerate their journey in identifying opportunities for improvement and measuring progress on opioid stewardship.

BACKGROUND

In 2017, the U.S. Department of Health and Human Services (HHS) declared a public health emergency and announced a five-point strategy to combat the opioid crisis.[50] That year, the American Hospital Association (AHA) published Stem the Tide: Addressing the Opioid Epidemic.[3] In an attempt to drive reductions in morbidity and mortality associated with opioids and improve pain management, many opioid-related measures have since been conceptualized and used by hospitals and health systems to identify opportunities for improvement and measure progress. Some measures have been developed and adopted by payers, as well as state and national regulators including the Joint Commission (TJC) in its *Standards for Pain Assessment and Management*.[28, 27] As of 2019, the National Quality Forum (NQF) has identified over 200 health care quality measures related to pain management.[36] In addition to all of these available measures, many efforts related to identifying and promoting best practices have emerged; HHS recently issued a report[51] identifying best practices in acute and chronic pain management, inclusive of five categories of nonopioid pain management approaches. The report emphasizes functional outcomes and quality of life.

Given the abundance of opioid-related measures and best practices being implemented, some experts are concerned that misapplication coupled with rapid and strict adoption may lead to unintended consequences, including increased deaths from illicitly obtained opioids, withholding opioids when they are appropriately indicated, and other poor patient outcomes.[15] In addition, many hospitals and health systems are struggling to identify the best opportunities for driving improvements in opioid stewardship within their organization and community. Understanding these circumstances, the AHA has created this Guide along with a compilation of measures and measure concepts in a Menu of Measures to assist hospitals and health systems in identifying opportunities for and measuring progress on improvement in opioid stewardship. The measures included in this Guide are not intended or recommended for use beyond internal quality improvement purposes.

DEFINITIONS AND SCOPE

Opioid stewardship is intended to be an encompassing term that considers judicious and appropriate opioid prescribing, appropriate opioid disposal, diversion prevention, and management of the effects of the use of opioids, including identifying and treating opioid use disorder and reducing mortality associated with opioid overdoses. Opioid stewardship programs have been described as coordinated programs that promote appropriate use of opioid medications, improve patient outcomes and reduce misuse of opioids.[49]

The Menu of Measures within the Guide lists measures that can be used at a local level for quality improvement within hospitals and health systems. They are not being recommended for use in standard setting, accountability or payment purposes.

The measures fall into three domains: acute pain management, harm reduction, and identification and treatment of opioid use disorder.

Several patient populations fall outside the scope of this Guide: patients undergoing active cancer treatment or in palliative care or hospice care. Further, though polysubstance use is a critical driver for hospital-related outcomes for people with opioid use disorder, management of issues relating to polysubstance use also falls outside the scope of this Guide.[4]

HOW TO USE THIS GUIDE

This Guide is designed to offer hospitals and health systems an actionable resource to implement best practices in using data to drive improvement efforts in opioid stewardship.

When using this Guide, note that your organization will have unique priorities and resources available.

The Guide includes a compilation of measures and measure concepts in the Menu of Measures within Element 3 as a starting point for organizations looking for a summary of measures being used in published literature or aligned with what is being used in various regulatory programs. The Menu is by no means exhaustive, and not all included measures may be applicable or appropriate for all hospitals or health systems.

Complementary to existing clinical guidelines, literature reviews, evidence-based tools and other resources related to pain management and opioid stewardship, the Guide contains critical elements in developing a data-driven improvement strategy. Six elements were identified as necessary components in a measurement implementation strategy. (See Figure 1.) However, this is not intended to reflect a sequential process. In addition, these elements are not unique to opioids or pain management and could be applied to a broader range of subjects.

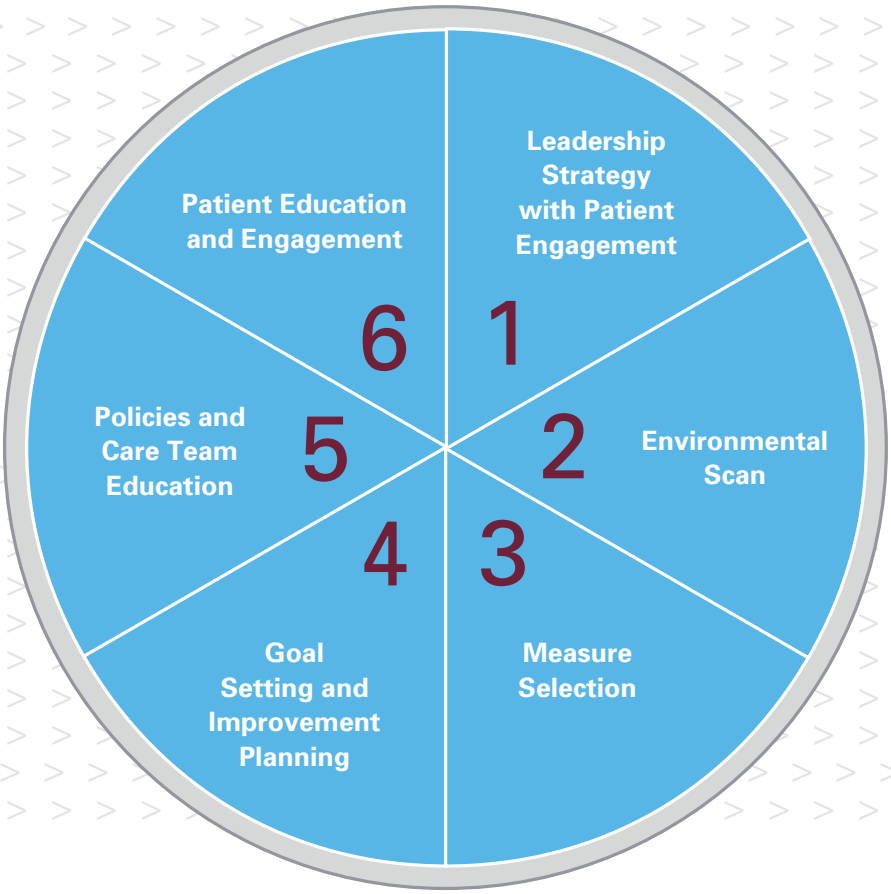


Figure 1. Elements in Developing an Opioid Stewardship Measurement Strategy

Source: AHA, 2020.

ELEMENT 1 LEADERSHIP STRATEGY WITH PATIENT ENGAGEMENT

The Joint Commission's Standards for Pain Assessment and Management include requirements in leadership, medical staff, and performance improvement. Specifically, The Joint Commission calls for a leader or leadership team that develops and monitors performance improvement activities with involvement of medical staff on pain management and opioid prescribing.[28]

Even if you're not considering seeking Joint Commission accreditation, an effective leadership team should elevate awareness, define direction and drive efforts related to pain assessment and management. Many published papers, referenced here, describe the formation, rationale, and recommendations for development of a systemwide, cohesive leadership team and oversight strategy for opioid stewardship.[6, 21, 35, 38, 42, 45, 54]

Considerations for Forming a Leadership Team

1. **Executive leadership.** Create an executive leadership team that includes chief medical or quality directors. Sponsorship from executive leadership demonstrates organizational priority and can assist when resources or funding is needed.
2. **Multiple service lines/departments.** Leaders with responsibilities across departments or service lines provide a broad line of sight, which helps organize and prioritize the work into a cohesive plan. Support for opioid stewardship must span the entire organization; an interdisciplinary approach is critical to gain fresh perspectives on your project and how it fits with your business strategy.
3. **Project management.** Setting the appropriate scope, schedule and budget improves your chances of achieving desired results. Efficient use of management tools ensures effective use of time and encourages forward momentum.
4. **Information technology.** This perspective is essential to provide insight into current capabilities and ease of data retrieval.
5. **Legal or compliance.** Useful given ever-changing regulatory requirements.
6. **Patient advocates.** They bring urgency to the work and convey critical but often unseen perspectives. Consider including representatives from Patient and Family Advisory Councils if available.

It also is important to emphasize inclusivity of existing projects, specialists and subject matter experts to gain broad organizational buy-in by engaging and empowering existing department champions.

Inspiring a Patient-focused Vision

Once a leadership team has been formed, a proven strategy for increasing engagement starts with inspiring a shared vision that emphasizes the "why"[44] or a sense of purpose for the work. Stories from patients, families and your community can inspire people throughout all levels of your organization.[35] Opioid stewardship is not about the regulations or the measures. Opioid stewardship efforts should be focused around why we assist the patients we serve.[14]

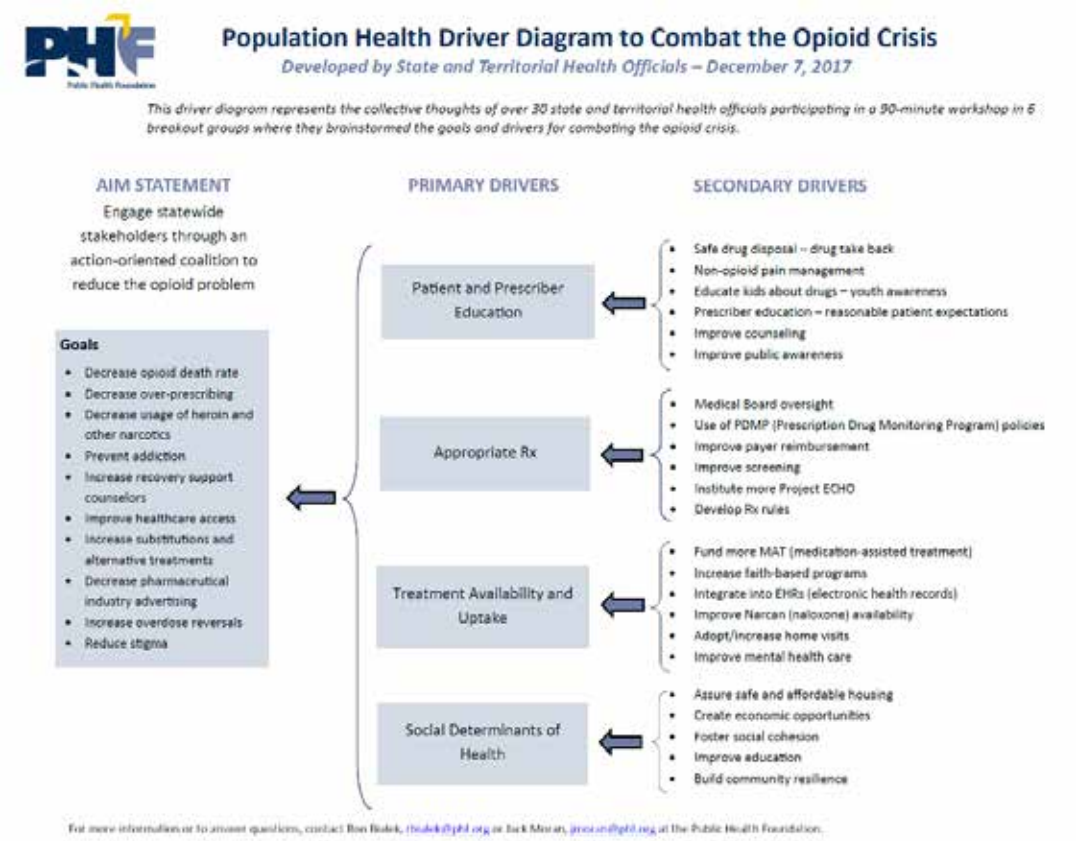
> *"[Many of us] know first-hand the pain and challenges families face. It's a lifetime journey, so every new patient we can keep safe is a victory. Let's give this our best effort."*
>
> — JOAN MAXWELL, JOHN MUIR HEALTH PFAC AND PFCC PARTNERS COORDINATOR

> *"Hospitalization is a reachable moment to initiate and coordinate addiction care, and we see strong outcomes in terms of patient and provider experience, substance use disorder treatment linkage, and medication initiation rates for opioid use disorder. This work is critical. Given that hospitals are where many interprofessional health care providers train, delivering best practices in addiction care in hospitals is essential to training the workforce. Finally, hospitalized patients with substance use disorder often experience discrimination and have traumatizing experiences in hospitals. This work has the potential to shift that and make hospitals places of healing and health for all."*
>
> — HONORA ENGLANDER, DIRECTOR/PI & IMPROVING ADDICTION CARE TEAM

Developing a Strategy

To develop a strategy that will fulfill your team's patient-focused vision, consider creating a driver diagram or value stream map[21, 40] that is tailored to your organization and community. A driver diagram can help your team capture and organize your ideas for changes and also help ensure that any new or existing work complements larger organizational aim statement(s). The driver diagram or value stream map should be flexible and adaptable for inclusion of new organizational priorities, regulations or mandated quality goals.[40]

Figure 2. Example of an Opioid-Related Driver Diagram[40]



Source: Public Health Foundation, 2017.

Engaging Patients and Caregivers

Patient and caregiver advocates or councils, especially those with people who've had experiences with pain management or opioid use disorder, should be included in all facets of your opioid stewardship work.[14, 35] Note that different patients may have unique experiences with pain management and opioids. The Institute for Patient- and Family-Centered Care has produced a comprehensive guide, Partnering with Patients and Families to Strengthen Approaches to the Opioid Epidemic.[35] One key strategy is to ensure that patient and family advocates are included in developing the overall strategy. To emphasize this importance, the advisory group formed to create this Guide included two patient representatives to ensure the patient voice was accentuated throughout this resource.

Leveraging Information Technology

The ability to leverage information technology (IT) resources in developing your strategy is critical to provide benchmarking of opioid use, collect timely metrics and build best practices with clinical decision support tools.[21, 32, 38, 54] Your strategy should consider and leverage IT; however, applying prepackaged electronic health record (EHR) screening and assessment tools regarding pain management requires professional discretion to ensure that those tools have been validated for the intended application.

Here are several strategies to leverage IT resources:

- Develop a form or flowsheet in the EHR with discrete data elements that allows for date and time stamps.
- Use an order set containing desired outcomes. Order sets also can promote best practices and supplement clinical decision support tools.
- Set the default number of opioid pills prescribed upon discharge to a lower quantity. Long-acting opioids can be removed from the preferred drug list.
- Automatically include specific patient education materials as part of the discharge summary.
- Create a direct portal to the prescription drug monitoring program through your EHR.

ELEMENT 2 ENVIRONMENTAL SCAN

It is critical to identify and leverage existing resources and partners, both internally and externally, to help achieve your team's vision in opioid stewardship. Relationships with community partners in particular can create strong communication channels that optimize transitions for patients. "Effective solutions will only emerge from strong partnerships across government, legal, medical and other community stakeholders."[5]

Hospitals and health systems should ascertain:

> What services exist internally, and what is our capacity to offer new or improved services?

> Who are our partners?

> What services and initiatives exist within our community?

Essentia Health, Duluth, Minn., State-of-the-Art Rural Care Network

NALOXONE DISTRIBUTION

Timely access to proven therapies is critical for patients with opioid use disorder. Rural communities are hit especially hard by the lack of resources addressing substance use. Essentia built a robust regional consortium comprised of a broad range of partners across Minnesota, North Dakota and Wisconsin. Essentia created a network of clinics and community partners including Center for Alcohol & Drug Treatment in Duluth, Range Mental Health Center and St. Louis County Public Health & Human Services in Virginia, Well-Being Development in Ely, the FATHER Project, and ShareHouse in Fargo, N.D. This network is reversing trends and improving quality measures by ensuring access to treatment and interventions addressing social determinants of health in clinics and in their rural communities.

Considerations for an Environmental Scan

Health Care Professional Partners

> **Waivered prescribers within your organization.** It is important to know what resources exist related to providing opioid use disorder treatment within your hospital or health system and then consider opportunities to increase access to treatment by increasing the number of providers who are waivered. Having prescribers who are waivered to initiate opioid use disorder treatment in the ED or inpatient setting can improve the likelihood that the patient will continue treatment, compared to receiving a referral alone.[18] SAMHSA provides a national listing of prescribers authorized, or waivered, to treat opioid dependency with buprenorphine by state.[48] Identifying opioid use disorder and initiating treatment are just the first steps. Effective care transitions and strong partnerships are key to patient-centered success.

> **Access to telehealth services.** In July 2019, CMS recommended creating new bundled episodes of care for treatment of opioid use disorder, which include new codes for care management and counseling that could incorporate digital health and connected services. Telehealth can improve care coordination and expand the reach of care providers in treating people, particularly in underserved parts of the country.[12]

Marshall Medical Center, Placerville, Calif.

Marshall Medical Center started treatment with buprenorphine in their ED in August 2017 using the California Bridge program model. In 2019, with the help of a substance use navigator, over 120 patients with opioid use disorder received medications and were referred to treatment. Over 90% of referrals presented to an outpatient clinic for follow-up treatment. Over 70% of patients are still in treatment after one year. Patient satisfaction scores have increased with the growth of the medications for opioid use disorder program. The ED left-without-being-seen rate is at an all-time low. Critical to success is a hospital culture of providing treatment options for patients with opioid use disorder and a strong relationship with outpatient clinics that can offer standing appointment times for ED referrals.

Community Services

> **Community-based mental health providers specializing in pain management or substance use disorders.** SAMHSA provides a buprenorphine practitioner locator and a behavioral health treatment center locator for people seeking services for substance use disorder or mental health issues or both.

> **Drug disposal locations.** Disposing of unused medications safely is an important step to prevent misuse and abuse of opioids. Many communities have permanent drug disposal boxes at police departments, pharmacies, fire stations, hospitals or municipal buildings. Rules and regulations for drug disposal boxes vary by state and local municipalities.

- Many hospitals have drug disposal locations on site. If your organization is considering becoming a disposal location, consult your legal staff to be aware of any liability or safety issues that should be addressed first.
- On a federal level, the Drug Enforcement Administration does allow for take-back and destruction of controlled substances.
  - » Drug disposal locations accepting controlled substances can be found at the DEA website:[17] Controlled Substance Disposal Location Finder.

> **Community access to naloxone.** Many states have improved access to naloxone through pharmacies, community health centers and community education programs. Access to naloxone for caregivers and patients at risk of overdose has proved to save lives.[5] As of January 2019, all 50 states and the District of Columbia have enacted legislation to improve access to naloxone through pharmacies.[33] It's important to identify access points to naloxone in your community.

Highland Hospital, Oakland, Calif.

The hospital provides no-cost naloxone to patients at risk, their caregivers and any other visitors who might benefit from having access to this lifesaving medication. Under a hospitalwide standing order, a team works to identify eligible recipients, distribute naloxone and educate recipients on how to safely use it. This program operates adjacent to the pharmacy department and allows for anonymous dispensing to overcome the stigma associated with opioid use disorder. The hospital acquires naloxone at no cost via the California Department of Health Care Service's Naloxone Distribution Project.

> **Support groups.** Programs such as Narcotics Anonymous and SMART Recovery are available at no cost at local offices around the country. These are nonprofessional, self-supporting organizations where providers can refer individuals struggling with addiction.

Quality Improvement Collaboratives

> **Local hospital associations.** Connect with your local hospital association for information on local quality improvement efforts and state-specific considerations.

Kentucky SOS (Statewide Opioid Stewardship) Program

The Kentucky Hospital Association has launched, in collaboration with the Kentucky Cabinet for Health and Family Services, the Kentucky Statewide Opioid Stewardship (KY SOS) program. The program's goal is to reduce the number of opioid prescriptions in Kentucky by one-third by 2025. Overseen by an interdisciplinary advisory committee, the program has developed guidelines for opioid use in inpatient, perioperative and ED settings. More than 114 facilities statewide are participating in this opioid stewardship program. Each facility signed a commitment letter and completed a baseline needs assessment survey. KY SOS provides both education for clinicians and public resources and toolkits for facilities and their patients and families at www.kentuckysos.com. KY SOS requires monthly data collection and submission, which began January 1, 2020. Participating facilities will be able to compare opioid stewardship efforts with others in state and with like-size facilities utilizing the Kentucky Quality Counts data collection system.

> **Designated Medicare quality improvement organization (QIO).** Quality Innovation Network (QIN)-QIOs are responsible for working with health care providers and the community on data-driven projects to improve patient safety, reduce harm and improve clinical care at the local level.[41] If you are interested in learning more about these projects or collaborating in your area, reach out to your local QIO.

> **State or county opioid collaboratives.** Communities are joining forces across the U.S. to work together to combat the opioid epidemic. These local collaboratives offer learning opportunities and the ability to connect resources and work together on quality improvement projects.

Minnesota Health Collaborative, Bloomington, Minn.

The 18 health care delivery systems and health plans represent nearly 80% of Minnesota's population. The goal is to reduce and eliminate prescription opioid overdose deaths by promoting safer, patient-centered prescribing and better statewide coordination. Acute nonsurgical pain efforts have resulted approximately 2.1 million fewer pills in the community and 105,000 fewer patients placed at risk of opioid misuse. Postoperative discharge prescribing efforts have led to average morphine milligram equivalents (MME) reduced from 205 MME to 150 MME. The collaborative's goal is to engage every surgeon statewide in this effort through specialty-focused cohorts working together to catalyze the work.

Local Government Partners

> **911 Good Samaritan Laws.** Laws vary across states, but all exist with the intent to reduce barriers to calling 911 in the event of an overdose. Many police officers have been trained to carry and administer naloxone. Knowledge and education about the responsibilities, immunities and liabilities of 911 Good Samaritan Laws can reduce potential for harm in an at-risk population. Strong partnerships with local paramedics, first responders and law enforcement also can reduce stigma and strengthen community support for people in crisis.[5]

> **Judicial system and law enforcement.** Some health systems have forged partnerships with local judicial systems to support people in the criminal justice system entering and successfully completing treatment for opioid use disorder.

Margaret Mary Health, Batesville, Ind.

HEALING PARTNERSHIPS

Margaret Mary Health came together with the local court system and child protective services to form an alternative sentencing addiction treatment program. In this program, 99% of patients have presented with an intravenous (IV) methamphetamine and/or heroin use disorder. This intensive outpatient program is 12 hours per week and includes trauma-informed, cognitive behavioral therapy-based addiction care, job/resume interview training and placement services, free adult education services, intensive in-home weekly case management, parenting and family therapy, weekly peer support services, medications for opioid use disorder and psychiatric consultation, and food and housing security placements. To date, 75% of graduates go through the eight-month program without relapsing. Another 12% relapse once, but reengage with services and complete the program, and 12% leave the program prematurely. Margaret Mary Health is proud to partner with its community to help patients and families heal.

ELEMENT 3 MEASURE SELECTION

Measurement is a critical part of implementing and testing change. The opioid stewardship leadership team, together with medical directors and department leaders, should select a set of measures that reflect the strategy outlined in Element 1, align with your organization's mission and values, address problems your community faces, and complement goals related to state and federal mandates. Creating a system-specific cohesive driver diagram or value stream map of opioid initiatives, demonstrated in Element 1, Leadership Strategy with Patient Engagement, is critical to highlight these connections. In some cases, organizations may already be retrieving data and reporting measures to state or national quality programs. Most of this data could be similarly applied to a department, service line or prescriber for quality improvement initiatives.

The Institute for Healthcare Improvement (IHI) suggests using a variety of measure types for improvement efforts: outcome measures, process or structural measures, and balancing measures. IHI defines a balancing measure as "looking at a system from different directions or dimensions to ensure that the changes designed to improve one part of the system are not causing new problems in another part of the system." A variety of measures can evaluate the system from different dimensions and more comprehensively evaluate how the system affects the values of patients and their health and well-being.[26]

Measures at the organizational level should fit the following criteria:[6]

> Address a problem in the hospital/health system or community.

> Are supported with up-to-date and evidence-based internal guidelines, policies or procedures.

> Show success or a need for improvement with established goals; are longitudinal.

> Are supported with a level of evidence to positively influence patient outcomes.

> Identify variation between departments, units or prescribers.

> Are balanced with counter measures to ensure desired changes do not cause new problems in the system.

Community Hospital of the Monterey Peninsula, Calif.

SELECTING A BALANCED SET OF MEASURES

Realizing the importance of considering many different perspectives when trying to understand successful pain management, the hospital assembled a multidisciplinary team to take on pain management. Clinicians were given multiple options for nonopioid relief of pain — beyond the standard nonsteroidal anti-inflammatory drugs and acetaminophen — allowing for physicians to easily choose nonopioid treatment strategies or opioid-sparing treatment strategies. The team also took a comprehensive look at measuring success with pain management. This approach allowed them to come up with effective performance measures for pain, including using nonpharmacological modalities for pain, using multimodal therapies for pain and monitoring for oversedation events in hospitalized patients. The use of nonopioid therapies increased significantly over the measurement period.

ELEMENT 3

Menu of Measures

After significant literature review, input and vetting from the advisory group, the following Menu of Measures was created. The intent of this menu is to offer hospitals and health systems a compilation of measures and measure concepts that may be useful as a starting point to identify opportunities for improvement and track progress in opioid stewardship. The measures included in the menu are not intended or recommended for use beyond internal quality improvement purposes.

The menu in Table 1 includes a mixture of process and outcome measures. Tracking process measures can help assess uptake and adoption of new workflows, guidelines and best practices as well as demonstrate compliance with regulation. Outcome measures can assess progress toward a desired objective outcome. Some measures could be considered structural, such as assessing an organization's capacity, systems and processes.[43] Depending on the development of your opioid stewardship program, different measures in this menu will have different varying utility across implementation timelines, departments and projects.

Measure Prioritization and Matrices

In order to mitigate risk of overmeasuring and potential impact on provider burnout, the selected measures have been prioritized based on level of effort for implementation and potential impact on patient care. Advisory group members evaluated the measures for effort of data collection and interpretation (1 = least amount of effort, 5 = most difficult), and impact to patient care and patient safety (1 = lowest impact, 5 = highest impact). These evaluations led to the creation of a priority matrix for each measurement domain.

DOMAIN: ACUTE PAIN MANAGEMENT

Table 1. Menu of Measures Encompassing a Comprehensive Approach to Opioid Stewardship

	Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs* (2020)
Domain: Acute Pain Management					
1	Average total MME per prescription [32,42]	Average MME	Number of opioid prescriptions	**Outcome** Reduction in average total MME	Medicaid ACS, MSSP
2	MME per opioid prescription [32,42]	Total MME	Number of opioid prescriptions	**Outcome** Decrease in MME	Medicaid ACS, MSSP
3	Number of opioid prescriptions per prescriber at discharge [42]	Number of opioid prescriptions at discharge	Patient volume per prescriber	**Outcome** Decrease in total number of opioid prescriptions	
4	Average MME dose administered per inpatient day [42]	Opioid MME dose administered per day	Patient days with opioids administered	**Outcome** Decrease in average MME dose administered	TJC
5	Percentage of patients receiving opioid only for pain management [13]	Patients discharged with only an opioid medication for pain relief	Patients discharged with a prescription for a pain medication of any kind	**Outcome** Decrease in patients receiving opioids only for pain	TJC
6	Percentage of patients receiving multimodal pain management [13]	Patients with at least one opioid analgesic dose and at least one nonopioid analgesic dose *OR* patients with no opioid dose and at least one dose of each non-opioid analgesic from at least two different pharmaceutical classes	Inpatient and observation patient encounters discharged who received at least one dose of an analgesic medication during their stay	**Outcome** Increase in patients receiving multimodal pain management	TJC
7	Proportion of hospitalized patients who have documentation of patient defined comfort and function goals [23, 42, 51, 52]	Patients with documented comfort and function goals	Admitted patients receiving a dose of any pain medication	**Process** Increase in percentage of patients with defined goals	TJC
8	Patient pain management planning and education [25, 37, 42, 47, 51]	Number of plans documented	Number of patients expected to experience pain	**Process** Increase in patients documented as having planning and education	MIPS IA, TJC
9	Baseline assessment of pain and opioid utilization upon admission [25, 37]	Number of assessments documented in EHR	Number of patients on opioids of any length or dose	**Process** Increase in number of baseline assessments	TJC
10	Pain reassessment within 60 minutes of administration of pain medication [13]	Percentage of patients with pain reassessed within 60 minutes	Admitted patients receiving a dose of any pain medication	**Process** Increase in patients with reassessment in desired timeframe	TJC
11	Use of pre-op analgesia, local anesthetic with surgery, anesthesia type, anesthesia adjuncts [45, 47]	Number of patient encounters with ALTO ordered	Number of surgical patient encounters	**Outcome** Increase in utilization of alternatives to opioids	TJC

* Definitions of Abbreviations for Federal Programs: TJC: The Joint Commission, HEDIS: Healthcare Effectiveness Data and Information Set, MIPS (QM or IA): Merit-Based Incentive Payment System (Quality Measure or Improvement Activity) (CMS), MSSP: Medicare Shared Savings Program (CMS), HIQRP: Hospital Inpatient Quality Reporting Program (CMS), Medicaid ACS: Medicaid Adult Core Set

Source: American Hospital Association Opioid Stewardship Advisory Group, 2020.

Measure Domain with Examples from the Field

Acute pain management (11 measures): Four measures (1, 2, 3, 4) are related specifically to utilization of opioids. Four measures (5, 6, 10, 11) are related to pain management, emphasizing utilization of alternative and multi-modal approaches. Three measures (7, 8, 9) are related to patient engagement and patient-centered care. Four measures (7, 8, 9, 10) are process measures, and seven measures (1, 2, 3, 4, 5, 6, 11) are outcome measures.

Anne Arundel Medical Center, Annapolis, Md.

PRESCRIBER VARIABILITY

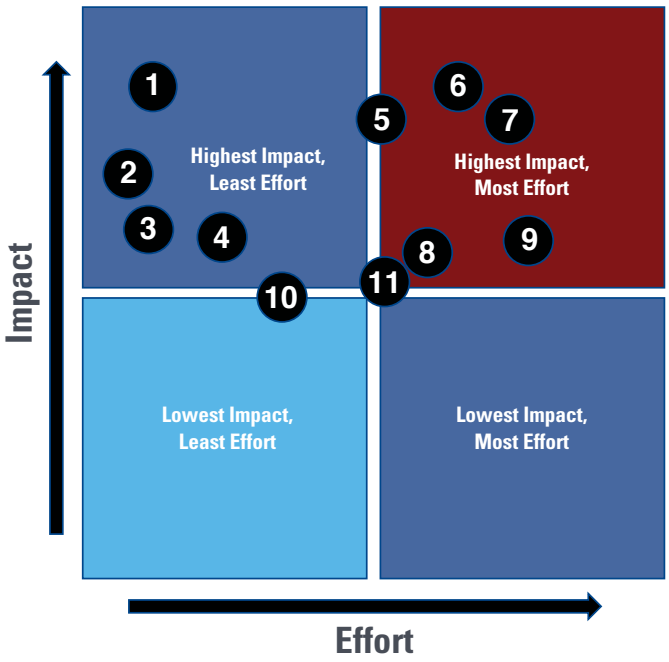
The medical center greatly reduced variability among prescribers in the emergency department by measuring and sharing practices of individual prescribers. Data were collected through the EHR and shared with the ED medical director. Prescribers who were outliers expressed an appreciation for seeing the data compared to peers, not realizing they were outliers. Despite pre-implementation concerns about objections over autonomy, prescribers expressed satisfaction with the idea of "guidelines" as a way of communicating with patients.

Johns Hopkins Hospital, Baltimore, Md.[30]

PROCESS MEASURES TO ADDRESS HEALTH INEQUITIES

A quality improvement study examining an enhanced recovery after surgery (ERAS) pathway after colorectal surgery compared outcomes and process adherence across patient demographics, including racial and socioeconomic status. Process measure adherence stratified by groups and phase of care favored white and high socioeconomic patients. The group concluded that ERAS pathway process measures may be an important quality assessment tool to act as an early indicator for surgical disparities.

Figure 3A. Acute Pain Management Related Measures



List of Measures:

1. Average Total MME Per Prescription
2. MME Per Opioid Prescription
3. Number of Opioid Prescriptions Per Prescriber at Discharge
4. Average MME Dose Administered Per Inpatient Day
5. Percent of Patients Receiving Opioid Only for Pain Management
6. Percent of Patients Receiving Multimodal Pain Management
7. Proportion of Hospitalized Patients who have Documentation of Patient Defined Comfort and Function Goals
8. Patient Pain Management Planning & Education
9. Baseline Assessment of Pain and Opioid Utilization Upon Admission
10. Pain Reassessment within 60 Minutes of Administration of Pain Medication
11. Use of Pre-Op Analgesia, Local Anesthetic with Surgery, Anesthesia Type, Anesthesia Adjuncts

**Denotes example provided by an advisory group member.*

DOMAIN: HARM REDUCTION

Table 1. Menu of Measures Encompassing a Comprehensive Approach to Opioid Stewardship

continued

	Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs* (2020)
Domain: Harm Reduction					
1	Percentage of patients with opioids and benzodiazepines co-prescribed [8, 10, 34]	Patients prescribed both opioids and benzodiazepines	All patients	**Outcome** Decrease in number of patients co-prescribed	HEDIS, Medicaid ACS, HIQRP, MSSP
2	Naloxone prescribed for opioid overdoses or high-risk patients [37, 42]	Number of naloxone prescriptions	Number of patients presenting with OD or opioid MME >50	**Outcome** Increase in naloxone prescriptions	
3	Opioid prescriptions > 90 MMEs daily [5, 37, 42]	Prescriptions > 90 MMEs daily	All prescriptions	**Outcome** Decrease in opioid prescriptions >90MME daily	Medicaid ACS
4	Proportion of hospitalized patients administered naloxone [9, 28]	Number of naloxone administrations per admission	Discharges of adult patients over 12 months	**Outcome** Decrease in naloxone administered in hospital	HIQRP, TJC
5	Number of adverse safety events due to opioids (ex: Pasero opioid-induced sedation scale (POSS) score > 3) [28, 42, 45, 54]	Number of major (or minor) ADEs after first dose of opioids	Total number of patient days	**Outcome** Decrease in number of adverse safety events	TJC
6	Number of urine/blood drug screens [16, 42, 51, 54]	Number of urine toxicology screens ordered	Number of patients on opioids >90 days	**Process** Increase in number of drug screens	
7	Opioid/controlled substance agreement signed [10, 38, 54]	Number of plans documented	Number of patients on opioids >6 weeks	**Process** Increase in documented agreements	MIPS QM
8	Rates of accessing prescription drug monitoring program (PDMP) [10, 21, 37, 38, 54]	Number of patients on opioids of any length or dose	Number of patients on opioids of any length or dose	**Process** Increased rate of PDMP utilization	MIPS IA
9	Opioid tapering plan documented [37, 51]	Number of tapering plans documented	Number of patients on opioids >90 (or 30, or fewer) days	**Process** Increase in documented tapering plans	

* Definitions of Abbreviations for Federal Programs: TJC: The Joint Commission, HEDIS: Healthcare Effectiveness Data and Information Set, MIPS (QM or IA): Merit-Based Incentive Payment System (Quality Measure or Improvement Activity) (CMS), MSSP: Medicare Shared Savings Program (CMS), HIQRP: Hospital Inpatient Quality Reporting Program (CMS), Medicaid ACS: Medicaid Adult Core Set

Source: American Hospital Association Opioid Stewardship Advisory Group, 2020.

Measure Domain with Examples from the Field

Harm reduction (9 measures): Five measures (1, 4, 5, 6, 8) are related to care and processes when a patient is admitted, while seven measures (1, 2, 3, 6, 7, 8, 9) also can cross into the discharge or ambulatory prescribing. Four process measures (6, 7, 8, 9) require supporting policies and procedures to aid nonstigmatizing and compassionate clinical decision-making.

Hennepin Healthcare, Minneapolis, Minn.*

URINE DRUG SCREENS

At Hennepin Healthcare, urine drug screens are done every six months for all patients on chronic opioids; this is one tool to aid holistic decision-making. A systemwide pain agreement written at a fourth-grade reading level clearly defines expectations for urine drug screens. Hennepin's clinic-based community pharmacies have access to the medical record and, for patients on pain agreements, can order urine drug screens, interpret results and provide recommendations to providers.

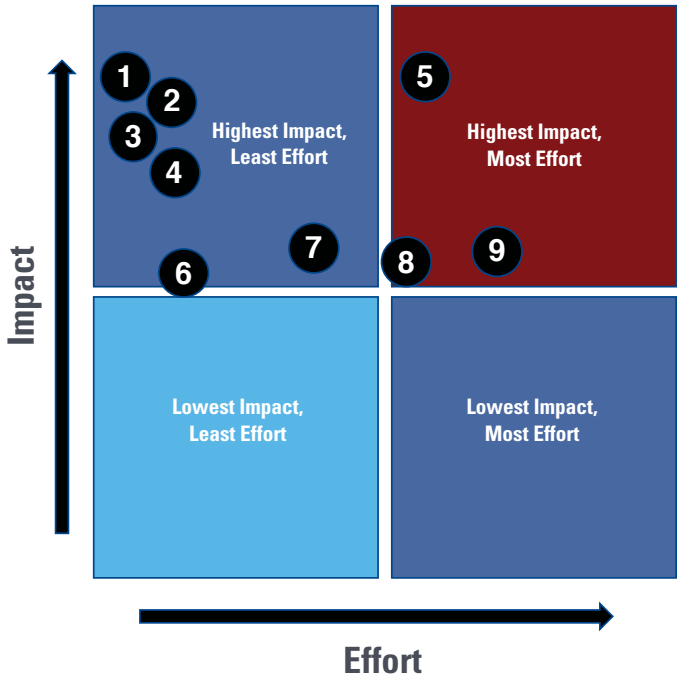
Hennepin Healthcare, Minneapolis, Minn.*

ACCESS TO NALOXONE

Hennepin Healthcare has increased its take-home naloxone dispensing by 400% using a strategy to involve pharmacists across the system. Hospital pharmacists identify patients admitted for opioid overdose and provide naloxone. Community pharmacists identify appropriate patients and provide naloxone for ambulatory and ED discharge patients. Free naloxone kits are placed in the Omnicell in the health system's EDs.

**Denotes example provided by an advisory group member.*

Figure 3B. Harm Reduction Related Measures



List of Measures:

1. Percent of Patients with Opioids and Benzodiazepines Co-Prescribed
2. Naloxone Prescribed for Opioid Overdoses or High-Risk Patients
3. Opioid Prescriptions > 90 MMEs Daily
4. Proportion of Hospitalized Patients Administered Naloxone
5. Number of Adverse Safety Events Due to Opioids (Ex: Pasero Opioid-Induced Sedation Scale (POSS) Score > 3)
6. Number of Urine / Blood Drug Screens
7. Opioid / Controlled Substance Agreement Signed
8. Rates of Accessing PDMP
9. Opioid Tapering Plan Documented

DOMAIN: IDENTIFICATION & TREATMENT OF OPIOID USE DISORDERS

Table 1. Menu of Measures Encompassing a Comprehensive Approach to Opioid Stewardship

continued

	Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs* (2020)
Domain: Identification & Treatment of Opioid Use Disorders					
1	Number of referrals for OUD/ MOUD treatment [8, 28, 36, 51, 54]	Number of referrals ordered	Number of patients identified with OUD	**Outcome** Increase in referrals or use of addiction consult service	Medicaid ACS, TJC
2	Neonatal withdrawal syndrome (NWS) treatment measures [36, 51, 53]	Total postpartum opioid exposure	All infants with neonatal withdrawal syndrome (NWS)	**Outcome** Reduction in opioid exposure	
3	New patient starts for MOUD [8, 18, 36, 38, 54]	MOUD initiated	Number of patients identified with OUD	**Outcome** Increase in number of new starts	Medicaid ACS
4	Completed/successful referrals for OUD treatment [8, 28]	Number of referrals completed	Number of referrals ordered	**Outcome** Increase in number of completed referrals	Medicaid ACS, TJC
5	Long term recovery/abstinence 12 months out or longer [9, 36]	Number of patients deemed stable	MOUD patient panel	**Outcome** Increase in number of patients reporting abstinence	MIPS QM
6	Screening for OUD/SUD [21, 37, 38, 43]	Number of risk assessments documented in EHR, percentage of patients screened	Number of patients on opioids for longer than 6 weeks	**Process** Increase in number of screens	MIPS QM
7	Number of referred patients still in treatment 30 days later [8, 36, 43]	Number of patients still in active treatment program	Number of treatment referrals completed	**Outcome** Increase in number of patients still engaged in treatment	Medicaid ACS
8	Identification & planning for patients with OUD/in MOUD upon admission [38, 51, 54]	Number of plans documented	Number of patients with OUD dx or MOUD treatment	**Process** Increase in number of documented plans	Medicaid ACS
9	Screening patients with OUD for infectious diseases (Ex: Hepatitis B/C, HIV) [36, 37, 43]	Percentage of patients screened	Number of patients on opioids for longer than 6 weeks	**Process** Increase in number of screens	
10	Functional outcomes and quality of life patient-reported outcome measures (PROMs) for treatment engaged patients (ex: PROMIS29) [2, 36]	PROM score over time	Baseline PROM	**Outcome** Improvement in score of PROM over patient baseline	

* Definitions of Abbreviations for Federal Programs: TJC: The Joint Commission, HEDIS: Healthcare Effectiveness Data and Information Set, MIPS (QM or IA): Merit-Based Incentive Payment System (Quality Measure or Improvement Activity) (CMS), MSSP: Medicare Shared Savings Program (CMS), HIQRP: Hospital Inpatient Quality Reporting Program (CMS), Medicaid ACS: Medicaid Adult Core Set

Source: American Hospital Association Opioid Stewardship Advisory Group, 2020.

Measure Domain with Examples from the Field

Identification and treatment of opioid use disorder (10 measures): Six measures (2, 4, 5, 6, 8, 10) account for activities occurring during admission, and the other four (1, 3, 7, 9) measures are more longitudinal. Patient functional outcomes and quality of life are acknowledged as a critical outcome measure to treatment for opioid use disorder, but also a current measures gap. While these measures are potentially more difficult to monitor, they are encouraged for use to ensure patients have continued access to treatment programs after discharge. We also acknowledge that an organization's ability to track the longitudinal outcome measures related to opioid use disorder treatment may be challenging.

Dell Seton Medical Center and Dell Medical School at the University of Texas, Austin*

MEASUREMENT PROVES CONCEPT

Stakeholders worked collaboratively to start a multidisciplinary program that treats hospitalized patients with opioid use disorder. The B-Team (Buprenorphine Team), which does not rely on formal addiction medicine services, includes nurses, pharmacists, social workers, physicians, palliative care practitioners, chaplains and peer recovery coaches. The team screens patients for opioid use disorder, offers buprenorphine therapy, provides education throughout the organization and promotes harm reduction including naloxone distribution. At discharge, patients are provided a "warm handoff" to a specialized clinic where they can continue their recovery and receive primary care. The B-Team has implemented stigma reduction trainings and hosted buprenorphine X-waiver classes for all practitioners of the hospital and community. Measures created around several components served initially as proof of concept and are leveraged to continually engage stakeholders.

Birmingham VA Medical Center, Ala.*

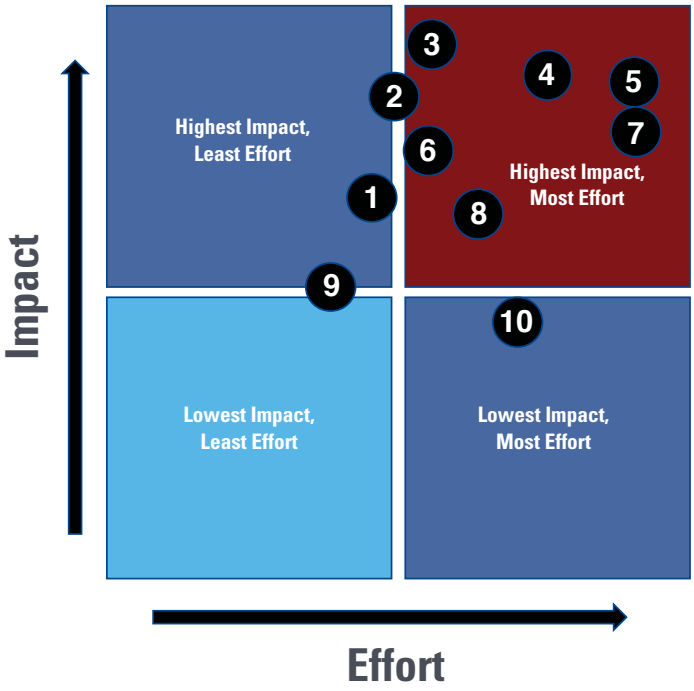
LEVERAGING PATIENT-CENTERED OUTCOME MEASURES

Patients who have been treated with opioids for chronic pain can attend a series of shared medical appointments (SMAs), with a team of MDs, RNs, LPNs and clinical pharmacists, for education on safe opioid usage as well as utilization of integrative pain management modalities using a whole health conceptual framework. As part of pre-and post-assessments, the PROMIS-29 survey was administered to track subjective efficacy. Opioid usage was tracked using a database metric tool available in the VA computerized Patient Record System. Of 86 participants, there were no statistical differences in subjective pain or functional scores pre-and post-SMA as assessed with the PROMIS-29. Opioid utilization was substantially reduced in patients who continued to participate in monthly maintenance sessions in correlation to engagement in other pain management modalities.

**Denotes example provided by an advisory group member.*

Measure Domain with Examples from the Field, continued

Figure 3C. Identification & Treatment of Opioid Use Disorders (OUD) Related Measures



List of Measures:

1. Number of Referrals for OUD/MOUD Treatment
2. Neonatal Withdrawal Syndrome Treatment Measures
3. New Patient Starts of Medication for OUD
4. Completed/Successful Referrals for OUD Treatment
5. Long-Term Recovery/ Abstinence 12 Months out or Longer
6. Screening for OUD/SUD
7. Number of Referred Patients Still in Treatment 30 Days Later
8. Identification & Planning for Patients with OUD/in MOUD Upon Admission
9. Screening Patients with OUD for Infectious Diseases (Hepatitis B/C, HIV)
10. Functionality and Quality of Life Patient-Reported Outcome Measures for Treatment Engaged Patients (Ex: PROMIS-30)

For more detailed information on the prioritization metrics and pro/cons for each measure, please see the Advisory Group Input Menu of Measures Prioritization Detail Table in the Appendix.

An Eye Toward Future Measures

While the Menu of Measures provided presents a compilation of measures and concepts identified, there remain opportunities for measure development. In 2020, NQF, commissioned by CMS, completed an assessment of existing measures related to opioids and opioid use disorder.[36] The final report recognized five gap priority areas, listed here. Additional potential gaps related to telehealth (#6) and continuation of pharmacotherapy for opioid use disorder (#7) at the care delivery level were identified through development of this guide:

1. Long-term recovery from opioid use disorder
2. Physical and/or psychiatric comorbidities in opioid use disorder/substance use disorder
3. Opioid-tapering strategies
4. Special populations in opioid use disorder treatment (e.g., pregnant women, people experiencing homelessness, people experiencing incarceration, adolescents, Native Americans and LGBTQ communities)
5. Patient-centered pain management measures
6. Use of telehealth for remote assessment or treatment of pain or opioid use disorder
7. Continuity of pharmacotherapy for opioid use disorder at the care delivery level

Measures available in the menu that fit within some of these gap areas are currently being used in organizations across the U.S. to track improvement; however, further study and development of these and other measures in these gap areas are important to help health systems identify and improve opportunities to better meet the needs of their patients.

ELEMENT 4 GOAL SETTING AND IMPROVEMENT PLANNING

Setting clear and bold aims for the measures selected can be powerful in building a system to generate change and improvement. When developing a quality improvement plan at a department or prescriber level, the focus should be on quality improvement to promote a culture of safety. According to the Institute for Healthcare Improvement, "Without a strong safety culture, the ability of an organization to authentically prioritize challenges and effectively implement protocols to improve the safety of pain management is likely to be limited."[25]

With a driver diagram, supporting organizational guidelines, and data, you will have a solid start to establishing your baselines, setting goals and implementing improvement plans around your measures. Quality improvement plans can be implemented using a variety of tools. It is recommended that you engage your organization's safety or quality department or access the many free resources at the IHI Resources Page.

Establish Baselines and Set Goals

As you begin to review the baseline data displayed by your organization's selected measures, you may see differences across departments and prescribers. Medical directors and department chairs play an integral role in championing opioid stewardship efforts, facilitating conversations with prescribers and following up on mutually determined goals. It may be appropriate to establish varied incremental goals to encourage improvement while averting unintended consequences of aggressive improvement goals. One example is to improve by 10% over the baseline measurement. Generally, smaller projects related to a specific department or group of similar prescribers are most successful as the intervention can be more specific and tailored to the department's baseline. Some organizations allow department leaders to choose individualized projects and measure(s) related to opioid stewardship.

Prescriber attribution can be complicated[1] as patients transition through acute and ambulatory care settings in hospitals and health systems. Multiple prescribers might be involved in a patient's care, even in just one acute care stay. Attribution in an academic or teaching environment brings its own challenges as well. Measures specific to a prescriber should emphasize a culture of safety and can be used to coach providers on their individual performance.

Examples from the Field

Applying the idea that smaller improvement plans can contribute to large organizational goals, many organizations have successfully implemented improvement plans across and within various departments and service lines.[26] A key to success of these smaller plans is recruiting passionate peer champions. These champions can help develop the process, exemplify applying best practices and serve as a resource when prescribing questions arise. The examples from our advisory group and peer-reviewed literature demonstrate how small improvement plans can have a large impact on opioid stewardship across an organization.

EXAMPLES FROM THE FIELD

ORGANIZATIONWIDE ▶

Brigham and Women's Hospital, Boston, Mass.,* created a metrics tool to determine the percentage of opioid prescriptions for greater than 90 morphine milligram equivalents per day. Using this tool, it was discovered that over 20% of the hospital's opioid prescriptions were for these high doses and came mainly from a few clinics affiliated with the hospital. Information was used to introduce a comprehensive protocol in those clinics, including random chart reviews to ensure safe practices and using pharmacists to manage tapers when appropriate. By looking only at overall opioid prescriptions without considering the potency of the prescriptions, important insights were being missed.

Anne Arundel Medical Center, Annapolis, Md.,* implemented a bundle of solutions including eliminating long-acting opioids from preoperative pain cocktails, using a sedation scale by nursing prior to any opioid administration, and creating an easy-to-access opioid tracker in the EHR so all pain medication dosing would appear in one easy-to-access place. As a result, Anne Arundel achieved and sustained 95% improvement in the safety profile of in-hospital opioids (as measured by validated naloxone rescue).

SURGERY SERVICE ▶

Regions Hospital, St. Paul, Minn.[46] The hospital's Department of Plastic and Hand Surgery implemented a multimodal pain management plan utilizing a 3x5 card as a memory aide and supporting order sets. Postoperative prescription guidelines also were recommended. In just three months, opioids prescribed postprocedure were reduced by 15% to 48% across the different evaluated procedures, with no increase in requests for opioid refills. By implementing these guidelines, data collected one year after implementation demonstrate that reductions on prescribed opioids and prescriber variation were sustained.

EXAMPLES FROM THE FIELD

SURGERY SERVICE ▶

Michigan Opioid Prescribing Engagement Network (OPEN).* To ascertain the impact of their new prescribing recommendations and patient counseling related to opioid use, Michigan OPEN conducted an analysis to compare postoperative opioid prescribing before and after the release of their recommendations. The effect of dissemination of Michigan OPEN's prescribing recommendations was published in the New England Journal of Medicine in August 2019.[52] Hospitals that implemented Michigan OPEN's model saw postoperative opioid prescribing fall by 30%; opioid consumption decreased by 50%; and patient-reported satisfaction with overall care and pain management in the week after surgery remained stable.

Anne Arundel Medical Center, Annapolis, Md.* The orthopedics department standardized postoperative prescribing for over 15 different procedures using a consensus-driven approach and published recommendations. The new guidelines called for 50% to 75% fewer opioids (MMEs) than previously prescribed. Adherence to the guidelines was greater than 90%, enforced by active monitoring. Moreover, the first-level changes are being adjusted by using real time (not recalled) patient diaries to measure consumption and by tracking requests for second prescriptions. Further reductions were then built into the revised guidelines based on data showing actual consumption was less than previously assumed.

INTEGRATING OPIOID USE DISORDER TREATMENT IN THE INPATIENT SETTING ▶

Oregon Health and Science University (OHSU)'s Improving Addiction Care Team (IMPACT)* created an interprofessional addiction consult service, including physicians, advanced practice providers, social workers and peer mentors. IMPACT provides comprehensive substance use disorder assessments and care that includes initiating medication for opioid use disorder. Seventy percent (70%) of IMPACT patients with opioid use disorder who were not on treatment upon hospitalization started medications with plans to continue after hospitalization, doubling the odds of posthospital substance use disorder treatment engagement compared to matched controls. IMPACT's experience highlights that hospital-based addiction care can be a critical touchpoint to engage high-risk, "not-seeking-treatment" adults in lifesaving treatment.[17]

*Denotes example provided by Advisory Group member.

EXAMPLES FROM THE FIELD

INTEGRATING OPIOID USE DISORDER TREATMENT IN THE INPATIENT SETTING ▶

Zuckerberg San Francisco General Hospital, Calif.* Providers in medical/surgical, obstetrics and intensive care units routinely treat patients with opioid use disorder who are admitted for acute medical or surgical issues. Patients who are on methadone or buprenorphine prior to admission are continued on their medication, and patients who have not yet engaged in treatment are offered these evidence-based medications. The hospital offers X-waiver trainings twice a year for 50 to 100 participants. Providers are waived in departments across the hospital. Order sets for starting and continuing these medications are integrated into the EHR, and multiple departments focus on naloxone distribution in their quality improvement efforts. Approximately 100 patients per month receive buprenorphine or methadone, with one-third newly initiating treatment and connecting to outpatient care.

ELEMENT 5 POLICIES AND CARE TEAM EDUCATION

Developing and revising organizational guidelines, policies and procedures related to opioid stewardship should be a priority as your team considers executing its strategy and improvement plan. Policies and procedures should be evidence based, comprehensive, cohesive and compassionate across all facets of opioid stewardship, and should adhere to state and federal regulations. As you review policies, ensure that they do not perpetuate stigma and that they offer guidance to adequately attend to the individualized nature of pain management. Patient and caregiver advocates can provide valuable perspectives to address biases and reduce stigma in guideline and policy development.

Links to several updated policy examples are included in the Appendix section of this Guide. Table 2 identifies opioid stewardship best practice recommendations from the advisory group.

Recommended Guidelines and Policies

Table 2. Recommended Opioid Stewardship Guidelines, Policies and Procedures

Acute Pain Management
> Multimodal pain management strategies
> Patient education on multimodal pain management upon discharge, risks associated with opioids, and proper disposal of unused medications
> Prescribing guidelines for nonoperative pain management medications
> Prescribing guidelines for postoperative pain management, potential framework for specific procedures
> Acute pain management in patients with chronic pain
Chronic Pain Management
> Multimodal nonopioid medications and nonpharmacologic treatments
> Multifaceted team support for opioid-tapering plans and management
> Universal utilization of patient risk screening, controlled substance agreements, urine drug screening, checking the prescription drug monitoring program
Harm Reduction Strategies
> Access to naloxone for patients at risk for overdose
> Administration of naloxone to hospitalized patients who exhibit signs of overdose
> Medication review for high-risk combinations (e.g., benzodiazepines, muscle relaxants, sedatives)
> Screening for hepatitis A, B and C, and HIV for high-risk patients
> Opioid harm reduction in pregnancy and neonatal care
Supporting Patients with Opioid Use Disorder
> Maintaining current opioid use disorder treatment for any admitted patient
> Screening for concomitant substance use disorder and behavioral health conditions
> Developing a pain management plan for a surgical patient with opioid use disorder
> Initiation of medication therapy for treatment of opioid withdrawal or opioid use disorder
> Transitions of care planning for patients engaged in treatment for opioid use disorder
> Transitions of care planning for patients engaged in treatment for OUD

Prescriber and Care Team Education

An important lever for mobilizing change in your organization is providing education to care teams and prescribers. Education should include updates along with training on new or revised organizational guidelines and should address stigma as well as personal biases.

Many states mandate education on opioids for prescribers. Most organizations require attendance and completion of learning regarding opioid utilization and pain management.

When considering education for prescribers and care teams, some essential points to address include: [32]

- The link between overprescribing and opioid dependency in individual patients
- The link between overprescribing and diversion of opioids into the community
- The mismatch between postoperative prescribing and patient actual use and need
- Identifying medical conditions that put patients at high risk for dependency
- The limited data that supports opioids for chronic pain
- How to use opioid alternatives

While education and training do not always translate to changes in practice, there is consensus on the need to ensure that educational efforts are far reaching, comprehensive and conducted.[22, 31, 32, 45, 47, 54] There are several process measures that can be used to demonstrate application of learning (see Table 1. Menu of Measures Encompassing a Comprehensive Approach to Opioid Stewardship.)

Dell Medical School and Dell Seton Medical Center at the University of Texas at Austin

Focusing on stigma reduction is a hallmark of Dell Seton's care team education work. It views opioid use disorder as a chronic medical disease that all can address in a meaningful way. For example, patients with diabetes receive counseling, an evidence-based medication and follow-up after hospitalization. Dell Seton has learned to incorporate a similar model for patients faced with addiction. Care teams speak using person-first and recovery-centered language, provide access to proven pharmacologic interventions and facilitate outpatient follow-up. This provides an appropriate, safe, ethical and value-based approach to treating substance use disorders.

Using different education and dissemination strategies and methods has shown the most success[22] in creating dialogue around "the why" and more broadly disseminating opioid stewardship advancements at organizations.[6, 21, 22, 38, 42, 45, 54]

Identified educational strategies include:

- Recorded on-demand learning modules that can be assigned to individuals and easily tracked for completion.
- Live presentations, like grand rounds or lunch and learns, that can be approved for continuing education.
- Posters and project dashboards to create visual reminders of the ongoing work.
- Pocket cards or quick reference guides that can aid prescribing, patient education and utilization of appropriate diagnosis codes. (See the Appendix for examples and links.)
- Links to educational materials within EHR order sets that can provide easy and timely access at the point of care.
- Internal or external social media campaigns that can quickly share patient-centered care and care team success stories.
- Training key team members to become "opioid prescribing liaisons," which offers rapid dissemination and a level of expertise at critical organizational touchpoints.

Mayo Clinic in Arizona

The clinic was challenged to integrate enterprise guidelines and state laws into local practice protocols and disseminate new requirements quickly throughout the organization. To accomplish this, one key leader in each division/department completed a 90-minute training program to become an opioid prescribing liaison. Liaisons were educated on the new patient screening and opioid prescribing requirements, as well as organizational resources, patient education material, referral policies for opioid use disorder and their role in metric monitoring. Opioid prescribing liaisons met with division/department leadership to customize their policies and present recommendations to colleagues. All providers receive quick reference guides on prescribing policies and are directed to their intranet opioid stewardship page for resources and to ask questions.

Engaging Patients in Care Team Education

In designing education efforts for prescribers and care teams, being aware of our own biases and potential biases within our organizations is the first step to fostering a culture where patients can discuss substance use, create space for connection, treatment engagement, and healing.[14, 35] Being aware of how we frame scenarios and choose words is key to connecting with this patient population. Patient advocates and peers with lived experience can be powerful in changing the narrative.

Brigham and Women's Hospital, Boston, Mass.

TEACHING PARTNERS PROGRAM

Staff in the ED partnered with their patient/family advisors who developed a teaching partners program to improve empathy and the patient experience in the ED. Newly hired nursing assistants received communication skill training then met with their patient advisor partner over four weeks. Feedback was positive all around. Staff scores on the Jefferson Scale of Empathy[23] showed a statistically significant increase after completing the program.

Oregon Health and Science University, Portland, Ore.

PEER SUPPORT IN HOSPITAL CARE

The Improving Addiction Care Team (IMPACT) hospital-based addiction consult service includes peers with lived experience in recovery. Peers play a critical role in engaging patients, building trauma-informed systems and supporting hospital-based harm reduction efforts. IMPACT has developed guidelines that other hospitals may use to support effective integration of peers in hospital care.[19]

Educational Atmospheres Vary Across Organizations

The educational atmosphere of an academic health center provides several advantages when applied to opioid stewardship. Opioid educational curricula can be a required portion of the experiential education for health professional students and residents.[11] Medical residents at some organizations complete a qualifying training course to become waivered to prescribe and dispense buprenorphine upon full licensure. Advisory group members in academic institutions note that this is an important opportunity to affect the next generation of prescribers. They also recognize how learners empowered with knowledge around opioid prescribing and stewardship have taken these skills to more senior clinicians.

Even at organizations without formal medical training programs, educating the medical staff and prescribing community is a necessary first step toward reducing overprescribing.[32]

Depending upon the degree of organization at nonteaching hospitals, organizations may still have department grand rounds or medical staff meetings with or without CME credit. Because unlearning established practices is harder than learning new ones, such sessions should be led by practicing physicians with credibility who are familiar with the prescribers' environment and pressures. An effective method of getting prescribers' attention is to host a discussion with them featuring a patient or family member of someone who was injured from well-intended but injudicious prescribing. Another potential tool for hospital medical staff is to require members to obtain one or more hours of CME in some topic of pain management or safe prescribing offered by an external organization.

ADDITIONAL EDUCATION RESOURCES

Project ECHO (Extension for Community Healthcare Outcomes) programs are occurring across the U.S. to facilitate learning among health care providers and promote expansion of access to treatment for opioid use disorder and other substance use disorders, particularly in rural and underserved areas.[29] More information can be found by joining or creating an ECHO program.

Providers Clinical Support System, funded by SAMHSA, provides over 700 educational resources at no cost for prescribers of opioids and other health professionals, including recorded webinars, online modules, courses such as Substance Use Disorders 101 Core Curriculum and Chronic Pain Core Curriculum, naloxone training, free buprenorphine waiver training, and a mentor program.[39]

Opioid Response Network, also funded by SAMHSA, provides education and training at a local level on evidence-based practices in the prevention, treatment and recovery of opioid use disorders.

ELEMENT 6 Patient Education and Engagement

This Guide highlights important examples of how patient and caregiver engagement can shape and contribute to the success of opioid stewardship quality improvement initiatives and related measures. Additionally, it is important to consider the development of patient education materials and strategies to engage patients in shared decision-making about their pain management and treatment options.

Components of Patient Education Materials

It is critical to continuously revise and improve patient education material and tools to reflect changes in prescribing and treatment practices.[14, 35] To be successful, material and tools must align with the information that patients receive from providers.

Mayo Clinic in Arizona

When Mayo Clinic implemented new guidelines and policies related to opioid prescribing, many patients had questions about the changes, and providers often spent a considerable amount of time responding to these questions. In response, the organization developed a one-sheet patient handout outlining the purpose of the changes and emphasizing their role in promoting patient safety. The sheet (in the Appendix) was made available to outpatient and inpatient providers and resulted in improved patient education and provider satisfaction.

Table 3. Key Components for Patient Education Materials on Pain Management and Opioid Use [14, 32, 35]

Pain Management and Comfort Care
> Set pain expectations.
> Caution that opioids are powerful medicines and have risks even at low doses for short periods.
> Emphasize nonopioid and multimodal pain management strategies.
> Reserve opioids (if prescribed) for severe breakthrough pain.
Harm Prevention
> Wean off opioids (if prescribed) as pain resolves.
> Do not mix with other medications and/or alcohol.
> Do not share medications.
> Store properly, out of the sight and reach of children, preferably locked.
> Have a disposal plan for unused opioids at the end of treatment.
> Educate patients and caregivers on the importance of carrying naloxone if appropriate and ensure access.
Opioid Use Disorder
> Establish a referral process for opioid use disorder.
> Create protocols for buprenorphine initiation.
> Provide neonatal withdrawal syndrome care and follow-up.

Health Literacy and Hidden Barriers

All written materials should be reviewed by your patient advocates, patient advisory group or patient education department for medical jargon or stigma-inducing language. The Agency for Healthcare Research and Quality has a Health Literacy Universal Precautions Toolkit for more detailed information. Examples shared by the advisory group about the value of health literacy reviews include:

> One advisory group organization noted that, in their review, they changed the "analgesic itinerary" to the "pain management plan." Others noted a preference for "comfort care" over "pain management."

> Patient information sheets related to co-prescribed naloxone should emphasize potential risks of unintentional overdose with appropriately prescribed opioids, while deemphasizing illicit drug use, abuse or addiction to opioids.

> In supporting patients who begin medication for opioid use disorder in the hospital or ED, instead of "Key Points for Safe Home [Drug Name] Induction" consider "Your Guide to Safely Taking [Drug Name] at Home."

Integrating Shared Decision-Making

Shared decision-making is a process that involves a partnership based on empathy that acknowledges patients know information about their body, circumstances and goals for life and health care.[31] Shared decision-making is a conversation between the patient and the prescriber or care team member to discuss and mutually agree on a treatment plan.

Collaboratively Developing a Pain Management (or Comfort) Plan[35]

> Agree on realistic pain management expectations in advance.

> Discuss and encourage multimodal and nonpharmacologic pain management tools.

> Focus on functional outcomes versus a pain score.

Creating an Agreement for Treatment with Medication for Opioid Use Disorder[39]

> Include follow-up medical appointments and monitoring.

> Discuss proper prescription storage and safety precautions.

> Identify and encourage participation in support networks as well as involvement of family and friends.

> Commit to be open, honest and compassionate.

The Mayo Clinic Shared Decision Making National Resource Center has general resources and care team training opportunities.

SAMHSA has an online Decisions in Recovery: Treatment for Opioid Use Disorder tool to help patients learn about treatment, compare treatment options and locate resources.

General Public Education Campaigns

Successful community education can help establish general expectations regarding appropriate pain management and opioid use. Educating the public, and the portion of the public who are patients, should be done simultaneously with other initiatives.[32] Fortunately, awareness and concerns regarding medicinal opioid prescribing have generally

increased among the public due to media coverage of the opioid epidemic. Feedback from physicians and organizations who have experience in this effort suggests that most patients are grateful for the extra concern demonstrated during a discussion of why opioids might be avoided or given for shorter durations.

Much of the material for public education campaigns is already available through public health departments or other groups and need not be created anew. Public service campaigns around opioid use are common in many communities; however, you also can highlight your own organizational changes and initiatives with low-cost public education strategies. Examples include local radio and television interviews with physicians, editorials or columns published in local newspapers, various social media platforms or your organization's website.[29] Many opportunities for collaboration and partnerships will surface with local public service campaigns.
Here are examples:

> **The University of Texas at Austin Dell Medical School** blog regularly promotes work related to community partnerships in opioid treatment services and harm reduction partnerships.

> **Essentia Health in Duluth, Minn.,** regularly partners with local media, like The Detroit Lakes Tribune, to promote their opioid stewardship program and strengthen relationships in the community.

ACTION PLANNING AND MOVING THE WORK FORWARD

Stemming the tide of the opioid epidemic will not be quickly or easily accomplished. However, with persistent application of the evidence-based strategies presented here, we can curb the rise in opioid use and rates of death from opioid overdose and boost the rates of identification and treatment for opioid use disorder. The fundamental elements of implementing opioid stewardship measurement to drive these changes include:

1. Developing your leadership team and oversight strategy. Start a conversation with your key stakeholders and define a patient-focused vision. Define your organizational "why."
2. Identifying internal partners and resources. Engage your community partners to foster collaboration and build on existing resources.
3. Identifying available data sources and appropriate measures related to your organizational priorities. Design a balanced set of measures to comprehensively evaluate your opioid stewardship efforts.
4. Setting aims and implementing improvement plans around your measures. Remember, tailored projects within departments or groups of like prescribers can be very effective.
5. Ensuring the guidelines, policies and procedures related to your opioid stewardship efforts are updated, cohesive and compassionate. Use a comprehensive education and dissemination strategy throughout your organization. Tap into external educational resources to complement your efforts.
6. Engaging and educating patients are key components throughout this process. Patient and caregiver advocates can help you better understand your community and strengthen skills for collaboration.

This Guide's outlined elements, coupled with the Menu of Measures, offer hospitals and health systems an actionable resource to implement best practices in using data to identify opportunities and measure progress in quality improvement efforts in acute pain management, opioid-related harm reduction, and identification and treatment of opioid use disorder.

This work affects the health care system as well as our entire nation and will require multifaceted and complex approaches to address. As the common saying goes, we all must "start where we are and do what we can, with what we have." Many organizations have already contributed significant and meaningful advancements in opioid stewardship that contributed to the development of this Guide. Hospitals and health systems can use this Guide to accelerate the incredible work already underway. We must continue to carry a patient-inspired vision to push this work forward, analyze progress and needs, and align resources and measures.

Armed with these key elements and a selection of measures that align with the priorities of your organization, you can take your organization's and community's opioid stewardship efforts to the next level. Our society relies on hospitals and health systems as leaders in advancing health, and we hope these resources will be used nationwide to accelerate progress on stemming the tide of the opioid epidemic.

APPENDIX

These resources are organized in closest alignment with the corresponding Guide element. Many are "open source" resources, and the hyperlink goes to an external website. Several are not open source, and those links (marked with an *) go to the shared document included at the end of this Guide.

Element 1: Leadership Strategy with Patient Engagement

American Hospital Association: Health Research & Educational Trust Hospital Improvement Innovation Network Case Studies

American Society of Health System Pharmacists Opioid Management Spotlight Gallery

CDC Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain

Institute for Healthcare Improvement: Quality Improvement Toolkit: Driver Diagram

Institute for Patient- and Family-Centered Care 2018 White Paper: Partnering with Patients and Families to Strengthen Approaches to the Opioid Epidemic

National Quality Partners Playbook™: Opioid Stewardship

Leveraging Information Technology through Clinical Decision Support

National Academy of Medicine: Optimizing Strategies for Clinical Decision Support

Implementation of Clinical Decision Support Rules, American Journal of Health-System Pharmacy

Centers for Medicare and Medicaid Services. Clinical Decision Support: More Than Just 'Alerts' Tip sheet

Advancing Clinical Decision Support Key Lessons in Clinical Decision Support Implementation

Element 2: Environmental Scan

Substance Abuse and Mental Health Services Administration (SAMHSA) home page is a clearing house for a variety of patient and healthcare provider resources

American Hospital Association: Treatment Options for Opioid Use Disorders

FDA's Safe Opioid Disposal – Remove the Risk Outreach Toolkit

APPENDIX

Element 3: Measure Selection

Menu of Measures Encompassing a Comprehensive Approach to Opioid Stewardship*

Advisory Group Input Menu of Measures Prioritization Detail Table*

Patient Assessment Tools

Brief Pain Inventory (Short Form)

Defense and Veterans Pain Rating Scale (DVPRS)

PEG (Pain, Enjoyment, General Activity) Scale

PROMIS-29 Profile v2.0

Element 5: Policies and Care Team Education

Acute Care Opioid Treatment and Prescribing Recommendations, Michigan OPEN

Ambulatory Opioid Prescribing Guidelines for Non-malignant Pain, Essentia Health*

Best Practices for Inpatient Opioid Use Disorder Order Sets, California Bridge

Buprenorphine Hospital Quick Start Guide, California Bridge

Controlled substance diversion prevention guidelines

Pain Control Optimization Pathway, Michigan OPEN

Provider Education

MME Pocket Card for typical discharge opioids, Essentia Health*

4 Reasons for Changing Opioid Prescribing Habits, Michigan OPEN

Health and Human Services Guide for Tapering or Stopping Long-term Opioid Use

HEDIS ICD-10 Diagnosis Codes Associated with Substance Use Disorder, OSHU IMPACT*

Element 6: Patient Education and Engagement

Naloxone and Opioid Overdose Education Pamphlet, Brigham & Women's Hospital*

Naloxone Patient Brochure, Michigan OPEN

Opioid Crisis Public Fact Sheet, Essentia Health*

Opioid Patient Education, Mayo Clinic*

Opioid Safety and How to Use Naloxone Brochure, San Francisco Health Network

APPENDIX

Pain Management Plan, Patient Engagement Tool, Brigham & Women's Hospital*

Safe Pain Medicines, California Bridge

Urine Testing and Concerning Behavior Flier, San Francisco Health Network

General: Open Source Websites

Specific tools from these websites may be referenced above, but these sites contain other resources and tools that may be useful to hospitals and health systems as well.

American Society of Health System Pharmacists Pain Management Toolkit

Brigham and Women's Comprehensive Opioid Response and Education Program

California Bridge Program

Michigan OPEN (Opioid Prescribing Engagement Network)

Minnesota Health Collaborative: Opioids

Ohio Department of Mental Health and Addictions Services

Oregon Health & Science University (OHSU) Improving Addiction Care Team (IMPACT) program

San Francisco Health Network Pain Management Resources

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TOOLS

MME Pocket Card for typical discharge opioids, Essentia Health

MME Opioid Dosing Limit Examples

Post-Surgical: Minor Surgeries

No more than a three day/ 20 pill/ 100 MDE** total supply of low-dose, short-acting opioids.

MEDICATIONS	MME	Sig	Max QTY	MME**
Codeine/APAP* 30/325 mg tab	4.5 MME	1 Q4H PRN X 3 days	#18	81
Hydrocodone/APAP* 5/325 mg tab	5 MME	1 Q4H PRN X 3 days	#18	90
Hydromorphone 2 mg tab	8 MME	1 Q4H PRN X 3 days	#12	96
Oxycodone/APAP* 5/325 mg tab	7.5 MME	1 Q4H PRN X 3 days	#12	90
Tramadol 50 mg tab	5 MME	1 Q4H PRN X 3 days	#18	90

*APAP = acetaminophen
**MME=morphine milligram equivalent

M53282

Essentia Health

MME Opioid Dosing Limit Examples

Post-Surgical: Major Surgeries

No more than a seven day/200 MDE* total supply of opioids.

MEDICATIONS	MME	Sig	Max QTY	MME**
Codeine/APAP** 30/325 mg tab	4.5 MME	1 Q4H PRN X 7 days	#42	189
Hydrocodone/APAP** 5/325 mg tab	5 MME	1 Q4H PRN X 7 days	#40	200
Hydromorphone 2 mg tab	8 MME	1 Q4H PRN X 7 days	#25	200
Oxycodone/APAP** 5/325 mg tab	7.5 MME	1 Q4H PRN X 7 days	#26	195
Tramadol 50 mg tab	5 MME	1 Q4H PRN X 7 days	#40	200

*MME=morphine milligram equivalent
**APAP = acetaminophen

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Essentia Health

Menu of Measures Encompassing a Comprehensive Approach to Opioid Stewardship

Measures are not intended or recommended for use beyond internal quality improvement purposes.

	Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs* (2020)
Domain: Acute Pain Management					
1	Average total MME per prescription [32,42]	Average MME	Number of opioid prescriptions	**Outcome** Reduction in average total MME	Medicaid ACS, MSSP
2	MME per opioid prescription [32,42]	Total MME	Number of opioid prescriptions	**Outcome** Decrease in MME	Medicaid ACS, MSSP
3	Number of opioid prescriptions per prescriber at discharge [42]	Number of opioid prescriptions at discharge	Patient volume per prescriber	**Outcome** Decrease in total number of opioid prescriptions	
4	Average MME dose administered per inpatient day [42]	Opioid MME dose administered per day	Patient days with opioids administered	**Outcome** Decrease in average MME dose administered	TJC
5	Percentage of patients receiving opioid only for pain management [13]	Patients discharged with only an opioid medication for pain relief	Patients discharged with a prescription for a pain medication of any kind	**Outcome** Decrease in patients receiving opioids only for pain	TJC
6	Percentage of patients receiving multimodal pain management [13]	Patients with at least one opioid analgesic dose and at least one nonopioid analgesic dose *OR* patients with no opioid dose and at least one dose of each non-opioid analgesic from at least two different pharmaceutical classes	Inpatient and observation patient encounters discharged who received at least one dose of an analgesic medication during their stay	**Outcome** Increase in patients receiving multimodal pain management	TJC
7	Proportion of hospitalized patients who have documentation of patient defined comfort and function goals [23, 42, 51, 52]	Patients with documented comfort and function goals	Admitted patients receiving a dose of any pain medication	**Process** Increase in percentage of patients with defined goals	TJC
8	Patient pain management planning and education [25, 37, 42, 47, 51]	Number of plans documented	Number of patients expected to experience pain	**Process** Increase in patients documented as having planning and education	MIPS IA, TJC
9	Baseline assessment of pain and opioid utilization upon admission [25, 37]	Number of assessments documented in EHR	Number of patients on opioids of any length or dose	**Process** Increase in number of baseline assessments	TJC
10	Pain reassessment within 60 minutes of administration of pain medication [13]	Percentage of patients with pain reassessed within 60 minutes	Admitted patients receiving a dose of any pain medication	**Process** Increase in patients with reassessment in desired timeframe	TJC
11	Use of pre-op analgesia, local anesthetic with surgery, anesthesia type, anesthesia adjuncts [45, 47]	Number of patient encounters with ALTO ordered	Number of surgical patient encounters	**Outcome** Increase in utilization of alternatives to opioids	TJC

	Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs* (2020)
Domain: Harm Reduction					
1	Percentage of patients with opioids and benzodiazepines co-prescribed [8, 10, 34]	Patients prescribed both opioids and benzodiazepines	All patients	**Outcome** Decrease in number of patients co-prescribed	HEDIS, Medicaid ACS, HIQRP, MSSP
2	Naloxone prescribed for opioid overdoses or high-risk patients [37, 42]	Number of naloxone prescriptions	Number of patients presenting with OD or opioid MME >50	**Outcome** Increase in naloxone prescriptions	
3	Opioid prescriptions > 90 MMEs daily [5, 37, 42]	Prescriptions > 90 MMEs daily	All prescriptions	**Outcome** Decrease in opioid prescriptions >90MME daily	Medicaid ACS
4	Proportion of hospitalized patients administered naloxone [9, 28]	Number of naloxone administrations per admission	Discharges of adult patients over 12 months	**Outcome** Decrease in naloxone administered in hospital	HIQRP, TJC
5	Number of adverse safety events due to opioids (ex: Pasero opioid-induced sedation scale (POSS) score > 3) [28, 42, 45, 54]	Number of major (or minor) ADEs after first dose of opioids	Total number of patient days	**Outcome** Decrease in number of adverse safety events	TJC
6	Number of urine/blood drug screens [16, 42, 51, 54]	Number of urine toxicology screens ordered	Number of patients on opioids >90 days	**Process** Increase in number of drug screens	
7	Opioid/controlled substance agreement signed [10, 38, 54]	Number of plans documented	Number of patients on opioids >6 weeks	**Process** Increase in documented agreements	MIPS QM
8	Rates of accessing prescription drug monitoring program (PDMP) [10, 21, 37, 38, 54]	Number of patients on opioids of any length or dose	Number of patients on opioids of any length or dose	**Process** Increased rate of PDMP utilization	MIPS IA
9	Opioid tapering plan documented [37, 51]	Number of tapering plans documented	Number of patients on opioids >90 (or 30, or fewer) days	**Process** Increase in documented tapering plans	
Domain: Identification & Treatment of Opioid Use Disorders					
1	Number of referrals for OUD/ MOUD treatment [8, 28, 36, 51, 54]	Number of referrals ordered	Number of patients identified with OUD	**Outcome** Increase in referrals or use of addiction consult service	Medicaid ACS, TJC
2	Neonatal withdrawal syndrome (NWS) treatment measures [36, 51, 53]	Total postpartum opioid exposure	All infants with neonatal withdrawal syndrome (NWS)	**Outcome** Reduction in opioid exposure	
3	New patient starts for MOUD [8, 18, 36, 38, 54]	MOUD initiated	Number of patients identified with OUD	**Outcome** Increase in number of new starts	Medicaid ACS

	Measure Description/ Measure Concept	Numerator	Denominator	Desired Quality Improvement Trend	Alignment with Federal Quality or Accountability Programs* (2020)
4	Completed/successful referrals for OUD treatment [8, 28]	Number of referrals completed	Number of referrals ordered	**Outcome** Increase in number of completed referrals	Medicaid ACS, TJC
5	Long term recovery/abstinence 12 months out or longer [9, 36]	Number of patients deemed stable	MOUD patient panel	**Outcome** Increase in number of patients reporting abstinence	MIPS QM
6	Screening for OUD/SUD [21, 37, 38, 43]	Number of risk assessments documented in EHR, percentage of patients screened	Number of patients on opioids for longer than 6 weeks	**Process** Increase in number of screens	MIPS QM
7	Number of referred patients still in treatment 30 days later [8, 36, 43]	Number of patients still in active treatment program	Number of treatment referrals completed	**Outcome** Increase in number of patients still engaged in treatment	Medicaid ACS
8	Identification & planning for patients with OUD/in MOUD upon admission [38, 51, 54]	Number of plans documented	Number of patients with OUD dx or MOUD treatment	**Process** Increase in number of documented plans	Medicaid ACS
9	Screening patients with OUD for infectious diseases (Ex: Hepatitis B/C, HIV) [36, 37, 43]	Percentage of patients screened	Number of patients on opioids for longer than 6 weeks	**Process** Increase in number of screens	
10	Functional outcomes and quality of life patient-reported outcome measures (PROMs) for treatment engaged patients (ex: PROMIS29) 2, 36	PROM score over time	Baseline PROM	**Outcome** Improvement in score of PROM over patient baseline	

* Definitions of Abbreviations for Federal Programs: TJC: The Joint Commission, HEDIS: Healthcare Effectiveness Data and Information Set, MIPS (QM or IA): Merit-Based Incentive Payment System (Quality Measure or Improvement Activity) (CMS), MSSP: Medicare Shared Savings Program (CMS), HIQRP: Hospital Inpatient Quality Reporting Program (CMS), Medicaid ACS: Medicaid Adult Core Set

Advisory Group Input Menu of Measures Prioritization Detail Table

	Measure Description/ Measure Concept	Effort Score (1-5) (n)	Impact Score (1-5) (n)	Advisory Group Pros/Cons List
Domain: Acute Pain Management				
1	Average total MME per prescription[31]	2.1 (10)	3.72 (11)	N/A
2	MME per opioid prescription[31]	1.81 (11)	3.91 (12)	N/A
3	Number of opioid prescriptions per prescriber at discharge[42]	1.45 (11)	3.25 (12)	N/A
4	Average MME dose administered per inpatient day[42]	2.45 (11)	3.41 (12)	N/A
5	Percentage of patients receiving opioid only for pain management[13]	3 (11)	3.5 (11)	N/A
6	Percentage of patients receiving multimodal pain management[13]	3 (10)	3.9 (12)	Con: Difficult to determine data points for inclusion
7	Proportion of hospitalized patients who have documentation of patient defined comfort and function goals[23, 42, 51, 52]	3.9 (10)	3.8 (11)	Con: Difficult to gauge quality and effectiveness of intervention
8	Patient pain management planning & education[25, 37, 42, 47, 51]	3.6 (10)	3.7 (12)	Con: Difficult to gauge quality and effectiveness of intervention
9	Baseline assessment of pain and opioid utilization upon admission[25, 37]	3.3 (10)	3.5 (12)	N/A
10	*Pain reassessment within 60 minutes of administration of pain medication[13]	3 (10)	2.9 (11)	N/A
11	Use of pre-op analgesia, local anesthetic with surgery, anesthesia type, anesthesia adjuncts[45, 47]	3.3 (10)	3.6 (11)	N/A
Domain: Harm Reduction				
1	Percentage of patients with opioids and benzodiazepines co-prescribed [8, 10, 34]	1.8 (11)	4.5 (13)	N/A
2	Naloxone prescribed for opioid overdoses or high-risk patients [37, 42]	1.6 (11)	4.4 (13)	Con: Various ways to define high-risk patients Con: Actual confirmation of dispensing/access may be a better measure
3	Opioid prescriptions > 90 MMEs daily [5, 37, 42]	1.75 (12)	4.1 (13)	N/A
4	Proportion of hospitalized patients administered naloxone [9, 28, 45]	1.6 (11)	3.6 (13)	N/A
5	Number of adverse safety events due to opioids (ex: Pasero opioid-induced sedation scale (POSS) score > 3) [28, 42, 45, 54]	2.5 (9)	4.0 (10)	N/A
6	Number of urine/blood drug screens [16, 42, 51, 54]	2.3 (10)	2.7 (11)	Con: Without a policy supporting use, could lead to unintended outcomes Pro: Useful in patients prescribed chronic opioids
7	Opioid/controlled substance agreement signed [54]	2.7 (10)	3.1 (12)	Con: Without a policy supporting use, could lead to unintended outcomes
8	Rates of accessing prescription drug monitoring program (PDMP) [10, 21, 37, 38, 54]	3.4 (10)	3.3 (12)	Con: Difficult to measure if not linked into the EHR

	Measure Description/ Measure Concept	Effort Score (1-5) (n)	Impact Score (1-5) (n)	Advisory Group Pros/Cons List
9	Opioid tapering plan documented [37, 51]	3.0 (10)	3.25 (12)	Con: Without a policy supporting use, could lead to unintended outcomes
Domain: Identification & Treatment of Opioid Use Disorders				
1	Number of referrals for OUD/MOUD treatment[54]	3.0 (10)	3.25 (12)	N/A
2	Neonatal withdrawal syndrome (NWS) treatment measures [36, 51, 53]	3 (11)	4.2 (9)	N/A
3	New patient starts for MOUD [8, 18, 36, 38, 54]	3.1 (15)	4.4 (12)	Pro: Demonstrates system capacity to do this work
4	Completed/successful referrals for OUD treatment [8, 28]	3.9 (14)	4.3 (11)	Con: Difficult to track longitudinal outcomes with external partners
5	Long-term recovery/abstinence 12 months out or longer [9, 36]	4.1 (13)	4.1 (11)	Con: Difficult to track longitudinal outcomes with external partners
6	Screening for OUD/SUD [21, 37, 38, 43]	3.1 (15)	3.7 (12)	Con: Without a policy supporting criteria, could lead to unintended outcomes Con: Not useful if resources do not facilitate starting treatment if patient desires
7	Number of referred patients still in treatment 30 days later[43]	4.1 (14)	3.8 (11)	Con: Difficult to track longitudinal outcomes with external partners
8	Identification and planning for patients with OUD/in MOUD upon admission[54]	3.4 (13)	3.5 (10)	N/A
9	Screening patients with OUD for infectious diseases (ex: Hepatitis B/C, HIV) [36, 37, 43]	2.8 (13)	3.0 (10)	N/A
10	Functional outcomes and quality of life patient reported outcome measures (PROMs) for treatment engaged patients (ex: PROMIS29) [1, 36]	3.5 (8)	2.8 (6)	Pro: Longitudinal measure intended to be repeated through OUD Treatment

What NOT To Do During an Opioid Overdose

- Do not put the person in a bath
- Do not give the person something to drink
- Do not try to wake up the person in a way that could hurt them (slapping, kicking, burning, etc)
- Do not wait to check for opioid overdose! Check breathing right away!

Massachusetts Good Samaritan Overdose Prevention Law

Protects people who overdose or seek help from someone overdosing from being charged with drug possession.

Where to get Narcan

Your local pharmacy (like CVS or Walgreens) will provide this without a prescription

Additional Resources

For assistance with finding addiction treatment, support groups, or recovery services:

1. **The Massachusetts Substance Abuse Information and Education Helpline** 1-800-327-5050 or www.helpline-online.com

2. **Brigham and Women's Faulkner Hospital Outpatient Suboxone Program**: 617-983-7060 (option 2)

3. "**Learn 2 Cope":** www.learn2cope.org

What are Opioids?

Opioids, sometimes called narcotics, are powerful prescription medicines that relieve pain. However, they can also cause slower heart rate, nausea, constipation, and decreased breathing=.

Opioids include:

- Oxycontin or Percocet (Oxycodone)
- Vicodin, Lortab, Norco (Hydrocodone)
- Fentanyl (Duragesic, Fentora)
- Dilaudid, Exalgo (Hydromorphone)
- Methadone
- MS Contin (Morphine)
- Codeine
- Opana (Oxymorphone)
- Heroin

What is Narcan?

Narcan, also known as naloxone, is a medicine that reverse the negative effects of opioids. When the body has more opioids than it can handle, this is called an opioid overdose. An opioid overdose can lead to slow breathing, which can cause permanent brain damage or even death.

This medication only works when there are opioids in still in your body. No opioids = No effect.
If you give this medication to someone without opioids in their body, it will not cause any harm. Narcan should be given to someone experiencing an opioid overdose

Risk Factors for Opioid Overdose

- Mixing opioids with alcohol or benzodiazepines (drugs like Valium or Ativan)
- Tolerance (a higher dose is needed to achieve the desired effect)
- Buying opioids from somewhere other than a pharmacy
- Physical health
- Previous overdoses
- Taking opiates on an empty stomach

BRIGHAM AND WOMEN'S HOSPITAL

Narcan and Opioid Overdose Education Pamphlet

How to give Narcan, In Case of an Overdose

Step 1: Know the Signs of Overdose

Overdose occurs when a person is unresponsive, not breathing, or struggling to breathe.

- Person is passed out and you cannot wake them up.
- Person has slow or no breathing
- Person is making a snoring sound
- Blue, grey, or pale skin color

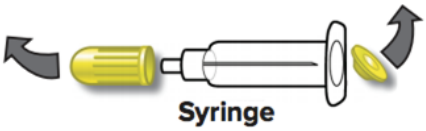
If you are worried about overdose, call 9-1-1

Step 2: Call 9-1-1

- When you call, tell them that you think someone has overdosed
- **You and the overdosed person are protected from criminal charges under Massachusetts Law.**

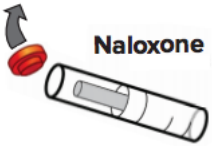
Step 3: Give Narcan as soon as possible

A. Take the yellow caps off the syringe

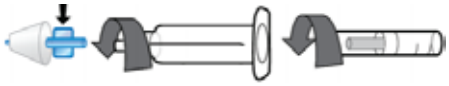


B. Screw the white cone onto top of the syringe until tight

C. The red (or purple) cap off the Narcan vial (note: there may be two vials in the kit).



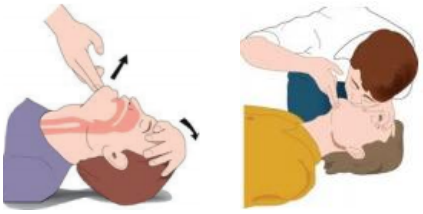
D. Screw the vial into the bottom of the syringe without pressing too hard



E. Insert the white cone into one nostril. Spray half of the medicine in one nostril, and half in the other nostril. To spray the medicine into the nostril, firmly push on the end of the syringe.

Step 4: Give Rescue Breathing

- Make sure nothing is in the person's mouth
- Tilt the head back, lift the chin, pinch the nose
- Start with two breaths into the person's mouth.
- Continue giving 1 breath every 5 seconds until the person is breathing on their own or help arrives

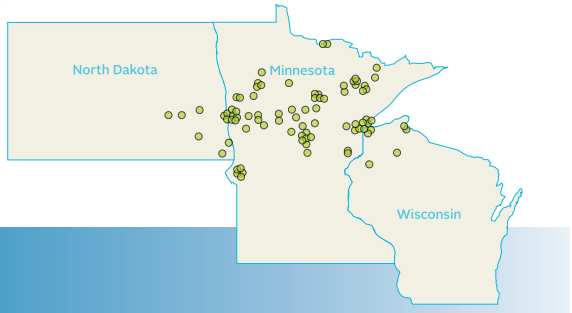


Step 5: Stay Until Help Arrives

- Stay with the person until help arrives
- If the person is not responding, continue rescue breathing for 3-5 minutes.
- If the person is not responding, give the spare dose of Narcan included in the kit
- Do not let the person take any more opioids after they wake up.
- If you must leave, put the person in the "rescue position"

Adapted from NY State Department of Health and MA State Department of Health

Essentia Health



Addressing the Opioid Crisis

Collaborating to Make a Healthy Difference

Recognizing a serious problem and developing a mission statement

In 2013, a team of physicians, leaders and experts from across Essentia Health reviewed scientific and medical opinions regarding the safety of opiates for use in treating chronic pain. Together they created:

A mission statement recognizing:

- The unproven effectiveness of opiate medications for chronic pain.
- The significant dangers associated with some forms of opioid prescribing and use.
- The harm of prescription opioid diversion to communities.

A three-pronged approach to keep our patients and communities safe by:

- Minimizing the number of new patients started on opioid therapy.
- Reducing the number of patients currently on opioids for chronic pain by educating about the risks and phasing out opioids in favor of other treatments.
- Reducing diversion and abuse of opioids through increased monitoring.

Educating our physicians and advanced practitioners

An important first step to success was educating our providers about the changed thinking regarding the safety and effectiveness of opiates in treating chronic pain and screening for Opioid Use Disorder.

- National expert lecture series at Grand Rounds
- Primary Care Clinic educational presentations across our organization

A comprehensive program for responsible opioid prescribing for chronic pain

We established and implemented a standard of care for patients on chronic opioid medication across our organization. All patients receive the same care at any Essentia Health primary care clinic.

- Each patient has regular primary care appointments annually for pain management. Opioid prescriptions only available at a visit.
- Prescription Monitoring Program check prior to each appointment.
- Regular prescription pill counts.
- Annual random urinary drug screen and pill count.
- Tools for improved decision-making.
- Tools for patient education.
- Regular screening of patient for depression, anxiety, response to treatment.
- Clinical pharmacist partner with physicians to assist with medication tapers for patients.

Community engagement

Discussion groups to share information, tools and processes were created between our health system and other hospitals and clinics in each of our market areas. These discussions resulted in:

- A common mission statement recognizing that long-term use of opioids poses significant risks to patients for unsubstantiated benefits.
- Ongoing community task forces committed to stemming the opioid crisis. Now includes law enforcement, dentistry and government agencies.

Our Progress
Reducing use of opioids for chronic pain

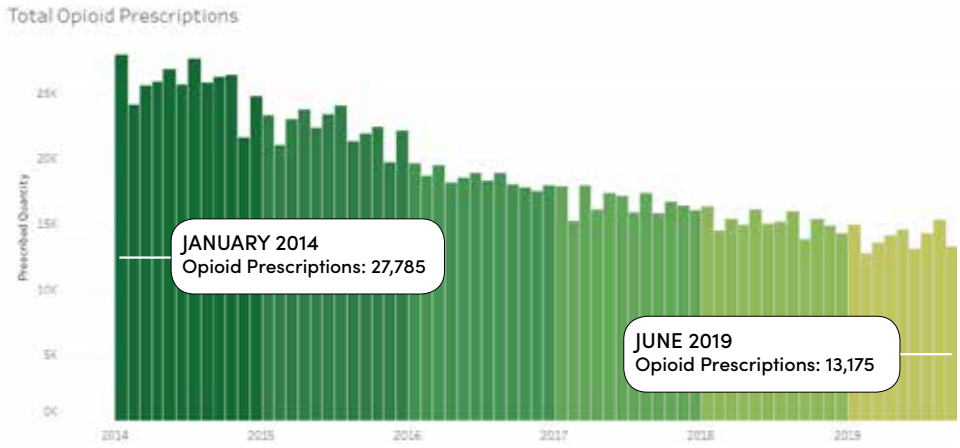
Fewer Patients on Opioid Medications

June 2014 → June 2019

64% decrease in new patients started on opioids for chronic pain

52% decrease in total number of patients on opioids for chronic pain

Fewer Opioid Prescriptions



The work continues...

2018-2019 Focus

- Essentia-wide implementation of opioid prescribing guidelines for acute pain.
  - a. Post-surgical
  - b. Emergency Department and Urgent Care
  - c. Primary Care acute pain
  - d. Coordination with dental prescribing
- Increase number of waivered providers to identify and treat Opioid Use Disorder through training on Medication Assisted Treatment (MAT).

2020 focus

- Increase access to evidence-based prevention, treatment, and recovery services for substance abuse/opioid use disorder (SUD/OUD).
- Continued implementation of a comprehensive approach to pain management and addiction.

Ongoing focus:

- Development of community resources for evaluation and treatment of opioid use disorder.
- Providing education about opioid use disorder within the health system and the greater community.
- Creating new, collaborative approaches between our health system and community programs to meet the needs of patients with chronic pain and opioid use disorder.

Essentia Health

For more information, contact:
Joe Bianco, MD | 218-365-7900
Kelly Black, Opioid Treatment Program | 218-576-0827

M53495

MAYO CLINIC

PATIENT EDUCATION

About Mayo Clinic Guidelines for Prescribing Opioid Medications

Mayo Clinic is committed to ensuring your safety. To achieve this goal, Mayo Clinic has developed guidelines health care providers must follow when they prescribe opioid medications.

Opioids are strong medications. They usually are prescribed to help you manage acute pain for a few days only after an injury or surgery.

Opioids include oxycodone, hydrocodone, morphine, hydromorphone, fentanyl, codeine, and tramadol. You may hear opioids referred to as narcotics, pain killers or controlled substances.

When opioids are used for the right reason and for the right length of time, the benefits usually outweigh the risks.

You may wonder why things are different now than in the past when you received a prescription for an opioid medication. This is because health care providers now know that prescribing too much medication for too long increases the risk of becoming dependent on opioids.

Opioids are the number one cause of death related to medications.

In response to this epidemic, hospitals, clinics, and professional organizations are developing guidelines for prescribing opioids. In addition, some states have passed laws to limit opioid prescriptions.

As a result of Mayo Clinic's opioid prescribing guidelines, you may receive an opioid that is different from one you received in the past, you may receive fewer pills, or you may not receive an opioid prescription at all.

However, know that your Mayo Clinic health care provider works with you to develop a plan to manage pain. By taking an active part in managing pain, you and your health care provider can find the best plan for you.

If your health care provider does prescribe an opioid for you, know that you play a critical role in ensuring your safety and the safety of others while you take them. Follow all instructions you have been given about taking opioids.

If you have questions about opioids or your pain management plan, talk with your health care provider.

MAYO CLINIC | 200 First Street SW | Rochester, MN 55905 | mayoclinic.org

MC7891-03

Pain Control Plan

Pain should be expected after surgery. Pain has a usual course; it should decrease over time. But, it can't be completely avoided. This isn't to say that nothing can be done about it. Accepting that it will happen makes it easier to deal with the pain and allows the pain control methods to work better. Using a few different ways to lessen the pain should shorten the time it takes you to recover from surgery.

You are the patient; no one else can make any decisions for you. But, you can and should get help from others along the way. Everyone involved in your care here at Brigham can assist you. This includes the surgical team, nurses, anesthesia and pain management providers, therapists, and patient care assistants; to name a few. They will help you in many ways, including in terms of pain management. They can't take away the pain completely, but will help you be as comfortable as possible, so you can reach your recovery goals.

Dr. [Name] will be one of your providers; he will help you come up with your pain control plan. He will give you suggestions, but you will make the final decisions. The success of your pain control plan depends on your involvement at all stages. The plan will be individual to you and may need to be changed along the way to make your pain control better.

Pain Control Plan

Created by: [Patient Name & Physician Name, M.D.]

Preparation before coming on the day of surgery:

- Non-medication method(s) I will practice:
- Medication(s) I will continue:
- Medication(s) I will decrease or stop:
- Medication(s) I will begin:

While I am in the hospital:

Before and During the Surgery

- Recommendation(s) for my anesthesia team:

After the Surgery

- I will remember that I am the most important partner in the pain management plan and recovery process, but I will get help from my providers too!
- My desired outcome goal(s):
- Functional goal(s) I will work to achieve:
- Non-medication method(s) I will use, whenever possible:
- Recommendation(s) for my surgical team:
- The Postoperative Pain Service is available if my surgical team needs assistance .
- I will remember that it isn't a problem or failure if the plan needs to be changed, since a change of plans can be a good thing to make my pain control even better.

After I leave the hospital:

- I am aware the pain should last about:
- Non-medication method(s) I will continue:
- I know to use my pain medications as instructed; this includes over-the-counter medications.
- I am aware I should only need opioids for about:
- Medication(s) I must decrease before I stop:
- My follow-up call with the pain specialist should occur about weeks after discharge.
- If “warning sensations” occur, I will let my surgeon know promptly since they can then get in contact with the right person to help.

EH Policy # EHPPS3006
Attachment A

ESSENTIA HEALTH AMBULATORY OPIOID PRESCRIBING GUIDELINES FOR NON-MALIGNANT PAIN

Table of Contents

1. INTRODUCTION AND SOURCES

The opioid epidemic is the most urgent public health issue nationally and locally. Minnesota has seen the rate of deaths due to opioid overdoses increase over 500% from 1999 to 2014. St. Louis County has one of the highest opioid overdose death rates in the state. Wisconsin and North Dakota are experiencing similar increases in overdoses and deaths. Unlike other public health epidemics, the opioid epidemic is largely a result of the opioid prescribing by the medical community. What is now known to be inappropriate and dangerous prescribing of opioids for acute and chronic pain was considered best practice only a few years ago.

Patient and community safety are greatly impacted by adoption of safe opioid prescribing policies/guidelines for acute and chronic pain.

> Safe and appropriate guidelines/polices for prescribing opioids can prevent patients from becoming dependent or addicted and limits the number unused medications circulating in the community.

> Comorbidities and the elderly.

> It is the responsibility of health care organizations, including Essentia, to impact the health and vitality of our communities by:

> Developing and adopting appropriate opioid prescribing polices/guidelines for safe, more effective treatment.

> Developing and adopting appropriate opioid prescribing polices/guidelines to minimizing the volume of narcotics available in the community.

Links to References/Sources:

MDH (April 2018)	MN Opioid Prescribing Guidelines	First Edition 2018
ICSI (August 2017)	ICSI Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management
CDC (March 2017)	CDC Guideline for Prescribing Opioids for Chronic Pain

2. NON-OPIOID AND NON-PHARMACOLOGIC PAIN MANAGEMENT

> Utilize alternatives to opioid analgesia for mild-to-moderate acute pain. Consider additional non-opioid pain management for acute pain when opioids are prescribed. (see Policy Attachment I: Pain Assessment and Non opioid pain management strategies for links to resources)

> Introduce multi-modal therapies to all patients in the post-acute pain period. (see Policy Attachment I for links to resources)

> Include pain education—such as therapeutic neuroscience education—as part of the multi-modal therapeutic plan for all patients.

> Implement a multidisciplinary approach to chronic pain management and tailor treatment modalities based on the patient's biopsychosocial factors.

3. OPIOID PRESCRIBING FOR ACUTE PAIN (0 TO 4 DAYS FOLLOWING AN ACUTE EVENT)

> Use multi-modal, non-opioid analgesia (e.g, NSAIDS and acetaminophen) as the first line of drug therapy for acute pain.

> Review the appropriate Prescription Monitoring Program (PMP) prior to prescribing an opioid for Acute Pain.

> Avoid prescribing more than a three-day supply of low-dose, short acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (not 100 MME per day). Patient should not take more than 50 MME per day.

> Limit the initial prescription for acute pain following an extensive surgical procedure or major traumatic injury to no more than 7 days or up to 200 MME, unless circumstances clearly warrant additional opioid therapy. Patient should not take more than 50 MME per day. (Certain surgical procedures may require additional pain management (i.e. total joint replacement, major spine surgery).

> Do not prescribe opioids for patients experiencing dental pain.

> Avoid prescribing opioids to patients with a history of substance use disorder and those with an active substance use disorder. In the rare case when opioids are necessary, use extreme caution, frankly discuss the risks and plan for close follow-up.

> Do not increase opioid dosage for acute pain for COAT patients in the absence of a verifiable new injury. For an identifiable new injury or procedure:

> Use the recommended dose and duration limit for chronic pain patients (3 days/no more than 100 MME total Rx)

> For patients who are already on COAT of ≥ 90 MME/day, manage new acute pain in collaboration with the COAT prescriber and acute pain prescriber (e.g., a surgeon).

> Consult with a clinician trained in the pharmacology of buprenorphine or naltrexone when prescribing opioids to a patient receiving either medication as Medication Assisted Therapy for Opioid Use Disorder.

> Acute opioid dosing for children ages 0-12 should be proportional by weight (kg) to the acute pain dose and duration limit.

> Screen children over the age of 10 for risk of opioid-related harm.

> Check the PMP for all children prescribed an opioid for acute pain, to confirm that the child is not at risk for parental diversion.

> Avoid prescribing children codeine in any setting given the high risk posed to ultra-fast metabolizer.

> Do NOT prescribe long acting opioids

> Whenever possible, prescribe opioids via electronically submitted prescriptions (EPCs) to reduce potential for diversion.

4. OPIOID PRESCRIBING FOR POST-ACUTE PAIN (5 TO 45 DAYS FOLLOWING AN ACUTE EVENT)

> Assess and document pain at each follow-up visit. Consider the patient's presentation of pain in relation to tissue damage and healing following an acute event, whenever possible.

> Assess and document function at each follow visit. Do not continue opioid therapy solely based on reports of improved physical function once the tissue healing is sufficient.

> Consider re-evaluating the etiology of the pain for those patients who do not demonstrate expected improvements based on the nature of the injury or pathology.

> Increase assessment of risk factors for opioid-related harm and chronic opioid use over the post-acute pain period for patients who request continued opioid analgesic therapy. See the Acute and Post-Acute Pain Prescribing and Assessment Guide for recommended screenings and timelines.

> Introduce multi-modal therapies to all patients in the post-acute pain phase.

> Prescribe opioids no more than 200 MME per 7-day period and no more dispensed than the number of doses needed. Prescribing should be consistent with expected tissue healing, with expected tapering.

> Avoid prescribing in excess of 700 cumulative MME in order to reduce the risk of chronic opioid use and opioid-related harm.

> Consider a formal taper schedule if patient demonstrates withdrawal symptoms as he or she attempts dose reductions or based on the duration of use.

> Taper COAT patients receiving additional opioid therapy for acute pain to the pre-surgical or pre-injury dose as tissue healing progresses.

> Do NOT prescribe long acting opioids

> Whenever possible, prescribe opioids via electronically submitted prescriptions (EPCs) to reduce potential for diversion.

5. OPIOID PRESCRIBING FOR CHRONIC PAIN (> 45 DAYS FOLLOWING ACUTE EVENT)

> Perform a detailed evaluation of the patient with chronic pain and establish or confirm the etiology of pain, (as outlined in Policy Attachment F; EH COAT Standard of Care).

> Avoid initiating or continuing COAT as an interim therapy while diagnosing or confirming pain etiology. An unknown or unconfirmed pain generator is not a reason to prescribe opioid therapy.

> Assess patient with indeterminate pain generators and/or whose pain generators inadequately explain their pain experience for opioid-induced pain and develop treatment approach.

> Assess and treat mental health conditions prior to initiating COAT. Continue assessment on ongoing basis if COAT is prescribed to assure opioid prescribing is appropriate and/or any underlying mental health conditions are being addressed.

Guidelines from Essentia Health

- Establish specific, measurable treatment goals with the patient prior to initiating COAT. Assess potential barriers to active participation in the treatment plan with the patient.
- Implement a multidisciplinary approach to treating patients with chronic pain. Identify in the treatment plan the person who will coordinate care across providers and services.
- Execute a Treatment Agreement prior to beginning COAT for every patient, or continuing opioid therapy in a new patient, (see Policy Attachment F; EH COAT Standard of Care).
- Prescribe opioids at the lowest dose, with no more than 50 MME/day. Avoid increasing daily dosage to 90 MME/day.
- Clinicians who decide to increase daily dose to 90 MME/day must carefully document that the risks and benefits were weighted and benefits warrant the risk.
- Limit the duration of the prescription to one month. Face to face visits with the prescribing provider should occur based on patients level of risk.
- Offer to taper to a reduced dose or to discontinuation at every face to face visit.
- Avoid initiating COAT in patients with untreated substance use disorder or a history of substance use disorder or Opioid Use Disorder.
- Prescribe immediate release/short acting opioids when initiating COAT.
- Avoid routine rotation of opioids without a clear indication.
- Avoid using methadone interchangeably with other extended release/long acting opioids.
- Exercise extreme caution when considering fentanyl therapy for pain.
- Whenever possible, prescribe opioids via electronically submitted prescriptions (EPCs) to reduce potential for diversion.
- Implement risk mitigation strategies when initiating COAT and continue through the duration of therapy as outlined in the EH COAT Standard of Care (Attachment F). Strategies and frequency should be commensurate with risk factors and include:
- Annual random urine drug screening
- Pill counts at each visit
- Checking the PMP prior to each visit
- Monitoring for overdose potential and for the presence of OUD
- Providing overdose education
- For patients who violate their Treatment Agreement, consider referral for assessment and treatment for OUD.
- Offer or arrange evidence-based treatment for patients with OUD.

6. BIOPSYCHOSOCIAL AND RISK ASSESSMENT

> Assess and document pain, function and quality of life using validated (if available) or standardized assessment tools.

> Screen patients for depression and anxiety using a validated tool at each follow-up visit for pain management. If screening tools indicate an active mental health condition, provide aggressive treatment concomitant to analgesia strategies.

> Assess and document suicidality in every setting for every initial opioid prescription. Reassess suicidality in patients receiving COAT at least once a year.

> Assess patients for substance use disorders using a brief, validated tool. Conduct a structured interview using the DSM-5 criteria when the patient screens positive, or refer patient to a specialist for additional screening.

> Assess patient for fear avoidance tendencies or pain catastrophizing using a brief, validated tool. Refer patients who screen positive to a physical therapist or pain psychologist.

> Assess patients for a history of trauma or abuse prior to initiating chronic opioid analgesic therapy. Refer patients with a history of trauma or abuse who have not been previously treated for appropriate psychotherapy.

> Discuss with the patient sources and/or targets of anger or injustice related to his or her own pain.

> Ask patients about their beliefs and attitudes about pain, its origin and what it represents during an initial clinic visit.

7. TAPERING OR DISCONTINUING OPIOID THERAPY

> Address tapering and discontinuing opioid therapy in advance of initiating chronic opioid analgesic therapy and with every dose increase.

> Offer to taper COAT to a reduced dosage or to discontinuation at least every 3 months. Offer tapering to all patients, regardless of their risk of harm.

> Taper opioid therapy to a reduced dose or to discontinuation when the risks of continued opioid therapy outweigh the benefits.

> Consider collaboration with EH Clinical Pharmacist to guide patient through taper process. (See Attachment H: Tapering Algorithm).

> Tapering high-risk patients to less than 50 MME/day is reasonable initial goal.

> Offer non-opioid and non-pharmacologic therapies to treat pain that may re-emerge during the opioid taper and to treat any withdrawal symptoms that occur during the taper.

8. WOMEN OF CHILDBEARING AGE

> Assess pregnancy or risk of pregnancy in all women of childbearing age prior to prescribing an opioid.

> Avoid prescribing opioids to pregnant women. Educate pregnant women about the known risks of opioids to both the mother and the fetus.

> Prescribe no more opioids than will be needed for initial tissue recovery following a cesarean section or complicated vaginal birth. Avoid prescribing more than 7 days or up to 200 MME (total prescription).

> Provide proper pain control to lactating women experiencing acute pain following birth and surgical procedures. If opioids are prescribed to lactating women for acute pain, prescribe the lowest dose and duration adequate to manage the pain.

> Discuss monitoring reproductive health in all women of childbearing age who receive COAT.

9. DEFINITIONS, TERMS AND GLOSSARY

I. Opioid Naïve: no opioids within the previous 90 days (ICSI)

II. Opioid Tolerant: Prior 7 days of opioids at or greater than 60 MME/day (FDA)

III. Glossary of Terms and Abbreviations (MN Opioid Prescribing Guidelines; First Edition: April 2018)

Aberrant Drug-Related Behaviors	A set of behaviors suggestive of problematic prescription opioid use, including: aggressively requesting medications, reports of lost or stolen prescriptions, decreasing functionality or frequent accidents while using opioids, repeat noncompliance, unsanctioned dose escalations, early refill requests, obtaining opioids from multiple sources and use of non-prescribed drugs.
Addiction *(not specific to substance use)*	A primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. Addiction is characterized by the inability to abstain consistently, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationship and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death *(ASAM, 2011)*.
Acute Pain	Acute pain is an expected physiologic experience to noxious stimuli that can become pathologic, is normally sudden in onset, time limited and motivates behaviors to avoid actual or potential tissue injuries *(National Pain Strategy, 2016)*.
Biopsychosocial	A medical problem or intervention that combines biological, psychological and social elements or aspects.
Chronic Opioid Analgesic Therapy (COAT)	Opioid therapy prescribed > 45 days following an acute event.
Chronic Pain	Pain persisting longer than 45 days following an acute event and beyond normal tissue healing time
Chronic Non-Cancer Pain	Chronic pain that is not due to a malignancy.
Cumulative Morphine Equivalence Exposure (Cumulative MME)	The sum of all MME prescribed over a prescribed period of opioid exposure.
Hospice	A model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Hospice involves an interdisciplinary approach to provide health care, pain management and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as in freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.
Medication-Assisted Treatment (MAT)	The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
Minnesota Health Care Programs (MHCP)	The public health care programs administered by the Department of Human Services under chapters 256B and 256L and the Minnesota restricted recipient program. Minnesota Health Care Programs include Medical Assistance (Medicaid) and MinnesotaCare.

Morphine Milligram Equivalence (MME)	The equipotent dose of an opioid expressed as the equivalent dose of oral morphine determined by using the Center for Medicare and Medicaid Services conversion factors.
Opioid Prescriber	A licensed health care provider authorized to prescribe Schedule II-V medications by the Drug Enforcement Agency.
Opioid Prescribing Improvement Program (OPIP)	A comprehensive effort led by the Department of Human Services to improve opioid prescribing by health care providers in light of the current epidemic of opioid misuse and abuse. Resources developed under the program include: these guidelines on appropriate opioid prescribing; opioid prescribing sentinel measures; educational resources for providers; and an opioid-prescribing quality improvement program among Minnesota Health Care Program-enrolled providers.
Opioid Prescribing Work Group (OPWG)	A legislatively-mandated expert panel tasked with developing recommendations to DHS about the OPWG program components. See Appendix A Opioid Prescribing Work Group Membership.
Opioid Therapy (OT)	The use of opioid medications for pain.
Opioid Use Disorder (OUD)	A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria.
Opioid-induced Hyperalgesia	Opioid-induced hyperalgesia (OIH) is defined as a state of nociceptive sensitization caused by exposure to opioids. The condition is characterized by a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli. The type of pain experienced might be the same as the underlying pain or might be different from the original underlying pain *(Lee, 2011)*.
Pain Phase	Refers to specific time intervals within the cycle or continuum of pain. The three pain phases addressed in the Opioid Prescribing Improvement Program are: 1) acute pain; 2) post-acute pain; and 3) chronic pain.
Palliative Care	Palliative care includes a multidisciplinary approach to treating physical, emotional, psychological and spiritual sources of distress to promote quality of life for individuals with a life-limiting disease or condition. Chronic pain and hospice care can be considered palliative care within these principles. The distinction occurs when there is a shift in goals from disease-directed/curative therapies to focusing on comfort, hygiene and dignity. Symptom management becomes the forefront to ensure the greatest degree of comfort and is supported by clear ethical guidelines *(Private communication with Gillette's Children's Hospital)*.
Physical Dependence	A state of adaptation manifested by a drug-class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist.

	interventions attempt to limit the development of disabilities and other complications of chronic pain after it has developed.
Prevention – Opioid Overdose	*Primary prevention* includes efforts to reduce the supply of opioids in the community and address conditions that create health. *Secondary prevention* includes interventions that assist individuals already taking prescription opioids and/or using illicit opioids. *Tertiary prevention* includes harm reduction efforts and emergency responses to opioid overdoses.
Recurrent Acute Pain	Severe, acute painful episodes caused by tissue damage, for which the underlying mechanism is a chronic disease. An example of recurrent acute pain is sickle cell anemia.
Sentinel Measures	Measures of opioid use that identify variations in prescribing practices during the prescribing intervals
Substance Use Disorder	The essential feature of substance use disorder is a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. SUD diagnosis is based on a pathological pattern of behaviors related to use of the substance. The diagnostic criteria can be considered to fit within the following groupings: impaired control, social impairment, risk use and pharmacological criteria *(APA, 2013)*.
Tolerance	A state of adaptation in which exposure to a drug induces changes that result in diminution of one or more the drugs' effects over time.

HEDIS ICD-10 Diagnosis Codes Associated with Substance Use Disorder, OSHU IMPACT

Value Set Name	Code	Definition	Code	Category
AOD Rehab and Detox	94.61	Alcohol rehabilitation	ICD9PCS	Alcohol
AOD Rehab and Detox	94.62	Alcohol detoxification	ICD9PCS	Alcohol
AOD Rehab and Detox	94.63	Alcohol rehabilitation and detoxification	ICD9PCS	Alcohol
AOD Procedures	94.61	Alcohol rehabilitation	ICD9PCS	Alcohol
AOD Procedures	94.63	Alcohol rehabilitation and detoxification	ICD9PCS	Alcohol
AOD Dependence	291.0	Alcohol withdrawal delirium	ICD9CM	Alcohol
AOD Dependence	291.1	Alcohol-induced persisting amnestic disorder	ICD9CM	Alcohol
AOD Dependence	291.2	Alcohol-induced persisting dementia	ICD9CM	Alcohol
AOD Dependence	291.3	Alcohol-induced psychotic disorder with hallucinations	ICD9CM	Alcohol
AOD Dependence	291.4	Idiosyncratic alcohol intoxication	ICD9CM	Alcohol
AOD Dependence	291.5	Alcohol-induced psychotic disorder with delusions	ICD9CM	Alcohol
AOD Dependence	291.81	Alcohol withdrawal	ICD9CM	Alcohol
AOD Dependence	291.82	Alcohol induced sleep disorders	ICD9CM	Alcohol
AOD Dependence	291.89	Other alcohol-induced mental disorders	ICD9CM	Alcohol
AOD Dependence	291.9	Unspecified alcohol-induced mental disorders	ICD9CM	Alcohol
AOD Dependence	303.00	Acute alcoholic intoxication in alcoholism, unspecified	ICD9CM	Alcohol
AOD Dependence	303.01	Acute alcoholic intoxication in alcoholism, continuous	ICD9CM	Alcohol
AOD Dependence	303.02	Acute alcoholic intoxication in alcoholism, episodic	ICD9CM	Alcohol
AOD Dependence	303.90	Other and unspecified alcohol dependence, unspecified	ICD9CM	Alcohol
AOD Dependence	303.91	Other and unspecified alcohol dependence, continuous	ICD9CM	Alcohol
AOD Dependence	303.92	Other and unspecified alcohol dependence, episodic	ICD9CM	Alcohol
AOD Dependence	305.00	Alcohol abuse, unspecified	ICD9CM	Alcohol
AOD Dependence	305.01	Alcohol abuse, continuous	ICD9CM	Alcohol
AOD Dependence	305.02	Alcohol abuse, episodic	ICD9CM	Alcohol
AOD Dependence	535.30	Alcoholic gastritis, without mention of hemorrhage	ICD9CM	Alcohol
AOD Dependence	535.31	Alcoholic gastritis, with hemorrhage	ICD9CM	Alcohol
AOD Dependence	571.1	Acute alcoholic hepatitis	ICD9CM	Alcohol
AOD Dependence	F10.10	[F10.10] Alcohol abuse, uncomplicated	ICD10CM	Alcohol
AOD Dependence	F10.120	[F10.120] Alcohol abuse with intoxication, uncomplicated	ICD10CM	Alcohol
AOD Dependence	F10.121	[F10.121] Alcohol abuse with intoxication delirium	ICD10CM	Alcohol
AOD Dependence	F10.129	[F10.129] Alcohol abuse with intoxication, unspecified	ICD10CM	Alcohol
AOD Dependence	F10.14	[F10.14] Alcohol abuse with alcohol-induced mood disorder	ICD10CM	Alcohol
AOD Dependence	F10.150	[F10.150] Alcohol abuse with alcohol-induced psychotic disorder with delusions	ICD10CM	Alcohol
AOD Dependence	F10.151	[F10.151] Alcohol abuse with alcohol-induced psychotic disorder with hallucinations	ICD10CM	Alcohol
AOD Dependence	F10.159	[F10.159] Alcohol abuse with alcohol-induced psychotic disorder, unspecified	ICD10CM	Alcohol

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F10.180	[F10.180] Alcohol abuse with alcohol-induced anxiety disorder	ICD10CM	Alcohol
AOD Dependence	F10.181	[F10.181] Alcohol abuse with alcohol-induced sexual dysfunction	ICD10CM	Alcohol
AOD Dependence	F10.182	[F10.182] Alcohol abuse with alcohol-induced sleep disorder	ICD10CM	Alcohol
AOD Dependence	F10.188	[F10.188] Alcohol abuse with other alcohol-induced disorder	ICD10CM	Alcohol
AOD Dependence	F10.19	[F10.19] Alcohol abuse with unspecified alcohol-induced disorder	ICD10CM	Alcohol
AOD Dependence	F10.20	[F10.20] Alcohol dependence, uncomplicated	ICD10CM	Alcohol
AOD Dependence	F10.220	[F10.220] Alcohol dependence with intoxication, uncomplicated	ICD10CM	Alcohol
AOD Dependence	F10.221	[F10.221] Alcohol dependence with intoxication delirium	ICD10CM	Alcohol
AOD Dependence	F10.229	[F10.229] Alcohol dependence with intoxication, unspecified	ICD10CM	Alcohol
AOD Dependence	F10.230	[F10.230] Alcohol dependence with withdrawal, uncomplicated	ICD10CM	Alcohol
AOD Dependence	F10.231	[F10.231] Alcohol dependence with withdrawal delirium	ICD10CM	Alcohol
AOD Dependence	F10.232	[F10.232] Alcohol dependence with withdrawal with perceptual disturbance	ICD10CM	Alcohol
AOD Dependence	F10.239	[F10.239] Alcohol dependence with withdrawal, unspecified	ICD10CM	Alcohol
AOD Dependence	F10.24	[F10.24] Alcohol dependence with alcohol-induced mood disorder	ICD10CM	Alcohol
AOD Dependence	F10.250	[F10.250] Alcohol dependence with alcohol-induced psychotic disorder with delusions	ICD10CM	Alcohol
AOD Dependence	F10.251	[F10.251] Alcohol dependence with alcohol-induced psychotic disorder with hallucinations	ICD10CM	Alcohol
AOD Dependence	F10.259	[F10.259] Alcohol dependence with alcohol-induced psychotic disorder, unspecified	ICD10CM	Alcohol
AOD Dependence	F10.26	[F10.26] Alcohol dependence with alcohol-induced persisting amnestic disorder	ICD10CM	Alcohol
AOD Dependence	F10.27	[F10.27] Alcohol dependence with alcohol-induced persisting dementia	ICD10CM	Alcohol
AOD Dependence	F10.280	[F10.280] Alcohol dependence with alcohol-induced anxiety disorder	ICD10CM	Alcohol
AOD Dependence	F10.281	[F10.281] Alcohol dependence with alcohol-induced sexual dysfunction	ICD10CM	Alcohol
AOD Dependence	F10.282	[F10.282] Alcohol dependence with alcohol-induced sleep disorder	ICD10CM	Alcohol
AOD Dependence	F10.288	[F10.288] Alcohol dependence with other alcohol-induced disorder	ICD10CM	Alcohol
AOD Dependence	F10.29	[F10.29] Alcohol dependence with unspecified alcohol-induced disorder	ICD10CM	Alcohol
Acute Condition	F10.920	[F10.920] Alcohol use, unspecified with intoxication, uncomplicated	ICD10CM	Alcohol
Acute Condition	F10.921	[F10.921] Alcohol use, unspecified with intoxication delirium	ICD10CM	Alcohol
Acute Condition	F10.929	[F10.929] Alcohol use, unspecified with intoxication, unspecified	ICD10CM	Alcohol
Acute Condition	F10.94	[F10.94] Alcohol use, unspecified with alcohol-induced mood disorder	ICD10CM	Alcohol
Acute Condition	F10.950	[F10.950] Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions	ICD10CM	Alcohol
Acute Condition	F10.951	[F10.951] Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations	ICD10CM	Alcohol
Acute Condition	F10.959	[F10.959] Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified	ICD10CM	Alcohol
Acute Condition	F10.96	[F10.96] Alcohol use, unspecified with alcohol-induced persisting amnestic disorder	ICD10CM	Alcohol
Acute Condition	F10.97	[F10.97] Alcohol use, unspecified with alcohol-induced persisting dementia	ICD10CM	Alcohol
Acute Condition	F10.980	[F10.980] Alcohol use, unspecified with alcohol-induced anxiety disorder	ICD10CM	Alcohol
Acute Condition	F10.981	[F10.981] Alcohol use, unspecified with alcohol-induced sexual dysfunction	ICD10CM	Alcohol
Acute Condition	F10.982	[F10.982] Alcohol use, unspecified with alcohol-induced sleep disorder	ICD10CM	Alcohol

Value Set Name	Code	Definition	Code	Category
Acute Condition	F10.988	[F10.988] Alcohol use, unspecified with other alcohol-induced disorder	ICD10CM	Alcohol
Acute Condition	F10.99	[F10.99] Alcohol use, unspecified with unspecified alcohol-induced disorder	ICD10CM	Alcohol
AOD Dependence	304.30	Cannabis dependence, unspecified	ICD9CM	Cannabis
AOD Dependence	304.31	Cannabis dependence, continuous	ICD9CM	Cannabis
AOD Dependence	304.32	Cannabis dependence, episodic	ICD9CM	Cannabis
AOD Dependence	305.20	Cannabis abuse, unspecified	ICD9CM	Cannabis
AOD Dependence	305.21	Cannabis abuse, continuous	ICD9CM	Cannabis
AOD Dependence	305.22	Cannabis abuse, episodic	ICD9CM	Cannabis
AOD Dependence	F12.10	[F12.10] Cannabis abuse, uncomplicated	ICD10CM	Cannabis
AOD Dependence	F12.120	[F12.120] Cannabis abuse with intoxication, uncomplicated	ICD10CM	Cannabis
AOD Dependence	F12.121	[F12.121] Cannabis abuse with intoxication delirium	ICD10CM	Cannabis
AOD Dependence	F12.122	[F12.122] Cannabis abuse with intoxication with perceptual disturbance	ICD10CM	Cannabis
AOD Dependence	F12.129	[F12.129] Cannabis abuse with intoxication, unspecified	ICD10CM	Cannabis
AOD Dependence	F12.150	[F12.150] Cannabis abuse with psychotic disorder with delusions	ICD10CM	Cannabis
AOD Dependence	F12.151	[F12.151] Cannabis abuse with psychotic disorder with hallucinations	ICD10CM	Cannabis
AOD Dependence	F12.159	[F12.159] Cannabis abuse with psychotic disorder, unspecified	ICD10CM	Cannabis
AOD Dependence	F12.180	[F12.180] Cannabis abuse with cannabis-induced anxiety disorder	ICD10CM	Cannabis
AOD Dependence	F12.188	[F12.188] Cannabis abuse with other cannabis-induced disorder	ICD10CM	Cannabis
AOD Dependence	F12.19	[F12.19] Cannabis abuse with unspecified cannabis-induced disorder	ICD10CM	Cannabis
AOD Dependence	F12.20	[F12.20] Cannabis dependence, uncomplicated	ICD10CM	Cannabis
AOD Dependence	F12.220	[F12.220] Cannabis dependence with intoxication, uncomplicated	ICD10CM	Cannabis
AOD Dependence	F12.221	[F12.221] Cannabis dependence with intoxication delirium	ICD10CM	Cannabis
AOD Dependence	F12.222	[F12.222] Cannabis dependence with intoxication with perceptual disturbance	ICD10CM	Cannabis
AOD Dependence	F12.229	[F12.229] Cannabis dependence with intoxication, unspecified	ICD10CM	Cannabis
AOD Dependence	F12.250	[F12.250] Cannabis dependence with psychotic disorder with delusions	ICD10CM	Cannabis
AOD Dependence	F12.251	[F12.251] Cannabis dependence with psychotic disorder with hallucinations	ICD10CM	Cannabis
AOD Dependence	F12.259	[F12.259] Cannabis dependence with psychotic disorder, unspecified	ICD10CM	Cannabis
AOD Dependence	F12.280	[F12.280] Cannabis dependence with cannabis-induced anxiety disorder	ICD10CM	Cannabis
AOD Dependence	F12.288	[F12.288] Cannabis dependence with other cannabis-induced disorder	ICD10CM	Cannabis
AOD Dependence	F12.29	[F12.29] Cannabis dependence with unspecified cannabis-induced disorder	ICD10CM	Cannabis
Acute Condition	F12.90	[F12.90] Cannabis use, unspecified, uncomplicated	ICD10CM	Cannabis
Acute Condition	F12.920	[F12.920] Cannabis use, unspecified with intoxication, uncomplicated	ICD10CM	Cannabis
Acute Condition	F12.921	[F12.921] Cannabis use, unspecified with intoxication delirium	ICD10CM	Cannabis
Acute Condition	F12.922	[F12.922] Cannabis use, unspecified with intoxication with perceptual disturbance	ICD10CM	Cannabis
Acute Condition	F12.929	[F12.929] Cannabis use, unspecified with intoxication, unspecified	ICD10CM	Cannabis
Acute Condition	F12.950	[F12.950] Cannabis use, unspecified with psychotic disorder with delusions	ICD10CM	Cannabis
Acute Condition	F12.951	[F12.951] Cannabis use, unspecified with psychotic disorder with hallucinations	ICD10CM	Cannabis
Acute Condition	F12.959	[F12.959] Cannabis use, unspecified with psychotic disorder, unspecified	ICD10CM	Cannabis
Acute Condition	F12.980	[F12.980] Cannabis use, unspecified with anxiety disorder	ICD10CM	Cannabis

Value Set Name	Code	Definition	Code	Category
Acute Condition	F12.988	[F12.988] Cannabis use, unspecified with other cannabis-induced disorder	ICD10CM	Cannabis
Acute Condition	F12.99	[F12.99] Cannabis use, unspecified with unspecified cannabis-induced disorder	ICD10CM	Cannabis
AOD Dependence	304.20	Cocaine dependence, unspecified	ICD9CM	Cocaine
AOD Dependence	304.21	Cocaine dependence, continuous	ICD9CM	Cocaine
AOD Dependence	304.22	Cocaine dependence, episodic	ICD9CM	Cocaine
AOD Dependence	305.60	Cocaine abuse, unspecified	ICD9CM	Cocaine
AOD Dependence	305.61	Cocaine abuse, continuous	ICD9CM	Cocaine
AOD Dependence	305.62	Cocaine abuse, episodic	ICD9CM	Cocaine
AOD Dependence	F14.10	[F14.10] Cocaine abuse, uncomplicated	ICD10CM	Cocaine
AOD Dependence	F14.120	[F14.120] Cocaine abuse with intoxication, uncomplicated	ICD10CM	Cocaine
AOD Dependence	F14.121	[F14.121] Cocaine abuse with intoxication with delirium	ICD10CM	Cocaine
AOD Dependence	F14.122	[F14.122] Cocaine abuse with intoxication with perceptual disturbance	ICD10CM	Cocaine
AOD Dependence	F14.129	[F14.129] Cocaine abuse with intoxication, unspecified	ICD10CM	Cocaine
AOD Dependence	F14.14	[F14.14] Cocaine abuse with cocaine-induced mood disorder	ICD10CM	Cocaine
AOD Dependence	F14.150	[F14.150] Cocaine abuse with cocaine-induced psychotic disorder with delusions	ICD10CM	Cocaine
AOD Dependence	F14.151	[F14.151] Cocaine abuse with cocaine-induced psychotic disorder with hallucinations	ICD10CM	Cocaine
AOD Dependence	F14.159	[F14.159] Cocaine abuse with cocaine-induced psychotic disorder, unspecified	ICD10CM	Cocaine
AOD Dependence	F14.180	[F14.180] Cocaine abuse with cocaine-induced anxiety disorder	ICD10CM	Cocaine
AOD Dependence	F14.181	[F14.181] Cocaine abuse with cocaine-induced sexual dysfunction	ICD10CM	Cocaine
AOD Dependence	F14.182	[F14.182] Cocaine abuse with cocaine-induced sleep disorder	ICD10CM	Cocaine
AOD Dependence	F14.188	[F14.188] Cocaine abuse with other cocaine-induced disorder	ICD10CM	Cocaine
AOD Dependence	F14.19	[F14.19] Cocaine abuse with unspecified cocaine-induced disorder	ICD10CM	Cocaine
AOD Dependence	F14.20	[F14.20] Cocaine dependence, uncomplicated	ICD10CM	Cocaine
AOD Dependence	F14.220	[F14.220] Cocaine dependence with intoxication, uncomplicated	ICD10CM	Cocaine
AOD Dependence	F14.221	[F14.221] Cocaine dependence with intoxication delirium	ICD10CM	Cocaine
AOD Dependence	F14.222	[F14.222] Cocaine dependence with intoxication with perceptual disturbance	ICD10CM	Cocaine
AOD Dependence	F14.229	[F14.229] Cocaine dependence with intoxication, unspecified	ICD10CM	Cocaine
AOD Dependence	F14.23	[F14.23] Cocaine dependence with withdrawal	ICD10CM	Cocaine
AOD Dependence	F14.24	[F14.24] Cocaine dependence with cocaine-induced mood disorder	ICD10CM	Cocaine
AOD Dependence	F14.250	[F14.250] Cocaine dependence with cocaine-induced psychotic disorder with delusions	ICD10CM	Cocaine
AOD Dependence	F14.251	[F14.251] Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	ICD10CM	Cocaine
AOD Dependence	F14.259	[F14.259] Cocaine dependence with cocaine-induced psychotic disorder, unspecified	ICD10CM	Cocaine
AOD Dependence	F14.280	[F14.280] Cocaine dependence with cocaine-induced anxiety disorder	ICD10CM	Cocaine
AOD Dependence	F14.281	[F14.281] Cocaine dependence with cocaine-induced sexual dysfunction	ICD10CM	Cocaine
AOD Dependence	F14.282	[F14.282] Cocaine dependence with cocaine-induced sleep disorder	ICD10CM	Cocaine
AOD Dependence	F14.288	[F14.288] Cocaine dependence with other cocaine-induced disorder	ICD10CM	Cocaine

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F14.29	[F14.29] Cocaine dependence with unspecified cocaine-induced disorder	ICD10CM	Cocaine
Acute Condition	F14.90	[F14.90] Cocaine use, unspecified, uncomplicated	ICD10CM	Cocaine
Acute Condition	F14.920	[F14.920] Cocaine use, unspecified with intoxication, uncomplicated	ICD10CM	Cocaine
Acute Condition	F14.921	[F14.921] Cocaine use, unspecified with intoxication delirium	ICD10CM	Cocaine
Acute Condition	F14.922	[F14.922] Cocaine use, unspecified with intoxication with perceptual disturbance	ICD10CM	Cocaine
Acute Condition	F14.929	[F14.929] Cocaine use, unspecified with intoxication, unspecified	ICD10CM	Cocaine
Acute Condition	F14.94	[F14.94] Cocaine use, unspecified with cocaine-induced mood disorder	ICD10CM	Cocaine
Acute Condition	F14.950	[F14.950] Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions	ICD10CM	Cocaine
Acute Condition	F14.951	[F14.951] Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations	ICD10CM	Cocaine
Acute Condition	F14.959	[F14.959] Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified	ICD10CM	Cocaine
Acute Condition	F14.980	[F14.980] Cocaine use, unspecified with cocaine-induced anxiety disorder	ICD10CM	Cocaine
Acute Condition	F14.981	[F14.981] Cocaine use, unspecified with cocaine-induced sexual dysfunction	ICD10CM	Cocaine
Acute Condition	F14.982	[F14.982] Cocaine use, unspecified with cocaine-induced sleep disorder	ICD10CM	Cocaine
Acute Condition	F14.988	[F14.988] Cocaine use, unspecified with other cocaine-induced disorder	ICD10CM	Cocaine
Acute Condition	F14.99	[F14.99] Cocaine use, unspecified with unspecified cocaine-induced disorder	ICD10CM	Cocaine
AOD Rehab and Detox	94.67	Combined alcohol and drug rehabilitation	ICD9PCS	Combination
AOD Rehab and Detox	94.68	Combined alcohol and drug detoxification	ICD9PCS	Combination
AOD Rehab and Detox	94.69	Combined alcohol and drug rehabilitation and detoxification	ICD9PCS	Combination
AOD Procedures	94.67	Combined alcohol and drug rehabilitation	ICD9PCS	Combination
AOD Procedures	94.69	Combined alcohol and drug rehabilitation and detoxification	ICD9PCS	Combination
AOD Dependence	304.70	Combinations of opioid type drug with any other drug dependence, unspecified	ICD9CM	Combination
AOD Dependence	304.71	Combinations of opioid type drug with any other drug dependence, continuous	ICD9CM	Combination
AOD Dependence	304.72	Combinations of opioid type drug with any other drug dependence, episodic	ICD9CM	Combination
AOD Dependence	304.80	Combinations of drug dependence excluding opioid type drug, unspecified	ICD9CM	Combination
AOD Dependence	304.81	Combinations of drug dependence excluding opioid type drug, continuous	ICD9CM	Combination
AOD Dependence	304.82	Combinations of drug dependence excluding opioid type drug, episodic	ICD9CM	Combination
AOD Dependence	304.50	Hallucinogen dependence, unspecified	ICD9CM	Hallucinogen
AOD Dependence	304.51	Hallucinogen dependence, continuous	ICD9CM	Hallucinogen
AOD Dependence	304.52	Hallucinogen dependence, episodic	ICD9CM	Hallucinogen
AOD Dependence	305.30	Hallucinogen abuse, unspecified	ICD9CM	Hallucinogen
AOD Dependence	305.31	Hallucinogen abuse, continuous	ICD9CM	Hallucinogen
AOD Dependence	305.32	Hallucinogen abuse, episodic	ICD9CM	Hallucinogen
AOD Dependence	F16.10	[F16.10] Hallucinogen abuse, uncomplicated	ICD10CM	Hallucinogen
AOD Dependence	F16.120	[F16.120] Hallucinogen abuse with intoxication, uncomplicated	ICD10CM	Hallucinogen
AOD Dependence	F16.121	[F16.121] Hallucinogen abuse with intoxication with delirium	ICD10CM	Hallucinogen
AOD Dependence	F16.122	[F16.122] Hallucinogen abuse with intoxication with perceptual disturbance	ICD10CM	Hallucinogen
AOD Dependence	F16.129	[F16.129] Hallucinogen abuse with intoxication, unspecified	ICD10CM	Hallucinogen
AOD Dependence	F16.14	[F16.14] Hallucinogen abuse with hallucinogen-induced mood disorder	ICD10CM	Hallucinogen

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F16.150	[F16.150] Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions	ICD10CM	Hallucinogen
AOD Dependence	F16.151	[F16.151] Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations	ICD10CM	Hallucinogen
AOD Dependence	F16.159	[F16.159] Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified	ICD10CM	Hallucinogen
AOD Dependence	F16.180	[F16.180] Hallucinogen abuse with hallucinogen-induced anxiety disorder	ICD10CM	Hallucinogen
AOD Dependence	F16.183	[F16.183] Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)	ICD10CM	Hallucinogen
AOD Dependence	F16.188	[F16.188] Hallucinogen abuse with other hallucinogen-induced disorder	ICD10CM	Hallucinogen
AOD Dependence	F16.19	[F16.19] Hallucinogen abuse with unspecified hallucinogen-induced disorder	ICD10CM	Hallucinogen
AOD Dependence	F16.20	[F16.20] Hallucinogen dependence, uncomplicated	ICD10CM	Hallucinogen
AOD Dependence	F16.220	[F16.220] Hallucinogen dependence with intoxication, uncomplicated	ICD10CM	Hallucinogen
AOD Dependence	F16.221	[F16.221] Hallucinogen dependence with intoxication with delirium	ICD10CM	Hallucinogen
AOD Dependence	F16.229	[F16.229] Hallucinogen dependence with intoxication, unspecified	ICD10CM	Hallucinogen
AOD Dependence	F16.24	[F16.24] Hallucinogen dependence with hallucinogen-induced mood disorder	ICD10CM	Hallucinogen
AOD Dependence	F16.250	[F16.250] Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions	ICD10CM	Hallucinogen
AOD Dependence	F16.251	[F16.251] Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations	ICD10CM	Hallucinogen
AOD Dependence	F16.259	[F16.259] Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified	ICD10CM	Hallucinogen
AOD Dependence	F16.280	[F16.280] Hallucinogen dependence with hallucinogen-induced anxiety disorder	ICD10CM	Hallucinogen
AOD Dependence	F16.283	[F16.283] Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)	ICD10CM	Hallucinogen
AOD Dependence	F16.288	[F16.288] Hallucinogen dependence with other hallucinogen-induced disorder	ICD10CM	Hallucinogen
AOD Dependence	F16.29	[F16.29] Hallucinogen dependence with unspecified hallucinogen-induced disorder	ICD10CM	Hallucinogen
Acute Condition	F16.90	[F16.90] Hallucinogen use, unspecified, uncomplicated	ICD10CM	Hallucinogen
Acute Condition	F16.920	[F16.920] Hallucinogen use, unspecified with intoxication, uncomplicated	ICD10CM	Hallucinogen
Acute Condition	F16.921	[F16.921] Hallucinogen use, unspecified with intoxication with delirium	ICD10CM	Hallucinogen
Acute Condition	F16.929	[F16.929] Hallucinogen use, unspecified with intoxication, unspecified	ICD10CM	Hallucinogen
Acute Condition	F16.94	[F16.94] Hallucinogen use, unspecified with hallucinogen-induced mood disorder	ICD10CM	Hallucinogen
Acute Condition	F16.950	[F16.950] Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions	ICD10CM	Hallucinogen
Acute Condition	F16.951	[F16.951] Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations	ICD10CM	Hallucinogen
Acute Condition	F16.959	[F16.959] Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified	ICD10CM	Hallucinogen
Acute Condition	F16.980	[F16.980] Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder	ICD10CM	Hallucinogen
Acute Condition	F16.983	[F16.983] Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)	ICD10CM	Hallucinogen

Value Set Name	Code	Definition	Code	Category
Acute Condition	F16.988	[F16.988] Hallucinogen use, unspecified with other hallucinogen-induced disorder	ICD10CM	Hallucinogen
Acute Condition	F16.99	[F16.99] Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder	ICD10CM	Hallucinogen
AOD Dependence	F18.10	[F18.10] Inhalant abuse, uncomplicated	ICD10CM	Inhalant
AOD Dependence	F18.120	[F18.120] Inhalant abuse with intoxication, uncomplicated	ICD10CM	Inhalant
AOD Dependence	F18.121	[F18.121] Inhalant abuse with intoxication delirium	ICD10CM	Inhalant
AOD Dependence	F18.129	[F18.129] Inhalant abuse with intoxication, unspecified	ICD10CM	Inhalant
AOD Dependence	F18.14	[F18.14] Inhalant abuse with inhalant-induced mood disorder	ICD10CM	Inhalant
AOD Dependence	F18.150	[F18.150] Inhalant abuse with inhalant-induced psychotic disorder with delusions	ICD10CM	Inhalant
AOD Dependence	F18.151	[F18.151] Inhalant abuse with inhalant-induced psychotic disorder with hallucinations	ICD10CM	Inhalant
AOD Dependence	F18.159	[F18.159] Inhalant abuse with inhalant-induced psychotic disorder, unspecified	ICD10CM	Inhalant
AOD Dependence	F18.17	[F18.17] Inhalant abuse with inhalant-induced dementia	ICD10CM	Inhalant
AOD Dependence	F18.180	[F18.180] Inhalant abuse with inhalant-induced anxiety disorder	ICD10CM	Inhalant
AOD Dependence	F18.188	[F18.188] Inhalant abuse with other inhalant-induced disorder	ICD10CM	Inhalant
AOD Dependence	F18.19	[F18.19] Inhalant abuse with unspecified inhalant-induced disorder	ICD10CM	Inhalant
AOD Dependence	F18.20	[F18.20] Inhalant dependence, uncomplicated	ICD10CM	Inhalant
AOD Dependence	F18.220	[F18.220] Inhalant dependence with intoxication, uncomplicated	ICD10CM	Inhalant
AOD Dependence	F18.221	[F18.221] Inhalant dependence with intoxication delirium	ICD10CM	Inhalant
AOD Dependence	F18.229	[F18.229] Inhalant dependence with intoxication, unspecified	ICD10CM	Inhalant
AOD Dependence	F18.24	[F18.24] Inhalant dependence with inhalant-induced mood disorder	ICD10CM	Inhalant
AOD Dependence	F18.250	[F18.250] Inhalant dependence with inhalant-induced psychotic disorder with delusions	ICD10CM	Inhalant
AOD Dependence	F18.251	[F18.251] Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	ICD10CM	Inhalant
AOD Dependence	F18.259	[F18.259] Inhalant dependence with inhalant-induced psychotic disorder, unspecified	ICD10CM	Inhalant
AOD Dependence	F18.27	[F18.27] Inhalant dependence with inhalant-induced dementia	ICD10CM	Inhalant
AOD Dependence	F18.280	[F18.280] Inhalant dependence with inhalant-induced anxiety disorder	ICD10CM	Inhalant
AOD Dependence	F18.288	[F18.288] Inhalant dependence with other inhalant-induced disorder	ICD10CM	Inhalant
AOD Dependence	F18.29	[F18.29] Inhalant dependence with unspecified inhalant-induced disorder	ICD10CM	Inhalant
Acute Condition	F18.90	[F18.90] Inhalant use, unspecified, uncomplicated	ICD10CM	Inhalant
Acute Condition	F18.920	[F18.920] Inhalant use, unspecified with intoxication, uncomplicated	ICD10CM	Inhalant
Acute Condition	F18.921	[F18.921] Inhalant use, unspecified with intoxication with delirium	ICD10CM	Inhalant
Acute Condition	F18.929	[F18.929] Inhalant use, unspecified with intoxication, unspecified	ICD10CM	Inhalant
Acute Condition	F18.94	[F18.94] Inhalant use, unspecified with inhalant-induced mood disorder	ICD10CM	Inhalant
Acute Condition	F18.950	[F18.950] Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions	ICD10CM	Inhalant
Acute Condition	F18.951	[F18.951] Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations	ICD10CM	Inhalant

Value Set Name	Code	Definition	Code	Category
Acute Condition	F18.959	[F18.959] Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified	ICD10CM	Inhalant
Acute Condition	F18.97	[F18.97] Inhalant use, unspecified with inhalant-induced persisting dementia	ICD10CM	Inhalant
Acute Condition	F18.980	[F18.980] Inhalant use, unspecified with inhalant-induced anxiety disorder	ICD10CM	Inhalant
Acute Condition	F18.988	[F18.988] Inhalant use, unspecified with other inhalant-induced disorder	ICD10CM	Inhalant
Acute Condition	F18.99	[F18.99] Inhalant use, unspecified with unspecified inhalant-induced disorder	ICD10CM	Inhalant
AOD Dependence	304.00	Opioid type dependence, unspecified	ICD9CM	Opioid
AOD Dependence	304.01	Opioid type dependence, continuous	ICD9CM	Opioid
AOD Dependence	304.02	Opioid type dependence, episodic	ICD9CM	Opioid
AOD Dependence	305.50	Opioid abuse, unspecified	ICD9CM	Opioid
AOD Dependence	305.51	Opioid abuse, continuous	ICD9CM	Opioid
AOD Dependence	305.52	Opioid abuse, episodic	ICD9CM	Opioid
AOD Dependence	F11.10	[F11.10] Opioid abuse, uncomplicated	ICD10CM	Opioid
AOD Dependence	F11.120	[F11.120] Opioid abuse with intoxication, uncomplicated	ICD10CM	Opioid
AOD Dependence	F11.121	[F11.121] Opioid abuse with intoxication delirium	ICD10CM	Opioid
AOD Dependence	F11.122	[F11.122] Opioid abuse with intoxication with perceptual disturbance	ICD10CM	Opioid
AOD Dependence	F11.129	[F11.129] Opioid abuse with intoxication, unspecified	ICD10CM	Opioid
AOD Dependence	F11.14	[F11.14] Opioid abuse with opioid-induced mood disorder	ICD10CM	Opioid
AOD Dependence	F11.150	[F11.150] Opioid abuse with opioid-induced psychotic disorder with delusions	ICD10CM	Opioid
AOD Dependence	F11.151	[F11.151] Opioid abuse with opioid-induced psychotic disorder with hallucinations	ICD10CM	Opioid
AOD Dependence	F11.159	[F11.159] Opioid abuse with opioid-induced psychotic disorder, unspecified	ICD10CM	Opioid
AOD Dependence	F11.181	[F11.181] Opioid abuse with opioid-induced sexual dysfunction	ICD10CM	Opioid
AOD Dependence	F11.182	[F11.182] Opioid abuse with opioid-induced sleep disorder	ICD10CM	Opioid
AOD Dependence	F11.188	[F11.188] Opioid abuse with other opioid-induced disorder	ICD10CM	Opioid
AOD Dependence	F11.19	[F11.19] Opioid abuse with unspecified opioid-induced disorder	ICD10CM	Opioid
AOD Dependence	F11.20	[F11.20] Opioid dependence, uncomplicated	ICD10CM	Opioid
AOD Dependence	F11.220	[F11.220] Opioid dependence with intoxication, uncomplicated	ICD10CM	Opioid
AOD Dependence	F11.221	[F11.221] Opioid dependence with intoxication delirium	ICD10CM	Opioid
AOD Dependence	F11.222	[F11.222] Opioid dependence with intoxication with perceptual disturbance	ICD10CM	Opioid
AOD Dependence	F11.229	[F11.229] Opioid dependence with intoxication, unspecified	ICD10CM	Opioid
AOD Dependence	F11.23	[F11.23] Opioid dependence with withdrawal	ICD10CM	Opioid
AOD Dependence	F11.24	[F11.24] Opioid dependence with opioid-induced mood disorder	ICD10CM	Opioid
AOD Dependence	F11.250	[F11.250] Opioid dependence with opioid-induced psychotic disorder with delusions	ICD10CM	Opioid
AOD Dependence	F11.251	[F11.251] Opioid dependence with opioid-induced psychotic disorder with hallucinations	ICD10CM	Opioid
AOD Dependence	F11.259	[F11.259] Opioid dependence with opioid-induced psychotic disorder, unspecified	ICD10CM	Opioid
AOD Dependence	F11.281	[F11.281] Opioid dependence with opioid-induced sexual dysfunction	ICD10CM	Opioid
AOD Dependence	F11.282	[F11.282] Opioid dependence with opioid-induced sleep disorder	ICD10CM	Opioid
AOD Dependence	F11.288	[F11.288] Opioid dependence with other opioid-induced disorder	ICD10CM	Opioid

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F11.29	[F11.29] Opioid dependence with unspecified opioid-induced disorder	ICD10CM	Opioid
Acute Condition	F11.90	[F11.90] Opioid use, unspecified, uncomplicated	ICD10CM	Opioid
Acute Condition	F11.920	[F11.920] Opioid use, unspecified with intoxication, uncomplicated	ICD10CM	Opioid
Acute Condition	F11.921	[F11.921] Opioid use, unspecified with intoxication delirium	ICD10CM	Opioid
Acute Condition	F11.922	[F11.922] Opioid use, unspecified with intoxication with perceptual disturbance	ICD10CM	Opioid
Acute Condition	F11.929	[F11.929] Opioid use, unspecified with intoxication, unspecified	ICD10CM	Opioid
Acute Condition	F11.93	[F11.93] Opioid use, unspecified with withdrawal	ICD10CM	Opioid
Acute Condition	F11.94	[F11.94] Opioid use, unspecified with opioid-induced mood disorder	ICD10CM	Opioid
Acute Condition	F11.950	[F11.950] Opioid use, unspecified with opioid-induced psychotic disorder with delusions	ICD10CM	Opioid
Acute Condition	F11.951	[F11.951] Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations	ICD10CM	Opioid
Acute Condition	F11.959	[F11.959] Opioid use, unspecified with opioid-induced psychotic disorder, unspecified	ICD10CM	Opioid
Acute Condition	F11.981	[F11.981] Opioid use, unspecified with opioid-induced sexual dysfunction	ICD10CM	Opioid
Acute Condition	F11.982	[F11.982] Opioid use, unspecified with opioid-induced sleep disorder	ICD10CM	Opioid
Acute Condition	F11.988	[F11.988] Opioid use, unspecified with other opioid-induced disorder	ICD10CM	Opioid
Acute Condition	F11.99	[F11.99] Opioid use, unspecified with unspecified opioid-induced disorder	ICD10CM	Opioid
AOD Dependence	304.60	Other specified drug dependence, unspecified	ICD9CM	Other
AOD Dependence	304.61	Other specified drug dependence, continuous	ICD9CM	Other
AOD Dependence	304.62	Other specified drug dependence, episodic	ICD9CM	Other
AOD Dependence	304.90	Unspecified drug dependence, unspecified	ICD9CM	Other
AOD Dependence	304.91	Unspecified drug dependence, continuous	ICD9CM	Other
AOD Dependence	304.92	Unspecified drug dependence, episodic	ICD9CM	Other
AOD Dependence	305.90	Other, mixed, or unspecified drug abuse, unspecified	ICD9CM	Other
AOD Dependence	305.91	Other, mixed, or unspecified drug abuse, continuous	ICD9CM	Other
AOD Dependence	305.92	Other, mixed, or unspecified drug abuse, episodic	ICD9CM	Other
AOD Dependence	F19.10	[F19.10] Other psychoactive substance abuse, uncomplicated	ICD10CM	Other
AOD Dependence	F19.120	[F19.120] Other psychoactive substance abuse with intoxication, uncomplicated	ICD10CM	Other
AOD Dependence	F19.121	[F19.121] Other psychoactive substance abuse with intoxication delirium	ICD10CM	Other
AOD Dependence	F19.122	[F19.122] Other psychoactive substance abuse with intoxication with perceptual disturbances	ICD10CM	Other
AOD Dependence	F19.129	[F19.129] Other psychoactive substance abuse with intoxication, unspecified	ICD10CM	Other
AOD Dependence	F19.14	[F19.14] Other psychoactive substance abuse with psychoactive substance-induced mood disorder	ICD10CM	Other
AOD Dependence	F19.150	[F19.150] Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions	ICD10CM	Other
AOD Dependence	F19.151	[F19.151] Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations	ICD10CM	Other
AOD Dependence	F19.159	[F19.159] Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified	ICD10CM	Other

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F19.16	[F19.16] Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder	ICD10CM	Other
AOD Dependence	F19.17	[F19.17] Other psychoactive substance abuse with psychoactive substance-induced persisting dementia	ICD10CM	Other
AOD Dependence	F19.180	[F19.180] Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder	ICD10CM	Other
AOD Dependence	F19.181	[F19.181] Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction	ICD10CM	Other
AOD Dependence	F19.182	[F19.182] Other psychoactive substance abuse with psychoactive substance-induced sleep disorder	ICD10CM	Other
AOD Dependence	F19.188	[F19.188] Other psychoactive substance abuse with other psychoactive substance-induced disorder	ICD10CM	Other
AOD Dependence	F19.19	[F19.19] Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder	ICD10CM	Other
AOD Dependence	F19.20	[F19.20] Other psychoactive substance dependence, uncomplicated	ICD10CM	Other
AOD Dependence	F19.220	[F19.220] Other psychoactive substance dependence with intoxication, uncomplicated	ICD10CM	Other
AOD Dependence	F19.221	[F19.221] Other psychoactive substance dependence with intoxication delirium	ICD10CM	Other
AOD Dependence	F19.222	[F19.222] Other psychoactive substance dependence with intoxication with perceptual disturbance	ICD10CM	Other
AOD Dependence	F19.229	[F19.229] Other psychoactive substance dependence with intoxication, unspecified	ICD10CM	Other
AOD Dependence	F19.230	[F19.230] Other psychoactive substance dependence with withdrawal, uncomplicated	ICD10CM	Other
AOD Dependence	F19.231	[F19.231] Other psychoactive substance dependence with withdrawal delirium	ICD10CM	Other
AOD Dependence	F19.232	[F19.232] Other psychoactive substance dependence with withdrawal with perceptual disturbance	ICD10CM	Other
AOD Dependence	F19.239	[F19.239] Other psychoactive substance dependence with withdrawal, unspecified	ICD10CM	Other
AOD Dependence	F19.24	[F19.24] Other psychoactive substance dependence with psychoactive substance-induced mood disorder	ICD10CM	Other
AOD Dependence	F19.250	[F19.250] Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions	ICD10CM	Other
AOD Dependence	F19.251	[F19.251] Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	ICD10CM	Other
AOD Dependence	F19.259	[F19.259] Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified	ICD10CM	Other
AOD Dependence	F19.26	[F19.26] Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder	ICD10CM	Other
AOD Dependence	F19.27	[F19.27] Other psychoactive substance dependence with psychoactive substance-induced persisting dementia	ICD10CM	Other
AOD Dependence	F19.280	[F19.280] Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder	ICD10CM	Other
AOD Dependence	F19.281	[F19.281] Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction	ICD10CM	Other

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F19.282	[F19.282] Other psychoactive substance dependence with psychoactive substance-induced sleep disorder	ICD10CM	Other
AOD Dependence	F19.288	[F19.288] Other psychoactive substance dependence with other psychoactive substance-induced disorder	ICD10CM	Other
AOD Dependence	F19.29	[F19.29] Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder	ICD10CM	Other
Acute Condition	F19.90	[F19.90] Other psychoactive substance use, unspecified, uncomplicated	ICD10CM	Other
Acute Condition	F19.920	[F19.920] Other psychoactive substance use, unspecified with intoxication, uncomplicated	ICD10CM	Other
Acute Condition	F19.921	[F19.921] Other psychoactive substance use, unspecified with intoxication with delirium	ICD10CM	Other
Acute Condition	F19.922	[F19.922] Other psychoactive substance use, unspecified with intoxication with perceptual disturbance	ICD10CM	Other
Acute Condition	F19.929	[F19.929] Other psychoactive substance use, unspecified with intoxication, unspecified	ICD10CM	Other
Acute Condition	F19.930	[F19.930] Other psychoactive substance use, unspecified with withdrawal, uncomplicated	ICD10CM	Other
Acute Condition	F19.931	[F19.931] Other psychoactive substance use, unspecified with withdrawal delirium	ICD10CM	Other
Acute Condition	F19.932	[F19.932] Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance	ICD10CM	Other
Acute Condition	F19.939	[F19.939] Other psychoactive substance use, unspecified with withdrawal, unspecified	ICD10CM	Other
Acute Condition	F19.94	[F19.94] Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder	ICD10CM	Other
Acute Condition	F19.950	[F19.950] Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions	ICD10CM	Other
Acute Condition	F19.951	[F19.951] Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations	ICD10CM	Other
Acute Condition	F19.959	[F19.959] Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified	ICD10CM	Other
Acute Condition	F19.96	[F19.96] Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder	ICD10CM	Other
Acute Condition	F19.97	[F19.97] Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia	ICD10CM	Other
Acute Condition	F19.980	[F19.980] Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder	ICD10CM	Other
Acute Condition	F19.981	[F19.981] Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction	ICD10CM	Other
Acute Condition	F19.982	[F19.982] Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder	ICD10CM	Other
Acute Condition	F19.988	[F19.988] Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder	ICD10CM	Other
Acute Condition	F19.99	[F19.99] Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder	ICD10CM	Other
AOD Dependence	304.10	Sedative, hypnotic or anxiolytic dependence, unspecified	ICD9CM	Sedative
AOD Dependence	304.11	Sedative, hypnotic or anxiolytic dependence, continuous	ICD9CM	Sedative

Value Set Name	Code	Definition	Code	Category
AOD Dependence	304.12	Sedative, hypnotic or anxiolytic dependence, episodic	ICD9CM	Sedative
AOD Dependence	305.40	Sedative, hypnotic or anxiolytic abuse, unspecified	ICD9CM	Sedative
AOD Dependence	305.41	Sedative, hypnotic or anxiolytic abuse, continuous	ICD9CM	Sedative
AOD Dependence	305.42	Sedative, hypnotic or anxiolytic abuse, episodic	ICD9CM	Sedative
AOD Dependence	F13.10	[F13.10] Sedative, hypnotic or anxiolytic abuse, uncomplicated	ICD10CM	Sedative
AOD Dependence	F13.120	[F13.120] Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated	ICD10CM	Sedative
AOD Dependence	F13.121	[F13.121] Sedative, hypnotic or anxiolytic abuse with intoxication delirium	ICD10CM	Sedative
AOD Dependence	F13.129	[F13.129] Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified	ICD10CM	Sedative
AOD Dependence	F13.14	[F13.14] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder	ICD10CM	Sedative
AOD Dependence	F13.150	[F13.150] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	ICD10CM	Sedative
AOD Dependence	F13.151	[F13.151] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	ICD10CM	Sedative
AOD Dependence	F13.159	[F13.159] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	ICD10CM	Sedative
AOD Dependence	F13.180	[F13.180] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder	ICD10CM	Sedative
AOD Dependence	F13.181	[F13.181] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction	ICD10CM	Sedative
AOD Dependence	F13.182	[F13.182] Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder	ICD10CM	Sedative
AOD Dependence	F13.188	[F13.188] Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder	ICD10CM	Sedative
AOD Dependence	F13.19	[F13.19] Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder	ICD10CM	Sedative
AOD Dependence	F13.20	[F13.20] Sedative, hypnotic or anxiolytic dependence, uncomplicated	ICD10CM	Sedative
AOD Dependence	F13.220	[F13.220] Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated	ICD10CM	Sedative
AOD Dependence	F13.221	[F13.221] Sedative, hypnotic or anxiolytic dependence with intoxication delirium	ICD10CM	Sedative
AOD Dependence	F13.229	[F13.229] Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified	ICD10CM	Sedative
AOD Dependence	F13.230	[F13.230] Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	ICD10CM	Sedative
AOD Dependence	F13.231	[F13.231] Sedative, hypnotic or anxiolytic dependence with withdrawal delirium	ICD10CM	Sedative
AOD Dependence	F13.232	[F13.232] Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance	ICD10CM	Sedative
AOD Dependence	F13.239	[F13.239] Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified	ICD10CM	Sedative
AOD Dependence	F13.24	[F13.24] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder	ICD10CM	Sedative
AOD Dependence	F13.250	[F13.250] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	ICD10CM	Sedative

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F13.251	[F13.251] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	ICD10CM	Sedative
AOD Dependence	F13.259	[F13.259] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	ICD10CM	Sedative
AOD Dependence	F13.26	[F13.26] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder	ICD10CM	Sedative
AOD Dependence	F13.27	[F13.27] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia	ICD10CM	Sedative
AOD Dependence	F13.280	[F13.280] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder	ICD10CM	Sedative
AOD Dependence	F13.281	[F13.281] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction	ICD10CM	Sedative
AOD Dependence	F13.282	[F13.282] Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder	ICD10CM	Sedative
AOD Dependence	F13.288	[F13.288] Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder	ICD10CM	Sedative
AOD Dependence	F13.29	[F13.29] Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder	ICD10CM	Sedative
Acute Condition	F13.90	[F13.90] Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated	ICD10CM	Sedative
Acute Condition	F13.920	[F13.920] Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated	ICD10CM	Sedative
Acute Condition	F13.921	[F13.921] Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium	ICD10CM	Sedative
Acute Condition	F13.929	[F13.929] Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified	ICD10CM	Sedative
Acute Condition	F13.930	[F13.930] Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated	ICD10CM	Sedative
Acute Condition	F13.931	[F13.931] Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium	ICD10CM	Sedative
Acute Condition	F13.932	[F13.932] Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances	ICD10CM	Sedative
Acute Condition	F13.939	[F13.939] Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified	ICD10CM	Sedative
Acute Condition	F13.94	[F13.94] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder	ICD10CM	Sedative
Acute Condition	F13.950	[F13.950] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	ICD10CM	Sedative
Acute Condition	F13.951	[F13.951] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	ICD10CM	Sedative
Acute Condition	F13.959	[F13.959] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	ICD10CM	Sedative
Acute Condition	F13.96	[F13.96] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder	ICD10CM	Sedative
Acute Condition	F13.97	[F13.97] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia	ICD10CM	Sedative
Acute Condition	F13.980	[F13.980] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder	ICD10CM	Sedative
Acute Condition	F13.981	[F13.981] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction	ICD10CM	Sedative

Value Set Name	Code	Definition	Code	Category
Acute Condition	F13.982	[F13.982] Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder	ICD10CM	Sedative
Acute Condition	F13.988	[F13.988] Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder	ICD10CM	Sedative
Acute Condition	F13.99	[F13.99] Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder	ICD10CM	Sedative
AOD Dependence	304.40	Amphetamine and other psychostimulant dependence, unspecified	ICD9CM	Stimulant (not cocaine)
AOD Dependence	304.41	Amphetamine and other psychostimulant dependence, continuous	ICD9CM	Stimulant (not cocaine)
AOD Dependence	304.42	Amphetamine and other psychostimulant dependence, episodic	ICD9CM	Stimulant (not cocaine)
AOD Dependence	305.70	Amphetamine or related acting sympathomimetic abuse, unspecified	ICD9CM	Stimulant (not cocaine)
AOD Dependence	305.71	Amphetamine or related acting sympathomimetic abuse, continuous	ICD9CM	Stimulant (not cocaine)
AOD Dependence	305.72	Amphetamine or related acting sympathomimetic abuse, episodic	ICD9CM	Stimulant (not cocaine)
AOD Dependence	F15.10	[F15.10] Other stimulant abuse, uncomplicated	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.120	[F15.120] Other stimulant abuse with intoxication, uncomplicated	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.121	[F15.121] Other stimulant abuse with intoxication delirium	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.122	[F15.122] Other stimulant abuse with intoxication with perceptual disturbance	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.129	[F15.129] Other stimulant abuse with intoxication, unspecified	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.14	[F15.14] Other stimulant abuse with stimulant-induced mood disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.150	[F15.150] Other stimulant abuse with stimulant-induced psychotic disorder with delusions	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.151	[F15.151] Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.159	[F15.159] Other stimulant abuse with stimulant-induced psychotic disorder, unspecified	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.180	[F15.180] Other stimulant abuse with stimulant-induced anxiety disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.181	[F15.181] Other stimulant abuse with stimulant-induced sexual dysfunction	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.182	[F15.182] Other stimulant abuse with stimulant-induced sleep disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.188	[F15.188] Other stimulant abuse with other stimulant-induced disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.19	[F15.19] Other stimulant abuse with unspecified stimulant-induced disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.20	[F15.20] Other stimulant dependence, uncomplicated	ICD10CM	Stimulant (not cocaine)

Value Set Name	Code	Definition	Code	Category
AOD Dependence	F15.220	[F15.220] Other stimulant dependence with intoxication, uncomplicated	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.221	[F15.221] Other stimulant dependence with intoxication delirium	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.222	[F15.222] Other stimulant dependence with intoxication with perceptual disturbance	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.229	[F15.229] Other stimulant dependence with intoxication, unspecified	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.23	[F15.23] Other stimulant dependence with withdrawal	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.24	[F15.24] Other stimulant dependence with stimulant-induced mood disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.250	[F15.250] Other stimulant dependence with stimulant-induced psychotic disorder with delusions	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.251	[F15.251] Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.259	[F15.259] Other stimulant dependence with stimulant-induced psychotic disorder, unspecified	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.280	[F15.280] Other stimulant dependence with stimulant-induced anxiety disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.281	[F15.281] Other stimulant dependence with stimulant-induced sexual dysfunction	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.282	[F15.282] Other stimulant dependence with stimulant-induced sleep disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.288	[F15.288] Other stimulant dependence with other stimulant-induced disorder	ICD10CM	Stimulant (not cocaine)
AOD Dependence	F15.29	[F15.29] Other stimulant dependence with unspecified stimulant-induced disorder	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.90	[F15.90] Other stimulant use, unspecified, uncomplicated	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.920	[F15.920] Other stimulant use, unspecified with intoxication, uncomplicated	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.921	[F15.921] Other stimulant use, unspecified with intoxication delirium	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.922	[F15.922] Other stimulant use, unspecified with intoxication with perceptual disturbance	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.929	[F15.929] Other stimulant use, unspecified with intoxication, unspecified	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.93	[F15.93] Other stimulant use, unspecified with withdrawal	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.94	[F15.94] Other stimulant use, unspecified with stimulant-induced mood disorder	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.950	[F15.950] Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.951	[F15.951] Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations	ICD10CM	Stimulant (not cocaine)

Value Set Name	Code	Definition	Code	Category
Acute Condition	F15.959	[F15.959] Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.980	[F15.980] Other stimulant use, unspecified with stimulant-induced anxiety disorder	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.981	[F15.981] Other stimulant use, unspecified with stimulant-induced sexual dysfunction	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.982	[F15.982] Other stimulant use, unspecified with stimulant-induced sleep disorder	ICD10CM	Stimulant (not cocaine)
Acute Condition	F15.988	[F15.988] Other stimulant use, unspecified with other stimulant-induced disorder	ICD10CM	Stimulant (not cocaine)

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