EMERGING MEASURES IN THE HOSPITAL SETTING FOR SAFE OPIOID MANAGEMENT IN THE HOSPITAL

September 12, 2019

11:00am -12:00pm Pacific Time

Cal Hospital Compare

Opioid Care Honor Roll 2019 Webinar Series - 5 of 5

Continuing Education Credits

ABQAURP
American Board of Quality Assurance and Utilization Review Physicians

Promoting Health Care Quality and Patient Safety Through Certification and Education

ACCME ACCREDITED WITH COMMENDATION

Cal Hospital Compare
Designating Opioid Safe Hospitals
Emerging Measures in the Hospital Setting for Safe Opioid Management
Online Live Webinar
September 12, 2019

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Dr. Steve Tremain is a stockholder of Allergan. This presentation has been reviewed and found to contain no bias. Dr. Tremain has no other relevant financial relationships to disclose in regard to the content of this presentation.

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Using Zoom

All lines MUTED upon entry, UNMUTE yourself as needed

Recommend calling in via phone

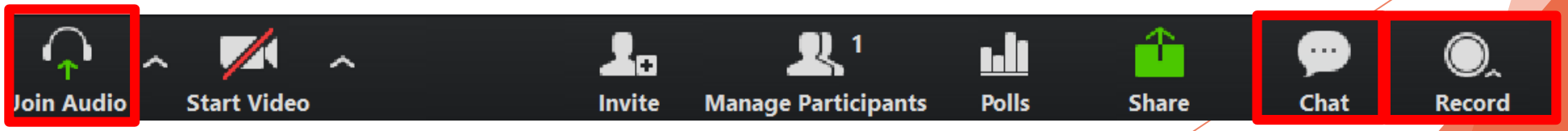
Click “chat” to open the chat box

Select To: “all panelist and attendees”

Meeting is being recorded

Recording available on calhospitalcompare.org

Want to download the slides?
CHC website >About > Opioid Care Honor Roll



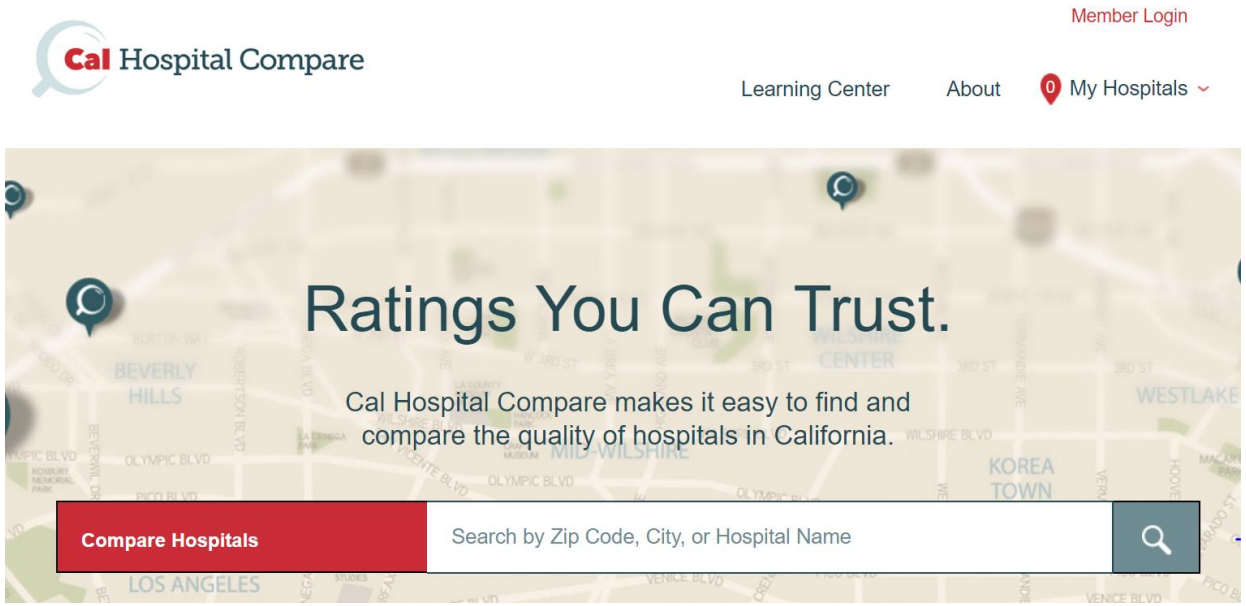
Meeting Objectives

- **Identified** the steps your hospital will take to apply for the Opioid Safe Care Honor Roll by Sept. 18
- **Analyzed** your hospital's current approach to measuring the impact of opioid safe practices on patient outcomes
- **Examined** emerging measures at the state & national level
- **Explored** novel ways measure impact of safe opioid practices on reducing opioid use disorder deaths
- **Heard** from peer hospitals the steps they have taken to measure opioid safe practices

Opioid Care Honor Roll
2019 Webinar Series Roadmap

Cal Hospital Compare

About: For more than a decade, Cal Hospital Compare (CHC) has been providing Californians with objective hospital performance ratings. CHC is a non-profit organization that is governed by a multi-stakeholder board, with representatives from hospitals, purchasers, consumer groups, and health plans. In effort to accelerate improvement and recognize high performance by California hospitals, CHC publishes an annual Patient Safety Honor Roll and Low-Risk C-section Honor Roll.



Facilitators

Alex Stack

Director, Programs & Strategic Initiatives, CHC

Aimee Moulin

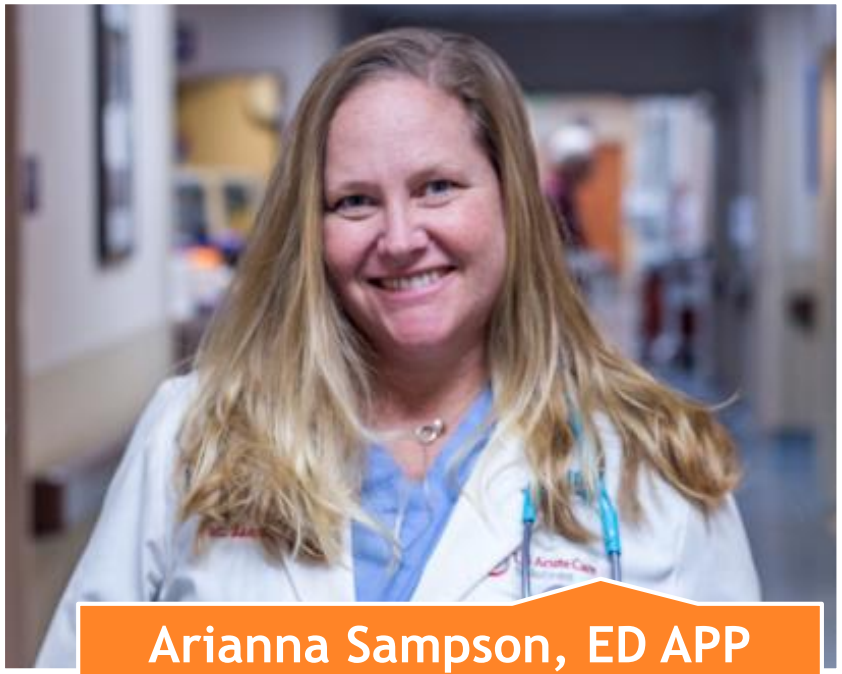
Co-Director
ED Bridge

Steve Tremain

Physician Improvement Advisor Cynosure Health

Guest Speakers

Reb Close, MD
Community Hospital
Monterey Peninsula



Arianna Sampson, ED APP
Marshall Medical Center
Co-Director CA BRIDGE

POLL:

What are you currently working on to improve opioid safety in your hospital?

Opioid Care Honor Roll

Frequently Asked Questions

What is the threshold?

- Relevant threshold
- Score at least one point in each domain

What is the value of attaining the Opioid Care Honor Roll

- Accelerate your hospital's progress
- Announcement in Oct. 2019 by Dr. Mark Ghaly, Secretary of CA HHS
- Special recognition on Cal Hospital Compare website

When is the assessment window?

- Ends Sept. 18, 2019
- Each hospital must submit responses & any supporting documents via e-survey here

Source: Opioid Safe Hospital Designation Frequently Asked Questions

Countdown!

6
days

POLL:

When will your hospital apply for the Opioid Care Honor Roll?

Bringing it all together

Mapping it back to the Self-Assessment

Measure	Intent	Level 3 (1 pt)	Level 2 (2 pts)	Level 1 Opioid Safe (3 pts)	Example *(comparative tool & resource)*
Prevent new opioid starts • Prescribing guidelines • Alternatives to opioids for pain management				Overdose Prevention • Naloxone education & distribution program	
Identification & Treatment • MAT • BUP Waiver				Cross-cutting Opioid Safe Hospital Best Practices • Organizational infrastructure • Provider/staff education • Patient education • Formulary management • Handoff to the community	

Source: *Opioid Safe Hospital Self-Assessment*

Scanning the Landscape

CMS

- Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act signed by President Trump (Oct.2018)
- Roadmap for fighting the opioid crisis

National Quality Forum

- Opioid and Opioid Use Disorder: An Environmental Scan (Jul 2019)
- Use this to craft specific measurement recommendations to HHS for the purposes of improving management, prevention, diagnosis, and treatment of persons using or misusing opioids.

Publicly Available Data

CA Opioid Overdose Surveillance Dashboard

- By zip code &/or county:
  - Deaths
  - ED Visits
  - Hospitalizations
  - Prescriptions

Death Data

- Request from county coroner's office

Outcome Measure

Outcome
• Deaths related to any opioid overdose

***Pro Tip**: select 1 outcome, 2-3 process, and 1 balancing measures*

Process Measures Pick List

Discharge prescribing

- Appropriate Prescribing for First Fill of Opioids
- Avoidance of LA or ER Opiate Prescriptions
- Avoidance of Opiate Prescriptions > 3 Days Duration for Acute Pain
- Initial opioid prescription compliant with CDC recommendations
- All-cause re-admission
- Avoidance of Opiates for Low Back Pain or Migraines
- Communication about Treating Pain Post-Discharge
- Concurrent Use of Opioids and Benzodiazepines (COB)
- Consideration of Non-Pharmacologic Interventions
- Evaluation of High-Risk Pain Medications for MME

Identification & treatment

- Identified w/ OUD
- Alcohol & Other Drug Use Disorder Treatment at Discharge (MAT)
- Accepting referral to treatment
- BUP Prescriptions
- X-waivered providers or X-waiver coverage
- Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
- Counseling Regarding Pharmacological Treatment for Opioid Dependence

Overdose prevention

- Discharge Prescription of naloxone after Opioid Poisoning or Overdose
- Discharge Prescription of naloxone for all patients receiving an Opioid Prescription
- Naloxone kit distribution to patients and their families
- Patient education on naloxone use and follow up

***Pro Tip**: select 1 outcome, 2-3 process, and 1 balancing measures*

Balancing Measures Pick List

Balancing
• Pain control • Patient satisfaction • Provider satisfaction • Opportunity cost (time & energy) • Demand versus capacity (visits) • Supply chain management

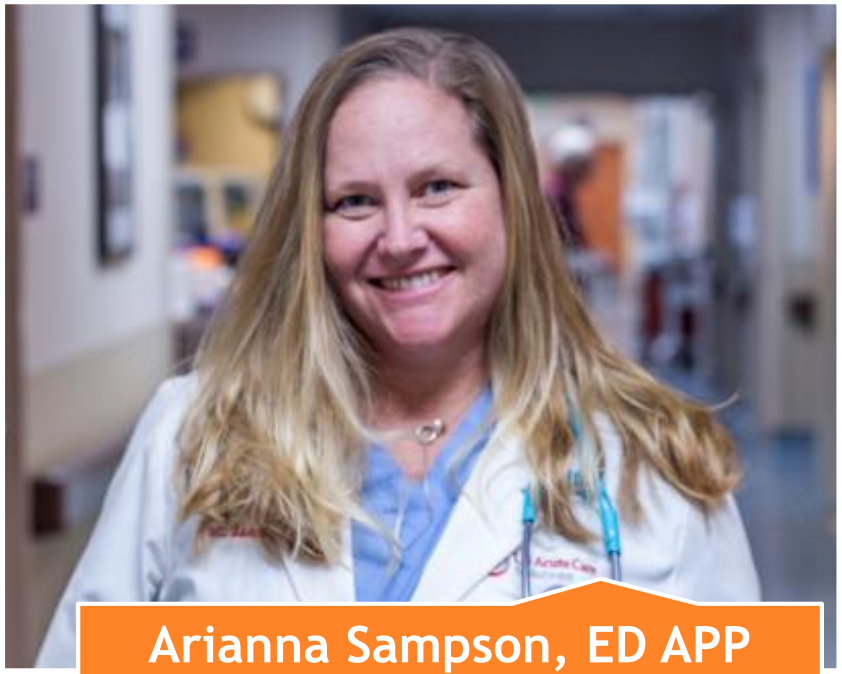
***Pro Tip**: select 1 outcome, 2-3 process, and 1 balancing measures*

CHAT:

What measure most resonates with you?

Guest Speakers

Reb Close, MD
Community Hospital
Monterey Peninsula



Arianna Sampson, ED APP
Marshall Medical Center
Co-Director CA BRIDGE

Reb JH Close, MD

Emergency Department

Community Hospital of the Monterey Peninsula

Lead Clinical Physician

Monterey County Prescribe Safe Initiative

Volunteer Physician Liaison

Monterey County Sheriff's Office – Coroner Division

Monterey County Prescribe Safe Initiative 2019

Overdose cases

Fatal – Monterey County Coroner's Cases

- Review and record information regarding substance(s) found and blood concentrations on tox reports

Non-fatal – Community Hospital ICD10 coding information

- Review presentations and circumstances

Information collected

Ethnicity
Age/Gender
Zip code of OD
Zip code of home address listed
Circumstance/intent – if known
Presence or absence of marijuana – if known, given recent changes in California law
Physicians caring for the patient – medication bottles found on scene, CURES, medical records

How is the information used

Trends – we were seeing fentanyl deaths before we knew to look for it

High risk medication regimens

Provider notifications

- Non-accusatory information sharing
- Reminder to use CURES
- Information shared on how to decrease future risk
  - Naloxone co-prescribing
  - Safer prescribing methods
  - The Holy Trinity

Overdose notifications to providers

MONTEREY COUNTY, CALIFORNIA
SHERIFF'S OFFICE
Keeping the peace since 1850

STEVE BERNAL
Sheriff-Coroner

Monterey County Coroner's Office
1414 Natividad Road
Salinas, CA 93906
(831) 755-3795

Date

Dear _____ (name prescriber),

This is a courtesy communication to inform you that your patient (Name, Date of Birth) died on (date). Prescription drug overdose was either the primary cause of death or contributed to the death.

The Monterey County Coroner's office sees quite a number of prescription medication-related deaths each year. A significant proportion of deaths are due to the combination of multiple prescription medications. Patients may obtain legitimate prescriptions for opioids, benzodiazepines, muscle relaxants, and sleep aids from more than one prescriber. When taken in any combination, these medications put patients at greater risk of death. We also see many deaths that are a result of long-term therapeutic prescribing.

Controlled Substance Utilization Review and Evaluation System (CURES) *helps prescribers who are dedicated to avoiding prescribing controlled substances when they are likely to do more harm than good.* CURES contains information about whether other clinicians had prescribed controlled substances to your patient. This type of information can help prescribers make informed decisions and avoid duplicate or additive types of medications from being provided to patients. We ask that you commit to prescribe safely by registering for and regularly logging in to CURES before prescribing controlled substances. On the CURES website you may run a report on any patient you are considering prescribing controlled substances to in order to find their detailed prescription history. CURES data is available for only the last 12 months for patients.

You can register for CURES at

https://cures.doj.ca.gov/registration/confirmEmailPnDRegistration.xhtml.

You can access CURES at https://cures.doj.ca.gov

The following evidence-based interventions also lower overdose death rates:

1. **Avoid co-prescribing** an opioid and a benzodiazepine. This combination is found in over 50% of CURES reports and in over 20% of toxicology results of patients who died of an overdose.

2 **Minimize opioid prescribing for acute pain.** According to the Centers for Disease Control and Prevention (CDC), clinicians should avoid opioids, and when necessary, start with the lowest effective dose of immediate-release opioids. Three days or less will often be sufficient. Opioids should not be considered first-line or routine therapy for chronic pain.[1]

1414 Natividad Road, Salinas CA 93906 ▪ (831) 755-3700 ▪ www.montereysheriff.org

MONTEREY COUNTY, CALIFORNIA
SHERIFF'S OFFICE
Keeping the peace since 1850

STEVE BERNAL
Sheriff-Coroner

3. **Taper opioids to safer doses.** The CDC recommends that for patients already on long-term opioid high dose opioid therapy, taper to a dose that is lower than 50 milligrams of morphine equivalent and that slow opioid tapers as well as pauses in the taper may be needed for long-term users.[2]

4. **Avoid "the 90-day cliff."** We found that nearly 70% of patients who died were prescribed the same medication for 3 consecutive months. The CDC recommends opioids s should be discontinued if benefits do not outweigh risks (if realistic goals for pain and function have not been met).[3]

5. **The CDC recommends prescribing naloxone** to patients on higher than 50 milligrams of morphine equivalents daily.[4]

We are aware of the challenges in balancing the potential harm and benefit of controlled medication prescribing for your patients. Therefore, please visit:

http://www.montagehealth.org/prescribe-safe/

and click the link named "Did you get a letter from the Coroner's Office?" Here you will find links to the CDC guidelines, local addiction referral resources, including medication-assisted treatment, a clinical advice hotline, regimens for successful tapering and other information.

Learning of your patient's death can be difficult. We hope that you will take this as an opportunity to join us in preventing future deaths from drug overdose.

Sincerely,

Sgt. Dan Karamitis Dr. Reb Close

Coroner's Office Community Hospital of the Monterey Peninsula

[1]Recommendations #1, 6, CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
[2] Recommendation #5, 7 CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
[3]Recommendation #2, 7, CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
[4]Recommendation #8, CDC Guideline for Prescribing Opioids for Chronic Pain, 2016

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Future work

We have raw data for our county

We are working to find a method of analysis that allows trending as we are frequently asked for data

- Quarterly updates
- Annual overdose information – types and subtypes of substances
- Location of overdoses
- Can assess outreach efforts from both fatal and non-fatal notifications to see if certain areas or patient populations need additional outreach

CHAT:
What questions do you have?

One hospital's approach to measuring opioid safe care

LEARNINGS FROM MARSHAL MEDICAL CENTER

MARSHALL
MEDICAL CENTER

About

- Placerville, CA population of 10,936
- Gold Rush “Hangtown”
- El Dorado County population 188,722

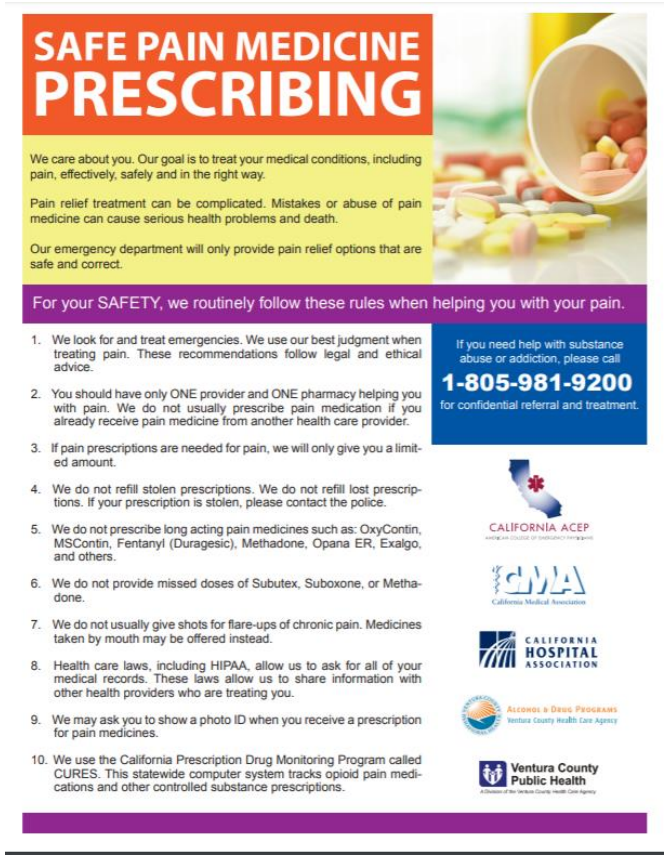
- Hospital size - 125 Beds
- Emergency Department size - 24 beds
- ED volume ~ 33,000/year

- Opioid overdoses decreased in 2017 by 49%
- Overdose deaths were similar in 2018

- Regional isolation issues in County

How did we get started?

Initial tactics



SAFE PAIN MEDICINE PRESCRIBING

We care about you. Our goal is to treat your medical conditions, including pain, effectively, safely and in the right way.

Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death.

Our emergency department will only provide pain relief options that are safe and correct.

For your SAFETY, we routinely follow these rules when helping you with your pain.

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only ONE provider and ONE pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we will only give you a limited amount.
4. We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long acting pain medicines such as: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.
6. We do not provide missed doses of Subutex, Suboxone, or Methadone.
7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.

If you need help with substance abuse or addiction, please call

1-805-981-9200

for confidential referral and treatment.

CALIFORNIA ACEP

CMA California Medical Association

CALIFORNIA HOSPITAL ASSOCIATION

Alcohol & Drug Programs Ventura County Health Care Agency

Ventura County Public Health

CURES 2.0

Request for Data…

The New York Times

THE TREATMENT GAP

This E.R. Treats Opioid Addiction on Demand. That's Very Rare.

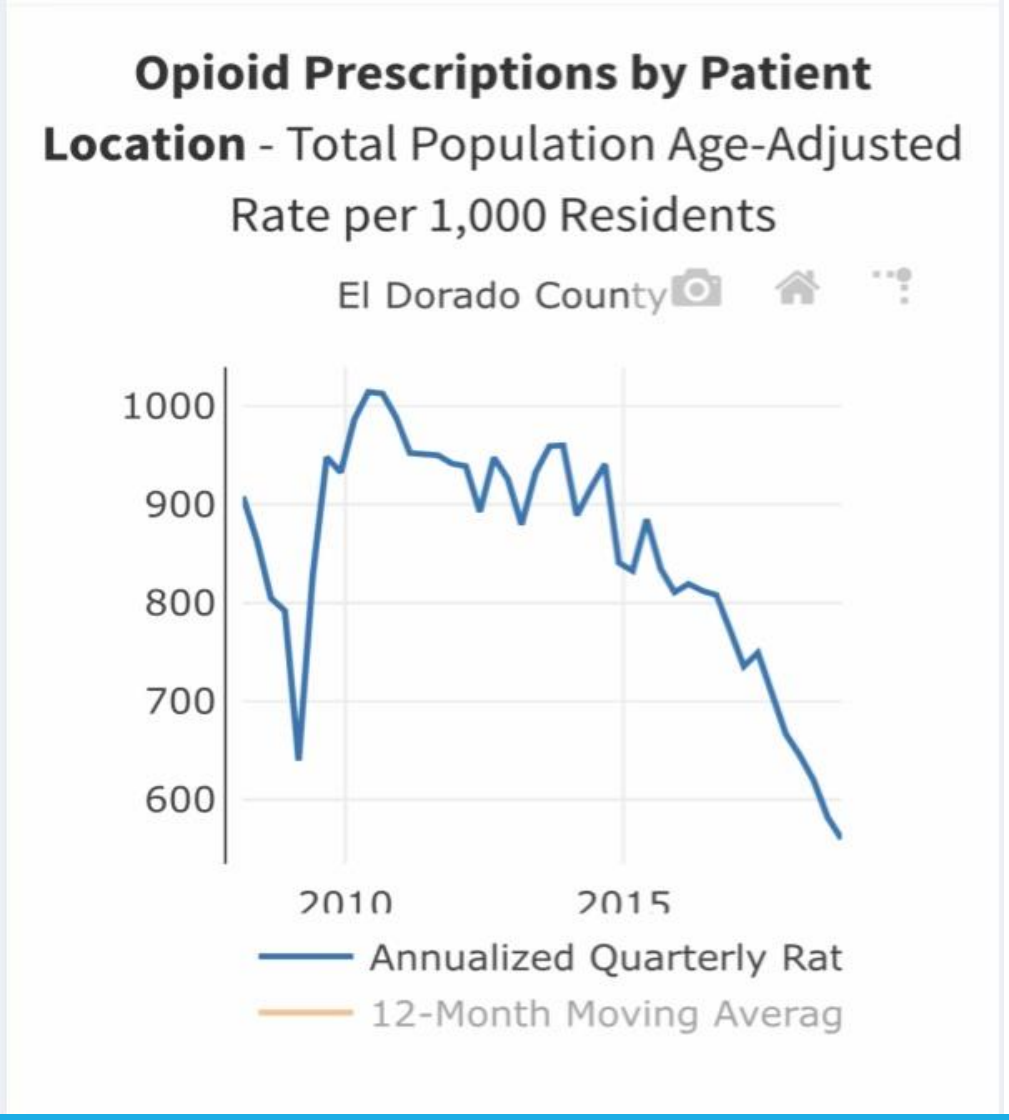
Some hospital emergency departments are giving people medicine for withdrawal, plugging a hole in a system that too often fails to provide immediate treatment.

Initial findings

Opioid Rx rates were decreasing

We took a look at data from 1st almost 1 year of program:

- We treated <1 patient per week.
- Follow-up rate was 92% after ED start.
- 74% of patients were still in treatment at 1 year.



Data Driven Decision Making

Strengths

- Simplicity of treating first in ED with next day follow-up
- Decreasing stigma
- Using objective info to identify patients
- Identifying small projects to pilot
- Choosing to study Rx rates for opioid naive patients as target

Opportunities

- Safe tapering
- Standardize treatment
- Real time provider feedback to providers
- Community partnerships

Safe Tapering

What to Measure?

- MME with safe taper only
- Combo Opioid and Benzo
- Opioid naïve patient prescription vs standard of care by specialty/surgery type and type of surgery
- Clinic Referrals and Follow-up

Researchers find alarming risk for people coming off chronic opioid prescriptions

Patients on chronic opioid prescriptions were 3x more likely to die of an overdose in the years that followed coming off opioids

Date: September 6, 2019

Source: University of Washington Health Sciences/UW Medicine

Summary: A recent study found an alarming outcome: Patients coming off opioids for pain were three times more likely to die of an overdose in the years that followed.

Standardize treatment

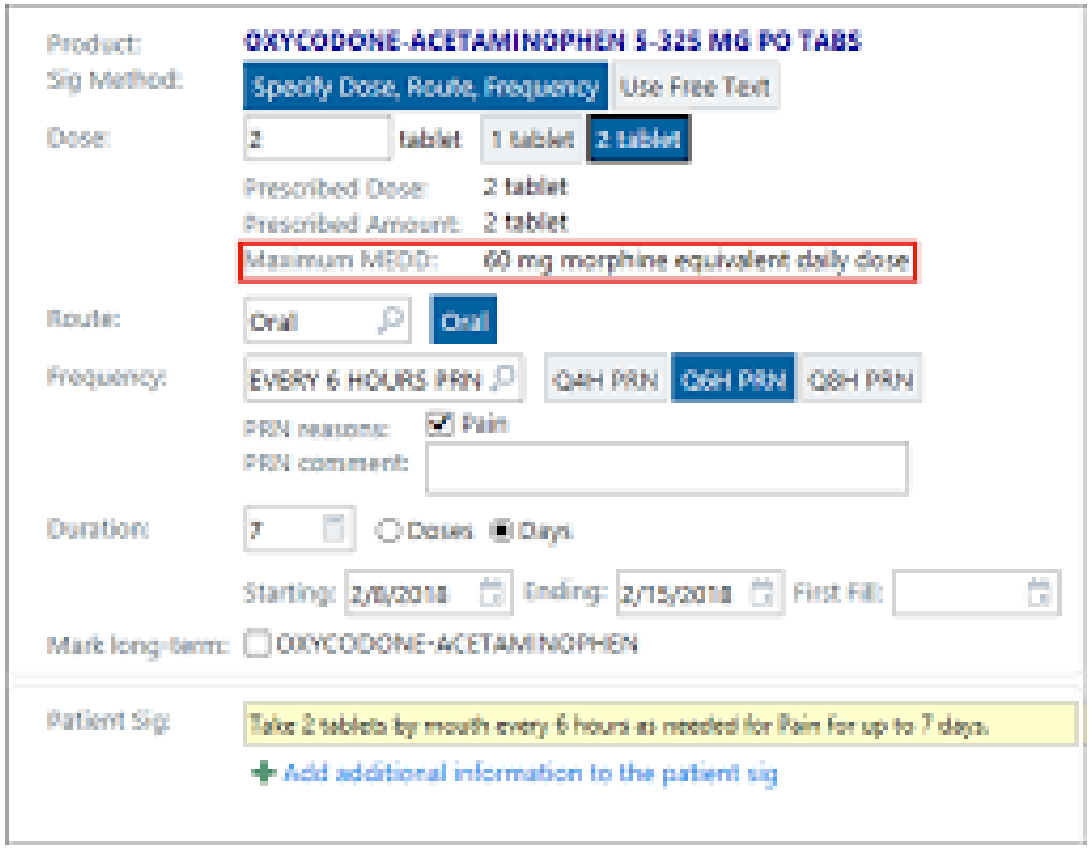
November 2018

Association of Lowering Default Pill Counts in Electronic Medical Record Systems With Postoperative Opioid Prescribing

Alexander S. Chiu, MD[1]; Raymond A. Jean, MD[1,2]; Jessica R. Hoag, PhD[3]; et al

» Author Affiliations

JAMA Surg. 2018;153(11):1012-1019. doi:10.1001/jamasurg.2018.2083



Real time feedback to providers

- Standardize opioid updates at Monthly Provider Meetings, similar to Stroke/Sepsis updates with clear goals (ie. X-waiver push)
- Interdisciplinary education push across hospital system
- CURES report column in chart with objective indications
- Celebrate successes, share the stories
- Identify gaps in treatment and Act/Educate
- Monitor community level data

Community Partnerships

California Bridge Champions: Hospitalist, ED, OB, Peds, Clinic, SUN, VP Population Health, Director Inpatient Care: outreach to each department

Opioid VSST Committee

Opioid Education

County Opioid Coalition

Syringe Services Program Development

SUN outreach

HOT Team

Engage at all hospital committee meetings to standardize and normalize treatment as recurring agenda item.

Internal Measures

What we are tracking:

# of patients in Inpatient setting identified w/ OUD

identified in ED w/ OUD

identified by SUN w/ OUD

seen by SUN

offered MAT

accepting referral to treatment

BUP Rx

with SUN follow-up

who follow-up with clinic

EMR Report with BUP start

Future tracking ides:

Community Impact measures:

- Crime
- HIV/Hep C
- Homelessness

Readmission w/ OUD

# of OUD patients we miss

Comparative length of stay with co-occurring Psych

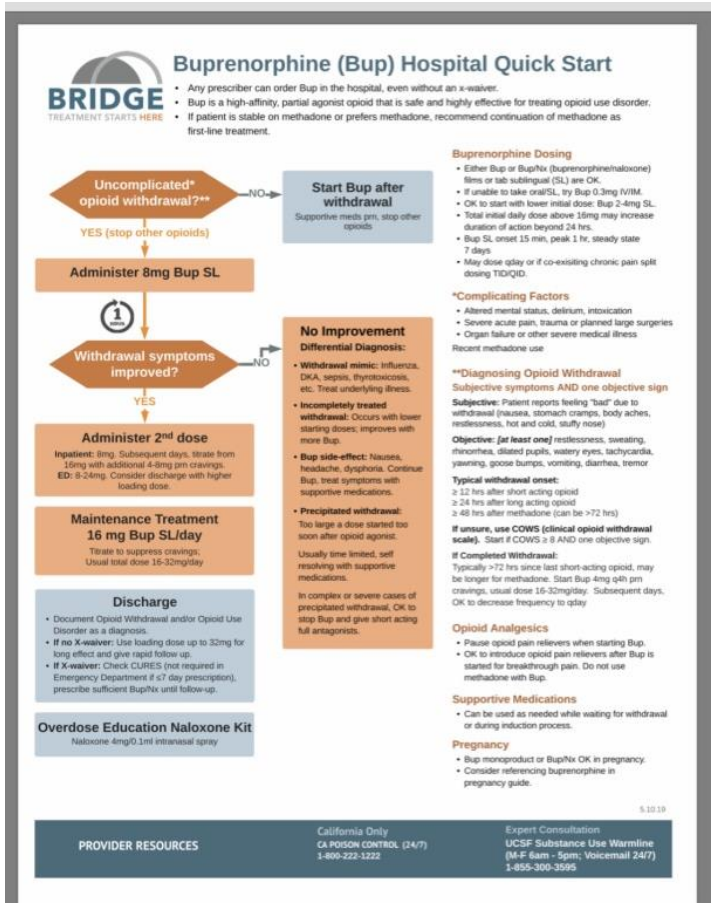
Comparative readmission with co-occurring Psych

Effect of SUN on access to care

Residential treatment successes w/ BUP start & referral

NAS treatment & effect on community

Evidence Based Medicine



BRIDGE
TREATMENT STARTS HERE

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

Uncomplicated* opioid withdrawal?**
NO → **Start Bup after withdrawal**
Supportive meds prn, stop other opioids

YES (stop other opioids)

Administer 8mg Bup SL

1 hour

Withdrawal symptoms improved?
NO →

No Improvement
Differential Diagnosis:
- **Withdrawal mimic:** Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlying illness.
- **Incompletely treated withdrawal:** Occurs with lower starting doses; improves with more Bup.
- **Bup side-effect:** Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
- **Precipitated withdrawal:** Too large a dose started too soon after opioid agonist.

Usually time limited, self resolving with supportive medications.

In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short acting full antagonists.

YES

Administer 2nd dose
Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment
16 mg Bup SL/day
Titrate to suppress cravings;
Usual total dose 16-32mg/day

Discharge
- Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
- **If no X-waiver:** Use loading dose up to 32mg for long effect and give rapid follow up.
- **If X-waiver:** Check CURES (not required in Emergency Department if ≤7 day prescription), prescribe sufficient Bup/Nx until follow-up.

Overdose Education Naloxone Kit
Naloxone 4mg/0.1ml intranasal spray

Buprenorphine Dosing
- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days.
- May dose qday or if co-exisiting chronic pain split dosing TID/QID.

*Complicating Factors
- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness

Recent methadone use

**Diagnosing Opioid Withdrawal
Subjective symptoms AND one objective sign

Subjective: Patient reports feeling "bad" due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)

Objective: *[at least one]* restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor

Typical withdrawal onset:
≥ 12 hrs after short acting opioid
≥ 24 hrs after long acting opioid
≥ 48 hrs after methadone (can be >72 hrs)

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.

If Completed Withdrawal:
Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

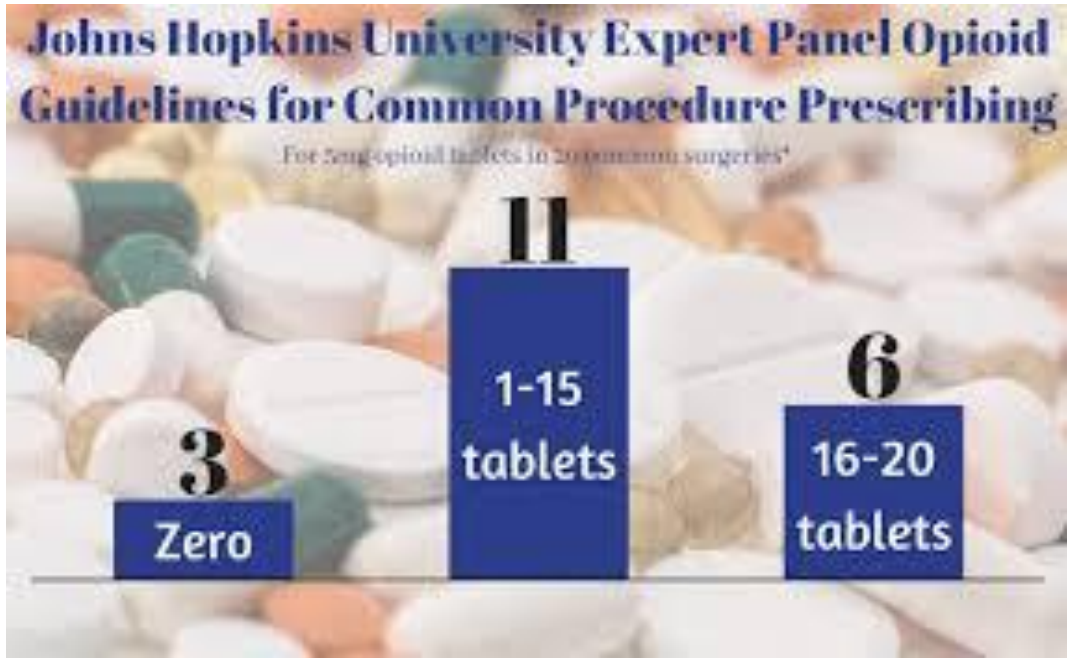
Opioid Analgesics
- Pause opioid pain relievers when starting Bup.
- OK to introduce opioid pain relievers after Bup is started for breakthrough pain. Do not use methadone with Bup.

Supportive Medications
- Can be used as needed while waiting for withdrawal or during induction process.

Pregnancy
- Bup monoproduct or Bup/Nx OK in pregnancy.
- Consider referencing buprenorphine in pregnancy guide.

5.10.19

PROVIDER RESOURCES	California Only	Expert Consultation
	CA POISON CONTROL (24/7) 1-800-222-1222	UCSF Substance Use Warmline (M-F 6am - 5pm; Voicemail 24/7) 1-855-300-3595



The Results

- Prescribing Practices for post op opioid naive patients are quite variable and not always guideline based. There is room for education and accountability.
- BUP Treatment was 1 patient per week in 2017 to approximately 4 per week now. Are we overwhelmed? <1% of patients. Follow-up rate is high, 100% some months with treatment.
- County overdose death rate initially fell 49%, now stable according to Coroner.
- Gaps in the system are revealed when doing the work, now is the time to address gaps as resources are available.
- Running parallel programs is effective.
- Treating OUD as a goal directed program in the hospital helps create a wave of change. People do not realize impacts of programs until results are monitored and shared. This should be done in real time as program progresses.

What did we learn?

- Empower EHR for reports, Pharmacy is great resource
- Paper system with EHR does not work well
- Make it easy
- Lead with evidence and education
- Stigma can run deep
- Not all high-risk patients have a CURES report that is concerning
- Change in treatment creates a wave of change in prescribing and stigma
- Running parallel programs is effective and patient centered.
- Early interdisciplinary education is ESSENTIAL

What can others learn from us?

- Supports continuous QI
- Leadership buy in is ESSENTIAL
- Tracking data supports small test of change, particularly to making clinical workflow changes in response to changes in evidence-based medicine
- Important to integrate this work into larger substance use conversation. We are building infrastructure to address all addiction.
- Surprises at follow-up rate, adherence to program. TREAT FIRST!!!
- Patient Centered approach that REMOVES BARRIERS is GOAL.

“Where the governments see statistics,
I see the faces of my friends.”

Yvette, Raphael, HIV+ since 2000

Questions?

Arianna Sampson, PA-C, APP Lead

Marshall Medical Center, Placerville, CA

Director, CA Rural Bridge Program

Co-Director, CA Substance Use Navigator (SUN) Program

Northern CA Director, CA Bridge Program

Arianna@bridgetotreatment.org

(530)409-3048

Office hours every Tuesday 8:30AM

CA BRIDGE
TREATMENT STARTS HERE

MARSHALL
MEDICAL CENTER

CHAT:
What questions do you have?

Key Points

Wrap up

Webinar Schedule

All calls start at 11:00am PT

Sept. 18 

- **Submit Opioid Safe Hospital Self-Assessment!**

Spring/Summer 2020

- Kickoff year 2

Register at calhospitalcompare.org

Resources & Follow Up Materials

Resources:

About the Opioid Safe Hospital Designation

Frequently Asked Questions

Opioid Safe Hospital Self Assessment

To further accelerate hospital progress, CHC will offer a no cost, 5-part webinar series, with peer-to-peer support, starting May 2019 with the kick-off webinar. The webinar series is designed for Chief Medical Officers, Chief Nursing Officers, Chief Quality Officers, Quality and Emergency Department leadership, and other individuals involved in improving opioid safety. CHC will actively work with Opioid Safe Hospital Program participants to select relevant topics for the webinar series. Registration links below (*please note all webinars are scheduled for 11am PST*):

Webinar #1 (May 9): Addressing California's Opioid Epidemic – Introducing the Opioid Safe Hospital Program

Webinar #1 Recording

Webinar #1 Slide Presentation

Source: *Cal Hospital Compare Website – About – Opioid Care Honor Roll*

Questions?

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Requesting CMEs? Please refer to the CE instructions on our website

Thank you!

Please give us the gift of feedback and complete the event evaluation

Cal Hospital Compare