11-11-2016

An Interdisciplinary Process Change: Conversion of PICC Line Capping Solution From Heparin to Normal Saline

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Prevalence of Prescription Opioid Abuse in Patients With Pain

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Background: Studies showed that 20% to 30% of opioid analgesic drugs prescribed for chronic pain in the United States are misused, while the rate of opioid addiction is approximately 10%. The study describes methods to identify high-risk behavior and forward recommendations to decrease opioid abuse.

Purpose: To assess prevalence and correlate multiple variables with opioid abuse and to forward appropriate recommendations to decrease the prevalence of opioid abuse in the primary care setting.

Methods: A prospective study was conducted at a primary health care clinic, Aurora Sinai Medical Center (Milwaukee, WI). Over 6 months, a total of 49 consecutive patients who take opioids were included in the study. Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), with a cutoff score of 18 (out of 24), is used to screen abuse/aberrant drug use. Additional variables were obtained by patient chart review. Data analysis was done using Minitab analysis software.

Results: A total of 49 patients (23 males, 26 females) were included in the study. Mean age of patients was 45.7 ± 7 years; 22 (44.9%) patients were on hydrocodone, 16 (32.7%) on oxycodone, 7 (14.3%) on tramadol, 3 (6.1%) on fentanyl patch and 1 (2%) on methadone. This means 33 (66.3%) patients were on an opioid other than oxycodone. Of the 16 on oxycodone, 12 were male (52% of gender population) compared to 4 female (15.4% of gender population), P=0.013. Five (10.2%) patients had high SOAPP-R scores; 3 (13%) of the males had a high SOAPP-R score compared to 2 (7.7%) females. Regarding males on oxycodone, 3/12 (25%) had a high SOAPP-R score; 1/4 (25%) females on oxycodone had a high SOAPP-R score. As age increased, the number of male patients using oxycodone trended upward. Older males on oxycodone had a higher SOAPP-R score compared to younger patients. No patient had prescriptions by more than one prescriber; 45 (91.9%) patients had no pain contract. Urine drug screen was done in 11 (22.5%) patients.

Conclusion: Prescription opioid drug abuse is not uncommon in primary care clinics. Use of the SOAPP-R, along with other appropriate patient evaluations, can help primary care providers identify high-risk behavior and decrease opioid abuse.

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Background: Heparin-induced thrombocytopenia (HIT) and HIT with thrombosis syndrome (HITTS) are serious conditions. Patients are at increased risk for developing HIT/HITTS with any exposure to heparin, even intravenous line flushes. Patients may be exposed to heparin multiple times each day when they have a peripherally inserted central catheter (PICC) that is flushed and capped with heparin. At Aurora Health Care, heparin is the standard capping solution for PICCs, but with a recent switch to positive pressurized caps, normal saline may be a capping option that reduces patient exposure to heparin.

Purpose: To reduce heparin exposure at a single hospital by replacing heparin with normal saline (0.9% sodium chloride) as the standard PICC capping solution.

Methods: We implemented an interdisciplinary pilot process change and evaluated whether normal saline was noninferior to heparin for maintaining PICC patency. Primary outcome measurements of patency include alteplase use due to occlusion. Secondary objectives were any change in invasive line infection rates and cost comparisons. The baseline patency rate for the hospital was derived from data extracted through a retrospective chart review from October 2013 through October 2014.

Results: Our baseline patency rate was 65.42% (N=3,095); 33% of all PICC lines placed during the 12-month period were treated with alteplase. Patency rates during our pilot period were based on retrospective chart reviews of patients with PICC lines placed from February to May 2015. During this period, a total of 979 PICC lines were evaluated. Of these, 30.4% were treated with alteplase. This resulted in a pilot patency rate of 69.5%, which is 4.1% greater than our baseline patency rate. Given the prespecified noninferiority margin of 5%, our pilot demonstrates that normal saline is noninferior to heparin for maintaining PICC line patency when used with positive pressurized caps (α=0.05). Although number of infections increased 16%, only 9% with line infections were part of our pilot. The estimated yearly cost of both capping solutions is equal, at approximately $3,960 per our baseline
Cost-Effectiveness of Genomic-Based Warfarin Therapy

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Background: With over 40 years of demonstrated clinical efficacy, warfarin remains the world’s most used pharmaceutical to prevent ischemic stroke in patients with atrial fibrillation (AF). However, warfarin has many challenges. Thus, despite known effectiveness, warfarin is a leading cause to drug-induced morbidity and mortality. Over 50 different warfarin therapy protocols, including a number of pharmacogenomic-based (PG) protocols, with as many as 14 independent variables, have been developed to improve safety and efficacy, thereby reducing ischemic strokes and intracranial hemorrhages (ICH).

Purpose: To conduct a preliminary cost-effectiveness study to determine the price point at which using warfarin PG dosing to prevent ischemic stroke and ICH would provide a neutral cost difference for the AF patient population at Aurora Health Care.

Methods: Using a 15-year retrospective electronic medical record, we generated a large enough simulated AF population using Bayesian Network modeling to conduct a series of simulated warfarin therapies. We used five different PG and non-PG warfarin therapy protocols. The protocols with various levels of personalization used different PG and non-PG dosing algorithms for initial, adjustment and maintenance warfarin dosing. The simulation platform was able to predict daily international normalized ratio values and the rate of ischemic stroke and intracranial hemorrhages (ICH). Algorithms for initial, adjustment and maintenance warfarin dosing. The simulation platform was able to predict daily international normalized ratio values and the rate of ischemic stroke and intracranial hemorrhages (ICH).

Results: Using five different PG and non-PG warfarin therapy protocols. The protocols with various levels of personalization used different PG and non-PG dosing algorithms for initial, adjustment and maintenance warfarin dosing. The simulation platform was able to predict daily international normalized ratio values and the rate of ischemic stroke and intracranial hemorrhages (ICH). Algorithms for initial, adjustment and maintenance warfarin dosing. The simulation platform was able to predict daily international normalized ratio values and the rate of ischemic stroke and intracranial hemorrhages (ICH).

For 1,000 AF patients initiating warfarin therapy in Aurora, switching to a PG protocol would save $55,299.94 in acute care costs and $59,198.50 in 5-year ongoing care.

Conclusion: At a cost of $59.20 per patient, warfarin PG dosing is cost neutral. With substantial decreases in genotype costs in recent years, it is likely this price is currently achievable. Therefore, although there is only incremental clinical benefit from warfarin PG dosing, it is likely cost-effective.

Identifying Disparities in Colorectal Cancer Screening Rates in Milwaukee-Based Academic and Nonacademic Clinics

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Background: The Institute for Healthcare Improvement’s Triple Aim focuses on improving the patient’s experience of care, improving population health and reducing the per capita cost of care. As health care systems and providers continuously seek to improve quality of care through understanding what percentage of their patients are achieving quality-of-care standards for various indicators, including immunizations, tobacco cessation, asthma and cancer screening. As health care moves toward reimbursing for value-based care, deepening our understanding of patient population characteristics within each of these conditions is vital to continuous quality improvement.

Purpose: To determine if there are race/ethnicity/age/preferred language (REAL) disparities in care to patients 50 years old or older who are eligible for colorectal cancer (CRC) screening in family medicine residency clinics.

Methods: A retrospective analysis of all patients eligible for CRC screening at two Milwaukee-based family medicine residency teaching clinics (referred to as FM1 and FM2) and nonacademic clinics in greater Milwaukee (NAC-MKE) during a 12-month period (December 2014 – November 2015) was undertaken in collaboration with health care system quality improvement specialists. Percentage of patients achieving CRC screening metric was reported by REAL and gender. As the ultimate goal was to identify subpopulations to target for improvement, categories with N < 25 were omitted and criterion for disparity within a category was defined as > 10%.

Results: The largest CRC screening disparity was associated with age, with gaps ranging from 13% to 15% between populations > 65 years old versus 50–54 years old: NAC-MKE (79% vs 66%), FM1 (81% vs 68%), and FM2 (80% vs 65%). CRC screening disparities varied by black/African-American race per location, 54% at NAC-MKE and 67% at FM2 (N ≤ 25 at FM1). Other race, ethnicity and gender were < 10%.

Conclusion: For the Centers for Disease Control and Prevention, the African-American/black race has the highest