

MyPractice

General Surgery

A tailored report for quality care

PRIVATE AND CONFIDENTIAL

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Version 1.2

Dr. Sample Physician

Reporting Period: March 31, 2023



**Ontario
Health**

Opioid Dispensing Within 7 Days Postsurgery

Reporting Period: October 01, 2022 - March 31, 2023

Includes opioids dispensed to your patients (i.e., prescribed by you and/or other providers).

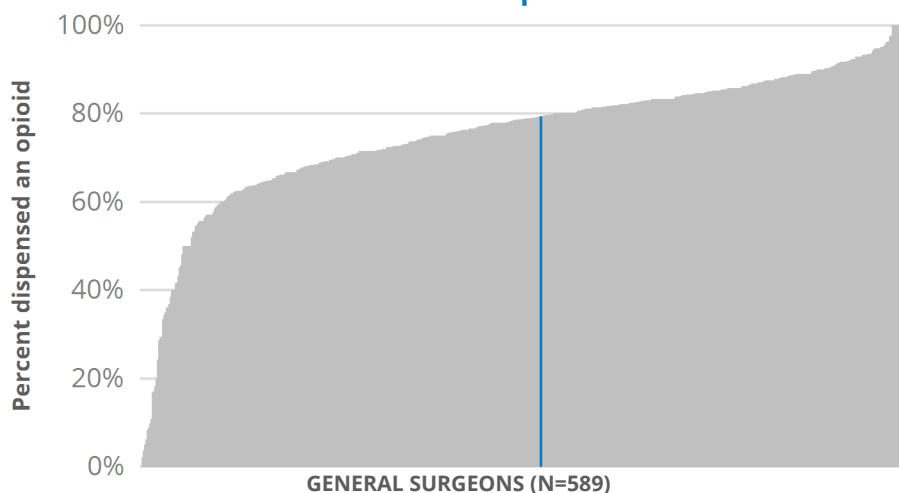
My total cases of laparoscopic appendectomies, laparoscopic cholecystectomies and select hernia repairs¹: **29**
 Excludes patients with pre-operative opioid dispensation²

Percent of patients dispensed an opioid

79.3%

My rate is **higher than** most of my peers

How do I compare?



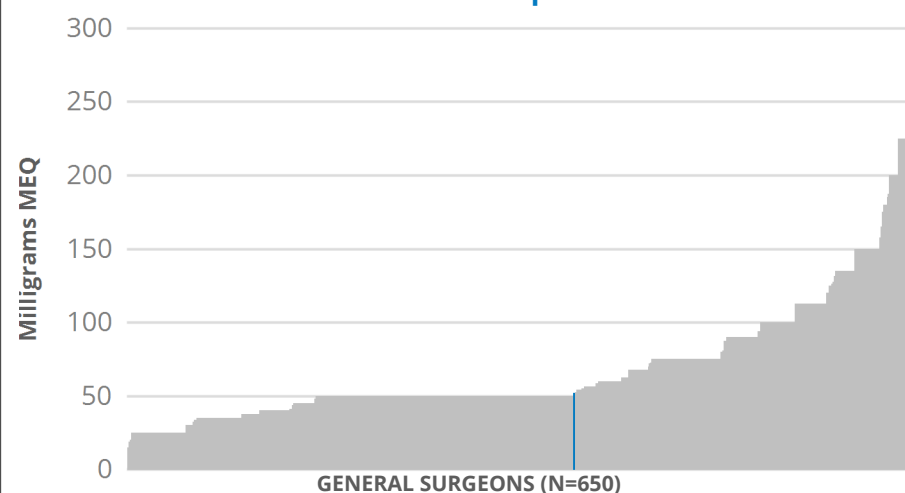
Median dose initially dispensed

11

1 mg pills of HYDROMORPHONE³
 (52 mg MEQ)

My dosage is **similar to** many of my peers

How do I compare?



Note: This graph does not include surgeons with suppressed data or those without any surgeries within the reporting period.

▲ Due to scale limitations, data over 300 mg MEQ is not shown

¹ Only includes outpatient laparoscopic and open inguinal/femoral and umbilical hernia repairs.

² Pre-operative opioid dispensation is defined as having an opioid dispensed with days supplied overlapping the surgical admission date.

³ Your prescription has been converted from the total MEQ (morphine equivalents) dispensed to the most commonly dispensed opioid by you.

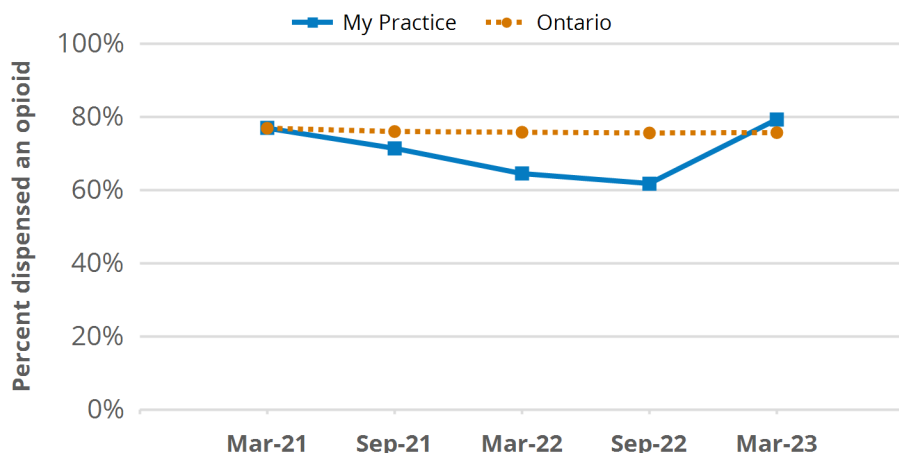
 **How can I improve my pain management and opioid prescribing practices for my patients after surgery?**
 (Please see pages 4 - 5)

Trend Data

Reporting Period: October 01, 2020 - March 31, 2023

Includes opioids dispensed to your patients (i.e., prescribed by you and/or other providers).

Percent of patients dispensed an opioid



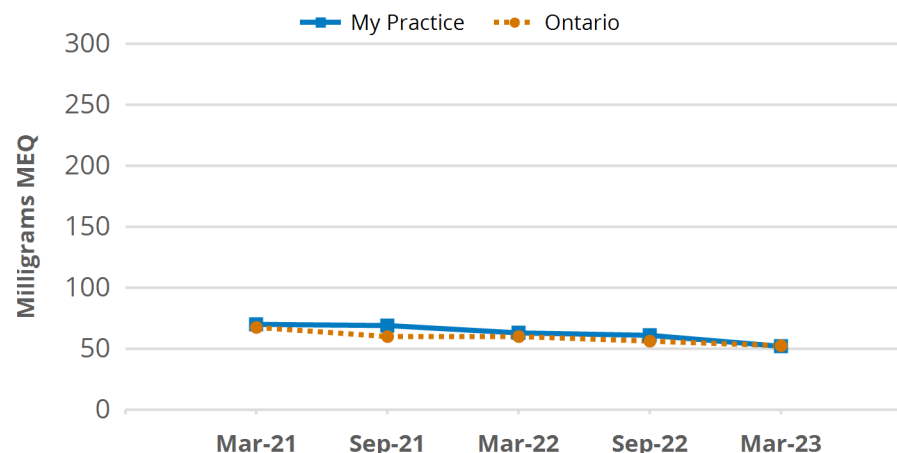
As of March 31, 2023:

- My percentage of patients dispensed an opioid is **79.3%**
- My percentage of patients dispensed an opioid is **higher than** the Ontario percentage of 75.7%

Prescribing Tip

- Consider prescribing nonopioid medications to reinforce the continued use of nonopioid analgesics for postdischarge pain management.
- An example postoperative prescription for pain medication at discharge is included on page 4.

Median dose initially dispensed



As of March 31, 2023:

- My median mg MEQ is **52** for patients dispensed an opioid
- My dosage is **lower than** the Ontario median of 53 mg MEQ

Tip

If patients experience pain beyond the expected recovery period:

- Contact the patient's primary care provider to discuss the patient's ongoing pain management plan.
- Book an early postoperative follow-up appointment (virtual or in person) to reassess that recovery is progressing without complications and to adjust the pain management plan.

Change ideas

Steps you can take to improve your opioid prescribing patterns



1: Create a multimodal pain management plan

- Use non-pharmacological strategies including physical interventions: physiotherapy, rest, ice, and positioning; and psychological interventions: relaxation techniques
- Use nonopioid medications as appropriate (e.g., acetaminophen, NSAIDs, etc.)
- Use opioids only when necessary to provide adequate pain relief



2: Develop a common protocol for prescribing opioids at discharge

Type: One immediate-release opioid

Duration: The shortest duration necessary

Dose: Lowest effective dose of opioid for expected level of pain

Taper: Taper opioids as quickly as possible while continuing nonopioid analgesics

When opioids are prescribed

- Review your patient's medication use over the 24 hours before discharge
- Check [prescription history](#) to avoid duplicate prescriptions, potentially harmful medication interactions, and diversions

Example Prescription (Clarke et al., 2020)

**Use clinical judgement when prescribing opioids for individual patients*

- 1. Acetaminophen** 1 g, PO TID for 7 days then PRN
- 2. Ibuprofen** 400 mg, PO QID for 3 days then PRN
- 3. Morphine** 5 mg tabs, Take 1-2 tabs q4h PRN for a maximum of 3 days. Maximum 4 tablets/day. Dispense quantity: 12 tabs. Prescription expires 30 days after date of issue.

Resources for Prescribers

- Best Practice in Surgery: [Recommended amount of opioid for common surgical procedures \(2020\)](#)
- Ontario Health: [Opioid Prescribing for Acute Pain](#)
- Illinois Surgical Quality Improvement Collaborative: [Prescribing Recommendations \(2020\)](#)
- Michigan Opioid Prescribing Engagement Network (OPEN): [Prescribing Recommendations \(2020\)](#)
- Solving Pain: [A Project by Ontario's Anesthesiologists \(2022\)](#)

Change ideas

Steps you can take to improve your opioid prescribing patterns



3: Inform and educate the patient and caregivers about pain management

As you prescribe opioid medications, discuss the following with your patients/ caregivers:

- The [expected outcomes/milestones](#) with respect to pain management
- The safe storage of unused opioids
- The safe [disposal of unused opioids](#) at any pharmacy
- The benefits and harms of opioid use
- A plan for tapering/discontinuing opioid medication
- A written transition plan that includes appropriate use of opioids when transitioning from hospital to home. For example: [Patient Oriented Discharge Summary](#)

Resources to Share with Your Patients

- Choosing Wisely Canada: [Opioids: When you need them - and when you don't Patient Reference Guide](#)
- Institute for Safe Medication Practices: [Opioids for pain after surgery: Your questions answered](#) and [Safe Storage and disposal information card](#)
- Michigan OPEN: [Mindful Breathing](#)
- Ontario Health: [Opioid Prescribing for Acute Pain](#)
- Find [drop-off location](#) for returning unused medications
- Ontario Health: [Transitions from hospital to home](#) (2020)

Idea for organizational change:

Participate in the Ontario Surgical Quality Improvement Network yearly campaign.

Enhanced Recovery After Surgery (ERAS) is an evidence-based, best practice care model that standardizes care before, during and after surgery, reducing surgical complications and shortening hospital stays. In previous years, the campaigns included emphasis on pain control and helped health-care providers and their patients and caregivers better plan and prepare for surgery together. Find out how you can get started, and download resources [here](#).

Methods

Data sources

Administrative databases that were used to generate this report include: The Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) for inpatient and outpatient surgical procedure data, respectively; the Registered Persons Database (RPDB) for patient demographic and vital statistics data; the Ontario Health Insurance Plan (OHIP) database for physician billing claims data; and the Narcotics Monitoring System (NMS) for opioid and Opioid Maintenance Treatment dispensing data.

General surgeries that were included in the report

Laparoscopic appendectomies; laparoscopic cholecystectomies; and inguinal, femoral or umbilical hernia repairs performed at outpatient settings, with either open or laparoscopic approach.

Identifying your patients

To identify the patients you have cared for, your College of Physicians and Surgeons of Ontario (CPSO) number was used to link to health care administrative databases housed at ICES. First, the surgical records were extracted from the DAD and NACRS by using intervention codes. Then a set of surgical fee codes from OHIP were used to link with patient's inpatient and outpatient data to identify the surgeon who performed the procedure and to narrow down hernia repairs to inguinal/femoral and umbilical cases.

To facilitate a fairer comparison between surgeons, we have excluded patients with the following conditions from the analysis: patients staying in hospital for 7 days or longer; patients who had prior opioid dispensed with day supplies overlapping with the admission date; palliative care patients; patients having Opioid Maintenance Treatment within 30 days prior to admission; and patients with the most responsible diagnosis as primary or secondary malignant neoplasm on their surgical procedure records.

Indicator calculation

Patients' initial opioid dispensation within 7 days post-surgery was linked to their surgical procedure records to define the following indicators: 1) The percentage of patients receiving at least one opioid dispensation within 7 days post-surgery among all patients with the selected general surgeries during the reporting period; and 2) the median dose of initial opioid dispensation in patients with opioids dispensed during the reporting period. To facilitate comparisons, the opioid dose was converted to the morphine equivalents (MEQ). This MEQ was then translated to the number of pills of the most commonly dispensed opioid by you for easy interpretation.

For a complete list of databases used, details about cohort inclusions/exclusions, and how each indicator is calculated, please refer to the [Technical Appendix](#).

Data Interpretation Considerations

Opioid dispensation data from the NMS

The opioid data presented in this report are derived from the NMS which contains dispensing related information. Opioids administered during hospitalization are not captured in the NMS. Patients who receive opioid prescriptions from their healthcare providers, but do not have the prescription dispensed are not captured in the NMS. Also, the NMS dataset captures dispensing but not administration/use of opioids or the appropriateness/reasons for the dispensing.

Data reported at aggregated level for the three surgeries

In consultation with our Scientific Committee, we have included only general surgeries that were considered lower risk and quick recovery. Our provincial level analyses showed that the proportion of patients with an opioid dispensed within 7 days post-surgery and the median dispensed dose in patients had relatively small variations among the selected appendectomy, cholecystectomy and hernia repair procedures. In addition, the recommended opioid doses for the three procedures are similar. As such, the indicator results are aggregated and reported for the three procedures. Further investigation will be conducted to evaluate the usefulness and feasibility of reporting the indicators by procedure type.

Risk factors that may impact the post-operative opioid prescribing

As mentioned above, certain exclusions have been applied to the cohort in an effort to create a homogeneous patient group for fair comparisons between surgeons. However, the current administrative databases do not have the full information on all pre-existing conditions/factors which may impact post-operative opioid prescribing. As such, it is challenging to assess the appropriateness of opioid prescriptions. Surgeons are encouraged to use their local data and supports to explore opportunities for improvement.

Data suppression

Data are suppressed or additionally suppressed as per ICES' privacy policy for the following reasons: (a) Counts or summary statistics are between 1 and 5; or (b) To prevent residual disclosure of suppressed values.

Data timeliness

Data included in this report are not as current as would be preferred. However, they do provide a snapshot of your performance at a moment in time and a comparison to your peers for context. While Ontario Health and our partners are always looking for ways to provide more timely data, we encourage you to also use local data sources to track and measure your progress.

Participation and Confidentiality

You are receiving this report because you have registered at Ontario Health's website. Your *MyPractice* report will only be sent to the hospital affiliated or validated email address you provided upon registration and will not be shared with others, including other agencies, the college, surgeon groups, or other members of your surgical team.

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About ICES

This work was supported by ICES, which is funded by an annual grant from the Ontario Ministry of Health. The opinions, results and conclusions reported in this document are those of the authors and are independent from the funding sources. No endorsement by ICES or the Ontario Ministry of Health is intended or should be inferred. Parts of this material are based on data and information compiled and provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the authors, and not necessarily those of CIHI.

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