OPMP content were more beneficial for increasing engagement than weekly text, email, or phone communications. Future clinical strategies for increasing client engagement in OPMP might include requiring in-person meetings versus remote communication with a health coach.

3A Current Opioid Use State: Use/Misuse and Abuse
Pamela Geyer JD, RN-BC, CFN, FACFE, DABFN. *Henry Mayo Newhall Hospital*

The presenter will provide attendees data for the current state of opioid prescribing in the United States. Data compiled from regulatory bodies will include the CDC/HHS/DOJ/DEA and others. Identification of PDMP programs and impact will also be covered. The presentation will provide information on determining how to share information and educate providers across the spectrum to assist in the reduction of opioid deaths caused by overdose from prescription pain medications. The presenter will provide an introduction of functional pain assessment and evaluation of importance as well as information on evaluating changes to current practice required to reduce loss of life.

3B New Strategies in Opioid Stewardship
Christina Marie Wiekamp APRN, CNS, ACHPN,
Yleana T. Baggenstos PharmD, BCPS, CPE. *HealthEast*

This program was designed to address the prevalent issues related to opioid use in the hospital. The idea was to introduce and reinforce an opioid stewardship program. The program has been running since 7/26/17. Pharmacists and APRN met once a week to build the program and work out the components of the program, technologically and logistically. The pharmacists review obtained computer generated reports to screen for potential problems with opioid therapy. The health care providers continue to provide high level stewardship tracking, comprehensive medication review, and then provide reccomendations (to possible change bowel meds, lab monitoring, chemical dependency, psychiatry, psychology, acupuncture, massage, anesthesia, ortho, neuro, or palliative care involvement). A primary goal of the program is to reduce medication associated events and improve pain control. The pharmacists and APRNs continue to be involved in comprehensive opioid reviews and pain consults separately.

3C Pediatric Chronic Pain and Opioids
James M. DeMasi RN, CPNP-AC/PC,
Molly M. Kroschewsky PA-C. *Children's Medical Center of Dallas*

Chronic non-malignant pain (often defined as persistent and recurrent pain) in children and adolescents is a significant problem worldwide with prevalence rates reported as high as 35%. Untreated persistent pain may lead to significant pain-related disability, emotional disturbance, and poor school performance. These patients frequently have seen many specialists and have been placed on a multitude of medications, opioids included, without relief. However, use of opioids for non-malignant chronic pain is not supported in the pediatric literature except in limited circumstances or as part of a structured treatment plan. There is growing consensus that treatment should be focused on a multidisciplinary, multi-modal approach and some centers are reporting success while attempting to maximize the likelihood of improved outcomes. The most common chronic conditions seen are musculoskeletal pain, headaches, back pain and abdominal pain. Management of pain in this population does require an appreciation of ongoing assessment identifying the presence and severity of pain in the individual while having skills with a utilization of a multi-modal approach. Left untreated, these young people will often go on to have issues as adults that may lead to chronic disability, suboptimal functionality, and an overall decreased quality of life. The presentation will present some of common problems managed at The Children's Medical Center of Dallas Center for Pain Management, discuss the multi-modal approach currently utilized in practice, and attempt to answer the following questions: 1) should opiates be prescribed for children with chronic non-malignant pain, 2) if yes, what screening is required in this age group, and 3) will the opioid epidemic have any impact on prescription practices moving forward on patients who have chronic non-malignant pain?

3D Ready, Set, Get Published!
Patricia Bruckenthal PhD, APRN-BC, FAAN. *Stony Brook University School of Nursing*
Elaine T. Miller PhD, RN, CRRN, FAAN, FAHA. *University of Cincinnati, College of Nursing*

Pain management nurses are in a unique position to extend what we know to others about expert care and practice. This session will facilitate participants in bringing their clinical ideas, quality improvement or evidence based projects, or research study results to publication. The Editors of Pain Management Nursing will review the process of developing a publishable manuscript and experts from the editorial board will provide small group mentoring. Participants will be asked to bring an idea, outline or rough draft for a manuscript. Mentors will work on framing an idea, outlining a manuscript, conducting a literature search, and actual writing skills. All participants will leave the session with “next steps” toward publication and a writing mentor contact.

3E.1. A Multimodal Approach to Postoperative Pain Management after Spine Surgery: The Back-Up Plan
Donna M. Mangruen MSN, RN, APN, ACNS-BC, CMSRN. *Advocate Condell Medical Center*

AIM OF INVESTIGATION
Life is not without pain. In fact, 100 million Americans suffer from chronic pain (National Institute of Health, 2011). Back pain ranks high among the offenders. According to the National Institute of Neurological Disorders and Stroke (2014), approximately 80 percent of adults will have some form of back pain. Although many may recover, others must undergo various medical treatments before surgical intervention becomes a viable solution for relief. Surgical interventions however, are not without risk. These include but are not restricted to more pain, surgical site infection, cardiac and pulmonary complications and even unrealistic patient expectations. Strategies to minimize surgical complications associated with colorectal and total joint arthroplasty surgery have proven to be most effective through programs that optimize patients' physiological status by “Enhancing Recovery After Surgery” (Carli, 2014). It is to this end that the surgical team approach to advanced recovery (STAAR) for lumbar spine surgery was developed. The purpose of the STAAR Program was to explore the benefits of applying an evidenced based, standardized care pathway to patients undergoing lumbar spine surgery.

METHODS
Prospective data collection regarding early mobilization, average pain scores, complications, length of stay and patient satisfaction of the STAAR pathway group will be compared to patients who received the traditional medical management based on retrospective chart reviews.

RESULTS
It is postulated that STAAR pathway patients will have more favorable outcomes including pain management than those treated by traditional methods.

CONCLUSIONS
The efficacy of applying a standardized, evidenced based approach to patients undergoing spine surgery may be most advantageous in effectively managing postoperative pain, minimizing complications and increasing patient satisfaction.

3E.2. The Effect of an Enhanced Recovery Protocol in Bariatric Surgery Postoperative Pain
Brittani A. Seagren DNP, APRN-NP, FNP-C, RN-BC. *Riverside Medical Group*

Pain management in bariatric surgery patients is challenging because of multiple factors including chronic pain conditions, perception differences, and varied impacts of pain medications. As a result, postoperative pain tends to be poorly managed leading to increased opiate consumption in this population (Raebel et al., 2013). The enhanced recovery protocol is a newer multimodal postoperative management protocol with demonstrated improved pain control in abdominal surgery patients (Thompson et al., 2012). It has also been shown to be safe in bariatric surgery patients

(Awad et al., 2012). In order to study its effects as a pain management protocol in bariatric surgery patients, a retrospective chart analysis was completed of 285 bariatric surgery patients at a Midwestern hospital. Statistical analysis comparing surgical patients from October 1, 2015 to March 31, 2016 (Traditional Recovery) to patients from April 1, 2016 to September 30, 2016 (Enhanced Recovery) demonstrated a nonsignificant decrease in average pain scores (pre vs post, $p>0.05$). There was a statistically significant decrease in the length of stay in the enhanced recovery patients, compared to the traditional recovery group ($p<0.05$). While there was no statistically significant change in HCAHPS scores, there were noticeable increases in satisfaction for enhanced recovery patients. Due to the homogeneous nature of the samples, it is thought that much of the change was due to the protocol. However, there was no analysis of rates of chronic pain conditions between populations, which could have impacted the findings.

3E.3. Cognitive Behavioral Therapy for Spinal Cord Injury Patients with Chronic Neurogenic Pain

Judith Salazar BSN, RN, CHPN-BC. *Rancho Los Amigos National Rehabilitation Center*

The incidence of neuropathic pain after spinal cord injury (SCI) has been estimated at 75%. A common treatment for this pain is often ongoing opioid prescription medication despite limited evidence that these medication are effective for neurogenic pain. Recognizing the need to decrease the number of patients with SCI on continuous opioid medications, the often overlooked approach of Cognitive Behavioral Therapy (CBT) was tested in a group of six patients.

METHODS

A pilot group was started with 6 SCI patients, these patients were chosen due to their history of frequent requests for escalating doses of opiates and early refills. Outbursts of verbal abuse and threats against staff were common. The group met every two weeks and was led by a Pain Resource Nurse and Physician Assistant. Activities included guided imagery, meditation, and education about pain, pain medications, and other non-pharmacological pain management techniques.

RESULTS

Requests for early refills still occurred however, the patients handled this in a more appropriate manner by calling ahead of time and and discussing the issue with the Pain Management Nurse, this intervention provided an outlet to discuss the reasons for the need for the early refill and develop a plan for managing the pain without the early refill. Episodes of behavioral outbursts aimed at staff decreased and self-management of chronic pain symptoms was evident. Data from the Brief Pain Inventory assessment tool showed improvement in “pain at its worst in the last 24 hours” from an average of 9.75 at group initiation to 7.2 at four months post. Conclusions CBT is a beneficial tool for management of chronic pain in a small group of patients with SCI. It may not be as effective with larger groups.

4A Patient and Prescriber Anxiety about Benzodiazepines Combined with Opioids: Alternatives for the Non-Psychiatric Practitioner

June E. Oliver RN-BC, MSN, CCNS, APN/CNS. *Swedish Covenant Hosptial*

With the rise of public and professional attention on opioid overdose deaths, benzodiazepines (BZDs) have emerged as a significant risk factor for fatal overdose when combined with opioids. Studies vary in calculating a 4 to 10 fold increase in risk of death with combined opioids and benzodiazepines. At the same time, anxiety is a common comorbidity in chronic pain patients- as well as in many patients recovering from acute pain episodes. Side effects and risks of BZDs alone and in combination with opioids is explored in this session, along with recommendations for anxiety management including non-pharmacologic interventions and pharmacologic therapy with non-BZD medications. Understanding these principles can aid the pain management practitioner in communicating BZD risk and safer alternatives to patients and in discussion with other healthcare prescribers to foster a safe and effective team approach addressing the patient's physical and psychological needs.

4B Chronic Opioid Therapy in Persistent Pain: Patient Selection and Risk Reduction Strategies

Michelle M. Lavelle-Henry RN-C, MSN, APRN, CNP. *Fairview Ridges Hospital*

The aim of the presentation is to review safe opioid prescribing in the patient population of persistent chronic non-cancer pain within the CDC Guidelines for Prescribing Opioid. The method utilized is a convenience sample of subjects in a community based Comprehensive Pain Clinic. During the initial interview all patients were screened for comorbid conditions that increase the risk of unintended opioid overdose. In addition, current opioid analgesia, current medication list and prior pain therapies were reviewed. All patients, if on opioids, were assessed for dose lowering strategies. A particular emphasis was placed on patients at risk for adverse events related to opioid use, those with a morphine equivalent dose (MME) greater than 80 mg per day and patients that were pain treatment naïve. Patients with substance use disorder were excluded and referred for treatment. Patients agreeable for opioid lowering strategies were tapered at 10-15 % every 1-2 weeks while incorporating multimodal analgesia, physical reconditioning and cognitive behavioral therapy as indicated. The results of the study suggest that patients whose opioids were tapered to goal of less than or equal to 80 mg MME demonstrated an improvement in pain control and quality if life. In conclusion, patients with chronic persistent non cancer pain on opioid therapy, have better quality of life and less pain with opioids at less than or equal to 80 MME. The risk of unintended opioid related events are further reduced while incorporating strategies that look at patient selection with and implementing non opioid treatment strategies Opioid tapering at 10-15 % is safe, effective and well tolerated. Future studies to replicate these results should continue. Application of this study, can not be generalized to the primary care. Future study within primary care that targeting early intervention to prevent high dose opioid therapy should be considered.

4C Reducing Unintended Variation in Discharge Opioid Prescribing in a Pediatric Hospital Setting

Benjamin Bernier MSN, RN, CCRN, Sara Hahn MSN, RN. *Children's Hospital Colorado*

BACKGROUND AND AIM

In 2017, Children's Hospital Colorado finalized a clinical pathway to reduce unintended variation in opioid prescribing for pediatric patients with acute pain. Subsequently, the team aimed to analyze baseline prescribing data for Orthopedic Surgery inpatients and to design an improvement project to implement the pathway's recommendations. The improvement project will launch in early 2018 to increase compliance with the clinical pathway's recommendation to limit discharge prescriptions to a maximum of 7 days.

METHODS

A multi-disciplinary team conducted a retrospective review of prescribing data from January to December 2017. Based on the data, the team designed an improvement project to facilitate implementation of the clinical pathway at the bedside. Improvement strategies included dissemination of the pathway, enhanced substance use risk screening by nurses, EMR-based clinical decision support tools, education materials for patients/caregivers and pharmacist review of discharge opioid prescriptions exceeding 7 days.

RESULTS

At baseline, 1190 Orthopedic Surgery patients were discharged with opioids. The median patient age was 11, 48% were female and 26% were Hispanic/Latino. Patients were discharged with an average of 7.75 days' supply of opioids, with a range of .04 to 58 days prescribed. 51% ($n = 602$) of discharge prescriptions followed the recommended 7-day maximum. The pilot project will launch in March 2018 and aims to increase compliance with the 7-day maximum to 75% by July 2018. Outcome data will be available to report at the conference.

CONCLUSIONS

The clinical pathway and improvement project are innovative strategies for appropriate utilization of opioids for acute pain in pediatric patients. The pilot will expand to other departments in 2018. The initiative also highlights lessons for other healthcare entities, including: (1) building an