Compass SHARP

Perioperative Opioid Stewardship Playbook

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COMPASS HEALTHCARE COLLABORATIVE
EPIFLUENCE, LLC

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INTRODUCTION

The Compass SHARP Program

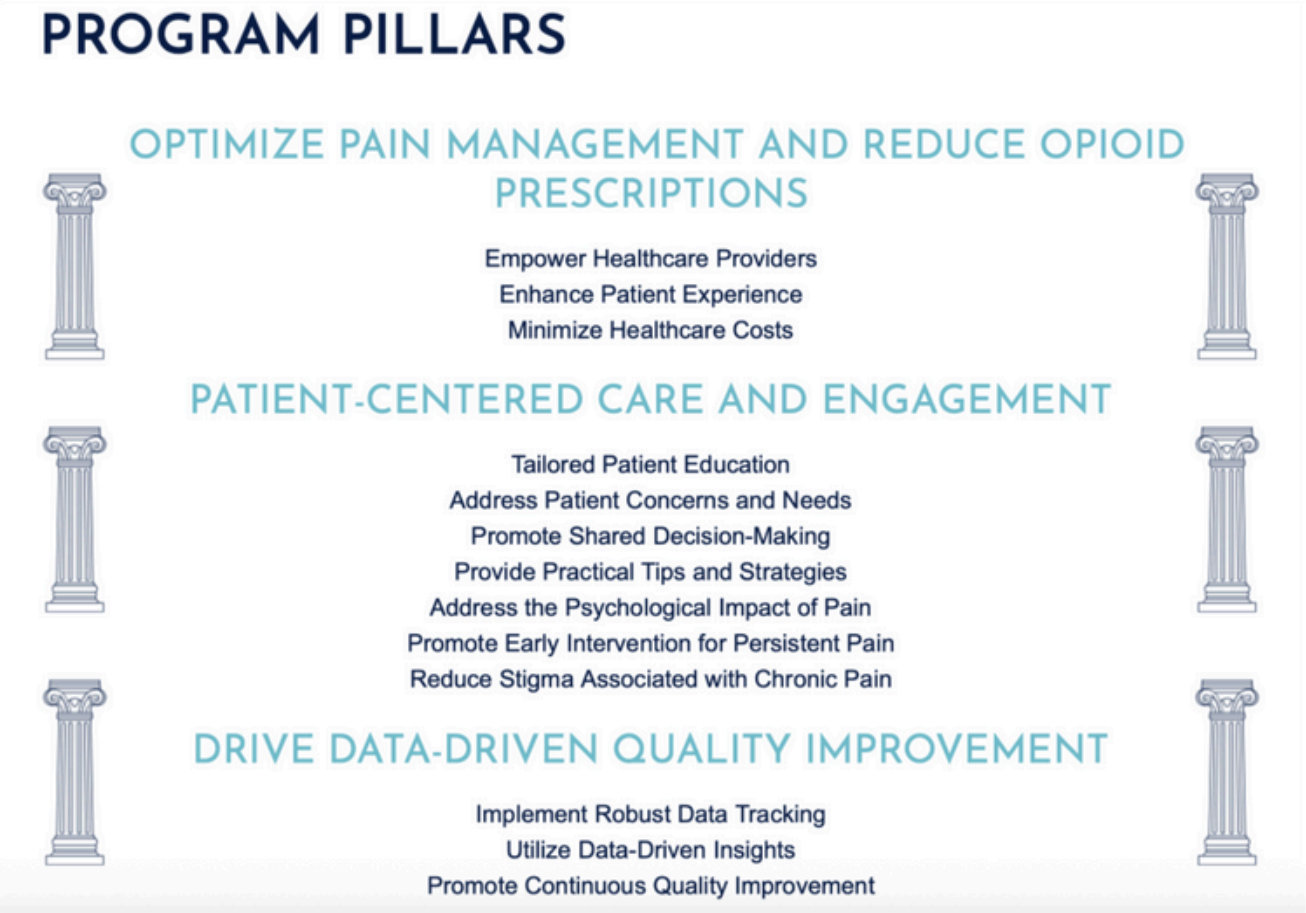
Welcome to the Compass **S**urgical & **H**ealthcare **A**lliance for enhanced **R**ecovery & **P**ain management (SHARP) Perioperative Opioid Stewardship Playbook. This guide was created to support safer, more effective pain management for patients undergoing surgery. Whether you are a patient preparing for a procedure, a nurse providing bedside care, a provider making clinical decisions, or a quality improvement leader driving system change—this playbook is for you.

Compass SHARP is a multidisciplinary partnership between the **Compass Healthcare Collaborative** and **Epifluence**, sponsored by **Iowa Health and Human Services** to provide Iowa surgical providers, clinical teams, and patients with free perioperative opioid stewardship education and resources. SHARP integrates national guidelines, real-world data, and patient-centered strategies to support every phase of care: preoperative, intraoperative, and postoperative.

This playbook is organized into four tailored sections for each discipline:

1. **Patients** will find clear, compassionate guidance on what to expect before, during, and after surgery—including pain management options, safe use of medications, and how to advocate for their needs.
2. **Providers** will find clinical recommendations, prescribing guidelines, and protocols for managing complex cases, including patients on chronic opioids or medications for opioid use disorder (MOUD).
3. **Nurses** will find practical tools for screening, education, and communication, along with strategies to reduce stigma and support shared decision-making with patients.
4. **Quality Improvement Teams** will find implementation tools, data dashboards, and PDSA cycle examples to support sustainable change and meet accreditation standards.

Compass SHARP is built on the belief that safer pain care is possible—and that every member of the care team has a role to play. By working together, we can ensure that patients receive the right care, at the right time, with the right tools to recover safely.



SECTION 1

For Patients

As a patient, surgery can be a big moment in your life. You may feel nervous about pain, unsure of your medications, and anxious about your recovery. This guide is here to help you understand what to expect and how to work with your care team to stay safe and comfortable.

The Compass SHARP program helps patients and their providers make smart choices about pain management—especially when opioids are involved. Whether you've never taken opioids or have used them for a long time, this guide is for you.

Introducing Tom

Tom Bowen is a pain advocate, educator, author, and self-management pundit. He actively shares what he has learned from his own surgery, his 15-plus-year personal journey with pain, and his time at a 3-week interdisciplinary pain rehabilitation program.

Getting Ready for Surgery (Preoperative Phase)

Prehabilitation: Preparing Your Body and Mind

Getting ready for surgery isn't just about showing up on the day. You can help your body heal faster by preparing ahead of time. Many times, surgeries are planned well in advance, giving you time to make these adjustments. This is called **prehabilitation**.

Here are some things you can do:

- **Stay active:** Gentle movement like walking, stretching, or light exercise helps your muscles and heart stay strong.
- **Eat healthy foods:** Good nutrition gives your body the fuel it needs to recover.
- **Sleep well:** Rest helps strengthen your immune system and lowers stress.
- **Practice relaxation:** Deep breathing, meditation, or listening to calming music can help you feel more in control.

Tips from Tom

"What you do before surgery can affect your outcome and your recovery. While it's normal to be anxious, stay calm and think positively, expecting the best. Create a picture of success in your mind."

Ask your care team if there are special exercises or tips they recommend before surgery.

This short video can help you get started preparing for surgery:
Preparing for Surgery

Planning Your Pain Management

Before surgery, your care team will talk with you about:

- Your health history
- Any pain you already have
- Medications you take, including opioids
- What has worked or not worked for you in the past

This is called **shared decision-making**. It means you and your team make choices together. You'll talk about:

- Whether opioids are needed
- Non-opioid options like acetaminophen, ibuprofen, nerve blocks, or ice packs
- What to expect after surgery

You can ask:

- Will I need opioids? If yes, for how long?
- What are the risks?
- What are my other options?
- How do I safely store and get rid of leftover pills?

Tips from Tom

"Make a prioritized list of topics/questions you want to cover at the appointment. Arrange for a family member or another trusted support person to accompany you to your appointments as a second set of ears and to take notes."

During Surgery

What Happens in the Operating Room

Your surgical team will use special techniques to help reduce pain:

- **Multimodal pain control:** Using different types of medicine together
- **Regional anesthesia:** Numbing a part of your body with a nerve block
- **Non-opioid medications:** Like acetaminophen or anti-inflammatory drugs

These choices help lower the need for opioids and support faster healing. You may not be awake for these decisions, but your preferences shared before surgery will guide the team's choices.

This short video can help you understand pain better: **What is Pain?**

The 5 Medicines:
1. Mind is Medicine
2. Movement is Medicine
3. Sleep is Medicine
4. Knowledge is Medicine
5. Medicine is Medicine

After Surgery (Postoperative Phase)

Managing Pain Safely

After surgery, you may feel sore or uncomfortable. Your care team will help you manage pain with:

- Non-opioid medications
- Short-term opioids (if needed)
- Self-management tips for rest, movement, and comfort

What happened to Tom?

Tom was prescribed opioids after surgery for short-term pain relief. When the pain didn't go away, his opioid medication was continued and his pain became a chronic issue.

You'll get instructions on how to take medicine safely and how to taper off opioids if they're prescribed.

Learn more about managing pain after surgery, by watching these short videos:

Postoperative Pain: Pharmacologic Treatments

Postoperative Pain: Non Pharmacologic Treatments

Tips from Tom "Take opioids as prescribed for severe pain while healing that isn't managed by other non-opioid strategies, knowing that zero pain isn't always possible."

How Much Medicine Will I Need?

Compass SHARP uses guidance from **Michigan OPEN**, a research group that studies how much pain medicine people really need after surgery. Their goal is to help doctors prescribe the right amount—not too much, not too little.

Here's a chart showing typical opioid needs after common surgeries:

Procedure	Typical Days Supply	Typical # of Pills
Gallbladder Removal	0-3 days	0-10 tablets
Hernia Repair	0-3 days	0-10 tablets
Breast Surgery (Mastectomy)	3-5 days	10-15 tablets
Cesarean Section	3-5 days	10-15 tablets
Knee Replacement	5-7 days	15-20 tablets

These numbers are based on real patients. They help prevent overprescribing, which can lead to leftover pills and safety risks. Your doctor will adjust based on your needs.

You can find more information on managing pain after surgery with opioids here:

Managing Pain After Surgery With Opioids

If You Take Opioids for Chronic Pain

If you live with chronic pain or take opioids regularly, surgery may feel complicated. You might worry about being judged or not getting enough pain relief.

Your care team is here to support you and will:

- Respect your experience
- Avoid assumptions
- Work with you to adjust your pain plan
- Make sure your regular medications are continued safely

You deserve care that is kind, safe, and based on your needs.

Learn more about opioid medications by watching this short video:
Understanding Opioids

Tom's thoughts about chronic opioid needs

"While some patients with chronic pain may report short-term improvement with opioids, evidence of long-term benefits is limited. The use of opioids is a shared provider-patient decision based on risk and reward. If the decision is to reduce or stop opioid therapy, tapering should be done with education about the benefits of opioid reduction and provider oversight. If the decision is to use opioids, they should be prescribed at the safest, lowest dose. Either decision should include pain rehabilitation and self-management strategies. Fortunately, for many patients, there is no increase in pain (or even less pain), improved function, and better quality of life after tapering off opioids."

Naloxone: A Safety Tool

If you go home with opioids, your care team may offer **naloxone**. Naloxone is a medicine that can reverse an opioid overdose. It's safe, easy to use, and can save lives.

You should consider having naloxone if:

- You take opioids regularly
- You are prescribed opioids after surgery
- You live with someone who takes opioids

Ask your provider:

- Can I get naloxone?
- How do I use it?
- Where should I keep it?

Tips from Tom

"Accidental prescription opioid overdose is a real risk. Naloxone is a good safety net. Follow your doctor's instructions."

Having naloxone is like having a fire extinguisher—it's there just in case.
Learn more about naloxone and how to use it: **Naloxone and Overdose**

Other Ways to Manage Pain

You don't have to rely only on medicine. These tools can also help:

- Ice or heat packs
- Gentle movement or walking
- Breathing exercises
- Distraction (music, TV, puzzles)
- Support from family or friends

Talk to your care team about what works best for you. They may also suggest physical therapy, massage, or other treatments.

Tips from Tom

"Remember that the goal of pain management is not to get rid of all the pain, but to make it easier for you to move, rest, and heal after surgery. Using self-management strategies, like those listed here, can help."

Your Role in Recovery

You are the most important part of your care team. By asking questions, sharing your concerns, and following your plan, you help make your recovery safer and smoother.

Tips for Success

- Keep a pain journal to track your symptoms
- Follow your medication plan closely
- Reach out if something doesn't feel right
- Use support services if you need help

APPENDIX 1

Patient Resources

- **Full patient toolkit**

- **Educational Handouts:**
  - Understanding Pain
  - Getting Ready for Surgery
  - Managing Pain After Surgery
  - Managing Pain After Surgery With Opioids
  - Tapering Opioids Before Surgery
  - Naloxone and Overdose
  - Safe Storage and Disposal

- **Procedure Specific Pain Management Guides:**
  - Laparoscopic Cholecystectomy
  - Sinus Surgery
  - Joint Replacement Surgery
  - Hernia Repair
  - Orthopedic and Sports Medicine
  - General Abdominal Surgery

- **Educational Videos:**
  - What is Pain?
  - Understanding Opioids
  - Preparing for Surgery
  - Postoperative Pain: Pharmacologic Treatments
  - Postoperative Pain: Non Pharmacologic Treatments

- **Microlearning Series**

SECTION 2

For Providers

The Compass SHARP program was developed to support clinicians in delivering safer, more effective perioperative pain care. As opioid-related harms continue to impact surgical populations, providers are uniquely positioned to lead change through evidence-based prescribing, patient-centered communication, and system-level stewardship. This section offers practical guidance for surgeons, anesthesiologists, advanced practice providers, and perioperative teams. It draws from national guidelines, institutional protocols, and real-world implementation data to support safer prescribing, reduce variation, and improve outcomes across the surgical continuum.

Meet Dr. Jennifer Hah, MD, MS

Dr. Jennifer Hah is triple-board certified in anesthesiology, pain medicine, and addiction medicine, and serves as Associate Professor in the Division of Pain Medicine at Stanford. She leads NIH-funded clinical trials identifying risk factors for persistent postoperative pain and opioid use and studies interventions to improve postoperative pain. She is the PI of the SPARKLE (Stanford Pain Alleviation through Research and Knowledge for Long-term Efficacy) Lab also studying the mechanisms of neuromodulation and imaging biomarkers of pain. As Co-director of the Stanford Pelvic Pain Program and a Certified Interventional Pain Sonologist, she has spent over 15 years educating clinicians in ultrasound-guided interventions and evidence-based pain treatments.

Key Concepts from Guidelines

Compass SHARP is grounded in recommendations from the CDC, SAMHSA, the ERAS Society, and the Joint Commission/ Det Norske Veritas (DNV). These guidelines emphasize the importance of multimodal analgesia, opioid risk screening, shared decision-making, and continuity of care for patients on medications for opioid use disorder (MOUD). The CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain encourages individualized care, non-opioid therapies as first-line treatment, and careful tapering when opioids are used. SAMHSA's TIP 63 outlines best practices for managing MOUD in surgical settings, including the continuation of buprenorphine and methadone perioperatively. The Joint Commission's NPSG.03.05.01 calls for opioid stewardship programs that include education, monitoring, and safe prescribing policies.

Compass SHARP integrates these principles into a cohesive framework that supports clinicians in making informed, consistent decisions across preoperative, intraoperative, and postoperative phases.
See full SHARP **Guidelines on Limiting Opioid Use in the Perioperative Setting**

"The landscape of perioperative pain management has quickly evolved in response to the opioid crisis and now more than ever, clinicians have many tools to optimize pain management for patients undergoing surgery. We've consolidated the latest evidence base into educational content that is easy to access and recall. Our hope is that this educational resource may guide implementation of new perioperative pain management strategies and also reaffirm your current, cutting-edge clinical practice."- Dr. Hah

Top 10 Clinical Recommendations

1. **Screen all surgical patients for opioid use and risk factors preoperatively**. Use validated tools to assess current use, history of substance use disorder, and psychosocial risk factors. Document findings in the EHR and flag patients who may benefit from additional support.
2. **Use multimodal analgesia as standard practice.** Combine non-opioid medications (e.g., acetaminophen, NSAIDs), regional anesthesia, and non-pharmacologic strategies (e.g., physical therapy, cognitive behavioral therapy) to reduce reliance on opioids.
3. **Avoid opioid monotherapy for postoperative pain.** Opioids should be used only when necessary and always in combination with other modalities.
4. **Right-size opioid prescriptions using Michigan OPEN data.** Reference procedure-specific guidelines to determine appropriate days supply and pill count. Avoid default prescribing and tailor to patient needs.
5. **Continue MOUD (buprenorphine, methadone) unless contraindicated.** Coordinate with addiction medicine and pharmacy to ensure uninterrupted treatment and avoid withdrawal or relapse.
6. **Co-prescribe naloxone for patients prescribed opioids.** This especially holds true for high risk patients, such as those on high-dose opioids, concurrent benzodiazepines, or with a history of substance use disorder.
7. **Document personalized pain management plans in the EMR.** Include medication reconciliation, tapering strategy, and patient education notes.
8. **Educate patients on safe use, storage, and disposal of opioids.** Provide written instructions and reinforce during discharge planning.
9. **Use shared decision-making to guide prescribing.** Engage patients in discussions about risks, benefits, and alternatives. Respect their preferences and concerns.
10. **Track prescribing trends and outcomes through PDSA cycles.** Use data to identify variation, improve protocols, and meet accreditation standards.

Opioids vs. Opioid Alternatives

Alternatives to opioids (ALTOs) are central to the Compass SHARP multimodal analgesia strategy, which emphasizes targeting multiple pain pathways simultaneously to reduce reliance on opioids and improve patient outcomes. ALTOs encompass a range of pharmacologic and non-pharmacologic interventions that act synergistically to manage surgical pain effectively.

Meet Rachael Duncan, PharmD

Rachael is a clinical pharmacist, board certified in pharmacotherapy. She specializes in opioid stewardship best practices, pain management strategies that emphasize "alternatives to opioids" or ALTOs, and overdose prevention. Her clinical practice is at a critical access hospital.

Pharmacologic ALTOs

These agents are selected for their ability to modulate pain through distinct mechanisms, allowing for additive or synergistic effects when used in combination:

- **Acetaminophen:** A foundational analgesic with central action, often used preoperatively and postoperatively.
- **NSAIDs (COX-1/COX-2 inhibitors):** Reduce inflammation and nociceptive pain; ketorolac is commonly used intraoperatively.
- **Gabapentinoids (e.g., gabapentin, pregabalin):** Target neuropathic pain and reduce central sensitization.
- **Dexamethasone:** Offers anti-inflammatory effects and may reduce postoperative nausea, enhancing recovery.
- **Lidocaine (IV or topical):** Useful for both intraoperative and postoperative pain control, especially in abdominal surgeries.
- **Ketamine (low-dose):** Acts on NMDA receptors to prevent central sensitization and opioid tolerance.
- **Magnesium, Esmolol, Dexmedetomidine:** Emerging agents with roles in modulating pain and reducing opioid requirements.

These medications are deployed across the perioperative timeline—preoperative, intraoperative, postoperative, and at discharge—to ensure continuous pain control without excessive opioid use.

"Opioids may be appropriate for short-term use in select patients, but they should never be the default. Alternatives offer effective pain relief with fewer risks." – Dr. Duncan

When hospitals and surgical centers in Iowa were asked their opinions about opioid stewardship and opioid prescribing, 67% responded that they feel "opioid prescribing has improved due to opioid stewardship programs, but further work is needed".

Non-Pharmacologic ALTOs

- **Regional anesthesia and nerve blocks:** Provide targeted pain relief and reduce systemic medication needs.
- **Neuraxial techniques (e.g., epidural, spinal anesthesia):** Especially effective for lower abdominal and orthopedic procedures.
- **Anesthetic infiltration of surgical sites:** Enhances local pain control and minimizes systemic exposure.
- **Patient education and expectation setting:** Empowering patients with knowledge about pain management options and recovery timelines reduces anxiety and perceived pain intensity.

Clinical Integration

The guidelines recommend that surgical teams adopt ALTOs as part of a standardized multimodal analgesia protocol. This includes:

Dr. Duncan advises, "Clinicians should assess each patient's risk profile, preferences, and clinical context when selecting pain management strategies. The goal is to maximize comfort while minimizing harm."

- Preoperative planning with risk stratification and patient counseling.
- Intraoperative use of ALTOs tailored to procedure type and patient comorbidities.
- Postoperative monitoring and adjustment based on pain scores and functional recovery.
- Discharge planning that prioritizes non-opioid regimens and includes safe opioid prescribing when necessary.

By integrating ALTOs into every phase of surgical care, providers can reduce opioid exposure, mitigate risks of dependence, and enhance recovery. This approach aligns with broader Compass SHARP goals of opioid stewardship, patient-centered care, and data-driven quality improvement.

For more information on ALTOs, see the Compass SHARP **Multimodal Analgesia Guidelines for Surgical Practice** Guidelines

Addressing Bias and Building Trust

Patients with chronic pain or substance use histories often face stigma in healthcare settings. This can lead to under-treatment, mistrust, and poor outcomes. Providers must actively work to counter bias by using neutral language, validating patient experiences, and applying consistent screening and education protocols. Avoid assumptions about misuse or exaggeration. Instead, focus on safety, function, and recovery goals.

Dr. Hah suggests, "Shared decision-making is a powerful tool for reducing stigma. When patients are invited to participate in their care planning, they feel respected and empowered. This improves adherence, satisfaction, and clinical outcomes."

Prescribing Policies and Shared Decision-Making

Compass SHARP encourages providers to follow institutional prescribing policies that limit opioid quantities, require naloxone co-prescribing, and support multimodal analgesia. These policies are designed to reduce variation and promote safety. Providers should explain these policies to patients in a supportive, transparent manner.

Dr. Hah advises, "Shared decision-making should begin in the preoperative phase and continue through discharge. Discuss pain expectations, treatment options, and tapering plans. Provide written materials and reinforce key messages during follow-up visits. Use teach-back methods to confirm understanding and address concerns."

Compass SHARP asked, "What are the most significant barriers to implementing best practices in pain management, specifically in relation to opioid stewardship and the promotion of nonopioid pain management strategies?"

"Challenges related to patient expectations." -Iowa hospital clinician

Preoperative Phase

The preoperative phase is critical for risk assessment and care planning. Providers should:

- Conduct structured screening for opioid use, mental health, and social support.
- Reconcile medications and quantify daily morphine milligram equivalents (MME).
- Counsel patients on pain expectations and multimodal options.
- Document pain management plans and tapering strategies in the EMR.
- Coordinate with anesthesia, pharmacy, and addiction medicine as needed.

Dr. Hah advises, "Patients should leave the preoperative visit with a clear understanding of what to expect and how their pain will be managed.

Intraoperative Phase

During surgery, the focus shifts to implement the pain management plan. Providers should:

- Apply multimodal analgesia protocols tailored to the procedure and patient.
- Use regional techniques when appropriate to reduce systemic opioid needs.
- Avoid long-acting opioids unless clinically justified.
- Communicate pain management plans across the surgical team to ensure consistency.

Anesthesia teams play a key role in optimizing intraoperative pain control and setting the stage for recovery.

Postoperative Phase

Postoperative care includes pain management, education, and follow-up. Providers should:

- Prescribe opioids only when necessary and in limited quantities.
- Use resources such as Michigan OPEN data to guide days supply and pill count.
- Co-prescribe naloxone for patients with elevated risk.
- Provide disposal instructions and reinforce tapering plans.
- Monitor for side effects, misuse, and functional recovery.

Patients should be encouraged to use non-opioid strategies and reach out if pain is not well controlled. Follow-up visits are an opportunity to reassess and adjust the plan.

Compass SHARP asked, "What are the largest knowledge gaps you perceive in the area of pain management, particularly regarding the management of chronic pain and the safe and effective use of opioids?"

"Patient expectation that they will have no pain, chronic pain patients that refuse to use Tylenol/NSAIDs with their opioids because they 'don't work.'" -Iowa Surgical Center Clinician

Meet Dr. Susan Bradley, PharmD, JM

Susan is a clinical pharmacist with a Juris Master degree focused on healthcare regulation. She specializes in opioid stewardship, policy and protocols, and building standardized systems that support best practice. Her clinical practice is at a critical access hospital.

"Hospitals, health systems, and surgical teams should implement standardized protocols for opioid prescribing after surgery to promote consistency, safety, and evidence-based practice"

Michigan OPEN Prescribing Recommendations

Procedure	Typical Days Supply	Typical # of Pills
Laparoscopic Cholecystectomy	0-3 days	0-10 tablets
Hernia Repair	0-3 days	0-10 tablets
Breast Surgery (Mastectomy)	3-5 days	10-15 tablets
Cesarean Section	3-5 days	10-15 tablets
Knee Replacement	5-7 days	15-20 tablets
Lumpectomy	0-3 days	0-10 tablets
Thyroidectomy	0-3 days	0-10 tablets
ACL Reconstruction	5-7 days	15-20 tablets
Vaginal Delivery	0-3 days	0-10 tablets
Hysterectomy (Laparoscopic)	3-5 days	10-15 tablets
Spinal Fusion	7-10 days	20-30 tablets
Carpal Tunnel Release	0-3 days	0-10 tablets

As Dr. Bradley advises, "These recommendations are based on patient-reported consumption and help prevent overprescribing. Providers should adjust based on individual needs and clinical judgment."

Please note: the above recommendations do not apply to patients taking chronic opioids or medications for opioid use disorder (MOUD) prior to surgery.

APPENDIX 2

Provider Resources

Full Compass SHARP Provider Toolkit

Clinical Guidelines and Resources

- Opioid Medication Dictionary
- Non-Opioid Medication Dictionary
- Medication Quick Guide
- Guidelines on Limiting Opioid Use in the Perioperative Setting
- Perioperative Management of Patients on Opioids
- Multimodal Analgesia Guidelines for Surgical Practice
- Postoperative Follow Up Call Form
- 5-Step Implementation Tool
- Opioid Patient Scripting Tool: Communicating with Patients on Postoperative Pain Relief
- TAPS Screening Workflow
- Best Practices for Interpreting TAPS

Model Policies

- Patient Controlled Analgesia (PCA) Model Policy
- LAST Model Protocol
- Epidural or Spinal (Neuraxial) Analgesia (with or without PCEA) Model Policy
- Low-Dose Ketamine for Analgesia

APPENDIX 2

Provider Resources (cont)

Resources to Provide Patients:

- **Educational Handouts:**
  - Understanding Pain
  - Getting Ready for Surgery
  - Managing Pain After Surgery
  - Managing Pain After Surgery With Opioids
  - Tapering Opioids Before Surgery
  - Naloxone and Overdose
  - Safe Storage and Disposal
  - Smoking Cessation Handout

- **Procedure Specific Pain Management Guides:**
  - Laparoscopic Cholecystectomy
  - Sinus Surgery
  - Joint Replacement Surgery
  - Hernia Repair
  - Orthopedic and Sports Medicine
  - General Abdominal Surgery

- **Educational Videos:**
  - What is Pain?
  - Understanding Opioids
  - Preparing for Surgery
  - Postoperative Pain: Pharmacologic Treatments
  - Postoperative Pain: Non Pharmacologic Treatments

- **Microlearning Series**

SECTION 3

For Nursing

Nurses play a central role in perioperative opioid stewardship. From preoperative education to postoperative monitoring, nursing staff are often the first and most consistent point of contact for patients navigating pain management. The Compass SHARP program recognizes nursing as a cornerstone of safe, compassionate, and effective care.

This section provides practical guidance for bedside nurses, pre-operative and postanesthesia care unit (PACU) teams, inpatient units, and ambulatory surgical centers. It includes scripting, screening tools, and strategies to support patient-centered communication, reduce stigma, and promote shared decision-making.

Meet Brooke Stoesz, MBA, BSN, RN

Brooke has been a nurse for 15 years and specializes in clinical education and quality improvement. She most recently practiced in the inpatient setting. Throughout this section, she shares her practical insights and real-world nursing wisdom.

Key Concepts

- **Multimodal Analgesia:** Nurses should advocate for and administer non-opioid pain relief strategies such as acetaminophen, NSAIDs, nerve blocks, and non-pharmacologic interventions.
- **Opioid Stewardship:** Nurses are responsible for monitoring opioid use, educating patients on risks, and ensuring safe administration, storage, and disposal.
- **Screening and Documentation:** Use validated tools (e.g., NIDA Quick Screen, AUDIT-C+2, TAPS) to assess substance use risk and document findings in the EMR.
- **Patient Education:** Nurses should provide clear, consistent education on pain expectations, medication safety, and tapering plans.
- **Continuity of Care:** Ensure that pain plans are communicated across shifts and transitions, including discharge planning and outpatient follow-up.

"As nurses, we're the constant presence for our patients—the eyes, ears, and voice of advocacy. Stewardship isn't just about medications; it's about the conversations, the reassurance, and the small actions that help patients feel safe and understood."
- Brooke, RN

Talking to Patients / Screening

Nurses are often the first point of contact for patients during the perioperative journey, making them uniquely positioned to initiate conversations about pain, medications, and substance use. These interactions are critical for identifying risk, building trust, and setting the tone for safe and compassionate care.

For help discussing these challenging topics with patients, see the Compass SHARP **Opioid Patient Scripting Tool: Communicating with Patients on Postoperative Pain Relief**

Brooke suggests, "Screening should be routine, respectful, and framed as a standard part of clinical practice—not as a judgment or accusation."

Why Screening Matters

Substance use disorders (SUDs) are common and often under-identified in surgical settings. Early recognition allows the care team to tailor pain management strategies, avoid complications, and connect patients with appropriate support. Screening also helps identify patients who may be at risk for opioid misuse, overdose, or withdrawal.

How to Introduce Screening

Use clear, nonjudgmental language to explain why you're asking about substance use. Here are examples of scripting that can be adapted for different settings:

- **General Introduction**
  - "We ask all patients about their use of medications, alcohol, and other substances. This helps us provide the safest and most effective care during and after surgery."
- **When a Patient Seems Hesitant**
  - "These questions are part of our routine assessment. We ask everyone the same things, and your answers help us understand how to best support you."
- **If a Patient Discloses Use**
  - "Thank you for sharing that. It's helpful to know so we can make sure your pain is managed safely and that you're supported throughout your recovery."

- **If a Patient Asks Why You're Asking**
  - "We've learned that understanding a patient's full medication and substance use history helps us prevent complications and tailor pain management. It's not about judgment—it's about safety."
- **When Screening for Opioid Use History**
  - "Have you ever taken opioid medications like oxycodone, hydrocodone, or morphine? If so, how did they work for you?"
- **When Screening for Substance Use Disorder Risk**
  - "Have you ever had concerns about your use of medications or substances, or felt like you needed help cutting back?"

Documentation and Follow-Up

All screening results should be documented in the patient's chart using the appropriate EMR fields. If a patient screens positive or discloses a history of substance use, notify the provider and consider involving addiction medicine, social work, or behavioral health. Use clinical judgment to determine whether additional assessments or referrals are needed.

Brooke advises, "Don't let positive screens sit in the chart. Loop in the team, document your actions, and keep communication open."

Maintaining a Supportive Tone

"Patients may feel vulnerable when discussing substance use. It's important to maintain a calm, supportive tone and avoid language that implies blame or shame," advises Brooke, RN. Use terms like "opioid therapy" instead of "drug use," and "substance use history" instead of "addiction." Reinforce that your goal is to help—not to punish.

For additional guidance, see the Compass SHARP **TAPS Screening Workflow** and **Best Practices for Interpreting TAPS** guides.

Addressing Stigma and Shared Decision-Making

Patients with chronic pain or substance use histories may feel judged or misunderstood. Nurses can reduce stigma by:

- Using person-first language (e.g., "person with a substance use disorder" instead of "drug user")
- Validating patient concerns
- Avoiding assumptions about misuse or exaggeration
- Reinforcing that screening is routine and supportive

Shared decision-making means involving patients in their care. Nurses can support this by:

- Asking about past experiences with pain and medications
- Offering choices when possible
- Explaining the rationale behind treatment plans
- Encouraging questions and feedback

Brooke says, "When patients feel safe with us, they tell us the truth. That honesty is what keeps them safe."

Preoperative Phase

In the pre-op setting, nurses should:

- Review the patient's pain history and current medications
- Administer screening tools and document results
- Educate patients on what to expect during and after surgery
- Reinforce multimodal pain strategies and non-opioid options
- Ensure naloxone is prescribed when indicated

Brooke's thoughts: "When patients feel heard, they're more engaged in their recovery—and that's when we see the best outcomes."

Nursing and Patient Education

"Use handouts and visual aids to support education. Encourage patients to ask questions and express concerns—this is your chance to set the tone for safe recovery." – Brooke, RN

Nursing Handouts

- Safe Handling
- Storage
- Disposal and Naloxone Education

Patient Handouts

- Naloxone and Overdose
- Safe Storage and Disposal

Surgery / Intraoperative Phase

While nurses may not administer anesthesia, they play a key role in:

- Communicating patient pain plans to the surgical and anesthesia teams
- Monitoring for adverse reactions to medications
- Supporting regional anesthesia techniques (e.g., nerve blocks)
- Preparing for postoperative pain control based on the patient's risk profile

"Team communication in the OR is just as important as technical skill. When everyone's aligned on the pain plan, patients benefit." - Brooke, RN

Postoperative Phase

In the PACU and inpatient units, nurses should:

- Monitor pain levels and medication effectiveness
- Administer non-opioid medications on a scheduled basis
- Use opioids only as needed and per protocol
- Educate patients on tapering, safe use, and disposal
- Assess for side effects, misuse, or signs of withdrawal

"Use teach-back to confirm understanding. A few extra minutes up front can prevent readmissions or complications later." – Brooke, RN

APPENDIX 3

Nursing Resources

Full Compass SHARP Nursing Toolkit

Clinical /Practice Resources

- TAPS Screening Workflow
- Best Practices for Interpreting TAPS
- Safe Handling, Storage, Disposal and Naloxone Education
- Surgical Protocols and PDSA Cycles
- Evidence Based Opioid Stewardship & Crosswalk
- Pre-Visit Assessment
- Phone Call Triage Form
- Opioid Medication Dictionary
- Non-Opioid Medication Dictionary
- Medication Quick Guide
- Postoperative Follow Up Call Form
- 5-Step Implementation Tool
- Opioid Patient Scripting Tool: Communicating with Patients on Postoperative Pain Relief

Model Policies

- Patient Controlled Analgesia (PCA) Model Policy
- LAST Model Protocol
- Epidural or Spinal (Neuraxial) Analgesia (with or without PCEA) Model Policy
- Low-Dose Ketamine for Analgesia

APPENDIX 3

Nursing Resources (cont)

Resources to Provide Patients:

- **Educational Handouts:**
  - Understanding Pain
  - Getting Ready for Surgery
  - Managing Pain After Surgery
  - Managing Pain After Surgery With Opioids
  - Tapering Opioids Before Surgery
  - Naloxone and Overdose
  - Safe Storage and Disposal
  - Smoking Cessation Handout

- **Procedure Specific Pain Management Guides:**
  - Laparoscopic Cholecystectomy
  - Sinus Surgery
  - Joint Replacement Surgery
  - Hernia Repair
  - Orthopedic and Sports Medicine
  - General Abdominal Surgery

- **Educational Videos:**
  - What is Pain?
  - Understanding Opioids
  - Preparing for Surgery
  - Postoperative Pain: Pharmacologic Treatments
  - Postoperative Pain: Non Pharmacologic Treatments

- **Microlearning Series**

SECTION 4

Quality Improvement

Quality improvement (QI) is the engine behind sustainable change in perioperative opioid stewardship. The Compass SHARP program provides a structured framework for hospitals and surgical teams to implement, monitor, and refine evidence-based practices that reduce opioid-related harms and improve patient outcomes. This section is designed for QI leaders, data teams, and clinical champions who are responsible for translating stewardship principles into measurable progress.

Meet Amanda, BSN, RN, CDCES, CPHQ, CPPS.

Amanda has been an Iowa nurse for 20 years and specializes in clinical education and quality improvement. She supports Iowa hospital teams trying to implement surgical best practices.

Key Concepts

1. Accreditation Alignment

Compass SHARP maps directly to key regulatory standards:

- **Joint Commission NPSG.03.05.01:** Reduce harm associated with opioid use through standardized screening, education, and prescribing protocols.
- **CMS Opioid Misuse Strategy:** Track opioid-naïve to chronic use transitions, implement audit and feedback, and promote naloxone distribution.
- **DNV Medication Safety Goals:** Ensure safe prescribing, patient education, and continuity of care for patients on MOUD.

The Compass SHARP **Evidence Based Opioid Stewardship & Crosswalk** provides a detailed mapping of Compass SHARP recommendations to each accreditation standard, along with supporting evidence and implementation tools.

"Compass SHARP supports facilities in aligning with national standards, including Joint Commission NPSGs, CMS Conditions of Participation, and DNV medication safety goals. Through structured gap analysis, PDSA cycles, and real-time data tracking, QI teams can identify opportunities, implement targeted interventions, and demonstrate impact."
– Amanda, RN

2. Gap Analysis and Baseline Assessment

Meaningful, actionable data is inseparable from effective quality improvement. Before we can meaningfully improve, we first need to understand where we are and where we want to go. **A baseline needs assessment** captures the current state of practice – what our clinicians, systems, and patients are actually experiencing today. It provides a clear, data-informed picture of how pain is managed before, during, and after surgery: prescribing patterns, patient-reported pain control, opioid use, and follow-up outcomes. Key data points for opioid stewardship include:

- What pain management medications are currently on formulary in the hospital?
- Of those stocked, which opioid medications are used most frequently? Which non-opioid pain medications are used?
- What are our most common surgeries that involve opioid administrations and opioid prescriptions?
- What proportion of post-operative patients receive a prescription for an opioid?
- How do these patterns vary across provider?

A **gap analysis** builds on that foundation by comparing this current state to best practices, guidelines, and desired outcomes. It identifies the specific areas where our processes, education, or systems are falling short – and where focused effort could make the biggest impact. Key areas to evaluate include:

- What medications should be stocked that we currently don't have?
- In our utilization assessment, which medications are we relying on too much and which are we underutilizing considering evidence-based best practices?
- Do we have any "outlier providers" whose administration and prescription patterns significantly differ from the organization norm – and how do all our providers compare to standard best practices?

Meet Dr. Alexandra Mannerings, PhD. Alexandra is a data scientist who works to translate data into meaningful outcomes for hospitals and clinicians. After over 15 years wrestling with healthcare data, she knows how complex and time-consuming it can be to extract the insights needed to drive change. Researching in resource-limited locations around the world taught Dr. Mannerings the importance of focusing on the questions that really matter to those most impacted by the challenge you're seeking to solve – and then letting go of the rest. She believes that when we combine the power of data with the wisdom of humans, we can find our way to a better future, together.

Together, these tools are powerful catalysts for change. They help hospitals move from intuition to evidence, from one-size-fits-all interventions to targeted improvements. By grounding quality improvement in data and reflection, teams can set priorities that are both realistic and transformative. They make it possible to align resources, engage clinicians, and measure progress over time, ensuring that efforts to manage patients' pain are not only safer and more effective but also sustainable long after the initial project ends.

Ultimately, a thoughtful baseline assessment and gap analysis transform "we think" into "we know" – and that knowledge is what allows hospitals to deliver compassionate, evidence-based pain care that effectively serves patients and communities.

"Gathering baseline information from hospitals is critical to understanding current strengths, identifying gaps, and conceptualizing an implementation plan. You have to know where you are, where you want to go, and the route you can take to get there." – Dr. Mannerings, PhD

Facilities can begin by completing a structured gap analysis to assess current practices across domains such as:

- Preoperative screening and documentation
- Patient education and shared decision-making
- Opioid prescribing protocols
- Naloxone distribution
- MOUD continuity
- Data tracking and feedback loops

Tools like a needs assessment and gap analysis help teams identify strengths and opportunities for improvement.

3. PDSA Cycle Implementation

At the heart of continuous quality improvement is the **Plan-Do-Study-Act** (PDSA) cycle—a simple but powerful tool for testing and refining change. Rather than trying to overhaul an entire system at once, PDSAs allow teams to make small, focused changes, observe what happens, learn quickly, and adapt before spreading successful practices more broadly. This iterative approach builds confidence, minimizes disruption, and fosters a culture of learning rather than perfection.

To implement a PDSA, start with a clear **Plan:** identify one small, specific change aligned with your opioid stewardship goals – such as revising post-surgical prescribing defaults, adding non-opioid options to order sets, or piloting a new patient pain education script. During the **Do** phase, test that change on a limited scale – perhaps one surgical team or one week of cases – and collect simple, relevant data (e.g., patient pain scores, refill requests, or clinician feedback). Next, **Study** the results: did the change improve outcomes or introduce new challenges? Finally, **Act** on what you learned – adopt, adapt, or abandon the change, then plan the next cycle based on those insights.

In surgical pain management, PDSAs might look like:

- Testing a standardized multimodal pain protocol in one type of surgery (e.g., laparoscopic cholecystectomy) and comparing post-op pain and prescribing patterns before and after.
- Trying a new discharge counseling workflow – where nurses review safe opioid use and disposal with patients– and tracking understanding and satisfaction.
- Adjusting EHR prescription defaults to reflect evidence-based limits and monitoring whether providers accept or override them.

Each PDSA builds on the previous, transforming improvement from a one-time project into an ongoing process of discovery. Over time, this steady cycle of testing, learning, and refining creates real, lasting change – ensuring that hospitals not only reduce unnecessary opioid use, but also provide safer, more effective, and more patient-centered pain care.

Compass SHARP encourages the use of Plan-Do-Study-Act (PDSA) cycles to test and refine interventions. Examples include:

- Reducing discharge opioid prescriptions for laparoscopic appendectomy from 40 to 10 tablets
- Increasing naloxone co-prescribing rates for high-risk patients
- Improving documentation of pain plans in the EMR

The Compass SHARP **Surgical Protocols and PDSA Cycles** and Microlearning Series include real-world case studies and templates for implementing and evaluating PDSA cycles.

"Rapid PDSA Cycles are instrumental in quickly refining new processes to meet the needs or busy clinical teams."
– Amanda, RN

4. Data Tracking and Dashboards

Collecting data is not the same as using it – and using it well is what drives real change. Once hospitals have identified their goals through baseline assessment and gap analysis, the next step is to build the systems that make progress visible, meaningful, and sustainable.

Effective **data tracking** starts with clear definitions. Everyone should agree on what's being measured, how it's captured, and why it matters. Consistent data definitions and reliable sources ensure that when a team looks at a dashboard, they can trust what they see. Equally important is **accessibility** – data must be available to the people who need it, in forms they can understand and act upon. A dashboard shouldn't be a static report that lives in a forgotten corner of somebody's desktop; it should be a living tool that sparks conversation, prompts reflection, and supports daily decision-making.

To achieve that, hospitals should focus on building **useable and actionable dashboards:**

- **Useable** means intuitive layouts, clear visuals, and simple navigation so busy clinicians and leaders can quickly grasp what's happening.
- **Actionable** means every metric connects directly to a behavior or process someone can influence – such as changing a perioperative protocol for a particular procedure, improving patient education, or reducing utilization of inappropriate medications.

QI teams should establish dashboards to monitor:

- Opioid prescribing trends by procedure and provider
- Naloxone distribution rates
- Screening completion rates
- Patient satisfaction with pain management
- Opioid-naïve to chronic use transitions

"Establishing a data collection strategy up front will help hospitals and clinical teams understand if they've achieved the desired outcome." – Dr. Mannerings, PhD

Sustaining these tools requires intentional infrastructure. Automated data pipelines reduce manual burden and errors. Consider ways to set up automated extracts or direct connections into key electronic medical record (EMR) or automated dispensing machine (ADM) data. Set up a refresh/update schedule that is management but also matches the frequency at which team members are utilizing the results.

Regular validation keeps the information accurate. And embedding data review into routine practice – monthly huddles, QI team meetings, surgical department updates – ensures it remains a driver of change rather than a compliance checkbox.

Ultimately, dashboards should serve as **mission control** for stewardship: a shared space where teams can see progress, celebrate success, and identify the next frontier for improvement. When hospitals build data systems that are accessible, trustworthy, and connected to clinical action, they transform information into insight – and insight into safer, more effective pain care for every patient.

Imagine trying to fly to the moon without continual feedback on the rocket's heading, speed, and location relative to the ultimate destination. NASA would never do this – and neither should we.

5. Patient-Centered Metrics

Traditional stewardship metrics often focus on the medications themselves – how many opioids were prescribed, at what dose, and for how long. While those measures are critical for understanding patterns and preventing overuse, they only tell part of the story. True improvement in surgical pain management requires seeing through the patient's eyes.

Patient-centered metrics expand the frame. They ask: Did the patient feel their pain was well managed? Did they understand their medication plan? Were they able to resume daily activities safely and comfortably? These measures emphasize outcomes that matter most to patients – comfort, function, confidence, and safety – not just compliance or counts of pills dispensed.

Creating such metrics takes listening. Hospitals can gather patient input through post-discharge surveys, follow-up calls, or partnerships with patient advisory councils. Integrating patient feedback into data systems ensures that success isn't defined solely by reduced prescribing, but by whether patients experience better recovery and fewer complications or risks.

Patient-centered metrics often differ from traditional stewardship indicators in that they balance clinical effectiveness with human experience. Pain is a personal experience, and part of ensuring meaningful quality improvement is ensuring that we are achieving qualitative change in that patient experience. For example:

- Instead of only tracking "average morphine milligram equivalents prescribed," track "percentage of patients reporting adequate pain control without unplanned refills."
- Alongside "percent of cases using multimodal analgesia," include "patient satisfaction with pain education and shared decision-making
- To understand the experience of pain, consider measures such as "Improvements in daily functioning" and "Reduction in pain interference"

By pairing stewardship metrics with patient-centered ones, hospitals gain a fuller picture of quality. The goal is not simply to minimize opioid use, but to optimize healing – ensuring every patient feels heard, supported, and safely guided through recovery. When patients' voices shape the metrics, stewardship becomes not just a clinical initiative, but a human one.

Appendix 4: Quality Improvement Resources

- Surgical Protocols and PDSA Cycles
- Evidence Based Opioid Stewardship & Crosswalk
- Compass SHARP Needs Assessment Quiz
- Microlearning Modules
- 5-Step Implementation Tool

A few final thoughts from the Data Team:

1. Data are for learning, not judging.

When data are used punitively, clinicians disengage. When data are used for learning, it invites providers to lean in. Make sure your metrics and dashboards are framed as tools for understanding variation and improving systems – not assigning blame. This shift from accountability to people toward accountability with people is essential for sustaining trust and progress. Sit on the same side of the table and view the challenge together.

2. Small, rapid cycles of data use matter more than big reports.
Annual outcomes are important, but they're too slow to guide day-to-day improvement. Use data in Plan-Do-Study-Act (PDSA) cycles – short feedback loops where teams test changes, review results within weeks, and adapt. This approach builds momentum, reduces resistance, and turns data into an active partner in change rather than a retrospective scorecard.

3. Context beats comparison.
Benchmarking is useful, but context explains why numbers look the way they do. Evaluate differences in case mix, surgical complexity, or social risk factors before drawing conclusions. Data are most powerful when paired with qualitative insights – conversations with clinicians, patients, and pharmacists that reveal the why behind the what.

4. Let data amplify hidden voices.
Stewardship data can unintentionally hide disparities in pain control or access to non-opioid alternatives. Stratify data by meaningful patient characteristics that could relate to barriers to quality care, such as socio-economic status, sex, rural vs urban location, age, primary language, social determinants of health, and more. Disaggregation surfaces where the current process may not suit sub-populations and require directed change to ensure every patient has the same opportunity for high-quality care.

5. Measure both the progress and the story.
Hard data show outcomes, but stories show meaning. Track numbers – prescribing rates, refill requests, ED visits – but also gather narratives from patients and staff about what has changed in their experiences of pain management. These stories motivate teams, contextualize data shifts, and help communicate the "why" of stewardship to leadership and the community.

6. Plan for sustainability from the start.
Data systems need stewardship, too. Identify who owns each measure, how often it's reviewed, and how results flow back into decision-making. Build feedback loops into clinical pathways, onboarding, and continuing education. That way, data use remains part of the hospital's culture long after the initial QI project ends.

In short: evaluation isn't the end of the improvement process – it's the engine of it. When QI teams use data to learn continuously, ask better questions, and connect numbers to human experience, opioid stewardship becomes not just a compliance activity, but a sustained culture of safer, more compassionate care.

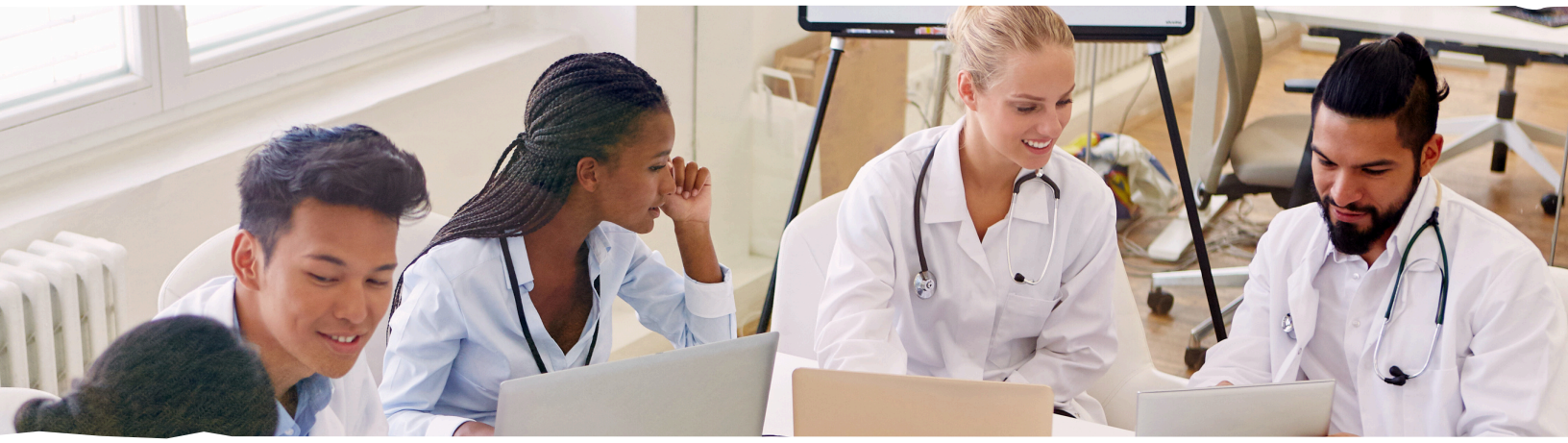
Compass SHARP Coaches' Thoughts on Long-Term Program Impact and Value for Providers

"Once you do engage with the clinical team or have that established relationship, folks always see the value. It's just getting them to the table." – Rachael Duncan, PharmD, on program value for providers

"We can serve your patients and take a load off of you -- patients come better prepared, have questions answered, and aren't overburdening your nurse line." – Don Stader, MD, on patient-centered impact

"We want hospitals to have everything they need [with this Playbook] to do a pretty decent job at having a perioperative pain management opioid stewardship program." – Rachael Duncan, PharmD, on long-term sustainability

"We created really high-quality educational content… these are good resources, and they're free." – Jennifer Hah, MD, on program assets



Closing

The Compass SHARP Perioperative Opioid Stewardship Playbook is more than a set of guidelines – it is a shared commitment to safer, more compassionate perioperative care.

> "Across disciplines, we each play a vital role in improving how pain is managed before, during, and after surgery." – Dr. Hah, MD

Whether you are a patient preparing for a procedure, a nurse supporting recovery, a provider making clinical decisions, or a quality improvement leader driving system change, your contributions matter.

Compass SHARP is built on the belief that opioid stewardship is not about restriction, but about responsibility. It is about ensuring that every patient receives the right care, at the right time, with the right tools to heal safely. It is about listening, educating, and partnering with patients to reduce harm and promote recovery.

This playbook has provided tailored guidance for each role:

- Patients have learned what to expect and how to advocate for their needs.
- Nurses have gained tools for screening, education, and stigma-free communication.
- Providers have reviewed evidence-based prescribing strategies and clinical protocols.
- Quality improvement teams have explored data-driven approaches to implementation and evaluation.

Together, we can change the culture of pain management. We can reduce unnecessary opioid exposure, support patients with complex needs, and build systems that prioritize safety, equity, and healing.

Sincerely,
The Compass SHARP Team

Compass SHARP

Thank You

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COMPASS HEALTHCARE COLLABORATIVE
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