Addressing the Opioid Crisis in Ambulatory Care

Alicia Agnoli, MD, MPH
Mary Ellen Benzik, MD
Andrew Jorgensen, MD
Greg Sawin, MD, MPH
Randi Sokol, MD, MPH, MMedEd

Facilitated by Mara Laderman, MSPH

April 21, 2017
9:30 AM – 12:30 PM
Objectives

- Understand the magnitude of the opioid crisis in the United States
- Describe different strategies to address multiple drivers of the opioid crisis, including physician prescribing, prescriber education, treatment for opioid use disorder, and partnering with communities
- Identify change ideas and strategies to overcome barriers that they can test at their organization
Session Agenda

- Faculty Introductions
- Case Studies from three organizations (+ a break!)
- Table Top Discussions
- Final Q&A and wrap up
Faculty Introductions
Driver Diagram: Addressing the opioid crisis in a community

Address the opioid crisis in a community

- Overdose rate
- Fatal overdose rate
- Individuals in treatment
- Prescription opioid rate

Raise awareness of risk of opioid addiction

- Prescribing practices
- Dispensing practices
- Diversion
- Pharmaceutical production
- Availability of alternative pain management treatment

Identify and manage opioid dependent population

- Identification and education of patients at greater risk for addiction
- Provider education
- Adolescent education
- Adult education
- Reducing stigma around substance abuse

Treat individuals with opioid use disorder

- Compassionate, consistent care
- Tapering
- Pain management education
- Availability of alternative pain management treatment
- Education of patients and families

Identify individuals with opioid use disorder

- Identification individuals with opioid use disorder
- Availability of detox facilities
- Availability of long-term ongoing, comprehensive addiction treatment
- Availability of supportive social services
- Prevention of fatal overdose
How Can Primary Care Address the Opioid Epidemic?

Use of an Interdisciplinary team-based group visit model to provide Buprenorphine/Naloxone (B/N) in primary care PCMH clinic

Alicia Agnoli, MD, MPH
Greg Sawin, MD, MPH
Randi Sokol, MD, MPH, MMedEd
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2015

- Any Opioid
- Heroin
- Natural & Semi-Synthetic Opioids (e.g., fentanyl, tramadol)
- Other Synthetic Opioids
- Methadone

Some states have more opioid prescriptions per person than others.

Number of opioid prescriptions per 100 people

- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.
Sources of Prescription Opioids Among Past-Year Non-Medical Users

- Given by a friend or relative for free
- Prescribed by ≥1 physicians
- Stolen from a friend or relative
- Bought from a friend or relative
- Bought from a drug dealer or other stranger
- Other

Number of Days of Past-Year Non-Medical Use

- Any
- 1-29
- 30-99
- 100-199
- 200-365

Percent of Users

---

a Obtained from the US National Survey on Drug Use and Health, 2008 through 2011. Estimate is statistically significantly different from that for highest-frequency users (200-365 days) (P< .05).

b Includes written fake prescriptions and those opioids stolen from a physician’s office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.

Natural History of Opioid Use Disorder

- Euphoria
- Normal
- Withdrawal
- Tolerance & Physical Dependence

Acute use

Chronic use
OUD & Treatment Capacity

Gap between # with past year OUD & combined buprenorphine & methadone capacity

Gap=914,000

Figure 2. Receipt of substance use treatment at a specialty facility in the past year among people aged 12 or older who needed substance use treatment in the past year: 2015

19.3 million did not receive substance use treatment at a specialty facility (89%)

2.3 million received substance use treatment at a specialty facility (11%)

21.7 million people aged 12 or older needed substance use treatment

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.
<table>
<thead>
<tr>
<th>Etiology</th>
<th>Asthma</th>
<th>HTN</th>
<th>Addiction (ETOH, Opiates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Prevalence (USA)</td>
<td>12.9%</td>
<td>90%</td>
<td>9%</td>
</tr>
<tr>
<td>Heritability (genetics)</td>
<td>0.36 - 0.7</td>
<td>0.25 - 0.5</td>
<td>0.34 – 0.55</td>
</tr>
<tr>
<td>Environment</td>
<td>Air quality, SES</td>
<td>Cultural salt intake, stress</td>
<td>Peer group behavior, SES, etc</td>
</tr>
<tr>
<td>Personal Choice</td>
<td>Smoking, Exercise</td>
<td>Diet, Exercise</td>
<td>Decision to use</td>
</tr>
<tr>
<td>Relapsing Course</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% seeking care each year to achieve symptomatic relapse</td>
<td>70%</td>
<td>50%</td>
<td>30% – 50 %</td>
</tr>
<tr>
<td>Importance of Patient Engagement</td>
<td>Medication Adherence Rates</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Lifestyle Adherence Rates</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>% meeting national quality goals</td>
<td>30%- 50%</td>
<td>30%- 50%</td>
</tr>
</tbody>
</table>

Chronic Disease Model
Approach to OUD

Medication
● Manage Cravings
● Prevent Withdrawals

Behavioral Treatment
● Develop healthy coping skills
● Build Community
Medication Assisted Treatment (MAT) for OUD

- **Methadone** and **buprenorphine** → most evidence for recovery
  - At 1 year, 40-60% of patients maintained on methadone or buprenorphine remain sober

- **Naltrexone** - less effective
Office-Based Opioid Therapy (OBOT)

- Buprenorphine MAT:
  - Medically effective
  - Cost-effective
  - Safe
  - Higher patient satisfaction
  - Higher provider satisfaction

- Underutilized
Figure 1. Number of family physicians prescribing opioid analgesics vs. those certified to prescribe buprenorphine to treat opioid use disorder in 2013. (DATA = Drug Abuse Treatment Act.)

Information from 2013 Medicare Part D data and the U.S. Drug Enforcement Administration's DATA waiver roster.
- Schedules patients
- Manages incoming calls
- Follows up for missed visits
- Participates in team wrap-up

- Triaging: reviews charts; directs to appropriate treatment
- Conducts intakes
- Provides continuity with patients as contact for questions/issues
- Submits prior authorizations
- Follows up with patients during the week

- Writes buprenorphine prescriptions
- Communicates progress with PCP
- Leads team wrap-up
- Bills visits appropriately
- Direct precepting of resident
- Follows up with patients during the week

- Learns to lead group, employing small group facilitation skills
- Leads didactic
- Participates in medical decision making around addictions management

- Collects urine
- Participates in team wrap-up

- Certified Addictions Nurse

- Front Desk

- Patients

- Attending Physician

- Medical Assistant
What happens in group?

- Urine drug screens (publically posted)/settle (prior to group)
- Introductions (3m)
- Ground Rules (2m)
- Didactic (10m)
- Check-in (45m)
- Prescriptions (we use paper) (at end)
What Happens Between Groups

• RN & MD call “struggling” patients or new patients to check in
• Care coordination with: psych, SW, PCP, Parole officers, DCF, patients currently inpatient (in IOP, detox, residential)
• Follow up with patient’s urine drug screens (“so your urine came back with cocaine in it….”)
• Ongoing screening of new patient referrals + intake appts
• Prepare didactics
→ RN & MD time ~5-6 hours/week each
Resident perspective:

- deeper, more authentic understanding of patients
- value of team-based approach
Patient perspective: group keeps them honest/ holds them accountable

It’s showing up every week and knowing that you have to be accountable for your actions. For me, I’m all about consequences ... there’s another 80 times where I’ve almost slipped up and thought about this group, and didn’t do it because I didn’t want to look at all y’all in the face and say I did it again.
Patient perspective: Group fosters shared identity

It’s good to have, and to be in an atmosphere with those other people like you that understand you... you know, I feel like I’m not alone, there’s other people, you know, similar situations. I have support, you know? I don’t really have support outside of here. My family, you know, they’re there, but they’re not -- my sisters aren’t addicts, so they don’t understand it. My parents don’t understand it. So it just feels good. I don’t feel alone coming here.
In the beginning, I really didn’t care about anybody, I didn’t care about myself. I didn’t care what anybody had to say, I’m like, “Is it three o’clock yet? Like, can I get the f*ck out of here?” Now I look forward to coming, coming here and seeing everybody
Clinic perspective

• Destigmatizes addiction
• Comprehensive care: treat addiction while treating other medical problems in 1° care
• Lucrative + minimal staff:
  1 clinic session:
  - 1 FD, 1 RN 1 MA, 1 MD
  - 20-30 patients
Estimated Staff Resource Time/Week
(care of 40-50 pts)

Doctor: 7 hours
- 2 hours group
- 1 hour Team meeting
- 3 hours group prep
- 3 hours screening + intakes
- 2 hours coordinating care
- 1 hour notes

LPN: 10 hours
- 2 hours group
- 1 hour Team meeting
- 3 hours intakes
- 4 hours phone follow ups + care coordination

Front Desk: 3 hours
- 2 hours calls/ appointment management/schedule prep
- 1 hr Team meeting

MA: 7 hours
- 2 hours group
- 2 hours group prep/follow up
- 3 hours paperwork

Resident: 5 hours
- 4 hours group afternoon
- 1 hour didactic prep
References


Center for Health Information and Analysis *Access to Substance Use Disorder Treatment in Massachusetts* April 2015


References


Sokol, R et al. Why Use Group Visits for Opioid Use Disorder Treatment in Primary Care? A Patient-Centered Qualitative Study. *Substance Abuse*. In Review.

*Substance Abuse Treatment: Group Therapy. Treatment Improvement Protocol (TIP) Series, No. 41*. Rockville, MD: Center for Substnce Abue Treatment Substance Abuse and Mental Health Services Administration (SAMHSA); 2005.

Questions?
Small Clinic, Big Issues

Andrew Jorgensen, MD, FACP, FAAP
Chief Medical Officer, Outer Cape Health Services

IHI Summit
April 20 – 22, 2017

#IHISummit
Opiate Overdose Deaths in Massachusetts

Opiate Overdose Deaths on Cape Cod

- 395 overdose deaths on Cape Cod from 2000-2015
- Barnstable County ranked No. 3 for fatal overdoses in the state in 2015, with 30.3 deaths per 100,000 people

**Fatal Overdoses Per 100,000 Population by County 2000-2015**
Dukes County ranked No. 1, Barnstable County No. 3 for overdose rates in 2015

Source: Massachusetts Department of Public Health / U.S.Census | Chart: Gregory Bryant / Cape Cod Times
About Outer Cape Health Services

- Rural FQHC formed 1987
- Serves Eight outermost towns of Cape Cod
- 200 square-mile catchment area
- Designated by HRSA as underserved for Medical, Dental, & Mental Health
- Closest Emergency Room is one hour away from Provincetown
OCHS-Provincetown
• 16 exam rooms
• CHC farthest from a hospital in Massachusetts (60 miles away)
• Renovated 2010

OCHS-Wellfleet
• 8 exam rooms
• Oldest CHC building in Massachusetts (1966)

OCHS-Harwich
• 5 small exam rooms
• Rental space; opened 2011
Chronic pain case management: Two-pronged approach

- Optimizing risk management by PCP team
- Changing prescriber behavior
Chronic Pain Case Management (CPCM) Program

- Pilot began March 2015
- Registry of patients receiving opiate Rx’s developed
- Tiered, consistent risk monitoring by nurse case manager oversees registry
- One-on-one meetings with providers
- Team discussions
# Chronic Pain Registry excerpt

<table>
<thead>
<tr>
<th>D.O.B.</th>
<th>MEQ Dosage</th>
<th>Tier</th>
<th>Reason</th>
<th>Date Contract Annual</th>
<th>Last UDS</th>
<th>PMP Date</th>
<th>Psych Dx</th>
<th>Red Flag</th>
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<tbody>
<tr>
<td>/1983</td>
<td>127.5</td>
<td>1</td>
<td>Torticollis</td>
<td>7/22/2013</td>
<td>4/10/2012</td>
<td>None</td>
<td>Depression, major</td>
<td></td>
</tr>
<tr>
<td>/1950</td>
<td>15</td>
<td>3</td>
<td>Hip pain</td>
<td>4/15/2013</td>
<td>4/15/2013</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>/1976</td>
<td>45</td>
<td>2</td>
<td>Chronic headaches</td>
<td>5/14/2014</td>
<td>8/6/2014</td>
<td>None</td>
<td>Cognitive deficits</td>
<td></td>
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<tr>
<td>/1963</td>
<td>67.5</td>
<td>2</td>
<td>Lumbar spondylosis</td>
<td>5/21/2014</td>
<td>8/21/2011</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
## NIDA Opioid risk tool

**OPIOID RISK TOOL**

<table>
<thead>
<tr>
<th>Item</th>
<th>Mark each box that applies</th>
<th>Item Score If Female</th>
<th>Item Score If Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (Mark box if 16 – 45)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of Pre-adolescent Sexual Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ]</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>[ ]</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Score Risk Category</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Risk 0 – 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Risk 4 – 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk &gt; 8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** www.drugabuse.gov/nidamed-medical-health-professional
Tiered risk structure

**Tier 1**
- MEQ 100mg+, or
- Benzodiazepines, or
- Red flags

**Tier 2**
- Average MEQ
- No benzodiazepines
- No red flags

**Tier 3**
- Low MEQ
- No benzodiazepines
- No red flags
## CPCM Workflow and Guidelines

### CPCM 1 Risk Tier

#### “High risk”

- High daily dose = MS equiv 100mg or higher/day, or
- Benzo use, or
- Red flags or a combination of these risks

### CPCM 2 Risk Tier

#### “Average risk”

- 10-99 MS equivalent/daily
- No benzo
- No red flags
- Bulk of patients

### CPCM 3 Risk Tier

#### “Low risk”

- Low dose <10 mg MS equiv/day
- No benzo
- No red flags

### Problem List

- RN selects tier using the description above; PCP input may be sought if questions
- March 2016 patient lists have been tiered by DON/Med Director as a starting point using June data
- RN can change the tier as doses reduce or benzo use stops or red flag issues resolve
- RN locates “dummy code CPCM1”, just as you would find any ECW problem list assessment code
- Adds to ‘top of problem list’ for easy reference

- Same; Dummy code CPCM2
- Same; Dummy code CPCM3

### PEG scale

- MA asks pt to complete at visit, prior to PCP visit (paper form)
- MA enters PEG info from form into ECW
- HPI “PEG” at visit
- For example: P9, E8, G6=23
- Discards paper form

- Same
- Same

### Opioid Risk Tool

- Located in ROS
- PCP completes risk assessment at least once (not once/year) for PCP information about risk

- Same
- Same
CPCM Workflow and Guidelines

<table>
<thead>
<tr>
<th>CPCM 1 Risk Tier</th>
<th>CPCM 2 Risk Tier</th>
<th>CPCM 3 Risk Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“High risk”</strong></td>
<td><strong>“Average risk”</strong></td>
<td><strong>“Low risk”</strong></td>
</tr>
<tr>
<td>UDS capture by MA/RN</td>
<td>Quarterly</td>
<td>Annually</td>
</tr>
<tr>
<td>- Monthly</td>
<td>- At visit or RX pickup</td>
<td>- At visit or RX pickup</td>
</tr>
<tr>
<td>- At visit or RX pickup</td>
<td>- RN Prompts the prescription in med closet or the OV note</td>
<td>- RN Prompts the prescription or the OV note</td>
</tr>
<tr>
<td>- RN Prompts the prescription in med closet or the OV note</td>
<td>- RN reminds PCP to order UDS monthly standing order</td>
<td>- Monthly standing order UDS at RN discretion (in case random UDS requested by RN)</td>
</tr>
<tr>
<td>- RN reminds PCP to order UDS monthly standing order</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PMP (Physician Monitoring Program) check by RN delegate**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarterly</strong></td>
<td><strong>Every 6 months</strong></td>
<td><strong>Annual check</strong></td>
</tr>
<tr>
<td>- RN print/sign</td>
<td>- RN print/sign</td>
<td>- RN print/sign</td>
</tr>
<tr>
<td>- To provider to sign/file</td>
<td>- To provider to sign/file</td>
<td>- To provider to sign/file</td>
</tr>
<tr>
<td>- MA delegate may be assigned to do this for PCPs by RN</td>
<td>- MA delegate may be assigned to do this for PCPs by RN</td>
<td>- MA delegate may be assigned to do this for PCPs by RN</td>
</tr>
<tr>
<td>- Delegates need to be notarized- see Medical Director for details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RN review of CPCM patient list at least monthly**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same</td>
<td>Same</td>
</tr>
<tr>
<td>- To ensure PCP OV every 3 months per policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- RN (who can assign MA) to reach out to non-compliant pt to facilitate OV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- To prompt upcoming OVs if UDS/Contract due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- To ensure new patients added appropriately and promptly for CPCM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Call-in for pill counts/UDS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Consider random pill count periodically, otherwise, same</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Random pill counts suggested quarterly</strong></td>
<td><strong>Same</strong></td>
<td></td>
</tr>
<tr>
<td>- By RN or provider for any red flag or concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- If patient seems inappropriate at RX pick-up or OV, call-in within week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- DNKA, call-in within week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Bell curve of risk tiers
Changing provider behavior

- Follow new MA and CDC guidelines with frequent reminders
- Expectations for tapering high MEQ
- Optimizing safer strategies: **Honest group discussions**
- **Regularly scheduled meetings with PCPs and RNs**
- Initially optional before regular meetings, now part of provider meeting
- Model best practices, practice difficult conversations
- **Team-building**, team support critical
- Quarterly statistic tracking
- Existing general monthly peer review
Concurrent State Efforts

Opioid Therapy and Physician Communication Guidelines
Measures of success

- Improvement in urine drug screening, PMP, annual agreements (80% goal)
- Decline in numbers of patients being prescribed high dose opiates
- More referrals to OCHS Behavioral Health
- Improvement in PCP satisfaction with care for patients with pain
Patient enrollment in CPCM program
Distribution of risk tiers

Tier 1

Tier 2

Tier 3
Results

Controlled substance agreement status

- Up to date
- Expired
- None on file
Results

PMP report status

- Up to date
- Out of date
- Never

Results

Urine drug screening

- Up to date
- Out of date
- Never
Results

Office visits up to date

Reasons for discontinuation of Rx

- Died/moved/transferred: 15%
- Stopped prescribing due to discordant UDS: 13%
- Referred to pain specialist: 3%
- tapered off; no longer needed: 69%

77 discontinued (8/2016 – 2/2017)
Challenges & barriers

• Changing behavior is hard work, not just for patients, but for providers as well
• Like all change processes, providers have different capacities for change
• Nurse Care Manager is a grant funded position and it is an effort to embed work in care teams
• Morning discussion meeting useful but the work can overwhelm other important efforts at the Health Center
Success stories

- 54 year-old woman with chronic abdominal pain related to cirrhosis from Hepatitis C
- Initially using Oxycodone 90 mg every 6 hours; also using other high risk medications including clonazepam and Ritalin
- Began seeing her when prior PCP retired; patient very resistant to weaning
- Worked closely with behavioral health team including co-located Psychiatrist to manage overall risk
- Treated her Hepatitis C
- Patient also worked on her abusive relationship with her husband
- After 12 months no longer using any opiates
Future & sustainability

- Working on embedding care management in to primary care teams as part of PCMH
- Spread approach to other high risk medications such as benzodiazepines
- Integrate metrics in to overall quality improvement efforts to help with sustainability
Remembering those lost to addiction

Source: Cape Cod Times
Break
Mission
We provide innovative, high-value health care solutions to companies, improving the health and well-being of the people we serve.

Vision
We will transform the delivery of health care as a trusted partner to the companies we serve. Together, we will create a culture of health and become our patients’ most cherished benefit.
STEP 1 – CREATE THE CONVERSATION

- Physician leadership
- Create a clear message and a burning platform
  - “This is a national crisis not a QuadMed crisis and we are a critical part of the solution.”
  - 78 people die every day in opioid-related deaths
  - 28,470 people a year
  - Equal to a “9/11 event” every six weeks
STEP 2 – COLLECT DATA

Experience. Solutions. Results.

October 6, 2014
Hydrocodone
Class Change

Start of our QM journey
into safe opioid prescribing
## STEP 3 – DEVELOP A WORK PLAN

<table>
<thead>
<tr>
<th>2016</th>
<th>Providers</th>
<th>Physician Leadership</th>
<th>Exec Leadership</th>
<th>Clinical Leadership</th>
<th>Compliance</th>
<th>IT</th>
<th>Quality</th>
<th>Training</th>
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<td>Create strategy for our community</td>
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</table>
KEY FACTORS IN THE POLICY

1. Patient and provider to review and sign controlled substance policy
   • Patient agrees to use one pharmacy
   • To only take meds as prescribed
   • Will have QM as their medical home, not obtaining narcotics from any other provider
   • Agree to urine drug testing and pill counts as deemed necessary by the provider

2. If a patient states their medication is stolen – a police report must be filed prior to replacing medication

3. A urine drug screen must be obtained when the medication is initially prescribed and as deemed necessary by the provider at least annually
KEY FACTORS IN THE POLICY

4. State registries must be queried with each initial and refill prescription

5. A query score is to be generated – with an assessment for potential abuse or addiction

6. QuadMed providers are strictly prohibited from issuing prescriptions for controlled substances for the maintenance of drug or alcohol addiction and/or for detoxification treatment to patients. If a QuadMed provider has a patient who is in need of addiction treatment, the QuadMed provider should refer the patient to an existing facility through the following website:

   findtreatment.samhsa.gov
IT TOOLS TO HELP US BE SUCCESSFUL

• Workflow sheet

• Capacity to query the state database from EMR

• Tool to calculate the morphine mg equivalents in EMR

• Linkage in the tool to find treatment programs in the area

• Narcotic pain contract
• Document a patient’s pain score at its worst and best

• Document neuropathic pain

• Document hypersensitivity or fibromyalgia pain

• Document location of pain, intensity and how the pain affects the patient’s daily living

• SOAPP and COMM tools are available within the form
### CHRONIC PAIN QUESTIONNAIRE FORM

**Where is your pain?**

- Abdomen
- Ankle left
- Ankle right
- Arm left
- Arm right
- Back lower

**Quality of pain:**

- Aching
- Burning
- Exhausting
- Gnawing
- Miserable
- Nagging

**Interferes w/ usual activities:**

- 0: Not at all
- 1
- 2
- 3
- 4
- 5

**Interferes w/ Sleep:**

- 0: Not at all
- 1
- 2
- 3
- 4
- 5

**Negatively Affects Mood:**

- 0: Not at all
- 1
- 2
- 3
- 4
- 5

**Relief pain meds provide?:**

- 0: Not at all
- 1
- 2
- 3
- 4
- 5
CONTROLLED SUBSTANCE FORM FEATURES

- Compliance counters reset after one year
- Morphine Milligram Equivalent (MME) calculator
- Order urine drug screen and results
- Document random pill count
- Launch directly to state prescription monitoring program
- Document medication contract on file
- Opioid risk tool
- Set next refill dates
- Direct access to pain contracts
## Controlled Substance Form

### Indications
- ADHD
- Anxiety disorder
- Cancer treatment
- Chronic back pain
- Narcolepsy
- Osteoarthritis
- PTSD
- Other

### Co-morbidities
- ADHD
- Anxiety
- Bipolar disorder
- Depression
- Prior substance abuse
- Other

### Prior Evaluation/Additional Information

### Pain Rating
- Best: 5
- Worst: 8
- Current: 5

### Urine Drug Screen
- Previous Date
- Previous Value
- Enter Results
- Order Drug Screen

### Random Controlled Substance Pill Count
- Previous Date
- Previous Value
- Enter Results

### Prescription Monitoring Program Review (must perform on all new patients)
- Previous Date
- Previous Value
- Enter Results
- Go to Website

### Medication Contract on File
- Previous Date
- Previous Value
- Enter Results
- Print Contract

### Opioid Risk
- Total Score
- Risk Category
- Enter Results
- Opioid Risk Tool

### Additional Information
- Next refill due in __ days
- Set refill date
- Next refill date
- Do Not Refill Controlled Substances PRIOR to this Date
# Controlled Substance Form

**Monitoring**

- ADHD
- Anxiety disorder
- Cancer treatment
- Chronic back pain
- Narcolepsy
- Osteoarthritis
- PTSD
- Other

**ADLs-Opioid Risk**

- ADHD
- Anxiety
- Bipolar disorder
- Depression
- Prior substance abuse
- Other

**Management**

- Prior Evaluation/Additional Information

**MME**

- Include prior values in note
- Calculate MME

**Pain Rating**

- Best: 5
- Worst: 8
- Current: 6

**Urine Drug Screen**

- Previous Date: 01/26/2017
- Previous Value: acceptable
- Enter Results: [Current]
- Previous Date: 01/26/2017
- Previous Value: pass
- Enter Results: [Current]
- Order Drug Screen

**Random Controlled Substance Pill Count**

- Previous Date: 01/26/2017
- Previous Value: pass
- Enter Results: [Current]
- Commit

**Prescription Monitoring Program Review (must perform on all new patients)**

- Previous Date: 01/26/2017
- Previous Value: reviewed
- Enter Results: [Current]
- Go to Website

**Medication Contract on File**

- Previous Date: 01/26/2017
- Previous Value: Reviewed and Signed
- Enter Results: [Current]
- Print Contract
Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.
## Opioid Risk Tool

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Include prior values in note</th>
<th>Update flowsheet with all values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Criteria</strong></td>
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</tr>
<tr>
<td>Age 16-45</td>
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<td>no</td>
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<tr>
<td><strong>Family History of Substance Abuse</strong></td>
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<tr>
<td>Alcohol</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Illegal Drugs</td>
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<td>no</td>
</tr>
<tr>
<td>Prescription Drugs</td>
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<td>no</td>
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<tr>
<td><strong>Personal History of Substance Abuse</strong></td>
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</tr>
<tr>
<td>Alcohol</td>
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<td>no</td>
</tr>
<tr>
<td>Illegal Drugs</td>
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<td>no</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>History of Preadolescent Sexual Abuse</td>
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<tr>
<td><strong>Psychological Disease</strong></td>
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<td>Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, or Schizophrenia</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Depression</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

### Opioid Risk Total Score: 17

### Total Score Risk Category: High Risk
Patient Information

For: Moe Test

Opioid Contract

I agree to use opioid (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state, and federal governments. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions:

I am responsible for my pain medications. I agree to take the medication only as prescribed. I understand that increasing my dose without the close supervision of my physician can lead to drug overdose causing severe sedation, respiratory depression and death. I understand that decreasing or stopping this medication without the close supervision of my physician can lead to withdrawal symptoms such as severe pain, anxiety, and seizures.
### CONTROLLED SUBSTANCE FLOWSHEETS

**Dynamic Flowsheet**

- **Moe Test**
  - Resp Provider: PCP
  - Home: None
  - Work: None
  - Cell: (262) 555-5555

**Patient Information**
- 31 Years Old Female
- DOB: 12/04/1985
- Patient ID: 1000653758
- Ins Name: Quad/Graphics Medical

**Flowsheet View**
- Controlled Substance History

**Flow Details**

<table>
<thead>
<tr>
<th>Date</th>
<th>Indications</th>
<th>Co-morbidities</th>
<th>Opioid Risk Score</th>
<th>Pain Management</th>
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<tr>
<td>01/26/2017</td>
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</tbody>
</table>

**Additional Options**
- Graph
- Organize
- Edit
- Medscape General Search

**Set Attached View**

**Use Date Range**

**Dropdown Options**
- View: Pain Management
- Set Attached View
- Use Date Range

**Columns**
- Days
- Indication
- Co-Morbidities
- Opioid Risk Score
- SOAPP Score
- COMM Score
- Contract on File
- State Review
- Drug Screen
- Pill Count
- Next Refil Date
- Pain Last 3 mos
- Pain Right Now
- Pain at Best
- Pain at Worst
- Pain Location
- Quality of pain
- Interferes Mood
- Sleep Patterns
- Prior Treatments
- Overall Functions
"You can’t manage what you can’t measure."
- Peter Drucker

- Number of mg of morphine equivalents being prescribed by the network
- Opioids with benzodiazepines (BZD), or antidepressants
- Opioids with sleep apnea
- Patients with high-dose opioids

“In God we trust, everyone else must bring data” - Deming
END OF 2017 DATA

Experience. Solutions. Results.

October 6, 2014
Hydrocodone Class Change

Start of our QM journey
into safe opioid prescribing

Total CII by Year
2013 - Nov 2016

Grand Total
Providers
• Analyzed data to select providers

Patients with MME > 100 and BZD (July through December 2016) 60

Patients with MME > 100 (January 2017) 36

• Meet monthly to discuss the challenges and provide support to safely manage patients
• Team controls the agenda and discussion topics to focus on areas of need
• Will shape the program for the remainder of the group
SAFE PRESCRIBING

• Integrated into QuadMed KPIs reported to the board
• Metric is part of the management and provider bonus calculation
• Peer review of charts for all providers prescribing opioids over 100 MME and concurrent BZD
  ▪ Providers role to limit the number of patients to be peer reviewed
  ▪ Organizational support of the peer review structure
• Mandatory completion of education and knowledge assessment for all providers on the controlled substance policy, with HR implications for non-compliance
PROVIDERS RESPONSE

- “The policy gives me a frame to begin the discussion with my patients.”
- “The decision support tool helped me learn about the MME and made it easy to do the right thing.”
- “The learning cohort gives me the opportunity to work this through with other providers.”

PATIENT STORY

- Provider helped a patient move from extremely high MME with BZD to a successful weaning of all her meds
- “She was a new person, more alive and engaging to everyone in the health center.”
1. **IT clinical decision support**
   - Adding weaning template and calculator to the EMR tools
   - Adding discharge education
   - Considering discharge information on disposal of medications

2. **Clinical aspects**
   - Getting health centers to utilize their local 211 resources
   - Signage in the health centers
   - Standardization of the stocking and prescribing of naloxone in the health centers
   - Continuing to adjust the policy

3. **Monitoring and training**
   - Continued training using computer-based resources
   - Monthly data sharing at the CMO forum
   - Tracking and engaging with all new providers at 30, 60 and 90 days

4. **Partnering with employers in high-risk geography**
THANK YOU – KEY RESOURCES

- https://www.cdc.gov/drugoverdose/index.html
- www.scopeofpain.org
- www.opiodprescribing.org
- http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/All-New-Products/SMA16-4742
Exercise
Topic Tables

1. Safe opioid prescribing – changing provider behavior at the individual level
2. System changes to facilitate evidence-based care
3. Patient education about chronic pain, pain management, and risks of opioids
4. Using teams to treat addiction in primary care
5. Making addiction treatment more accessible/available
6. Linking with community-based efforts
7. Other topics – please nominate!
Final Q&A and Wrap Up