Addressing Patient Safety and Provider Support through the Implementation of a Controlled Substance Policy, Clinic-Based Monitoring Program, and Interdisciplinary Opioid Action Plan

Mary Blankson, DNP, APRN, FNP-C
Chief Nursing Officer
The Community Health Center Inc.
Middletown, Connecticut
Presenter Disclosures

No personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months.
Federally Qualified Health Centers (FQHCs)
- Nation’s largest safety net setting
- Located in designated high need communities
- Caring for 24 million patients annually
- 93% served are below 200% poverty & 35% uninsured

CHC Profile
- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Annual budget: $100m
- Staff: 1,000
- Patients/year: 100,000 (est. 2017)
- Specialties: onsite psychiatry, podiatry, chiropractic
- Specialty access by e-Consult to 15 specialists

Elements of Model
- Fully Integrated teams and data
- Integration of key populations into primary care
- Data driven performance
- “Wherever You Are” approach

Weitzman Institute
- QI experts; national coaches
- Project ECHO* — special populations
- Formal Research and Development
- Clinical Workforce Development
Chronic Pain in the US

- Chronic pain affects at least 116 million Americans and costs up to $635 billion in medical treatment and lost productivity\(^1\)
- Majority of patients with pain seek care in a primary care setting\(^1\)
- Primary Care Providers express low knowledge and confidence in pain management and receive little pain management education\(^2\)
- Opioids are heavily relied on for pain management in primary care
- Prescription opioid overdose is a major and growing public health concern
Oxycodone Consumption (mg/capita) 1980-2013
International Narcotics Control Board, World Health Organization
Opioid Crisis

Providers
Alleviate Suffering & Improve Quality of Life

Industry
Treat Pain & Develop a Market

Patients
Struggling with Chronic Pain, Unrecognized/Untreated Trauma & Many with Prior History of Substance Use Disorder or other BH Comorbidities
Added Complexity

- Insurance Coverage
- Lack of Access to Specialists
- Transportation Issues
- Health Literacy (Perception of pain, other modalities, lifestyle modification)
- Changing guidelines
- And others
Pain patients are like beach balls at a concert
Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- Telehealth
- Learning and Collaboration
- Oversight
- Prevention & Treatment of Substance Use Disorder

http://diysolarpanelsv.com/free-clipart-support.html
Supporting Primary Care Providers to Improve Pain Care

- **Standards**
- E.H.R. Solutions
- Data Tools
- Telehealth
- Learning and Collaboration
- Oversight
- Prevention & Treatment of Substance Use Disorder
CHCI Standard Policy for Opioid Prescribing

All patients receiving COT* must have

• Signed opioid agreement scanned and saved in the HER, Updated Yearly
• Random Drug screen at least once every 6 months
• Follow up visit every 3 months (minimum) using pain template and functional assessment
• Review of State PMP
• Behavioral Health co-management encouraged

Primary care providers should avoid:

Rx > 90MME

Opioids and benzodiazepines in combination

*COT defined as receipt of 90 days or more of prescription opioid analgesic medication
Stepwise Approach to Pain

• Non-opioid treatments. Non-controlled medication.
• Alternative Services
  • Chiropractic care
  • Acupuncture
  • Physical Therapy
  • Nursing Support
  • Nutritional Support
• Behavioral Health Co-Management
• Realistic goals and expectations: function vs. pain free
Supporting Primary Care Providers to Improve Pain Care

- Standards
- **E.H.R. Solutions**
- Data Tools
- Telehealth
- Learning and Collaboration
- Oversight
- Prevention & Treatment of Substance Use Disorder

http://diysolarpanelsv.com/free-clipart-support.html
Customize EHR to Support Quality Pain Care
Use an Opioid Agreement

Controlled Medication Agreement

Name: ___________________________  Date of Birth: ___________________________

- Some medicines (“controlled medications”) can be dangerous and addictive. Problems can include driving accidents, confusion, vomiting, breathing problems, itching, constipation and more. If used incorrectly, these medications can also cause death.

- I understand that this medication carries the risk of dependence and/or overdose.
- Sharing my medication may also result in harm or death. I promise to keep my medication safe.
- The problem we are treating is: ___________________________. If I do not reach the goal, the medicine may be stopped.

- The goal of treatment is: ___________________________.
- I will have my controlled prescriptions filled only at this pharmacy: ___________________________.
- I cannot ask for an early refill, and I will not call after-hours for refills. That means I will only call between 8:30 AM and 4:30 PM Monday through Friday. I also agree to always be polite to office staff. When it is time for a refill, I will make an appointment if my provider asks me to.
- My provider will ask me to follow up regularly for these medicines, and missing appointments may result in my medicine being stopped.
- Unless there is an emergency, I will only get my prescriptions from this clinic. If there is an emergency, I will call as soon as possible to let the clinic know.
- Because these medications can be dangerous, I agree to random drug tests (urine or saliva) and medication checks. A medication check means I will be called, and must come in with my medications on the day I am asked. Refusing drug tests or medication checks may result in the medicine being stopped.
- I will not use illegal drugs or abuse alcohol.
- I understand that changing a prescription is a crime.

- Because of the dangers of these medications, they will be stopped if the risk appears to be more than the benefit. If someone calls and says I am selling or misusing my medicine, the medicine may be stopped.

Date: ___________________________  Patient Signature: ___________________________

Date: ___________________________  Provider/Nurse Signature: ___________________________
Routine Drug Screens

• Frequent, but irregularly timed drug screens
• Know how to correctly order urine screens from your local lab
  • Capture all lab codes
• Know how to correctly interpret urine drug tests
  • Confirming Rx’d medication presence
  • Confirming Non-Rx’d medication absence
Use State Prescription Monitoring Sites

Use State Prescription Monitoring Sites

Connecticut Prescription Monitoring & Reporting System (CPMRS)

www.ctpmp.com
Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- **Data Tools**
- Telehealth
- Learning and Collaboration
- Oversight
- Prevention & Treatment of Substance Use Disorder

http://diysolarpanelsv.com/free-clipart-support.html
Use Data to Monitor: Dashboard

- % Panel on COT
- Presence/absence of opioid agreements
- Presence/absence of toxicology screening
- Last Pain Assessment (template used—includes functional assessment & risk mitigation)
- Last CTPMP check
- Last BH encounter
- Next BH encounter
- BH provider
## Opioid Management Dashboard

**Data as of: 10/1/2012**

<table>
<thead>
<tr>
<th>Total of Chronic Opioid Patients</th>
<th>Total of Current Opioid Patients</th>
<th>Panel Size (12-mon)</th>
<th>% of Panel on Chronic Opioids</th>
<th>Total of 1-Utx Opiates (1-mon)</th>
<th>% Of Contract Patients (ever)</th>
<th>% of Opioid Contract (ever)</th>
<th>Total of Opioid Contract (12-mon)</th>
<th>% of Survey Patients (3-mon)</th>
<th>Total of Survey Patients (3-mon)</th>
<th>Patients Not Seen (Hed) within 3-mon</th>
<th>% Not Seen within 3-mon</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>32</td>
<td>952</td>
<td>3.57%</td>
<td>20</td>
<td>62.50%</td>
<td>84.38%</td>
<td>18</td>
<td>56.25%</td>
<td>6</td>
<td>18.75%</td>
<td>3</td>
</tr>
<tr>
<td>65</td>
<td>61</td>
<td>976</td>
<td>6.66%</td>
<td>50</td>
<td>81.97%</td>
<td>51</td>
<td>83.61%</td>
<td>30</td>
<td>49.18%</td>
<td>4</td>
<td>6.56%</td>
</tr>
<tr>
<td>45</td>
<td>43</td>
<td>1076</td>
<td>4.18%</td>
<td>25</td>
<td>58.14%</td>
<td>33</td>
<td>76.24%</td>
<td>26</td>
<td>60.47%</td>
<td>11</td>
<td>25.58%</td>
</tr>
<tr>
<td>55</td>
<td>52</td>
<td>1209</td>
<td>4.55%</td>
<td>38</td>
<td>73.98%</td>
<td>29</td>
<td>55.77%</td>
<td>9</td>
<td>17.31%</td>
<td>7</td>
<td>13.46%</td>
</tr>
<tr>
<td>13</td>
<td>13</td>
<td>662</td>
<td>1.96%</td>
<td>7</td>
<td>53.85%</td>
<td>11</td>
<td>84.62%</td>
<td>10</td>
<td>76.92%</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>112</td>
<td>106</td>
<td>1111</td>
<td>10.08%</td>
<td>86</td>
<td>81.13%</td>
<td>99</td>
<td>93.90%</td>
<td>84</td>
<td>79.25%</td>
<td>27</td>
<td>25.47%</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>677</td>
<td>0.15%</td>
<td>1</td>
<td>100.00%</td>
<td>1</td>
<td>100.00%</td>
<td>1</td>
<td>100.00%</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>682</td>
<td>1.17%</td>
<td>5</td>
<td>62.50%</td>
<td>5</td>
<td>62.50%</td>
<td>5</td>
<td>62.50%</td>
<td>3</td>
<td>37.50%</td>
</tr>
<tr>
<td>21</td>
<td>15</td>
<td>1271</td>
<td>1.65%</td>
<td>7</td>
<td>46.76%</td>
<td>11</td>
<td>73.33%</td>
<td>9</td>
<td>60.00%</td>
<td>2</td>
<td>13.33%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>882</td>
<td>0.45%</td>
<td>3</td>
<td>75.00%</td>
<td>2</td>
<td>50.00%</td>
<td>1</td>
<td>25.00%</td>
<td>3</td>
<td>75.00%</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>584</td>
<td>0.17%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>443</td>
<td>1.13%</td>
<td>4</td>
<td>80.00%</td>
<td>4</td>
<td>80.00%</td>
<td>4</td>
<td>80.00%</td>
<td>3</td>
<td>60.00%</td>
</tr>
<tr>
<td>14</td>
<td>12</td>
<td>1160</td>
<td>1.21%</td>
<td>3</td>
<td>25.00%</td>
<td>7</td>
<td>58.33%</td>
<td>3</td>
<td>25.00%</td>
<td>2</td>
<td>16.67%</td>
</tr>
<tr>
<td>15</td>
<td>15</td>
<td>200</td>
<td>7.50%</td>
<td>11</td>
<td>73.33%</td>
<td>9</td>
<td>60.00%</td>
<td>0</td>
<td>33.33%</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>945</td>
<td>0.85%</td>
<td>5</td>
<td>71.43%</td>
<td>4</td>
<td>57.14%</td>
<td>4</td>
<td>57.14%</td>
<td>1</td>
<td>14.29%</td>
</tr>
<tr>
<td>82</td>
<td>77</td>
<td>1012</td>
<td>7.79%</td>
<td>50</td>
<td>64.94%</td>
<td>65</td>
<td>84.42%</td>
<td>49</td>
<td>63.64%</td>
<td>42</td>
<td>10.39%</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>832</td>
<td>0.60%</td>
<td>4</td>
<td>80.00%</td>
<td>5</td>
<td>100.00%</td>
<td>5</td>
<td>100.00%</td>
<td>2</td>
<td>40.00%</td>
</tr>
<tr>
<td>67</td>
<td>63</td>
<td>661</td>
<td>10.14%</td>
<td>37</td>
<td>58.73%</td>
<td>38</td>
<td>60.32%</td>
<td>32</td>
<td>50.79%</td>
<td>28</td>
<td>44.44%</td>
</tr>
<tr>
<td>15</td>
<td>15</td>
<td>625</td>
<td>2.40%</td>
<td>15</td>
<td>100.00%</td>
<td>8</td>
<td>53.33%</td>
<td>8</td>
<td>53.33%</td>
<td>8</td>
<td>53.33%</td>
</tr>
<tr>
<td>21</td>
<td>18</td>
<td>830</td>
<td>2.53%</td>
<td>12</td>
<td>66.67%</td>
<td>11</td>
<td>61.11%</td>
<td>8</td>
<td>44.44%</td>
<td>10</td>
<td>55.56%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>962</td>
<td>0.42%</td>
<td>12</td>
<td>50.00%</td>
<td>3</td>
<td>75.00%</td>
<td>2</td>
<td>25.00%</td>
<td>1</td>
<td>5.56%</td>
</tr>
</tbody>
</table>

---

**Chronic Opioid Patients**

**Community Health Center, Inc.** Where health care is a right, not a privilege, since 1972.
## Systems and Technology and Process Collaborative Care Dashboard

- **Planned Care in Behavioral Health**
- **Delivery of Integrated Services**

<table>
<thead>
<tr>
<th>ID</th>
<th>Total Therapy Visits</th>
<th>Intake Date</th>
<th>Last Therapist</th>
<th>Last Psychiatry Provider</th>
<th>Initial CarePlan</th>
<th>Last Review</th>
<th>Last Discharge</th>
<th>Last PHQ</th>
<th>Controlled Substance</th>
<th>Auth ReqD</th>
<th>Alerts</th>
<th>Flu Shot Due</th>
<th>Fluoride Varnish Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>8/27/2015</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>8/27/2015</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>10/8/2012</td>
<td>9/7/2015</td>
<td>N/A</td>
<td>4/2/2015</td>
<td>11/26/2013</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>4/2/2015</td>
<td>7/29/2015</td>
<td>N/A</td>
<td>3/31/2015</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>8/18/2015</td>
<td>1/24/2013</td>
<td>1/6/2015</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

For New Britain Medical

<table>
<thead>
<tr>
<th>Appt Start</th>
<th>Appt Stop</th>
<th>Resource Name</th>
<th>Appt status</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:20:00 AM</td>
<td>9:40:00 AM</td>
<td></td>
<td>Scheduled</td>
<td>8H Diagnosis</td>
</tr>
<tr>
<td>9:40:00 AM</td>
<td>10:00:00 AM</td>
<td></td>
<td>Scheduled</td>
<td>Opioid Patient</td>
</tr>
<tr>
<td>9:40:00 AM</td>
<td>10:00:00 AM</td>
<td></td>
<td>Scheduled</td>
<td>Opioid Patient, Last PHQ &gt;= 15</td>
</tr>
</tbody>
</table>
Rethinking the warm hand-off process: Proactive vs. Reactive

- Medical initiated warm hand-off and behavioral health initiated warm hand-off
- Staggered vs. consecutive visits – make our presence known
- Criteria:
  - No BH services and PHQ above 15
  - No BH services and BH Diagnosis
  - No BH services and chronic pain patient
Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- **Telehealth**
- Learning and Collaboration
- Oversight
- Prevention & Treatment of Substance Use Disorder
Treat Pain by Moving Knowledge, Not Patients

- **F2F**
  - Face to face

- **Telehealth**
  - Direct specialist to patient consults

- **Project ECHO**
  - Provide ongoing case-based learning and consultation with an expert, multidisciplinary team

- **eConsults**
  - Provide PCPs with access to quick, useful electronic consults from specialists

Moving Knowledge, Not Patients
10/21/2015 01:33 PM

52 yo female with hx of lumbar spine decompression surgery 6 years ago and continued stenosis and pain with radiculopathy and neuropathy. Hx of left hip pain on MRI shows left gluteal tear and surrounding muscular atrophy. Tried and failed Physical therapy, Hx of osteoporosis and gets reciast once a year. Tried and failed fentanyl patches with pain management and does not want to go back on this medication. Currently on MS contin 15mg 2 tabs BID and Percocet 7.5 TID, Gabapentin 800 mg TID, Voltaren gel PRN and ibuprofen PRN for pain relief.

My plan: Rerefer to pain management, rerefer to physical therapy, obtain most recent lumbar MRI to assess if patient needs to see orthopedic surgeon again, goal is to decrease her narcotics doses that she came to me on. Questions: [1] What further management can I offer this patient? [2] For gluteal tear, is PT contraindicated as this was a concern? [3] Any other recommendations. Thank you!

Hello! Dr L here.

Physical therapy is the ticket for the gluteal tear. Not contraindicated at all. If there is a complete tear of the tendon and there is really nothing that can be done other than improve the mechanics of the hip using surrounding muscles. The patient will need to be very compliant with home exercise program, this is the kind of thing that people need to work on at least 4 days a week with her home exercise program.

You didn't mention weight, if the patient is overweight, that weight loss will help quite a bit with hip mechanics and reduce the chance of degenerative disease related to the dysfunction of the hip muscles.

As far as exercise, cardiovascular exercise might include pool therapy when this is available if it is available and recumbent bike that sort of thing. That is going to be very important for protecting the hip and the back as well.

I would suggest that before you make the goal of decreasing narcotics use for a goal for transitioning to an aggressive lifestyle medicine-based program that includes exercise, weight loss if indicated, improving sleep. It is always best to do that before you start focusing on the opioid unless the opioid is causing severe side effects that need to be addressed through a decrease or unless you were concerned about misuse or diversion of the opioid. These are not big doses. One small change might be to change to 30 mg twice a day of MS Contin and eliminate the Percocet, or 15 mg 3 times a day and eliminate the Percocet. Regardless of the FDA labeling, MS Contin often does not last 12 hours, i.e. dosing is the most common dosing regimen United States, consequently.
Pain Management eConsult example (continued)

Make sure to set concrete functional goals, what is it she is not able to do that she would like to do? What is she able to do but not as well as she would like to? Use those to measure progress. Not changes in medication doses - although reduction in medication dose can be a secondary outcome measure.

Finally, reviewing the MRI to see if there is persistent or recurrent nerve root compression that might relate to leg pain/sciatica is a good idea. It may be that you're pain medicine consultant (we want to get away from using the phrase "pain management" because that is often connotes pharmacotherapy and pulses back to talking about pills instead of the things we want to talk to patient about) can do epidural injections, and if there is severe stenosis, he might refer for surgical evaluation if the patient is interested. However, a good lifestyle medicine plan that includes exercise, working on sleep, weight loss, smoking cessation (generic recommendations since I don't know this patient well) needs to be established first. A great reference for how to prep your patient for surgery (and how to recognize a patient who isn't ready) can be found on page 212 of Dr. David Hanscom's book "Back in Control" http://www.amazon.com/Back-Control-surgeons-roadmap-chronic/dp/0988272903.

Please let me know how helpful this is!
Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- Telehealth

- **Learning and Collaboration**
- Oversight
- Prevention & Treatment of Substance Use Disorder

http://diysolarpanelsv.com/free-clipart-support.html
Learning & Collaboration: Team Based Care

- Empower staff to manage challenging encounters
  - De-escalation Training
- Project ECHO CCM Didactics for RNs
  - Chronic Pain
  - Substance Use Disorder
  - MAT/Harm Reduction
- BH Groups as well as one-on-one
- Performance Appraisal measures for all clinical team members
Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- Telehealth
- Learning and Collaboration
- **Oversight**
- Prevention & Treatment of Substance Use Disorder

http://diysolarpanelsv.com/free-clipart-support.html
Opioid Review Committee

Committee with oversight over opioid prescribing (sub-committee of Pharmacy & Therapeutics)

- Establish Formulary (Do Not Rx, 2nd Tier Review, etc.)
- High dose opioid oversight and review
- 2\textsuperscript{nd} level review/authorization
- Review outlier providers (high pill counts, high MEQ, dangerous combos)
- Establish internal guidelines
- Follow up directly with prescriber
Figure 1. **Quarterly provider report on opioid prescribing**, page 1 (sample)

**Question a: How am I doing compared to other providers at my site and in the agency?**

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>CURRENT</th>
<th>CURRENT Site</th>
<th>CURRENT CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total prescriptions for opioids</td>
<td>115</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>Prescriptions with a high pill count</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Prescriptions with MME&gt;=90</td>
<td>17</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Prescriptions with MME&gt;=120</td>
<td>10</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Do Not Prescribe Prescriptions</strong>*</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

**High Risk Opioids**

- Nucynta or Tapentadol: 0
- Oxycontin: 5
- Opioid & Benzodiazepines: 7

**Question b: How am I doing compared to myself over time?**

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>PERIOD 3</th>
<th>PERIOD 2</th>
<th>PERIOD 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted data for period comparison (Reference is Period 1)</td>
<td>101</td>
<td>116</td>
<td>109</td>
<td>121</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>17</td>
<td>19</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>7</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>11</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**Definitions**

- **High pill count:** Dispensed 180 or more pills
- **Do not prescribe prescriptions:** Dilaudid, Soma and Hydromorphone

*Excludes Soma for Periods 1 and 2*

<table>
<thead>
<tr>
<th></th>
<th>Begin</th>
<th>End</th>
<th>Days</th>
<th>Working Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline (PERIOD 1):</strong></td>
<td>6/2/2014</td>
<td>9/15/2014</td>
<td>105</td>
<td>74</td>
</tr>
<tr>
<td><strong>PERIOD 2:</strong></td>
<td>7/21/2015</td>
<td>10/20/2015</td>
<td>91</td>
<td>65</td>
</tr>
<tr>
<td><strong>PERIOD 3:</strong></td>
<td>12/1/2015</td>
<td>3/29/2015</td>
<td>119</td>
<td>84</td>
</tr>
<tr>
<td><strong>CURRENT:</strong></td>
<td>4/1/2016</td>
<td>7/31/2016</td>
<td>121</td>
<td>84</td>
</tr>
</tbody>
</table>
**Provider Specific Opioid Data Report (Pg. 2)**

**Figure 2. Quarterly provider report on opioid prescribing**, page 2 (sample)

### Which of my patients does this report include?

<table>
<thead>
<tr>
<th>Prescriptions with High Pill Count</th>
<th>ID</th>
<th>Opioid</th>
<th>Pill Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>Percocet-5/325</td>
<td>200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>Opioid</th>
<th>MME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Morphine Sulfate ER</td>
<td>90</td>
</tr>
<tr>
<td>2</td>
<td>Oxycodone</td>
<td>270</td>
</tr>
</tbody>
</table>

### Co-Prescribing Opioids and Benzodiazepines

<table>
<thead>
<tr>
<th>ID</th>
<th>Opioid</th>
<th>Benzodiazepine</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oxycodone</td>
<td>Klonopin</td>
</tr>
<tr>
<td>2</td>
<td>Percocet-5/325</td>
<td>Ativan</td>
</tr>
<tr>
<td>3</td>
<td>Oxycodone Hydrochloride</td>
<td>Diazepam</td>
</tr>
<tr>
<td>4</td>
<td>Vicodin</td>
<td>Diazepam</td>
</tr>
<tr>
<td>5</td>
<td>Oxycontin</td>
<td>Lorazepam</td>
</tr>
<tr>
<td>6</td>
<td>Oxycodone</td>
<td>Alprazolam</td>
</tr>
</tbody>
</table>

### Do Not Prescribe

<table>
<thead>
<tr>
<th>ID</th>
<th>Opioid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dilaudid</td>
</tr>
</tbody>
</table>

### High Risk Prescriptions

<table>
<thead>
<tr>
<th>ID</th>
<th>Opioid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nucynta</td>
</tr>
<tr>
<td>2</td>
<td>Oxycontin</td>
</tr>
</tbody>
</table>

### Patients Meeting Multiple Criteria

<table>
<thead>
<tr>
<th>ID</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oxycontin and Co-Prescribing Opioids and Benzodiazepines</td>
</tr>
<tr>
<td>2</td>
<td>MME&gt;=90, Do Not Prescribe</td>
</tr>
<tr>
<td>3</td>
<td>MME&gt;=90, Co-Prescribing Opioids and Benzodiazepines</td>
</tr>
</tbody>
</table>
Components of Targeted Chart Review

- Has history, Physical Exam, and appropriate diagnostic imaging testing been documented?
- Has an assessment of risk for substance abuse, misuse, or addiction been documented?
- Has a discussion of therapeutic harms and benefits of opioids been documented?
- Is there a current controlled substance agreement on file?
- Has a discussion of goals, expectations, risks, and alternatives been documented?
- Has the patient been screened for behavioral health comorbidities such as depression, anxiety, etc.?
Components of Targeted Chart Review

- Has the patient had a visit at least once every three months in which pain management was assessed and discussed and a treatment plan was documented?
- Has a functional assessment score been documented and reviewed at least once every three months?
- Is there documentation that the PMP database has been accessed and that there are no aberrancies?
- Is random toxicology screening performed at least twice yearly?
- For patients with a history of substance abuse, psychiatric issues, or serious aberrant behaviors, have more frequent toxicology screens been performed?
Components of Targeted Chart Review

• Has a multi-modal treatment plan been developed, implemented, and documented, including referrals to behavioral health for co-management along with additional referrals as appropriate to other specialists including but not limited to the following:
  • Physical Therapy/Occupational Therapy
  • Addiction Treatment
  • Chiropractic Care
  • Acupuncture
  • Mindfulness
  • Pain Management or Physical Medicine
Components of Targeted Chart Review

• Is there documentation that the provider has asked about adverse effects from opioid medications?

• Has the provider appropriately discontinued opioid medications in the following circumstances:
  • Aberrant drug-related behavior
  • Abuse
  • Diversion
  • Lack of progress toward goals
  • Adverse reactions/effects from medication?
# Post ORC: Chronic Opioid Prescribing Practices

## Table 1. Chronic Opioid Prescribing: Percentages by measure across CHC (12 month look back)

<table>
<thead>
<tr>
<th>Measure</th>
<th>First Opioid Report (Nov. 2015) (n=100,097)</th>
<th>Most Recent Report (Sept. 2016) (n=103,520)</th>
<th>p-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent panel on opioids (90-days or more or 3+ Rx for opioid)</td>
<td>2.85% (2,857/100,097)</td>
<td>2.61% (2,702/103,520)</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>CTPMP (every 12 months)</td>
<td>39.45% (1,127/2,857)</td>
<td>68.17% (1,842/2,702)</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Utox (every 6 months)</td>
<td>41.62% (1,189/2,857)</td>
<td>77.13% (2,084/2,702)</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Opioid agreement ever</td>
<td>77.18% (2,205/2,857)</td>
<td>77.35% (2,090/2,702)</td>
<td>Not statistically significant</td>
</tr>
<tr>
<td>Pain assessment done</td>
<td>34.23% (978/2,857)</td>
<td>54.77% (1,480/2,702)</td>
<td>p&lt;.001</td>
</tr>
</tbody>
</table>
Post ORC: Opioid Prescribing Practices in 3 Month Period

Table 2. **Opioid Prescribing: Prescribing in three month period across CHC**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions with high pill count (&gt;180 pills)</td>
<td>4.3% (205/4,721)</td>
<td>1.6% (55/3,410)</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Prescriptions with MME &gt;=90</td>
<td>19.4% (916/4,721)</td>
<td>14.8% (506/3,410)</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Prescriptions from the &quot;Do Not Prescribe&quot; list</td>
<td>3.1% (148/4,721)</td>
<td>1.4% (48/3,410)</td>
<td>p&lt;.001</td>
</tr>
</tbody>
</table>
Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- Telehealth
- Learning and Collaboration
- Oversight

- Prevention & Treatment of Substance Use Disorder
The Opioid Crisis

• Opioid Overdose deaths have quadrupled since 1999 and account for roughly 63% of drug overdose deaths in the US in 2015³

• Sharp increase between 2006-2015³
  • Increase in the supply and use of heroin
  • Increase of mixing fentanyl into heroin supply
  • Increase in deaths involving synthetic opioids without heroin

***The strongest risk factor for heroin use and dependence is misuse of or dependence on prescription opioids***
Opioid Action Plan

• Inclusion of all departments (clinical & non-clinical)
• Interventions designed to:
  • Enhance patient and community education
  • Improve Access (to MAT, ancillary care, etc.)
  • Engage community partners
  • Improve team support (standing orders, BH groups, etc.)
  • Involve all care delivery sites (SBHCs, W.Y.A., Prenatal, etc.)
  • Measure/evaluate impact (short-term, intermediate and long-term effects)
  • Share Successes and Best Practices
### Opioid Action Plan

#### CHC Opioid Action Plan: Logic Model

**Purpose:** CHCI is committed to implementing a comprehensive action plan that will work to:

1. Prevent abuse and addiction
2. Improve access to effective treatment for addiction
3. Reduce contributing factors to abuse and addiction
4. Reduce the number of deaths by opioid overdose AND
5. Support and care for individuals and families affected by opioid addiction and deaths by overdose

<table>
<thead>
<tr>
<th>Response</th>
<th>Inputs &amp; Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Effects/Outcomes</th>
</tr>
</thead>
</table>
| #1       | Project ECHO (Pain & Buprenorphine) | *Twice Monthly (Pain) or Monthly (Bup) videoconference didactics  
*Case-Based learning and knowledge transfer                       | *Provider Attendance  
*Provider Case Presentations                                      | *Improved Provider Awareness of Evidence Based Guidelines and CHCI Policy with regard to Pain Management and Chronic Opioid Use  
*Improved Provider Perception of Resource Availability  
*Patient Access to Specialty Consult |
| #1       | PainNET                           | *Online Peer Consults  
*Online Discussion Forums                                           | *Provider Use of Online Community                                                         | *Provider Knowledge and Self-Efficacy with regard to Pain Management & Chronic Opioid Use  
*Patient Access to Specialty Consult |
| #1       | eConsults (Pain & Buprenorphine)  | *Timely, Patient-Specific, Expert Consultations                                               | *Provider Initiated eConsults                                                              | *Patient Uptake of MAT  
*Improved Patient Outcomes & treatment of opioid addiction  
*Death by Overdose |
| #2       | Providers                         | *Require/Incentivize x-License  
*Incentivize Increased Caseload  
*Train/Enroll NP/PA staff                                               | *Providers with x-License  
*Potential Patient Treatment “slots”  
*All Provider Types with x-License                                      | *% of Providers with x-License (all provider types)  
*Patient Access to MAT  
*All Team Members Implementing Role-Specific Support for MAT (eg. MA, RN, BH) |
| #2       | Grand Rounds                      | *Provider/Team Education on MAT Options                                                          | *Grand Rounds Attendance                                                                  | *Patient Uptake of MAT  
*Improved Patient Outcomes & treatment of opioid addiction  
*Death by Overdose |
| #2       | Nursing Practice Updates          | *Nursing Standing Orders for MAT Support  
*Structured Template Creation  
*Training/Implementation                                                  | *Training Attendance                                                                    |                                                                                |
Opioid Action Plan

• Policy Issues (CHC & State/National)
• Narcan
• EHR Updates (templates, documented patient ed, etc.)
• Other providers: BH, Chiropractors, Dieticians
• CCM
• Prenatal
• SBHC
• W.Y.A.
• HR
• Leadership/Regional VPs
• Communications
Conclusion and Next Steps

- Chronic Disease Approach/Chronic Disease Support
  - MI/SMG Opioids/Chronic Pain/Addiction
- Planned Primary Care
  - Planned Care Dashboard Alerts
  - Standing Orders
  - Streamlined Nursing Visits
  - Consider Studying Required Chiro prior to Opioid Initiation
- Address Behavioral Health Co-Management/Co-Prescribing Responsibilities
- Formal OAP Scorecard to Track Outcomes
Implications for the DNP

• The possibilities are endless
  **BUT**…

• You have much responsibility
  • Demonstrate Leadership
  • **Focus** on Change that Makes a REAL Difference
  • Innovate
  • Don’t Be Afraid to Think Too Small or Too Big
  • Measure, Measure, Measure
  • Celebrate Success & Failure
  • Listen to Your Mentors
  • Support Others Along the Way
Other Key Individuals

• Margaret Flinter, PhD, APRN, FNP-BC, Sr. Vice President & Clinical Director
• Veena Channamsetty, MD, Chief Medical Officer of CHCI
• Daren Anderson, MD, Chief Quality Officer of CHCI and Director of the Weitzman Institute (WI)
• Tim Kearney, PhD, Chief of Behavioral Health of CHCI
• Sheela Tummala, DDS, Chief Dental Officer
• Nick Ciaburri, Director of Business Intelligence
• Zachary Manville, Database Developer II
• Tierney Giannotti, MPA, Quality Improvement Data Analyst for CHCI & WI
References


QUESTIONS?

Contact:
Mary Blankson, DNP, APRN, FNP-C
Chief Nursing Officer
Community Health Center Inc.
675 Main Street
Middletown, CT 06457
mary@chc1.com