Safe Prescribing Action Group:

Core components of safe clinic culture and resident teaching

Agenda

- Welcome
- Housekeeping, Quick Introductions
- Purpose of Action Group, Objectives for our Kick-Off Webinar, Introduce Faculty
- CHCF perspective
- What Does Good Look Like?
- Design of the Action Group: Elements, Calendar, Basecamp, Homework, Next Steps
- Open for Questions

Housekeeping

- This session will be recorded
- Slides and recording will be posted on action group website (Basecamp) within a week
- To ask a question:
  - Logistical questions: Use CHAT to the Host
  - Questions for Speakers : Use CHAT to ALL
- Webinar Evaluation: please take a moment at the end of the webinar to give feedback

Who's in the (Virtual) Room?

Objectives for Action Group

- Learn how clinics can reinforce safe prescribing practices
- Learn how residency clinics integrate evidence-based addiction treatment (e.g. buprenorphine in primary care)
- Learn about teaching resources for residency curricula
- Develop and implement an action plan for your clinic
- Learn from others, with support of faculty and coach

Faculty

Kelly Pfeifer, MD
Director, High-Value Care
CHCF

Diana Coffa, MD
Residency Director
UCSF/SFGH Family Medicine
Residency Program

Kristene Cristobal, MS
Cristobal Consulting, LLC

Sharone Abramowitz, MD
Director, Behavioral and
Addiction Medicine
Highland Hospital

Dan Alford, MD
Associate Professor of
Medicine, Boston University
School of Medicine

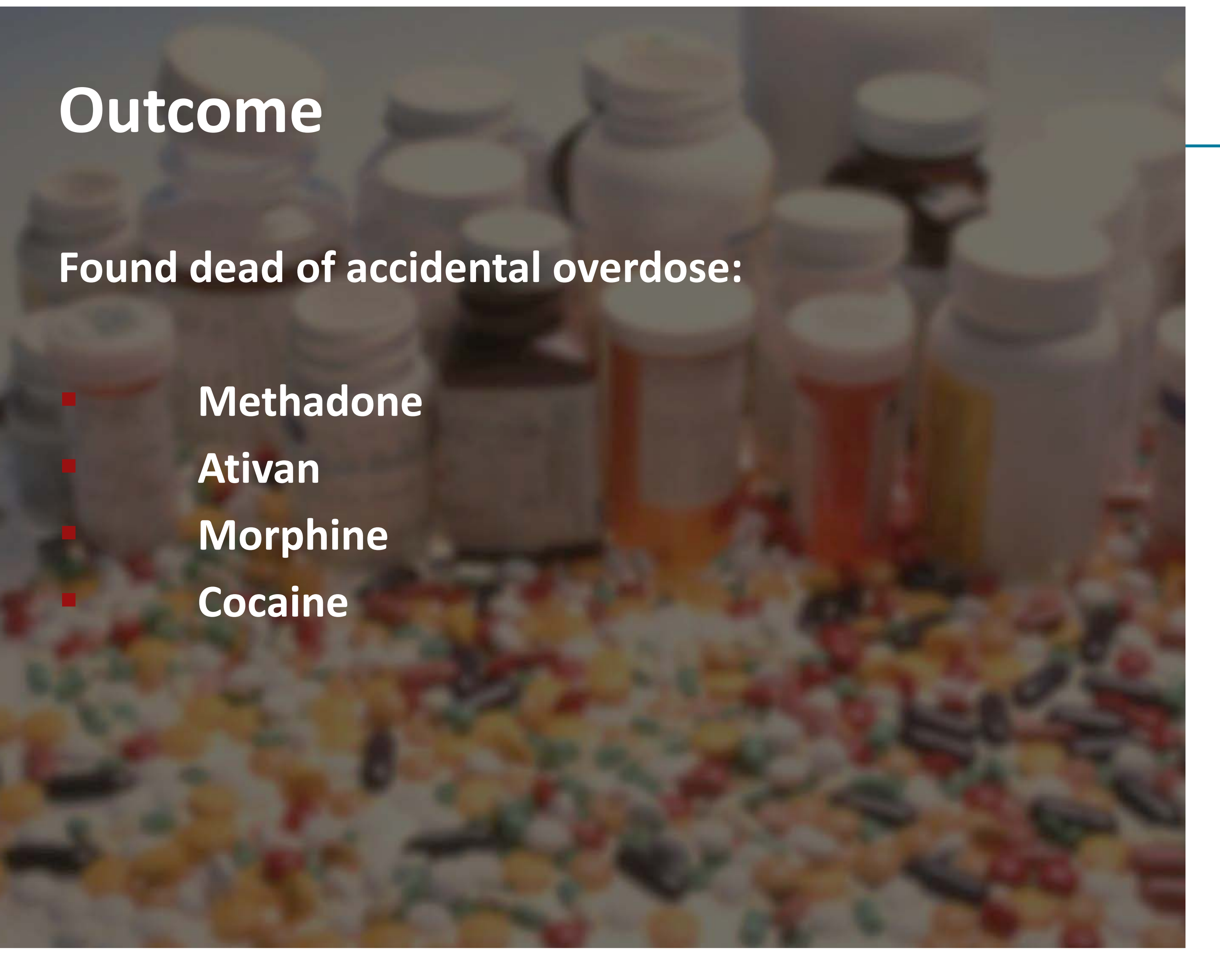
Striking a Balance: opioid safety

CHCF perspective

"Look, you've got to stop thinking that one little pill is going to solve all your problems...You need to take at least *four*, twice a day."

Beth's story

- Chronic low back pain
- Inherited her on 180 mg daily of morphine plus lorazepam
- Some concerning behaviors:
  - 1 urine positive for cocaine
  - 1 drug test refused
  - Didn't follow through with PT or behavioral referral



Outcome

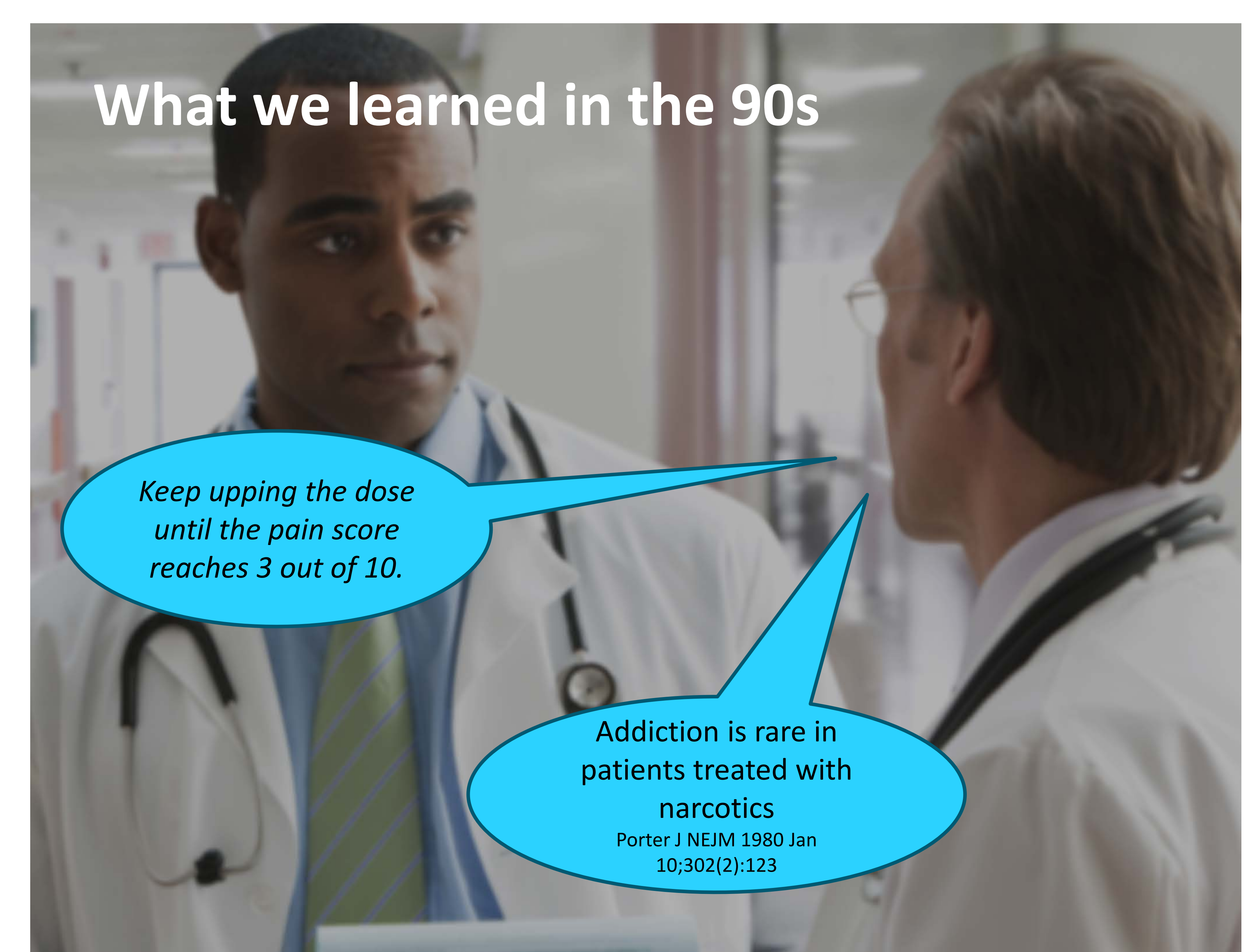
Found dead of accidental overdose:

- Methadone
- Ativan
- Morphine
- Cocaine

What did I do wrong?

- According to Medical Board of CA
  - Combined benzos and opiates
  - Did not diagnosis substance abuse disorder, and then taper or switch to buprenorphine
  - Did not insist on behavioral health evaluation
  - Did not assess whether opioids improved function
  - Poor indication (opiates not effective in chronic low back pain)

GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN


What we learned in the 90s
Keep upping the dose until the pain score reaches 3 out of 10.
Addiction is rare in patients treated with narcotics
Porter J NEJM 1980 Jan 10;302(2):123

What we know now in 2015

- Addiction in chronic opioid use: 30%
- Dose-dependent increase in death rate
- Medical complications of long-term opioid use:
  - Sleep apnea
  - Osteoporosis
  - Hyperalgesia
  - Depression
- Long-term opioid use has profound impacts on the brain neurochemistry
  - Repair takes years
  - Not always reversible

CHCF strategy based on 3 national priorities

- **Safe Prescribing**: training, resources and guidelines
- **Medication-Assisted Treatment**: expand access
- **Increase use of naloxone**, an antidote to reverse overdoses

STRATEGY 1:

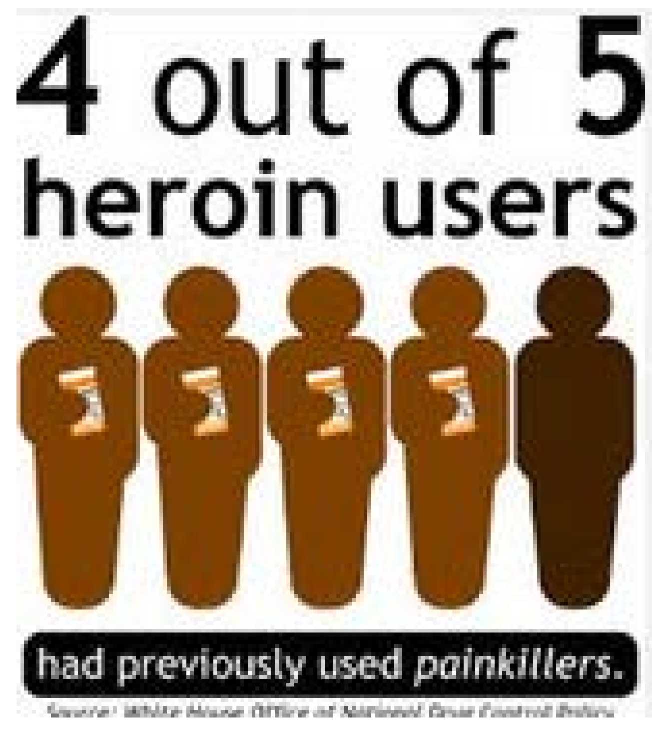
Promote safe prescribing practices

EXAMPLES:

1. Acute pain:
    - Use opioids judiciously and in small doses
    - Avoid the 90 day cliff
2. Chronic pain
    - Avoid high-risk meds: benzo/opioids, methadone
    - Monitor for and act on concerning behaviors
    - Utilize buprenorphine for opioid use disorder and/or mixed pain and substance use
    - Recognize high-risk threshold:
        - >100 mg morphine equivalents and >40 mg methadone
        - Avoid escalations above threshold
        - Slowly wean down where possible

STRATEGY 2:

Expand Access to Medication-Assisted Treatment: don’t create opioid refugees



Which patient should be fired?

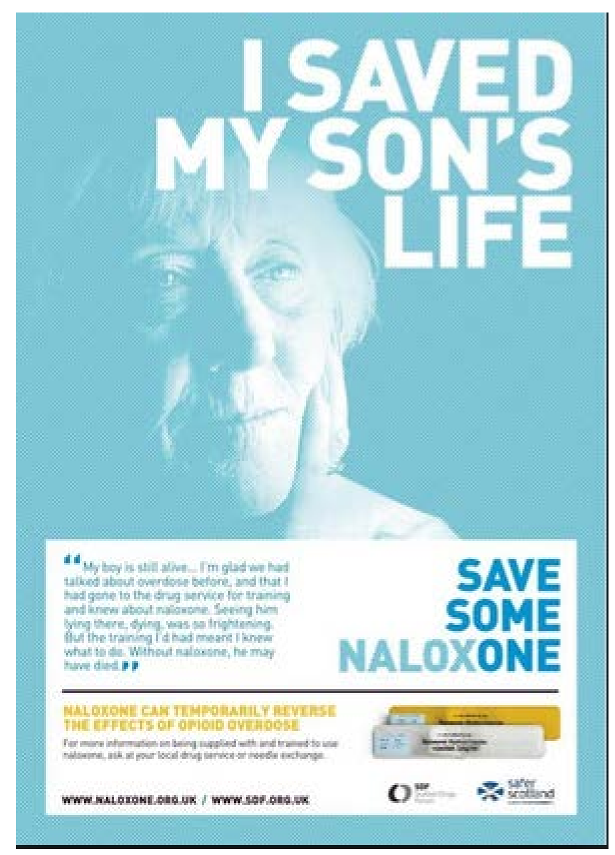
Addiction is a chronic neurochemical disease.

Buprenorphine compensates for broken dopamine pathways – decreases use of heroin and street opioids.

Buprenorphine access in communities cuts overdose rates in half.

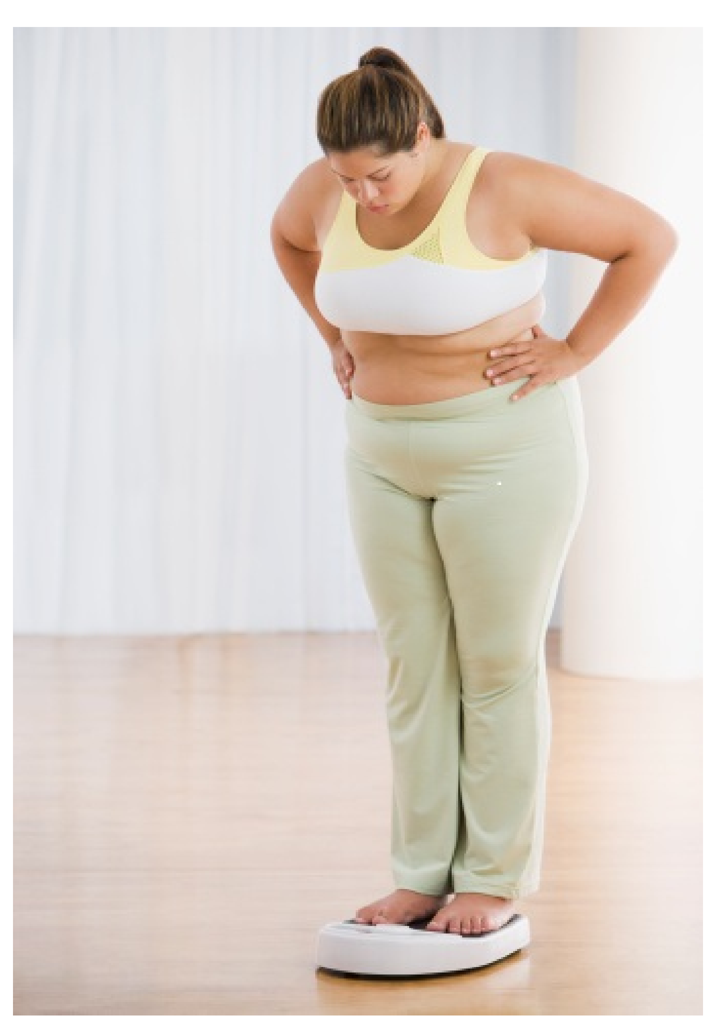
STRATEGY 3:

Increase Use of Naloxone, *an overdose antidote*



County	Overdose deaths per 100,000 (total # 2008-12)	Vicodin per resident per year 2013
Alameda (Highland)	1.7 (132)	45
Contra Costa	3.5 (64)	64
Fresno	6.1 (53)	53
Los Angeles (White)	1.8 (905)	21
Monterey (Salinas)	4.1 (86)	103
San Bernadino (Loma Linda)	2.2 (221)	56
Sonoma (Santa Rosa)	7.1 (95)	49
Stanislaus (Modesto)	4.2 (109)	95
Ventura	6.6 (220)	52
California Average	4.0 (7428)	123

Success story: Molly



What does “good” look like?

Example of a residency program that has deeply invested in a safe prescribing culture

Diana Coffa, MD

Residency Director
UCSF/SFGH Family Medicine
Residency Program

The Problem

"To hear about pain is to have doubt;
to experience pain is to have certainty."

Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World*, 1987

Increased awareness of opioid risks leading to anger and frustration, lack of compassion, and clouding of clinician judgment.

High-yield interventions at SFGH

1. Consistent policies – supported by all faculty
2. Controlled substances review committee – reviews high-risk cases by report and by referral
3. Robust curriculum, including medication-assisted addiction treatment
4. Options for nonopioid treatments, including resident rotation through pain groups

Consistent Policy

- Initial patient assessment
  - Addiction and overdose risk
    - Opioid Risk Tool
    - Mental health assessment
  - Assessment of function
    - Physical, emotional, social, sleep
- Reassessment at standard intervals
  - Frequency
    - Monthly for moderate to high risk patients
    - Q3 months for low risk and stable patients
  - Monitor for functional improvement

Consistent Policy

- Refill policy
  - Early refills allowed once a year
  - Early refills must be reported to the review committee
- Monitoring for misuse
  - Urine Drug Screen and CURES report at least annually for ALL patients on opioids
  - Otherwise based on risk assessment and with dose changes

Consistent Policy: teaching compassion during tough conversations

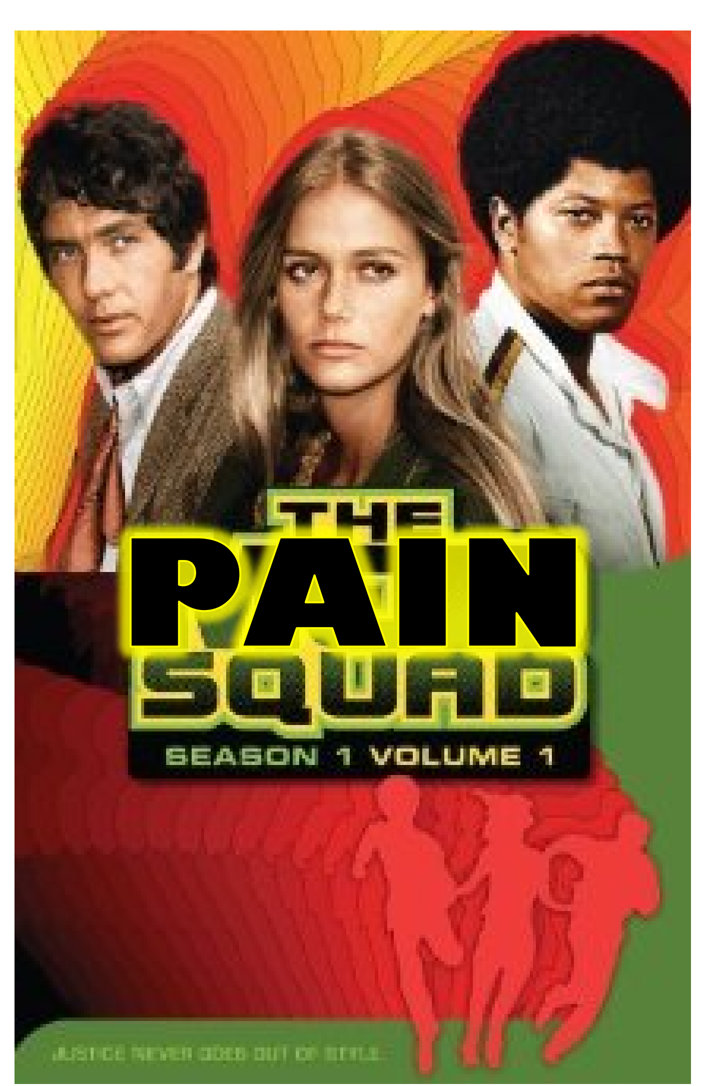
- Lisinopril analogy
  - BP of 90/40? D/C Lisinopril for safety, not punishment.
  - Review new treatment plan

- Identify compassionate reason for d/c'ing med -- stay in touch with that throughout the conversation
  - "I am concerned and will keep working with you"
  - "I care about your safety"
  - "If you cannot function without opioids, buprenorphine is a safer option"

Controlled substances review committee

Tasks for multi-disciplinary team:

- Review patient cases and develop recommendations
- Develop clinic policies
- Manage pain-related QI projects



Case Reviews

- New patients (referrals from other clinics)
- Solicit referrals from providers, RNs, MAs, Clerks, and Behavioral Clinicians
  - Worried about opioid misuse
  - Worried about overdose risk
  - Inadequate pain control
- Case-find using registry
  - Positive urine drug test
  - High dose
  - Combo benzos/opioids

Medication-Assisted Treatment for Opioid Use Disorders

- Buprenorphine-naloxone training for residents
  - Medication –assisted treatment lecture
  - Site visit to the SF Office-based Buprenorphine Induction Clinic (OBIC)
  - Optional rotation in OBIC clinic

Chronic Pain Group

- Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT) and relational model
- Better functional outcomes than opioids[1]
- Equal or better pain management outcomes[1]
- Combination of
  - Self management teaching
  - Education
  - Cognitive reframing and thought management
  - Social support

1. Morley S et. al. Systematic review and meta-analysis of randomized controlled trials of cognitive behavior therapy and behaviour therapy for chronic pain in adults, excluding headache. Pain, March 1999, 80:1-2, pp 1-13

Impact

- Patients:
  - “I realized I’m not alone”
  - “I still have pain, but now I can live with it. It doesn’t bother me the way it did”
  - “After just the first session, everything changed. I have hope now”
- Residents:
  - Increased interest in chronic pain patients
  - Increased empathy
  - Exposure to group visit model
  - “I actually enjoyed working with chronic pain patients!”

Offering nonopioid alternatives

- How do you make it happen?
  - Students/interns – partner with other professional schools
  - Attendings with additional skills (bill for medical visit, also provide acupuncture)
  - Group visits (bill for individual component)
  - Volunteers
  - Link with low-cost community resources

Pharmacologic

- Neuroleptics
- Antidepressants
- Anesthetics (lidocaine patch)
- Muscle relaxants
- Topicals (capsacin)
- Opioid medications/Tramadol
- Procedural pain clinic:
  - baclofen pumps, etc.
- Buprenorphine
- Naloxone

Physical

- Physical Therapy/Physiatry consults
- Joint injections
- Spine injections
- Surgery
- Stretching/strengthening exercises
- Recommendations for pacing daily activity
- Heat or ice
- Trigger point injections

Complementary and Alternative Medicine

- Acupuncture
- Mindfulness Based Stress Reduction and meditation
- Yoga Classes
- Tai-chi classes
- Massage
- Strain-counterstrain
- Anti-inflammatory diets and herbs
- Supplements
- Guided imagery

Cognitive and Behavioral

- Pain Group
- Individual therapy
- Brief cognitive and behavioral interventions in clinic
- Visualization, deep breathing, meditation
- Sleep hygiene
- Gardening, being outdoors, going to church, spending time with friends and family, etc.

Action Group Elements

Convenings	• Two in-person, full-day sessions • Oct 1 morning SCOPE training - open to public • Oct 1 afternoon teams only • March 2016, TBD – Sharing what we learned
Webinars	• Seven 90-min webex sessions through Feb 2016 • Key topics and time for sharing
Office Hours	• Four webex sessions • Two teams each session • Presentations and informal sharing, Q& A
Coaching	• Monthly coaching on goals, measures, action steps • As-needed coaching on clinical issues with faculty (Diana Coffa and Sharone Abramowitz)

Your QI Project	• Two topics:
	  • Improving clinic culture
	  • Residency training

Calendar

Webinars 90 min	7/22 12pm	8/10 12pm	9/8 11am		11/9 12pm	12/14 12pm	1/11 12pm	2/8 12pm	
Office Hours			9/21 11am		11/23 12pm		1/25 12pm	2/29 12pm	
In-person				10/1 9-5pm					Weeks of 3/14 or 3/21?
Topics	Addiction and pain	QI and Change Mgmt	Behavioral Health	SCOPE, Team planning	Patient engagement, self-care, integrative medicine	Art and science of opioid tapering	Medication-assisted treatment	TBD	Harvest our learnings
Coaching	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly

Any (major) date conflicts? Feedback on topics?

Communication and Sharing Tool

What is Basecamp for?

- Repository of Action Group materials
- Share tools and resources with each other
  - Risk assessment tools
  - Curriculum
  - Opioid agreements
- Message each other

How do I get onto Basecamp?

- Watch for an invitation to Basecamp from "Kristene Cristobal (Basecamp)", create log on
- Post your first assignment – SMART goals

Team Homework

1. Complete brief baseline assessment (http://goo.gl/forms/2pX9zVu7ak)
2. Sign up for coaching calls with Kristene (Link from SignUpGenius)
3. Meet as a team:
    - Create 2 SMART goals
    - Set up meeting calendar
    - Assign responsibilities
4. Share SMART goals next webinar

SMART GOALS	On target examples	Not so much
SPECIFIC	We will design and test 8 hours of residency training for first year residents	We will improve our curriculum
MEASURABLE	80% of attendings will sign a commitment to follow safe prescribing guidelines by June 2016	We will get buy in for a new culture
ACHIEVABLE	We will identify members of a review committee and review at least 2 charts a month for 3 months	We will implement guidelines, start a review committee, and implement a complementary care clinic by September
RELEVANT	At least 2 attendings will get bupe licenses by June	We will hire two more pain specialists
TIME-BOUND	Design urine drug screen workflow by September, test through December, review at provider meeting in January, adopt by June	Our clinic will be a better place to work eventually

PRIORITIZING: “PICK chart”

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P
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C
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IMPLEMENT **Low effort, high impact**	**POSSIBLE** **High effort, high impact**
CONSIDER Low effort, low impact	KABOSH High effort, low impact

Sample agenda for team meeting

BRAINSTORM –

Put everything you wish you could do on post-its

PRIORITIZE –

Create PICK chart and place the post-its in categories:

Implement, Possible, Consider, Kabosh

CHOOSE – what 2 things are achievable in the next year?

1 project to improve clinic culture

1 project on residency teaching

SET SMART GOALS FOR EACH

Specific Measurable Achievable Relevant Time-bound

MAKE ASSIGNMENTS

Who will do what by when?

Next Steps

- Webinar Evaluation: please take a moment to respond
- Visit our Basecamp
  - Slides and recording will be posted within a week
- Calendar: review and submit major conflicts to Kristene
- Schedule Your Team Meetings
- Complete homework
- Expectations for next webinar (7/22): Assessment and SMART Goals
- Reminder about October 1 convening:
  - Morning open to all
  - Afternoon just action group teams

Questions?

- Kristene Cristobal, coach and project manager
  cristobalconsulting@gmail.com
- Kelly Pfeifer, MD, Project Lead
  kpfeifer@chcf.org
- Diana Coffa, MD, faculty
  Diana.Coffa@ucsf.edu
- Faculty to be introduced in future sessions:
  Sharone Abramowitz, MD
  http://www.abramowitz-psychiatry.com/about.html
  www.pcbehavioralhealth.com

  Dan Alford, MD MPH
  http://www.bumc.bu.edu/care/faculty/daniel-alford/
  https://www.scopeofpain.com/