Creating a Culture of Safe Prescribing in Clinics

April 1, 2015

We strongly encourage you join the call by receiving a call-back.

If you choose to dial-in, please be sure to use your **attendee #** found under the "Event Info" tab.

California HealthCare Foundation

California Improvement Network

Better Ideas for Care Delivery

Today's Speakers

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Petaluma Health Center

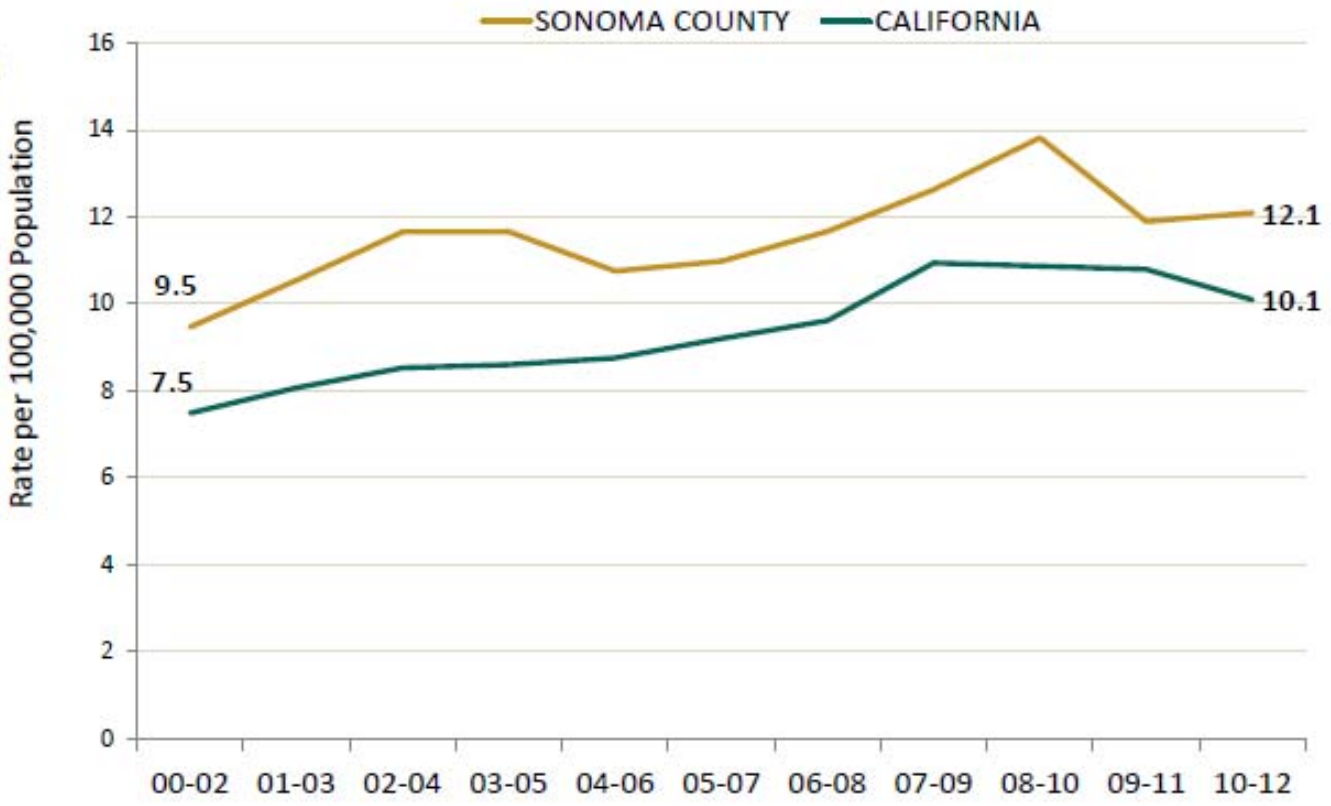
Take Home Points

- Step 1: Adhere to an accepted policy that promotes the highest standard of care
- Step 2: Expand the care team that provides care management
- Step 3: Utilize quality improvement methods to expand the capacity and decision making of that team

Petaluma Health Center

- Southern Sonoma County
- Community Health Center
- 23,000 patients
- What makes us tick:
  - Quality Improvement
  - Patient Centered Medical Home
  - Team Based Health Care

Drug poisoning death rate, Sonoma County and California, 2000-02 to 2010-12



Rates are age-adjusted to the 2000 US standard population

Source: CDPH Vital Statistics Death Statistical Master Files

Prepared by: CDPH, Safe and Active Communities Branch, Report generated from http://epicenter.cdph.ca.gov

Step 1: Policy

Petaluma Health Center: 2005

PHC in 2005: Data

- 12,000+ patients
- 400 patients on chronic opioids
- Paper charts
- Patients not on panels
- Next appt: 2-5 weeks
- Care Team Model: provider/MA teamlet
- Wellness/Groups: a few groups in place

First step: Policy

- Pain management policy created utilizing standards of care
- High agreement about need for change
- Multiple provider and staff meetings to build consensus and ensure adherence
- 45 patients taken off of opioids in the first year

Keys to a Successful Policy

Patient Centered:

Improvement of Health

Reduction of Harm

Transparency

Consistency

Reliability

BEST CURRENT POLICY:

OREGON PAIN GUIDANCE

www.southernoregonopioidmanagement.org/opioid-prescribing-guidelines/introduction/

Key Elements:

- New patient policy
- Step wise treatment plan with non-opioid alternatives
- Contraindications to opioid therapy and indications to stop opioid therapy
- Appointment, monitoring, and refill process
- Peer Review and Case Review
- Three physicians obtained buprenorphine licenses to care for opioid use disorder

Step 2: Expand the Team

PHC Care Team Expansion

Registered Nurse:

Phone screening procedure

Mandatory phone screening for all new pain patients; review of medications and explanation of clinic policies:

1. Records from previous physicians need to be in place prior to prescribing medications
2. Medications may not be prescribed for at least 30 days or at all according to PHC guidelines
3. The patient will be assigned to one physician, and they will need to stay with that physician
4. Patient Activity Report (CURES) obtained

Medical Assistant:

Required Testing and Screening

- Urine drug screen
- Medication agreement
- Patient Activity Report (CURES)
- Use of template in the electronic medical record
- Introduction to groups and wellness
- Depression Screening PHQ 2
- Alcohol Use screening
- Tobacco screening

PHC Care Team Expansion

Integrated Behavioral Health (IBH):

- All patients referred to IBH for evaluation, unless already in care
- Patients who smoke offered either one-on-one IBH appointments or shared medical visits focused on cessation coaching and education

Groups, Wellness & Ancillary Services:

- Pain management education shared medical visits: standard curriculum
- Ongoing peer support in shared medical visits
- Physical therapy referral
- Nutrition services
- Integrative medicine consultation
- Acupuncture
- Group exercise and wellness classes

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* ***Integrative Medicine*:**

Acupuncture

WHO:

* Acupuncture can help with almost any condition. We treat many people with pain (both new and old), anxiety, depression, stress, sinusitis, headaches, fibromyalgia, chronic fatigue, and more.

WHAT:

* Acupuncture is an ancient Chinese practice dating back thousands of years. Very thin needles are inserted at specific points throughout the body and left in place while you relax in a comfortable reclining chair.

WHY:

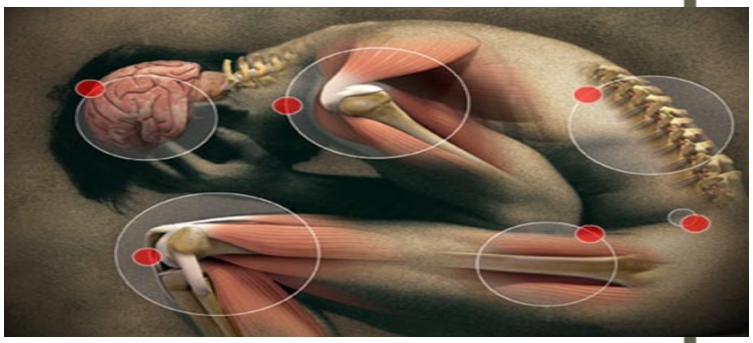
* Because it's safe and effective!

HOW:

* Ask your provider for a referral today!

***PAIN MANAGEMENT GROUP*:**

Living with Chronic Pain



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WHO:

Any person who has had ongoing pain for more than 6 weeks.

WHEN:

8 weekly two-hour sessions

Every Wednesday from 2:45 – 4:30 PM

WHAT:

This class series is designed to give you the tools necessary to live your life to the fullest despite chronic pain. Each class will include a topic discussion, as well as movement and relaxation exercises. Some techniques we have used in the past: Chi Gong, Biofeedback, Meditation, Mindfulness, Gentle Physical Exercise, Multifidus strengthening, Medicinal Salve-Making Workshop, Supplements and Herbs for Pain, Sleep Hygiene, Pacing, Communication Skills…. The list is too long!

WHY:

Because you owe it to yourself to learn all the “tricks” to help you minimize your pain and maximize your functioning!

Ask your provider for a referral today!

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* ***Mental Health Series:***

MANAGING DEPRESSION AND ANXIETY

* WHO:
* Anyone who wants to learn techniques to help with symptoms of depression and anxiety:
* -Sadness, feeling “blue”, feeling discouraged
* -Anxiety, worry, panic attacks
* -Difficulty concentrating
* -Negative thoughts
* -Sleep and eating disturbances
* -Irritability, muscle tension
* WHEN:
* 8 weekly hour and a half sessions every Tuesday 8:45 - 10:30 AM
* WHAT:
* This class series is designed to teach you new tools to improve your mood. You will learn mindfulness techniques, how to think more positive thoughts, identify behaviors you may want to change, receive encouragement, and develop healthier habits.
* WHY:
* Because you owe it to yourself to find new ways of managing depression or anxiety!

Step 3: QI, Data, and Expanding Decision Making Beyond the Team

2015: Teams receive routine reports about their comparative performance

- Patient-specific actionable data
- Team-based actionable data
- Metric definition
- Data analysis to measure success

Patients with chronic pain are more likely than other PHC patients to be up to date with health maintenance

65% are up to date with cervical cancer screening

60% are up to date with breast cancer screening

52% are up to date with colon cancer screening

56% of patients over 55 have a completed advance directive on file

2015: Multi-disciplinary review team supports PCP with objective case review and decisions

- Team as consultant to PCP
- Independent review of high risk patients without the need for PCP referral
- Team training via UC Davis Project ECHO

2015: New external drivers of change

Managed Medi-Cal Oversight:

- Required Authorization requests
- Required weaning plans
- Removal of high risk meds from formulary
- Reporting requirements
- Quality based incentives

Regional Population Health Perspective: ACO Decision Making

- Medicare population (many disabled) with chronic pain
- Cost data and quality data for these patients shared
- Regional and health center perspective and support on necessary next steps

Call to Action:
work is not complete:

Top 3 Opiates Prescribed

1. **Hydrocodone**
2. **Oxycodone**
3. **Morphine**

28% of chronic pain patients are on >100 mg morphine equivalents a day

Top 3 LONG ACTING Opiates Prescribed

1. **Morphine**
2. **Methadone**
3. **Oxycodone**

34 patients with hydromorphone on medication list

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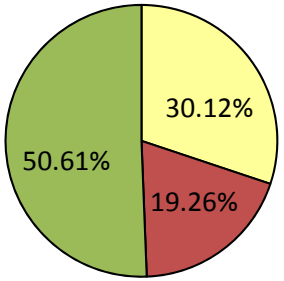
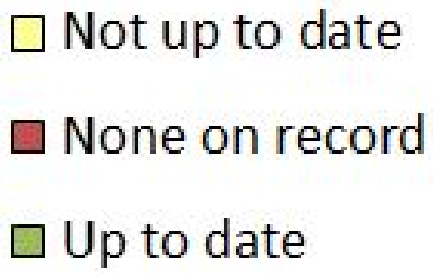
Buprenorphine is ONLY 2% of long acting opiates prescribed at PHC

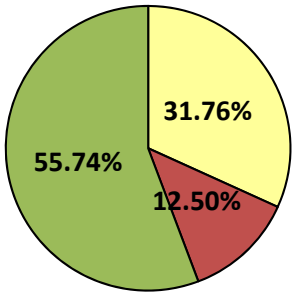
MORE THAN 60% of Patients Are Missing a Key Element of Chronic Pain Care

Medication Use Agreement

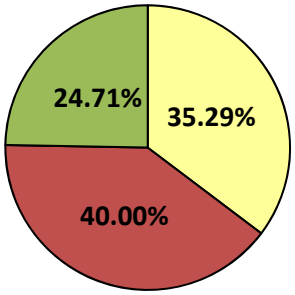




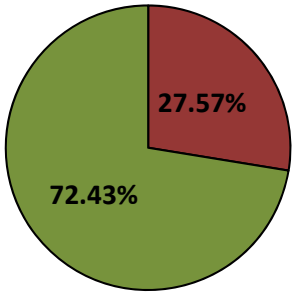
Patient Activity Reports



Methadone EKG Monitoring



Drug Screening



2015: Overall Impact of Initiative

- Safer and consistent prescribing practices
- Improved patient data, documentation, and decision support in the electronic medical record
- Enhanced care via expanded team member roles
- Team accountability through panel management and comparative data
- Less provider and staff turnover
- Increased provider confidence: “I am not in it alone”
- Improved patient satisfaction

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Recovery Oriented Pain Management for Homeless Individuals

Rachel Solotaroff, MD, MCR

Chief Medical Officer, Central City Concern

California HealthCare Foundation Webinar

April 1, 2015

CENTRAL CITY CONCERN

HOMES HEALTH JOBS

Objectives

- Brief introduction of the opioid crisis in our community and in our clinic
- Our process as a clinic to understand and address this crisis
- Lessons learned

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Background

Central City Concern and The Old Town Clinic

The Opioid Epidemic in Oregon

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Central City Concern

- CCC's Mission:

"To provide comprehensive solutions to ending homelessness and achieving self-sufficiency"

- Continuum of integrated services:
  - Affordable housing
  - Addictions treatment
  - Mental health services
  - Recovery support
  - Employment services
  - Primary care

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The Old Town Clinic

- Integrated into CCC in 2001
  - Healthcare for the Homeless Clinic
  - 4,500 patients; 15,000 PCP visits
  - 5% uninsured
  - 99% at 100% FPL or below
  - 60-80%homeless
  - High prevalence of addiction & mental health disorders
  - Internal medicine; integrated behavioral health (BH), Pharmacy & Occupational Therapy (OT)
  - Strong complementary medicine (naturopathy, acupuncture)
  - Social medicine curriculum with OHSU Dept. of Internal Medicine
  - Other robust academic partnerships (Pharmacy, Psych NP, OT)

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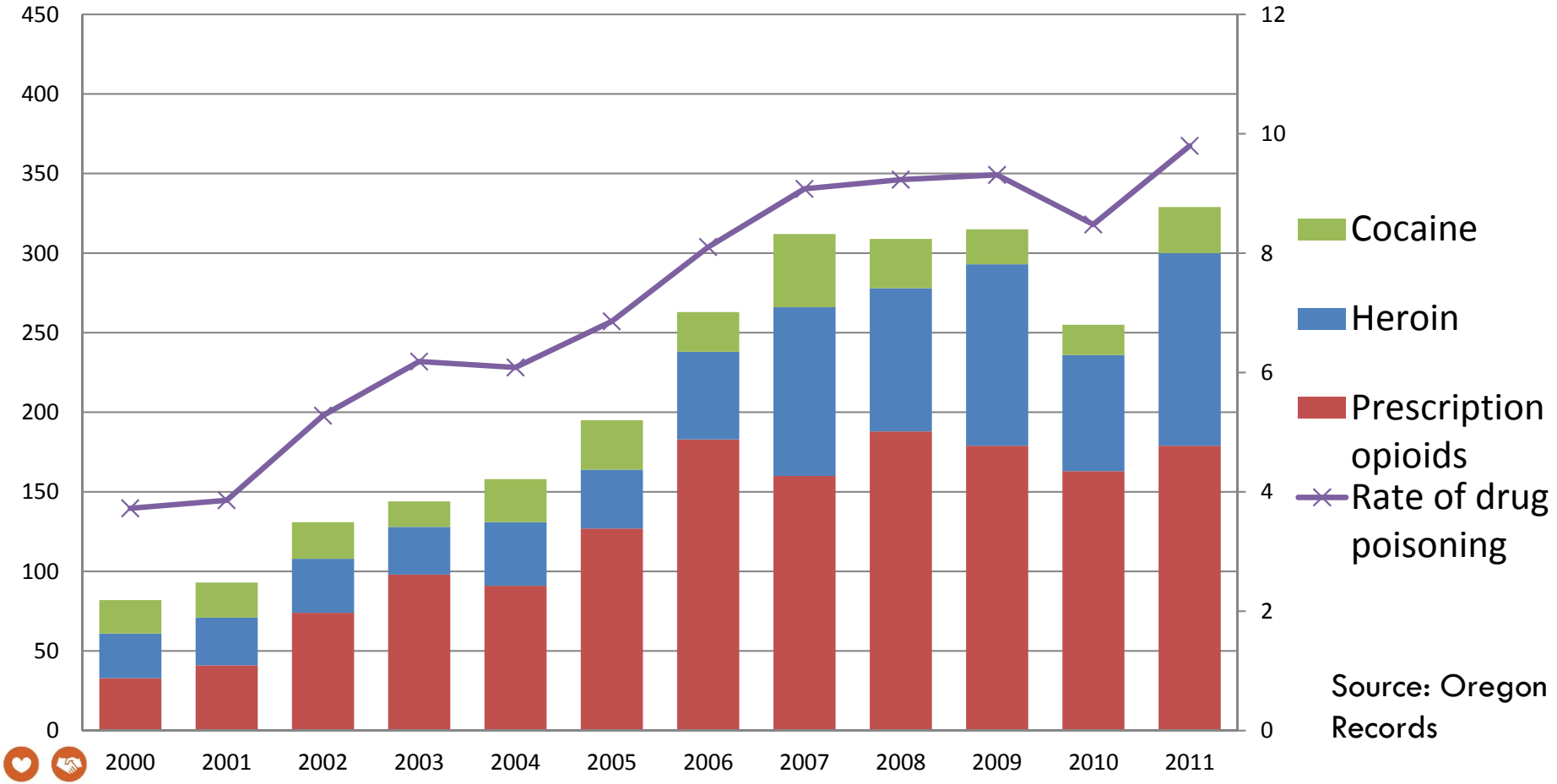
Drug Poisoning Deaths Rising: Opioids as Primary Driver

Unintentional drug poisoning deaths by year and drug type, Oregon 2000-2011



Source: Oregon Vital Records

Slide courtesy of Dagan Wright

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Opioid Misuse Growing in Oregon

2008: Oregon is **5th** highest state for nonmedical use of prescription painkillers*

6.6% of persons ≥12 years

8.2% of persons 12-17 years

17.9% of persons 18-25 years – highest in any US state

2013: Oregon is **THE** highest state for nonmedical use of prescription pain relievers:

- 6.4% of all persons ≥12 years
- 7.4% of persons 12-17 years
- 15% of persons 18-25 years

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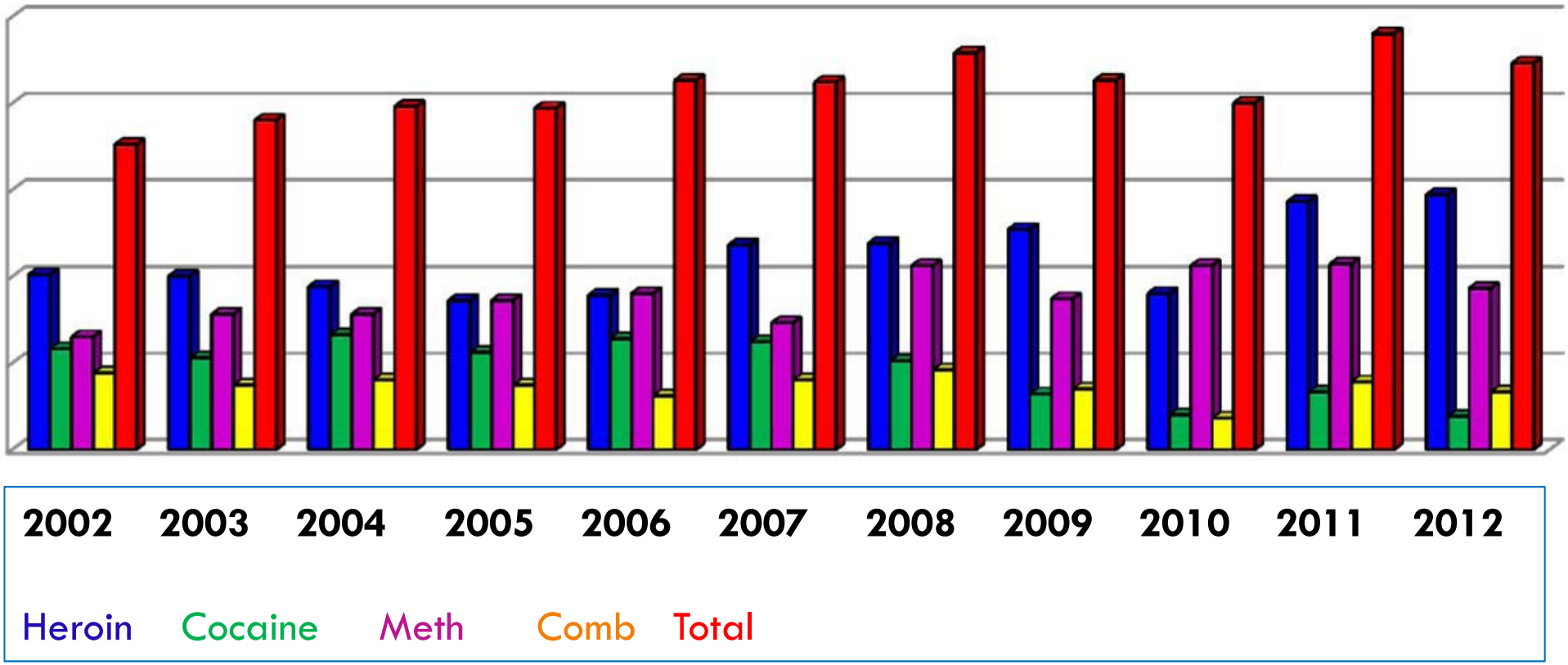
SAMHSA- 2008, 2013 National Survey on Drug Use and Health, state level data

Concurrent Rise in Heroin Related Deaths in OR

Illicit Drug-Related Deaths in Oregon, 2002-2012



Oregon State Medical Examiner, 2013

In 2012, **Heroin** was the leading cause of illicit drug deaths with 147 recorded deaths; a 2.5% increase over the previous record number (143) recorded in 2011.

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Addressing the Opioid Crisis at Old Town Clinic

Clinical Guidelines & Controlled Substances Review Committee

Segmenting the Population

Standardizing the Program

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Back at Home…

- Providers:
  - Aware of lack of evidence and risks of opioids
  - Trying to grapple with patient expectation that "a pill will make me pain free"
  - Lack of patient engagement with alternative modalities for pain management
  - Clinic sessions clogged with patients needing refills
  - Calls from the Medical Examiner when a death occurred
  - No recourse other than discharge for the "dirty U/A"
- Support Staff:
  - Struggling with phone calls and walk-ins for refills
  - Managing behavioral issues when refills not granted as expected or patients discharged from opioids

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Step 1: Establish Uniform Oversight and Prescribing Guidelines

- **Controlled Substances Review Committee (CSRC):**
  - Reviews all episodes of serious misuse or misconduct
  - Reviews all requested new starts on chronic opioid therapy
  - Provides guidance for complex pain management cases

- **Early prescribing guidelines:**
  - When to refer to CSRC
  - Prescribing to patient on methadone maintenance, in alcohol and drug treatment
  - Process for new opioid starts
  - Other contra-indicated substances

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Chelminski et al. *BMC Health Services Research* 2005

Step 2: Integration of non-pharmacologic pain management and Addictions Treatment

- Evidenced Based Treatment for Chronic Pain:
  - Occupational Therapy
  - Physical Therapy
  - Acupuncture
  - Behavioral Health: CBT, ACT
  - Focus on function, not pain level

- Attention to Concurrent Chronic Pain and Substance Use Disorder:
  - Integrated Chronic Pain and Addictions Program – "Hot Sauce"
  - Led by drug counselor
  - 12-week curriculum
  - Focus on triggers, relapse prevention, alternative pain management, communication w/PCP
  - Integration of buprenorphine

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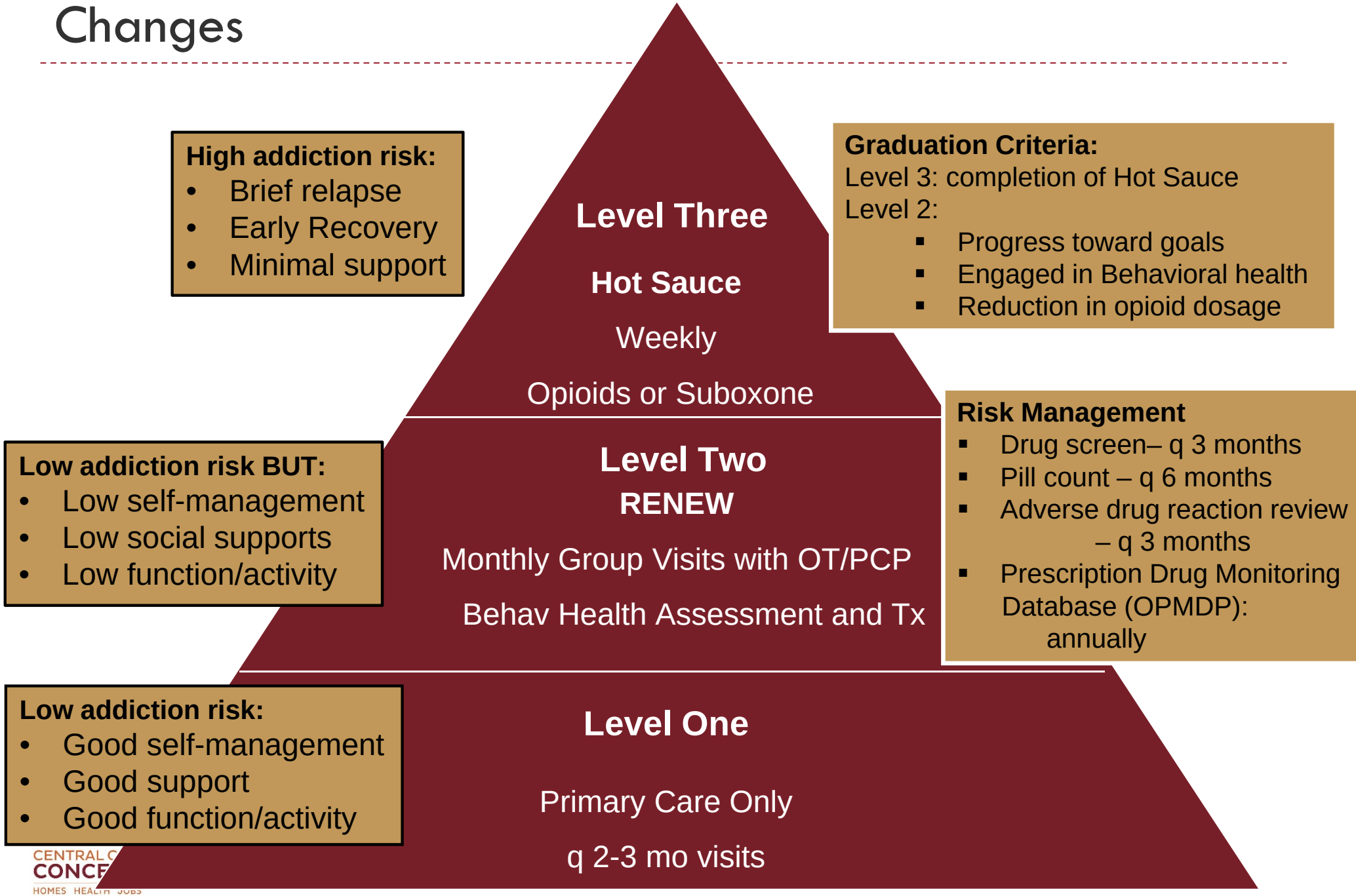
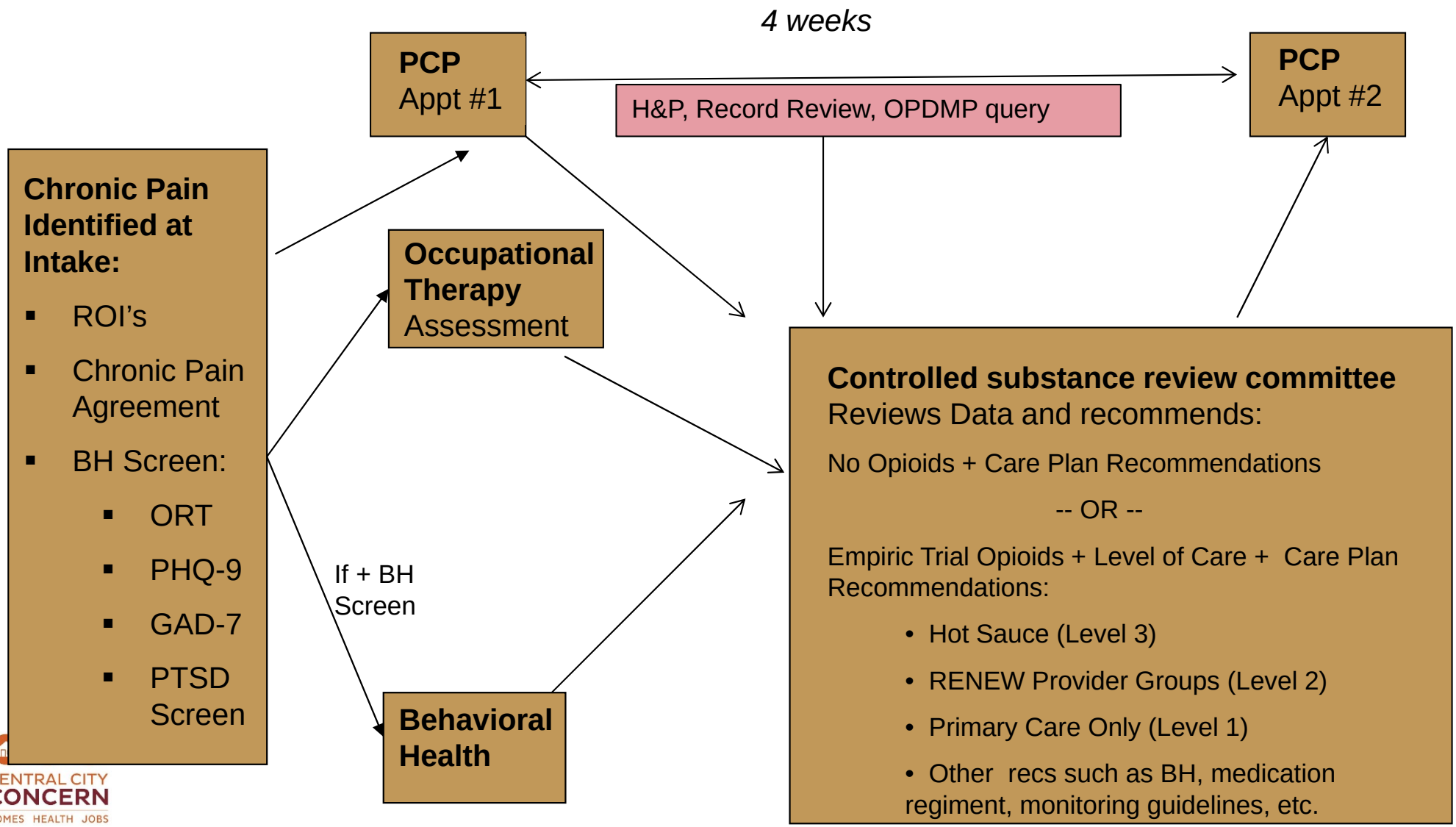
Step 3: Segment the Population and "Hardwire" the Changes



Chronic Pain and Substance Use Assessment Map



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Provider, Staff and Patient Response

- Providers:
  - Relieved at no longer having to "go at it alone"; "makes being strict less personal"; "enables discussions around public health concerns"
  - Appreciative that we were no longer a "juice bar"; still feel patients need to embrace acceptance of their responsibility in pain management
  - Appreciate structure, team support, multiple modalities of treatment (addition of buprenorphine and more intensive A&D program helpful)

- Staff:
  - Perceived decreased burden of phone calls and walk-ins
  - Patient expectations better managed; streamlined pathways for new patients

- Patients:
  - Some feel groups are supportive and helpful; others felt they are a waste of time
  - Those with untreated behavioral conditions, social isolation, trauma are more challenged, fearful, angry

Lessons Learned

- Absolute necessity and benefit of guidelines and review committee to which we all adhere
- "Cognitive dissonance" between population level data and the patient sitting in front of you
- While it's great to have so many wellness resources, patient still needs to be motivated
- Addictions/Chronic Pain program such as "Hot Sauce" is innovative, but integration of buprenorphine has been the game-changer
- After nearly seven years, pendulum slowly swinging to midpoint: appreciate need for "healthy opioid system" AND a strong, patient-centered rehabilitative program
- Need better focus on/understanding of intersection of trauma, addictions and chronic pain

For more information, please contact:

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