How to Build a Controlled Substance Review Committee in Your Primary Care Clinic: Why? Who? How?

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Disclosures

• None
Acknowledgements

• LOTS
  – All the colleagues that have taught me about how to develop, improve, and tweak a controlled substance committee.
    • Diana Coffa
    • Paula Lum
    • Scott Steiger
    • Barb Wismer
    • Doug Price-Hanson
    • Claire Horton

Roadmap

• Audience questions
• Why develop a controlled substance review committee?
• How could we do it?
• Who will this benefit?
• Take-home points
Roadmap

• Audience questions
• Why develop a controlled substance review committee
• How could we do it?
• Who will this benefit?
• Take-home points

Audience Questions

• Does your clinic currently have a controlled substance review committee?
  – Yes
  – No
Audience Questions

• Do you have in your clinic, or are you member to, a behavioral health team?
  – Yes
  – No

Audience Questions

• Do you have pharmacy support in your clinic?
  – Yes
  – No
Audience Questions

• Have you taken care of ≥ 5 patients suffering from chronic pain?
  – Yes
  – No

Roadmap

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• Why develop a controlled substance review committee?
• How could we do it?
• Who will this benefit?
• Take-home points
Why: Provider Opinion

The following summarizes my opinion about the Controlled Substance Review Committee in GMC:

Answered: 75  Skipped: 0

- I think this is a good idea. It makes my job of managing patients with chronic pain less...
- I think this is a good idea for patient safety.
- I don’t think this is important because it is unlikely to change the provider and patient.
- I don’t have an opinion

Provider Survey

- Anonymous, web-based survey of providers in the Richard Fine People’s Clinic at ZSFG
  – Urban, academic teaching clinic, Internal Medicine
- Respondents (n=76)
  – 55% residents, 37% attendings, 6% NPs
  – Majority with <5 patients taking chronic opioids
Why: Cultural Changes & Safety

![Image showing news articles about pain and opioid addiction]

Overdose Deaths Involving Opioids, United States, 2000-2015

![Graph showing the increase in overdose deaths involving opioids, with separate lines for Any Opioid, Commonly Prescribed Opioids, Heroin, and Other Synthetic Opioids]

Remember the Guidelines

• CDC Opioid Guidelines*
  – Opioids not 1st line
  – Non-pharm. and non-opioid tx are preferred
  – Chronic opioids often start with acute rxs. Use lowest dose, <3d
  – Limit MME to <50mg daily
  – Monitor closely: urine drug screen, PDMP, risk/benefit


Peer Review

• Peer review
  – Process whereby provider(s) evaluate the quality of their colleagues’ work in order to ensure that prevailing standards of care are being met
  – Origins in the 19th century when standardization of care was needed to protect the public
  – Required by joint commission (peer credentialing)
Why: Evidence Base

- Opioid Peer Review
  - Chart review tool in a family medicine clinic (n=99 charts, 14 FCM MDs):
    - **Patients**: >60% of patients with “agreement violation” before intervention, 28% with multiple violations, mean dose 76mg/day MME
    - **Intervention**:
      - chart review by anonymous peer (MD or pharmacist, 3/mo)
      - form filled out (based on prior 6 months),
      - optional in chart


## Controlled Substance Review Form

**Please:**
- Limit chart review to last 6 months.
- Please document how time to complete form.

**Medical record #**

**PCP being reviewed (initials):**

**What controlled substance? (Please circle, & write dose & amount of pills):**

<table>
<thead>
<tr>
<th>Controlled Substance</th>
<th>Dose/amt of tabs per month</th>
<th>Dose/amt tabs per min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone/Percocet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine/MS contin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alprazolam/Valium</td>
<td></td>
<td></td>
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<tr>
<td>Klonopin (Clonapam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dilaudid (hydromorphone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tramadol (ultram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valium (Diazepam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indication for controlled substance (ie back pain, fibromyalgia, etc):**

**Number of PCP Clinic visits in past 6 months. Does not include phone contact or visits to other providers in ACC clinic.**

**Is there evidence of narcotic contract in the chart? (either narcotic contract printed at somepoint, or other evidence of discussion done?)**
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Soyara Azari, MD

Is the patient in violation of controlled-substance policy by any of the below items:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failing to arrive at scheduled follow-up appointments (either PCP or referred specialist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to submit to requested urine testing or pill counts (or abnormal results on urine box or pill count)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing dose of meds without discussing w. PCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeking early refills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calling after hours for refills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting controlled substances from other healthcare providers without discussing with PCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not treating staff respectfully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misrepresenting facts or failing to discuss info to providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If patient has violated narcotic contract, how many documented violations exist?

Table 4. Provider practices per charts reviewed (n = 99)

| Percentage of patients with documented controlled substance treatment agreement in chart | 50.1 |
| Percentage of patients with urine drug screens in past 6 months |                      |
| None                                                                                   | 35.0 |
| 1                                                                                    | 20.5 |
| 2                                                                                    | 18.0 |
| 3 or more                                                                             | 26.5 |
| Percentage of patients with UDT, with abnormal results (n = 26)                       | 41   |
| Among patients with abnormal UDT, patient with prescribed drug missing (n = 20)       | 77   |
| Abnormal drug present (n = 7)                                                         | 27   |
| Percentage of patients with a random pill count in past 6 months                      | 1    |
| Percentage of charts with provider documentation of decreased pain or improved quality of life | 29   |
| Percentage of charts with provider documentation of symptoms that can be explained by possible side effects from controlled substance | 23   |
• Opioid Peer Review  
  – Outcome:  
    – mean decrease 2.6mg MED/day (v. 7mg/d increase before intervention)  
    – 16% taken off meds  
    – “I have greatly benefited from it and would certainly support a standardized approach.”

Why: Case 1

• 62yo M with hx of COPD, CAD, DM (poorly controlled), HTN, HCV, HL, R knee trauma s/p surgery with ongoing chronic pain on opioids, and seizure disorder coming for follow-up with PCP.  
• Primary complaint is poorly controlled pain. Pain is excruciating (10/10); he’s newly in wheelchair, and quite depressed “all I do is lay in bed and sleep”  
  – Requesting early refill and dose increase of opioids  
  – Reports taking friend’s methadone to control his pain because current meds not sufficient  
• Current meds:  
  – Oxycodone 20mg 1-2 tabs po TID  
  – Morphine sulfate CR 60mg po tid  
  – Clonazepam 2mg PO tid  
  – MEQ = 300mg/day
Case 1

- **Patient perspective**
  - My pain is out of control. I need more of my medicine. I know what helps me. Why can’t you increase my dose.

- **Provider perspective**
  - You are already on extremely high dose, but you are clearly suffering.
  - You are clearly depressed, but haven’t engaged with behavioral health. You missed the ortho appointment to discuss your total knee replacement, but I started these meds.

Roadmap

- Audience questions
- Why develop a controlled substance review committee?
- **How could we do it?**
- Who will this benefit?
- Take-home points
How Could We Do It?

• RFPC Controlled Substance Issues (CSI) Committee
  – Who: 1 RN, 1 behavioral health clinician (LCSW), 1 pharmacist, 1 medical assistant, 1 MD
  – When: monthly meetings, 1 hour long, over lunch hour
  – Number of Cases Reviewed: 1-4
  – Means of Referral:
    • providers (preference)
    • external referral (RNs, front-line staff)
    • registry data

How Could We Do It?

• RFPC Controlled Substance Issues Committee
  – Process:
    • Provider fills out intake form* →
    • Committee* discusses case and reviews additional information
      – Alternative pain treatments being used,
      – PAR,
      – urine drug screen data,
      – attendance at appointments,
      – behavioral health involvement →
    • Recommendations sent to provider by email
      – *optional in/out of official medical record
How Could We Do It?

- **RFPC Controlled Substance Issues Committee**
  - **Process:**
    - Provider fills out intake form* →
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  ![Diagram](image)

How Could We Do It?

- **If done well**
  - Reviews are supportive, not punitive
  - Pools knowledge and resources
  - Provides “external” perspective
  - Assist with patient communication (if possible)
  - Institutional support
    - Clinical FTE, blocked patient(s) slots
    - Public acknowledgment

![Diagram](image)
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Intake Form

GMC Controlled Substances Issues (CSI) Committee Intake Form

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MIN</th>
<th>DOR</th>
<th>PCP</th>
</tr>
</thead>
</table>

Morphine Equivalent Dose (MED) | Patient/Provider Agreement signed |

What is your reason for referral? What are you hoping to obtain from the committee?

Abnormal medication related behaviors

Any history of concerning behaviors? [Yes] [No] [Unknown]. *If Yes or Unknown, please see check list on back of this form.

Urine Toxicology Testing

Last urinalysis screening | Were results consistent with prescribed medication? [Yes] [No]

History of prior urinalysis screening? [Yes] [No]

Risk Factors for Opioid Abuse/Diversion/Overdose

- History of substance use disorder, including marijuana, alcohol, and marijuana
- Family history of substance abuse/dependence
- History of trauma or specific mental health A (depression, ADHD, PTSD, BPD, OCD, etc.)
- History of overutilization of medication
- History of physical or sexual abuse
- On methadone maintenance

Diagnosis/case of pain:

(Required: Current medication list, including controlled substances, up to date in EHR? [Yes] [No]

Has patient improved with opiod therapy? [Yes] [No] [Unknown]

Pain Management History

Red Flags

- Manipulative or abusive behavior directed at caregivers, including intimidation or coercion, and aimed at acquisition and continuation of the substance abuse
- Urine drug screen negative for the prescribed medication
- Urine drug screen positive for other controlled substances
- Refusal of diagnostic workup or consultation
- Multiple provider visits to PCP visits and other appointments that are part of treatment plan (i.e., behavioral health, PT, healthy spine, pain referral clinic)
- Consent for psychosocial interventions, after being told this is inappropriate
- Multiple (5+) episodes of lost or stolen prescription or medications
- Prescription forgery
- Stealing drugs from others
- Selling prescription drugs
- Obtaining prescription drugs from non-medical sources

Yellow Flags

- These are behaviors that might suggest opioid abuse or diversion, but might also be rational and normal responses to undertreated pain or to fear of pain. They have low specificity for abuse and diversion.
  - Anger or irritability when questioned closely about pain
  - More concern about controlled substance than about the underlying medical problem that persists beyond the first few visits
    - may indicate inadequate treatment of pain
  - Report of multiple medications, assuming
    - may be true, or may be the patient’s way of making sure to get the medications that they know work best for their pain
  - Request for specific drugs or refusal to take generic medications
    - may be a truly significant observation by the patient that he/she is seeking a specific opioid medication or other opioids
  - Unexplained increase in dosage or two times
    - may indicate inappropriate treatment of pain
  - Aggressive complaints about the need for more drug
    - may be a true need for increased dose
  - Open acquisition of similar drugs from other medical sources one or two times, e.g. in the ER
    - may indicate inappropriate treatment of pain or inadequate coverage of flares
  - Drug poisoning during periods of reduced symptoms
    - may include unsaturation during periods of reduced pain and is also a rational response to difficulty scheduling timely appointments and concerns about emergency preparations
  - Resistance to a change in therapy associated with “tolerable” adverse effects, with expressions of anxiety related to the return of severe symptoms
    - reasonable reaction when patient has experienced increased pain as part of withdrawal

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Example of recommendations

<table>
<thead>
<tr>
<th>GMC Controlled Substance Issues (CSI) Committee Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>PCP:</td>
</tr>
<tr>
<td>Opioid Dose: Oxycodone 10mg IR - 3 pills (30mg MEO per day)</td>
</tr>
</tbody>
</table>

**Summary:** Male 47 with a history of obesity and chronic back and knee pain on chronic opioids. Her care was evaluated because of her high dosage as an SFHP patient. Generally speaking, this patient has attempted several treatments: knee pain (pain in the knee), treated with knee injections; referred for pool therapy, tried diet, and back pain (pain previously in the spine). She was seen in Pain Clinic with and started on adjunct agents for pain. She attends PCP appointments and is up to date on pain agreement (6/2/14) and USA (4/10/14). Her PCP reports that her pain has diminished with opioids and function has improved. Her only concerning behavior has been a strong resistance to a change in therapy.

The committee recommends the following:
1. Patient should have repeat urine toxicology screen at next visit
2. The patient needs a follow-up appointment scheduled with PCP (6/2/14) seen in LCR and last apt was 6/11/13 (12/23/13)
3. Given that dose will have to be decreased in accordance with the new SFHP payment guidelines. **NOTE:** Starting 6/2/14, the non-opioid agents recently added should be titrated up. A taper schedule is provided below (4-6 week increments). We would recommend discussing this with the patient at the next visit and starting as soon as possible given the difficulty of tapering:

- Oxycodone 10mg IR 3 pills in AM, 3 pills at noon, 2 pills at 6pm, 5 pills at bedtime x weeks
- Oxycodone 10mg IR 3 pills in AM, 2 pills at noon, 2 pills at 6pm, and 2 pills at bedtime x weeks
- Oxycodone 10mg IR 3 pills in AM, 2 pills at noon, 2 pills at 6pm, and 2 pills at bedtime x weeks
- Oxycodone 10mg IR 3 pills in AM, 2 pills at noon, 2 pills at 6pm, and 2 pills at bedtime x weeks

Other Recommendation Templates

<table>
<thead>
<tr>
<th>Total morphine equivalents of current regimen:</th>
</tr>
</thead>
</table>

**Opiate Oversight Committee Recommendations**

- **Recommended Medication Changes**
  - Increase dose of oxycodone
  - Add non-opioid analgesics
  - Add gabapentin
  - Add^

- **Recommended Procedure or referrals**
  - MRI
  - CAT scan
  - Colonoscopy
  - CT scan
  - Mammogram
  - Bone scan
  - Abdominal ultrasound
  - Lung biopsy
  - Pulmonary function test

Behavioral and Psychological

- Individual therapy
- Group therapy
- Family therapy
- Cognitive behavioral therapy
- Chronic pain support group
- Pain management group
- Depression support group
- Social support group
- Pacing
- Pain management education

Case Continued

- 62yo M with hx of COPD, CAD, DM (poorly controlled), HTN, HCV, HL, R knee trauma s/p surgery with ongoing chronic pain on opioids, and seizure disorder coming for follow-up with PCP.
- Primary complaint is poorly controlled pain (10/10); he’s newly in wheelchair, depressed “all I do is lay in bed and sleep”
  - Requesting early refill and dose increase of opioids
  - Reports taking friend’s methadone to control his pain because current meds not sufficient
- MED = 300mg/day

Case

- Over the past 6 months patient has struggled with outpatient follow-up & chronic disease management:
  - No-shows to appointments (DM clinic, orthopedics to discuss knee replacement, neuro to discuss seizure regimen)
  - Does not bring meds for med reconciliation
  - Seen in ED for seizure – ethol level neg
  - Reports to PCP that he passed out a week ago and fell down stairs w/LOC – HCT neg. Sleepy at apt.
- Urine drug screens are frequently abnormal:
  - neg oxycodone,
  - pos methadone,
  - neg BZD
- Pain is terrible – only ancillary agent is gabapentin for pain
### Case

- Patient was referred to clinic controlled substance review committee. Committee recommended:
  - Utox at next visits and if abnormal, taper meds
  - Review controlled substance agreement
  - Discuss methadone
  - Rx naloxone
- Patient had repeat utox that was abnormal (pos methadone, neg oxy). PCP did not elect to taper meds given complaints of uncontrolled pain.
- Patient found dead 3 months later.
  - Cause of death: opioid overdose

### Controlled Substance Committees: Pain v. Addiction

- Distinguishing between pain and an opioid use disorder?
  - Opioid use disorder
    - 4 Rs
      - Risk of bodily harm
      - Relationship trouble
      - Role failure
      - Repeated attempts to cut back
    - 4 Cs
      - Loss of Control
      - Continued use despite harm
      - Compulsion (time & activities) need more pills, early refill requests
      - Craving
  - Withdrawal and tolerance

<table>
<thead>
<tr>
<th>Mild: 2-3 criteria</th>
<th>Moderate: 4-5</th>
<th>Severe: 6+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent episode of passing out;</td>
<td>Laying in bed all day, doing nothing</td>
<td>Time/S for methadone</td>
</tr>
<tr>
<td>Sleepy at visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I need more pills, early refill requests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time/S for methadone</td>
<td></td>
<td></td>
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</table>
Controlled Substance Committees: the 4 Quadrants

Pharmacologic

Physical

Complementary and Alternative Medicine

Cognitive and Behavioral

Pharmacologic (links to medication lists & SFHP Medical coverage)
1. Anti-inflammatory
2. Muscle Relaxants
3. Neuropathic Agents
4. Topical Agents
5. Agents for Chronic Abnormal Pain
6. Opioids
   a. Side Effects Patient Brochure here
   b. Taking Opioids safely Patient Brochure here
7. Suboxone/Naltrexone (Suboxone) for opioid use disorders and chronic pain. Covered by Medical
   carve-out.
   a. RFPC Opioids Guidelines here and home
   inclusion guide
8. Pain Consultation for Medication & Interventional Pain Management: ZSFG Pain Management Clinic;
   external
9. Non-Benzodiazepine Treatment Guide here
10. How to Prescribe NALOXONE FOR OVERDOSE PREVENTION here
   a. EEO Screen Shot here
   b. Additional PHF info on naloxone here
   c. Directions here

Complementary and Alternative Medicine

Cognitive and Behavioral

1. Physical
   a. Physical & Occupational Therapy
   b. Logan’s Fonda Ayap Therapy: external
   c. Home-based patient: Health at Home Referral
   d. Back Class: external
2. Healthy Spine Clinic: GAC and FHC patients: how to refer
3. Physical Referral (flexion, bracing): external
4. Joint Injections
   a. Ortho Joint Injection Clinic: West SFHC: external
   b. Intraarticular Injections: external
   c. Knee Injection: arthrotomy & video
   d. Shoulder Injection: arthrotomy & video
5. Orthotics Form, (stability) please here
6. Exercise Programs
   a. Wellness Center calendar
   b. Simple Back Exercise handout here, or here
   c. Sanitation Army own membership $25/ mo, 240

Cognitive and Behavioral

1. Chronic Pain Group: 12 weeks, Monday afternoons at ZSFG, Room via Behavioral Health Team
2. Warm handoff to Behavioral Health in Clinic. Referral via Behavioral Health Team
   a. Short-term therapy
   b. Group classes, Epsy & Spans
3. Mental Health ACCESS line (all SF): 415-255-3777
4. Chronic Pain in 5 Minutes Video x2, and with Spanish subtitles x2
5. Chronic Pain Toolkit Video (intro) here
6. Sleep Hygiene handout here
7. Chronic Pain toolkits for patients: Pain / Flare pain
8. Ladies Night: Mission Neighborhood Resource Center, Third nights, Frs. 165 Capp (near 17th street)
9. RAISE Peer Support Wellness Center (Market and 9th, 1252 Market) - cooking, art, and exercise classes, free
10. EDUCATION: refer patients to the American Cancer Society.

https://goo.gl/Ggsemj

Another Referral

• LE is a 65yo M with a hx of DJD, remote “substance abuse,” HTN, HCV, and depression presenting for follow-up. He has been on long-standing chronic opioid therapy for DJD pain with the following:
  – Oxycontin 180mg po tid
  – Methadone 20mg po tid
  – MEQ = 1400mg

• Has repeatedly abnormal urine drug screens, including:
  – Absence of oxycodone
  – Presence of opiates (morphine)
  – Presence of benzodiazepines (not prescribed)
• Oxycodone not high enough to control his pain. He is also prescribed ibuprofen. He declines knee injection and has not attended physical therapy (despite re-schedules and reminders from PCP).
• Given repeated concerning behaviors despite warnings, provider initiated taper.
• Next urine drug screen positive for heroin and patient referred to CSI.
• CSI Recommendations
  – Given history and recurrent concerning behaviors with poor pain control, recommendations made to change patient to buprenorphine-naloxone

• Epilogue
  – Patient has been stable on bupe-nal >6 months
  – “I’m so glad I’m off Oxycontin”

What do Providers Actually Want?
Provider Opinion on the Role(s) of the Controlled Substance Review Committee in GMC

- Review all new starts for chronic opioid therapy: 87%
- Review all new starts for high-risk patients for chronic opioid therapy: 83%
- Create clinic-wide policies for how all providers should respond to concerning behaviors: 85%
- Make final decisions about whether a person’s chronic opioid therapy should be stopped: 88%
- Make suggestions about alternative therapies for pain: 87%
- Have the primary care provider present at meetings in which her/his patient is discussed: 67%
- Provide guidance on monitoring of patients on chronic opioid therapy: 83%
- Provide guidance on opioid tapers: 87%
- Communicate to patients about suspension of pain agreements: 53%
- Sign annual pain agreements with patients: 35%
- Other: 5%
Other Clinics
(aka, my colleagues and friends)

• Family Health Center: Pain Squad
  – Once monthly peer review
    • Used to be twice monthly to discuss clinic policies/panel management
    • Bulk of work in policies & population management
  – *Start:* RN, clerk, MA, MD, PA, NP, psychologist →
    *Now:* data manager, QI lead, MD, PA, NP, psychologist (lunch provided)
  – Email recommendations, optional to put in medical record

Other Clinics

• Tom Waddell Urban Health Center “Yellow Flag Committee”
  – Twice monthly peer review, facilitated discussion
  – Referrals by providers, often from team meetings
  – Meetings in AM (during clinic closure)
  – Recommendations emailed to provider

• Central City Concern, Portland
  – Reviews all new starts, all episodes of misuse or misconduct, and provides guidance on complex cases
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Chronic Pain and Substance Use Assessment Map

Step 3: Segment the Population and “Hardwire” the Changes

Who Will This Benefit?

- **Patients**
  - More eyes, more ideas, greater perspective
  - Maintain relationship with PCP
- **Providers**
  - “I don’t have to be the ‘bad guy.’”
- **Staff**
  - Changed the culture of opioid prescribing in our clinic
  - We know who to ask for help

Cautious Optimism: Downsides

- **Time**
  - Wrangling schedules is difficult and participant time
- **Buy-In**
  - Providers need enough time to respond and/or take action on the recommendations
  - Providers may (often) disagree with recs (what if in medical record?)
- **Needs a Champion**
- **Down-Stream Effects**
  - PCP change requests (leadership support)
  - Opioid refugees
Take-Home Points

• Controlled substance review committees are perceived by providers to be helpful in provider support & enhancing patient safety.
• Review committees have many possible designs:
  – In-person meetings with facilitated discussion
  – Individual, anonymous chart review
  – Provider panel review
• Opioid peer review is associated with a decrease in amount of opioids received by patients.
• Success of a review committee will depend on interest by providers, support by leadership, and a willingness to engage on this topic by colleagues.

Resources

• Intake Form
• Reviewer Form
• Chart Review Tool (BU)
Questions?

NEXT WEBINAR:

Friday, 09/22/2017
Transitioning High-Dose Opioid Chronic Pain Patients to Buprenorphine

Friday, 10/27/2017
Medication Assisted Treatment for Alcohol Use Disorder: A Guide for Primary Care Providers
How to Build a Controlled Substance Review Committee in Your Primary Care Clinic: Why? Who? How? / Soyara Azari, MD

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for a small fee for CME/CEU
on the CSAM Education Center at:
http://cme.csam-asam.org/

OR

Free on the CHCF TAPC Program Resource Page at:

For more information about the Naloxone Distribution Grant program

Visit: www.CDPH.CA.GOV

Or contact Nancy Bagnato
Phone: 916.552.9846
Email: Nancy.Bagnato@cdph.ca.gov
Thank you for participating in today’s webinar.

Stay online after the webinar ends and you will be connected to the post webinar quiz and evaluation.

You will also receive a link via email.

Save the date!
CSAM Addiction Medicine Review Course and Board Exam Preparation
August 24 - August 27, 2017
Hilton San Francisco Union Square