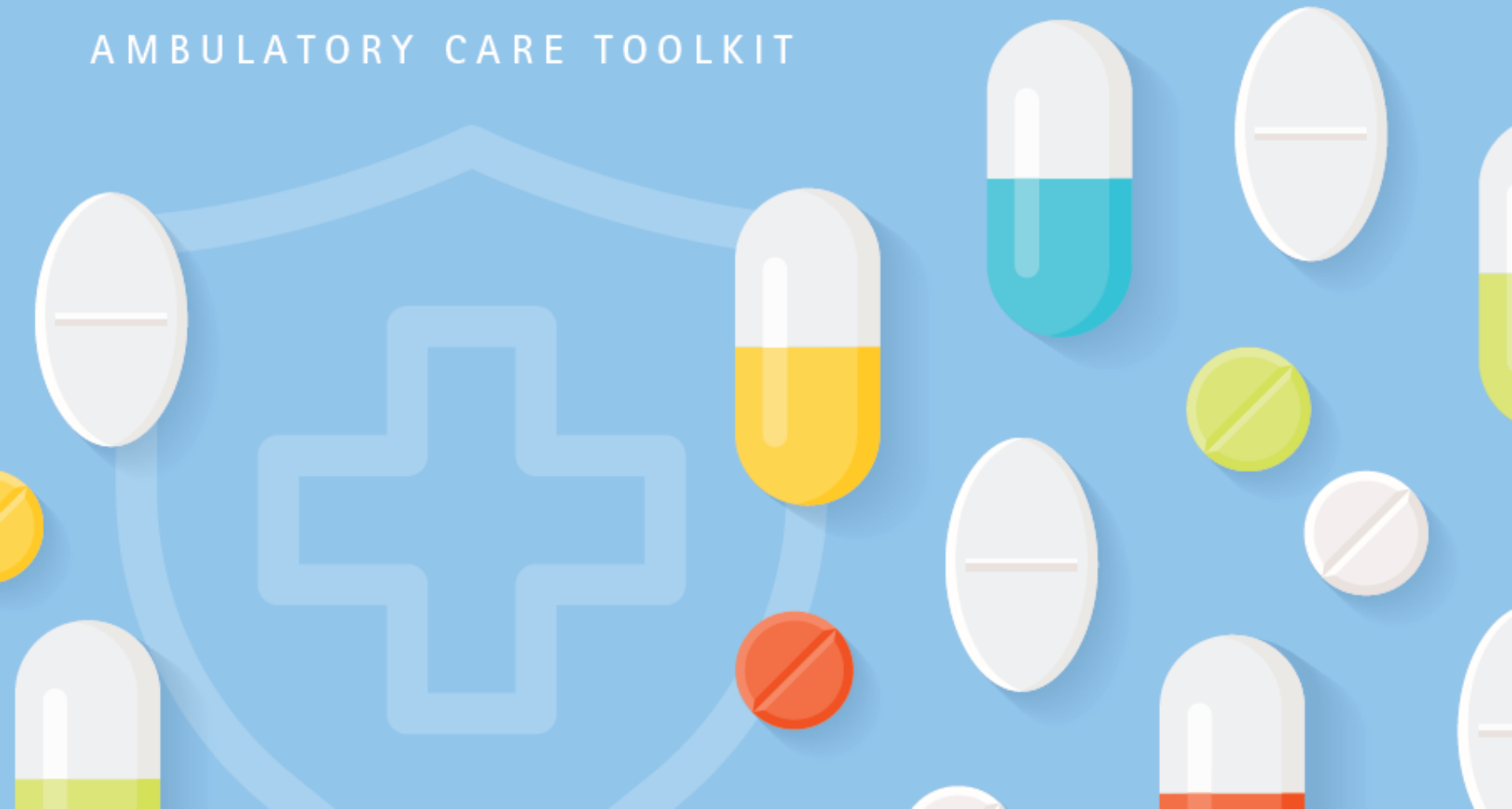
Accelerating Opioid Safety

AMBULATORY CARE TOOLKIT

CQC
CALIFORNIA QUALITY COLLABORATIVE
Breakthroughs for Better Health Care



California Department of Public Health (CDPH) data for 2017 show that while total opioid deaths in California dropped slightly and opioid prescribing declined, fentanyl deaths increased by 57%.

"We continue to step up our efforts to build a system of care in California where treatment is easier to get than street drugs...

We urgently need 'no wrong door' access to medication-assisted treatment. It should be accessible wherever people present for care."

– Kelly Pfeifer, MD
Director, High-Value Care
California Health Care Foundation

California Health Care Foundation

[California Opioid Overdose Surveillance Dashboard]

HOUSEKEEPING

- All lines are muted
- To ask a question:
  - You can submit a question at anytime through the Q&A platform located at the bottom center of your screen (NOT the chat function).
- This session will be recorded
  - The recording and slides will be available on the CHCF website.
  - You will receive an email with a link once they are available.

FACULTY

Crystal Eubanks, MS

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Breakthroughs for Better Health Care

Rachel Mashburn, PharmD, MPH

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Susie Foster, FNP

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HEALTH & WELLNESS CENTER

AGENDA & OBJECTIVES

1. Explore the California landscape through current initiatives and data.
2. Access the CQC Opioid Safety Toolkit.
3. Distinguish between 4 opioid safety improvement strategies and impactful change interventions.
4. Hear improvement stories from 2 peer organizations.
5. Discuss experiences.

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Think about your reasons for joining this session today.

What motivated you to take this time out of your busy day?

Someone I know has been impacted personally

This is an important issue at my organization

Opioids significantly impact my daily work.

Interested in learning about quality improvement efforts

Curious about what other organizations are doing

Other?

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http://calquality.org/storage/documents/Toolkits/AcceleratingOpioidSafety_Ambulatory_Care_Toolkit.pdf

Authors:

Crystal Eubanks, MS — CQC California Quality Collaborative

Denise Armstorff — Armstorff Consulting

Advisory Group Members:

Amy Nguyen Howell, MD, MBA — America's Physician Groups

Stephen Steinberg, MD — Kaiser Permanente

Sharon Isonaka, MD, MS — Cedars-Sinai

Madrone Styles, RN, MSN — Sutter Health

Kelly Pfeifer, MD — California Health Care Foundation

Lisa Ward, MD — Santa Rosa Community Health

Hannah Snyder, MD — UCSF University of California San Francisco

Jennifer Wong, MPH — Integrated Healthcare Association

Interview Informant Organizations:

blue california

Kaiser Permanente

Partnership HealthPlan of California

Santa Rosa Community Health

Cedars-Sinai

LifeLong Medical Care — Health Services For All Ages

SHOUT — Support for Hospital Opioid Use Treatment

SHARP Rees-Stealy Medical Group

El Dorado Community Health Centers

MCHC Health Centers

Safe Med LA

Shasta Community Health Center

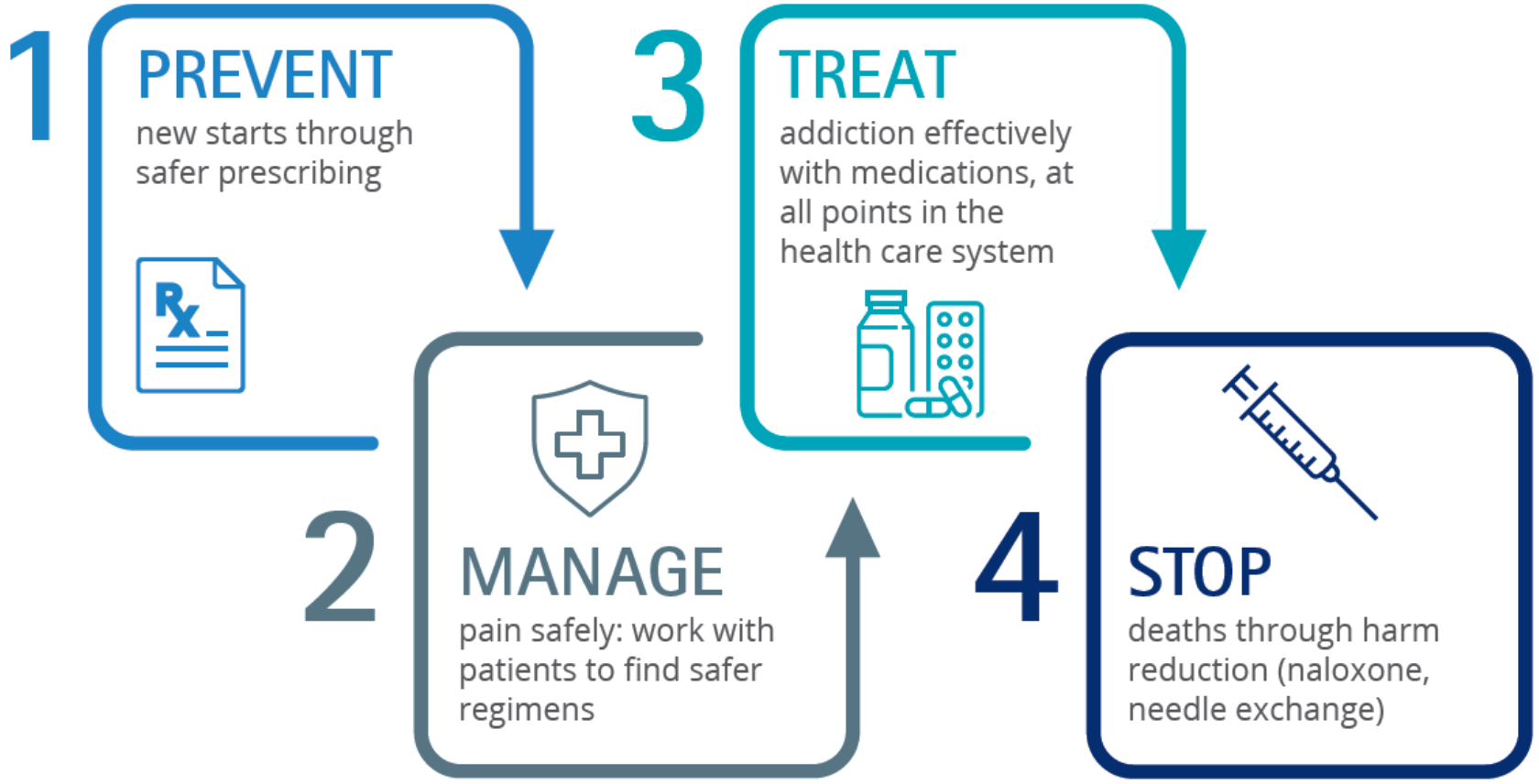
Hill Country

opendoor Community Health Centers

San Francisco Health Plan — Here for you

Western Sierra Medical Clinic — Better Health Together

IMPROVEMENT STRATEGIES



Steps to Success

1. Encourage passionate people to pilot small changes
2. Obtain leadership support
3. Convene a multi-stakeholder group
4. Standardize provider prescribing of opioids for new starts and safe tapers
5. Monitor and support prescribing compliance with guidelines
6. Expand safe prescribing to other drug types and medication combinations
7. Increase access to addiction treatment

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STRATEGY TWO

MANAGE

What are we trying to accomplish?

Reduce opioid-related harm by working with patients on risky regimens (high-dose opioids, or opioids and sedatives) and support tapering to safer doses, where medically indicated.

How will we know a change is an improvement?

Impact	Measure
Decrease number of patients prescribed opioids from escalating to unsafe dosage	✔ Percent of patients with opioid prescriptions in the measurement period whose dosage increased from the prescribed dosage in the 90 days before the first day of the measurement period
Decrease number of patients prescribed unsafe regimens	✔ Number of patients per 1,000 prescribed daily opioids for longer than 30 days Percent of patients on more than 90 MME daily (for more than 30 days) ✔ Percent or number of patients per 1,000 simultaneously prescribed opioids and benzodiazepines ✔ Percent of patients on more than 90 MME
Identify opioid use disorder; provide appropriate treatment	✔ Percent of patients with documented opioid use/prescriptions who have appropriate urine drug screening results ✔ Number of patients with four or more prescribers or pharmacies ✔ Percent of patients on chronic opioid therapy who have been screened for substance use disorder
Reduce inappropriate ED use	✔ Percent of nonfatal opioid overdoses in the ED
Decrease number of patients with addiction	✔ Number of patients diagnosed with opioid use disorder (OUD)

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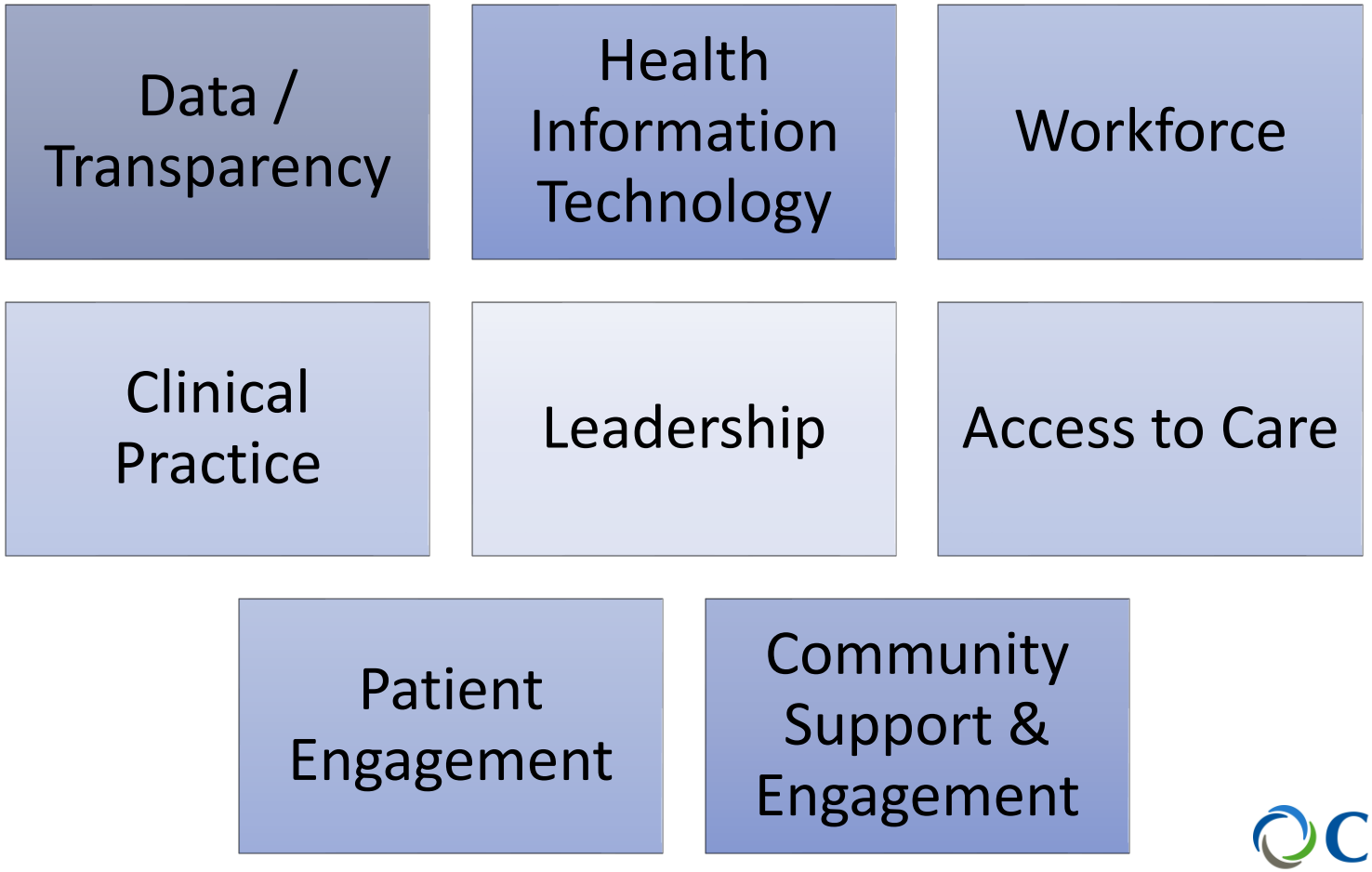
What changes can we make that will result in improvement?

Change Category	Change Ideas	Resources
Data / Transparency	» Review county-level data for prescription rates and opioid-naïve residents with long-acting opioid prescriptions. » Monitor and share data on prescribing rates and utilization of alternative therapies.	» California Opioid Overdose Surveillance Dashboard
Health Information Technology	» Create electronic health record (EHR) visit template for pain management. » Integrate pain assessment tools. » Add patient materials for pain management and therapies. » Develop a registry of patients managing chronic pain. » Selectively build in decision support to guide safer prescribing.	» See appendix for a resource list of assessment tools and sources of patient materials.
Workforce	» Disseminate education and training resources to providers for appropriate opioid prescribing and non-opioid pain treatments	» CDC Guideline Resources and Clinical Tools » Alameda County Prescriber Toolkit

CHANGE CATEGORIES



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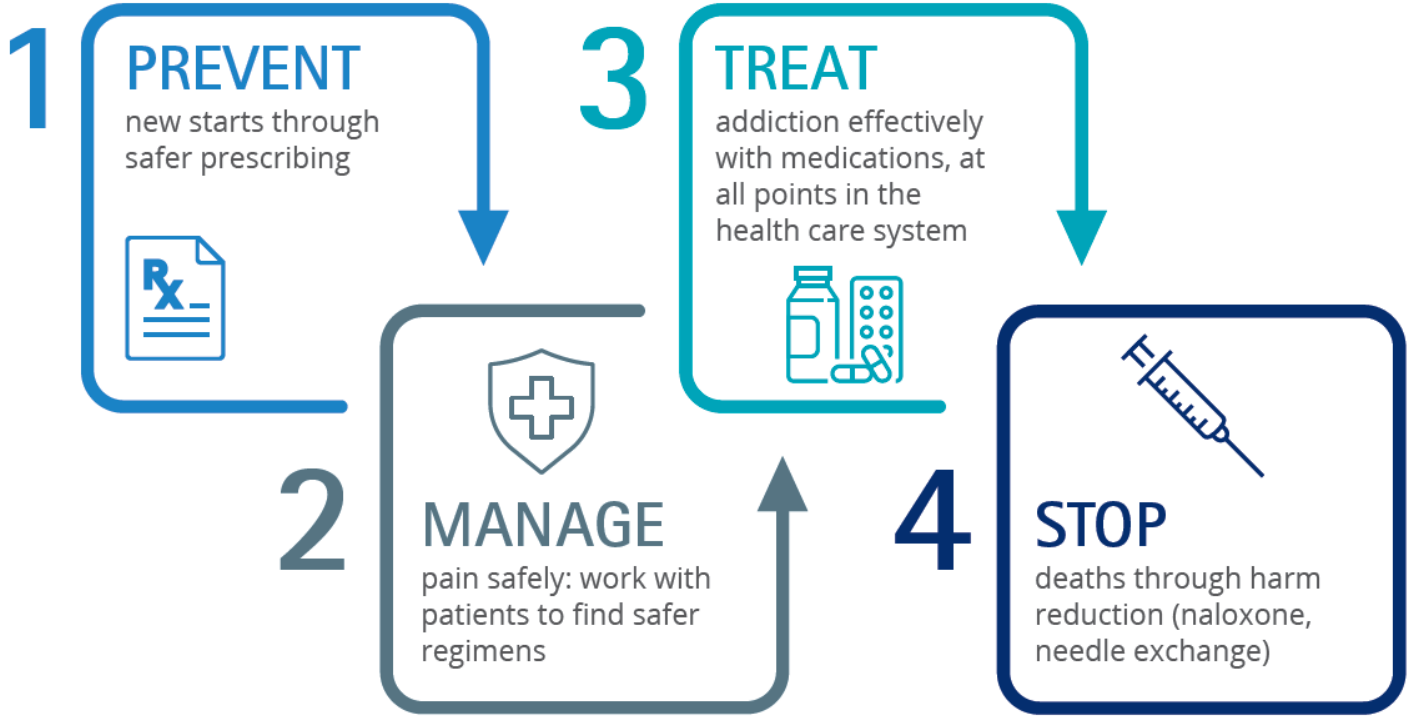
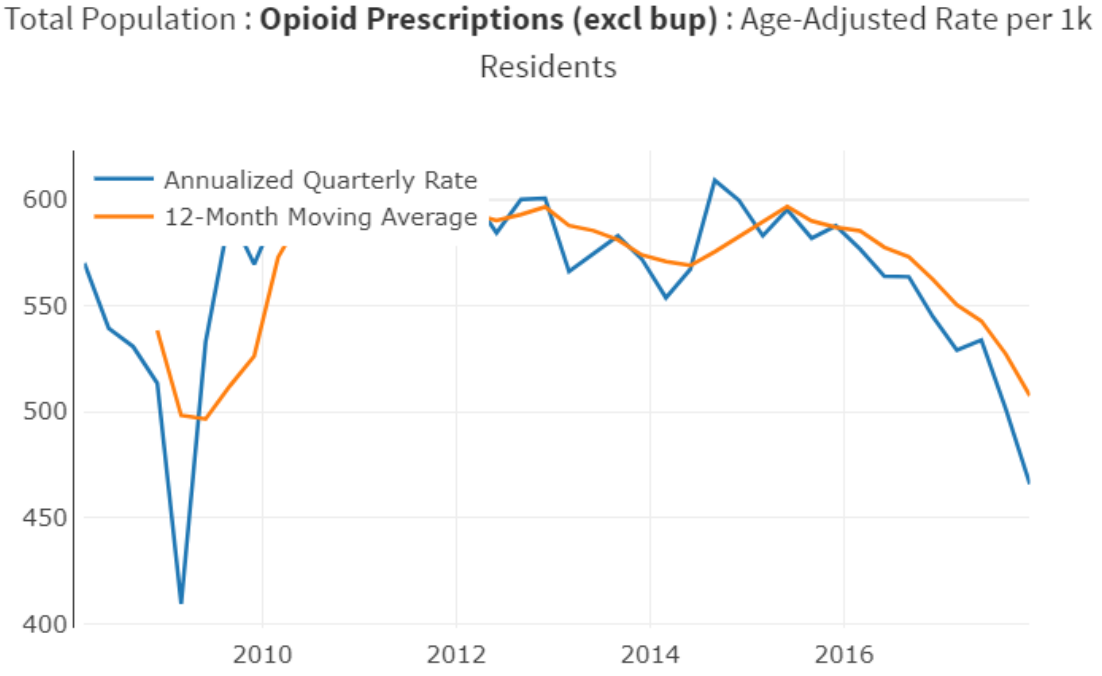
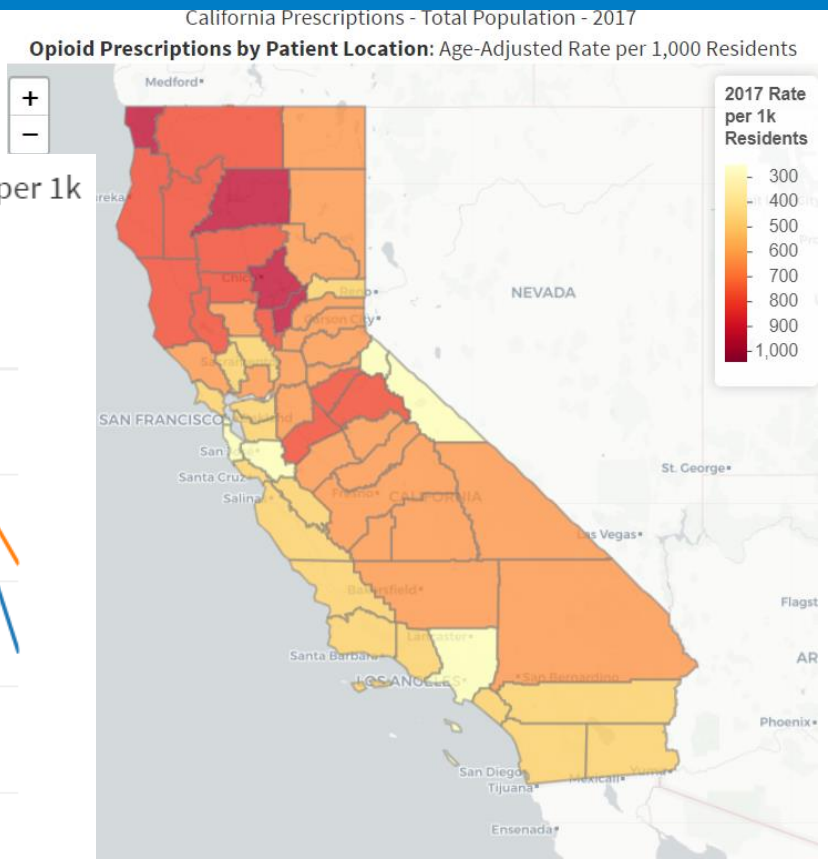
Which opioid safety strategy is top priority for your organization right now?



Strategy One: Prevent





Strategy One: Prevent

Health Information Technology

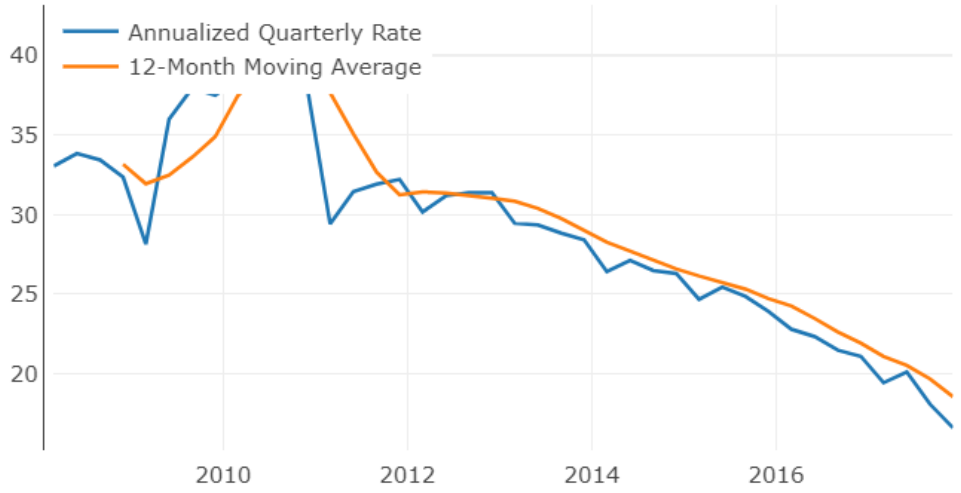
- » Create electronic health record (EHR) visit template for pain management.
- » Integrate pain assessment tools.
- » Add patient materials for pain management and therapies.
- » Develop a registry of patients managing chronic pain.
- » Selectively build in decision support to guide safer prescribing.

Access to Care

- » Identify access points for alternative pain management.
- » Offer group medical visits for chronic pain management.
- » Work with health plan, local coalition, and community to identify behavioral health specialists, evidence-based pain specialists, and SUD treatment resources.
- » Develop chronic pain management service packages, integrating evidence-based alternative pain management therapies.

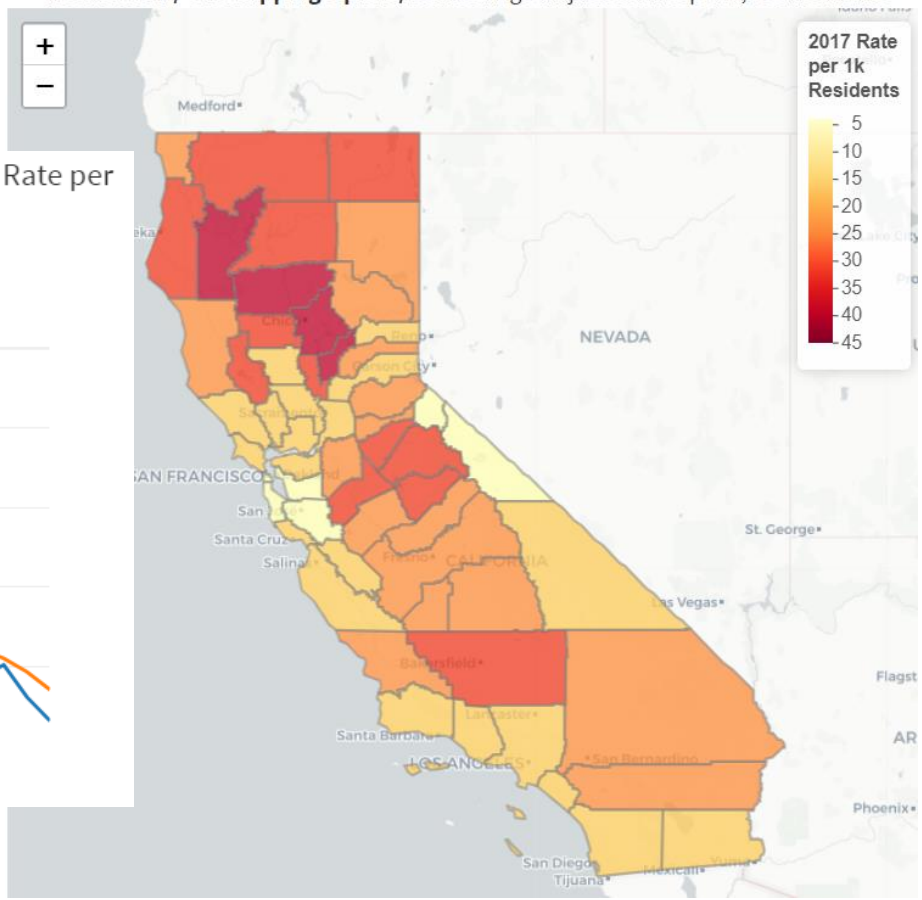
Strategy Two: Manage

Total Population : **Residents on > 90 MMEs of Opioids** : Age-Adjusted Rate per 1k Residents



California Prescriptions - Total Population - 2017

Residents w/ Overlapping Opioid/Benzos: Age-Adjusted Rate per 1,000 Residents



Strategy Two: Manage

Health Information Technology

- Create EHR alerts for:
  - + Prescribing outside of clinical guidelines
  - + High doses for new starts
  - + Concurrent prescription of benzodiazepines and opioids
  - + Checking the Controlled Substance Utilization, Review and Evaluation Systems (CURES) every four months, and for initial prescriptions
- Create EHR visit templates for taper plans and pain monitoring with treatment outcomes.
- Add patient educational materials about opioids and appropriate use.
- Deactivate specific unsafe medications in the EHR formulary, including carisoprodol and oxymorphone ER.
- Integrate screening tools for substance use disorders.
- Develop a sub-registry of patients with high dose and/or chronic use of opioids and use panel management with a care team.

Strategy Two: Manage

Clinical Practice

- Adopt Guidelines and Policies
- Prescribe buprenorphine and naloxone
- Work collaboratively with patients
- Customize tapers
- Avoid involuntary tapers

Strategy Two: Manage

Patient Engagement

- Share patient materials about safe prescribing, treatment considerations, and tapering.
- Engage patients in a dialogue about treatment and goals by using a patient-centered tool, also known as informed consent and agreements, but do not use it as a punitive contract to deny opioid treatment or dismiss from care.
- Include chronic pain patients at higher risk (high dose, combination with sedatives) in care management or behavioral health programs to help manage anxiety and needs if tapers are indicated.
- Ensure social and psychological supports are in place to manage the psychological "pain of life" issues that may resurface when opioids are reduced.

INNOVATIVE IDEA

Addressing the psychology and physiology of pain

Cedars-Sinai Medical Care Foundation has implemented a chronic pain program — a multidisciplinary and multimodal approach to the ambulatory management of patients with chronic pain, including those with chronic opioid usage. After extensive literature review and discussion with experts who demonstrate "best practices," Cedars-Sinai developed an approach to leverage a multidisciplinary team to support primary care physicians in their management of these patients. Patients with chronic pain can access the services of the team led by a Medical Director working closely with primary care physicians. Patients on high dose opioids or with severe needs are cared for directly by the program's Medical Director, a pain specialist experienced in both acute and chronic pain management, interventional therapies, pharmacotherapy, and opioid tapering. Other patients remain under the care of the primary care physician and receive additional support through a pharmacist-supported opioid tapering clinic as well as individual and group cognitive behavioral therapy led by a pain psychologist.

Foundational to their efforts has been the recognition of the role of pain psychology — behavioral elements of pain perception — that can be powerful in engaging patients in more effective partnership. These programs interface with a network of contracted physical therapists to develop and tailor a package of services to meet different patient needs. Looking forward, the program is scaling up with the addition of clinicians and mental health specialists aligned with the vision and experienced in navigating restrictive patient coverage for adjunctive mental health services.

Patients on high dose opioids or with severe needs are cared for directly by the program's Medical Director, a pain specialist experienced in both acute and chronic pain management, interventional therapies, pharmacotherapy, and opioid tapering.

Rachel Mashburn, PharmD

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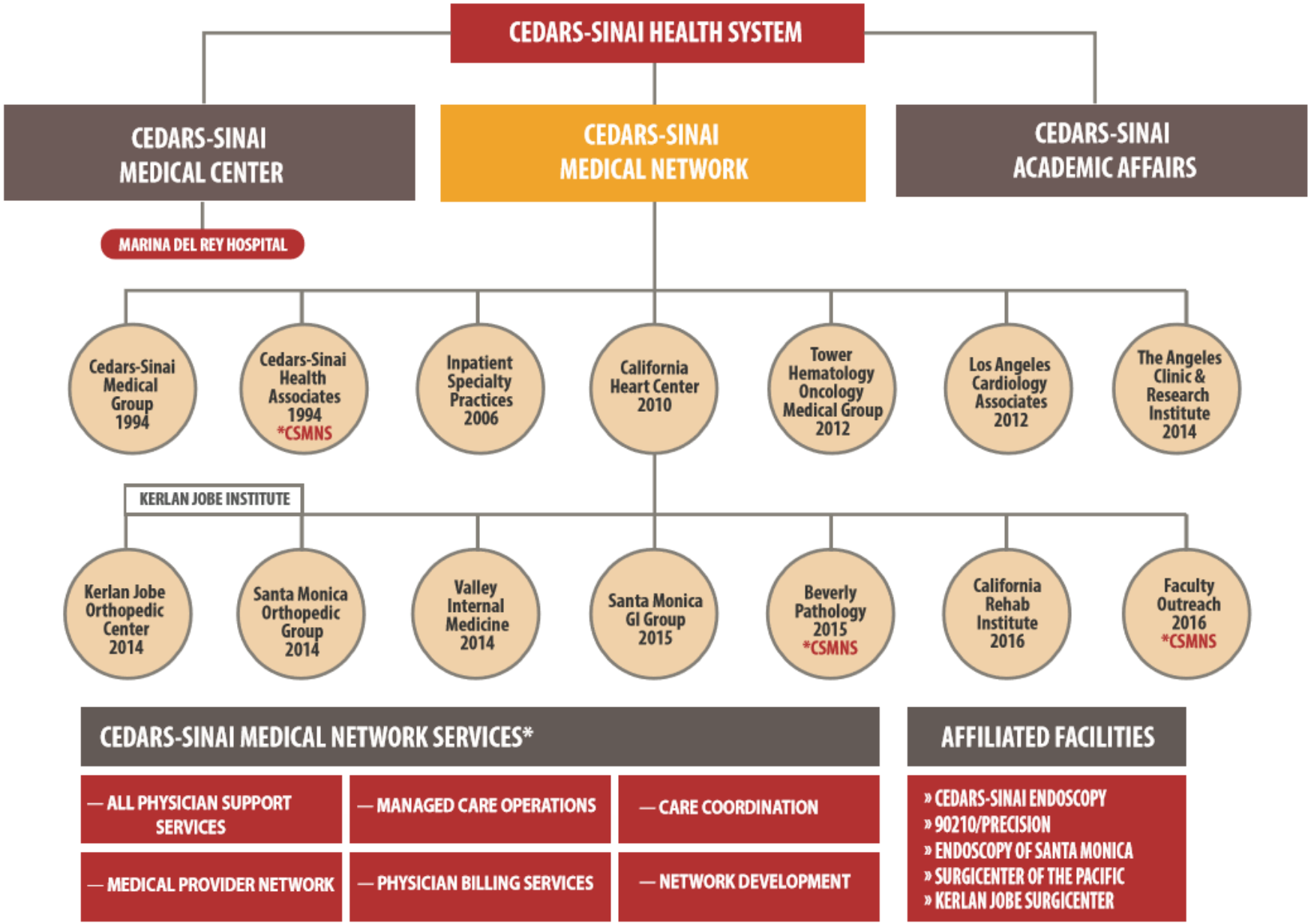
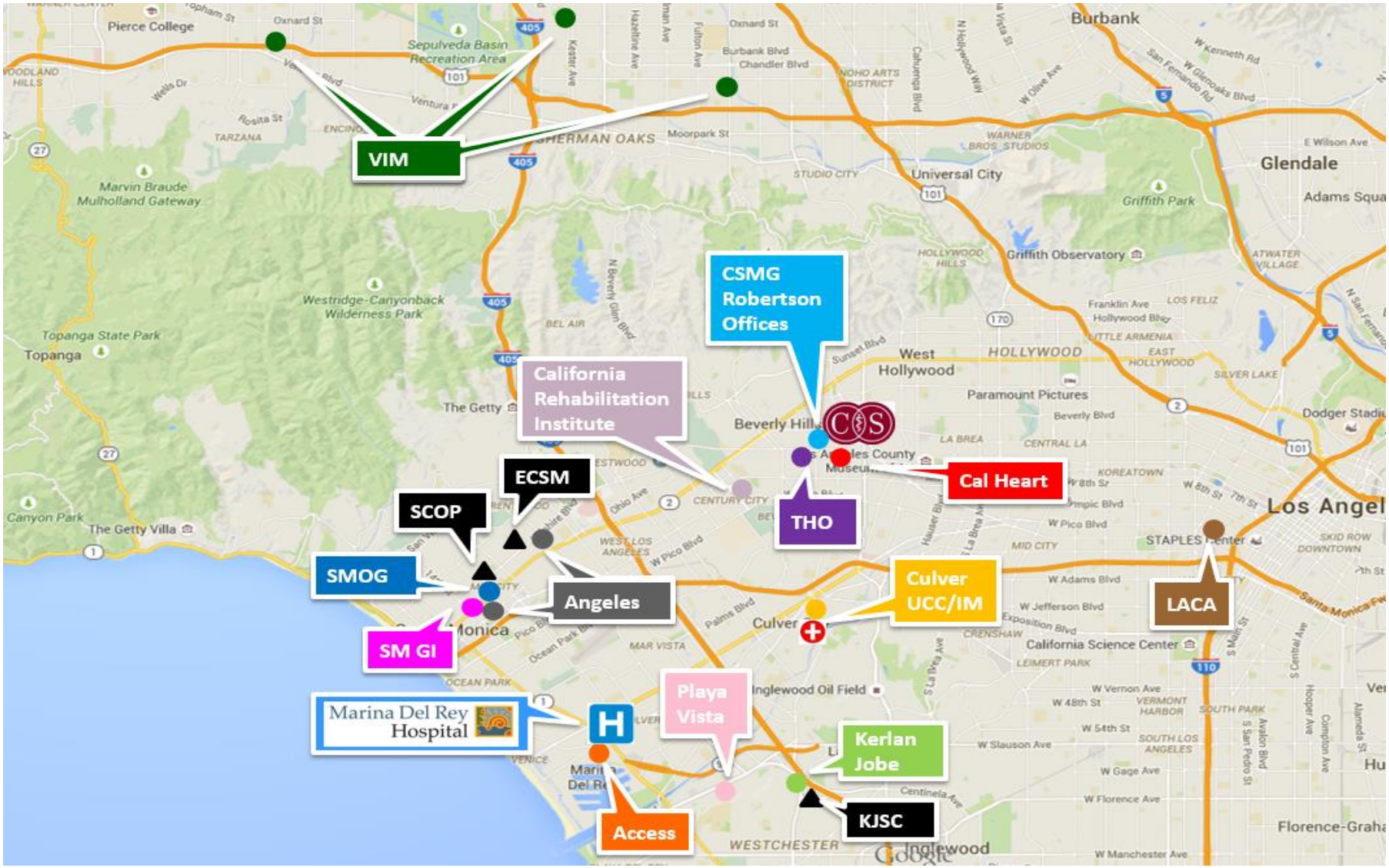

CEDARS-SINAI HEALTH SYSTEM
CEDARS-SINAI MEDICAL CENTER
CEDARS-SINAI MEDICAL NETWORK
CEDARS-SINAI ACADEMIC AFFAIRS
MARINA DEL REY HOSPITAL
Cedars-Sinai Medical Group 1994
Cedars-Sinai Health Associates 1994 *CSMNS
Inpatient Specialty Practices 2006
California Heart Center 2010
Tower Hematology Oncology Medical Group 2012
Los Angeles Cardiology Associates 2012
The Angeles Clinic & Research Institute 2014
KERLAN JOBE INSTITUTE
Kerlan Jobe Orthopedic Center 2014
Santa Monica Orthopedic Group 2014
Valley Internal Medicine 2014
Santa Monica GI Group 2015
Beverly Pathology 2015 *CSMNS
California Rehab Institute 2016
Faculty Outreach 2016 *CSMNS
CEDARS-SINAI MEDICAL NETWORK SERVICES*
— ALL PHYSICIAN SUPPORT SERVICES
— MANAGED CARE OPERATIONS
— CARE COORDINATION
— MEDICAL PROVIDER NETWORK
— PHYSICIAN BILLING SERVICES
— NETWORK DEVELOPMENT
AFFILIATED FACILITIES
» CEDARS-SINAI ENDOSCOPY
» 90210/PRECISION
» ENDOSCOPY OF SANTA MONICA
» SURGICENTER OF THE PACIFIC
» KERLAN JOBE SURGICENTER

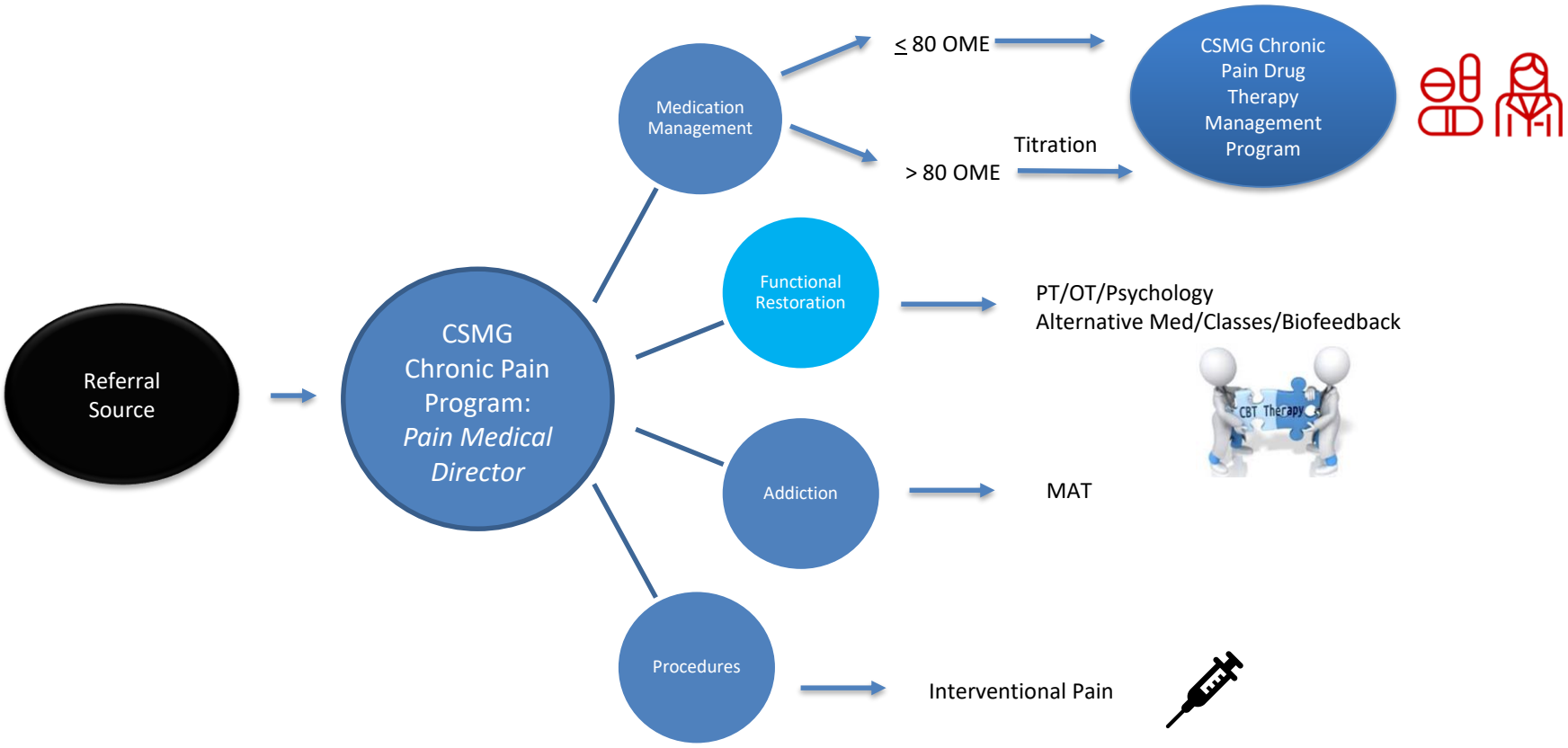
Cedars-Sinai Medical Network Locations



Approach to the Opioid Epidemic

- Creation of an **Opiate Steering Committee**
  - Broad multi-specialty and multi-disciplinary representation
  - Define and consolidate approach to the epidemic for Medical Network providers
  - Identify clinical activities in place to support our efforts
- **Develop policies** to support providers and clarify expectations
- Develop reports and **dashboards** to support efforts and guide goals and targets
- Communication and **education campaign**
- Work to identify and expand **programs and resources** to manage crisis
- Leverage the **electronic medical record**

Interdisciplinary Chronic Pain Management Model



Chronic Pain Medication Management Programs

CSMG Pain Management Program

Opioid Prescribing and Management:

- Pain Medical Director, Dr. Joseph Tu ***becomes*** the opioid prescriber of record and the ***treating*** physician for the patient
- Medication management

Who to Refer:

- Complex chronic pain patient (diagnosis > 6 months)
- Taking > 80 OME per day with/without benzodiazepines
- Deemed appropriate by treating physician to see pain specialist

CSMG Chronic Opioid Drug Therapy Program

Opioid Prescribing & Management:

- The clinical pharmacist ***becomes*** the opioid prescriber of record for his/her patient, however the ***treating*** physician will be consulted for any issues pertaining to patient's medications
- Refill management only; currently no opioid tapering

Who to Refer:

- Stable chronic pain patient
- Taking ≤ 80 OME per day
- Requiring chronic opioid therapy for next 3 to 6 months
- Deemed appropriate by treating physician for clinical pharmacy management

Opioid and Benzo Taper Programs

CSMG Opioid Taper Program

Opioid Prescribing and Management:

- The clinical pharmacist ***becomes*** the opioid prescriber of record for his/her patient, however the ***treating*** physician will be consulted for any issues pertaining to patient's medications
- Urine drug screen done at initial visit then when appropriate per the clinical pharmacist and CURES check at every visit
- Naloxone prescription provided at initial visit

Who to Refer:

- Any patient currently on opioids for pain who the treating physician deems appropriate for tapering off of opioids by a clinical pharmacist.

Objectives:

- Reducing doses of opioids as tolerated with the goal of tapering completely off opioids when possible.
- Monitoring for signs and symptoms of opioid withdrawal and pain medication adverse events and managing such events appropriately
- Support processes and documentation for chronic pain management to ensure compliance with medical board requirements.

CSMG Benzo Taper Program

Benzo Prescribing & Management:

- The clinical pharmacist ***becomes*** the benzo prescriber of record for his/her patient, however the ***treating*** physician will be consulted for any issues pertaining to patient's medications
- Urine drug screen done at initial visit and CURES check at every visit
- Naloxone prescription provided if appropriate

Who to Refer:

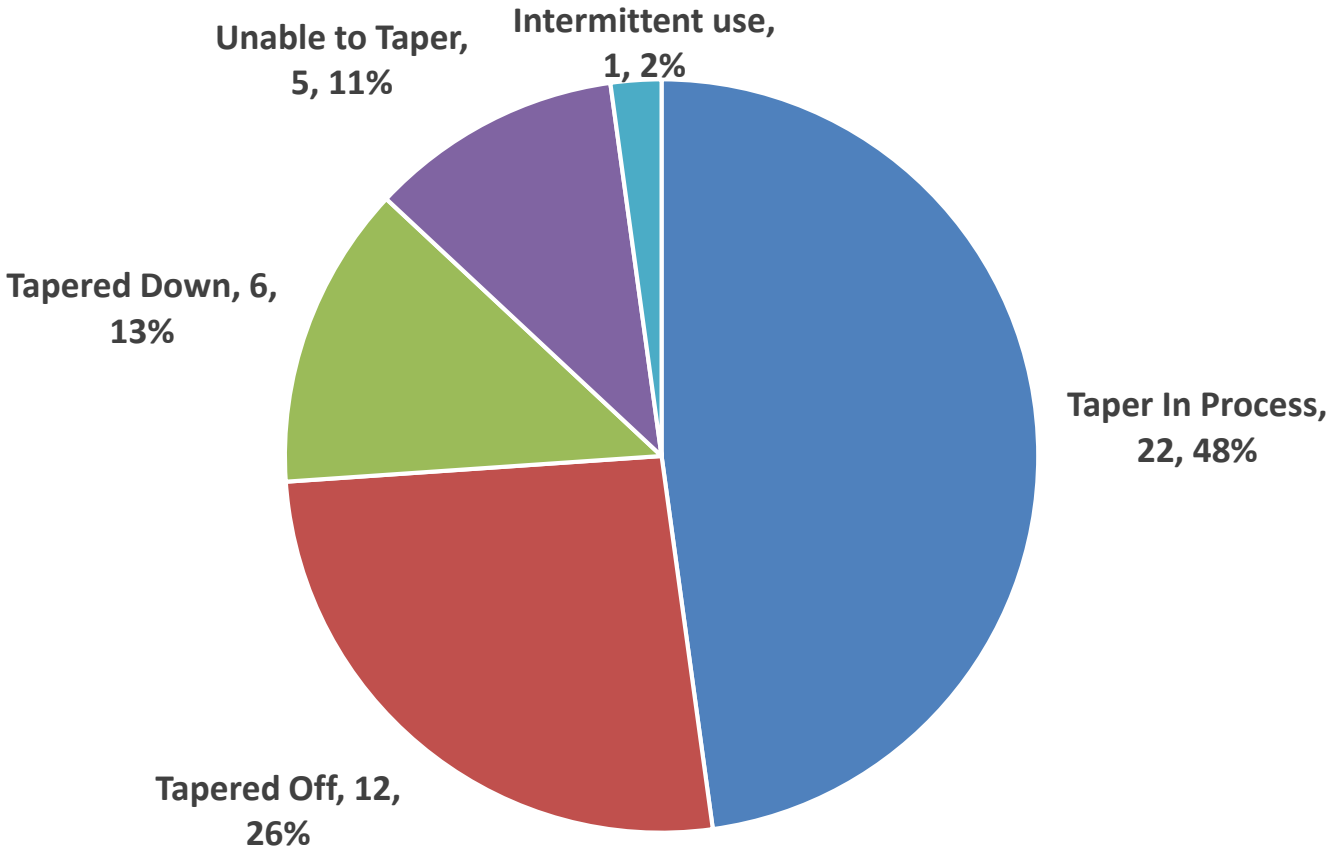
- Any patient wishing to be tapered off benzodiazepines
- Deemed appropriate by treating physician for clinical pharmacy management

Objectives:

- To educate patients on risks associated with benzodiazepine, including risks of withdrawal.
- To aid patients in the tapering and discontinuation of benzodiazepines

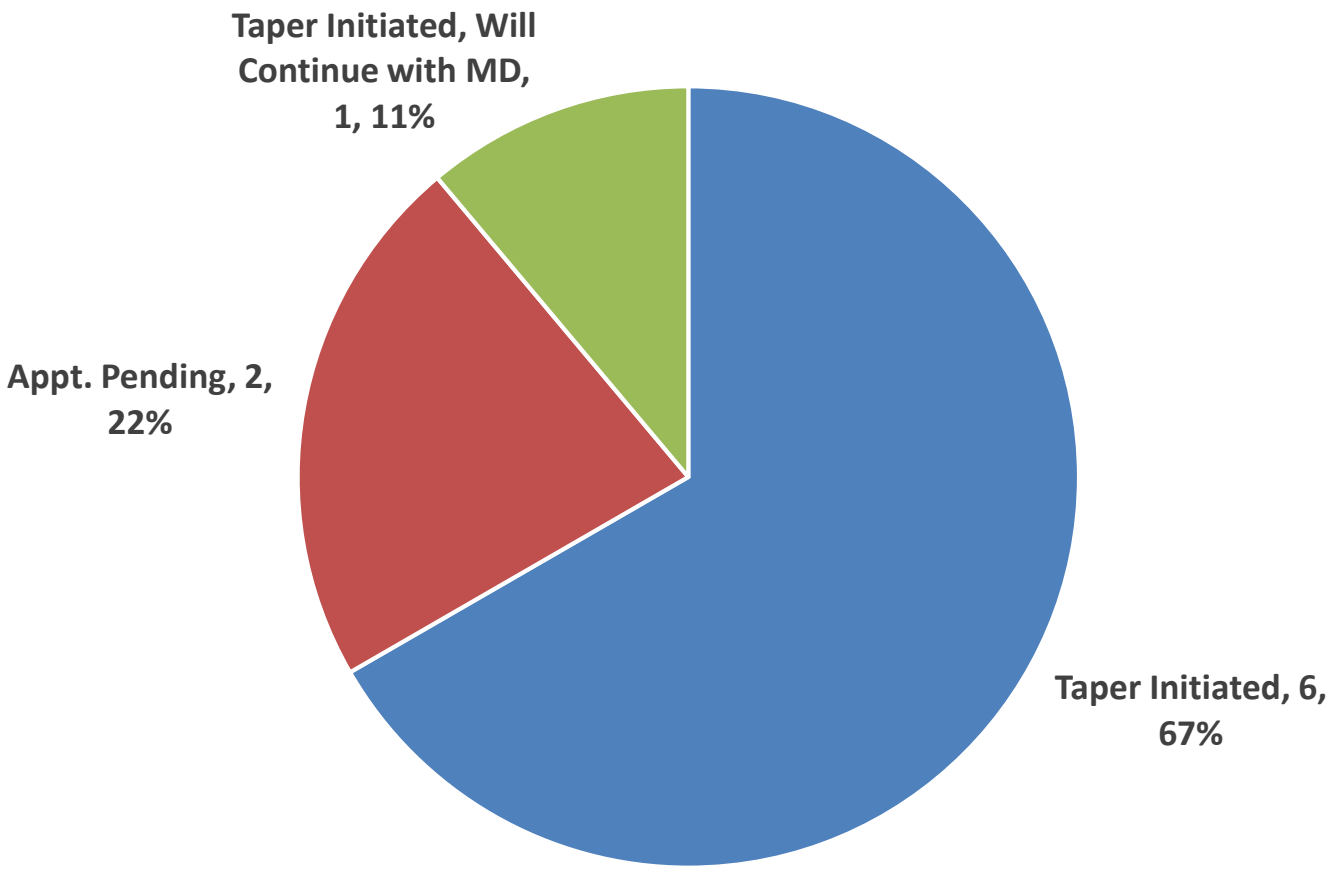
Benzo Taper Program: Current Outcomes

March 2017 to September 2018
N = 46



Opioid Taper Program: Current Outcomes

April 2018 to September 2018
N = 9



Lessons Learned and Advice to Others

- Managing chronic pain requires a multi-disciplinary team and a multi-modal approach
- Having the right physician leader is key! – aligned treatment philosophy and breadth of experience
- PCP buy-in and engagement is very important
- Value of having a pain psychologist on the team – engaging/empowering the providers and staff
- Provide providers data on prescribing patterns and adherence to best practices
- Academic detailing when needed
- Leverage EMR

INNOVATIVE IDEA

Shared decision making tools for chronic pain management

In partnership with the UC Davis Center for Design in the Public Interest (DiPi), Hill Country Health and Wellness Center in Shasta County designed new participatory patient tools "to invite discussion, create awareness, encourage questions, build trust, and work toward better health outcomes through shared decision making and more effective doctor-patient communication." DiPi Design — Pain Project offers a variety of patient-centered, open-source materials for adaptation to local patient and provider needs.

New Patient Pain Treatment Packet — Friendly, welcoming comic book outlining patient expectations and the philosophy and logistics of treating chronic pain at Hill Country clinics.

Alternative Treatments Poster and Companion Card Deck — Introduces patients to a variety of non-medication options for treating chronic pain.

Controlled Substance and Wellness Agreement (CSWA) — A very different version of the traditional patient-prescriber agreement, this tool is designed to help patients slow down, reflect, and record questions and notes to discuss with their provider, written in plain language with a welcoming tone.

Introduction to Opioids Patient Booklet and Video — Covers important topics related to opioid risks, safety, and prescribing policies.

Outpatient Radio — A participatory community radio show produced in collaboration with Hill Country. Weaving together the stories of eight chronic pain patients, the program explores ways to help patients and communities talk about chronic pain and chronic pain treatment.

Susie Foster, FNP-BC

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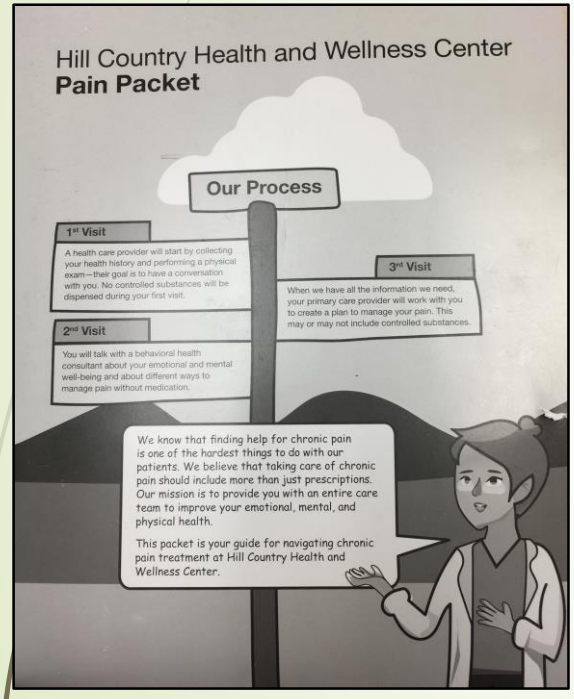
Hill Country from a Distance

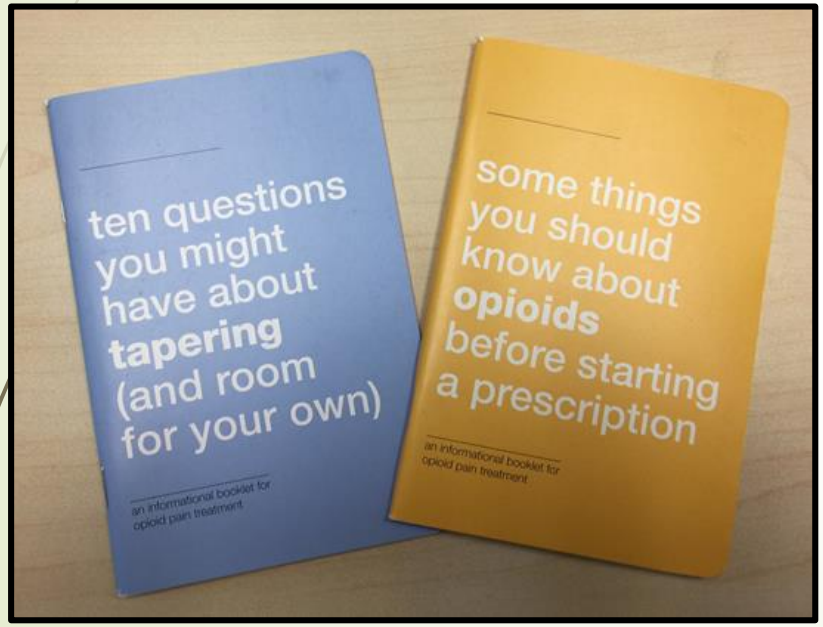
- 6,131 Patients
- 34,233 Visits
- 80% patients at or below 200% FPL
- Main site in Round Mountain, Shasta County (35 miles east of Redding)
  - Nearest pharmacy or gas station 30 miles
- Satellite sites
  - 2 medical
  - 1 behavioral health
  - 1 walk-in urgent mental health site

Controlled Substance Management at Hill Country



- UC Davis Center for Design in the Public Interest (DiPi Design)

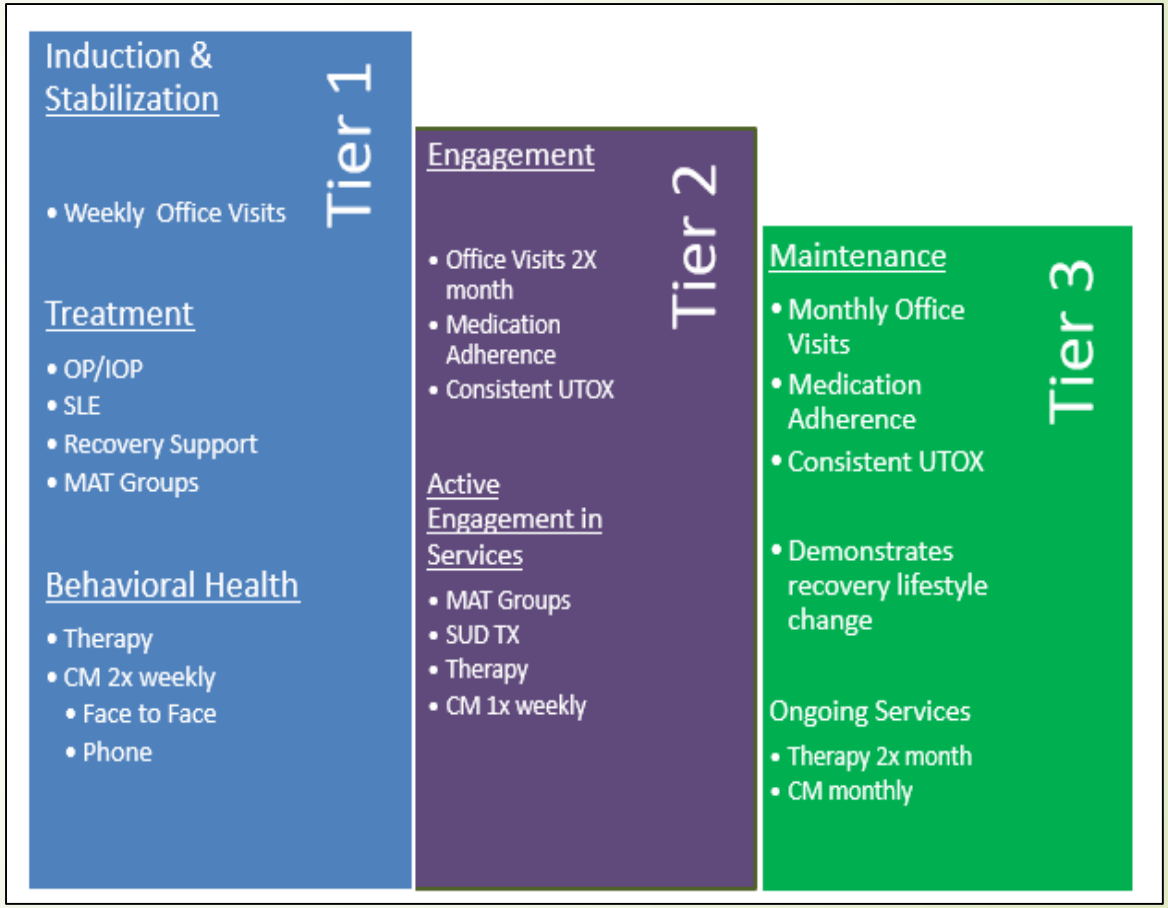
More Tools from DiPi



MAT Plus at Hill Country

MAT Team

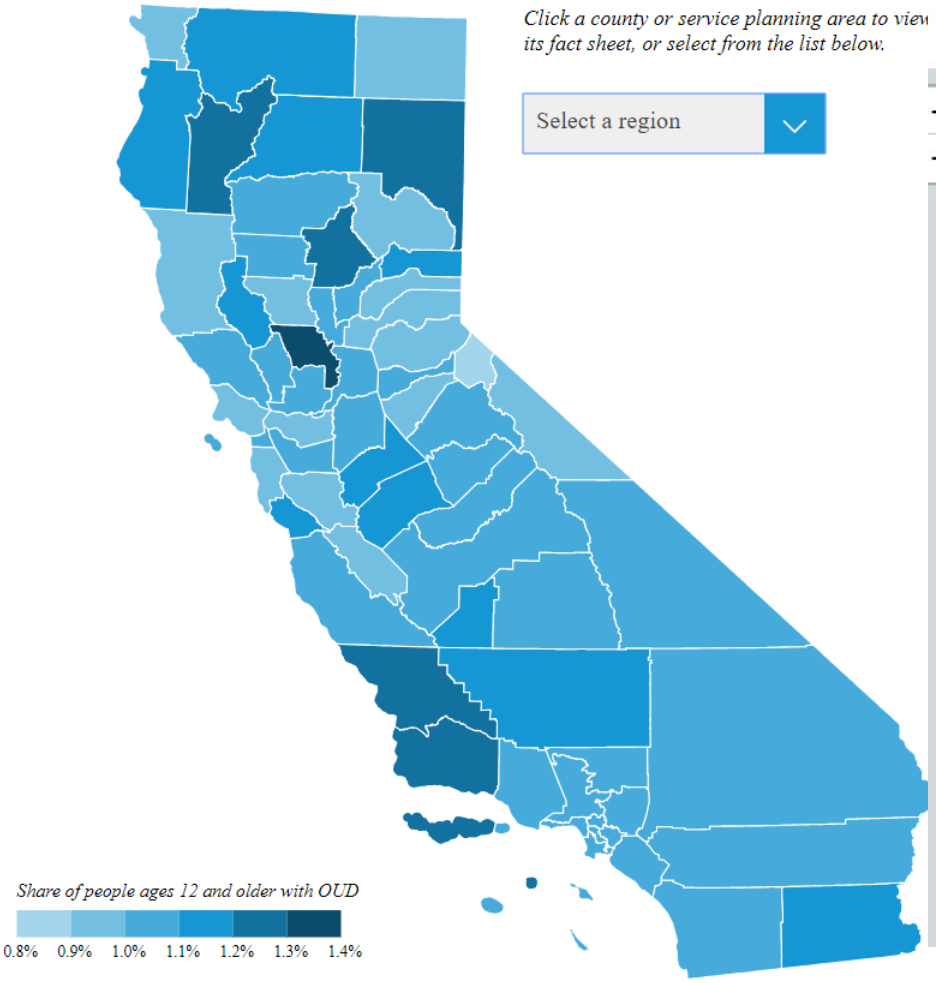
- PCP
- X-Licensed Provider
- Case Manager
- LCSW

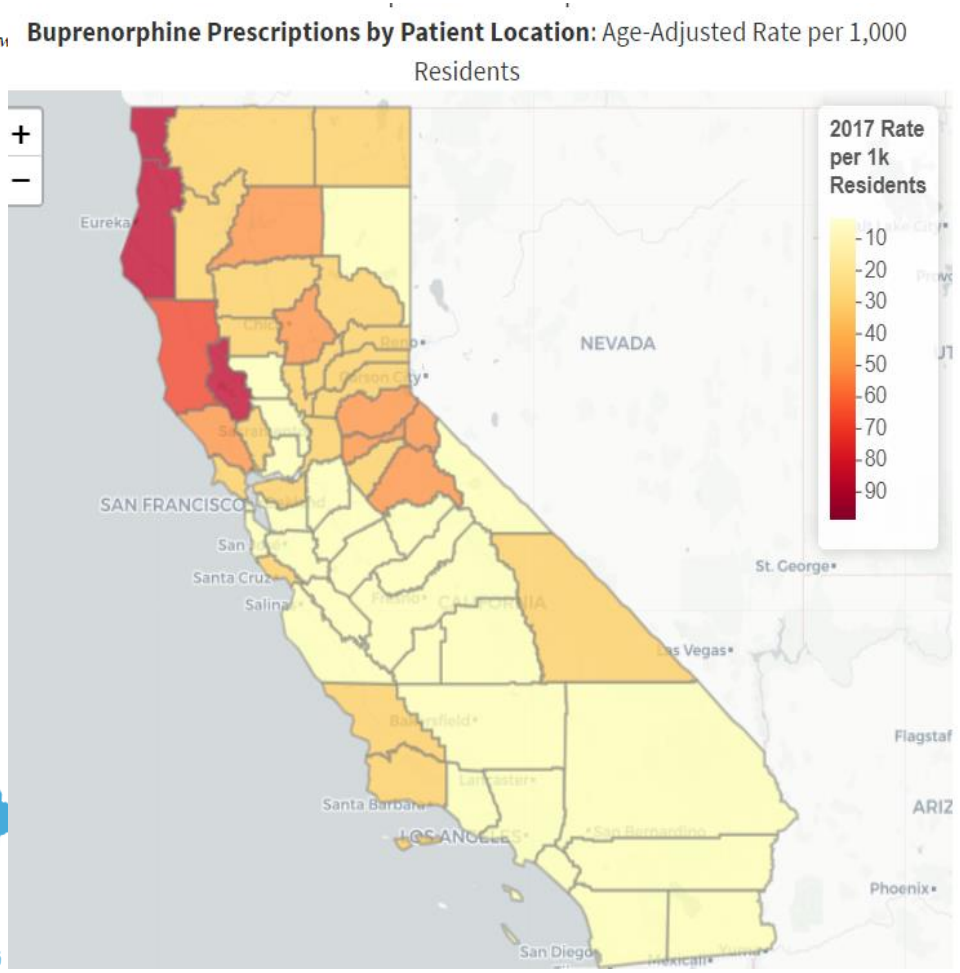


Outcomes/Next Steps

- Patient- Centered Approach which builds relationships
- Team approach wraps around the patient and Provider
- About 70 patients in MAT with a ~60% retention rate in MAT at 6 months
- Hired an SUD Counselor to work in Round Mountain to run groups and engage in one on one check-ins with patients.

Strategy Three: Treat





Strategy Three: Treat

Workforce

- Train all prescribers in MAT or select a passionate subgroup to treat all patients in the practice.
- Support newly x-waivered providers with experienced mentors to answer questions, shadow visits, and do case conferences or peer learning.
- Train staff and providers on harm reduction, trauma-informed care, opioid use disorder, and the case for MAT.
- For a more robust approach, create a multidisciplinary MAT care team that includes a clinician, a case manager (navigator or nurse), and a behavioral health specialist (e.g. certified drug and alcohol counselor, or licensed clinical social worker). Proactively mitigate case manager burnout, as they are doing most of the direct patient contact.

Strategy Three: Treat

Clinical Practice

- Adopt MAT Guidelines and Policies
- Optimize intake workflows and low-threshold MAT protocols for timely access
- Define tiers of care for step-up and step-down of service intensity
- Provide behavioral health specialists with flexible schedules

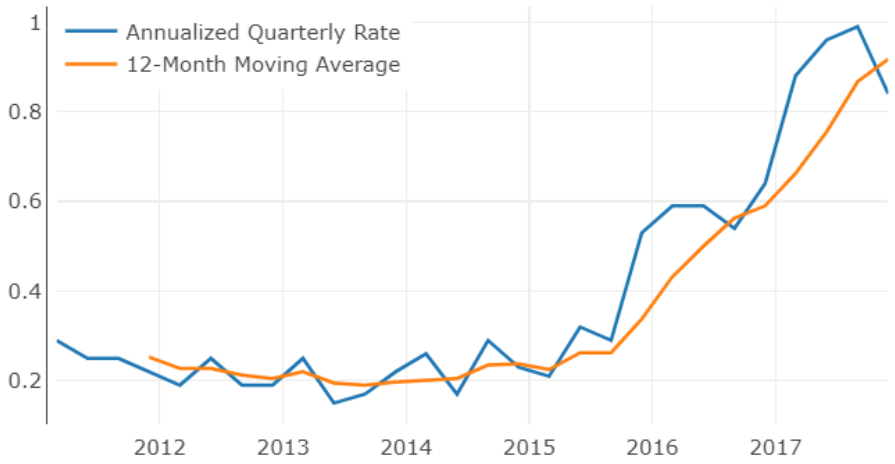
Strategy Three: Treat

Access to Care

- Create rapid primary care access for patients initiating MAT, especially for patients referred from hospitals or jails ("bridge clinics" offer walk-in hours and MAT quick-starts, or allow drop-in appointment flexibility).
- Offer group visits, facilitated by a behavioral health specialist in parallel with one-on-one MAT clinician appointments before/ after group.
- Offer home inductions of buprenorphine with patient instruction sheets.
- Consider partnerships with telehealth providers.

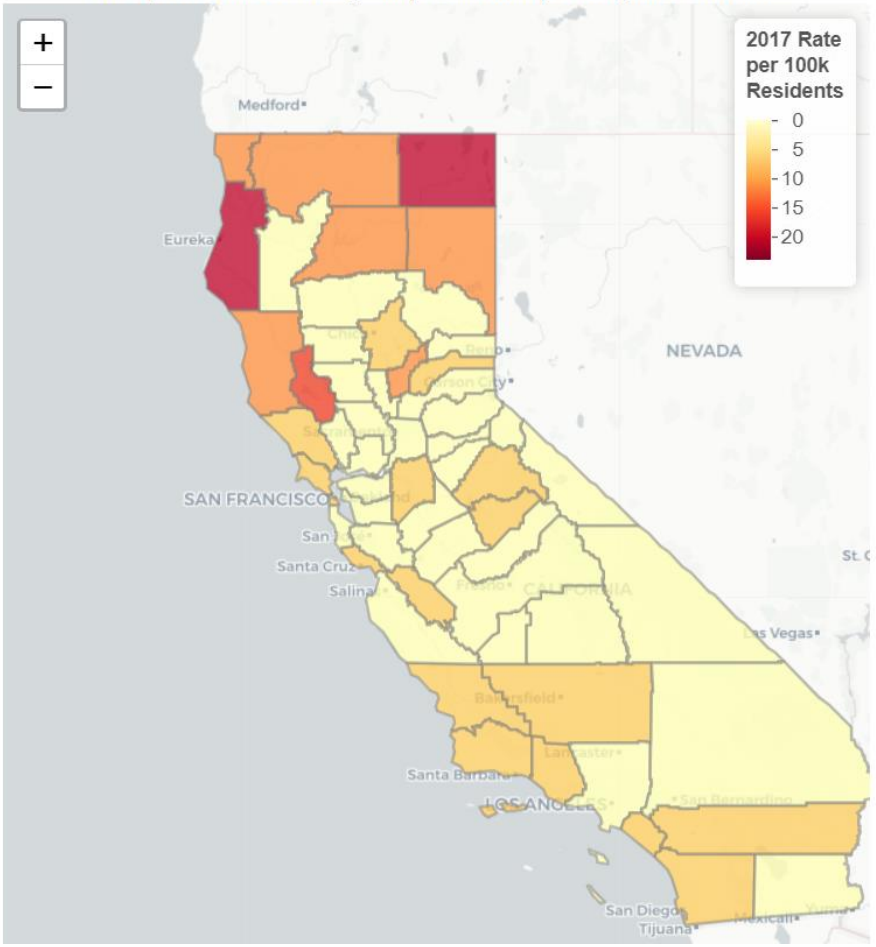
Strategy Four: Stop Deaths

Total Population : **Fentanyl Overdose (Preliminary)** Deaths : Age-Adjusted Rate per 100k Residents



California Deaths - Total Population - Prelim. 2017

All Opioid Overdose: Age-Adjusted Rate per 100,000 Residents



Strategy Four: Stop Deaths

Health Information Technology

» Create EHR alerts for:
  + History of overdose
  + Overdose risk
  + Prescription of naloxone

Patient Engagement

» Share patient materials about overdose risk and naloxone.

» Encourage pharmacists to teach patients about naloxone.

FUTURE OPPORTUNITIES

DATA/ TRANSPARENCY	Providers and plans need to collaborate on data analysis to measure outcomes and costs.
HEALTH INFORMATION TECHNOLOGY	EHR improvements: risk stratification reports and clinical alerts, comprehensive pharmacy drug list, CURES checkboxes, patient-friendly care management plans.
WORKFORCE DEVELOPMENT	MAT training opportunities across the spectrum: beginner to advanced.
CLINICAL PRACTICE	Easier access to CBT for pain, and provider training in setting appropriate expectations of pain and addressing patient readiness.

FUTURE OPPORTUNITIES

LEADERSHIP AND SUSTAINABILITY	Sustainable ways to fund MAT: alternative payment models, HRSA funding, group visits, Drug Medi-Cal.
ACCESS TO CARE	Telemedicine: therapy, medication management. Primary care providers can set up referral relationships to facilitate ongoing treatment after new MAT starts in other settings through the MAT Expansion Program.
PATIENT ENGAGEMENT	Reports are increasing about "opioid crackdown" approaches leading to bad outcomes, including suicide and street drug use. Fast tapers from high doses and mandatory tapers to zero are likely to cause more harm than benefit.
COMMUNITY SUPPORT AND ENGAGEMENT	Prevention and addressing the stigma of addiction in the community, including engaging youth and partnering with law enforcement.

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Crystal Eubanks, Senior Manager – Practice Transformation
ceubanks@calquality.org

HILL COUNTRY
HEALTH & WELLNESS CENTER

Susie Foster, Chief Medical Officer
sfoster@hillcountryclinic.org

CEDARS-SINAI®

Rachel Mashburn, Senior Manager – Pharmacy Operations
mashburnr@csmns.org

Please rate your agreement with this statement:

Today's webinar was a good use of my time.

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Breakthroughs for Better Health Care

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