Teamwork, Communication, and Data: 3 Keys to Large-Scale Practice Change in Opioid Prescribing

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Teamwork, Communication, and Data: 3 Keys to Large-Scale Practice Change in Opioid Prescribing

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Nothing to disclose

Ryan Dix, PsyD, MS, NCTTP and Linda Cruz, MD today have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Objectives

1. Explain a scalable approach, using CDC guidelines, to implement a pathway to reduce opioid prescribing in primary care

2. Discuss three key principles of implementing a pain-care pathway in a team-based care environment

3. Begin to develop an opioid care pathway action plan at your organization
Poll Everywhere

• Log into PollEv.com/ryandix588
• Or Text RYANDIX588 to 223333
• Where are you from?
Where are you from?
Setting the stage

• 1.5 billion people worldwide suffer from chronic pain
  – 3 - 4.5% of the global population suffers from neuropathic pain, with incidence rate increasing with age
  (Global Industry Analysts, Inc. Report, January 10, 2011.)

• In 2011, at least 100 million adult Americans had chronic pain conditions
  – A conservative estimate because it did not include acute pain or children (IOM, 2011)

• According to Johns Hopkins health economists $560-635 billion annually, an amount equal to about $2,000.00 for everyone living in the U.S (IOM, 2011)
Our project

- Providence St Joseph Health is a not-for-profit Catholic health care system operating multiple hospitals across 7 western states
  - Includes 51 hospitals
  - More than 35 non-acute facilities in Oregon alone
  - Numerous other health, supportive housing and educational services
  - Alaska, Washington, Montana, Oregon and California and Texas

- Four-year implementation of a pain-care pathway
  - 45 patient-centered medical home (PCMH) clinics in Oregon Providence Medical Group (PMG)
  - Utilized PCMH team, communication, and data to improve pain management and reduce risk
  - PMG was able to realize a 68% reduction of patients on high-dose opioids

- Broader behavioral health integration
Project Timeline

2012 Practice variation

2013 Data

2014-Q1 Education
35 clinics
lunch meetings
and videos

2014-Q2&3 Complex Case Reviews

2015 Guideline
due to lack of changes after case reviews

Ongoing Standardized quarterly reviews between medical director and pharmacist

Brought in behavioral health
A recognition of practice variation

• New providers joining the practice, and leaders managing panels after a provider left recognized significant variation in prescribing patterns amongst providers without clear clinical consensus

• Led to patients moving from clinic to clinic and interpreting variance as a personal judgment
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Data Driven

- Our prescribing data was for one clinic chosen to trial the workflow

- First Clinic 27 patients over 120 MED (chosen in 2014 based on Washington guidelines)

- Average MED 337 for patients over 120
Initial data across primary care clinics

Percent of patients on > 120 MED
PMG North, South, Hood River, North Coast

- Quarter 4 2014: 0.34%
- Quarter 1 2015: 0.26%
- Quarter 2 2015: 0.23%
- Quarter 3 2015: 0.19%
- Quarter 4 2015: 0.15%
- Quarter 1 2016: 0.12%
Project Timeline

Brought in behavioral health

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2. Ellen DeGeneres took an epic celebrity selfie at the Oscars ceremony. The selfie also set the record for the most-retweeted tweet of all time.
Clinic by clinic education

- Provided education on persistent pain focused on understanding pain as a neural output from the brain by our resident faculty and physical therapist in small groups in the clinic

- [https://www.youtube.com/watch?v=VNdZAxCkXtw&feature=youtu.be](https://www.youtube.com/watch?v=VNdZAxCkXtw&feature=youtu.be)
Project Timeline

- **2012** Practice variation
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Brought in behavioral health
Teamwork: Complex Case conferences

- Broader context
- Patient centered/whole person
- Co-morbidities
- Functional markers

- Team composed of PCP, other clinic providers, clinical pharmacist, case manager and Behavioral Health Provider
The focus was on Pain Management

A few of the approaches for patients include:

• Treating the whole person
• How to change the pain process
• Retraining to move differently and be less afraid of pain and injury
• Relaxation techniques to quiet the stress response
• Engagement for participation and involvement are key (Motivation evaluated through PAM, work w BH)
Communication

The three areas of focus in communication included:

• Communication between team members caring for the patient

• Regular review of the data at the clinic level by PharmD and Clinic Medical Director

• Regular report out to the medical group and leaders on the progress towards goals
How many of you have integrated behavioral health?

Yes

No
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Brought in behavioral health
Team work: BHI in the clinic

- Billed through patient medical insurance using health and behavior codes
- Warm handoffs
- Documents in the same medical record as PCP
- Coordinates with other resources in clinic
- Complex Case Conference/Complex Illness Clinic
BHI for Pain

**Brief Intervention**
- CBT, Behavioral Activation, Relaxation/Grounding, Exposure, Motivational Interviewing, de-escalation of situation

**Assessment/Consultation**
- Rapid screening/diagnostic clarification for psychosocial concerns, Assess readiness for invasive/difficult procedures, Functional/Occupational assessment, Assessment of comorbid mental health concerns

**Education/Skill Building**
- Education regarding mind/body connection to health particular to Explain Pain model, Stress management, Parenting/relational skills, Sleep hygiene, Thought challenging

**Treatment Adherence/Motivation**
- Address barriers to adherence, Health risk factor modification (exercise, diet, smoking cessation)

**Triage/Liaison to Outpatient Mental Health Care**
- “Warm referral” to reduce stigma of mental health, appointment coordination and follow-up, provide support, address barriers, and involve family

**Provider Assistance/Training**
- Model difficult conversations, model motivational interviewing, discuss ways to set boundaries
BHI for pain

1\textsuperscript{st} Appointment: Relationship building/assess belief model

2\textsuperscript{nd} Appointment: Relationship building/assess belief model and co-morbid conditions

2\textsuperscript{nd}/3\textsuperscript{rd} Appointment: Start education of patient on Explain Pain model/changing the frame

4\textsuperscript{th} Appointment: Identify baseline

5\textsuperscript{th} Appointment: Increase baseline and discuss/address SIMS/DIMS model

6\textsuperscript{th}-??? Appointment: address ongoing SIMS/DIMS areas and reinforce progress
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Case conference and education were insufficient alone

• The use of data and a goal helped providers focus on the change

• In 2015 a goal was set for Primary Care Providers to reduce the number of patients on greater than 120 MED to zero by January 2016

• We had no process or balance measures, but had a process of 2 supported case reviews per clinic and used data to measure progress and reinforce the work
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Brought in behavioral health
Ongoing

• Medication reviews by pharmacy team

• Coordinated with medical director

• Results shared with providers
End of 2017
Final Data (337/352,092 pt)

% of patients on >90 MED
(% = # on >90 MED/total # of patients in medical group)

Data collected by PMG OR Region Clinical Pharmacy Specialists
Created by Dara Johnson, PharmD, BCPP
Future
Behavioral Health of the future

- Educating medical providers of how to have the conversation
- Expanding billing
- Standardized pain group curriculum/standardized pain approach/education
- MAT competencies
Medical group of the future

• Peg scores as a marker of efficacy and goal setting

• Trauma informed care

• Knowing the conversation

• Patient-centered goals
Less than successful parts

- Note template
  - Providers don’t want to be told how to chart
- Guiding the provider/patient conversation
- Standardizing workflows without the benefit of identifying patients in a uniform way prior to the visit (gathering screeners, UDS and PDMP)
- Adoption of tools was low
What less than successful things have you tried for pain?
Lessons Learned

• Team is really important
  – Different skills, leading to different perspectives and focus for patients

• Communication
  – Never stop at both local and organizational level

• Data Driven and Targets

• Local accountability
Group Discussion

• 1, 2, 4 exercise

• Take 1 minute to reflect on what resonated for you

• Turn to your colleague and talk/listen for 2 mins on what you heard

• Spend 4 mins at your table discussing next steps
What's the thing you will do on your next day of work to move your pain work forward?
Questions
appendix
Overview of pre-visit data collection- caregivers

Before the Visit

Goal
The goal of this step is to complete necessary screenings and checks in order to set up the visit for success. This step should be completed by support staff if available.

Step 1
- Schedule an appointment and assign completion of pre-visit work.
- Assess patient's baseline status:
  - Assess baseline characteristics including medication history, current psychiatric and medical history, and previous treatments.
  - Complete and document in Ambulatory Screening navigator under the PAIN/NEURO tab if available. The PDMP printout should be provided to the clinician at the time of the visit.

Step 2
- Complete pre-visit mental health screenings:
  - PEG: [Three Item Scale Assessing Pain Intensity and Interference](#)
  - PHQ-9: [Patient Health Questionnaire depression screening](#)
  - GAD-7: [Generalized Anxiety Disorder screening](#)
  - ORT: [Opioid Risk Tool: Done at the first assessment, to assess risk for opioid abuse when used as chronic pain treatment](#)
  - Others: Drug/Alcohol use screener, Tobacco use status

Step 3
- Assess the patient's risk (frequency is determined by management classification):
  - Check State PDMP (Prescription Drug Monitoring Program- see below)
  - Complete Urine Drug Screen (UDS)
  - Calculate Morphine Equivalency Daily Dose (MEDD)
Outpatient Morphine Equivalent Daily Dose (MEDD) prompt in schedule for chart scrub (Rooming MA or other caregiver – prompts PDMP and UDS collection)

- “Daily MED” PAF for Multi-provider Schedule:
Opioid Management Pathway:

Opioid Risk Tool (ORT)

- The ORT is a brief screening tool for adults used to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain.
- Patients are usually screened once.
- Scoring differs for males vs females (currently, ORT looks at legal sex).
- The ORT score is used as a baseline for determining Management Classification.

[Image: Opioid Risk Tool (ORT) - Opioid Risk Management Tool]

- FAMILY HISTORY OF SUBSTANCE ABUSE
  - Family history of substance abuse: Alcohol
    - 0: No (0) 1: Yes (1)
  - Family history of substance abuse: Illicit Drugs
    - 0: No (0) 2: Yes (2)
  - Family history of substance abuse: Prescription Drugs
    - 0: No (0) 4: Yes (4)

- PERSONAL HISTORY OF SUBSTANCE ABUSE
  - Personal history of substance abuse: Alcohol
    - 0: No (0) 3: Yes (3)
  - Personal history of substance abuse: Illicit Drugs
    - 0: No (0) 4: Yes (4)
  - Personal history of substance abuse: Prescription Drugs
    - 0: No (0) 5: Yes (5)
  - Age 16-45 Years
    - 0: No (0) 1: Yes (1)
  - History of Preadolescent Sexual Abuse
    - 0: No (0) 3: Yes (3)

- PSYCHOLOGICAL CONDITION
  - ADHD, OCD, Bipolar, Schizophrenia
    - 0: No (0) 2: Yes (2)
  - Depression
    - 0: No (0) 1: Yes (1)

- ORT TOTAL SCORE (Opioid Risk Tool)
  - 5

- Responsible: [Name]
- Create Note
- Time taken: 1652 10/6/2017
Opioid Management Pathway: 
**PEG Tool (Pain, Enjoyment of Life, General Activity)**

- The **PEG** tool is useful in the primary care setting for tracking patient pain levels over time.
- The score is an average of the three individual item scores.
- Helps providers develop pt centered goals, monitor improvement.
During the Visit with the provider

- **Goals for the visit include:**
  1. Assess for risk of SUD and Aberrancy (PDMP, UDS, and red flags) assess for SUD
  2. Evaluate the patient
     a) HPI focused on pain hx, current and previous treatment and response, PEG and mental health assessment,
     b) Focused physical
  3. Assess Risk and Benefit of opioids and determine next steps for opioids in chronic pain
  4. Create a care plan with the patient
  5. Assess patient for other treatment options possible referrals and optimize mental health care
  6. Consider Naloxone Rx/training. Review and sign medication agreement and set follow up
Clinical Decision Support Algorithm
Opioid Management Classification for Providers

- Doc Flowsheet
  - Identify state PDMP(s) checked
  - Hyperlinks to state PDMP websites
  - Calculate button to pull MEDD into flowsheet
  - Pre-adjustment Management Classification (based on MEDD)
  - Manually-adjusted Management Classification (based on ORT score)
  - Medical Comorbidities
  - Concurrent High Risk Co-Prescriptions
  - Management Classification Adjusted by Comorbidities and Concurrent Meds

In order to see ORT score from previous encounter, Show Last Filed must be checked