Addressing Patient Safety and Provider Support through the Implementation of a Controlled Substance Policy, Clinic-Based Monitoring Program, and Interdisciplinary Opioid Action Plan

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Presenter Disclosures

No personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months.

Community Health Center, Inc.

Where health care is a right, *not a privilege*, since 1972.

Federally Qualified Health Centers (FQHCs)

- Nation's largest safety net setting
- Located in designated high need communities
- Caring for 24 million patients annually
- 93% served are below 200% poverty & 35% uninsured

CHC Profile

- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Annual budget: $100m
- Staff: 1,000
- Patients/year: 100,000 (est. 2017)
- Specialties: onsite psychiatry, podiatry, chiropractic
- Specialty access by e-Consult to 15 specialists

Elements of Model

- Fully Integrated teams and data
- Integration of key populations into primary care
- Data driven performance
- "Wherever You Are" approach

Weitzman Institute

- QI experts; national coaches
- Project ECHO®— special populations
- Formal Research and Development
- Clinical Workforce Development

CHC Locations in Connecticut

THREE FOUNDATIONAL PILLARS

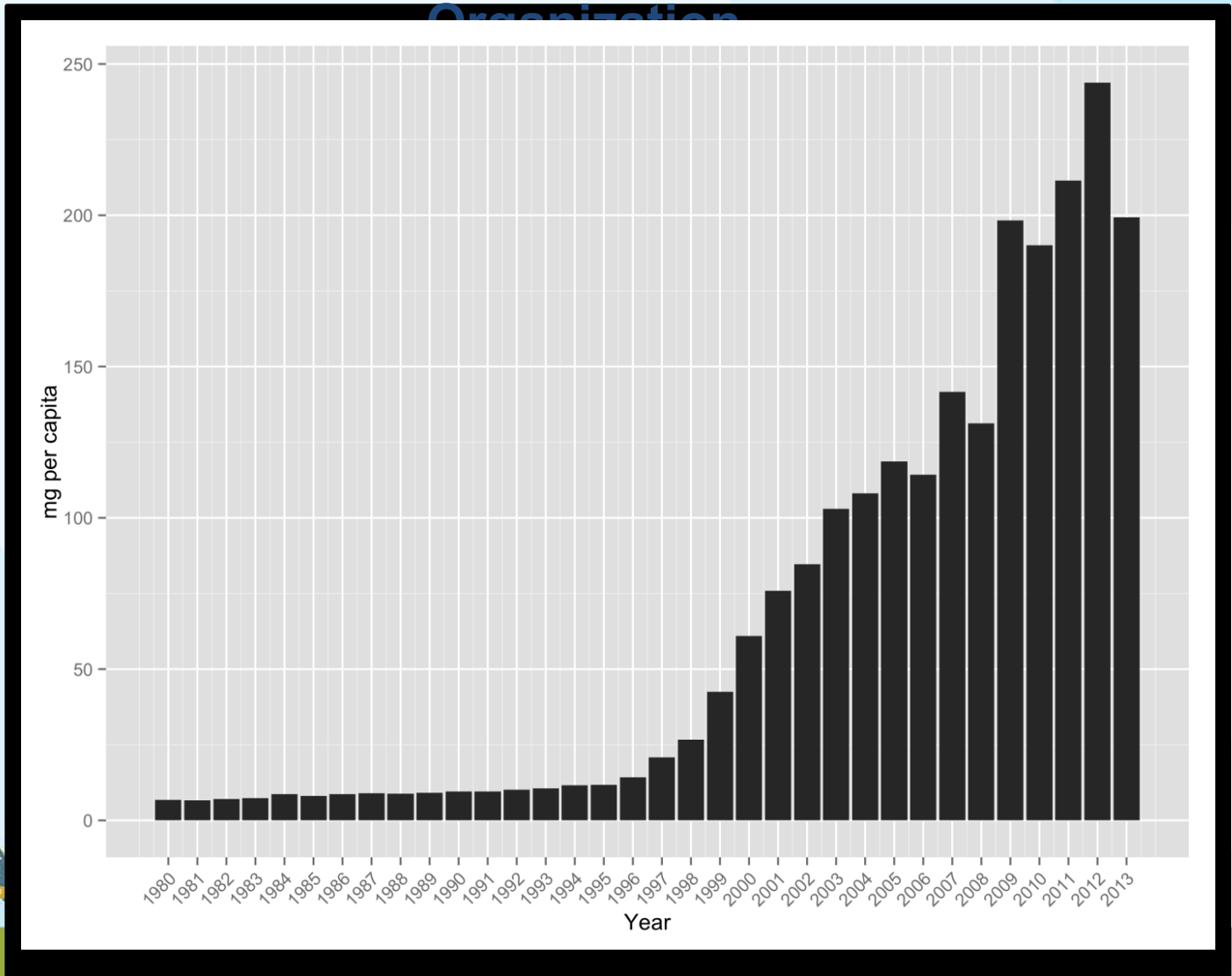
1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Chronic Pain in the US

- Chronic pain affects at least 116 million Americans and costs up to $635 billion in medical treatment and lost productivity[1]
- Majority of patients with pain seek care in a primary care setting[1]
- Primary Care Providers express low knowledge and confidence in pain management and receive little pain management education[2]
- Opioids are heavily relied on for pain management in primary care
- Prescription opioid overdose is a major and growing public health concern

Oxycodone Consumption (mg/capita) 1980-2013

International Narcotics Control Board, World Health Organization



Industry

Treat Pain & Develop a Market

Providers

Alleviate Suffering & Improve Quality of Life

Patients

Struggling with Chronic Pain, Unrecognized/ Untreated Trauma & Many with Prior History of Substance Use Disorder or other BH Comorbidities

Opioid Crisis

Added Complexity

- Insurance Coverage
- Lack of Access to Specialists
- Transportation Issues
- Health Literacy (Perception of pain, other modalities, lifestyle modification)
- Changing guidelines
- And others

Pain patients are like beach balls at a concert

Shaun Lowe/iStockphoto.com

Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- Telehealth
- Learning and Collaboration
- Oversight
- Prevention & Treatment of Substance Use Disorder

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Supporting Primary Care Providers to Improve Pain Care

- **Standards**
- E.H.R. Solutions
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CHCI Standard Policy for Opioid Prescribing

All patients receiving COT* must have

- Signed opioid agreement scanned and saved in the HER, Updated Yearly
- Random Drug screen at least once every 6 months
- Follow up visit every 3 months (minimum) using pain template and functional assessment
- Review of State PMP
- Behavioral Health co-management encouraged

Primary care providers should avoid:

Rx > 90MME

Opioids and benzodiazepines in combination

*COT defined as receipt of 90 days or more of prescription opioid analgesic medication

Stepwise Approach to Pain

- Non-opioid treatments. Non-controlled medication.
- Alternative Services
    - Chiropractic care
    - Acupuncture
    - Physical Therapy
    - Nursing Support
    - Nutritional Support
- Behavioral Health Co-Management
- Realistic goals and expectations: function vs. pain free

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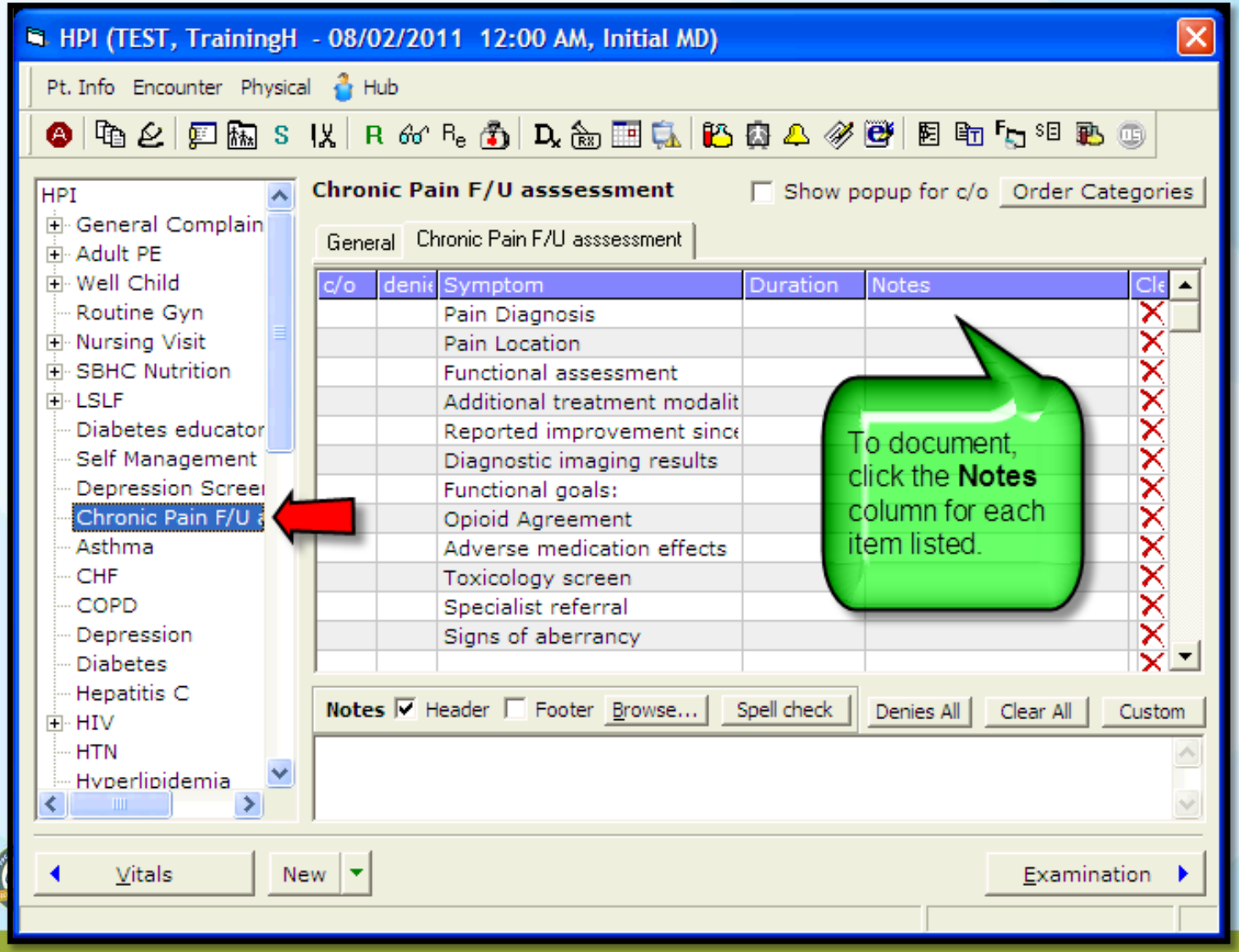
Customize EHR to Support Quality Pain Care



Use an Opioid Agreement

Controlled Medication Agreement

Name: _____ **Date of Birth:** _____

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- Some medicines ("controlled medications") can be dangerous and addictive. Problems can include driving accidents, confusion, vomiting, breathing problems, itch, constipation and more. If used incorrectly, these medications can also cause death.

- I understand that this medication carries the risk of dependence and/or overdose.
- Sharing my medication may also result in harm or death. I promise to keep my medication safe.
- The problem we are treating is: _____
- The goal of treatment is _____. If I do not reach the goal, the medicine may be stopped.
- I will have my controlled prescriptions filled only at this pharmacy: _____
- I cannot ask for an early refill, and I will not call after-hours for refills. That means I will only call between 8:30 AM and 4:30 PM Monday through Friday. I also agree to always be polite to office staff. When it is time for a refill, I will make an appointment if my provider asks me to.
- My provider will ask me to follow up regularly for these medicines, and missing appointments may result in my medicine being stopped.
- Unless there is an emergency, I will only get my prescriptions from this clinic. If there is an emergency, I will call as soon as possible to let the clinic know.
- Because these medications can be dangerous, I agree to random drug tests (urine or saliva) and medication checks. A medication check means I will be called, and must come in with my medications on the day I am asked. Refusing drug tests or medication checks may result in the medicine being stopped.
- I will not use illegal drugs or abuse alcohol
- I understand that changing a prescription is a crime.
- Because of the dangers of these medications, they will be stopped if the risk appears to be more than the benefit. If someone calls and says I am selling or misusing my medicine, the medicine may be stopped.

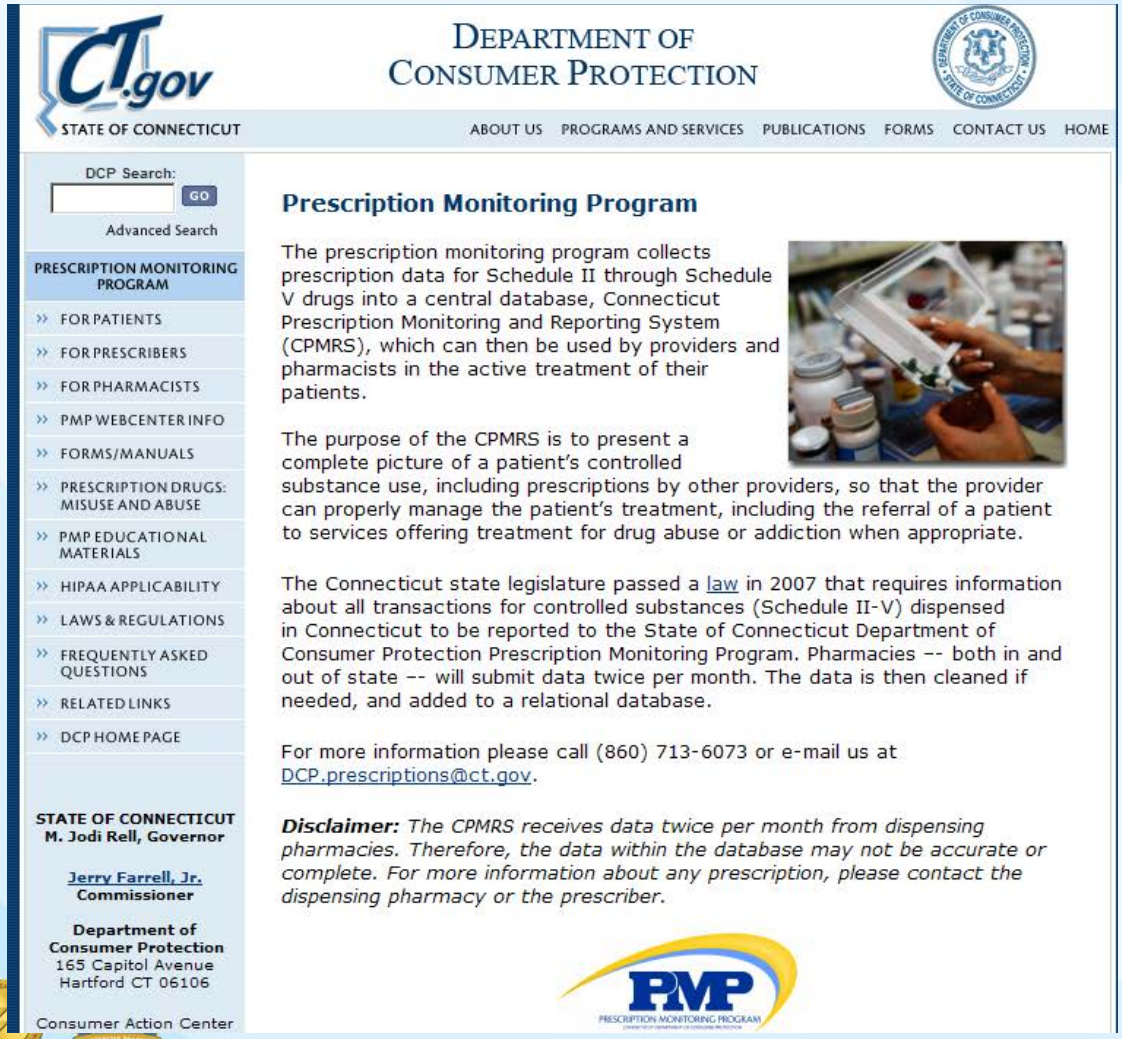
Date: _____ Patient Signature: _____

Date: _____ Provider/Nurse Signature: _____

Routine Drug Screens

- Frequent, but irregularly timed drug screens
- Know how to correctly order urine screens from your local lab
    - Capture all lab codes
- Know how to correctly interpret urine drug tests
    - Confirming Rx'd medication presence
    - Confirming Non-Rx'd medication absence

Use State Prescription Monitoring Sites



CT.gov
STATE OF CONNECTICUT

DEPARTMENT OF CONSUMER PROTECTION

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PRESCRIPTION MONITORING PROGRAM
- FOR PATIENTS
- FOR PRESCRIBERS
- FOR PHARMACISTS
- PMP WEBCENTER INFO
- FORMS/MANUALS
- PRESCRIPTION DRUGS: MISUSE AND ABUSE
- PMP EDUCATIONAL MATERIALS
- HIPAA APPLICABILITY
- LAWS & REGULATIONS
- FREQUENTLY ASKED QUESTIONS
- RELATED LINKS
- DCP HOME PAGE

STATE OF CONNECTICUT
M. Jodi Rell, Governor

Jerry Farrell, Jr.
Commissioner

Department of Consumer Protection
165 Capitol Avenue
Hartford CT 06106

Consumer Action Center

Prescription Monitoring Program

The prescription monitoring program collects prescription data for Schedule II through Schedule V drugs into a central database, Connecticut Prescription Monitoring and Reporting System (CPMRS), which can then be used by providers and pharmacists in the active treatment of their patients.

The purpose of the CPMRS is to present a complete picture of a patient's controlled substance use, including prescriptions by other providers, so that the provider can properly manage the patient's treatment, including the referral of a patient to services offering treatment for drug abuse or addiction when appropriate.

The Connecticut state legislature passed a law in 2007 that requires information about all transactions for controlled substances (Schedule II-V) dispensed in Connecticut to be reported to the State of Connecticut Department of Consumer Protection Prescription Monitoring Program. Pharmacies -- both in and out of state -- will submit data twice per month. The data is then cleaned if needed, and added to a relational database.

For more information please call (860) 713-6073 or e-mail us at DCP.prescriptions@ct.gov.

Disclaimer: *The CPMRS receives data twice per month from dispensing pharmacies. Therefore, the data within the database may not be accurate or complete. For more information about any prescription, please contact the dispensing pharmacy or the prescriber.*

PMP
PRESCRIPTION MONITORING PROGRAM

Connecticut Prescription Monitoring & Reporting System (CPMRS)

www.ctpmp.com

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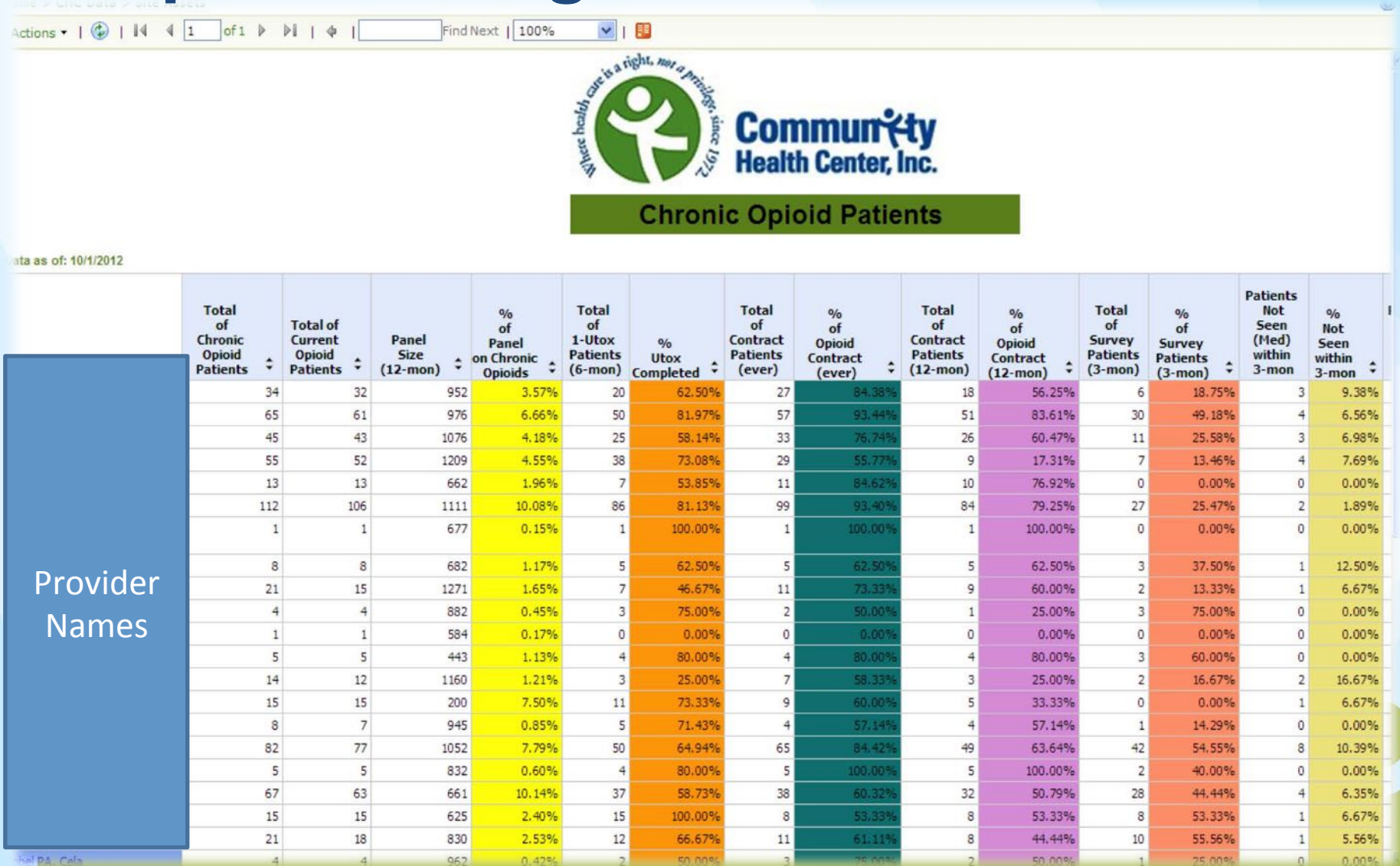
Use Data to Monitor: Dashboard

- % Panel on COT
- Presence/absence of opioid agreements
- Presence/absence of toxicology screening
- Last Pain Assessment (template used—includes functional assessment & risk mitigation)
- Last CTPMP check
- Last BH encounter
- Next BH encounter
- BH provider

Opioid Management Dashboard



Actions | 1 of 1 | Find Next | 100%

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Chronic Opioid Patients

Data as of: 10/1/2012

Provider Names

Total of Chronic Opioid Patients	Total of Current Opioid Patients	Panel Size (12-mon)	% of Panel on Chronic Opioids	Total of 1-Utox Patients (6-mon)	% Utox Completed	Total of Contract Patients (ever)	% of Opioid Contract (ever)	Total of Contract Patients (12-mon)	% of Opioid Contract (12-mon)	Total of Survey Patients (3-mon)	% of Survey Patients (3-mon)	Patients Not Seen (Med) within 3-mon	% Not Seen within 3-mon
34	32	952	3.57%	20	62.50%	27	84.38%	18	56.25%	6	18.75%	3	9.38%
65	61	976	6.66%	50	81.97%	57	93.44%	51	83.61%	30	49.18%	4	6.56%
45	43	1076	4.18%	25	58.14%	33	76.74%	26	60.47%	11	25.58%	3	6.98%
55	52	1209	4.55%	38	73.08%	29	55.77%	9	17.31%	7	13.46%	4	7.69%
13	13	662	1.96%	7	53.85%	11	84.62%	10	76.92%	0	0.00%	0	0.00%
112	106	1111	10.08%	86	81.13%	99	93.40%	84	79.25%	27	25.47%	2	1.89%
1	1	677	0.15%	1	100.00%	1	100.00%	1	100.00%	0	0.00%	0	0.00%
8	8	682	1.17%	5	62.50%	5	62.50%	5	62.50%	3	37.50%	1	12.50%
21	15	1271	1.65%	7	46.67%	11	73.33%	9	60.00%	2	13.33%	1	6.67%
4	4	882	0.45%	3	75.00%	2	50.00%	1	25.00%	3	75.00%	0	0.00%
1	1	584	0.17%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
5	5	443	1.13%	4	80.00%	4	80.00%	4	80.00%	3	60.00%	0	0.00%
14	12	1160	1.21%	3	25.00%	7	58.33%	3	25.00%	2	16.67%	2	16.67%
15	15	200	7.50%	11	73.33%	9	60.00%	5	33.33%	0	0.00%	1	6.67%
8	7	945	0.85%	5	71.43%	4	57.14%	4	57.14%	1	14.29%	0	0.00%
82	77	1052	7.79%	50	64.94%	65	84.42%	49	63.64%	42	54.55%	8	10.39%
5	5	832	0.60%	4	80.00%	5	100.00%	5	100.00%	2	40.00%	0	0.00%
67	63	661	10.14%	37	58.73%	38	60.32%	32	50.79%	28	44.44%	4	6.35%
15	15	625	2.40%	15	100.00%	8	53.33%	8	53.33%	8	53.33%	1	6.67%
21	18	830	2.53%	12	66.67%	11	61.11%	8	44.44%	10	55.56%	1	5.56%
4	4	962	0.42%	2	50.00%	3	75.00%	2	50.00%	1	25.00%	0	0.00%

Systems and Technology and Process Collaborative Care Dashboard

- Planned Care in Behavioral Health
- Delivery of Integrated Services

ID	Total Therapy Visits	Intake	Last Therapist	Last Psychiatry Provider	Initial CarePlan	Last Review	Last Discharge	Last PHQ	Controlled Substance	Auth Reqd	Alerts	Flu Shot Due	Fluoride Varnish due
[redacted]	3	8/27/2015	[redacted]	[redacted]	N/A	N/A	N/A	8/27/2015	N/A				
	107	6/29/2012			N/A	9/7/2015	N/A	12/4/2013	4/4/2013				
	79	10/8/2012			N/A	9/7/2015	N/A	4/2/2015	11/26/2013	Yes			
	10	4/2/2015			4/29/2015	7/29/2015	N/A	3/31/2015	N/A				
	9	10/13/2012			N/A	7/29/2015	3/10/2015	7/15/2014	8/14/2015				
	9	8/18/2015			N/A	N/A	1/24/2013	1/6/2015	N/A				
	55	11/26/2013			10/29/2014	6/24/2015	11/19/2014	8/25/2015	N/A				

s for New Britain Medical

Appt Start	Appt Stop	Resource Name	Appt status	Reason
9:20:00 AM	9:40:00 AM	[redacted]	Scheduled	BH Diagnosis
9:40:00 AM	10:00:00 AM		Scheduled	Opioid Patient
9:40:00 AM	10:00:00 AM		Scheduled	Opioid Patient, Last PHQ >= 15

Rethinking the warm hand-off process: Proactive vs. Reactive

- Medical initiated warm hand-off *and* behavioral health initiated warm hand-off
- Staggered vs. consecutive visits – make our presence known
- Criteria:
    - No BH services and PHQ above 15
    - No BH services and BH Diagnosis
    - No BH services and chronic pain patient

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Treat Pain by Moving Knowledge, Not Patients

F2F
Face to face

KNOWLEDGE

Telehealth
Direct specialist to patient consults

KNOWLEDGE

Project ECHO®
Provide ongoing case-based learning and consultation with an expert, multidisciplinary team

KNOWLEDGE

eConsults
Provide PCPs with access to quick, useful electronic consults from specialists

Moving Knowledge, Not Patients

Pain Management eConsult example

10/21/2015 01:33 PM

52 yo female with hx of lumbar spine decompression surgery 6 years ago and continued stenosis and pain with radiculopathy and neuropathy. Hx of left hip pain on MRI shows left gluteal tear and surrounding muscular atrophy Tried and failed Physical therapy, Hx of osteoporosis and gets reclast once a year Tried and failed fentanyl patches with pain management and does not want to go back on this medication Currently on MS contin 15mg 2 tabs BID and Percocet 7.5 TID, Gabapentin 800 mg TID, Voltaren gel PRN and ibuprofen PRN for pain relief
My plan: Rerefer to pain management, rerefer to physical therapy, obtain most recent lumbar MRI to assess if patient needs to see orthopedic surgeon again, goal is to decrease her narcotics doses that she came to me on Questions: [1] What further management can I offer this patient? [2] For gluteal tear, is PT contrindicated as this was a concern? [3] Any other recommendations. Thank you!

Hello! Dr [redacted] here.

Physical therapy is the ticket for the gluteal tear. Not contraindicated at all. If there is a complete tear of the tendon and there is really nothing that can be done other than improve the mechanics of the hip using surrounding muscles. The patient will need to be very compliant with home exercise program, this is the kind of thing that people need to work on at least 4 days a week with her home exercise program.

You didn't mention weight, if the patient is overweight, that weight loss will help quite a bit with hip mechanics and reduce the chance of degenerative disease related to the dysfunction of the hip muscles.

As far as exercise, cardiovascular exercise might include pool therapy when this is available if it is available and recumbent bike that sort of thing. That is going to be very important for protecting the hip and the back as well.

I would suggest that before you make the goal of decreasing narcotics use for a goal for transitioning to an aggressive lifestyle medicine-based program that includes exercise, weight loss if indicated, improving sleep. It is always best to do that before you start focusing on the opioid unless the opioid is causing severe side effects that need to be addressed through a decrease or unless you were concerned about misuse or diversion of the opioid.These are not big doses. One small change might be to change to 30 mg twice a day of MS Contin and eliminate the Percocet, or 15 mg 3 times a day and eliminate the Percocet. Regardless of the FDA labeling, MS Contin often does not last 12 hours, t.i.d. dosing is the most common dosing regimen United States, consequently.

Pain Management eConsult example (continued)

Make sure to set concrete functional goals, what is it she is not able to do that she would like to do? What is she able to do but not as well as she would like to? Use those to measure progress, Not changes in medication doses - although reductionin medication dosecan beA secondary outcome measure.

Finally, reviewing the MRI to see if there is persistent or recurrent nerve root compression the that might relate to leg pain/sciatica is a good idea. It may be that you're pain medicine consultant (we want to get away from using the phrase "pain management" because that is often connotes pharmacotherapy and pulses back to talking about pills instead of the things we want to talk to patient about) can do epidural injections, and if there is severe stenosis, he might refer for surgical evaluation if the patient is interested. However, a good lifestyle medicine plan that includes exercise, working on sleep, weight loss, smoking cessation (generic recommendations since I don't know this patient well) needs to be established first. A great reference for how to prep your patient for surgery (and how to recognize a patient who isn't ready) can be found on page 212 of Dr David Hanscom's book "Back in Control" http://www.amazon.com/Back-Control-surgeons-roadmap-chronic/dp/0988272903 .

Please let me know how helpful this is!

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PROJECT ECHO

Pain Management

Community Health Center, Inc.

integrativepain center of arizona

EL RIO COMMUNITY HEALTH CENTER

Westside Family Healthcare
We treat you well.

open door Community Health Centers

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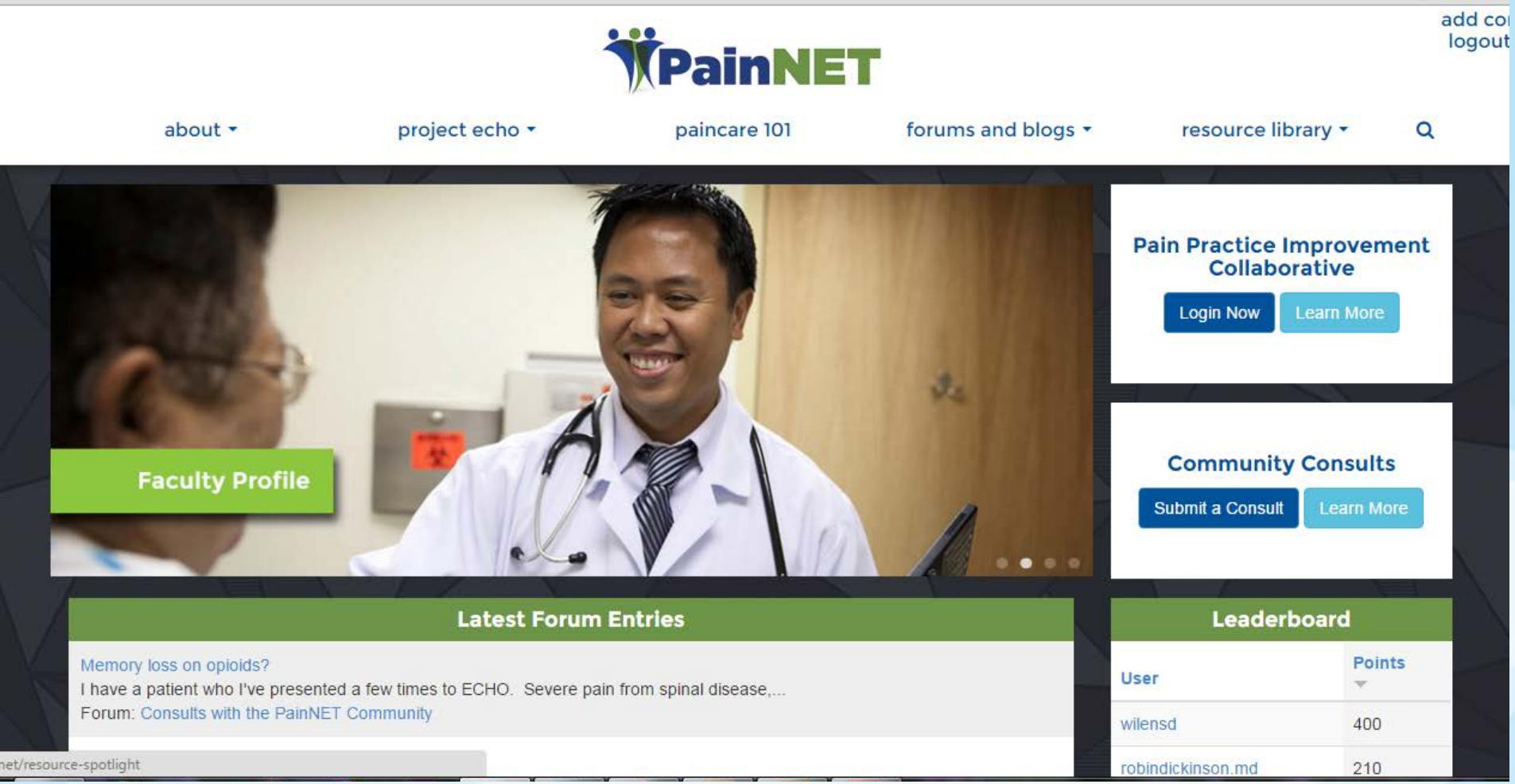
PainNET
add co
logout
about
project echo
paincare 101
forums and blogs
resource library
Faculty Profile
Pain Practice Improvement Collaborative
Login Now
Learn More
Community Consults
Submit a Consult
Learn More
Latest Forum Entries
Memory loss on opioids?
I have a patient who I've presented a few times to ECHO. Severe pain from spinal disease,...
Forum: Consults with the PainNET Community
Leaderboard
User
Points
wilensd
400
robindickinson.md
210

Learning & Collaboration: Team Based Care

- Empower staff to manage challenging encounters
    - De-escalation Training
- Project ECHO CCM Didactics for RNs
    - Chronic Pain
    - Substance Use Disorder
    - MAT/Harm Reduction
- BH Groups as well as one-on-one
- Performance Appraisal measures for all clinical team members

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Opioid Review Committee

Committee with oversight over opioid prescribing (sub-committee of Pharmacy & Therapeutics)

- Establish Formulary (Do Not Rx, 2nd Tier Review, etc.)
- High dose opioid oversight and review
- 2nd level review/authorization
- Review outlier providers (high pill counts, high MEQ, dangerous combos)
- Establish internal guidelines
- Follow up directly with prescriber

Provider Specific Opioid Data Report (Pg.)

Figure 1. **Quarterly provider report on opioid prescribing**, page 1 (sample)

Question a: How am I doing compared to other providers at my site and in the agency?

		Average	
Reporting Period	CURRENT	CURRENT	CURRENT
Measure		Site	CHC
Total prescriptions for opioids	115	72	72
Prescriptions with a high pill count	0	2	1
Prescriptions with MME>=90	17	11	10
Prescriptions with MME>=120	10	4	6
Do Not Prescribe Prescriptions*	2	3	1
High Risk Opioids			
Nucynta or Tapentadol	0	0	0
Oxycontin	5	2	3
Opioid & Benzodiazepines	7	9	7

Question b: How am I doing compared to myself over time?

CURRENT	PERIOD 3	PERIOD 2	PERIOD 1
Adjusted data for period comparison (Reference is Period 1)			
101	116	109	121
0	1	1	0
15	17	19	16
9	10	7	10
2	0	2	3
0	0	0	0
4	1	1	3
6	11	N/A	N/A

Definitions

High pill count:
Dispensed 180 or more pills

Do not prescribe prescriptions:
Dilaudid, Soma and Hydromorphone

***Excludes Soma for Periods 1 and 2**

	Begin	End	Days	Working Days
Baseline (PERIOD 1):	6/2/2014	9/15/2014	105	74
PERIOD 2:	7/21/2015	10/20/2015	91	65
PERIOD 3:	12/1/2015	3/29/2015	119	84
CURRENT:	4/1/2016	7/31/2016	121	84

Provider Specific Opioid Data Report (Pg. 2)

Figure 2. **Quarterly provider report on opioid prescribing**, page 2 (sample)

Which of my patients does this report include?

Prescriptions with High Pill Count

ID	Opioid	Pill Count
	Percocet-5/325	200

Prescriptions with MME>=90

ID	Opioid	MME
	Morphine Sulfate ER	90
	Oxycontin	270

Do Not Prescribe

ID	Opioid
	Dilaudid

High Risk Prescriptions

ID	Opioid
	Nucynta
	Oxycontin

Co-Prescribing Opioids and Benzodiazepines

ID	Opioid	Benzodiazepine
	Oxycodone	Klonopin
	Percocet-5/325	Ativan
	Oxycodone Hydrochloride	Diazepam
	Vicodin	Diazepam
	Oxycodone	Lorazepam
	Oxycontin	Alprazolam

Patients Meeting Multiple Criteria

ID	Criteria
	Oxycontin and Co-Prescribing Opiods and Benzodiazepines
	MME>=90, Do Not Prescribe
	MME>=90, Co-Prescribing Opioids and Benzodiazepines

Components of Targeted Chart Review

- Has history, Physical Exam, and appropriate diagnostic imaging testing been documented?
- Has an assessment of risk for substance abuse, misuse, or addiction been documented?
- Has a discussion of therapeutic harms and benefits of opioids been documented?
- Is there a current controlled substance agreement on file?
- Has a discussion of goals, expectations, risks, and alternatives been documented?
- Has the patient been screened for behavioral health comorbidities such as depression, anxiety, etc.?

Components of Targeted Chart Review

- Has the patient had a visit at least once every three months in which pain management was assessed and discussed and a treatment plan was documented?
- Has a functional assessment score been documented and reviewed at least once every three months?
- Is there documentation that the PMP database has been accesses and that there are no aberrancies?
- Is random toxicology screening performed at least twice yearly?
- For patients with a history of substance abuse, psychiatric issues, or serious aberrant behaviors, have more frequent toxicology screens been performed?

Components of Targeted Chart Review

- Has a multi-modal treatment plan been developed, implemented, and documented, including referrals to behavioral health for co-management along with additional referrals as appropriate to other specialists including but not limited to the following:
    - Physical Therapy/Occupational Therapy
    - Addiction Treatment
    - Chiropractic Care
    - Acupuncture
    - Mindfulness
    - Pain Management or Physical Medicine

Components of Targeted Chart Review

- Is there documentation that the provider has asked about adverse effects from opioid medications?
- Has the provider appropriately discontinued opioid medications in the following circumstances:
    - Aberrant drug-related behavior
    - Abuse
    - Diversion
    - Lack of progress toward goals
    - Adverse reactions/effects from medication?

Post ORC: Chronic Opioid Prescribing Practices

Table 1. **Chronic Opioid Prescribing: Percentages by measure across CHC** (12 month look back)

	First Opioid Report (Nov. 2015) (n=100,097)	Most Recent Report (Sept. 2016) (n=103,520	p-values
Percent panel on opioids (90-days or more or 3+ Rx for opioid)	**2.85%** (2,857/100,097)	**2.61%** (2,702/103,520)	p<.001
CTPMP (every 12 months)	**39.45%** (1,127/2,857)	**68.17%** (1,842/2,702)	p<.001
Utox (every 6 months)	**41.62%** (1,189/2,857)	**77.13%** (2,084/2,702)	p<.001
Opioid agreement ever	**77.18%** (2,205/2,857)	**77.35%** (2,090/2,702)	Not statistically significant
Pain assessment done	**34.23%** (978/2,857)	**54.77%** (1,480/2,702)	p<.001

Post ORC: Opioid Prescribing Practices in 3 Month Period

Table 2. **Opioid Prescribing: Prescribing in three month period across CHC**

	First Opioid Report (Nov. 2015)	Most Recent Report (Sept. 2016)	p-values
Prescriptions with high pill count (>180 pills)	**4.3%** (205/4,721)	**1.6%** (55/3,410)	p<.001
Prescriptions with MME >=90	**19.4%** (916/4,721)	**14.8%** (506/3,410)	p<.001
Prescriptions from the "Do Not Prescribe" list	**3.1%** (148/4,721)	**1.4%** (48/3,410)	p<.001

Supporting Primary Care Providers to Improve Pain Care

- Standards
- E.H.R. Solutions
- Data Tools
- Telehealth
- Learning and Collaboration
- Oversight
- **Prevention & Treatment of Substance Use Disorder**

http://diysolarpanelsv.com/free-clipart-support.html

The Opioid Crisis

- Opioid Overdose deaths have quadrupled since 1999 and account for roughly 63% of drug overdose deaths in the US in 2015[3]
- Sharp increase between 2006-2015[3]
    - Increase in the supply and use of heroin
    - Increase of mixing fentanyl into heroin supply
    - Increase in deaths involving synthetic opioids without heroin

*****The strongest risk factor for heroin use and dependence is misuse of or dependence on prescription opioids*****

Opioid Action Plan

- Inclusion of all departments (clinical & non-clinical)
- Interventions designed to:
  - Enhance patient and community education
  - Improve Access (to MAT, ancillary care, etc.)
  - Engage community partners
  - Improve team support (standing orders, BH groups, etc.)
  - Involve all care delivery sites (SBHCs, W.Y.A., Prenatal, etc.)
  - Measure/evaluate impact (short-term, intermediate and long-term effects)
  - Share Successes and Best Practices

Opioid Action Plan

CHC Opioid Action Plan: Logic Model

Purpose: CHCI is committed to implementing a comprehensive action plan that will work to:

1) Prevent abuse and addiction
2) Improve access to effective treatment for addiction
3) Reduce contributing factors to abuse and addiction
4) Reduce the number of deaths by opioid overdose AND
5) Support and care for individuals and families affected by opioid addiction and deaths by overdose

Response	Inputs & Resources	Activities	Outputs	Effects/Outcomes		
				Short-Term	Intermediate	Long-Term or Ultimate Effect
#1	Project ECHO (Pain & Buprenorphine)	•Twice Monthly (Pain) or Monthly (Bup) videoconference didactics •Case-Based learning and knowledge transfer	•Provider Attendance •Provider Case Presentations	•Improved Provider Awareness of Evidence Based Guidelines and CHCI Policy with regard to Pain Management and Chronic Opioid Use •Improved Provider Perception of Resource Availability •↑Patient Access to Specialty Consult	•↑ Provider Knowledge and Self-Efficacy with regard to Pain Management & Chronic Opioid Use	•Improved patient outcomes and treatment of chronic pain •Improved adherence to CDC recommendations and CHCI policy with regard to Chronic Opioid Use
#1	PainNET	•Online Peer Consults •Online Discussion Forums	•Provider Use of Online Community			
#1	eConsults (Pain & Buprenorphine)	•Timely, Patient-Specific, Expert Consultations	•Provider Initiated eConsults			
#2	Providers	•Require/Incentivize x-License •Incentivize Increased Caseload •Train/Enroll NP/PA staff	•Providers with x-License •Potential Patient Treatment "slots" •All Provider Types with x-License	•↑ % of Providers with x-License (all provider types) •↑ Patient Access to MAT •All Team Members Implementing Role-Specific Support for MAT (eg. MA, RN, BH)	•↑ Patient Uptake of MAT	•Improved Patient Outcomes & treatment of opioid addiction •↓ Death by Overdose
#2	Grand Rounds	•Provider/Team Education on MAT Options	•Grand Rounds Attendance			
#2	Nursing Practice Updates	•Nursing Standing Orders for MAT Support •Structured Template Creation •Training/Implementation	•Training Attendance			

Opioid Action Plan

- Policy Issues (CHC & State/National)
- Narcan
- EHR Updates (templates, documented patient ed, etc.)
- Other providers: BH, Chiropractors, Dieticians
- CCM
- Prenatal
- SBHC
- W.Y.A.
- HR
- Leadership/Regional VPs
- Communications

Conclusion and Next Steps

- Chronic Disease Approach/Chronic Disease Support
  - MI/SMG Opioids/Chronic Pain/Addiction
- Planned Primary Care
  - Planned Care Dashboard Alerts
  - Standing Orders
  - Streamlined Nursing Visits
  - Consider Studying Required Chiro prior to Opioid Initiation
- Address Behavioral Health Co-Management/Co-Prescribing Responsibilities
- Formal OAP Scorecard to Track Outcomes

Implications for the DNP

- The possibilities are endless

BUT…

- You have much responsibility
  - Demonstrate Leadership
  - Focus on Change that Makes a REAL Difference
  - Innovate
  - Don't Be Afraid to Think Too Small or Too Big
  - Measure, Measure, Measure
  - Celebrate Success & Failure
  - Listen to Your Mentors
  - Support Others Along the Way

Other Key Individuals

- **Margaret Flinter, PhD, APRN, FNP-BC,** Sr. Vice President & Clinical Director
- **Veena Channamsetty, MD**, Chief Medical Officer of CHCI
- **Daren Anderson, MD**, Chief Quality Officer of CHCI and Director of the Weitzman Institute (WI)
- **Tim Kearney, PhD**, Chief of Behavioral Health of CHCI
- **Sheela Tummala, DDS,** Chief Dental Officer
- **Nick Ciaburri**, Director of Business Intelligence
- **Zachary Manville,** Database Developer II
- **Tierney Giannotti, MPA**, Quality Improvement Data Analyst for CHCI & WI

References

[1]Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington (DC): National Academies Press (US); 2011. Available from: https://www.ncbi.nlm.nih.gov/books/NBK91497/

[2]Anderson, D. R., Zlateva, I., Coman, E. N., Khatri, K., Tian, T., & Kerns, R. D. (2016). Improving pain care through implementation of the Stepped Care Model at a multisite community health center. *Journal of Pain Research*, *9*, 1021–1029.

[3]Rudd, R.A., Seth, P., David, F., & Scholl, L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *MMWR*, 65, 1445–1452.

Dowell, D., Haegerich, T.M., Chou, R. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR*, 65:1–49.

QUESTIONS?

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