Tools, Technology, and Teams to Transform Pain Care in Primary Care

Veena Channamsetty, MD

Chief Medical Officer

Community Health Center, Inc.

Weitzman ECHO®

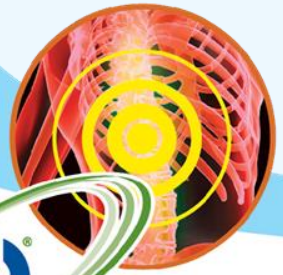
Buprenorphine

cecn

Community eConsult Network, Inc.

AddictionNET

Comprehensive Tools to Tackle the Pain and Opioid Crisis



Weitzman ECHO®

Chronic Pain

PainNET

CLINICAL WORKFORCE DEVELOPMENT

Practice Transformation Learning Collaboratives

Weitzman ECHO® Pain

EL RIO COMMUNITY HEALTH CENTER

Community Health Center, Inc.


PainNET
Evidence
Guided Practice
Committed to Making a Difference for Patients with Chronic Pain
eConsults
Project ECHO
PainCare 101
Resource Library
PainNET

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Community eConsult Network, Inc.

A Primary Care-Focused eConsult Network for Pain and Other Specialties

CeCN

Pain Medicine eConsult

Consult Question

47 year old female with left shoulder pain, SLAP tear, chronic Hill Sacks deformity. Has been on opioid from pain mgmt. clinic but discharge due to absence of medication in UDS. Now taking gabapentin, started Cymbalta and tramadol at today's visit. Pt requesting Percocet but I'm not sure if this is appropriate. Low dose Percocet or other opioid is appropriate at this time?

Specialist Response

I really don't see a role for opioids in a 47-year-old with the same shoulder pathology I have - from personal experience I know that this hurts but it doesn't need opioid. Not only that, he opioid may be going to the street for cash given the negative UDS.

The scan of thing is all about patient's self management, staying with the exercises and so on. It is a long process, 6 months or more to really see a lot of benefit From the PT . Again, I would not prescribe any opioid to this patient. I don't see a role for the neuropathic medications such as gabapentin And Cymbalta for pain control. This is nociceptive pain, not neuropathic pain. I would suggest not pursuing those medicines for pain- although it may help quite a bit with psychologically-based issues, and might be useful for that reason. Consider topical NSAID trial - sometimes not so good for shoulder pain but sometimes it is. The biggest mistakes people make his they don't consistently use the medication 3 times a day and they don't keep it up for least 2 weeks before deciding whether it works.

Sometimes large SLAP tears get better with arthroscopic surgery, but usually not in this age group. There are other orthopedic procedures that can palliate pain and if she has not had an orthopedic consult it is worth it.

Opioid Review Committee

Committee with oversight over opioid prescribing

- Establish Formulary
- 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. 1)

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

Pain Documentation

	Baseline 2011 N=108 (%)	Evaluation 2014 N=213 (%)	p-values
Documentation of Pain	69 (64)	174 (81)	<0.001
Source or Cause of Pain	67 (62)	158 (74)	0.025
Functional Assessment	5 (5)	42 (19)	<0.001
Review of Diagnostic Tests	6 (6)	37 (17)	<0.003
Treatment Plan	99 (92)	209 (98)	0.006
Pain Med Ordered	102 (94)	182 (85)	0.017
Pain Consult Ordered	7 (7)	60 (28.2)	<0.001
Patient Education	16 (15)	47 (22)	0.121
Diagnostic Imaging Ordered	25 (23)	59 (28)	0.379
Assessment of Treatment Effectiveness	18 (17)	83 (39)	<0.001

Changes in Practice

	Pre-ECHO	Post ECHO
Functional assessment documented*	14%	60%
Documented pain re-assessment*	40%	65%
Visit with behavioral health**	29%	34%
Prescribed any opioid**	49%	45%

Increase knowledge → Change practice

*Source: Chart review

**Source: Follow up EHR data

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

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

Response	Inputs & Resources	Activities	Outputs	Effects/Outcomes		
				Short-Term	Intermediate	Long-Term or Ultimate Effect
#4	CHCI Policy/ Procedure Updates	•Update Agency-Wide Policies regarding Controlled Medication •Update all tools & dashboards	•Policies updated and approved •Tools & Dashboards updated & implemented	•↑ Provider Awareness of CHC Policies & Procedures for controlled substances •↑ Provider awareness of available tools & dashboards	•↑ Panel Management sessions dedicated to Opioid patients •↑ Pain eConsults •↑ Project ECHO Pain, Buprenorphine and CCM cases presented	•↓ # of patients on chronic opioids •Improved Adherence to CDC Recommendations and CHCI Policy with regard to Chronic Opioid Use
#4	ORC	•Continue Red Flag Reports to all providers	•Reports submitted to providers	•↑ Provider/Team access to data		
#5	BH Groups	•Develop groups agency-wide for individuals impacted by pain and/or addiction	•Curriculum created •Groups implemented	↑ Consistency in programming agency-wide for BH services •↑ Patient access to BH services	•↑ Patient uptake of BH services •Improved relapse prevention	•Improved Patient Outcomes & treatment of pain and/or opioid addiction •↓ Death by Overdose •Improve patient perception of pain
#5	CCM Program	•Develop Project ECHO CCM didactic for opioid addiction •Create EHR templated visit for nurses for MAT	•Didactic completed •EHR templates created •Agency-wide training/ Roll-Out	•Nurses implementing role-specific support for MAT	•↑ Patient uptake of nursing services •↑ Project ECHO CCM cases presented	•Improved patient outcomes and treatment of chronic pain & opioid addiction
#5	Chiropractors	•Policy to prioritize chiro evaluation prior to initiating opioid	•Policies updated and approved	•Chiro implementing role-specific support for chronic pain management	•↑ Patient uptake of chiro services	•Improved patient outcomes and treatment of chronic pain •↓ # of patients on chronic opioids
#5	Dieticians	•Proactive referral to dietician services for all chronic pain patients	•Agency-wide training/ Roll-Out	•Dieticians implementing role-specific support for chronic pain management	•↑ Patient uptake of dietician services	

Opioid Action Plan

Response	Inputs & Resources	Activities	Outputs	Effects/Outcomes		
				Short-Term	Intermediate	Long-Term or Ultimate Effect
#6	SBHCs	•Implement adolescent SBIRT •Implement student education curriculum •Develop "first responder" protocol for SBHC BH team	•PDSA at SBHC followed by agency-wide Roll-Out of SBIRT •Curriculum developed •Protocol completed	•↑ Team awareness of benefit of adolescent SBIRT •↑ Availability of educational materials •"First responder" team trained	•↑ Adolescent SBIRT •↑ Student Awareness of Risk •↑ in Student Receipt of educational materials	•↑ Identification of students in need of Treatment •↓ Overall drug use/ abuse due to early identification and preventive education •↓ Death by Overdose
#6	W.Y.A.	•Continue regular delivery of addiction services •Assess program success	•Success metrics established	•↑ Provider/Team access to data	•↑ Patient uptake of substance abuse services	•Improved Patient outcomes & treatment of opioid addiction •↓ Death by Overdose
#7	HR Recruiters	•Recruit clinical staff experienced in or interested in delivering MAT •Organize a campaign describing EAP specific to supporting employees touched by the opioid crisis	•Providers with x-License •All Provider Types with x-License •EAP campaign completed	•↑ % of Providers with x-License (all provider types) •All Team Members Implementing Role-Specific Support for MAT (eg. MA, RN, BH) •↑ Patient Access to MAT	•↑ Patient Uptake of MAT	•Improved Patient Outcomes & treatment of opioid addiction •↓ Death by Overdose •↑ employee satisfaction with EAP process

Opioid Action Plan

Response	Inputs & Resources	Activities	Outputs	Effects/Outcomes		
				Short-Term	Intermediate	Long-Term or Ultimate Effect
#10	Prenatal	•Provider/Team Education on identifying opioid use during pregnancy as well as options for MAT for these patients •Develop drug screening protocols (universal verbal screening) •Develop protocols for coordinating treatment and care once identified •Facilitate interprofessional approach for transition of patient post-partem and for infant post delivery •Implement patient education (brochure based for individuals in the prenatal program)	•Provider Attendance •Protocol document created for maternal drug screening •Protocol document created for maternal support if positive on screening •Protocol document created for maternal post-partem transition, and infant transition •Implementation of new workflow into normal clinic flow	•↑ Standardization in Prenatal specific procedures to address opioid use in this population •↑ Patient Screening for Opioid use •All Team Members Implementing Role-Specific Support for MAT	•↑ Patient Uptake of MAT and other supports	•↑ Identification of Individuals in need of Treatment •↓ # of patients on chronic opioids •↓ Overall drug use due to early identification and preventive education •Improved Patient Outcomes & treatment of opioid addiction •↓ Death by Overdose

Summary

- Policy on Prescribing Controlled Medication
- Multifaceted provider education
- Non-opioid Medications
- Alternative Services
- Team based approach
- Risk Mitigation Strategies
- Templated EHR visits
- EHR/clinical alerts and reports
- Monitoring , oversight, and Tracking
- Larger Action Plan

Questions