A Collaborative Approach to Primary Care Opioid Management

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Problem Addressed

- Chronic pain affects ~ 30 million people in the U.S. (10% of U.S. population)
- Providing reactive rather than proactive pain management care may → poor use of clinic resources, inadequate pain control, & decreased patient quality of life
  - Sub-optimal chronic pain management due to lack of care coordination → undue burden on practice & patient
Problem Addressed

- Lack of opioid prescribing standards & oversight → widely variable practices
- Documentation variances → wasted time & energy searching charts

- Opportunities exist for standardization:
  - Monitoring patient response to treatments including medications & other services
  - Evaluating clinician practices (peer review)
Enter “CCSRAG”

- Chronic Controlled Substance Review & Advisory Group (CCSRAG)
  - A multi-disciplinary peer review team to help facilitate effective care of patients taking daily opioid medications
    - MD/DO, RN, mental health, clinic manager
  - Monthly 1 hour meetings (7:30am)
    - 2-3 thorough reviews/meeting; Top 10 registry review
      - Included patients: those with non-cancer pain taking > 30 morphine equivalents for ≥ 3 consecutive months
      - Identified by a registry sent once monthly to RN supervisor
    - Guidelines developed → treatment recommendations
## Patient Registry

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age Y</th>
<th>Cancer On?</th>
<th>Last Vist</th>
<th>Next Vist</th>
<th>WCCAST</th>
<th>Wcyt</th>
<th>Prob List</th>
<th>Most Recent Drug Test</th>
<th>Daily Morphine Eq</th>
<th>Per Day Morphine Eq</th>
<th>Start Dats</th>
<th>End Dats</th>
<th>Medication</th>
<th>Strength</th>
<th>Qty</th>
<th>Day</th>
<th>Order Source</th>
<th>FOP</th>
<th>Ordering Peer</th>
<th>Ordering List</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>56</td>
<td>N</td>
<td>Y</td>
<td>10/3/16</td>
<td>3/3/17</td>
<td></td>
<td></td>
<td>Hydrocodone Acetaminophen 7.5-500 mg</td>
<td>7.5-500 mg</td>
<td>200</td>
<td>11/15</td>
<td>3/3/17</td>
<td></td>
<td></td>
<td>1500</td>
<td>1500</td>
<td>Order</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>21</td>
<td>Y</td>
<td>Y</td>
<td>10/3/16</td>
<td>3/3/17</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
**Project Outcomes**

- **Enhanced two-way communication with PCP**
  - PCPs can choose to exclude their eligible patients from the protocol

- **Standardized treatment plans:**
  - Prescribing practices
    - Quantity (28 days)
    - Refills (Educated about schedule rules, etc)
  - Documentation
    - One contract (Combined from 3 older versions!)
    - Updated problem lists - “Chronic pain” (338.29A)
      - Annotated using “.dvnnarcprob”
Project Outcomes

– Documentation (cont.)
  • Comprehensive visit template
    – Annotated using “.dvnnarc”
  • Add or update NC / CSA / FYI

– Ancillary support routinely incorporated
  • Alternating RN/PCP visits every 3 months
  • Inter-disciplinary team eval. recommended prn
    – Patient, PCP, Specialists, PT, OT, health psych

– Standard monitoring for long-term use
  • At least once annual urine drug screening
    – Obtaining results needs to be cost effective, timely
      » Adopted K501 ($250, 2 days) vs.
        “Verona special” ($900, 2 wks)
The Review Form

- Reason patient is being reviewed
- Cause of chronic pain
- Check for use of standard documentation
- Review of prior work-up / evaluations
- Review of ancillary services / other medications tried
- Effectiveness of therapeutics / QOL
- Discussion → CCSRAG recommendations
Improvement Strategy

- Plan-Do-Study-Act (PDSA) cycles were used for improvement of patient registry accuracy & content, pain management visit content, lab order details, forms revision (opioid contract & CCSRAG review questions), EMR documentation, & clinician feedback
Clinician Survey Results

N = 9  (53% responding)

- I am aware of the current care processes recommended by our clinic's Chronic Controlled Substance Review and Advisory Group (CCSRAG).
  - Strongly Agree: 4.28

- Since implementing the CCSRAG, my level of uncertainty and/or frustration with care processes that involve opioid management has decreased.
  - Agree: 3.78

- Including standardized information on the patient’s problem list under the “Chronic Pain” problem has improved my ability to efficiently find the information necessary for opioid refills when requested.
  - Agree: 3.78

- Receiving a list of my unique patients who take opioids for their chronic pain has helped to ensure my chart documentation (i.e., FYI, problem list) is consistent for each patient.
  - Agree: 3.39

- The urine drug screen now routinely used by our lab allows for effective decision making regarding appropriateness of ongoing opioid prescribing.
  - Agree: 3.67

- I find the feedback and/or advice provided by the CCSRAG to be helpful in managing my patients who take opioids.
  - Strongly Agree: 4.11
Clinician Survey Comments

- “… CCSRAG feedback came at a critical time in my decision making about patient & I feel better about having support of peers & ability to tell patient my decisions are supported by this larger group.”

- “Problem list – I think clinicians need to use the chronic pain designation more consistently. We’re not to the point yet where we can trust the problem list is up to date.”

- “Good ideas, limited implementation overall (not the group’s fault, but a fault of us individual clinicians), but would like to see implementation continue to move forward.”

- “It’s really the overall process that helps more than the specifics.”
Advantages of CCSRAG

- A better understanding of the clinic workflow & the patient population can be maintained
- Standardized documentation benefits all points-of-care & optimizes care coordination
  - Refill issues are reduced & more easily covered by practice partners
  - Call volume & time spent on each call can be reduced
- Patients’ unique needs are better known & consistency with patient/staff relationships is enhanced
Advantages of CCSRAG

- Clinicians appreciate assistance with care coordination without feeling loss of autonomy surrounding chronic pain care
- Clinician knowledge regarding chronic pain management may increase by sharing review findings & recommendations
- PCP clinic site documentation facilitates a more streamlined transition to specialty care …
Pre-appointment planning

- Initial mailing: Welcome letter, attendance policy, pain questionnaire
  - This mailing may occur months prior to appt (3 mos waiting list to get into clinic)

- Current practice: RN calls 1 week prior to appt to remind them to bring completed questionnaire & all imaging to appt
  - Opportunity for RN to review chart
Pre-appointment planning

- Next step: Trial of pt orientation to pain clinic 1 week prior to MD appt with RN.
  - Complete paperwork/questionnaire.
  - Bring imaging studies to be scanned.
  - Complete release of information paperwork for prior treatment to obtain prior to appt.
  - Orientation to pain clinic & expectations for treatment.
  - No-shows a problem for initial Pain Clinic eval – hopefully will decrease!
Improving communication

- Difficulty streamlining communication process between PCP & Pain Clinic provider to make it effective & efficient.

- Current practice:
  - Referral form with clinical question.
  - Contact PCP after pt’s first appt regarding medication prescribing, recommendations
    - Usually just a routine CC’ed chart clinic note
Improving communication

- Next step: Contact PCP *prior* to appt.
  - Clarify goals of treatment.
    - Comprehensive eval vs. one time eval.
    - Specific question regarding treatment.
  - Discuss medication prescribing.
    - Preferred medications, medications PCP is comfortable / uncomfortable prescribing.
    - No maintenance prescribing – transfer prescribing to PCP after treatment completed.
  - Red flags for this pt, prior abuse.
Improving communication

- Send letter to PCP 1-2 wks prior to appt.
  - Check boxes & fill in the blank (regarding previously discussed items).
  - Keep it simple! We are currently developing a template that will not require much time or effort to complete.
  - Sign form to indicate that PCP will take over prescribing when treatment complete.
  - Fax back to Pain Clinic for review when pt presents for initial eval.
Improving communication

- Addressing pre-appt issues will help ease transition from pain clinic back to PCP.
- Medication prescribing is a big issue.
  - PCP & pain clinic provider are on the same page prior to starting treatment.
  - Allows pain clinic provider to start treatment for pt at first appt, rather than waiting to communicate with PCP after appt.
  - Less anxiety & frustration for providers & patient when prescribing roles are clear.
Thank you!!!