A comprehensive primary care / systems engineering partnership model aimed at mitigating the prescription opioid epidemic

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- UW Health Primary Care Clinics
- Advisory panel
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  - Roger Chou, MD
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Disclosures

• No significant financial relationships
Overview

- Background/motivation for study
- Aims
- Methods
- Anticipated outcomes & future work
President Obama Is Taking More Steps to Address the Prescription Drug Abuse and Heroin Epidemic

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Summary: Today in Atlanta, President Obama will join individuals in recovery, family members, medical professionals, and law enforcement officials at the National Rx Summit.

President Obama Speaks at the National Rx Drug Abuse & Heroin Summit
Opioid Prescriptions Dispensed by Retail Pharmacies—United States, 1991–2011

Number of Prescriptions (in millions)

Prescriptions 76 78 80 86 91 96 100 109 120 131 139 144 151 158 169 180 192 201 202 210 219

High Opioid Dose and Overdose Risk

* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

Motor Vehicle Traffic, Poisoning, and Drug Poisoning (Overdose) Death Rates
United States, 1980–2010

Aims of the Project

- Goal is to improve patient safety by instituting a set of universal precautions for opioid prescribing in primary care
- R34 grant mechanism is specifically for testing the feasibility, acceptability, and preliminary effectiveness of novel implementation strategies in preparation for larger trials
Implementation Strategy: Systems Consultation

- Proven in a large randomized trial of addiction treatment organizations (Gustafson et al., 2013) and used by ~ 4000 organizations nationwide
- Systems engineering tools:
  - Walkthrough exercises
  - Group decision making (nominal group technique)
  - Plan-Do-Study-Act change cycles
- What adaptations are needed to translate the NIATx approach to primary care?
Peer coaching: The key to cost-effective dissemination (Gustafson et al., 2013)

Coaching model

The usual approach to organizational change in healthcare: surveillance, scolding, etc.

Our approach: self determination theory

  Competence
  Relatedness

  **Autonomous motivation**

Perspective, empathy, and homophily
First things first....

Opioid Treatment Guidelines

Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain

Workgroup

Pain management specialists (3)
Primary care physicians (3)
Systems engineers (2)
Addiction and drug policy (1)
Integrated Group Process (Gustafson et al., 1993)

1. Choose participants
2. Develop a straw model through telephone interviews
3. Convene the group and revise the straw model
4. Design case scenarios
5. Enumerate the model
6. Identify sources of conflict
7. Average the smaller differences
8. Report the group’s judgment
Patient archetypes

1. An existing patient of the clinic, not currently using opioids, with a new chronic pain complaint, who might be a candidate for opioid therapy

2. An existing patient of the clinic already on long-term opioid therapy

3. An “inherited” patient (i.e., a patient that is new to the clinic but is already on long-term opioid therapy)
Mapping the recommendations onto an actionable, checklist-based implementation guide

☐ Review and discuss the Treatment Agreement and have the patient sign it.

☐ If checking the PDMP produced warnings, document details in the patient’s chart and discuss with the patient.

☐ Screen the patient for opioid misuse risk using the DIRE assessment tool, if this has not been done. Positive results warrant further assessment.

☐ Screen the patient for the risk for substance use disorders, if this has not been done. Positive results warrant further assessment.

☐ Screen the patient for depression using a validated tool such as PHQ2 or PHQ9, if this has not been done. Positive results warrant further assessment.

☐ Check the patient’s medication list for opioid/benzodiazepine co-prescribing. If present, discuss strategies for tapering benzodiazepine and/or opioid dose.

☐ Order a urine drug test and discuss a plan for future monitoring of opioid therapy using urine drug testing.

☐ Assess pain using the Brief Pain Inventory tool. If it is above 8 with doses near 100 MEDD, consider other therapeutic options (physical therapy, behavioral health consultation, acupuncture, etc.) or referral to a pain specialist.
General approach

• Create a detailed flowchart of Rx refill process and monitor incoming requests
• Compare patient’s chart to checklist and set up appointments with patients to take steps towards risk minimization
• Set a clinic-wide expectation to limit dose to 100 MEDD for current/future patients.
• Use skill, judgment, and advice in dealing with inherited and/or high-dose patients.
Where we are now…

4 implementation clinics recruited (7 approached)

Initial site visits to be completed on May 24, 2016

6-month intervention period extends through end of 2016 (staggered)

Mixed-methods evaluation
Coming next…

- Parsing the systems consultation implementation strategy into a set of discrete components
- National study using SMART design to promote systems-level improvement in the most efficient manner possible
For more information, see:

Thanks!

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