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Improving management of opioid prescribing for patients with chronic non-cancer pain



Learning objectives:

- Understand the Rapid Process Improvement Workshop approach
- Understand practice changes required
- Understand the implementation and performance measures used
- Discuss lessons learned

Improving management of opioid prescribing for patients with chronic non-cancer pain



Agenda

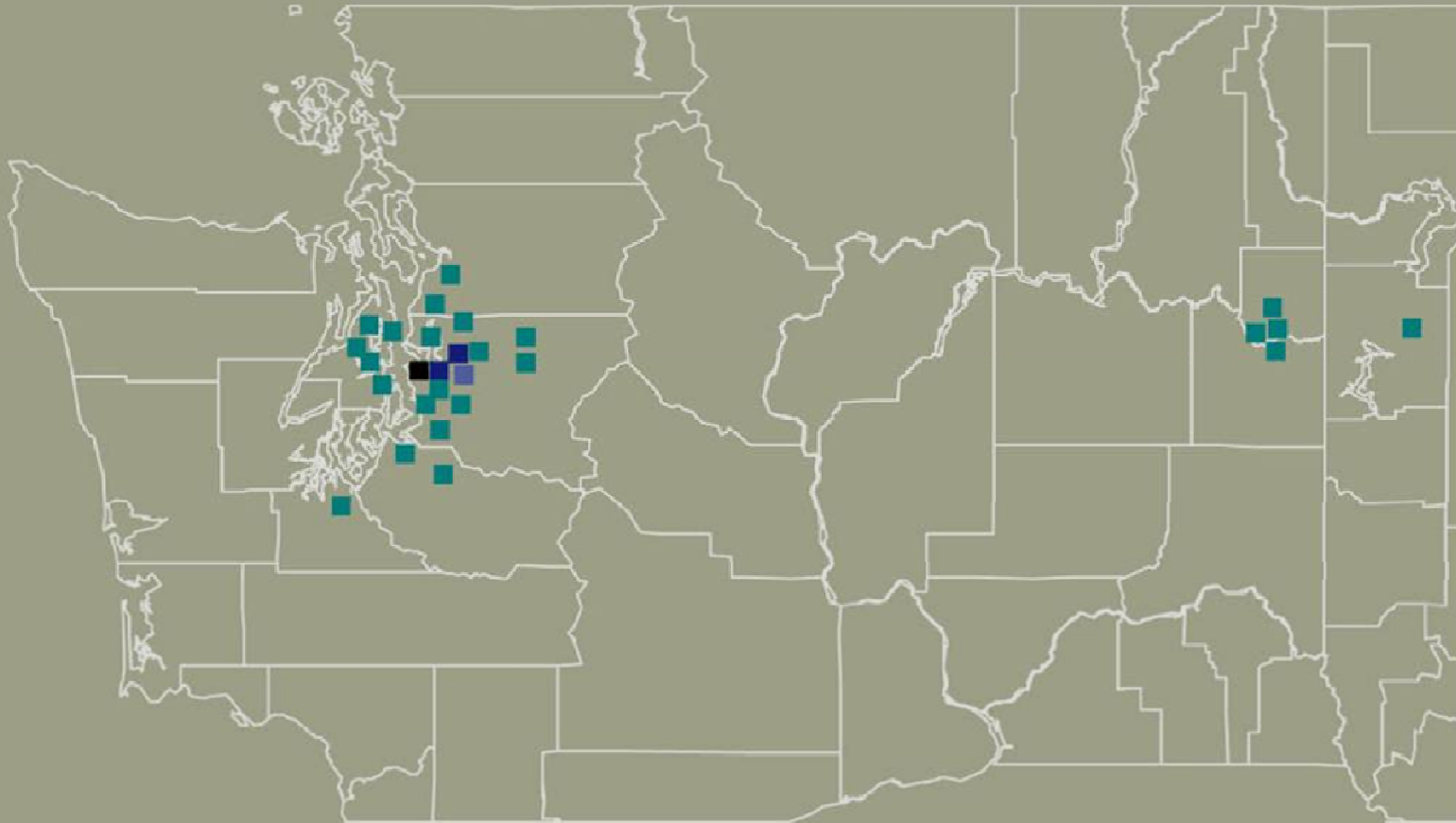
- Who is Group Health?
- Why did we adopt COT program?
- How did we design the COT program?
- Basic elements of the Design
- Implementing the Program

Who we are

- Integrated health delivery system
 - Founded in 1946
 - Consumer governed, non-profit
 - Membership: 661,500 Staff: 9,365
 - Revenues (2009): \$3 billion
- Multispecialty Group Practice
 - 26 primary care medical centers
 - 6 specialty units, 1 maternity hospital
 - 985 salaried medical group members
 - Contracted network
 - > 9,000 practitioners, 39 hospitals
- Group Health Research Institute
 - 34 investigators
 - 235 active grants, \$39 million (2009)



Group Health



Context - Baseline Condition



- **Long History of good Primary care;**
 - EMR in place 10 years
 - Patients paneled with Primary Care
 - Teams and case management in place
 - Population thinking, belief in evidence based care
 - 24/7 Consulting Nurse Services (CNS)
 - Good access

- **Coordination of Primary care with**
 - Occupational Health
 - Behavioral health
 - Specialty services

Context - Baseline Condition



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Myth 1: All our providers follow the same guidelines

Myth 2: Employed physicians do what we tell them to do

Myth 3: We have sophisticated data and tracking

Why did we develop COT program? The stars aligned



Washington State Guidelines

VA hospital training materials

GH Foundation grant for medical leadership

Primary Care Medical Director with passion and experience

The Current State was unsatisfactory



The unsatisfactory “Current State”



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- **Some patients receiving opioids for chronic noncancer pain feel like they are treated unfairly or “like a drug addict”**
- **Providers vary widely from those who will not prescribe opioids to anyone with chronic pain to those who are liberal in their opioid prescribing.**
- **It is often not clear who originated the original prescription or what the plan is for their continued use in any given patient.**
- **The lack of consistent assessment, documentation, prescription instructions, and use of urine drug screening makes team management of these patient extremely difficult.**
- **Complaints, confusion, wasted energy, unhappy staff, patients, and health risks for patients**

Why:

We had Confidence we could do it



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Improving opioid prescribing practices was not possible for us until now. Two things made it possible:

1. Enhanced Primary Care

- Medical Home elements provided framework

2. Adopting Lean management system:

- Consistency across clinics
- Standard work for providers, clinic staff, managers and leaders
- Visibility and accountability

Opioid Management RPIW

June 21-24, 2010



Who participated



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- **Primary Care focused**
- **Other areas we needed support from to ensure success:**
 - Pharmacy
 - Nursing
 - Physical Medicine and Rehabilitation
 - Behavioral Health
 - Addiction Medicine
 - Urgent Care
 - Consulting Nurse Service

Rapid Process Improvement Workshop



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- Review the **Current State**
- Define principles and goals of future state
- Define **New** process and standard work
- Define measurement plan

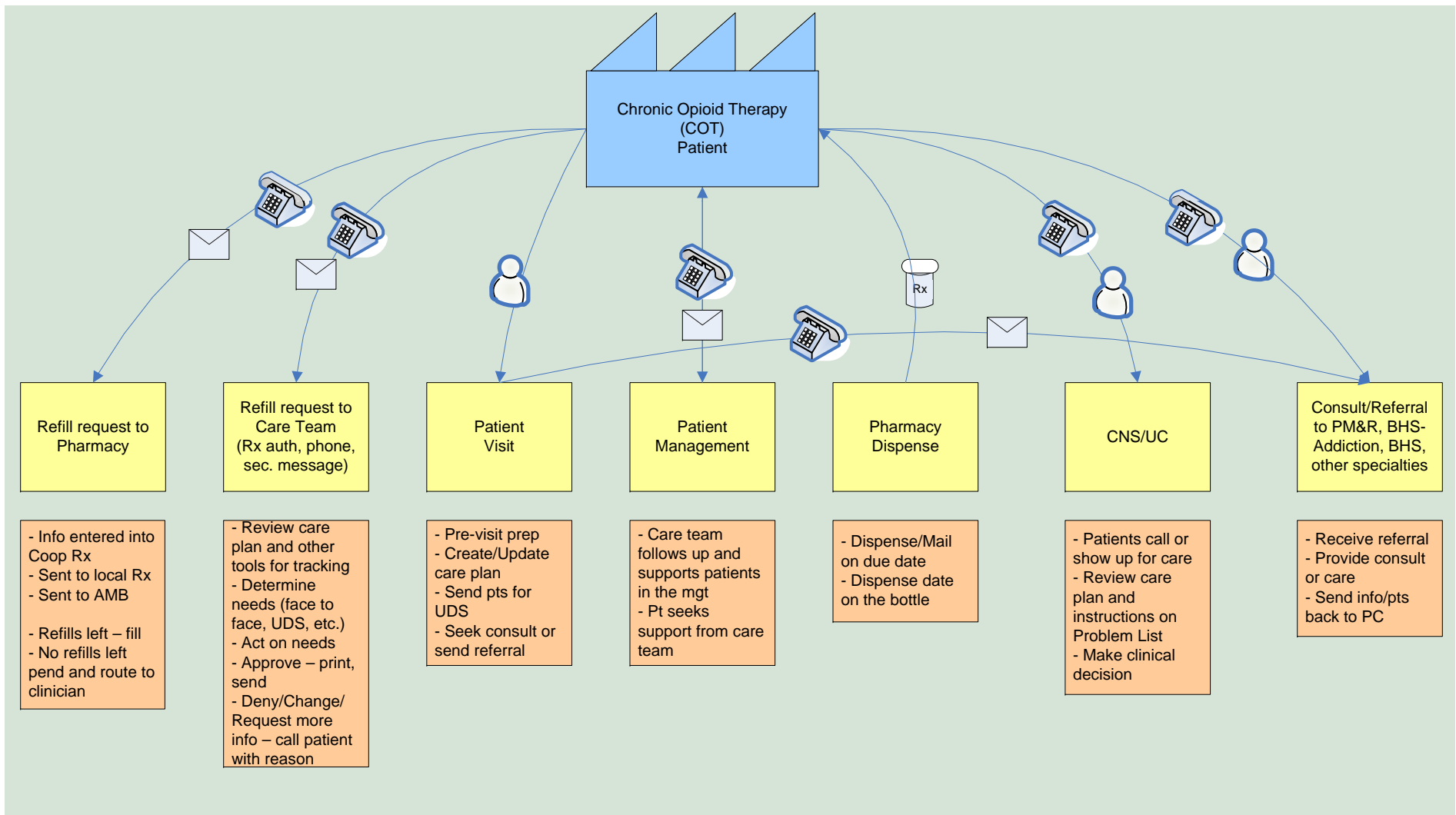
Guiding principles for a better “Future State”



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- Improving patient **Safety**
- Improving our culture of **Respect** for our patients
- Improving the **Quality** of care
- Improving patient and care team **Satisfaction**
- Reducing **Waste** throughout the system
- Making it **Easy** to do the right work

COT Process Flow



Some key specifics of the “Future State”



- **All patients on Chronic Opioid Therapy (COT) have a collaborative care plan in place that’s visible on the problem list that makes it clear:**
 - The “responsible clinician”
 - The expectations around prescription instructions, refills, monitoring, and urine drug screening for each patient

- **Standard work to support this:**
 - Scripting for care teams
 - Integration into pre-visit standard work
 - Standardizing the refill processes in Pharmacy
 - Clear plan and expectations for cross coverage, CNS calls, and Urgent Care visits, etc
 - How and when to refer to PM&R, BHS, and Addiction Medicine

Key Take Aways



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- **PCP**
 - Learn Guideline
 - Verify patient population and stratify by risk group
 - Meet with patient and develop collaborative care plan
 - Follow the care plan!

- **Other providers: urgent care, covering PCP, consulting nurse**
 - Find the Care plan
 - Follow the care plan!

Key Take Aways



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➤ **Clinical Pharmacist**

- Consult with providers on tapers, med conversions, dose adjustments, adjunct meds, complex med history

➤ **RN, Flowstaff, Clinical Pharmacist**

- Use standard refill smartphrases if request comes to them
- Use scripting to refer patients with opioid concerns to PCP to all stay in support of the care plan

Key Take Aways



➤ **RN**

- Follow up with patients on med/dose changes, side effect/symptom management
- Will not add to Chronic Disease case load in the short term
- Contact patient for additional information, change to Rx, or denial of Rx as directed by provider

➤ **Flowstaff (Medical Assistant or LPN)**

- Pre-visit preparation
 - COT care plan and Urine Drug Screen (UDS) needs
 - Add COT as chief complaint
 - Complete Wellness section during rooming

How does this work operationally?



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- **Pharmacy produces a list for each provider showing COT patients stratified by high, medium and low dose (based on morphine equivalent dose daily).**
- **Providers verify list and adjust risk category based on behavior, personal and family history and age.**
- **Providers put “GHC.17 CHRONIC OPIOID THERAPY” on the problem list for each patient.**
- **All patients with “GHC.17 CHRONIC OPIOID THERAPY” have a clear standardized care plan associated with that diagnosis.**
- **All clinical staff involved with care for a COT patient refer to this care plan to guide their behavior.**

Who is in the Chronic Opioid Therapy (COT) population?



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To support the implementation of this guideline, patients will be identified as being on chronic opioid therapy if they have:

- **Filled at least 5 prescriptions for opioids in the past 90 days**

OR

- **Taking opioids for at least 90 days in a pattern or quantity that indicates daily or near-daily use**

How big is this population?



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Total = 6388 patients (paneled to a GH MD and getting prescriptions filled at a GH pharmacy)

Range by clinic = 30 – 709 patients

Range by 1.0 FTE = 12.5 – 68.4 patients

High Dose (>120mg MED*) = 854 patients

Med Dose (20 – 119mg MED*) = 3,419 patients

Low Dose (<20mg MED*) = 2,115 patients

* MED = Morphine Equivalent Dose

Definitions of monitoring groups



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Table 1. Definitions

Group	Category	Patient Attributes
High intensity monitoring (may be time limited – i.e. for 1 year)	High Dose/Risk	<ul style="list-style-type: none"> • Taking more than 120 mg MED /day • Taking Methadone
	High Abuse Risk	<ul style="list-style-type: none"> • Current alcohol and/or drug abuse • 25 years old and under • Repeated problems following opioid management treatment plan. Examples include: <ul style="list-style-type: none"> ○ Frequent early refill requests ○ Escalating dose without consultation with physician ○ Getting opioids from multiple prescribers
Moderate intensity monitoring	Medium Dose	<ul style="list-style-type: none"> • Taking between 20mg and 120 mg MED
	Medium Abuse Risk	<ul style="list-style-type: none"> • Personal or family history of alcohol and/or drug abuse • Personal or family history of mental health issues
Low intensity monitoring	Low Dose	<ul style="list-style-type: none"> • Taking less than 20 mg MED¹
	Low Abuse Risk	<ul style="list-style-type: none"> • Compliant with medication plan • No personal or family history of alcohol and/or drug abuse • No mental health issues

Minimum requirements for monitoring and follow up



Table 2. Summary Grid (See respective sections for more information)

Group	Assessment	Urine Drug Screen	Treatment Plan Update
High intensity monitoring (may be time limited – i.e. for 1 year)	At least twice a year in person with the prescribing clinician.	At least twice a year	At least twice a year with the prescribing clinician.
Medium intensity monitoring	At least once a year in person with the prescribing clinician	At least once a year	At least once a year with the prescribing clinician.
Low intensity monitoring		Consider once per year.	

Wrapping up the documentation: Add GHC.17 CHRONIC OPIOID THERAPY CARE PLAN and Comment to Problem List



Problem List

Share in MyChart: Full Comments

Priority	Class	Noted	MyChart?	Resolved	Updated
	▶ Insomnia, unspecified [780.52]	5/27/2010	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Resolve	5/27/2010 Physician On...
	▶ CHRONIC OPIOID THERAPY CARE PLAN [GHC.17]	8/12/2010	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Resolve	! 8/12/2010 Physician O...

▼ Care plan discussed with patient: yes 8/12/2010
Medication Treatment Plan updated by Dr. Lee on 8/12/2010

Responsible Clinician: Dr. Lee
Participating Specialists: none

Reason for treatment (be as specific as possible): LBP from MVA 9/9/2000
Medication and strength: Oxycodone LA 10 mg
Sig: Take one tablet every 12 hours
of days supply: 28
Pharmacy: GHC Redmond
Allowable variation: 1 day +/-

Supporting evaluation documentation visit(s) (date) 9/10/2000 initial visit for MVA injury, 6/5/2001 Ortho consult, 11/22/2001 Neuro consult, 4/17/2002 Surgery
Pertinent history related to opioids: LBP tx w/Vicodin, Oxycodone post surg, convert to LA in 4/2008, stable since 12/2008
Opioid Agreement signed: no
Level of monitoring: MODERATE
Frequency of Office Visit: 1x/yr
Last office visit addressing pain: 2/5/2010
Frequency of UDS: 1x/yr
Last urine drug screen: None
CNS/Urgent care instructions: 2 rescue refills (to last through next business day) per year

Progress Note Smartphrases

.OPIOIDINITIAL

.OPIOIDFU

Urine Drug Screening



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- **It is recommended that the clinician have a discussion with the patient before the Urine Drug Screen that includes:**
 - The purpose for testing
 - What will be screened for
 - What results the patient expects
 - Prescriptions or any other drugs the patient has taken
 - Time of last dose of opioids
 - Actions that may be taken based on the results of the screen
 - The patient should be notified that the results will become part of their permanent medical record.



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Measurement

Each Provider will receive list of COT Patients



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Month **Oct-10**
Clinic **RNT**

8/9/2010

KLASSEN LAWRENCE

Clinic	Date	MRN	Birthdate	Avg MED	Dosage Level	Monitoring Level	Provider	Date Added To Problem List	Date of last UDS	Date of next UDS	Date of last Care Plan Update (during visit)	Date of next Care Plan update	Remove Patient	Reason for Removal
RNT	1/1/2010	015251		300.99	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		271.11	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		213.33	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		159.20	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		134.33	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		131.34	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		127.86	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		123.14	Hi	Hi	ABRAHAM SUMAM							
RNT	1/1/2010	015251		102.67	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		99.80	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		79.60	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		65.01	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		63.09	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		59.70	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		58.33	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		58.05	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		46.67	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		44.88	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		42.00	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		41.34	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		37.32	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		30.00	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		29.85	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		26.57	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		24.88	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		23.22	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		22.50	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		22.39	Med	Med	ABRAHAM SUMAM							
RNT	1/1/2010	015251		18.67	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		18.66	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		15.00	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		14.93	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		13.33	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		12.00	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		11.11	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		10.00	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		6.67	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	015251		5.00	Low	Low	ABRAHAM SUMAM							
RNT	1/1/2010	006435		404.85	Hi	Hi	BJARKE CHRIS							
RNT	1/1/2010	006435		403.48	Hi	Hi	BJARKE CHRIS							
RNT	1/1/2010	006435		398.01	Hi	Hi	BJARKE CHRIS							
RNT	1/1/2010	006435		260.04	Hi	Hi	BJARKE CHRIS							
RNT	1/1/2010	006435		232.47	Hi	Hi	BJARKE CHRIS							
RNT	1/1/2010	006435		197.51	Hi	Hi	BJARKE CHRIS							
RNT	1/1/2010	006435		184.91	Hi	Hi	BJARKE CHRIS							

Initial Verification by Providers



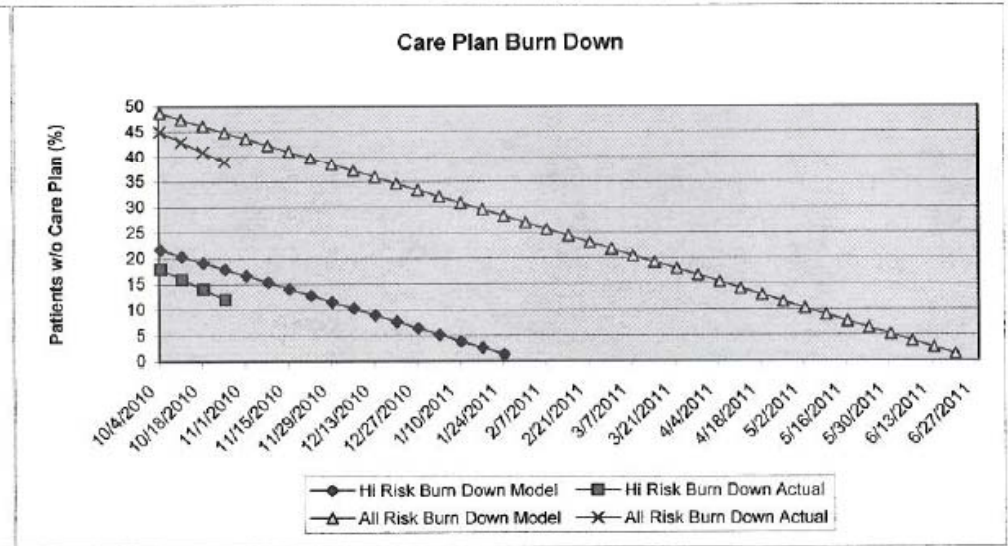
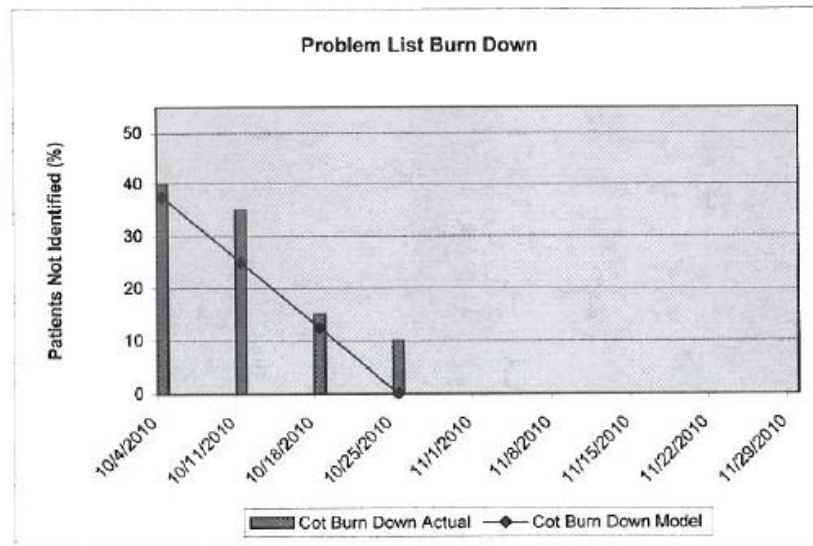
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- **Each provider asked to verify their list of COT patients**
- **Providers may choose to:**
 - Change a patient's monitoring level
 - Remove patients from the list (with brief reason why)
 - Add patients that should be on the list
- **Providers add GHC.17 to Problem List for all verified patients**
 - Not expected to create a Care Plan at this time
 - GHC.17 simply flags patient as part of COT population
- **Admin Specialists assist with tracking & measurement:**
 - During initial verification, update clinic tracking grid weekly based on Provider notes
 - On ongoing basis, receive green sheets weekly for COT patients and update date of last care plan on SharePoint

Burndown Charts will display actual performance against the expected pace of work over time



BRN Total



Training and resources



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- On-line CME training for the Care Team mandated for prescribers, pharmacists and team RN. Highlights shared with team in mandatory trainings.
- Primary Care team-based training on the process and tools (MD/PA/ARNP, RN, LPN, MA, RPh)
- Medical chief and clinical champion from each clinic attended 8 hours of Train-the-trainer CME on content and process
- Coaching available for providers: having difficult conversations about tapering/stopping COT and about urine drug screening

Timeline



- Jul/Aug 2010 – Develop materials and schedule trainings
- Sep 7, 2010 – Kickoff at Regional Forums
- Oct 31, 2010 – All patients verified have “GHC.13 CHRONIC OPIOID THERAPY” on their problem list
- Dec 31, 2010 – All staff trained on the new process
- Jan 31, 2011 – All high dose patients have a care plan
- Jun 30, 2011 – All COT patients have a care plan
- Dec 31, 2011 – Incentive payout based on performance

- **Making the work visible**
 - Care plans are explicit and easy to find
 - Completion rates posted by provider
- **Make the providers accountable**
 - Did they have the visits and create the care plans
 - Did they follow the care plan
- **A handful of physicians not able to impose boundaries**

Current Status



- **Tightly defining the roles of the team members**
 - Avoiding ambiguity
 - Avoiding inappropriate delegation
- **Ordering UDS was the hardest practice to change**

Current Status



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- **Best rollout ever**
- **Decreased patient complaints**
- **Decreased tension in the clinics**
- **Fewer patients on high doses**
- **Much more urine screening**
- **Starting to develop better programs for chronic pain**



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Questions