UT HEALTH'S RESPONSE TO THE OPIOID CRISIS

Clinical Safety & Effectiveness
Cohort # 21 Team 10

UT Health San Antonio

THE TEAM

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BACKGROUND

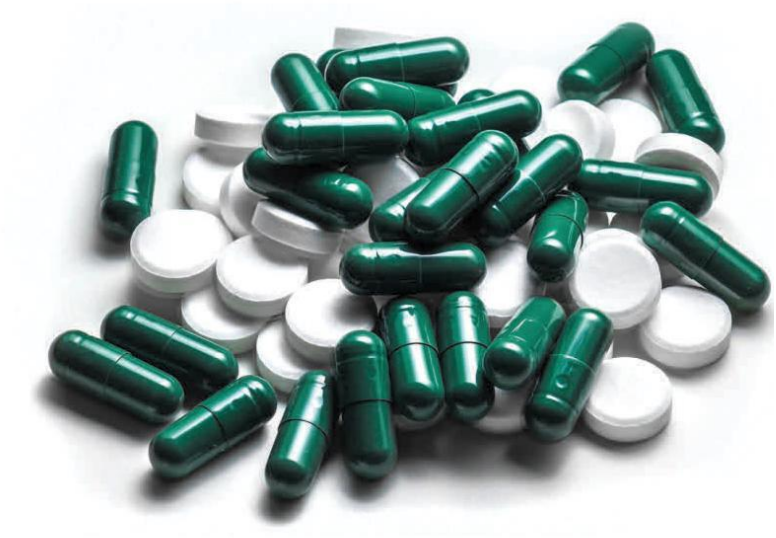
- Americans, comprise 5% of world's population, consume 80% of world's opioid supply
- 2016, 66.5 opioid prescriptions per 100 people written
- The probability of long-term opioid most sharply in the first days of therapy
- Four in five new heroin users started out misusing prescription painkillers
- Heroin and synthetic opioids overdose accounted for more than 35,000 deaths in 2016
- From 2002-2015, benzodiazepine deaths involving opioids increased two fold more than those not involving opioids

The Opioid Epidemic

Since 2000, the rate of overdose deaths involving opioids has increased . . .

200%

. . . according to the U.S. Centers for Disease Control and Prevention.

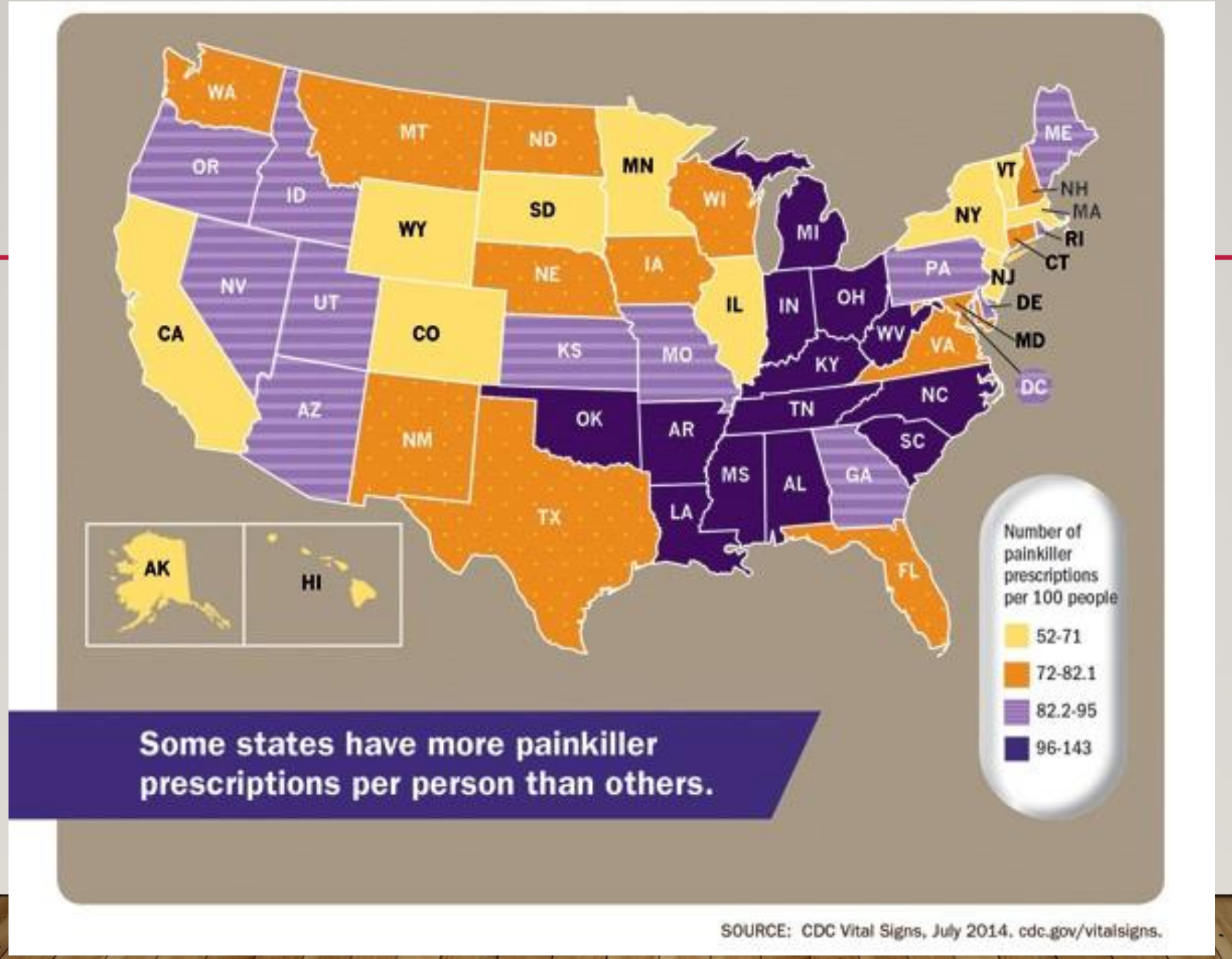


In 2015, opioid related overdoses accounted for **33,067** deaths in the US. Half involved a prescription opioid.

Opioid pain reliever prescribing has quadrupled since 1999.

4x Increase

Each day, 78 Americans die from an opioid overdose.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SC
NC
VA
PA
NY
ME
VT
NH
MA
RI
CT
NJ
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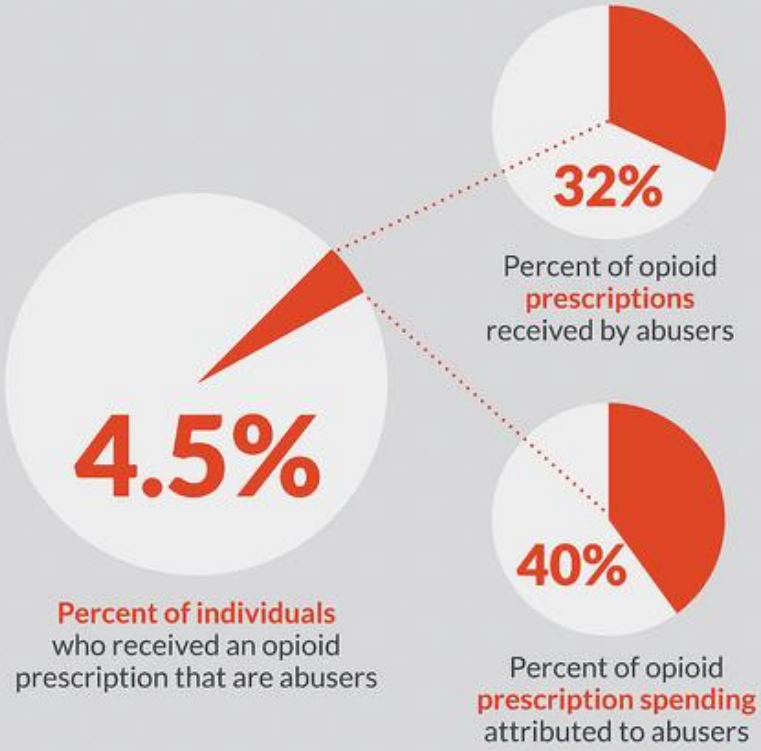
AK
HI
Number of painkiller prescriptions per 100 people
52-71
72-82.1
82.2-95
96-143
Some states have more painkiller prescriptions per person than others.
SOURCE: CDC Vital Signs, July 2014. cdc.gov/vitalsigns.

PRESCRIPTIONS

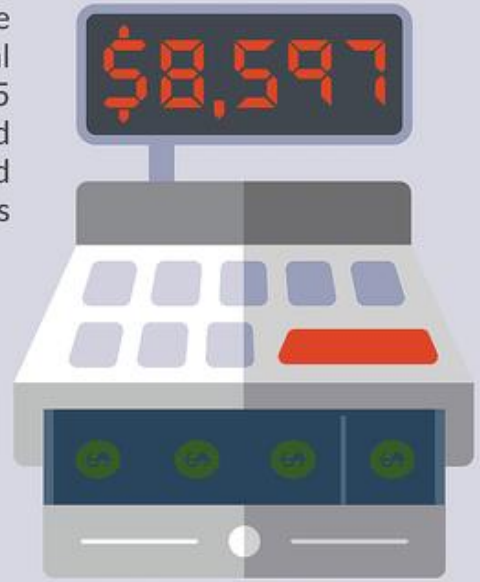
One out of every three (32%) opioid prescriptions is being abused. Moreover, 4.5% of individuals who have received an opioid prescription are opioid abusers, accounting for 32% of total opioid prescriptions and 40% of opioid prescription spending. This finding indicates that a disproportionate percentage of prescriptions for opioids are being prescribed to patients who abuse these medications. Furthermore, it illustrates that a relatively small number of individuals account for a large share of spending on opioid prescriptions.

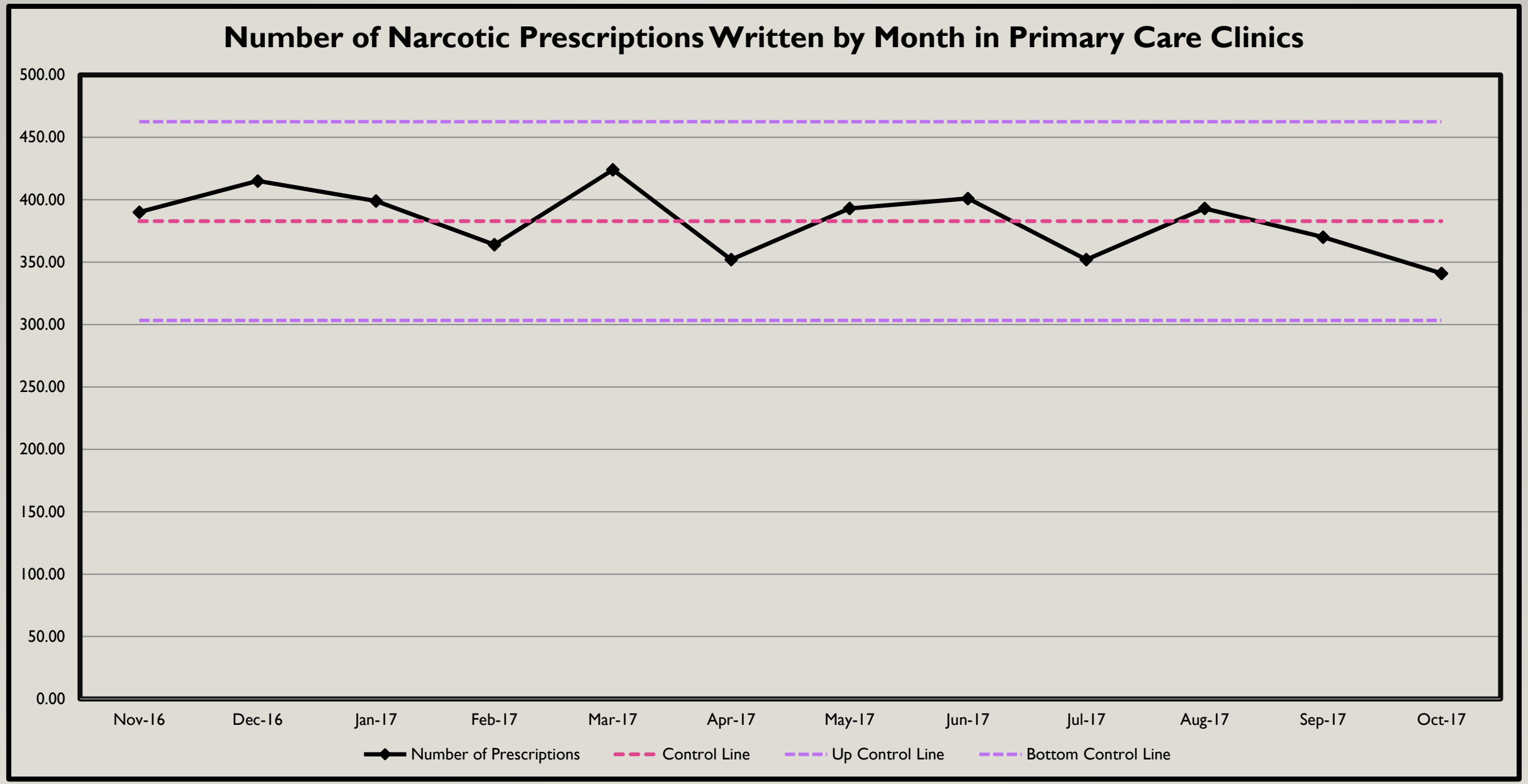


MEDICAL SPENDING

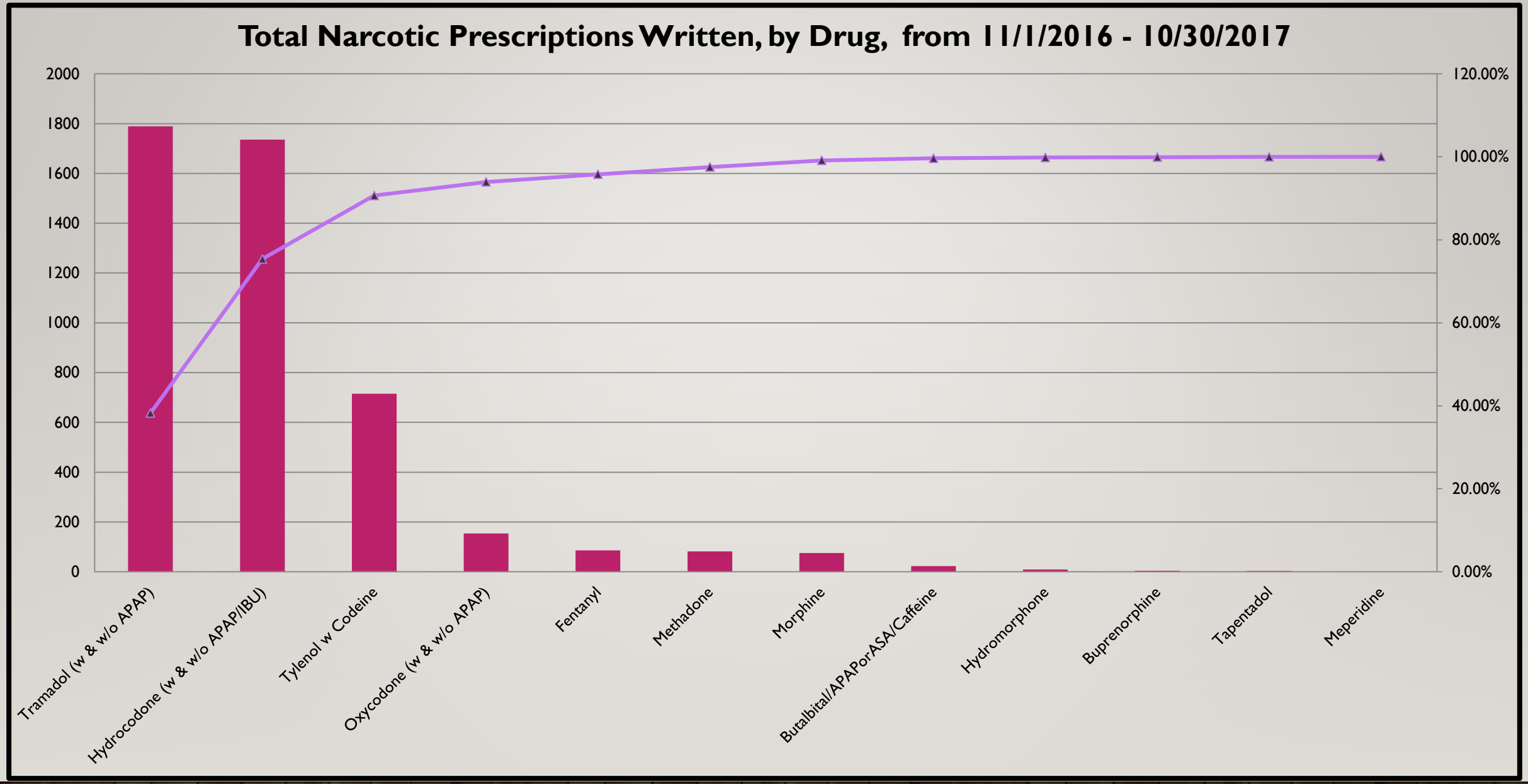
Opioid abusers cost employers nearly twice as much ($19,450) in healthcare expenses on average annually as non-abusers ($10,853). Individuals who abused opioids had total 2015 medical costs that were, on average, $8,597 higher than those who did not. Based on Castlight's estimate, opioid abuse could be costing employers as much as $8 billion per year.[10] Considering that absenteeism and presenteeism tied to opioid misuse and abuse is costing employers an additional estimated $10 billion, this crisis represents a significant drain on America's employers.[11]

The difference in total medical costs for 2015 between opioid abusers and non-abusers

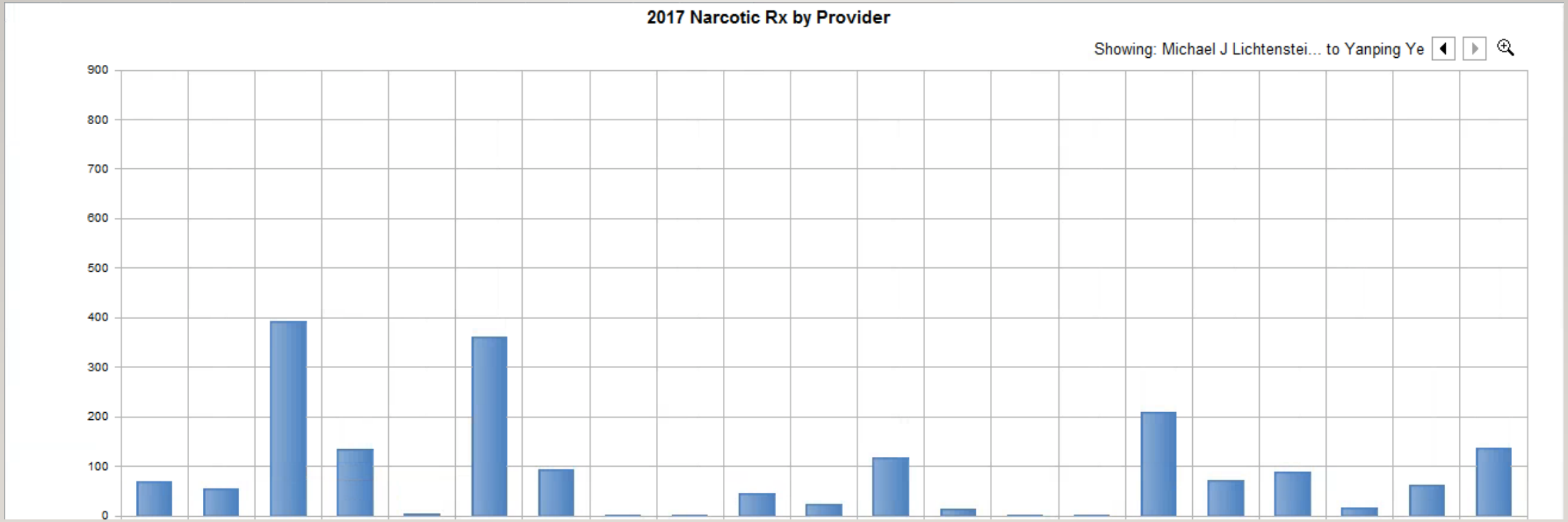



Number of Narcotic Prescriptions Written by Month in Primary Care Clinics
500.00
450.00
400.00
350.00
300.00
250.00
200.00
150.00
100.00
50.00
0.00
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Number of Prescriptions
Control Line
Up Control Line
Bottom Control Line

Total Narcotic Prescriptions Written, by Drug, from 11/1/2016 - 10/30/2017



NUMBER OF NARCOTIC PRESCRIPTIONS WRITTEN PER INDIVIDUAL PCP PROVIDER SINCE 1/1/2017



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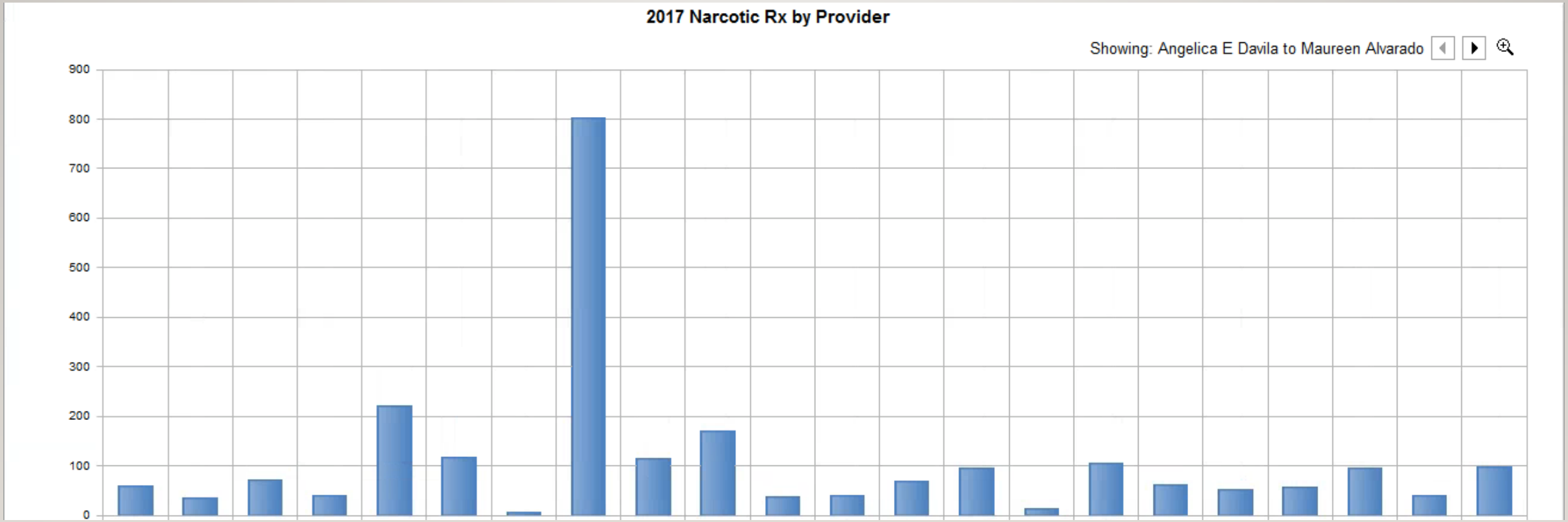


AIM STATEMENT

- Reduce the number of prescriptions for narcotics for non-cancer; non-postoperative patients in the Primary Care Clinics who are not suitable candidates for long-term opioid prescriptions by 25% by June 30, 2018.

- DIRE Score: 70% of patients evaluated for narcotics in Primary Care Clinics for non-cancer; non-postoperative pain will have a DIRE score completed as part of their evaluation.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

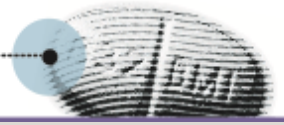
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed



4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

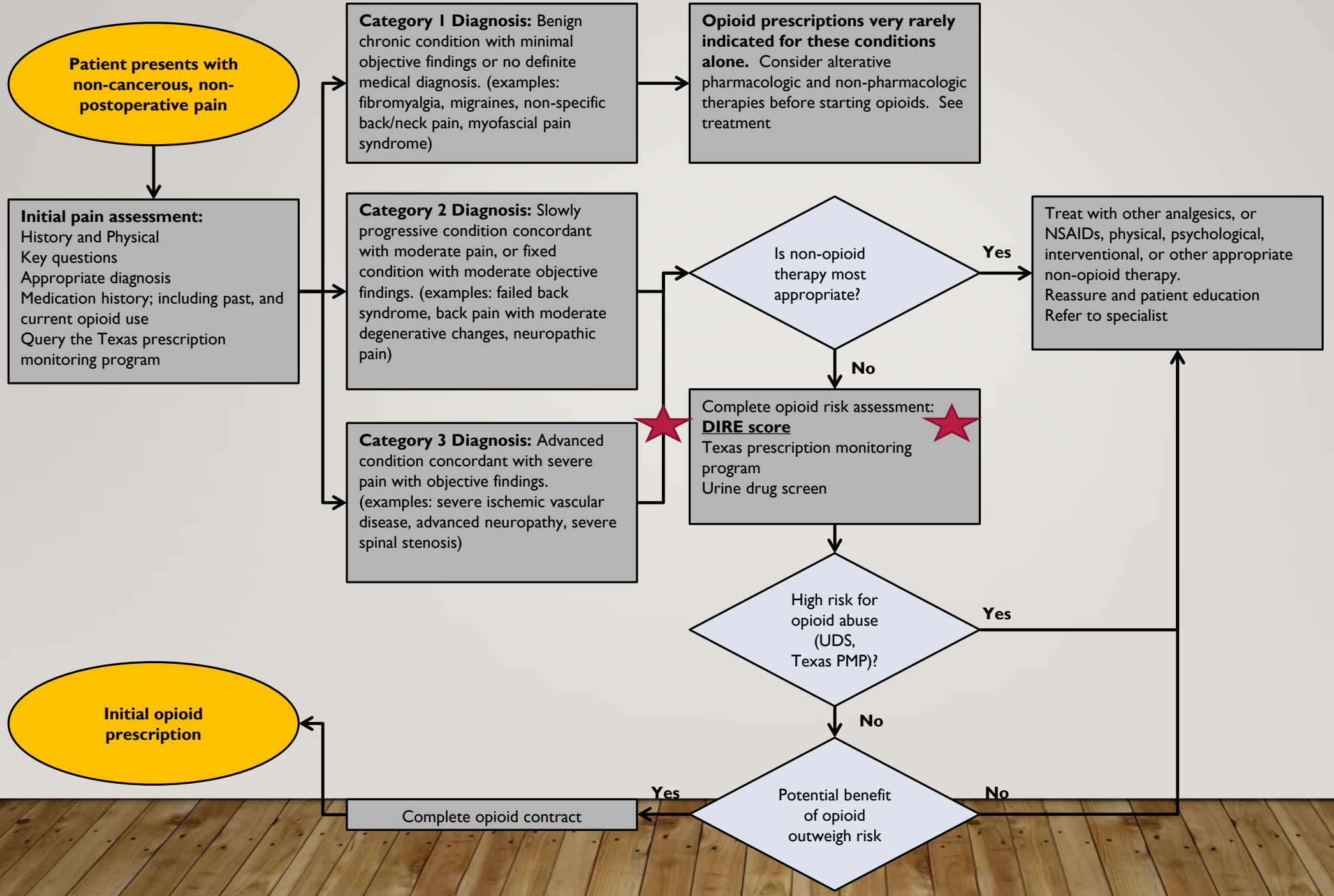
11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

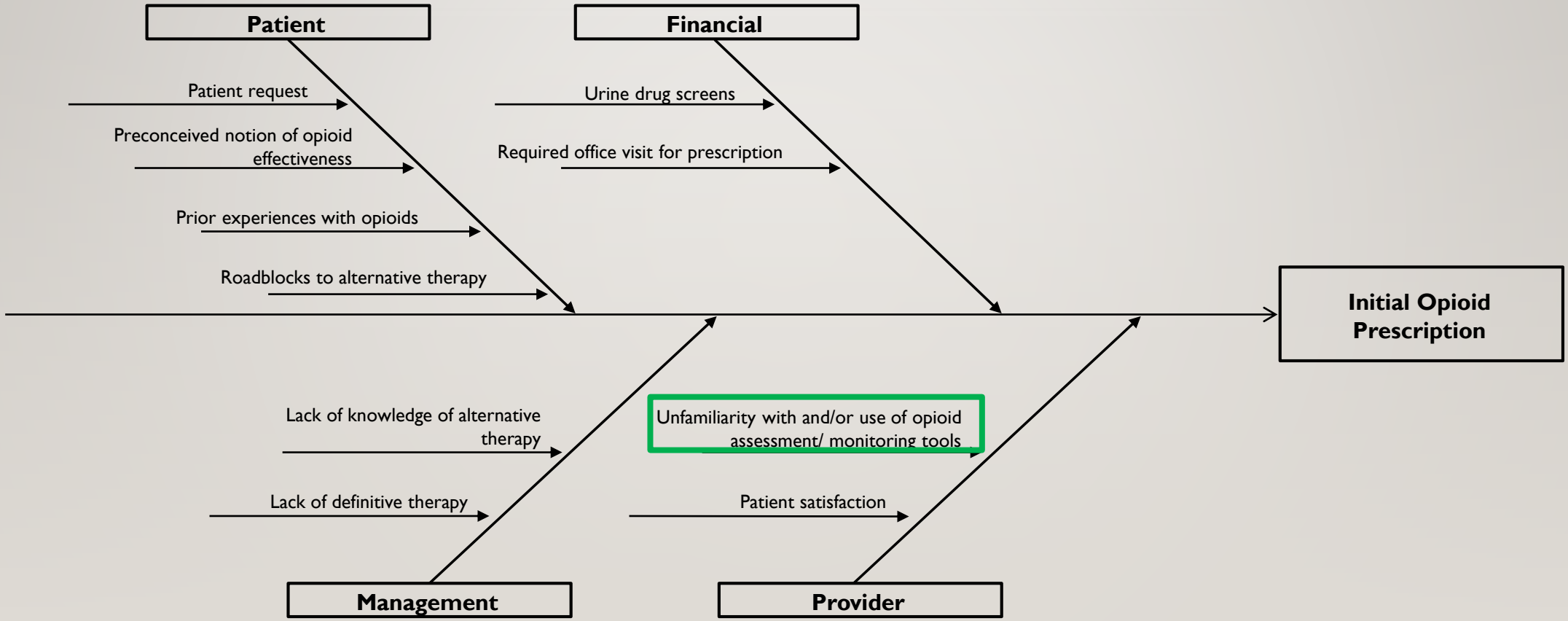
12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

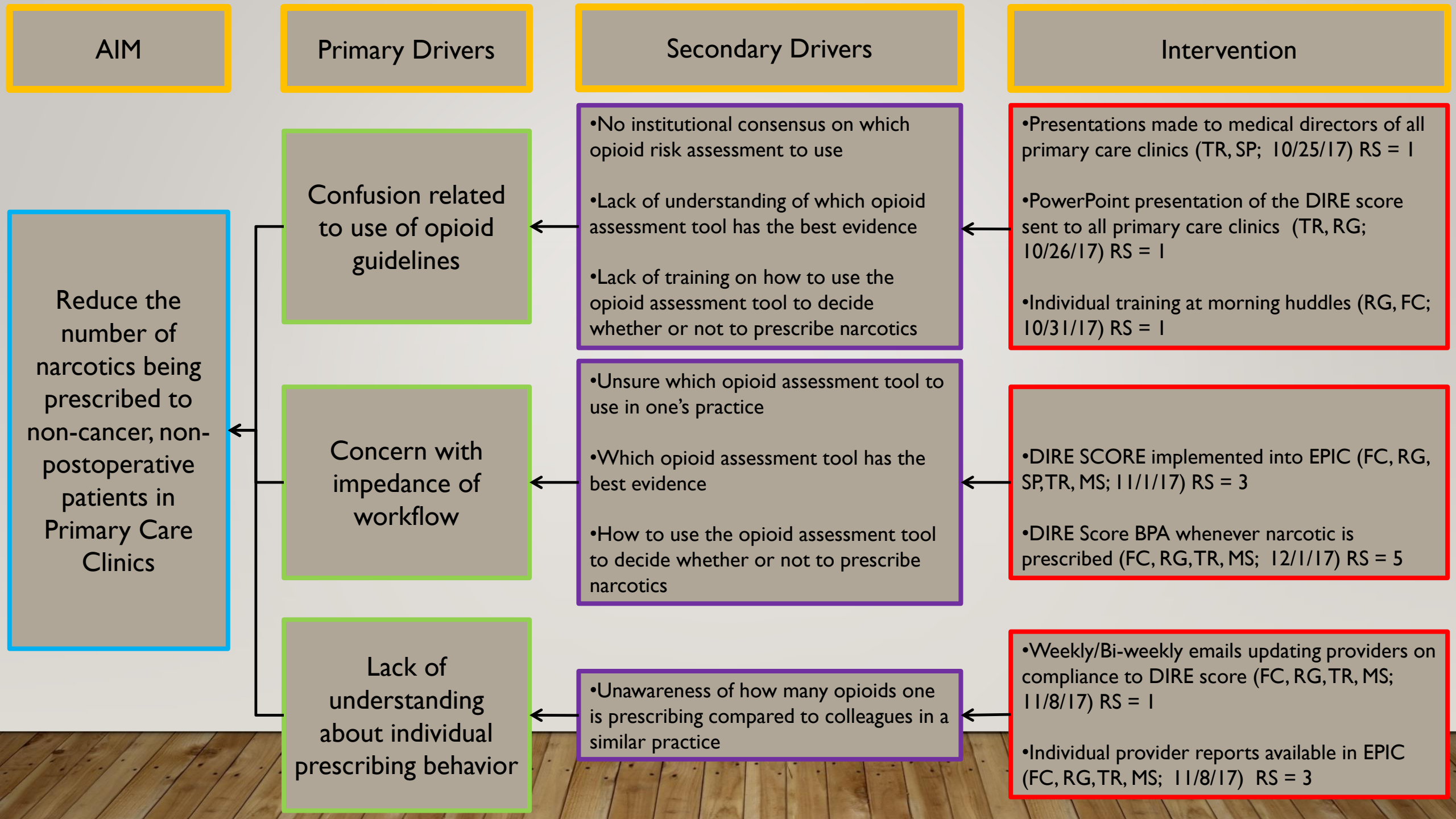
CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

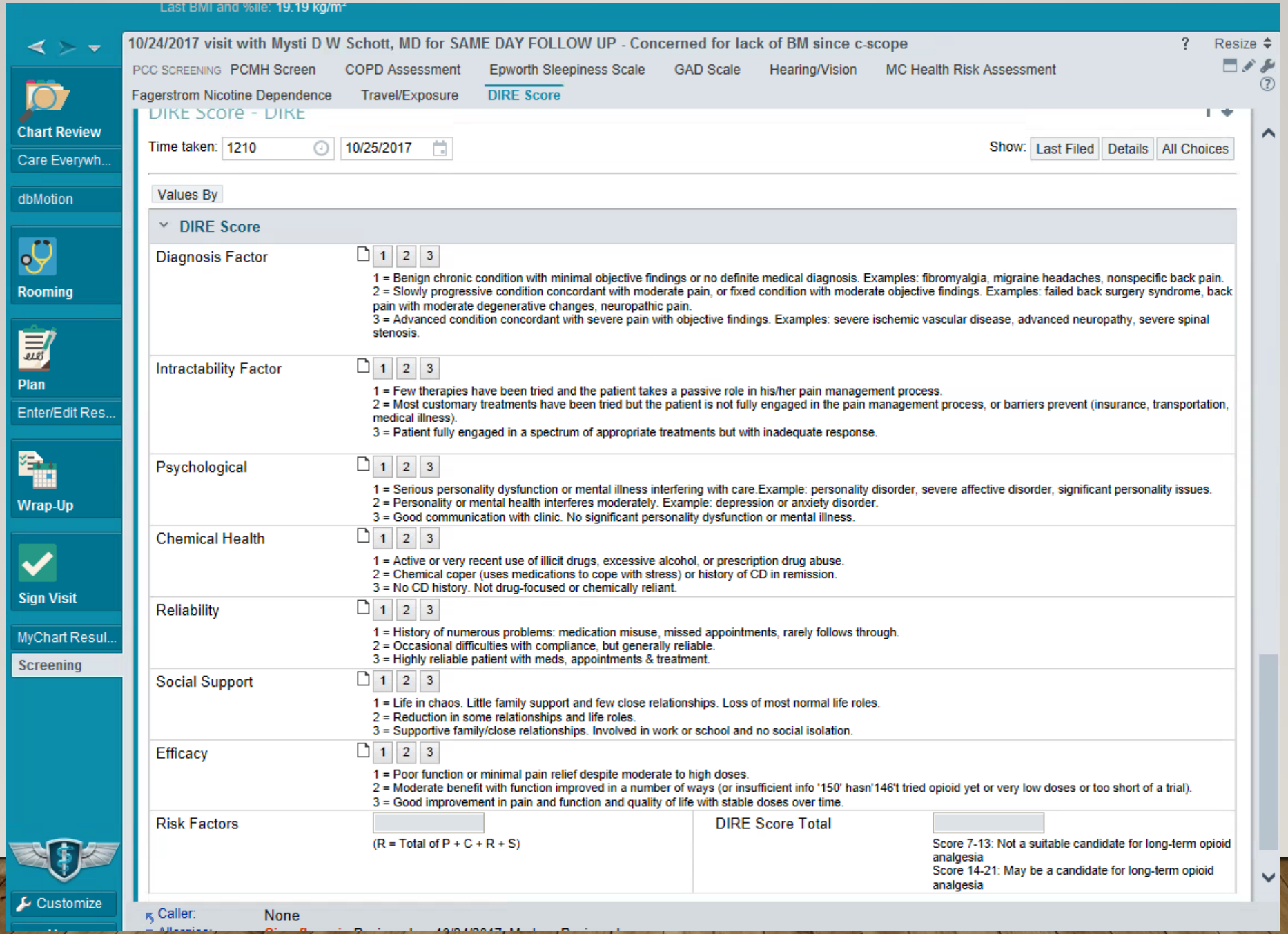

Patient presents with non-cancerous, non-postoperative pain
Initial pain assessment:
History and Physical
Key questions
Appropriate diagnosis
Medication history; including past, and current opioid use
Query the Texas prescription monitoring program
Category 1 Diagnosis: Benign chronic condition with minimal objective findings or no definite medical diagnosis. (examples: fibromyalgia, migraines, non-specific back/neck pain, myofascial pain syndrome)
Opioid prescriptions very rarely indicated for these conditions alone. Consider alterative pharmacologic and non-pharmacologic therapies before starting opioids. See treatment
Category 2 Diagnosis: Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. (examples: failed back syndrome, back pain with moderate degenerative changes, neuropathic pain)
Category 3 Diagnosis: Advanced condition concordant with severe pain with objective findings. (examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis)
Is non-opioid therapy most appropriate?
Yes
Treat with other analgesics, or NSAIDs, physical, psychological, interventional, or other appropriate non-opioid therapy.
Reassure and patient education
Refer to specialist
No
Complete opioid risk assessment:
DIRE score
Texas prescription monitoring program
Urine drug screen
High risk for opioid abuse (UDS, Texas PMP)?
Yes
No
Potential benefit of opioid outweigh risk
Yes
No
Complete opioid contract
Initial opioid prescription

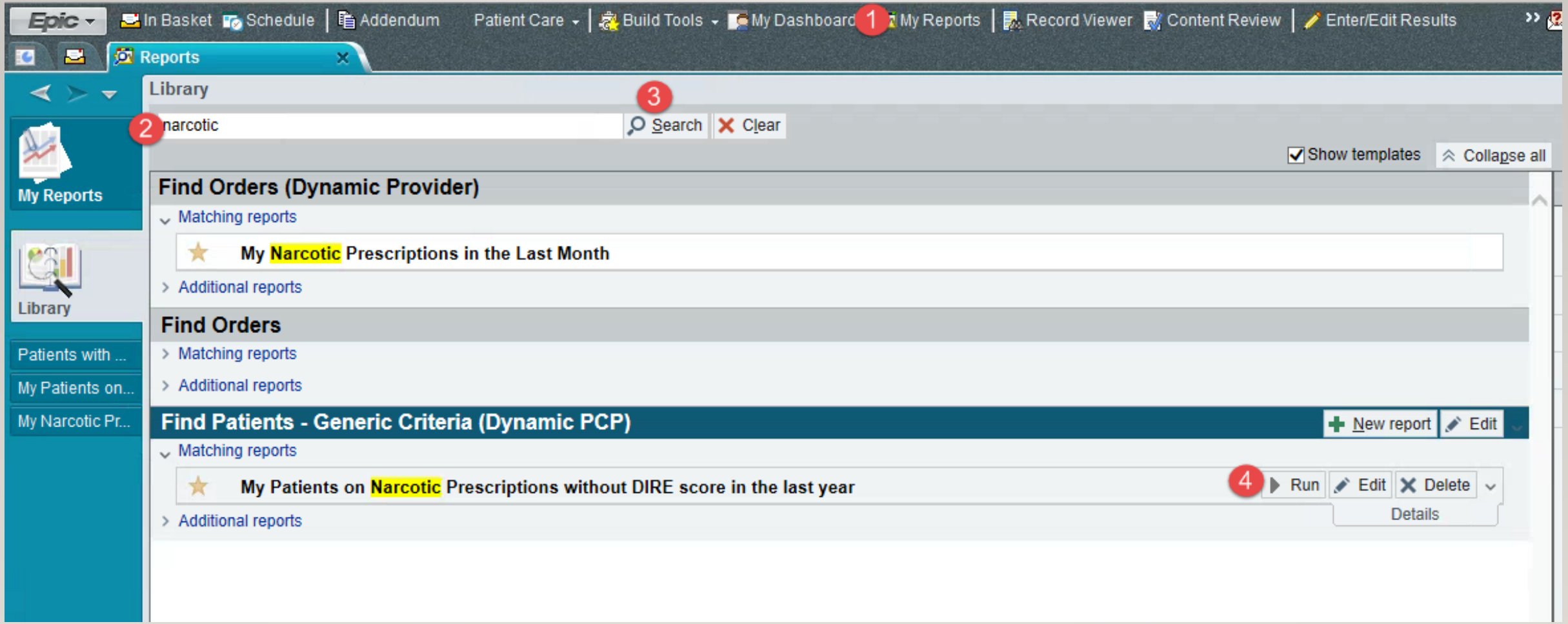

Patient
Financial
Patient request
Preconceived notion of opioid effectiveness
Prior experiences with opioids
Roadblocks to alternative therapy
Urine drug screens
Required office visit for prescription
Initial Opioid Prescription
Lack of knowledge of alternative therapy
Lack of definitive therapy
Unfamiliarity with and/or use of opioid assessment/ monitoring tools
Patient satisfaction
Management
Provider


AIM
Primary Drivers
Secondary Drivers
Intervention
Reduce the number of narcotics being prescribed to non-cancer, non-postoperative patients in Primary Care Clinics
Confusion related to use of opioid guidelines
Concern with impedance of workflow
Lack of understanding about individual prescribing behavior
•No institutional consensus on which opioid risk assessment to use
•Lack of understanding of which opioid assessment tool has the best evidence
•Lack of training on how to use the opioid assessment tool to decide whether or not to prescribe narcotics
•Unsure which opioid assessment tool to use in one's practice
•Which opioid assessment tool has the best evidence
•How to use the opioid assessment tool to decide whether or not to prescribe narcotics
•Unawareness of how many opioids one is prescribing compared to colleagues in a similar practice
•Presentations made to medical directors of all primary care clinics (TR, SP; 10/25/17) RS = 1
•PowerPoint presentation of the DIRE score sent to all primary care clinics (TR, RG; 10/26/17) RS = 1
•Individual training at morning huddles (RG, FC; 10/31/17) RS = 1
•DIRE SCORE implemented into EPIC (FC, RG, SP, TR, MS; 11/1/17) RS = 3
•DIRE Score BPA whenever narcotic is prescribed (FC, RG, TR, MS; 12/1/17) RS = 5
•Weekly/Bi-weekly emails updating providers on compliance to DIRE score (FC, RG, TR, MS; 11/8/17) RS = 1
•Individual provider reports available in EPIC (FC, RG, TR, MS; 11/8/17) RS = 3

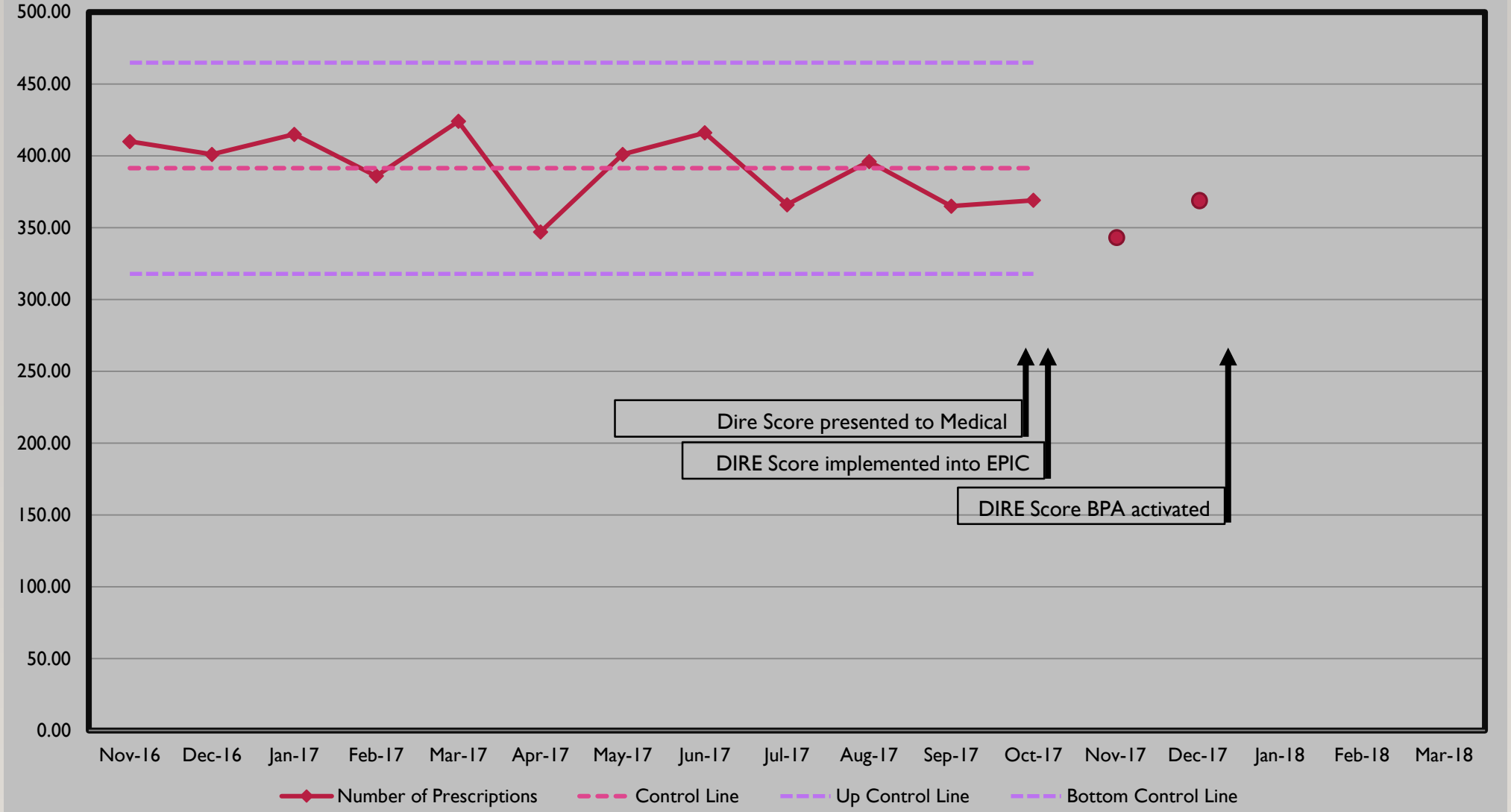
INTERVENTIONS

- EMR interventions
  - DIRE score located in the EMR under PCC Screening (11/1/17 - 1/15/18)
  - Starting 1/16/18, DIRE score will be a BPA that alerts the physician when prescribing a narcotic if no DIRE score has been completed in the last year
- Training/Education
  - Presentation made to the medical directors of the primary care clinics
  - Powerpoint presentation on DIRE score sent to primary care clinics for continued use
  - Education provided at morning huddles at individuals clinics
- Performance Reports
  - Providers have access to a report indicating the number of narcotics they have prescribed and the number of DIRE scores completed


Last BMI and %ile: 19.19 kg/m²
10/24/2017 visit with Mysti D W Schott, MD for SAME DAY FOLLOW UP - Concerned for lack of BM since c-scope
Resize
PCC SCREENING
PCMH Screen
COPD Assessment
Epworth Sleepiness Scale
GAD Scale
Hearing/Vision
MC Health Risk Assessment
Fagerstrom Nicotine Dependence
Travel/Exposure
DIRE Score
Chart Review
Care Everywh...
dbMotion
Rooming
Plan
Enter/Edit Res...
Wrap-Up
Sign Visit
MyChart Resul...
Screening
Customize
DIRE Score - DIRE
Time taken: 1210
10/25/2017
Show: Last Filed Details All Choices
Values By
DIRE Score
Diagnosis Factor
1 2 3
1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain.
2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain.
3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
Intractability Factor
1 2 3
1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process.
2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness).
3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
Psychological
1 2 3
1 = Serious personality dysfunction or mental illness interfering with care.Example: personality disorder, severe affective disorder, significant personality issues.
2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder.
3 = Good communication with clinic. No significant personality dysfunction or mental illness.
Chemical Health
1 2 3
1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse.
2 = Chemical coper (uses medications to cope with stress) or history of CD in remission.
3 = No CD history. Not drug-focused or chemically reliant.
Reliability
1 2 3
1 = History of numerous problems: medication misuse, missed appointments, rarely follows through.
2 = Occasional difficulties with compliance, but generally reliable.
3 = Highly reliable patient with meds, appointments & treatment.
Social Support
1 2 3
1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles.
2 = Reduction in some relationships and life roles.
3 = Supportive family/close relationships. Involved in work or school and no social isolation.
Efficacy
1 2 3
1 = Poor function or minimal pain relief despite moderate to high doses.
2 = Moderate benefit with function improved in a number of ways (or insufficient info '150' hasn'146't tried opioid yet or very low doses or too short of a trial).
3 = Good improvement in pain and function and quality of life with stable doses over time.
Risk Factors
(R = Total of P + C + R + S)
DIRE Score Total
Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a candidate for long-term opioid analgesia
Caller: None


Epic
In Basket
Schedule
Addendum
Patient Care
Build Tools
My Dashboard
1
My Reports
Record Viewer
Content Review
Enter/Edit Results
Reports
Library
3
2
narcotic
Search
Clear
Show templates
Collapse all
My Reports
Library
Patients with ...
My Patients on...
My Narcotic Pr...
Find Orders (Dynamic Provider)
Matching reports
My Narcotic Prescriptions in the Last Month
Additional reports
Find Orders
Matching reports
Additional reports
Find Patients - Generic Criteria (Dynamic PCP)
New report
Edit
Matching reports
My Patients on Narcotic Prescriptions without DIRE score in the last year
4
Run
Edit
Delete
Details
Additional reports

Number of Narcotic Prescriptions Written by Month in Primary Care Clinics



Percent Completion of DIRE Score when Evaluating Patient for Narcotic

RETURN ON INVESTMENT

- Delivery System Reform Incentive Payment (DSRIP)
  - Established in 2011
  - Incentive payments to hospitals and other providers that increase quality and cost-effectiveness
  - DSRIP Bundle for UT Medicine, 52 points = $9 million dollars
  - "All or nothing"
  - Achieving our AIM (H3-288: Pain Assessment and Follow-up measure) = $346,153.00 to UT Medicine

WHAT'S NEXT?

- Turn on DIRE score BPA (1/16/18)
- Further Expansion of "UT Health's Response to the Opioid Crisis" in the future
  - Implementation of further monitoring processes:
    - Urine Drug Screens
    - Texas PMP references
  - Decreasing the number of patients taking narcotics and benzodiazepines at the same time
  - Decreasing the morphine milliequivalents being prescribed, especially for patients on high dose narcotics