Introduction

DO NO HARM

Do No Harm: Putting Safer Pain Management into Practice

Oklahoma Primary Healthcare Improvement Cooperative

OU College of Medicine and OU-TU School of Community Medicine

Start Date: 12/01/2019
End Date: 11/30/2022

This program was made possible through a partnership with the Oklahoma Department of Mental Health and Substance Abuse Services, federal grant funding.

Overview

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Practice Systems: Module 6

Modules		
#	Title	Time
1	Overview	60 Minutes
2	Epidemic	15 Minutes
3	Pain	15 Minutes
4	Analgesia	30 Minutes
5	Patient Engagement	30 Minutes
6	Practice Systems	60 Minutes

Accreditation Statements:

ACCME/AMA PRA Accreditation Statement:
The University of Oklahoma College of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The University of Oklahoma, College of Medicine designates this internet activity enduring material for a maximum of 3.50 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Module 1 – Overview – 1.00 *AMA PRA Category 1 Credits™*
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Module 3 – Pain - .25 *AMA PRA Category 1 Credits™*
Module 4 – Analgesia - .50 *AMA PRA Category 1 Credits™*
Module 5 – Patient Engagement - .50 *AMA PRA Category 1 Credits™*
Module 6 – Practice Systems – 1.00 *AMA PRA Category 1 Credits™*

Successful completion of the post-test(s) is/are required to earn *AMA PRA Category 1 Credit™*. Each module is separate; successful completion is defined as a cumulative score of at least 80% percent correct. Upon passing the post-test and completing the evaluation credit will be awarded. You have three (3) attempts to pass each test.

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Module 2 – Epidemic - .25 AAPA Category 1 CME credits
Module 3 – Pain - .25 AAPA Category 1 CME credits
Module 4 – Analgesia - .50 AAPA Category 1 CME credits
Module 5 – Patient Engagement - .50 AAPA Category 1 CME credits
Module 6 – Practice Systems – 1.00 AAPA Category 1 CME credits

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Module 1 – Overview – 1.00 OSBP Contact Hours 20190130-OK-0631A
Module 2 – Epidemic - .25 OSBP Contact Hours 20190130-OK-0631B
Module 3 – Pain - .25 OSBP Contact Hours 20190130-OK-0631C
Module 4 – Analgesia - .50 OSBP Contact Hours 20190130-OK-0631D
Module 5 – Patient Engagement - .50 OSBP Contact Hours 20190130-OK-0631E
Module 6 – Practice Systems – 1.00 OSBP Contact Hours 20190130-OK-0631F

Successful completion of the post-test is required. Successful completion is defined as a cumulative score of at least 80% percent correct.

Expert Review Panel and Planning Committee

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Planning and authoring committee:

- Steven A. Crawford, MD, DABFM, Family Medicine, Co-author, Narrator
- F. Daniel Duffy, MD, MACP Internal Medicine, Lead Author
- Shannon D. Ijams, MPAS, PA-C – Family Medicine
- Kathryn M. L. Konrad, MS, RNC-OB, LCCE, FACCE
- James W. Mold, MD, MPH, DABFM Family Medicine, Co-author

Expert review panel:

- Jeffery Alderman, MD, MS, FACP – Palliative Care
- Dorothy Gourley, DPh – Consultant Pharmacist
- Martina Jelley, MD, MSPH, FACP – Primary Care Internal Medicine
- Andrew Kolodny, MD, DABAM, DABPN – Psychiatry, Public Health
- Michael Maxwell, MD, FACP – Primary Care Internal Medicine
- Layne Subera, DO, MA, FACOFP – Primary Care Family Medicine
- Bryan VanDoren, MD, DABAM, FASAM – Internal Medicine, Addiction and Pain Medicine
- William Yarborough, MD, FACPM – Internal Medicine, Addiction and Pain Medicine

Relevant Disclosure and Resolution Planning and Authoring Committee

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Under Accreditation Council for Continuing Medical Education guidelines disclosure must be made regarding relevant financial relationships with commercial interests within the last 12 months.	
Steven A. Crawford, MD, DABFM	Have no relevant financial relationships or affiliations with commercial interests to disclose.
F. Daniel Duffy, MD	
Kathryn M. L. Konrad, MS, RNC-OB, LCCE, FACCE	
James W. Mold, MD, FABFM	
Shannon D. Ijams, MPAS, PA-C - Family Medicine	

Relevant Disclosure and Resolution for Expert Review Panel

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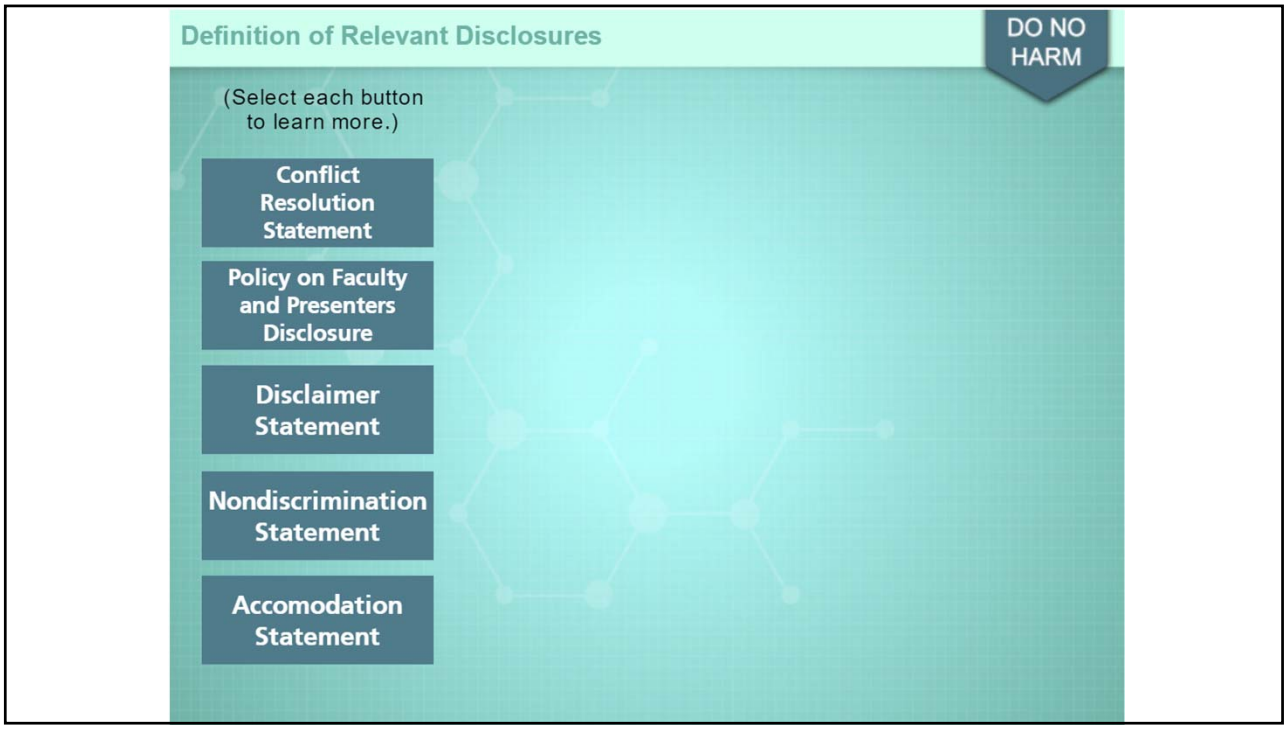
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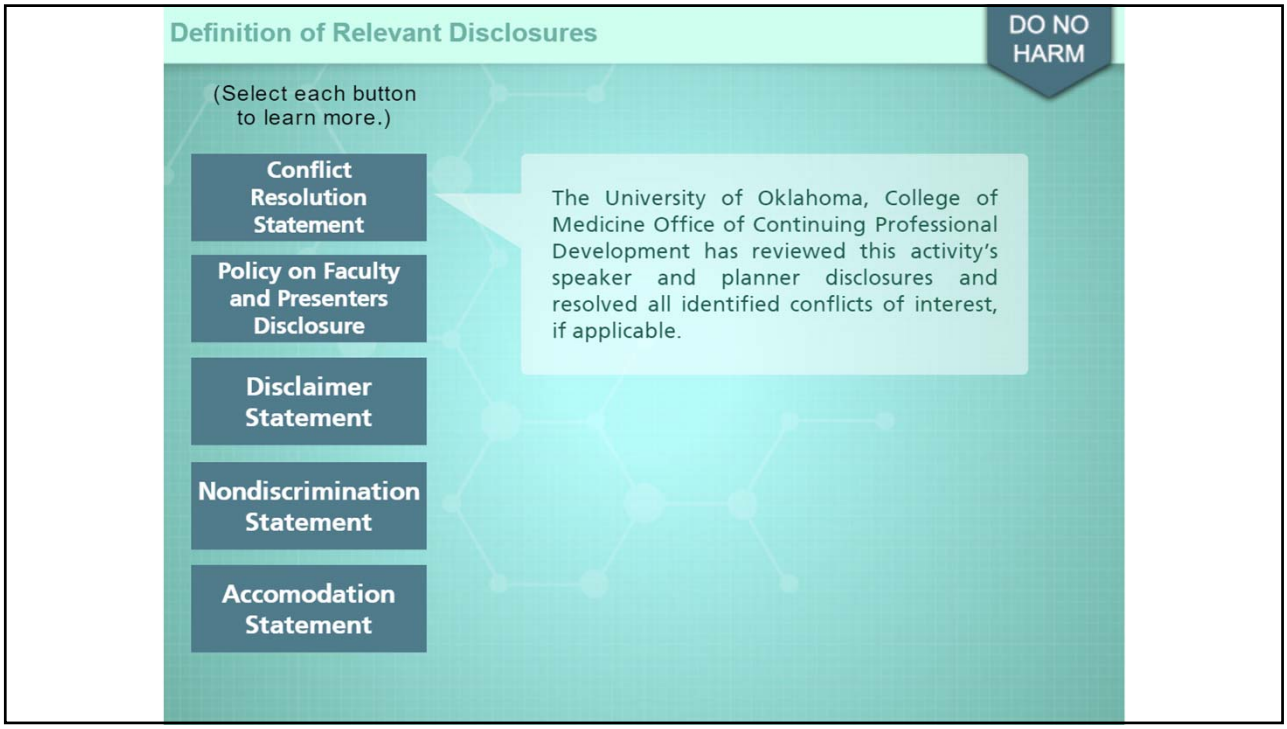
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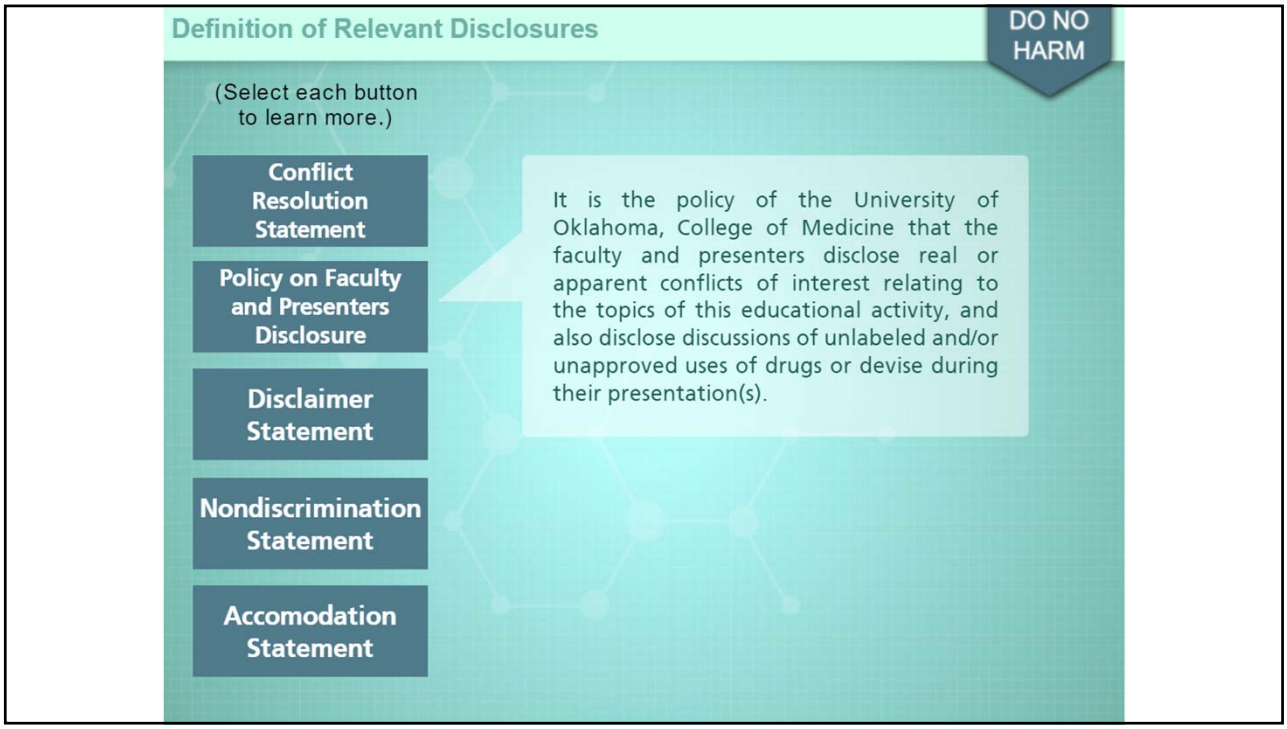
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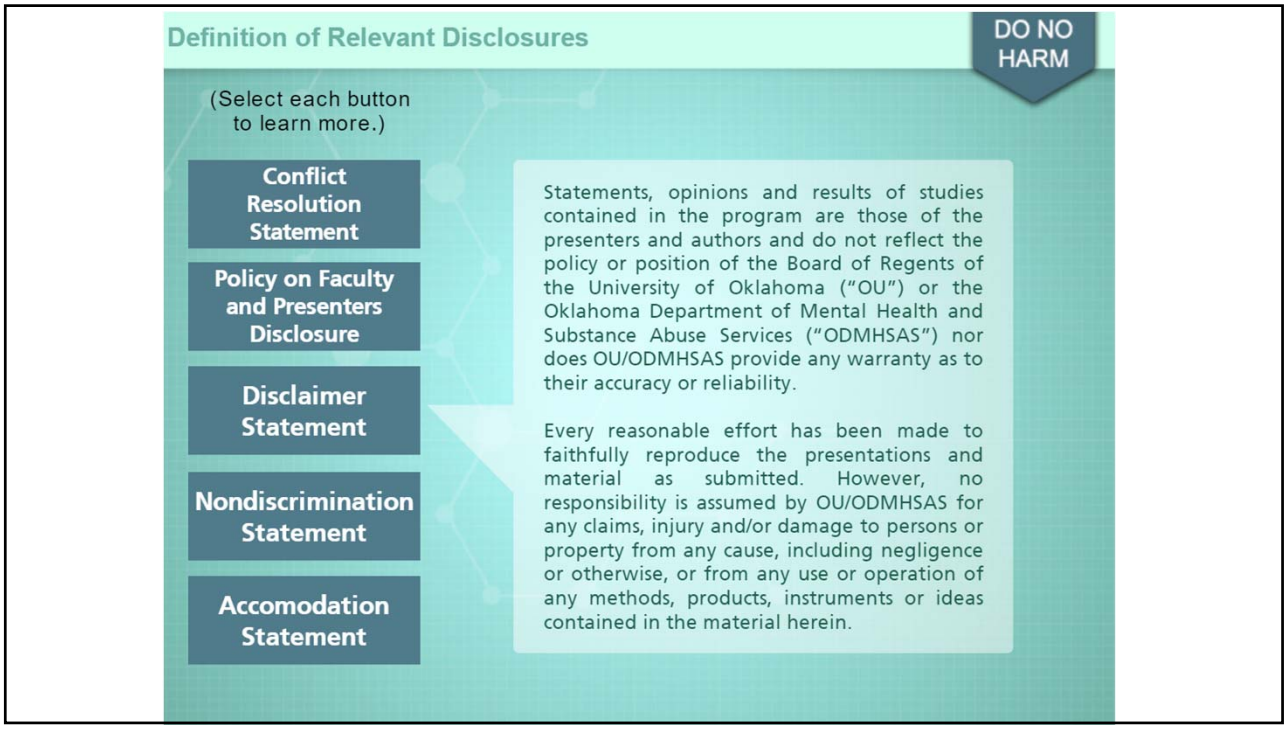
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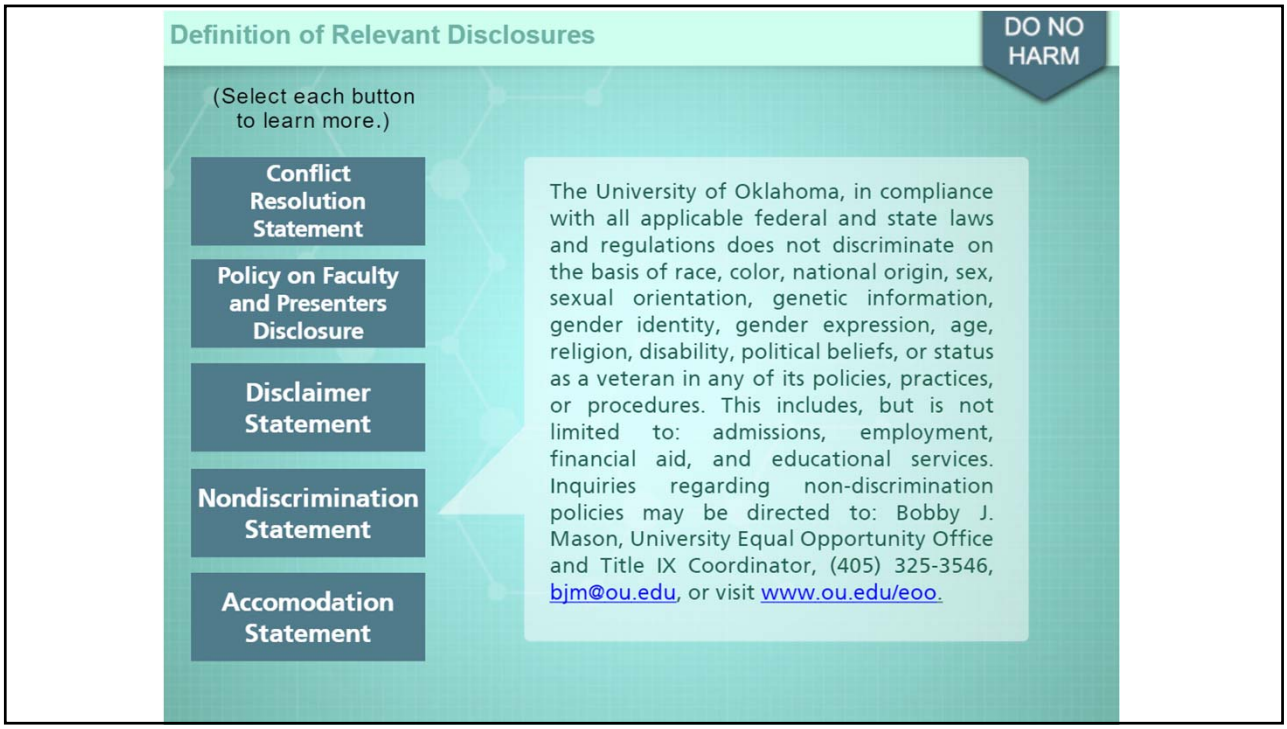
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Accommodations are available by contacting Jan Quayle at 405-271-2350, ext. 8 or e-mail to: jan-quayle@ouhsc.edu.

Professional Practice Gap Being Addressed

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GAP: Oklahoma healthcare providers may not have written office policies and procedures for acute and chronic pain management, with particular attention to the safer prescribing and monitoring of chronic opioid therapy that aligns with best practices and Oklahoma law.

Learning Objectives

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Upon completion of this module, participants will improve their competence and performance by being able to:

- Develop and implement written office policies and procedures for pain and opioid management.
- Develop workflow strategies for implementation of office policies and procedures.
- Name changes in office care delivery design, patient education and self-care support, clinical decision support, and information technology that incorporate community resources.

Written Office Policies

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Any provider authorized to prescribe opioids shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing provider and qualifying opioid therapy patient.

"Qualifying opioid therapy patient" means:

- A patient requiring opioid treatment for more than three (3) months;
- A patient who is prescribed benzodiazepines and opioids together
- A patient is prescribed a dose of opioids that exceeds 100 MME per day according to Oklahoma law.

Guidance Document

OKLAHOMA SENATE BILL 1446 – BEST PRACTICE FOR AN ACT REGULATING OF OPIOID DRUGS

Effective November 1, 2018

Continuing Medical Education: Physicians are required to complete one (1) hour of CME in pain management per year.

OBNDD: May provide licensing boards with unsolicited referrals of physicians if a patient receives one (1) or more prescriptions in quantities or frequency inconsistent with accepted standards of safe practice. 63 O.S. §2-309D(M)

Prescription Monitoring Program – PMP: Failure to check PMP is grounds for disciplinary action by licensing board. PMP must be checked at the initial prescription and then at least every 180 days. 63 O.S. §2-309D(G)(2)(a), 63 O.S. §2-309D(G)(4)

Acute Pain Prescription Limits: For acute pain, practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding seven (7) day supply. Prescription shall be for the lowest effective dose of immediate-release opioid drug. 63 O.S. §2-309I (A). Following the initial seven (7) days, a second subsequent 7-day prescription may be issued, for an immediate-release opioid drug in Schedule II in a quantity not to exceed seven (7) days if: (i) The subsequent prescription is due to a major surgical procedure and/or "confined to home" status as defined in 42 U.S.C. 1395n(a); (ii) The practitioner provides the subsequent prescription on the same day as the initial prescription; (iii) The practitioner provides written instruction on the subsequent prescription indicating the earliest date on which the prescription may be filled (i.e. "do not fill until" date); and (iv) The subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription. 475:30-1-4 If the if the aforementioned conditions are NOT met, a second 7-day prescription may be issued, after consultation* (in person or by telephone), if practitioner determines prescription is necessary and appropriate, documents the rationale for the prescription and determines and documents it does not present undue risk of abuse, addiction or diversion. * For best practice, the 7-day consultation should be performed by the physician; however, it does not appear to be required. If a medication needs to be changed due to allergy, ineffective dose or other medical condition, document thoroughly in the record the need and rationale for change.

Chronic Pain Prescriptions: If continuing treatment for three months or more, practitioner shall: (1) review every three months the course of treatment, any new information regarding etiology of pain and progress toward treatment objectives; (2) assess patient prior to every renewal to determine if patient is experiencing dependency and document assessment; (3) periodically make reasonable efforts, unless clinically contraindicated to stop, decrease dosage or try other treatment modalities; (4) review PMP; (5) monitor compliance with pain management agreement. 63 O.S. §2-309I(F). *Assessment may be performed by a mid-level PA/APRN. Face-to-face assessment is recommended but not required.

Morphine Milligram Equivalent - MME: the law references 100 MME as a safe patient threshold. If you choose to prescribe greater than 100 MME, document the rationale thoroughly.

Prior to Initial Prescription for Pain a Prescription for a Schedule II or any Opioid: Practitioner shall: (1) take and document a thorough medical history; (2) conduct and document a physical exam; (3) develop a treatment plan; (4) access the PMP; (5) limit supply to no more than seven days; (6) if under 18, enter into a Patient-Provider Agreement [Pain Agreement] with patient. 63 O.S. §2-309I(B)

Informed Consent & Risk Discussions: Prior to initial prescription and again prior to third prescription, practitioner must discuss risks including: (1) risks of addiction and overdose, dangers of taking opioids with alcohol, benzodiazepines and other CNS depressants; (2) reason the prescription is necessary; (3) alternative treatment available; (4) risks can include fatal respiratory depression. Practitioner shall document the discussion in the medical record. 63 O.S. §2-309I(D)

Patient-Provider Agreement [Pain Management Agreement]: Practitioner shall enter into a Patient-Provider Agreement [Pain Management Agreement] with a patient: (1) at the time of the third prescription for opioid or Schedule II drug; (2) If patient requires more than three months of pain management; (3) if patient is prescribed benzodiazepines and opioids together; (4) if patient requires more than 100 mg morphine milligram equivalents (MME); (5) If patient is pregnant; or (6) with the parent or guardian if the patient is a minor. 63 O.S. §2-309I(I); 63 O.S. §2-309I(B)(6),(7)

Excluded: The requirements of SB 1446 do not apply to patients receiving active treatment of cancer, hospice, palliative care, or residents of a long-term care facility. 63 O.S. §2-309I(G)

Written Policy: Any provider authorized to prescribe opioids shall adopt and maintain a written policy regarding the same. 63 O.S. §2-309I (I)

Disclaimer: This Best Practices document is subject to change without notice and is made available to facilitate understanding of SB1446. This is not intended to be an official interpretation or commentary on the intent of the law. Revision 10/25/2018

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Pain Management of Tulsa · OkPMA Oklahoma Podiatric · OSA

Practice System Policies and Processes

DO NO HARM

Delivery System Design	• Structured Chronic Pain Visits • Teamwork Protocols & Scripts
Patient Education Self-Care	• Self-Care for Better Health • Informed Consent
Clinical Decision Support	• Difficult Decisions • Difficult Conversations
Information Technology	• Referral & Co-Management • Quality Improvement

Adapted from the Chronic Care Model, developed by the MacColl Center for healthcare innovations
http://www.maccollcenter.org/

Delivery System Design

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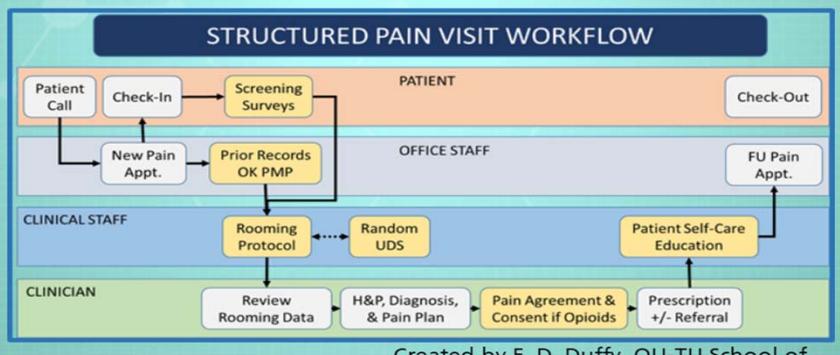
Structured visits:
- Clinical workflow.
- EHR templates.

Teamwork:
- Protocols and standing orders.
- Scripts for routine processes.



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Patient Education and Self-Management

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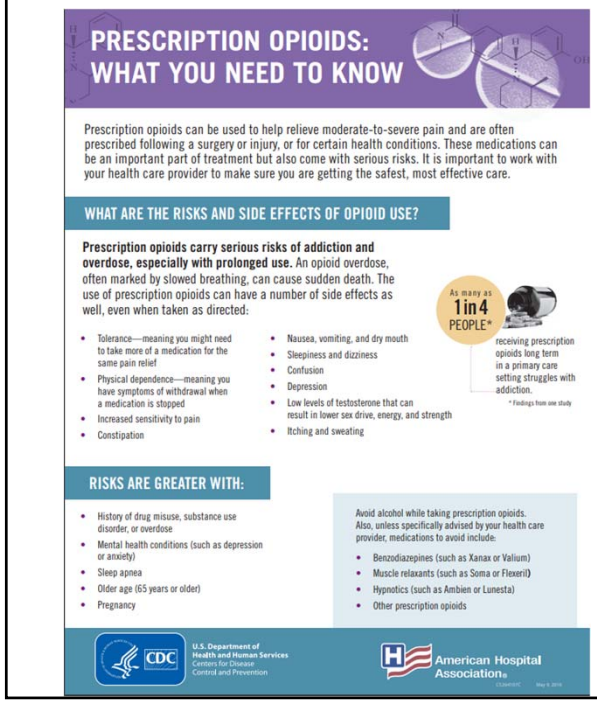
- Graphical information.
  - Pain treatment agreement.

(Click images to enlarge.)

https://www.cdc.gov/drugoverdose/pdf/AHA-Patient-Opioid-Factsheet-a.pdf



PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as **1 in 4 PEOPLE*** receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

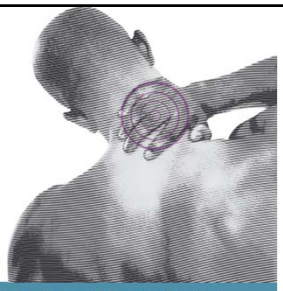
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

American Hospital Association

KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- Pain relievers such as acetaminophen, ibuprofen, and naproxen
- Some medications that are also used for depression or seizures
- Physical therapy and exercise
- Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- Never take opioids in greater amounts or more often than prescribed.
- Follow up with your primary health care provider within ___ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

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

Clinical Decision Support

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Algorithms and protocols.

Useful materials or websites:

- MMED dose calculation.
- Tapering schedule.
- Interpretation of urine test results.

Scripts for difficult conversations:

- Suspected misuse.
- Asking questions about risk.

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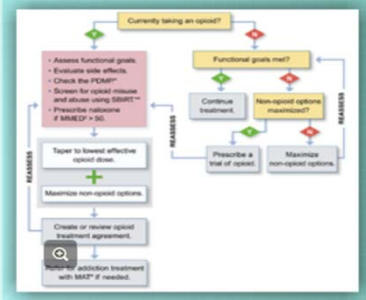
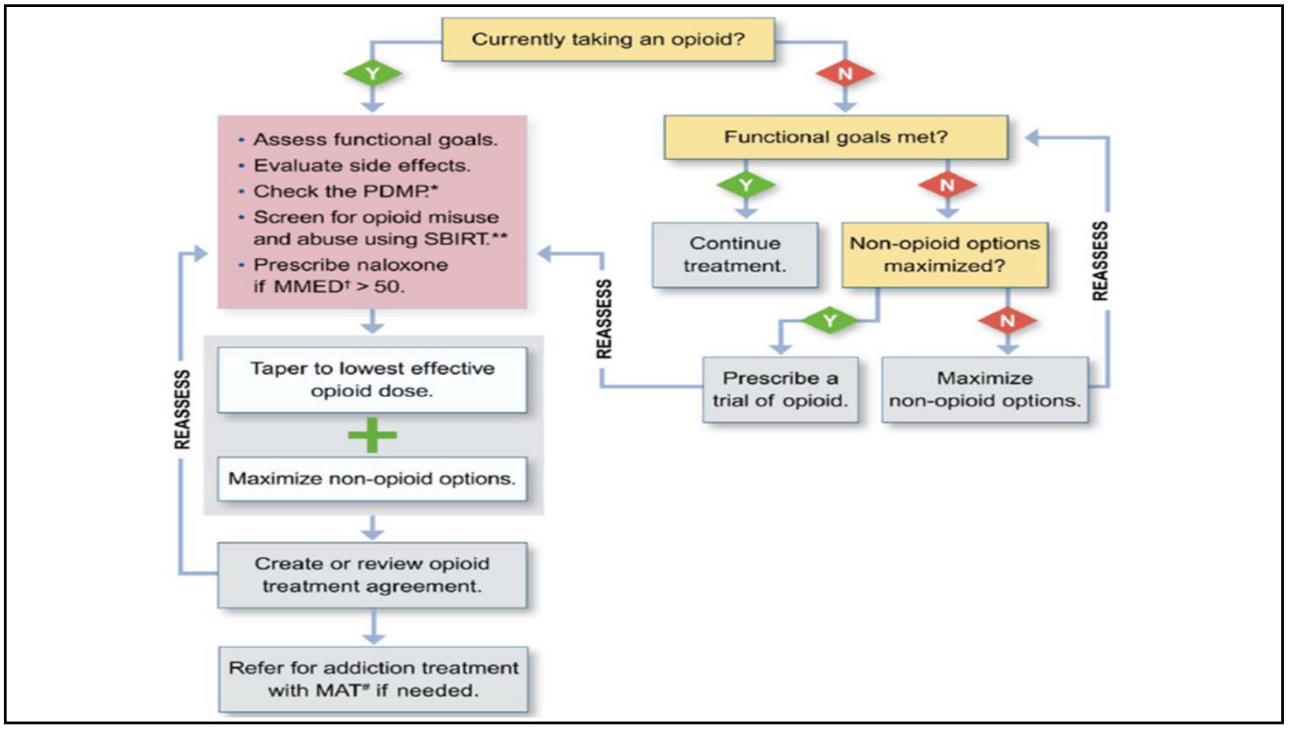


Interpretation of Opiate Urine Drug Screens



Information Technology

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- EHR templates.
- Oklahoma Prescription Monitoring Program (PMP).
- ED and hospital records.
- Practice-based registries.
- Health Information Exchange.

Delivery System Design

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Structured Initial Pain Assessment

Clinical Staff Teamwork

Pre-Visit Protocol
- ❑ Obtain prior medical records
- ❑ Obtain prior lab/imaging reports
- ❑ Attach OK PMP report

Pre-Visit Patient Questionnaires
- ❑ P.E.G. score
- ❑ SBIRT initial screen (AUDIT, DAST-10, PHQ-9, Others)
- ❑ Medication list
- ❑ Medical History form

Rooming Protocol
- ❑ Affect, appearance, behavior
- ❑ Review med list and OK PMP
- ❑ Review pre-visit questions

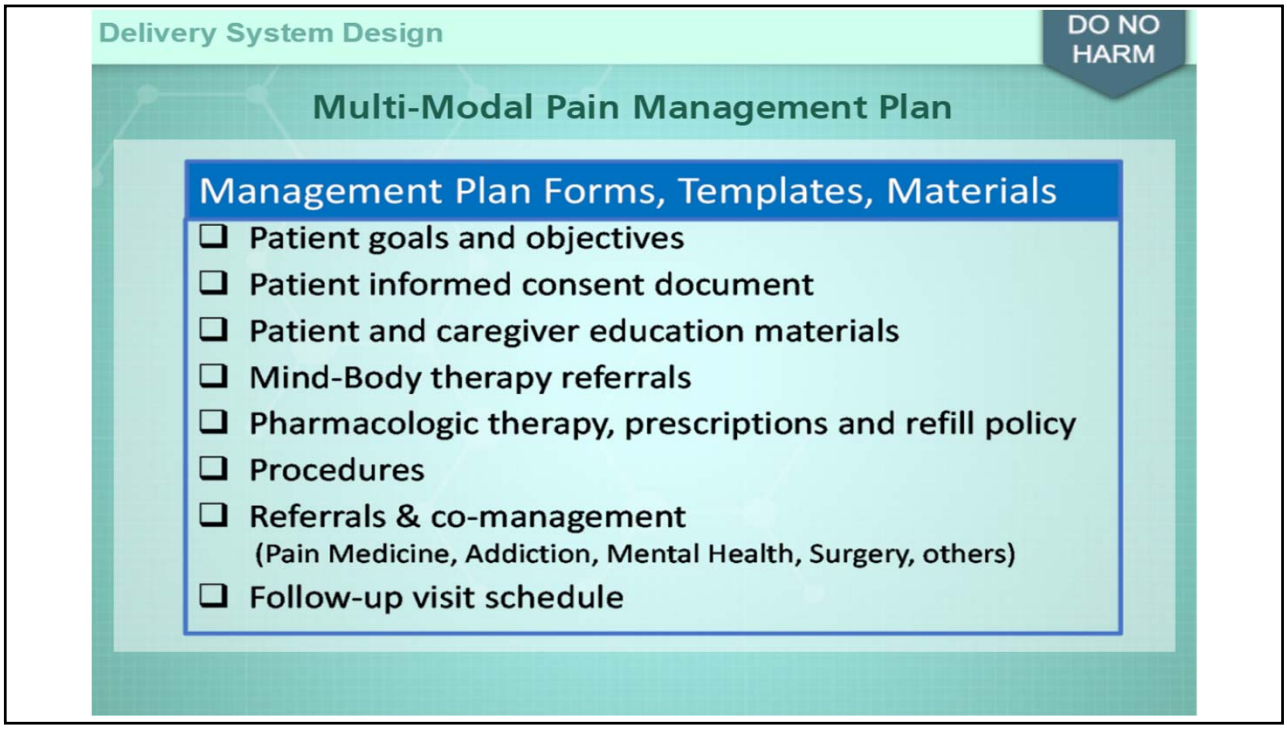
Clinician Initial Assessment

Review Rooming Data
- ❑ Prior data and history form
- ❑ Behavioral health screen

History and Physical Exam
- ❑ Interview, observe, examine
- ❑ Patient goals for better function

Assessment
- ❑ Diagnosis, prognosis, risks
- ❑ Agreement on goals for treatment

Multi-Modal Pain Plan
- ❑ Signed informed consent (opioids)
- ❑ Patient education; monitoring plan
- ❑ Referrals, co-management
- ❑ Prescriptions; opioid refill policy


Delivery System Design
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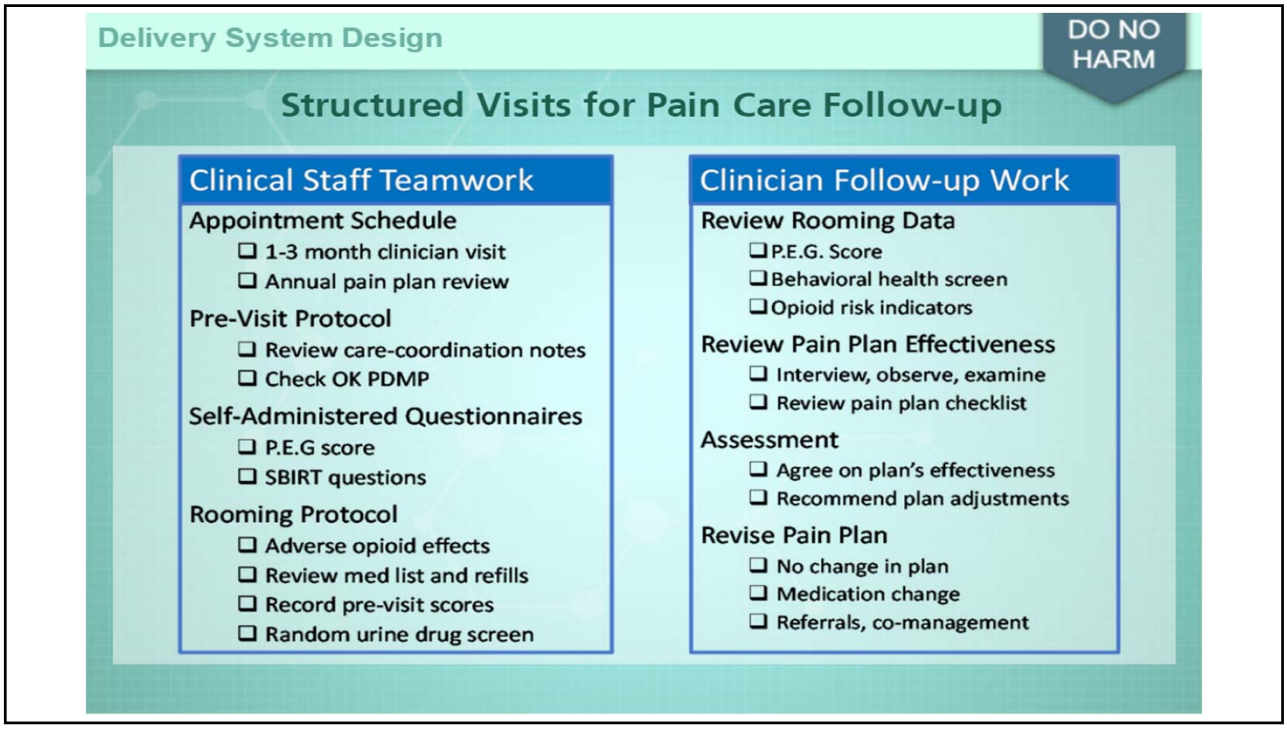
Multi-Modal Pain Management Plan
Management Plan Forms, Templates, Materials
❑ Patient goals and objectives
❑ Patient informed consent document
❑ Patient and caregiver education materials
❑ Mind-Body therapy referrals
❑ Pharmacologic therapy, prescriptions and refill policy
❑ Procedures
❑ Referrals & co-management
(Pain Medicine, Addiction, Mental Health, Surgery, others)
❑ Follow-up visit schedule


Delivery System Design
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Structured Visits for Pain Care Follow-up
Clinical Staff Teamwork
Appointment Schedule
❑ 1-3 month clinician visit
❑ Annual pain plan review
Pre-Visit Protocol
❑ Review care-coordination notes
❑ Check OK PDMP
Self-Administered Questionnaires
❑ P.E.G score
❑ SBIRT questions
Rooming Protocol
❑ Adverse opioid effects
❑ Review med list and refills
❑ Record pre-visit scores
❑ Random urine drug screen
Clinician Follow-up Work
Review Rooming Data
❑ P.E.G. Score
❑ Behavioral health screen
❑ Opioid risk indicators
Review Pain Plan Effectiveness
❑ Interview, observe, examine
❑ Review pain plan checklist
Assessment
❑ Agree on plan's effectiveness
❑ Recommend plan adjustments
Revise Pain Plan
❑ No change in plan
❑ Medication change
❑ Referrals, co-management

Delivery System Design

DO NO HARM

Controlled Drug Prescription Refill Policy

- Replacement prescriptions for lost, stolen, or destroyed meds will not be given routinely.
- Early refills will not be given without a face-to-face visit.
- Patients may pick-up prescription without being seen, if no dose change and they have been seen within 90 days.

Patient Self-Care Support

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- Define chronic pain.
- Goal: Reduce pain to improve function.
- Self-care for overall better health.
- Non-medication therapy is effective.

Patient Education

Practice Education

- Substance (opioid) use disorder is a serious, treatable disease.
- Chronic pain, behavioral health, and social determinants are intertwined.
- Empathic, patient-centered, motivational support.

Signed Informed Consent

DO NO HARM

- Goal – Improved function.
- Opioid benefits small, risks high for dependence, withdrawal, addiction, overdose death.
- Continue opioid therapy if function improved.
- Discontinue opioids if function not improved or adverse events develop.
- Support, taper, appropriately treat.
- No early refills or replacement for lost, stolen, destroyed medications.
- Agree to monitoring.
- Commitment to help patient.

Clinical Decision Support

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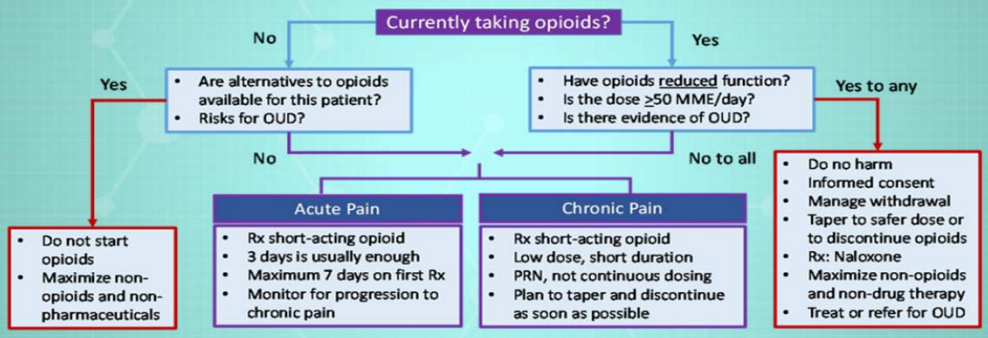
Are opioids appropriate for this patient's non-life terminating illness pain?



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Clinical Decision Support

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What Do I Do when Chronic Pain Has Increased or Function Has Deteriorated?

Has clinical condition changed? — Yes → Has Clinical Condition Progressed?
- Use non-opioid treatments
- If possible, avoid increasing opioids
- Avoid long-acting opioids

No ↓

Are opioid adverse effects suspected? — Yes → Tolerance, OIH, Dependence?
- Attempt opioid taper, avoid withdrawal
- Avoid dose increase
- Treat anxiety, depression, and OUD

No ↓

Are There Psychosocial Problems?
- Consider taper
- Treat or refer for behavioral health problems
- Refer for social determinants

OUD (Addiction)?
- Taper opioids
- Buprenorphine or other addiction meds
- Counseling, treatment referral
- Naloxone

OIH = Opioid Induced Hyperalgesia
OUD = Opioid Use Disorder

Created by F. D. Duffy, OU-TU School of Community Medicine, © 2018

Clinical Decision Support

DO NO HARM

What Do I Do with Legacy Patients?

Long-term patients, new referrals.

Risk of opioid interruption:
- Withdrawal syndrome, anxiety, self-treatment.
- If OUD has developed, drug seeking from other doctor, friends, or others.

Suggested approach:
- DO NO HARM: Do not abruptly stop opioid medications!
- Patient education, new expectations, informed consent, balance harms.
- Prescribe naloxone to reduce risk of overdose death.
- Compassionate, persistent slow taper and discontinue risky combinations.
- Carefully manage withdrawal, use dependence medications, get consultation.

Clinical Decision Support

DO NO HARM

After a non-fatal opioid overdose:

- 7% of patients will have a subsequent overdose
- Provide frequent follow-up
- Use high risk care management
- Reduce to discontinue opioids
- Recommend naloxone for family and caregiver
- OUD resources are available at www.okimready.org.

Boyer, EW. Management of opioid analgesic overdose. N Engl J Med. 2012;367(2):146-55.

Clinical Decision Support

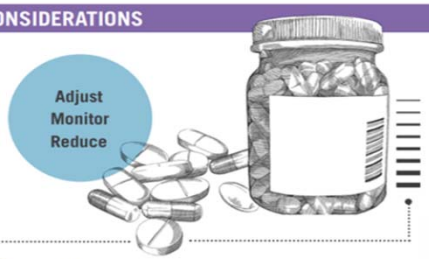
DO NO HARM

How Do I Taper and Stop Opioids?

TAPERING PLAN

1. ***GO SLOW***
   - Minimize withdrawal
   - Maximize non-opioid pain treatment
   - Rate 10%/week, 10%/month
2. ***CONSULT***
   - Treatment experts
   - Detoxification and OUD treatment
3. ***SUPPORT***
   - Watch for anxiety, depression, OUD
   - Refer for treatment, give naloxone
4. ***ENCOURAGE***
   - "Most people improve function, pain not worse"
   - "You can do this, I'll stick by you."

CONSIDERATIONS



1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

www.cdc.gov/drugoverdose

Clinical Decision Support

DO NO HARM

What Are Clues of Developing Opioid Use Disorder?

Static Risk Factors

- ❑ 16 to 45 years old
- ❑ Family history of substance abuse
- ❑ Personal history of substance abuse
- ❑ ACE score >4
- ❑ Current mental illness

Opioid Risk Monitoring

- ❑ Illicit substances found in UDS
- ❑ Prescribed drugs not found in UDS
- ❑ Seeking medications from other prescribers (OK PDMP)
- ❑ Requests early refills, higher doses, or specific preparations.

Symptoms of Adverse Effect

- ❑ Fatigue, not as much energy
- ❑ Trouble thinking clearly or remembering
- ❑ Angry, irritable, argumentative
- ❑ Others Complain patient not getting things done
- ❑ Getting pills from someone else to have enough
- ❑ Worrying about running out and getting more
- ❑ Worrying about how they are handling or obsessing about medications
- ❑ Using opioids for getting to sleep, relieving stress, or "feeling good"
- ❑ Excessively drowsy, nodding off
- ❑ Respiratory depression

UDS = Urine Drug Screen
OK PDMP = Prescription drug monitoring program

DSM-5 Criteria for Opioid Use Disorder

DO NO HARM

OUD Diagnosis is based on at least 2 of the following criteria over the past 12 months.

Loss of Control

1. Takes more or longer than intended
2. Can't cut down or control use
3. Lots of time pursing, using, and recovering

Craving

4. Strong desire or urge to use opioids

Adverse Consequences

5. Failure to fulfill major role obligations
6. Use causes interpersonal problems or danger
7. Give up or reduce social/job/ leisure activity
8. Use in physically hazardous situations
9. Use knowing the substance causes physical/psychological problems

Tolerance

Takes more to get desired effect

Withdrawal

A - After heavy or prolonged opioid use, stopping opioid or reducing dose, OR administering an opioid antagonist
B - 3 or more of: dysphoric mood, anxiety, nausea, vomiting, muscle aches, tearing, insomnia, runny nose, dilated pupils, goose bumps, sweating, diarrhea, yawning, fever, or insomnia

Diagnosing and Managing OUD

DO NO HARM

Confirm the diagnosis of OUD

- Conduct history and physical examination
- Urine drug screen, review the OK PDMP
- Use DSM-5 Criteria, or refer to specialist in addiction medicine (OKImReady.org for referrals)

OUD exists on a continuum:

- 2-3 Symptoms over 12 months = MILD OUD
- 4-5 Symptoms over 12 months = MODERATE OUD
- ≥ 6 Symptoms over 12 months = SEVERE OUD

Treat OUD like other chronic illnesses

- Do not dismiss patients from primary care
- Approach patient with compassion
- Assess and manage risk of overdose, use naloxone
- Explain treatment methods
- Arrange for evidence-based treatment – Medication Assisted Treatment is considered best option for OUD (OKImReady.org)

Clinical Decision Support

DO NO HARM

Managing Adverse Opioid Events

Adverse Opioid Event Monitoring	*Action*
Constipation, Confusion, Sleep Side-Effect Symptoms	Treat, adjust meds
Substance (Opioid) Use Disorder SBIRT, AUDIT, DAST-10, UDS, OKPMP, Aberrant behavior, Overdose survival	Buprenorphine, refer for treatment
Psychosocial Problems SBIRT, PHQ-9, GAD-7, PCPTSD	Taper, stop, treat or refer
Drug Diversion UDS, OKPMP	Stop prescribing

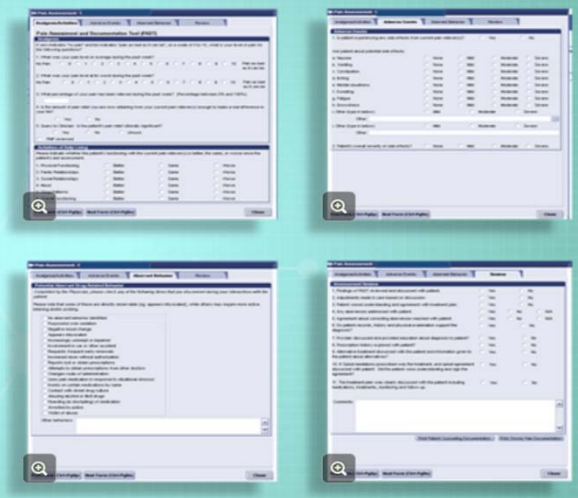
Information Technology Support

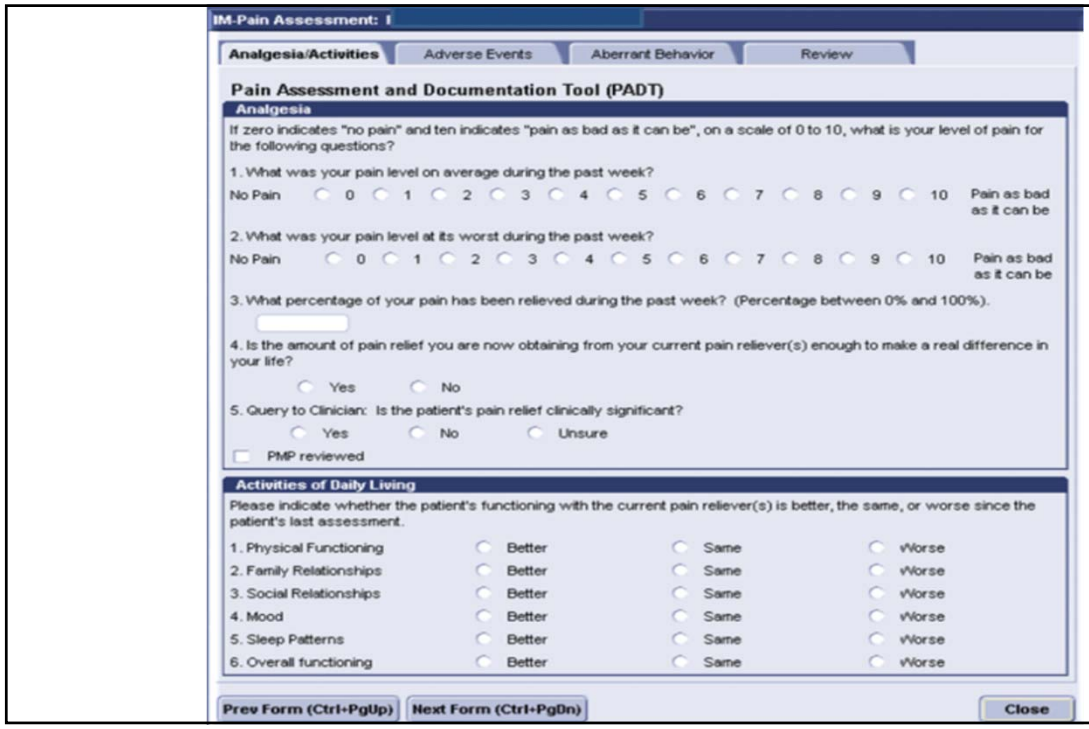
DO NO HARM

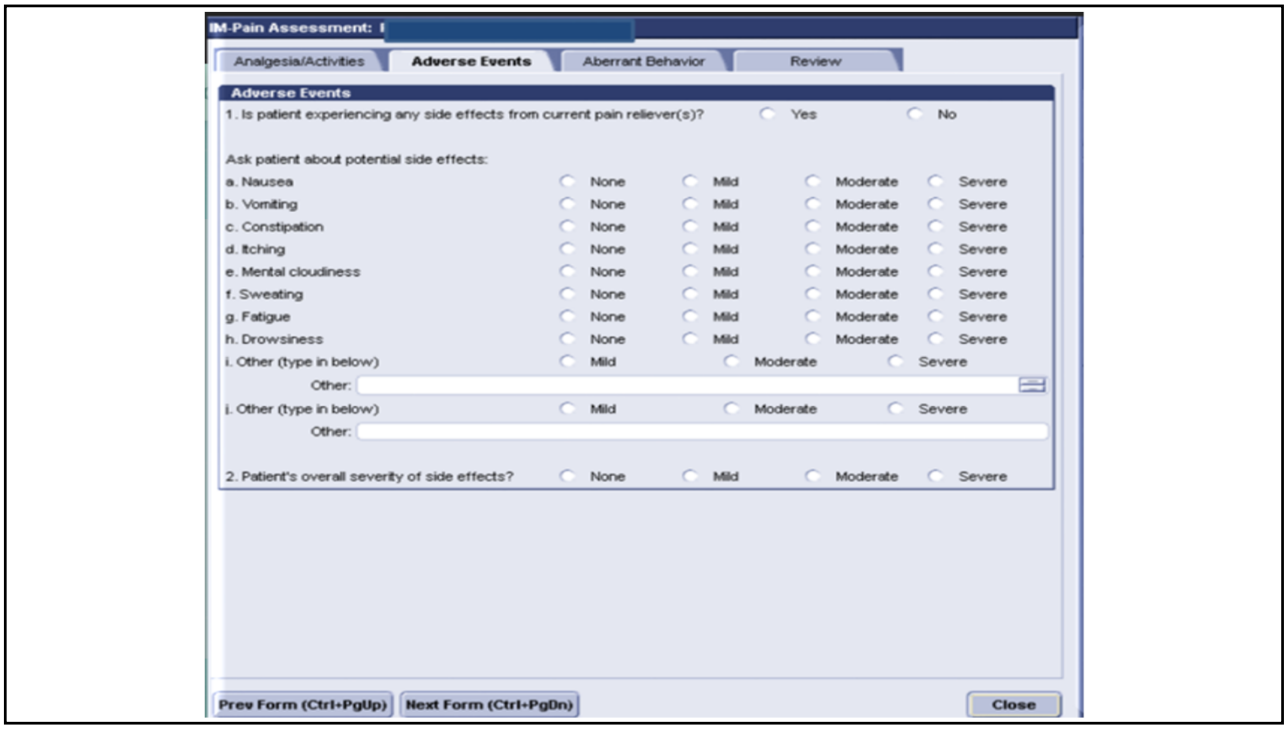
Record Keeping

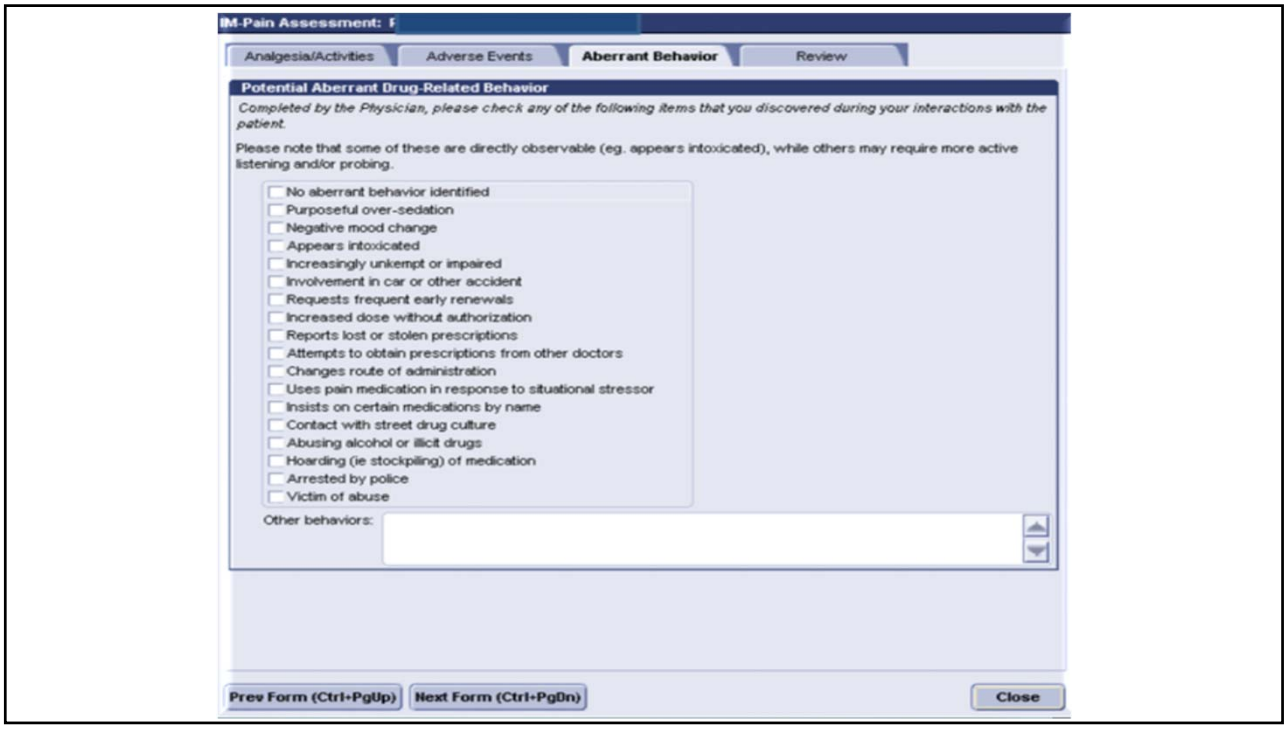
- Progress notes:
  - Progress toward patient's goals.
  - P.E.G. score and change.
  - PMP check, urine drug testing.
  - Adverse drug symptoms.
  - Appearance, mood, and behavior.
- Assessment and plan.
- Medication list update.
- Phone calls, e-mails, faxes.
- HIPAA and communication with family members.

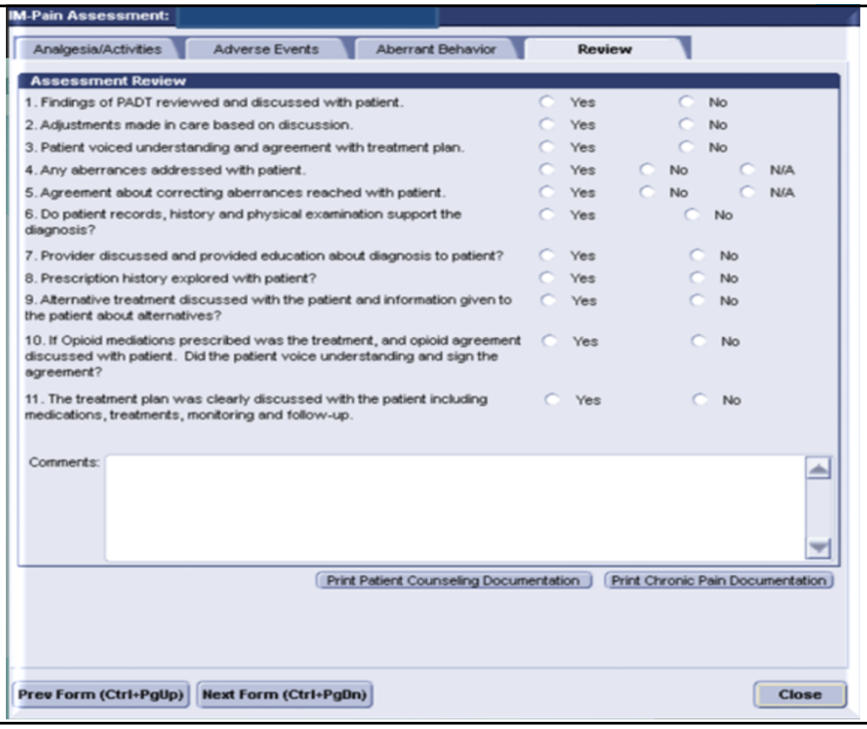
(click each image to enlarge)






IM-Pain Assessment:
Analgesia/Activities
Adverse Events
Aberrant Behavior
Review
Adverse Events
1. Is patient experiencing any side effects from current pain reliever(s)?
Yes
No
Ask patient about potential side effects:
a. Nausea
b. Vomiting
c. Constipation
d. Itching
e. Mental cloudiness
f. Sweating
g. Fatigue
h. Drowsiness
None
Mild
Moderate
Severe
i. Other (type in below)
Other:
i. Other (type in below)
Other:
2. Patient's overall severity of side effects?
None
Mild
Moderate
Severe
Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close


IM-Pain Assessment:
Analgesia/Activities
Adverse Events
Aberrant Behavior
Review
Potential Aberrant Drug-Related Behavior
Completed by the Physician, please check any of the following items that you discovered during your interactions with the patient.
Please note that some of these are directly observable (eg. appears intoxicated), while others may require more active listening and/or probing.
No aberrant behavior identified
Purposeful over-sedation
Negative mood change
Appears intoxicated
Increasingly unkempt or impaired
Involvement in car or other accident
Requests frequent early renewals
Increased dose without authorization
Reports lost or stolen prescriptions
Attempts to obtain prescriptions from other doctors
Changes route of administration
Uses pain medication in response to situational stressor
Insists on certain medications by name
Contact with street drug culture
Abusing alcohol or illicit drugs
Hoarding (ie stockpiling) of medication
Arrested by police
Victim of abuse
Other behaviors:
Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close



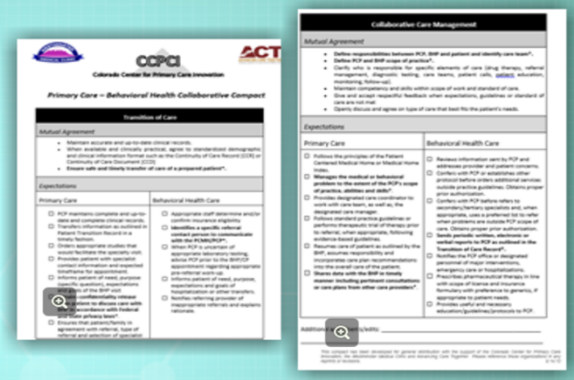
Information Technology Support

DO NO HARM

(Click each image to enlarge.)

Referral and Co-Management:

- Specialist compacts:
  - Pain Specialist.
  - Addiction Specialist.
  - Treatment Programs.
  - Psychiatry/Psychology.
- High risk patient care.
- Referral tracking system.
- Electronic record transfer.
- ED and hospital discharges.



Click here to view the details of the specialist physician compact which has been developed for general distribution with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative

CCPCI

Colorado Center for Primary Care Innovation

Primary Care – Behavioral Health Collaborative Compact

Transition of Care

Mutual Agreement

- Maintain accurate and up-to-date clinical records.
- When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD]
- **Ensure safe and timely transfer of care of a prepared patient*.**

Expectations

Primary Care	Behavioral Health Care
☐ PCP maintains complete and up-to-date and complete clinical records. ☐ Transfers information as outlined in Patient Transition Record in a timely fashion. ☐ Orders appropriate studies that would facilitate the specialty visit. ☐ Provides patient with specialist contact information and expected timeframe for appointment. ☐ Informs patient of need, purpose (specific question), expectations and goals of the BHP visit ☐ **Obtains confidentiality release from patient to discuss care with BHP in accordance with Federal and State privacy laws*.** ☐ Ensures that patient/family in agreement with referral, type of referral and selection of specialist	☐ Appropriate staff determine and/or confirm insurance eligibility ☐ **Identifies a specific referral contact person to communicate with the PCMH/PCP*.** ☐ When PCP is uncertain of appropriate laboratory testing, advise PCP prior to the BHP/CP appointment regarding appropriate pre-referral work-up. ☐ Informs patient of need, purpose, expectations and goals of hospitalization or other transfers. ☐ Notifies referring provider of inappropriate referrals and explains rationale.

Collaborative Care Management

Mutual Agreement

- **Define responsibilities between PCP, BHP and patient and identify care team*.**
- **Define PCP and BHP scope of practice*.**
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met
- Openly discuss and agree on type of care that best fits the patient's needs.

Expectations

Primary Care	Behavioral Health Care
☐ Follows the principles of the Patient Centered Medical Home or Medical Home Index. ☐ **Manages the medical or behavioral problem to the extent of the PCP's scope of practice, abilities and skills*.** ☐ Provides designated care coordinator to work with care team, as well as, the designated care manager. ☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. ☐ Resumes care of patient as outlined by the BHP, assumes responsibility and incorporates care plan recommendations into the overall care of the patient. ☐ **Shares data with the BHP in timely manner including pertinent consultations or care plans from other care providers*.**	☐ Reviews information sent by PCP and addresses provider and patient concerns. ☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. ☐ Confers with PCP before refers to secondary/tertiary specialists and, when appropriate, uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization. ☐ **Sends periodic written, electronic or verbal reports to PCP as outlined in the Transition of Care Record*.** ☐ Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations. ☐ Prescribes pharmaceutical therapy in line with scope of license and insurance formulary with preference to generics, if appropriate to patient needs. ☐ Provides useful and necessary education/guidelines/protocols to PCP.

Additional agreements/edits: _____

_____

Information Technology Support

DO NO HARM

Billing and Coding

- SBIRT CPT codes –Care Manager:
  - 99408 (private) – 15-30 SBI SUD.
  - G3396 (Medicare).
  - HOO49 (Medicaid).
- Screening Codes – Primary Care:
  - G044 – Medicare depression screen.
  - 96127 (brief emotional assessment.)
- Medicare BH/Collaborative Care:
  - 99492-4, 99484.
- FQHC/RHC Medicare/BH/CC:
  - G512.
  - G511.

Chronic Pain – Opioid visits billed on time and complexity and are usually level:

- 99214 (Level IV) or.
- 99215 (Level V).

SAMHSA, Reimbursement of Mental Health Services in Primary Care

Information Technology Support

DO NO HARM

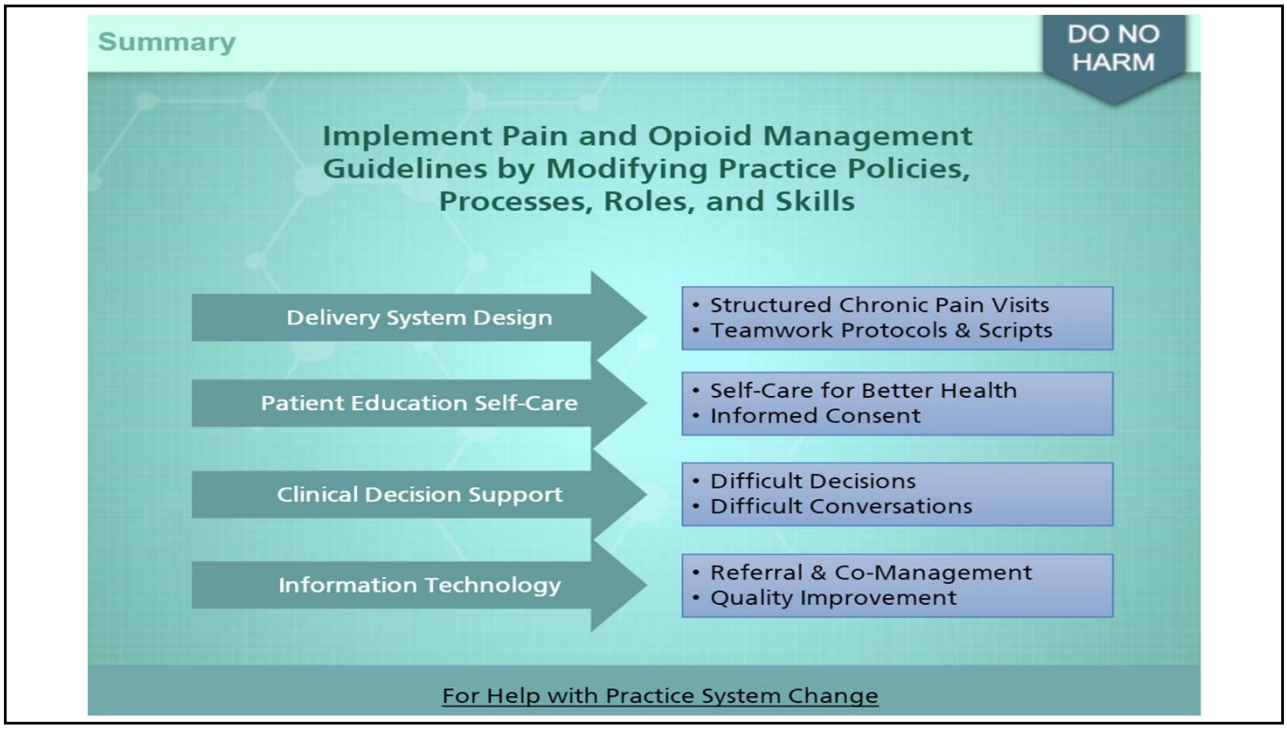
Data Driven Practice Improvement

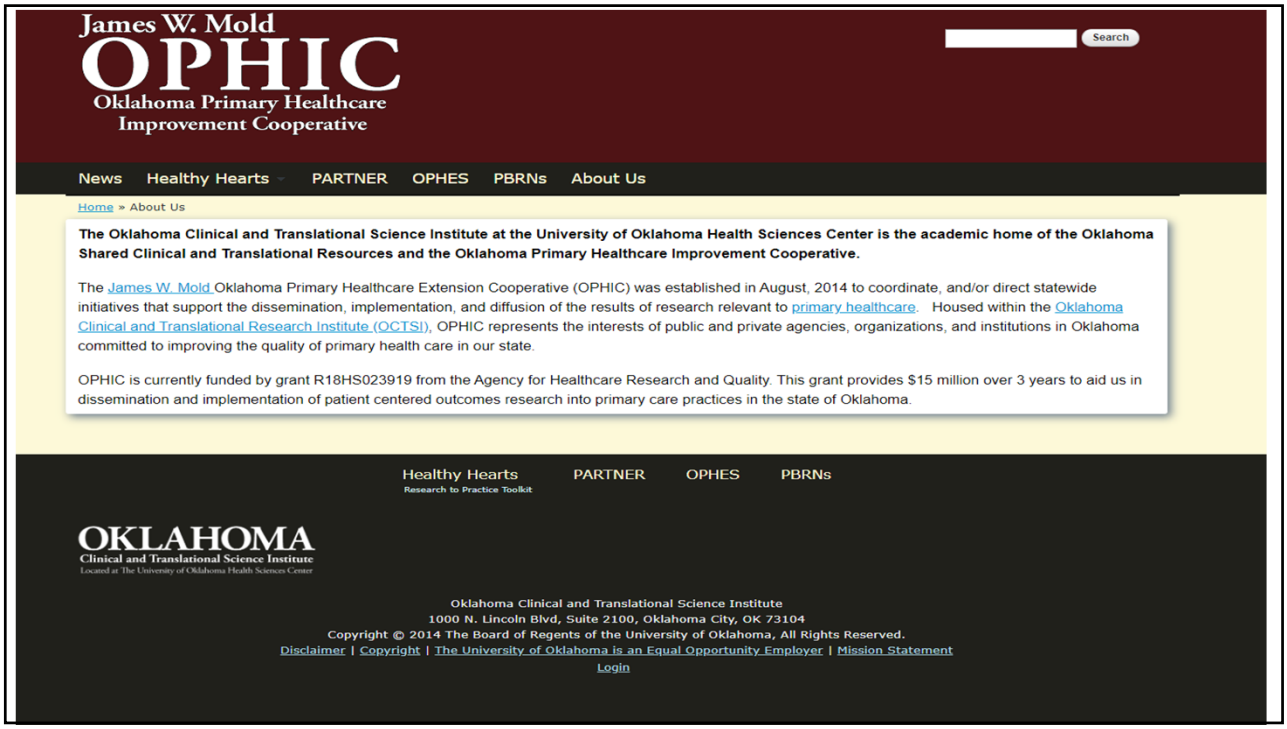
Performance Measures

- Pain Assessment.
- Informed consent.
- Screening for SUD – OUD.
- Screening for psych-social conditions.
- Monitoring for opioid misuse:
  - PMP check.
  - Opioid risk questions.
  - Urine drug testing.

Deming Principles For Healthcare Process Improvement

Using Health IT Technology to Support QI


Summary
DO NO HARM
Implement Pain and Opioid Management Guidelines by Modifying Practice Policies, Processes, Roles, and Skills
Delivery System Design
• Structured Chronic Pain Visits
• Teamwork Protocols & Scripts
Patient Education Self-Care
• Self-Care for Better Health
• Informed Consent
Clinical Decision Support
• Difficult Decisions
• Difficult Conversations
Information Technology
• Referral & Co-Management
• Quality Improvement
For Help with Practice System Change


James W. Mold
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Oklahoma Primary Healthcare Improvement Cooperative
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The Oklahoma Clinical and Translational Science Institute at the University of Oklahoma Health Sciences Center is the academic home of the Oklahoma Shared Clinical and Translational Resources and the Oklahoma Primary Healthcare Improvement Cooperative.
The James W. Mold Oklahoma Primary Healthcare Extension Cooperative (OPHIC) was established in August, 2014 to coordinate, and/or direct statewide initiatives that support the dissemination, implementation, and diffusion of the results of research relevant to primary healthcare. Housed within the Oklahoma Clinical and Translational Research Institute (OCTSI), OPHIC represents the interests of public and private agencies, organizations, and institutions in Oklahoma committed to improving the quality of primary health care in our state.
OPHIC is currently funded by grant R18HS023919 from the Agency for Healthcare Research and Quality. This grant provides $15 million over 3 years to aid us in dissemination and implementation of patient centered outcomes research into primary care practices in the state of Oklahoma.
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Self Assessment Questions

DO NO HARM

- ✓ Questions are embedded in the program to test your knowledge and competence.
- ✓ All of the questions are single-best answer among multiple choices.
- ✓ You will receive immediate feedback on your answer.
- ✓ If you answer incorrectly, you will be directed to select another response.

☐	A.
X	B.
☐	C.
☐	D.

References and Resources

DO NO HARM

- Six building blocks of better care- https://www.improvingopioidcare.org/
- Urine Drug Testing: https://www.mayoclinicproceedings.org/article/S0025-6196(16)30825-4/pdf
- Oklahoma SB-1446: https://www.okoha.com/Images/OHADocs/Advocacy/State/SB%201446%20Opioid%20Prescribing%20Guidelines/10-26-18%20Final%20Best%20Practice%201446%20w%20Hyperlinks%20and%20Logos.pdf

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The University of Oklahoma Office of Continuing Professional Development is providing the following types of credit:
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