

HealthierHere

The Accountable Community for Health of King County

Addressing the Opioid Crisis Workgroup - Prescribing Practices

May 7, 2018



HealthierHere

Opiate Prescribing Practices

Project Goal

Immediate: Reduce deaths, non-fatal overdoses, onset of opiate use disorder and harm to King County residents from prescription opioids, while expanding use of non-opioid pain management.

Long-term: Reduce risks by making pain treatment safer and more effective.

Focus Populations

Medicaid beneficiaries age 18 – 64 on high-dose chronic opioid therapy and patients with concurrent sedative prescriptions.

Interventions

- Distribute to opiate prescribers the Washington State Medical Association (WSMA)/Washington State Hospital Association (WSHA)/ HCA opioid-prescribing variance reports that include feedback and comparison metrics. This allows prescribers to evaluate their prescribing practices relative to others in the state and to update and improve their practice.
- Increase the number of providers, including dentists, trained on the Washington State Agency Medical Directors Group (AMDG) Interagency Guidelines of Prescribing Opioids for Pain with available information and training on the AMDG prescribing guidelines.
- Promote the use of the PDMP and its linkage into electronic health record systems in an effort to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
- Promote adoption and use of best practices among health care providers for prescribing opioids for acute and chronic pain through implementation of the Six Building Blocks framework for opioid pain management by primary care providers and dentists and promote access to the team of Six Building Blocks experts and practice coaches for individual consultation and assistance with implementation within primary care practices.
- Support adoption of non-opioid pain management strategies where appropriate.
- Promote safe storage and disposal of opioid and other medication.

Metrics

- Inpatient Hospital Utilization
    - For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
- *New Opioid patients Transitioning to Chronic Opioids
    - Numerator: Number of patients who are prescribed >60 days supply of opioids in the current calendar quarter with at least one opioid prescription in the previous quarter, and no opioid prescription in the prior quarter. Denominator: Number of patients with at least one opioid prescription in the previous quarter who have no opioids prescribed in the prior quarter. Report as incidence per 1,000 population, age and sex adjusted.
- All Cause Emergency Department Visits per 1000 Member Months

  - The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
- Patients Prescribed High-Dose Chronic Opioid Therapy
  - Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
- Patients with Concurrent Sedatives Prescriptions
  - Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the
  - overall, annual estimate required for DSRIP performance measurement.
- Substance Use Disorder Treatment Penetration (Opioid)
  - The percent of Medicaid beneficiaries with an identified opioid use disorder treatment need who received medication assisted treatment (MAT) or medication-only treatment for opioid use disorder in the measurement year.
- *Number of providers trained and/or given educational information about the AMDG guidelines; changes in prescribing practices by provider; and use of the PMP including modifications to EHRs.
- *Number of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain.
- *Linkage to and engagement with a primary health home, peer support-related service provision, and improved health outcomes.
- *Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages or linking to the PDMP.
- *Number of prescribers aware of their prescribing patterns and trained on the AMDG prescribing guidelines.
- *Number of prescribers registered and querying the PMP.
- *Access to non-opioid pain management strategies.
- *Numbers of naloxone kits distributed, and individuals trained; and number of opiate-related deaths.

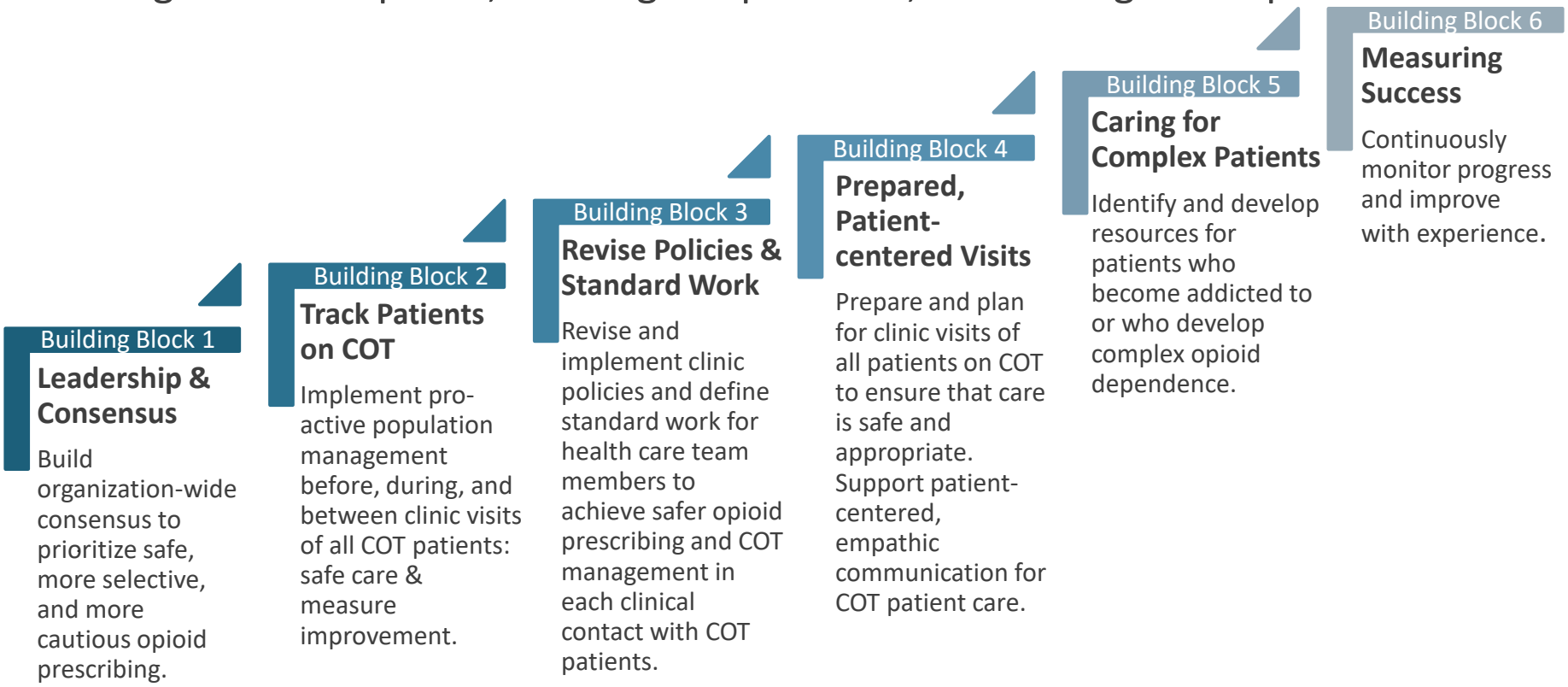
*Metrics in addition to Healthier Washington pay for performance metrics for this project

Evidence-Based Approaches: OUD Treatment

Evidence Based Approach	Model Description
Six Building Blocks	Provides readiness tools for primary care practices to assess readiness for expanding their practice to include Buprenorphine prescribing.
Medication Assisted Treatment (MAT)	For individuals with OUD, create low-barrier access and same day induction with linkage to care team and recovery support whenever possible for both Buprenorphine and Methadone.
Office Based Opiate Treatment Approach (OBOT) through Collaborative Care	Provide additional clinical support needed to manage the complex needs of individuals with OUD in a primary care setting. Includes nurse care managers (registered nurses) who complete buprenorphine training and follow treatment protocols related to OBOT.
Recovery Coaches/Peer Support Specialists	Expand recovery support leveraging case managers and peer support specialists to coordinate care, especially for individuals with significant social needs. Certified Peer Counselors work with their peers (adults and youth) and the parents of children receiving mental health services drawing upon their experiences to help peers find hope and make progress towards recovery.
Hub & Spoke Model	Centralized induction sites supported by “spokes”, agencies that refer to the prescribing physician and/or who provide addiction treatment and recovery supports to individuals receiving MAT.

Addressing the Opioid Crisis Approaches: Six Building Blocks

A team-based approach to improving opioid management in primary care (piloted in Eastern Washington and Idaho) centered on six building blocks and involved creation of an opioid quality improvement team at each site, facilitation by an external practice coach, team-building Welcome Visit with clinic-wide self-assessment of six building blocks, implementation of selected best practices to manage chronic opioids, tracking of opioid use, and management practices.



Addressing the Opioid Crisis Approaches: Medication Assisted Treatment (MAT)

- Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.
- The prescribed medication (e.g., methadone, naltrexone, or buprenorphine) operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug.
- Creating low-barrier access and same day induction with linkage to recovery supports whenever possible would expand access to both Buprenorphine and Methadone for individuals with OUD. Strategies could include efforts to increase the number of available prescribers as well as encourage currently waivered prescribers to increase care for individuals with OUD.

Addressing the Opioid Crisis Approaches: Office Based Opiate Treatment Approach (OBOT) through Collaborative Care

Program in which physicians, nurse practitioners, and/or physician assistants have been waivered to treat persons with buprenorphine within a medical or behavioral health clinic.

- Nurse care managers (registered nurses) would complete buprenorphine training, follow treatment protocols related to OBOT, and provide additional clinical support needed to manage the complex needs of individuals with OUD in a primary care setting.
- Responsibilities would include:
  - Assessing clients for appropriateness for OBOT
  - Educating patients
  - Developing treatment plans
  - Overseeing medication management
  - Referring to other addiction treatment
  - Monitoring treatment adherence
  - Communicating with prescribing physicians, addiction counselors, and pharmacists.

Addressing the Opioid Crisis Approaches: Peer Recovery Coaches/Support Specialists

Expand recovery support leveraging case managers, recovery coaches, and peer support specialists instead of nurses to coordinate care, especially for individuals with significant social needs.

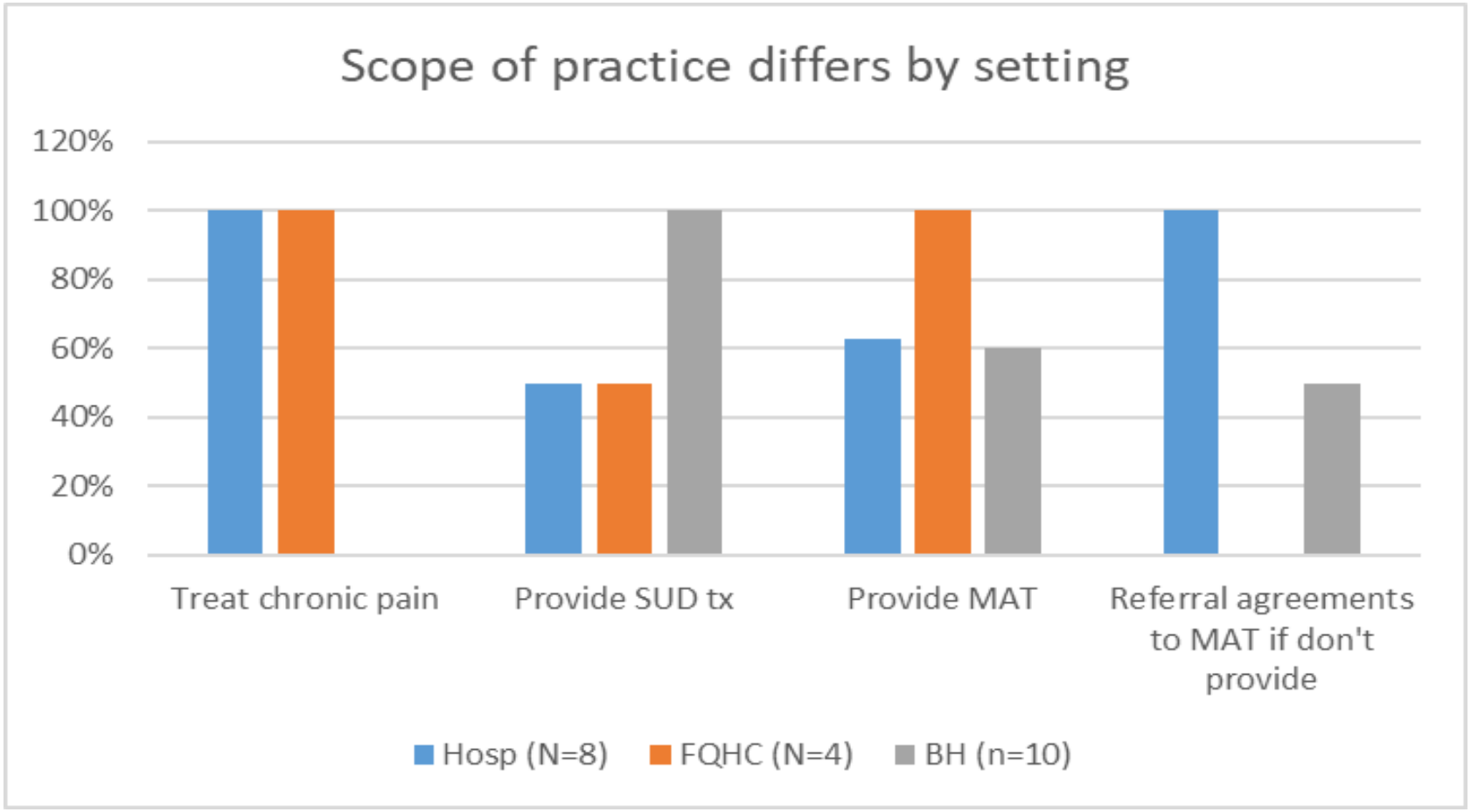
- Washington State's Peer Support Program has trained and qualified mental health consumers as Certified Peer Counselors since 2005.
- Certified Peer Counselors work with their peers (adults and youth) and the parents of children receiving mental health services.
- Peer Counselors draw upon their experiences to help peers find hope and make progress toward recovery. Because of their own life experience, they are uniquely equipped to provide support, encouragement, and resources to those with mental health challenges. There are many tasks performed by peer support specialists that may include:
  - Assisting their peers in articulating their goals for recovery
  - Learning and practicing new skills
  - Helping them monitor their progress
  - Supporting them in their treatment
  - Modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience
  - Supporting them in advocating for themselves to obtain effective services

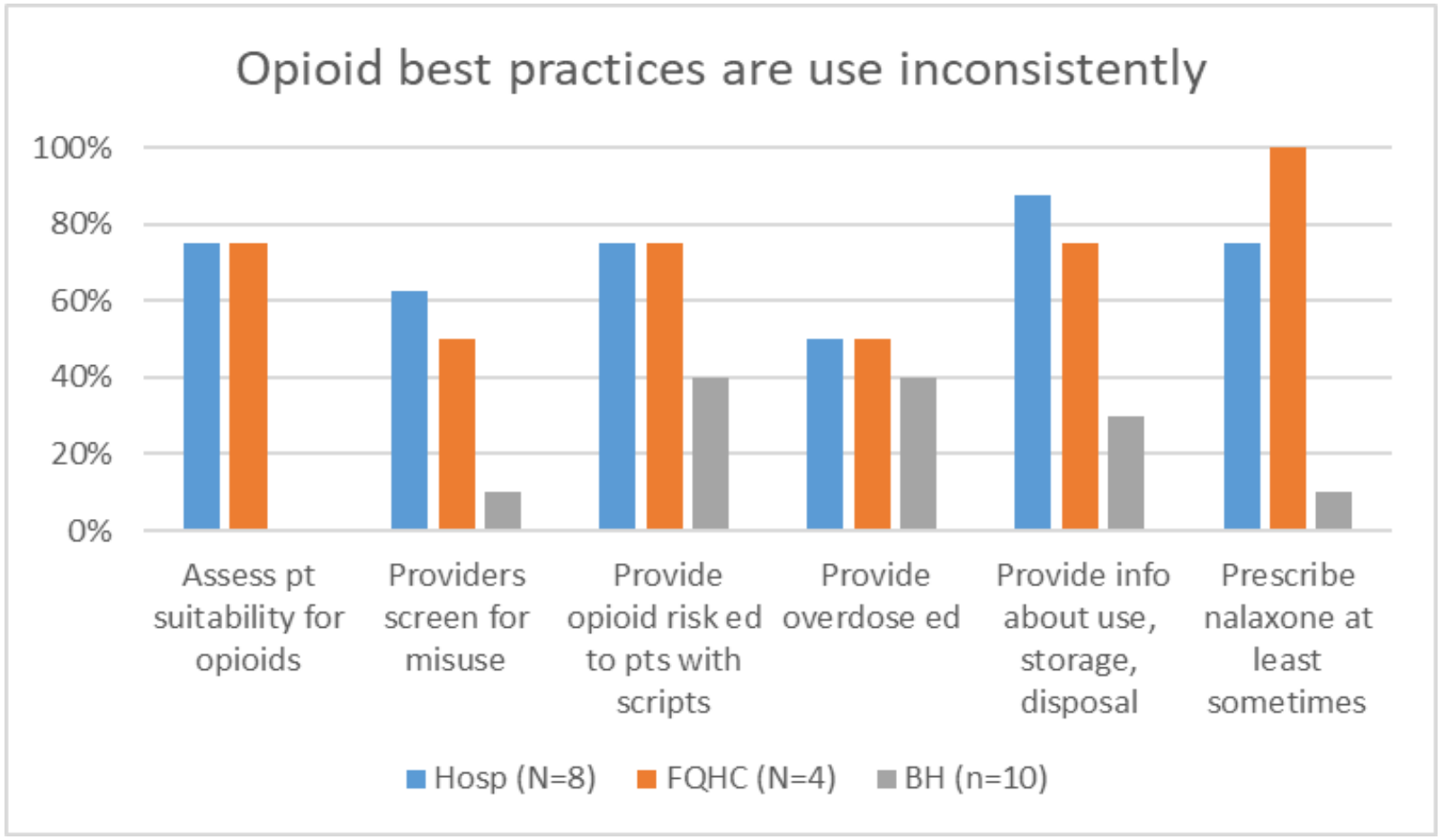
Addressing the Opioid Crisis Approaches: Hub & Spoke Model

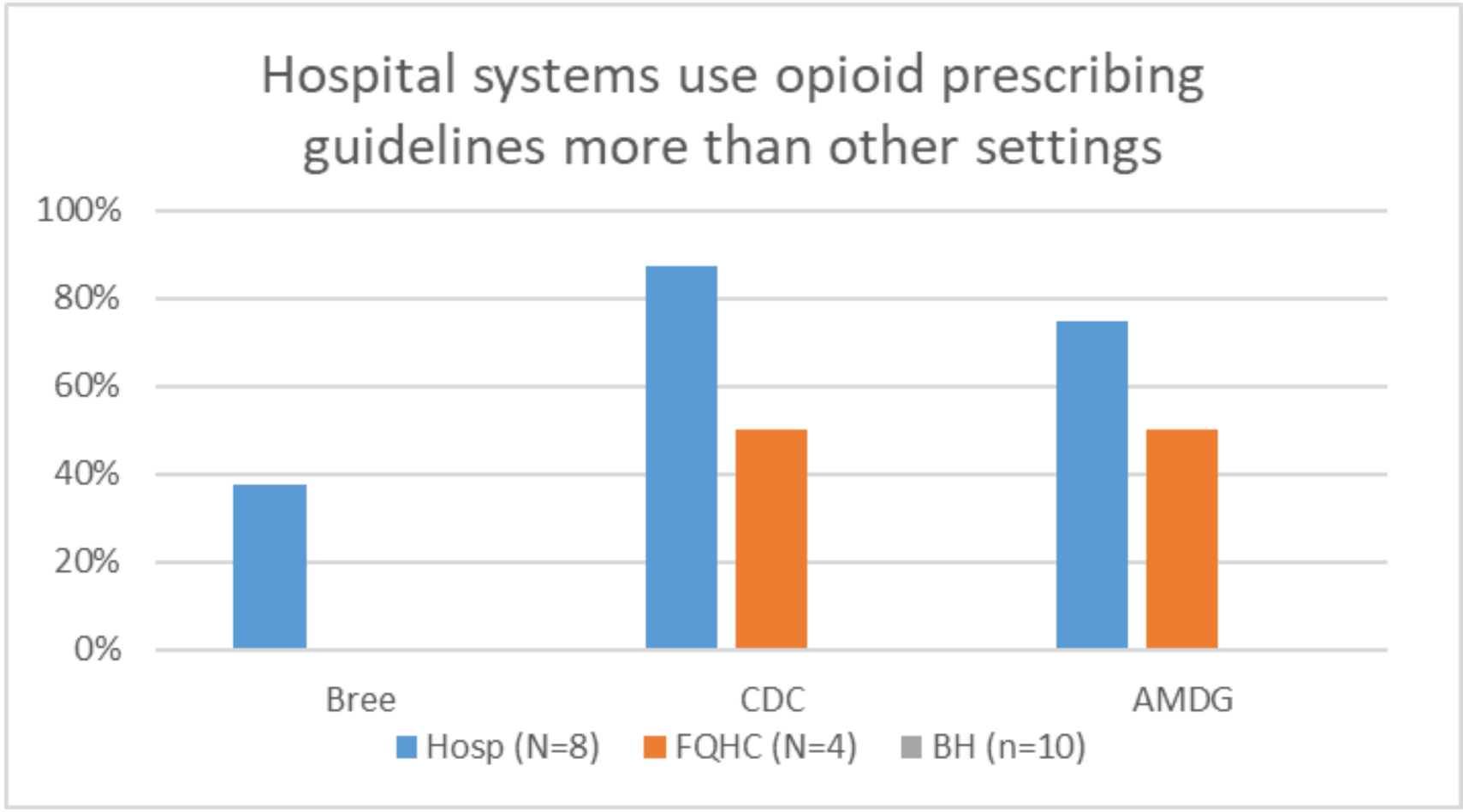
Currently running in California and Vermont. Hubs are Opioid Treatment Programs, with expanded services and strong connections to area Spokes. Each Hub is the source for its area's most intensive opioid use disorder treatment options, provided by highly experienced staff.

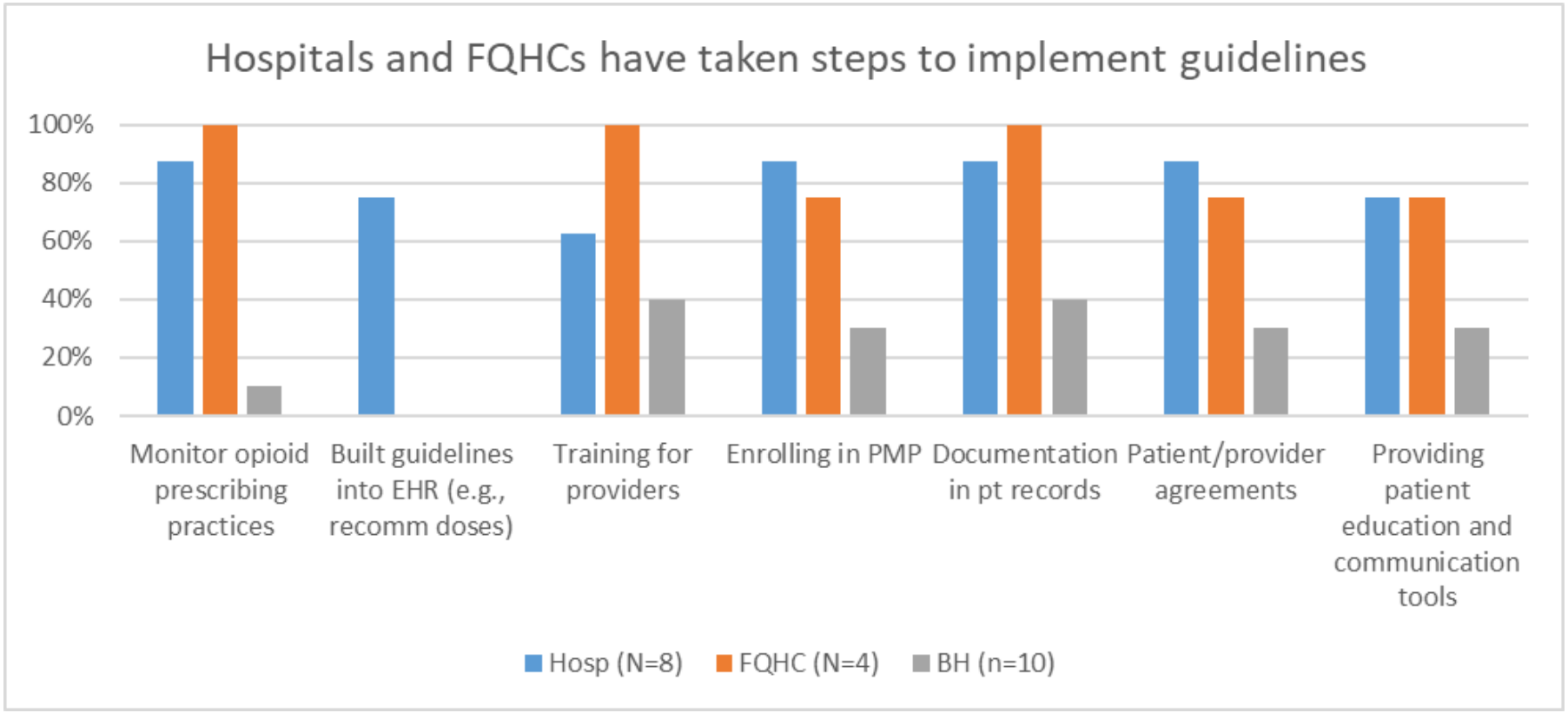
- Hubs offer the treatment intensity and staff expertise that some people require at the beginning of their recovery, at points during their recovery, or all throughout their recovery.
- Hubs provide daily medication and therapeutic support.
- A as their treatment needs change, patients receiving buprenorphine or vivitrol may move back and forth between Hub and Spoke settings over time.
- Hubs offer all elements of Medication Assisted Treatment (i.e., assessment, medication dispensing, individual and group counseling, etc.).
- Additional Health Home supports are made available at Hubs through the Hub & Spoke staffing and payment model (i.e., case management, care coordination, management of transitions of care, family support services, health promotion, and referral to community services).
- In addition to treating their own patients, Hub staff offer trainings and consultation to the Spoke provider.

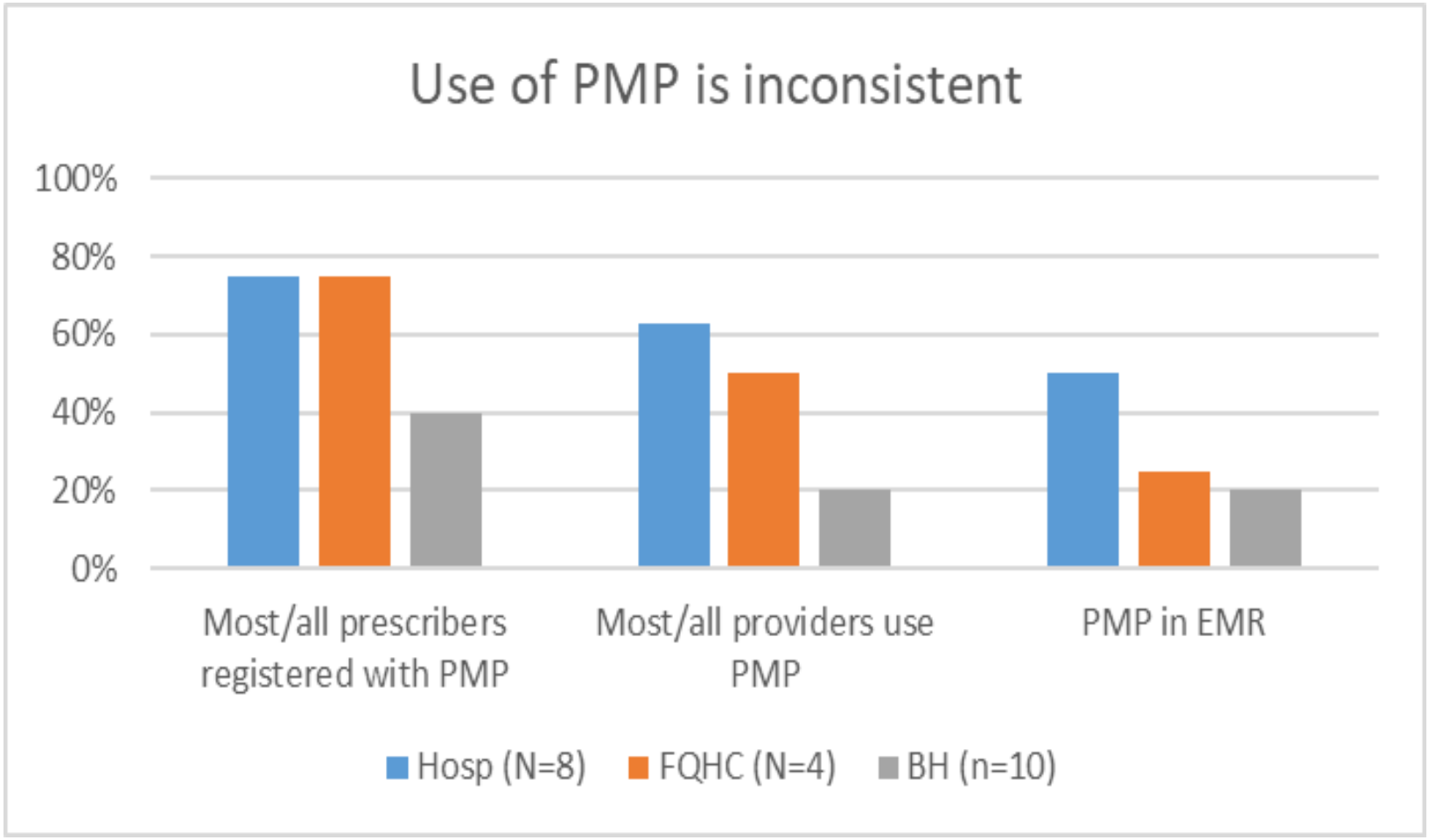
Opioids: Project-specific Results from Current State Assessment

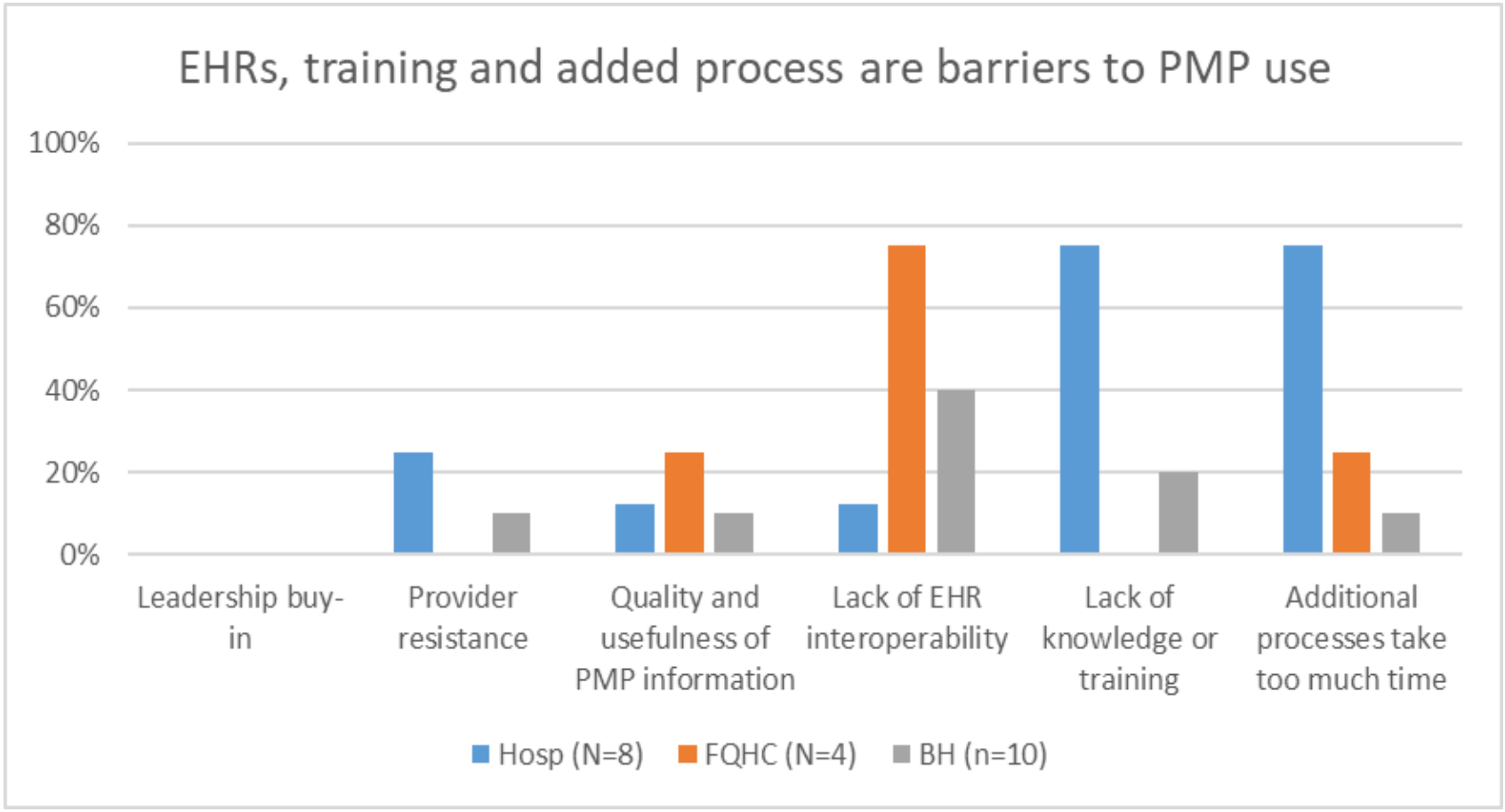

Scope of practice differs by setting
120%
100%
80%
60%
40%
20%
0%
Treat chronic pain
Provide SUD tx
Provide MAT
Referral agreements to MAT if don't provide
Hosp (N=8)
FQHC (N=4)
BH (n=10)


Opioid best practices are use inconsistently
100%
80%
60%
40%
20%
0%
Assess pt suitability for opioids
Providers screen for misuse
Provide opioid risk ed to pts with scripts
Provide overdose ed
Provide info about use, storage, disposal
Prescribe nalaxone at least sometimes
Hosp (N=8)
FQHC (N=4)
BH (n=10)

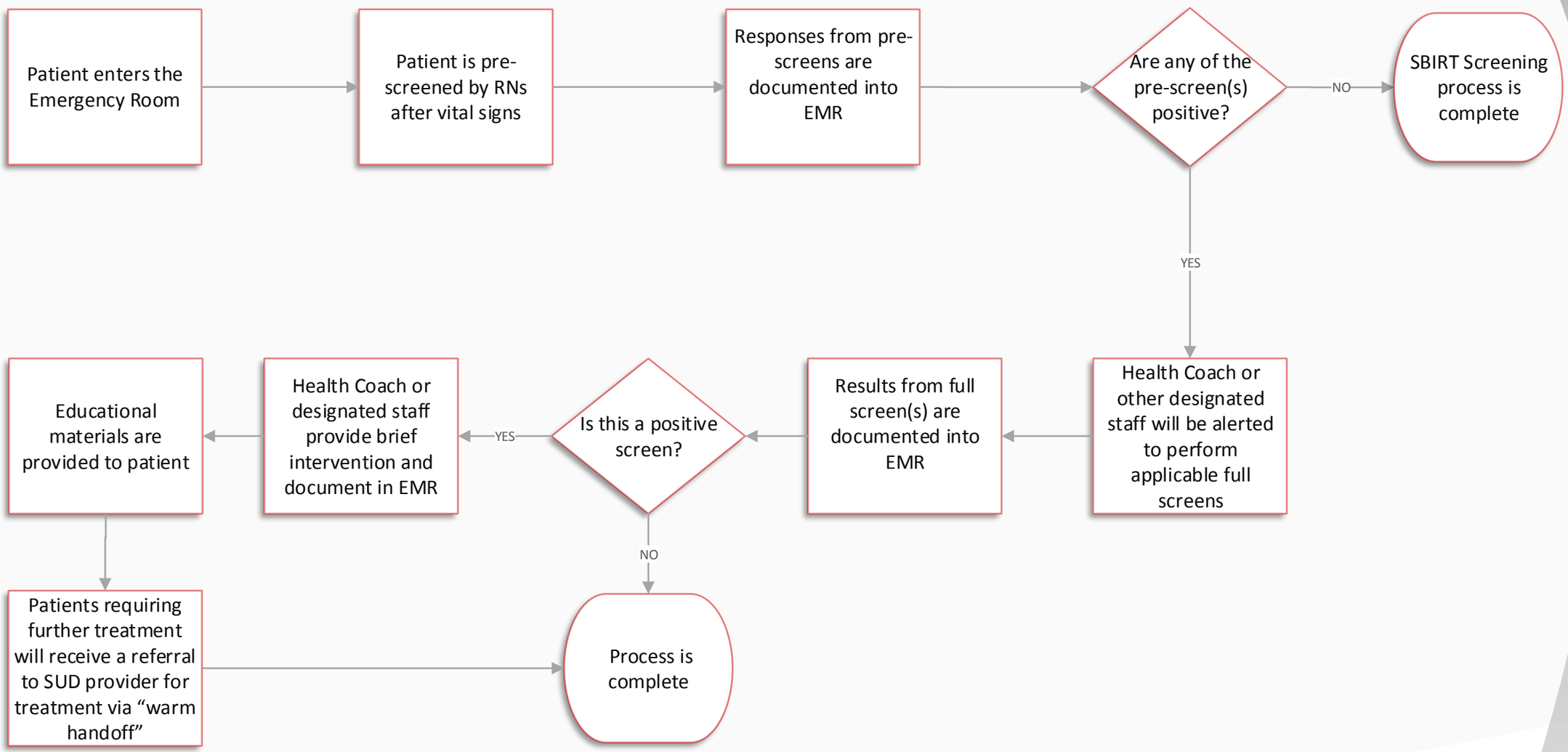

Hospital systems use opioid prescribing guidelines more than other settings
100%
80%
60%
40%
20%
0%
Bree
CDC
AMDG
Hosp (N=8)
FQHC (N=4)
BH (n=10)


Hospitals and FQHCs have taken steps to implement guidelines
100%
80%
60%
40%
20%
0%
Monitor opioid prescribing practices
Built guidelines into EHR (e.g., recomm doses)
Training for providers
Enrolling in PMP
Documentation in pt records
Patient/provider agreements
Providing patient education and communication tools
Hosp (N=8)
FQHC (N=4)
BH (n=10)


Use of PMP is inconsistent
100%
80%
60%
40%
20%
0%
Most/all prescribers registered with PMP
Most/all providers use PMP
PMP in EMR
Hosp (N=8)
FQHC (N=4)
BH (n=10)


EHRs, training and added process are barriers to PMP use
100%
80%
60%
40%
20%
0%
Leadership buy-in
Provider resistance
Quality and usefulness of PMP information
Lack of EHR interoperability
Lack of knowledge or training
Additional processes take too much time
Hosp (N=8)
FQHC (N=4)
BH (n=10)

Substance Abuse Prevention and Identification Initiatives Flow Chart



Suffolk Care Collaborative