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Assessing Prescriber and Staff Readiness for Change and Evaluation of Chronic Pain Management

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Assessing Prescriber and Staff Readiness for Change and Evaluation of Chronic Pain Management

Collin Anderson, MS
Community Health Castleton
Project Mentor: Dr. Bradley Berryhill
February–March 2020

Problem Identification

- ▶ 2017: 114 opioid overdose deaths reported in Vermont (20.6 deaths per 100,000 persons)
 - Exceeds national rate of 14.6 deaths per 100,000.¹
- ▶ 2018: Rutland County second most accidental or undetermined opioid deaths (14% of state total, or 27.1 per 100,000).²
 - Also second most prescription opioid-related deaths (5 of 35 state total).

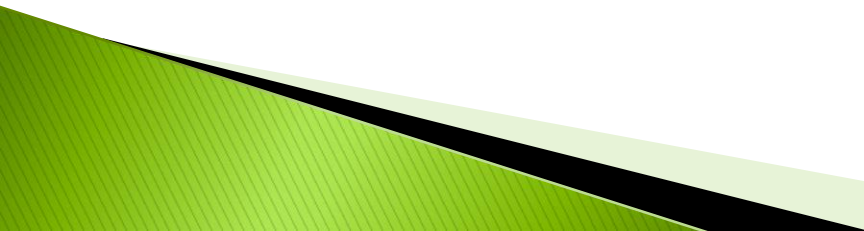


The Vermont Center for Geographic Information

Source:

<http://www.vermont251in365.com/rutland-county/>

Cost Considerations

- ▶ CDC estimates total economic burden of prescription opioid misuse in US is **\$78.5 billion/year** (includes cost of healthcare, lost productivity, addiction treatment, and criminal justice involvement).³
 - ▶ Suboxone was the top drug by gross spend in Vermont, around **\$13.3 million** in 2018 (18.8% increase from 2017).⁴
 - ▶ Opioid partial agonists also top therapeutic class by utilization, **\$14 million** in 2018 (16.8% increase from 2017).
- 

Community Perspective

- ▶ **Strengths of Medication Assisted Treatment (MAT) program at Community Health Castleton (CHC):**
 - **Accommodating** patients with appointment times, working around job schedules (early morning, late night hours, open 5 days/week)
 - Making patients feel **safe and comfortable** coming in to seek treatment
- ▶ **Opportunity areas:**
 - **Licensed Alcohol Drug Abuse Counselor (LADC)** could help fill psychological/emotional care gap, avoid referrals and potential noncompliance
 - **More providers** to see/treat MAT patients. Bottleneck may be number of prescribers with DEA waiver; 26-hour training for midlevels, 10-12 hours for physicians

–Heidi Welch, MAT Care Manager

Community Perspective

▶ Strengths

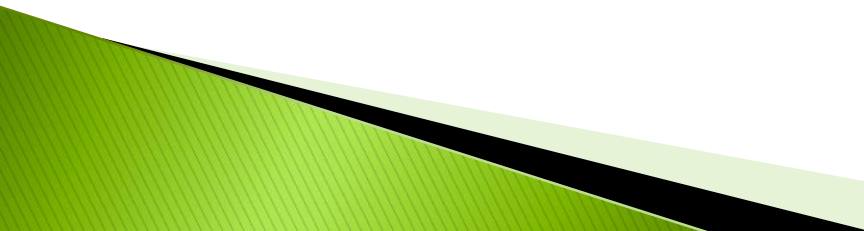
- **Care Manager** devoted to MAT. Helps with social supports, care coordination, and double-checking urine drug screen (UDS)
- **Convenient** for patients, many of whom live close by
- **Screening** for non-MAT-related conditions (cervical cancer, colonoscopy, etc), keeps patients in network

▶ Opportunity areas:

- **UDS protocol** could be updated, patients have expressed concerns, could be more seamless
- **LADC** could benefit patients in the form of social support, and would be an extra check for UDS information

– Theresa Haywood, MSN, FNP

Intervention and Methodology

- ▶ Administered anonymous surveys to prescribers (MD, PA, NP) and staff (RNs, care managers, administration).
 - ▶ Surveys came from Appendix B and C of University of Vermont Office of Primary Care's Opioid Prescription Management Toolkit for Chronic Pain, 3rd Edition.⁵
 - ▶ Data was compiled and analyzed using Microsoft Excel.
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Intervention and Methodology

Prescriber Survey - Readiness for Change and Evaluation of Current Practice

Instructions: Think about how your practice helps patients with chronic pain needs. Does it need to change? Is it ready to change? Please provide your opinions by rating each statement below according to how it applies to your practice now.

Circle one answer in response to each statement below:

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
1. My practice has clear and well-organized policies and approaches to opioid prescribing for chronic pain.				
2. My practice has updated our patient contract/agreement to reflect current state law.	1	2	3	4
3. The opioid prescribers in my practice have agreed to manage patients with chronic pain consistently as a practice.	1	2	3	4
4. The whole practice (staff and prescribers) has a team approach to opioid prescribing for chronic pain patients.	1	2	3	4
5. Our providers and staff are willing to use a structured process to plan and make changes to the way we prescribe opioids.	1	2	3	4
6. Our practice is able to give at least one provider and two staff time off from regular duties for about 8 hours of team meetings to work on a quality improvement project.	1	2	3	4
7. We have a provider leader who can share information with other providers and champion the results of a team that works on opioid prescribing.	1	2	3	4
8. We are able to avoid being distracted or overwhelmed by competing demands (such as other big projects) or financial concerns.	1	2	3	4
9. The people I work for can handle the challenges that might arise in implementing changes in opioid prescribing.	1	2	3	4
10. I believe that improving opioid prescribing is good for patients with chronic pain.	1	2	3	4

Please circle your response:

	Yes	No	Don't know
11. Are you registered to use the prescription drug monitoring program (VPMS in Vermont)?	2	1	0
12. Do you have a "delegate" (someone else in your office) who can use the Vermont Prescription Monitoring System for you?	2	1	0

For the following questions, we will ask you about care for patients who have chronic pain that is treated with opioids. How often do you use the following strategies with these patients?

	Never	A few patients	Complex patients	Some patients	Most patients	All patients
13. A special patient visit type (such as Chronic Pain Management) to see patients with chronic pain specifically for opioid management.	0	1	2	3	4	5
14. A roster of patients on chronic pain medication to identify and track them easily.	0	1	2	3	4	5
15. A template, check list, or flow sheet to display data for patients with on chronic pain medication.	0	1	2	3	4	5
16. An initial assessment tool to evaluate pain, ability to function, or risk of diversion (examples: SOAPP, SF12, Oswestry, Rapid 3).	0	1	2	3	4	5
17. Ongoing assessments for pain, function, and risk of diversion or abuse for patients on opioids for chronic pain (examples: COMM, OAT, 5 As).	0	1	2	3	4	5
18. Prescriptions for chronic pain management planned in 7 day increments (for example, every 14, 28, 56, or 84 days).	0	1	2	3	4	5
19. Issuing multiple prescriptions on the same day to be filled at staggered intervals by patients.	0	1	2	3	4	5
20. Review of patients and care plans at provider meetings (example: "Pain Management Council") to evaluate opioid usage and changes in the patient's plan.	0	1	2	3	4	5
21. Urine screens to monitor patients.	0	1	2	3	4	5
22. RANDOM urine screens to monitor patients.	0	1	2	3	4	5
23. RANDOM pill counts to monitor patients.	0	1	2	3	4	5
24. Tamper resistant prescription packaging for accurate pill counts (such as bubble packs or punch packs).	0	1	2	3	4	5
25. Prescription drug monitoring program (VPMS in Vermont) at least once/year and at initiation of treatment of opioids for chronic pain.	0	1	2	3	4	5
26. Patient agreement/contract for patients on long term opioid therapy for chronic pain.	0	1	2	3	4	5
Satisfaction: Please rate		Very unsatisfied 1				Very satisfied 4
27. Your satisfaction with the system for prescribing opioids in your office.		1	2	3	4	
28. Your patients' satisfaction with the system for prescribing opioids in your office		1	2	3	4	
29. Overall I would rate my knowledge, skill, and comfort with prescribing opioids safely and effectively	Fair 1	Good 2	Very good 3	Outstanding 4		

Intervention and Methodology

Staff Survey - Readiness for Change and Evaluation of Current Practice

Instructions: Circle one answer in response to each statement below. Rating scales below range from strongly disagree to strongly agree. You do not need to put your name on this survey.

Please choose the best single answer to describe your office practice:

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	Don't Know 0
1. My practice has clear and well-organized policies and approaches to opioid prescribing for chronic pain.					
2. My practice has updated our patient contract/agreement to reflect current state law.	1	2	3	4	0
3. The opioid prescribers in my practice have agreed to manage patients with chronic pain consistently as a practice.	1	2	3	4	0
4. The whole practice (Staff and prescribers) has a team approach to opioid prescribing for chronic pain patients.	1	2	3	4	0
5. Our providers and staff are willing to use a structured process to plan and make changes to the way we prescribe opioids.	1	2	3	4	0
6. Our practice is able to give at least one provider and two staff time off from regular duties for about 8 hours of team meetings to work on a quality improvement project.	1	2	3	4	0
7. We have a provider leader who can share information with other providers and champion the results of a team that works on opioid prescribing.	1	2	3	4	0
8. We are able to avoid being distracted or overwhelmed by competing demands (such as other big projects) or financial concerns.	1	2	3	4	0
9. The people I work for can handle the challenges that might arise in implementing changes in opioid prescribing.	1	2	3	4	0
10. I believe that improving opioid prescribing is good for our patients with chronic pain.	1	2	3	4	0

For the following questions, we will ask you about care for patients who have chronic pain that is treated with opioids. You may skip those you are uncertain about. How often does your practice use the following strategies with these patients:

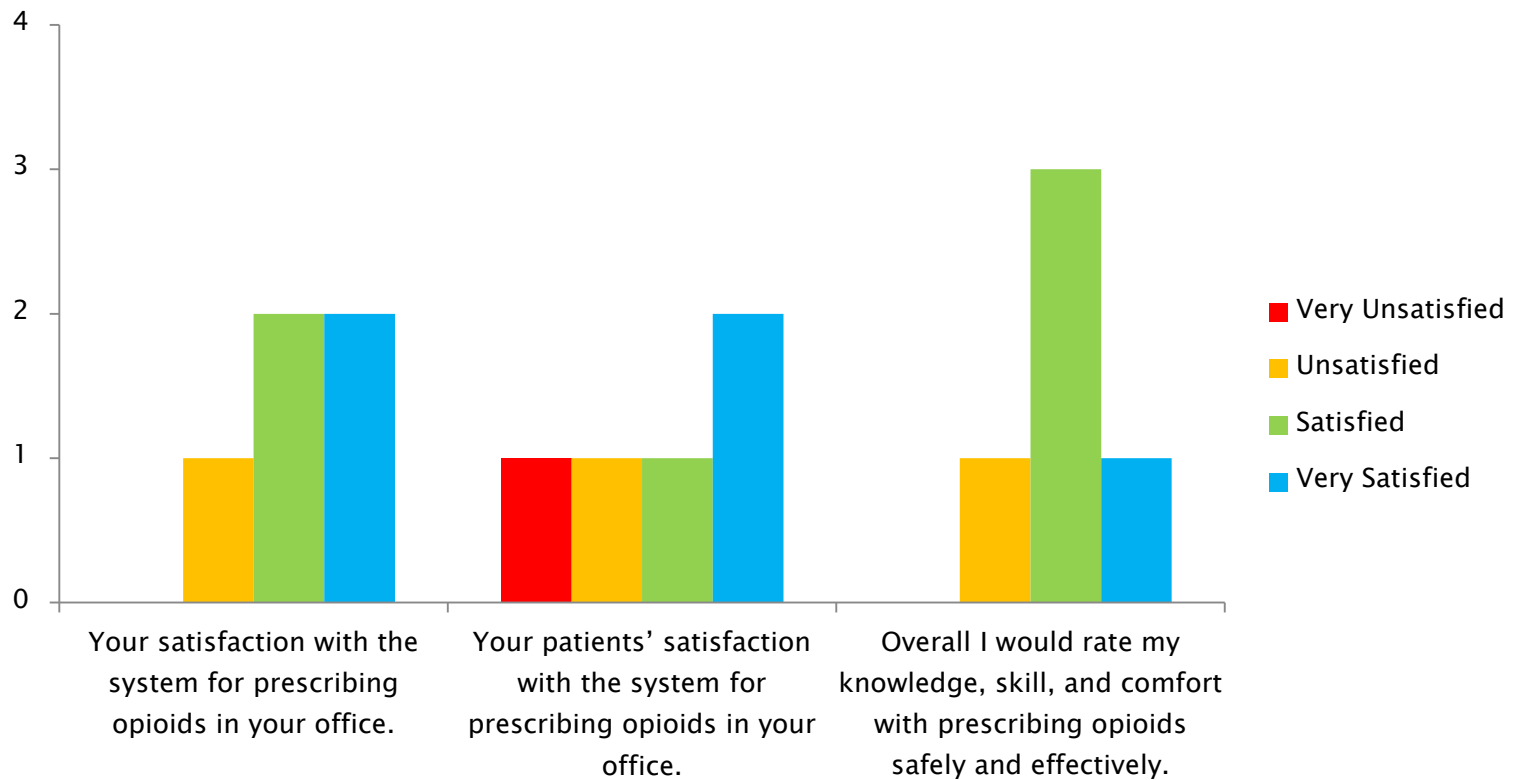
	Never 0	A few patients 1	Complex patients 2	Some patients 3	Most patients 4	All patients 5
11. A special patient visit type (such as Chronic Pain Management) to see patients with chronic pain specifically for opioid management.	0	1	2	3	4	5
12. A roster of patients on chronic pain medication to identify and track them easily.	0	1	2	3	4	5
13. A template, check list, or flow sheet to display data for patients' chronic pain medication	0	1	2	3	4	5
14. An initial assessment tool to evaluate pain, ability to function, or risk of diversion (examples: SOAPP, SF12, Oswestry, Rapid 3).	0	1	2	3	4	5
15. Ongoing assessments for pain, function, and risk of diversion or abuse for patients on opioids for chronic pain (examples: COMM, OAT, 5 As).	0	1	2	3	4	5
16. Prescriptions for chronic pain management planned in 7 day increments (for example, every 14, 28, 56, or 84 days).	0	1	2	3	4	5
17. Issuing multiple prescriptions on the same day to be filled at staggered intervals by patients.	0	1	2	3	4	5
18. Review of patients and care plans at provider meetings (example: "Pain Management Council") to evaluate opioid usage and changes in the patient's plan.	0	1	2	3	4	5
19. Urine screens to monitor patients.	0	1	2	3	4	5
20. RANDOM urine screens to monitor patients.	0	1	2	3	4	5
21. RANDOM pill counts to monitor patients.	0	1	2	3	4	5
22. Tamper resistant prescription packaging for accurate pill counts (such as bubble packs or punch packs).	0	1	2	3	4	5
23. Prescription drug monitoring program (VPMS in Vermont) at least once/year and at initiation of treatment of opioids for chronic pain.	0	1	2	3	4	5
24. Patient agreement/contract for patients on long term opioid therapy for chronic pain.	0	1	2	3	4	5
Satisfaction: Please rate						
		Very unsatisfied 1	2	3	Very satisfied 4	
25. Your satisfaction with the system for prescribing opioids in your office.		1	2	3	4	
26. The patients' satisfaction with the system for getting opioids for chronic pain (whether by phone or in person).		1	2	3	4	
27. The patients' overall attitude regarding visiting the office for chronic pain management (i.e. patient frustration, anger or confusion).		1	2	3	4	
Registration						
	Yes 2	No 1	Don't know 0			
28. Are there one or more staff members (other than prescribers) who are able to act as a delegate on the prescription drug monitoring program (VPMS in Vermont)?	2	1	0			

Results

- ▶ Prescribers (n=7)
 - 57% **disagreed** that the whole practice has a team approach to prescribing opioids.
 - 80% **disagreed** that the practice could give one provider and two staff time off from regular duties for ~8 hours of team meetings to work on a quality improvement project.
 - 33% **disagreed** that they were able to avoid being distracted or overwhelmed by competing demands or financial concerns.
 - There was **overwhelming agreement** (> 80% agree or strongly agree) surrounding clear policies/approaches to prescribing opioids, a structured process to plan and adapt opioid prescribing, and the belief that improving opioid prescribing is good for patients with chronic pain.

Results

► Prescribers (n=5, 2 abstained)

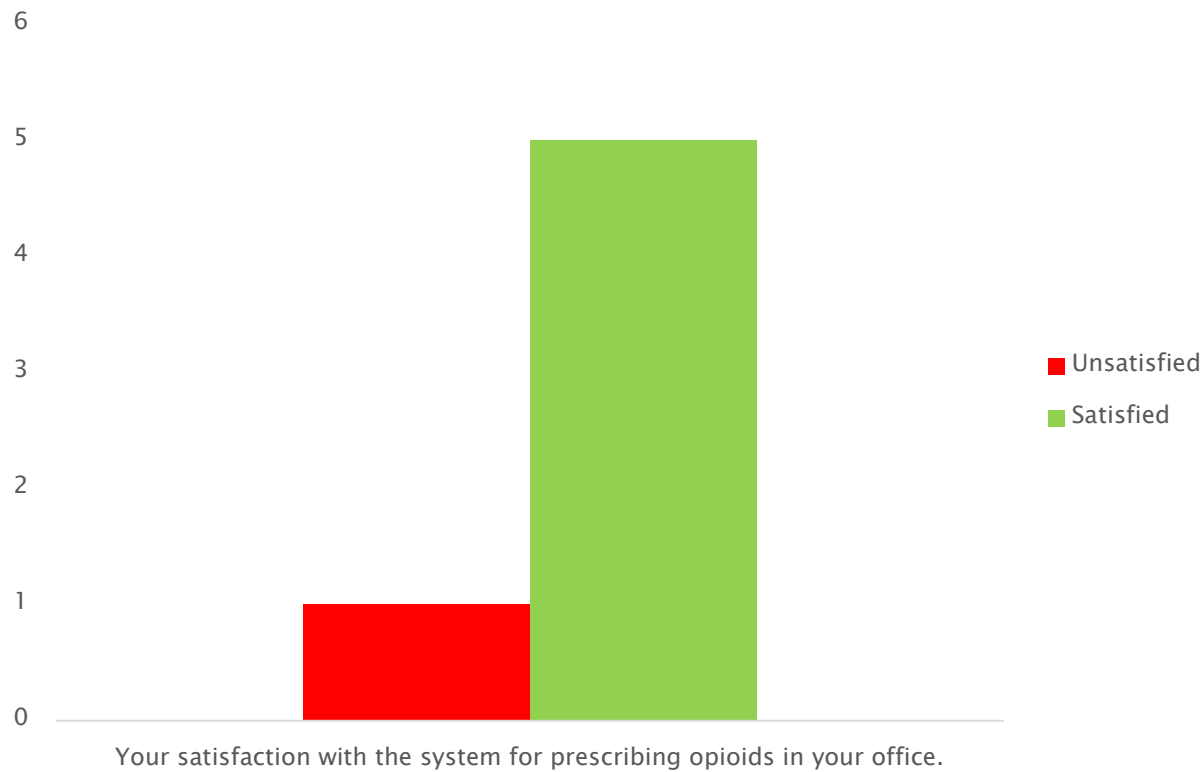


Results

- ▶ Staff (n=6)
 - **33% disagreed** that the whole practice has a team approach to prescribing opioids.
 - **50% disagreed** or **strongly disagreed** that the practice could give one provider and two staff time off from regular duties for ~8 hours of team meetings to work on a quality improvement project.
 - **50% disagreed** that they were able to avoid being distracted or overwhelmed by competing demands or financial concerns.
 - There was **overwhelming agreement** (> 80% agree or strongly agree) surrounding clear policies/approaches to prescribing opioids, a structured process to plan and adapt opioid prescribing, and the belief that improving opioid prescribing is good for patients with chronic pain.

Results

▶ Staff (n=6)



Effectiveness / Limitations


▶ Effectiveness

- Surveys are a cost-effective, reasonable method of obtaining previously hidden information.
- Dual surveys allow for contrast between prescriber and staff vantage points.

▶ Limitations:

- Not every prescriber nor every staff member received a survey, leading to small sample size (N=13).
- **Response Bias:** Questions subject to all individual biases of previous responses, and whether they relate to recent or significant life experience and other factors.
- Quantitative Likert scale data does not allow for in-depth responses or anecdotal reports.

Recommendations for Future Interventions

- ▶ CHC may consider the following:
 1. Hire **LADC** to augment care coordination (average annual salary=\$40,221) ⁶
 2. **Staff meeting** to promote MAT program, and clarify roles/responsibilities of providers and staff
 3. Incentivize more prescribers to complete MAT training with **paid time**, as added patient base may offset training costs
- 

References

1. Vermont Opioid Summary, National Institute on Drug Abuse, Rev March 2019, www.drugabuse.gov
2. Opioid-Related Fatalities Brief 2018, Vermont Department of Health, www.healthvermont.gov/
3. Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Med Care*. 2016;54(10):901-906. doi:10.1097/MLR.0000000000000625.
4. Pharmacy Best Practices and Cost Control Program, 2018, Agency of Human Services, Department of Vermont Health Access
5. Opioid Prescription Management Toolkit for Chronic Pain, Clinic Workbook, Third Edition, University of Vermont Office of Primary Care Faculty, www.med.uvm.edu
6. Average Certified Addiction Drug and Alcohol Counselor Hourly Pay, payscale.com/research

Interview Consent Form

- ▶ Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview.

Consented: X

Name: Heidi Welch, Care Manager

Did NOT Consent:

Consented: X

Name: Theresa Haywood, MSN, FNP

Did NOT Consent: