Group Health Innovations in Opioid Prescribing for Chronic Pain

Michael Von Korff Sc.D.
Group Health Research Institute
Seattle, WA

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Group Health steps to reduce chronic opioid therapy risks: *Altered Prescribing Expectations*

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2007

State Government

WA State Agency Medical Director's Group Guideline
for opioid prescribing for chronic non-cancer pain

Group Health Integrated Group Practice

Altered prescribing expectations

Implementation Methods

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Consulting specialist and medical staff leader guidance towards more cautious opioid prescribing for chronic pain.

Periodic, voluntary in-service training sessions on opioid prescribing discouraging use of higher doses.

Reports to physicians and clinic Medical Directors tracking chronic opioid therapy patients receiving high doses (≥120 mg. MED).

Guidance for physicians with unusually large numbers of patients on high doses.

Group Health steps to reduce chronic opioid therapy risks: *Multi-Faceted Risk Reduction*

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2010

State Government

Update of WA State AMDG Guideline
Enabling legislation

Group Health Integrated Group Practice

Multi-faceted risk reduction

Multi-faceted Risk Reduction

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A single physician was designated as responsible for managing opioids for every COT patient

Individualized COT care plans were developed with COT patients and documented in standardized format in the EMR

Standardized tools for patient education, treatment agreements, care plans, morphine equivalent dose calculation were made available

Minimum standards were set for frequency of COT monitoring visits and for urine drug screening based on risk stratification by dose and drug abuse risk factors

Refill ordering processes were altered to prevent short-notice refills and patients running out over a weekend

Trescott et al., Health Affairs, 2011

Implementation Methods

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Guideline defining prescribing policies for all clinicians and staff

Rapid Progress Improvement Workshop to define *standard work*

Registry of chronic opioid therapy patients flagging high dose patients

Performance measures (Care plan documentation in EHR for all COT patients)

Clinic-based *incentives* for achieving targets on performance measures

Medical staff *leadership* and *consulting specialist advocacy* for changes

On-line CME with in-clinic meeting to discuss changes

In-clinic clinician *local experts* to provide guidance and support

Effects of Altering Prescriber Expectations on Opioid Prescribing

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Can high dose COT prescribing be substantially reduced in community practice via altered prescriber expectations?

Percent of patients on high COT doses (≥ 120 mg. MED) was lowered by 63% from 2006 to 2014 in GH Clinics

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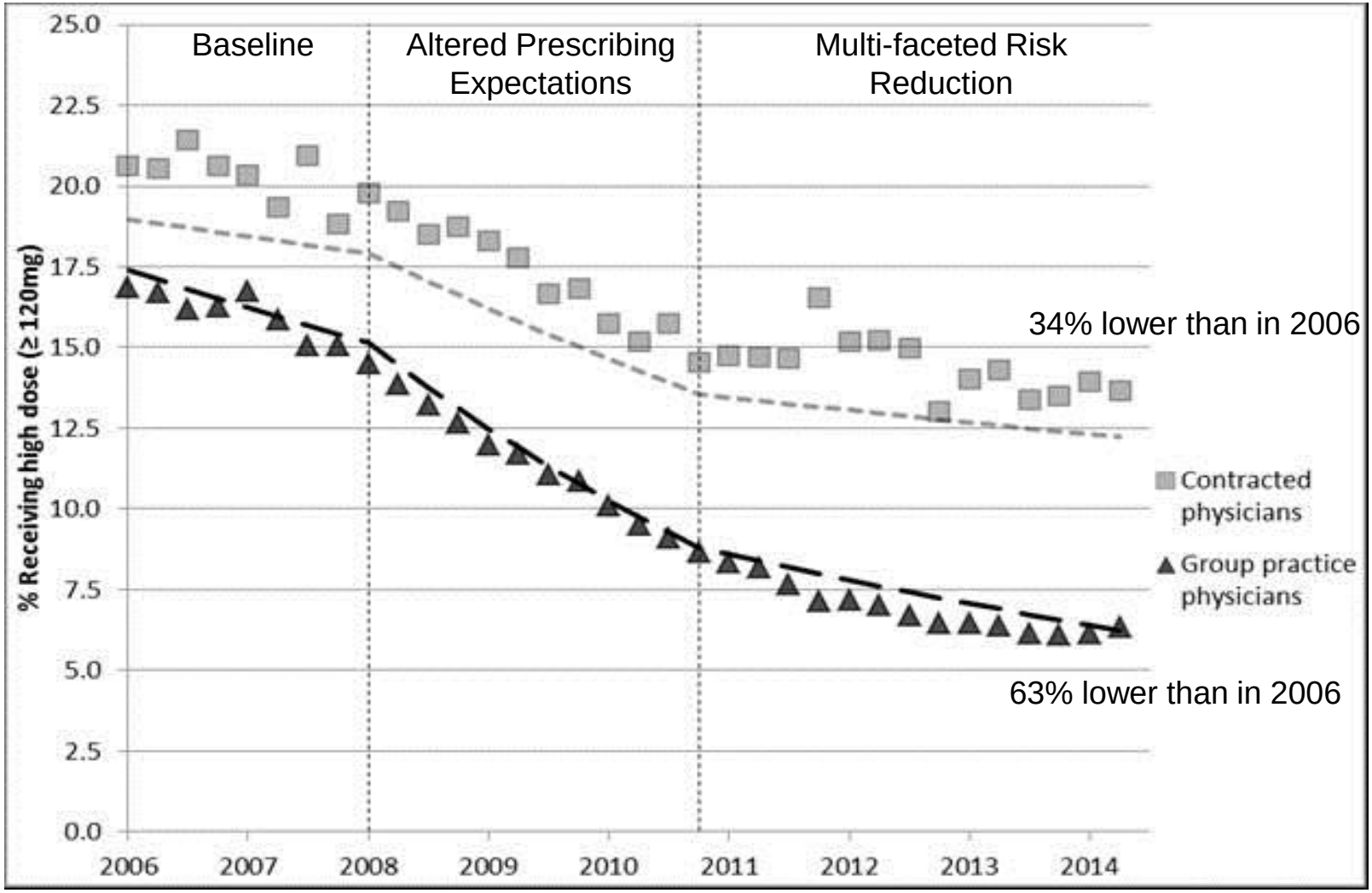

Percent of patients getting excess days supply of opioids was lowered by 57% from 2006 to 2014 in GH Clinics

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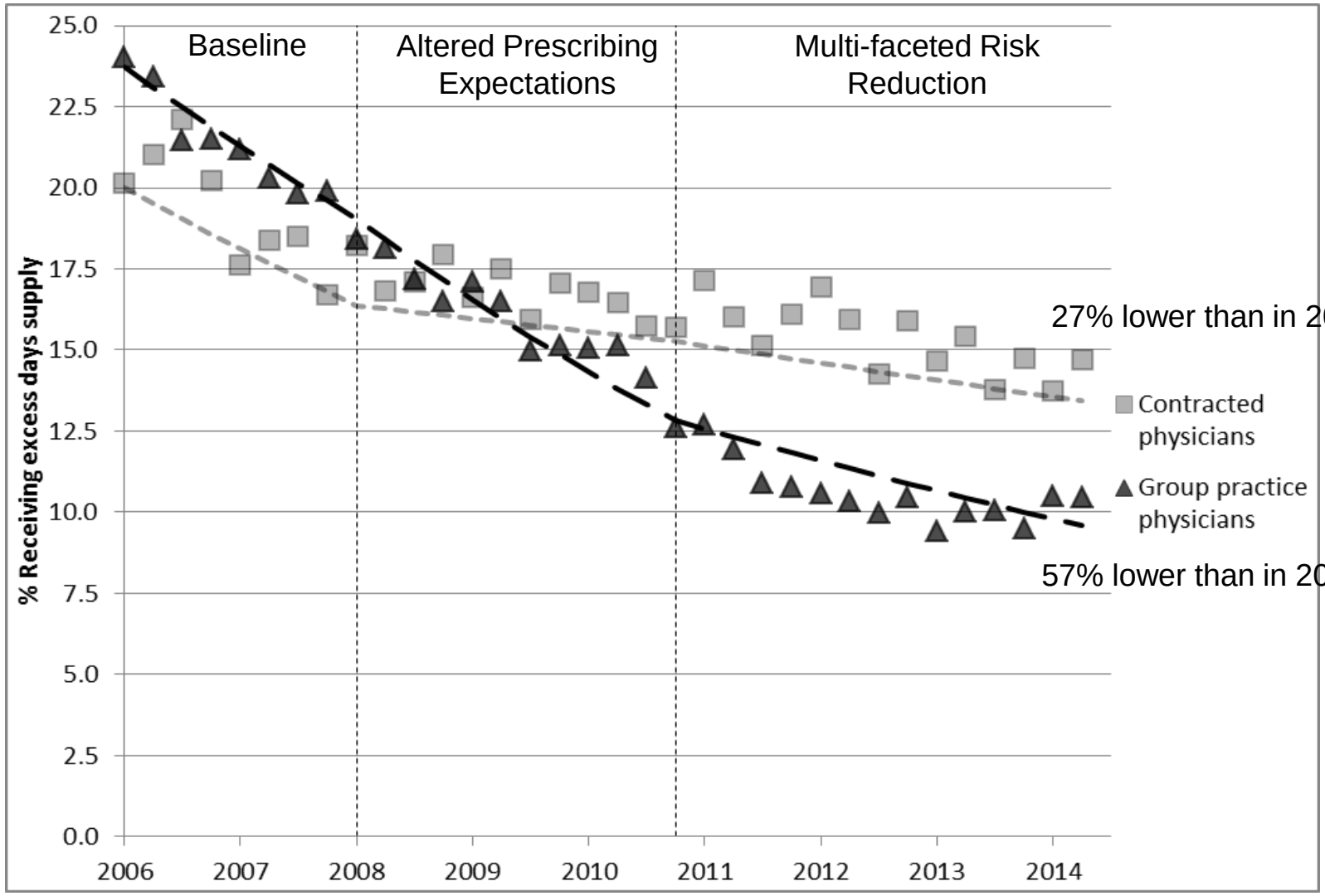

Reductions in COT dose at Group Health were achieved primarily by avoiding dose escalation

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COT Dose at Baseline	Percent at High Dose at One Year Follow-up: Integrated Group Practice	Percent at High Dose at One Year Follow-up: Contracted Physicians
High dose (≥120 mg.)	77.8 %	82.3 %
Medium dose (40 to <120 mg.)	7.6 %	10.7 %
Low dose (< 40 mg.)	0.4 %	0.9 %

Modest changes in dose escalation rates had a large cumulative impact on the percent of COT patients on high dose regimens

Large dose reduction was achieved by GH group practice physicians by….

Avoiding large escalation of COT dose

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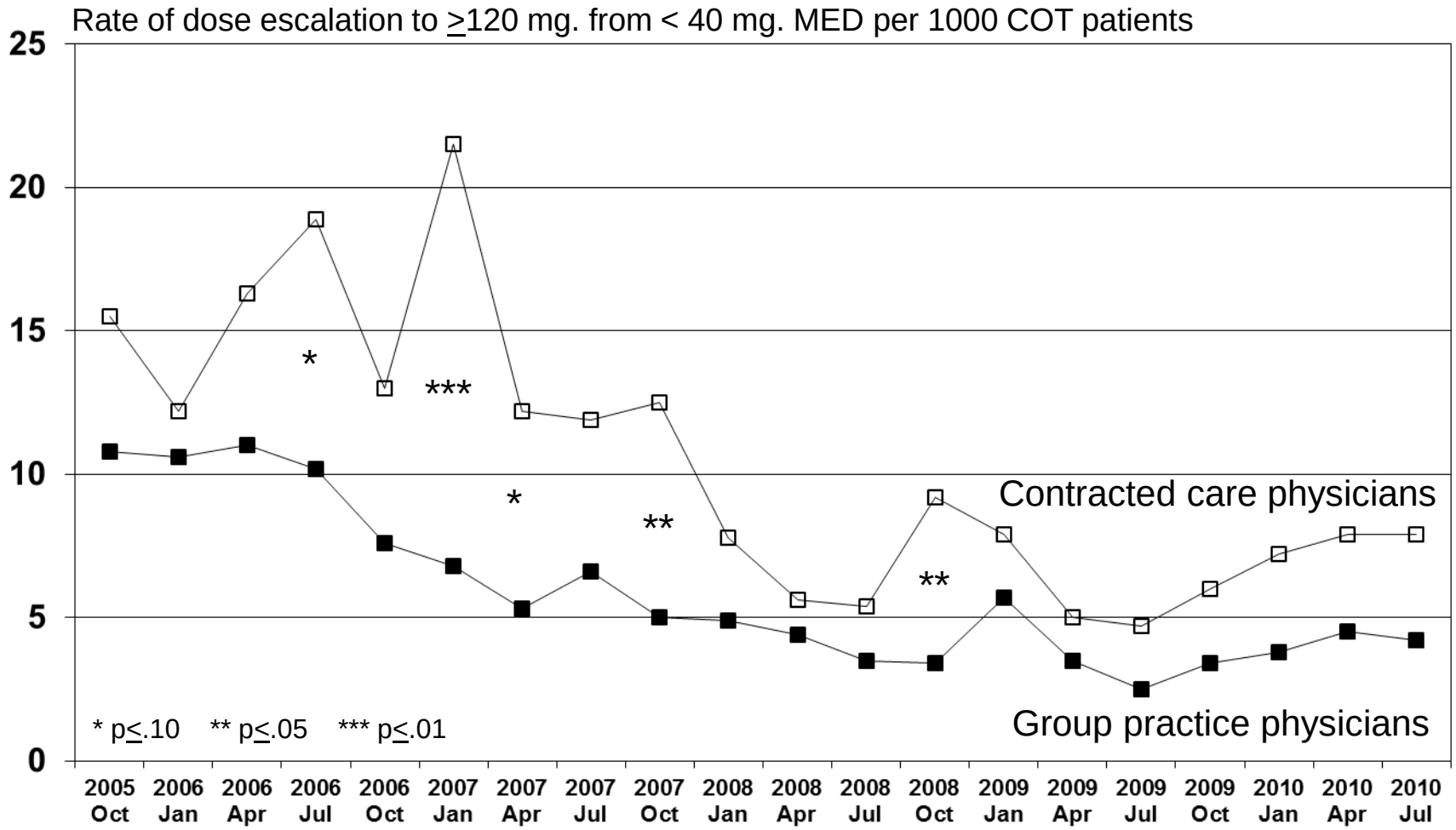

Large dose reduction was achieved by GH group practice physicians by….

Avoiding small escalation of COT dose

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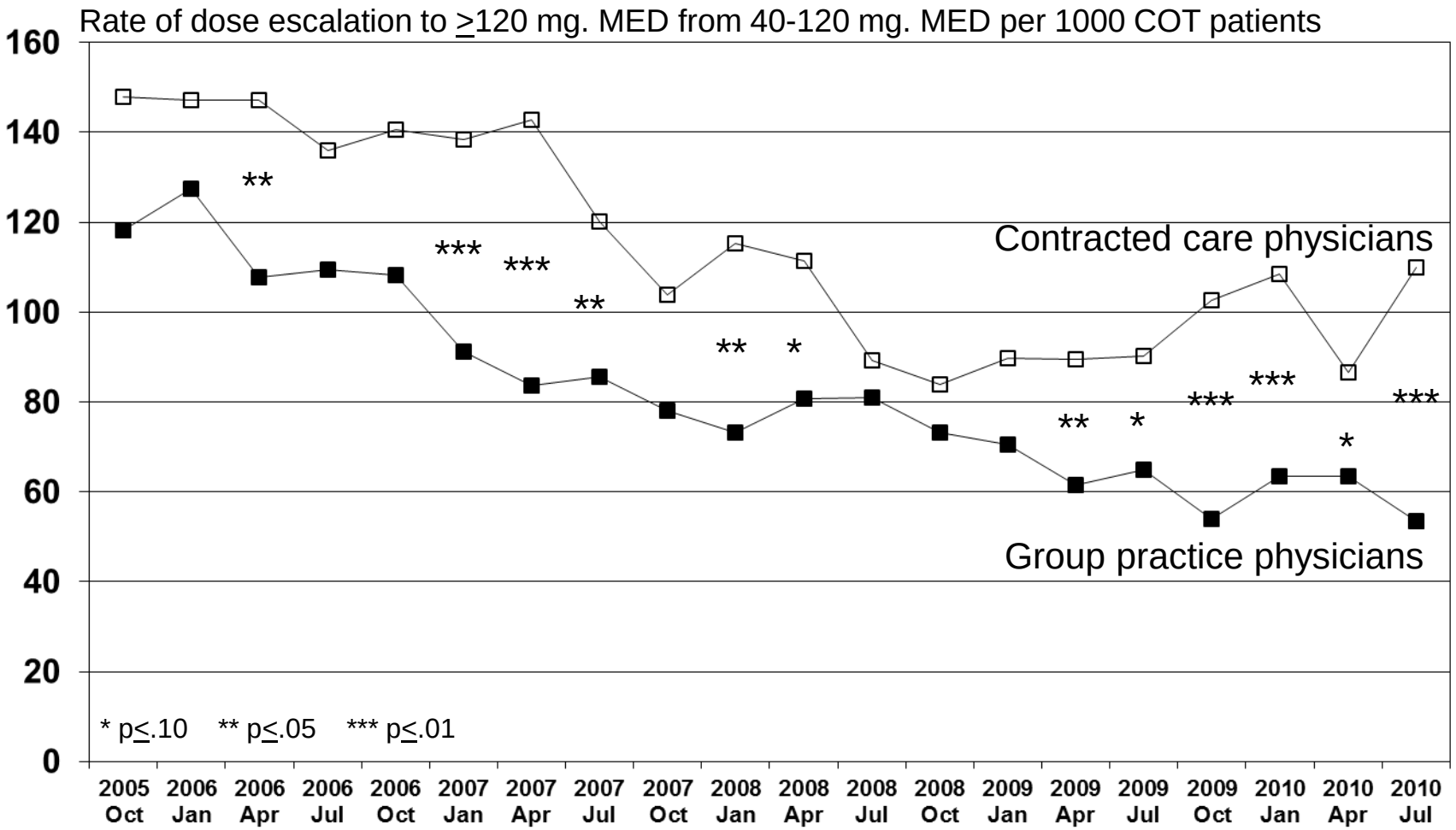

Large dose reduction was achieved by GH group practice physicians by….

Partial tapering to intermediate COT dose

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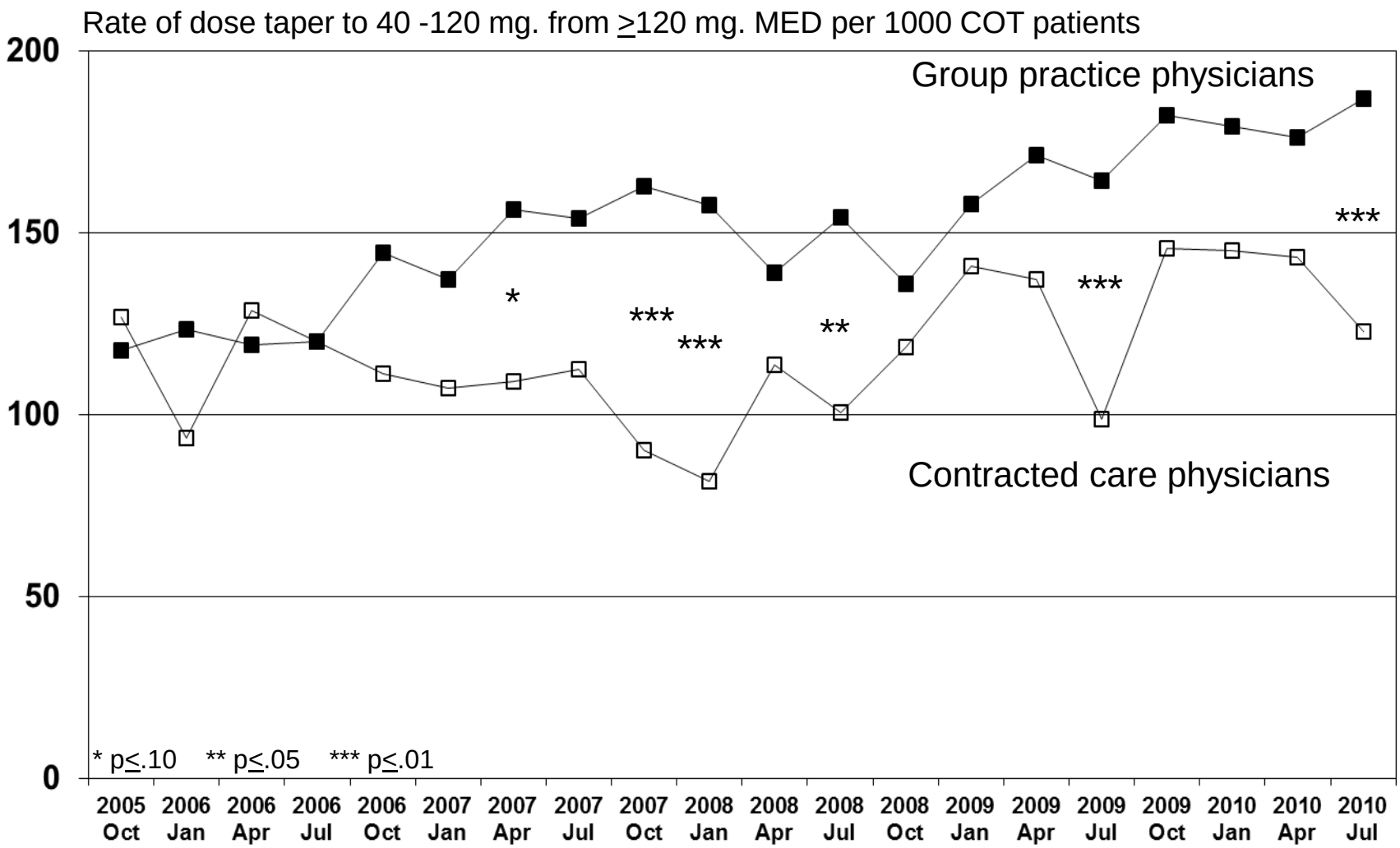
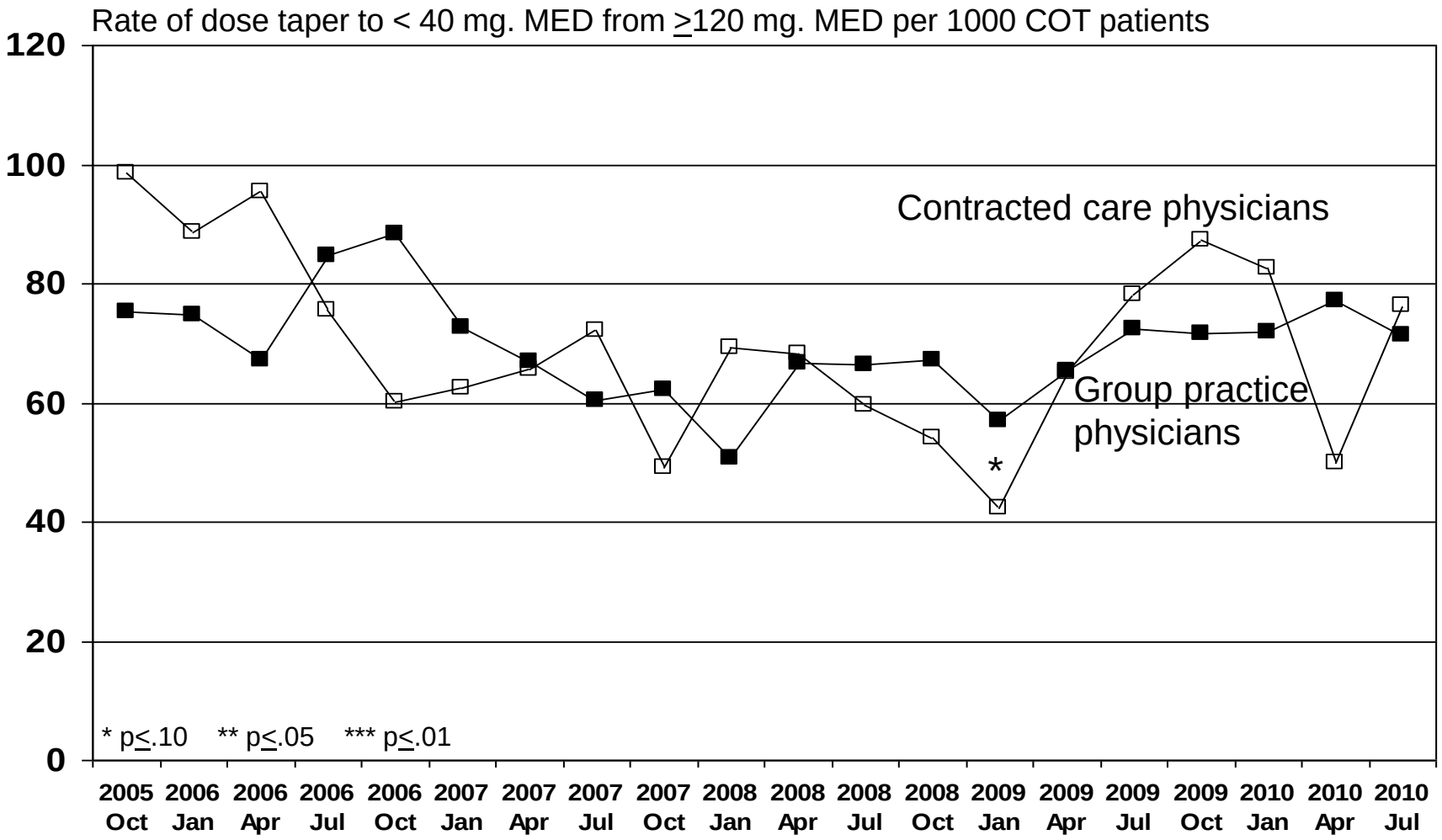


However, large tapers to low COT dose did not contribute to achieving lower COT doses



Although opioid dose levels were reduced, use of COT continued to increase among Group Health patients

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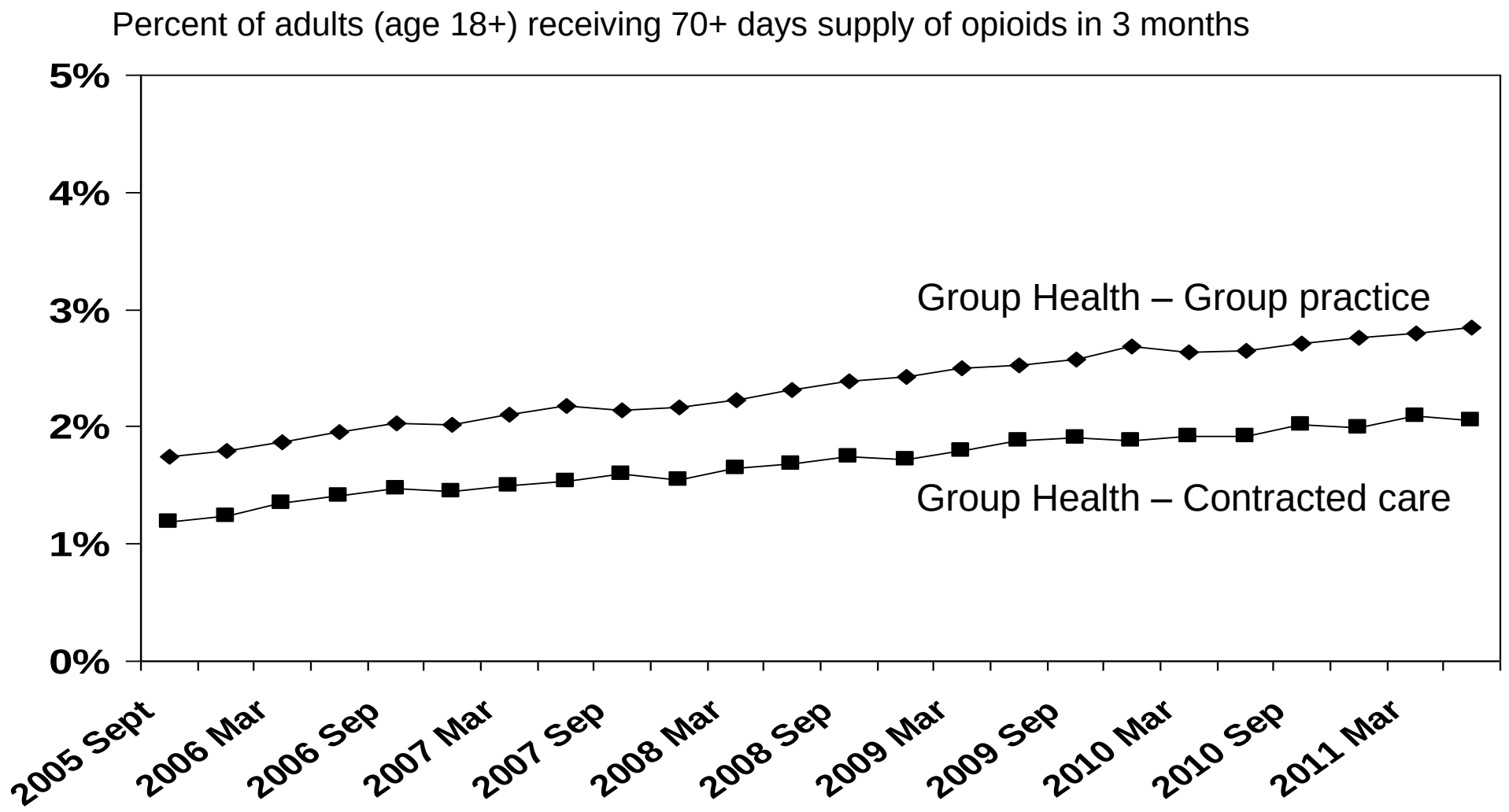

Effects of Altering Prescriber Expectations on Chronic Opioid Therapy Management

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Can use of "universal" precautions be increased by a quality improvement initiative?

COT care plans were developed for almost all Group Health patients within one year (N ≅ 7000)

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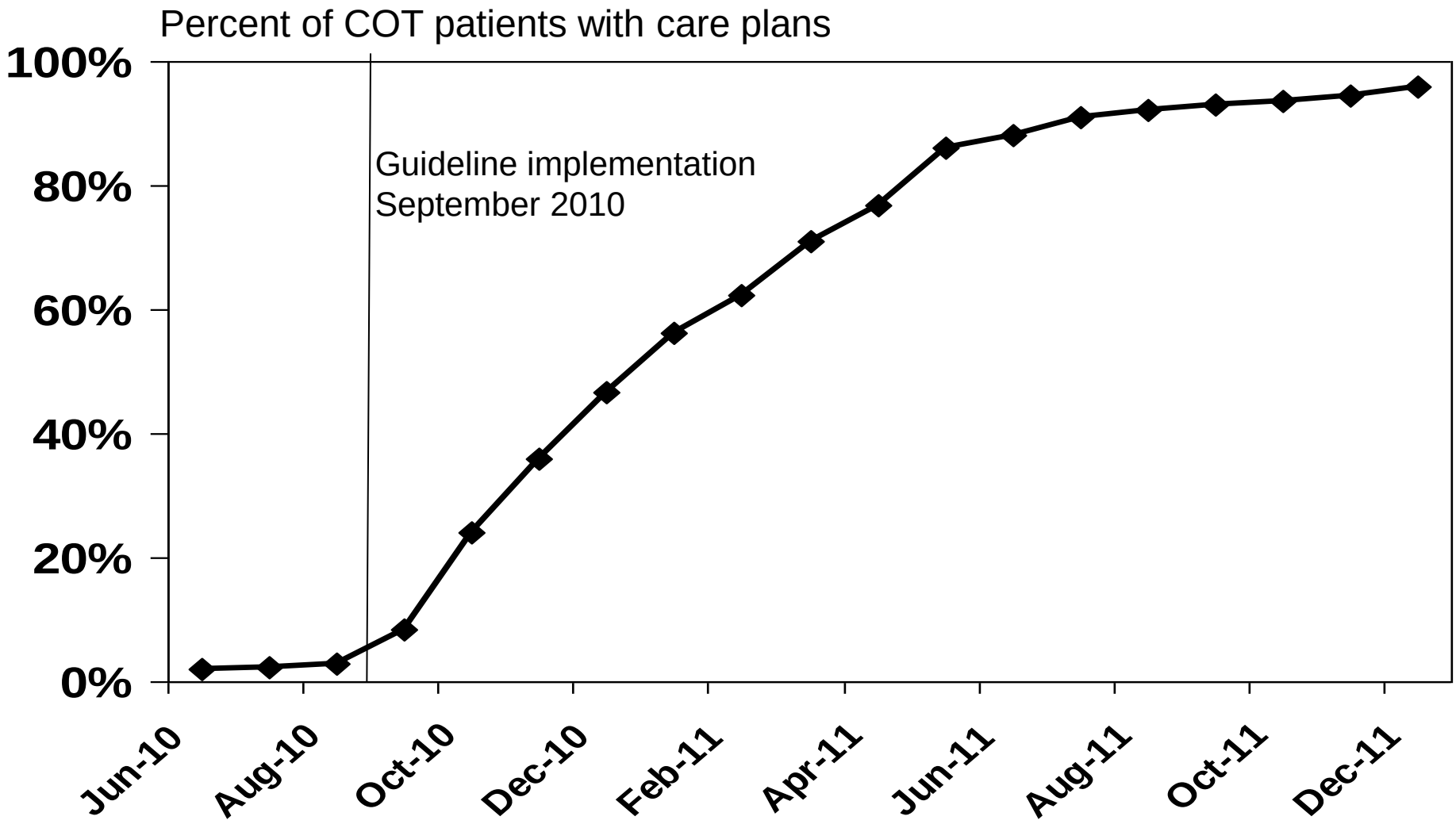

Trescott et al., Health Affairs, 2011

Urine drug screening rates, previously low, increased markedly with guideline implementation

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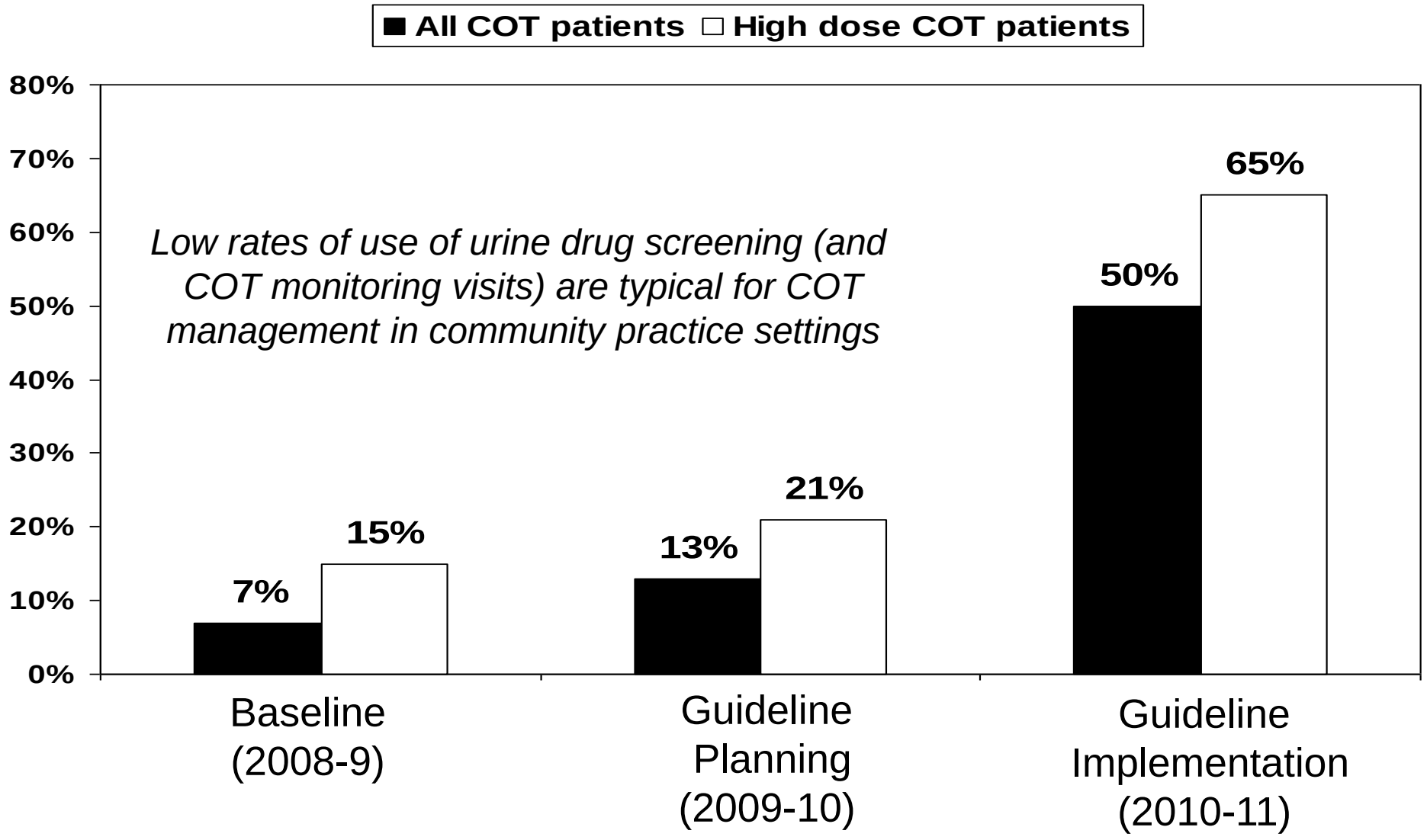

Take Home Ideas

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Find common ground with chronic pain patients by emphasizing concerns for their safety.

Medical staff leaders and consulting specialists: Advocate for change!

Translate guidelines into clinical policies and standard work.

Establish a registry, track performance measures, incentivize goal achievement.

Change shared expectations of clinicians.