Management of Chronic Opioid Therapy at The Everett Clinic…(the Journey)

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- June 12, 2015

Largest independent medical group in the Pacific Northwest

- **5th** largest private employer in county
- **9** locations throughout Snohomish County
- **>40** medical specialties
- **>500** Providers
- **>2,000** Employees
- **> 5,000** Patients under WC
- **>300,000** Patients all payers
- **>900,000** Annual visits

The Everett Clinic

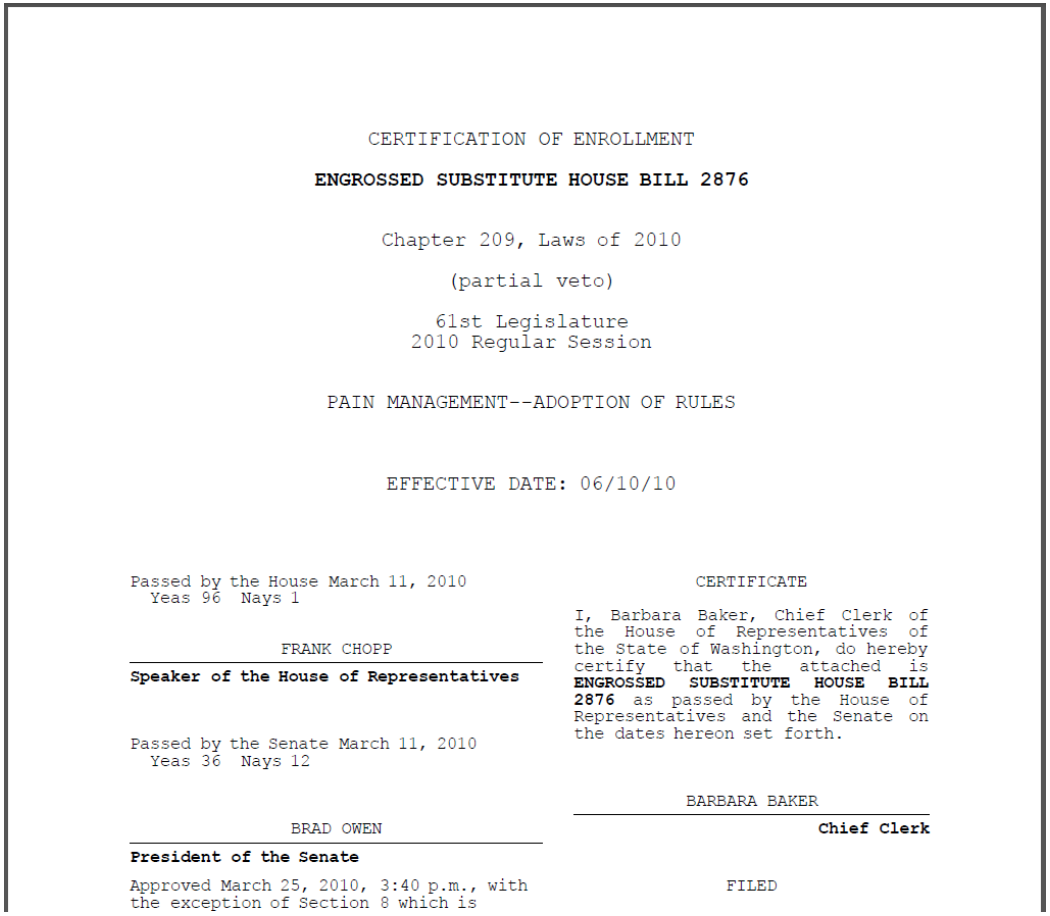
TEC has Core Values which:

- Inform our work
- Provide a moral compass
- Act as guiding principals

Our Core Purpose:

- To make lives better together through health and healing

2010: Landmark Legislation Work to do…



CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE HOUSE BILL 2876

Chapter 209, Laws of 2010

(partial veto)

61st Legislature
2010 Regular Session

PAIN MANAGEMENT--ADOPTION OF RULES

EFFECTIVE DATE: 06/10/10

Passed by the House March 11, 2010
Yeas 96 Nays 1

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 11, 2010
Yeas 36 Nays 12

BRAD OWEN

President of the Senate

Approved March 25, 2010, 3:40 p.m., with the exception of Section 8 which is

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE HOUSE BILL 2876** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

2011…TEC Chronic Controlled Substance Guideline and tools directed to physicians rolled out

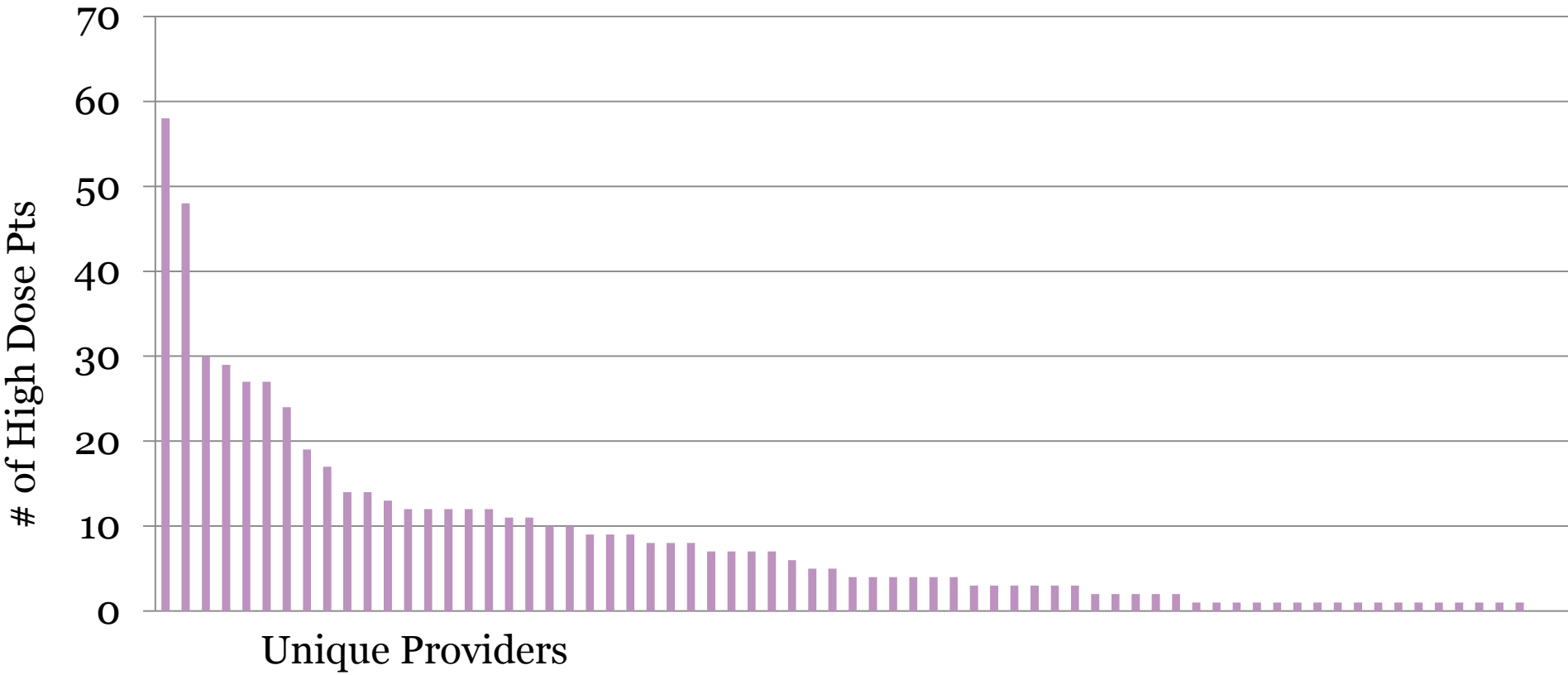
2012…Review of incorporation of these best practices revealed low adoption

Fourth Core Value…

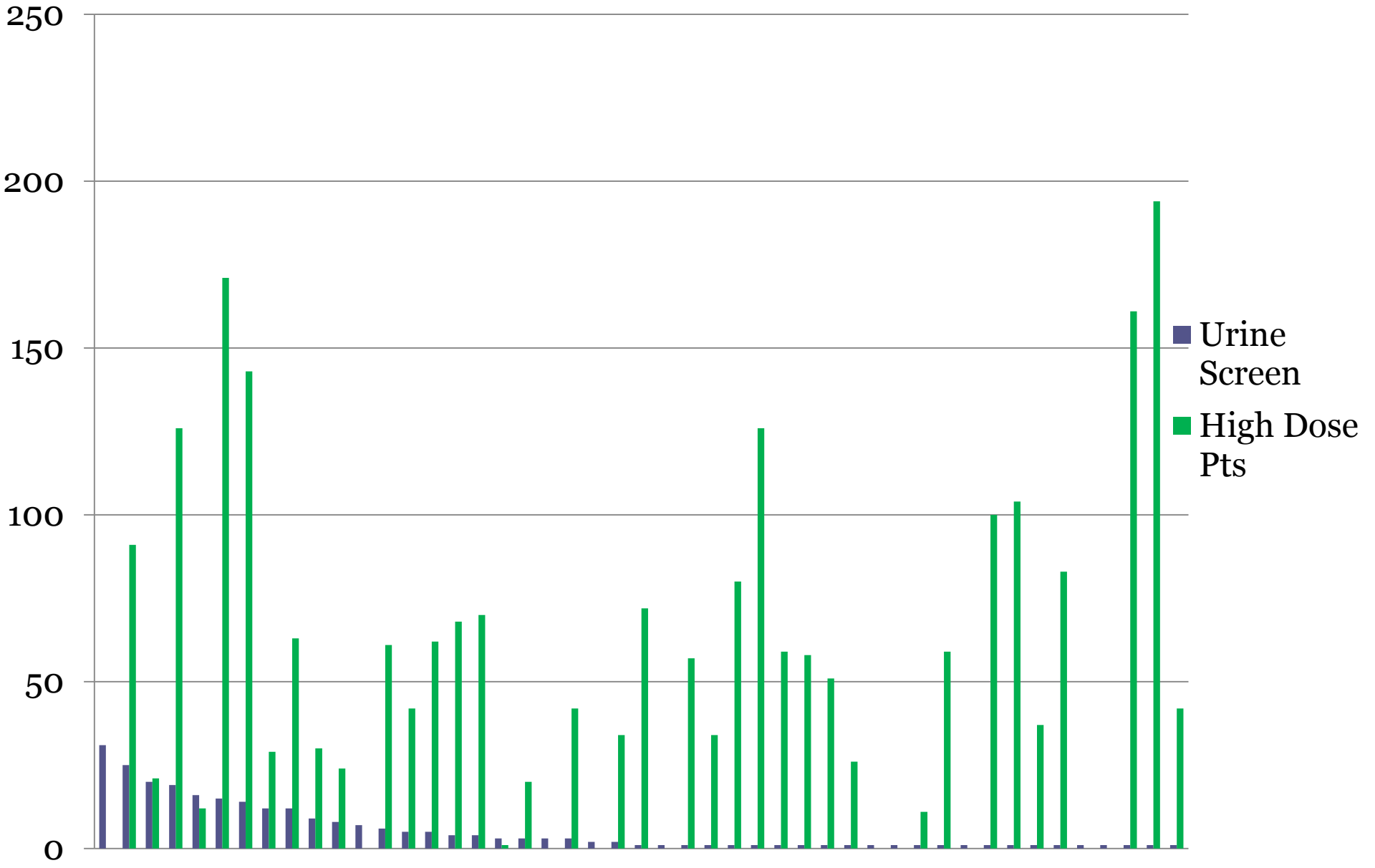
Manual audit of high dose prescribers:

Dec 2012

- Approximately 5000 patients on COT
- Max MEDs upper 2000's
- **High dose prescribers: 66**



Drug Screens versus # COT Patients (by Provider)



2012 Assessment: How were we really doing?

1. COT was not managed as a chronic disease state
2. Low use of problem list entry and corresponding plan
3. Low use of drug contract i.e. establishing agreement with patient
4. Low use of PMP
5. Low use of drug testing or wrong test ordered

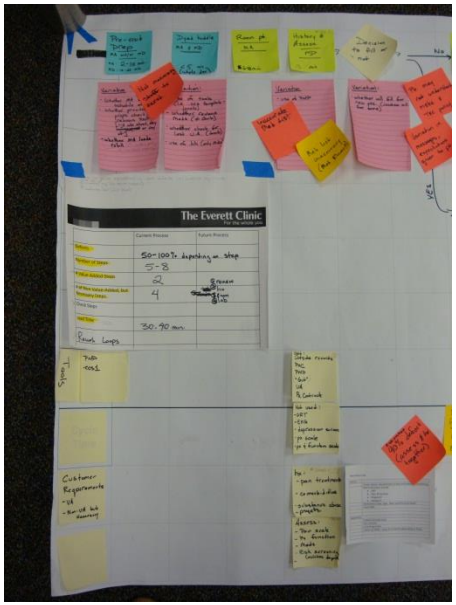
What was the problem?

1. Not “Doing the right thing for each patient”
2. Providers out of compliance with WA state law
3. Guideline (voluntary approaches in past without team approach): unsuccessful
4. Data mining capacity not in sync with regulatory environment (diagnostic codes, PMP)
5. Providers relying on judgment rather than data
6. Iatrogenic contribution to increased morbidity and decreased function
7. Potential increased cost of care
8. Increased organizational risk
9. Increased utilization of staff services

Plan/Do/Check/Act:

Baseline established then..

- Guideline revised to updated COT **policy**. Effective: November 2013
- Rapid Process Improvement Event: March 2014



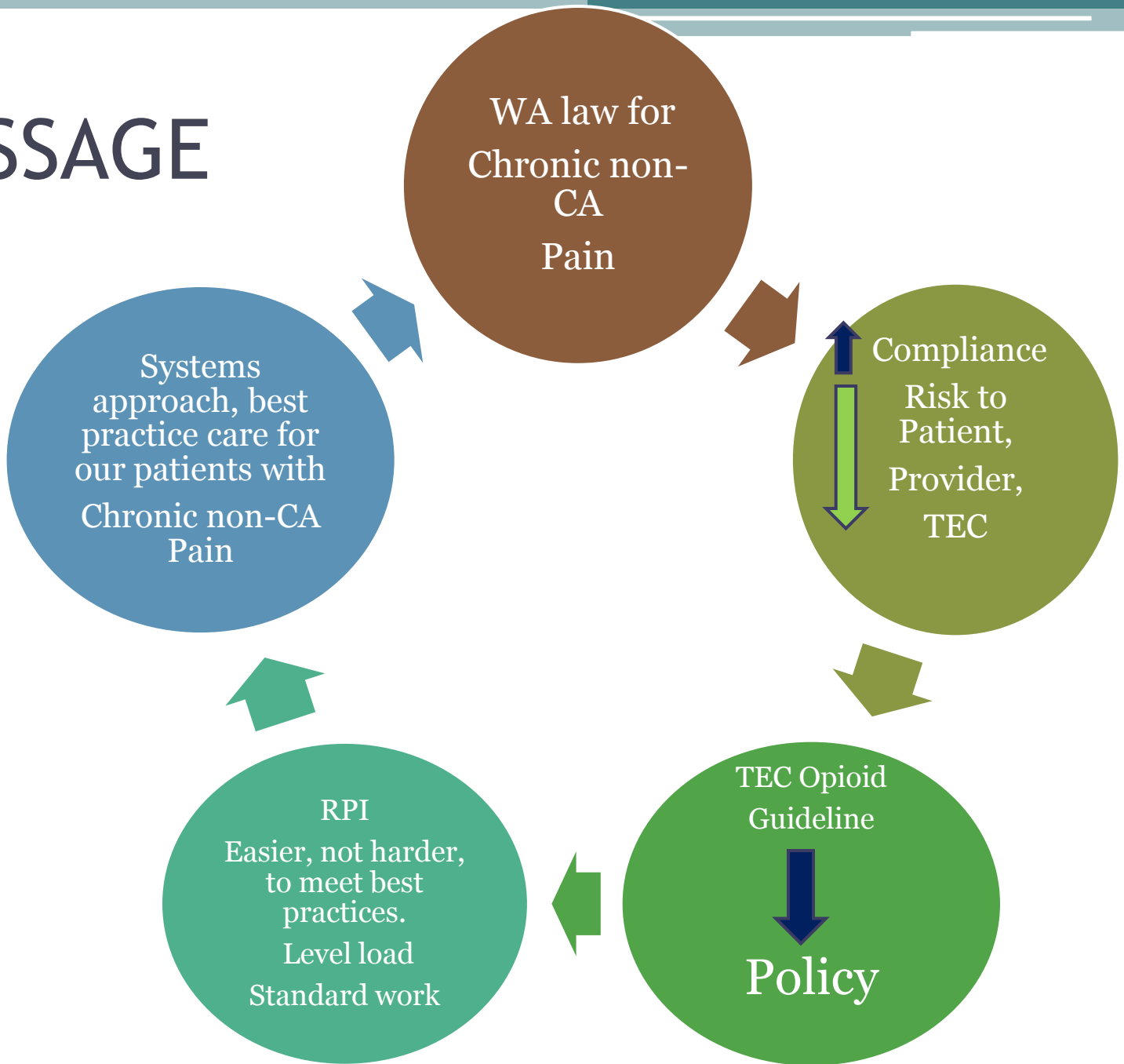
Initial Wins:

- Organizational support for change was key
- Reviewed prior opioid guideline and decided opioid **policy** needed instead (compliance with the law not optional)
- Switched drug testing labs for best value and clarity of reporting
- Explored other best practices: site visit, CME Measured our baseline
- Multidisciplinary lean work group created (RPI).
- Presented to various stakeholders for input: Ethics committee, WIC, primary care, ASC/surgery

And Finally…..

- COT policy training and updated tools with team engagement completed in Primary Care and Occupational Medicine Departments: July 2014

KEY MESSAGE


WA law for Chronic non-CA Pain
Compliance Risk to Patient, Provider, TEC
TEC Opioid Guideline
Policy
RPI
Easier, not harder, to meet best practices.
Level load
Standard work
Systems approach, best practice care for our patients with Chronic non-CA Pain

Key Elements

Clarity and teeth: Opioid Guideline became a ***Policy***

Created e-Tools

- ✓Templates
- ✓Educational materials/Resources for providers/patients
- ✓Intranet COT tool kit

Created process and standard work

- ✓ Level loaded
- ✓ Team engagement

Developed audit processes for Operations including gap report.

Core COT committee continues to meet for PDCA

Progress

Urine Drug Screens	2013	2014
Pain management panel, with GCMS confirmation	**1,019 (59%)**	**2,944**
Urine drug screen, rapid qualitative	714	849
Total	1,733	3,793 (↑220%)

Additional Successes

- Team management of COT
- Can better identify COT patients through problem list entry (46% and growing weekly) or via a gap report (still manual)
- Identified high prescribing providers to direct further mentoring
- Reset patient expectation for refills, new transfers into system
- Physician champions who take ownership
- *THE MOST SUCCESSFUL PROVIDERS EMPOWER THEIR TEAMS*

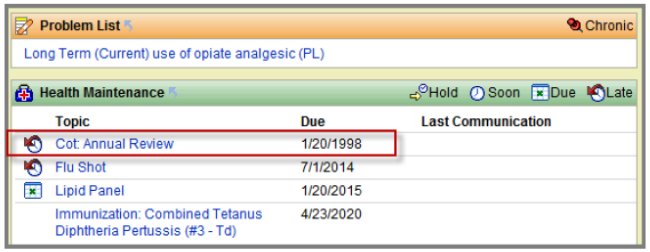
Job Aids – A Health Maintenance topic with an annual reminder….

Document Title: COT Pt. Visit Job Aid		Associated Standard Work #: SW-132	Department/Service Line: Primary Care	The Everett Clinic For the whole you. JOB AID
Date Effective: 4/21/14	**Date Revised:** **1/20/15**	**Date Reviewed:** 12/4/2014	**Owner:** Associate Administrator for Primary Care/ Medical Director	**Approved by:** Jeff Bissey, MD
Definition of Job Aid: *Shows or explains HOW to do the work. Visual snapshots, training documents, shortcuts, checklists and/or flow charts.*				

SCREEN SHOTS FOR STANDARD WORK

MA

1. Comb provider schedule up to 2 weeks out and daily prn
2. Identify COT (Chronic Opioid Therapy) patients by Snapshot and Med Drug Class or by COT prompt (COT Annual Review). All patients with Treatment Code of 1017 – Long Term (Current) use of opiate analgesic (PL) will have this automatically on their chart.



3. Edit Appointment notes or reason for visit- add COT identifier for recurring patient (if patient is new to TEC, provider responsible to complete)4. Review chart and PMP/screen for missing elements
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5. For Initial Visit, Reception give patient COT Assessment Questionnaire (form) now or MA gives after rooming (Step 10)
6. Load COT Smartset and review HM due – only one. May choose Full documentation (COT Full Soap Note) or only the subjective part (COT HH pain)

Landmines

- Provider variation: *requires quality improvement pathway for outliers*
- Sustaining use of best practices: *staff role in developing new routines*
- COT process adding more time to visit for the team (*10-15 min*)
- Audit process not yet automated *adding to busy managers' task lists*
- Changing patient expectations while honoring patient dignity/satisfaction

Opportunities:

- Higher organizational visibility for Chronic Pain
- Develop and evolve pain ecosystem within integrated ambulatory care system (TEC)
- Address BH comorbidities (PC/BH integration)

Becoming part of the solution, not part of the problem

Words of Advice…..

Focus on Lean processes and Level Loading with Patient and Healthcare Team Engagement
Organizational initiative

It’s a marathon, not a sprint- be prepared

Future Steps