Opioid Stewardship
Davies Presentation

Todd Burstain, MD
CMIO
Ochsner Health Systems

Deborah Simonson, Pharm D.
Vice President, Pharmacy
Ochsner Health Systems

Richard Guthrie, MD
Chief Quality Officer
Ochsner Health Systems

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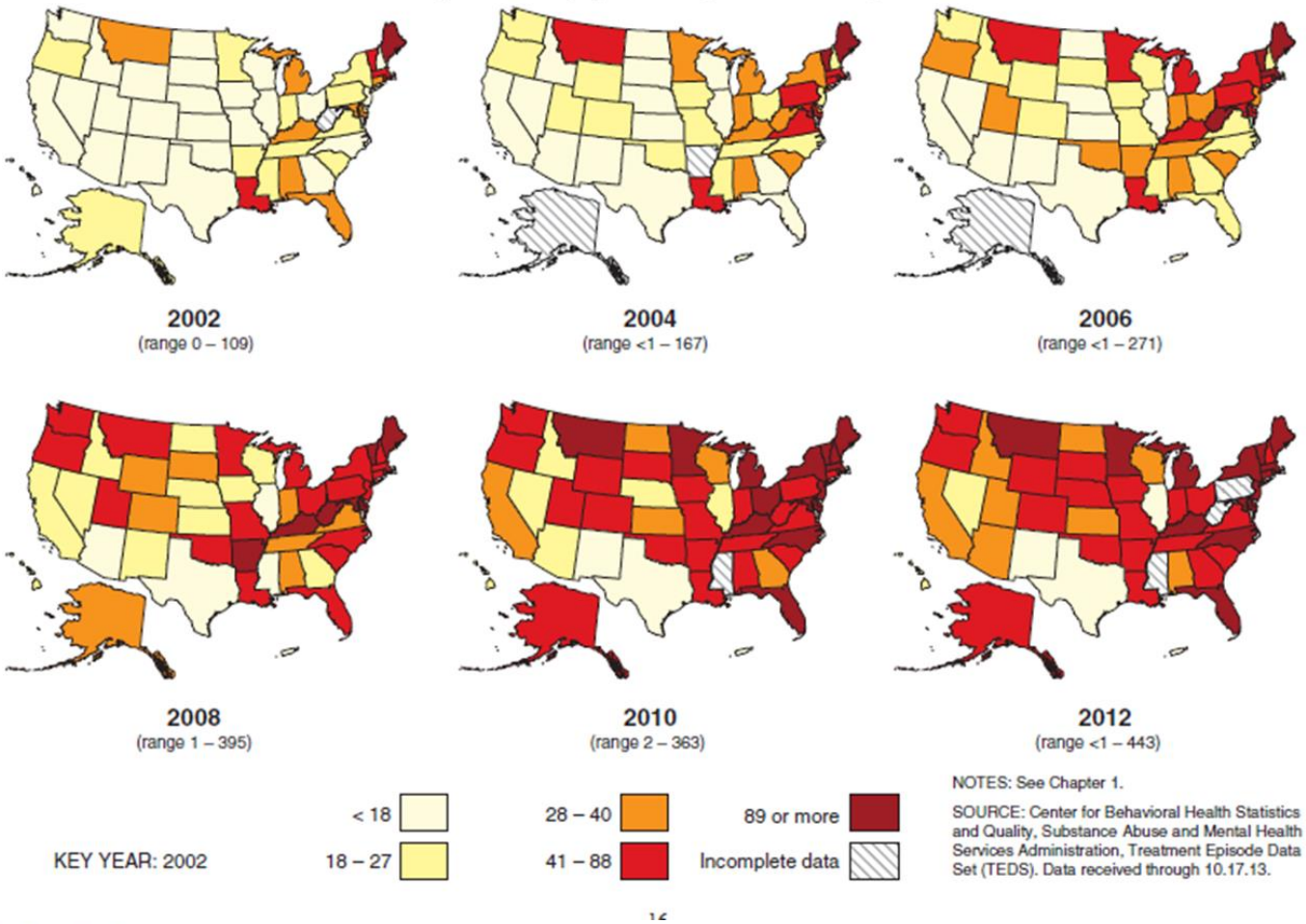
The Start of an Epidemic

Figure 7. Primary non-heroin opiates/synthetics admission rates, by state or jurisdiction: 2002-2012
(per 100,000 population aged 12 and older)



NOTES: See Chapter 1.

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.17.13.

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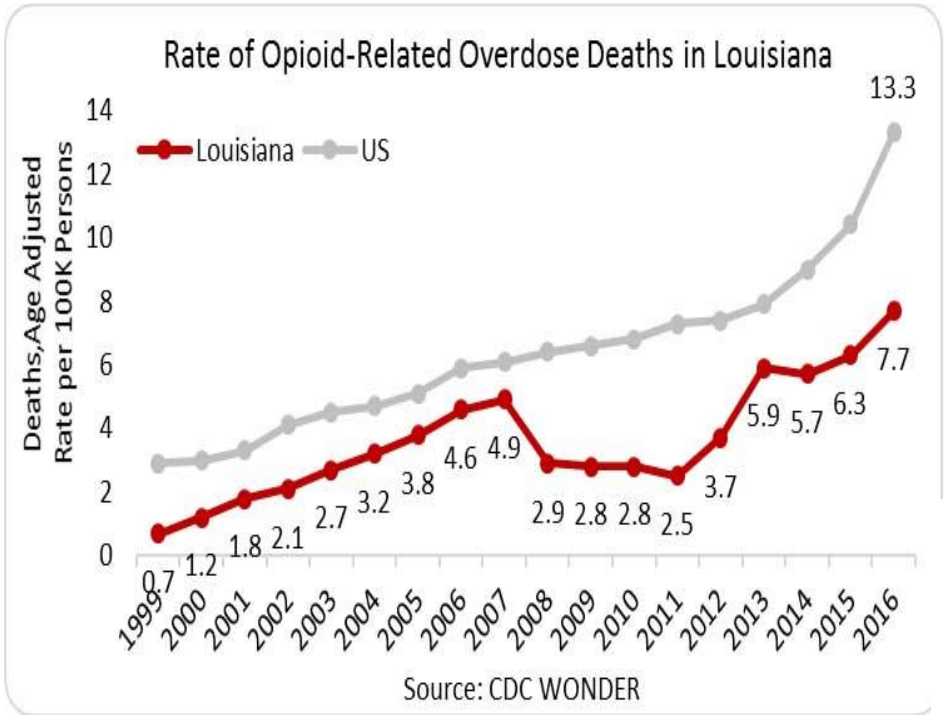
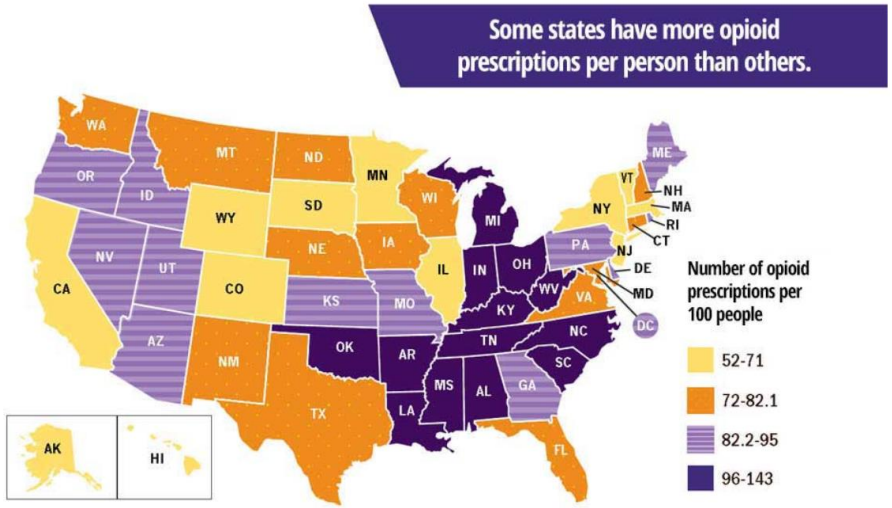
The Opioid Crisis – Nationally and Locally



- **63,632 Americans died in 2016 from Drug Overdose**
- **66% from prescription/illicit opioids**
- **Prescription opioid overdose death rate up 10.6% (2015-6)**
- **21-29% of patients given opioids for chronic pain end up misusing them**
- **80% of patients abusing Heroin began with abusing prescription opioids**
- **2003 to 2013 Neonatal Abstinence Syndrome in La increased by 380%**
- **Economic cost to US over $78 billion/year**
- **Deaths from overdose > homicide in Orleans Parish 2016**
- **6th highest rx/pt in US in LA at 1.02 rx/person in state**



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Opioid Crisis at Ochsner

- **Slow steady rise in opiate prescription**
- **Values – Patient First, Compassion, Integrity, Excellence and Teamwork**
- **Mission – Heal, Serve, Lead, Educate and Innovate**
- **Vision – "leader who will change and save lives"**

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Overall Strategy

- Build Governance Structure
- Educate Providers and Patients
  - Why is it important
  - What is best practice
- Provide analytic feedback data
  - Target Key areas
- Build Best Practice into Epic
  - Hardwire workflows
  - Intelligent Decision Support
- Develop Community Resources
- Report on Success of Intervention

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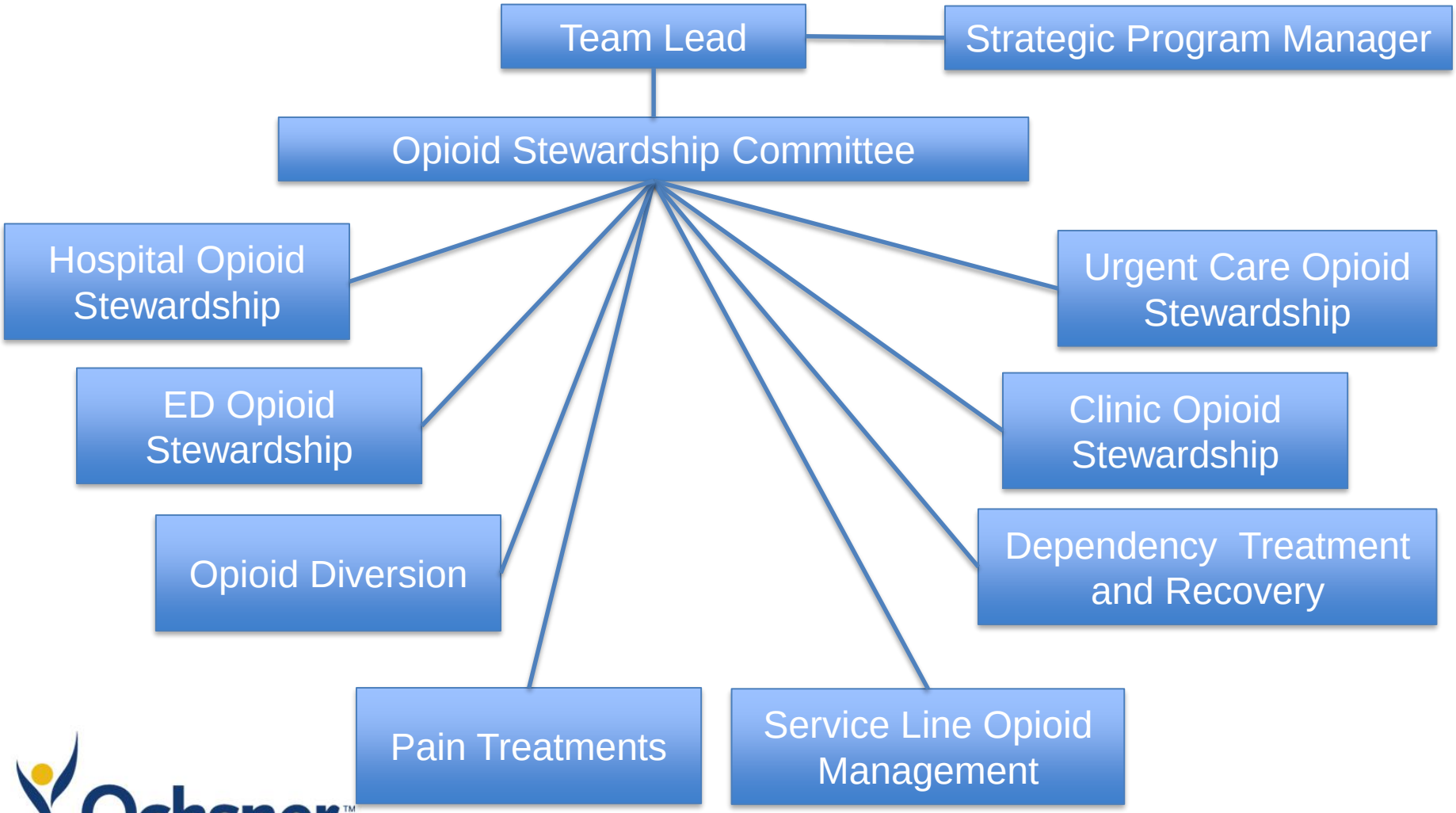
The Ochsner Opioid Stewardship Team



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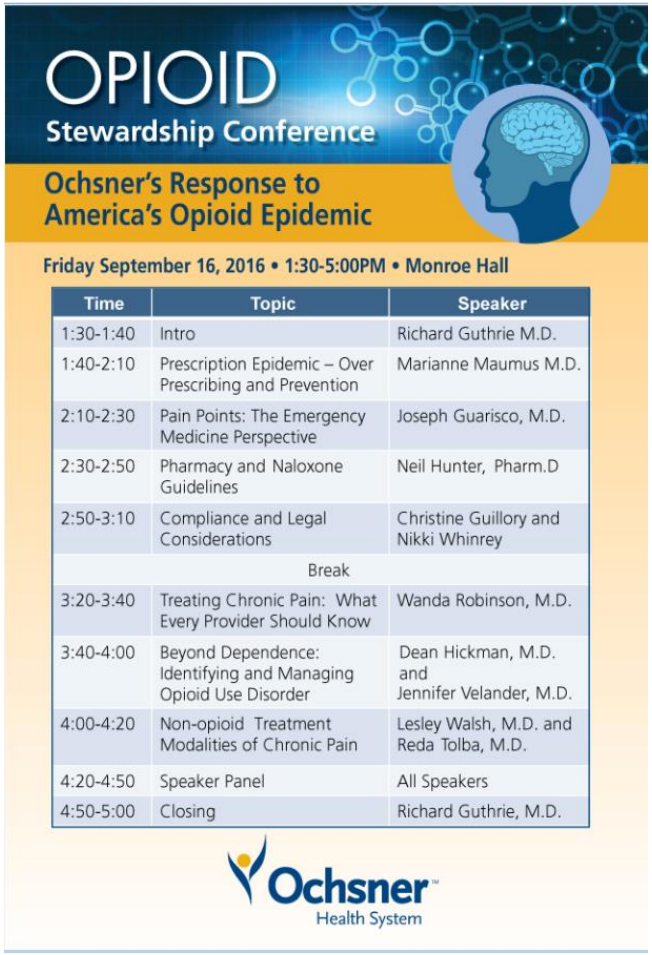
Building up the volume



OPIOID
Stewardship Conference

Ochsner's Response to America's Opioid Epidemic

Friday September 16, 2016 • 1:30-5:00PM • Monroe Hall

Time	Topic	Speaker
1:30-1:40	Intro	Richard Guthrie M.D.
1:40-2:10	Prescription Epidemic – Over Prescribing and Prevention	Marianne Maumus M.D.
2:10-2:30	Pain Points: The Emergency Medicine Perspective	Joseph Guarisco, M.D.
2:30-2:50	Pharmacy and Naloxone Guidelines	Neil Hunter, Pharm.D
2:50-3:10	Compliance and Legal Considerations	Christine Guillory and Nikki Whinrey
	Break	
3:20-3:40	Treating Chronic Pain: What Every Provider Should Know	Wanda Robinson, M.D.
3:40-4:00	Beyond Dependence: Identifying and Managing Opioid Use Disorder	Dean Hickman, M.D. and Jennifer Velander, M.D.
4:00-4:20	Non-opioid Treatment Modalities of Chronic Pain	Lesley Walsh, M.D. and Reda Tolba, M.D.
4:20-4:50	Speaker Panel	All Speakers
4:50-5:00	Closing	Richard Guthrie, M.D.

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Patient and Provider Education

Ochsner Emergency Department provides pain relief options that are safe and appropriate.

For your safety, we DO NOT:

- ☒ Prescribe long-acting opioid painkillers such as oxycodone, morphine, fentanyl patches or methadone.
- ☒ Prescribe more than a short course of opioid painkillers—3 days in most cases.
- ☒ Refill lost, stolen or destroyed prescriptions.

Item: S6141
Revised: 07/2016

Did You Know?

- Opioid painkillers can be as dangerous as illegal drugs.
- People can become addicted to opioid painkillers.
- Opioid painkillers can cause increased sensitivity to pain.
- An overdose of opioid painkillers can cause a person to stop breathing and die.

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Healthcare With Peace Of Mind

Keep your prescription opioid painkillers safe!

Ochsner Provides Safer, More Effective Pain Management.

Your Primary Care Team is committed to your safety by:

- following evidence-based medicine in the treatment of chronic pain conditions.
- evaluating possible dependency by using an Opioid Risk Assessment tool.
- providing education on opioid dangers and alternative pain treatment options.

Did you know?

As many as

1 out of 4

people

receiving prescription opioids long-term in a primary care setting struggle with addiction.

Discuss all risks of opioid treatment and therapy with your doctor.

Item:
Revised: 06/2017

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Healthcare With Peace Of Mind

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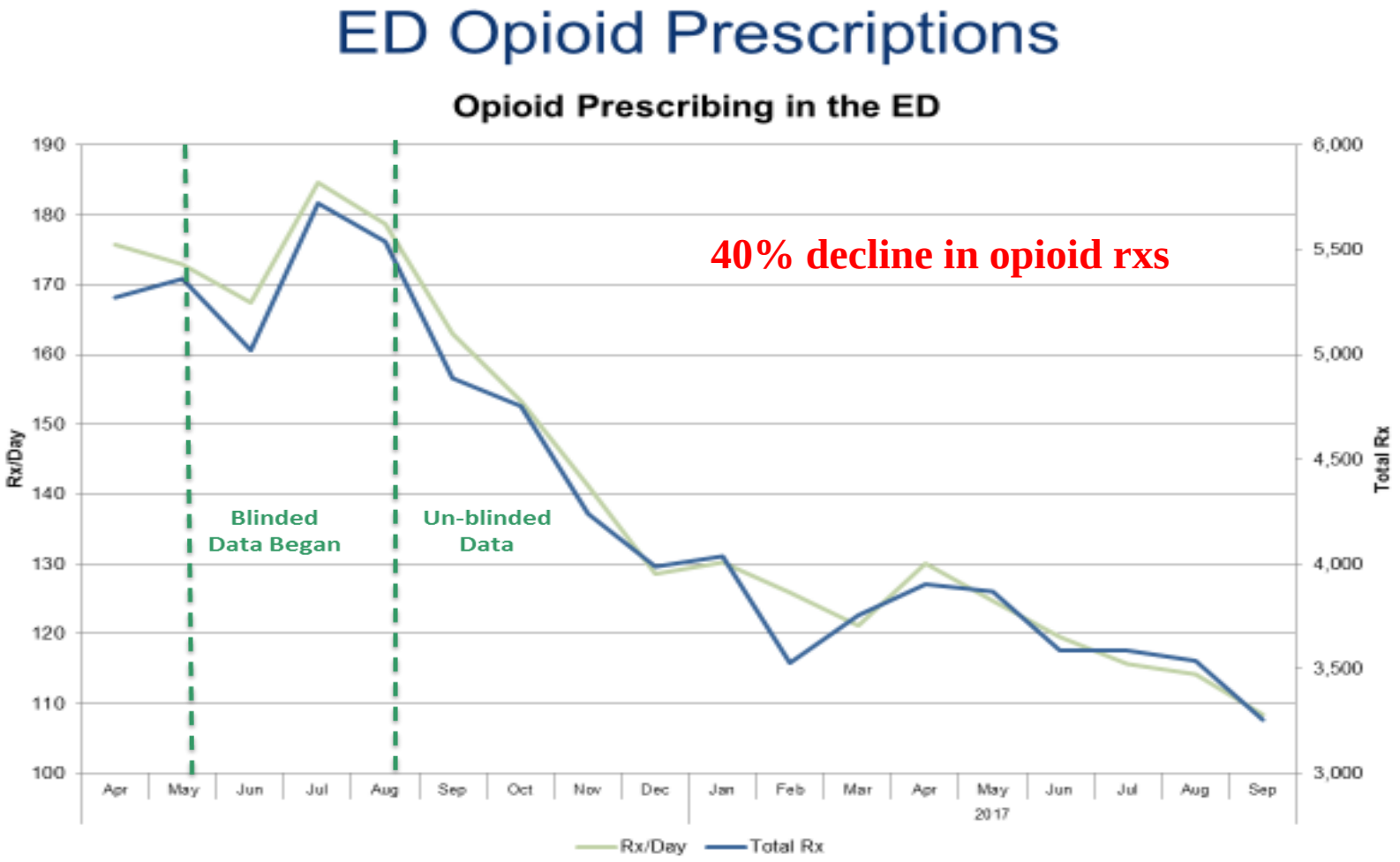
First Blinded data, then remove the blindfolds



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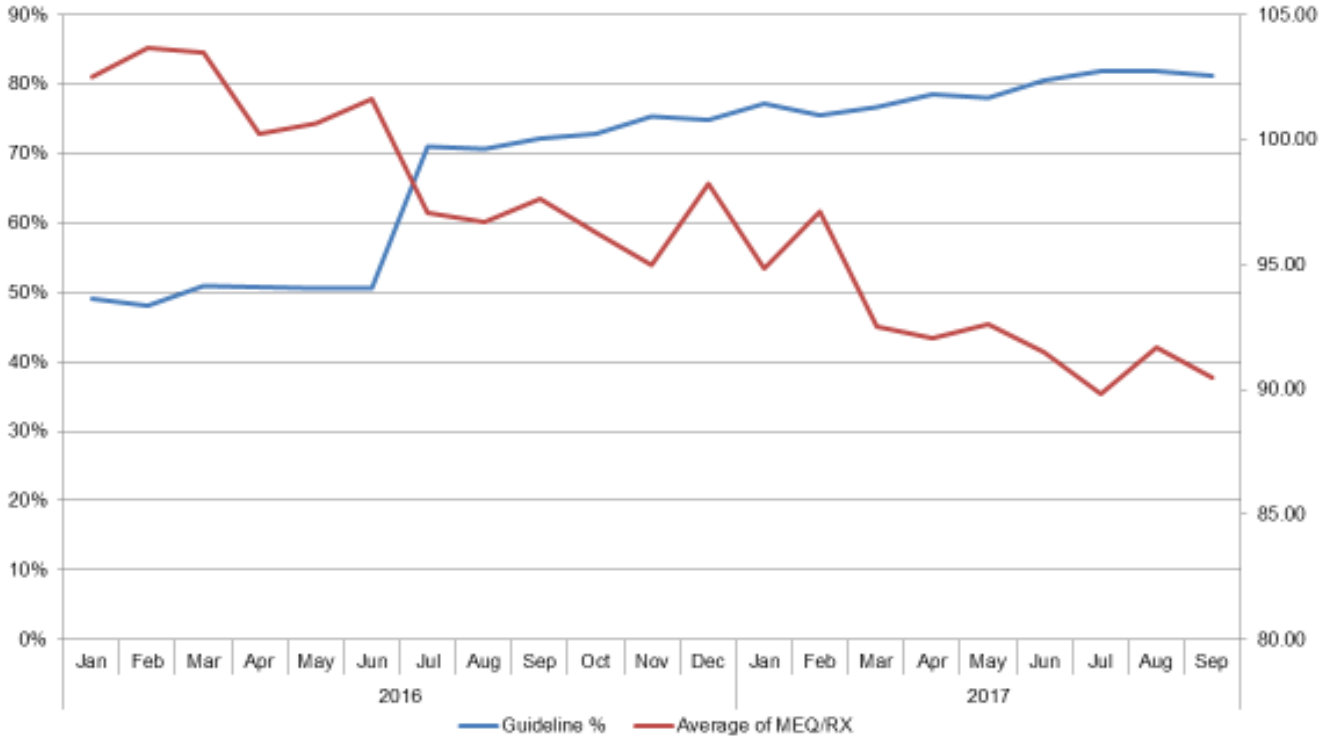
MEQ/Rx and % following guideline (3d/rx)

ED Alignment To Guidelines



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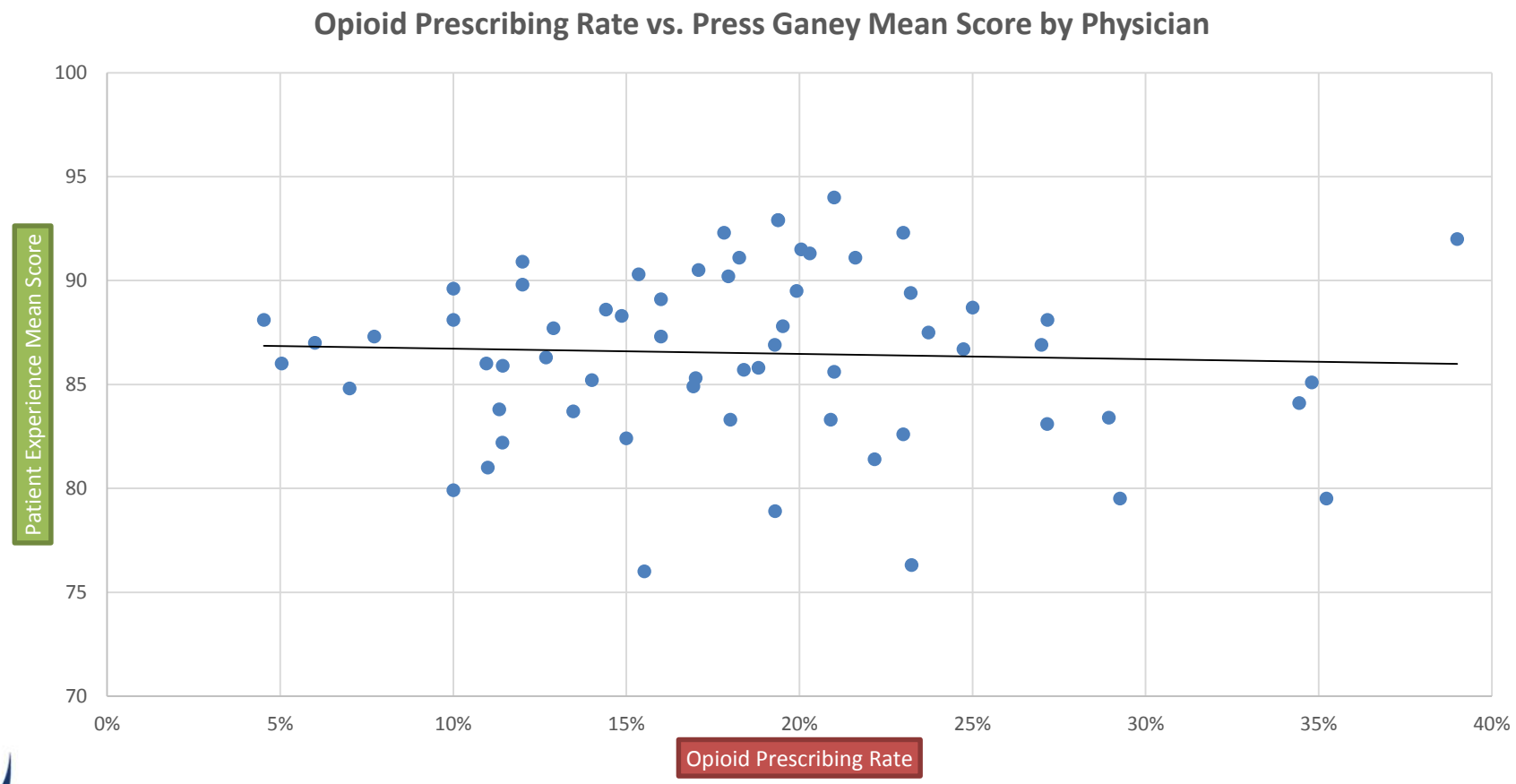
Initial Resistance: HCAHPS

Physicians Who Prescribe Less Have Same Patient Experience



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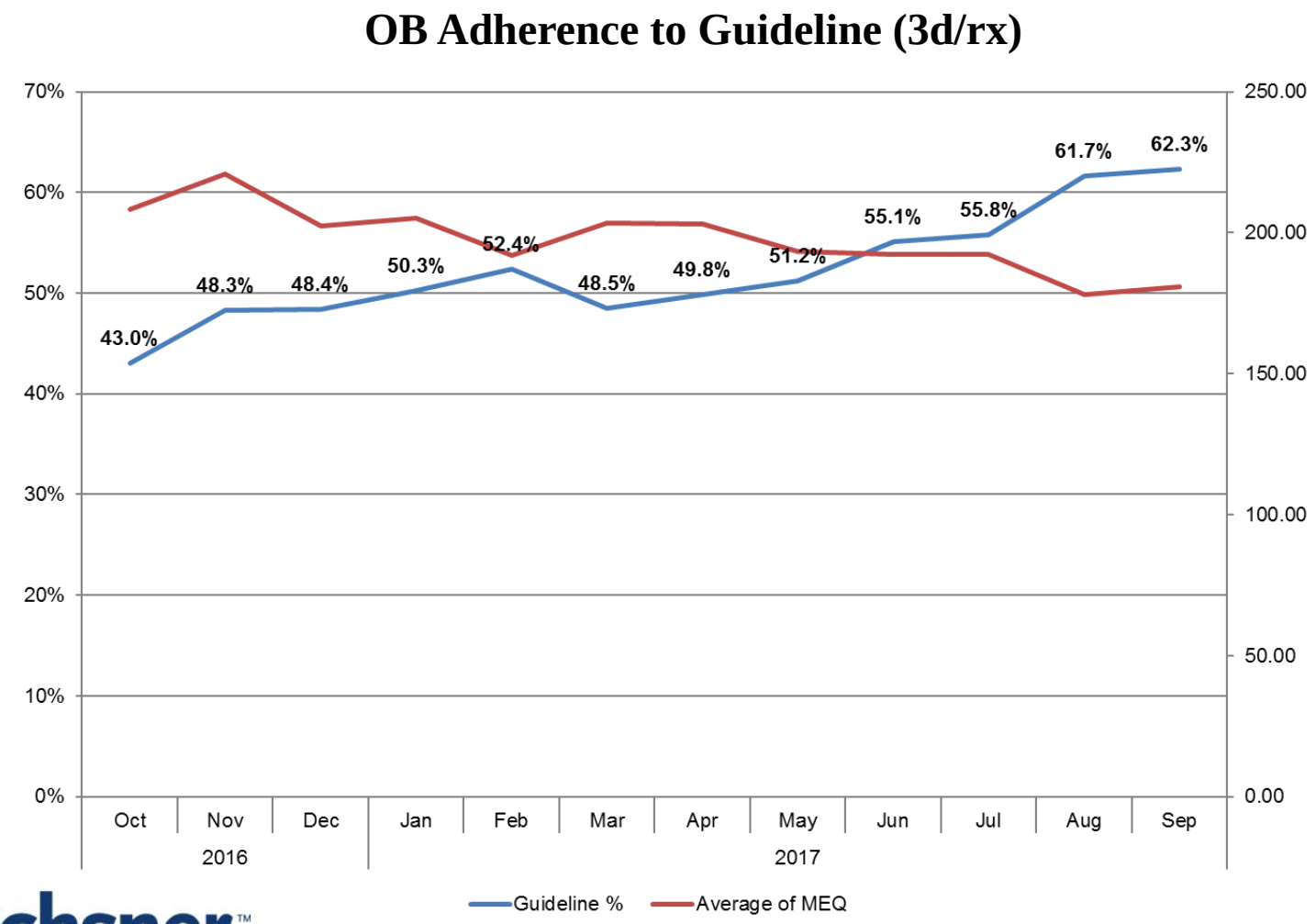
To Ease Fears, Removed Patient Satisfaction for Pain Despite Lack of Correlation

Expand the Pilot – Inpatient OB discharges
Hardwire into D/C Ordersets



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Not just less prescribing, better prescribing

- Identify low risk vs high risk patients
- What did literature say
- Design best way to monitor patients getting opioids
  - Minimize risk
  - Monitor for misuse
  - Communicate expectations with patients
- Hardwire best practices into workflow
- Monitor results and provide feedback

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Can we identify who is at risk for misuse?

- Opioid Risk Tool Questionnaire – University of Utah
  - 5.6% of low risk patients developed misuse of opioid
  - 90.9% of high risk patients developed misuse of opioids
  - Coefficient 0.82 for males, 0.85 for females

Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool FREE

Lynn R. Webster, MD ✉, Rebecca M. Webster

Pain Medicine, Volume 6, Issue 6, 1 November 2005, Pages 432–442,
https://doi.org/10.1111/j.1526-4637.2005.00072.x
Published: 02 December 2005

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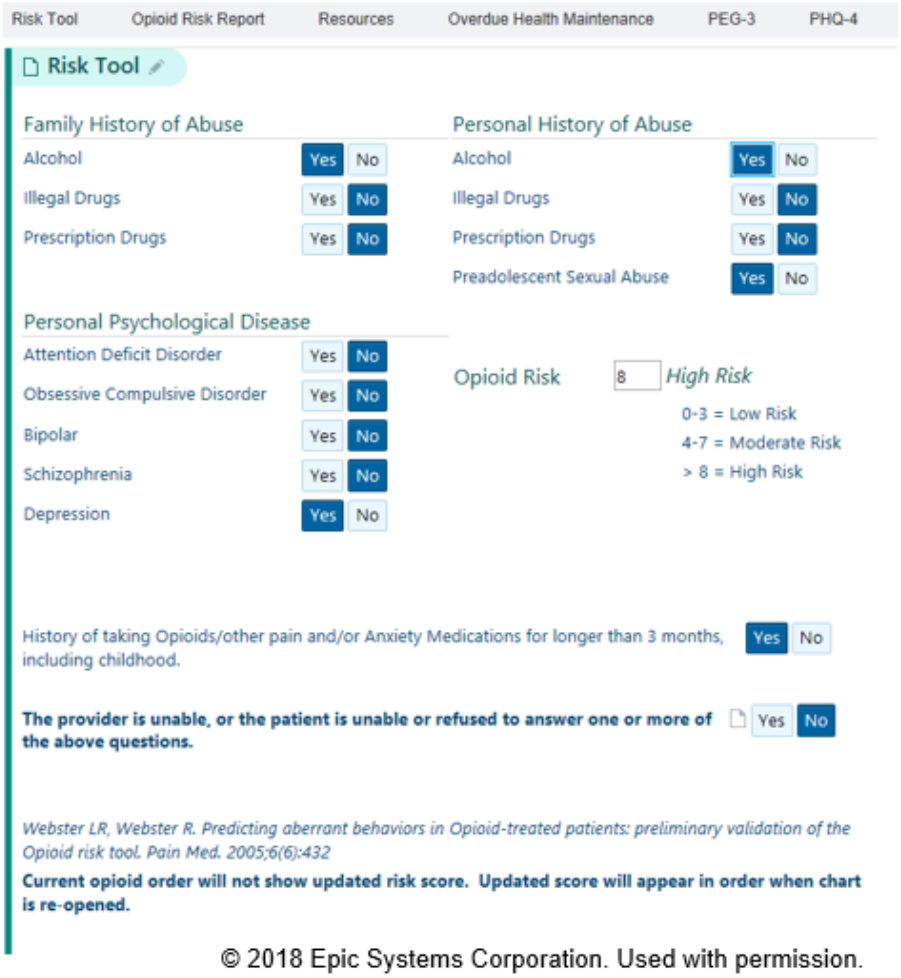
Custom Built Opioid Management Activity in Epic



Minimize End User Data Entry

Auto Flags based on Problem List

Auto Flags based on Family Hx

Auto Flags based on Social Hx

Differentiates between validated and non-validated scores

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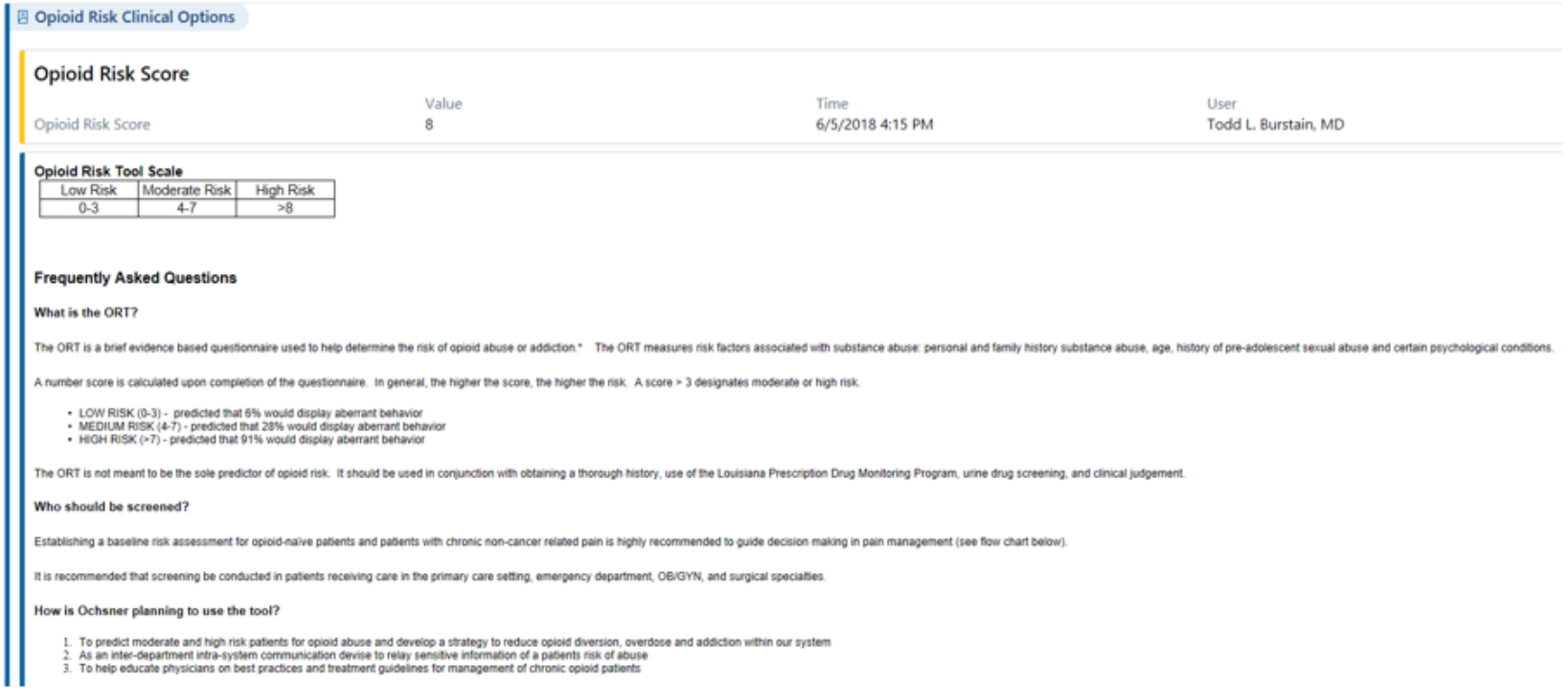
Opioid Risk Tool Report and Explanation



Opioid Risk Clinical Options

Opioid Risk Score

	Value	Time	User
Opioid Risk Score	8	6/5/2018 4:15 PM	Todd L. Burstain, MD

Opioid Risk Tool Scale

Low Risk	Moderate Risk	High Risk
0-3	4-7	>8

Frequently Asked Questions

What is the ORT?

The ORT is a brief evidence based questionnaire used to help determine the risk of opioid abuse or addiction.* The ORT measures risk factors associated with substance abuse: personal and family history substance abuse, age, history of pre-adolescent sexual abuse and certain psychological conditions.

A number score is calculated upon completion of the questionnaire. In general, the higher the score, the higher the risk. A score > 3 designates moderate or high risk.

- LOW RISK (0-3) - predicted that 6% would display aberrant behavior
- MEDIUM RISK (4-7) - predicted that 28% would display aberrant behavior
- HIGH RISK (>7) - predicted that 91% would display aberrant behavior

The ORT is not meant to be the sole predictor of opioid risk. It should be used in conjunction with obtaining a thorough history, use of the Louisiana Prescription Drug Monitoring Program, urine drug screening, and clinical judgement.

Who should be screened?

Establishing a baseline risk assessment for opioid-naïve patients and patients with chronic non-cancer related pain is highly recommended to guide decision making in pain management (see flow chart below).

It is recommended that screening be conducted in patients receiving care in the primary care setting, emergency department, OB/GYN, and surgical specialties.

How is Ochsner planning to use the tool?

1. To predict moderate and high risk patients for opioid abuse and develop a strategy to reduce opioid diversion, overdose and addiction within our system
2. As an inter-department intra-system communication devise to relay sensitive information of a patients risk of abuse
3. To help educate physicians on best practices and treatment guidelines for management of chronic opioid patients

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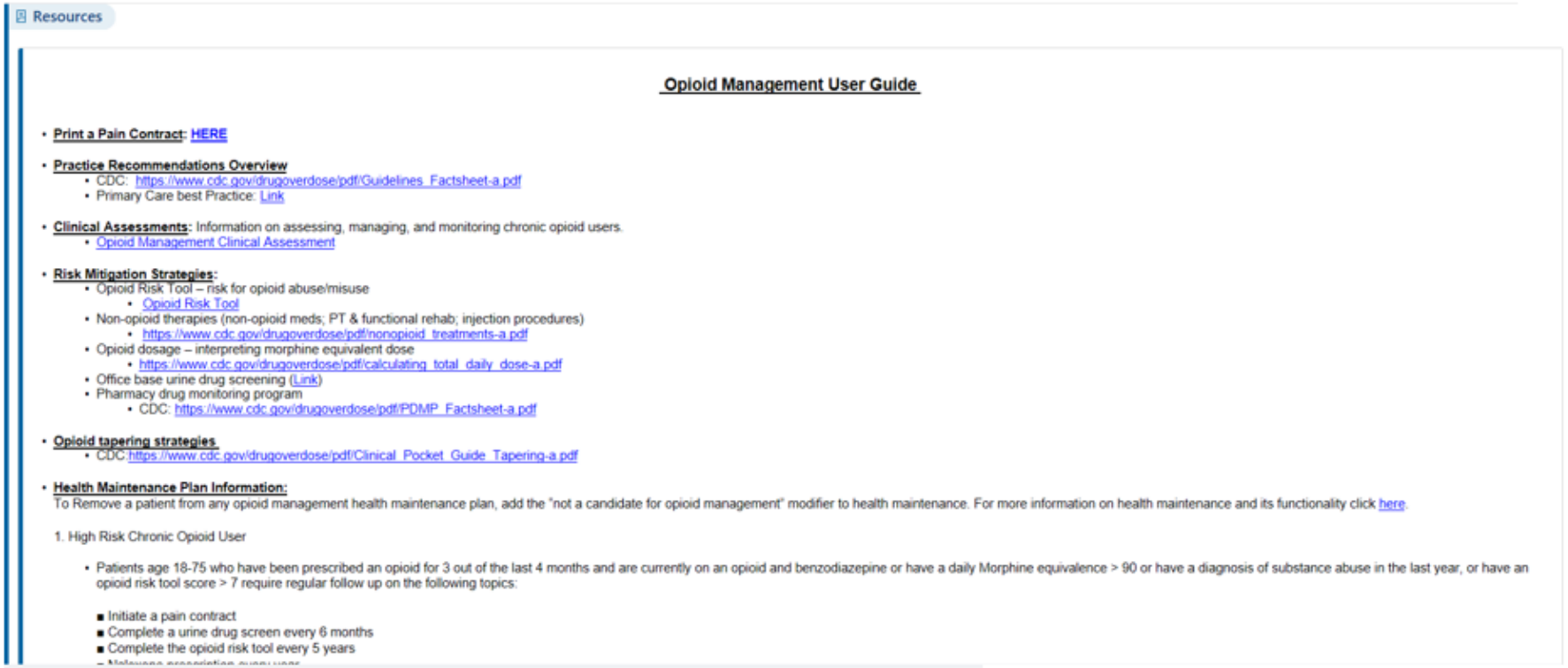
Opioid Management Tool - Resources



Resources

Opioid Management User Guide

- **Print a Pain Contract:** HERE
- **Practice Recommendations Overview**
  - CDC: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf
  - Primary Care best Practice: Link
- **Clinical Assessments:** Information on assessing, managing, and monitoring chronic opioid users.
  - Opioid Management Clinical Assessment
- **Risk Mitigation Strategies:**
  - Opioid Risk Tool – risk for opioid abuse/misuse
    - Opioid Risk Tool
  - Non-opioid therapies (non-opioid meds; PT & functional rehab; injection procedures)
    - https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf
  - Opioid dosage – interpreting morphine equivalent dose
    - https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf
  - Office base urine drug screening (Link)
  - Pharmacy drug monitoring program
    - CDC: https://www.cdc.gov/drugoverdose/pdf/PDMP_Factsheet-a.pdf
- **Opioid tapering strategies**
  - CDC:https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf
- **Health Maintenance Plan Information:**

To Remove a patient from any opioid management health maintenance plan, add the "not a candidate for opioid management" modifier to health maintenance. For more information on health maintenance and its functionality click here.

1. High Risk Chronic Opioid User

- Patients age 18-75 who have been prescribed an opioid for 3 out of the last 4 months and are currently on an opioid and benzodiazepine or have a daily Morphine equivalence > 90 or have a diagnosis of substance abuse in the last year, or have an opioid risk tool score > 7 require regular follow up on the following topics:

  - Initiate a pain contract
  - Complete a urine drug screen every 6 months
  - Complete the opioid risk tool every 5 years

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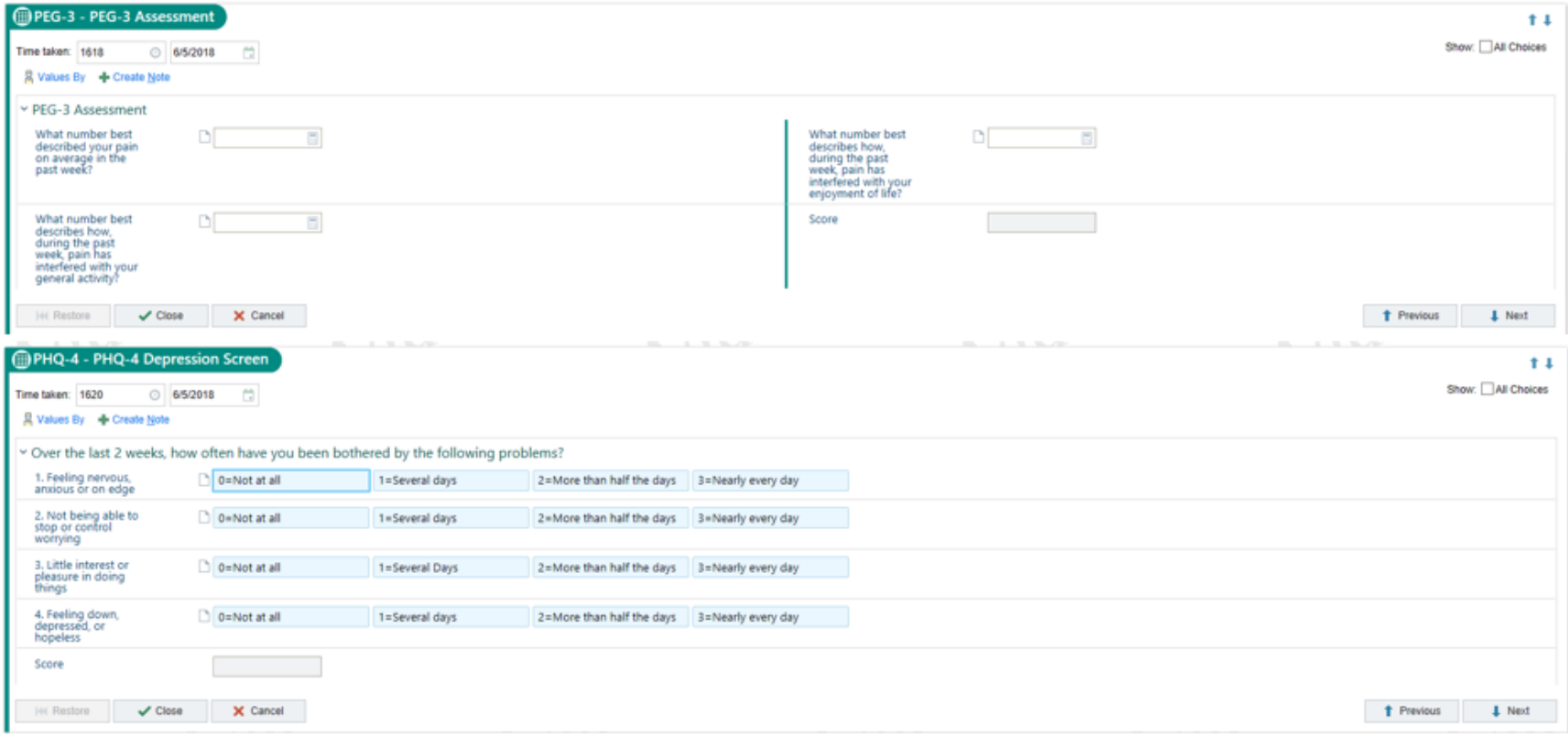
Direct Links to Patient Assessment
PEG 3 and PHQ 4



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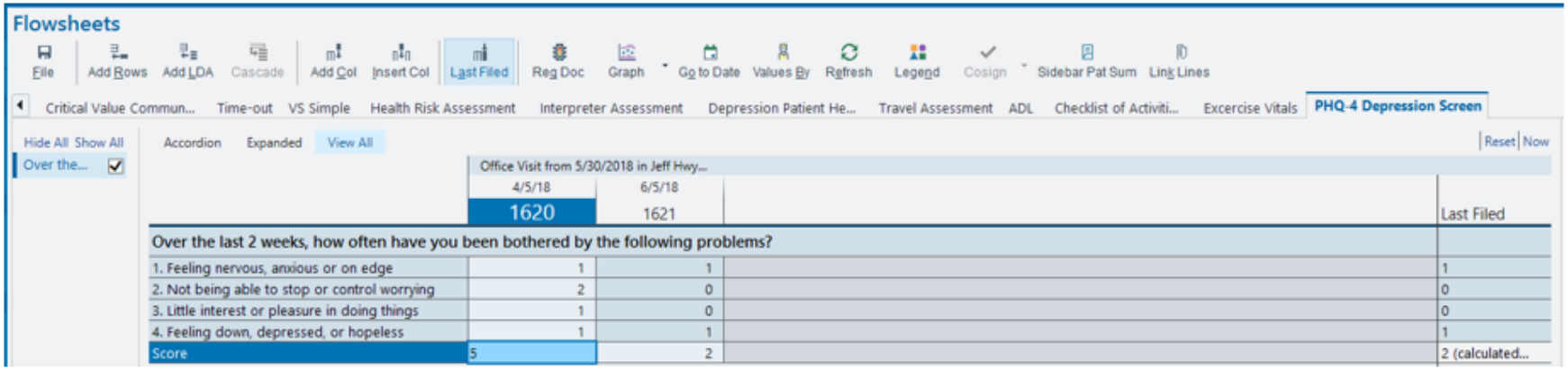
Tracking over Time



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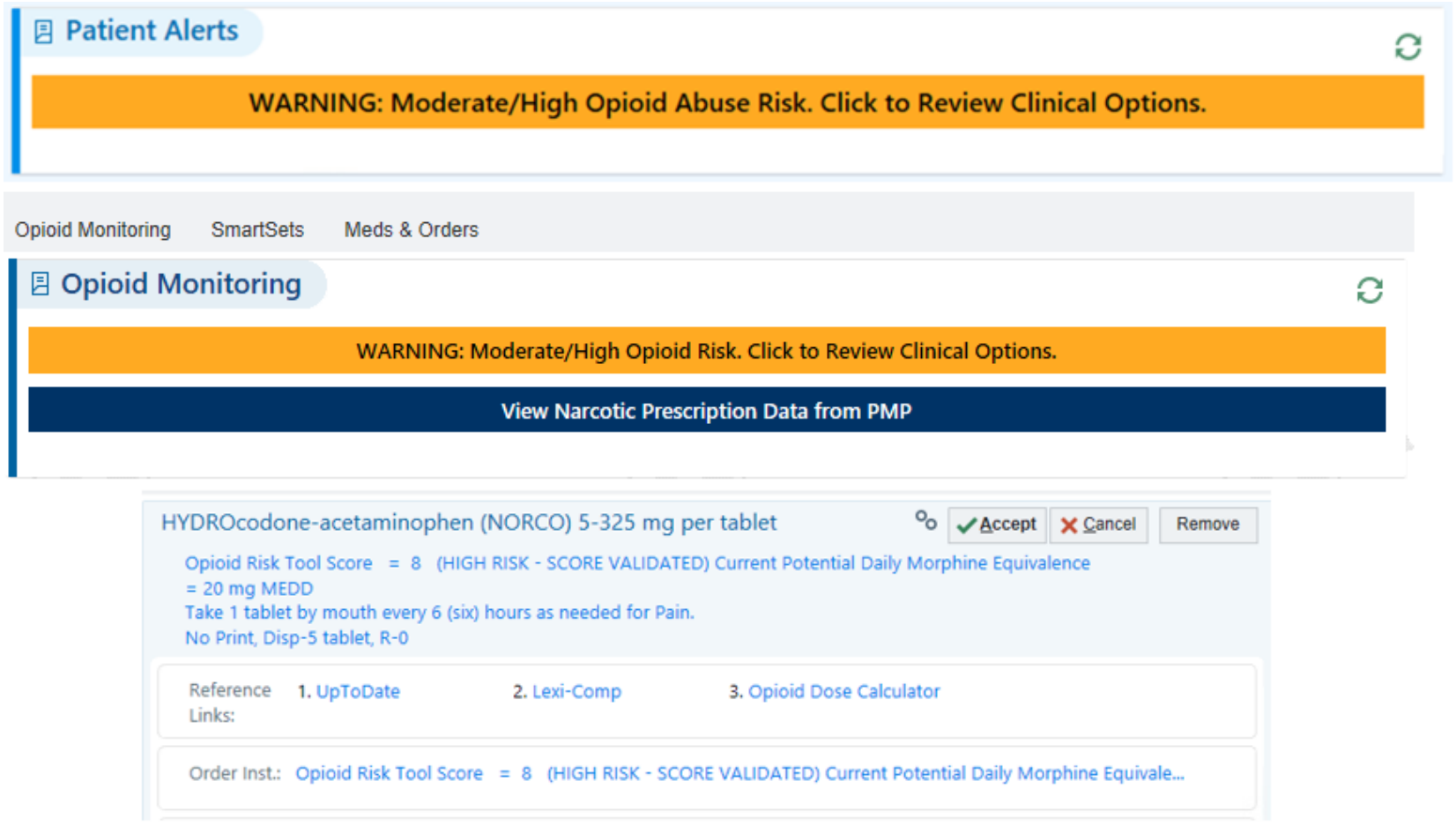
Displaying the Score to End User



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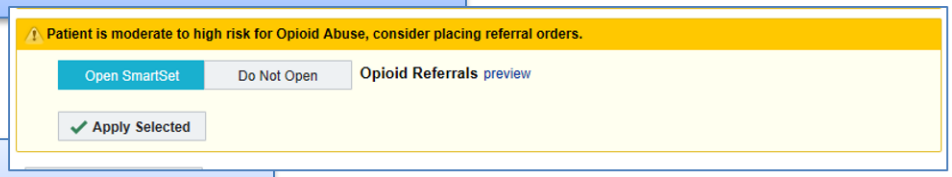
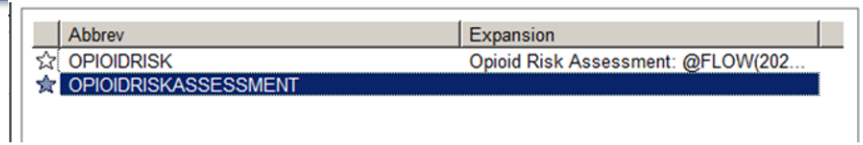
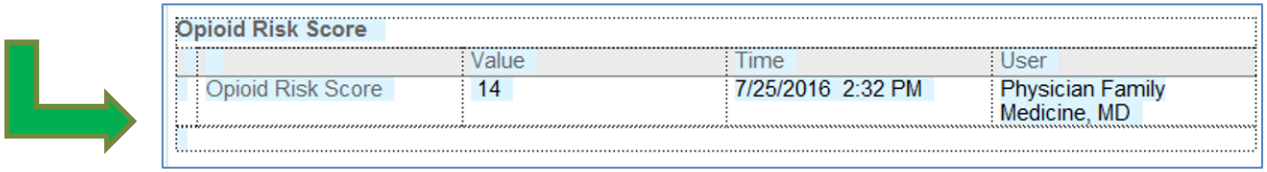
Epic Referrals and Documentation

BPA for mod/high risk patients for placing referral orders



Smartphrase to pull documentation into note





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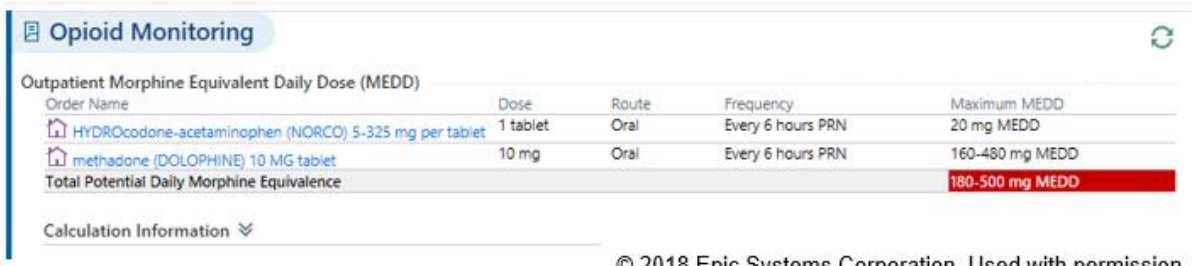
How strong is that prescription?

- Concept of Morphine Equivalents Daily Dose (MEDD)
- Issues of prn sig on prescriptions
- Complexities of Methadone in MEDD



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Best Practice of Care Based on Risk

- Separating acute from chronic users
- Minimizing Risk
  - Naloxone Prescription
  - Opioid Risk Tool Evaluation
- Monitoring Compliance
  - Urine Drug Screens
- Communicating Expectations with Patients
  - Pain Contracts
- Using tools End Users Familiar With – Health Maintenance

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Separating Acute from Chronic Users

- Rule based on 3 active rx for opioid in last 4 months
- Age > 18 (had age limit of 80 but removed this later)
- Not on hospice care
- No active diagnosis of cancer
- Inclusion rule added patients to registry based on risks
  - Low risk – ORT score low, no hx of substance abuse, MEDD<90, no concomitant benzodiazepine use
  - Med risk – ORT score medium, no hx of substance abuse, MEDD<90, no concomitant benzodiazepine use
  - High risk – ORT score high, or hx of substance abuse or MEDD>=90 or concomitant benzodiazepine use
- Vetted results with sample end users to confirm accuracy

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Patient Letter

- **Send to:** All patients receiving opioids for 3 of the last 4 months
  - Once we figure out the roll out date we can back into this
- **Send to:** All patients receiving opioids from a provider who no longer works for us
  - Ongoing basis
- **Delivery Mechanism:** Mail to patients directly
  - Each Primary Care location print the letter on their letterhead so their patients have the clinic number readily available at the top of the letter
- **Education:** Notify Providers at Primary Care Council meeting (prior to letter "going live")
- **Tracking:** Track letter delivery/sent through MyChart and Letters Tab

At Ochsner, one of our most important priorities is providing safe medical treatment to you.

Our records show you have been prescribed a controlled pain medication, also known as an opioid or narcotic. Considering the current national crisis concerning these medications, Ochsner doctors are working closely with patients to ensure controlled medications are used appropriately.

For your safety, Ochsner health care teams follow these new national care guidelines:

1. You will have only one doctor responsible in prescribing your controlled pain medications.
2. You will participate with your doctor in developing a pain contract and treatment plan.
3. Your doctor will regularly check the Louisiana Prescription Monitoring Program.
4. You may be asked to comply with periodic urine drug screenings.
5. Your doctor may discuss with you a medication to reverse an overdose.
6. You must store your medication safely and not share it with others.
7. You should not change the medicine amount you take unless your doctor tells you to change it.

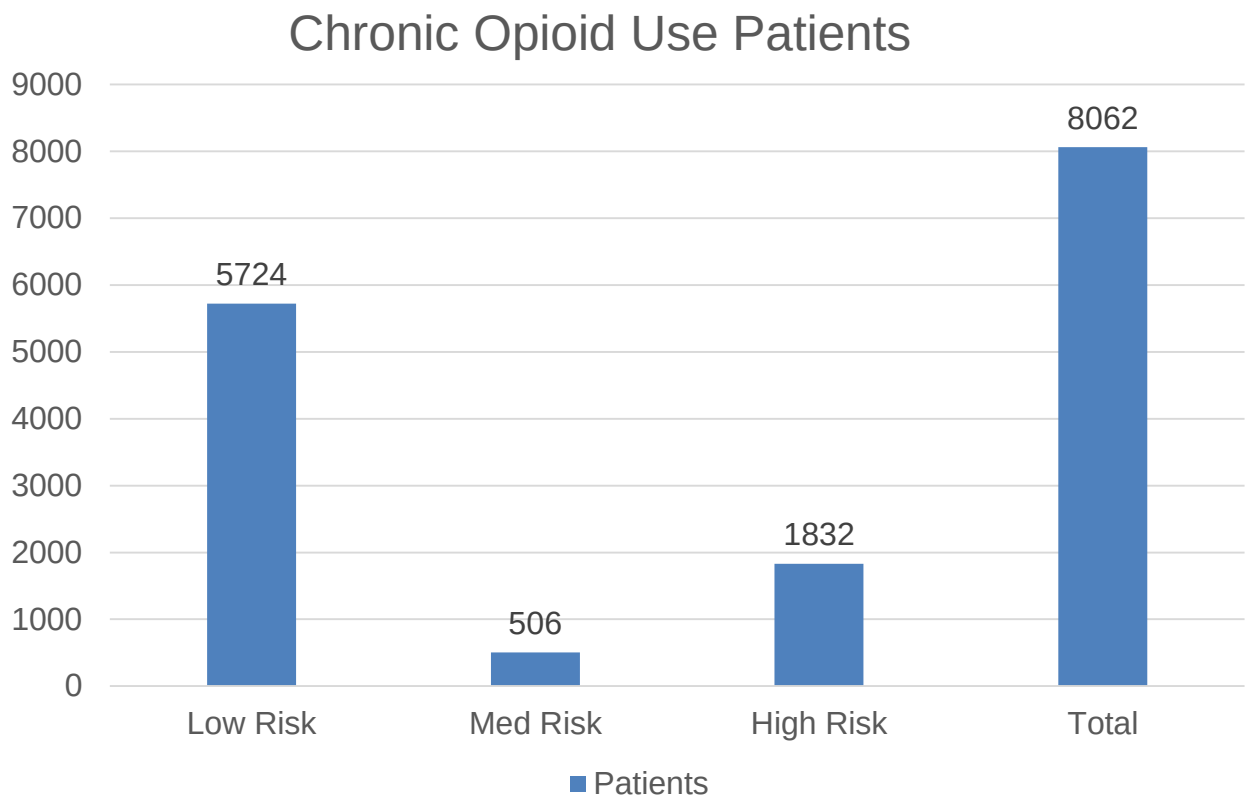
Your health care team will talk with you about the controlled pain medicines you may be taking at your next visit. In the meantime, if you need to schedule an appointment or begin care with a new doctor, call 1-866-OCHSNER (1-866-624-7637) right away to avoid a delay in your care.

Thank you for choosing Ochsner.

Sincerely,
Your Ochsner Health Care Team

Learn more about the national opioid crisis
by visiting the Centers for Disease Control website at
www.cdc.gov/drugoverdose/opioids

Breakdown of Chronic Opioid Users



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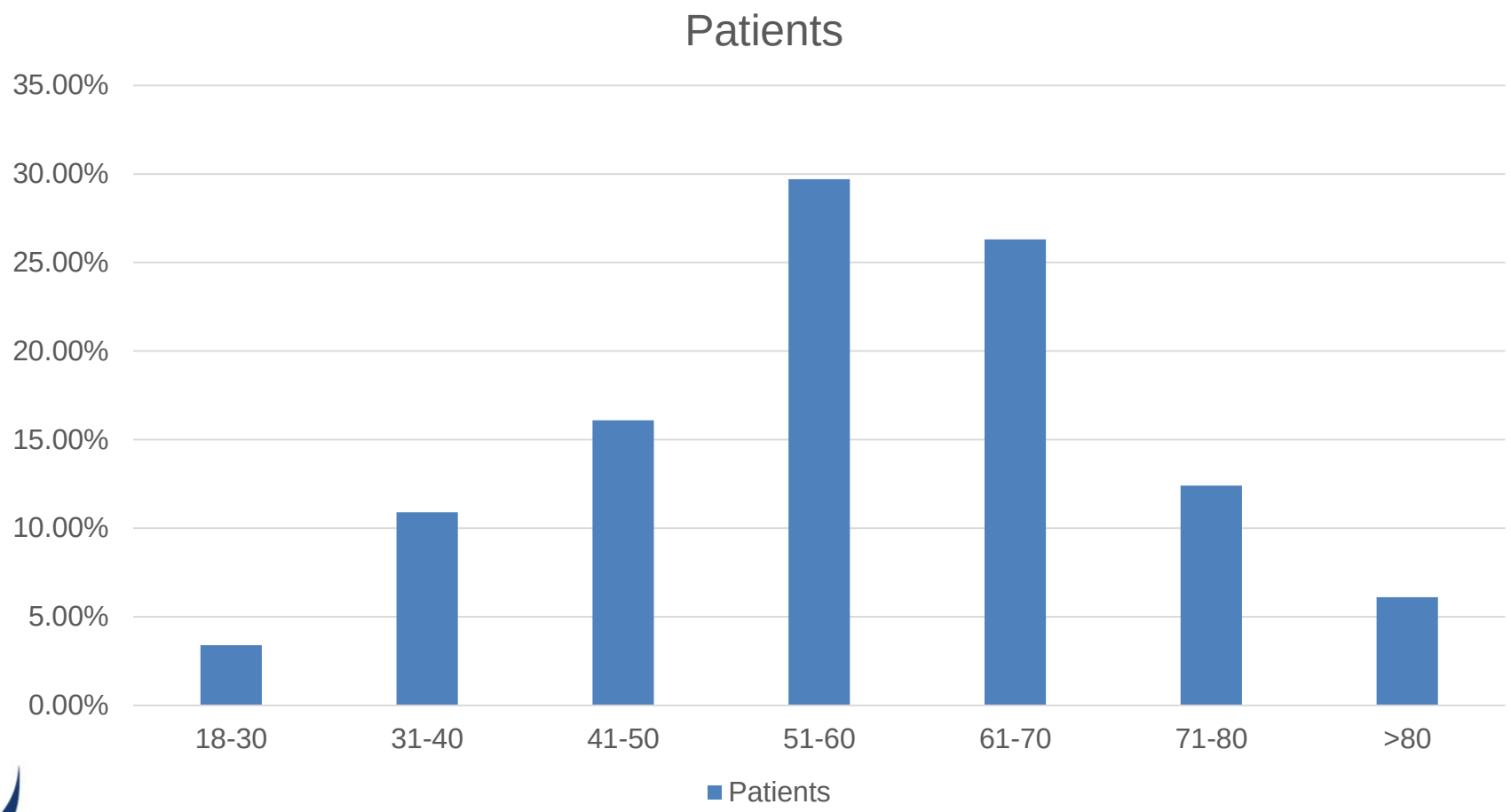
Breakdown of Chronic Opioid Use by Age



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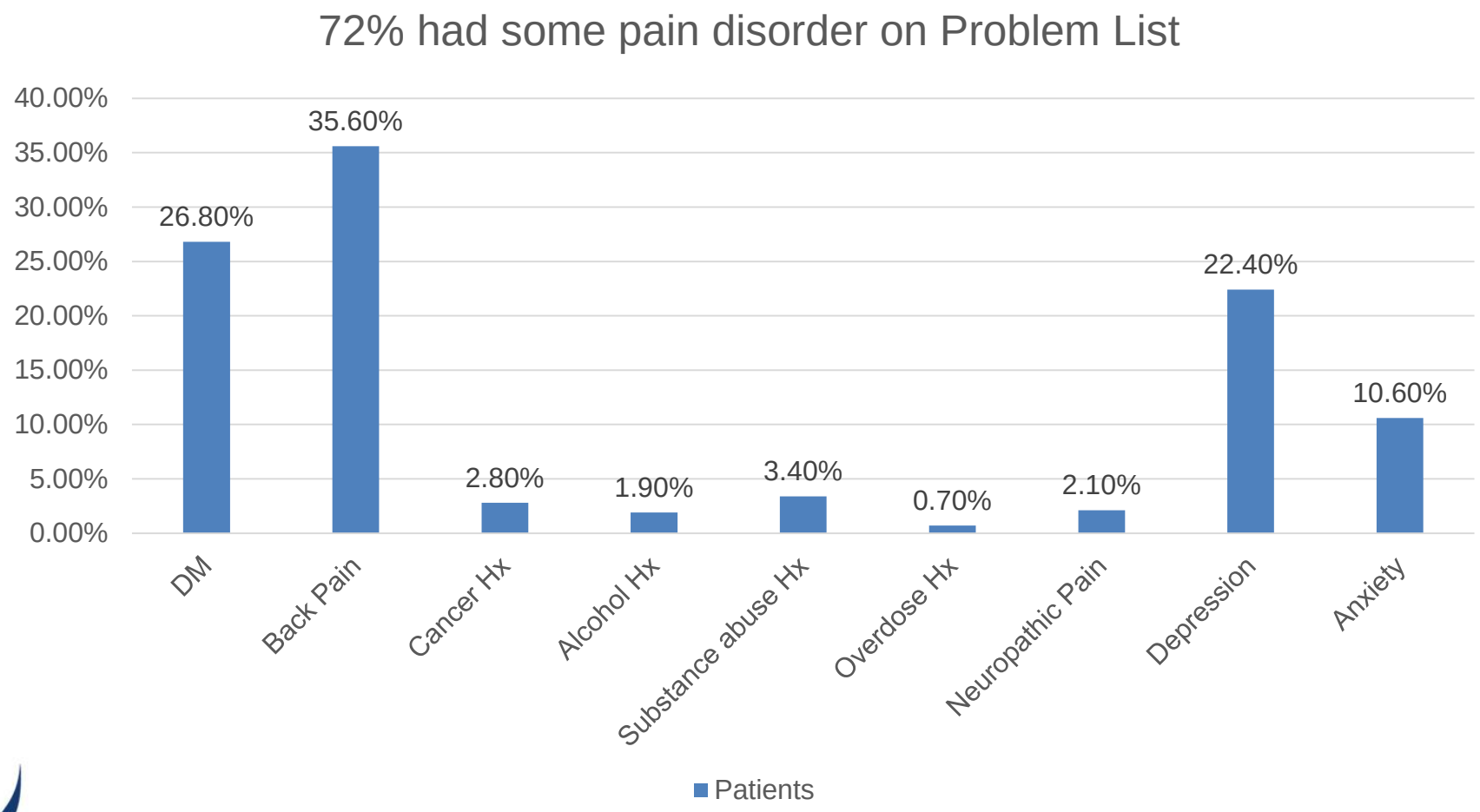
Various Diagnosis among Chronic Opioid Users



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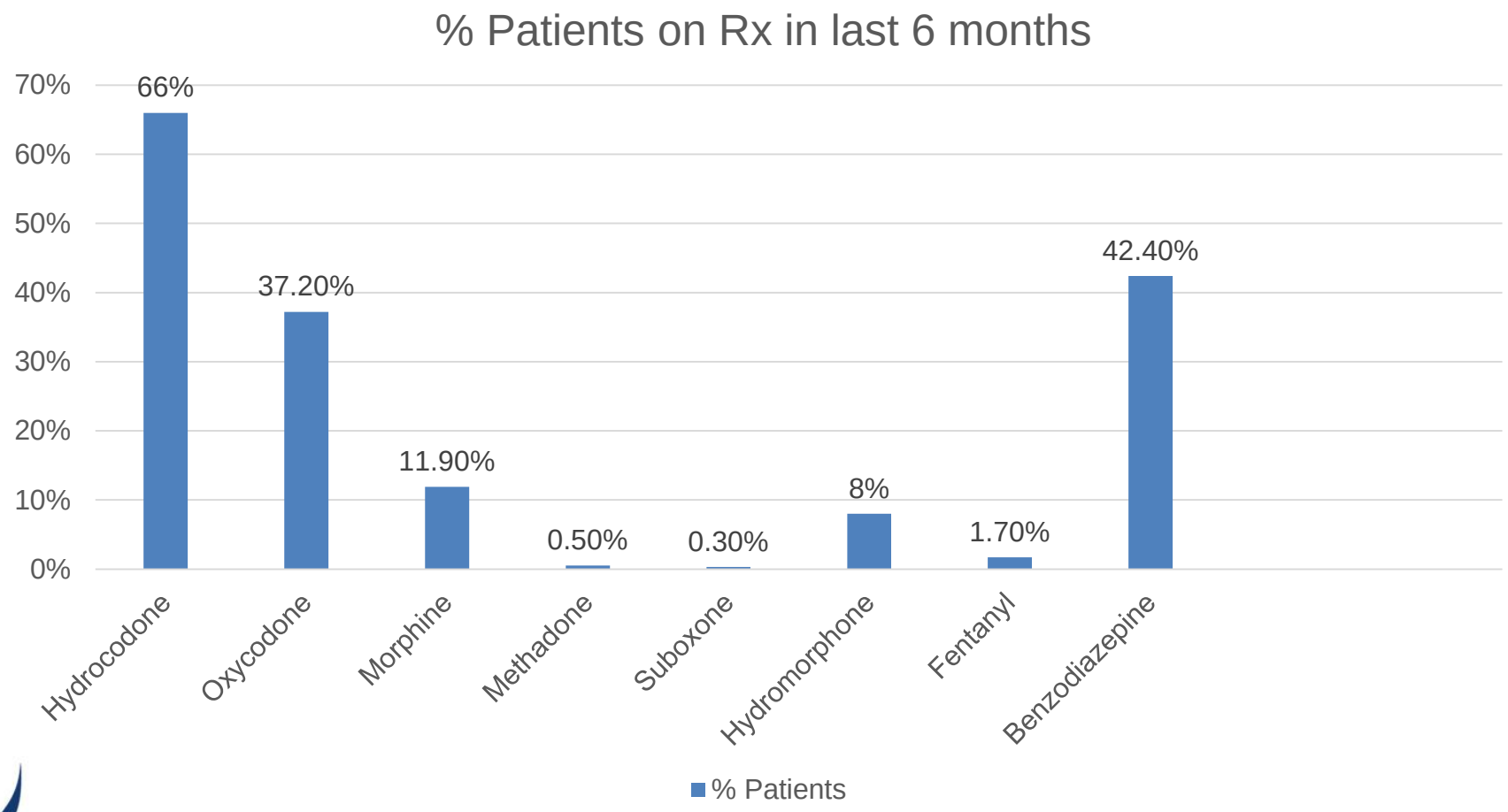
Narcotic Prescribed and Benzodiazepine Use



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Health Maintenance Topic Rules

- **Low Risk**
  - **ORT completed**
  - **Pain Contract signed**
- **Medium Risk**
  - **Same as low**
  - **UDS yearly**
- **High Risk**
  - **Same as low**
  - **UDS every 6 months**
  - **Naloxone rx yearly**

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Ad hoc modifiers

- Created so can add patients to HM even if not in system for 3 months yet
- Can exclude patients to HM by modifiers as well
- Allowed physician discretion

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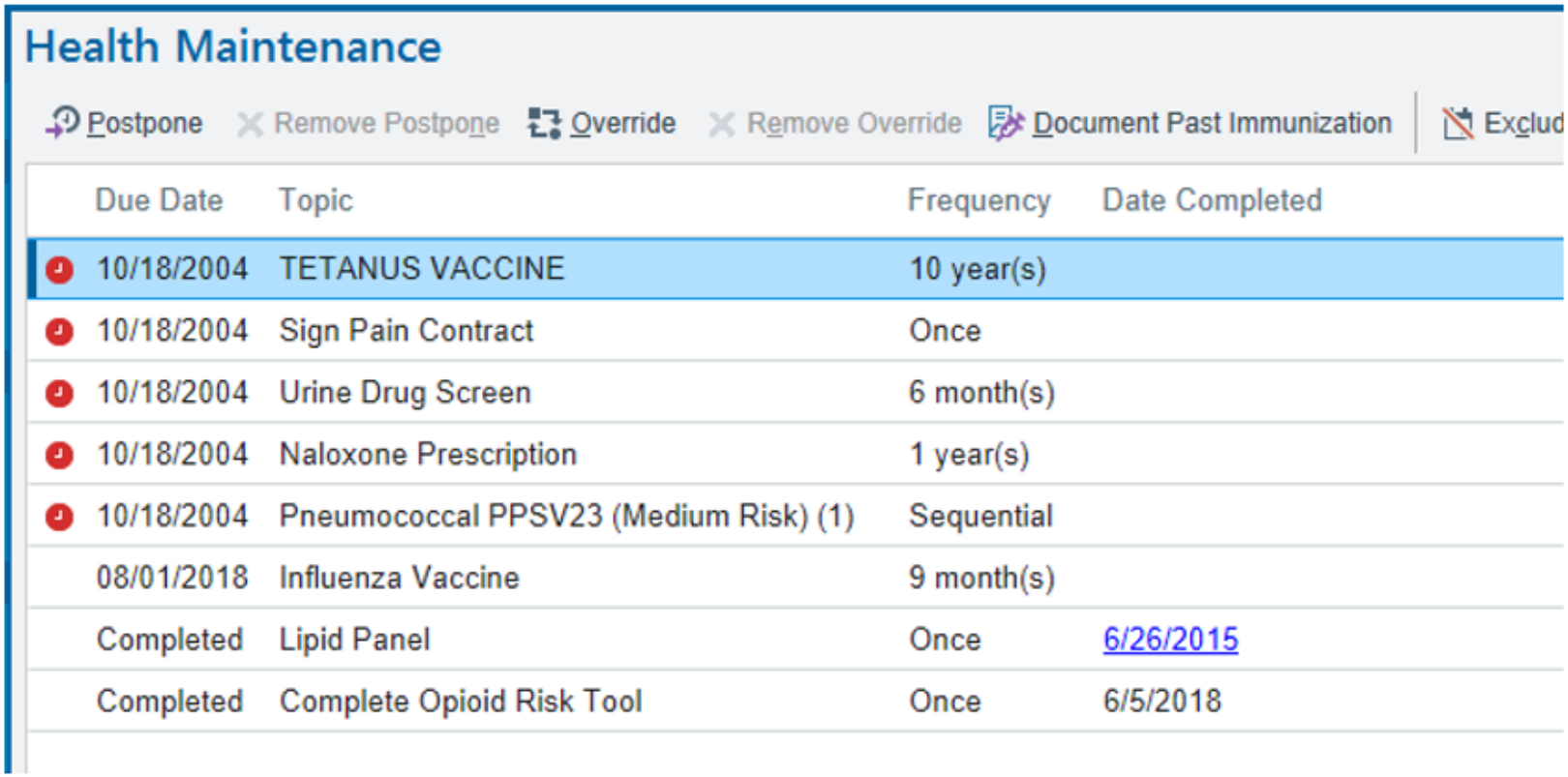
Building Out Health Maintenance Rules



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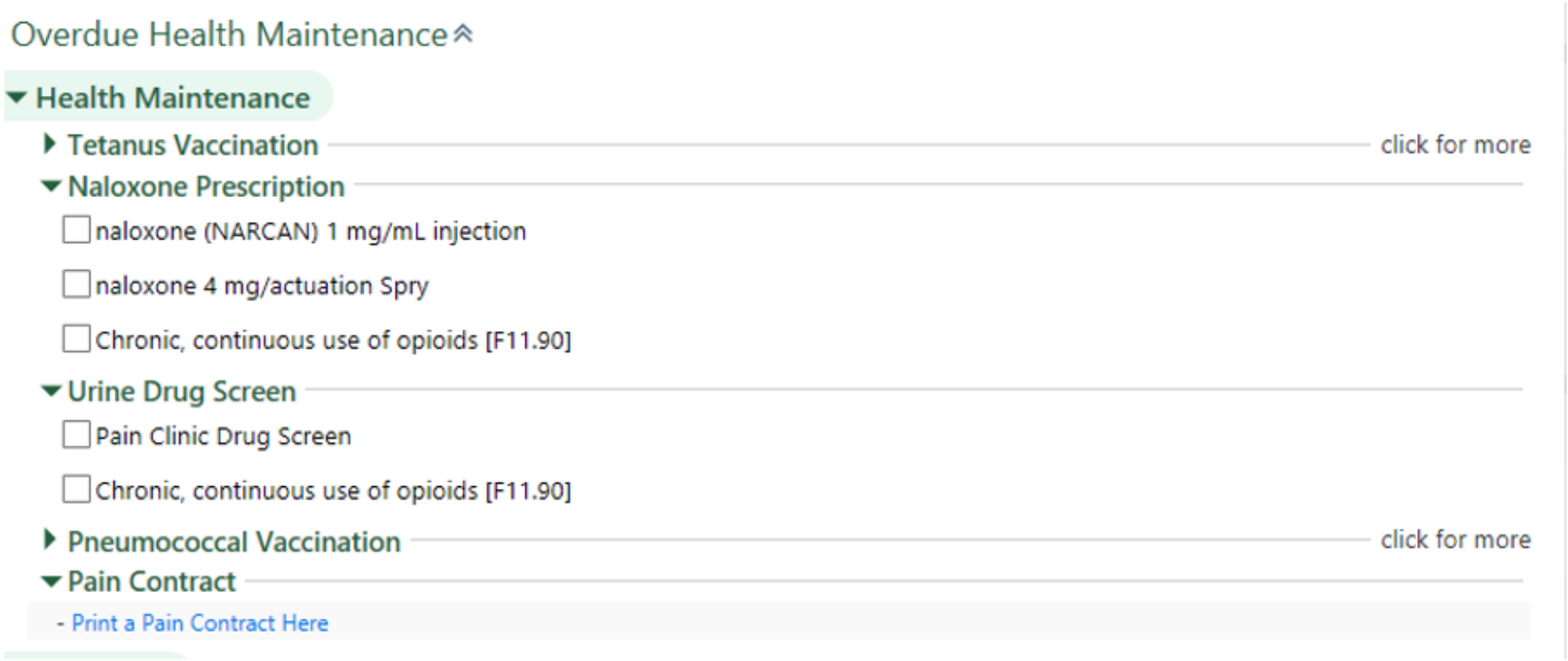
Build HM into HM Overdue SmartSet



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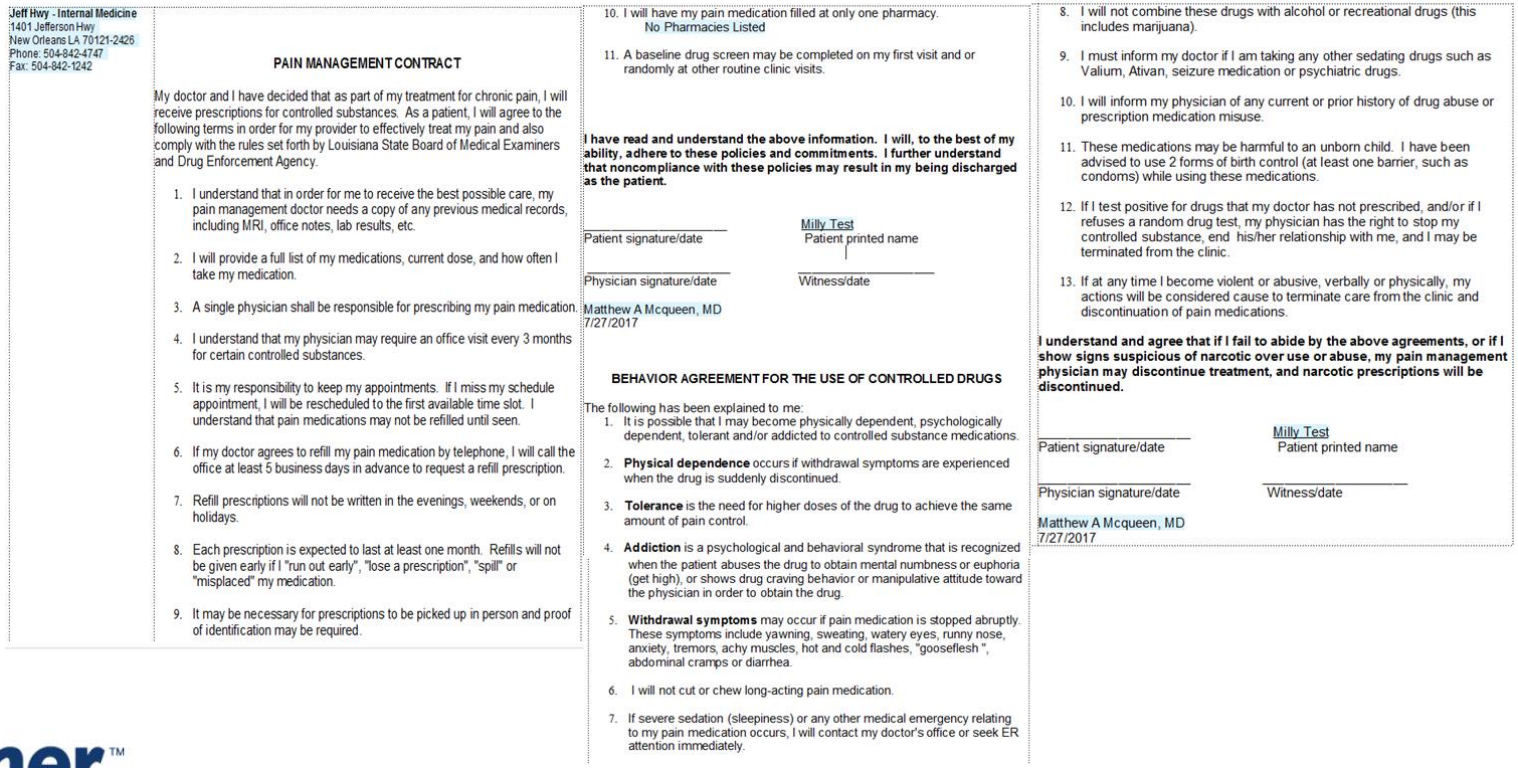
Integrating Pain Contract Documents

- Created document type of pain contract for scanned documents
- Fax form with standard contract available via one click link
- Trained staff and HIM to scan documents into media tab



Jeff Hwy - Internal Medicine
1401 Jefferson Hwy
New Orleans LA 70121-2426
Phone: 504-842-4747
Fax: 504-842-1242

PAIN MANAGEMENT CONTRACT

My doctor and I have decided that as part of my treatment for chronic pain, I will receive prescriptions for controlled substances. As a patient, I will agree to the following terms in order for my provider to effectively treat my pain and also comply with the rules set forth by Louisiana State Board of Medical Examiners and Drug Enforcement Agency.

1. I understand that in order for me to receive the best possible care, my pain management doctor needs a copy of any previous medical records, including MRI, office notes, lab results, etc.
2. I will provide a full list of my medications, current dose, and how often I take my medication.
3. A single physician shall be responsible for prescribing my pain medication.
4. I understand that my physician may require an office visit every 3 months for certain controlled substances.
5. It is my responsibility to keep my appointments. If I miss my schedule appointment, I will be rescheduled to the first available time slot. I understand that pain medications may not be refilled until seen.
6. If my doctor agrees to refill my pain medication by telephone, I will call the office at least 5 business days in advance to request a refill prescription.
7. Refill prescriptions will not be written in the evenings, weekends, or on holidays.
8. Each prescription is expected to last at least one month. Refills will not be given early if I "run out early", "lose a prescription", "spill" or "misplaced" my medication.
9. It may be necessary for prescriptions to be picked up in person and proof of identification may be required.
10. I will have my pain medication filled at only one pharmacy.
    No Pharmacies Listed
11. A baseline drug screen may be completed on my first visit and or randomly at other routine clinic visits.

I have read and understand the above information. I will, to the best of my ability, adhere to these policies and commitments. I further understand that noncompliance with these policies may result in my being discharged as the patient.

Patient signature/date — Milly Test Patient printed name

Physician signature/date — Witness/date

Matthew A Mcqueen, MD
7/27/2017

BEHAVIOR AGREEMENT FOR THE USE OF CONTROLLED DRUGS

The following has been explained to me:

1. It is possible that I may become physically dependent, psychologically dependent, tolerant and/or addicted to controlled substance medications.
2. **Physical dependence** occurs if withdrawal symptoms are experienced when the drug is suddenly discontinued.
3. **Tolerance** is the need for higher doses of the drug to achieve the same amount of pain control.
4. **Addiction** is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria (get high), or shows drug craving behavior or manipulative attitude toward the physician in order to obtain the drug.
5. **Withdrawal symptoms** may occur if pain medication is stopped abruptly. These symptoms include yawning, sweating, watery eyes, runny nose, anxiety, tremors, achy muscles, hot and cold flashes, "gooseflesh ", abdominal cramps or diarrhea.
6. I will not cut or chew long-acting pain medication.
7. If severe sedation (sleepiness) or any other medical emergency relating to my pain medication occurs, I will contact my doctor's office or seek ER attention immediately.
8. I will not combine these drugs with alcohol or recreational drugs (this includes marijuana).
9. I must inform my doctor if I am taking any other sedating drugs such as Valium, Ativan, seizure medication or psychiatric drugs.
10. I will inform my physician of any current or prior history of drug abuse or prescription medication misuse.
11. These medications may be harmful to an unborn child. I have been advised to use 2 forms of birth control (at least one barrier, such as condoms) while using these medications.
12. If I test positive for drugs that my doctor has not prescribed, and/or if I refuses a random drug test, my physician has the right to stop my controlled substance, end his/her relationship with me, and I may be terminated from the clinic.
13. If at any time I become violent or abusive, verbally or physically, my actions will be considered cause to terminate care from the clinic and discontinuation of pain medications.

I understand and agree that if I fail to abide by the above agreements, or if I show signs suspicious of narcotic over use or abuse, my pain management physician may discontinue treatment, and narcotic prescriptions will be discontinued.

Patient signature/date — Milly Test Patient printed name

Physician signature/date — Witness/date

Matthew A Mcqueen, MD
7/27/2017

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Louisiana Legislation

Act #76 (Senate Bill 55)

- Requires **Accessing a Patient's PMP Every 90 Days for Patients on Opioids >90 Days.**
- **Auto Enroll Prescribers into the PMP** Who Get a New License and at Renewal (Every 3 Years)
- **Require 3 Hours of Continuing Education Prior to License Renewal***

Act #82 (House Bill 192)

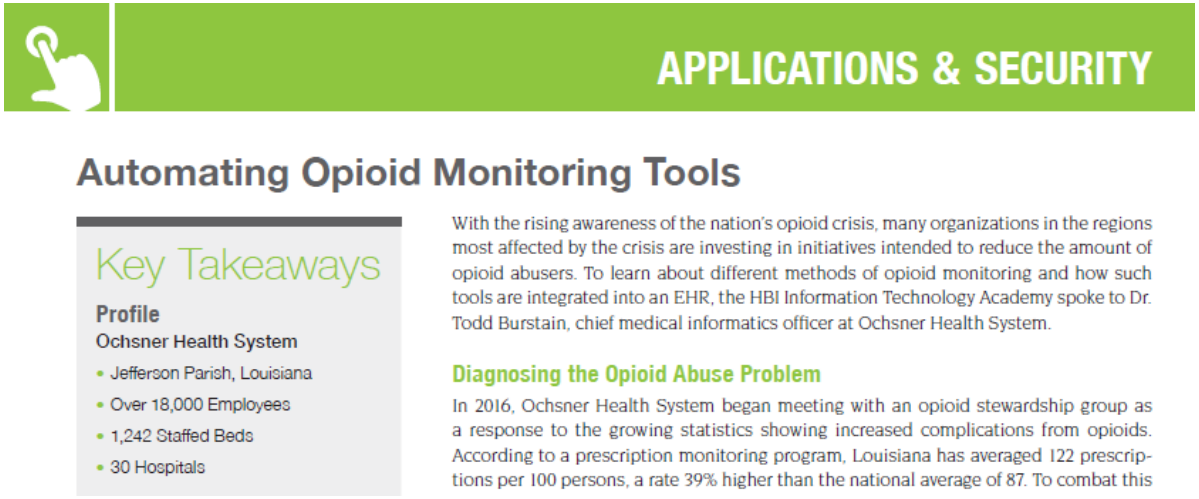
- Limit Opioid Prescriptions to **Seven Days for a Patient's First Prescription****
  - Acute Pain (adults)
  - ANY TIME (minors)
- Providers must to do both of the following prior to issuing a prescription for an opioid:
  1. Consult with the patient **regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity.**
  2. Inform the patient of the **risks associated with the opioid prescribed.**

Act #88 (House Bill 490)

- Created an Advisory Council on Heroin and Opioid Prevention and Education

Monitor for Misuse with PMP Link

- **Identify vendor for HIE – Appriss**
- **Develop call out protocol and matching criteria**
- **Mark in Employee record who has PMP access**
- **One click solution**



APPLICATIONS & SECURITY

Automating Opioid Monitoring Tools

Key Takeaways

Profile

Ochsner Health System

- Jefferson Parish, Louisiana
- Over 18,000 Employees
- 1,242 Staffed Beds
- 30 Hospitals

With the rising awareness of the nation's opioid crisis, many organizations in the regions most affected by the crisis are investing in initiatives intended to reduce the amount of opioid abusers. To learn about different methods of opioid monitoring and how such tools are integrated into an EHR, the HBI Information Technology Academy spoke to Dr. Todd Burstain, chief medical informatics officer at Ochsner Health System.

Diagnosing the Opioid Abuse Problem

In 2016, Ochsner Health System began meeting with an opioid stewardship group as a response to the growing statistics showing increased complications from opioids. According to a prescription monitoring program, Louisiana has averaged 122 prescriptions per 100 persons, a rate 39% higher than the national average of 87. To combat this

Information Technology Academy Journal 4/18

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In application PMP report viewing

Age: 28 Data as of: 6/6/2018

Demographics

Summary

Summary		Narcotics* (excluding buprenorphine):		Buprenorphine*	
Total Prescriptions:	3	Current Qty:	0	Current Qty:	0
Total Prescribers:	3	Current MME/day:	0.00	Current mg/day:	0.00
Total Pharmacies:	1	30 Day Avg MME/day:	0.00	30 Day Avg mg/day:	0.00

Prescriptions

Prescriptions Total Prescriptions: 3 Private Pay: 0

Fill Date	ID	Written	Drug	Qty	Days	Rx #	Prescriber	Pharmacy	Refill	Daily Dose *	Pymt Type	PMP
11/22/2016	1	11/22/2016	HYDROCODONE-ACETAMIN 5-325 MG	30	30	00624458	MI MCN	LOUISI	0	5.00 MME	Comm Ins	LA
10/20/2016	1	10/20/2016	HYDROCODONE-ACETAMIN 7.5-325	15	4	00618851	JA SMI	LOUISI	0	28.12 MME	Comm Ins	LA
09/09/2016	1	09/09/2016	HYDROCODONE-ACETAMIN 10-325 MG	10	2	00611899	DA COF	LOUISI	0	50.00 MME	Comm Ins	LA

*Per CDC guidance, the MME conversion factors prescribed or provided as part of the medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain. Buprenorphine products have no agreed upon morphine equivalency, and as partial opioid agonists, are not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids. MME = morphine milligram equivalents. mg = dose in milligrams.

Providers Total Providers: 3

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Doing Our Part:
Drug Diversion Response Team

- Use Data Analytics to Audit Internal Controlled Substance Utilization
- Investigate Any Reports of Drug Diversion or Loss of Controlled Substances
- Monthly Interdepartmental Meeting
  - Representation from Pharmacy, Nursing, Compliance, Legal, and Pain Management
- In Pilot Phase- Plan to Expand to All Ochsner Sites in 2018

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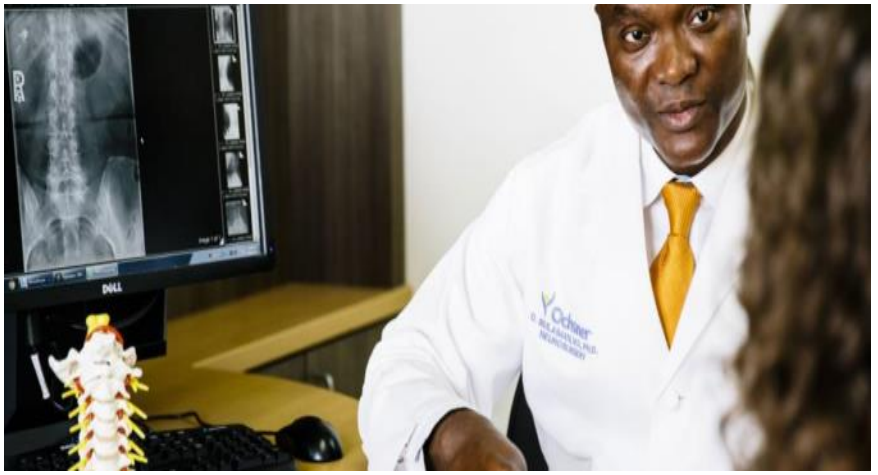
Innovative Approaches to Pain Treatment

- Healthy Back Program
  - 10 Week Program- Two Times Per Week
  - Patients Reported a 62.5% Decrease in Pain After 10 Weeks of Treatment
- Medicaid Grants to Provide Services Not Usually Covered:
    - PT
    - Paravertebral Facet Joint Blocks
- Virtual Reality to Reduce Initial Exposure to Opioids



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Functional Restoration Program

- Outpatient, Multidisciplinary, Three-Week Program Includes:
  - Pain Medicine, Pain Psychiatry Specialists, Physical & Occupational Therapists, Social Workers & Nutrition Coaches
- Focus on Reclaiming Function & Patient-Centered Goals
- Program Currently Completing 6th Cohort, 30-days After Program, Patients Report:
  - 51% Decrease in Disability Due to Pain
  - 32% Improvement in Sleep
  - 63% Improvement in Mood

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Opioid Free Cases

- Opiate Free Protocol
  - Cases > 2 Hours
  - Pre-operative IV Acetaminophen and IV Ibuprofen
- Started with Colorectal & Urology Procedures
- Other Procedures to Limit Opioid Use: Knee & Hip Replacements

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Expanding Opioid Use Disorder Treatment Options

- Our New Psychiatric Hospital- ***River Place Behavioral Health***- Will Open a Dual Diagnosis Unit in 2018
  - Offering Detoxification and Induction with Buprenorphine for Opioid Dependent Patients with Acute Psychiatric Issues
- Psychiatry's Suboxone Program (OchMAT) is Underway
  - Adding Additional Support to Capture a Greater Range of Disease Severity.
- Intensive Outpatient Program for Substance Use (Addictive Behavior Unit) is Streamlining its Services for Opioid Dependent patients
  - Providing Easier Access to Outpatient Suboxone Treatment.

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Partnerships with Treatment Facilities

Partnerships with Behavioral Health LGEs

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Outcomes

- Prescription rates
- Guideline Compliance
- PMP registration
- Best Practice – Health maintenance
  - ORT
  - Pain Contracts
  - UDS
  - Naloxone Rx
- Expansion
  - Concomitant benzodiazepine usage

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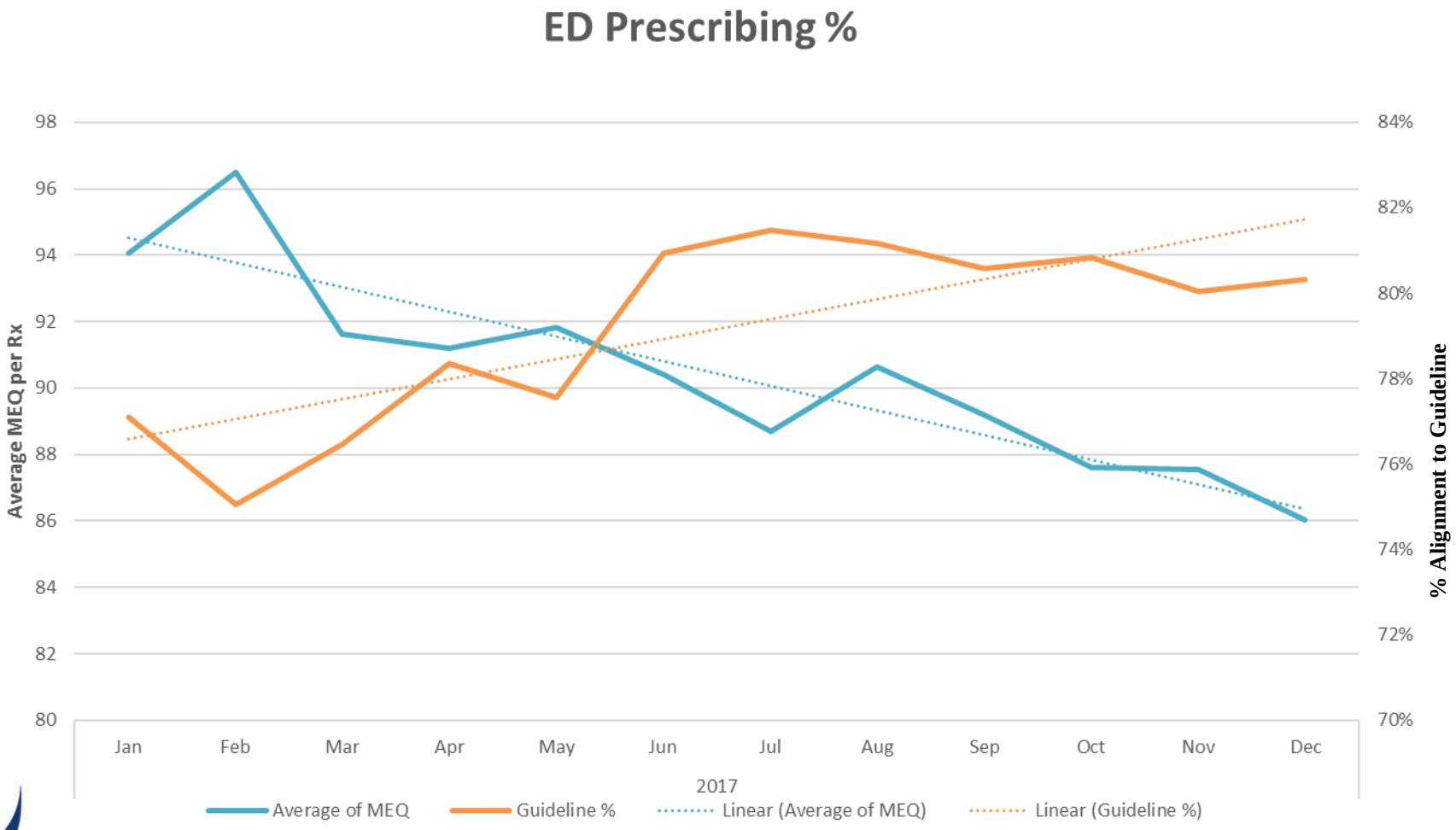
ED Prescription Data

(Began at 105 MEQ/rx and 50% guideline alignment (3d/rx))



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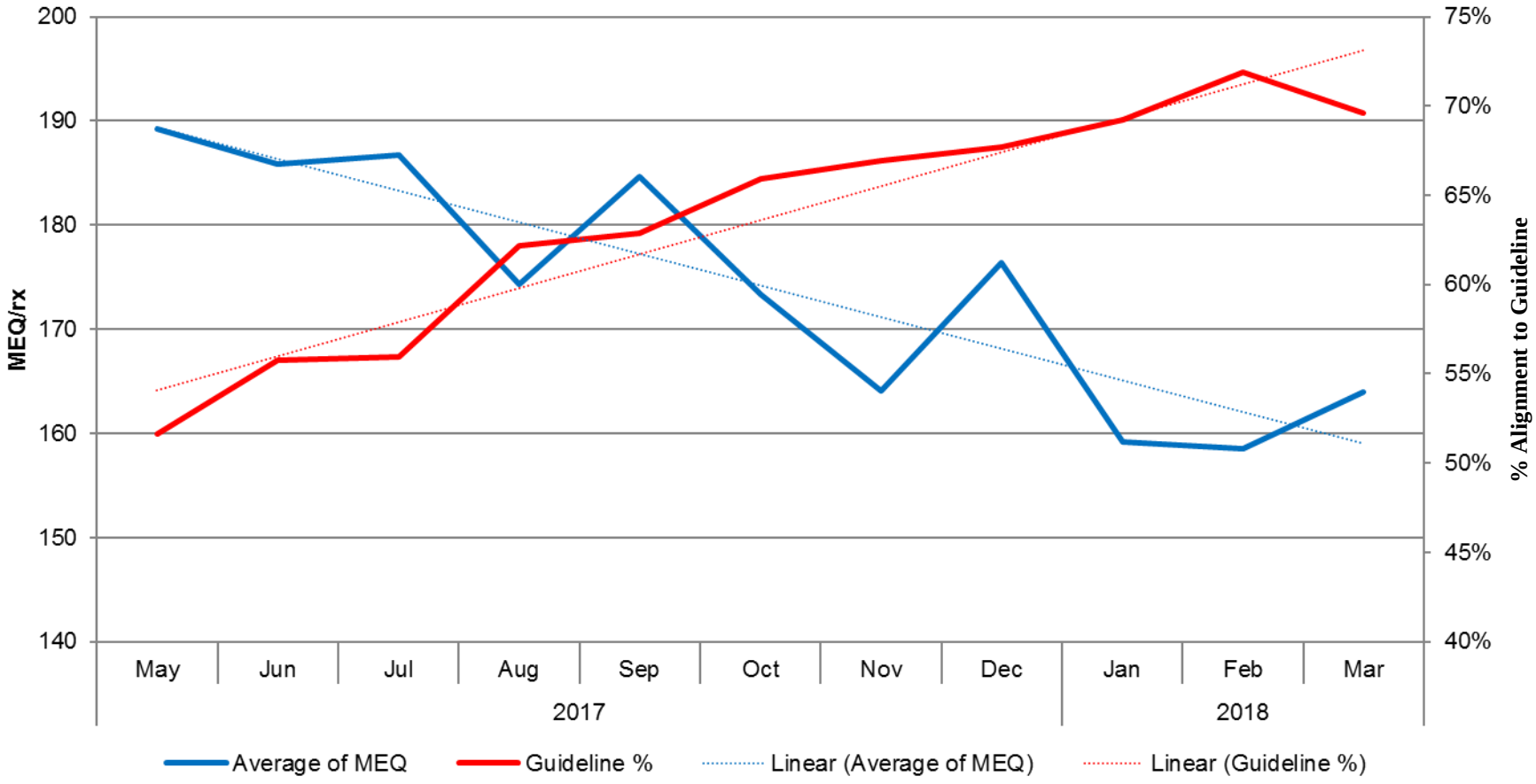
OB Prescription Data

Alignment to Guideline (3d/rx)



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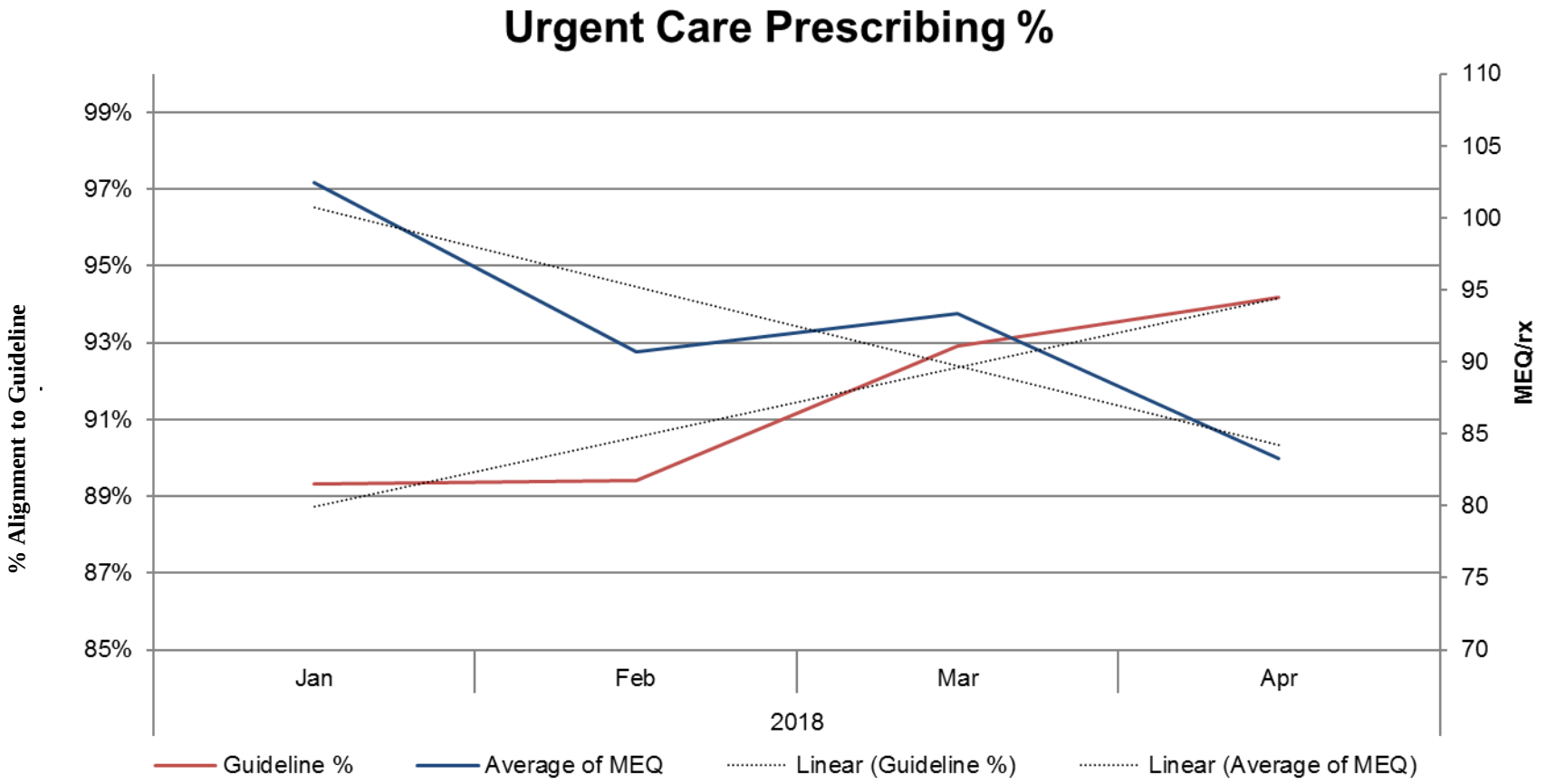
Urgent Care Prescription Data

Alignment to Guideline (3d/rx)



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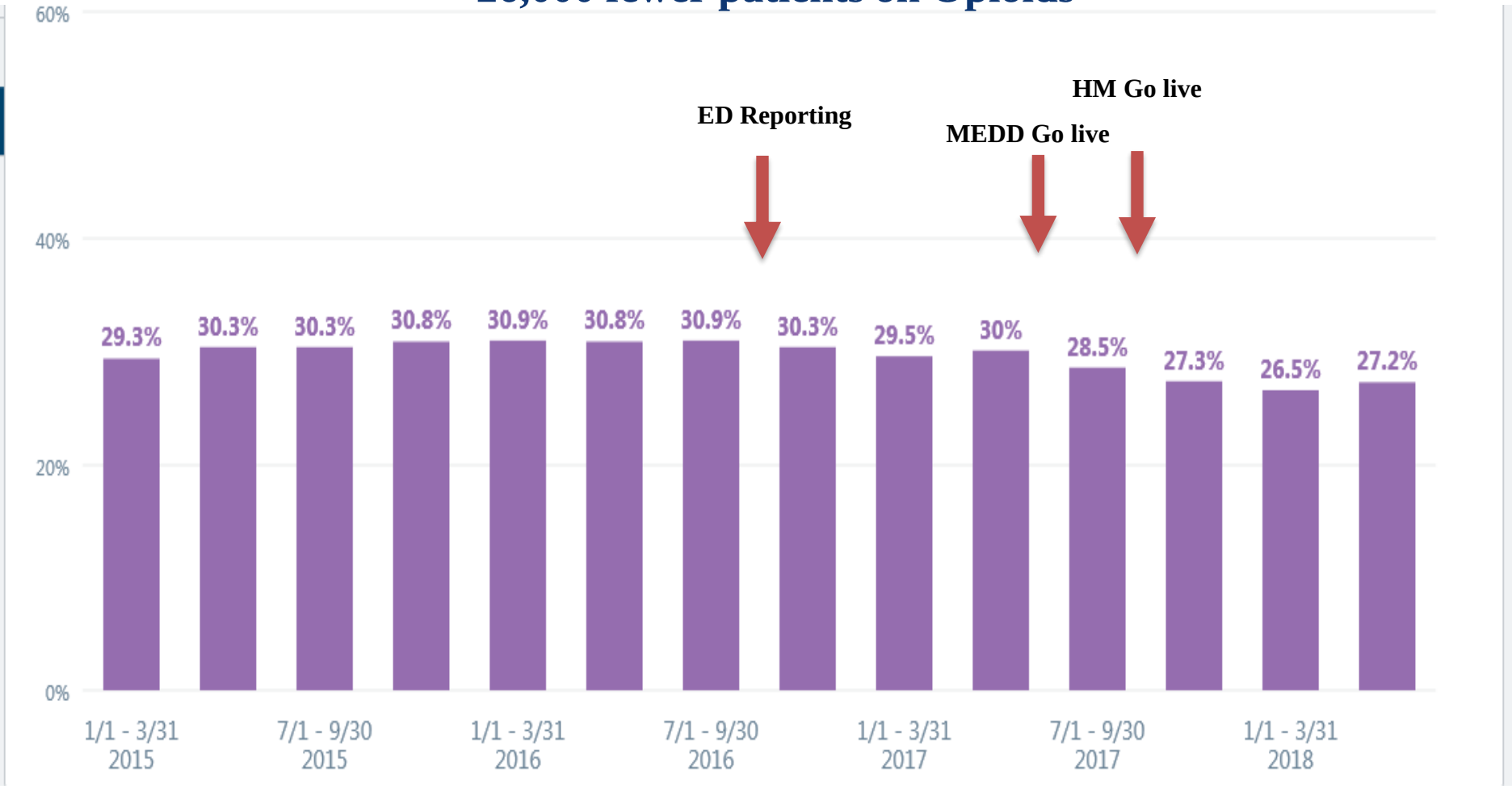
System Wide Prescription Data

% Patients Seen in Office/ED/Hosp given Opioid

26,000 fewer patients on Opioids



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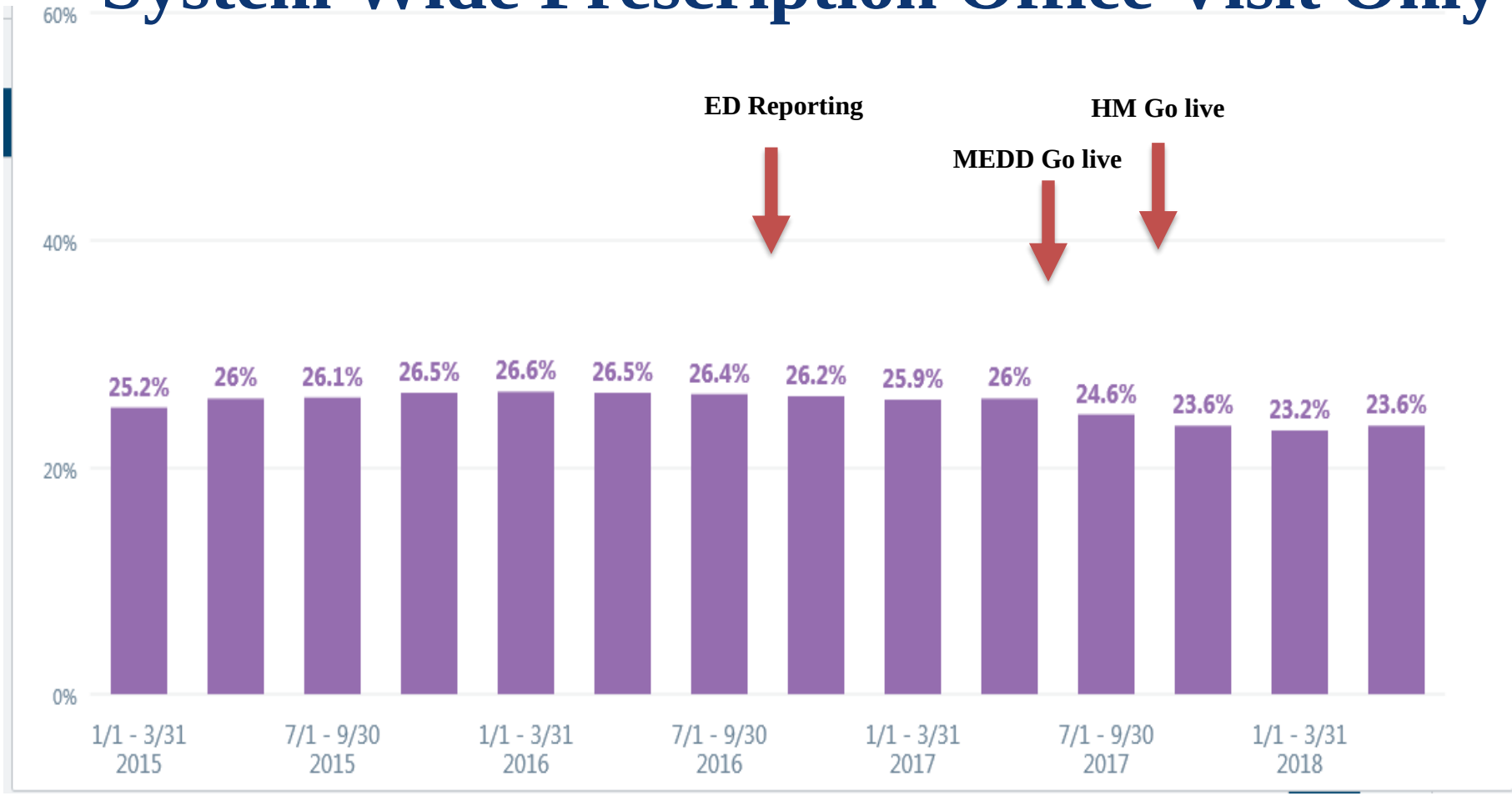
System Wide Prescription Office Visit Only



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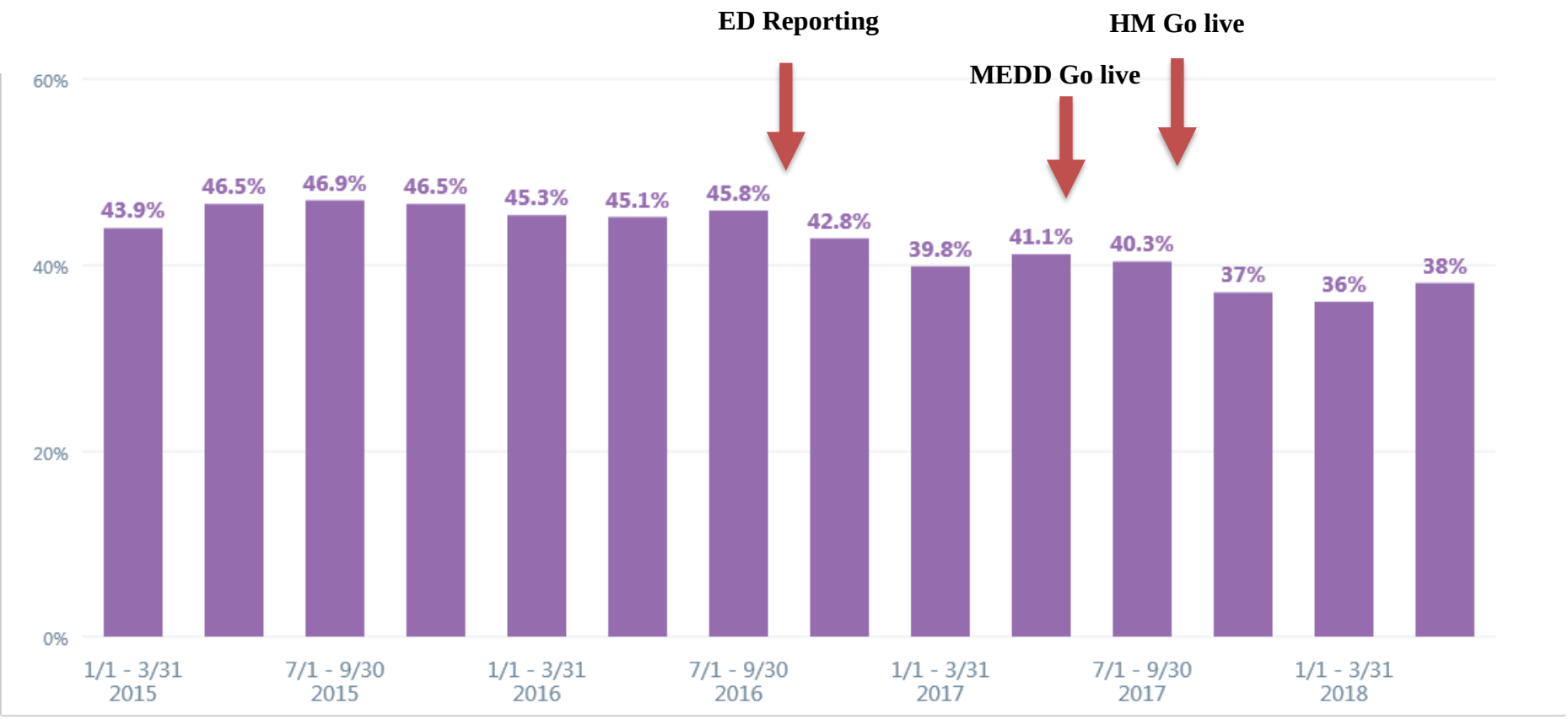
System Wide Prescription ED Only



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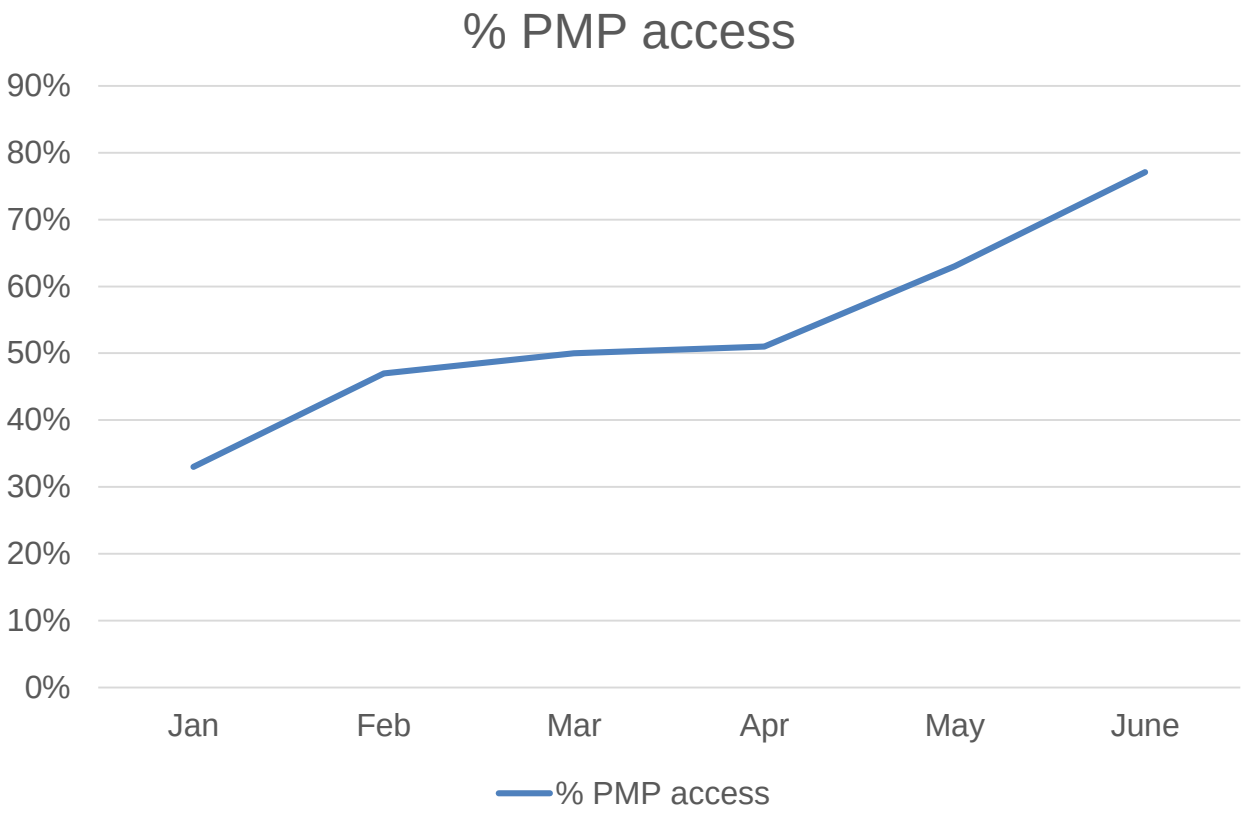
PMP Registration



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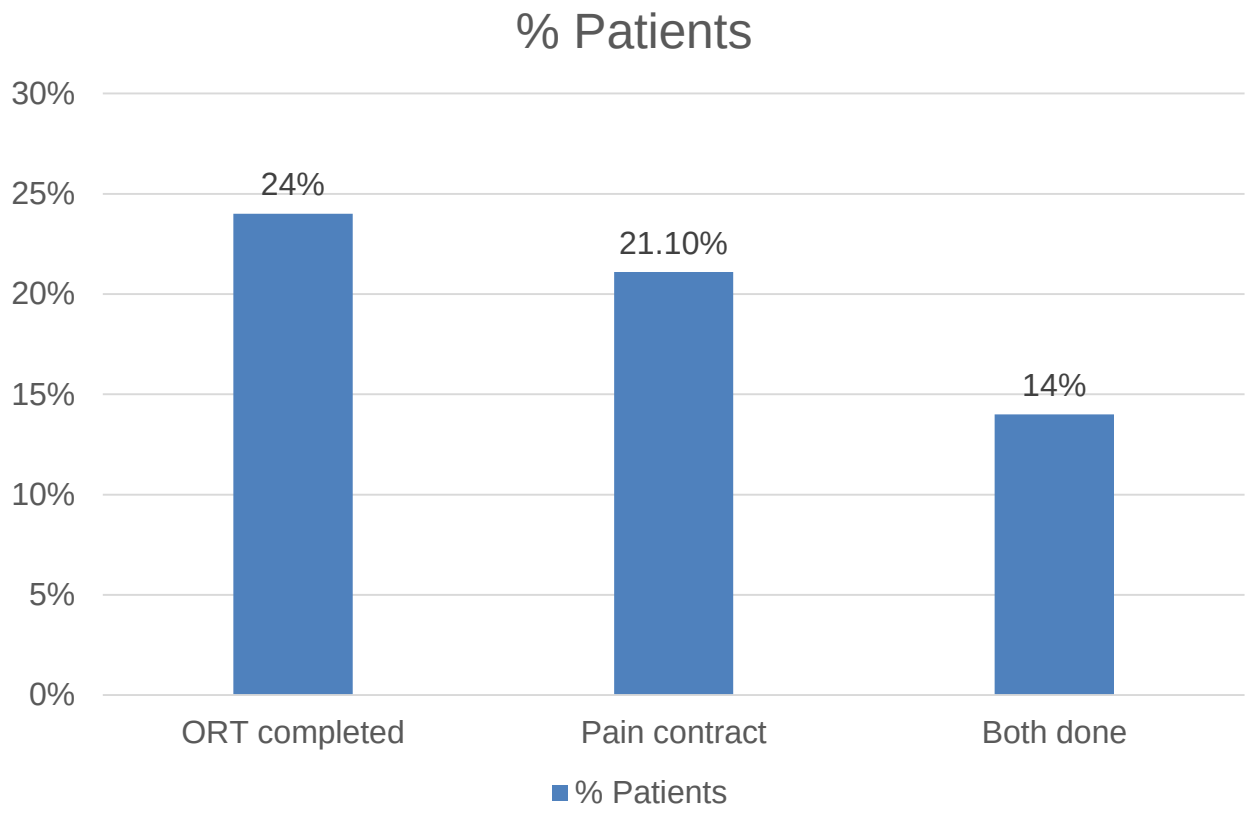
Health Maintenance Outcomes – Low Risk



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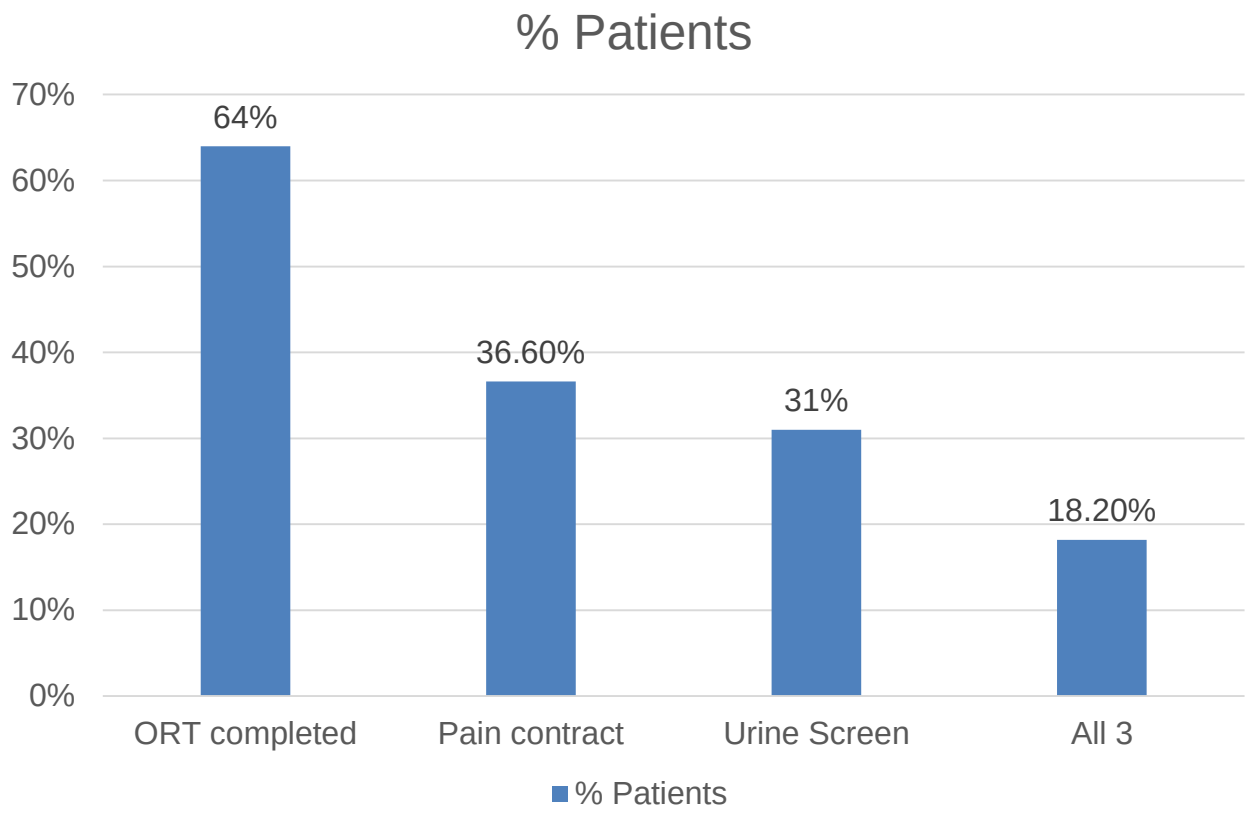
Health Maintenance Outcomes – Med Risk



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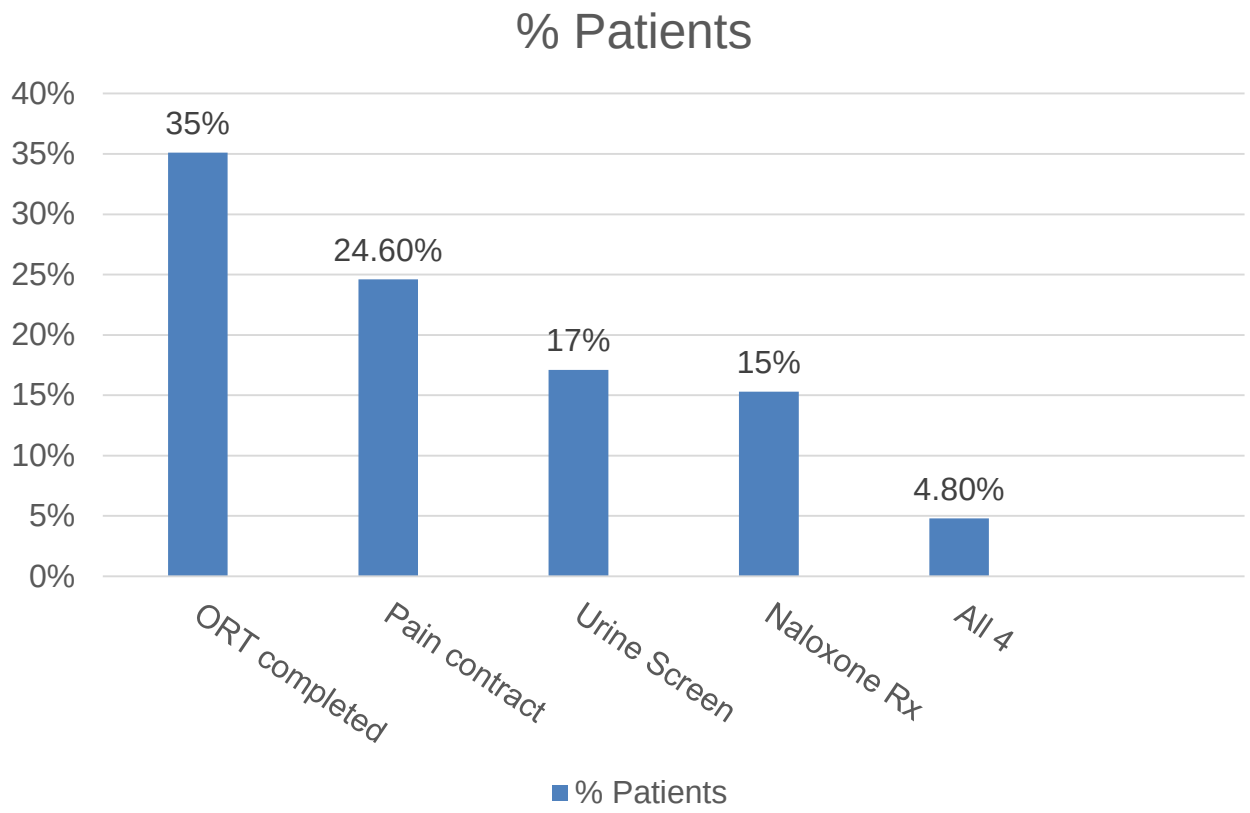
Health Maintenance Outcomes – High Risk



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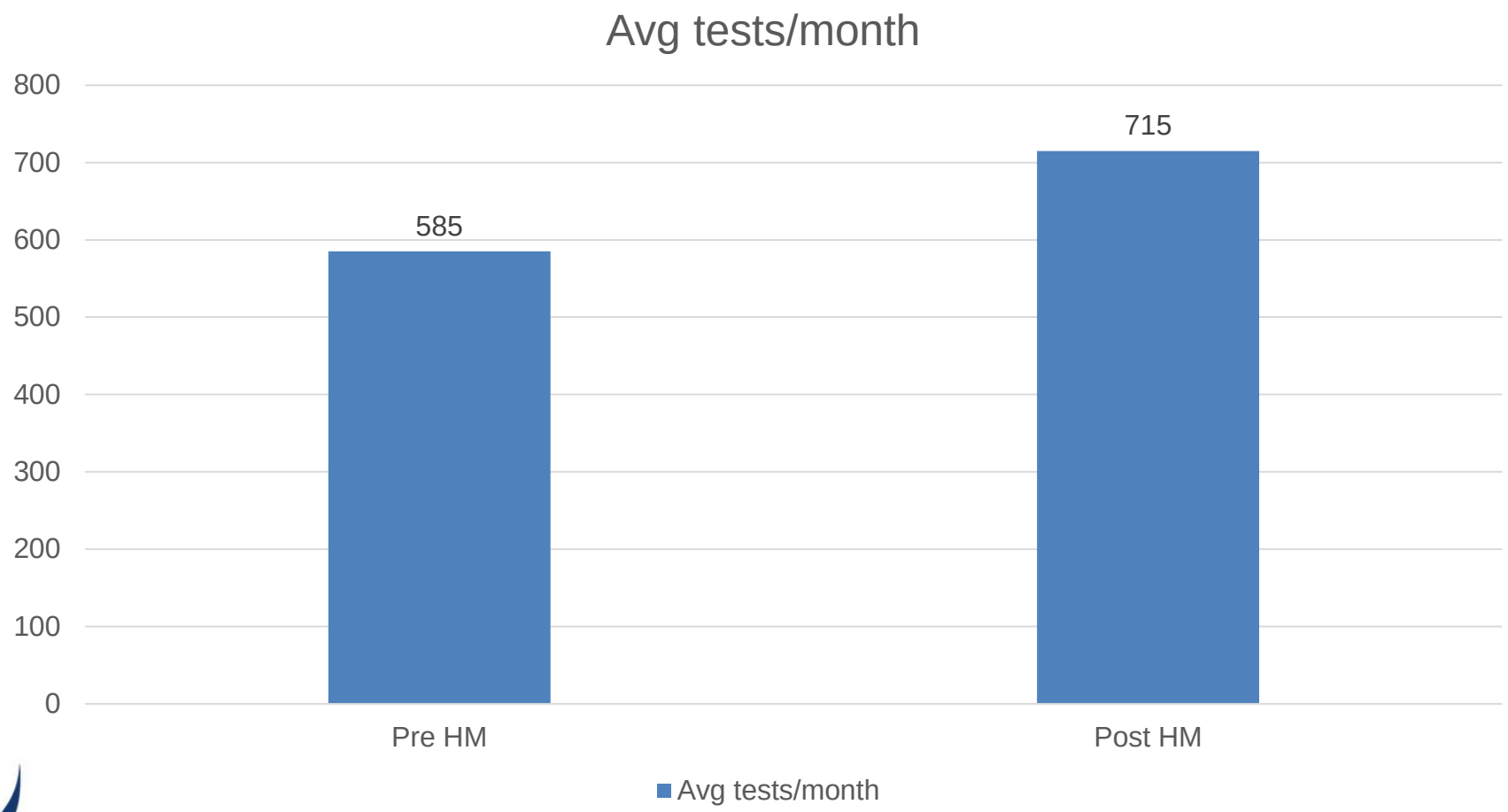
Frequency of Urine Drug Screening

22% increase



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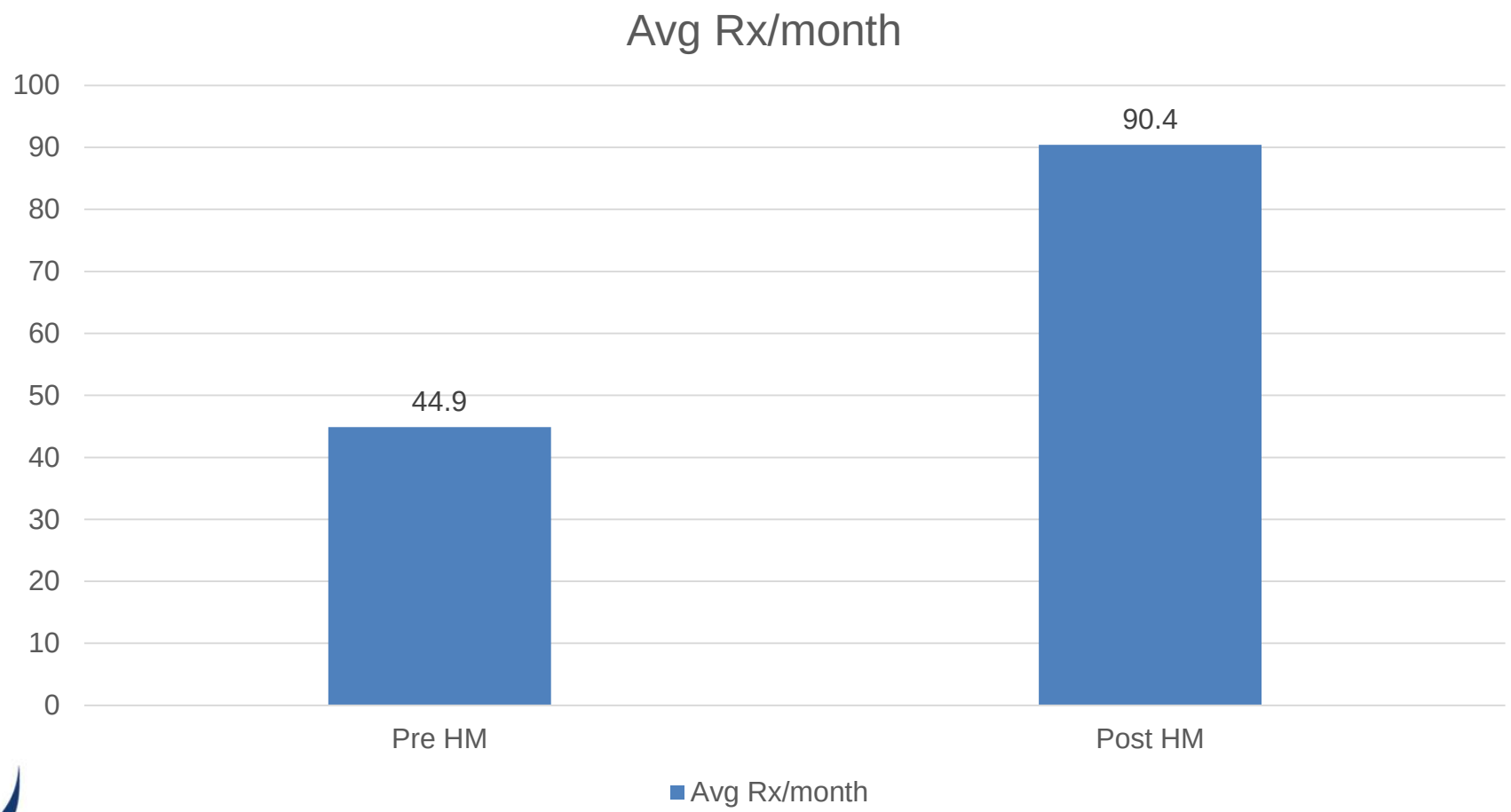
Naloxone Prescriptions

101% increase



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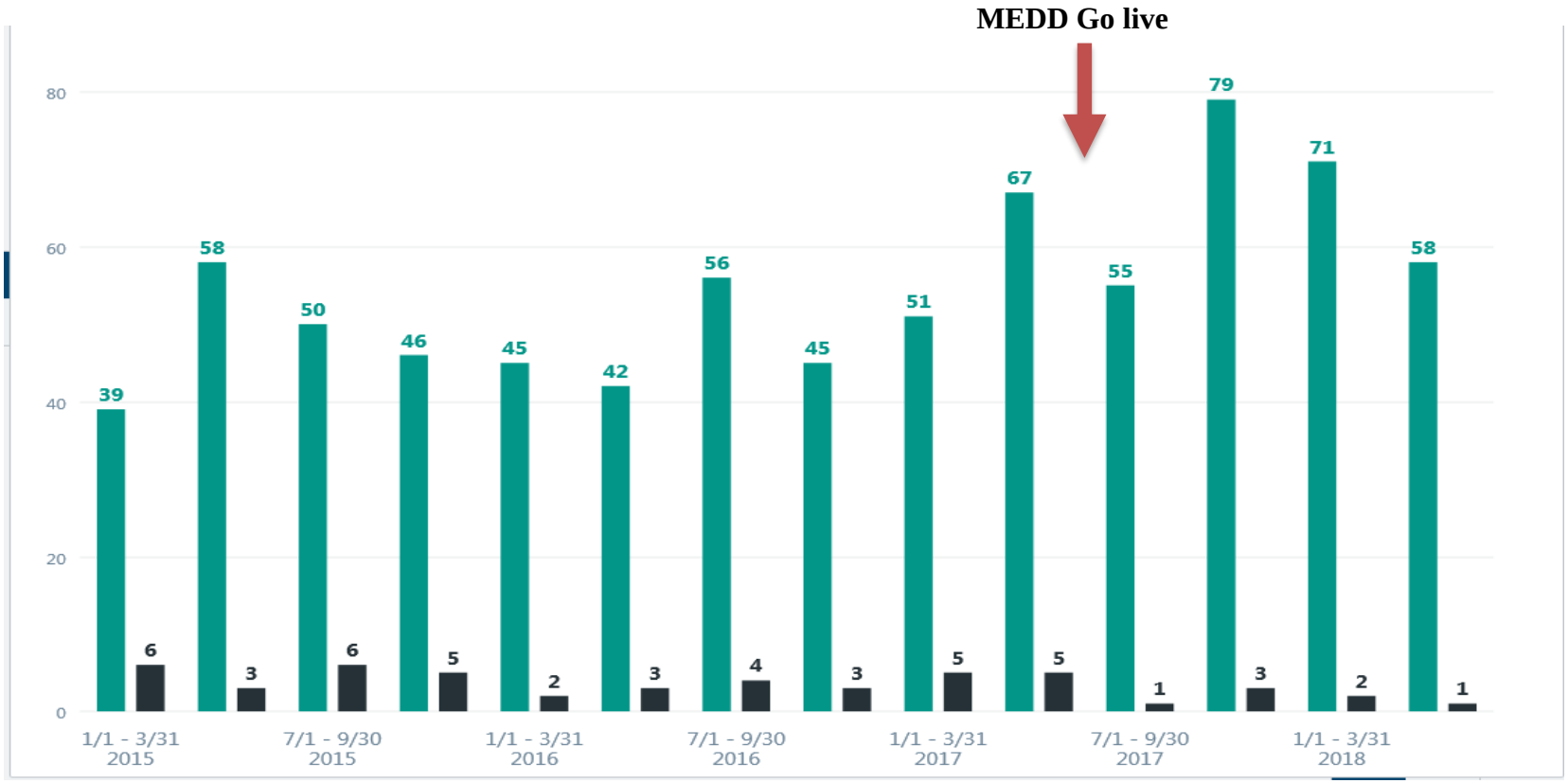
Non Heroin OD of Opiate in ED and Survival

4.2 deaths/quarter pre HM/MEDD, 1.75 deaths/quarter post HM/MEDD



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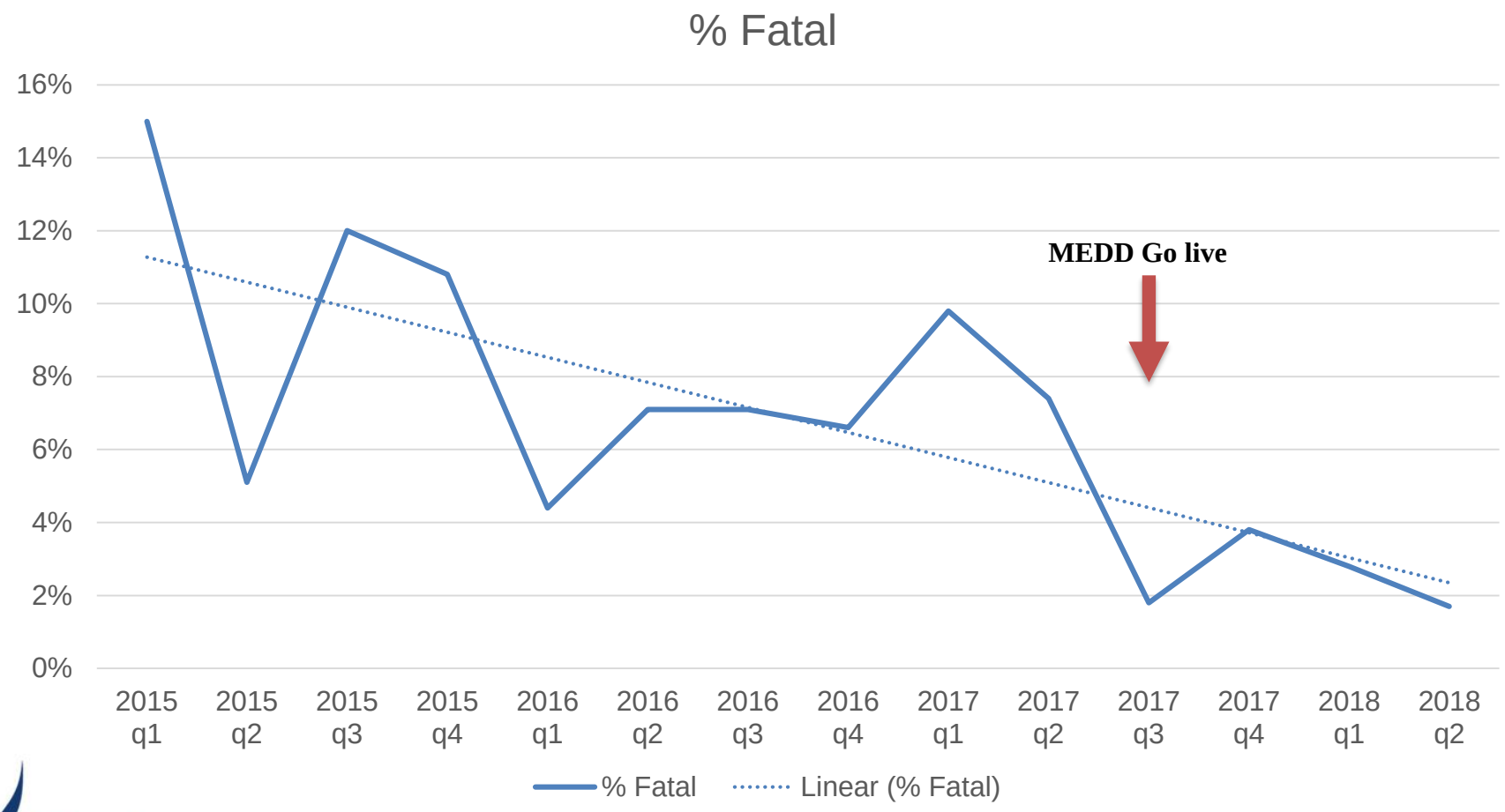
% Deceased Non Heroin Opioid OD in ED



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Publishing Results

Ochsner Journal 18:30–35, 2018

Intelligent Clinical Decision Support to Improve Safe Opioid Management of Chronic Noncancer Pain in Primary Care

Eboni G. Price-Haywood, MD, MPH, FACP,[1,2,3] Wanda Robinson, MD,[1,2] Jewel Harden-Barrios, MEd,[1,3] Jeffrey Burton, PhD,[1,3] Todd Burstain, MD[1]

[1]Department of Internal Medicine, Ochsner Clinic Foundation, New Orleans, LA [2]The University of Queensland, Ochsner Clinical School, New Orleans, LA [3]Center for Applied Health Services Research, Ochsner Clinic Foundation, New Orleans, LA

Background: Opioid prescription drug abuse is a major public health concern. Healthcare provider prescribing patterns, especially among non–pain management specialists, are a major factor. Practice guidelines recommend what to do for safe opioid prescribing but do not provide guidance on how to implement best practices.

Methods: We describe the implementation of electronic medical record clinical decision support (EMR CDS) for opioid management of chronic noncancer pain in an integrated delivery system. This prospective cohort study will examine relationships between primary care physician compliance with EMR CDS–guided care (vs usual care), delivery of guideline-concordant care, and changes in the morphine equivalent of prescribed opioids. We report baseline characteristics of patients receiving chronic opioid therapy and organizational prescribing trends.

Results: Between August and October 2016, we identified 2,759 primary care patients who received chronic opioid therapy. Of these patients, approximately 71% had chronic noncancer pain, and 62% had diagnoses of depression/anxiety. Six of 36 primary care clinics each had >100 patients receiving chronic opioid therapy. When the EMR CDS launched in October 2017, we identified 54,200 patients who had received opioid therapy for at least 14 days from various specialty and primary care providers during the prior 24 months. Of these patients, 36% had a benzodiazepine coprescription, and 13% had substance abuse diagnoses.

Conclusion: Health system research that examines workflow-focused strategies to improve physician knowledge and skills for safely managing opioid therapy is needed. If EMR CDS proves to be effective in increasing adherence to practice guidelines, this EMR strategy can potentially be replicated and scaled up nationwide to improve population health management.

Keywords: *Analgesics–opioid, chronic pain, decision support system–clinical, electronic medical records, primary health care*

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