Multidisciplinary teams to manage pain patients receiving chronic opioids

Charlie Reznikoff, MD, FACP
Institute for clinical systems improvement (ICSI)
Hennepin County Medical Center (HCMC)
October 2017
I have no relevant financial relationships to disclose
Overview

• The challenges of prescribing opioids
• Opioid receiving patients a high risk group
• Core services for chronic opioid prescribing
• “CMC,” the HCMC approach
• Improving care in multiple practice settings
• “ECHO,” help is on the way
• The Collaborative outcome
Multimodal pain treatment

• Besides opioids, a pain patient needs multimodal care:
  – Physical therapy
  – Non opioid medications
  – Pain subspecialty consultation
  – Behavioral health
  – Surgery or intervention treatments
  – PM&R or Occupational Medicine
  – Acupuncture, massage, other integrative medicine
Prescribing opioids for pain requires system support

- Manage refills when the doc is not in the office
- Appropriate documentation of opioid/pain agreement and care plan
- Obtaining and interpreting urine toxicology
- Checking the PMP and meeting other guidelines
- EHR support, e.prescribing
- Ongoing process of updated prescribing practices to accord with new guidelines
More system supports for opioid receiving patients...

- Communication with pharmacy on behavioral concerns and drug interactions
- Case management, social work for patients
- Patient rep for handling dissatisfied patients
- Security staff, safety procedures, behavioral management
- Physician wellness to prevent burn out
- Physician incentives and patient satisfaction scores
Comorbidities in chronic pain patients

• Very high mental health comorbidity (50%)
  – Mental health complicates opioid use and pain
  – Mental health often not adequately addressed

• High rates addictive disorders (10%)
  – Overt addictions may be barriers to pain care
  – Undiagnosed addiction lead to mortality and provider uncertainty

• High medical comorbidity
  – The majority of deaths in this population are cardiovascular and infectious (pna)
Premise: chronic pain patients on opioids is a sick group, who require complex treatment, and pose many demands on the system
Premise: chronic pain patients on opioids are a sick group, who require complex treatment, and pose many demands on the system

We are underserving these patients
## Essential Core Services Summary

<table>
<thead>
<tr>
<th>Pain Management Program Components</th>
<th>Pain Management Specialist</th>
<th>Pharmacist</th>
<th>Pain Psychologist</th>
<th>Psychiatrist</th>
<th>Addiction Medicine</th>
<th>Physical Therapy</th>
<th>Care Manager</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Core services for patients treated with opioids for chronic pain

- Psychiatry or pain psychology referral
- Addiction Medicine referral
- Physical Therapy referral
- Pain subspecialty referral
- Pharmacist
- Care management
HCMC approach: Conservative Management Center (CMC)

- A dedicated clinic with a PharmD, nurse, nurse aid for patients on chronic opioids for pain
- All patients enrolled after 3 months of opioids
- Primary doc continues to prescribe
- The CMC monitors, educates and dispenses
- The patient interfaces with the CMC to pick up their opioids, and all opioid related interventions and services
CMC benefits

- Willing, trained, staff manage opioid issues for all patients: unburdens other clinics’ staff
- All providers are supported to meet latest guidelines
- Care is uniform system-wide
- The CMC staff forms longitudinal relationships with patients
- The CMC identifies outlying physicians and high risk patients, and intervenes
- The CMC staff meets to review patients once a week
- The CMC arranges referrals to the pain, addiction, PT, psychology and psychiatry as needed
Protocol-driven PharmD opioid tapers

- The pain PharmD had been conducting tapers and dose adjustments for at-risk patients
- She now offers voluntary opioid tapers, driven by protocols and her experience, and engaging the patients wishes
- So far, dozens of patients have voluntarily enrolled in the opioid tapering process
- This process is embedded in the CMC
HCMC’s pain clinic and CMC have the highest outpatient satisfaction scores in the HCMC downtown campus.
CMC finances and outcomes

• The PharmD documents visits and bills using treatment codes (MTM codes)
• Occasionally the nurse documents and bills
• The CMC runs slight financial losses
• The CMC generates referrals that results in net profit
• The CMC improves the flow of the primary care clinics, improving their efficiency
• Provider satisfaction dramatically improved
CMC review outcomes and referrals

The first three years, multidisciplinary review of chronic pain patients, outcomes:

• D/C opioids 27% (99/354)
• Addiction referral 24% (86/354)
• Continue with more monitoring 19% (69/354)
• Pain psychology 13% (45/354)
• Pain specialist (interventionalist) 8% (27/354)
HCMC is now in the process of extending CMC to other departments beyond Internal Medicine
Unintended consequences of CMC system?

• Inadvertent increase or facilitate opioid prescribing... “opioid autopilot”
• Patients no longer follow up with their primary doc as frequently
• Loss of system wide competence or training on these issues
• A minority of physicians dislike the oversight
• Recommendations are only partially evidence based, and still evolving
Multidisciplinary teams are judgment neutral on the topic of opioids for chronic pain.

The institution must provide guiding principals around opioids to the multidisciplinary team.
There is no one-size-fits-all approach

• CMC may not work for everyone:
  – Rural clinics, not geographically localized
  – Clinics with no ready access to subspecialists
  – For clinics with smaller total number of patients this might not be practical
  – Financial constraints
  – For “robust” systems, CMC may be largely redundant
## Promising Practices Essential Core Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Pain Management Program Components</th>
<th>Pain Management Specialist</th>
<th>Pharmacist</th>
<th>Pain Psychologist</th>
<th>Psychiatrist</th>
<th>Addiction Medicine</th>
<th>Physical Therapy</th>
<th>Care Manager</th>
<th>Other</th>
<th>If other is checked</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECHO</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>video conferencing</td>
</tr>
<tr>
<td>VA Program</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>telementoring</td>
</tr>
<tr>
<td>Telemedicine for MMT patients</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>mobile phone</td>
</tr>
<tr>
<td>SCOPE</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>✓</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>telephone device</td>
</tr>
<tr>
<td>Hub and Spoke program</td>
<td>✓</td>
<td>☐</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>✓</td>
<td>✓</td>
<td>☐</td>
<td>☐</td>
<td>MAT</td>
</tr>
</tbody>
</table>
ECHO project

• Started in New Mexico
• Provides teleconferencing physician to physician consultation for a geographically large area
• Offers consultation and debriefing on uncertain pain and opioid addiction cases
• Supports buprenorphine prescribing
• Funded by the state
ECHO project MN

- MN has adopted the ECHO project
- The Leaders of ECHO will be Dr. Bart and Grahan at HCMC (addiction)
- Many other ECHO centers statewide
- MN ECHO will provide addiction and other provider to provider consultation caring for high risk pain patients
- Expect more information in 2018
ICSI and Hospital Collaborative outcome on multidisciplinary teams

• ICSI and the hospital collaborative acknowledge core services required for safe opioid use in chronic pain patients
  – Psychiatry/Psychology, Addiction Medicine, Physical Therapy, Pain, Pharmacist, Care management

• Hospital systems will need to uniquely fit these services into their existing system

• ECHO may help provide consultation to underserved areas of the state
References

• Morasco J Pain 2017 april 18(4) p437
• Davis JABFM july-aug 2017 vol 30 no 4
• Wayne JAMA 2016 315(22) p. 2415
• Hasin AmJ Psych Aug 2013 170:8
• Vowles pain april 2015
• Boscarino J addictive disorder 2011 30(3) 185
• Gaither jgim Feb 2016
• Hser j of addiction medicine april 20, 2017
Thanks!
Questions?