
Assessing Chronic Opioid Management at an Internal Medicine-Pediatrics Clinic

Anh-Thu Tiffany Vu, Jeremiah Cheng

Introduction:

The number of deaths attributed to synthetic opioids has nearly tripled in the US from 1999 to 2014. Although there is limited evidence regarding the effectiveness of long-term opioid therapy for chronic pain, a condition estimated to affect 11.2% of the US adult population; opioids are often prescribed for this reason in the outpatient setting. The CDC has produced guidelines regarding safe opioid prescribing methods, however changes are also necessary within clinic systems to improve the safety and management of opioid prescriptions. This is particularly important in resident led clinics where multiple providers often see patients over the course of their care. Our quality improvement (QI) project aimed to standardize clinic workflow and management of chronic opioid prescription by implementing routine surveillance screening and creating a new patient survey. Providers were also encouraged to do the following: 1) update problem lists, 2) document specific surveillance dates and signed agreements, and 3) utilize a pre-made progress note template to address specific concerns with chronic opioid use.

From Loma Linda University Medical Center
(A.T.V., J.C.)

Accepted for Publication: November, 2018
The authors have no funding, financial relationships, or conflicts of interest to disclose.

Send correspondence to: *ANHVu@llu.edu

Methods:

On 10/1/16 the QI group introduced the following routine surveillance suggestions to clinic: 1) requiring an annually signed chronic pain agreement, 2) urine drug screen (UDS) collection at least every 6 months, 3) Controlled Substance Utilization Review and Evaluation System (CURES) report checked at every clinic visit. A template for chronic pain visits was created and shared with all clinic providers in an effort to improve these measures. Data was collected on clinic patients one year prior to implementation of the QI group interventions (10/1/15 - 10/1/16) and six months after implementation (10/1/16 - 6/1/17). To identify patients on chronic opioid therapy, an Epic report was generated, which filtered for specific pre-determined ICD-9 codes. Additionally, a physical list was kept in clinic on which providers would document the MRN and visit date of a patient who was on chronic opioid therapy. Eligible patients were flagged for any of the following if occurred during the collection time period: 1) pain agreement signed in the past 1 year, 2) weaning opiate therapy discussed, 3) CURES report checked, 4) UDS screen ordered in the past 6 months, 5) abnormal UDS/CURES report documented, and 6) alternate therapies discussed.

Results:

Pre-intervention data was collected from 10/01/15 to 10/01/16 (n=56). Pre-intervention data showed the following: 25.4% of encounters had documentation of a

pain agreement within the last year, 35.4% of encounters documented that weaning was discussed, 21.4% of encounters documented that CURES was checked or mentioned, and 37.5% of encounters documented that a screening UDS was performed within the last six months. Of 39 patients with documented UDS or CURES, 9 (23.0%) had a documented abnormal report.

Post-intervention data was collected from 10/01/16 to 06/01/17 (n=37) and showed the following: 72.2% of encounters documented a pain agreement within the last year, 81.0% of encounters documented a discussion of weaning medications, 88.5% of encounters documented that CURES was checked or mentioned, and 80.5% of encounters had documented that a screening UDS was performed within the last 6 months. Of 27 post-intervention patients, 12 patients (44.4%) had a documented abnormal UDS or CURES.

There were statistically significant differences in encounters documenting a pain agreement within the last year ($p < 0.001$), encounters in which weaning was discussed and documented ($p < 0.001$), encounters in which CURES was checked or mentioned and documented ($p < 0.001$), and encounters in which there was documentation that a screening UDS was performed within the last six months ($p = 0.001$). There was not, however, a statistically significant difference in the percentage of encounters in which UDS or CURES was abnormal ($p = 0.22$).

Conclusions:

The QI intervention shows a statistically significant increase in provider compliance to a new clinic-specific standardized workflow and management practice for opioid prescriptions given to chronic opioid

users. This, however, did not result in a decrease in the number of patients with an abnormal UDS or CURES though data was only collected for a six-month period after the intervention began.

The data was fully dependent upon documentation by the provider, which creates the possibility of introducing bias into results. As compliance with the progress note template increases, the degree of error arising from the assumption of the correlation of documentation and real practice should decrease accordingly.

Primary care physicians are responsible for a significant burden of opioid prescriptions. Introducing a new opioid-centered clinic template improved clinic workflow and potentially may lead to safer prescribing methods. These efforts reflect an effort to minimize prescription opiate abuse. The next steps in our QI project aims to evaluate safety and efficacy by utilizing information that will now be documented in every chronic pain clinic visit, specifically morphine equivalents, PEG scores, concurrent benzodiazepine use, and concomitant high risk diseases (alcohol abuse, depression, anxiety).

References:

1. Rudd RA, Set P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths- United States, 2010-2015. *MMWR Morb Mortal Wkly Rep* 2016;65:1445-1452.
2. Nahin RL. Estimates of pain prevalence and severity in adults: United States, 2012. *J Pain*. 2015; 16(8):769-780.