OPIOID PRESCRIBING PROCESS AND QUALITY IMPROVEMENT PROJECT (OPPIP)

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Introduction

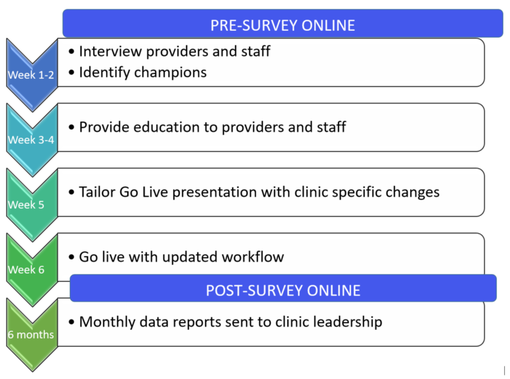
In 2018, North Carolina health care providers wrote 61.5 opioid prescriptions for every 100 persons, roughly 10 more prescriptions than the US average. That same year, nearly 80% of North Carolina fatal overdoses involved opioids. It is critical that health systems implement ongoing strategies for safe opioid prescribing.[1]

At Duke University Health System, our team of clinicians is working to improve opioid prescribing processes for patients with chronic pain across primary care and specialty practices. Our team's ultimate goal is to develop clinic-specific processes and education that aide practices to meet current expectations and regulatory standards in managing patients who receive chronic opioid therapy.

Quality Improvement Approach

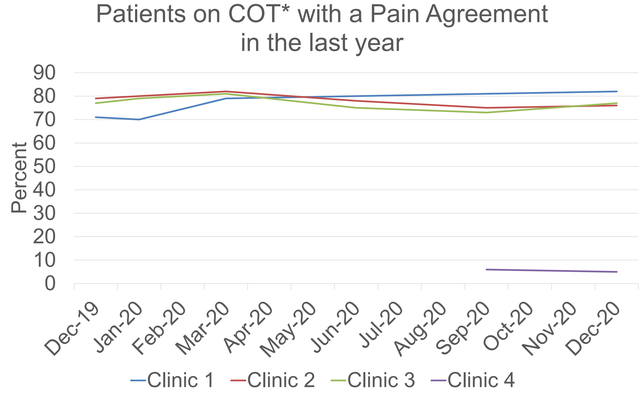
We utilize EHR data to identify high-opioid-prescribing clinics that are underutilizing urine drug screens, pain agreements and naloxone, and who may benefit from a system-based approach to opioid prescribing. Our multi-step quality improvement cycle includes:

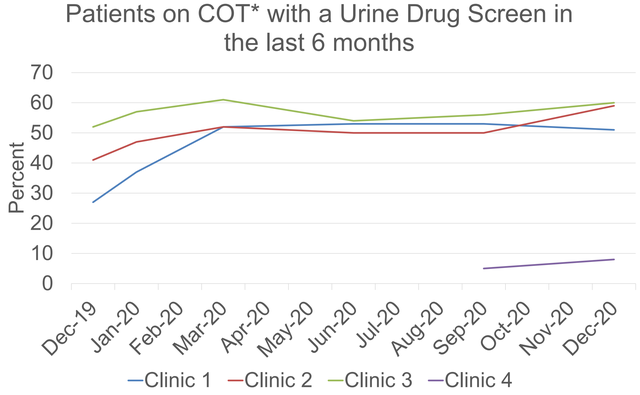
1. needs assessment
2. champion identification
3. tailored education
4. updated workflow(s)
5. ongoing support and monthly data reports for six months post-intervention



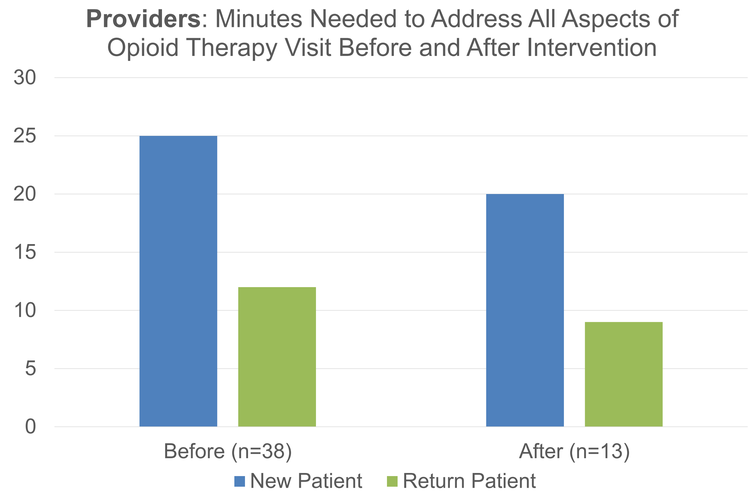
1. NIDA. 2020, April 3. North Carolina: Opioid-Involved Deaths and Related Harms. Retrieved from https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/north-carolina-opioid-involved-deaths-related-harms on 2021, March 17

CLINICAL MONITORING OUTCOMES





CHANGE IN PROVIDER BEHAVIOR



Results

Participating clinics increased overall use of urine drug screens and pain agreements for patients on chronic opioid therapy.* Although these improvements in monitoring stagnated during early months of the pandemic, they have since rebounded and been sustained.

After the intervention, providers reported needing less time to address all aspects of an opioid therapy visit for both new and returning patients. Staff involvement in pre-screening for opioid refills increased from 19% to 50% (pre and post intervention).

One of the four participating clinics did not demonstrate improvement in use of urine drug screens and pain agreements. This clinic had low readiness and the most provider resistance, underscoring the importance of buy in from all levels.

Conclusions

Opioids can be an appropriate treatment to help patients manage their chronic pain and should continue to be prescribed in primary care and specialty practices.

Chronic pain management with opioids requires ongoing monitoring and risk-benefit analysis centered in patient safety. Creating a culture of shared responsibility through quality improvement can streamline clinic activities and take some burden off providers.

Acknowledgements

This research project was funded by the Duke Endowment. This project is supported by the Duke School of Medicine's Opioid Collaboratory, administered through the Department of Population Health Sciences. The Collaboratory's mission is to save lives and reduce the harmful impact of opioids in North Carolina through the development, implementation, and/or evaluation of system-level interventions.

***Chronic Opioid Therapy (COT)** defined as: Patients with at least one 90-day opioid prescription, three consecutive 30-day opioid prescriptions, or an up-to-date pain agreement in a 12-month period

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