



DEPARTMENT OF THE AIR FORCE
59TH MEDICAL WING (AETC)
JOINT BASE SAN ANTONIO - LACKLAND TEXAS

18 MAY 2016

MEMORANDUM FOR ST
ATTN: SANDRA VALTIER

FROM: 59 MDW/SGVU

SUBJECT: Professional Presentation Approval

1. Your paper, entitled **Feasibility of Implementing an Opioid Risk Mitigation System** presented at/published to the **2016 SURF Meeting, TX 20 May 2016** with MDWI 41-108, and has been assigned local file #**16213**.
2. Pertinent biographic information (name of author(s), title, etc.) has been entered into our computer file. Please advise us (by phone or mail) that your presentation was given. At that time, we will need the date (month, day and year) along with the location of your presentation. It is important to update this information so that we can provide quality support for you, your department, and the Medical Center commander. This information is used to document the scholarly activities of our professional staff and students, which is an essential component of Wilford Hall Ambulatory Surgical Center (WHASC) internship and residency programs.
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Linda Steel-Goodwin

LINDA STEEL-GOODWIN, Col, USAF, BSC
Director, Clinical Investigations & Research Support

PROCESSING OF PROFESSIONAL MEDICAL RESEARCH/TECHNICAL PUBLICATIONS/PRESENTATIONS

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5. PROTOCOL TITLE: (NOTE: For each new release of medical research or technical information as a publication/presentation, a new 59 MDW Form 3039 must be submitted for review and approval.) Identification Of Risk Factors That Predict Long-Term Opioid Use And Subsequent Adverse Events			
6. TITLE OF MATERIAL TO BE PUBLISHED OR PRESENTED: Feasibility of Implementing an Opioid Risk Mitigation System			
7. FUNDING RECEIVED FOR THIS STUDY? ☒ YES ☐ NO FUNDING SOURCE: JPC-5 Substance Abuse Working Group			
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LAST NAME, FIRST NAME AND M.I.	GRADE/RANK	SQUADRON/GROUP/OFFICE SYMBOL	INSTITUTION (If not 59 MDW)
a. Primary/Corresponding Author Erin Finley			UTHSCSA/South Texas VA
b. Jennifer S. Potter			UTHSCSA
c.			
d.			
e.			
f.			
I CERTIFY ANY HUMAN OR ANIMAL RESEARCH RELATED STUDIES WERE APPROVED AND PERFORMED IN STRICT ACCORDANCE WITH 32 CFR 219, AFMAN 40-401_IP, AND 59 MDWI 41-108. I HAVE READ THE FINAL VERSION OF THE ATTACHED MATERIAL AND CERTIFY THAT IT IS AN ACCURATE MANUSCRIPT FOR PUBLICATION AND/OR PRESENTATION.			
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Feasibility of Implementing an Opioid Risk Mitigation System

Qualitative Lead: Erin P. Finley, Ph.D., M.P.H.

Principal Investigator Jennifer Sharpe Potter, Ph.D., M.P.H.

May 20, 2016



Disclaimer

The views expressed are those of the presenters and do not reflect the official views or policy of the DoD or its components.

The voluntary, fully informed consent of the subjects used in this research was obtained as required by 32 CFR 219 and DODI 3216.02_AFI 40-402.

Overview

- Qualitative Goals
- Data collection methods
- Preliminary findings
- Next steps and problem-solving

Goals

Wave 1

- To identify providers' knowledge, attitudes, and behaviors regarding opioid prescription management and monitoring
- To learn from providers about what would be necessary to make expected reports useful and functional in their setting/context

Wave 2

- Return to providers with plan for PDMP and/or generated reports to assess feedback, barriers and facilitators, and training/facilitation needs for successful implementation

Recruitment and Methods

- Referrals, calling and follow-up
- BAMC visit
- Brief telephone interviews (15-20 minutes)
- No audiorecording -> corroborated note-taking

Interviews

25 formal (6 informal), with diversity in:

- **Specialty:** emergency medicine physicians (13), psychologist , orthopedic surgeon, internists (4), geriatrics/palliative care, nurse manager (MSN, RN), RN, PharmD, PA, Pain specialists (2, 1 scheduled), family/community medicine
- **Roles:**
 - 5 identifiers
 - 19 prescribers (1 more scheduled)
 - 1 responder
- **Services:**
 - 12 Air Force (including retired and active duty)
 - 13 Army
 - 5 Civilian

Interview Content

- PARIHS (Promoting Action on Implementation Research in Health Services)
- Literature review focusing on:
 - Barriers and facilitators/implementation/uptake

PARIHS

Perceived Evidence

- Research/practice guidelines
- Clinical experiences and perceptions
- Patient experiences, needs, and preferences (perceived)
- Local practice information
- Characteristics of the targeted evidence-based practice

Context

- Leadership support
 - Culture
 - Evaluation capabilities
 - Receptivity to the targeted innovation/change
- 

Literature search

- Facilitators
 - PDMP users believe in their utility
- Barriers
 - Lack of awareness
 - Lack of training
 - User interface complexity
 - Time burden
 - Delay in data
- Little available literature on contextual readiness and facilitation

Analysis

- Dedoose
 - Online software for mixed-method studies
- Revision(s) of initial coding scheme
- Initial coding and training (2 coders, 3rd for 50%)
- 16 interviews coded
- Focus on “big bucket” coding → themes identified using PARIHS and prior literature search
- Attentive to emergent concerns

Results

- Complex clinical decision-making

- Baseline behaviors for opioid prescribing and monitoring

Crux of the decision depends on whether it's acute or chronic pain. For acute, I am likely to give opiates. For fracture or traumatic injuries, I will certainly give opioids. Hydrocodone rather than oxy because oxy causes more nausea. Chronic pain I'm very less likely to give opioids unless it is one of the situations where 'oh the dog ate my prescription', then I will give 10 pills to hold them over until they talk to or get back to their pain management specialist. I only give enough to bridge them over until they can see their primary. I very much disapprove of pain meds for chronic pain.

Clinical Experiences and Perceptions

- Provider role/setting
- Education/training
 - Formal training in pain or substance abuse relatively rare
- Prior PDMP experience
 - Few mention use of Texas PDMP
 - More common mention of PDMP use (self/observed) during residency elsewhere

I really liked it. For residents it was very helpful. However, all you can do is judge based on info on the screen. There's not really a way to assess if there were holes in the information. For us, we were at the state border, so the patient information wouldn't always carry over into the system. Sometimes we wouldn't see if they got a medication across the border.

Clinical Experiences and Perceptions

- Tensions and balancing act
 - Appropriate/ethical practice
 - Patient satisfaction

There are the ones [providers] that give out all the meds that patients ask for. There's also clinical reasons for less concerned providers. It depends on the setting. Also depends on recent ratings in emergency medicine. Patient satisfaction is usually based on if they get what they want. You're aware that your [patient satisfaction] score increases or decreases depending on that. We typically take criticism from our supervisor or whoever reviews the complaints, but there are competing interests in the way the system works.

Patient Needs and Preferences

- Patient population
 - Active duty, retirees, dependents, injured, polytrauma
- Opioid abuse/misuse/diversion
- Patient needs and vulnerabilities
 - *Let me make a comment on the civilian side. Oxy and hydrocodone were made Schedule II last year. You have to have a triplicate to get it. Most guys don't have that and they're just giving them Tylenol 3, but it doesn't work for 20% of the patients who have the enzyme to break it down in the body. What's going on is that people can't get the oxy anymore because people don't prescribe them anymore, so now we have this huge surge in heroin. Any kind of attempt to limit opiate access... these people are sick and they have an addiction, they are going to get heroin instead.*

Perceived Characteristics of PDMPs

- Relative advantage
 - *[The current system] would only come back positive on CHCS if they used Tricare. If they went to see someone paying in cash, You wouldn't see that. The Louisiana [PDMP] would tell you that no matter what method they use to pay. The DoD is limited in that you can only see what Tricare was being billed for. Louisiana is contracted by several other states that would ping other nearby states. Ideally [the military PDMP] it would be integrated with state systems and neighboring states.*

Perceived Characteristics of PDMPs, II

- Compatibility, complexity, and design
 - Ease of use
 - Ease of access (e.g., available to residents, mid-levels, medical licenses in other states)
- Acceptability
 - *Any tool that makes me a better provider for my patient would be good. My colleagues would say the same thing.*
 - Concerns/perceived problems with PDMP
 - *It's hard for us to see too many downsides. The only thing is that it may avoid people from getting medication that they need. Other than that can't see anything else*

Context

- New electronic health record (EHR)
- Military slow to adopt
- Busy providers
- Current workflow
- Leadership/chain of command
- Experiences with military EHRs

There's already a system [in the military] called CHCS, which is an EHR system. It is not user friendly. Ideally, [a new PDMP] would be something that needs to be integrated into the current system or workflow. If there's some way to monitor what meds are getting to some people. The only ones we can see is from military providers. If you want to see what non-military providers are prescribing, you have to really dig for it. It's not an intuitive method to find it. You have to really know how to do it. There's so many steps to go through... It needs to be robust in the sense that it needs to be comprehensive and can access easily. It needs to be integrated.

PDMP Reports

- Information to include
 - Diagnosis
 - Prescriptions, prescriber, setting received, dose, number pills
 - Varying time periods
 - Prior history of substance abuse or other risk factors
- User interface
- Location
- EHR Integration

Conclusions

- Military providers at times struggle to access necessary information to inform safe and high-quality pain care
- Providers report that a military-based PDMP would offer valuable tool for clinical decision-making
- PDMP would need to be well-integrated into current/future EHR systems and clinic workflows to be of highest utility
- Ease of access across clinical team should be considered
- Initial and ongoing training on PDMP is likely to be important in ensuring optimal use and continuous learning

Thank you!

Contact: Erin P. Finley, PhD MPH
finleye@uthscsa.edu