Community in Crisis: A Collaborative Approach to Responding to the Opioid Epidemic
The survey that put Wilmington on the map... literally.

Castlight Study

#1 in the Nation

For opioid ABUSE

Wilmington, NC
Impact in the Region

NC Population 10,042,802

2016→ 9,285,207 prescriptions for controlled substances
663,041,229 pills dispensed for controlled substances.

Enough for 60 pills per person

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Prescriptions per 100 Residents</th>
<th>Total Pills</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hanover County (2016)</td>
<td>220,358</td>
<td>102.7</td>
<td>15,301,444</td>
</tr>
<tr>
<td>Brunswick County (2016)</td>
<td>122,765</td>
<td>110.7</td>
<td>11,484,062</td>
</tr>
<tr>
<td>Columbus County (2016)</td>
<td>58,098</td>
<td>189.1</td>
<td>8,144,173</td>
</tr>
<tr>
<td>Pender County (2016)</td>
<td>57,611</td>
<td>50.6</td>
<td>4,632,414</td>
</tr>
</tbody>
</table>
SEAHEC’s Role

- Member of Southeastern North Carolina Regional Health Collaborative- Health Directors voiced concern
- Bridge education to practice for providers
- Has established professional relationships in community with health providers and other stakeholders
- Took lead role in developing opioid harm reduction initiative
A Community in Crisis Requires a Community Solution

July 27th, Call to Action with State Health Director

Areas of Priority Identified:

- Communication & Collaboration
- Education & Awareness
- Punitive to Supportive Systems
- Access & Crisis Response

Resulted in 2-Day Conference

Day 1: Education on Priority Areas
Day 2: Strategies and Solutions for Priority Areas
## AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00—8:30am</td>
<td>Registration &amp; Light Breakfast</td>
<td></td>
</tr>
<tr>
<td>8:30—8:50am</td>
<td>Welcome &amp; Overview</td>
<td></td>
</tr>
<tr>
<td>8:50—9:00am</td>
<td>How Did We Get Here?</td>
<td>Howard Williams, MD, FACOG&lt;br&gt;Director of Health Services &amp; State Health&lt;br&gt;Raleigh, NC</td>
</tr>
<tr>
<td>9:00—9:15am</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>9:15—9:30am</td>
<td>The Opioid Epidemic: The Scope of the Problem in North Carolina</td>
<td>Allen Deukowski, Jr., BS, MPH&lt;br&gt;Chief Medical Officer, Division of Substance Abuse Prevention &amp; Policy, Raleigh, NC</td>
</tr>
<tr>
<td>9:30—10:00am</td>
<td>Response from the US Attorney’s Office</td>
<td>Leslie K. Conley, JD&lt;br&gt;Deputy Chief Criminal Deputy Attorney&lt;br&gt;United States Attorney’s Office&lt;br&gt;Raleigh, NC</td>
</tr>
<tr>
<td>10:00—10:15am</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>10:15—11:00am</td>
<td>Reaching, Teaching, and Treating the Community: A Comprehensive Approach</td>
<td>Fred Wells Branden II&lt;br&gt;President/CEO, Project Lincoln&lt;br&gt;Monroe Falls, NC</td>
</tr>
<tr>
<td>11:00—11:15am</td>
<td>Quick Response Team: One Community’s Response to the Heroin/Opiate Epidemic</td>
<td>Daniel P. Murphy, DDS&lt;br&gt;Deputy Director of Public Health&lt;br&gt;Raleigh, NC</td>
</tr>
<tr>
<td>11:15—12:00pm</td>
<td>The Opioid Epidemic: Response from a Major Health System</td>
<td>Larry Greenside, MD&lt;br&gt;Duke Health&lt;br&gt;Greenville, NC</td>
</tr>
<tr>
<td>12:00—1:30pm</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1:30—2:15pm</td>
<td>LEAD-OFF: An Intensive Intervention Program</td>
<td>Harry Johnson, LCSW&lt;br&gt;Executive Director&lt;br&gt;Santa Fe, NM</td>
</tr>
<tr>
<td>2:15—3:00pm</td>
<td>Planning for the Future: Trellis Health Resources’ Recovery Oriented System of Care</td>
<td>Christopher McClelland, MD, LCSW&lt;br&gt;Director of Opioid Programs&lt;br&gt;Santa Fe, NM</td>
</tr>
<tr>
<td>3:00—3:15pm</td>
<td>A Place of Refuge: The Faith-Based Community’s Role in Fighting the Opioid Epidemic</td>
<td>Pastor Mark Atkins&lt;br&gt;Faith Community Church&lt;br&gt;Winston-Salem, NC</td>
</tr>
<tr>
<td>3:15—4:00pm</td>
<td>Action Plan in Winston-Salem / Wrap-Up</td>
<td></td>
</tr>
<tr>
<td>4:00—4:15pm</td>
<td>Next Steps / Adjourn</td>
<td></td>
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</tbody>
</table>

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#1 in the Nation

For opioid ABUSE

Wilmington, NC

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Over 300 participants filled Union Station to hear about best practices for opioid harm reduction from organizations and entities from across the country. Those in attendance included:

- 5 Hospitals and Health Systems
- Law Enforcement from 6 counties
- Behavioral Health and Substance Abuse Agencies representing 26 counties
- Department of Social Services from 4 counties
- Local and State Judicial System Representation
- 8 School Systems, Higher Education, and Academic Institutions
- Pharmacy representation from 3 counties
- First Responders from 7 counties
- 7 Health Departments
- Grassroots Organizations
- Faith Based Community
- Legislators
- Community Members
Best Practices...

Quick Response Team
- Colerain Township: In 2011 there were 51 heroin related overdoses
- By 2014 there was 141
- Police, Firefighters and Paramedics working together connected by a social worker/case manager
When a person receives Narcan, the SW is notified and makes the connection
- Engage patients where they are → 80% enter treatment

LEAD (Law Enforcement Assisted Diversion)
- Allows officers to redirect low level offenders engaged in drugs to community based services instead of jails
- Participants begin working with case managers to access services
- Goal to reduce harm to participant and community
- Diversion in pre-booking bypassing costs and time and provides access to case management

Project Lazarus Model
The Project Lazarus model can be conceptualized as a wheel, with three core components (The Hub) that must always be present, and seven components (The Wheel) which can be initiated based on specific needs of a community.
Strengthen Opioid Misuse Prevention (STOP) Act (House Bill 243)

- Passed unanimously by both houses of the General Assembly and signed by Governor in June, 2017
- Targeted Schedule II and Schedule III Opioids

Prescribers Provisions

- Limits first-time prescriptions of targeted controlled substances for acute pain to ≤5 days
- Prescriptions following a surgical procedure limited to ≤7 days
- Allows follow-up prescriptions as needed for pain
- Limit does not apply to controlled substances to be wholly administered in a:
  - hospital, nursing home, hospice facility, or residential care facility
- Dispensers not liable for dispensing a prescription that violates this limit

Effective January 1, 2018

Prescribers Provisions

Requires a Controlled Substance Reporting System (CSRS) check prior to prescribing targeted controlled substances for the first time and then every 90 days if prescription continues
- Must review patient information in CSRS for past 12 months
- Must document CSRS check in medical record
- CSRS check not required for controlled substances administered in a:
  - health care setting, hospital, nursing home, dialysis facility, or residential care facility
- CSRS check not required for controlled substances prescribed for:
  - hospice or palliative care or for the treatment of cancer pain
- DHSS shall:
  - conduct periodic audits of the review of CSRS by prescribers
  - report violations of the requirement to check CSRS to licensing boards,
  - Boards may suspend or revoke prescribers’ licenses

Effective date: only after CSRS achieves certain improvements
The structure of collaboration...

- Supported stakeholders and agencies in coming together to discuss their organizational resources and needs

- Development of Community Partners Coalition
  - The Community Partners Coalition (CPC) works to improve collaboration and coordination between those who provide care to individuals seeking access to mental health and substance use services.
  - Does not function primarily to begin new initiatives
  - Works to align current initiatives
Assess Needs & Resources (Data Action Team)

Prioritize

Select/Develop Strategies

Evaluate

Implement/Act

Community Partners Coalition

Healthcare, Mental Health, Substance Use

First Responders

Faith Based

Public Health

Grassroots/Nonprofits

Courts

Government

Housing

Transportation

Business

Community Members

Education
It's all about the framework...
**Action Plan**

**Primary Prevention:**
1) Increase Med Safety Efforts
2) Prevent opioid misuse and abuse in youth.
3) Educate seniors in region on medication safety.
4) Develop/implement community “Reframe Pain” campaign.

**Professional Intervention**
1) Create and distribute regionally specific clinical practice prescribing resource guide.
2) Transition pain messaging from rating pain to achieving function.
3) Disseminate best practice education for providers in region.

**Treatment and Recovery:**
1) Educate provider community and encourage use of underutilized resources.
2) Disseminate information throughout provider community on trends, best practice, resource deficits, and resource underutilization.
3) Work with First Responders to assess needs and better utilize involuntary commitment process.

**Infrastructure and Support:**
1) Secure comprehensive electronic platform that community members can access to seek services.
2) Disseminate and market platform through various systems, sectors, organizations, and communities.
Primary Prevention Goal: Prevent opioid use and misuse.

Strategy: Increase med safety efforts.
- Partnered with large regional church to hold awareness and education event with resource fair; over 1200 in attendance and 50 on-site resources/vendors.
- Medication lock-boxes provided for patients at risk of having medications diverted in five counties in region.
- Seven permanent medication drop boxes added in community.
- Medication Take-Back Event on 10.28.17; 9 sites in 4 counties collected nearly 2900 pounds of medications, approximately 25,000 sharps, and was able to donate over $52,000 worth of medications and supplies.
- Upcoming Take-Back Event at 6 Counties, in 15 different counties, with 5 health systems.

Strategy: Prevent youth use and misuse.
- Working with County school system to educate teachers and administration on effects of adverse childhood events, substance use and Mental Health First Aid.
- Hosting youth engagement summit with multiple organization Summer 2018.

Strategy: Educate seniors on medication safety.
- Working with senior centers in region to develop curriculum for educational sessions.
- Training senior volunteers to host educational sessions.
- Educational forum targeting seniors planned Summer 2018.

Strategy: Develop and implement community “Reframe Pain” campaign.
- Partnering with Professional Intervention Action Team to develop simultaneous message to providers and community.
- Working with SMEs to create message of redefining pain and function of daily living.
- Working on community informational material regarding safe opioid-use tips as well as use of non-pharmacological resources for pain management.
How’s It Going?

**Professional Intervention- Goal:** Enable standardization of pain management in region.

**Strategy:** Create regional clinical practice controlled substance prescribing guide.

- Completed. Being distributed throughout region. [WORKBOOK](#)

**Strategy:** Transition pain messaging from rating pain to achieving function.

- Working with SMEs to create training opportunities for prescribers.
- Identifying tools to use for assessment.

**Strategy:** Disseminate best practice and education for providers in region.

- Worked with regional health system to help develop system-wide safe prescribing policies for controlled substances
  - Working to standardize guidelines through region.
- Over 500 prescribers educated on the CDC safe prescribing guidelines PLUS education provided on pain management
  - Currently focused on providing opportunities for providers to receive support for difficult cases.
- Partnered with large regional church to host education event for pastors from over 80 churches in region focused on best practices in opioid harm reduction and the church’s role in response to the epidemic.
- Providing quarterly web-based opportunities to disseminate updates in best practice.
- Working to identify and reach providers who need additional support and resources in treating population.
How’s It Going?

Treatment and Recovery: Goal- Improve gaps in service by better utilization of resources.

Strategy: Increase provider education on underutilized resources.

- Holding monthly team site visits at unknown or underutilized organizations to learn more about services offered.
- Creating fact sheets about organizations that are electronically distributed to service providers in multiple sectors.
- Created cards for first responders to distribute to individuals post reversal and their family members regarding services in area.

Strategy: Work with providers and First Responders to develop innovative treatment options and address service gaps.

- Development and implementation of LEAD program allowing officers to redirect low level offenders engaged in drugs to community based services instead of jails.
- Development, advocacy, and implementation of Quick Response Team designed to engage those successfully reversed by naloxone with treatment
  - Pilot funded
- Development and implementation of Navigation Project aimed to reduce over utilization of emergency departments for mental health and substance use disorder when other levels of more appropriate
  - Pilot funded
How’s It Going?

Infrastructure and Support: Goal- Align resource and service information dissemination in region.
Strategy: Secure comprehensive electronic platform so community can access and seek services to resources.

- Funding secured with grant and sustainability by health system.
- Vendor selected and site in build.
- Compiled comprehensive list of various resources used throughout the region by multiple agencies.
- Developing marketing plan for platform via various sectors/stakeholders.

Our Community Link

A social determinants platformed designed to help people access the services they need to achieve their best health.
- Resource guide based on eligibility
- Ability to screen for social determinants
- Loop closure/case management communication between agencies
Is it making a difference?

New Hanover County

172 OPIOID OVERDOSE EMERGENCY DEPARTMENT VISITS

2017 YTD

Opioid Diagnosis ED Visits by Month:
New Hanover County, 2017 YTD

172 Year-to-Date Opioid Diagnosis ED Visits in New Hanover
versus January to December 2016 178

Source: NC DETECT, ED Syndrome: Overdose: Opioid Overdose (ICD-9-CM)

Note: Counts based on diagnosis (ICD-9-CM code) of an opioid overdose of any intent (accidental, intentional, assault, and undetermined) for North Carolina residents. Opioid overdose causes include poisonings with opium, heroin, opioids, methadone, and other synthetic narcotics.

Opioid Diagnosis ED Visits by Age Group

Opioid Diagnosis ED Visits by Race

New Hanover, 2017 YTD North Carolina, 2017 YTD

White

Black

Other

0%
10%
20%
30%
40%
50%
60%

0-4
5-9
10-14
15-19
20-24
25-34
35-44
45-54
55-64
65+

NORTH CAROLINA INJURY AND VIOLENCE PREVENTION

www.injuryfreenc.ncdhhs.gov 1/16/2018
## Is it making a difference?

### First Responders Overdose Response Calls

<table>
<thead>
<tr>
<th>County</th>
<th>Jan-March 2017</th>
<th>Jan-March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>124</td>
<td>79</td>
</tr>
</tbody>
</table>

### Heroin Related Deaths

<table>
<thead>
<tr>
<th>County</th>
<th>2016</th>
<th>2017 (provisional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hanover</td>
<td>46</td>
<td>19</td>
</tr>
<tr>
<td>Pender</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Brunswick</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Columbus</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Duplin</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

### Fentanyl and/or Analogue-Related Deaths

<table>
<thead>
<tr>
<th>County</th>
<th>2016</th>
<th>2017 (provisional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hanover</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>Pender</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Brunswick</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Columbus</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Duplin</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
### Is it making a difference?

#### Raw # Pills
- **October 2017**: 322679
- **November 2017**: 301650
- **December 2017**: 287771
- **January 2018**: 292427

#### Raw # Pills per Patient Encounter
- **October 2017**: 78.99
- **November 2017**: 73.77
- **December 2017**: 72.96
- **January 2018**: 75.31

#### Raw # Prescriptions
- **October 2017**: 7525
- **November 2017**: 6909
- **December 2017**: 6703
- **January 2018**: 6454

#### Raw # Prescriptions per Patient Encounter
- **October 2017**: 1.84
- **November 2017**: 1.69
- **December 2017**: 1.70
- **January 2018**: 1.72

#### # Naloxone Prescriptions
- **October 2017**: 151
- **November 2017**: 57
- **December 2017**: 23
- **January 2018**: 16

#### # Patients with Duplicate Narcotics
- **October 2017**: 1960
- **November 2017**: 1780
- **December 2017**: 1714
- **January 2018**: 1370

#### % Patients Receiving Adjuvant Meds
- **October 2017**: 31.11%
- **November 2017**: 31.78%
- **December 2017**: 31.72%
- **January 2018**: 31.14%

The data shows a consistent decrease in the number of raw # pills and raw # prescriptions over the months of October to January 2018. The # of Naloxone Prescriptions also shows a decrease, while the # of Patients with Duplicate Narcotics decreases slightly. The percentage of patients receiving adjuvant meds remains relatively stable.
Lessons Learned...

- Community needed a bridge
  - People/Organizations doing great work that no one knew about
  - Need a person/agency to engage and bridge all sectors together
- All about relationships
- You don’t have to spend a lot of money to collaborate and coordinate.
- TIME CONSUMING
  - Bridge organization/person spends majority of time working with other organizations
- Goal is destigmatizing addiction. Period.
- **This is not about opioids; it’s about SYSTEMS**
  - Opioids are what brought people to the table but it’s not just about opioids; about the conditions around why individuals use
    - Social Determinants of Health
  - The system that is failing is the system we created
    - If we don’t address all, change will not sustain
- We’ve got to get better at telling our **story**.
PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS Mentors are a national network of providers with expertise in **addictions**, pain, **evidence-based treatment** including medication-assisted treatment.

  - 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.

  - No cost.

For more information visit: pcssnow.org/mentoring
Have a clinical question?

Ask a Colleague

A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now
PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

<table>
<thead>
<tr>
<th>American Academy of Family Physicians</th>
<th>American Psychiatric Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Neurology</td>
<td>American Society of Addiction Medicine</td>
</tr>
<tr>
<td>Addiction Technology Transfer Center</td>
<td>American Society of Pain Management Nursing</td>
</tr>
<tr>
<td>American Academy of Pain Medicine</td>
<td>Association for Medical Education and Research in Substance Abuse</td>
</tr>
<tr>
<td>American Academy of Pediatrics</td>
<td>International Nurses Society on Addictions</td>
</tr>
<tr>
<td>American College of Emergency Physicians</td>
<td>American Psychiatric Nurses Association</td>
</tr>
<tr>
<td>American College of Physicians</td>
<td>National Association of Community Health Centers</td>
</tr>
<tr>
<td>American Dental Association</td>
<td>National Association of Drug Court Professionals</td>
</tr>
<tr>
<td>American Medical Association</td>
<td>Southeastern Consortium for Substance Abuse Training</td>
</tr>
<tr>
<td>American Osteopathic Academy of Addiction Medicine</td>
<td></td>
</tr>
</tbody>
</table>
Educate. Train. Mentor

@PCSSProjects
www.facebook.com/pcssprojects/

www.pcssNOW.org
pcss@aaap.org

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Where to Start?

To be compliant with the NC STOP Act and to provide high quality care for patients prescribed chronic pain medication, it is important to take the time to understand your practice’s current controlled substance prescribing behaviors. These behaviors may vary by prescriber, resulting in multiple workflows that cannot be easily monitored.

With help from the Greensboro AHEC’s Practice Support Team and members of SEAHEC, NHRMC, Trillium, Community Care of the Lower Cape Fear, Lower Cape Fear Hospice and Coastal Horizons, this workbook has been developed to help you in your practice follow a systematic approach to:

1. Understanding the NC STOP Act and how it affects your practice.
2. Assessing your current controlled substances prescribing procedures and workflows.
3. Implementing changes that can help reduce confusion, complexity, and waste.
4. Ensuring the safety of your patients.

Examples of practice workflows, policies, and patient controlled substance treatment agreements are included. We encourage you to use these examples as starting points in developing documents that would best fit your practice.

This workbook does not suffice as a project management workbook; therefore, we encourage you to assign a point person in your practice to manage this project and ensure its completion.

In addition to using this controlled substance prescribing workbook, the SEAHEC Practice Support team is available to work with you and help your practice assess workflows and develop policies and procedures related to this topic, or other areas within your practice.

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STOP Act Summary

During the Summer of 2017, North Carolina Governor Roy Cooper signed House Bill 234, the STOP Act, into law.¹ The STOP Act, which stands for the Strengthen Opioid Misuse Prevention Act, seeks to help curb epidemic levels of opioid drug addiction and overdose in North Carolina.

<table>
<thead>
<tr>
<th>What Changes for You?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education Requirements</strong></td>
</tr>
<tr>
<td><strong>Effective July 1, 2017</strong> Physicians must complete 3 hours per 3 year cycle of Category 1 Controlled Substance CME.</td>
</tr>
<tr>
<td>PAs are required to complete 2 hours per 2 year cycle.</td>
</tr>
<tr>
<td><strong>Effective January 1, 2020</strong> Pharmacies are required to report targeted controlled substance prescriptions to NC CSRS by close of business the day after a prescription is delivered.</td>
</tr>
</tbody>
</table>

The STOP Act went into effect July 1, 2017 and only applies to the “targeted controlled substances” Schedule II and III opioids and narcotics per the North Carolina Controlled Substance Act.²³
Policy Assessment Workbook

What is your practice’s policy for prescribing controlled substances?

Whether your practice currently has a formal policy in place, an unwritten process, or no policy at all, you can follow these 12 steps below as a guideline to ensuring your practice has a robust policy in place.

1. **Assess your current policy.**
   - Is this policy written down? **YES** **NO** Skip to Step 2
   - Where is this policy kept? Location: __________
   - Has this policy been reviewed/updated within the last year? **YES** **NO** Review Date:
   - Does this policy reflect actual clinic workflows? **YES** **NO** Skip to Step 4
   - Had this policy been reviewed with staff within the last year? **YES** **NO** Skip to Step 2
   - Can you easily write down this policy? **YES**
   - Set deadline to write this policy.
   - Policy approved by management.
   - Policy reviewed with staff.
   - Policy will be reviewed at X frequency going forward.

2. **Assemble a team to create a policy for prescribing controlled substances.**
   (See page 9 for policy example).
   A diverse team helps to see the process from several different angles and to gain perspective to pieces of the process that are unfamiliar or overlooked. In addition, it fosters ownership and encourages buy-in.
   Team Members: ________________________________

3. **Establish a regular meeting with the team.**
   Regularly scheduled meeting helps keep the momentum going, and makes it easier for tasks to stay on track.
   Meeting Date: ________________________________
   Frequency of Meetings: ________________________________

4. **Write down the current process, limiting the process to 5-7 steps.**
   Define specific tasks, who is involved, and what the outcome of the task is. Defining the process with a team allows each member to see who the process stakeholders are and gain a better understanding of the process.
   **Defining a Process Example**

<table>
<thead>
<tr>
<th>1. Process</th>
<th>Patient arrives at clinic for pain management.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Output</td>
<td>Patient is able to talk with provider about their pain.</td>
</tr>
<tr>
<td>3. Customer</td>
<td>Patient</td>
</tr>
<tr>
<td>4. Input</td>
<td>Pain Scheduled appointment</td>
</tr>
<tr>
<td>5. Suppliers</td>
<td>Patient Front Desk Staff</td>
</tr>
</tbody>
</table>
Define your Practices’ processes using the table below.

| 1. Process | The action steps that transform the inputs into outputs |
| 2. Output | The final product or service resulting from the process |
| 3. Customer | The person, process, or organization that receives the output |
| 4. Input | The information materials or service provided |
| 5. Suppliers | Provides resources to the process |

5. Observe the process in real time. (See page 7 for workflow examples.)
   Observing the process as it is happening or doing a walk-through where the work occurs allows you to confirm the process, and clearly see unnecessary steps and barriers.
   Date of Observation: ____________________________________________
   Date of Observation: ____________________________________________
   Date of Observation: ____________________________________________

6. Brainstorm potential gaps in your current process that could be making it burdensome less-than-optimal.
   By this point, your team is familiar with the process, and there has likely been some discussion regarding roadblocks. More important than the barriers themselves is what is causing the barriers – the root cause.
   Allow the team to brainstorm root causes, recording each person’s ideas – keep in mind no idea is too big, too small, too silly, or too haphazard at this point. All ideas should be welcome! It’s helpful to record ideas on post-it notes or index cards, with one idea per post-it or card.
   Next, the team should work together to sort the ideas into similar concepts or categories. Give a title to each category, and now you have an affinity diagram! The title of each category represents a gap in your current process.
   Category 1 Gap: _______________________________________________
   Category 2 Gap: _______________________________________________
   Category 3 Gap: _______________________________________________

7. The 5 Whys approach can be used to drill down to each gap’s root cause.
   For each gap, you ask the question “Why?” five times (or as many times as it takes) until you get to an actionable root cause for the gap.
   Here is an example - Gap: There are many patients who don’t have their family history or personal history of substance abuse documented.
     Why?: Patients are not asked about family or personal history during their visit.
     Why?: The staff didn’t know that they every patient should be asked.
     Why?: The staff didn’t receive training on the controlled substance policy.
     Why?: Training requirements weren’t updated when the policy was implemented.
     Why?: Suzie normally updates the training requirements, but she was on vacation the week the policy was implemented.
   Gap: _______________________________________________________
     1. Why? ___________________________________________________
     2. Why? ___________________________________________________
     3. Why? ___________________________________________________
     4. Why? ___________________________________________________
     5. Why? ___________________________________________________
8. For each root cause, come up with one solution to test out.

A good way to eliminate root causes is to use a problem solving technique called Plan-Do-Study-Act, or PDSA.

- Using the root cause in the example from Step 7, let’s look at what a PDSA may look like.

<table>
<thead>
<tr>
<th>Plan:</th>
<th>Do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure there is a back-up for updating training requirements when Suzie is on vacation.</td>
<td>Assign a staff member to be Suzie’s back-up. Ensure the staff member knows how to update training requirements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study:</th>
<th>Act:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does Suzie’s back-up know how to make the changes to training requirements if a new policy is updated? Did the task get done while Suzie was on her vacation last week and a new policy was created?</td>
<td>We learned that it was helpful to ensure that training requirements would get updated even if Suzie wasn’t at the office, but we didn’t really see a significant change in the number of patients with their history documented. We should try another PDSA.</td>
</tr>
</tbody>
</table>

Complete your Practices’ PDSA using the table below.

<table>
<thead>
<tr>
<th>Plan:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Study:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Act:</th>
</tr>
</thead>
</table>

9. Implement any successful solutions into your current process.

When the solution trialed through a PDSA in effective is closing the gap and reducing barriers, you want to ensure it remains a part of your process and ultimately is recorded in the policy. What are you keeping in place from your PDSA?

10. Record the steps of the process in policy format.

   Document each step of the process in policy format. Include who is responsible for completing each step and by when, and how often policy will be monitored.

   Date Policy Will be Written: ____________________________

   Frequency of Policy Review: ____________________________

11. Ensure ALL clinic staff are aware of and understands the new policy.

   Date Reviewed Policy with Staff: ________________________

12. Continue to search for ways to improve the process.

   What Project Will You Start Working on Next?:

Start over at Step 2 with new problem.

Contact a Practice Support Consultant to help plan or facilitate project improvement efforts in your clinic!
Initial Pain Sample Pathway

Continuous conversation around pain

SELF CARE
- practice mindfulness
- encourage sleep hygiene
- healthy eating
- physical fitness

ORAL NON-OPIOID PHARMACOTHERAPY
- Acetaminophen
- NSAIDs
- Antidepressants
- Anticonvulsants

BEHAVIORAL THERAPIES
- cognitive behavioral therapy
- support groups
- hypnotherapy

TOPICAL NON-OPIOID PHARMACOTHERAPY
- NSAIDs
- Lidocaine
- Methyl salicylate
- Capsaicin

NON-PHARMACOLOGIC THERAPY
- massage therapy
- chiropractic services
- acupuncture
- yoga
- physical therapy
- occupational therapy
- ice and heat therapy

Re-evaluation of functionality and risk with use of PEG Scale, ORT and/or DIFE Score

Adapted from: https://www.pbmmedicine.com/download/2014/PBM_Academic_Detailing/ServicingDocuments/Academic_Detailing_Educational_Material_Catalog/Pain_Details/Pain_Educational_Briefing_Catal.pdf
# DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient’s score from 1-3 based on the explanations in the right-hand column.

<table>
<thead>
<tr>
<th>SCORE</th>
<th>FACTOR</th>
<th>EXPLANATION</th>
</tr>
</thead>
</table>
|       | **DIAGNOSIS**     | 1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain.  
2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain.  
3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis. |
|       | **INTRACTABILITY**| 1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process.  
2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness).  
3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response. |
|       | **RISK**          | \( R = \text{Total of P+C+R+S below} \)                                                                                                                                                                     |
|       | **Psychological** | 1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues.  
2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder.  
3 = Good communication with clinic. No significant personality dysfunction or mental illness. |
|       | **Chemical Health**| 1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse.  
2 = Chemical copes (uses medications to cope with stress) or history of chemical dependence (CD) in remission.  
3 = No CD history. Not drug-focused or chemically reliant. |
|       | **Reliability**    | 1 = History of numerous problems: medication misuse, missed appointments, rarely follows through.  
2 = Occasional difficulties with compliance, but generally reliable.  
3 = Highly reliable patient with meds, appointments & treatment. |
|       | **Social Support** | 1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles.  
2 = Reduction in some relationships and life roles.  
3 = Supportive family/close relationships. Involved in work or school and no social isolation. |
|       | **EFFICACY SCORE** | 1 = Poor function or minimal pain relief despite moderate to high doses.  
2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn’t tried opioid yet or very low doses or too short of a trial).  
3 = Good improvement in pain and function and quality of life with stable doses over time. |

**Total score = D + I + R + E**

**Score 7-13:** Not a suitable candidate for long-term opioid analgesia  
**Score 14-21:** May be a good candidate for long-term opioid analgesia  

**NOTES**  
A DIRE Score of \( \leq 13 \) indicates that the patient may not be suited to long-term opioid pain management.

Used with permission by Miles J. Belgrade, MD
PEG Pain Screening Tool

1. What number best describes your pain on average in the past week:
   0  1  2  3  4  5  6  7  8  9  10
   No pain  Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?
   0  1  2  3  4  5  6  7  8  9  10
   Does not interfere  Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?
   0  1  2  3  4  5  6  7  8  9  10
   Does not interfere  Completely interferes

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.
### Opioid Risk Tool

<table>
<thead>
<tr>
<th>Family history (parents and siblings):</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>(3)</td>
<td>(1)</td>
</tr>
<tr>
<td>Illegal drug use</td>
<td>(3)</td>
<td>(2)</td>
</tr>
<tr>
<td>Prescription drug abuse</td>
<td>(4)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal history:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>(3)</td>
<td>(3)</td>
</tr>
<tr>
<td>Illegal drug use</td>
<td>(4)</td>
<td>(4)</td>
</tr>
<tr>
<td>Prescription drug abuse</td>
<td>(5)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of ADD, OCD, bipolar, schizophrenia</td>
<td>(2)</td>
<td>(2)</td>
</tr>
<tr>
<td>Diagnosis of depression</td>
<td>(1)</td>
<td>(1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 16-45 years</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>History of pre-adolescent sexual abuse</td>
<td>(0)</td>
<td>(3)</td>
</tr>
</tbody>
</table>

**Total**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Scoring:**

- **0-3** low risk: 6% chance of developing problematic behaviors
- **4-7** moderate risk: 28% chance of developing problematic behaviors
- **>= 8** high risk: >90% chance of developing problematic behaviors

Adapted from: Webster, LR and Webster, RM, *Pain Med*: 2005; 6:432-442
### CDC Recommendations for Prescribing Opioids for Chronic Pain Outside of Active Cancer, Palliative Care, and End-of-Life Care

<table>
<thead>
<tr>
<th>Determining When to Initiate or Continue Opioids for Chronic Pain</th>
<th>Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation</th>
<th>Assessing Risk and Addressing Harms of Opioids</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nonpharmacological therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacological therapy and non-opioid pharmacologic therapy, as appropriate.</td>
<td>4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. Use immediate-release opioids when starting. 5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥90 MME/day. <strong>Start low and go slow.</strong> 6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed. When opioids are needed for acute pain, prescribe no more than five days or seven days for post-operative pain. Do not prescribe ER/LA opioids for acute pain. 7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continue therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioid to lower dosages or to taper and discontinue opioids. <strong>Follow-up and reevaluate risk of harm. Reduce or taper dose and discontinue when needed.</strong></td>
<td>8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risks, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, high opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present. Evaluate risk factors for opioid-related harm. 9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. <strong>Check NC CSRS to make sure patient is filling the prescription appropriately and not receiving opioid medication from other locations.</strong> 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing as least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. <strong>Order urine drug testing to identify prescribed substances and undisclosed substance use.</strong> 11. Clinicians should avoid prescribing opioid pain medications and benzodiazepines concurrently whenever possible. <strong>Avoid concurrent prescribing of benzodiazepines and opioids.</strong> 12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. <strong>Arrange treatment for opioid use disorder if needed.</strong></td>
</tr>
</tbody>
</table>
## ABC Practice Controlled Substance Prescribing Policy
### Treatment of Chronic Non-Cancer Pain with Long Term Opioid Therapy Sample

<table>
<thead>
<tr>
<th>Policy:</th>
<th>Safe and effective treatment of chronic non-cancer pain (CNCP) with long-term opioids requires a team-based approach. These guidelines have been created to promote the cautious and selective prescribing of opioids while continuing to provide this treatment option for patients when the benefits outweigh the risks. In doing so we will promote the safety of our patients. For some existing patients, the most appropriate treatment plan may not conform to these guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure:</td>
<td>1. Providers should prescribe opioids cautiously – using safer alternatives first and documenting what has been tried and failed. When opioids are indicated, providers should begin with low-dose, short-acting preparations and make the decision to extend treatment beyond a trial period after a careful evaluation of benefits, harms, and any adverse events.</td>
</tr>
<tr>
<td></td>
<td>2. For patients not currently receiving opioid therapy, providers can reduce risk of harm by carefully selecting patients who are candidates for long-term opioid therapy by doing a thorough risk assessment:</td>
</tr>
<tr>
<td></td>
<td>• Patients should be screened for depression.</td>
</tr>
<tr>
<td></td>
<td>• Patients should be screened for alcohol and drug abuse.</td>
</tr>
<tr>
<td></td>
<td>• The NC controlled substances reporting system should be consulted, urine drug screen considered, and controlled substance treatment agreement administered for patients being considered for long-term opioid therapy.</td>
</tr>
<tr>
<td></td>
<td>3. Providers can reduce risk of harm by limiting use of high-risk drugs, doses, and drugs combinations.</td>
</tr>
<tr>
<td></td>
<td>• 90 mg morphine equivalent dose (MED) per day is suggested as the upper dosing limit for any one patient.</td>
</tr>
<tr>
<td></td>
<td>• Methadone should only be prescribed by physicians knowledgeable of its pharmacokinetics.</td>
</tr>
<tr>
<td></td>
<td>• Fentanyl should be used by providers knowledgeable of its use and pharmacokinetics.</td>
</tr>
<tr>
<td></td>
<td>• Providers are discouraged from prescribing opioids to patients who are known to be taking chronic benzodiazepines (regardless of prescriber of benzodiazepines).</td>
</tr>
<tr>
<td></td>
<td>• Providers should consider prescribing Naloxone to patients at high risk for overdose.</td>
</tr>
<tr>
<td></td>
<td>4. To ensure patient safety, once a provider decides to initiate long-term opioid therapy, this therapy should include the following:</td>
</tr>
<tr>
<td></td>
<td>• An identified prescribing primary care provider (PCP).</td>
</tr>
<tr>
<td></td>
<td>• A meaningful assessment including complete history, physical, and work-up of the etiology of the pain. The diagnosis resulting in chronic pain should be documented on the problem list, in addition to the diagnosis “Encounter for Chronic Pain Management.”</td>
</tr>
<tr>
<td></td>
<td>• Providers are encouraged to use the EMR dot phrase”.painmgmtoverview” to aid in documentation.</td>
</tr>
<tr>
<td></td>
<td>5. Controlled substances should not be prescribed on the patient’s first visit to the ABC practice. Providers are encouraged to request previous records and review them prior to prescribing opioids for new patients.</td>
</tr>
<tr>
<td></td>
<td>6. A new provider assuming patient after another provider leaves should fully evaluate any patients on long-term opioids and may elect to continue with or modify the treatment plan.</td>
</tr>
<tr>
<td></td>
<td>7. Providers on extended leave will partner with a covering provider to care for their patients with Control Substance Treatment Agreements. Covering Providers may elect to change a patient’s regimen if necessary.</td>
</tr>
<tr>
<td></td>
<td>8. Patients with a Controlled Substance Treatment Agreement may require treatment by other providers for acute pain. This should be limited to urgent situations (unexpected surgery, fractures, etc.) ABC providers who prescribe a controlled substance in this situation should send a message to the patient’s PCP.</td>
</tr>
</tbody>
</table>
ABC Practice
Controlled Substance Treatment Agreement Sample

Patients must complete this contract before doctors at ABC Practice will be willing to prescribe narcotics for non-terminal patients.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>MRN</th>
<th>Diagnosis</th>
<th>PCP</th>
</tr>
</thead>
</table>

Treatment goals:

Physical movement:

Functional/Activities of daily living:

Social activities:

Medicine Directions Number per month

Pharmacy/Location Telephone

Pharmacy/Location Telephone

I agree to the following:

- I will only get prescriptions for controlled medicines from doctors at the ABC Practice.
- I agree to tell any other doctors taking care of me about this agreement and to tell my clinic doctor about any changes in my medicine made by other doctors.
- I will only use the pharmacy listed on this agreement.
- I will only ask for medicine changes at my office visits.
- I understand that if my medicine(s) or prescription(s) are lost or stolen, they will not be refilled early or another copy given to me – no exceptions.
- If I use up my supply of medicine early, I understand that my doctor may not give me extra medicine and that I may suffer symptoms of withdrawal.
- I agree to random urine drug tests and will provide a sample when asked.
- I will not sell or share my medicines listed on this contract with anyone.
- I will not abuse alcohol or use illegal drugs which includes marijuana.
- I will go to any specialist, counseling, or therapy visit to help with my pain, sleep or nerves if set up by my doctor.
- I will come to all of my doctor’s appointment and bring my pill bottles.

The doctors at the ABC Practice will periodically utilize the North Carolina Controlled Substance Reporting System to ensure I am not receiving controlled substances from another physician. Other states’ reporting systems may also be utilized periodically if the need arises.

Taking controlled substances, such as pain medicines or nerve medicines, may increase my risk for:

- Memory and concentration problems
- Delirium and changed mental state
- Daytime hangover, fatigue, or grogginess
- Balance problems
- Falls and broken bones
- Car crashes
- Medicine addiction, dependence, or overdose
- Constipation

These side effects may be more common after a dose change or with higher doses, more frequent doses, multiple medicines, or medical problems such as sleep apnea or obesity.

I understand that my doctor may stop, change, or taper me off of my medications for medical reasons or to protect my safety including but not restricted to:

- I am not showing progress towards achieving my listed goals
- I am not able to follow the requirements laid out in this agreement.
- My medical issues change and the medication is no longer indicated, causing too many side effects, or the risks outweigh the benefits.

If I do not follow this agreement, the ABC Practice doctors will stop the medicine listed on this agreement and may stop other controlled medications.

I have read this agreement and it has been explained to me by the ABC Practice and/or their staff, and I fully understand the consequences of violating any of the terms of this agreement.

Patient Signature________________________ Printed Name________________________ Date ________

Provider Signature________________________ Printed Name________________________ Date ________

☐ Patient viewed Controlled Substances Video ☐ Patient received copy of contract ☐ Treatment Agreement Update Annually
CONTROLLED SUBSTANCE AGREEMENT

Narcotic pain medications are useful for short-term pain or cancer pain and to help dying patients with pain. There is little evidence that long-term use of narcotic pain medications helps chronic non-cancer pain and in fact could worsen it by leading to inactivity. Side effects of narcotic medication include but are not limited to: drowsiness, dizziness, constipation, nausea, confusion, respiratory depression, and death. I may also become psychologically or physically addicted to these medications. I accept full responsibility for these risks when I take these medications. I understand my prescriber may choose alternative treatment options and it may be necessary to gradually decrease the amount of medication I am taking. To ensure that the medications are used in a safe manner, I agree to the following:

1. I am responsible for my controlled substance medications.
   a. I will take the medication only as prescribed.
   b. Prescriptions/medication will not be replaced if it is lost, misplaced/stolen or if I use it up sooner than prescribed.
   c. I agree to not share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
   d. I will not participate in the diversion of my medications for illegal use.
   e. I understand I cannot drive while taking these medications or engage in activities that put me at risk.

2. As a condition to receiving controlled substances, I understand my prescriber may require me to:
   a. Pursue non-medication pain management therapies such as physical therapy or cognitive behavioral therapy or non-opioid medications. If I fail to do so, this agreement may be terminated.
   b. Obtain an opioid-reversal medication, such as naloxone.
   c. Submit drug screens.

3. I understand that prescriptions for controlled substance medications:
   a. Will be provided only during regular office visits. I will not page my prescribers/healthcare providers to request a refill nor will I call them at home. Prescriptions will be sent electronically unless a technology issue prevents this.
   b. Will not be provided if I miss an appointment.
   c. Will not be provided if I run out of the medication early. I am responsible for taking the medication as it is prescribed and for keeping track of the amount remaining.
   d. May take 72 hours to process.

4. This agreement will be terminated for:
   a. Hostile behavior towards staff, attempting to refill prescriptions early or too frequently.
   b. Altering, forging, or attempting to get medications in an illegal manner; actions will be reported to the proper authority.
   c. When deemed to be in the best interest as determined by my prescriber.
   d. If I am arrested or incarcerated related to legal or illegal drugs.
   e. Saving up medications or taking more than prescribed.
   f. Failure to give a urine sample when requested or presence of unapproved drugs or lack of expected drugs in urine.

5. Should my prescription medication or dosage need to be changed prior to my due date, all unused medications must be brought to the NHRMC Outpatient Pharmacy and disposed of. Receipt of disposal will be given to patient.

6. I understand the prescription of controlled substances is under the supervision of many government agencies and adherence to regulations is my responsibility. If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

7. I give my prescriber permission to discuss all diagnostic and treatment details with dispensing pharmacies or other healthcare professionals for the purpose of maintaining accountability.

8. I will not hold my provider liable if I am involved in an accident while taking the controlled substance they have prescribed.

9. FOR FEMALES: I understand that if I become pregnant, or if I am suspicions that I am pregnant, I will notify the staff of the office. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the office and all staff harmless for injuries to the embryo/fetus/baby.

10. I will only accept a prescription from me, and other prescribers within the practice. I will not request or accept controlled substance medication from any other prescriber, healthcare provider, or individual. The only exception is if the medication is prescribed while I am admitted to the hospital.

11. I will select and use one pharmacy to fill my controlled medication prescription.

My pharmacy is:
Name: __________________________
Address: ________________________
Phone: __________________________

I have been fully informed by __________________________ regarding my treatment with the medications listed above as well as the reason for this agreement. I will receive a copy of this agreement and the original agreement will be kept in my medical record. This agreement will be updated, and re-signed anytime my primary care physician changes.

Patient: __________________________
Date: ____________________________
Time: ____________________________

Prescriber Signature/Credentials: __________________________
Date: ____________________________
Time: ____________________________

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

*0774*
Controlled Substance Agreement ORIGINAL - MEDICAL RECORDS YELLOW - PATIENT OP-133 (08/2017)
Urine Drug Testing (UDT) Guidelines

<table>
<thead>
<tr>
<th>Urine Drug Testing</th>
<th>No Urine Drug Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician’s predictions of UDT results are frequently inaccurate. ¹</td>
<td>• Many physicians work under the “truth bias”; that is, they have no reason to not believe their patients regarding narcotic use. ²</td>
</tr>
<tr>
<td>• Contextual evidence review found that urine drug testing can provide useful information about patients assumed not to be using unreported drugs. ³</td>
<td>• Clinical evidence review did not find studies evaluating the effectiveness of UDT for risk mitigation during opioid prescribing for pain. ⁵</td>
</tr>
<tr>
<td>• Experts agree that prior to starting opioids for chronic pain and periodically during opioid therapy, clinicians should use UDT to assess for prescribed opioids as well as other controlled substances and illicit drugs…⁶</td>
<td>• Experts disagree on how frequently UDT should be conducted during long-term opioids therapy; however agreed that UDT at least annually for all patients was reasonable.⁷</td>
</tr>
<tr>
<td>• Because infrequent drug use is difficult to detect regardless of testing frequency, the benefits of frequent drug testing are greatest in patients who engage in moderate drug use.⁷</td>
<td></td>
</tr>
<tr>
<td>• The frequency of UDT could be based on a risk assessment of the individual patient. High-risk patients require more frequent monitoring, whereas low-risk patients do not need to be monitored as frequently.⁸</td>
<td></td>
</tr>
</tbody>
</table>

Key UDT Recommendations for Practice ⁷

<table>
<thead>
<tr>
<th>Clinical Recommendation</th>
<th>Evidence Rating</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunoassay tests are the preferred initial test for urine drug screening.</td>
<td>C</td>
<td>10</td>
</tr>
<tr>
<td>Positive results from an immunoassay test should be followed by gas chromatography/mass spectrometry or high-performance liquid chromatography.</td>
<td>C</td>
<td>10</td>
</tr>
<tr>
<td>An extended opiate panel is needed to detect commonly used narcotics, including fentanyl (Duragesic), hydrocodone (Hycodan), methadone, oxycodone (Roxicodone, OxyContin), buprenorphine, and tramadol (Ultram).</td>
<td>C</td>
<td>10</td>
</tr>
<tr>
<td>Appropriate collection techniques and tests of specimen integrity can reduce the risk of tampering.</td>
<td>C</td>
<td>15–17</td>
</tr>
</tbody>
</table>

A=consistent, good-quality patient-orientated evidence; B=inconsistent or limited-quality patient-orientated evidence; C=consensus, disease-orientated, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml

Reference List


Other Resources

North Carolina Drug Control Unit https://www.ncdhhs.gov/divisions/mhddsas/ncdcu
Organization Members

Addiction Consulting Training Associates
Alliant Quality
Blue Ribbon Commission
Brunswick County Health Department
Brunswick County Schools
Cape Fear Public Utility Authority
City of Wilmington
Coastal Carolina Criminal Enterprise Task Force
Coastal Carolina Health Alliance
Coastal Horizons
Columbus County Health Department
Community Care of the Lower Cape Fear
Community Members
Community Prevention Services
Duplin County Health Department
Heart of Wilmington
Integrated Family Services
LINC
Lower Cape Fear Hospice
MedNorth Health Center
National Alliance on Mental Illness
New Hanover & Pender County Courts
New Hanover County
New Hanover County Department of Social Services
New Hanover County Emergency Management
New Hanover County Health Department
New Hanover County Schools
New Hanover County Senior Resource Center
New Hanover County Sheriff’s Office
New Hanover Regional Medical Center
North Carolina Harm Reduction Coalition
Onslow County Health Department
Onslow County Schools
Pender County Health Department
Pender County Sheriff’s Office
Port City Community Church
Port Health
Prodigal Recovery
RHA Health Services
RI International
SEAHEC
Trillium Health Services
United Way of the Cape Fear Region
University of North Carolina Wilmington
Vidant Duplin
Wave Transit
Wilmington Chamber of Commerce
Wilmington Fire Department
Wilmington Police Department
Wilmington Treatment Center
2018 Guide to Health: Combatting the Opioid Epidemic
Action Plan
Background

The Community Partners Coalition (CPC) formed in May of 2017, under the initial guidance of a regional opioid harm reduction initiative originated by the South East Area Health Education Center (SEAHEC), New Hanover Regional Medical Center, and the Southeastern North Carolina Regional Health Collaborative.

Community Partners Coalition

The Community Partners Coalition works to improve collaboration and coordination between those who provide care to individuals seeking access to mental health and substance use services.

Membership Includes:

- Addiction Consulting Training Associates
- Alliant Quality
- Blue Ribbon Commission
- Brunswick County Health Department
- Brunswick County Schools
- City of Wilmington
- Coastal Carolina Criminal Enterprise Task Force
- Coastal Carolina Health Alliance
- Coastal Horizons
- Columbus County Health Department
- Community Care of the Lower Cape Fear
- Community Members
- Community Prevention Services
- Duplin County Health Department
- Heart of Wilmington
- Integrated Family Services
- LINC
- Lower Cape Fear Hospice
- MedNorth Health Center
- National Alliance on Mental Illness
- New Hanover & Pender County Courts
- New Hanover County
- New Hanover Community Justice Services
- New Hanover County Department of Social Services
- New Hanover County Emergency Management
- New Hanover County Health Department
- New Hanover County Schools
- New Hanover County Senior Resource Center
- New Hanover County Sheriff’s Office
- New Hanover Regional Medical Center
- North Carolina Harm Reduction Coalition
- Onslow County Health Department
- Onslow County Schools
- Pender County Health Department
- Pender County Sheriff’s Office
- Port City Community Church
- Port Health
- Port Behavioral Health
- Prodigal Recovery
- RHA Health Services
- RI International
- Recovery Resource Center
- SEAHEC
- Trillium Health Services
- United Way of the Cape Fear Region
- University of North Carolina Wilmington
- Vidant Duplin
- Wave Transit
- Wilmington Chamber of Commerce
- Wilmington Fire Department
- Wilmington Police Department
- Wilmington Treatment Center
- Wilmington Wellness City
Action Plan

In June of 2017, the first action team assembled as part of the CPC. The Data Action Team gathered data related to prevention, treatment, and recovery efforts as well as opioid overdoses, encounters with the criminal justice system, and special populations. This process was completed so to better understand existing gaps and to develop a plan for action to combat this crisis.

Based on the work of the Data Action Team, the CPC developed the following teams to address priority areas: the Primary Prevention Action Team, the Professional Intervention Action Team, the Treatment and Recovery Action Team, and the Infrastructure and Support Action Team.

The action teams have developed data driven plans to address the opioid epidemic in the region and to create opportunities to fill gaps in our local service systems.

The 2018 Guide to Health: Combatting the Opioid Epidemic Action Plan serves as a resource to inform community members, agencies, entities, and organizations of the collective efforts of the Community Partners Coalition.

Agencies interested in learning more about the CPC can contact Olivia Herndon at olivia.herndon@seahec.net.
Primary Prevention Action Team

Goal: Prevent opioid misuse and abuse.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| 1. Increase medication safety efforts in our region.  
*68% of people 12 and older who have abused prescription pain relievers within the past year say they got them from a friend or relative.*¹ | a. Participate in the Spring National DEA Take-Back Day on April 28, 2018, by partnering with various stakeholders throughout the region to have multiple disposal sites.  
b. Assist in marketing the take-back event to unique populations such as retail stores, housing developments, senior centers, apartment complexes, PTAs, dental offices, veterinarian offices, funeral homes, and realtors.  
c. Create pamphlet containing medication safety tips and permanent drop box locations to distribute to participants of the take-back event. |
| 2. Prevent opioid misuse and abuse in youth.  
*Every day, more than 1,700 children and young adults begin experimenting with prescription drugs. These drugs range from pain relievers and depressants to stimulants and over-the-counter (OTC) medicine.*² | a. Partner with the North Carolina Department of Justice to host Youth Empowerment Summit targeting adolescents from Southeastern North Carolina. Summit will allow youth to come up with community action plans for preventing youth from using substances, particularly opioids.  
b. Serve as a resource for youth participants to assist in implementing their action plans following the summit. |

². http://www.lockyourmeds.org/meducation/
3. **Strategy**

   **Educate seniors in our region on medication safety.**

   *More than 80 percent of older patients (aged 57 to 85 years) use at least one prescription medication daily, with more than 50 percent taking more than five medications or supplements daily.³*

3. **Action Steps**

   a. Develop curriculum for educational sessions at local senior centers on medication safety.

   b. Train senior volunteers to host training sessions at local senior centers.

   c. Plan and hold an education forum and other community outreach targeting seniors on medication safety and resources.

4. **Strategy**

   **Develop and implement a community-wide “Reframe Pain” campaign.**

   *In a survey of patients receiving high-dose opioid medications for chronic pain, nearly half reported wanting to cut down or stop, yet 80% were receiving high-dose opioids 1 year later.⁴*

4. **Action Steps**

   a. Work with subject matter experts to create message about redefining pain and function in daily living.

   b. Develop interactive, online educational material for the community at large, as it pertains to pain and improved function.

   c. Create informational material for community members on safe opioid-use tips as well as use of non-pharmacological resources for pain management, to be distributed at appropriate community venues.

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Professional Intervention Team

Goal: Enable standardization of pain management in region.

<table>
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<tr>
<th>Strategy</th>
<th>Action Steps</th>
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</table>
   b. Modify models to include local tools and resources such as work-flow charts and pain contracts.  
   c. Create and disseminate first iteration of regional workbook to manage pain. |

*With the passage of the STOP Act in the summer of 2017 by the NC Legislature, clinical providers face greater scrutiny and responsibility. This comes as practices in our region struggle to keep up with the regulatory changes. By providing tools that can be easily incorporated into a practice’s workflow we can help them achieve compliance and greater standardization of care.*

2. Transition pain messaging from rating pain to achieving function.  

*Pain control has been assessed using a numeric scale. The scale is difficult to implement because of the variability in which persons perceive pain.*

<table>
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<tr>
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</table>
| 3. Disseminate best practice education for providers in region. | a. Identify and offer training opportunities for prescribers.  
   b. Identify tools that can be used to assess pain from a functional perspective.  
   a. Work collaboratively with organizations to promote existing lunch and learn opportunities for provider education on best practices.  
   b. Provide quarterly web-based opportunities to disseminate updates in best practices.  
   c. Utilize existing practice support teams to assist with implementation and quality improvement follow-up for practices in the region. |

*Changing practice patterns is difficult. It will require assistance at a practice level to enable successful intervention and continued educational support.*
Treatment and Recovery Team

Goal: Improve gaps in service by better utilization of resources.

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<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
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<tbody>
<tr>
<td>1. As a provider community, educate ourselves and encourage appropriate use of underutilized resources.</td>
<td>a. Hold monthly team site visits at unknown or underutilized organizations to learn more about services offered.</td>
</tr>
<tr>
<td>After meeting, the team discovered that there are numerous organizations that offer crucial services that are little-known and underutilized in the region.</td>
<td>b. Support these organizations by appropriately navigating service consumers to them.</td>
</tr>
<tr>
<td>2. Improve the understanding and workflow for Involuntary Commitment patients to better determine the appropriate level of care and resources needed.</td>
<td>c. Create fact sheets about organizations to be electronically distributed to service providers in multiple sectors.</td>
</tr>
<tr>
<td>There are many points of care for individuals needing mental health and substance use services prior to crisis. If patients are on or in need of Involuntary Commitment, there is an opportunity to better educate all parties involved on the workflow and expected outcomes of the process.</td>
<td>a. Process map for a patient on or in need of IVC for all first responders including: EMS, Police, Fire, Sheriff, Mobile Crisis, and the Emergency Department.</td>
</tr>
<tr>
<td>b. Identify opportunities for better collaboration, legislative needs, and counter measures to specific barriers.</td>
<td></td>
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Infrastructure and Support Team

Goal: Align resource and service information dissemination in region.

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<th>Strategy</th>
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<tbody>
<tr>
<td>1. Secure comprehensive electronic platform that community members can access to seek services and resources.</td>
</tr>
<tr>
<td>Those seeking treatment can go to the Substance Abuse and Mental Health Services Administration (SAMHSA) website to search for providers and agencies who offer treatment for opioid use disorder. However, individuals most often need resources after treatment to help support them in their recovery. Currently, there is no local electronic, mobile friendly, platform where individuals and providers can access to assist in managing care.</td>
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<th>Action Steps</th>
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<tbody>
<tr>
<td>a. Evaluate existing tools in community for potential viability, secure funding and sustainability for tool, and select resource platform.</td>
</tr>
<tr>
<td>b. Compile comprehensive list of various resources used throughout the region by agencies.</td>
</tr>
<tr>
<td>c. Review, validate, and update service provider information.</td>
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</tbody>
</table>

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<th>Strategy</th>
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</thead>
<tbody>
<tr>
<td>2. Disseminate and market platform through various systems, sectors, organizations, and communities.</td>
</tr>
<tr>
<td>Through evaluation of existing resource tools in the community, the team found that these tools have been underutilized and have did not have a robust marketing and promotion plan. It will be vital that this community resource platform be marketed throughout the region by various stakeholders to ensure optimal use.</td>
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<tr>
<th>Action Steps</th>
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<tbody>
<tr>
<td>a. Develop system/sector specific ideas for how platform will be marketed (i.e. Can/How will this tool be marketed by our transportation system?).</td>
</tr>
</tbody>
</table>
| b. Create and disseminate materials about the platform to be distributed at appropriate community venues.