Opioid Review and MAT Clinic Weekly Controlled Substance Care Team Meetings

May 23, 2018

Learning Objectives

- Assess the important aspects of chart review to evaluate patients on narcotics
- Organize the implementation of recommendations

Announcements

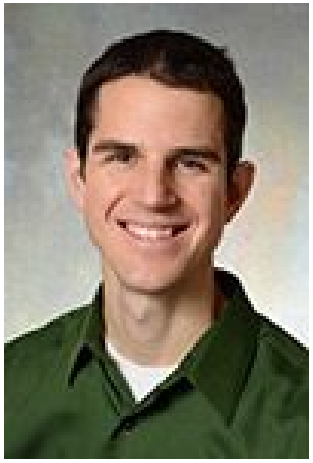
Announcements

- CME evaluation forms are due to Katie Stangl by Friday, May 25th at 4:00pm.

Special Speakers

- **May 30**: Dr. Brian Grahan

  "BUP and MAT"



- **June 13**: Nathan Erickson, LADC

"Introduction to Motivational Interviewing"

CSCT Review Form

- Form created to highlight pertinent issues from nurse and/or social worker in a “user friendly” view.

CSCT Review Form

- Review includes:
  - Previous work-ups
  - Scans
  - Previous treatments
  - Diagnosis
  - Medications
  - Previous UDAS
  - Care plan expiration date

CSCT Recommendations

- Recommendations formulated based on provider review (DeVine/Bell)
- Discussed with primary provider

CSCT Recommendations

- Components of recommendations
  - Dose reductions to safer MME
  - Further work-up or updated work-up
  - Discontinuation of other medications due to risk (benzodiazepines)

CSCT Recommendations

- Components of recommendations
  - Physical therapy or occupational therapy
  - Taper if medical condition doesn't warrant pain medication
  - Discontinued if proved diversion or if no evidence that the patient is taking the medication

CSCT Priority Patients

- Provider or nurse referral
- Drug refill issues (RN reviews)
- Police information
- Pharmacy concerns
- Slowly working the “list”

CSCT Priority Patients

- These are the patients that make the biggest impact on physician culture
  - Best opportunity for MD-MD discussion
- CDC guidelines didn't change prescribing habits until something unforeseen happened
  - Program evolution
  - Overdoses, pill mill, diversion, "good" patients, urine results

Recommendations Form

PCP

CSCT REVIEW

Dr._____, Date: _____

The CSCT has reviewed the following patient:

Patient Name: _____ DOB: _____ MRN: _____

Diagnosis: _____

_____

Recommendations Form

Medication Agreement/Care plan signed: Y/N, Date: _____

Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N,_____

Mental Health Provider/Therapist: _____

Current Medications of Concern:

_____

_____

_____

Recommendations Form

Usually most recent pertinent are printed and attached

Images Reviewed: Y/N_____

Other Modalities attempted: _____

_____

UDAS in past year: Y/N, Date of most recent UDAS: _____

UDAS Findings:

- _____
- _____
- _____

Recommendations Form

Pill Counts: _____

PMP Reviewed: Y/N, Findings: _____

Social History: _____

_____

Social Needs identified:_____

Recommendations Form

Recommendations: _____

_____

Form scanned in to EMR: Y/N

Signed: _____

MOCK CSCT MEETING