CONNECTING SOUTH WEST ONTARIO

Digital Health Drug Repository: Adding value to opioid contract monitoring within primary care

Evaluating benefits is an important component of the connecting South West Ontario (cSWO) Program that helps to support and demonstrate the realization of health system benefits through the adoption of an electronic health record (EHR). By pursuing the measurement of organizational value (improvements in the efficiency of care delivery such as time-savings and redirected resources) and clinical value (patients undergo fewer unnecessary tests, patients have improved access to care), patients ultimately benefit from higher quality, better informed clinical decision-making.

In the Fall of 2016, the Ministry of Health and Long-Term Care (MOHLTC) began an initiative to integrate the Digital Health Drug Repository (DHDR) into the cSWO Regional Clinical Viewer, ClinicalConnect™ to enhance the data and information available in the EHR. Three early adopter health service provider sites in Guelph were provided with access to drug information in this initial stage with a focus on testing the ability to share information currently available via a standalone drug profile viewer (DPV) with a more widely dispersed interface (the EHR). The data that is shared through the DHDR includes similar data elements to those that already exist in DPV, as well as expanded access to dispensed drug events, including Narcotics Monitoring System (NMS) data.

By pursuing the measurement of clinical value (improved opioid contract monitoring), patients will ultimately benefit from higher quality, better informed clinical decision-making.

Value statement

Using a reliable source for patient narcotic information, which is now available through the DHDR, will improve monitoring of patients with opioid contracts, allowing physicians to identify drug-seeking behavior and better inform clinical decision-making pertaining to opioid prescribing.

Prescription opioid use

Opioids are primarily prescribed in primary care to manage chronic pain, which is a serious medical issue in Canada, present for an estimated one in five people and attributed to a range of clinical conditions (e.g., acute pain following injury, cancer pain, or chronic non-cancer pain).[1] Canada and the USA have the highest prescription opioid consumption in the world.[2] Opioid addiction has become a crisis within Canada, as in Ontario alone, rates of opioid overdose deaths rose by 242 per cent between 1991 and 2010.[2] Switching to more potent opioids, giving opioid to someone already taking methadone, or adjusting methadone dosage are practices associated with increased accidental opioid-related death.[3] An Ontario survey of 658 family physicians revealed that 85 per cent of physicians had concerns about the opioid use of one or more of their patients.[4]

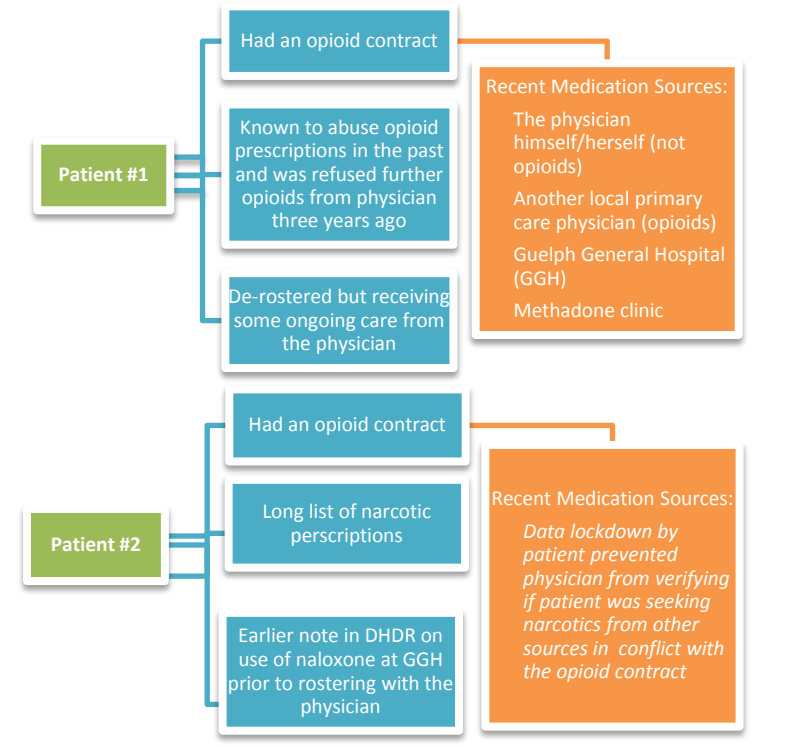
Use of opioid contracts

Some primary care physicians have instituted the use of opioid contracts (or Treatment Agreements) as a way to manage their concerns and patient risks associated with opioid prescribing. Opioid contracts are formal, written agreements between physician and patient that delineate key aspects of opioid therapy and define a course of action and obligations for patients. For example, a contract may commit a patient to agree to random urine drug screening, and/or identify one prescribing physician and one dispensing pharmacy. Despite a lack of evidence to suggest opioid contracts encourage patient adherence to appropriate opioid therapy,[5] support for opioid contracts is high among primary care physicians.[6] One study found that opioid contracts provided structure, support, and monitoring for long-term chronic pain management in a primary care setting.[7] Canadian guidelines for family physicians suggest that opioid contracts might be considered when the patient is not well known to the physician or for individuals at a higher risk of misuse.[8]

CONNECTING SOUTH WEST ONTARIO

DHDR and opioid practice management: two patient cases

As part of the early roll out of the DHDR, a physician at the Guelph Family Health Team (FHT) reviewed patient charts for two residents currently taking opioids for pain. The physician used the DHDR to look for instances in which these patients were prescribed narcotics from other sources.



Clinical Value of DHDR for Monitoring Opioid Contracts:

- Highlighted several sources of narcotics including another primary care clinician
- Information could be useful for physician prescribing decisions, avoiding potential adverse drug events and raising the possibility that patient could be exceeding 200mg morphine equivalent

These cases (to the left) draw attention to the need for appropriate guidelines around how and when to contact another physician in the circle of care to communicate information gained through the DHDR. The second patient case raises additional questions around if and how the terms of an opioid contract can be viewed by other care providers even if the patient has locked down their data. If a patient has an opioid contract, should they be prevented from restricting other providers from viewing their narcotics information, in order to avoid harm?

One suggestion from a physician participating in the DHDR early adopter initiative was to include a place in a text box where physicians could include the terms of the opioid contract so that other attending physicians would be able to see it. This case has created more questions than answers, which are important to consider as the narcotics data becomes available within the EHR across south west Ontario. There is need to understand the potential clinical benefit of this increased drug information, and any accessibility or functional issues that may prevent the value from being realized within the patient care workflows.

Questions

For questions, comments, or to participate in cSWO's Benefits Realization (BR) program, please contact: Julia Bickford, BR Specialist, Change Management and Adoption Delivery Partner, eHealth Centre of Excellence: Julia.Bickford@eHealthCE.ca

Sources

[1] Centre for Addictions and Mental Health, *Prescription opioid policy framework*. 2016: Toronto, Canada.

[2] Gomes, T., et al., *Trends in high-dose opioid prescribing in Canada.* Canadian Family Physician, 2014. **60**: p. 826-32.

[3] Madadi, P., et al., *Characteristics of opioid-users whose death was related to opioid-toxicity: a population-based study in Ontario, Canada.* PLoS One, 2013. **8**(4): p. e60600.

[4] Wenghofer, E., et al., *Survey of Ontario primary care physicians' experiences with opioid prescribing.* Canadian Family Physician, 2011. **57**: p. 324-32.

[5] Arnold, R.M., P.K.J. Han, and D. Seltzer, *Opioid Contracts in Chronic Nonmalignant Pain Management: Objectives and Uncertainties.* The American Journal of Medicine. **119**(4): p. 292-296.

[6] Hwang, C.S., et al., *Primary care physicians' knowledge and attitudes regarding prescription opioid abuse and diversion.* The Clinical Journal of Pain, 2016. **32**(4): p. 279-284.

[7] Hariharan, J., G.C. Lamb, and J.M. Neuner, *Long-term opioid contract use for chronic pain management in primary care practice. A five year experience.* Journal of General Internal Medicine, 2007. **22**(4): p. 485-490.

[8] Kahan, M., et al., *Canadian guideline for safe and effective use of opioids for chronic noncancer pain: Clinical summary for family physicians. Part 1: general population.* Canadian Family Physician, 2011. **57**(11): p. 1257-1266.

CONNECTING SOUTH WEST ONTARIO

Published: March 2017

Funded by eHealth Ontario