

# PS Suite EMR Guide for Complex Care: Opioids

Reviewed in 2019



## ACTT

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# Panel Segmentation & Marking the Record

Establishing and maintaining an accurate panel is a critical step to leveraging the EMR for managing patient care. Please refer to the Panel Identification and Panel Maintenance sections of **PS Suite EMR Guide for Patient’s Medical Home** as needed.

Managing a patient panel to reduce harms associated with opioid use begins with identification of patients that are using opioids as well as those patients experiencing problematic opioid use. The process of identifying a sub-group of patients within the panel is called panel segmentation. Marking the patient record identifies the panel segment, by using a standardized term to facilitate the use of searches and applicable point-of-care reminders.

There are 2 panel segments of interest for this population:

1. **All patients using opioids:** includes prescribed opioids and illicit use
2. **Patients diagnosed with Opioid Use Disorder (OUD):** a clinical diagnosis characterized by a pattern of problematic opioid use (E.g. cravings, social or interpersonal problems, tolerance, withdrawal) linked to a clinically significant impairment in function. Commonly includes patients prescribed Suboxone or Methadone.

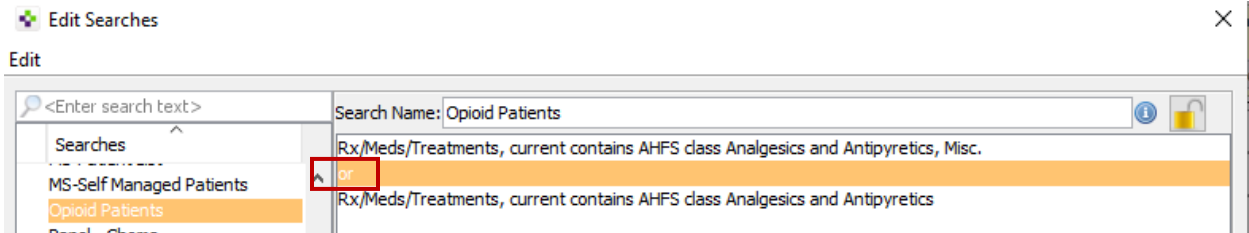
Identifying and maintaining a list of patients using opioid medication requires an active review to ensure accuracy of information. However there are several methods to facilitate the development of a panel segment patient list.

## a) Panel Segment: patients using an opioid medication

**Recommended method:** Using the below table of common opioid medications, generate a search that will identify patient records with an active prescription. Incorporate into the search, medications either by trade names, generic names or by class, such as:

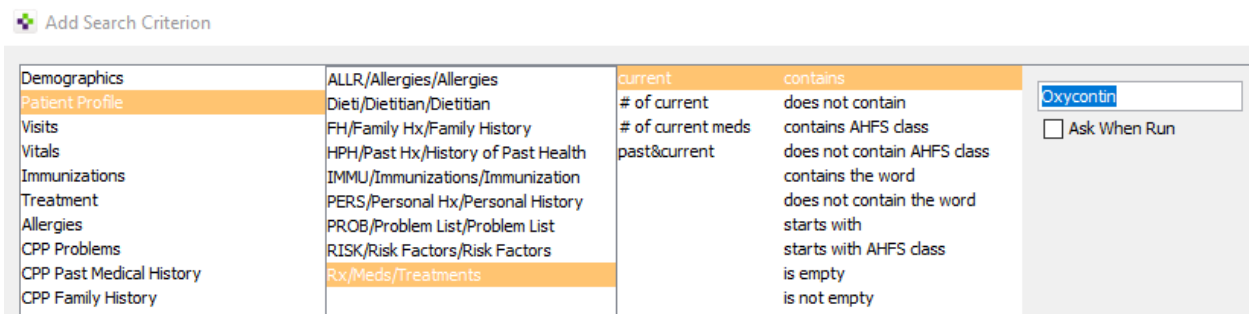
<u>Generic Name</u>	<u>Trade Names</u>
Morphine	STATEX, M-ESLON, KADIAN, MS-CONTIN
Hydromorphone	DILAUDID, HYDROMORPH CONTIN, JURNISTA
Oxycodone	OXYNEO, PERCOCET, TARGIN
Tramadol	ULTRAM, ZYTRAM XL, TRIDURAL, RALIVIA, TRAMACET, DURELA
Codeine	CODEINE CONTIN, TYLENOL #1, TYLENOL #2, TYLENOL #3, TYLENOL #4
Tapentadol	NUCYNTA
Buprenorphine	BELBUCA, BUTRANS
Fentanyl	DURAGESIC

To identify all patients currently prescribed an opioid the simplest search will search by Class. In PS Suite, the database of medications will produce a list of patients by selecting both classes shown below. This will include all patients on an opioid as well as patients prescribed Suboxone or Methadone and documented in the medication module.

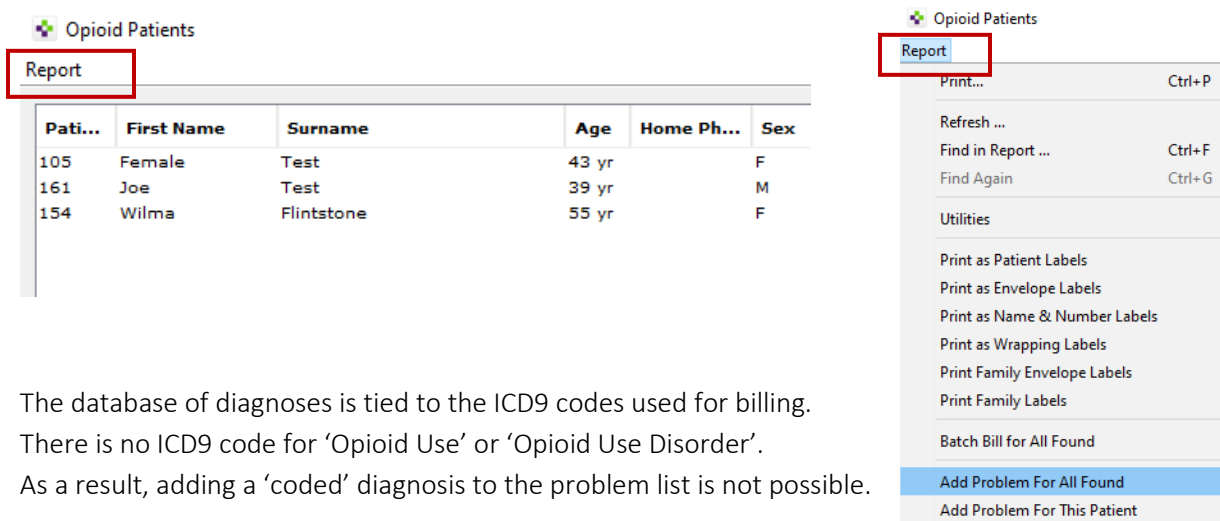


**TIP:** Some physicians may only prescribe a few types of opioids. Ask, and that will help limit the search.

If the list of patients is too long, break the search into manageable sizes, (i.e., by age, one provider at a time, or search individual medications most commonly prescribed). See below for an example of how to search by a single medication.



Once the medication lists are current and the list is reviewed by the provider, mark the patient record with the term 'Opioid Use' in the problem list/patient profile using the Bulk/ Batch Actions feature.



The database of diagnoses is tied to the ICD9 codes used for billing. There is no ICD9 code for 'Opioid Use' or 'Opioid Use Disorder'. As a result, adding a 'coded' diagnosis to the problem list is not possible.

Free texted problem list entries are acceptable and searchable.

**TIP:** Another option for entering ‘Opioid Use’ or ‘Opioid Use Disorder’ is creating a stamp that can be entered directly into the problem list. This can avoid typos or variation in data entry.

Additional methods to improve accuracy of list:

- Use the CPSA MD Snapshot (with physician permission) to identify patients prescribed an opioid by this physician. Patients included in this report may not be panelled patients so it’s important to confirm attachment prior to adding.
- Use the providers triplicate pad to identify patients prescribed an opioid.
- Consider existing physician documentation practice and the ability to generate searches from those locations (i.e. EMR fields such as: History, Profile, Risks).
- If the physician is not using the medication module to record prescriptions, recommend a standardized process is implemented to record opioid medications in the EMR:
  - Triplicate prescriptions can be scanned into patient records and searched when standardized term is used.

**TIP:** When asking a physician to verify the EMR-generated list of patients using opioids consider including the following fields:

- Name (first, last)
- Date of birth (or age)
- Gender
- Last visit date

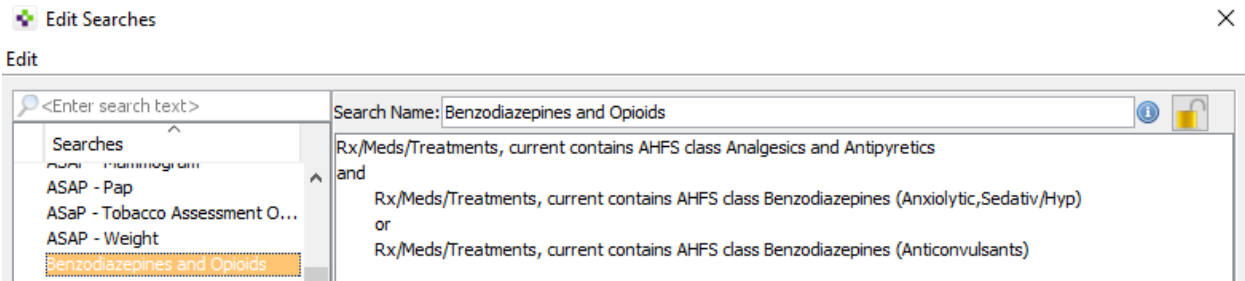
Pati...	First Name	Surname	Age	Home Ph...	Sex	Last Seen Date	Privacy
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When configured, the search columns will look like this. To learn more about configuring columns when creating searches refer to the PS Suite EMR Help file on Performing Searches for additional learning material.

**TIP:** Other sub-populations that may be of interest include:

- concurrent opioid & benzodiazepine use
- over age 70 & using an opioid
- multiple opioids
- opioid use for chronic pain
- long-term opioid use
- concurrent prescribed and illicit drug use

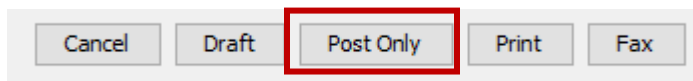
Below is an example of a search to produce a list of patients prescribed concurrent opioids and benzodiazepines. Note the indents as well as the ‘and/or’ logic. See PS Suite EMR Help File on Creating New Searches for additional learning materials.



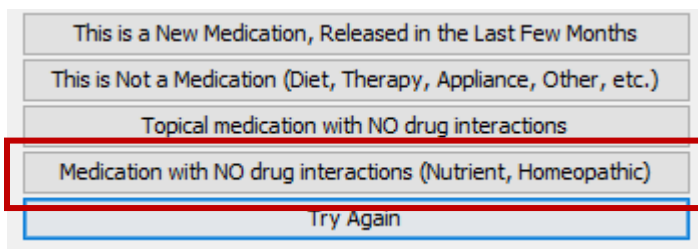
## Documentation of Illicit drug use

The opioid crisis is driven by both prescription and illicit drug use. Providers caring for patients with complexities and multiple co-existing conditions can benefit from having accurate and complete information at their fingertips. Recording illicit drug use in a standardized way will enable this information to be searchable and more accessible to the health care team. With an accurate prescribed medication list and documented illicit drug use in the patient chart, this can potentially enhance clinical decision-making, ongoing management and clearer communication. Documentation of illicit drug use may also be beneficial when considering treatment options, referral to community resources or identifying higher risk patients. Consider documenting illicit drug use either at the beginning of the implementation of opioid processes or incorporate this into existing processes at the clinic.

PS Suite does not have specific fields for external medications or illicit drugs, but there are alternative options. Standardization of data entry is key to successful searches that include this risk factor. Any prescription entry can be turned into a medication favorite individually or configured in Admin to be shared by all clinic providers. Select the option to 'post only' for any medication that is considered 'external', meaning not prescribed by the primary provider.



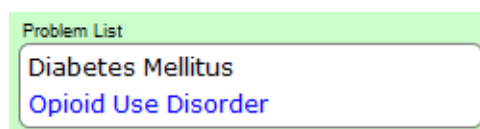
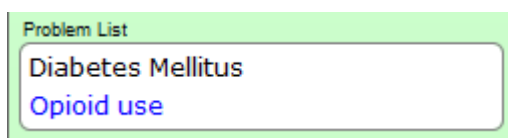
If entering for the first time, Select 'Medication with NO drug interactions' when prompted. When this option is chosen, it will be accepted without any further prompts.



Stamps can also be used to create a standardized entry either as a specific drug or an indicator such as "illicit drug use", instead of using a prescription favorite (with details to be recorded in the encounter notes). Recording specific drugs can provide more detail in searches. Refer to page 478 of the PS Suite user guide (Version 5.11) in the portal for additional instructions.

## b) Panel Segment: patients diagnosed with opioid use disorder

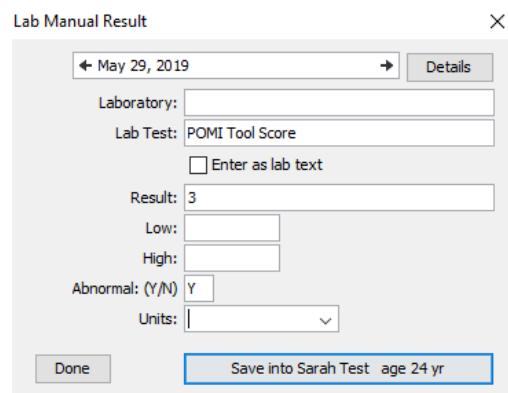
**Recommended method:** Physician records 'Opioid Use Disorder' to the problem list/patient profile at the time of diagnosis. 'Opioid Use Disorder' criteria is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). **Once a patient has been diagnosed with 'Opioid Use Disorder', remove 'Opioid Use' from the Problem List/ Patient Profile. Each problem list entry will have an associated set of Reminders.** See the [Care Management](#) section of this guide for the recommended reminders and activities. This is important for ensuring the appropriate EMR activity prompts appear.



The following searches may help generate an initial list for physicians to review for potential diagnosis of 'Opioid Use Disorder' however some initial work may be required to populate the data fields:

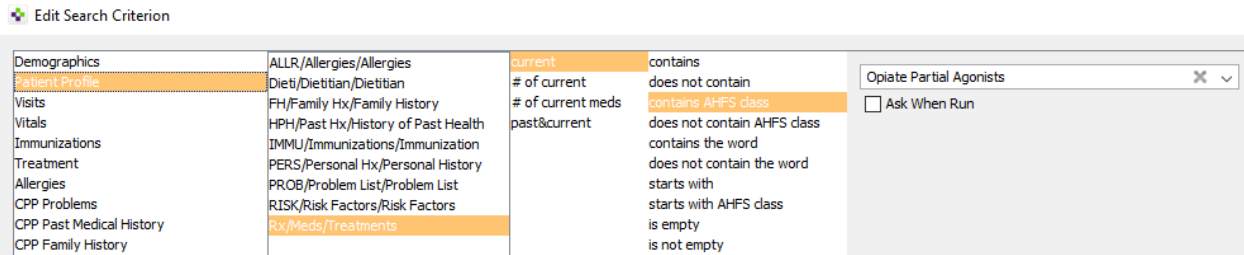
- Billing codes: Search diagnostic codes 304 (Opioid Dependence), 305 (Opioid Abuse), or 970.1 Opioid Agonist Therapy.
- Clinical tools: Search a list of patients who have a Prescription Opioid Misuse Index (POMI) score of 2 or more. PS Suite has several options for capturing this score that are all searchable.
  - *Manual Lab Result:* PS Suite cannot configure the Manual Lab Options to make data entry more efficient or standardized. Only free text is available for a Manual lab Result.

### From the chart > Data tab> Lab Manual Result

A screenshot of the 'Lab Manual Result' form in PS Suite. The form is titled 'Lab Manual Result' and has a close button (X). It shows a date selector for 'May 29, 2019' and a 'Details' button. The form fields include: 'Laboratory:' (empty), 'Lab Test:' (POMI Tool Score), a checkbox for 'Enter as lab text' (unchecked), 'Result:' (3), 'Low:' (empty), 'High:' (empty), 'Abnormal: (Y/N)' (Y), and 'Units:' (empty). At the bottom, there are 'Done' and 'Save into Sarah Test age 24 yr' buttons.

- *Encounter Assistant:* To standardize POMI Score documentation, an Encounter Assistant can reproduce the POMI Tool and provide drop down menus and radio buttons to avoid variation in data entry. Creation of encounter assistants is an advanced EMR skill. Ask the vendor for a demonstration if considering this approach.

- *Stamps:* Stamps can be used in two ways.
  - A simple stamp can be created to record the score only (See PS Suite EMR Help file on Stamps, for additional learning material)
  - There is a feature called ‘Questionnaire Stamps’. This type of stamp effectively reproduces the POMI Tool questions with radio buttons to select variables. Once completed it calculates the score and enters it into the progress note. This type of stamp is more complex to build but highly effective and a nice alternative to using a custom form. One interviewer-administered stamp that is included with the system is the MMSE (Mini Mental Status Exam). This stamp is often hidden. Ask the support team to install and demonstrate its use. (See PS Suite EMR Help file on Questionnaire Stamps for additional learning material)
- Medications: Suboxone® or methadone prescription documented in the EMR, triplicate pad or other sources. Search individually for Suboxone/ Methadone prescriptions or search by class. Suboxone and Methadone are listed under class: Opiate Partial Agonists



- Problem Lists: Review list of patients where ‘Opioid Use’ or other terms that have been recorded in the problem list/patient profile.

## Care Management

The following section outlines some EMR point-of-care reminders that can be enabled but this does not replace clinical judgement or consideration of individual patient circumstances. It is intended to provide a ‘safety net’ to alert the physician and care team to considerations in managing patients using opioids.

### a) Managing Panel Segment: patients using opioid medication

Establishing point of care reminders for these care management activities can support the care team by identifying tasks that may be appropriate to be completed at the encounter or a recommendation to conduct outreach to a patient. Refer to the PS Suite EMR Help file on Reminders for extensive learning material on building reminders.

The six care activities recommended for ‘Opioid Use’ are:

1. **Review Alberta Netcare at every encounter.**

Prior to prescribing an opioid, the Alberta Netcare medication profile should be reviewed for each patient. Many physicians find it helpful to have a team member print the medication list from Netcare before the patient visit. The care team member assigned this task, must be able to view the problem list/patient profile section of the record.

2. **Advise patient about risks of opioid use and offer Naloxone kit.**

Prior to prescribing an opioid the physician discusses the risks and benefits of opioid therapy. It can be helpful to include a 'SIG' instruction to opioid prescriptions which can be used to instruct patients to inquire about a naloxone kit to reinforce messaging. Sample SIG instruction:

*"An opioid overdose can result in death. Ask if a naloxone kit is recommended."*

**TIP:** Virtually every EMR is capable of creating provider specific medication favorites. To make data entry more efficient, this feature can be useful to save several commonly used opioid prescriptions. For more information please refer to [the Creating Medication Favorites](#) section of EMR guide or the PS Suite EMR Help File on Creating Medication Favorites, for additional learning material.

PS Suite has two options for this:

- *Prescription Favorites:* To make data entry more efficient, this feature can be useful to save several commonly used opioid prescriptions with associated SIG instructions. See example below of how this message will look. By default, prescription favorites are created and available to the provider. After they are created, they can be made available to all prescribers in the clinic.

**Treatment Management** ✕

**Treatment Information**

**oxycodone 10 mg** (Oral Tablet Sustained Release 12 hr)  
PIN Rx#:  
Instructions: 1 tablet 1 time daily for 10 days An opioid overdoes can result in death. Ask if a naloxone kit is recommended  
Status: Active  
Last Prescribed: May 27, 2019  
Quantity: 10 tablet(s) Refills:

- *Medication Stamps:* If your prescriptions or treatments include complicated and frequently used text for medication names or medication instructions, creating a medication stamp is another option. See PS Suite EMR Help File on Medication Stamps for additional learning material.

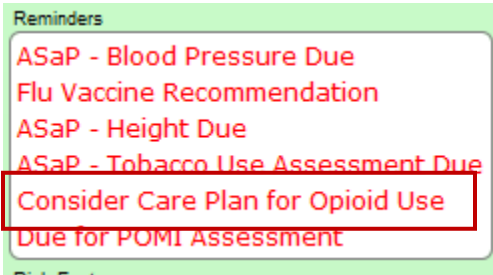
3. **Complete relevant assessments for pain and function**

Ongoing work to have common assessments and templates available in all EMRs is under development. However, some providers may choose to use paper based tools to record patient assessments. Consider scanning relevant documents into the EMR with a standardized keyword to

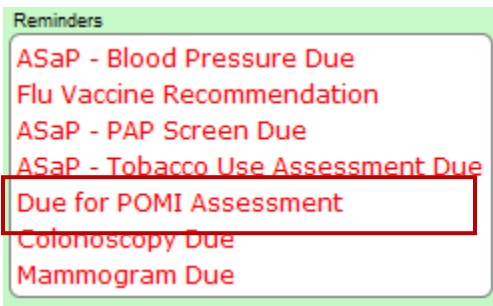


enable search functionality. A list of common assessments/templates are found in the AMA website in the Opioids Resource Centre.

4. **Document, share or receive patient care plan (with permission) with patients care team members.**  
Providing and coordinating care for patients diagnosed with ‘Opioid Use Disorder’ may be supported by a more formalized care planning process. Reminders created and linked to a care planning template can alert providers and team members to reassess patients at regular intervals..



5. **Complete a POMI assessment**  
Patients using an opioid medication should be periodically screened for opioid use disorder. Enter the POMI score as a manual lab entry, an encounter assistant or a questionnaire stamp to enable searches and point of care reminders. A POMI score of two or more suggests further assessment is needed and may indicate a diagnosis of opioid use disorder may be warranted.



6. **Establish appropriate reminders for following up on opioid management at every encounter.**  
*Global Visit Reminders* – Global reminders for patient recall/outreach for 12 weeks after any visit creates a ‘safety net’ for follow up on opioid treatment goal or an opportunity to remove ‘Opioid Use’ from problem list/patient profile. (See PS Suite EMR Help File on Global Reminders for additional learning material)  
*Individualized Tasks* - Opioid therapy reassessment is very important, and the College of Physicians and Surgeons of Alberta has established suggestions based on dosing stage (see table below). Developing an individualized recall notice that matches this schedule should enhance patient care. (See PS Suite EMR Help File on Individual Reminders for additional learning material)

Dosing Stage	Recommended Visit Frequency
Dose Taper	Weekly
Dose Adjustment	4 Weeks
Stable Dose	12 Weeks

## b) Managing Panel Segment: patients with opioid use disorder

Patients with ‘Opioid Use Disorder’ will require care activities 1-4 as outlined in the Opioid Use section. These patients will not require a POMI tool to be completed because the diagnosis of OUD has already been made.

Additional care activities for ‘Opioid Use Disorder’ include:

### 1. Establish reminders for follow-up

*Global visit reminders* for patient recall/outreach for 12 weeks after any visit creates a ‘safety net’ for follow up on opioid treatment goal.

### 2. Opioid Agonist Therapy (OAT).

#### a. Offer of OAT Reminders

*Global reminders* to offer OAT for all OUD patients every 3 months.

#### b. Documented offers of care

Documenting the offer of care for OAT is an important step as it demonstrates due diligence in the provision of quality care and as it is expected to take multiple offers of care to build patient readiness to address ‘Opioid Use Disorder’.

It is important to use 2 different configured options for the different outcomes of the offer of OAT to support documentation of all offers of care and measurement. The ideal method for capturing these accepted and declined offers may be with Stamps. Manual lab results and encounter assistants may be alternatives to consider.

- **Offered/ Accepted** – Select this option if a patient has accepted the offer of OAT to be provided in the medical home or a referral to an OAT prescriber has been completed

**May 29, 2019**

MBC

The patient has been Offered Opioid Agonist Therapy (OAT) and accepted a treatment course appropriate to their health needs.

- **Offered/ Declined** – Select this option if the patient was offered OAT but declined. Patients may receive many offers before they accept. At the patient level a provider could track how many offers were made before OAT was accepted.

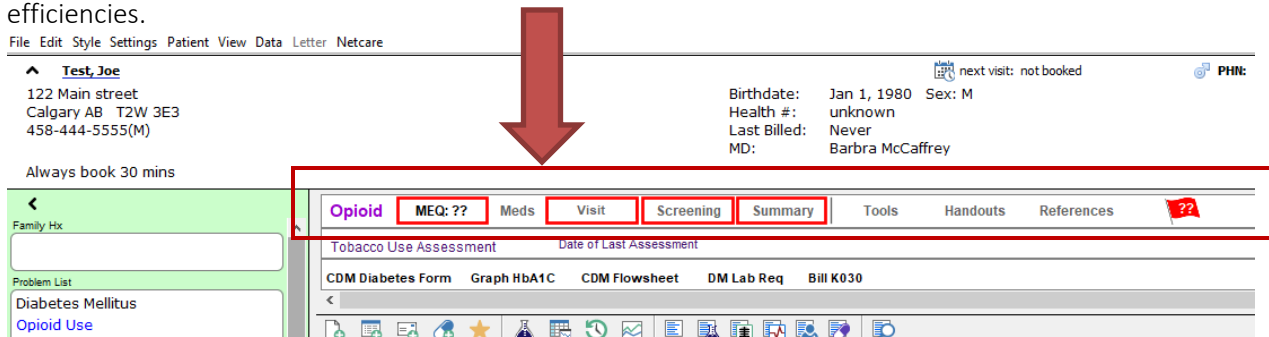
☐ **May 29, 2019**

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The patient has been Offered Opioid Agonist Therapy (OAT) and has chosen to decline at this time.

## c) Special Feature Unique to PS Suite

PS Suite has designed a special toolbar specifically for providers supporting patients taking opioids. The toolbar is created as a custom form with one-click buttons to make documentation and workflows more efficient. Once the toolbar is imported, a reminder is created to automatically place the toolbar in the chart when any patient is prescribed an opioid. This feature can be customized and tailored to a provider’s needs. Helpful one-click buttons include things such as: a Morphine equivalent calculator, links to patient handouts, visit forms and more. The toolbar is not listed in the library of custom forms. Request this toolbar from the vendor support team and explore the features to increase charting efficiencies.

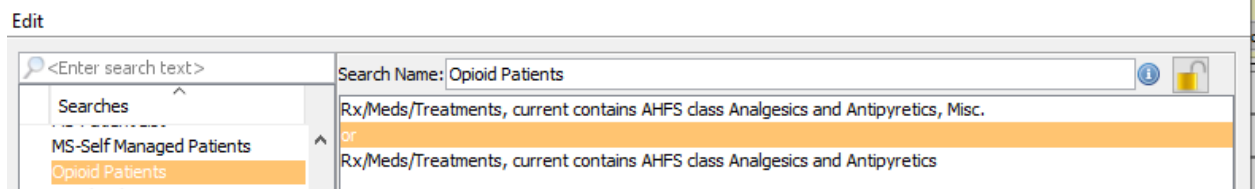


## Quality Improvement and Measurement

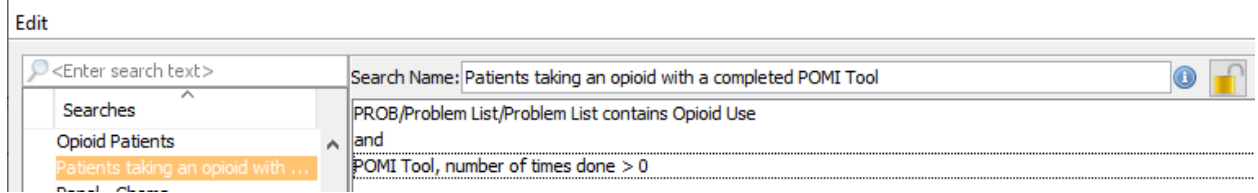
Quality improvement (QI) is a systematic approach used to monitor practice efforts, review and reflect on the current state and to look for opportunities of improvement. Measurement can be a way to monitor clinic operations and monitor improvement. How and why the team uses measurement may require a discussion with the team and the improvement facilitator. Consider the reason for measurement; is it a spot check or long term monitoring? A team can benefit from reflecting on data produced from the EMR to help inform next steps, focused follow-up or ongoing patient monitoring.

The following examples are searches that a team may wish to perform in their EMR for their patients who use opioids:

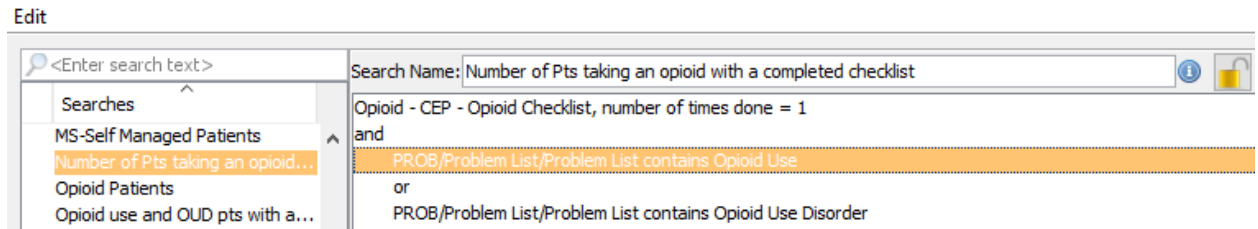
- Number of active patients prescribed an opioid medication



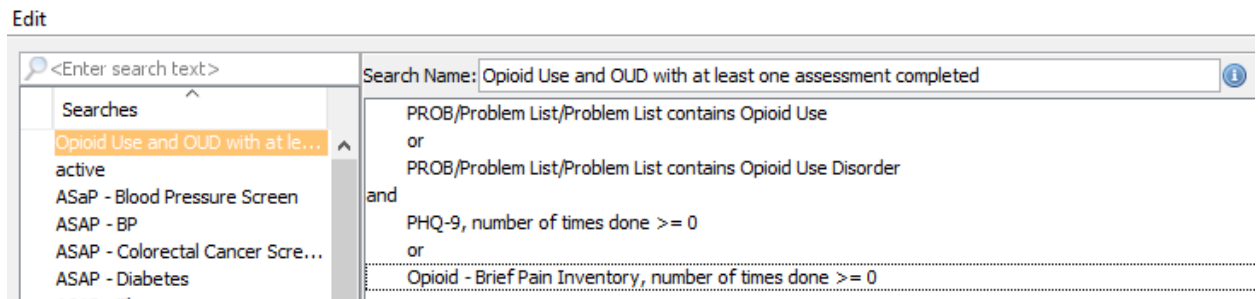
- Number of patients assessed with a standardized tool (i.e., POMI tool)



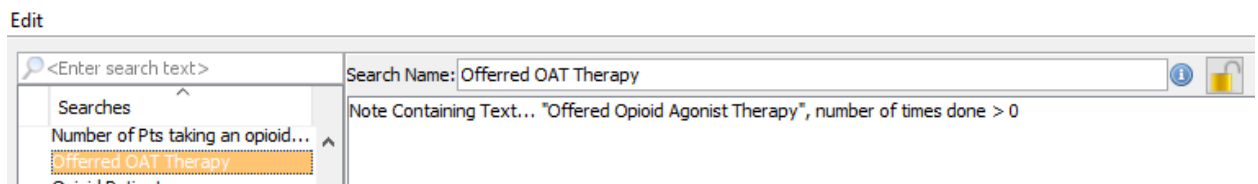
- Number of patients with a documented opioid checklist



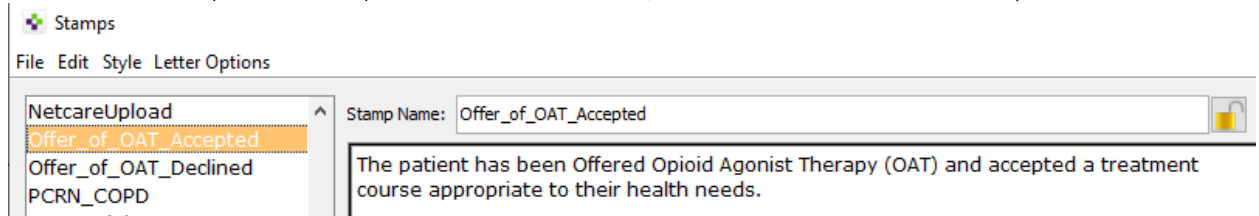
- Number of patients with at least one assessment completed (any tool that assesses pain, function, mental health). This example shows the Brief Pain Inventory and the PHQ-9. Include relevant assessments that a provider typically uses.



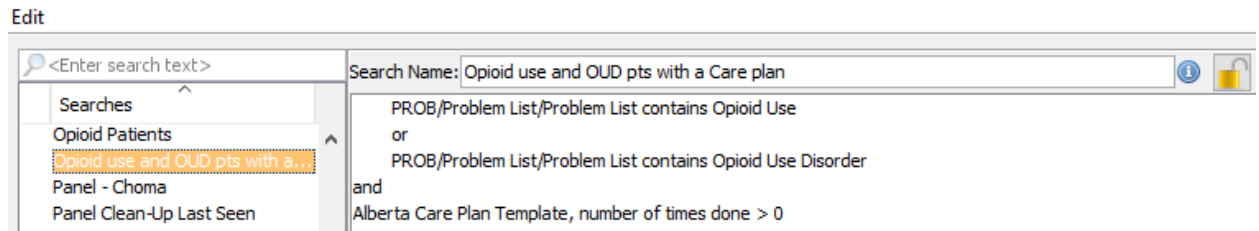
- Number of patients offered OAT (using stamps to track offers)



Below is an example of a stamp created to track offers, then reflected in Search example above.

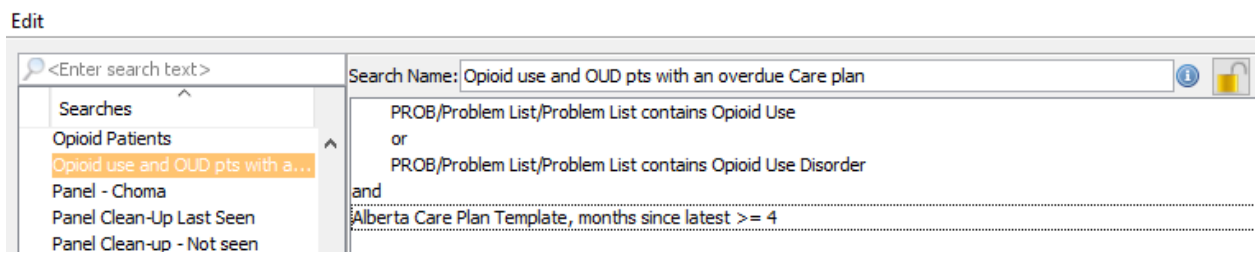


- Number of patients with a documented care plan



- Number of patients with an overdue reassessment

Note: If the interval for assessment is 3 months, choose  $\geq 4$ . If the search is written as  $\geq 3$ , the search will include those patients in the third month and the search needs to find patients who are overdue.



Decide what measures are meaningful to the team. Start simply, by choosing one or two measures and expand the work where desired.

**TIP:** Were some searches unable to be performed because the data was not standardized in the EMR? Discuss as a team what documentation/charting may need to change moving forward for the purpose of patient population monitoring and process improvement.