Interdisciplinary Controlled Substance Review Committee at a Federally Qualified Health Center: A Pilot Project

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Abstract

Interdisciplinary controlled substance review committees (CSRC) are increasingly utilized to support providers in navigating challenging cases involving controlled substances and improving patient outcomes. This quality improvement (QI) project was the continuation of a previous project that developed an interdisciplinary CSRC at a federally qualified health center (FQHC) in the Pacific Northwest. It sought to facilitate the referral and case review process to the CSRC via a pilot. However, at the initiation of this project, it became clear that the necessary elements to pilot the CSRC referral and case review process were not in place as anticipated. The focus of the interventions shifted from piloting to re-establishing CSRC membership, establishing an interim referral process, and a monthly meeting for the committee. This project successfully created the foundational infrastructure needed to make a pilot of the CSRC referral and case review process feasible in the future.

Keywords: controlled substances, controlled substance review committee, advisory committee, quality improvement, interprofessional, multidisciplinary, interdisciplinary

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Problem Description

Prescription drug abuse was declared an epidemic in 2011 due to the opioid crisis (Centers for Disease Control and Prevention, 2011). While the opioid crisis brought prescription misuse and abuse to the forefront, it arguably disregarded other controlled substances, such as benzodiazepines, z-drugs, and stimulants, with similar potential for abuse and misuse; and to cause harm or even death. Many experts are increasingly expressing concern that these medications are either a hidden epidemic or the next epidemic of prescription drug misuse due to parallels to the opioid epidemic (Brumbaugh et al., 2022; Lembke et al., 2018; Sarangi et al., 2021; Via, 2019).

In 2020, 16.1 million Americans over the age of 12 reported misusing prescribed psychotherapeutic medication in the past year (Substance Abuse and Mental Health Services Administration, 2020). Of the 16.1 million individuals, 6.2 million misused tranquilizers or sedatives, and 5.1 million misused stimulants. These medications, when used appropriately, can be very effective. However, given the parallels to the opioid epidemic and the potential for misuse, abuse, and diversion, one could argue that this requires diligent evaluation to ensure appropriate and safe prescribing practices are utilized. This is bolstered by the increasing rates of prescriptions for benzodiazepines, stimulants, and z-drugs.

Between 1996 and 2013, there was a 67% increase in the number of adults filling benzodiazepine prescriptions, and the quantity tripled (Bachhuber et al., 2016). An increase in benzodiazepine and z-drug prescriptions was observed at the start of the COVID-19 pandemic (Milani et al., 2021). It is notable that long-term use of these medications is not clinically indicated; however, despite well-documented risks of chronic use, it is not uncommon in practice. From 2019 to 2020,

deaths from prescription benzodiazepines increased by 22%, and benzodiazepines were implicated in 17% of all overdose mortalities (CDC, 2021).

Brumbaugh et al. (2022) found that despite insignificant increases in ADHD or narcolepsy diagnoses, stimulant prescriptions increased by 250% between 2006 and 2016. The majority of these prescriptions were for individuals aged 20 and older, with adult prescriptions over taking pediatric ones. This is of particular concern considering this population may be at increased risk of adverse outcomes. Additionally, increasing stimulant prescriptions in the context of a methamphetamine epidemic reflects a trend observed at the beginning of the opioid epidemic.

Available Knowledge

There has been a growing trend of healthcare institutions implementing interdisciplinary groups or committees to review and provide consultation for cases in which patients are receiving controlled substances (Bourgeois et al., 2020; Cunningham et al., 2022; Gernant et al., 2015; Hulen et al., 2018; Rivich et al., 2018; Zeigler et al., 2017), which is consistent with previous literature that supports the role of the health care team "in the effective management of controlled substances" (Gernant et al., 2015). These committees or groups were developed primarily in response to the opioid epidemic to support providers, namely primary care providers, managing chronic pain with these medications (Bourgeois et al., 2020; Cunningham et al., 2022; Gernant et al., 2015; Hulen et al., 2018; Rivich et al., 2018; Zeigler et al., 2017). They recognized the inherent complexity in navigating, interpreting, and applying guidelines in these cases; physician's distress and conflict in the patient-provider relationship regarding controlled substances prescribing; and limited time, resources, and training.

The implementation of these committees resulted in a meaningful reduction of morphine equivalent doses (MED) (Bourgeois et al., 2020; Gernant et al., 2015; Rivich et al., 2018; Zeigler et al., 2017), and recommendations were generally implemented at high rates, 76% for dose reduction and

32% for elimination (Gernant et al., 2015); 50.1% of any recommendation, though it varied by type of recommendation, 58% of recommendations for dose modification were implemented (Bourgeois et al., 2020). Varying levels of recommendation adoption by type were also reflected in Zeigler et al.'s (2017) findings. Additionally, these committees were found to preserve the patient-provider relationship and minimize conflict (Cunningham et al., 2022; Gernant et al., 2015; Hulen et al., 2018; Zeigler et al., 2017). Recommendations extended beyond pharmacotherapy and included alternative therapies, nonpharmacological interventions, communication strategies, ways to approach and navigate difficult interactions, and risk mitigation (Bourgeois et al., 2020; Cunningham et al., 2022; Gernant et al., 2015; Hulen et al., 2018; Zeigler et al., 2017)

Hulen et al. (2018) found that the sources of stress related to opioid management were primarily associated with challenges of pain management, patient attachment to opioids, and provider frustration, with associated themes emerging in each domain. Challenges of pain management included the lack of objective assessments of pain, an uncoordinated approach resulting in the underutilization of nonpharmacological treatments, and changing guidelines. Themes identified regarding patient attachment to opioids were all in the context of tapering or withdrawing this medication and included threatening statements by the patient, feelings of abandonment, and a sense of entitlement, with some patients feeling penalized. Conflict during patient visits, complex social determinants of health, and patients' minimal engagement with mental health services contributed to provider frustration.

While many of these projects are primarily concerned with opioids, it is reasonable to extrapolate the value of controlled substance advisory groups (CSAG) or controlled substance review committees (CSRC) for all controlled substances. The themes and challenges inherent to managing opioids in the outpatient setting appear to apply to other controlled substances, such as benzodiazepines, stimulants, and Z-drugs.

Rationale

The literature review revealed clear challenges associated with managing controlled substances and provided preliminary evidence for CSRC's role in addressing these challenges while improving patient safety, outcomes, and quality of care. Community behavioral health centers with providers who prescribe controlled substances would likely benefit from having a CSRC available to support providers with challenging and complicated cases.

This quality improvement (QI) project resumed a previously established QI project, which identified the need for and focused on developing a CSRC at the same location. Since the previous QI project developed a CSRC, this project primarily focused on the referral process and conducting pilot case reviews. However, given the pause between projects, it was prudent to reestablish communication with the individuals interested in CSRC and ensure that its' membership is interdisciplinary.

The Institute for Healthcare Improvement's (IHI) Model for Improvement (MFI) served as the framework for this project (Langley et al., 2009). This model is well-suited for complex and adaptive systems as it provides a nonlinear process that encourages ongoing learning and adaptation. It utilizes a plan, do, study, act (PDSA) cycle to trial changes and learn from them. Each PDSA cycle generates new information that informs the next cycle, allowing for continual improvement and learning.

Aims

This project aimed to facilitate the referral process to the CSRC to promote safe, effective, equitable, patient-centered care. The CSRC will meet and review one case by mid-January 2023.

Methods

Context

This large nonprofit organization is located in the Pacific Northwest, integrating behavioral health, substance use, primary care, and housing services. The organization serves over 18,000 individuals every year at more than 75 locations across the state, including four outpatient integrated health centers located in a metropolitan area. Three of these clinics are designated Certified Community Behavioral Health Centers (CCBHC), with two also being granted Federally Qualified Health Center (FQHC) status. These outpatient health centers are the setting for an interprofessional Controlled Substances Review Committee pilot before being implemented on a larger scale.

For this QI project, the organization's medical and health integration division was of interest, though, as mentioned above, it focused on the four outpatient clinics. Across these clinics, there were 190 employees within this division, including 33 medical/nursing professionals. These employees included three psychiatrists, 12 psychiatric mental health nurse practitioners (PMHNPs), five contracted licensed medical professionals (LMPs), one family nurse practitioner (FNP), two primary care physicians, nine registered nurses (RNs), four program directors, one chief medical and health integration officer, and one program medical director. There was also a partnership with a pharmacy, which has a location in an outpatient health center.

The health centers served 9,865 individuals in the metropolitan area during the 2021 fiscal year. The majority of clients served identified as White, followed by individuals identifying as Hispanic or Latino, Asian, Black, multiracial, American Indian or Alaskan Native, representing the smallest racial group served.

Intervention

The planned intervention for this project was to pilot a CSRC at one of the outpatient clinics, which was planned to include the case referral and review process. The CSRC and process are congruent with the existing literature (Bourgeois et al., 2020; Cunningham et al., 2022; Gernant et al., 2015; Zeigler et al., 2017, 2017). Treatment teams will have the opportunity to refer cases, using a standard referral

form, to the CSRC for review and consultation regarding controlled substances. The CSRC will conduct a thorough chart review for referred patients before the review meeting. Ideally, someone from the referring treatment team will attend the review meeting to present the case and answer questions. The multidisciplinary CSRC will discuss the case and formulate evidence-based recommendations, both pharmacological and nonpharmacological. These recommendations will be shared with the treatment team and documented in the patient's electronic health record (EHR).

The initial plan, do, study, act cycle was focused on re-establishing communication with previously identified individuals who expressed interest in being part of the CSRC and ensuring interdisciplinary representation.

Study of Interventions

The study of the intervention included tracking case referrals and reviews, feedback regarding the process, CSRC's schedule of meetings, a method for contacting the CSRC, estimated time commitment, recommendations made, and adoption of recommendations; which was meant to inform assessing the feasibility and acceptability of the intervention. Given that this was an implementation trial or pilot, these aspects are essential to analyze how the process is working and inform the next stages of the project. If there is a lack of referrals, it would be clear that the intervention is not working. If there are referrals, surveys and meeting notes will aid in revealing more details regarding the facilitators and inhibitors to the process. The baseline data will likely be more useful in future stages of the project as it will allow for a macro-level analysis of the impact on patient care and is critical for the current project to establish the baseline.

Measures

Baseline measures included the number of grievances related to controlled substances, the number of controlled substance prescriptions, high-risk prescribing patterns, how often controlled substance agreements are utilized, and provider stress. Outcome measures included provider stress,

how frequently CSRC's recommendations are implemented, and the types of recommendations made. Process measures consisted of a standardized way to contact the CSRC, the number of referrals to CSRC, how many cases were reviewed, the schedule of CSRC meetings, and feedback on the referral and case review process. Balancing measures included the time commitment required as a member of CSRC and the amount of time for a referring provider to complete the referral process.

Analysis

Baseline data was collected at the project's beginning and used to test improvement. It should be noted that this data will likely be more beneficial as this project progresses beyond the pilot phase. Data sources included EHR, meeting notes, and surveys. Quantitative data was collected, documented in Excel, and displayed in appropriate charts. Qualitative data was collected, recorded, and analyzed for themes.

Ethical Considerations

This project was determined to comply with HIPAA, as a peer case review is care coordination and therefore considered a health care operation. However, it is crucial to consider the principles of autonomy and beneficence and how they may come into conflict in controlled substance management. Therefore, it is essential for referring treatment teams to be transparent with patients about their decision to refer the cases to the CSRC. This raises an ethical question of how to proceed if a patient refuses, which at this time, is unanswered. One potential solution is to include this in the controlled substance agreement. In the future, patients should be aware of the CSRC and have the opportunity to refer or request a referral to the CSRC for a case review. This project was submitted to the Institutional Review Board (IRB) and granted IRB exemption.

Results

Between January 1, 2021, and December 31, 2022, there were 1,794 clients with active prescriptions for controlled substances, 1,572 were prescribed multiple controlled substances, 2,743

active prescriptions for controlled substances, and a total (active and discontinued) of 7,257 controlled substance prescriptions. Information about controlled substance agreements and grievances related to controlled substances could not be retrieved. Throughout the project LMPs at this clinic inquired if the CSRC was accepting referrals yet.

Prior to implementation, there was a follow-up with the director of quality improvement and population health regarding the electronic referral process, which was part of the previous QI project. The electronic referral process to the CSRC was not in place, as expected. Consequently, an interim referral process was created. The original plan was to have an email group for the CSRC and receive referrals that way. However, after receiving feedback that Microsoft Teams may be a more secure option, a Team was created for CSRC. The provider referral form and CSRC recommendations form were each added as a workflow in Teams. A link to the provider referral form was created so staff not on the CSRC can access the form to make referrals.

Communication was reestablished with previously identified individuals interested in participating in the CSRC to inform them that the project is progressing. Two of the nine individuals were no longer with the organization, and another's availability changed. Efforts were made to replace representation from disciplines but were unsuccessful (see Appendix B for representation by discipline). A survey was sent to the seven members to identify a day and time to meet. Two responses were recorded, and qualitative feedback suggested that the survey be revised for clarity. The revised survey had a 71.4% response rate. A monthly meeting was established for the CSRC to meet.

During the first meeting, members reviewed the referral and recommendation forms and provided qualitative feedback, which resulted in minor changes to the forms (see Appendix C). Themes reflected in the feedback and subsequent changes included patient-centeredness and objective language.

Due to the referral process not being in place at the initiation of this project, we could not pilot the referral and case review process. Consequently, there were no referrals, no cases reviewed, feedback could not be gathered on the referral and case review process, frequency of recommendation implementation could not be collected, and no information on the recommendations made was available. Additionally, the time commitment as a member of the CSRC and the time it takes to complete the referral process could not be captured. Data on provider stress was not collected due to the project's focus needing to shift.

Throughout this iterative process, clear and relevant themes emerged (see Appendix D). Notable themes included policy, collaboration, evidence-based practices, and patient-centeredness.

Summary

This QI project facilitated the referral process to the CSRC at an FQHC between October 2022 and January 2023. It successfully established a monthly, hour-long meeting for the CSRC, re-established interdisciplinary membership, and created an interim referral process. The first meeting was on January 26, 2023. However, the referral and case review process could not be piloted due to the electronic referral process not being in place as anticipated. Additionally, 87.6% of clients were prescribed multiple controlled substances.

Interpretation

There seemed to be an incongruence between organizational readiness and the scope of this project, which may, in part, be related to the hiatus between the projects. While the previous project developed a CSRC by identifying interested members across disciplines, one-third of the members were lost at the initiation of this project. Additionally, the progress regarding the electronic referral was suspended during this pause, resulting in it not being in place or close to being in place, as anticipated. As a result, the focus of interventions had to pivot from facilitating the referral and case review process via a pilot to facilitating this process by establishing the necessary foundational aspects for this process,

such as a monthly meeting, interim referral process, and re-establishing CSRC membership. This project successfully created the infrastructure to pilot the referral and case review process and will likely help sustain the momentum necessary for continued improvement.

The most salient theme that emerged was policy, which seems to go back to the incongruence mentioned above and is likely to affect other identified themes. While this did not necessarily affect the outcomes here, one could reasonably argue that it is likely to have future implications, and it would be beneficial to ensure the organization's policies support the CSRC.

The organization's ongoing interest in establishing a CSRC and providers' inquiries about whether the CSRC was accepting referrals throughout the project seems to support the need and desire for a CSRC.

Limitations

This project had several limitations. There was an appreciable pause between the prior project's conclusion and the initiation of this one, which caused the project to lose momentum within the organization. Time was a notable limitation, both the time constraints of individuals and the time-limited nature of this project. Additionally, staff turnover and role changes resulted in the loss of previously identified members, and regaining new representation presented a number of challenges. At the conclusion of this project, the membership was interdisciplinary but still lacked representation from disciplines that would add value. The results of this project may have limited generalizability, given that it occurred at a single clinic within a relatively large organization.

Conclusion

Healthcare organizations are increasingly implementing CSRC to support providers and enhance patient outcomes (Bourgeois et al., 2020; Cunningham et al., 2022; Gernant et al., 2015; Hulen et al., 2018; Rivich et al., 2018; Zeigler et al., 2017). This QI project supported an organization in facilitating the CSRC referral and review process. While the pilot was unsuccessful, the infrastructure needed to pilot

the CSRC referral and review process is in place. Future directions for this project include publicizing that the CSRC is open to referrals, piloting the referral and review process, collecting relevant data, continuing PDSA cycles, updating organizational policies, and working to transition the interim referral and recommendation forms into the EHR as a more permanent option. Additionally, ongoing efforts are needed to gain and maintain interdisciplinary representation on the committee.

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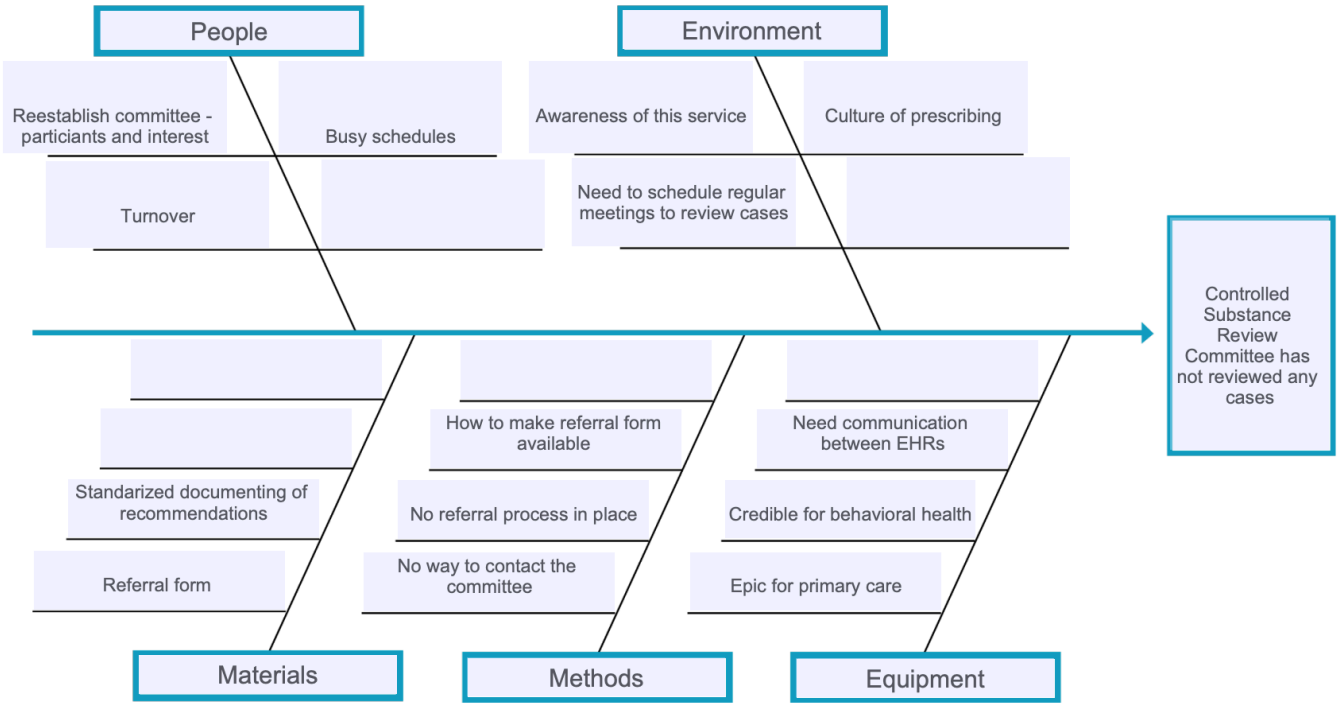
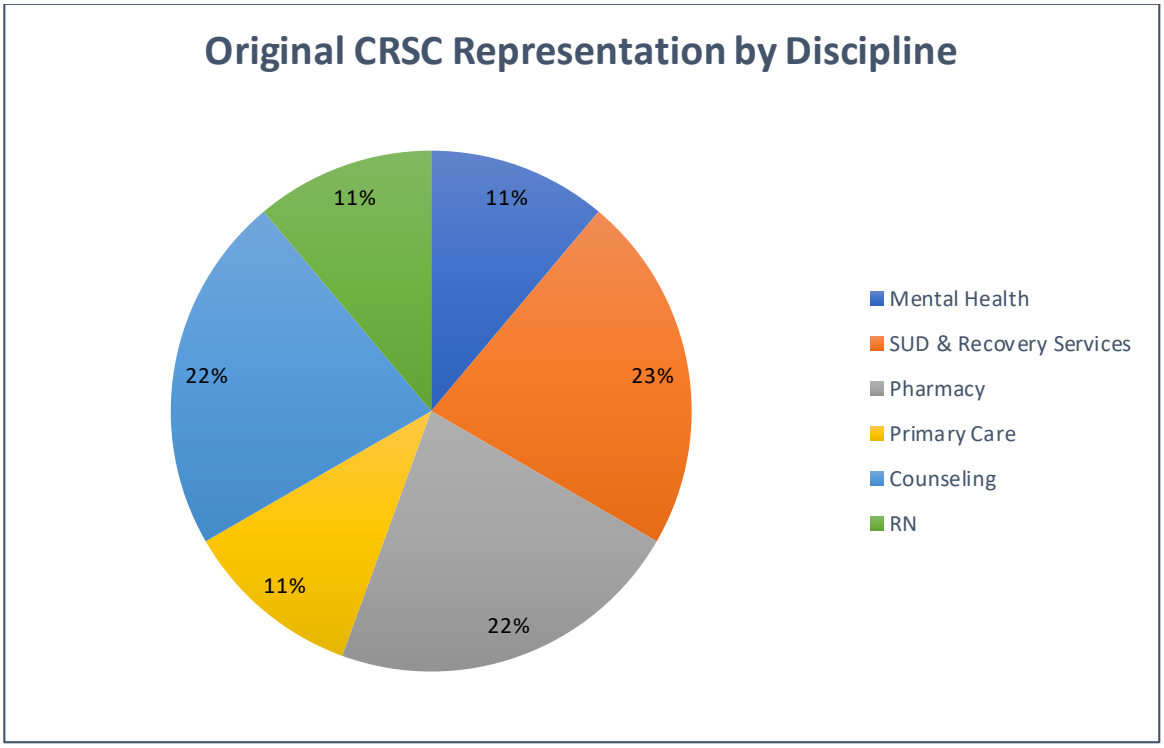
Appendix A

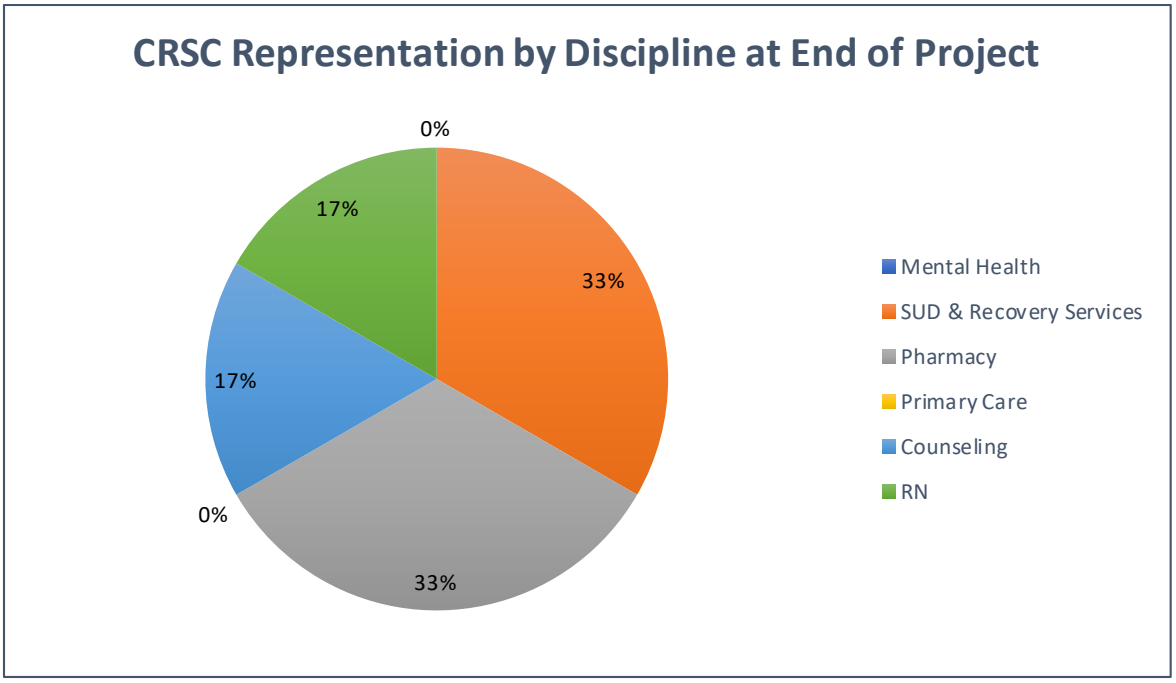
Fishbone Diagram – Root Cause Analysis



Appendix B

CRSC Representation by Discipline and Evolution Through the Project





Appendix C

Development of Referral and Recommendation Forms

Original to be Added as Workflow in Microsoft teams

Provider Submission Template

1. Medical/behavioral condition for which patient is receiving or requesting a controlled substance?
2. Current controlled substance and dosage (if applicable)?
3. Substance Use/Addiction History:

Your question for the committee?

Committee Response Template

The Controlled Substances Review Committee met with regard to [patient name's] case on [date].
The Committee addressed the following questions:
1. Does the patient have a verifiable medical/behavioral diagnosis that warrants treatment with a controlled substance? Have other modalities been attempted and failed?
2. Does the patient have a high-risk history that makes controlled substances absolutely or relatively contraindicated?
3. Has the patient previously violated a controlled substances agreement at [clinic name], been reviewed before by the CSRC, or been discharged from by another clinic for violation of a controlled substances agreement?
4. Does the patient have a mental health diagnosis? Is it being treated appropriately?
5. Is the controlled substance and dosage appropriate?
Based on the above findings, the CSRC recommends the following:
[recommendation for prescribing.
If yes, discuss parameters for ongoing care, monitoring, etc.
If no, provide alternatives (Rx and non-Rx)
Consider recommendations for communication strategies

Original Workflow in Microsoft Teams

Provider Submission Template

1. Medical/behavioral condition for which patient is receiving or requesting a controlled substance?
2. Current controlled substance and dosage (if applicable)?
3. Substance Use/Addiction History:

Your question for the committee?

Committee Response Template

1. The Controlled Substances Review Committee met with regard to the following patient [patient name's]
2. The Controlled Substances Review Committee met on the following date [Please insert date m/dd/yyyy]
3. Does the patient have a verifiable medical/behavioral diagnosis that warrants treatment with a controlled substance? Have other modalities been attempted and failed?

4. Does the patient have a high-risk history that makes controlled substances absolutely or relatively contraindicated?
5. Has the patient previously violated a controlled substances agreement at [clinic name], been reviewed before by the CSRC, or been discharged from by another clinic for violation of a controlled substances agreement?
6. Does the patient have a mental health diagnosis? Is it being treated appropriately?
7. Is the controlled substance and dosage appropriate?
8. Based on the above findings, the CSRC recommends the following:

[recommendation for prescribing. If yes, discuss parameters for ongoing care, monitoring, etc. if no, provide alternatives (Rx and non-Rx). Consider recommendations for communication strategies]

Revised Workflow in Microsoft Teams

Provider Submission Template

1. Medical/behavioral condition for which patient is receiving or requesting a controlled substance?
2. What is the patient's goal for treatment? (This can be either provider's summary of the patient's goal, or a direct statement from the patient)
3. Current controlled substance and dosage (if applicable)?
4. Substance Use/Addiction History:
5. Please enter the urine drug test (UDT) date and results. Please do NOT submit this form until this has been completed.
6. Please state your question for the committee.

Committee Response Template

1. The Controlled Substances Review Committee met with regard to the following patient [enter patients name]
2. The Controlled Substances Review Committee met on the following date [please input date m/d/yyyy]
3. Does the patient have a verifiable medical/behavioral diagnosis that warrants treatment with a controlled substance? Have other modalities been attempted and failed?
4. Does the patient have a high-risk history that makes controlled substances absolutely or relatively contraindicated?
5. Has the patient previously violated a controlled substances agreement at [clinic name], been reviewed before by the CSRC, or been discharged from another clinic for violation of a controlled substances agreement? Any history of misuse (e.g., multiple lost or early refills, unexpected UDTs)?
6. Does the patient have a mental health diagnosis? Is it being approached with current evidenced-based guidelines (e.g., consider therapy modality, patient engagement, current and past medications)?
7. If on a controlled medication currently, Is the medication dosage within recommended guidelines?
8. Based on the above findings, the CSRC recommends the following:

[recommendation for prescribing? If yes, discuss parameters for ongoing care, monitoring, etc. If no, provide alternatives (Rx and non-Rx). Consider recommendations for communication strategies]

Appendix D

Themes