Environmental Scan and Needs Assessment for Provider Education and Training Related to Opiates

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JSI
John Snow, Inc.

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Acknowledgements

John Snow, Inc. (JSI) would like to thank all the providers and practice transformation organizations that were interviewed but are not named in this report.

Additionally, we are grateful for the insights of many stakeholders around the state who represent various organizations, some of which include:

Colorado Access

Colorado Hospital Association

Colorado Association for School-Based Health Care

Colorado Health Extension System

Colorado Department of Public Health and Environment

Colorado Consortium for Prescription Drug Abuse Prevention

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Executive Summary

The Tri-County Health Department (TCHD)—in coordination with the Tri-County Overdose Prevention Partnership (TCOPP)—contracted with John Snow, Inc. (JSI) to conduct an environmental scan and needs assessment of medical provider education and training related to opioid drug prescribing practices in Adams, Arapahoe, and Douglas Counties. As part of the project, JSI curated a list of relevant training opportunities identified by key stakeholders; reviewed websites that identify resources and/or best practices to effectively address the opioid epidemic; and interviewed fifteen key informant providers, six practice transformation organizations (PTOs), and various stakeholders.

Boston University's SCOPE of Pain, The Collaborative Opioid Prescribing Education (COPE) program, and JSI's New Hampshire Center for Excellence are three valuable websites that provide resources on managing chronic pain; trainings to increase provider knowledge, competence, and satisfaction in prescribing opioids; and technical assistance related to prevention, treatment, and recovery, respectively. But academic detailing has proven to be the most effective program for educating health care providers on opioids. Interactive trainings are more effective than exposure to guidelines alone. Appendix B outlines the many in-person or online trainings available to providers that cover three main content areas: safe prescribing, medication-assisted treatment (MAT), and alternatives to opioid prescribing.

JSI interviewed fifteen providers from academic institutions, hospitals, safety-net clinics, and federally qualified health centers (FQHCs), representing primary and specialty care practices, including pulmonologists, palliative care providers, psychiatrists and addiction medicine specialists, behavioral/mental health providers, hospitalists, dentists, and pharmacists. The providers reported prescribing opioids at their clinics for chronic and acute pain as well as for lacerations, cough, cancer, post-operative or surgery-related pain, peripheral neuropathy, acute injuries, and acute abscesses.

Most of the providers use a set of internally created guidelines that have been informed or influenced by the Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing. All the interviewed providers have used the Prescription Drug Monitoring Program (PDMP) before prescribing opioids, and most are pleased with the website, though some noted technological or logistical barriers to using the system.

Just over half the respondents want training on opioid use disorders and substance use disorders (OUDs/SUDs). Nearly every provider wants further training on alternatives to opioid prescribing, and they preferred in-person trainings first or online second. Other topics of interest include:

- Team-based training for the entire staff
- Psycho-social aspects of persons facing addiction
- Guideline updates

- Medication-assisted treatments (MAT)
- Communication with patients
- Pain management

JSI conducted six PTO interviews working with practice facilitators (PFs), clinical health information technology advisors (CHITAs), and regional health connectors (RHCs) to transform care delivery to more patient-centered, valued-based models. All of the PTOs are participating in the State Innovation Model (SIM), Comprehensive Primary Care Plus (CPC+), and/or Transforming Clinical Practice Initiative (TCPi).

All the PTOs are familiar with or trained in IT MATTTRs 2 (Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado), the MAT team-training program. None of the PTOs has a specific quality improvement initiative devoted to opioid prescribing, though most are prepared to offer resources and training if practices request them. The monetary and educational incentives for providers include the following:

- IT MATTTRs 2 offers a $1,400 incentive for the practices; $760 for MDs, DOs, and Residents; and $1,800 for NPs and PAs once they complete the waiver training and team training modules;
- COPIC Insurance Company offers points to reduce insurance costs;
- SIM offers $40,000 small grant awards to help practices meet their milestones;
- Comprehensive Primary Care Plus (CPC+) offers bonus payments to primary care providers who better coordinate care for their patients (most Colorado payers and 360 providers are participating)
- Continuing Medical Education (CME) credits for IT MATTTRs 2 and other trainings like Project ECHO; and
- MAT training and knowledge related to treating patients with OUDs/SUDs.

Other key informant interviews referenced their work on preventing drug diversion as well as the Opioid Safety Pilot conducted by the Colorado Hospital Association (CHA) and its partners across 10 emergency departments (EDs) with the goal of reducing the administration of opioids in EDs.

The nine key recommendations for TCOPP are as follows:

1. Leverage existing partnerships;
2. Incentivize PTOs and providers;
3. Target smaller practices;
4. Engage dynamic and respected speakers;
5. Conduct trainings on chronic pain, opioid use disorder, and alternatives to opioids;
6. Create a comprehensive list of opioid prescribing guidelines for primary care providers and targeted specialists;
7. Partner with Colorado Access;
8. Use academic detailing models; and
9. Support efforts to expand the pilot.

Background and Introduction

The Tri-County Health Department (TCHD), the District Public Health Agency for the Counties of Adams, Arapahoe, and Douglas, Colorado, contracted with JSI to conduct an environmental scan and needs assessment of medical provider education and training related to opioid drug prescribing in order to support the work of TCHD's Overdose Prevention Partnership (TCOPP). TCHD serves approximately 1,400,000 residents in the three county area. TCOPP is a community-based partnership of public and private partners serving the three counties, with two main priorities:

1. Prevent opioid overdose deaths in Adams, Arapahoe, and Douglas Counties;
2. Increase awareness and education about factors leading to and preventing opioid overdose deaths.

TCOPP's work consists of six strategy areas: youth prevention, public awareness, provider education, safe disposal, Naloxone, and treatment. This scan and needs assessment falls under the provider education strategy, though it addresses some of the other strategy areas as well.

Contract Details

JSI submitted a proposal to the Tri-County Health Department on November 13, 2017, in response to a Bid Request. An amended response was re-submitted on December 6, 2017. The aim of the project is to conduct an environmental scan and needs assessment of medical provider education and training related to opioid drug prescribing to support the work of the TCOPP. JSI proposed assessing seven project components: 1) Local medical provider training needs/interests, 2) Practice Transformation Organizations in the TCHD region, 3) Relevant training opportunities, 4) Best practices and models for provider training, 5) Provider training details, 6) Recommendations, and 7) Strategies for marketing and recruitment of provider trainings. This report is the final deliverable for TCOPP. The total contract award is $15,500.00.

It should be noted that JSI is a Practice Transformation Organization (PTO) for the State Innovation Model (SIM), Transforming Clinical Practice Initiative (TCPi), and the Colorado Team-Based Care Initiative. This report was informed by our experience around the state working with practices on their redesign efforts as well as our commitment to curbing the opioid epidemic and preventing deaths around the nation.

Methods

JSI used the following methods to conduct an environmental scan and needs assessment: 1) a review of relevant training opportunities identified by key stakeholders;

2) a review of credible websites that identify resources and/or best practices to effectively address the opioid epidemic; and 3) key informant interviews with providers, practice transformation organizations, and other stakeholders including members of the Colorado Consortium for Prescription Drug Abuse Prevention. Following collection of the qualitative data described above, JSI used an inductive method of analysis to bring together specific experiences, observations, and facts for this report.

Limitations

The limitations to this synthesis include the following:

1. The websites referenced in the synthesis include non-published information. While the websites are highly credible and include relevant information, they are not empirical or peer-reviewed research, in most cases.
2. Provider availability was limited, specifically among specialty providers and during the winter holiday season. While we did not reach saturation with the answers we received, this report does provide substantial information from a wide range of sources.
3. Providers chosen for interviews were not from a randomized sample; they were chosen based on their expertise in this area and/or their connections with JSI staff.

As a result of these limitations, our final report includes provider interviews that should not be taken as representative of the entire Tri-County provider population.

Website Review: Best Practices and Models for Provider Training

JSI curated a list of web resources that can be found in Appendix A. There are a plethora of resources, ranging from promotional content to academic research to facilitated and self-paced training opportunities. Web resources include information developed by state and federal departments, provider associations, and other prevention groups. The table in Appendix A lists the URLs for the various websites, the sponsor, a description of the resources provided, and available tools.

As described in the next section, JSI also compiled a list of provider trainings that we identified as best practices across a variety of modalities. Information gathered from our key informant interviews, as described in more detail later in this report, indicates that different models of training appeal to different providers. A few specific trainings and modalities have been recognized as best practices, as described below.

SCOPE of Pain, developed by Boston University, is a series of online and in-person continuing medical education/continuing nursing education activities designed to help practitioners safely and effectively manage patients with chronic pain, and when appropriate, with opioid analgesics. This training has received national recognition and

holds promise as an effective dissemination strategy to increase confidence, attitudes, and guideline-based, safe opioid prescribing knowledge.

The Collaborative Opioid Prescribing Education (COPE) program is an online training course designed to increase physicians' knowledge, competence, and satisfaction in using opioid medications to manage patients' chronic, non-cancer pain. COPE is based on the chronic care model, in which healthcare providers and patients make treatment decisions collaboratively to achieve positive health outcomes. COPE teaches providers communication skills for provider–patient goal setting in relation to starting, stopping, or continuing opioid therapy. COPE is listed on SAMHSA's National Registry of Evidence-based Programs and Practices.

JSI's New Hampshire Center for Excellence (the Center) is a statewide technical assistance resource for practitioners, organizations, systems of care, and communities to promote and improve best practices to prevent, treat, and support recovery from substance misuse. Technical assistance comes in various forms and services, from strategic planning consultation and data analysis to learning communities and best practice implementation support provided by the staff at the Community Health Institute/JSI. The Center has identified the Community of Practice (CoP) program as a best practice model for training providers. CoP convenes a group of individuals interested in a similar topic to share knowledge, information, and experiences in an effort to learn more about a topic and improve current practices. The Center offers a Medication Assisted Treatment (MAT) Community of Practice to promote and support the successful implementation of an integrated MAT approach in health care settings. Practices interested in initiating or expanding MAT services have the opportunity to gain knowledge and information and share experiences with other MAT settings.

To date, the most consistently effective programs to educate practicing health care providers in opioids and their appropriate use is the model of academic detailing. This educational outreach approach uses providers to make brief, face-to-face educational visits to practices. In 1986, an economic analysis of one such "drug detailing" effort concluded that face-to-face detailing visits conducted by academic providers were a more cost-effective method of prescription education than those conducted by industry representatives.[1] More recently, detailing was used in Utah to decrease prescription opioid deaths. In Utah, the detailing presentations included county-specific data about the scope of the epidemic and recommended six strategies for safe prescribing. The most significant lesson learned from this project was the importance of collaborating with local organizations and staff. JSI has included academic detailing as one of our final recommendations to TCOPP.

[1] Wiese, H.J.C., Piercey, R.R., Clark, C.D., 2018. Changing Prescribing Behavior in the United States: Moving Upstream in Opioid Prescription Education. Clin Pharmacol Ther. 10.1002/cpt.1015

While we have identified best practice models that include both interactive and didactic modalities, interactive training is more effective than exposure to practice guidelines alone.[2]

Provider Training Resources

The Provider Training Resources table has been included with this report as Appendix B. There are many trainings available for providers, and they vary across three main categories: safe prescribing, MAT, and alternatives to opioids. The training resources listed are offered by a range of educational, practice transformation, and government entities. The training modalities are either online or in-person and vary significantly in time requirements. The cost for trainings ranges from free to $200. Continuing Medical Education (CME) credits and COPIC (the medical liability insurer) points are offered by some of the trainings.

Key Informant Interviews

Provider Interviews

JSI interviewed fifteen medical providers, seven of whom are in primary care settings (including internists, general practitioners, family medicine, and pediatrics), and eight of whom represent specialties in pulmonology, palliative care, psychiatry and addiction medicine, behavioral/mental health, emergency, dental, and pharmacy. All providers interviewed serve patients in the Tri County area but may have offices located outside the three counties.

The interview guide used for provider interviews is attached as Appendix C. Questions were organized into three categories: practice background, evidence, and training. Appendix D is a table of all the responses we received during the provider interviews. Note that the columns have been randomized to protect confidentiality. The following narrative summarizes the answers we received.

Practice Background

JSI interviewed providers from various specialties and primary care offices, including, but not limited to, family medicine providers, pulmonologists, addiction medicine specialists, emergency room providers, and dentists. Practices range in size from small (fewer than ten full-time providers) to large (more than fifty providers), including those from academic institutions, hospitals, safety-net clinics, and federally qualified health centers (FQHCs). The providers see as many as twenty-four patients a day or as few as three, with one provider no longer seeing patients but overseeing providers who do. The

[2] Sullivan MD, Gaster B, Russo J, Bowlby L, Rocco N, Sinex N, Livovich J, Jasti H, Arnold R: Randomized trial of web-based training about opioid therapy for chronic pain. Clin J Pain 26:512-517, 2010

most prevalent patient population is people on Medicare and Medicaid, with a significant percentage of the providers' patient populations being low income and from underserved populations (including ethnic and racial minorities). The average full-time equivalency (FTE) seeing patients is roughly 58% (or about 3 days per week). Most providers do not prescribe opioids frequently to their patients, though some prescribe an opiate at almost all of their visits. Those who frequently prescribe an opioid work in pain management clinics or addiction treatment centers (JSI assumes these providers are prescribing suboxone or methadone, both of which are narcotics, technically). The top diagnoses for which these providers might prescribe an opiate are as follows:

- Chronic pain
- Lacerations
- Cough
- Lung cancer
- Post-operative- or surgery-related pain
- Abdominal pain
- Peripheral neuropathy
- Back pain
- Acute injuries
- Acute abscesses

All interviewed providers have prescribing authority, and most are Medical Doctors (MDs). A small number of interviewees are Nurse Practitioners (NPs). JSI did not interview any Doctors of Osteopathic Medicine (DOs) or Physician Assistants (PAs). Though the sample size for provider interviews is relatively small, it represents a wide cross section of healthcare professionals who prescribe opioids.

Evidence

Those providers who use evidence-based guidelines when prescribing an opioid to their patients generally use guidelines from or similar to those of the Centers for Disease Control & Prevention (CDC). Many use guidelines that their practices created through research and input from providers and their Medical Directors. All interviewees know of the CDC guidelines, even if they do not use them in their prescribing practices. A very small number of providers use or even know of the Colorado State guidelines or the American College of Emergency Physicians guidelines.

The barriers providers encounter when trying to use any guidelines vary greatly. Time does seem to be a barrier for a number of the providers: One provider said, "I don't have time to go through [the guidelines] initially and dissect the language that's not always applicable to my patient population." Others mentioned "unhappy" or "pushy" patients, referring to those people who expect to receive an opioid prescription but are denied one for any reason. Interviewees mentioned that there has been a kind of cultural shift from over-prescribing to now under-prescribing, but there does not seem to be a common, standardized methodology for choosing to prescribe opioids or specifically not prescribing.

The Prescription Drug Monitoring Program (PDMP) is a resource that all the providers are familiar with and have used, even if they do not prescribe regularly. Only one provider seemed unsure of their login information, though that provider reported prescribing opiates to less than 1% of their patient population. Barriers to using the PDMP were mostly technical in nature ("slowness of the website," "a lag," "the program takes time while I'm seeing patients"). Some providers mentioned the need to have a delegate or proxy use the site, which presents its own challenges: "You can have a delegate, but it's hard to train MAs who turn over often," one provider said. Another remarked, "I wish there was a better process for a non-provider to look up info and have their own login. If that exists now, (I would like) more info about how to set that up."

Almost every provider appreciates the PDMP and speaks highly of it as a resource, even if they do not use it often because of the lack of opioids they prescribe. One noted, "It's a very good indicator of whether patients are getting narcotics elsewhere." Another said it's a "wonderful resource for patients you don't know very well; it's a nice introduction to say to the patient, 'Let's talk about it before I look it up online.'"

Training

Providers expressed an interest in having further training on a range of topics. Some of those include the following:

- Team-based training for the entire staff
- Psycho-social aspects of those with addiction
- Guideline updates
- Medication-assisted treatments (MAT)
- Communication with patients
- Pain management

Just over half the respondents want training on opioid use disorders and substance use disorders (OUDs/SUDs). Nearly every provider wants further training on alternatives to opioid prescribing. The most common answer for the preferred modality is in-person followed by the preference for online learning modules.

Practice Transformation Organization Interviews

JSI interviewed six Practice Transformation Organizations (PTOs), all with transformation initiatives in the Denver-metro area. A PTO hires practice facilitators (PFs) and clinical health information technology advisors (CHITAs) who collaborate with regional health connectors (RHCs) to build community linkages, then work directly with healthcare practices in their redesign efforts. Each organization deploys their PFs and CHITAs to primary and specialty care clinics around the state, partnering with the RHCs who work at local host organizations, to consult on system redesign, integrated data reporting and processes, and clinic-community connections, respectively. All PTOs are working to achieve the Quadruple Aim: lower per capita costs, higher patient satisfaction, better health outcomes for patients, and reduced burnout among staff and providers. In the Tri-county area, some of the larger PTOs include organizations like the

Colorado Regional Health Information Organization (CORHIO), HealthTeamWorks, and the Colorado Community Health Network (CCHN).

PTO Background

Of the PTOs we interviewed, most are participating in the State Innovation Model (SIM), Comprehensive Primary Care Plus (CPC+), and the Transforming Clinical Practices Initiative (TCPi). The goal of these initiatives is the same: to prepare practices for value-based care and payment models. SIM is focused on behavioral health integration into primary care practices around Colorado (or "reverse integration" in some cases: adding primary care to behavioral health practices); CPC+ is trying to improve quality, access, and efficiency of primary care nationwide through delivery redesign and payment reform; and TCPi is an initiative aimed at improving the quality improvement activities of clinics around the country. All the PTOs we interviewed work with practices in the Tri-County region, and most are familiar with and trained in IT MATTTRs 2 (Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado), the MAT team training program. More details about IT MATTTRs 2 can be found in Appendix F. None of the PTOs have a specific initiative devoted to opioid prescribing, though most are prepared to offer resources and training if practices request them.

The PTOs serve a range of practices and providers in specialty and primary care, and all of them have at least one practice in the Tri-County region with whom they are working. Of the trends PTOs noticed in their providers, some were still concerned about specialists over-prescribing. One PTO said their practices are curious to know more about managing patients with chronic pain, including the use of screening, pain contracts, and multidisciplinary team management (similar requests were confirmed by providers we interviewed). While all the PTOs are aware of and concerned about the opioid epidemic, only one of them appears to be doing systematic, data-driven analyses and work, and even then, they are only addressing one small part of the problem.

Incentives

The financial incentives for practices participating in opioid-related training include the following:

- IT MATTTRs 2 offers a $1,400 incentive for the practices; $760 for MDs, DOs, and Residents; and $1,800 for NPs and PAs once they complete the waiver training and team training modules;
- COPIC points to reduce insurance costs;
- $40,000 small grant awards to meet State Innovation Model (SIM) milestones;
- Comprehensive Primary Care Plus (CPC+) offers bonus payments to primary care providers who better coordinate care for their patients (most Colorado payers and 360 providers are participating).

The educational incentives are as follows:

- Continuing Medical Education (CME) credits for IT MATTTRs 2 and other trainings like Project ECHO;
- MAT training and knowledge related to treating patients with OUDs/SUDs.

Training

All the trainings the PTOs referenced are listed in Appendix B.

Our interviews revealed that almost none of the PTOs have committed to specific quality improvement (QI) initiatives addressing the opioid epidemic, though all are aware of the problem and are well-versed in systematic, data-driven improvement strategies. This may be because the PTOs are not receiving incentives outside the IT MATTTRs 2 program. IT MATTTRs 2 has been widely marketed to PTOs and practices, and it does seem to be a popular strategy for dealing with one part of the epidemic: treatment of individuals facing opioid use disorders. One reason for this may be the monetary incentives for practice facilitators at PTOs, the prescribing provider, and the practice, but those incentives are not particularly large, especially for bigger practices/systems since the program offers only one $1,400 incentive for an entire practice, regardless of how many providers and staff are in attendance. Executive and/or clinical leadership needs to buy in to the training since the dollars alone are probably not as enticing. Another reason the IT MATTTRs 2 program seems popular may be because of the marketing push, incentivizing PTOs, providers, and practices alike.

Other Key Stakeholder Interviews

JSI interviewed a total of seven other stakeholders who represented Consortium members, hospital systems, health plans, state departments, statewide initiatives, police departments, and school-based health centers. While defined themes did not emerge across these stakeholder interviews, the information we gathered helped to inform this report and the questions we asked in the provider and PTO interviews. These stakeholders also directed JSI to websites, provider trainings, and provider key informants for interviews.

In general, providers and staff at larger systems, such as hospitals, mentioned using internally created guidelines for prescribing, many of which are modeled after the CDC guidelines. There were no common themes that emerged from the interviews around best practices in training providers. One key informant at a large practice is focusing on drug diversion and training staff and providers on processes to eliminate the possibility of narcotics being diverted to unintended sources. The need for this training arose after the practice read reports of drug diversion occurring at Swedish Hospital in 2016.[3] Upon further analysis and using internally collected data, administrators at the practice put their own strict policies in place to help address drug diversion.

Another key informant discussed the Opioid Safety Pilot conducted by the Colorado Hospital Association (CHA) and its partners across ten emergency departments (EDs) over a six-month span from June 2017 through November 2017 with a goal of reducing

[3] https://www.thedenverchannel.com/news/local-news/surgical-tech-in-needle-swap-scandal-at-swedish-medical-center-has-hiv-officials-confirm

the administration of opioids in EDs. The cohort of 10 participating sites achieved a 36% decrease in opioid administration through the course of the pilot, as well as an increase of 31.4% in the administration of alternatives to opioids ("ALTOs"). Throughout the pilot, educational offerings included in-person trainings, training materials, and webinars. Coaching calls and peer mentorship were also made available to providers.

Strategies for Marketing Trainings and Recruiting Providers

Recognizing that one size does not fit all in terms of recruiting for and planning trainings for providers, there are strategies that many of our key informants find effective. Providers did seem to respond positively to incentives, including CME credits or risk reduction (COPIC) points to reduce their insurance rates. Another effective strategy may be to partner with known entities such as local Area Health Education Centers (AHECs), hospitals, or medical societies to both create content/curriculum as well as assist in advertising efforts. Providers also mentioned they preferred powerful and respected speakers at trainings, so recruiting dynamic and engaging individuals for speaking engagements will be an important tactic.

Generally, speakers are offered a small compensation ranging from $200 to $500, depending on the duration of the training and travel expenses are covered as applicable. Additionally, social science and psychology research has proven that consumers assign a greater value to paid events over free ones, so we suggest charging a modest registration fee should TCOPP choose to organize a unique training. One key informant suggested that the $30 to $40 range is the sweet spot for provider training registration fees. Serving food at an event can also be enticing; offering an after-work dinner with training can be an effective strategy to attract busy providers. One provider mentioned they preferred interactive, team-based learning opportunities, much like problem-based learning (PBL) activities in medical school. TCOPP might consider a slightly unorthodox working session with expert clinical facilitators. In the provider interviews, while a strong theme did not emerge in terms of training logistics that appeal to all providers, the following preferences are worth noting:

- Provide plenty of advanced notice for the training;
- Fit into existing meetings that providers are attending, if possible;
- A half day training works well only if the speakers are powerful;
- For shorter trainings (two hours or less), afternoons or early evenings are generally best;
- Trainings later in the week (Thursday or Friday) are preferred.

Recommendations

Based on findings from our environmental scan and needs assessment, we recommend the following nine strategies for TCOPP to consider:

1. JSI strongly recommends creating a plan that leverages existing partnerships and other training opportunities. TCOPP might consider a partnership with the Colorado Consortium for Prescription Drug Abuse Prevention and Project ECHO Pain, two organizations conducting trainings on opioid prescribing. The Consortium trainings and planning topics are attached as Appendix G. Project ECHO likely will resume ECHO Pain in the fall of 2018, which connects primary care providers with a multidisciplinary team of pain specialists to improve the management of patients with chronic pain. The two-year ECHO Pain in Colorado training targeted providers who serve Medicaid members and ran from 2015 to 2017. CMEs were offered for the series that included two two-hour sessions per month during lunch hours. At providers' request, the ECHO team reduced the duration from two hours to ninety minutes. TCOPP might also consider partnering with the Colorado Health Extension System (CHES) at the University of Colorado to bring high-quality presentations to a Collaborative Learning Session (CLS). The next CLS for front-range practices participating in SIM and TCPi is scheduled for May 18, 2018.

2. TCOPP might consider incentivizing PTOs to send practice facilitators into practices for training on prescribing or other prevention activities. The PTOs could target specialty practices that do not have the time for full conferences or in-person lectures but may still be concerned about the prescribing practices of their providers. TCOPP should provide clear guidance about the goals for the practice facilitators and possibly create a change package that outlines the steps in a plan to achieve those goals. For those practices participating in SIM, facilitators could work on specific clinical quality measures around substance use disorders for alcohol and other drug dependence.[4] Because practice transformation efforts are intended to be collaborative in nature—allowing practices to choose the measures most important to them and their patient population—TCOPP might effectively incentivize PTOs but will still need buy-in from practices themselves. Any strategy aimed at PTOs should also include incentivizing practices and providers as well. For instance, as a partner to TCOPP, JSI is receptive to sending facilitators into practices with specific prescribing trainings in mind, but practices and providers may not have the same goals or believe their patient population can benefit from this focus. In this case, providing CME credits, COPIC points, and incentive dollars might be more enticing. Additionally, since one of the requirements of transformation initiatives is participation in quarterly Learning Networks (short trainings, lectures, or webinars on various topics of interest to a small cohort of practices), TCOPP might direct dollars

[4] See pg. 48 for specific NQF measures related to substance use disorders: http://www.practiceinnovationco.org/wp-content/uploads/vfb/2016/06/FINAL_SIM-CQM-GUIDEBOOK_20160609.pdf

towards those efforts: providing meals and free space for in-person trainings, a small stipend for participating providers, and/or CME credits or COPIC points. Since there are many practices in the Tri County area that are not participating in practice transformation efforts like SIM or TCPi, TCOPP should ensure they have a mechanism for reaching a wide range of specialty and primary caregivers in the area.

3. TCOPP should consider that smaller practices (like safety-net clinics or those with a small number of providers) may benefit most from trainings since they may not have standardized processes in place for prescribing or guidelines to follow. Providers in larger systems, whether they are FQHCs or hospital systems, already have training resources regarding opioid prescribing available to them. Although, with training resources available, most providers interviewed would like additional training. As noted in the provider interview section, just over half the respondents want training on opioid use disorders and substance use disorders, and nearly every provider wants further training on alternatives to opioid prescribing.

4. Findings from this assessment indicate there is not an ideal geographic location or time in the week for trainings, though most providers interviewed prefer in-person trainings but with some caveats. What seems to matter most is that the speakers/trainers are engaging and that incentives are offered; whether that be CMEs, risk reduction points, and/or a meal. TCOPP might choose to host an engaging webinar on alternative treatment options first, in order to build interest in an in-person training.

5. Because chronic pain is the main condition for which these providers might prescribe an opioid, future trainings could be geared towards methods of handling pain more broadly rather than opioid prescribing specifically. Part of the reason for this is that some providers do not prescribe opioids regularly enough to warrant taking time from their day to train on that topic, but those same providers likely have patients who are in pain from acute and chronic conditions. Given that alternative therapies are of great interest to providers and medical societies (as well as the interest in pain management more broadly), we recommend a kind of Pain Summit much like the PAINWeekEND event in Denver for frontline clinicians March 10th and 11th.[5] TCOPP might try to partner with groups around the metro area, seek sponsorships, and leverage existing relationships with expert faculty and clinicians. For example, TCOPP might consider partnering with the Colorado Health Extension System (CHES) at the University of Colorado Anschutz Medical Campus to bring high-quality presentations to a Collaborative Learning Session (CLS). The next CLS for front-range practices participating in TCPi and SIM is set for May 18, 2018. TCOPP might consider arranging a keynote speaker on the topic of pain management or alternatives to opioids and offer speakers at no cost for breakout sessions.

[5] painweek.org/painweekend/2018-locations-dates/denver.html

6. As noted in the provider interview findings, a very small number of providers use or even know of the Colorado State guidelines or the American College of Emergency Physicians (ACEP) guidelines. JSI recommends offering literature and information related to these guidelines, as a compliment to the CDC guidelines that many providers know, have adapted, and follow. Most providers seem knowledgeable of and are satisfied using the CDC guidelines, so there may not be a need for a full training on all of the various guidelines. Instead, TCOPP could create a short flyer for providers that serves as a comparison of all the guidelines, CDC's recommendations compared to those from the state compared to those from ACEP, for example. Additionally, for any specialists of interest (particularly dentists), TCOPP might choose to include in the comparison a list of specialty guidelines.

7. TCOPP might consider partnering with the Regional Accountable Entity (RAE) Colorado Access. Colorado Access is interested in conducting targeted training with providers in 2018 and recently has had staff trained in IT MATTTRs 2. In addition to coordinating targeted efforts, TCOPP should explore opportunities to cooperatively outreach providers with Colorado Access as well as potentially jointly incentivizing providers to participate in trainings. Additionally, in 2017, Colorado Access implemented a screening and early identification process known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT requires screening of every patient for potential alcohol or other drug problems, and a response which reinforces non-harmful use, educates about the impact of substance misuse on overall health and safety, and supports patients with problematic use in accessing further assessment, diagnosis, and treatment. TCOPP could explore ways to support expansion of SBIRT with Colorado Access, though these efforts are broader than opioid misuse and prescribing.

8. Academic detailing uses specially trained clinical educators who meet one-on-one with physicians, nurse practitioners, and physician assistants (at their practice locations), to discuss the most recent research data on a particular medical topic. This approach provides an effective and convenient way for providers to stay up-to-date on the latest research findings, with the ultimate goal of improving prescribing decisions and patient care. The consortium is working with the Colorado Department of Public Health and Environment to pilot test an academic detailing program for safe opioid prescribing, and if successful, may continue to offer this type of program in the future. TCOPP could explore ways to support these efforts.

9. The Opioid Safety Pilot referenced earlier in the report was clearly successful. The cohort achieved a 36 percent decrease in opioid administration through the course of the pilot, as well as an increase of 31.4 percent in the administration of ALTOs. Throughout the pilot, educational offerings included in-person trainings, training materials and webinars. Coaching calls and peer mentorship were also made available to providers. TCOPP might consider supporting efforts to expand the pilot to include additional EDs in the Tri-county area.

Appendices

Appendix A. Website Resources			
Sponsor	**Website Information**	**Program Description**	**Noteworthy Tools**
Massachusetts Technical Assistance Partnership for Prevention (MassTAPP)	http://masstapp.edc.org/	The Bureau of Substance Abuse Services (BSAS) has developed a collection of educational materials about opioid overdose prevention that are distributed free of cost within Massachusetts. The materials were developed with community partners and with focus groups with the target populations. The items are available from theMassachusetts Health Promotion Clearinghouse	This Practice Guidance provides information and resources for organizational readiness and staff training as well as for ensuring that overdose prevention, recognition and response are included in all stages of treatment
American Hospital Association (AHA)	https://www.aha.org/guidesreports/2017-11-07-stem-tide-addressing-opioid-epidemic	This toolkit, released by the AHA, provides guidance and information to hospitals and health systems on how they can partner with patients, clinicians and communities to address the opioid epidemic. Developed with input from a multidisciplinary team of front-line clinicians and subject matter experts, the toolkit includes links to guidelines, training, webinars, reports and other resources.	Clinical education on prescribing practices and non-opioid pain management
Substance Abuse and Mental Health Services Administration (SAMHSA)	https://www.samhsa.gov/medication-assisted-treatment/training-resources/opioid-courses	SAMHSA funds continuing medical education (CME) courses on prescribing opioids for chronic pain developed by local and state health organizations across the United States. Most of these courses also include resources that address practice management, legal and regulatory issues, opioid pharmacology, and strategies for managing challenging patient situations.	Website includes links to a plethora of CME courses
Centers for Disease Control & Prevention (CDC)	https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm	Recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. Intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death.	Guidelines
Colorado Consortium for Prescription Drug Abuse Prevention	http://www.corxconsortium.org		
Colorado Department of Public Health & Environment (CDPHE)	https://www.colorado.gov/pacific/cdphe/pdo-prevention	Provides overdose data, prevention, and treatment information for Colorado, including links to naloxone standing orders for pharmacies, harm reduction agencies, and law enforcement.	
PCSS-O	https://pcss-o.org/	A national training and mentoring project which makes available at no cost CME programs on the safe and effective use of opioids for treatment of chronic pain and safe and effective treatment of opioid use disorder.	
American College of Emergency Physicians (ACEP)	https://www.acep.org/opioids/#sm.000006gt5y0j0hdghxk4o8ua5nztb		Guidelines
Agency Medical Directors' Group (AMDG)	http://www.agencymeddirectors.wa.gov/Files/20171026FINALDentalOpioidRecommendations_Web.pdf	Dental Guideline on Prescribing Opioids for Acute Pain Management	Guidelines
American Society of Addiction Medicine (ASAM)	https://www.asam.org/resources/guidelines-and-consensus-documents/npg	National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use	Guidelines
Illuminate Colorado	https://www.illuminatecolorado.org/sen/	Network of four established organizations partnering to build brighter childhoods through education, advocacy, and family support. Offers various programs on substance use and recovery.	
American College of Obstetricians and Gynecologists (ACOG)	https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy	Educational resources to aid clinicians in providing obstetric and gynecologic care	Guidelines

Sponsor	Website Information	Program Description	Noteworthy Tools
American Society for Pain Management Nursing (ASPMN)	http://www.aspmn.org	To advance and promote optimal nursing care for people affected by pain by promoting best nursing practices.	See Position Statements
American Academy of Family Physicians (AAFP)	https://www.aafp.org/patient-care/clinical-recommendations/all/opioid-prescribing.html	Affirmation of Value	Links to CDC guidelines
Federation of State Medical Boards	https://www.fsmb.org		Guidelines. See https://www.fsmb.org/Media/Default/PDF/Advocacy/Opioid_Guidelines_As_Adopted_April2017.pdf
U.S. Department of Health and Human Services	https://www.hhs.gov/opioids/	Help, resources and information on the national opioids crisis	Many provider links to SAMHSA resources for providers
Substance Abuse and Mental Health Services Administration (SAMHSA)	https://www.samhsa.gov/medication-assisted-treatment	Information about Medication-assisted treatment (MAT)	
Substance Abuse and Mental Health Services Administration (SAMHSA)	https://store.samhsa.gov/shin/content//SMA18-5054/SMA18-5054.pdf	Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants	

Appendix B. Provider Training Resources

Title	Target Audience	Goals	Content	Modality	Cost	Time Requirement	Comments	Safe Prescribing	MAT Training	Alternatives to Opioids
Colorado Opioid Safety Summit	Chief executive officers, chief medical officers, chief nursing officers, ED physicians and nurses, quality directors, behavioral health professionals and upper management	Learning Objectives include: -Describe the opioid crisis and the role of healthcare providers, specifically emergency department providers -Explore different state-wide opioid reduction strategies and the impact on Colorado's opioid epidemic -Discover the benefits of integrating an alternative to opioid approach in the emergency department -Learn about the new Colorado State Targeted Response to the Opioid Crisis Grant and potential opportunities for opioid use disorder and MAT involvement	This Summit will bring together a broad range of experts to increase participant knowledge of the state of Colorado's opioid epidemic and progress in opioid reduction strategies. This includes results from a statewide 10 emergency department alternatives to opioids pilot, information on the OBH Colorado Opioid State Targeted Response to the Opioid Crisis Grant, and other innovative ideas to combat the opioid crisis from a local perspective to a nationwide perspective.	In-person conference	$25	8 a.m. to 3:45 p.m. on Jan. 25 at the Denver Marriott South at Park Meadows		x	x	x
Understanding Substance Use Disorders (www3.thedatabank.com/dpg/423/donate.asp?formid=MEET_HEK&c=5587359)	Undergraduate and graduate students, behavioral health and health providers, and social services professionals who do not have a background in addictions or want a refresher	Learn about: -Why people start taking substances and the effects of substances. -The continuum of substance use from not using (abstinence) to a substance use disorder. -How substances affect the brain, causing a chronic, relapsing brain disease. -Best practices for treating substance use disorders and maintaining recovery.	Provides a science-based introduction to substance use, substance use disorders (SUDs), and SUD treatment	Self-paced online	Free for certificate of completion; $10 for 2.0 continuing education credit hours from NAADAC, NASW, NBCC, CNE or CHES	Self-paced, 2-hour training	Developed by the University of Missouri-Kansas City (UMKC) School of Nursing and Health Studies' Collaborative for Excellence in Behavioral Health Research and Practice, with funding by grants from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).			
IT MATTTRs2 Colorado (practiceinnovationco.org/itmatttrs2/)	Physicians, nurse practitioners, and physician assistants	To complete the medication assisted treatment (MAT) waiver training to become certified to prescribe medication for the treatment of opioid use disorders (OUD). In addition, support is provided through tools, resources and team training to practice staff on implementing MAT programs.	There are five 1-hour modules. The Practice Team Training helps to identify and assess patients who are appropriate for MAT, apply knowledge of buprenorphine to manage patients with OUD, discuss psychiatric diagnoses and co-morbidities associated with OUD, and help to build a clinical team that has knowledge, skills, and resources to treat OUD. For practices that have a MAT certified prescriber, the practice team training will equip all staff members with the expertise and tools to support a successful MAT program within a clinic.	DEA waiver training can be completed partially in person with an online component or online only. The five team training modules are completed in person with a practice facilitator.	Free. MDs, DOs, and Residents are compensated: $95*8hrs=$760 * NPs and PAs are compensated: $75*24hrs=$1,800* *Participating providers applying for their DEA waiver will receive an additional $240.	Eight hours or 24 hours depending on licensure plus optional five hours of team training modules	The University of Colorado Department of Family Medicine is collaborating with the Colorado Health Extension System (CHES), and the Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado (IT MATTTRs Colorado) project to conduct this training.		x	
Prescribe To Prevent (prescribetoprevent.org)	Medical providers in primary car, chronic pain and palliative care settings, and pharmacists	To help health care providers educate their patients to reduce overdose risk and provide naloxone rescue kits to patients.	This training is designed to help health care providers educate their patients to reduce overdose risk and provide naloxone rescue kits to patients. They offer information needed to start prescribing and dispensing naloxone (Narcan) rescue kits, including some useful resources containing further information about this life-saving medicine. Providers learn tips to engage in proactive dialogue with patients to minimize poisoning, over sedation, and overdose risk with patients who need opioid medications to improve function. Discussing an emergency overdose/poisoning/oversedation plan and naloxone prescribing is an essential component of that dialogue. They provide some sample documents that may facilitate the process. For pharmacists, a pharmacist guidance document, developed by the College of Psychiatric & Neurologic Pharmacists, provides an overview on helpful topics such as product acquisition, prescribing and dispensing, patient inclusion, and brief case studies.	Online	Resources are available for free online. For those desiring in-depth technical assistance they can contact the organization for rates and availability at PrescribeToPrevent@gmail.com.			x		

Title	Target Audience	Goals	Content	Modality	Cost	Time Requirement	Comments	Safe Prescribing	MAT Training	Alternatives to Opioids
SCOPE of Pain (scopeofpain.com)	Physicians, nurse practitioners, physician assistants, registered nurses, nurses, dentists, pharmacists and allied healthcare professionals	To help providers safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics.	SCOPE of Pain is a series of continuing medical education/continuing nursing education activities designed to help providers safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics. Their program consists of a 2-module cased-based online activity, live conferences held around the US, and a printed monograph.The FDA has mandated manufacturers of extended release/long-acting (ER/LA) opioid analgesics, as part of a comprehensive Risk Evaluation and Mitigation Strategy (REMS), to make available comprehensive prescriber education in the safe use of these medications based on the FDA curriculum known as the Blueprint for Prescriber Education for Extended Release and Long-Acting Opioid(ER/LA) Analgesics. The SCOPE of Pain curriculum covers all aspects of this blueprint and more to provide a comprehensive educational program.	Online and in-person	Online training is free. In-person conference costs vary depending on the host of the conference.	Online training is 2 hours. The conference time varies.		x		
Providers' Clinical Support System (pcssmat.org/about/)	Physicians, nurse practitioners, and physician assistants	To goal of this organization is to develop a comprehensive electronic repository of training materials and educational resources to support evidence-based treatment of opioid use disorder; create a mentoring program to provide guidance, direction and advice to help prescribers and key health professionals who are new to the field of Medication Assisted Treatment; and continue to offer waiver training for physicians interested in providing buprenorphine treatment under the DATA 2000.	This online resource offers modules, podcasts and webinars on Medication Assisted Treatment (MAT) of Substance Use Disorders and MAT waiver training. The modules are geared to enhance providers' knowledge and skills regarding safe and effective use of MAT. Modules are free and most offer CME credit. The webinars address a wide range of topics. Most include CME credit and all are offered at no cost.Live webinars are recorded and archived for on-demand viewing.	Online	Free	16 hours of MAT training; 8 hours of MAT waiver training; modules and waivers vary in length according to topic area covered			x	
Providers' Clinical Support System-For Opioid Therapies (pcssmat.org/about/)			A national training and mentoring project developed in response to the prescription opioid overdose epidemic. The consortium of major stakeholders and constituency groups with interests in safe and effective use of opioid medications offers extensive experience in the treatment of substance use disorders and specifically, opioid use disorder treatment, as well as the interface of pain and opioid use disorder. PCSS-O makes available at no cost CME programs on the safe and effective use of opioids for treatment of chronic pain and safe and effective treatment of opioid use disorder.					x		
American Medical Association (AMA) Opioid Education Microsite, (end-opioid-epidemic.org/)	Physicians	To end the nation's opioid epidemic	The microsite includes nearly 300 education and training resources across three major categories: recommendations from the AMA Opioid Task Force, state medical society resources, and medical specialty society resources. Physicians can use the site's "State Selector" and "Specialty Selector" to find tailored education and training resources. The AMA Opioid Task Force also has identified numerous national education and training resources. The site highlights the progress physicians have made in using prescription drug monitoring programs, reducing the nation's opioid supply, increasing treatment capacity and increasing access to naloxone.	Online	Free	Varies	This resource is fantastic, very comprehensive.	x		
Institute for Research, Education, and Training in Addictions (ireta.org/consulting-solutions/)	Health and human service providers, policymakers, advocates, and researchers	Webinars, online courses, webinar library, SBIRT for Youth Learning Community, and custom online training by request	Evaluation services to measure behavioral health and related outcomes; Quality improvement assistance to pinpoint meaningful outcomes and implement processes to achieve them; Strategic planning to adapt to healthcare reform, parity, medication-assisted treatment, and other changes in the behavioral health landscape	Online	Varies	Varies				

Title	Target Audience	Goals	Content	Modality	Cost	Time Requirement	Comments	Safe Prescribing	MAT Training	Alternatives to Opioids
SAMHSA Opioid Prescribing and Buprenorphine Training for Physicians Courses (https://www.samhsa.gov/medication-assisted-treatment/training-resources/webinars-workshops-summits)	Treating physicians	Increase patient awareness of the safe use of MAT medications and improve their prospects for a full recovery.	Most of these courses also include resources that address practice management, legal and regulatory issues, opioid pharmacology, and strategies for managing challenging patient situations.	Online	Varies	Varies		x	x	
Addiction Technology Transfer Center Network (http://attcnetwork.org/calendar/search.aspx)	Varies		Courses include the following: Opioid Use Disorder, Treatment Planning MATRS - King County Providers, Developing Clinical Supervision Skills II - King County Providers, Medication Assisted Treatment, Addiction Counselor Ethics - NYC, Medicated Assisted Treatment: Enhancing the Potential for Recovery - NYC, Cognitive Behavioral Therapy - King County Providers and more	Varies	Varies	Varies		x	x	x
Pain Week (https://www.painweek.org/painweek-end/2018-locations-dates/denver.html)	Practitioners and industry representatives		Lectures on various topics including pathophysiology, fentanyl and heroin, pain diagnostics, chronic pain assessment and management, nonopioid analgesics, and more	In person conference	Practicing Healthcare Professionals: $199 Industry: $249	Two day conference		x	x	x
Colorado Consortium for Prescription Drug Abuse Prevention (http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CHWE/training/Online/Pages/RxAbuse.aspx#)	Medical providers including physicians, pharmacists, behavioral health providers, dentists, NPs, MAs, RNs, LPNs, public health professionals and others.	Reduce prescription drug abuse	Varied; see attachment	In-person and distance learning (Zoom)	Varies	Varies		x		x
Project ECHO-Extension for Community Healthcare Outcomes (https://echo.unm.edu/nm-teleecho-clinics/chronic-pain-and-opioid-management/)	To be eligible for ECHO training, you must be connected to a primary care team from a HRSA-funded health center. Priority is given to health centers which received HRSA's Substance Abuse Service Expansion (SASE) award.	Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. ECHO provides training in opioid addiction treatment at no cost, with a variety of bi-weekly schedules to choose from. Using simple videoconferencing technology, healthcare teams connect to a community of learners.		Online, interactive	Free	Varies		x	x	x
Collaborative Opioid Prescribing Education (COPE - http://www.coperems.org/)	Healthcare providers	The goal of this training is that providers are able to recognize when it's safe to prescribe opioids—how to start, stop or switch opioid therapies; communicate effectively when facing difficult situations with patients; manage ongoing treatment plans by recognizing the risks associated with different opioid regimens and patient characteristics; document treatment and patient action plans, and counsel patients on how to safely use, store and dispose of opioid medications; discuss general and product-specific drug information concerning extended-release and long-acting opioids; and treat chronic pain without promoting addiction.	This self-paced course promotes a shared decision-making approach between providers and patients. It includes video vignettes of providers and patients that demonstrate how to handle tough situations; interactive exercises; practical tools and pharmacological information. Course content covers opioid safety requirements as described by the US Food and Drug Administration (FDA) in its 2012 approval of a Risk Evaluation and Mitigation Strategy (REMS) for long-acting and extended-release opioids.	Online	Free	The COPE course takes 2 to 3 hours to complete and has six interactive chapters.	This training is included in SAMHSA's National Registry of Evidence-based Programs and Practices.	X		

Appendix C. Provider Interview Guide

Key Informant Interview Guide - Providers

Thank you for your time today; we appreciate your perspective. We've scheduled a 30-minute conversation, though it may not take as long to complete.

As a reminder, my name is Jeremy Make and I work for John Snow, Inc. (JSI) in Denver. We have been contracted by the Tri County Health Department to assess provider training needs and interests related to opioid prescribing, specifically in Adams, Arapahoe, and Douglas Counties.

Responses to this interview will be aggregated in our final report. We'll be summarizing responses by specialty and the county in which you are located with the Department.

We are especially grateful for your answers, thank you. If at any time, you need to stop, please let me know.

Do you have any questions before we begin?

Practice Background

1) Can you confirm your specialty?
2) What type of practice are you in? (Outpatient, inpatient hospital-based, ED or urgent care, ambulatory surgical centers, etc)
3) What is your FTE seeing patients (full time equivalent)? (Or how many hours per week are you seeing patients?)
4) Approximately what is the average number of patients you see per day?
    a) Can you tell me about the socio economic characteristics of the patients you serve? For example, insurance status, race or ethnicity, or other key demographics.
5) How many providers prescribe opioids at your practice? How many of those are physicians, nurse practitioners, physician assistants?
6) In your practice, do you track the number of patients who receive an opiate prescription?
    a) Of those patients in your care, in a typical week, approximately what percentage have you prescribed an opioid?
    b) In your practice, please list the 5 most common diagnoses for which you prescribe an opioid.

Evidence

1) Do you utilize any evidence-based guidelines for opioid prescribing? If so, which ones?
2) Are you familiar with the CDC opioid prescribing guidelines? If so, have you used them for opioid prescribing?
3) Are you familiar with the state of Colorado opioid prescribing guidelines? If so, have you used them for opioid prescribing?
4) Are you familiar with the Colorado ACEP (American College of Emergency Physicians) opioid prescribing guidelines? If so, have you used them for opioid prescribing?
5) Please list several barriers you run into when trying to follow any of the professional guidelines you could use.
6) Are you registered with the Colorado Prescription Drug Monitoring Program?
    a) In a typical week in your practice, about how often do you or one of your assistants access the PDMP when making decisions about opioid prescribing?
    b) What barriers are you experiencing to using the program?
    c) What is working well when using the PDMP?
    d) What challenges do you have when using the PDMP?

Training. We are focusing the next set of questions specifically on training related to opioid prescribing or prevention of abuse of opioid drugs.

1) Have you participated in any formal training related to opioid prescribing ? These could be in person, webinars, online or other formats.
    a) If so, what was the subject of the training?
    b) The approximate date?
    c) Who provided the training?
    d) What presentation format was the training done in?
2) What topics for training would be most helpful for you?
    a) Do you have a need for training around managing patients with opioid abuse? What about training around other substance use disorders?
    b) Do you have a need for training around alternative pain management?
3) In general, what presentation format works best for you when you participate in a training? (In person, online, webinar, etc)
    a) Are there particular days of the week that work best for you to participate in a training?
    b) How about specific times during the day or evening?
    c) How far are you willing to drive to attend an in-person training? (Excluding conferences)
4) In your experience, how long is too long for a training?

Do you have any additional comments or thoughts you'd like to share with me today?

Are there other providers in the Denver-metro area with whom you think I should speak?

Those are all of the questions I have for you. Thank you again for taking the time to speak with me. Do you have any questions for me before we end?

Appendix D. Randomized Provider Answer Summary

PRACTICE BACKGROUND						EVIDENCE									TRAINING			
1) Specialty	3) FTE	4) Pts per day	4a) Population trends	6a) Opioid Rx	6b) Most common diagnoses	1) EBGs	2) CDC	3) CO	4) ACEP	5) Barriers	6) PDMP	6b) Barriers	6c) Working well	6d) Challenges	2) Topics of interest	2a) OUD / SUD	2b) Alternatives	3) Preferred modality
Hospital emergency room	60%	3	Low-income, undocumented	5%	Peripheral neuropathy, back pain, osteo-arthritis, central pain syndromes, abdominal pain	Not for dental. We do educate providers on the studies from ADA: ibuprofen and tylenol may be as effective or more effective than opioids.	Yes	Yes	No	Time is a big barrier and resources. Many guidelines recommend non-pharm methods (home exercises, etc) takes more time than giving someone a medication. A lot of maintenance issues (chronic diseases) and not a lot of time left over for teaching. Patient engagement is a barrier (they may want a pill, but they may be taken aback when we tell them they'll manage their own health). Mental health issues. Health literacy (lack of understanding of what we're asking them to do).	Yes	So many different websites to sign into. I don't have the link copied. I wait for an email asking me to look it up. It's a personal thing rather than an improvement to be made to the website.	It is the right information. I like that it is out there.	N/A	They are looking into getting suboxone support, so sub training would be good. Appropriate diagnoses for long-term opioids would be good. How to properly wean people off of opioids. Clinical effectiveness of alternative treatments.	No	That could always be helpful. In the same way that 200 other topics would be helpful. They could all have better strategies. Not many providers in his clinic would be interested.	In person best. Given time and resources, webinars are also helpful.
Hospital emergency medicine	50%	30 per week	Mostly on Medicaid, mix of white, hispanic, some African American	<5%	Chronic pain. He hardly uses them for acute pain, continue what he inherited	Yes, internal influenced by the Washington state guideline.	Yes	Hasn't specifically looked over these.	Yes	There are certain classes of people who can't get alternative medications (people who can't take the anti-inflamatory) their bleeding risk too high	Yes	It's an awkward system. It is unwieldy. There is not a simple print out to put in a patient's chart.	The purpose of it is to see who prescribes and how often they have gotten prescription filled. Quantity, who other care providers are and which pharmacies they have gotten them filled.	N/A	He has a good handle on it himself personally. As an administrator what he would like to see for providers is to really understand what the limitations should be on opioid prescribing – the max morphine equivalence. Everyone should have a restrictive formulary. Most importantly, training on how to wean down or get them off. Particularly for those who don't meet the criteria for substance use disorder. Providers need to have more training on how to wean them off narcotics.	Yes	Yes, that would be awesome!	Depends on situation. If I don't have time for a seminar in person, I'd rather get the same info online in a webinar. I tend to try to attend in person or webinar.
Outpatient, family medicine	20%	25	Safety net aspect so a lot of Medicaid, CICP (Indigent Care Program), handful of insured, handful of Medicare	No response	Post-op/surgical pain, pregnancy related pain – those are her two big ones. Any other acute pain symptoms most fall into these two categories.	Haven't looked at recently, but use EBG to inform pts they may not be a good candidate for opiates. Up to date app.	Unsure for dental	No guidelines for MAT	Yes	None	Yes	Asking the Nurse or the MCM (Medical Care Managers) b/c they have to dig it up.	When the data's complete, I can see last Rx fill so I know when they're due for the next one.	N/A	Patient education maybe, how to have discussions with patients	He doesn't think it is necessary in his clinic. There is a resource in his clinic, if there are patients struggling with addiction, with the provider prescribing servoxin (sp?) and behavioral health team so have resources at fingertips. Individual provider just needs to point patient in the right direction. Issues may still lie with older providers who were in culture where you prescribe anything, if in private practice or a solo doc, they just go along doing what they do. You need someone to be the bad guy/good guy, a boss, who says don't do this anymore and we will back you when patients are upset. In small practice, with small number of patients and a percentage who are chronic users, it could be a loss of income for that provider to say no to opioid prescribing. They will refer to a pain clinic if	No	In person with shadowing/participating in clinical activities (like STD training with hands on work) as long as we're getting paid for it and not doing it for free.
Family medicine, majority pediatric	100%	6	Payer mix – 1/3 Medicaid, 1/3 Medicare, 1/3 private. 1-2% is self pay. Mixed and varied demographics. Tend to focus on lower end socio-economic, b/c they do take Medicaid.	<10%, but 80% on opioids for addiction practice	Acute abscess (hard tooth), difficult oral surgeries with complications (like extractions, suturing, retrieve root tip that's been broken)	ASAM buprenorphine guidelines. Also the ones developed by Denver Health in their methadone clinic. I also use EBG with PCSS for MAT. Also use the Massachusetts Model (getting MAT into FQHC, Nurse Care Mgr. model).	Yes	Yes	No	We've been following our own guideline for several years and having to switch to a newer guideline. Given the importance of this around the nation, I feel like I'm not prescribing opioids as much as I used to say 5 yrs ago.	Yes	In its current state, pretty good. Mostly technical difficulties getting on. You can have a delegate, but hard to train MAs who turover often. It's time consuming also. Pain visits can be mostly administrative and take awhile. You have to make judgement calls. It would be great if it was there and ready for you, but it's not.	I like how I can pull up the total # of opioids that were prescribed by practitioners and pharmacy.	I know they have updated the system, but I don't think I've visited it.	Emergency guidelines, I also want to know what the bottom is (what's the new guideline and how low will it go?), alternatives to opioid therapy (but it has to be paid for)	Yes, possibly	Yes. Aside from traditional method of pain meds, what alternatives exist.	N/A
Outpatient primary care with integrated BH	70%	20	Mostly insured through health plan, good majority of Medicare (about 50%) and a sprinkling of Medicaid (5-10%). Adults 18-90 yrs old. Predominately white. Higher % female (60-40). Next highest group: Latino then At. Am.	5-10%	History of trauma/chronic pain stemming from trauma, diabetic neuropathy/diabetes, musculoskeletal pain, fibromyalgia, EOL care (cancer, liver disease from alcoholism)	She follows the American Family Physicians about how long people would need opioids. Never prescribes.	Yes	Yes	No for dental	Having time to go through them initially and dissect the language that's not always applicable to my pt population. Access to internet to do it. Up to date is paid for by my other job.	Yes	I don't know if it's still the same way, but the program takes time while I'm seeing pts. I wish there was a better process for a non-provider to look up info and have their own login. If that exists now, more info about how to set that up.	N/A	Technical pieces – login, password you can't remember, timing if they just filled it.	An overview of what guidelines are available, and how best to use them. Also, training around identifying when people cross line from using opioids for pain to addiction; more information on addiction. More help on weaning people off of. How to help those people. What resources are out there. And, bigger picture – more information on how to effectively utilize and coordinate care between mental and physical health statewide.	Not me personally, but other providers in the practice would benefit from it.	Already trained in that area	Working with teams in their practice. Maybe once per quarter and return to it often. Providers would probably like call in opportunities for 30 minute lunch pain case studies, like office hours.
Outpatient family medicine	100%	21-22	Majority of patients are Medicaid. Private pay is about 20% of patients. Majority are white (40%); 30% Hispanic, 20% black	10% of about 30/week	Lung cancer, COPD, interstitial lung disease, schleroderma, cystic fibrosis, amputations (phantom pain), RA patients ("I have three high functioning RA pts who are holding a job b/c they're on an opioid"), MCTD (mixed connective tissue disease)	Embedded pathways for various things like dental and back pain, things that are chronically and historically been abused by opioids	Yes	Not really	No	The big barrier is that they shouldn't be the first line of defense in pain. Trying alternative agents but benzos have their own problems. Not really an issue for the kinds of patients I see.	Yes	None	It is easy to use. Having it integrated into EHR makes it easy to use.	None	Chronic pain mgmt	Intersting to get training on how to do that in the primary care setting. There are not a lot of places to send people to treatment. Would love to know how to do that in primary care setting better.	Always	More likely to do a webinar, but is more likely to learn something from an in-person webinar
Outpatient dental	Unclear	15	All underserved patients, mostly Medicare and Medicaid, many transient populations, marginalized groups including refugees, LGBT+ persons, severe and persistent mental health diagnoses, etc.	1 per week	Acute injury, severe ostio arthritis, cancer related pain,	Combination of many guidelines, reviewed internally	Yes	Yes	No	Physicians who are resistant to following guidelines and want to continue bad prescribing behavior. Also, patients who are alerady on them who they have to wean down or transfer to a pain specialist.	Yes	None	It seems to mostly have a pretty accurate record of the prescribing… sometimes there seem to be gaps. May be a particular pharmacy. But mostly it is accurate. Usually he's not looking in there to change his decision. Usually it is with new patient coming in to ask for narcotics, he won't prescibe for them, but the PDMP will help him understand the patterns of the patients and how many providers he's getting it from. If someone has acute pain, and he sees abuse in the PDMP, he won't prescribe.	Common names can be a bit of a problem.	Interactive, team-based trainings, getting the entire staff on board to work through common issues that arise (early refills, calling clinic in a panic after missed appt). Not necessarily didactic; we need to know how to put it into practice. Team, case-based learning, work with teams over a lunch.	Always great to get an update	No response	In person. A good half day is good. If it is thorough with breaks, a full day training is also reasonable. CME is also important. If we can get credit through professional orgs that would be helpful.

PRACTICE BACKGROUND						EVIDENCE									TRAINING			
1) Specialty	3) FTE	4) Pts per day	4a) Population trends	6a) Opioid Rx	6b) Most common diagnoses	1) EBGs	2) CDC	3) CO	4) ACEP	5) Barriers	6) PDMP	6b) Barriers	6c) Working well	6d) Challenges	2) Topics of interest	2a) OUD / SUD	2b) Alternatives	3) Preferred modality
Pulmonary, outpatient hospital	50%	14	Low income	<1%	Post-operative pain, discitis (protracted inflammation of one of the discs in the back), cervicalgia (diagnosis that involves neck pain)	Not a lot out there for pain. CDC, overdose studies (2010 study), strongly evidence based.	Yes	We rely more on CDC b/c large medicare pop.	No	Particular aspect of most guidelines – having clear medical records at the time when you are making your choice. That is often a challenge – looking at medical records vs. listening to what patient is saying. Confirming patient experience in moment and patient history in records.	Yes	Previously it was time – to log in, to enter search criteria, run seaerch, generate report and review. That all took 4 to 5 minutes. In her practice a visit is 20 minutes. Now, with the updates, that time is cut in half.	Very good indicator of whether patients are getting narcotics elsewhere. That is main thing he uses it for. It's not perfect, not all pharmacies report, but there is a lag time also. He thinks it is 2 weeks.	N/A	He doesn't feel like he needs training at this point. He's not sure where other providers would stand. For the docs struggling and having a hard time saying no, maybe need a simulated role play for a patient agressively asking for narcotics, how do you deal with it. For others maybe a simple training on PDMP. One provider at clinic licensed to do suboxone prescribing – maybe they would feel time to time additional training would be useful. As they hire new providers, all those new providers are impressed with Salud's policy that you are not to write any narcotic prescriptions and if people complain the organization will support you, senior providers will guide you.	No	Yes	Love in person. Online are also valuable. Workshops are great. Phones and webinars are less effective b/c of distractions.
Outpatient pharmacist and pain mgmt	100%	3	Mostly Medicaid, some self pay, ¼ patients of color, SES is mostly low income/poor, a lot of mental health services	5%	Back pain, hip pain, upper respiratory infection	CDC	Yes	No	No guidelines for MAT	None	Yes	None	It sends me pt alerts and tells me they're using multiple prescribers. The database is great; it's been a helpful resource.	None	Updates and advances in non-opioid pain mgmt. Other pharm advances. Non-pharm mgmt. Also learning counseling techniques to teach pts self-mgmt. We know that CBT shows some of the best evidence for chronic pain mgmt, so how do I teach CBT methods to pts to improve self-efficacy.	Yes	Sure	In person.One place where no one would mind it and you can get a lot of people. Salud often has a half day when all providers get together. Educational portion to this, that would be the time to do a training.
Outpatient family medicine	40%	12-14	Pretty mixed. In low socio economic area. Worst demographic for insurance coverage. Have a whole population of Tri-care, high proportion of unisnured	<25 prescriptions per week	Abdominal pain, pelvic pain, fractures, other musculoskelatal injuries and kidney stones	Yes, internal based on CDC	Yes	No, his are stricter than the state's guidelines	No	Biggest thing is patient expectation about medication prescribing. Patients who come to ED have different expectations about their pain management, and being prescribed medication. They expect it more in an ER.	Yes	Time. And slowness of the website. There's a delay after you click and a lot of clicks to go through. Also just the will to do it feels burdensome. There's not a lot of bang for your buck. Those with chronic pts (not new pts), less than once/yr am I actually seeing something I wouldn't have caught otherwise.	Defaults are good; I like how it's organized	Logs you out very quickly. The page stays up there so it doesn't even tell you you've been logged out.	Yes, that would be good. Psych-social aspect for people with addiction. Alcohol would be good too. Use of benzos being better defined too.	Yes, certainly, I want to know more about. It's also a question of where I can send them, and those places aren't available to Medicaid pts. The majority of ppl underuse [opioids] than over.	Sure! Make sure that training also addresses how to get opioid users to use something else. Most opioid users don't want to change.	Online learning is required training and during our medical staff meetings with an outside presentation. Grand Rounds are one thing, but better to do at annual medical staff meeting.
Outpatient family medicine	20%	24	Mostly do HIV primary care, skews younger, skews towards racial and ethnic minorities (about 50%), much lower SES at the jails and other clinic	About 8-10 pts/week on opiate	Low back pain by far #1, severe osteoarthritis (knees, hips, shoulders), complex regional pain syndrome, some musculoskeletal pain	They have built in guidelines into their work flow. They are slightly different from CDC, b/c they do more acute pain and less chronic pain	No guidelines for MAT	No	No	5 yrs since the guidelines switched to "let's get ppl off opiates," and in the beginning it was a lot trickier. Not easy to get people off opioids. Didn't necessarily see the benefit from providers or pts. Opioids not as much of a panacea. Hard to get older practicing providers to stop using them so regularly. Easier in theory but ppl are still coming in w/ severe pain and psychiatric needs are strong. Providers don't want to deal with angry patients. Hard to help providers do this in real life with ppl who are clearly in distress. Create a team approach to managing pts w/ complex issues. How does mental/cognitive state affect pain and how can we manage these pts. Getting MA on board b/c they have their own biases – they can be allies or they can inhibit the process. Front Desk answering calls from pts asking for opiates. All staff are getting involved, having educational sessions, learning to navigate this. Biggest barrier is just really making it happen. We all want to prescribe less opioids. Making sure that all the team members are involved (incl. new providers right out of school who haven't dealt with pts in real life).	Yes	the way it displays the information is less than optimal. That has been conveyed to the developers. Very difficult to understand the graph displays.	Wonderful resource for pts you don't know very well. It's a nice introduction, "Let's talk about it before I look it up online." It's a tool for communication.	None. I just look to see if there are patients I have. I don't use it much unless I get a message from CO about a new feature of the site or important news. I don't remember getting those messages very frequently.	AAAP is going to offer advanced bup training (after the 8-hour/24- hour training and have some experience). Those might be good. Also more beginning training for others in the organization (MCMs, psycho-social folks, even Call Center!) so there's less stigma, more general knowledge about opioids.	No	Yes	Different topics lend themselves to different formats. They also teach in the school of public health. They try to do things in small group formats. Discussing format is extremely helpful
Outpatient internal medicine and addiction medicine	80-90%	10-15	Most are at or below FPL, they serve about 50% Medicaid, 6% insured, about 40% are completely uninsured. Demographically, they serve a lot of Hispanic patients both English and non-English speaking, documented and undocumented. Also a large percentage of refugee intakes in Colorado.	1%	Fracture, abdominal and chest pain, burns	CDC	Yes	No	No, not in an ER	The biggest barrier is unhappy patients. That is probably the challenge for people in his generation (40s). Weren't trained in residency to say no to people. Providers have a hard time saying no to inappropriate requests. 10 to 15 years ago, very little support for physician who didn't want to provide narcotics, or excessive amounts, now swung the other way. Young providers know, older providers now know.	Yes	It has gotten pretty good. Occasionally there is a delay in medications showing up. Mostly resolved now. There was a lag.	New format, function to put in partial name to aggregate results, ability to look up multiple states.	None	How to manage pain for pts who are already on opioids for medical reasons, how to work with pts who are shopping for narcotics.	No response	Yes! Outside of the recovery room there is no place for narcotics. Period. Pain is a fact of life, deal with it. We have decreased our life expectancy. JAHCO has a fifth vital sign and that is pain.	In person would be his preference if time wasn't a factor. Webinars and online trainings are nice for go-at-your-own pace
Outpatient palliative care and oncology	20%	18	At or below poverty level, sliding fee for anyone above poverty level, 60% medicaid, 60% hispanic, refugee pts, Asian pts	90%	Cough, COPD, lung cancer, other cancers, rheumatologist might for arthritis pain.	CDC	No	No for dental	Not really	Morphine equivalent dosing has a ton of different numbers, no standardization. CO Medicaid is 250, Medicare is 120, lit says 150, CDC say 50 and 90. Hard to apply to specific pts. Conversion tables are getting better but a lot of them and all a little different. Internal tables vs. Medicare vs. Medicaid.	Yes	None personally, but some other providers in his practice forget their password or have terrible logging on. Maybe they haven't taken the time to sort it out computer difficulties. He uses it frequently enough	Since they have it embedded in their EMR, they can use it quickly and easily.	N/A	Utility of pathways is most useful. As well as reasonable list of Altos. Alternative things that are helpful to try.	Yes, that would be helpful from a dental perspective. They come every once and awhile for a Rx without actually doing anything about the tooth problem. They'll use their one bad tooth as a bait.	I'll always say yes to that but I feel pretty confident about that. I feel good about the meds as a pharmacist, but there's always non-pharm interventions for pain that might be helpful to know about.	In-person if speaker is really engaging. Any other format if speaker is not engaging.
Outpatient addiction medicine	0% currently, but overseeing 2 full time staff	14	50% monlingual Spanish speaking, 98% are at or below 200% of poverty level, currently have payer mix of 53% Medicaid, 30-40% uninsured, rest of Medicare and private pay.	95% of my patients, a small handful tapered off. Tracked through risk strat model (low-PDMP, urine every 12 mos; med-every 6 mos; high-every 3 mos)	Lacerations, kidney stones, recent fractures/bone breaks, toenail removal, ovarian cysts	I've been doing it for so long now … It goes so far back in my training that I'm not sure I could name a source. I try and use opioid sparing regimens a lot, esp with older adults.	Yes	Yes	Yes	There's a large component of untreated mental illness and anxiety. Really hard to treat without a benzo. Benzos are easy and we've used them in low dose for a long time. The pts who need to see a counselor won't see one. A lot of pushback from pts because they're feeling so anxious. Not funding for the things that could be done instead of benzos: PT, for example. It would be great if all pts had 36 PT sessions/yr and they would use it if they had access to it: massage, acupuncture, PT but none are actually covered by Medicaid. If they paid for it, most people like PT and would use it. It's a common refrain w/ Medicaid pts. Some people have a chemical dependency and we try to manage it, and it's hard for Medicare pts to manage this. Addiction specialists tend to only take private insurance. Low dose naltrexone I'm prescribing for anyone who can afford it. Very successful for pts who can afford them. I have pts who would be willing to do it but can't afford it. Marijuana creams work for pain (CBD). A lot of my pts don't want to be altered. There are no guidelines for marijuana use. CDC is talking about how marijuana fits in, but it's not prescribed, it's not regulated. We discourage ppl at [my clinic] from inhaling it; I'll talk with people about it if they want to discuss it and I'll recommend the cream. Need stricter guidelines so we can actually prescribe it. Marinol is not covered and doesn't seem efficacious for pain.	Yes	Pt shows up multiple times (e.g. under different address). Copy and paste results into my notes and it gets a little complicated with the new format (not a huge barrier). We have 28 different pharmacies but I'm looking for meds filled outside (so I want to select pharmacies and exclude some)	I think it's a great idea CO developed it, and I'm thankful it exists.	N/A	Novel meds for chronic pain mgmt, off label use like bup/suboxone, any new risks to be aware of for identifying potential overdoses/SUDs	No response	Yes	ECHO is a great model. Interactive online. Provider feedback has been great. Didactic component and bringing a case to discuss together.
Ambulatory community health center, NP midwife	100%	18	A lot of Medicare, many Medicaid	3%		CDC	Yes	No	No	Frequency of patient visit, availability of expert support (pain management specialists to help with advice on prescribing), servoxian support for patients who don't meet guidelines and there may be concern for addiction (other resources for patients who are already on opioid but don't meet criteria for long term opioid), affordable alternative options like acupuncture and intesnse PT	Yes	It is great, he loves it. One barrier in the past (they have fixed it) that no one but physician can look at it. Now they can delegate. He wishes he could get it out of his EHR, have to go to site.	Cross state searches now with update and that is a great addition.	None	An update on guidelines, b/c I'm not sure all physicians know the guidelines unless they prescribe often.	Probably. We refer to chemical dependency dept. Maybe I need to identify earlier.	In general, yes, but not for us	In person listening and seeing

JOHN SNOW, INC.

Appendix E. PTO Interview Guide

Key Informant Interview Guide - PTOs

Thank you for your time today; we appreciate your perspective. We've scheduled a 30-minute conversation, though it may not take as long to complete.

As a reminder, my name is Jeremy Make and I work for John Snow, Inc. (JSI) in Denver. We've been contracted by the Tri County Health Department to assess PTOs in the Denver-metro area that may be targeting opioid prescribing as a quality improvement initiative and to understand the work they're doing with providers, specifically in Adams, Arapahoe and Douglas Counties.

We are grateful for your answers, thank you. If at any time, you need to stop, please let me know. Do you have any questions before we begin?

PTO Background

1) What practice transformation initiatives in Colorado is your PTO involved in?
    a) What is the goal of each initiative?
    b) What is the total number of providers you're trying to reach in each initiative?
2) What work is your PTO doing around opioids (including prescribing, prevention of misuse, and medication-assisted treatment, for example)?
3) What specific quality improvement initiatives is your PTO working on related to opioids?

Provider Population

1) What primary care practices in the Tri County area are you working with on opioid-related activities?
2) What specialty practices?
3) How are you identifying practices to work with on opioid related activities?
4) What trends have you noticed about their training and knowledge gaps around opioid prescribing best practices?
5) What steps, if any, do you think providers working with your PTO are taking to combat the opioid epidemic?

Incentives

1) What financial incentives are available for providers and practices to inform their opioid-prescribing practices?
2) What educational incentives?

Training

1) What training does your PTO offer that details best practices in opioid prescribing?
2) What are the goals of the training or initiative?
3) What other training opportunities do you know of locally or nationally that address opioid prescribing?

Are there documents you can share about the initiative?

Is there anyone else you think I should speak with who is doing work and/or training around opioid prescribing in the Denver metro area?

Those are all the questions I have for you. Thank you again for taking the time to speak with me. Do you have any questions for me before we end?

Appendix F. IT MATTTRs 2 Promotional Flyer

IT MATTTRs 2 Colorado

Training practices and providers about opioid use disorder and medication assisted treatment.

The University of Colorado Department of Family Medicine is collaborating with the Colorado Health Extension System (CHES), and the Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado (IT MATTTRs Colorado) project to help address the opioid epidemic affecting our state. This is a response to calls from our healthcare communities for help in diagnosing opioid use disorders (OUD) and supporting patients in medication assisted treatment (MAT) programs. With funding provided by the Office of Behavioral Health, we are recruiting 300 providers to complete the MAT waiver training to become certified to prescribe medication for the treatment of OUD. In addition, we will provide support through tools, resources and team training to practice staff on implementing MAT programs.

Providers

Who is Eligible

Providers and providers in training which include physicians, nurse practitioners, and physician assistants are all eligible to complete the buprenorphine waiver training. Physicians require 8 hours of MAT training; NPs and PAs require 24 hours of MAT training. Only providers who have completed the training after May 1st, 2017 are eligible for compensation.

Compensation

Medical Doctors (MDs), Doctors of Osteopathic Medicine (DOs), and Residents will be compensated for the 8 hours required to complete the waiver training at a rate of $95/hr. Licensed Nurse Practitioners (NPs) and Physician Assistants (PAs) will be compensated for the 24 hours required to complete the waiver training at a rate of $75/hr. Distribution of the funds is at the discretion of each individuals employer, and their respective organizations' policy. Please check your organization's policies to determine whether you can receive compensation directly or if it must be sent to your organization.

MDs, DOs, and Residents: $95*8hrs=$760*
NPs and PAs: $75*24hrs=$1,800*

*Participating providers applying for their DEA waiver will receive an additional $240.

All MAT waiver training and compensation information can be found at:
www.practiceinnovationco.org/itmatttrs2

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Practices

Onsite Practice Facilitation

The High Plains Research Network (HPRN) and the Colorado Research Network (CaReNet) worked with the American Society of Addiction Medicine (ASAM), local community practice coaches, and research liaisons to create a curriculum to train the entire practice team staff on how to provide a comprehensive MAT program for patients with OUD.

The IT MATTTRs Practice Team Training curriculum contains five 1-hour modules:

Module 1: Opioids, Receptors, Colorado, and You – Epidemiology, science and pharmacology of opioids, addiction, and medication assisted treatment

Module 2: The Patient - Identifying, preparing, treating, and managing the patient

Module 3: The Practice - Preparing the practice, facility, and staff to offer MAT

Module 4: Special Populations - Offering care to special populations like adolescents and pregnant women

Module 5: SBIRT (Screening, Brief Intervention, and Referral to Treatment)

The Practice Team Training will help you to identify and assess patients who are appropriate for MAT, apply knowledge of buprenorphine to manage patients with OUD, discuss psychiatric diagnoses and co-morbidities associated with OUD, and help you to build a clinical team that has knowledge, skills, and resources to treat OUD.

For practices that have a MAT certified prescriber, the practice team training will equip all staff members with the expertise and tools to support a successful MAT program within a clinic.

Compensation

Practices will receive $1,400 for completing the five-session series. Practices who are currently participating in SIM are not eligible to receive additional compensation beyond their achievement-based payments, but are encouraged to incorporate the IT MATTTRs curriculum into their efforts.

IT MATTTRs 2 Colorado

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Appendix G. Colorado Consortium for Prescription Drug Abuse Prevention Trainings and Training Ideas

Upcoming Trainings

Municipality/Region/Organization	Date	Topic (if known) or Title of Event	Type of Event
Denver Back Pain Specialists	April 11, 2018	"Moving from What to How"	In person
Canon City (Region 13)	April 18, 2018	"Moving from What to How"	In person
Montrose Hospital	April 20, 2018	Clinical Pearls for Safe Opioid Prescribing	Distance Learning (Zoom)
Montrose Hospital	May 4, 2018	Abuse and Diversion	Distance Learning (Zoom)
Jefferson County	May-June TBD	"Moving from What to How"	In person
La Junta	May TBD	"Moving from What to How"	In person
Summit County	TBD	TBD	In person
San Luis Valley (Alamosa)	TBD	TBD	In person
Nurse Educators Conference (Vail, National Conference)	July 9, 2018	Behavioral Aspects of Pain; Non-Opioid Pain Management; Pain Procedures; Acupuncture	In person

Title	Subject Matter Expert
Basics of Assessment	TBD
Behavioral Aspects of Pain	TBD
Overview of behavioral treatments	TBD
Pharmacologic Management (non-opioid)*	TBD
Non-Pharmacologic Management*	TBD
Acupuncture*	TBD
Pain Procedures*	TBD
Safe Prescribing 101	TBD
Safe Prescribing 201	TBD
Laws and Regulations	TBD
Weaning and Discontinuation	TBD
Motivational Interviewing*	TBD
Overdose Prevention/Harm Reduction	TBD
Urine toxicology*	TBD
Intro to OUD	TBD
Intro to MAT	TBD
Special Populations*	TBD
Special topics in pain mgmt: HA, FM, Back pain*	TBD
Management of acute/urgent pain	TBD
The role of the pharmacist in pain mgmt.*	TBD
Dental opioid management*	
Veterinary opioid management*	
Counseling, recovery & 12 step groups*	

*Still in development