Take Charge Ohio

Ohio Pain Management Toolkit:

Implementing the Ohio Rules and Guidelines for Prescribing Opioids for Acute, Subacute and Chronic Pain in the Primary Care Setting.

Department of Health

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Executive Summary

Ten strategies to assist Primary Care Practices with Implementing Ohio's Acute and Chronic & Subacute Pain Opioid Prescribing Guidelines.

In order to stem prescription opioid analgesic misuse and diversion issues which have contributed to a statewide drug addiction epidemic, the Ohio Department of Health (ODH) has developed the Ohio Pain Management Toolkit: Implementing the Ohio Rules and Guidelines for Prescribing Opioids for Acute, Subacute and Chronic Pain in the Primary Care Setting.

As implied by its title, this document has been created specifically for primary care physicians and staff who treat patients for pain. In Ohio, nearly seven of every 10 opioid analgesic prescriptions emanate from a family doctor making primary care offices the appropriate setting for directing additional tools, resources, and information for treating chronic, subacute and acute pain conditions.

The Ohio Pain Management Toolkit contains ten suggested strategies for primary care offices to follow to assure a consistent approach to pain management and reduce the potential for over-prescribing opioid analgesics as part of a patient's clinical care treatment plan.

While non-pharmacological options for pain management are preferred, the Ohio Pain Management Toolkit will help primary care physicians and their staff to appropriately assess the potential benefits of opioid analgesics against the risk of addiction when treatment with opioid analgesics is determined to be clinically necessary.

The Ohio Pain Management Toolkit includes Ohio rules and guidelines for treating pain. It also includes national best practices as reported by the Centers for Disease Control (CDC), resources from Take Charge Ohio, and other pain management tools available for physicians.

If implemented, the strategies in the Ohio Pain Management Toolkit will support primary care physicians in providing the highest quality patient care, reduce the number of prescriptions for opioid analgesics, lessen the amount of pain medication dispensed, and save lives.

ODH drew support from Medical Advantage Group and the Ohio State Medical Association to create the Ohio Pain Management Toolkit.

Medical Advantage Group

Ohio State Medical Association

Introduction

This toolkit is broken into ten strategies created to help Ohio clinicians improve their pain management processes and achieve better patient health outcomes. These strategies can be replicated across the state and hold promise to sharply reverse the state's troubling opioid analgesic misuse and addiction issues.

Strategy 1 Practice Team and Philosophy

Secure a practice-wide commitment to opioid prescribing pain management by creating a team and practice philosophy.

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Adopt a team approach to implementing the practice's philosophy and standards of care.

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Strategy 7 Planned Care Visits

Develop a Planned Care Visit to ensure that evaluation, monitoring, and documentation of patients on opioid analgesic therapy occurs proactively and consistently.

Strategy 8 Patient Education

Use patient education materials that promote patient understanding of the practice's philosophy and standards of care.

Strategy 9 Chart Audits

Conduct periodic chart audits on opioid analgesic patients to ensure that practice protocols are implemented consistently.

Strategy 10 Pain Management Council

Develop a pain management council to periodically review treatment plans for high-risk patients.

Toolkit Layout

Each strategy in the toolkit begins with a narrative on the strategy's relevance to improving patient safety and outcomes.

Following the narrative, each strategy is laid out in sections that include:

Action Items - concrete steps that practices can take to implement that strategy.

Things to Consider:

Recommendations and guidance on successfully implementing Action Items.

The recommendations and guidance in this toolkit were pulled from several primary resources, indicated throughout with the following icons:

Ohio Rules for Acute Pain

Ohio Administrative Code 4731-11-13 "Prescribing of opiate analgesics for acute pain"
http://codes.ohio.gov/oac/4731-11-13

Ohio Rules for Subacute and Chronic Pain

Ohio Administrative Code 4731-11-14 "Prescribing for subacute and chronic pain"
http://codes.ohio.gov/oac/4731-11-14

Ohio Rules for OARRS

Ohio Administrative code 4731-11-11 "Standards and procedures for review of 'Ohio Automated Rx Reporting System' (OARRS)": http://codes.ohio.gov/oac/4731-11-11v1

Best Practice Recommendations:

- The Ohio Guidelines for Acute Pain
- The Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, 2016
- Improving Opioid Prescribing: Sustainable Solutions for Vermont: Practice Fast Track and Facilitators Toolkits

At the end of each strategy is a list of relevant **Appendices** documents pertaining to the Action Items within that strategy.

Key Terms

This toolkit uses some terms that may not be universally understood.

- **Opioid analgesic** means a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system, including but not limited to the following drugs and their varying salt forms or chemical congeners: buprenorphine, butorphanol, codeine (including acetaminophen and other combination products), dihydrocodeine, fentanyl, hydrocodone (including acetaminophen combination products), hydromorphone, meperidine, methadone, morphine sulfate, oxycodone (including acetaminophen, aspirin, and other combination products), oxymorphone, tapentadol, and tramadol.

- **Ohio Automated Rx Reporting System (OARRS)** is Ohio's Prescription Drug Monitoring Program (PDMP.) OARRS collects information on all outpatient prescriptions for controlled substances that are dispensed by Ohio licensed pharmacies and personally furnished by licensed prescribers in Ohio. The information in OARRS is available to prescribers (or their delegates) when they treat patients, pharmacists (or their delegates) when presented with prescriptions from patients, law enforcement officers and health care regulatory boards during active investigations. Clinicians can register for access to OARRS at **https://www.ohiopmp.gov/Registration/Default.aspx**.

- **A morphine equivalent dose (MED)** means a conversion of various opioid analgesics to a morphine equivalent dose by the use of accepted conversion tables provided by the State of Ohio board of pharmacy at **https://www.ohiopmp.gov/MED_Calculator.aspx**. Morphine is widely regarded as the "standard" for the treatment of moderate to severe pain and is commonly used as the reference point. As MED increases, the likelihood of an adverse effect increases, therefore identifying patients on high MED therapy is a crucial first step towards improving patient safety.

- **"Press Pause"** is an action used in the Ohio Guidelines as an opportunity to stop and review the patient treatment plan before making a decision that could jeopardize patient safety and/or decrease the potential for prescription drug abuse and misuse.

- **"Trigger point"** describes an event in which the provider and/or clinical team decides it is time to "press pause" to ensure patient safety. One such event is when a patient has met or exceeded the threshold of 80mg Morphine Equivalent Daily Dose (MED) for longer than 3 continuous months. It is an opportunity to review the patient treatment plan, the patient's response to treatment, and modify the treatment plan to ensure a favorable risk-benefit balance for the patient.

- **Acute Pain** is pain that normally fades with healing, is related to tissue damage, significantly alters a patient's typical function and is expected to be time limited and not more than six weeks in duration.

- **Subacute Pain** means pain that has persisted after reasonable medical efforts have been made to relieve it, and continues either episodically or continuously for more than six weeks but less than twelve weeks following initial onset of pain. It may be the result of underlying medical disease or condition, injury, medical or surgical treatment, inflammation, or unknown cause.

- **Chronic Pain** means pain that has persisted after reasonable medical efforts have been made to relieve it and continues either episodically or continuously for twelve or more weeks following initial onset of pain. It may be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause. Chronic pain does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.

- **Treatment Plan** is a patient medical record document that is based on clinical information obtained and includes diagnosis, objective goals for treatment, rationale for the medication choice and dosage, the planned duration of treatment, and steps for further assessment and follow-up.

Getting Started

State-wide training webinars were provided when this toolkit was released to the public. The purpose of the training was to provide context on the goals of the toolkit and a summary of the contents for Ohio clinicians and practices. A recording of this training is available on the webpage where you downloaded this toolkit.

While implementation of the strategies in this toolkit is meant to be a team effort, initiation of the project will inevitably fall on one or a few practice leaders. Those leaders can start by spearheading the first Action Item in Strategy #1 - developing an Opioid Prescribing Pain Management Team. The team can then proceed with the second Action Item in Strategy #1 – create a Pain Management Philosophy Statement. These two Action Items will establish a unified foundation for implementation of the remaining strategies.

Strategies #2 through #10 can be implemented in any order, although they are organized to maximize momentum and create a comprehensive opioid analgesic prescription management system.

For practices that elect to move through the strategies in a different order, it is strongly recommended that you start by utilizing the Chart Audit Worksheets from Strategy 9 to evaluate the practice's current compliance with Ohio's opioid prescribing rules as outlined in the Ohio Administrative Code. A preliminary audit of about 20 charts per clinician for patients recently prescribed opioid analgesics will provide insight on gaps in compliance that could be impacting patient safety and clinician liability. The Chart Audit Worksheets are the final item found in the Toolkit **Appendices**.

Strategy #1: Practice Team and Philosophy

Secure a practice-wide commitment to opioid prescribing pain management by creating a team and practice philosophy.

The Practice Team

As with all improvements made within a practice, there will be challenges. Therefore, it is imperative to create a practice team to lead the effort and keep it going. The new practice standards of care and protocols will invariably involve all the areas within a practice, i.e., front desk, clinical staff, and physicians. It is beneficial to include staff who have knowledge of the processes from each area of the practice. This team will commit to communicating and engaging the entire staff in the development of new (or revised) standards of care.

A Standard of Care Philosophy

Before beginning work on the protocols and workflows, all members of the practice should agree to adopt a standard of care philosophy. This standard of care philosophy adheres to Ohio rules when prescribing opioid analgesics for acute, subacute and chronic pain management. The philosophy supports goals of limiting use of opioid analgesics, decreasing the availability of unused opioid analgesics, and ensuring long-term patient safety. The philosophy should comprise a high level of consistency that will contribute to reducing the level of decision-making used from patient to patient.

Action Item - Create an Opioid Prescribing Pain Management Team.

Things to Consider:

- The team should minimally consist of one prescriber, a member of clinical staff with knowledge of patient care processes, the office manager and/or a member of the front desk that is knowledgeable of scheduling and front desk processes.
- Team members should present a true engagement, passion and motivation for the project.
- The team should understand that they will be the liaisons for communication and collaboration with the rest of the staff.
- The team should choose a "champion" to keep the team engaged, on track and motivated.
- Depending on the size of your organization, additional members that may participate on an as-needed basis can include:
    - **Pharmacist** – making medication recommendations or designing opioid analgesic weaning protocols.
    - **IT member** – making EHR changes to flowsheet, clinical decision drop-downs, or smart phrases.
    - **Patient(s)** – offering education input
    - Other staff with expertise on specific issues.

Action Item - The opioid pain management team will create a philosophy statement.

Things to Consider:

- Survey all practice staff before changing anything. This will help your team prepare for and evaluate its work. The survey can be handed out in paper form or emailed using software such as SurveyMonkey. Pre-project and post-project practice surveys can be found in the **Appendices**.
- The philosophy statement should be a written statement.
- The philosophy statement can be a goal statement or incorporate a practice mission statement. It should be consistent with the practice's approach to pain management, whether acute, subacute or chronic. The practice philosophy should drive the creation of new protocols, processes, and workflows that all team members will adopt.
- The philosophy statement should take into consideration the practice's current view on opioid prescribing pain management, your patient population, and your purpose as a practice, and any future direction you are moving in.
- Include the opioid pain management philosophy in a brochure or document that is shared with patients. A practice may also want to post the philosophy in the waiting/exam rooms.

Philosophy Examples:

- **Example 1:** The practice has adopted a consistent standard of care for acute, subacute and chronic pain management patients who need monitoring and follow up for good care and to ensure patient safety.
- **Example 2:** To ensure the safety of its patients, our office has adopted best practice standards of care in non-pharmacologic and pharmacologic treatment for managing patients with acute, subacute and chronic pain.

Appendices:

- Pre-project Practice Survey
- Post-project Practice Survey

Strategy #2: Patient Safety Standards of Care

Select and develop protocols for patient safety standards of care to ensure care consistency across all patients receiving opioid pain management therapy.

Perhaps the most difficult aspect of prescribing and managing opioid pain management is identifying patients who may be abusing or misusing their medication. Fortunately, there are several best practice protocols that can be incorporated into practice policy to identify and address aberrant behavior.

This toolkit recommends a "universal precaution" approach that treats all non-terminal, acute, subacute, and chronic pain management patients prescribed opioid analgesics consistently by all providers in the practice. Providers should avoid deviating from the practice's standard of care among patients by age, employment, how well they know the patient, or other criteria.

It is important to capture these protocols in a written document that is easy to follow by all staff. The protocol document helps the staff maintain consistency and provides the foundation for operational excellence and good patient care.

Action Item - Select standards of care and develop practice protocols that align with your practices philosophy and to ensure patient safety.

Things to Consider:

- In this Toolkit, the term "protocol" incorporates the policy and a process. Sample protocols are included in the **Appendices** and can be used as a general guide to be modified to suit each practice's philosophy, protocols, and workflows.
- Policies and processes set expectations of the correct way of doing things; they guide day-to-day activities.
    - Policies are the basic principles by which an organization is guided. Policies support staff in making good decisions by providing guidance that eliminates misunderstanding.
    - Processes explain when and how to take action. Processes can be visualized as a road map, giving direction and highlighting details. It helps staff to consistently manage a task or communicate information in a timely, efficient manner.
- Have providers and staff complete the practice survey from Strategy #1 as it may give guidance on what is working and what is not working to assist you in policy and process development.
- If policies or processes are developed at an organizational level, consult appropriate leadership for approval or change.
- Review standard of care protocols annually and document the review and revisions. Keep a running list of revisions in the footer.
- Recommended protocols that are core to the practice's new standards of care may include:
    - Urine Drug Screens
    - OARRS
    - Opioid Prescription Limits
    - Naloxone Prescribing

Urine Drug Screens

Urine drug screens can be incorporated into the practice's routine standards of care to avoid having a request for a urine drug screen become a confrontation that affects the clinician-patient relationship. Practices should consider using urine drug screens as frequently as necessary to confirm therapeutic compliance patients being treated for addiction. Urine samples sometimes produce a result that the patient contests. Discus this policy with patients prior to prescribing opioid analgesics, and share the practice's policy in writing to help avoid a confrontation in the future.

Ohio Rules for Acute Pain

The Ohio Rules for Acute Pain do not specify when to do a urine drug screen.

Ohio Rules for Subacute and Chronic Pain

Ohio Rules for Chronic Pain state that before prescribing opioid analgesics for subacute or chronic pain, the physician should complete assessment activities to assure appropriateness and safety of the medication. These assessment activities include urine drug screening if evidence of substance misuse or substance use disorder exists.

Patients prescribed an average of fifty MED per day or above should be assessed no less than every three months, and the assessment should include screening for medication misuses or substance abuse disorder, which may include urine drug screening based on the clinical assessment of the physician. Frequency of urine drug screening should be based on the presence or absence of aberrant behaviors or other indications of addiction or drug abuse.

Best Practice Recommendations:

The CDC Guidelines state: "when prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs." The CDC has created a resource titled, "Additional Guidance on Urine Drug Testing", and a copy can be found in the **Appendices**.

*A sample Urine Drug Screen Protocol is included in the **Appendices**.*

Ohio Automated Rx Reporting System (OARRS)

The Ohio Automated Rx Reporting System (OARRS) is an electronic prescription drug monitoring program (PDMP) that is used to monitor controlled substance prescribed in Ohio. It helps providers identify if a patient is taking dangerous combinations of drugs or receiving drugs from more than one provider. OARRS collects information from Ohio-licensed pharmacies and licensed prescribers that dispense controlled substances or personally furnish controlled substances, for all outpatient prescriptions.

Access to OARRS is allowed for any prescriber and delegated staff working for the prescriber's practice. Pre-registration and authorization are required.

For more information: https://www.ohiopmp.gov/Registration/Default.aspx

Ohio Rules for OARRS

Ohio rules for OARRS state that prescribers should obtain and review an OARRS report at the following points of opioid analgesic prescription management:

- Before initially prescribing or personally furnishing an opioid analgesic or a benzodiazepine to a patient for a period exceeding seven days.
- If the course of treatment continues for more than 90 days.
- Every 90 days while a patient is receiving long-term opioid analgesic therapy.
- When any red flags are observed pertaining to the patient, for instance if the patient is found to have forged or altered a prescription, produces a drug screen that is inconsistent with the treatment plan, frequently requests early refills, or receives reported drugs from multiple prescribers without clinical basis.
- Receipt and assessment of the OARRS report must be documented in the patient's medical record. If the OARRS report is not available, this must be documented in the medical record.

A copy of the Ohio Administrative Code 4731-11-11 "Standards and procedures for review of 'Ohio Automated Rx Reporting System' (OARRS)" is included in the **Appendices**.

*A sample OARRS Protocol is included in the **Appendices**.*

Opioid Prescribing Limits

It is important for providers to follow Ohio's pain prescribing rules. By doing so, providers will be saving lives by ensuring patient safety and limiting the number of unused opioid analgesics that are available for diversion. The state rules have put limits on days-supply and the daily morphine equivalent dosage (MED), while allowing the provider to prescribe beyond these limits based on clinical assessment and provider judgment as long as there is reason and documentation. As a part of this toolkit implementation, all of the practice's prescribing providers should review Ohio's Opioid prescribing rules found in the **Appendices**.

Ohio Rules for Acute Pain

The Ohio rules for prescribing opiate analgesics for pain recommend that providers should first consider non-pharmacologic and non-opioid analgesic therapies.

When opioid analgesics are prescribed for acute pain, the provider shall:

- Prescribe the minimum quantity and potency needed to treat the expected duration of pain with the understanding that a 3-day supply or less is frequently sufficient
- Not prescribe extended-release or long acting opioid analgesics
- Not prescribe more than a 7-day supply with no refills for adults
- Not prescribe more than a 5-day supply with no refills for minors, and only with written consent from the parent or guardian.
- Not exceed an average of 30 morphine equivalent dose (MED) per day, except as provided for in the rules.
- "Press Pause"- There are provisions within the rule that allow prescribing beyond theses set limits as long as the provider documents the reason for exceeding the limit and the reason it is the lowest dose consistent with the patient's medical condition.

A copy of the Ohio Administrative Code 4731-11-13 "Prescribing of opiate analgesics for acute pain" is included in the **Appendices**.

Ohio Rules for Subacute and Chronic Pain

Some key components of the rule require that providers shall:

- Prescribe the minimum quantity and potency needed to treat the expected duration of pain and improve the patient's ability to function.
- "Press Pause" before prescribing an opioid analgesic, prior to increasing an opioid analgesic to an average dosage of 50 MED daily, and prior to increasing an opioid analgesic dosage to 80 MED or greater daily.
- Not exceed a 90-day supply.
- Not prescribe a dosage that exceeds an average of 120 MED per day except as for provided in the rules, which includes receiving and documenting a written recommendation from a board certified pain medicine physician or board certified hospice and palliative care physician.

A copy of the Ohio Administrative code 4731-11-11 "Prescribing for subacute and chronic pain" is included in the **Appendices**.

Best Practice Recommendations:

- An online morphine equivalence calculator can be found at https://www.ohiopmp.gov/MED_Calculator.aspx.
- Health care providers are not obligated to use opioid analgesics when a favorable risk-benefit balance cannot be documented. Providers should consider non-pharmacologic and non-opioid analgesic therapies first. Providers must be vigilant to the wide range of potential adverse effects associated with long-term opioid analgesic therapy and misuse of extended-release formulations.
- Long-term opioid analgesics and co-prescribing should be avoided. That vigilance and detailed attention must be present from the outset of prescribing and continue for the duration of treatment. Co-management of the patient's needs, by multiple providers, must be clearly documented and understood by the patient and providers, especially in determining which provider will be the prescriber.
- Opioid analgesic refills may be provided by the on-call provider with the same medication and the same dosage and instructions, and only enough until the prescribing physician returns.
- Unscheduled refills will be allowed only during an office visit and only enough until next scheduled appointment.

Prescribing Naloxone

Naloxone is a medication used to counter the effects of opioid analgesic overdose. When administered during an overdose, naloxone blocks the effects of opioid analgesics on the brain to restore effective breathing. In the presence of physical dependence on opioid analgesics, naloxone will induce withdrawal symptoms. The intended use of naloxone is to prevent opioid analgesic overdose. Naloxone can be legally prescribed by a physician, physician assistant, or advanced practice registered nurse who is an Ohio authorized prescriber. An authorized prescriber is required by law to instruct the individual receiving the naloxone supply or prescription to summon emergency services either immediately before or immediately after administering naloxone to an individual apparently experiencing an opioid analgesic-related overdose. An authorized prescriber can prescribe Naloxone to a family member, friend, or other individual who is in a position to assist an individual who is apparently experiencing or at risk of experiencing an opioid analgesic-related overdose.

Ohio Rules for OARRS

To ensure patient safety when prescribing an opioid analgesic, a provider shall offer and/or provide a prescription of naloxone to the patient if:

- The patient has a past medical history of overdose.
- The dosage exceeds an average of 80 MED daily or at lower doses if the patient is co-prescribed with another medication such as benzodiazepine, sedative hypnotic drug, carisprodal, tramadol, or gabapentin.
- The patient has a concurrent substance use disorder.

*A sample Prescribing Naloxone is included in the **Appendices**.*

Appendices:

- CDC "Additional Guidance on Urine Drug Testing"
- Urine Drug Screen Protocol
- Ohio Administrative Code 4731-11-11
  "Standards and procedures for review of 'Ohio Automated Rx Reporting System' (OARRS)"
- OARRS Protocol
- Ohio Administrative Code 4731-11-13 "Prescribing of opiate analgesics for acute pain"
- Ohio Administrative Code 4731-11-14 "Prescribing for subacute and chronic pain"
- Opioid Prescribing Limits
- Prescribing Naloxone Protocol

Strategy #3: Patient Assessments

Conduct initial and ongoing patient assessments for opioid risk, mental health, and pain.

In 2017, Ohio had 4,292 overdose deaths, making it the state with the second highest rate of drug overdose deaths in the United States at 39.2 deaths per 100,000. The national average is 14.6 deaths per 100,000. *The Annals of Internal Medicine* concluded that "patients receiving higher doses of prescribed opioid analgesics are at an increased risk for overdose, which underscores the need for close supervision of these patients" *(Dunn, et al., 2010)*.

Before prescribing opioid analgesics, assessment of the patient is critical. Through use of risk assessment, pain assessment and mental health assessment, it is possible to reduce the risk of misuse and abuse, reduce pain, and improve function and address other mental/behavior issues that are involved in stratifying treatment. It is also important to determine when reassessment is warranted as a follow-up.

Action Item - Choose risk assessments that meets your practice's philosophy and standards of care.

Things to Consider:

- Many risk assessments are available; do not get overwhelmed and start small. This toolkit identifies three types of risk assessments, initial, ongoing, and general substance abuse and mental health. Begin with one type of risk assessment and decide later when the practice shall incorporate the others.

- Examples of initial opioid risk assessments that can be found in the **Appendices** include:
    - **ORT** – Opioid Risk Tool
    - **SOAPP-R** – Screener and Opioid Assessment for Patients with Pain
    - **DIRE Score** – Diagnosis, Intractability, Risk Efficacy

- Examples of ongoing risk assessment that can be found in the **Appendices** include:
    - **COMM** – Current Opioid Misuse Measure
    - **ABC** - Addiction Behavior Checklist

- Examples of general substance abuse and mental health assessments that can be found in the **Appendices** include:
    - **ASSIST** – Alcohol, Smoking, and Substance Involvement Screening Test
    - **CAGE** – Substance Abuse Questionnaire
    - **PHQ-9** – Patient Health Questionnaire
    - **SOAR web** - based risk assessment tool

Things to Consider:

- Remember that there are many examples of risk assessments, and these are only a few examples. Continue to search until the right assessments are found that meet the practice's philosophy and standards of care.
- The following questions should assist you in choosing a practice assessment. Ask:
    - What patient group is most important to begin assessing more routinely, for example, adults, adolescents, or seniors?
    - What constraints does the practice have in conducting the assessment, for example, time required or assessments that may already be in the EHR?
    - How will the practice act on the results of the assessment? For example, what resources does your practice have to follow up? Which team members can help to identify resources?

Best Practice Recommendations:

- Minimal standards suggest risk assessment be completed annually, however more frequent risk reassessment may be needed based on higher scoring of initial risk assessment or aberrant behavior.
- Ongoing risk assessments may be incorporated into a planned care visit (PCV, Strategy 7) or when assessing response to treatment or at a "trigger point" event.
- The "trigger point" of an opioid analgesic prescription for 80mg, for more than 3 months, as well as some aberrant behavior issues provides an opportunity to further assess addiction risk or mental health concerns, using the Screening, Brief Intervention and Referral to Treatment (SBIRT) tool.
- SBIRT is screening, brief intervention, and referral to treatment. SBIRT is evidence-based and used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- **SBIRT** – **S**creening, **B**rief **I**ntervention and **R**eferral to **T**reatment tools to administer can be found in the **Appendices**.
    - **S** - Screening- This toolkit suggests use of the ASSIST - Alcohol, Smoking and Substance Involving Screening Test.
    - **BI** - Brief Intervention – Brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling and NOT intended to treat patients with serious substance dependence.
    - **RT** – Referral to Treatment-consists of assisting the patient with accessing specialized treatment including referral to an addiction specialist when appropriate. Example referral documents can be found in the **Appendices**.

Action Item - Develop a protocol for risk assessment that aligns with your practice's philosophy or ensuring patient safety.

Things to Consider:

Ohio Rules for Acute Pain

When assessing patients presenting with acute pain, initial considerations should include psychological factors, including personal and/or family history of substance use disorder.

Ohio Rules for Subacute and Chronic Pain

- Before prescribing an opioid analgesic for subacute or chronic pain, the prescribing provider shall complete or update and document assessment activities to assure the appropriateness and safety of the medications including screening for risk, substance misuse and/or substance misuse or substance use disorder.
- Prior to increasing the opioid analgesic dosage to a daily average of 50 MED or greater the provider shall review and update assessment and formulate a new treatment plan as needed.
- Based on clinical presentation, when prescribing 50 MED or greater, the provider shall document consideration of a consultation with a specialist in addiction medicine or addiction psychiatry, if aberrant behaviors in indicating medication misuse or substance use disorder are noted.

*A sample Risk Assessment Protocol is included in the **Appendices**.*

Action Item - Choose a Functional Pain Assessment that aligns with your practice's standards of care.

Things to Consider:

- What location of pain is most consistent within your patient population, for example, back, or neck?
- The pain assessment shall include the patient's ability to engage in work or other pertinent activities, the pain intensity and how it interferes with activities of daily living, the quality of family and social life, and the physical activity of the patient?
- Is the practice desiring an assessment that will produce a numeric score or other objective metrics?
- Examples of tested and validated pain assessment tools can be found in the Appendices and include:
    - Rolland- Morris- Low Back Pain Questionnaire
    - Oswestry Disability Index

- Remember that there are many more examples of pain assessments and these are only a few examples. Continue the search until the right assessments are found to meet the practices standards of care. A list of clinically tested and validated pain assessments can be found at **https://www.practicalpainmanagement.com/resource-centers/opioid-prescribing-monitoring/list-clinically-tested-validated-pain-scales**

Action Item - Choose a Functional Pain Assessment that aligns with your practice's standards of care.

Things to Consider:

Ohio Rules for Subacute and Chronic Pain

- Before prescribing an opioid analgesic for chronic pain, the provider shall complete and document a standardized functional pain assessment that includes the patient's ability to engage in work or other pertinent activities, the pain intensity and how it interferes with activities of daily living, quality of family and social life, and the physical activity of the patient.
- Prior to increasing the opioid analgesic dosage to 50 MED or greater, the provider shall review and update the functional pain assessment and incorporate it into the patient treatment plan as needed.

Best Practice Recommendations:

- Ohio Acute Guidelines suggest that when prescribing an opioid analgesic for acute pain, the prescriber should document the following notes in the patient's record:
    - Location, intensity and severity of the pain and associated symptoms
    - Quality of pain: somatic (sharp or stabbing), visceral (ache or pressure) and neuropathic pain (burning, tingling, or radiating)
- For persisting acute pain, providers should reevaluate the pain characteristics and consider using a standardized tool (e.g. Oswestry Disability Index), treatment methods, reasons for continued pain and additional management options, including consultation with a specialist.
- Per the Ohio Guidelines for Acute Pain, pain reevaluation of acute pain management patients who receive an opioid analgesic will be considered if the opioid analgesic therapy will continue beyond 14 days, and should occur again for unresolved pain after 6 weeks to determine whether treatment should be adjusted.

*A sample Pain Assessment Protocol is included in the **Appendices**.*

Appendices:

- ORT
- SOAPP-R
- DIRE
- COMM
- ABC
- ASSIST
- CAGE
- PHQ
- SOAR
- SBIRT
- Referral to Behavioral Health
- Behavioral Health Feedback to Primary Care
- Behavioral Health Request for Information
- Risk Assessment Protocol
- Oswestry Disability Index
- Roland-Morris Low Back Pain and Disability Questionnaire
- Pain Assessment Protocol

Strategy #4: Patient Agreements

Implement Medication Treatment Agreements and written Informed Consent for patients on opioid pain management therapy.

When pain management includes opioid analgesic therapy, clinicians should discuss the known risks, realistic benefits, and patient and clinician responsibilities of treatment. Using written Medication Treatment Agreements (MTA) and an Opioid Informed Consent documents can improve patient compliance and help protect physician liability. The MTA and Opioid Informed Consent can be combined into one document if the practice desires. In this Toolkit, the two agreements are presented individually. These documents should be stored in the patient medical record.

The opioid MTA outlines patient responsibilities and requires the patient to agree to the terms required within the agreement, as identified by the practice's standards of care and state rules. The MTA is intended to improve communication between the patient and the provider and educate the patient of necessary assessments for an effective treatment plan to ensure patient safety and care.

Opioid Informed Consent covers the benefits and risks of the medication, including potential for addiction and risk of overdose, as well as the patient's responsibility to safely store and appropriately dispose of the medication.

Action Item - Develop a written Medication Treatment Agreement (MTA) document.

Things to Consider:

- If the practice already has a written MTA:
    - Review the document for needed revisions, regarding any new standards of care implemented by the practice; and,
    - After completing revisions, include the date of the revisions on the MTA.
- If the practice is creating their first MTA, obtain samples for providers to review so they can comment on language and terms to include.
- Include key elements of the practice's standards of care into the MTA.
- In the agreement, include what Ohio rules state that the patient shall agree to:
    - Drug screening and a release to speak with other practitioners;
    - Cooperation with pill counts to assure compliance;
    - Only receiving an opioid analgesic prescription from the provider treating the pain; and,
    - The dosage being tapered if not effective or if the patient does not abide by the agreement.

- Include patient responsibilities, for example being present at scheduled appointment or not allowing phone or portal requests for refills.
- Include provider responsibilities, for example being cognizant and sensitive to the patient's pain and emotions associated with the pain condition.
- Describe plans for ending opioid analgesic therapy as function improves.
- Include plans for aberrant behavior.
- Include that the goals of providing opioid analgesic treatment are to improve function and possibly provide some pain relief.
- Review and revise annually.

*A sample Medication Treatment Agreement is included in the **Appendices**.*

Action Item - Develop a practice protocol for implementation of an opioid Medication Treatment Agreement.

Things to Consider:

- Include the signed MTA in the patient's medical record
- Consider whether both the provider and the patient will sign the MTA

Ohio Rules for Subacute and Chronic Pain

Prior to increasing the opioid analgesic dosage to a daily average of eighty MED or greater, the physician shall enter into a written pain treatment agreement with the patient that outlines the physician's and patient's responsibilities during treatment, and requires the patient or patient guardian's agreement to all of the following provisions:

- Permission for drug screening and release to speak with other practitioners concerning the patient's condition or treatment;
- Cooperation with pill counts or other checks designed to assure compliance with the treatment plan and to minimize the risk of misuse or diversion;
- The understanding that the patient shall only receive an opioid analgesic prescription from the physician treating the chronic pain unless there is written agreement among all of the prescribers of opioid analgesics outlining the responsibilities and boundaries of prescribing for the patient; and,
- The understanding that the dosage may be tapered if not effective or if the patient does not abide by the treatment agreement.

Best Practice Recommendations:

There are times when a practice may want to engage the use of a medication treatment agreement with acute pain managed patients. Acute pain is expected to resolve within days to weeks. If pain is present at 6 weeks it is considered subacute, and at 12 weeks it is considered chronic pain and should be treated accordingly. The practice may want to incorporate a MTA for acute pain opioid analgesic management at the 6 or 12 week reevaluation if a patient demonstrates aberrant behavior.

The MTA should be used with any patient who displays aberrant behavior, regardless of opioid analgesic dosage or longevity.

If the MTA has already been signed and the patient exhibits aberrant behavior, re-educate the patient on the MTA and have the patient sign the agreement again. One violation of the MTA may not justify tapering of opioid analgesics.

*A sample Medication Treatment Agreement Protocol is included in the **Appendices**.*

Action Item - Develop a written Informed Consent document.

Things to Consider:

Ohio Rules for Acute Pain

Ohio's rules require a provider to obtain written consent from a parent or guardian prior to prescribing an opioid analgesic to a minor. The informed consent must include the risks and benefits, including the risk for addiction, and be documented in the medical record.

Ohio Department of Health offers a 'Start Talking' Minor Informed Consent. It is included in the **Appendices**.

Best Practice Recommendations:

- Include side effects in the Informed Consent document. For example: nausea, constipation, and sedation risks.
- Besides risk of addiction include, the possibility of misuse, abuse, or diversion.

*A sample Informed Consent Form is included in the **Appendices**.*

Action Item - Develop a practice protocol for implementation of Informed Consent.

Things to Consider:

- Include the signed Informed Consent in the patient's medical record.
- If patient exhibits aberrant behavior, the provider may choose to have the patient sign the informed consent again after discussion of the risks and benefits and potential for addiction, misuse or abuse.
- Include where the form will be located with the medical record.
- Provide Staff training on the Informed Consent document and protocol.

Ohio Rules for Subacute and Chronic Pain

Before prescribing an opioid analgesic for subacute or chronic pain, the physician shall complete or update and document assessment activities to assure the appropriateness and safety of the medication including discussion with the patient or guardian regarding:

- Benefits and risks of the medication, including potential for addiction and risk of overdose; and
- The patient's responsibility to safely store and appropriately dispose of the medication
- Prior to increasing the opioid analgesic dosage to a daily average of fifty MED or greater the physician shall obtain from the patient or the patient's guardian written informed consent which includes discussion of all of the following:
- Benefits and risks of the medication, including potential for addiction and risk of overdose; and,
- The patient's responsibility to safely store and appropriately dispose of the medication

*A sample Informed Consent Protocol is included in the **Appendices**.*

Appendices:

- Medication Treatment Agreement sample
- Medication Treatment Agreement Protocol
- 'Start Talking' Minor Informed Consent
- Informed Consent Form sample
- Informed Consent Protocol

Strategy #5: Team-based Approach for Implementation

Adopt a team approach to implementing the practice's philosophy, and standards of care, and protocols.

Once protocols are written, it is time to create new workflows for implementation. A workflow is a step-by step process for putting standards of care into action. The written protocol will be the foundation for creating the workflow process, but the workflow may contain more details on exactly how the work will be performed. The practice providers and staff shall assume specific roles in supporting the new standards of care. These roles help reinforce the protocols while increasing the likelihood for sustained practice adherence and success. Therefore, it is important that the practice team creates a culture for staff engagement in the workflow process, including provider and staff involvement in creating, training, testing, and supporting the workflow development.

Action Item - Use an Implementation Plan to assign responsibilities and deadlines for each new workflow.

Things to Consider:

- Use an Implementation Plan for planning implementation of each workflow process. A sample template and example plan can be found in the Appendices.
- The plan is an organizational tool to keep track of the progress toward implementing the steps for the process. The plan should be reviewed at each meeting for changes that need to be addressed and where workload may need adjusting.
- Identify what activities are needed for a successful process change/improvement.
- Identify who will take the lead for each activity. The lead may depend on the knowledge and experience of team members.
- Consider workload of team members and time availability.
- Consider a team member's interest for an activity.
- Identify when the activity should be completed or reviewed for progress.
- There may be unavoidable slowdowns with activity completion that make plan adjustment a necessity.
- As a team, meet with the practice leaders to review and acquire approval for the Project Management Plan.
- Throughout the project implementation process provide regular staff updates. Communicate with the staff how well the workflows are being adapted, adopted, and adhered to. Keep the staff updated on progress of the Project Management Plan and any changes that have developed.
- Ensure staff understanding of the work plan and communicate who the leads are for each workflow for staff input and concerns.

Action Item - Develop a practice protocol for implementation of Informed Consent.

Things to Consider:

- Map a new workflow for each new protocol, creating a meaningful visualization of the process.
- This can best be accomplished by seeing the process through the eyes of the patient.
- Obtain team member input and perspective from each practice area for each workflow process:
    - Identify who currently performs activities and tasks.
    - What activities and tasks would better be performed by another staff member?
    - Are there unnecessary or nonvalue-added activities and tasks that the practice might choose to eliminate?
- Convey the sequence of activities and tasks to clarify key work processes. This can be done in a simple diagram.

- Practices may want to implement the Plan-Do-Study-Act (PDSA) model to test the new workflow process. PDSA is a method for breaking down an improvement initiative into manageable chunks. PDSA directions and examples, including a sample PDSA worksheet, can be found in the Appendices.
- Consider testing workflows with just one care team (i.e. provider and MA) before training and implementing the workflows practice-wide. This prevents confusion and frustration that can result from teaching a new workflow, then changing it as the workflow naturally evolves.
- If workflows are implemented widely across the practice before “real-life” testing, be vigilant about communicating updates to providers and staff. Failure to communicate changes effectively may result in different workflows for different care teams.
- Consider possible patient behaviors that concern the practice (aberrant behaviors) and include a section of the workflow to address them. For example, if a urine drug test result returns positive, or patient calls requesting an early refill due to ‘lost pills’.
- Practices may want to include patients in the process change, i.e., a letter explaining the new process, what changes to expect during an office visit, and how patients’ feedback will help guide the process change.
- Consider a patient survey before and after implementation to measure patient satisfaction with their opioid analgesic therapy related visits.
- Practice protocols may need to be revised as the team tests and improves workflows.

Action Item - Set goals to assure the standard of care workflow implementation is successful.

Things to Consider:

- Use SMART Goals: Goals you are working to accomplish must be **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound. A SMART Goal Template is included in the Appendices for more information.

  Do _____ ....in order to.... _____ by _____.

  Example: *Practice will implement the new workflow process for Informed Consent to improve the number of written Informed Consents completed for chronic pain management patients by 25% in the next 3 months.*

- Goals may vary depending on the level that your team was created, e.g.: care team level, practice level, organization level. In general, teams created at higher levels of the organization have broader and more complex responsibilities and therefore, more complex goals.

- Include staff in goal development whenever possible.

- Consider a pre- and post-implementation staff survey to measure team confidence in the new workflows, and in opioid analgesic prescription management in general. This will help to identify levels of staff satisfaction, create engagement and empower staff to meet goals.

- Provide timely feedback on goals to the staff performing the processes in order to maintain engagement, empower improvement, and reinforce what needs to be done in the future.

- Feedback information can be accomplished in many ways:
  - White board
  - Staff email
  - Breakroom bulletin board

- Consider including positive feedback within an organization's newsletter to let everyone know about the improvements being made and highlight staff engagement that is occurring within your practice.

- Include patients understanding of the workflow process in your goals when applicable.

Appendices:

- Implementation Plan Worksheet
- Implementation Plan Example
- PDSA Directions and Examples
- SMART Goal Template

Strategy #6: Flowsheet and Documentation

Develop and use electronic patient flow sheets for data collection and assessment.

Accurate and complete documentation is key to providing optimal care and patient safety. A flow sheet (or similar EHR template) collects all data pertinent to opioid analgesic therapy in one location in the medical record. This creates an easy to follow reference for decision making with patients and formulating a treatment plan.

These templates are helpful for:

- Allowing providers to make accurate and efficient decisions related to prescribing opioid analgesics.
- Prompting staff and providers to address gaps in care.
- Standardizing visit workflows across providers and staff.
- Monitoring compliance with practice protocols.
- For practices on paper records, all of the criteria below can be incorporated into a paper flowsheet.

Action Item - Design a template or flowsheet that encompasses care based on the practice's philosophy, standards of care, and protocols.

Things to Consider:

- Consider the information gathered during the medical exam that assists staff and providers with a complete historical and current workup.
- Contact your EHR Vendor at the beginning of the project to find out what flowsheet and documentation options are already built in the system and available.
- If the practice must create and set up its own EHR flowsheet, consider using a paper flowsheet for documentation tracking until processes are solidified. Changes to the EHR can be costly, and it is best to know exactly what the practice wants to document before building an electronic template.

- Consider including the following items in the flowsheet or template:
    - Opioid analgesic prescription and refill dates
    - Naloxone prescription dates
    - Informed Consent dates
    - Medication Treatment Agreement dates
    - OARRS report dates and results
    - Urine drug screen dates and results
    - Pill count dates and results
    - Opioid risk assessment dates and results
    - Mental health assessment dates and results
    - Substance abuse assessment dates and results
    - Pain assessment dates and scores
    - Patient and family/caregiver education
    - Specialist referrals
    - Mental health/substance abuse referral
    - Pain management referral

Action Item - In conjunction with IT or the EHR vendor, integrate the developed flowsheet into the EHR.

Things to Consider:

Determine which key metrics from above are already incorporated into the patient chart as structured data fields, and which ones may need to be added as unstructured free-text fields. Structured fields are preferable because they can usually be searched and reported on, while free-text fields cannot.

- Could lab results and dates flow automatically into the flowsheet?
- Could care gap reports be run from the flowsheet?
- Can providers and staff document multiple dates for fields? For instance, OARRS reports will be pulled every 90 days. Can the flowsheet store the dates for all OARRS report, or only the date of the most recent?
- Can you build flowsheets yourself, or do you need to ask the EHR vendor to build them for you? There may be a cost associated with having flowsheets or templates built by you EHR vendor.
- Could you build a pain management or planned care visit note template that would automatically populate portions of the flowsheet?
- Could links be included in the flowsheet to allow providers and staff to go directly to the section of the chart related to that field?

Action Item - Determine how the flowsheet will be used in the practice and at the point of care, and consider developing a written protocol.

Things to Consider:

- Who will be responsible for entering data in the flowsheet? When will data be entered? Optimally, flowsheets will be updated as much as possible before the provider sees the patient.
- Who will review the flowsheet for care gaps before or during the patient's appointment?
- Is the flowsheet easily accessible in the medical record? Staff and providers are less likely to use it if it is difficult to find.
- Can alerts be created in your EHR that pertain to items on the flowsheet?
- Review and update flowsheet and protocol annually and document revisions.
- Given the wide variability in flowsheet design and functionality, a sample protocol is not included in this toolkit.

Strategy #7: Planned Care Visits

Develop a Planned Care Visit to ensure that evaluation, monitoring, and documentation of patients on opioid analgesic therapy occurs proactively and consistently.

Consistently scheduled patient visits intended specifically for pain management ensure that assessment, treatment, documentation and monitoring of the patients undergoing treatment using opioid analgesics are planned for and addressed, rather than incidental to other medical needs that arise. With the focus of the visit on pain management, the provider and patient can be assured of having the time needed for a conversation about the current effectiveness of treatment and the need for any changes in the treatment plan. A benefit of this type of planned care visit strategy can be fewer unexpected calls or provider interruptions because there will always be a next scheduled visit for this purpose. The frequency of these visits can range depending on the whether the pain is acute, subacute or chronic.

Effective planned visits lead to better clinical control of the patient's functional status, reduce misuse and abuse of opioid analgesics, and ensure patient safety. Planned care visits may also lead to fewer acute care visits, patient emergency department visits, reduced costs, and greater patient satisfaction.

Action Item - Decide on the components of the practice's Planned Care Visits (PCV).

Things to Consider:

Utilize the process improvement method from Strategy 5 to design and implement a planned care visit (PCV) process.

Ohio Rules for Subacute and Chronic Pain

During the course of treatment with an opioid analgesic at doses below the average of fifty MED per day, the physician shall periodically complete and document the following:

- Follow-up assessment and documentation of patient's functional status
- Patient's progress toward treatment objectives
- Indicators of possible addiction, drug abuse or diversion
- Notation of any adverse drug effects

- During the course of treatment with an opioid analgesic at doses at or above the average of fifty MED per day, the physician shall complete and document in the patient record the following no less than every three months:
    - Review of the course of treatment and the patient's response and adherence to treatment.
    - Assessment that shall include:
        - Ohio Pain Management Toolkit 32
        - Review of any complications or exacerbation of the underlying condition causing the pain through since the previous assessment
        - Physical examination
        - Any appropriate diagnostic tests
        - Specific treatments to address the findings
    - Assessment of the patient's adherence to treatment, including any prescribed nonpharmacological and non-opioid analgesic treatment modalities
    - Rational for continuing treatment using opioid analgesics and nature of continued benefit, if present
    - Results of an OARRS check
    - Screening for medication misuse or substance use disorder. Urine drug screen should be obtained based on clinical assessment of the physician with frequency based upon presence or absence of aberrant behaviors and other indications of addiction or drug abuse
    - Evaluation of other forms of treatment and the tapering of opioid analgesics if continued benefit cannot be established

Best Practice Recommendations:

Consider adding the following components to the PCV, if they align with the practice's philosophy and standards of care: standards of care:

- Functional Pain Assessment
- Urine drug test for all opioid analgesic patients at least once every twelve months
- Review of Informed Consent at least once every twelve months
- Review of Medication Treatment Agreement at least once every twelve months
- Personal Care Plan for Chronic Pain, developed in collaboration with the patient. A sample can be found in the **Appendices**.
- Patient education (See Strategy 8)

Action Item - Develop a practice protocol for implementation of Planned Care Visits.

Things to Consider:

- Before beginning your protocol, consider which team members will complete each component of the visit. For example, will medical assistants ask patients to complete a risk assessment or pain assessment as part of the rooming process?
- Consider adding a section to the protocol outlining where in the EHR each visit component will be documented, and by whom.
- Ohio Pain Management Toolkit 33
- Consider adding a section to the protocol outlining what happens if a patient does not come to their scheduled Planned Care Visit.
- A sample Planned Care Visit protocol can be found in the **Appendices**.

Action Item - Determine a frequency for Planned Care Visits (PCV) based on patient dosage and risk for opioid analgesic misuse or abuse. Build these appointment types into your scheduling software for each applicable provider.

Things to Consider:

- Ohio's OARRS rules require review of a current OARRS every 90 days for patients on chronic opioid analgesic therapy. It may be easiest to comply with this regulation by setting PCV frequency at 90 days also.
- Ohio Rules for Subacute and Chronic Pain require "periodic" follow-up for patients on dosages less than 50 MED average, but require follow-up "no less than every 90 days" for patients on dosages at or above 50 MED average. It may be easier to standardize that all patients on opioid analgesic therapy are seen at least every 90 days, rather than creating different standards for patients based on dosage.
- Creating a patient roster, as outlined in Strategy 9, may help determine how many PCVs need to be incorporated into each provider's schedule each quarter.
- What is the current scheduled time allotment for patients presenting with chronic pain? Does it need to be adjusted to allow for all components of the PCV?
- Patients at higher risk of substance misuse or abuse or exhibiting aberrant behavior may require more frequent visits.

Appendices:

- Personal Care Plan for Chronic Pain
- Planned Care Visit Protocol

Strategy #8: Patient Education

Use patient education materials that promote patient understanding of the practice's philosophy and standards of care.

Now that the practice has developed a practice-wide philosophy and standards of care, notify the patient so that they know what to expect. This information will help the patient understand that their provider has a plan for them that includes patient responsibility and is ultimately structured towards helping the patient get the help they need from their doctor. Patient education on the how/what/why of pain management and opioid analgesic prescribing will lead to greater compliance and reduce the risk of addiction or diversion. Setting strict guidelines and engaging the patient in the shared decision-making process enhances the patient-provider relationship, improves understanding and adherence, motivates patients to become better self-managers, and leads to improved quality of life.

Action Item - Create educational material for patients to introduce the practice's philosophy and standards of care.

Things to Consider:

- Capture highlights of the practice's pain management philosophy and highlights of the new standards of care in a one-page pamphlet or letter that can be given or mailed to all patients on opioid analgesic therapy. Written educational documents should be at grade 6 reading level or lower.
- Who will write and design the pamphlet?
- How will the pamphlet be printed?
- Consider adding elements of the philosophy and standards of care into documents already used within the practice, such as a practice brochure that includes information about providers, staff, mission and values.
- Include the philosophy and highlights of the standards of care on the Informed Consent or Medication Treatment Agreement.
- Include the philosophy and standards of care on the practice's website.
- Post the philosophy statement in the waiting room and in exam rooms.

Action Item - Discuss the practice's new philosophy and standards of care with pain management patients face-to-face.

Things to Consider:

- Determine how the practice will start implementing the education with the patient. Which team members will deliver education, and during which part of the appointment?
- Before patient education begins, consider role playing or develop a script and share it with the team. Include an explanation of why the changes are occurring. Gather feedback on the script and time involved in educating the patient through a discussion.
- The Centers for Disease Control (CDC) created a resource titled, "Working Collaboratively with Patients Receiving Long-term Opioid Therapy: Principles and Examples." This guide offers tips and sample scripts to help you prepare for these conversations. This resource can be found in the **Appendices**.
- The provider can review the philosophy and overview of the standards of care when the Informed Consent and/or Medication Treatment Agreement are discussed and signed.
- Consider mailing a practice letter introducing the pain management patients to the philosophy, standards of care, and process changes they will encounter at the next visit. A sample letter can be found in the **Appendices**.
- Educate all opioid analgesic therapy patients, regardless of the pain diagnosis, opioid analgesic dosage, or risk level.
- Use the "teach back" technique when talking to patients to ensure understanding.
- For minor children and their parents, utilize teaching aids from the Be Smart website: **www.osma.org/BeSmart** or on the Start Talking Ohio website: **http://starttalking.ohio.gov/**
- Document the education session and patient understanding in the medical record.
- Consider a patient survey to include questions regarding the patient's understanding of the philosophy and standards of care.
- Common patient education topics include:
    - Non-pharmacologic and non-opioid analgesic treatment options
    - Risks and benefits of opioid analgesic and other controlled substance medications
    - Securing and disposing of medications
    - Goal setting and patient self-management
    - Recognizing possible substance abuse or misuse

Appendices:

- CDC "Working Collaboratively with Patients Receiving Long-term Opioid Therapy: Principles and Examples"
- Sample Letters to Patients
- OSMA Be Smart Education for Patients
    - Be Smart Non-Opioid Relief & Alternative Pain Management
    - Be Smart If You Are Prescribed Opioids for Pain Relief
- ODH Take Charge Ohio:
    - Take Charge Ohio Brochure
    - Take Charge of Pain Medication Safety
    - Recognizing When Someone is in Danger
    - Prescription Opioids: What You Need to Know
    - Take Charge Ohio Material Order Form

Strategy #9: Chart Audits

Conduct periodic chart audits on patients undergoing treatment using opioid analgesics to ensure that practice protocols are implemented consistently.

Chart audits offer practices the opportunity to identify gaps between written processes and real-life workflows. Reviewing patient charts for required documentation highlights areas of implementation success and opportunities for improvement. Accountability is an effective motivator during improvement, especially when significant changes are involved, as in this project.

The chart audit worksheets created for this strategy, and the toolkit as a whole, are based on the Ohio Administrative Code rules for prescribing opiate analgesics for acute pain and for subacute and chronic pain. Completing chart audits using the provided tool will provide insight on where providers are currently meeting Ohio rules and where they are not.

Action Item - Create a roster of patients on opiate analgesics.

Things to Consider:

- Before starting audits, the practice will need to start identifying relevant patients. The list of patients should include the patient name and date of birth, at a minimum. This can be done in a few different ways:
    - From the EHR:
        - Run a list of active patients who have been ordered an opiate medication in the last year. A list of brand name and generic opiate medications can be found at https://www.rehabcenter.net/list-opioids-united-states/#list.
        - Run a list of patients seen in the last year who had an ICD-10 code on their problem list that is commonly used in pain management. A list of codes can be found at https://www.dominiondiagnostics.com/sites/default/files/ICD-10-CM%20Pain%202017.pdf
    - From the Practice Management software: Run a list of active patients with a claim submitted in the last year containing an ICD-10 code that is commonly used in pain management. See the bullet above for a list of these codes.
    - From OARRS: Run a report of patients for whom any of the practice's providers have prescribed a controlled substance in the last year.
- Keep in mind that each of the computer-generated lists above will require review, as they may contain names of patients who have expired, are no longer on opioid analgesic therapy, or are no longer seen at your practice. Likewise, some opioid analgesic patients may not be included. This roster of patients will be a constantly evolving list.

- Ohio Pain Management Toolkit 38
- Consider "flagging" opioid analgesic therapy patients in the EHR so that staff and providers can easily identify these patients for implementation of practice policies.
- Identify patients on the list of opioid analgesic treatment who fall under the exclusion criteria: cancer diagnosis, terminal illness diagnosis, or under hospice or palliative care. It is still important to flag these patients for patient safety reasons, but they may be exempt for the practice's protocols, per Ohio's rules. These patients may be difficult to identify through EHR reports, but they can be noted manually, as they are recognized by physicians and staff during office visits.
- If electronic reports are not available to identify opioid analgesic therapy patients, simply begin a list on paper or in Excel and add patient names as they are identified during office visits.
- The patient roster will contain sensitive Protected Health Information (PHI), so it should only be available to staff members with relevant clinical responsibilities. Keep the electronic or paper list protected from unauthorized access.

Action Item - Create an audit worksheet or spreadsheet to guide chart review.

- Chart audit worksheets are included in the Appendices. This tool was designed to assess compliance with the Ohio Administrative Code (OAC) rules for prescribing opiate analgesics. While the practice may choose to augment or redesign this audit tool to make the process more efficient for your practice, keep in mind that all criteria included are considered minimum standards of care by the state of Ohio.
- Completing a baseline audit of 20 charts per provider, before implementing any policy workflow changes, will offer valuable insight on areas where practice providers may not be complying with Ohio opiate prescribing rules. These compliance gaps present a threat to patient safety and medical liability, and should be top priority in redesigning the practice's standards of care.
- Robust EHRs may have the ability to produce reports that eliminate the need to complete some or all parts of the audit manually. For example, if the EHR can report a list of patients on opiate therapy, the date of their last opiate prescription, and the date of their last OARRS review, this report can easily evaluate whether OARRS reports are consistently reviewed at the time of prescription order entry.

Action Item - Complete the chart audits and share the results with leadership, physicians, and staff.

- Accountability and feedback are essential to maintaining sustainable change. Audits are a time consuming task, but they offer evidence that demonstrates how successfully (or unsuccessfully) the practice has improved.
- Competition is a strong motivator for physicians and staff. Consider sharing all providers' results openly.
- If the chart audits demonstrate improvement, celebrate the team's success! Publicly recognize "above and beyond" individual contributions that led to the improvement.

Appendices:

- Chart Audit Worksheets

Strategy #10: Pain Management Council

Develop a pain management council to periodically review treatment plans for high-risk patients.

The pain management council shall include providers that meet on a regular and/or on an as-needed basis to provide an objective assessment on issues such as treatment history, need for an opioid analgesic, or referral to a specialist, behavioral health provider or another community resource. The council meeting would allow providers time to review patient-specific situations comparable to that in a case review or in a team discussion for chronic care management.

Action Item - Create a charter that outlines who will serve on the council, and how often the council will meet.

Things to Consider:

A charter is a document that describes the purpose of a group and guidelines for how it will operate. For creation of the charter, consider the following:

- For an independent practice, will the council be composed of internal providers only, or both internal and external providers?
- Will a minimum number of meetings be held? For example, at least 2 times a year?
- Will minutes or case review notes be taken?
- Will discussion take place on patients that overdose and die?
- Will ad hoc meetings occur for time-sensitive patient issues? How much advance notice will be needed?
- Will providers meet for transitions of patients when providers retire or leave the practice?

Action Item - Determine how content for Council meetings will be selected for discussion.

Things to Consider:

- Will patient records reviewed be selected randomly or based on specific incidents that require attention?
- Providers will need to gather patient information and present it in a succinct format with questions that need answering.
- Define provider specific incidents that require review during scheduled meetings: patients strongly objecting to current processes or requesting a different doctor within the practice, weaning a complex patient, patients with addiction and need for detox or rehab, guidelines needed for referral to pain specialists, decision to discharge patient due to non-compliance (if not already in the standard of care), etc.
- Define incidents that will trigger an "as needed" meeting: suicide potential due to opioid analgesic misuse, patient hand-off due to provider retiring or new provider joining practice, etc.

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