Improving Opioid Prescribing

Caring for Patients with Chronic Pain

Fourth Edition

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This Toolkit reflects knowledge based on the regulatory environment of the State of Vermont, 2012–2025.
Please check indicated websites for updates and new information as you proceed with this project.

University of Vermont
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Welcome to the Toolkit!

This resource is designed for ambulatory care leaders, providers, and staff who want to improve opioid prescribing for patients with non-palliative, chronic pain. We appreciate your dedication to improving care and are excited to support you on this journey.

About the Toolkit

This Toolkit addresses three common scenarios in managing opioids for chronic pain:

A. Starting opioid treatment for patients with chronic pain, when needed
B. Transitioning opioids across providers, such as to a new prescriber
C. Adjusting care for patients on high-dose opioids or at risk for a poor outcome

The Toolkit does this by helping the practice create a roster of long-term patients treated with opioids, organize office practice workflows to make use of the roster, and select proven strategies to manage opioid prescribing, such as monthly meetings with prescribers to manage opioids consistently with well-established tools. Developed specifically for ambulatory care clinics in Vermont, this Toolkit can be applied broadly to many settings.

Toolkit Objectives

1. **Provide a step-by-step guide** to plan and use strategies for managing opioid prescribing to reduce diversion and misuse while helping patients manage chronic pain.

2. **Assist providers and staff** in improving office workflows for alignment with local and state policies and professional expectations about opioid prescribing.

3. **Decrease inappropriate opioid use** to reduce prescription misuse, opioid-related morbidity and mortality, and overall healthcare costs.

4. **Facilitate understanding and support** for all prescribers and staff by making the opioid prescribing process clear and promoting a team-based approach to care.

5. **Engage clinic leadership** in developing a comprehensive, practice-wide approach to opioid prescribing, evaluation, and improvement, aimed at providing optimal long-term pain management therapy for each patient.

Navigating the Toolkit

This Toolkit is a resource designed to adapt to your needs and provide practical solutions for improving opioid prescribing practices. It is organized into three main parts:

#1: Improve Opioid Prescribing with QI

Start Here

Introduces essential Quality Improvement (QI) steps to plan strategies on opioid prescribing.

#2: Select Your Focus - Which Scenario?

Explore

Choose one of three prescribing challenges that healthcare providers often face. It is recommended to begin with the scenario most relevant to the needs or your prescribers.

Each scenario (A, B, or C above) has links connected with QI strategies (Section #3 below) to choose from. Links move the reader back and forth between scenarios and related strategies.

Contents

Use this option to browse the entire Table of Contents and see how all the pieces fit together.

#3: Strategic Implementation

Enhance Your Approach

Strategic Implementation offers 28 actionable strategies linked to each Scenario (A, B, or C above), complete with detailed steps, to include in your QI process. Navigation links move the reader between scenarios and strategies.

#1: Improve Opioid Prescribing with QI Foundations

The QI Foundations section is the cornerstone of this toolkit, guiding your practice through a structured process to improve opioid prescribing. It consists of five essential steps, each designed to build upon the previous one, ensuring a comprehensive and collaborative approach to quality improvement.

Step 1 Self-Assess & Select Focus

Assess current practices and select a focus area.

Step 2 Prepare a QI Team

Select and prepare your quality improvement (QI) team.

Step 3 Analyze Workflow

Learn about your clinical workflow process with your team.

Step 4 Design the New Process

Design a new workflow process for the practice.

Step 5 Implement and Monitor

Carry out the implementation plan and measure the results.

Step 1: Self-Assess & Select Focus

Quality Improvement is a significant effort, but its impact can be transformative. By refining opioid prescribing, you are enhancing patient outcomes, safety, and consistency of care.

The following step-by-step pages serve as a worksheet, complete with check marks and spaces for notes, to help you stay organized as you work through each phase.

Estimated Time: 2 Hours

1.1 Conduct Pre-Project Survey

Use the questions below to create baseline pre-project surveys **for all providers and staff**. These questions are also available on a Practice Survey Google Form template.

Rate each statement below according to how it applies to your practice now.

Strongly disagree O O O O O Strongly agree

- ➔ My practice has clear and well-organized policies and approaches to opioid prescribing for chronic pain.
- ➔ My practice has updated our patient contract/agreement to reflect current state law.
- ➔ The opioid prescribers in my practice have agreed to manage patients with chronic pain consistently as a practice.
- ➔ The whole practice (staff and prescribers) has a team approach to opioid prescribing for patients with chronic pain.
- ➔ Our providers and staff are willing to use a structured process to plan and make changes to the way we prescribe opioids.
- ➔ Our practice is able to give at least one provider and two staff time off from regular duties for about 8 hours of team meetings to work on a quality improvement project.
- ➔ We have a provider leader who can share information with other providers and champion the results of a team that works on opioid prescribing.
- ➔ We are able to avoid being distracted or overwhelmed by competing demands (such as other big projects) or financial concerns.
- ➔ The people I work for can handle the challenges that might arise in implementing changes in opioid prescribing.
- ➔ I believe that improving opioid prescribing is good for patients with chronic pain.

Yes No Don't know

- ➔ *Prescriber only*: Are you registered to use the prescription drug monitoring program (VPMS in Vermont)?
- ➔ *Prescriber only*: Do you have a "delegate" (someone else in your office) who can use the PDMP for you?
- ➔ STAFF ONLY: Are there one or more staff members (other than prescribers) who are able to act as a delegate on the prescription drug monitoring program?

Never | A few patients | Complex patients | Some patients | Most patients | All patients

- ➔ How often do you schedule a special visit type (such as a Chronic Pain Management appointment) specifically for patients with chronic pain who are being treated with opioids?
- ➔ How often do you use a roster or list of patients on chronic pain medication to identify and track them easily?
- ➔ How often do you use a template, check list, or flow sheet to display data for patients prescribed with chronic pain medication?
- ➔ How often do you use an initial assessment tool to evaluate pain, ability to function, or risk of diversion (examples: Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients with Pain (SOAPP), or Chronic Pain Assessment/DIRE).
- ➔ How often do you use ongoing assessments for pain, function, and risk of diversion or abuse for patients on opioids for chronic pain (examples: Pain, Enjoyment, General Activity (PEG); Current Opioid Misuse Measure (COMM); or 5 Additional Assessments (5As with PEG)).
- ➔ How often do you plan prescriptions for chronic pain management in increments of 7 days (such as every 7, 14, 28, 56, or 84 days)?
- ➔ How often do you issue multiple prescriptions on the same day for patients to fill at staggered intervals (e.g., one prescription now and another to be filled later)?
- ➔ How often do you review patients and their care plans during provider meetings (such as a “Pain Management Council”) to evaluate opioid usage and make adjustments to their treatment plans?
- ➔ How often do you use urine screens to monitor patients?
- ➔ How often do you use RANDOM urine screens to monitor patients?
- ➔ How often do you use RANDOM pill counts to monitor patients?
- ➔ How often do you use tamper resistant prescription packaging for accurate pill counts (such as bubble packs or punch packs)?
- ➔ How often do you use a Prescription Drug Monitoring Program (such as VPMS in Vermont) at least once a year and at the start of opioid treatment for chronic pain?
- ➔ How often do you use patient agreement/contract for patients on long term opioid therapy for chronic pain?

Very Unsatisfied O O O O O Very Satisfied

- ➔ Please rate your satisfaction with the system for prescribing opioids in your office.
- ➔ Please rate your patients’ satisfaction with the system for prescribing opioids in your office.
- ➔ STAFF ONLY: Please rate your patients’ overall attitude regarding visiting the office for chronic pain management (i.e. patient frustration, anger or confusion).

Fair Good Very good Outstanding

- ➔ PRESCRIBER ONLY: Overall I would rate my knowledge, skill, and comfort with prescribing opioids safely and effectively

1.2 Time Commitment

Decide if your practice can support a quality improvement team that dedicates approximately eight hours over several months to implement the Toolkit. This team should include a prescribing provider, a clinical staff member assisting with patient care, and a front desk staff member. Other members may be included as needed.

We commit to dedicating about eight hours of practice time as a team to improve prescribing.

☐ We agree Date: _____

1.3 Treatment Commitment

Will all prescribers commit to a consistent treatment approach for patients prescribed opioids for non-palliative, chronic pain? A single, standard guideline that all prescribers agree to will make opioid prescribing easier and more effective across the practice.

Before committing, consider:

- This only applies to providers who prescribe opioids for chronic pain .
- A consistent approach means the prescribers will consistently apply strategies like pain and functional assessments, risk evaluation, treatment plans, and monitoring.
- Cross-covering providers will handle unscheduled refills, substance use concerns, and patient behavior issues consistently across the practice.
- Prescribing policies will apply to all patients, regardless of factors like age, income, or personal history with the provider.

We commit to maintaining a consistent and standardized treatment approach for all patients across the practice, ensuring continuity and quality of care.

☐ We agree Date: _____

1.4 Team Commitment

Decide if your practice can adopt a team-based care approach, where all members—clinical and non-clinical—collaborate to assist patients treated with opioids. Every role in the practice, from providers to front desk staff, impacts patient education and reinforces practice protocols around opioids. Empathy and understanding are key in supporting all patients. Shared education across practice maintains a consistent, empathetic approach.

A team-based approach ensures that policies are implemented and maintained consistently, increasing the effectiveness of patient care.

We commit to utilizing a team-based care approach, where all members of the practice - clinical and non-clinical - collaborate to support patients receiving opioid treatment.

☐ We agree Date: _____

1.5 Assess Compliance with the Law

- Review the legal requirements for opioid therapy specific to your state. As an example, refer to Vermont Board of Medical Practice Policy: Opioid Analgesics for Chronic Pain.
- Discuss each item in a provider meeting and check any that your clinic does not currently meet for patients with chronic pain receiving non-palliative opioid therapy. Keep this checklist for your later work in Steps 3 and 4 in this Toolkit.

IDENTIFY STATE LEGAL REQUIREMENTS (Example is Vermont)

☐ **Recommend Non-Opioid and Non-Pharmacological Treatment for chronic pain**
- Nonsteroidal anti-inflammatory drugs (NSAIDs) and/or acetaminophen
- Acupuncture
- Chiropractic
- Physical therapy
- Yoga

Only prescribe opioids if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, combine with non-opioid alternatives.

☐ **Query PDMP (Vermont: VPMS; check your state's program)**
- First-Time Prescriptions:
  - Prior to writing a first opioid prescription for 10+ pills (e.g. opioids, tramadol)
  - Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
  - Prior to starting a patient on a chronic opioid (90+ days) for non-palliative therapy
- Re-evaluation: At least annually (at least twice annually for buprenorphine)
  - Centers for Disease Control (CDC) recommendation: every prescription, or at least every 90 days
- Replacement: Prior to writing a replacement (e.g. lost, stolen) of any scheduled II-IV controlled substance

☐ **Provide Patient Education and Obtain Informed Consent**
- Discussion of risks, including side effects, risk of dependence and overdose, alternative treatments, appropriate tapering and safe storage and disposal
- Provide patient with the state-supported Patient Education handout
- Obtain signed informed consent, even for acute prescriptions
- Access education resources: (example is from Vermont Health Department) https://www.healthvermont.gov/alcohol-drugs
- CDC education resources: https://www.cdc.gov/drugoverdose/
- CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

☐ **Prescribe Nasal Naloxone when Indicated**
- High Dose: 90+ Morphine Milligram Equivalent (MME) per day
- Concomitant benzodiazepine: Patients prescribed both an opioid and a benzodiazepine CDC recommends avoiding co-prescribing of opioids and benzodiazepines
- CDC: History of overdose, history of substance use disorder, 50+ MME per day prescriptions

☐ **Arrange Evidence-Based Treatment for Patients with Opioid Use Disorder**
- CDC: Offer evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

☐ **Complete Continuing Education Requirements**

- Complete at least two hours of continuing education for each licensing period on the topic of controlled substances and for physicians an additional hour on pain management. Visit your state websites (in Vermont: vtad.org, vtmd.org/cme-courses) or check your professional society.

☐ **Prescribe Lowest Effective Dose of Immediate-Release Opioids**

- **Pediatrics:** Consider discussing the benefits and risks of prescribing an opioid to a pediatric patient with a colleague or specialist. Use extreme caution. Calculate dose for patient's age and body weight. Consider the indication, pain severity, and alternative therapies. Limit prescriptions to 3 days or less with an average MME of 24 or less. Do not write additional prescriptions without evaluating the patient.
- **Adults**
  - **Minor Pain** (sprains, headaches, dental pain): no opioids
  - **Moderate Pain** (non-compounded bone fractures, soft tissue surgery, most outpatient laparoscopic surgery):

	Average Daily:	**Total Rx:**
Hydrocodone 5mg	MME: 24/0-4 tablets	0-5 days/0-20 tablets
Oxycodone 5mg	MME: 24/0-3 tablets	0-5 days/0-15 tablets

  - **Severe Pain**

Hydrocodone 5mg	MME: 32/0-6 tablets	0-5 days/0-30 tablets
Oxycodone 5mg	MME: 32/0-4 tablets	0-5 days/0-20 tablets

  - **Extreme Pain**
    Pain (beyond severe) in adults is limited to a 7 day max with a 350 MME max. This should be rare in primary care. Exceptions must be clearly documented. For the complete rules, visit the Rule Governing the Prescribing of Opioids for pain found at your state health department (in Vermont at: https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf)
    - Include the maximum daily dose or a "not to exceed" equivalent on the prescription.
    - CDC: Prescribe immediate-release formulations when initiating opioids.

☐ **Evaluate Patients Regularly Using Best Practices**

- CDC: Reevaluate patients (and document) at least every 90 days
- CDC: If benefits do not outweigh harms, taper opioids
- CDC: Use urine drug screening prior to initiating opioids. Rescreen at least annually
- Calculate MME. Consider 50-89 daily MME a "yellow light" and 90+ MME a "red light"
- Use evidence-based tools to reevaluate adherence to the pain management therapy plan, functional goals (e.g. RAPID3), and potential for abuse and diversion (e.g. COMM)

☐ **Document, Document, Document**

- Medical evaluation, including physical and functional exams and assessment of comorbidities
- Diagnosis which supports the use of opioids for chronic pain and whether to continue opioids
- Individual benefits and risks, using evidence-based tools (e.g. RAPID3, 5As, SOAPP, COMM)
- Non-opioid and non-pharmacological treatments tried and trial use of the opioid
- PDMP query (Vermont Prescription Monitoring System or VPMS in Vermont)
- Department of Health Patient Education handout provided (as available)
- That the prescriber has asked the patient if they currently, or has recently been, dispensed methadone or buprenorphine or prescribed and taken any other controlled substance
- *Signed Controlled Substance Treatment Agreement and Informed Consent:* update annually
- Acknowledgement that a violation of the agreement will result in re-evaluation of therapy plan

Step 2: Prepare a QI Team

Commit to consistency in treatment across your practice by assembling a QI team that includes at least one prescriber and related staff roles. Assign roles, establish a team charter to define purpose and objectives, and choose an impact measure that reflects a current challenge.

Estimated Time: 2 Hours (sections 2.1 - 2.4)

2.1 Select Team Members

Identify project champion, team leader, facilitator, and team members of Opioid Prescribing Project (OPP), schedule team meetings, and identify other resources for the team's work.

- **OPP Practice leader champion:** decision-maker(s) or influencer(s) in the practice who decide to work on a particular project. Example: medical director, owner(s) of the practice
- **OPP Team leader:** one person with the responsibility to conduct the project by convening a team. Examples: practice provider, clinical staff, manager/supervisor
- **OPP Team facilitator:** a person from the practice or from outside the practice who guides the team through this Toolkit, usually not the "team leader" role above
- **OPP Team members:** members of the practice who meet and work together

OPP Practice Leader Champion _____

OPP Team Leader _____

OPP Team Facilitator _____

Other team members, including a prescriber, a clinical staff member, and a front desk staff member _____

Schedule of team meetings

Frequency (i.e. weekly, bi-weekly) _____

Duration (i.e. minimum 1 hour) _____

Modality (i.e. in person, online) _____

Meeting Location? _____ White board, flip chart, & & markers? _____

Community partner(s)? _____

Who keeps track of project materials? _____

2.2 Select Focus

Choose the scenario that will provide the greatest benefit to your practice based on your current needs. Focus on the patient population that requires the most immediate attention. Remember, you can always revisit and select a different scenario later if needed.

Rank the following scenarios from 1 to 3, with 1 being the most critical and 3 being the least critical. Use the space provided to indicate your prioritization.

A. **Starting Opioid Treatment for Patients with Chronic Pain**
Plan the initiation of opioid therapy for patients with chronic pain.

Rank : _____ (1: highest; 2: 2nd highest; 3: 3rd highest)

B. **Transitioning Opioid Prescribing across Providers**
Develop strategies for care when a new prescriber joins, or a past prescriber leaves.

Rank: _____ (1: highest; 2: 2nd highest; 3: 3rd highest)

C. **Adjusting Care for Patients on High-Dose Opioids**
Implement changes in management for patients receiving high doses of opioids.

Rank: _____ (1: highest; 2: 2nd highest; 3: 3rd highest)

Please select one scenario to start with:

- ☐ **Starting Opioid Treatment for Patients with Chronic Pain**
- ☐ **Transitioning Opioid Prescribing across Providers**
- ☐ **Adjusting Care for Patients on High-Dose Opioids**

Date: _____

2.3 Set Team Charter

A Team Charter is an explicit way to start an efficient and focused project team that understands its purpose and objectives.

Set the Purpose

The **OPP Practice leader champion, OPP Team leader, and OPP Team facilitator** meet before the first team meeting to set the purpose. Together, create a sentence that clearly identifies what your team will focus on.The statement should begin with "We will focus on..." and specify the areas that are most relevant to your practice.

> *Ex. “We will focus on creating and implementing a roster of patients treated with long-term opioids to ensure safe and effective care and follow up.”*
>
> *Ex. “We will focus on implementing a Chronic Pain Management Council that meets at least monthly to support providers prescribing long-term opioids.”*

We will focus on… _____

_____

_____

Set the Objective

Together, create a second statement that identifies what the project team is expected to do. This statement should clearly identify what your project team aims to accomplish, and how and when you plan to do it.

1. **Identify the Problem:** Start by stating what specific issue your team will address, such as improving opioid prescription management.
2. **Select Strategies:** State that your team will choose strategies from the toolkit, specifying any specific strategies to include or exclude.
3. **Plan for Approval:** Indicate that the team will present these strategies to practice leaders for approval before moving forward.
4. **Set a Deadline:** Provide a clear timeline for when the team will complete its work, ensuring adequate time for meetings.

> *Ex. “The project team will create a roster of patients treated with long-term opioids and plan workflows to use the roster in planning, delivering, and following up safe and effective care for their chronic pain using strategies from the toolkit. The team will present its recommendations at a provider and staff meeting in three months for review before moving forward with implementation.”*

The project team will create…

This charter (Section 2.3) becomes the starting point for the first team meeting.

2.4 Pick Impact Measure

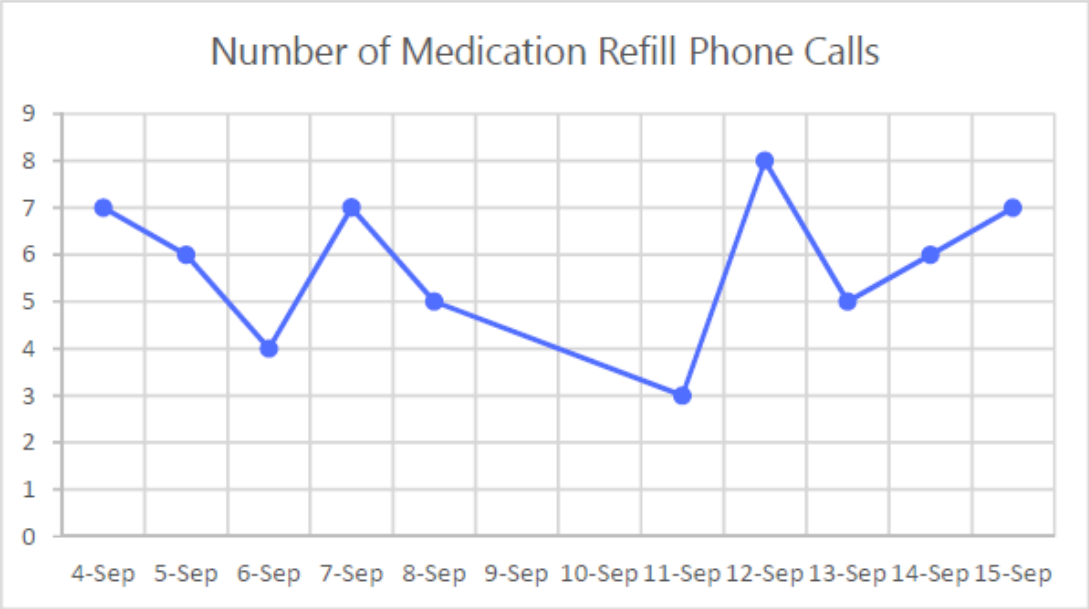
The **OPP Practice leader champion, OPP Team leader, and OPP Team facilitator** meet again to identify a key indicator related to your team's objective that can be measured starting now. This indicator should address a current challenge in your practice. Examples:

- Number of patient requests for opioid prescription refills outside of office visits.
- Provider interruptions regarding opioid prescription refills.
- Pharmacy phone calls about opioid prescription refills.

For patient-centered measures, consider:

- Percentage of qualifying patients educated about/supplied with Narcan (naloxone) seen within a two-week period.
- Percentage of patients exceeding 90 Morphine Milligram Equivalents (MME) daily seen within a two-week period.
- Percentage of patients receiving opioid treatment without a supportive diagnosis seen in a two-week period.
- Patient survey percentage change (such as PEG - Pain, Enjoyment, and General Activity) on outcomes

Data Collection:
Use a simple method, like a log or list, to track occurrences of the indicator during daily workflow and patient care. Choose a two-week period that represents a typical work schedule for your practice (avoid times with holidays, vacations, or significant absences). This log will help you gather relevant data for the project and measure its success later. For example, you could track the total number of medication refill phone calls by day, excluding weekends.



Name of Impact Measure: _____

How will data be collected? _____

Who will collect the data? _____

Date started? _____

Date ended? _____

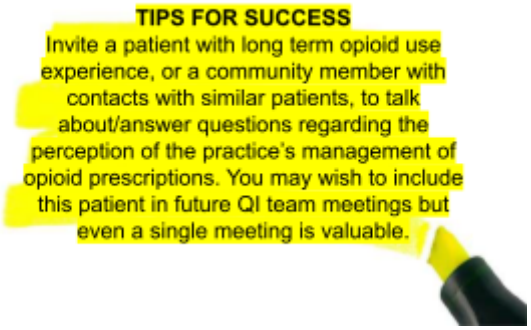
Step 3: Understand Process with the Full Team

In your first team meeting, review the Focus, Charter, and Impact Measure with all team members. Using the following steps, identify key issues by analyzing the flow of opioid prescription processes in your practice. Document, map, and review each step, pinpoint obstacles, and select strategies from the toolkit to address identified challenges.

Estimated Time: 3 Hours

3.1 Start Up Team & Identify Key Issues

Checklist of team meeting prep tasks:



- Folder for each team member
- Legal Requirements checklist (if needed)
- Results of Pre-Survey baseline measure
- List of strategies (QI Strategic Implementation)
- Team members
- Team schedule
- Team Focus and Charter
- Results of Impact Measure

Provide each team member with a folder for their notes. During the first meeting, review the following:

1. **The Team Focus and Charter:** Ask if team members have questions about the focus and charter.
2. **Results of the Baseline Practice Survey (section 1.1) and Legal Compliance (section 1.5):** Discuss any questions or concerns practice members might have that should be addressed.
3. **Results of the Baseline Impact Measure (section 2.4):** Evaluate how well the current prescription management process is working.
4. **Team Discussion:** Write the team's responses to the following question on a whiteboard or flip chart, and have each member keep notes in their folders:
   "What do we already know about our patients, our community, and our way of prescribing opioids in our practice that we should keep in mind?"

Document _____

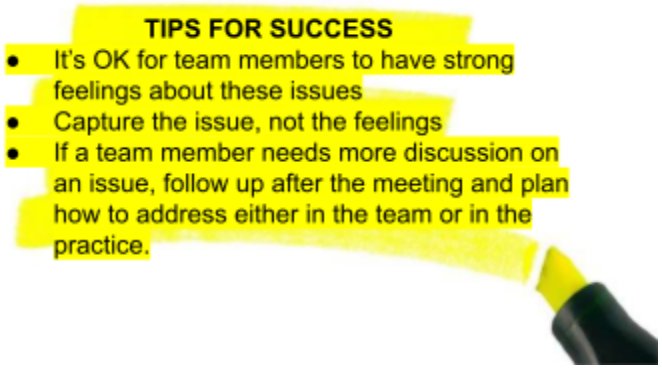
_____

_____

3.2 Analyze the Flow of Work

Make 3 lists:

1) List the concerns the team has about what does not work well in prescribing opioids for patients with chronic pain (too many phone calls, difficulties in tracking what the patients agreed to...)
2) List the strengths the practice has in helping these patients (relationships with patients, a consistent philosophy about caring for patients with chronic pain...)
3) List in what ways a roster of your patients with chronic pain (whether you have one now or not) to identify patients, see them regularly, and document their care consistently might be useful in working on your Team Focus.

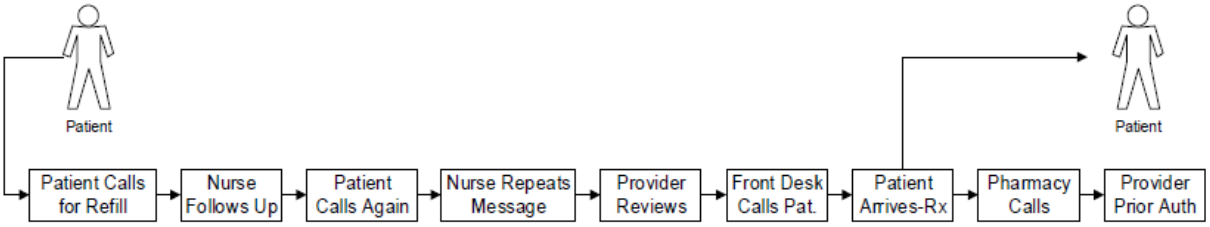


The example used in this Toolkit is: "Scenario B - Transitioning Care: We frequently have patients calling for an early refill from their new prescriber." The team can use this example or another that has been identified as important to prescribers (from the pre-project surveys or the legal compliance review or another source).

Document the following steps on a whiteboard or flip chart, while team members document them in their folders:

A. List the steps that happen in the scenario chosen for the team, detailing each job function involved. For example, if a patient calls for an early refill, the steps might be as follows:
    1. Patient calls for refill
    2. Nurse follow up with chart review and messages provider
    3. Patient calls again to ask about refill
    4. Nurse repeats message to provider
    5. Provider reviews message and chart, refills prescription, and messages front desk
    6. Front desk calls patient to pick up prescription
    7. Patient arrives to pick up prescription
    8. Pharmacy calls to notify that prior authorization is needed
    9. Provider arranges for prior authorization

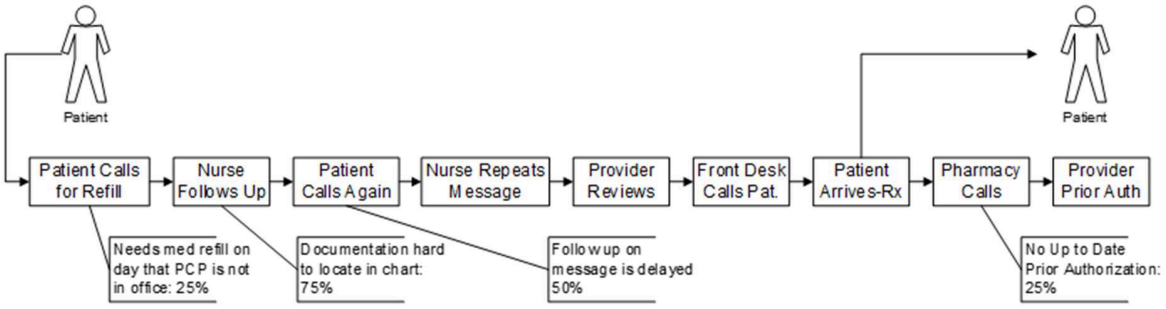
B. Map the steps to illustrate the path taken by the patient to present the process **from the patient's perspective**. Example process map tracking patient experience:



C. Review the process map with the team, stopping at each process step to ask the team the following three questions, one at a time.
   - How often do patients, providers, or staff **experience delays** at this step that make them wait or cause them to make different choices?
   - How often do providers or staff **lack the information** needed for this step?
   - How often do providers or staff **lack resources** (EHR access, clinical supplies, educational materials, etc.) needed for this step?

D. For each process step in which any of the above problems occur, draw a line down from the process step and make a note of the problem and how often it occurs:

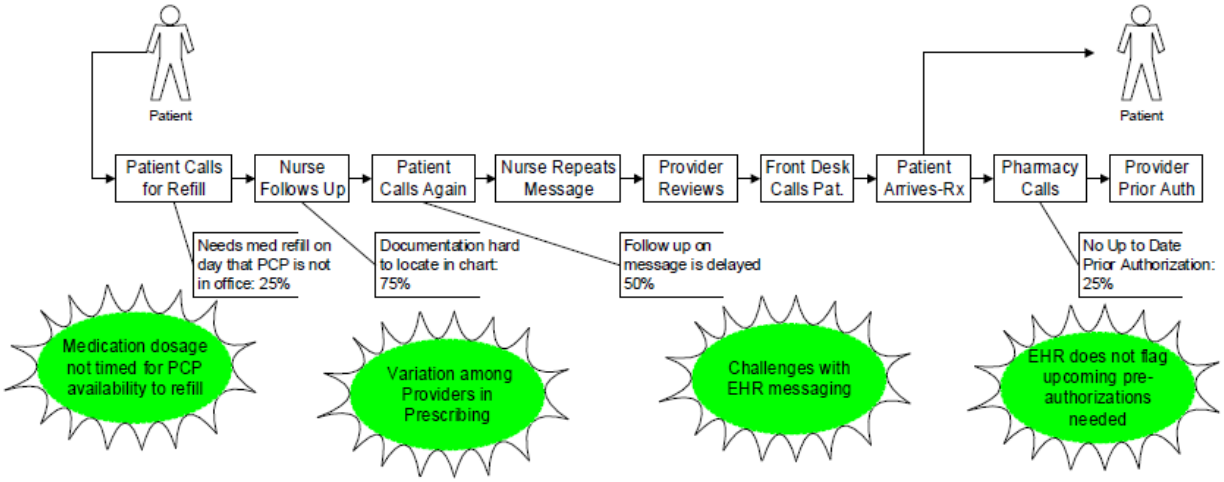
Infrequently: 25% **About half the time:** 50% **Most of the time:** 75% **Always:**100%



3.3 Analyze Challenges and Pick Strategies

Analyze the causes of challenges identified in the process map.

For each problem identified in the process map, ask: "what are the causes of the problems that make it hard to help the patient?" Often a cause has other root causes; ask "why does that happen" until no further causes can be identified. Capture these observations in lightning bursts near the process step. Example:



Review the strategies suggested for your team's scenario (A, B, or C) and select those that are relevant to your prescribers and practice. Note: two strategies have been pre-selected for you as highly recommended:

	Strategies Selected
☑ Strategy 1: Patient Roster	#9: Patient Roster
☑ Strategy 2: Chronic Pain Management Council	#10: CPM Council
☐ Another strategy from your scenario	
☐ Another strategy from your scenario	
☐ Another strategy from your scenario	

Step 4: Design New Process

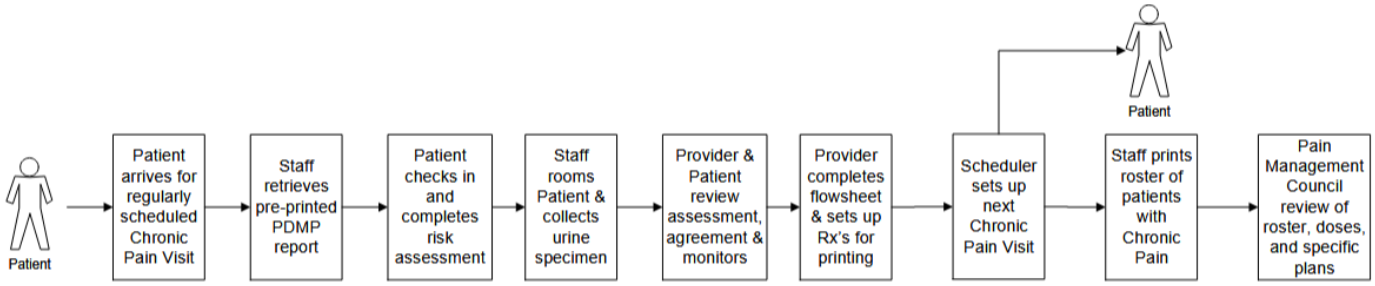
Use the selected strategies to design a new, patient-centered opioid prescription process. Create a new process map, plan the implementation, list all necessary tasks, and ensure thorough communication with every member of the practice.

Estimated Time: 2 Hours

4.1 Design New Opioid RX Process

Map out the workflow that includes your selected strategies to make the workflow clear and smooth for patients and practice members.

A. Create a new process map that incorporates the strategies selected from your Kit and your team's ideas. Map the process from **the patient's perspective**. Example:



B. Every new workflow design can have hidden flaws; this is normal. Consider each of the following possible patient behaviors and check those that might upset the planned workflow. For those checked, plan a response that the whole practice can use for when:

- ☐ Patient can't urinate for urine screen during visit
- ☐ Patient shows up unscheduled and says "I'll wait for the doctor/NP/PA"
- ☐ Someone who is not the patient arrives to pick up the patient's prescription
- ☐ Patient misses specialty appointment(s)
- ☐ Unexpected urine result (either positive or negative)
- ☐ Patient calls for early refill
- ☐ Patient doesn't show up for random urine screen/pill count
- ☐ Patient is rude/loses control
- ☐ Established patient disagrees with the new plan for managing opioid prescriptions
- ☐ Patient asks for different provider than than current prescriber
- ☐ Practice receives an anonymous tip about a patient
- ☐ Patient is very compliant with no "end point;" in other words, the behavior is so stable and predictable that it seems to be "too good to be true"

C. Using your practice's method of developing procedures or protocols, develop a procedure or protocol for the practice to test out using the team's new process map.

Sample Protocol for Team Approach to Opioid Prescription Management

OUR GOAL

Develop consensus among providers to control the prescribing of controlled medications in a way that is consistent across the practice and reduces stress on providers and staff to serve the patients of our community.

OUR CHRONIC PAIN PATIENTS ARE:

- Patients whose treatment is with an opioid for four weeks or more (such as Vicodin, T#3, Percocet, Dilaudid, Fentanyl)
- Patients who are on a stable dose of opioids
- Patients who are seen on fixed interval visits, not more than 84 days apart
- In the electronic record, patients who are listed on the Registry with “R” beside their name

OUR VPMS LOOK UP PROCESSES

Nurse A will:

- Look up patients on the PDMP (Vermont: VPMS) the day prior to visit
- Leave report or notes on the provider’s desk the day prior
- Check for updated agreement/contract and enter in the pink sticky note stating when it was last signed
- Give each nurse a list of patients who need a new contract. Contracts will only be updated for patients who are scheduled for a Chronic Pain Management (CPM) visit, not an acute unrelated issue.

Nurse A will also put into action the Rx prior authorization preparation process.

Provider will review the PDMP patient list and determine who will need a urine sample.

PATIENT ARRIVES

a. Patient arrives on time
b. Nurse will room the patient
c. Patient provides a urine sample
d. Patient is given the updated narcotic contract (if it needs to be updated and the visit is specifically for Chronic Pain)
e. Provider reviews:
    - PDMP (Vermont: VPMS)
    - Labs
    - Telephone encounters
    - Current signed agreement
    - Specialty notes

PATIENT ENCOUNTER

a. Patient Care
b. Provider will go over the agreement/contract with patient and answer any questions regarding the contract. Point out Rx will only be filled at Chronic Pain visits
c. Agreement signed with patient
d. Three prescriptions printed, signed, stapled, and placed in the wall file/basket
e. Future prescriptions will have a DO NOT FILL DATE
f. DO NOT GIVE TO PATIENT until he/she is at check out
g. Attach the updated contract with the prescriptions for check out staff to scan and give to patient
h. Counseling on prior authorization

CHECKOUT/PHARMACY

A. Schedule the next CPM visit
B. Give prescription to patient and instruct to bring it to their pharmacy
C. Scan the new agreement/contract
D. Give copy of contract to patient
E. Patient gives all three prescriptions to their designated pharmacy to be filled and to keep future prescriptions
F. Nurses have a prior authorization binder. This is kept in the nurses’ station and updated monthly by the Referral Nurse

4.2 Plan Implementation

Create an implementation plan, listing all tasks needed to carry out the implementation plan.

Instructions: Develop an implementation plan for each step in the new process. Name each task, who will take the lead, and the date the task should next be updated with the team.

Select measures to track to help make sure that the strategies are working.

What	Who	By When	Outcome & Next Step
Current Plan			
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
Measurement:			
1)			
2)			
3)			

TIPS FOR SUCCESS

When putting your Implementation Plan into action, pick one or two strategies to try out at a time. This helps the team:

- Learn quickly about what's working and what's not
- Make adjustments that don't disrupt other parts of the Implementation Plan

Example Implementation Plan:

What	Who	By When	Outcome & Next Step
Current Plan			
1) Maintain Registry of Opioid patients	All Providers	Ongoing	Staff A will run a new report. Providers will recheck and remove patients who are occasional users.
2) Develop Front Desk Protocol	Staff B, Staff C, and Practice Manager	**DONE**	Check with staff at next meeting for fine tuning and adjustments. • Patients who will not be scheduled for Chronic Pain Management visits will not be on registry • Patients who are on the registry and call for an early re-fill will be told "No" by all staff • Patients not on the registry and call for a refill or an early refill will be transferred via message to the PCP. If the PCP is not available, the covering provider will refill to next PCP visit.
3) PDMP Review prior to Chronic Pain Management visit	Nurse A	Soon	Waiting for password from Health Department. Will trial and share with nursing staff.
4) Update agreement to include "refills at appointments only"	Practice Manager & providers	9/15/25	Finalize draft, remove all old copies, and replace Nurses to include with PDMP reports
5) Wall sleeve for Rx mounted near printer (Front Desk basket for now); stapler nearby	Practice Manager	9/25/25	To be ordered
6) Prior authorization notebook with monthly tabs for tickler	Nurse B	9/18/25	Set up and share with all nursing staff
7) Add updated Patient Agreement to rooming process	Nurse A	Soon	
8) Identify case studies from roster for next Pain Management Council mtg	Project Champion	October	Provider meeting agenda item to be updated every month for six months
Measurement:			
1) Track phone call volume for opioid refills	Nurse A, Nurse B, & Practice Manager	Completed for 1st 2 weeks June	Repeat for 1st half of October by Triage Nurses. Practice Manager will post data sheet on wall.
2) Note practice deviations from protocol	Everyone	Ongoing	Bring to next meeting - August
3) Post-Project Survey to be repeated in early Dec.	Staff D		1st half of December

4.3 Communicate

Communicate thoroughly with every member of the practice, clinical & non-clinical. Use multiple methods:

How will info be shared? _____

_____

_____

Who will share the info? _____

Date Started: _____

Date Ended: _____

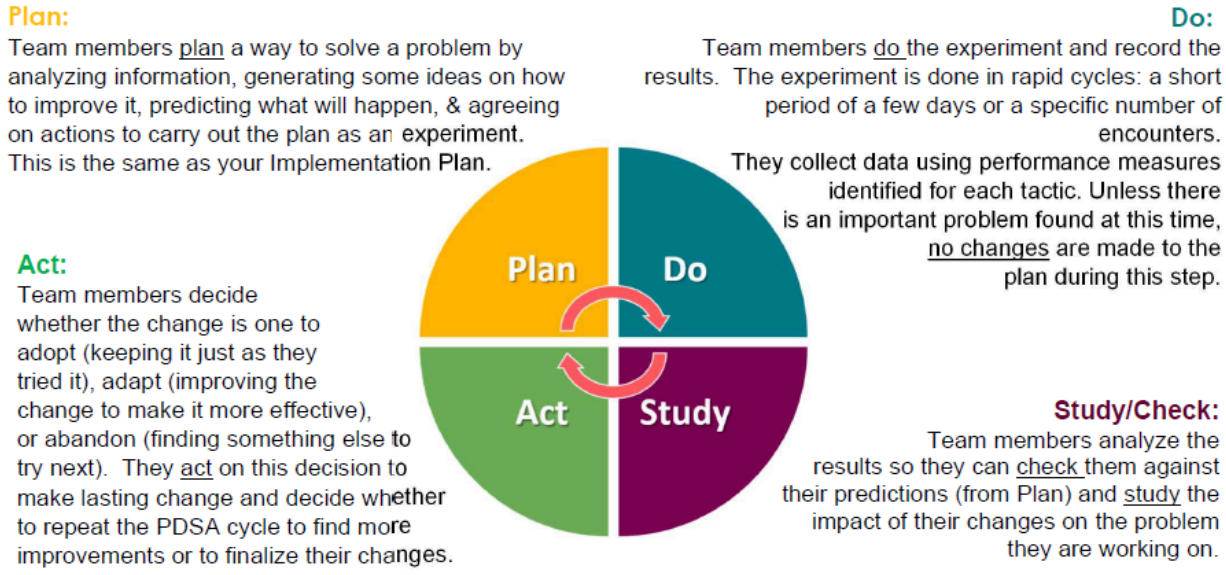
Step 5: Implement

Regularly meet to monitor progress using Plan-Do-Study-Act (PDSA) cycles. Utilize the provided PDSA cycle check-in form for documentation. As you near completion, re-measure the key indicator, set up post-surveys, and conclude the project by celebrating your team's success.

Estimated Time: 3 Hours

5.1 Check In

Meet briefly and regularly to check on progress, using PLAN | DO | STUDY | ACT cycles (PDSA). PDSA is similar to the methods used by scientific studies when applied to problem solving. It is used by many healthcare organizations for quality improvement projects. The four steps of PDSA are often presented as a repeating cycle of continuing step



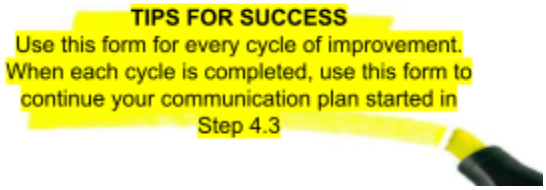
PDSA is a repetitive, four-step cycle of problem-solving, represented by arrows pointing in a clockwise direction. For a health care example, please watch this 6-minute video:

https://youtu.be/8Q7qnNpTWxM?si=yFOpW2dQxWj3HzZj

Use the PDSA Cycle Check-In-Form on the next page to track the team's work over several meetings until the new process fits the practice workflow and is stable.

PDSA Cycle Check-In-Form

For each team meeting in this step, discuss and document the following:



Cycle # and date _____

Our PLAN for this cycle: _____

We will DO this cycle and measure the results by:

We STUDIED the results and have the following conclusions:

We ACTED on our conclusions by deciding to adopt, adapt, or abandon the following parts of our plan and continue to a new PDSA cycle (on a new page) or to end our team's work here:

5.2 Repeat Impact Measure From Step 2

When the team's work is nearly done, repeat measurement of the key indicator from Step 2.4. As before, select a two-week period that is "normal" for the practice (no holidays, vacations, large number of absences due to medical leave, etc.). Compare the baseline measures to current. Example graphs of baseline and post project data below show medication refill phone calls by day (without weekends).

Name of Impact Measure: _____

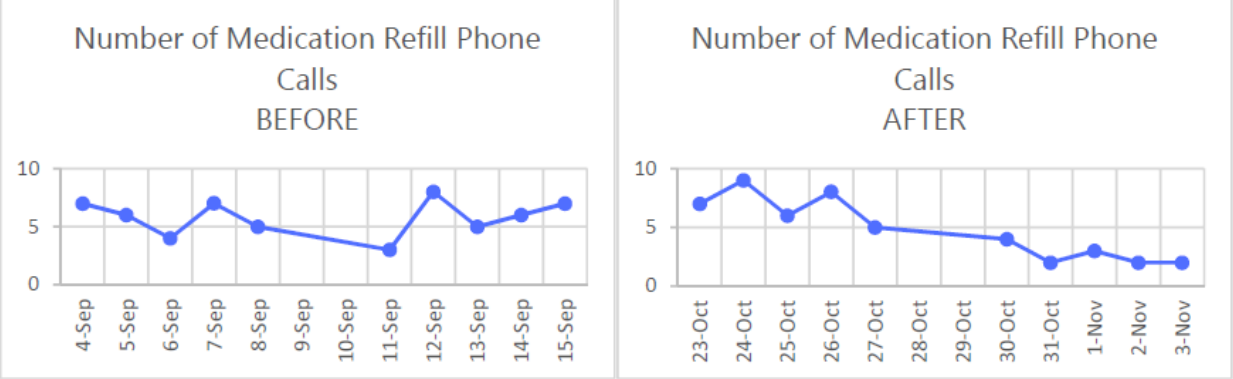
How will data be collected? _____

Who will collect the data? _____

Date Started: _____

Date Ended: _____

Example:



5.3 Post-Project Survey

Redistribute the survey from 1.1 Conduct Pre-Project Survey to conduct post-surveys for all practice members as a current measure.

TIPS FOR SUCCESS

Remember that teamwork is always something to celebrate. Even if the team didn't accomplish everything it planned to, celebrate what it did accomplish. There can always be a "next time" to try some strategies again!

5.4 Conclude and Celebrate

How and when will you celebrate the completion of Toolkit?

_____

_____

Scenario A: Start Opioid Treatment for Patients with Chronic Pain Patients

Patients who are not currently on opioids need a thorough evaluation before starting.

"What are all the factors I should consider before prescribing?"

Starting a patient with chronic pain on opioids

When taken together, the guidelines and latest research have a sobering message: that there are very few patients who get clinically significant improved pain and function by using opioids for chronic pain. Most patients who feel that they are getting improvement from opioids are likely experiencing reduced pain-related anxiety as opposed to reduction in pain and an improvement in function. Therefore, the vast majority of patients with chronic pain should not be on opioids for their pain management.

This begs the question: Who should be on opioids for chronic pain? What characteristics define the patients that will truly benefit from opioids? There is no direct research that answers this question. However, we can assemble available research and guidelines to come up with some ideas. The following guide is meant to provide a structured approach to evaluating patients who may benefit from opioids for chronic pain. It is meant to enhance but not replace a clinician's own assessment along with other information available for specific patients that may influence medical decision making.

There are two ways to prescribe opioids for chronic pain: daily scheduled use and opioids for breakthrough only. Less information is available to identify candidates for breakthrough only.

Daily use of opioids

Step 1. Assess likelihood of benefit

A. Does the patient have severe, debilitating pain? Mild to moderate pain without major impact on function is usually well controlled by other lower risk measures. Quantifying the functional impact of chronic pain is ideally done by using a validated tool.
B. Has the patient tried all disease specific and general chronic pain treatments? Due to advances in research, there is a very long list of evidence-based therapies for most specific causes of chronic pain and for chronic pain in general. Though barriers to some of these therapies may exist for some patients, a patient reporting a lack of access to an evidence based therapy should not immediately rule in the use of opioids as an alternative. It is common for patients in chronic pain to lack self-efficacy both in their health and finances. Patient empowerment is not only preferable, but can be very therapeutic and part of the recovery process.
C. Does the patient have a health condition likely to respond to opioids? Many conditions are felt to be unresponsive to long term use of opioids either due to the nature of the condition or possibly the effects of tolerance. In some cases opioids are felt to worsen the

underlying condition. The following list comes from consensus and/or research. Patients who have one of the following conditions should refrain from taking opioids long-term, on a daily basis: migraine, fibromyalgia, irritable bowel and functional bowel syndromes, or non-specific low back pain. By extension myofascial pain of any type arguably should not be treated with opioids.

Step 2. Assess the risk of opioid therapy

A. Risk of addiction –The research suggests that most patients on opioids for chronic pain are much more likely to develop addiction than they are to have a meaningful improvement in pain and function. Selecting patients with low risk for addiction is an important step in increasing a favorable risk-benefit ratio. There are three methods of determining risk of addiction; the use of validated tools, epidemiological predictors, and urine drug screens.
B. Risk of overdose – patients on benzodiazepines in addition to opioids are the largest risk factor for overdose. In addition, the use of other sedating medication, alcohol use, and sleep apnea are other potential risks to consider
C. Risk of other complications – chronic constipation, presence of a second cause of pain that could get worse on opioids (such as migraines), potential for medication interaction
D. Safe environment for medication storage and delivery – A concerning phenomenon has been the abuse of prescription drugs by family members and other caregivers including overdose. When patients are unable to store and administer their own medication extra caution should be exercised and precautions be put in place.

Step 3. Assess response to opioids

Patients who are started on scheduled opioid therapy should have their response to therapy closely monitored. Specifically, function should be measured by a validated tool and whenever possible confirmed another way. According to the CDC, improving one's function is not enough. At least a moderate improvement in function (30% or more) is required to validate the ongoing use of opioids and balance the potential risks of therapy.

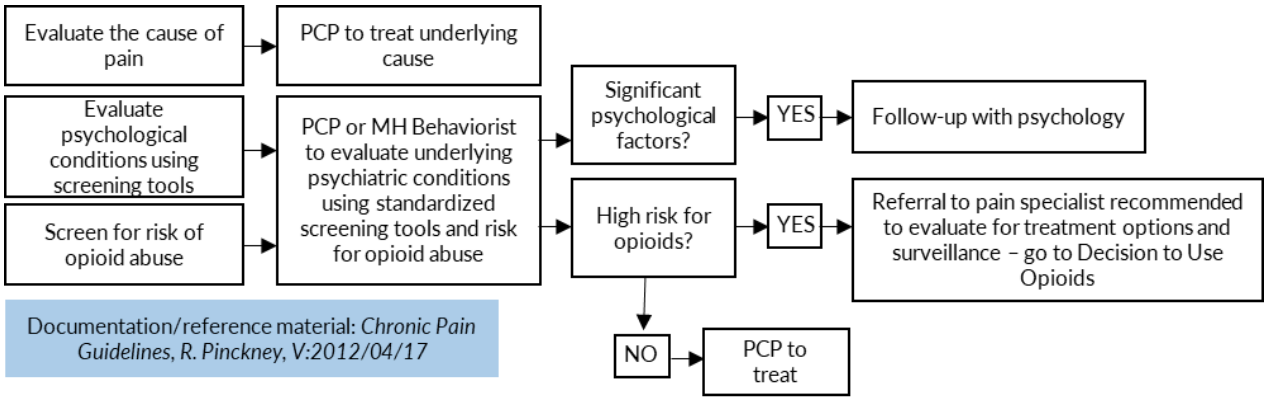
Use of opioids for breakthrough pain only

For some patients, their daily pain is successfully managed by other methods but they experience intermittent, severe, debilitating exacerbations in their pain. Many pain treatments are not easily administered for acute pain or require time to work, making opioids an attractive option. The challenge in determining ideal candidates for breakthrough-only opioid treatment is that there are no long-term data about the success of this approach as there is for daily opioid therapy. Also, functional tools are not validated for breakthrough pain treatments.

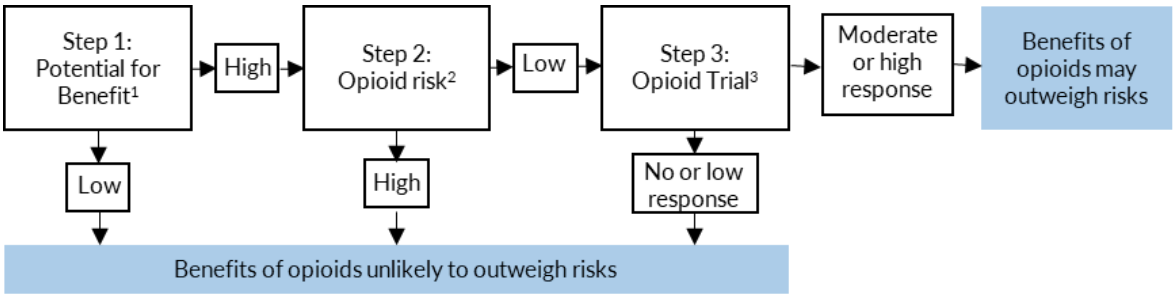
Scenario A: Start Opioid Treatment for Chronic Pain Patients

Guidelines for Use of Opioids in Chronic Pain

Initial Evaluation



Treatment General



[1]Potential for benefit is high when:
a. The patient has severe debilitating pain AND
b. The patient has tried all disease specific treatments and general chronic pain treatments AND
c. The patient does not have one of the following causes of chronic pain: Fibromyalgia, Migraines, osteoarthritis of the knee or hip, functional bowel syndrome, non-specific low back pain

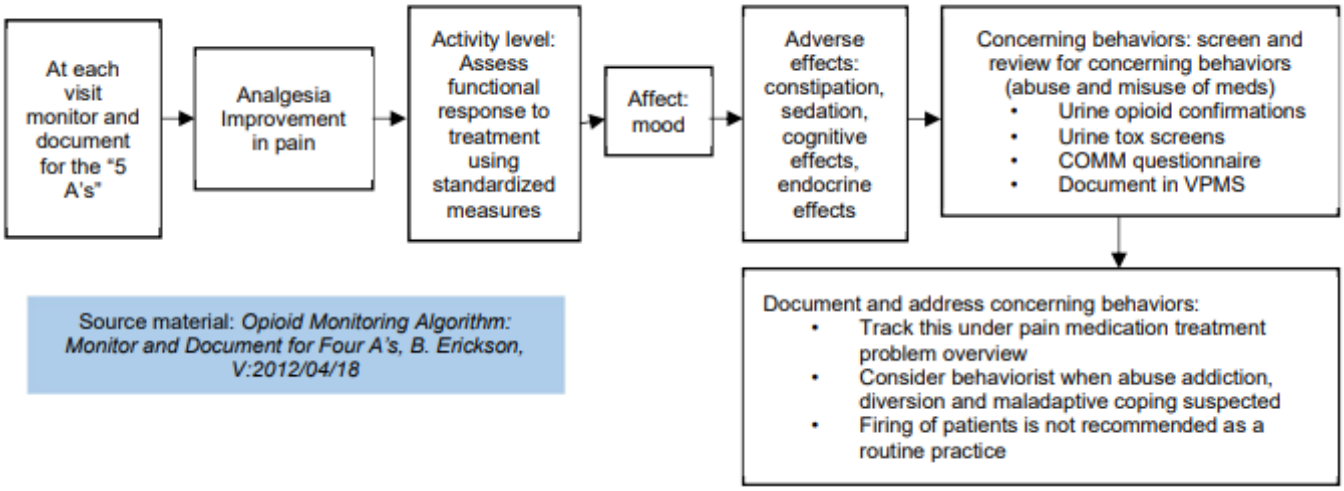
[2]Opioid risk is low when:
a. Addiction risk is low
➢ No addiction risk factors:
- No incarceration
- Non smoker
- No substance abuse history
- No family hx substance abuse
- No current THC use
➢ ORT or SOAP-PR is negative
➢ Negative urine drug screen
a. Overdose risk is low
➢ No use of benzodiazepines
➢ See other risks above
a. No medical contraindications
b. Safe environment for storage and administration

[3]Opioid trial:

A patient should have a 30% or greater improvement in a standardized measure of function and of pain

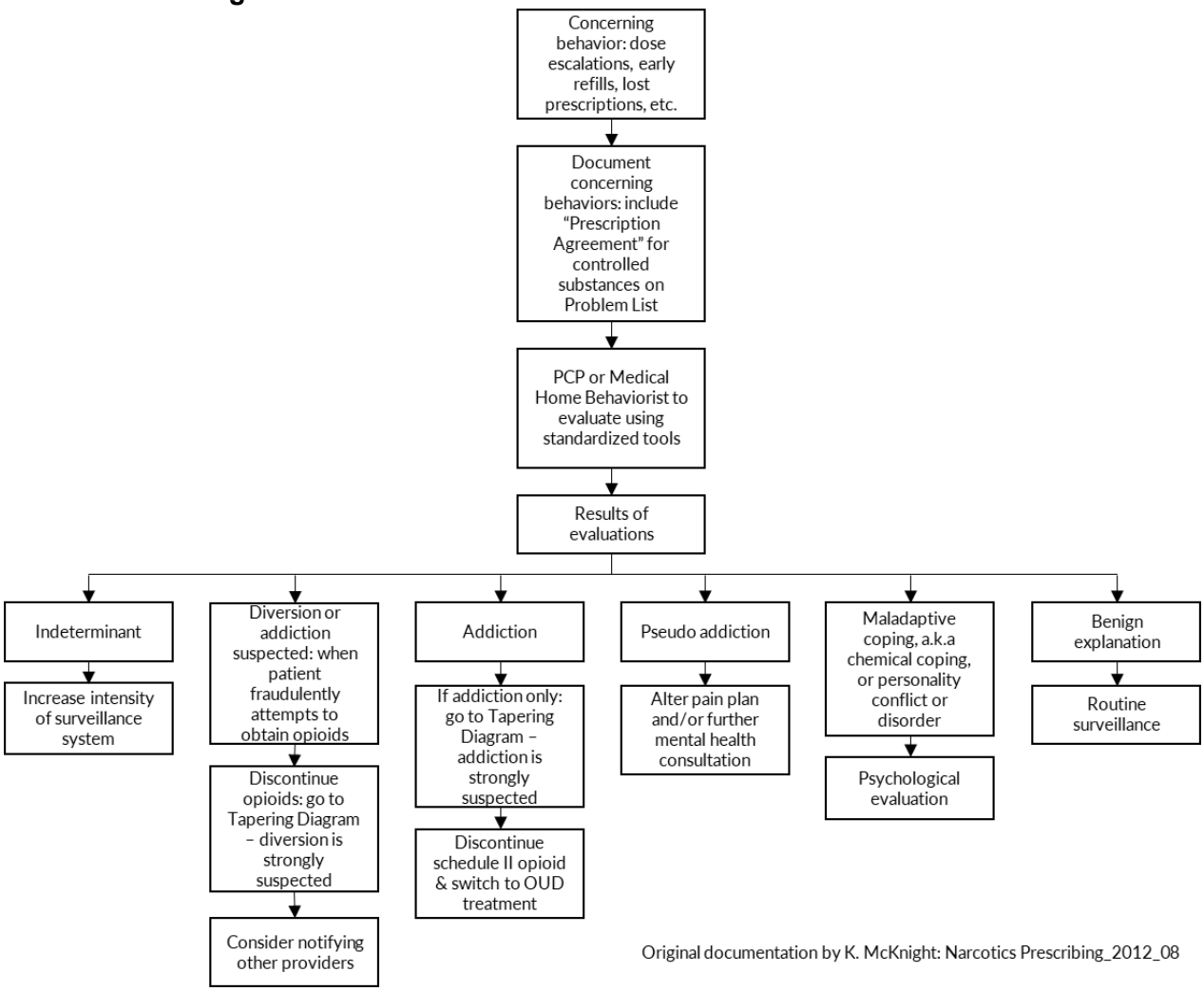
Scenario A: Start Opioid Treatment for Chronic Pain Patients

Opioid Monitoring



Source material: *Opioid Monitoring Algorithm: Monitor and Document for Four A's, B. Erickson, V:2012/04/18*

Concerning Behaviors



Original documentation by K. McKnight: Narcotics Prescribing_2012_08

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Questions to consider

- "What are all the factors I should consider before prescribing?"

Assess

- “How do I conduct an initial risk assessment?”
- “How do I identify and find alternatives to opioids for managing chronic pain?”
- "How do I address a co-existing Opioid Use Disorder and co-existing mental health conditions?"
- “How can I monitor and manage side effects for my patients with chronic pain while on opioid therapy?”
- "How can I track and improve a patient's ability to perform daily activities while on opioid therapy?"
- "How do I assess and manage a patient's pain during opioid therapy?"
- "How can I recognize behaviors that may signal opioid misuse and engage patients in therapeutic conversations that promote safety and trust?"

Manage

- “How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?”
- “How can I share important patient care issues and cases with my peers?”

Monitor

- “How often should I check the Prescription Drug Monitoring Program?”
- “How often should I collect urine samples from patients on opioid therapy?"
- “How should I establish and maintain expectations with patients starting opioid therapy?”

Prescribe

- "How should I approach the initiation of opioids while adhering to CDC guidelines and considering the risks associated with dosage levels?"
- “How should I optimize medication dosages to enhance patient convenience and adherence?”

Document

- "How should I track and manage opioid dosages?"

Schedule

- "How should I manage the transition from short-term to long-term opioid therapy?"

Engage

- “How can I help my patients find community resources that offer alternative methods for managing chronic pain?”
- “How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?”
- “How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?”
- “How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?”

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Assess

This step involves evaluating the patient's pain condition, medical history, and risk factors for opioid misuse. It includes assessing pain intensity, duration, and impact on daily life, as well as screening for any co-existing conditions or substance use disorders.

Assess at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How do I conduct an initial risk assessment?"	#1 Initial Risk Assessment
"How do I identify and find alternatives to opioids for managing chronic pain?"	#2 Non-Opioid and Non-Pharmacological Treatment
"How do I address a co-existing Opioid Use Disorder and co-existing mental health conditions?"	#3 Arrange MAT for OUD Patients and Those with High-Risk Traits
"How can I monitor and manage side effects for my patients with chronic pain while on opioid therapy?"	#5 Assess side effects (bowel habit, nausea, vomiting…)
"How can I track and improve a patient's ability to perform daily activities while on opioid therapy?"	#6 Assess patient function
"How do I assess and manage a patient's pain during opioid therapy?"	#7 Assess patient pain
"How can I recognize behaviors that may signal opioid misuse and engage patients in therapeutic conversations that promote safety and trust?"	#8 Recognize special issues

Assess

"How do I conduct an initial risk assessment"

Before starting a patient on opioid treatment, it is necessary to assess their risk of misusing or abusing controlled substances. These assessments are quick and can be done by the provider during the medical exam or by the patient before the appointment.

Factors that increase the risk of abuse include personal or family history of substance abuse, past experiences of preadolescent sexual abuse, mental health conditions, social habits involving drug use (including cigarettes), stress levels, signs of abuse or misuse behaviors, and poorly managed pain (which is the main risk factor for misuse).

Scenario A: Start Opioid Treatment for Chronic Pain Patients

To mitigate the risk of misuse and abuse, patients should be screened to identify any potential risks, and treatment should be tailored accordingly. Various tools are available for this initial assessment in *Appendix 1: Initial Assessments*, including:

- **ORT** (Opioid Risk Tool) – A questionnaire with 5 questions to be completed by the clinician with the patient.
- **SOAPP-14** (Screener and Opioid Assessment for Patients with Pain) - 14 questions
  SOAPP-SF (Screener and Opioid Assessment for Patients with Pain) - 5 questions
- **SOAPP-R** (Revised Screener and Opioid Assessment for Patients with Pain) – 24 questions
- **Chronic Pain Assessment Algorithm and DIRE Score** – Evaluates 7 risk factors and is conducted by the provider.

Additionally, there are related tools available online or from professional organizations, such as:

- **Patient Self-Report Tool**
- **Mental Health Screening Tool**
- **Substance Abuse Risk Factors Tool**

Additional tools are available in this Toolkit for ongoing monitors of risk (Strategy #4) and side effects (Strategy #5).

These assessments help ensure that opioid treatment is used safely and effectively, minimizing the risk of misuse, abuse, and addiction by starting with an initial assessment before prescribing starts.

Go to #1 Initial Risk Assessment for specific QI strategies.

Assess

"How do I identify and find alternatives to opioids for managing chronic pain"

Research shows that opioids aren't necessarily better than other treatments for chronic pain. Instead of opioids, there are many options to consider. These include:

- **Medications:** Acetaminophen, NSAIDS, certain antidepressants, and injections into painful joints.
- **Topical** medication
- **Non-Drug Options:** Such as chiropractic care or osteopathic manipulation, low-level laser (for low back pain and chronic neck pain), acupuncture, physical therapy, yoga, tai chi, and counseling to change thoughts and behaviors.

It's important to weigh the pros and cons of each treatment carefully before deciding what's best for each patient. See Krebs, E. E., A. Gravely, et al. (2018) for comparison of alternative treatments (Methods:https://jamanetwork.com/journals/jama/fullarticle/2673971; see References).

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Go to #2 Non-Opioid or Non-Pharmacological for specific QI strategies.

Assess

"How do I address a co-existing Opioid Use Disorder and co-existing mental health conditions?"

Many patients with opioid addiction also have chronic pain or/and mental health issues like anxiety, depression, ADHD, or PTSD. They may have experienced difficult life events or trauma. It's important for primary care clinicians to watch for signs of substance abuse and connect patients with the right treatment, like medication-assisted therapy.

Patients diagnosed with Opioid Use Disorder (OUD) are not candidates for non-palliative opioid therapy for pain, whether short-term or long-term. Primary care clinicians may need to decide whether to keep seeing a patient or refer them for treatment. This decision should consider the patient's needs, office staff, and the community. Suddenly stopping care could make the problem worse and affect future treatment.

Go to #3 Arrange MAT… for specific QI strategies.

Assess

“How can I monitor and manage side effects for my patients with chronic pain while on opioid therapy?”

Common side effects of opioids include nausea, constipation, over-sedation, itching, and feeling depressed. Less common side effects can be serious, like breathing problems, stomach issues, increased pain sensitivity, and muscle stiffness. Regularly ask your patients about these side effects to catch and manage them early.

Go to #5 Assess side effects … for specific QI strategies.

Assess

"How can I track and improve a patient's ability to perform daily activities while on opioid therapy?"

At the initial appointment, assess how well the patient is able to do daily activities. It's important to focus on improving function, even if pain is still present. While the benefits of opioid therapy can vary, the risks are well-known.

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Use tools to set and track realistic goals with patients. For example, the Pain, Enjoyment, and General Activity (PEG) Assessment Scale measures improvements in daily activities, with a moderate improvement defined as a 30% decrease in pain and function-interference scores.

Available tools for ongoing assessment are found in *Appendix 2: Ongoing Assessment*:

- ☐ **PEG:** Pain, Enjoyment, and General Activity
- ☐ **SF12:** Short Form 12
- ☐ **Oswestry** neck and back
- ☐ **Rapid 3**: Routine Assessment of Patient Index Data
- ☐ **PADT:** Pain Assessment and Documentation Tool

Go to #6 Assess Patient Function for specific QI strategies.

Assess

"How do I assess and manage a patient's pain during opioid therapy?"

At the initial appointment, assess the patient's pain levels. It's important to keep track of pain throughout opioid therapy, though the main goal should be improving function. Discuss realistic goals for reducing pain with patients early on, as chronic pain may not completely go away for many patients.

According to CDC guidelines, if patients using opioids don't experience pain relief within a month, they're unlikely to benefit and should have their dosage tapered or reduced.

Tools for ongoing pain assessment found in *Appendix 2: Ongoing Assessments* include:

- **PEG** includes “Pain, Enjoyment of life, and General activity” (PEG) as recommended by the Centers for Disease Control (CDC). A significant improvement is considered a 30% decrease in pain and function-interference scores.
- **PADT:** Pain Assessment & Documentation Tool (completed by provider and patient)

Go to #7 Assess Patient Pain for specific QI strategies.

Assess

"How can I recognize behaviors that may signal opioid misuse and engage patients in therapeutic conversations that promote safety and trust?"

In addition to the validated tools used for the assessment of an individual’s risk for misuse, prescribers can be alert to other behaviors that may be associated with opioid misuse, such as: negative urine test, incorrect pill counts, missing appointments, repeatedly misinterpreting instructions, rude behavior with staff, creating conflict between prescriber and staff (“splitting”), and others. Using a respectful and thoughtful team approach assures consistent messaging and helps keep prescribers and staff on the same page. Conversations with patients that share

observations and ask open ended questions to elicit new information can help in updating treatment plans appropriately.

Go to #8 Recognize Special Issues for specific QI strategies.

Manage

In managing the care of chronic pain patients when initiating opioids, it is important to have a systematic way to manage the panel and use approaches to care supported by all prescribers. These two strategies connect clinicians with their panel of patients with long term opioids and with each other.

Manage at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?"	#9 Roster: Use your health record system's registry to create population management reports
"How can I share important patient care issues and cases with my peers?"	#10 Update your Chronic Pain Management Council

Manage

"How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?"

Panel management is useful in managing many chronic conditions. It is characterized by a set of tools and processes to identify patients and support structured workflows based on evidence-based protocols, especially for those at high risk. Panel management depends on customizable, timely data reporting under local control and the ability to benchmark to guide improvement.

Prescription Drug Monitoring Programs (PDMPs), which track controlled substance prescriptions, provide a widely available source for panel management. PDMP data, when aggregated across clinicians, can provide a practice-wide view of prescribed medications, dosage, prescribing intervals, and concurrent prescriptions of benzodiazepines, to support a panel management approach to opioid treatment.

Go to #9 Roster… for specific QI strategies.

Manage

"How can I share important patient care issues and cases with my peers?"

The Chronic Pain Management Council gives primary care clinicians time to review and discuss each patient's treatment history and plans. This helps maintain a consistent approach across the practice, especially when new providers join or long-term providers leave. It also shares the

responsibility of opioid prescribing and provides a second opinion on the patient's suitability for chronic opioid therapy.

Providers meet regularly or as needed to review the charts of long-term chronic pain patients on opioid treatment. Decisions about medication changes or discontinuations happen separately from patient visits. The primary provider gathers information from the patient and presents it to the Council, which then offers an objective perspective. The primary provider then meets with the patient to review the Council's recommendations and plan the next steps.

Go to #10 Update your Chronic Pain Management Council …for specific QI strategies.

Monitor

Before initiating opioid therapy for chronic pain patients, it is important to establish a monitoring plan to ensure safe and effective treatment. This strategy involves several key actions for checking on your patient. These measures help mitigate risks, promote patient safety, and facilitate informed decision-making in the management of chronic pain with opioids.

Monitor at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How often should I check the Prescription Drug Monitoring Program?"	#11 Check Prescription Drug Monitoring Program
"How often should I collect urine samples from patients on opioid therapy?"	#12 Screen urine at least annually for presence/absence of substances
"How should I establish and maintain expectations with patients starting opioid therapy?"	#14 Provide patient education on benefits and risks…

Monitor

"How often should I check the Prescription Drug Monitoring Program?"

Your PDMP provides access to all dispensed medications by pharmacies in your state regardless of payer source, including cash, but may not include medications dispensed in Emergency Departments, hospitals, or clinics specializing in addiction management (i.e., Suboxone clinics). Access to your PDMP is allowed to any prescriber and delegated staff working for the prescriber's practice. Pre-registration and authorization are required. For more information visit the PDMP of your State Department of Health[1].

Prescribers are advised to query the PDMP in the following circumstances:

- Prior to writing a first opioid prescription for 10+ pills (e.g., opioids, tramadol)
- Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
- Prior to starting a patient on an opioid for a trial or short-term treatment of chronic pain
- Prior to starting a patient on a chronic opioid (90+ days) for non-palliative therapy
- Prior to writing a replacement (e.g., lost, stolen) of any scheduled II-IV controlled substance

[1] For Vermont sites, visit Vermont Prescription Monitoring System (VPMS)

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Go to #11 Check Prescription Drug Monitoring Program for specific QI strategies.

Monitor

"How often should I collect urine samples from patients on opioid therapy?"

Periodically, and at least annually, collect a urine sample from all opioid therapy patients to test for the presence/absence of controlled substances. Note that there is no high-quality evidence that urine testing is an effective monitoring activity. However, urine screening is included in many national and state guidelines and is an expectation of good practice, even for low-risk patients. Depending on your practice's experience with collecting urine samples, random collection may be appropriate at non-predictable intervals. There is a great deal of anecdotal evidence that most patients who comply with urine screening are not misusing or abusing their medications. However, those who do misuse often have strategies to conceal this fact from their providers. Random screening helps providers identify patients who are not honest about their medication usage.

Go to #12 Screen urine at least annually… for specific QI strategies.

Monitor

"How should I establish and maintain expectations with patients starting opioid therapy?"

Prescribers should provide comprehensive patient education on the benefits and risks of opioid therapy. This includes discussing the potential for dependence, side effects, and the goals of treatment. The education process should emphasize that opioid therapy is not necessarily a permanent treatment for pain and that the ultimate goal is to maintain or improve health and function. This information should be reflected in the informed consent and patient agreement documents.

At regular intervals, and at least annually, review the patient agreement with the patient. Ensure both the patient and provider are complying with the agreed-upon expectations. This is important because the risk of opioid misuse remains high throughout the entire treatment period. Regularly reviewing the expectations helps reinforce the understanding that opioid therapy is not necessarily a permanent solution for pain. It reminds the patient that the ultimate goal is to maintain or improve their health and function.

Go to #14 Provide patient education… for specific QI strategies.

Prescribe

Consider how to tailor prescribing practices, including such strategies as co-prescribing naloxone and adhering to prescribing opioids in multiples of seven days. These practices are designed to enhance patient care by minimizing risks associated with opioid therapy while promoting responsible prescribing habits aligned with current guidelines.

Prescribe at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How should I approach the initiation of opioids while adhering to CDC guidelines and considering the risks associated with dosage levels?"	#15 Best practices in prescribing for targeted patients
"How should I optimize medication dosages to enhance patient convenience and adherence?"	#16 Prescribe in multiples of 7 days in duration of dosage

Prescribe

"How should I approach the initiation of opioids while adhering to CDC guidelines and considering the risks associated with dosage levels?"

When starting opioid therapy, begin with the smallest effective dose and increase gradually, typically using immediate-release medications. It's important to reassess the risks and benefits, especially if the dose surpasses 50 morphine milligram equivalents (MME) per day, as higher doses increase the risk of overdose and death. Doses exceeding 90 MME/day are in the highest risk category and require thorough documentation to justify their necessity.

Naloxone, a non-addictive medication, reverses opioid effects and can quickly counter life-threatening issues like breathing problems, sedation, and loss of consciousness. Patients on higher opioid doses, those also using benzodiazepines, and those with a history of overdose or substance use disorder face an increased risk of overdose death, despite potentially not recognizing their own risk. Encourage all patients, family members, and caregivers to have naloxone readily available to respond promptly to opioid emergencies.

Go to #15 Best practices in prescribing for specific QI strategies.

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Prescribe

"How should I optimize medication dosages to enhance patient convenience and adherence?"

When prescribing medications, choose doses that last for multiples of 7 days (e.g., 28 days, 56 days, 84 days). This approach is useful for medications that don't come in fixed packages from the manufacturer. For example, prescribing for 28 days instead of 30 avoids refills falling on weekends and ensures they coincide with days when the prescribing clinician is available.

It's beneficial to start medication refills mid-week (Tuesdays through Fridays). This timing helps ensure that refill requests arrive when the practice is open, avoiding delays due to weekends. Patients may take up to three days to fill their prescriptions, so adjust the quantity to ensure the next refill is due on a day when the primary provider is typically available to handle refill requests.

Go to #16 Prescribe in Multiples of 7 for specific QI strategies.

Document

Proper documentation is a critical step in the process of initiating opioid therapy for chronic pain. It ensures that prescribers have a clear and accurate record of the patient's treatment plan, dosage, and response to the medication.

Document at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How should I track and manage opioid dosages?"	#21 Track dosage in MMEs, not quantity dispensed

Document

"How should I track and manage opioid dosages?"

Prescribers should have a readily available method for converting different opioids into milligram morphine equivalents (MME). The Centers for Disease Control (CDC) offers online and phone apps to help with this. Remember, methadone dosing can be tricky because its conversion rate changes based on the daily dose.

Go to #21 Track dosage in MMEs of 7 for specific QI strategies.

Schedule

Scheduling follow-up appointments is an important step in initiating opioid therapy for chronic pain. This step ensures that prescribers can closely monitor the patient's response to the new medication, adjust the dosage if necessary, and manage any potential side effects.

Schedule at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How should I manage the transition from short-term to long-term opioid therapy?"	#23 Short interval follow up after initiating new Rx to review effect

Schedule

"How should I manage the transition from short-term to long-term opioid therapy?"

When patients move from short-term to long-term opioid therapy, the transition can sometimes be unclear. It's important to be extra cautious during the early stages of opioid therapy. This means having frequent follow-ups and regularly reassessing the risks and benefits. Many clinicians suggest creating a clear "exit plan" when starting therapy. This plan includes discussing how long the treatment is expected to last and what to do if it doesn't work. This information is often included in patient consent and treatment agreement forms (see #14 Patient Education).

Go to #23 Short interval follow up… for specific QI strategies.

Engage

The "Engage" step focuses on connecting patients with resources, building a comprehensive patient library, fostering community support, and sharing valuable skills. These actions are important for ensuring patients receive well-rounded care.

Engage at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I help my patients find community resources that offer alternative methods for managing chronic pain?"	#25 Identify community resources that may be helpful and update periodically
"How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?"	#26 Build a patient library with books, CDs, etc.
"How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?"	#27 Build community support with other partners/agencies
"How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?"	#28 Share skills that are widely useful, e.g. how to have "trigger" conversations

Engage

"How can I help my patients find community resources that offer alternative methods for managing chronic pain?"

Every community offers unique resources that can help patients manage chronic pain in different ways. Create a one-page guide with website links so patients can easily access these resources:

- Chiropractic care
- Low-level laser (for low back pain and chronic neck pain)
- Acupuncture
- Traditional Chinese Medicine
- Mind/Body approaches like stretching, medication management, relaxation techniques, stress management, and mindfulness
- Chi Kung or Qigong (Chinese yoga) or Tai Chi
- Behavioral health providers who can help with self-management plans for health behaviors

Scenario A: Start Opioid Treatment for Chronic Pain Patients

Go to #25 Identify resources… for specific QI strategies.

Engage

"How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?"

Develop a collection of resources that patients can borrow or purchase from our practice. Resources such as books, audio programs, and websites have proven beneficial to many patients but also change over time, so consider how to maintain this collection once developed.

Go to #26 Build a patient library… for specific QI strategies.

Engage

"How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?"

Every community has resources – schools, faith-based organizations, hospitals, recovery centers, housing programs, and shelters – that can support a community response for assisting its members in responsible opioid use and effective responses to opioid misuse. Leaders from such organizations in your community can learn about local opioid use and join forces to create community goals in response to reports on community-based statistics. They can assist directly in sharing information, raising community awareness, and working through existing community programs to provide support.

Go to #27 Build community support… for specific QI strategies.

Engage

"How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?"

Due to the widespread opioid crisis in the US, there's been a strong focus on creating educational resources for prescribers and office staff. The CDC guidelines are widely used as a basic guide for responsible opioid prescribing. In 2018, the FDA updated the "Risk Evaluation and Mitigation Strategy" (REMS), requiring pharmaceutical companies to educate healthcare providers on prescribing opioids and counseling patients about their risks and benefits.

These conversations may be prompted by signs of risky behavior, serious side effects, or patient preferences, leading to discussions about alternative treatments or reducing opioid use.

Go to #28 Share skills that are widely useful for specific QI strategies.

Scenario B: Transitioning Care for Patients with Chronic Pain

Patients transitioning between primary care clinicians due to departure or new clinician arrivals may require extra attention as prescribing patterns may differ. Questions to consider:

- Assess
  - "What non-opioid and non-pharmacological treatments can I consider for my chronic pain patients previously managed by a different provider?"
  - "How can I regularly assess the risks and benefits of opioid treatment for my chronic pain patients previously treated by a different provider?"
  - "How can I monitor and manage side effects for my chronic pain patients previously treated by a different provider?"
  - "How can I evaluate and improve the functional status of my chronic pain patients previously treated by a different provider?"
  - "How can I evaluate and manage the pain of my chronic pain patients previously treated by a different provider?"
  - "How can I identify and address special issues presented by my chronic pain patients previously treated by a different provider to improve therapeutic conversations?"
  - See also: How should I document strategies related to chronic pain management?
- Manage
  - "How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?"
  - "How can I share important patient care issues and cases with my peers?"
- Monitor
  - "How can I effectively use the PDMP to manage opioid prescriptions for chronic pain patients after their previous provider has left?"
  - "How can I effectively implement annual urine screening for opioid therapy patients with chronic pain, especially when transitioning care from a previous provider?"
  - "How can I ensure safe and responsible chronic pain management for patients transitioning care from a previous provider?"
- Prescribe
  - "What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"
  - "How should I prescribe medication durations for chronic pain patients after a provider change?"
  - "How should I handle prescription management for chronic pain patients when the previous provider has left?"
  - "How should I adjust prescription packaging for chronic pain patients when the risk of misuse is increasing?"
- Document
  - "How should I track opioid dosage using milligram morphine equivalents (MME)?"
  - "How should I document strategies related to chronic pain management?"

Scenario B: Transition Opioid Prescribing Across Providers

- Schedule
  - "How frequently should pain management visits be scheduled for chronic pain patients on opioid treatment?"
- Engage
  - “How can I help my patients find community resources that offer alternative methods for managing chronic pain?”
  - “How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?”
  - “How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?”
  - “How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?

Assess

When taking over care for chronic pain patients during a transition between prescribers, begin by conducting a thorough assessment of their current treatment plan. This includes considering non-opioid and non-pharmacological options, ongoing risk evaluations, monitoring side effects, and assessing patient function and pain levels while addressing any special issues through therapeutic conversations.

Assess at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"What non-opioid and non-pharmacological treatments can I consider for my chronic pain patients previously managed by a different provider?"	#2 Non-Opioid and Non-Pharmacological Treatment
"How can I regularly assess the risks and benefits of opioid treatment for my patients with chronic pain previously treated by a different provider?"	#4 Ongoing risk assessment, such as COMM, and update plan regularly
"How can I monitor and manage side effects for my chronic pain patients previously treated by a different provider?"	#5 Assess side effects (bowel habit, nausea, vomiting…)
"How can I evaluate and improve the functional status of my chronic pain patients previously treated by a different provider?"	#6 Assess patient function
"How can I evaluate and manage the pain of my patients with chronic pain previously treated by a different provider?"	#7 Assess patient pain
""How can I identify and address special issues presented by my chronic pain patients previously treated by a different provider to improve therapeutic conversations?""	#8 Recognize special issues presented by patients for therapeutic conversations

"What non-opioid and non-pharmacological treatments can I consider for my chronic pain patients previously managed by a different provider?"

Research shows that non-opioid options can be just as effective as opioids for many chronic pain patients. Non-opioid options include acetaminophen, NSAIDs, certain antidepressants, joint injections, and topical treatments, as well as non-drug treatments like chiropractic or osteopathic manipulation, low-level laser (for low back pain and chronic neck pain), acupuncture, physical

therapy, yoga, tai chi, and cognitive behavioral therapy. Evaluate the pros and cons of each treatment strategy for your patients, and with your patients.

Go to #2 Non-Opioid and Non-Pharmacological Treatment… for specific QI strategies

Assess

"How can I regularly assess the risks and benefits of opioid treatment for my patients with chronic pain previously treated by a different provider?"

Regularly, and at least once a year, check how well opioid treatment is working for your patients. Chronic pain can change over time, and so can the risks of treatments. New treatments or studies may offer better options. Keeping up with these changes helps you monitor your patients for new risk factors, support their self-management, and advise them on safe medication use.

Go to #4 Ongoing risk assessment… for specific QI strategies.

Assess

“How can I monitor and manage side effects for my patients with chronic pain previously treated by a different provider?”

Common side effects of opioids include nausea, constipation, over-sedation, itching, and feeling depressed. Less common side effects can be serious, like breathing problems, stomach issues, increased pain sensitivity, and muscle stiffness. Regularly ask your patients about these side effects to catch and manage them early.

Go to #5 Assess side effects … for specific QI strategies.

Assess

"How can I evaluate and improve the functional status of my patients with chronic pain previously treated by a different provider?"

Regularly check how well your patients can function in their daily lives, aiming for functional improvements even if their pain persists. Improved function is a key goal, as the benefits of opioid therapy can vary, but the risks are clear. Use tools like the Pain, Enjoyment, and General Activity (PEG) Assessment Scale to set and monitor realistic functional goals. A 30% improvement (decrease) in pain and function-interference scores is considered meaningful progress.

Go to #6 Assess patient function… for specific QI strategies.

Assess

"How can I evaluate and manage the pain of my patients with chronic pain previously treated by a different provider?"

Regularly check your patients' pain levels, while also focusing on improving their ability to function. Set realistic pain improvement goals early, as many chronic pain patients may never be completely pain-free. Use tools like the **PEG Assessment Scale** to monitor pain and set meaningful goals, aiming for a **30% improvement in pain and function-interference scores**. According to CDC guidelines, **if patients don't experience pain relief within a month of using opioids, they should be tapered off.**

Go to #7 Assess patient pain … for specific QI strategies.

Assess

"How can I identify and address special issues presented by my patients with chronic pain previously treated by a different provider to improve therapeutic conversations?"

Look out for behaviors that might indicate opioid misuse, like **missing appointments**, **misunderstanding instructions**, or **causing conflicts**. Use a team approach to ensure consistent communication with your patients. Having respectful conversations, sharing observations, and asking open-ended questions can help you gather important information and update treatment plans effectively.

Go to #8 Recognize special issues … for specific QI strategies.

Manage

In managing the care of chronic pain patients when initiating opioids, it is important to have a systematic way to manage the panel and use approaches to care supported by all prescribers. These two strategies connect clinicians with their panel of patients with long term opioids and with each other.

Manage at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?"	#9 Roster: Use your health record system's registry to create population management reports
"How can I share important patient care issues and cases with my peers?"	#10 Update your Chronic Pain Management Council

Manage

"How can I systematically keep track of my panel of patients treated with long-term opioids and plan for follow-up when needed?"

Panel management is useful in managing many chronic conditions. It is characterized by a set of tools and processes to identify patients and support structured workflows based on evidence-based protocols, especially for those at high risk. Panel management depends on customizable, timely data reporting under local control and the ability to benchmark to guide improvement.

Prescription Drug Monitoring Programs (PDMPs), which track controlled substance prescriptions, provide a widely available source for panel management. PDMP data, when aggregated across clinicians, can provide a practice-wide view of prescribed medications, dosage, prescribing intervals, and concurrent prescriptions of benzodiazepines, to support a panel management approach to opioid treatment.

Go to #9 Roster… for specific QI strategies.

Manage

"How can I share important patient care issues and cases with my peers?"

The Chronic Pain Management Council gives primary care clinicians time to review and discuss each patient's treatment history and plans. This helps maintain a consistent approach across the practice, especially when new providers join or old ones leave. It also shares the responsibility of opioid prescribing and provides a second opinion on the patient's suitability for chronic opioid therapy.

Scenario B: Transition Opioid Prescribing Across Providers

Providers meet regularly or as needed to review the charts of long-term chronic pain patients on opioid treatment. Decisions about medication changes or discontinuations happen separately from patient visits. The primary provider gathers information from the patient and presents it to the Council, which then offers an objective perspective. The primary provider then meets with the patient to review the Council's recommendations and plan the next steps.

Go to #10 Update your Chronic Pain Management Council …for specific QI strategies.

Monitor

In the "Monitor" step of managing care for chronic pain patients during transition between prescribers, it is essential to conduct regular checks using tools like the Prescription Drug Monitoring Program (PDMP), screen urine samples, perform pill counts, and offer ongoing patient education. These measures ensure comprehensive oversight of treatment effectiveness and patient safety throughout their care journey.

Monitor at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I effectively use the PDMP to manage opioid prescriptions for chronic pain patients during transition between prescribers?"	#11 Check Prescription Drug Monitoring Program and repeat annually
"How can I effectively implement annual urine screening for opioid therapy patients with chronic pain, especially when transitioning care between prescribers?"	#12 Screen urine at least annually for presence/absence of substances (may be random)
"How can I maintain safe and responsible chronic pain management for patients transitioning care from a previous prescriber?"	#14 Provide patient education on benefits and risks…

Monitor

"How can I effectively use the PDMP to manage opioid prescriptions for individual patients with chronic pain during transition between prescribers?"

Most states require prescribers to check the PDMP before starting new opioid prescriptions or initiating certain treatments like benzodiazepines or buprenorphine. This ensures comprehensive monitoring of opioid use, excluding medications dispensed in certain settings like emergency departments or addiction management clinics. Access to the PDMP is available to prescribers and their authorized staff, helping maintain oversight and patient safety.

In addition to checking before initiating opioid treatment, prescribers are advised to query the PDMP prior to writing a replacement (e.g. lost, stolen) of any scheduled II-IV controlled substance. Regular queries are recommended, not less frequently than annually.

Go to #11 Check PDMP and repeat… for specific QI strategies.

Monitor

“How can I effectively implement annual urine screening for opioid therapy patients with chronic pain, especially when transitioning care between prescribers?”

Prescribers are advised to collect a urine sample at least annually from all patients using opioid therapy to check for controlled substances. While there isn't strong evidence that urine testing effectively monitors treatment, it aligns with national and state guidelines and is considered good practice, even for patients at low risk. Random urine tests, scheduled at unpredictable times, can help identify any patients who may not be honest about their medication use, ensuring safe and effective pain management.

Go to #12 Screen Urine Annually for specific QI strategies.

Monitor

“How can I maintain safe and responsible chronic pain management for patients transitioning care from a previous prescriber?”

Ensure patients understand the benefits and risks of their treatment by educating them thoroughly. Establish a treatment agreement that outlines expectations, such as obtaining prescriptions from one prescriber and pharmacy. Regularly update and review these documents with patients to confirm compliance and address any concerns. Remember, ongoing education and clear agreements help mitigate the risk of opioid misuse and reinforce the goal of improving patient health and function.

Go to #14 Provide patient education … for specific QI strategies.

Prescribe

In the "Prescribe" strategies, prescribers focus on ensuring safe and effective medication management for patients with chronic pain during a provider transition. These strategies help maintain continuity of care and enhance patient safety throughout the treatment process.

Prescribe at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"	#15 Best practices in prescribing for patients
"How should I prescribe medication durations for patients with chronic pain during a care transition?"?	#16 Prescribe in multiples of 7 days in duration of dosage
"How should I handle prescription management for chronic pain patients during a care transition?"	#17 Pre-write prescriptions for up to 84 days when management is stable
"How should I adjust prescription packaging for chronic pain patients when the risk of misuse is increasing?"	#18 Prescribe bubble packs if risk level increasing, depending on availability

"What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"

Best Practices in Prescribing

When prescribing opioids, follow these best practices to ensure patient safety:

1. **Treat with Immediate Release Opioids**: Treatment with immediate release formulations minimizes risks. Adjust the dose gradually.
2. **Limit Dose to 50-90 MME/Day**: Avoid prescribing doses higher than 50 MME per day without careful consideration. Doses exceeding 90 MME/day are in the highest risk category and require thorough justification.
3. **Avoid Concurrent Benzodiazepines**: Refrain from prescribing benzodiazepines alongside opioids, as this combination significantly increases the risk of overdose.
4. **Offer Naloxone**: Provide naloxone, an opioid reversal medication, to patients on high doses, those using both opioids and benzodiazepines, or those with a history of overdose or substance use disorder. Naloxone can quickly reverse life-threatening opioid

effects, such as impaired breathing and sedation. Encourage patients, their families, and bystanders to carry naloxone if they are at risk.

Go to #15 Best practices in prescribing… for specific QI strategies.

Prescribe

"How should I prescribe medication durations for patients with chronic pain during a care transition?"

When prescribing medications, prescribe them in durations that are multiples of 7 days (like 28 days, 56 days, or 84 days). This ensures prescriptions align with office availability and don't run out on weekends. Start prescriptions on Tuesdays, Wednesdays, Thursdays, or Fridays whenever possible to manage refill requests effectively during office hours. Adjust dose quantities so that the next prescription aligns with the days their prescriber is available to handle refill requests, considering patients may take up to three days to fill prescriptions.

Go to #16 Prescribe in multiples of 7 … for specific QI strategies.

Prescribe

“How should I handle prescription management for patients with chronic pain during a transition of care?”

When managing stable patients with predictable refill needs, consider pre-writing prescriptions for up to 84 days, typically in 28-day increments as discussed earlier. These prescriptions should include a "do not fill before" date aligned with the patient's treatment plan. Options include holding prescriptions at the front desk for pickup, providing them to the patient for safekeeping (with caution against loss or damage), direct delivery to pharmacies, or electronic transmission where feasible. Avoid mailing prescriptions due to security and reliability concerns.

Go to #17 Pre-write prescriptions for up to 84 days… for specific QI strategies.

Prescribe

“How should I adjust prescription packaging for patients with chronic pain when the risk of misuse is increasing?”

If your patient's risk of medication misuse is rising and local pharmacies can accommodate, consider prescribing medications in secure packaging like bubble packs or other sealed formats. These packaging types are individually marked, linking each dispensed package to a specific patient. This helps ensure patients receive the correct medication amount, reducing the risk of misuse or sharing medications.

Go to #18 Prescribe using bubble packs… for specific QI strategies.

Document

In managing care for chronic pain patients after a provider's departure, the "Document" step focuses on recording essential details such as prescribed dosage, duration of treatment, and specific medications chosen.

Document at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How should I track opioid dosage using milligram morphine equivalents (MME)?"	#21 Track dosage in MMEs, not quantity dispensed
"How should I document strategies related to chronic pain management?"	#22 Use a flowsheet to document repeating strategies for opioid management

Document

"How should I track opioid dosage using milligram morphine equivalents (MME)?"

To monitor opioid dosage, primary care clinicians should calculate the dosage in milligram morphine equivalents (MMEs) to track the total opioid intake more accurately. Note that methadone dosing is especially complex due to varying conversion rates based on daily doses.

Go to #21 Track dosage in MMEs… for specific QI strategies.

Document

"How should I document strategies related to chronic pain management?"

Use a flowsheet to document strategies selected from assessments and reassessments, as well as actions taken before prescribing medications. This ensures consistent recording of chronic pain-related visits, prompts for specific data gathering, and integrates documentation into the practice's health record system.

Columns (or data fields) in the flowsheet can be selected based on the strategies chosen by the practice. Data fields can include:

- Current medications
- Treatment goal
- PDMP result and date
- Urine drug screen result and date

- Pill count result and date
- Risk assessment score and date
- Pain score and date
- Functional status score and date
- Bowel habit and date
- Cognitive function and date
- Patient agreement present and date
- Special issues (e.g. alcohol use, illicit substance use, prescription mishandling, canceled appointment)
- Drug and alcohol counseling completed: result and date
- Quantity dispensed
- Visit required for next prescription.

A flowsheet example representing different patients on a given date:

Date	Current Meds	Treatment Goal	PDMP Result	Urine Drug Screen	Pill Count - Last date or overdue	Risk Assessment Tool-COMM	Pain Score	Functional Status
2024-07-16	Opioids, NSAIDs	Reduce pain intensity	Clear (VPMS)	Negative	2024-04-23	Moderate	5/10	Limited mobility
2024-07-16	NSAIDs	Improve function	Clear (VPMS)	Positive	N/A	Low	3/10	Full
2024-07-16	Gabapentin	Manage neuropathy	Clear (VPMS)	Negative	Due	High	2/10	Limited mobility

The above flowsheet can be interpreted to indicate need for follow up with the second patient listed (not prescribed opioids, assessed as low risk, but positive urine drug screen).

Go to #22 Use a flowsheet… for specific QI strategies.

Schedule

In the "Schedule" step of managing care for chronic pain patients after provider departure, the focus is on setting regular follow-up visits to monitor treatment effectiveness and adjust plans as needed. This includes preparing updates for the Pain Management Council on patient progress and any adjustments in pain management strategies.

Schedule at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How frequently should pain management visits be scheduled for patients with chronic pain receiving opioid treatment?"	#24 Pain management visit every 84 days

Schedule

"How frequently should pain management visits be scheduled for patients with chronic pain receiving opioid treatment?"

Regular visits specifically for managing chronic pain ensure that prescribers can assess, treat, and monitor patients receiving opioid therapy consistently, without it being incidental to other medical needs. Some states, such as Vermont, require patients on chronic opioid therapy, including tramadol, to have a visit every 90 days. These visits focus on discussing the effectiveness of treatment and any necessary adjustments, reducing unexpected calls or interruptions by ensuring there is always a planned follow-up.

Go to #24 Pain management visit every 84 days… for specific QI strategies.

Engage

In managing the care of chronic pain patients after their provider has departed, it is essential to engage available resources. This step involves connecting patients with educational materials, utilizing community support networks, and enhancing their coping skills to ensure comprehensive and continuous care.

Engage at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I help my patients find community resources that offer alternative methods for managing chronic pain?"	#25 Identify resources that may be helpful and update periodically
"How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?"	#26 Build a patient library with books, CDs, etc.
"How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?"	#27 Build community support with other partners/agencies
"How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?"	#28 Share skills that are widely useful, e.g. how to have "trigger" conversations

Engage

"How can I help my patients find community resources that offer alternative methods for managing chronic pain?"

Every community offers unique resources that can help patients manage chronic pain in different ways. Create a one-page guide with website links so patients can easily access these resources:

- Chiropractic care
- Low-level laser (for low back pain and chronic neck pain)
- Acupuncture
- Traditional Chinese Medicine
- Mind/Body approaches like stretching, medication management, relaxation techniques, stress management, and mindfulness
- Chi Kung or Qigong (Chinese yoga) or Tai Chi
- Behavioral health providers who can help with self-management plans for health behaviors

Go to #25 Identify community resources… for specific QI strategies.

Engage

"How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?"

Develop a collection of resources that patients can borrow or purchase from our practice. Resources such as books, audio programs, and websites have proven beneficial to many patients but also change over time, so consider how to maintain this collection once developed.

Go to #26 Build a patient library… for specific QI strategies.

Engage

"How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?"

Every community has resources – schools, faith-based organizations, hospitals, recovery centers, housing programs, and shelters – that can support a community response for assisting its members in responsible opioid use and effective responses to opioid misuse. Leaders from such organizations in your community can learn about local opioid use and join forces to create community goals in response to reports on community-based statistics. They can assist directly in sharing information, raising community awareness, and working through existing community programs to provide support.

Go to #27 Build community support… for specific QI strategies.

Engage

"How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?

Due to the widespread opioid crisis in the US, there's been a strong focus on creating educational resources for prescribers and office staff. The CDC guidelines are widely used as a basic guide for responsible opioid prescribing. In 2018, the FDA updated the "Risk Evaluation and Mitigation Strategy" (REMS), requiring pharmaceutical companies to educate healthcare providers on prescribing opioids and counseling patients about their risks and benefits.

These conversations may be prompted by signs of risky behavior, serious side effects, or patient preferences, leading to discussions about alternative treatments or reducing opioid use.

Go to #28 Share skills that are widely useful… for specific QI strategies.

Scenario C: Adjust Care for Patients on High-Dose Opioids

Patients on high-dose opioids require careful tapering and frequent reassessment to balance pain management and minimize risks. Questions to consider:

- Assess
  - "What non-opioid and non-pharmacological treatment options should be considered for managing chronic pain?"
  - "How should I manage patients with Opioid Use Disorder (OUD) or high-risk behaviors, and what key factors should guide the decision to engage in treatment versus dismissing the patient?"
  - "How can I evaluate and improve the functional status of my patients with chronic pain while on opioid therapy?"
  - "How can I evaluate and manage the pain of my patients with chronic pain while on opioid therapy?"
  - "How can I recognize and address behaviors that may indicate opioid misuse during therapeutic conversations?"
- Manage
  - “How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?”
  - “How can I share important patient care issues and cases with my peers?”
- Monitor
  - “How frequently should urine samples be collected from patients on opioid therapy, and what are the benefits and limitations of random screening?”
  - “What are the potential benefits and limitations of random pill counts for patients on opioid therapy?"
- Prescribe
  - "What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"
  - “When should I consider using secure packaging like bubble packs for patients on high-dose opioids, and how does this practice help manage risk and ensure proper medication use?”
  - “How should I determine when to taper or discontinue opioid therapy for patients, and what factors should guide this decision?”
  - “What do I need to know about Buprenorphine as an alternative pain medication, and what factors should guide shared decision-making?”
- Document
  - "How can I accurately track and convert opioid dosages into milligram morphine equivalents (MME), and what should I be aware of when dealing with medications like methadone?"
- Schedule
  - "How often should I follow up with patients on high-dose opioid therapy, and what key elements should be included in the exit plan for therapy?"

Assess

When managing a patient on high-dose opioids, it's important to carefully evaluate the next steps in their care. This section will guide you through the key considerations and best practices for making necessary adjustments.

Assess at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"What non-opioid and non-pharmacological treatment options should be considered for managing chronic pain?"	#2 Non-Opioid and Non-Pharmacological Treatment
"How should I manage patients with Opioid Use Disorder (OUD) or high-risk behaviors, and what key factors should guide the decision to engage in treatment versus dismissing the patient?"	#3 Arrange MAT for OUD Patients and Those with High-Risk Traits
"How can I evaluate and improve the functional status of my patients with chronic pain while on opioid therapy?"	#6 Assess Patient Function
"How can I evaluate and manage the pain of my patients with chronic pain while on opioid therapy?"	#7 Assess Patient Pain
"How can I recognize and address behaviors that may indicate opioid misuse during therapeutic conversations?"	#8 Recognize special issues presented by patients for therapeutic conversations

Assess

"What non-opioid and non-pharmacological treatment options should be considered for managing chronic pain?"

Non-Opioid and Non-Pharmacological Treatment

Research shows that opioids are not more effective than non-opioid alternatives in reducing pain and improving function for most patients with chronic pain. Non-opioid options include medications such as acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), certain antidepressants, joint injections, and topical treatments. Additionally, non-pharmacological approaches like chiropractic or osteopathic manipulation, low-level laser (for low back pain and chronic neck pain), acupuncture, physical therapy, yoga, tai chi, and cognitive behavioral therapy can be considered. It's important to carefully evaluate the individual risks and benefits of each treatment option to ensure the best care for the patient.

Medication-Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD)

Patients on high doses for long periods of time may need evaluation for opioid use disorder (OUD). Many patients with OUD must also deal with chronic pain and mental health issues like anxiety, depression, ADHD, or PTSD. They may have experienced significant stress or trauma. Be alert to signs of substance use disorders in your patients and help them access evidence-based treatments like medication-assisted therapy (MAT) or medications for opioid use disorder (MOUD) when needed. You might need to weigh the pros and cons of dismissing a patient from your practice versus helping them engage in treatment for their substance use disorder. Remember, abruptly firing a patient can create ongoing issues for them, your staff, and the community.

Go to #2 Non-Opioid and Non-Pharma… for specific QI strategies.

Assess

"How should I manage patients with Opioid Use Disorder (OUD) or high-risk behaviors, and what key factors should guide the decision to engage in treatment versus dismissing the patient?"

Arrange for Medication Assisted Treatment (MAT) for Patients with Opioid Use Disorder (OUD)

For patients with Opioid Use Disorder (OUD) or those who develop and maintain high-risk behaviors, it's important to arrange for Medication Assisted Treatment (MAT) and engage them in the treatment process. Many patients with OUD also experience chronic pain and mental health disorders like anxiety, depression, ADHD, or PTSD, often due to past trauma or psychosocial stressors.

Prescribers should stay vigilant for signs of substance use disorders (SUD) in patients with chronic pain and ensure they receive appropriate, evidence-based treatment, such as MAT, when needed. It's important to weigh the pros and cons of dismissing a patient from your practice versus continuing to work with them on their treatment journey. This decision should consider the perspectives of the patient, office staff, the prescriber, and the broader community—abruptly ending care could worsen the situation and have negative consequences for the patient's future care and the community as a whole.

Go to #3 Arrange MAT… for specific QI strategies.

Assess

"How can I evaluate and improve the functional status of my patients with chronic pain while on opioid therapy?"

Regularly check how well your patients can function in their daily lives, aiming for functional improvements even if their pain persists. Improved function is a key goal, as the benefits of opioid therapy can vary, but the risks are clear. Use tools like the Pain, Enjoyment, and General Activity (PEG) Assessment Scale to set and monitor realistic functional goals. A 30% improvement (decrease) in pain and function-interference scores is considered meaningful.

Go to #6 Assess patient function… for specific QI strategies.

Assess

"How can I evaluate and manage the pain of my patients with chronic pain while on opioid therapy?"

Regularly check your patients' pain levels, while also focusing on improving their ability to function. Set realistic pain improvement goals early, as many chronic pain patients may never be completely pain-free. Use tools like the **PEG Assessment Scale** to monitor pain and set meaningful goals, aiming for a **30% improvement in pain and function-interference scores**. According to CDC guidelines, **if patients don't experience pain relief within a month of using opioids, they should be tapered off.**

Go to #7 Assess patient pain … for specific QI strategies.

Assess

"How can I recognize and address behaviors that may indicate opioid misuse during therapeutic conversations?"

Recognize Special Issues in Therapeutic Conversations

Beyond using validated tools to assess a patient's risk of opioid misuse (see Strategy #4), prescribers should be aware of other behaviors that might indicate misuse. These behaviors can include negative urine test, incorrect pill counts, missing appointments, frequently misunderstanding instructions, being rude to staff, or attempting to create conflict between the prescriber and staff ("splitting").

Taking a respectful and collaborative team approach ensures that both the prescriber and staff deliver consistent messages and stay aligned in their care strategies. Engaging in conversations with patients that share your observations and ask open-ended questions can help uncover new information and guide necessary updates to treatment plans.

Go to #8 Recognize special issues… for specific QI strategies.

Manage

In managing the care of chronic pain patients when adjusting care, it is important to have a systematic way to manage the panel and use approaches to care supported by all prescribers. These two strategies connect clinicians with their panel of patients with long term opioids and with each other.

Manage at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?"	#9 Roster: Use your health record system's registry to create population management reports
"How can I share important patient care issues and cases with my peers?"	#10 Update your Chronic Pain Management Council

Manage

"How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?"

Panel management is useful in managing many chronic conditions. It is characterized by a set of tools and processes to identify patients and support structured workflows based on evidence-based protocols, especially for those at high risk. Panel management depends on customizable, timely data reporting under local control and the ability to benchmark to guide improvement.

Prescription Drug Monitoring Programs (PDMPs), which track controlled substance prescriptions, provide a widely available source for panel management. PDMP data, when aggregated across clinicians, can provide a practice-wide view of prescribed medications, dosage, prescribing intervals, and concurrent prescriptions of benzodiazepines, to support a panel management approach to opioid treatment.

Go to #9 Roster… for specific QI strategies.

Manage

"How can I share important patient care issues and cases with my peers?"

The Chronic Pain Management Council gives primary care clinicians time to review and discuss each patient's treatment history and plans. This helps maintain a consistent approach across the practice, especially when new providers join or old ones leave. It also shares the responsibility of opioid prescribing and provides a second opinion on the patient's suitability for chronic opioid therapy.

Scenario C: Adjust Care for Patients on High-Dose Opioids

Providers meet regularly or as needed to review the charts of long-term chronic pain patients on opioid treatment. Decisions about medication changes or discontinuations happen separately from patient visits. The primary provider gathers information from the patient and presents it to the Council, which then offers an objective perspective. The primary provider then meets with the patient to review the Council's recommendations and plan the next steps.

Go to #10 Update your Chronic Pain Management Council …for specific QI strategies.

Monitor

In managing a patient on high-dose opioids, careful and continuous monitoring is essential to ensure their safety and the effectiveness of their treatment plan. This section will guide you through best practices for ongoing monitoring, including how frequently to screen urine for the presence or absence of substances.

Monitor at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How frequently should urine samples be collected from patients on opioid therapy, and what are the benefits and limitations of random screening?"	#12 Screen urine at least annually
"What are the potential benefits and limitations of random pill counts for patients on opioid therapy?""	#13 Conduct a random pill count, depending on risk

Monitor

"How frequently should urine samples be collected from patients on opioid therapy, and what are the benefits and limiations of random screening?"

Urine samples should be collected periodically, and at least annually, from all patients on opioid therapy to test for the presence or absence of controlled substances. While there is no high-quality evidence that urine testing is highly effective for monitoring, it is included in many national and state guidelines and is considered a good practice. Regular urine screening helps ensure compliance and can be part of a broader strategy to manage opioid therapy responsibly.

Random urine screening can be beneficial as it may help identify patients who are not honest about their medication usage. While anecdotal evidence suggests that most patients who comply with urine screening are not misusing or abusing their medications, those who misuse may attempt to conceal their behavior. Random screenings at non-predictable intervals can be an effective way to detect potential misuse or abuse, even though high-quality evidence on its effectiveness is lacking.

Go to #12 Screen urine at least annually… for specific QI strategies.

Monitor

Random Pill Counts: "What are the potential benefits and limitations of random pill counts for opioid therapy patients?"

Randomly review pill containers or bubble packs to confirm the number of doses remaining in the prescription period. This strategy can be conducted in tandem with Urine Screens (see above). Patients are called (for scheduled or unscheduled visits) with a reminder to bring their prescription medications in their original containers to their visits.

Go to #13 Conduct a random pill count, depending on risk… for specific QI strategies.

Prescribe

This section will guide you on key aspects of prescribing, including when to offer naloxone as a precautionary measure, utilizing bubble packs to support medication adherence, and scheduling follow-up appointments based on the selected tapering plan. These practices help optimize patient outcomes, reduce risks associated with opioid therapy, and support a smooth transition in their treatment regimen.

Prescribe at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"	#15 Best practices in prescribing for targeted patients; e.g.: offer naloxone when appropriate
"When should I consider using secure packaging like bubble packs for patients on high-dose opioids, and how does this practice help manage risk and ensure proper medication use?"	#18 Prescribe using bubble packs if risk level is increasing, depending on availability in local pharmacies
"How should I determine when to taper or discontinue opioid therapy for patients, and what factors should guide this decision?"	#19 Tapering schedule with follow up patient visits based on individual need
"What do I need to know about Buprenorphine as an alternative pain medication, and what factors should guide shared decision-making?"	#20 Prescribing Buprenorphine

Prescribe

"What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"

Best Practices in Prescribing

When prescribing opioids, follow these best practices to ensure patient safety:

1. **Treat with Immediate Release Opioids**: Treatment with immediate release formulations minimizes risks. Adjust the dose gradually.
2. **Limit Dose to 50-90 MME/Day**: Avoid prescribing doses higher than 50 MME per day without careful consideration. Doses exceeding 90 MME/day are in the highest risk category and require thorough justification.

3. **Avoid Concurrent Benzodiazepines**: Refrain from prescribing benzodiazepines alongside opioids, as this combination significantly increases the risk of overdose.
4. **Offer Naloxone**: Consider providing naloxone, an opioid reversal medication, to patients on doses of 50 MME/day or more (per CDC), and always for patients on doses of 90 MME/day or more, those using both opioids and benzodiazepines, or those with a history of overdose or substance use disorder. Naloxone can quickly reverse life-threatening opioid effects, such as impaired breathing and sedation. Encourage patients, their families, and bystanders to carry naloxone if they are at risk.

Go to #15 Best practices in prescribing… for specific QI strategies.

Prescribe

"When should I consider using secure packaging like bubble packs for patients on high-dose opioids, and how does this practice help manage risk and ensure proper medication use?"

Prescribe with Secure Packaging

If you notice an increasing risk level in a patient on high-dose opioids, and if local pharmacies offer the service, consider prescribing medications in secure packaging options such as bubble packs, bingo cards, or tear-off strips. These packaging methods are uniquely stamped and linked to the specific patient, which helps ensure that the patient receives the correct medication and dosage. This approach helps prevent potential misuse, such as borrowing or renting pills, by allowing for accurate medication checks.

Go to #18 Prescribe using bubble packs… for specific QI strategies.

Prescribe

"How should I determine when to taper or discontinue opioid therapy for patients, and what factors should guide this decision?"

Tapering Schedule with Follow-Up

When adjusting care for patients on high-dose opioids, it's important to periodically evaluate the risks and benefits of continuing treatment. If the risks begin to outweigh the benefits, opioids should be tapered. The decision to taper should be made collaboratively between the patient and provider. Consider tapering opioids or discontinuing therapy if the patient:

- Requests a dosage reduction.
- Does not experience significant improvement in pain and function (e.g., less than a 30% decrease in pain and function-interference scores on the PEG scale or similar tool).
- Is on doses of 50+ MME per day without seeing benefits.
- Uses both opioids and benzodiazepines.

- Shows signs of substance use disorder or other concerning behaviors (e.g., issues with work or family, difficulty controlling use, positive COMM score, problems with PDMP).
- Experiences an overdose or other serious adverse effects.
- Displays early warning signs of overdose risk, such as confusion, excessive sedation, or slurred speech.

Go to #19 Tapering schedule… for specific QI strategies.

Prescribe

"What do I need to know about Buprenorphine as an alternative pain medication, and what factors should guide shared decision-making?"

Buprenorphine: an alternative that can provide adequate analgesia with less misuse potential

Evidence for the use of buprenorphine for pain management, rather than opioid use disorder, is growing. As a partial mu-opioid agonist, it provides a possible safer alternative to more traditional Schedule II opioids in the management of chronic pain.

Go to #20 Prescribing Buprenorphine… for specific QI strategies.

Document

This section will guide you on how to document opioid prescriptions and adjustments, including the use of morphine milligram equivalents (MME) to track dosage levels.

Document at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How can I accurately track and convert opioid dosages into milligram morphine equivalents (MME), and what should I be aware of when dealing with medications like methadone?"	#21 Track dosage in MMEs, not quantity dispensed

Document

"How can I accurately track and convert opioid dosages into milligram morphine equivalents (MME), and what should I be aware of when dealing with medications like methadone?"

Track Dosage in MME

Clinicians should consistently track opioid dosages using milligram morphine equivalents (MME) to ensure accurate monitoring and adjustment. Familiarize yourself with the conversion of various opioids into MME, and use tools provided by the Centers for Disease Control, available both online and via phone applications, for assistance. Keep in mind that methadone has a complex dosing conversion rate that changes with the daily dose, so special attention is needed when calculating MME for this medication.

Go to #21 Track dosage in MMEs… for specific QI strategies.

Schedule

It is important to establish a follow-up schedule to review the effects of any new prescriptions or adjustments. This section will guide you on scheduling short-interval follow-up visits after initiating a new prescription to assess its impact, monitor patient response, and make necessary adjustments.

Schedule at a Glance

Below is an at-a-glance guide that outlines the prescriber guiding questions and the corresponding strategic implementations for quick reference.

Prescriber Guiding Q&A	Strategic Implementation
"How often should I follow up with patients on high-dose opioid therapy, and what key elements should be included in the exit plan for therapy?"	#23 Short interval follow up

Schedule

"How often should I follow up with patients on high-dose opioid therapy, and what key elements should be included in the exit plan for therapy?"

Short Interval Follow-Up

When managing patients on high-dose opioids, it's important to schedule frequent follow-up visits, especially during the initial phase of therapy. Many patients start with acute opioid treatment, which can lead to an unclear transition to chronic use. To ensure safety and effectiveness, closely monitor the patient's response and reassess the risks and benefits regularly. Establish a clear "exit plan" when initiating therapy, including a discussion about the expected duration of treatment and conditions under which it may be discontinued if it proves ineffective. This plan should be documented in patient consent and treatment agreement forms.

Go to #23 Short interval follow up… for specific QI strategies.

QI Strategic Implementation

Welcome to the strategic implementation section of the opioid prescribers toolkit. Whether you are setting your team's objectives (Section 2.3) or selecting strategies to respond to challenges in prescribing opioids (Section 3.3), you are ready to look at specific strategies for Quality Improvement (QI).

Assess
- #1 Initial Risk Assessment
- #2 Non-opioid & non-pharmacological treatment
- #3 Arrange MAT for OUD patients and those with high-risk traits
- #4 Ongoing risk assessment, such as COMM, and update plan regularly
- #5 Assess side effects (bowel habit, nausea, vomiting…)
- #6 Assess patient function
- #7 Assess patient pain
- #8 Recognize special issues presented by patients for therapeutic conversations

Manage
- #9 Roster: Include patient in registry for population management reports
- #10 Update your practice's Pain Management Council at next regular meeting

Monitor
- #11 Check Prescription Drug Monitoring Program and repeat annually
- #12 Screen urine at least annually for presence/absence of substances (may be random)
- #13 Conduct random pill count, depending on risk of individual
- #14 Patient education, treatment agreement, & obtain informed consent

Prescribe
- #15 Best practices in prescribing for targeted patients
- #16 Prescribe in multiples of 7 days in duration of dosage
- #17 Pre-write prescriptions for up to 84 days when management is stable
- #18 Prescribe bubble packs if risk level increasing, depending on availability
- #19 Tapering schedule - Schedule patients based on selected tapering schedule
- #20 Buprenorphine for chronic pain

Document
- #21 Track dosage in MMEs, not quantity dispensed
- #22 Use a flowsheet to document repeating strategies for opioid management

Schedule
- #23 Short interval follow up
- #24 Ongoing visits at least every 90 days (84 when using 7 day strategy above)

Engage
- #25 Identify community resources that may be helpful and update periodically
- #26 Build a patient library with books, CDs, etc.
- #27 Build community support with other partners/agencies
- #28 Share skills that are widely useful, e.g. how to have "trigger" conversations

Assess

⬅️BACK **"How do I conduct an initial risk assessment" (Scenario A)**

#1 Initial Risk Assessment

1. **Select an initial assessment tool** - *Appendix 1: Initial Assessments*

- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients with Pain (SOAPP-R)
- Chronic Pain Assessment/DIRE

2. **Plan the Assessment Process**

- Determine when patients will receive the tool (e.g., in the waiting room or exam room).
- Decide who will give the tool to patients (clinical staff or provider).
- Figure out who will help patients with the tool (clinical staff or provider).
- Assign responsibility for scoring the results during the clinical exam.
- Designate who will document the results in the patient's chart.
- Determine where in the chart the results will be recorded.

3. **Trial Run the Assessment**

- Test the assessment with one provider and a small group of patients (around eight).

4. **Evaluate the Trial**

- Decide whether to continue using the assessment or try a different tool.
- If you continue, consider incorporating the assessment into the electronic record system.

Measure Success

Example: Conduct a chart audit to review number of initial assessments performed before prescribing a new opioid treatment.

⬅BACK "How do I identify and find alternatives to opioids for managing chronic pain" (Scenario A)

⬅BACK "What non-opioid and non-pharm treatments can I consider for my chronic pain patients previously managed by a different provider?" (Scenario B)

⬅BACK What non-opioid and non-pharmacological treatment options should be considered for managing chronic pain? (Scenario C)

#2 Non-Opioid and Non-Pharmacological Treatment

1. Ensure proper documentation in the electronic health record of non-opioid alternatives shared with or attempted by the patient. Document the strategy used and the duration of the non-opioid alternative.
2. Compile a list of non-opioid community resources available for pain management (see Strategy 25).
3. Explore disease-specific treatments, such as triptans for migraines, and consider their suitability for the patient's condition.
4. Develop patient education materials that advocate for non-opioid treatments as the first-line approach for managing chronic pain.

Measure Success

Example: Conduct a chart audit to review occurrence of documented alternative treatments discussed before prescribing a new opioid treatment.

⬅BACK "How do I address a co-existing Opioid Use Disorder and co-existing mental health conditions?" (Scenario A)

⬅BACK "How should I manage patients with Opioid Use Disorder (OUD) or high-risk behaviors, and

#3 Arrange MAT or MOUD for OUD Patients and Those with High-Risk Traits

1. Identify and address co-existing mental health conditions that may be contributing to the patient's symptoms.

2. Develop a list of community providers that can provide care for specific mental health conditions (anxiety, depression, ADHD, or PTSD), including information about limitations with respect to insurance carriers accepted. In Vermont, identify the "hub and spoke" organizations affiliated with your practice.

3. Support referral and visits with mental health providers.

what key factors should guide the decision to engage in treatment versus dismissing the patient?"
(Scenario C)

4. Chronic pain patients are at increased risk for suicide. Screen for suicidality when developing a plan for care.

Measure Success

Example: Track referrals and confirm mental health visit uptake.

⬅️**"How can I regularly assess the risks and benefits of opioid treatment for my patients with chronic pain previously treated by a different provider?"**
(Scenario B)

#4 Ongoing risk assessment, such as COMM, and update plan regularly

5. **Review pain assessment tools and select one that the practice will use consistently -** *Appendix 2: Ongoing Assessments*:
    - **a.** Pain, Enjoyment, General Activity (PEG)
    - **b.** Current Opioid Misuse Measure (COMM)
    - **c.** Short Form 12 (SF12)
    - **d.** Oswestry
    - **e.** Rapid 3
    - **f.** Pain Assessment and Documentation Tool (PADT)
    - **g.** 5 Additional Assessments (5As, including PEG above)

6. **Decide how to identify and document pain assessment**
    a. Who will assess the patient and when in the course of the visit?
    b. Who will document the results in the chart?
    c. Where will the results be documented in the chart?

7. **Trial the assessment with one provider and a sample of patients (~ 8 patients)**
    a. Establish realistic treatment goals when initiating therapy
    b. Re-evaluate within 1-4 weeks of initiating opioid therapy and at least every 3 months thereafter
    c. Re-evaluate with any increases in dosage, especially if patients are using methadone or fentanyl or are on 50+ MME doses per day
    d. If benefits do not outweigh risks, taper opioids (see Strategy #19).

8. **Decide if the trial will continue into implementation or if adjustment is needed**

Measure success

a. Example: Chart audit for pain assessment

⬅️BACK "How can I monitor and manage side effects for my patients with chronic pain while on opioid therapy?" (Scenario A)

⬅️BACK "How can I monitor and manage side effects for my patients with chronic pain previously treated by a different provider?" (Scenario B)

#5 Assess side effects (bowel habit, nausea…)

1. **Identify Symptoms to Track:**

- Review and choose which side effects (e.g., bowel habits, nausea) your practice will consistently monitor.

2. **Determine the Process for Assessment and Documentation:**

- **Who:** Decide who will assess the patient's symptoms and at what point during the visit this will occur.
- **How:** Establish how the symptoms will be assessed (e.g., through specific questions, observations).
- **Who Documents:** Assign responsibility for documenting the assessment results.
- **Where:** Decide where in the patient's chart the results will be recorded.

3. **Conduct a Trial:**

- Test the assessment process with one provider and a small group of patients (approximately 8 patients).

4. **Evaluate and Decide on Next Steps:**

- Determine whether to continue the trial into full implementation or if adjustments are necessary.

Measure Success:

- Example: Perform a chart audit to ensure symptom tracking is being documented as planned.

⬅️BACK "How can I track and improve a patient's ability to perform daily activities while on opioid therapy?" (Scenario A)

#6 Assess patient function

1. **Select a Functional Assessment Tool:**

- Review available functional assessment tools and choose one that your practice will use consistently.

- Examples found in the Appendix:
  - **PEG:** Pain, Enjoyment, and General Activity
  - **SF12:** Short Form 12
  - **Oswestry** neck and back
  - **Rapid 3**: Routine Assessment of Patient Index Data

⬅BACK "How can I evaluate and improve the functional status of my patients with chronic pain previously treated by a different provider?" (Scenario B)

⬅BACK "How can I evaluate and improve the functional status of my patients with chronic pain previously while on opioid therapy?" (Scenario C)

- **PADT:** Pain Assessment and Documentation Tool

2. **Determine the Process for Assessment and Documentation:**

- **Who:** Decide who will assess the patient's function and at what point during the visit this will take place.
- **Who Documents:** Assign responsibility for documenting the assessment results.
- **Where:** Determine where in the patient's chart the results will be recorded.

3. **Conduct a Trial:**

- Test the functional assessment process with one provider and a small group of patients (around 8 patients).

4. **Establish and Monitor Treatment Goals:**

- Set realistic treatment goals when starting therapy.
- Reevaluate the patient's function within 1-4 weeks of starting opioid therapy, and then at least every 3 months.
- Reassess function whenever there is an increase in dosage, especially if the patient is using methadone, fentanyl, or doses above 50 MME per day.
- If the risks of opioid therapy outweigh the benefits, consider tapering the opioids.

5. **Evaluate and Adjust:**

- Decide whether to move forward with full implementation or if adjustments are needed based on the trial.

Measure Success:

- Example: Perform a chart audit to ensure that functional assessments are being documented as planned.

⬅BACK "How do I assess and manage a patient's pain during opioid therapy?" (Scenario A)

⬅BACK "How can I evaluate and manage the pain of my patients with chronic pain previously

#7 Assess patient pain

1. **Select a Pain Assessment Tool:**

- Review available pain assessment tools and choose one that your practice will use consistently.
- Examples from Appendix:
  - **PEG:** Pain, Enjoyment, and General Activity
  - **5As:** 5 Additional Assessments (with **PEG,** above)
  - **PROMIS Pain Interference**
  - **PROMIS Pain Intensity**
  - **SF12:** Short Form 12
  - **Oswestry** neck and back
  - **Rapid 3**: Routine Assessment of Patient Index Data
  - **PADT:** Pain Assessment and Documentation Tool

treated by a different provider?" (Scenario B)

"How can I evaluate and manage the pain of my patients with chronic pain while on opioid therapy?" (Scenario C)

- Other examples available on the Internet:
  - Brief Pain Inventory
  - Wong-Baker Faces Pain Rating 0-10 Scale

2. **Determine the Process for Assessment and Documentation:**
- **Who:** Decide who will assess the patient's pain and at what point during the visit this will occur.
- **Who Documents:** Assign responsibility for documenting the assessment results.
- **Where:** Determine where in the patient's chart the results will be recorded.

3. **Conduct a Trial:**
- Test the pain assessment process with one provider and a small group of patients (around 8 patients).

4. **Establish and Monitor Treatment Goals:**
- Set realistic treatment goals when starting therapy.
- Reevaluate the patient's pain within 1-4 weeks of starting opioid therapy, and then at least every 3 months.
- Reassess pain whenever there is an increase in dosage, especially if the patient is using methadone, fentanyl, or doses above 50 MME per day.
- If the risks of opioid therapy outweigh the benefits, consider tapering the opioids.

Evaluate and Adjust:

- Decide whether to move forward with full implementation or if adjustments are needed based on the trial.

Measure Success:

- Example: Perform a chart audit to ensure that pain assessments are being documented as planned.

"How can I recognize behaviors that may signal opioid misuse and engage patients in therapeutic conversations that promote safety and

#8 Recognize special issues presented by patients for therapeutic conversations

1. **Identify Special Issues to Track:**
- Review common special issues that may arise during therapeutic conversations and select those your practice will consistently monitor.
- Examples to consider: negative urine test, incorrect pill counts, missed appointments, frequently misunderstood instructions,

trust?" (Scenario A)

"How can I identify and address special issues presented by my patients with chronic pain previously treated by a different provider to improve therapeutic conversations?" (Scenario B)

"How can I recognize and address behaviors that may indicate opioid misuse during therapeutic conversations?" (Scenario C)

being rude to staff, or attempting to create conflict between the prescriber and staff ("splitting").

2. **Determine the Process for Identifying and Documenting Special Issues:**
- **Who:** Decide who is responsible for identifying special issues as they arise.
- **What:** Determine what information will be documented in the patient's chart and how providers will be alerted to these issues.
- **Who Documents:** Assign responsibility for documenting the identified issues.
- **Where:** Decide where in the patient's chart the documentation will be recorded.

3. **Conduct a Trial:**
- Test the process of identifying and documenting special issues over a set period.

4. **Evaluate and Adjust:**
- Decide whether to move forward with full implementation or if adjustments are needed based on the trial.

Measure Success:

- Example: Perform a chart audit to ensure that special issues are being documented as planned.

Manage

🔙BACK "How can I systematically see my panel of patients treated with long-term opioids and plan for follow-up when needed?" Scenario A)

🔙BACK "How can I systematically keep track of my panel of patients treated with long-term opioids and plan for follow-up when needed?" (Scenario B)

🔙BACK "How can I systematically keep track of my panel of patients treated with long-term opioids and plan for follow-up when needed?" (Scenario C)

#9 Roster: Create a roster of patients treated with opioids for panel management reports and follow up

1. **Create or Update a Patient Roster:**

- **Develop the Roster:**
  - **Providers' Input:** Build the roster over several months as patients come in for prescription renewals.
  - **PDMP Download:** Use the Prescription Drug Monitoring Program (PDMP), such as the VPMS in Vermont, to download a list of prescriptions by a specific prescriber, using a two year lookback period. Instructions for VPMS downloading are in *Appendix 3: Roster Instructions Using PDMP data*:
    - Part 1: Providers download their PDMP records
    - Part 2: Combine Prescriber PDMP Data
  - **Electronic Medical Record (EMR) System:** If applicable, define the roster based on billing or pharmacy codes.
  - **Practice-Specific Tools:** Consider using tools within the practice's EHR system to add a specific problem code (e.g., Chronic Pain Syndrome [ICD9 - 338.4] or Other Chronic Pain [ICD10 – R52.2]).

2. **Organize and Review the Roster:**

- **Print and Review:**
  - Print the roster organized by practice and by prescriber.
  - Early in the project, review the roster to:
    - Identify missing patients who should be included
    - Remove those who do not belong on the roster
    - Decide if cross-covering providers should be included or consulted as the team progresses.

3. **Track Patients for Follow-Up:**

- **Utilize the Roster:**
  - Use the roster to monitor patients needing follow-up based on:
    - The practice's chronic pain management protocols (e.g., patients requiring follow-up).
    - Strategies from the Toolkit, such as scheduling regular Chronic Pain Management visits or identifying patients for random urine screens.
    - Care management and chart reviews according to chronic pain protocols.

Measure Success:

- Cross-reference the roster with patient visit history.
- Cross-reference the roster with medications prescribed.

🔙BACK "How can I share important patient care issues and cases with my peers?" (Scenario A)

🔙BACK "How can I share important patient care issues and cases with my peers?" (Scenario B)

🔙BACK "How can I share important patient care issues and cases with my peers?" (Scenario C)

#10 Update your Chronic Pain Management Council at next meeting

1. **Schedule Regular Meetings:**
- Set consistent meeting times for the Chronic Pain Management Council to facilitate group discussions and support decision-making for complex patient cases.

2. **Rotate Case Presentations among providers:**
- Ask providers to take turns presenting selected patient case histories during the meetings for review as part of the Pain Management Council.

3. **Review reports on patient populations** treated with long-term opioids. See *Appendix 4: Report Examples* for sample reports:
    - Reports by provider
    - Details of provider prescribing

Measure Success:

- **Prescriber Satisfaction:**
    - Assess the satisfaction of prescribers with the process, ensuring it effectively supports their clinical decisions and patient care.

Monitor

[⬅️BACK "How often should I check the Prescription Drug Monitoring Program?" (Scenario A)]

[⬅️BACK "How can I effectively use the PDMP to manage opioid prescriptions for chronic pain patients during transition between prescribers" (Scenario B)]

#11 Check Prescription Drug Monitoring Program

1. Determine Review Frequency:

- Decide how often to review patients' PDMP records, either at every pain-related visit or at regular intervals.

2. Assign Responsibilities:

- Decide who will review the PDMP records (prescriber, delegated nurse, medical assistant, or other staff) and when they will do it. For example:
  - **For pain-related visits:** Review as part of pre-visit preparations (e.g., when printing the superbill, prepping the chart, or during the reminder phone call).
  - **At regular intervals:** Review patients' records in batches to combine multiple requests into a single report.

3. Ensure Training and Access:

- Make sure all prescribers and delegated staff are trained and have active passwords for the PDMP.

4. Utilize the PDMP Functions:

- Consider using the Bulk Patient Search and Report functions within the PDMP to streamline the review process.

Measure Success:

- **Evaluate PDMP access:**
  - Discuss with providers and staff on the use of PDMP data as part of patient care

[⬅️BACK "How often should I collect urine samples from patients on opioid therapy" (Scenario A)]

[⬅️BACK "How can I effectively implement annual

#12 Screen urine at least annually

1. Determine Urine Screening Protocol:

- Decide whether to implement routine or random urine screening:
  - **Routine Testing:** Regular screening of all patients at predictable intervals (e.g., annually).

[urine screening for opioid therapy patients with chronic pain, especially when transitioning care between prescribers?"](#) (Scenario B)

[BACK "How frequently should urine samples be collected from patients on opioid therapy, and why is this practice important?"](#) (Scenario C)

- **Random (Scheduled or On-Demand)Testing:** Screening conducted at unpredictable intervals.

2. Prepare for Key Issues:

- Consider the following when planning urine screening:
  - Understand specific detection windows for substances screened to interpret results accurately.
  - Evaluate benefits and potential barriers of witnessed sample collection, accounting for cultural and gender considerations.
  - Establish a clear protocol for maintaining chain of custody for urine samples.
  - Develop procedures for handling positive results contested by patients.
  - Assess financial implications for patients, the practice, and the healthcare system.

3. Plan Logistics for Urine Sample Collection:

- Address logistical considerations within the practice:
  - Allocate appropriate physical space for sample collection.
  - Integrate urine sample collection into the rooming process.
  - Decide between internal or external testing services.
  - Decide whether to conduct witnessed samples and, if so, staff protocol for accompanying the patient for collection
  - Include in a sample collection protocol guidance the specific method required to confirm a valid sample (for example: the amount of sample needed, temperature, specific gravity) and how to record all requirements.
- Support prescriber understanding when to order opioid screening tests and opioid confirmation tests and how to order each, or both together.

4. Plan Decision-Making for Random Sampling:

- Determine criteria and methods for selecting patients for random urine sampling:
  - For scheduled visits, base decisions on documented issues or quarterly screening plans.
  - For on-demand visits, consider random assignment based on provider schedules or patient rosters.
  - For on-demand visits, develop scripts for phone calls to contact patients to come to clinic/office unexpectedly.

5. Establish Documentation Procedures:

- Create a structured process for documenting urine screening results:
    - Document responses from on-demand visit calls and manage non-responses or no-shows.
    - Address situations where patients are unable to provide a sample during the visit.

Measure Success:

- Implement methods to assess the effectiveness of urine screening procedures:
    - Maintain logs of on-demand visit phone calls.
    - Conduct chart audits to verify the presence and follow-up of lab results in the treatment plan.

⬅️BACK **"What are the potential benefits and limitations of random urine screening for opioid therapy patients?" (Scenario C)**

#13 Conduct a random pill count, depending on risk of individual

1. Consider the Risks vs. Benefits of Pill Counts:

- Determine if the benefit of doing a pill count is greater than the risk of asking patients to carry controlled, unsecured substances with them over the course of the day.

2. Develop Plan for Determining if a Pill Count is Needed:

- For scheduled visits, the decision can be dependent on:
    - A special issue documented in the chart indicating unexpected behavior (calling in for medication refills).
    - Regular screening, such as at least once/quarter.
    - Random screening, such as by a coin toss
- For on-demand visits, patients may be randomly assigned to a "day of the week" based on the primary provider's schedule in the practice.
    - A random subset of "Monday's" patients are called on Monday morning and are required to come to the practice for a pill count.
    - Use the patient roster (Strategy #9) of patients with chronic pain to randomly select a subset to call.

3. Determine who makes the decision and when the decision gets made:

- For on-demand visits, develop a phone call script to assist callers

4. Plan a documentation process for results:

- For on-demand visits: non-responders or no-shows
- Unable to produce medications (for example, forgot to bring them)

Measure Success:

- For on-demand visits: log of phone calls made and responses
- Chart audits to confirm pill-count documentation
- Chart audits to confirm follow up in treatment plan for unexpected results.

⬅️BACK "How should I establish and maintain expectations with patients starting opioid therapy?" (Scenario A)

⬅️BACK "How can I maintain safe and responsible chronic pain management for patients transitioning care from a previous prescriber?" (Scenario B)

#14 Provide patient education on benefits and risks

1. Define Practice Expectations for Opioid Therapy Patients:

- Determine clear expectations for patients using opioid therapy for chronic pain within your practice.

2. Develop Informed Consent and Patient Agreement Template:

- Create or update an informed consent and patient agreement template applicable to all chronic pain patients.
  - Ensure the template accommodates patients with varying literacy levels and avoids technical jargon.
  - Coordinate with your healthcare system or health department for additional review and alignment with evolving expectations.

3. Implement Agreement Replacement Plan:

- Plan the rollout of the updated patient agreement:
  - Outline steps to replace the old agreement with the new version.
  - Schedule regular reviews and updates of the agreement, documenting these dates in patient records for easy tracking.

4. Ensure Documentation and Distribution:

- Document each agreement review date in the patient's medical record, using a flowsheet or similar method.
- Establish procedures to provide patients with a copy of the agreement and retain a signed copy in their medical records.

- Consider sharing completed agreements with other healthcare providers, such as Emergency Departments, for continuity of care.

5. Establish Regular Review Process with Patient:

- Determine the procedure for ongoing review of patient agreements
- Assign responsibility for chart review to identify when the next agreement review is due.

Measure Success:

- Evaluate the effectiveness of the agreement management process:
    - Verify the presence of the updated agreement in patient charts.
    - Monitor the recency of the last agreement update to maintain current practice standards.

Prescribe

[⬅BACK "How should I approach the initiation of opioids while adhering to CDC guidelines and considering the risks associated with dosage levels?"](#) **(Scenario A)**

[⬅BACK "What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"](#) **(Scenario B)**

[⬅BACK "What are the recommended practices for prescribing opioids, and how can naloxone be effectively used to enhance patient safety?"](#) **(Scenario C)**

#15 Best practices in prescribing for patients

1. **Engage Prescribers in MME Discussion:**
   - Discuss and agree with prescribers on calculating Morphine Milligram Equivalents (MME) and documenting them in patient charts.
2. **Utilize Electronic Health Record for MME:**
   - Explore how your electronic health record system can support the documentation of MME calculations.
3. **Inform Patients about Naloxone Availability:**
   - Inform patients about where they can obtain naloxone:
     i. In Vermont, pharmacists can sell naloxone without a prescription.
     ii. Some health departments (Vermont) provide free naloxone at various locations statewide. Research this for your own state and advise patients accordingly about obtaining a naloxone rescue kit.
     iii. Recommend patients update their clinic and pharmacy medication profiles to reflect their naloxone use.
4. **Calculate MME and Set Thresholds:**
   - Calculate MME for opioid prescriptions:
     i. 50-89 MME per day is considered a "yellow light."
     ii. 90+ MME per day is considered a "flashing red light."
     iii. See Strategy #21 for conversions
5. **Offer Naloxone to All Patients on Chronic Opioids:**
   - Offer naloxone to all patients on chronic opioids, regardless of apparent risk factors.
6. **Create Patient Education Materials:**
   - Develop materials to reduce stigma associated with naloxone use.
   - Emphasize that naloxone is for preventing adverse outcomes, similar to carrying epinephrine for severe allergic reactions.
7. **Educate Patients on Naloxone Use:**
   - Educate patients on how to use naloxone and encourage them to educate family members or others who may be present during an overdose.

8. **Maintain Naloxone Supply and Train Staff:**
    - Ensure a supply of naloxone is available in the clinic.
    - Train staff on accessing and administering naloxone in case of an overdose on-site.

Measure Success

- **Documented MME in Charts:**
    - Verify presence of MME documentation in patient charts.
- **Patient Education and Treatment Plan Adjustments:**
    - Confirm patient education and adjustments in treatment plans for doses exceeding 50 MME/day.
- **Naloxone Offered for High-Risk Patients:**
    - Ensure naloxone is offered to patients with doses exceeding 50 MME/day or those concurrently using benzodiazepines.

🔙BACK **"How should I optimize medication dosages to enhance patient convenience and adherence?" (Scenario A)**

🔙BACK **"How should I prescribe medication durations for patients with chronic pain during a care transition?" (Scenario B)**

#16 Prescribe in multiples of 7 days in duration of dosage

1. **Post Monthly Calendars:**
    - Hang monthly calendars in prescription writing areas (like exam rooms) for easy counting of prescription durations.
2. **Prescribe in 7-Day Multiples:**
    - Ensure all opioid prescriptions are written in multiples of 7 days using a unified system (either electronic or handwritten, not both):
        - Change 30 days to 28 days
        - Change 60 days to 56 days
        - Change 90 days to 84 days

Measure Success

- **Monitor Prescription Date Cycles:**
    - Track how prescription dates align with the calendar to ensure consistent scheduling.
- **Survey Provider and Staff Satisfaction:**
    - Gather feedback from providers and staff to gauge satisfaction with the new prescription scheduling system.

⬅️BACK "How should I handle prescription management for patients with chronic pain during a transition of care?" (Scenario B)

#17 Pre-write prescriptions for up to 84 days when management is stable

1. Determine your state's position on pre-written prescriptions

- Investigate whether your state law allows prescribers to write multiple prescriptions of opioids for use at future dates.

2. Decide on Prescription Handling:

- Determine whether the front desk will hold the prescriptions to be filled in the future or if they will be given directly to the patient.

3. Establish the Process for Dispensing Prescriptions:

- **If Given to the Patient:**
  - Decide whether the provider will hand the prescriptions directly to the patient or take them to the front desk, requiring the patient to "check out" and complete any additional steps, such as scheduling the next visit.
- **If Left at the Pharmacy:**
  - Identify pharmacies willing to hold unfilled opioid prescriptions, as some retail pharmacies may not accept this responsibility.
- **If Held by the Front Desk:**
  - Create a log-in/sign-out protocol for office staff to manage the prescriptions securely.

4. Plan for Prior Authorization Needs:

- Consider whether "prior authorization" will be needed for some prescriptions. If so, keep information about the next renewal date easily accessible so staff can initiate the renewal process in advance.

Measure Success:

- **Log of Prescription Pick-Up:** Track when and how prescriptions are picked up.
- **Patient Phone Volume:** Monitor the number of patient calls related to prescription requests.

⬅️BACK **"How should I adjust prescription packaging for patients with chronic pain when the risk of misuse is increasing?" (Scenario B)**

⬅️BACK **"When should I consider using secure packaging like bubble packs for patients on high-dose opioids, and how does this practice help manage risk and ensure proper medication use?" (Scenario C)**

#18 Prescribe using bubble packs if risk level is increasing, depending on availability in local pharmacies

1. Identify Pharmacies Offering Bubble Packs:

- Research and identify pharmacies by geographic location that can dispense medications in bubble packs.

2. Determine Costs and Insurance Coverage:

- Find out if bubble pack packaging will incur additional costs for the patient or if it is covered by insurance plans.

3. Decide on Pharmacy Changes:

- Determine if the provider will require patients to switch pharmacies to use this strategy.

4. Make Pharmacy Information Easily Accessible:

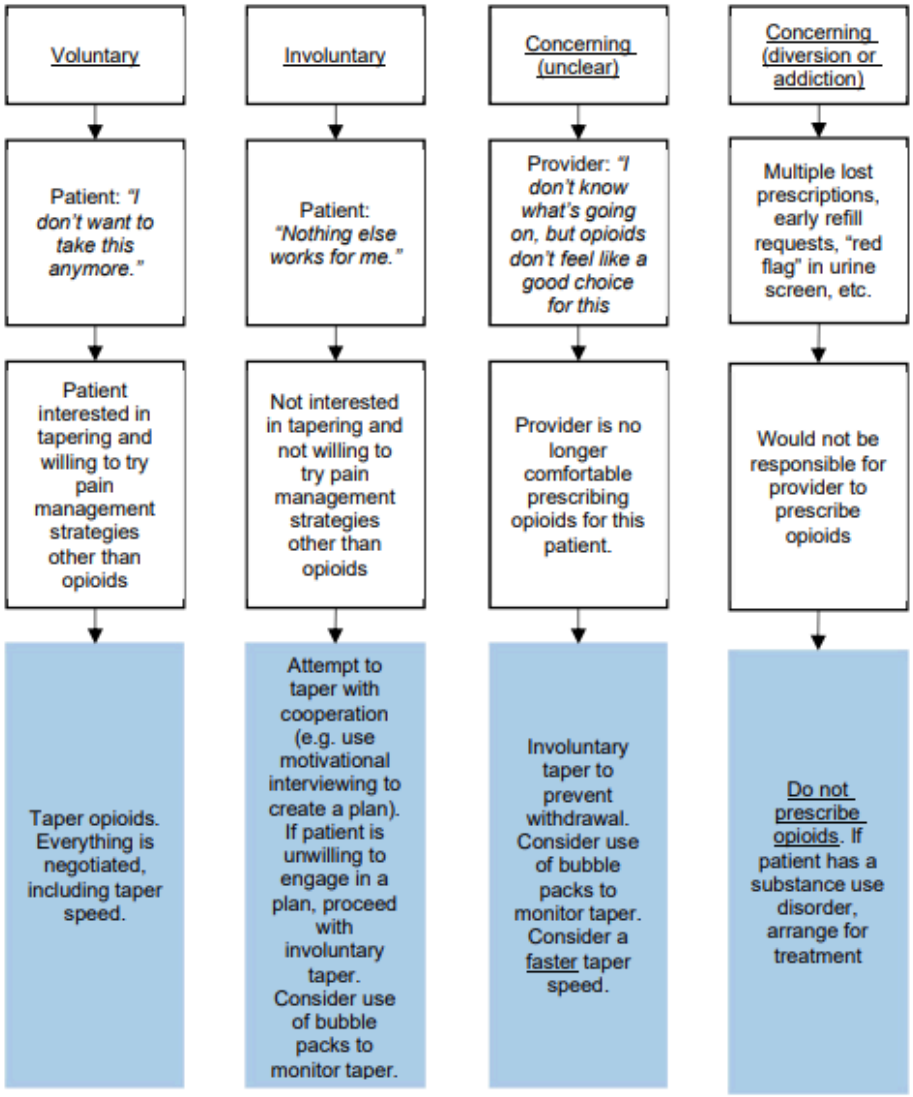
- Place lists of cooperating pharmacies in exam rooms or embed them in the documentation system for quick access by prescribers.

Measure Success:

- **List of Available Pharmacies:** Ensure an up-to-date list of pharmacies that provide bubble packs is readily available.
- **Prescription Records:** Review patient charts to track the use of bubble packs in prescriptions.

⬅BACK "How should I determine when to taper or discontinue opioid therapy for patients, and what factors should guide this decision?" (Scenario C)

#19 Tapering schedule with follow up patient visits based on individual need



1. Engage Prescribers on Key Considerations:

- **Pregnancy Screening:**
  - Ensure prescribers agree to ask or screen patients for pregnancy before tapering.
  - If the patient is pregnant, involve specialists (e.g., high-risk obstetrics) and do not attempt tapering unless you have specific experience and training in this area.
- **Opioid Use Disorder (OUD):**

    - If tapering or discontinuing due to newly identified OUD, arrange for evidence-based treatment.
- **Non-Opioid Pain Management:**
    - Initiate behavioral and other non-opioid pain management strategies alongside the tapering process.

2. Plan the Tapering Process:

- **Calculate Total MME:**
    - Determine the patient's total daily Morphine Milligram Equivalent (MME) for their opioid regimen.
- **Prioritize Tapering:**
    - If the patient is on multiple opioids or an opioid and a benzodiazepine, decide which medication to taper first.
- **Adjust Dosage:**
    - Use available strengths to gradually reduce the dose, ensuring the patient understands and can follow the plan.
    - Consider using bubble packs to help the patient adhere to the tapering schedule.

3. Monitor Patient Progress:

- **Regular Check-Ins:**
    - Follow up with the patient frequently, especially if the taper is progressing quickly.
- **Adjust the Tapering Pace:**
    - Slow down the taper if the patient experiences withdrawal symptoms.
- **Monitor Pain and Function:**
    - Use evidence-based tools like the PEG scale to monitor pain and function during the tapering process.
- **Withdrawal Monitoring:**
    - Consider using tools like the Clinical Opiate Withdrawal Scale (COWS) to track withdrawal symptoms.

4. Leverage Electronic Health Records (EHR):

- Explore how your EHR can support documentation and tracking of the tapering process.

Measure Success:

- **Chart Review:**
    - Review patient charts to ensure adherence to the tapering protocol and consider case reviews for complex situations.

⬅️BACK "What do I need to know about #20 Prescribing Buprenorphine for Chronic Pain

Buprenorphine as an alternative pain medication, and what factors should guide shared decision-making?" (Scenario C)

1. **Background Information on Buprenorphine:**
    - Buprenorphine is widely used in the care of patients with Opioid Use Disorder (OUD), with increasing use in the primary care setting.
    - Although opioid prescribing for chronic pain is decreasing, many patients continue with long-term opioid therapy (LOT).
    - Patients who remain on LOT are sometimes interested in transitioning from full opioid agonists to buprenorphine given its superior safety profile.

2. **Formulations of Buprenorphine:**
    - A Schedule III partial opioid agonist that has uniquely high binding affinity for the mu opioid receptor, making it effective for treatment of OUD.
    - In addition, provides analgesia with some formulations FDA approved for pain management:
        i. Transdermal patch (Butrans)
        ii. Buccal film (Belbuca)
    - Off-label alternatives:
        i. Sublingual films (Suboxone)
        ii. Sublingual tablets (Zubsolv)

3. **Safety Advantages and Health Risks:**
    - Less physical dependence
    - Less opioid-induced hyperalgesia
    - Less respiratory depression
    - However, although less common, risks include respiratory depression, especially when used with other sedating substances such as alcohol and benzodiazepines

4. **Endorsements**
    - Department of Health and Human Services: for patients requiring around-the-clock opioid treatment for chronic pain
    - Veteran's Affairs/Department of Defense: to lower risk for overdose and misuse (VA National Guidance)
    - However, the evidence base is still underdeveloped

5. **Patients to consider for transition to buprenorphine**
   Review checklist with patient for shared decision-making:
        ☐ Need for continued opioid therapy OR difficulty with tapering

- ☐ AND concern for adverse effects of long-term agonist treatment:
    - ☐ Increasing age
    - ☐ Underlying respiratory disease
    - ☐ Disordered sleep (such as sleep apnea)
    - ☐ Mild-moderate hepatic or renal impairment
    - ☐ Significant side effects from full-agonist treatment (constipation, hypogonadism, etc)
    - ☐ High-dose opioid treatment (> 90-120 MME)
    - ☐ History of opioid misuse/overdose (or at increased risk per COMM)
    - ☐ Current opioid treatment ineffective in improving functional status or providing analgesia
    - ☐ Concomitant sedative use (e.g. gabapentinoids, alcohol, and benzodiazepines - recognize increased risk of respiratory depression)
    - ☐ Patient preference

6. **Buprenorphine Transition Choices**:
    - Recognize that the evidence base is limited; some is based on using buprenorphine for OUD
    - When using buprenorphine for chronic pain, the goal is to manage pain and to improve functional status and quality of life. When used for OUD, the primary goal is harm reduction.
        i. Patients with chronic pain may stabilize on lower doses of buprenorphine than typically used in OUD
        ii. Lower doses of buprenorphine are usually not sufficient or appropriate for treatment of OUD

7. **Buprenorphine Initiation**
    - Traditional transition approach (STOP/START)
        i. Patient abstains from full-agonist opioids for 12-48 hours
        ii. Can include taper to lower-dose full-agonist dosing prior to transition
        iii. Initiation of buprenorphine as early withdrawal symptoms start
        iv. Pros: Quick, and often tolerated; Able to assess buprenorphine effectiveness for pain; Similar to traditional buprenorphine induction for OUD (although typically use lower doses of buprenorphine); Some PCPs may have experience with OUD induction
        v. Cons: Withdrawal symptoms are uncomfortable; Pain can be exacerbated; May be a barrier to agreement to transition, especially if withdrawal been difficult in past
    - Low-dose Buprenorphine Induction (Microinduction)
        i. Continuation of full-agonist opioid as low-dose buprenorphine is initiated (with expectation that withdrawal symptoms will be minimized)
        ii. Gradual increase of buprenorphine dose

iii. When buprenorphine at target dose, full-agonist opioid discontinued
iv. Pros: Minimizes withdrawal symptoms; Lower likelihood of pain exacerbation
v. Cons: More complicated dosing schedule; Less familiar than STOP/START approach for many clinicians; evidence base on use and varied recommendations on what protocol to choose

- Buprenorphine Formulation Choice
  i. Transdermal (ie Butrans):
     1. Patch remains in place for 7 days
     2. Primarily for patients on < 30-50 MME/day
     3. If > 30 MME, recommend taper to MME 30 and then transition directly to 10 mcg patch when next dose due
     4. Not recommended for higher baseline MME
  ii. Buccal (i.e., Belbuca):
     1. Film applied to inside of cheek, held for 5 sec and left in place until dissolved (~ 30 minutes)
     2. Rinse after dissolved to decrease dental complications
     3. Per package insert, recommend taper to 30 MME before transitioning (see below for recommendations)
     4. However, others (including the VA) have recommended direction conversion (or use in microinduction)
        a. MME 30-89: 150 mcg/12 hours
        b. MME 90-160: 300 mcg/12 hrs
        c. MME > 160: Consider using SL buprenorphine (or alternately 450 mcg/12 hours)
  iii. Sublingual (ie Suboxone):
     1. Not FDA approved for chronic pain
     2. May need to dose more frequently for pain (as compared to OUD)
     3. More typical to use in patients with:
        a. Higher doses of full-agonist therapy (i.e. > 90-160 MME)
     4. Poor symptom control or behavioral risks (without a diagnosis of OUD)
  iv. Options include STOP/START or microinduction

8. Transition Options Based on Baseline Opioid Dosing

- STOP/START Dosing: dosing typically 8-12 hours after last opioid or when early withdrawal symptoms begin:

	MME < 30	MME 31-59	MME 60-89	MME 90-160	MME > 160
Transdermal	5-10 mcg	Taper to 30 MME or 10 mcg	-------	-------	------
Buccal	75 mcg 1-2 times/day	150 mcg BID	150 mcg BID	300 mcg BID	Can consider 450 mcg BID
Sublingual	--------	--------	--------	Similar to treatment of OUD with titration to 8-16 mg/day	Similar to treatment of OUD with titration to 8-16 mg/day

- Low-dose Buprenorphine Induction (Microinduction)
  - **i.** Multiples ways to initiate low-dose buprenorphine induction/microinduction
  - **ii.** Published protocol vary from 3-7 day overlap
  - **iii.** Conversions are not predictable
    1. Earlier protocols often used higher end-doses of buprenorphine
    2. For patients on 50 MME, 4-6 mg may be adequate
    3. For higher MME, may need 8-16 mg
  - iv. Example of Microinduction in patient on MME > 100

	Full agonist	Buprenorphine SL dose
Day 1	Continue	0.5 mg
Day 2	Continue	0.5 mg BID
Day 3	Continue	1 mg BID
Day 4	Continue	2 mg BID
Day 5	Continue	4 mg BID
Day 6	STOP	4 mg BID

9. Key Points

- Conversion of patients on full agonist opioid treatment to buprenorphine is an emerging option in efforts to reduce the harm from long-term opioid therapy for chronic pain.
- Clinicians should continue to follow opioid best-practices when using buprenorphine for pain
- Discussions around transition to buprenorphine should adhere to patient-centered shared decision-making practices.

- Current transition options include a STOP/START approach (similar to induction for OUD) or low-dose buprenorphine initiation in which full-dose opioid therapy and increasing doses of buprenorphine overlap (often referred to as microinduction).
- Given limited evidence and lack of clear standards of care, clinicians should carefully document rationale and logistics of transitions

Measure Success

- **Documented Buprenorphine Transition in Charts:**
  - Verify presence of Buprenorphine initiation in patient charts and regular follow-up.
- **Patient Education and Treatment Plan Adjustments:**
  - Confirm patient education and adjustments in treatment plans after Buprenorphine is stabilized.

Document

⬅BACK **"How should I track and manage opioid dosages?" (Scenario A)**

⬅BACK **"How should I track opioid dosage using milligram morphine equivalents (MME)?" (Scenario B)**

⬅BACK **"How can I accurately track and convert opioid dosages into milligram morphine equivalents (MME), and what should I be aware of when dealing with medications like methadone" (Scenario C)**

#21 Track dosage in MMEs, not quantity dispensed

1. Agree on MME Calculation:

- **Team Discussion:**
  - Ensure all prescribers agree on how to calculate Morphine Milligram Equivalents (MME) and the importance of documenting this in the patient's chart.
- **As of 2025, conversion includes:**
  - Oxycodone: 20 mg = 30 mg MME
  - Hydrocodone: 30 mg = 30 mg MME
  - Hydromorphone 6 mg = 30 mg MME
  - Morphine: 30 mg = 30 mg MME
  - Fentanyl patch 25 mcg patch = **50** mg MME
  - Tramadol 150 mg = 30 mg MME
  - Methadone: Methadone varies by dose and should only be used by prescribers with experience and with caution
- **Use an up to date MME Calculator:**
  - The CDC MME Calculator website is not maintained
  - As of 2025, the Ohio Automated Rx Reporting System is up to date

2. Integrate MME Documentation into EHR:

- **Electronic Health Records:**
  - Determine how your electronic health record (EHR) can support consistent documentation of MME calculations.

3. Calculate and Interpret MME:

- **Assess MME Levels:**
  - Calculate the patient's daily MME. Consider 50-89 daily MME as a "yellow light" (caution) and 90+ MME as a "flashing red light" (high risk).

Measure Success:

- **MME Documentation:**
  - Review patient charts to ensure that MME calculations are consistently documented.

"How should I document strategies related to chronic pain management?" (Scenario B)

#22 Use a flowsheet to document repeating strategies for opioid management

1. Design the Flowsheet or Template:

- **Customization:**
  - Create a flowsheet or template that aligns with your practice's philosophy, protocols, and the strategies outlined in the Toolkit.

2. Assign Data Entry Roles:

- **Role Definition:**
  - Clearly define who is responsible for entering specific data, such as lab results or updates to the Prescription Drug Monitoring Program (PDMP) fields.

3. Test the Flowsheet's Usability:

- **Trial Run:**
  - Conduct a trial to evaluate how well the flowsheet works, focusing on:
  - **Field Arrangement:**
    - Ensure the fields are logically arranged for efficient data entry.
  - **Response Options:**
    - Check the usability of dropdown choices and other input methods.
  - **Review Process:**
    - Assess how the flowsheet appears and functions when revisited during later patient visits.

Measure Success:

- **Documentation Review:**
  - Regularly review charts to ensure adherence to the documentation standards established.
- **Provider Feedback:**
  - Gather feedback from providers regarding their experience using the flowsheet, both as the primary provider and when covering for others.

Schedule

⬅️BACK **"How should I manage the transition from short-term to long-term opioid therapy?" (Scenario A)**

⬅️BACK **"How often should I follow up with patients after initiating high-dose opioid therapy, and what key elements should be included in the exit plan for therapy?" (Scenario C)**

#23 Short interval follow up

1. Set Patient Expectations:

- **Communicate Clearly:**
  - Inform patients that the early stages of transitions related to opioid treatment or any adjustments will require regular follow-up. When initiating opioids, assessments are scheduled no later than 4 weeks after initiation.

2. Integrate Follow-Up with Scheduling:

- **Scheduling Coordination:**
  - Ensure that the start or change in opioid treatment is directly linked to the practice's scheduling system, so follow-up appointments are automatically arranged.

Measure Success:

- **Review Visit Patterns:**
  - Monitor the visit schedules of patients who are on new or adjusted opioid therapy to ensure they align with the established follow-up intervals.
- **Monitor Patient Communication:**
  - Keep track of patient phone calls, looking out for unexpected requests such as medication adjustments or early refill requests, which may indicate a need for closer follow-up.

⬅️BACK **"How frequently should pain management visits be scheduled for patients with chronic pain receiving opioid treatment?" (Scenario B)**

#24 Ongoing visits at least every 90 days (84 when using 7 day strategy #16 above)

1. Establish a "Chronic Pain Management" Visit Type:

- **Scheduling System Integration:**
  - Create a specific visit type within the scheduling system dedicated to "Chronic Pain Management."

2. Set Visit Frequency Expectations:

- **Practice Guidelines:**

- Determine and standardize how often Chronic Pain Management visits should occur (e.g., every 84 days; see Strategy #16) across the practice.

3. Communicate with Patients:

- **Patient Engagement:**
  - Make it clear to patients that each Chronic Pain Management visit will conclude with scheduling the next visit.
- **Initial Introduction:**
  - Begin the process for the clinic/office practice by scheduling the first set of visits and communicating the new plan either through a letter from the practice or a conversation with their primary providers.

Measure Success:

- **Monitor Visit Patterns:**
  - Track the visit schedules of patients on opioid therapy to ensure adherence to the established 84-day intervals.
- **Watch for Patient Communication:**
  - Keep an eye on patient phone calls, particularly for unexpected requests like medication adjustments or early refills, which could signal a need for closer monitoring.

Engage

"How can I help my patients find community resources that offer alternative methods for managing chronic pain?" (Scenario A)

"How can I help my patients find community resources that offer alternative methods for managing chronic pain?" (Scenario B)

#25 Identify community resources that may be helpful and update periodically

1. Develop a Resource List:

- **Non-Opioid Pain Management Resources:**
  - Create a comprehensive list of community resources available for non-opioid pain management.

2. Confirm Availability:

- **Resource Validation:**
  - Ensure these resources are accessible and willing to work with patients dealing with chronic pain.

3. Periodic Updates:

- **Resource List Maintenance:**
  - Regularly review and update the resource list to reflect any changes in availability or new options.

Measure Success:

- **Track Participation:**
  - Monitor use of community resources.
- **Evaluate Impact:**
  - Assess how meaningful participants find the resources.

"How can I provide patients with additional resources to help them manage their chronic pain outside of regular appointments?" (Scenario A)

"How can I provide patients with additional resources to help them manage their chronic pain

#26 Build a patient library with books, CDs, etc.

1. Engage Prescribers:

- **Resource Recommendations:**
  - Discuss with prescribers to identify books, CDs, and other resources they would recommend to patients. Some suggestions to consider:

Books:

- *Managing Pain before it Manages You* by Margaret A. Caudill (Workbook format, ISBN 978-1-59385-982-4)
- *Natural Pain Relief* by Shinzen Young (Short book with CD of exercises, ISBN 978-1-60407-088-0)

outside of regular appointments?" (Scenario B)

Audio Files:

- *Mindfulness Meditation for Pain Relief* by Jon Kabat-Zinn (https://www.youtube.com/watch?v=QCNXi_0lsCk)

Apps for Smartphones:

- *Autogenic Training and Progressive Muscle Relaxation* by 01 Digitales Design (Includes techniques for chronic pain relief, with a fee)
- *Stop, Breathe, and Think* (Award-winning app available for free, focuses on mindfulness)
- *Mindfulness Training App* by Sounds True (Features expert-led mindfulness sessions)
- *Headspace* (Offers free trial and subscription-based meditation instruction, including sessions for pain management)

Websites:

- *Best Advice for People Taking Opioid Medication* by Jon Doc Mike Evans https://www.youtube.com/watch?v=7Na2m7lx-hU

These resources aim to support patients in managing their pain effectively and enhancing their well-being.

2. Select and Procure Resources:

- **Resource Curation:**
  - Decide which recommended resources the practice will offer or recommend, either for loan or purchase by patients.
- **Procurement and Storage:**
  - Establish a process for acquiring, organizing, and storing these resources for patient use.

3. Implement a Loan System:

- **Resource Access:**
  - Develop a system for patients to borrow or purchase the resources, ensuring easy access and return.

Measure Success:

- **Track Participation:**
  - Monitor use of patient library.
- **Evaluate Impact:**
  - Assess how meaningful participants find the resources.

🔙BACK "How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?" (Scenario A)

🔙BACK "How can I collaborate with local partners and agencies to build community support for responsible opioid use and effective responses to opioid misuse?" (Scenario B)

#27 Build community support with other partners/agencies

1. Identify Community Stakeholders:

- **Engage Interested Organizations and Leaders:**
  - **Health Care Providers:** Medical, behavioral, preventative, and acute/emergency care providers.
  - **Recovery Centers:** Organizations focused on addiction recovery.
  - **Public Health Providers:** Health departments and public health initiatives.
  - **Educators:** Schools, colleges, and educational organizations.
  - **Community Program Coordinators:** Leaders of community-based programs.
  - **Funders:** Organizations or businesses willing to fund training or initiatives.
  - **Community Businesses:** Businesses committed to health, wellness, prevention, or education.
  - **Legislators:** Engage when the legislature is not in session.
  - **Community Agencies/Organizations:** Churches, town governments, and other local entities.

2. Assess Existing Information:

- **Collect Community Data on Opioid Use:**
  - Gather reports from the state Department of Health.
  - Review summary statistics from your practice's opioid prescribing registry.
  - Collect information from other local initiatives.
- **Ensure Privacy:**
  - Share only aggregated data to maintain privacy, describing groups by age category rather than individuals.

3. Develop Community Engagement Goals:

- **Set Broad Goals and Specific Objectives:**
  - Request time on agendas at regular meetings of identified organizations.
  - Consider hosting a community event to engage broader participation.
- **Address Predictable Issues:**
  - Discuss topics like needle exchange programs, naloxone distribution and training, and updates from Medication

Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD) teams.
    - Cover trends in care, new standards, and primary care treatment in the use of prescription and non-prescription opioids.

4. Plan Community Work Logistics:

- **Assess Identified Needs:**
    - New educational programs may require funding or conference space.
    - Existing community needs without supportive programs may require start-up support.
- **Develop Support Tools and Methods:**
    - Create communication networks.
    - Draft grant applications to secure funding.
    - Develop educational resources to support community initiatives.

Measure Success:

- **Track Participation:**
    - Monitor attendance and participation in community meetings and events.
- **Evaluate Impact:**
    - Assess how meaningful participants find the work.
    - Measure participation in specific projects and the completion of tangible projects, such as community summits.
- **Strengthen Networks:**
    - Evaluate the development and inclusion within networks, focusing on diversity and consistency of activities.

🔙BACK "How can I educate my patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?" (Scenario A)

🔙BACK "How can I educate my

#28 Share skills that are widely useful, e.g. how to have "trigger" conversations

1. Engage in Educational Programs:

- **Participate in Relevant Training:**
    - Enroll in educational programs focused on opioid prescribing and management. May provide continuing education credits and meet state requirements.
    - **Examples Include:**
        - **Boston University SCOPE of Pain Program:** Offers online core content and supplemental

patients and staff about responsible opioid prescribing and effectively discuss high-risk behaviors and side effects?"
(Scenario B)

training for opioid prescribers, including patient-centered approaches to opioid tapering.
- **American Society of Addiction Medicine CO*RE/ASAM Curriculum:** Covers pain management, opioids, balancing risks & benefits.
- **Veterans Administration's Opioid Taper Decision Tool:** Provides print materials focused on opioid tapering.
- **Defense and Veterans Center for Integrative Pain Management Video:** Features a 35-minute video on initiating collaborative tapering, including difficult conversations about opioid tapering.

2. Identify Local and National Experts:
- **Find Available Educators:**
  - Locate local experts who can provide education to office staff and prescribers on managing chronic pain. Consider academic detailing programs or other local resources.
- **Contact the NCCC:**
  - The National Clinic Consultation Center provides a confidential, peer-to-peer consultation session with an expert requiring no patient-identifying information

3. Implement Lessons Learned:
- **Discuss and Apply Insights:**
  - Engage the practice in discussions about lessons learned from the educational programs.
  - Develop strategies to incorporate these insights into your local practice to improve communication and pain management approaches, such as Medical Group Visits for opioid treatment for chronic pain.

Measure Success:

- **Evaluate Implementation:**
  - Assess the integration of new skills and approaches into practice.
  - Collect feedback from staff and prescribers on the effectiveness of the training and its impact on managing difficult conversations.

Appendix: Screening Tools, PDMP Data & Reports

1. Initial Assessments
    a. **ORT** (Opioid Risk Tool) – A questionnaire with 5 questions to be completed by the clinician in conversation with the patient.
    b. **SOAPP-14** (Screener and Opioid Assessment for Patients with Pain - 14 questions) – A questionnaire completed by the patient.
    c. **SOAPP-SF** (Screener and Opioid Assessment for Patients with Pain - 5 questions) – A short version of the patient-completed questionnaire.
    d. **SOAPP-R** (Revised Screener and Opioid Assessment for Patients with Pain) – A more extensive assessment with 24 questions, also completed by the patient.
    e. **Chronic Pain Assessment Algorithm and DIRE Score** – This evaluates 7 risk factors and is conducted by the provider.

2. Ongoing Assessments
    a. **PEG:** Pain, Enjoyment, and General Activity
    b. **COMM:** Current Opioid Misuse Measure
    c. **5As:** 5 Additional Assessments (with **PEG,** above)
    d. PROMIS Pain Interference
    e. PROMIS Pain Intensity
    f. **SF12:** Short Form 12
    g. **Oswestry** neck and back
    h. **Rapid 3**: Routine Assessment of Patient Index Data
    i. **PADT:** Pain Assessment and Documentation Tool

3. Roster Instructions Using PDMP Data
    a. PDMP Download Part 1
    b. PDMP Combine Data Part 2

4. Panel Management Report Examples using PDMP Data
    a. Opioid Prescribing Panel Management Report Example 1: By Prescriber - Summary
    b. Opioid Prescribing Panel Management Report Example 2: By Prescriber - Detailed

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