Elements of Leverage Point #3: Applying Universal Precautions to Chronic Opioid Therapy	Purpose	Patients	Professionals	Processes	Patterns
1. Diagnosis with reasonable differential	Determine appropriate course of treatment. This is what we do for all diagnoses.	Helps pt understand what needs to be treated and potential treatment outcomes.	Mindful, conscious effort to make the differential diagnosis FIRST before considering medication. Supports provider focusing on treating/discussing the root cause of the pain (etiology). Support providers in seeking out other professionals for input in the diagnosis process (via case review)	Differentiate who to treat with opioids Tactic/Strategy: Increase use of peer to peer and team case review prior to initiating long term opioid therapy (this should take place during the "trial" period for new pts. and at routine intervals for those pts currently receiving COT)	Historical pattern may be to consider medication before explore all treatment options associated with the diagnosis.
2. Psychological assessment including risk of addictive disorders	More in-depth information to apply to diagnosis and treatment direction. This assessment process may result in the increased use of adjunctive therapies (CBT, relaxation etc.) Another data point in assessing the risk vs. benefit of the treatment will diffuse the emotionality associated with opiate-based	Help mitigate bias – some pts may fear addiction and refuse opioid-based therapies. Need to consider how this new assessment process will be introduced and received by pts currently on COT. 1 page, patient-friendly handout needed.	Provider may not be the best to conduct psychological assessment. Educate pts that this assessment process is what we do for all pts (initial screen) and that because we are considering a medication that is addictive we are taking these extra precautions (more in-depth screen specific to risk for addiction.	Communicate to new pts vs current pts receiving opioid therapy -needed: straightforward, usable tool that is embedded in EMR workflow (example: controlled substances template expanded to both risk and functionality assessment) Tactic/Strategy: Chronic Pain pathway in EMR expanded to include risk assessment	New patient vs. Current COT patient → differences in visit lengths and how to determine the time needed to conduct risk assessment(s).

	medications.		Support providers in how to explain a dosing reduction based upon assessed risk for addiction. A factual, medical script is needed to support equitable, comfortable decision-making		
3. Obtain informed consent accompanied by patient education materials	The "contract" clearly defines the expectation of informing the patient. The informed consent should be expanded to education materials related to both risk & benefit of opioid-therapy. This document is intended to facilitate the conversation/discussion with the patient and within the health care system/setting.	Understand that informed consent is used to increase communication between provider and patient. Within the informed consent, pt education, treatment agreement process patients should understand that this (opioid medications) is <u>one</u> treatment option to support you – medication is not a stand-alone resource.	Provider is ultimately responsible for informed consent. This process should become more comprehensive and be inclusive of informed consent, pt education and Agreement. Provider should have reasonable knowledge of the risk assessment process outlined in informed consent.	Informed consent, pt education and Agreement are currently different elements within the process. This should become one comprehensive document/approach/conversation with pt. The document should be system-wide and communicated through 1 page patient education material (to all patients not just those on/seeking treatment for pain). Tactic/Strategy: if "fail" to meet pt obligations within the informed consent and/or agreement the "order" for opioid-based medications is moved to the allergies box within EMR. Tactic/Strategy: ID higher risk populations (pregnant women) and use additional pt education	Opportunity for team-based care using the content of informed consent, pt education materials and Pain Treatment Agreement to outline/identify roles for the care team (RN, Care Manager, Behavioral Health Consultants, Psych NPs, LCSWs and psychiatrists.

				and informed consent content i.e. women of child bearing age should be given pregnancy test before prescribed opioid-based medications.	
4. Patient Pain Treatment Agreement (PPTA or PPA) that identifies both the patient & provider's responsibilities		Goals should be referenced in the treatment agreement. Patients should be made aware of what a "fail" means within the CHC system.	Patient and provider responsibilities include: -Safety (toxicity and pt adherence to safe storage, disposal and ownership) -Dosing compliance (this is the recommended dose and this is why) -Effects of treatment (side effects, reasonable expectations for pain relief, focus on improved functionality, use of adjunctive therapies/resources) These 3 elements support pt goal attainment	Treatment agreement will be an element of informed consent and required pt education. Tactic/Strategy: As part of the agreement all women of child-bearing age receive contraceptive information (similar to what is done for Accutane) and the risks associated with opioid use during pregnancy. Tactic/Strategy: Apply the "driver evaluation form" to the Treatment Agreement (specific to those with existing conditions that require form, bus drivers and commercially licensed individuals.	Frequency of treatment plan review as determined by provider, input from assessments and potential for positive outcomes (decreased pain, increased functionality, reduction in abuse, addiction and diversion potential).
5. Pre and post-intervention assessment of pain level <u>and function</u>	Assessing function demonstrates the effectiveness of treatment. If a pt hasn't improved this can help inform treatment.	Much of what is assessed is based upon self-reporting. Positive: patient feels they have direct ownership of their treatment. Negative: patients with ulterior motivates may skew their reporting.	Prioritize with the pt when reviewing their Treatment plan, base pain and functional assessment on their goals by applying a Likert scale to the goals of greatest priority.	Function will be assessed depending upon frequency of visit. Tactic/Strategy: No pt on COT should go longer than 3 months without functional assessment and review of treatment goals.	Goals set at onset of treatment and reviewed at set intervals alongside the informed consent, pt education information needed and Treatment Plan.

		Educate patient on the use of screening tools and if/what other professional resources at Health Center will be supporting their care. Increase pt understanding that "pain free" may not be the ultimate goal – patient identify their preferred level of pain management with increased functionality (what activities would greatly improve their quality of life)	Provider is the expert on interpreting the impact of side effects as compared to relief and functionality. Defer to patient education staff or others to teach pts how to chart goal setting and achievement over time ("even though I still have pain I have been able to go to my son's basketball games for the past 4 weeks")		
6. Appropriate trial of Opioid Therapy +/- Adjuvant Meds and therapies	Due to the risk associated with medication treatment we need to determine what is most appropriate for the pt to increase quality of life and reduce the pain.	Patient understands that a trial will also help identify the impact side effects may have on their improved functionality and pain relief. For opiate naive pts. a trial will help inform what is going to work best for you. Determining if a trial is needed affirms that the pt has been heard by their provider, that their pain is "real" and provides time to have the "chronic may mean	Need more research and discussion on what a trial period is (21 days) and the maximum dosage associated with a trial) Need more training in pseudo-addiction vs. addiction	When initiating a trial pt should be seen in the office for risk, pain level and functional assessment purposes within 2-4 weeks of initiation.	New patient specific

		lifelong" conversation(s).			
7. Reassessment of pain score and level of function	Help inform the course of treatment and provide patient with tangible milestones to work towards.	Increase pt understanding of the need to monitor toxicity and safety within the reassessment process Apply a familiar context (for other chronic conditions we reassess at every visit)	Align this conversation with a familiar context (hypertension, cholesterol, diabetes etc.) and build upon provider's level of comfort in assessing and conversing with pts. -needed: straightforward, usable tool that is embedded in EMR workflow (example: controlled substances template expanded to both risk and functionality assessment) Include provider in determining the amount of time needed to conduct initial assessment and reassessment (population management).	Tactic/Strategy: Pt seen within 2-4 weeks of initiating opioid trial. If prescribed longer term opioid therapy patient seen no longer than 3 month intervals for full assessment of risk, pain level and functionality. Pts currently on COT seen at a minimum of 3 month interval for full reassessment	Increase in provider education Increase in CHC administration education Increase in education for CHC Community Boards – they should be seen as ambassadors of the potential community and public health benefit of treating chronic pain and how opiates are prescribed.
8. Regularly assess the "4 A's"of pain medicine: ▪ Analgesia (pain relief) ▪ Activities of daily living (ADLs; functional outcomes) ▪ Adverse effects (side	Provides a simple checklist of elements within the informed consent, pt education process and Treatment plan. Providing this clinical	Increase pts awareness of risks and adverse effects. Provide opportunity to give pt solutions and resources during course of treatment	Supporting providers in asking direct questions associated with the 4 A's What is the value of the signature on the informed consent that outlines the 4	The 4 A's are a method within the proposed process changes. The 4 A's should be referenced in pt education materials, self management/goal setting and part of the 3 month reassessment.	With supporting policies, training and systems these elements will become part of an organic, routine conversation with patients receiving or seeking pain management with COT.

effects) ▪ Aberrant drug-related behaviors (appropriate use and adherence vs. misuse or addiction-related outcomes).	summary at the close of the visit supports the Meaningful Use of the EHR.	Increase understanding of agreement content and decrease the "I didn't know" response when aberrant behaviors are confirmed.	A's, pt education materials and Treatment plan?	Completion of all elements will require more time. A separate visit that utilizes team members from physical and behavioral health is recommended to meet all processes to implement Universal Precautions. Assessment and pt education process should also recognize protective factors (locking up your meds & safe disposal, travel considerations).	
9. Periodically review pain diagnosis and co-morbid conditions including addictive disorders	Helps the CHC, providers and associated professionals with data for identifying high risk patient population on an ongoing basis.			Implement a process of notification through EMR (monthly basis) of what patients are being tapered off of opiate medications and may need increase outreach/support.	Addiction should be considered a co-morbid condition.
10. Maintain objective, verifiable, ongoing documentation	Reduces risk to patient, provider/prescriber and health center.	Confirm and validate patient improvement (graphs that mean something to the pt).	Readily accessible physical description of pills (preferably on the prescription bottle) Need a list of conditions that do not respond to long term opioid use. These are the diagnoses that trigger immediate peer or team review and a higher threshold of documentation, goal	Crafting a comprehensive template, with defined/searchable fields as well as narrative notes will result in more verifiable documentation. Need to train providers in crafting objective goals with patient and/or delegating to behavioral health or pt education staff to conduct goal setting and monitor	Need to change behavioral patterns associated with sharing medical & legal information that is verifiable and objective ("hiding behind HIPPA").

			setting and patient engagement (increased frequency of visits).	goal attainment. Other forms of documentation to increase objectivity and verifiability: defined process for pill counts, communicating with pharmacies and Emergency Departments, local dental providers. Tactic/Strategy: Use of pre-visit planning for pts receiving COT. Pre-visit checklist to include review of documentation and the PMP.	