Bemidji Area Opioid Stewardship Workbook

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Opioid Stewardship within the Indian Health Service (IHS) is an integral component of the overall IHS strategy to improve outcomes for patients diagnosed with chronic pain syndromes or opioid use disorder (OUD). Effective opioid stewardship strategies utilize practice-level interventions to organize and improve the management and coordination of long-term opioid therapy; involves interdisciplinary team-based approaches to care; involves establishing policies; uses evidenced-based standards; and involves data to track performance measures. Secondary benefits of opioid stewardship include increasing the capacity of health care providers and systems of care to integrate evidence-based opioid prescribing strategies into practice; and creating a standard of care across the health system.

Opioid quality assurance and performance improvement processes are the responsibility of local and regional health system leadership, in concert with health care professionals across the care spectrum, and requires a comprehensive strategy that builds on advanced planning, engages interdisciplinary care teams, and collaborates to leverage resources. This systems approach requires balancing interventions specific to opioids, such as responsible de-prescribing and access to withdrawal management and medication assisted treatments (MAT), paired with broader strategies that include work force development and training programs, enhanced peer support systems and participation in collaborative learning networks, robust surveillance strategies, information sharing, and trauma informed responses.

Core Elements of the Opioid Stewardship Program

1. **Promote leadership commitment and organizational culture**: dedicating necessary resources to optimize chronic pain and chemical dependency services including providing a consistent workforce development program, supporting establishment of interdisciplinary care teams, dedicating adequate patient appointment time, and promoting prescriber medical decision-making support.
2. **Establish accountability and create standardization**: establishing shared commitment and vision from the organization and the interdisciplinary pain team. Prescriber accountability and buy-in is necessary to achieve program outcomes surrounding safe opioid prescribing. Standardized approaches and policies are helpful to create uniformity and responsibility.
3. **Establish and support functional interdisciplinary pain teams**: supporting teams that consist of representatives from medicine, nursing, pharmacy, physical /occupational therapy (i.e. rehabilitation staff), behavioral health, social work, laboratory, pain management specialists, and substance abuse disciplines, as available.
4. **Create relevant action plans**: creating annual plans that include program goals, activities, assignments, timelines, outcome measures, implementation strategies, and evaluation components.
5. **Track, monitor, and report performance data**: regular reporting and analysis surrounding opioid prescribing to clinicians, interdisciplinary pain teams, and health system leadership.
6. **Advance clinical knowledge and expertise through work force development**: educating health system front-line clinicians, leadership, and general staff about opioids, dependence, and addiction.

Indian Health System Values Surrounding Opioid Stewardship

Utilize integrated systems where available	Use data-driven, science-based interventions	Integrate relationship-based and trauma-responsive care
Utilize culturally-informed approaches	Incorporate peer-supported systems	Utilize holistic approaches that leverage community resources
Ground interventions in community wellness	Establish comprehensive and compassionate care for patients with OUD	Leverage all available resources

Opioid Stewardship Goals

1. Improve patient safety and reduce risk with chronic opioid therapy
2. Improve professional peer evaluation practices surrounding opioid prescribing through adoption of standardized quality assurance processes and data surveillance
3. Enhance patient experience of care and improve patient outcomes

Leadership Commitment and Key Support

The work of opioid stewardship program leaders is greatly enhanced by the support of other key groups in health care organizations where they are available.

- **Health System Leadership** is essential to ensure adequate resource allocation, on-going provider and health system personnel education, support for interdisciplinary care, support for professional practice evaluation, and support for prescriber decision making and patient care planning.
- **Clinicians and department managers** are fully engaged in and supportive of efforts to improve patient assessment, pain management, and the safety of opioid prescribing in health systems.
- **Nursing and Care Managers/Coordinators** can assist with care coordination, patient education, risk assessments, and patient engagement.
- **Quality Department Personnel** can be key partners and provide unique insight into quality of care, risk management, and patient safety.
- **Pharmacists** can assist with patient assessment, management, patient treatment planning, and quality assurance activities as required by IHS and Federal policy.
- **Behavioral Health Staff** can assist with psychosocial assessment, diagnostic clarification, provide behavioral therapy and intervention, conduct motivational interviewing, and assist with negotiated interviews.
- **Others from the interdisciplinary care team membership** as listed above.

Establish and Support Functional Interdisciplinary Pain Teams

Key points

- Management of chronic pain is an interdisciplinary process and includes teams comprised of medicine, nursing, pharmacy, physical /occupational therapy (i.e. rehabilitation staff), behavioral health, social work, laboratory, pain management specialists, and substance abuse disciplines, as available.
- Every effort should be made to communicate information to all members of the patient's health care team regarding the patient's pain experience. This includes clinical condition, past medical history, and pain management goals clearly documented in the patient record.

- Interdisciplinary Pain Teams should meet regularly to review the care of patients on chronic opioid therapy.
- Recent and upcoming transitions of care should be coordinated with the patient and documented in the patient record that includes patient and family education surrounding discharge care coordination, side effects, changes in activities of daily living, home environmental concerns, safe opioid use and storage, and safe disposal of unused opioids.

Integrative Pain Management Components: Integrative pain management components should be considered core features in the treatment of all patients on chronic opioid treatment and should be offered where available.

- **Balanced** pain management based on a biopsychosocial model of care.
- **Individualized,** patient-centered care which is vital to addressing the opioid crisis.
- Improved and **safer opioid** stewardship through **risk assessment** based on a patient's medical, social, and family history to ensure safe and appropriate prescribing.
- Approached in a **multidisciplinary** manner that focuses on the patient's medical condition and co-morbidities. Various aspects of care include:
  - **Medications.** Employ the benefits of different classes of medications to treat pain with consideration given to pain source, the specific patient's medical conditions, and past medical history.
  - **Restorative movement therapies.** Evaluate available physical and occupational therapy, massage therapy and aqua therapy to restore strength and encourage mobility.
  - **Interventional procedures.** Utilize different types of minimally invasive procedures that can be important for both acute and chronic pain management. Examples include dry needling, trigger point injections, etc.
  - **Complementary** and **integrative health.** Acupuncture, yoga, tai chi, chiropractic, and meditation support a holistic approach to pain management.
  - **Behavioral health/psychological interventions.** Coping skills and cognitive behavioral therapy can support patients in their pain journey.
  - **Multi-modal approach** to acute pain in the surgical, injury, burn and trauma setting if applicable.
  - **Perioperative surgical home and acute pain guidelines** to provide a framework for expectations improving the patient experience and outcomes. This may include enhanced care coordination between the primary care prescriber and surgical referral center.
- **Access to specialized care** is vital with an expanded workforce of pain specialists and behavioral health clinicians to help guide and support appropriately trained primary care clinicians.
- **De-stigmatized** treatment. Empathy and a non-judgmental approach is critical to minimize barriers and maximize treatment and patient outcomes.
- **Informed decision making** through societal awareness, provider education and training, and patient education are needed to understand choices and promote therapeutic alliances between patients and providers.

Create Relevant Facility Action Plans

Key points

- Implement facility policies that support evidenced-based guidelines and reference IHS agency requirements. Avoid implementing too many policies and interventions simultaneously. Always prioritize interventions based on the needs of the health system and community as defined by outcome measures and other tracking and reporting metrics as well as balanced with available resources.
- Utilize specific interventions that target organizational needs that can be divided into three categories: strengthen program management and operations; access to care; and quality/safety of care.
- Define evaluation criteria at inception to measure impact of change and identify additional potential improvement areas.
- Utilize standard tools to create action plans, track assignments, analyze data, and report outcomes.

Sample Action Plan—see Appendix A

Tracking and Reporting of Opioid Metrics

Measurement is critical to identify successes, opportunities for improvement, and to assess the impact of improvement efforts. For opioid stewardship, measurement may involve evaluation of outcome, process, and balancing measures to monitor impact of change.

Implementing an Opioid Prescribing Dashboard

Facilities perform periodic assessments of the use of opioids in the management of chronic non-cancer pain in accordance with evidenced based standards and IHS policy. Applicable prescribing metrics may include the following:

Total controlled Substances RXs Dispensed
% of Total Prescriptions Dispensed that are Controlled Substances
Average Daily Morphine Milligram Equivalents (MME) per Script
Total MME Dispensed
Total # Patients Who Used Any Opioids
Number of Patients with Total DMME > 50
Number of Patients with Total DMME > 90
Number of Patients with ANY concurrent opioid + benzodiazepine
Number Co-Prescribed Naloxone Units Dispensed

Professional Peer Evaluation

The Interdisciplinary Pain Team/Medication Safety Committee can assist the Clinical Director with the identification of systems-based protocols surrounding chronic pain management as well as the creation and use of a standardized tool to assist with performing an assessment of quality and appropriateness of care. Pain management treatment planning notes should include progress toward pain management goals including functional ability (for example, improved pain, improved or preserved physical function, quality of life, mental and cognitive symptoms, and sleep habits). Quality assurance findings may be referred for peer review, for data collection, or for further analysis. Peer review findings can be incorporated into the Ongoing Professional Peer Evaluation (OPPE) process and reported to the

Clinical Director for review, follow-on analysis, and intervention if needed. Benchmarking between prescribers may be considered to identify potential prescriber outliers.

See Samples in Appendix B-D

Workforce Development & Education

Effective opioid stewardship requires on-going review and study of available chronic pain management innovations to address both national and local issues. Information should be shared between care teams, regionally, and nationally if indicated. The IHM Part 3, Chapter 30 includes a statement surrounding controlled substance prescriber training requirements. There may also be opioid training requirements based upon state licensure. There are many options for providing education on opioid prescribing such as formal and informal didactic presentations; messaging through posters, flyers and newsletters; or electronic communication to facility groups. Another useful approach is utilization of tele-health strategies, such as participation in ECHO or warm line platforms, to review de-identified cases with specialty providers to make recommendations to patient treatment plans. A variety of web-based educational opportunities are available. Education has been found to be most effective when paired with corresponding interventions and measurement of outcomes.

Resources

1. National Quality Forum (NQF). National Quality Partners Playbook: Opioid Stewardship. Washington, DC: NQF, 2018.
2. VHA Opioid Safety Initiative - VHA Pain Management. Accessed March 29, 2019.
3. Trauma Informed Approaches- SAMHSA - Accessed April 1, 2019.
4. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. Dowell D, Haegerich TM, Chou R , MMWR Recomm. Rep 2016;65(No. RR-1):1–49. DOI.
5. Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations - Accessed March 29, 2019.
6. IHS Pain and Opioid Use Disorder

Appendix A: Opioid Stewardship Action Plan SAMPLE

Strategy: Increase quality, safety, accountability, and standardization across the health system and between prescribers to foster shared vision and goals and improve patient outcomes.

Links to IHS Strategic Plan 2019-2023: Goal 1.1; 1.3; 2.1; 3.2

Topic	Recommendation	Status/Updates
Create a data surveillance standard *Measurement is critical to identify opportunities for improvement and assess program effectiveness. For opioid stewardship, measurement may involve evaluation of outcome, process, and balancing measures to monitor impact of change.*	Recommended Measures Responsible Party: Frequency: # Total Controlled Substances RXs Dispensed per 100 RX % of Total Prescriptions Dispensed that are Controlled Substances Average Daily MME per Script Total MME Dispensed Total # Patients Used Any Opioids Number of Patients with Total DMME > 50 Number of Patients with Total DMME > 90 Number of Patients with ANY concurrent opioid + BZD Number Co-prescribed Naloxone Units Dispensed Opioid dashboard/score card (using RRIP; Qliksense; etc.) Responsible Party: Frequency:	

Topic	Recommendation	Status/Updates
Create Local Chronic Non-Cancer Pain Management Policy *Ensure creation of facility chronic non-cancer pain management strategy and communication of policy requirements to relevant stakeholders.*	Date Policy Enacted: Click or tap here to enter text. Ensure Policy Alignment with ☒IHM Part 3, Chapter 30 ☒IHM Part 3, Chapter 32 ☐CDC Guidelines	
Increase Staff Training *Ensure completion of relevant staff training to establish a core competency for health care workers across the healthy system. Additional information is included in the workforce development strategy.*	☐General Opioids 101 training (all health system staff) ☐IHS Essential Training in Pain and Addictions (all new prescribers within 6 months of on-boarding) Completion rates: MD: Click or tap here to enter text. NP: Click or tap here to enter text. RN: Click or tap here to enter text. RPh: Click or tap here to enter text. ☐ Reported to NAD-Q ☐IHS Opioid Refresher Training (all controlled substance prescribers—every 3 years) ☐CDC QI Collaborative (optional/supplemental materials)	
Increase Access to Naloxone *Ensure access to naloxone for chronic pain patients at risk for overdose.*	☒Implement co-prescribed naloxone pharmacist collaborative practice agreement for all health system pharmacists ☐Order set in place for high-dose MME quick orders ☐Evaluate access to alerts for naloxone prescribing ☐Retrospective data analysis and naloxone distribution as fail-safe in place for MME>50 ☐Establish naloxone train the trainer program to assist community distribution models • Evaluation Criteria: o Rate of co-prescribed naloxone per chronic opioid treatment agreement o Rate of co-prescribed naloxone per MME>50 o # of outside RXs for naloxone	

Topic	Recommendation	Status/Updates
Improve Clinical Documentation *Improve the accurate and timely documentation of clinical encounters to and reflect the scope of services provided and improve clinical quality data extraction.*	☐Prescribers utilize EHR chronic non-cancer pain management template to assist with the accurate capture of chronic pain management documentation ☐PDMP documentation is standardized to use education codes or treatment regimen planning ☐Clinical Decision Support & Interoperability are optimized to the extent possible—INSERT new functionality when available. ☐Patient screening results are documented correctly: 4Ps, DAST, SOAPP, COMM ☐Pain agreement and informed consent are present and updated as required per policy ☐Functional status assessment is fully and accurately documented Identified facility functional status assessment tool: Click or tap here to enter text.	
Increase Patient and Family Engagement *Ensure better and safer opioid stewardship through risk assessment based on patients' medical, social, and family history to ensure safe and appropriate prescribing and patient engagement*	☒Comprehensive patient informed consent on file to include documentation of the following patient education topics: storage, drug interaction, dependence and withdrawal definitions, risks and signs of diversion, risk of dependence, naloxone use for OD reversal. ☐Pain Management agreement on file. ☐Consider development and use of a patient satisfaction survey or a community needs assessment to assist with improving patient and family engagement	
Expanded Employee Relations and Ongoing Professional Peer Evaluation structures to identify and address potential prescriber outliers.	☐Develop system to detect and engage potential prescriber outliers through the use of quality tracking mechanism and dashboards. ☐Develop support structures and processes for health care personnel that display signs of OUD ☐Establish drug diversion and detection policies	

Strategy: Improve Access to Evidence-Based Pain Management Therapies

Links to IHS Strategic Plan 2019-2023: Goal 1.3

Topic	Recommendation	Status/Updates
Conduct current pain management therapy review to identify current utilization patterns and develop plans to address gaps. *The CDC and Interagency Pain Management Task force have developed and released recommendations surrounding optimized chronic opioid therapy.* *A separate action plan is necessary to address documented gaps.*	☐Currently available chronic pain modalities are balanced and based on a biopsychosocial model of care As evidenced in our facility by: Click or tap here to enter text. ☐Medication Safety Committee or multi-disciplinary chronic pain management team is established and meeting at the frequency defined in committee profile As evidenced by: Click or tap here to enter text. ☐A complete review of pain management (both pharmacologic and non-pharmacologic) was last conducted on: Click or tap here to enter text. As evidenced in our facility by: Click or tap here to enter text. ☐The last Pharmacy & Therapeutics formulary review of pain management medications was conducted on Click or tap here to enter text. As evidenced by: Click or tap here to enter text. ☐Conduct an evaluation of the Interdisciplinary Pain Team to ensure the appropriate scope and function of the group to improve interdisciplinary patient management and outcomes ☐Utilize de-identified dispensing data to ensure prescribers are aware of aggregate opioid prescribing patterns and to evaluate trends ☐Evaluate assignment of patient assessment and patient screening duties and documentation to available care team members. Patient	

	screening for SUD may be improved through use of nursing or paraprofessional staff.	
Conduct a review of trauma informed care/trauma responsive care and empathy evaluation for health system.	☐Review of trauma informed/trauma responsive care conducted in our health system (https://www.integration.samhsa.gov/about-us/innovation-communities-2018/trauma-informed-approaches). Click or tap here to enter text. As evidenced in our facility by: Click or tap here to enter text.	

Strategy: **Strengthen IHS program management and operations to include a focus on workforce development. A fully trained, engaged, and equipped workforce is necessary to improve chronic pain management outcomes and to enhance the patient experience. Core competencies surrounding evidence-based pain and addiction interventions need to be developed at each health system to reduce the risk of adverse events and improve patient outcomes.**

Links to IHS Strategic Plan 2019-2023: Goal 1.1; 1.3; 2.1; 3.2

Topic	Recommendation	Status/Updates
Evaluate current practices based upon established, evidence-based standards. *A formal evaluation of current clinical practices and potential knowledge gaps should be conducted and planning discussions hosted with key stakeholders.*	Core Pain Management Competencies (defined at the SU level): • Activity/functional status based pain assessments • Assessing patient risks (SOAPP, COMM, etc.) • Ordering and interpretation of UDS results • Conducting patient pain assessments to include distinguishing pain quality and treatment based upon pain type • Peer to peer evaluation Advanced Training: • Vulnerable populations (elderly, pediatrics, pregnancy, patients with history of Substance Use Disorder, etc.) • Enhanced communication techniques in difficult conversations (lexicon, and motivational interviewing)	

	• Opioid de-escalation strategies • Psychosocial pain interventions (central sensitization) and care planning ☐DATA Waiver training encouraged for all opioid prescribers ☐Identify current business acumen and leadership support for opioid stewardship to ensure sustained organizational culture shifts to evidence based models ☐Support prescriber ownership of interdisciplinary models of opioid stewardship	
Evaluate local, regional, national access to peer learning collaboratives to improve proficiency with pain management practices.	☐Evaluation and participation in ECHO pain and addiction modules ☐Evaluation and participation in available tele-mentoring warm-lines ☐Evaluation and participation in available tele-health support programs	
Stigma *Stigma is a major barrier to treatment, so it is important to provide empathy and a non-judgmental approach to improve treatment and outcomes.*	☐Address stigma associated with dependence and addiction As evidenced by: Click or tap here to enter text. ☐Educate AI/AN about substance misuse and addiction. Opioids 101 curriculum assigned Opioids 101 curriculum required ☐Mitigate staff turnover among behavioral health and primary care providers: Proactively address recovery and support staff turnover to improve the availability and quality of services ☐Address empathy and compassion fatigue	

Appendix B: SAMPLE System-Based Protocol Chronic Opioid Therapy for Non-Cancer Pain (Outpatient, Adult)

Note: Protocol-driven care is intended to support, not replace, clinical decision making on a case-by-case basis.

Item	Elements	Intervention
Initiation & Continuation	1. Assessment 2. Other Treatment Modalities 3. Treatment Planning 4. Reassessment	○ Comprehensive H&P includes biopsychosocial assessment (see p.2) and indication/diagnosis for pain treatment. ○ Non-pharmacologic and non-opioid pharmacologic treatments are preferred either alone, or in combination with COT. ○ Informed consent: Realistic goals for pain and function outweigh risks and both are discussed with the patient. ○ Periodic review of indications, benefits, and risks of COT is conducted (minimum 1-4 weeks after initiation or dose titration).
Assessment/Management	Evaluation for Harm 1. I.H.S. Manual State PDMP Policy Link: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c32 2. Urine Drug Screens Risk Mitigation 1. Naloxone 2. SBIRT 3. Treatment agreement and treatment plan review	○ Initial & periodic assessment of risk-factors for COT-related harms (see tools p2). ○ Initial and periodic (every Rx) review of state PDMP. ○ Initial & periodic urine drug screen to assess for prescribed opioid & illicit substances. ○ Avoidance of COT for high risk patients including 1) Life-threatening allergy, 2) Active substance use disorder, 3) Suicide risk, 4) Concomitant benzodiazepine use, 5) Age < 30y. ○ Naloxone is prescribed with increased overdose risk (i.e. prior overdose, high dose). Includes overdose education. ○ Discuss opioid risks w/driving and concurrent alcohol/sedative use. ○ Initiate written opioid agreement/consent form with provider/patient responsibilities. ○ Referral for combined medication assisted treatment & behavioral therapy for patients with opioid use disorder.
Treatment Plan & Duration	1. Initiation of Treatment 2. Serial Re-Evaluation 3. Dose Titration & Tapering	○ For opioid-naïve patients, begin treatment with immediate-release rather than extended-release or long-acting opioids. ○ Short-duration trial of opioid therapy (1-12 weeks) then assess response to therapy. ○ Use lowest effective dose—caution with doses that exceed 50MME ○ Risk/benefit reassessment (minimum Q3mos, more often with titration). ○ Request pain management specialty consultation for MME> 90. ○ When risk > benefit, taper and/or discontinue opioid therapy. ○ General taper rate 5-20% reduction Q1m. ○ Discontinue COT for evidence of diversion.

2017 VA/DoD Components of Biopsychosocial Assessment

- Pain assessment including history, physical exam, comorbidities, previous treatment and medications, duration of symptoms, onset and triggers, location/radiation, previous episodes, intensity and impact, patient perception of symptoms.
- Patient functional goals
- Impact of pain on family, work, life
- Review of previous diagnostic studies
- Additional consultations and referrals
- Coexisting illness and treatments and effect on pain
- Significant psychological, social, or behavioral factors that may affect treatment
- Family history of chronic pain
- Collateral of family involvement
- Patient beliefs/knowledge of; 1)The cause of their pain, 2) Their treatment preferences, 3)The perceived efficacy of various treatment options
- For patients already on OT, include assessment of psychological factors (e.g. beliefs, expectations, fears) related to continuing vs. tapering.

2016 CDC Alternative Pain Treatments

- Cognitive Behavioral Therapy
- Exercise Therapy
- Interventional Treatments
- Multimodal Pain Treatment
- Non-opioid Pharmacologic Treatments:
    - Acetaminophen
    - Nonsteroidal anti-inflammatory drugs
    - Antidepressants
    - Aticonvulsants

Risk Screening Tools

- Screener and Opioid Assessment for Patients With Pain (SOAPP-8)
- Brief Risk Interview (BRI)
- Current Opioid Misuse Measure (COMM-9)
- Opioid Risk Tool (ORT)

Opioid Type	Medications	Notes About Therapy
Pure Agonists	-Codeine -Oxycodone -Hydrocodone -Oxymorphone -Morphine -Levorphanol -Hydromorphone -Methadone -Fentanyl -Meperidine	- Mainstay of therapy for moderate to severe cancer pain. - No clinically relevant ceiling effect to analgesia; as dose is raised, analgesic effects increase until analgesia is achieved or dose-limiting side effects supervene. - Meperidine not preferred due to potential effects of toxic metabolites. - Methadone must be used with caution; only clinicians who are knowledgeable about risks posed should use this drug w/o guidance.
Agonist-Antagonists	Partial Agonists -Buprenorphine Mixed Agonists/Antagonists -Butophanol -Dezocine -Nalbuphine -Pentazocine	- Agonist-antagonists include mu-receptor agonists with lower intrinsic efficacy (partial agonists) & drugs that have agonist effects at one opioid receptor and antagonist effects at another (mixed agonist-antagonists). - Most were developed to be less attractive to individuals with the disease of addiction; this characteristic does not rationalize widespread use for cancer pain. - All have a ceiling effect for analgesia. - All have the potential to induce acute abstinence in patients with physical dependency to agonist opioids. - Some (pentazocine and butorphanol) have a high risk of psychotomimetic side effects. - Buprenorphine is available in a transdermal patch and may be of use in relatively opioid-naïve cancer patients.
Pure Antagonists	-Alvimopan -Naltrexone -Methylnaltexone -Nalmafene -Naloxone	- Compete with endogenous and exogenous opioids at mu-receptor sites. - Administered for prevention or reversal of opioid effects. - Alvimopan and methylnaltrexone have been developed specifically to treat opioid-induced bowel dysfunction.
Mixed Mechanism Drugs	-Tramadol -Tapentadol	- Centrally acting analgesics that have agonist actions at the mu-receptor and block reuptake of monoamines.

Adapted from UpToDate

References:

1. Dowell, D et al, CDC Guideline for Prescribing Opioids for Chronic Pain, JAMA, April 19, 2016, Vol. 315, No. 15, pp 1624-1625.
2. VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, Department of Veterans Affairs, Department of Defense, Versionj 3.0- 2017.
3. UpToDate, Accessed 9.2017.

SUMMARY INFORMATION											
Chart #:		☐**MME > 50**					☐**MME > 90**				
Age:		**Diagnosis**									
Gender:	M F U	**Prescriber**									
Prescribed Opioid:							**TDMME**				

PATIENT ASSESSMENT								YES	NO	N/A
Cancer Related Pain										
Chronic Pain (daily/near daily use>60 days over past 90-day period) diagnosis/indication present on problem list										
Concurrent Benzodiazepine: Medication Dose: Start date:										
Diagnosis for co-occurring disorder										
Last Pain Assessment	/ /20	Within past 90 days?								
Last Functional Status Assessment	/ /20	Within past 90 days?								
Risk Assessment Completed:	/ /20	Within last 12 months?								
If yes – what type (circle)	NIDA Quick screen	ORT	COMM	DAST	SOAPP-R	DIRE	Other:			

DOCUMENTATION								YES	NO	N/A
Informed consent (signed & in chart)	/ /20	Within last 12 months								
Current Pain Agreement	/ /20	Within last 12 months								
Pain agreement includes therapeutic/pain management goals										
Re-assessment/treatment plan reviewed within last 3 months										
Complementary and alternative medicine (CAM) interventions ordered?										
Documented CAM follow-up										
Multidisciplinary case consultation documented (MME>90)										
If yes – what type (circle)	ECHO	Specialty Clinic	Medication Safety							
Date of last UDS:	/ /20	Within last 12 months?								
Note addressing UDS results present in chart										
Date last PDMP documented:	/ /20	Within past 6 months?								
Note addressing PDMP findings present in chart										
Patient Education documented within last 6 months										
ANY Naloxone RX										
If yes – number of refills within last 365 days										

Initials of person completing form: _____ Date of Form Completion: _____

CLINICAL REVIEW (PEER Review Supplement)			
Chronic pain indication/diagnosis identified on the chronic patient problem list			
Evidence of realistic, collaborative pain and functional and pain management objective present in care plan			
Evidence of comprehensive assessment and appropriate periodic follow-up (at least Q3m) thereafter?			
Documentation of initial and/or combination non-pharmacologic and non-opioid pharmacologic treatments to de-emphasize opioids?			
Reassessment of indications, benefits, & risks 1-4 weeks after initiation or dose titration			
Presence of any patient red flag behavior concerns present in chart			
Any evidence of specialty consultation for MME>90			
Chronic Opioid Therapy (COT) appropriate			
Date of Medication Safety Committee Review:			

OPPORTUNITIES TO IMPROVE CARE:

ACTION PLAN:

Determination of Issue:	☐Not applicable	**Preventability:**	☐Not applicable
☐system-related	☐provider-related	☐non-preventable	☐potentially preventable
☐disease-related	☐unable to determine	☐preventable	☐unable to determine

Corrective action:

☐not necessary	☐guideline/protocol	☐resource enhancement
☐trend/track similar occurrences	☐counseling	☐privilege/credentialing review
☐education	☐peer review	☐Other_____

☐Chart complete – No further review needed.

☐Discussed with provider_____ Date: _____

To committee for review

☐Medication Safety Committee

☐Clinical Director for review

☐Medical Executive Committee

Date of review: **Reviewed by:**

☐ Copy SENT TO PROVIDER for review & comments

Provider Feedback Form

MRN#:		***PROVIDER:***	

Comments/FEEDBACK: ☐ Reviewed Case

Provider: _____ *Date:* _____

Reviewed by: _____ *Date:* _____

Appendix D: SAMPLE Opioid Professional Practice Evaluation—Peer Review Supplement Measure

Primary Care – Opioids for Chronic Non-Cancer Pain Management

Provider Name: _____

Reviewed by: _____ **Date of Review:** _____

Period Reviewed: _____ Chart Number: _____

Item	YES	NO	N/A	Comments
1. Evidence of comprehensive H&P including biopsychosocial assessment initially and periodically (at least every 3mo) thereafter				
2. Reassessment of indications, benefits, & risk present within 4 weeks of initiation or dose change				
3. Chronic pain indication/diagnosis identified and updated on the chronic problem list				
4. Pain management treatment plan clearly defined with appropriate use of ancillary services and consultations				
5. Evidence of initial and periodic reassessment of risk factors for potential aberrant behavior (using appropriate screening tools and labs)				
6. Presence of any patient red flag behavior concerns documented in chart				
7. Documentation of initial and/or combination non-pharmacologic and non-opioid pharmacologic treatments to de-emphasize opioids (if opioids initiated after 2017)				
8. Clearly stated indication for use of MME>90				
9. Evidence of informed consent and current signed opioid treatment agreement				
10. Evidence of initial and periodic review of state prescription drug monitoring program per IHS policy				
11. Naloxone co-prescribed for Chronic Opioid Therapy with MME>50				

Further comments/action: _____

_____

Appendix E: Tele-mentoring Pilot Concept

Bemidji Area Office
Opioid Stewardship Tele-mentoring Program
Statement of Work SAMPLE

Goals: to create a clinical case consultation pilot project delivered via a tele-mentoring model to increase prescriber capacity and improve opioid prescribing practices across the Bemidji Area. This program will support the global Bemidji Area opioid surveillance strategy to impact local opioid prescribing patterns; to inform professional peer evaluation strategies and interventions; to increase the capacity of health care providers and systems of care to integrate evidence-based opioid prescribing strategies into practice; to create a uniform standard of care; to collaborate with prescribers to improve safety and quality surrounding treatment of chronic pain and overall patient outcomes. This project will evaluate effectiveness of this substance abuse prevention model as well as improve patient outcomes for patients at risk for substance use/opioid use disorder.

Background: the three Federal sites within the Bemidji Area are collaborating to create a regional opioid surveillance and opioid stewardship project to improve outcomes for patients diagnosed with chronic pain disorders and substance use disorders as well as to implement IHS policy requirements in a standardized way. An improvement charter has been approved to establish program milestones and timelines to support this critical work.

Intended audience:
Integrated pain management teams that include prescribers and non-prescribers.

Program Description

- Sites will use dispensing data and patient documentation to identify appropriate cases that may benefit from specialty case consultation (MME>90; pregnancy and OUD/pain syndrome; chronic pain syndrome and past history of SUD, etc.).
- Site coordinator will utilize ECHO referral forms and Opioid QA case review forms to evaluate and submit patient cases in advance of tele-mentoring session.
- Two, two-hour sessions will be offered each week during scheduled multidisciplinary pain management team meetings. Facilitators will review cases and access EHR documentation in advance of the sessions. Group discussions and de-identified patient case reviews will be facilitated by one pain management specialist and one addiction medicine specialist. Three to five cases per hour will be the target for the session.
- Sites will be encouraged to identify local resources for any co-occurring BH cases.

Plan:

1. **Schedule: Thursday Afternoons—1330-1530 MST—starting April 18th** (pending contract amendment)
2. **Meeting format**
   - ECHO UNM Case presentation form—3 to 5 cases per session
   - Presented in classroom format—using conference phone to assist with audio--webcam for provider presentation.
   - Consultation recommendations to be submitted as a paragraph that can be transcribed into the EHR as a treatment recommendation. Recommend back-date to reflect date of the consultation.
   - Treatment plans should not be implemented outside of patient care appointment.

Next Steps:

1. Evaluation strategy:
   - Pre-survey to be generated and sent 04April via email. Please complete prior to initial session.
   - Provider Empathy Survey: at baseline and at program completion.

- Prescribing trends—baseline FY18, 6, and 12 months

2. First site _____
3. Prepare patient cases—multi-disciplinary/supported

Tele-mentoring EHR Documentation

Specialty pain management consultation for <Patient first name> was conducted on <date>. The reason for referral was <Combo Box: MME > 90 (default); MME > 50; concurrent opioid + benzodiazepine; opioid de-escalation; other>. <Text comment box>

The below patient treatment recommendations were received:

Word processing box indent 2

Assessment: Today's POV

Plan:

A total of <visit time> was spent in the coordination of care for this patient. I intend to discuss the following chronic pain management treatment plan changes with <Patient First Name> <word processing box>.

<Check box> Patient/RN Care Manager to schedule follow-up appointment <1, 2, 4> <days, weeks, months> to discuss above treatment plan recommendations.