ICSI Opioid Prescribing Improvement Guide

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About ICSI

The Institute for Clinical Systems Improvement has been a trusted influencer in healthcare for over 25 years. As ICSI, healthcare leaders work together to find solutions to healthcare's toughest challenges, initiating positive change and improving health outcomes. ICSI is an independent, objective non-profit organization with one clear goal – improving health together. ICSI has supported healthcare improvement with evidence-based guidelines and implementation science for collective impact in our region.

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Introduction

Prescription opioid medications continue to be a significant cause of overdose and death in Minnesota. Although standards of practice for safe opioid prescribing exist, prescribers across settings may struggle to provide patient-centered pain management amidst changing recommendations and regulations that come from multiple sources.

In Minnesota, independent practitioners, large and small health care delivery systems, health plans and the Minnesota Department of Human Services (DHS) are working side by side to advance safe opioid prescribing practices, especially in the ambulatory setting. Most of these organizations have developed internal resources to support individual prescribers and are eager to provide assistance.

This guide, based on improvement and implementation science, is designed to help individual prescribers build safer opioid prescribing habits. It is also helpful for healthcare organizations as they build systems that support opioid prescribing practices that will decrease harms from acute and long-term opioid use, including overdose and death. This improvement guide can be used by prescribers to implement and document their quality improvement work.

When faced with any problem there is a strong tendency to "just do something." Taking time methodically to understand the gap in care, identify specific barriers to successful change, and then identify and secure the resources needed will assure that the work is more likely to result in success and lasting change.

This guide does not promote the use of opioids nor does it promote total absence of opioid prescribing. It identifies and supports safer opioid prescribing in the ambulatory setting when the use of opioids may be indicated. The guide addresses opioid prescribing for patients with acute, subacute, and chronic pain.

Guidance for effective pain management for individual patient care is not included; instead such guidance can be found in guidelines that address pain management and specific conditions that have associated pain (e.g., ICSI Pain Guideline **https://www.icsi.org/guideline/pain/**).

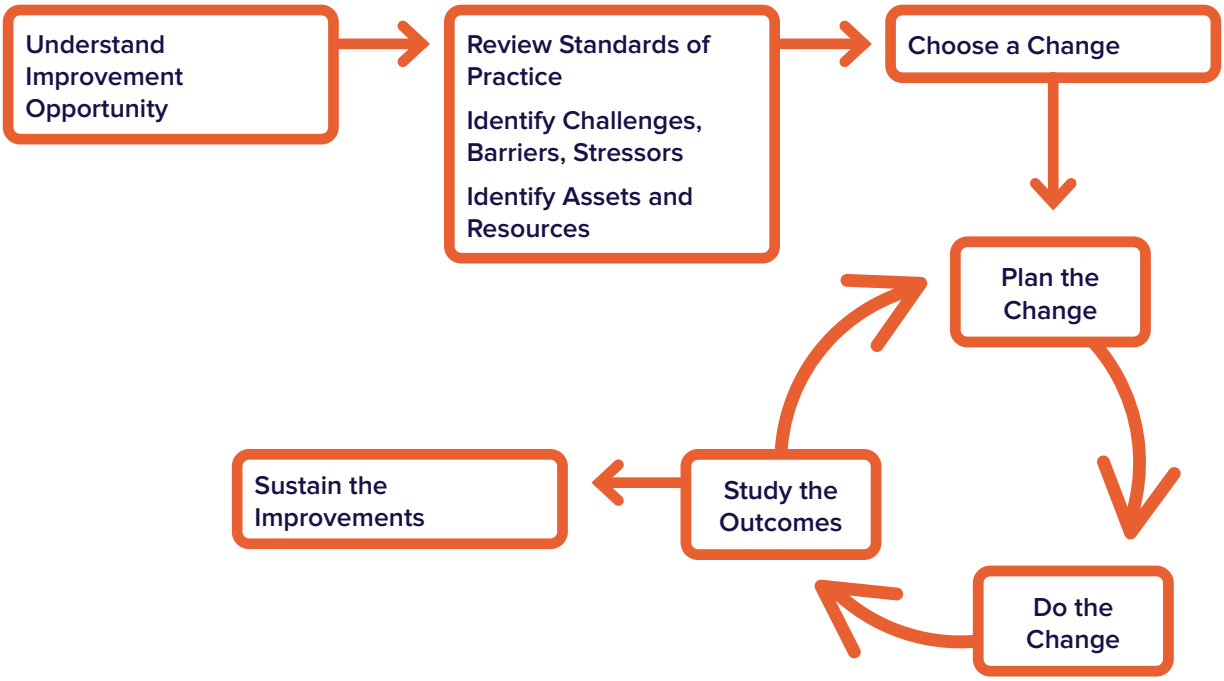
Contents

How to use this ICSI Opioid Prescribing Improvement Guide

- Individual prescribers who wants to review their opioid prescribing patterns can independently use this guide to better understand the opportunities for improving their prescribing, the barriers that might limit their success in improvement, and the assets they can tap to support their identified practice changes. The **REACH OUT** tips throughout the guide are for suggestions on how and when to collaborate with peers or administration.
- Because opioids are generally prescribed within a clinical practice, multiple members of the care team are involved in the care of patients with pain conditions. We do not recommend that prescribers do this alone. Engaging all members of the care team allows prescribers to better understand how to maximize team support for improvement.
- An organization that wants or needs to review their providers' prescribing patterns can use this guide to identify opportunities systematically to overcome barriers to safe prescribing (e.g., Electronic Medical Record (EMR) & workflow, etc.), to utilize all available assets (e.g., improvement experts, practice coaches, mentors, etc.) that support safe opioid prescribing. Please see the **Systems Leaders Guide (Appendix A)**.

This guide can be used as a workbook, allowing users to document their plans and discoveries as they progress through the improvement process. This record of improvement activities may be useful, if documentation of change efforts is requested by regulatory or other oversight organizations. (e.g. MN DHS)

ICSI Opioid Prescribing Improvement Model



Identify the Opportunities for Improvement

Using data to understand prescribing practices is a foundational step to identifying opportunities for improvement. But data alone are not enough. Knowing what data are available, the key metrics (e.g., benchmarks, key targets, goals) and how to identify gaps between the imagined future state (safe opioid prescribing) and current state (suboptimal prescribing) is important. If a gap is identified by your organization, comparative data that shows your prescribing patterns in relationship to peers are often available. If the gap has been identified by an outside agency, more information may need to be gathered to understand how its conclusion was reached. The following topics will help in your process to identify the opportunities for improvement.

How do I understand my prescribing patterns?

Have you been notified about your prescribing patterns (e.g., by DHS, PMP, health plan, practice leadership)?

REACH OUT **What comparative data are available to help me compare my practice to my colleagues?**

From my system/clinic/department _____

From health plans _____

From the state _____

Others _____

Discover "What makes my prescribing patterns different?"

How would I know if my **practice** is different from and/or the same as my colleagues?

QUICK TIP **Sometimes the best understanding is gained by reviewing 10-20 charts of patients who have been prescribed an opioid. Look for clinical and workflow issues that may provide insight.**

My patient population The way I manage acute pain The way I manage chronic pain My opioid prescribing or refill patterns The setting of my practice Other things impacting my practice	**Observations:**

REFLECT Why do I think the difference in how I prescribe exists? What is the root cause?

_____

_____

QUICK TIP **One way to identify the root cause of a problem is to ask "Why?" five times. When a problem presents itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" again and again until you reach the root cause.**

See tools at: http://www.ihi.org/resources/Pages/Tools/5-Whys-Finding-the-Root-Cause.aspx.

REFLECT What have I learned about my prescribing patterns as compared to my peers?

Once you've explored your prescribing practice, doing an assessment of current state compared to accepted standards of practice (or common practice amongst peers) may yield specific opportunities for improvement. Implementation science has shown that understanding existing barriers to change and available assets for change are key to planning a successful improvement effort.

Assess Congruence with Standards of Practice

The following standards are derived from expert consensus and evidence-based sources and are accepted as best practices in the Minnesota medical community. References for evidence-based guidelines are available in **Appendix B**. Assessing your patterns of using opioids to treat acute, subacute and chronic pain against these standards could identify potential practice changes that would improve safe opioid prescribing. The chart below is a comprehensive list of all Minnesota opioid prescribing standards. You are encouraged to prioritize those that are attainable and serve to add the highest value to your particular practice.

Recommended Standards and Processes for Ambulatory Opioid Prescribing and Management

When Treating Acute Pain

- ❑ Avoid opioids if possible and only prescribe for indicated conditions
- ❑ Use scheduled acetaminophen and/or NSAIDs unless contraindicated
- ❑ Prescribe an initial dose of 100 Morphine Milligram Equivalent (MME) or less in the total prescription
- ❑ Prescribe a 3-day supply, or less, of opioid pain medication
- ❑ Instruct patient what to do if pain does not resolve

When treating Postacute or Episodic Pain

- ❑ Assess for **risk of transition to chronic use****, or risk of harm
- ❑ Assess for biopsychosocial concerns influencing pain
- ❑ Verify patient understanding of how to use opioids
- ❑ Limit number of prescribers where possible
- ❑ Reduce quantity of the prescribed refill
- ❑ Communicate plans across prescriber transitions
- ❑ Avoid prescribing over 700 cumulative MME

Additional Considerations for Postoperative Pain

- ❑ Preoperatively, create a plan for those on chronic opioid therapy
- ❑ Support consistent messages about pain from all staff
- ❑ Use multimodal and non-opioid options for pain first
- ❑ Use scheduled acetaminophen and/or NSAIDs unless contraindicated
- ❑ Use patient-centered, procedure-specific opioid dosing
- ❑ Communicate plans during transitions to other facilities and across prescriber transitions (emergency department, primary care, etc.)

When Treating Chronic Pain

- ❑ Avoid initiating opioids for chronic pain
- ❑ Avoid prescribing over 50 MME/day, and avoid increases to above 90 MME/day
- ❑ Avoid prescribing opioids and benzodiazepines together
- ❑ Increase management commensurate with risks/comorbidities
- ❑ Limit the number of prescribers
- ❑ Screen for **Red Flags for Opioid Use Disorder**** more frequently and provide immediate referral for intervention or treatment if needed
- ❑ Regularly offer and discuss tapering options with patients
- ❑ **DO NOT ABRUPTLY STOP OPIOIDS** without a clear plan

Universal Actions

- ❑ Communicate realistic expectations about anticipated pain
- ❑ Start with non-opioid options
- ❑ Conduct a risk assessment (e.g. ABCDPQRS*)
- ❑ Weigh risks vs. benefits
- ❑ Educate patient/family about opioid risks, safe use and disposal
- ❑ Check the Prescription Monitoring Program
- ❑ Use lowest strength, short-acting dose for shortest duration
- ❑ Offer Naloxone for patients at risk of overdose
- ❑ Avoid "PRN" instructions, clearly explain how to take and stop opioids

*ICSI Pain guideline (icsi.org/guideline/pain/)

Risks for chronicity**:

- ❑ Second prescription or refill
- ❑ 700 MME cumulative dose
- ❑ Initial 10-30 day supply
- ❑ Long-acting opioids
- ❑ Tramadol
- ❑ Drug use disorder
- ❑ Mental health diagnoses
- ❑ Opioid Rx before age 18

Red Flags for Opioid Use Disorder**:

- ❑ Signs of impaired control
- ❑ Signs of social impairment
- ❑ Risky use of opioids
- ❑ Predisposition to addiction
- ❑ Multiple prescribers
- ❑ Signs of tolerance or withdrawal

REFLECT What recommended standard(s) should I focus on for this improvement cycle?

Identify Stressors and Barriers to Change

Implementation science has shown that both individual and system factors influence the success of an improvement plan. Knowledge is only one factor that influences individual change, and is often not the primary barrier. Individual motivation to change is multifactorial, including likelihood of success, fear of failure, peer behavior, incentives, leadership support, and a sense of autonomy.

We recognize that system factors or context may be fixed (e.g., clinic space) or may need to be changed to support an individual's change efforts (e.g., EMR tools). It may also be that differing and changing expectations between the provider and patient about opioid prescribing can be a significant stressor. Examples of barriers to optimal prescribing are listed in the following table, with the goal of prompting you to consider **your** specific individual or systems barriers in changing opioid prescribing. **Use the space to consider key barriers you encounter**.

Common Stressors and Barriers Impacting Improvement

Challenges for Acute/Subacute Pain: **KNOWLEDGE / SKILLS / BELIEFS EXAMPLES:** Unsure how to calculate MME. Don't feel up-to-date on opioid standards. Unsure how to treat patients already on opioids with new acute pain.	**LIST YOUR SPECIFIC BARRIERS HERE:**
RELATIONSHIPS EXAMPLES: I'm the only one prescribing opioids in my clinic. Difficulty saying "no" to a patient requesting opioids. Unsure how to engage patients in other pain management strategies.	
ORGANIZATIONAL AND SYSTEM CHALLENGES EXAMPLES: Fear sanctions or malpractice. Conflicting rules, regulations and policies. EMR tools are not available or difficult to use.	
Challenges for Chronic Opioid Use: **KNOWLEDGE / SKILLS / BELIEFS EXAMPLES:** Lack understanding of how to safely taper opioids. Unsure what non-opioid treatments are effective. Uncomfortable treating mental health issues.	**LIST YOUR SPECIFIC BARRIERS HERE:**
RELATIONSHIPS EXAMPLES: Inheriting difficult patients on legacy opioids. Unsure how to navigate difficult conversations. Fear adverse outcomes of a taper.	
ORGANIZATIONAL AND SYSTEM CHALLENGES EXAMPLES: Limited resources for addiction or MAT. Patients receive conflicting information. EMR doesn't support registries or care coordination.	
OTHER CHALLENGES, STRESSORS, AND BARRIERS IMPACTING IMPROVEMENT:	

REFLECT Choose one or two of your barriers/stressors from the above table to focus on.

Identify Assets and Resources

Identifying barriers that might limit successful change can be daunting. Fortunately in Minnesota, because of the extensive work done over the last several years to both decrease overall opioid use and to promote safer use when opioids are needed, there are many resources available to prescribers.

These resources may be easier to identify in a large system, but small practices have many excellent supports available from agencies, professional societies, community organizations and others. Continuous feedback from staff is essential.

REACH OUT **It's likely that your organization is already creating resources to assist you in safe opioid prescribing. Reach out to your peers or administration to discover available resources.**

The following is a list of potential assets to help you overcome barriers to improvement. **Check all that apply**.

Assess the assets available to support change

Healthcare systems internal assets:

- ❑ Senior leadership or champion
- ❑ Opioid Steering/oversight committee
- ❑ Pain and/or opioid case review committee
- ❑ EMR optimizers/experts
- ❑ Quality improvement facilitators
- ❑ Clinical experts (pain specialists, anesthesiologists, addiction specialists, mental/behavioral health)
- ❑ Patient educators
- ❑ Pharmacists
- ❑ Peers and colleagues
- ❑ Clinical staff/care team
- ❑ Administrators/operations support

External assets:

- ❑ Pharmacists (local pharmacies, hospital pharmacists)
- ❑ Expert referral network (pain specialists, anesthesiologists, addiction , mental health)
- ❑ Health plans may have pharmacists or care managers who can provide support, as well as additional data about your practice
- ❑ EMR vendor
- ❑ Professional societies and trade organizations: MMA, MHA, ACP, AAFP, AAP, ADA, AANP, AAPA
- ❑ Prescription Drug Management Program
- ❑ State and Federal Agencies: DHS, MDH, Boards of Pharmacy, Medical Practice, and Nursing, DEA, CDC, SAMHSA
- ❑ Regional collaboratives: ICSI, Stratis
- ❑ Project ECHO or virtual case reviews
- ❑ Institute for Healthcare Communication

OTHER ASSETS AVAILABLE:

Putting it all together

At this phase of quality improvement, practitioners may experience a strong urge to "just do something"; however, taking time methodically to complete the process (understand the gap in care, identify specific barriers to successful change, then identify and secure the resources needed) is more likely to result in success and lasting change.

REFLECT What have you learned so far?

What problem in my prescribing patterns or gap in standards of care did I identify?

What needs to change?

What barriers to change or stressors do I need to address?

What assets and resources have I identified that will support my efforts?

Plan the Change

Planning helps practitioners think through the key components that will be needed for change. Planning is a critical step for any successful change initiative. In order to select a potential solution or activity aimed at improvement, you need to understand the problem you are trying to solve, understand what is perpetuating the problem, and whether the solution you choose will actually solve the problem.

Examples of "tested change strategies," or practices that have been tried by peers in the community and found promising are in **Appendix B**. ICSI has curated these promising practices that can be used to overcome barriers to improve safe opioid prescribing. These are provided to prime your thinking about possible actions you might take. Any change that you select may need to be adapted to your specific practice based on resources or patient populations. **Please review the appendix before proceeding**.

REACH OUT **Planning should not occur in a vacuum; it is likely others are also addressing safe opioid prescribing. Reach out to peers and administration to understand other organizational efforts and how you can connect with those who are already testing change.**

What change will I try and what improvement will I see?

Plan the test of change:

Does the change selected need to be adapted to my specific setting? How?

What new knowledge is needed and for whom? How will this be accomplished?

What tools need to be developed or implemented?

What processes/workflows are impacted? Do they need to be changed?

Whose role is impacted? Does it need to be modified?

What is the timeline to test this change? When will it start/end?

QUICK TIP **In the planning stage, it is often useful to ask the question, "What can I do to assure this test of change fails? This question can identify barriers to sustaining motivation.**

http://www.liberatingstructures.com/6-making-space-with-triz/

How will I know if this change is leading to an improvement?

Measuring process changes does not have to be onerous or complex. Data for improvement, as opposed to data for accountability (which helps you develop an understanding of the problem), should be simple, easy to collect, and require minimal time, cost and expertise. The information gathered needs to tell you if you are moving in the right direction.

REACH OUT **Most clinics or systems already have data and resources to help you monitor change and are eager to engage you in this work.**

- **Start by asking administration how they can help.**
- **Ask your team members how this is working for them and for patients.**
- **Ask a peer to work together or review cases for feedback and improvement.**

Who might be available to help me with this?

How can I easily measure the change? What data will I need to collect?

What unintended consequences should be monitored? Quantitative data? Qualitative data?

QUICK TIP **Small tests of change can be done with one provider, one patient and one encounter. If change is needed, make changes, and test it on a second patient. Repeat the iteration as needed.**

REFLECT What are the next steps to begin the change?

REFLECT What improvement do I expect to see?

Do the Change

Improvement science teaches us that knowledge is acquired through testing and learning. During the "Do" phase you will gain insight into what works, what doesn't and what has potential. You are testing a hypothesis.

- ❑ Run the test on a small scale,
- ❑ collect the data,
- ❑ document what occurred.

Considerations

While implementing your change and collecting improvement data, it is important to monitor implementation fidelity. Well-planned change efforts often fail because they were not implemented as planned; or because the new tools, processes, etc., being tested are not used as planned.

REACH OUT **Most lack of fidelity may be caused by numerous factors and often uncovers a barrier that was initially overlooked. Engaging your team in this step is preferred and generally most effective.**

Are changes being implemented as planned?

Am I and/or is my team using the new workflows/tools/processes as we planned?

Are there things we forgot to consider or plan for (new barriers)?

What do I need to do next?

Sustained motivation is another important reason that well-planned change efforts falter. Those who need to change do not remain motivated to make the change. What actions need to be taken to keep me/others motivated to change?

Reminders

Meetings or huddles
New information
Stories of early success
More leadership support

Ideas:

Are we seeing any changes in our data?

Were there team members being impacted by this test of change that I did not anticipate?

REFLECT Based on how successful my test(s) of change were what changes will I make to my plan?

Study the Outcomes

This step sounds challenging, but in a well-planned and implemented change, it is easy to understand if you have been successful. By using small tests of change, those things that aren't working as planned can easily be adapted or abandoned for the next test.

Was this change successful in addressing the identified problem or gap? Why or why not?

What was the impact on other staff and colleagues?

What was the impact on patients?

Is this change ready to be fully adopted going forward?

Does this change need to be adapted and retested?

Should I abandon this and try something else?

REACH OUT **It's useful to discuss these questions with someone outside of your team. It's easy to "fall in love" with your change idea and be blind to its faults.**

What have I learned about making change in my practice?

REFLECT Did this change help me solve the problem I've identified? Was my hypothesis correct?

REFLECT Looking back at the problem(s) I identified, what action will I take next?

Sustain the Improvements

Evidence on change in health care shows that many successful changes are not sustained, the behavior reverts to the old way of doing things, and the improvements are lost. Take time to consider what needs to happen to make the new way the norm. It is important to assure that the changes you've made to improve patient safety and health outcomes continue.

How can I assure that the successful changes are sustained in my practice?

REACH OUT **In this phase it is imperative to communicate your needs to your team and administration, with a specific focus on ease and consistency.**

REFLECT Who can I partner with in this new process to sustain the improvements?

REFLECT What workflows could be "hard-wired" going forward to make it easier for me to be consistent?

Appendix

A: Systems Leader Guide

This guide will be a resource to anyone who is leading improvement work around opioids within a clinic, or healthcare system. The resources are designed to help the user support prescribers who fall outside standards of practice. The examples of best practice in this section are designed more for systems changes vs. individual changes.

B: Tested Change Strategies

This section includes tested strategies ("promising practices") to improve prescribing, contributed by independent practitioners, large healthcare delivery systems, and health plans participating in the MN Health Collaborative. You'll find options designed to help individual prescribers build safer opioid prescribing habits within their clinics and organizations. This also includes annotated resources to provide users with trusted resources on education, clinical guidelines, quality improvement, and references to support the document.

APPENDIX A: Leader Guide

The ICSI Opioid Prescribing Improvement Guide is designed for an individual prescriber and their care team to use to improve opioid prescribing. The guide draws upon evidence-based frameworks and processes from implementation and improvement science as well as motivation and persuasion literature. While individuals can be successful in individual behavior change, the support that systems and leadership can provide will increase successful individual outcomes. This guide is to provide leaders with "thought" frameworks to help you plan for needed changes.

The first framework, based on Consolidated Framework for Implementation Research (CFIR), is for use as you consider how your ***organizational context*** might be optimized to support improvement in opioid prescribing practices by your colleagues.

The second framework, based on behavior change theories, is to enhance the role you might play to ***motivate an individual*** to change their opioid prescribing habits.

The third framework supports planning for what might be ***challenging conversations*** with your colleagues about the need for practice change. This is a version of ICSI's Collaborative Conversations. Map and more detail is available **here**.

A quick review of the full Opioid Prescribing Improvement Guide and the Appendix B: Tested Change Strategies for Improving Opioid Prescribing will help you understand where this process may need to be adapted for your organization. For example, the recommended QI process is agnostic to model of change, so if your organization has a preferred model, you made need to include this in your thinking about supporting change.

Organizational Context

Multiple studies on successful change have shown the importance of context; the setting in which individuals and teams initiate and implement change. There are contextual elements that cannot be changed (geographic location), but others can be affected by organizational leadership in ways that increase an individual's ***readiness to engage*** in change efforts. These contextual elements are based on the Consolidated Framework for Implementation Research (CFIR), but do not encompass its rich entirety.

Organizational priority

Goals: Are the goals for opioid stewardship well-articulated? Where do these goals fall in the priority list, as seen by prescribers? Are the goals emphasized as an ongoing priority by senior leadership? Does the organization routinely review its progress?

Climate for change

Professional identity to constantly improve: How is ongoing practice improvement overtly valued? As new processes/workflows are deployed is there opportunity for providers to make adaptations for their setting, including collecting data to see if the adaptation has the needed outcomes?

Resources for improvement: Are there available and accessible QI or other improvement staff to support care team improvement? What support is available for measurement? What EMR support is available?

Tension for change: A productive level of distress, as defined in Heifetz' Adaptive Leadership work is needed to keep attention on change. How can you modulate this, avoiding both too much pressure and too little pressure to change?

Structural

Dashboards: Creating a dashboard can show organizational commitment to opioid stewardship. How are data that support the organizational goals presented to prescribers? Are the data well explained and useful for QI support?

Audit and Feedback: While audit and feedback has been shown to support and sustain behavior change, this technique does not itself motivate change. How are you using evaluation to support prescriber change?

Leadership support

Champions: How are your champions being supported? What role do they play in opioid stewardship? What ongoing resources are provided? How are they supported to build the needed trusting relationships with colleagues to improve how their messages are received?

Networks and Communication

Peer pressure: Are data presented "unblinded"? Are prescribers publicly acknowledged for implementing change or for improving outcomes? Are there opportunities for prescribers to work on improvement together? To discuss cases together?

Seeing successful practices: Is there an opportunity to shadow a prescriber who is skilled in working with challenging patients? Is there an opportunity for a care team field trip to another clinic to understand new processes in operation?

Individual Motivation for Change

Even the most effective leaders cannot cause someone to change. Motivation to change is driven by individual psychological needs. However, leaders can use their understanding of motivation to increase engagement in change activities. Self-Determination Theory posits three aspects to motivation.

Competence

Professional identity is often wrapped up in being competent to do the job. So, belief that one has the tools, knowledge and skills to be successful, is key to the motivation to take on a new task or behavior. Opioid prescribing is done in a complex system involving the EMR, care team members, and patients and families. Prescribers who have been identified as outliers may feel that their competence has been officially challenged. Successful change in this setting requires the technical knowledge about safe prescribing standards, but also the interpersonal skills to navigate difficult discussions, the time for teams to develop new shared practices, the ability to optimize electronic tools and more.

What are the adaptive and technical challenges that your colleagues face in this complex system, and what actions can you take to ease them?

Relatedness

Trusting relationships and connectedness increase the psychological safety of engaging in change. Peer and team support (and pressure) to change, can increase motivation. This also applies to the relationship an individual has with the organization. An individual who feels valued and trusted by the organization is more likely to be motivated to engage in a change that supports organizational success.

How can you, as a leader, ensure that your colleagues know you value them and trust them to make decisions in the best interests of their patients? How can you communicate this in the situation where you need them to make changes to assure safe patient outcomes? Who already has the needed relationships and might be called on to support your actions?

Autonomy

Feeling little control over one's own actions or choices has been written about as one aspect of professional burnout. It is clear that standardization and consistency have increased safety and have improved outcomes in healthcare. And it is also clear that removing all individual choice is demotivating. This constant tension is one leaders need to manage thoughtfully. The continuum of extrinsic to intrinsic motivation is valuable to understand when making choices. Behavior change is more likely to be successful and sustained when motivations are more intrinsic than extrinsic.

How can you use Motivational Interviewing practices to listen for those intrinsic motivators that may help change opioid prescribing? Is this a case where punishments are the best option?

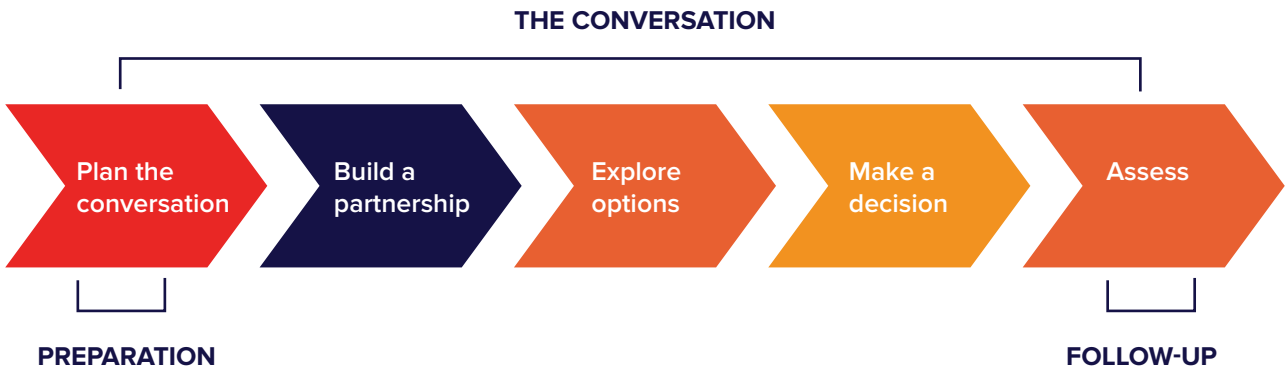
Extrinsic Motivation — **Intrinsic Motivation**

I'm forced to change	I feel guilty if I don't change	I will change.	I want to change.
(I will be punished or rewarded.)	**(Cultural norms or practices require this.)**	**(This is part of my professional role.)**	**(This is consistent with my values and beliefs.)**

Collaborative Conversations

Preparation: Conversations with prescribers about changing their practice habits benefit from thoughtful preparation. When prescribers are notified that they are an outlier in opioid prescribing by a state agency or other sources, they often feel that their professional identity has been threatened. Consider what you know about the individuals and their practice.

What possible response(s) might you expect to encounter? What aspect of motivation might be most salient? How can motivation be enhanced?



Plan the Conversation: What do you want to have happen as the result of this conversation? Awareness or action? Another goal? What additional information would be helpful to review ahead of the conversation? What time and place will be "safe"? What will you say first, to start the conversation?

Build a Partnership: Knowing that you are willing to partner with the prescriber to make change over time, can increase motivation. What is the status of your current relationship? What needs to happen in this conversation to strengthen the relationship? How might you be a partner in exploring the problem that has been identified? Have you reviewed pertinent cases? Are there contextual supports to be highlighted? How will you listen effectively?

While this is the opening of the conversation, consider what you might do even when scheduling the meeting that shows your goal of supporting them through change.

Explore Options: Considering your goals for this conversation, what level of movement toward change is needed by the end of the conversation? What next steps are reasonable? Better understanding of the problem? Planning a test of change? Collecting three to five options is a way to move beyond the answer the prescriber might think you want to hear, and is likely to reveal options with more "ownership."

Make Decisions: Listen to the language being used for determining the next step. Where does the language fall on the motivation scale? Is there a way or a need to move closer to intrinsic motivation? What are the next steps that you, as a leader, have agreed to?

Follow-up: A written summary of the discussion and decisions made should be made available. Be clear about the next steps, including time frame, resources and other support.

Assess: How did the conversation go? Did you achieve your goal(s)? Were you effective in listening? What did you learn about the prescriber(s) and their practice? What do you need to do to increase organizational readiness by influencing contextual elements? What did you learn about this prescriber's motivation? What might you do to increase motivation (autonomy, relatedness, competence)?

Reference links:

Consolidated Framework for Implementation Research (CFIR): **https://cfirguide.org/**

Heifetz, R; Grashow, A; Linsky, M; *The Practice of Adaptive Leadership: Tools and Tactics to Change your Organization and the World*, 2009

ICSI's Collaborative Conversations Map / **Collaborative Conversations**

Miller, W; Rollnick, S; *Motivational Interviewing: Helping People Change*, Third Edition, 2013

Self-Determination: **https://selfdeterminationtheory.org/**

APPENDIX B: Tested Change Strategies for Improving Opioid Prescribing

This section includes tested strategies ("promising practices") to improve prescribing contributed by independent practitioners, large health care delivery systems, and health plans participating in the MN Health Collaborative. You'll find options designed to help individual prescribers build safer opioid prescribing habits within their clinics and organizations.

Scroll to sections that fit your needs with resources for:

- Building General Knowledge/Skills
- Strategies for
  - Treating Acute / Postacute pain
  - Chronic Opioid Therapy
  - Identifying Opioid Use Disorder & Tapering
  - Enhancing communications skills
  - Building your team
  - Optimizing your EMR
  - Calculating MME
  - Improvement Support/ Measurement

Building General Knowledge/Skills

There are numerous options available for learning more about how to treat pain and how to prescribe and manage patients safely using opioids. The insights you gained as you identified the opportunity to improve your prescribing should guide what type of knowledge and skills you seek to enhance.

If you wish to enhance your clinical knowledge related to recommended standards and best practices for opioid prescribing and management it may be best to start by reading the available guidelines. These are some of the guidelines used to develop this guide:

Document/Resource	Content/Audience
Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated 2017. **https://www.icsi.org/guideline/pain/**	ICSI guideline for ambulatory treatment of pain (acute, postacute, dental, and chronic) includes an extensive section on opioids.
Institute for Clinical Systems Improvement Perioperative guideline, 2019. **https://www.icsi.org/guideline/perioperative-guideline/**	ICSI guideline on perioperative management that includes an updated opioid section for pain management during this period.
Institute for Clinical Systems Improvement Opioid Postoperative Prescribing Toolkit 2020. **https://www.icsi.org**	Data-driven postoperative prescribing standards for initial discharge prescription that is patient-centered, and procedure-specific. Includes tested change strategies.
Minnesota Opioid Prescribing guidelines 2018. **https://mn.gov/dhs/opip/opioid-guidelines/** This site also includes the QI program, provider education and measurement resources.	This guideline includes opioid prescribing for acute, postacute and chronic pain, as well as tapering, discontinuing opioids and considerations for women of childbearing age.
Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, 2016. MMWR 2016; 65:1-49. **https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**	CDC guideline for prescribing opioids for chronic pain.
US Health and Human Services Opioid Tapering Guidelines 2019. **https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf**	Includes recommendations and guidance on when to safely tapering opioids as well as shared decision-making. Also includes suggestions for how to talk about tapering with patients.

Document/Resource	Content/Audience
Minnesota Medical Association. **https://www.mnmed.org/advocacy/Key-Issues/Prescription-OpioidTask-Force/Best-Practices-for-Prescribing-Opioids**	CME resources for opioid prescribing that meet the state requirements.
Minnesota Dental Association Protocol for Assessment and Treatment of Oral/Facial Pain, 2015. **https://www.mndental.org/files/MDA-Protocol-1.pdf**	This guideline covers acute dental pain treatment.
Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain **https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf**	This document describes practice-level strategies to organize and improve the management and coordination of long-term opioid therapy.
Six Building Blocks: A team-based approach to improving opioid management in primary care. **https://depts.washington.edu/fammed/improvingopioidcare/6-building-blocks/**	These extensive tools to improve prescribing were developed by the University of Washington Department of Family Medicine and Kaiser Permanente Washington Health Research Institute.
Opioids AHRQ Works: Building Bridges Between Research and Practice. **https://www.ahrq.gov/sites/default/files/wysiwyg/topics/impact-opioid-final.pdf**	Summary of resources created by the Agency for Healthcare Research and Quality (AHRQ) related to opioids.
Pathways to Safer Opioid Use **https://health.gov/our-work/health-care-quality/trainings-resources/pathways-safer-opioid-use**	These are interactive videos with actual story telling of “how” and “why”.
CDC: Prescribing Practices: Changes in Opioid Prescribing **https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html**	Resources of data and trends.

Treating Acute / Postacute Pain

Use this section if:

- You usually practice in urgent care or ED where opioids are often prescribed
- You write most of the postop prescriptions on discharge
- Your dental practice involves extensive and painful procedures
- You treat many patients with acute or postacute pain in your practice

Tested Strategies

- Seek education on opioid topics that relate specifically to the problem you need to solve.
  - Non-opioid therapies are often effective for managing pain and clinicians should first consider all non-opioid options. An NIH study reports that the majority of patients (72%) report preferring non-narcotic drugs for pain control. Many patients don't take all of the opioids prescribed.
  - Long-term opioid use often begins with treatment of acute pain. The likelihood of chronic opioid use increases with each additional day of opioid supplied beyond the third day, a second opioid prescription or refill, 700 morphine milligram equivalents (MME) or higher cumulative dose, patients started on a long-acting opioid or tramadol, and an initial 10 or 30-day supply (Shah, 2017).
  - The ABCDPQRS mnemonic addresses potential contraindications/ risks to opioid use and can be used each time a prescription is being considered. (ICSI Pain guideline, 2017)

    A – Alcohol Use
    B – Benzodiazepines and Other Drug Use
    C – Clearance and Metabolism of Drug
    D – Delirium, Dementia and Falls Risk
    P – Psychiatric Comorbidities
    Q – Query the Prescription Monitoring Program
    R – Respiratory Insufficiency and Sleep Apnea
    S – Safe Driving, Work, Storage and Disposal

- See also the companion document **ICSI Opioid Postoperative Prescribing Toolkit 2020**.
- If you are prescribing outside the recommendations you may wish to seek peer review of patient records to assist you in determining what else could have been done for the patient and what other support is available to you.
- Work with your care team to understand what workflows may need to change (see below).
- Work with your EMR experts or vendor to find solutions (see below.)

HEALTHCARE SYSTEM **"One of the first things we did was to review diagnoses that are not recommended as appropriate for opioid prescriptions, such as migraines, low back pain, and fibromyalgia. This identified many opportunities to improve prescribing through provider education."**

Chronic Opioid Therapy

Use this section if:

- You manage a large patient population with chronic pain.
- You inherited a practice of patients on legacy opioids.
- You are a subspecialty practitioner who receives referrals for pain management.

Tested Strategies

- If you find that you have many chronic opioid patients, determine whether you are equipped for or desire this focus in your practice, and communicate what you need to peers and leadership.
- Do not abandon your patients or abruptly taper their opioids.
- Work with your care team to optimize all the tools and skills for safely managing patients (see below).
- For evidence-based management steps refer to the Minnesota guideline, the CDC guideline or the ICSI Pain guideline above.
- Consider your communication style and your ability to have difficult conversations with patients about alternatives or tapering options (see below).
- Communicate with referral/referring providers about appropriateness. Referrals for alternative pain management are appropriate. Referrals to manage chronic opioids may be inappropriate.
- Develop specific peer/case review procedures for high-risk patients to determine if there are other options.

HEALTHCARE SYSTEM **"We provide a mentor for prescribers who prescribe outside of recommended practice. In some cases we help them change their practice completely so they work with patients who would not be prescribed opioids."**

Identifying Opioid Use Disorder & Tapering

Use this section if:

- You don't know how to determine when your patient has an Opioid Use Disorder (OUD).
- You don't know how to safely taper someone from their high-dose opioid.

Tested Strategies

- Often long-term patients are so familiar to you and comfortable on their opioids that it's hard to see that they have developed an OUD.
- Use one of the examples below to help you identify these patients for screening and diagnosis. The safest thing to do is get them to treatment to avoid adverse events or overdose. DO NOT suddenly stop opioids without a clear plan for the patient's safety.
- Recommendations for tapering a patient who is on opioid doses long-term (especially high MME doses) include offering the opportunity to taper every three months, which is essentially at each follow-up visit. Since this is a difficult conversation, we offer the tools below that include suggested language to use with your patient.

PATIENT FEEDBACK **"It would be awesome if the provider could tell me right up front that at every visit we will discuss tapering or discontinuing my opioid. Then I'm not anxious about it and I won't be defensive.**

Document/Resource	Content/Audience
MN Health Collaborative Demystifying Opioids package released 2019. **https://www.icsi.org/wp-content/uploads/2019/04/DemystifyingOpioidsPacket4.1.19.pdf**	Guidance on Opioid Use Disorder Algorithms & Tapering Frequently Asked Questions (FAQs)
Minnesota Opioid Prescribing Flip the Script **https://mn.gov/dhs/opip/provider-education/**	Resources to improve communication about tapering and opioid use
US Health and Human Services Opioid Tapering Guidelines 2019. **https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf**	Includes recommendations and guidance on safely tapering opioids as well as shared decision-making
Bree Collaborative: Motivational Interviewing in the SBIRT Model training. **http://www.breecollaborative.org/implementation/watch-our-webinars/**	Video training on how to have respectful, motivating conversations with patients via brief interventions. The Bree Collaborative website has numerous other similar materials.
Oregon Pain Guidance Group: Tapering – BRAVO – A Collaborative Approach, Clinical Update March 2020. **https://www.oregonpainguidance.org/guideline/tapering/**	Tips for tapering and discussing with patients.
BRAVO A Collaborative Approach to Opioid Tapering **https://www.oregonpainguidance.org/wp-content/uploads/2020/04/BRAVO-FINAL-3.13.20.pdf**	Broaching the Subject Risk Benefit Assessment Addiction and Dependence Happens Velocity and Validation Other Strategies for Coping with Pain
CDC: Guideline for Prescribing Opioids for Chronic Pain **https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf**	Pocket Guide: Tapering Opioids for Chronic Pain.

Enhancing Communication Skills

Use this section if:

- You are uncomfortable with difficult conversations (denying acute opioids, starting a taper, etc.).
- You have limited success motivating your patients to try non-opioid options.
- You are uncomfortable treating patients with coexisting mental health issues.

Tested Strategies

- Understand how your relationship with patients may inhibit frank conversations about their use of opioids. You may be perceived as having more power, or they may be friends or neighbors.
- Make it "normal" to discuss how each patient will both start and stop taking their opioids.
- When patients are identified as having co-existing mental health issues, it is important to coordinate with mental health providers to diagnose, develop a care plan, and co-manage patients. Ideal conditions would include fully integrated behavioral health within primary care.
- Motivating change is a key strategy to manage opioids and pain safely and effectively.
- Dialogue around opioids can often be difficult conversations. Brushing up on your communication skills will help you navigate this process. See the scripting options below.

Document/Resource	Content/Audience
ICSI's Collaborative Conversations Map **https://www.icsi.org/guideline/pain/appendix-d-icsi-shared-decision-making-model/**	Includes tools for shared decision-making and challenging conversations.
Miller, W; Rollnick, S; *Motivational Interviewing: Helping People Change*, Third Edition, 2013	This is a comprehensive book about motivational interviewing.
Minnesota Opioid Prescribing Flip the Script **https://mn.gov/dhs/opip/provider-education/**	Resources to improve communication about tapering and opioid use.
Oregon Pain Management Commission. The Art of Difficult Conversations **https://www.oregonpainguidance.org/guideline/the-art-of-difficult-conversations/**	These training modules require registration.
Oregon Pain Management Commission. Changing the Conversation about Pain: Pain Care is Everyone's Job **https://www.oregon.gov/oha/HPA/dsi-pmc/Pages/module.aspx**	These training modules require registration.
Connecting with your Patient About Pain: Changing the Conversation about Pain: Pain care is Everyone's Job **https://www.oregon.gov/oha/HPA/dsi-pmc/PCT/ConnectingWithPatients_Scripting.pdf**	This is a short scripting tool to motivate change in patients.

Build Your Team

Use this section if:

- You are not currently being supported
- Need ideas on whom to include in your "team"

Tested Strategies

Optimize Your Care Team:

- Use team-based care to allow all staff to work at their highest level (e.g., pharmacy, nursing, advanced practice professionals (APPs), support staff, etc.).
- Prescribers need to engage their team and work together to safely manage patients on opioids.
- Train staff to meet the needs of your population:
  - Pharmacist who can help manage a taper, educate patients and dispense meds
  - Clinical staff, nurses, or social workers for care coordination and assessment
  - APPs to manage visits for chronic patients (e.g., three out of four visits/year)
  - Rooming staff to perform screening and documentation
  - Community health workers to do pill counts or safety visits
- Work with administration to clarify roles and assess the capacity of the team.

Build Virtual Team Members:

- Help your organization establish relationships within the community to support treatment of pain, safe use and disposal of opioids, mental health treatment, and OUD treatment.
- Work with area emergency departments to understand common needs for coordination.
- Consider becoming wavered to treat OUD with medication assisted treatment (MAT) and/or work with local providers who are.
- Determine if your team would benefit from using a centralized clinical team to support difficult patient panels.

HEALTHCARE SYSTEM **"We offer a centralized clinic where patients who receive MAT for OUD can come for their screening tests and where we review patient agreements, provide assessment, and dispensing of their MAT drugs."**

Optmizing Your EMR

Use this section if:

- You feel your EMR could make the work easier for you
- There are tools in your EMR that you are unfamiliar with

Tested Strategies

- Verify that your imbedded EMR workflows support recommendations (alerts, order sets, preferences, existing protocols/ guidelines, decision-support tools, etc.).
- Add hard-stops to prescribing over the maximum MME, requiring an over-ride step.
- Setting default opioid quantities in the EMR may discourage thoughtful prescribing for each patient and cause over or under treatment.
- Use and maintain registries of patients with chronic pain, and who are receiving long-term opioid therapy.
- Use a data dashboard to monitor changes.
- Ask your EMR expert/optimizer to show you how to support your work better.
- Facilitate calculation of Morphine Milligram Equivalent (MME); both total Rx and daily dose (see below).
- Consider adding language in the patient consent form to include sharing addiction and mental health personal health information for care and treatment, and work with referral providers to do the same.
- Assure that your opioid medication lists are reviewed for accuracy, and that your systems recognize tramadol and tapentadol products as opioids.
- Review and update standardized patient education materials related to pain and opioids and assure that everyone in the organization uses the same messages with patients.

HEALTHCARE SYSTEM **"We discovered that because we hardwired our EMR orders to dispense 20 opioid pills a few years ago, we were both exceeding the 100 MME because not all opioids are the same, and we were potentially overprescribing."**

HEALTHCARE SYSTEM **"We assigned one person to find all the order sets that included opioids across the organization. Once found, they were replaced with standardized orders meeting guidelines."**

Calculating MME

Use this section if:

- Calculating MME Is a barrier to your prescribing

Tested Strategies

Unfortunately, there are numerous metrics used over the past 10 years to quantify opioid doses (e.g., pills or days prescribed, MME total dose, Morphine Equivalent Daily Dose [MEDD]).

- Efforts are being made to standardize doses around morphine equivalents to enhance safety.
- Most systems were not designed to calculate MME and are being retrofitted to do so.
- EPIC (common in the Midwest states), enhanced the prescribing software to add daily dose for chronic opioid use, and are adding total prescription dose now for acute prescriptions.
- It's important not to confuse the two types of calculation.
  - Daily dosing is used to understand how many MME are being given during a 24 hour period, especially when there is more than one prescription given. Most of the existing online calculators are designed to show how two prescriptions combine for a daily dose.
  - Acute prescriptions, especially postop, potentially have higher initial daily doses with the intention of decreasing the quantity/day as tissue heals. The total MME prescription is important. Many guidelines for acute prescribing are based on total prescription MME. When using the most common online calculators you need to add the total milligrams in the prescription.

One example of an online MME calculator is from the Agency of Medical Directors Group in Washington State. http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

Like most calculators it is designed to determine the daily MME dose for patients on chronic opioids. In **Figure 1** the patient has a daily dose of Tramadol (50 mg 4 x/d) and is given Oxycodone for recent acute pain (5 mg q 4 hrs). The daily MME is 65.

Opioid Dose Calculator

← Back to AMDG Home

Instructions: Fill in the mg per day* for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day.

Patient's Name:
Today's Date: August 16, 2020

Opioid (oral or transdermal):	mg per day:*	Morphine equivalents:
Codeine		0
Fentanyl transdermal (in mcg/hr)		0
Hydrocodone		0
Hydromorphone		0
Methadone†		0
Morphine		0
Oxycodone	30	45
Oxymorphone		0
Tapentadol		0
Tramadol	200	20
	Total	**65**

Figure 1

Figure 2 shows how to use the same calculator to determine a total MME per prescription. To do this you multiply the milligrams/pill times the number of pills prescribed (Oxycodone 5 mg x 30 pills). This total 150 milligram/prescription goes into the mg/day column and will calculate the total MME (225).

Opioid Dose Calculator

← Back to AMDG Home

Instructions: Fill in the mg per day* for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day.

Patient's Name:
Today's Date: August 18, 2020

Opioid (oral or transdermal):	mg per day:*	Morphine equivalents:
Codeine		0
Fentanyl transdermal (in mcg/hr)		0
Hydrocodone		0
Hydromorphone		0
Methadone†		0
Morphine		0
Oxycodone	150	225
Oxymorphone		0
Tapentadol		0
Tramadol		0
	Total	**225**

Figure 2

Ideally your EMR includes this MME calculation:

1. Total MME Calculation
   # of pills x mg dose per pill = total mg
   total mg x MME conversion factor = total MME
2. Daily MME Calculation
   # of pills per day x mg dose per pill = total mg/day
   total mg/day x MME conversion factor = total daily MME
3. Link to the CDC Opioid-Morphine-EQ- Conversion Factors: **https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-Aug-2017.pdf**

Improvement Support/Measurement

If you do not have experience in Quality Improvement (QI) and do not have QI support within your organization, consider referring to this simple toolkit for additional tools, available for free upon registering with IHI. (Institute for Healthcare Improvement Quality Improvement Essentials Toolkit. Boston, Massachusetts, USA. **http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx**)

Tested Strategies

- Data used to understand how you compare to your peers can often be found by reaching out to whoever identified you as an outlier. Larger organizations may also have comparative data.
- Employ quality improvement processes and measures to monitor progress and potential unintended consequences.
- Sample measures for improvement can be found in several of the guideline documents referenced in this appendix, including ICSI and State of Minnesota materials.
- Keep the QI measures focused, simple, and timely.
- Consider using one process measure (how many times did I do the right thing) and one outcome measure (did it change the outcome) for each improvement technique selected.
- Tracking data at the beginning, middle and end of your improvement cycle is a minimum goal.
- If you have capacity to do so, tracking frequently and graphing on a run chart will help you see your improvement over time.
- Making note of changes you made on the run chart will help you see if changes made a difference (e.g., start new form).

Document/Resource	Content/Audience
MN Health Collaborative Call to Action: Opioid Acute Non-Surgical Prescribing, ICSI. Minneapolis, Minnesota. 2020. (Available at **www.icsi.org**)	Specifications used to extract EMR data for acute prescribing for opioid naïve patients in ambulatory dental, ED and clinic settings.
ICSI Adult Opioid Postoperative Prescribing Toolkit. 2020. (Available at **www.icsi.org**)	Specifications for extracting health system EMR data using procedure bundles to measure initial MME prescribed postoperatively for QI. Appendix B: Specifications for extracting health plan claims data using procedure bundles to determine quartiles of initial MME prescribed postoperatively
MN DHS Opioid Prescribing Improvement Program: Overview of Sentinel Measures MN DHS **https://mn.gov/dhs/opip/**	Details measures used to generate provider reports using claims data.
Quick Reference Guide – How to Run a Patient Request in Prescription Monitoring Program AWARxE **https://bit.ly/2WoXzeA**	This explains how to run a report on a specific patient in the PMP. At a minimum, you must provide: First name, last name, date of birth, prescription fill dates.
Solberg LI, Mosser G, McDonald S. *The three faces of performance measurement: improvement, accountability, and research*. Jt Comm J Qual Improv. 1997;23(3):135-147. doi:10.1016/s1070-3241(16)30305-4	This article explains the differences between measuring for research, accountability (e.g., opioid report cards), and for improvement (the type you need here).

Sustaining Change

Work with administration and EMR experts to be certain that tested changes become hard-wired into your workflow to make it easy to do the right thing.

- New or updated policies and procedures
- Forms, workflow changes
- Monitoring systems like registries that need to be kept current
- Changes to job descriptions or responsibilities for staff