

# Chronic Pain and Long-term Opioid Medication: Building a New Culture

*activated by* **icsi.**

# Chronic Pain and Long-term Opioid Medication: Building a New Culture

The ever-changing evidence and regulations around opioids in the past several years have led to frustrated patients and providers. Well-intended efforts to reduce opioid use have led to unintended consequences, including sudden changes in physician practices and sudden withdrawal of opioid medications from patients. These changes have left clinicians feeling unsupported, and at times, feeling like they do not know what to do. The changes have also left patients feeling unsupported, potentially at risk for withdrawal, and at risk for dangerous erratic dosing of opioids. In particular, shifting practices around opioids in the setting of chronic pain has led to uncertainty and distrust from patients and providers alike.

ICSI was tasked with developing a better understanding of the challenges faced by both the patient and prescribers in the setting of chronic opioid use for chronic pain. One initial consideration for the outcome of this work was to identify a list of conditions or diagnoses that could be considered exempt from guidelines and regulations. However, it became clear, early in conversations, that this simplistic approach would not address the complex and dynamic challenges faced by the diversity of people suffering from chronic pain. Instead the healthcare system needs to rethink and redesign approaches to more reliably provide safe and effective care for people with chronic pain and on opioid therapy.

To guide our exploration process, we leveraged a Human Centered Design (HCD) framework to iteratively explore, prioritize, and develop system redesign opportunities that were rooted in the experiences and values of both prescribers and patients. The HCD process allowed us to facilitate an in-depth series of discussions and community interviews that were held both with people who have had experience with long-term opioid therapy for their chronic pain, as well as prescribers who care for this population. [Full details available in [Methodology](#)]

The process offered safe space for the complex issues to be stated and understood from multiple viewpoints over time. As key themes surfaced, a number of system redesign principles were identified and prioritized:

## **Moving from Transactions to Partnerships: Cultivating Relationships**

One of the major themes that arose was the transactional nature of the prescriber-patient relationship when opioids are involved; very different from the typical chronic condition care relationship. How might we create policies and practices that support building effective relationships?

## **Navigating the Whitewater of Guidelines & Policy: Personalizing Care within the Boundaries**

Another major theme was how guidelines for opioid therapy are perceived and interpreted differently across different provider systems, and sometimes interpreted as a mandate, which can short-change care for some individuals. How can systems ensure that personalizing care is accomplished?

## **Supporting the Whole Person: Addressing Mental Health and Well-Being**

Sobering themes echoed across participants of the chronic pain community were a sense of hopelessness, despair and fear that comes with their diagnoses, compounded by a lack of viable and accessible treatment options. How can systems normalize the assessment and support of mental health, substance use, and social needs as part of best care for people with chronic pain?

## **Combating Misinformation: Interpreting the Evidence**

The evidence on chronic pain and opioids is still emerging. Varying interpretations and perspectives on how best to deal with chronic pain and opioids can lead to a fracturing of the prescriber-patient relationship and the perpetuation of myths, creating a vicious cycle of misinformation and mistrust. How do we support both patients and clinicians to discern good quality evidence, and deconstruct myths?

## **Re-Thinking Empowerment: Supporting Patient Self-Advocacy**

People who have chronic pain and are on opioids are often labeled as difficult, or are negatively perceived as “doctor shopping,” when seeking care. How might we develop a better, more formalized infrastructure to help patients and prescribers in building a relationship that supports patient self-advocacy?

## **Everyone Needs a Team: Supporting Prescriber Needs**

With varying perspectives around opioid therapy for chronic pain, some prescribers reported feeling isolated or even acutely alienated from their peers and their healthcare systems. How can we use team models, as used for other chronic conditions, to better support prescribers?

## **Perception Matters: Removing Stigma**

While cautions around opioid therapy are needed, fears have led to stigma that in many ways have become structural, embedded into practices and policies that then become barriers to care and functioning. How can health systems identify and dismantle the social and structural stigma regarding chronic pain and opioids?

# Redesigning Systems for Chronic Pain and Opioids

The following re-design framework was developed to acknowledge the tensions that exist in chronic pain care and to find practical approaches to navigate them in a person-centered way. Given the complexities involved in chronic pain management and long-term opioid therapy, this framework is intended to guide meaningful action at the point of care rather than offer an overly prescriptive checklist of tasks. There is no “right” or “wrong” way to use the information in this document. We recommend reviewing the framework to identify the principles that best align to current system challenges, assets, and priorities. Redesigning practices and protocols in one area is likely to have a positive impact on other principles outlined in this document and to support policy and practice changes in the future. **The ultimate goal is to better support providers, patients, and health systems in safely navigating chronic pain and opioid use, while supporting maximum patient function and well-being.**





## Moving from Transactions to Partnerships

### Cultivating Relationships

This prescriber-patient relationship is fraught with apprehension on both sides, with opioids often being cited as feeling like the third person in the room. Several patients noted being “deathly afraid of doing something wrong” and being dismissed from a practice, or getting a false positive test result on a routine urine drug screen making it difficult to continue with the current medication plan. In a similar way, several prescribers also noted being afraid of doing something wrong as it could impact their professional career or licensure. And worse, the severe psychological effect, if a patient died of overdose while under their care. When both parties come into the room with these hidden fears, it can compromise the relationship before it even begins.

This anxiety can lead to the transactional interactions between prescriber and patients. This type of “I’ll do this, if you do that” discussion can limit the ability to develop a shared understanding of care needs and values. This can be detrimental for patients with chronic conditions whose medical and social needs are often complex.

Prescribers and patients described building a relationship based on empathetic communication as an important prerequisite to establishing and navigating chronic pain management, including opioid treatment plans. Both felt that there must be meaningful opportunities for each (patient and prescriber) to share their stories, their values, and previous experiences of struggle and success to build a constructive working relationship.

### *Principles for System Redesign*

#### **Create policies and practices that support building effective relationships.**

In medicine, there is an unavoidable power dynamic in the room between provider and patient, which can make it difficult to have open and honest conversations. Shifting the power dynamics so that both patients and prescribers feel they are in partnership, rather than transactions, can be an important step to create effective care plans that all parties can adhere to.

#### **Examples include:**

- Rather than opioid contracts which are often cited as transactional and punitive, consider alternate approaches to establishing the expectations that both parties have.
- Validate that the patient’s pain, and their pain management journey, is real and does not have to be “proven” (especially important for women and people of color whose pain tends to be more readily dismissed).
- Create formal ways for patients to share their pain experience, including function/well-being limitations and hopes for their future function/well-being.
- Ask what the patient wants to get out of the visit –align expectations of what can be addressed in the allotted time.
- Normalize discussions about common friction points through planned communication (needing same day refills or early refills, relapse, positive drug screen, safety concerns)

- Use motivational interviewing practices to establish patient values, goals and actions.
- Instead of consequences for a failed plan, consider what processes might be established to negotiate a new plan, support patient and prescriber goals and reconcile the relationship.

**Ensure that the transition to a new prescriber is safe and seamless.**

Transitioning to a new care provider was noted by patient and prescriber to be a particularly vulnerable and challenging time. For prescribers, the information needed to understand past patient experiences and current state might be present in the record, but hard to access and hard to know what might be salient at a given point in time. For patients, re-telling their story and worrying about being believed can be a traumatic experience.

**Examples include:**

- Formalize methods of communication (e.g., templated note) between former and new prescriber to ensure a warm handoff.
- Acknowledge that while important, it may be difficult for patients to “tell their story” repeatedly, particularly if they feel they have not been believed in the past.
- Avoid appointments being made just as opioid medications from the previous provider run out.
- Assist the patient with referrals or access to a new prescriber to avoid unsafe delays due to limited access.
- Use care coordination to proactively communicate with new patients.
- Prioritize responsive communication for patients between office visits.
- Offer guidance to patients as to how they might approach their first visit with a new provider, and what they might expect.
- Offer guidance to prescribers as to what is expected of them in their first visit with a new chronic pain patient.



## **Navigating the Whitewater of Guidelines & Policy**

### **Personalizing Care within the Boundaries**

As the opioid crisis hit the nation, justified concern for patient safety led to generalized messages on opioids as part of a public health approach. However, for a subset of patients with complex conditions, this tension between population-based guidance and individual health needs can be especially difficult to navigate.

Because of all the varied policies, guidelines and other recommendations about opioid use in recent years, patients have expressed feeling like they are receiving cookbook medicine designed to assure rules are followed, rather than treatment plans that are tailored to their individualized needs. Guidelines, meant to provide guidance to support prescribers in safer use of opioids, are sometimes being used to make rigid regulations.

Some of the solutions developed during the opioid crisis have worsened this tension. Prescribers and patients expressed frustration that policies in different settings use different standards. Some prescribing policies focus on the number of days prescribed, others the number of pills, while others use the better

metric of total or daily morphine milligram equivalents (MME). Insurance coverage for medications are inconsistent, pharmacy chains/benefit managers have dispensing rules that may be at odds with the patient's care plan, and care delivery systems may have implemented pathways in electronic health records (EHRs) that limit options.

For prescribers, there is an ongoing concern that even when trying to develop personalized plans, patients still may be dissatisfied if that plan does not include an opioid. While there is no magic bullet for differing expectations and goals between prescriber and patient, it is important to have an honest discussion of the patient's situation and reasons why the prescriber is personally concerned (a discussion that focuses on the patient and not regulations, i.e., "I can't because of the state rules"). Although often done in an effort to preserve the clinician-patient relationship, blaming regulatory bodies for prescribing decisions only contributes to distrust and the patient feeling that their care is not individualized. Giving patients explicit, individualized reasons (e.g. "you have sleep apnea that puts you at higher risk for respiratory suppression") is critical to demonstrating that the care plan is being made for a particular patient and not just a population.

Personalized care does not mean that prescribers or patients should unilaterally choose the management course. Rather, it involves collaboration from both sides, with open and evolving discussions about expectations so that the care goals better match the care plan. Although prescribers have the required authority over controlled substances, the patient has the right to refuse the prescription or change prescribers. Personalized care also involves each party acknowledging their own limitations/biases. Prescribers and patients cannot assume that they share the same values, preferences, or goals.

- While clinicians can have empathy for patients with chronic pain, they cannot truly understand the challenges and must rely on the patient's expertise arising from their own experiences. Managing chronic pain is a full-time job for many patients.
- Patients need to recognize that it is difficult to be an objective observer of oneself. Patients with chronic pain, who are under constant stress, may be less apt to recognize their dependence on opioids or acknowledge safety concerns related to their use of opioid therapy. Prescribers can help patients by fully discussing risks and benefits of treatment plans.

This is not easy and does not happen overnight. Rather, it takes a partnership, outlined above and developed over time, to create and execute an individualized care plan.

### ***Principles for System Redesign***

#### **Create opportunities to align population level health initiatives with the patient's individualized needs.**

In an environment of ever-increasing guidelines and policies, particularly around opioids, patients can feel that they are receiving care that is not individualized. While it is critical for clinicians to understand current clinical recommendations and system regulations, it is even more important that this guidance and regulation be considered in the context of the patient's previous experiences and personalized goals and care plan.

#### **Examples include:**

- Prescribers need to be clear about the boundaries within which they are working, an honest description of the rules, regulations and guidance that they are using. At the same time, assure patients that within these boundaries, there are many ways to work together to meet individual patient goals.

- Systems should routinely review and update their policies and practices to accurately reflect the current state of knowledge and regulations.
- Offer a straightforward format for patients to describe their pain management experience to date, including function and well-being limitations and hopes and goals for the future such as a pain function chart.
- Offer various approaches to communicate with patients about pain experiences and management strategies (visual, data-driven, use of a translator, etc.).
- Discuss opioid safety concerns with patients through the lens of immediate and long-term function (how will this impact their ability to live the life they want to live).
- Offer purposeful shared decision-making discussions with patients to craft a care plan with clear and practical pain management strategies.
- Focus on goals related to function rather than goals only focused on pain reduction.
- Use chronic condition management tools and techniques to assure that patients are well supported as they work towards treatment goals.
- Use motivational interviewing to discuss and document patient assets (e.g., friends, family, community resources) and approaches to pain management that have worked well in the past.



## Supporting the Whole Person

### Addressing Mental Health & Well-Being

A key theme among the chronic pain community was the feeling of hopelessness, despair and fear that comes with their diagnoses and compounded by a lack of viable and accessible treatment options. There was extensive discussion about the mental health effects of chronic pain, particularly uncontrolled pain, and how it can lead to anxiety, depression, and in tragic circumstances, illicit drug use and even suicide. Some patients noted feeling isolated and not able to share their pain journey because of concerns about being shamed for taking opioid medications. Patients expressed that routinely and proactively assessing and addressing their mental health needs was important. But they were also clear that these assessments were not to be used to support the notion that the pain is “all in their head.”

Mental health and well-being is certainly affected by chronic pain itself. But for patients with chronic pain, there may be other specific stressors to be explored. Patients talked about pain interfering with stable employment and limited how they can care for their family. Financial concerns may be driven by unstable employment, but also by costs associated with medical care. A treatment plan for chronic pain that does not include assessment and intervention/referrals for these needs does a disservice to the patient and jeopardizes the success of the rest of the plan.

While patients may feel confident that their use of opioid medications is not misuse, or does not put them at risk for opioid use disorder, prescribers noted that this is a condition that they must monitor. Opioids are an addictive medication and if opioid use disorder is identified, it may require additions or changes to a care plan.



## Principles for System Redesign

### Normalize the assessment of mental health, substance use and social needs as part of best care for people with chronic pain.

The use of PHQ9, GAD7 and other tools is becoming more routine in practice. Assessment of social needs is increasing. Assessment for substance use disorders is less common and may be more challenging in this setting. Most commonly these tools are used on a set timeline, but in high-risk populations, screening on a set timeline may not serve patients well who have conditions that are changing.

#### Examples include:

- As part of beginning the patient relationship, set the norm that this screening will be frequently conducted.
- Routinely plan opportunities for the patient to discuss mental health concerns and the patient's emotional well-being. Use the whole team, not only the prescriber.
- Use technology, patient portals for assessments.
- Use integrated behavioral health resources as part of routine care.
- Assess for and address social isolation.
- Assure that prescribers and their teams understand how to interpret screening results.



## Combating Misinformation

### Interpreting the Evidence

While we are learning more and more about the dangers of opioids in recent years, the evidence on chronic pain and opioids is still emerging. Unfortunately, different interpretations and perspectives on the current evidence can lead to a fracturing of the prescriber-patient relationship. It also leads to the perpetuation of myths, creating a vicious cycle of misinformation and mistrust.

With easy accessibility to all types of information, it is critical to help patients and clinicians discern good quality evidence from poor quality evidence. Sometimes, there is a dearth of evidence, and that too needs to be recognized as well. Prescribers and patients need a shared understanding of the evidence, what is known and what isn't, and how the evidence applies to each individualized management plan for patients dealing with complex conditions.

Furthering this chasm are educational materials that oversimplify the complexities of chronic pain and opioids. Patient education materials are often too generic for a sophisticated patient population that has been living with their illnesses for years. Prescriber education materials can also be too high level, and not adequately reflect the many nuanced situations that come up when caring for this patient population.

While not all evidence is created equal; true misinformation abounds. In addition, research funded by and influenced by pharmaceutical companies is well documented as part of the increasing misuse of opioids in the United States. Many of the patients on long-term opioids were started on these by well-intentioned clinicians acting on what was thought to be best practice at that time.

## Principles for System Redesign

### Develop educational opportunities that patients and prescribers need.

Keeping abreast of the medical literature, determining quality of evidence and translating this to clinical care is a herculean task. Clinicians and patients need to have trusted knowledge consolidators and distributors.

#### Examples include:

- Develop or identify ongoing clinician educational training that accurately reflects the current state and limitations of the evidence for chronic pain and opioids.
- Offer literature reviews for prescribers that outline safe practices, including the dangers of abruptly reducing opioids or one-size-fits-all tapers that do not incorporate patient preferences.
- Develop or identify patient education materials in multiple forms that accommodate varying levels of education and learning styles (e.g., some short and to the point, others more in-depth and summarizing the evidence, some more visual).
- Ensure that summary materials for prescribers and patients avoid generalizations that aren't supported by evidence.
- Use standard media and social media to spread relevant and truthful information.
- Agencies and organizations that write guidelines, regulations and policies need transparent processes for updates that include a diversity of perspectives from chronic pain patients.
- Consider a prescriber template for discussion that anticipates common patient questions and common myths.



## Re-Thinking Empowerment

### Supporting Patient Self-Advocacy

Patients are specifically looking for ways to advocate for themselves which include, 1) knowing their rights, 2) knowing how to enter and navigate a prescriber relationship and 3) who/what to turn to when questions or concerns arise.

We heard from both patients and prescribers that patients who advocate for themselves are often labeled as difficult, or when they switch doctors to find a better fit they are negatively perceived as “doctor shopping.” Prescribers say they do not have a reliable way of determining which patients are looking for the right fit in a therapeutic relationship and which patients are changing doctors frequently, which might result in unsafe use of opioids.

Patients have the right to determine whether they want to have a recommended procedure or treatment, but don't always feel like they can say no for fear of being turned away from care. Prescribers recognize that some patients have agreed to surgeries and procedures that were non-beneficial because they were desperate for pain relief. Further, patients who do their own research are sometimes seen as difficult and dismissed as not being able to understand evidence, or using only what supports their viewpoint.

There was a strong theme in our interviews of patients feeling disempowered in the prescriber-patient relationship, with some noting “they were at the mercy of their clinician” as to whether they would receive

their prescriptions. Patients noted that the urgency they felt in needing help to manage their chronic pain was not shared by the health system/clinicians they were engaged with. Patients working in this project worried that any changes aimed at better supporting them would take too long or never show up in their specific clinic. Patients are looking for ways to advocate for themselves in sharing their personal stories and identifying providers that are a good fit.

### ***Principles for System Redesign***

#### **Support patients in searching for and developing prescriber relationships.**

Finding a clinician-patient fit is important to care for any complex, chronic condition, and especially for those with chronic pain. The system needs to develop a better, more formalized infrastructure to help these complex patients in finding a relationship that works, understanding that the better the relationship, the more successful and safe the care plan will be.

#### **Examples include:**

- Create accurate and specific materials about how a given practice approaches care for chronic pain, including but not limited to use of opioids.
- Offer “interview” visits, where there is a clear expectation that no prescriptions will be written at that visit.
- Consider who on the prescriber’s care team might be skilled at having conversations about fit ahead of meeting the prescriber.
- Thoughtfully, and well in advance, plan for patient transition when a prescriber retires or leaves a practice.
- Reinforce the idea that finding a prescriber that is a good fit for each patient is best practice in healthcare across the entire care team.
- Discuss patient fears about recommended procedures or treatments based on previous experiences.
- Consider how systems might better identify patients who are a safety risk due to frequent changes in providers, and act on this information.
- Create opportunities for patients to discuss what they are willing to do to manage their chronic pain (e.g., Where do you see yourself in five years? What do you feel you can do to reach these functional goals?).

#### **Support clinics and prescribers in creating an experience where patients are expected and encouraged to be self-advocates.**

Given previous negative experiences with the healthcare system, patients are often afraid to share honestly about their story and their goals. They are afraid of being perceived as a difficult patient and that this perception will directly affect their care.

#### **Examples include:**

- Encourage patients to ask questions, using a variety of methods at the visit, on-line or via phone visits.
- Encourage prescribers to share their approach to pain and opioid management.
- Co-develop goals of care and an evidence-based care plan that outline goals, and values.

Anticipate specific situations where there could be a breach in the relationship or when safety is a concern and how it will be handled by both parties.

- Ask about successful and unsuccessful clinician relationships patients have had in the past.
- Use a story guide to support describing patient experience, including function, well-being, limitations and hopes.
- Create an advocacy call-in line for patients and providers to call and gain advice when something unexpected happens or just to navigate new prescriber-patient relationships.
- Provide an avenue for patients to give feedback and make sure concerns are addressed appropriately.



## Everyone Needs a Team

### Supporting Prescriber Needs

Using teams to care for patients with chronic disease is a well-established model of care that has shown to improve outcomes and patient adherence to care plans. And yet, prescribers reported sometimes feeling isolated when working with patients on opioid therapy for chronic pain. Some felt acutely alienated from their peers and their healthcare systems.

Conversely, prescribers who feel supported by their system and being part of a team reported more successful patient relationships. Prescribers noted that it was beneficial having access to a reliable resource (ideally within the same clinic) for support when taking on a new patient into their patient panel who was transitioning from another prescriber. This was especially the case in rural areas of Minnesota, where prescribers may have less experience working with patients using chronic opioids and where pain specialists can be difficult to find.

Prescribers also reported a lack of access to other treatment modalities. Access to non-opioid treatment for pain was a common concern, either due to limited practitioners or limited coverage by insurers. Access to treatment for Opioid Use Disorder was a significant barrier for both metro and rural prescribers. There are still fewer medication assisted therapy (MAT) prescribers than needed.

### Principles for System Redesign

#### Build a multidisciplinary, multifunctional team to support the primary prescriber.

Team support can take the form of collegial support at a clinic, but also support from the broader healthcare system. Consider support that might be available outside the clinic walls as well as using expertise of local colleagues and staff. Rethink the team concept to include participation from the community.

#### Examples include:

- Formalize the team and introduce them to the patient, especially care managers.
- Take advantage of technology to engage with formal consult teams for case reviews and support during tapers.
- Consider resources available from local pharmacies, health plans, and mental health providers.

- Engage team members and experts remotely using virtual interdisciplinary teams.
- Expand the team beyond healthcare. Patients with chronic pain may have associated disabilities and be receiving services from state agencies or others. These organizations may have care navigators/managers.
- Engage the patient and their caregivers in finding community-based resources that might be helpful to support them, and add these to the patient’s team.
- Expand access to MAT providers to support Opioid Use Disorder treatment.

**Provide the knowledge, skills and time to support team effectiveness.**

Team members have specific roles and responsibilities, so what each team member needs varies. There is likely a core team in a clinic that needs the most specific and in-depth knowledge, but community team members may benefit from understanding more about evolving topics, such as physiology of chronic pain and effects of long term opioid use.

**Examples include:**

- Offer routine training for the whole team in general chronic pain topics, and specialized training for specific roles.
- As with any chronic condition, create a registry of patients with chronic pain and of patients who use chronic opioids and routinely review aspects of their care with the core team to assure treatment goals are managed.
- Plan for visits and between visit care, assigning tasks.
- Use data dashboards to track improvements and identify opportunities for improvement.



## Perception Matters

### Removing Stigma

There is both social and structural stigma around opioid therapy. Patients reported a very one-way narrative in healthcare and in the public: “Opioids are bad.” They noted experiencing social stigma that makes it difficult to share their experiences with others, even those that could potentially be supportive, including family members. Patients also noted the drastic pendulum swing from opioids being an accepted treatment to feeling criminalized for being on opioid therapy. This stigma is not just around opioid therapy. It exists around the diagnosis of chronic pain. Irrespective of opioid therapy, chronic pain patients expressed feeling not believed, judged, and dismissed by the healthcare system.

Prescribers noted that not many years ago healthcare focused on “pain as the fifth vital sign” which made it acceptable, even optimal, to treat chronic pain with opioids. Now, much of the education aims to avoid the use of opioids at all costs. Patients that were started on chronic opioid therapy by one health system are now being told by the same system that they need to stop using opioids. They are “stuck” in-between old and new practices, with few options and feeling alienated from family, health systems and public opinion.

Unfortunately, opioid information tends to be sensationalized in public communication. Overdoses from illicit drugs cast a shadow on those managing chronic pain with opioids in a closely managed clinical

setting. Prescribers who receive communication from regulatory or governing bodies about prescribing patterns react defensively and feel a sense of being watched by big brother. We need to reframe the way we communicate with patients and prescribers to clarify expectations without shame and blame. There is a need for messaging around the harms of opioids but the unintended consequences of this messaging, social and structural stigma, can also be harmful.

### ***Principles for System Redesign***

#### **Identify and dismantle social and structural stigma regarding chronic pain and opioids, together and separately.**

Research into stigma surrounding mental health conditions shows that there have been positive changes. There is decreasing stigma around mental health conditions, with more Americans seeing these as diseases, not personal failings. Shifting from a blaming model to a chronic disease model can support this change in thinking. Similarly, for chronic pain and opioids, it is critical to build messaging that shifts from blame, shame and stigma to being centered around the chronic care model.

#### **Examples include:**

- Work with all clinic staff to change attitudes and messaging. Chronic pain is common: are there co-workers with lived experiences who might help? Discuss how care for people with chronic pain on opioids is the same or different than people with other chronic conditions, and identify where your current practices are the same for each condition, or different.
- Avoid labeling terms such as “addict” and instead use people-first language such as “people with substance use disorder.”
- Identify as a team which clinic processes and policies may be contributing to or reinforcing judgment and stigma.
- Identify ways in which structural stigma may be embedded in practices (e.g., are positive urine drug screens, “dirty screen,” interpreted as character failing?).

## **Summary**

The goal of this document is to provide healthcare systems and individuals with principles that can be applied right now to improve the experience of patients and prescribers. Opioid therapy for chronic pain has been a loaded and sensitive topic, which adds to stigma and creates distancing, which can ultimately result in patient harm. It is critical that we look afresh at the situation from both patient and prescriber perspectives.

In addition to the rich feedback provided by prescribers and patients in the community covered within, further insights that were out of scope of this document were forwarded to Minnesota Department of Human Services (DHS) to help them prioritize future work. These include, but are not limited to, access to care, payment/coverage issues, use of buprenorphine, and concerns with prescriber/organization metrics.

## Methodology

This work was commissioned by the Minnesota Department of Human Services (DHS) from the State Opioid Response Grants awarded by the Department of Human Services and funded by SAMHSA, as a part of their Opioid Prescribing Improvement Program (OPIP). DHS wanted to better understand the gaps and pitfalls between standards and practice, with the goal of helping both patients and prescribers safely navigate the challenges of chronic pain and chronic opioid use.

This work is the culmination of several months of information gathering and includes:

- A series of meetings and interviews facilitated by ICSI, involving three different groups: Chronic Pain Steering Committee, Chronic Pain Opioid Prescribers, and Community Consultants (people with lived experience either as patients or family members). Each group met multiple times over the course of three months, coming together as one large group for one final session. There were 22 prescribers from 17 organizations and seven community consultants that participated in this series of meetings over three months. In addition, the community consultants conducted further interviews and surveys and brought those insights to the work.
  - Composition of the prescriber groups:
    - 10 large healthcare systems / 7 smaller practices
    - 7 rural or outstate / 10 metro with rural connections
    - Included both primary care prescribers and pain specialists, all with experience prescribing opioids for chronic pain
  - Composition of the community consultant group:
    - 7 community consultants
    - 3 metro/4 outstate
    - 4 individuals identified as white and 3 non-white
    - Consultant ages ranged from 30s–70s
    - Included 5 individuals with chronic pain and being prescribed opioids and 2 individuals caring for those with chronic pain and being prescribed opioids.
  - Group work, specifically the community consultant work, was guided by the principles of Human Centered Design (HCD). An iterative meeting process was developed to allow community consultants to use HCD interviewing methods, between each meeting, to capture experiences and perspectives from individuals within their professional and personal networks, allowing the team to access community perspectives that would be inaccessible through other means.
  - The community consultants systematically reached out to peers between meetings which brought input from a more diverse population, including 70 additional responses to survey questions.
  - The community consultants also conducted 34 individual interviews with community members (in their personal and professional networks), 38% of which were with non-white individuals.

- This work is also informed by previous input from the community facilitated by the Minnesota DHS over the past three years of the Opioid Prescribing Quality Improvement Program Technical Assistance (OPIP) project, and by members of their Opioid Prescribing Working Group.
- The ICSI and DHS teams also facilitated quality improvement consultation calls with participating prescribers and their organizations which contributed to this content.

**Limitations:** While we gained much insight from our cohorts, we acknowledged limitations based on groups not included. Our work groups did not include patients who were successfully managing pain without opioids or who have successfully tapered off opioids. We also did not include clinicians who are not managing patients on opioids. These would be important populations to interview in future work.



## Resources

### ICSI

- Opioid Main Page: <https://www.icsi.org/programs/mn-health-collaborative-opioids/>
- Opioid Prescribing Improvement Guide: <https://www.icsi.org/wp-content/uploads/2021/11/ICSI-Opioid-Prescribing-Improvement-Guide.pdf>
- Opioid Postoperative Prescribing Toolkit: <https://www.icsi.org/wp-content/uploads/2021/11/ICSI-Opioid-Postop-Toolkit.pdf>
- Opioid Postoperative Prescribing Improvement Story: <https://www.icsi.org/wp-content/uploads/2021/11/ICSI-Postop-StoryF.pdf>
- Demystifying Opioids Package (Opioid Use Disorder Algorithm & Opioid Tapering FAQs): <https://www.icsi.org/wp-content/uploads/2021/11/DemystifyingOpioidsPacket4.1.19.pdf>
- Pain Guideline: <https://www.icsi.org/guideline/pain/>

### DHS

- Main Page: <https://mn.gov/dhs/opioids/>
- Statewide Data: <https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html>
- Opioid Prescribing Guidelines: <https://mn.gov/dhs/opip/opioid-guidelines/>
- Opioid Prescribing Improvement Program: <https://mn.gov/dhs/opip/>

### Stigma

- Conceptualizing Stigma Author(s): Bruce G. Link and Jo C. Phelan Reviewed work(s): Source: Annual Review of Sociology, Vol. 27 (2001), pp. 363-385 Published by: Annual Reviews Stable URL: <http://www.jstor.org/stable/2678626> . Accessed: 19/02/2013 10:28
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