Planned, Patient-Centered Visits: Resources and Tips

Introduction

This document offers resources and tips for achieving the milestones in the Planned, Patient-Centered Visits Building Block. It also reviews approaches to overcoming common challenges.

Overview

Planning for patient visits can make a big impact! Care gaps can be identified by "scrubbing charts" the day before or during the morning huddle, resulting in delegation of tasks to different team members to close the gaps. For example, who is going to review the new patient agreement form with the patient and get their signature? Who is going to check the state prescription monitoring program database before the visit? Who will order and ensure the patient goes to the lab for a urine drug test, if needed? Clinicians and staff can also anticipate and briefly rehearse how to have what might be difficult conversations with those few patients who have demonstrated aberrant behaviors, such as early prescription refill requests or an abnormal urine drug test. Or how to best introduce the topic of tapering opioid medications with a patient who has been using high dose, long term opioid therapy for many years.

Summary of Milestones, Resources, and Common Challenges

Milestones	Relevant Resources
Data are used for pre-visit planning	*Purposes of tracking and monitoring*
EHR pain visit templates are in place to cover key elements of the pain visit as outlined in the revised policy	*Pain Tracker* *Clinical Decision Support tools* *WSMA opioid management dot phrases*
Standardized pre-visit planning and pain visits are integrated into the practice	*Chronic pain appointment workflow* *Care plan model* *Pain Tracker* *Turn the Tide pocket guide for clinicians* *BRAVO protocol* *VA Opioid Taper decision tool* *HHS Guide for Clinicians (tapering)*
Patients receive education on chronic pain management and opioid risks	*CDC patient education example* *Patient letter* *Chronic pain self-management resources* *Compilation of patient education resources*

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Milestones	Relevant Resources
Training in patient engagement is offered to staff and clinicians (e.g., difficult conversations, motivational interviewing)	*Empathic communication resources* *Provider guide to difficult conversations* *Staff guide to difficult conversations* *Difficult conversations video vignette* *Oregon Pain Guidance: difficult conversations* *Social determinants of health and pain management* *Stigma and chronic pain*
Alternatives to opioids are regularly considered and discussed, and integrated into care processes	*CDC Alternative treatments fact sheet* *Evidence on complementary and alternative approaches to chronic pain* *AHRQ's Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review* *AHRQ's Treatments for Acute Pain: A Systematic Review*

Common Challenges
Our appointments are very backed up.
Some clinicians are not using the state prescription monitoring database.
Some care teams are not calculating MED.
Patients feel labeled by having to do urine drug tests.
We have a provider leaving and we need to re-distribute his/her patients using long-term opioid therapy.

Tips for Accomplishing Each Milestone

Data Are Used for Pre-Visit Planning

Run multiple tests of change with actual patients to consider the following questions.

- What information is needed for pre-visit planning? What steps are needed to make these data consistent and available?
- How does your clinic know when a patient using long-term opioid therapy has an upcoming appointment that needs pre-visit planning?
- What will the process be to review and use data for pre-visit and pre-refill planning?
- Who is responsible for pre-visit planning tasks?
- How will these staff and clinicians train on these processes?

Once a new policy is in place, having a workflow in place for pre-visit and pre-refill planning helps support policy implementation. Investigate how information is used now for pre-visit planning. How could it be done better? Test and adjust to build effective workflows for tracking and monitoring data for pre-visit and pre-refill planning. Continue to iterate this approach over time as experience and

capacity grow. Refer to the example *Chronic pain appointment workflow* and the example *Opioid refill workflow*.

EHR Pain Visit Templates Are in Place to Cover Key Elements of the Pain Visit as Outlined in the Revised Policy

- Embed care components, such as assessments (e.g. *Opioid Risk Tool* - ORT, *Pain, Enjoyment, and General Activity scale* - PEG, and the *Patient Health Questionnaire* - PHQ) and goal setting, into an electronic health record (EHR) template so the provider does not need to look for these scales in multiple places during a visit.
- EHR templates should be simple to follow and only include essential items. Templates that are too long or complicated may not be used by care teams.
- Run multiple tests of change to ensure templates are easy to use.

Standardized Pre-Visit Planning and Pain Visits Are Integrated into the Practice

After developing and training on workflows to support pre-visit planning and pain visits, the next steps are to verify that they are in use as expected and to support care teams in overcoming implementation obstacles. Strategies sometimes employed to monitor workflow implementation include:

- Reviewing tracking and monitoring reports (e.g., date of last patient agreement review, date of last urine drug test) to see what is and is not being done, then adjust workflows to support these processes
- Peer chart reviews: clinicians can be assigned to review another clinician's charts for one or two priority activities (e.g., state prescription monitoring database check)
- Check-ins during staff and clinician meetings to gather feedback on processes, celebrate success stories, and discuss challenges and solutions.

Patients Receive Education on Chronic Pain Management and Opioid Risks

- Decide which patient education materials your clinic wants to make available for patient care. Take a look at the list of *patient education materials* and *chronic pain self-management resources*. Some to consider include:
    - *Opioid risks* (e.g., addiction, respiratory depression, hormone disruption)
    - *Risks of combining opioids and benzodiazepines*
    - *Naloxone*: what is it and how to administer it
    - Opioid induced conditions (e.g., hyperalgesia, constipation)
    - Tapering
    - *Self-management strategies*
    - *Activity pacing*
- Adapt resources so they are appropriate for your clinic's patients.
- Consider asking your patients for their advice on materials.

LESSON LEARNED

Consider utilizing a care coordination model for your patients using long-term opioid therapy. What can you learn from a care coordination approach to managing patients with diabetes?

- Consider who will review these materials with patients and when. Will your clinic use care coordinators? MAs? Think through how to take advantage of a team-based care model in order to carve out adequate time for education with the patient.

Training in Patient Engagement Is Offered to Staff and Clinicians (e.g., Difficult Conversations, Motivational Interviewing, Stigma)

- Make the CDC webinars *Communicating with Patients*, *Motivational Interviewing*, and *Fostering Collaborative Patient-Provider Relationships in Pain Management and Opioid Prescribing* available to clinicians and staff
- Watch the *Difficult Conversations Vignette* during a medical staff meeting and discuss strategies used (refer to *provider scripts*, *staff scripts*, and resources on *Oregon Pain Guidance*)
- Identify if anyone on your staff has skills in the desired training areas (e.g., motivational interviewing) and invite them to present/train
- Reflect on how to attend to social determinants of health as they relate to pain management
- Review strategies to address stigma and chronic pain and determine which are appropriate for your organization
- Show the *NIH videos* on stigma during a medical staff meeting
- Consider doing case reviews and role-playing difficult conversations

Alternatives to Opioids Are Integrated into Care Processes

- Review the alternatives to opioids available to patients (*Alternative treatments fact sheet*, *Evidence on non-opioid approaches to chronic pain)* and discuss which treatments your organization can offer (i.e., resources in your community or your clinic)
- Outline these alternatives during medical staff meetings and how to connect to them
- Make the CDC webinar *Treating Chronic Pain Without Opioids* available to clinicians and staff
- Routinely look for new resources in your community or ask your peers or professional organizations for ideas on what others are offering.

Overcoming Common Challenges

What follows are approaches we have seen clinics use to overcome common challenges.

Our Appointments Are Very Backed Up

- Ask patients to schedule their next appointment before leaving each visit.
- Consider nurse or care coordinator visits to address all care gaps related to opioids and chronic pain management.
- Consider timing appointments based on risk level (e.g., low risk every 12 months, moderate risk every 6 months, high risk every 3 months)

Some Clinicians Are Not Using the State Prescription Monitoring Database

- Ensure clinicians and staff understand why the state prescription monitoring database is an important part of patient care and how they can use the data. Give examples and tell specific patient stories from other clinicians about what they learned or how it was helpful to them.
- Assign a delegate to each provider who can look up information in the state prescription monitoring database. Have the delegate look up this information as part of routine pre-visit planning and document this in the patient's chart on behalf of the provider.
- Track and monitor the use of the state prescription monitoring database and share the data with the care teams.

LESSON LEARNED

One Medical Director shared a story with his clinic about how easy it is to let care processes slip. One day a clean-cut college student came asking for a controlled substance refill. The patient was new and normal procedures would suggest the provider not write the prescription on the first visit, but he seemed on the up-and-up. A check of the PDMP at a later date showed that he was using other controlled substances.

Some Care Teams Are Not Calculating MED

- Ensure that you have properly educated care teams on the importance on these calculations (e.g., overdose risk increases with MED).
- Train staff to support clinicians in calculating MED.
- Put the MED calculator or a link on all computers. If you are able, insert a link to the calculator (or embed the calculator itself) within the EHR next to a discrete MED field.
- If your clinic has one person or team in charge of refills, have them calculate MED.
- Regularly share MED data at huddles or staff meetings. This will demonstrate that the clinic cares about these numbers, will foster competition among teams, and will create opportunities for collaboratively thinking through tough cases.

Patients Feel Labeled by Having to Do Urine Drug Tests

- Train staff and clinicians on scripts for these conversations. Refer to the *Provider guide to difficult conversations* and the *Staff guide to difficult conversations* for conversation script ideas.
- Remind patients that this is standard care for all patients using long-term opioid therapy, that it is part of the patient agreement, and that this testing is being done for their safety. The CDC suggests the following script in their module *Reducing the Risks of Opioids*:
    - "I use urine drug testing with all patients who are prescribed controlled substances. The information can help me make sure that controlled substances are used in a way that is safe for patients."

We Have a Clinician Leaving and We Need to Re-Distribute Patients

- If possible, the departing clinician should create a list of his/her patients using long-term opioid therapy, annotate with key information, identify an accepting provider, and discuss the patients with this provider.

- Develop an agreed-upon re-distribution process in collaboration with other clinicians. This process might re-distribute patients based on patient request and current patient load.
- Consider using risk-tiering of patients to help with re-distribution. Low risk patients can be given to any provider and high-risk patients only to those more comfortable/experienced with pain management.
- Review the resource *Tips for Managing Patients on Legacy Prescriptions* during a clinician meeting so clinicians have suggested approaches for the first appointments with any patients using legacy prescriptions.