# Loss control snapshot and action plan

Opioids

| Assessment | Yes | No | Action needed Y/N | Action items | Date to be completed |
|---|---|---|---|---|---|
| Does the organization: | | | | | |
| a. Require thorough and regular training for all opioid prescribers? | | | | | |
| b. Have an active and adequately staffed opioid compliance program in place that monitors all opioid prescribing practices, actively identifies clinician outliers, counsels and educates them and sets expectations that clinical practice patterns should be consistent with similar practitioners treating the same types of patients? | | | | | |
| Is there an opioid prescription program (for non-cancer patients) in place that is in full compliance with state and federal regulations and guidelines (such as the FDA Guidance on Initiating Opioid Therapy, Center for Disease Control Guidelines for Prescribing Opioids for Chronic Pain, or HHS Inter-Agency Task Force Recommendations Pain Management Best Practices)? | | | | | |
| Is an addiction screening tool used to evaluate patients who have a genetic or social predisposition or a history of past addiction prior to initiating opioid therapy? | | | | | |
| Are treatment agreements reviewed and signed by chronic pain patients prior to initiating opioid therapy (that is anticipated to last for longer than a 14-day period) that: | | | | | |
| a. Outline that an initial urine drug screen will be completed and, in the case of long-term treatment, continued in an unannounced, unscheduled ongoing manner. | | | | | |

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| b. Discusses the right of the physician to discontinue treatment if the patient is failing to comply with treatment, take pain medications as ordered, has urine which tests positive for non-prescribed medications or other drugs, shows signs of addiction or engages in other acts of non-compliance that interfere with treatment goals. | | | | | |
| Is an informed consent obtained when the decision is made to initiate long-term, chronic opioid treatment for non-cancer patients that includes a discussion of: | | | | | |
| a. The limited evidence of the benefits of long-term opioid treatment (except for cancer patients). | | | | | |
| b. The potential cognitive and physical side effects of opioids that could impact normal bodily functions (including bowel function and personal safety). | | | | | |
| c. The likelihood that a tolerance and addiction to the medication will develop. | | | | | |
| d. The risk of substance abuse disorder, overdose and death. | | | | | |
| e. The clinician's prescribing policies including the number and frequency of refills, early refills and lost or stolen medication. | | | | | |
| f. The reasons for which the drug treatment plan may be changed or terminated (including the violation of the treatment agreement). | | | | | |
| g. The fact that complete elimination of pain is not to be expected with the use of opioid medications. | | | | | |
| If a patient is suspected to be addicted to long acting opioids, is there an addiction specialist on staff or available for consultation to guide the care and treatment of the patient? | | | | | |
| If a patient is seen in the ER, is there a protocol, policy or procedure that addresses the elimination of all other methods of pain control prior to prescribing opioid therapy? | | | | | |
| a. If opioid therapy is the only option for the control of pain in the ER, is the prescription limited to a 3-5-day supply of medication? | | | | | |

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| b. Is there a quality control program in place that compares the prescribing habits of ER clinicians and identifies outliers? Is that information used to educate and bring about a positive change in prescription practices? | | | | | |
| c. Is there an addiction specialist either on staff or available for consultation to support the ER physician's decision making and to refer patient to upon discharge? | | | | | |
| Are surgical patients discharged with less than a 15-day supply of opioids? | | | | | |
| Are prescribing patterns for all pain medication prescribers within the organization reviewed for positive or negative deviation on a regular basis? | | | | | |
| a. Are the findings of the prescribing pattern reviews made available to individual prescribers so that they are aware of how their practice compares to other similar practitioners? | | | | | |
| b. If a negative deviation is identified by a prescriber, are there peer review processes in place that address the negative variance and to educate, coach and train the prescriber? | | | | | |

## NOTES

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