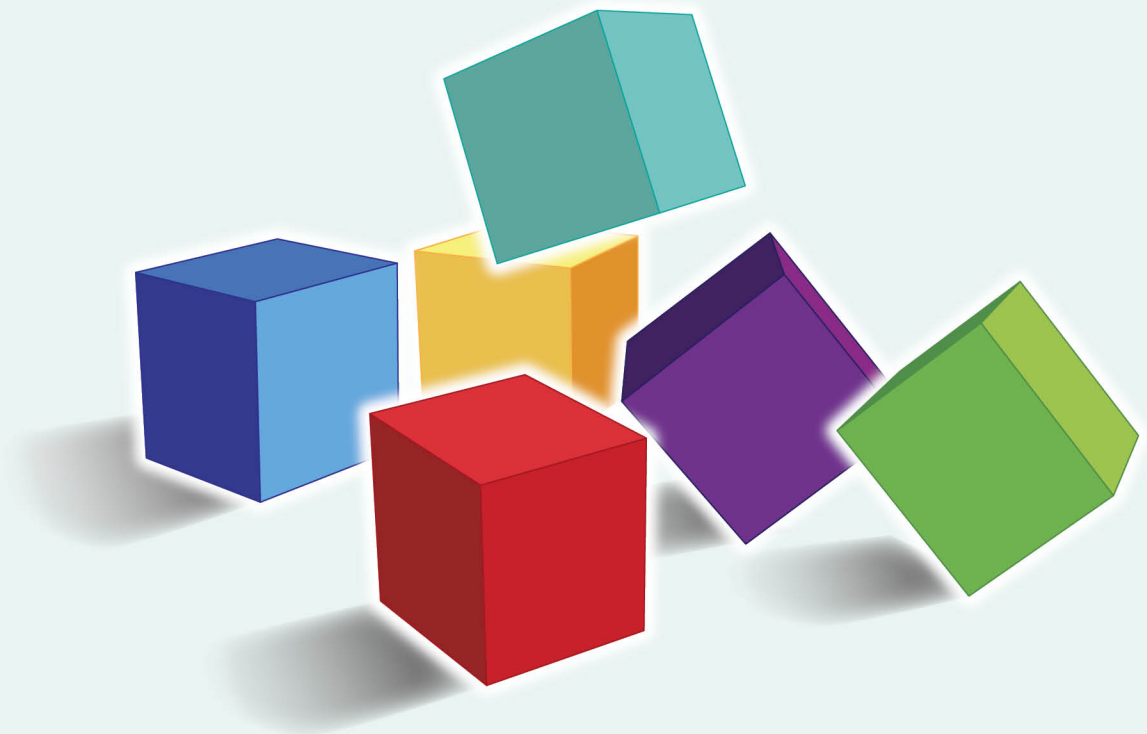


OVERVIEW

Six Building Blocks

*A Team-Based Approach to Improving
Opioid Management in Primary Care*



The Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care How-To-Implement Toolkit: Overview

Prepared for:

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Disclosure

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Six Building Blocks How-To-Implement Toolkit

Who Should Use This Toolkit?

The Six Building Blocks for Improving Opioid Management (Building Blocks or 6BBs) program offers a roadmap for improving a primary care clinic’s management of patients who are on long-term opioid therapy (LtOT) for chronic pain. The 6BBs address these key areas:

- Addressing leadership support;
- Revising and aligning clinic policies, patient agreements, and workflows;
- Tracking and monitoring the population of patients using LtOT;
- Conducting planned, patient-centered visits;
- Caring for patients with complex needs; and
- Measuring success.

A How-To-Implement Toolkit (hereafter, Implementation Toolkit) was developed to provide clinics with support for engaging in this improvement work. The Six Building Blocks Implementation Toolkit is meant to be used independently by primary care clinics and their organizations.

Two Approaches To Improve Opioid Management

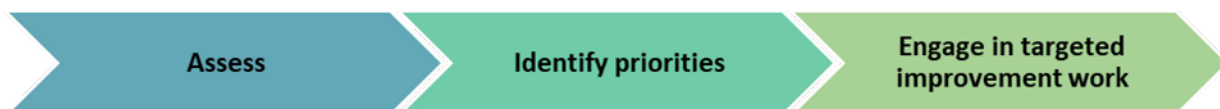
The 6BBs Implementation Toolkit offers **two potential approaches to engaging in this improvement work**, depending on an organization’s capacity and starting point, each of which is described below.

Fast Track Approach

The Six Building Blocks **Fast Track Approach** is intended to be used by organizations that have already completed some improvement work or intend to undertake a more targeted effort to make systems-based changes to the management of opioid prescribing and chronic pain care. A Fast Track Approach Guide has been written for **clinical leaders, quality improvement (QI) leaders**, or anyone who can drive change in a primary care organization.

The Fast Track Approach Guide leads you through an assessment of your organization’s support systems and processes for chronic pain and opioid management, helps you identify priority areas ready for change, and directs you to resources to help you implement improvement in the areas you identify as being ready for change (see diagram below). Before engaging in this improvement work, it is important to gain organizational leadership and clinical care team support.

Full Program Approach

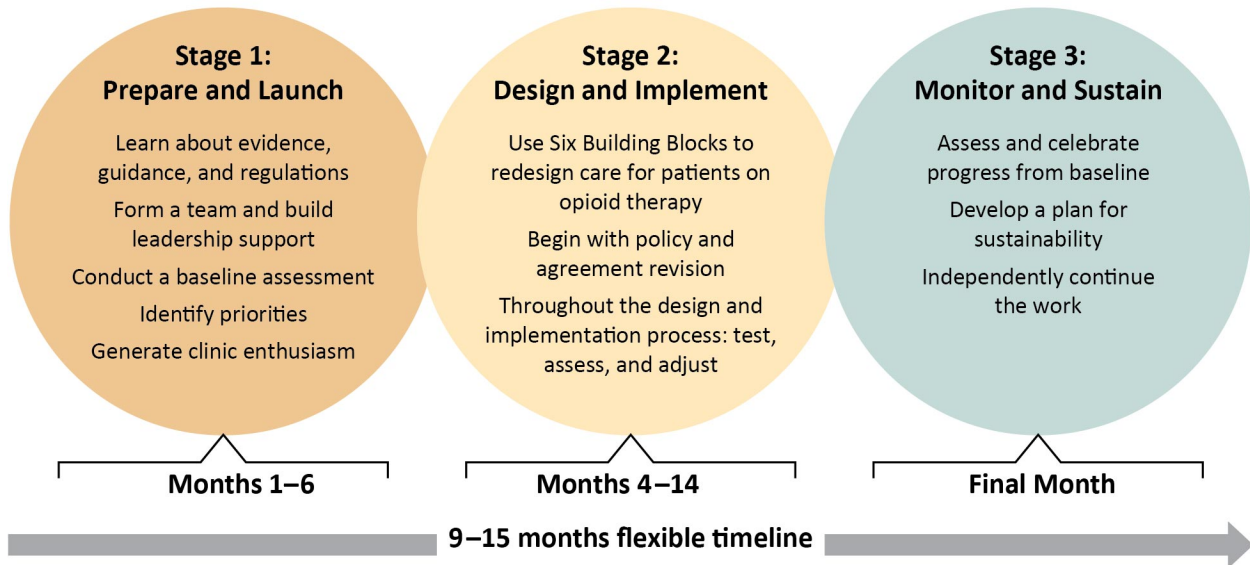


For organizations that want to engage in a systematic improvement effort using the evidence-based 6BBs approach, the **Full Program Approach** consists of three implementation stages: *Prepare and Launch*, *Design and Implement*, and *Monitor and Sustain*; see timeline below in Exhibit.

A guide for each implementation stage includes step-by-step instructions and resources. While anyone can use these materials to implement improvements in opioid medication management, the target audience is **QI leaders** and **project managers**, who can use the materials to guide improvement and care teams through the 6BBs implementation process.

To learn more about whether the Full Program Approach is a good fit for your clinic, see the readiness assessment, *Is Implementing the Six Building Blocks Independently Right for Us?*

Exhibit. Full Program Approach Timeline



Why This Work Is Important

We Are in the Midst of an Opioid Crisis

The opioid epidemic is hurting our communities. Listen to people affected by opioids tell their *stories*. Opioids are one of the most commonly prescribed medications in the United States.¹ Another consideration complicating treatment is that the evidence base for use of opioids long-term is sparse.² In 2017, total outpatient prescription opioid expenses for adults totaled \$7.7 billion.³

Furthermore, evidence shows that alternative, nonopioid medications can be as effective as opioid medications for acute pain.^{4,5} Primary care providers prescribe over half of all prescription opioids in the United States.⁶ Improving the management of chronic pain and opioid prescribing practices in primary care is a critical element in the effort to address the opioid crisis in the United States.

Opioid Management Contributes to Work Life Stress

Evidence is growing that shows caring for patients with chronic pain on LtOT contributes to stress among providers and staff in primary care settings.⁷ Providers, staff, and patients with chronic pain alike describe their interactions as challenging and frustrating.^{8,9, 10} Providers struggle with uncertainty and a lack of comfort and satisfaction with their ability to provide effective chronic pain management.^{11,12}

What Are the *Six Building Blocks*?

The 6BBs focus on improving care quality for patients with chronic pain using LtOT. When implemented, the Building Blocks can improve the health of your patients and the work life experience of your providers and staff. The six key work areas are described below.



Leadership and Consensus

Demonstrate leadership support and build organizationwide consensus to prioritize more selective and cautious opioid prescribing.



Policies, Patient Agreements, and Workflows

Revise, align, and implement clinic policies, patient agreements, and workflows for healthcare team members to improve opioid prescribing and care of patients with chronic pain.



Tracking and Monitoring

Implement proactive population management before, during, and between clinic visits of all patients on chronic opioid therapy.



Planned, Patient-Centered Visits

Plan and prepare for the clinic visits of all patients on chronic opioid therapy. Support patient-centered, empathic communication for care of patients on chronic opioid therapy.



Caring for Patients With Complex Needs

Develop policies and resources to ensure that patients who develop opioid use disorder or need mental/behavioral health resources are identified and provided with appropriate care, either in the care setting or by outside referral.



Measuring Success

Continuously monitor progress and improve with experience.

How Can the Six Building Blocks Help?

The ultimate goal of the Six Building Blocks is to support clinics in building their capacity to help patients with chronic pain maximize their functional status and quality of life with a treatment plan that minimizes risk to patients and their providers.

The 6BBs derive from *the best practices* taken among 20 primary care clinics across the United States that were identified as having exemplar, team-based clinical innovations. Kaiser Permanente of Washington Health Research Institute and the University of Washington (UW) tested the Six Building Blocks program in an AHRQ-funded practice facilitator-guided program to help rural-serving primary care organizations with 20 clinics make improvements in opioid management. After the program was implemented, clinics saw a significant **decrease in both the number of patients using LtOT and the percentage of patients on high doses of opioids.**¹³

In addition, **providers and staff in clinics that participated in the 6BBs program reported an improvement in their work life** after implementation.¹⁴ Reported improvements in work life included increased confidence and comfort in caring for patients using LtOT, increased collaboration and teamwork, improved ability to respond to external administrative requests (e.g., from insurers, government organizations), and improved relationships with patients. These improvements contributed to an overall reported decrease in stress among providers and staff.

“Everybody that works in this clinic says to me, “Do you remember how much turmoil there was around it [opioid prescribing]? Wow, we don’t have any of that anymore.”

– Medical Director

Ready To Start?

If you think your organization should begin the 6BBs right away, open the *Fast Track Approach Guide*.

If you think the 9- to 15-month **Full Program Approach** is the right fit for your organization, gather together the appropriate leadership to approve your taking on this program—such as your medical director—and those who will likely be involved in implementing the changes (e.g., QI personnel, clinic manager, clinician champion, behavioral health provider, pharmacist, and data manager).

Convene a *Leadership Commitment Meeting* to formally determine if, and when, you want to begin implementing improvements to opioid management. Once you have leadership commitment, open the first of the Full Program Approach three stage guides, the *Prepare and Launch*.

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FULL PROGRAM:
PREPARE AND LAUNCH GUIDE

Six Building Blocks

*A Team-Based Approach to Improving
Opioid Management in Primary Care*

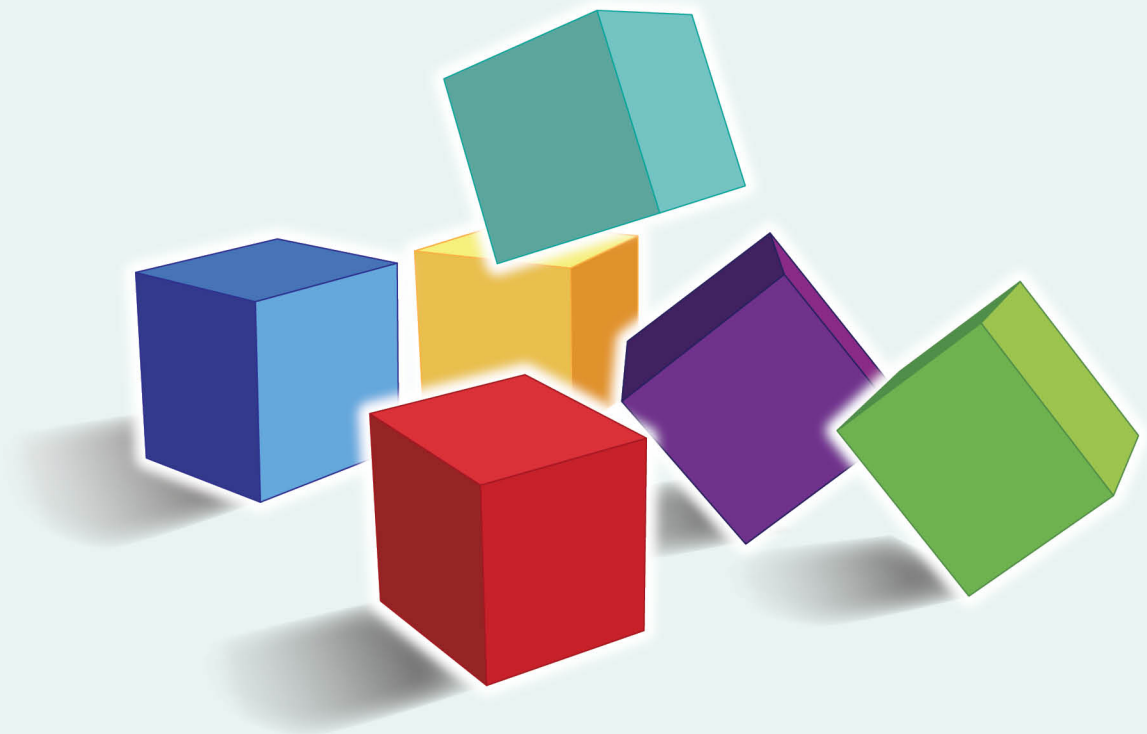


Table of Contents

Introduction	1
What Is the Prepare and Launch Guide?	1
What Is in the Prepare and Launch Guide?	1
Prepare and Launch Process	2
Preparatory Work Ahead of Orientation and Assessment Meeting	3
What Is Going on During This Step	3
How To Do It	3
Helpful Website Resources	6
Milestone Aims	6
Orientation and Assessment Meeting	7
Time	7
Objectives	7
Who Should Attend.....	7
Helpful Website Resources	7
Agenda (outline)	7
Agenda (details)	8
Milestone Aims	9
Preparatory Work Ahead of the Kickoff Planning and Assessment Meeting	10
What Is Going on During This Step	10
How To Do It	10
Helpful Website Resources	13
Milestone Aims	13
Kickoff Planning and Assessment Meeting	14
Time	14
Objectives	14
Who Should Attend.....	14
Helpful Website Resources	14
Agenda (outline)	14
Agenda (details)	14
Preparatory Work for the Clinicwide Kickoff	17
What Is Going on During This Step	17

Helpful Website Resources	17
Clinicwide Kickoff.....	18
Time	18
Objectives	18
Milestone Aims	18
Appendix	20
Six Building Blocks Self-Assessment Tool.....	20

Introduction

The Six Building Blocks for Improving Opioid Management (Building Blocks or 6BBs) program offers a roadmap for improving a primary care clinic’s management of patients who are on long-term opioid therapy (LtOT) for chronic pain. The 6BBs supports you in **redesigning opioid management** processes by:

- Addressing leadership support;
- Revising and aligning clinic policies, patient agreements, and workflows;
- Tracking and monitoring the population of patients using LtOT;
- Conducting planned, patient-centered visits;
- Caring for patients with complex needs; and
- Measuring success.

A 6BBs How-To-Implement Toolkit (hereafter, Implementation Toolkit) was developed to support clinics in engaging in this improvement work. Depending on an organization’s capacity, there are two approaches: the Fast Track Approach and the Full Program Approach; see [Six Building Blocks Implementation Toolkit Overview](#) for further information.

What Is the Prepare and Launch Guide?

The Prepare and Launch Guide is a resource for the first stage of the Full Program Approach: Prepare and Launch. While anyone can use these materials to implement improvements in chronic pain and opioid medication management, it is specifically written for quality improvement (QI) leaders and project managers to use in guiding an improvement team and care teams through the Six Building Blocks implementation process.

What Is in the Prepare and Launch Guide?

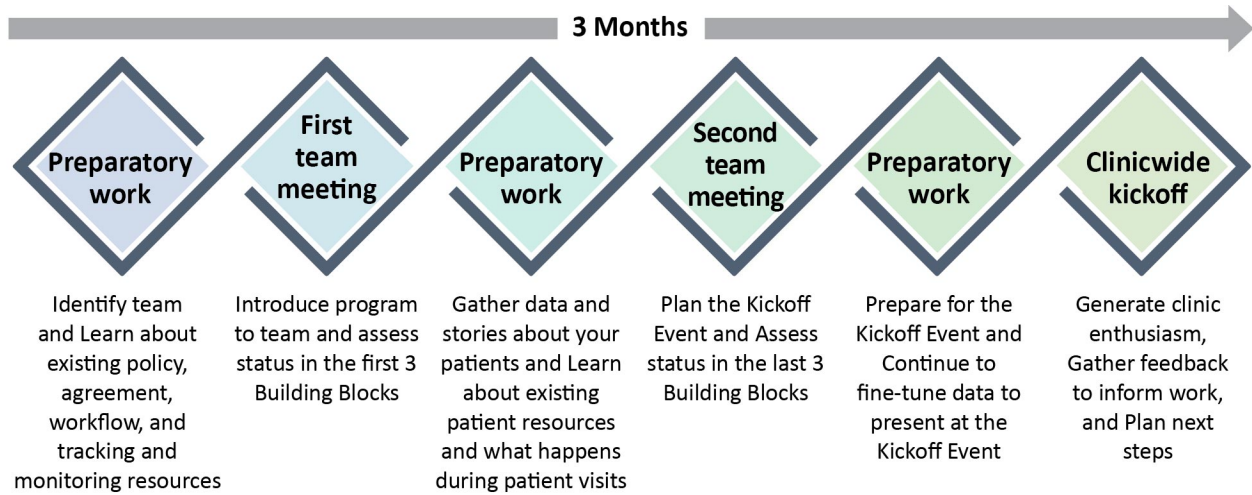
- The Prepare and Launch Guide walks you through preparing for and facilitating three meetings as outlined below. By going through the steps outlined in this guide, you will achieve the aims of this stage listed to the right.
- As the QI lead, you can use this guide to coach a primary care organization through the 3-month Prepare and Launch stage of the 6BBs program.
- Track your progress with the [Six Building Blocks coaching log](#).

Stage 1: Prepare and Launch Aims

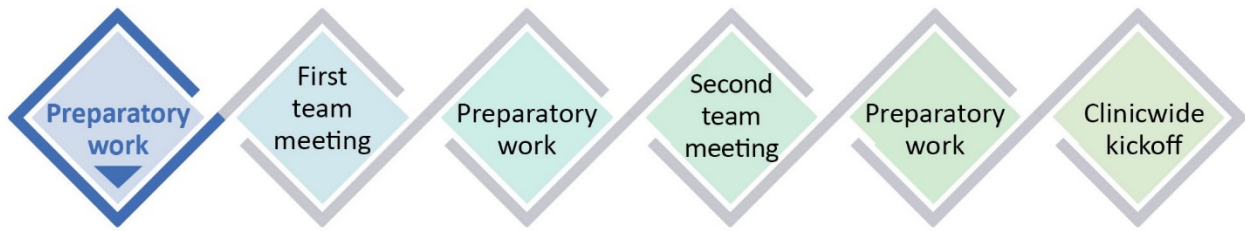
- Learn about evidence, guidelines, and regulations.
- Form a team and build leadership support.
- Conduct a baseline assessment.
- Identify priorities.
- Generate clinic enthusiasm.

Prepare and Launch Process

This guide walks you through the process outlined below for preparing for and facilitating three meetings.



The following pages walk you step by step through the stages of this diagram.



Preparatory Work Ahead of Orientation and Assessment Meeting

What Is Going on During This Step

QI lead (you):

- Builds an opioid management improvement team.
- Schedule meetings.
- Collects *existing policy, agreement*, and *tracking and monitoring* resources and relevant evidence, guidelines, and regulations.
- Prepares information to present to the team.
- Talks with clinicians and staff about the Six Building Blocks.

How To Do It

1. Build an Opioid Improvement Team

The opioid improvement team works in the clinic to support the implementation of opioid management improvements using the 6BBs program. The team is responsible for leading the work, such as revising policy, developing and implementing workflows, and tracking progress.

As it is a working group, consider keeping the team small. The team should meet at least monthly throughout the implementation process. You might consider including a patient on your opioid improvement team; see resources from the *Institute for Healthcare Improvement (IHI)* for more information on quality improvement teams.

Use the following table—which describes positions, time commitments, role characteristics, and responsibilities—to identify team members.

LESSON LEARNED

Find your “Yoda.” Throughout the project you and the opioid improvement team will be approached with many clinical questions. It can be extremely helpful to identify a local expert in your own clinic system, an expert in a local pain clinic, or a consultant resource, such as ECHO, to reach out to when those questions arise.

Position	Time Commitment Estimates	Role Characteristics	Responsibilities
QI lead (required)	2 to 8 hours per month (more during early months)	<ul style="list-style-type: none"> • QI experience or ability to be trained (e.g., online <i>introductory QI courses</i> courses) • Interest in this topic 	<ul style="list-style-type: none"> • Leads the day-to-day work • Organizes meetings • Oversees QI processes such as test, assess, and adjust
Clinical champion (required)	2 to 4 hours per month	<ul style="list-style-type: none"> • Critical to success • Interest in this topic • Sway in the organization 	<ul style="list-style-type: none"> • Builds consensus among clinicians and staff • Maintains leadership support for program • Provides lead clinical voice on the team
Tracking and monitoring lead	Highly variable depending on your system, 4+ hours per month	<ul style="list-style-type: none"> • Protected time for tracking and monitoring • Skills in clinical data and technology • Ready access to prescription and refill data 	<ul style="list-style-type: none"> • Works with data to develop and generate reports
Others, as desired (e.g., medical assistant (MA), nurse, social worker, behavioral health provider, clinic manager, pharmacist, medication for opioid use disorder (MOUD) provider)	2 to 4 hours per month		<ul style="list-style-type: none"> • Represents roles important to team-based care of patients on LtOT

2. Schedule Prepare and Launch Meetings

Work with team members and the clinic to reserve meeting space and protect time for the following Prepare and Launch stage meetings.

Prepare and Launch Meeting	Who	Time	Purpose
Orientation and assessment meeting	Opioid improvement team	1 to 1.5 hours	<ul style="list-style-type: none"> • Orient the team to the opioid management problem, related guidelines and regulations, and the 6BBs approach. • Assess status of the first three Building Blocks, including beginning to identify priorities.
Kickoff planning and assessment meeting	Opioid improvement team	1 to 1.5 hours	<ul style="list-style-type: none"> • Plan the kickoff. • Assess status of the last three Building Blocks.
Clinicwide kickoff*	All staff and clinicians	1 to 1.5 hours	<ul style="list-style-type: none"> • Convene all staff and clinicians to share their ideas and concerns regarding opioid management in the clinic and to build enthusiasm for the work.
First action plan meeting	Opioid improvement team	1.5 to 2 hours	<ul style="list-style-type: none"> • Reflect on learnings from the Prepare and Launch stage and develop a plan for the next 3 months of work. This meeting generally happens directly after the clinicwide kickoff.

* This meeting is essential to the program's success.

3. Collect Existing Resources and Prepare Information To Present to the Team at the Orientation and Assessment Meeting

In the Orientation and Assessment Meeting, you will report out and discuss what resources and processes currently exist in your organization related to the first three Building Blocks: Leadership and Consensus; Policies, Patient Agreements, and Workflows; and Tracking and Monitoring. It is also an opportunity to review relevant evidence and guidelines related to opioid management. Prepare for this meeting by completing the following items:

Orientation Materials

- Collect relevant evidence, guidelines, and regulations. For example, are there any State regulations related to opioid prescribing, such as maximum dose, prior authorization, prescription drug monitoring program (PDMP) checks, or continuing medical education (CME) requirements? A slide in the [commitment presentation](#) provides more information.

Policies, Patient Agreements, and Workflows

- Collect any existing policies, patient agreements/contracts, and workflows within your organization related to opioid management.
- Look at the examples provided on the Six Building Blocks [website](#).
- Complete the following Policy, Patient Agreement, and Workflow table.

Type of Document	Name of Document	Date of Last Update	Extent of Use	Opportunities To Align With Guidelines/Regulations and Each Other*
Policy				
Patient agreement				
Workflow				

*Refer to the examples provided on the Six Building Blocks website.

Tracking and Monitoring

- Identify any existing electronic health record (EHR) templates, EHR clinical decision support tools, flowsheets, reports, or registries related to opioid management.
- Research the following questions:
 - Does our clinic or do any of our care teams track and monitor patients on LtOT? If yes, how does that currently work?
 - Are all the clinicians signed up for the PDMP? Any designees?

4. Talk With Clinicians and Staff About the 6BBs

- As you build an opioid improvement team and start learning about current resources and processes, clinical staff will be curious about the work being taken on by your organization. It can be useful to prepare for discussions with clinical staff by reviewing the “[Elevator Speech on Six Building Blocks](#).”

Helpful Website Resources

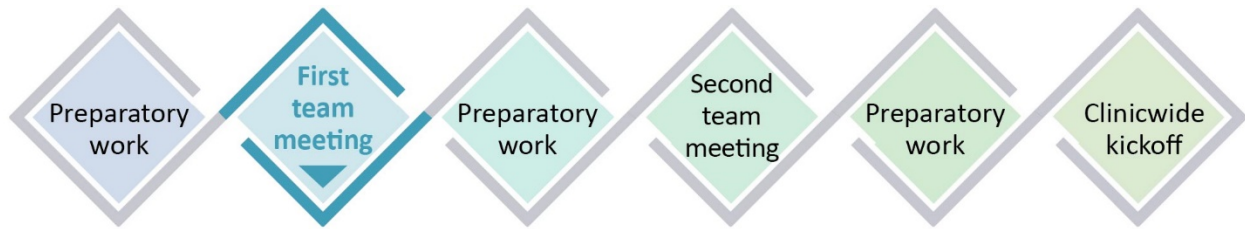
The following resources relevant to the preparatory work ahead of the first team meeting are available in the Resource Library at www.improvingopioidcare.org.

- [Building an opioid improvement team.](#)
- [Model opioid prescribing policy.](#)
- [Model patient agreement.](#)
- Model workflows such as [chronic pain appointment](#), [opioid refill](#), [tracking and monitoring](#), and [remote urine drug testing](#).
- [Approaches to identifying patients on LtOT.](#)
- [Elevator speech on the Six Building Blocks.](#)

Milestone Aims

Once you have finished the preparatory work ahead of the first team meeting, you should have:

- Collected existing policies, patient agreements, and workflows within your clinic.
- Learned about relevant evidence, guidelines, and regulations regarding opioid prescribing.
- Formed an opioid improvement team.
- Protected time for the opioid improvement team and clinic to meet.



Orientation and Assessment Meeting

Time

1 to 1.5 hours.

Objectives

Orient the opioid improvement team to the breadth of the opioid management problem, current evidence/guidelines/regulations, and 6BBs program; begin identifying priorities; and assess the status of the first three Building Blocks.

Who Should Attend

Opioid improvement team.

Helpful Website Resources

The following resources for the Orientation and Assessment Meeting are available at the Resource Library at www.improvingopioidcare.org.

- [Commitment presentation.](#)
- [Opioid harm stories.](#)
- [CDC Guideline for Prescribing Opioids for Chronic Pain.](#)
- [CDC training and webinars.](#)
- [Six Building Blocks Self-Assessment.](#) (See Appendix.)
- [Data To Consider Tracking.](#)

Agenda (outline)

1. [Six Building Blocks program orientation.](#) *NOTE:* This orientation is only needed if members of the opioid improvement team were not at the leadership commitment meeting—see [Six Building Blocks Implementation Toolkit Overview.](#)
2. Assess baseline status for the first three Building Blocks:
 - a. Leadership and Consensus: complete the [Six Building Blocks Self-Assessment](#);
 - b. Policies, Patient Agreements, and Workflows; and
 - c. Tracking and Monitoring.
3. Review [preparatory work](#) to be completed ahead of the second team meeting.

Agenda (details)

Use what you learned during the preparatory work to lead the opioid improvement team through the following tasks.

1. Six Building Blocks Program Orientation

Use the introductory section of the *commitment presentation* to orient the opioid improvement team to the opioid management problem—why this work is important, relevant evidence, guidelines, and regulations—and the Six Building Blocks program. This meeting is a chance to build support for this work.

Let the team know the ultimate goal of the 6BBs is to build clinic capacity to help patients with chronic pain maximize their function and quality of life while minimizing risk to the patients and their clinicians.

2. Assess Baseline Status of the First Three Building Blocks

Walk the opioid improvement team through an indepth assessment of the first three Building Blocks: Leadership and Consensus; Policies, Patient Agreements, and Workflows; and Tracking and Monitoring.

Leadership and Consensus

Complete the *Six Building Blocks Self-Assessment* questionnaire as a team to begin building leadership and consensus on where the clinic is starting from and where you want to go. Make sure all voices in the room are heard. Use this process to foster a conversation about:

- Where are the overall gaps and strengths in the organization’s current approach to care of patients using LtOT?
- Why are you implementing improvements to opioid management using the 6BBs? What motivated you to take on this project? What do you hope will change?
- What are your improvement priorities/aims? The *Six Building Blocks Milestones* can be a useful resource to have on hand for this discussion.

Policies, Patient Agreements, and Workflows

Present information on and facilitate a conversation about your clinic’s current policies, agreements, and workflows based on your preparatory work. This presentation should cover:

- Whether these documents exist;
- How recently they were reviewed;
- How they were developed;
- Extent of use; and
- Opportunities for aligning these documents with one another, and with evidence, national or State guidelines, and regulations.

IMPORTANT LESSON LEARNED

The purpose of self-assessment is to start a conversation about the current state of opioid management in the clinic and any opportunities for improvement.

Doing the self-assessment with others tends to highlight different perspectives and why they exist. It also is a practical way to dig into the Six Building Blocks concepts. Pay attention to the “level 12” descriptors as they give a picture of where the work is heading.

Later, at the kickoff, the entire clinic will have a chance to go through this process.

Tracking and Monitoring

Present information on and facilitate a conversation about current tracking and monitoring processes and capacity. Based on existing capacity, the QI lead and the tracking and monitoring lead should propose an approach to identifying patients on LtOT for the kickoff presentation.

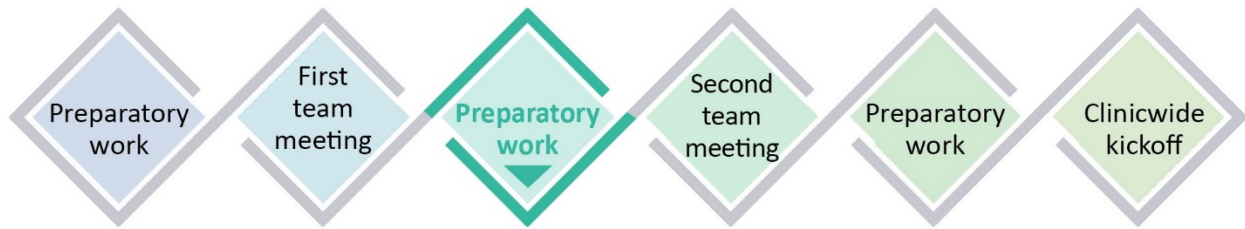
3. Review Preparatory Work To Be Done Ahead of the Kickoff Planning and Assessment Meeting

Work with the team to make a plan to complete the next *preparatory work* activities.

Milestone Aims

By the end of this meeting, the opioid improvement team should have:

- Learned about the opioid management problem, guidelines, regulations, and 6BBS.
- Built team support for the opioid improvement work.
- Completed the *Six Building Blocks Self-Assessment* questionnaire.
- Begun identifying improvement priorities/aims.
- Located and assessed use of existing opioid management policies, agreements, and workflows.
- Identified any existing tracking and monitoring resources.



Preparatory Work Ahead of the Kickoff Planning and Assessment Meeting

What Is Going on During This Step

QI Lead (you):

- *Collects available resources for patients related to opioid management.*
- *Learns what happens during patient visits and refill requests related to opioid management.*
- Reviews the *kickoff manual* in order to lead a discussion during the Kickoff Planning and Assessment Meeting.

Tracking and Monitoring Lead:

- *Gathers baseline data to present at the kickoff.*

Clinical Champion:

- Identifies stories to share at the kickoff.

How To Do It

1. Collect Existing Resources and Prepare Information To Present to the Team at the Kickoff Planning and Assessment Meeting

In the Kickoff Planning and Assessment Meeting, you will report out and discuss what resources and processes currently exist in your organization related to the last three Building Blocks: Planned, Patient-Centered Visits, Caring for Patients With Complex Needs, and Measuring Success. Prepare for this meeting by completing the following tasks.

Planned, Patient-Centered Visits

- Identify currently used patient education materials related to opioid management.
- Locate existing nonopioid treatment resources for patients with chronic pain, such as physical therapy and behavioral health.

Caring for Patients With Complex Needs

- Find existing resources in the community and clinic for patients with opioid use disorder (OUD) or mental health concerns such as depression, anxiety, and post-traumatic stress disorder (PTSD).

Measuring Success

- Begin to gather baseline data by following step 3 below.

2. Learn What Happens During Patient Visits and Refill Requests

Talk with care teams to answer the questions below.

- How do staff and clinicians prepare for visits with patients using LtOT?
- How does your organization prepare for opioid-related visits? For example, do you use chart reviews, a tracking system, or PDMP?
- What happens when a patient comes in for an appointment that will include an opioid prescription? What is the process? Do any State laws require a check of the PDMP before refilling? How is this task completed and documented?
- What happens when a patient calls for an opioid refill? What is the process?
- What clinical tools are available and in use to support assessment and management of patients using LtOT? Listed below are examples of **assessment resources** available in the Resource Library at www.improvingopioidcare.org:
 - Calculation of **morphine equivalent dosing (MED)**;
 - Patient function (e.g., **PEG**);
 - Risk for OUD (e.g., **ORT**);
 - Opioid misuse (e.g., **COMM**);
 - Anxiety, depression (e.g., **PHQ**, **GAD-7**);
 - PTSD (e.g., **PC-PTSD**); and
 - Sleep apnea (e.g., **STOP-Bang**).

LESSON LEARNED

Clinics sometimes find an individual care team with a high-functioning approach to patient visits or refills, which can help inform future workflow development across the entire clinic.

3. Gather Baseline Data To Present at the Kickoff

Work with the tracking and monitoring lead to identify baseline data to share with clinicians and staff during the kickoff. In trying to produce baseline data, you will have a chance to learn more about the limitations and strengths of your tracking and monitoring capacity. For example, does your EHR have discrete fields (e.g., MED) you can query on your patients using LtOT?

Suggested Ideas of Data to Share, Based on Your Current Tracking and Monitoring Capacity:

- How many patients do you have on LtOT for noncancer pain (by clinic and by clinician)?
- If you can, consider reporting by clinic, by clinician, and by patient:
 - #/% of patients on LtOT with MED ≥ 50 , ≥ 90
 - #/% of patients on LtOT with a signed patient agreement
 - #/% of patients on LtOT also prescribed sedatives

CAUTION

Depending on your data capacity, trying to identify data to share about your patients on LtOT can be challenging. You are not alone. Remember, these are just first steps to identify who your patients are and how you might track their care in the future.

Definition of a patient using LtOT: Generally, a patient who takes opioids for 3 consecutive months is considered to be using LtOT. How you practically define this term can vary. A clinician may know his or

her patients and be able to identify these patients. Alternatively, a staff member who handles opioid refills may do so when refilling a patient's medications. One common definition when using EHR data is any patient who has received at least two opioid prescriptions in the past 3 months, at least 28 days apart.

Approaches To Identify the Above Data:

Query your EHR for one of the following and have clinicians/MAs validate the list:

- How many patients have an **MED calculated** in the past 3 months?
- How many patients have a **signed patient agreement** in the past 12 months?
- If you use any kind of **label or specific diagnosis code for patients using LtOT**, how many patients have that label/diagnosis? (potential ICD-10 codes: Z79.891, F11.90)
- How many patients have been **prescribed any opioid medication** (refer to [opioid list](#))?

Once you know who your patients using LtOT are, consider using the list to apply a consistent diagnosis code to all these patients to track and monitor them more easily. Clinics often ask MAs to help track patients.

Use the Prescription Drug Monitoring Program to create a list by:

- Having each clinician or designee generate a summary report from the PDMP, as possible.
- Verifying the list with each clinician.

Use proprietary software to produce reports from your EHR.

Proprietary software can be used to reach into your EHR to produce reports about patients using LtOT. If you use such proprietary software, it is worth exploring what it would take to use it to identify patients using LtOT and to track and monitor patients using LtOT.

Manually develop a list.

Ask clinic personnel who are responsible for refills to manually create a list as patients get their opioid refills over the course of 3 months. Alternatively, use lists that care teams have created for their own use. If you need to use this approach, you may not finish by the time of the kickoff, and you may need to consider other data to share at the kickoff so you do not stall progress.

4. Identify Stories To Share at the Kickoff (Clinical Champion)

The clinical champion identifies stories about patients using LtOT to share during the clinicwide kickoff. These stories should represent why this project is important. For instance, the champion could share a story of an adverse outcome—such as overdose, death, or diversion—for a patient using LtOT or it could be a success story about tapering someone effectively while increasing function and quality of life. Stories are motivating and help center the organization on why this work is important. They are particularly important if no data are available for the kickoff.

Helpful Website Resources

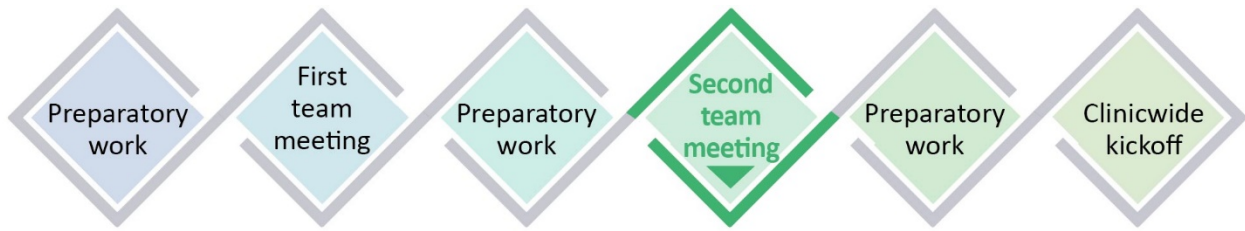
The following resources related to the preparatory work ahead of the Kickoff Planning and Assessment Meeting are available at the Resource Library at www.improvingopioidcare.org:

- *Approaches to identifying patients.*
- *List of opioid names.*
- *List of sedative names.*
- *Tracking and monitoring example spreadsheet.*
- *Event tally.*
- *Kickoff manual.*

Milestone Aims

By the end of this step, you will have:

- Identified currently used patient education/support resources related to opioid management.
- Investigated what currently happens during patient visits and refill requests related to opioid management.
- Identified currently used resources for patients with complex needs, such as mental health conditions and OUD services.
- Produced baseline data reports, as possible.
- Identified stories to present at the kickoff.



Kickoff Planning and Assessment Meeting

Time

1 to 1.5 hours.

Objectives

Plan the clinicwide kickoff and assess the status of the last three Building Blocks.

Who Should Attend

Opioid improvement team.

Helpful Website Resources

The following resources for the Kickoff Planning and Assessment Meeting are available in the Resource Library at www.improvingopioidcare.org.

- *Success metrics.*
- *Kickoff manual.*

Agenda (outline)

1. *Plan the clinicwide kickoff.*
2. *Assess baseline status of the last three Building Blocks:*
 - a. Planned, Patient-Centered Visits;
 - b. Caring for Patients With Complex Needs; and
 - c. Measuring Success.

Agenda (details)

1. Plan the Clinicwide Kickoff

The clinicwide kickoff is a 1.5-hour meeting for **all** staff and clinicians to come together to share their ideas and concerns regarding opioid management in the clinic and to build enthusiasm for the Six Building Blocks program. Coming together as a clinic to share perspectives and priorities is an essential

step to successful implementation of improvements to opioid management. An example agenda for this meeting is provided below.

Topic	Person	Time
Why addressing LtOT is important to our patients, staff, and leadership	Clinical champion	15 minutes
What is happening—the data and stories—at our clinic	Clinical champion	10 minutes
Overview of the Six Building Blocks program	Quality improvement lead	10 minutes
We want to hear from you! Small group activity: <i>baseline self-assessment</i>	Quality improvement lead	25 minutes
Self-assessment reflection and feedback	Quality improvement lead	25 minutes
Program next steps and how you can help (complete <i>kickoff survey</i>)	Clinical champion	5 minutes

When planning the clinicwide kickoff, lead the team in:

- Reviewing the purpose and activities of the kickoff.
- Editing the above agenda template.
- Confirming that all care teams, front desk staff, clinicians, and administrators have been invited to the kickoff, that space is reserved, and that the required technology (laptop/projector/screen) is available.
- Deciding if you want to provide food and beverages.
- Reviewing what the clinical champion will say about why addressing LtOT is important.
- Looking at the *Six Building Block resources* and deciding which ones to share during the kickoff. Typical resources to include are:
 - *CDC guideline factsheet;*
 - *CDC patient education handout;*
 - *VA tapering guidelines;*
 - *Tips for difficult conversations;*
 - Clinical education resources handout; and
 - PDMP registration information.

2. Assess Baseline Status of the Last Three Building Blocks

Walk the opioid improvement team through an indepth assessment of baseline status of the last three Building Blocks: Planned, Patient-Centered Visits; Caring for Patients With Complex Needs; and Measuring Success.

Planned, Patient-Centered Visits

The QI lead (you) presents information on and facilitates a conversation about:

CAUTION

Do not let data woes hold you back from hosting the kickoff. Sometimes organizations cannot identify their patients before the kickoff. If that is true for you, focus on telling stories to paint a baseline picture instead. There might also be other, simpler data you could present. For instance, you could use the *event tally* form to track a measure of interest over the course of 2 weeks (e.g., early refill calls).

When clinics cannot gather data to share at the kickoff, they often include this situation as part of the story of why this project is important and emphasize that building a tracking and monitoring system is a program goal.

- Existing patient education materials related to opioid management.
- Existing nonopioid treatment resources, such as physical therapy and behavioral health.
- Current processes that occur during patient visits and refill requests related to opioid management.
- Existing *assessment tools* in use and suggested by the Six Building Blocks.

Caring for Patients With Complex Needs

The QI lead (you) presents information on and facilitates a conversation about existing resources for patients with complex needs (e.g., OUD, substance use disorder, or mental health concerns, such as depression, anxiety, and PTSD). These could be resources within your clinic or resources that require a referral or other process to ensure patients are connected to these resources.

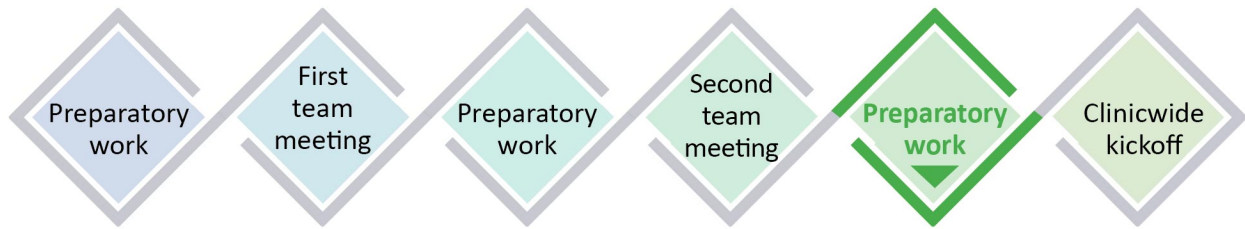
Measuring Success

The tracking and monitoring lead presents information on and facilitates a conversation about:

- Currently available data on patients using LtOT for noncancer pain.
- Strengths and weaknesses of the organization's current capacity to measure success.

The clinical champion shares deidentified patient stories of harm from opioids or of success in improving function and quality of life and opens it up to the group to share their stories. The clinical champion then leads a discussion on what **data** and **stories** they should present during the clinicwide kickoff to build buy-in for improving care of patients using LtOT and to give a picture of the baseline story.

The opioid improvement team reviews the *Measuring Success Metrics* document to begin considering what metric it would like to use to measure success and what is feasible to measure with the clinic's data. The team will select at least one measure at the first action plan meeting to begin tracking.



Preparatory Work for the Clinicwide Kickoff

What Is Going on During This Step

QI Lead (you):

- Reviews the *kickoff manual* to understand how to run the kickoff.
- Makes copies of agreed-on resources to share during the clinicwide kickoff.
- Makes copies of *Six Building Blocks Self-Assessment* for the small group activity and the *clinicwide kickoff survey*.
- Confirms room reservation and arranges for appropriate technology, such as laptop, screen, and projector, and room setup that is conducive to small-group activity.
- Ensures all presenters have their materials.
- Compiles clinicwide kickoff materials such as PowerPoint presentation and pens to complete self-assessment small group activity.

Tracking and Monitoring Lead:

- Makes any last-minute adjustments to the data that will be presented during the kickoff.

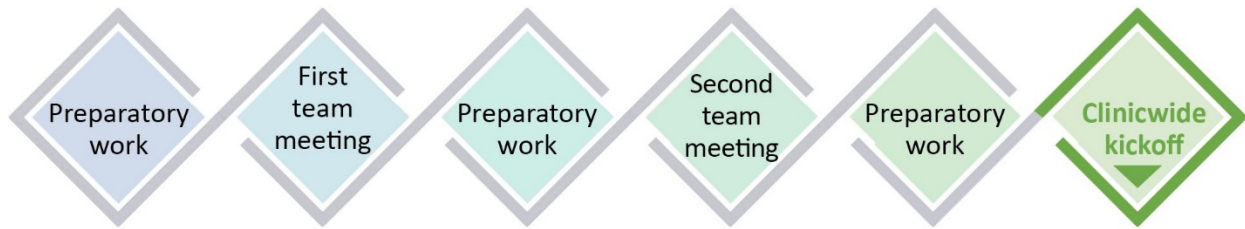
Clinical Champion:

- Prepares to talk about why the project is important to the clinic with baseline data and stories to support that message.

Helpful Website Resources

The following resources for the clinicwide kickoff are available in the Resource Library at www.improvingopioidcare.org.

- *Kickoff manual*.
- *Kickoff slides*.
- *Six Building Blocks Self-Assessment*. (See Appendix.)
- Clinicwide *kickoff survey*.
- *Six Building Blocks “shared” resources*.
- *CDC opioid harm stories*.
- *CDC Guideline for Prescribing Opioids for Chronic Pain*.
- *CDC training and webinars*.



Clinicwide Kickoff

Time

1.5 hours with all clinicians and staff.

Objectives

Orient all clinic staff and clinicians to the breadth of the opioid management problem and the Six Building Blocks program, share ideas and concerns regarding opioid management, and build support for implementing improvements to opioid management.

Who Should Attend

All clinicians and staff, including front desk staff and administrators.

Agenda

1. Why addressing LtOT is important to our patients, staff, and leadership. What are the current evidence, guidelines, and regulations? What is the breadth of the problem?
2. What is happening—data and stories—at our clinic.
3. Overview of the Six Building Blocks program.
4. Your ideas and input! Small group activity: baseline self-assessment.
5. Next steps and how you can help.

Milestone Aims

By the end of this step, you should have:

- Hosted a kickoff with all clinicians and staff, during which feedback was gathered and project support was generated.
- Assessed the clinic’s current status on all 6BBs.

LESSON LEARNED

The clinicwide kickoff is a critical step in the implementation process. It allows everyone in the clinic to engage with the process and helps garner buy-in and good ideas. When thinking back on the process, many participants emphasize that the kickoff was essential.

“For this project, just to have them all in the room and talking to each other. Because there are some providers that talk to their MA’s but maybe not talk to another MA. So, we broke into groups, and there was just a lot of good discussions, and they asked everyone what they felt they would like to get out of the project. There were some really, really good conversations.”

—Clinic Manager

“We presented what our plan was and where we were going with this to all the different clinics. That helped to get buy in and also it gave us a launching point so that we really could accomplish the goals that we wanted to accomplish. So, I think that was the most useful part of this whole thing.”

—Clinical Champion

End of Prepare and Launch Stage

NEXT UP: First action plan meeting with opioid improvement team; *see the Design and Implement Guide.*

Appendix

Six Building Blocks Self-Assessment Tool

Instructions: Review and consider each question and circle the answer that best reflects your organization’s current status. Three numbered options for each answer allow you to select how far along you are within that answer. If completing this assessment with other stakeholders, keep in mind that it is okay if the group disagrees on the answer. It is helpful to know that not everyone has the same experience at your organization and discuss why differences exist.

Leadership and Consensus Building Block

Demonstrate leadership support and build organizationwide consensus to prioritize more selective and cautious opioid prescribing.

Leadership prioritizes the work	1	2	3	4	5	6	7	8	9	10	11	12
1. The commitment of leadership in this clinic to improving management of patients on LtOT...	...is not visible or communicated.			...is rarely visible, and communication about use of opioids for patients with chronic pain is ad hoc and informal.			...is sometimes visible and communication about patients on long-term opioid therapy is occasionally discussed in meetings.			...is communicated consistently as an important element of meetings, case conferences, emails, internal communications, and celebrations of success.		
Shared vision	1	2	3	4	5	6	7	8	9	10	11	12
2. A shared vision for safer and more cautious opioid prescribing...	...has not been formally considered or discussed by clinicians and staff.			...has been discussed, and preliminary conversations regarding a clinicwide opioid prescribing standard have begun.			...has been partially achieved, but consensus regarding a clinicwide opioid prescribing standard has not yet been reached.			...has been fully achieved. Clinicians and staff consistently follow prescribing standards and practices.		
Responsibilities assigned	1	2	3	4	5	6	7	8	9	10	11	12
3. Responsibilities for practice change related to patients on LtOT...	...have not been assigned to designated leaders.			...have been assigned to leaders, but no resources have been committed.			...have been assigned to leaders with dedicated resources, but more support is needed.			...have been assigned. Dedicated resources support protected time to meet and engage in practice change.		

Policies, Patient Agreements, and Workflows Building Block

Revise, align, and implement clinic policies, patient agreements, and workflows for healthcare team members to improve opioid prescribing and care of patients with chronic pain.

Policy development/revision	1	2	3	4	5	6	7	8	9	10	11	12
4. Comprehensive policies* regarding LtOT that reflect evidence-based guidelines, such as the CDC Guideline for Prescribing Opioids for Chronic Pain or State-based opioid prescribing guidelines...	...do not exist.			...exist but have not been recently revised and updated.			...exist and have been recently updated but still lack essential components.			...exist, have been recently updated to reflect recent evidence-based guidelines, and are comprehensive.		
Policy implementation	1	2	3	4	5	6	7	8	9	10	11	12
5. Policies regarding long-term opioid therapy...	...have not been distributed to clinicians and staff.			...have been distributed to clinicians and staff but have not been discussed.			...have been distributed and discussed with all clinic staff and clinicians but are not consistently followed.			...have been distributed, have been discussed with all clinic staff and clinicians, and are consistently followed.		
Patient agreements	1	2	3	4	5	6	7	8	9	10	11	12
6. Formal signed patient agreements regarding long-term opioid therapy...	...do not exist.			...exist but do not align with current clinic policies or are not consistently used.			...exist and align with current clinic policies but are not consistently used.			...exist, align with current policies, and are consistently used with all patients on chronic opioid therapy.		
Workflows	1	2	3	4	5	6	7	8	9	10	11	12
7. Clinic workflows for managing patients on LtOT...	...do not exist.			...exist but do not support current clinic policies.			...exist and support current clinic policies but are not fully implemented.			...exist, support current clinic policies, and are fully implemented.		

* Examples of areas that a comprehensive policy might address include these areas from the CDC Guidelines:

- *Prescribing opioids for acute pain*
- *Duration and dose of opioids for chronic pain*
- *Use of nonopioid and nonpharmacologic therapies*
- *Coprescribing of opioids and benzodiazepines*
- *Urine drug screening*
- *Monitoring of state-controlled substances database*
- *Patient agreements*
- *Patient education*
- *Tapering of opioids*
- *Use of naloxone*
- *Use of buprenorphine*
- *Use of methadone*

Tracking and Monitoring Patient Care Building Block

Implement proactive population management before, during, and between clinic visits of all patients on LtOT.

Tracking and monitoring of patients prescribed long-term opioids	1	2	3	4	5	6	7	8	9	10	11	12
8. Use of a system to proactively track and monitor patients prescribed long-term opioids to ensure their safety...	...has not been explored or is not possible with existing data systems.			...is technically possible, but systems to get useful reports are not yet in place.			...is possible and systems are in place to produce basic reports on a regular basis.			...is possible, systems are in place, and reports are produced that allow tracking of patient care and monitoring of clinician practices.		
Tracking and monitoring data collection workflows established	1	2	3	4	5	6	7	8	9	10	11	12
9. Workflows to enter data into the tracking and monitoring system...	...have not been developed.			...are in development but not established.			...are established but are not consistently implemented.			...are established and consistently implemented. Responsibilities are assigned and protected time is available to complete assigned responsibilities.		
Tracking and monitoring data use workflows established	1	2	3	4	5	6	7	8	9	10	11	12
10. Workflows to use data to track patient care and monitor clinician practices...	...have not been developed.			...are in development but not established.			...are established but are not consistently implemented.			...are established and consistently implemented. Responsibilities are assigned and protected time is available to complete assigned responsibilities.		

Planned, Patient-Centered Visits Building Block

Prepare and plan for the clinic visits of all patients on LtOT. Support patient-centered, empathic communication for care of patients on LtOT.

Planned opioid patient visits	1	2	3	4	5	6	7	8	9	10	11	12
11. Before routine clinic visits, patients on LtOT...	...are not identified. There is no advance preparation for patient visits for LtOT.			...are sometimes identified, but there is no discussion or advance preparation for visits with patients prescribed long-term opioids.			...are identified, and a discussion or chart review to prepare for the visit sometimes occurs.			...are consistently identified and discussed before the visit. The chart is reviewed and preparations made to address safe opioid use.		
Empathic communication	1	2	3	4	5	6	7	8	9	10	11	12
12. Training on patient-centered, empathic communication emphasizing patient safety, e.g., risks, dose escalation, and tapering...	...has not been offered to clinicians and staff.			...has been offered to clinicians and staff, but participation was limited.			...has been offered and most of the clinicians and staff participated.			...is consistently offered, with widespread, regular participation.		
Patient involvement	1	2	3	4	5	6	7	8	9	10	11	12
13. Training on how to involve patients on LtOT in making decisions, setting goals for improvement, and providing support for self-management...	...has not been offered to clinicians and staff.			...has been offered to clinicians and staff, but participation was limited.			...has been offered and most of the clinicians and staff participated.			...is consistently offered, with widespread, regular participation.		
Care plans	1	2	3	4	5	6	7	8	9	10	11	12
14. Care plan* templates for chronic pain management...	...do not exist.			...exist but do not align with current clinic policies or are not consistently used.			...exist and align with current clinic policies but are not consistently used.			...exist, align with current policies, and are consistently used.		
Patient education	1	2	3	4	5	6	7	8	9	10	11	12
15. Patient education materials that include explanation of the risks and limited benefits of long-term opioid use...	...do not exist.			...exist, but strategies to disseminate to patients do not exist.			...exist and dissemination strategies exist, but the strategies have not been fully implemented.			...exist, dissemination strategies exist, and the strategies have been fully implemented.		

* A chronic pain care plan is a tailored set of written steps and key information a provider and patient agree will be used to manage the patient's pain. It can include goals such as functional activities; current or planned treatments, such as physical activity prescription and medications; and a timeframe for reevaluation, such as followup in 3 months.

Caring for Patients With Complex Needs Building Block

Develop policies and resources to ensure that patients who develop OUD or who need mental and behavioral health resources are identified and provided with appropriate care, either in the primary care setting or by outside referral.

Identifying patients with complex needs	1	2	3	4	5	6	7	8	9	10	11	12
16. Policies, clinic-selected screening tools, and workflows to identify opioid misuse, diversion, and addiction and to recognize mental/behavioral health needs...	...do not exist.			...partially exist.			...exist but are only partially implemented.			...exist and are consistently implemented.		
OUD resources	1	2	3	4	5	6	7	8	9	10	11	12
17. OUD treatment...	...is difficult to obtain reliably.			...exists but is not timely or convenient.			...is available and is usually timely and convenient.			...is readily onsite or available from an organization that has a referral protocol or agreement with our practice setting.		
OUD training	1	2	3	4	5	6	7	8	9	10	11	12
18. Training on diagnosing opioid use disorder...	...has not been offered to clinicians.			...has been offered to clinicians, but participation was limited.			...has been offered and most of the clinicians participated.			...is consistently offered, with widespread, regular participation.		
Behavioral health resources	1	2	3	4	5	6	7	8	9	10	11	12
19. Mental/behavioral health services...	...are difficult to obtain reliably.			...are available from behavioral health specialists but are not timely or convenient.			...are available from behavioral health specialists and are usually timely and convenient.			...are readily available from behavioral health specialists who are onsite or who work in an organization that has a referral protocol or agreement with our practice setting.		
Stigma training	1	2	3	4	5	6	7	8	9	10	11	12
20. Training on addressing stigma surrounding OUD and mental/behavioral health needs...	...has not been offered to clinicians and staff.			...has been offered to clinicians and staff, but participation was limited.			...has been offered and most of the clinicians and staff participated.			...is consistently offered, with widespread, regular participation.		

Measuring Success Building Block

Continuously monitor progress and improve with experience.

Monitoring progress	1	2	3	4	5	6	7	8	9	10	11	12
21. A system to measure and monitor progress in opioid therapy practice change...	...does not exist.			...exists, including overall tracking goals, but regular tracking reports on specific objectives have not been produced.			...is used to produce regular tracking reports on specific objectives. Leadership reviews are done occasionally but not on a formal schedule.			...has been fully implemented to measure and track progress on specific objectives. Leadership reviews progress reports regularly and adjustments and improvements are implemented.		
Assessing and modifying	1	2	3	4	5	6	7	8	9	10	11	12
22. Adjustments to achieve safer opioid prescribing based on monitoring data...	...are not being made.			...are occasionally made but are limited in scope and consistency.			...are often made and are usually timely.			...are consistently made and are integrated in overall quality improvement strategies.		

FULL PROGRAM:
DESIGN AND IMPLEMENT GUIDE

Six Building Blocks

*A Team-Based Approach to Improving
Opioid Management in Primary Care*

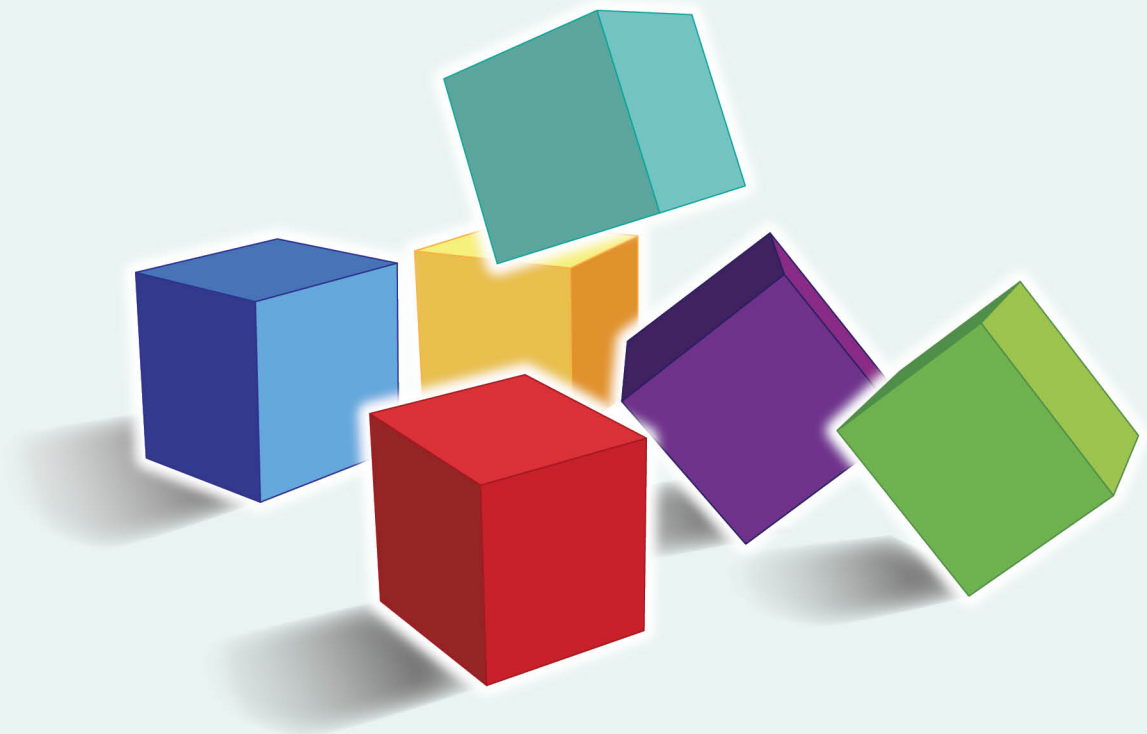


Table of Contents

Introduction	1
What Is the Design and Implement Guide?	1
What Is in the Design and Implement Guide?	2
Design and Implementation Process	3
First Action Plan Meeting	4
Time	4
Objectives	4
Who Should Attend.....	4
Helpful Website Resources	4
Agenda (Outline).....	4
Agenda (Details).....	5
Future Opioid Improvement Team Meetings	8
Time	8
Frequency	8
Purpose	8
Relevant Materials To Bring to These Meetings.....	8
Agenda (Outline).....	8
Agenda (Details).....	8
How To Implement the Six Building Blocks	10
Contents.....	10
Leadership and Consensus	11
Overview	11
Tips for Accomplishing Each Milestone	12
Overcoming Common Challenges.....	13
Policies, Patient Agreements, and Workflows	15
Overview	15
Tips for Accomplishing Each Milestone	16
Overcoming Common Challenges.....	19
Tracking and Monitoring	20
Overview	20
Tips for Accomplishing Each Milestone	21

Overcoming Common Challenges.....	24
Planned, Patient-Centered Visits	26
Overview	26
Tips for Accomplishing Each Milestone	27
Overcoming Common Challenges.....	29
Caring for Patients With Complex Needs.....	31
Overview	31
Tips for Accomplishing Each Milestone	32
Overcoming Common Challenges.....	34
Measuring Success	35
Overview	35
Tips for Accomplishing Each Milestone	35
Overcoming Common Challenges.....	36
Appendix 1: Action Plan Templates	37
Detailed Action Plan.....	37
Simple Action Plan	37
Appendix 2: Example First Action Plan.....	38
Leadership and Consensus Activities	38
Policies, Patient Agreement, and Workflow Activities	39
Tracking and Monitoring Patient Care Activities	40
Milestones for Next Time.....	40
Success Measure.....	40

Introduction

The Six Building Blocks for Improving Opioid Management (Building Blocks or 6BBs) program offers a roadmap for improving a primary care clinic's management of patients who are on long-term opioid therapy (LtOT) for chronic pain. The 6BBs supports you in **redesigning opioid management** processes by:

- Addressing leadership support;
- Revising and aligning clinic policies, patient agreements, and workflows;
- Tracking and monitoring the population of patients using LtOT;
- Conducting planned, patient-centered visits;
- Caring for patients with complex needs; and
- Measuring success.

A 6BBs How-To-Implement Toolkit (hereafter: Implementation Toolkit) was developed to provide clinics with support for engaging in this improvement work. Depending on an organization's capacity, there are two approaches: the Fast Track Approach and the Full Program Approach; see [Six Building Blocks Implementation Toolkit Overview](#) for further information.

What Is the Design and Implement Guide?

The Design and Implement Guide is a resource for the second stage of the Full Program Approach: Design and Implement. While anyone can use these materials to implement improvements in chronic pain and opioid medication management, it is specifically written for quality improvement (QI) leaders and project managers to use in guiding an improvement team and care teams through the Six Building Blocks implementation process.

What Is in the Design and Implement Guide?

- The Design and Implement Guide walks you through leading the opioid management improvement team in creating action plans, setting and tracking measures, responding to challenges, and running small cycles of change.
- As the QI lead, you can use this guide to coach a primary care clinic in developing and executing action plans to improve opioid medication management based on the Six Building Blocks and the areas identified during the Prepare and Launch Stage as opportunities for improvement.
- Track your progress with the [Six Building Blocks coaching log](#).

The Design and Implement Guide Includes:

- The [first action plan meeting guide](#), which walks you through the key steps of this first Design and Implement stage meeting: selecting measures and aims and creating your clinic's first plan for implementing improvements.
- The [future opioid improvement team meetings guide](#), which outlines how to drive the work forward using QI approaches during opioid improvement team meetings
- The tips on [how to implement](#) the Six Building Blocks and overcome common obstacles section, which is very detailed and is meant to give you the information you need to coach your team and clinic in implementing improvement to opioid management.
- Action plan [templates](#) and [an example](#), which show the structure of an action plan.

Stage 2: Design and Implement Aims

Use Six Building Blocks to redesign care for patients using opioid therapy.

Begin with policy and agreement revision.

Throughout the design and implementation process: test, assess, and adjust.

Design and Implementation Process

The above diagram outlines the work involved in the Design and Implement Stage. By completing the Prepare and Launch Stage work, you and your team are well positioned for this next phase of the work.



The point at which a clinic begins the Design and Implement Stage work varies based on where it is at baseline and the priorities clinic personnel identify. Often, the implementation process involves the following steps:

- In general, the process starts with revising policies and the patient agreement and making sure these are in alignment. At the same time, many clinics continue the work they began during the Prepare and Launch Stage by either completing identification of patients using LtOT or beginning to develop a tracking and monitoring system.
- Once policies and agreements are approved, clinic teams work together to design and test workflows to implement the policies and patient agreement.
- At the same time, many clinics begin developing patient outreach plans and identifying resources for patients with complex needs such as opioid use disorder (OUD) or mental/behavioral health needs.
- To ensure the changes they are making are improvements, clinics track and assess success measures and milestones.
- Throughout this process, clinics demonstrate commitment to these QI efforts by regularly discussing the project and by requesting and responding to feedback on changes they have made in opioid management. Clinicians and staff also take time to celebrate improvements.

First Action Plan Meeting

This meeting generally takes place directly after the clinicwide kickoff.

Time

1.5 to 2 hours.

Objectives

1. Decide on one or two measures of success to begin tracking and sharing with care teams.
2. Identify overall milestones to achieve during the Design and Implement stage.
3. Develop an action plan for the next 3 months.

Who Should Attend

Opioid improvement team.

Helpful Website Resources

The following resources relevant to the First Action Plan Meeting are available in the Resource Library at www.improvingopioidcare.org.

- [Six Building Blocks milestones](#)
- [Measuring success metrics](#)
- [DIY run charts \(a tool to track a measure over time\)](#)
- [Action plan templates](#)
- [Model policy](#)
- [Model patient agreement](#)

Agenda (Outline)

1. Debrief on clinicwide kickoff.
2. Discuss using data to measure success.
3. Review [Six Building Blocks Milestones](#) and identify milestones to achieve.
4. Develop first action plan.

CAUTION

Even if you currently have no feasible way to identify your patients using LtOT, it is still important to identify a measure of success early on.

Consider instead: (a) tracking a measure for a representative sample from each provider of patients using LtOT; (b) tracking a count rather than a percentage (e.g., starting at 0, how many patients sign a patient agreement?); or (c) manually tracking a measure of importance, such as number of early refill calls.

Something can always be measured and reported to encourage program participation and track progress from baseline. It is just a matter of deciding what is feasible on a regular basis.

Agenda (Details)

1. Debrief on Kickoff

What did you and your team learn during the clinicwide kickoff? What did you hear were priorities for the work? Was anything surprising?

2. Discuss Using Data To Measure Success

Throughout the Design and Implement Stage, it is important for the opioid improvement team—and the clinic staff—to review data to support continual improvement. These data can be both quantitative, such as percentage of patients with a signed agreement in the chart, and qualitative, such as perspectives from medical assistants (MAs) on current patient visit workflows.

You will be guiding the team in making and testing changes to improve how your clinic helps patients using LtOT. Data allow you to see how those changes are going and to think through how to adjust as appropriate.

The three basic elements of measuring success are outcome measures, process improvements, and small tests of change.

Outcome Measures

It is vital to consider why your clinic is doing this work. What is important to your clinic in improving care? Identify what these overarching aims are and consider how it might be possible to measure them. Examples of aims include:

- Reduce the number of patients with a morphine equivalent dose (**MED**) of **50/90** or higher by XX% by DATE.
- Reduce the number of patients on **concurrent sedatives** and opioids by XX% by DATE.
- Increase the number of patients using LtOT who are prescribed **naloxone** by XX% by DATE.
- XX% of patients using LtOT have reviewed and signed an updated **patient agreement** that reflects our policies by TARGET DATE.
- XX% of patients' **function** was assessed at their last patient visit by TARGET DATE.

Think through what is feasible to measure now and increase the number of measures as your tracking and monitoring capacity grows. When considering which of the above aims your clinic wants to measure and track, consider if you have the capacity to measure:

- Number and percentage of patients on LtOT with an MED of 50/90 or higher.
- Number and percentage of patients on LtOT who are on concurrent sedatives.
- Number and percentage of patients on LtOT with a prescription for naloxone.
- Number and percentage of patients on LtOT who have reviewed and signed an updated patient agreement.
- Number and percentage of patients on LtOT whose function was assessed at their last patient visit.

Additional outcome measure examples may be found in the [Centers for Disease Control and Prevention \(CDC\) quality improvement metrics](#) and [Pharmacy Quality Alliance Opioid Measure Set](#).

Process Improvements

To improve safety and reach your aims, you will lead the team and clinic in making process improvements. The Six Building Blocks program lays out key process improvements other clinics have found important to improving opioid management; see [Six Building Blocks Milestones](#). Consider your

team's current process improvement focus and how you will measure the success of that process improvement. Examples of process improvement aims include:

- Identify and label all **patients using LtOT** with the same ICD-10 code by DATE.
- Provide a **dashboard of measures** that track improvement (e.g., MED average and by patient) to the opioid improvement team and to clinicians and staff quarterly by DATE.
- By DATE, have a process in place to **identify care gaps** for all patients using LtOT and discuss them during morning huddles (e.g., no State prescription drug monitoring program [PDMP] check in the last 6 months).
- Develop, train, and implement **new workflows** that support our revised policies by DATE.
- Have an **MED on record** for all patients on LtOT by DATE.

Small Tests of Change

Throughout the Design and Implement stage, you will guide the opioid improvement team and your clinic in running **small tests of change** and then assessing if these changes are associated with improvements.

Generally, it is a good idea to test a change on a small scale, evaluate how it went, and adjust as appropriate before implementing a change clinicwide.

You and the QI team will need to look at data to evaluate these small tests. Examples of small test measures include:

- Experience of front desk staff in using an iPad to give patients **annual pain visit forms** over the course of 1 week.
- Ease of use of a **new electronic health record (EHR) template** by a pilot care team during 2 weeks of patient visits.

Initial Aims

Select one or two outcome or process improvement aims to begin tracking, monitoring, and sharing with care teams that are:

- Important to the clinic;
- Feasible to measure; and
- Motivating to clinicians and staff by encouraging buy-in.

It is useful to look at these measures by clinic, by provider, and by patient. You might also consider using a run chart to track your measures. Keep in mind that it takes effort and resources to produce these measures of success, so start small. You can add to it over time as your capacity to track grows.

3. Review Six Building Blocks Milestones

Review the **Six Building Blocks Milestones** as a team. Consider what your team learned from the baseline assessment process and what you heard from care teams during the clinicwide kickoff:

- Do the milestones reflect what your team wants to achieve through this project?
- Does your team want to add or remove any milestones from the list?
- Which milestones are the biggest priorities for your team? Which do you want to start working toward first?

Create a set of milestones your team can refer to throughout the Design and Implement process when designing action plans and assessing success.

4. Develop the First Action Plan

Looking at the milestones your team identified as early priorities, where do you want to begin the work? Organizations generally begin by focusing on achieving the following milestones:

- *Protected time for the improvement team to meet and work;*
- *Regular emphasis of project importance and solicitation of feedback during staff and clinician meetings;*
- *Clinical education opportunities offered to staff and clinicians;*
- *Policy revised to align with evidence-based guidelines;*
- *Patient agreement revised to support revised policy and educate patients about risks;*
- *Patients using LtOT identified;*
- *All clinicians and delegates registered with the State PDMP;*
and
- *Consistent MED calculation easy for clinicians and staff.*

Be sure to write down the team's action plan for achieving your first identified milestones (see the [action plan templates](#) and [example first action plan](#) in the Appendixes). Be sure to think through clear, attainable steps; who is responsible; and when tasks will be done. Refer to the [How To Implement the Six Building Blocks](#) section for ideas about how to do this work. You will use these action plans to keep the project on track

EXAMPLE

MN clinic heard from clinic staff that a priority was to make calculating MED on every patient easy, accessible, and integrated into rooming workflow. Currently, their EHR has no field to enter these data. Therefore, the Opioid Improvement Team decided it would be important to focus on building and testing a workflow for MED calculation and charting as a first step.

Future Opioid Improvement Team Meetings

Time

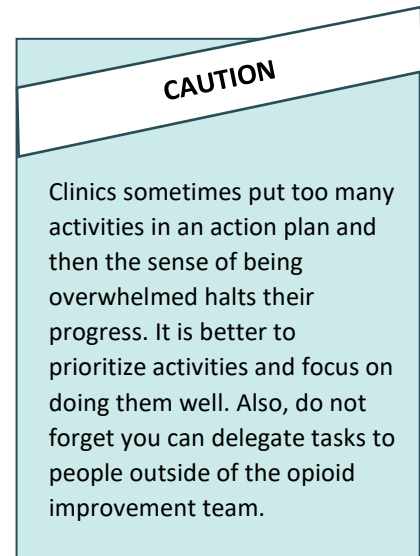
1 hour.

Frequency

At least monthly as a working group. At least quarterly for reviewing data as a larger team.

Purpose

These meetings are the engines for the Six Building Blocks process. They are where you lead your opioid improvement team in designing and implementing the changes described in the remainder of this Design and Implement Guide.



Relevant Materials To Bring to These Meetings

- Current Action Plan;
- *Six Building Block Milestones*;
- *Relevant Six Building Blocks resources*;
- *Run chart or other measures of success*; and
- *Template to document the action plan*.

Agenda (Outline)

1. Review work accomplished.
2. Review data.
3. Brainstorm plans and resources to handle challenges.
4. Develop next action plan.

Agenda (Details)

1. Review Work Accomplished

Discuss the progress made in each section of the last action plan. Take time to celebrate successes and how to share these successes with the rest of the clinic.

2. Review Data

Look at data to ascertain if the changes your clinic is making are leading to improvements. What do the data tell you? Remember to use both quantitative and qualitative data. Refer to the earlier sections on data for more information (*overarching patient care measures*, *process measures*, and *small test measures*).

3. Brainstorm Plans and Resources To Handle Challenges

What challenges or new information arose while implementing the action plan and running small tests of change? What did your team learn from your experiences and the data? How can your clinic adjust to continue to improve? Refer to **Overcoming Common Challenges** under each Building Block in the **How To Implement the Six Building Blocks** section of this guide for ideas. Edit the action plan to include the next steps your team will try to overcome identified challenges and the next small tests of change you will try.

4. Develop Next Action Plan

Considering the work that is still ongoing from the last action plan, do your team and clinic have capacity to take on additional activities? If so, refer to the **Six Building Blocks Milestones** and **How To Implement the Six Building Blocks** to identify new activities to add to the action plan.

How To Implement the Six Building Blocks

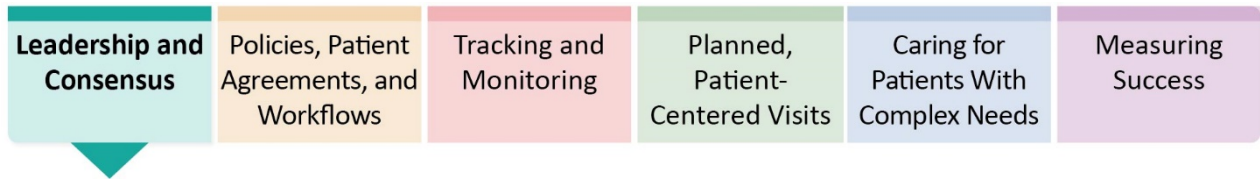
This section walks through suggestions for implementing improvements to opioid management in each of the Six Building Blocks areas. For each Building Block, it includes:

- An overview of the work, milestones, relevant resources, and common challenges;
- Tips for accomplishing each milestone; and
- Suggested approaches for overcoming common challenges.

It is useful to refer to this section when developing action plans.

Contents

- Building Block: Leadership and Consensus
- Building Block: Policies, Patient Agreements, and Workflows
- Building Block: Tracking and Monitoring Patient Care
- Building Block: Planned, Patient-Centered Visits
- Building Block: Caring for Patients With Complex Needs
- Building Block: Measuring Success



Leadership and Consensus

Overview

Leadership plays an important role by both prioritizing the work and creating opportunities for conversations among clinicians and staff to reach a shared understanding of how patients on LtOT are managed. Leaders help set clinicwide performance goals and help clinicians and staff understand their roles and responsibilities with patients on LtOT.

Milestone	Relevant Resources
Provide protected time for opioid improvement team to meet and work.	<i>Building an opioid improvement team</i>
Regularly emphasize project importance and solicitation of feedback during staff and clinician meetings.	<i>Opioid harm stories</i> <i>Motivating providers slow to adopt</i> <i>Levers of motivation guide</i> <i>Elevator speech on the Six Building Blocks</i>
Offer clinical education opportunities to staff and clinicians, including on the science of chronic pain.	<i>University of Washington TelePain resources</i> <i>CDC training and webinars</i> <i>OPMC CME Pain Management Course</i> <i>Compilation of clinical educational opportunities</i> <i>Oregon Pain Guidance Online Courses</i>

Common Challenges
Our opioid improvement team/clinicians/staff/leadership are struggling to complete assigned tasks.
We are not sure how to encourage and help staff/clinicians get on board with the changes.
We have not been able to build consensus among clinicians on a specific issue.

Tips for Accomplishing Each Milestone

Protected Time for Opioid Improvement Team To Meet and Work

- The opioid improvement team should have a standing monthly meeting to work.
- If your opioid improvement team is large, consider forming a smaller core-working group.
- Members of the larger team can be part of subcommittees that take on specific assigned action items and provide input, such as a representative for the MA perspective.
- The larger team can meet less frequently, such as quarterly, to review reports on success (e.g., MED levels and coprescribing statistics across the practice) and identify next steps, such as further investigation or additional tests of change.

Regular Emphasis of Project Importance and Solicitation of Feedback During Staff and Clinician Meetings

- Ask the clinical champion to keep the project on the mind of staff and clinicians.
- Emphasize the project by discussing it in meetings and informal one-on-one conversations.
- Make it a standing agenda item and provide updates at weekly and monthly staff meetings.
- Identify specific patients with early successes and share stories with clinicians and teams. Stories are important buy-in motivators.
- Offer opportunities for clinicians to share and discuss difficult cases at meetings.
- Consider doing peer chart reviews of patients using LtOT.
- Share measures of success with clinicians and staff.
- Obtain and respond to feedback from staff and clinicians about the Six Building Blocks efforts.
- Post data in a hallway or other commonly used area, such as a thermometer that tracks progress toward a success measure.
- Make clinicwide goals fun, such as a prize for the first care team to accurately apply the appropriate diagnosis code to their patients using LtOT.

Clinical Education Opportunities Offered to Staff and Clinicians

- Start the opioid management improvement work by offering training to clinicians and staff on the science of chronic pain and chronic pain treatment. This training could be a short video, such as *Tame the Beast*, or a class, such as the *Oregon Pain Management Commission Pain Management Course*.
- Identify a simple clinical education opportunity on chronic pain and opioid management to offer to your staff and clinicians. For example, UW TelePain has a weekly webinar series.
- Advertise educational opportunities to care teams.

LESSON LEARNED

Remember to include staff in the clinical education opportunities you provide. Staff report a growing empathy for patients and a sense of pride in their work after participating in educational opportunities.

“People don't start out [as] addicts; it evolves into that. And that's what I learned from attending the webinars, from talking to people, from listening to the providers and their insight. So, it was a huge learning experience for me, and I hear the medical assistants and the LPNs say the same thing. It's like, my gosh, these are people—these are people with problems, you know, and they're not the enemy. So, I think it has changed the way we look at that population.”

—Staff member

- If it is a regular virtual opportunity, it can be helpful to assign someone to reserve a room and get the technology in place for anyone in the clinic to drop in and participate.
- Review other available clinical education opportunities, including any available through your organization, [CDC](#), or local universities. For example, in one clinic a member of the team had the skills to train staff in motivational interviewing. The clinic invited that provider to three of their staff “Lunch and Learn” sessions to conduct the training.
- If possible, identify opportunities relevant for different learning styles and schedules.
- Some webinar series record the webinars or publish the slides. If so, assign someone to make these materials available to the clinic.
- During clinic and staff meetings, ask if anyone wants to present on or share about learning from these opportunities to further spread the knowledge.

Overcoming Common Challenges

Building consensus and effectively getting work done can be challenging. What follows are common challenges clinics have reported and approaches we have seen them use to overcome these challenges.

“We Are Struggling To Complete Assigned Tasks”

- Try breaking up your team’s work into smaller and more specific tasks rather than assigning large projects. Use shorter deadlines rather than deadlines scheduled far out.
- Start with tasks that interest the key individuals.
- Remember that you can engage clinicians and staff outside of the team to help complete tasks that has the added benefit of encouraging ownership and buy-in of changes beyond the opioid improvement team.
- Try to work on doable, key tasks during meetings. For example, clearly highlight potential policy changes and revise during medical staff meetings.

“We Are Not Sure How To Encourage Buy-In”

- Emphasize that these changes are about reducing potential harm to patients and putting systems in place that support clinicians and staff in the practice.
- Train clinicians and staff to emphasize that caring for patients on LtOT requires a team approach.
- Ensure that the workflow meets the needs of the practice to follow evidence-based guidelines. Teach staff how to change the workflow if it is not working for them.
- Make policies and workflows easily accessible so that they can be referenced whenever needed. Consider storing them on a shared computer network and post them physically where clinicians and staff can see them.
- Use tracking and monitoring of data to ensure fidelity to the systems that have been tested and put in place to ensure high-quality care. Access to useful patient panel data (e.g. which patients are high-risk and have care gaps) helps clinicians and staff understand the utility of the new tracking and monitoring approaches.

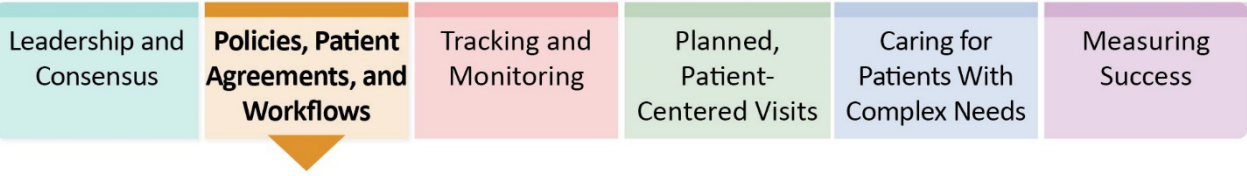
LESSON LEARNED

Stories about individual patients can be helpful in gaining and sustaining clinician and staff engagement in doing this work. It can be a story about a patient who was harmed, a patient or family member who expressed concerns about risks of opioid use, or a positive story about a patient or family member who is grateful for opioid dose reduction and improved functioning.

- Have the clinical champion attend huddles to provide continued advocacy for following clinic policies and to answer questions as needed.
- As needed, assess the root cause of deviations from policies. Consider adjusting workflows and conducting refresher trainings to remind those in your clinic about the opioid management policy and workflow implementation and to get those who have reverted to old ways back on track.
- Encourage participation in clinical training opportunities related to managing chronic pain. Regular discussion of challenging cases and education keeps clinicians and staff engaged with the topic and increases comfort in caring for patients with chronic pain.
- Identify champions and early adopters at each individual clinic location who can help encourage implementation and share success stories.

“We Have Not Been Able To Build Consensus Among Clinicians”

- Invite a third party (pain expert/academic faculty/other respected external colleague) to give a short presentation or facilitate a discussion among clinicians, administrators, and members of the opioid improvement team.
- Meet after hours in more of a social setting to discuss issues for which your clinic is trying to build consensus.
- Focus on evidence about patient harm from LtOT to drive consensus building.
- In some cases, it is more efficient to be prescriptive on specific aspects of the policy rather than leaving each decision up for debate among clinicians, especially if these segments of the policy can be supported by State regulations (e.g., States that have specific requirements for patients on higher dosages to be regularly assessed or referred to specialists). For critical issues, add core measures to performance appraisals and intervene as needed.
- Be sure to use data to help providers see the need for change. Deeper analyses of patient panels will help to gain buy-in.



Policies, Patient Agreements, and Workflows

Overview

Clinic **policies** about opioid prescribing for chronic pain create a shared understanding and agreed-on standards about how patients on LtOT are to be managed by all clinicians and staff.

A **patient agreement** is a document that communicates key clinic policies that affect the logistics of patient care and the practice’s philosophy around chronic pain management. It is important that the patient agreement aligns with clinic policies, and many clinics find it helpful to view the signed patient agreement as a type of informed consent used to communicate risks to patients.

Finally, **workflows** illustrate the step-by-step procedures for putting the policy into action.

THREE LEGS OF THE STOOL

The policies, patient agreement, and workflows are like three legs of a stool. They support—and align with—each other. The policies outline the critical aspects for opioid management, the patient agreement informs patients about these policies and educates them about risks of opioid medications, and the workflows support practical implementation of the policies.

Milestone	Relevant Resources
Policy revised to align with evidence-based guidelines and regulations (e.g., CDC, State guidelines).	<p><i>Policy model</i></p> <p><i>CDC opioid prescribing guideline</i></p> <p>State and local guidelines</p> <p><i>Tips for patients on legacy prescriptions</i></p> <p><i>Suggested opioid management schedule</i></p> <p><i>Risk stratification and opioid prescribing</i></p>
Patient agreement revised to support the policy and educate patients about risks.	<p><i>Patient agreement model</i></p>
Workflows written to support policies.	<p><i>Chronic pain appointment workflow</i></p> <p><i>Opioid refill workflow</i></p> <p><i>Opioid list manager workflow</i></p> <p><i>Remote urine drug testing FAQ and workflow</i></p>
Training conducted on policies, agreement, workflows, and supporting EHR templates.	<p><i>Rollout and training</i></p> <p><i>Provider guide to difficult conversations</i></p> <p><i>Staff guide to difficult conversations</i></p>
Common Challenge	
We want to encourage patient buy-in and help patients understand the new policies and procedures.	

Tips for Accomplishing Each Milestone

Policy Revised To Align With Evidence-Based Guidelines and Regulations

- This foundational activity for implementing opioid management improvements that is critical to program success.
- It contains elements such as policies for prescribing opioids for acute pain, for patients transitioning to chronic pain, for patients new to a patient panel who are already using LtOT, and actions to take if a patient falls out of line with a patient agreement.
- Even if your clinic has recently revised its policy, take time to compare it to evolving regulations, national and State guidelines, and evidence about effective chronic pain management.
- Be sure to make time for the clinicians in your practice to review and discuss the policy revision to ensure it reflects a consensus about the kind of care your organization wants to provide to patients with chronic pain. This process helps build understanding and buy-in for new approaches.
- It can help to frame the policy revision as an opportunity to support clinicians and staff as they work to decrease harm to patients and that clinicians can still individualize treatment.
- Be prescriptive where necessary (e.g., when matching with national guidelines) but solicit and incorporate feedback from staff and clinicians wherever possible.

Example Steps That Have Worked for Policy Revision at Other Organizations

1. One person reviews the documents—*model, guidelines*, existing policy, and other relevant materials, as appropriate—highlighting for the rest of the team areas that are different than your existing document. Be sure to check for relevant updated local, State, and national guidelines.
2. Send a document highlighting the differences to the opioid improvement team for review.
3. Have the opioid improvement team review the documents before the revision planning meeting.
4. Hold a revision planning meeting with the opioid improvement team:
 - a. Revision approach: Will your team use the *model policy*? Adopt it with modifications? Only use it as a guide and draft your own policy?
 - b. Process: What are the steps for drafting, review, and approval? Who needs to be involved? Will edits happen in person or over email? How will the team get feedback from clinicians and staff? What is the timeline for each of these steps?
5. Finalize according to clinic protocols.

LESSON LEARNED

Defining standards for patient agreements, urine drug tests, and 28-day refill cycles gave ABC Clinic providers the support they needed when encountering resistance from patients.

Patient Agreement Revised To Support Revised Policy and Educate Patients About Risks

- The patient agreement—a.k.a. treatment agreement, contract—is an opportunity to educate patients about your clinic’s policies and have an informed discussion with the patient about the risks of and safe practices for managing LtOT.
- It should be designed to communicate that the patient and practice are working together to ensure the safest possible practices in managing the patient’s pain.

- It contains elements such as provider-patient agreements about opioid medication refills, ways to lower harm, and the provider-patient partnership.
- Be sure to consider health literacy, language barriers, and procedures if the patient asks for alterations to the agreement.

Example Steps That Have Worked for Patient Agreement Revision at Other Organizations

1. Once there is a draft revised policy to work from, assign someone to begin revising the patient agreement so that it aligns with the revised policy. Use “track changes” to highlight the differences for the opioid improvement team. Use the *model patient agreement* as an example.
2. Send a document highlighting the differences to the opioid improvement team for review.
3. Have the opioid improvement team review the revised patient agreement before the next team meeting.
4. During a team meeting, determine:
 - a. What are the next steps for drafting, review, and approval?
 - b. Who needs to be involved?
 - c. Will edits happen in person or over email?
 - d. How will you get feedback from clinicians and staff?
 - e. What is the timeline for each of these steps?
5. Finalize according to clinic protocols.

Once the patient agreement is revised, think through how care teams will introduce and discuss the new patient agreement with patients. Ideas to consider include:

- Bring patients in according to their birth month for a chronic pain-only visit to review and sign the patient agreement.
- Identify someone (e.g., physician assistant) to review the patient agreement with all patients using LtOT and obtain their signature on the document.
- Train MAs or care coordinators to review the patient agreement and obtain the patient’s signature before rooming the patient.
- Offer training on difficult conversations and motivational interviewing to support staff in these interactions.

Workflows Written To Support Policies

- Review the revised policy and identify the workflows needed to support implementing the policy. Consider including workflows for:
 - Steps to prepare for pain visits (e.g., checking State prescription drug database);
 - Patient visits (e.g., calculating MED);
 - Refill requests;
 - Urine drug testing; and
 - Patient agreement review and signature.
- Compile your practice’s existing workflows and the Six Building Blocks models, including:
 - *Chronic pain appointment workflow*;
 - *Opioid refill workflow*;
 - *Opioid list manager workflow*; and
 - *Remote urine drug testing workflow*.
- Look back at what your team learned during the Prepare and Launch Stage about:
 - What happens when a patient with chronic pain comes in for a visit that results in an opioid refill.
 - What happens when a patient calls for an opioid refill.
- Include MAs and nurses on the workflow development/revision team as they are the ones most familiar with the processes included in the workflows.
- Develop workflows that shift responsibility from providers to MAs and nurses, as appropriate. Specifically consider:
 - Completing previsit planning tasks;
 - Checking the State prescription drug database;
 - Preparing paperwork;
 - Calculating MED; and
 - Filling out part of the visit template with the patient before the provider sees the patient.
- Clearly define the roles of each individual in the clinic in implementing the policies. For example, can individuals at the front desk hand out the revised patient agreement before the patient is roomed by the MA? This approach will help decrease confusion or misunderstandings regarding policy implementation.
- Locate or create EHR templates that align with your clinic’s workflows. Consider creating different templates for each role, such as steps an MA completes and steps a provider completes. This approach supports your clinic’s tracking and monitoring efforts and, importantly, is an easy reminder of needed care processes.
- Identify a care team to pilot the draft workflows to determine the most efficient approach. For example, is it easiest to use paper or electronic forms? What can be completed at the front desk?
- Run several tests of change before rollout to ensure that what you are proposing can work.

Training Conducted on Policies, Agreement, Workflows, and Supporting EHR Templates

- It can be overwhelming to implement new care processes all at once. Consider a slow rampup. For example, prioritize new elements and train on one or two key changes at each staff meeting. This approach also allows you to remind and reinforce earlier trainings—and celebrate the successes.
- Create and distribute a one-page summary highlighting the key changes for each training.
- Consider identifying champions at each location to be a resource for others.
- Be sure to highlight the value of the changes to patients and to clinicians and staff members when introducing them.
- Train and remind through multiple platforms such as in-person trainings, meetings, email “touch-backs,” champion check-ins, and handouts.
- When training on new workflows, be ready to provide clinicians and staff with a realistic estimate of how long the processes will take.
- Provide thorough training on how to use EHR templates so clinicians and staff can implement with confidence.
- Provide needed resources, such as [AHRQ Clinical Decision Support Tools](#), to guide implementation of new activities. For example, provide instructions for signing up for the State prescription monitoring database, print out copies of the new workflow, and print screenshots and instructions for the EHR template.
- Include a plan for refresher trainings and trainings for new employees.

LESSON LEARNED

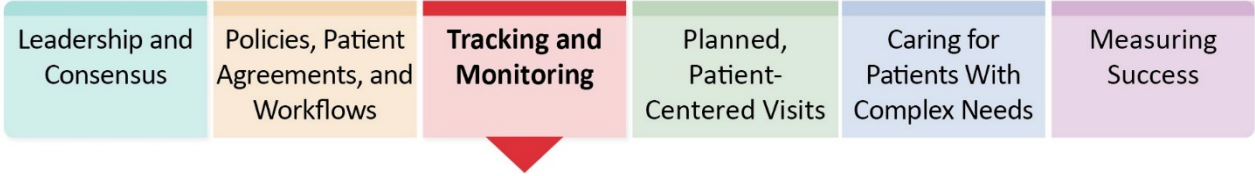
XYZ clinic conducted trainings with clinicians and staff together in the same room, so they were able to strategize team-based care implementation.

Overcoming Common Challenges

Below are approaches clinics use to overcome common challenges.

“We Want To Help Patients Understand and Accept the New Policies and Procedures.”

- Distribute a letter, either during a patient visit or by mail, to all patients before implementing the new policy and patient agreement. Describe the key changes and explain why your clinic is making these changes. Refer to the [example letter](#) for letter content ideas.
- Host a community question/answer event and invite patients and community leaders, such as school board members and law enforcement, to attend.
- Take time with patients to review the patient agreement—and educate patients on risks—and ensure that they understand its content. Explain why specific changes are being made and how they will improve their care and reduce their risks.
- Remember that patients have different levels of health literacy, including some patients who need to have it read aloud as they sign each element. Thus, help each patient to read and sign the patient agreement.
- Anticipate questions and challenges patients may raise. Discuss these with clinicians and staff during training and provide possible solutions to make them feel comfortable in addressing these concerns. Refer to the [provider guide to difficult conversations](#) and the [staff guide to difficult conversations](#) for conversation script ideas.



Tracking and Monitoring

Overview

Identifying which patients are using LtOT for their chronic pain is important for several reasons:

- Any patient using LtOT, regardless of dose, has a risk of adverse events, including overdose;
- Identifying patients using LtOT provides an opportunity to identify those at highest risk so that they do not “fall between the cracks” in a busy primary care clinic;
- A population tracking system can be used to identify care gaps between scheduled visits and to conduct outreach and followup with those patients; and
- Population tracking provides an opportunity to know if efforts to improve care are successful.

Milestone	Relevant Resources
Patients using LtOT are identified.	Approaches to identifying patients Opioid names
All clinicians and delegates—if applicable—are signed up for the State PDMP. (<i>Delegates are staff who may access the data on behalf of a clinician.</i>)	State PDMP profiles and contacts
Calculating MED as dose or medication changes is possible and easy for clinicians and staff.	WA AMDG MED calculator CDC Guideline App , which includes an MED calculator How to manually calculate MED
A dashboard of key measures is available for all patients using LtOT.	Data to consider tracking Tracking and monitoring example spreadsheet Developing a tracking and monitoring dashboard
Data are used to monitor care gaps, high-risk patients, and clinical variation.	Purposes of tracking and monitoring Chronic pain management teams

Common Challenges
Data from our tracking and monitoring reports are not accurate.
It is too time consuming to track and monitor patients using LtOT.
Clinicians do not have time to look at the tracking and monitoring data.

Tips for Accomplishing Each Milestone

Patients Using LtOT Are Identified

Knowing which patients are using LtOT is critical to providing guideline-consistent opioid management. It ensures that staff and clinicians can identify patients for previsit planning and it helps with the process of monitoring success.

Tracking and monitoring can identify clinical variation, high-risk patients, and care gaps. Depending on the tracking and monitoring approach taken, this could mean:

- Identifying patients using LtOT within the EHR using a unique diagnostic code or drug codes and pulling reports using EHR tools based on the codes. (Potential ICD-10 codes: Z79.891 or F11.90.)
- Keeping a manually updated list of patients in an Excel registry as a stop-gap measure until your own EHR system can track and monitor these patients.
- Using proprietary software to pull reports from the EHR.

Identifying these patients can be surprisingly challenging. It is best for sites to continue developing their tracking and monitoring approach even if they have not yet identified their patients.

Revisit what you learned during the Prepare and Launch Stage about the pros and cons of different methods to identify your clinic's patients using LtOT. Based on those learnings, determine what further investigations are needed. Consider:

- What challenges is your team trying to address?
- What strengths did you identify for tracking and monitoring?
- What makes sense for next steps?

Refer to the resource [Approaches to identifying patients](#) for ideas.

All Clinicians and Delegates Are Registered With the State PDMP

Regularly checking State PDMP data allows prescribers to determine whether a patient is using opioids as prescribed or receiving opioids from other clinicians. In addition, prescribers can note whether dangerous opioid dosages or combinations—such as with sedatives—are putting patients at risk for adverse events. To access the data, prescribers need to register.

If permitted in your State, sign up delegates—staff who can check the State PDMP database on the clinician's behalf—who might have more time to check the database before patient visits.

It can be more challenging than expected to get all clinicians signed up for the State PDMP. For instance, clinicians often struggle to find the time to go through the signup process or clinicians do not have all the information needed when they go to sign up.

COMMON QUESTION

Do we need to track patients only taking opioids “as needed”?

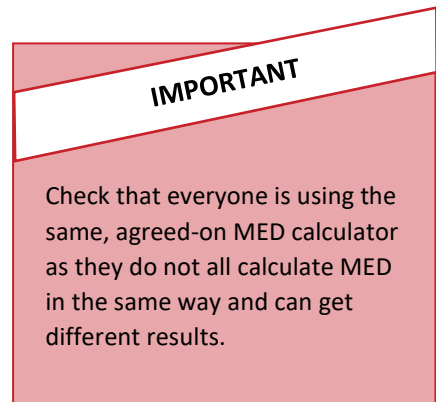
Yes, because you still want to educate these patients about risks, storage, and disposal and assess for aberrant behaviors and OUD. All patients using LtOT deserve high-quality, evidence-based care.

Potential approaches to overcome these issues include:

- Assign someone to sit with unregistered clinicians and walk them through the registration process.
- Block off a patient appointment slot at the start of the morning or afternoon session to make time for the process.
- Use a medical staff meeting to walk all clinicians through the signup process.
- Provide registration instructions as a handout. It might be helpful to break it out into smaller, simpler chunks.
- Strategize approaches with MAs about the best ways to sign up their clinicians.

Consistent MED Calculation Is Possible and Easy for Clinicians and Staff

- Check that an MED calculator is available. Having an MED calculator available on all clinic and office computers makes it more likely that MED will be checked before a change in opioid prescription such as dose or type of medication. Approaches to consider include:
 - Investigate if your EHR has a built-in MED calculator. If so, check the accuracy of the calculation to determine if your clinic wants to rely on it.
 - Put a link to an MED calculator on every computer (e.g., on the desktop, within the EHR, as an internet browser bookmark) and train providers and staff on where to find the calculators.
 - Put an Excel version of an MED calculator on every computer (e.g., on the desktop) within the EHR.
 - Suggest clinicians that use a smart phone download the [CDC Guideline App](#), which includes an MED calculator.
- Identify whether the MED is recorded in the same field within the EHR by everyone and whether that field is retrievable into reports.
- Determine if training on MED calculation is needed. If so, designate someone to manage this process.
- Consider whether an MA or nurse can calculate the MED before rooming or as part of planned visit prep each day.



A Dashboard of Key Measures Is Available for All Patients Using LtOT

To develop a dashboard of key measures for patients using LtOT, it is important for the opioid improvement team to consider:

- What data to track.
- How to collect and store the data.
- How to view and retrieve the data for monitoring success, care gaps, high-risk patients, and clinical variation.

What Data To Track

- The first step in identifying what data to track is to review potential data elements and whether they exist in a form that can be easily stored and pulled for monitoring. Complete the table in the resource [Data to consider tracking](#) to begin this process.

- Based on what your clinic currently records in discrete fields, what is possible, and what your organizational priorities are, what data can you start tracking right now? Make a list of one or two variables to prioritize tracking at first.
- Create an ideal list that includes data not yet able to be tracked but aspirational.
- For organizations with more resources, it might be possible to dive into the ideal list right away.

How To Collect and Store the Data

Investigate how the data your clinic wants to track are currently collected and stored. Consider:

- When the data are collected.
- How data are collected.
- Whether data are collected consistently.
- Whether the data are in discrete fields. If not, can you create discrete fields?
- What needs to change.
- How workflows can support doing this work well.

Consider whether your clinic wants to collect and store data manually (e.g., Excel) or electronically based on your EHR system and its functionality. If you plan to manually track data, consider modifying the [Tracking and monitoring example spreadsheet](#) to include the prioritized variables.

Whatever approach your clinic chooses, it is critical to create [workflows](#) that lay out who will update the data, when, and how.

How To View and Retrieve the Data for Monitoring Success, Care Gaps, High-Risk Patients, and Clinical Variation

Start by developing an approach to pulling a report on your team’s prioritized measures of success.

- Select the best possible approach to tracking and monitoring the prioritized measure of success and stick with it. It may not be perfect, but it is worth trying to regularly review and share data about patients using LtOT as soon as possible to motivate staff and make improvements. Even if the measure is not 100 percent accurate, your clinic will still be able to see the direction it is going over time.
- Continue improving the measurement and reporting approach if needed.
- Once you have identified a feasible way to monitor a prioritized measure of success, use that knowledge to:
 - Add other measures of success;
 - Develop an approach to retrieving data to monitor care gaps and high risk-patients; and
 - Develop an approach to monitor data and measures by clinician so the clinic can examine variation across providers.
- Approaches used by other sites include:
 - Using EHR-embedded dashboards;
 - Querying the EHR and putting the data into a report;
 - Using proprietary software to pull reports from the EHR;
 - Querying an external registry connected to the EHR;
 - Querying an external manual registry (e.g., an Excel spreadsheet maintained by staff); and
 - Pulling reports from the State PDMP database.

Data Are Used To Monitor Care Gaps, High-Risk Patients, and Clinical Variation

- Consider creating a chronic pain management team to review the care of high-risk patients identified through tracking and monitoring data and to make care recommendations to the primary care provider. Refer to the [Chronic Pain Management Teams](#) resource for more information.
- Think through:
 - Who will be involved in putting reports together?
 - How frequently? Often, organizations will review reports quarterly.
 - What will the chronic pain management team do with these data?
- Refer to the example [Opioid list manager workflow](#) for ideas.

Overcoming Common Challenges

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

“Data from Our Tracking and Monitoring Reports Are Not Accurate”

- Ensure staff and clinicians understand why your clinic is collecting the data, how they get collected, how they are being used at the clinic level, and how the clinic, clinicians, and staff can use the data. Emphasize the benefits to patients and care teams.
- Regularly share the data with staff and clinicians, which can motivate clinicians and staff to take the time to enter data accurately.
- Identify which clinicians and staff are struggling to enter accurate data in the EHR, either due to lack of understanding or late adoption. Work with these individuals to identify the problem and assist where needed.
- Conduct refresher training for existing staff and training for new staff on how and where to enter data into the EHR.
- Review whether your process accurately identifies your patients using LtOT. Troubleshoot problems you identify.
- Ensure that clinicians and staff enter data into the EHR consistently and in the same location. For example, MED should be calculated in a similar manner and documented in the designated EHR field for each patient.

“It Is Too Time Consuming To Track and Monitor Patients”

- Identify more than one person who will be responsible for updating and pulling reports. Explore having a care coordinator, refill processor, nurse, MA, or information technology staff member assist with this process.

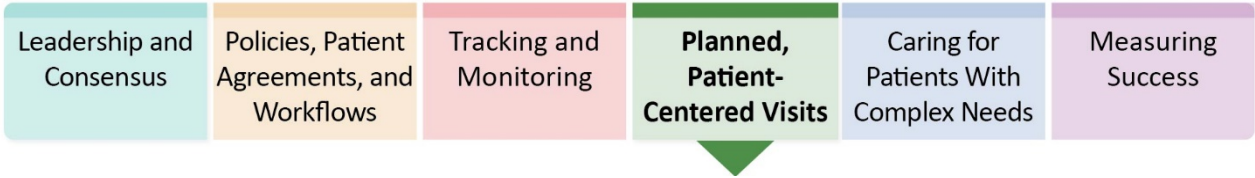
LESSON LEARNED

Do not forget the power of stories to garner buy-in for tracking and monitoring. Think about a relevant story where care could have been better if tracking and monitoring were functioning appropriately. For example, tell a story about a patient who was not in the tracking database. Therefore, when she showed up for a visit, no one had time to check the PDMP. Therefore, it was not recognized that this patient had received a benzodiazepine from another provider in another clinic, placing her at high risk of overdose.

- Ensure your team is tracking only key variables you plan to use for patient care or quality improvement. Only track data you consistently use.
- Build tracking and monitoring tasks into your clinic workflows. Make sure the tracking and monitoring workflow is compatible with other workflows for chronic pain management.
- Consider including the specific duties of tracking and monitoring in a person’s job description.

“Clinicians Do Not Have Time To Look at the Tracking and Monitoring Data”

- Use a list manager who will update patient charts before each visit with pertinent information from the tracking and monitoring system to identify issues such as care gaps.
- Ensure that nurses and MAs have access to the tracking and monitoring system so they can pull data for a provider’s patient if needed.
- Review the data regularly in clinician and staff meetings to ensure that everyone knows the importance of the data.



Planned, Patient-Centered Visits

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 a signature? Who is going to check the State PDMP 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 unusual behaviors, such as early prescription refill requests or an abnormal urine drug test. They can also practice how to best introduce the topic of tapering opioid medications with a patient who has been using high dose LtOT for many years.

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

Milestone	Relevant Resources
Training on patient engagement is offered to staff and clinicians, such as difficult conversations and 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, discussed, and integrated into care processes.	Nonopioid 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 PDMP 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 redistribute the patients using LtOT.	

Tips for Accomplishing Each Milestone

Data Are Used for Previsit Planning

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

- What information is needed for previsit planning? What steps are needed to make these data consistent and available?
- How does your clinic know when a patient using LtOT has an upcoming appointment that needs previsit planning?
- What will the process be to review and use data for previsit and prerefill planning?
- Who is responsible for previsit planning tasks?
- How will these staff and clinicians be trained on these processes?

Once a new policy is in place, having a workflow in place for previsit and prerefill planning helps support policy implementation. Investigate how information is used now for previsit planning. How could it be done better? Test and adjust to build effective workflows for tracking and monitoring data for previsit and prerefill planning. Continue to iterate this approach 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 *Opioid Risk Tool*; *Pain, Enjoyment, and General Activity scale*; and *Patient Health Questionnaire*—and goal setting into an EHR template so the provider does not need to look for these scales in multiple places during a visit.
- Ensure that EHR templates are 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 Previsit Planning and Pain Visits Are Integrated Into the Practice

After developing and training on workflows to support previsit 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 used 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 adjusting workflows to support these processes;
- Conducting peer chart reviews. Clinicians can be assigned to review another clinician’s charts for one or two priority activities (e.g., State PDMP database check); and
- Having 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*;
- *Understanding Naloxone*: what is it and how to administer it;
- Opioid-induced conditions (e.g., hyperalgesia, constipation);
- Tapering;
- *Self-management strategies*; and
- *Activity pacing*.

- Adapt resources so they are appropriate for your clinic’s patients.
- Consider asking your patients for their advice on materials.
- 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 to carve out adequate time for education with the patient.

LESSON LEARNED

Consider using a care coordination model for your patients using LtOT. What can you learn from a care coordination approach to managing patients with diabetes?

Training on 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 at the *Oregon Pain Guidance* website).
- Identify if anyone on your staff has skills in the desired training areas—such as motivational interviewing—and invite them to present and 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 nonopioid 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 note 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

Below are approaches clinics have used 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 that clinicians and staff understand why the State PDMP 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 PDMP database. Have the delegate look up this information as part of routine previsit planning and document this information in the patient’s chart on behalf of the provider.
- Track and monitor the use of the State PDMP database and share the data with the care teams.

“Some Care Teams Are Not Calculating MED”

- Ensure that you have properly educated care teams on the importance of 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 can, 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 approach will demonstrate that the clinic cares about these numbers, will foster competition among teams, and will create opportunities for collaboratively thinking through tough cases.

LESSON LEARNED

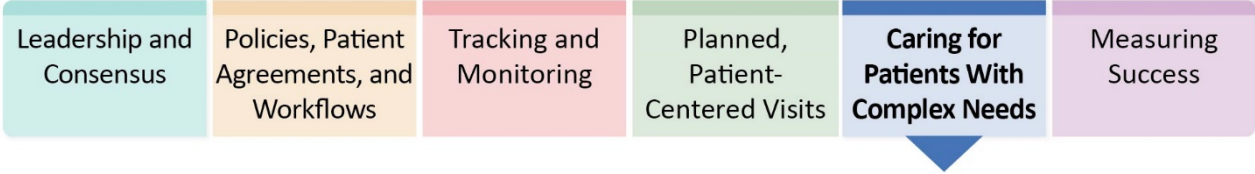
One medical director shared a story with his clinic about how easy it is to let care processes slip. One day, a clean-cut college student came asking for a controlled substance refill. The patient was new and normal procedures would suggest the provider not write the prescription on the first visit, 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.

“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 testing is standard care for all patients using LtOT, that it is part of the patient agreement, and that it is being done for their safety. 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.”

“A Clinician Is Leaving and We Need To Redistribute Patients”

- If possible, have departing clinicians create a list of their patients using LtOT, annotate with key information, identify an accepting provider, and discuss the patients with this provider.
- Develop an agreed-on redistribution process in collaboration with other clinicians. This process might redistribute patients based on patient request and current patient load.
- Consider using risk tiering of patients to help with redistribution. Low-risk patients can be given to any provider and high-risk patients only to those more comfortable and experienced with pain management.
- Review the resource [Patients on legacy opioid prescriptions](#) during a clinician meeting so clinicians have suggested approaches for the first appointments with any patients using legacy prescriptions.



Caring for Patients With Complex Needs

Overview

Chronic pain can be complicated by other conditions that require special attention, namely mental/behavioral health conditions, OUD, and other substance use disorders (SUDs). Insufficiently addressed mental/behavioral health conditions can interfere with successful pain management.

For patients with OUD, full-agonist opioids used to treat pain (e.g., oxycodone, hydrocodone) are rarely the best choice and often the wrong medication for their pain. Medications such as buprenorphine, naltrexone, and methadone are needed for patients with OUD. Patients with other SUDs require assessment and treatment for their disorder in addition to treatment for their chronic pain.

Identifying additional and appropriate resources for these patients and creating systems to connect patients to these resources are essential for an effective chronic pain management plan. Some of these resources might be developed or brought “in-house” within the primary care clinic setting, while others will need to be identified in the local community and linkages established to them.

By implementing opioid management improvements using the Six Building Blocks, clinics become more aware of the existence of OUD. Clinics find that offering buprenorphine treatment onsite allows them to provide their patients a full spectrum of care.

Milestone	Relevant Resources
Tools are selected and consistently in use to identify patients with complex needs, such as mental or behavioral health disorders, OUD, or other SUDs.	Assessment tools web page MATx Mobile App OUD diagnosis form Substance use screening and assessment instruments database
Educational opportunities are provided to clinicians on how to identify and treat patients with OUD and other SUDs.	CDC, Assessing and Addressing Opioid Use Disorder UW TelePain, Assessing Chronic Pain Patients for Opioid Use Disorder UW TelePain, Buprenorphine in Primary Care Practice Harvard Medical School, Identification, Counseling, and Treatment of OUD Harvard Medical School, Collaborative Care Approaches for the Management of OUD PCSS Mentoring Program SAMHSA, Substance Use Treatment for Persons wWith Co-Occurring Disorders

Milestones	Relevant Resources
There is an approach to connecting patients to mental/behavioral health resources, integrated in the primary care setting, in the community, or through telehealth.	AHRQ, Integrating Behavioral Health and Primary Care Playbook The Behavioral Health Specialist
There is an approach to connecting patients with OUD or SUD to treatment, either internally through waived providers or externally through identified treatment facilities.	PCSS Online MAT Waiver Training Developing a Buprenorphine Treatment Program for Opioid Use Disorder in Primary Care SAMHSA, Find Medication-Assisted Treatment webpage SAMHSA, A Guide to Substance Abuse Services for Primary Care Clinicians
Confidentiality regulations and other information sharing hurdles have been addressed so that patient information can be shared between medical, behavioral health, and SUD clinicians.	SAMHSA fact sheet on 42 CFR Part 2 Revised Rule SAMHSA decision guide on 42 CFR Part 2 Release form from PCSS
Training is provided to clinicians and staff on overcoming stigma about patients with mental/behavioral health needs, OUD, and other SUDs.	Alberta Health Services, Reducing Stigma Johns Hopkins, Guiding Principles for Addressing the Stigma on Opioid Addiction PCSS, Changing Language to Change Care
Common Challenges	
Some of our patients cannot access mental/behavioral health resources.	
Clinicians are not comfortable asking the question about past sexual abuse included in the Opioid Risk Tool.	
We do not have medication for OUD treatment services available for patients with OUD.	

Tips for Accomplishing Each Milestone

Tools Are Selected and Consistently in Use To Identify Patients With Complex Needs

- During policy and workflow development, select tools and intervals for use that allow your clinic to identify patients with complex needs. Refer to the [model policy](#) and [assessment tools web page](#).
- Train clinicians and staff on where to access these tools and how to use them.
- Have a member of your team who offers medication treatment for OUD review tracking and monitoring data to identify patients who need additional screening.
- Provide additional training for clinicians and staff about recognition and treatment of OUD, other SUDs, and common coexisting mental/behavioral health conditions.

Educational Opportunities Are Provided to Clinicians on How To Identify and Treat Patients With OUD and Other SUDs

- Make trainings on diagnosing and treating OUD and other SUDs—such as the CDC webinar [Assessing and Addressing Opioid Use Disorder](#)—available to clinicians and staff.

There Is an Approach to Connecting Patients to Mental/Behavioral Health Resources, Integrated in the Primary Care Setting, in the Community, or Through Telehealth

- Identify resources in your clinic and in your community for addressing mental/behavioral health needs.
- Consider insurance coverage and travel distance limitations when identifying resources.
- Consider developing telemedicine resources for patients with mental/behavioral health needs if they are not available onsite or in the community.
- Build relationships with external organizations that offer mental/behavioral health services.
- Train clinicians and staff on processes to connect patients to these resources.

There Is an Approach to Connecting Patients With OUD or Other SUDs to Treatment, Either Internally Through Waivered Providers or Externally Through an Identified Medication for OUD Treatment Facility

- Identify resources in your clinic and in your community for addressing complex issues, such as outpatient substance use treatment programs, methadone clinics, addiction specialists, and pain management specialists.
- Encourage clinicians to get waivered to prescribe buprenorphine.
- Use the [Developing a Buprenorphine Treatment Program for Opioid Use Disorder in Primary Care](#) guide to support your clinic's waivered clinicians in prescribing buprenorphine.
- Consider insurance coverage and travel distance limitations when identifying resources.
- Consider developing telemedicine resources for patients with OUD if they are not available onsite or in the community.
- Build relationships with external organizations that offer medication for OUD. Train clinicians and staff on processes to connect patients to these resources.

Confidentiality Regulations and Other Information Sharing Hurdles Have Been Addressed So That Patient Information Can Be Shared Between Medical, Behavioral Health, and SUD Clinicians

- Determine whether your practice or department is covered under [42 CFR Part 2](#). SAMHSA provides a [decision guide](#) to identify if your organization or practice needs to be compliant. If applicable to your organization, it is critical that clinic administration puts systems in place to ensure that these regulations are followed.
- If applicable, ensure that all clinic staff and clinicians understand the confidentiality policies that adhere to 42 CFR Part 2.
- If applicable, ensure that your clinic's permission for record disclosure form is compliant with 42 CFR Part 2.
- Ensure your clinic has a standardized process to have patients sign a Release of Information form with primary care, behavioral health, and SUD departments or agencies so they can communicate about their treatment plans.
- Ensure a way for behavioral health and SUD clinicians to have a direct way to contact primary care providers about urgent concerns and vice versa.

Training Is Provided to Clinicians and Staff on Overcoming Stigma About Patients With Mental/Behavioral Health Needs, OUD, and Other SUDs

- Connect clinicians and staff to training on overcoming stigma, such as [Changing Language to Change Care: Stigma and Substance Use Disorder](#).

Overcoming Common Challenges

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

“Some of Our Patients Cannot Access Behavioral Health Resources”

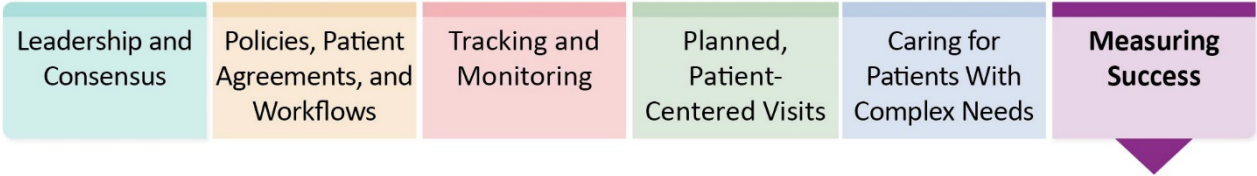
- Look into options outside your community, such as telemedicine opportunities.
- Contact your State health department or [SAMHSA](#) for a list of resources.

“Clinicians Are Not Comfortable Asking the Question About Past Sexual Abuse in the Opioid Risk Tool”

- Encourage the provider to seek further training on asking potentially sensitive questions and addressing difficult issues.
- Have the patient fill out the [Opioid Risk Tool](#) on paper. The provider can then review the recorded results with the patient.
- Give clinicians scripts with language to use and have them practice using these scripts with each other.
- Encourage participation in clinical education programs that discuss the strong evidence base for asking this question. A history of sexual abuse is a risk factor for OUD. Asking about a history of sexual abuse can also help identify individuals with post-traumatic stress disorder.
- Ensure that clinicians know that asking about past sexual abuse can provide an opportunity to get patients the help they have been afraid to ask for but want.
- Consider using the [ORT-OUD](#) assessment instead, which is validated for assessing the risk of developing OUD but does not ask the sexual abuse question.

“We Do Not Have Medication for OUD Treatment Services Available”

- Consider starting medication for OUD treatment services in your clinic.
- Identify the nearest treatment program with medication for OUD and develop a relationship with that program.
- Identify and connect with local, State, and national resources that support clinicians in offering medication for OUD treatment. Provide the support needed for your clinicians willing to begin prescribing medication for OUD.



Measuring Success

Overview

Teams need to see that the changes they are asked to implement are having the desired effect. Selecting a set of one or more measures to track over time and providing that information to the entire clinic team at the local level are crucial to improving and sustaining the work. Examples might include percentage of patients with a signed updated patient agreement or percentage of patients using high-dose opioids.

Set an aim for improvement over a set period and provide clinicians and staff with frequent updates on progress. Finally, make reporting of these measures a standing agenda item, such as at monthly staff meetings and clinic huddles.

Milestone	Relevant Resources
Success measures identified	Measuring success metrics metrics Six Building Blocks milestones CDC QI metrics DIY run chart Measuring outcomes survey
Success measure regularly reviewed and reported at the clinician level	Purposes of tracking and monitoring Chronic pain management teams

Common Challenges
We do not have the infrastructure to pull EHR-based reports on patients using LtOT.
We do not know enough about our patient population to set a goal.

Tips for Accomplishing Each Milestone

Success Measures Identified

- Do not let perfection get in the way of selecting a measure and sharing it with your clinic. The purpose is to be able to see your progress for any measurable aim that is important to your clinic. Start small and grow as your capacity to measure grows.
- See the section [Discuss Using Data To Measure Success](#) for additional ideas.

Success Measure Regularly Reviewed and Reported at the Clinician Level

- Consider creating a chronic pain management team to monitor and respond to tracking and monitoring data. Refer to the [Chronic Pain Management Teams](#) resource for more information.
- Think through:
 - Who will be involved in putting reports together.
 - How frequently reports will be issued. Often, organizations will review reports quarterly.
 - What will be done with these data.
- Refer to the example [Opioid list manager workflow](#) for ideas.

LESSON LEARNED

One clinic used televisions in staff areas to report quality measures overall, by team, and by clinician. This approach demonstrated transparency and promoted a healthy culture of competition to achieve clinic quality goals.

Overcoming Common Challenges

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

“We Do Not Have the Infrastructure To Pull EHR-Based Reports”

- Consider approaches that clinics used before the era of EHRs. For instance, if early refills are an area of focus for your clinic, have an MA or refill coordinator hand **tally** calls for early refills for one week each quarter.
- Pick one feasible, important measure and focus on how to gather, review, and share those data quarterly in a consistent manner. The data do not need to be perfect. You can grow your reports as your capacity increases.
- Track MED manually with each refill and track how the data change over time.

“We Do Not Know Enough About Our Patient Population To Set a Measure of Success”

- Even if your team does not have much formal data about your clinic’s patient population, your clinicians and staff are familiar with what is currently challenging about providing care to patients using LtOT. Talk with clinicians and staff to identify a goal that is meaningful to your organization and that you can feasibly measure.
- Remember that this task can be as simple as a hand tally of a measure important to your staff or clinicians.
- Consider measuring clinician and staff burnout over time as an outcome of this work.
- Add population health goals once your team has established a tracking and monitoring program.

End of Design and Implement Stage

NEXT UP: Celebrate successes and plan sustainability; see *the Monitor and Sustain Guide*.

Appendix 1: Action Plan Templates

Detailed Action Plan

Activity:

Manager of this process:

Date for completion:

Steps necessary to achieve this goal (What)	Person responsible (Who)	When

Simple Action Plan

Activity	Manager of process	Date for completion

Appendix 2: Example First Action Plan

This Action Plan is to guide your clinic’s work over the next three months (through May 1). It outlines the activities we discussed during our Action Plan Meeting and includes clear steps, responsible parties, due dates, and supporting resources.

Leadership and Consensus Activities

Activity: **Regularly emphasize project importance and solicit feedback**

Manager of this process: **Jan**

Date for completion: **Continuous, but plan in place by February 28**

Relevant resources:

- *Opioid harm stories*
- *Motivating providers who are slow to adopt*
- *Levers of motivation guide*

Steps necessary to achieve this goal (What)	Person responsible (Who)	When
Add a thermometer or other visual about the Six Building Blocks work to quality boards in the hallway downstairs. First thermometer will record progress on getting correct chronic pain diagnosis in chart.	Monica	By early February
Add Six Building Blocks work as a standing item at meetings (ideas: share success stories, discuss difficult cases, update on success measure, share other data)	Bill	By late February

Activity: **Offer clinical education opportunities to staff and clinicians**

Manager of this process: **Jan**

Date for completion: **Continuous, but TelePain access begun by March**

Relevant resources:

- *UW TelePain resources*
- *CDC training and webinars*

Steps necessary to achieve this goal (What)	Person responsible (Who)	When
Register with TelePain	Sonia	By early February
Set up in the main room with the big television and let people know they can join	Jan	By late February
Distribute TelePain didactic slides each month to clinic	Sonia	Once a month
Add to Lunch and Learns; identify topics and organize (include a training by Steve on Motivational Interviewing)	Monica, Jan, Marcy	By late February

Policies, Patient Agreement, and Workflow Activities

Activity: **Revise our policy to align with evidence-based guidelines**

Manager of this process: **Bill**

Date for completion: **April**

Relevant resources:

- [Policy model](#)
- [CDC Guideline](#)
- VA [taper decision tool](#)
- [Tips for patients](#) on legacy prescriptions

Steps necessary to achieve this goal (What)	Person responsible (Who)	When
Identify initial revisions after reviewing the Six Building Blocks model and state guidelines and send these revision ideas to Heather	Bill	January
Draft initial edits for policy and send to core working group	Jan	January
Review new draft to make additional edits before bringing to the larger Opioid Improvement Team (include Mike)	Core working group (Bill, Jan, Monica, Joy?)	February
Opioid Improvement Team will review draft and make additional edits before sending to the clinicians for review	Opioid Improvement Team	February
Clinicians will review and provide feedback	Bill	March
Staff will review and provide feedback	Jan	March
Final edits	Jan	April
Approval process	Bill	April

Activity: **Revise our patient agreement to support our policy and educate patients about risks**

Manager of this process: **Bill**

Date for completion: **May**

Relevant resource:

- [Patient agreement model](#)

Steps necessary to achieve this goal (What)	Person responsible (Who)	When
Based on policy drafted for provider review, identify initial revisions to the patient agreement and send to Heather	Bill	February
Draft initial edits for agreement and send to core working group	Jan	February
Review new draft and make additional edits before bringing to the larger Opioid Improvement Team (include Mike)	Core working group (Bill, Jan, June, Joy?)	March
Opioid Improvement Team will review draft and make additional edits before sending to the clinicians for review	Opioid Improvement Team	March
Clinicians will review and provide feedback	Bill	April
Staff will review and provide feedback	Jan	April
Final edits	Jan	May
Approval process	Bill	May

Tracking and Monitoring Patient Care Activities

Activity: **Identify patients using LtOT with the diagnosis (F11.90) in the EHR**

Manager of this process: **Jan**

Date for completion: **February**

Steps necessary to achieve this goal (What)	Person responsible (Who)	When
Give each provider (and their MA) their list of patients who should have F11.90 in the chart and those who have it but should not (NOTE: this clinic had already identified who their patients were through the state prescription drug monitoring program and provider checks)	Jan	Mid-January
Advertise that this is the first success measure for the Six Building Blocks project	Bill (and June with thermometer in hall?)	Mid-January
MAs guide clinicians and ensure that they assign the correct diagnosis of chronic pain (F11.90) in the problem list for appropriate patients	Jan	January 31

Activity: **Develop EHR pain visit templates to cover key elements of the pain visit as outlined in the revised policy**

Manager of this process: **Smith**

Date for completion: **After policy revision**

Relevant resources:

- [Pain Tracker](#)

Steps necessary to achieve this goal (What)	Person responsible (Who)	When
Develop Epic smart sets to support the policy	Smith	March

Milestones for Next Time

Calculating MED consistently is possible and easy for clinicians.

Success Measure

By February 2019, all patients using chronic continuous opioids (F11.90) have this diagnosis in the chart and those who are not using chronic continuous opioids do not have this diagnosis in the chart.

FULL PROGRAM:
MONITOR AND SUSTAIN GUIDE

Six Building Blocks

*A Team-Based Approach to Improving
Opioid Management in Primary Care*

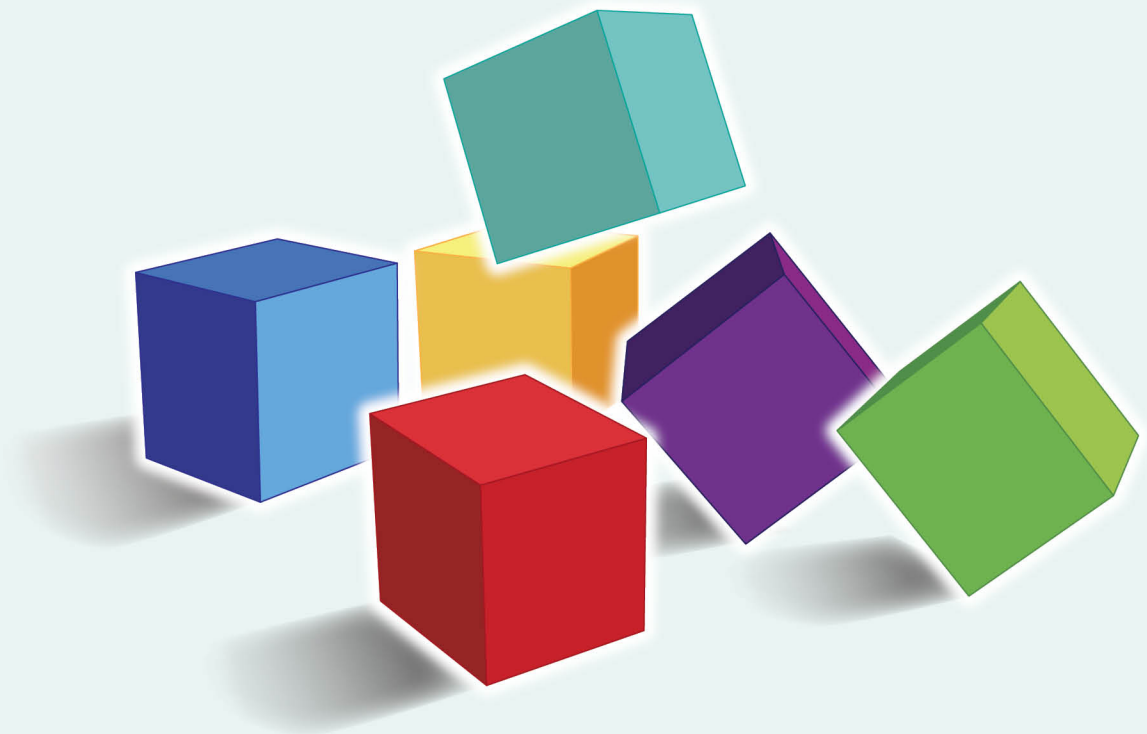


Table of Contents

- Introduction1**
 - What Is the Monitor and Sustain Guide?..... 2
 - What Is in the Monitor and Sustain Guide?..... 2
 - Monitor and Sustain Process 2
- Prepare for the Success and Sustainability Meeting3**
 - Objective 3
 - What Is Going on During This Step 3
- Facilitate the Success and Sustainability Meeting.....4**
 - Success and Sustainability Meeting Overview 4
 - Success and Sustainability Meeting Details 5
- Launch the New Stage of Work: Monitor and Sustain Improvements.....7**
 - Ongoing Activities 7
- Congratulations!8**
- Appendix 1: Six Building Blocks Resource Library9**

Introduction

The Six Building Blocks for Improving Opioid Management (Six Building Blocks or 6BBs) program offers a roadmap for improving a primary care clinic's management of patients who are on long-term opioid therapy (LtOT) for chronic pain. The 6BBs supports you in **redesigning opioid management** processes by addressing:



Leadership and Consensus

Demonstrate leadership support and build organizationwide consensus to prioritize more selective and cautious opioid prescribing.



Policies, Patient Agreements, and Workflows

Revise, align, and implement clinic policies, patient agreements, and workflows for healthcare team members to improve opioid prescribing and care of patients with chronic pain.



Tracking and Monitoring

Implement proactive population management before, during, and between clinic visits of all patients on chronic opioid therapy.



Planned, Patient-Centered Visits

Plan and prepare for the clinic visits of all patients on chronic opioid therapy. Support patient-centered, empathic communication for care of patients on chronic opioid therapy.



Caring for Patients With Complex Needs

Develop policies and resources to ensure that patients who develop opioid use disorder or need mental/behavioral health resources are identified and provided with appropriate care, either in the care setting or by outside referral.



Measuring Success

Continuously monitor progress and improve with experience.

A 6BBs How-To-Implement Toolkit (hereafter, Implementation Toolkit) was developed to provide clinics with support for engaging in this improvement work. Depending on an organization's capacity, there are two approaches: the Fast Track Approach and the Full Program Approach; see Six Building Blocks Implementation Toolkit Overview.

What Is the Monitor and Sustain Guide?

The **Monitor and Sustain Guide** is a resource for the third stage of the Full Program Approach: **Monitor and Sustain**. The work of this stage focuses on setting up a plan for maintaining the improvement clinics have made during the Design and Implement stage. While anyone can use these materials to implement improvements in chronic pain and opioid medication management, it is specifically written for quality improvement leaders and project managers to use in guiding an improvement team and care teams through the Six Building Blocks implementation process.

What Is in the Monitor and Sustain Guide?

- The Monitor and Sustain Guide walks you through transitioning your organization from intensive opioid management improvement work to less intensive continuous improvement and sustainability.
- The Guide walks you step by step through preparing for and facilitating a Success and Sustainability Meeting with your opioid improvement team.

Stage 3: Monitor and Sustain

- Assess and celebrate progress from baseline
- Develop a plan for sustainability
- Reassess evidence, guidelines, and regulations and revise approach as needed

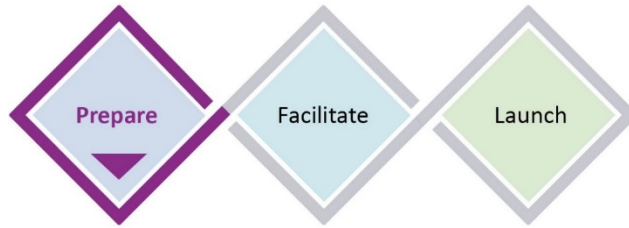
Monitor and Sustain Process

An organization is ready to move on to the Monitor and Sustain Stage once it has completed most of its prioritized Six Building Blocks Design and Implement Milestones and feels capable of continuing the improvement work with less hands-on time.

Generally, this achievement happens about 6 to 12 months into the second stage, Design and Implement. The Monitor and Sustain Stage takes about 1 month to put into place and then it is a continuous process.

It is a time to thoughtfully transition to a less intensive focus on opioid management improvement while sustaining the successes achieved through the Design and Implement Stage. The three steps in the Monitor and Sustain Stage are:





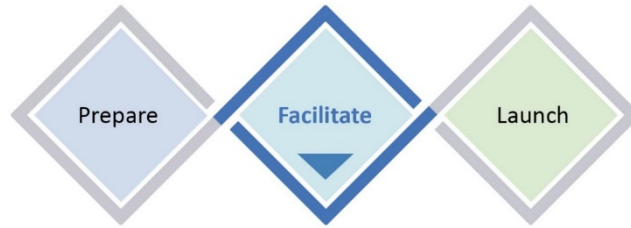
Prepare for the Success and Sustainability Meeting

Objective

Gather and summarize data that can be used in the Success and Sustainability Meeting.

What Is Going on During This Step

- Complete the *Measuring Outcomes Survey*.
- Prepare a summary of progress from baseline and potential next steps for the opioid improvement team.
 - Review your Prepare and Launch Stage notes, baseline Self-Assessment summary, Kickoff Survey summary, milestones checklist you have maintained, and Measuring Outcomes Survey.
 - Use these documents to prepare the summary. Consider using *the Success and Sustainability PowerPoint template*.



Facilitate the Success and Sustainability Meeting

Success and Sustainability Meeting Overview

Time

1 hour

Objectives

Celebrate successes, identify potential next steps, and think through sustainability.

Who Should Attend

Opioid improvement team

Relevant Materials To Bring to This Meeting

- *Success and Sustainability slides*
- *Sustainability handout*
- *Monitor and Sustain activities checklist*
- *Relevant Six Building Blocks resources*

Agenda

1. Celebrate successes.
2. Plan next steps.
3. Think through challenges to sustainability.

Success and Sustainability Meeting Details

Use the [Success and Sustainability slides](#) you updated to guide the opioid improvement team through the content of this meeting.

Celebrate Successes

- Review and celebrate key successes of the opioid management improvement work.
- Share any data that illuminate progress over time. For example, show data comparing baseline and end of project data from the [Measuring Outcomes Survey](#) or any [run charts](#) in use.

Plan Next Steps

- Reflect on challenges identified both at baseline and through the improvement process, as well as identified priorities. Celebrate progress and make a plan for any areas that present an opportunity for improvement.
- Review any [milestones](#) not yet achieved and develop a plan and supports for that work.

Think Through Challenges to Sustainability

Consider the following sustainability concepts (from the [Sustainability Handout](#)) to help make a sustainability plan. The concepts were adapted from [How To Build Sustainability Into the Innovation Process](#).

Engagement

Continue to keep leadership, staff, and clinicians engaged in the process by:

- Continuing to share data related to opioid management publicly at clinician and staff meetings and promote success stories (both about patients and about improved worklife) to remind everyone of the value of the work.
- Checking in at least annually to see if the processes are still working and that any new changes are in fact improvements (e.g., by scheduling regular check-in meetings or integrating this work into standing quality improvement processes).
- Continuing to identify ways you can make changes in policies, agreements, workflows, tracking and monitoring, resources for complex patients, and other items in response to feedback. Ensure you have compelling reasons for any changes and that changes are supported and evaluated to see if a change results in an improvement.

Education

Continue to educate staff and clinicians by:

- Integrating opioid management training into regular staff meetings, trainings, newsletters, and other communication. Training is not “one and done.”
 - Including opioid management training in onboarding. Make sure new staff understand the key opioid policies and processes and why they are important.
 - Continuing to provide opportunities for staff and clinicians to receive education on opioid management. Evidence-based medicine evolves. See the [Clinical Education Opportunities](#) resource for ideas.
 - Continuing to adapt and improve in response to new evidence-based guidelines. Educate clinicians and staff about the compelling reasons for any changes and involve them in developing and iterating new workflows to support the changes.

Culture

If possible, integrate opioid management into a culture of patient safety and continuous improvement at your organization. One way to do this is to make reviewing measures a regular part of clinic activities.

Measurement

By continuing to monitor opioid management measures and share them with key stakeholders (e.g., leadership, involved staff and clinicians), you can:

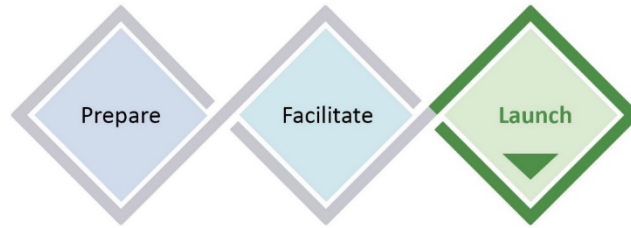
- Encourage continual buy-in for the processes.
- Identify any issue that needs further investigation and adjustment.

Infrastructure

Identify ways to “hardwire” your changes. You have done much of this already by writing policies and workflows and updating your electronic health record templates. You might also consider including tasks integral to maintaining the opioid management program in job descriptions.

Staffing

Your opioid improvement team has been instrumental in keeping this work moving forward. So what happens if one of you leaves? It is important to have a backup for key roles.



Launch the New Stage of Work: Monitor and Sustain Improvements

You should now be able to transition to less intensive opioid management improvement in order to continually improve quality of care for patients on LtOT. Below are suggested activities for this new stage.

Ongoing Activities

Leadership and Consensus

- Continue to protect time to monitor and sustain the work (e.g., include opioid management improvements in standard quality improvement processes);
- Continue to engage leadership, staff, and clinicians by regularly sharing opioid performance measure data and stories;
- Periodically assess adequacy of resources needed to support opioid management processes and identify additional resources if needed;
- Obtain feedback from staff and clinicians about what is working and what is not working and test approaches to address concerns;
- Identify reluctant clinicians and staff and identify *strategies* to improve *engagement*; and
- Stay up to date with evidence-based guidelines and new regulations (Medicaid, Centers for Disease Control and Prevention, State).

Policies, Patient Agreements, and Workflows

- Revisit and revise policies, patient agreements, and workflows; this task should be completed annually or as needed based on feedback, new evidence, and regulations.

Tracking and Monitoring Patient Care

- Adjust and iterate best possible tracking and monitoring approaches.

Planned, Patient-Centered Visits

- Offer educational opportunities in opioid management, empathic communication, and patient involvement to clinicians and staff;
- Integrate opioid management processes into standard training, including onboarding new employees; and

- When workflows need development or updating, involve those who will do the work and do small-cycle tests of change before implementing changes across the organization.

Caring for Complex Patients

- Ensure clear referral pathways for complex patient resources and close the loop on referrals; and
- If not already in place, consider providing opioid use disorder treatment within the clinic.

Measuring Success

- Produce clinician-specific reports on measures and discuss during medical staff meetings;
- Regularly review performance measure data at the level of the clinic during staff meetings and other opportunities; and
- Identify additional opportunities for improvement and implement small-cycle tests of change.

Congratulations!

You have completed the Six Building Blocks How-To Implementation Toolkit, Full Program Approach.

Throughout the toolkit, we have referred to the many resources available from the Six Building Blocks [website](#). Appendix 1 shares information and links to the Six Building Blocks Resource Library sections.

Appendix 1: Six Building Blocks Resource Library

The Six Building Blocks program has created a [Resource Library](#) to help clinics and practice facilitators improve opioid management using the Six Building Blocks.

The resources are divided into the following three sections.

[Resources for Clinics](#)

These resources support clinics in implementing each Building Block. Resources include a model policy, tapering guidelines, and tips for having difficult conversations with patients on long-term opioid therapy.

[Recommended Assessments](#)

This page contains clinical assessment tools, such as the Opioid Risk Tool and the Pain, Enjoyment, and General Activity assessment. It also includes suggested frequencies for tool use and relevant articles.

[Resources for Practice Facilitators](#)

These resources support the practice facilitator in helping clinics implement the Six Building Blocks. The Prepare and Launch Guide, Design and Implement Guide, and Monitor and Sustain Guide walk the practice facilitator through the steps of each implementation stage.