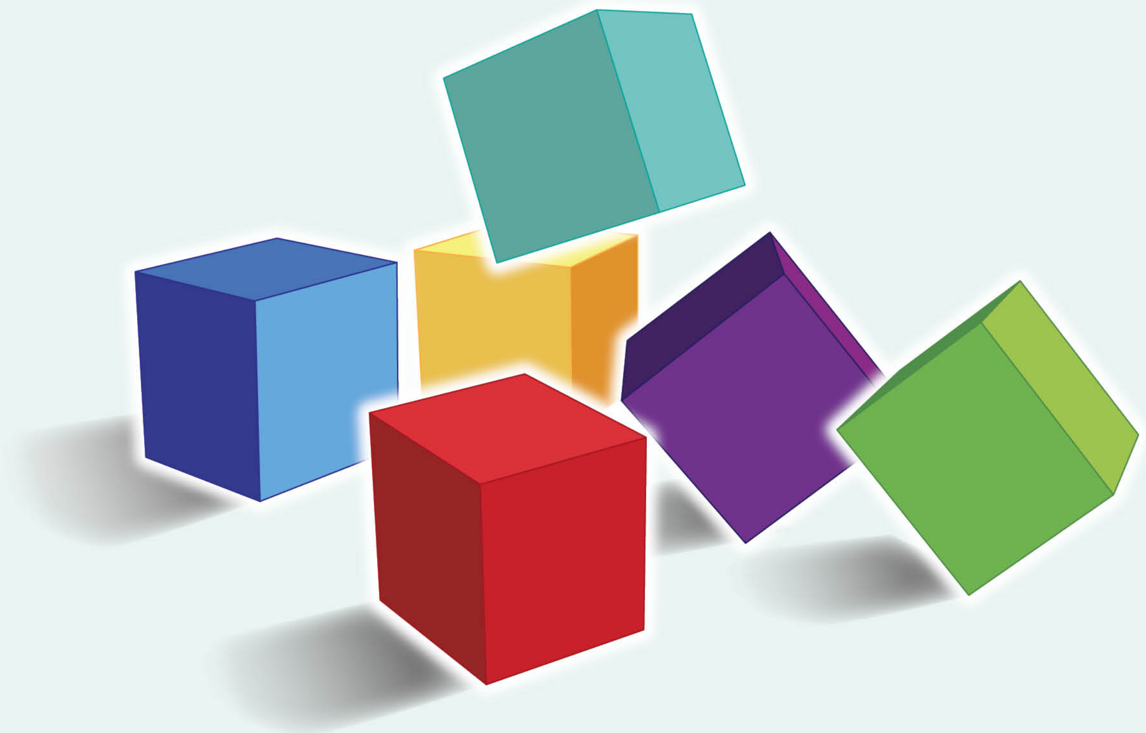
How-To-Implement Toolkit

FULL PROGRAM:
DESIGN AND IMPLEMENT GUIDE

Six Building Blocks

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



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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***.

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.

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.

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

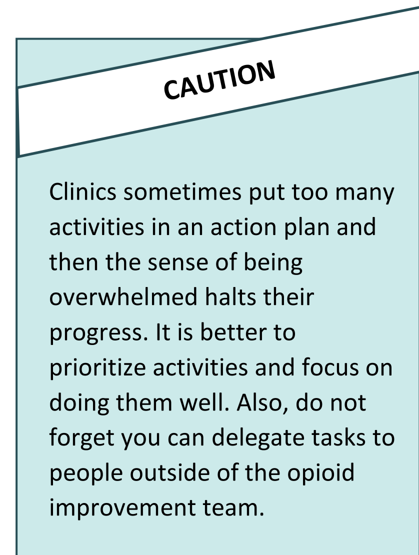
EXAMPLE

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

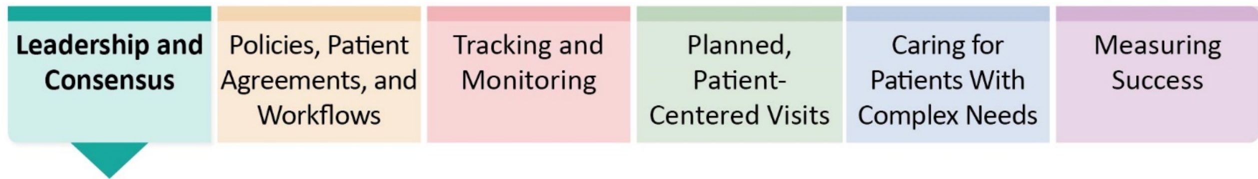
This section walks through suggestions for implementing improvements to opioid management in each of the Six Building Blocks areas. For each Building Block, it includes:

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

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.

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

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.

- 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.

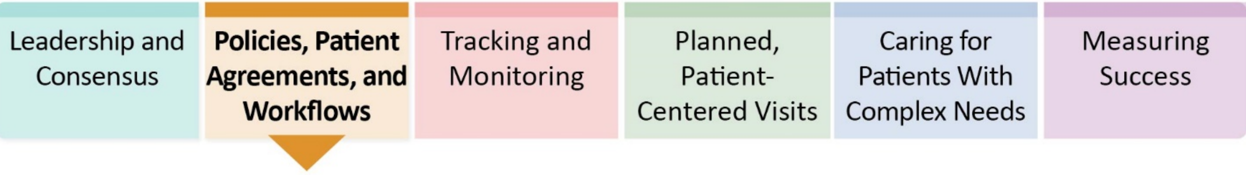
LESSON LEARNED

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).	***Policy model*** ***CDC opioid prescribing guideline*** State and local guidelines ***Tips for patients on legacy prescriptions*** ***Suggested opioid management schedule*** ***Risk stratification and opioid prescribing***
Patient agreement revised to support the policy and educate patients about risks.	***Patient agreement model***
Workflows written to support policies.	***Chronic pain appointment workflow*** ***Opioid refill workflow*** ***Opioid list manager workflow*** ***Remote urine drug testing FAQ and workflow***
Training conducted on policies, agreement, workflows, and supporting EHR templates.	***Rollout and training*** ***Provider guide to difficult conversations*** ***Staff guide to difficult conversations***
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.

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.

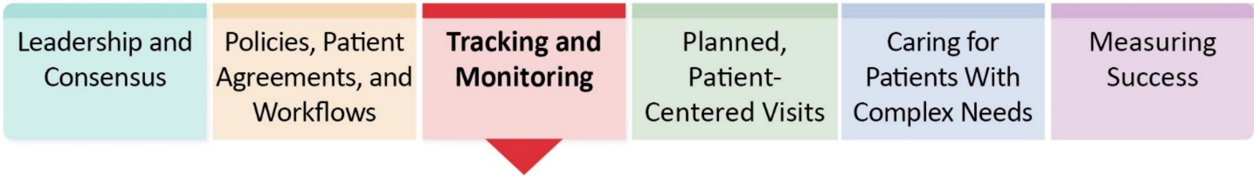
- When training on new workflows, be ready to provide clinicians and staff with a realistic estimate of how long the processes will take.
- Provide thorough training on how to use EHR templates so clinicians and staff can implement with confidence.
- Provide needed resources, such as ***AHRQ Clinical 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.

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. (*Delegates are staff who may access the data on behalf of a clinician.*)	***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.

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.

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.

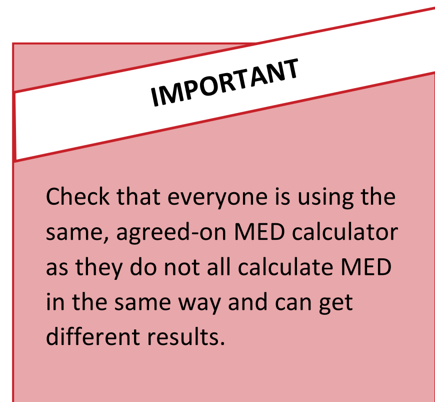
If permitted in your State, sign up delegates—staff who can check the State PDMP database on the clinician's behalf—who might have more time to check the database before patient visits.

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.

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.

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.

"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.

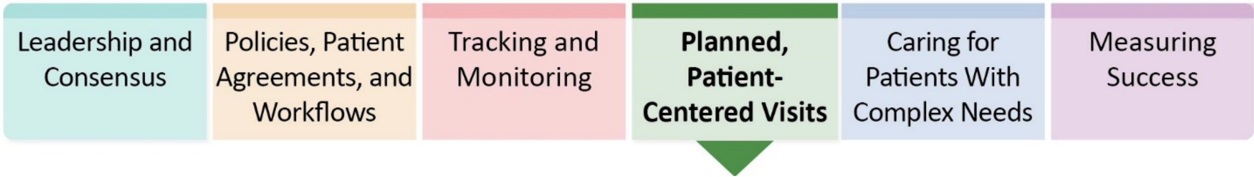
"It Is Too Time Consuming To Track and Monitor Patients"

- 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.

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

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

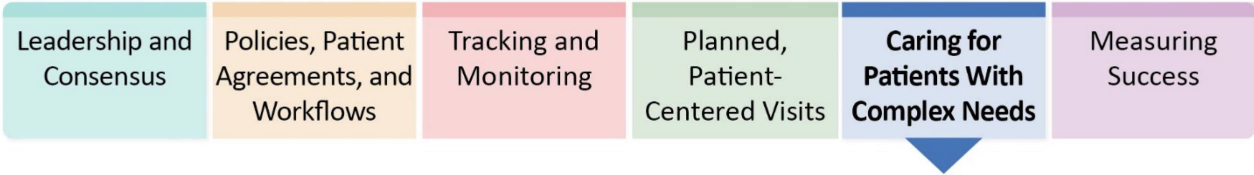
One medical director shared a story with his clinic about how easy it is to let care processes slip. One day, a clean-cut college student came asking for a controlled substance refill. The patient was new and normal procedures would suggest the provider not write the prescription on the first visit,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

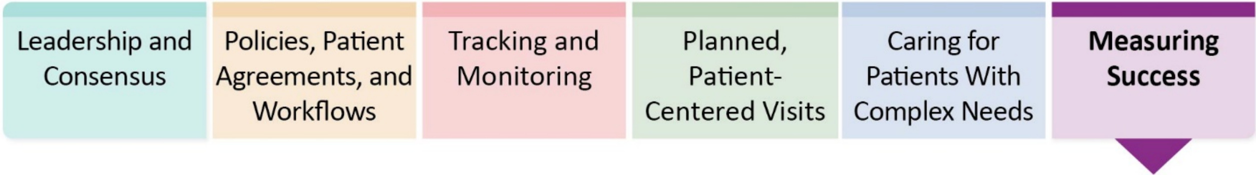
- Look into options outside your community, such as telemedicine opportunities.
- Contact your State health department or ***SAMHSA*** for a list of resources.

"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.