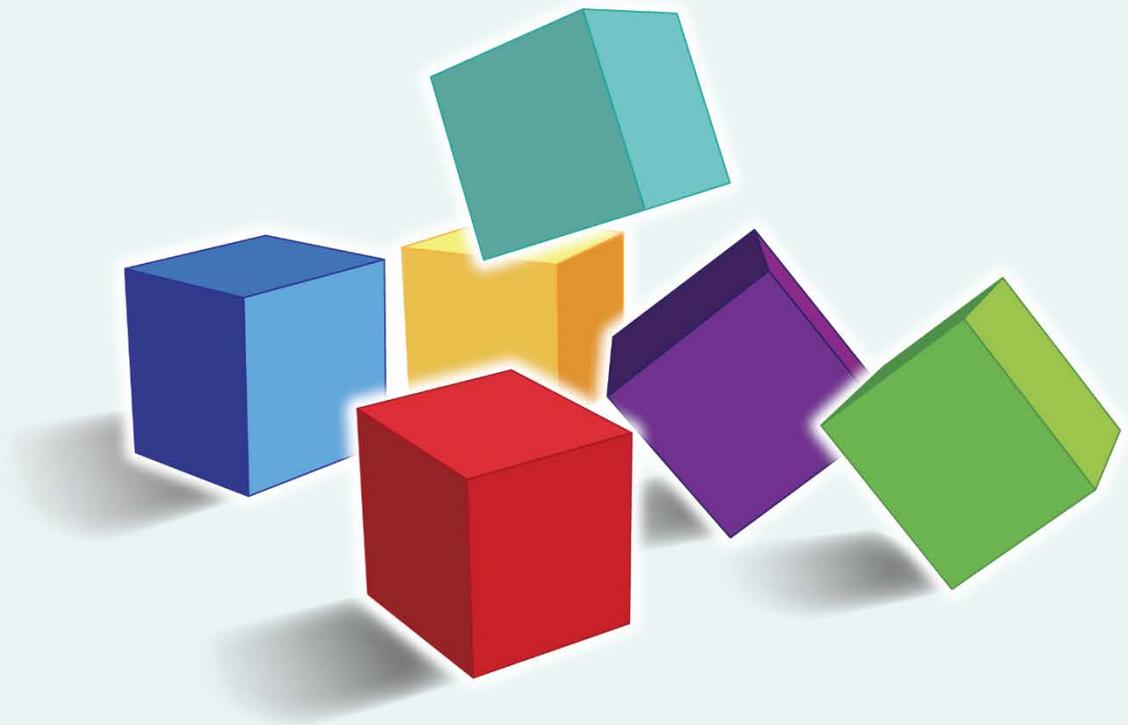


Design & Implement

# Six Building Blocks

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



## Stage 2: Design & Implement

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

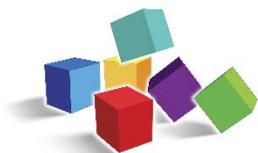
Begin with policy and agreement revision

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

- You (QI Lead) can use this guide to coach a primary care clinic through 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.
- The guide walks you through leading the opioid improvement team in creating action plans, setting and tracking measures, responding to challenges, and running small cycles of change.
- *Track your progress with the [Six Building Blocks coaching log](#).*

## This Guide Includes:

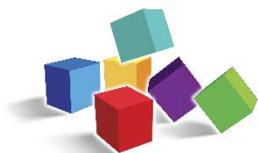
- [The first Action Plan meeting guide](#), which walks you through the key steps of this first Design & Implement stage meeting: selecting measures and aims and creating your first plan for implementing improvements.
- [The future opioid improvement team meetings guide](#), which outlines how to drive the work forward using quality improvement approaches during opioid improvement team meetings.
- The tips on [how to implement](#) the Six Building Blocks Milestones 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 through implementing improvement to opioid management.
- Action Plan [templates](#) and [an example](#), which show the structure of an action plan.



## Design & Implementation Process



- Completion of the Prepare and Launch Stage positions you and your team for the next phase of the work, the Design and Implement Stage. The order and timing of this process varies based on where a clinic is at baseline and the priorities that clinic personnel identify.
- In general, the process starts with revising policies and the patient agreement and making sure that they align. At the same time, many clinics continue the work they began during the Prepare and Launch Stage by either completing identification of patients using long-term opioid therapy and/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 more complex patients.
- 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 quality improvement efforts by regularly discussing the project, and by requesting and responding to feedback on

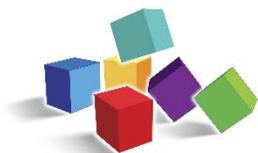


changes they have made in opioid management. They also take time to celebrate improvements.

## Acronyms and terms

The following acronyms are used in this Guide.

- **LtOT:** Long-term opioid therapy, sometimes referred to as chronic opioid therapy (COT)
- **CDC:** Centers for Disease Control and Prevention
- **VA:** Department of Veterans Affairs
- **MED:** morphine equivalent dose, also known as MME or morphine milligram equivalents
- **EHR:** electronic health record
- **PDMP:** State prescription drug monitoring program
- **QI lead:** quality improvement lead for implementing opioid management improvements using the Six Building Blocks at your organization; one of the key roles on the opioid improvement team and the person this How-To Guide is addressing
- **PA:** physician assistant
- **MA:** medical assistant
- **MAT:** medication-assisted treatment
- **WA AMDG MED calculator:** the Washington State Agency Medical Director's Group morphine equivalent dose (MED) calculator, which takes into account methadone's exponential MED increases.
- **Agreement:** refers to a Patient Agreement/Patient Contract



# 1<sup>st</sup> Action Planning Meeting

This meeting generally takes place directly after the clinicwide kickoff.

## Time

1.5 – 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 & Implement stage.
3. Develop an action plan for the next 3 months.

## Who Should Attend

Opioid improvement team

## Helpful Website Resources

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

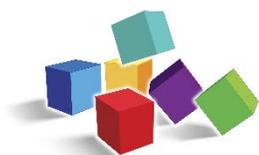
## Agenda (Outline)

1. Debrief on 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 have no feasible way to identify your patients using long-term opioid therapy, it is still important to identify a measure of success.

Consider instead: a) tracking a measure for a representative sample of patients using long-term opioid therapy from each provider, 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. There is always *something* that can be measured and reported to encourage program participation and track progress from baseline. It is just a matter of deciding what is feasible to do on a regular basis.



## Agenda (Details)

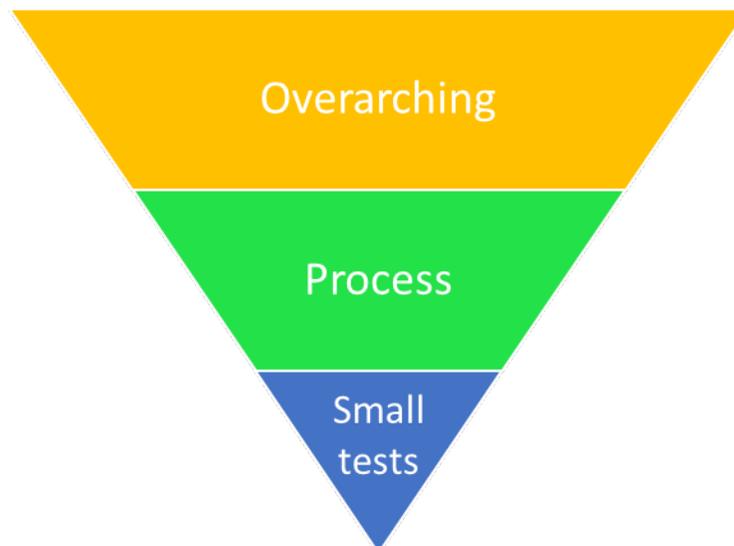
### 1. Debrief on Kickoff

What did you learn during the 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) to review data to support continual improvement. This can be both quantitative (e.g., percentage of patients with a signed agreement in the chart) and qualitative (e.g., perspectives from 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 long-term opioid therapy. Data allow you to see how those changes are going and to think through how to make plans to adjust as appropriate.

There are three basic kinds of data measures that will be helpful in measuring success.

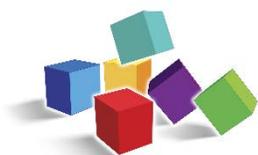


#### Overarching data measures

It is vital to consider why you are 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. Depending on your current capacity, this can be the hardest to measure at first, so think through what is feasible now and grow these measures as your tracking and monitoring capacity grows. Examples of overarching measurable aims include:

- Reduce the number of patients with an **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 long-term opioid therapy prescribed **naloxone** by XX% by DATE.

Additional examples may be found in the [\*CDC quality improvement metrics\*](#).



### Process data measures

To improve safety and reach your overarching patient care aims, you will lead the team and clinic in making process improvements. The Six Building Blocks lays out key process improvements that other clinics have found important to improving opioid management (see [Six Building Blocks Milestones](#)). Consider what your current process improvement focus is and how you will measure success. Examples of process-based measurable aims include:

- Identify and label all **patients using long-term-opioid therapy** with the same ICD-10 code by DATE.
- Have XX% of patients using long-term opioid therapy review and sign an updated **patient agreement** that reflects our policies by DATE.
- Assess function of XX% of patients at their last patient visit by DATE.
- Provide a **dashboard of measures** that track our 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 long-term opioid therapy, and discuss them during morning huddles, e.g., no State prescription drug monitoring program 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 long-term opioid therapy by DATE.

### Small tests data measures

Throughout the Design & Implement stage, you will guide the opioid improvement team and clinic in running *small tests of change* to see if the changes you are putting into place 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 will need to look at data to evaluate these small tests. Examples of small test measures include:

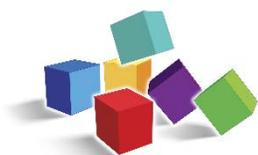
- Experience of front desk staff using an iPad to give patients **annual pain visit forms** over the course of 1 week.
- Ease of use of a **new EHR template** by a pilot care team during 2 weeks of patient visits.

### Selecting initial measures

Select one or two overarching or process measures of success to begin tracking, monitoring, and sharing with care teams that are:

- Important to the clinic.
- Feasible to measure.
- Motivating to clinicians and staff (encourages 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. Considering what you learned from the baseline assessment process and what you heard from care teams during the kickoff:

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

Create a set of milestones that 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 you 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 on long-term opioid therapy identified*
- *All clinicians and delegates signed up for the State prescription monitoring program*
- *MED calculated consistently.*

Make sure to write down your action plan for achieving your first identified milestones (see the *Action Plan templates* and *example first Action Plan* in the Appendices). Be sure to think through:

- Clear, attainable steps.
- Who is responsible.
- When it 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

LMN clinic heard from clinic staff that a priority is to make calculating MED on every patient easy, accessible, and integrated into rooming workflow. Currently, there is no field in their EHR to enter these data. Therefore, the opioid improvement team decided that 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 next 30 pages of this Guide.

## Relevant Materials To Bring To These Meetings

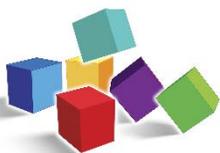
- Current Action Plan
- [\*Six Building Block Milestones\*](#)
- [\*Relevant Six Building Blocks resources\*](#)
- [\*Run chart or other measures of success\*](#)
- [\*Template\*](#) to document the action plan

## Agenda (Outline)

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

### CAUTION

Clinics sometimes put too many activities in an action plan and then the sense of being overwhelmed halts their progress. It is better to prioritize activities and focus on doing them well. Also, don't forget you can allocate tasks to people outside of the opioid improvement team.



## Agenda (Details)

### 1. Review Work Accomplished

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

### 2. Review Data

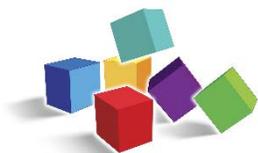
Look at data to ascertain if the changes you are making are leading to improvements. What do the data tell you? Remember to use both quantitative and qualitative data. Refer to the earlier sections on data for more information (*overarching patient care measures, process measures, and small tests measures*).

### 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 you learn from your experiences and the data? How can you adjust to continue to improve? Refer to the *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 you 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, does 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* section 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.
- Suggested approaches for overcoming common challenges.

It is useful to refer to this section when developing Action Plans.

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### Building Block: Planned, Patient-Centered Visits

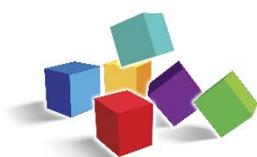
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# Leadership and Consensus

## Overview

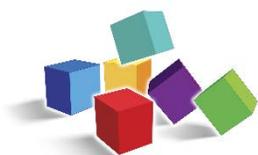
Leadership plays an important role by both prioritizing the work and creating opportunities for conversations among clinicians and staff to reach a shared understanding of how patients on long-term opioid therapy are managed. Leaders help set clinicwide performance goals and help clinicians and staff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

Milestones	Relevant resources
Protected time for opioid improvement team to meet and work	
Regularly emphasize project importance and solicitation of feedback during staff and clinician meetings	<a href="#"><i>Opioid harm stories</i></a> <a href="#"><i>Motivating slow to adopt providers</i></a> <a href="#"><i>Levers of motivation guide</i></a>
Clinical education opportunities offered to staff and clinicians	<a href="#"><i>University of Washington TelePain resources</i></a> <a href="#"><i>CDC training and webinars</i></a> <a href="#"><i>Compilation of clinical educational opportunities</i></a>
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 a part of subcommittees that take on specific assigned action items and provide input (e.g., as a representative for the Medical Assistant perspective).
- The larger team can meet less frequently (e.g., quarterly) to review reports on success (e.g., MED levels and co-prescribing statistics across the practice) and identify next steps (e.g., if further investigation or additional tests of change are needed).



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

- Use the clinical champion to keep the project on the mind of staff and clinicians.
- Emphasize project importance by making it a standing item 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 long-term opioid therapy.
- Transparently 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 (e.g., a thermometer that tracks progress toward a success measure).
- Make clinicwide goals fun (e.g., a prize for the first care team to accurately apply the appropriate diagnosis code to their patients using long-term opioid therapy).

## Clinical Education Opportunities Offered to Staff and Clinicians

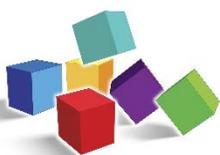
- Identify a simple clinical education opportunity to offer to your staff and clinicians. For example, *University of Washington TelePain* has a weekly webinar series.
- Advertise educational opportunities to care teams.
- If it is a regular virtual opportunity, like the weekly University of Washington TelePain series, then 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, the *CDC*, or local universities. For example, in one clinic a member of the team had the skills to train staff in Motivational Interviewing. That clinic invited that provider to three of their staff “Lunch and Learn” sessions to conduct the trainings.
- If possible, identify opportunities relevant for different learning styles and different time availabilities.
- Sometimes webinar series record the webinars or publish the slides. If so, assign someone to make these materials available to the clinic.

### LESSON LEARNED

Remember to include staff in the clinical education opportunities you provide. Staff report a growing empathy for patients and 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



- During clinic and staff meetings you can ask if anyone wants to present on or share about learnings 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 that clinics have reported and approaches we have seen them use to overcome these challenges.

### We Are Struggling To Complete Assigned Tasks

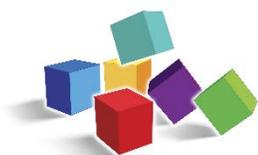
- Try breaking up your work into smaller and more specific tasks rather than assigning large projects. Use shorter deadlines rather than deadlines scheduled far out.
- Start with tasks that interest the key individuals.
- Remember that you can engage clinicians and staff outside of the team to help complete tasks, which 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 discuss and edit during medical staff meetings.

### We Are Not Sure How To Encourage Buy-In

- Emphasize that these changes are about reducing potential harm to patients from long-term opioid use, and putting systems in place that support clinicians and staff in the practice.
- Train clinicians and staff together and in person to emphasize that caring for patients on long-term opioid therapy 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 clinicians and staff can reference them 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, have care gaps) helps clinicians and staff understand the utility of the new tracking and monitoring approaches.
- Have the clinical champion attend huddles to provide continued advocacy for following clinic policies and to answer questions as needed.

**LESSON LEARNED**

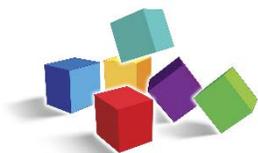
Stories about individual patients can be helpful in gaining and sustaining clinician and staff engagement in doing this work. It can be a story about a patient who was harmed, a patient or family member who expressed concerns about risks of opioid use, or a positive story about a patient or family member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



- 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/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 facilitate a discussion among clinicians, administrators, and the opioid improvement team.
- Meet after hours in more of a social setting to hold a discussion on issues for which you are trying to build consensus.
- Focus on evidence about patient harm from long-term opioid use 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

## THREE LEGS OF THE STOOL

The policies, patient agreement, and workflows are like 3 legs of a stool. They support (and align with) each other. The policies outline the critical guides 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.

### Overview

Clinic **policies** about opioid prescribing for chronic pain create a shared understanding and agreed-upon standards about how patients on long-term opioid therapy 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 that is used to communicate risks to patients. Finally, **workflows** illustrate the step-by-step procedures for putting the policy into action.

Milestones	Relevant resources
Policy revised to align with evidence-based guidelines and regulations (e.g., CDC, State guidelines)	<a href="#"><i>Policy model</i></a> <a href="#"><i>CDC Guideline</i></a> <a href="#"><i>State and local guidelines</i></a> <a href="#"><i>VA taper decision tool</i></a> <a href="#"><i>Tips for patients on legacy prescriptions</i></a>
Patient agreement revised to support the policy and educate patients about risks	<a href="#"><i>Patient agreement model</i></a>
Workflows written to support policies	<a href="#"><i>Chronic pain appointment workflow</i></a> <a href="#"><i>Opioid refill workflow</i></a> <a href="#"><i>Opioid list manager workflow</i></a>
Training conducted on policies, agreement, workflows, and supporting EHR templates	

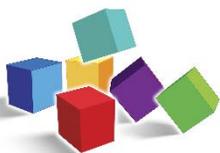
### Common Challenge

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 is a 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, patients transitioning to chronic pain, and patients new to a patient panel who are already using long-term opioid therapy, and what to do if a patient falls out of line with a patient agreement.
- Even if you have recently revised your policy, take time to compare it with 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. We have seen that a top-down approach is less likely to result in putting the changes into practice.
- It can help to frame the policy revision as an opportunity to create support for clinicians and staff as they work to decrease harm to patients and emphasize 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

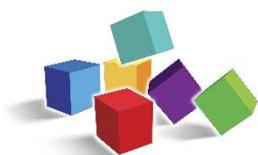
1. Have one person review documents (*model, guidelines, existing policy, and other relevant materials, as appropriate*) highlighting for the rest of the team areas that are different than in your existing document. Be sure to check for relevant updated local, State, or national guidelines.
2. Send a document highlighting the differences to the opioid improvement team for review.
3. Have the opioid improvement team review the documents ahead of the revision planning meeting.
4. Hold a revision planning meeting with opioid improvement team.
  - a. Revision approach: Will you 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 long-term opioid therapy.
- 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, harm reduction, and the provider-patient partnership.
- Be sure to consider health literacy, language barriers, and what to do if the patient asks for alterations to the agreement.

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

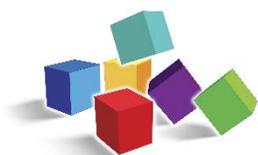
1. Once there is a draft revised policy to work from, assign someone to begin revising the patient agreement so that it aligns with the revised policy. Use “track changes” to highlight the differences for the opioid improvement team. Use the *model patient agreement* as an example.
2. Send a document 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., a PA) to review the patient agreement with all patients using long-term opioid therapy 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 what workflows are needed to support implementing them. Consider including workflows for:
  - How to prepare for pain visits (e.g., checking State prescription drug database).
  - Patient visits (e.g., calculating MED).
  - Refill requests
  - Urine drug testing.
  - Patient agreement review and signature.
- Compile your practice’s existing workflows and the Six Building Blocks models, including:



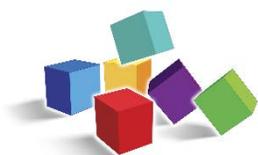
- *Chronic pain appointment workflow*
- *Opioid refill workflow*
- *Opioid list manager workflow*
- Look back at what you learned during the Prepare and Launch Stage about:
  - What happens when a patient with chronic pain comes in for a visit that results in an opioid refill.
  - What happens when a 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/nurses, as appropriate. Specifically consider:
  - Completing previsit planning tasks.
  - Checking the State prescription drug database.
  - Preparing paperwork.
  - Calculating MED.
  - 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 will help decrease confusion or misunderstandings regarding policy implementation.
- Locate or create EHR templates that align with your workflows. Consider creating different templates for each role (e.g., steps an MA completes, steps a provider completes). This supports your 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 prior to 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 ramp-up. For example, prioritize new elements and train on one or two key changes at each staff meeting. This 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

**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.



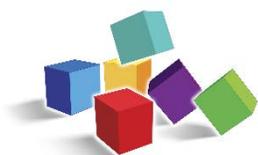
- to clinicians and staff members when introducing them.
- Train and remind through multiple platforms (e.g., in-person trainings, meetings, email “touch-backs,” champion check-ins, and handouts).
  - When training on new workflows, be ready to provide clinicians and staff with a realistic estimate of how long the processes will take.
  - Provide thorough training on how to use EHR templates so clinicians and staff can implement with confidence.
  - Provide necessary 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, print screenshots and instructions for the EHR template, etc.
  - Include a plan for refresher trainings and trainings for new employees.

## Overcoming Common Challenges

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

### We Want To Help Patients Understand and Accept the New Policies and Procedures

- Send a letter to all patients prior to implementing the new policy and patient agreement and describe some of the key changes. Explain why you are making these changes. ([Example letter](#))
- Host a community question and answer session and invite patients and community leaders to attend (e.g., school board members, law enforcement).
- Take time with patients to review the patient agreement 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. Use the patient agreement process as an opportunity to educate patients about the risks of long-term opioid use.
- Remember that patients have different levels of health literacy; thus, help each patient to read and sign the patient agreement. Some patients may need to have the agreement read out loud as they sign each element.
- Anticipate questions and challenges that may be raised by patients. Discuss these with clinicians/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 long-term opioid therapy for their chronic pain is important for several reasons:

- 1) Any patient using long-term opioid therapy, regardless of dose, has a risk of adverse events, including overdose;
- 2) Identifying patients using long-term opioid therapy provides an opportunity to identify those at highest risk so that they don't "fall between the cracks" in a busy primary care clinic;
- 3) A population tracking system can be used to identify care gaps between scheduled visits and to conduct outreach and followup with those patients; and
- 4) Population tracking provides an opportunity to know if efforts to improve care are successful.

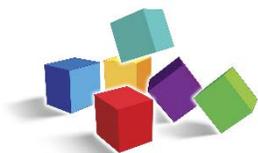
Milestones	Relevant Resources
Patients using long-term opioid therapy are identified	<a href="#"><i>Approaches to identifying patients</i></a> <a href="#"><i>Opioid names</i></a>
All clinicians and delegates are signed up for the State prescription monitoring program (Delegates are staff who may access the data on behalf of a clinician)	<a href="#"><i>List of state prescription monitoring database program websites</i></a>
Calculating MED as dose or medication changes is possible and easy for clinicians and staff	<a href="#"><i>WA AMDG MED calculator</i></a> <a href="#"><i>CDC Guideline App, which includes an MED calculator</i></a> <a href="#"><i>How to manually calculate MED</i></a>
There is a dashboard of key measures for all patients using long-term opioid therapy	<a href="#"><i>Data to consider tracking</i></a> <a href="#"><i>Tracking and monitoring example spreadsheet</i></a>
Data are used to monitor care gaps, high-risk patients, and clinical variation	<a href="#"><i>Purposes of tracking and monitoring</i></a> <a href="#"><i>Chronic pain management teams</i></a>

## Common Challenges

Data from our tracking and monitoring reports are not accurate.

It is too time consuming to track and monitor patients using long-term opioid therapy.

Clinicians don't have time to look at the tracking and monitoring data.



## Tips for Accomplishing Each Milestone

### Patients Using Long-Term Opioid Therapy Are Identified

Knowing which patients are using long-term opioid therapy 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 long-term opioid therapy within the EHR using a unique diagnostic code or drug codes and pulling reports using EHR tools based on that code/s. (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 about the pros and cons of different methods to identify your patients using long-term opioid therapy during the Prepare & Launch stage (Stage 1). Based on those learnings, determine what further investigations are needed. Consider:

- What challenges are you 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 Signed Up for the State Prescription Monitoring Program

Regularly checking State prescription monitoring program data allows prescribers to determine whether a patient is using opioids as prescribed or receiving opioids from other clinicians, and whether dangerous opioid dosages or combinations (e.g., with sedatives) are putting him or her at risk for adverse events. In order to access the data, prescribers need to register. If permitted in your State, sign up delegates (staff who can check the State prescription monitoring database on the clinician's behalf) who might have more time to check the database ahead of patient visits.

It can be more challenging than expected to get all clinicians signed up for the State prescription monitoring program. 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. Here are potential approaches to try to overcome these issues.

#### 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 opioid use disorder. All patients using long-term opioid therapy deserve high-quality, evidence-based care.



- 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.

### Calculating MED Consistently Is Possible and Easy For Clinicians and Staff

- Having an MED calculator available on all clinic and office computers makes it more likely that MED will be checked prior to a change in opioid prescription (e.g., dose or type of medication).
- Approaches to consider:
  - Investigate if your EHR has a built-in MED calculator. If so, check the accuracy of the calculation to determine if you want 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 necessary. If so, designate someone to manage this process.
- Consider whether the MA or nurse can calculate the MED before rooming or as part of planned visit prep each day.

**IMPORTANT**

Check that everyone is using the same, agreed-upon MED calculator as they don't all calculate MED in the same way and can get different results.

### There Is a Dashboard of Key Measures for All Patients Using Long-Term Opioid Therapy

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

1. What data to track.
2. How to collect and store the data.
3. How to see/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 you currently record in discrete fields, what is possible, and organizational priorities, what data can you start tracking right now? Make a list of one or two variables to prioritize tracking at first.
- Also 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 you want 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 you want to collect and store data manually (e.g., Excel) or electronically based on your electronic health record 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 you choose, it is critical to create [workflows](#) that lay out who will update the data, when, and how.

## How To See/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 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 long-term opioid therapy as soon as possible to motivate and make improvements. Even if the measure is not 100 percent accurate, you 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.



- Develop an approach to monitor data/measures by clinician so you can examine variation across providers.
- Approaches used by other sites:
  - 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)
  - Pulling reports from the State prescription monitoring program 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.

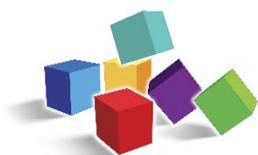
#### Data From Our Tracking and Monitoring Reports Are Not Accurate

- Ensure staff and clinicians understand why you are collecting the data, how they get collected, how they are 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/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 necessary.
- Conduct refresher training for existing staff and training to new staff on how and where to enter data into the EHR.

**LESSON LEARNED**

Don't forget the power of stories to garner buy-in for tracking and monitoring. Try to think of 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. As a result, it was not recognized that this patient had received a benzodiazepine from another provider in another clinic, placing her at high risk of overdose.



- Review whether you are accurately identifying your patients using long-term opioid therapy. Troubleshoot problems that 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. Look into having a care coordinator, refill processor, nurse, MA, or information technology (IT) staff member assist with this process.
- Ensure you are tracking only key variables that you plan to use for patient care or quality improvement. Only track data that you consistently use.
- Build tracking and monitoring tasks into your 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 into a person's job description.

#### **Clinicians Don't 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 (e.g., identified care gaps).
- Ensure nurses/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

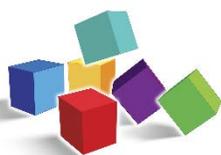
## Overview

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 patients and get their signature? Who is going to check the State prescription monitoring program database before the visit? Who will order and ensure the patient goes to the lab for a urine drug test, if needed? Clinicians and staff can also anticipate and briefly rehearse how to have what might be difficult conversations with those few patients who have demonstrated aberrant behaviors, such as early prescription refill requests or an abnormal urine drug test. Or how to best introduce the topic of tapering opioid medications with a patient who has been using high-dose, long-term opioid therapy for many years.

Milestones	Relevant Resources
Data are used for previsit planning	<a href="#"><i>Purposes of tracking and monitoring</i></a>
EHR pain visit templates are in place to cover key elements of the pain visit as outlined in the revised policy	<a href="#"><i>Pain Tracker</i></a> <a href="#"><i>Clinical Decision Support tools</i></a>
Standardized previsit planning and pain visits are integrated into the practice	<a href="#"><i>Chronic pain appointment workflow</i></a> <a href="#"><i>Care plan model</i></a> <a href="#"><i>Pain Tracker</i></a> <a href="#"><i>Turn the Tide pocket guide for clinicians</i></a>
Patients receive education on chronic pain management and opioid risks	<a href="#"><i>CDC patient education example</i></a> <a href="#"><i>Patient letter</i></a> <a href="#"><i>Chronic pain self-management resources</i></a> <a href="#"><i>Compilation of patient education resources</i></a>
Training in patient engagement is offered to staff and clinicians (e.g., difficult conversations, motivational interviewing)	<a href="#"><i>Empathic communication resources</i></a> <a href="#"><i>Provider guide to difficult conversations</i></a> <a href="#"><i>Staff guide to difficult conversations</i></a> <a href="#"><i>Difficult conversations video vignette</i></a>
Alternatives to opioids are regularly considered and discussed, and integrated into care processes	<a href="#"><i>CDC Alternative treatments fact sheet</i></a> <a href="#"><i>Evidence on complementary and alternative approaches to chronic pain</i></a>

## Common Challenges

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



## 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 do you know when a patient using long-term opioid therapy 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 train 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 over time as experience and capacity grow. Refer to the example [Chronic pain appointment workflow](#) and the example [Opioid refill workflow](#).

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

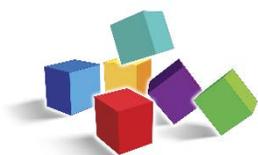
- Embed care components, such as assessments (e.g., [Opioid Risk Tool](#) - ORT, [Pain, Enjoyment, and General Activity scale](#) - PEG, and the [Patient Health Questionnaire](#) - PHQ) and goal setting, into an electronic health record (EHR) template so the provider does not need to look for these scales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

### Standardized 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 sometimes used to monitor workflow implementation include:

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

### Patients Receive Education on Chronic Pain Management and Opioid Risks



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This study is funded by the Agency for Healthcare Research and Quality under Contract No. HHSP2332015000131

- Decide which patient education materials you want to make available for patient care. Take a look at the list of *patient education materials* and *chronic pain self-management resources*. Some to consider include:
  - *Opioid risks* (e.g., addiction, respiratory depression, hormone disruption).
  - *Risks of combining opioids and benzodiazepines*.
  - *Naloxone*: what it is and how to administer it.
  - Opioid-induced conditions (e.g., hyperalgesia, constipation).
  - Tapering.
  - *Self-management strategies*.
  - *Activity pacing*.
- Adapt resources so they are appropriate for your patients.
- Consider asking your patients for their advice on materials.
- Consider who will review these materials with patients and when. Will you use care coordinators? MAs? Think through how to take advantage of a team-based care model in order to carve out adequate time for education with the patient.

**LESSON LEARNED**

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

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

- Make the CDC webinars *Communicating With Patients*, *Motivational Interviewing*, and *Collaborative Patient-Provider Relationship in Opioid Clinical Decision Making* available to clinicians and staff.
- Watch the *Difficult Conversations Vignette* during a medical staff meeting and discuss strategies used (refer to *provider scripts* and *staff scripts*).
- Identify if anyone on your staff has skills in the desired training areas (e.g., motivational interviewing) and invite them to present/train.
- 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 how to connect to them.
- Make the CDC webinar *Treating Chronic Pain Without Opioids* available to clinicians and staff.
- Routinely look for new resources in your community or ask your peers or professional organizations for ideas on what others are offering.



## Overcoming Common Challenges

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

### Our Appointments Are Very Backed Up

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

### Some Clinicians Are Not Using the State Prescription Monitoring Database

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

#### LESSON LEARNED

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

### Some Care Teams Are Not Calculating MED

- Ensure that you have properly educated care teams on the importance 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 you have one person or team in charge of refills, have them calculate MED.
- Regularly share MED data at huddles or staff meetings. This will demonstrate that the clinic cares about these numbers, will foster competition among teams, and will create opportunities for collaboratively thinking through tough cases.

### Patients Feel Labeled by Having To Do Urine Drug Tests

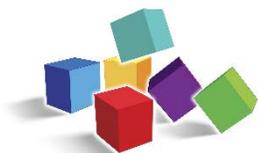
- Train staff and clinicians on scripts for these conversations. Refer to the *Provider guide to difficult conversations* and the *Staff guide to difficult conversations* for conversation script ideas.



- Remind patients that this is standard care for all patients using long-term opioid therapy, that it is part of the patient agreement, and that this testing is being done for their safety. The CDC suggests the following script in their module [\*Reducing the Risks of Opioids\*](#):
  - "I use urine drug testing with all patients who are prescribed controlled substances. The information can help me make sure that controlled substances are used in a way that is safe for patients."

### We Have a Clinician Leaving and We Need To Redistribute Patients

- If possible, have the departing clinician create a list of his/her patients using long-term opioid therapy, annotate with key information, identify an accepting provider, and discuss the patients with this provider.
- Develop an agreed-upon 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/experienced with pain management.
- Review the resource [\*Tips for Managing Patients on Legacy Prescriptions\*](#) during a clinician meeting so clinicians have suggested approaches for the first appointments with any patients using legacy prescriptions.





# Caring for Complex Patients

## Overview

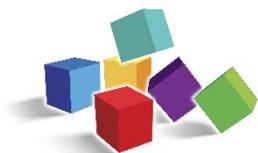
Chronic pain can be complicated by other conditions, such as mental/behavioral health conditions. Some patients using long-term opioid therapy have developed opioid use disorder. Identifying additional and appropriate resources for these patients and creating systems to connect patients to these resources is 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. 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 opioid use disorder. Clinics find that offering buprenorphine treatment allows them to provide their patients a full spectrum of care.

Milestones	Relevant resources
Tools selected and in use to identify complex patients, such as those with mental or behavioral health disorders or those with opioid use disorder	<a href="#"><i>Assessment tools webpage</i></a> <a href="#"><i>MATx Mobile App</i></a>
Clear referral pathways in place for complex patient resources	<a href="#"><i>Buprenorphine information from SAHMSA</i></a> <a href="#"><i>Naloxone information from SAHMSA</i></a>
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-assisted treatment services available for patients with opioid use disorder.	

## Tips for Accomplishing Each Milestone

### Tools Selected and In Use To Identify Complex Patients, Such as Those With Mental or Behavioral Health Disorders or Those With Opioid Use Disorder

- During policy and workflow development, select tools and intervals for use that allow your clinic to identify patients with complex issues. Refer to the [\*model policy\*](#) and [\*assessments tools web page\*](#).
- Train clinicians and staff on where to access these tools and how to use them.
- Make the CDC webinar [\*Assessing and Addressing Opioid Use Disorder\*](#) available to clinicians and staff.
- Have a member of your team who offers medication-assisted treatment for opioid use disorder review tracking and monitoring data to identify patients who need additional screening.



- Provide additional training for clinicians and staff about recognition and treatment of opioid use disorder and common coexisting mental/behavioral health conditions.

### Clear Referral Pathways in Place for Complex Patient Resources

- Identify resources in your clinic and in your community for addressing complex issues (e.g., behavioral health providers, outpatient substance use treatment programs, methadone clinics, addiction specialists, pain management).
- Consider insurance and geographic distance limitations.
- Consider developing telemedicine resources for patients with behavioral health or opioid use disorders.
- Build relationships with external organizations that offer behavioral health services or medication assisted treatment.
- Train clinicians and staff on processes to connect patients to these resources.

## Overcoming Common Challenges

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

### Some of Our Patients Cannot Access Behavioral Health Resources

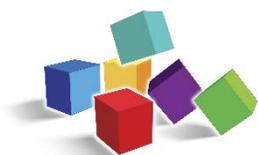
- Look into options outside your community, such as telemedicine opportunities.
- Contact your State health department or [SAMHSA](#) for a list of resources.

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

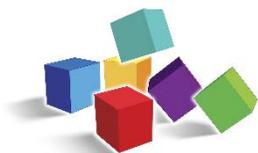
- Encourage the provider to seek further training on asking potentially sensitive questions and addressing difficult issues.
- Have the patient fill out the Opioid Risk Tool on paper. The provider can then review the recorded results with the patient.
- Give clinicians scripts with language to use and 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 opioid use disorder. Asking about a history of sexual abuse can also help identify individuals with post-traumatic stress disorder (PTSD).
- Make sure 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.

### We Do Not Have Medication-Assisted Treatment Services Available

- Consider starting medication-assisted treatment services in your clinic.
- Identify the nearest medication-assisted treatment program and develop a relationship with that program.



- Identify and connect with local, State, and national resources that support clinicians in offering medication-assisted treatment. Provide the support needed for your clinicians willing to begin prescribing medication-assisted treatment.





# 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 is crucial to improving and sustaining the work. Examples might include process measures, such as proportion of patients with a signed updated patient agreement, or more distal outcomes, such as proportion of patients using high-dose opioids. Set a goal for improvement over a set time period, and provide clinicians and staff with frequent updates on progress. Finally, make reporting of these measures a standing agenda item at monthly staff meetings, clinic huddles etc.

Milestones	Relevant resources
Success measures identified	<a href="#"><i>Measuring success</i></a> <a href="#"><i>Six Building Blocks milestones</i></a> <a href="#"><i>CDC QI metrics</i></a> <a href="#"><i>DIY Run chart</i></a>
Success measure regularly reviewed and reported at the clinician level	<a href="#"><i>Purposes of tracking and monitoring</i></a> <a href="#"><i>Chronic pain management teams</i></a>
Common Challenges	
We do not have the infrastructure to pull EHR-based reports on patients using long-term opioid therapy.	
We do not know enough about our patient population to set a goal.	

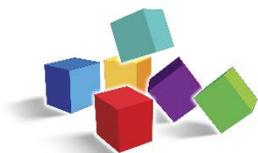
## Tips for Accomplishing Each Milestone

### Success Measure 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.

### LESSON LEARNED

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



## 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? Often, organizations will review reports quarterly.
  - What will they do with these data?
- Refer to the example [Opioid list manager workflow](#) for ideas.

## Overcoming Common Challenges

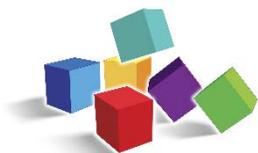
What follows are approaches we have seen clinics use to overcome common challenges.

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

- Consider approaches that clinics used before the era of electronic health records. 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 don't 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 you don't have much formal data about your patient population, your clinicians and staff are familiar with what is currently challenging about providing care to patients using long-term opioid therapy. Talk with clinicians and staff to identify a goal that is meaningful to your organization and that you can feasibly measure.
- Remember that this 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 you have established a tracking and monitoring program.



# Appendix 1: Action Plan Templates

## Detailed Action Plan

Activity:

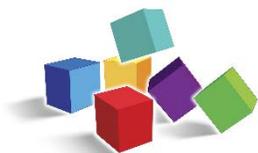
Manager of this process:

Date for completion:

List the 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 work over the next three months (through DATE). It outlines the activities we discussed during our Action Plan Meeting and includes clear steps, responsible parties, due dates, and supporting resources.

## Leadership & Consensus Activities

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

Manager of this process: **Heather**

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

Relevant resources:

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

List the 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 Feb
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)	Ron	By late Feb

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

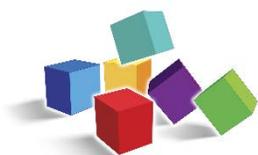
Manager of this process: **Heather**

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

Relevant resources:

- UW TelePain resources
- CDC training and webinars

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



## Policies, Patient Agreement, and Workflow Activities

Activity: **Revise our policy to align with evidence-based guidelines and WA 1427**

Manager of this process: **Ron**

Date for completion: **April**

Relevant resources:

- Policy model
- CDC Guideline
- Veterans Affairs (VA) taper decision tool
- Tips for patients on legacy prescriptions

List the steps necessary to achieve this goal (What)	Person responsible (Who)	When
Identify initial revisions after reviewing the Six Building Blocks model and 1427 and send these revision ideas to Heather	Ron	January
Draft initial edits for policy and send to core working group	Heather	January
Review new draft to make additional edits before bringing to the larger Opioid Improvement Team (include Mike)	Core working group (Ron, Heather, Monica, Joy?)	February
Opioid Improvement Team will review draft and make additional edits before sending on to the clinicians for review	Opioid Improvement Team	February
Clinicians will review and provide feedback	Ron	March
Staff will review and provide feedback	Heather	March
Final edits	Heather	April
Approval process	Ron	April

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

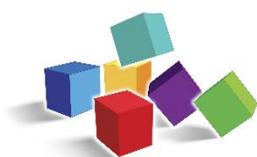
Manager of this process: **Ron**

Date for completion: **May**

Relevant resource:

- Patient agreement model

List the 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 these revision ideas to Heather	Ron	February
Draft initial edits for agreement and send to core working group	Heather	February
Review new draft and make additional edits before bringing to the larger Opioid Improvement Team (include Mike)	Core working group (Ron, Heather, June, Joy?)	March
Opioid Improvement Team will review draft and make additional edits before sending on to the clinicians for review	Opioid Improvement Team	March
Clinicians will review and provide feedback	Ron	April
Staff will review and provide feedback	Heather	April
Final edits	Heather	May
Approval process	Ron	May



## Tracking & Monitoring Patient Care Activities

Activity: **Identify patients using long-term opioid therapy with the diagnosis (F11.90) in the EHR**

Manager of this process: **Heather**

Date for completion: **February**

List the 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)	Heather	mid-January
Advertise that this is the first success measure for the Six Building Blocks project	Ron (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	Heather	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

List the 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.

