Design & Implement Workbook for Practice Facilitators

## This workbook includes:

* An [overview](#_Design_&_Implementation) of the Design and Implement process.
* [Tracking checklists](#_Design_and_Implement) to use to track progress through the Design and Implement process. To track your overall progress through this and future stages for multiple sites, use the [Multi-Site Log](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Multisite-PF-Log.xlsx).
* *The* [*First Action Plan Meeting Guide*](#_Future_Opioid_Improvement), which walks you through the key steps of this first Design & Implement Stage meeting: selecting measures and aims and creating the first plan for implementing improvements.
* [Kickoff Follow-Up Work](#_Kickoff_Follow-Up_Work), which outlines Practice Facilitator activities for immediately after the Kickoff.
* [In-Between Action Plan Meetings Work](#_In-Between_Action_Plan), which outlines the activities the Practice Facilitator and site will be engaged in between each of the quarterly Action Plan Meetings.
* *The* [*Future Action Plan Meetings Guide*](#_Future_Action_Plan), which outlines how to drive the work forward using quality improvement approaches during Opioid Improvement Team meetings
* An Action Plan [*template*](#_How_to_Implement)*,* which shows the structure of an Action Plan. To track a site’s progress implementing opioid management improvements in the Design and Implement Stage, we suggest you use the Action Plan Template, which includes a detailed milestones table.
* A [Shared Learning Call Guide](#_Appendix_2:_Shared), which you can use if you choose to facilitate monthly Shared Learning Calls between multiple sites.

## Acronyms and terms

The following acronyms are used in this Workbook.

* **Agreement**: this refers to a Patient Agreement/Patient Contract
* **Clinic, organization, and site:** These terms are used interchangeably to refer to the organization implementing the opioid management improvements.
* **CDC**: Centers for Disease Control & Prevention
* **EHR**: electronic health record
* **LtOT**: Long-term opioid therapy, sometimes referred to as chronic opioid therapy (COT)
* **MA**: Medical Assistant
* **MAT**: Medication assisted treatment
* **MED**: morphine equivalent dose, also known as MME or morphine milligram equivalents.
* **PA**: Physician Assistant
* **PDMP**: state prescription drug monitoring program; also referred to as PMP
* **VA**: Department of Veterans Affairs
* **WA** [AMDG MED calculator](http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm): the Washington State Agency Medical Director’s Group morphine equivalent dose (MED) calculator, which takes into account methadone’s exponential MED increases.

## Design & Implementation Process



* Completion of the Prepare and Launch Stage positions the site 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 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 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.

# Design and Implement Progress Tracking

Use this section to track the site’s progress through the Design and Implement Stage. If you are working with multiple sites, you can also track progress in the [Multi-Site Log](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Multisite-PF-Log.xlsx).

## Practice Facilitator activities

These are the activities you will do as a Practice Facilitator during the Design and Implement Stage. In addition to the below items, you will check in with the site between Action Plan Meetings, respond to site requests, and send the site resources relevant to their current work. In addition, if you are working with multiple sites, you might also consider facilitating monthly Shared Learning Calls, described in the appendix.

As you schedule and complete activities, it can be helpful to record them here.

### ​[ ]  Facilitate Kickoff Action Plan Meeting: Click or tap to enter a date.

#### Objectives

Reflect on learnings from the Prepare and Launch Stage in order to set aims and create an Action Plan to start the design and implement work.

### [ ]  Complete Kickoff Follow-Up Work Click or tap to enter a date

#### Objectives

Document baseline for the site to help them identify work priorities and track progress.

### [ ]  Second Action Plan Meeting: Click or tap to enter a date.

#### Objectives

Review progress on Action Plan, brainstorm solutions to challenges, and update the Action Plan.

### [ ]  Third Action Plan Meeting: Click or tap to enter a date.

#### Objectives

Review progress on Action Plan, brainstorm solutions to challenges, and update the Action Plan.

### [ ]  Fourth Action Plan Meeting: Click or tap to enter a date.

#### Objectives

Review progress on Action Plan, brainstorm solutions to challenges, and update the Action Plan.

## Milestones checklist

These are the milestones sites generally work toward achieving through the Design and Implement Stage. At the Kickoff Action Plan Meeting the site will select milestones, so you should adapt this list accordingly. The list below is a simple checklist you can use. However, many Practice Facilitators prefer to use the more [detailed milestones table](#_Six_Building_Blocks) in the Action Plan Template in the appendices.

### Leadership & consensus

[ ]  Protected time for improvement team to meet and work

[ ]  Regularly emphasize project importance and solicit feedback during staff & clinician meetings

[ ]  Clinical education opportunities offered to staff and clinicians, including on pain etiology

### Policies, patient agreements, & workflows

[ ]  Policy revised to align with evidence-based guidelines (e.g., CDC, AMDG)

[ ]  Patient agreement revised to support the policy and educate patients about risks

[ ]  Workflows written to support policies

[ ]  Training conducted on policies, agreement, workflows, and supporting EHR templates

### Tracking & monitoring patient care

[ ]  Patients on long-term opioid therapy identified

[ ]  All clinicians and delegates signed up for the prescription data monitoring program

[ ]  Calculating MED as dose or medication changes is possible and easy for clinicians and staff

[ ]  There is a dashboard of key measures for all patients on long-term opioid therapy

[ ]  Data are used to monitor care gaps, high-risk patients, and clinical variation

### Planned, patient-centered visits

[ ]  Data are used for pre-visit planning

[ ]  EHR pain visit templates are in place to cover key elements of the pain visit as outlined in the revised policy

[ ]  Standardized pre-visit planning and pain visits are integrated into the practice

[ ]  Patients receive education on chronic pain management and opioid risks

[ ]  Training in patient engagement is offered to staff and clinicians (e.g., motivational interviewing)

[ ]  Alternatives to opioids are regularly considered and discussed, and integrated into care processes

### Caring for patients with complex needs

[ ]  Tools selected and consistently in use to identify patients with complex needs (i.e., mental/behavioral health disorders, opioid use disorder, or other substance use disorders)

[ ]  Educational opportunities are provided to clinicians on how to identify and treat patients with opioid use disorder

[ ]  There is an approach to connecting patients to mental/behavioral health resources, either integrated in the primary care setting, in the community, or through telehealth

[ ]  There is an approach to connecting patients with opioid use disorder to treatment, either internally through waivered providers or externally through an identified medication for opioid use disorder treatment facility

[ ]  Confidentiality regulations and other information-sharing hurdles have been addressed so that patient information can be shared between medical, behavioral health, and substance use disorder clinicians

[ ]  Training is provided to clinicians and staff on overcoming stigma about patients with mental/behavioral health needs, opioid use disorder, and other substance use disorders

### Measuring success

[ ]  Success metric identified

[ ]  Success metric regularly reviewed and reported at the clinician level

# 1st Action Planning Meeting Overview

This meeting generally takes place directly after the clinic-wide Kickoff.

Even if the site has no feasible way to identify their 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 percent (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.

CAUTION

## 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

* *[Design and Implement milestones](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx)*
* [Measuring](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Measuring-success-metrics_2019-05-02.pdf) *[success](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Measuring-success-metrics_2019-05-02.pdf)*
* [*DIY run charts*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/03/DIY-run-chart-tool.xls) (a tool to track a measure over time)
* *[Action Plan templates](#_How_to_Implement)*
* [*Model policy*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/09/Model-opioid-prescribing-policy_2019-09-11.docx)

## Agenda

1. Debrief on Kickoff
2. Discuss using data to measure success
3. Review [*Design and Implement milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx) and identify milestones to achieve
4. Develop first Action Plan

# 1st Action Planning Meeting Content

## Debrief on Kickoff

What did you learn during the Kickoff? What did you hear were priorities for the work? Was anything surprising?

## Discuss using data to measure success

Take some time to introduce to the Opioid Improvement Team how data will be used to measure success in their Six Building Blocks Program work. You can distribute the [*Measure Success handout*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Measuring-success-metrics_2019-05-02.pdf) at the meeting.

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., percent 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 the clinic helps patients using long-term opioid therapy. Data allows them to see how those changes are going and to think through how 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 for the clinic to consider why they are doing this work. What is important to the clinic in improving care? Help the clinic identify what these overarching aims are and consider how it might be possible to measure them. Depending on their current capacity, this can be the hardest to measure at first, so help them think through what is feasible now and remind them they can grow these measures as their 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*](https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-FactSheet-At-A-Glance_Opioid-Measures-508.pdf)*.*

### Process data measures

In order to improve safety and reach their overarching patient care aims, the clinic will be making process improvements. The Six Building Blocks Program lays out key process improvements that other clinics have found important to improving opioid management (see [*Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx)). Help the clinic consider what their current process improvement focus is and how they will measure success. Examples of process-based measurable aims include:

* Identifying and labeling all **patients using long-term-opioid therapy** with the same ICD-10 code by DATE.
* XX% of patients using long-term opioid therapy have reviewed and signed an updated **patient agreement** that reflects our policies by DATE.
* XX% of patients’ function was assessed 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, the Opioid Improvement Team and clinic should be running [*small tests of change*](http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx) to see if the changes they 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 clinic-wide. They 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 one week.
* Ease of use of a **new EHR template** by a pilot care team during two weeks of patient visits.

### Selecting initial measures

Help the clinic 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 consider suggesting they use a [*run chart*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/03/DIY-run-chart-tool.xls) to track their measures. Help them remember that it takes effort and resources to produce these measures of success, so they should start small. They can add to it over time as their capacity to track grows.

## Review Six Building Blocks Milestones

Review the [*Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx) with the Opioid Improvement Team. Considering what they learned from the baseline assessment process and what they heard from care teams during the Kickoff:

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

Create a set of milestones that the team can refer to throughout the Design and Implement Stage when designing Action Plans and assessing success.

## Develop the First Action Plan

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

* Protecting time for the improvement team to meet and work
* Regularly emphasizing project importance and soliciting feedback during staff & clinician meetings
* Clinical education opportunities offered to staff and clinicians

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 this 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.

EXAMPLE

* 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
* Calculating MED consistently

Facilitate a conversation with the team about the steps they will take to achieve their first prioritized milestones. Refer to the resource [*Tips for Achieving Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Tips-for-Achieving-the-Six-Building-Blocks-Milestones.docx) for ideas about how the site can do this work. Be sure to get the site to think through:

* Clear, attainable steps
* Who is responsible
* When it will be done

You will likely find that action step ideas arise throughout this meeting, not just in this specific conversation. Be sure to track those ideas for the site as well.

# Kickoff Follow-Up Work

## Objective

Officially close out the Prepare and Launch Stage by summarizing baseline findings for the site.

What’s Going on During This Step

### Practice Facilitator

[ ]  Summarize your Prepare and Launch Workbook notes for your record of the site’s baseline. If appropriate, share with the site.

[ ]  Summarize the Six Building Blocks Self Assessment results, combining the Opioid Improvement Team’s responses and the clinic’s responses from the Kickoff (see example). Share with the site.

[ ]  Summarize the results from the Kickoff Survey and share with the site.

[ ]  Write out the site’s Action Plan. You will use these Action Plans to help the site keep the project on track. The site may or may not regularly engage with the Action Plans, depending on their style. Refer to the Action Plan Template in the appendices.

[ ]  Send the site any resources relevant to their work.

[ ]  Send the site the [*Measuring Outcomes Survey*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Measuring-outcomes-survey.docx) and ask them to complete it once they are able to estimate most of the data in the survey for pre-Six Building Blocks status.

[ ]  Schedule the next Action Plan Meeting.

[ ]  Schedule Shared Learning Calls if doing them. (See Shared Learning Call Guide in appendix.)

# In-Between Action Plan Meetings Work

This describes the work the Practice Facilitator and site will engage in between each of the Action Plan Meetings of the Design and Implement Stage.

## Objective

Successful completion of the plans made during the last Action Plan Meeting.

What’s Going on During This Step

### Practice Facilitator

[ ]  Regularly reach out to the site to see if they need any support. Refer to the [website](http://www.improvingopioidcare.org) and the resources [*Tips for Achieving the Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Tips-for-Achieving-the-Six-Building-Blocks-Milestones.docx) and [*Common Obstacles Clinics Face and Potential Solutions*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Obstacles-and-Solutions_2019-05-15.pdf) for ideas on how to help the site.

[ ]  Provide site support and connection to [resources](http://www.improvingopioidcare.org), as requested.

[ ]  Help sites connect to [clinical education](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Clinical-Education-Opportunities-on-Opioids.pdf) (e.g., University of Washington TelePain).

[ ]  If working with multiple sites, facilitate monthly Shared Learning Calls (see Shared Learning Call Guide in the appendix for more details.)

### Site

[ ]  Follow through on developed Action Plans.

[ ]  Assess opioid management improvement work through small tests of change, inquiries of staff and clinicians, and data reviews.

[ ]  Reach out to the Practice Facilitator when support or resources needed.

[ ]  Encourage clinicians and staff to participate in clinical education.

[ ]  Meet at least monthly as an Opioid Improvement Team to drive the work forward.

[ ]  If occurring, participate in Shared Learning Calls.

# Future Action Plan Meetings Overview

## Time

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.

CAUTION

1 hour

## Frequency

Approximately quarterly.

## Objectives

Review progress on Action Plan, brainstorm solutions to challenges, and update the Action Plan.

## Who Should Attend

Opioid Improvement Team

## Relevant Materials to Bring To These Meetings

* Current Action Plan
* [*Six Building Block Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx)
* *[Relevant Six Building Blocks resources](https://depts.washington.edu/fammed/improvingopioidcare/helpful-resources/resources-for-clinics/)*
* *[Run chart or other measures of success](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/03/DIY-run-chart-tool.xls)*
* [*Template*](#_How_to_Implement) to document [the](#_Appendix_1:_Action) Action Plan

## Agenda

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

# Future Action Plan Meetings Content

## Review Work Accomplished

* Discuss the progress made in each section of the last Action Plan.
* Take time to celebrate successes.
* Think through how the site will share these successes with the rest of the clinic.

## Review Data

* Review any existing measuring success data to ascertain if the being made are leading to improvements. (Remember to use both quantitative and qualitative data.)
* What do the data tell the team and how will that affect next steps?

## 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 the site learn from their experiences and the data?
* How can they adjust to continue to improve?
* What are the next steps? Who will do these next activities and by when?

Refer to the [website](http://www.improvingopioidcare.org) and the resources [*Tips for Achieving the Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Tips-for-Achieving-the-Six-Building-Blocks-Milestones.docx) and [*Common Obstacles Clinics Face and Potential Solutions*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Obstacles-and-Solutions_2019-05-15.pdf) for ideas on how to help the site.

## Develop Next Action Plan

* Considering the work that is still ongoing from the last Action Plan, does the team and clinic have capacity to take on additional activities?
* If so, refer to the [*Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Measuring-success-metrics_2019-05-02.pdf) and [*Tips for Achieving the Six Building Blocks Milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Tips-for-Achieving-the-Six-Building-Blocks-Milestones.docx) to identify new activities to add to the Action Plan.
* Help the site think through what the next steps are, who will do these activities, and by when.

# Appendix 1: Action Plan Template

NOTE FOR PRACTICE FACILITATOR: Delete any sections not relevant in the current Action Plan. For example, the site might not have activities within each Building Block. In addition, there might be multiple activities under a Building Block. If so, just copy-paste to add additional activities.

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. Please note these activities are organized by Building Block category and align with the milestones beginning on page NUMBER. Please reach out to PRACTICE FACILITATOR with any questions or needs.

## Overview of Current Activities

|  |  |  |
| --- | --- | --- |
| Activity | Lead | Page |
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|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Program Goal/s

You identified the following goal/s for your participation in the Six Building Blocks Program:

## Leadership & Consensus Activities

Activity:

Manager of this process:

Date for completion:

Relevant resources:

|  |  |  |
| --- | --- | --- |
| **List the steps necessary to achieve this goal (What)** | **Person responsible (Who)** | **When** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Policies, Patient Agreements, and Workflows Activities

Activity:

Manager of this process:

Date for completion:

Relevant resources:

|  |  |  |
| --- | --- | --- |
| **List the steps necessary to achieve this goal (What)** | **Person responsible (Who)** | **When** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Tracking and Monitoring Activities

Activity:

Manager of this process:

Date for completion:

Relevant resources:

|  |  |  |
| --- | --- | --- |
| **List the steps necessary to achieve this goal (What)** | **Person responsible (Who)** | **When** |
|  |  |  |
|  |  |  |
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|  |  |  |

## Planned, Patient-Centered Visits Activities

Activity:

Manager of this process:

Date for completion:

Relevant resources:

|  |  |  |
| --- | --- | --- |
| **List the steps necessary to achieve this goal (What)** | **Person responsible (Who)** | **When** |
|  |  |  |
|  |  |  |
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|  |  |  |

## Caring for Patients with Complex Needs Activities

Activity:

Manager of this process:

Date for completion:

Relevant resources:

|  |  |  |
| --- | --- | --- |
| **List the steps necessary to achieve this goal (What)** | **Person responsible (Who)** | **When** |
|  |  |  |
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## Measuring Success Activities

Activity:

Manager of this process:

Date for completion:

Relevant resources:

|  |  |  |
| --- | --- | --- |
| **List the steps necessary to achieve this goal (What)** | **Person responsible (Who)** | **When** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Future Activities

This is a holding place for future activities the site wants to take on next.

## Six Building Blocks Milestones Tracking

NOTE FOR PRACTICE FACILITATORS:

 It is helpful to include a milestones tracking table in the Action Plan in order to keep track of progress toward achieving milestones. Below is a detailed tracking table that includes relevant resources and a column (“date completed & notes”) to record key accomplishments and activities.

Some Practice Facilitators prefer to just use the simple [Design and Implement Milestones Checklist](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-DI-milestones-checklist.docx) instead.

Below are the key milestones you plan to work to achieve through implementing the Six Building Blocks along with (hyperlinked) relevant resources to support your work toward achieve these milestones, and notes on the work you have done or plan to do. When developing action plans and assessing progress, it is a good idea to do a quick check on where you are at in the process by updating this worksheet.

| Milestone | Status | Relevant website resources | Date completed & notes |
| --- | --- | --- | --- |
| **Leadership & consensus** |  |  |  |
| Protected time for improvement team to meet and work | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority |  |  |
| Regularly emphasize project importance and soliciting feedback during staff & clinician meetings | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Opioid harm stories*](https://www.cdc.gov/rxawareness/stories/index.html)[*Motivating slow to adopt providers*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/07/Motivating-slow-to-adopt-providers_2018-07-10.pdf)[*Levers of motivation guide*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/Levers-of-Motivation-guide_2018-10-02.pdf) |  |
| Clinical education opportunities offered to staff and providers, including pain etiology | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*UW TelePain resources*](https://depts.washington.edu/anesth/care/pain/telepain/)[*CDC training and webinars*](https://www.cdc.gov/drugoverdose/training/index.html)*Clinical* [*education*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Clinical-Education-Opportunities-on-Opioids.pdf) *opportunities* |  |
| **Policies, patient agreements, & workflows** |  |  |  |
| Policy revised to align with evidence-based guidelines (e.g., CDC, AMDG) | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Policy model*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/09/Model-opioid-prescribing-policy_2019-09-11.docx)[*Policy checklist*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Policy-checklist_2019-05-23.docx)[*CDC Guideline*](https://www.cdc.gov/drugoverdose/prescribing/guideline.html)[*AMDG Guideline*](http://agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf)[*VA taper decision tool*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/VA-Opioid-Taper-Decision-Tool.pdf)[*Tips for patients on legacy prescriptions*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Patients-on-legacy-prescriptions_2019-05-23.docx) |  |
| Patient agreement revised to support revised policy and educate patients about risks | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Patient agreement model*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/09/Model-opioid-prescribing-patient-agreement_2019-07-11_w-attribution.docx) |  |
| Workflows written to support policies | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Chronic pain appointment workflow*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Chronic-Pain-Appointment-Workflow_2019-05-15.docx)*[Opioid refill workflow](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Opioid-Refill-Workflow_2019-05-30.pdf)*[*Opioid list manager workflow*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Opioid-List-Manager-Workflow_2019-05-15.docx) |  |
| Training conducted on policies, agreement, workflows, and supporting EHR templates | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Rollout and training tips*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Training-and-Rollout.docx) |  |
| **Tracking & monitoring patient care** |  |  |  |
| Patients on long-term opioid therapy identified and labeled with appropriate diagnosis in the chart | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Approaches to identifying patients on chronic opioids*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/01/Approaches-to-identifying-patients.pdf)[*Opioid names*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-opioid-names_Bree-collaborative.pdf)*Sedative* [*names*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) |  |
| All clinicians signed up for the prescription monitoring program | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*List of PMPs*](http://www.pdmpassist.org/content/state-pdmp-websites) |  |
| Calculating MED consistently is possible and easy for clinicians and staff | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*AMDG MED calculator*](http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm) |  |
| Can see a dashboard of key measures for all patients on long-term opioid therapy | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Data to consider tracking*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/01/Data-to-consider-tracking.docx)[*Tracking and monitoring example spreadsheet*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Tracking-and-monitoring-example-spreadsheet_2018-01-31.xlsx) |  |
| **Planned, patient-centered visits** |  |  |  |
| Using data for pre-visit planning | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Purposes of tracking and monitoring*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Purposes-of-Tracking-and-Monitoring_2018-05-15.pdf) |  |
| Using data to monitor high-risk patients and clinical variation | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Purposes of tracking and monitoring*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Purposes-of-Tracking-and-Monitoring_2018-05-15.pdf)[*Chronic pain management teams*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/11/Chronic-pain-management-teams_2018-11-15.pdf) |  |
| EHR pain visit templates in place to cover key elements of the pain visit as outlined in the revised policy | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Pain Tracker*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/PainTracker_PatientVersion.pdf) |  |
| Standardized pre-visit planning and pain visits occurring | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Chronic pain appointment workflow*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Chronic-Pain-Appointment-Workflow_2019-05-15.docx)[*Care plan model*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/02/Care-Plan_2019-02-20.pdf)[*Pain Tracker*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/PainTracker_PatientVersion.pdf)[*Turn the Tide pocket guide for clinicians*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/TurnTheTide_PocketGuide-a.pdf) |  |
| Patients receiving education on chronic pain management and opioid risks | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*CDC patient education example*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/CDC-patient-education_6BB.CME_.pdf)[*Patient letter*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/05/Patient-letter_2018-05-23.docx)[*Chronic pain self-management resources*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Chronic-Pain-Self-Management-Resources_2019-05-02.pdf)[*Patient education resources*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Education-Resources-for-Patients-with-Chronic-Pain_2019-05-02.pdf) |  |
| Training offered to staff and clinicians in patient engagement (e.g., difficult conversations, motivational interviewing) | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Empathic communication resources*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/02/Empathic-Communication-Resources_2019-02-13.pdf)[*Provider guide to difficult conversations*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Principles-and-language-suggestions-for-talking-with-patients.pdf)[*Staff guide to difficult conversations*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/2018/09/Difficult-Conversations-for-Staff_2018-09-19.docx)[*Difficult conversations video vignette*](https://www.youtube.com/watch?v=KvlQuaOogUE&feature=youtu.be) |  |
| Alternatives to opioids integrated into care processes | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*CDC Alternative treatments fact sheet*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/nonopioid_treatments-a.pdf)[*Evidence on non-opioid approaches to chronic pain*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/08/Complementary-and-Alternative-Medicine-for-Chronic-Pain_2018-08-13_new.pdf) |  |
| **Caring for complex patients** |  |  |  |
| Tools selected and consistently in use to identify patients with complex needs (i.e., mental or behavioral health disorders, opioid use disorder, or other substance use disorders) | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Assessment tools webpage*](https://familymedicine.uw.edu/improvingopioidcare/helpful-resources/recommended-assessments/)[*MATx Mobile App*](https://www.nfartec.org/matx-a-mobile-app-to-support-the-treatment-of-opioid-use-disorder/)*OUD diagnosis form* |  |
| Educational opportunities are provided to clinicians on how to identify and treat patients with opioid use disorder | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | *CDC,* [Assessing and Addressing Opioid Use Disorder](https://www.cdc.gov/drugoverdose/training/oud/index.html)*UW TelePain,* [Assessing Chronic Pain Patients for Opioid Use Disorder](https://www.youtube.com/watch?v=IgfC92R-Ya4)*UW TelePain,* [Buprenorphine in Primary Care Practice](https://www.youtube.com/watch?v=tckR7DTvVmM)*Harvard Medical School,* [*Identification, Counseling, and Treatment of OUD*](https://cmeregistration.hms.harvard.edu/events/identification-counseling-and-treatment-of-oud/event-summary-fdaa0a8f057049f5821fce69c22ca9c2.aspx?dvce=1)*Harvard Medical School,* [*Collaborative Care Approaches for Management of OUD*](https://cmeregistration.hms.harvard.edu/events/collaborative-care-approaches-for-the-management-of-oud/event-summary-821dadf3c6f84e2f83f684e1375c24d9.aspx?dvce=1)*PCSS Mentoring Program* |  |
| There is an approach to connecting patients to mental/behavioral health resources, either integrated in the primary care setting, in the community, or through telehealth | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority |  |  |
| There is an approach to connecting patients with opioid use disorder to treatment, either internally through waivered providers or externally through an identified medication for opioid use disorder treatment facility | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*PCSS Online MOUD Waiver Training*](https://learning.pcssnow.org/p/onlinematwaiver)[*Developing a Buprenorphine Treatment Program for Opioid Use Disorder in Primary Care*](https://familymedicine.uw.edu/improvingopioidcare/wp-content/uploads/sites/9/2020/09/BuprenorphineProgram-in-PrimaryCare_attributed-09-10-2020.pdf)[*SAMHSA Find Medication-Assisted Treatment webpage*](https://www.samhsa.gov/medication-assisted-treatment/find-treatment) |  |
| Confidentiality regulations and other information sharing hurdles have been addressed so that patient information can be shared between medical, behavioral health, and substance use disorder clinicians | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority |  |  |
| Training is provided to clinicians and staff on overcoming stigma about patients with mental/behavioral health needs, opioid use disorder, and other substance use disorders | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Reducing Stigma*](https://www.albertahealthservices.ca/assets/info/hrs/if-hrs-reducing-stigma.pdf) ***from Alberta Health Services***[*Guiding Principles for Addressing the Stigma on Opioid Addiction*](https://americanhealth.jhu.edu/article/guiding-principles-addressing-stigma-opioid-addiction) *from Johns Hopkins*[*Changing Language to Change Care*](https://learning.pcssnow.org/p/ChangingLanguage) *from PCSS* |  |
| **Measuring success** |  |  |  |
| Success metric identified | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Measuring success metrics*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Measuring-success-metrics_2019-05-02.pdf)[*Six Building Blocks milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx) |  |
| Success metric regularly reviewed and reported at the clinician level | [ ]  Complete[ ]  In progress[ ]  Plan to do in the future[ ]  Not a priority | [*Purposes of tracking and monitoring*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/05/Purposes-of-Tracking-and-Monitoring_2018-05-15.pdf)[*Chronic pain management teams*](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/11/Chronic-pain-management-teams_2018-11-15.pdf)*DIY* [*run*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/03/DIY-run-chart-tool.xls) *chart*[*Six Building Blocks milestones*](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2019/06/Six-Building-Blocks-Milestones-with-resources_2019-06-11.docx) |  |

# Appendix 2: Shared Learning Call Guide

“I found the Shared Learning Calls to be very helpful. It was nice to hear from other teams who were going through and struggling with different points, because some of them had already rewritten their policies while we were working on doing that. Others were still working the same stages we were. So just having the understanding of what other groups are struggling with and succeeding with was helpful.”

## Overview

Shared Learning Calls are an opportunity for the multiple sites a Practice Facilitator coaches help one another through implementing improvements to opioid management using the Six Building Blocks. If you work with multiple sites, we highly recommend you facilitate monthly Shared Learning Calls. These calls are a terrific way for your sites to share successes and brainstorm through the real challenges that arise in this difficult work. We suggest that the entire Opioid Improvement Team attend the call, if possible.

During calls, the role of the Practice Facilitator is to be curious, make connections, cross-pollinate ideas, generate conversation between the participating organizations, share useful resources, and celebrate successes. The Practice Facilitator should work to make the conversation not a report out of what sites have done, but a sharing of ideas about how to do the work.

## Schedule

Shared Learning Calls should take place once a month and last for one hour. We recommend setting a regular schedule for these calls to take place at the same day and time each month. The calls should begin after the Kickoff. Don’t worry if the sites are at varying stages of implementation. Previous sites in this program have reported that it was useful to hear about what other sites are doing and learn from each other’s struggles and successes. It is best to have 3-6 sites on a call.

## Format

One week before the call, you should ask sites for conversation topics and prepare an agenda. General, ongoing topics to consider for the discussion include:

* What are some recent successes and challenges?
* What is the current focus of your work regarding this initiative?
* Is there anything you need help with or resources you are looking for?
* Is there anything specific you would like to discuss on this call?

At the beginning of the call, ask each site to provide brief responses to the questions above. Next, prepare additional topics based on what you know each site is working on at the time. Below is a list of potential topics.

* Emphasizing project importance and sharing stories and data at clinician and staff meetings
* Connecting staff and clinicians to clinical education
* Policy revision
* Patient agreement revision
* Strategies for tracking and monitoring
* Identifying variables to track for pre-visit planning and tracking and monitoring success
* MED calculation
* Signing up clinicians and designees for the state prescription drug monitoring program
* Using the state prescription drug monitoring program
* Urine drug testing processes
* Identifying and using pain visit templates/flow sheets
* Assessment tools for identifying complex patients and plans for approaching complex patients
* Roll and training
* Educating patients about opioid risks and new policies
* Generating staff, clinician, and patient buy-in
* Handling patients on legacy prescriptions
* Quality improvement strategies (e.g., PDSA cycles)
* Monitoring implementation of policies and workflows
* Measuring success
* Referral pathways for non-pharmacologic treatment and complex patient resources and alternative approaches when there are limited resources
* Implementing and iterating workflows to identify patients, review the chart, and prepare for visits
* Difficult conversations with patients on chronic opioid therapy (e.g., about tapering)
* Training opportunities for empathic communication and patient involvement
* Patient distribution and transfer
* Developing an Opioid Review Team
* Addressing reluctant clinicians
* Sustainability

Periodically check in with the sites to see if they are getting what they need from the calls and if they have any specific requests for discussion topics. If the calls are not useful to each site, discuss together what changes need to be implemented to make them as useful as possible.

## Example agenda

|  |  |
| --- | --- |
| Time | Topic |
| 15 min | **Introductions*** Current focus and work
* Successes and challenges
 |
| 20 min | **Rollout of written workflows*** How are you approaching workflow rollout? Staged? All at once?
* What challenges have arisen? How have you worked through them?
* What has been successful?
 |
| 20 min | **How are you using tracking and monitoring data?** (see attached *Purposes of tracking and monitoring*)* Planning for visits and refills
* Monitoring the patient population to improve care quality
* Looking for clinical variation
* Monitoring overall success
 |
| 5 min | **Future Shared Learning Call topics** |