Tips for Achieving the Six Building Blocks Milestones

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.

Contents

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

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

Tips for Accomplishing Each Milestone

Protected Time for Opioid Improvement Team to Meet and Work

- The opioid improvement team should have a standing monthly meeting to work.
- If your opioid improvement team is large, consider forming a smaller core working group.
- Members of the larger team can be 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

- Ask the clinical champion to keep the project on the mind of staff and clinicians by discussing it in meetings and informal one-on-one conversations.
- Make it a standing agenda item and provide updates at weekly & 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 clinic-wide 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)

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

Clinical Education Opportunities Offered to Staff and Clinicians, Including on the Science of Chronic Pain

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

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- 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.
- 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 team's work into smaller and more specific tasks rather than assigning large projects. Use shorter deadlines rather than deadlines scheduled far out.
- Start with tasks that interest the key individuals.
- Remember that you can engage clinicians and staff outside of the team to help complete tasks, 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 assure 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.

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.

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

We Have Not Been Able to Build Consensus among Clinicians

- Invite a third party (pain expert/academic faculty/other respected external colleague) to give a short presentation and/or 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 your clinic is 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 necessary.
- 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)	*Policy model* *CDC Guideline* State and local guidelines *Tips for patients on legacy prescriptions* *Suggested opioid management schedule* *Risk stratification and opioid prescribing*
Patient agreement revised to support the policy and educate patients about risks	*Patient agreement model*
Workflows written to support policies	*Chronic pain appointment workflow* *Opioid refill workflow* *Opioid list manager workflow* *Remote urine drug testing FAQ and workflow*
Training conducted on policies, agreement, workflows, and supporting EHR templates	*Rollout and training* *Provider guide to difficult conversations* *Staff guide to difficult conversations*

Common Challenge
We want to encourage patient buy-in and help patients understand the new policies and procedures.

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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, for patients transitioning to chronic pain, for 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 your clinic has recently revised its' policy, take time to compare it to evolving regulations, national and state guidelines, and evidence about effective chronic pain management.
- Be sure to make time for the clinicians in your practice to review and discuss the policy revision to ensure it reflects a consensus about the kind of care your organization wants to provide to patients with chronic pain. This process helps build understanding and buy-in for new approaches. 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 a support for clinicians and staff as they work to decrease harm to patients and that clinicians can still individualize treatment.
- Be prescriptive where necessary (e.g., when matching with national guidelines), but solicit and incorporate feedback from staff and clinicians wherever possible.

Example Steps That Have Worked for Policy Revision at Other Organizations

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

LESSON LEARNED

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

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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, lowering harm, 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. Opioid improvement team reviews the revised patient agreement ahead of 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:
    - Preparing for pain visits (e.g., checking state prescription drug database)

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    - 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*
    - *Remote urine drug testing workflow*
- Look back at what your team learned during the Prepare and Launch Stage about:
    - What happens when a patient with chronic pain comes in for a visit that results in an opioid refill
    - What happens when a patient calls for an opioid refill
- Include MAs and nurses on the workflow development/revision team as they are the ones most familiar with the processes included in the workflows.
- Develop workflows that shift responsibility from providers to MAs/nurses, as appropriate. Specifically consider:
    - Pre-visit 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 clinic's workflows. Consider creating different templates for each role (e.g., steps an MA completes, steps a provider completes). This supports your clinic's tracking and monitoring efforts, and importantly is an easy reminder of needed care processes.
- Identify a care team to pilot the draft workflows to determine the most efficient approach. For example, is it easiest to use paper or electronic forms? What can be completed at the front desk?
- Run several tests of change prior to roll out to ensure that what you are proposing can work.

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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 1 or 2 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 to clinicians and staff members when introducing them.
- Train and remind through multiple platforms (e.g., in-person trainings, during 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.

LESSON LEARNED

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

Overcoming Common Challenges

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.

- Distribute a letter, either during a patient visit or by mail, to all patients prior to implementing the new policy and patient agreement and describe some of the key changes. Explain why your clinic is making these changes. (*Example letter*)
- Host a community question and answer event 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.

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- 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.

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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 do not "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 follow-up 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	*Approaches to identifying patients* *Opioid names*
All clinicians and delegates (if applicable) are signed up for the state prescription monitoring program (Delegates are staff who may access the data on behalf of a clinician)	*List of state prescription monitoring database program websites*
Calculating MED as dose or medication changes is possible and easy for clinicians and staff	*WA AMDG MED calculator* *CDC Guideline App, which includes an MED calculator* *How to manually calculate MED*
There is a dashboard of key measures for all patients using long-term opioid therapy	*Data to consider tracking* *Tracking and monitoring example spreadsheet* *Developing a tracking and monitoring dashboard*
Data are used to monitor care gaps, high-risk patients, and clinical variation	*Purposes of tracking and monitoring* *Chronic pain management teams*
Common Challenges	
Data from our tracking and monitoring reports are not accurate.	
It is too time consuming to track and monitor patients using long-term opioid therapy.	
Clinicians do not have time to look at the tracking and monitoring data.	

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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 pre-visit 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.
- Use proprietary software to pull reports from the EHR.

COMMON QUESTION

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

Yes, because you still want to educate these patients about risks, storage, and disposal, and assess for aberrant behaviors and opioid use disorder. All patients using long-term opioid therapy deserve high-quality, evidence-based care.

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

Revisit what learned about the pros and cons of different methods to identify your clinic's 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 is your team trying to address?
- What strengths did you identify for tracking and monitoring?
- What makes sense for next steps?

Refer to the resource *Approaches to identifying patients* for ideas.

All Clinicians and Delegates Are 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, 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 sign-up 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.

- Assign someone to sit with unregistered clinicians and walk them through the registration process.

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- 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 sign-up 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 your clinic wants to rely on it.
    - Put a link to an MED calculator on every computer (e.g., on the desktop, within the EHR, as an internet browser bookmark) and train providers and staff on where to find the calculators.
    - Put an Excel version of an MED calculator on every computer (e.g., on the desktop, within the EHR).
    - Suggest clinicians that use a smart phone download the *CDC Guideline App*, which includes an MED calculator.
- Identify whether the MED is recorded in the same field within the EHR by everyone and whether that field is retrievable into reports.
- Determine if training on MED calculation is 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 do not 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.

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- Based on what your clinic currently records 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 your clinic wants to track are currently collected and stored. Consider:

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

Consider whether your clinic wants to collect and store data manually (e.g., Excel) or electronically based on your electronic health record system and its functionality. If you are planning to manually track data, consider modifying the *Tracking and monitoring example spreadsheet* to include the prioritized variables.

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

How to 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 team's prioritized measures of success.
- Select the best possible approach to tracking and monitoring the prioritized measure of success and stick with it. It may not be perfect, but it is worth trying to regularly review and share data about patients using long-term opioid therapy as soon as possible to motivate and make improvements. Even if the measure is not 100% accurate, your clinic will still be able to see the direction it is going over time.
- Continue improving the measurement and reporting approach if needed.
- Once you have identified a feasible way to monitor a prioritized measure of success, use that knowledge to:
    - Add other measures of success
    - Develop an approach to retrieving data to monitor care gaps and high risk-patients
    - Develop an approach to monitor data/measures by clinician so the clinic 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

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- 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.

LESSON LEARNED

Do not forget the power of stories to garner buy-in for tracking and monitoring. Think about if there is 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.

Overcoming Common Challenges

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

Data from Our Tracking and Monitoring Reports Are Not Accurate

- Ensure staff and clinicians understand why your clinic is collecting the data, how it gets collected, how it is being used at the clinic level, and how the clinic, clinicians, and staff can use the data. Emphasize the benefits to patients and care teams.
- Regularly share the data with staff and clinicians. This 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.
- Review whether your process accurately identifies 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.

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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 your team is 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 clinic workflows. Make sure the tracking and monitoring workflow is compatible with other workflows for chronic pain management.
- Consider including the specific duties of tracking and monitoring into a person's job description.

Clinicians Do Not Have Time to Look at the Tracking and Monitoring Data

- Utilize 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.

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Planned, Patient-Centered Visits

Overview

Planning for patient visits can make a big impact! Care gaps can be identified by "scrubbing charts" the day before or during the morning huddle, resulting in delegation of tasks to different team members to close the gaps. For example, who is going to review the new patient agreement form with the patient and get 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 pre-visit planning	*Purposes of tracking and monitoring*
EHR pain visit templates are in place to cover key elements of the pain visit as outlined in the revised policy	*Pain Tracker* *Clinical Decision Support tools* *WSMA opioid management dot phrases*
Standardized pre-visit planning and pain visits are integrated into the practice	*Chronic pain appointment workflow* *Care plan model* *Pain Tracker* *Turn the Tide pocket guide for clinicians* *BRAVO protocol* *VA Opioid Taper decision tool* *HHS Guide for Clinicians (tapering)*
Patients receive education on chronic pain management and opioid risks	*CDC patient education example* *Patient letter* *Chronic pain self-management resources* *Compilation of patient education resources*
Training in patient engagement is offered to staff and clinicians (e.g., difficult conversations, motivational interviewing)	*Empathic communication resources* *Provider guide to difficult conversations* *Staff guide to difficult conversations* *Difficult conversations video vignette* *Oregon Pain Guidance: difficult conversations* *Social determinants of health and pain management* *Stigma and chronic pain*

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Milestones	Relevant Resources
Alternatives to opioids are regularly considered and discussed, and integrated into care processes	*CDC Alternative treatments fact sheet* *Evidence on complementary and alternative approaches to chronic pain* *AHRQ's Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review* *AHRQ's Treatments for Acute Pain: A Systematic Review*

Common Challenges
Our appointments are very backed up.
Some clinicians are not using the state 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 re-distribute his/her patients using long-term opioid therapy.

Tips for Accomplishing Each Milestone

Data Are Used for Pre-Visit Planning

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

- What information is needed for pre-visit planning? What steps are needed to make these data consistent and available?
- How does your clinic know when a patient using long-term opioid therapy has an upcoming appointment that needs pre-visit planning?
- What will the process be to review and use data for pre-visit and pre-refill planning?
- Who is responsible for pre-visit 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 pre-visit and pre-refill planning helps support policy implementation. Investigate how information is used now for pre-visit planning. How could it be done better? Test and adjust to build effective workflows for tracking and monitoring data for pre-visit and pre-refill 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.

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- Run multiple tests of change to ensure templates are easy to use.

Standardized Pre-Visit Planning and Pain Visits Are Integrated into the Practice

After developing and training on workflows to support pre-visit 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 employed to monitor workflow implementation include:

- Reviewing tracking and monitoring reports (e.g., date of last patient agreement review, date of last urine drug test) to see what is and is not being done, then adjust 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

- Decide which patient education materials your clinic wants to make available for patient care. Take a look at the list of *patient education materials* and *chronic pain self-management resources*. Some to consider include:
    - *Opioid risks* (e.g., addiction, respiratory depression, hormone disruption)
    - *Risks of combining opioids and benzodiazepines*
    - *Naloxone*: what is it 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 clinic's patients.
- Consider asking your patients for their advice on materials.
- Consider who will review these materials with patients and when. Will your clinic use care coordinators? MAs? Think through how to take advantage of a team-based care model in order to carve out adequate time for education with the patient.

LESSON LEARNED

Consider utilizing 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 *Fostering Collaborative Patient-Provider Relationships in Pain Management and Opioid Prescribing* available to clinicians and staff
- Watch the *Difficult Conversations Vignette* during a medical staff meeting and discuss strategies used (refer to *provider scripts*, *staff scripts*, and resources on *Oregon Pain Guidance*)

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- Identify if anyone on your staff has skills in the desired training areas (e.g., motivational interviewing) and invite them to present/train
- Reflect on how to attend to social determinants of health as they relate to pain management
- Review strategies to address stigma and chronic pain and determine which are appropriate for your organization
- Show the *NIH videos* on stigma during a medical staff meeting
- Consider doing case reviews and role-playing difficult conversations

Alternatives to Opioids Are Integrated into Care Processes

- Review the alternatives to opioids available to patients (*Alternative treatments fact sheet*, *Evidence on non-opioid 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)

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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 pre-visit planning and document this 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 on 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 are able, insert a link to the calculator (or embed the calculator itself) within the EHR next to a discrete MED field.
- If your clinic has one person or team in charge of refills, have them calculate MED.
- Regularly share MED data at huddles or staff meetings. This 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 Re-Distribute Patients

- If possible, the departing clinician should 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.

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- Develop an agreed-upon re-distribution process in collaboration with other clinicians. This process might re-distribute patients based on patient request and current patient load.
- Consider using risk-tiering of patients to help with re-distribution. 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.

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Caring for patients with complex needs

Overview

Chronic pain can be complicated by other conditions that require special attention, namely mental/behavioral health conditions, opioid use disorder (OUD), and/or other substance use disorders. Insufficiently addressed mental/behavioral health conditions can interfere with successful pain management. For patients with opioid use disorder, the full agonist opioids used to treat pain (e.g., oxycodone, hydrocodone) are rarely the best choice and often the wrong medication for their pain. Medications such as buprenorphine, naltrexone, and methadone are needed for patients with opioid use disorder. Patients with other substance use disorders require assessment and treatment for their disorder in addition to treatment for their chronic pain. Identifying additional and appropriate resources for these patients and creating systems to connect patients to these resources 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. Through 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 on-site allows them to provide their patients a full spectrum of care.

Milestones	Relevant resources
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)	*Assessment tools webpage* *MATx Mobile App* *OUD diagnosis form* *Substance use disorder assessment* *Substance use screening and assessment instruments database*
Educational opportunities are provided to clinicians on how to identify and treat patients with opioid use disorder and other substance use disorders	*CDC,* Assessing and Addressing Opioid Use Disorder *UW TelePain,* Assessing Chronic Pain Patients for Opioid Use Disorder *UW TelePain,* Buprenorphine in Primary Care Practice *Harvard Medical School, Identification, Counseling, and Treatment of OUD* *Harvard Medical School, Collaborative Care Approaches for Management of OUD* *PCSS Mentoring Program* *SAMHSA Substance Use Treatment for Persons with Co-Occurring Disorders*
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	*Integrating Behavioral Health and Primary Care Playbook* *The Behavioral Health Specialist*

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

Tips for Accomplishing Each Milestone

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)

- During policy and workflow development, select tools and intervals for use that allow your clinic to identify patients with complex needs. Refer to the *model policy* and *assessments tools webpage*.
- Train clinicians and staff on where to access these tools and how to use them.
- Have a member of your team who offers medication treatment for 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, other substance use disorders, and common co-existing mental/behavioral health conditions.

Educational Opportunities Are Provided to Clinicians on How to Identify and Treat Patients with Opioid Use Disorder and Other Substance Use Disorders

- Make trainings on diagnosing and treating OUD and other substance use disorders, such as the CDC webinar *Assessing and Addressing Opioid Use Disorder*, available to clinicians and staff.

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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

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

There Is an Approach to Connecting Patients with Opioid Use Disorder or Other Substance Use Disorders to Treatment, Either Internally Through Waivered Providers or Externally Through an Identified Medication for Opioid Use Disorder Treatment Facility

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

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

- Determine whether your practice or department is covered under 42 CFR Part 2. SAMHSA provides a decision guide to identify if your organization or practice needs to be compliant. Federal 42 Code of Federal Regulations (CFR) Part 2 regulations have been put in place to protect patient confidentiality related to treatment for substance use disorders (SUD). If applicable to your organization, it is critical that clinic administration puts systems in place to ensure that these regulations are followed.
- If applicable, ensure all clinic staff and clinicians understand the confidentiality policies that are adherent to 42 CFR Part 2.
- If applicable, ensure that your clinic's permission for record disclosure form is compliant with 42 CFR Part 2.
- Ensure your clinic has a standardized process to have patients sign an ROI with primary care, behavioral health, and substance use disorder departments or agencies so they can communicate about their treatment plan(s).

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- Ensure a way for behavioral health and substance use disorder clinicians to have a direct way to contact primary care providers about urgent concerns and vice versa.

Training Is Provided to Clinicians and Staff on Overcoming Stigma about Patients with Mental/Behavioral Health Needs, Opioid Use Disorder, and other Substance Use Disorders

- Connect clinicians and staff to training on overcoming stigma, such as Changing Language to Change Care: *A PCSS Learning Module on Substance Use Disorder.*

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.
- Consider using the ORT-OUD assessment instead, which is validated for assessing the risk of developing opioid use disorder but does not ask the sexual abuse question.

We Do Not Have Medication for Opioid Use Disorder Treatment Services Available

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

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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 proportion of patients with a signed updated patient agreement or proportion of patients using high-dose opioids. Set an aim 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	*Measuring success metrics* *Six Building Blocks milestones* *CDC QI metrics* *DIY Run chart* *Measuring outcomes survey*
Success measure regularly reviewed and reported at the clinician level	*Purposes of tracking and monitoring* *Chronic pain management teams*
Common Challenges	
We do not have the infrastructure to pull EHR-based reports on patients using 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 *Decide on a Measure of 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.

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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 do not need to be perfect. You can grow your reports as your capacity increases.
- Track MED manually with each refill and track how the data changes over time.

We Do Not Know Enough about Our Patient Population to Set a Measure of Success

- Even if your team does not have much formal data about your clinic's patient population, your clinicians and staff are familiar with what is currently challenging about providing care to patients using 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 your team has established a tracking and monitoring program.

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