Obstacles and Solutions to Six Building Blocks Implementation

The following document helps practice facilitators think through how to help organizations overcome common obstacles. We list common obstacles, organized by Building Block, and the successful strategies we have seen organizations employ.

Contents

Six Building Blocks materials created by University of Washington Department of Family Medicine and Kaiser Permanente Washington Health Research Institute. Funded by Agency for Healthcare Research & Quality (#R18HS023750, #HHSP233201500013I), Washington State Department of Health (CDC #5 NU17CE002734), National Institute on Drug Abuse (#UG1DAO13714), and the Washington State's Olympic Communities of Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of AHRQ, WA DOH, NID.

Leadership & Consensus

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.
- 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.

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.

- 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

Clinicians and staff are too busy to read the policy; it seems too long

- Create and distribute a one-page summary highlighting the key changes.
- Talk about 2 or 3 key changes in each staff meeting.
- Create workflows to support the key elements of the policy.

Clinicians are concerned the clinic policy or patient agreement will force them to treat their patients with chronic pain in a certain way that they may not agree with

- Emphasize that the new policies and patient agreement are meant to be a guide and a support for clinicians and staff to decrease harm to patients. The patient agreement is designed to communicate that "the patient and practice are working together to ensure the safest possible practices in managing the patient's pain." Clinicians can still individualize treatment.

Clinicians feel overwhelmed with the amount of new work required of them

- It can be overwhelming to implement new care processes all at once. Consider a slow ramp-up. For example, during a patient's first patient visit after the changes, do the patient agreement. Wait until the next visit to do a urine drug test.
- Develop workflows that transfer responsibility from the provider to medical assistants (MAs)/nurses, especially for pre-visit planning tasks, checking the state prescription drug monitoring database, preparing paperwork, calculating MED, filling out part of the visit template with the patient before the provider comes in, etc.
- Conduct PDSA cycles to determine the most efficient workflows. For example, is it easiest to use paper or electronic forms? What can be completed at the front desk? Test with early adopters.
- When training on new workflows, be ready to provide clinicians and staff with a realistic estimate of how long the processes will take.
- 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 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 receive support from clinicians and/or staff.
- Provide thorough training on how to use any templates so clinicians and staff can implement with confidence. Conduct trainings with clinicians and staff in the same room so they are able to strategize team-based implementation.
- Provide necessary resources to guide implementation of new activities. For example, provide instructions for signing up for the state drug database, print out copies of the new workflow, print screenshots and instructions for the EHR template, etc.
- If the initial patient agreement process is too time-consuming for the provider to complete thoroughly, consider assigning the patient agreement process to a specific staff member, such as a nurse/MA or care coordinator.

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.
- Anticipate questions and challenges that may be raised by patients. Discuss these with clinicians/staff during training and provide possible solutions to make them feel comfortable in addressing these concerns. Refer to the *provider guide to difficult conversations* and the *staff guide to difficult conversations* for conversation script ideas.

Tracking and Monitoring

We are challenged in identifying which patients are on long-term opioid therapy

- Refer to the resources *Approaches to Identifying Patients*.
- Use one of the measures you are consistently tracking to identify patients (for example, patient agreement, morphine equivalent dose - MED, UDT). If visits are required every 3 months to authorize a refill, your patient list should be nearly complete within 4-6 months.
- Ask those responsible for medication refills (e.g., MAs) to write down the names of patients as they request a long-term opioid refill. The list should be at a good starting place after four months.
- Add the ICD-10 diagnosis code Z79.891 for "Long term (current) use of opiate analgesic" and assign each patient this code when they request a long-term opioid refill.
- The person in charge of tracking and monitoring should be in regular communication with the nurse/MA/care coordinator to receive regular updates on new long-term opioid therapy (LtOT) patients to add or if a patient should be removed from the list. Clearly establish this process in a workflow.
- Take advantage of state prescription drug monitoring databases to create or cross-check your long-term opioid therapy patient list. Ask clinicians to print out all of their opioid prescriptions from the state drug database in the past year, and ask them to identify which of these patients is a long-term opioid user or has received opioid prescriptions for 3 or more months.
- Ask clinicians to validate your list.

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.

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.

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.

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.

Planned, Patient-Centered Visits

Our Appointments Are Very Backed Up

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

Some Clinicians Are Not Using the State Prescription Monitoring Database

- Ensure clinicians and staff understand why the state prescription monitoring database is an important part of patient care and how they can use the data. Give examples and tell specific patient stories from other clinicians about what they learned or how it was helpful to them.
- Assign a delegate to each provider who can look up information in the state prescription monitoring database. Have the delegate look up this information as part of routine 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.
- 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.

Caring for Patients with Complex Needs

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.

Measuring Success

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.