The Six Building Blocks of Pain Management and Safe Opioid Therapy in Primary Care

SAMPLE CLINIC - ANYTOWN, OR

2018 FOLLOW-UP CHANGE REPORT

(Changes in 6BB scores from February to August 2018)

Project Description

SAMPLE CLINIC in Anytown, Oregon has been revising its policies and procedures related to pain management for patients since 2014. This effort was supported by the Oregon Health Authority's (OHA) Pain Management Improvement Team (PMIT) since spring 2018. OHA's Six Building Blocks of Pain Management and Safe Opioid Therapy in Primary Care (The 6 Building Blocks) is a tool based on the CDC Guidelines for Prescribing Opioid Prescribing for Chronic Pain (https://stacks.cdc.gov/view/cdc/38440) that has been adapted for use in Oregon to assess and guide practice change related to pain management. The Regional Research Institute for Human Services (RRI) at Portland State University is conducting the evaluation of this project for the Oregon Health Authority. The RRI was established in 1972 and is a part of the PSU Graduate School of Social Work. Funding for PMIT, the 6 Building Blocks and this evaluation is provided by a four-year grant to OHA from the U.S. Centers for Disease Control and Prevention (CDC) (Grant #1U17CE002751). The grant period is September 2015 – August 2019.

6 Building Block Assessment Methodology

In order to further guide this process, implementation of the 6 Building Blocks at SAMPLE CLINIC was assessed in February 2018 and again in August 2018 by rating multiple indictors in each Building Block, then deriving an average score per block. Indicators were rated on a 4-point scale where 1 =*Limited or no policies,* 2= *Policies, but No Implementation,* 3= *Partial Implementation,* and 4=*Optimal implementation.* Each indicator has a specific definition for what those levels of implementation look like. The baseline scores in this report were averaged across ratings provided by four key staff members. The follow-up assessment was conducted jointly with the clinic director, a member of the PMIT and the PSU evaluator in August 2018. As a result of that follow-up discussion, some of the original baseline scores were adjusted down to better reflect where the clinic fell in accordance with the indicator definitions. These score adjustments are noted in the comments section for each indicator at the end of this report.

The purpose of this report is to provide feedback to Salem staff regarding the progress they have made and areas where they can increase fidelity to the 6 Building Blocks model. Questions regarding the work of the PMIT or this report, can be addressed to PMIT Lead, Nadejda Razi Robinson at nrazirobertson@gmail.com or the PSU co-investigator, Karen Cellarius at cellark@pdx.edu.

Key Findings

SAMPLE CLINIC started the year with a higher score than other PMIT sites due to its early work around Pain Management and Opioid Prescribing. This work was most apparent in the areas of *Leadership* (BB#1) and *Policies (BB#2)*, each rated at 2.7 at baseline on a scale of 1 to 4, indicating that most pain management and prescribing policies had been developed and implementation had begun.

In February 2018, SAMPLE CLINIC started the year with an overall baseline score of 2.3 out of 4, indicating that most pain management and prescribing policies had been developed and implementation was beginning.

By August 2018, SAMPLE CLINIC had increased its score to 3.0, with the most progress in the areas of Measuring Success and Identifying and Tracking

Anytown continued to make progress during the period that it worked with OHA's Pain Management Improvement Team. As of August 2018, *SAMPLE CLINIC* had increased its alignment with the CDC Prescribing Guidelines and the other practices recommended in the 6 Building Blocks, achieving an overall score of 3.0 out of 4, a 23% increase from its score in February.

SAMPLE CLINIC made the greatest progress in the areas of *Measuring Success* (BB#6) and *Identifying and Tracking Patients* (BB#3). The score for *Measuring Success* went from 1.9 to 3.3; a 42% increase. Metrics have been developed and are starting to be tracked, and leadership now meets at least monthly to discuss goals and policies. The score for *Identifying and Tracking Patients* went from 1.8 to 2.9; a 38% increase. As of August 2018, *SAMPLE CLINIC* was creating a tracking system for high risk patients that was expected to contain all high risk patients by September 2018. Risk stratification for complex patients was occurring through notifications to the behavioral health specialist and the practice of scheduling their medical appointments on days when the behaviorist was on-site.

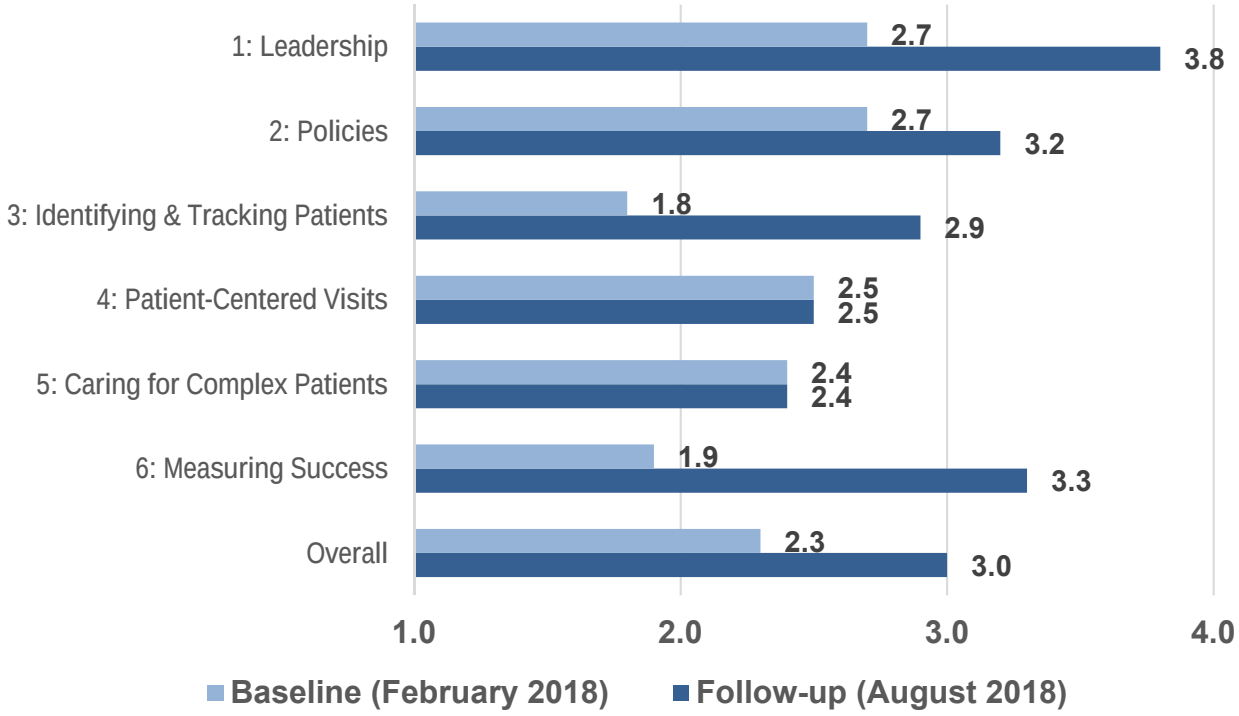
Areas to concentrate on in the future include Patient Centered Visits and Caring for Complex Patients.

The Clinic Director acknowledges that some practices are not yet in place and tracking implementation is less consistent than he would like. Barriers to greater implementation include competing priorities over the past year as well as the geographic isolation of the Center. Areas to concentrate on in the future include Patient Centered Visits (BB#4) and Caring for Complex Patients (BB#5). These areas were already being implemented at baseline, but did not progress over the study period. Due to the progress made in other areas of the 6BB, *Patient Centered Visits* and *Caring for Complex Patients* became the least advanced at follow-up. Nevertheless, the clinic is well on its way to full implementation of the 6 Building Blocks of pain management as well as the CDC prescribing guidelines for opioids.

The following two pages show the change in Block scores as well as individual indicators. The logic behind individual scores can be found in the Comments section under each indicator starting on page 5 of this report. Sites may decide to use this information to guide where to focus further efforts, then re-administer this tool to themselves at least annually in order to be sure that alignment with 6 Building Blocks is maintained.

SAMPLE CLINIC
Mean 6BB Score by Building Block and Month

Scale: 1=Limited or no policies, 2= Policies, but No Implementation, 3=Partial Implementation, 4=Optimal implementation



SAMPLE CLINIC 6 Building Blocks Implementation Scores in Detail

Indicator		February 2018	August 2018
Building Block #1: Leadership	Mean➔	**2.7**	**3.8**
Goals and Priorities		2.8	4.0
Policies to Support Goals		3.0	4.0
Assigned Responsibilities and Timelines		2.3	3.0
Community collaboration		2.7	4.0
Building Block #2: Policies	Mean➔	**2.7**	**3.2**
Acute Pain Prescribing Policies for Opioids		3.0	3.0
Chronic Pain Prescribing Policies for Opioids		3.5	3.5
Non-Opioid and Non-Pharmacological Therapies for Pain		2.0	4.0
Co-Prescribing Benzodiazepines		3.3	4.0
Urine Drug Screening (UDS)		3.3	3.0
Prescription Drug Monitoring Program (PDMP)		3.3	3.5
Treatment Agreements		3.7	3.7
Patient Education		2.7	3.5
Tapering		2.3	3.5
Naloxone		1.5	1.5
Buprenorphine		1.5	2.0
Methadone		1.7	3.5
Building Block #3: Identifying & Tracking Patients	Mean➔	**1.8**	**2.9**
Tracking Patients on Opioids		2.3	3.0
Risk Stratification for Complex Patients		1.3	2.8
Building Block #4: Patient-Centered Visits	Mean➔	**2.5**	**2.5**
Planned Patient Visits		2.5*	2.5
Workflows for Planned Visits		2.3	2.3
Empathic Patient Communication		3.7	3.7
Shared Decision Making		2.7	2.7
Care Plans		1.5*	1.5
Building Block #5: Caring for Complex Patients	Mean➔	**2.4**	**2.4**
Identifying High Risk, Complex Patients		3.0	3.0
Care Plans for High Risk, Complex Patients		1.0*	1.0
Behavioral Health (Mental Health Care& Addiction Treatment)		3.3	3.3
Building Block #6: Measuring Success	Mean➔	**1.9**	**3.3**
Tracking Outcomes		2.3	3.0
Tracking Processes		1.5	3.5
	Overall mean	**2.3**	**3.0**

**Original baseline score was adjusted down based on addition information provided during follow-up assessment.*

Building Block #1: Leadership

The organization's and/or clinic's leadership sets the goals for treatment of pain, both acute and chronic, and the safe use of opioids where appropriate. The goals are measurable and progress towards the goals is reviewed by leadership at least quarterly. Individuals are assigned with the responsibility of working on these goals and tracking progress and necessary resources committed. To achieve buy in, leadership will engage all providers and clinical teams in understanding the importance of goals and the plans for meeting them. The organization will collaborate with other health care organizations and agencies in the local community to ensure good communication between all parties participating in the health and safety of patients and families in the community.

Goals and Priorities	Rating	1	2	3	4
Leadership agrees on goals for treatment of pain, both acute and chronic, and the safe use of opioids. They prioritize the work so that it is accomplished in the most effective manner.	**4**	Leadership has not evaluated current practices and policies for (1) pharmacological and non-pharmacological treatment of acute and chronic pain, (2) safe use of opioids, and (3) consistency among prescribers.	Leadership has evaluated current practices and policies for pain management and safe use of opioids, but no goals have been developed.	All of the above, plus: Leadership has drafted goals for (1) improving treatment of acute and chronic pain, (2) safe use of opioids and (3) improving consistency of practice. The work has been prioritized.	All of the above, plus: Staff members agree with the goals and priorities and are actively working to implement them.
		Comment: Score increased from 2.8 to 4.			
Policies to Support Goals	**Rating**	**1**	**2**	**3**	**4**
Each goal has corresponding policies. These policies are fully understood by all prescribers and staff and are the new standard of care. NOTE – Recommended policies are defined in Building Block #2	**4.0**	Pain management and prescribing goals do not exist OR Goals do exist but policies to support them have not been identified.	Leadership has reviewed the recommended policies in Building Block #2, compared them to existing clinic policies, and identified where more specific policies are needed.	Clinic/agency policies are in place for: (1) treating acute and chronic pain, (2) providing non-opioid or non-pharmaceutical therapies, (3) treating complex, high risk patients and (4) educating and engaging patients in their own care.	All of the above, plus: The policies are fully understood by all providers and staff and are the new standard of care.
		Comment: Score increased from 3.0 to 4. Policies are in place as the new standard of care. However, providers could be more accessible.			

Assigned Responsibilities and Timelines	Rating	1	2	3	4
Clinical and operational champions are identified who are responsible for achieving goals and policies and providing progress reports to leadership. An implementation timeline is followed and monitored. A process of continuous quality improvement is implemented which includes identifying and spreading best practices.	**3.0**	Individuals responsible for achieving goals and associated policies, and reporting progress (champions) have not been identified.	Champions have been identified and a time limited pilot phase to test the new practices has begun.	Further champions have been identified, pilots have been completed and lessons learned incorporated into policy and practice. Scale up to organization wide implementation has begun and timeline established. Work on the next set of priorities has begun.	Organization wide implementation has been achieved. Champions are monitoring fidelity to the new model of care and providing regular progress reports to leadership. CQI methods are used to identify and spread best practices.
		Comment: Score increased from 2.3 to 3.0. Clinic director has been working on process since the beginning. RN and LCSW have also been hired. Staff are on board with policies, but patients are not yet there. Rural locations and separation from other sites make monitoring difficult.			
Community Collaboration	**Rating**	**1**	**2**	**3**	**4**
Leadership is collaborating with other community health care organizations and agencies to improve the management of chronic pain and use of prescription opioids to reduce the number of pills in circulation, expand access to alternative therapies and addictions treatment, and help educate the community.	**4.0**	Leadership has not engaged in a community-level effort to collaborate and coordinate pain management, care for patients and families, and reduce the availability of opioids.	Leadership has engaged somewhat with other community health care organizations and agencies, but not in a systematic way.	Leadership has engaged in a community level effort. Community goals have been set and agreed upon by participating organization(s).	All of the above, plus: Leadership has committed resources to achieve community wide goals.
		Comment: Score increased from 2.7 to 4. Leadership works toward community wide collaboration. Staff are trying to engage other providers. Not a lot of providers in that area.			

Building Block #2: Policies

The organization's goals need to be supported by corresponding policies ("What") and associated workflows ("How"). Patient education is an essential component that explains how these clinic policies ensure patient safety and promote improved quality of life. The treatment agreement is a key part of patient education.

Acute Pain Prescribing Policies for Opioids	**Rating**	**1**	**2**	**3**	**4**
Opioid prescribing policies for acute pain treatment are defined, incorporating the key CDC guidance: utilizing immediate-release opioids, lowest effective dose, and for no longer than 3- 7 days without justification or re-evaluation. Non-opioid modalities are encouraged and promoted.	**3.0**	Prescribing policies either do not exist or do not cover many prescribing situations.	Dosing guidelines exist in keeping with the CDC prescribing guidelines and input from pharmacy and staff, but have not yet been implemented.	All of the above, plus: Guidelines have been implemented. Policies, EHR pharmacy prompts, and QI assessment are in place, but staff have not been trained.	All of the above, plus: All staff have been trained in the use of the policy and a process for tracking progress is instituted.
	Comment: No change in score. Guidelines and policies are in place at clinic, but staff have not been trained. Tracking has not yet begun.				
Chronic Pain Prescribing Policies for Opioids	**Rating**	**1**	**2**	**3**	**4**
Opioid prescribing policies for chronic pain treatment are in keeping with the CDC guidelines, including duration (opioids for 90 days or greater) and dose, (< 50 MED, rarely more than 90 MED).	**3.5**	Prescribing policies either do not exist or do not cover many prescribing situations.	Policies exist and are in keeping with the CDC prescribing guidelines and input from pharmacy and staff, but have not yet been implemented.	All of the above, plus policies have been implemented. Prescribers are aware of them, but there is no consistent mechanism to achieve compliance.	All of the above, plus: Policies are well-defined and monitoring occurs monthly or quarterly.
	Comment: No change in score. Tracking system is not in place.				

Non-Opioid and Non-Pharmacological Therapies for Pain	Rating	1	2	3	4
Non-opioid and non-pharmacological therapies for pain (acute and chronic) are used as first line treatment. The organization works with payers to streamline authorization procedures for non-opioid and non-pharmacological therapies. Lifestyle changes, such as better sleep habits, are recommended.	**4.0**	Policies do not exist and there is no reference list of non-opioid and non-pharmacological therapies. There is no list of authorized non-pharmacological treatments.	A list of non-opioid and non-pharmacological therapies has been circulated to all prescribers. The providers have discussed barriers and proposed solutions. Preliminary list of authorized non-pharmacologic treatments is available.	All of the above, plus: Policies are being developed. Model care plans using non-opioid and non-pharmacological therapies for pain are circulated between prescribers. Payer policies have been collected. Most prescribers consistently recommend opioid alternatives.	Policies are well-defined. An updated list of payer authorized non-opioid and non-pharmacological treatments is circulated each month/quarter. Care plans for all patients being treated for pain include non-opioid and non-pharmacological therapies.
	Comment: Score increased from 2 to 4. Referral policy includes non-pharma options. Behavioral health consultant sees patients and encourages pain groups. Clinic knows and follows Medicaid and Medicare coverage.				
Co-Prescribing Benzodiazepines	**Rating**	**1**	**2**	**3**	**4**
Organizational policies discourage co-prescribing of opioids and benzodiazepines (or other medications such as z-drugs, carisoprodol, etc.) Existing patients on both are being tapered to safe levels defined in the policies. Behavioral health or psychiatric consultations are made where indicated.	**4.0**	Policies do not exist. Prescribers and care-team do not consistently check for co-prescribed opioids and benzodiazepines (or other medications such as z-drugs and carisoprodol).	Mechanisms for identification of co-prescribed sedatives have been created, but analysis is inconsistent.	Systematic identification of co-prescribing is utilized throughout the clinic but adherence is inconsistent.	All of the above, plus: Policies are well-defined. Co-prescribing is systematically monitored and patients with co-prescribed sedatives are tapered to safe levels defined in the policies. Psycho-pharmacology consultation is an established part of managing difficult patients.
	Comment: Score increased from 3.3 to 4.0 Very few patients are co-prescribed opioids and benzodiazepines. Those that are prescribed are at very low or are tapering down. Patients on a combination of opioids and benzodiazepine are referred regularly to Behavioral Health.				

Urine Drug Screening (UDS)	Rating	1	2	3	4
Urine drug screening is used for all patients on opioids at regular intervals as defined in the policy. Actions for positive screens are defined and followed.	**3.0**	Policies regarding UDS for patients on opioids do not exist.	The clinic has agreed on a UDS policy and regular testing intervals, but screenings are inconsistently ordered.	Screenings are ordered for all patients on opioids at regular intervals, but positive screens are inconsistently acted upon.	Screenings are ordered for all patients on opioids at regular intervals as defined in the policy. Actions for positive screens are defined and followed.
	Comment: Score decreased from 3.3 to 3.0 Drug screens are ordered annually. However, provider group is pensive around drug screen results. There is no formal pathway for all positive drug screens, possibly due to the idea that implementing a follow-up policy may not be a patient-centered intervention. Site may want to re-open the discussion around developing a follow-up protocol treatment referrals are just one of many options.				
Prescription Drug Monitoring Program (PDMP)	**Rating**	**1**	**2**	**3**	**4**
The organization has clear policy on consulting the PDMP for every new controlled substance prescription and periodically (as needed and at a minimum defined time by the organization) for continuing prescriptions. All prescribers of controlled substances have registered with the PDMP.	**3.5**	Policy does not exist for use of the PDMP.	The clinic has agreed on a policy for prescribers and their delegates to register for the PDMP and check for prescribed controlled substances at defined intervals, but the policy is inconsistently followed.	The clinic has an agreed upon policy, and is actively working to implement. Unregistered prescribers are identified and scheduled to register, but the PDMP is inconsistently checked.	All of the above, plus: All prescribers or their delegates consult the PDMP for every new controlled substance prescription and at defined intervals for continuing prescriptions, and for concerning patient behavior.
	Comment: Score increased from 3.3 to 3.5 Director reports some progress since baseline, but there is more to be done.				

Treatment Agreements	Rating	1	2	3	4
Treatment agreements are signed by every patient on opioids. They are a key component of patient education about opioid risks and clear patient responsibilities. Both patient and provider expectations are delineated in keeping with clinic policies. The OMB requires the Material Risk Notice to be completed on all patients receiving chronic opioid therapy. This is a separate form and should be attached to ALL patient treatment agreements.	**3.7**	Treatment agreements/OMB Material Risk Notices do not exist or are not used consistently.	A standard treatment agreement and OMB Material Risk Notices are key components of patient education about opioid risks and patient responsibilities. Patient and provider expectations are both included in the agreement. Clinic policy requires that all patients on opioids must sign them.	All of the above, plus: A process for all new patients on opioids to review and sign the treatment agreement and OMB Material Risk Notice is in place.	Treatment agreements have been signed by every patient on opioids. A separate OMB Material Risk Notice is attached to ALL treatment agreements for all patients receiving chronic opioid therapy.
	Comment: No change in score. Treatment agreements have been signed by every patient on opioids. A Materials Risk Notice may be embedded in patient agreement, but it is not a stand-alone document.				
Patient Education	**Rating**	**1**	**2**	**3**	**4**
Providers continue to educate their patients through conversations and education materials – the differences between acute and chronic pain, the risks of opioids, the benefits of non-opioid therapies and patients' engagement in their own recovery. Patients are encouraged to participate in treatment decisions and to set their personal goals.	**3.5**	No policy around patient education on pain and opioids exists. Minimal materials are available and patient education varies across providers.	The clinic has a policy regarding educational conversations with all patients on opioids that include: (1) acute vs. chronic pain, (2) the risks of opioids, and (3) the benefits of (a) non-opioid therapies and (b) patient engagement in their own recovery. For patients prescribed greater than 50 MED, these conversations are the precursor to tapering. Additional educational resources have been identified.	All of the above, plus: The clinic has a defined policy on patient communication and education. Providers have been trained on how to have better patient conversations. But not all patients have had the conversation and received education materials.	All patients on opioids have had an educational conversation with their provider and received education materials. Patients are encouraged to participate in treatment decisions and to set their personal goals as part of their care plan.
	Comment: Score increased from 2.7 to 3.5 Conversations with patients happen on a regular basis. Materials and supports vary by provider.				

Tapering	Rating	1	2	3	4
The clinic has a standardized definition and tapering policy for high risk Chronic Opioid patients: Dose > 90 MED, documented aberrancy, unsafe co-prescribing, overdose, unapproved multiple prescribers, an inconsistent +/- UDS, or credible concerns for diversion by family, community, pharmacy, or police. Buprenorphine is available for patients who are identified as having OUD.	**3.5**	Policy around identification and tapering of high risk patients does not exist or is inconsistent.	The clinic has created a policy to both identify high risk patients and to provide education and support to both patients and providers in achieving appropriate treatment and tapering goals.	All of the above, plus: The identification and tapering policy is being implemented. Protocols for slow versus rapid taper are established with patient safety as the primary rate-determining factor. Behavioral supports are available to aid successful tapering.	All of the above, plus: High risk patients are consistently identified and prescribers are aware of their status. Tapering plans are being implemented for all high risk patients and offered to all high dose patients. Buprenorphine is available for patients who are identified as having an opioid use disorder. A protocol for clinical peer/expert review is utilized for all patients on high doses who are not tapered.
	Comment: Score increased from 2.3 to 3.5. If patients are not being tapered, it is because they are on pause with the discussion or terminal. Buprenorphine discussions could be improved.				
Naloxone	**Rating**	**1**	**2**	**3**	**4**
All patients receiving opioids (>50 MED), as well as those with opioid use disorder, should have naloxone prescribing offered to a close associate of the patient as part of the treatment plan. Co-prescribing is encouraged at lower doses, especially when co-existing risks, such as chronic pulmonary disease, are present. This is at the discretion of the provider or in consort with more stringent regional/organizational goals.	**1.5**	Naloxone is not co-prescribed or offered consistently to patients on higher dose opioids or at higher risk for opioid overdose.	Policies and procedures have been developed in conjunction with local pharmacies regarding co-prescribing naloxone with prescriptions of high dose opioids, but are not consistently implemented. Educational materials are available regarding overdose risk and naloxone. A scripted message is available for any clinic staff member to encourage the use of naloxone for at-risk patients.	Written procedures for encouraging naloxone co-prescribing are being implemented. Procedures include clear methods of enlisting the help of patient's family and friends in this safety measure. All staff are aware of the scripted message around co-prescribing.	All of the above, plus: Friends and family of all patients receiving opioids above 50 MED, diagnosed with an opioid use disorder, and/or otherwise identified as at-risk are offered naloxone.
	Comment: No change in score. Procedures may not happen consistently yet and could be reviewed to see how comprehensive they are. Naloxone is available. RNs have standing orders to prescribe Naloxone. A scripted message is available around safety. It is unknown whether message includes co-prescribing Naloxone or how widely it is used.				

Buprenorphine	Rating	1	2	3	4
Any clinic that manages chronic pain patients with opioid therapy shall have buprenorphine treatment readily available to easily provide continuity of care when opioid use disorder is identified. This may include supporting providers to obtain their X waiver, or developing partnerships with community providers.	**2.0**	Buprenorphine treatment is not provided by or facilitated for patients diagnosed with opioid use disorder.	A plan is in place to facilitate prescribers obtaining an x-waiver for buprenorphine treatment, and/or a system exists for referring patients to community-based Medication Assisted Treatment (MAT) providers.	Prescribers are in the process of obtaining x-waivers for prescribing buprenorphine. Incentives are offered to staff or community partners to get trained and/or provide buprenorphine-assisted treatment to appropriate patients.	All staff are trained to understand substance use disorder. Buprenorphine treatment is available to all patients diagnosed with an opioid use disorder, either through prescribers with x-waivers or partnerships with community addiction treatment providers. Prescribers with x-waivers encourage the use of available community supports (NA groups, clergy) where possible.
	Comment: Score increased from 1.5 to 2.0. Buprenorphine has been available for about 4 years. Some staff have been trained, but not all. One prescriber has an x-waiver who divides his time across multiple sites, but sees patients there occasionally. Additional support is available at another site. Director notes that patients at the clinic are more reluctant than at other sites to accept that they have an SUD.				
Methadone	**Rating**	**1**	**2**	**3**	**4**
All patients being prescribed methadone for pain management will maintain their dose no higher than 30 mg/d. The initiation of methadone is discouraged for chronic pain management, and is not used to treat acute pain.	**3.5**	There is no policy around the use of methadone for pain management.	Methadone prescribing policies have been created that include educating patients, tapering methadone doses to less than 30 mg/day, avoiding initiation of methadone for chronic pain management, and avoiding its use for acute pain, but the policies have not been implemented.	All of the above, plus: Staff are aware of the methadone prescribing policies, and implementation is under way.	No patient is initiated on methadone for chronic pain, and methadone is not used to treat acute pain. Patients on methadone are limited (or being tapered) to 30 mg/day or less, with a protocol for exceptions only in appropriate persons based on case review by peers/experts.
	Comment: Score increased from 1.7 to 3.5. Methadone is no longer covered by OHP (Medicaid), but it is still covered by Medicare. Chronic pain policy includes not starting anyone on Methadone, but there are a few legacy patients who get it. The maximum prescription level for Methadone is estimated at 30, but levels may not be reviewed regularly.				

Building Block #3: Identifying and Tracking Patients

The patient population includes all patients receiving opioids. As the goals include pain management, both acute and chronic, organizations will consider whether to include, for example, chronic pain patients who may not be receiving opioids, but who would benefit by being included in the process improvement initiative. It may be helpful to identify high risk, complex patients within this population for more urgent action and more frequent monitoring. Each organization will determine the most efficient way to identify and track this population given the tools and staff skills available.

Identifying and Tracking Patients on Opioids	**Rating**	**1**	**2**	**3**	**4**
The clinic has a registry it uses to identify and track all patients on opioids. The registry is an updated list of patients taking opioids, as well as other items useful in managing their care. Clinics determine what should go on the registry, which usually includes the following: MED, opioid risk score, sedative co-prescribing, tapering status, and functional status. This information is reviewed monthly or quarterly by leadership and other prescribers to monitor progress towards treatment goals.	**3.0**	There is no clinic registry for tracking patients on opioids.	The clinic has a plan for creating a registry that can be supported with the clinic's tools and staff resources, but this has not been implemented. The plan lists the elements that are to be included in the registry for each patient, including a method for identifying high risk or complex patients.	The clinic has implemented a registry for patients on opioids. The registry contains some patients and some of the items for each patient. Interim tracking and monitoring is done, but not regularly and/or does not capture the entire population.	The system tracks all patients on opioids, and all the elements identified by the clinic. Data are reviewed at least quarterly by clinical leadership and prescribers to monitor progress towards treatment goals and formally document decisions on patient treatment.
	Comment: Score increased from 2.3 to 3.0. Site has just started creating a tracking system that is expected to be fairly robust by the end of August 2018. System tracks some of the identified items for some patients. The registry is reviewed once every two weeks. By end of September, everyone will be on the registry for all clinic sites.				
Risk Stratification for Complex Patients	**Rating**	**1**	**2**	**3**	**4**
All patients identified as high risk, complex pain patients (see BB #5) are reviewed monthly, by PCP, care team and clinic leadership to ensure progress towards goals and patient safety.	**2.8**	There is no current process for identifying or tracking high risk, complex pain patients.	The definition of high risk patients is agreed upon by leadership and providers. High risk patients are identified, but not in a systematic way.	A tracking mechanism identifies all complex or high risk patients, but there is not a systematic process to monitor progress and safety for patients in those categories.	All of the above, plus: All high risk, complex pain patients are reviewed at least monthly, by PCP, care team and clinic leadership to ensure progress towards goals and patient safety. If there is lack of progress over a period, the prescriber will develop and document an action plan.
	Comment: Score increased from 1.3 to 2.8. The mechanism for identifying or tracking high risk, complex pain patients has begun. The prescriber emails the behavioral health specialist when he sees a complex patient. The clinic is trying to schedule complex pain patients on the one day a week that the behavioral health specialist is in clinic. The care team talks a lot about high risk patients and tapering.				

Building Block #4: Patient-Centered Visits

Through planned visits, conduct pro-active population management before, during, and between clinic visits of all patients on chronic opioid therapy to ensure that care is safe and appropriate. Support patient-centered, empathic communication for patient care.

Planned Patient Visits	Rating	1	2	3	4
Before routine clinic visits by patients with persistent pain, clinic notes, PDMP, etc. are discussed in advance to prepare for the visit. If need for behavioral health (or PT, etc.) is anticipated, a list of local or regional resources is available. Open conversations with recommendations from the last visit, e.g. "Nice to see you today. How did your referral to a counselor, therapist, PT go for you?"	**2.5**	Visits by patients with persistent pain are not known in advance by the care team.	Visits are known in advance by the care team, but there are no advance preparations for the visit (PDMP review, chart review, or team discussion).	Visits are known by the care team. Advance preparations usually occur, including a chart review, looking up prescription activity on the PDMP, and discussing the case with the care team.	Advance preparations include described components and always occur for all patients with persistent pain. Past visits and past referrals are discussed with patients.
	Comment: Baseline score reduced to 2.5. No change in score at follow up. The care team agrees with the need for planned visits for chronic pain patients, but staffing could be higher. The behavioral health specialist proactively reaches out to the provider before the appointment or the provider will work with them in advance. Another behavioral health specialist is starting part-time. PDMP is not checked every time.				
Workflows for Planned Visits	**Rating**	**1**	**2**	**3**	**4**
The work needed to plan for a visit with patients receiving or potentially initiating chronic opioid therapy has been clearly defined, and work has been delegated across the team, and is consistently implemented by all team members.	**2.3**	The workflows needed to plan for a visit with patients receiving or potentially initiating chronic opioid therapy have not been defined and are not known.	The workflows for planned visit have been defined, but implementation has not yet begun.	Workflows for planned visits have been defined, but tasks are not delegated across the team and implementation is inconsistent.	Workflows for planned visits have been defined and are consistently implemented by all team members.
	Comment: No change in score. There are no workflows for chronic pain visits, but workflows for co-visits with multiple provider types (MAs, BHCs, etc.) do exist.				
Empathic Patient Communication	**Rating**	**1**	**2**	**3**	**4**
Patient-centered, empathic communication emphasizing patient safety is consistently used with patients with persistent pain to discuss opioid use, dose escalation, or to encourage tapering. For example, "I care about you and your safety and together we need to discuss other options. Is this a good time to talk about that?" Providers are empathetic listeners to what is important to patient, engage the patient in shared decision making, and make referrals as needed for non-opioid treatment options.	**3.7**	Patient safety and empathy is not consistently used with patients with persistent pain. There is no discussion of safety, co-prescribing naloxone or referrals to other services or outside supports.	There is a policy around empathic communication and safety planning with patients with persistent pain, but it is not consistently followed.	Empathic communication, safety planning, and shared decision making usually occurs, but outside services and supports are not discussed.	Empathic communication, safety planning, and shared decision making occurs with all persistent pain patients. Referrals are made as needed for other services or outside supports
	Comment: No change in score. Empathic communication, safety planning, and shared decision making occur with all persistent pain patients. But there is no policy around empathic communication. Director reports that more safety planning around overdosing would be helpful.				

Shared Decision Making	Rating	1	2	3	4
Shared decision making, setting goals for improvement, and providing support for self-management with patients with persistent pain (whether or not opioids are prescribed) is embraced by the care team and includes identifying patient priorities of care, setting goals for functional improvement and/or providing support for self-management. Patient education handouts are readily available.	**2.7**	Care team is not trained in shared decision making, goal setting, or support for self-management for patients with persistent pain.	Care team has been trained, but implementation isn't consistent. Priorities of care are identified, but goals for functional improvement are not set and there is no support for self-management.	Shared decision making, goal setting, and support for self-management usually occurs, but it is inconsistent and may be missing some key elements.	Shared decision making, goal setting, and support for self-management occurs for all persistent pain patients.
	Comment: No change in score. Director reports that there is still room for improvement and has a plan in place for that improvement. The conversation is ongoing.				
Care Plans	**Rating**	**1**	**2**	**3**	**4**
Care plans for patients with persistent pain (whether or not prescribed opioids) are developed collaboratively with patients and are recorded/easy to find. The care plans include self-management goals, clinical goals, the medication regimen, and a monitoring schedule. They are routinely used to guide care.	**1.5**	Care plans for patients with persistent pain are not developed.	When care plans are developed, they are created by the prescribing clinician and only include the medication regimen and a monitoring schedule.	Care plans for pain, regardless of chronic opioid treatment, are developed collaboratively with most patients. They include self-management goals, clinical goals, the medication regimen, and a monitoring schedule. They are entered into the patient's record.	All of the above, plus: care plans are developed, easy to find and routinely used to guide care for all chronic pain patients.
	Comment: Baseline score adjusted down to 1.5. No change in score at follow up. While clinical notes and after visit summaries exist, no specific care plans are created for patients with chronic pain. No formal care plan has been developed, though a care plan form is available in EPIC.				

Building Block #5: Caring for Complex Patients

Develop policies, screening tools, and resources to identify patients who are high risk, complex pain patients. This includes determining opioid dependence, addiction, and substance use disorder. These patients often require diagnosis expertise and treatment options that cannot be provided with the clinic's in-house resources and need to be referred to specialists. When this is indicated, the clinic has coordinated with the resources and specialists in the community and have referral agreements in place.

Identifying High Risk, Complex Patients	**Rating**	**1**	**2**	**3**	**4**
The clinic has policies, screening tools, and work flows to identify opioid misuse, diversion, abuse, addiction and for recognizing complex opioid dependence. Recommended screening tools are PHQ-4, PC-PTSD, FSQ, PCS, and PEG. Clinic consistently uses agreed screening tools.	**3.0**	No policies exist regarding identifying pain patients at high risk for opioid misuse, diversion, abuse, addiction and for recognizing complex opioid dependence.	Policies exist regarding identifying high risk, complex pain patients. One or more recommended screening tools have been selected (PHQ-4, PC-PTSD, FSQ, & PEG), and providers are being trained.	The agreed upon screenings are being conducted, but inconsistently. There is limited follow-up when problems are identified.	The agreed upon screening tools are consistently used. All identified problems receive follow-up, as defined in policy.
	Comment: No change in score. Screenings are being conducted, but it is not known if they occur every time. Some policies for identifying high risk patients may exist but no screening tools have been formally identified. PHQ-9 is used consistently to screen for depression, anxiety and suicide risk. Behavioral health provider uses ASAMs. SBIRT is also used frequently.				
Care Plans for High Risk, Complex Patients	**Rating**	**1**	**2**	**3**	**4**
Each patient has a specific care plan addressing the identified risks. This may involve tapering, conversion to buprenorphine, behavioral health consultation if available in the clinic and/or referral to specialists in pain, addiction, behavioral health. Patients are monitored monthly by clinic leadership.	**1.0**	No standard care plan exists for high risk, complex patients that addresses identified risks.	A standard care plan for high risk, complex patients exists, but not all symptoms and behaviors are addressed and is not consistently used.	The care plan is being used by most prescribers with high-risk patients, but not all symptoms and behaviors are addressed. Progress is not regularly monitored by leadership.	Each high risk, complex pain patient has a specific care plan addressing the symptoms and behaviors identified as risky. Patient progress is monitored at least monthly by clinic leadership.
	Comment: Baseline score adjusted down to 1.0. No change in score at follow up. Director reports that no care plan is being written down.				
Behavioral Health (Mental Health Care and Addiction Treatment)	**Rating**	**1**	**2**	**3**	**4**
The clinic has behavioral health (mental health and chemical dependency) services readily available from behavioral health specialists who are onsite or who work in an organization that has a referral agreement. Process are in place to ensure timely treatment.	**3.3**	Behavioral health referrals are not available on site and there is no organized process to locate or refer externally.	On site behavioral health referrals or processes to obtain them externally are available but aren't timely or convenient.	On site behavioral health referrals or processes to obtain them externally are available and are usually timely and convenient.	Behavioral healthcare is readily available on site or through an organization that has a referral agreement. Processes are in place to ensure timely treatment.
	Comment: No change in score. A behavioral health provider is on site one/day a week and can be seen on other days at other sites. There is no on-going behavioral health treatment on site. The process for obtaining it externally is usually timely and convenient.				

Scale: 1=Limited or no policies, 2= Policies, but No Implementation, 3=Partial Implementation, 4=Optimal implementation

Building Block #6: Measuring Success

The goals and clinical measures defined in building block #1 are monitored and reported on monthly or quarterly by the individual responsible in regularly scheduled (monthly/quarterly) meetings with the leadership and other providers. The leadership shares and discusses results with the clinical team and encourages suggestions for improvement. Leadership decides if any changes or adjustments to the process improvement project is needed. Changes are implemented as a high priority for the clinic/organization.

Tracking Outcomes	**Rating**	**1**	**2**	**3**	**4**
Tracking outcomes evaluates the extent to which the work is having the desired impact. It can be used to compare results over time and focus efforts on a common goal.	**3.0**	No metrics have been defined related to current guidelines for pain treatment and opioid prescribing.	Clinical metrics have been defined related to current CDC prescribing guidelines. Methods for measuring them are in place.	Tracking clinical metrics has begun, but is inconsistent. Reports are not consistently reviewed by leadership or shared with clinical team.	Clinical metrics are reviewed at least quarterly. Leadership shares and discusses results with the clinical team and encourages suggestions for improvement. Compliance with prescribing guidelines is fully monitored and enforced with all prescribers.
	Comment: Score increased from 2.3 to 3.0 Tracking has begun, but is not yet consistent. The process is mainly reactive, rather than proactive.				
Tracking Processes	**Rating**	**1**	**2**	**3**	**4**
Tracking processes evaluates the extent to which clinical teams are implementing suggested practices. It can be used to detect short-term change, explain why certain outcomes are occurring or not occurring, and guide mid-term corrections. It holds clinical team members accountable for conducting the activities needed to achieve the desired outcomes.	**3.5**	There is no plan in place to track overall changes in clinical practices.	Methods to measure progress on goals and associated policies have been defined. The method includes rescoring the 6BB self-assessment or something similar. Measuring progress has not yet begun.	Measuring progress on work plan goals has begun, but measurement is inconsistent or occurs less frequently than every three months. Reports are not consistently reviewed by leadership or shared with clinical team.	Measuring progress on work plan goals occurs at least quarterly. Leadership shares and discusses results with the clinical team and encourages suggestions for improvement. Leadership decides what changes or adjustments are needed. These changes are implemented as a high priority.
	Comment: Score increased from a 1.5 to 3.5. Leadership meets at least monthly to discuss goals and policies, but progress is not systemically planned or monitored. Director reviewed progress toward the 6 Building Blocks of Pain Management and Opioid Prescribing six months after the initial assessment. A specific Opiate committee is expected to start in September. Prescribers participate in a community of practice.				

Six Building Block Authors and Contributors

The Six Building Blocks and their Indicators in this report were adapted from the Six Building Blocks of Safer Opioid Prescribing© for the **OHA Prescription Drug Overdose (PDO) prevention project** in collaboration with the OHA PDO Implementation Workgroup. The Six Building Blocks for Safer Opioid Prescribing© were developed in 2015 as part of a research project on **Team Based Opioid Management** in rural clinics. The three-year research study is a collaboration between 20 rural and rural-serving clinics in Washington and Idaho. Funding was provided by the U.S. DHHS AHRQ grant # R18HS023750. For further information, contact Dr. Michael Parchman (parchman.m@ghc.org), Director, MacColl Center for Innovation, Kaiser Permanente Washington Health Research Institute.

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OHA PDO Assessment version –Fall 2017 Above authors and Karen Cellarius, Lisa Shields, and members of the OHA PDO Pain Management Improvement Team: Laura Heesacker, Jim Shames, Simon Parker-Shames, Nadejda Razi-Robertson, John Kolsbun. (Originally called the web survey version).

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