Clinic Name:	Who completed questionnaire (role & discipline):	Date:

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

Oregon Health Authority, Oregon Prescription Drug Overdose Project

Self-Assessment Questionnaire – Workshop Version *(with Indicator Definitions)*

Last updated May 2018

Background: This clinical self-assessment and the accompanying web survey 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. Ten healthcare organizations around Oregon are using this self-assessment tool in collaboration with the OHA PDO Practice Management Improvement Team to explore and improve clinical practices. The current project is limited to staff at the original six organizations through August 31, 2018. Funding is provided by the U.S. Centers for Disease Control and Prevention Grant # 1U17CE002751. For more information on the PDO project, contact Lisa Shields (lisa.m.shields@dhsoha.state.or.us) PDO Project Manager, Oregon Health Authority.

Six Building Blocks© Background: 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.

CDC Guidelines Alignment: The 2017 CDC Guidelines for Prescribing Opioids for Chronic Pain has twelve recommended policies for prescribers. *All the CDC recommendations are incorporated in Building Block #2.*

Instructions for completing the Self-Assessment Questionnaire

1. *Read the definition for each level of implementation and check the level of implementation your clinic or organization has achieved. NOTE! - If your clinic only meets some of the elements in the rating description, choose the lower level. Often clinics rate themselves high initially, and realize later that they need to change to a lower level.*
2. *Below each indicator, describe what aspects of the measure your clinic has currently implemented and/or is working on.*
3. *When done, transfer the numerical scores on the scoring sheet at the back of the questionnaire and calculate the mean score per block.*

General description of each level:

Level 1	Level 2	Level 3	Level 4
Limited or no policies: Very little has been done on a clinic basis. No clinic wide documentation exists. Some prescribers may implement parts, but most do not.	Policies but limited or no implementation: Some clinic policies have been documented and some prescribers are following them. Implementation is fragmented.	Partial implementation: Clinic policies are well-defined and documented. The majority of prescribers understand and follow the policies. However, progress and compliance is not monitored.	Optimal implementation: Clinic policies are fully implemented. All prescribers and clinical staff support and follow policies. Compliance is monitored monthly or quarterly with follow-up on any variances.

Building Block #1: Leadership

Goals and Priorities

1	2	3	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**.

Why did you choose this rating?

Policies to Support Goals

1	2	3	4
Pain management and prescribing **goals do not exist** OR Goals do exist but **policies to support goals 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.**

Why did you choose this rating?

Assigned Responsibilities and Timelines

1	2	3	4
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.

Why did you choose this rating?

Community Collaboration

1	2	3	4
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**.

Why did you choose this rating?

Building Block #2: Policies

Acute Pain Prescribing Policies for Opioids

1	2	3	4
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**.

Why did you choose this rating?

Chronic Pain Prescribing Policies for Opioids

1	2	3	4
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.

Why did you choose this rating?

Non-Opioid and Non-Pharmacological Therapies for Pain

1	2	3	4
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.**

Why did you choose this rating?

Co-Prescribing Benzodiazepines

1	2	3	4
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.

Why did you choose this rating?

Urine Drug Screening (UDS)

1	2	3	4
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.**

Why did you choose this rating?

Prescription Drug Monitoring Program (PDMP)

1	2	3	4
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.

Why did you choose this rating?

Treatment Agreements

1	2	3	4
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.

Why did you choose this rating?

Patient Education

1	2	3	4
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.**

Why did you choose this rating?

Tapering

1	2	3	4
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.

Why did you choose this rating?

Naloxone

1	2	3	4
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.**

Why did you choose this rating?

Buprenorphine

1	2	3	4
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.

Why did you choose this rating?

Methadone

1	2	3	4
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 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.

Why did you choose this rating?

Building Block #3: Identifying and Tracking Patients

Identifying and Tracking Patients on Opioids

1	2	3	4
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.

Why did you choose this rating?

Risk Stratification for Complex Patients

1	2	3	4
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.**

Why did you choose this rating?

Building Block #4: Planned Patient-Centered Visits

Planned Patient Visits

1	2	3	4
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.

Why did you choose this rating?

Workflows for Planned Visits

1	2	3	4
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.**

Why did you choose this rating?

Empathic Patient Communication

1	2	3	4
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.

Why did you choose this rating?

Shared Decision Making

1	2	3	4
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.**

Why did you choose this rating?

Care Plans

1	2	3	4
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**.

Why did you choose this rating?

Building Block #5: Caring for Complex Patients

Identifying High Risk, Complex Patients

1	2	3	4
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.

Why did you choose this rating?

Care Plans for High Risk, Complex Patients

1	2	3	4
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.

Why did you choose this rating?

Behavioral Health (Mental Health Care and Addiction Treatment)

1	2	3	4
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**.

Why did you choose this rating?

Building Block #6: Measuring Success

Tracking Outcomes

1	2	3	4
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.

Why did you choose this rating?

Tracking Processes

1	2	3	4
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.**

Why did you choose this rating?

Scoring Summary Sheet

Clinic Name:	Who completed questionnaire (role & discipline):	Date:

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

Indicator	Preliminary Score & Subtotals	Average Score for Block
Goals and Priorities		
Policies to Support Goals		
Assigned Responsibilities and Timelines		
Community collaboration		
Building Block #1: Leadership Subtotal:		
Acute Pain Prescribing Policies for Opioids		
Chronic Pain Prescribing Policies for Opioids		
Non-Opioid and Non-Pharmacological Therapies for Pain		
Co-Prescribing Benzodiazepines		
Urine Drug Screening (UDS)		
Prescription Drug Monitoring Program (PDMP)		
Treatment Agreements		
Patient Education		
Tapering		
Naloxone		
Buprenorphine		
Methadone		
Building Block #2: Policies Subtotal:		

Indicator	Preliminary Score & Subtotals	Average Score for Block
Tracking Patients on Opioids		
Risk Stratification for Complex Patients		
Building Block #3: Identifying & Tracking Patients Subtotal:		
Planned Patient Visits		
Workflows for Planned Visits		
Empathic Patient Communication		
Shared Decision Making		
Care Plans		
Building Block #4: Planned Patient-Centered Visits Subtotal:		
Identifying High Risk, Complex Patients		
Care Plans for High Risk, Complex Patients		
Behavioral Health (Mental Health Care& Addiction Treatment)		
Building Block #5: Caring for Complex Patients Subtotal:		
Tracking Outcomes		
Tracking Processes		
Building Block #6: Measuring Success Subtotal:		
Overall total and mean scores:		