Oregon Prescription Drug Overdose Project

Pain Management and Safe Opioid Therapy in Primary Care

Six Building Blocks and Self-Assessment Questionnaire

**September 22, 2017**

### Background

The Six Building Blocks© were developed 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 is 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.

The Six Building Blocks have been adapted for the **Oregon State Prescription Drug Overdose (PDO) project**. This project is broader in scope and scale, involving eight regions in Oregon and their respective local healthcare communities and agencies. The target organizations vary from sole practitioners to larger health care systems . For information on the PDO project, contact Lisa Shields (lisa.m.shields@dhsoha.state.or.us ) PDO project manager, Oregon Health Authority. For information on the PDO Six Building Blocks, contact Mark Stephens (mark.r.stephens@comcast.net ) PDO project consultant.

**CDC Guidelines Alignment** – The [CDC Guideline for Prescribing Opioids for Chronic Pain](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm) has 12 recommended policies for prescribers. *All the CDC recommendations are incorporated in Building Block #2.* We cross reference the CDC recommendations.

Overview of the Six Building Blocks

### Building Block #1: Leadership, goals, and assigned responsibilities

The organization’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 resources committed. To achieve buy in, leadership engages all providers and clinical teams in understanding the importance of the goals and the plans for meeting them. The organization collaborates 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.

### Building Block #2: Produce policies, workflows, treatment agreements, patient education materials

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.

### Building Block #3: Identify the patient population and develop ways to track progress

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 monitor this population given the tools and staff skills available.

### Building Block #4: Planned, 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.

### 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, substance use disorder. These patients often require diagnosis expertise and treatment options that cannot be provided with the clinics 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.

### 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.

Instructions for using the Six Building Blocks and completing the Self-Assessment Questionnaire

The Six Building Blocks provides a framework for improving the treatment of patients with pain, including the use of opioids. As a starting point, we recommend that organizations do a self-assessment to evaluate their current policies and practice using a level 1 to 4 self-assessment system. We highly recommend that this initial self-assessment is done in conjunction with a consultant or practice coach with expertise in the six building blocks who has worked with other organizations. This initial self-assessment accomplishes two things. First, it clearly identifies strengths, weaknesses and gaps in how pain is treated and how safely and effectively opioids are used as compared to the [CDC Guideline for Prescribing Opioids for Chronic Pain](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm). Second, it helps the organization decide on overall goals, and identify and prioritize specific practice changes they want to make.

A common reaction to the self-assessment is that the magnitude of possible areas to address is overwhelming. However, we do not recommend that organizations take on more than they have resources or capacity to undertake. We suggest you select some high payoff areas, especially where patient safety is at risk. It is important that your clinical teams are part of the decision making process and the goals are strongly supported by everyone on the team. One component though is essential, that you have a robust system to first identify the patients and providers involved, and to track progress regularly where both leadership and the clinical teams review results and make continuously improvements.

## Six Building Block Authors and Contributors

Initial version for research project on Team Based Opioid Management

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Building Block #1: Leadership

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| Goals |  |  |  |  |
|  | 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 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.  | All of the above, plus: Staff members agree with the goals and are actively working to implement them.  |
| Policies to Support Goals |  |  |  |  |
|  | 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.  |

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| Assigned Responsibilities and Timelines |  |  |  |  |
|  | 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.  |
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| Community Collaboration |  |  |  |  |
|  | 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.  |

Building Block #2: Policies

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| Acute Pain Prescribing Policies for Opioids |  |  |  |  |
|  | Prescribing policies either do not exist or do not cover many prescribing situations.  | Dosing guidelines exist guided by best practices 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.  |
| Chronic Pain Prescribing Policies for Opioids  |  |  |  |  |
|  | Prescribing policies either do not exist or do not cover many prescribing situations.  | Policies exist and are guided by best practices (CDC guidelines: fewer than 90 days; below 50 MED) 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.  |
| Non-Opioid and Non-Pharmacological Therapies for Pain |  |  |  |  |
|  | 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.  |

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| Co-Prescribing Benzodiazepines |  |  |  |  |
|  | Policies do not exist. Prescribers and care-team do not consistently check for co-prescribed sedatives.  | Mechanisms for identifying co-prescribed sedatives have been created, but use is inconsistent.  | Prescribers and care teams understand and identify at risk patients. Patients are being tapered off opioids and/or sedatives (including those prescribed by mental health) according to developed policies.  | All of the above, plus: Policies are well-defined. Co-prescribing is systematically monitored and patients with co-prescribed sedatives are tapered. Psycho-pharmacology consultation is an established part of managing difficult patients.  |
| Urine Drug Screening (UDS) |  |  |  |  |
|  | 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. Actions for positive screens are defined and followed.  |
| Prescription Drug Monitoring Program (PDMP) |  |  |  |  |
|  | 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 the level of 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 inconsistent checked.  | All of the above, plus: All prescribers or their delegates consult the PDMP for every new controlled substance prescription and periodically for continuing prescriptions. All prescribers of controlled substances have registered with the PDMP.  |
| Treatment Agreements  |  |  |  |  |
|  | Treatment agreements/Material risk notices do not exist or are not used consistently.  | A standard treatment agreement and 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 it.  | All of the above, plus: A process for all new patients on opioids to review and sign the agreement is in place.  | Treatment agreements have been signed by every patient on opioids. A separate OMB Material Risk form is attached to ALL treatment agreements for all patients receiving chronic opioid therapy.  |
| Patient Education |  |  |  |  |
|  | No policy around patient education on opioids exists. Minimal materials are available and patient education varies across providers.  | The clinic has a plan to have educational conversations with all patients on opioids: (1) acute vs. chronic pain, (2) the risks of opioids, and (3) the benefits of alternative therapies and patient engagement in their own recovery. For patients prescribed greater than 50 MEDs, these conversations are the precursor to tapering. Additional educational materials 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.  |
| Tapering |  |  |  |  |
|  | Policy around identification and tapering of high risk patients does not exist or is inconsistent.  | The clinic or health system has created a policy to identify, educate and taper high risk patients. Supports for both patients and providers have been identified. The definition of a high risk patient may include: (1) doses above 90 MED, (2) documented aberrancy, (3) unsafe co-prescribing, (4) past overdoses, (5) unapproved multiple prescribers, (6) inconsistent drug screens, or (7) credible concerns for diversion by family, community, pharmacy, or police.  | 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.  | Patients are regularly assessed for overdose or addiction risk. Tapering plans are being implemented for all high risk patients. Buprenorphine is available for patients who are identified as having an opioid use disorder.  |
| Naloxone |  |  |  |  |
|  | Naloxone is not co-prescribed with high dose opioid prescriptions or offered consistently to patients on high dose opioids.  | 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 patients receiving opioids above 50 MED and/or diagnosed with an opioid use disorder (or a close associate) are offered a prescription for naloxone. Co-prescribing is encouraged at lower doses, especially when co-existing risks, such as chronic pulmonary disease, are present.  |
| Buprenorphine |  |  |  |  |
|  | Buprenorphine treatment is not available for patients diagnosed with an opioid use disorder.  | A plan is in place to facilitate physicians obtaining an x-waiver to provide in-house buprenorphine treatment, and/or a system exists for referring patients to community-based MAT providers.  | In-house staff are being trained to provide buprenorphine treatment. Physicians are in the process of obtaining x-waivers for prescribing buprenorphone to patients. Incentives are offered to staff or community partners to get trained and/or provide buprenorphine-assisted treatment to appropriate patients.  | Buprenorphine treatment is available to all patients diagnosed with an opioid use disorder, either through physicians with x-waivers or partnerships with community addiction treatment providers. Physicians with x-waivers encourage the use of available community supports (NA groups, clergy) where possible.  |
| Methadone |  |  |  |  |
|  | 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, and avoiding use of methadone for acute pain, but they have not been implemented.  | Staff are aware of the methadone prescribing policies, and implementation is under way.  | Methadone is not used to treat acute pain. Methadone is rarely, if ever, used for chronic pain management. Patients on methadone are being limited (or tapered) to 30 mg/day or less.  |

Building Block #3: Tracking Patients

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| Tracking Patients on Opioids (Patient Registries) |  |  |  |  |
|  | There is no clinic or organization registry for tracking patients on opioids.  | The clinic has determined the best approach to creating a registry that can be supported with the clinic’s tools and staff resources, but this has not been implemented.  | The clinic has implemented a registry of patients on opioids that dose levels, functional status, risk level, whether sedatives are co-prescribed and/or tapering has been initiated. Interim tracking and monitoring is done, but not regularly and/or does not capture the entire population.  | The registry includes all patients on opioids and is reviewed at least quarterly by clinical leadership and other prescribers to monitor progress towards treatment goals.  |
| Risk Stratification for Complex Patients |  |  |  |  |
|  | There is no current process for tracking high risk 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.  |

Building Block #4: Patient-Centered Visits

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| Planned Patient Visits |  |  |  |  |
|  | Patient visits 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.  | Before routine clinic visits all patients with persistent pain are in a registry. The 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 available 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?"  |
| Workflows for Planned Visits |  |  |  |  |
|  | The workflows needed to plan for a visit with patients receiving or potentially initiating complex opioid treatment have not been defined and are not known.  | The workflows needed to plan for a visit with complex opioid patients have been defined, but implementation has not yet begun.  | Workflows have been defined, but tasks are not delegated across the team and implementation is inconsistent.  | Workflows for planning visits by complex opioid patients have been defined and are consistently implemented by all team members.  |

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| Empathic Patient Communication |  |  |  |  |
|  | "I'm being forced to reduce your medication." Communication around reducing opioids includes forced taper or discontinuation of opioids, blaming someone else for the decision to taper, and no shared decision making with the patient. There is no discussion of safety, co-prescribing naloxone or referrals to other services or outside supports.  | "Your risky behavior makes it necessary for me to taper your medications." Communication includes forced taper or discontinuation of opioids, patient blaming and minimal shared decision making. There is no discussion of safety, co-prescribing naloxone or referrals to other services or outside supports.  | "This medication is very risky, we need to start making some changes." Communication includes a safety and a moderate amount of shared decision making. Naloxone can be co-prescribed, but there are no referrals to other services or outside supports.  | “I care about you and your safety, so together we need to discuss other options. Is this a good time to talk about that?” Patient-centered, empathic communication is consistently used to discuss continued opioid use, dose escalation, or to encourage tapering. There is a high amount of listening and shared decision making. to what is important to patient. Referrals are made as needed for other services or outside supports |
| . Patient Involvement |  |  |  |  |
|  | Patients are not involved in planning their treatment.  | Patients are asked to identify their priorities of care, but not about their goals for functional improvement or support for self-management. Patient education handouts are inconsistently available.  | Patients are asked about their priorities and goals, but treatment decisions are not shared. Support for self-management of pain is discussed and educational handouts are available. Most, but not all of the care team, understand patient involvement.  | Patients are asked about their priorities and goals and involved in all decision-making. Support for self-management of pain, regardless of COT, is provided, along with educational handouts. The entire care team embraces patient involvement.  |
| Care Plans |  |  |  |  |
|  | 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 COT, 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 used for ALL chronic pain patients, are easy to find and routinely used to guide care.  |

Building Block #5: Caring for Complex Patients

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| Identifying High Risk, Complex Patients |  |  |  |  |
|  | No policies exist regarding screening for high risk patients.  | Policies exist regarding opioid misuse, diversion, abuse, addiction, and recognizing complex opioid dependence. 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.  |
| Care Plans for High Risk, Complex Patients |  |  |  |  |
|  | No standard care plan exists for addressing risks identified for complex patients.  | A standard care plan exists that includes tapering, conversion to buprenorphine, behavioral health consultation, if available in the clinic, and/or referrals to specialists in pain, addiction, behavioral health. The plan is not consistently used, and there is no access to buprenorphine prescribers.  | The standard care plan is being used by most prescribers with high-risk patients. There is some access to buprenorphine.  | Each complex patient has a specific care plan addressing their identified risks. Prescriptions for buprenorphine are readily available. Patient progress is monitored at least monthly by clinic leadership.  |
| Behavioral Health (Mental Health Care and Addiction Treatment) |  |  |  |  |
|  | Behavioral health referrals are difficult to obtain and there is no organized process to locate or refer externally.  | Behavioral health referrals, or processes to obtain externally, are available but aren’t timely or convenient.  | 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.  |

Building Block #6: Measuring Success

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| Tracking Outcomes |  |  |  |  |
|  | Measurement in relation to state and national metrics is not being done. No measurement is being done.  | Measurement in relation to state or national metrics is being done. Clinical metrics have been agreed. Methods for measuring them have been defined.  | All of the above, plus: Clinical metrics are being measured regularly, but reports are not consistently reviewed by leadership or shared with providers.  | Clinical metrics in relation to state or national metrics are measured regularly. Results are reviewed by leadership and providers at least quarterly. Compliance with prescribing guidelines is fully monitored and enforced with all providers. Suggestions for systematic improvement are encouraged. Leadership decides what changes or adjustments are needed. These changes are implemented as a high priority.  |
| Tracking Processes |  |  |  |  |
|  | Pain management and opioid prescribing practices have not been reviewed.  | Methods to measure progress on goals and associated policies have been defined, but only partially implemented.  | Progress on goals and associated policies are being measured regularly. Reports are occasionally reviewed by leadership, but not consistently. Compliance is not fully monitored and enforced with all providers.  | Goals and policies are monitored and reported on at least quarterly with leadership and other providers. The 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.  |
| Tracking Patient Satisfaction/ Quality of Life |  |  |  |  |
|  | Patient satisfaction related to pain management is not assessed, other than the traditional 0-10 pain scale.  | A method for assessing patient satisfaction has been developed and includes a broad array of indicators, including ability to function and Quality of Life.  | All of the above, plus data collection has begun on patient satisfaction.  | All of the above, plus patient satisfaction results are shared at least quarterly by a quality improvement team and at least annually with the entire staff. If areas for improvement still exist, action plans to address those areas are developed and acted upon.  |