The Six Building Blocks of Pain Management and Safe Opioid Therapy in Primary Care (6BB)

Oregon Health Authority, Oregon Prescription Drug Overdose Project

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.*

Overview of the OHA 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 is reviewed by leadership at least quarterly. Individuals are assigned 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 Pre-Assessment Staff Survey

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 conduct a facilitated self-assessment to evaluate their current policies and practice. The Six Building Blocks is a four level assessment system where level 1 equals "No implementation" and level 4 equals "Full implementation". We highly recommend that this initial self-assessment be done in conjunction with a consultant or practice coach with expertise in the six building blocks who has worked with other organizations. Clinic staff can be introduced to the concepts by completing a 15 minute pre-assessment web survey. The survey results provide a starting point for the conversation. The overall assessment process 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 Guidelines for Prescribing Opioids for Chronic Pain. 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 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 continuous improvements.

Six Building Block Authors and Contributors

Initial version for research project on Team Based Opioid Management

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Revised and expanded version for Oregon State Prescription Drug Overdose project – Spring 2017

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OHA PDO Web survey version –Fall 2017

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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	**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.	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.
Policies to Support Goals	**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	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.
Assigned Responsibilities and Timelines	**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.	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.

Community Collaboration	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.	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

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	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.	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.
Chronic Pain Prescribing Policies for Opioids	**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).	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.

Non-Opioid and Non-Pharmacological Therapies for Pain	**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.	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.
Co-Prescribing Benzodiazepines	**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.	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. Psychopharmacology consultation is an established part of managing difficult patients.
Urine Drug Screening (UDS)	**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.	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.
Prescription Drug Monitoring Program (PDMP)	**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.	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.

Treatment Agreements	**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 form to be completed on all patients receiving chronic opioid therapy. This is a separate form and should be attached to ALL patient treatment agreements.	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.
Patient Education	**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.	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.

Tapering	**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.	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.
Naloxone	**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.	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.
Buprenorphine				
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.	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.

Methadone	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.	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 underway.	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.

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	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.	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.
Risk Stratification for Complex Patients	**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.	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.

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	**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?"	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.
Workflows for Planned Visits	**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.	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.
Empathic Patient Communication	**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.	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

Shared Decision Making	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.	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.
Care Plans	**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.	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.

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.

Identifying High Risk, Complex Patients	**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.	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.
Care Plans for High Risk, Complex Patients	**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.	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.
Behavioral Health (Mental Health Care and Addiction Treatment)	**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**.**	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.

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	**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.	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.
Tracking Processes	**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.	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.