Obstacles and Solutions to Six Building Blocks Implementation

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

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Leadership and consensus

Our Opioid Improvement Team/providers/staff/leadership are struggling to complete assigned tasks.

- Try breaking up your work into smaller and more specific tasks rather than assigning large activities. Use shorter deadlines rather than large tasks with deadlines scheduled far out.
- Start with tasks that interest the key individuals. For example, if the patient agreement is of more immediate importance because of its frequent use, try revising the agreement first and then revising the policy so it aligns with the agreement.
- Remember you can engage providers and staff outside of the team to help complete tasks, which has the added benefit of encouraging ownership and buy-in of changes outside of the Opioid Improvement Team.
- Try to work on doable, key tasks during meetings. For example, clearly highlight potential policy changes and discuss and edit during medical staff meetings.
- During editing and development of policies or patient agreements, it can be easier to work with smaller advisory groups that represent roles/clinics and can take the ideas back to their larger affiliated groups.

We want to encourage and help staff/providers to get on board with the changes.

- During the development of the clinic policy and patient agreement, be prescriptive where necessary (e.g., when matching with national guidelines), but solicit and incorporate feedback from staff and providers wherever possible.
- Emphasize that these changes are about reducing potential harm to patients from long-term opioid use, and putting systems in place that support providers and staff in the practice.
- Clearly define the roles of each individual in the clinic in implementing the policies. This will help decrease confusion or misunderstandings regarding policy implementation.
- Train providers and staff together and in person to emphasize that caring for patients on chronic opioid therapy requires a team approach.
- Make policies and workflows easily accessible so that providers and staff can reference them whenever needed. Consider storing on a shared computer network location and post physically where providers and staff can see them.
- Use tracking and monitoring of data to support patient care. Access to patient panel data (e.g., which patients are high-risk, have care gaps) encourages providers and staff to do the work needed to support the tracking and monitoring so they continue to have access to that useful data.
- Share transparent data to show providers and staff where they are at in meeting clinic goals.
- During meetings, have time set aside to share success stories and to brainstorm how to approach challenging cases.
- Have the Champion attend huddles to provide continued advocacy for following clinic policies and answer questions as needed.
- As needed, conduct refresher trainings to remind those in your clinic about the policy specifics and workflow implementation, and to get those who have reverted to old ways back on track.
- Encourage participation in clinical training opportunities related to managing chronic pain. Regular discussion of challenging cases and education keeps providers and staff engaged with the topic and increases comfort.
- Identify champions/early adopters at each individual clinic location who can help encourage implementation and share success stories.

Refer to the "Motivating slow to adopt providers" document for further suggestions on motivating late/slow adopters.

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We have not been able to build consensus among providers on a specific issue.

- Invite a third party (pain experts/academic faculty/other respected external colleagues) to facilitate a discussion among providers, administrators, and the Opioid Improvement Team.
- Meet after hours in more of a social setting to hold discussion on issues for which you are trying to build consensus.
- Focus on evidence about patient harm from long term opioid use to drive consensus-building.
- In some cases, it is more efficient to be prescriptive on specific aspects of the policy rather than leaving each decision up for debate among providers, especially if these segments of the policy can be linked to national or regional guidelines.

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Policies, patient agreements, and workflows

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

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

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

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

Providers feel overwhelmed with the amount of new work required of them.

- It can be overwhelming to implement new care processes all at once. Consider a slow ramp-up. For example, during a patient's first chronic pain visit after the changes, do the patient agreement. Wait until the next visit to do a urine drug test.
- Develop workflows that transfer responsibility from the provider to medical assistants (MAs)/nurses, especially for pre-visit planning tasks, checking the state drug database, preparing paperwork, calculating MED, filling out part of the visit template with the patient before the provider comes in, etc.
- Conduct PDSA cycles to determine the most efficient workflows. For example, is it easiest to use paper or electronic forms? What can be completed at the front desk? Test with early adopters.
- When training on new workflows, be ready to provide providers and staff with a realistic estimate of how long the processes will take.
- Embed care components, such as assessments (e.g. Opioid Risk Tool - ORT, Pain, Enjoyment, and General Activity scale - PEG, and the Patient Health Questionnaire - PHQ) and goal setting, into an electronic health record (EHR) template so the provider does not need to look in multiple places during a visit.
- EHR templates should be simple to follow and only include essential items. Templates that are too long or complicated may not receive support from providers and/or staff.
- Provide thorough training on how to use any templates so providers and staff can implement with confidence. Conduct trainings with providers and staff in the same room so they are able to strategize team-based implementation.
- Provide necessary resources to guide implementation of new activities. For example, provide instructions for signing up for the state drug database, print out copies of the new workflow, print screenshots and instructions for the EHR template, etc.
- If the initial patient agreement process is too time-consuming for the provider to complete thoroughly, consider assigning the patient agreement process to a specific staff member, such as a nurse/MA or care coordinator.

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Tracking and monitoring patient care

We are challenged in identifying which patients are on chronic opioid therapy.

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

Data from our tracking and monitoring reports are not accurate.

- Ensure staff and providers understand why you are collecting the data, how it gets collected, and how the clinic, providers, and staff can use the data. Emphasize the benefits to the clinic and patients and regularly share the data with staff and providers. This can motivate providers and staff to take the time to complete data entry accurately.
- Identify which providers/staff are struggling to enter accurate data in the EHR, either due to lack of understanding or late adoption. Work with these individuals to identify the problem and assist where necessary.
- Conduct refresher training for existing staff and training to new staff on how and where to enter data into the EHR.
- Review whether you are accurately identifying your patients on chronic opioid therapy and that you are not pulling patients who do not belong on the list. Troubleshoot why the problem is occurring.
- Ensure providers and staff enter data into the EHR consistently and in the same location. For example, MED should be calculated in a similar manner and documented in the same EHR field for each patient.
- If you track patients' next scheduled appointments, you can use these dates as a cue to update their data after that appointment if it is an external registry. If it is an EHR-based registry, you can use that date as a cue to check for missing care processes and alert the care team through EHR notes or huddles.

It is too time consuming to track and monitor patients on chronic opioid therapy.

- Identify more than one person who will be responsible for updating and pulling reports. Look into having a care coordinator, refill processor, nurse, MA, or IT staff member assist with this process.
- Ensure you are tracking only key variables that you plan to use for patient care. Only track data that you consistently use.
- Build registry tasks into your workflows. Make sure the tracking and monitoring workflow is compatible with other workflows for chronic pain management.

Providers don't have time to look at the tracking and monitoring data.

- Utilize a list manager who will update patient charts before each COT visit with pertinent information from the registry.

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- Ensure nurses/MAs have access to the tracking and monitoring data so they have the ability to pull data for a provider's patient if needed.

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Planned, patient-centered visits

Our appointments are very backed up and it is difficult to get patients an appointment every 3 months.

- Require patients to schedule their next appointment before leaving each visit.
- Consider nurse only visits to address all care gaps related to opioids and chronic pain management.
- Consider setting timing of appointments based on risk level (e.g., low risk every 6 months)

Some providers are not registered with the state drug database. Some providers are not using the state drug database.

- Provide registration instructions as a handout. It might be helpful to break it out into smaller, simpler chunks.
- Assign someone to sit with all unregistered staff and providers and walk them through the registration process. Block off a patient appointment at the start of the morning or afternoon session to make time for the process.
- Ensure providers and staff understand why the state drug database is an important part of patient care and how they can use the data. Give examples and tell specific patient stories from other providers about what they learned or how it was helpful to them.
- Assign a delegate to each provider who can look up information in the state drug database and document this in the patient's chart on behalf of the provider.

Some care teams are not calculating MED.

- Train staff to support providers in calculating MED.
- Put the MED calculator or a link on all computers. If you are able, insert a link to the calculator (or the calculator itself) within the EHR next to a discrete MED field.
- If you have one person or team in charge of refills, have the refill team calculate MED.
- Regularly share MED data at huddles or staff meetings.

We want to encourage patient buy-in and help patients understand the new policies and procedures.

- Send a patient letter to all COT patients prior to implementing the new policy and patient agreement and describe some of the key changes. Explain why you are making these changes.
- Host a community question and answer session.
- Take time with patients to review the patient agreement and ensure that they understand its content. Explain why specific changes are being made and how they will improve their care and reduce their risks. Use the patient agreement process as an educational opportunity and a risk communication tool. Remember that patients have different levels of health literacy; thus, help each patient to read and sign the patient agreement.
- Anticipate questions and challenges that may be raised by patients. Discuss these with providers/staff during training and provide possible solutions to make them feel comfortable in addressing these concerns. (Refer to the "Principles and language suggestions for talking with patients" handout for conversation scripts.)

Patients feel labeled by having to do drug screens

- Train staff and providers on scripts for these conversations. Refer to "Principles and language suggestions for talking with patients."
- Remind patients that this is standard care for all patients, is part of the patient agreement, and that this testing is being done for their safety.

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We have a provider leaving and we need to re-distribute his/her patients using chronic opioids.

- If possible, the departing provider should create a list of his/her patients on chronic opioids, annotate with key information, and discuss them with the accepting provider.
- Develop an agreed-upon re-distribution process in collaboration with clinic providers. This process might re-distribute patients based on patient request and current patient load.
- Consider using risk-tiering of patients to help with re-distribution. Low risk patients can be given to any provider and high-risk patients only to those more comfortable/experienced with pain management.

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Caring for complex patients

Some of our patients cannot access mental/behavioral health resources.

- Look into options outside your community, such as telemedicine opportunities.
- Contact your state health department or SAMHSA for a list of resources. (https://www.samhsa.gov/find-help)

Providers are not comfortable asking about past sexual abuse included in the Opioid Risk Tool.

- Have the patient fill out the questionnaire on paper. The provider can then review the recorded results with the patient.
- Give providers scripts with language to use and have them practice using these scripts with each other.
- Encourage participation in clinical education programs that discuss the strong evidence base for the importance of asking this question. A history of sexual abuse is a risk factor for opioid use disorder. Asking about a history of sexual abuse can also help identify individuals with post-traumatic stress disorder (PTSD).
- Make sure that providers know that asking about past sexual abuse can provide an opportunity to get people the help that they often want but are fearful of asking for.

We do not have medication-assisted treatment (MAT) services available.

- Identify where the nearest MAT program is.
- Begin providing MAT within clinic.

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Measuring success

We do not have the infrastructure to pull reports on patients using chronic opioid therapy.

- Consider approaches that clinics before the era of electronic health records. For instance, if early refills are a struggle for your clinic, have the front desk hand tally calls for early refills for one week each quarter.
- Pick one feasible, important measure and focus on how to gather, review, and share those data quarterly in a consistent manner. The data don't need to be perfect. You can grow your reports as your capacity increases.
- Track MED manually with each refill over 6-8 weeks and review the data using a run chart (a line graph of data plotted over time).

We do not know enough about our patient population to set a goal.

- Even if you don't have much formal data about your patient population, your providers and staff are familiar with what is currently challenging about providing care to patients on chronic opioid therapy. Talk with providers and staff to identify a goal that is meaningful to your organization and that you can feasibly measure. Remember that this can be as simple as a hand-tally. Reducing provider and staff burnout is another measure to consider. You can add population health goals once you have established a tracking and monitoring program.

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