OMB
Attachment E
4/1/20

Self-Assessment Questionnaire for Primary Care Practices

This self-assessment questionnaire is for primary care practices pursuing an opioid quality improvement (QI) initiative to improve their opioid prescribing practices. The questionnaire serves two purposes – as a tool for reflecting on progress pursuing a quality improvement (QI) initiative at baseline and periodically throughout the QI initiative. Secondly, it includes questions to ascertain the extent to which care provided is consistent with guideline recommendations. The questionnaire is based on the prior work of several individuals.[1]

Part I is for the champion for the QI effort in a practice to reflect on and indicate their practice's status in progressing through the Six Building Blocks of Opioid Management.

Part II of the self-assessment questionnaire asks practices to indicate the extent to which clinicians in their practice provide care consistent with each of the CDC Guideline recommendations, and other evidence-based guidance for opioid prescribing and/or care of older adult patients.

This survey can be completed by the champion for the QI initiative in the practice or by several people involved in the initiative and serve as a point of feedback if people have different assessments on the status of implementation, or the extent to which clinicians are providing care consistent with the Guideline recommendations. When the survey is completed by multiple individuals, you can calculate an average on each of the steps in Part I. For Part II you can sum the responses by category, or even combine the top two categories if 'very often' or 'always' are sufficient targets for your system on the Guideline recommendations.

PART I: Six Building Blocks Self-Assessment

[1] The self-assessment questionnaire is loosely based on the 6 Building Blocks self-assessment questionnaire, and its various iterations, developed by Michael Parchman, Mark Stephens and Laura Heesacker.

Funded by Agency for Healthcare Research & Quality (#R18HS023750, #HHSP233201500013I), Washington State Department of Health (CDC #5 NU17CE002734), National Institute on Drug Abuse (#UG1DAO13714), and the Washington State's Olympic Communities of Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of AHRQ, WA DOH, NIDA, or WA DOH.

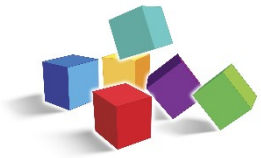
The purpose of the self-assessment is to initiate a discussion among the opioid improvement team (or all members of your clinic) about the current state of your organization regarding the management of patients who are on long-term opioids for their chronic pain. The results highlight opportunities for improvement. By repeating this at regular intervals, you can track the progress your clinic is making.

Instructions: Please review each question and circle the answer that best reflects your organization's current status. There are three number options for each answer to allow you to select how far along you are within that answer.

Leadership & consensus

Demonstrate leadership support and build organization-wide consensus to prioritize more selective and cautious opioid prescribing.

Leadership prioritizes the work	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
1. The commitment of leadership in this clinic to improving management of patients on long-term opioid therapy...	...is not visible or communicated.	...is rarely visible, and communication about use of opioids for patients with chronic pain is ad hoc and informal.	...is sometimes visible and communication about patients on long-term opioid therapy is occasionally discussed in meetings.	...is communicated consistently as an important element of meetings, case conferences, emails, internal communications, and celebrations of success.
Shared vision	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
2. A shared vision for safer and more cautious opioid prescribing...	...has not been formally considered or discussed by clinicians and staff.	...has been discussed, and preliminary conversations regarding a clinic-wide opioid prescribing standard have begun.	...has been partially achieved, but consensus regarding a clinic-wide opioid prescribing standard has not yet been reached.	...has been fully achieved. Clinicians and staff consistently follow prescribing standards and practices.
Responsibilities assigned	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
3. Responsibilities for practice change related to patients on long-term opioid therapy...	...have not been assigned to designated leaders.	...have been assigned to leaders, but no resources have been committed.	...have been assigned to leaders with dedicated resources, but more support is needed.	...have been assigned. Dedicated resources support protected time to meet and engage in practice change.



Policies, patient agreements, & workflows

Revise, align, and implement clinic policies, patient agreements, and workflows for health care team members to improve opioid prescribing and care of patients with chronic pain.

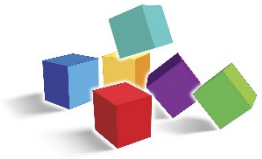
Policy development/revision	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
4. Comprehensive policies* regarding long-term opioid therapy that reflect evidence-based guidelines, such as the CDC Guideline for Prescribing Opioids for Chronic Pain or state-based opioid prescribing guidelines...	...do not exist.	...exist, but have not been recently revised and updated.	...exist, have been recently updated, but are still lacking essential components.	...exist, and have been recently updated to reflect recent evidence-based guidelines, and are comprehensive.
Policy implementation	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
5. Policies regarding long-term opioid therapy...	...have not been distributed to clinicians and staff.	...have been distributed to clinicians and staff, but have not been discussed.	...have been distributed, have been discussed with all clinic staff and clinicians, but are not consistently followed.	...have been distributed, have been discussed with all clinic staff and clinicians, and are consistently followed.
Patient agreements	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
6. Formal signed patient agreements regarding long-term opioid therapy...	...do not exist.	...exist, but do not align with current clinic policies and/or are not consistently used	...exist, align with current clinic policies, but are not consistently used.	...exist, align with current policies, and are consistently used with all patients on chronic opioid therapy.
Workflows	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
7. Clinic workflows for managing patients on long-term opioid therapy...	...do not exist.	...exist, but do not support current clinic policies.	...exist, support current clinic policies, but are not fully implemented.	...exist, support current clinic policies, and are fully implemented

*Examples of areas that a comprehensive policy might address include:

- Prescribing opioids for acute pain (CDC #6, #7)
- Duration and dose of opioids for chronic pain (CDC #4, #5, #8)
- Use of non-opioid and non-pharmacological therapies (CDC #1)
- Co-prescribing of opioids and benzodiazepines (CDC #11)

- Urine drug screening (CDC #10)
- Monitoring of state controlled substances database (CDC #9)

- Patient agreements (CDC #2)
- Patient education (CDC #2, #3)
- Tapering of opioids (CDC #5, #7)
- Use of naloxone (CDC #8)
- Use of buprenorphine (CDC #12)
- Use of methadone (CDC #4, #7)



Tracking & monitoring patient care

Implement pro-active population management before, during, and between clinic visits of all patients on long-term opioid therapy.

Tracking & monitoring of patients prescribed long-term opioids	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
8. Use of a system to pro-actively track & monitor patients prescribed long-term opioids to ensure their safety…	…has not been explored or is not possible with existing data systems.	…is technically possible, but systems to get useful reports are not yet in place.	…is possible and systems are in place to produce basic reports on a regular basis.	…is possible, systems are in place, and reports are produced that allow for tracking of patient care and monitoring of clinician practices.
Tracking & monitoring data collection workflows established	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
9. Workflows to enter data into the tracking & monitoring system…	…have not been developed.	…are in development, but not established.	…are established, but aren't consistently implemented.	…are established and consistently implemented. Responsibilities are assigned and protected time is available to complete assigned responsibilities.
Tracking & monitoring data use workflows established	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
10. Workflows to use data to track patient care and monitor clinician practices…	…have not been developed.	…are in development, but not established.	…are established, but aren't consistently implemented.	…are established and consistently implemented. Responsibilities are assigned and protected time is available to complete assigned responsibilities.

Planned, patient-centered visits

Prepare and plan for the clinic visits of all patients on long-term opioid therapy. Support patient-centered, empathic communication for care of patients on long-term opioid therapy.

Planned opioid patient visits	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
11. Before routine clinic visits, patients on long-term opioid therapy...	...are not identified. There is no advance preparation for patient visits for long-term opioid therapy.	...are sometimes identified, but there is no discussion or advance preparation for visits with patients prescribed long-term opioids.	...are identified, and a discussion or chart review to prepare for the visit sometimes occurs.	...are consistently identified and discussed before the visit. The chart is reviewed and preparations made to address safe opioid use.
Empathic communication	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
12. Training on patient-centered, empathic communication emphasizing patient safety, e.g., risks, dose escalation, and to tapering...	...has not been offered to clinicians and staff.	...has been offered to clinicians and staff, but there was limited participation.	...has been offered and the majority of clinicians and staff participated.	...is consistently offered with widespread, regular participation.
Patient involvement	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
13. Training on how to involve patients on long-term opioid therapy in decision-making, setting goals for improvement, and providing support for self-management...	...has not been offered to clinicians and staff.	...has been offered to clinicians and staff, but there was limited participation.	...has been offered and the majority of clinicians and staff participated.	...is consistently offered with widespread, regular participation.
Care plans	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
14. Chronic pain care plan* templates for chronic pain management...	...do not exist.	...exist, but do not align with current clinic policies and/or are not consistently used	...exist, align with current clinic policies, but are not consistently used.	...exist, align with current policies, and are consistently used.
Patient education	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
15. Patient education materials that include explanation of the risks, and limited benefits of long-term opioid use...	...do not exist.	...exist, but strategies to disseminate to patients do not exist.	...exist and dissemination strategies exist, but the strategies have not been fully implemented.	...exist, dissemination strategies exist, and the strategies have been fully implemented.

* A chronic pain care plan is a tailored set of written steps and key information that a provider and patient agree will be used to manage the patient’s pain. It can include: goals (e.g., functional activities), current or planned treatments (e.g., physical activity prescription, medications), and a timeframe for reevaluation (e.g., follow-up in 3 months).

Caring for complex patients

Develop policies and resources to ensure that patients who develop opioid use disorder and/or who need mental/behavioral health resources are identified and provided with appropriate care, either in the care setting or by outside referral.

Identifying complex patients	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
16. Policies, clinic-selected screening tools, and workflows to identify opioid misuse, diversion, addiction, and to recognize mental/behavioral health needs...	...do not exist.	...partially exist.	...exist, but are only partially implemented.	...exist and are consistently implemented.
Behavioral health resources	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
17. Mental/behavioral health services...	...are difficult to obtain reliably.	...are available from behavioral health specialists but aren't timely or convenient.	...are available from behavioral health specialists and are usually timely and convenient.	...are readily available from behavioral health specialists who are onsite or who work in an organization that has a referral protocol or agreement with our practice setting.

Measuring Success

Continuously monitor progress and improve with experience.

Monitoring progress	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**
18. A system to measure and monitor progress in opioid therapy practice change...	...does not exist.	...exists, including overall tracking goals, but regular tracking reports on specific objectives have not been produced.	...is used to produce regular tracking reports on specific objectives. Leadership reviews are done occasionally, but not on a formal schedule.	...has been fully implemented to measure and track progress on specific objectives. Leadership reviews progress reports regularly and adjustments and improvements are implemented.
Assessing and modifying	**1 2 3**	**4 5 6**	**7 8 9**	**10 11 12**

19. Adjustments to achieve safer opioid prescribing based on monitoring data...	...are not being made.	...are occasionally made, but are limited in scope and consistency.	...are often made and are usually timely.	...are consistently made and are integrated in overall quality improvement strategies.

PART II: Extent to which Care provided is Consistent with Guideline Recommendations ix Building Blocks Self-Assessment

How often do *clinicians in your system* provide care consistent with the following *CDC Opioid Guideline* recommendation statements? Mark your response with an "X" in the box.

Nonpharmacologic and Nonopioid Therapies (Recommendation 1)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.					
If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.					
Pain and Functional Assessment (Recommendation 2)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks.					
Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.					
Counsel on Risks and Benefits (Recommendation 3)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic					

benefits of opioid therapy and patient and clinician responsibilities for managing therapy.					
Prescribe Immediate Release Opioids (Recommendation 4)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.					
Caution with High MMEs (Recommendation 5)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to 50 morphine milligram equivalents (MME) or more per day.					
Clinicians should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day.					
Limit Days' Supply for Acute Pain (Recommendation 6)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids.					
When opioids are used for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.					
Follow-up within 4 Weeks (Recommendation 7)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.					
Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.					
If benefits do not outweigh harms of					

continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages, or to taper and discontinue opioids.					
Naloxone (Recommendation 8)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.					
Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50MME/d), or concurrent benzodiazepine use, are present.					
PDMP (Recommendation 9)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain.					
Clinicians should review PDMP data periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.					
Urine Drug Testing (Recommendation 10)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
When prescribing opioids for chronic pain, clinicians should administer urine drug tests before starting opioid therapy to assess presence of prescribed opioids as well as other controlled prescription drugs and illicit drugs.					
When prescribing opioids for chronic pain, clinicians should administer urine drug tests at least annually to assess presence of prescribed opioids as well as other controlled prescription drugs and illicit					

drugs.					
Co-Prescribing Benzodiazepines (Recommendation 11)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.					
Medication-assisted Treatment (Recommendation 12)	**Never**	**Rarely**	**Sometimes**	**Very Often**	**Always**
Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder					