Practice Agreement to Participate

Opioid Management

The Six Building Blocks

Project Description: The Practice Innovation Program at the University of Colorado School of Medicine and the Colorado Community Health Network (CCHN) aim to:

1. Support implementation of opioid prescribing guidelines to decrease risky opioid prescribing for chronic non-cancer pain
2. Increase utilization of behavioral health interventions for patients with chronic pain

Implementation of two evidence-based care models – the Six Building Blocks of Prescription Opioid Management and integrated behavioral health will occur with 20- primary care sites through funding allocated from the Colorado Department of Public Health and Environment (CDPHE).

Identified primary outcomes for the program are:

1. Reduce the percentage of non-cancer chronic pain patients on chronic opioid therapy (COT) with a morphine equivalent dose (MED) of 90 or higher by 5%
2. Offer all patients on COT at participating clinics evidence-based behavioral health (BH) services
3. Increase the number of COT patients participating in longitudinal BH services by 5%

To achieve these outcomes CCHN, University of Colorado, and expert consultants will provide quality improvement services and training tailored to the clinic needs. These services include onsite practice facilitation and coaching, expert consultation, shared learning calls, and electronic health record support for clinical metric reporting.

Practice Facilitation and Technical Support

All participating clinics will receive:

- 15 months of practice facilitation to support improvement teams in building customized approaches to workflow and efficiency related to opioid prescribing and management of patients on long-term opioid therapy
- Orientation of the Opioid Improvement Team and clinic to the opioid management problem and the Six Building Blocks approach.
- Preparation for and attendance of -a kickoff event with the clinic opioid improvement team and clinic providers and staff.
- Guidance in the collection of program metrics and the development of a plan to achieve improved opioid management milestones.
- Regularly scheduled (e.g., monthly) practice facilitation meetings (in-person and/or virtual) to review the action plan, discuss and problem solve barriers to implementation, and self-assess progress on implementing improvements to opioid management.
- Opioid management related resources, such as sample policies, treatment agreement, workflows, and patient education materials.

- Assistance in connecting the organization's providers to the state Prescription Data Monitoring Program (PDMP).
- Assistance to address questions and concerns raised by participating clinics as needed.
- Bi-monthly (every other month) shared learning calls at which participating sites learn from clinical experts and each other as they implement improved opioid management.
- Facilitation of a closing site visit at 15 months to review progress made and discuss plans for maintenance of changes made and next steps.
- Access to a clinical health information technology (HIT) advisor to assist with data workflows for clinical quality metric reporting if necessary
- A $2500 stipend for project-related activities ($1000 stipend upon completion of baseline assessment and reporting baseline metrics; another $1500 upon reporting metrics quarterly (April 2020, July 2020, November 2020, and January 2021) and completion of the final assessments and metrics. Payment will be issued by the Practice Innovation Program upon receipt of a completed invoice once the deliverable is met.

Practice Participation Requirements

All participating clinics must:

- Provide primary care services to adults (family medicine or general internal medicine)
- Have a majority of clinicians within the practice agree to participate in the project
- Have the authority to determine site-level clinical guidelines, protocols, and processes of care
- Participate fully in the **Practice Assessment and Evaluation Activities** (described below)
- Have practice leadership that supports the effort and empowers the practice team throughout the program to
    - Create an opioid improvement team that includes a clinical champion, a program manager, a tracking and monitoring lead, and others from the clinic as desired to work with the practice facilitator
    - Dedicate time monthly to working on improvements with the practice facilitator
    - Regularly update action plans to achieve milestones.
    - Provide protected time for a designated staff member to develop and begin implementing an approach to tracking and monitoring patients on long-term opioid therapy, including:
        - updating patient data, as necessary;
        - generating reports for patient care planning;
        - generating regular performance reports for tracking clinical metrics.
    - Provide protected time for the opioid improvement team to meet internally at least once each month to review and assess progress, practice data, and make plans to continue the improvement work.
    - Provide time to participate in bi-monthly Shared Learning calls with the Practice Facilitator, Expert Faculty and other participating clinics.
    - Provide time for the clinical champion and other clinicians and staff to participate in clinical education.
    - Be willing to share policies, workflows, and materials as appropriate with the Six Building Blocks team and with regional colleagues to maximize learning for all.

Practice Assessment and Evaluation
Activities

All clinics will be asked to complete:

- A Practice Survey and Six Building Blocks Self -Assessment, to provide information about practice demographics and characteristics (at baseline, 9 months, and 15 months)
- Practice Roster to provide information about practice demographics and prescribing clinician characteristics (at baseline, and updated in SPLIT quarterly)

All clinics will be asked to work with the practice facilitator and clinical HIT advisor to:

- Extract and submit clinical quality metrics quarterly (electronically or through chart audit) from baseline through 15 months. after baseline
    - # COT patients (Non–Cancer Pain)
    - # COT patients w >90 MME
    - # COT patients offered evidence-based interventions by integrated BHP
    - # COT patients engaged in longitudinal BH services by integrated BHP (defined as 3+ encounters in the last year)
    - # COT patients referred for external behavioral health services

- Aggregated clinical quality metrics of all participating clinics may be visible to all 6 Building Blocks clinics, the evaluation team, CDPHE (funder), the practice transformation organizations and consultants that may be engaged to support the project to facilitate shared learning.

The following clinical metrics will be obtained from the Colorado Prescription Drug Monitoring Program (PDMP) for all prescribing clinicians associated with the clinic at baseline and quarterly

- #prescribers
- # COT patients
- # COT patients w >90 MME
- # COT patients w multiple opioids
- # COT patients co prescribed benzos
- # COT patients w multiple physicians

Some clinics will also be asked to participate in:

- Additional in-depth practice observation and key informant interviews (~60 minutes) with clinicians and staff

As members of _____, we agree to participate in the 6 Building Blocks project, fully understanding the requirements and benefits of the project as described above.

Please sign and return the letter to the University of Colorado Department of Family Medicine at:

Lauren Quintana
University of Colorado School of Medicine
Department of Family Medicine
Lauren.Quintana@cuanschutz.edu

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Practice Name

_____
Practice Address

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Practice NPI#

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Practice Phone

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Contact Person Name

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Contact Person Email

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Contact Person Phone

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Signature

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Date