



**Title of Project**

**ACP Quality Connect: Chronic Pain Management** - *Enhancing Effective, Safe Chronic Pain Management in PCMH-Recognized and ACO-Participating Primary Care Practices*

**Principal Investigator and Team Members**

**PI: Greg Hood, MD, FACP, Chair**, Immediate-Past Governor, Kentucky Chapter, American College of Physicians; Medical Director, Quality Independent Physicians/The Physicians' Network

**Team Members:**

**Laura Lee Hall, PhD**, Director, Center for Quality, American College of Physicians

**Matthew J. Bair, MD, MS**, Research Scientist, Roudebush VA Center of Health Information and Communication and Regenstrief Institute; Associate Professor of Medicine, Indiana University School of Medicine

**Melia Glass, L.P.N.**, Precision Healthcare Delivery; Clinical Care Coordination Director, Quality Independent Physicians

**Jill Marsteller, PhD, MPP**, Associate Professor, Johns Hopkins Bloomberg School of Public Health; Associate Director for Quality, Center for Health Services and Outcome Research

**Doron Schneider, MD FACP**, Chief Patient Safety and Quality Officer, Abington Health

**Paula Straub, RPh**, Director of Pharmacy-Association of Primary Care Physicians/The Physicians Network/Quality Independent Physicians

**Selam Wubu**, Associate, Quality Improvement and Research, American College of Physicians

**Organization**

American College of Physicians, Inc and Kentucky Chapter of the American College of Physicians

**Inclusive Dates of Project**

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**Project Officer**

Greg Hood, MD, FACP

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**Grant Award Number**

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## ACP Quality Connect: Chronic Pain Management

*Enhancing Effective, Safe Chronic Pain Management in PCMH-Recognized and ACO-Participating Primary Care Practices*

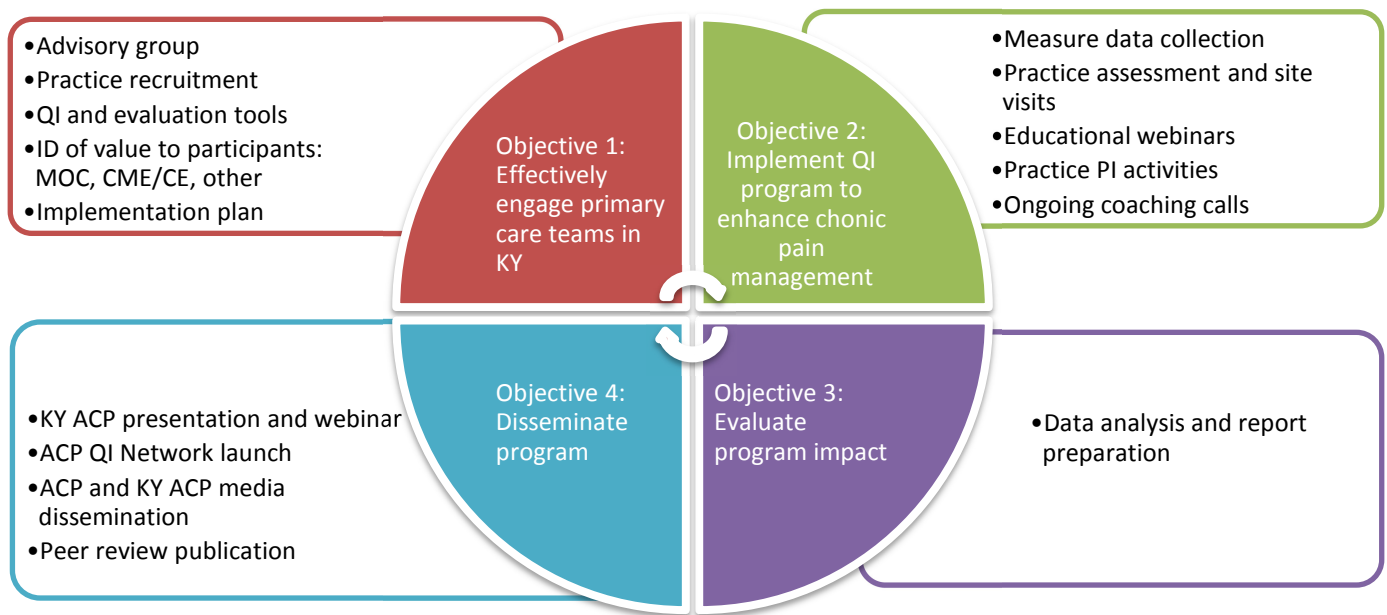
The national and Kentucky Chapter of the American College of Physicians (ACP) launched the ACP Quality Connect: Chronic Pain Management initiative, a quality improvement (QI) program aimed at improving the screening, diagnosis, and safe and effective treatment of chronic pain in primary care practices that are part of Accountable Care Organizations (ACOs) and/or are pursuing recognition of a patient-centered medical home (PCMH). The primary goal of this initiative was to implement and disseminate a QI program that enhances safe, evidence-based chronic pain recognition and treatment among primary care providers (PCPs) in Kentucky who are involved in ACOs and/or the PCMH recognition process.

Specific objectives for the initiative included:

- Recruit PCPs in PCMH recognition process and part of ACOs in KY
- Enhance patient-centered, safe, and evidence-based screening, diagnosis, treatment, and referral of patients with chronic pain through QI initiative
- Evaluate impact on provider attitudes, knowledge, and practice as well as performance measure improvement; and
- Disseminate best practices

### Program Overview:

A project work plan was developed at the onset of this initiative to achieve each of the specific objectives for the QI program. The program structure is summarized in the following chart:



ACP collaborated with the KY ACP Chapter to assemble an advisory group for the program and recruit 5-10 primary care practices to participate in the initiative. Recruiting efforts were led by the program's primary investigator, Dr. Gregory Hood, immediate-past Governor of the KY ACP Chapter and Medical Director of the Quality Independent Physicians ACO and Paula Straub, RPH, Director of Pharmacy-Association of Primary Care Physicians/The Physicians Network/Quality Independent Physicians. A total of eight primary care practices were recruited to participate in the initiative.

### **Practice Background**

Eight ACO-participating, private primary care practices, both internal medicine and family practice, were engaged in the ACP Quality Connect: Chronic Pain Management initiative. The practices were recruited from two Kentucky-based ACOs: Quality Independent Physicians, LLC and Southern Kentucky Healthcare Alliance. All of the participating practices are also working on achieving PCMH recognition. Each practice assigned a physician and non-physician member to serve as their QI champion project leaders for their respective practices in this initiative. The QI champions were responsible for serving as liaisons between their practice and ACP QI leaders, as well as leading the implementation of QI activities in their practices. The practices also engaged additional clinical and office support staff to participate in the program—a total of 41 clinicians were involved in the program.

ACP QI leaders developed the ACP Quality Connect: Chronic Pain Management Practice Assessment Tool in order to assess each practice's background, QI experience and capacity, and current chronic pain management strategies. The practice assessment tool was developed based on a literature review of evidence-based assessment tools and chronic care management guidelines (ACIC, 2000<sup>1</sup>; Joly et al., 2013<sup>2</sup>; Hooten et al., 2013<sup>3</sup>). The tool is comprised of three sections: I) practice background; II) QI goals and capacity; and III) chronic illness management. Parts I and II are designed to evaluate each practice's background, organization, experience with implementing QI activities, and top QI priorities. Questions for Part III of the assessment tool were developed based on priorities identified by the ACP Quality Connect: Chronic Pain Management Advisory Group as well as the Institute for Clinical Systems Improvement (ICSI) guidelines for the assessment and management of chronic pain (2013). The full ACP Quality Connect: Chronic Pain Management Assessment Tool is available in Appendix A of this report.

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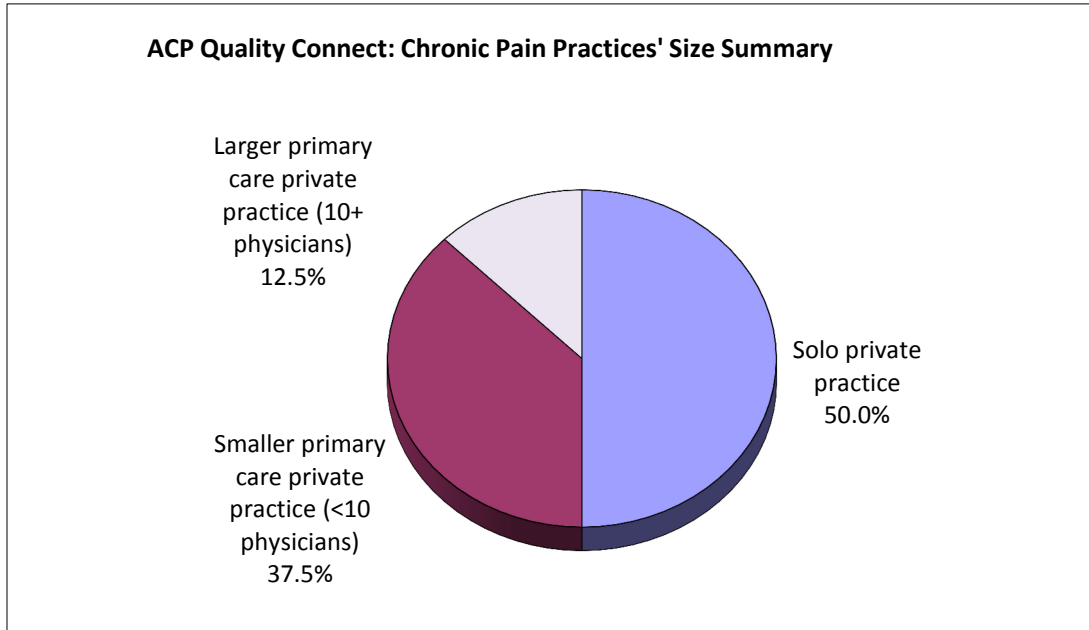
<sup>1</sup> The Assessment of Chronic Illness Care (ACIC), copyright 2000, The MacColl Center for Health Care Innovation, Group Health Cooperative.

<sup>2</sup> Hooten WM, Timming R, Belgrade M, Gaul J, Goertz M, Haake B, Myers C, Noonan MP, Owens J, Saeger L, Schweim K, Shteyman G, Walker N. Institute for Clinical Systems Improvement (ICSI). Assessment and Management of Chronic Pain. Updated November 2013.

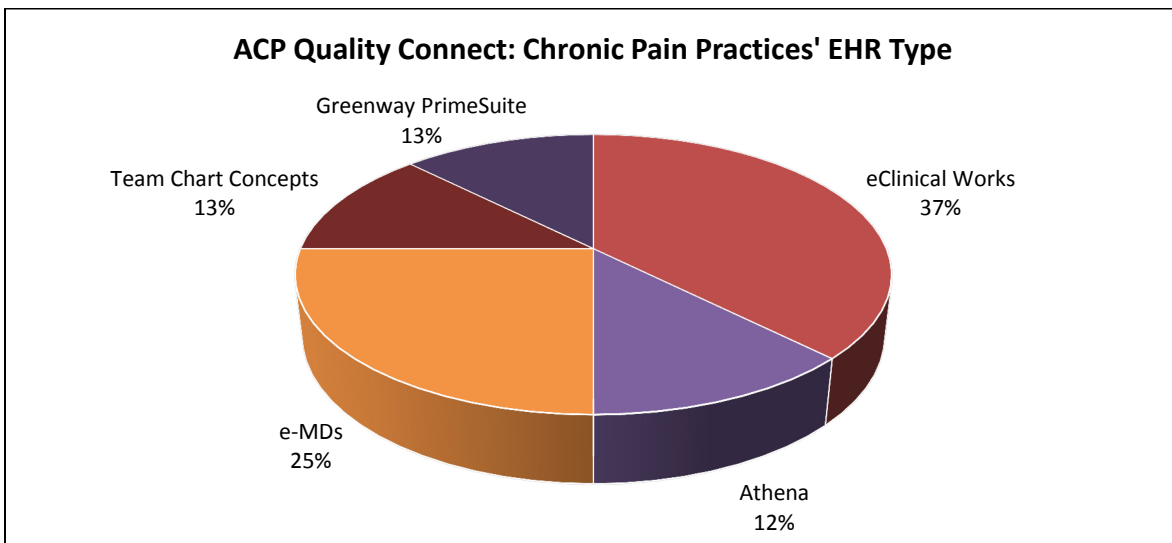
<sup>3</sup> Joly BM, Booth M, Mittal P, Shaler G. (2012). Measuring QI in Public Health: The Development and Psychometric Testing of a QI Maturity Tool. *Evaluation & the Health Professions*, 35(2) 119-147.

Practice Assessment Section I: Practice Background Results

The majority of participating practices are smaller practices with 1-10 physicians; only one practice had more than 10 physicians. Fifty percent of the practices were solo private primary care practices-- three internal medicine and one family medicine.



Results from the practice assessment show that six practices use electronic health records (EHRs) and two practices use a combination system that incorporated elements of an EHR and paper chart. Two EHRs: eClinical Works and e-MDs are used by the majority of practices participating in this initiative. Seven out of eight practices have been using their EHR system for at least two years. One practice recently implemented a new EHR and has been using the system for less than six months.



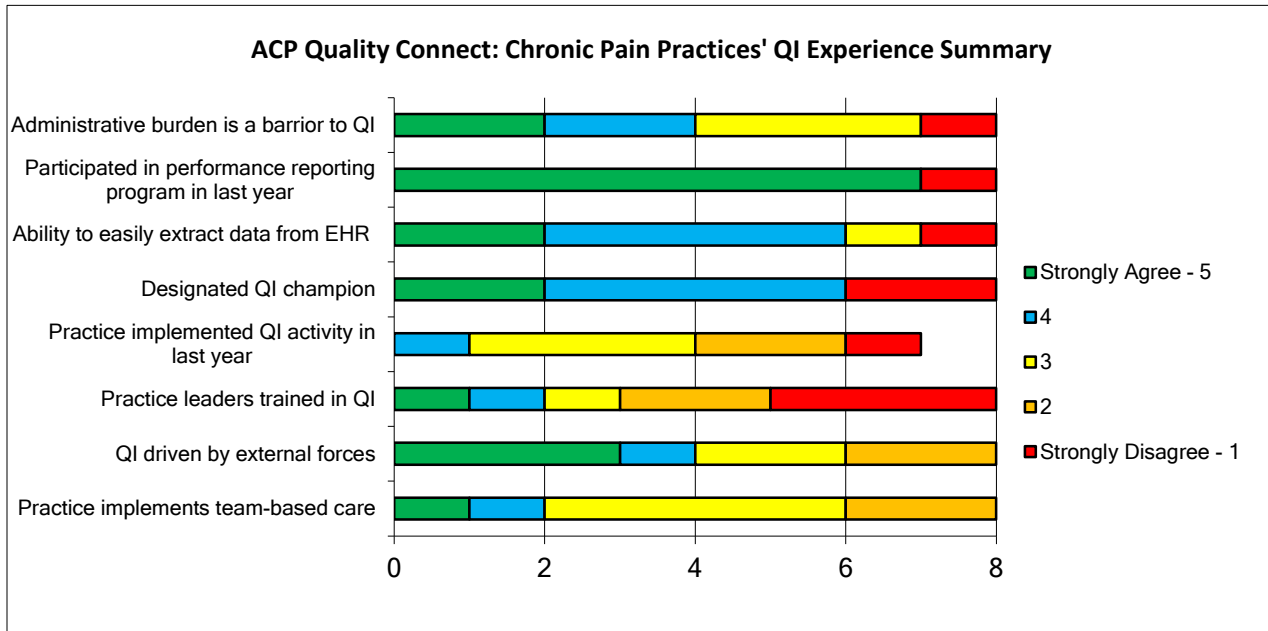
The following table provides an overall summary of the background characteristics of the participating practices:

<b>Characteristics of ACP Quality Connect: Chronic Pain Primary Care Practices (n=8)</b>	
<b>Accountable care organization</b>	
Quality Independent Physicians	6
Southern Kentucky Health Care Alliance	2
<b>Work setting</b>	
Solo private practice	4
Small primary care private practice (<10 Physicians)	3
Large primary care private practice (10+ Physicians)	1
<b>Location</b>	
Lebanon	2
Lexington	1
Louisville	3
Sellersburg (Indiana)	1
Versailles	1
<b>Health/Medical records system</b>	
Combination system that incorporates elements of an EHR and a paper chart	2
Computerized EHR system	6
<b>Years in using the EHR system</b>	
Less than 6 months	1
More than 2 years	7

Practice Assessment Section II: QI Experience and Capacity Results

The QI experience among the participating practices was quite varied. All of the practices participated in performance reporting programs in the past year through their ACOs. However, the majority of practices did not have experience implementing a QI activity in the past year and their practice leaders have not been trained in various QI processes including Plan-Do-Study-Act (PDSA) cycles as well as Lean and Six Sigma methodologies.

The following chart provides a summary of the practices' QI experience:



The following table shows the percentage of practices that responded positively (a 4 or 5 on a scale from 1 to 5) for each question in Section II of the practice assessment tool. Medians and ranges of responses are also shown. For most questions, responses ranged from the lowest possible score to the highest. All but one practice reported having participated in a performance-reporting program. Most of the practices also had a QI officer or champion and were capable of using extracted EHR data to inform QI efforts. However, fewer reported positive responses for exposure to some existing QI tools or methods, such as team huddles for enhancing team-based care (25%) and PDSA cycles (14%). Half of the practices agreed that their QI activities were mostly motivated by external forces, such as funders, accreditation, regulation, and peer pressure.

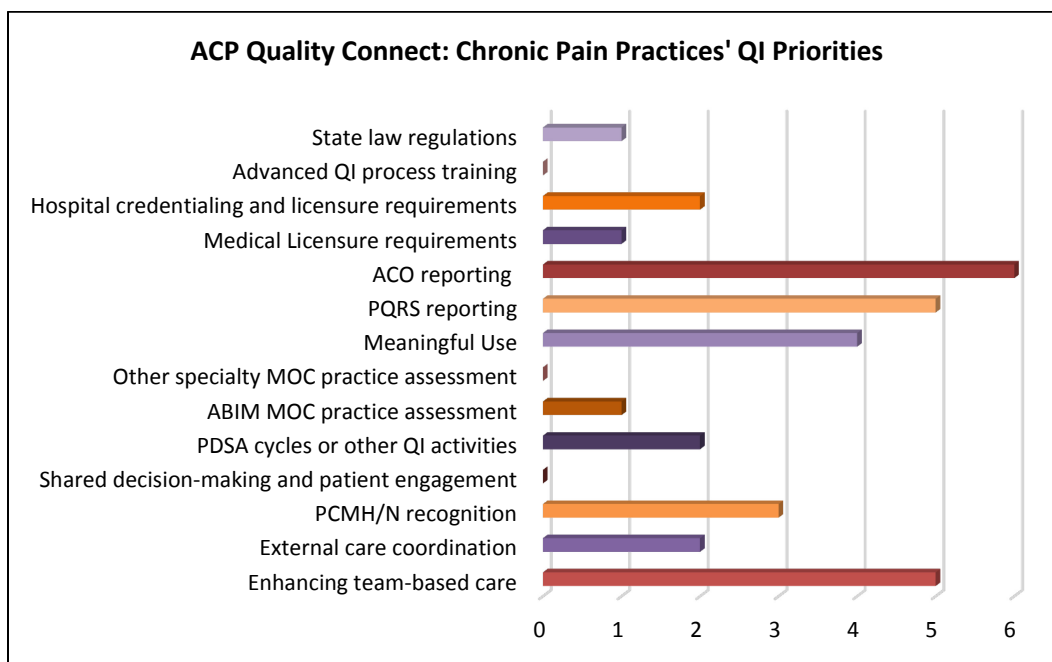
Question Items <sup>1</sup>	Percent Positive Responses <sup>2</sup> (n = 7-8)	Median	Range (Min - Max)
Our practice implements team huddles and other methods for enhancing team-based care.	25%	3	(2 - 5)
The impetus for improving quality in my practice is largely driven by external forces (e.g. funders, accreditation, regulation, peer pressure).	50%	3.5	(2 - 5)
Leaders of my practice are trained in methods for evaluating and improving quality, such as Plan-Do-Study-Act (PDSA) cycles, Six Sigma, Lean, etc.	25%	2	(1 - 5)
My practice has implemented PDSA cycles or other QI initiatives in the last year.	14%	3	(1 - 4)
My practice has designated a QI officer or champion.	75%	4	(1 - 5)

Question Items <sup>1</sup>	Percent Positive Responses <sup>2</sup> (n = 7-8)	Median	Range (Min – Max)
My practice has the ability to easily extract data from our EHR or clinical charts to inform QI activities.	75%	4	(1 – 5)
My practice has participated in a performance reporting program in the past year (e.g. Physician Quality Reporting System (PQRS), Meaningful Use (MU), etc.).	88%	5	(1 – 5)
Administrative burden is a barrier to QI in my practice.	50%	3.5	(1 – 5)

<sup>1</sup>Rated 1–5 from “strongly disagree” to “strongly agree” with higher values representing greater agreement

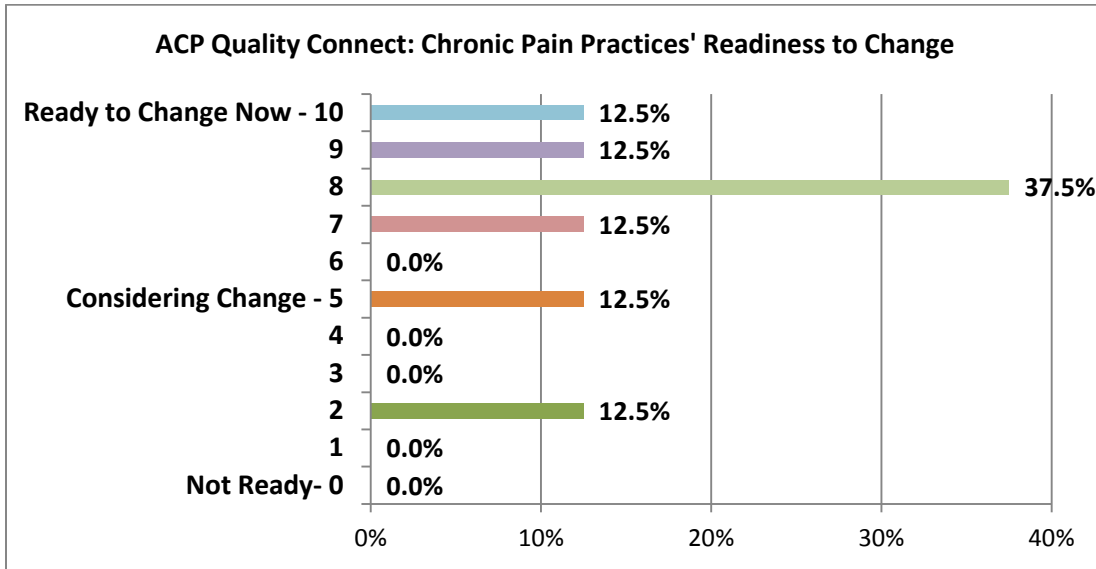
<sup>2</sup>Percentage of respondent who chose “4= Agree” or “5= Strongly Agree”

*QI Priorities:* The practices were also asked to identify their top QI priorities. Performance and reimbursement reporting requirements (e.g., ACO, PQRS, and Meaningful Use requirements) were top priorities for the practices. Enhancing team-based care was also identified as a priority for the majority of practices.



*Readiness to Change:* Practices were also asked to rate the importance of improving chronic pain care for their patients. Seven out of eight practices said improving chronic pain care was either “Very Important” or “Extremely Important.” Practices were also asked to rank their readiness to change their current chronic pain care on a 10 point scale, with 0 indicating “Not ready” and 10 indicating “Ready to Change Now.” The eight participating practices reported high readiness for changing their chronic pain management practice (median = 8 on a scale from 1-10). They believed that it is important to improve chronic pain care in the practice and also felt confidence that they could make the change. For respondents who did not select the highest score (10) on the change readiness question, lack of time was the most frequently mentioned reason they did not feel fully

prepared (n=4). One respondent mentioned that there were also many other active projects in the practice. Another respondent indicated his practice did not have an organizational system that could support the change. A summary of all practice responses is provided in the chart below:



Practice Assessment Section III: Chronic Pain Management Strategies Results

The practice assessment also surveys whether each practice used the various tools for chronic pain care at baseline, including pain assessment, mental health assessment, controlled substance agreement, risk screening, and urine drug testing. The information is helpful to understand the starting point in the participating practices, informing the program implementation. Results show participating practices had diverse experience with using these tools and tests, with varied administration frequency and choice of instrument.

The following table provides a summary of practice responses for the chronic pain management assessment:

	Pain Assessment	Mental Health Assessment	Controlled Substance Agreement	Risk Screening	Urine Drug Testing
<b>Administration of a pain assessment/risk screening tool</b>					
Yes, to all patients	50%			75%	
Yes, but no systematic method	38%			0%	
No	12%			25%	
<b>Use of a mental health screening tool/controlled substance agreement</b>					
Always		38%	63%		
Sometimes		50%	25%		
Rarely		12%	0%		



	Pain Assessment	Mental Health Assessment	Controlled Substance Agreement	Risk Screening	Urine Drug Testing
Never		0%	12%		
<b>Administration of urine drug test</b>					
Yes, to all chronic patients					88%
Yes, to high risk chronic patients					12%
No					0%
<b>Frequency of tool administration</b>					
At every patient visit	13%	0%		0%	
Every 3-6 months	63%	12%		38%	
Once a year	0%	63%		24%	
No particular systematic method is used	12%	0%		0%	
Not applicable	12%	25%		38%	
<b>Tool used</b>	- Brief Pain Inventory: n=1 - Numeric rating scale: n=3 - Verbal descriptive scale: n=4 - Other (i.e., tool in EHR): n=1	- PHQ-2: n=2 - PHQ-9: n=4 - Other (e.g., MMSE, anxiety screen, GDS): n=2		- Opioid Risk Tool: (n=2) - Other (e.g., verbal pain scale, face scale): n=1	

### Collaborative/Group Activity with Practices

The ACP Quality Connect: Chronic Pain Management practices were actively engaged throughout the course of the initiative. The program was launched with an advisory group meeting held in Louisville, Kentucky on Saturday, May 17, 2014. Physician and non-physician QI champions from each practice were invited to participate in the advisory group meeting. Representatives from seven out of the eight participating practices attended the advisory group meeting. The meeting also served as a live educational program and began with a presentation given by the primary investigator, Dr. Gregory A. Hood, FACP on the regulatory landscape and legal requirements for opioid prescribing in Kentucky. Dr. Hood reviewed the requirements of House Bill 1 (HB1), which was passed by the Kentucky General Assembly in 2012 and regulates pain clinics, controlled substance prescribing, and controlled substance abuse in Kentucky.

There were also educational presentations by national pain expert, Dr. Matthew Bair, on evidence-based practices for chronic pain management in primary care; national QI expert, Dr. Doron Schneider, FACP on quality

improvement with a focus on primary care; and evaluation expert, Dr. Jill Marsteller, on evaluation structures for QI initiatives. The full agenda for the advisory group meeting can be found in Appendix B of this report.

Involving the practice QI champions in the early phase of the program increased the engagement and enthusiasm of the participating practices and ensured that educational focus of the project was relevant to their top chronic pain management priorities. At the end of the meeting, it was determined that the educational interventions would focus on the following priorities identified by the advisory group:

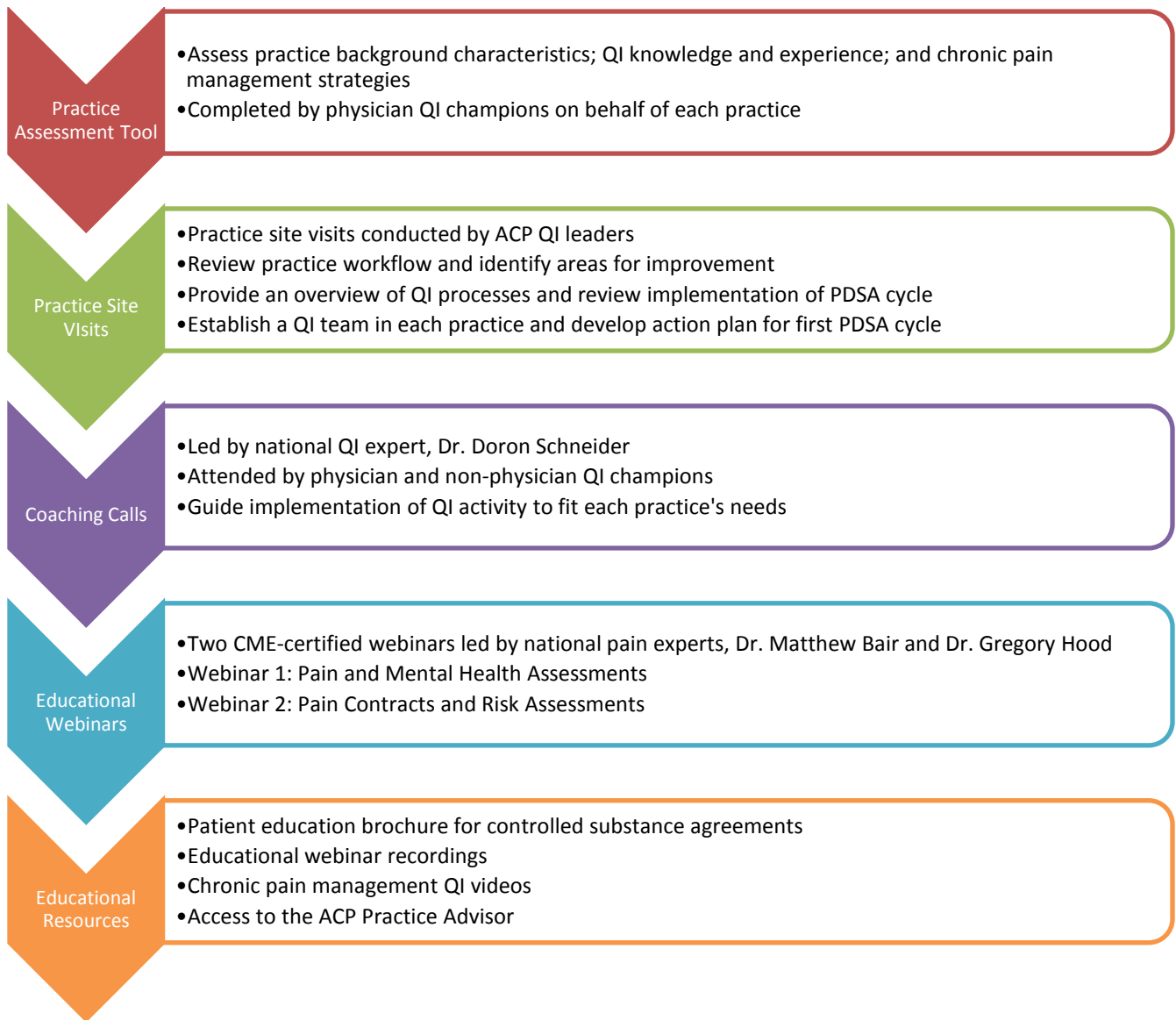
1. Pain assessments
2. Mental health assessments
3. Risk assessments
4. Patient education and controlled substance agreements

The advisory group also decided that a core set of measures would be used across the board for all participating practices. The following measures were selected:

<b>Measure Title</b>	<b>Measure Description</b>
<b>Screening for Clinical Depression</b>	Documentation of screening for clinical depression and follow up plan in adult patients
<b>Assessment and management of chronic pain</b>	Percentage of chronic pain patients with documentation of pain assessment completed at initial visit using a standardized tool that addresses pain intensity, location, pattern, current functional status, and follow-up plan
<b>Increase use of opioid agreement forms and urine toxicology tests</b>	Percentage of chronic pain patients who are prescribed an opioid who have an opioid agreement form and urine toxicology screen documented in the medical record

Based on feedback from the practice QI champions and advisory group members, it was determined that in lieu of a live educational program, participants would benefit more from intensive site visits to each practice to support implementation of QI activities designed to improve chronic pain management. Additional web-based and telephonic support would also be provided to the practices to guide them through the course of the initiative.

Following the advisory group meeting, a program work plan was developed to implement the ACP Quality Connect: Chronic Pain initiative. The following chart outlines the implementation of the program:



ACP Quality Connect: Practice Assessment Tool:

As previously discussed, the ACP Quality Connect Chronic Pain practice assessment tool was developed to assess each practice’s background characteristics, QI knowledge and experience, and current chronic pain management strategies. The practice assessment was completed by the physician QI champion on behalf of each practice. Results from the ACP Quality Connect: Chronic Pain Management Practice Assessment Tool were shared with ACP QI leaders and used to help develop tailored interventions and educational tools for the initiative.

Practice Assessment Site Visit:

Following the completion of the Practice Assessment tool, ACP QI leaders conducted 60-90 minute practice assessment site visits with each of the practice locations in August 2014. The goals of these site visits were to:

- Meet with QI project leaders, including physician and healthcare team member champions
- Review baseline performance data
- Conduct a practice walkthrough to gain a better understanding of office workflow
- Review practice assessment results
- Finalize measure selection and develop data collection strategies
- Provide a QI overview
- Review next steps of the project

A protocol was developed to provide guidance for ACP QI leaders conducting the site visit. The protocol includes a site visit agenda, performance measure information, PDSA worksheets, and educational resources for the practice QI champions. The practice site visit protocol can be found in Appendix C of this report. The following table provides an overview of the practice site visits:

<b>Agenda Item</b>	<b>Key Practice Staff</b>	<b>Details</b>	<b>Time</b>
Part I: Practice Walkthrough	Office manager or nurse	<p>Tour practice with office manager or nurse</p> <ul style="list-style-type: none"><li>• Observe practice layout, processes and characteristics</li><li>• Take note of opportunities for improvement</li></ul>	30 minutes
Part II: Review of QI Practice Assessment Results	Physician QI Champion	<ul style="list-style-type: none"><li>• Review and discuss QI results from ACP Quality Connect: Chronic Pain management Practice Assessment Tool (focus on questions 5 and 6)</li><li>• Review baseline performance data submitted prior to visit</li><li>• Identify QI goals for the project based on highest priorities identified in question 6</li><li>• Identify performance gaps and select general areas for improvement</li></ul>	15 minutes

Agenda Item	Key Practice Staff	Details	Time
Part III: Measure Selection and Data Collection	Project leaders, additional office staff members are recommended	<ul style="list-style-type: none"> <li>Review and discuss pain question results from ACP Quality Connect: Chronic Pain management Practice Assessment Tool (focus on questions 11-18)</li> <li>Identify project focus</li> <li>Review potential measures</li> <li>Develop data collection plan</li> </ul>	20 minutes
Part IV: QI Overview	Project leaders, additional office staff members recommended	<ul style="list-style-type: none"> <li>Review PDSA cycles</li> <li>Brainstorm ideas for improvement</li> <li>Review interventions list</li> </ul>	20-30 minutes
Part V: Project Next Steps	Project leaders, additional office staff members recommended	<ul style="list-style-type: none"> <li>Project leaders should identify which webinar(s) they would like to participate in based on Part III discussion</li> <li>Identify team members who will participate in follow up coaching calls</li> <li>Set timeline for data collection, PDSA cycle implementation, and follow up data collection</li> </ul>	15 minutes

At the end of the site visit, each practice identified their top chronic pain management priorities and developed a preliminary action plan. Increasing use of pain assessments was listed as a top project priority by six out of the eight participating practices. The following chart provides an overview of the top two project priorities as identified by the physician QI champions on the practice assessment tool:

ACP Quality Connect: Chronic Pain Project Priorities		
Practice 1	Controlled substance agreements	Patient education
Practice 2	Pain assessments	Mental health screenings Risk screenings
Practice 3	Pain assessments	Risk screenings
Practice 4	Pain assessments	Controlled substance agreements and patient education
Practice 5	Pain assessments	Mental health screenings
Practice 6	Controlled substance agreements and patient education	Risk screenings
Practice 7	Pain assessments	Controlled substance agreements and patient education
Practice 8	Pain assessments	Mental health screenings

Coaching Calls:

Coaching calls with national QI expert, Dr. Doron Schneider, were held with each practice in October and November 2014. The coaching calls were designed to check in with the practices and get an update on their QI activities thus far. Dr. Schneider provided tailored guidance to practice leaders on how to continue implementing QI activities and overcome practice-specific challenges. The coaching calls provided an opportunity for the practice QI leaders to share their success stories and ask specific questions on how to continue implementing change.

Educational webinars:

Two CME-certified educational webinars were held to address the educational priorities identified by the practice QI champions. The first webinar was held on October 2, 2014 and led by Dr. Matthew Bair on “Pain and Mental Health Assessments in Primary Care.” Dr. Bair is a Core Investigator at the VA Health Services Research and Development (HSR&D) Center for Health Information and Communication (CHIC) at the Regenstrief Institute and an Associate Professor of Medicine at Indiana University School of Medicine. The hour-long webinar was attended by seven physician QI champions and two clinic support staff. A recording of the webinar was distributed to all providers participating in the initiative.

The meeting objectives and agenda for the “Pain and Mental Health Assessments in Primary Care” webinar are provided below:

*Meeting objectives:*

- Understand evidence-based guidelines for effective use and implementation of pain assessment tools
- Understand evidence-based guidelines for effective use and implementation of mental health screening tools
- Increase use of pain assessment tools with chronic pain patients
- Increase use of mental health screening tools with chronic pain patients

*Agenda:*

7:00 pm	Evidence-based guidelines for use and implementation of pain assessment and mental health screening tools	<i>Dr. Bair</i>
7:45 pm	Q&A	
8:00 pm	Adjourn for evening	

The second webinar was held on November 13, 2014 and led by Dr. Gregory Hood on “Risk Assessments and Pain Contracts.” Dr. Hood is a practicing internist, the primary investigator for ACP Quality Connect: Chronic Pain initiative in KY, the Medical Director of the Quality Independent Physicians ACO. He is also the immediate-past governor of the KY ACP chapter and writes the weekend call column for Medscape. The hour-long webinar was attended by three physician QI champions and three clinic support staff. A recording of the webinar was distributed to all providers participating in the initiative.

The meeting objectives and agenda for the “Risk Assessments and Pain Contracts” webinar are provided below:

*Meeting objectives:*

- Understand evidence-based guidelines for effective use and implementation of risk assessment tools
- Improve patient education on controlled substance agreements
- Increase use of risk assessments with chronic pain patients

*Agenda:*

6:00 pm	Controlled Substance Patient Education and Risk Assessments	<i>Dr. Hood</i>
6:45 pm	Q&A	
7:00 pm	Adjourn for evening	

Enduring Educational Materials:

A number of enduring educational materials and online resources were made available to all participating providers. The two educational webinars were recorded and made available to participating health care providers. In addition to the webinar recordings, the following tools and resources were provided to participants:

*ACP Practice Advisor:*

All providers were given free access to the ACP Practice Advisor, an online practice management tool based on the Patient-Centered Medical Home model. There are two clinical modules within the ACP Practice Advisor that are relevant to this initiative, including the Chronic Pain Management and Opioid Risk Management modules. The Chronic Pain Management module is approved by the American Board of Internal Medicine (ABIM) for 20 Maintenance of Certification Practice Assessment points. The measures selected for the initiative are aligned with this MOC module; therefore physicians were offered the opportunity to earn 20 MOC practice assessment points through their participation in the initiative.

The ACP Practice Advisor modules include a practice biopsy tool, designed to assess how well each practice addresses chronic pain or opioid risk management, and uses a team-based approach for improving care of chronic pain patients. The modules also provide case study examples of a three-clinician primary care practice implementing a QI activity to improve chronic pain care or opioid risk management. Each module also has a library of resources and improvement tools. These resources include webinar recordings, journal articles, community resources, and assessment tools (e.g., pain assessment, risk assessment, and mental health screening tools).

*Patient Education Brochure:*

A patient education brochure was also developed to help physicians teach their patients about the risks and benefits of controlled substances, as well as the need for the controlled substance agreement. The brochure discusses the following elements:

- Understanding controlled substances
- How to use controlled substances
- Potential benefits of controlled substances
- Potential risks of controlled substances
- Understanding legal and regulatory issues with controlled substances
- How to partner with physicians when on controlled substances

The brochure was designed to allow practices to add their own contact information and practice logo prior to distributing to their patients. The brochure is designed to help clinicians have a conversation about controlled substances and help the patient better understand and manage their chronic pain treatment plan. The full patient education brochure can be found in Appendix D of this report.

#### *Chronic Pain QI Videos:*

A series of three videos are also being developed as a result of this initiative. Faculty members, Dr. Matthew Bair and Dr. Gregory Hood, will be featured in three, 10 minute videos on the following topics:

- 1) Pain and Mental Health Assessments
- 2) Risk Assessments
- 3) Controlled substance agreements

The videos are designed to provide an overview of the importance of each of these chronic pain management tools and how to implement them in practice. They will also feature an example PDSA cycle at the end of each video. An accompanying PDSA worksheet is being developed for each of these videos as well. The QI videos and worksheets will be added to the ACP Practice Advisor modules.

#### **Performance Improvement Methodology**

Each practice selected their own project priorities and developed tailored quality improvement plans, under the guidance of ACP QI leaders, to fit their practice needs. A number of common themes emerged across each practice's improvement activities. All of the practices engaged in team-based care to improve chronic pain management. Physician assistants, medical assistants, nurses, and other office staff from each practice were involved in the implementation of PDSA cycles. Health care team members worked to identify their chronic pain population, flag patient charts and/or identify items missing for the patients' records.

A number of practices also took advantage of their EHRs to help streamline the PDSA cycle implementation process. Practices developed methods to better identify their chronic pain patient population. They used coding systems and created structured data sets that would help automate their ability to keep track of their chronic pain patient population and identify missing pain assessments, controlled substance agreements, mental health screenings, etc.

Several practices with more than one physician decided to pilot their PDSA cycle implementation with a smaller group of clinicians within the practice. Their plan was to use this initiative as a pilot to show the success of practice changes in the management of their chronic pain patients. The data from the study could then be used



to provide an evidence-base following the initiative to support widespread adoption of changes in their practice to improve chronic pain care.

The following section provides an overview of each practice’s improvement activities over the course of the initiative.

Practice 1:

Practice 1 is a small, private practice with three internal medicine physicians and an additional 22 clinical and office support staff. The practice had relatively high baseline performance data, as summarized in the table below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician A	84%	16%	80%
Physician B	100%	84%	92%
Physician C	100%	88%	88%
Average	94.67%	62.67%	86.67%

The practice focused on implementing team-based care to increase use of pain assessments for their chronic pain patients. The practice’s office staff had patients fill out pain assessments with an open response space on the form for the patients to address any concerns with their physicians. A member of the office staff then entered the pain assessment score into the patient’s medical record. Following the visit, the physician notified staff members to ensure their visit notes were entered into the patient’s medical record.

Practice 2:

Practice 2 is a large multi-specialty practice with 11 physicians, each of which has their own team of clinical support staff. The practice decided to focus on working with a smaller group for this initiative. The QI project was initially implemented by the physician QI champion’s team, which consists of the physician, a licensed practical nurse (LPN), and a medical assistant. The intention was to share results from this initiative with the entire practice at their monthly partner meeting with hopes of expanding adoption of change and transformation to the entire practice.

The practice site visit revealed that there was no formal process for assessing pain, screening for depression, and/or documenting a follow-up plan. Their baseline performance data is summarized in the table below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician D	20%	0%	60%

During the baseline data collection process, the practice realized they do not have a good system for identifying their chronic pain population. One of the first steps taken was to start coding chronic pain diagnosis codes into

patients’ record to make it easier to identify the patient population. The physician QI champion engaged his team to implement a plan to incorporate standard pain assessments and mental health screening tools into the practice work flow. They discovered a standard pain assessment tool was already embedded in their EHR. The non-physician QI champion was charged with gathering the necessary additional documents prior to the patient visit.

Practice 3:

Practice 3 is a solo private practice that went through a large staff turnover at the beginning of the project; a number of clinic support staff members were fired and a new triage nurse was hired. The practice was not using standard pain assessment tools prior to the initiative, all pain assessments were done verbally and were not documented in the patients’ record. Practice 3’s baseline data is summarized in the table below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician E	56%	0%	48%

The practice developed a plan for the non-physician QI champion to flag chronic pain patients prior to their visit and engage the newly hired triage nurse to pull necessary documents (e.g., pain assessment tool, depression screening tool, and controlled substance agreement) prior to the physician seeing the patient. The practice was also focused on making data system improvements to help incorporate use of assessments into the workflow. They created patient-specific alerts in the EHR for chronic pain patients who did not have a controlled substance agreement. The non-physician champion also began entering a reason code in the EHR to document chronic pain visits. They are also planning to add a code to indicate whether the pain assessment has been completed.

Practice 4:

Practice 4 is a large internal medicine practice with over 10 physicians. This group also decided to focus on working with one physician for this initiative, with the hopes of expanding to the rest of the practice. In this practice, each physician has their own assigned medical assistant and an additional group of medical assistants who are shared across all physicians. Each physician works independently and there is no centralized workflow. The physician QI champion’s hope for this initiative is to provide an evidence-base to show the effectiveness of the QI project to encourage developing a more centralized workflow and foster a culture of quality among the physicians.

The physician QI champion’s baseline data reveals relatively high performance for mental health screenings and controlled substance agreements and urine drug screens. However they do not use a formal standardized pain assessment tool with their chronic pain patients. Practice 4’s baseline data is summarized in the table below.

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician F	69.23%	0%	69.23%

The practice focused on having strong pre-visit planning to implement improved care. The medical assistant printed the following day’s schedule and flagged charts for any chronic pain patients. The physician also has a health maintenance tracking sheet that he checks for each patient prior to their visit, which includes a checklist for a variety of preventive health measures (e.g., mammogram, flu shot, colonoscopy, etc.). Additional lines were added to the maintenance tracking sheet to check for chronic pain screens (pain assessments, mental health screenings, urine drug tests, and controlled substance agreements).

Practice 5:

Practice 5 is a solo private practice in a rural county in Kentucky, with one physician, two full-time nurse practitioners (NPs), 1 part-time NP, and 10 office staff. The practice has a large patient population on Suboxone (buprenorphine and naloxone), so improving management of these patients was a significant driving factor for their participation in this initiative. The practice has an advanced EHR system and it was easy for them to pull a list of chronic pain patients for the purposes of this study. The practice’s baseline data shows their performance for urine drug screens and controlled substance agreements was high, however, they were not using formal pain assessment tools or mental health screenings. Practice 5’s baseline data is summarized in the table below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician G	0%	0%	88%

This practice developed a system to flag chronic pain patients within the EHR and provide a notification for forms that are missing from the patient’s record. The practice focused on incorporating the Brief Pain Inventory pain assessment tool, a controlled substance agreement, the Opioid Risk Tool, and PHQ-2 depression screening forms into their office work flow.

Practice 6:

Practice 6 is a small, physician-owned private practice based in Indiana with three physicians (specialties include IM and pediatrics) and 10 office staff. Only one physician had a large enough chronic pain patient population to participate in the study, but they plan on expanding the quality improvement project to the other physicians after this study is complete. The physician’s baseline data reveals large performance gaps in the depression screen and controlled substance agreement measures, as shown below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician H	0%	76%	0%

The physician QI champion decided to set up a dedicated pain evaluation visit for his chronic pain patients. This gave the physician more time to engage and communicate with the patient about how to live with and manage their chronic pain. He also engaged the medical assistant to identify the chronic pain population and keep track

of whether or not the patient has a pain assessment, mental health assessment, and signed controlled substance agreement on file. Because the practice is based in Indiana, they are not subject to the same state regulations as the other practices. However, Indiana recently changed state laws to limit opioid refills. As a result, the practice has modified their workflow to identify and keep track of patients who call in for opioid prescription refills. This has helped identify a larger of chronic pain population than originally thought. The practice is making sure to appropriately code these patients for chronic pain so they can better monitor this population moving forward.

Practice 7:

Practice 7 is a solo private, concierge practice with one physician and two support staff members. The physician has a smaller patient population and is able to devote 30 minutes for each patient visit. The baseline data reveals that the practice is performing a depression screen on 100 percent of their chronic pain patients, however, they are not using a formal pain assessment tool and do not have signed controlled substance agreements in place for their patients on opioids. Practice 7’s baseline data is summarized below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician I	100%	0%	0%

After reviewing their baseline data, the QI champions developed a team-based action plan to increase pain assessments for their chronic pain patients. The non-physician QI champion performed a chart review for all patients and flagged charts for each chronic pain patient. Once these patients were flagged, the QI champion would put together a packet of all the missing forms required. During the visit, the physician provided patients with a summary of the Kentucky House Bill 1 regulation, which he used to educate them on the new requirements and help them understand why they are required to complete the packet of assessment forms and sign a controlled substance agreement.

Practice 8:

Practice 8 is a solo private family practice with one physician, three physician assistants (PAs) and six office staff. The physician QI champion has strong experience in QI and has implemented PDSA cycles in the past year. The practice’s baseline data is summarized below:

	<b>Depression screening</b>	<b>Pain assessments</b>	<b>Opioid agreement forms and urine toxicology tests</b>
Physician J	68%	0%	40%

The practice printed a number of standard assessment tools, including the Brief Pain Inventory, SOAPP RR, and PHQ-4 assessments, on a laminated sheet and provided these forms to patients in the waiting room with dry erase markers. When the chronic pain patient checked in, they were handed the laminated forms to fill out in the waiting room. The results were then entered into the patient’s record electronically. They also created a

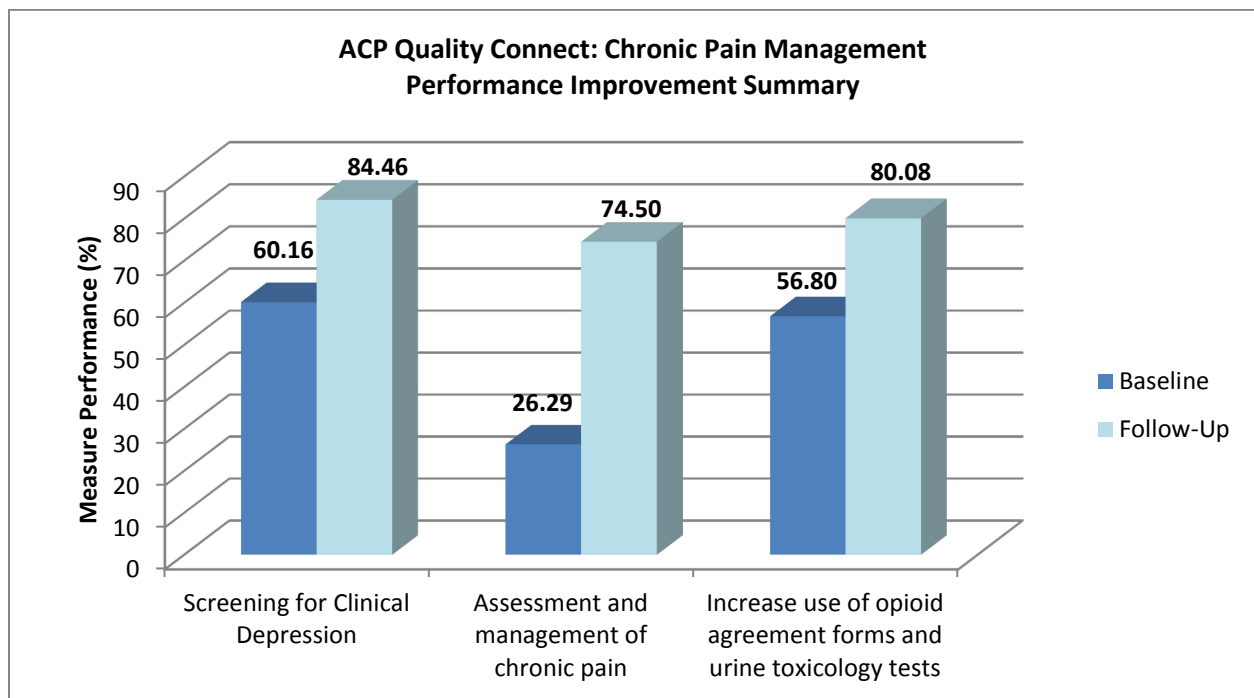
structured data set within the EHR under a preventative medicine tab dedicated for chronic pain management to allow them to keep better track of these patients.

### Outcomes Summary

The success of the ACP Quality Connect: Chronic Pain initiative was evaluated based on outcomes from several data sources including performance measure data, educational webinar evaluations, and provider surveys. Evaluation analysis for this initiative was conducted in partnership with the Center for Health Services and Outcome Research at the Johns Hopkins Bloomberg School of Public Health (JHU).

#### Performance Measure Outcomes:

Performance measure data was collected from each practice at the beginning of the initiative, in August 2014, and follow-up data was collected after four months, in December 2014. Each participating physician provided data for 25 chronic pain patients, age 18 and older, for both the baseline and follow-up data sets. Results of the performance measure data show a significant improvement in each of the three measures included in the initiative. The overall performance improvement by measure is summarized in the following chart:



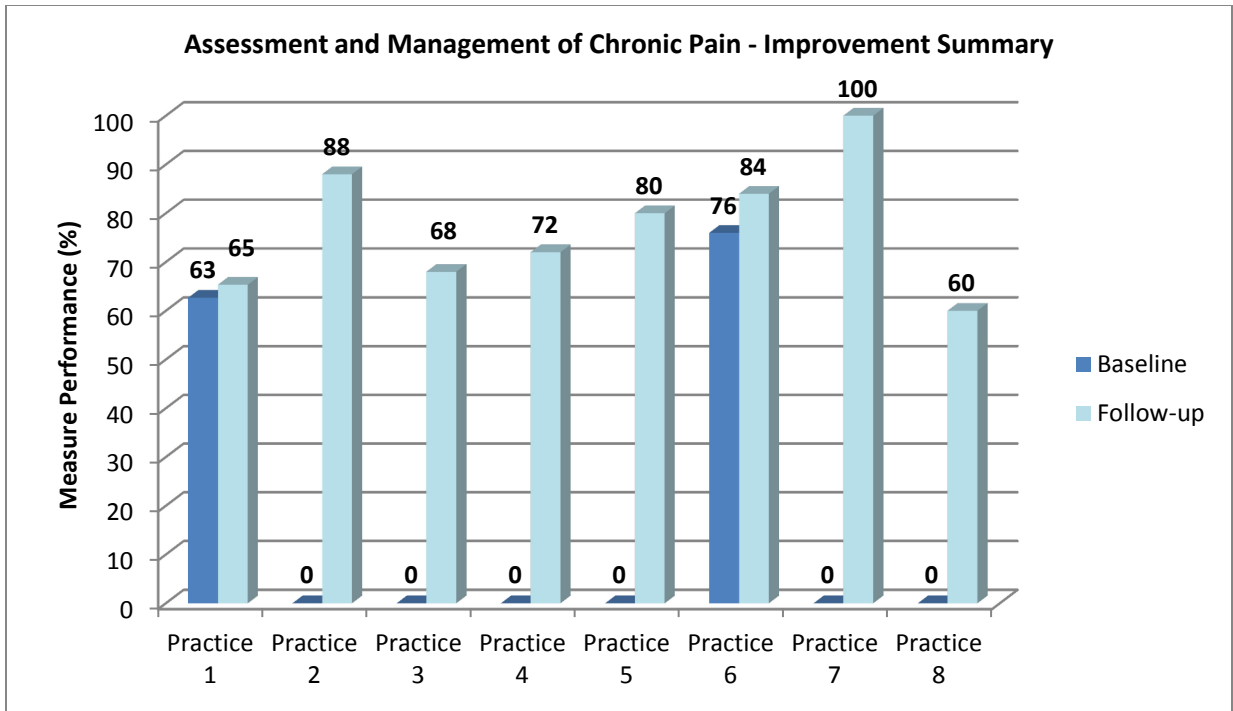
The program’s impact on providers’ practice in using these tools was assessed by comparing these measures at baseline and follow-up. Chi-squared tests or Fisher’s exact tests were used to test whether the differences were statistically significant. Data was analyzed from all eight participating practices together and also conducted the analysis by practice. Results of the analysis are found in the table below:

Percent of sampled patients receiving:	Depression Screening			Pain Assessment			Controlled Substance Agreement and Urine Drug Test		
	Baseline	Follow-up	P value	Baseline	Follow-up	P value	Baseline	Follow-up	P value
<b>Overall (10 physicians; 251 patients each for baseline and follow-up)</b>	60%	84%	<0.001	26%	75%	<0.001	57%	80%	<0.001
<b>Practice 1 (3 physicians; 75 patients each for baseline and follow-up)</b>	95%	100%	0.120	63%	65%	0.734	87%	100%	0.001
<b>Practice 2 (1 physician; 25 patients each for baseline and follow-up)</b>	20%	92%	<0.001	0%	88%	<0.001	60%	80%	0.123
<b>Practice 3 (1 physician; 25 patients each for baseline and follow-up)</b>	56%	76%	0.136	0%	68%	<0.001	48%	60%	0.395
<b>Practice 4 (1 physician; 26 patients each for baseline and follow-up)</b>	69%	84%	0.214	0%	72%	<0.001	69%	68%	0.925
<b>Practice 5 (1 physician; 25 patients each for baseline and follow-up)</b>	0%	88%	<0.001	0%	77%	<0.001	88%	88%	0.959
<b>Practice 6 (1 physician; 25 patients each for baseline and follow-up)</b>	4%	28%	0.049	76%	84%	0.480	0%	24%	0.022
<b>Practice 7 (1 physician; 25 patients each for baseline and follow-up)</b>	100%	100%	-	0%	100%	<0.001	0%	100%	<0.001
<b>Practice 8 (1 physician; 25 patients each for baseline and follow-up)</b>	68%	76%	0.529	0%	60%	<0.001	40%	80%	0.004

The results showed that application pain assessments, depression screenings, controlled substance agreements, and urine toxicology tests increased significantly after the program. Sixty percent of the patients at baseline and 84% of the patients in the post-program period received depression screening; use of a pain assessment increased from 26% to 75% of patients; and use of the controlled substance agreement and urine drug tests were also increased from 57% to 80%. Moreover, the use of these tools varied extensively at baseline. For example, providers at Practice 1 and Practice 7 screened for depression in almost all of their patients at baseline, while none of the sampled patients were screened for depression in Practice 5. However, in the follow-up data, all three measures were applied to the majority of the patients in all eight practices, except in Practice 6, where use of depression screening, controlled substance agreements and urine drug testing still reveals considerable room for improvement. The results suggest that the program has successfully increased providers' use of these three evidenced-based tools for chronic pain care among the participating practices.

#### Assessment and Management of Chronic Pain

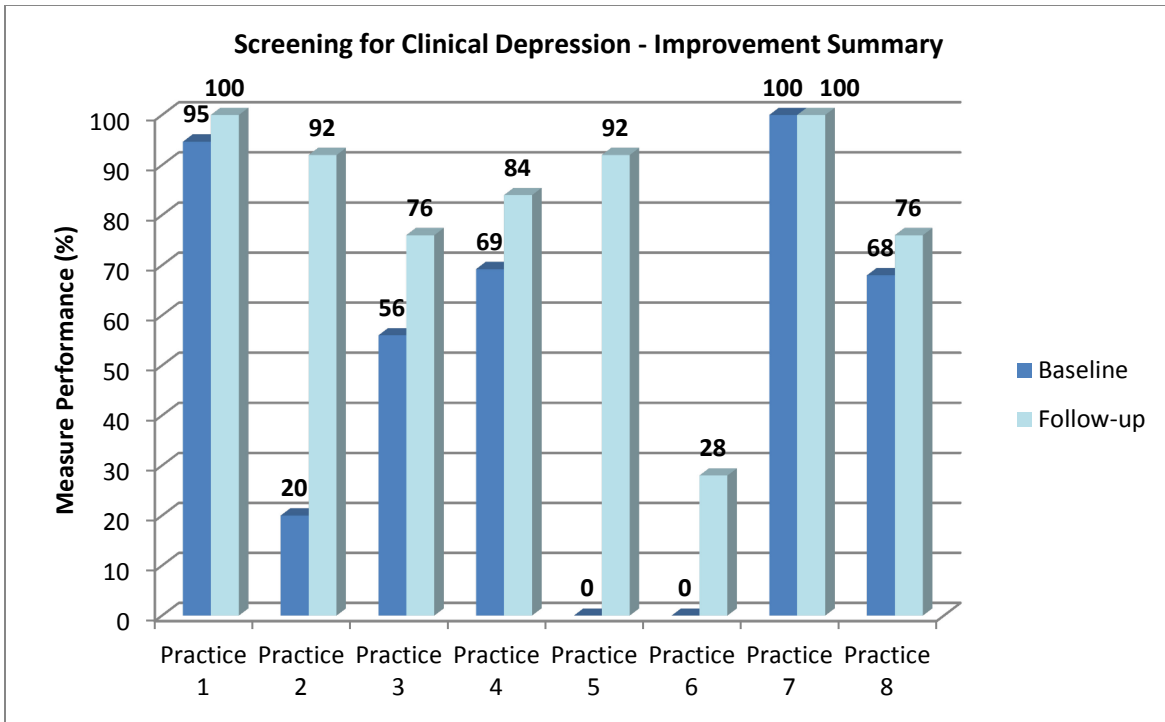
The most significant increase was seen with the “assessment and management of chronic pain” (pain assessment) measure, which rose from 26.29% at baseline to 74.50% at follow-up—showing an improvement of 48.2% over the course of four months. These results are in line with the top project priorities identified by each practice: six out of eight practices selected pain assessments as a top priority for this QI initiative. The pain assessment measure had the lowest initial performance among the practices, starting at 26.29% compared to 60.16% for clinical depression screening and 56.80 for increasing use of opioid agreement forms and urine toxicology tests. As a result, this measure also had the largest room for improvement. A summary of performance improvement for the pain assessment measure by practice is summarized in the following chart:



The pain assessment measure is the only measure out of the three included in this study that is not aligned with performance reporting or state regulatory requirements, which may contribute to the lower average baseline performance. Six out of eight practices did not use any standard pain assessments with their chronic pain patients. During the practice site visits, many of the physician QI champions explained that they assess pain verbally; however, they did not have a formal system in place to assess and document their patients' pain levels. Many of these practices chose to focus on using the Brief Pain Inventory assessment tool to assess and manage their patient's chronic pain.

#### Screening for Clinical Depression

Group performance for the "screening for clinical depression" measure improved from 60.16% at baseline to 84.46% at follow-up (+24.30%). Taking a deeper look into the measure performance by practice reveals the largest improvements were shown in Practices 2 and 5, which saw improvements of 72% and 92%, respectively. The overall improvement for this measure is summarized in the chart below:



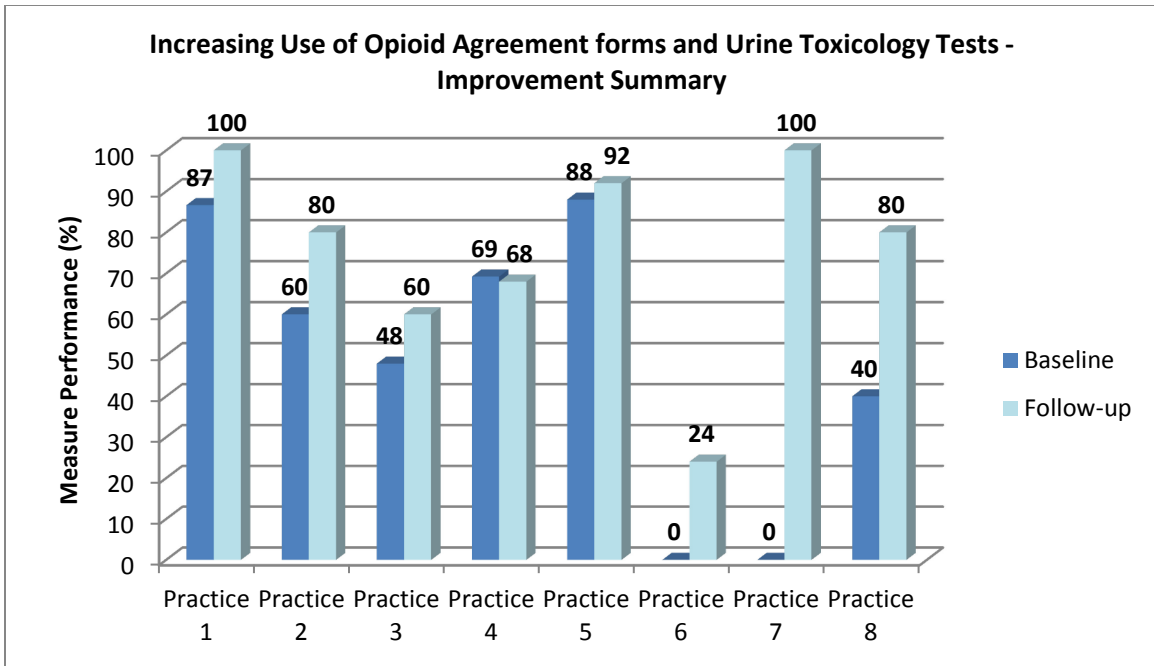
The screening for clinical depression measure had the highest baseline performance of all three measures. This may be due to the fact that all of the practices participate in an ACO and are required to report on this measure for their Medicare patient population. The majority of practices (five out of eight) had baseline performance rates of over 50% for this measure. Results from the practice assessment tool showed that meeting performance reporting requirements for ACOs is a top priority for the majority of participating practices. This is supported by the higher baseline performance for this ACO measure.

Overall improvement for this measure was further limited by two outliers—Practices 1 and 7, which both had very high baseline performance rates (95% and 100%, respectively). When these practices are removed, the average performance improvement increases from 36% at baseline to 75% at follow-up—an increase of 39%.

#### Increasing Use of Opioid Agreement forms and Urine Toxicology Tests

The average baseline performance among all practices for the controlled substance agreement and urine toxicology tests measure was 56.80%. Half of the practices had baseline performance rates higher than 50% (Practices 1, 2, 4, and 5). The following table provides an overview of average performance for this measure by practice.





Recent state regulations in Kentucky (House Bill 1) have placed new requirements for physicians prescribing controlled substances that may contribute to the higher baseline performance for the “increase use of opioid agreement forms and urine toxicology tests.” Although the exact requirements for House Bill 1 are open to interpretation, elements of the bill discuss mandating use and documentation of controlled substance agreements, utilization of the Kentucky state prescription drug monitoring program to identify high-risk patients, review of relevant medical history for chronic pain patients on controlled substances, as well as conducting urine drug tests and follow-up risk assessments.

#### Evaluation of Educational Webinars

Respondents filled out a survey to provide feedback after each educational webinar. There were six responses for the Pain and Mental Health Assessment webinar (response rate = 66.67%) and two for the Pain Contract and Risk Assessment Webinar (response rate = 33.33%). The respondents were internal medicine and family practice physicians. The respondents were very positive about the webinars. The median rating of the overall quality was 4 for both webinars on a 5-point Likert scale. The rating of the lecturers’ teaching was high as well, 4.5 and 4. All scores were 4 or 5. Respondents agreed that the webinars met their objectives to help participants understand the evidence-based practices and tools in chronic pain care and increase the use of those practices and tools. They also reported to have plans to change their practice and use the tools introduced in the webinars. However, not all respondents strongly believed that the changes would lead to improved patient health status or treatment outcomes. Fifty percent of the respondents to the Pain and Mental Health Assessment webinar, and both respondents to the Pain Contract and Risk Assessment webinar, replied ‘Maybe.’ The barriers to applying what was learned in both webinars were cited as lack of time, remembering to do it, and to a lesser extent, patient adherence.

Results from the webinar evaluations are provided in the table below:

<b>ACP Quality Connect: Chronic Pain Webinar Evaluation Results</b>		
<b>Evaluation Questions</b>	<b>Pain and Mental Health Assessment</b>	<b>Pain Contract and Risk Assessment</b>
Number of responses	6 (100%)	2 (100%)
<b>Respondents' profession, n (%)</b>		
Internal practice	5 (83%)	1 (50%)
Family medicine	1 (17%)	1 (50%)
<b>Overall quality of the webinar, median (range)</b>	4 (4-5)	4 (4-4)
<b>Quality of lecture's teaching, median (range)</b>	4.5 (4-5)	4 (4-4)
<b>The webinar meets the following learning objectives (%):</b>		
Understand evidence-based guidelines for effective use and implementation of pain assessment tools	100%	-
Understand evidence-based guidelines for effective use and implementation of mental health screening tools	100%	-
Increase use of pain assessment tools with chronic pain patients	100%	-
Increase use of mental health screening tools with chronic pain patients	100%	-
Understand evidence-based guidelines for effective use and implementation of risk assessment tools	-	100%
Improve patient education on controlled-substance agreements	-	100%
Increase use of risk assessments with chronic pain patients	-	100%
<b>Respondents plan changes for the following (%):</b>		
Using pain assessment tools with chronic pain patients	100%	-
Using mental health screening tools with chronic pain patients	100%	-
Using risk assessment tools with chronic pain patients	-	100%
Educating patients on controlled-substance agreements	-	100%
<b>The changes will lead to improved patient health status or treatment outcomes (%):</b>		
Yes, definitely	50%	0%

ACP Quality Connect: Chronic Pain Webinar Evaluation Results			
Evaluation Questions	Pain and Mental Health Assessment		Pain Contract and Risk Assessment
Maybe	50%		100%
No, definitely not	0%		0%
<b>Barriers to applying what's learned in the webinar (%):</b>			
Cost	0%		0%
Insurance/reimbursement issues	0%		0%
Lack of administrative support/recourses	0%		0%
Lack of time to assess/counsel patients	67%		100%
Patient compliance issues	17%		0%
Remembering to do it	33%		50%
Uncertain	0%		0%

Provider Survey Outcomes:

Provider surveys were developed in collaboration with colleagues at JHU to assess each individual provider's background, as well as their knowledge and attitudes towards QI and chronic pain management. The provider surveys were administered to physician and non-physician QI champions at each practice at the beginning and end of the initiative. Fifteen QI champions filled out the provider surveys. Eleven of them submitted both baseline and follow-up surveys, while two respondents submitted only baseline survey and the remaining two completed the follow-up survey only. The response rate was 81.25% for both baseline and follow-up. All the respondents are Caucasians. The median age is 48. Six of them are internal medicine or family practice physicians; others are physician assistants, registered nurses, medical assistants, and office managers.

Characteristics of Provider Survey Respondents		
	n = 15	Percentage
<b>Survey response</b>		
<b>Answered both baseline and post-program survey</b>	11	74%
<b>Answered only baseline survey</b>	2	13%
<b>Answered only post-program survey</b>	2	13%
<b>Gender</b>		
<b>Female</b>	7	47%
<b>Male</b>	7	47%
<b>Missing</b>	1	6%
<b>Race</b>		
<b>Caucasian</b>	14	93%

Characteristics of Provider Survey Respondents		
Missing	1	7%
<b>Profession</b>		
Physician: Family Practitioner	2	13%
Physician: General Internist	6	40%
Physician Assistant	1	7%
Registered Nurse	1	7%
Medical Assistant	2	13%
Office Manager	3	20%
Years in current position, median (IQR)	14	(7 - 25)
Age, median (IQR)	48	(46 - 57)

*Changes in providers' knowledge:* The table below shows the percentages of correct answers for the knowledge questions in the provider survey at baseline and follow-up. Results are also reported by physicians and other respondents. Although the percentage of correct answers decreased for 4 questions and increased for 1 question from baseline to follow-up, there were no statistically significant changes found using Fisher's exact tests, due to small sample size. The results suggest that the educational materials in this program did not improve participants' knowledge about chronic pain care; we must keep in mind, however, that we do not have baseline information for 2 respondents and we do not have follow-up for 2 respondents. This results in some difference in the populations assessed at baseline and follow-up, which may explain some portion of the apparent lack of improvement. It may also be that the knowledge questions used here were not able to capture the expansion of knowledge that occurred, since participants reported very positive feedback to the webinars. Moreover, physicians were more likely to answer some of the questions correctly than other respondents. This may suggest that physician knowledge expanded but that they may not have communicated these lessons to other clinicians and practice staff.

Provider Survey Knowledge Questions	Percent Correct Answer					
	All		Physicians		Non-physician	
	Baseline (n =11-12)	Follow-up (n =13)	Baseline (n =6)	Follow-up (n =6)	Baseline (n =5-6)	Follow-up (n =7)
True or False: Increased severity of pain reduces depression treatment response (answer: true)	75%	69%	100%	100%	50%	43%
Which of the following is true about the Opioid Risk Tool? A) It contains five items and takes less than 1 minute to administer and score; B) Screens for risk of deviant behavior associated with substance abuse in pain patients; C) Has not been validated in non-pain population; D) Asks about family history of substance abuse; E) All of the above (answer: E)	100%	77%	100%	100%	100%	57%

Provider Survey Knowledge Questions	Percent Correct Answer					
	All		Physicians		Non-physician	
	Baseline (n =11-12)	Follow-up (n =13)	Baseline (n =6)	Follow-up (n =6)	Baseline (n =5-6)	Follow-up (n =7)
All of the following can obtain a report from a state prescription drug monitoring database EXCEPT: A) Health care professionals; B) Law enforcement officers for drug-related investigators; C) Licensure boards for an investigation of a license; D) Patients; E) Dispensers for pharmaceutical treatment of a patient (answer: D)	92%	92%	83%	83%	100%	100%
True or False: Prescribers can log in to the state prescription drug monitoring database and run a report (e.g., reverse KASPER) to determine if fraudulent controlled substance prescriptions are being filled under his/her DEA number (answer: true)	100%	100%	100%	100%	100%	100%
True or False: A main reason for controlled substance abuse agreements is to protect a physician from liability (answer: false)	50%	38%	67%	50%	33%	29%
True or False: Urine drug tests are considered a standard of care in monitoring patients taking opioid medications for chronic noncancer pain (answer: true)	100%	92%	100%	83%	100%	100%
True or False: Anxiety disorders occur in more than 1/3 of persons with chronic pain (answer: true)	82%	100%	100%	100%	60%	100%

<sup>1</sup>No statistically significant changes between baseline and follow-up were found based on Fisher's exact tests.

*Changes in providers' attitudes:* Generally, respondents reported higher scores in the attitudes questions (on a scale from 1-5 from Disagree Strongly to Agree Strongly) at follow-up compared to those at baseline. Improvements in two questions were statistically significant. Compared to the baseline, the respondents had stronger beliefs at follow-up that they put all their patients with chronic pain on appropriate drugs or therapies (p=0.045). They were also more confident that they make appropriate and timely referrals of chronic pain patients to pain subspecialists and mental health providers (p=0.022).

The following table provides a summary of the changes in provider attitudes:

Question items <sup>1</sup>	Agreement Score				P Value <sup>2</sup>
	Baseline (n =13)		Follow-up (n =13)		
	Median (Range)	Mean (SD)	Median (Range)	Mean (SD)	
Managing chronic pain is challenging	3 (3-5)	3.77 (1.01)	5 (3-5)	4.23 (1.01)	0.249
Time is a barrier to optimal care for patients with chronic pain	3 (3-5)	3.46 (0.88)	3 (3-5)	3.62 (0.96)	0.665
Patients understand the importance of management of chronic pain	3 (1-3)	2.85 (0.55)	3 (3-5)	3.15 (0.55)	0.166
I feel like there are enough community resources to help my patients with chronic pain management	3 (3-5)	3.15 (0.55)	3 (1-3)	2.85 (0.55)	0.166
I feel competent in using the newer medications for chronic pain	3 (1-5)	2.85 (0.99)	3 (3-3)	3.00 (0.00)	0.548
I put all of my patients with chronic pain on appropriate drugs or therapies	3 (1-3)	2.85 (0.55)	3 (3-5)	3.46 (0.88)	0.045
I am confident that I make appropriate and timely referrals of my chronic pain patients to pain subspecialists and mental health providers	3 (1-5)	3.00 (0.82)	3 (3-5)	3.92 (1.04)	0.022

<sup>1</sup>Rated 1–5 from “strongly disagree” to “strongly agree” with higher values representing greater agreement

<sup>2</sup>From Wilcoxon Rank sum tests

**Conclusion:**

The ACP Quality Connect: Chronic Pain Management initiative showed promising results in terms of positive reactions to the webinars, improved belief that all patients with chronic pain are put on appropriate drugs or therapies, and greater confidence that appropriate and timely referrals to pain subspecialists and mental health providers are made. In addition, the results showed increased use of the recommended screening tools, the controlled substance agreement and regular urine testing. It is important to note limitations that may affect interpretation of these data. Primarily, the sample size is small (as is typical for pilot studies), which reduces the chances of being able to statistically detect small effects of the intervention. In addition, the time frame for intervention was short, and additional effects may accrue over time as the intervention continues. Noting these limitations, however, the importance of the demonstrated changes is emphasized, and highlights the promise of the intervention and of expansion of QI activities around chronic pain management in Kentucky and elsewhere.

**Lessons Learned**

The overwhelming success of the ACP Quality Connect: Chronic Pain initiative in Kentucky has provided a blueprint for ACP’s QI programs moving forward. The model of partnering with state ACP chapters in collaboration with health systems, in this case, ACOs, proved particularly successful in the recruitment phase of the initiative. Dr. Gregory Hood, the Medical Director of the Quality Independent Physicians ACO, and Paula Straub, Pharmacy Director of the ACO, were critical leaders of the recruitment and were able to target practices throughout the state of Kentucky to participate in the program. Having strong commitment to the QI program

from the ACO's leadership had a positive impact on practice engagement. Working with the Ms. Straub, who was familiar with each practice through her role as Pharmacy Director and was able to provide regional support throughout the course of the initiative, was also a key element to the success of the program.

There were a number of additional driving factors that contributed to the overall success of the program. One major factor was engagement of QI champions at the early stages of the initiative. Inviting physician and non-physician QI champions to the advisory group meeting helped ensure that the educational content was relevant and the program design would address their top educational and QI priorities. Advisory group members were able to get direct feedback from the participating QI champions and work collaboratively to develop a project work plan moving forward.

A number of critical program planning decisions were made as a result of the advisory group meeting with direct input from the participating practices, including:

- 1) Selection of a relevant core measure set
- 2) Identification of top four educational priorities
- 3) Decision that practice site visits and follow-up coaching calls would be favorable and more effective than a live educational program

The advisory group was mindful of the administrative burden that QI projects may place on practices, so efforts were made to ease the burden throughout the initiative. Educational webinars and coaching calls were held in the evenings to fit each physician's schedule. Health care team members were engaged to help with data collection and implementation. ACP QI leaders also offered telephonic support and guidance throughout the course of the initiative.

Providing tailored QI interventions was another critical component to the success of this initiative. The ACP Quality Connect: Chronic Pain Practice Assessment Tool and follow-up practice site visits provided critical information about each practice's background, QI knowledge and current chronic pain strategies. This data, along with the baseline performance data, allowed ACP QI leaders to provide tailored guidance on the implementation of QI activities in each practice. At the end of each practice site visit, the project leaders had a clear understanding of what their next steps should be to begin implementing PDSA cycles. Follow-up coaching calls were scheduled with each practice to check in on the status of their QI activities.

As a result of this initiative, the use of a formal, standardized practice assessment tool has been adopted in all of the ACP Quality Connect programs, which currently cover chronic pain, adult immunizations, and diabetes. The ACP Quality Connect practice assessment tools follow the same structure used for the chronic pain assessment tool. The first two sections assess practice background, characteristics, and QI experience. The third section of the assessment tool is tailored to evaluate best practices for the specific clinical focus of the QI initiative.

Overall, this initiative has shown significant improvements in performance measure outcomes and many of the practices have indicated that they plan on continuing to adopt the changes made in their practices beyond the course of the initiative.

One of the physician QI champions provided the following feedback at the end of the initiative:

*Our practice is familiar with quality improvement concepts and have used them to guide our processes over the years. However, when we applied rigorous methodology per the study guidelines, we markedly improved how we care for chronic pain patients and how we document that care. We appreciate what the study has done for these patients and for our ability to deal with quality issues in general as we move into this new era of medicine.*



**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

**ACP Quality Connect: Chronic Pain Management**  
*Practice Assessment Tool*

The following practice assessment tool is designed to help you review your practice’s current quality improvement (QI) capacity and chronic pain care so as to identify effective strategies for practice improvement. Your individual practice results will not be disclosed to anyone outside of the project leaders.

Your Name:	Date:
Email Address:	Practice Address:
Practice Name:	
Practice Phone Number:	

**Directions for Completing the Practice Assessment**

1. Answer each question from the perspective of your practice. This assessment should be completed by the physician QI champion from your practice.
2. For each question, select the response that best describes your current approach to care
3. Once you have completed the survey, please email, mail, or fax your responses to:

Selam Wubu  
25 Massachusetts Ave NW, Suite 700  
Washington, DC 20001  
Fax: 202-835-0443  
Telephone: 202-261-4583  
Email: [swubu@acponline.org](mailto:swubu@acponline.org)

4. For more information on how to complete the survey, please contact:

Paula Straub, RPh  
Precision Healthcare Delivery  
2301 River Rd, Ste 302  
Louisville, KY 40206  
502-814-3156  
[pstraub@phdelivery.com](mailto:pstraub@phdelivery.com)

Or Selam Wubu  
American College of Physicians  
25 Massachusetts Ave NW, Suite 700  
Washington, DC 20001  
202-261-4583  
[swubu@acponline.org](mailto:swubu@acponline.org)

**Background and Acknowledgement**

The Kentucky ACP chapter (KY-ACP), in collaboration with the national ACP, has been awarded a grant from Pfizer to conduct a QI project aimed at improving the screening, diagnosis, and safe and effective treatment of chronic pain in primary care practices that are part of ACOs and/or are pursuing recognition of a patient-centered medical home (PCMH). ACP is also working with the Center for Health Services and Outcomes Research (CHSOR) at the Johns Hopkins University Bloomberg School of Public Health to evaluate the impact and effectiveness of this program.

**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

**Part I. Practice Background**

The following questions provide basic information about your practice, which will help determine the best QI approach for your team.

1. Which of the following best describes your primary work setting (where you spend the majority of your professional time in medicine)?
  - Solo private practice
  - Smaller primary care private practice (<10 physicians)
  - Larger primary care private practice (10+ physicians)
  - Other (please specify) \_\_\_\_\_
  
2. Which of the following best describes the health/medical records system used for current patients in your primary work setting? (Choose one)
  - A computerized electronic health record (EHR) system
  - A combination system that incorporates elements of an EHR and a paper chart
  - Paper chart
  - Not applicable
  
3. If you indicated that you use an EHR system in your practice, which system does your work setting use?  
\_\_\_\_\_
  
4. How long has your practice been using this EHR system?
  - Less than 6 months
  - 6 months – 1 year
  - 1 – 2 years
  - More than 2 years

**APPENDIX A:  
ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

**Part II. Quality Improvement Goals and Capacity**

The following questions are designed to assess your practice’s QI goals and capacity. This will help in selecting QI interventions to address your performance gaps as well as meet your interests, professional goals, and needs.

5. Please complete the following items about your practice’s QI experience<sup>4</sup> by selecting the most appropriate box.

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Our practice implements team huddles and other methods for enhancing team-based care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The impetus for improving quality in my practice is largely driven by <i>external</i> forces (e.g. funders, accreditation, regulation, peer pressure).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaders of my practice are trained in methods for evaluating and improving quality, such as Plan-Do-Study-Act (PDSA) cycles, Six Sigma, Lean, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My practice has implemented PDSA cycles or other QI initiatives in the last year.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My practice has designated a QI officer or champion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My practice has the ability to easily extract data from our EHR or clinical charts to inform QI activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My practice has participated in a performance reporting program in the past year (e.g. Physician Quality Reporting System (PQRS), Meaningful Use (MU), etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administrative burden is a barrier to QI in my practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<sup>4</sup> Adapted from: Joly BM, Booth M, Mittal P, Shaler G. (2012). Measuring Quality Improvement in Public Health: The Development and Psychometric Testing of a QI Maturity Tool. *Evaluation & the Health Professions*, 35(2) 119-147.

**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

6. Which of the following are the highest priorities for your QI program? (Choose your **top two** priorities)

- Enhancing team-based care
- Care coordination with external specialists and hospitals
- Patient-Centered Medical Home or Neighborhood (PCMH/N) recognition
- Increasing shared decision-making tools and patient engagement
- Learning how to implement PDSA cycles or other QI activities
- ABIM MOC practice assessment
- Other specialty or subspecialty MOC practice assessment
- Performance reporting/reimbursement requirements. **Please select all that apply:**
  - MU
  - PQRS reporting
  - Accountable Care Organization (ACO)
  - Licensure
  - Hospital credentialing and privileging
  - Advanced QI process and training (e.g., Lean, Six Sigma, etc.)
  - State law regulations or reimbursement requirements (please describe):  


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  - Other (please specify): 

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7. Please indicate how ready your practice is to change chronic pain care by selecting the appropriate number on the scale.

Not Ready				Considering Change				Ready to Change Now			
0	1	2	3	4	5	6	7	8	9	10	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. If you selected less than a 10 for your practice on the readiness to change scale, why did you not select a 10?

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9. How important is improving chronic pain care to your practice?

Not Important			Extremely Important		
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

10. How confident are you that your practice can make improvements to chronic pain care?

Not Confident			Highly Confident		
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

**Part III. Chronic Pain Management Assessment**

The following questions are designed to help you assess your practice's current chronic pain management care.

11. Pain Assessments

- a. Does your practice administer a standard pain assessment tool?
  - Yes, to all patients
  - Yes, to some patients; please check all that apply:
    - Medicare patients
    - Chronic pain patients
    - Patients with specific diagnoses (please specify): \_\_\_\_\_
  - No
  
- b. How often are pain assessments administered to patients in your practice?
  - At every patient visit
  - Every 3-6 months
  - Once a year
  - At the patient's first visit only
  - Other (please specify): \_\_\_\_\_
  - Not applicable
  
- c. Which pain assessment tool is used in your practice? Please check all that apply:
  - Brief Pain Inventory (BPI)
  - Numeric rating scale (0 to 10 score)
  - Verbal descriptive scale (mild, moderate, severe)
  - Face pain scale
  - Physical Functional Ability Questionnaire (FAQ5)
  - PEG-3
  - SF-36 Bodily Pain Scale
  - Other (please specify): \_\_\_\_\_
  - Not applicable
  
- d. Please describe how pain assessments are used to develop a patient's pain management plan:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

**12. Mental Health Screenings**

a. Does your practice administer a mental health screening tool for depression or anxiety (or other mental health conditions) to patients with chronic pain?

- Always
- Sometimes
- Rarely
- Never

b. How often are mental health screenings administered to patients with chronic pain?

- At every visit
- Every 3-6 months
- Once a year
- At the patient's first visit only
- Other (please specify): \_\_\_\_\_
- Not applicable

c. Which mental health screening tool is used in your practice? Please check all that apply:

- Primary Care Evaluation of Mental Disorders (PRIME-MD)
- Patient Health Questionnaire (PHQ)-2
- PHQ-4
- PHQ-9
- Generalized Anxiety Disorder (GAD)-2
- GAD-7
- Other (please specify): \_\_\_\_\_
- Not applicable

d. Please describe how mental health screenings are used to develop a patient's pain management plan:

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**13. Controlled Substance Agreements and Patient Education**

a. Does your practice use controlled substance agreements for patients on controlled substances including chronic opioid therapy?

- Always
- Sometimes
- Rarely
- Never

**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

- b. Does your practice educate patients about their controlled substance agreements?
- Yes
  - No
- c. If you selected “Yes” above, please describe your approach to educating patients about their controlled substance agreements:

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**14. Risk Screenings**

- a. Does your practice assess risk of prescription opioid misuse for patients with chronic pain?
- Yes, for all patients who are currently on, or being considered for, chronic opioid therapy
  - Yes, for all patients who are currently on chronic opioid therapy only
  - Yes, for all patients who are being considered for chronic opioid therapy only
  - No

- b. How often are risk-assessments administered to patients with chronic pain?

- At every visit
- Every 3-6 months
- Once a year
- At the patient’s first visit only
- Other, please specify \_\_\_\_\_
- Not applicable

- c. Which risk-assessment tool is currently used in your practice? Please check all that apply:

- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients in Pain (SOAPP®)
- Current Opioid Misuse Measure (COMM™)
- Prescription Drug Use Questionnaire (PDUQ)
- Screening Tool for Addiction Risk (STAR)
- Screening Instrument for Substance Abuse Potential (SISAP)
- Pain Medicine Questionnaire (PMQ)
- Other (please specify): \_\_\_\_\_
- Not applicable

- d. Please describe how risk assessments are used to develop a patient’s pain management plan:

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**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

15. Urine Drug Testing

- a. Does your practice perform urine drug tests (UDTs) on chronic pain patients who are currently on or being considered for chronic opioid therapy?
  - Yes, for all chronic pain patients
  - Yes, for “low-risk” patients only
  - Yes, for “high-risk” patients only
  - No
  
- b. Do you have a set protocol for performing UDT on patients?
  - No
  - Yes, please describe:

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16. Kentucky All Schedule Prescription Electronic Reporting (KASPER) System

- a. Does your practice use the KASPER system to document a patient’s history of drug use?
  - Yes, for all patients who are currently on, or being considered for, chronic opioid therapy
  - Yes, for all patients who are currently on chronic opioid therapy only
  - Yes, for all patients who are being considered for chronic opioid therapy only
  - No
  
- b. How confident does your practice feel using the KASPER system?

Not Confident						Highly Confident
1	2	3	4	5		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

- 17. Are there any other topics that your practice would like to address through this initiative (e.g., use of pill counts)? If so, please describe below:

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**APPENDIX A:**  
**ACP Quality Connect: Chronic Pain Management Practice Assessment Tool**

18. Which of the following areas of focus are highest priorities for your practice for this initiative? (Please **select your top 2**):

- Pain assessments
- Mental health screenings
- Controlled substance agreements and patient education
- Risk screenings
- UDT
- KASPER system
- Other (please specify): \_\_\_\_\_

## APPENDIX B: ADVISORY GROUP MEETING AGENDA

### Enhancing Effective, Safe Chronic Pain Management in PCMH-Recognized and ACO-Participating Primary Care Practices:

#### *A Kentucky ACP Chapter ACP Quality Connect Initiative*

Saturday, May 17, 2014  
8:15am – 1:15pm

Precision Healthcare Delivery  
2301 River Road, Suite 302 Board Room  
Louisville, KY 40206

#### Meeting Objectives:

- Review project proposal and ACP Quality Connect approach
- Appraise the implications of the current chronic pain care environment, including:
  - House Bill 1 and 201 KAR 9:260 requirements
  - Evidence-based practices for chronic pain management in primary care
  - Quality improvement methodology
- Consider program evaluation strategies
- Tailor the project design to participating practice needs
- Identify next steps

Time	Agenda Item	Presenter/ Discussion Facilitator
8:15—8:30 am	Continental Breakfast	
8:30—8:45 am	Welcome and Introductions	Dr. Hood
8:45—9:10 am	Project Overview (15 minutes)  Q & A (10 minutes)	Dr. Hall, Ms. Wubu
9:10—9:35 am	House Bill 1 and 201 KAR 9:260 requirements (15 minutes)  Discussion by Advisory Group (10 minutes)	Dr. Hood
9:35—10:15 am	Evidence-based Practices for Chronic Pain Management in Primary Care (30 minutes)  Discussion by Advisory Group (10 minutes)	Dr. Bair
10:15—10:30 am	Break	
10:30—11:10 am	Quality Improvement Methodology (30 minutes)  Discussion by Advisory Group (10 minutes)	Dr. Schneider
11:10—11:35 am	Participating Practice Background and Needs (10 minutes)  Discussion by Advisory Group (15 minutes)	Ms. Straub
11:35 am—12:00 pm	Evaluation Approach and Options (15 minutes)  Discussion by Advisory Group (10 minutes)	Dr. Marsteller
12:00—12:10 pm	Break & Retrieve Lunch	
12:10—1:15 pm	Discussion of Program Design and Next Steps	Drs. Hood and Hall
1:15 pm	Adjourn	

## APPENDIX B: ADVISORY GROUP MEETING AGENDA

### Advisory Group Participants

**Greg Hood, MD, FACP, Chair**, Immediate-Past Governor, Kentucky Chapter, American College of Physicians; Medical Director, Quality Independent Physicians/The Physicians' Network

**Laura Lee Hall, PhD**, Director, Center for Quality, American College of Physicians

**Matthew J. Bair, MD, MS**, Research Scientist, Roudebush VA Center of Health Information and Communication and Regenstrief Institute; Associate Professor of Medicine, Indiana University School of Medicine

**Melia Glass, L.P.N.**, Precision Healthcare Delivery; Clinical Care Coordination Director, Quality Independent Physicians

**Jill Marsteller, PhD, MPP**, Associate Professor, Johns Hopkins Bloomberg School of Public Health; Associate Director for Quality, Center for Health Services and Outcome Research

**Doron Schneider, MD FACP**, Chief Patient Safety and Quality Officer, Abington Health

**Paula Straub, RPh**, Director of Pharmacy-Association of Primary Care Physicians/The Physicians Network/Quality Independent Physicians

**Selam Wubu**, Associate, Quality Improvement and Research, American College of Physicians

### Practice Participants

**Jessica Abner**, Administration, Drs. Borders Associates, P.S.C.

**Greg Ciliberti, MD**, Greater Louisville Internal Medicine; CEO Precision Healthcare Delivery; Medical Director, Quality Independent Physicians

**Tonya Clayton**, Office Manager, Sellersburg Internal Medicine and Pediatrics

**Jenna Daniel, PA-C, MHSA**, Versailles Family Medicine

**David George, MD**, Family Internal Medicine Associates in Lebanon, Southern KY Health Alliance

**Eugene Giles, MD**, Omni Medical Center, Quality Independent Physicians

**Mike Harper, MD**, Sellersburg Internal Medicine and Pediatrics; Medical Director, Quality Independent Physicians

**Debbie Hill, M.A.**, Family Internal Medicine Associates in Lebanon

**William Kirk, MD**, William Kirk, MD, PLLC, Southern KY Health Alliance

**Rachelle Perkins**, Office Manager, Greater Louisville Internal Medicine

## **APPENDIX B: ADVISORY GROUP MEETING AGENDA**

**Janelle Perry, M.A.**, Molloy G. Veal MD, PSC

**Wanda Podgursky**, Office Manager Omni Medical Center

**Trina Sandusky, RN**, Practice Administrator, William Kirk, MD, PLLC

**Brian Smith, MD**, Versailles Family Medicine, Quality Independent Physicians

**Molloy G Veal, MD**, Molloy G. Veal MD, PSC, Quality Independent Physicians

## APPENDIX C: PRACTICE ASSESSMENT SITE VISIT PROTOCOL

### ACP Quality Connect: Chronic Pain Management

#### *Practice Assessment Site Visit Protocol*

As a part of the ACP Quality Connect: Chronic Pain Management initiative, ACP's quality improvement (QI) leaders will visit each practice to conduct a practice assessment site visit. The site visit is a follow up to the ACP Quality Connect: Chronic Pain Management Practice Assessment Tool, which will be completed by the physician QI champion at least three days prior to the visit. **The goal of the site visit is to understand the practice and work with project leaders, including the physician and healthcare team member QI champions, to improve chronic pain management.** ACP's QI leaders will meet with the project leaders from each practice to collect and review baseline performance data, establish the QI team, select performance measures, facilitate the setting performance goals, and develop a project timeline. The following protocol provides an agenda, overview, and tools for ACP QI leaders conducting the practice assessment site visit.

#### Prior to site visit:

- 1) Identify QI project leaders, including a physician and healthcare team member champion, for each practice
- 2) Schedule time for a 90 minute site visit with project leaders and email a copy of the ACP Quality Connect: Chronic Pain Management Practice Assessment Tool to the physician QI champion
- 3) The assessment should be completed by the physician QI champion and **returned no later than 3 days prior to the site visit**
- 4) Request a copy of any performance data relevant to the program from the last year.
  - a. Performance reports from previous QI activities relevant to chronic pain (if applicable)
  - b. Number of chronic pain patients and diagnoses
  - c. Number of patients on controlled substances
  - d. Example controlled substance agreements
  - e. Urine drug testing protocols
  - f. Patient education materials
- 5) Review practice assessment and results as well as baseline performance data

#### Site Visit Agenda:

Part I: Practice Walkthrough	30 minutes
Part II: Review of QI Practice Assessment Results	15 minutes
Part III: Measure Selection and Data Collection	20 minutes
Part IV: QI Overview	20-30 minutes
Part V: Project Next Steps	5-10 minutes

#### **Background and Acknowledgement**

The Kentucky ACP chapter (KY-ACP), in collaboration with the national ACP, has been awarded a grant from Pfizer to conduct a QI project aimed at improving the screening, diagnosis, and safe and effective treatment of chronic pain in primary care practices that are part of ACOs and/or are pursuing recognition of a patient-centered medical home (PCMH). ACP is also working with the Center for Health Services and Outcomes Research (CHSOR) at the Johns Hopkins University Bloomberg School of Public Health to evaluate the impact and effectiveness of this program.

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Practice Visit Overview

Agenda Item	Key Practice Staff	Details	Time
Part I: Practice Walkthrough	Office manager or nurse	Tour practice with office manager or nurse <ul style="list-style-type: none"> <li>• Observe practice layout, processes and characteristics</li> <li>• Take note of opportunities for improvement</li> </ul>	30 minutes
Part II: Review of QI Practice Assessment Results	Physician QI Champion	<ul style="list-style-type: none"> <li>• Review and discuss QI results from ACP Quality Connect: Chronic Pain management Practice Assessment Tool (focus on questions 5 and 6)</li> <li>• Review baseline performance data submitted prior to visit</li> <li>• Identify QI goals for the project based on highest priorities identified in question 6</li> <li>• Identify performance gaps and select general areas for improvement</li> </ul>	15 minutes
Part III: Measure Selection and Data Collection	Project leaders, additional office staff members are recommended	<ul style="list-style-type: none"> <li>• Review and discuss pain question results from ACP Quality Connect: Chronic Pain management Practice Assessment Tool (focus on questions 11-18)</li> <li>• Identify project focus</li> <li>• Review potential measures</li> <li>• Develop data collection plan</li> </ul>	20 minutes
Part IV: QI Overview	Project leaders, additional office staff members recommended	<ul style="list-style-type: none"> <li>• Review PDSA cycles</li> <li>• Brainstorm ideas for improvement</li> <li>• Review interventions list</li> </ul>	20-30 minutes
Part V: Project Next Steps	Project leaders, additional office staff members recommended	<ul style="list-style-type: none"> <li>• Project leaders should identify which webinar(s) they would like to participate in based on Part III discussion</li> <li>• Identify team members who will participate in follow up coaching calls</li> <li>• Set timeline for data collection, PDSA cycle implementation, and follow up data collection</li> </ul>	15 minutes

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Part I: Practice Walkthrough

*Time:* 30 minutes

*Who should attend?:* Office manager or nurse

At the start of the site visit, the ACP QI leader should meet with the office manager or nurse from the practice to tour the office. This time should be used to observe and assess the general layout of the practice, as well as gain a better understanding of office procedures, staffing, data systems, and chronic pain patient population. The practice facilitator should use this opportunity to observe the practice and identify opportunities for improvement.

The following checklist<sup>5</sup> should be used as a guide for the practice walkthrough:

<b>Practice Walkthrough</b>	
Observe general layout of the practice (waiting room, check-in, exam room)	Notes:
<b>Check-in Process</b>	
What is the check-in procedure?	

<sup>5</sup> Adapted from: Appendix of Meeting Agendas and Tools. April 2009. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/systems/primary-care/coachmnl/coachap.html>

**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

<p>What forms are filled out during check-in? Are there specific forms for chronic pain patients?</p>	
<p>Are there any educational materials relevant to chronic pain management available for the patients?</p>	
<p>How long do patients spend waiting for their appointment?</p>	
<p><b>Review Office Staffing</b></p>	
<p>How many physicians?</p> <ul style="list-style-type: none"> <li>• How many general internists?</li> <li>• How many family practitioners?</li> <li>• How many subspecialists?</li> </ul>	
<p>How many healthcare team members? (PA, NP, RN, etc)</p>	
<p>How many office staff? What are their roles?</p>	
<p><b>Practice Background</b></p>	
<p>Is the practice physician-owned? Hospital-owned? Part of an Independent Practice Association (IPA)? Part of an ACO? Etc.</p>	



**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

What level of PCMH-recognition has the practice achieved?	
<b>Data System</b>	
How is the EHR used to support QI? <ul style="list-style-type: none"> <li>• Identify chronic pain patients?</li> <li>• Calculate performance measures</li> </ul>	
Are there prompts built in to the EHR designed to assist with chronic pain management?	
What is the burden associated with EHR use? <ul style="list-style-type: none"> <li>• Time</li> <li>• Ease-of-use</li> </ul>	
<b>Chronic Pain Patient Population and Management</b>	
How many chronic pain patients are seen per week?	
What is the typical pre-visit protocol for chronic pain patients (e.g., KASPER check, pre-visit reminder phone call, etc.)?	
What is the follow-up protocol for chronic pain patients? (e.g., schedule next appointment in 90 days,	
<b>Decision Support</b>	
Are there decision-support tools relevant to chronic pain management in place?	

**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

How do physicians and healthcare team members get information about clinical guidelines relevant to chronic pain?	
Are there guideline-based patient materials available?	
<b>Self-Management Support</b>	
How does the practice support patients' self-management of their chronic pain?	
Do patients and their families understand the central role they play in their own chronic pain management?	
Does the practice use effective self-management support strategies that include assessment, goal-setting, action planning, problem solving, and follow up?	
<b>Community Resources</b>	
What community resources or agencies do you find most useful for your chronic pain patients?	
Are all healthcare team members equally aware of resources in the community?	
Is there an established protocol for referrals to community resources?	

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Part II: Review of QI Assessment

*Time:* 15 minutes

*Who should attend?:* Physician QI champion

Review QI results from practice assessment with the physician QI champion (Questions 5 and 6 from ACP Quality Connect: Chronic Pain management Practice Assessment Tool). Ask follow up questions to gain a better understanding of their QI goals, capacity, and experience. Ask additional questions to assess what the main barriers are to QI implementation in their practice.

#### Question 5: Review and Follow-up

Practice Assessment Questions	Potential Follow-up Questions
<p>Our practice implements team huddles and other methods for enhancing team-based care.</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• How frequently does the team meet?</li> <li>• Who leads the meetings?</li> <li>• What is the goal of the team huddle?</li> <li>• What is your level of satisfaction with these meetings?</li> <li>• Are the roles of the team clearly defined?</li> <li>• What are their roles?</li> </ul>
<p>The impetus for improving quality in my practice is largely driven by <i>external</i> forces (e.g. funders, accreditation, regulation, peer pressure).</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• What is the status of board certifications for you and other members of your team?                             <ul style="list-style-type: none"> <li>○ When do you need to recertify?</li> <li>○ If you are certified by ABIM, are you aware of new requirements for MOC?</li> <li>○ Have you completed the practice assessment (part IV) requirement for MOC? Would you like to use this initiative to meet the practice assessment requirement?</li> <li>○ Do other physicians on your team need to earn their MOC practice assessment points?</li> </ul> </li> <li>• What level of PCMH recognition has your practice reached?</li> <li>• Which payers do you work with? Do they have performance-based reporting requirements?</li> </ul>
<p>Leaders of my practice are trained in methods for evaluating and improving quality, such as Plan-Do-Study-Act (PDSA) cycles, Six Sigma, Lean, etc.</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• Please describe the QI activities.</li> <li>• What topics/areas did you focus on?</li> <li>• Who was involved in the projects?</li> <li>• Did you assign specific roles to each team member to complete the QI activities?</li> <li>• What is your level of satisfaction with past QI activities?</li> </ul>
<p>My practice has implemented PDSA cycles or other QI initiatives in the last year.</p>	

**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

Practice Assessment Questions	Potential Follow-up Questions
<p><b>Practice response:</b> _____</p>	
<p>My practice has designated a QI officer or champion.</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• What does being the QI champion for your practice entail?</li> <li>• What are the major responsibilities of the QI champion?</li> </ul>
<p>My practice has the ability to easily extract data from our EHR or clinical charts to inform QI activities.</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• How much time does it take to extract data for specific patient populations (e.g., chronic pain patients)?</li> <li>• Is patient information accessible via EHR?               <ul style="list-style-type: none"> <li>○ Pain assessment results</li> <li>○ Mental health screening results</li> <li>○ Risk screening results</li> <li>○ Urine drug test results</li> <li>○ Pain contract</li> <li>○ KASPER information</li> </ul> </li> <li>• How can documentation be improved?</li> </ul>
<p>My practice has participated in a performance reporting program in the past year (e.g. Physician Quality Reporting System (PQRS), Meaningful Use (MU), etc.).</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• How was PQRS data reported?               <ul style="list-style-type: none"> <li>○ By group practice reporting or by individual?</li> <li>○ Via EHR-based, claims-based, or registry reporting?</li> <li>○ What measure group did you report on?</li> </ul> </li> <li>• Have you successfully attested for MU for the EHR incentive program?               <ul style="list-style-type: none"> <li>○ Which stage?</li> </ul> </li> <li>• Are there any ACO measures that align with this initiative?</li> </ul>
<p>Administrative burden is a barrier to QI in my practice.</p> <p><b>Practice response:</b> _____</p>	<ul style="list-style-type: none"> <li>• How much time was spent on a weekly basis working on QI for past projects?</li> <li>• What is the most burdensome aspect of QI?               <ul style="list-style-type: none"> <li>○ Data collection                   <ul style="list-style-type: none"> <li>▪ EHR use, reporting to registry, etc.</li> </ul> </li> <li>○ Implementation</li> <li>○ Follow up</li> <li>○ Team engagement</li> </ul> </li> </ul>

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Question 6: Review and Follow-Up

Practice Assessment Questions	Potential Follow-up Questions
Enhancing team-based care	See follow-up questions from table above ( <i>Our practice implements team huddles and other methods for enhancing team-based care. </i> )
Care coordination with external specialists and hospitals	<ul style="list-style-type: none"> <li>• Does your practice currently have a protocol for external patient referrals?</li> <li>• Are you and your staff aware of the local pain and mental health specialists in the area?</li> <li>• What are some of the biggest challenges you face with care coordination?</li> <li>• What is the protocol for communication with patient who go to the ER?</li> </ul>
PCMH/N recognition	<ul style="list-style-type: none"> <li>• What level of PCMH recognition has your practice reached?</li> <li>• What is your goal for the next year?</li> <li>• Are you familiar with the ACP Practice Advisor – Building the Foundation modules?</li> </ul>
Increased shared decision-making tools and patient engagement <sup>6</sup>	<ul style="list-style-type: none"> <li>• Does your practice staff encourage patients and families to participate in care planning and decision making?</li> <li>• Does your practice staff encourage and support patient and their families to set goals and create action plans for self-management of chronic conditions?</li> <li>• Do patient understand the purpose and importance of taking their medications, adhering to their controlled substance contracts, etc?</li> <li>• Do patient understand what they are responsible for in managing their health?</li> </ul>
Learning how to implement PDSA cycles or other QI activities	See above table for follow-up questions ( <i>Leaders of my practice are trained in methods for evaluating and improving quality, such as Plan-Do-Study-Act (PDSA) cycles, Six Sigma, Lean, etc. AND My practice has implemented PDSA cycles or other QI initiatives in the last year. </i> )
MOC practice assessment	See above table for follow-up questions ( <i>The impetus for improving quality in my practice is largely driven by external forces (e.g. funders, accreditation, regulation, peer pressure).)</i> )
Performance reporting/reimbursement requirements	See above table for follow-up questions ( <i>My practice has participated in a performance reporting program in the past year (e.g. Physician Quality Reporting System (PQRS), Meaningful Use (MU), etc.). </i> )

<sup>6</sup> Follow up questions adapted from Primary Car Survey. Self-Assessment Survey Institute for Patient and Family-Centered Care

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Part III: Measure Selection and Data Collection

*Time:* 20 minutes

*Who should attend?:* Physician and practice QI champions, additional office staff members are recommended

Review and discuss pain question results from ACP Quality Connect: Chronic Pain Management Practice Assessment Tool (focus on questions 11-18) and baseline performance data submitted prior to practice site visit. The goal of this discussion is to identify the top two focus areas for the QI projects, select measures for this study, identify potential data sources, and develop a plan for baseline data collection.

#### Measures Selection

1. Review questions 11-18 and baseline performance data to identify areas needing most improvement. Particularly focus on question 18, where physician QI champion identified the practice's top 2 priorities. Use this data to inform measure selection discussion.
2. If physicians have indicated an interest in earning MOC Practice Assessment points through participation in this project, then the QI leader should recommend that the practice focus on measures from ACP Practice Advisor: Chronic Pain Management module (see Appendix A for Practice Advisor measures)
3. Review additional measures from "Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain" (see Appendix B)

#### Data Collection

1. Once measures have been selected, identify data collection needs for performance measures selected
  - a. If selecting measures from the ACP Practice Advisor, walk through data entry on the platform and review how to access resources (see Appendix A for MOC survey)
  - b. If selecting additional measures, review the measure details (see Appendix C) to identify data elements for measure calculation.
    - i. ACP can support development of excel spreadsheet for practices to use for data collection for additional measures
2. Identify data sources
  - a. Can practice staff easily populate a list of the chronic pain population
    - i. Use ICD-9/ICD-10 codes: low back pain, headache, neck pain, fibromyalgia, chronic pain
  - b. Review baseline performance data to identify existing data sources from previous QI projects/activities
3. Develop plan timeline for baseline data collection
  - a. Identify team member(s) who will be primarily responsible for data collection and entry
  - b. Identify appropriate number of patients for baseline data
    - i. For MOC purposes, 25 patients (pre- and post) per physician will be required
  - c. ACP can support baseline data entry at the end of the site visit

PRACTICE NAME, DATE

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Part IV: QI Overview

*Time: 20-30 minutes*

*Who should attend:* Physician and practice QI champions, additional office staff members are recommended

Once the project focus has been identified, the ACP QI leader should provide the project leaders with an overview of the QI process. The nature of this discussion will depend on the QI experience of the practice. Beginners should be given a more extensive overview of PDSA cycles. After reviewing PDSA cycles, the QI leader should facilitate a team brainstorm to identify potential QI activities to address the focus areas identified in Part III of the practice visit. The QI leader should use the resources listed in Appendix D, as well as observations from previous the practice walkthrough to help facilitate the discussion.

- Review PDSA cycle (see Page 11 and 12)
- Build the QI team (see Page 13)
- Brainstorm ideas for improvement with the team that can be implemented using the PDSA cycle process (see Page 14). **Think about processes that already occur in the workflow that the action plan can fit into or replace!**
  - Where are opportunities to implement change?
    - Team meetings (daily huddles or weekly meetings)
    - Pre-visit protocol for patients
      - Chart review
      - Phone calls for reminder appointments
    - What can be done when the patient is in the waiting room?
    - Are relevant documents easily accessible in exam room?
  - Questions to consider
    - Is patient information accessible via EHR?
      - Pain assessment results
      - Mental health screening results
      - Risk screening results
      - Urine drug test results
      - Pain contract
    - How can documentation be improved?
    - Does practice have/use decision support tools?
    - Does the practice have patient education materials? Are they being distributed to patients effectively?
  - Review potential interventions
    - Suggested interventions list (see Appendix D)
    - Review resources on the ACP Practice Advisor
- Begin filling out PDSA worksheet (see Page 15)

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### PDSA Overview

#### 1) Plan

- a. Set Aim
  - i. Which area will the practice focus on?
  - ii. What is the specific improvement goal?
- b. Develop sampling methodology for data collection
  - i. Small number
  - ii. Assign staff and design methodology to fit within workflow
- c. Develop plan to test change
- d. Predict what will happen as a result of the test

#### 2) Do

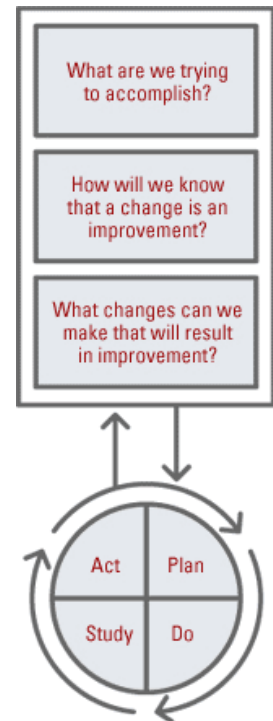
- a. Carry out test
- b. Set time frame: 1-2 weeks
- c. Identify patient population to test
- d. Document problems

#### 3) Study

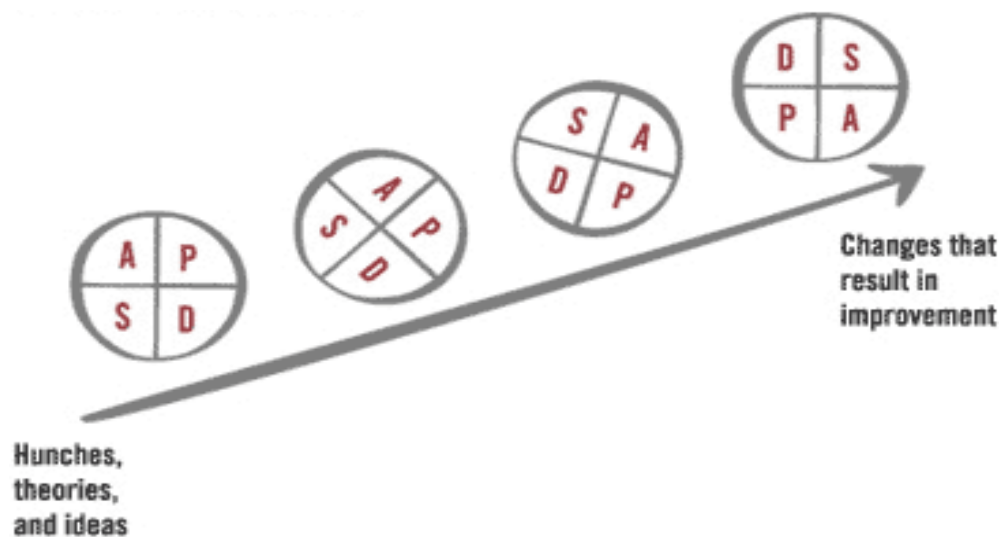
- a. Analyze data (follow up data collection on a small sample)
- b. How does data compare to your initial predictions?
- c. Have there been any improvements?

#### 4) Act

- a. Based on analysis, what is the next step in the change cycle?
- b. Abandon, adopt, or change design



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### PDSA Example



**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

PDSA Cycle 1	Example
<p><b>Plan</b></p> <ul style="list-style-type: none"> <li>• Plan the test (change in process)</li> <li>• Plan for collecting data</li> <li>• Make predictions of what will happen and why</li> <li>• Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)</li> </ul>	<p><b>Goal:</b> Increase the presence of a signed pain contract in patients who are being prescribed narcotics from 20% to 80% in the next 3 months.</p> <p><b>What change</b> – All patients who are prescribed narcotics will be provided with a pain contract at their next visit and have it reviewed and signed</p> <p><b>Who will do it</b> – Medical Assistant will take vitals. The doctor will identify the patient as being on a narcotic and will offer, review and obtain a signed contract</p> <p><b>Where</b> – To start with only Dr. Jones’ patients</p> <p><b>When</b> – Starting next Tuesday</p> <p><b>What Measurement</b> - % of patients with narcotics who have a signed contract in the medical record.</p> <p><b>When/How/By Whom will measurement be done</b> – 10 charts a week of Dr Jones’ patients abstracted by the office manager when she is re-filing the charts after the visit.</p> <p><b>What/Where will be Run-Chart</b> – Conference room, updated by Medical Assistant</p>
<p><b>Do</b></p> <ul style="list-style-type: none"> <li>• Implement the new process during a trial period (try out the test on a small scale)</li> <li>• Document problems and unexpected observations</li> </ul>	<p>Dr Jones administers the contract as appropriate</p>
<p><b>Study</b></p> <ul style="list-style-type: none"> <li>• Analyze the data and study the results</li> <li>• Compare the data to your predictions</li> <li>• Summarize and reflect on what was learned</li> </ul>	<p>Low success rate 30% the first week (3/10) and 20% (2/10) the next.</p>

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

PDSA Cycle 1	Example
<p><b>Act</b></p> <ul style="list-style-type: none"> <li>• Abandon the change – consider entirely new design</li> <li>• Adapt the change – modify the design slightly and retest for further (get more data) – go back to Plan</li> <li>• Adopt – change is working well . Will continue as part of the practice</li> <li>• Again – you may not have enough data so you elect to run the test for another period of time</li> </ul>	<p>Current design will be adapted (modified) as upon further review it was found that the doctor forgot and was overburdened by other issues.</p>

Next step: link the next PDSA cycle to the previous one:

PDSA Cycle 2	Example
<b>Plan</b>	MA identifies patients as being on narcotics as part of initial process of rooming the patient. MA flags the chart using a simple sticky on the superbill. MD sees sticky and grabs contract for review....
<b>Do</b>	give sheet out for 3 weeks
<b>Study</b>	40% (4/10) on week 1 and 60% week 2
<b>Act</b>	Things seem to be improving. The practice decides to continue the current design for several more weeks

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### PDSA Tips

- 1) Be specific: Set a numerical goal and time frame
- 2) Be realistic: set a goal that is achievable
- 3) Use the Institute of Medicine dimensions of quality as a guide—care should be safe, effective, patient-centered, timely, efficient, and equitable
- 4) Use sampling methodology that fits into workflow – focus on small number of charts abstracted weekly
- 5) Integrate data collection with current work activities (e.g., refilling charts, rooming patients, calling for appointment reminders, etc.)
- 6) Use run charts to view data over time
- 7) Always test on a small scale
- 8) Start with easy changes
- 9) Learn from previous cycle
- 10) The end of your first cycle should lead directly to the beginning of your next cycle

**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

**Building the QI Team**

- 1) Identify all staff members who will be engaged in QI activity
  - a. How many physicians?
  - b. How many office staff?
  - c. External staff (e.g., care coordinator, pharmacists, etc)?
- 2) Identify the role of each team member
  - a. Team leader(s)
  - b. Baseline data collection
  - c. Implementation
  - d. Follow up data collection
- 3) Fill out QI team worksheet below

**Chronic Pain QI Team**

Practice Name: \_\_\_\_\_

Physician QI Champion: \_\_\_\_\_

Office Staff Champion: \_\_\_\_\_

<b>Physician Team Members</b>	<b>Healthcare Team Members</b>
Name:  Role(s):	Name:  Role(s):
Name:  Role(s):	Name:  Role(s):
Name:  Role(s):	Name:  Role(s):
Name:  Role(s):	Name:  Role(s):
Name:  Role(s):	Name:  Role(s):

**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

**QI Brainstorming Worksheet - Plan**

<b>Goal</b>	<b>Person(s) Responsible</b>	<b>Plan Details (When/How/Why)</b>
<i>Example: Increase mental health screenings</i>	<i>Front desk</i>	<ul style="list-style-type: none"> <li>• <i>Preparation: identify all chronic pain patients scheduled for the day</i></li> <li>• <i>At check in, front desk will review patient record for date of last mental health screening</i></li> <li>• <i>If screening is out of date, patient will be asked to complete screening in the waiting room</i></li> <li>• <i>Physician will review screening during visit</i></li> <li>• <i>Results will be added to patient records</i></li> </ul>

**APPENDIX C: PRACTICE SITE VISIT PROTOCOL**

**PDSA Worksheet – Cycle #: \_\_\_\_\_**

**PLAN –**

Plan: \_\_\_\_\_

Goal: \_\_\_\_\_

Prediction: \_\_\_\_\_

Team lead(s): \_\_\_\_\_

Tool/resource: \_\_\_\_\_

Steps:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Timeline: \_\_\_\_\_

**DO - What did you observe?**

\_\_\_\_\_  
\_\_\_\_\_

**STUDY - Did you meet your goal? What did you learn?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACT - What did you conclude from this PDSA cycle? What will you do next?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## APPENDIX C: PRACTICE SITE VISIT PROTOCOL

### Part V: Project Next Steps

*Time:* 5-10 minutes

*Who should attend?:* Physician and practice QI champions, additional QI team members are recommended

At the end of the practice site visit, the ACP QI leader should provide the practice with an overview of the project's next steps.

- Set timeline for data collection and PDSA cycle implementation
  - Baseline data collection should be collected prior to first webinar
- Webinars
  - Practice should identify which webinar(s) they would like to participate in
  - Identify preferred time(s) and days of week for each practice
  - Practice must participate in at least one webinar prior October
- Coaching Calls
  - Identify team members who will participate in follow up coaching calls
  - Assess coaching call needs for the practice
    - Inform practice that baseline data and information gathered from practice site visit will be provided to national QI physician expert who will lead a follow up coaching call with QI team members
    - Additional coaching calls led by ACP QI leaders will focus on project management, technical support, and fulfillment of MOC practice assessment credit

Tentative webinar schedule\*:

Webinar Topic	Timeline
Intervention: Mental Health Screening	September
Intervention: Risk Assessment	October
Intervention: Pain Assessment Scale	October
Intervention: Urine Drug Testing	November
Intervention: Contract	November

\*Please note, the timeline for webinars is subject to change based on practice availability and interest

## Understanding Controlled Substances

- Controlled substances are serious medicines, with risks and benefits.
- Medicines that are controlled substances can be habit forming (cause addiction)
- Controlled substances include many medicines used for pain, problems sleeping, weight loss, anxiety, and other conditions.
- Risk of addiction may increase if more than one controlled substance is used at the same time.
- You should talk to your doctor about side effects of each medicine and the risk of addiction.
- A controlled substance should only be started when you and your doctor agree that it will help you and is better than the side effects or risk of addiction.

## APPENDIX D: PATIENT EDUCATION BROCHURE

### Partnering with You

- Before each office visit, be ready to talk about any symptoms, problems or diagnoses, as well as what is working well, and what is not.
- Your doctor may want to change the amount of medicine you take so that you have the right amount to safely treat your pain or other symptoms.
- Talk to your doctor about the potential risks and benefits of reducing the strength or frequency of the controlled substance.
- Follow-up visits within a certain time period are required by law to check-in on your treatment plan. These appointments are important to make sure the medicines are working even if you are not out of pills at the time.
- Use one pharmacy for controlled substances.

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# Managing Your Chronic Pain with Controlled Substances

**INSERT PRACTICE NAME**

PRACTICE ADDRESS  
PHONE NUMBER

INSERT LOGO





## How to Use Controlled Substances

- Controlled substances should not be mixed with alcohol.
- Review your current medicines with your doctor before starting to use controlled substances.
- Follow the label instructions.
- Always talk to your doctor if you have any questions.

## Potential Benefits of Controlled Substances may include:

- Relief of acute (severe or sudden) pain that happens some of the time
- Relief of chronic pain (persistent over time)
- Relief of cancer-related pain
- Improvement in ability to do daily activities
- Improvement in how well or how much you sleep
- Weight loss, when combined with your doctor's advice for exercise and diet change
- Improved concentration (when prescribed for concentration)
- Reduction in the risk of seizures
- Control of anxiety, nervousness or panic

- Control of muscle spasms or spinal spasticity
- Control of involuntary tics
- Treatment of alcohol withdrawal
- Weaning off from a previous controlled substance
- Other benefits as explained by your doctor

## Potential Risks of Controlled Substances may include:

- Dry mouth, constipation, urination problems
- Nausea, vomiting, loss of appetite
- Breathing too slow, or stopping breathing
- Confusion, altered thinking/judgment
- Slowed reaction times, loss of coordination and/or balance
- Increased depression or mood swings
- Seizures or other neurologic complications
- Damage to internal organs
- Low sex drive or impotence
- Physical dependence
- Psychological dependence
- Addiction
- Loss of effectiveness over time
- Risks to unborn children
- Becoming a target of criminals
- Death
- Other risks as explained by your doctor

## Understanding Legal and Regulatory Issues

- The decision to start using controlled substances is a legal agreement between you and your doctor.
- This agreement has requirements that both you and your doctor must follow by law.
- State medical boards require your doctor to follow rules when prescribing controlled substances to patients. Doctors who do not follow these rules can lose their license to practice medicine.
- State regulations may require drug testing for patients taking controlled substances even if your insurance doesn't cover the test.
- For long-term use of controlled substances, you and your doctor will sign an agreement for your pain care plan.
  - It will describe what you and your physician agree to as a part of your treatment plan.
  - Your treatment plan may require surveys and other tools to ask about the best way to manage your pain care.