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Creating an Organizational Self-Assessment Tool to Evaluate Progress toward System Change

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Creating an Organizational Self-Assessment Tool to Evaluate Progress toward System Change

Studies have shown that programs with higher fidelity to certain evidence-based practices have better treatment outcomes than programs with lower fidelity. This clinical assessment method can be adapted to create a tool for measuring how closely an organization is implementing system change and maintaining it over time, while also educating program staff on what optimal implementation looks like.

Standardized Fidelity Assessment Tools

Assertive Community Treatment Fidelity Scale

AGENCY: _____
TEAM: _____
REVIEWER: _____
DATE: _____

CRITERION		RATINGS / ANCHORS				
HUMAN RESOURCES: STRUCTURE &		-1	-2	-3	-4	-5
H1	SMALL CASELOAD: Client/provider ratio of 10:1	50 clients/clinician or more.	35 - 49	21 - 34	11 to 20	10 clients or fewer
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5	CONTINUITY OF STAFFING: Program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20-39% turnover in 2 years.	Less than 20% turnover in 2 years.

Integrated Dual Disorders Treatment

Integrated Dual Disorders Treatment Fidelity Scale

	1	2	3	4	5
1a. Multidisciplinary Team: Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team	< 20% of clients receive care from multidisciplinary team (i.e., most care follows a brokered CM or traditional outpatient approach)	21% - 40% of clients receive care from a multidisciplinary team	41% - 60% of clients receive care from a multidisciplinary team	61% -79% of clients receive care from a multidisciplinary team	≥80% of clients receive care from a fully multidisciplinary team with a strong emphasis on accessing a broad range of services and excellent communication between all disciplines
1b. Integrated Substance Abuse Specialist: Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT	No substance abuse specialist connected with agency	IDDT clients are referred to a separate substance abuse department within the agency (e.g., referred to drug and alcohol staff)	Substance abuse specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	Substance abuse specialist is assigned to the team, but is not fully integrated; attends some meetings; may be involved in treatment planning but not systematically	Substance abuse specialist is a fully integrated member of the treatment team; attends all team meetings; involved in treatment planning for IDDT clients; models IDDT skills and trains other staff in IDDT
2. Stage-Wise Interventions: Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)	≤20% of interventions are consistent with client's stage of recovery	21%- 40% of interventions are consistent	41%- 60% of interventions are consistent	61% - 79% of interventions are consistent	≥80% of interventions are consistent with client's stage of recovery

Steps for Developing a Tool for Measuring System Change

Work with staff to ….

1. Identify key program areas within their model (leadership, policies, services)?
2. Identify indicators within each program area to be assessed (leadership: goals, resources, communication)
3. Fill in the indicator definitions: What does no implementation look like? What does partial implementation look like? What does optimal implementation look like?
4. Make sure that items to be assessed do not appear in multiple indicators (example: Leadership communicates goals to staff. Does this fall under goals or under communication?)
5. Identify the data sources (leadership, front line staff, databases, meeting agendas/minutes)
6. Develop data collection instruments (Interview, web survey, record review, observation)
7. Collect data
8. Rate instrument and document logic for each rating
9. Review preliminary findings in a facilitated discussion (Ratings can be changed during this discussion if additional information is provided
10. Create final report that can be used as a planning document for continued system change
11. Re-assess at regular intervals (quarterly, annually)

The 6 Building Blocks of Pain Management and Safe Opioid Therapy in Primary Care

Six Building Blocks Self-Assessment Questionnaire – Workshop Version (with Indicator Definitions)

Scoring Summary Sheet

Clinic Name:	Who completed questionnaire (role & discipline):	Date:

Scale: 1=Limited or no policies, 2= Policies, but No Implementation, 3=Partial Implementation, 4=Optimal implementation

Indicator	Preliminary Score & Subtotals	Average Score for Block
Goals and Priorities		
Policies to Support Goals		
Assigned Responsibilities and Timelines		
Community collaboration		
Building Block #1: Leadership Subtotal:		
Acute Pain Prescribing Policies for Opioids		
Chronic Pain Prescribing Policies for Opioids		
Non-Opioid and Non-Pharmacological Therapies for Pain		
Co-Prescribing Benzodiazepines		
Urine Drug Screening (UDS)		
Prescription Drug Monitoring Program (PDMP)		
Treatment Agreements		
Patient Education		
Tapering		
Naloxone		
Buprenorphine		
Methadone		
Building Block #2: Policies Subtotal:		

Indicator	Preliminary Score & Subtotals	Average Score for Block
Tracking Patients on Opioids		
Risk Stratification for Complex Patients		
Building Block #3: Identifying & Tracking Patients Subtotal:		
Planned Patient Visits		
Workflows for Planned Visits		
Empathic Patient Communication		
Shared Decision Making		
Care Plans		
Building Block #4: Planned Patient-Centered Visits Subtotal:		
Identifying High Risk, Complex Patients		
Care Plans for High Risk, Complex Patients		
Behavioral Health (Mental Health Care& Addiction Treatment)		
Building Block #5: Caring for Complex Patients Subtotal:		
Tracking Outcomes		
Tracking Processes		
Building Block #6: Measuring Success Subtotal:		
Overall total and mean scores:		

Building Block #4: Patient-Centered Visits (Block Score=1.7)

Planned Patient Visits

Rating	1	2	3	4
2.0	**Visits** by patients with persistent pain **are not known in advance** by the care team.	**Visits are known in advance** by the care team, **but there are no advance preparations** for the visit (PDMP review, chart review, or team discussion).	**Visits are known** by the care team. **Advance preparations usually occur**, including a chart review, looking up prescription activity on the PDMP, and discussing the case with the care team.	**Advance preparations** include described components and **always occur for all patients with persistent pain**. Past visits and past referrals are discussed with patients.

Comment: **Score increased from 1.0 to 2.0**. Panel coordinator is planning visits as part of huddle prep. Team discussion takes place at huddle. Huddle Prep includes cueing for: LCSW/PCP Reverse and Co-Visits, CADC involvement, RN Education, and Clinical Pharmacist/Narcan consult and prescribing. Comments from Baseline: Clinic reports undefined workflows for planned patient visits, no identified methods for shared decision making, no care plans.

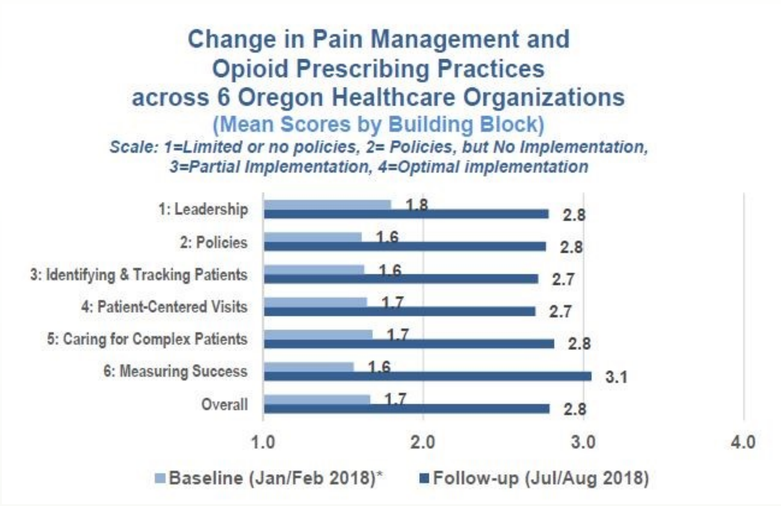
Workflows for Planned Visits

Rating	1	2	3	4
2.5	The **workflows** needed to plan for a visit with patients receiving or potentially initiating chronic opioid therapy **have not been defined** and are not known.	The **workflows** for planned visit **have been defined, but implementation has not yet begun.**	**Workflows** for planned visits **have been defined, but tasks are not delegated** across the team **and implementation is inconsistent.**	**Workflows** for planned visits have been defined and **are consistently implemented by all team members.**

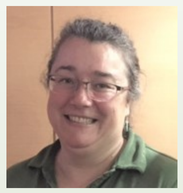
Comment: **Score increased from 1.0 to 2.5**. "We moved to a 2.5, with some delegation of team tasks at huddle." Comments from Baseline: *Clinic reports **undefined workflows** for planned patient visits, no identified methods for shared decision making, no care plans.*

Year 1 Results (2018)

1) All six sites made progress in implementing policy and practice change
2) Sites developed new workflows and educational tools for treating patients with chronic pain and or high doses of opioids
   - -Resource binders in patient rooms
   - -Reverse handoffs, so behavioral health saw patient before PCP
   - -MA and Behavioral Health staff participated in pre-appointment huddles
3) Prescribing patterns changed
4) Prescriptions were tracked on a regular basis
5) Legacy patients were tapered
6) Overall opioid prescribing went down at individual sites

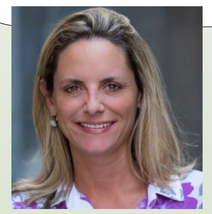


Staff Feedback on the Assessment Process



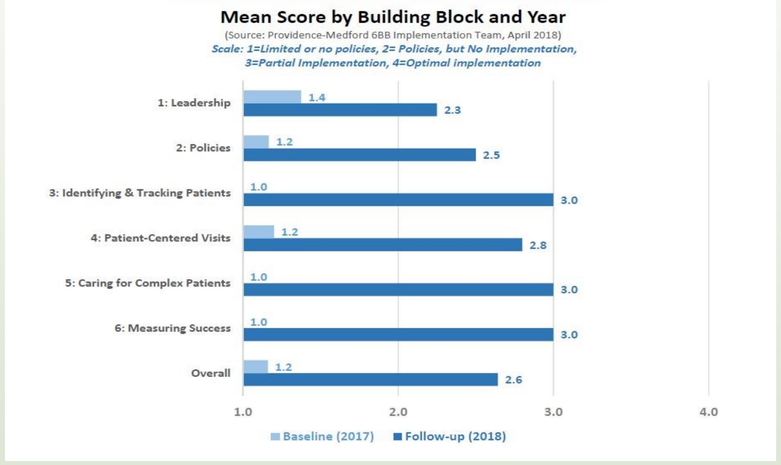
"6BB is a great evaluation tool to see where we are and where we need to go. ….To identify the low areas and how we can do it. It tells you where you can improve, then it tells you how you can improve."

-Hospital Pain Management Improvement Team



"When I started I had an attachment to a higher score. But when we went back, we saw that we really didn't have these policies. It was helpful to have this tool to let people know it is a snapshot without judgement. The data is what it is. This is where we are at and it is a reminder that we need to continue to do that work."

-Clinic Quality Improvement Manager



Background

The OHA 6 Building Blocks clinical self-assessment and the accompanying web survey were adapted from the Six Building Blocks of Safer Opioid Prescribing © for the **OHA Prescription Drug Overdose (PDO) Prevention Project** in collaboration with the OHA PDO Implementation Workgroup. Six healthcare organizations around Oregon used this self-assessment tool in collaboration with the OHA PDO Pain Management Improvement Team to explore and improve clinical practices in Year 1 (2018). Funding for this adaptation and the accompanying study is provided by the U.S. Centers for Disease Control and Prevention Grant # 1U17CE002751. Six Building Blocks Year 1 Study Findings were collected and analyzed by the Regional Research Institute for Human Services at Portland State University. Questions regarding specific scores in this poster can be addressed to Karen Cellarius (cellark@pdx.edu). For more information on the PDO project itself, contact Lisa Shields (lisa.m.shields@state.or.us) PDO project manager, Oregon Health Authority.

The original Six Building Blocks for Safer Opioid Prescribing© were developed in 2015 as part of a research project on **Team Based Opioid Management** in rural clinics. The three-year research study is a collaboration between 20 rural and rural-serving clinics in Washington and Idaho. Funding was provided by the U.S. DHHS AHRQ grant # R18HS023750. For further information, contact Dr. Michael Parchman (parchman.m@ghc.org), Director, MacColl Center for Innovation, Kaiser Permanente Washington Health Research Institute.