HSAG OSP Gap Assessment | Specific Considerations for AZ Critical Access and Rural Hospitals

The Arizona Center for Rural Health (AzCRH) in collaboration with HSAG created the following tables to serve as a guide to healthcare organizations to consider concrete ways to move towards implementation and measurements of their Opioid Stewardship Programs (OSPs) within the context of their organization and community.

The tables include:
- **Stakeholders**: Those who may benefit the most from implementing, refining, and evaluating the item.
- **Tasks**: Specific tasks that can be implemented based on the organizations level of, or progress, towards implementation.
- **Evaluation**: Ways to evaluate implementation progress.
- **Culturally and Linguistically Appropriate Services (CLAS)**: Ways implementation can meet CLAS standards.

Comments About Evaluation

For implementing a new or refined evaluation strategy we suggest organizations consider the following:
- What is our exact question we want to answer? (e.g., how many people receive an opioid prescription between two specified dates?)
- Why is it important to our stakeholders? (e.g., quality care; cost)
- Where will we get data? (e.g., electronic health record [EHR]; provider surveys)
- What are our timeframes/intervals (e.g., before and after implementation, once a year)?
- Who will ensure data are collected and recorded as specified? (e.g., providers; quality management personnel)
- Who will analyze these data and at what frequency (e.g., quality management; quarterly)?
- Are these data that will be collected indefinitely or over a specified period?
- Will these evaluation activities cost us anything (e.g., systems, personnel)?

Comments on CLAS

The Office of Minority Health (OMH) offers a comprehensive way to enhance culturally and linguistically appropriate health care services. The tables offer examples of ways organizations might plan for responding to cultural and linguistic diversity.

Acute Care and Emergency Department (ED)

The HSAG OSP assessment differentiates between acute care and EDs. The strategy tables do not, as there are many similarities, and we are aiming for coordinated efforts throughout the organization. We acknowledge there may be times when modifications will be necessary based on the setting (e.g., workflows, evaluation measures).

January 2023

Commitment Strategies (CS)

CS.1: An OSP leadership team is in place with representatives from various departments and disciplines (e.g., administration, emergency department, informatics, surgery, pharmacy, internal medicine, behavioral health, case management).

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
	Not implemented/no plan Develop interdisciplinary team. Define overall goals for opioid safety. Provide initial training on opioid safety, prescribing, and treatment for OUD.	Document the timeline/barriers/facilitators for developing and institutionalizing the OSP leadership team. Document the timeline//barriers/facilitators for developing, reviewing, and disseminating opioid safety goals. Percent of personnel who participate in initial.	Does the leadership team reflect the cultural and linguistic diversity of the organization? (3) Are the goals available in languages reflective of the patient population, easy to understand, and accessible? (8)
Patients & families Facility personnel	**Plan to implement/no start date** Determine metrics that can be used to monitor opioid safety and identify baseline. Designate who and how review of opioid safety will be regularly monitored. Integrate opioid safety plan into the organizational policies and procedures.	Document process for determining what metrics are used and why. Percent of personnel who know who is responsible for monitoring safety and how its monitored Document process for integrating opioid safety plan into organizational policies and procedures.	Is the opioid safety plan available in languages reflective of the organizational stakeholders? (2) Were patients/families included in the development, implementation, and evaluation? (13)
Practitioners Administrators Payors	**Plan to implement/start date set** Designate leaders/champions responsible for supporting opioid stewardship efforts. Specify time commitment for implementation activities. Develop team charter.	Percent of personnel who know the designated OSP leaders. Document the FTE available to support implementation efforts. Document process for developing team charter. Document baseline metrics.	Do the leaders/champions reflect the organizational stakeholders? (3) Does the team charter consider issues of CLAS? (2)
	In place less than 6 months Facilitate regular interdisciplinary meetings, communications, and monitor progress towards goals. Conduct quality improvement to evaluate effectiveness of strategies and tactics.	Count the number of meetings facilitated and tasks completed. Count the number of communications from OSP leadership which discuss OSP safety goals, strategies, and tactics.	Are meeting notes available to stakeholders for review? (15) Are communications easy to understand and include print, multimedia, and signage that available in languages of the stakeholders? (8)
	In place more than 6 months Conduct annual quality improvement review of OSP opioid safety goals and leadership team composition.	Percent of stakeholders who are aware of the opioid safety goals and leadership composition.	Are personnel, patients, and families asked about the OSP leadership teams progress towards CLAS-standards? (10

January 2023

CS.2: A workflow is in place that facilitates the required Arizona Controlled Substance Prescription Monitoring Program (PMP) review for discharging patients prescribed opioids.

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**Not implemented/no plan** Ensure qualified prescribers have access to PMP. Designate time to train prescribers on the use of PMP and include information on the treatment for OUD.	Number of qualified prescribers who have access to PMP. Number of qualified prescribers who are trained on PMP. Percent of qualified prescribers who know the state requirements for using the PMP.	Does the training include information about CLAS policies and practices? (4)
	Plan to implement/no start date Ensure the appropriate professional disciplines are involved in developing the workflow (e.g., pharmacist; nursing). Create workflow and EHR alerts that integrate checking PMP for patients prescribed opioids.	Percent of personnel who know who was involved in developing the workflow. Document the process for creating workflow and EHR alerts.	Does the workflow consider language assistance? (7) Does the workflow include collection of reliable demographic data? (11)
	Plan to implement/start date set Implement workflow with one or two prescribers to ensure its effectiveness and efficiency.	Document feedback regarding the workflow effectiveness and efficiency. Document baseline metrics.	Does the workflow consider ways to reduce potential bias in treatments (e.g., alternative prescriptions; refusal to treat)? (1)
	In place less than 6 months Integrate workflow with all prescribers using EHR. Ensure providers are using the PMP per state requirements.	Percent of patients with opioids and benzodiazepines co-prescribed. Count the number of patients offered and/or referred to OUD treatment. Percent of qualified prescribers who indicate the clinical utility of workflow and alerts Rates of access to PMP	Do qualified prescribers review the PMP for all patients being prescribed opioids? (9) Is there a conflict resolution or grievance process for personnel, patients, and families if they think they were treated unfairly? (14)
	In place more than 6 months Conduct annual review and training on the workflow to ensure it continues to be effective, efficient, and clinically, organizationally, financially useful.	Number of qualified prescribers who participate in annual training. Percent of qualified prescribers who know the state requirements for using the PMP. Percent of personnel who report the workflow is effective, efficient, and clinically, organizationally, and financially useful.	Does the annual review consider issues of CLAS? (10) Does the organization communicate its progress towards CLAS? (15)

January 2023

CS.3: Your facility utilizes Enhanced Recovery After Surgery (ERAS) protocols (such as in areas like perioperative, inflammatory, musculoskeletal, and neuropathic injury settings).

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**Not implemented/no plan** Examine current practices for preoperative counseling, preoperative nutrition, fasting and carbohydrate recommendations, anesthetic and analgesic uses, and postoperative mobility. Provide training and mentorship for perioperative care teams such as that provided through ERAS Society: Implementation - ERAS® Society (erassociety.org).	Document current practices. Percent of personnel who attend trainings on ERAS and multimodal analgesia. Percent of personnel who know about the current ERAS practices.	What might be the potential bias in ERAS practices for culturally and linguistically diverse groups (e.g., perceptions of pain thresholds)? (2) Does the training include information about CLAS? (4)
	Plan to implement/no start date Develop workflow for implementing ERAS protocol. Train personnel on multimodal analgesia and ERAS workflow.	Document the process of protocol and workflow development. Percent of personnel trained on workflow.	Does the workflow inform all individuals about ERAS protocols in their preferred language? (8) Does the training include information about CLAS? (4)
	Plan to implement/start date set Implement ERAS protocol in one or two surgical settings.	Document the process of implementation in pilot settings. Document baseline metrics.	Are there any differences in implementation based on demographic data? (11) Were all patients informed about the availability of language assistance? (6)
	In place less than 6 months Implement in all surgical settings.	Rates of adherence to ERAS protocol across socio-demographic patient populations.	Are patients provided language assistance if necessary (5) Were surgery materials provided in easy-to-understand print and multimedia formats?(8)
	In place more than 6 months Conduct annual review on ERAS protocols and implementation processes. Offer annual training on ERAS and multimodal analgesia.	Percent of stakeholders who know the progress made on ERAS protocols. Percent of personnel who attend annual trainings on ERAS and multimodal analgesia.	Did the organization conduct an assessment to determine the populations perceptions of ERAS protocols? (10) Does the training include information about CLAS? (4)

CS.4: Your facility provides treatment for opioid withdrawal.

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families **Facility personnel** **Practitioners** **Administrators** **Payors**	**Not implemented/no plan** Develop organizational policies to address the needs of patients with OUD by engage frontline clinicians. Identify an algorithm for early identification and assessment to alleviate acute opioid withdrawal signs and symptoms. Ensure providers have the appropriate waiver for offering treatment for opioid withdrawal/ treatment, if necessary. Ensure medications for opioid use disorder are on hospital formulary and readily available for administration in the ED/inpatient setting.	Document process of algorithm and policy development. Percent of personnel who know the policy related to OUD. Count the number of providers trained, licensed to offer SUD/OUD screening, treatment, and referral. Document process for establishing formal or informal agreements to have OUD treatment medications. Percent of personnel who report being confident to offer SUD/OUD screening, treatment, and referral.	Are providers who offer SUD/OUD treatment trained to understand the potential cultural differences in medication usage? (4)
	Plan to implement/no start date Develop specific treatment protocols for rapid, patient-centered screening, treatment/ intervention and/or referral of opioid use disorder. Include IT to leverage EHR capabilities to support protocols developed. Conduct training on the socio-psycho-biological factors associated with SUD and evidence-based prevention, intervention, and referral. Identify programs that enhance partnerships with community organizations.	Document process for developing tools, organizational guidelines inclusive of IT personnel. Percent of providers who understand the socio-psycho-biological factors associated with SUD/OUD. Document programs available for referral within the service area.	Are all patients informed about language assistance if necessary? (6) Are the treatments offered appropriate based on CLAS goals and policies? (9)
	Plan to implement/start date set Implement protocol in one or two settings.	Document the process for implementation in pilot settings. Document baseline metrics.	Do personnel, patients, and/or caregivers find the services effective, equitable, understandable, and respectful? (1)

January 2023

CS.4: Your facility provides treatment for opioid withdrawal.			
Stakeholders	**Tasks**	**Evaluation**	**CLAS (Standard Number)**
Patients & families Facility personnel Practitioners	**In place less than 6 months** Implementation in all hospital settings.	Percent of patients who are prescribed opioids or have an OUD. Count the types of treatments offered/provided. Percent of patients screened, treated, and/or referred to higher level of care. Percent of patients who are in remission from or have resolved their SUD/OUD issue. Percent of patients with improved functional and quality of live outcomes? Percent of providers who report being confident to offer SUD/OUD screening, treatment, and referral.	What types of organizations are being partnered with for SUD/OUD services and support? (13)
Administrators Payors	**In place more than 6 months** Conduct annual review on protocols and implementation processes. Offer annual training on OUD treatments. Share process and outcome results with leadership and other stakeholders.	Document progress made on implementation. Percent of personnel who participate in annual OUD training. Percent of stakeholders who know the progress made to offer treatment for opioid withdrawal?	Does the community know about and support the organizations efforts to offer treatments for opioid withdrawal? (10)

Action Strategies (CS)

AS.1: Your facility has an established method to identify patients who may require OUD treatment (e.g., opioid risk tool, single screening questions, clinical opiate withdrawal scale [COWS] score).

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families **Facility personnel** **Practitioners** **Administrators** **Payors**	**Not implemented/no plan** Review the 2018 ADHS prescribing guidelines. Review and select at least one screening tool to identify patients in need of OUD treatment which includes risk of future overdose based on past substance use and overdose. Review and select screening tools that assess mental health issues including depression, trauma/ACEs, and anxiety. Train practitioners on how to start a conversation about OUD/SUD.	Number of providers who have reviewed the 2018 prescribing guidelines. Document process for selecting screening tool(s) appropriate for the patient population. Percent of providers who feel confident starting a conversation about OUD/SUD.	Are the screening methods available in the languages of the patient population? (8) Does training including information about CLAS? (4) Are the screening methods presented in a way that considers health literacy? (8)
	Plan to implement/no start date Train practitioners how to administer and interpret screening tools. Develop workflow for screening, reviewing the PMP, initiation of MOUD, and/or prescribing naloxone for those at increased risk for opioid overdose. Identify factors for determining if further assessment and referral is necessary.	Percent of practitioners who are trained and skilled at administering and interpreting screening tools. Document process for developing workflow. Document decision making process for further assessment/referral.	Did the workflow designers' partner with the community to determine if there is unintentional bias in the process? (13)
	Plan to implement/start date set Pilot workflow in one or two hospital settings.	Document process for implementation for the pilot. Document baseline metrics.	Are all patients informed about language assistance if necessary? (6)

January 2023

AS.1: Your facility has an established method to identify patients who may require OUD treatment (e.g., opioid risk tool, single screening questions, clinical opiate withdrawal scale [COWS] score).

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families **Facility personnel** **Practitioners** **Administrators** **Payors**	**In place less than 6 months** Implement workflow in all hospital settings.	Percent of providers who adhere to the workflow. Number of screening/risk assessments completed. Count the number and types of services and support offered. Number of referrals provided. Number of referrals completed. Number of naloxone kits offered and/or prescribed.	Were screening and services offered that were effective, equitable, understandable, and respectful? (1))
	In place more than 6 months Review workflow annually. Conduct annual training on OUD treatment. Share process and outcome results with leadership and other stakeholders.	Document progress made for identifying patients who may required OUD treatment. Percent of personnel who participate in annual OUD treatment training. Percent of stakeholders who know the progress made to offer to identify patients who may require OUD treatment.	What are the communities' strengths and resiliency factors and needs? (12)

January 2023

AS.2: Your facility refers for medication-assisted treatment (MAT)/substance use disorder treatment (i.e., buprenorphine or methadone in combination with behavioral health therapies)

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**Not implemented/no plan** Review the 2018 ADHS prescribing guidelines. Develop a checklist for determining when to treat and refer. Develop a list of MAT/SUD providers located in the area or via telemedicine.	Number of providers who have reviewed the 2018 prescribing guidelines. Document process for developing the checklist. Document the process for developing the list of MAT/SUD providers.	Does the checklist and provider list align with CLAS goals, policies, and management accountability? (9)
	Plan to implement/no start date Develop workflow for screening, reviewing the PMP, naloxone distribution, collecting UDS. Train practitioners on how to introduce referrals with patients. Work with recovery support specialists on linking patients to ongoing care. Identify programs that enhance partnerships with community organizations. Identify factors for determining if further assessment and referral is necessary.	Document process for developing workflow. Percent of practitioners trained. Count the number of recovery support specialists who can link patients to care. Document process for identifying partnerships and determining if further assessment/referral.	Does the workflow consider unintentional bias? (2) Do the referral organizations personnel reflect the patient population? (13)
	Plan to implement/start date set Pilot the workflow in one or two hospital settings.	Document the process for implementing the pilot. Document baseline metrics.	Do patients and caregivers know that language assistance is available? (6)

January 2023

AS.2: Your facility refers for medication-assisted treatment (MAT)/substance use disorder treatment (i.e., buprenorphine or methadone in combination with behavioral health therapies)

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**In place less than 6 months** Implement workflow in all hospital settings	Percent of practitioners who consistently use workflow. Percent of screening/risk assessments completed. Percent of patients who were offered, accepted, and provided SUD/OUD treatment. Count the number and types of services and support offered. Percent of patients referred to and assessed by referral organization. Percent of caregivers who were included in treatment decision making. Percent of caregivers who were offered referrals/supports. Percent of patients and caregivers who report acceptability of referral process. Number of referred patients still in treatment 30 days later.	Is information about referrals to SUD/OUD treatment available in easy-to-understand print and multimedia in the preferred languages of the patient population? (8)
	In place more than 6 months Review workflow annually. Share process and outcome results with leadership and other stakeholders.	Document progress made toward the organizations progress for referring for OUD/SUD treatment. Percent of stakeholders who report knowing the progress made.	Does the community know about and support the organizations efforts to offer treatments for SUD/OUD? (10)

AS.3: The electronic health record (EHR) has embedded workflow alerts related to opioid prescribing practices. (e.g., PDMP review, morphine milligram equivalent [MME] >50 per day at time of discharge, the concomitant use of benzodiazepines and opioids, patients at higher risk for adverse drug events [ADEs] related to opioids, naloxone prescription upon discharge)

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**Not implemented/no plan** Convene OSP leadership and IT teams to develop a plan for integrating workflow alerts including accountability measures (e.g., defining opioids as high alert medications, integration of PMP review, clinical decision-making tools, co-prescribing opioids, and benzodiazepines). Finalize plan including considering human and financial resources needed.	Document process for developing workflow alerts and determining accountability measures. Document expected and actual costs.	Did OSP and IT leadership consider how, if at all, alerts may introduce bias in prescribing? (4)
	Plan to implement/no start date Integrate workflow alerts into EHR. Test workflow alerts with one or two providers Train personnel on how to read and respond to alerts by including the patient.	Document process for integrating workflow alerts and accountability measures in EHR. Document process for testing workflow alerts. Percent of personnel trained on reading and responding to alerts.	Do alerts offer prompts for culturally responsive prescribing considerations (e.g., bias related to pain based on race/ethnicity)? (3)
	Plan to implement/start date set Deploy workflow alerts to one or two settings.	Document process for implementing workflow in one or two settings. Document baseline metrics.	Are workflow alerts linked to demographic data for monitoring impact of CLAS standards? (11)
	In place less than 6 months Implement in all hospital settings.	Percent of personnel who respond appropriately to alerts. Count the number of opioid prescriptions >90 MMEs daily. Average total MME per prescription. Percent of practitioners who report the workflow alerts are clinically relevant and helpful.	Is there a conflict or grievance resolution process to identify, prevent, and resolve conflicts? (14)
	In place more than 6 months Review workflow alerts annually. Share process and outcome results with leadership and other stakeholders.	Document progress made towards implementing workflow alerts. Percent of stakeholders who know about the progress made towards implementing workflow alerts.	Are the communities' strengths and resiliency factors and needs identified and responded to? (12)

Track and Report Strategies (TRS)

January 2023

TRS.1: Your facility incorporates, tracks, and trends naloxone discharge prescribing.

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**Not implemented/no plan** Convene OSP leadership team to draft policies and procedures for dispensing/administering naloxone. Train personnel on policies and procedures for dispensing/administering naloxone and resources (e.g., OAR Line).	Document process for developing policies and procedures. Percent of personnel trained on policies and procedures for dispensing/administering naloxone.	Do the policies and procedures include CLAS standards? (9) Did the training consider the standards of CLAS? (4)
	Plan to implement/no start date Develop clinical decision-making tools for when and how to provide patients with naloxone. Determine where to obtain naloxone. Incorporate tracking methods into the EHR.	Document the process for determining opioid overdose risk levels. Document process for determining where to obtain naloxone. Document process for incorporating naloxone prescribing and distribution methods into EHR.	Are there any unintended bias associated with documenting opioid overdose risk levels? (9) Are naloxone kits available with instructions in the language of the patient population? (8)
	Plan to implement/start date set Pilot test clinical decision-making tools in one or two settings and track results in EHR.	Document implementation process for the pilot. Document baseline metrics.	Does the EHR link reliable demographic data to monitor and evaluate the impact of CLAS? (11)

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Facility personnel Practitioners Administrators Payors	**In place less than 6 months** Implement clinical decision-making tools for naloxone in all hospital settings.	Percent of personnel who consistently use the decision-making tools. Percent of personnel who consistently track results in EHR. Count of post discharge follow up phone calls attempted, and percentage completed. Percent of personnel who use the OAR Line and the number of times. Number of patients/caregivers connected with OAR Line. Number of patients/caregivers provided a naloxone kit. Number of patients/caregivers provided a prescription naloxone kit. Number of patients/caregivers who report using naloxone.	Are the decision-making tools effective, equitable, understandable, and respectful? (1)
	In place more than 6 months Monitor trends in naloxone discharge prescribing annually. Share process and outcome results with leadership and other stakeholders	Document trends by using run or control chart using evaluation metrics. Document progress made towards offering naloxone at discharge. Percent of stakeholders who know about the progress made towards offering naloxone at discharge.	Do reports of trends include demographic data? (11)

January 2023

TRS.2: Your facility tracks and trends opioid quality measures on a dashboard that is shared with an interdisciplinary team (e.g., MME prescribing, naloxone administration, co-prescribing with benzodiazepines).

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families **Facility personnel** **Practitioners** **Administrators** **Payors**	**Not implemented/no plan** Convene OSP leadership team to develop plans for tracking opioid quality measures. Designate quality measures that are already tracked and others of relevance (e.g., MME; pain indicators). Consider related quality measures which track resilience and health promotion factors (e.g., behavioral/lifestyle changes; patients/family strengths). Engage key personnel in the development plans and timeline for implementing the dashboard.	Document timeline for developing and/or identifying opioid and other quality measures. Document successes/challenges with developing dashboard. Document adjustments to quality measure(s) through a systematic method(s).	Does the organization partner with the community to design, implement, and monitor dashboard metrics to ensure CLAS? (13)
	Plan to implement/no start date Vet the plan and timeline with stakeholders. Develop and operationalize dashboard within the EHR. Test dashboard for acceptability and usability.	Document the process for vetting plan with stakeholders. Document the process for operationalizing dashboard. Percent of personnel who report the dashboard is acceptable and useful.	Does the plan incorporate CLAS goals, policies, and management accountability? (9)
	Plan to implement/start date set Train interdisciplinary team members on dashboard metrics and uses. Pilot the implementation dashboard in one or two settings.	Percent of interdisciplinary team members trained on dashboard metrics and uses. Document process for pilot implementation. Document baseline metrics.	Do the dashboard results consider patient demographics? (11)

January 2023

TRS.2: Your facility tracks and trends opioid quality measures on a dashboard that is shared with an interdisciplinary team (e.g., MME prescribing, naloxone administration, co-prescribing with benzodiazepines).			
Stakeholders	**Tasks**	**Evaluation**	**CLAS (Standard Number)**
Patients & families Facility personnel Practitioners Administrators Payors	**In place less than 6 months** Deploy dashboard throughout the organization.	Percent of interdisciplinary team members consistently using dashboard. Percent of interdisciplinary team members who communicate dashboard results to other stakeholders. Count the number of opioid prescriptions >90 MMEs daily. Average total MME per prescription. Number of patients/caregivers provided a naloxone kit. Number of patients/caregivers provide a prescription naloxone kit. Number of patients/caregivers who report using naloxone. Percent of patients co-prescribed benzodiazepines with opioids.	Is language assistance offered to patients who have limited English proficiency or other communication needs on education about opioids? (5)
	In place more than 6 months Conduct annual reviews of dashboard Develop reports that are shared with stakeholders on a regular basis. Track trends over time.	Percent of OSP leadership team members who regularly use and communicate dashboard measures and trends with interdisciplinary teams and stakeholders. Document progress made towards opioid quality measures. Percent of stakeholders who know about the progress made towards implementing opioid quality measures. Document trends over time using run or control chart using evaluation metrics.	Did the organization communicate its progress towards implementing and sustaining quality measures with stakeholders? (15)

Education and Expertise Strategies (EES)

EES.1 Your facility offers staff members and providers educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based upon need.

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Practitioners Administrators Payors	**Not implemented/no plan** Convene OSP leadership to determine current educational resources that exist. Identify gaps and potential ways to fill these gaps either internally or through outside training (e.g., trauma/ACEs; overdose; prescribing; alternatives; complex pain; screening/assessment; integrated/coordinated care). Consider balancing the types of training to include ways to support/increase resilience and health promotion. Identify trainings that offer providers strategies for patients who are opioid naïve, exposed, and who have an OUD. Determine what, if any, costs, or reimbursements are associated with training efforts.	Document process for determining educational resources, gaps, and costs.	Does the organization consider training a method for providing effective, equitable, understandable, and respectable care for personnel, patients, and caregivers? (1)
	Plan to implement/no start date Develop resources for personnel to select and engage in regular training for SUD/OUD. Convene department heads to discuss importance of ongoing training and ways to ensure release time.	Document process for identifying training resources. Document procedures for ensuring personnel have time for training.	Do the trainings offer information about CLAS? (4) Do all personnel have access to the trainings and adequate time to participate? (4)
	Plan to implement/start date set Encourage participation in training through regular communications. Discuss and document compliance with Arizona's provider requirement for continuing education in SUD/OUD. Add ongoing training activities to employee evaluations. Release training resources to personnel.	Document methods for communicating the relevance and requirements of ongoing SUD/OUD training. Document process for including SUD/OUD training into employee evaluations. Document timeline for releasing training resources. Document baseline metrics.	Are trainings available in the language personnel prefer to learn? (1)

January 2023

EES.1 Your facility offers staff members and providers educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based upon need.

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Practitioners Administrators Payors	**In place less than 6 months** Monitor training attendance and types accessed.	Percentage of personnel who participate in educational resources/ training. Count the types of educational resources personnel access. Percentage of patients/caregivers who report personnel offer pain assessment, pain management, and opioids.	Do personnel have access to trainings that promote CLAS standards? (4) Do training resources support the provision of effective, equitable, understandable, and respectful care? (1)
	In place more than 6 months Review and update the training resources. Report to OSP leadership on the types and frequency of SUD/OUD trainings.	Percent of OSP leadership who are aware of the types and frequency of SUD/OUD trainings that personnel.	Do stakeholders know the organization's progress made towards personnel development? (15)

January 2023

EES.2 Your facility provides education to patients/caregivers regarding risks/benefits of opioid therapy and alternatives to opioids.			
Stakeholders	**Tasks**	**Evaluation**	**CLAS (Standard Number)**
Patients & families **Practitioners** **Administrators** **Payors**	**Not implemented/no plan** Convene group of patients/caregivers to seek their educational needs regarding SUD/OUD. Develop a multi-pronged approach and timeline for coordinating education for patients/caregivers (e.g., patients/caregivers; patients-providers; providers-providers). Determine reimbursement mechanisms, if any, for multi-pronged approach for offering patient/caregiver education.	Document process of convening a group of patients/caregivers. Diagram multi-pronged approach and timeline. Document reimbursement mechanisms and codes.	Does the approach consider appropriate goals, policies, and management accountability? (9)
	Plan to implement/no start date Identify potential alternatives to opioids and offer training to personnel. Develop or identify written and multi-media educational materials. Develop or identify verbal talking points for personnel to discuss opioid therapy and alternatives with patients/caregivers. Develop a shared decision-making plan that can be deployed with patients about the risk/benefits of opioid therapy.	Document list of alternative pain treatments. Percent of personnel who know of alternative pain treatments. Percent of personnel who consistently use written or multimedia educational materials Percent of personnel who consistently use a shared decision-making plan.	Are materials easy to understand and available in languages of the population? (8)
	Plan to implement/start date set Implement educational activities in one or two settings.	Percent of personnel who consistently use a shared decision-making plan. Percent of personnel who consistently use written or multi-media educational materials. Document baseline metrics.	Are all individuals informed about the availability of language assistance? (6)

EES.2 Your facility provides education to patients/caregivers regarding risks/benefits of opioid therapy and alternatives to opioids.

Stakeholders	Tasks	Evaluation	CLAS (Standard Number)
Patients & families Practitioners Administrators Payors	**In place less than 6 months** Implement patient/caregiver educational activities throughout the organization.	Percent of patients with defined goals Percent of patients documented as having planning and education Percent of patients with baseline assessments Percent of patients with reassessment in desired timeframe. Percent of patients who report receiving education about opioids therapy and alternatives via shared decision-making plan.	Is reliable demographic data available to look monitor health equity? (11)
	In place more than 6 months Review educational strategies annually.	Percent of patients who report receiving education about opioid therapy and alternatives via shared decision-making plans.	Does the shared decision-making model support the provision of effective, equitable, understandable, and respectful care? (1)

To know more: AzCRH OD2A page https://crh.arizona.edu/od2a

January 2023