



PCSS Implementation Pilot Initiative – Lessons Learned Cohort 1 (N=3)

Clinical Sites and Context	<ul style="list-style-type: none"> • Primary care clinic within a larger health system in a rural setting • Community-based networked health facility (multiple clinics) in a rural setting • FQHC with integrated medical, behavioral, and dental services in an urban area
Implementation Goals	<ul style="list-style-type: none"> • Short term: integrate buprenorphine treatment for OUD within existing patient caseloads; long term: make buprenorphine treatment for OUD available to new patients • Provide OUD and MAT education to all staff and waiver training to prescribers; set up EMR and workflow to accommodate SUD treatment • Provide OUD and MAT education to all staff, partner with outside organizations for higher levels of care, initiate onsite MAT for OUD (within 6 months) and add recovery coaches to clinic staff (from onsite patient pool)
Resources/ Strengths	<p><u>Internal: Providers and Patients</u></p> <ul style="list-style-type: none"> • Waivered providers already on team; some prescribing experience • Staff supports initiating or expanding MAT <p><u>Internal: Organization</u></p> <ul style="list-style-type: none"> • EMR already supports documentation of SUD and mental health screening, diagnosis, MAT, medications • Senior management support integration of MAT and having additional staff become waivered; strong buy-in from leadership (executive team considers MAT a priority) • Identified champion • Diverse implementation team (nursing, clinic administration, medical technicians, physicians) • Behavioral health staff already co-located; already working collaboratively with medical providers • Site provides a lot of health education already; clinic philosophy is to allocate as much time as needed to meet patient needs • Currently using an integrated care model <p><u>External</u></p> <ul style="list-style-type: none"> • Access to additional resources (e.g., state funding to support SUD integration) • State made funding improvement through Medicaid; MAT services reimbursable by Medicaid; MAT for OUD available • State DOH developed education initiative (instruction for prescribers and non-prescribers); established expectations • Recently merged with a larger health system increasing available services and resources • Referrals available for psychiatric inpatient and SUD IOP in the community

<p>Needs/ Barriers</p>	<p><u>Internal: Providers and Patients</u></p> <ul style="list-style-type: none"> • Stigma: SUDs in general, treating patients with SUD, factors that can adversely affect patient engagement and patient adherence (e.g., physical and psychosocial complexities of patients with SUD) • High percentage of patients uninsured with challenges paying for MAT • Patients not interested in group treatment options (e.g., group therapy that might be more efficient) • Insufficient knowledge, training, or experience on MAT and addiction among all staff, including prescribers • Patients have significant transportation challenges, including long distances to treatment facility <p><u>Internal: Organization</u></p> <ul style="list-style-type: none"> • Prior attempts to integrate SUD treatment and/or MAT were not successful; staff is hesitant to revisit and possibly repeat • No behavioral health onsite • Limited time for MDs to see patients (e.g., 10-25 patients/day) • Concern about adding complex patients that might require more physician time • No protocol for systematic SUD screening; not currently using validated screening tools • “Change fatigue” among staff due to competing new initiatives/pulled in numerous directions • Concurrent clinic activities (e.g., clinic moving locations) • Existing workflow challenges without a care coordinator (e.g., to maintain records, track patients) • Identifying stable peer recovery supports is challenging early in the implementation process <p><u>External</u></p> <ul style="list-style-type: none"> • Limited experience with referrals to community programs; limited knowledge of (severity) levels of community-based care • Challenges of providing continuity of care (e.g., communication and coordination of consulting with outside referrals) • Funding barriers, and reimbursement concerns • Wait-lists at outside referrals (e.g., 6-9 months to see a psychiatrist) • Limited number of practices that accept pregnant patients on MAT • Negative patient experiences at pharmacies (e.g., limits to the number of years of buprenorphine; unnecessary authorizations delaying dispensing) • Local 12-step meetings that do not support MAT; probation requiring NA; local residential recovery facility has an abstinence only policy (i.e., no MAT) • Transportation issues (limited treatment facilities in rural areas; limited public transportation) • Housing issues (e.g., families with SUD, women with children who are homeless) • Services for women with children (e.g., detox, inpatient beds) • Concerns about successful induction with State’s 8mg buprenorphine dose ceiling for Day 1
<p>Materials/ Resources Provided</p>	<ul style="list-style-type: none"> • SUD 101 education modules (presented to full staff –clinical and administration) • Waiver training information • Induction models • SBIRT resources to address prevention and early intervention • SUD screening tools

	<ul style="list-style-type: none"> • Peer recovery resources • BMC OBOT manual (nurse care manager model) • Intake/follow up templates (for modification) • Tapering protocols • PCSS Mentor program • PCSS Core Curriculum on Pain • Clinic workflow model • Business Plan for integrating SUD into primary care • Quality improvement indicator worksheet (to monitor launch)
Foundation and Preparation Phase Outcomes	<ul style="list-style-type: none"> • Identified champion and additional medical expertise; buy-in from leadership enhanced readiness • Presentation to staff by implementation facilitators on SUD and MAT, with Q/A process • Face-to-face consultations, with combined education • Providers received buprenorphine waiver training • Providers completed PCSS Core Curriculum on Pain • Identified champions at each of the 12 sites • Clinic staff attended “Nursing Essentials” workshop and clinic shadowing (nurse care manager model) • Clinic staff attended Peer Recovery training; working on Certification as a recovery coach • Working with risk management department to develop MAT medical release to facilitate work with behavioral health organization and other facilities • Partnered with a local behavioral health program that offered to spend 1 day/week in the clinic providing SUD counseling; now integrated into clinic • Engaging a local behavioral health vendor to assist and support • Screening patients 14 years and older for SUD
Time to Launch	Average: 9 months; range=6-12 months
Lessons Learned	<ul style="list-style-type: none"> • Reducing stigma through personal stories (e.g., co-worker disclosed SUD history during all staff meeting which created a tangible shift in attitude, enhanced momentum, relevance of the work) • Provide space for all staff to receive addiction education and to process expectations about the integration of MAT for OUD • Tailor pre-existing resources • Take a step-by-step approach, monitor attitudes and other matters along the way, continue to adapt the implementation process as needed • Medical champion in leadership role is important; engage multidisciplinary staff throughout process • Recognize and validate concerns during workflow development to enhance ownership and respect for all positions • When possible, include a local addiction specialist in the implementation process to share resources (e.g., treatment protocols and workflow processes that can be tailored) and other geographic specific information • In a multiple clinic setting, start in a few local clinics before expanding to all clinics

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| | <ul style="list-style-type: none">• Include naloxone distribution protocols (e.g., provided at one site with at least one OD reversal prevented)• MAT implementation is feasible and supported by several key facilitators: leadership buy-in is critical (including state-level expectations), integrated behavioral/medical services, lower stigma, and financial supports (e.g., state initiatives for funding, education)• Unobserved induction feasible and effective• Utilizing patients as peer recovery supports (once stable) takes time• Lives saved by offering MAT and including naloxone distribution |
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