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

Clinical Sites and Context	• 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	• 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	<u>Internal: Providers and Patients</u> • Waivered providers already on team; some prescribing experience • Staff supports initiating or expanding MAT <u>Internal: Organization</u> • 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 <u>External</u> • 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

Needs/ Barriers	<u>Internal: Providers and Patients</u> • 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 <u>Internal: Organization</u> • 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 <u>External</u> • 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
Materials/ Resources Provided	• 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

	• Peer recovery resources • BMC OBAT 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	• 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	• 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

	• 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