PCSS Implementation Pilot Initiative – Lessons Learned Cohort 1 (N=8)

The Implementation Pilot was a three year project within the Providers Clinical Support System (PCSS), which is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). In an effort to increase healthcare providers' knowledge and skills in the prevention, identification, and treatment of Substance Use Disorders (SUD) and Opioid Use Disorders (OUD), the goal of the Implementation Pilot was to provide OUD/SUD treatment implementation technical assistance to healthcare and mental health organizations for the use and/or expansion of SUD services.

Despite the known benefits of medications for addiction treatment (MAT), local healthcare teams are often unsure how to initiate the use and management of its delivery. Throughout this pilot, five facilitating organizations (AAAP, APA, AOAAM, ASAM and AMERSA) worked closely with the clinicians, administrators, and support staffs of eight clinical sites to facilitate education, support preparation activities, and assist in identifying and overcoming barriers to delivery of SUD services. Initial status of SUD integration, geographic location, and internal and external strengths and barriers varied between sites, resulting in eight unique experiences, but also highlighting numerous common lessons learned. To learn more about this PCSS Implementation Pilot Project, PCSS developed the lessons learned document below which includes information on each clinical site, their strengths, barriers, defined goals to overcome barriers to providing evidence-based practices and lessons learned, including resources used.

Clinical Sites and Context	• Primary care clinics within larger health systems in rural, suburban and urban settings • Community-based networked health facility (multiple clinics) in rural and urban settings • Standalone community based healthcare facility in a rural setting • FQHC with integrated medical, behavioral, and dental services in an urban area • Mental health program in a rural setting
Implementation Goals	• Integrate buprenorphine treatment for OUD within existing patient caseloads • Make buprenorphine treatment for OUD available to new patients • Develop a bridge with other clinics at the site to support linkage to MOUD • Expand from a small scale clinic to a larger program, incorporating higher levels of care • Provide OUD and MOUD education to all staff and waiver training to prescribers • Set up electronic medical record and create staff workflow to accommodate SUD treatment • Partner with outside organizations for higher levels of care • 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 • Provider already sought outside clinical mentorship • Staff supports initiating or expanding MAT <u>Organization</u> • EMR supports documentation of SUD and mental health screening, diagnosis, MOUD, medications • Senior management support integration of MOUD and having additional staff become waivered • Strong buy-in from leadership (executive team considers MOUD a priority) • Key stakeholders across the organization are supportive • Identified champion • Diverse implementation team (nursing, clinic administration, medical technicians, physicians) • Behavioral health staff co-located; already working collaboratively with medical providers • Site provides health education; clinic philosophy is to allocate as much time as needed to meet patient needs • Currently using an integrated care model • Outpatient induction protocol already developed <u>External</u> • Access to additional resources (e.g., state funding to support SUD integration) • State made funding improvement through Medicaid; MOUD services reimbursable by Medicaid; MOUD 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, including patients with SUD in general primary care settings, factors that can challenge patient engagement, adherence, and retention (e.g., physical and psychosocial complexities of patients with SUD) • High percentage of patients uninsured with challenges paying for MOUD (high variability across states) • Patients not interested in group treatment options (e.g., group therapy that might be more efficient) • Insufficient knowledge, training, or experience of MOUD and addiction among all staff, including prescribers • Patients have significant transportation challenges, including long distances to treatment facility (magnified in rural settings) • Waivered providers are not prescribing

	• Concern about patient diversion of medication, how to monitor and how to set boundaries <u>Organization</u> • Prior attempts to integrate SUD treatment and/or MAT were not successful; staff is hesitant to revisit and possibly repeat • Lack of ownership in providing care for patients with OUD (whose job is it) • 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; introduction of new electronic medical record software) • 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 • Change in priorities for upper management causing a pause in progress <u>External</u> • Limited experience with referrals to community programs; limited knowledge of levels of community-based care • Challenges of providing continuity of care (e.g., communication and coordination of consulting with outside referrals) • Funding barriers, 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 MOUD • 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 MOUD; probation requiring NA; local residential recovery facility has an abstinence only policy (i.e., no MOUD) • 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 and algorithms

	• SBIRT resources to address prevention and early intervention • SUD screening tools • Peer recovery resources • BMC OBAT manual (nurse care manager model) • Integrated care models • 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 all clinic sites who were required to complete SUD 101 modules • Identified champion became an approved PCSS Waiver Training instructor • 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 MOUD medical release to facilitate work with behavioral health organization and other facilities • Engaging a local behavioral health vendor to assist and support; integrated into clinic • Screening patients 14 years and older for SUD • Advocacy on pharmacy-related concerns on a state and national level • New found resources as a result of collaborations with community organizations • Integrated both extended-release naltrexone and buprenorphine • Received ongoing support from state grants and agencies • Constructed a strategic plan to resolve staffing issues and a business plan for resource allocation

Time to Launch	Average: ≅9 months; range=6-12 months All 8 sites began prescribing; 2 sites did not achieve sustainable implementation
Lessons Learned	• Reduce 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 to meet site-specific needs • Utilize a systematic, step-by-step process of integration; start small with a few patients, utilize rapid assessment cycles • Identify and address staff concerns and stigma early in the process to promote forward movement • Monitor attitudes and other indicators along the way, continue to adapt the implementation process as needed • Medical champion in leadership role as well as motivational support from upper management 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 • Understand other organizational priorities and set concrete timeframes and goals • Include naloxone distribution protocols (e.g., provided at one site with at least one OD reversal prevented) • MOUD implementation is feasible and supported by several key facilitators: leadership buy-in (including state-level expectations), integrated behavioral/medical services, increase awareness of stigma, and financial supports (e.g., state initiatives for funding, education) • Unobserved induction feasible and effective (i.e., home induction) • Utilize former patients as peer recovery supports (once stable), but recognize that this takes time and support • Lives saved by offering MOUD and including naloxone distribution • Conduct a community needs assessment; assist in motivation, supports team building, identifies new resources
Overall Results	• 27 separate clinic sites participated; 45 providers received waiver training; 19 providers are currently prescribing.

TABLE NOTES:

BMC OBAT manual (nurse care	The purpose of this manual is to provide detailed policies and protocols of the Office Based Addiction Treatment

manager model)	program for the use of buprenorphine (alone and in combination with naloxone) and naltrexone (oral and extended-release injectable formulations) in the treatment of substance use disorders at Boston Medical Center. These policies and protocols are meant to provide best practice guidelines to clinicians utilizing buprenorphine and/or naltrexone for the management of opioid and alcohol use disorders in mainstream medical practices, and to expand access to treatment
Business Plan for integrating SUD into primary care	Service delivery models for buprenorphine in primary care
EMR	Electronic Medical Record
FQHC	Federally Qualified Health Center
Induction models and algorithms	Models and documents outlining the procedure to be followed on the patient's first day of induction onto buprenorphine/naloxone and to make staff aware of potential adverse events
Intake/follow up templates	**Intake templates** and questionnaires used by treatment program personnel to obtain information from a prospective patient and to provide information to them about the program, services offered and expectations of patients receiving MAT. **Follow up templates** outline patient follow-up appointments, their scheduling, and what type of activities shall occur at those appointments. These templates also outline patient behaviors to identify to assist with relapse prevention and the COE's response to those behaviors
Integrated care models	Models illustrating how opiate addiction treatment is integrated into the current health and substance abuse treatment continuum of care
MAT	Medications for Addiction Treatment (formerly known as medication assisted treatment)
MOUD	Medications for Opioid Use Disorder
OD	Overdose
OUD	Opioid Use Disorder
PCSS Core Curriculum on Pain	This course provides clinicians with a solid foundation in treating chronic pain. The curriculum was created in an effort to consolidate the vast amount of information available to clinicians into a course that provides clinicians with the information, resources, and knowledge they need to treat their patients who suffer from chronic pain, including non-pharmacological treatments. The result is the most comprehensive and up to date curriculum developed thus far for

	the treatment of chronic pain.
PCSS Mentor program	PCSS Mentor Program is aimed at improving providers' confidence and skills in preventing, identifying, and treating substance use disorders, opioid use disorder and chronic pain. The program is designed to assisted providers in using evidence-based practices when prescribing opioids and the effective use of medications in treating OUD.
Peer recovery resources	Recovery-related resources about peer supports and services
Quality improvement indicator worksheet (to monitor launch)	A framework to guide the evaluation of implementation strategies to promote public health outcomes
SBIRT resources to address prevention and early intervention	Resources for Screening, Brief Intervention and Referral to Treatment (SBIRT)
SUD 101 education modules	An introductory course on substance use disorders designed for all staff working within a health care setting, from the administrative staff at the front desk, all clinical staff, and even the CEO. The goal is to provide a better understanding of substance use disorders and the basics on how to prevent, identify, and treat them. Each module includes clinical case discussions
SUD screening tools	Tools, templates and questionnaires used to screen Substance Use Disorders
Tapering protocols	Protocols to support the tapering of patients off medications for addiction treatment
MAT Waiver training information	While PCSS provides trainings on a broad range of substance use disorder treatments, its primary focus is on treatment of opioid use disorders (OUD). Opioids include a class of drugs often prescribed for pain—morphine, fentanyl, oxycodone, and hydrocodone—as well as illicit drugs, such as heroin. The Federal Drug Administration (FDA) has approved three medications for the treatment of OUD: methadone, buprenorphine, and naltrexone. PCSS offers free MAT waiver training to eligible providers (physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, and physician assistants) to fulfill the 8 hour and 24 hour training requirements. Visit PCSS for a listing of available courses.